Update

Vol 36 - No 1

Fall 2011

IN THIS ISSUE

Featured Article:

CBT for Insomnia and Poor Sleep

which includes a Continuing Education 3.0 CEU Test

NASW NEW YORK STATE CHAPTER
National Association of Social Workers

NASW-NYS Veterans Initiative Receives Grant from NYS Health Foundation

The Veterans' Mental Health Training Initiative (VMHTI) has been awarded a $150,000 grant from the NYS Health Foundation to advance the second year of this statewide workforce development project. The VMHTI sponsored by the NYS Chapter of the National Association of Social Workers provides training on veteran specific mental health disorders, military culture, the impact of deployment on military families, and promotes awareness of available veterans' services and resources to mental health professionals across the state through a series of regional conferences.

The VMHTI is a multi-year comprehensive training project aimed at increasing the number of community mental health professionals who are knowledgeable about the assessment and treatment of mental health issues specific to veterans and their families. The first year of the VMHTI was successful in reaching and educating hundreds of mental health providers across New York State, however the need for additional and more advanced clinical training in this area is critical to building skill proficiency.

The VMHTI is a unique statewide effort to build the capacity of New York's community mental health workforce to meet the needs of returning veterans and their families. The goal of the second year of the VMHTI is to host regional conferences with expanded training content which includes an Advanced Clinical Track providing evidence-based assessment and treatment methods for veteran specific conditions such as combat specific PTSD, traumatic brain injury (TBI), and depression/ suicide prevention in addition to core sessions on military culture, impact of deployment on service members and their families, women in the military, and military sexual trauma.

Each regional event will host an exhibit area for programs, services and resources serving veterans and/or their families to inform mental health professionals in attendance about veterans' specific resources and benefits in their area.

VMHTI training curriculum is developed by an Advisory Committee comprised of veterans' experts, representatives from veterans' service programs, relevant federal, state and local agencies as well as current and retired members of the military, military family members and other stakeholder organizations. In addition to the development and provision of training curriculum, the VMHTI is creating a Policy Council to explore and identify current gaps in services/resources to meet the mental health needs of returning soldiers and their families. The Policy Council which will be chaired by NYS Senator Greg Ball (R, C–Patterson), will make policy recommendations to address such service gaps and advance policy recommendations through legislative action at the state and federal level. Senator Ball will convene a legislative hearing on veterans' issues on November 15th at West Point.

For more information on NASW-NYS' Veterans' Mental Health Training Initiative visit: www.naswnys.org/veterans.html

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western@naswnys.org

Advertising In Update

Publication Frequency

update is published four times a year.

Deadlines & Submission Details

Available at:
www.naswnys.org/newsad.htm

Submission of Advertising Materials

Camera-ready artwork is appreciated, although not required. The text of the ad, and a billing address, may be mailed to the NASW New York State Chapter office at 188 Washington Avenue, Albany, New York 12210, attn: Advertising. They may also be faxed to (518) 463-6446.

Display Ad Rates

Business Card	**$90**
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One-half page	**$410**
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Pre-payment for Classified Ads is required.

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www.naswnys.org

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Use your existing username and password for the NASW National site.

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Executive Director
Celisia Street, LMSW, Managing Editor

Announcement of Election Results

The Secretary of the NASW-NYS Board of Directors Judith Azzato is pleased to announce the results of our June 2011 chapter election. The successfully elected candidates are listed below with their respective offices. All terms became effective on July 1, 2011. Please join us in welcoming our newly elected members and thanking the Chapter Committee on Nominations and Leadership Identification for all their time and work on our behalf.

Board of Directors

PRESIDENT-ELECT
Debra Fromm Faria

SECRETARY
Elaine Rinfrette

BOARD MEMBER-AT-LARGE
Marcia Levy

MSW STUDENT REPRESENTATIVE
Christina Horsford

BSW STUDENT REPRESENTATIVE
Gerald Welch

Division Director to the Board of Directors

HUDSON VALLEY
Laura Eastman-Follis

MOHAWK VALLEY
Ward Halverson

NASSAU
Warren Graham

SOUTHERN TIER
Carmela Pirich

SUFFOLK
Staci Spencer

Division Representatives to the Committee on Nominations and Leadership Identification

CENTRAL
Domingo Rogel

GENESEE VALLEY
Tammy Franklin

NORTHEAST
Nicole MacFarland

WESTCHESTER
Anne Treantafeles

WESTERN
Jesse Grossman

Members in the News

SUNY Chancellor Nancy L. Zimpher recognizes faculty for innovation in study abroad programs

Spring 2011, State University of New York Chancellor Nancy L. Zimpher announced the winners of the 2011-2012 Chancellor's Award for Internationalization (CAFI).

Debra Fromm Faria
NASW-NYS President Elect

CAFI encourages the establishment of new and innovative study abroad programs in less commonly traveled destinations. Also taken into consideration is the exploration of underrepresented academic disciplines in study abroad. SUNY works as a consortium for study abroad, therefore new programs are available to students from throughout the SUNY system. Recipients receive $4,000 to support the program and to help make it more affordable for students.

Coordinated by SUNY Global's Office of International Programs (OIP), the top proposals were selected by a committee of five SUNY campus representatives from applications submitted from across the state. Debra Fromm Faria, Assistant Professor, Department of Social Work, College at Brockport, and NASW-NYS President Elect, was selected for the "Integrative Approaches to Global Social Work" project in Russia.

Social Worker responds to New York Times article on man with schizophrenia accused of killing caregiver

A letter to the editor from Westchester social worker Sherry Saturno was published by the New York Times on June 24, 2011. Saturno highlighted the need for legislation at the national level to address violence against social workers by promoting safety. Saturno called for the enactment of the Teri Zenner Social Worker Safety Act, a measure supported by NASW.

Become Part of the NASW-NYS Leadership Team

Call for Nominations for the 2012 Chapter Leadership Election

Our Chapter is filled with social workers from across the state, who work in a variety of capacities and bring with them different talents, interests, values and cultural backgrounds. What unites us is being a member of the social work profession. As the professional association for such a diverse profession, our leadership must be as robust and diverse as our membership to represent the issues and engage in the activities that are important to each of you.

Annually the chapter has a variety of elected leadership roles that become available. The available opportunities for the 2012 election are identified below. The Chapter's Committee on Nominations & Leadership Identification (CNLI) asks you to review these opportunities and consider running for one that fits your skills and interests as a way of giving back to your profession and enhancing your own leadership skills.

Upon election, the Chapter will provide orientation to your new role, information about current chapter initiatives, as well as opportunities for leadership development. Holding a leadership position offers you an influential role at the state and/or local level to guide our programmatic and policy priorities for the organization.

You may nominate yourself, a friend, or colleague who is also a member of NASW-NYS. The members of our CNLI committee as well as our CNLI chairperson and staff liaison are all available to discuss the various opportunities with you and help you decide which role best suits you. Experienced leaders are welcome and new candidates are also encouraged to nominate.

FY 2012 Leadership Vacancies

(Term Begins July 1, 2012)

Board of Directors Officers and At-Large Members

Vice President	(2 Yr Term)
Treasurer	(2 Yr Term)
Board Member-At-Large	(2 Yr Term)
MSW Student Representative	(1 Yr Term)
BSW Student Representative	(1 Yr Term)

Division Director & Representative to the Board Of Directors (2 Yr Term)

Divisions:
- Central
- Genesee Valley
- Northeast
- Westchester
- Western

Chair Of The Committee On Nominations and Leadership Identification (2 Yr Term)

Division Representative to the Committee on Nominations and Leadership Identification (2 Yr Term)

Divisions:
- Hudson Valley
- Mohawk Valley
- Suffolk
- Nassau
- Southern Tier

Delegates To The National Delegate Assembly (3 Year Term)

13 Delegate Positions

Nominations Must Be Received By The Chapter Office By: October 28, 2011

Description of Positions

Vice President

The Vice President fulfills the duties of the President in the event of the absence of the President, attends all meetings of the Board of Directors and Executive Committee, represents the President as requested and serves as Chairperson of the Program Committee.

Treasurer

The Treasurer attends all meetings of the Board of Directors and Executive Committee, serves as Chairperson of the Finance Committee, provides at least quarterly financial reports to the Board of Directors, safeguards and conserves the Chapter's assets, and sees that Chapter fiscal policies are implemented and are in conformance with national's standards for Chapter operations.

