WORKING LIFESTYLES AND SLEEPLESS NIGHTS: THE ROLE OF WORK IN PATIENT EXPLANATORY MODELS OF INSOMNIA

Dana L. McClellen, B.A.

Thesis Prepared for the Degree of

MASTER OF ARTS

UNIVERSITY OF NORTH TEXAS

December 2006

APPROVED:

Kevin Yoder, Major Professor
Doug Henry, Committee Member
David Williamson, Committee Member and Chair of the Department of Sociology
Thomas L. Evenson, Interim Dean of the College of Public Affairs and Community Service
Sandra L. Terrell, Dean of the Robert B. Toulouse School of Graduate Studies

Interviews conducted with patients receiving treatment for insomnia at one of two sleep medicine clinics, located in Texas and Oregon, suggest that work is a pivotal influence in shaping the respondents’ interpretations, explanations and behaviors relating to insomnia. “Work” includes such facets as the nature of one’s occupation, the associated volume or amount of work required, mental demands related to work, work schedules and work-related stress. Specifically, results reveal: 1) nearly 60% of the sample identify work as a primary or perpetuating cause of their insomnia, 2) respondents often report work as influencing the nature and importance of their sleep, 3) sleep is considered a problem, and medical intervention is solicited, after work is affected, and 4) work performance is a major consideration in determining treatment efficacy and compliance.
# TABLE OF CONTENTS

LIST OF TABLES ................................................................................................... iv

Chapters

1. **INTRODUCTION** ................................................................................ 1
   - Defining Insomnia ........................................................................... 1
   - Working Lifestyles in the United States ....................................... 3
   - Significance of the Study .............................................................. 3
   - Theoretical Framework ............................................................... 5
   - Focus of the Study ...................................................................... 6

2. **LITERATURE REVIEW** ..................................................................... 7
   - Effects of Insomnia on Work ...................................................... 7
   - Sociology of Sleep ...................................................................... 8
   - Sleepless America .................................................................... 11
   - Effects of Work on Insomnia ..................................................... 12

3. **METHODS** ..................................................................................... 15
   - IRB Approval ........................................................................... 15
   - Methodology ............................................................................ 16
   - Data Collection and Analysis .................................................... 16
   - Sample Characteristics .............................................................. 17

4. **RESULTS** ........................................................................................ 19
   - Work and the Experience of Insomnia ...................................... 19
   - Sleep, Productivity and Therapy .............................................. 23
   - Cognitive Labor and the Never-ending Workplace .................... 26
   - Case Study: Donna ................................................................. 30

5. **CONCLUSION** .................................................................................. 33
   - Discussion ................................................................................ 34
   - Limitations ............................................................................. 36
# LIST OF TABLES

<table>
<thead>
<tr>
<th></th>
<th>Table Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Selected Respondent Demographics</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>Summary of Findings</td>
<td>33</td>
</tr>
</tbody>
</table>
Insomnia is the largest sleep-related complaint in the United States. At least one of its symptoms affects as many as 40% of adults annually (NSF, 2003; USDHHS, 2002). Research indicates that a majority of Americans do not sleep the seven to nine hours each night recommended for optimal health and functioning (NSF, 2003; Schor, 1991; Williams, 2003). Such sleep deprivation can compromise cognitive, motor and disease-fighting abilities (NSF, 2003; Williams, 2003), often translating into decreased work performance, irritable moods, weakened immune systems and lowered states of mental alertness (Leger, 2006; Doi & Minowa, 2002; Chilcott & Shapiro, 1996).

Defining Insomnia

The most common symptoms of insomnia include difficulty falling and/or staying asleep (Billiard & Bentley, 2004; NSF, 2003; USDHHS, 2006). As a result, most insomniacs report that they obtain an undesirable quality and amount of sleep. Many who complain of poor sleep quality wake frequently during the night and experience trouble returning to sleep. Others wake too early in the morning, find themselves unable to go back to sleep and consequently feel as though they have not slept for an adequate amount of time (USDHHS, 2006). The disorder is often labeled as transient, intermittent, or chronic, depending on the length of time it is experienced. “Chronic” refers to insomnia that persists longer than one month; transient insomnia is short-term, and intermittent indicates that it occurs periodically. Diagnosis of the disorder
generally requires the patient, or the patient's bed partner, to complete a sleep diary and, in some cases, may require a laboratory sleep study where the patient's sleep is observed first-hand (USDHHS, 2006).

Insomnia may also be classified as either primary or secondary. Primary insomnia is treated as a disorder in itself, while secondary insomnia is regarded as the byproduct of some other ailment (Billiard & Bentley, 2004; USDHHS, 2006). This classification of the disorder can be essential to effective treatment but is sometimes unclear. When two disorders are present – for example, insomnia and depression – it can be difficult to determine causality. Given that insomnia is a known symptom of depression, it is often assumed that if both are present, insomnia is a secondary disorder resulting from the depression. Recent studies, however, suggest that insomnia may act as the primary disorder triggering the depression (Billiard & Bentley, 2004). Some cases of insomnia are thought to occur as a direct result of one’s irregular, or abnormal, work hours. This sleep problem has become common enough to warrant its own distinct label: “shift work sleep disorder.” The term is used to describe the poor quality of sleep and excessive sleepiness experienced by shift-workers (Drake, Roehrs, Richardson, Walsh & Roth, 2004; Regestein & Monk, 1991). Although it has increasingly gained medical attention, its validity as a disorder is still disputed. Many consider sleep problems among shift workers “a natural consequence of the work schedule” (Regestein & Monk, 1991, p. 1487) and not a medical condition.
Working Lifestyles in the United States

Workweeks have been steadily lengthening in the U.S. during recent years. It has been estimated that the average employed American works the equivalent of one additional month annually (Schor, 1991). According to the 2005 “Sleep in America Poll” conducted by the National Sleep Foundation (NSF), the average workweek for employed Americans is 46 hours. In the same study, about 38% of survey participants indicated that their workweek consists of more than 50 hours per week (NSF, 2005). Economist Juliet Schor suggests that labor-intensive lifestyles inevitably deplete leisure time and consequently “strain the social fabric” (1991, p. 15). Schor has documented a concomitant surge in work hours and rate of Americans who seek treatment at sleep clinics, explaining, “sleep has become another casualty of modern life...often sacrificed in favor of long work hours, demanding work schedules and...a twenty-four-hour business culture” (Schor, 1991, p.11). In a more recent study, NSF researchers determined that 52% of study participants could be identified as poor sleepers - close to 40% of whom were likely to have characterized themselves as working long hours (NSF, 2005).

Significance of the Study

This study sheds sociological light on the powerful role of work in patient perceptions of the nature of insomnia, its causes and treatment efficacy. Specifically, results suggest a correlation between sleeplessness and modern working lifestyles in American culture. Work has increasingly become the central activity around which most
Americans organize their lives (Hochschild, 1997; Schor 1991), and it similarly emerges as the salient theme in patient descriptions of insomnia experiences. Few sociological, qualitative inquiries have been made into the social nature of sleep and associated disorders, although several scholars have drawn attention to this paucity in the literature, argued for the sociological relevance of sleep, and urged for empirical research studying its socio-cultural aspects (Taylor, 1993; Williams, 2003). This research will contribute to the existing body of sociological knowledge about sleep, insomnia, contemporary working lifestyles and perhaps most importantly, the intersection of all three.

