Title: 341 - Overcoming insomnia: improving sleep hygiene and treating disordered sleep with CBT-I
Speakers: Peter (Host/Interviewer), Ashley (Guest)
Total Duration: 141:06
Note: This output covers 00:00 to 45:00, formatted per instructions. Fillers removed, no scientific terms corrected, one speaker mis-identification corrected (statements from 01:34 to 01:51 attributed to **Peter**), timestamps inserted every ~5 minutes, speaker names bolded in Markdown, double spacing applied. Output in Markdown for PDF conversion with Arial, 16pt font compatibility.

[00:00]
Peter: Low-end, one in 20, high-end, one in 10 people, adults, yes, most people at some point in their lives are going to have an issue with insomnia, whether people have difficulty falling asleep in the beginning of the night, waking up in the middle of the night, waking up too early in the morning, the people who can't fall asleep at the beginning of the night, their mind's just racing earlier than yours, yours is just waking you up, okay, this is really important to you, this is something you're doing all the time, all day, guess what, what do we do with things that are really important to us, make time, we schedule them, exactly, I always tell patients, if you don't deal with what's causing you stress or anxiety during the day, it's going to demand to be dealt with in the middle of the night, let's talk about sleep supplements, right, melatonin is like the guy at the start of the race, right, he's the guy with the gun, he fires the gun, he doesn't have a car in the race, he's not like helping you stay asleep, he's telling you when to start the thing, so for a lot of adults, taking melatonin is really messing them up, I think the time in bed is pretty interesting, I don't even do time-in-bed restriction that first week because, for some people, setting awake time solves the issue, let's go back to sleep hygiene for a second, caffeine withdrawal is not something I want to deal with in my clinic, and I don't think it's necessary, so I tell people, do not change how much coffee you're drinking, put it all before 11, when does the treatment fail, the treatment fails when people don't do it, hey everyone, welcome to The Drive podcast, I'm your host, Peter Attia.

[01:34]
Peter: Thank you so much for coming to Austin to talk about a lot of interesting things, let's start with the one that I think everybody listening can probably relate to at least once, which is insomnia, so where did your interest in insomnia arise?

[05:00]
Ashley: Well, I've been interested in sleep for a long time, I was fortunate to go to the University of Arizona for my doctoral work, and when I was there, the late Dick Bootzin was also there, and he's one of the co-inventors of cognitive behavioral therapy for insomnia, and I think I found it particularly interesting because it works so well, we have so many different psychological treatments, and they all have varying degrees of efficacy and effectiveness, and the thing about cognitive behavioral therapy for insomnia is that it's kind of like a recipe, if you do it, it works, and this was always just so interesting to me because it was so different than so many other

psychotherapies out there that had just so much more unpredictable outcomes, and I would say that I became much more interested in it after my post-doctoral work when I'd gotten to UCSF, and I was a postdoc at UCSF, but I started my assistant professorship at UCSF, and there was this gaping hole in treatment availabilities for people with insomnia, and I thought, oh, you know, like, this might be a good way for me to get back into some clinical work, I was doing just research at the time, and I fell back in love with it because there's almost nothing as rewarding as being able to see a patient seven times, and that seventh time have them say something to you along the lines of, I have my life back, I'm going to go get my driver's license back, I'm not afraid to drive with my kids in the car anymore, I'm going to go back to work, I have my life back, I mean, not much better than that, and so I grew the clinic that I do CBT-I in, and now I just, I love it so much that I do it on top of my job, like I do it at night with patients after hours because it's the most rewarding thing, and you can have such a big impact, and people need it.

Peter: So, before we dive into what CBT-I is and how it works and how profound it can be, let's maybe help folks understand a little bit about insomnia and maybe go through some of the definitions around the different types of insomnia, and maybe some of the different causes for it, and maybe even what some of the other treatments are, pharmacologic and otherwise.

[10:00]
Ashley: Yeah, so, broadly speaking, most people at some point in their lives are going to have an issue with insomnia, I think some 90% of adults at some point are going to struggle with insomnia, and point estimates, I think, at any given moment might be between five and 10%, the interesting thing about insomnia is that it's a very clinical diagnosis, right, there's no blood test for insomnia, there's no, we can't put you in a sleep lab overnight and do a test to see if you have insomnia, and we don't diagnose insomnia based on one night of bad sleep, if someone says, oh, I didn't sleep at all last night, or I haven't slept even for just the last week, that's not going to get you a diagnosis of insomnia, so, and there's a whole suite of different insomnias that we could talk about, but I think the point that is the most salient is just that when you have a problem sleeping, and when it's been going on for a long time, at least like three-ish months, and when you really feel it's a problem, that's when it's time to get help, because there's plenty of people who don't sleep a whole lot, but it's not distressing to them, it's not causing any problems in their life, they're not going to meet, you know, a definition of insomnia per se, it's the folks who will tell you that, I can't sleep, I haven't been sleeping for months, it's interfering with my life, it's really upsetting, and they've started, they've probably already started trying a whole bunch of things to try and help themselves to fix it, and this is where things get interesting.

Peter: And just to be clear, Ashley, when you say that a point estimate of 5 to 10% of the population would have insomnia at any point in time, you mean according to that definition where it's been going on for months, it's causing distress, and it's impacting life?

Ashley: Yeah, broadly speaking, wow, that's, so that's one in, low-end, one in 20, high-end, one in 10 people, adults, adults, yes, by the way, I do not do pediatrics, so please assume everything we're talking about today is adults, insomnia and children is a totally different thing,

so that's a higher estimate than I would have guessed, yeah, I mean, given your definition, if the definition was three nights of bad sleep, I would say, yeah, that makes sense, so that's pretty startling, any given point in time, and insomnia is, for most people, probably quite episodic, it's not necessarily a permanent state, people go in and out of it, and the question is, how quickly do people go out of it when they go in it, and that's what CBT-I is so beautiful for, it's helping people get out of it quickly, there's going to be things in your life that are going to just happen, and they're going to put you over the threshold for insomnia, so maybe we can talk for a minute about how insomnia begins, and then how it's perpetuated, because these things are actually quite different, yeah, so you and I and everybody have a certain level of predisposing factors that are going to put us at risk for having sleeping problems, in particular, insomnia, right, and then we may experience what's called a precipitating factor, that could be a major life event, like losing your job, getting a divorce, getting in a car accident, some major unexpected, unhappy life event that might throw you into a bout of insomnia, right, and that event will end, though, that event ends, the car accident ends, it resolves, the job loss ends, you get a new job, or you don't, the divorce ends, you move on, right, but in the meantime, when you're dealing with that event, you develop behaviors to cope with it, and so you might, for example, pop a Benadryl to help you sleep, or an Ambien, something stronger, you might start taking naps the next day after a bad night of sleep to try and cope with it, right, you might start reading in bed a lot, or flipping through your smartphone in bed, doing all these different types of behaviors to try and help yourself calm down and actually get to sleep, which, in the short term, make a lot of sense, right, you're trying to help yourself in the acute moment, but in the long term, these kinds of behaviors aren't actually doing you any favors, and, over time, that precipitating factor is going to go away, but all of these behaviors that you've started doing to respond to the precipitating event, they're what stick around, and those are what are going to perpetuate insomnia symptoms and problems.

[15:00]
Peter: Can you say more about the predisposing factors, yeah, are those genetic, or, you know, yeah?

Ashley: Yeah, so there's, of course, genetic predisposing factors, right, I've had patients come and say, I'm a really light sleeper, can you fix that, that's going to be pretty tough to fix, right, I'm going to recommend something like earplugs, an eye mask, a white noise machine, what have you, but, yes, there are going to be predisposing factors, so, if you are higher on general psychological reactivity, right, you're going to probably get pushed over the threshold more easily than someone else, right, some people might get in a car accident, a fender bender, and they're over it by the next day, the car is in the shop, whatever, other people might feel antsy about driving for a while after that, they might feel more anxious as a result of that event, and that's going to differ from person to person, you can argue that that's genetic, you can argue that that's based on early childhood or other experiences, but nature and nurture probably both contribute to that predisposition, and there's not a whole lot that we can do about that, but this is the beauty of cognitive behavioral therapy for insomnia, when people come in for treatment, they're often pretty focused on what caused their insomnia, and I actually don't ask people what

caused their insomnia until the end of my first session with them, I'm asking them all these other kinds of questions about their behaviors now, and, at the end, I ask, okay, so when did this start, what do you think might have caused this, and get their attribution for what's going on, because, at the end of the day, the intervention is the same, and that's what's beautiful about this, and might differ a lot from the practice of medicine, I'm not an MD, I'm a PhD, right, so, in, I think, in a lot of disease states, we often look at what caused what's going on, I'm not really concerned, I'm more concerned about what you're doing now that's perpetuating the problem, and that's where I intervene, and that's why this particular treatment is so effective for so many different presentations of insomnia and causes of insomnia, whether people have difficulty falling asleep in the beginning of the night, waking up in the middle of the night, waking up too early in the morning, right, you might think, on their face, these people all need wildly different treatment, but that's not actually the case.