Member of the Board of Directors

Applies to Division Directors, Board Members-at-Large, MSW and BSW Student Representatives

Board members are expected to attend all Board of Directors meetings, fulfill their job description, and conduct the business of the Chapter in accordance with Chapter By-Laws, participate in decision-making process to fulfill the mission of the Chapter, serve on other committees as requested by the President, and interpret Board policies and decisions to Chapter membership.

The Division Directors represent their respective Divisions, while MSW and BSW Student Board members represent students statewide. These Board members must be able to identify issues and concerns of their respective constituencies and advocate on their behalf. Division Directors are also responsible for the implementation of Chapter goals and local program activity in their respective divisions. They serve as chairpersons of their local division steering committees.

Committee on Nominations and Leadership Identification (CNLI)

Committee members participate in annually developing at least a double slate of candidates for chapter elections that reflect the Association's Diversity Plan, inform all candidates and appointees of the duties and responsibilities of office and are available to meet (via conference call or in person) as often as necessary to assure a sound nomination process. They work closely with their Division Director and are a member of their division's steering committee. CNLI Chair is responsible for the leadership and coordination of the CNLI, to ensure it fulfills its responsibilities and providing quarterly committee reports to the Board of Directors, as well as filing of required election documents to the NASW national office.

Delegate to National Delegate Assembly

The Delegate Assembly is the representative, decision-making body – comprised of 277 elected delegates – through which NASW members set broad organizational policy, establish program priorities, and develop a collective stance on public and professional issues. Article V of the National Bylaws addresses Delegate Assembly. The Delegate Assembly meets once every three years.For details go to:
www.socialworkers.org/da/default.asp

The Nomination Process

Complete the Nomination Form for Elective Office and submit to the Chapter office or your CNLI representative. Nominees will also be asked to complete a biographical fact sheet to provide the CNLI with additional information about the prospective candidate. For additional information regarding leadership opportunities, please contact your CNLI Representative.

CNLI Committee Members

CNLI Chair		
Denise Krause	(716) 645-1223	dkrause@buffalo.edu
Central		
Domingo Rogel	(315) 383-1966	drogel@daemen.edu
Hudson Valley		
Amy Ghio	(845) 518-0249	amyeghio@gmail.com
Genesee Valley		
Tammy Franklin:	(585) 643-0039	tf865@yahoo.com
Mohawk Valley – VACANT		
	Contact: Celisia_Street@naswnys.org	
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	NicoleSarette@nycap.rr.com	
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Suffolk		
Michelle Cavaleri	mcavaleri1@optonline.net	
Westchester		
Anne Treantafeles	fergiekelly@gmail.com	
Western		
Jesse Grossman	(716) 816-2588	
	JesseGmanLCSW@MSN.com	

Continued on page 6

2012 Nomination Form for Elected Office

Nominations due by October 28th, 2011

The Nominations & Leadership Committee uses this information to establish the preliminary slate for elected governance positions and appointments to committees and task forces. You may nominate yourself or another colleague. All nominees must be a member in good standing of the NASW-NYS Chapter. **Nominees will also be asked to complete a Biographical Fact Sheet to be considered for selection.

Name of Nominee: _____
(Please print)

Credentials: _____ **NASW Member ID#:** _____
(PhD, ACSW, LMSW, etc.)

Nominee's Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Phone: _____ **Email Address:** _____

Business/School Name: _____

Business/School Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Ethnicity:

❑ African American ❑ American Indian/Native Alaskan ❑ Asian American or Pacific Islander
❑ Mexican American ❑ Puerto Rican ❑ White
❑ Other Hispanic/Latino ❑ Other (please specify): _____

Role the nominee is most interested in and qualified for having within the chapter? Please identify all that apply.

Elected positions available in 2012:

___ Vice-President ___ Treasurer ___ Board Member-at-Large

___ BSW Student Representative ___ MSW Student Representative

___ Division Director on the Board of Directors (Central, Genesee Valley, Northeast, Westchester, Western)

___ Chair–Committee on Nominations & Leadership Identification

___ Committee on Nominations & Leadership Identification Representative
(Hudson Valley, Mohawk Valley, Suffolk, Nassau, Southern Tier)

___ Delegate to National Delegate Assembly

Please list area(s) of expertise held by the nominee that you believe qualifies the person for the position(s) indicated:

_____

_____

Name of Nominee (if other than nominee): _____

Phone: _____ **Email Address:** _____

Submit Nomination Form by October 28, 2011 to: NASW-NYS Attn: CNLI, 188 Washington Ave, Albany, NY 12210
Fax: 518-463-6446
Email: Annmarie_Graybash@naswnys.org

CUT OUT AND RETURN

Welcome to the New Blythedale.

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In December, born from one such visionary concept, Blythedale will open the doors of its new state-of-the-art children's hospital—a place where seriously ill children and their families can also dream big… about their health, their future, and the quality of their lives.

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We emphasize an innovative treatment program that incorporates teaching, ongoing research and advocacy. At Blythedale, administrators, clinicians and parents work collaboratively toward the goal of achieving overall patient health and independence.

For our young patients and their families, our progressive approach and positive energy has always been a source of inspiration and hope. Today, we have the healthcare environment that can routinely transform their dreams into medical wonders.

The new inpatient hospital opens December, 2011. Arrange a pre-opening tour by contacting: Susan Murray, Director of Social Work at susangm@blythedale.org, or call (914) 831-2443.

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Call for Nominations: 2012 NASW-NYS Social Work Awards

Celebrate Excellence and Service in the Field of Social Work

NASW-NYS is searching for nominees for **Social Worker of the Year, Lifetime Achievement, Agency of the Year, Public Citizen of the Year, and Student of the Year Award.** We need your help celebrate and honor individuals who represent the best in social work and fulfill the social work mission.

The Social Worker of the Year Award recognizes the commitment and achievements of an outstanding member of our profession. The Lifetime Achievement Award honors a social worker who has devoted his or her career, and made exceptional accomplishments on behalf of those in great need and the profession of social work. We are also seeking a non-social worker who, through her or his business, professional, and/or community activities, best exemplifies the goals and ideals of the social work profession for the Public Citizen of the Year Award. Agency of the Year Award honors an agency, department, organization, or government entity within the NASW-NYS catchment area, which best exemplifies social work values in the field.

Please consider the following nominee criteria in making your nomination.

Social Worker of the Year

An individual considered for this award should demonstrate exceptional professional qualities that make her or him stand out beyond the expectations of her/his job.

The person you nominate must:

- be a member in good standing of NASW-NYS
- demonstrate leadership qualities of an exceptional nature
- effectively integrate experience with education in an outstanding effort to help people
- show a willingness to take risks for improved social services
- enlist public support for improved social services
- contribute to the public's knowledge of social work
- represent the professional ethics of social work as defined in the NASW Code of Ethics

Public Citizen of the Year

An individual considered for this award should have made outstanding contributions to the area of human services, which go beyond the expectations of her/his job. In addition, she or he cannot be a social worker.

The person you nominate must have:

- demonstrated leadership qualities
- made an important contribution to the social work profession
- advocated for or taken risks on behalf of one or more of social work's client group
- contributed to a positive public image of professional social work
- contributed to the amelioration of a pressing social problem
- acted in concert with the professional ethics and values of the social work profession
- helped improve the quality of life in the community

SOCIAL WORKER OF THE YEAR
PUBLIC CITIZEN OF THE YEAR
LIFETIME ACHIEVEMENT AWARD
AGENCY OF THE YEAR AWARD
STUDENT OF THE YEAR AWARD

Lifetime Achievement Award

In addition to meeting all of the criteria for Social Worker of the Year, the candidate must also demonstrate:

- repeated outstanding achievements
- recognition beyond the social work profession
- contributions with a lasting impact
- outstanding creativity and courage

Agency of the Year Award

Honors an agency, department, organization, or government entity within the NASW-NYS catchment area, which best exemplifies social work values in the field.

