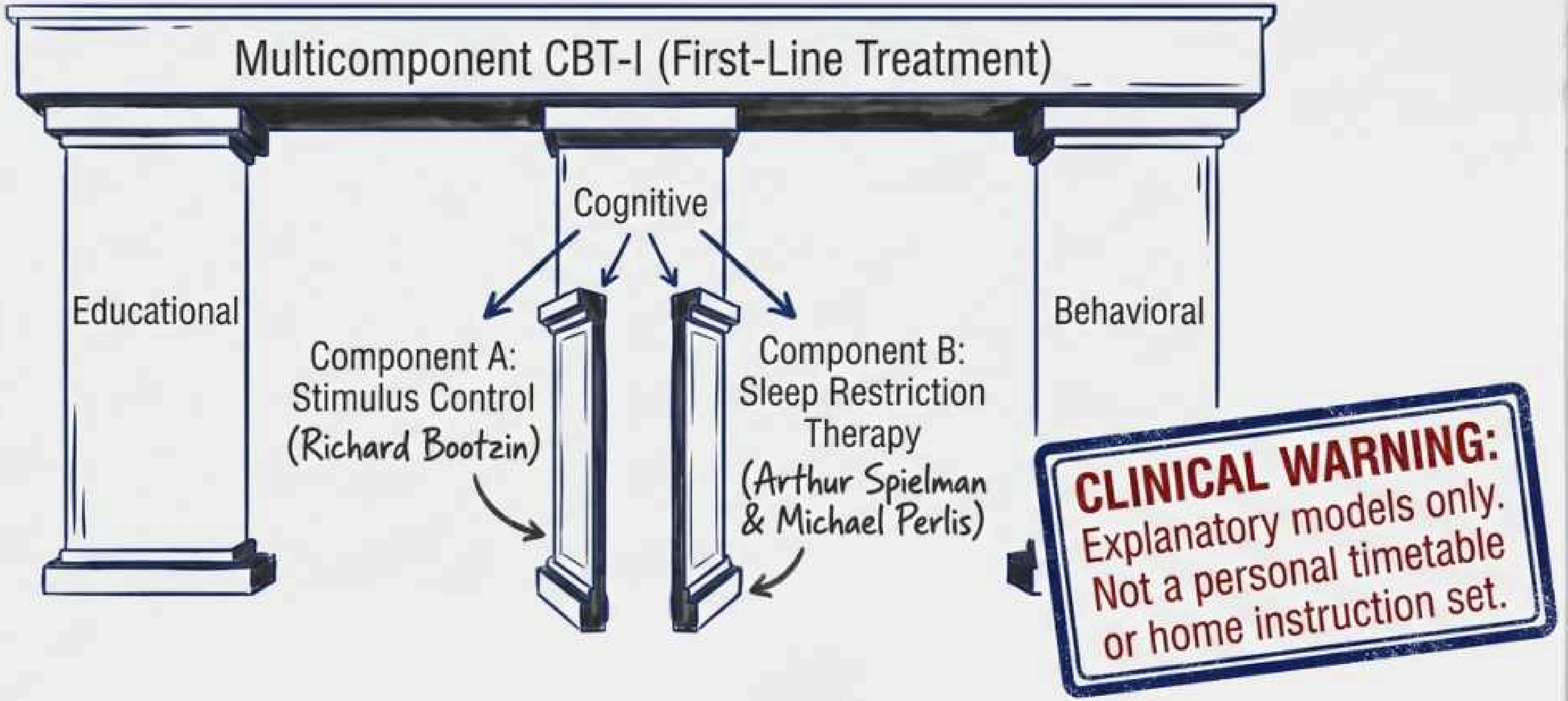
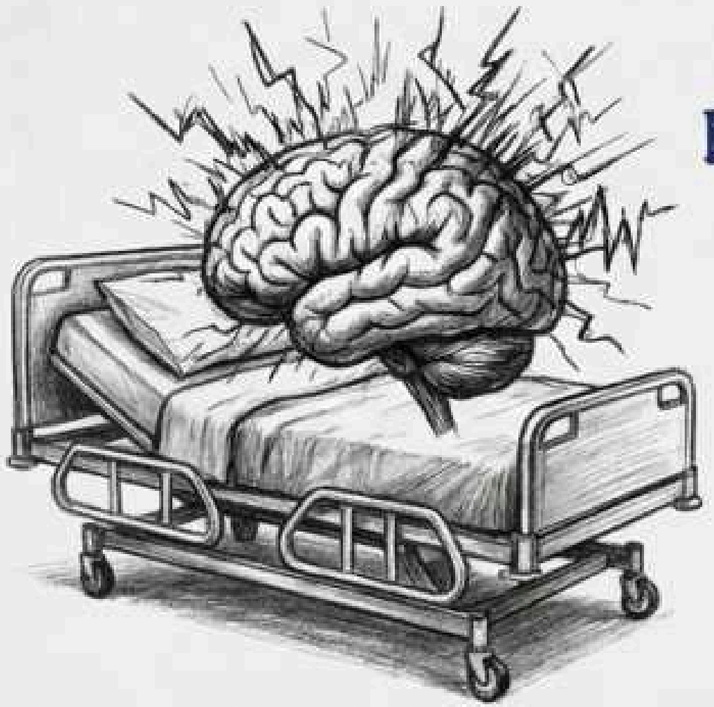
CBT-I = Behavioral + Cognitive + Educational



