Introduction: Awaken to Sleep

Sleep, that knits up the ravell’d slave of care,
The death of each day’s life, sore labour’s bath,
Balm of hurt minds, great nature’s second course,
Chief nourisher in life’s feast.

–William Shakespeare
(Cook, 1999)

The restorative importance of sleep has long been appreciated. But now modern medical science is emphasizing that sleep is not merely important, it is the cornerstone of human health, longevity and well being. Yet sleep problems are estimated to be the number one health issue in the United States today (Breus, 2006). In fact, some sleep experts assert that sleep problems constitute the major health concern in the industrialized world (Naiman, 2008).

At least 70 million Americans have some difficulty sleeping, and upwards of 20 million are thought to suffer from sleep apnea.

Nearly two-thirds of fatal auto accidents are associated with driver sleepiness. Two hours less sleep than normal can impair functioning equivalent to 2-3 alcoholic drinks, while being awake for 24 hours has the same detrimental effect on driving ability as 0.10 BAC (Blood Alcohol Content) which is enough to be charged with driving while intoxicated in most states (Epstein, 2007).

Losses to industry are in the billions of dollars annually due to sleep loss. Human error in relation to night shift work and excessive sleepiness was implicated in the Bhopal, India, chemical accident, the Exxon Valdez oil spill, the nuclear accident at 3-Mile Island, and the reactor meltdown at Chernobyl in the Ukraine.

Loss problems are thought to have adverse effects on the body’s inflammatory processes, digestive hormones, stress chemicals, immune system function, insulin regulation and blood pressure (Stein, 2005). Short sleep duration is also associated with coronary artery calcification, obesity, diabetes, colon and breast cancer, heart disease and stroke (King, 2008).

But it is the corrosive effect of sleep loss on mental health and well being that is the major concern of this course. Even in healthy subjects, sleep deprivation has been shown to cause emotional instability and pathological psychiatric patterns (Anderson, 2007). Recent research shows that adolescents with insomnia are at greater risk of somatic and psychological problems (“Chronic Insomnia,” 2008). Poor sleep and insomnia often go untreated in mental health patients and may contribute to or worsen mental illness (“For Mental Health,” 2008).

According to Dr. Michael Perlis, Director of the University of Rochester Sleep Research Lab, the evidence with respect to psychiatric illness is clear and compelling. Patients with persistent and untreated insomnia are at between 2 and 10 times the risk for new onset or recurrent episodes of major depression. There is also good evidence that insomnia is a risk factor for the development and/or recurrence of anxiety disorders and substance abuse (Perlis, 2004). Approximately 80% of people with mental health problems also suffer from insomnia, and the comorbidity with clinical depression runs as high as 85%. Contrary to the long-standing view that insomnia is symptomatic of and secondary to depression, sleep science is now asserting that insomnia is also a major cause of clinical depression (Naiman, 2006). The National Sleep

Learning Objectives

1) To conceptualize the role for clinical social workers, apart from but in collaboration with sleep medicine professionals, in which clients experiencing insomnia and poor sleep are helped directly during the normal course of clinical social work practice;

2) To understand the behavioral nature of insomnia and be able to apply one or more behavioral, cognitive and sleep hygiene interventions to help clients sleep better;

3) To be able to work with clients around the application of sleep efficiency in behavioral insomnia treatment, including the use of the Sleep Efficiency Form, and to be able to administer one or more relaxation, stress reduction and sleep induction protocols.
Foundation (NSF) (www.sleepfoundation.org) describes this relationship as “bi-directional.”

This knowledge brings the Social Work Profession to a new clinical crossroads where social workers are challenged to conceptualize and treat mental health and sleep issues as bi-directional and equally worthy of best-practice interventions. The “new” social work practice will have increased awareness of the insidious role that insomnia and poor sleep play in the lives of clients, and will more boldly target and competently treat insomnia along with the other psychosocial maladies that have been and remain the object of social work interventions. Social workers and clients alike will, hopefully, become more aware of sleep issues and value the importance of good sleep in this sleep-depriving age.

Merely offering clients good counseling and psychotherapy enhanced with relaxation training and stress reduction skills in the hope of improved sleep is insufficient without also directly targeting the sleep hygiene, behavioral and cognitive components of insomnia generally referred to as the cognitive-behavioral treatment for insomnia (CBT-I). This is due to the fact that insomnia, unlike the more than 80 medically-related sleep disorders, has powerful behavioral underpinnings that respond well to CBT-I methods. Major studies have shown CBT-I to be more effective than medication in both the short and long term (Jacobs, Pace-Schott, Stickgold & Otto, 2004). Further evidence of the behavioral foundation for insomnia and the appropriateness of non-medical, behavioral treatment lies in the fact that polysomnography (PSG), or sleep study, is not indicated for making a diagnosis of insomnia like it is with most all other medically-related sleep disorders.

Merely a decade ago, medical students received about two hours of sleep education. The 2009 NSF poll found that fewer than one-third of patients have initiated discussion with their physician about their sleep problems, and fewer than two-thirds have ever been asked about their sleep by a physician. When sleep problems are discussed, the result is usually a prescription for sleep medication. In 2005, 43 million prescriptions for sleep meds were written by physicians. Sales projections by 2010 are $5 billion annually.

According to a January 23, 2009, National Sleep Foundation Alert, one in four Americans take some kind of sleep medication, and they are admonished by the NSF to focus instead on improving their sleep practices through behavioral approaches. The NSF Alert referenced the January 16, 2009 release of the Thomson Reuters Study reporting on an alarming three-fold increase in the use of prescription sleep aids by 18 to 24-year-olds between 1998 and 2006. During this same period, prescribed sleeping pill use among adults under the age of 45 increased 50 percent. Two of the sleep aids used by this population--AmbienCR and Lunesta--accounted for nearly two-thirds of all the sleep medication taken. Interestingly, these very same drugs have been proven in recent studies by Edinger, Jacobs, et al, to be far less effective than the cognitive-behavioral treatment (CBT-I) for insomnia (Jacobs, 2007). What a stunning irony and sad commentary on the efficacy of medically-based insomnia treatment.

A thorough discussion of sleep medication would need to address many levels and dimensions of the issue such as the role of “big pharma,” expediency for the health care delivery system, medica
cal education, actual efficacies, etc. For example, sleeping pills shorten sleep latency (the time it takes to fall asleep) on average by only ten minutes, and some popular sleep meds actually create amnesia for awakenings during the night to mask broken sleep (Naiman, 2008). An eye-opening and provocative online resource is Dr. Kripke’s website (www.darksideofsleepingpills.com).

The American Academy of Sleep Medicine (AASM) offers board certification for MD’s in sleep medicine. The writer has professional relationships with two such “sleep docs” where one is a pulmonologist and the other a neurologist. They both have acknowledged their difficulty in treating insomnia medically and appreciate being able to make referrals for behavioral intervention. Likewise, the writer has made numerous referrals to these sleep docs after the counseling relationship with clients revealed tell-tale signs of sleep apnea. Every referral to date has resulted in a medical diagnosis, confirmed in the sleep lab by polysomnography (PSG), of a breathing-related sleep disorder such as obstructive sleep apnea (OSA).