The agency should:

- Promote and uphold NASW standards and code of ethics
- Develop/ implement innovative approaches for the provision of more effective services
- Make a significant contribution to an area or population of concern to the social work profession such as advocacy for consumers, impact on social policy, exceptional practice, program creation, administration development, and/ or innovative research
- Has a diversity of employees that reflects their clientele and/or has policy that implements culturally competent practice

Student of the Year Award

The NASW-NYS Social Work of the Year Award is presented to a Masters or Baccalaureate level social work student who has demonstrated academic excellence and personifies the values of the Social Work Profession as defined by the NASW Code of Ethics. The Student selected will have demonstrated leadership skills and interest in community involvement within the University or greater community setting. The student's work or volunteer interest should demonstrate contributions through community involvement which make a difference in the lives of others, through the use of social work skills and abilities; commitment to advocacy; and improving the quality of life for others.

Deadline for Nominations: **NOVEMBER 11, 2011**

The award recipients will be personally notified and the announcement of the award winners will be published in the Winter 2011-12 newsletter. The awards will be presented at our annual Power of Social Work Conference, Awards Luncheon, on Friday, March 16, 2012 in Albany NY.

Award Recipients will receive free admission to our annual statewide conference and be provided with transportation to and from the conference. (Transportation limited to train, bus, and mileage.)

Continued on page 10

2012 NASW-NYS Chapter Awards Nomination Form

Nominations due by November 11th, 2011

Check the award for which your candidate is being nominated:

❑ Student of the Year ❑ Social Worker of the Year ❑ Public Citizen of the Year

❑ Lifetime Achievement Award ❑ Agency of the Year

Name of Nominee: _____

Current Position: _____

Business Address: _____

Office Phone: _____ **Home/Cell Phone:** _____

Email Address: _____

Description of Nominee's Contributions/Activities:

Please attach supporting documents describing your nominee's qualifications for the identified award- Resume, news articles featuring nominee, letters of support, volunteer work.

_____

_____

_____

_____

Name of Nominator: _____

Nominator's Address: _____

Phone: _____ **Signature:** _____

Your complete information will help the program committee get a full impression of your nominee.
Please submit the nomination form by Friday, November 11, 2011.

Send completed nominations to:

NASW-NYS Chapter Program Committee
188 Washington Avenue, Albany, NY 12210
Fax: 518-463-6446
Attn: Jacqueline Melecio

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*Fee includes workbook with complete sample tests. Lunch is on your own.

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Long Island, NY–Hyatt Regency Hauppauge

April 21 & 22, 2012
Westchester, NY–Radisson Hotel New Rochelle

June 23 & 24, 2012
Albany, NY–Marriott Hotel

September 15 & 16, 2012
Rochester NY–Hyatt Regency, 125 E. Main Street

Register Online at www.NASWNYS.org

Approved Continuing Education Programs/NASW CERP

The following programs have been accredited for the listed number of Category I contact hours by the NASW-NYS Chapter Continuing Education Recognition Program (CERP). The CERP both accredits programs for continuing education credits and provides NASW members with an opportunity to have their credits recorded. Members who accumulate 90 contact hours of credit in a three-year period are eligible for a continuing education certificate.

Program providers who wish to have their programs accredited should submit an application form, the program schedule, the resumes/vitae of all the presenters and the review fee. The fees for providers are: $100 per program, $150 for multiday events, $350 for five programs in a 12-month period or $900 for unlimited programs in a 12-month period. NASW members wishing to participate in the CERP must register with the program. The service is free for NYS Chapter members; for all others, there is a $60 fee, for one three-year registration period.

For additional information, or to obtain application or registration forms, please contact the NYS Chapter office at (800) 724-6279 ext. 17, (518) 463-4741, or e-mail at james_koonce@naswnys.org. For information on a particular program, please call the contact number found in the listing.

October – November 2011

13 October, 2011 **Administrative Supervision**
SUNY Buffalo School of Social Work Buffalo (716) 829-3939 11 CEUs

14 October, 2011 **Privacy, Confidentiality, Privilege, and the Duty to Warn: Ethical and Legal Implications Clinicians Need to Know**
SUNY Buffalo School of Social Work Buffalo (716) 829-3939 6. CEUs

14 October, 2011 **Connecting the Dots: The Effects of Adverse Childhood Experiences**
Community Cradle Albany, NY 5184261153 6. CEUs

17 October, 2011 **Assessing and Effectively Treating Obsessive Compulsive Disorder: Implications for Trauma Treatment**
SUNY Buffalo School of Social Work Buffalo (716) 829-3939 6. CEUs

25 October, 2011 **Diversity in Mental Health Symposium**
SUNY Buffalo School of Social Work Mainsville, NY (716) 829-3939 2. CEUs

3 November, 2011 **Early Experience and Child Maltreatment through a Neurodevelopmental Lens and the Neurosequential Treatment Model**
Adelphi University New York City (516) 877-4343 6. CEUs

3 November, 2011 **Reducing Risk of Alzheimer's and Other Age-Related Cognitive Decline**
Health Ed Albany, NY (715) 552-9517 6. CEUs

10 November, 2011 **Psychological Testing: Turning Scores into Strategies and Solutions**
Jewish Child Care Association New York City (212) 558-9949 3. CEUs

10, 17 November, 2011 **Strategic Marketing and Community Relations**
SUNY Buffalo School of Social Work Buffalo (716) 829-3939 11 CEUs

15 November, 2011 **9th Annual Geriatric Palliative Care Conference**
Jewish Home Lifecare New York City (212) 870-4997 6. CEUs

15 November, 2011 **Wolves, Sheep, and Shepherds: Identification and Response to Sex Offenders in General Clinical Practice** SUNY Buffalo School of Social Work Buffalo (716) 829-3939 6. CEUs

Welcome to the Newest Members of NASW-NYS

Angel Luis Ramos Estrada
Emily Anne Karas
Danika Mills
Kelly O'Connell, LMSW
Stephanie Anita Rodriguez
Laura Stunden
Rebecca Vandersluis
Kelly Lynn Ziemer

CENTRAL

Karen Lisa Coleman, MSW
Corinna Doctor
Jessica Farnett, BSW
Kimberly Figueroa
Diane L. Fromm
Evelyn Hanna
Michele P. Hart, LMSW
Shirley Ann Hurlburt
Allyson Leigh Luce
Jennifer Marsh, LMSW
Michael Nunno
Lisa Anne Parlato
Karen A. Peruzzi
Amber Marie Roy
Katrina Skeval
Christina Ann Sylver
Susan Weibezahl Porter

GENESEE VALLEY

Portia Archer, MSW
Christopher Campbell
Michelle R. Carello
Tammie Delforte-Papas
Tahrea Michelle Flemming
Lauren Renee Ferrimani
Meghan Elizabeth Gansemer
James X. Kennedy, LMSW, MS
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Laurie Perry
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Jennifer L Byrnes, LMSW
Sarah Elspeth Coughtry, B.A.
Madelin DeLeon, MSW
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CBT for Insomnia and Poor Sleep

Richard E. Madden, MSW, PhD

Course Description

Insomnia is a risk factor in the development and recurrence of anxiety and depressive disorders and substance abuse. Despite the popularity of sleep medications, cognitive behavioral treatment for insomnia (CBT-I) is proven to work better than drugs. This course will introduce the four major components of CBT-I intervention along with salient sleep science, common sleep disorders, client handouts and online resources.

Course Learning Objectives

Upon completion of this course the reader/clinician can expect to be able to:

1. **Discuss the causes of insomnia from cultural, physiological, environmental and psychosocial perspectives;**
2. **Demonstrate knowledge of sleep science sufficient to motivate and guide clients toward sleep improvement goals;**
3. **Screen and refer to sleep medicine for common co-occurring medical sleep disorders including sleep apnea;**
4. **Calculate sleep efficiencies using handout forms to help clients develop their own sense of sleep self-efficacy;**
5. **Perform at least one behavioral, cognitive, educational, stress reduction and sleep induction intervention for insomnia.**

Richard E. Madden,
Founder & President

About the Author

Richard Madden has degrees in Anthropology/Pre-med, Social Work and Electromedical Sciences with advanced training and certification in biofeedback and REBT/CBT. Dr. Madden is a founding member, Society of Behavioral Sleep Medicine and is the founder of the Center for Sleep Counseling Studies, Inc., offering training and certification to mental health practitioners in Clinical Sleep Counseling (www.sleepcounseling.org).

To learn more about Richard E. Madden's course and insomnia, visit www.sleepcounseling.org

Introduction: The Perils of Sleep Loss

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

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 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.

Sleep 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).

