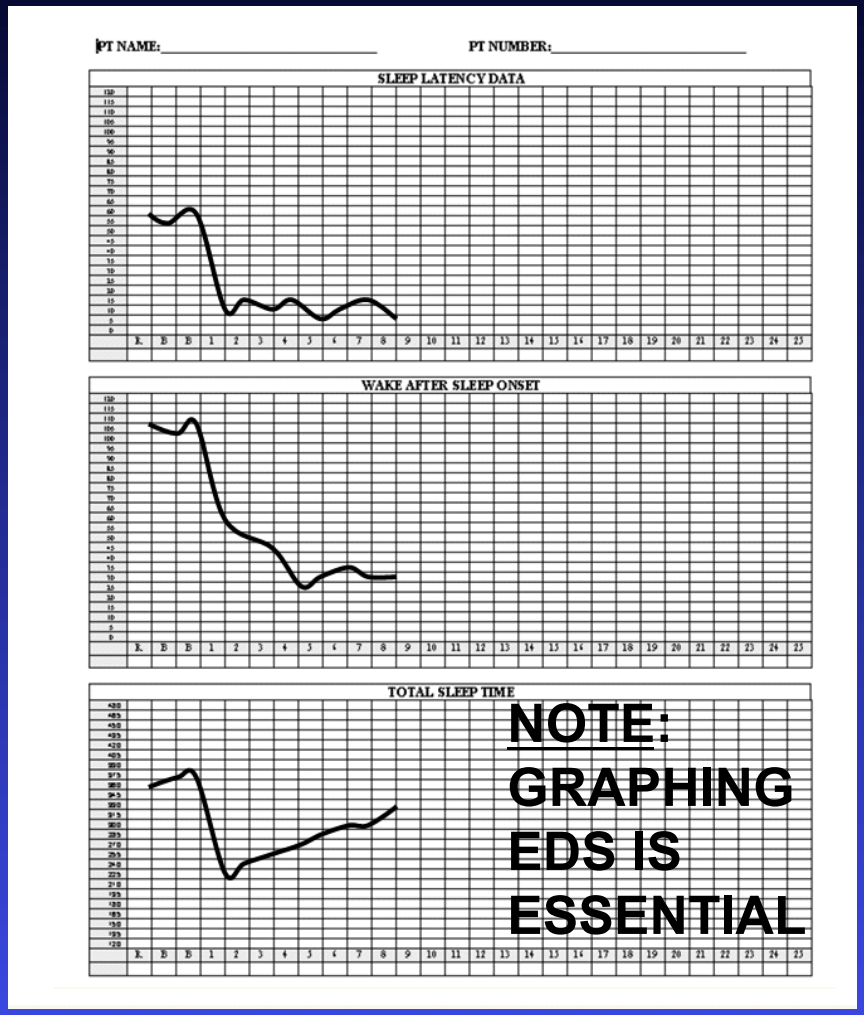
INSOMNIA

SESSION 4,6,7 – TREATMENT

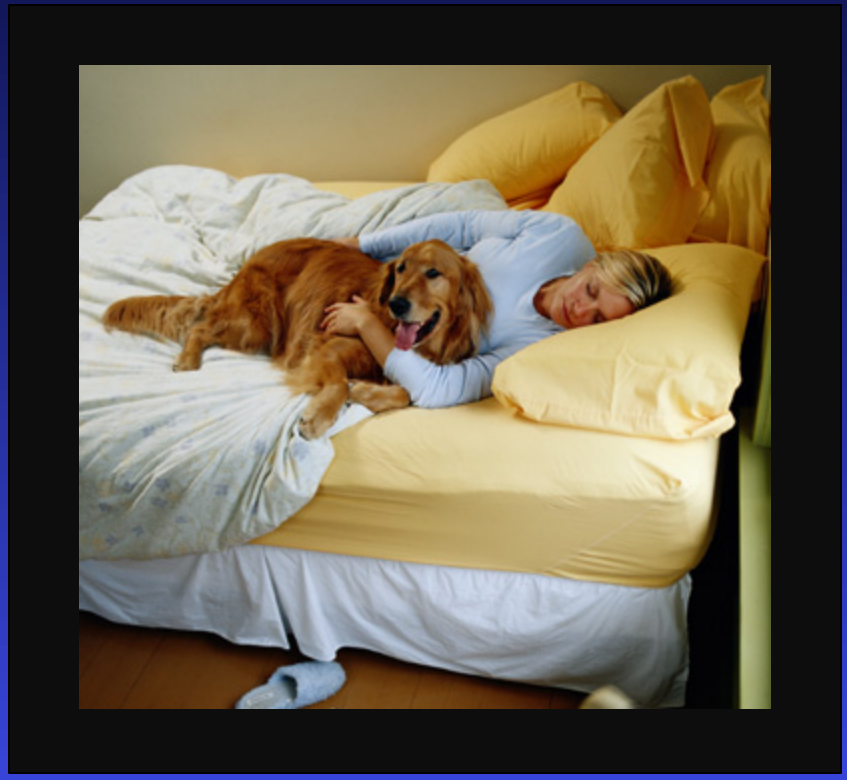
“WHAT ARE WE GOING TO DO TODAY?”
THE SAME THING AS EVERY DAY … !

