INSOMNIA

CBT-I
COMPONENTS
TX DELIVERY

OK. SO IT WORKS.
WHAT IS IT ?

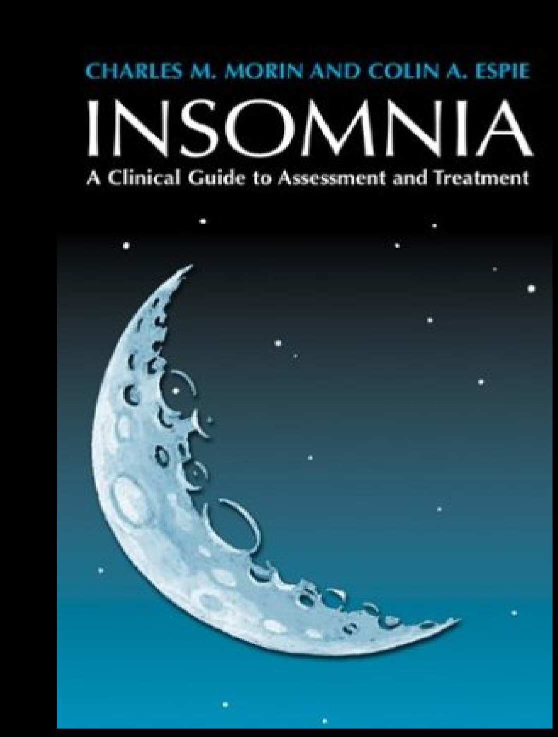
A HX PERSPECTIVE

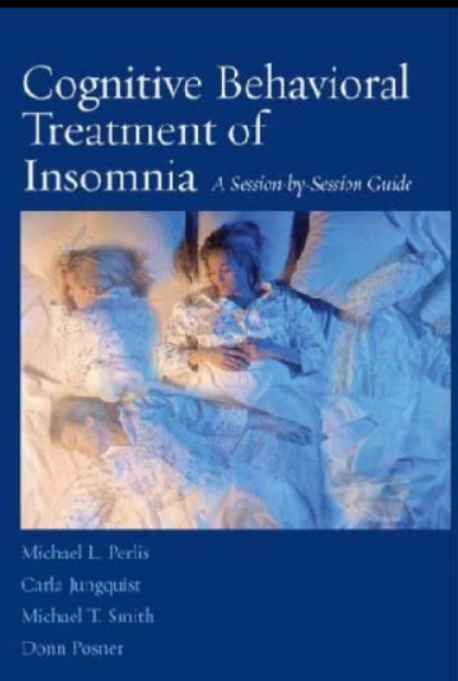
COGNITIVE & BEHAVIORAL TXs

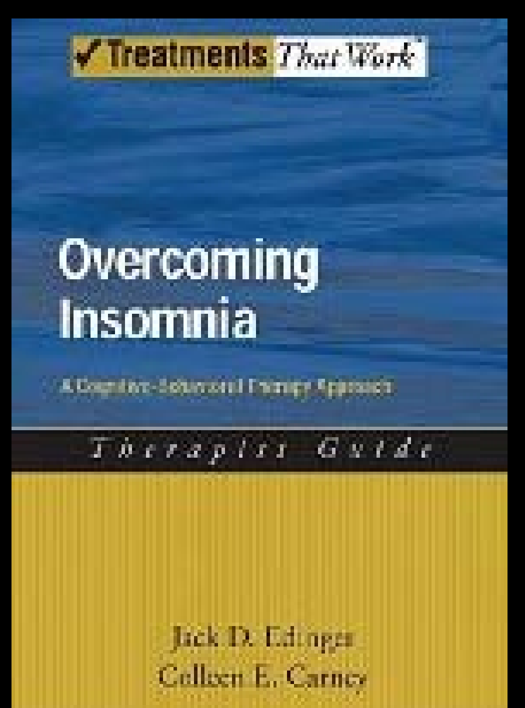
SLEEPLESSNESS.

culled from the *Glasgow Herald* :

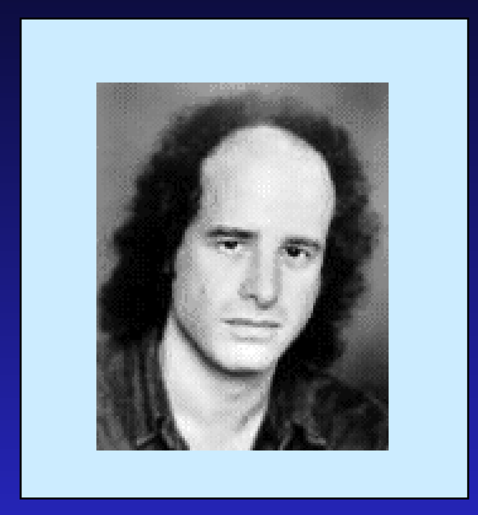
Soap your head with the ordinary yellow soap; rub it into the roots of the hair until your head is just lather all over, tie it up in a napkin, go to bed, and wash it out in the morning. Do this for a fortnight. Take no tea after 6 P.M.


CHARLES M. MORIN AND COLIN A. ESPIE
INSOMNIA
A Clinical Guide to Assessment and Treatment


Cognitive Behavioral Treatment of Insomnia
A Session-by-Session Guide
Michael L. Perlis
Carla Jungquist
Michael T. Smith
Donn Posner


Treatments That Work
Overcoming Insomnia
Therapist Guide
Jack D. Edinger
Colleen E. Carney

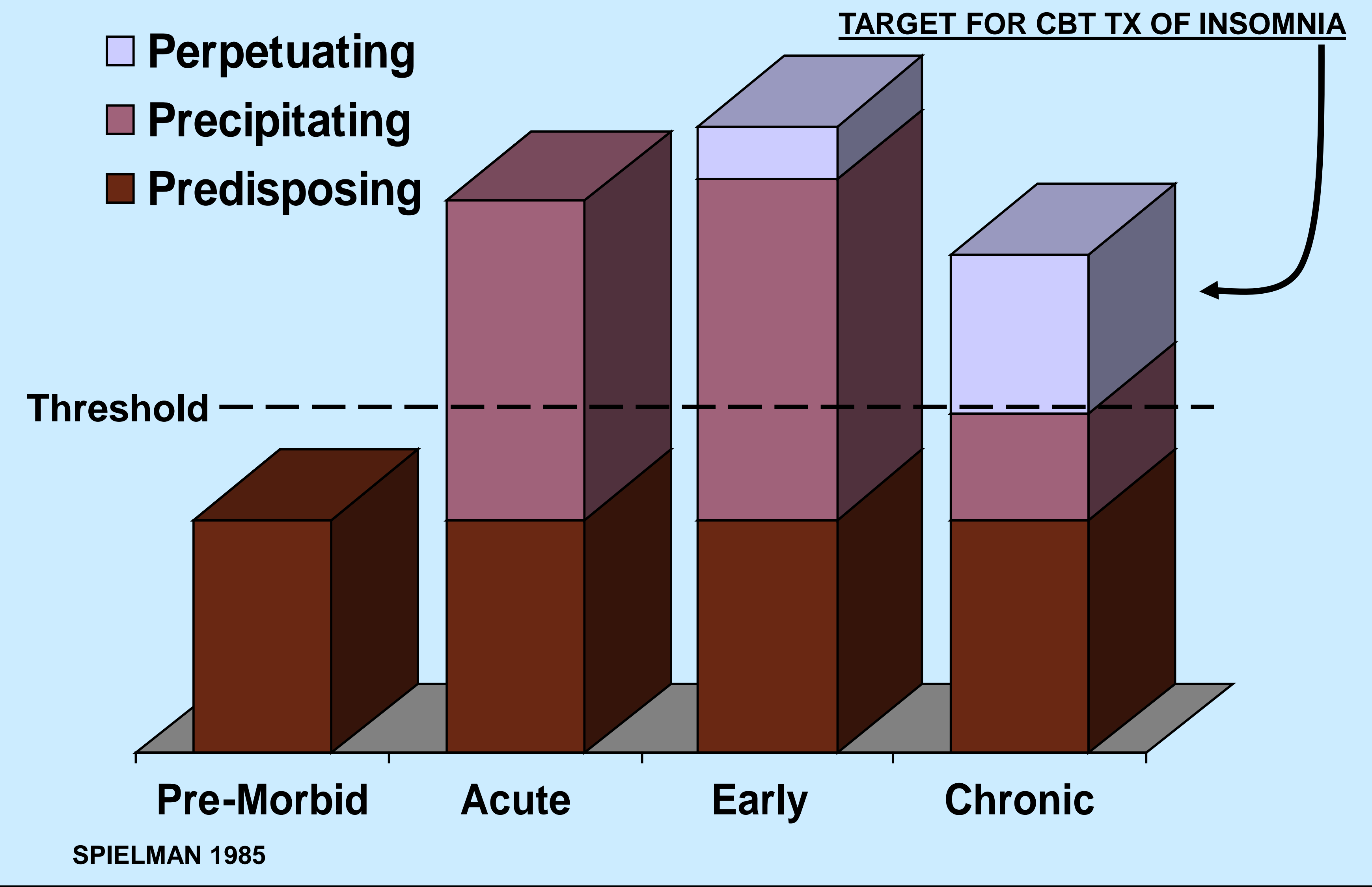
SO WHAT'S THE BETA ON CBT ?



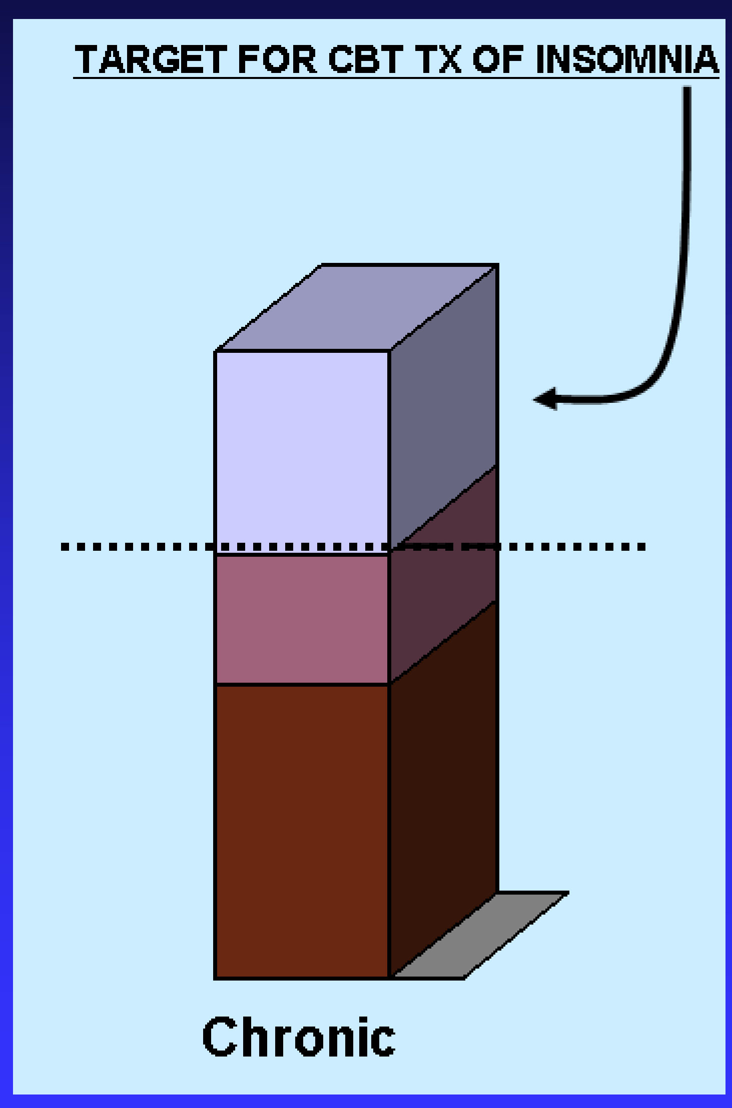
WHEN I WOKE UP THIS MORNING MY GIRLFRIEND ASKED ME, “DID YOU SLEEP GOOD?” I SAID,

“NO, I MADE A FEW MISTAKES.”

