DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar:

Sleep Disturbance: Assessment and Evidence-based Clinical Interventions in the Active-duty and Veteran Populations

Jan. 23, 2013, 1-2:30 p.m. (EST)

Moderator: Cmdr. Renee M. Pazdan, M.D
U.S. Public Health Service
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Fort Carson, Colo.

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

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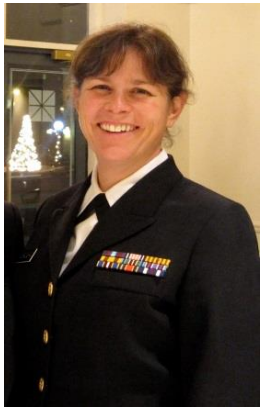
Presenters:

Anthony Panettiere, M.D
Neurology and Sleep Medicine
National Intrepid Center of Excellence
Bethesda, Md.

Jonathan Olin, M.D.
Psychiatry and Sleep Medicine
Medical Director at Sleep Laboratory
Evans Army Community Hospital
Fort Carson, Colo.



Capt. Laura M. Grogan, U.S. Public Health Service, OTR/L
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Webinar Details

- Live closed captioning is available through federal relay conference captioning (see the “Closed Captioning” pod)

- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: **888-877-0398**
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- Webinar information
  - Visit **dcoe.mil/webinars**
  - Full presentation, a webinar resource list, and handouts are also available in the FILES pod

- Question-and-answer session
  - Submit questions via the Adobe Connect and Defense Connect Online question pod

Continuing Education Details

Continuing education credit is not available for this event.

Webinar Overview

This webinar will focus on the assessment and treatment of mild to moderate sleep disturbance in the active-duty and veteran populations. An interdisciplinary panel of three sleep subject matter experts will introduce evidence-based practices associated with sleep clinical assessment, treatment of nightmares, initiating/maintaining sleep interventions, presenting medication and non-medication options, collaborating with patients to practice proper sleep hygiene and identifying when to order a sleep study or sleep consultation.

Webinar participants will learn to:

- Integrate the key principles of conducting a sleep assessment
- Explain evidence-based practices that improve patient complaints of disturbed sleep and nightmares
- Discriminate when a medication or non-medication sleep intervention would be most beneficial to the patient
- Engage the patient in practicing and documenting sleep hygiene techniques
- Determine when a patient would be a good candidate for a sleep study/sleep consult

Sleep and Insomnia Assessments

23 JAN 2014

Dr. Jonathan Olin
Psychiatry and Sleep Medicine Medical Director at Sleep Laboratory

Evans Army Community Hospital
Fort Carson, Colo.

Presenter: Dr. Jonathan Olin

Dr. Jonathan Olin

- Dr. Olin completed a psychiatric residency at Massachusetts General Hospital and became board certified in psychiatry and forensic psychiatry
- More recently he has specialized in sleep medicine and interpreting sleep studies
- Dr. Olin currently serves as medical director of the sleep lab at Evans Army Community Hospital at Fort Carson, Colo.

Disclosure

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Sleep is Important

- Improving your patients' sleep will help them overall improve
- Disrupted/inadequate sleep is associated with increased
  - Morbidity
  - Mortality
  - Obesity
  - Diabetes
  - Cardiovascular disease
  - Anxiety
  - Mood disorders

Improved Sleep = Happier Person

- Unhappiness is closely associated with three conditions:
  - Sleep disorders
  - Depression
  - Pain

- If you can help someone with his/her sleep the result is a happier person

Does Adequate Sleep = Good Health?

- Adequate sleep is necessary BUT is not sufficient for good health
- If your patient complains of feeling anxious/depressed and sleeping very poorly
- For your patient to feel better his/her sleep will need to improve

The Importance of Adequate Sleep

- How many of your patients report sleeping poorly, but feeling good the remainder of the 24-hour day?

