BASIS GGZ: DOEN WAT WERKT

BEHANDELING VAN SLAAPSTOORNISSEN IN DE BASIS GGZ

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LOOKING FURTHER

WORKSHOP 45 MINUTEN

- Introductie
  - Definitie, omvang en gevolgen slaapproblemen
- Behandeling
  - Typen behandeling
  - Evidence en richtlijnen
- CGT cursus in de huisartspraktijk en basis GGZ
- Praktische implicaties
- Stellingen

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Wat wilt u weten na deze workshop?

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SLAAPSTOORNISSEN

Vanaf DSM-5: slaap-waak stoornissen!

Verschillende typen

1. Insomnia – te weinig slapen
2. Hypersomnia - te veel slapen
3. Parasomnia bijv nachtmerries, slaapwandelen

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INSOMNIA DISORDER DSM-5

1. Symptomen
   - Niet in slaap kunnen komen
   - Niet in slaap kunnen blijven
   - Te vroeg wakker worden
2. Ernst
   - Minstens 3 nachten per week
   - Minstens 3 maanden
   - Veroorzaakt problemen in dagelijks functioneren
3. Niet toe te schrijven aan
   - Onvoldoende gelegenheid tot slapen
   - Een andere slaap-waak stoornis
   - Drugs / medicatie
   - Andere mentale of somatische stoornissen

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OMVANG, CO-MORBIDITEIT EN GEVOLGEN

Een van de meest voorkomende mentale problemen

- 30% van de bevolking heeft enige problemen met slapen
- 10% voldoet aan DSM criteria

Hoge co-morbiditeit met andere aandoeningen

- Depressie en angst
- Cardiavasculaire aandoeningen en mortaliteit

Gevolgen

- Verlies kwaliteit van leven
- Hoge (maatschappelijke) kosten

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BEHANDELING: MEDICATIE

Benzodiazepinen + non-benzodiazepinen (Z-drugs)

Voordelen:

- Werkzaam, doorbreekt patroon, snel

Nadelen

- Verslavend
- Overdag nog slaperig (kans op vallen en ongelukken)
- Patient leert niet beter te slapen

60% van alle patienten krijgt (langdurig) medicatie

BEHANDELING

Sinds juni nieuwe NHG standaard

Kernboodschappen:

- Medicatie alleen bij uitzondering (max 1 * 15 tabletten)
- Voorlichting en gedragsmatige adviezen belangrijk
- Chronisch gebruikers bij voorkeur laten stoppen

Belangrijkste wijziging

- Uitbreiding aanbevelingen voor gedragsmatige aanpak

Behandeling volgens NHG standaard

1. Voorlichting (slaap, slaaphygiene)
2. gedragsmatige behandeling: stimulus-controle, slaaprestrictie, ontspanningsoefeningen, cognitieve therapie
3. Stimuleren structurele lichaamsbeweging

Behandeling volgens NHG standaard

1. Voorlichting (slaap, slaaphygiene)
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3. Stimuleren structurele lichaamsbeweging

1+2 = CGT
= voorkeursbehandeling

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REVIEW

Psychological And Behavioral Treatment Of Insomnia:Update Of The Recent Evidence (1998-2004)

[1]Charles M. Morin, PhD, (Chair); [2]Richard R. Bootzin, PhD; [3]Daniel J. Buysse, MD; [4]Jack D. Edinger, PhD; [5]Colin A. Espie, PhD; [6]Kenneth L. Lichstein, PhD

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Background: Recognition that psychological and behavioral factors play an important role in insomnia has led to increased interest in therapies targeting these factors. A review paper published in 1999 summarized the evidence regarding the efficacy of psychological and behavioral treatments for persistent insomnia. The present review provides an update of the evidence published since the original paper. As with the original paper, this review was conducted by a task force commissioned by the American Academy of Sleep Medicine in order to update its practice parameters on psychological and behavioral therapies for insomnia.

Methods: A systematic review was conducted on 37 treatment studies (N = 2248 subjects/patients) published between 1998 and 2004 inclusively and identified through PsycInfo and Medline searches. Each study was systematically reviewed with a standard coding sheet and the following information was extracted: Study design, sample (number of participants, age, gender), diagnosis, type of treatments and controls, primary and secondary outcome measures, and main findings. Criteria for inclusion of a study were as follows: (a) the main sleep diagnosis was insomnia (primary or comorbid), (b) at least 1 treatment condition was psychological or behavioral in content, (c) the study design was a randomized controlled trial, a nonrandomized group design, a clinical case series or a single subject experimental design with a minimum of 10 subjects, and (d) the study included at least 1 of the following as dependent variables: sleep onset latency, number and/or duration of awakenings, total sleep time, sleep efficiency, or sleep quality.

