Better Sleep, Better Outcomes: A Practical Guide to CBT-I for Psychiatrists

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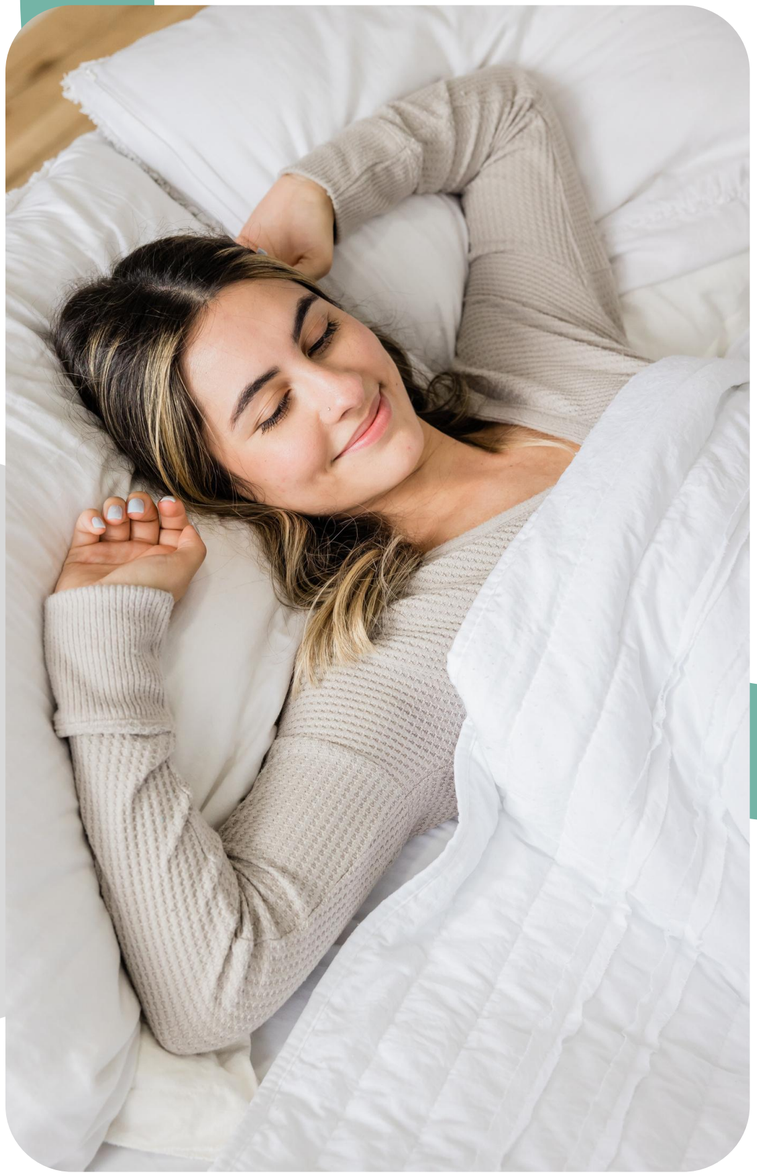


