September 15, 2017 Pierre, SD

End the Insomnia Struggle: An Individualized Approach to Treating Insomnia Using CBT-I and ACT

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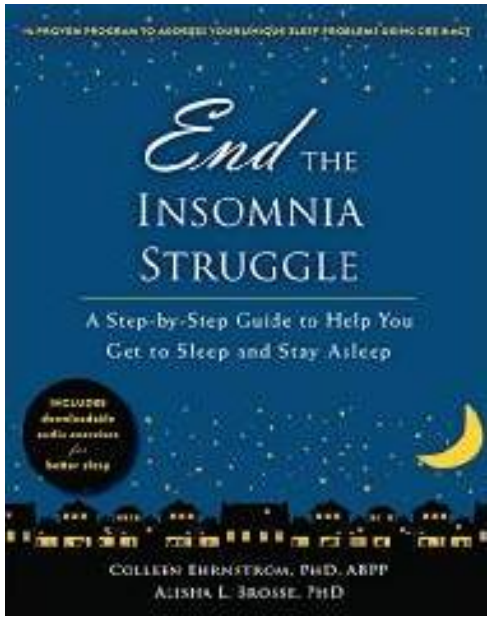


Schedule

8:30	Assessment; acceptance
9:30	Models (psychoeducation)
10:00	Break
10:15	Behavioral interventions
11:45	Lunch
1:30	Cognitive strategies [break 2:45-3:00]
3:15	Sample treatment plans/Cases
4:00	State of the evidence & summary
4:30	Q&A

Sessions 1 & 2

- Assessment
- Acceptance
- Models (Psychoeducation)

Assessment Goals

- Differential diagnosis
-

Differential Diagnosis

- Insomnia
  - Difficulty initiating or maintaining sleep, or non-restorative sleep, *despite adequate opportunity*
  - Associated daytime distress or dysfunction
- Circadian Rhythm Disorders
  - Generally can sleep well, but not at desired time
  - Advanced Sleep Phase Syndrome (fast clocks; get tired early and awaken early in a.m.)
  - Delayed Sleep Phase Syndrome (slow clocks; get tired late and sleep late)

Differential Diagnosis (cont.)

- Excessive Daytime Sleepiness (EDS)
  - Sleep Apnea
  - Narcolepsy
  - Periodic Limb Movements Disorder (PLMD)
  - Restless Leg Syndrome (RLS)

Assessment Goals

- Differential diagnosis
- Select treatment components
- Determine sequencing
- Determine referrals for medical workup

Assessment Tools

- Questionnaires
- Sleep Log
- Clinical Interview
  - Daytime CONSEQUENCES
  - THOUGHTS:
    - *"Tell me what's going on in your mind as you go to bed/awaken?"* (content and process)
    - *"How much do you think about your sleep or the consequences of your insomnia?"*
    - *"Are you anxious about sleep?"*
  - ENVIRONMENTAL factors, including bed partners
  - Typical evening/sleep/rising
  - Past/current INTERVENTIONS

Assessment Tools (cont.)

- Polysomnography
- Physical with bloodwork

Sessions 1 & 2

- Assessment
- Acceptance
- Models (Psychoeducation)

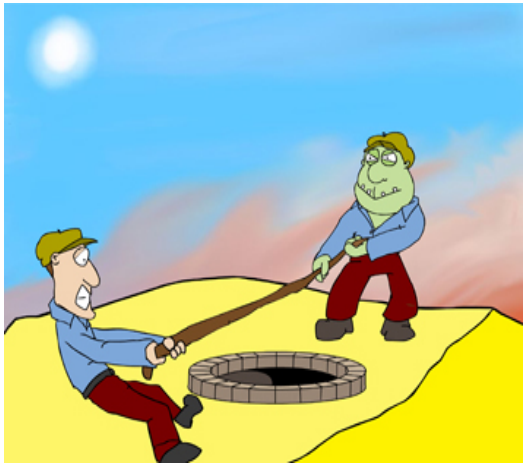
The Message We Get (YIKES!)

Taken from yourlocalsecurity.com

Antidote: Acceptance/Willingness

Metaphors/Exercises:

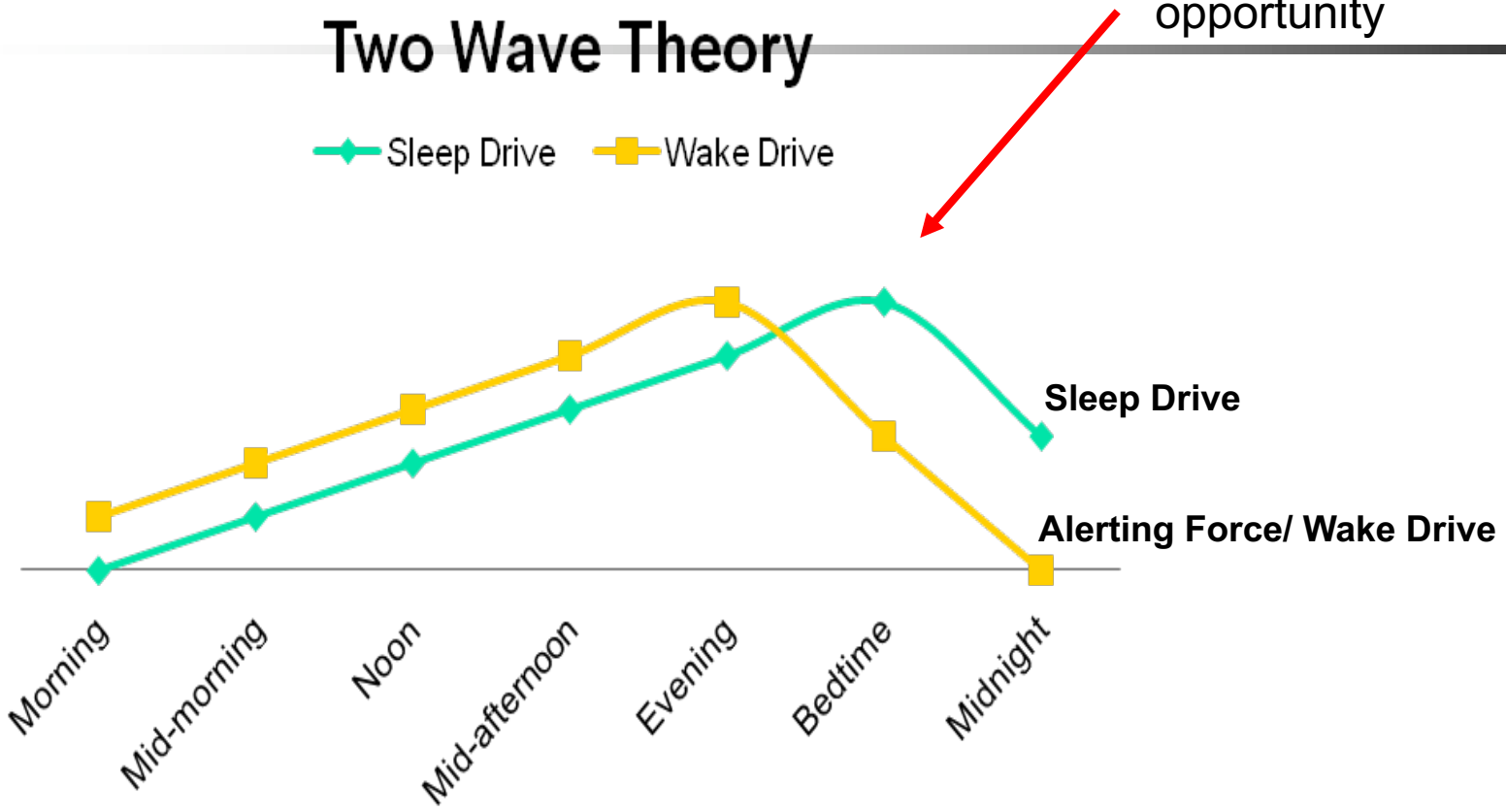
- Tug O' War
- Gun-to-head
- Chinese Fingertraps