Tasks
Summarize & Graph Sleep Diary
Assess Treatment Gains and Compliance
Determine if upward Titration is warranted

GRAPH MEAN SLEEP CONTINUITY



POSITIVE TREATMENT RESPONSE



GWEN HAS SUCCESS

TX NON-RESPONSE OR RESPONSE WITH AEs

I'M DOING BETTER – BUT I FEEL HORRIBLE DURING THE DAY !

POSSIBLE EXPLANATIONS

PT WAS COMPLIANT WITH A TOO SEVERE A SRT

OCCULT OSA OR PLMs ?
OCCULT MEDICAL OR PSYCHIATRIC ILLNESS ?

SUBSTANCE USE OR ABUSE

SLEEP STATE MISPERCEPTION

SLEEP STATE MISPERCEPTION
AKA
PARADOXICAL INSOMNIA

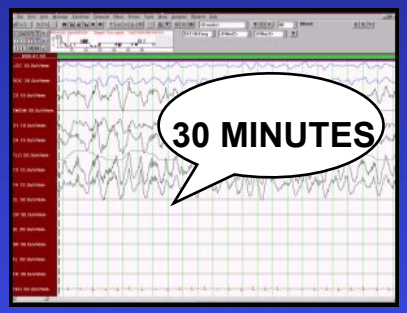
WHAT IS THIS ?!

AND

WHAT ARE THE IMPLICATIONS FOR CBT-I ?!

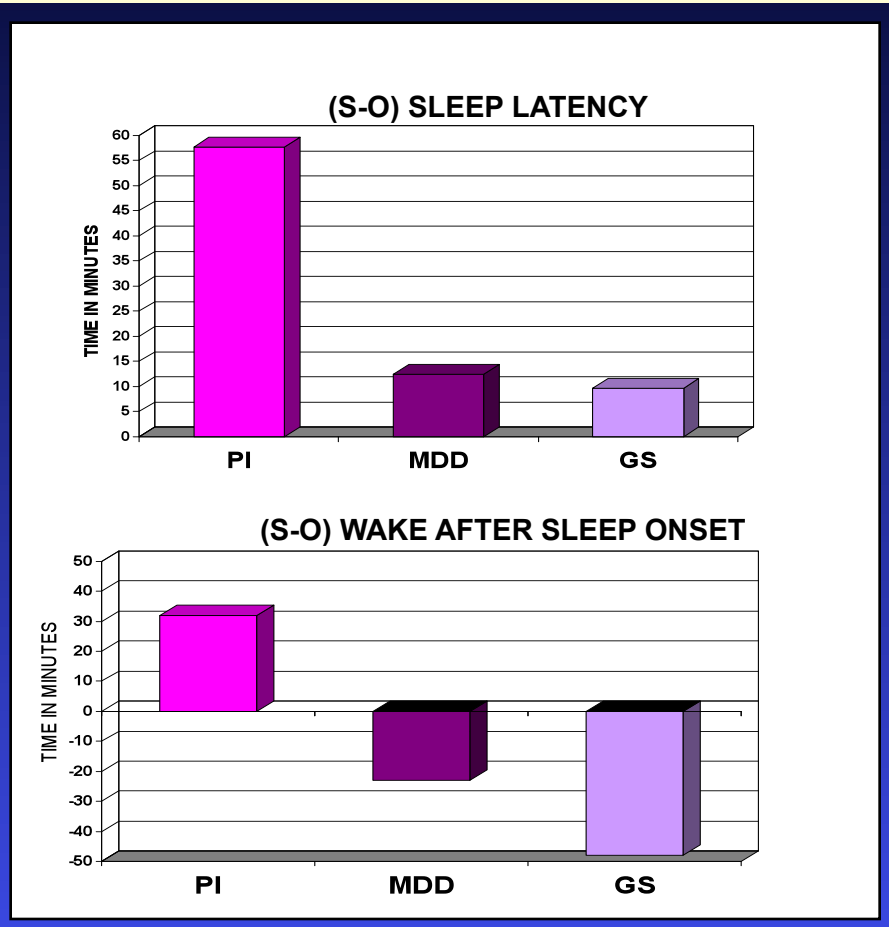
“SLEEP STATE MISPERCEPTION”

