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Treating Insomnia

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DESCRIPTION OF INSOMNIA

Insomnia influences an individual's psychological, occupational, and physical health, as well as his or her economic status, and can result in decreased overall functionality and production (American Psychiatric Association [APA], 2013). Nearly 29 % of the population in 2013 were impacted by frequent episodes of insomnia (Karlson, Gallagher, Olson, & Hamilton, 2013) suggesting that many people struggle with insomnia on a daily basis. There is the potential for the condition to develop at any age, including childhood, adolescence, menopause, and later in life (APA, 2013). The risk of developing insomnia; however, increases with age, with 65 % of individuals over 65 years of age reporting difficulty with insomnia. Women are also more likely to have trouble with insomnia reporting rates twice as high as men (Insomnia, 2014). There have also been some cultural patterns identified with insomnia. African American males tend to report lower than average rates of insomnia (12%) compared to African American women (19%), and European American men and women (14%) in the elderly population (Bryson & Edwards, 2013).

Insomnia Disorder is classified as a Sleep-Wake disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Insomnia Disorder is a specific type of sleep disturbance that involves insomnia, as evident in its name, characterized by difficulty initiating, maintaining or returning to sleep (APA, 2013). Transient insomnia, mild and irregular bouts of insomnia, often, but not always, precedes chronic, regular and frequent bouts of insomnia. Insomnia can occur as a single episode (e.g., transient insomnia) or multiple episodes lasting weeks to years (e.g., chronic insomnia) and there may be extreme variability between sleeping patterns (APA, 2013), making it frustrating and difficult for people with insomnia to cope.

IDENTIFICATION/ASSESSMENT STRATEGIES

Insomnia Disorder can be precipitated by various biological, sociological, and environmental factors that may be considered when assessing symptoms and rendering a diagnosis. It sometimes occurs as a response to a situational trigger, such as a stressful life event, and can last anywhere from a few days to weeks. In these cases, the insomnia typically resolves soon after the stressor subsides. In persistent cases of insomnia, the condition is likely to remain for longer (APA, 2013). In such cases, assessment strategies are helpful in differentiating insomnia from another sleep-wake disorder or a medical condition.

Professional Counselors are able to diagnose most sleep-wake disorders, including Insomnia Disorder, through the use of diagnostic, clinical interviews. Formal assessment tools may be used in addition to clinical interviews to increase diagnostic accuracy, identify symptoms and evaluate the severity of the disorder. As with the use of all assessment tools, professional counselors are responsible for assuring that they are competent to use the instruments and they need to make a referral to a medical physician when warranted.

Polysomnography (Sleep Study)

In occasions where symptoms are extreme or clinical presentation is atypical, professional counselors may choose to make a referral to a sleep disorder center or to a sleep disorder specialist (e.g., a physician certified in sleep medicine) for laboratory examinations, which include all-night polysomnography (e.g., records of EEG activity). The medical testing may increase the accuracy of the diagnosis and treatment approach of many sleep-wake disorders within a controlled, safe environment.

Resource:

Paylo, M. J., Kress, V. E., & Kelly Gilea, B. L. (2014). Sleep-wake disorders, sexual dysfunctions, paraphilic disorders, and gender dysphoria. In V. Kress & M. Paylo (Eds.), *Treating mental disorders: A strength-based, comprehensive approach to case conceptualization and treatment* (pp. 498-521). Columbus, Ohio: Pearson.

SleepMed Insomnia Index (SII)

The SleepMed Insomnia Index is a self-report questionnaire used to screen for a possible sleep disorder by asking an individual to evaluate feelings about his or her sleep using a 0-4 Likert-scale (0= “no problems with sleep,” 4 = “a big problem with how you feel about the quality of your sleep”). Results range from normal sleep to insomnia. Individuals who score above normal are encouraged to complete a formal sleep study.

Resource:

SleepMed Insomnia Index: sleepclinician.com

Bogan, R. K., & Turner, J. A. (2007). New assessment tools that measure sleep vital signs: *The SleepMed Insomnia Index and the Sleep Matrix. Neuropsychiatric Disease and Treatment*, 3(4), 501-510.