-- STEPHEN WRIGHT


NATURE OF INSOMNIA OVER TIME
3 FACTOR MODEL
TARGET FOR CBT TX OF INSOMNIA
Perpetuating
Precipitating
Predisposing
Threshold
Pre-Morbid
Acute
Early
Chronic
SPIELMAN 1985

WHAT ARE PERPETUATING FACTORS

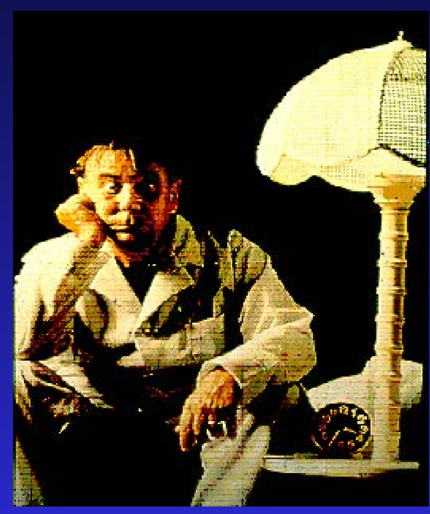


PERPETUATING FACTORS

Common Compensatory Strategies Used to Cope with Insomnia

COMPENSATORY STRATEGY	EFFECT ON SLEEP
EXTENDING SLEEP OPPORTUNITY	
Go to Bed Early	De-primes "sleep homeostat" leading to insomnia and shallow sleep. Possible circadian dysregulation
Sleep in (Wake up later)	De-primes "sleep homeostat" Possible circadian dysregulation
Napping	De-primes "sleep homeostat."
COUNTER FATIGUE MEASURES	
Increased use of stimulants and/or inappropriately-timed use of stimulants	Increases sleep interfering states of arousal.
Avoid or decrease physical activity	May de-prime "sleep homeostat." Can lead to conditioned arousal if increased time spent resting in bed or in bedroom.
RITUALS & STRATEGIES	
Stay in bed and wait	Promotes a lack of stimulus control.
Increase in non-sleep behaviors in the bedroom to "kill time"	Promotes a lack of stimulus control.
Sleep somewhere other than the bedroom	Promotes a lack of stimulus control.
Engage in "rituals" which are thought to promote sleep (use of special herbs, teas, etc.)	Promotes a dependence on the behaviors and anticipatory anxiety when not available.
Avoidance of behaviors thought to inhibit sleep (e.g., sex, going outdoors near bedtime, etc.)	Promotes anticipatory anxiety when behaviors occur

INSOMNIA



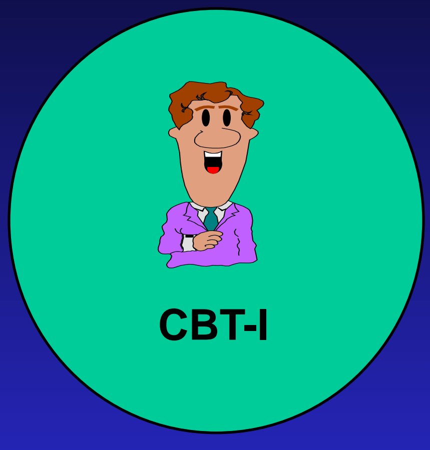
TREATMENTS

- Sleep Restriction
- Stimulus Control
- Sleep Hygiene
- Cognitive Therapy
- Phototherapy
- Relaxation

