

Managing Sleep Issues in Primary Care

Cognitive Behavioral Therapy for Insomnia

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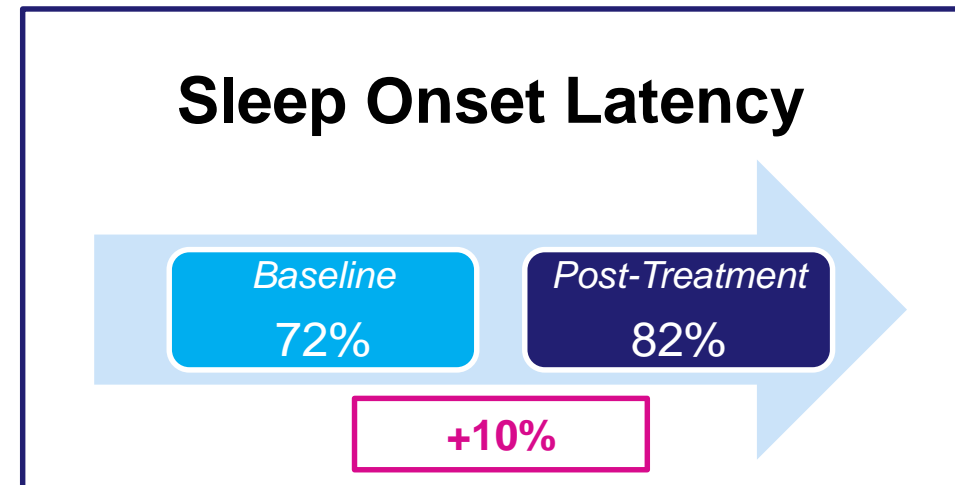
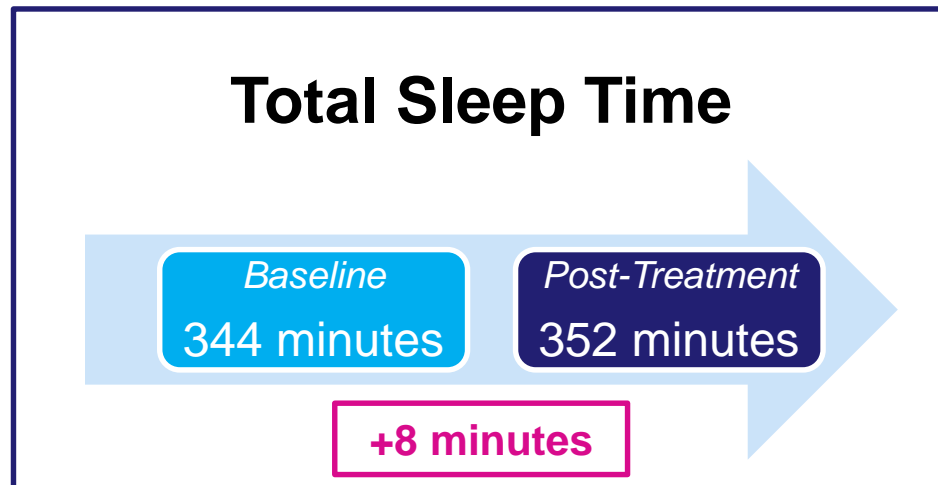
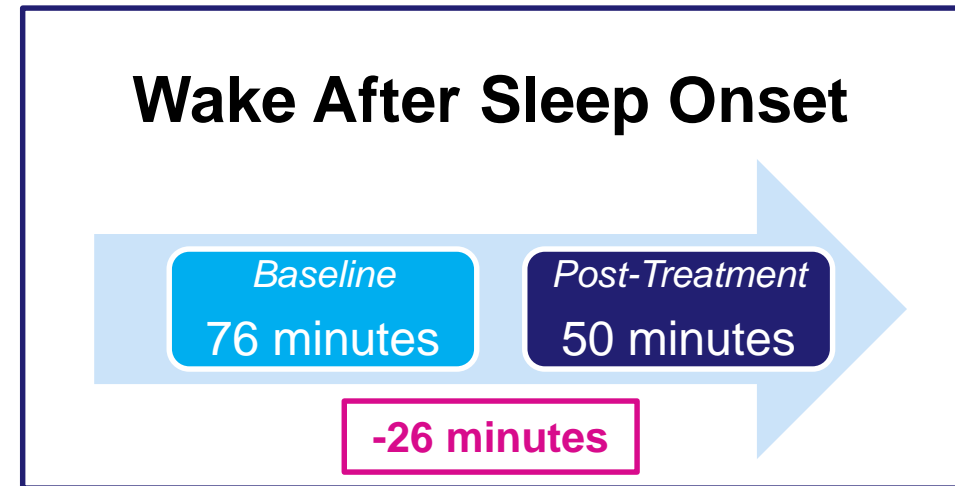
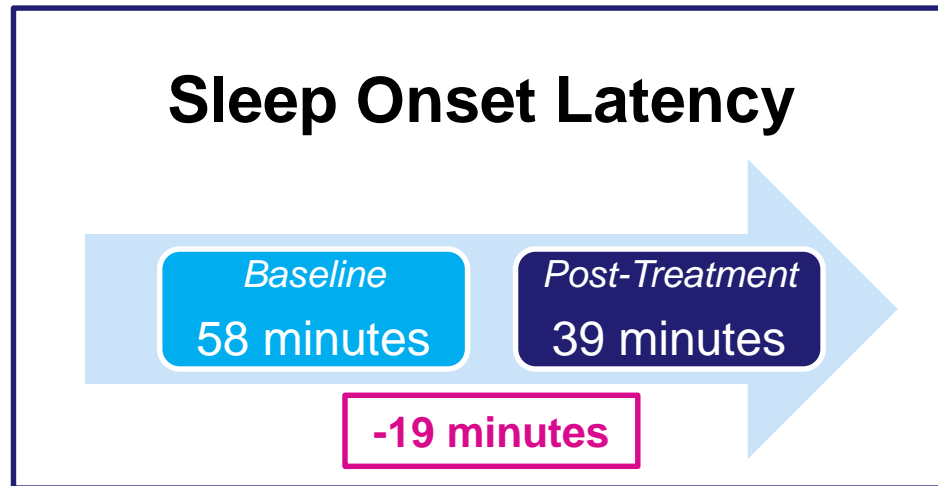
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Objectives

Recognize	the prevalence of insomnia and the impact that this has had on mental health
Increase	understanding of the problems associated with the overreliance on sleep medications for the management of chronic insomnia
Develop	an awareness of the basic principles of Cognitive Behavioral Therapy for Insomnia (CBT-I)
Consider	collaborative treatment alongside behavioral medicine psychologists

Does CBT-I work?

A meta-analysis of 20 RCTs showed the following changes following treatment



Why do we sleep?



