INSOMNIA

CBT-I
COMPONENTS
TX DELIVERY
OK. SO IT WORKS. WHAT IS IT?
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.
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

- Perpetuating
- Precipitating
- Predisposing

TARGET FOR CBT TX OF INSOMNIA

Threshold

Pre-Morbid  Acute  Early  Chronic

SPIELMAN 1985
WHAT ARE PERPETUATING FACTORS

TARGET FOR CBT TX OF INSOMNIA

Chronic
# PERPETUATING FACTORS
Common Compensatory Strategies Used to Cope with Insomnia

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

TREATMENTS

• Sleep Restriction
• Stimulus Control
• Sleep Hygiene
• Cognitive Therapy
• Phototherapy
• Relaxation
THE BT TRINITY

Sleep Restriction
Stimulus Control
Sleep Hygiene
THERAPY

CBT-I

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%)
TIB: BEFORE, OVER TIME, AND W/ TX

Schematic representation by Michael Grandner PhD
THERAPY

CBT-I

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.

Disclaimer--illness & driving
1. Lie down to go to sleep at the prescribed TTB.

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.

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
WORRY IN BED
WORK IN BED
CLEAN BDRM
EAT IN BED
READ IN BED
WATCH TV IN BED

WHAT IS “STIMULUS CONTROL?”
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.
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.

- Prevents micro & mini sleeps
- Promotes full wakefulness

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**
- **PROMOTES CIRCADIAN REGULARITY**
- **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

4 FACTOR MODEL

- Conditioned Arousal
- Perpetuating
- Precipitating
- Predisposing

Threshold

Pre-Morbid Acute Early Chronic Acute Tx + Response

STIMULUS CONTROL INST
HYPNOTICS
SADs
OREXIN ANTAGONISM

SLEEP RESTRICTION
STIMULUS CONTROL INST

EXERCISE
RELAXATION
GEN. PSYCHOTHERAPY
THERAPY

CBT-I

SLEEP RESTRICTION

STIMULUS CONTROL

SLEEP HYGIENE

COGNITIVE THERAPY
# 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

Phillip 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 (psychophysiological 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/B978-0-12-385224-8.00031-1
© 2013 Elsevier Inc. All rights reserved.
THERAPY

CBT-I

SLEEP RESTRICTION
STIMULUS CONTROL
SLEEP HYGIENE
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

THIS

bears repeating.
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 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

Just break it.
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
PREREQUISITES

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

NOTE: This case example is not drawn from an individual case and does not represent a patient case. The note used to identify the example is fictitious. The report is for training purposes only and is not intended to be used for educational purposes.

Date of Evaluation: July 17, 2023

Identifying Information: Mr. Busch is a 42-year-old, white male who works as a security guard. He and his wife have a 12-year-old son and a 3-year-old daughter. He is 6'0" and weighs 190 lbs. (Other intake forms: 2)

PRESENTING COMPLAINT & SLEEP INFORMATION

Presenting Complaint: Mr. Busch reports trouble falling asleep once a week. It’s been pretty bad lately and I am afraid it is not going to go away.

Daytime Tolerance/Impairments: He reports difficulty with concentration and irritability at work. He has also noted difficulty with daytime sleep on occasion. He states that he has been having trouble falling asleep once a week.

History of Presenting Complaint: Mr. Busch reports that he has been experiencing insomnia for the past several months. He has been having trouble falling asleep once a week.

Prior Treatments for Sleep Disorders: Mr. Busch reports that he has been treated with several medications in the past, including trazodone, zolpidem, and ramelteon. He has also tried several over-the-counter sleep aids, but none have been effective.

Drugs Currently Taking: He is currently taking trazodone at 100 mg at bedtime.

Physical Examination: Mr. Busch looks healthy and well-nourished. He appears to be in good physical condition.

Cognitive/Behavioral Assessment: Mr. Busch reports that he has difficulty concentrating during the day and feels fatigued during the day.

Psychological/Behavioral Assessment: Mr. Busch reports that he has difficulty concentrating during the day and feels fatigued during the day.

Behavioral Sleep Medicine Service — Progress Note

Name: S. Busch
Session: 3
CPT Code: 90851

Medications: Trazodone 100 mg at bedtime.