Learning Objectives

01 Identify key evidence-based components of CBT-I and their role in improving sleep and psychiatric symptoms

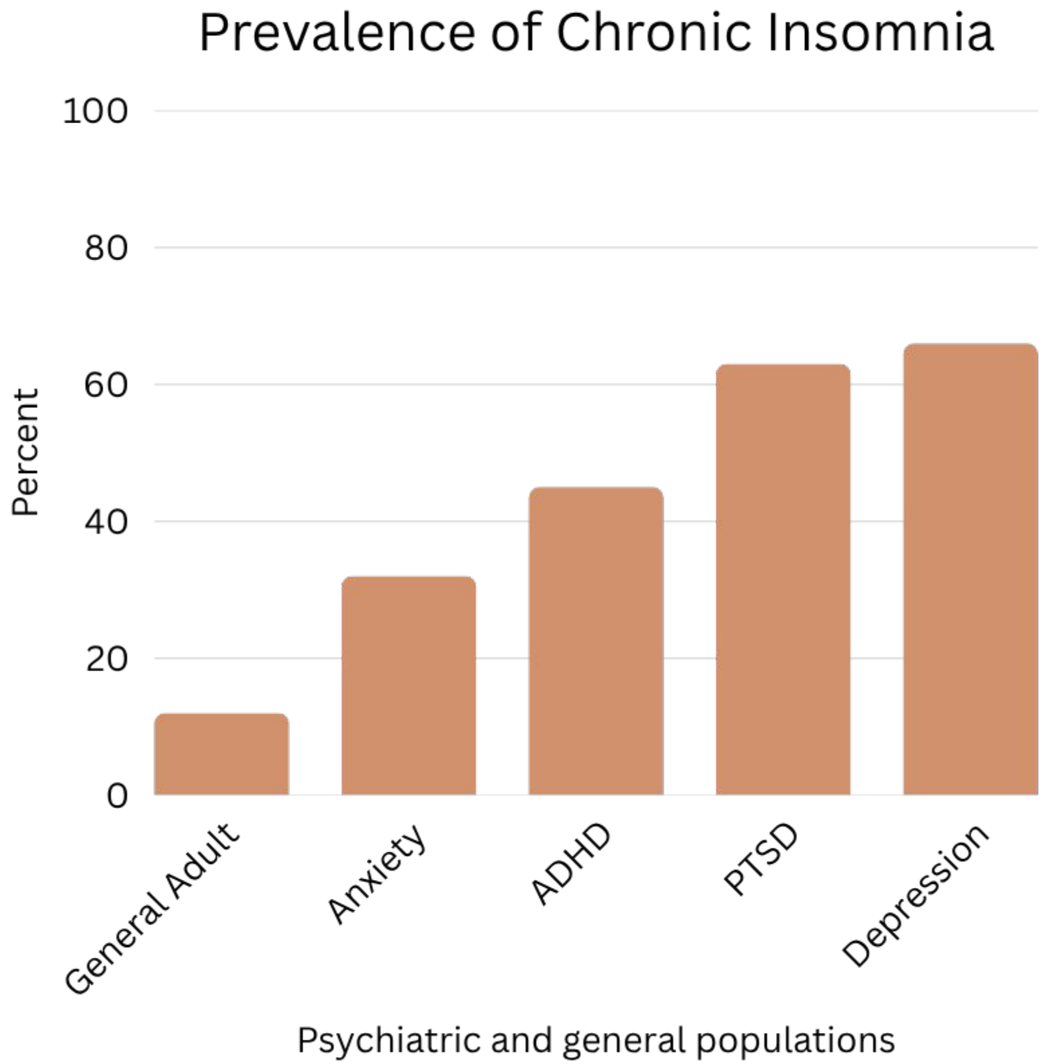
02 Determine which patients are appropriate candidates and when CBT-I may need modification or is contraindicated.

03 Describe strategies to build motivation for behavioral treatment in patients accustomed to medication treatment only.

04 Refer patients to qualified CBT-I providers and resources, including telehealth & self-help options.

Why CBT-I Matters

- At any given time, 10–15% of adults have chronic insomnia; 30–50% in psychiatric populations.
- Insomnia often persists even when primary disorders remit.
- Hypnotics provide short-term relief but lose efficacy and have side effects.
- CBT-I is first-line per ACP (Qaseem et al., 2016) with durable benefit at 6–24 months.



Note: *Prevalence estimates are based on DSM-defined insomnia or comparable criteria from large-scale peer-reviewed studies. Rates vary by population and assessment method. References available upon request*

How Sleep Impacts Mental Health

Depression

Insomnia doubles risk;
CBT-I + therapy = 60% better response

(Manber 2008; Blom 2015)

PTSD

70–90% experience insomnia; CBT-I can reduce PTSD severity ≈ 50%

(Germain 2013)

Anxiety

Poor sleep heightens anxiety sensitivity
CBT-I reduces GAD

(Belleville 2011)

ADHD

Improved sleep boosts executive function & may reduce need for higher stimulant doses

(Kirov 2014)

Common Objections

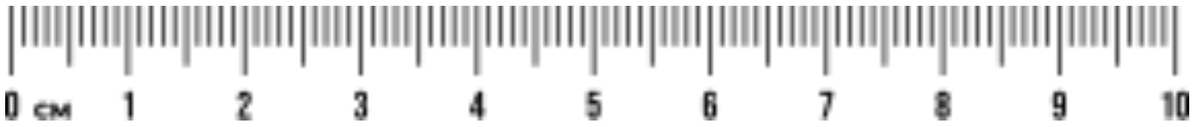
- “I’ve tried everything; nothing works.”
- “I’m afraid you’ll take away my medication.”
- “I’d sleep if I wasn’t so stressed or anxious.”
- “I don’t have time for therapy.”
- “Getting out of bed & sleep restriction feels distressing.”