THE BT TRINITY

Sleep Restriction
Stimulus Control
Sleep Hygiene

THERAPY



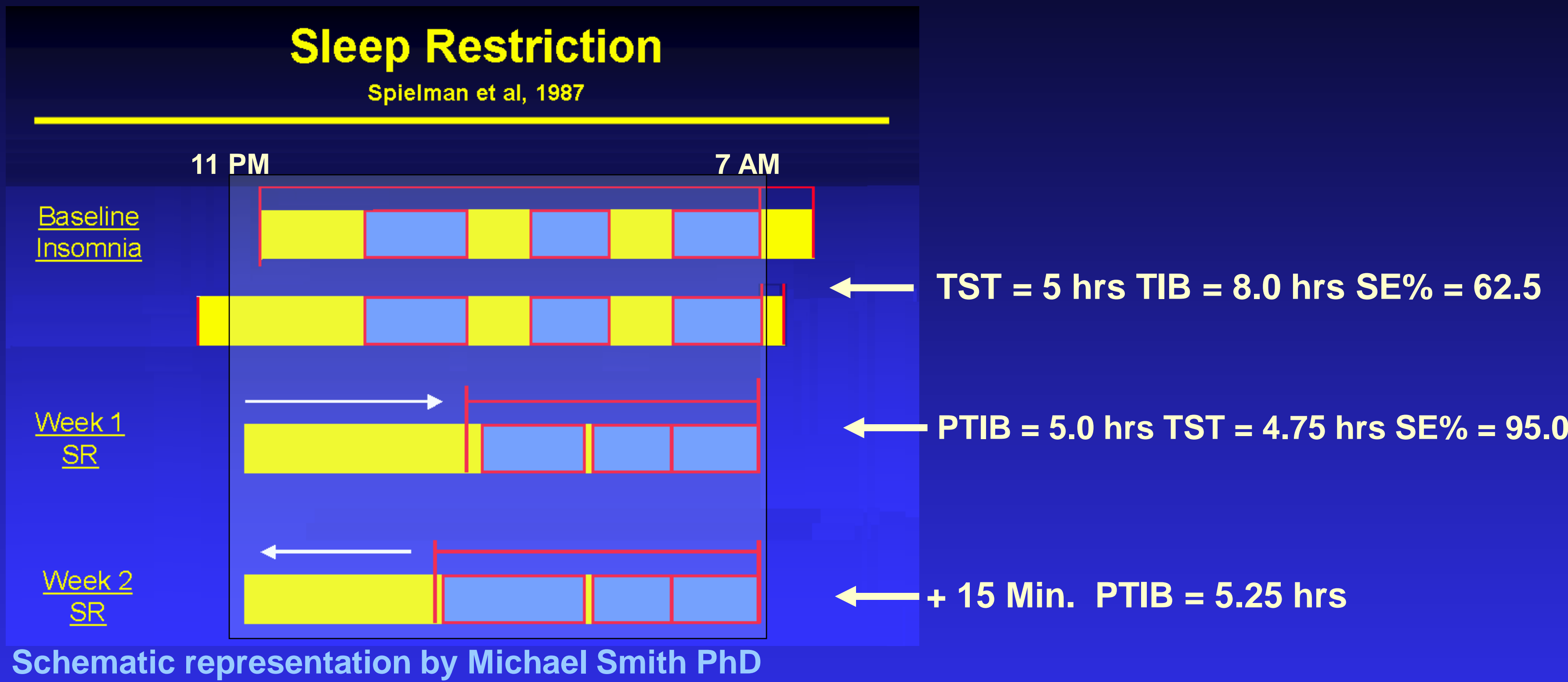
SLEEP RESTRICTION

STIMULUS CONTROL

SLEEP HYGIENE

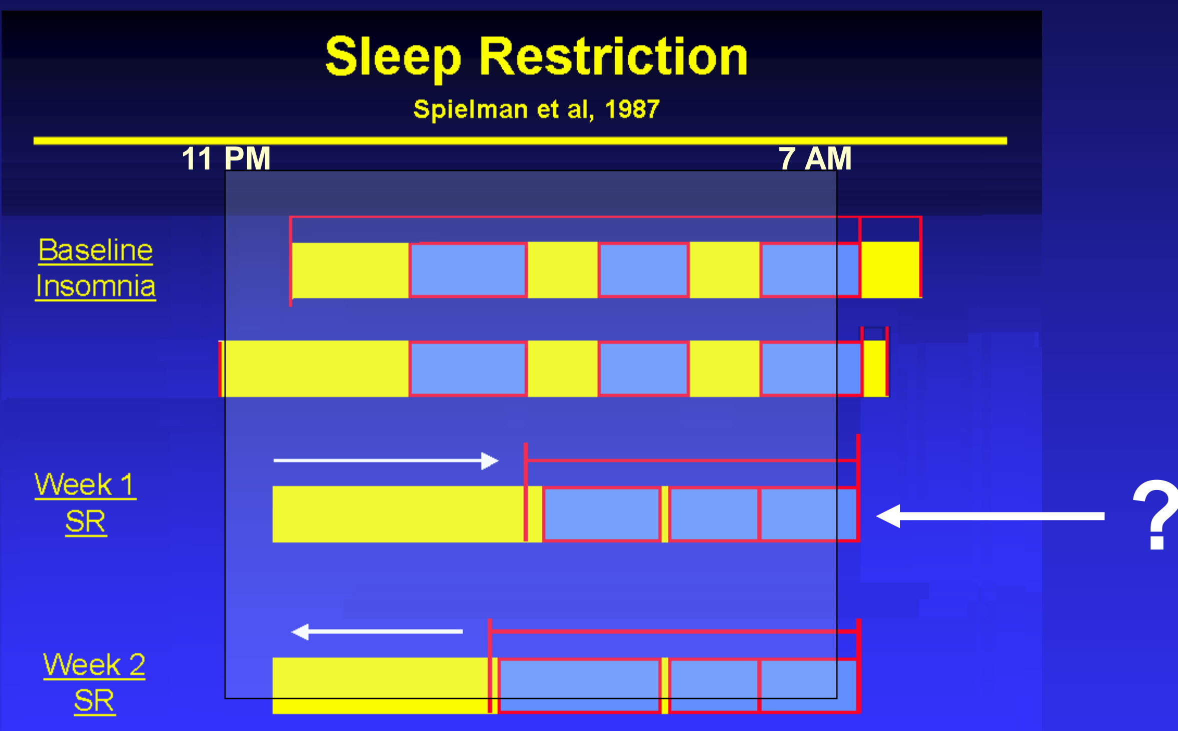
COGNITIVE THERAPY

SLEEP RESTRICTION



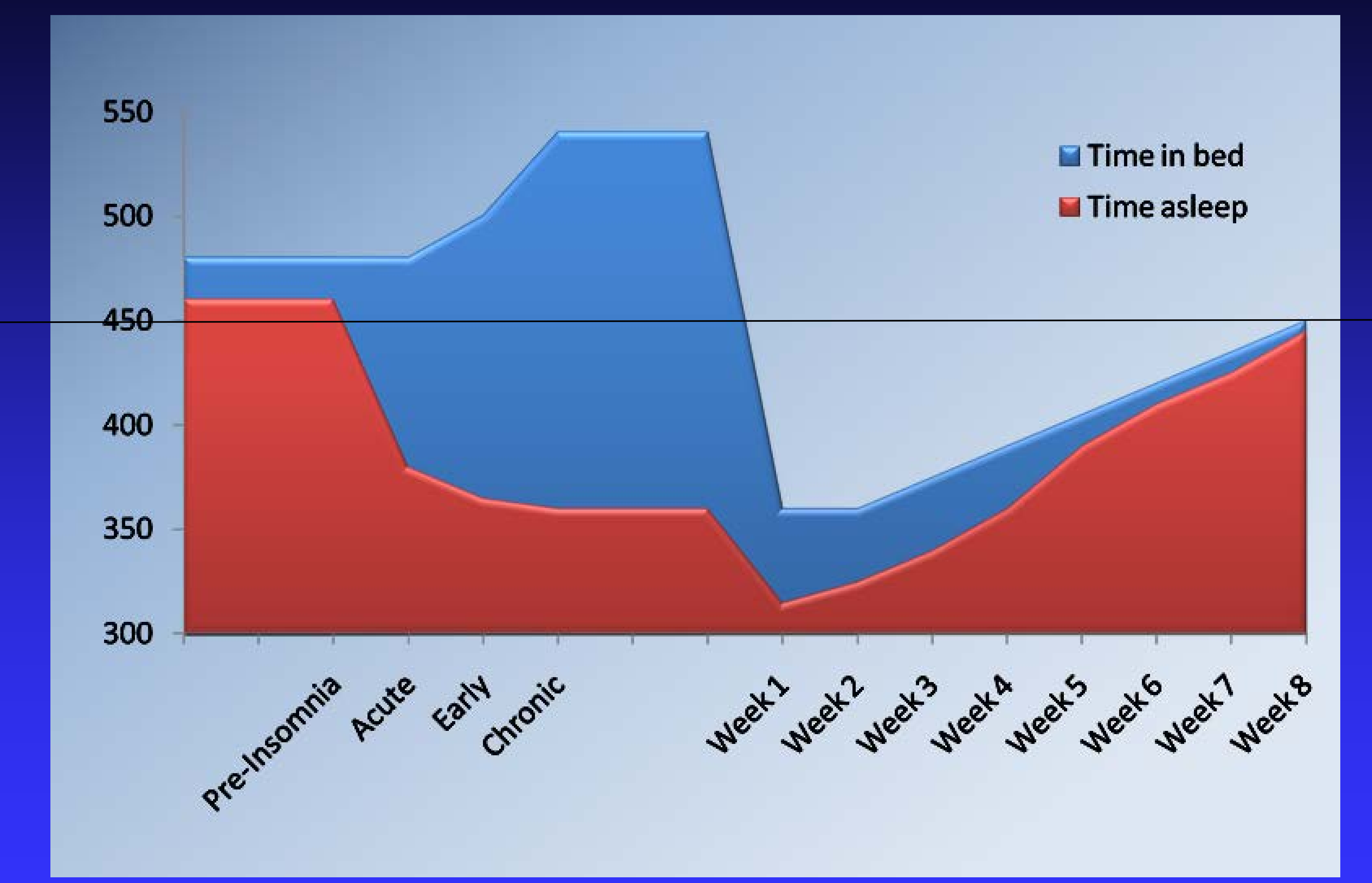
- Restrict to the number of hours in bed = average TST
- 4.0 Hrs should be the min - PCNA 1987:10(4),547
- PTTB and PTOB are inflexible
- Review ways to stay awake
- Keep diary
- Titration based on diary data (< 85%, 85-90%, > 90%)

SLEEP RESTRICTION



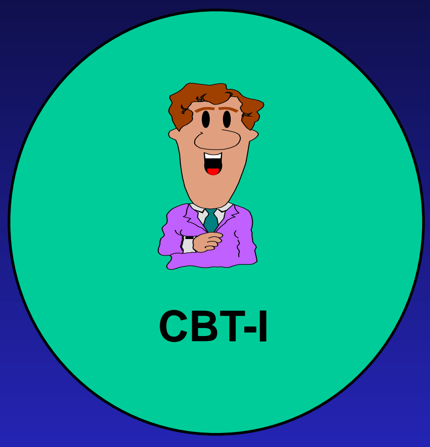
Schematic representation by Michael Smith PhD

TIB: BEFORE, OVER TIME, AND W/ TX



Schematic representation by Michael Grandner PhD

THERAPY



SLEEP RESTRICTION

STIMULUS CONTROL

SLEEP HYGIENE

COGNITIVE THERAPY

STIMULUS CONTROL

1. Lie down to go to sleep only when you are sleepy / sleep only in the bedroom.

2. Do not use your bed for anything except sleep and sex.

3. If you find yourself unable to fall asleep, get up and go into another room. Stay up as long as you wish and then return to the bedroom to sleep.

4. If you still cannot fall asleep, repeat step (3).

5. Set your alarm and get up at the same time every morning irrespective of how much sleep you got during the night.

6. Do not nap during the day.

<u>Disclaimer--illness & driving</u>

STIMULUS CONTROL

1. Lie down to go to sleep at the prescribed TTB   sleepiness

2. Do not use your bed for anything except sleep and sex.

3. If you find yourself unable to fall asleep, get up and go into Another room. Stay up for 30,60, or 120 minutes.   wishing

4. If you still cannot fall asleep, repeat step (3).

5. Set your alarm and get up at the same time every morning irrespective of how much sleep you got during the night.

6. Do not nap during the day.

WHAT IS "STIMULUS CONTROL ?"

GOOD STIMULUS CONTROL

ODDS 1 IN 2

BEDROOM BEDTIME

SEX

SLEEP

STIMULUS DYSCONTROL

ODDS 1 IN 8

BEDROOM BEDTIME

SEX

SLEEP

STIMULUS CONTROL
MORE THAN MEETS THE EYE

1. Lie down to go to sleep only when you are sleepy / sleep only in the bedroom.

↓

INSTRUMENTAL CONDITIONING
STRENGTHENS ASSOCIATION OF SLEEP RELATED STIMULI WITH SLEEPINESS AND SLEEP

CLASSICAL CONDITIONING
SETS THE STAGE FOR SLEEP RELATED STIMULI TO ELICIT SLEEP AND SLEEPINESS

2. Do not use your bed for anything except sleep and sex.

INSTRUMENTAL CONDITIONING
STRENGTHENS ASSOCIATION OF SLEEP RELATED STIMULI WITH SLEEPINESS AND SLEEP

CLASSICAL CONDITIONING
SETS THE STAGE FOR SLEEP RELATED STIMULI TO ELICIT SLEEP AND SLEEPINESS

New!

3. If you find yourself unable to fall asleep, get up and go into another room. Stay up as long as you wish and then return to the bedroom to sleep.

FULL WAKEFULNESS DURING THE SLEEP PERIOD MAY "PAY DIVIDENDS"

(CIRCADIAN EFFECTS ON HOMEOSTASIS)

4. If you still cannot fall asleep, repeat step (3).

ENSURES EFFECTS FROM INSTRUCTIONS 1-3

5. Set your alarm and get up at the same time every morning irrespective of how much sleep you got during the night.

CONTINGENT SLEEP RESTRICTION

PREVENTS SLEEP EXTENSION
&
SLEEP
HOMEOSTASIS DYSREGULATION

6. Do not nap during the day.

PREVENTS SLEEP EXTENSION
&
SLEEP
HOMEOSTASIS DYSREGULATION

A WORD ABOUT SCT AND SRT

SOME OF THE GREATEST DUOS OF ALL TIME

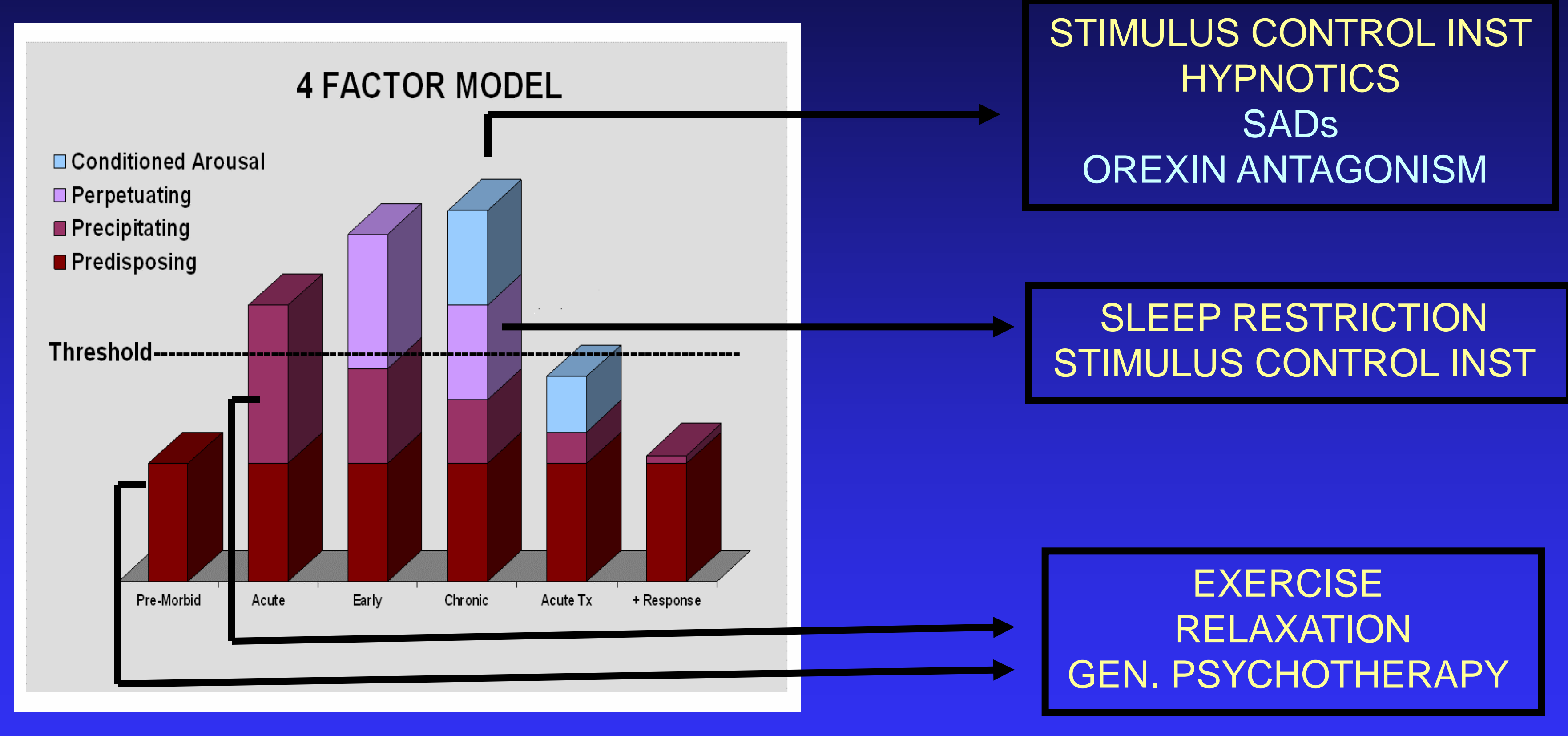
STC – WHEN TO GO TO BED:

A: SRT (PTIB)

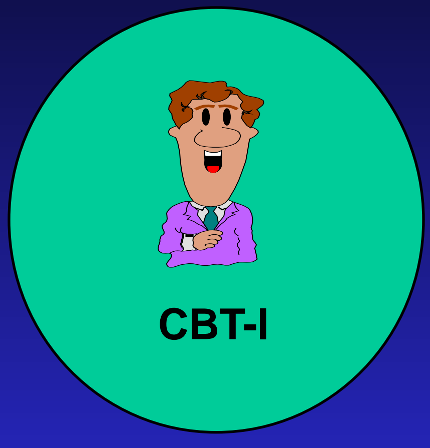
SRT – WHAT DO WHEN AWAKE”

A: SCT

FOUR FACTOR MODEL



THERAPY



SLEEP RESTRICTION

STIMULUS CONTROL

SLEEP HYGIENE

COGNITIVE THERAPY

SLEEP HYGIENE

SLEEP HYGIENE

1. **Sleep only as much as you need to feel refreshed during the following day.**

Restricting your time in bed helps to consolidate and deepen your sleep. Excessively long times in bed lead to fragmented and shallow sleep. Get up at your regular time the next day, no matter how little you slept.

2. **Get up at the same time each day, 7 days a week.**

A regular wake time in the morning leads to regular times of sleep onset, and helps to set your "biological clock."

3. **Exercise regularly.**

Schedule exercise times so that they do not occur within 3 hours of when you intend to go to bed. Exercise makes it easier to initiate sleep and deepen sleep.

4. **Make sure your bedroom is comfortable and free from light and noise.**

A comfortable, noise-free sleep environment will reduce the likelihood that you will wake up during the night. Noise that does not awaken you may also disturb the quality of your sleep. Carpeting, insulated curtains, and closing the door may help.

5. **Make sure that your bedroom is at a comfortable temperature during the night.**

Excessively warm or cold sleep environments may disturb sleep.

6. **Eat regular meals and do not go to bed hungry.**

Hunger may disturb sleep. A light snack at bedtime (especially carbohydrates) may help sleep, but avoid greasy or "heavy" foods.

7. **Avoid excessive liquids in the evening.**

Reducing liquid intake will minimize the need for nighttime trips to the bathroom.

8. **Cut down on all caffeine products.**

Caffeinated beverages and foods (coffee, tea, cola, chocolate) can cause difficulty falling asleep, awakenings during the night, and shallow sleep. Even caffeine early in the day can disrupt nighttime sleep.

9. **Avoid alcohol, especially in the evening.**

Although alcohol helps tense people fall asleep more easily, it causes awakenings later in the night.

10. **Smoking may disturb sleep.**

Nicotine is a stimulant. Try not to smoke during the night when you have trouble sleeping.

11. **Don't take your problems to bed.**

Plan some time earlier in the evening for working on your problems or planning the next day's activities. Worrying may interfere with initiating sleep and produce shallow sleep.

12. **Do not *try* to fall asleep.**

This only makes the problem worse. Instead, turn on the light, leave the bedroom, and do something different like reading a book. Don't engage in stimulating activity. Return to bed only when you are sleepy.

13. **Put the clock under the bed or turn it so that you can't see it.**

Clock watching may lead to frustration, anger, and worry which interfere with sleep.

14. **Avoid naps.** Staying awake during the day helps you to fall asleep at night.

SLEEP HYGIENE

SLEEP HYGIENE
IS ALMOST ALWAYS PART OF "CBT"

Chapter 3

Sleep Hygiene

Donn Posner
Department of Psychiatry, Brown University, Providence, RI
The Sleep Disorders Center of Lifespan Hospitals, Providence, RI

Philip R. Gehrman
Department of Psychiatry, University of Pennsylvania, Philadelphia, PA

PROTOCOL NAME

Sleep hygiene.

GROSS INDICATION

Sleep hygiene is indicated for patients who engage in habits, consume substances, and/or set up sleep environments that are not conducive to initiating or maintaining sleep.

SPECIFIC INDICATION

To date, there is no evidence to suggest that this form of therapy is differentially effective for one or another type of insomnia (psychophysiologic vs idiopathic vs paradoxical insomnia) or for any of the phenotypes/subtypes of insomnia (initial vs middle vs late insomnia). This said, it stands to reason that sleep hygiene factors are an important precipitating or perpetuating factor for "inadequate sleep hygiene insomnia" and, conversely, are of little relevance for "idiopathic insomnia".

CONTRAINDICATIONS

While it is generally held that sleep hygiene is a benign intervention for which there are no contraindications, it may be that specific rules, in specific patients, may not be carried out safely. For example:

- physical activity may not be possible for patients with physical limitations;
- evening snacking may not be appropriate for patients with GERD or other disorders that require restrictive diets;
- rapid smoking cessation in heavy smokers may prove to be as deleterious to sleep as smoking itself;

Behavioral Treatments for Sleep Disorders. DOI: 10.1016/B978-0-12-381522-4.00003-1
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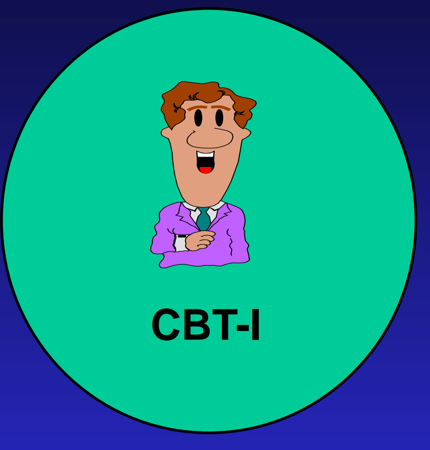
THERAPY



SLEEP RESTRICTION

STIMULUS CONTROL

SLEEP HYGIENE

COGNITIVE THERAPY

COGNITIVE THERAPY

Cognitive therapy

OFTEN NOT A PART OF “CBT”

WHEN INCLUDED IT’S

NOT WELL STANDARDIZED

NOT WELL EVALUATED

TWO TYPES: GENERAL CT AND TARGETED CT

COGNITIVE THERAPY – GENERAL

SETTING EXPECTATION & INSURING COMPLIANCE

- WILL GET WORSE BEFORE BETTER
- CHANGE/RE-FRAME END GOAL FROM MORE SLEEP TO
- SHORT SL AND LOW WASO, BUT LESS SLEEP
- COMMIT TO THE PROCESS (# of nights)
- LONG-TERM GOALS

  DON'T EXPECT TO

    SLEEP LIKE A BABY

    NEVER HAVE ANOTHER NIGHT OF INSOMNIA

  DON'T EXPECT 8 HOURS – YOU MAY NOT NEED IT

- THINK OF ACUTE INSOMNIA IN RESPONSE TO STRESS AS A SOLUTION VS A PROBLEM

YOU HEARD IT BEFORE – BUT

LONG-TERM GOALS

NOMOTHETICS ≠ IDIOGRAPHICS

INDIVIDUALS MAY SEEK MORE SLEEP THAN THEY NEED WHEN IDIOGRAPHIC SLEEP NEEDS ARE DEFINED BY NOMOTHETIC GOALS.
LICHSTEIN 2010

LONG-TERM GOALS

“DON’T EXPECT 8 HOURS – YOU MAY NOT NEED IT”

COGNITIVE THERAPY

SOMETHING SPECIFIC

CHANGING THE GOAL

FROM

GETTING MORE SLEEP

TO

GETTING TO SLEEP FASTER AND STAYING ASLEEP !