Central question of why we sleep remains a mystery



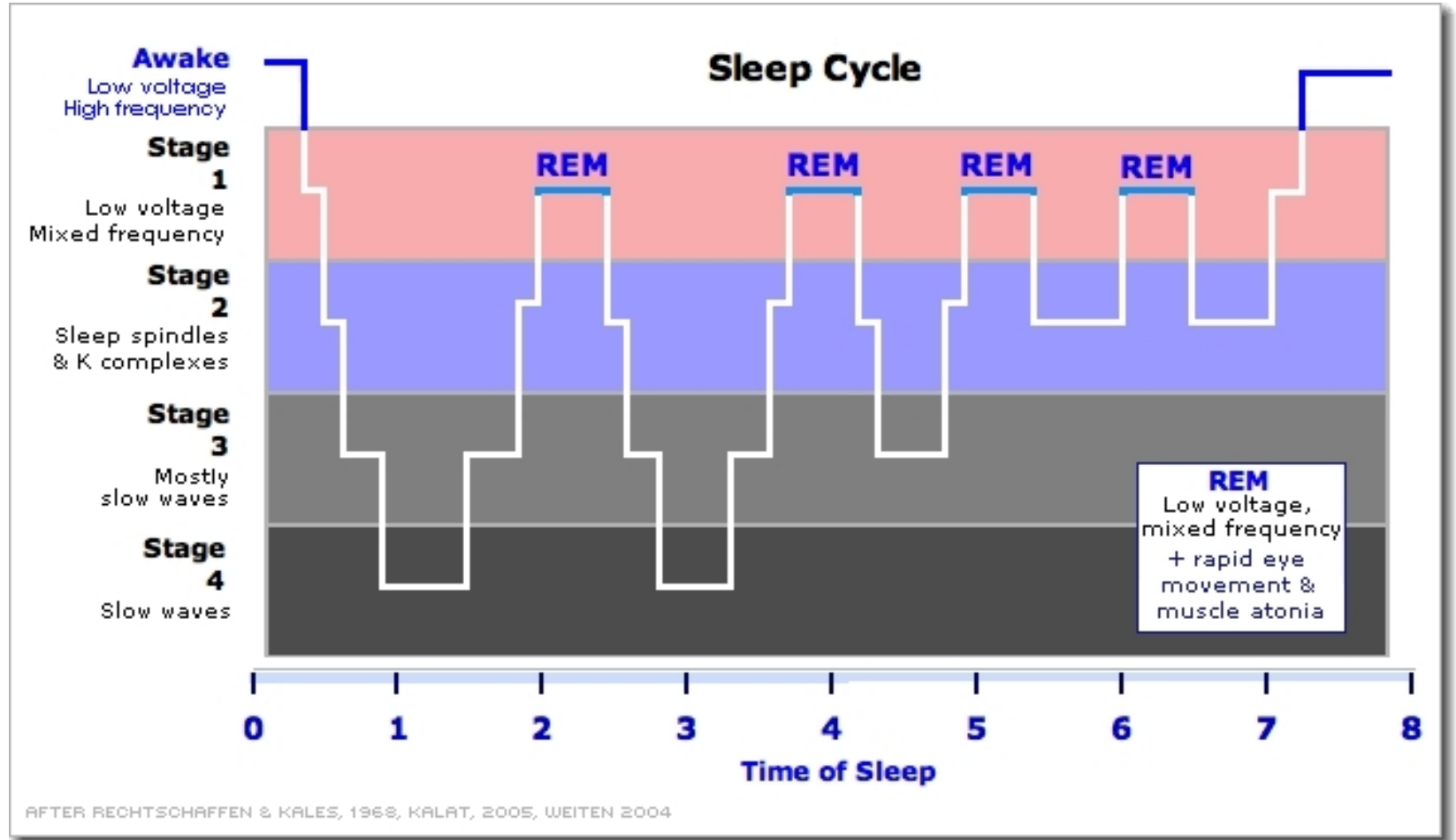
Research on deep sleep shows a state of profound rest



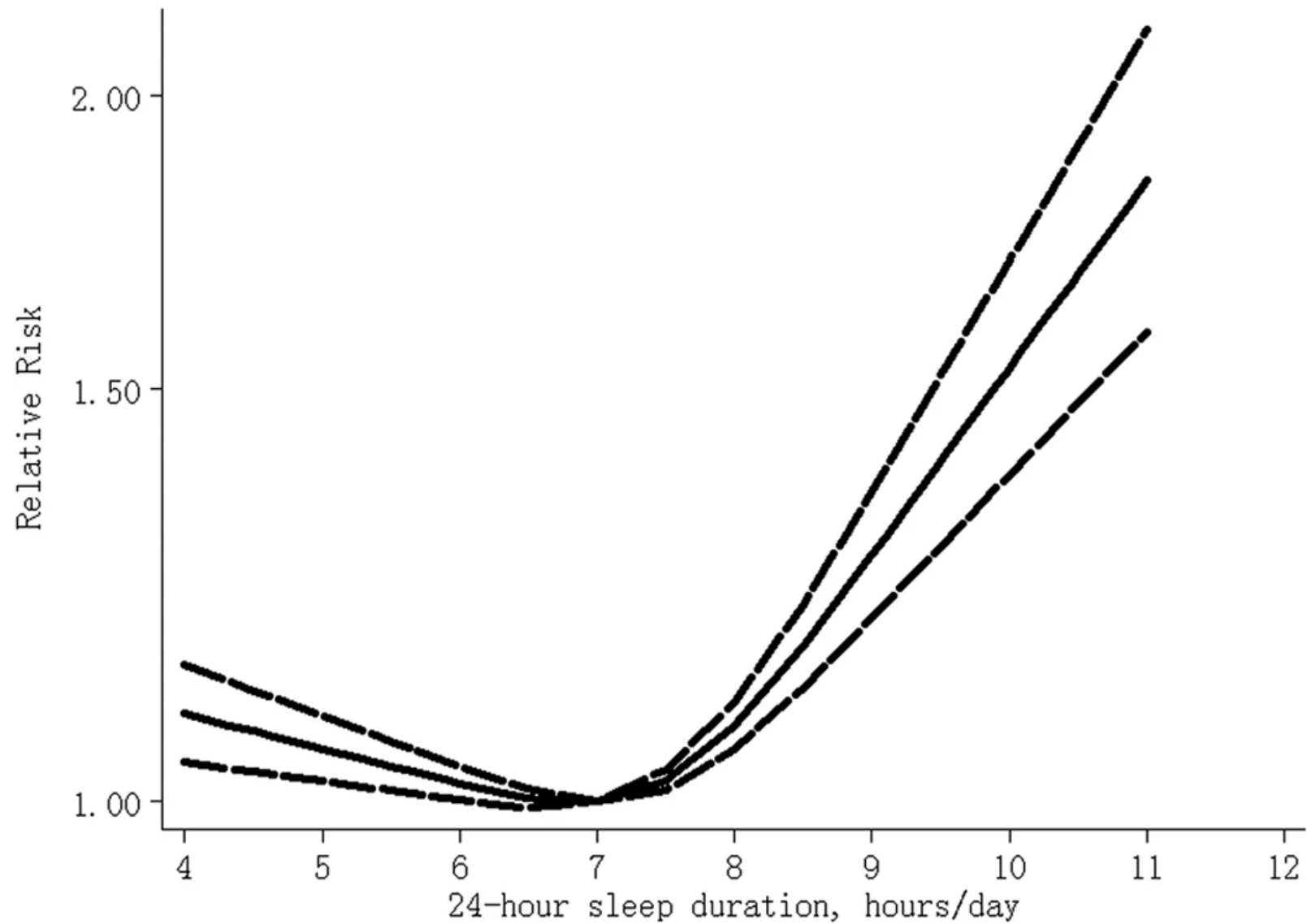
Memory consolidation and processing

Sleep stages

Stage	Characteristics
1	Drowsy, relaxed state between waking and sleeping; daydreaming
2	Light sleep, easily awakened
3	Deep sleep
4	Deep sleep
REM	Primary dreaming state; most likely to be awakened from

