A TREATMENT MAP® FOR PATIENTS WITH INSOMNIA

Thad R. Harshbarger, Ph.D.

Introduction

This is a draft of a textbook on the treatment of patients who have insomnia, in the context of ongoing psychotherapy. It may *look* like an article or chapter, but it is actually an online book with more than 40 chapters (all of which are also in draft or outline form) that are accessible through links.

To use these materials, …

- First save the digital form of this Main Section – it contains all the links to text sections. Then print a copy, so you can easily review, make notes, etc.
- Save and print the Checklist, which provides an overview of the map in menu form. A printed copy can be taken into session for quick reminders of choices and treatments.
- Save a copy of the Link List in electronic form – it roughly approximates the Checklist, with direct links to the individual content sections.

Background and Overview

The purpose of this Treatment Map is to have a systematic way to address many of the issues that can come up when a person complains of not being able to sleep. The map is directed to therapists working in general psychotherapy practices, who encounter some patients with insomnia issues.

Here the entire focus is on treating one patient. Theories, general issues, population characteristics, all of these are interesting and may be relevant. But we only bring them in when we need them to help the current patient deal with insomnia.

When we begin with a patient, we generally can't anticipate what he/she needs. We start where the patient is. We work together with each patient to order and understand his/her symptoms, eliminate possible sources of the problem, and refine our understanding of it. A Treatment Map helps with this process. It suggests a reasonable sequence to follow in understanding and eliminating sources of this patient's insomnia, with the goal of better sleep and the benefits that follow.

In this approach, the process of treatment includes both choices and interventions. The traditional medical approach of "diagnose first and then treat" is wasteful and misleading when applied to psychotherapy. We often can't gather all the relevant information at the beginning of treatment, and when we try, we risk misdiagnosing and mistreating, along with the potential for loss of patient motivation. Here, clinical choices and partial or tentative treatments are all stages and steps in the process of helping the patient sleep.

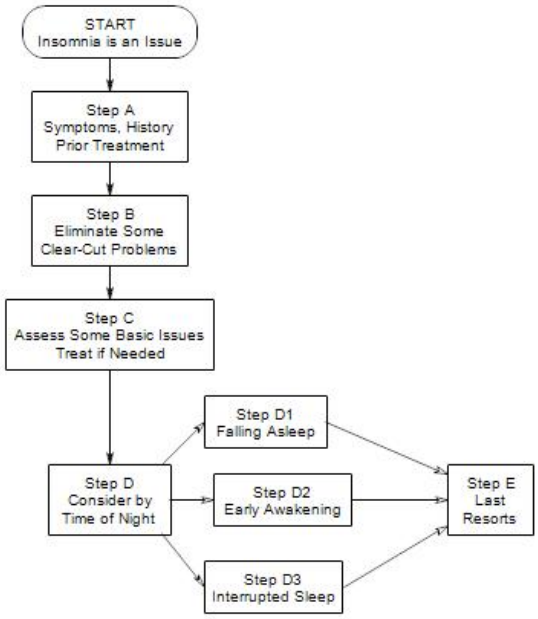
In a Treatment Map, topics are placed in a different order from the order typically encountered in academic texts about clinical work. Rather than create chapters for domains of understanding and theory, the approach here is to create sections on specific diagnostic and treatment issues. There is no chapter on "The scope of the problem." If a patient complains of insomnia, the problem is universal for

that patient. There is no chapter on “Diagnostic Considerations.” Diagnosis here is ongoing and partial. Each step is informative and has a bearing on patient relief.

Instead of chapters, there are two levels of organization to this material. At the broader level, the treatment process is divided into five sequential steps, ordered to reflect their usual order in the therapy of patients. The five steps are

A. Discuss the patient’s insomnia problem (symptoms, history, prior treatment) from the patient’s perspective.
B. Ask about some relatively specific issues that could interfere with sleep (night shift work, variable shifts, Monday morning insomnia, sleep phase disorder), mostly to rule them out. If this is sufficient to resolve the patient’s insomnia, move on to other psychological problems that the person may have.
C. Explore a variety of possible sources of insomnia (medical disorders, life stress, diet, sleep environment, etc.) Arrange to treat any that apply to this patient.
D. If the person still suffers from difficulty sleeping, examine the timing of the patient’s insomnia (falling asleep, waking too early, or interrupted sleep). Narrow the search if possible. Refine your focus to a point that you can try a specific treatment, and see whether it helps. If it doesn’t, there are others; or you may have to re-evaluate the patient’s issue.
E. If none of the work so far has been effective, there are a few additional things to try. If all fails, you may have to refer the person to a sleep specialist.

