CONCEPTUALIZATION 
& 
TREATMENT PLANNING

I. Case Conceptualization

A. Presenting Problem, Screenings, Rule Outs, Hypotheses
B. Treatment Planning, Empirically Supported Protocols, Informed Consent
C. Persons (2008)
   i. describes problems
   ii. hypothesizes causal and maintenance mechanisms
   iii. proposes precipitants
   iv. proposes origins

D. Kuyken, Padesky & Dudley (2009)
   i. collaborative empiricism
   ii. strengths focus

II. Basic Principles: Hex of Insomnia

<table>
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<tr>
<th>regulating</th>
<th>interfering</th>
<th>interpreting</th>
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<tbody>
<tr>
<td>A. circadian rhythms</td>
<td>C. arousal</td>
<td>E. beliefs</td>
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<td>B. homeostat</td>
<td>D. lifestyle</td>
<td>F. associations</td>
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III. My Basic Principles: Individual Psychology

A. idiographic
B. heirarchical personality structure
   i. bad habit
   ii. misunderstanding → bad habit
   iii. compensatory strategy

C. types of interventions (Gross & Garrison, 2000)
   i. education
   ii. counseling
   iii. psychotherapy

IV. Psychobiological Model (Espie, 2002)

A. good sleep = organismic natural state
B. multiple interfering factors
C. treatment = restoration of good sleep

V. Insomnia Complaint (diagnosis)

A. sleep normative data
   i. 28% slept 6 or fewer hrs
   ii. 63% slept 7 or 8 hrs
   iii. 8.5% slept 9 or more hrs
B. after age 50

i. more awakenings
ii. decreased sleep efficiency
iii. increased variability
iv. frequent arousals
v. changes in quality
vi. hypnotic use hazards

C. ICSD-2 diagnosis

i. difficulty
   a) initiating sleep
   b) maintaining sleep
   c) waking up too early OR
   d) nonrestorative sleep

ii. 6 months duration unless temporally associated with a stressor

iii. daytime impairments
   a) fatigue or malaise
   b) attention, concentration, or memory impairment
   c) social or vocational dysfunction or poor school performance
   d) mood disturbance or irritability
   e) daytime sleepiness
   f) motivation, energy, or initiative reduction
   g) proneness for errors or accidents at work or while driving
   h) tension, headaches, or gastrointestinal symptoms in response to sleep loss
   i) concerns or worries about sleep

D. are there other temporal associations?

i. medical

ii. psychiatric

E. circadian misalignment

VI. Course

A. long term

i. Life Line (Garrison & Eckstein, 2009)
ii. PPP model (Spielman, 1986)
   a) extending sleep opportunity
   b) counter fatigue measures
   c) rituals
   d) self-medication

VI. Sleep Habits

A. Sleep Efficiency (TIB / TST)

B. short term variability: three groups (Vallieres, Ivers, Bastien, Beaulieu-Bonneau, & Morin, 2005; Vallieres, Ivers, Beaulieu-Bonneau, & Morin, 2011)

i. unpredictable (26%)
ii. constant poor sleep (21%)
iii. high likelihood of good night of sleep following 1, 2, or 3 nights of poor sleep (34%)

C. inertia

i. wakefulness
ii. sleep
D. typical night and day
E. daytime functioning

VIII. Screenings and Rule Outs

A. mental health
i. depression
ii. anxiety
iii. worry
iv. hopelessness
v. control issues
vi. health preoccupation

B. sleep disorders
i. apnea
ii. RLS
iii. REM SDB
iv. circadian rhythm disorders

C. nocturnal symptoms
i. restless sleeper
ii. sleep walking
iii. medical symptoms
iv. pain
v. bruxism
vi. nightmares

IX. Glasgow Sleep Effort Scale (Broomfield & Espie, 2005)

A. Scoring
i. not at all = 0
ii. to some extent = 1
iii. very much = 2

B. Cut offs
i. score of 2 identified
   a) 92.1% of insomnia patients and
   b) 87.3% of good sleepers

X. Initial Treatment Plan for Insomnia

A. sleep hygiene
B. sleep scheduling
   i. get your body clock on your side – curtail your jet-setting
   ii. stay awake long enough to ensure a buildup of sleep drive
   iii. train your body that bed is a place for sleep
C. relaxation training
D. nightmares > image rehearsal therapy

XI. Key Points

A. sleep is default state
B. description and hypotheses separate
C. ruleouts
D. screenings
E. empirically supported treatments
References