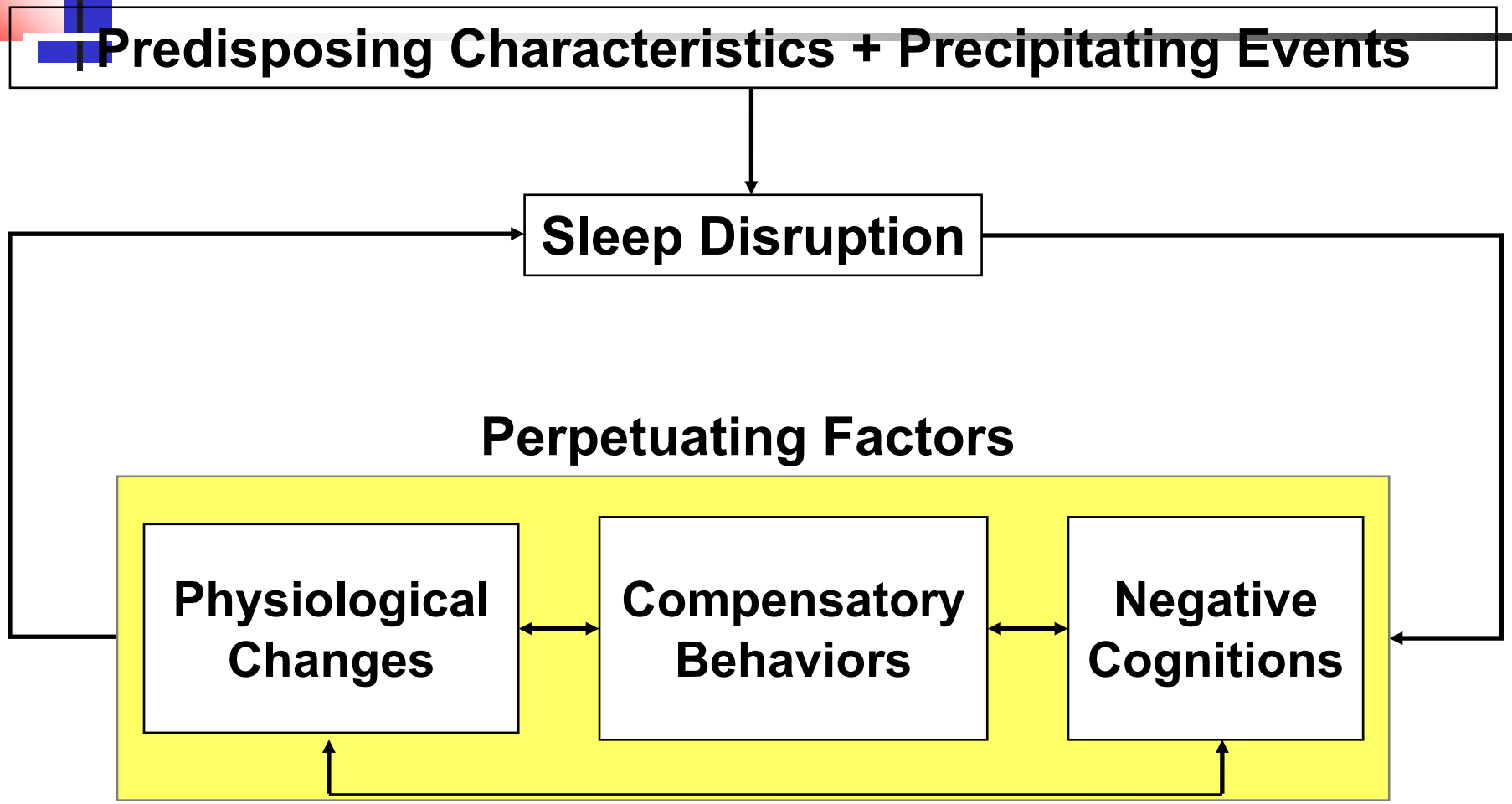
Sessions 1 & 2

- Assessment
- Acceptance
- Models (Psychoeducation)