- If your patients have inadequate sleep, that issue will likely need to improve for them to feel better

Sleep Deprivation

- Patients may underestimate the importance of sleep
- There is evidence that 100 years ago, adults slept 8-9 hours at night
- Sleep deprivation is associated with our more recent ability to turn night into day with electricity

Drilling Down

- Is it really a primary sleep condition, or is sleep condition co-morbid and adversely affected by something else?
  - Mood
  - Pain or medical disorder
  - Environment
  - Medications
  - Substance abuse

Treatment and Follow-up

- Optimize mood and lessen anxiety
- Minimize pain
- Improve sleep environment
- Minimize medications, substance use
- If the co-morbid condition is adequately treated, is sleep still an issue?

Sleep Assessment

- Review patient's sleep chief complaint
  - Not enough sleep – insomnia
  - Too much sleep – obstructive sleep apnea or excessive daytime sleepiness
  - Parasomnia – things that go bump in the night.

Sleep Assessment cont'd

- Ask the patient about:
  - Average daily caffeine use
  - Average daily/weekly alcohol intake
  - Psychiatric history (e.g., posttraumatic stress disorder {PTSD})
  - Medical history (chronic pain)

Sleep Assessment cont'd

- Family sleep history
- Vital signs
- Physical examination
  - Examine nose and oral cavity
  - General appearance
    - Is the patient snoring in the waiting room?
    - Does the patient appear anxious?

Restless Leg Syndrome (RLS) Assessment

- Tell the patient you have a long question to ask (with four components):
  - Do you have an urge to move or a creepy crawly feeling in your arms or legs?
  - Is it worse at night?
  - Does it interfere with falling asleep?
  - Does the feeling improve/feel better if you move around?
- Need confirmation with ***all*** components to diagnose RLS
- Ask how many nights per week this occurs

Obstructive Sleep Apnea (OSA) Assessment

- Ask your patient the following questions:
  - Do you snore?
  - If you snore, how would you classify it, mild, moderate or severe?
  - Has anyone observed you stopping breathing or choking while you were sleeping?

OSA Assessment cont'd

- Do you fall asleep unexpectedly during the day?
  - Consider using the Epworth Sleepiness Scale
  - Scores of 10 or greater suggest excessive sleepiness
  - May speak with bed partner to confirm history of snoring/OSA

Insomnia Assessment

- Review patient's average daily schedule
  - How does s/he get ready for bed?
  - About what time does his/her head hit the pillow?
  - Then what?
    - How long to fall asleep?
    - How long does s/he sleep?

Insomnia Assessment cont'd

- On average what are the number and duration of awakenings?
- What is the total sleep time?
- Is there a weekend variation?
  - Does the patient sleep in?
- Does the patient watch the clock at night?
- Does the patient complain of nightmares?

Insomnia due to Nightmares

Nightmares, defined by AASM

- A. Recurrent episodes of awakenings from sleep with recall of intensely disturbing dream mentations, usually involving fear or anxiety, but also anger, sadness, disgust, and other dysphoric emotions.
- B. Full alertness on awakening, with little confusion or disorientation; recall of sleep mentation is immediate and clear.
- C. At least one of the following associated features is present:
  - i. Delayed return to sleep after the episodes
  - ii. Occurrence of episodes in the latter half of the habitual sleep period

--Journal of Clinical Sleep medicine, Vol 6, No 4, 2010

Sleep Treatment

- Prioritize treatment
  - In complex cases, ask the patient what percentage of insomnia is due to nightmares, RLS, OSA, etc.
  - May explain that insomnia is often a “straws on a camel’s back” situation (i.e., multi-factorial)
  - It is our job as providers to remove the straws/small factors or cinder blocks/big factors so the patient gets better

Indications for Overnight Sleep Study

- Concerns about Obstructive Sleep Apnea
  - Significant snoring
  - Observed apneas
  - Often, but not always excessive daytime sleepiness