Re-pairing the environmental cue to the physiological state



Frustration / Wakefulness

Clinical Rules Filter:

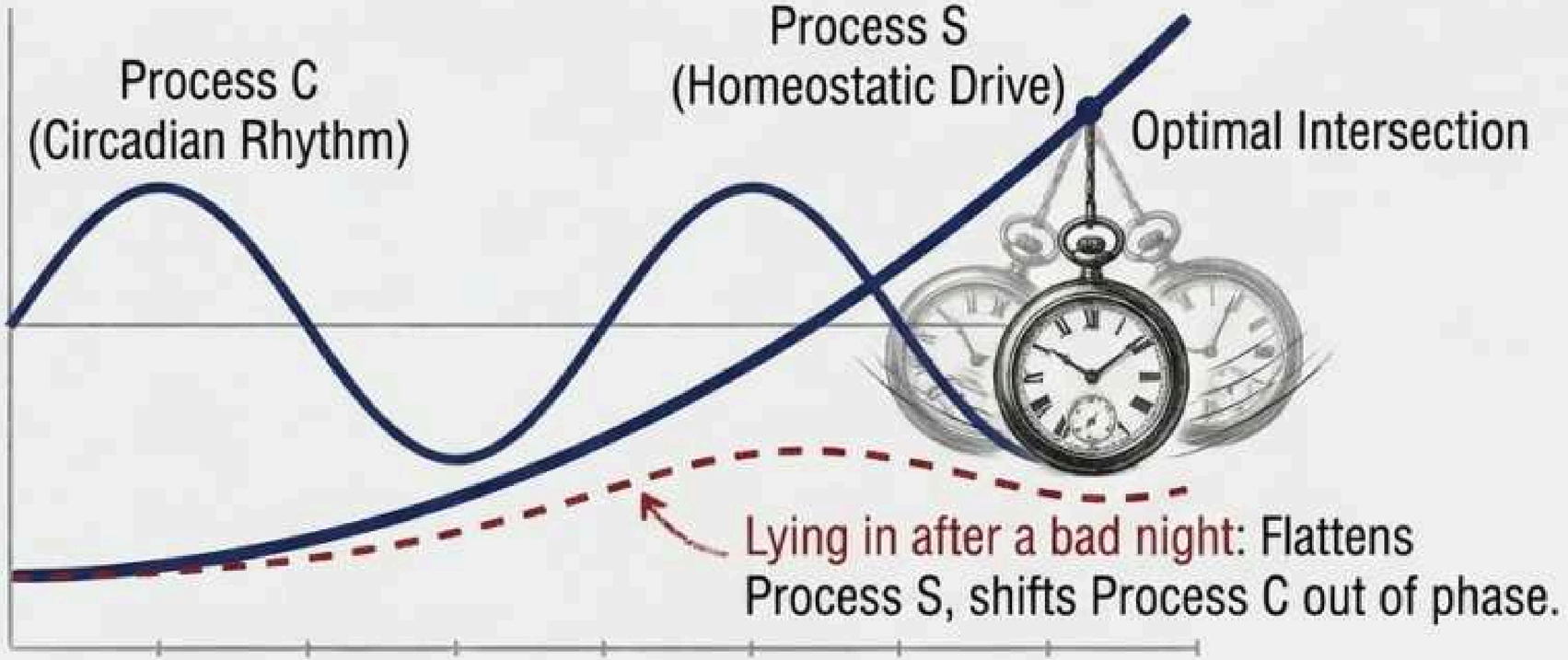
- Leave bed if awake
- Consistent rise time
- Caution with naps