Two Wave Theory



3P Model of Insomnia

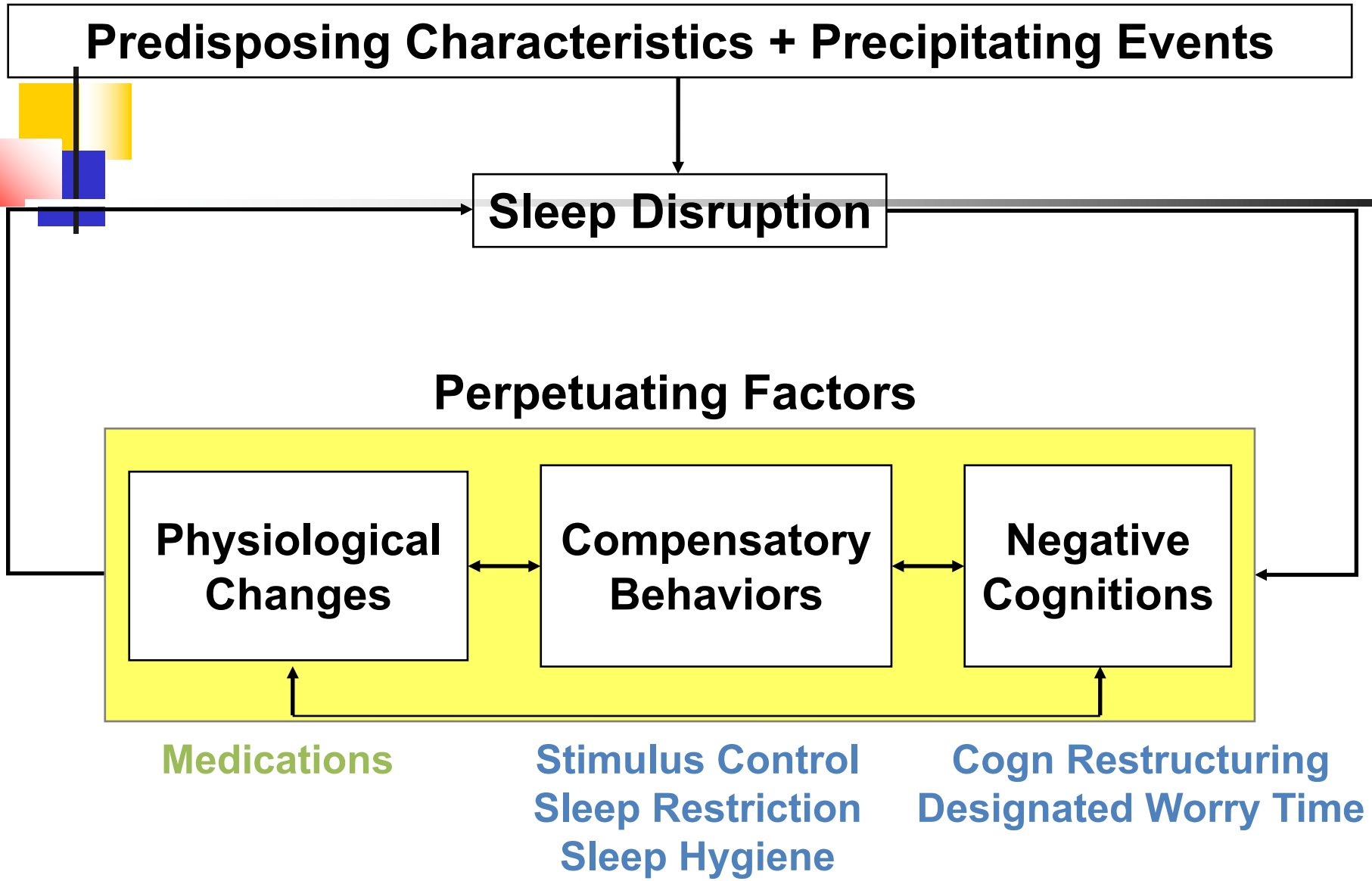


3P Model of Sleep Disorders

(Glovinsky & Spielman, 2006)

- Predisposing characteristics
  - operative before sleep disorder develops
  - inherited or acquired
- Precipitating events
  - often readily identifiable and tagged as “the cause”
  - acute stress, injury, etc.
- Perpetuating attitudes and practices**
  - behavioral coping strategies that go awry
  - negative thought patterns

**most effective place for intervention



Insomnia Intervention Key: Medical

CBT-I

Behavioral Strategies

- Stimulus Control Therapy (SCT)
- Sleep Restriction Therapy (SRT)
- Sleep Hygiene
- Paradoxical Intention
- Relaxation Training

Stimulus Control Therapy

- First behavioral program developed and tested (1970s)
- Goal: retrain brain to associate bed with sleep and sex ONLY

Stimulus Control Guidelines

1. Limit behavior in bed/bedroom to sleep and sex.
2. Lie down only when sleepy.
3. If, at any time during the night you are awake for more than 20 minutes, leave the bedroom and do something boring or relaxing.
4. Return to bed when sleepy. (Don't sleep elsewhere.)

Stimulus Control Guidelines

5. Repeat steps 3-4 as needed.
6. Fix your wake up time – get up at the same time each morning regardless of how much sleep you got.
7. No daytime naps.

If Only it Were So Easy….