Results: Psychological and behavioral therapies produced reliable changes in several sleep parameters of individuals with either primary insomnia or insomnia associated with medical and psychiatric disorders. Nine studies documented the benefits of insomnia treatment in older adults or for facilitating discontinuation of medication among chronic hypnotic users. Sleep improvements achieved with treatment were well sustained over time; however, with the exception of reduced psychological symptoms/distress, there was limited evidence that improved sleep led to clinically meaningful changes in other indices of morbidity (e.g., daytime fatigue). Five treatments met criteria for empirically-supported psychological treatments for insomnia: Stimulus control therapy, relaxation, paradoxical intention, sleep restriction, and cognitive-behavior therapy.

Discussion: These updated findings provide additional evidence in support of the original reviews conclusions as to the efficacy and generalizability of psychological and behavioral therapies for persistent insomnia. Nonetheless, further research is needed to develop therapies that would optimize outcomes and reduce morbidity, as would studies of treatment mechanisms, mediators, and moderators of outcomes. Effectiveness studies are also needed to validate those therapies when implemented in clinical settings (primary care), by non-sleep specialists. There is also a need to disseminate more effectively the available evidence in support of psychological and behavioral interventions to health-care practitioners working on the front line.

Keywords: Insomnia, treatment, behavioral, psychological, non pharmacological

Citation: Morin CM; Bootzin RR; Buysse DJ et al. Psychological and behavioral treatment of insomnia: update of the recent evidence (1998-2004). SLEEP 2006;29(11):1398-1414.

1.0 INTRODUCTION

INSOMNIA IS A PREVALENT COMPLAINT BOTH IN THE GENERAL POPULATION AND IN CLINICAL PRACTICE. IT MAY PRESENT AS THE PRIMARY COMPLAINT or in association with another physical or mental-health problem. Prevalence estimates indicate that about one third of the adult population reports insomnia symptoms, 9%-12% experience additional daytime consequences, and approximately 6% meet formal criteria for an insomnia diagnosis.[1] Insomnia is more common among women, middle-aged and older adults, shift workers, and patients with medical or psychiatric disorders. Persistent insomnia can produce an important burden for the individual and for society, as evidenced by reduced quality of life, impaired daytime functioning and increased absenteeism at work, and higher health-care costs. Persistent insomnia is also associated with increased risks of depression and chronic use of hypnotics.[2-5]

Disclosure Statement

This was not an industry supported study. Dr. Morin has received research support from Sanofi-Aventis; has provided consulting services to Sepracor, Pfizer, Neurocrine, Takeda, and Shire Biochem; and has participated in speaking engagements supported by Takeda, Sanofi-Aventis, and Merck. Dr. Buysse is a consultant for Actelion, Cephalon, Eli Lilly, GlaxoSmithKline, Merck, Neurocrine, Pfizer, Respironics, Sanofi-Aventis, Servier, Sepracor,

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Non-pharmacological management of chronic insomnia in primary care

One-fifth of patients consulting in primary care have 'insomnia' and prevalence in the population ranges from 10–12% to over 20% in older adults.[1,2] It is the most common symptom of mental illness, regardless of age, sex, or ethnic group.[3] Insomnia is more common than worry, and twice as common as anxiety or depressive symptoms. Typically, insomnia is associated with reduced daytime alertness and productivity, poorer quality of life, impaired relationships, and increased ill health.[4] It is the largest, potentially treatable, risk factor for depression[5] and is a major cause of accidents.[6]

Persistent insomnia presents a challenge for most GPs. The problem is often unrecognised and management is generally unsatisfactory.[7] Many doctors manage the condition with 'off-label' prescribing of hypnotic or sedative antidepressant drugs, neither of which have demonstrated more than marginal efficacy.[8] There is little evidence that the new generation of hypnotics has improved the management of persistent insomnia.[9] Adverse effects of hypnotics are common[10] and an investigation of drug-associated hospital admissions among older patients has shown that up to 10% may be due to benzodiazepines.[11] Despite the fact that many would prefer a non-pharmaceutical approach if an effective one were available, hypnotics are nevertheless often requested by patients and withdrawal often poses difficulties for doctors and patients as a result of physical and psychological dependence. It is therefore important to offer an alternative.

