Using ACT to Optimize Cognitive Behavioral Therapy for Insomnia

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Objectives

Why care about sleep?

What is CBT-I

When CBT-I works

ID'd areas of growth

CE Credit?

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A Quick Note on Values

Insomnia in Clinical Context

4 Flavors of Insomnia

- Difficulty falling asleep
- Difficulty staying asleep
- Waking up too early
- Poor quality sleep

Impacts quality of life or daytime functioning…

- Fatigue
- Daytime Sleepiness
- Attention, Concentration or Memory Impairment
- Poor work performance
- Irritability
- Headaches
- Anxiety

Why Target Sleep Directly?

PREVALENT

1 of ever 3 (100+ million) Americans have occasional bouts of insomnia.

1/3 go on to have chronic insomnia (~23% of US population)

Sleep loss associated with daytime impairment (50-70 million)

Why Target Sleep Directly?

UBIQUITOUS

- Virtually all psychiatric disorders are associated with sleep disruption

Why Target Sleep Directly?

RISK FACTOR

- For the development of medical illnesses (hypertension, heart disease, diabetes)
- Increasing evidence of its role as a likely mediating (causative) variable for the development of a new onset mental illness

Why Target Sleep Directly?

NON-RESPONSE

- Insomnia represents a risk factor for non-response to standard treatments for "primary" MH conditions

Why Target Sleep Directly?

RELAPSE RISK

- Untreated insomnia is a significant risk factor for relapse & recurrence of mental illness
- Doubling the chance of depression relapse (as a causal factor)

Why Target Sleep Directly?

IMPROVES COMORBID CONDITIONS

- Treatment has been shown to produce improvements in the "primary" issues of depression & chronic pain

Why Target Sleep Directly?

DOESN'T HAVE TO BE TIMED

- CBT-I has been found to be as effective for insomnia that occurs co-morbidly as it is with "primary" insomnia.

Why Target Sleep Directly?

Two (old) assumptions

- Sleep issues are usually are a symptom of something larger, not an independent issue
- Successful treatment of underlying primary disorder will result in amelioration of the sleep disturbance

Why Target Sleep Directly?

SUMMARY

- Shift in perspective →away from primary/secondary
- Significant factor in clinical response
- Significant factors in vulnerability to other MH processes
- Often needs focused, specialized treatment to improve
- Not directly targeting sleep symptoms = disservice
- Treatment exists!

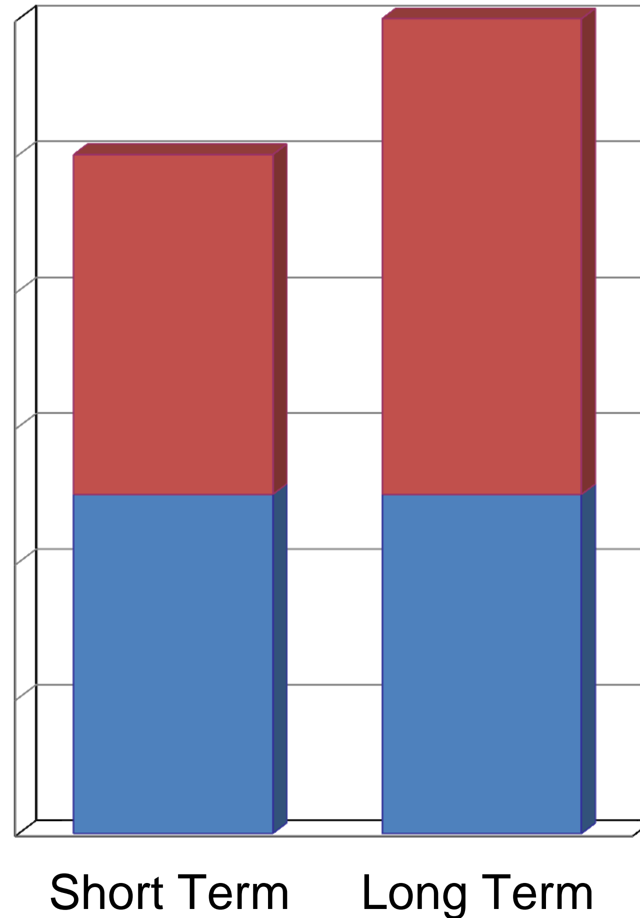
  ...over 30 years of evidence suggests that CBT-I is the most effective

What is CBT-I?

- Multi-Component
- Non-Pharmalogical
- Robust Evidence
- Manualized & Idiopathic

Efficacy

- CBT-I (over 50 clinical trials)
- Sleep Meds



Target Areas

CBT-I is efficacious in:

- reducing time to fall asleep
- reducing amount of wake time during the night
- improving sleep efficiency

Note: CBT-I provides an improvement, not cure

It is estimated 20-30% return to “normal sleep”

Case Example?

Causes of Chronic Insomnia

Medical disorders: CHF, COPD, asthma, GERD, cancer, chronic pain, hyperthyroidism, BPH, Parkinson’s, fibromyalgia.

