Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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Supporting Behavior Change in Cognitive-Behavioral Therapy (CBT) for Insomnia

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Outline

• Clinical scenarios

• A brief review or introduction
  • Insomnia definition
  • The two-part process of sleep
  • A cognitive-behavioral model of insomnia
  • Multi-component CBT for insomnia
  • Stimulus control and sleep restriction

• Supporting behavior change
  • Sharing typical patterns during treatment
  • Stimulus control and/or sleep restriction
  • Considering willingness

• Return to clinical scenarios
Clinical Scenarios
Worried when reason sleeps

Rita is 68 years old, and she has had a lifelong tendency toward worry. However, about 2 years ago, she started waking up more at night and found herself more worried than usual. She often would think about her mother being in hospice and also how her father is struggling to care for himself. This was paired with her adult daughter going back to school and needing help with her children. Plus, once she started noticing that she was sleeping poorly on a regular basis, she would also worry about her sleep, “It is 4am and I have the grandchildren all day tomorrow.”
Worried when reason sleeps

Rita went to her primary care doctor and was prescribed citalopram each morning, trazodone each evening, and clonazepam as needed during the night. She found some improvement in her sleep and anxiety with medication, but still did not feel like her regular self. After taking medication for a few months, her average total sleep time was 6 hours and her average time awake during the night was 2.5 hours. So, she was sleeping about 71% of the time she was in bed (sleep efficiency = 6 hours of sleep/8.5 hours of time in bed x 100).
No time for insomnia

Dave is 60 years old. He has had a longer history of difficulties falling and staying asleep, mostly related to work stress. He has struggled to find a medication that is helpful for sleep and does not have side effects. His longest awakening is usually when he is attempting to fall asleep. He often has a hard time turning off his mind and is thinking through the events of the day or what he has to do the next day. Once asleep, he may wake up a 1-2 times to use the restroom, but he can return to sleep fairly easily.
No time for insomnia

Dave’s life is very full at the moment. He rarely has time to decompress prior to going to bed and thinks “I can’t have insomnia—I’ve got too much going on!” He has tried sleep medications, but no medication was helpful for sleep and most made him feel very groggy and worse the next day. At his first behavioral treatment intake appointment, his average total sleep time was 4 hours and his average time awake during the night was 3.25 hours. So, he was sleeping about 55% of the time he was in bed (sleep efficiency = 4 hours of total sleep time/7.25 hours of time in bed x 100).
A Brief Review or Introduction
DSM-5 Criteria for Insomnia Disorder

- One or more:
  - difficulty initiating sleep
  - difficulty maintaining sleep
  - waking up too early

- Sleep difficulty occurs:
  - despite adequate opportunity for sleep
  - at least 3 nights a week
  - at least 3 months

- Daytime consequences

- Not explained by another sleep-wake disorder or substance use

- Co-existing mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia
The Two-Part Process of Sleep

- Homeostatic regulation (the sleep drive)
- Circadian regulation (the body’s clock)
- Keeping in mind hyperarousal/conditioning

A Cognitive-Behavioral Model of Insomnia

- **Cognitive Factors**
  - Sleep Effort
  - Unhelpful Sleep-Related Thoughts & Beliefs

- **Homeostatic Dysregulation**
  - Sleep Extension

- **Circadian Disruption**
  - Irregular Sleep Scheduling

- **Inhibitory Factors**
  - Poor Sleep Hygiene
  - Hyperarousal
  - In-bed Habits
  - Conditioned Arousal

- **Chronic Insomnia**

Cognitive-Behavioral Therapy (CBT) for Insomnia: A Multi-Component Treatment

• Typically includes:
  • Stimulus control
  • Sleep restriction therapy
  • Cognitive therapy
  • Sleep hygiene

• May or may not include:
  • Relaxation therapies

Efficacy of Cognitive-Behavioral Approaches

- Well-established treatments
  - Relaxation
  - Stimulus Control
  - Sleep Restriction
  - CBT for insomnia