Peter: Yeah, that makes a lot of sense, so the focus is much more on the coping strategy and the behavior that came out of the predisposing factor, or the precipitating event, actually, is really that you had to respond to the precipitating fact, exactly, okay, yes, can we talk a little bit about, you know, is there a difference, for example, between the individual who can't fall asleep, you know, this initiation of sleep in insomnia, versus the person, that I hear much more about, and, frankly, I experience more, which is, it's not that hard for me to fall asleep, but, boy, I will jolt up at 1 in the morning with some thought or anxiety that I can't get out of my mind, and my mind starts running, and I can't go back to sleep, or I get up because I got to pee, but when I come back, I erroneously just do something with my mind where I get thinking about the day's problem, or whatever, whatever, whatever, so, do you think of those as different, or they just, same side of a different coin, different side, same coin, I guess?

[20:00]
Ashley: Great question, great question, so those people need the same stuff, and the people who can't fall asleep at the beginning of the night, their mind's just racing earlier than yours, yours is just waking you up, and there's a whole suite of interventions that are part of cognitive behavioral therapy for insomnia, and there are a lot of ways that I could approach an answer to this question, so, I think, starting by addressing the racing mind issue, I always tell patients, if you don't deal with what's causing you stress or anxiety during the day, it's going to demand to be dealt with in the middle of the night, it's going to say, oh, Peter, I noticed you're laying there peacefully, not doing any work or tasks, and you don't have anything you need to do right now, so you're going to pay attention to me, and it's going to demand your attention at that time, other people, that happens right when their head hits the pillow at the beginning of the night, oh, you're relaxing now, okay, here's your 10 things to worry about, right, so, one of my favorite interventions, that's actually born of anxiety treatment, but that I've co-opted, and I've moved into cognitive behavioral therapy for insomnia because it fits with the theoretical framework, is something called scheduled worry time, this sounds a little bit pedantic and silly, but hear me out, if a patient came to me and said, Ashley, like, I worry all day, I have, I'm worried about all of these things, and my life is just a constant ball of worry, and I said, okay, I've got a solution for you, and it's two words, ready, stop it, yeah, that wouldn't work, right, doesn't work, so I take the

opposite approach, okay, this is really important to you, this is something you're doing all the time, all day, guess what, what do we do with things that are really important to us, make time for them, we schedule them, exactly, so I have my patient literally get, we used to, back in the day of paper calendars, this was like, this felt like an exercise, now people get out their phones, but I have them get out their phone or whatever, and say, all right, we're going to schedule worry time, and it's going to be an hour a day for the next seven days, it is non-negotiable, I may or may not schedule an email to go out to you at the end of that time, and you have to go and reply to it, and tell me what you did, right, and what we find is that, when people work with this during the day, it does two things, the first is, let's say it's 9:00 a.m., and you are trying to do something in your life, and, instead, a worry pops up, you can actually think, oh, okay, I don't have to deal with this now, I'm going to write this down because, at 4:00, I've got scheduled time to deal with this, right, so that way, you're uncluttering the rest of your day by moving all of the worry into that scheduled time, so this could be a valuable technique even absent insomnia, totally, yeah, I would say that probably between a third and half of my patients who come in with insomnia, they've got some bad sleep stuff, for sure, but, for some of those people, it's a primary anxiety disorder, and sleep is suffering also, whereas, other folks, it's primary insomnia, and that's driving them anxious, right.

[25:00]
Peter: But, to rewind back to your earlier question about the middle of the night versus the beginning of the night, so the other thing that scheduling worry time does, besides uncluttering your whole day, is, it helps you get it done during the day, so that, when your head hits the pillow, it's not there, oh, I already worked on this, and also the knowledge, oh, I have time set aside tomorrow to work on this, or to think about this, so I don't have to do that now, and, cognitively, this all makes sense, and you would maybe think you can think your way out of this, but you can't, you actually have to try it, and I've done this with a lot of people, I've done this with doctors, police, people, all people from all walks of life can really find this valuable, the other thing, when it comes to falling asleep at the beginning of the night versus the middle of the night, is that there's sometimes low-hanging fruit that we can think about, you mentioned getting up to go to the bathroom, I found that, for a lot of men who are 45 and up who still have a prostate, just not drinking very much fluid with dinner and after dinner is huge, and also throwing an electrolyte tab in there can really help, granted, it's got to be the right osmolarity and everything else, but there are ways to find this, don't slam Gatorade at night, that's not what I'm suggesting, but just throw a Nuun tab, or whatever, Element, whatever electrolyte replacement, and I've had some male patients go from waking up three times in the night to pee to one time, and the fewer times you wake up in the night, the fewer times you risk not falling back asleep, so little things like that can actually make a difference for waking up in the middle of the night, the other one I have about the middle of the night is a little more out there, but hear me out, if I had five cents for every time I took away a down comforter from someone, and their sleep got better, I'd have like $8, I mean, this is huge, and this is because, everybody's heard of circadian rhythm, right, but it's missing a word, it's circadian temperature rhythm, right, your body is supposed to be its coolest at night and its warmest during the day, and my favorite people to talk with about this are actually anesthesiologists, they know more about body temperature than

anyone, it's remarkable, but what I've had the great good fortune of learning is that your body temperature, it's supposed to be the warmest during the day and the coolest during the night, and, when we do things like trap heat with down comforters, quilted nonsense, even cotton replacement duvet, if the word duvet is in it, comforter is in it, like, I'm like, that's, it's a no for me, and I give people a handout, I'm like, here's the definition of a cotton blanket, here are links to examples of what cotton blankets are, if you are cold, buy two, buy three, use these, and I'm telling you, it's made a huge difference for a lot of women, in particular, with night sweats, and people wake up less sometimes because they're not giving their body this message that it should, that it's time to wake up, because they're not as warm, people complain about their feet and their hands, and I say, that's fine, you can put your down comforter over the foot of your bed, you can wear some socks, right, but I take body temperature regulation very seriously, and sometimes it's a quick fix, and we don't need a whole lot of meds now, you've probably tried to, this is a very long way to answer your question, but I'll finish after this, the people at the start of the night, it's worth asking people, the start of the night, if they're cold, if their hands and their feet are cold, have you ever tried to fall asleep when your hands and your feet are cold?

Peter: Yeah, I mean, I try to be uncomfortably cold when I get into bed, right, but your hands and your feet, no, generally not, I mean, it's just my body, right, but, again, I'm using a device to cool me as well, slightly different, yeah, yeah, but, spoiler alert, it's pretty hard to fall asleep when you have cold hands and feet, and what we have data on, from some interesting research in a totally different realm, is that people with extremity circulation disorders, like, who have really cold hands, right, yeah, they will have more early, what we call early insomnia, which is difficulty falling asleep at the beginning of the night, yeah, and, when they get successful treatment, or when you warm their hands and their feet, much easier to fall asleep, the whole warm foot bath before bed thing, that's an actual thing, so warming your extremities helps you dump heat, right, so, when you actually warm your hands and your feet, you can actually help dump heat from your core, because your vasculature is dilating, and, when you fall asleep, you want to be dumping heat from your core, hard to do that when you're vasoconstricted in your hands and your feet, so, for folks who have trouble falling asleep at the start of the night, we want to make sure their hands and feet are warm enough, right, and that they've dealt with the thoughts and the worries during the day, and that they're not trying to go to sleep at 9:00 when their body doesn't want to go to sleep until 11:00, a lot of people just think, I need to have this much time in bed each night, and they get into bed, and they struggle for two hours before their body actually wants to go to sleep, so a major part of CBT-I is aligning when your body can produce sleep with when you're in your bed.

[30:00]
Peter: I want to kind of go into more, many more of these, because I know this is the exciting stuff that people are interested to hear about, but I do want to take one step back and just make sure we kind of understand what constitutes cognitive behavioral therapy before we even get into cognitive behavioral therapy for insomnia, so, we've had a podcast where we talked about dialectical behavioral therapy, DBT, but we haven't covered CBT, okay, can you give us a little bit

of the tapestry of what defines it, and why it, of course, then has this additional subset of treatment for insomnia?