Sleep / Sex Only

Change the pairing between place and state,
Change the pairing between place and state, rather than wrestling the mind into sleep.

Consistent rise times anchor the dual processes of sleep regulation

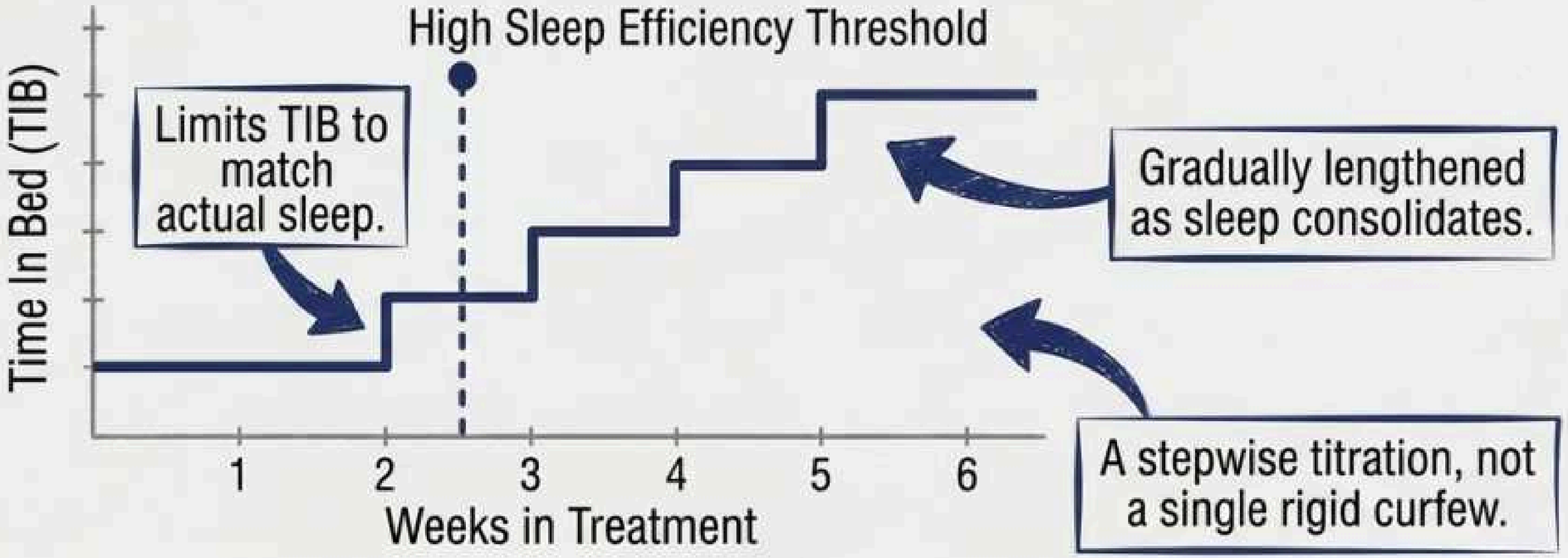


Hypothesis of sleep regulation: Protects daily build-up of sleep pressure and steadies the body clock. Not a moral judgment on laziness.