- Not efficacious as a stand alone treatment
  - Sleep Hygiene only
  - Cognitive Therapy only

Stimulus Control: 
Reassociating the Bedroom with Sleeping & Setting the Body’s Clock

• Select a standard wake-up time
• Select a standard bedtime (but waiting until sleepy to go to bed)
• Avoid sleep-interfering activities in bed
• Get out of bed after 15-30 minutes when unable to sleep and engage in non-stimulating activities
• Avoid napping
• Go to bed only when sleepy

Bootzin (1972)
Sleep Restriction Therapy: Increasing Sleep Drive & Setting the Body’s Clock

• Using a sleep log of 1-2 weeks
• Compute average total sleep time (TST)
• Limit time in bed (TIB) to TST + 30 min (the sleep restriction prescription)
  • Best to never go below 5.5 hours
• Increase TIB 30 min when sleep efficiency ≥ 85% and still fatigued and/or sleepy
• Decrease TIB 30 min. when sleep efficiency is < 80 %
• Stay with current amount of TIB if sleep is going well and not fatigued or sleepy

Spielman et al. (1987)
Supporting Behavior Change: Sharing Typical Patterns During Treatment
Typical patterns during treatment

• Insomnia and daytime consequences often get a little worse before they get better
  • Exercise analogy: Starting CBT for insomnia is like when you return to exercise after not exercising for awhile and feel sore at first

• Main effect of treatment is decreasing total wake time; total sleep time usually does not increased greatly

• Setbacks happen and are an opportunity to practice working with intermittent sleep challenges
Supporting Behavior Change: Stimulus Control and/or Sleep Restriction
Stimulus Control and/or Sleep Restriction

• These interventions are the most efficacious and commonly used treatments, often offered together with multi-component CBT for insomnia

• However, both of these interventions have been demonstrated to be efficacious as stand-alone treatments

• Thus, to support behavior change, it can helpful to think about making change smaller and more manageable by focusing on one of these interventions versus both of them
How to decide about stimulus control?

• Reasons to consider using stimulus control:
  • You have longer awakenings in the night
  • These awakenings are often with an active mind or tense body

• Reasons to consider **not** using stimulus control:
  • You feel very overwhelmed by the thought of having a regular sleep schedule, getting out of bed at night, and/or not having the option of napping
  • Your sleep environment does not work for getting out of bed at night (e.g., you have a roommate, bed partner, or pet that would be very disturbed)
  • You have health concerns that would make it difficult to get out of bed at night (e.g., challenges getting out of bed without assistance, nighttime medication that makes you feel groggy and unstable, history of falling during the night)
  • You have a condition that is exacerbated by reduced sleep like bipolar disorder or a seizure disorder
How to decide about sleep restriction?

• Reasons to consider using sleep restriction:
  • You spend a good portion of time awake in bed (more than 15% of the time)
  • Your nighttime awakenings are brief or long

• Reasons to consider *not* using sleep restriction:
  • You feel very overwhelmed by having a regular sleep schedule with limited time in bed and/or avoiding napping
  • Your sleep environment is not conducive to having an alarm set or another way to insure your regular wake-up time
  • You take a medication that is too sedating to stay with a sleep restriction prescription
  • You have a condition that is exacerbated by reduced sleep like bipolar disorder or a seizure disorder
Supporting Behavior Change: Considering Willingness
What is willingness?

- Being open to your experience, whatever it is
- Similar in concept to acceptance
- The opposite of struggle
- It is *not* resigning to insomnia for a lifetime, but instead being open to what this night in front of you brings

What are the willingness challenges for CBT for insomnia?

• Willingness to make behavioral changes that are uncomfortable
• Willingness to make behavioral changes that take time to show effects
• Willingness to not control sleep
• Willingness to support and nurture sleep

• Tug-o-war metaphor/practice
Questions in Considering Willingness

• Stimulus Control:
  • Where will I go when getting out of bed?
  • What will I do when I am out of bed?
  • How do I need to prepare?

