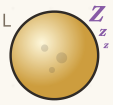
NCLEX 2026 MENTAL HEALTH ● SLEEP-WAKE DISORDERS ● PSYCHOSOCIAL INTEGRITY



Insomnia

A clinical-judgment reference for sleep-wake dysregulation — including hyperarousal pathophysiology, pharmacologic priorities, CBT-I, and high-yield NCLEX traps.

DSM-5-TR · ICD-10 G47.00
Domain · Psychosocial Integrity
System · CNS / Sleep-Wake
Test Plan · 2026 NCLEX

01 Definition & Overview

What it is: Persistent difficulty **initiating** sleep, **maintaining** sleep, or experiencing **non-restorative** sleep despite adequate opportunity — with clinically significant daytime distress or impairment.

DSM-5-TR criteria: Symptoms occur **≥3 nights/week** for **≥3 months** (chronic). Short-term insomnia < 3 months.

Why it matters: Insomnia worsens depression, anxiety, cardiovascular risk, and impairs psychomotor function — increasing accident, fall, and suicide risk.

Types: *Primary* (psychophysiological, no identifiable cause) vs. *Secondary* (due to medical, psychiatric, or substance-related cause — most common).

~30%
U.S. ADULTS WITH INSOMNIA SYMPTOMS

10%
MEET CRITERIA FOR CHRONIC INSOMNIA DISORDER

2×
MORE COMMON IN WOMEN THAN MEN

3-3-3
NIGHTS/WEEK · MONTHS · "ADEQUATE" OPPORTUNITY

02 Pathophysiology — The Hyperarousal Model

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
Trigger	**↑ HPA axis**	**↓ GABA**	**↓ Melatonin**	**Conditioning**
Stress, pain, mood disorder, substance, or medical illness →	Cortisol & ACTH rise; SNS tone increases →	Inhibitory tone falls → cortical hyperarousal →	Circadian rhythm dysregulates; bedtime cue lost →	Bed = wakefulness → self-perpetuating cycle

Neurochemical Imbalance

- **↓ GABA & ↓ adenosine** — sleep-promoting
- **↑ Orexin/hypocretin** — wake-promoting
- **↑ Norepinephrine, ↑ cortisol** — arousal
- **↓ Melatonin secretion** from pineal gland
- **↓ Slow-wave & REM sleep** = non-restorative

Behavioral & Cognitive Factors

- **Conditioned arousal** — bed becomes a cue for wakefulness
- **Catastrophic thinking** — "I'll never function tomorrow"
- **Compensatory behaviors** — naps, alcohol, early bedtimes (worsen the cycle)
- **Clock monitoring** — increases sympathetic arousal

03 Signs & Symptoms

Early / Mild

PRESENTING

- Sleep latency >30 minutes (difficulty falling asleep)
- Frequent nighttime awakenings, fragmented sleep
- Early-morning awakening, unable to return to sleep
- Daytime fatigue, drowsiness, low energy
- Difficulty concentrating, slowed processing
- Irritability or mild anxiety
- Reduced motivation, decreased productivity
- Frequent yawning, eye fatigue, tension headaches

Late / Severe

RED FLAGS

- Worsening of depression or anxiety PRIORITY
- New or escalating **suicidal ideation** 911 / SAFETY
- Microsleep episodes — falling asleep mid-task DRIVING RISK
- Significant cognitive impairment, memory loss
- Increased fall risk (esp. older adults) FALL
- Hallucinations or psychotic symptoms (severe deprivation)
- Worsening hypertension, arrhythmias, glycemic control
- Substance misuse (alcohol, OTC sleep aids, stimulants)

04

Priority Nursing Interventions

ASSESS **First — complete sleep history:** sleep latency, awakenings, duration, daytime impairment, naps. Use a 1–2 week sleep diary.

SCREEN **Safety first:** assess fall risk, driving safety, and **suicide risk** with worsening symptoms. Insomnia is an independent suicide risk factor.

REVIEW **Medications & substances:** caffeine, nicotine, alcohol, stimulants, beta-blockers, steroids, SSRIs, decongestants.

IDENTIFY **Comorbidities:** depression, anxiety, PTSD, GERD, pain, OSA, restless legs, perimenopause, hyperthyroidism.

PROMOTE **Sleep hygiene** (foundational education) and **stimulus control** — bed for sleep & sex only.

REFER **CBT-I = first-line treatment** (gold standard) — more effective long-term than medications.

TEACH **Sleep restriction therapy:** limit time in bed to match actual sleep, then gradually extend as efficiency improves.

ADMINISTER **Pharmacotherapy** only when needed — lowest effective dose, shortest duration. Adjunct, not replacement, for behavioral therapy.

MONITOR **Drug effects:** next-day sedation, complex sleep behaviors (zolpidem), falls, paradoxical agitation (esp. elderly).