Graphically, this can be represented as follows:



Each broad step of the treatment process is divided into sections that focus on specific aspects of the process – a section for each choice point and a section for each intervention or treatment component. Sections are numbered, but the numbers are arbitrary place-holders that don’t reflect their order. In fact, the sections may be used in different orders for different patients.

The sections are not included as part of this overview. Instead, they are all online, and you link to each section if and when you want to read it. That way, you can make use of the outline and overview without the distraction of text that you may not need.

At first reading, it may appear that there are a lot of sections here. There *are*, especially by comparison to texts with 8-12 chapters. However, the sections are more focused and less dense than chapters, which should make it easier to negotiate them. It is also easier, once you are familiar with the format, to skip around to useful sections as you choose.

A Treatment Map differs from academic texts in a second way: although it allows for theoretical discussions and historical background information, they are treated as asides to clinicians who want them. These kinds of information may be important, but they are not central to clinical process. Many self-help books eliminate history and theory also, because those books are directed to people with an urgent need for answers. The current version of the map is very short on theory – that will have to be included later on.

This approach differs from academic approaches in a third way: clinical decisions are given equal weight to discussions of treatment techniques. The uses and limitations of a technique are not treated as afterthoughts, mentioned in passing once the technique has been presented. They are integral components of the treatment process. The focus here is not on treatments but on treatment. Choices come before techniques. In the ideal situation, the patient and clinician make several decisions and arrive at only one treatment, which works because it has been carefully chosen.

For a clinician, one additional implication is that you don't need to have all possible treatments in mind at all times you are with patients. Choices are made when they are needed, and the material supports that. Treatment options are suggested at each stage of therapy, depending on what you know and have already considered. Major choices are also made in order, often between sessions.

Because of the organization of materials, this may look like a mechanistic approach to treatment selection. That is not the intent behind it. The goal of this approach is to help find relevant information in a way that matches regular clinical practice. The choices are made by the therapist and patient. That decision process involves many issues that can't be addressed by outsiders, such as…

- Which of the current options are actually relevant and appropriate to this patient?
- What order should you consider the relevant choices?
- What is the likely effectiveness of each of the current options?
- What are possible side effects of each of the options – some of which might be beneficial and some adverse.
- Is there an abuse potential? This might especially be important for medications.
- Is the patient likely to follow through with his/her part?
- What is the risk of failure? For example, might the patient become discouraged?

<u>Organization of Materials</u>

The Insomnia Treatment Map® can be seen as electronic textbook with several steps. This overview is the heart of the textbook, with links to each of the sections of text, references, charts, handouts, and so on. It is relatively sparse. It serves as a reminder for the entire book. You can print out a copy that doesn't take much space, then go back to the electronic version when you need to link to specific sections.

A brief outline can also be printed and taken to sessions, if you like.

Disclaimer:

This map is a draft, not a finished work. It represents a major shift in format from earlier drafts, and it should be easier to use. However, it is far from complete, even in approaching its own goals.

I am a clinical psychologist in private practice, with a major interest in organizing knowledge for the treatment of individual patients. I am not a specialist in insomnia. For both of these reasons, I have relied on secondary and internet sources to produce this manuscript: much of the information is already pre-digested and readily available in other places when you want to learn more. However, the resources I have found elsewhere are often adequate in describing treatment techniques but painfully weak when it comes to choosing among them. The map is designed to help with choices first and treatments when they are appropriate.

It is clear to me that there is still substantial room for improvement. If you find that some of this material is incomplete, or badly organized, or wrong, please let me know so I can extend, correct and improve it.

Thad Harshbarger
Trh4tm@gmail.com

A TREATMENT MAP ® FOR PATIENTS WITH INSOMNIA
MAIN SECTION DRAFT October 2017

Plan for Using This Map

The map is designed to support your work with a patient who has insomnia. With many patients, it should help to follow the map from start through as far as you need to. This isn't a fixed program, however, and it may pay to skip some sections or jump around.