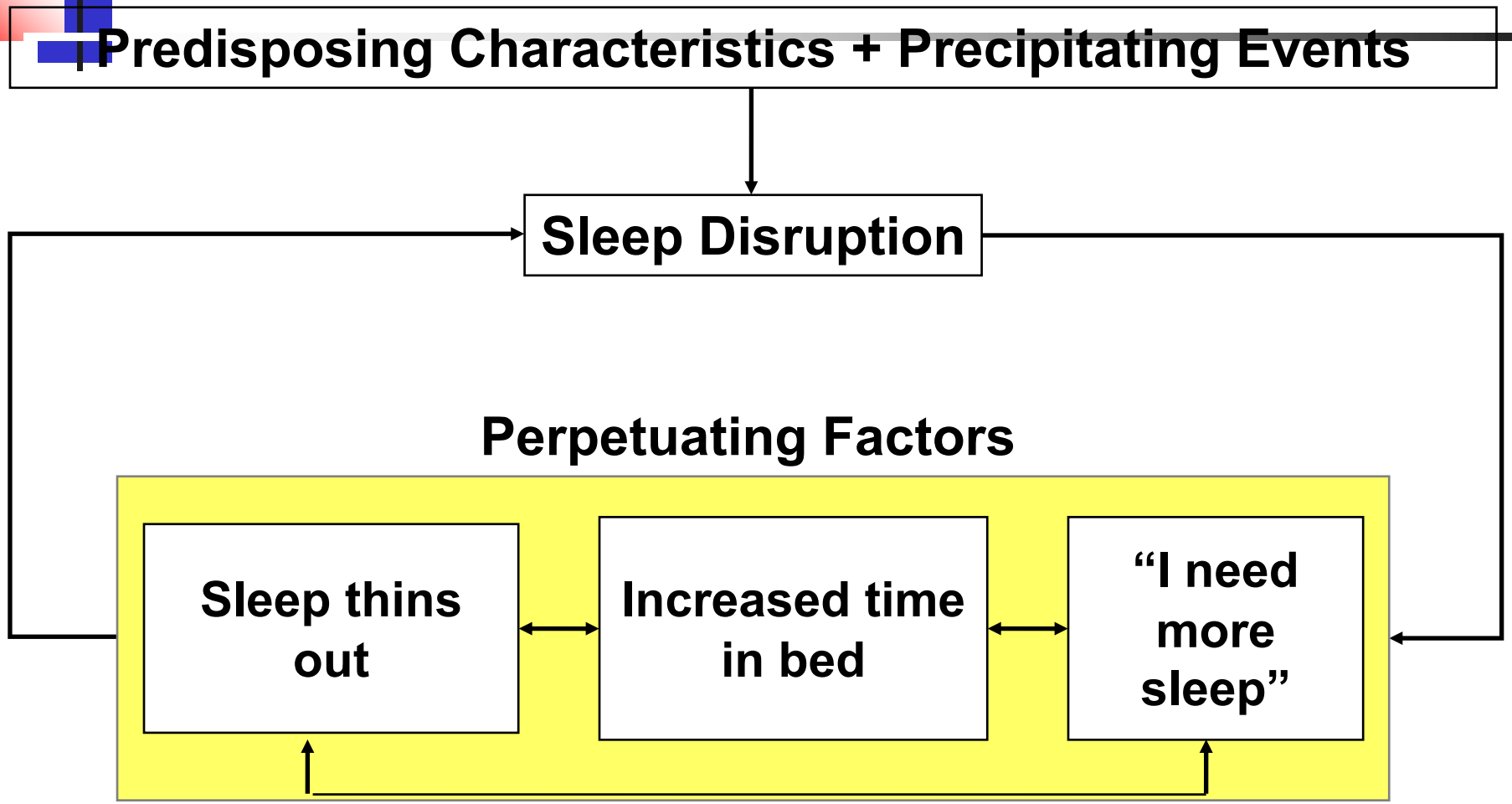
SCT: Implementation Tips

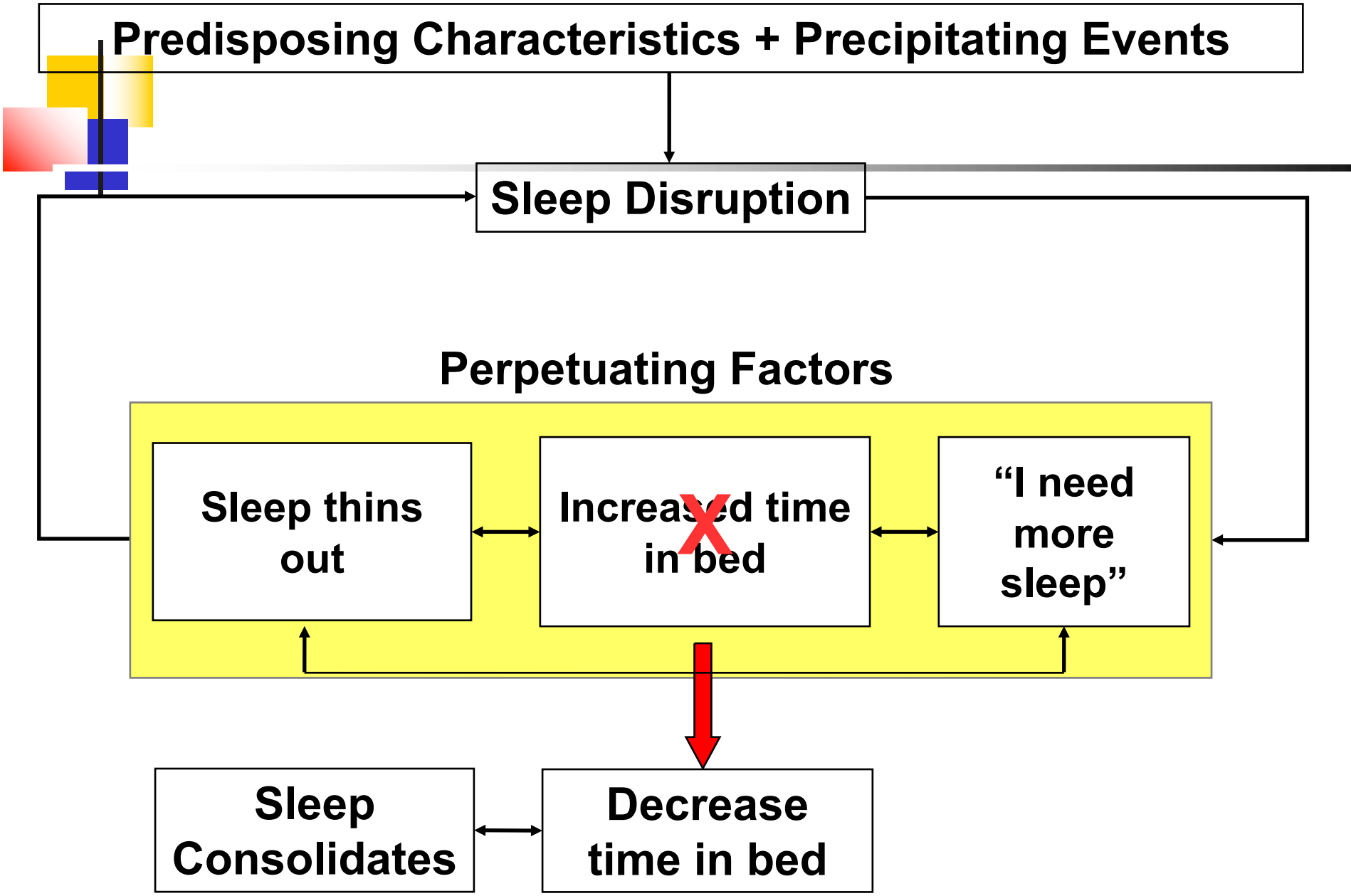
- Warn patients: they may feel worse before they feel better
- Provide a strong, credible rationale
- Develop a specific plan – write it down!
- Collect data with sleep log
- Caution: Don't use, or modify technique, if too little sleep is a trigger for major psychiatric disturbance (e.g., manic episode; psychosis)

Sleep Restriction Therapy

- Prioritizes quality over quantity of sleep
- Goal: consolidate sleep

SRT Rationale




Predisposing Characteristics + Precipitating Events
Sleep Disruption
Perpetuating Factors
Sleep thins out
Increased time in bed
"I need more sleep"
Sleep Consolidates
Decrease time in bed

Sleep Restriction Guidelines

1. Calculate your average total sleep time (TST), average time in bed (TIB), and sleep efficiency (SE) using sleep log data for 10-14 days.
2. Limit your time in bed to your average TST, but not less than 5 hours. To accomplish this, set a consistent bedtime and rising time
3. No daytime naps.