Sleep efficiency determines the titration of time in bed

$$SE = \left(\frac{TST}{TIB}\right) \times 100$$

Sleep Efficiency = Total Sleep Time / Time In Bed



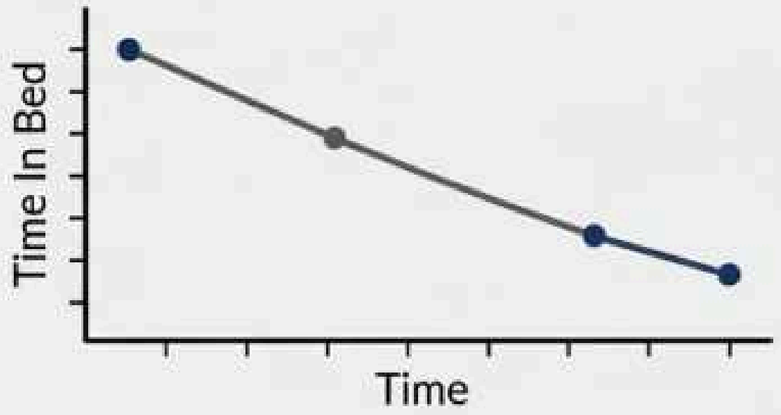
Calibrating the intervention to patient tolerance and health

Sleep Restriction



Immediate adjustment to match Total Sleep Time.

Sleep Compression



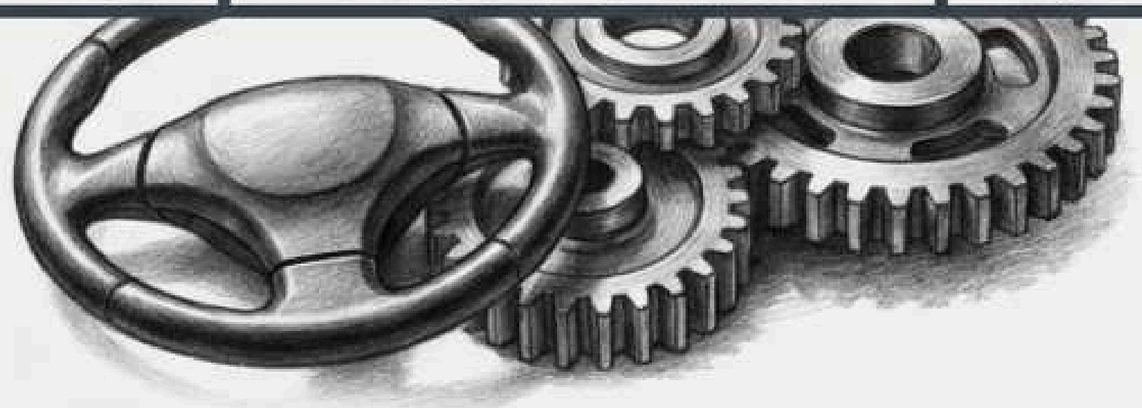
Gradual reduction for older, fragile, or low-tolerance patients.



Decisions placed inside a structured course of treatment.
The existence of variants warns against standardizing internet advice.

Clinical contraindications require mandatory treatment modifications

Condition	Clinical Risk	Requirement
Bipolar Disorder	Manic shift after sleep loss	Substantial modification
Seizure Disorders	Seizure threshold reduction	Substantial modification
Untreated Sleep Apnea	Apnea exacerbation	Explicit contraindication
Safety-Sensitive Duties	Occupational hazards	Explicit contraindication



SRT increases short-term daytime sleepiness. A qualified clinician must judge implementation safety.