The research presented here is significant to social scientists and medical practitioners alike. Social scientists have long contended that illnesses are “known and interpreted via social activity and therefore should be examined using social and cultural analysis” (Lupton, 2003, p. 12). Understanding illness from a patient’s perspective is essential in designing and prescribing effective interventions and other therapeutic strategies. According to Kleinman, Eisenberg and Good (1978), “eliciting the patient model gives the physician knowledge of the beliefs the patient holds about his illness, the personal and social meaning he attaches to his disorder, his expectations about what will happen to him and what the doctor will do, and his own therapeutic goals” (p. 256).
Theoretical Framework

A social constructionist perspective elucidates the socio-cultural interaction and context from which individuals derive and attach meaning to their experiences. In adopting this approach to a patient’s illness experience, “most social constructionists acknowledge that experiences such as illness, disease and pain exist as biological realities, but also emphasize that such experiences are always inevitably given meaning and therefore understood and experienced through cultural and social processes” (Lupton, 2003, p. 14). Leon Eisenberg (1977) distinguishes between illness and disease, using the former to represent what a patient experiences and the latter to describe what a physician treats. This distinction is important, according to Eisenberg, because patients “experience illnesses as disvalued changes in states of being and in social function” (p. 11). Therefore, it is useful for sociologists to examine one’s involvement in social activities such as work, for example, as well as the broader cultural context in which a patient exists. This provides an effective framework for determining the patient’s perspective of the illness. Such perspectives are often referred to as “patient explanatory models” and account for the socio-cultural influences on an illness experience. Specifically, these models offer insight into the explanations related to etiology, symptom onset, physiological processes, illness severity and treatment decisions from the patient’s perspective (as cited in Helman, 2002).

---

1 There are many theoretical perspectives that could be applied here, including ones that specifically address the sociology of work or specifically address the sociology of health and illness. For instance, Karl Marx and Max Weber are both well-known for their analyses on the social organization and implications of work. However, the social constructionist perspective sufficiently serves the purpose of this paper and is the only one presented here in order to accommodate time and length constraints.
Focus of the Study

This study illuminates the cultural context in which insomnia exists and concentrates attention on the social activity that dominates patient explanations - work. “Work” includes such facets as the nature of one’s occupation, the associated volume or amount of work required, mental demands related to work, work schedules and work-related stress. The interrelationship between work and sleep is explored from the patient’s perspective, examining the effects of one on the other. Researchers have acknowledged “a reciprocal link between work conditions and sleep disorders” (Metlaine, Leger & Choudat, 2005, p.11) but have largely examined the disorders as causal agents engendering poor working conditions (Linton, 2004; Bastien, Vallieres & Morin, 2004; Edell-Gustafsson, Kritz & Borgen, 2002). Few studies investigate the reverse: how occupational activities and conditions may affect sleep for those who have trouble sleeping. In this research, qualitative techniques are employed to ascertain patient explanatory models surrounding insomnia and analyze the role of work therein. Specific research questions guiding this study are: 1) How do respondents interpret and explain their trouble sleeping? 2) What do they report are the causes? 3) Why did they seek medical attention? 4) What are their expectations and decisions about treatment?
CHAPTER 2

LITERATURE REVIEW

Effects of Insomnia on Work

In the occupational realm, absenteeism is among the primary concerns about the effects of insomnia on work. Insomniacs are more likely to request sick leave from work and are predicted to be absent about twice as often as those without sleep disorders (Leger, et al., 2006; Doi & Minowa, 2002; Chilcott & Shapiro, 1996). Leger, Massuel and Metlaine (2006) found this to be true in a cross-sectional study of workers in which researchers paired an insomniac with a good sleeper to analyze any difference in work-related outcomes. Their conclusions, and those of similar studies, are that not only are workers with insomnia more likely to be absent from work, but they are also at a higher risk for involvement in work-related accidents, tend to report lower job satisfaction, and experience decreased levels of efficiency at work (Leger, et al., 2006; Doi & Minowa, 2002; Chilcott & Shapiro, 1996). Doi and Minowa (2002) researched daytime sleepiness among Japanese workers in an occupational setting and found that a lack of nocturnal sleep and irregular sleep-wake patterns were the primary predictors of excessive sleepiness during work. The researchers suggest a ban on overtime work hours as one solution to diminishing excessive daytime sleepiness on the job.

Work-related effects of insomnia inevitably carry financial repercussions. The economic burden of insomnia is tremendous. When accounting for the financial losses incurred due to absenteeism, decreased productivity/efficiency, accidents and corresponding healthcare costs, the monetary expense associated with the disorder is
calculated to be between $30 and $35 billion per year. Researchers report that this estimate of direct, indirect and related costs of insomnia is actually conservative (Chilcott & Shapiro, 1996). It reflects the value of a dollar in 1994 and is expected to have increased since the initial research was conducted.

Despite their social and economic weight, sleep disorders have been afforded little attention from social scientists. One sociologist estimates that human beings spend roughly a third of their lives sleeping (Taylor, 1993). Although this may be a liberal estimation more accurately reflecting what humans should be sleeping instead of what they actually are, social scientists have largely neglected this significant chunk of time in human life (Taylor, 1993; Hislop & Arber, 2002; Williams, 2003) and thus a potentially significant social problem.

Sociology of Sleep

Many studies attribute causes of sleep disturbances to poor habits and practices such as caffeine and alcohol intake, exercise, napping patterns and high stress levels, although research has suggested that these individualistic behaviors do not fully explain or account for the problem (Ellis, Hampson & Cropley, 2002; USDHHS, 2006). In a study of sleep quality among older adults, published by Ellis, Hampson and Cropley (2002), such habits and practices are referred to as “sleep hygiene.” Sleep hygiene encompasses many factors including the ones listed above, plus variables such as external noise, bedroom temperature, cognitive activity and use of medication. Sleep conditions and quality were measured under the assumption that good sleep practices
would promote better sleep and poor sleep practices would result in sleep disturbances or a poor quality of sleep. The study discovered that most of the behaviors or situations had little to no effect on the quality of sleep reported by the participants. The most significant factors were the use of medication and the noise-level of the sleeping environment. Perhaps these proposed predictors were not that indicative of sleep quality because only individual factors were considered. Sleep patterns are subject to and inextricably linked with social factors that influence, compound or potentially cause some disorders.

In an effort to include sleep in the study of social activity, Brian Taylor (1993) posits that people “do” sleep. He examines the manner in which sleep is discussed and executed, how it may be socially patterned and explores the sociolinguistic meanings associated with the activity. In addition to researching relationships between sleep and social groups, Taylor suggests there are “more complex ways of examining the sociological dimensions of sleep and these ought to involve consideration of the wider cultural context” (p. 467). Consistent with this idea, Simon Williams (2003) suggests that the prevalence of diagnosable sleep disorders, the “bursting sleep industry,” (p. 178) and the increasingly 24-hour society represent yet another medicalized phenomenon. He examines sleep management as another social problem to fall under the jurisdiction of biomedicine, and avers that the growing epidemic of sleep disorders is an indication that “we are...a sleep-sick society” (p. 187) unable to wisely and healthfully manage our sleep. He contends that much of the resulting sleep debt may
be attributable to work demands and commitments that “interfere with or reduce our
sleep time” (Williams, 2003, p. 188).