SUBJECTIVE-OBJECTIVE DISCREPANCY



“SLEEP STATE MISPERCEPTION”

SUBJECTIVE-OBJECTIVE DISCREPANCY



“SLEEP STATE MISPERCEPTION”

SUBJECTIVE-OBJECTIVE DISCREPANCY

WHAT ARE THE IMPLICATIONS FOR CBT-I

UNKNOWN

OPTIONS

CONTINUE STANDARD CBT-I

CONTINUE STANDARD CBT-I WITH MODAFINIL

EXPERIMENT WITH THE ISR PROTOCOL

TRY SLEEP COMPRESSION

MEDICATION (BZs VS BZRAs)

SLEEP LAB BASED - FEEDBACK

20% REDUCTION OF TST REVERSES DISCREPANCY BETWEEN SUBJECTIVE AND EEG BASED TIMES TO FALL ASLEEP

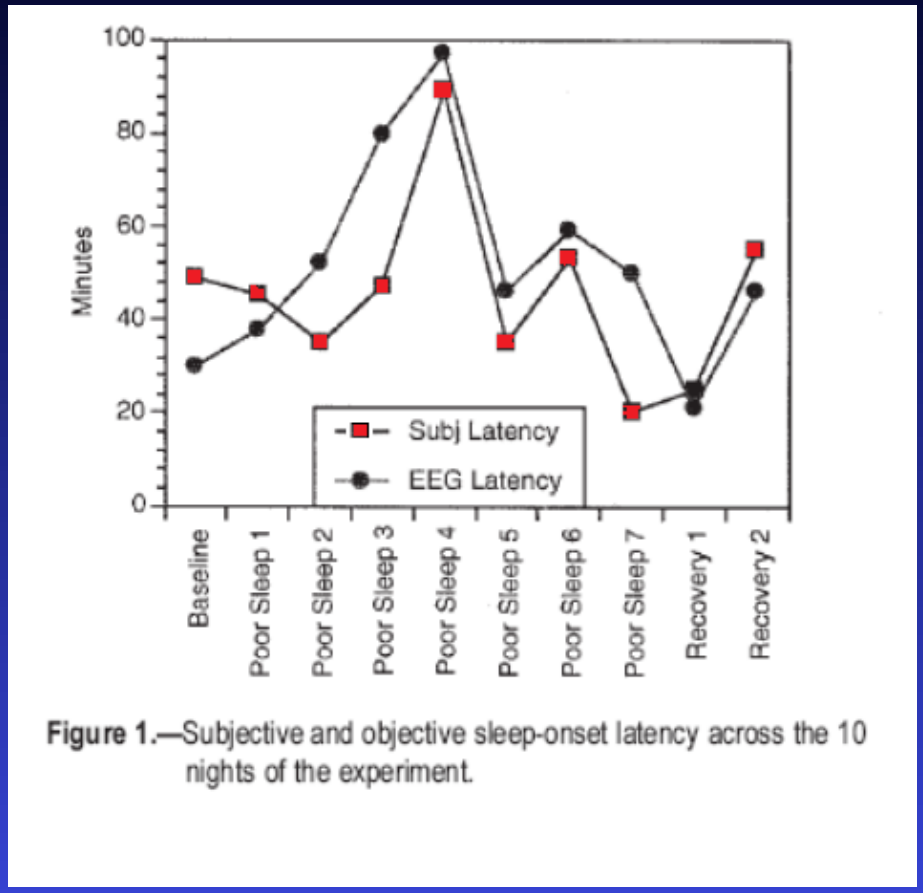