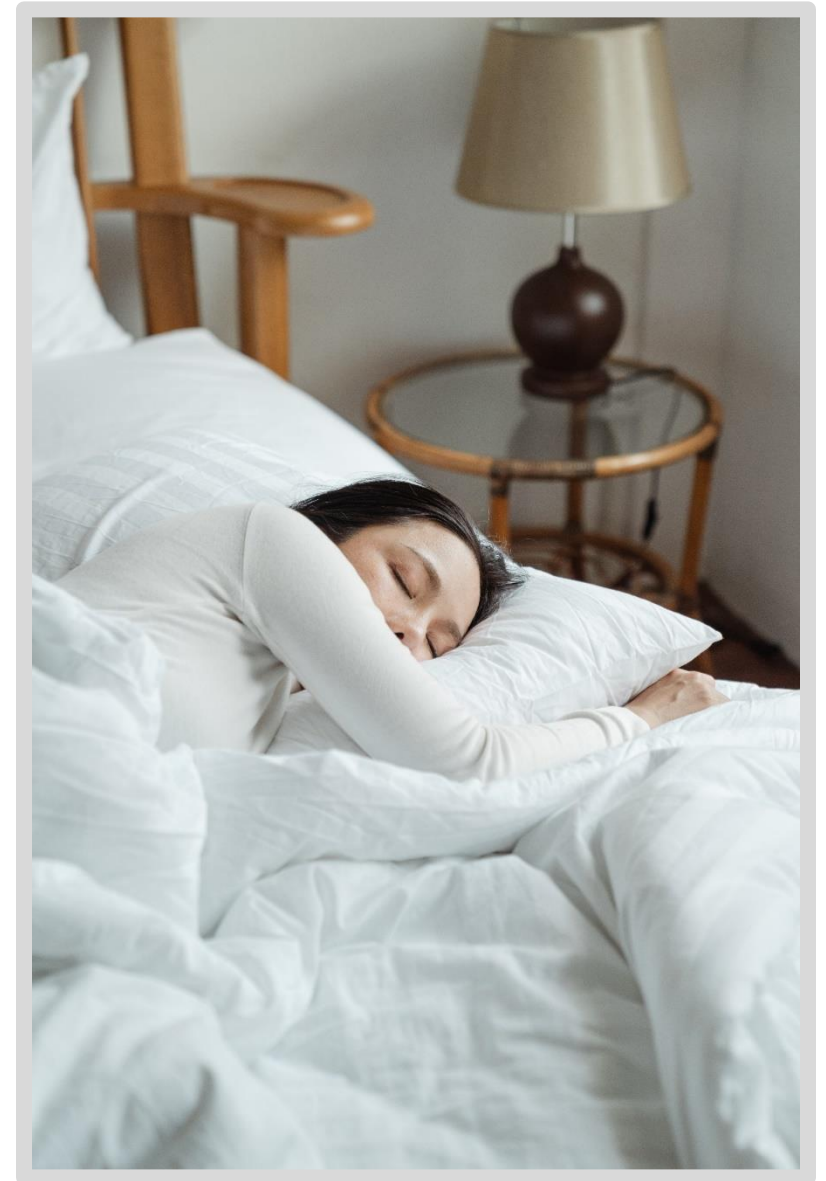


Sleep duration and health



Core sleep

- ▶ Severe sleep loss has more significant impacts on daytime performance than moderate sleep loss
- ▶ Core sleep is equivalent to the loss of one 90-minute sleep cycle
- ▶ 7-hour sleep → core sleep = 5.5 hours
- ▶ During core sleep, we experience 100% of deep sleep needed and 50% of our REM sleep
- ▶ If core sleep is not obtained, brain creates homeostatic sleep pressure to obtain core sleep the next night



Sleep needs change as we age



Newborn

16-18 hours



10-year old

10 hours



Teenager

8 hours



Middle Age

7 hours



70s

6.5 hours*

*additional hour of
daytime napping is
common

Defining insomnia

Sleep onset insomnia

Sleep maintenance
insomnia

Early morning
awakening

- ▶ Present **3x/week** or more
- ▶ Chronic insomnia **>3 months**
- ▶ Perceived **impairment**
- ▶ Occurs despite **adequate opportunity** for sleep
- ▶ Not better explained by and does not occur exclusively in the context of another sleep-wake disorder
- ▶ Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia

3P Model of Insomnia

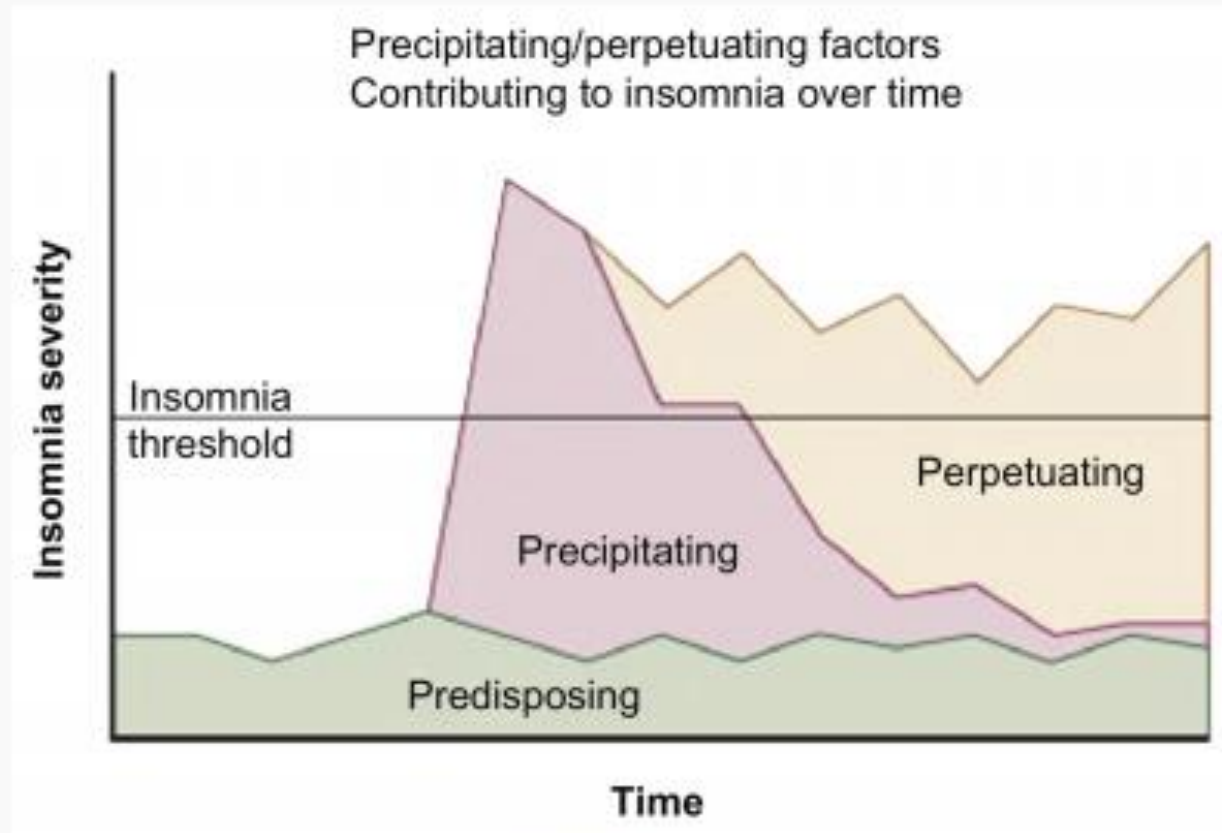



Fig. 1 : 3P Model of Insomnia: Paresh, Oxana, et al. Prevalence, putative mechanisms, and current management of sleep problems during chemotherapy for cancer. *Nature and science of sleep* 4 (2012): 151. 