While there appears to be a gap in the empirical research regarding the effect of
work on sleep, gender has often been studied as a variable that either interferes with or
enables one’s ability to achieve adequate sleep. Being female has consistently proved
to be a risk factor for poor quality sleep and susceptibility to sleep disorders (Hislop &
biological, aspects of being female seem to account for this as several landmark studies
have documented gender inequality in sleep. In her exploratory study of dual-career
families, Arlie Hochschild (2003, p. 10) notes that many working women “could not tear
away from the topic of sleep.” They talked about how little sleep they could function
on, apologized for how much sleep they felt they needed, and revealed strategies to
avoid waking fully in order to get back to sleep after tending to a child during the night.
Hochschild (2003, p. 10) writes, “These women talked about sleep the way a hungry
person talks about food.” In a similar vein, Jenny Hislop and Sara Arber (2003)
investigated interfering factors in the sleep of “mid-life” women in the United Kingdom
and coined nighttime as “the invisible workplace” where women are still expected to
care for the family’s physical and emotional well-being. This includes physically caring
for a child during the night but also providing 24-hour emotional support for their
families (including their husbands, parents and children of any age). Many women in
the study cited children’s needs, snoring or easily-awakened partners and aging parents
as primary sources of sleep disruption. Hislop and Arber term this “emotional labor”
and argue that entrenched in this, women find it difficult to get a good night’s sleep. These studies acknowledge that the social context and culture of sleep is an essential component in understanding sleep disorders.

Sleepless America

A phrase that may best capture contemporary cultural attitudes toward sleep is the title of a *Time* magazine article, “Sleep is for Sissies.” The article explores the dwindling time spent sleeping by Americans, by choice or necessity, due to long work hours and busy schedules (Walter, Aguayo, Bowers, Crittle & Whitaker, 2004). The authors examine the lives of several busy Americans who believe increased productivity is worth the sacrifice of sleep. They distinguish between insomnia (an *inability* to sleep) and an *unwillingness* to sleep (which they humorously term “somnorexia”). Somnorexia reflects the condition suffered by numerous Americans, whereby they starve themselves from sleep in an effort to carve out more opportunities for productivity in order to accommodate their busy lives.

The concept of time has become equated with economic productivity, often regarded as “currency...not passed but spent” (as cited in Schor, 1991, p. 50). As the amount of time Americans spend working increases, “time on basics, like sleeping” decreases significantly (Schor, 1991, p. 5). The resulting time crunch has been termed the “time squeeze” (Schor, 1991), the “time famine” (Vuckovic, 1999), or the “time bind” (Hochschild, 1997). According to Schor, “shift-work, long working hours, the growth of a global economy (with its attendant continent-hopping and twenty-four-hour
business culture), and the accelerating pace of life have all contributed to sleep deprivation” (p. 11). Richard DeGrandpre (2000) terms this accelerated pace of American life “the rapid-fire culture” in his book *Ritalin Nation*. The rapid-fire culture characterizes “the urgency that animates everyday American life” (p. 16) and the tendency to provide “plenty of stimulation to go around – twenty-four hours, seven days a week” (p. 25). DeGrandpre connects “today's culture of work and hurried lifestyles” (p. 41) to the inability to slow down, relax and be idle – all of which are requirements for sleep. Both Schor (1991) and DeGrandpre (2000) highlight the societal movement toward speed and efficiency and Schor notes that as workers became more efficient, they also had more time to work. With the extra time now generated from efficient technology, American workers collectively began to work more (during this time) instead of utilizing it in other ways – such as sleep, leisure or family time (Schor, 1991). These high-intensity lifestyles yield negative implications when confronted with an “empty hour” (DeGrandpre, 2000, p. 35). As evidence of the effects of constant stimulation (or the demand for it), DeGrandpre writes, “Ask yourself,...When your body is not racing but your mind still is, do you need a sleeping potion to knock you out?” (p. 35).

Effects of Work on Insomnia

Risk factors for insomnia are often categorized as “predisposing,” “precipitating,” or “perpetuating,” with each classification indicating a different impact on the disorder at different times throughout its course (Bastien, Vallieres & Morin, 2004). Predisposing
factors reflect a heightened susceptibility to the disorder and are usually researched as hereditary, physiological or psychological. Precipitating factors are associated with triggering the onset of insomnia and perpetuating factors promote the continuation of the disorder, encumbering possible recovery (Bastien, Vallieres & Morin, 2004). More often than not, work is considered a precipitating factor at best, and rarely is it regarded as a predisposing one. In a study examining precipitating factors of insomnia, the category containing work was one of the most commonly identified factors (Bastien, Vallieres & Morin, 2004). Within this category, the most powerful predictors associated with the onset of insomnia appear to be: stress in the workplace and shift-work. Following these were the less powerful factors “change of employment and retirement” (Bastien, Vallieres, Morin, 2004). Respondents indicate that stress on the job originates from sources such as “conflicts with a supervisor, interpersonal relationship difficulties, workload and financial strain” (Bastien, Vallieres, Morin, 2004). In another study, looking specifically at work-related stress as a predictor of insomnia, the risk of developing the disorder doubled for those who reported a “poor psychosocial work environment“ (Linton, 2004). Factors contributing to new episodes of insomnia were analyzed – as opposed to factors contributing to chronic insomnia. In order to effectively discern the new development of an episode, only employees who had not experienced sleep problems during the past three months were recruited to participate. Respondents answered a baseline survey regarding work-related stress, sleep and overall health and were then contacted again one year later to determine whether or
not a sleep problem ensued. Interestingly, irregular work hours did not prove to be a significant factor in the formation of a sleep problem (Linton, 2004).
CHAPTER 3

METHODS

This study was designed to explore the socio-cultural aspects of insomnia, and the illness experience, as described by those who have been diagnosed with the disorder. To my knowledge, no studies have investigated the insomniac's explanatory model as it incorporates work, and such insight would be difficult to glean from quantitative surveys. It was established that original research would be needed in order to generate the desired information. Therefore, given the exploratory and subjective nature of this study, a qualitative approach was adopted in an effort to meet these goals.