COGNITIVE THERAPY – TARGETED

TYPES

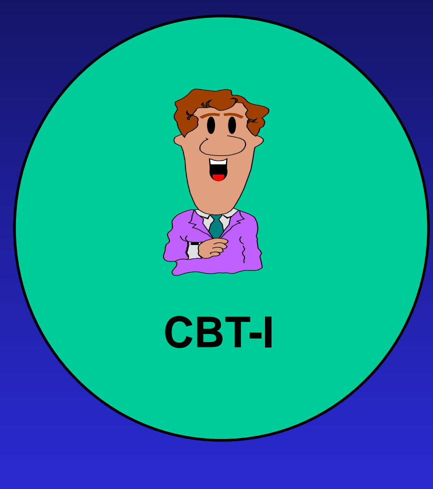
DEBUNKING DYSFUNCTIONAL BELIEFS - MORIN

COGNITIVE RESTRUCTURING - HARVEY

- WORRY AND RUMINATION
- ATTENTION BIAS
- SAFETY BEHAVIORS

DECATASTROPHIZATION - PERLIS

THERAPY



TX DELIVERY

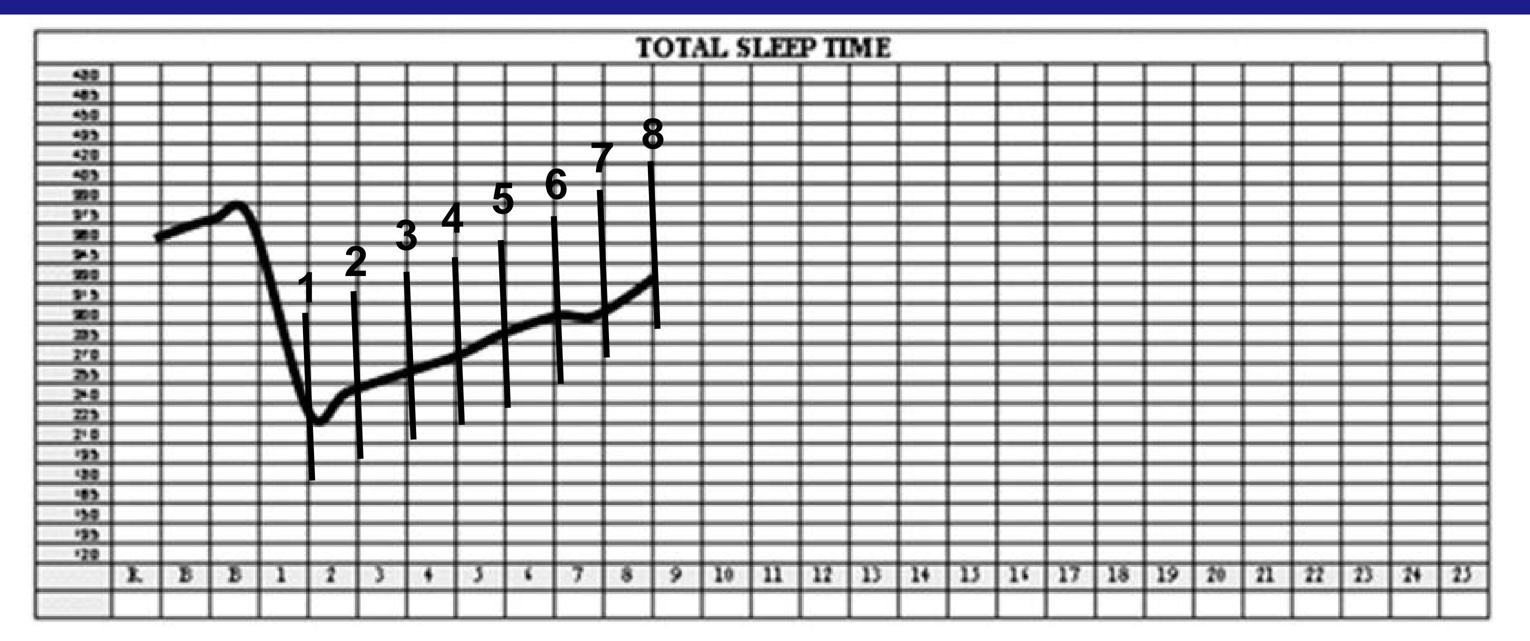
THERAPY SCHEDULE

Session 1- Assessment and providing sleep log
Session 2- Education, restriction, stimulus control
Session 3- Problem solve and sleep hygiene
Session 4- Upward titration
Session 5- Upward titration & cognitive Tx
Session 6- Upward titration
Session 7- Upward titration
Session 8- Relapse prevention

WHY 8 SESSIONS ?

HERE'S 8 REASONS

(ASSUMING PERFECT COMPLIANCE)



WHY 8 SESSIONS ?

- WHAT AMOUNT OF SUCCESS GUARANTEES COMPLIANCE ?
- WHAT AMOUNT OF BEHAVIORAL CHANGE – CHANGES COGNITION ?
- HOW MUCH IMPROVED SLEEP LEADS TO COUNTER CONDITIONING

AND FOR THAT MATTER HOW MUCH TREATMENT IS REQUIRED/STANDARD FOR CBT FOR OTHER ILLNESSES ?!

WHY NOT 12 OR 16 SESSIONS ?

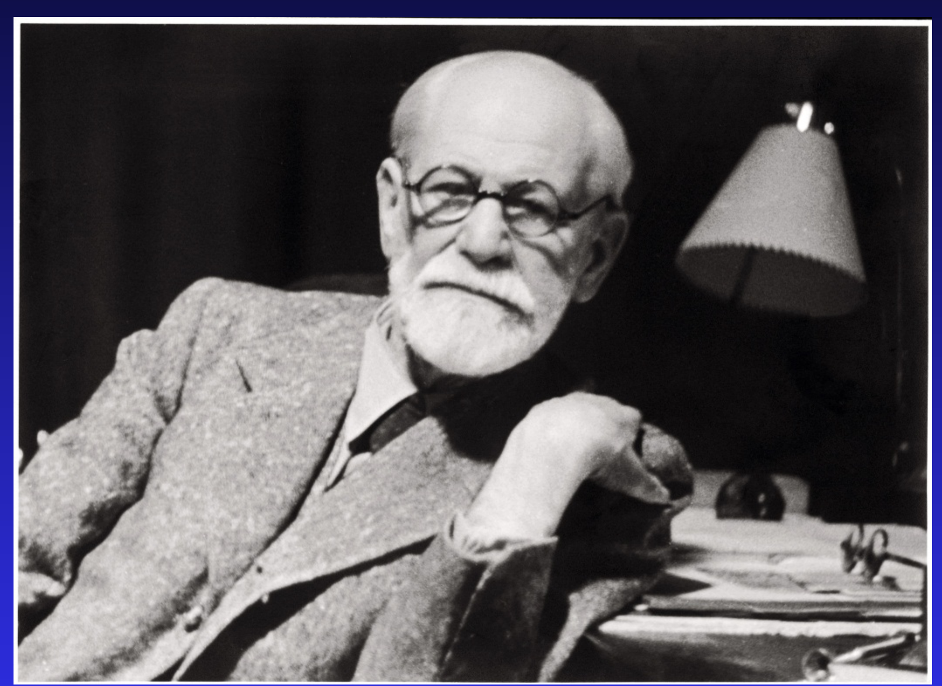
THE VALUE OF FIX-IT-BREAK-IT

INCREASED SELF EFFICACY

ENHANCED SLEEP ABILITY

TESTING SLEEP NEED

THERAPIST



TREATMENT SETTING

- PRIVATE PRACTICE – HOME OFFICE
- SLEEP DX CENTER – PRIVATE OFFICE
- SLEEP DX CENTER - SHARED SPACE
- PRIMARY CARE - SHARED SPACE

TREATMENT TOOLS

- WHITE BOARD
- ROUND TABLE
- CALCULATOR OR EXCEL CALCULATOR
- INTERNET ACCESS ?
- RECORDING EQUIPMENT

SETTING EXPECTATIONS

- THEY ARE IN “THE RIGHT PLACE WITH THE RIGHT PERSON”
- THERAPY IS SHORT TERM (6-12 WEEKS)
- THEY WILL GET WORSE BEFORE THEY GET BETTER
- LONG-TERM GOALS (BABY AND NEVER AGAIN)
- WHAT’S LEARNED IS FOR LIFE…
- TX IS VERY EFFECTIVE
- TO GAIN THEY MUST COMPLY

PRERQUISITES

- MEDICALLY AND PSYCHIATRICALLY STABLE
- ADEQUATE LANGUAGE COMPREHENSION
- TIME FOR TREATMENT
- TIME TO BE “OFF THEIR GAME”
- COMPLIANCE WITH DIARIES
- COMPLIANCE WITH PRESCRIPTIONS

CHARTING

4/25/2004 8:31 AM 120

NOTE: This case example is not drawn from an individual case and as such does not represent any one patient. The name used to identify the patient in the case example is fictitious. The report itself is longer than might be written for a typical clinical practice. The breadth of this review is intended to serve an education purpose.

Date of Evaluation: July 7th 2004

Identifying Information. Mr. Busch is a 62-year-old, married, Euro-American male who works part-time as a financial consultant. He and his wife have a 29-year-old son, and a 31 year-old daughter. He is 5'10" and weighs 190 lbs (Body Mass Index = 25).

PRESENTING COMPLAINT & SLEEP INFORMATION

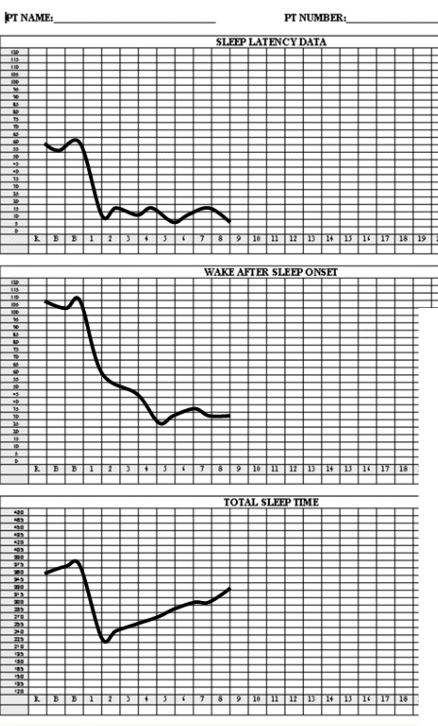
Presenting Complaint
"I have had trouble falling asleep since college. It's been pretty bad lately and I am afraid it will prevent me from returning to work full-time."

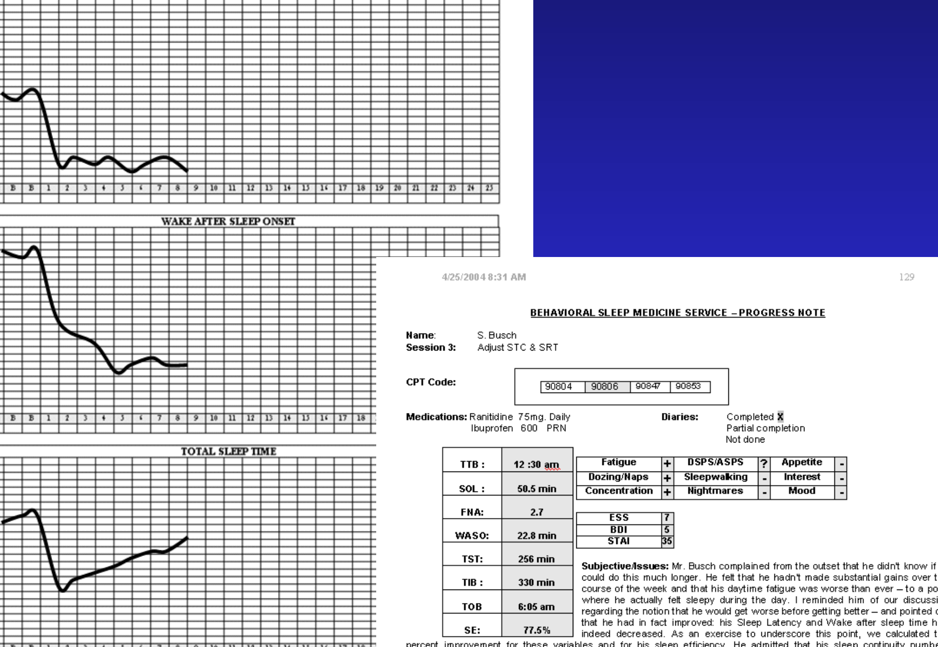
Daytime Functioning/Symptoms. Mr. Busch reportedly wakes up with a dry mouth and headaches 1-2 mornings per week. He stated that his daytime fatigue interferes with his ability to work and enjoy daily activities. He expressed a specific concern that his problems with insomnia might interfere with his plans to return to a full-time work schedule.