Comorbid sleep disorder: OSA, RLS, periodic limb movement disorder, circadian rhythm disorder

Psychiatric disorders

Substance Abuse

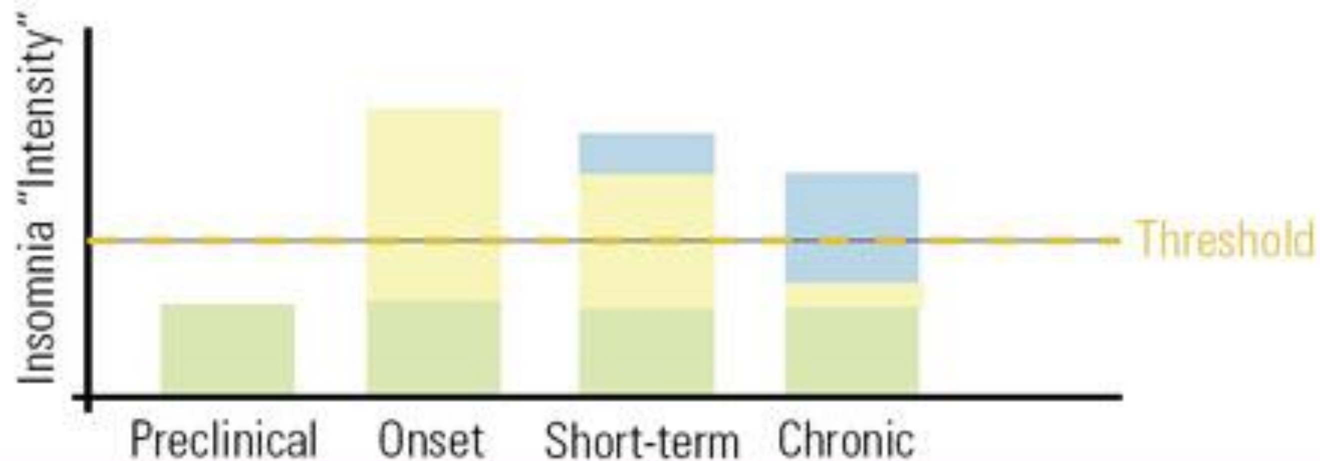
Medications: anticholinergics, antidepressants, antiepileptics, CNS stimulants, steroids

A Model of Chronic Insomnia

Predisposing Factors
- Biological traits
- Psychological traits
- Social factors

Precipitating Factors
- Medical illness
- Psychiatric illness
- Stressful life events

Perpetuating Factors
- Excessive time in bed
- Napping
- Conditioning



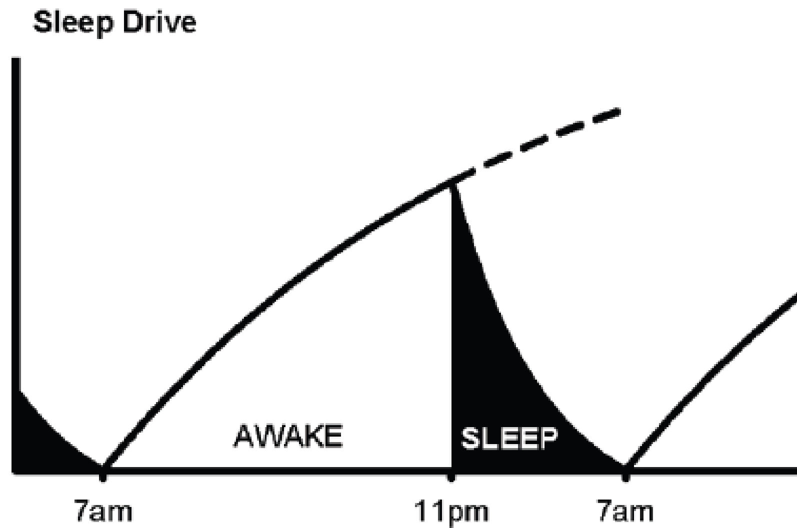
Perpetuating Factors

- **Excessive time in bed**
- **Increase in non-sleep related behaviors occurring in the bedroom**
- Naps & stimulant use
- Sleep aids
- Unhelpful & dysfunctional sleep related