IRB Approval

Pursuant to state and federal regulations, approval from the Institutional Review Board (IRB) at the University of North Texas was obtained prior to conducting research or communicating with study participants. Final approval for the project was granted on 03/10/2005 (IRB Approval #550118048). The proposed research design, interview guide and consent form was first submitted in March 2005. Minimal modifications to the interview guide and consent form were required, which the principal investigator (PI) adjusted and resubmitted. Once final approval was granted, interviewing and transcription lasted for about seven months, beginning in April 2005 and continuing through October 2005.
Methodology

Semi-structured interviews were conducted with 24 diagnosed insomniacs receiving treatment at one of two sleep clinics – one located in Oregon and one in Texas. Interview questions were constructed to reflect the main tenets of a patient’s explanatory model. The actual interview guide utilized during each session is included in Appendix B. Kleinman, Eisenberg and Good (1978, p. 256) set forth the following eight questions, from which our interview guide was adapted, in order to extract the patient’s explanatory model:


Data Collection and Analysis

Respondents were informed about the study by their sleep physician during medical appointments, and if willing to participate, signed an informed consent with HIPAA release form (Appendix A), and allowed their telephone number to be passed to the PI. The PI verified that patients were knowledgeable and willing to participate in the study, and one of three interviewers called to schedule an interview time. While the majority of interviews took place in patient homes, others were conducted at public restaurants, coffee shops and the respondent’s workplace. Interviews ranged in length of time from about 45 to 90 minutes, though most lasted about one hour. Each interview was audio-recorded and later transcribed by the research team. Transcription
resulted in a total of 321 pages of data and together the researchers developed a basic coding scheme reflecting broad, emergent themes from the interviews. Data were coded by hand and also with ATLAS.ti. Each researcher separately coded the transcribed interviews and reviewed the data for specific patterns and trends that became evident from the analysis. In order to increase reliability, the researchers met weekly to discuss and compare coding. Pseudonyms were assigned to each participant and are used throughout in order to ensure confidentiality.

Sample Characteristics

Study participants consist of 24 clinically diagnosed insomniacs, 16 of whom receive treatment at a sleep center in North Texas and 8 who receive treatment at a clinic in Oregon. Table 1 (on the following page) presents basic socio-demographic information about them. The average age of the participants is about 53 with the youngest respondent being 22 and the oldest 72. The highest concentrated income category in this study is $41,000 to $70,000 with about 38% of the informants occupying this group. Female respondents comprise about 79% of the sample total and a vast majority of respondents (91.7%) identify themselves as Caucasian. More than half of the participants are married and approximately 83% have children. Of the respondents who have children, 35% report that they still have at least one child living at home with them. The majority of patients are employed outside of the home - almost 46% work full-time, about 17% work part-time or are on leave and nearly 38%
are retired. Additionally, about 33% of the interviewed insomniacs have a history of shift-work.

Table 1

*Selected Respondent Demographics*

<table>
<thead>
<tr>
<th>Demographic</th>
<th># of Respondents</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Anglo</td>
<td>22</td>
<td>91.7</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>79.2</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>54.2</td>
</tr>
<tr>
<td>Children Not Living at Home</td>
<td>13</td>
<td>54.2</td>
</tr>
<tr>
<td>Working Full-Time</td>
<td>11</td>
<td>45.8</td>
</tr>
<tr>
<td>Insomnia is Chief Problem*</td>
<td>11</td>
<td>45.8</td>
</tr>
</tbody>
</table>

*This is how the patient perceives the disorder.
CHAPTER 4
RESULTS

Just as work has become a salient theme in American culture (Schor, 1991; Walter et al., 2004), it also emerges as a salient theme in patient descriptions of insomnia. This becomes apparent in that: 1) nearly 60% of respondents identify work as a cause in the development or perpetuation of their insomnia; 2) work influences when and how much one will sleep, as well as its importance; 3) respondents tend to consider insomnia a problem, and solicit medical intervention, only when it affects work; and 4) productivity and how one feels at work are major considerations in evaluating treatment efficacy. Furthermore, respondents appear to internalize work in such a way that it manifests itself (outside of the workplace) as cognitive labor and continued problems into retirement.

Work and the Experience of Insomnia

Insomnia, as an illness experience, provides a kind of structure through which respondents interpret (or at least unconsciously comment on) the nature of work in their lives. When asked what was going on when they first started having trouble sleeping, several respondents answered rather directly, “My job,” or “Just work,” or “Job anxiety.” Specifically, fourteen respondents indicated that work contributed to their trouble sleeping, and seven explained that work actually caused its onset. Interestingly, even other perceived causes of insomnia, such as depression, seem to be linked to work. When asked if she thought depression played a part in her insomnia,
one patient answered, “I’m depressed. I’m depressed because I don’t sleep and I hate my job.” Another respondent, June, 63 and retired, indicates that she was struggling with depression at the onset of insomnia and describes it in terms of work:

Eight years ago I was still struggling with depression. I had quit home schooling and realized that I needed to go to work. I felt very inadequate during this job. My boss was a dear, but my typing skills were not good. I had retired as an office manager for an insurance agency. I was just slow and felt very stupid and slow to catch on and all that.

Even Angie, a 29-year-old bank teller who identifies traumatic life events as the precipitators of her insomnia, attributes the perpetuation of the problem to work. When asked if a better night's sleep is often related to work, she admits, “It is always.” Such responses demonstrate the powerful role of work in patient lives, even when they do not directly attribute work as a cause of their insomnia.

**Work is a Primary Cause of Insomnia**

Melanie, a 34-year-old attorney and single mother, attributes her sleep problems solely to work. She illustrates this by stating simply, “That's [being an attorney] why I don’t sleep.” She reports that her workdays last anywhere between 12 and 14 hours and explains, “I have no trouble falling asleep. I can lay down and be asleep, dead to the world. And then at 2:30 every morning, I just wake up all at once thinking about work.” In further assessing culpability for the disorder, she gives work-related issues precedence even over personal ones.

I did have some personal stuff going on when it [trouble sleeping] first started happening, but that’s not why, because when I would wake up in the middle of the night I was thinking about my job, not the personal stuff.
Melanie’s perception that work provoked her disorder is not unusual, although others specify stress or schedules associated with work as the culprit. For example, when asked what she thought was causing her sleep problem, Donna, a 64-year-old office manager, replied, “Stress. I want to quit work.” May, 57, also interprets work-related stress as a cause of her insomnia, explaining:

I think stress has something to do with it [trouble sleeping]. Work. I’ve been in a very stressful position at the company where I worked for 25 years. I had been promoted like 12 times and had a lot of responsibility, people to manage, etc. So I would lay awake and not sleep.

Similarly, when Dorothy (a 66-year-old retired nurse) was asked what was going on in her life when she started having trouble sleeping, she answered, “…I think just the stress of everyday life. Getting to work, keeping up.” Other patients, like Don, a 58-year-old retired airline pilot, attribute the cause of their sleep problems to work schedules rather than work-related stress. Don notes that his insomnia began during a string of successive night-flights.

I think it goes back about five years, during irregular schedules and flying all-nighters… I flew all-nighters five nights a week from about 9:45 until about 6:30 in the morning and it got me totally messed up. I counted on getting to bed about 6:30 and go right to sleep. About two hours later, I’d wake up and about the fifth night, I was really dragging. I went back to regular schedules the next month…but that really messed me up.

Not only is Don illustrating his perception that work precipitated his disorder, but also the manner in which work dictated when and how much he slept.

Work Influences the Nature of One’s Sleep

Other patients also describe how work structures their sleep. For example, Joe is
a retired 72-year-old who has had trouble sleeping for “as long as [he] can remember.”