Building Motivation

Brief MI

- **Emphasize empathy first:**
  - “You’ve been trying to fix this for years”
- **Normalize ambivalence:**
  - “Most patients come in skeptical — that’s okay.”
- **Explore Pros/Cons**
- **Link sleep to valued goals**
  - E.g., parenting, performance, health

Readiness Ruler



1. **How important** is your sleep to you right now? (1-10)
2. **How confident** are you that you can practice these strategies? (1-10)
3. **How ready** are you to start now? (1-10)

Follow up:

Why isn’t it a lower number?

Why isn’t it a higher number?

What would it take to move to a higher number?

Who is an Ideal Candidate for CBT-I

- ✅ Chronic insomnia (> 3 months, ≥ 3 nights/week)
- ✅ Motivated for behavioral change
- ✅ Medically and psychiatrically stable
- ✅ Open to structured, short-term treatment
- ✅ Capable of tolerating temporary fatigue
- ✅ Willing to track sleep with a diary or app

**You do not need to exclude by age — CBT-I has strong evidence across the lifespan.*

***Refer to sleep medicine for suspected OSA, RLS, parasomnias or abnormal sleep–wake cycle unresponsive to behavioral change*

Comorbidities & CBT-I: When to Treat, Modify, or Defer		
Treat in Parallel	**Modify CBT-I**	**Defer Until Stable**
Depression (mild–moderate)	Bipolar disorder	Untreated obstructive sleep apnea
Anxiety disorders (GAD, panic, social)	PTSD / trauma	Active mania or hypomania
OCD (mild–moderate)	Schizophrenia (stable)	Acute psychosis or severe disorganization
Chronic pain, arthritis, headache	ADHD	Acute suicidality or severe depression
Asthma, allergies, congestion	Pregnancy	Acute trauma crisis / grief
Diabetes, thyroid dysfunction, nocturia:	Chronic pain / fatigue syndromes	Uncontrolled medical instability or pain flare
Menopause or PMS	Severe chronic medical illness	

Adapted from Jacobs (2009); Wu et al. (2017).

Recommended Assessment Before CBT-I

CATEGORY	MEASURES
Recommended for All Adults	- Sleep Diary (2+ weeks) - Insomnia Severity Index (ISI) - Epworth Sleepiness Scale (ESS) - Pittsburgh Sleep Quality Index (PSQI)
Child/Adolescent Measures	- Children's Sleep Habits Questionnaire (CSHQ) - BEARS Sleep Screening Tool (Bedtime, Excessive daytime sleepiness, Awakenings, Regularity, Snoring)
Supplementary	- STOP-BANG (if OSA suspected) - PHQ-9 / GAD-7 (to assess comorbid depression/anxiety) - Actigraphy (if circadian rhythm or sleep–wake schedule uncertain)
Not Recommended for Standard AX	- Polysomnography (PSG) unless sleep-disordered breathing, parasomnia suspected -Multiple sleep latency tests (if narcolepsy is suspected)

Assessment recommendations adapted from Williams et al. (2013), Chest.

Meet Maya

- 42 yo Indian American woman, referred 1 year ago for PPD and anxiety
- Treated with sertraline 100 mg, now euthymic for 6+ months
- Persistent insomnia for 8 mo (awakenings, 3–4 a.m.)
- Reports: “My body jolts me awake before I’ve had enough sleep.”
- Tried Ambien (3 wks, ineffective/brain fog) and hydroxyzine (no longer effective)
- Preoccupied with sleep; nightly searches for medical explanations
- Values being highly capable and finds it distressing that she cannot “push through”
- Prefers scientific, practical approaches; first time considering therapy