History of Presenting Complaint. Mr. Busch first experienced insomnia when in college and has been intermittently bothered by sleep initiation and maintenance problems since then (0-3 nights weekly). He indicated that he tolerated his sleep difficulties, which flared periodically during times of stress, until 2001. At this time, his sleep initiation problem worsened in association with some job-related turmoil (Mr. Busch was a Corporate VP in an organization that was in the midst of a massive "downsizing"). In response to the demands of his job, he began working late into the night and attempted to cope with daytime fatigue by drinking large quantities of caffeine (9 to 15 cups a day) during the week days and by sleeping late on the weekends. In 2002, his contract was not renewed, reportedly because of the corporate restructuring. In 2003 he experienced a 2nd significant life stressor with his wife's being diagnosed with uterine cancer. At this time, he gained 30 lbs. (from 190 to 220 lbs.) and his insomnia worsened to the point where it was a significant problem every night. He first sought evaluation and treatment for sleep disturbance at that time.

Prior Treatment for Sleep Disorders. In February 2002, Mr. Busch was evaluated by Dr. Pickwick at the Dickens' Sleep Disorders Center, Atlanta, Georgia. He sought help at this time, at the urging of his wife who complained that he was snoring excessively at night. In addition to trouble initiating and maintaining sleep, he reported that, at this time, he experienced severe daytime sleepiness in addition to fatigue. He underwent a PSG study and the results indicated mild obstructive sleep apnea (Respiratory Disturbance Index [RDI] 10 per hour. No evidence of other intrinsic sleep disorders was obtained. Treatment recommendations were to lose weight and to use nightly CPAP (a form of ventilation, which increases the patency of the oropharyngeal airway during sleep). Mr. Busch reportedly lost 25 pounds, with noticeable improvement in snoring and daytime sleepiness, but he still reported trouble falling and staying asleep. He reportedly did not tolerate the CPAP device, which he stated made his insomnia "way worse".

After discontinuing CPAP, he sought treatment from his primary care physician (PCP) who worked with Mr. Busch to cut back on caffeine and attend to sleep hygiene issues. He no longer drinks coffee after 12 noon and he exercises regularly 3 times a week for 30-60 minutes per





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BEHAVIORAL SLEEP MEDICINE SERVICE – PROGRESS NOTE

Name: S. Busch
Session 3: Adjust STC & SRT

CPT Code:

90804	90806	90847	90853

Medications: Ranitidine 75mg. Daily
Ibuprofen 600 PRN

Diaries: Completed X
Partial completion
Not done

TTB :	12 :30 am
SOL :	50.5 min
FNA:	2.7
WASO:	22.8 min
TST:	256 min
TIB :	330 min
TOB	6:05 am
SE:	77.5%

Fatigue	+	DSPS/ASPS	?	Appetite	-
Dozing/Naps	+	Sleepwalking	-	Interest	-
Concentration	+	Nightmares	-	Mood	-

ESS	7
BDI	5
STAI	35

Subjective/Issues: Mr. Busch complained from the outset that he didn't know if he could do this much longer. He felt that he hadn't made substantial gains over the course of the week and that his daytime fatigue was worse than ever – to a point where he actually felt sleepy during the day. I reminded him of our discussion regarding the notion that he would get worse before getting better – and pointed out that he had in fact improved: his Sleep Latency and Wake after sleep time had indeed decreased. As an exercise to underscore this point, we calculated the percent improvement for these variables and for his sleep efficiency. He admitted that his sleep continuity numbers appeared to be moving in the right direction, and further he acknowledged that the increase in fatigue was something that was predicted at the last session. We discussed ways to combat the emergent fatigue (including outdoor walks, the judicious use of caffeine, phototherapy, and/or the use of a prescription stimulants for the first few weeks of therapy). Mr. Busch seemed glad to hear that there were some alternatives but felt that at this point he'd "tough it out".

Areas of concern center on the fact that the patient admits to still falling asleep on the sofa before bedtime, and that he is not consistently getting out of bed for awakenings that occur after sleep onset. The former is explained by the idea that he just cant stay awake, and the latter by the idea that he sometimes feels that if he just waits in bed longer that he will eventually fall asleep. Each of these issues were discussed. Ways of staying awake until the prescribed bedtime were reviewed. If these aspects of compliance continue to be problematic, we'll consider monitoring him with actigraphy. This will provide not only some additional data regarding his sleep continuity but – more importantly – as means towards measuring compliance.

Treatment Plan: Given that Mr. Busch did not reach the target SE of 90%, we did not recommend that he upwardly titrate his TIB. Although disappointed that he will not be able to sleep more yet, he seemed pleased enough with his progress that he'd be willing to "give it a shot" for another week. As indicated above, most of session was spent on working on problem solving in the service of compliance. Sleep hygiene will be covered in the next session since time did not allow for it in this session.

Date : 7/28/04 **RTC :** 8/4/04 **Signature**________________________

CHARTING

4/25/2006 6:31 AM 120

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"I have had trouble falling asleep since college. It's been pretty bad lately and I am afraid it will prevent me from returning to work full-time."

Daytime Functioning/Symptoms. Mr. Busch reportedly wakes up with a dry mouth and headaches 1-2 mornings per week. He stated that his daytime fatigue interferes with his ability to work and enjoy daily activities. He expressed a specific concern that his problems with insomnia might interfere with his plans to return to a full-time work schedule.

History of Presenting Complaint. Mr. Busch first experienced insomnia when in college and has been intermittently bothered by sleep initiation and maintenance problems since then (0-3 nights weekly). He indicated that he tolerated his sleep difficulties, which flared periodically during times of stress, until 2001. At this time, his sleep initiation problem worsened in association with some job-related turmoil (Mr. Busch was a Corporate VP in an organization that was in the midst of a massive "downsizing"). In response to the demands of his job, he began working late into the night and attempted to cope with daytime fatigue by drinking large quantities of caffeine (9 to 15 cups a day) during the week days and by sleeping late on the weekends. In 2002, his contract was not renewed, reportedly because of the corporate restructuring. In 2003 he experienced a 2nd significant life stressor with his wife's being diagnosed with uterine cancer. At this time, he gained 30 lbs. (from 190 to 220 lbs.) and his insomnia worsened to the point where it was a significant problem every night. He first sought evaluation and treatment for sleep disturbance at that time.

Prior Treatment for Sleep Disorders. In February 2002, Mr. Busch was evaluated by Dr. Pickwick at the Dickens' Sleep Disorders Center, Atlanta, Georgia. He sought help at this time, at the urging of his wife who complained that he was snoring excessively at night. In addition to trouble initiating and maintaining sleep, he reported that, at this time, he experienced severe daytime sleepiness in addition to fatigue. He underwent a PSG study and the results indicated mild obstructive sleep apnea (Respiratory Disturbance Index [RDI] 10 per hour. No evidence of other intrinsic sleep disorders was obtained. Treatment recommendations were to lose weight and to use nightly CPAP (a form of ventilation, which increases the patency of the oropharyngeal airway during sleep). Mr. Busch reportedly lost 25 pounds, with noticeable improvement in snoring and daytime sleepiness, but he still reported trouble falling and staying asleep. He reportedly did not tolerate the CPAP device, which he stated made his insomnia "way worse".

After discontinuing CPAP, he sought treatment from his primary care physician (PCP) who worked with Mr. Busch to cut back on caffeine and attend to sleep hygiene issues. He no longer drinks coffee after 12 noon and he exercises regularly 3 times a week for 30-60 minutes per

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Date of Evaluation:
Identifying Information.

PRESENTING COMPLAINT & SLEEP INFORMATION

Presenting Complaint
Daytime Functioning/Symptoms.
History of Presenting Complaint.
Prior Treatment for Sleep Disorders.
Sleep Continuity/Quality.
Sleep Habits and Environment:

FAMILY & SOCIAL HISTORY

MEDICAL AND PSYCHIATRIC INFORMATION

Medical History.

Current Medications.
Psychiatric History.
Mental Status Exam.

SUMMARY OF RESULTS FROM ASSESSMENT MEAURES

INSTRUMENT	MEASURE OF	SCORE RANGE	PATIENT'S SCORE
ISI [1]	Severity of Insomnia	0 – 28	19
PSQI [2]	Sleep Disturbance	0 – 21	15
ESS [3]	Daytime Sleepiness	0 – 24	9
KSS [4]	Daytime Sleepiness	0 - 9	6

1. ISI – Insomnia Severity Scale
2. PSQI - The Pittsburgh Sleep Inventory
3. ESS - The Epworth Sleepiness Scale
4. KSS - The Karolinska Sleepiness Scale
5. MFI - The Multi-Factorial Fatigue Inventory
6. BDI - The Beck Depression Inventory
7. STAI - The State Trait Anxiety Inventory
8. POMS - The Profile of Mood States

CASE CONCEPTUALIZATION

Socioeconomic and Cultural Factors.
Social and Behavioral Factors.
Life Events.
Genetic and Temperament.

OVERALL CONCEPTUALIZATION

DIAGNOSIS & TREATMENT PLAN

Diagnostic Impression:

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Treatment Plan

CHARTING

CASE CONCEPTUALIZATION

From VA Roll out for CBT-I, Program Chair Rachel Manber PhD

1. What factors may be weakening the signal from the patient's biological clock? (e.g., irregular rise time, time in bed window that is not congruent with the patient's circadian type.)

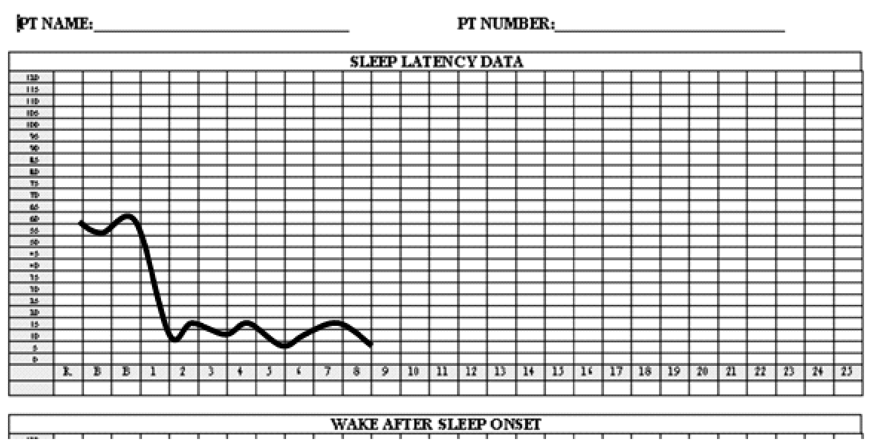
2. What factors may be weakening the patient's sleep drive? (e.g., extended time in bed, dozing off in the evening, daytime napping)

3. What aspects of hyper-arousal are evident? (e.g., conditioned arousal, excessive sleep effort, specific erroneous beliefs about sleep, presence of hyper-active mind in bed)

