Insomnia: Overview, Assessment, and Behavioral Treatment

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Can you remember...

...the last time you had a night of poor sleep?

We all have trouble sleeping sometimes!
Not all nights of poor sleep develop into sleep disorders...

...but what about when they do?
Insomnia: Criteria

• Difficulty falling asleep and/or staying asleep
  • Frequent awakenings, difficulty returning to sleep after awakenings, or awakening too early with inability to return to sleep
• Must have adequate opportunity to sleep, not due to environment
• Sleep-related daytime distress or impairment
  • Mood, ability to function, work, concentration, daytime fatigue
• Chronic: At least 3 nights per week for at least 3 months

DSM-5; ICSD-3; Buysse 2013, JAMA
Insomnia

- Disorder occurs in ~10-20%, with approximately 50% of those having a chronic course
- Symptoms occur in approximately 33% to 50% of adults
- More than 2/3 of patients report symptoms for at least 1 year
- Consistent risk factors include older age, female sex, comorbid (medical, psychiatric, sleep, and substance use) disorders, shift work
  - Potentially unemployment and lower SES

Pathophysiological Model

Levenson, Kay, & Buysse, 2015, CHEST
Insomnia: 3P Model

- Predisposing Factors
- Precipitating Factors
- Perpetuating Factors

The 3 P’s

- Pre-morbid
- Acute Insomnia
- Early Insomnia
- Chronic Insomnia

Spielman 1987, Psych Clin N Amer
Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults

Sharon Schutte-Rodin, M.D.; Lauren Broch, Ph.D.; Daniel Buysse, M.D.; Cynthia Dorsey, Ph.D.; Michael Sateia, M.D.

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Insomnia is the most prevalent sleep disorder in the general population, and is commonly encountered in medical practices. Insomnia is defined as the subjective perception of difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity for sleep, and that results in some form of daytime impairment. Insomnia may present with a variety of specific complaints and etiologies, making the evaluation and management of chronic insomnia demanding on a clinician’s time. The purpose of this clinical guideline is to provide clinicians with a practical framework for the assessment and disease management of chronic adult insomnia, using existing evidence-based insomnia practice parameters where available, and consensus-based recommendations to bridge areas where such parameters do not exist. Unless otherwise stated, “insomnia” refers to chronic insomnia, which is present for at least a month, as opposed to acute or transient insomnia, which may last days to weeks.

Citation: Schutte-Rodin S; Broch L; Buysse D; Dorsey C; Sateia M. Clinical guideline for the evaluation and management of chronic insomnia in adults. J Clin Sleep Med 2008;4(5):487-504.
Assessment of Insomnia

• Sleep History
  • Sleep/daytime function
  • Medical comorbidities
  • Psychiatric comorbidities
  • Common contributing medications

• Physical and Mental Status Exam

• Supporting Information

• Questionnaires

• Sleep Diary
The Consensus Sleep Diary

Treatment goals

- Improve sleep quality and quantity
- Improve sleep efficiency
- Improve daytime impairments
- Reduction of distress

What are *NOT* the goals?

Schutte-Rodin et al 2008, *JCSM*
Treatments for insomnia

• Disclaimer: Pharmacotherapy treatment options exist – we are not going to talk about them!

• Psychological and behavioral interventions show short and long term efficacy – few side effects!

CBTI: What is it?

Cognitive Behavioral Therapy for Insomnia

• Some combination of
  • Educational: psychoeducation, sleep hygiene
  • Behavioral: sleep restriction, stimulus control, relaxation
  • Cognitive: identifying and challenging dysfunctional beliefs

• Gold standard treatment for insomnia
  • 2016 ACP recommended CBT alone without pharmacotherapy as first-line tx

CBTI: Efficacy

Van Straten 2018 Meta-analysis:
• N=87 studies, included at least one CBTI component
  • 43% were full CBTI, 11% behavioral therapy, 19% relaxation, 26% other

• Group, individual, and self-help
  • Usually 6 sessions

van Straten et al 2018, Sleep Med Rev
CBTI: Efficacy

Positive statistically significant effects on all outcomes

Large effects for:
• ISI
• SE
• PSQI
• WASO
• SOL

van Straten et al 2018, *Sleep Med Rev*
Individual Treatment Components
Stimulus Control

• Individuals become conditioned to associate the bed with wakefulness

• Goal: eliminate or lessen the negative association between the bed and being awake (as well as frustration and worry)

• Use the bed for sleep (and sex) only
Sleep Restriction

• What is the typical response to difficulty sleeping at night?

• Decrease time spent awake in bed, increase sleep continuity

• Limit the time in bed to the total sleep time
  • Increases sleep drive
  • Lessens the opportunity to be awake in bed (attempting to sleep)

• Short-term strategy

• Time in bed gradually increased once sleep continuity improves
Cognitive Therapy

• Identify and address maladaptive thoughts and beliefs

• Focus primarily on thoughts related to sleep and wake processes
  • "If I don't get 8 hours of sleep I'll feel terrible"
  • "It's already 2am, I just know that I'll never sleep tonight"
  • “There’s no way to protect myself from COVID"
Relaxation Therapy

• Lower somatic and cognitive arousals associated with sleep

• Progressive Muscle Relaxation
• Guided Imagery
• Abdominal Breathing
Sleep Hygiene*

• Healthy lifestyle practices intended to improve sleep

• Are these specifically indicated for insomnia?

• Keeping a regular schedule; exercise; avoid napping, manage substance use; have a good sleep environment; smart technology use
Special considerations

• Medical comorbidities
• Psychiatric comorbidities
• Age
• Environmental limitations
Thank you!

Looking forward to seeing you at the live Q&A session!