Insomnia and Mental Health

According to Dr. Michael Perlis, Director of the UPenn Sleep Medicine Program, 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 (Perlis, 2004). There is also good evidence that insomnia is a risk factor for the development and/or recurrence of anxiety disorders (25%) and substance abuse (7%).

Post-treatment depression resolution is accompanied more than 50% of the time by residual insomnia–effectively debunking the myth that insomnia is merely a symptom of depression. "What came first really doesn't matter–insomnia is a risk factor," states Dr. Colleen Carney who urges mental

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health clinicians to offer CBT-I to any client with insomnia symptoms irrespective of the presence of other medical or psychiatric symptoms (Carney, 2010).

Dr. Allison Harvey at UC Berkeley cites empirical evidence indicating that sleep disturbance may be one causal pathway that leads to relapse in bipolar disorder. Challenging the common assumption that insomnia is symptomatic of or secondary to the "primary" psychiatric disorder, Dr. Harvey argues on the basis of new evidence that insomnia may be "an important but under-recognized mechanism in the multifactorial cause and maintenance of psychiatric disorders (Harvey, 2008)."

A 2001 University of Michigan study compared relapse rates following alcoholism treatment of subjects with and without insomnia. Sleep maintenance insomnia had the highest correlation with relapse and, overall, post treatment relapse was greater among those with insomnia. Brower, et al, concluded that sleep and insomnia assessments during alcoholism treatment could potentially prevent relapse and improve recovery (Patrick, 2009).

A recent Harvard study measuring reduced levels of GABA in insomnia subjects speculated that anxiety, depression and insomnia may all share a similar underlying physiology ("Brain GABA Reduced," 2008). All this new knowledge brings the Social Work Profession to an interesting clinical juncture where social workers are challenged to conceptualize and treat mental illness and insomnia as bi-directional in nature. The "new" social work clinical practice will have increased awareness of the insidious role that insomnia and poor sleep play in the lives and afflictions 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.

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 90 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 overnight laboratory sleep study, is not indicated for making a diagnosis of insomnia like it is with most all other medically-related sleep disorders.

Sleep Med Madness

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 estimates for the year 2010 were $5 billion.

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 less effective than the non-drug, cognitive-behavioral treatment (CBT-I) for insomnia (Jacobs, 2007). What a sad commentary this is on the efficacy of medically-based insomnia treatment in America today.

A thorough discussion of sleep medication would need to address the many dimensions of the issue including the role of "big pharma," expediency for providers, medical education and efficacy vs. effectiveness. For example, some sleeping pills shorten sleep latency (the time it takes to fall asleep) on average by only ten minutes while some popular sleep meds actually create amnesia for awakenings during the night to mask broken sleep (Naiman, 2008). A revealing and provocative online resource is pioneering sleep researcher Dr. Daniel Kripke's website (**www.darksideofsleepingpills.com**).

Meds: Yes-No-Maybe

New clients are often already taking medications intended for sleep that have been prescribed by their primary care physicians. There is a down side to most all long term use of sleep meds and even a dark side to the use of some, according to Dr. Kripke. Despite possible intuitive appeal of a combined CBT and medication approach to the treatment of insomnia, there is no clear empirical support for using drug and non-drug approaches together (Morin, 2004).

A combined approach (CBT-I and meds) also risks patient attribution of success to the drug. This tendency is eliminated

after medication is discontinued. Sleep self-efficacy is bolstered when clients, free of medication, choose to apply newly-learned sleep skills to cope with bouts of rebound insomnia without immediately turning to medication as they probably did in the past. Long term use of CBT-I methods has been shown repeatedly to be superior to either drug or combined use and, probably due to de-conditioning effects, actually yields gradually increased sleep improvement for up to two years after treatment.

It is generally agreed upon in the CBT-I literature that administration of this treatment displaces sleep medication, however, there is no agreement about how to handle clients who enter treatment already on sleep meds. Some clinics refuse admission until the client has already withdrawn from all sedative-hypnotics and sleep meds, except for any psychotropic medications necessary for emotional stability. Completing withdrawal before CBT-I treatment has the added advantage of generally avoiding setbacks later on during or after treatment (Perlis, 2004).

Dr. Gregg Jacobs explains that, alarmingly, 65% of patients who are prescribed benzodiazepines for short-term use (usually 2-4 weeks) are still taking them one year later, and as many as 30% are on them at least 5 years. But Jacobs reveals some very encouraging results in helping long-term benzo users to quit meds while they are participating in CBT-I treatment. He cites a study by Dr. Charles Morin, et al, of 76 subjects aged 55 to 72 who complained of insomnia even though they had been using sedative-hypnotics for 20 years. On average, they made at least six attempts to stop their benzo use during this time without success; and some were using two or more hypnotics (Jacobs, 2007).

The study randomized these subjects into 3 groups: (1) medication tapering only; 2) CBT-I only; and (3) combined CBT-I and medication tapering. After treatment, the following percentages of patients were medication-free for the three groups, respectively: (1) 48%; (2) 54%; (3) 85%. Not only was the combined approach far more effective in helping patients get off medication, but all the patients who tapered off meds also experienced more slow wave, deep sleep as evidenced by sleep lab EEG recordings.

The manual and study guide for the new practice specialty of Clinical Sleep Counseling (**www.sleepcounseling.org**) contains several recommended tapering protocols, but the clinician is advised to work with the primary care physician in establishing a reasonable schedule for the client to titrate down and off of medication dependence. In rare cases detox may be indicated for severe benzo dependency on meds like Valium and Librium.

Brief Biology of Sleep

It is not even known for sure why we sleep, but the reason appears related to cell and tissue growth and repair along with memory consolidation and learning. Human growth hormone, for instance, is secreted during NREM 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 atonia, or paralysis, prevents the acting-out of dreams that, otherwise, could cause injury. Unlike deep sleep, waking from REM results in a rapid orientation generally without much grogginess and often with vivid recall of prior dreaming.

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).

Melatonin, the darkness hormone, normally begins around 9 pm to promote sleep around 11 pm. Low light, activity and stimulation levels are needed to accomplish the "perfect storm" of sleep in the evening when core body temperature drops along with cortisol and adrenaline levels. Normal room lighting at night, however, can reduce melatonin production by 30%. Noise, chemical, light, activity and mental stimulation, plus stress residual from the day can further interfere with or prevent the perfect storm of sleep.

Light management is key to Clinical Sleep Counseling so that clients understand how the timing of their exposure to light and darkness affects their sleep cycle and sleep quality. The nadir, or lowest point, of the core body temperature in the 24-hour cycle is about two hours before awakening, around 4 am. With adequate light exposure before 9 am, the biological clock daily resets to promote sleep readiness approximately

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16 hours later. A constant rising time along with light in the morning is crucial to regular and sound sleep.

The reader is urged to visit **www.cet.org** where the night owl/morning lark test can be taken to show times of melatonin production. There is also an automated depression inventory for clients to take online along with resources related to the fascinating field of Chronotherapeutics. This is an excellent resource for therapists and clients alike.

Culture of 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 8¼ hours to 6⅔ 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 night and the biological imperative to sleep. And then what? Like 70 million other Americans, we may have trouble falling asleep or staying asleep and feel unrefreshed 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.

Sleeplessness Defined

Primary ("psychophysiologic" or "conditioned") insomnia is now considered to be a distinct diagnostic entity whereas secondary insomnia is viewed (sometimes erroneously) as symptomatic of an underlying medical or psychiatric condition. An underlying condition might be depression, pain, diabetes or menopause. Nearly everyone is bound to experience a few nights of transient insomnia now and then, or even a week or two of short-term or acute insomnia.

Duration of a month or longer, however, qualifies as chronic insomnia although six months is often used clinically to distinguish chronic primary insomnia (CPI). The average person with chronic insomnia who seeks help has suffered for at least 10 years. Very often the precipitating event or stressor has been long forgotten and classical conditioning effects serve to reinforce and maintain the state of heightened physiologic arousal that prevents sleep and is so characteristic of chronic insomnia.

Primary insomnia can be defined as *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* (AASM, WHO, DSM-IV).

Clinical Sleep Counseling also offers an innovative and profoundly simple working definition that captures the essence of insomnia:

- **Unsatisfying sleep with daytime impairment and sleep efficiency < 85%**.