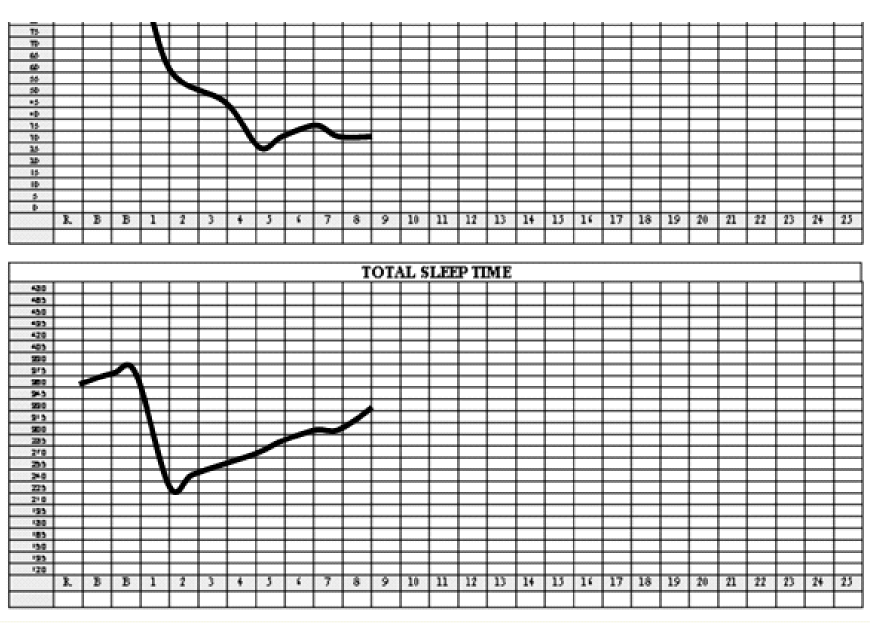
4. What substances may be interfering with sleep? (e.g., sleep medications, caffeine, alcohol, nicotine, marijuana/other drugs, stimulants, other medications, nocturnal eating)

5. What comorbidities may impact the patient's sleep and how? (e.g., depression may contribute to excessive time in bed, PTSD is associated with hyper-vigilance, improperly adjusted CPAP therapy may be interfering with sleep)

CHARTING



SUPERVISION IS FAR EASIER WITH GRAPHS



CHARTING

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BEHAVIORAL SLEEP MEDICINE SERVICE – PROGRESS NOTE

Name: S. Busch
Session 3: Adjust STC & SRT

CPT Code:

90804	90806	90847	90853

Medications: Ranitidine 75mg. Daily
Ibuprofen 600 PRN

Diaries: Completed X
Partial completion
Not done

TTB :	12 :30 am
SOL :	50.5 min
FNA:	2.7
WASO:	22.8 min
TST:	256 min
TIB :	330 min
TOB	6:05 am
SE:	77.5%

Fatigue	+	DSPS/ASPS	?	Appetite	-
Dozing/Naps	+	Sleepwalking	-	Interest	-
Concentration	+	Nightmares	-	Mood	-

ESS	7
BDI	5
STAI	35

Subjective/Issues: Mr. Busch complained from the outset that he didn't know if he could do this much longer. He felt that he hadn't made substantial gains over the course of the week and that his daytime fatigue was worse than ever – to a point where he actually felt sleepy during the day. I reminded him of our discussion regarding the notion that he would get worse before getting better – and pointed out that he had in fact improved: his Sleep Latency and Wake after sleep time had indeed decreased. As an exercise to underscore this point, we calculated the percent improvement for these variables and for his sleep efficiency. He admitted that his sleep continuity numbers appeared to be moving in the right direction, and further he acknowledged that the increase in fatigue was something that was predicted at the last session. We discussed ways to combat the emergent fatigue (including outdoor walks, the judicious use of caffeine, phototherapy, and/or the use of a prescription stimulants for the first few weeks of therapy). Mr. Busch seemed glad to hear that there were some alternatives but felt that at this point he'd "tough it out".

Areas of concern center on the fact that the patient admits to still falling asleep on the sofa before bedtime, and that he is not consistently getting out of bed for awakenings that occur after sleep onset. The former is explained by the idea that he just cant stay awake, and the latter by the idea that he sometimes feels that if he just waits in bed longer that he will eventually fall asleep. Each of these issues were discussed. Ways of staying awake until the prescribed bedtime were reviewed. If these aspects of compliance continue to be problematic, we'll consider monitoring him with actigraphy. This will provide not only some additional data regarding his sleep continuity but – more importantly – as means towards measuring compliance.

Treatment Plan: Given that Mr. Busch did not reach the target SE of 90%, we did not recommend that he upwardly titrate his TIB. Although disappointed that he will not be able to sleep more yet, he seemed pleased enough with his progress that he'd be willing to "give it a shot" for another week. As indicated above, most of session was spent on working on problem solving in the service of compliance. Sleep hygiene will be covered in the next session since time did not allow for it in this session.

Date : 7/28/04 **RTC :** 8/4/04 **Signature**________________________

SLEEP DIARIES

NAME: ______________________ DATE ___________________________

COMPLETE: IMMEDIATELY BEFORE BED CONCERNING HOW YOU FELT TODAY

	MON	TUES	WED	THUR	FRI	SAT	SUN	MEAN
TYPICAL DAY? (YES/NO) *								
FATIGUE (NONE 0—1—2—3—4—5 A LOT)								
STRESS (NONE 0—1—2—3—4—5 A LOT)								
ALERT (NOT VERY 0—1—2—3—4—5 VERY)								
CONCENTRATION (GOOD 0—1—2—3—4—5 BAD)								
MOOD (BAD 0—1—2—3—4—5 GOOD)								
TIME SPENT EXERCISING (MIN.)								
NUMBER OF ALCOHOLIC BEVERAGES								
HEALTH (FELT FINE 0—1—2—3—4—5 BAD)								
MENSTRUATE TODAY (YES/NO)								
MENSTRUAL PAIN (NONE 0—1—2—3—4—5 BAD)								

** PLEASE INDICATE ON THE BACK OF THIS SHEET WHY ANY GIVEN DAY WAS NOT TYPICAL AND/OR WHAT MEDICATIONS YOU TOOK ON ANY GIVEN DAY.

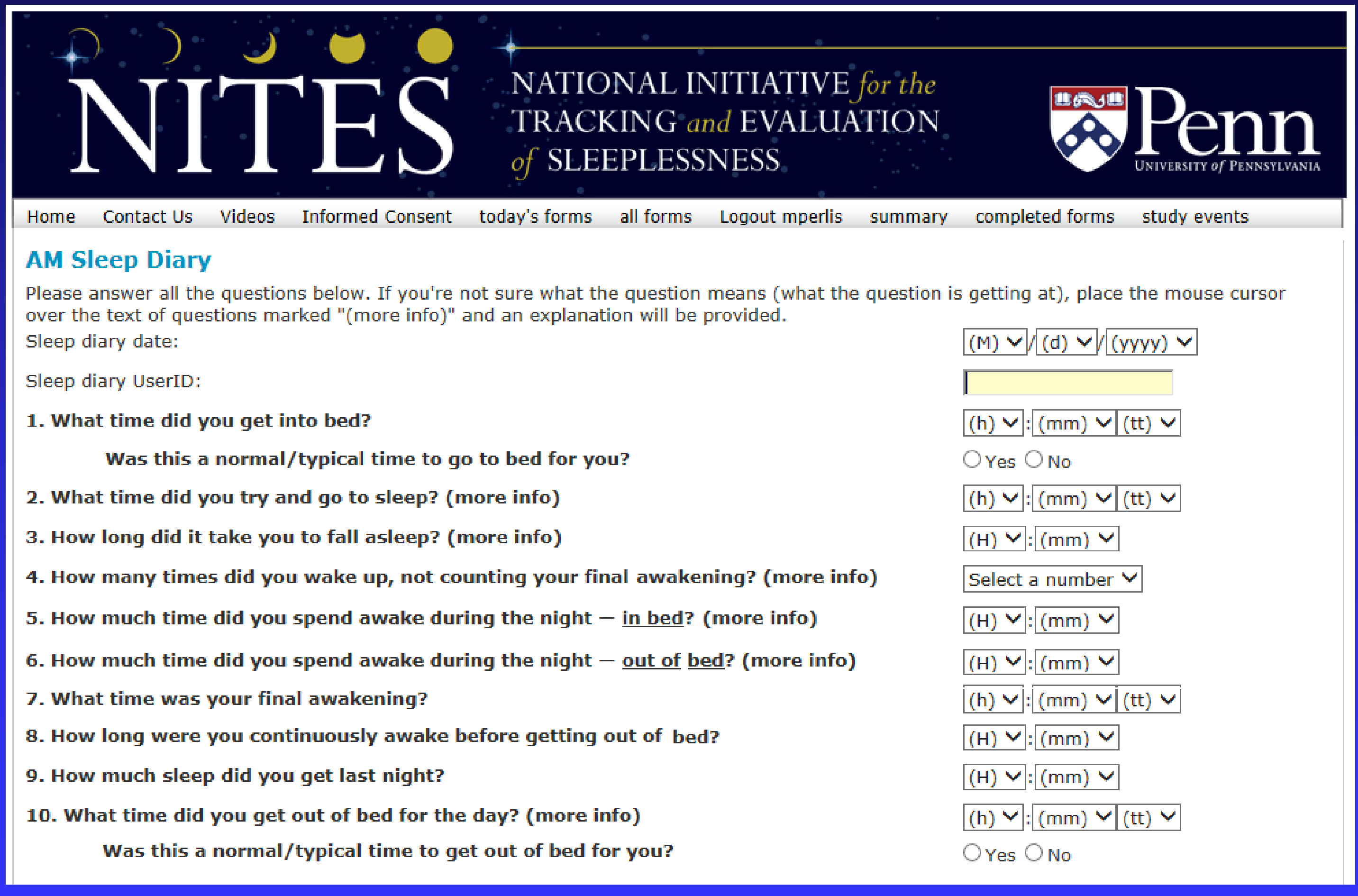
THE PRICE OF THERAPY (ASIDE FROM $$) IS DIARIES

COMPLETE IMMEDIATELY ON AWAKENING (PLEASE CACULATE TOTAL TIME IN BED AND TOTAL SLEEP TIME)