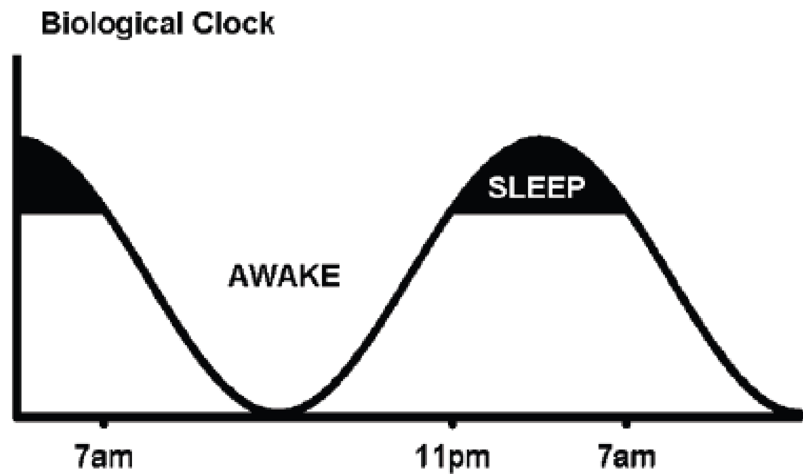
Behavioral Sleep Medicine

Biology

1. How long you've been awake



2. The Biological Clock



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Multi-Component Approach

Technique	Purpose
Sleep restriction	Restrict time in bed to consolidate sleep and improve depth of sleep
Stimulus control	Strengthen bed/bedroom as sleep stimulus via behavior recommendations & focus on a consistent sleep-wake schedule
Cognitive therapy	Address thoughts and beliefs that interfere with sleep
Relaxation training	Reduce arousal & decrease anxiety
Psychoeducation	Education about factors (environment, health habits, & sleep habits) that help/hurt sleep.

Stimulus Control (Bootzin, 1972)

aka de-program sleep-interfering associations

1. Wake up at the same time (including weekends). Set alarm.
2. Use bed only for sleep and sex.
3. Go to bed only when sleepy
4. Get out of bed when unable to fall asleep
5. Avoid daytime napping

Sleep Restriction

Limit time in bed

mild sleep deprivation → sleep consolidation

How:

- Reduce time in bed to estimated total sleep
- Wake up time is fixed
- Adjust weekly based on response

Advantages & Disadvantages

Advantages of CBT-I

- Non-pharmacological option
- Explicit focus on causative factors over symptom reduction - skills and strategies to use over time
- Effects are durable over time

Disadvantages of CBT-I

- Meds are widely available & rapid (when effective)
- Attrition due to discomfort
- Improvements typically are not seen until 3-4 weeks

Cognitive Strategies

SLEEP OR DIE

NOT GETTING THE RIGHT AMOUNT OF SLEEP EACH NIGHT CAN HAVE SERIOUS HEALTH RISKS AND CAN LEAVE LONG-LASTING EFFECTS ON YOUR BODY AND MIND.

HEALTH RISKS OF NOT SLEEPING

Taken from yourlocalsecurity.com

Behavioral change is challenging.

Wanda was proud of herself for sticking to her one-cup-a-day limit...

Multi-Component Approach

Technique	Purpose
Sleep restriction	Restrict time in bed to consolidate sleep and improve depth of sleep
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Psychoeducation	Education about environmental factors, health practices & sleep habits that promote or interfere with sleep.

CBT-I initially focused on sleep-<u>interpreting</u> cognitive processes.

CBT Thought Record

Situation	Moods	Automatic Thoughts	Evidence for the Hot Thought	Evidence against the Hot Thought	Alternative Thoughts	Moods Now

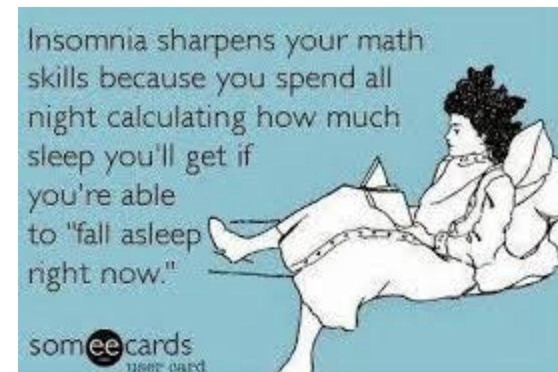
Sleep is a
MUST
for Good
Health!

thesavedrunner.com

CBT-I then augmented with sleep-<u>interfering</u> cognitive processes.

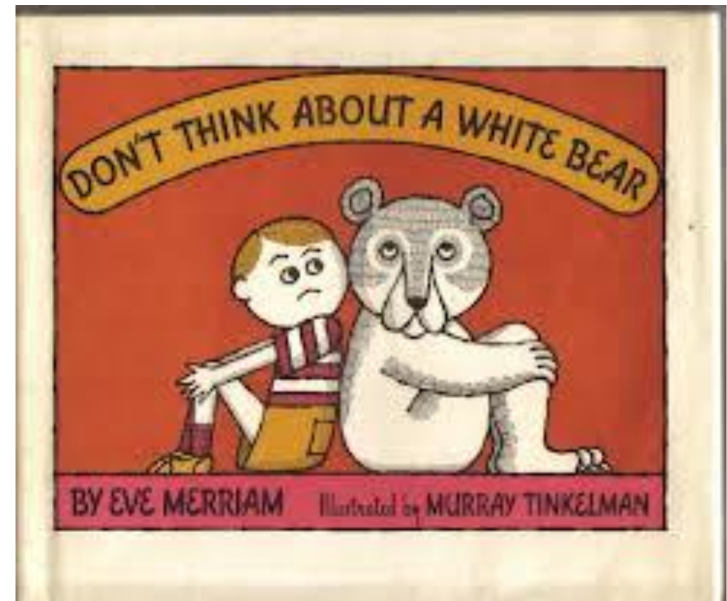
Pre-sleep processes

Level of cognitive activation



People with insomnia tend to

use more thought control strategies (thought suppression, reappraisal, and worrying).
(Harvey & Payne, 2002)



People with insomnia

are more involved in excessive verbal thinking that is counter-productive both with regards to sleep and daytime functioning.