Maya’s Baseline Assessment

Measure	Baseline Score	Interpretation
Insomnia Severity Index (ISI)	18	*Moderate*
Epworth Sleepiness Scale (ESS)	5	*Normal daytime sleepiness*
PHQ-9	7	*Mild depressive symptoms*
GAD-7	10	*Moderate anxiety*
STOP-BANG	2	*Low risk for OSA*
Sleep Diary (2 weeks)	Avg. TIB: 9 hrs Avg. TST: 6 hrs SE: 67% Early awakenings ~3–4 a.m.	*Pattern consistent with conditioned early awakenings and sleep effort*

Maya's 3P's

Predisposing

- High-achieving, perfectionistic temperament

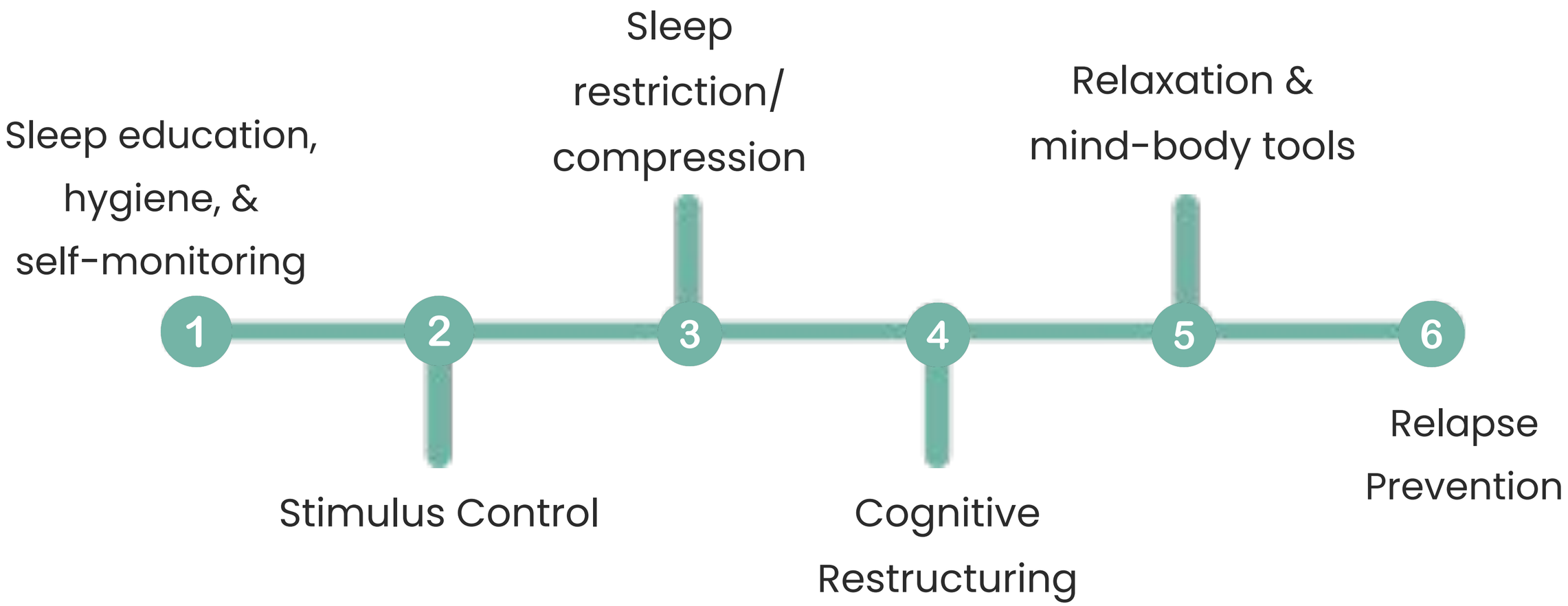
Precipitating

- Postpartum depression & anxiety
- Frequent night wakings for infant
- Hormonal shift
- Adjustment to new baby

Perpetuating

- Going to bed early "to catch up"
- Scrolls on phone in bed
- Early-morning wakefulness is reinforced by productivity
- Ruminating about sleep and health

Core CBT-I Components:

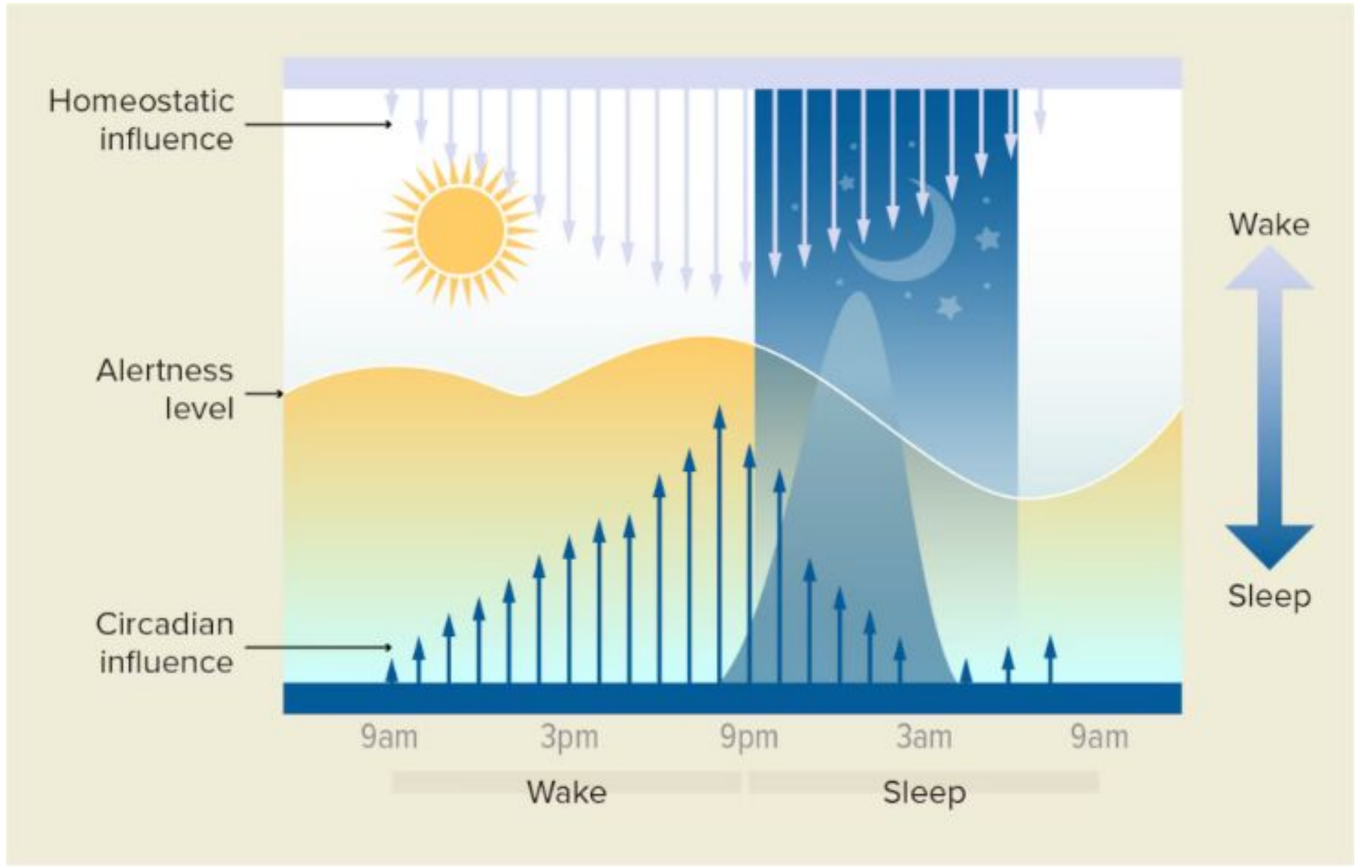


1: Sleep Education

- **Teach sleep physiology**
  - 3 P Model, sleep pressure, circadian rhythm
- **Review 2-week sleep diary** → track efficiency (SE = TST / TIB).
- **Clarify myths** ("8 hours" rule, catastrophizing health impact, trying harder to sleep).
- **Target maladaptive compensations & review sleep hygiene**
  - No going to bed early, napping, or stimulating activities close to bedtime
  - Create a winding down window at least 30-60 min before bed:
    - stop work, chores, planning, or screen-based tasks — and shift into relaxing, low-arousal activities
- **Emphasize exercise timing** (3–6 h before bed improves sleep)

Q: What targeted behavioral strategies would you feel comfortable introducing in a brief visit?

