Cognitive Behavior Therapy for Insomnia (CBT-I): Behavioral Intervention to Insomnia

Led as a 15-20 minute group discussion with active participation from the trainees. Use handouts as visual components.

Objectives

1. Learn how to engage veteran to consider alternative, non-pharmacological insomnia management method.
2. Understand goals, components, and benefits of Cognitive Behavioral Therapy for insomnia (CBT-I).
3. Know how to present CBT-I to patients, and make appropriate referrals.
4. Prepare chart review of assigned clinic patient (to be completed prior to session).
5. Discuss appropriateness of CBT-I for assigned patient.

Teaching Pearls for CBT-I

♦ Current Challenges
  • Discussion with trainees:
    • Imagine you are trying to encourage a 72 year-old male veteran who has been taking sleep aids for over two years to discontinue use.
    • What has your experience been like having this conversation?
    • What was helpful? Not helpful?
  • Teaching point: For any changes to happen, patient must value taking the risk and making the effort.

♦ Introduction to CBT-I
  • Prompt trainees:
    • Who’s heard of Cognitive Behavioral Therapy for Insomnia?
    • Who’s referred pts to CBT-I?
    • Who struggled to refer pts to CBT-I?
    • Who can tell me what CBT-I is?
    • Do you have any pts who benefited from CBT-I?
  • Teaching point: Highlight the importance of trainee’s awareness of basic concepts of CBT-I to make appropriate pitch for service.

♦ CBT-I Facts
  • What is Cognitive Behavioral Therapy for Insomnia?
    • A multi-component treatment that addresses an individual’s sleep-related behaviors and cognitions
  • What are the benefits?
    • CBT-I showed short term and long term reduction in sleep disruptions.
    • CBT-I has been shown to be effective for veterans.
• Patients with elevated depression sx showed positive outcome with CBT-I, including improvements in insomnia sx, perceived level of energy, reduced irritability, and self-esteem.

• Patients with comorbid chronic pain conditions, cancer, mild TBI, and PTSD also demonstrated benefit.

• What does CBT-I involve?
  • Behavioral components:
    • Sleep restriction (decrease wakefulness after sleep onset; 80-90% efficiency)*
    • Stimulus Control (sleep hygiene, bed = cue for sleep)*
  • Cognitive component:
    • Cognitive Restructuring: maladaptive sleep beliefs “I must take X to get any sleep”*
  • Patients are expected to set goals, track sleep, and make changes!

• Who can provide CBT-I?
  • Individual COE Health Psychology team
    • 6 x 60 min sessions
    • May be shorter, or longer with vets with MH comorbidities
  • CBT-I group (Check with your facility re: availability)
    • 6 x 90 minutes sessions
  • CBT-I Coach app
    • Great resource with learning and practice tools
    • Not a substitute for treatment

♦ Problem Solving
  • Working with lack of receptivity
    • Situation 1: Veteran reports barriers: “These strategies seem so easy!”, “I’ve already tried all of this!” “I already stopped drinking coffee and it made no difference!”, “I tried restricting sleep and it didn’t work!”
      • Reflect veteran’s effort.
      • Educate the importance of comprehensive treatment: “It’s great you tried that! Good quality sleep is important to you. What you tried is one piece of the program, and all parts together work better!”
  • Situation 2: Veteran declines.
    • Reflect veteran’s statement.
    • Reassess readiness next primary care visit.
    • Keep an open ear for worries and trend.

• Working with health psychology
  • One health psychology visit can assist veterans in making an informed decision by providing more robust education or using motivational interview.
• If veteran is not the best fit for CBT-I, health psychology can still offer strategies.
• Setting expectations for veterans
  • Educate possible temporary rebound after discontinuing medication.
  • Share the good news that alternative non-pharmacological intervention (CBT-I) is hard work, but has long-term benefits.

References