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Insomnia and its management in Unani medicine

Shafia Mushtaq[1]*, Azhar Jabeen[1], Fasihuzaman[1], Musadiq Mushtaq[2], Shazia Jilani[1], Sadia Nikhat[3], Shah Alam[1]

[1]*Departmen of Moalijat, Faculty of Medicine, Jamia Hamdard, Hamdard Nagar, New Delhi, India.*
[2] *Department of Paediatrics under National Rural Health Mission. GB Pant Children Hospital, Jammu and Kashmir, India.*
[3]*Department of Tahaffuzi-wa-samaji Tib, Jamia Hamdard, Hamdard Nagar, New Delhi, India.*

CASE REPORT

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**Author for correspondence*
E-mail: shafiya.mushtaq786@gmail.com
Mobile/ Tel.: 0000000000

ABSTRACT

According to Unani system of medicine, health is attributed to the equilibrium of *akhlat* (humors), besides this there is *asbab-e-sittah zarooriya* (six essential factors). These are air, food and drinks, bodily movements and repose (*harkat-wa-sakoon badni*), mental activity and repose (*harkat-wa-sakoon nafsani*), sleep and wakefulness (*naum wa yaqza*) and retention and excretion (*ahtibas wa istifiragh*). Any imbalance in any of the above factors is likely to cause disease. Normal sleep is thought to be because of *ratoobat* wa *baroodat* i.e. wetness and cold in our body and if there is derailment of balance in sleep and wakefulness, it implies the predominance of *yuboosat* wa *hararat* i.e. dryness and hotness widespread in the brain. Insomniacs complain of difficulty falling asleep, difficulty staying asleep, poor quality sleep, or inadequate sleep despite adequate opportunity. In addition, the sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning. Herein, we report a case study of secondary insomnia female patient, who also suffered from chronic depression. The patient was treated with *nutool* therapy with some specific oils, and the dose of antidepressants was tapered off gradually. The patient showed significant improvement in 12 sittings.

INTRODUCTION

Women are at more risk for insomnia than men (Pigeon, 2010). It may be because of continuous changes in hormones such as in the menstrual cycle (a) 36% during menstruation, (b) 14% during late luteal phase; the pregnancy and post pregnancy (Katz and McHorney, 2003); the pre/postmenopausal period (Shaver, 2002). Around 40% of individuals with insomnia have a psychiatric condition associated with it. A study reported about 69% of cases of insomnia is followed by depression, whereas an anxiety disorder preceded by insomnia 73% of times (Johnson et al., 2006). There is an association between the insomnia and a coexisting diagnostic and statistical manual of mental disorders, 4th edition, text revision (DSM-IV-TR) as reflected in the following: (a) Onset of the insomnia coincides with the onset of the associated mental disorder; (b) Course of the insomnia coincides with the course of the mental disorder (Johnson et al., 2006). Sleep is a state of unconsciousness in which the brain is relatively more responsive to internal than to external stimuli. According to Unani system of medicine health is attributed by equilibrium of *akhlat* (humours), besides this there are *asbab-e-sittah zarooriya* (six essential factors) i.e. air, food and drinks, bodily movements and repose (*harkat-wa-sakoon badni*), mental activity and repose (*harkat-wa-sakoon nafsani*), sleep and wakefulness (*naum wa yaqza*) and retention and excretion (*ahtibas wa istifiragh*). Any imbalance in any of the above factors is likely to cause disease. Normal sleep is thought to be because of *ratoobat* wa *baroodat* i.e. wetness and cold in our brain and if there is derailment of balance in sleep and wakefulness, it implies the predominance of *yuboosat* wa *hararat* i.e. dryness and hotness widespread in the brain (Kabeeruddin, 1921). Insomnia is Latin word *insomnis* which is composed of 'in' mean "not" and 'somnus' means "sleep" which means 'no sleep'.

In Unani system of medicine *sehar* (insomnia) can be defined as 'sleeplessness' or 'awakening' which occurs mainly as a result of imbalance in the temperament of brain due to excess of *yaboosat wa hararat* and secondarily due to some other causes such as medical or mental disorders (Ibn Sina 2001). Excess of awakening is known as *sehar* as quoted by Ibn Sina (Ibn Sina 2001). Another eminent scholar Ismail Jurjani says that sleeplessness and excessive awakening are called *sehar* (Jurjani, 1903). As per the concept of Akbar Arzani *sehar* is *bedarie mufrat* (prolonged awakening) (Arzani, 2002). Insomnia is both a risk factor for depression and a consequence of depression. Insomnia is a predisposing

factor for onset and recurrent major depressive disorder (MDD). Both disorders are highly prevalent and frequently can occur at any age but old age and women are at high risk (Edinger et al., 2004). According to cause insomnia can be defined as: (a) *Primary insomnia*: (psycho-physiological, paradoxal, idiopathic) which doesn't have any known cause. (b) *Secondary insomnia*: (medical, psychiatry illness) here the cause of insomnia is known. According to Unani system of medicine three types of possible causes which can be broadly classified as: (a) *Ikhtiyari asbaab* (voluntary causes) which are voluntarily and under our control; (b) *Aarzi asbaab* (temporary causes) which are temporary in origin and when removed or decreased sleep is restored e.g. stress; (c) *Marzi asbaab* (diseases) which are causes because of diseases e.g. mania (Arzani, 2002).