Indications for an Overnight Sleep Study cont'd

- The relatively uncommon condition of narcolepsy
- Atypical parasomnia (e.g., violence, sleep walking outside)
- ***Rarely*** to evaluate RLS or other leg movement disorders

Refer to Sleep Medicine Specialist

- Referral to a sleep medicine specialist depends upon several variables, including your skills and your patient's response
- It is appropriate for most behavioral health providers who are not prescribers to refer for
  - Possible OSA
  - Possible narcolepsy
  - RLS
  - Insomnia, nightmares that are refractory to non-medication treatments

Rational Use of Hypnotics to Treat Insomnia

23 JAN 2014

Anthony Panettiere, M.D.
Neurology & Sleep Medicine

The National Intrepid Center of Excellence (NICoE)
Bethesda, MD

Presenter: Dr. Anthony Panettiere

Dr. Anthony Panettiere

- Dr. Panettiere is a retired Navy captain who served 25 years on active duty
- He served as the Surgeon General's specialty advisor for neurology, and was involved in the establishment of the sleep laboratory at Naval Medical Center Portsmouth
- He completed fellowship training at Duke University in sleep medicine, and is board certified in both neurology and sleep medicine
- Dr. Panettiere is currently employed as a clinician and researcher in traumatic brain injury (TBI) and PTSD at the National Intrepid Center of Excellence (NICoE) in Bethesda, Md

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Objectives

- Discuss a decision algorithm for
  - when to use hypnotic medications
  - and the order of choices

- Review current prescription and OTC sleep medications used for insomnia

When to Consider a Hypnotic Medication?

- How severe is the insomnia?
  - Number of nights/week
  - Number of awakenings/night
  - Time awake each awakening
  - Daytime functioning

Pharmacological Treatments for Insomnia

- Over the counter (OTC) antihistamines
- Benzodiazepine receptor agonists (BzRAs)
- Non-benzodiazepine receptor agonists
- Melatonin and melatonin receptor agonist
- Other (anticonvulsants, antipsychotics, pain meds, dopamine agonists, barbiturates)

Insomnia

OTC antihistamines

- Histamine promotes alertness
- Anti-histamine blocks alerting effect
- 4-6 hours of effect duration
- Side effects:
  - daytime sleepiness
  - memory deficits or confusion
  - potential difficulty with urination

Insomnia

Herbals and nutriceuticals

- Valerian root
- Hops
- Passion flower
- Kava
- Chamomile
- Marijuana

Insomnia

- American Academy of Sleep Medicine (AASM) Guidelines on medication usage
  - OTC antihistamines/sleep aids and herbal/nutritionals **NOT** recommended for chronic insomnia due to lack of efficacy and safety data

AASM Guidelines, Journal of Clinical Sleep Medicine, Vol. 4, No. 5, 2008

Insomnia

Benzodiazepine Receptor Agonists (BzRAs)

- **Anxiety** prominent
  - alprazolam (Xanax)
  - clonazepam (Klonopin)
  - diazepam (Valium)
  - lorazapam (Ativan)

Insomnia

Benzodiazepine Receptor Agonists (BzRAs)

- **Insomnia** prominent
  - temazepam (Restoril)
  - triazolam (Halcion)
  - estazolam (ProSom)

Insomnia

Non-Benzodiazepine Receptor Agonists

- zolpidem (Ambien—regular and controlled release (CR), Intermezzo, Edluar, Zolpimist)
- zaleplon (Sonata)
- eszopiclone (Lunesta)

Tapering off hypnotics

- Taper rate depends on med, dose and duration of treatment
  - Non-benzodiazepine hypnotics
  - Benzodiazepine sedatives

Insomnia

- OTC Melatonin (3 mg)
  - Most effective when taken 5-6 hours before Dim Light Melatonin Onset (DLMO)
  - Advances sleep latency 38 minutes in Delayed Sleep Phase Disorder (DSPD)
  - Best assessed by actigraphy, sleep log and salivary DLMO