The body clock

Runs on a 24-hour cycle and influences the timing behaviors of sleep and other physiological processes

Melatonin

- Time setter and mild sedative
- Levels rise 3-5 hours prior to sleep onset
(0.1mg-0.5mg is enough to induce)
- Suppressed by blue light
- Most powerful time setter: bright morning light
- Keeps body clock on regular schedule

Natural sleep window

- 12am to 9am
- Sleeping outside this window increases risk of depression and social jetlag

Low arousal activities

- Prior to bedtime to wind down

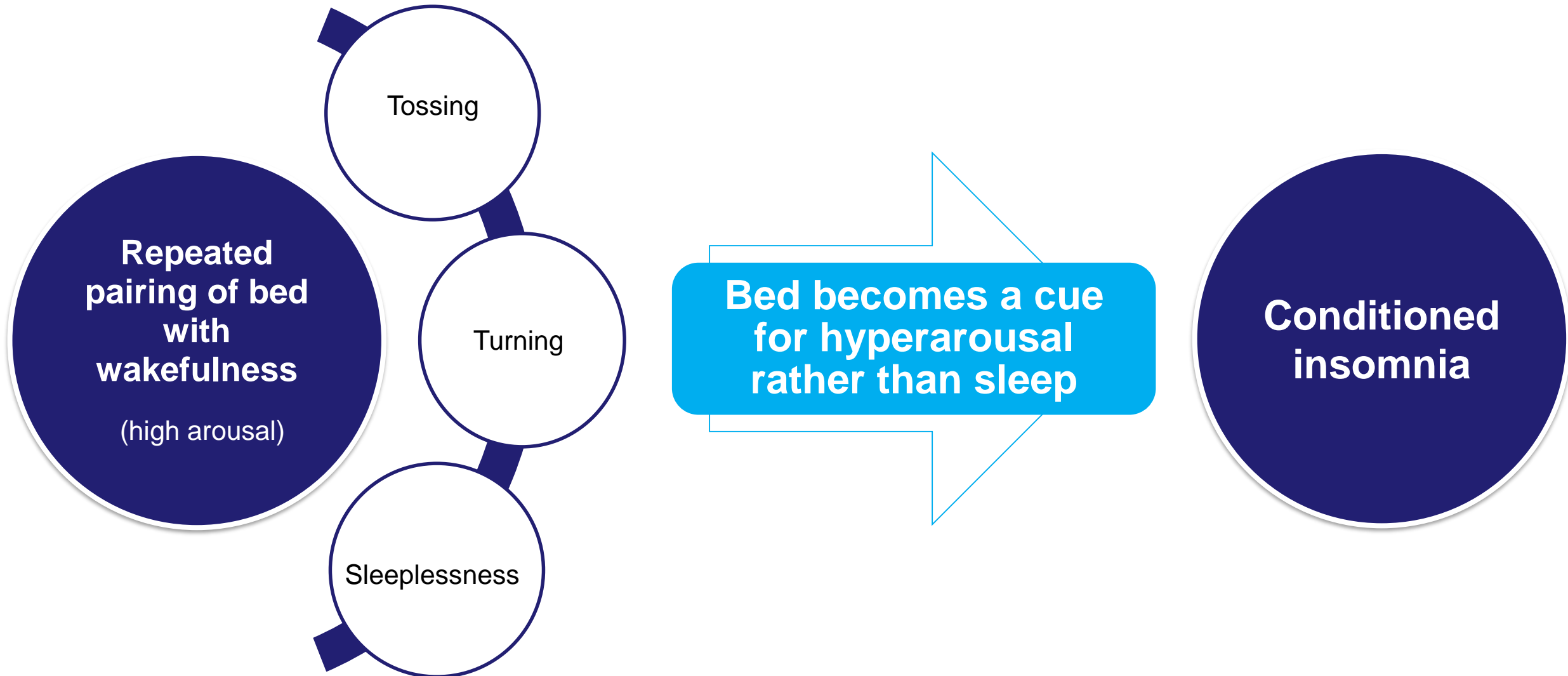
Unhelpful beliefs about sleep

- “I need 8 hours of sleep to function tomorrow”
- “I can’t sleep without medications”

Conditioned arousal

- Bed becomes associated with being awake, alert, anxious

Conditioned arousal



Insomnia prevalence has increased since COVID-19

- ▶ A recent meta-analysis (Cénat et al, 2021) puts the global prevalence rate of insomnia at 24%
- ▶ Many factors contributing to these rising insomnia rates
- ▶ In one study (Killgore et al., 2020), suicidal ideation was found to be much more strongly predicted by insomnia severity than by fears related to the pandemic



Contributing factors during the pandemic

- ▶ Loss of daily routine and structure (sleep/rise time, shifting work and parenting expectations)
- ▶ Reduced light exposure
- ▶ Blurred boundaries between work and recreation (space, accessibility)
- ▶ Increased stress/anxiety due to reduction in outlets for stress-reduction (visiting friends and family, shopping, dining, attending cultural/supporting events/concerts, exercise)
- ▶ Parenting changes (shift in demands of home schooling, changes in children's sleep schedules)

Assessment of insomnia

- ▶ Sleep history
- ▶ Medical conditions that can worsen sleep
- ▶ Prescription and OTC medication side effects
- ▶ Illicit drug use
- ▶ Mental health problems
- ▶ Underlying sleep disorders
 - Sleep apnea
 - Periodic Limb Movement Disorder
 - Restless Leg Syndrome
 - Delayed Phase Disorder
 - Hypersomnia
 - Poor sleep quality/multiple awakenings

Assessment tools

- Insomnia Severity Index
- Sleep Need Questionnaire
- Morningness-Eveningness Questionnaire
- Dysfunctional Beliefs about Sleep-16
- Restless Legs Syndrome Rating Scale
- STOP BANG

Case Application 1

Insomnia		Anxiety	
First onset of symptoms began after recent divorce			
Nightly sleep onset latency of 2 hours	Generalized worry	Tightness in body	
Difficulties with sleep duration	Difficulty with focus/concentration	Pacing and fidgeting	
Early morning awakenings	Rumination and difficulty completing tasks	Increased HR and chest tightness	
Identifies mind racing as cause of sleep difficulties	Withdrawal/avoidance		

Sleep aid

0.5mg Xanax daily

Measure	Result	Interpretation
ISI	22	Clinical insomnia – severe
RLS	29	Severe
DBAS-16	91	Higher scores indicate more distressing thoughts
MEQ	44	Intermediate type
STOP BANG	2	Low OSA risk
Sleep Needs Questionnaire	21	Higher scores indicate higher need