  Sleep efficiency will be explained and its use demonstrated in Part B of this course.

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 irrespective of the absence of a formal diagnosis of clinical-grade insomnia.

Insomnia Assessment

Formal assessment of insomnia can employ the use of questionnaires such as Dr. Charles Morin's Insomnia Severity Index (ISI) and the NSF's sleep inventories, however, brief dialogue about sleep with clients can quickly, easily and accurately screen for insomnia.

In fact, waiting room ice-breakers, routine greeting or even session start-up can simply inquire of clients as to how well they slept the night before. A "fine" or "great" response supported by congruent observation of their energy, alertness and affect generally removes insomnia from the list of immediate concerns and issues.

"Fair," "Okay," "Lousy," and "I didn't sleep at all last night," are all possible responses that open the door to further insomnia exploration and sleep understanding; *but only if the reader wishes to investigate these symptoms at the time. Sleep Counseling's purpose is neither to direct nor to hijack your treatment with clients but, rather, to help you add an additional thread of sleep treatment to the existing fabric of your therapeutic tapestry with clients and patients.*

You may wish to ask clients:

- How they slept the night before, how typical that sleep was and how satisfied they are, generally, with their sleep. If unhappy with their sleep, ask if:
- They have trouble falling asleep within 30 minutes and staying asleep (more than 3 awakenings for more than 10 minutes each generally signals insomnia);
- Their sleep is usually refreshing and restorative;
- They experience daytime distress and impairment such as feeling tired and fatigued, depressed, irritable, unproductive, anxious, brain fog, etc.

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 (EDS) appearing as napping, dozing or nodding-off is not characteristic of insomnia like it is of sleep apnea and narcolepsy. In fact, most PWI (people with insomnia) can't nap when they try. This is all due to the heightened state of arousal that prevents sleep from happening–day or night.

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.

There is also a worthwhile role to be played by Clinical Sleep Counseling in screening for OSA, facilitating referrals to sleep medicine for consults and/or laboratory sleep studies, addressing patient resistance in following through, and providing support for clients who would benefit from using the prescribed positive airway pressure devices.

Medical Sleep Disorders

Sleep Counseling using CBT only targets behavioral insomnia (clinical) and poor sleep (subclinical insomnia) yet there are over 90 medically-related sleep disorders. For purposes of making timely and appropriate referrals to sleep medicine, however, it is useful for social workers to gain a working knowledge of the more common comorbid medical sleep disorders frequently identified during work with clients.

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 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 (OSA)

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, unrefreshing 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

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treated for depression without further 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; but so can the medical consequences.

Frequent apneas (breath-holding) and hypopneas (partial breath) common to OSA sufferers, cause severe oxygen de-saturation that challenges the cardiovascular system to the point of increasing the risk for heart attack and stroke. This is what inspired Dr. Dement's warning above and also makes screening for OSA such an important function of Clinical Sleep Counseling. Sleep-aware social workers will be making many more referrals to Sleep Medicine and, potentially, helping to save many lives in the process.

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 Screening (AQS-10) and the Epworth Sleepiness Scale (Edinger, 2008).

Restless Legs Syndrome (RLS)

This is the third most prevalent sleep disorder after insomnia and OSA. Symptoms include "creepy-crawly" sensations in the legs when resting quietly or even burning and painful feelings that are relieved by walking or moving.

Periodic Limb Movements (PLM)

These involuntary movements of the limbs occur in brief (less than 5 seconds) episodes and follow a sequence of four distinct twitches or movements of toe, ankle, knee and hip.

Episodes are from 15 to 40 seconds apart and often are not as disruptive to the patient's sleep as to the bed partner's sleep. Many people diagnosed with RLS also have PLM.

Narcolepsy

Narcolepsy is characterized by: (1) excessive daytime sleepiness(EDS) including brief sleep attacks or microsleeps; (2) cataplexy or sudden loss of muscle tone (going limp) triggered by strong emotion like laughter, anger, fright, shock or sadness; (3) hallucinations on the way into and out of NREM Stage 2 sleep that can be weird or scary; (4) sleep paralysis during sleep/wake transitions that may be accompanied by hallucinations and out-of-body sensations. Less than 25% have all four symptoms.

Parasomnias

People with OSA are more vulnerable to parasomnias which are behaviors that intrude into sleep, happen when transitioning from one sleep stage into another, or occur during sleep/wake transitions. They are disorders of arousal and may include sleepwalking, sleepeating, and sleep terrors that occur during slow wave, deep sleep in the first part of the night sleep. Waking from deep sleep produces grogginess and disorientation.

REM Sleep Behavior Disorder (RBD)

RBD occurs during REM sleep when bodily movement in relation to vivid dreaming is normally prevented by an accompanying state of atonia or muscle paralysis. RBD unfortunately allows the acting out of dreams including sudden, explosive and violent behaviors such as thrashing about. RBD commonly co-occurs with narcolepsy.

Nightmare Disorder

Unlike night terrors that occur during NREM sleep in the first half of the night, nightmares usually happen in the second half of the night. Also unlike sleep terrors that are not remembered, REM nightmares are usually recalled in great detail and evoke strong emotions. Common in children, they often grow out of nightmares.

Circadian Rhythm Disorders (CRD)

One of the indications of CRD is when the sleep pattern and corresponding melatonin levels are out of sync with the rhythm of the core body temperature. Perhaps 25% of patients presenting at sleep clinics with insomnia actually have CRD. Both RLS and CRD can masquerade as primary insomnia.

Delayed Sleep Phase Disorder (DSPD) is the most common and is marked by a sleep pattern whose onset is at least two hours later than is culturally customary–2 am or later. The amount and quality of sleep is normal but the cycle is delayed.

Advanced Sleep Phase Disorder (ASPD) is often associated with aging as sleep is skewed in the opposite direction and is only problematic when the individual is unable to stay awake late enough or awakens too early to function as desired.

CBT-Insomnia Intervention

Sleep Hygiene

Sleep hygiene suggestions abound these days in the media but many sleep prescriptions are incomplete or inaccurate to some degree and most are ignored anyway! This highlights an important role for Sleep Counseling in educating clients concerning good sleep hygiene, and supporting them to make and sustain these positive sleep changes over time.

The "Ten Commandments for Better Sleep" client handout was originally named, "Ten Tips," until it was realized that, for PWI (people with insomnia), these recommendations are actually rules, the violation or ignorance of which must result in the forfeiture of better sleep. Similar to followers of the biblical Ten Commandments, one decides if and when the sleep commandments will be observed; the tendency being to pick and choose rather than fully comply. Subclinical insomnia sufferers may thus indulge with only mild consequences, however, PWI can not afford to do so without experiencing significant or severe negative consequences.

A helpful response often used in Sleep Counseling when a client refers to the Ten (Sleep) Commandments complaining about "not being able to…" is to ask them how important obtaining better sleep really is to them, and then empathize how great it would be if we could get "right" results in life by doing the "wrong" things. The first part of this response re-orients the client to the importance of the goal and dislodges low frustration tolerance. The second part emphasizes rational "cause and effect" and challenges unfairness, self-pity and additional discomfort intolerance.

The Ten (Sleep) Commandments client handout not only includes important sleep hygiene education, it also briefly explains some important sleep science behind the recommendations. These explanations do not usually accompany the sleep hygiene suggestions that appear in electronic and print media. 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 and groups, and in community presentations and workshops.

Some clients will wish to ignore certain items on the Ten Commandments sleep hygiene handout and pick-and-choose the hygiene tips that they agree with or find easier to accomplish–just like the biblical Ten Commandments! 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 for PWI are really rules–not recommendations. Failure to comply with even one critical item, such as commandment number one, will probably preclude sleep success for a PWI no matter how closely the other commandments are followed.

Do's and don'ts lists are unpopular with many people. After all, who enjoys being told what to do? 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. Diligently following the Ten (Sleep) Commandments and practicing the other cognitive, behavioral and relaxation methods used in Clinical Sleep Counseling as described in this course, will produce the best prospects for the best sleep.

One third of the sleep tips contained in the Ten (Sleep) Commandments client handout relate to light. This reflects

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(sorry!) 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 core body temperature, cortisol levels and blood pressure.