The AASM has also offered board certification in Behavioral Sleep Medicine to MD’s and PhD’s since 2003. Often referred to as “sleep specialists,” these clinicians work with a range of medical sleep disorders and can apply CBT-I techniques to insomnia. Sleep specialists are quite few in number and located mostly in large, urban medical and sleep centers. Accordingly, their clinical value is high but their influence is minimal in relation to the large number of sleep sufferers who could benefit from their skilled help.

The information highlighted in this introduction builds a strong case for a greater role to be played by non-medical psychotherapists and counselors in the behavioral treatment of insomnia and poor sleep. This course will continue to demonstrate that behavioral insomnia treatment and sleep improvement intervention are well within the scope of clinical social work practice. This gaping service need presents an enormous opportunity for the social work profession to take the lead. If we don’t, others will. The author asserts that clinical social workers not only have the ability to help our clients sleep and feel better, but the obligation to do so. This course represents a step forward.

Who’s Who In Sleep

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Biology of Sleep

It is not even known for sure why we sleep, but it appears related to cell and tissue growth and repair along with memory consolidation and learning. Human growth hormone, for instance, is secreted during NREM (Non-Rapid Eye Movement) deep sleep when heart rate, blood pressure, respiration, temperature and brain wave activity are all dramatically lowered. REM (Rapid Eye Movement) sleep, however, is characterized by brain wave activity, heart rate and breathing approximating the fully wakeful state with nearly total loss of muscle tone. This paralysis prevents the acting-out of dreams that, otherwise, could cause injury.
Sleep architecture refers to the details of a night’s sleep including the time it takes to fall asleep, the amount of time spent in sleep stages 1-4 (NREM) and stage 5 (REM), the number of momentary sleep interruptions and the length of awakenings. We sleep in about five 90-110 minute cycles with a greater proportion of NREM deep sleep (stages 3 and 4) in the first half of the night and more REM dream sleep toward morning.

Even though our circadian rhythm slightly exceeds a 24 hour cycle, light and activity continually reset our biological clocks. Onset of darkness triggers melatonin production to induce sleep by lowering body temperature and blood pressure. Light stimulation at night, however, inhibits the secretion of melatonin necessary for sleep. Caffeine not only stimulates adrenaline to oppose sleep but it also binds to adenosine receptors in the brain to prevent the sensation of tiredness (Fisone & Borgkvist, 2004).

Cultural Insomnia

The industrial revolution followed by Thomas Edison’s 1879 invention of the light bulb transformed American life. One result of electric light was the gradual extension of day into night allowing greater productivity but less sleep in both quantity and quality. Not only has the amount of sleep decreased from about 8 1/2 hours to 6 1/2 hours over the last 50 years, but our approach to sleep has also changed. No longer do we spend evening hours in gentle candle or lamp light winding down from the day by reading, letter writing, doing light chores or craft work, music playing or story telling.

Instead of becoming less active under low light to gradually prepare for sleep by lowering adrenaline and increasing melatonin levels, we now continue the rat race in the evening and/or expose ourselves to melatonin-inhibiting light stimulation including television and electronic devices. Chemical stimulation like caffeine, sugar and high fructose corn syrup give us “counterfeit energies” to fuel our activity addiction throughout the day and into the night so that, as Dr. Rubin Naiman remarks, “half-awake in our sleep and half asleep in our waking, we are never completely at rest and seldom fully conscious (Naiman, 2006).”

After ignoring Nature’s urging at dusk to slow down and get ready for sleep, we continue to go for the gusto until adenosine levels and sleep need prevail. Reluctantly, we finally surrender to the temptation of the light bulb, which will keep us from being overtired or staying asleep and feel refreshed after sleep. Daytime impairment may include fatigue, irritability, depression, memory and concentration difficulties, decreased interest, energy and libido. This modern and behaviorally-based, biopsychosocial affliction is called insomnia.

Insomnia Defined

Primary or “psychophysiologic” insomnia is now considered to be a distinct diagnostic entity whereas secondary insomnia is symptomatic of an underlying medical or psychiatric condition. An underlying condition might be depression, pain, diabetes or menopause. Almost everyone experiences a few nights of transient insomnia now and then, or even a week or two of short-term or acute insomnia. But duration of a month or more qualifies as chronic insomnia. The average person with chronic insomnia has suffered for at least 10 years. Often the precipitating event or stressor has been long forgotten and classical conditioning effects reinforce and maintain the state of heightened physiologic arousal that prevents sleep and is so characteristic of chronic insomnia.

An amalgam of the many definitions of insomnia issued by various professional entities including the AASM, WHO (World Health Organization) and DSM-IV is as follows:

*Primary insomnia is a psychophysiologic disorder of somatized tension and learned sleep-preventing associations resulting in problems with initiating and/or maintaining sleep on at least 3 nights a week with complaints of non-restorative sleep and associated distress or impairment in mostly mood and energy during the hours of wakefulness.*

The author uses a profoundly simple working definition that captures the essence of insomnia: Unsatisfying sleep with daytime impairment and sleep efficiency < 85%.

Many prominent sleep specialists in recent years have demonstrated the efficacy of using cognitive and behavioral (CBT-I) interventions for both primary and secondary insomnia since research has shown even secondary insomnia to have behavioral components that are responsive to CBT-I. Of course it remains important to make sure that the underlying medical and/or psychiatric conditions are diagnosed and treated.

The author is convinced that these effective behavioral treatments can also benefit clients experiencing sub-clinical manifestations of insomnia where a diagnosis of insomnia might not fully apply due to lower frequency of poor sleep or less intensity of impairment (suffering). Most clients understandably are unknowing about the sleep paradoxes and behavioral traps that can rob them of more satisfying and restorative sleep. In the clinical setting it is incredibly rewarding to be able to help almost all clients experience better sleep regardless of the absence of a formal diagnosis of insomnia. This manner of intervention can be referred to as general “sleep improvement” or “sleep improvement training.” Clinical social work has an opportunity to include in its scope of practice both behavioral insomnia treatment and sleep improvement training.

Insomnia can, and often does, coexist with medical sleep disorders such as obstructive sleep apnea (OSA). It is important to know that many women with OSA present with symptoms of insomnia instead of the loud snoring which men often present. This one point demonstrates the importance of becoming more familiar, over time, with some of the common medical sleep disorders so that clients can be appropriately referred to a sleep clinic for medical evaluation and treatment.
(http://www.sleepfoundation.org), however, simply asking clients how they slept the night before, or if they are satisfied with their sleep, may be enough to identify sleep as problematic. Asking clients if they have trouble falling asleep, staying asleep and feeling refreshed after sleep further refines an assessment of insomnia. Finally, inquiring into any significant daytime distress or impairment such as feeling tired and fatigued, depressed, irritable, unproductive or anxious, may further substantiate an assessment of insomnia.