--Clinical Guidelines for CRSD, Sleep, Vol. 30, No. 11, 2007

Insomnia

- Melatonin Receptor Agonist
  - ramelteon (Rozerem)
    - Chronobiotic and hypnotic
    - Inhibits firing of suprachiasmatic nucleus, decreasing alertness
    - No next day residual effects of rebound
    - Compared to placebo, difference in mean latency to persistent sleep (LPS) was 15 minutes (week one) and nine minutes (month six)

Sleep, Vol. 32, No. 3, 2009

Insomnia

- Other Medications
  - Anticonvulsants
  - Antipsychotics
  - Pain medications
  - Dopamine agonists
  - Barbiturates

Nightmare medications

- prazosin
- clonidine
- propranolol
- atypical antipsychotics (risperidone, olanzapine)
- gabapentin
- trazadone

Journal of Clinical Sleep Medicine

Vol. 6, No.4, 2010

Nightmare medications

- Consider medication use if also needing to treat a second condition
  - Hypertension, Headaches, Anxiety, etc
- Consider medication use if nightmares are regularly and significantly sleep disrupting
  - And without a content pattern
  - Or for agitated arousals
- If sleep-disordered breathing (SDB) is suspected or diagnosed, treat that first

Prazosin

- Alpha-1 adrenoreceptor antagonist
- Dampens the enhanced CNS adrenergic activity that contributes to the pathophysiology of PTSD
- Low incidence of side effects if titrated slowly

A Trial of Prazosin for Combat Trauma PTSD With Nightmares in Active-Duty Soldiers Returned From Iraq and Afghanistan, Raskind et al, *Am J Psychiatry 2013;170:1003-1010*

Prazosin (cont'd)

- Start with 1 mg at bedtime for two nights then increase to 2 mg at bedtime
- Increase weekly, as needed by 1 or 2 mg to a maximum of 5 mg midmorning and 20 mg at bedtime (men) and 2 mg midmorning and 10 mg at night (women)
- Maintain titration at the dose that eliminates nightmares and agitated arousals

Insomnia

- AASM Guidelines on medication usage
  - Decisions to use mediation **supplemented with behavioral and cognitive therapies**
    - BzRAs (short/intermediate acting) or ramelteon
    - Sedating antidepressants (trazadone, amitriptyline (Elavil), doxepin (Silenor), mirtazapine (Remeron))
    - Combined BzRA or ramelteon with sedating antidepressant
    - Other sedating agents (gabapentin or tiagabine or atypical antipsychotics—quetiapine and olanzapine)

Cognitive Behavioral Therapy (CBT) for Insomnia

23 JAN 2014

CAPT Laura M Grogan, OTR/L
Occupational Therapy

Warrior Recovery Center
Ft Carson, Colorado

Presenter: CAPT Laura M. Grogan

CAPT Laura Grogan

- CAPT Grogan has been an active duty United States Public Health Service Officer for over 21 years
- She is an Occupational Therapist who started her career in mental health and is currently working towards her biofeedback certification
- She developed a cognitive behavioral sleep therapy program at the Warrior Recovery Center, a concussion specialty clinic, four years ago and enjoys this area of practice
- She served on the "DCoE/DVBIC Clinical Recommendation: Management of Sleep Disturbances Following mTBI: Guidance for Primary Care Managements in the Deployed and Non-deployed settings clinical recommendations" work group

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Cognitive Behavioral Therapy for Insomnia (CBT-I)

Cognitive behavioral therapy for insomnia (CBT-I) is a method for treating insomnia without (or alongside) medications. The goal is to reduce sleep onset latency and encourage sleep maintenance throughout the sleeping period. (Wikipedia)

Benefits of CBT and Sleep

- Fall asleep
- Stay asleep
- Sleep for an appropriate duration
- Feel refreshed / restored upon awakening
- Experience more pleasant dreams