Protocol variables must be strictly calibrated by a clinician

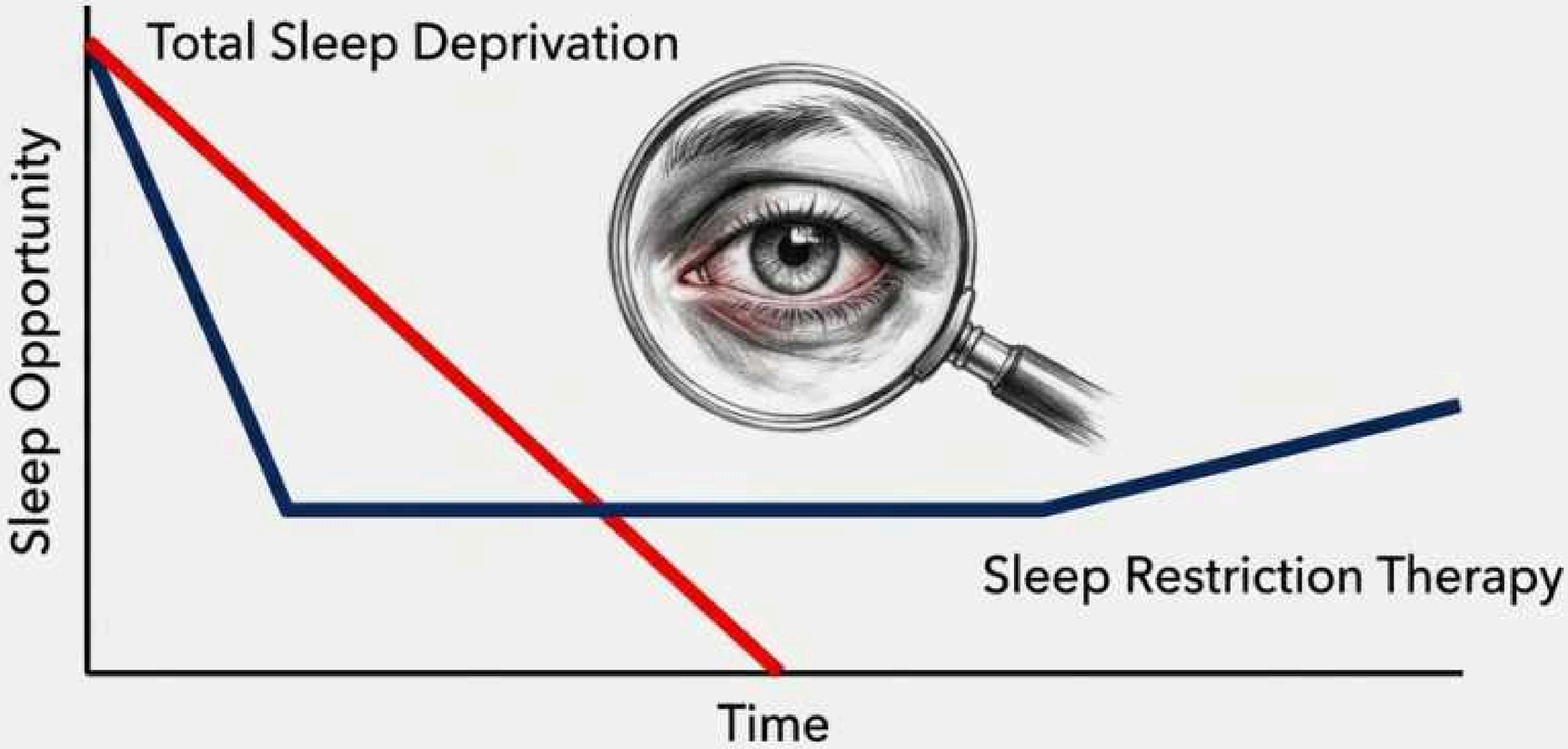


Figures belong to supervised treatment and are adjusted for the individual.

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Copying manual figures without assessment causes harm. The next step is a clinical conversation, not an experiment based on a paragraph.