(Nelson & Harvey, 2003)

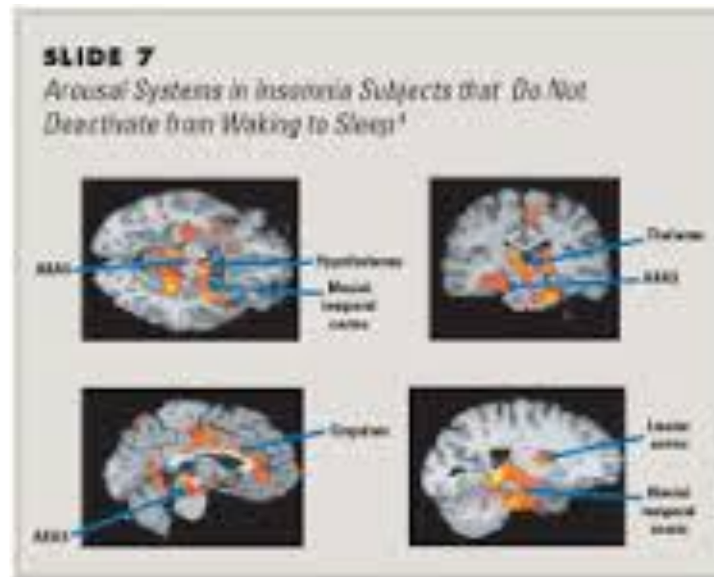
People with insomnia tend to

show more difficulty in letting go of verbal control both at night and during the day (researched via MSLTs).

(Lundh & Hindmarsh, 2002)

"When I can't sleep, I find that it sometimes helps to get up and jot down my anxieties."

Poor sleepers have more hyper-arousal and anxiety.



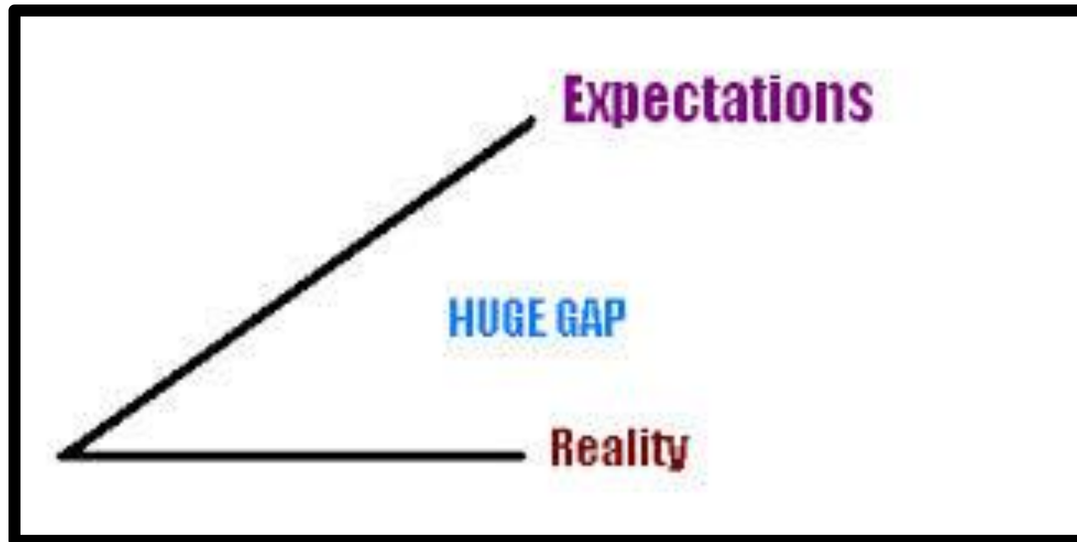
Nofzinger E.A., Buysse D.J., Germain A., Price J.C., Miewald J.M., & Kupfer D.J. (2004) Functional neuroimaging evidence for hyperarousal in insomnia. *American Journal of Psychiatry.* 161(11):2126-2128.

Mindfulness optimizes CBT-I

A Randomized Controlled Trial of Mindfulness Meditation for Chronic Insomnia
(in press)

Jason C. Ong, PhD
Rachel Manber, PhD
Zindel Segal, PhD
Yinglin Xia, PhD
Shauna Shapiro, PhD
James K. Wyatt, PhD

It is frustrating when EBT's are not effective.



CBT-I faces these challenges.