Motivators to address Insomnia

- Improve cognitive function
- Improve mood regulation
- Reduce effects of anxiety or depression
- Reduce daytime fatigue
- Improve physical performance, health and wellbeing
- Increase safety and enhance daily energy
- Learn a safe long term solution to address insomnia free of the need to take medication or experience medication side effects

Predisposing Factors:

Worrisome Thinking; Poor Sleep Habits; Anxiety; Depression; Aging

Precipitating Factors

- Acute Stress
- Personal Loss
- Family Conflict
- Work Problems
- Jet Lag
- Medical Problems
- Hospital Stay
- Certain Medications
- Chronic Low-level Stress
- Traumatic Experience

Perpetuating Factors

- Poor Sleep Habits
- Extreme Worry, Concern About Sleep
- Misinformation About Sleep and Effects of Poor Sleep
- Sleeping Pills
- Certain Medications
- Irregular Sleep Schedule
- Daytime Napping
- Anxious Thinking
- Excessive Time in Bed Not Sleeping
- Excessive Stimulation Prior Bed
- Poor Daily Routine

Sleep Hygiene

- Obtain natural light exposure each day/morning
- Follow a regular daytime and evening routine to include going to bed and getting up at the same time each day
  - Set consistent times for meals, exercise, medications, chores, fun….
- Avoid going to bed worried, stressed, angered, etc…. Wind down prior bed
- Plan medication use appropriately

Sleep Hygiene (cont.)

- Eliminate use of caffeine / nicotine / alcohol after lunch (3-6 hours prior bed)
- Exercise daily in the morning or early afternoon
- Avoid going to bed hungry, or overly full
  - Consider a light snack prior to bedtime
- Keep the bedroom quiet, dark, and a little bit cool
- Avoid sleeping with pets

Relaxation Therapy

- Schedule time each day to master relaxation
  - when the time comes you can quiet your mind, slow your breaths, reduce your heart rate, relax your muscles and fall asleep
- Progressive muscles relaxation, meditation, yoga nidra, guided imagery
- Prior to bed (and outside the bedroom) engage in your relaxation practice to prepare for sleep

Stimulus Control

- Go to bed only when tired and sleepy
- Use your bed for sleep and sex only!
- Avoid taking naps, or take limited naps
  - If you must nap: keep it under 30 minutes and six hours prior to normal bedtime
- Remove any electronics (TV, phones, computers, etc.…) from the bedroom
- Limit direct sight of the alarm clock

Stimulus Control (cont.)

- Once in bed, if you are awake after 15-20 minutes (no longer than 30), get up and do something relaxing and/or boring
  - Keep light dim; avoid use of electronics; avoid stimulating activity
- Once the onset of sleepiness develops or 30 minutes has passed (which ever comes first), return to bed
  - Repeat technique as often as necessary until sleep onset occurs
- Establish a regular sleep wake schedule with emphasis on the wake time
  - Seven days per week, 30-45 minute variation may be ok

Cognitive Restructuring

- Become aware of your current habits & routines and their impact on sleep
- Master positive sleep dialogue
  - Change negative thoughts, emotions and beliefs about sleep into positive ones
- Objectively measure sleep
- Provide information about “normal” sleep to dispel myths
- Develop better cognitive control

Sleep Restriction

- Sleep Efficiency = Total time slept divided by the total time in bed
- Ideally start by restricting the time in bed to the actual time slept (no less than 5 hours)
- Once 85-90 percent or more sleep efficiency has been reached for at least one week add 15-30 min to each night
  - Continue to add 15-30 min once a consistent 90 percent efficiency is reached
- Decrease time in bed by 15 minutes if sleep efficiency is less than 80 percent after the first 1-2 weeks

Track your progress!