Case Application 2

Insomnia	Anxiety (current)	Anxiety (historical, managed by Lexapro)
First onset of symptoms began after father's death 20 years ago but was well-managed until recent diagnosis of intraductal carcinoma		
Nightly sleep onset latency of 2 hours	Feeling of a pit in her stomach	Generalized worry
Occasional difficulties with sleep duration	Rumination related to sleep	Crying spells
Occasional early morning awakenings		Nervousness
Mood described as secondary to her sleep		Increased HR
		General feeling of "not like herself"

Sleep aid

0.5mg Xanax and a glass of wine daily

Measure	Result	Interpretation
ISI	23	Clinical insomnia – severe
RLS	0	No symptoms reported
DBAS-16	144	Higher scores indicate more distressing thoughts
MEQ	66	Morning type
STOP BANG	1	Low OSA risk
Sleep Needs Questionnaire	21	Higher scores indicate higher need

Treatment for insomnia

Patients on sleeping pills engaging in behaviors when not fully awake that resulted in injury and, in some cases, death

April 2019: FDA requires a Black Box warning to be added to the prescribing information for Lunesta, Sonata, and Ambien

With mounting concerns about these medications, there is growing interest in non-pharmacological treatments for insomnia

CBT for Insomnia (CBT-I) is the recommended treatment for chronic insomnia by various organizations (ACP, AASM, NIH, APA) because it

- Is a safer and more effective long-term treatment for insomnia
- Helps people fall asleep faster than sleeping pills and without any side effects
- Is the most effective behavioral intervention **for any health problem** for adults

The problem?

Lack of knowledge about CBT-I and lack of access

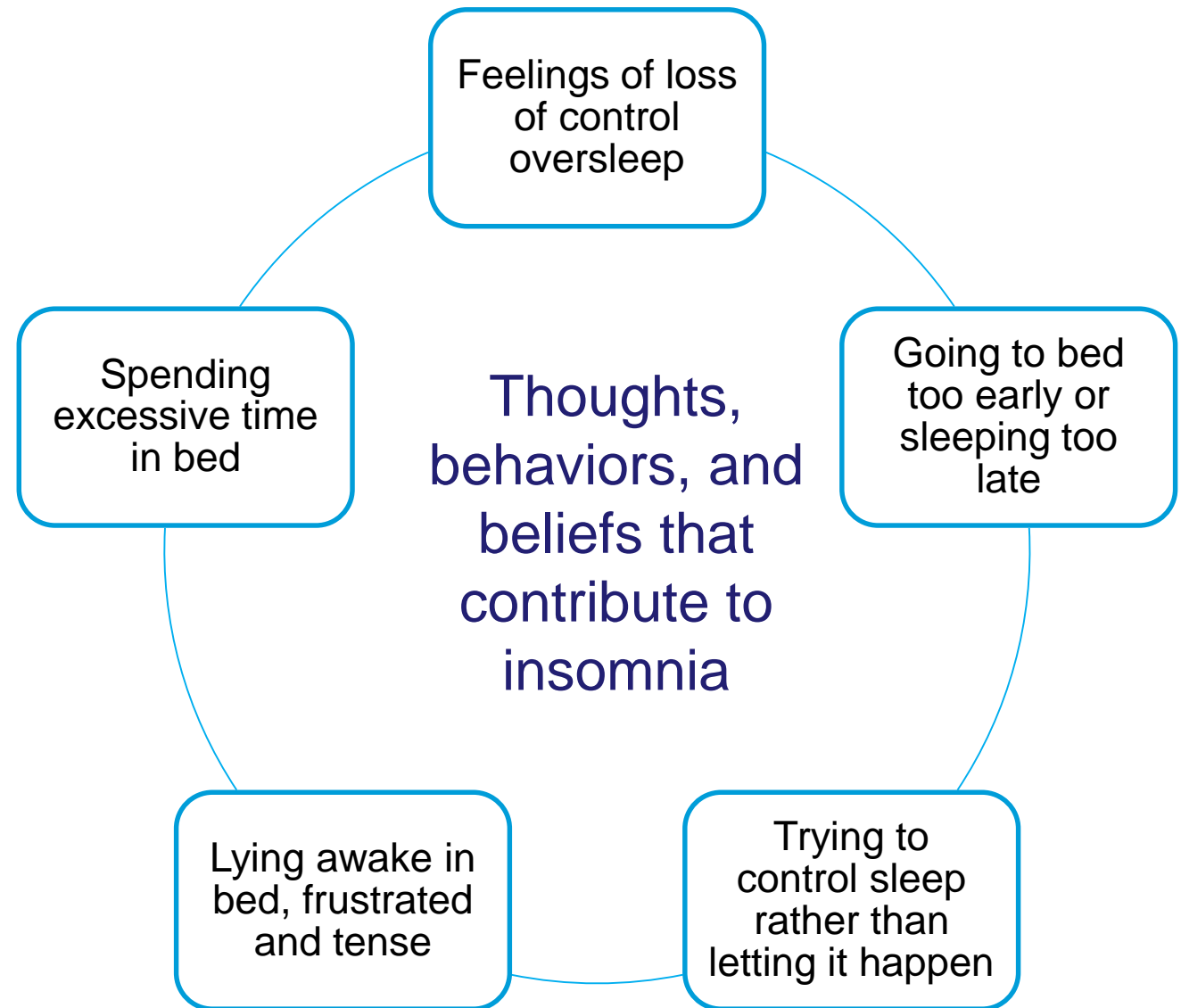
Sleeping pills don't cure insomnia because they don't treat the causes of insomnia

Consequently, relying on sleeping pills improves sleep while on the medication but rebound insomnia occurs when medication is discontinued maintaining the cycle of insomnia and sleeping pills



Chronic insomnia can only be overcome by addressing the underlying causes, which, in most cases, are sleep thoughts and sleep behaviors

CBT-I improves sleep because it effectively changes these sleep thoughts and sleep behaviors and heightens self-efficacy



Format of CBT-I

- ▶ CBT-I consists of 5 treatment sessions, typically spread out over the course of 6 weeks
- ▶ Effective in group or individual format
 - Group: more cost effective for patients and the clinician, offers advantage of social support, reinforcement and modeling
 - Individual: allows for more one-on-one interaction, feedback and flexibility in scheduling
- ▶ Effective in-person as well as through telehealth

Session Outline

- ▶ **Session 1:** Sleep Education and Cognitive Restructuring
- ▶ **Session 2:** Sleep Medication Withdrawal and Sleep Scheduling Techniques
- ▶ **Session 3:** Stimulus Control Techniques
- ▶ **Session 4:** The Relaxation Response
- ▶ **Session 5:** Sleep Hygiene Techniques

Session 1

Sleep Education & Cognitive Restructuring

- ▶ **Introduce patients to basic concepts: defining insomnia, providing rationale for CBT-I**
- ▶ **Introduce cognitive restructuring**
 - Thoughts have powerful effects on the body and sleep
 - Hallmark of insomnia is negative, inaccurate thoughts about sleep (NSTs)
 - The goal of cognitive restructuring is to recognize, challenge, and replace NSTs with more accurate, positive, adaptive positive sleep thoughts
- ▶ **Additional information regarding sleep/insomnia**
 - Effects of insomnia on health
 - Impact of insomnia on daytime functioning
 - Subjective estimates of sleep vs objective measurement