Sleep Diary:

<table>
<thead>
<tr>
<th>Time</th>
<th>Action</th>
<th>Duration (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1:</td>
<td>12:30 AM</td>
<td>0</td>
</tr>
<tr>
<td>S:</td>
<td>0:33 AM</td>
<td>1</td>
</tr>
<tr>
<td>E1:</td>
<td>1:30 AM</td>
<td>24</td>
</tr>
<tr>
<td>WA1:</td>
<td>2:45 AM</td>
<td>0</td>
</tr>
<tr>
<td>WA2:</td>
<td>5:45 AM</td>
<td>7</td>
</tr>
<tr>
<td>WA3:</td>
<td>9:45 AM</td>
<td>1</td>
</tr>
<tr>
<td>T2:</td>
<td>6:55 AM</td>
<td>4</td>
</tr>
<tr>
<td>S2:</td>
<td>7:55 AM</td>
<td>1</td>
</tr>
</tbody>
</table>

Subjective History: Mr. Busch reported that he had difficulty sleeping at night and that he was not getting enough rest during the day. He reported that he felt very tired during the day.

Additional Information: Mr. Busch reported that he had difficulty sleeping at night and that he was not getting enough rest during the day. He reported that he felt very tired during the day.

Assessment of Sleep: Mr. Busch had difficulty falling asleep and remained in bed for an average of 6.5 hours. He reported difficulty staying asleep throughout the night.

Recommended Actions: Mr. Busch was recommended to try a sleep hygiene program. This includes avoiding caffeine and alcohol before bedtime, maintaining a regular sleep schedule, and avoiding naps during the day.

Treatment Plan: Mr. Busch was referred to the sleep clinic for further evaluation. He was also recommended to try a sleep hygiene program.

Date: 7/30/23
CHARTING

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 MEASURES

<table>
<thead>
<tr>
<th>INSTRUMENT</th>
<th>MEASURE OF</th>
<th>COVRE RANGE</th>
<th>PATIENT'S SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISI</td>
<td>Severe Depression</td>
<td>0-21</td>
<td>16</td>
</tr>
<tr>
<td>PSQI*</td>
<td>Sleep Disturbance</td>
<td>0-21</td>
<td>16</td>
</tr>
<tr>
<td>RIS*</td>
<td>Insomnia Severity</td>
<td>0-9</td>
<td>4</td>
</tr>
</tbody>
</table>

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
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
**Behavioral Sleep Medicine Service - Progress Note**

**Name:** S. Buech  
**Session 1:** Adjust STC & SRT

**CPT Code:**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>99040</th>
<th>99045</th>
<th>90847</th>
<th>90853</th>
</tr>
</thead>
</table>

**Medications:** Ranitidine 75 mg Daily  
Ibuprofen 600 PRN

**Diaries:**  
- **Completed:**
- **Partial Completion:**
- **Not Done**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>+</td>
</tr>
<tr>
<td>DSPS/ASPS</td>
<td>?</td>
</tr>
<tr>
<td>Appetite</td>
<td>-</td>
</tr>
<tr>
<td>Boozing/Haze</td>
<td>+</td>
</tr>
<tr>
<td>Sleepwalking</td>
<td>-</td>
</tr>
<tr>
<td>Interest</td>
<td>+</td>
</tr>
<tr>
<td>Concentration</td>
<td>+</td>
</tr>
<tr>
<td>Nightmares</td>
<td>-</td>
</tr>
<tr>
<td>Mood</td>
<td>-</td>
</tr>
</tbody>
</table>

**Subjective Issues:** Mr. Buech 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 fell asleep 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 stimulant for the first few weeks of therapy). Mr. Buech seemed glad to hear that there were some alternatives but felt that at this point held “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 can’t 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 was 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. Buech did not reach the target SE of 90%, we did not recommend that he upweird 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.
## Sleep Diaries

The price of therapy (aside from $$) is diaries.