- Use a diary to track your daily and nightly activity
  - Multiple paper and mobile application versions are available
  - Customize your log to meet your needs and the needs of your providers
- Share your logs with others to include your providers

Weekly Sleep Log

WEEKLY ACTIVITY LOG

1. Fill in the date, the day of the week and the type of day (work, school, vacation, CQ)

2. Next use the following checked codes to log you activity during a 24 hour period:

( ) "M"= medication ( ) "C"= caffeine/stimulating product consumed (coffee, tea, soda, chocolate, energy drink, energy supplement, etc...) ( ) "A"= alcohol ( ) "N"= nicotine products ( ) "X"= anxiety/stress/worry/fear/sadness ( ) "E"= exercise ( ) "H"= headache/migraine /significant pain ( ) "T"= nightmares ( ) "S" = OT strategy or new behavior implemented ( ) "O"= other

_____

3. Enter a ~ to indicate what time you went to bed. If you got out of bed then use another ~ to indicate the return

4. Shade the box to indicate estimated time slept

5. Enter a \ to indicate when you got out of bed

BRING COMPLETED LOG TO YOUR APPOINTMENTS

Today's Date	Day of the Week	Type of Day	NOON	1230	1300 / 1 PM	1400 / 2 PM		1500 / 3 PM		1600 / 4 PM		1700 / 5 PM	1800 / 6 PM		1900 / 7 PM		2000 / 8 PM		2100 / 9 PM	2200 / 10 PM		2300 / 11PM		2400 / 12 AM	0100	0200	0300	0400	0500		0600	0700	0800	0900		1000	1100	
Sample	MON	Work	N	C			X	X	H	H	H	C	E	E		M	~								T				\	C	M				X	H	C	N	
Sample	SAT	Off							N	C	C				E	E			N	A	C	A	C	N		M	~			\	~				\	H	H	X