Case Example

- ▶ 70-year-old Caucasian, Irish American, cisgender, heterosexual, retired male
- ▶ Presented to treatment with sleep onset insomnia and moderate unspecified anxiety
- ▶ At the onset of treatment using Ambien as a sleep aid
- ▶ Due to cost sharing chose to commit to every other week sessions

Week 1		day 1	day 2	day 3	day 4	day 5	day 6	day 7	AVERAGE	
Dates		7/30/2019	7/31/2019	8/1/2019	8/2/2019	8/3/2019	8/4/2019	8/5/2019		
Bedtime (Time went into bed)	Q1_BT	1:00	1:30	1:30	3:00	2:00	2:00	0:30	1:38	Bedtime
Lights out (Try to go to sleep)	Q2_LO	1:00	1:30	1:30	3:00	2:00	2:00	0:30	1:38	Lights out
Latency to sleep (minutes to fall asleep)	Q3_SL	150.00	10.00	15.00	10.00	10.00	240.00	60.00	70.71	Latency to fall asleep
minutes awake in middle of night (how long awakenings last)	Q5_WASO	20.00	10.00	240.00	0.00	0.00	20.00	10.00	42.86	Minutes awake in middle of night
Wake time (time of final awakening)	Q6a_WT	7:30	9:00	8:00	9:45	8:30	9:45	8:30	8:42	Wake time
Mins awake too early (how many minutes earlier)	Q6c_EMA	120.00	0.00	120.00	0.00	0.00	120.00	0.00	51.43	minutes awake too early
Out of bed (out of bed for the day)	Q7_OB	8:30	9:30	8:30	9:45	8:30	10:00	8:30	9:02	out of bed for day
	BT	1.00	1.50	1.50	3.00	2.00	2.00	0.50	1.64	
	LO	1.00	1.50	1.50	3.00	2.00	2.00	0.50	1.64	
	WT	7.50	9.00	8.00	9.75	8.50	9.75	8.50	8.71	
	OB	8.50	9.50	8.50	9.75	8.50	10.00	8.50	9.04	
Time in Bed	TIB	7.50	8.00	7.00	6.75	6.50	8.00	8.00	7.39	Time in Bed
Total Sleep Time	TST	3.67	7.17	2.25	6.58	6.33	3.42	6.83	5.18	Total Sleep Time
Sleep Efficiency	SE (%)	48.89%	89.58%	32.14%	97.53%	97.44%	42.71%	85.42%	70.53%	Sleep Efficiency

Session 2

Sleep Medication Withdrawal & Sleep Scheduling

- ▶ Sleep medication and tapering techniques
- ▶ Sleep scheduling concepts
 - Prior wakefulness – number of hours elapsed from time out of bed until lights out at bedtime
 - More hours awake before going to sleep, the greater the pressure for sleep
 - Sleep efficiency = $\text{time asleep} / \text{time in bed}$
 - Want >85% - Goal not to increase total sleep time, but to improve efficiency
- ▶ Process of sleep scheduling
- ▶ Set a regular arising time
- ▶ Reduce time allotted for sleep (gradually by 1 hr/wk) to improve sleep efficiency
- ▶ Limit naps to 45 min and not after 4pm

Typical Sleep Medication Taper Plan

- ▶ Week 1: remove 1/2 dose 2 nonconsecutive nights
- ▶ Week 2: remove 1/2 dose every other day
- ▶ Week 3: eliminate dose 2 nonconsecutive nights
- ▶ Week 4: eliminate dose every other night
- ▶ Week 5: eliminate dose nightly

Sleep Scheduling Guidelines

- ▶ Set regular rising time
- ▶ Reduce time allotted for sleep to improve sleep efficiency
- ▶ Limit naps to 45 min and not after 4pm



Case Example

Week 2		day 1	day 2	day 3	day 4	day 5	day 6	day 7	AVERAGE	
Date		8/6/2019	8/7/2019	8/8/2019	8/9/2019	8/10/2019	8/11/2019	8/12/2019		
Bedtime (Time went into bed)	Q1_BT	1:30	1:00	1:25	0:30	0:30	0:47	0:30	0:53	Bedtime
Lights out (Try to go to sleep)	Q2_LO	1:30	1:00	1:25	0:30	0:30	0:47	0:30	0:53	Lights out
Latency to sleep (minutes to fall asleep)	Q3_SL	180.00	10.00	120.00	10.00	10.00	180.00	10.00	74.29	Latency to fall asleep
minutes awake in middle of night (how long awakenings last)	Q5_WASO	10.00	0.00	0.00	0.00	0.00	90.00	45.00	20.71	Minutes awake in middle of night
Wake time (time of final awakening)	Q6a_WT	10:00	8:15	7:00	7:00	7:00	7:40	8:00	7:50	Wake time
Mins awake too early (how many minutes earlier)	Q6c_EMA	0.00	0.00	30.00	0.00	0.00	0.00	0.00	4.29	minutes awake too early
Out of bed (out of bed for the day)	Q7_OB	10:15	8:20	7:00	7:00	7:15	7:00	8:15	7:52	out of bed for day
	BT	1.50	1.00	1.42	0.50	0.50	0.78	0.50	0.89	
	LO	1.50	1.00	1.42	0.50	0.50	0.78	0.50	0.89	
	WT	10.00	8.25	7.00	7.00	7.00	7.67	8.00	7.85	
	OB	10.25	8.33	7.00	7.00	7.25	7.00	8.25	7.87	
Time in Bed	TIB	8.75	7.33	5.58	6.50	6.75	6.22	7.75	6.98	Time in Bed
Total Sleep Time	TST	5.33	7.08	3.58	6.33	6.33	2.38	6.58	5.38	Total Sleep Time
Sleep Efficiency	SE (%)	60.95%	96.59%	64.18%	97.44%	93.83%	38.34%	84.95%	76.61%	Sleep Efficiency

Week 3		day 1	day 2	day 3	day 4	day 5	day 6	day 7		
Dates		8/13/2019	8/14/2019	8/15/2019	8/16/2019	8/17/2019	8/18/2019	8/19/2019		
Bedtime (Time went into bed)	Q1_BT	0:30	0:30	1:30	1:30	4:00	1:30	1:30	1:34	Bedtime
Lights out (Try to go to sleep)	Q2_LO	0:30	0:30	1:30	1:30	4:00	1:30	1:30	1:34	Lights out
Latency to sleep (minutes to fall asleep)	Q3_SL	150.00	60.00	10.00	10.00	10.00	10.00	10.00	37.14	Latency to fall asleep
minutes awake in middle of night (how long awakenings last)	Q5_WASO	0.00	60.00	10.00	60.00	0.00	60.00	0.00	27.14	Minutes awake in middle of night
Wake time (time of final awakening)	Q6a_WT	8:00	1:30	8:00	8:00	8:30	8:15	7:30	7:06	Wake time
Mins awake too early (how many minutes earlier)	Q6c_EMA	0.00	360.00	0.00	0.00	0.00	0.00	0.00	51.43	minutes awake too early
Out of bed (out of bed for the day)	Q7_OB	8:15	1:30	8:00	8:00	8:30	8:15	7:30	7:08	out of bed for day
	BT	0.50	0.50	1.50	1.50	4.00	1.50	1.50	1.57	
	LO	0.50	0.50	1.50	1.50	4.00	1.50	1.50	1.57	
	WT	8.00	1.50	8.00	8.00	8.50	8.25	7.50	7.11	
	OB	8.25	1.50	8.00	8.00	8.50	8.25	7.50	7.14	
Time in Bed	TIB	7.75	1.00	6.50	6.50	4.50	6.75	6.00	5.57	Time in Bed
Total Sleep Time	TST	5.00	-1.00	6.17	5.33	4.33	5.58	5.83	4.46	Total Sleep Time
Sleep Efficiency	SE (%)	64.52%	-100.00%	94.87%	82.05%	96.30%	82.72%	97.22%	59.67%	Sleep Efficiency