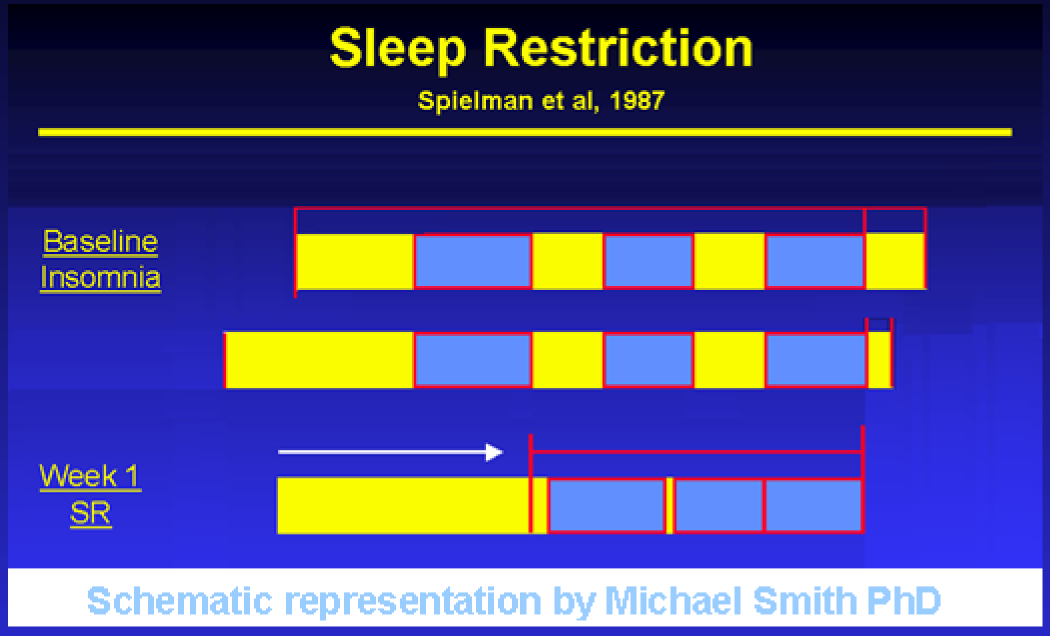
	MON	TUES	WED	THURS	FRI	SAT	SUN	MEAN
TIME TO BED (CLOCK TIME)								
TIME OUT OF BED (CLOCK TIME)								
(TIB) TOTAL TIME IN BED								
TIME TO BED (DEV FRM 11)								
TIME OUT OF BED (DEV FRM 7)								
(SL) TIME TO FALL ASLEEP								
(NUMA) NUMBER TIMES AWAKENED								
(WASO) WAKE AFTER SLEEP ONSET								
(TTOB) TOTAL AMOUNT TIME OUT OF BED								
(TST) TOTAL SLEEP TIME (MIN.)								
(SE) SLEEP EFFICENCY								
SLEEP QUALITY (POOR 0—1—2—3—4—5 GOOD)								
FATIGUE (NONE 0—1—2—3—4—5 A LOT)								

SLEEP DIARIES

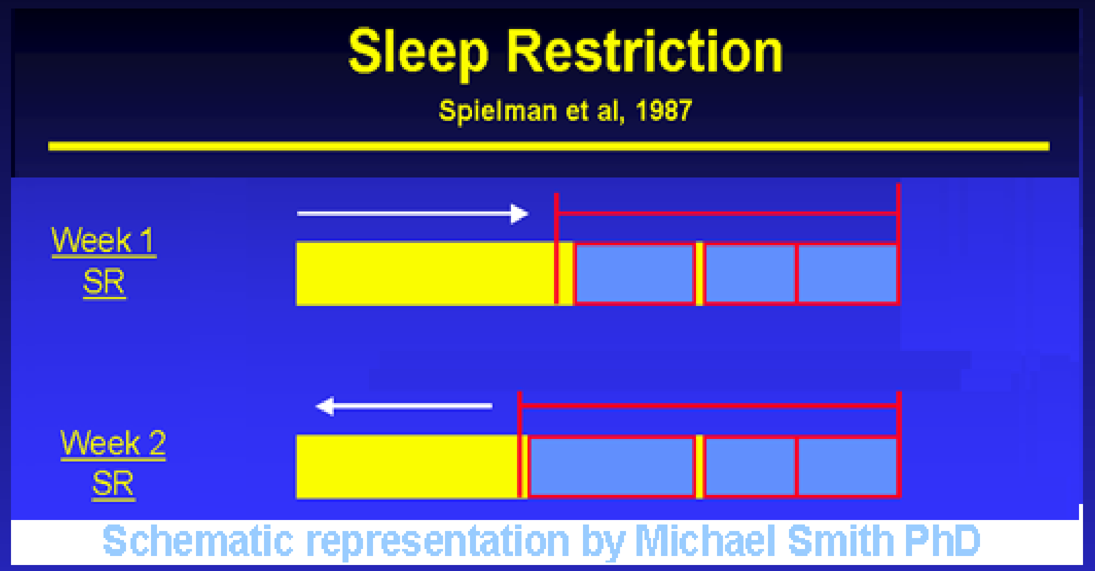
THINK ABOUT USING ON-LINE DIARIES OR APS



PATHWAY(S) TO
CLINICAL EXCELLNCE

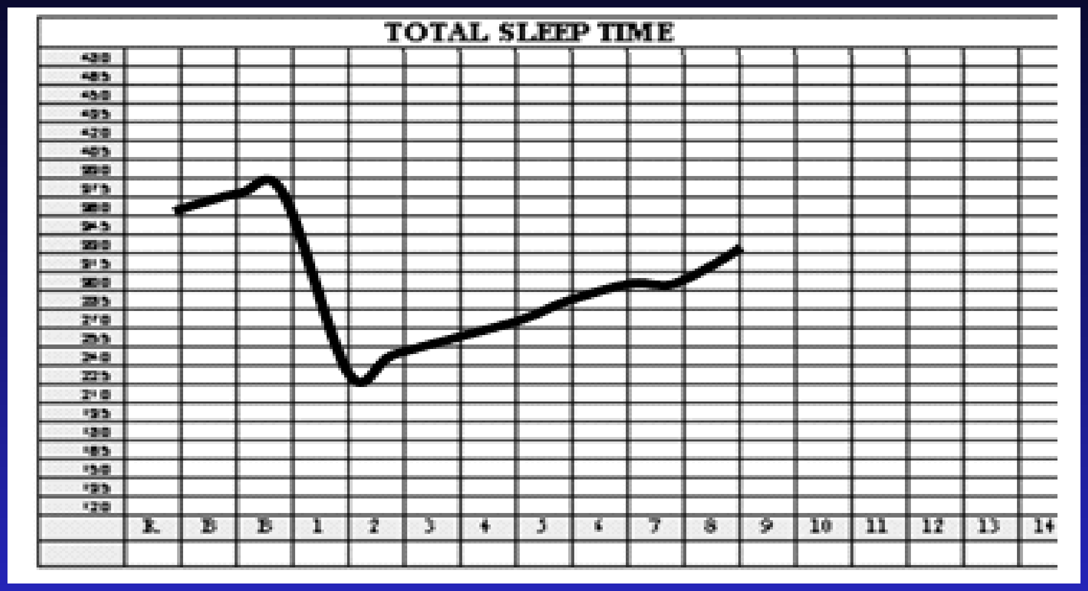


DO NOT UNDER DOSE SLEEP RESTRICTION



DO NOT OVER DOSE TIB DURING TITRATION

(> 15 min. extension)

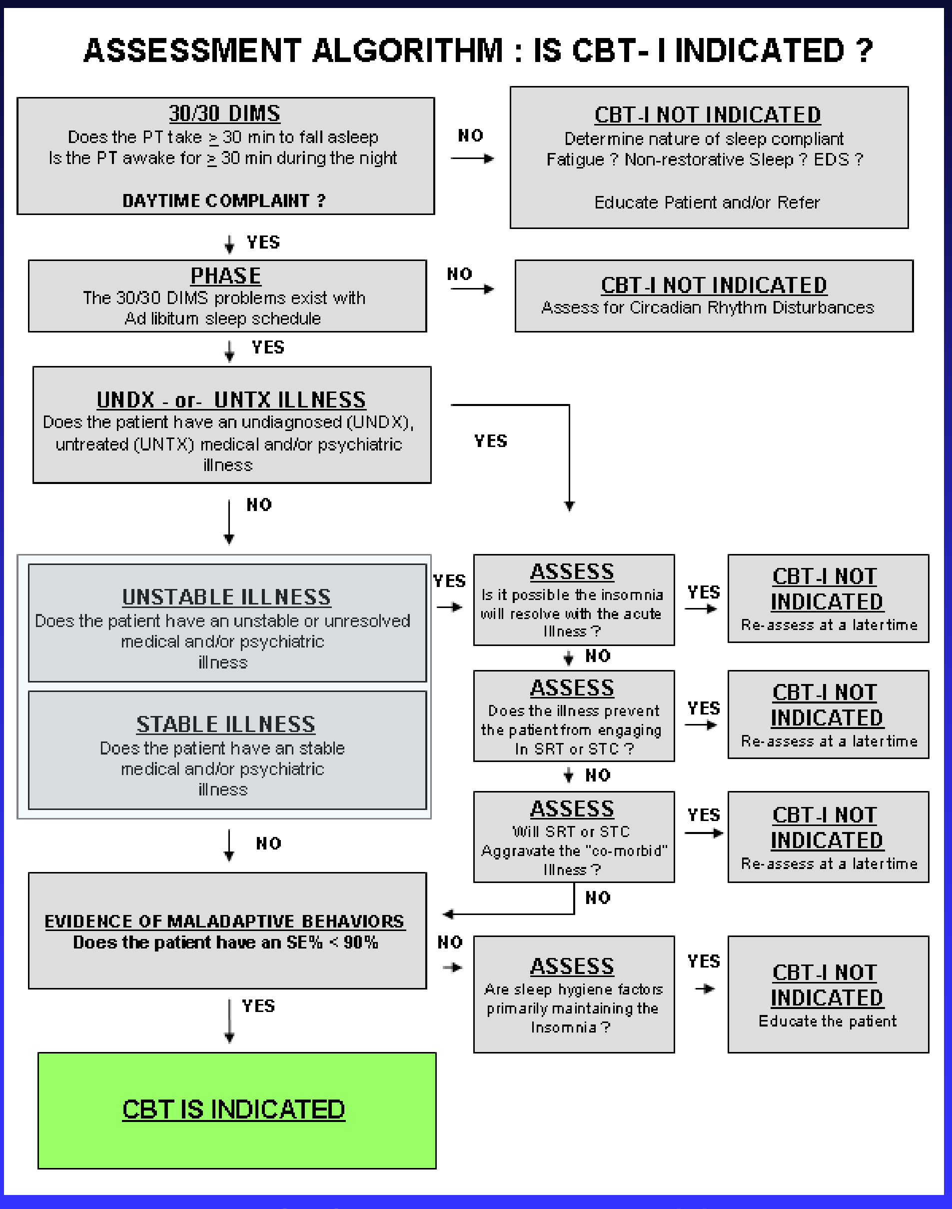


4-8 SESSIONS IS OFTEN NOT ENOUGH, STAY OPEN TO MORE SESSIONS THAN IS SOP…

FINALLY

WHO IS A GOOD CANDIDATE FOR CBT-I

WHO IS A GOOD CANDIDATE FOR CBT- I ?



HEALTH PSYCHOL. 2006 JAN;25(1):15-9.

BREAK