SLEEP DISTURBANCE

BEHAVIORAL DEFINITIONS

1. Complains of difficulty falling asleep.
2. Complains of difficulty remaining asleep.
3. Reports sleeping adequately, but not feeling refreshed or rested after waking.
4. Exhibits daytime sleepiness or falling asleep too easily during daytime.
5. Insomnia or hypersomnia complaints due to a reversal of the normal sleep-wake schedule.
6. Reports distress resulting from repeated awakening with detailed recall of extremely frightening dreams involving threats to self.
7. Experiences abrupt awakening with a panicky scream followed by intense anxiety and autonomic arousal, no detailed dream recall, and confusion or disorientation.
8. Others report repeated incidents of sleepwalking accompanied by amnesia for the episode.

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LONG-TERM GOALS

1. Restore restful sleep pattern.
2. Feel refreshed and energetic during wakeful hours.
3. Terminate anxiety-producing dreams that cause awakening.

4. End abrupt awakening in terror and return to peaceful, restful sleep pattern.
5. Restore restful sleep with reduction of sleepwalking incidents.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Describe the history and details of sleep pattern. (1, 2)	1. Assess the client's sleep history including sleep pattern, bedtime routine, activities associated with the bed, activity level while awake, nutritional habits including stimulant use, napping practice, actual sleep time, rhythm of time for being awake versus sleeping, and so on.
	2. Assign the client to keep a journal of sleep patterns, stressors, thoughts, feelings, and activities associated with going to bed, and other relevant client-specific factors possibly associated with sleep problems; process the material for details of the sleep-wake cycle.
2. Share history of substance abuse or medication use. (3)	3. Assess the contribution of the client's medication or substance abuse to his/her sleep disorder; refer him/her for chemical dependence treatment, if indicated (see the Substance Use chapter in this *Planner*).
3. Verbalize depressive or anxious feelings and share possible causes. (4)	4. Assess the role of depression or anxiety as the cause of the client's sleep disturbance (see the

Unipolar Depression or Anxiety chapters in this *Planner*).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational,

vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Keep physician appointment to assess possible medical contributions to sleep disorder and the need for psychotropic medications. (9)

9. Refer the client to a physician to rule out medical or pharmacological causes for sleep disturbance and to consider sleep lab studies and/or need for a prescription of psychotropic medications.

6. Take psychotropic medication as prescribed to assess the effect on sleep. (10)

10. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects.

7. Verbalize an understanding of normal sleep, sleep disturbances, and their treatment. (11, 12, 13)

11. Provide the client with basic sleep education (e.g., normal length of sleep, normal variations of sleep, normal time to fall asleep, and normal midnight awakening; recommend *The Insomnia Workbook: A Comprehensive Guide to Getting the Sleep You Need* by Silberman); help the client understand the exact nature of his/her "abnormal" sleeping pattern.

12. Provide the client with a rationale for the therapy, explaining the role of cognitive, emotional, physiological, and behavioral contributions to good and poor sleep.

13. Ask the client to read material consistent with the therapeutic approach to facilitate his/her progress through therapy

(e.g., *Say Good Night to Insomnia* by Jacobs; *The Harvard Medical School Guide to a Good Night's Sleep* by Epstein and Mardon).

8. Learn and implement calming skills for use at bedtime. (14, 15)

14. Teach the client relaxation skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing); teach the client how to apply these skills to facilitate relaxation and sleep at bedtime (see "Bedtime Relaxation Techniques" by Hauri and Linde).

15. Refer the client for or conduct biofeedback training to strengthen the client's successful relaxation response.

9. Practice good sleep hygiene. (16)

16. Instruct the client in sleep hygiene practices such as restricting excessive liquid intake, spicy late night snacks, or heavy evening meals; exercising regularly, but not within 3–4 hours of bedtime; minimizing or avoiding caffeine, alcohol, tobacco, and stimulant intake (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma).

10. Learn and implement stimulus control strategies to establish a consistent sleep-wake rhythm. (17, 18, 19, 20)

17. Discuss with the client the rationale for stimulus control strategies to establish a consistent sleep-wake cycle (see *Behavioral Treatments for Sleep Disorders* by Perlis, Aloia, and Kuhn).

18. Teach the client stimulus control techniques (e.g., lie down to sleep only when sleepy; do not use the bed for activities like watching television, reading, listening to music, but only for

sleep or sexual activity; get out of bed if sleep doesn't arrive soon after retiring; lie back down when sleepy; set alarm to the same wake-up time every morning regardless of sleep time or quality; do not nap during the day); assign consistent implementation.

19. Instruct the client to move activities associated with arousal and activation from the bedtime ritual to other times during the day (e.g., reading stimulating content, reviewing day's events, planning for next day, watching disturbing television).

20. Monitor the client's sleep patterns and compliance with stimulus control instructions; problem-solve obstacles and reinforce successful, consistent implementation.