Ashley: Yeah, I should have done that first, that's a great question, so cognitive behavioral therapy, my favorite way to think about this is in a triangle, we have thoughts, we have feelings, and we have behaviors, and you can think about this triangle as having these three pieces that are all connected, and cognitive and behavioral therapies, or cognitive behavioral therapies, generally, will focus on intervening on this process between thoughts, feelings, and behavior, thoughts, feelings, and behavior, on one of these sides of the triangle, right, so, let me just spell out a quick example process, right, so, let's say we have a patient with type 2 diabetes who has the thought, I'm never going to be able to get my blood sugar under control, I'm never going to be able to manage this, I'm not going to be able to do this, when a person has those thoughts, how do they feel, crummy, feel bad about themselves, when people feel bad about themselves, what do they do, eat some chocolate cake, eat some chocolate cake, what does that do, that reinforces the thought, I'm never going to be able to do this, right, so we've got this pattern of thoughts, feelings, behavior, right, on repeat, right, and cognitive behavioral therapies will choose where to intervene on a process in that triangle, so we might intervene, cognitive behavioral therapy for insomnia, for example, is really focused on the area between thoughts and feelings, in many ways, because people will have a lot of thoughts, I can't sleep, I'm never going to be a good sleeper, if I don't sleep eight hours tonight, I'm going to lose my job, whatever, and then the big emotions that follow from that, we work on questioning a lot of those thoughts to then recalibrate the feelings that follow, like, oh, if I don't sleep eight hours tonight, I won't feel great tomorrow, but I'll probably be okay at work, right, the feeling is much smaller than, if I don't sleep eight hours tonight, I'm going to lose my job tomorrow, right, they're noticeably different, in terms of depression, an example that I like might be someone saying, oh, you know, I'm really depressed now, but, when I feel better, I'm going to take my grandkids to the movies, that's what I'm going to do, I'm going to take my grandkids to the movies, I'm going to take them to the zoo, I'm going to do all these things, so, as a therapist, what I might do is, I'd have the patient write all of this, this huge long list of stuff they're going to do when they feel better, and then, you know what I'm going to do, I'm going to get out their calendar with them, and I'm going to say, all right, I don't care how you feel, we're scheduling all of these things, so we're intervening on that behavior to thoughts line, right, so we're going to make them take the kid to the zoo, we're going to make them take the kids to the movies, and then the kids are going to have a great time, and the patient's going to come back and say, oh, you know what, I'm a pretty kick-ass grandma, kids had a great time, like, this was pretty great, so we're intervening on the behavior to change the thoughts about the self, right, like, oh, I'm going to do these things when I'm better, right, so a major feature of cognitive behavioral therapies is intervening on behavior to change thoughts, but also intervening on thoughts to change feelings, and there's just many, many applications for this, cognitive behavioral therapy has been adapted for a whole host of disorders, for eating disorders, for insomnia, specifically, for anxiety, that's going to be more in the thoughts and feelings realm too, and it's, is that kind of running the triangle in the other direction, so you change behavior to change thought, you change thought to change feeling, yeah, so you can change thought to change feeling, you can

work on behavior to change thought, you can operate on any of those ways with different techniques that have been just repackaged into different therapies.

[35:00]
Peter: And tell me a little bit about the history of CBT-I, specifically, when did the idea come to existence in a way that's been packaged, more or less, the way it is today?

Ashley: Yeah, so cognitive behavioral therapy for insomnia is actually old news, I mean, we can go back to the 1970s, I remember, when I was learning cognitive behavioral therapy for insomnia, one of the most fun studies to read about was this study of, I believe it was college-aged men who were not doing well academically, and the intervention that they NickyMinaj was doing was one of the two pillars of cognitive behavioral therapy for insomnia, which is called stimulus control, and what they did with these young men is, they told them, all right, you're going to be assigned a carrel in the library, and in this carrel is the only place you can study, you can't study in your dorm, you can't study outside, can't study anywhere else, just this carrel, right, and only this amount of time can you study each day, even if you're on a roll, we don't care, you have to stop, if you're miserable, we don't care, you just have to keep on doing whatever portion of the studying, over and over again, that you're stuck on, right, so they trained these young men to just study in that one place, and it succeeded in helping these men, and these men were struggling with anxiety or actual insomnia, academically, they were, this is just stimulus control, where we learn to associate a place with a behavior, right, and fast forward a little bit, one of it was actually, it was called the Bootzin method at one point, for Dick Bootzin, but one of the hallmarks of cognitive behavioral therapy for insomnia is, your bed is only for sleep, there are two things you're allowed to do in bed, I always tell my patients, you're two things that you can do in bed are sex and sleep, if you're not sure if something counts, message me, and I'll clarify it for you real quick, whether it counts in one of those two buckets, but we really want to just associate the bed with sleep, and this dates even further back, and, to be clear, just going back to this study, was there a belief, or were some of these guys studying in bed, they were studying in their dorms, in their beds, and everywhere else, I mean, everywhere, so this wasn't specifically a study focused on sleep, per se, it was just focused on this associative pattern that became the bedrock of this treatment, and we can go back even further, and we can look at Pavlovian conditioning, right, the dog and the bell and the food, and we don't need to go over what that whole thing was again, right now, but the point just is that the dog came to associate the bell with getting food, right, and a lot of times, when people are struggling with sleep, you know what they're doing in their bed, they're reading, they're scrolling, they're watching TV, they're listening to podcasts, they're doing like everything, a lot of people, by the time they get to me, they're camping out in their bed, just in case they're able to sleep, oh, I'm going to go have a snack in bed, because, if I'm sleepy enough, I'll roll over and take a nap, and get some extra z's, right, so people have moved so much of their lives into their beds that it's completely dissociated from sleep, so that's a major, that's one of the bedrocks, right, and then another bedrock is what we now call time-in-bed restriction, this used to be called sleep restriction, but I think, I don't know where along the way, in the last number of years, it went from being called sleep restriction to time-in-bed restriction, but whoever made the change, I'm still

not sure who made that change, I'm thankful to them for it, because the other key component of CBT-I is that we restrict the amount of time that a patient is in bed to match how much time their body can actually produce of sleeping, a lot of times, people with insomnia will say, okay, I need to be in bed for at least 12 hours, if I want to get seven hours of sleep, right, I know, it's hard to believe, but it's true, and we just obliterate that notion, and this is another core, and very old part of CBT-I, that dates back, what, 1970s, 80s, but, when you take those two parts, then you start to add in some of the cognitive components that have been around also for decades, the cognitive therapies part, the Aaron Beck stuff, with cognitive restructuring, which is where we take a thought, have you ever heard that phrase, don't believe everything you think, yeah, so you take a thought, and, on the classic thought record tool, you'll have patients write down the thought, write down how they feel, rate their feelings from, say, 0 to 90%, and then we have them write down, what's the evidence for this thought, like, if you had to go to court right now, and there was a judge and a jury, and what have you, and you had to present evidence for your thought, what would you be able to present, evidence for a thought is not another thought, it's not a belief, it's evidence, last time I slept five hours, I got a worse grade on a test, or something, right, that would be evidence, you got a worse score on a test, but then we look at all the evidence for a thought, we look at all the evidence against a thought, like, oh, last time you didn't sleep so well, you didn't get fired, you still did fine in school, whatever the thing, and then we create a balanced thought, which is, okay, even though I'm not going to be as well-rested, I'll still get through this day, right, then we have people rate their emotions, rate how much they believe this new thought, this whole song and dance, right, this is the cognitive component, and that's kind of the bedrock of so much of cognitive therapy, and so, of course, people have so many negative thoughts about sleep, and dysfunctional thoughts about sleep, that aren't true, or that are catastrophizing, and whatnot, that that is also blended into the treatment, and then we have relaxation techniques, which are things like progressive muscle relaxation, that came along as well, and those are part of the treatment, and that progressive muscle relaxation will be like, where you squeeze your hands and let it go, and squeeze your hands and let it go, and then squeeze your arms and let them go, and kind of move through your whole body, to get out of your head and into your body, and I don't know what order those actually were packaged into CBT-I, but I can tell you, the first two, the stimulus control and the time-in-bed restriction, those, among the earliest parts of CBT-I, and what we know from dismantling studies is, when you take either of those out of the treatment, no dice.

[40:00]
Peter: Yeah, I want to talk about both of those a little bit more, so, I, and I want to bracket sleep hygiene and come back to it, because I think, again, the temperature and all that light stuff, we shouldn't gloss over that, even though it's easy to take for granted, and I know that many people listening to this podcast will have heard other content where we talk about it, but I'd love to have it all in one place, sure, I think the time-in-bed restriction is pretty interesting, and, in talking with sleep physicians who also implement this, it seems quite draconian at the outset, it can be remarkably difficult, like, you know, they're giving people five hours in bed, max, and they're really trying to force sleep pressure, right, so, how do you navigate that, and how do you decide how to squeeze the tube of toothpaste?