Session 3

Stimulus Control Techniques

- ▶ **Stimulus control:** stimuli in our environment become cues for certain behaviors
 - Positive stimulus control where bed is associated with sleep
 - Bed should be used for sleep and sexual activity only
 - Go to bed only when drowsy
 - Follow the 30/30 rule
- ▶ **Introduce relaxation response:** inborn quieting response that quiets the mind and body and counteracts the stress response (breathing, meditation, progressive muscle relaxation)

Session 4

The Relaxation Response

Stress response (fight or flight)

- ▶ Survival mechanism → generalized to more chronic, frequent, and psychological stressors
- ▶ The result is chronic, inappropriate, excessive activation of the stress response
- ▶ This level of arousal (elevated stress hormones) interferes with sleep
- ▶ Negative sleep thoughts also stimulate the awake system, causing insomnia

Relaxation response

- ▶ 4 key elements
 - a quiet place
 - a comfortable position and muscle relaxation
 - a mental focusing device
 - a passive disregard of everyday thoughts
- ▶ In-session practice

Session 5

Sleep Hygiene Techniques & Relapse Prevention

Sleep Hygiene

Lifestyle practices that improve sleep and help create an optimal sleep environment

- ▶ Review the effects of alcohol, caffeine, exercise, room temperature/baths, bright light, and noise on sleep
- ▶ Even though the program is only 6 weeks, it often takes more than this time to fully change years of poor sleep habits
 - With additional practice, your sleep will continue to improve and the techniques learned will become habits
- ▶ Temporarily reduce time allotted for sleep during periods of poorer sleep
- ▶ Utilize cognitive restructuring to better manage stress

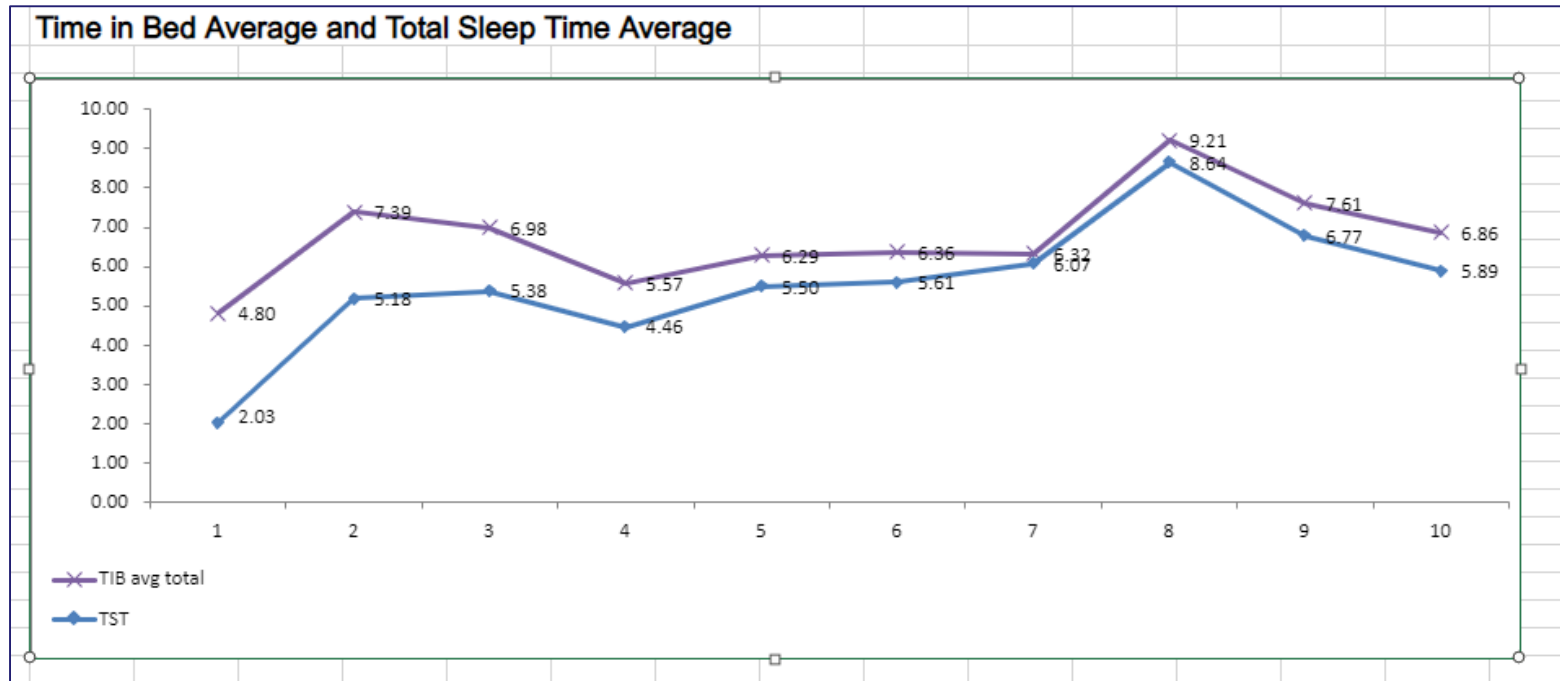
Sleep Hygiene Techniques

- ▶ Have a sleep schedule
- ▶ Exercise earlier in the day
- ▶ Avoid caffeine and nicotine
- ▶ Avoid alcoholic drinks before bed
- ▶ Avoid large meals and drinks before bed
- ▶ Try to avoid medicines that interfere with sleep, if possible
- ▶ Don't take naps after 3 pm and limit naps to under an hour
- ▶ Relax before bed
- ▶ No screen time an hour before bed
- ▶ Have a good sleep environment
- ▶ Don't lie awake in bed
- ▶ Limit the activities you do in your bed
- ▶ Have enough sunlight exposure