Since light has such powerful effects on our circadian rhythm, artificial light can be used therapeutically to influence the sleep cycle (visit **www.cet.org** to learn more about chronotherapeutics). Conversely, light-at-night (LAN) can not only damage sleep and have adverse health effects, but is now thought to be a cause of breast cancer in women. For many reasons, LAN is becoming an increasingly important field of study.

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 vastly increases the likelihood 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. For many of us, however, doing so will produce the ill effects of insomnia and poor sleep.

Please see page 29: Ten Commandments for Better Sleep client handout aka Ten (Sleep) Commandments

You have permission to use this form in your own clinical practice and may obtain free copies from **www.sleepcounseling.org**. Best results seem to come from going over this handout with clients in session and item-by-item, explaining as best you can at this point in your understanding, rather than merely giving it to the client to take home.

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:

SLEEP EFFICIENCY $\frac{\text{6 Hours: Total Sleep Time (TST)}}{\text{8 Hours: Time in Bed (TIB)}} = 75\%$

Would a sleep efficiency of 100% be indicative of a perfect sleeper? That would mean a sleep latency period (the time it takes to fall asleep) of zero. But taking less than ten minutes to fall asleep is usually symptomatic of sleep deprivation and excessive sleep debt indicating a need for longer duration nightly sleep--hardly the sign of a perfect sleeper! It normally should take at least 10 minutes, but less than 30 minutes, to fall asleep. Clients with sleep onset insomnia routinely 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, some clients we see for sleep concerns believe that sleep is a waste of time anyway; so the idea of improving their sleep efficiency may make good sense to them.

Many other 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 with insomnia (CWI) 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 CWI, every minute spent lying awake in bed conditions the brain to associate bed with not sleeping.

That is why CWI 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).

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Ten Commandments For Better Sleep

(Violation of which may doom you to insomnia hell if you are a PWI)

1 Try to maintain a regular sleep schedule by getting up at the same time every morning and avoiding sleeping in weekends beyond one extra hour. This practice will "anchor" your sleep schedule and become the foundation for your new and reconditioned sleep;

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;

2 Bed should be used only for sleep. Any other activity weakens the association of bed with sleep. Ideally, this means no television, computer, texting or talking on the phone, home or office work, and no eating, drinking or even sex (ideally) 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, but it is proven that they also contribute to shallow and disturbed sleep by causing frequent awakenings that are not remembered. Decide what is truly best for your sleep and health;

5 A 30 to 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, eating breakfast by a window or ample artificial light exposure may help satisfy this need for morning light stimulation before 9 am;

6 Regular exercise is essential for optimal health and well being including sound sleep. Exercising 3 to 6 hours before bedtime is optimal for relaxation and lowering of body core temperature to promote sleep as is a hot bath approximately 1-2 hours before sleep;

7 Eating and drinking close to bedtime can interfere with falling and staying asleep but so can hunger. A light snack of complex carbohydrates is fine if hungry before bedtime or during the night. Avoid stimulants like sugar, high fructose corn syrup and nicotine, especially later in the day, and try to limit liquids to one cup within 4 hours of bedtime;

8 The clinical effects of caffeine generally last from 4-6 hours and longer for some people who are especially sensitive. Generally, the last consumption should be at least six hours before bedtime. Alcohol close to bedtime actually lowers melatonin production, increases adrenaline and disrupts sleep throughout the night. OTC sleep aids, prescribed medication and supplements 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 Sheet;

10 Napping correctly can be very healthful but only after having successfully used these and other behavioral techniques to recondition your sleep. A 20-40 minute nap about half way through the day will then be refreshing without damaging your sleep at night.

Sleep (Efficiency) Sheet client handout aka Sleep Sheet

The Sleep (Efficiency) Sheet included in this course is a novel way to monitor sleep for quality and quantity. You have permission to use it in your own clinical practice. This form is for nightly use; a weekly form is also available at **www.sleepcounseling.org**.

Sleep Efficiency Sheet

Please Complete Right After Waking

Name: _____

Day: _____ **Date:** _____

A. What time did you go to bed last night?

B. When was "lights out" and readiness for sleep?

C. *About* how long did it take you to first fall asleep?
Estimate and circle:
(¼) (½) (¾) (1) (1¼) (1½) (1¾) (2) ( )hours

D. How many times did you wake up during the night?
Total # awakenings:
(1) (2) (3) (4) (5) (6) ( )times

E. After initial sleep, about how long were you awake last night?
Estimate total time awake:
(¼) (½) (¾) (1) (1¼) (1½) (1¾) (2) ( )hours

F. What was your final wake up time?

G. What time did you get out of bed?

H. What was your total Time in Bed (B until G)?

I. What was your Total Sleep Time [B until G – (C+E)]?

J. What sleep preparation, 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)

Poor		Fair		Good			Excellent		
1	2	3	4	5	6	7	8	9	10

Sleep Efficiency =
(I) Total Sleep Time (TST) X 100 = _____% SE
(H) Time in Bed (TIB)

SE Sheet Explained

It is a good idea to complete nightly Sleep Sheets for a week to evaluate your own sleep. Many of us have our own sleep issues and this is a good way to establish a baseline before applying CBT-I for our own sleep improvement. It is also the best way to learn what clients will be experiencing when completing their own sleep sheets.

(A) and (B) are important distinctions to make since clients may go to bed and engage in activities for awhile before desiring to go to sleep. Good sleepers can get away with poor sleep hygiene and still mostly sleep well, however, CWI will benefit from adhering to the Ten (Sleep) Commandments while applying CBT-I. Using bed strictly for sleep to retrain their brains to associate bed only with sleep means that the (A-B) time span should be very short. If not, all activities in the bed or bedroom other than sex should be strongly discouraged as per the Ten (Sleep) Commandments.

If sleep onset (C) reveals a latency period of less than 30 minutes, strict application of the Ten (Sleep) Commandments may be relaxed concerning activities and the time period between (A-B). Always reinforce to clients that one of the best investments in sound sleep is to practice strengthening the paired stimulus-response of bed and sleep. The cue for sleep is weakened by any stimuli other than bed.

The (F-G) differential indicates any early morning awakening often accompanying clinical depression and is referred to

as late or terminal insomnia (to differentiate it from early/onset insomnia or middle/maintenance insomnia). If (F) is close to rising time, getting up and starting the day is usually preferable to lying in bed awake reinforcing insomnia and lowering sleep efficiency.

(J) notes any meds taken or intentional preparation for sleep. (K) rates the subjective experience of refreshment and restoration from the night's sleep upon waking.

(H) and (I) are used to calculate sleep efficiency (SE) in percentage terms at the bottom of the form. Data from nightly sleep sheets can easily be transferred to weekly sleep sheets if desired. If session time allows, it is often productive to discuss sleep sheets with clients who usually have revelations about their sleep patterns to share.

Sleep sheets inform the behavioral treatment, especially stimulus control and sleep scheduling interventions to be discussed next.

CBT-I Behavioral Component

Stimulus Control (SC)

The "stimulus control" technique originated by Richard Bootzin, PhD, 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 any non-stimulating activity until they become very sleepy. This may include reading, television and listening to music.

When sufficiently sleepy, clients should 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 often noted within a week.

Clients should be reminded of sleep commandment #9 on the 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.

When clients return to bed after spending time under low light engaged in some non-stimulating activity, it is not necessary for them to worry about how much time is passing before they get up again (the prescription is 15 minutes). Instead, they can merely gauge their mental activity and state of arousal so well known to them. Asking themselves if, given this level of arousal, they are likely to still be awake in 15 minutes will allow them to get out of bed again right away (thus improving sleep efficiency and de-conditioning their insomnia) instead of lying there wondering if 15 minutes has passed.

Even though clients don't sleep appreciably less while practicing SC, their perception of and reaction to the procedure may be to feel somewhat more tired the next day than usual. This information can be shared with clients and a caution issued concerning driving long distances and the like. In anticipation of any increased tiredness during the day, initiating SC before a weekend may help adherence and outcome.

Trying to sleep is a sure-fire way to perfect wakefulness. A study that promised to reward subjects with a cash prize for quickly falling asleep found that they took three times longer to get to sleep than the subjects who were only asked to fall asleep without reward (Jacobs, 2007). Meditative and visualization techniques that focus on relaxed waiting for sleep to come are far superior to the mindset of making sleep happen. The last section of this course will present helpful relaxation and sleep induction techniques.