The tiredness and fatigue, as opposed to sleepiness, caused by insomnia results from the hyper-arousal and over-stimulation that preclude sleep. Excessive daytime sleepiness appearing as napping, dozing or nodding-off is not characteristic of insomnia like it is of sleep apnea and narcolepsy. In fact, most insomniacs can’t nap when they try. This is all due to the heightened state of arousal that prevents sleep from happening—day or night.

Medical Sleep Disorders

It is impossible and largely unnecessary to discuss here the more than 80 medical sleep disorders. Unlike behavioral insomnia treatment and sleep improvement training, the medical aspect of sleep disorders is, of course, beyond the scope of clinical social work practice. For purposes of making helpful and appropriate referrals to sleep medicine, however, it is useful for social workers to gain a working knowledge of the most common comorbid medical sleep disorders frequently identified during work with clients. This knowledge can be gradually acquired over time. Remember, most of these clients would not otherwise seek help or be helped with their insomnia and poor sleep were it not for your willingness to try to help them sleep and feel better. You don’t need to know it all!

Medical sleep disorders of particular interest include narcolepsy, periodic limb movement disorder, restless legs syndrome, parasomnias such as sleep eating and walking, REM sleep behavior disorder and nightmares, and circadian rhythm disturbances. But it is because of the prevalence and seriousness of the breathing-related sleep disorders, especially obstructive sleep apnea (OSA), that the remainder of this section will be devoted to discussion of OSA.

“In all of medicine, I can’t think of a single other serious condition that is so common, life-threatening, treatable, and yet so unrecognized,” says Dr. William Dement, pioneer in sleep medicine (Dement, 1999). Nearly 40 percent of the population has some sleep apnea and half of that number have a clinically significant disorder contributing to more than 38,000 fatal heart attacks and strokes annually, plus many more auto crashes and other accidents. OSA affects about twice as many men than women and the most common trait is excess body weight and thick neck. The risk for OSA increases with weight and there is a very high risk of OSA among the morbidly obese (Schenck, 2007).

Obstructive Sleep Apnea

Symptoms of OSA include loud snoring, gasping or choking, repeated breathing cessation, labored breathing and snorting sounds, dry mouth and/or headache in the morning, unrefreshed sleep, excessive daytime sleepiness, moodiness, impaired concentration/memory and high blood pressure. Other OSA risk and worsening factors include menopause, thyroid problems, enlarged tonsils and adenoids (especially in children), deviated septum, alcohol ingestion before sleep and weight gain. Although OSA affects over 2 million adult women and more than 4 million men, it is far more prevalent in postmenopausal women affecting one in ten (Kryger, 2004). Women complaining of insomnia to their physician are often treated for depression without investigation of possible sleep apnea.

One of the reasons that OSA is so harmful is that the sufferer may actually stop breathing up to hundreds of times during the night. Carbon dioxide builds up while blood oxygen levels drop dangerously low each time signaling the brain to increase blood pressure and wake up the individual. These numerous brief arousals, not known to the OSA sufferer, continually fragment sleep throughout the night causing unrefreshed sleep and daytime sleepiness which can be severe and hazardous.

The author suspected possible OSA in a 62-year-old overweight woman who sought psychotherapy for marital conflict, depression and memory loss. Although snoring was absent, she experienced morning headaches after unrefreshing sleep, excessive daytime sleepiness, and was taking medication for hypertension. The client readily agreed to, and followed through with, a sleep clinic referral largely because the author had a positive professional relationship with the sleep doc and could explain the process and support the client throughout. Otherwise, clients often resist sleep studies and put them off similar to colonoscopies and other unpleasant procedures. Polysomnography (PSG), or sleep study, revealed highly fragmented (and, therefore, unrefreshing) sleep due to hundreds of arousals (unknown to the client) during the night when her blood oxygen levels dropped precipitously. The study also indicated zero minutes of REM sleep (important for memory consolidation and learning) that helped to explain why this “depressed” client complained of memory problems.

The precipitous drop in blood oxygen levels referred to above requires further explanation because it is the main reason OSA increases heart attack and stroke risk. This client’s first PSG noted “severe (oxygen) de-saturation of 68%” at the lowest during sleep, plus “severely fragmented” sleep averaging 48 arousals per hour yielding a sleep efficiency(SE) of only 71% (vs. 95% optimal SE to be discussed later). Her normal or basal oxygen level was already low at 88%. Her second sleep study where positive airway pressure (CPAP) was applied, showed a steady oxygen saturation above 90% never dropping below 88% indicating a huge improvement. The author’s modest knowledge of OSA combined with a good relationship with sleep medicine worked to produce a life-altering, if not life-saving, intervention for this client during the normal course of counseling and psychotherapy.

There are numerous self-tests available for insomnia and sleep apnea screening as well as other medical sleep disorders. The NSF website (www.sleepfoundation.org) offers some downloadable forms. Other brief screening tools include the Apnea Quick...
Sleep Hygiene

Sleep hygiene suggestions abound these days in the media but most descriptions are incomplete or inaccurate to some degree. The “Ten Tips for Better Sleep” client handout presented here not only includes important sleep hygiene education, but it also briefly explains some of the sleep science behind the recommendations. These simple explanations do not usually accompany the sleep hygiene suggestions that appear in magazines and on the internet. Accordingly, this client handout provides an extra measure of education and can be used as a teaching tool and stimulus for discussion in counseling with individuals or groups, or in community presentations and workshops.

Some clients will want to ignore one or more items on the Ten Tips sleep hygiene handout and pick-and-choose the hygiene tips that they agree with or find easier to accomplish. Dieters and “recovering” clients tend to do the same thing regarding selective participation in their food plan or program, not yet ready to surrender to 100 percent adherence. No matter how carefully worded, sleep hygiene guidelines are really rules—not recommendations. Failure to comply with even one critical item, such as tip #1, virtually precludes sleep success no matter how closely the other tips are followed.

Do’s and don’ts lists are unpopular with many people. But when it comes to sleep, clients should be reminded that their own attempts to fix their broken sleep are largely responsible for causing and/or perpetuating their insomnia. Dutifully and diligently following the Ten Tips prescription for sleep combined with other cognitive, behavioral and relaxation methods contained in this course, will afford clients vastly improved sleep and freedom from insomnia in most cases.

One third of the sleep tips contained in the Ten Tips sleep hygiene handout relate to light. This reflects the important relationship of light with sleep, the technical aspects of which will not be discussed here beyond the fact that sufficient early morning light exposure promotes sleep about 16 hours later and evening darkness promotes sleep by triggering melatonin production to lower body core temperature and blood pressure. Since light has such powerful effects on our circadian rhythm, artificial light can be used therapeutically to influence the sleep cycle. Conversely, light-at-night (LAN) can not only damage sleep and have adverse health effects, but is now thought to be a cause for breast cancer in women. For these reasons, the study of LAN is becoming increasingly more important.

Clients may be tempted to sleep later the next morning when their allotted sleep time (the amount of time devoted to sleep or trying to sleep) or sleep quality has been diminished the night before. Doing so, however, will only tend to reduce their sleep pressure (the homeostatic sleep drive system based upon prior wakefulness) and their need for sleep the next night. This virtually guarantees that the client will experience two successive nights of insomnia instead of just one! And these two nights could be the start of, or the return to, a lifetime of insomnia.