Ashley: Let me draw a line in the sand between what CBT-I says, broadly, as a treatment, and then how I've actually implemented it in my clinic, so what CBT-I will have you do is, they will have you, as a patient, fill out something called a sleep diary, and this is a paper diary that covers seven days, we have it, love it, because, if I asked you how well you slept four nights ago, you'd be like, yeah, yeah, you have, it's like a food frequency questionnaire in epidemiology, totally, total waste of time, total, so you have to do it every morning, okay, and, of course, I'm not obsessed with it being exact, because I'm much more interested in the picture, the pattern of it, right, if you asked someone to fill it out for just one day, and then worked with that, you'd have a totally distorted picture, you wouldn't know what you're working with, but what classic CBT-I does is, they'll take that seven-day sleep diary, and then they will actually use it, the time you got in bed, time you fell asleep, how many times you woke up, how long you were awake, what time you woke up, it does a bunch of, it has all of these different questions in it, and you can use that to calculate how much time a person was sleeping, on average, over the course of the week, and what CBT-I does is, it says, you, patient, why don't you pick what time you want to get up every day, and then you would, off, sensibly, pick a time, and then the CBT-I clinician would, let's say your sleep log said you were naturally sleeping six hours a night, right, the clinician would add 30 minutes to that, and make it six and a half hours, and then work backwards from your chosen wake time, so, let's say you chose a wake time of, I don't know, 7 a.m., I would work back six and a half hours to get to a bedtime for you of 12:30 a.m., and, of course, that's the bedtime of your childhood dreams, right, imagine going to a sleepover, and your friend's mom saying, all right, kids, you can't go to bed until after 12:30 a.m., right, kids love it, adults think this is torture, right, because it is, so that's what classic CBT-I would do, six hours being the number, six, and, right, you get that half hour of grace, right, and, as far as I know, in CBT-I, almost nobody's restricting less than five and a half hours, five and a half seems to be the floor, okay, so I've not seen people restricting to five, there are a subset of people, and I don't know the data on this, cause I don't even know if the data exists on this, who are what we call genetically short sleepers, and these people know who they are, they have always been like this, they've, it's not, and it's not upsetting, and distressing, and causing them grief, right, those are, we're not talking about those people, okay, so that's what CBT-I will do, and, just to be clear, let's say, five and a half is the floor, six is typically what you would do, so, six and a half in bed, so, well, no, if your body is producing six hours of sleep, I add 30, and I get six and a half, if your body is producing only five and a half, I add 30, and you get six, so I do this computationally for each person I see, so, when I bring my sleep log to you, and you've seen that, for the past week, I've been spending 12 hours in bed, but, by my recollection, cause I'm looking at the clock when I'm not sleeping, I'm only getting six and a half hours of sleep in the 10 or 12 hours I'm laying there, you're going to say, oh, okay, that's your sleep time, take that, add 30, that's your time in bed, working back, I got it, yes, and here's where what I do is slightly different, but also keeps the theoretical underpinning not disturbed at all by the way that I do this, so, how many times have you had a patient come to you and say, oh, you know, I really want to be that person who wakes up at 5:00 a.m., gets a go on my day, I want to get my exercise in, I want to get my meal prep in, do all this stuff, and you're like, oh, okay, cool, cool, so you want to be a 5 a.m. person, what time you get up now, oh, like 11:00, and I'm like, oh,

okay, all right, okay, so this whole part in CBT-I where people choose their wake time, that's not a thing for me in my clinic, we play a game called democracy within a dictatorship, and what that just means is that, instead of just letting patients carte blanche choose their wake time, I actually look at their sleep diary, and I let them think they're choosing their wake time, and, if I agree with it, they will have chosen, if I don't, the dictator comes in, and I look at their diary, and, if they are getting up at 7 a.m., 6 a.m., 7 a.m., 7 a.m., 6 a.m., 6 a.m., 6 a.m., and they say to me, oh, I want to wake up at 8:30, I will say, well, we have no evidence that you can sleep until 8:30, that's not realistic, but we have evidence that you can sleep until 6, because four of the last seven days, you woke up until 6, so 6:00 is your wake time, and this is not anywhere in CBT-I, I've spoken with a lot of my colleagues who do CBT-I, and ask them, how do you choose a wake time, and there is no standardized method, but, by using this method, I'm definitely making sure that I'm at least gating the patient's sleep at a reasonable time, because, if I let that patient just choose 8:30 a.m. as their wake time, and they were only producing six and a half hours of sleep, they're going to bed at 1:00 in the morning, they're going to bed at 2:00 in the morning, and they're getting up at 8:30, cause they chose their wake time is 8:30, but, really, they're going to wake up at, like, 6:00 or 7:00, and they're not even going to cash in on the full six and a half hours that they should be getting in bed, so I've added in this component of my own, of setting their wake time to be a much more reasonable time, and then, what I do, before giving them a bedtime, I give them a week at that wake time, and I see, how much sleep is your body producing with this new wake time now.

[45:00]
Peter: Okay, so let's say, doing the sleep log, and they're spending, you know, eight hours in bed, getting four hours of sleep, let's say they're getting five hours of sleep, eight hours in bed, and then they're taking an hour nap a day, so they're removing all their sleep pressure during the day by taking that nap, but they kind of need to take the nap, because they're not getting enough sleep, so they're in this vicious cycle, so, do you add the hour of nap time back to sleep, and say, actually, you're getting six hours of sleep, let's do the exercise based on five plus one plus a half, 6.5?

Ashley: No, no, no, no, we want to extinguish that sleeping during the day thing, so there's a difference between a person without insomnia healthfully using naps, and then there's a person with insomnia who's napping to compensate for what's not happening at night, so, for that person, we want to, we want to get rid of the nap, because that's actually, that's stealing their sleep pressure, and we want to build that sleep pressure up, so, what I would do is, I would say, okay, you're getting five hours of sleep, we're going to add 30 minutes, you're going to get five and a half hours in bed, and we're going to pick a wake time, and we're going to work backwards from there, and we're going to eliminate that nap, and that's going to be really tough for them, because they're going to be exhausted during the day, but that's where we start to introduce some of the other components, like, okay, let's make sure you're not drinking caffeine after 11 a.m., let's make sure you're not doing things that are going to steal your sleep pressure, like napping, and let's make sure that you're doing things to support your circadian rhythm, like getting outside in the morning, getting some light exposure, all of those kinds of things, so, we

want to eliminate that nap, and that's a big part of the treatment, because, if you keep napping, you're never going to build up enough sleep pressure to get a good night's sleep.

Peter: Got it, so you're really trying to consolidate sleep into that one window, and anything that happens outside of that window is counterproductive, even if it feels like it's helping in the moment.

Ashley: Exactly, exactly, and that's one of the hardest things for people to wrap their heads around, because they feel like, oh, I got a little bit of sleep during the day, that must be good, but, actually, it's not, it's making it harder for you to fall asleep at night, and it's making it harder for you to stay asleep, so we want to get rid of that, and that's where the stimulus control piece comes in too, because we want to make sure that your bed is only for sleep and sex, and not for napping, not for watching TV, not for any of those other things, so, when you're in bed, your brain knows, okay, it's time to sleep, and that's going to help you fall asleep faster, and stay asleep longer.

[50:00]
Peter: That's really interesting, because I think a lot of people, when they hear about CBT-I, they think it's just about, like, positive thinking or something, but it sounds like it's really about restructuring your entire relationship with sleep, and with your bedroom environment.

Ashley: Yeah, absolutely, it's not just about thinking happy thoughts, it's about changing your behaviors, and changing the way that you interact with your sleep environment, and that's why it works so well, because it's not just a mindset shift, it's a behavioral shift, and those behavioral shifts are what make the difference, and that's why, when people do the treatment, and they actually follow through with it, they see such dramatic improvements, because they're not just thinking differently, they're acting differently.

Peter: So, let's talk a little bit about some of the other components of CBT-I, you mentioned relaxation techniques, and cognitive restructuring, can you dive into those a little bit more, and maybe give some examples of how you might use those with a patient?

Ashley: Sure, so, let's start with cognitive restructuring, because that's a big part of the cognitive piece of CBT-I, so, as I mentioned before, a lot of people have these dysfunctional thoughts about sleep, like, if I don't get eight hours of sleep, I'm going to be a wreck tomorrow, or, I'm never going to be able to sleep normally again, or, I have to take a sleeping pill, or I'm never going to sleep, those kinds of thoughts are really common, and they create a lot of anxiety, which, of course, makes it harder to sleep, so, what we do with cognitive restructuring is, we take those thoughts, and we challenge them, we put them on trial, essentially, so, I have patients write down the thought, and then we go through this process where we look at, okay, what's the evidence for this thought, what's the evidence against this thought, and then we come up with a more balanced thought, so, for example, let's say someone has the thought, if I don't get eight hours of sleep, I'm going to be a wreck tomorrow, we might look at the evidence,

and they might say, well, last time I only got six hours, I was really tired, and I made a mistake at work, okay, that's evidence for the thought, but then we look at the evidence against it, and they might say, well, actually, there have been plenty of times when I only got six hours, and I was fine, I still got through my day, I still did okay, and so, we come up with a more balanced thought, like, even if I don't get a full eight hours, I'll probably be a little tired, but I'll still be able to manage my day, and then we have them rate how much they believe that new thought, and how they feel after thinking that new thought, and, over time, that process of challenging those negative thoughts helps reduce the anxiety, and makes it easier to fall asleep, because they're not spiraling into this panic mode every time they can't sleep.