Insomnia Severity Index (ISI)

The Insomnia Sleep Index is a self-report questionnaire to assess the severity of sleep disturbance by asking an individual to rate symptoms on a scale of zero (none) to five (very severe). The ratings are added to get a total score of one’s sleep dissatisfaction. Results range from “none” to “very dissatisfied.” This tool has been evaluated as a valid screening tool for identifying insomnia.

Resource:

Insomnia Severity Index: <https://biolincc.nhlbi.nih.gov/static/studies/masm/Insomnia%20Severity%20Index.pdf>

Gagnon, C., Belanger, L., Ivers, H., & Morin, C. M. (2013). Validation of the Insomnia Severity Index in primary care. *Journal of the American Board of Family Medicine*, 26(6), 701-710.

Epworth Sleepiness Scale (ESS)

The Epworth Sleepiness Scale (ESS) is a questionnaire used to measure daytime sleepiness. This self-report instrument requires individuals to rate a series of questions on a scale ranging from zero (“would never doze”) to four (“high chance of dozing”). Dr. Murray Johns developed the instrument in 1991 and later revised in 1997. He offers a liability disclaimer directing users that he does not validate the tool as appropriate for any particular purpose, although the directions suggest that the tool measures daytime sleepiness.

Resource:

Epworth Sleepiness Scale: <http://epworthsleepinessscale.com/>

Epworth Sleep Center: <http://www.epworthsleepcentre.com.au/>

Sleep Diary

A sleep diary is a log of an individual’s sleep. Diagnostic preciseness may be correlated with detailed tracking of sleep patterns and difficulties, including: wake time, bedtime, nightmares, times when difficult to fall asleep or remain sleeping, how awake or tired one feels at different intervals during the day, etc. Specific attention should be given to self-reported issues with sleep. Data can be tracked for weeks or months, depending on symptom severity.

Resource: National Sleep Foundation: <http://sleepfoundation.org>

Sleep History

Those with insomnia may have a low quality of sleep, awake frequently during the night, wake in the early morning hours and are unable to fall asleep again (Garrison & Libby, 2010). A detailed exploration of an individual’s sleep history can provide a more accurate identification of insomnia.

Examples of diagnostic questions may include:

- How long have you been experiencing trouble with sleeping?
- How often do you have trouble falling to sleep? How long does it take you to fall asleep?
- How often do you wake through the night?
- How long do you go without sleep?
- How long have you been experiencing this problem?
- On a scale of 1-10, how much do your sleep issues impact your ability to work? Interact with family? Engage in interests?
- Do you have trouble sleeping on weekends or days off of work?
- Do you sleep at the same time every day (e.g., do you have a job that requires you to work both day and evening shifts)?
- When you wake from your sleep, how long does it take to fall back to sleep?
- How many hours do you sleep a night?

Resource:

American Sleep Association: <http://www.sleepassociation.org/>

INTERVENTION STRATEGIES

When treating Insomnia Disorder, professional counselors should first consider variation in sleep patterns and requirements as they change throughout the life span. Knowledge of an individual's sleep baseline will be necessary to outline realistic objectives and rule out other mental and emotional disorders. Confounding factors also warrant consideration (e.g., stress, frustration) and may become a focus of clinical attention (Suh et al., 2012). The most common treatment approaches include: (1) cognitive behavioural therapy; (2) behaviour therapy; (3) medications; (4) oral applications (e.g., a mouth guard); and (5) ventilators (Moul, Morin, Buysse, Reynolds, & Kupfer, 2007; Riemann & Perlis, 2009).

Because of the nature of their practice, professional counselors are most likely to employ the use of cognitive behavioural therapy and behaviour therapy interventions to treat insomnia. A combined approach that uses medications, cognitive behavioural therapy, and behaviour therapy interventions in the treatment of insomnia has proven to be effective (Gellis, Arigo, & Elliott, 2013; Jernelov et al., 2012). Depending on the method of treatment, those with insomnia may begin to notice an improvement after 1-2 months following incorporation of psychoeducation, lifestyle changes, good sleep hygiene, and Cognitive Behavioural Therapy (CBT) or other treatment modalities (Insomnia, 2014).