The reader can see just how fragile quality sleep is and how it needs to be nurtured and protected in order to give us the restoration we expect from sleep day after day. Taking sleep for granted is a luxury some people can afford. The vast majority of us, however, will suffer the ill effects of insomnia and poor sleep for doing so.

Ten Tips for Better Sleep

(Improved Sleep Hygiene Is Essential To Overcoming Insomnia)

1. Try to maintain a regular sleep schedule by getting up at the same time every morning and avoiding sleeping in on weekends. This practice will “anchor” your sleep schedule and become the foundation for your new and reconditioned sleep pattern.

2. Develop a 30 minute pre-sleep routine for mind and body to wind down from the stress and activity of the day. Reduce mental, physical and sensory (light and noise) stimulation. Soothing music, relaxation and meditation exercises, or pleasure reading may be helpful. Avoid bright light all evening and melatonin-blocking blue light from computer and television displays for at least 30 minutes preceding bedtime.

3. Bed should be used only for sleep and sex. Other activity weakens the association of bed with sleep. Ideally, this means no television, computer, texting or talking on the phone, no home or office work, and no eating or drinking in the bed or bedroom. A quiet, darkened, cool (≤ 68°F.) yet comfortable room that feels safe is very important.

4. Bed partners and pets may seem to promote a sense of comfort and well being, however, they may also contribute to shallow and disturbed sleep that can rob your rest. Decide what is truly best for your sleep and health, and make any necessary changes.

5. A 30-45 minute dose of early morning light is vital to maintaining your natural sleep/wake (circadian) rhythm and promoting sleep readiness 16 hours later. Walking the dog, doing outside chores and exercise, or eating breakfast by a window may help satisfy this need for bright light stimulation early in the day.

6. Regular exercise is critical for heart and brain health, emotional well being, weight control, stress management and sound sleep. Morning exercise is fine but exercise 3 to 6 hours before bedtime is optimal for relaxation and lowering of body core temperature to promote sleep.

7. Eating and drinking close to bedtime can interfere with falling and staying asleep. A light snack (≤ 150 calories) of complex carbohydrates may suffice before bedtime or if hungry during the night. Avoid stimulants like caffeine, sugar, high fructose corn syrup and nicotine, especially later in the day.

8. The half-life of caffeine is generally 3 to 6 hours and longer for some people who are especially sensitive to its effects. Alcohol
close to bedtime actually lowers melatonin production, increases adrenaline and disrupts sleep throughout the night. OTC sleep aids and prescribed medication are no substitute for these sleep hygiene recommendations.

9. Do not watch the clock during the night. Remove or turn the clock(s) around so that you can not tell the time. Set the alarm to quell any fear of over sleeping and to ensure your regular sleep schedule. Estimate your time awake for the Sleep Efficiency Form.

10. Napping correctly can be very healthful but ONLY after having successfully reconditioned your sleep using these and other advanced behavioral techniques. Then, and only then, a 20-30 minute nap half way through the day will be refreshing without damaging your sleep at night.

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**Sleep Efficiency**

A useful concept in the behavioral treatment of insomnia is that of sleep efficiency, or the relationship between the time spent in bed trying to sleep and the amount of time actually spent asleep, in percentage terms. For example, if a client goes to bed at 11 pm and rises at 7 am but only sleeps a total of 6 hours due to difficulty falling asleep and staying asleep, the sleep efficiency would be 75% and represented as follows:

\[
\text{Sleep Efficiency} = \frac{\text{6 Hours: Total Sleep Time (TST)}}{\text{8 Hours: Time in Bed (TIB)}} \times 75\%
\]

A sleep efficiency of 100% would seem indicative of a perfect sleeper. But that would also mean a sleep latency period (the time it takes to fall asleep) of zero. Taking less than ten minutes to fall asleep, however, is usually symptomatic of sleep deprivation or excessive sleep debt indicating a need for longer duration nightly sleep: hardly the sign of a perfect sleeper! It should take at least 10 minutes to fall asleep. Clients with sleep onset insomnia usually take longer than 30 minutes to fall asleep.

The concept of sleep efficiency can be taught to clients and many will embrace the idea, especially the “Type-A, activity-addicted, workaholic, racing, over-achieving, multi-tasking, hyper-stimulated, all-or-nothing, super hero, go for the gusto, do-it-yourself, jazzed and juiced, caffeine junkie” types whose personality and life styles predispose them to insomnia. Since our culture largely de-values sleep, many clients we see for sleep concerns believe that sleep is a waste of time anyway; so the opportunity to work on improving their sleep efficiency often seems like a good idea to them.

But some clients, as will be discussed later, perpetuate their insomnia and poor sleep by believing that lying in bed awake when unable to fall asleep is, at least, restful and better than nothing. Even though they may be unable to sleep, it seems to them that they are benefiting from rest which is second-best to sleep. Little do they know how wrong they are and how they have fallen victim to a classic insomnia paradox: their own attempt to fix their broken sleep results in worsening their insomnia.

It is very important that clients be disabused of this sleep-sabotaging belief that when they can’t sleep staying in bed at least affords some necessary rest, without which they would suffer even greater distress. For a client with chronic/severe insomnia, every minute spent lying awake in bed conditions the brain to associate bed with not sleeping.

That is why clients are urged to get out of bed initially when they haven’t fallen asleep within 30 minutes and thereafter upon awakenings of 15 minutes duration, and to repeat this procedure as often as necessary throughout the night. This method, originated by Dr. Richard Bootzin, will be explained in the upcoming Behavioral section (Bootzin, 1972).

The Sleep Efficiency Form included in this course is a novel way to monitor sleep for quality and quantity. This form is for one night’s use; a weekly form is also available from the author upon request.

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**Behavioral Strategies**

The first intervention to be discussed is the “stimulus control” technique originated by Richard Bootzin, PhD. Stimulus control has proven efficacy and is judged by sleep medicine to be a “monotherapy” or stand alone intervention (Morin & Espie, 2004).

Clients are advised that when sleep has not come within 30 minutes of wanting to fall asleep (allotted sleep time) or within 15 minutes after having had an unwanted awakening during the night, then they are to get out of bed and retire to another room. There, under very low light, they are advised to engage in a relaxing, non-stimulating activity of some kind until they become very sleepy. This may include pleasure reading, comforting craftwork, listening to soothing music or, preferably, practicing a relaxation or sleep induction procedure from the list of possibilities to be presented later.

When sufficiently sleepy, clients may then return to bed to see if sleep arrives within the next 15 or so minutes (estimated time without clock-watching). If not, the procedure is repeated again and again as often as necessary throughout the night. Carrying-out this protocol can be grueling for clients, making therapist support especially important. For clients really committed to this discipline, rewards can be rapid and substantial with sleep improvement experienced within a matter of days. Permanent use of stimulus control for insomnia will initially lead to reconditioning of sleep and then protect against relapse.