Engagement

Compliance

Response

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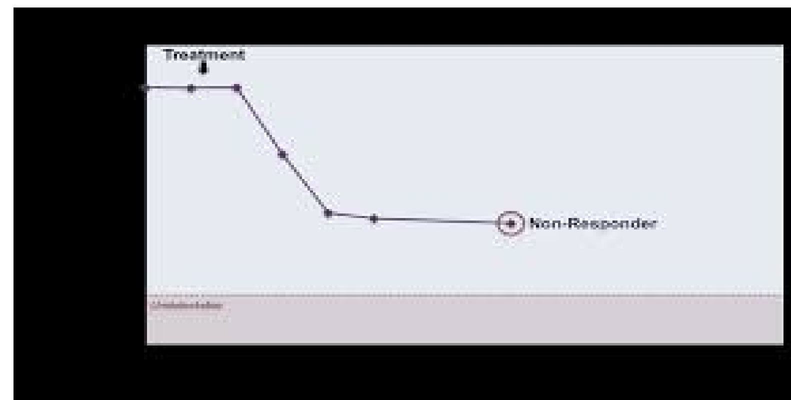
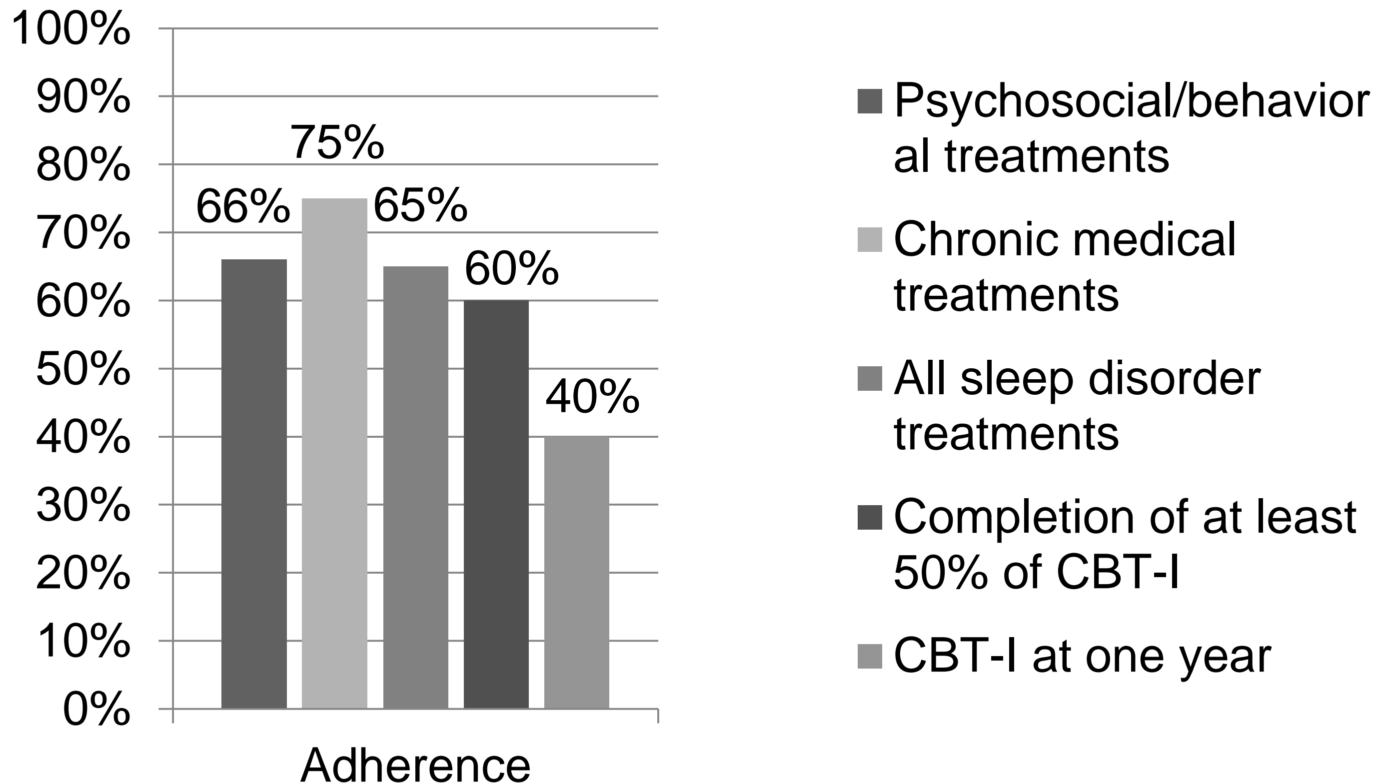


Adherence is a concern.



Explanations for non-engagement.

Self-efficacy

Motivation for Change

Level of Importance

Tolerance for discomfort

Do or do not. There is no try. (Yoda)

Explanations for non-compliance.