He explains how work shaped his sleep from a young age:

I was in high school and there were several of us that would deliver the paper in [city], it was small then, and I had the west side [of the city] and we’d go to pick up our papers, usually 9:00 Saturday night and we’d get through 8:30 or 9:00 Sunday morning. So I didn’t go to bed Saturday nights for a couple years. Then when I was in college, I did the same thing, I never went to bed on Saturday nights.

He explains how this continues while working and attending college:

I went to work at four o’clock in the afternoon and worked until midnight normally, then for two months we went for ten hours, I got off at two. Then for two months I went on twelve hour shifts and got off at four in the morning. And had an eight o’clock class. Carried nineteen hours and made straight A’s, made the National Honor Society.

Such irregular working hours required him to adjust his sleep schedule, and even forfeit a whole night of sleep once a week. After citing work-related stress as a cause of her insomnia, Dorothy later reveals that demanding work schedules have also interfered with her sleep:

I’ve never been a great sleeper. I was a nurse who worked nights and had a lot of call over the years...I worked 10 hour shifts and then sometimes a lot longer; call days sometimes until 4:00 in the morning.

Another example is Pam, a 52-year-old retired flight-attendant, who does not directly associate her work with the development of insomnia. She does, however, compare her current trouble sleeping to her previous ability to adjust to odd schedules while working:

I’ve never had a problem sleeping. I’ve been very fortunate in the past. And the job I worked in, was a job that sometimes you’d go to bed at 2 in the morning and sometimes you’d go to bed at 10 the next morning. I would work all-night flights and that was one thing I was able to do – was sleep any time. I adjusted
real well. I did a lot of international flights and I did a lot of time zones and they
never bothered me.

Even into retirement she explains her trouble sleeping as it pertains to work. For years,
Pam’s sleep schedules were determined by her work schedules. Since she had adjusted
her sleep to accommodate odd work hours in the past, she finds it difficult to
understand why she experiences so much trouble now operating on a “normal”
schedule. This reinforces the idea that insomnia as an illness experience serves as the
mechanism through which respondents consciously or unconsciously comment on the
nature of work in their lives.

Sleep, Productivity and Therapy

Sleep is perceived as a necessity for working lifestyles. Its importance is
revealed in patient explanations that a lack of it inhibits optimal work performance or
interferes with productivity. Sometimes this becomes the impetus for seeking medical
attention. Since sleep is vital to occupational success and work is an unavoidable
requirement, insomnia can become a big problem for many patients. For example,
Donna summarizes her sleep, and ability to get by on less, as necessary for work. “I’ve
just learned to get by on less….I mean, you don’t have any choice! You can’t just crawl
in a hole. You still have to go to work everyday.”

Insomnia Becomes a Medical Problem Only When it Affects Work

In an interview with 28-year-old Jennifer (which took place in her office), she
offers her rationale for wanting quality sleep:
I want to sleep. Because I have stuff I need to do. You know, like this is a pretty high-stress job and I have to be ‘on’. I have to be alert. I have to be talking to people on the phone all day. I have to remember what I’m doing and if I don't get sleep then I get disorganized. I don't think it affects my mood so much but…I get very disorganized.

Jennifer illustrates that her insomnia presents a problem at work, since it renders her disorganized and unable to adequately perform the job according to her standards. Many like Jennifer characterize their trouble sleeping as a “problem” only when it begins to threaten their occupational life. For example, 53-year-old Linda reveals that insomnia has affected her work to the point where she has had to reduce her work hours (affecting her income) and reports feelings of guilt and inadequacy:

And it's [insomnia] already affected my job. Because I was going from 40-50 hours down to 4-5, and even though I knew I wasn't going to get fired, I didn't feel good about what I was accomplishing. So I just fell apart…and you feel guilty that you didn’t put in a good day's work.

Such patient responses suggest that their inability to sleep would not concern them if it were not for their desire to achieve optimal work performance. Patients not only emphasize “good sleep” as a necessity for work but some define it according to work. Although Linda cites pain and other medical conditions as the source of her insomnia, when asked to describe the meaning of a “good night's sleep,” she measures it in relation to work:

For me...being able to wake up knowing that I can get up and go to work...if going to work, to feel sharp, not to feel groggy. And that I can feel happy, that I’m smiling at people – that I’m glad to be at work.

Some will not even visit healthcare professionals until they believe their job performance is being compromised, as evidenced by 66-year-old retired nurse and college instructor, Clara:
I would sleep two or three hours a night and getting up and teaching students all day, I had nursing students, I would be at the hospital with nursing students and they had IV meds to give and some of them weren't too good and I really got very anxious because I felt that my sleep problem was interfering with trying to teach and make sure that the students weren't going to have an error or there would be some problems. So that's when I started seeking some help.

Clara illustrates that work demands dictated how much sleep she thought she should obtain in order to function properly at work. When that amount went unattained, it became a problem for which she sought professional help. Not only do respondents describe and define the disorder by problems manifested through or experienced at work, but they also form expectations of treatment and measure its effectiveness in terms of work.

_work is a Tool for Treatment Evaluation_

Using work to define problems and quality or importance of sleep, inevitably translates into expectations about treatment outcomes. Clara elaborates on her decision to pursue medical attention and recounts her concern that the medication she was taking was ineffective:

I was taking the Ambien and I was taking up to ten milligrams a night. And it just wasn't effective. And I was just getting so little sleep and I was worried about having students the next day. So I just felt like I couldn't keep working, and certainly in such a responsible position, without getting more sleep. I was getting too exhausted and I was afraid I wasn't making good decisions.

Given that her job performance was not improving, she deemed the treatment ineffective. Clearly, Clara equates “more sleep” with better job performance and determines treatment efficacy by judging the latter. Another 66-year-old retired nurse,
Dorothy, harbors similar expectations. She discusses her use of sleeping pills as needed to get a good night’s sleep for work:

But I just need them to get a good night’s sleep. Especially when I was working; I’d just need to get a good night’s sleep....I was up half the night, and then have to go to work at 6:30 in the morning.

One patient even alters her prescribed treatment regime to accommodate work commitments. When Jennifer mentions that she took half of a pill the night before the interview, she explains that she “needed to be [nice and fresh] for work.” She further explains her decisions about when she will take her prescribed pills, often revolving around a busy work schedule:

Usually what I do is, knowing ahead of schedule, I know that ok, tomorrow I have this to do, the next day I’ve got this to do, I know I’m going to be out late tonight...I usually try to plan it when I have nothing to do the next day. That way I don’t have anything that will keep me awake, because if I have a big meeting I’d rather be up all night because it’s like, I may take a sleeping pill, but my worries of having something going on will keep me up. So there’s no sense in wasting the time, whereas if I have nothing going on the next day and it’s kind of a lax day, I can sleep. I can sleep in.

Cognitive Labor and the Never-ending Workplace

Patients seem to internalize work in such a way that they continue to work mentally, even after their workdays (or working lifestyles) are over. Many complain of coming home from work only to find that their minds are still there. Other, usually retired, patients express concern that years of work-structured sleep may yield indefinite consequences.
**Cognitive Labor**

Angie, the 29-year-old bank teller, clarifies that it is not the stress associated with the job, but its mental demands that often keep her awake.

