

Case Presentation: Cognitive-Behavioral Therapy for Insomnia



Deborah A. Gillman, PhD

The Comprehensive Lung Center at UPMC is the optimal setting for a behavioral sleep medicine practice. Patients referred for CBT-I, or Cognitive-Behavioral Therapy for Insomnia, have already been evaluated and treated for conditions such as sleep-disordered breathing. With the medical screening complete, I am free to address what patients know or think about their sleep—cognitive factors—as well as what they do with respect to their sleep—behavioral factors.

CBT-I refers to an assortment of therapeutic techniques that offer an alternative to pharmacotherapy for insomnia and that have demonstrated lasting efficacy. Cognitive interventions include psycho-education about how the body regulates sleep and how insomnia can develop, challenging perceptions about sleep needs or the consequences of a poor night's sleep, and targeting sleep-related anxiety. Behavioral interventions include sleep restriction, or limiting a patient's time in bed to closely match their total sleep time, in order to increase sleep efficiency over time. We also recommend stimulus control, removing non-sleep activities such as computer use or TV from bed, so that the bed becomes conditioned as a stimulus only for sleep. Other behavioral strategies include relaxation, planning nighttime activities that support sleepiness, adjusting bedtime, and sleep hygiene. Here are two very different patients who both derived benefit from CBT-I:

Case 1: J is a healthy 34-year-old man, and a business executive in a highly competitive job requiring extensive travel. His chief complaints were sleep-maintenance insomnia of six-months duration and nocturnal ruminations about work performance. To compensate for poor sleep during the week, he would sleep past noon on weekends. His sleep had not improved with other efforts to manage stress (exercise, listening to music, and meditation). He worked on his computer until minutes before bedtime. Insufficient sleep had impacted his mood, patience, energy, and creativity.

Cognitive interventions for J included education about how the body regulates sleep and the value of a consistent wake-up time, even on weekends. We explored his competitive mindset and challenged sleep-interfering cognitions, also using imagery. Behaviorally, we developed a plan for winding down away from

screens. J would instead create a “to-do” or “worry” list each evening and set it aside. He was advised never to lie in bed awake, akin to opening a door and inviting one's worries into the room. As an alternative, J prepared leisure readings for when he could not sleep. He benefitted as well from eliminating evening drinking at work functions.

Case 2: R, in contrast, is a 58-year-old woman with obstructive sleep apnea and multiple chronic pain issues. Her chief complaint was worsening sleep-maintenance insomnia since leaving work on disability, but she had a history of poor sleep dating back 30 years. She reported a recent history of depression. She had tried multiple medications for sleep. She recently discontinued lorazepam at night and had started a low dose of doxepin. Her bedtime was determined by pain and the need to lie down, with the result that R was spending extended evening time in bed reading and watching TV. She was spending nearly 11 hours in bed but sleeping just five to nine hours per night. She was compliant with CPAP.

Behaviorally, we discussed ways to rest and treat pain at night while removing non-sleep activities from bed as much as possible. R planned activities for extended nighttime awakenings. Cognitively, we worked to reframe sleep as challenging, given her comorbidities, but to exchange frustration with sleep for a mindset of acceptance. No good can come from being on a vigil for sleep. I validated that loss of work identity and routine can impact sleep. Finally, we strategized about potential obstacles to R's change goals. She opted to remain on doxepin, but reported greatly reduced time in bed and reduced tension about sleep, even on the occasional “bad night.”

The Society for Behavioral Sleep Medicine is one resource for finding a CBT-I therapist. For more information, visit www.behavioralsleep.org.