



Original Article

Chronic sleep difficulties in non-depressed young women: a longitudinal population-based investigation

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ABSTRACT

Objectives/Background: Young women are at a risk of poor sleep, but the extent to which their sleep difficulties remain chronic is not known. Little is also known about the frequency of seeking health care for sleep and satisfaction with that health care. This longitudinal study investigated these issues over nine years in women who reported sleep difficulties over the preceding 12 months.

Patients/Methods: Data from the Australian Longitudinal Study on Women's Health were analysed ($N = 9683$). Information on self-reported sleep difficulties, help seeking, and health-care satisfaction was obtained from four surveys collected from 2000 (aged 22–27 years) to 2009. Generalized estimating equations were conducted to calculate odds ratios (OR) for the likelihood of women who reported sleep difficulties in 2000 to report sleep difficulties at subsequent surveys.

Results: The prevalence of self-reported sleep difficulties 'often' was consistent at 9.1–10.8%. Women who reported sleep difficulties 'often' in 2000 had a markedly increased risk of continued sleep difficulties 'often' over the subsequent 9 years [2003: OR (95% confidence interval, CI) = 11.07 (8.03–15.27); 2006: 12.19 (8.08–16.88); 2009: 10.70 (7.57–15.12)]. Of women who reported sleep difficulties 'often' in 2000 ($N = 981$), 45.1% had persistent sleep problems and 21.1% experienced relapse of symptoms. About one-third of women who reported sleep problems 'often' sought help.

Conclusion: Self-reported frequent sleep difficulties in non-depressed young women strongly predicted a continuation of this level of sleep difficulty over a decade, even if help is sought. Current health practice may not be breaking the ongoing chronicity of sleep difficulties in young women.

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1. Introduction

Numerous epidemiological studies have estimated that about a third of the adult population report some dissatisfaction with their sleep. Insomnia, or difficulties with sleep onset, maintenance or early morning awakenings that cause significant daytime impairment and distress, has an estimated overall prevalence of 5–10% of the general population [1–3]. The prevalence increases with age, and it is twice as common in women as in men [2,4]. The course and prognosis of insomnia symptoms are highly variable. Sleep difficulties are often situational and transitory, lasting only a few weeks. In some cases, the sleep problems remain after the initial causal factor is removed.

However, in many cases, individuals may be predisposed to develop sleep difficulties because of personality traits or co-morbid conditions, often making the disorder chronic or recurrent over time. It is estimated that around 50% of those who experience an episode of insomnia will continue to have symptoms up to one year later [5]. Chronic insomnia is associated with an increased risk of psychopathology, including depression and anxiety [6,7] and other negative health outcomes [8,9].

Despite being a prevalent condition, there are limited data on the natural history of insomnia [10–12], particularly in those who are most vulnerable to the condition [13]. A number of studies have examined the trajectory of persistent insomnia in community cohorts, with prevalence rates of between 5% and 20%, depending on how insomnia was defined [5]. However, many of these studies are limited by short follow-up periods or retrospective data-analysis methods. In a short-term study, 69% of people who reported insomnia symptoms at baseline still had insomnia at one year follow-up, and the persistence of insomnia increased by 10% for each 10-year increase in age [14]. A study by Morin assessed the trajectory

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of insomnia in a community sample of >380 individuals over a three-year period [10]. Insomnia persisted in 46% of individuals across the 3 years, and it was more common in women and those with more severe symptoms at baseline. Remission rate was >50%; however, over half of these people eventually relapsed. In a Swedish community sample of 2602 men aged 30–69 years, those who had insomnia at baseline had a 6.45 times increased risk of having insomnia 10 years later [15]. Only 56% of the men who reported insomnia at baseline did not report insomnia at follow-up. These studies suggest that insomnia is a persistent condition, associated with low remission rates and high relapse rates.

Insomnia is becoming increasingly prevalent in young adults [7]. However, there are limited data regarding whether insomnia also persists in this age group. In a longitudinal study spanning 20 years, Buysse and colleagues assessed the chronicity of insomnia and co-morbid symptoms in 591 young adults [5]. The prevalence of insomnia increased slightly from the ages of 20–40 years, tended to persist within individuals and was higher in women. Longitudinal analysis indicated that pure insomnia (ie not co-morbid with other psychopathologies) was associated with future episodes of insomnia, with odds ratios (ORs) of between 2.5 and 4.0 across successive surveys. Whether the persistence of insomnia symptoms in women specifically is higher than this was not examined. Chronic insomnia increases the risk of a range of health issues and psychopathologies, and young women may be at a particularly high risk of depression and anxiety if sleep issues are not addressed [7]. Given the higher prevalence of insomnia in women, and its association with a number of negative health outcomes [8,9], it is important to understand the persistence of the disorder in this population. It is also not well documented whether insomnia not associated with another psychiatric condition also persists over time.