Case Example

Week 8		day 1	day 2	day 3	day 4	day 5	day 6	day 7	AVERAGE	
Date		9/14/2019	9/15/2019	9/16/2019	9/17/2019	9/18/2019	9/19/2019	9/20/2019		
Bedtime (Time went into bed)	Q1_BT	0:15	0:45	0:15	0:30	1:00	0:30	11:15	2:04	Bedtime
Lights out (Try to go to sleep)	Q2_LO	0:15	0:45	0:15	0:30	1:00	0:30	11:15	2:04	Lights out
Latency to sleep (minutes to fall asleep)	Q3_SL	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	Latency to fall asleep
minutes awake in middle of night (how long awakenings last)	Q5_WASO	0.00	10.00	105.00	10.00	30.00	0.00	0.00	22.14	Minutes awake in middle of night
Wake time (time of final awakening)	Q6a_WT	6:45	8:15	8:45	8:00	8:30	7:45	6:45	7:49	Wake time
Mins awake too early (how many minutes earlier)	Q6c_EMA	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	minutes awake too early
Out of bed (out of bed for the day)	Q7_OB	6:45	8:15	9:00	8:00	8:30	7:45	6:45	7:51	out of bed for day
	BT	0.25	0.75	0.25	0.50	1.00	0.50	11.25	2.07	
	LO	0.25	0.75	0.25	0.50	1.00	0.50	11.25	2.07	
	WT	6.75	8.25	8.75	8.00	8.50	7.75	6.75	7.82	
	OB	6.75	8.25	9.00	8.00	8.50	7.75	6.75	7.86	
Time in Bed	TIB	6.50	7.50	8.75	7.50	7.50	7.25	19.50	9.21	Time in Bed
Total Sleep Time	TST	6.33	7.17	6.58	7.17	6.83	7.08	19.33	8.64	Total Sleep Time
Sleep Efficiency	SE (%)	97.44%	95.56%	75.24%	95.56%	91.11%	97.70%	99.15%	93.11%	Sleep Efficiency

Case Example – Did this work long term?



	Week 1	Week 8
Latency to Sleep	70.71	10.00
Wake After Sleep Onset	42.86	22.14
Early Morning Awakenings	51.43	0.00
Time in Bed	7.39	9.21
Total Sleep Time	5.18	8.64
Sleep Efficiency	0.71	0.93

Patient was seen for 5 sessions over approximately 8 weeks

- Increased satisfaction with sleep
- Improvement in anxiety symptoms

2 booster sessions occurred during the height of the pandemic

- Actively using stimulus control techniques
- Actively using relaxation response
- Acute pandemic related stressors and loss of his mother
- Focused on sleep scheduling

Strategies for Patient Engagement

Goals

- What are the patient's goals/desires for improving their sleep?
- How will this make their life better?
- How will not addressing the sleep make their life worse?
- How does the insomnia impact their ability to behave in accordance with their values?

Importance

- How important is this to them?

Positivity

- To what degree does the discussion around this treatment generate positive feelings, including hope?

Expectations

- What are the patient's expectations for what will happen during the treatment?

Create safety and welcome

- How do I create a situation where this person feels welcomed and valued?
- What are the tangible things I do or offer?

Ask and listen

- What has made them come in and talk to me?
- How does this situation fit into this person's life and the constellation of demands and priorities?

Offer small bites of information

- How do I find out what the person knows about this and offer new information to fill the big picture?
- In what ways can I provide realistic hope while avoiding attempts to convince them?

Suggestions for Remote Workers

- ▶ Increased time and focus on cognitive restructuring skills
- ▶ Increased emphasis and use of relaxation skills/general stress management
- ▶ Longer wind-down period before bedtime
- ▶ Emphasis on restriction of time spent in bed
- ▶ Deliberate efforts to increase exposure to light, particularly earlier in the day
- ▶ Focus on creating a sense of structure to the day that may no longer be inherent in work/family/social obligations
- ▶ Structure may be able to be modified more towards natural circadian preference

Considerations for Parents

- ▶ Keep regular sleep times for your child(ren) and yourself
- ▶ Make the last 30 min before bedtime a regular routine that includes calming activities
- ▶ Avoid technological devices after dinner or too close to bedtime
- ▶ If your household space allows it, try to avoid children using their bed for activities other than sleeping
- ▶ If you can go out, it is best to go out in the morning, and have your breakfast in a place with bright light
- ▶ Keep the child's room comfortable (temperature at about 19°C, and dim light at night)
- ▶ Reassure children that keeping to schedules and routine helps them to sleep well and deal with their emotions
- ▶ In case of anxious awakenings, reassure children during the night
- ▶ Do not sleep in the same bed as the child. Instead, (repetitive) reassurance is more effective

Considerations for Night Workers

- ▶ Consider telehealth or mHealth solutions for treatment
- ▶ Importance of maintaining consistent sleep and wake schedule
- ▶ Daily exposure to sunlight
- ▶ Keep the room cool and dark
- ▶ Safety naps may be incorporated

Two Key Steps for Maintaining Success

Don't stay in bed awake for more than 15 minutes

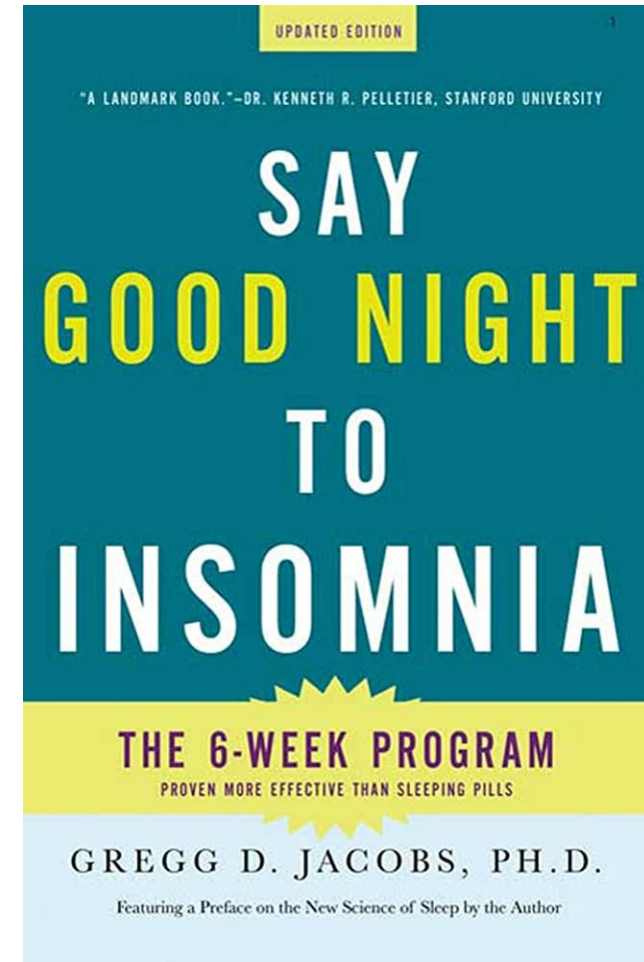
Don't compensate for a bad night – avoid going to bed early, sleeping late, or napping

Practical Patient Suggestions

- ▶ Keep the same wake up time daily
- ▶ Going to bed when you're sleepy but never before your regular bedtime
- ▶ The bed should be used for sleep and sex only
- ▶ Create a buffer zone before bed
- ▶ Engage in worrying and problem solving earlier in the day
- ▶ Reframe negative thoughts about sleep
- ▶ Do not try too hard to sleep
- ▶ Avoid napping
- ▶ Avoid alcohol, cigarettes, caffeine, or vigorous exercise leading up to bedtime
- ▶ Get out of bed
 - If you're unable to sleep
 - If you find yourself worrying or unable to shut off your thoughts
 - At the same time every day, even when you've had a bad night's sleep

Patient Resources

Certified CBT-I Providers



Clinician Certification

CBT-I Clinician Training and Certification

Thank you for your
time and attention!



**ANY
QUESTIONS?**