Clinical sleep restriction fundamentally differs from sleep deprivation



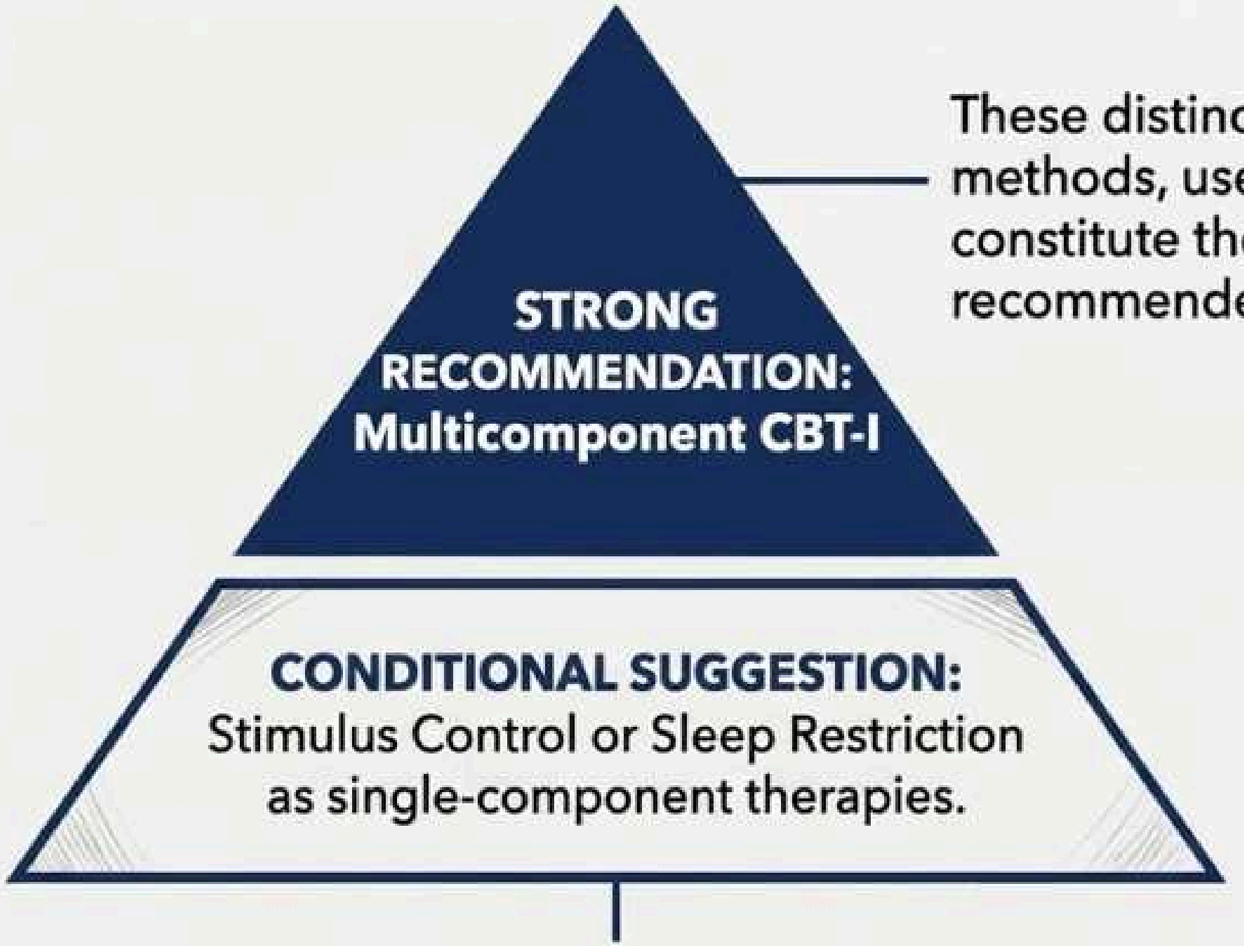
A protected nightly window is strictly maintained. The therapist's role is to explain rationale, monitor short-term sleepiness, watch for harm, and safeguard adherence when the natural wish is to hide under the covers.