MODIFY **Environment:** dim lighting, cool room (60–67°F / 16–19°C), white noise, blackout curtains, comfortable bedding.

ENCOURAGE **Relaxation techniques:** diaphragmatic breathing, progressive muscle relaxation, guided imagery, mindfulness.

EVALUATE **Treatment response:** total sleep time, sleep efficiency (≥85%), daytime functioning, mood, safety.

05 Pharmacology

Non-Benzodiazepine Receptor Agonists ("Z-drugs") PREFERRED

`zolpidem (Ambien) · zaleplon (Sonata) · eszopiclone (Lunesta)`

MECHANISM

Selective
BZ_1 (OMEGA-1)
GABA-A receptor agonist → CNS depression → sleep onset; less anxiolytic effect than benzos.

SIDE EFFECTS

COMPLEX SLEEP BEHAVIORS
(sleep-driving, sleep-eating, sleep-sex — **FDA BLACK BOX WARNING**), anterograde amnesia, daytime drowsiness, dependence with prolonged use.

NURSING CONSIDERATIONS

Take **IMMEDIATELY BEFORE BED** with 7–8 hr sleep window. No alcohol. ↑ Fall risk in older adults.
D/C IMMEDIATELY if complex sleep behaviors occur.

Benzodiazepines SHORT-TERM ONLY

`temazepam (Restoril) · triazolam (Halcion) · estazolam · flurazepam`

MECHANISM

Bind GABA-A receptor → ↑ chloride influx → CNS depression. Less selective than Z-drugs.

SIDE EFFECTS

Tolerance, dependence, rebound insomnia, **RESPIRATORY DEPRESSION**, anterograde amnesia, falls, paradoxical agitation in elderly.

NURSING CONSIDERATIONS

AVOID IN OLDER ADULTS (Beers Criteria).
NEVER COMBINE WITH OPIOIDS (Black Box).
TAPER SLOWLY — abrupt D/C → seizures, severe rebound.

Melatonin Receptor Agonist SAFEST

`ramelteon (Rozerem) · tasimelteon · melatonin (OTC)`

MECHANISM

Selective
MT_1/MT_2
agonist in suprachiasmatic nucleus → mimics endogenous melatonin → sleep onset.

SIDE EFFECTS

Generally minimal: dizziness, fatigue, headache.
NO ABUSE POTENTIAL.
Avoid in severe hepatic impairment.

NURSING CONSIDERATIONS

NON-CONTROLLED — first-choice for older adults & those with substance use history. Avoid fatty meals (↓ absorption).

Orexin Receptor Antagonists (DORAs) NEWER

`suvorexant (Belsomra) · lemborexant (Dayvigo) · daridorexant (Quviviq)`

MECHANISM

Block
OREXIN/HYPOCRETIN
(wake-promoting neuropeptide) → promotes sleep without GABA effects.

SIDE EFFECTS

Next-day drowsiness, abnormal dreams, sleep paralysis, mild cataplexy-like symptoms.

NURSING CONSIDERATIONS

Take 30 min before bed with ≥7 hr sleep window.
CONTRAINDICATED IN NARCOLEPSY.
Schedule IV controlled.

Sedating Antidepressants OFF-LABEL

`trazodone · doxepin (low-dose, Silenor) · mirtazapine`

MECHANISM

Antagonize
H_1 HISTAMINE
and serotonergic receptors → sedation. Useful when insomnia + depression coexist.

SIDE EFFECTS

ORTHOSTATIC HYPOTENSION, dry mouth, weight gain (mirtazapine), **PRIAPISM** with trazodone (rare but emergent — seek ED).

NURSING CONSIDERATIONS

Useful in comorbid depression. Educate on rising slowly. Trazodone: **REPORT ERECTION >4 HR IMMEDIATELY**.

Antihistamines (OTC) AVOID IN ELDERLY

`diphenhydramine (Benadryl, ZzzQuil) · doxylamine (Unisom)`

MECHANISM

H_1 blockade → sedation. Strong anticholinergic activity.

SIDE EFFECTS

Anticholinergic: DRY MOUTH, URINARY RETENTION, CONSTIPATION, BLURRED VISION, CONFUSION/DELIRIUM in elderly.

NURSING CONSIDERATIONS

AVOID IN OLDER ADULTS

(Beers Criteria). Tolerance develops in days. Not for chronic use.

06 | NCLEX Test Traps ⚠

TRAP 01 · First-Line Therapy

CBT-I, not medication, is first-line for chronic insomnia. Choose behavioral interventions OVER "administer zolpidem" when both are listed.

TRAP 02 · Drug Class Confusion

Z-drugs are NOT benzodiazepines, but share GABA-A mechanism. Both carry dependence risk; Z-drugs have unique **complex sleep behavior** warning.