It’s [her job] not stressful, it’s just that there’s a lot of responsibility that I have. So I just have to make sure that I’m there and I have to make sure that like, I balance my drawer and my ATM and all these things....So what keeps me up is my mind because I’m constantly just thinking about all different things. I mean, my mind just goes all over the place. So that’s what keeps me up and I can’t shut it off.

Numerous patients complained that racing minds and overactive brains were obstacles inhibiting good sleep. While the actual demands of work interfere with some, others suffer from the cognitive labor they are unable to cease performing. Angie illustrates this cognitive labor again when she further explains, “I’m constantly...running the motions through my mind. Did I do that correctly? Could I have done that better?”

This type of cognitive activity was often faulted as exacerbating sleep problems. June, a 51-year-old on-call nurse, reveals her work-related mental activity:

I used to be a charge nurse in an OR [operating room]. I would just lay there and think, ‘Ok. If this happens, what am I going to do? If someone calls in sick, what will I do?’ And it just got to a point where I realized, ok. I just can’t take call anymore. It’s not healthy for me to do this.

She perceived this work to be so damaging that she adds, “If I couldn’t work this job [on-call at a surgery center] and they said, ‘you have to work at the hospital,’ I would quit nursing. Because I just know that’s not healthy for me. I wouldn’t do it.” Work seems to permeate mental activity even in dreams. When Donna does sleep, she indicates that she sometimes dreams about quitting her job. Work also manifests itself in Dorothy’s dreams. She mentions a night in which she experienced deep sleep and
explains, “I was so asleep I was dreaming. I was even dreaming! I was dreaming about work.”

When asked about techniques used to facilitate sleep, Melanie states: I haven't watched television and I don't read because I get stressed and my mind starts racing. There's no way I can read because I’m thinking about what I didn't get done at work. Like, ‘Oh, I didn’t get a deposition done,’ when I don’t even have it on the calendar.

These high levels of mental activity were associated with busy, hurried, working lifestyles as evidenced by Linda:

Just thinking about all the things that need to get done, or should get done, you can’t quiet your mind to sleep....most people think it's people’s minds racing that causes insomnia. Big time. Because they can't think of anything but what they've got to get done today...they've got things to do, people they've got to meet.

Lynn is a 62-year-old real estate agent who mentions that her work “sometimes can be quite stressful.” She offers detailed descriptions about the demands of her work then adds, “You just don’t ever get a break.....you feel like you don’t have a life sometimes.” She holds this accountable for the sleep disruption she experiences.

You're just on overload, because there's too much to do and not any time for yourself. And so then, when you're trying to sleep...this stuff is churning in your brain....it's stuff that you're going to take care of when you get up, but at the time you're laying there, you're thinking about, ok I've got to remember to do this and this.....I go like a banshee all day long. And you just can’t shut down.

Respondent descriptions abound with machine-like imagery such as “overload” or “shut down.” Others express similar experiences, describing themselves much like machines. Jennifer explains that she has to be “on” for work and Angie explains that once she has fulfilled her actual work duties, she has difficulty shutting her mind “off.” Others indicate problems with “racing” or “running” minds and the difficulty experienced when
trying to “program” them to do otherwise. These responses support DeGrandpre’s thesis that we are culturally conditioned not to relax in the absence of stimulation. All of the work demands and pressures to be efficient and productive, without slowing down, provide us with constant stimulation. Julie, a 51-year-old teacher, would grade papers when she was unable to sleep until her physician informed her “that’s one of the worst things you can do is to stimulate the brain.” However, so many find it difficult to “de-stimulate” the brain when working lifestyles require that it consistently stand at attention.

The Never-Ending Workplace

Many of the insomniacs report that for years (in the past) they had basically programmed themselves to relax their minds and sleep around work demands. Retired airline pilot, Don, recounts his history of odd flying hours and inability to develop a regular sleep-wake pattern:

It was hard to get into a regular schedule. So now that I’m retired, he’s [sleep physician] trying to get me to go to bed at the same time, get up at the same time, go to bed at 11:00, get up at 6:00...he’s trying to train my brain. That’s what he says.

Perhaps more accurately, the physician is trying to retrain his brain after years of being programmed to operate according to work schedules. Dorothy, a 66-year-old retired nurse, illustrates her experiences as an on-call nurse for 40 years and its effect on her ability to relax:

When the beeper goes off in the middle of the night, you just hit the floor running, and I think I just haven’t learned to slow down....It’s a totally different way of life. It really is. I think anybody will tell you, when you’re on call,
medically, for surgery, it’s hard to relax. It just takes over your life, because you just never know…. [her sleep physician] thinks it may be permanent.

It seems as though many respondents have carved out some inescapable lifestyle from which recovery proves difficult, at best. Others, like Donna whose story is detailed below, explain that upon retirement they will likely be stressed about their financial situations. It would appear that even upon retirement, work-related issues and cognitive demands do not cease to affect one’s sleep.

Case Study: Donna

Donna’s story exemplifies the manner in which patients apprehend the role of work in their lives through the insomnia experience. The 64-year-old office manager attributes her sleep problems primarily to a stressful job and work environment, citing new responsibilities, little time to complete tasks, a demand for preciseness and little support from her manager as the sources of her work-related stress. She explains:

I work for an irrigation district and we’ve done a lot of piping projects, which involve the federal and the state government funds, which involves a lot of precise accounting and reporting and I’d work for a manager, an attorney, an engineer, and five board members, all of whom are men. And I don’t get any support from my manager. I mean, it’s basically, this is what I need and you have fifteen minutes to do it. Uh, and it needs to be right. And it’s in addition to my regular work, which includes doing the monthly financial statements, taking care of all the water transfers, and all the water leases, and all the title company requests, and on and on and on.

She further explains that she had previously been a “really good sleeper” but now can become “very short of temper” and “get angry very easily” which may create more problems at work. “I used to go to sleep. I slept, I woke up. And I wasn’t exhausted
when I woke up. I’m always exhausted now. I’m just, I don’t wake up happy.” In reflecting on her work situation, she mentions:

There are days when I think I’d rather work at Burger King then come into this place everyday...and face all these problems. It’s the same old story...my boss makes twice as much as I do and works half as hard.

Despite these issues, however, she waited three years until she sought medical attention to ease her problem. She explains, “I just kind of resigned myself to thinking that it’s just going be that way at least until I retire.”

Not only does she express an irritation with work in that it directly interferes with her sleep, but also in that it indirectly interferes by encumbering exercise and health routines she would like to initiate. She describes a recent time in which she had to miss an aerobics class in order to complete some work and complains:

It’s [work] just worn me down....I never catch up. I never seem to catch up. I want to quit work. I can’t afford to quit work....You know, it aggravates me, because if I was retired I could be doing these things that would be healthy for me. Instead of doing what I know is making my problems worse.

Although she expresses her desire to retire and thereby achieve reprieve for her sleep problem, Donna worries that once she does retire, she will not be able to support herself financially.