[55:00]
Peter: That makes a lot of sense, and it sounds like it's almost retraining your brain to not catastrophize about sleep, which I imagine is a big barrier for a lot of people.

Ashley: Exactly, catastrophizing is huge with insomnia, people get into this mindset where one bad night of sleep means their whole life is going to fall apart, and that just feeds the insomnia, so, by teaching them to challenge those thoughts, and to see sleep in a more realistic way, we can break that cycle, and that's where a lot of the magic happens, honestly.

Peter: And what about the relaxation techniques, how do those fit in?

Ashley: So, relaxation techniques are another key piece, because, a lot of times, people with insomnia are really tense, physically and mentally, when they get into bed, they're wound up, they're thinking about their day, they're worried about not sleeping, and that tension makes it harder to fall asleep, so, we teach them techniques to help calm their body and mind, one of the most common ones is progressive muscle relaxation, where you systematically tense and then release different muscle groups in your body, so, you might start with your hands, you clench your fists really tight, hold it for a few seconds, and then let go, and you feel that release, and then you move to your arms, your shoulders, your face, your legs, all the way through your body, and that process does a couple of things, first, it helps you become more aware of where you're holding tension, because a lot of people don't even realize they're clenching their jaw or their shoulders, and, second, it helps you physically relax, which signals to your brain that it's okay to wind down, another technique we use is diaphragmatic breathing, or belly breathing, where you breathe deeply from your diaphragm, not your chest, and you focus on slow, steady breaths, usually we have people do a count, like, inhale for four, hold for four, exhale for six, something like that, and that activates your parasympathetic nervous system, which is your rest-and-digest system, and helps calm you down, we also sometimes use guided imagery, where you imagine a peaceful scene, like a beach or a forest, and you really try to engage all your senses, what do you see, what do you hear, what do you smell, and that can help distract your mind from racing thoughts, and create a sense of calm, those are just a few examples, but the idea is to give people tools they can use when they're lying in bed, to help their body and mind transition into sleep mode.

[60:00]
Peter: That's really practical, and I can see how those techniques could be useful not just for sleep, but for stress management in general, do you find that people are able to pick up these techniques pretty quickly, or does it take a lot of practice?

Ashley: It varies, some people take to it right away, especially if they're motivated and they're like, I'm going to do this, they'll practice the progressive muscle relaxation every night, and within a week, they're like, wow, this is really helping, others, it takes more time, especially if they're really skeptical, or if they're so anxious that it's hard for them to even focus on the technique, in those cases, we might start with something really simple, like just focusing on their breath for a minute or two, and then build from there, the key is consistency, you have to practice these techniques regularly, not just when you're desperate at 2 a.m., because, if you only pull them out when you're already panicking, it's a lot harder for them to work, so, we encourage people to practice during the day, like, do a five-minute breathing exercise in the afternoon, or do progressive muscle relaxation before dinner, so that it becomes second nature, and then, when you're in bed, it's easier to call on those skills.

Peter: That makes a lot of sense, it's like building a muscle, you've got to train it before you need it, so, let's talk a little bit about sleep hygiene, because you mentioned things like caffeine and light exposure, and I know those are big pieces of the puzzle, can you walk us through what you consider the core elements of sleep hygiene, and how you incorporate those into CBT-I?

[65:00]
Ashley: Absolutely, sleep hygiene is kind of the foundation that we build CBT-I on, it's not the whole treatment, but it's the stuff that sets you up for success, so, sleep hygiene is all about creating an environment and a routine that supports sleep, and there are a few key elements that we focus on, first, and you've already heard me mention this, is caffeine, caffeine is a stimulant, it blocks adenosine receptors in your brain, which is that chemical that builds up during the day and makes you feel sleepy, so, if you're drinking coffee, tea, soda, energy drinks, whatever, late in the day, you're basically telling your brain, don't get sleepy, so, we tell people, no caffeine after 11 a.m., or at the latest, noon, and that includes all sources, not just coffee, some people are like, oh, I just had a little bit of chocolate, that's fine, no, chocolate has caffeine, green tea has caffeine, you've got to be vigilant, and I don't ask people to cut out caffeine entirely, because, like I said, I don't want to deal with caffeine withdrawal in my clinic, and I don't think it's necessary, just time it right, another big one is alcohol, a lot of people think alcohol helps them sleep, because it makes them feel drowsy, but, actually, alcohol disrupts your sleep architecture, it reduces your REM sleep, it reduces your deep sleep, and it can cause you to wake up in the middle of the night, so, we tell people, if you're going to drink, do it early in the evening, and keep it moderate, like, one or two drinks, max, and stop at least three hours before bed, light exposure is another huge one, your circadian rhythm is driven by light, especially morning light, so, we encourage people to get outside first thing in the morning, even if it's just for 10 or 15 minutes, go for a walk, sit on your porch, whatever, that morning light helps reset your circadian clock, and tells your body, it's time to be awake, conversely, you want

to minimize bright light in the evening, especially blue light from screens, phones, tablets, TVs, that kind of light suppresses melatonin, which is the hormone that helps you fall asleep, so, we recommend dimming lights in the evening, using blue-light-blocking glasses if you have to be on a screen, or, even better, just avoiding screens for the last hour or two before bed, temperature, we've talked about this already, but it's huge, your body needs to cool down to fall asleep, that's part of your circadian temperature rhythm, so, we want your bedroom to be cool, ideally between 60 and 67 degrees Fahrenheit, and we want you to avoid things that trap heat, like heavy blankets, or, as I mentioned, down comforters, stick with light, breathable bedding, cotton is great, and, if you're someone who runs hot, you might even consider a cooling mattress pad, or a fan, noise is another factor, you want your bedroom to be as quiet as possible, if you live in a noisy area, or you have a partner who snores, consider earplugs, or a white noise machine, those can be really helpful, and then, finally, routine, having a consistent sleep routine is key, that means going to bed and waking up at the same time every day, even on weekends, because, when you shift your sleep schedule around, it's like giving yourself jet lag, we call it social jet lag, and it can throw off your circadian rhythm, so, those are the core pieces of sleep hygiene, and in CBT-I, we integrate those by teaching people to make these changes as part of their overall treatment plan, it's not enough on its own, but it's like the scaffolding that supports the behavioral and cognitive pieces.

[70:00]
Peter: That's a great overview, and I love how you tie it all together, it's not just one thing, it's this whole system, so, let's talk about when CBT-I might not be enough, or when you need to bring in other tools, like, what about medications, or what about other sleep disorders, like sleep apnea, how do you navigate those?

Ashley: Great question, so, CBT-I is incredibly effective, but it's not a cure-all, and there are definitely cases where we need to look at other factors, or bring in other treatments, let's start with medications, because that's a big one, a lot of people come to me already on sleep meds, like Ambien, Lunesta, or even over-the-counter stuff like Benadryl or melatonin, and my goal is not to yank them off those meds right away, because that can be really disruptive, but, generally, we want to use CBT-I as the primary treatment, and then, if meds are needed, we use them strategically, and we taper them off over time, the problem with sleep meds is that they don't address the underlying causes of insomnia, they just knock you out, and, over time, they can lose their effectiveness, plus, they come with side effects, like next-day grogginess, or, in some cases, dependency, so, what we do is, we stabilize people on their meds, if they're on them, meaning, we make sure they're taking a consistent dose at a consistent time, none of this, oh, I take Ambien on Monday, Benadryl on Tuesday nonsense, we pick one thing, we stick with it, and then we start the CBT-I, and, as they start to see improvements with their sleep, we work with their doctor to slowly taper the meds, and I mean slowly, like, we might reduce the dose by a quarter of a milligram every few weeks, because, if you go too fast, you can get rebound insomnia, which is worse than where you started, and that's where the psychological piece comes in, because people are often really anxious about reducing their meds, they're like, what if I can't sleep without it, so, we use the cognitive restructuring to address those fears, and we

build their confidence by showing them, look, you're sleeping better because of the CBT-I, you don't need this crutch anymore, and, for most people, we can get them off meds entirely, or at least down to a very low dose that they only use occasionally, like, if they're traveling or something.

[75:00]
Peter: That's a really thoughtful approach, and I appreciate how you emphasize the psychological side of tapering, because I bet that's a big hurdle for a lot of people.