11. Learn and implement a sleep restriction method to increase sleep efficiency. (21)

21. Use a sleep restriction therapy approach in which the amount of time in bed is reduced to match the amount of time the patient typically sleeps (e.g., from 8 hours to 5), thus inducing systematic sleep deprivation; periodically adjust sleep time upward until an optimal sleep duration is reached.

12. Identify, challenge, and replace self-talk contributing to sleep disturbance with positive, realistic, and reassuring self-talk. (22, 23)

22. Explore the client's schema and self-talk that mediate his/her emotional responses counterproductive to sleep (e.g., fears, worries of sleeplessness), challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase the likelihood of establishing a sound sleep pattern

(see *Insomnia: A Clinical Guide to Assessment and Treatment* by Morin and Espie).

23. Assign the client a homework exercise in which he/she identifies targeted self-talk and creates reality-based alternatives (or assign "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement.

13. Implement a paradoxical instruction to stay awake as a means to counter anxiety interfering with sleep onset. (24)

24. Assign a paradoxical intervention in which the client tries to stay awake for as long as possible to diminish performance anxiety interfering with sleep; review implementation, reinforcing success; problem-solve obstacles.

14. Learn and implement skills for managing stresses contributing to the sleep problem. (25)

25. Use cognitive behavioral skills training techniques (e.g., instruction, covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client tailored skills (e.g., calming and coping skills, conflict-resolution, problem-solving) for managing stressors related to the sleep disturbance (e.g., interpersonal conflicts that carry over and cause nighttime wakefulness); routinely review, reinforce successes, problem-solve obstacles toward effective everyday use (see *Insomnia: A Clinical Guide to Assessment and Treatment by Morin* and Espie; *Treating Sleep Disorders* by Goetting, Perlis and Lichstein).

15. Verbalize an understanding of the cognitive-behavioral approach to treating sleeplessness. (26)

26. Assign the client to read material on the cognitive-behavioral treatment approach to sleeplessness (e.g., *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* by Edinger and Carney; *Say Good Night to Insomnia* by Jacobs).

16. Participate in a scheduled awakening procedure to reduce the frequency of night wakening. (27)

27. Use a scheduled awakening procedure in which the client is gently and only slightly awakened 30 minutes prior to the typical time of the first night wakening, sleep terror, or sleepwalking incident; phase out the awakening as sleep terrors decrease (see *When Children Don't Sleep Well* by Durand).

17. Learn and implement relapse prevention practices. (28, 29, 30, 31, 32)

28. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an occasional and reversible slip into old habits and relapse with the decision to return to old habits that risk sleep disturbance (e.g., poor sleep hygiene, poor stimulus control practices).

29. Identify and rehearse with the client the management of future lapses.

30. Instruct the client to routinely use strategies learned in therapy (e.g., good sleep hygiene and stimulus control) to prevent relapse into habits associated with sleep disturbance.

31. Develop a "coping card" or other reminder where relapse prevention practices are recorded for the client's later use.

32. Schedule periodic "maintenance sessions" to help the client maintain therapeutic gains.

18. Discuss experiences of emotional traumas that may disturb sleep. (33)

19. Discuss fears regarding relinquishing control. (34)

20. Disclose fears of death that may contribute to sleep disturbance. (35)

21. Share childhood traumatic experiences associated with sleep experience. (36, 37)

22. Reveal sexual abuse incidents that continue to be disturbing. (38)

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33. Explore recent traumatic events that may be interfering with the client's sleep.

34. Probe the client's fears related to letting go of control.

35. Probe a fear of death that may contribute to the client's sleep disturbance.

36. Explore traumas of the client's childhood that surround the sleep experience.

37. Probe the client for the presence and nature of disturbing dreams and explore their possible relationship to present or past trauma.

38. Explore for possible sexual abuse to the client that has not been revealed (see the Sexual Abuse Victim chapter in this *Planner*).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.42	Primary Insomnia
	307.44	Primary Hypersomnia
	307.45	Circadian Rhythm Sleep Disorder
	307.47	Nightmare Disorder
	307.46	Sleep Terror Disorder
	307.46	Sleepwalking Disorder
	309.81	Posttraumatic Stress Disorder

296.xx	Major Depressive Disorder
300.4	Dysthymic Disorder
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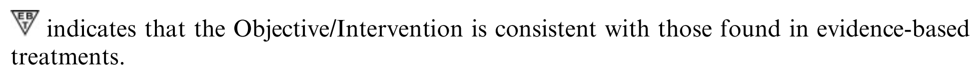
Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.42	G47.00	Insomnia
307.44	G47.10	Hypersomnolence Disorder
307.45	G47.xx	Circadian Rhythm Sleep-Wake Disorder
307.47	F51.5	Nightmare Disorder
307.46	F51.4	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleep Terror Type
307.46	F51.3	Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking Type
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.


indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.