Initial use of the Sleep Efficiency Form is a helpful compliment to stimulus control in that progress can be clearly seen and reinforced, and any additional problematic aspects of sleep can be discerned. For example, if there is any significant amount of time between A and B on the Sleep Efficiency Form, examining item #3 on the Ten Tips sleep hygiene handout would be appropriate. Nothing other than sexual activity is encouraged in bed, especially early on in the sleep reconditioning process.

Clients should be reminded of tip #9 on the Ten Tips sleep hygiene.
handout. The initial 30 minute sleep latency period and any subsequent 15 minute awake periods during the night are to be estimated without looking at the time. This is really important because time awareness can trigger sleep-defeating cognitions like “I’ve got to get to sleep; is that all it is; I can’t stand this; I’ll be no good tomorrow.” These negative sleep thoughts can fuel hyper-vigilance, hyper-arousal and anxiety that prevent sleep.

The second behavioral strategy is derived from Dr. Arthur Spielman’s Sleep Restriction Therapy approach that has also withstood the test of time along with stimulus control. (Glovinsky & Spielman, 2006). There are many variations of this approach and “sleep restriction” is somewhat of a misnomer because what is being restricted is not sleep but sleep opportunity to more closely match the actual time asleep, thus increasing sleep efficiency. Other names for sleep restriction are sleep scheduling and sleep compression.

If a client’s Sleep Efficiency Form completed for one week yields a SE score of ≤ 85%, then this would indicate that the client is spending a little too much time in bed awake relative to the time asleep. Compared with good sleepers who average ≥ 90% sleep efficiency, poor sleepers average only 65% SE. A client with a sleep efficiency of 65% is spending way too much time in bed awake relative to the time asleep.

In the use of sleep restriction, the client would be advised to reduce the time in bed to more closely match the total sleep time. This would immediately increase sleep efficiency yet the client would be sleeping no more or less than before. Although there is some disagreement among sleep specialists, the minimum time in bed recommendation ranges from five to six hours. Dr. Jacobs notes that “core sleep” equals 5.5 hours and is comprised of 100% NREM deep sleep and 50% REM sleep. Core sleep (5.5 hours) can be sustained nightly for long periods of time without negative health or adverse effects (Jacobs, 2007).

Since core sleep is 5½ hours and the average insomniac sleeps 5¾ hours, 6 hours is recommended as the minimum starting point to use for sleep scheduling as long as the time in bed (TIB) is somewhat longer (7½, 9 hours, etc.). Some sleep specialists recommend starting at 5 hours if clients are only getting 3 or 4 hours sleep due to very severe insomnia (Glovinsky & Spielman, 2006). Clients should be advised that, even though their actual sleep time will not be shortened at all, they may feel more tired during the day and should take appropriate precautions for the first few days.

After one week of ≥ 90% sleep efficiency, time in bed can be increased by a 15 or 30 minute increment for another week. This weekly upward titration can continue incrementally as long as SE remains about 90%. Should SE drop below 85% for the week, then time in bed gets adjusted downward by the same amount that it was previously raised.

Using 30 minutes as the increment for weekly upward titration is particularly helpful when clients are struggling with severe insomnia symptoms during the day. In this way, the optimal time in bed while maintaining ≥ 90% sleep efficiency will be arrived at in half the time it otherwise would using 15 minute increments. The shorter increments can be useful, however, in “fine-tuning” the optimal time in bed toward the conclusion of this sleep compression intervention. The entire process can take several weeks or longer. When it typically takes less than 10 minutes to fall asleep at night and/or awakening in the morning rarely occurs before the alarm, 15 minutes should be added to the allotted sleep time, to reduce the sleep debt, as long as SE remains around 90%.

This technique relies on the daily wake-up time remaining the same to serve as an “anchor” for effective sleep scheduling. For example, if the SE Form indicates that six hours would be a good starting TIB (time in bed) and the client wants to get up at 7am, then the suggested bedtime would be 1am. This new bedtime might be an hour or two later than the bedtime to which the client is accustomed and this new bedtime suggestion might be met with surprise or disapproval. A typical client reaction is, “I can’t do that: I won’t get enough sleep!” This probably means that the client is painfully questioning the apparent illogic of shortening the TIB when the present longer TIB isn’t even producing enough sleep. Explaining how and why sleep restriction works may quell client concern.

Another client reaction might be, “I won’t be able to stay up that late, I know it!” This concern is also understandable because it can be a struggle to occupy the evening hours and fight sleep. Some creative brainstorming with the client may be helpful in looking for effective, non-drug alternatives to sleep. These might include the use of bright light while working on a special project like scrap-booking, making a family-tree, doing craft work, and dancing or exercising when extreme sleepiness hits.

Once sleep is improved and sleep efficiency (SE) remains high (≥ 90%), the client may decide to re-introduce one or more enjoyable, but potentially insomnia-breeding, activities banned by the Ten Tips sleep hygiene handout. Watching TV in bed, using the computer right before sleep and stopping exercising are three of the most popular forms of regression to expect in clients as they take their new and improved sleep lives for granted. Helping clients to embrace the value of continuing to use the SE Form just as they would the bathroom scale will allow them to control their own sleep destiny. With their new found sleep self-efficacy, clients will know that they can improve their sleep whenever they wish by re-applying the sleep tools they have already acquired. Whenever there is a drop in a client’s weekly SE score < 85%, then too much time is being spent in bed awake. Time in bed should be reduced 15 minutes and/or the sleep-sabotaging behaviors that were re-introduced should be eliminated. Using the gold standard of SE ≥ 90% accompanied by the experience of refreshing sleep without daytime impairment, clients are free and able to manage their sleep mostly to their satisfaction.

Everyone is different when it comes to sleep need just as metabolism rates vary from person to person. While some people require 8 hours sleep, others need only six quality hours of sleep to feel and function well. Whether a long or short sleeper, the client can aspire to achieve optimal sleep that is: highly consolidated (good quality); closely matched to the time in bed (highly efficient); satisfying and refreshing (restorative); and, results in little or no daytime impairment in mood and energy.
Cognitive Restructuring

Cognitive interventions focus on irrational beliefs clients possess about sleep and insomnia. Helping clients to identify, dispute and replace these faulty cognitions with more realistic and adaptive ways of thinking can reduce anxiety about not sleeping. Rational thinking can also reduce the psychophysiological arousal (adrenaline, cortisol, body temperature, blood pressure, etc.) that prevents good sleep.

Just as a good day’s waking is key to a good night’s sleep, the things clients tell themselves during the day about their insomnia and poor sleep have an impact on their sleep experience at night. For instance, during the day clients may terrorize themselves with thoughts like, “what if I don’t sleep again tonight—that would be awful,” or “I just can’t live like this—I’ll wind up causing an accident.”

Thinking these and other sleep-defeating thoughts is natural for anyone suffering from insomnia, especially considering the toll it takes on energy, mood and attitude. This negative self-talk is a product of ignorance about sleep science combined with habitual, erroneous, automatic thinking. Thank goodness; sleep knowledge can be acquired and crooked thinking can be straightened out.