Sleep Scheduling (SS)

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 the term "sleep restriction" is 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. A more accurate name for sleep restriction is sleep constriction or sleep scheduling (SS).

If a client's sleep sheet completed for one week yields a SE score of $\leq$ 85%, then this would indicate that the client is spending too much time in bed awake relative to the time asleep. Compared with good sleepers who average $\geq$ 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–effectively conditioning the insomnia.

In the use of sleep scheduling, 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 actually be sleeping no more or less than before.

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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 PWI sleeps about 5¾ hours, 6 hours is recommended as the minimum starting point to use for sleep scheduling as long as the time in bed (TIB) the client has been spending is somewhat longer (7, 8½,10 hours, etc.).

This starting point, derived from 1-2 week use of sleep sheets to determine the average total sleep time (TST), is referred to as the prescribed time in bed (PTIB).

In review, the suggested sleep scheduling formula for determining the PTIB is:

- Average TST (obtained from nightly sleep sheets for 1-2 weeks)
- Minimum of 5 ½ hours
- Plus ½ hour (time for getting to sleep/brief awakening during the night)
- Equals the starting PTIB (6 hours minimum)

Some sleep specialists recommend a starting PTIB of 5 hours if clients are only getting 3 to 4 hours average TST due to very severe insomnia (Glovinsky & Spielman, 2006). Clinical Sleep Counseling recommends, however, that the starting PTIB be no less than six hours. Clients with such severe insomnia that their PTIB calculation prescribes less than 6 hours for a sleep scheduling starting point should be referred to a sleep specialist who is, preferably, boarded in behavioral sleep medicine (CBSM).

CWI using this sleep scheduling intervention 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 at least for the first few days. Clients should be advised to call if they become unusually tired, but be careful not to plant this suggestion.

To address an initial complaint of excessive tiredness, the starting PTIB can be increased by 15 or 30 minutes–the amount used for regular weekly titrations.

After one week of ≥ 90% sleep efficiency, determined by nightly sleep sheets, 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 above 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 would otherwise take 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 scheduling 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 at 90% or higher.

Sleep Self-Efficacy

Sleep scheduling relies on the daily wake-up time remaining the same to serve as an "anchor" for the sleep cycle. For example, if the SE sheet 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 scheduling 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 brain-storming with the client may be helpful in looking for effective, non-drug ways to stay awake. 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%), clients may decide to re-introduce one or more enjoyable, but potentially insomnia-promoting, activities banned by the Ten (Sleep) Commandments client handout. It is not advised, of course, that clients make such choices but we humans are noted for our self-defeating proclivities. Watching TV in bed, using the computer right before sleep and

sleeping-in are three of the most popular forms of regression to expect in clients as they take their new and improved sleep for granted.

Helping clients to embrace the value of continuing to use the SE sheet just as they would the bathroom scale will give them more control of their own sleep destiny. With their new found sleep self-efficacy, clients will know that they can improve their sleep whenever they wish to re-apply 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 more to their satisfaction.

Behavioral Interventions For Insomnia

Stimulus Control Not A Client Handout

1. Lie down in bed intending to sleep only when sufficiently sleepy;
2. Don't use your bed for any other activity except sex;
3. Get up and go to another room whenever unable to initially fall asleep within 30 min. or when unable to return to sleep within 10 min. after awakening during the night;
4. Do not watch the clock during the night; just estimate the time awake. Better yet, whenever you are in bed awake and experiencing that familiar mental activity and hyperarousal associated with not sleeping, get out of bed immediately without waiting the 10 minutes. The key is to re-train your brain to only associate bed with sleep;
5. When you go to another room, remember to keep light exposure to a minimum while moving about and when engaging in a relaxing or other activity. This activity should not be strongly goal or profit-oriented since it is important not to give your insomnia a purpose or function. It is also important not to fall asleep in the other room;
6. When very sleepy, return to bed and repeat step 3 as often as necessary;
7. Set the alarm for the same time every morning regardless of the amount of sleep;
8. Don't nap during the day until your sleep is thoroughly reconditioned; then ≤ 45 min.

Sleep Scheduling

1. After 2 weeks of SE sheet(s) recording, the average total sleep time (ATST) is calculated. Then the new sleep schedule or PTIB (prescribed time in bed) is determined by adding at least 30 minutes to the ATST with a PTIB minimum of 6 hours;
2. Collaboration is necessary to arrive at a reasonable morning wake-up time taking into consideration that the client will be staying up later on the new sleep schedule;
3. Should the new sleep schedule for the first week yield an avg. SE of ≥ 90% recorded on the SE sheets, then the TIB is increased by 15 minutes to arrive at a new PTIB for the upcoming week;
4. Should the new sleep schedule for the first week yield an avg. SE of < 85% recorded on the SE sheets, then it is likely that sleep hygiene and stimulus control guidelines are not being followed–necessitating clarification, support and encouragement;
5. Each week that the SE average is ≥ 90% recorded on the SE sheets, the PTIB is increased by 15 minutes; extending both the quantity and quality of sleep. When the SE is < 85%, PTIB is titrated downward 15 minutes to shorten the sleep period. When the SE remains between 85% and 90%, no change is made to the PTIB;
6. Wake-up time or TOB (time out of bed) must remain constant during the application of both stimulus control and sleep scheduling which are usually used together;
7. Even though actual sleep time is not shortened, clients may perceive less sleep and feel sleepier during the day, especially the first week. Accordingly, clients should be cautioned not to drive long distances or operate hazardous equipment if feeling sleepy. Contraindications include history of mania, seizures, parasomnias and risk of falls;
8. By using SE sheets to monitor SE, clients can manage their sleep like they would use a bathroom scale to manage their weight; gaining mastery and sleep self-efficacy.

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 minimal daytime impairment in mood and energy.

The use of sleep sheets and CBT-I can empower CWI to gain a greater sense of sleep self-efficacy. Contraindications include a history of mania, seizures, parasomnias (such as night terrors and sleep walking), and risk of falls (including the elderly and infirm).

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CBT-I Cognitive Component

Sleep-Defeating Thoughts

Cognitive interventions focus on the 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 help CWI manage their anxiety about not sleeping. Rational thinking can also reduce the psychophysiologic 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 PWI 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. PWI, however, average 5 ¾, 6 and 6½ hours sleep according to three different estimates.

Some sleep experts, the media and "big pharma" have sensationalized the deleterious consequences of getting less than 8 hours sleep, unfortunately contributing to the irrational beliefs of some PWI that they must get a full 8 hours sleep to remain healthy. The normal, healthy range is from 6 to 8 hours with short sleepers requiring even less.

Dr. Gregg Jacobs seems to have tried to correct many of these distortions about sleep 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 loss of 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 PWI 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 significant 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 (not 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 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 while the author acknowledges having advanced training in REBT/CBT. 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, CBT-I is very effective and easy to learn and apply.

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 straight-forward, however, 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.

CBT-I Relaxation/Stress Reduction Component

Letting Go To Sleep

"Don't go to sleep–let sleep come to you." 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." Fear and dread of not being able to sleep and the resulting anxiety and physiologic arousal that prevents sleep, is the hallmark of severe insomnia. The cognitive restructuring techniques in the preceding section were aimed at reducing anxiety and alarm through more rational thinking.

A highly recommended workbook is Quiet Your Mind & Get To Sleep: Solutions To Insomnia For Those With Depression, Anxiety Or Chronic Pain by Colleen Carney, PhD and Rachel Manber, PhD, for the mental/emotional/behavioral aspects of insomnia.

The techniques in this section are aimed at further reducing hyper-arousal by teaching clients relaxation and stress management skills to employ day and night. Remember that the best prescription for a good night's sleep is a good day's waking. Managing stress better during the day reduces physiologic arousal (adrenaline, blood pressure, muscle tension) at bedtime thereby promoting sleep.

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 methods such as Jacobson's Progressive Muscle Relaxation (PMR) 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 ourselves and can confidently share with clients may be the best to offer.

Sleep induction procedures can be designed to help clients fall asleep and may include progressive relaxation(PMR), temperature biofeedback, self-hypnosis, autogenic training, EFT, 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

Continued on page 32

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 Muscle Relaxation (PMR)

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 PMR 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 PMR 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 as important for PMR 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 and tense (lying);

FEET: gently bend each foot pointing toes away then toward face to create tension.