Even when I do retire, I’m not going to be able to quit working all together....I mean, it remains to be seen that if I am able to retire, whether that problem [insomnia] is going to get better. Then I’ll probably worry how I’m going to survive financially, so...there’s never been a time when I haven’t had to worry about money.

When Donna is not physically at work, she often remains there mentally. “I lay there and think about the problems I dealt with that day and whether I dealt with them properly and what I did wrong and what I need to do to fix it.” She also takes off
Fridays but mentions that this “only adds to the stress” because she needs to make “darn sure everything is done by the time I leave on Thursday.” Other workers in the office will sometimes call with questions on her day off. Although Donna dreams (literally and figuratively) of quitting her job, she mentions that even upon retirement, she will not be able to cease working altogether:

I mean, it remains to be seen that if I am able to retire, whether that problem is going to get better. Then I’ll probably worry how I’m going to survive financially, so...I’ve raised [son] by myself, and on a single woman’s salary with very little help from his father, so...there’s never been a time when I haven’t had to worry about money.

Regardless of these concerns, she keeps a running countdown (to the day) of when she will be eligible to retire.
CHAPTER 5

CONCLUSION

The purpose of this study was to explore the relationship between work and insomnia as part of the patient's explanatory model. Patient responses reveal that this sample of insomniacs interprets a mutual relationship between work experiences and sleep. While they express concern about sleep deprivation interfering with their work, they also tend to discuss work as a contributing and causal factor to their insomnia. Not only do many describe the very nature of the disorder in terms of work, but they often use work experiences to explain their symptoms, shape their expectations of treatment and dictate how they follow, or deviate from, prescribed treatment plans.

See Table 2 below for a summary of findings about patient explanations of insomnia as they pertain to work. These findings reinforce the correlations found among work and sleep in previous studies, but also identify the popular belief held by many respondents that work can act as the causal element in the relationship.

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Associated Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) How do respondents interpret and explain their trouble sleeping?</td>
<td>As a result of poor working conditions; as a barrier to optimal work performance</td>
</tr>
<tr>
<td>2) What do they report are the causes?</td>
<td>Long or unusual work hours, work-related stress, demanding careers</td>
</tr>
<tr>
<td>3) Why did they seek medical attention when they did?</td>
<td>Symptoms threatened occupational interference or did not subside upon retirement</td>
</tr>
<tr>
<td>4) What are their expectations and decisions about treatment?</td>
<td>Optimal work performance and ability to keep up with related demands</td>
</tr>
</tbody>
</table>
Discussion

Consistent with previous research, many reported a loss of income or productivity, sour moods or potential accidents as their most salient concerns about its effect on their jobs. It was only upon this threat of occupational interference that most patients acknowledged the existence of a disorder or sought help for their insomnia. Given this perceived correlation between sleep deprivation and occupational performance, satisfaction with treatment was often expressed as whether or not job performance was improving. This could be explained by Eisenberg’s assertion that “illnesses are experiences of disvalued changes in states of being and in social function” (1977, p. 11). Ultimately, patients defined insomnia as an impediment to occupational success and sought treatment as a means to restore normal functioning. They wanted from their treatment to be “glad to be at work,” as one respondent explained. On the other hand, demanding, working lifestyles topped the list of social culprits that respondents held responsible for their sleep troubles. One respondent, a single mother, explicitly stated that work-related concerns aggravated her sleep problem more than personal ones. Even retired informants seemed to couch their illness experience in terms of work, further evidencing the powerful role of work in patient explanatory models of insomnia. Many expected symptoms to subside upon retirement and wondered why their sleep had not improved, or why it had worsened, upon ceasing employment. This affirms the connection made by respondents between work and insomnia and illustrates the extended impact contemporary working lifestyles harbor for sleep.
Given that many informants described the onset of their insomnia in terms of work, it is worth asking if people are perhaps just more aware of time in terms of work. It is possible that work situations serve as the most pronounced points of one’s memory and is the reason why many patients recalled the onset of their insomnia in conjunction with those events. It is also possible that work events did, in fact, precipitate the disorder. The importance “work” has in one’s life is demonstrated either way. Ultimately, according to a social constructionist perspective, if a patient expresses a perception that work induces insomnia, this interpretation will drive subsequent behaviors.

Most patients described excessively busy work-lives that seemed to spill over into the nighttime, or even into retirement. Many reported making mental lists of what needed to be accomplished at work, how it needed to be done and which things needed to be done better. One respondent indicated that she “goes like a banshee all day long” and another that she hasn’t “learned to slow down.” Such responses could support Richard DeGrandpre’s position that an accelerated pace of life has “transformed human consciousness” and cultivated a constant requirement for stimulation (2000). Being in this constant state of stimulation (or needing it) makes a good night’s sleep difficult, at best. Some retired respondents pondered their condition, unable to comprehend its continuation during this “relaxing” phase of their lives. Most had previously led busy, activity-filled work-lives. Perhaps the effects and values of this type of lifestyle are irreversible. A retired nurse described her demanding career as “another way of life” and revealed that her sleep physician believed the effects may be
permanent. Others reported substituting various physical and cognitive activities in place of work. One retired respondent indicated that instead of obsessing about his work, he now obsesses about his wood-working hobby.

In a nation where “sleep is for sissies” (Walter et al., 2004), is it any wonder that these are the outcomes? Perhaps, much like Schor (1991) suggests, the lack of sleep is a trade-off. People work for many things – material possessions, a personal sense of worth and accomplishment, to feel productive...could sleepless nights be one of them?

One patient indicated that she had some job anxiety, but just “like anybody else” – no cause for concern. According to arguments made by Schor (1991) and DeGrandpre (2000), odds are she is just like anybody else – anybody operating within a rapid-fire culture in which sleep has little social value. Such cultural trends must be considered when examining the prevalence of insomnia in this society. One could convincingly argue that our hurried, high-intensity work culture predisposes our society to sleep disorders, generates a climate conducive for precipitating them and perpetuates existing problems.

Limitations

It should be noted that there are some limitations to this research. “Work” in this study refers only to paid employment outside of the home as the sample did not allow for a more inclusive definition. The sample is also lacking in minority representation and is geographically confined to two states – Texas and Oregon. Some patients may have been hesitant to participate due to required consent forms. This
may be considered a limitation in that it potentially prohibited us from achieving a truly
diverse sample for this study. Also, as with any qualitative research, the results from
this study are not generalizable to the entire insomniac population given the small, non-
random sample from which the data was collected (Berg, 2004). Nevertheless, the
results presented here reveal important patient explanations of insomnia and can
provide useful insight into how best to regard and treat the disorder.

Implications

As evidenced by the results, patient perspectives often dictate critical behaviors
such as help-seeking decisions and treatment compliance. It is imperative that sleep
physicians and researchers recognize the tendency of patients to define the disorder
and follow treatment regimes according to work-related issues, especially in order to
devise effective intervention and treatment strategies. Such understanding of a
patient’s explanatory model can facilitate better communication in the clinical setting
and expedite the treatment process. Furthermore, understanding the social
implications of a patient’s illness experience helps contribute to an integrated medical
approach. This approach enables the physician to treat the patient as opposed to the
disorder. In keeping with the social constructionist perspective, the illness could not
exist separately from the patient, but is manifested through and experienced by the
individual who imputes meaning upon it.

