Help Your Patients Sleep:

Tools for Addressing Insomnia in Youth

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Objective #1

The participant will be able to discriminate acute insomnia from Insomnia Disorder and articulate the importance of treating the chronic form as a specifically targeted co-morbidity.

Objective #2

The participant will be able to provide their patient with education regarding healthy sleep practices, basic behavioral interventions including sleep schedule adjustments and sleep hygiene, and make referrals for CBT-I when appropriate.

We should be asking about sleep!

Prevalence rate of 18.5% for ages 16–18 and 9.7% for ages 13-16.

Insomnia is a strong predictor for subsequent development of depression in adolescents

Impairment in cognitive performance, poor executive functioning, increased risk-taking behaviors, and lower academic performance

"Having three insomnia symptoms was associated with a 6.2-fold increased risk of suicidal ideation, a 10.4-fold increased risk of making a suicide plan, and a 10.5-fold risk of making a suicide attempt when compared to those with no insomnia symptoms."

de Zambotti, M., Goldstone, A., Colrain, I. M., & Baker, F. C. (2018). Insomnia disorder in adolescence: Diagnosis, impact, and treatment. Sleep medicine reviews, 39, 12–24. https://doi.org/10.1016/j.smrv.2017.06.009

DSM-V-TR Criteria

Insomnia Disorder

1. A predominant complaint of **dissatisfaction with sleep quantity or quality**, associated with one (or more) of the following symptoms:
    a. **Difficulty initiating sleep**. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.)
    b. **Difficulty maintaining sleep**, characterized by frequent awakenings or problems returning to sleep after awakenings. (In children, this may manifest as difficulty returning to sleep without caregiver intervention.)
    c. **Early-morning awakening** with inability to return to sleep.
2. The sleep disturbance causes **clinically significant distress or impairment** in social, occupational, educational, academic, behavioral, or other important areas of functioning.
3. The sleep difficulty occurs at least **3 nights per week.**

DSM-V-TR Criteria

Insomnia Disorder

4. The sleep difficulty is present for **at least 3 months**.

5. The sleep difficulty occurs **despite adequate opportunity for sleep**.

6. The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., narcolepsy, a breathing-related sleep disorder, a circadian rhythm sleep-wake disorder, a parasomnia).

7. The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).

8. Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.

Acute Insomnia

Acute insomnia (i.e. symptoms lasting less than three months but otherwise meeting criteria) should be coded as “Other Specified Insomnia Disorder”

How does acute insomnia become chronic?