TRAP 03 · Complex Sleep Behaviors

Sleep-driving, sleep-eating, sleep-walking on zolpidem = **EMERGENT — discontinue immediately**. Do *not* "monitor and document" — that's wrong.

TRAP 04 · Benzodiazepine Withdrawal

NEVER abruptly stop benzos. Risk: seizures, severe rebound, delirium. Always **taper**. Same applies to chronic Z-drug use.

TRAP 05 · Older Adults & Sedatives

Diphenhydramine and benzodiazepines are **on Beers Criteria** — AVOID in elderly. Best choices: **ramelteon**, low-dose doxepin, melatonin.

TRAP 06 · Alcohol "Helps Me Sleep"

Alcohol may shorten sleep latency but **disrupts sleep architecture**, suppresses REM, causes rebound awakening. **Worsens** insomnia overall.

TRAP 07 · Naps

Naps >30 min or after 3 PM **reduce sleep drive** and worsen nighttime insomnia. Brief power naps (≤20 min) may be acceptable.

TRAP 08 · Insomnia & Suicide

Insomnia is an **independent risk factor for suicide**. Always screen for SI when sleep deteriorates — especially in depression/PTSD.

TRAP 09 · Symptom vs. Disorder

Insomnia **symptom** ≠ Insomnia **disorder**. Disorder = **≥3 nights/wk × ≥3 months** + daytime impairment.

TRAP 10 · Timing of Z-drugs

Take zolpidem **only with ≥7–8 hr sleep window** available. Taking it at 3 AM for early awakening = next-morning sedation, driving risk.

07 Patient Education

Sleep Environment

- Keep bedroom **cool (60–67°F)**, dark, and quiet
- Use bed for **sleep and intimacy only** — no work, TV, or scrolling
- Blackout curtains, white noise, comfortable mattress & pillows
- **Turn clock away** — avoid clock-watching
- Reserve a "wind-down" space outside the bedroom

Schedule & Routine

- **Same bedtime & wake time daily** — including weekends
- Establish a 30–60 min relaxing pre-bed routine
- If unable to sleep in **20 min, get up** & do something calm in dim light until drowsy
- Limit daytime naps to <30 min, before 3 PM
- Get morning sunlight exposure to anchor circadian rhythm

Substances & Diet

- **No caffeine after noon** (half-life ~5–6 hr)
- Avoid **nicotine** — it is a stimulant, especially near bedtime
- Limit alcohol; avoid within 3 hours of bed
- No heavy/spicy meals 2–3 hr before bed
- Light snack (carb + protein) is OK if hungry

Screens & Light

- **No screens 1 hr before bed** — blue light suppresses melatonin
- Use night-mode/blue-light filters if needed
- Dim household lights in the evening
- Bright light therapy **in the morning** for circadian regulation
- Charge phone outside the bedroom

Exercise & Activity

- Aim for **30 min moderate exercise** most days
- Avoid vigorous exercise within 3 hr of bedtime
- Gentle yoga or stretching in evening is fine
- Spend time outdoors during the day

Worry & Relaxation

- Schedule a **"worry time"** earlier in the day — journal concerns
- Practice diaphragmatic breathing, progressive muscle relaxation
- Try guided imagery, mindfulness meditation, or 4–7–8 breathing
- Avoid catastrophizing: one bad night ≠ disaster tomorrow
- Report worsening mood or any **thoughts of self-harm immediately**

08 Memory Boosters & Mnemonics

Sleep Hygiene — SLEEP HYGIENE

S	**S**chedule consistent	**L**	**L**imit blue light
E	**E**xercise (early)	**E**	**E**nvironment cool/dark
P	**P**re-bed routine	**H**	**H**eavy meals avoid
Y	**Y**awn = go to bed	**G**	**G**et up if not asleep
I	**I**ntoxicants out	**E**	**E**liminate long naps
N	**N**o clock watching	**E**	**E**nd screens early

"3-3-3 Rule" — Insomnia Disorder Dx

≥**3** nights/week · For ≥**3** months · Despite adequate (**3** = ample) opportunity to sleep

The "Z-Drug Z's"

`Z` olpidem · `Z` aleplon · es `Z` opiclone

"BED" — Stimulus Control

Bed **E**quals **D**rowsy — bed for sleep & sex only

"CBT-I First"

Cognitive restructuring · **B**ehavioral (sleep restriction + stimulus control) · **T**herapy before pills · **I**nsomnia treatment of choice

"NO PILL" for Elderly Insomnia (Beers)

No benzos · **O**TC antihistamines avoid · **P**refer ramelteon · **I**ncreased fall risk · **L**ow-dose doxepin OK · **L**ifestyle first

Red Flag = "SAD-S"

Suicidal ideation · **A**ccident/driving risk · **D**elirium/psychosis · **S**evere mood worsening