Professional counselors may select varying techniques among the cognitive behavioural therapy approaches; however, most involve the use of progressive muscle relaxation, sleep hygiene rules, sleep restrictions and thought-stopping (Paylo et al., 2014).

Progressive Muscle Relaxation

Insomnia disorder is often a symptom of another medical condition and is most often co-morbid with anxiety or stress and muscular tension (Sadock & Sadock, 2007). Progressive muscle relaxation techniques can be used to decrease the aforementioned and lead to a restful night's sleep. The technique involves deliberately tensing a specific muscle group to heighten awareness of the tension followed by relaxation of the muscle group and in turn calling attention to the relaxed state of mind and body. When engaging in progressive muscle relaxation, the individual moves from one muscle group to the next through the series of deliberately tensing and relaxing the muscles. The process should result in overall muscle relaxation.

Resource:

American Medical Student Association/Progressive Muscle Relaxation: <http://www.amsa.org/healingthehealer/musclerelaxation.cfm>

Sadock, B. J., & Sadock, V. A. (2007). *Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Sleep Hygiene Rules

Behavioural patterns can have both a positive and negative influence on sleep. For example, drinking coffee before bed may correlate with difficulty falling asleep whereas a drinking chamomile tea may correlate with a restful night's sleep. Healthy sleep hygiene is recommended for individuals diagnosed with insomnia or sleep difficulties (e.g., maintaining a regular sleep schedule, restricting use of bed and bedroom to sleep, creating a dark and quiet sleep environment that has a pleasant temperature, avoid napping, avoid caffeine and alcohol, do not go to bed hungry and engaging in a regular exercise routine).

Resource:

New York Eye and Ear Infirmary of Mount Sinai/The Sleep Center: <http://www.nyee.edu/sleep-center-hygiene.html>
Ohio Sleep Medicine Institute: <http://sleepmedicine.com/content.cfm?article=36>

Sleep Restriction Therapy (SRT)

Sleep restriction therapy (SRT) is a specific cognitive behavioural technique used to treat insomnia. There are various ways to implement SRT and the differences in methodology impacts the ability to accurately measure the effectiveness of the approach. Nonetheless professional counselors may use this technique to reduce the symptoms of Insomnia. Most methods involve prescribing a specific number of hours of sleep each night (usually less than eight hours but more than four hours) to ensure sleepiness at bedtime. As insomnia decreases, the amount of prescribed sleep time is increased (Miller et al., 2014). One example includes the use of a sleep diary to develop a baseline for sleep patterns and time frame. The individual is prescribed less time in bed than he or she originally spent with the intended goal of sleeping during that time. Naps and periods of rest during the day are not encouraged. As a pattern of sleeping during the prescribed time increases, the prescribed sleep time may be increased by 15 minutes. Professional counselors may consider the limits of their competence and choose to collaborate with a medical professional before using this approach.

Resource:

Miller, C. B., Espie, C. A., Epstein, D. R., Friedman, L., Morin, C. M., Pigeon, W. R., ... S. D. (2014). The evidence base of sleep restriction therapy for treating insomnia disorder. *Sleep Medicine Reviews*, 18(5), 415-425.
Sleepdex Resources for Better Sleep: <http://www.sleepdex.org/restriction.htm>

Thought Stopping

Insomnia can be caused by triggering thought processes such as irrational beliefs about sleep (e.g., "I won't be able to fall asleep tonight"; Suh et al., 2012). Cognitive techniques, such as thought stopping, may be used to decrease sleep-deterrent thoughts. Thought stopping techniques involve an individual attempting to control his or her thoughts. Various techniques may be used with the most common and simplistic intervention requiring an individual to shout or visualize the word 'stop' when unwanted thoughts or beliefs enter his or her thoughts. Other suggestions involve wearing a rubber band around one's wrist and flicking it or directing one's focus to another thought (Bakker, 2009).

Resource:

Bakker, G. M. (2009). In defence of thought stopping. *Clinical Psychologist*, 13(2), 59-68.
Suh, S., Ong, J., Steidtmann, D., Nowakowski, S., Dowdle, C., Willett, E.,...Manber, R. (2012). Cognitions and insomnia subgroups. *Cognitive Therapy and Research*, 36(2), 120-128.
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