

SLEEP MEDICINE PEARLS

A treatment option for chronic insomnia

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A 73-year-old veteran presented with difficulty in initiating and maintaining sleep for several years. He had a history of moderate obstructive sleep apnea that was well treated with continuous positive airway pressure therapy. His bedtime ranged from 8 to 9 PM and it took more than 1 hour to initiate sleep. He woke up 3 times during the night and it took 15–60 minutes to reinitiate sleep after each awakening. During the wake times, he would engage in activities such as walking around the house, reading, and watching sports. His final awakening was around 6:00 AM, and his perceived total sleep time was 5–6 hours. Daytime symptoms included excessive fatigue and irritability. He denied a history of psychiatric disorders, including anxiety or

depression. The Insomnia Severity Index was 22/28. The veteran was diagnosed with chronic insomnia disorder. However, he was not able to commit to 6–8 sessions of cognitive-behavioral therapy for insomnia (CBT-I) because he cared for his wife. Additionally, he was unable to pursue online CBT-I as he was not “tech savvy” and did not want to use any sedative medications for his insomnia.

QUESTION: What treatment modality would you use for this patient’s chronic insomnia disorder?

Table 1—Sleep diary.

	Treatment Sessions				
	Session 1		Session 2	Session 3	Session 4
Sleep Diary	Week 1	Week 2	Week 3	Week 4	Week 5
SL	1 h, 16 min	1 h, 10 min	18 min	10 min	10 min
WASO	1 h, 27 min	1 h, 55 min	28 min	19 min	9 min
EMA	9 min	10 min	0 min	0 min	0 min
TIB	9 h, 58 min	10 h, 15 min	6 h, 0 min	6 h, 15 min	6 h, 30 min
TST	6 h, 4 min	6 h, 0 min	5 h, 14 min	5 h, 46 min	6 h, 11 min
SE	61%	59%	87%	92%	95%

Session 1: Pretreatment sleep diary (weeks 1 and 2) reviewed. Sessions 2, 3, 4: Sleep diary reviewed during each treatment session. EMA = early morning awakening, SE = sleep efficiency, SL = sleep latency, TIB = time in bed, TST = total sleep time, WASO = wake after sleep onset.

ANSWER: Brief behavioral therapy for insomnia

DISCUSSION

Brief behavioral therapy for insomnia (BBT-I) is a behavioral option for the treatment of chronic insomnia, especially for individuals who do not have access to clinical psychologists trained in delivering CBT-I.¹ Additionally, many patients are unwilling or unable to attend 6–8 intensive treatment sessions required for CBT-I. BBT-I is a type of brief therapy for insomnia, delivered over a duration of 4 consecutive weeks, and focuses on the behavioral modification techniques of stimulus control and sleep restriction;² it does not deliberately address cognitive errors or unhelpful attitudes about sleep.³ According to the most recent American Academy of Sleep Medicine clinical practice guidelines on the behavioral and psychological treatments for chronic insomnia disorder, multicomponent brief therapies have a “conditional” recommendation,⁴ which means that the patient’s values and preferences must be considered to determine the best treatment option, as was done in our case.

Our patient met with the sleep psychologist for an intake session, during which it was determined that the patient’s insomnia was primarily behaviorally determined. In an effort to improve his sleep, he was unintentionally spending an average of 10 hours in bed each night. This was contributing to a weakened sleep drive and conditioned arousal because he was spending several hours per night awake in bed. Although he demonstrated sleep effort, he did not report rumination about his sleep or significant dysfunctional beliefs about sleep. Given his limited availability, preferences, and the strong behavioral components of his insomnia, a shared decision was made with the patient to complete BBT-I. Due to the COVID-19 pandemic, all 4 sessions were carried out via clinical video telehealth, utilizing the center-to-home model. As our patient had access to a comprehensive sleep center, treatment sessions were delivered by the sleep psychologist. It should be noted that BBT-I can be delivered by a trained nurse or an allied

health professional and does not require the expertise of a sleep psychologist.

Prior to the patient’s first session, he was mailed a sleep diary that he was asked to complete over the 2 weeks leading up to the first BBT-I session. That session focused on assessing the veteran’s current sleep hygiene, providing education about the mechanisms of sleep regulation, and discussing the benefits and rationale of stimulus-control strategies and sleep restriction. The session concluded with a review and careful discussion of the sleep diary. The patient was surprised to find that his average time in bed was 10 hours. Sleep restriction was used to set a sleep prescription of 6 hours for the first week.

The second and third sessions focused on discussing the patient’s adherence to sleep hygiene recommendations, stimulus-control strategies, and sleep restriction. Our patient focused on increasing exercise during the day and avoiding a heavy meal before bed. He also demonstrated good adherence to stimulus-control strategies and his sleep prescription. During the second session he reported that sleep latency and wake after sleep onset were each less than 30 minutes. Therefore, he was instructed to begin increasing his time in bed by 15 minutes each week.

During the final session, progress was reviewed. See **Table 1** for an overview of the patient’s sleep diary. Our patient reported improved sleep quality and consolidated sleep. He was encouraged to continue using stimulus-control strategies, and sleep-restriction instructions were reviewed for increasing or decreasing time in bed as needed. At the end of treatment, his Insomnia Severity Index was 10/28.

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1. A shared decision-making approach, considering the patient’s values and preferences, must be utilized to determine the best treatment option for chronic insomnia.
2. BBT-I is a type of brief therapy for chronic insomnia disorder.

3. It can be delivered by a nurse or allied health professional, and therefore can reach patients with chronic insomnia who do not have access to a trained clinical psychologist.
4. BBT-I is most effective for patients without significant cognitive symptoms of insomnia and focuses on the behavioral modification techniques of stimulus control and sleep restriction.
5. As with CBT-I, the sleep-restriction component of the therapy may be contraindicated in patients with poorly controlled seizures or predisposition to mania/hypomania, and in high-risk-occupation workers such as drivers.

2. Troxel WM, Germain A, Buysse DJ. Clinical management of insomnia with brief behavioral treatment (BBT-I). *Behav Sleep Med*. 2012;10(4):266–279.
3. Germain A, Buysse DJ. Brief behavioral treatment of insomnia. In: Perlis ML, Aloia M, Kuhn BR, eds. *Behavioral Treatments for Sleep Disorders: A Comprehensive Primer of Behavioral Sleep Medicine Interventions*. Boston, MA: Academic Press; 2011:143–150.
4. Edinger JD, Arnedt JT, Bertisch SM, et al. Behavioral and psychological treatments for chronic insomnia disorder in adults: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2021;17(2):255–262.

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REFERENCES

1. Maguen S, Gloria R, Huggins J, et al. Brief behavioral treatment for insomnia improves psychosocial functioning in veterans: results from a randomized controlled trial. *Sleep*. 2021;44(3):zsaa205.

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