CASE REPORT

The present case is about a 35-year-old female of known case of (K/C/O) dysthymia for 15 years who visited to outpatient department (OPD), Majeedia Hospital, New Delhi, India on 28th February 2008 from Malviya Nagar, New Delhi, India. She was married, Muslim and housewife patient had a complain of (a) early wakefulness for 5 months; (b) difficulty in initiating sleep for 5 months; (c) concentration decreased for 2 months; (d) fatigue for 2 months. Patient was alright 5 months back then gradually developed difficulty in falling sleep. Her sleep onset latency exceeded 3-4 hours and wakes early in morning. Irritability associated with this patient was increased and doesn't like to talk with others. Patient also showed day time fatigue and anxiety. Patient wanted to keep herself busy and did not enjoy the things she used to do. Patient was failing to concentrate fully on things like before. Patient also felt loss of memory. Patient was K/C/O chronic depression with episodes of major depression once or twice a year. Last time i.e. one year back she had episode of major depression. Patient had no history of any other chronic disease. Patient was on antidepressants since last three month. Patient was taking tricyclic antidepressants in divided doses. And patient was also taking clonazepam (1 mg) hs (hora somni) daily. In family history, the elder sister had history of systemic sclerosis. No history of smoking and alcoholism was reported. Patient was conscious, well oriented. The blood pressure and pulse were recorded as 110/70 mmHg and 82/min respectively, respiratory rate (RR): normal, pupil size: normal, skin: normal, lymph nodes: normal. On systemic examination CVS, abdomen and chest appeared normal. CNS examination included the mood swings of patient. Cranial nerve examination was normal. Patient was asked to fill an insomnia screening questionnaire to confirm diagnosis. And it was confirmed that the patient has secondary insomnia (*sehar*).

Treatment included, Sharbat Ahmad Shahi-20 ml BD; Itrifal Ustukhudus-7 gm OD. Natool therapy included, Roghan Laboob Sab'a h + Roghan Kahu (1:1) (Kabeeruddin, 1921). Both oils were taken in equal quantity heated at 40 °C for 15minutes. Patient was asked to lie in supine position on massage table. After covering her eyes with gauze piece, lukewarm oil was poured on scalp from nutool apparatus at a distance (aprox. 65 cm.) gradually all over temporal region for at least 20 min. Oil was collected in container below, if enough oil collected then repeated after heating. This was followed by *dalak qaleel* i.e. short duration massage with soft hands on the temporal region for 2-3 min. Duration of therapy included, for first 14 days alternatively (7 sittings), after that twice weekly for two weeks (4 sittings) and then once weekly (1 sitting). Total sittings given to patient were 12.

DISCUSSION

From the above results it is evident that Unani management of insomnia not only treated insomnia but it also helped to reduce the depression of patient. *Nutool* with lukewarm oils are bestowed with *mussakine alam* (analgesic), *mukhadir* (sedative), *muratib (*emollient), *mubarid* (cold), *munavim*(hypnotic), *muqawwie dimag* (brain tonic properties) action increase the circulation on the temporal region and are absorbed in the circulation (Kabeeruddin, 1921; Pigeon, 2010; Majusi and Kamilsa, 2010). *Dalak qaleel* i.e. short duration massage was done to enhance circulation for better absorption (Hussain et al., 2011).

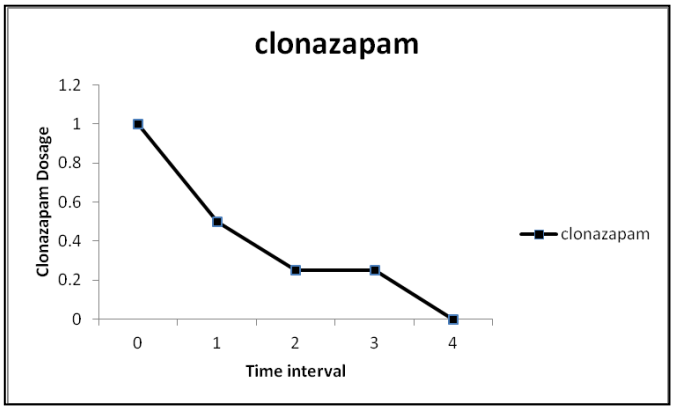

Figure 1. Tapering off doses of clonazepam.

Dalak also helps to enhance serotonin and endorphin secretion. Serotonin being regular component of various antidepressants and endorphin is a 'natural feel good chemical'. *Itrifal ustukhudus*, the compound Unani drug having *Lavendula stoechas* was given orally which is a brain tonic (Khan, 1996). It has been seen to have anxiolytic action. *Sharbat ahmad shahi* (Jamala et al., 2012) has long been used in treatment of various psychiatric disorders.

Table 1. Zung self-rating depression scale and personal health questionnaire depression scale (PHQ).

Scales	First visit (1-3-13)	After Rx (8-4-13)
Zung self-rating depression scale	40	38
Personal health questionnaire depression scale (PHQ)	9	3

CONCLUSION

The patient showed significant improvement in insomnia with Unani drug treatment. Thus *usool-e-ilaj* as per Unani literature for treatment of secondary insomnia because of depression is very effective.

CONFLICT OF INTEREST

None declared.

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