Why treat insomnia and what is CBT-I?
Is targeted treatment for insomnia warranted?

It is a long-standing tradition, both within medicine and psychology, to view insomnia as a symptom and not as an independent disease or disorder. As a result, the proper target for treatment has often been viewed as the underlying factors that give rise to the symptoms of disease.

Taken together, these considerations have suggested that specific treatment for insomnia is unwarranted. Further, implicit in this point of view, is that successful treatment of the underlying primary disorders will result in an amelioration of the insomnia itself.

This point of view has, within the sleep research and sleep medicine communities, been called into question with the publication of the following data:

- Insomnia is a substantial risk factor for the development of new onset mental illness.1,2
- Insomnia often does not resolve with the successful treatment of the ‘primary’ mental illness conditions.3,4
- Insomnia represents a risk factor for non-response to standard treatments for “primary” mental illness conditions.5
- Insomnia is a significant risk factor for relapse and recurrence of mental illness.6,7
- CBT-I has been found to be as effective with insomnia that occurs co-morbidly with other mental illnesses as it is with primary insomnia.6,9
- Targeted treatment with CBT-I has been shown to produce improvements in what was previously construed as the primary disorders (depression and chronic pain).

The evidence base for these claims has led to a paradigmatic shift where insomnia is now classified as a disorder which, when it occurs with other mental illnesses, is conceptualised as a co-morbid disorder. This reconceptualisation has set the stage for the point of view that targeted treatment for insomnia is indeed warranted.10-12

What is CBT-I?

CBT-I is a hyphenated/‘rodomised’ form of the acronym ‘CBT’. The addition of the ‘I’ is intended to elicit the response “I know what CBT is, but what the heck is CBT-I?” CBT-I stands for cognitive behavioural therapy for insomnia. This form of CBT is a multicomponent treatment that targets specifically sleep continuity disturbance (difficulty initiating sleep, maintaining sleep, or both) and typically comprises stimulus control procedures, sleep restriction therapy and sleep hygiene instructions.

While CBT-I often only includes a general form of cognitive therapy, which is intended to address adherence issues, there is also a variety of specific cognitive procedures that are used with the above three interventions including paradoxical intention procedures, sleep education, decatastrophisation and behavioural experiments. Some multi-component forms of CBT-I also include relaxation training.
How efficacious/effective is it?
Since the 1930s, more than 200 trials have been conducted on either single interventions for insomnia (stimulus control, PMR and sleep restriction) or multicomponent interventions that may be characterised as CBT-I. This extensive literature has been quantitatively summarised using meta-analytic statistics on at least three occasions, and there is at least one comparative meta-analysis which evaluates the relative efficacy of CBT-I as compared to benzodiazepine receptor agonists (BZRAs). Consistent with the conclusions of the NIH State of the Science Conference, the data from this literature suggest that CBT-I is highly efficacious; BZRAs and CBT-I produce comparable outcomes in the short-term; and that CBT-I appears to have more durable effects when active treatment is discontinued.

Beyond the issue of efficacy is the issue of effectiveness. That is, are the clinical outcomes observed in clinical trials comparable to investigations of treatment outcome in patients with insomnia comorbid with other medical and/or psychiatric illnesses, and/or studies of patients who are treated in clinical care settings? To date, there have been more than 20 studies in patient samples that suffer such co-morbidities as cancer, chronic pain, depression and PTSD. The data from these studies not only show CBT-I to be effective, but also that the clinical outcomes are, by and large, comparable to those found with patients with primary insomnia. In some cases, the effects are actually larger. As noted above, there have also been a variety of clinical case series studies. The effect sizes for these studies also appear comparable to those obtained in randomised clinical trials.

What resources are out there to learn CBT-I?
One of the major challenges for the field is the problem of how to disseminate and implement CBT-I at both national and international levels. That is, how does one go about making the public aware of the CBT-I treatment option, the relevant professional disciplines aware of the CBT-I treatment option, and putting into place the requisite training and credentialing processes? These represent truly daunting questions and are currently the major focus of the newly established Society of Behavioral Sleep Medicine (SBSM).

This said, significant advances have been made in recent years within this domain, particularly with respect to the issues of training and credentialing. First, there are at least three published treatment manuals which delineate how to conduct CBT-I. Second, there are several multiday courses that are available on an annual or bi-annual basis. One such course, which is largely an introduction to the variety of interventions that comprise behavioural sleep medicine, has been available through the American Academy of Sleep Medicine (AASM) since 2004 and will continue to be available through the SBSM for the foreseeable future. Another is a dedicated training seminar in CBT-I, which has been offered annually since 2006 through the University of Rochester, and is currently offered through the University of Pennsylvania. Third, in 2005 and 2006, the BSM committee of the AASM established training opportunities via the credentialing of BSM fellowships and mini fellowships. Fourth, as result of the vision and generosity of the AASM, there is (as of 2004), a credentialing board for BSM that is underwritten and administered by the academy.

Concluding remarks
It is hoped that this brief summary serves as a reasonable introduction to the current conceptualisation of insomnia and to CBT-I. Further, the membership of the ABCT is encouraged to pursue the educational opportunities that exist for the dissemination and implementation of CBT-I and forging the next generation of treatments for not only insomnia but the entire compendium of sleep disorders.

References
6. Ford DE, Kamerow DB. Epidemiologic study of sleep disturbances and psychiatric...
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Further references available on request