Also self-defeating is a client’s denial of sleep debt and all the disruptive and distressing symptoms resulting from insomnia. Some clients have accommodated their poor sleep and rationalize that they have never slept well and that this is just the way they are. Sadly, they push on and suffer without investigating what help might be available to them.

Besides collaboratively questioning and disputing a client’s misguided belief that the inconvenience, difficulty and discomfort caused by insomnia constitute a horror (de-catastrophizing), clients can be reassured with accurate information produced by recent sleep research. For example, clients should be told that most insomniacs get the sleep they need even though they may not get the (optimal) sleep they want in order to feel and function their best. Sleep research reveals that longevity and health declines are associated with less than 4.5 hours of sleep per night for sustained periods; however, insomniacs average 5.75 to 6.0 hours of sleep.

Many of the negative health implications clients read and hear about are based upon research in regard to sleep deprivation and breathing-related medical sleep disorders that are wrongly generalized to apply to insomnia. Some sleep experts and the media have sensationalized the deleterious consequences of getting less than 8 hours sleep. This can feed the irrational belief of some insomniacs that they must get 8 hours sleep to remain healthy even though we know that many people are short sleepers who do not need 8 hours of nightly sleep.

Dr. Gregg Jacobs seems to have done the most to correct many of these distortions and inaccuracies concerning insomnia. He points out, for instance, that some of the sleep deprivation studies fail to control for stress being the possible cause of the deleterious health results rather than simply the lost sleep. He also cites a study finding no association with greater mortality risk for subjects getting 3.5 to 4.5 hours of sleep, and that sleeping 5 hours was associated with longer life expectancy than sleeping 8 hours.

Moreover, short sleep has been found to fight depression while daytime alertness does not suffer unless core sleep (5½ hours) is not satisfied. There is considerable evidence, according to Dr. Jacobs, suggesting that when core sleep is obtained, many people experience no alertness, memory, problem-solving or performance declines even for extended periods of time.

Because insomniacs have a stronger “wake drive” and hyper-aroused physiologic state, they do not respond to sleep loss (deprivation) the same way normal sleepers do. This stronger wake drive reduces the tendency toward daytime drowsiness and performance impairment. As long as a client with insomnia is sleeping at least 5 to 6 hours, the main ways they suffer relate to mood and include lethargy and fatigue (vs. sleepiness), loss of interest and motivation, dysphoria, anxiety, irritability and frustration (Jacobs, 2007).

Getting by on 5½ hours sleep hardly results in optimal energy, mood and well being. But it is important for clients to realize that they can do just that—get by—safely and healthfully until their sleep improves over the course of sleep counseling. Client self-talk like, “nobody can live on this little sleep,” can be compassionately confronted with the facts and supported by the expectation of positive change.

Sleep-defeating thoughts can be elicited from clients by suggesting they close their eyes and visualize the evening with bedtime approaching, or during the night while lying in bed after having awakened from sleep. Clients can then be asked to share their specific thoughts triggered by and associated with the mental imagery. This will often expose some problematic thinking that can be addressed in sleep counseling.

Sleep-promoting thoughts can be listed in the form of positive affirmations, however, it is the author’s opinion that they comprise a weaker intervention than rational disputation of sleep-defeating thoughts already discussed. The following are some examples of rational sleep affirmations derived from sleep research that can be used with clients:

1) The worst that will happen if I do not sleep well tonight is that I may feel moody and out-of-sorts (like when I have a cold) but I will still be able to function (like when I have a cold). I really hate feeling beat during the day but I can stand it even if it isn’t easy;

2) Research clearly shows that we tend to over-estimate how long it takes to fall asleep and under-estimate how long we have slept (by one full hour) due to a perceptual distortion of time created by insomnia. It may seem like I haven’t slept enough even when I have obtained my core sleep (5½ hours);

3) When I have an exceptionally poor night’s sleep, the increased sleep pressure the next day will promote sleep at night, and the brain’s sleep recovery system will ensure that I get extra amounts of the important sleep (deep and REM sleep) that I need to function.
Thought records typically used in cognitive therapy can be assigned to clients who are willing to monitor their automatic, sleep-defeating thinking. Since most sleep counseling is ancillary to the primary counseling or psychotherapy, the decision to push for client thought recording can be made on a case by case basis. CBT worry control methods along with refuting irrational ideas can be found in The Relaxation & Stress Reduction Workbook (Davis, 2008).

This course has addressed thus far three of the four major components of the CBT-I treatment of insomnia: sleep hygiene education, behavioral strategies and cognitive restructuring. The final component to be discussed is more generic to all of counseling and psychotherapy and not specific to insomnia treatment and sleep improvement counseling. Before we examine the role of relaxation and stress reduction, some important clarification is in order.

The reader is by now aware of the strong emphasis in this course on cognitive-behavioral methods and the author does have advanced training and certification in REBT/CBT (Rational Emotive Behavior Therapy/Cognitive Behavioral Therapy). The reason for the CBT emphasis, however, is the fact that Jacobs, Edinger, Morin, Perlis and others have empirically demonstrated the efficacy of this approach and shown CBT-I to be more effective than sleep medication. Even if the reader is not very comfortable with or enamored of the CBT approach, its value in improving sleep is undeniable.

The clarification needed here is that the CBT-I “toolbox” can be added as an adjunct to all psychotherapeutic approaches specifically for the purpose of treating sleep without changing the way regular counseling and psychotherapy is conducted by the clinical social worker. The science of sleep counseling is pretty straightforward; the art of sleep counseling is anything but. Weaving sleep assessment, information and treatment into the course of regular counseling without hijacking the process away from the original therapy agenda can be exceedingly difficult with some clients. Also challenging are clients who have habituated to poor sleep, deny its importance and refuse to address their broken sleep even though it can be fixed and their distress significantly relieved. Though challenging, behavioral insomnia treatment and sleep improvement constitute some of the most important and rewarding work within the realm of clinical social work practice.

**Relaxation & Stress Reduction**

“Don’t go to sleep; let go to sleep.” This biobehavioral invitation to sleep is easier said than done but it does reflect the fact that psychophysiological “control” is a passive process that comes from “letting” and not “making.” Nowhere is this more apparent than in temperature biofeedback training where clients are helped to relax by either using the feedback from the device or else autogenically experiencing warmth. Trying to relax most often produces the opposite—tension—while letting go clears the path to relaxation.