1: Sleep Education



SOURCE: ADAPTED FROM V. RIETHMEISTER / *SLEEP AND FATIGUE OFFSHORE* 2019 KNOWABLE MAGAZINE

Understanding Sleep Regulation

1. **Homeostatic Sleep Drive** – The longer we're awake, the stronger our sleep drive.

2. **Circadian Rhythm** – Internal clock regulating wakefulness & sleep.

The Forbidden Zone: A period of increased alertness before natural sleep onset.

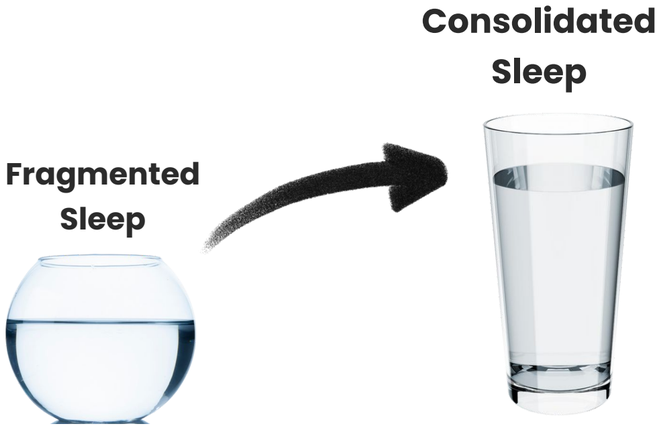
Insomnia sufferers underestimate how much they sleep. Their brain doesn't register fragmented sleep.

Key takeaway: Sleep is a biological process we can adjust through interventions.

2: Stimulus Control

- **Based in learning theory;** Retrains the brain to associate the bed with sleepiness
- **Get out of bed:**
  - If awake > 20 min
  - If you're worrying and can't shut your mind off
  - At the same time every day, even after a bad night
- Engage in low stimulation activities outside of the bed (e.g., reading or listening to music) if awake during the night
- **Bed = Sleep & Sex only**
- Review sleep logs, check they are keeping a consistent wake time

