

CBTI

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Insomnia: What it is and isn't

“Normal” sleep is being able to initiate sleep within 30 minutes, and resume sleep within 20 minutes upon awakening

Difficulty initiating sleep AND/OR

Difficulty maintaining sleep

Often precipitated by a stressful life event or medical issue

It is NOT: hypersomnia, circadian rhythm disorder, non-restorative sleep (despite ICD-10 criteria), nighttime insomnia due to daytime napping

What is Cognitive-Behavioral Treatment for Insomnia (CBT-I)?

Since 2016 has been considered the gold standard of care for treatment of insomnia.

Should be utilized as first line of treatment rather than medication

Can be done concurrently with other counseling

85% success rate

Less successful with: PTSD, chronic pain, unmotivated clients, hx of substance abuse, and people who say they've never slept well; also so far seems less successful with long-COVID patients

What is CBT-I

Three sessions, typically every two weeks; can be virtual or in-person

Review of sleep schedule, hygiene, habits

Sleep log/diary

Sleep education

Stimulus control therapy

Sleep restriction

Cognitive restructuring techniques

Cognitive visualization techniques for quieting the mind

Why we are not fans of sleep meds

Black box warnings for Zolpidem (Ambien) and Eszopiclone (Lunesta)

On average, they give 11-18 extra minutes of sleep

Often result in some daytime effects

Often reduce deep sleep (N3)

Clients often attribute all of their sleep success to the pill and all of their failures to themselves

CBT-I has vastly superior outcomes, particularly long-term

How to refer patients to the Sleep Center

Sleep Center: (320)251-0726

If you are concerned a patient may have a medical sleep disorder (ex., sleep apnea, parasomnias, narcolepsy), you should refer to SLEEP MEDICINE.

If you have a patient with insomnia, you may refer directly to Dr. Miller. The correct referral is AMB CONSULT—SLEEP PSYCHOLOGY

To claim CME credit (Must complete by 12-27-2024)



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 - iPhone: use camera to take you to the site
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