Psychiatric Illness

Pre-treatment levels of sleepiness

Pre-treatment disturbance severity

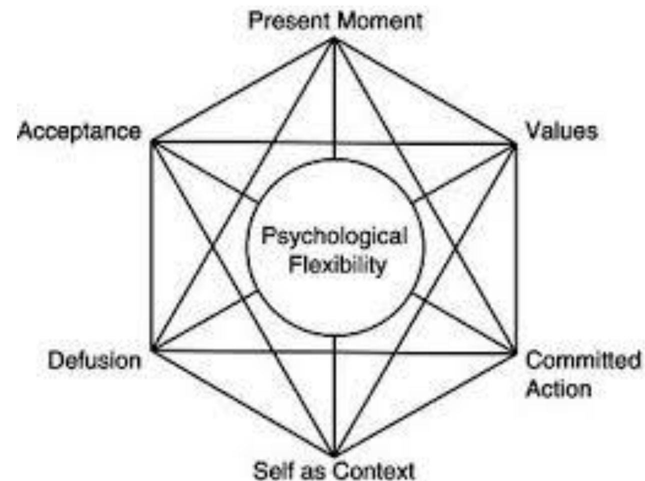
Tolerance for discomfort

Experience is the teacher of all things. (Julius Caesar)

Adherence is contextual and often rule-governed.

"Adherence should be conceptualized as a set of interacting behaviors influenced by individual, social, and environmental forces."

Matthews, Arnedt, McCarthy, Cuddihy, & Aloia, (2013) Adherence to Cognitive Behavior Therapy for Insomnia, A Systematic Review. *Sleep Medicine Review*, (17), 453-464.

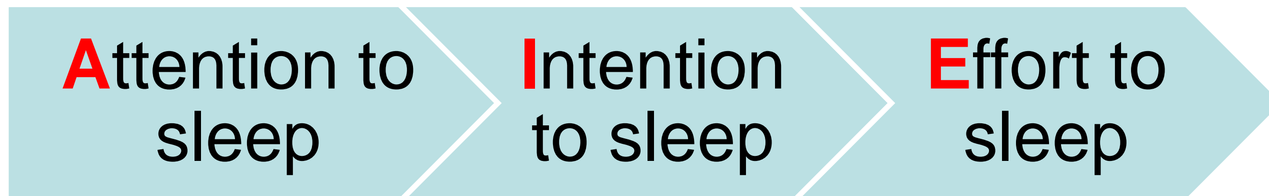


Controlling the Controlling is a problem.

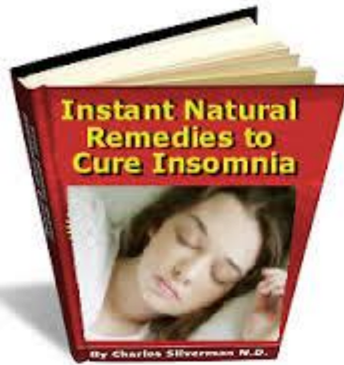
Attention-Intention Effort (AIE) pathway

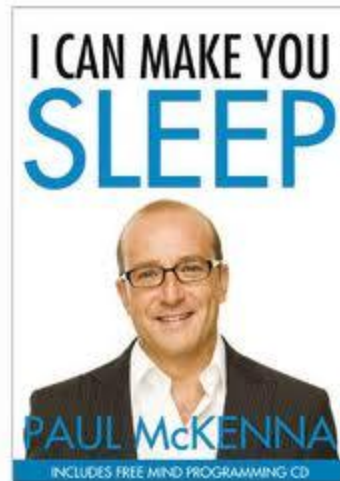
Espie, Broomfield, MacMahon, Macphee & Taylor (2006)

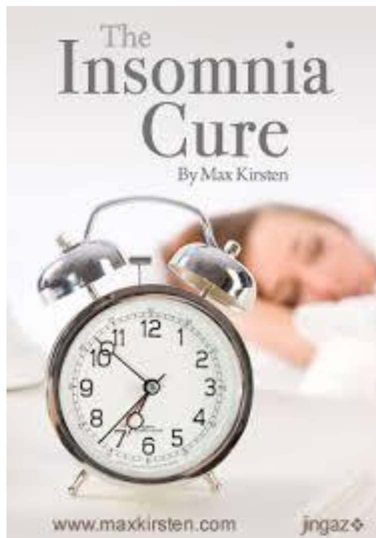
Normal and automatic sleep processes become disrupted when individuals selectively focus on:



We are led to believe we can control sleep.