Predisposing Factors

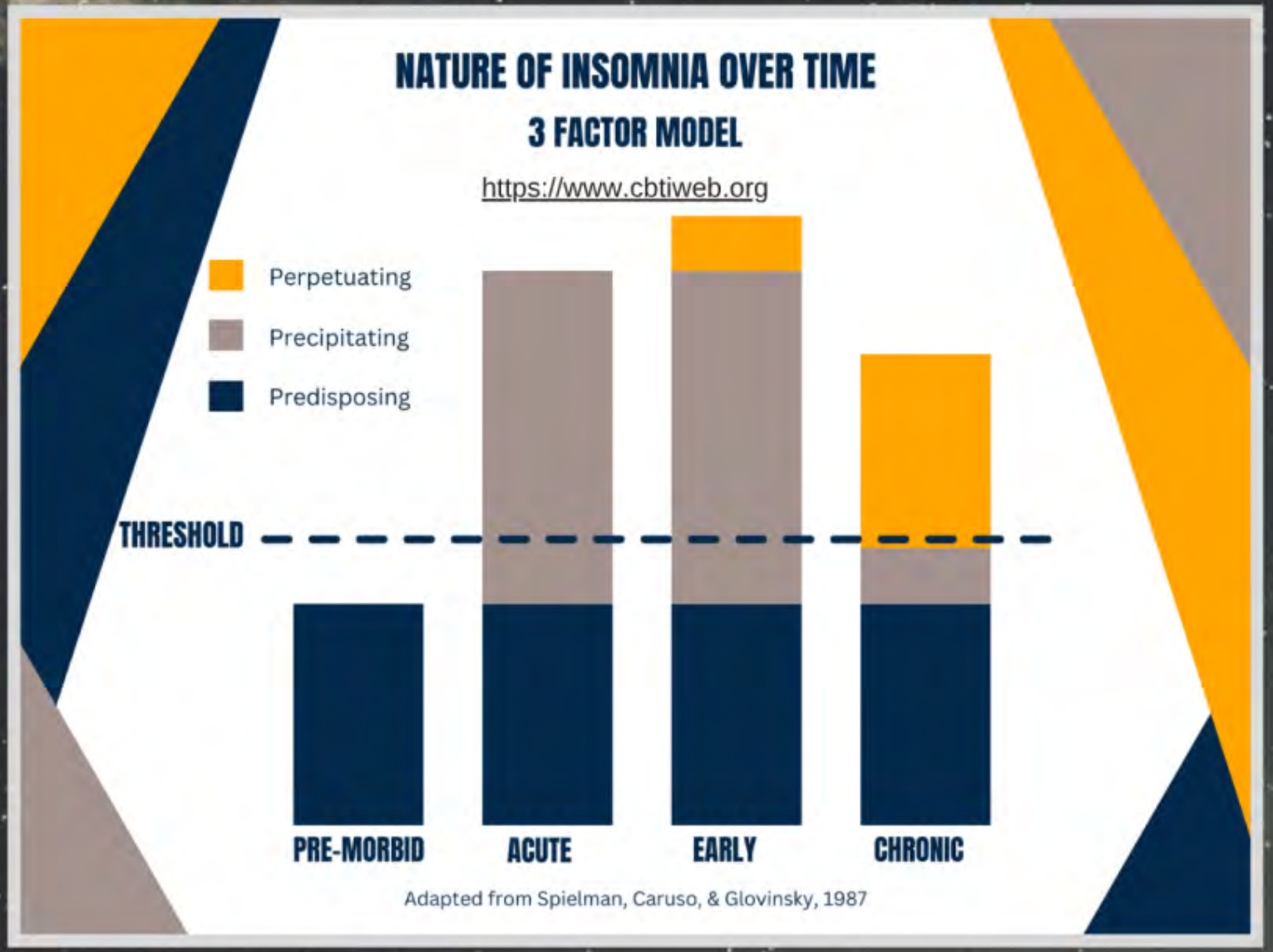
genetics, personality traits, lifestyle factors

Precipitating Factors

stressful life events/transitions, illness, travel (jet lag)

Perpetuating Factors

behaivors that are meant to cope with or manage poor sleep



Screening for Sleep Habits

Ask about sleeping habits annually at well-child visits!

"How many hours of sleep do you typically get per night?"

Use this as a spring board for follow up questions no matter the answer.

"What time do you go to sleep? Wake up time? Do you have trouble staying asleep? Are you napping or sleeping any during the day?"

There are great screeners out there (such as the Insomnia Severity Index), but you really don't need to complicate it for a basic screen.

Patient Discussion Topic #1

We treat sleep like money in the bank!

Because there is so much information out there about poor sleep, we think we are supposed to earn (or deposit into the bank) a certain number of hours every night. How much have you been told you should earn?

Eight hours?

Yes! That is what everyone says. For the general public who do not have insomnia, that's actually a good rule of thumb. If you are not having trouble falling asleep, staying asleep, or waking too early, then you should give yourself the opportunity to sleep about eight hours. However, for those who have trouble sleeping, trying to force yourself to sleep eight hours can actually perpetuate insomnia.

Patient Discussion Topic #2

We make up for poor sleep in three ways!

The amount of warnings given to our society about the negative impacts of poor sleep can lead to a lot of pressure to "bank" enough hours every night. If we do not think we have slept enough hours, we will behaivorally make up for those hours in one of three ways:

- Sleeping in (extending wake up time to later in the day)
- Napping/Dozing
- Going to bed earlier than typical

Patient Discussion Topic #3

Our sleep drive is like a stretched rubberband

Our sleep drive (how much our body needs sleep at any given time) is like a stretched rubberband. The more hours we are awake, the more light we get during the day, the more physical acitivity, etc. all stretches our rubberband. We want our rubberband to be really stretched out with lots of tension on it when are ready to let it go (fall asleep), so that it snaps quickly.