Fear and dread of not being able to sleep and the resulting anxiety and physiologic arousal that prevents sleep, is the hallmark of se-

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**Sleep Efficiency Form**

*Please complete upon awakening for accurate recall.*

**Client Name:** _____________________________  
**Date:** _____________________________

A. What time did you go to bed last night? 
B. What time did you turn out the lights? 
C. About how long did it take you to fall asleep? (use ¼ hour increments) 
D. How many times did you wake up during the night? 
E. About how long were you awake during the night? (total time of awakenings, e.g. ½, ¾ hours, etc) 
F. What was your final wake up time? 
G. What time did you get out of bed? 
H. What was your Time in Bed (B until G)? 
I. What was your Total Sleep Time? [B until G – (C +E)]? 
J. What sleep ritual, induction or meds did you use? 
K. How would you rate the refreshing quality of your sleep last night? (please circle a number below)

<table>
<thead>
<tr>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th>EXCELLENT</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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Sleep Efficiency = (I) Total Sleep Time (TST) = ___%  
(H) Time in Bed (TIB)  
Date: ___
The skills taught to clients in this section ought to reflect the therapeutic orientation and preferences of the therapist as to what methods are most effective and feasible. There are those best-practice equivalents such as Jacobson’s Progressive Relaxation (PR) whose efficacy, especially for sleep onset insomnia, has been demonstrated over time. But many methods have value and work well with certain clients. Those that social workers use themselves and can confidently share with clients may be among the best to offer. And let us not forget the stress reduction benefit for clients who experience positive therapy outcomes contributing to improved well being, stress reduction and sleep quality.

Sleep induction procedures can be designed to help clients fall asleep and may include progressive relaxation(PR), temperature biofeedback, self-hypnosis, autogenic training, EFT (Emotional Freedom Techniques), guided imagery and visualization, brain wave entrainment, mindfulness meditation, focusing, yoga, and various breathing and breath-counting techniques (Weil & Naiman, 2007). These methods may also be used by clients to return to sleep after awakening during the night. The limited scope of this course does not allow description of all these methods; The Relaxation & Stress Reduction Workbook is a compendium of effective protocols and practices from which clients and therapists can benefit (Davis, 2008).

Progressive Relaxation (PR)

This is an adaptation, of which there are many, of Dr. Edmund Jacobson’s 1929 classic technique to reduce muscle tension, central nervous system arousal and, indirectly, autonomic hyper-reactivity (Lehrer & Woolfolk, 1993). It is the premier non-drug treatment for sleep onset insomnia due to hyper-arousal and muscle tension. Once learned in its long form, this procedure can be shortened into one huge body spasm held for 10 seconds, or else 3 body segments (head/neck/shoulders/arms, entire torso, legs/feet) addressed one at a time again for 10 seconds each. This short form of PR can be used to “clear the decks” and relax the muscles before any kind of meditation or relaxation exercise. Rarely will clients continue to practice the long form of PR unless they are using it as a sleep induction technique, just before bedtime or while lying in bed, to initiate sleep or to return to sleep after unwanted awakenings during the night.

Instructions to clients include asking them to make themselves comfortable in a lying or seated position. Body posture is not important for PR like it is for meditation. Then clients are asked to first tense (for 10 seconds) then relax (for 30 seconds) each of the 15 muscle groups outlined below. When relaxing a particular muscle group, clients are to focus their attention only on the feelings and sensations in that area of the body. Muscle tightening followed by release heightens the experience of soothing relaxation that can be further dramatized by clients telling themselves to “let go.”

(Caution: Clients should be instructed to only tighten their muscles to the point of tension—not discomfort, and to avoid exercising any vulnerable or painful body area.)

For each muscle group below, first tense for 10 seconds then relax for 30 seconds while focusing only on the muscle sensations and say: let go, loose and limp like a rag doll:

HANDS: with the arms bent at the elbows, clench your fists while relaxing your arms;
ARMS: again bend the arms at the elbows but relax the hands while tensing the arms;
FOREHEAD: keeping eyes closed, raise eyebrows up high as if to touch the ceiling;
EYES: squeeze your already closed eyes even more tightly shut and hold the tension;
FACE: make an exaggerated smile with teeth clenched and squirm up nose and cheeks;
JAW: open your mouth wide to experience tension without discomfort;
TONGUE: press the tongue against the roof of your mouth and hold the tension;
NECK: slowly turn head to left and right, then chin way down and up, stretching;
SHOULDERS: raise your shoulders all the way up as if to touch them to your ears;
CHEST: take in a huge breath and hold it creating tension;
BACK: gently arch your back forward and backward, stretching without straining;
ABDOMEN: pull your belly in and hold, then push your belly outward and hold;
BUTTOCKS: squeeze your buttocks tightly together and hold the tension;
LEGS: push each foot into floor (sitting), or straighten each leg while relaxing your arms;
FEET: gently bend each foot pointing toes away then toward face to create tension.

PR can be followed by post procedure instructions to help clients benefit from the use of additional self-hypnotic and autogenic techniques. It might be suggested to clients that they take a few extra minutes, now that they are feeling more relaxed, to go through their body again; this time in reverse order starting with...
the feet and focusing on creating a feeling of warmth and heaviness in each muscle group by saying, “it feels warm and heavy, heavy like a lead weight pulling me down deeper and deeper into relaxation.”

**Quieting Reflex (QR)**

The Quieting Reflex is a diaphragmatic breathing-based procedure developed by Dr. Charles Stroebel and the version that appears here has been adapted by the author who considers QR to be one of the most powerful and practical stress reduction tools in the entire stress management arsenal. Instead of waiting for stress symptoms to build up during the day before figuring out how in the world to get relaxed, QR attempts to intercept stress as it appears. This is done, theoretically, by matching the elemental unit of anxiety (a 6 second wave) with a diaphragmatic or belly breath (a 6 second relaxer), enhanced by some things to think and feel, so that the wave of anxiety is neutralized by the wave of relaxation. Canceling out stress with relaxation like this hundreds of times a day has the intended effect of preventing stress, instead of treating it, in the first place.

Before QR can be embellished as described below, basic diaphragmatic breathing (belly breathing) needs to be taught to the client. Just like with PR, the reader is probably already familiar with belly breathing. If not, the following summary may be helpful:

**BASIC BELLY BREATHING:**

- Start by exhaling completely;
- Now inhale through the nose while pushing the belly out;
- Then exhale through the mouth while pulling the belly in;
- Purse lips together making a faint whirring sound;
- Focus on not moving the chest while breathing;

When your BB technique is correct, add the following:

**INHALE:**

- **Smiling Eyes:** Actually practice an exaggerated smile in private for a day or two as often as you can. Thereafter, only THINK of smiling during QR while cultivating feelings of compassion, gratitude, love, etc.
- **Counting In:** After reaching a level of comfort with “smiling eyes” on the inhale, add slow and silent counting: 1…..2…..3….. on the inhale.

**EXHALE:**

- **Jaw & Shoulder Drop:** Taken from PR and used here as a cue for generalized relaxation, let the jaw & shoulders go limp and your body relax like a rag doll. Continuing to practice PR will make QR more powerful.
- **Counting Out:** Silently and slowly count: 1….2….3…. on the exhale and gradually extend the count to 4, 5 and even 6 (if desired) so that you linger longer in the relaxing exhalation phase of your breath cycle. Imagine stress draining from your body.

The key to successful use of this powerful stress reducer is invoking the QR at the slightest sign of tension, anxiety and muscle tightness a hundred or more times/day.