To use the map, Start with Step A. Ask about the person's symptoms of insomnia, then the history of symptoms, any theory about the source or causes, some information about timing of sleep loss, and prior attempts to treat the problem. The sections of Step A should be helpful here.

Often a good place to start is the patient's experience of the night before your session. Gather whatever information you can about it, and go over it together. Section 1 contains some possible questions to get started. You can also suggest that the person keep track of some of the information for the next week.

The following session, follow up on whatever the person has noticed. Then start to explore the issues of Steps B and C, to look for possible sources of insomnia. You can always go back to the symptoms and history of Step A as the person becomes more attentive to them or the overall diagnostic picture becomes clearer to you. Section 1 includes a preliminary sleep log that the person can use to keep track of sleep and related issues.

Continue the Step B and C issues over time. This could happen the next session, or over several sessions, if you are working on non-sleep issues concurrently.

If there are no clear general problems causing the person's insomnia, you can move on to look at treatments relative to the person's type of insomnia – falling asleep, waking early, or interrupted sleep. These are discussed in Step D.

If none of the above is effective, go on to Step E .

Moving On

So much for the introduction and overview. Now we turn to the Map itself.

The map is designed to help in diagnosis and treatment of a single patient, so it is best if you read the materials with a particular person in mind. Follow through for that person, and see where you get to. Or follow the case examples I have provided.

Step A **Initial Approach to the Problem**

To make use of this map, start with a patient – someone who is having difficulty sleeping. Think of that person as you go through the various steps and sections.

The three online sections of Step A present materials that begin to define the patient's sleep problem. If you aren't already familiar and comfortable with them, it pays to refer to them in order.

Section 1
First, you need to understand the patient's concern about insomnia, and gather some basic data on symptoms, timing, and other issues, to get going. Section 1 is intended to address these issues

Section 2
A brief history of the person's insomnia can help start the diagnostic and treatment process. You will need some idea of when it began and what else was happening in the person's life at that time. Has it been continuous or episodic? This can help look for initial causes or sources, which may still be operating. Section 2 also includes discussion on the treatment of situational, stress-related and short-term insomnia.

Section 3
Ask About prior treatment attempts. This information helps you refine the diagnosis and eliminate treatments with drawbacks or unwanted side effects, as well as treatments that aren't likely to work.

Section 4
Review some basic sleep information and common misconceptions. This may be enough for the person to resolve his/her insomnia issues without further treatment.

If the person needs more help, go on to Step B.

Step B Consider Some Specific Issues

Here we begin consideration of chronic insomnia and its possible sources. These sections are in no particular order – they just form a list of issues to consider.

The following issues are could be a problem for some people. For others who don't have them, it's good to drop them from consideration at this point.

- Sunday Night Insomnia or End-of-Holiday Insomnia occurs when a person regularly has a dramatic change of schedule at different times of the week or month, or after holiday weekends. See Section 35
- A person who works a Night Shift may have difficulty sleeping on a different schedule from everyone else. See Section 26.
- If the person works a variable shift, the ability to relax and fall asleep can be compromised at every change of schedule. See Section 31.
- If the person has a sleep phase disorder he/she may become systematically out-of-synch with others, commonly by going to sleep later and later over time. See Section 28.

Step C Next, Look At Some General Issues That Could Be the Cause

These are broad categories of sources of insomnia. They can affect sleep at different times of the night. If one of these is the cause of the person' insomnia, you may be able to resolve the problem and move on to other psychological issues; or the other issues may be resolved when the person is sleeping normally. Our propensity as psychotherapists is to look for psychological sources (anxiety, depression, trauma, etc.) first. But as Jacobs points out, patients may become anxious when they can't sleep and blame the anxiety for their insomnia. The same may be true for other issues.

Listed here are categories of sources of insomnia, to be sure that you check them all. There are many components to each category. Go to the corresponding linked sections for the next level of analysis.

The categories are not necessarily in order. Your best approach is probably to consider them as they arise in a general discussion of the person's insomnia. Then go back to any you have missed as you see fit.