Sleep Restriction Guidelines

4. Adjust time in bed:
   - when 1-week avg SE is 90% or more (85% for older adults), add 15 minutes to TIB
   - if 1-week avg SE is under 85% (80% for older adults), decrease TIB to current average TST, but not less than 5 hours.
   - else, make no change.
1. Repeat step 4 until you reach target amount of sleep
2. Continue to log sleep each night

SRT: Implementation Tips

- Warn patients: this likely will be painful!
- However, it's also a powerful technique
- Develop a specific plan – write it down!
- Daytime accommodations?
- Sleep log essential
- Caution: Don't use, or use more mild version, if too little sleep is a trigger for major psychiatric disturbance (e.g., manic episode; psychosis)

Sleep Hygiene: Targets

Sleep Drive and Alerting Force (2-Wave Model)

- Limit daytime naps
- Limit alcohol
- Limit stimulants
- Regular exercise
- Wind-down period
- Limit electronics near bedtime

Environmental Factors

- Room temperature
- Light
- Noise
- Comfortable sleep surface
- Limit interference from bed partners (human, canine, feline)
- Phone - “airplane” mode or out of room

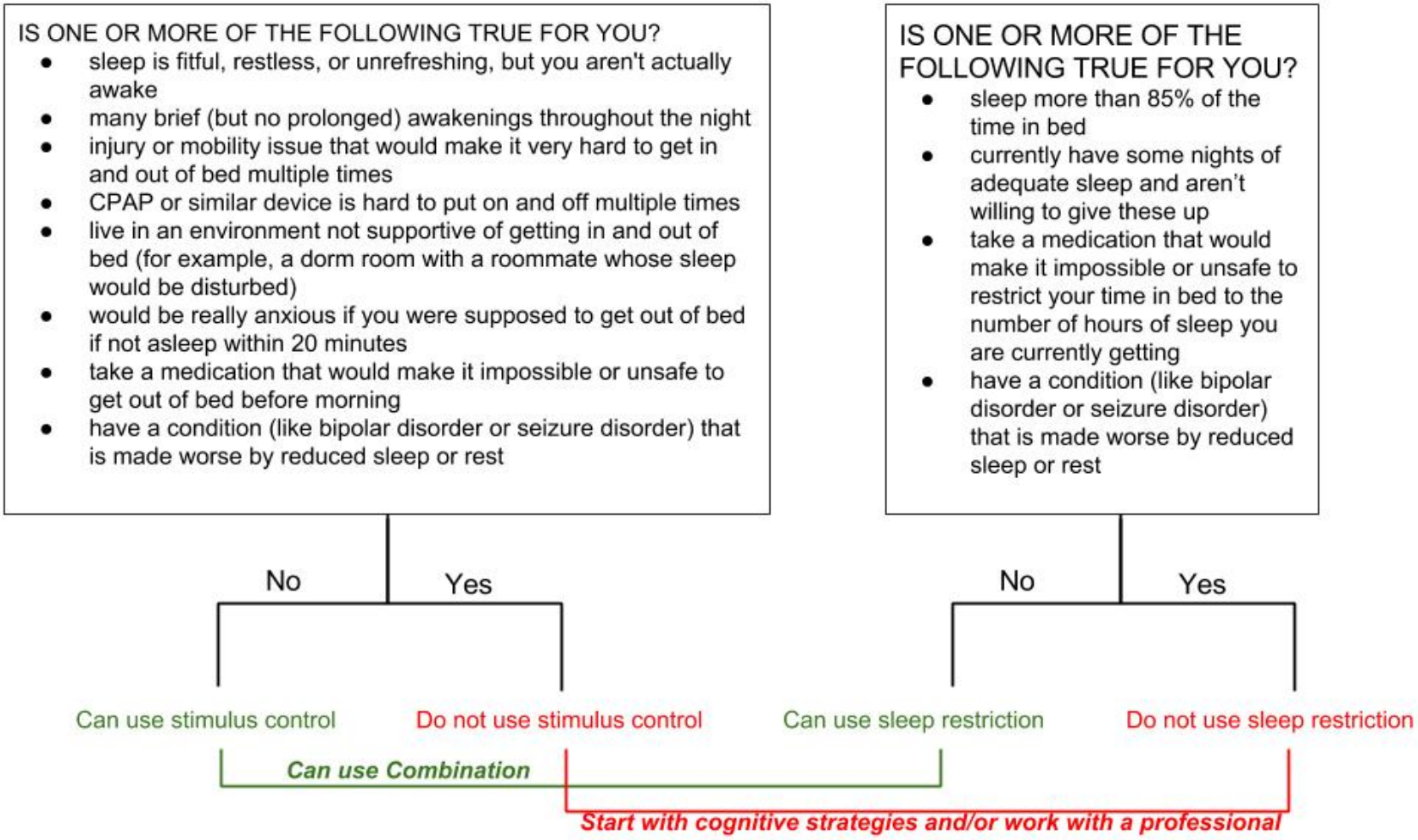
SH: Implementation Tips

- Guidelines, not rules (provide rationale)
- Time lag between changing behaviors and improved sleep
- Varying levels of sensitivity (e.g., may need to abstain from alcohol and caffeine all together)
- One change may not make a noticeable difference, but changing several things may
- Collect data to evaluate impact
- Sleep hygiene ≠ CBT-I! Not (usually) effective on own.

SCT, SRT, SH... or Combo?

- Consider:
  - Sleep pattern: awake long enough for SCT? SE under 85%?
  - Contraindications: dangerous to get out of bed? Medications interfere?
  - Treatment history
  - Willingness

Exercise 5.2 Should you use stimulus control, sleep restriction, or both?



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SCT, SRT, SH... or Combo?

- Consider:
  - Sleep pattern: awake long enough for SCT? SE under 85%?
  - Contraindications: dangerous to get out of med? Meds interfere?
  - Treatment history
  - Willingness
- Small group exercise
  - Which behavioral program(s)?
  - Starting prescription? (e.g., how many and which hours in bed for SRT? Suggested rise time for SCT?)