*LIFE IS IN THE BREATH. HE WHO ONLY HALF BREATHES, HALF LIVES.*

---Old Proverb

PR and QR are deemed effective as sleep induction and stress reduction strategies respectively. Sleep counseling, however, is inclusive and welcomes any and all established or promising approaches to stress relief and sleep promotion. The relaxation and stress reduction component of sleep improvement is a helpful intervention but remains incomplete without the accompanying sleep hygiene, behavioral and cognitive components already addressed in this course.

**Conclusion**

In addition to building knowledge and skills for clinical social work practice relating to behavioral insomnia treatment and sleep improvement, this course has shown that:

1) Sound sleep is essential for the health and well being of our clients.

2) Clinical social work practice should now incorporate effective CBT-I interventions for the non-medical treatment of behavioral insomnia.

3) Failure to address clients’ poor sleep during the course of therapy is tantamount to a breach of ethics and clinical best-practice guidelines.

**Waking Up the Profession**

In early 2008, the author conducted an email survey of six major schools of social work in New York State. Sixty clinical faculty were asked about the existence of any sleep content in the classroom or in the field. Not one faculty member replied in the affirmative. A short time later in the year, one of the largest annual psychotherapy conferences boasting 150 workshops offered one pertaining to sleep and dreaming.

In the January/2008 NASW News, Dr. Elizabeth Clark, NASW Executive Director, was quoted as saying, “the unanswered question is whether we can make social work relevant to the problems society faces today.” The author offers one answer to the Profession: seize this opportunity to distinguish clinical social workers, from among all the non-medical helping professions, as those to whom the public can turn for insomnia treatment and sleep improvement.

To do this, our profession must act swiftly to:

1) Introduce sleep educational and clinical components into social work graduate and undergraduate curricula.
2) Create continuing education opportunities for professional social workers around sleep issues and intervention.

3) Promote “sleep and social work” public awareness campaigns.

**Resource: Sleep Study Group**

Clinical social workers interested in expanding their practice to include insomnia and sleep improvement are invited to join the Sleep Study Group. This free conference call is a special opportunity to learn, share and grow in this worthwhile work. To receive call information or to request the weekly Sleep Efficiency Form and other sleep handouts, just email your interest to the author at: sleepcounseling@gmail.com

**Author Bio**

Richard E. Madden (“Rick”) has a masters degree in Social Work and a doctorate in Electromedical Sciences. He completed training in Rational-Emotive-Behavior Therapy at the Albert Ellis Institute in 1985 before entering private practice. Rick is a Certified Cognitive-Behavioral Therapist (NACBT) and has recently founded the Rip Van Winkle Sleep & Stress Institute in Catskill, NY. Rick presented a dynamic workshop at the March 2008 NYS Social Work Conference wherein he challenged the profession to “wake up” to the importance of clients’ sound sleep as key to their health and emotional well being. Rick welcomes contact at: sleepcounseling@gmail.com or (518) 943-1000.

**References**


Circle all correct answers.

1. The most powerful sleep/wake system for promoting sleep at night is:
   (a) circadian system with light exposure at night
   (b) homeostatic system with blue light exposure at night
   (c) circadian system with light exposure in the morning
   (d) homeostatic system with blue light exposure in the morning

2. Which of the following is not necessary for insomnia assessment?
   (a) results of a laboratory sleep study (PSG)
   (b) daytime impairment in energy and/or mood
   (c) difficulty falling or staying asleep
   (d) feeling unrefreshed after sleep

3. Excessive daytime sleepiness is most often associated with:
   (a) insomnia only
   (b) sleep apnea only
   (c) insomnia and narcolepsy
   (d) narcolepsy and sleep apnea

4. The key point in using the concept of sleep efficiency with clients is:
   (a) closer matching of sleep opportunity with actual sleep
   (b) incrementally increasing sleep opportunity to improve efficiency
   (c) reduce the time it takes to fall asleep
   (d) improve sleep quality so less sleep is needed

5. A client experiencing insomnia should try to go to bed earlier in order to increase the opportunity to get more satisfying sleep.
   (a) True
   (b) False

6. The one intervention that is not part of the stimulus control technique is:
   (a) getting out of bed when unable to sleep
   (b) using light stimulation to promote sleep
   (c) relaxing activity until very sleepy
   (d) repeating the procedure as necessary

7. When a client with insomnia has slept poorly the night before, she should:
   (a) sleep later the next morning;
   (b) take a mid-afternoon nap;
   (c) go to bed when sleepy the next night;
   (d) go to bed earlier the next night.

8. Sleep restriction therapy is so effective because it compresses poor sleep into quality sleep, resulting in less need for sleep.
   (a) True
   (b) False

9. When doing sleep scheduling with a client who takes less than 10 minutes to fall asleep, the client should be advised to:
   (a) reduce time in bed (TIB) by 30 minutes
   (b) increase TIB by 15 minutes
   (c) reduce TIB by 15 minutes
   (d) increase LAN by 15 minutes

10. All the following are examples of cognitive therapeutic techniques except:
    (a) identifying sleep-defeating thoughts
    (b) designing positive sleep affirmations
    (c) sharing scientific sleep facts
    (d) increasing sleep efficiency ≥ 90%

11. The four major components of the CBT-I approach to insomnia treatment are behavioral strategies, cognitive restructuring, sleep hygiene and exercise.
    (a) True
    (b) False

12. Important points associated with the use of PR with clients do not include:
    (a) alternately tensing then relaxing muscles
    (b) experiencing the feeling of “letting go”
    (c) diaphragmatic or belly breathing
    (d) cautioning clients not to hurt themselves

13. Which of the following is not essential to the practice of QR?
    (a) correct posture and body position
    (b) diaphragmatic breathing and smiling eyes
    (c) counting and jaw/shoulder drop
    (d) smiling eyes and counting.
14. There is an important role for clinical social workers to play in the behavioral treatment of insomnia because of the fact that social workers:
   (a) have extensive post graduate training in CBT-I methods
   (b) receive significant educational and clinical exposure to sleep improvement
   (c) can learn sleep science facts and CBT-I methods
   (d) can not prescribe medication which is the best treatment for insomnia

15. Even though effective insomnia treatment and sleep improvement training include the use of some cognitive and behavioral methods, it is not at all necessary for therapists to change their theoretical orientation or helping approach.
   (a) True
   (b) False

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**COURSE EVALUATION**

Please indicate whether the following learning objectives were achieved:

1) Readers will learn to conceptualize the role for clinical social workers, apart from but in collaboration with sleep medicine professionals, in which clients experiencing insomnia and poor sleep are helped directly during the normal course of clinical social work practice.
   Achieved in full 5 4 3 2 1 Not Achieved

2) Readers will learn to understand the behavioral nature of insomnia and be able to apply one or more behavioral, cognitive and sleep hygiene interventions to help clients sleep better.
   Achieved in full 5 4 3 2 1 Not Achieved

3) Readers will learn to be able to work with clients around the application of sleep efficiency in behavioral insomnia treatment, including the use of the Sleep Efficiency Form, and to be able to administer one or more relaxation, stress reduction and sleep induction protocols.
   Achieved in full 5 4 3 2 1 Not Achieved

4. Please provide comments on current course & suggestions for future courses.

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