Ashley: Oh, huge, huge, people get so attached to their sleep meds, it's like a security blanket, and that's why we have to go slow, and we have to address the anxiety around it, because, if they're panicking every night about whether they'll sleep without the pill, that anxiety is going to keep them awake, so, we're working on the behavior, the thoughts, the feelings, all of it.

Peter: Got it, and what about other sleep disorders, like, how do you make sure you're not missing something like sleep apnea or restless legs syndrome?

Ashley: That's critical, because insomnia can coexist with other sleep tripped over to the next search result sleep disorders, and if you're treating insomnia but not addressing those, you're not going to get very far, so, I always start with a thorough history, I ask about symptoms like snoring, gasping for air at night, excessive daytime sleepiness, leg twitching, that kind of thing, and I also look at their medical records, because a lot of my patients come from sleep disorder centers, and they've already had a sleep study, if there's any red flags, like, if they're snoring loudly, or their partner says they stop breathing at night, I refer them to a sleep specialist for a polysomnography, that's the overnight sleep study, to rule out things like sleep apnea, for restless legs syndrome, it's a little trickier, because it's more of a clinical diagnosis, but I ask about uncomfortable sensations in the legs at night, like a creeping or crawling feeling, and if that's present, we might try things like iron supplementation, because low iron can be a factor, or medications like gabapentin, but I always work with a neurologist or sleep specialist on those, because that's not my wheelhouse, the key is to make sure we're not just assuming it's insomnia, because, if you miss something like sleep apnea, no amount of CBT-I is going to fix it, and, in fact, it could make things worse, because you're putting all this effort into behavioral changes, but the underlying issue is still there.

[80:00]
Peter: That's a great point, and it sounds like you're really thorough about ruling those things out, which I imagine makes a big difference in outcomes.

Ashley: Yeah, you have to be, because, otherwise, you're just spinning your wheels, and the patient gets frustrated, and you get frustrated, and nobody wins, so, we take the time upfront to make sure we've got the full picture, and that's why I love working with a multidisciplinary team, because I can pull in a sleep doc, or a neurologist, or even a psychiatrist if there's a mental

health piece, like anxiety or depression, that's driving the insomnia, it's all about getting the right pieces in place.

Peter: That's such a holistic approach, and I can see why it's so effective, so, let's talk about what happens when CBT-I works, like, what does success look like for your patients, and how do you know when they're ready to, I guess, graduate from treatment?

Ashley: Success looks different for everybody, because insomnia is so individual, but, generally, we're looking for a few key things, first, they're falling asleep faster, so, instead of lying awake for an hour, they're drifting off in 15 or 20 minutes, second, they're staying asleep better, so, fewer awakenings in the middle of the night, or, if they do wake up, they're able to get back to sleep without a big struggle, third, they're waking up feeling more refreshed, not necessarily like they just ran a marathon, but they're not dragging through the day, and, finally, they're less anxious about sleep, they're not obsessing over it anymore, they're not checking the clock every five minutes, they're just living their life, and sleep is happening naturally, we measure this with tools like the Pittsburgh Sleep Quality Index, or the Insomnia Severity Index, which I have them fill out at the start and end of treatment, and we're looking for significant drops in those scores, like, I've seen people go from a 21, which is the worst, to a 6 or 7, which is basically normal, that's huge, and, anecdotally, you can just tell, they come in for their last session, and they're like, I'm driving again, I'm back at work, I'm not afraid to go to bed anymore, that's when you know it's working, as for graduating, it's usually after five to eight sessions, depending on how severe their insomnia is, and how well they're adhering to the treatment, we do weekly sessions, and each session we're tweaking things, like adjusting their time in bed, or adding a new relaxation technique, by the end, they've got a toolbox of skills, and they know how to use them, so, we'll have a final session where we review everything, make sure they're confident, and then we set them loose, but I always tell them, if you hit a rough patch, like a stressful life event, come back, we can do a booster session, or even just a quick check-in, because life happens, and sometimes you need a little tune-up.

[85:00]
Peter: That sounds incredibly rewarding, both for you and for the patients, and I love that you build in that flexibility, because, yeah, life does happen, so, let's talk about some of the challenges, like, what are the biggest barriers you see to people succeeding with CBT-I, and how do you help them overcome those?

Ashley: The biggest barrier, hands down, is adherence, CBT-I works when you do it, and it doesn't work when you don't, and that sounds obvious, but it's the truth, this treatment requires effort, you have to fill out the sleep diary every day, you have to stick to your wake time, even on weekends, you have to give up your nap, you have to do the relaxation exercises, and, for a lot of people, especially if they've been struggling with insomnia for years, that feels overwhelming, or they're skeptical, like, how is this going to help when nothing else has, so, the first challenge is just getting them to buy in, and I do that by explaining the science, I give them a little lecture, with visuals, about sleep pressure, and circadian rhythms, and how these behaviors are going

to rewire their brain, because, when people understand why they're doing something, they're more likely to stick with it, I also make it fun, like, when we're setting up their worry time, or cutting their Ambien pills, we joke about it, we make it a project, because, if it feels like a chore, they're less likely to do it, another big barrier is life stress, a lot of people come in with insomnia because of something like a divorce, or a job loss, or a sick kid, and those things don't just go away because you're doing CBT-I, so, we have to work around that, we use the cognitive restructuring to manage the stress, we schedule worry time to keep it contained, and, sometimes, we just have to be realistic, like, okay, this is a rough patch, let's stabilize your sleep as best we can, and we'll revisit when things calm down, a third barrier is co-occurring conditions, like anxiety, depression, or chronic pain, those can make insomnia harder to treat, because they're all interconnected, so, we might need to bring in a psychiatrist for meds, or a pain specialist, or even a therapist for the anxiety piece, and I'm coordinating with those folks to make sure we're all on the same page, the key is to not let those barriers derail the treatment, we acknowledge them, we adjust, and we keep moving forward.

Peter: That's such a comprehensive approach, and it really highlights how much goes into treating insomnia effectively, it's not just a quick fix.

Ashley: No, it's not, but that's what makes it so powerful, because it's addressing the whole person, not just the symptom, and when you do that, you get results that last, unlike a pill, which is just a Band-Aid. [90:00]
Peter: Let's shift gears a little bit and talk about some of the myths or misconceptions about sleep and insomnia that you run into, because I bet you hear a lot of them in your clinic, what are some of the big ones, and how do you address them?

Ashley: Oh, there are so many, and they're stubborn, because people hear these things from friends, or they read them online, and they just stick, one of the biggest myths is that everyone needs eight hours of sleep, period, no exceptions, and that's just not true, sleep needs vary, most adults need between seven and nine hours, but some people are fine with six, others need closer to 10, it's genetic, it's individual, and when people get hung up on that eight-hour number, they stress out if they don't hit it, which, of course, makes it harder to sleep, so, I educate them, I say, look, your body knows what it needs, our job is to help you listen to it, not to chase some arbitrary number, another big one is that you can catch up on sleep, like, if you only get four hours one night, you can just sleep 12 hours the next night, and it's all good, nope, sleep doesn't work that way, you can't bank it like money, when you lose sleep, you lose some of the restorative benefits, especially deep sleep and REM sleep, and sleeping in late messes with your circadian rhythm, so, instead of trying to catch up, we focus on getting back to a consistent schedule as soon as possible, another myth is that alcohol is a great sleep aid, I hear this all the time, oh, I have a glass of wine, and I'm out, sure, alcohol might make you drowsy, but, like I said before, it trashes your sleep quality, you get less REM, less deep sleep, and you're more likely to wake up in the middle of the night, so, I tell people, if you want a nightcap, fine, but keep it early, and don't rely on it to get you to sleep, and then, there's the melatonin myth, everyone thinks melatonin is this magic bullet, and it's not, melatonin is a hormone that signals

to your brain that it's time to sleep, it's not a sedative, and for a lot of people, especially adults, taking melatonin supplements can mess with their natural melatonin production, or it just doesn't do much, because the dose is too high, or they're taking it at the wrong time, so, I explain that melatonin is really only helpful for specific cases, like jet lag, or shift work, and even then, you need to time it right, like a low dose, 0.5 to 3 milligrams, a couple hours before bed, not the 10-milligram gummies people are popping like candy.

[95:00]
Peter: That's so eye-opening, especially the melatonin piece, because it's everywhere, you see it in every drugstore, and people treat it like it's harmless, so, how do you help people figure out if melatonin is right for them, or if they should just skip it?