• Sleep Restriction:
  • How will I stay up and get up at the prescribed times?
  • What will I do with this extra time?

• Either or Both:
  • How will I avoid napping or dozing?
  • What will I have to give up in trying this strategy?
  • What discomfort may I experience?
  • Why am I willing to give up ____ (for now) and experience discomfort (for now)?
  • When do I know this is too much?
Return to Clinical Scenarios
Return to Clinical Scenarios

• Worried when reason sleeps (Rita)

  • Mostly longer awakenings with an active mind = good match for stimulus control

  • Spends more than 15% of time awake in bed = good match for sleep restriction

  • “It is 4am and I have the grandchildren all day tomorrow.”
Return to Clinical Scenarios: Worried When Reason Sleeps

• What makes you the most concerned about trying these strategies?
  • “Only having a certain amount of time to sleep—what if I have my grandkids the next day?” (a strike against sleep restriction)

• What comes up for you when you think about getting out of bed at night? (exploring stimulus control more specifically since sleep restriction seems overwhelming)
  • “I guess I would just need to figure out what I would be doing, but I think it would be ok. I see what you mean about having something to focus on like a book or television. But what if my mind is really going?” (showing some willingness for stimulus control while also communicating some need for further help with an active mind)
Return to Clinical Scenarios: Worried When Reason Sleeps

• If you woke up more than once during the night and had to get out of bed multiple times, when do you think you would experience “your edge”, meaning it would just be too much to handle?
  • “I think I could try it 1-2 times and then I would start to be worried about how I would feel the next day.” (showing willingness for stimulus control and when it would be too much)

• What would it be like to try a sleep schedule of 10:30pm to 6:30am and get out of bed and read or watch television (at least for the first 1-2 awakenings) until your mind is less active?
  • “I think I could do this.”

• Just to remind you, things may get a little worse before they get better, right? How will you take care of yourself if you notice this happening to you?
  • “I could take it easy the next day and remind myself that this is going to take some time.”
Return to Clinical Scenarios

• No time for insomnia (Dave)

  • Longer awakening only when attempting to fall asleep and little time for decompression = possibly a match for stimulus control

  • Frequent and shorter awakenings and spends more than 15% of time awake in bed = good match for sleep restriction

  • “I can’t have insomnia—I’ve got too much going on!”
Return to Clinical Scenarios: No Time for Insomnia

• **What makes you the most concerned about trying these strategies?**
  
  • “Just like I have no time for insomnia, I have no time for doing this. I just want to sleep.”

• **I hear you. I know this seems opposite of what you think might be helpful, but what if you went to bed a little later and had some additional time to relax before going to bed? (exploring sleep restriction)**
  
  • “I’m not sure it would work. If I go to bed later, I may just fall asleep even later.”

• **What kinds of relaxing activities have you been missing out on recently?**
  
  • “Everything. I used to read for fun or watch a little tv before bed, but it has been a long time.”
Return to Clinical Scenarios: No Time for Insomnia

• **What would it be like to go to bed just 30 minutes later so you had a little extra time to read or watch television?**
  • “I’m still concerned it would just mean I would lose out on 30 more minutes of sleep.”

• **What is the biggest sacrifice in losing out on sleep in the short-term to help sleep in the long-term?**
  • “I’m most concerned about work and being able to get through the day. Also, I get really irritable when I am sleep deprived, and I am not much fun to be around.”

• **How many nights would you feel ok going to bed a little later just to see what might happen?**
  • “Maybe 3 nights?”
Return to Clinical Scenarios: No Time for Insomnia

• Do you think there is a better/best time to try this 3-night experiment?
  • “This week is very busy with the end of the quarter, but I think I could try this next week.”

• What if this helped things out, would you be willing to go to bed even a little later?
  • “I would need to see some change first.”

• I hear you. Just a reminder that change takes time and may move a little more slowly if we take a more careful approach like we are taking. That being said, I think this more careful approach seems like the best fit with everything you have going on. What do you think?
Self-Help Resources
