

Overcoming Insomnia Without Drugs

By *THE NEW YORK TIMES*

Rahav Segev for The New York Times Wide awake at 3 a.m.?

Dozens of insomnia sufferers had [questions for the Consults blog](#) about alternatives to sleeping pills. Here, Shelby Freedman Harris, a psychologist and director of Montefiore Medical Center's Sleep Disorders Center, discusses the benefits of cognitive behavioral therapy, which can rival or exceed medications in providing long-term relief from insomnia.

Q.

I'm a young academic and I've had sleep problems for a very long time now — trouble falling asleep, staying asleep, going back to sleep when woken, feeling tired and not properly rested when waking, and needing earplugs and eye mask every night. Everyone in my field has told me they share the same problems. Most just stay awake nearly the whole night. They claim to get their work done that way, but for me it is too taxing to continue this way. Daily exercise doesn't seem to help much. I've tried medication, but it all makes me extremely nauseous and gives me bad dreams. Is there something natural one can do to avoid what seems like work-spurred destiny?

young prof, Rhode Island

Shelby Freedman Harris, Psy.D.

A.

Dr. Shelby Harris responds:

Cognitive behavior therapy for insomnia, or CBT-I, is considered by many to be the gold standard treatment for insomnia. This nondrug treatment can benefit many types of patients, including those with primary insomnia, chronic pain, depression or anxiety as well as older adults who have trouble sleeping. The technique consistently produces results that are comparable to, or even exceed, those of sleeping pills. Studies have shown that even one year after ending treatment, many patients continue to sleep well.

Treatment generally lasts from 4 to 12 sessions. In my own work, I often see patients make gains within the first three sessions. The remaining sessions are typically used for medication tapering, if necessary, and relapse prevention. CBT-I isn't a cakewalk, though; it takes effort.

CBT-I is based on the concept that chronic insomnia is sustained by a variety of factors that maintain the problem. Examples of these behaviors are sleeping in, going to bed early, napping, using alcohol as a sedative, caffeine use,

worrying about your sleep and tossing and turning in bed. These factors are the focus of the treatment.

At first, you'll be asked to track your sleep times and sleep hygiene to see if any patterns emerge. You'll also be taught about basic sleep hygiene, for example, limiting caffeine and nicotine, avoiding evening alcohol and liquids, exercising earlier in the day, winding down before bed and having a light snack before bed.

Insomnia patients often lie in bed watching TV, reading, worrying and thinking. As a result, the bed becomes associated not only with sleep, but also as a place to be awake. Stimulus control instructions like "only use the bed for sleep and sex" will be reviewed in detail. Although this is a tough module to follow properly, it is very effective.

Sleep restriction limits your time in bed, therefore increasing your body's drive to sleep. Your clinician will work with you, based on your sleep diary data, to set prescribed bed and wake times. As you sleep more soundly, this prescription will change and you'll gradually spend more time in bed.

The cognitive module teaches patients to recognize and modify inaccurate thoughts that affect your ability to sleep. For example, a number of my patients have the thought "I must get eight hours of sleep tonight to function well tomorrow." This thought puts an additional pressure on them to get eight hours of sleep, causing them to be tense and anxious — a state that clearly does not induce sleep. You will learn to swap inaccurate thoughts for more evidence-based ones. For example, it is quite possible that you might function well on seven hours of sleep instead. Other techniques to help with worry control will be introduced if needed.

Relaxation training is used to help quiet the mind and relax the body. There are a number of techniques that can be taught, like muscle relaxation, deep breathing and biofeedback. You must find what works for you. I often teach diaphragmatic breathing and progressive muscle relaxation and give patients a CD or MP3 of the session with my instructions to take home and practice. Patients who feel tense before bedtime show the most benefit from this module.

Patients do not necessarily need to discontinue sleep medication to benefit from CBT-I. Although it is ideal to begin treatment without sleep medication, a number of my patients decide to start treatment while on medication. Many

patients gradually taper off their sleep medications once they have learned alternative techniques for their insomnia.

Clinicians who specialize in CBT-I are often certified in Behavioral Sleep Medicine. You can find a listing of these providers at the [American Board of Sleep Medicine's Web site](#). Although the field is growing, there are not currently enough certified specialists to meet the demand. If you are unable to find someone in your area, contact your local sleep center to see if they provide these services or can recommend someone.

Self-help books offering CBT-I are also available. Two that I really like are “[The Insomnia Answer](#),” by Paul Glovinsky and Art Spielman, and “[Quiet Your Mind and Get to Sleep](#),” by Colleen E. Carney and Rachel Manber.