Faced with a complaint of chronic insomnia, potentially reversible causes such as pain, menopausal symptoms, or restless legs syndrome should be addressed. We should also always consider prescribed and non-prescribed stimulants such as caffeine, steroids, and decongestants, as well as illicit drugs such as amphetamines. Other drugs such as β-blockers, alcohol, and nicotine can also interfere with sleep. Depression and anxiety may contribute to and result from insomnia. They should be considered and appropriate management strategies discussed. Nevertheless, for a significant number of patients, even when all potential contributory causes are excluded or managed, insomnia will remain a problem.

The most common non-pharmaceutical approach for GPs faced with such a patient is to promote 'sleep hygiene'. This involves encouragement to establish a regular sleep habit, not going to bed too early, not staying in bed if unable to get to sleep in a reasonable time, having fixed routines and rituals at bedtime, and avoiding daytime napping. Vigorous exercise, heavy eating, and caffeine and alcohol consumption prior to bedtime are discouraged. However, there is little evidence that this approach is effective[12] and, somewhat perversely, people with insomnia often have better sleep hygiene than good sleepers. In common with many traditional — and ineffective — health promotion approaches, sleep hygiene largely involves giving people advice that they already know, without giving them the wherewithal to make crucial behavioural and attitudinal changes. Such behavioural and attitudinal changes are central to the approach of cognitive behavioural therapy (CBT).

Promising results have been achieved by combining some of the elements of sleep hygiene with CBT. CBT is a validated and evidence-based therapy comprising behavioural and mental strategies that can elicit substantial change in the whole approach to sleep. Insomnia often arises from psychological factors such as conditioned arousal (for example, from lying in a bed that is associated with sleeplessness) and sleep preoccupation,[13] regardless of whether the sleep problem is primary or presenting in the context of psychiatric problems.[14] Although meta-analyses have demonstrated clear benefit,[15] most CBT efficacy trials have been conducted among media-solicited participants, perhaps excluding patients with the type of complex presentations and comorbidities seen in general practice. Furthermore, the CBT interventions in these trials have generally been delivered by qualified clinical psychologists, a scarce resource in the NHS.[16]

In a recently published randomised controlled trial,[16] we showed that health visitors could be trained to deliver an effective CBT-based treatment for chronic insomnia to small groups of patients. The health visitors received 12 hours of small-group training delivered over 2 days by a clinical psychologist. The training was followed by 'apprenticeship' support where the health visitors were first participant observers in an ongoing treatment group and then took responsibility for their own group.

In 19 general practices, 201 patients were assigned at random to receive the CBT programme or treatment as usual. Half of the participants were taking hypnotic medication and most had mental health problems associated with their insomnia — usually anxiety or depression. The CBT programme was delivered to 19 groups of 4–6 patients over five 1-hour evening sessions. The course included general information, advice on sleep hygiene, scheduling, and developing cognitive approaches to recognise and avoid intrusive thought patterns. The programme came in the form of a manual and comprised therapist notes, presentations using PowerPoint® (15 slides per session), worksheets for 'break-off' times, and take-home notes with implementation guidelines. Clinical psychologists provided mentoring support to the health visitors but they took no part in the delivery of the programme.

This relatively inexpensive intervention, requiring 1 hour of health visitor time per patient, resulted in significant improvements in self-reported sleep latency (the time it takes to fall asleep once the lights are out), subsequent wakefulness after falling asleep (a reduction of 60 minutes), and an 11% greater improvement in sleep efficiency (the proportion of total sleep time in bed) compared with participants receiving treatment as usual. Benefits were not restricted to sleep alone. On the SF-36 scale, significant health-related quality of life improvement was observed among the CBT group in domains reflecting mental health and vitality. Improvements were generally sustained at follow-up at 6 months. The study was not powered to detect reductions in hypnotic use but other recent work has demonstrated that CBT can be effectively applied to hypnotic reduction as a primary outcome.[17]