The increasing prevalence of insomnia and general lack of sleep reported in the
United States reflect an important health and social problem. Recent efforts have been
made to address this growing problem and better reconcile family, life and work demands. The NSF has mobilized a “Drowsy Driving” campaign to increase public awareness about the dangerous effects of sleep deprivation and encourage healthful sleep patterns (NSF, 2006). Other researchers have proposed a restructuring of the workplace (Schor, 1991; Hochschild, 2000) including reduced work hours and more family-friendly policies. Some organizations, such as the Federal government, have implemented alternatives to the traditional work experience, such as flextime (flexible work schedules) and flexplace (opportunities to work from home). Such efforts are steps in a positive direction, although study results indicate that perhaps a cultural shift in attitudes and the way we think about work is necessary in order to effectively consider and treat insomnia.
APPENDIX A

RESEARCH CONSENT FORM
Doug Henry  
Department of Anthropology  
University of North Texas  

Institutional Review Board for the Protection of Human Subjects in Research (IRB)  
RE: Human Subject Application #05-066  

Dear Dr. Henry:  

The UNT IRB has received your request to modify your study titled “The Culture of Sleep.” As required by federal law and regulations governing the use of human subjects in research projects, the UNT IRB has examined the request to include the modification to this study is hereby approved for the use of human subjects. Approval for this project is March 22, 2005 through March 21, 2006.  

Enclosed is the consent document with stamped IRB approval. Please copy and use this form only for your study subjects.  

It is your responsibility according to U.S. Department of Health and Human Services regulations to submit annual and terminal progress reports to the IRB for this project. Please mark your calendar accordingly. The IRB must also review this project prior to any other modifications made. Federal policy 21 CFR 56.109(e) stipulates that IRB approval is for one year only.  

Please contact Shelia Boums, Compliance Administrator, at (940) 565-3940, or Boyd Herrdon, Assistant Director for Compliance, at (940) 565-3941, if you wish to make changes or need additional information.  

Sincerely,  

Scott Simpkins, Ph.D.  
Chair  
Institutional Review Board
University of North Texas

Research Consent Form and Authorization to Disclose Health Information

Patient name: ______________________  Date: ______________________

Title of Study
Culture and Sleep

Principal Investigator
Dr. Doug Henry

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Purpose of the Study
The purpose of this study is to look at things that might better inform medical diagnosis and treatment of insomnia.

Description of the Study
You can be in a research study called, "Culture and Sleep," by the University of North Texas. The study consists of about an hour-long interview. The choice to be in the study is yours, and you can choose not to be in the study or to stop being in the study at any time. Also, you can refuse to answer any questions asked.

Procedures to be used
If you choose to be in the study, you will be interviewed and asked questions about your life and your insomnia. The interview will be recorded and typed written. Recordings will be kept by the research staff for the duration of the study (one year) and stored in a locked cabinet. Recordings will be anonymous, with a code kept only by the Project Investigator.

Information that will be used or disclosed/Procedures for maintaining confidentiality
From your participation in the study, the research staff will know that you presented at the St. Charles High Desert Sleep Center for symptoms of insomnia. Your name will not be in any reports that result from this study. Any personal information about you that the study team collects will stay private to the extent possible by law.

Description of the foreseeable risks
Some of the topics may be hard to talk about. The interviewer will try to help you feel at ease. You can choose to stop the interview at any time.
Benefits to the subjects or others
You yourself may not benefit directly from being in this study. However, you may help the researchers learn better ways to diagnose and treat insomnia.

Who may use or disclose this information
If you agree to be in the study, the St. Charles High Desert Sleep Center will release only your name and phone number to Dr. Doug Henry, the principal investigator of the UNT study. The purpose of releasing your name and phone number to the UNT research staff is to offer you participation in the research study. No other information will be released. No one outside the project research staff will have access to this information.

Expiration of the Authorization
The research study will last through January 2006.

Right to revoke authorization
If you wish to revoke this authorization, you may do so by sending a written request to Dr. Doug Henry at the University of North Texas Department of Anthropology / PO Box 310409 / Denton, TX 76203. You do not have to take part in this study, and your refusal to participate or withdraw will involve no penalty, loss of medical care, loss of rights, or benefits.

Potential for re-disclosure
There is no foreseeable risk that your personal information will be disclosed to anyone outside the research team. Your name will not be in any reports that result from this study. Any personal information about you that the study team collects will stay private to the extent possible by law.

Review for the Protection of Participants
You may ask questions of anyone on the study team at any time. In addition, Dr. Doug Henry (940-565-3836) will be glad to answer any questions.

This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 or shoums@unt.edu with any questions regarding the rights of research subjects.

Research Subject's Rights
I have read or have had read to me all of the above. The researcher has explained the study to me and answered all of my questions. I have been told how my health information will be disclosed and used for the study. I have been told the risks and/or discomforts as well as the possible benefits of the study.

I understand that I do not have to take part in this study or authorize disclosure and use of my health information in this study. My refusal to participate or my decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop my participation at any time.
In case I have any questions about the study, I have been told I can contact Dr. Doug Henry in the Department of Anthropology at UNT, 940-565-3836.

I understand my rights as research subject and I voluntarily consent to participate in this study. I also consent to disclosure and use of my health information in this study. I understand what the study is about, how the study is conducted, and why it is being performed. I have been told I will be offered a signed copy of this consent form.

Signature of Subject

Date

For the Investigator or Designee:
I certify that I have reviewed the contents of this form with the subject signing above. I have explained the known benefits and risks of the research and the disclosure and use of the subject’s health information. It is my opinion that the subject understood the explanation.

Signature of Principal Investigator

Date

APPROVED BY THE UNT IRB
FROM 3/2/05 TO 3/1/06
APPENDIX B

INTERVIEW GUIDE
(1) What was going on in your life when you first started having trouble sleeping?

(2) Can you describe your symptoms? How do they start?

(3) What do you think is going on with your body at these times?

(4) How big would you say this problem is in your life?

(5) Let's list what you consider the most important contributing factors to your having trouble sleeping. Now please rank the factors you just mentioned from most important to least important.

(6) In as much detail as you can remember, when you first started having trouble sleeping what did you do?

(7) How did you end up at the sleep clinic? Had you ever sought other kinds of medical care for sleep?

(8) Did they have time to listen to all of your symptoms?

(9) What do you hope to get out of your treatment?

(10) What did you think about the diagnosis they gave you, and their prescribed treatment?

(11) Other than the doctor's advice, are there other things that you do now, or that you've tried in the past that either have worked or have not?

(12) So for you what does it mean to get a good night's sleep?

(13) Some people say that stress or depression plays a part in their problems sleeping. Does either of these bother you?

(14) Does dreaming affect your quality of sleep? How?

(15) Lastly, is there anything else you think would be important for us, to understand about you, your Insomnia, or Insomnia in general?
REFERENCES