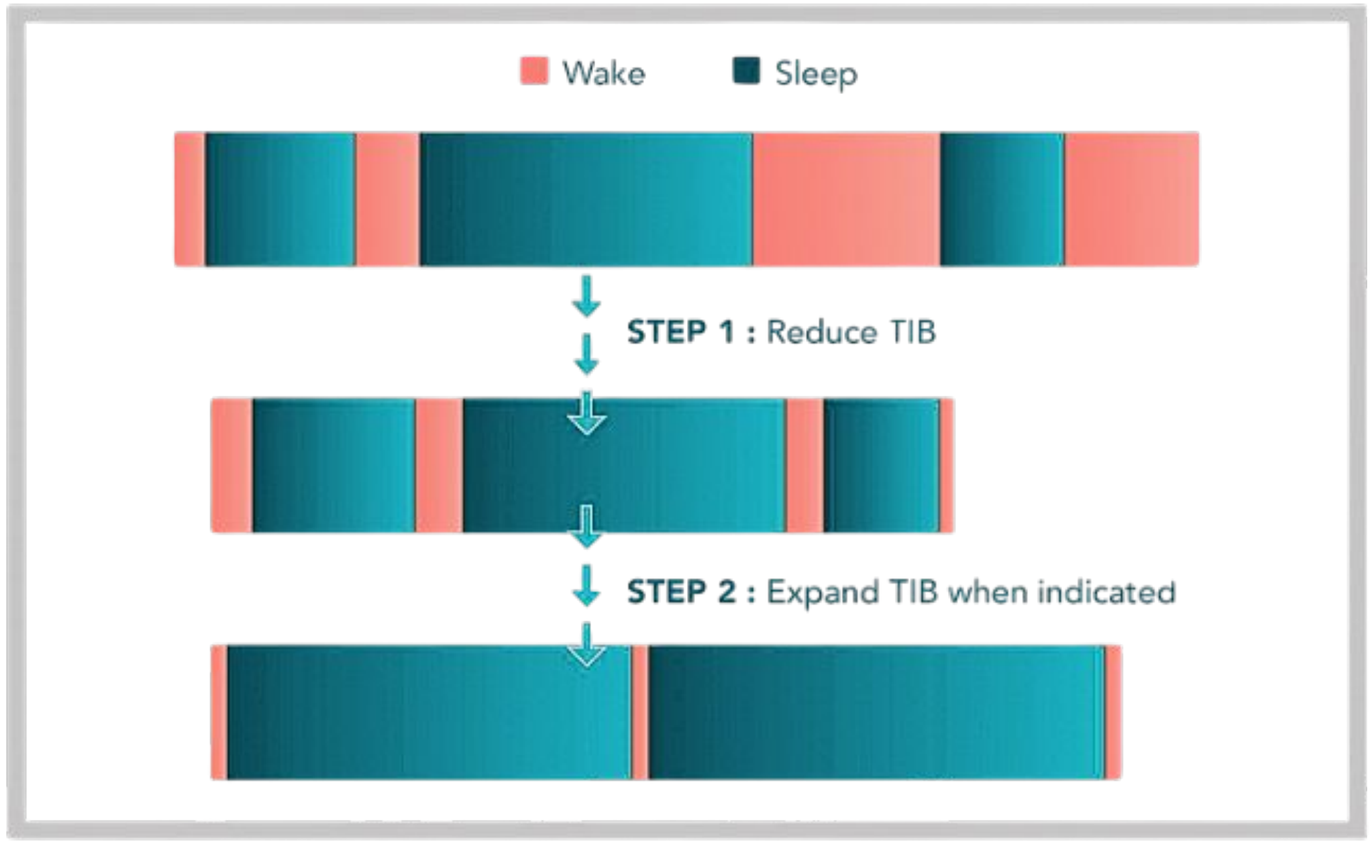
3: Sleep restriction/ compression



- **Sleep Restriction**
  - Match TIB to Avg TST.(e.g., TIB = 9 hr, Avg TST = 6 hrs → restrict to 6 hr)
  - Never less than 5 hr total
- **Sleep Compression**
  - Gradually shorten TIB by 15–30 min every 3 days (or 5 min/day)
  - Use for those at risk of destabilization (e.g., pain, fatigue, bipolar, pregnancy, older adults) but not less than 6 hrs total
  - Consider developmental needs for children, avoid excessive daytime sleepiness
- 🚫 **Do Not Use** for untreated OSA, parasomnias, RLS, or unstable medical or psychiatric conditions

Q: How might you introduce sleep restriction to help consolidate Maya's sleep?

3: Sleep restriction/ compression



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Adjusting the sleep window:

If SE ≥ 85% for a week, increase TIB by 15–20 min.

If SE < 80%, decrease TIB by 15–20 min.

If SE 80–85%, hold steady.

4: Cognitive Restructuring/ Changing Sleep-Related Beliefs

- Identify & challenge unhelpful sleep beliefs.
- Focus on probability (not possibility) of feared outcomes.
- Use behavioral experiments (e.g., track next-day function).
- Combine with mindfulness or cognitive defusion for rumination.
  - Look at thoughts, not from thoughts:
    - “The part of me that wants to perform well is saying…”
  - Notice thoughts instead of getting caught in them:
    - “Leaves on a stream” meditation.
  - Visualize letting thoughts go:
    - Imagine your unhelpful thought as a pop-up ad—just close it.

4: Cognitive Restructuring- Changing Sleep-Related Beliefs

Theme	Socratic Questions
Evidence	“What’s the evidence that ___ will happen?”
Past Experience	“Has this happened before? How did you handle it?”
Probability	“What’s the chance it’ll be as bad as your mind predicts?”
Alternative View	“What else could be true?”
Coping Plan	“If the worst happened, how would you cope?”
Perspective	“If your best friend said this, what would you tell them?”