CBT-I presents several hurdles...

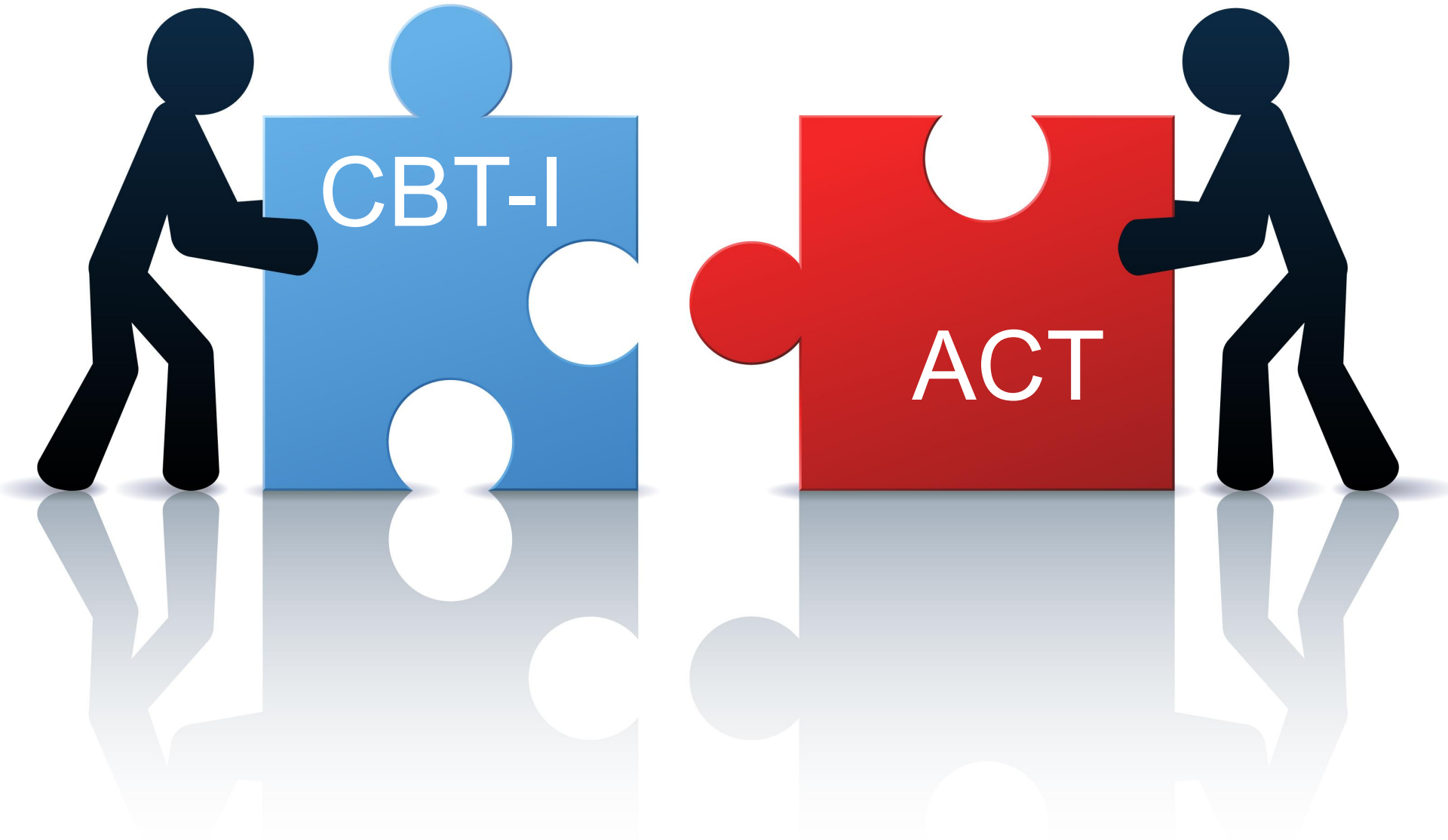
Client Hurdles

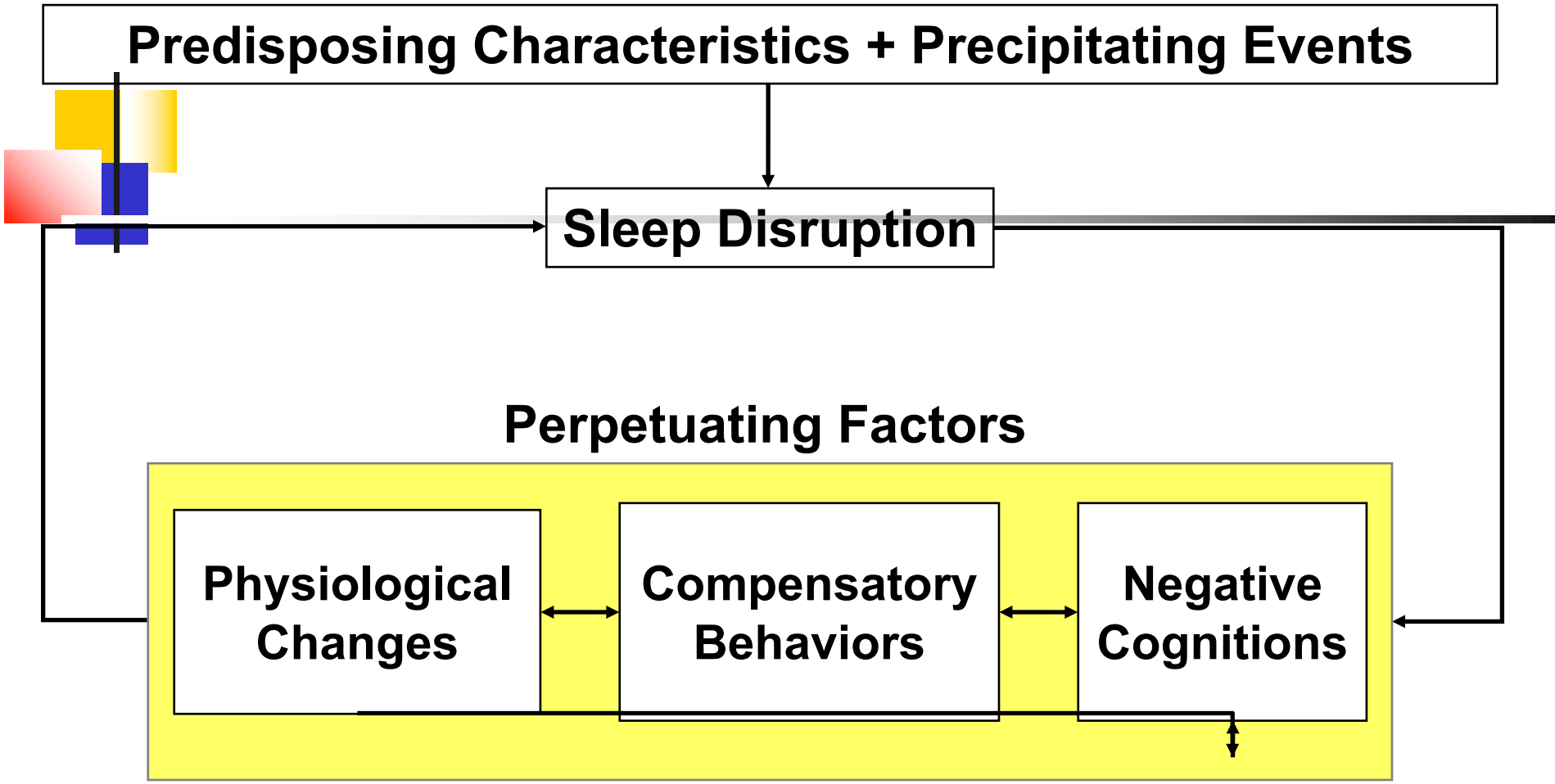
Wanda was proud of herself for sticking to her one-cup-a-day limit...