### Complete Immediately Before Bed Concerning How You Felt Today

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPICAL DAY?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FATIGUE (NONE 0—1—2—3—4—5 A LOT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STRESS (NONE 0—1—2—3—4—6 A LOT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALERT (NOT VERY 0—1—2—3—4—5 VERY)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONCENTRATION (GOOD 0—1—2—3—4—5 BAD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOOD (BAD 0—1—2—3—4—5 GOOD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME SPENT EXERCISING (MIN.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUMBER OF ALCOHOLIC BEVERAGES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.**

### Complete Immediately on Awakening (Please Calculate Total Time in Bed and Total Sleep Time)

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME TO BED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME OUT OF BED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TIB) TOTAL TIME IN BED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME TO BED (DEV FRM 11)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME OUT OF BED (DEV FRM ?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SL) TIME TO FALL ASLEEP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(NUMA) NUMBER TIMES AWAKENED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(WASO) WAKE AFTER SLEEP ONSET</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TTOB) TOTAL AMOUNT TIME OUT OF BED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(TST) TOTAL SLEEP TIME (MIN.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SE) SLEEP EFFICIENCY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLEEP QUALITY (POOR 0—1—2—3—4—5 GOOD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FATIGUE (NONE 0—1—2—3—4—5 A LOT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SLEEP DIARIES

**THINK ABOUT USING ON-LINE DIARIES OR APS**

### AM Sleep Diary

Please answer all the questions below. If you're not sure what the question means (what the question is getting at), place the mouse cursor over the text of questions marked "(more info)" and an explanation will be provided.

**Sleep diary date:**

<table>
<thead>
<tr>
<th>(M)</th>
<th>(d)</th>
<th>(yyyy)</th>
</tr>
</thead>
</table>

**Sleep diary UserID:**

1. **What time did you get into bed?**
   - *Was this a normal/typical time to go to bed for you?*
   - *(h) (mm) (tt)*
   - Select: Yes ☐ No ☐

2. **What time did you try and go to sleep?** *(more info)*
   - *(h) (mm) (tt)*

3. **How long did it take you to fall asleep?** *(more info)*
   - *(h) (mm)*

4. **How many times did you wake up, not counting your final awakening?** *(more info)*
   - Select a number ☑

5. **How much time did you spend awake during the night — in bed?** *(more info)*
   - *(H) (mm)*

6. **How much time did you spend awake during the night — out of bed?** *(more info)*
   - *(H) (mm)*

7. **What time was your final awakening?**
   - *(h) (mm) (tt)*

8. **How long were you continuously awake before getting out of bed?**
   - *(H) (mm)*

9. **How much sleep did you get last night?**
   - *(H) (mm)*

10. **What time did you get out of bed for the day?** *(more info)*
    - *Was this a normal/typical time to get out of bed for you?*
    - *(h) (mm) (tt)*
    - Select: Yes ☐ No ☐
PATHWAY(S) TO CLINICAL EXCELLENCE
DO NOT UNDER DOSE SLEEP RESTRICTION
DO NOT OVERDOSE 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?

ASSESSMENT ALGORITHM: IS CBT-I INDICATED?

30/30 DIMS
- Does the PT take ≥ 30 min to fall asleep
- Is the PT awake for ≥ 30 min during the night
- DAYTIME COMPLAINT?
- NO
- CBT-I NOT INDICATED
  - Determine nature of sleep complaint
  - Fatigue? Non-restorative Sleep? EOS?
  - Educate Patient and/or Refer
- YES
- PHASE
  - The 30/30 DIMS problems exist with Ad libitum sleep schedule
  - NO
  - CBT-I NOT INDICATED
  - Assess for Circadian Rhythm Disturbances
  - YES
- UNDX or UNTX ILLNESS
  - Does the patient have an undiagnosed (UNDX),
  - untreated (UNTX) medical and/or psychiatric illness
  - NO
  - CBT-I NOT INDICATED
  - YES
- UNSTABLE ILLNESS
  - Does the patient have an unstable or unresolved
  - medical and/or psychiatric illness
  - YES
  - CBT-I NOT INDICATED
  - NO
  - CBT-I NOT INDICATED
  - Re-assess at a later time
- STABLE ILLNESS
  - Does the patient have a stable
  - medical and/or psychiatric illness
  - YES
  - CBT-I NOT INDICATED
  - NO
  - CBT-I NOT INDICATED
  - Re-assess at a later time
- EVIDENCE OF MALADAPTIVE BEHAVIORS
  - Does the patient have an SEH < 30%?
  - NO
  - CBT-I NOT INDICATED
  - YES
  - CBT-I NOT INDICATED
  - Educate the patient

BREAK