Afterdeployment.org

Simple and Effective Tips to Improve Your Sleep

Simple and Effective Tips to Improve Your Sleep

1. **Cut Caffeine.** Simply put, caffeine can keep you awake. It can stay in your body longer than you think – up to **14** hours. So if you drink a cup of coffee at noon and are still awake at midnight that might be the reason. Cutting out caffeine at least **four** to **six** hours before bedtime can help you fall asleep easier.
2. **Drink alcohol in moderation.** Alcohol may initially help you fall asleep, but as your body clears it from your system, it can also cause symptoms that disturb sleep, like nightmares, sweats, and headaches. Drink one glass of water for every alcoholic beverage consumed to try to reduce these symptoms. Avoid alcohol **three** to **four** hours prior to bedtime.
3. **Restrict nicotine.** Having a smoke before bed – although it feels relaxing – actually puts a stimulant into your bloodstream. The effects of nicotine are similar to those of caffeine; nicotine can be alerting and can keep you up at night. Nicotine can remain in your body as long as **14** hours. It should be avoided particularly near bedtime and during sleep time hours. Do your best to avoid nicotine at least a few hours before sleep.
4. **Exercise and stretch at the time that is right for you.** Regular exercise and stretching can help you get a good night's sleep. The timing, type and intensity of exercise/stretching plays a key role in its effects on sleep. If you are the type of person who gets energized or becomes more alert after exercise, exercise well before dinner. Regular exercise in the morning or early afternoon can help relieve insomnia.
5. **Avoid napping.** Napping can reduce your drive and ability for night time sleep.If you must nap, keep it to a brief 15-30 minute power nap. A brief snooze about eight hours after you get up in the morning can actually be rejuvenating. Diaphragmatic breathing and meditation can also be restorative.
6. **Eat right, sleep tight.** If you tend to get hungry after dinner enjoy a light snack prior to bed in order to avoid the feeling of hunger. Eat light because an over full belly can keep you up. Heavy meals should be consumed at least 2-3 hours prior to bed for proper digestion. Keep in mind some foods can help with sleep. Milk contains tryptophan, which is a sleep-promoting substance. Other foods that help promote sleep include tuna, halibut, turkey, pumpkin, artichokes, avocados, almonds, eggs, peaches, walnuts, apricots, oats, asparagus, potatoes, buckwheat, and bananas. Also, try to avoid excessive beverages at least 1 hour prior to sleep to minimize or eliminate the need to use the bathroom during the night. If caffeinated best to limit them 4-6 hours prior to bed.
7. **Avoid bright light and electronic light exposure prior to bed.** The brain has an ability to register light and interpret it as a sign to stay or become alert. At least 1 hour prior to bed enjoy space with dim light free of watching any TV or doing computer activities.
8. **Stop engaging in work or anything disruptive at least one hour prior to bed.** Allow yourself to start relaxing and getting ready for sleep by incorporating things that are more conducive for sleep such as stretching, meditation, reading, a light walk, or other calming activities.
9. **Create a bedtime routine.** Develop some kind of pre-sleep ritual to break the connection between day and bedtime. Reading something light, meditating, aromatherapy, light stretching, progressive muscle relaxation, or taking a hot bath to initiate and maintain relaxation. Once in bed, avoid looking at the clock or engaging in activity that may disrupt relaxation (TV, electronic use, excessive thinking, etc. . .).
10. **Keep your bedroom quiet, dark and comfortable.** For many people, even the slightest noise or light can disturb sleep. Consider earplugs, window blinds or curtains, and /or a noise cancellation device or fan. Avoid the overhead light if you need to get up at night; use a small night-light instead. Ideal room temperature for sleeping is about 58 degrees. Temperature above 75 or below about 54 degrees can disrupt sleep.
11. **Use the bed for sleep and sex only.** Avoid watching TV, reading, eating, working, leisure, and/or discussing emotional issues in bed. Activities beyond sleep and sex can create an association between the bed and sleep that could then make it difficult for you to fall asleep. Excessive time in bed can also fragment sleep.
12. **Keep pets and children out of bed.** Does your pet and/or child sleep with you? This too may cause you to awaken during the night, either from lack of space, worry about the pet or child, movements and/or pet allergies.
13. **Keep regular bedtime and wake-up hours 7 days per week.** The brain has the ability to sense time and functions best on a consistent sleep schedule. Keeping a regular sleep-wake schedule will help restore healthy sleep.
14. **Only go to bed when sleepy.** Falling asleep should be a natural occurrence and when forced can lead to frustration and add to the difficulty of falling asleep. Lying in bed awake for prolonged hours can further fragment sleep.
15. **Get up if not asleep in roughly 15-20 minutes.** If you feel you have been in bed for 15-20 minutes and are not experiencing the sensation of being able to fall asleep soon, get up and engage in a mindless activity in a dimly lit room until you feel the sensation of being sleepy. Avoid anything stimulating or the use of electronics during this period of time. Repeat as needed until you are able to effortlessly fall asleep. Doing this can break the association between a bed/bedroom and alert state.
16. **Medications/Over the Counter Supplements.** Please speak with your health care provider about any medications or over the counter supplements you are taking that may interfere or help with sleep to ensure you are taking them appropriately.

Warfighter Sleep Kit

The Warfighter Sleep Kit includes:

-Facts and information to educate service members on the impact of sleep on mission effectiveness

-Tools and techniques to help individuals obtain adequate sleep

To request kits, email info@DVBIC.org

Thank you, questions?

- Submit questions via the Defense Connect Online question box located on the screen.
- The question box is monitored and questions will be forwarded to our presenter for response.
- We will respond to as many questions as time permits.

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Next DCoE TBI Webinar:

Joint Theater Trauma Systems Practice Guidelines/Recommendations

Feb. 13, 2014
1:00-2:30 p.m. (EST)

Next DCoE Psychological Health Webinar:

Tobacco Cessation in Military and Veteran Populations

Feb. 27, 2014
1:00-2:30 p.m. (EST)

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