Unwilling to do the treatment fully.

Unwilling to not sleep. Rigidly adhere to the treatment with a control agenda.

A Perfect Fit





Medications

Stimulus Control
Sleep Restriction
Sleep Hygiene

Cognitive Restructuring
Designated Worry Time
Acceptance/willingness
Cognitive Defusion
Mindfulness

Insomnia Intervention Key: Medical

CBT-I
ACT

Targets of CT/ACT

- *Misperceptions* about sleep that create concern, anxiety, physiological arousal, and/or compensatory behaviors
  - "I MUST have 8 hours of sleep!"
  - "If I don't sleep well tonight I'll really blow that presentation tomorrow!"
- Thoughts that, regardless of accuracy, are *counter-productive*
  - "If I fall asleep now I can get 6 hours of sleep… If I fall asleep now I'll get 5 hours of sleep… [etc]"

Targets of CT/ACT (cont.)

- Thoughts that *interfere* with implementation of behavioral strategies
  - "I *can't* give up caffeine!"
  - "It's hopeless – nothing's going to help."
- Thought *processes* that increase cognitive or physiological arousal
  - Racing thoughts
  - Rumination
  - Sheer volume of thoughts
  - Worry

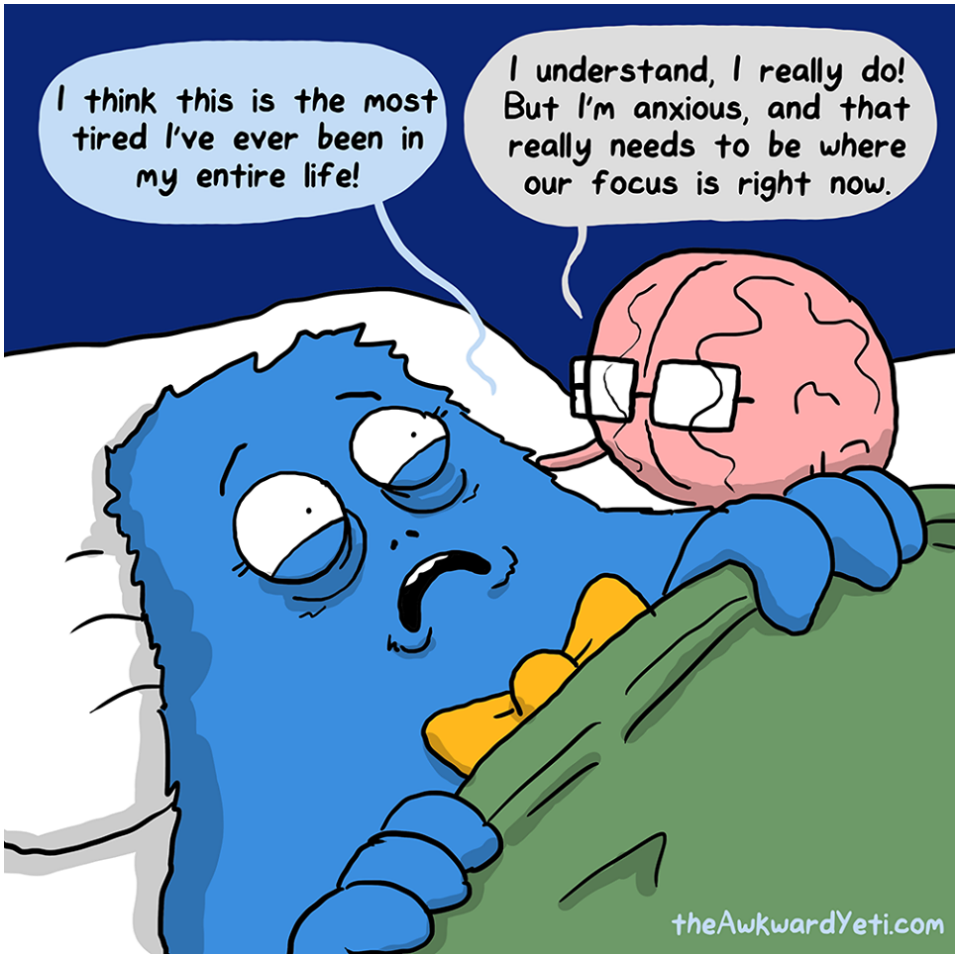
Cognitive Restructuring

1. Monitor sleep-related thoughts/ attitudes/beliefs with thought record
2. Challenge thoughts
   - Is this really true? What's the evidence?
   - If it is true, what does it mean to me?
   - Is it helpful for me to be thinking this way?
   - What would I tell a friend who was thinking this?
3. Replace inaccurate and counter-productive thoughts with more accurate/workable ones

CT: General Principles & Implementation Tips

- Tie to model; normalize
- Practice in-session
- Assign real-time monitoring/practice (HW)
  - Generally, complete during the day, not at bedtime
  - Anticipate and troubleshoot difficulties
  - Check-in during subsequent session(s)
- Help client create cards for common “negative cognitions” – “negative” on one side, more accurate/workable one on other