- Many different medical disorders can lead to loss of sleep, because they affect a person's comfort or alertness, or throw the person's schedule off to the point that sleep is disrupted. Section 6 discusses this issue.
- The problem may lie less in the person's medical diagnosis than in medications that he/she is taking to treat it. See Section 7 for more on this.
- Caffeine, alcohol, and other drugs all can have an impact of sleep See Section 8 for more.
- Consideration of the Sleep Environment includes many factors, including light, noise, animals, and other people. See Section 5.
- A person's life stresses can have an impact on his/her comfort, energy level, sleep and general health. This could include special responsibilities – waking with a newborn; an elderly dependent who needs attention in the night; being on-call for work, or working long shifts. See Section 33 for more.
- A person may be awakened by excessive movement during sleep, which could even include kicking the wall, throwing off the covers, or falling out of bed. See Section 12
- Sleep can be affected by what you eat, how much you eat, and when you eat it. Diet is discussed in Section 9
- People who exercise regularly tend to sleep better than those who don't; but it also depends on when they exercise. See Section 23
- A person who naps during the day may not be able to sleep on a normal schedule. See Section 32
- Sleep state misperception (Section 14), is where the person is convinced that he/she is not sleeping but really is getting plenty.
- Many psychological issues can have an impact on sleep, including anxiety, depression and post-traumatic stress. Some of these are discussed in Section 10.

Step D. **Next Look at the Timing of the Person's Sleep Problem**

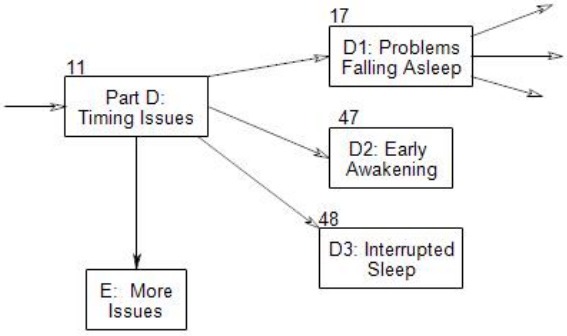
Once you have considered the general issues above without relieving the person's insomnia, consider when the problem occurs.

Most of the remaining treatments are cognitive or behavioral, and they are targeted to specific issues. So we have to clarify before we can treat. This is a time when the sequencing of diagnosis and treatment become more important than before, because the time of night that the person experiences symptoms suggests the choice of treatments that are likely to be helpful.

Sleep timing issues fall into three major categories:

- Problems falling asleep (Step D1)
- Waking too early or too late (Step D2)
- Interrupted sleep (Step D3)

General discussions of these broad categories and deciding among them can be found in in Section 11. Then each broad category leads to narrower choices.



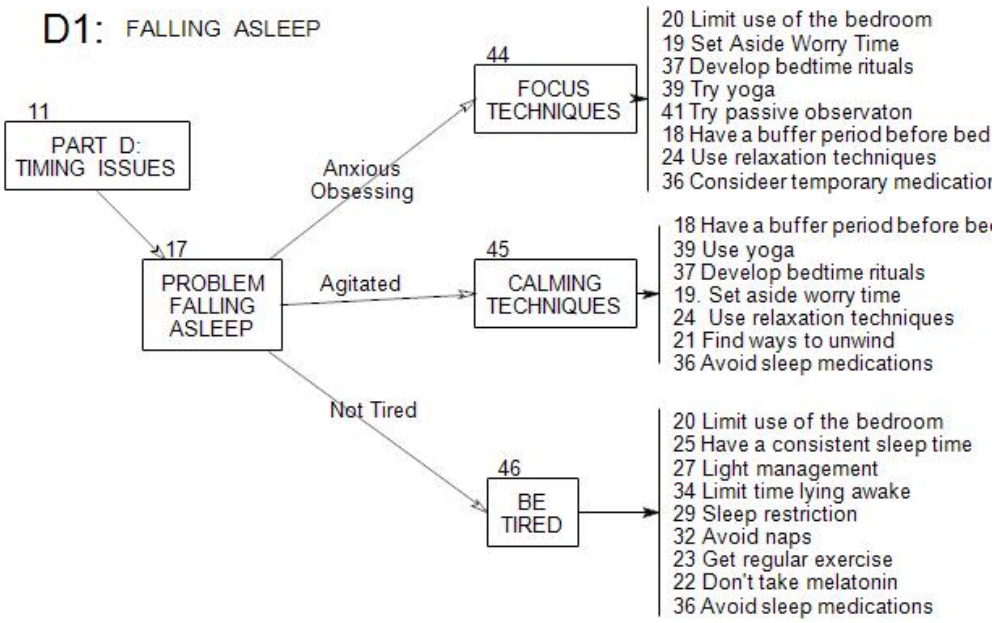
Here four of the boxes on the flow chart are numbered, as a reminder that these decision points are linked to text sections. Section 11 discusses general timing issues. Section 17 discusses different reasons for difficulty falling asleep. Section 47 considers treatments for early awakening, and Section 48 discusses some choices for dealing with interrupted sleep.