The cost-effective delivery of CBT

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INVITED COMMENTARY

ONLINE FIRST

Time to Disseminate Cognitive Behavioral Treatment of Insomnia

The efficacy of cognitive behavioral treatment for insomnia (CBTI) is supported by over 3 decades of research.[1,2] Evidence is accumulating that it is effective not only for primary insomnia but also for patients with insomnia and complex comorbidities including psychiatric disorders, chronic pain, and cancer.[3,5] Despite a wealth of data showing efficacy, CBTI has not been available in most practice settings, including many specialized sleep centers whose focus is on the assessment and treatment of sleep apnea. CBTI may be misperceived as being analogous to weight-loss treatment for obesity-related sleep apnea; that is, it is theoretically superior to all alternatives, but the obstacles to implementation seem overwhelming. CBTI involves initial demands for substantial behavioral changes that seem difficult to address in the context of most primary care settings. How does one help patients make changes in their sleep-wake activities that often are entrenched by years of habit? How does one refer patients for effective behavioral treatment? Unfortunately, CBTI remains limited to specialized sleep centers with trained behavioral sleep medicine specialists. Most primary care settings lack access to these resources, and there are concerns about stigma related to referrals to mental health treatment.

Behavioral sleep medicine rightfully claims great success in creating a treatment that in a few weeks achieves efficacy comparable with that of sedative hypnotics[6] and over the long term achieves greater satisfaction as reported by patients.[7] In an ideal health care system, one would expect behavioral treatment for insomnia to be widely disseminated because of the data showing efficacy, the cost savings that would accrue from reduced pharmacy costs, and reduced morbidity from sedative hypnotic-related falls and injuries. The message repeatedly finds its way into the scientific literature but not into practice settings.

CBTI has slowly evolved in the past decade in response to concerns about the need to move from efficacy to effectiveness oriented clinical trials. There have been successful demonstrations that the number of sessions can be reduced,[8] that it can be delivered in group format in primary care settings,[9] and that it can be adapted for Internet based treatment.[10] In this issue of the *Archives*, Buysse et al present encouraging results from a brief intervention for insomnia that was delivered in a primary care setting by a masters-level mental health nurse practitioner with no prior experience in sleep medicine. The treatment involves an initial 45- to 60-minute visit, a second 30-minute visit, and two 20-minute telephone calls over a treatment period of 4 weeks. The patient is given a workbook and individualized behavioral instructions and is taught to monitor their sleep with a sleep diary. The 4-week time period for assessing outcomes is shorter than most CBTI trials, based on the idea that participants might request medication therapy if shorter-term gains were not obtained. Buysse et al also reasoned that shorter-term treatment, if proven effective, would have a greater likelihood of being acceptable for wider dissemination. The results

CGT: WIE, WAT, WAAR?

Huisartspraktijk

- Door huisarts of POH-GGZ

Basis GGZ en gespecialiseerde GGZ

- Niet vergoed als primaire diagnose

Slaapklinieken

- Als er diagnostische vraag is of complexe problematiek

Vrije veld

- Bijv Slaapmakend, Teleac / NTR

ZELF-HELP

Onmogelijk iedereen face-to-face CGT aan te bieden

Zelf-hulp (boek, audio, video, internet)

- CGT wordt uitgelegd in tekst
- Case-vignetten
- Opdrachten
- Optioneel: feedback

INTERNET CURSUS INSOMNIA

- Insomnia cursus aan VU ontwikkeld
- Onderzoek in algemene bevolking
  - 75% maakte cursus helemaal af
  - Tweederde sliep beter
  - Afname slaapmedicatie
  - Minder angst en depressieve klachten

- Binnenkort: studie
- (kosten)effectiviteit in
- huisartspraktijk
- Begeleiding POH-GGZ

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ERVARINGEN IN DE PRAKTIJK

Als POH-GGZ:

- Verwijzing door HA bij slaapproblemen
- Wel/geen co-morbiditeit
- Zelfhulpboek

BasisGGZ:

- Verwijzing door HA bij vermoeden angst/depressie
- Slaapproblemen als belangrijke klacht
- Online cursus/ zelfhulpboek/ groepscursus