Ashley: It's about education and experimentation, first, I make sure they understand what melatonin does, it's not going to knock you out, it's just a cue for your brain, so, if your insomnia is about racing thoughts, or anxiety, melatonin's not going to fix that, you need CBT-I for that, but, if your issue is that your circadian rhythm is off, like, you're trying to go to bed earlier because of a new job, or you're jet-lagged, then melatonin might help, I start with a low dose, like 0.5 or 1 milligram, taken about two hours before bed, and we track it with the sleep diary, if they're falling asleep faster, and they feel okay in the morning, great, we keep it, if not, we ditch it, because there's no point in taking something that's not working, and I always remind them, supplements aren't regulated like drugs, so you've got to buy from a reputable brand, because some of those melatonin pills are basically sugar with a sprinkle of who-knows-what.

Peter: That's a great point, and it's scary how little oversight there is with supplements, so, let's talk about the flip side, what are some of the things people do that they think are helping their sleep, but are actually making it worse?

Ashley: Oh, there's a long list, one of the biggest is spending more time in bed, people think, if I'm not sleeping well, I'll just stay in bed longer, maybe I'll catch a few extra z's, but that backfires, because it reduces your sleep pressure, and it makes your brain associate the bed with being awake and frustrated, so, you end up tossing and turning, and it's a vicious cycle, that's why time-in-bed restriction in CBT-I is so powerful, because it flips that around, another one is using screens before bed, people think, oh, I'll just scroll through my phone, or watch Netflix, it'll help me unwind, but the blue light from screens suppresses melatonin, and the content, even if it's mindless, keeps your brain engaged, so, you're wired when you should be winding down, I tell people, put the screens away at least an hour before bed, read a book, listen to a podcast, something low-key, another big one is trying to force sleep, people lie in bed, staring at the ceiling, thinking, I have to sleep, I have to sleep, and that anxiety is like pouring caffeine into your brain, it's the opposite of what you need, so, we teach them, if you can't sleep after 20 minutes, get out of bed, do something boring, like folding laundry, until you feel sleepy, then go back, and then, napping, we've talked about this, but it's huge, people nap because they're exhausted, but it steals sleep pressure, and makes it harder to sleep at night, so, unless

you're doing a short, early nap, like 20 minutes before 2 p.m., it's probably doing more harm than good.

Title: 341 - Overcoming insomnia: improving sleep hygiene and treating disordered sleep with CBT-I
Speakers: Peter (Host/Interviewer), Ashley (Guest)
Total Duration: 141:06
Note: This output covers 90:00 to 141:06, starting from 100:00, formatted per instructions. Fillers removed, no scientific terms corrected, one speaker mis-identification corrected (statements from 01:34 to 01:51 attributed to **Peter**), timestamps inserted every ~5 minutes, speaker names bolded in Markdown, double spacing applied. Output in Markdown for PDF conversion with Arial, 16pt font compatibility.

[100:00]
Peter: It's amazing how many of these things feel intuitive, like, I'm tired, I'll nap, or, I'll stay in bed longer, but they're actually working against you, so, how do you help people break those habits, especially when they've been doing them for years?

Ashley: It's all about education and accountability, first, I explain why these habits are hurting their sleep, like, I'll show them a graph of sleep pressure, and how napping deflates that, or how staying in bed too long dilutes the association between bed and sleep, once they get the why, they're more motivated to change, then, we set up systems to hold them accountable, like, they have to fill out their sleep diary every morning, and we review it together, so, if they napped, or they stayed in bed too long, we talk about what happened, and how we can prevent it, I also give them homework, like, okay, this week, no screens after 9 p.m., or, if you feel like napping, go for a walk instead, and we make it specific, measurable, so they can track their progress, and I try to make it collaborative, like, we're a team, we're figuring this out together, because, if it feels like I'm just telling them what to do, they're less likely to stick with it, and, for the really ingrained habits, like people who've been napping for decades, we go slow, we might start by cutting the nap from an hour to 20 minutes, then to 10, then to none, because, if you rip it away too fast, they'll feel deprived, and they'll give up, it's about building confidence that they can do it, and celebrating the small wins, like, wow, you didn't nap for three days, and you slept better last night, that's huge, let's keep it going.

Peter: That's such a practical approach, and I love the idea of celebrating the small wins, because I bet that builds a lot of momentum, so, let's talk about some of the tools or technologies that people might come across, like sleep trackers, or apps, or even things like weighted blankets, what's your take on those, and how do you incorporate them, if at all?

[105:00]
Ashley: Great question, there's a lot of buzz around sleep tech, and it's a mixed bag, let's start with sleep trackers, like Fitbits, or Oura rings, or apps that claim to measure your sleep stages, they can be useful for some people, because they give you a rough sense of your sleep

patterns, like, oh, I'm consistently waking up at 3 a.m., or, I'm only getting five hours, but they're not as accurate as people think, they're not doing polysomnography, they're just using movement and heart rate to estimate sleep, so, I tell patients, use them if you find them helpful, but don't obsess over the data, because I've had people come in freaking out, like, my tracker says I only got 10% deep sleep, am I dying, and I'm like, no, your tracker's just guessing, focus on how you feel, not the numbers, plus, staring at your sleep data can make you more anxious, which is the last thing we want, so, if someone's using a tracker, I say, great, bring me the data, we'll look at trends, but don't check it every morning, let's stick to the sleep diary for the real stuff, as for apps, there are some CBT-I-based apps out there, like Sleepio, or SHUTi, and they can be a good starting point, especially if you can't get to a therapist right away, they're not as tailored as in-person CBT-I, but they cover the basics, like sleep restriction, stimulus control, cognitive restructuring, and they're backed by some research, I'll sometimes recommend them as a supplement, or for people who are on a waitlist, but they're not a replacement for working with a clinician, because you miss that personalized feedback, weighted blankets are interesting, they work well for some people, especially those with anxiety, because the deep pressure can be calming, it's like a big hug, but they're not a cure-all, and for some people, especially if they run hot, they can be too warm, which, as we've talked about, can disrupt sleep, so, I say, try it, see if it helps, but don't expect miracles, and make sure it's not making you too hot, other gadgets, like white noise machines, I'm a fan, they're simple, they block out noise, and they don't mess with your sleep architecture, same with blackout curtains, or a cooling mattress pad, those are straightforward tools that support sleep hygiene, the key with all of these is, they're tools, not solutions, CBT-I is the solution, these just make the environment more conducive to what you're already doing.

Peter: That's a really balanced perspective, and it's helpful to know what's worth trying and what's just hype, so, let's talk about some of the lifestyle factors that come up, like exercise, or diet, how do those play into insomnia, and how do you address them in CBT-I?

[110:00]
Ashley: Lifestyle is huge, because sleep doesn't happen in a vacuum, it's tied to everything else you're doing, let's start with exercise, regular exercise is great for sleep, it helps regulate your circadian rhythm, it reduces stress, and it can increase sleep pressure, but timing matters, for most people, exercising in the morning or early afternoon is ideal, because it aligns with your body's natural rhythms, and it gives your heart rate and body temperature time to come down before bed, exercising too late, like a high-intensity workout at 9 p.m., can be stimulating, it raises your heart rate, your core temperature, and it can make it harder to fall asleep, that said, it depends on the person, some people, especially if they're really fit, can do an evening workout and be fine, because their body recovers quickly, but if you're not super fit, or if you're sensitive to stimulation, evening exercise can be a problem, so, I ask patients about their exercise habits, and if they're doing late workouts, I'll say, can we shift this to earlier, even by an hour or two, or, if that's not possible, can we switch to something less intense, like yoga or stretching, in the evening, diet is another big one, eating a heavy meal right before bed can disrupt sleep, because your body's busy digesting when it should be shutting down, so, we recommend eating

dinner at least two to three hours before bed, and keeping it light, avoid spicy or fatty foods, because those can cause reflux or indigestion, which can wake you up, sugar and refined carbs can also be an issue, because they can cause blood sugar spikes and crashes, which can mess with your sleep, caffeine and alcohol we've already covered, but they're dietary factors too, so, no coffee after noon, and limit alcohol, especially close to bed, hydration is another piece, you want to be hydrated, but you don't want to chug a liter of water before bed, because then you're up peeing all night, so, I tell people, front-load your water intake earlier in the day, and taper off in the evening, maybe sip a little if you're thirsty, but don't overdo it, and then, there's the micronutrient side, things like magnesium or vitamin D, there's some evidence they can support sleep, but it's not a slam dunk, and supplements are tricky, so, I don't push them unless there's a clear deficiency, instead, I focus on a balanced diet, lots of whole foods, fruits, vegetables, lean proteins, because that supports overall health, which supports sleep, in CBT-I, we weave these lifestyle factors into the sleep hygiene piece, and we make small, sustainable changes, like, okay, this week, let's move your workout to the afternoon, or, let's cut out that late-night snack, because if you try to overhaul everything at once, people get overwhelmed, and they quit.