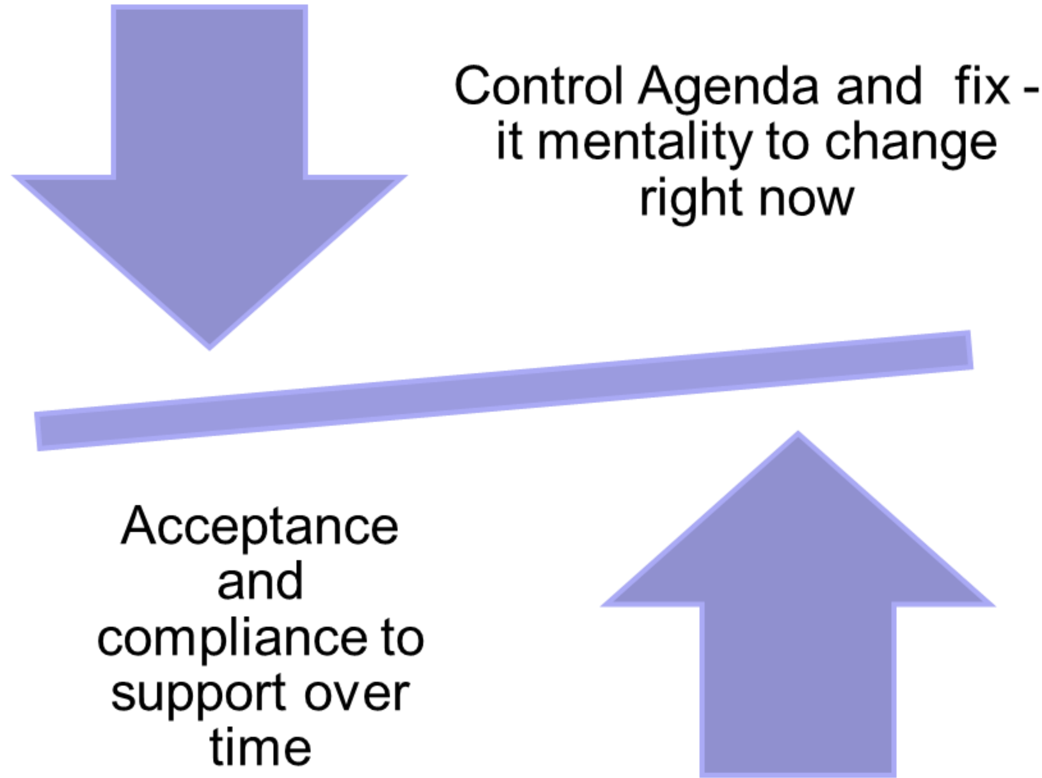
Cure insomnia through essential oils & herbal tea

www.HealthAndCare.in

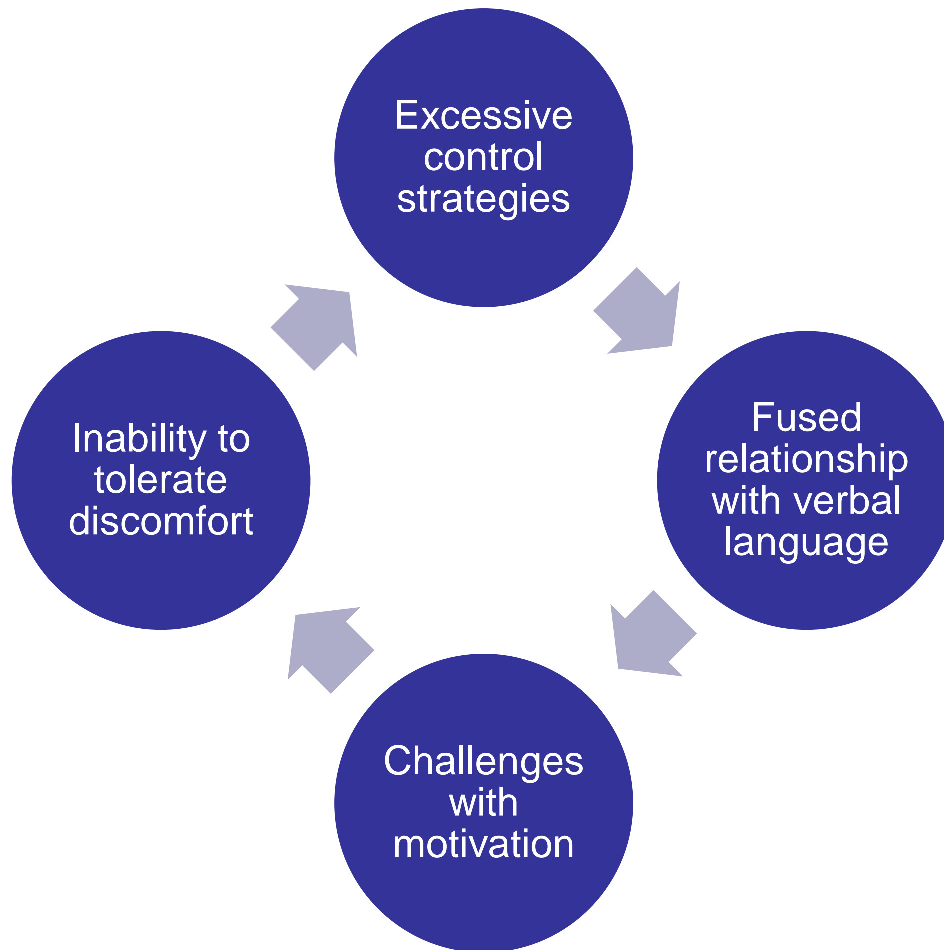
How To Sleep Better

We cannot control sleep.

ACT supports a flexible relationship with CBT-I.



ACT addresses challenges of CBT-I



Context optimizes the model.

Identify the contextual nature of:
1. sleep
2. resistance
3. CBT-I interventions

Use psychological flexibility to navigate personalized CBT-I plan.

A person's relationship with CBT-I matters.