PMR 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

PMR 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:

- Sound sleep is essential for the health and well being of our clients;
- Clinical social work practice should now include sleep counseling and CBT-I so that all CWI (clinical) and poor sleep (subclinical) may receive our help;
- Social work education has lagged the discovery of the profound transdiagnostic importance of insomnia to mental health and well being and, accordingly, is not yet preparing students in the effective use of CBT-I and clinical sleep counseling.

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Continuing Education Test–3.0 CEU's

CBT for Insomnia and Poor Sleep

After reviewing the course content, please indicate your answers to the following questions on the answer sheet provided and submit to NASW-NYS with the course fee. Individuals receiving a passing score on the test (at least 12 correct answers) will receive a Certificate of Completion documenting the 3.0 CEU's earned.

■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. non-stimulating 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 scheduling is so effective because it compresses poor sleep into quality sleep, lowering sleep efficiency and 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 is 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. 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

Continuing Education Test–Answer Sheet

CBT for Insomnia and Poor Sleep

Deadline for Submission: January 12, 2012

This answer sheet must be filled out completely and submitted to NASW-NYS along with a $30 processing fee for NASW-NYS Members/$45 Fee for Non-NASW-NYS Members (checks should be made payable to NASW-NYS) by the submission deadline: January 12, 2012.

You must answer at least 12 questions correctly to receive 2.0 Category I CEUs from NASW-NYS.

Name: _____

Mailing Address: _____

Phone: _____ **Email Address:** _____

NASW Membership ID#: _____

Please circle your answers:

1.	A	B	C	D
2.	A	B	C	D
3.	A	B	C	D
4.	A	B	C	D
5.	A	B		
6.	A	B	C	D
7.	A	B	C	D
8.	A	B		
9.	A	B	C	D
10.	A	B	C	D
11.	A	B		
12.	A	B	C	D
13.	A	B	C	D
14.	A	B	C	D
15.	A	B		

Submit Answer Sheet and Payment by January 12, 2012 to:

NASW-NYS Chapter
ATTN: James Koonce
188 Washington Avenue
Albany, NY 12210

Individuals receiving a passing score on the test (at least 12 correct answers) will receive a certificate of completion documenting the 3.0 CEU's earned.

CUT OUT AND RETURN

NASW-NYS Chapter Division Updates

Central Division

Call For Nominations: 2012 Central NY Division Social Work Awards

NASW-CNY Division is searching for nominees for Agency of the Year, Social Worker of the Year, BSW Student of the Year, and MSW Student of the Year Awards. We need your help to select and honor individuals who represent the best in social work and fulfill the social work mission. The Social Worker of the Year Award recognizes the commitment and achievements of an outstanding member of our profession. The BSW and MSW Student of the Year Awards recognize academic achievement, field placement experience; which best exemplifies social work values. The Agency of the Year Award honors an agency, department, organization, or government entity. Eligible candidates must be from any of CNY NASW catchment area which encompasses: *Jefferson, Cayuga, Cortland, Madison, Oswego & Onondaga Counties.*

Deadline For Receipt of Nominations: October 30, 2011

Visit our website for nomination details: www.naswnys.org/divisions/Central/events.htm

Steering Committee Meeting

Tuesday, November 8, 2011 • 5:30pm–7:30pm
Oasis Healthlink Center (first floor)- 6333 Route 298, East Syracuse, NY 13057

- Wheelchair accessible, FREE PARKING
- **All members and non-members are welcome**
- Pizza, soda & wings will be served

Please RSVP if you plan via email to: Marilyn Sharron, LCSW-R at: Sharronm@upstate.edu by 10/27/11.

SimpleThree: The Affordable End Defiance System

Presented by Ward Halverson, LCSW-R, M.Ed., Child, Family, and Veteran Therapist

Thursday, November 10, 2011 • 5:30pm–7:30pm

Oasis Healthlink Center (first floor)- 6333 Route 298, East Syracuse, NY 13057

- Wheelchair accessible, FREE PARKING
- Cost (includes a light dinner and program- 2 CEU's)
- NASW members–$10.00 • Non-NASW members–$15

Please RSVP if you plan to attend and indicate if you are a NASW member via email to: Marilyn Sharron, LCSW-R at: Sharronm@upstate.edu by 10/31/11 at 4pm.

Mail Payments to:
NASW-NYS Central Division c/o Paul Stasior, Director
120 Glendale Ave., Liverpool, NY 13088

Please make checks payable to:
NASW-NYS Central Division and must be received by 10/31/11 at 4pm.

Western Division

Save The Date: Self-Care Workshop

Friday, October 21st, 2011 • 1–4pm

Amherst Community Church
77 Washington Highway, Snyder

Co-sponsored by: The Behavioral Healthcare Network, the National Association of Social Workers-New York State Chapter - Western Division, and the Psychological Association of Western New York

General Membership Meeting

Monday, October 24th, 2011 • 6–8pm

United Way of Buffalo
742 Delaware Avenue, Buffalo

- Free food and parking available behind the building.

RSVP requested but not required

Contact Rebecca Eliseo-Arras, MSW, Western Division Director at western@naswnys.org

Save The Date: Social Work Movie Night

Thursday, November 17th, 2011 • 6–8:30pm

University at Buffalo
North Campus, 120 Clemens Hall

- Enjoy a movie, snacks, and discussion with area social workers

Upcoming Steering Committee Fall 2011 Meetings

All meetings take place at 10 AM

University at Buffalo
210 Parker Hall, South Campus

- October 15
- November 19
- December 17

Contact: Rebecca Eliseo-Arras, Western Division Director, western@naswnys.org or rebecca.eliseo.arras@gmail.com

Western Division Call for Awards Nominations

NASW-WNY is currently seeking nominations for the Annual Social Worker Awards Luncheon that will take place next year on Thursday, March 29 from 11-2PM at the Ramada Hotel & Conference Center (2402 N. Forest Road, Amherst) to recognize the various NASW members who have made significant contributions to the field. The deadline is **October 31st.** The different award categories include Social Worker of the Year, Public Citizen of the Year, and Lifetime Achievement Award. Internet applications will soon be made available on our website and for more information please contact Rebecca Eliseo-Arras at western@naswnys.org or rebecca.eliseo.arras@gmail.com.

August Social Worker Spotlight

Elaine Rinfrette, LCSW-R, PhD, is this month's social worker spotlight which aims to showcase special achievements made by our NASW members. She was drawn to the field of social work while being an intensive pediatric care nurse and seeing the challenges being faced by the entire family. After, getting her MSW from Boston University she had gardener rich varied experience within the field including an outpatient mental health agency and a substance abuse program. Now, with nineteen years of experience underway Elaine proceeded to get her PhD from the University at Buffalo to expand her academic research interest. For more of Elaine's personal story, please check out her profile on the NASW-NYS Division website.

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GARDEN CITY AREA: PT–Spacious, attractively furnished psychotherapy office in two room suite, with large windows and waiting room. Professional building with parking, located on Franklin Ave., right off Old Country Rd., close to public transportation and parkways. Very comfortable, convenient setting. Reasonable rates available from one to several days/eves. Please call (516) 379-7179

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MINEOLA/WILLISTON PARK: PT totally rebuilt, fully furnished, beautiful offices. Second floor, professional building. Centrally located. Waiting room. Full facilities. Warm, welcoming atmosphere. Suffolk office also available. Call Manny Plesent (516) 747-1344.

PLAINVIEW: Only few P/T offices left in suite with other successful LCSWs, LMFTs, Psychologists, Psychiatrist and other healthcare professionals. Modern, very attractive all-medical building decorated. Networking & supervision available. Dr Schuster, djschuster@aol.com, 516-931-5060.

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ROCKVILLE CENTRE : Office for rent full-time in Rockville Centre. Large space, big window, private closet. Waiting area shared with on other therapist. Great building with many mental health workers. Month-to-month or yearly lease. Perfect for private practice! Contact: (917) 796-7863.

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For Information Call:

Emanuel Plesent, Ed.D., LCSW, Director

(516) 747-1344

Ads for the Supervision of Clinical Social Work in NYS: NASW-NYS advises all individuals providing/receiving clinical social work supervision services in NYS to be aware of and in compliance with the laws, rules and regulations governing such practice which are outlined on the NYS Education Dept.-Office of the Professions Social Work website: www.op.nysed.gov

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