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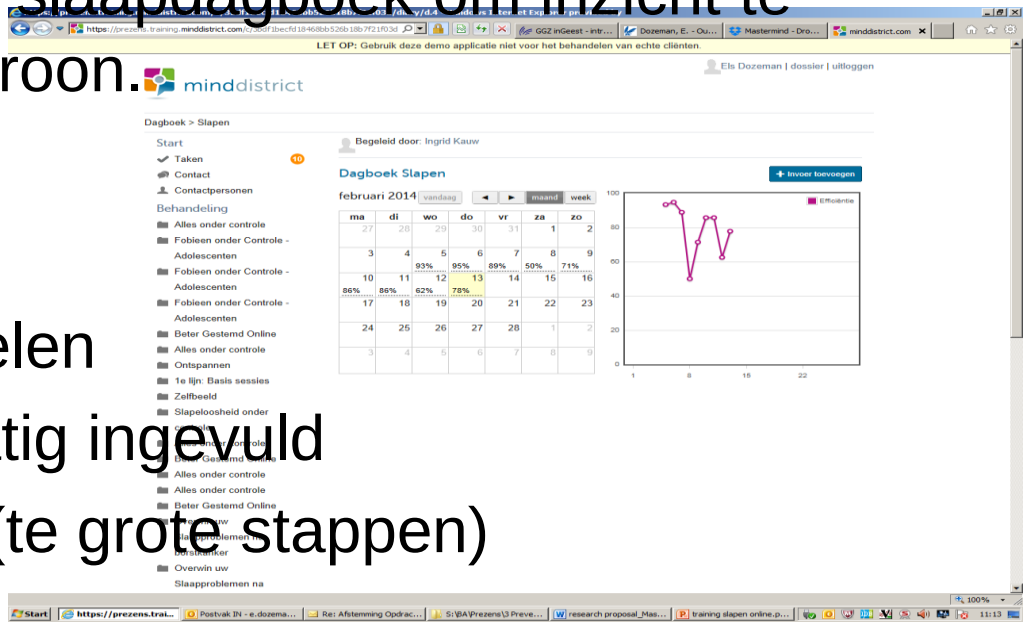
LES 1: PSYCHOEDUCATUE

Uitleg over slaap en functie

<u>Het huiswerk:</u>

- Het opstellen van doelen voor de cursus
- Het bijhouden van het slaapdagboek om inzicht te krijgen in het slaappatroon.



<u>Aandachtspunten:</u>

- Vaag omschreven doelen
- Dagboek niet regelmatig ingevuld
- Niet haalbare doelen (te grote stappen)

LES 2: SLAAPHYGIENE

Gezonde leefregels

Het huiswerk:

- Checklist met persoonlijke gewoontes en punten voor verbetering.
- Inbouwen van ontspanning gedurende de dag en het afbouwen van de dag.

Aandachtspunten:

- Lezen/TV kijken in bed
- Geen ontspannende activiteiten/moeite afbouw dag
- Alcohol/caffeine houdende dranken
- Rustmomenten overdag

LES 3: SLAAPPATROON VERANDEREN

Stimulus controle en slaaprestrictie:

<u>Het huiswerk:</u>

- Berekenen slaapgemiddelde over afgelopen 10 dagen
- Schrijven van een persoonlijk plan voor nieuw slaappatroon

<u>Aandachtspunten:</u>

- Slaapgemiddelde minder dan 5 uur
- Moeite om later naar bed te gaan
- Erg wisselend slaappatroon/weinig vooruitgang
- Smokkelen met slaapgemiddelde

LES 4 PIEKEREN EN ONTSPANNING

Het huiswerk:

- Test depressie (CES-D) en angst (Hads)
- Plan om piekeren te stoppen
- Ontspanningsoefeningen

Aandachtspunten:

- Niet consequent uitproberen oefeningen
- Uitblijven resultaat

LES 5 DENKFOUTEN OVER SLAAP

Het huiswerk:

- Benoemen niet helpende gedachten
- Uitdagen niet helpende gedachten

Aandachtspunten:

- Moeizame voortgang van de cursus
- Niet uitdagen van alle genoemde niet-helpende gedachten (“half werk”)
- Opdracht ingewikkeld

LES 6 TERUGVALPREVENTIE

Het huiswerk:

- Plan voor de toekomst

Aandachtspunten:

- Weinig concreet plan
- Belangrijke aandachtspunten weggelaten?