Patient Discussion Topic #4

Think about how making up for poor sleep last night impacts our sleep drive for tonight's sleep.

If we sleep in (let's say two hours as an example), then the stretching of the rubberband starts two hours later and therefore has two hours less stretch at bedtime.

If you take a nap, what did you just do? Reset your rubberband! It will stretch again before bedtime, but not nearly to the point of a normal wake-time stretch.

If you try to go to bed too early (before you are sleepy), you likely won't fall asleep easily.

Patient Discussion: Sleep Schedule Rules

Have a consistent wake time!

No sleeping in more than an hour on the weekends.

No napping!

Students may need to plan for taking walks or doing other activities to fight the after school nap.

Do not force sleep!

Try going to bed at your typical time, but don't force it. If you can't fall asleep, try a non-stimulating activity until sleepy.

Sleep Hygiene

Sleep Hygiene is a healthy practice, but it doesn't actually treat sleep.

A dentist will tell you to brush your teeth twice a day, but if you have a cavity, they are going to drill it out.

Caffeine

Adenosine is a sleep-promoting chemical that builds up in the brain the longer you are awake. The more it builds up, the sleepier you become.

Adenosine is responsible for stretching that rubberband!

Caffeine affects the brain by blocking adenosine receptors.

Caffeine has to wear off before Adenosine can be released to start stretching your rubberband again.

The half-life of caffeine can be up to 10 hours.

No caffeine past noon!

https://www.sleepfoundation.org/nutrition/caffeine-and-sleep

Nightly Routine

- A consistent routine can notify your brain that sleep is coming
- Spend 30-60 minutes “winding down” before bed
- Dim your lights to help with the natural release of melatonin
- Turn off all screens 30-60 minutes before bed. Screens create mental stimulation that is hard to shut off and they also generate blue light that may decrease melatonin production.
- Make relaxation your goal (rather than actually sleeping) to reduce the stress and pressure of sleep
- If you can’t fall asleep within about 20 minutes, get up and engage in a non-stimulating activity until sleepy.

https://www.sleepfoundation.org/sleep-hygiene

Case Study

14y/o female presents complaining of her stomach feeling tight, neck/jaw/extremities hurting, extremities twitching, and heavy breathing that began the evening before with slight symptom improvement overnight. She noted she was having trouble staying awake in class yesterday. Denies any new medications, recreational drugs, or vaping.

What questions would you ask regarding sleep?

Follow Up Questions

Have you consumed any caffeine in the last 24hrs?

"I drank 7 energy drinks yesterday."

What is your typical sleep schedule (in bed time, falling asleep time, wake time?)

"I can't fall asleep until 3am so I watch TikTok until then. I have to be up at 5am for school."

What about on the weekends? How long have you been sleeping this way?

"I can't sleep on the weekends either, so I usually sleep in until 1pm. Probably about 3 years."

Any naps? Any screentime use during "bedtime hours"?

"My 6th and 7th period teachers let me sleep in their classes."

Intervention

- Psychoeducation regarding behavioral ways we make up for poor sleep and how it sabotages our sleep drive for the next night.
- Discuss the “sleep rules”.
- Psychoeducation on how caffeine impacts sleep drive as well as education on recommended caffeine consumption limits.
- Psychoeducation on how screen time impacts sleep drive.
- Collaborate on actionable goals regarding sleep if patient is willing.

When to consider making a referral

Patient is having trouble following the "sleep rules"

Consider a referral to a behavioral health provider

Patient is following the "sleep rules", but is still meeting criteria for Insomnia

Consider a referral for CBT-I

Patient does not meet criteria for Insomnia, but reports excessive daytime fatigue

Consider a referral to a sleep specialist

CBT-I Training

https://www.cbtiweb.org

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Thank You!

Questions?