Consider CBT in Cases of Secondary Insomnia

BY JANE SALODOF MACNEIL
Senior Editor

SCOTTSDALE, ARIZ. — Cognitive-behavioral treatments can help people overcome chronic insomnia, even when a medical or psychiatric disorder appears to be the primary cause of sleeplessness, Edward J. Stepanski, Ph.D., said at a meeting on sleep medicine sponsored by the American College of Chest Physicians.

Traditionally, behavioral treatments have been reserved for primary insomnia and not recommended for people whose lack of sleep is secondary to other conditions, said Dr. Stepanski, vice president for scientific affairs of the Accelerated Community Oncology Research Network (ACORN) in Memphis, Tenn.

The underlying assumptions—both of which he challenged—are that insomnia will remit if the primary condition is resolved and that cognitive-behavioral treatment (CBT) approaches will not be effective against an etiology such as pain or depression. People continue to sleep poorly after successful treatment of posttraumatic stress disorder, he said, and randomized controlled trials have shown that people with a primary condition such as arthritis or chronic obstructive pulmonary disease can sleep better after CBT.

"Use [CBT] in any chronic insomnia," Dr. Stepanski said, suggesting comorbid insomnia would be a better name than secondary insomnia when diagnosed in patients with other conditions. "CBT has its place," he said. "There are always behavioral and cognitive features to a chronic patient with insomnia."

For most patients, he recommended that behavioral treatments come before cognitive therapy. Many worry that they will have a mental breakdown or lose their jobs if they don't get more sleep. Once they are sleeping better, he suggested they may be more open to cognitive restructuring—in particular, to considering how their lives would be different without insomnia. Not everyone will embrace the possibility.

"If every failure in their entire life is due to insomnia, they are not going to give that up," warned Dr. Stepanski. "Some personality disorder patients don't really want help."

For insomniacs who do want better sleep, he recommended trying a variety of behavioral treatments, as there is no way to predict which would be the most beneficial to a particular patient. These include:

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DR. STEPANSKI

► **Sleep hygiene education.** For example, telling patients that they can't drink coffee before bedtime or nap 3 hours in the afternoon and then expect to sleep through the night.

► **Stimulus control therapy.** The patient should only go to bed when sleepy and not use the bedroom for activities, such as television viewing or aerobic exercises, that are incompatible with sleep. If the patient can't sleep, he should get up and leave the bedroom. "If you force yourself to lie in bed wide awake, you are doing damage to yourself. [There's] nothing else to do but ruminate and catastrophize," he said.

► **Sleep restriction therapy.** The goal is to use partial sleep deprivation to increase homeostatic sleep drive. Use a sleep log to reduce time in bed to the amount of time the patient actually sleeps. Five hours of good sleep is better than 8 hours of intermittent sleep, said Dr. Stepanski: "Excess time in bed is death to normal sleep."

► **Relaxation training.** Examples include progressive muscle relaxation, guided imagery, biofeedback, and self-hypnosis.

As none of these techniques work quickly, Dr. Stepanski said practitioners should devote time early on to educating, reassuring, and encouraging patients—and preparing them for relapse. Patients "must understand the rationale for the treatment approach," he said. "Sleep is a biological rhythm. It doesn't change right away."

Medication works faster than CBT, but is not as effective, said Dr. Stepanski. Combining the two approaches can relieve panic about sleep deprivation while giving CBT more time to work. Studies have shown, however, that CBT alone is more effective than CBT combined with medication. ■