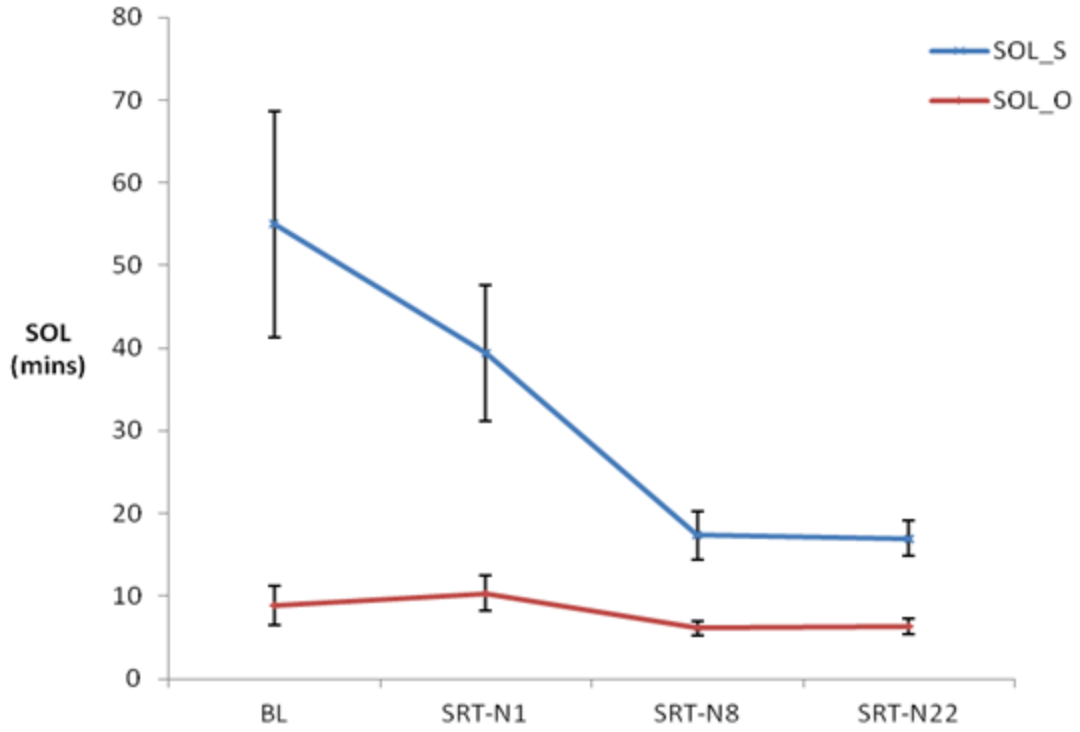


Figure 1.—Subjective and objective sleep-onset latency across the 10 nights of the experiment.

Bonnet & Arand 1998 Sleep 21(4) 359-368

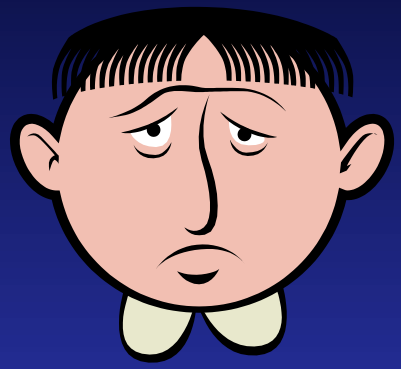
INFORMATION PROVIDED IN VA SLIDES AND MANUALS OF CBT-I

Figure 2: Subjective and objective sleep-onset latency throughout treatment nights



Kyle, Espie et al. Personal Communication 2013

QUESTIONS & RESISTANCES



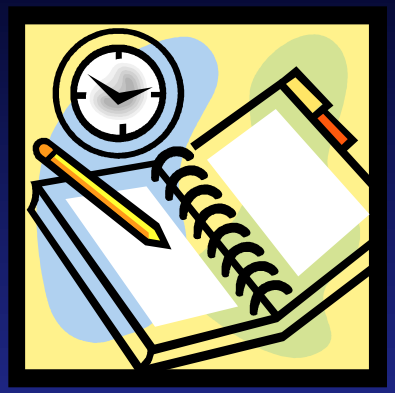
I'M DOING BETTER – CAN WE STOP NOW ?