5: Relaxation Training

- Relaxation ≠ sleep technique — it reduces arousal.
- Practice during the day to avoid performance anxiety at night.
- Options: paced breathing, progressive muscle relaxation (PMR), grounding, guided visualization, somatic release.
- Assign 10–15 min of daily practice

Recommended Self-Guided Resources:

- Insight Timer (breathing, PMR, visualization)
- VA Mindfulness Coach App (ACT-based grounding)
- Calm or Headspace (structured programs for stress & sleep)

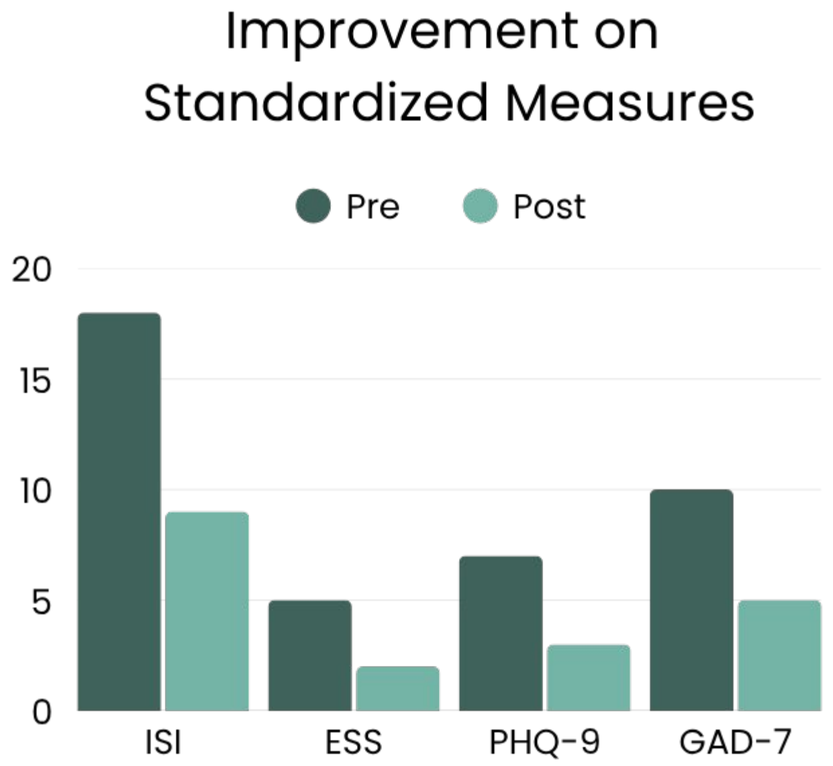
Q: How could relaxation training be introduced in a way that builds buy-in?

6: Relapse Prevention

- Occasional poor sleep is normal, not a sign of relapse
- Test flexibility (e.g., reading in bed again, co-sleeping)
- Recognize early warning signs: drifting bed/wake times, naps, “trying harder,” 3+ difficult nights in a week
- **Reminder:**
  - *“Insomnia can return, but you have the tools to address it. Occasional bad nights are normal, but go back to the CBT-I strategies that worked well for you when you have more than 3 bad nights in a row.”*

Maya’s Progress After 6 Sessions

- Sleep efficiency improved from 70% → 87%
- Early-morning awakenings reduced to 1–2 nights/week
- Total sleep time increased by ~30 minutes
- Reports lower anxiety about sleep
- Maintains consistent wake time, uses brief relaxation & stretching instead of phone use
- Added a 20-minute brisk walk after school pickup
- Going to bed later now allows for more “me-time” and “adult time” in the evenings



Delivery & State of the Evidence

Format	Effect Size / Durability	Typical Provider
Individual CBT-I	Large (d ≈ 0.9), ≥ 6-mo follow-up	Licensed MH clinicians or BSM-trained providers
Group CBT-I	Moderate–large, cost-effective & scalable	Licensed MH clinicians or BSM-trained providers
Telehealth CBT-I	Equivalent to in-person, high adherence (Huber 2021)	Licensed MH clinicians or BSM-trained providers
Brief / 1-session	Small–moderate; step-care entry	Nurses, peers, PCPs

Referrals & Resources

- **Directories**:
  - Behavioral Sleep Medicine (DBSM.org)
  - CBTI.directory
- **Low-cost / self-guided:**
  - Say Goodnight to Insomnia (Jacobs, 2009)
  - CBT-I Coach app
  - www.cbtforinsomnia.com
- **Telehealth:** evidence shows equivalence to in-person (Huber 2021).
- ***Note: start with least intensive and effectice option*** *(step-care) for healthy adults with stable mood and adequate daytime functioning*