Step D1 **Problems Falling Asleep**

There are at least three broad issues in falling asleep, into which most people fall. These require different kinds of treatment, so it is important to determine your patient's issue. The distinctions are discussed in Section 17. For each kind of issue, there are a number of possible treatments, so we will have to branch ahead to select an appropriate treatment for a particular patient.
The three issues are

- Being anxious and obsessing. If this is your patient's problem, Section 44 discusses the choice among possible treatments to focus the patient and reduce obsessing. Some possible treatments are…
    - Limit use of the bedroom (Section 20)
    - Ways to Unwind (Section 21)
    - Develop bedtime rituals (Section 37)
    - Try yoga (Section 39)
    - Try passive observation (Section 41)
    - Have a buffer period before bed (Section 18)
    - Use relaxation techniques (Section 24)
    - Consider temporary medication (Section 36)
- Being energized and physiologically restless but not necessarily anxious and obsessing. For these patients, the choice among calming techniques is discussed in Section 45. Techniques include
    - Have a buffer period before bed (Section18)
    - Use yoga (Section 39)
    - Develop bedtime rituals (Section 37)
    - Set aside worry-time (Section 19)
    - Use relaxation techniques (Section 24)
    - Find ways to Unwind (Section 21)
    - Avoid sleep medications (Section 36)
- Just not being sleepy (Section 46). A person may seemingly have very little to obsess about, and not a lot of energy, and still not be able to go to sleep at a reasonable time. Some possible treatments include
    - Limit use of the bedroom (Section 20)
    - Have a consistent sleep time (Section 25)
    - Light management (Section 27)
    - Limit time lying awake (Section 34)
    - Sleep restriction (Section 29)
    - Avoid naps (Section 32)
    - Get regular exercise (Section 23)
    - Don't take melatonin (Section 22)
    - Avoid sleep medications (Section 36)

The following figure restates the above menus graphically to show choices and treatments to be considered when a person is having difficulty falling asleep.



Here, the box for Section 11 is copied from the more general timing map, and the box for Section 17 deals with the decision about type of issue that keeps a patient from falling asleep.

The boxes numbered 44, 45 and 46 represent decisions about choosing particular techniques to treat more specific issues of being anxious and obsessing, being agitated, or just not being tired.

Other timing issues are discussed next.

Step D2. Waking Too Early

In this case, the person complains of waking far earlier than wanted, and not being able to return to sleep. A number of possible treatments apply here. A discussion of the choices among these treatments can be found in Section 47:

- Adjust schedule (Section 25)
- Limit use of the bedroom (Section 20)
- Deal with morning light (Section 27)
- Stop sleep medications (Section 36)
- Find ways to unwind (Section 21)
- Exercise regularly (Section 23)
- Use relaxation techniques (Section 24)
- Try yoga (Section 39)
- Check bedroom conditions (Section 5)
- Deal with any sleep phase issues (Section 28)

D3. Interrupted Sleep

Some people wake in the night and can't easily or quickly return to sleep. They need help to make changes. Some possible treatments are shown below. The choices are discussed in Section 48 .

Reconsider Part C issues

- Try passive observation (Section 41)
- Interruption management (Section 30)
- Use s leep restriction (Section 29)
- Stimulus Control (Section 34)

Step E. If All Else Fails, Consider These

It is not clear when to consider the remaining issues – one or more of them could come up much earlier than this. The person's problem could be

- Conditioned insomnia (Section 13), where the person has learned to not-sleep even though the original reasons for insomnia no longer apply. The conditioning is out of awareness, and the person consciously wants to sleep.
- Idiopathic insomnia (Section 15), which is part of the person's physiological /neurological system, and the source is possibly even genetic.

Finally, if you have considered all of these possible sources and treatments and the person's problem with sleep continues, you may need to refer the patient to a sleep specialist (Section 16).