Behavioral interventions require longitudinal clinical adjustment



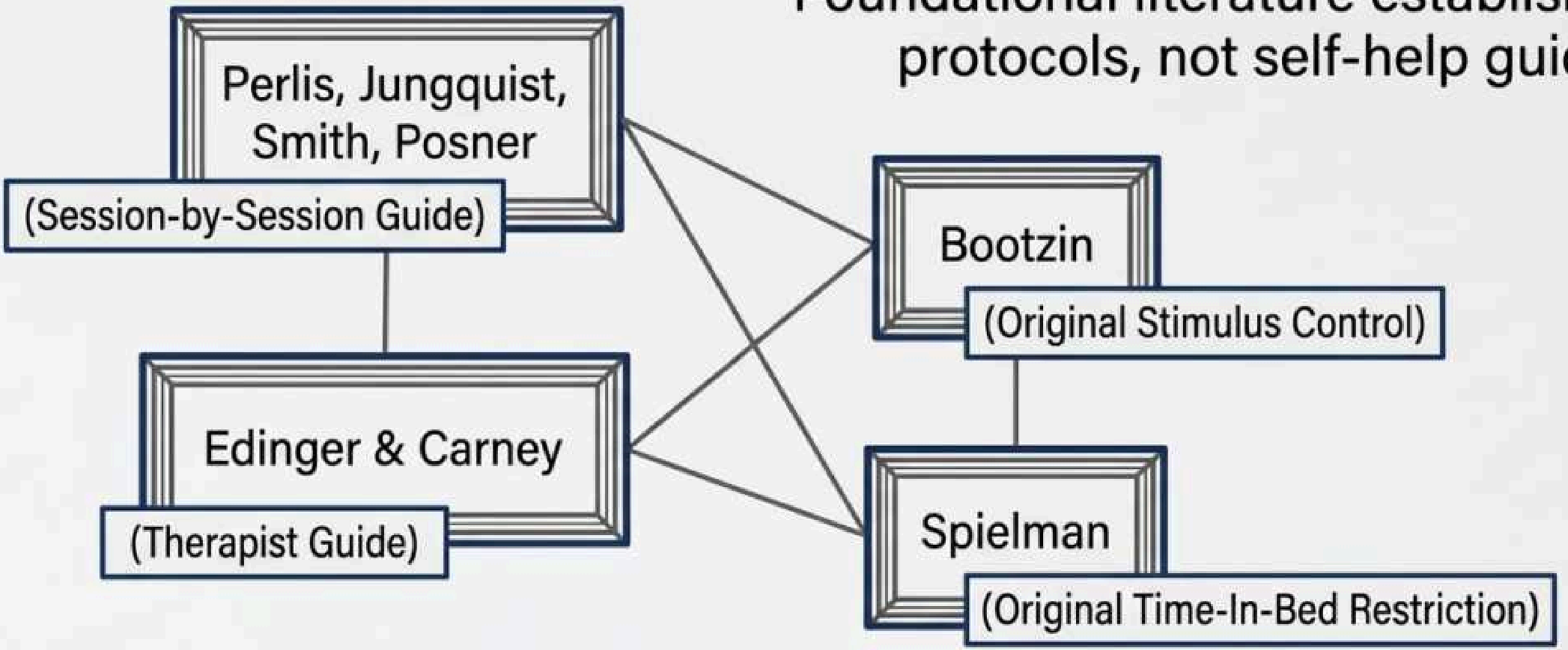
A structured, individualized program (per Edinger & Carney). Efficacy trials do not test weekend advice. This hour-long presentation is merely a map of the territory, not the treatment itself.

Multicomponent therapy holds the highest clinical recommendation



¶ 3.11

Foundational literature establishes protocols, not self-help guides



Written strictly for practice under professional responsibility.
Not a substitute for clinical training and supervision.

The dual behavioral engines of multicomponent CBT-I

Stimulus Control	Sleep Restriction
• Aim: Reconnect the bed with sleep. • Focus: Qualitative association.	• Aim: Consolidate sleep by matching TIB to ability. • Focus: Quantitative efficiency.



Both demand individual clinical judgment regarding **daytime sleepiness** and **medical safety**.

Next Phase: Lecture 4 – Cognitive Work, Relaxation, and Sleep Hygiene.