I WONDER IF I WOULD BE HAPPIER IF I PUT AS MUCH EFFORT INTO ACCEPTING MYSELF AS I DO INTO CHANGING MYSELF?

A Model of Chronic Insomnia

Predisposing Factors
- Biological traits
- Psychological traits
- Social factors

Precipitating Factors
- Medical illness
- Psychiatric illness
- Stressful life events

Perpetuating Factors
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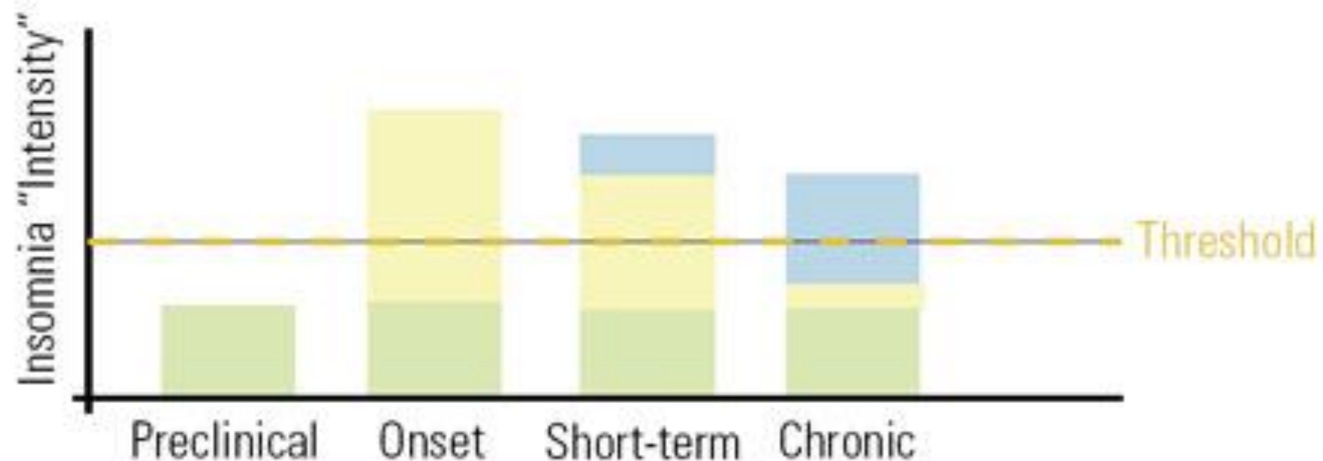
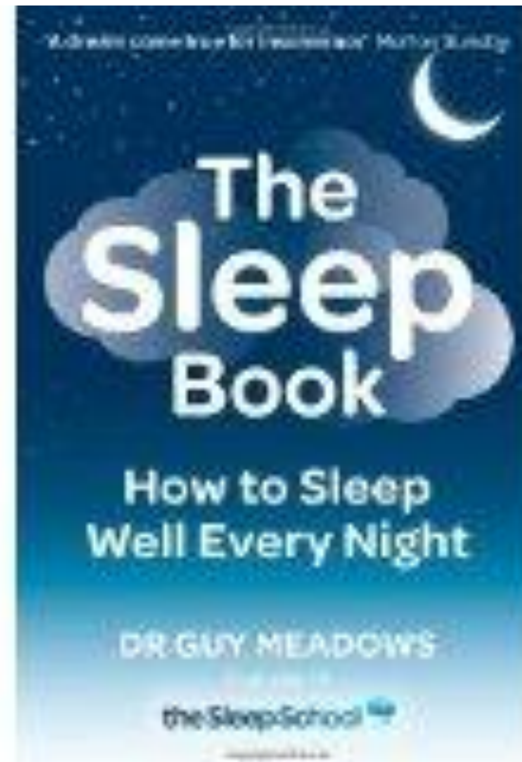


Perpetuating Factors can be addressed via ACT/ACT-I.

Awareness to experience

Openness to uncomfortable experiences

Engagement with values



Current trial on ACT for insomnia

Quality of Life Improvements after Acceptance and Commitment Therapy in Primary Insomnia

Department of Psychiatry and Psychotherapy, University of Freiburg Medical Center, Germany; Interdisciplinary Pain Center,

University of Freiburg Medical Center, Germany

The results suggest that ACT may improve important patient-centered outcomes in patients with PI. Specifically, a significant improvement of sleep-related QoL and subjective sleep quality was observed in non-responders to CBT-I with chronic PI directly after 6 weekly

outpatient sessions of ACT and at three month follow-up.

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We need research on the role of ACT in CBT-I.

Coming together is a beginning;
keeping together is progress;
working together is success.

Henry Ford

Challenges

Dissemination & Implementation on a large scale

…how to make the medical & psychological disciplines aware

…how to make the public aware

…how to make the required training & credentialing available

Want more?

Next steps…

- I'm kinda curious…
  - SBSM, books, articles
- I want to get training
  - Manuals
  - Practice ground, U Penn
  - Supervision 5-10 cases

Parting Words

Open opportunity clinically & research

Let’s continue this conversation

tinyurl.com/cbtiresources

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CE Credit?

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