BEST NOT TO.

WILL I HAVE TO DO SRT AND STC FOREVER ?!

YES AND NO.

NOTHING IS CERTAIN IN THIS WORLD
BUT DEATH, TAXES, AND STIMULUS CONTROL



NEXT WEEK

REVIEW YOUR SLEEP DIARY DATA

TITRATION & TROUBLE SHOOTING

COGNITIVE THERAPY

BREAK

The University of Pennsylvania

Michael Perlis PhD
Director, Upenn Behavioral Sleep Medicine Program
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WHAT ARE THE IMPLICATIONS FOR CBT-I

UNKNOWN

OPTIONS

CONTINUE STANDARD CBT-I

RELAXATION TRAINING

DO A SEVERE FORM OF CBT-I WITH MODAFINIL

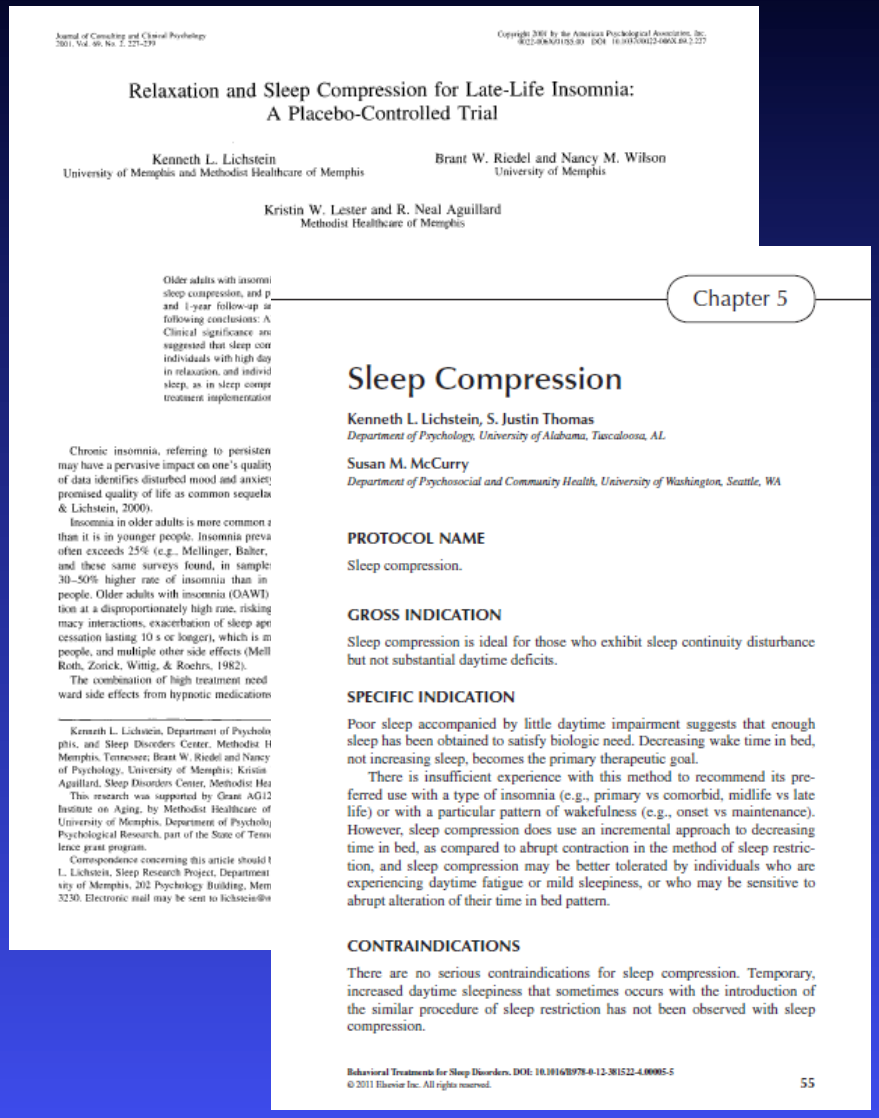
EXPERIMENT WITH THE ISR PROTOCOL

TRY SLEEP COMPRESSION

MEDICATION (BZs VS BZRAs)

