How can CBTI be adapted for delivery in primary care?

CBTI is a very flexible protocol that has been adapted for delivery in many non-traditional settings including primary care. Depending on the restraints of the setting, modifications can be made to the typical course of CBTI that still provide the effective ingredients to produce meaningful change in a patient's sleep.

Ultimately there is no single "right way" to adapt CBTI in a primary care setting. However, there are some principles that should be considered. First, tracking sleep via sleep diary is key. It is preferable if patients can begin tracking sleep prior to the initial appointment with the therapist in order to reduce the necessary number of appointments with the therapist. Second, it is wise to prioritize the treatment components that have the strongest evidence. At a minimum, you should include stimulus control instructions that are tailored to the patient's specific sleep pattern as indicated by the sleep diary. Some sleep psychoeducation should also be provided, as it may increase understanding of the stimulus control and sleep restriction recommendations. However, it can be abbreviated based on the patient's needs. If time allows, other treatment components may be selected based on the case conceptualization. For example, if you are reasonably sure the patient will return for additional titration sessions, sleep restriction is the component most often added to stimulus control in primary care settings. In addition, if the patient has high physiological arousal at bedtime, relaxation strategies may be prioritized. Alternatively, if the patient demonstrates very strong cognitive distortions related to sleep, cognitive therapy may be an important component.

One modification that is often necessary in a primary care setting is a reduction in the number of contacts or the length of each visit. A study by Edinger and Sampson (2003) gives an example of how that might be achieved. In this study, an abbreviated version of CBT-I was delivered in person with a therapist located in a primary care clinic across two 25-minute sessions two weeks apart. In the first session, the therapist reviewed the sleep log, provided sleep psychoeducation, and developed a sleep plan that used sleep restriction and stimulus control instructions. In the second session, the therapist reviewed the previous instructions, addressed treatment adherence problems, modified the sleep plan based on the sleep diary information, and provided brief relapse prevention information. Patients were also provided with written and audio take-home materials that summarized behavioral recommendations and provided educational information. The results of this study demonstrated that about half of the patients treated with abbreviated CBT-I demonstrated a significant improvement in their insomnia symptoms. Another example of CBT-I delivered across 3 sessions is given by Goodie, Isler, Hunter, & Peterson (2009).

CBT-I can also be delivered in a group format in primary care. For more information, please see our FAQ on group-delivered CBT-I. Additionally, articles by Davidson, Dawson & Krsmanovic (2019) and Sandlund, Hetta, Nilsson, Ekstedt & Westman (2017) outline their approaches to this topic.

For more detailed information on ideas for adapting CBT-I in primary care, please review a guide developed by Goodie & Hunter (2014).

References

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