Improve sleep with group CBT for insomnia

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For optimal results when leading group CBT-I, be consistent when teaching skills, checking patients' homework, and gaining compliance

Cognitive-behavioral therapy for insomnia (CBT-I) can be effective, regardless of whether chronic insomnia is primary or secondary to psychiatric, substance dependence, or psychophysiologic causes.[1] In fact, with a response rate of 70% to 80%,[2] CBT-I can be as effective as medication in the short term and even more effective in the long term.[3]

Delivered in 4 to 10 sessions, CBT-I typically includes assessment and monitoring of insomnia and sleep patterns, sleep restriction, stimulus control, sleep hygiene education, relaxation training, cognitive therapy, and relapse prevention. Goals are to:

- decrease the time spent awake in bed, thereby increasing sleep efficiency
- strengthen the association between the bedroom and sleep
- address maladaptive sleep habits and lifestyle factors that affect sleep
- remove extraneous stimuli from the bedroom.

Group therapy with CBT-I

At our clinic, we have modified standard CBT-I techniques into a group format that includes patients with other sleep disorders, medical conditions, or psychiatric diagnoses. Also, CBT-I can benefit mentally ill outpatients with persistent secondary insomnia despite adequate hypnotic dosages.

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Challenges to a CBT-I format include: member dropout, inconsistent attendance, disparate psychiatric diagnoses, and different forms of insomnia. In addition, motivating patients to change poor sleep habits that have been in place for decades can be difficult. Finally, CBT-I—although simple in concept—can be difficult to employ, particularly the behavioral components of stimulus control and sleep restriction. Many patients resist these behavioral interventions because they do not experience relief in the short term. Because improved sleep quality frequently is experienced toward the end of treatment, patient motivation and consistency are crucial for success.

For optimal results when leading group CBT-I, be consistent when teaching skills, checking homework, and gaining treatment compliance. Educate patients about CBT-I principles, and help them understand the rationale for what may seem like counterintuitive treatments, such as decreasing time spent in bed. Inform patients that they must practice these skills consistently and stick with the protocol until treatment ends. When patients know the treatment is time-limited and see others in the group begin to benefit, this commitment can seem less daunting.

References

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