SLEEP LAB BASED - FEEDBACK

SLEEP COMPRESSION PROTOCOL



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0022-006X/01/$5.00 DOI: 10.1037/0022-006X.69.2.227

Relaxation and Sleep Compression for Late-Life Insomnia:
A Placebo-Controlled Trial

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University of Memphis and Methodist Healthcare of Memphis

Brant W. Riedel and Nancy M. Wilson
University of Memphis

Kristin W. Lester and R. Neal Aguillard
Methodist Healthcare of Memphis

Older adults with insomni
sleep compression, and p
and 1-year follow-up a
following conclusions: A
Clinical significance an
suggested that sleep com
individuals with high day
in relaxation, and individ
sleep, as in sleep compr
treatment implementation

Chronic insomnia, referring to persisten
may have a pervasive impact on one's quality
of data identifies disturbed mood and anxiet
promised quality of life as common sequela
& Lichstein, 2000).

Insomnia in older adults is more common
than it is in younger people. Insomnia preva
often exceeds 25% (e.g., Mellinger, Balter,
and these same surveys found, in sample
30–50% higher rate of insomnia than in
people. Older adults with insomnia (OAWI)
tion at a disproportionately high rate, risking
macy interactions, exacerbation of sleep apn
cessation lasting 10 s or longer), which is m
people, and multiple other side effects (Mell
Roth, Zorick, Wittig, & Roehrs, 1982).

The combination of high treatment need
ward side effects from hypnotic medications

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phis, and Sleep Disorders Center, Methodist H
Memphis, Tennessee; Brant W. Riedel and Nancy
of Psychology, University of Memphis; Kristin
Aguillard, Sleep Disorders Center, Methodist Hea

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lence grant program.

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Chapter 5

Sleep Compression

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Susan M. McCurry
Department of Psychosocial and Community Health, University of Washington, Seattle, WA

PROTOCOL NAME

Sleep compression.

GROSS INDICATION

Sleep compression is ideal for those who exhibit sleep continuity disturbance but not substantial daytime deficits.

SPECIFIC INDICATION

Poor sleep accompanied by little daytime impairment suggests that enough sleep has been obtained to satisfy biologic need. Decreasing wake time in bed, not increasing sleep, becomes the primary therapeutic goal.

There is insufficient experience with this method to recommend its preferred use with a type of insomnia (e.g., primary vs comorbid, midlife vs late life) or with a particular pattern of wakefulness (e.g., onset vs maintenance). However, sleep compression does use an incremental approach to decreasing time in bed, as compared to abrupt contraction in the method of sleep restriction, and sleep compression may be better tolerated by individuals who are experiencing daytime fatigue or mild sleepiness, or who may be sensitive to abrupt alteration of their time in bed pattern.

CONTRAINDICATIONS

There are no serious contraindications for sleep compression. Temporary, increased daytime sleepiness that sometimes occurs with the introduction of the similar procedure of sleep restriction has not been observed with sleep compression.

Behavioral Treatments for Sleep Disorders. DOI: 10.1016/B978-0-12-381522-4.00005-5

DETERMINE AVERAGE SLEEP OPPORTUNITY AND SLEEP ABILITY USING 2 WEEKS OF DIARIES

DETERMINE THE DIFFERENCE BETWEEN TIB AND TST (DIFF)

DETERMINE AMOUNT OF SLEEP RESTRICTION (DIFF/ 5)

DELAY BEDTIME OR ADVANCE RISE TIME BY (DIFF/ 5) PER WEEK

TRACK SE% AND APPLY SRT TITRATION RULES