In clinical practice, insomnia is under-recognized and undertreated. Contributing factors are the general community's lack of knowledge regarding the treatment options for sleep and/or individuals not seeking treatment. Community surveys report that only a third of people with sleep problems sought help [4,16]. An Australian study found that 11% of the adult sample reported seeking help for sleep problems, but only 6% of those under 25 years of age reported seeking help [16]. This figure is higher in samples from primary care, with between 31% and 52% of respondents reporting that they have discussed their sleep with their physician [17–19]. Primary determinants of help seeking for insomnia have been identified, and they include being female, more severe insomnia, greater daytime symptoms, greater number of co-morbid conditions, and lower socio-economic status [4,16,18]. Some studies report that older age is associated with increased help seeking [16], whereas other studies in primary-care patients have found that younger people tend to seek more help for their sleep [18]. Understanding more about help-seeking behaviour for sleep difficulties, and the level of satisfaction with the outcomes of such help seeking, are important steps towards improved treatment and education about sleep problems in the community.

The aim of this study was to examine whether sleep difficulties persist over a 9-year time period in a large community sample of young women who, at baseline, do not have depression or anxiety. A secondary aim was to determine help-seeking behaviour in young women over time, the corresponding levels of satisfaction with the help sought and how these variables may interact with the level of sleep difficulty.

2. Methods

2.1. Data collection

The current study used data from the Australian Longitudinal Study on Women's Health (ALSWH). This longitudinal cohort study

is designed to track the health of women over a period of at least 20 years. The ALSWH sample was drawn from the database of the Health Insurance Commission, the universal provider of basic health insurance, which involves all women in Australia. The participants in the survey are broadly representative of the Australian population; however, women from rural and remote areas were sampled at twice the rate of women in urban areas. The surveys collected demographic and health data using a wide range of questionnaire items measuring physical, social, mental health status, exercise and diet, and health-care use (including the use of medications). All women had completed comprehensive health surveys in 1996, 2000, 2003, 2006 and 2009; the last four collection years were used in the current analyses.

The current study focused on the 1973–1978 birth cohort, which included women aged 22–27 years in 2000. The sample consisted of 9683 young women in the 2000 survey, 9078 women in the 2003 survey, 9140 in the 2006 survey, and 8196 women responded in 2009. The surveys can be accessed online [20], along with details of where specific questions have been validated or used previously [21].

2.2. Measures

2.2.1. Sleep difficulty

One item relating to *sleep difficulty* asked participants whether they had experienced sleep difficulties in the last 12 months, rated on a four-point scale ranging from 0 (never), 1 (rarely), 2 (sometimes) to 3 (often). Sleep difficulties 'often' was used as the independent variable.

2.2.2. Help-seeking behaviour

With regard to sleep difficulties, one item asked participants the following questions: (a) *did you seek help* and (b) *if you did seek help, please mark if you were NOT satisfied with that help*.

2.2.3. Psychological variables

Respondents were asked the following questions: *In the last three years, have you been diagnosed or treated for (a) depression (not post-natal) or (b) anxiety disorder?* Respondents were also asked: *In the past 12 months, have you had (a) depression or (b) episodes of intense anxiety?* This was rated on a four-point scale ranging from 0 (never), 1 (rarely), 2 (sometimes) to 3 (often).

2.2.4. Demographics and selected variables

A question regarding *education level* was categorized across seven levels (no formal qualification, year 10, year 12, trade/apprenticeship, certificate/diploma, university degree, and higher university degree). The *frequency of binge-drinking* question asked how often respondents had five or more standard drinks of alcohol on one occasion categorized across five levels ('never' to 'more than once a week'). *History of abuse* (physical, emotional or sexual, or harassment) was also recorded and scored dichotomously (yes or no). One question concerning *body-weight dissatisfaction* asked 'How much would you like to weigh now?' and the six options ranged from 1 (happy as I am), 2 (1–5 kg more), 3 (>5 kg more), 4 (1–5 kg less), 5 (6–10 kg less), to 6 (>10 kg less). A dichotomous variable was obtained by combining the first five options into one category, and the last option became a second category; thus, this variable only related to dissatisfaction with being ≥10 kg overweight. The above four variables were included in the adjusted regression model as they had been found in a previous study using this data set (2003 survey) to make a significant contribution to sleep difficulty when a range of other variables (including depression and anxiety) were controlled [22]. Respondents were also asked whether they had used different types of prescription medication ('prescription medication for your nerves', 'prescription medication to help you sleep' and 'prescription

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