Designated Worry Time

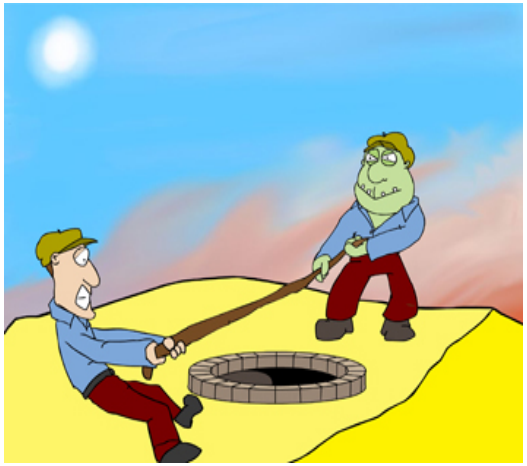


Acceptance/Willingness

- “If you’re not willing to have it, you will” (struggle)
- Increase willingness to experience short-term pain
- Increase willingness to sleep *(huh?)*
- “Never try to sleep!” (surrender)
- Expect non-linear progress; be willing to maintain or renew efforts

Metaphors/Exercises

- Tug O' War
- Gun-to-head
- Chinese Fingertraps



Cognitive Defusion

- Stepping back from thoughts; creating space; getting unstuck; recognizing thoughts as thoughts and nothing more
- Examples
  - Note card exercise
  - Mindfulness
  - Put thoughts on... leaves on a stream; clouds; bubbles; ticker tape at bottom of TV; parade signs
  - “I'm having the thought that...”
  - Sing it; funny voices; various fonts on screen

Mindfulness

- What it is: Paying attention, on purpose, in the present moment, without judgment
- What it is NOT: Relaxation; a hypnotic
- Practice during the day
  - Formal sitting practice
  - Mindfulness of daily activity
- How to use at night
  - non-striving

Treatment Planning

- Which behavioral program(s)?
- Which strategies for targeting unhelpful thoughts, cognitive processes, or cognitive hyper-arousal?
- Sequencing?

Case Examples

- #1: 17 y.o. male; onset & middle insomnia; “night owl” entire life; missing school – in danger of not graduating
- #2: 65 y.o. male; middle insomnia (awake 1-3 hrs, 5-6 nights/week)
- #3: 36 y.o. female; historically a long sleeper with high sleep inertia/low energy; recent onset insomnia; very anxious about it
- SRT=sleep restriction therapy; SCT=stimulus control therapy; DWT= designated worry time; TIB=time in bed; OEA=opposite-emotion-action

Sample Treatment Courses

	CASE #1	CASE #2	CASE #3
SESSION 1	Interview Instruct on sleep log Rx: stay up later	Interview Instruct on sleep log 3P & 2-wave models Rx: SCT	Interview Instruct on sleep log Gun-to-head metaphor
SESSION 2	Review log 3P & 2-wave models Rx: SRT	<2-month gap: had responded well to SCT> Reviewed SCT Rx: return to SCT	Review log Tug O' War Cognitive distortions Introduced SRT
SESSION 3	Review log & SRT Rx: SRT+15 min.		Rx: SRT
SESSION 4	Review log & SRT Psychoed re: meds DWT Rx: SRT+15 min		Review log & SRT 2-wave model; OEA mindfulness Rx: SRT; mindfulness
SESSION 5	Review log & SRT Relapse prevention		Review log & SRT Rx: SRT+1 hr
SESSION 6			Relapse! Return to original TIB=6 hrs

Research: Multi-component CBTi for Chronic Insomnia

- About two-thirds of participants respond (Edinger et al. 2001; Harvey et al. 2014; Perlis et al. 2000)
- Meta-analysis of 19 studies (Trauer et al. 2015):

➔ Improvements in sleep onset latency, wake after sleep onset, and sleep efficiency

➔ Marginal improvement in total sleep time

➔ Improvements maintained over time

-

Research: CBTi for Co-morbid Insomnia

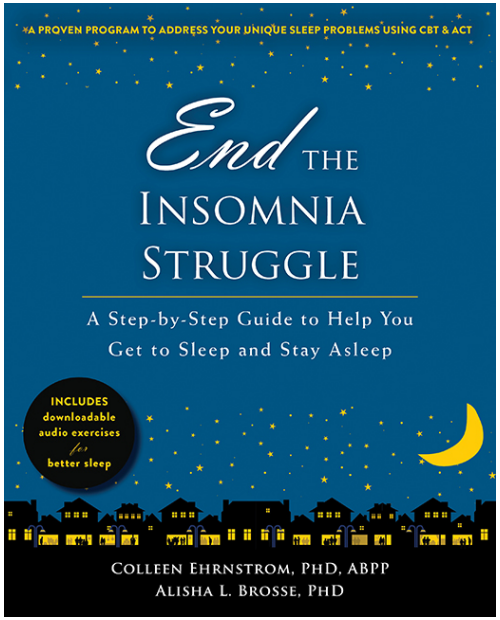
- MDD: 4-6 week CBTi improved sleep and resulted in remission of MDE in over two-thirds of participants (Ashworth et al. 2015; Taylor et al. 2007)
- Bipolar I Disorder: 8-week expanded CBTi protocol improved sleep and decreased mania relapse (Harvey et al. 2015)
- Cancer: 8 studies; improved sleep efficiency, sleep onset latency, wake after sleep onset, and self-reported insomnia severity (Johnson et al. 2016)
-

Summary: Choose Your Own Adventure

- Assess
- Orient pt toward destination (educate)
- Pick a (behavioral) path
- Add side trips (cognitive strategies; sleep hygiene)
- Track progress (sleep log)
- Effectiveness as compass
- Expect “switchbacks”
- Compassion for the burn of an uphill climb
- Celebrate & help maintain gains (wellness/rel. prev. plan)

Additional Training/Consult

- Monthly consultation group (email info@bouldercbt.com)
- Workbook with additional web resources



Other Resources

- “The Insomnia Answer: A personalized program for identifying and overcoming the three types of insomnia” (Glovinsky & Spielman, 2006)
- “The Insomnia Workbook: A comprehensive guide to getting the sleep you need” (Silberman, 2009)
- “The Sleep Book: How to sleep well every night” (Meadows, 2014) (ACT-I)

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