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Brief Behavioural Interventions for Insomnia
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Goals

- To promote a practical understanding of insomnia.
- To demonstrate how to incorporate brief behavioural interventions for insomnia into our everyday practice.

What is insomnia?

- Difficulty in initiating or maintaining sleep, or having sleep of subjectively poor quality which leads to daytime symptoms.
- Short sleep in the absence of daytime symptoms is not insomnia.
- Not getting enough sleep due to reduced sleep opportunity is not insomnia.

“How tablets and phones before bed could lead to a stroke: Insomnia sufferers have higher risk than those who sleep soundly – 18 to 34 year olds most effected” April 2014

“How insomnia can triple your risk of heart failure” March 2013

“Insomnia can double the risk of prostate cancer in men” May 2013

“Why insomnia can trigger arthritis” November 2012
Making the diagnosis

- Comprehensive sleep history.
- Use of rating scales i.e. Insomnia Severity Index and the Epworth Sleepiness Scale.
- Consideration of investigations e.g. blood investigations, actigraphy or PSG.

Duration of symptoms

<table>
<thead>
<tr>
<th>Diagnostic Manual</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD - 10 (F51.0 – Non Organic Insomnia)</td>
<td>1 month</td>
</tr>
<tr>
<td>DSM V</td>
<td>1 month</td>
</tr>
<tr>
<td>ICSD3</td>
<td>3 months (Chronic Insomnia)</td>
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The numbers

- UK – prevalence of 1 in 10 adults.
- Prevalence estimates vary between 10-48%.
- 2010 cost of sleep disorders in the UK was 5,630 million €.
- Insomnia costs the US $63 billion/year.

References 1-3
How does insomnia develop?

- **The 3P Model of Insomnia** adapted from reference 4

  - Predisposing
  - Precipitating
  - Perpetuating

- Insomnia Severity
- Insomnia Threshold
- No Insomnia
- Acute Insomnia
- Chronic Insomnia

Mental illness and insomnia

- Moving away from “primary” & “secondary” insomnia.
- The vast majority of insomnia exists in a co-morbid state.
- Insomnia is a powerful risk factor for psychiatric illness.
- Patients with insomnia have worse clinical outcomes than those without.
- Independent treatment of insomnia can also improve the co-morbid psychiatric condition.

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**References 5-11**
How do we treat this?

Historically

Cognitive Behavioural Therapy for Insomnia

- Effective in about 80% patients.
- This includes insomnia comorbid with physical and psychiatric illnesses.
- Cheap – groups of 5-6 over 5 sessions with 1 therapist.
- Reduces the amount of hypnotics needed leading to savings later on.
- Reduces the burden of insomnia on society.
Evidence for brief behavioural interventions?

Components of CBT-I

Psycho-education
Stimulus Control
Sleep Scheduling
Sleep Hygiene
Relaxation
Cognitive Therapy

Stimulus Control

- TV/Radio
- Computer
- TV
- Reading
- Eating
- Drinking
- Arguing
- Getting dressed

Stimulus Control Video

Goodnight Britain, clips from episodes 2&7, BBC 2013.
Sleep Scheduling – an example

- Mr B goes to bed at 10pm sharp every night. He lies awake until 12am before falling asleep. He then drifts in and out of un-refreshing sleep for the rest of the night, before reluctantly dragging himself out of bed at 7am to go to work. In total he thinks he gets about 6 hours of sleep.
- In an attempt to get more sleep he starts going to bed at 9pm.

Now he lies awake for 3 hours instead of 2!!!!

Sleep Scheduling

- This strengthens the association between the bed and wakefulness.
- It confirms his inability to sleep.
- Or worse he may have little micro-sleeps which reduce his chance of getting good, consolidated sleep.

So,
- If Mr B only sleeps 6 hours he should not be in bed for more than 6 hours.

We therefore advise him to:

- Get up at the same time seven days a week. This anchors his circadian rhythm and allows him to accumulate adequate fatigue through the day.
- He should not go to bed earlier than 6 hours before his rising time. Only once he has reached this “threshold time” AND he is sleepy should he go to bed.
- Once he is falling asleep quickly and his sleep fills up at least 90% of his time in bed, he can then move his threshold time backwards or his waking time later by 15 minutes.
Sleep Hygiene

- NOT effective as a mono-therapy.
- Many tenants are not tested.
- Best tailored to the individual.

Do not chase sleep

“Sleep (is like) a dove which has landed near one’s hand and stays there as long as one does not pay any attention to it; if one attempts to grab it, it quickly flies away”

Viktor E. Frankl, 1965

Discourage napping

- If fatigue is the fuel that drives sleep, then every nap is like stealing some of that sleep fuel from the night.
- It is better to push through the sleepy periods during the day and save that fatigue for the night.
- Once their sleep improves it will be easier to avoid napping.

A final few words of advice for your patients with insomnia

- Wake up at the same time EVERY day.
- Yes, even on weekends. Yes, even if you’ve slept badly.
- Sticking to a constant bed time can be a very bad idea. Go to bed when, and only when, you feel sleepy tired.
- If you are not asleep in 15-20 minutes get out of bed and out of the bedroom.
- Use the extra time out of bed to do something relaxing and enjoyable.
Teach the mantra

“I am not doing this to sleep better tonight. I may actually sleep worse tonight. I am doing this to sleep better in a month.”

References


References II