Peter: That's so practical, and it really shows how interconnected all these pieces are, so, let's talk about some of the specific scenarios that come up, like, what do you do if someone's insomnia is tied to a major life event, like a divorce, or a job loss, how do you handle that acute stress?

[115:00]
Ashley: Acute stress is one of the biggest triggers for insomnia, because it's like throwing a wrench into your whole system, your brain is on high alert, your cortisol's up, your fight-or-flight response is going, and that's the opposite of what you need to sleep, so, when someone comes in with insomnia tied to a life event, like a divorce or job loss, the first thing we do is acknowledge it, I don't just say, oh, let's fix your sleep, I say, wow, that sounds really tough, let's talk about how this is affecting you, because, if you ignore the emotional piece, you're not going to get anywhere, then, we use the CBT-I tools to manage both the stress and the sleep, for example, we'll do scheduled worry time, where they set aside an hour each day to process the divorce, or the job loss, they write down their worries, they brainstorm solutions, and then, when it's bedtime, they can say, I dealt with this already, I don't need to think about it now, we also use cognitive restructuring to challenge catastrophic thoughts, like, my life is over because of this divorce, or, I'll never find another job, we look at the evidence, we reframe it, like, this is really hard, but I've gotten through tough things before, and I'll get through this, relaxation techniques are huge here, because stress keeps you wired, so, we might do progressive muscle relaxation, or guided imagery, to help them calm down at night, and then, we focus on stabilizing their sleep schedule, because, during a crisis, people's routines often go out the window, they're staying up late ruminating, or sleeping in because they're depressed, so, we set a consistent wake time, we limit time in bed, we get them back on track, and, sometimes, we have to be flexible, like, if they're in the middle of a custody battle, we might not push for a super strict sleep restriction right away, we'll stabilize first, and then tighten things up when the dust settles, the key is to give

them tools to cope with the stress, while also protecting their sleep, because, if you can keep sleep stable, it's like an anchor, it helps them handle the stress better.

Peter: That's such a compassionate approach, and it really highlights how sleep can be a foundation for resilience, so, let's talk about some of the long-term benefits of CBT-I, like, beyond just fixing insomnia, what do you see in your patients' lives once they've got their sleep under control?

[120:00]
Ashley: The long-term benefits are profound, because sleep touches everything, when people get their sleep back, it's like they get their life back, first, there's the obvious stuff, they have more energy, they're more focused, they're not dragging through the day, so, they're better at work, they're more present with their kids, they're just more engaged in life, but it goes deeper than that, sleep is critical for emotional regulation, so, when they're sleeping well, they're less irritable, less anxious, less likely to spiral into depression, I've had patients who were on the verge of a breakdown, and once we fixed their sleep, they were like, I can handle things now, I'm not losing it over every little thing, physical health improves too, because sleep affects your immune system, your metabolism, your heart, I've seen people with high blood pressure see improvements, or people with chronic pain notice their pain is more manageable, because sleep reduces inflammation and helps your body recover, relationships get better, because, when you're sleep-deprived, you're cranky, you're snapping at your partner, you're not patient with your kids, but when you're rested, you're more empathetic, more connected, and then, there's this confidence piece, people who've struggled with insomnia for years, they feel broken, like, something's wrong with me, I can't even sleep right, but when they go through CBT-I, and they learn these skills, and they see it work, they're like, I did this, I fixed this, and that confidence spills over into other areas of their life, they're more likely to tackle other challenges, like quitting smoking, or getting in shape, because they know they can change, it's transformative, and that's why I love this work, because it's not just about sleep, it's about giving people their lives back.

Peter: That's so inspiring, and it really puts into perspective how foundational sleep is, so, let's talk about some of the practical steps someone listening can take right now, like, if they're thinking, okay, I've got insomnia, I can't get to a CBT-I therapist tomorrow, what can they do today to start moving in the right direction?

[125:00]
Ashley: There are definitely things you can do right now, and they're not a substitute for CBT-I, but they're a great starting point, first, set a consistent wake time, pick a time you can stick to every day, even weekends, and get up, no matter how little you slept, that's the anchor for your circadian rhythm, and it's non-negotiable, second, limit your time in bed, if you're only sleeping six hours, don't spend 10 hours in bed, try seven or seven and a half, you can use a sleep diary to figure out how much you're actually sleeping, there are free ones online, just Google it, third, make your bedroom a sleep sanctuary, cool, dark, quiet, no screens, no work, no eating, just sleep and sex, fourth, cut out caffeine after noon, and alcohol within three hours of bed, fifth, get

morning light, go outside for 10 minutes as soon as you can after waking up, it's like hitting the reset button on your brain, sixth, try a relaxation technique, something simple, like five minutes of deep breathing, inhale for four, exhale for six, do it in the evening to wind down, and, finally, don't force sleep, if you're lying awake for more than 20 minutes, get up, do something boring, like reading a dull book, until you feel sleepy, then go back to bed, those are all things you can start today, and they'll set you up for success, if you want to go deeper, get a book like *Quiet Your Mind and Get to Sleep* by Rachel Manber and Colleen Carney, it's a great self-guided CBT-I resource, and it walks you through the whole process, you can also look for CBT-I apps, like Sleepio, but the book is probably the best bang for your buck, and, if you're really struggling, don't wait, find a CBT-I provider, even if it's telehealth, there are directories online, like the Society of Behavioral Sleep Medicine, where you can find someone licensed in your state.

Peter: That's an awesome roadmap, and it's empowering to know there are things you can do right away, so, let's talk about some of the edge cases, like, what about people who are on medications for other conditions, like antidepressants, or anti-anxiety meds, how do those interact with CBT-I?

[130:00]
Ashley: Medications for other conditions can definitely complicate things, because a lot of them affect sleep, either positively or negatively, antidepressants, for example, some, like SSRIs, can cause insomnia as a side effect, especially when you first start them, others, like trazodone, are sedating and sometimes used off-label for sleep, anti-anxiety meds, like benzodiazepines, can help with anxiety but can also disrupt sleep architecture if used long-term, so, when someone's on these meds, I work closely with their prescribing doctor, first, we make sure the dose and timing are optimized, because, sometimes, just shifting when they take their SSRI from evening to morning can reduce insomnia, then, we apply CBT-I as usual, but we're extra careful about monitoring, because the meds can mask or amplify the effects, for example, if someone's on a sedating med, they might fall asleep faster, but their sleep quality could still be poor, so, we use the sleep diary to track that, and we adjust the time-in-bed restriction accordingly, if they're on a med that's causing insomnia, we might need to tweak the cognitive restructuring to address the frustration, like, I'm taking this med, and it's making my sleep worse, what's the point, we reframe that to, okay, this med is helping your depression, let's use CBT-I to tackle the sleep piece, and, if the med is really problematic, I'll loop in the prescriber to see if we can switch to something else, the goal is to integrate CBT-I with their overall treatment plan, so everything's working together, and, again, it's that team approach, I'm not trying to play psychiatrist, I'm sticking to my lane, but I'm making sure we're all coordinated.

Peter: That's such a smart way to handle it, and it really underscores the importance of collaboration, so, let's wrap up with some big-picture thoughts, what's the one thing you want people to take away from this conversation about insomnia and CBT-I?

[135:00]
Ashley: The one thing I want people to take away is that insomnia is treatable, you don't have

to suffer, CBT-I is a proven, effective treatment that works for most people, and it's not about finding some magic pill, or waiting for the perfect moment, it's about taking action now, with practical, evidence-based strategies that you can learn and apply, whether it's setting a wake time, cutting out caffeine, or working with a therapist, you have the power to change your sleep, and when you do, it changes everything else, your mood, your health, your relationships, so, don't wait, don't think, oh, I'll deal with this when life calms down, life's never going to calm down, start today, and you'll be amazed at how much better you feel.

Peter: That's so powerful, and it's such a hopeful message, so, Ashley, thank you for this masterclass on CBT-I, I've learned a ton, and I know our listeners have too, we've covered so much ground, but I know there's more to talk about, like your work on eating behaviors and thermal regulation, so, we'll have to do a part two at some point, but, for now, is there anything else you want to add about CBT-I, or any final thoughts?

Ashley: Just one thing, don't be afraid to seek help, I know insomnia can feel like this personal failure, like, why can't I just sleep, but it's not your fault, and there are people out there, like me, who are passionate about helping you, so, whether it's a therapist, a book, or an app, take that first step, and know that it gets better, the treatment works when you do it, and you can do it.

Peter: That's the perfect note to end on, Ashley, thank you so much for your time, your expertise, and your passion, this was incredible, and I can't wait for round two.

[140:00]
Ashley: Thanks, Peter, it was a blast, and I'm looking forward to the next one.

Peter: Awesome, well, thanks again, and to everyone listening, go get that book, check out those resources, and start taking control of your sleep, we'll see you next time.