SAMENVATTING COGNITIEVE GEDRAGSTHERAPIE

1. **Psycho-educatie**
   - Wat is slaap, functie, stoornissen etc
2. **Slaaphygiene**
   - Leefregels voor gezonde slaap (koffie, alcohol, rust overdag, slaapkamer)
3. **Stimulus controle**
   - Zelfde tijd naar bed en op, bed alleen om te slapen, opstaan bij wakker
4. **Slaaprestrictie**
   - Beperk aantal uren in bed, slaapschuld, kort aantal uren slaap achter elkaar, uitbreiden bij slaapefficientie > 80%
5. **Piekeren en ontspanning**
   - Voorkom piekeren over slaap
6. **Opsporen denkfouten over slaap**
   - Leer gedachten opsporen en uitdagen
7. **Terugval preventie**

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REACTIES VAN DEELNEMERS

- Ik kan concluderen dat deze 6-weekse cursus mij een flink stuk op weg heeft geholpen om mijn slaappatroon de normaliseren.

- Bedankt voor deze cursus. Ik had niet gedacht dat het zo goed zou helpen.

- Ik heb nieuwe dingen geleerd. En als ik weer problemen ga ervaren met slapen weet ik waar ik prioriteit aan moet geven.

REACTIE:

Dank voor je vriendelijke woorden bij het eind van de cursus. Ik heb het als een voorrecht ervaren er aan mee te mogen doen. De cursus heeft me veel goeds gebracht. Was ik aanvankelijk zo goed als wanhopig en niet in staat een goede nachtrust te genieten; thans is er zicht op een betere toekomst. Wellicht grote woorden, maar niet minder waar. Heel veel dank voor je geduld en begeleiding

REACTIE:

Allereerst dank voor alle (snelle) feedback en je begeleiding. Ik heb dat als prettig ervaren! Je vroeg naar mijn ervaring met deze cursus. Deze is zeer positief. Ik worstel eigenlijk al mijn hele leven met slaapproblemen, en ze zijn nog niet over, maar deze cursus is de eerste die structureel een positief effect heeft gehad. Dit komt zeker ook door de vorm van een internetbehandeling: gestructureerd, behapbare informatie die teruggelezen kan worden, interactief, dynamisch. En, heel belangrijk: de cursus kan thuis gevolgd worden. Gesprekken op locatie beklijven minder omdat de informatie mondeling wordt overgedragen.

STELLINGEN VAN PATIENTEN

1. Ik heb 8 uur slaap nodig om overdag goed te kunnen functioneren
2. Als ik me overdag geïrriteerd of neerslachtig voel komt dat door een gebrek aan slaap
3. Mijn slaap wordt steeds slechter en ik geloof niet dat daar iets aan te doen is
4. Ik denk dat slapeloosheid het resultaat is van het missen van een chemische stof
5. Met een slaapprobleem kan ik geen bevredigend leven leiden

Waar / ten dele waar / niet waar???

STELLING 1

Ik heb 8 uur slaap nodig om overdag goed te kunnen functioneren

Niet waar

- De behoefte aan slaap varieert
- Minder bij ouderen
- Geen 1-op-1 relatie tussen uren slaap en energie overdag
- Ook goede slapers hebben soms geen energie

STELLING 2

Als ik me overdag geïrriteerd of neerslachtig voel komt dat door een gebrek aan slaap

Ten dele waar

- Slaap beinvloedt kwaliteit van leven
- Maar niet alle kwaliteit van leven hangt van slaap af
- Welke andere zaken beinvloeden uw stemming en energie?

STELLING 3

Mijn slaap wordt steeds slechter en ik geloof niet dat daar iets aan te doen is

Waarschijnlijk niet waar

- Zorg voor realistisch beeld, er zijn ook betere nachten
- Om een goed leven te leiden is geen perfect slaap nodig
- Het is nooit te laat om iets te doen aan slaapproblemen

STELLING 4

Ik denk dat slapeloosheid het resultaat is van het missen van een chemische stof

Ten dele waar

- Het is waarschijnlijk dat er een lichamelijke oorzaak is
- Maar is niet de enige oorzaak
- Slapeloosheid ontstaat altijd door meerdere factoren
- Aan een (groot) deel daarvan kunt u wel iets doen

STELLING 5

Met een slaapprobleem kan ik geen bevredigend leven leiden

Waarschijnlijk niet waar

- Slaapproblemen kunnen iemand hopeloos maken
- Van belang: niet laten overheersen
- Plan voldoende activiteiten (ongeacht de nacht)
- (plezierige) activiteiten verbeteren de stemming
- Wellicht ook betere slaap na actieve / plezierige dag

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