
This article was published online first at www.annals.org on 9 June 2015.

In this issue, Trauer and colleagues (1) report important findings from a systematic review and meta-analysis of 20 randomized, controlled trials ($n = 1162$ participants) evaluating the efficacy of cognitive behavioral therapy for insomnia (CBT-i). The results indicate that CBT-i, a brief, pragmatic, nonpharmacologic intervention, produces significant improvements in sleep, with no adverse outcomes. More important, the improvements were well-sustained over time. This article adds to the already strong evidence base supporting the short- and long-term efficacy of CBT-i for persistent insomnia (2, 3). Given the high prevalence and heavy personal and societal burden of insomnia, as well as the shortcomings of sleep medications, these findings are timely and underscore that CBT-i is an effective option for management of the most common sleep disorder. Yet, some might question the generalizability of these findings and the feasibility of implementing CBT-i in the context of routine clinical practice.

This review was restricted to studies of patients without comorbid medical or psychiatric disorders, whereas most patients presenting with insomnia in clinical practice have comorbidity. Fortunately, clinical studies not included in Trauer and colleagues’ review show that insomnia-specific therapies (both psychological and pharmacologic) produce significant sleep improvements in patients with such comorbid conditions as major depression (4), chronic pain (5), and cancer (6). The studies also provide evidence that insomnia treatment enhances remission rates for some of those conditions (such as depression). Thus, the presence of medical or psychiatric comorbid conditions should not be a contraindication to using CBT-i.

Despite the robust statistical significance of most findings on such outcomes as sleep onset latency, wake after sleep onset, and sleep efficiency, one could question the clinical significance of the improvements in terms of patients’ well-being. For example, does falling asleep 19 minutes faster or spending 26 fewer minutes awake during the night improve next-day functioning and long-term psychological and physical
health outcomes? Aside from sleep improvements, other critical end points should be considered in the
treatment of insomnia, including fatigue, psychological distress, and quality of life. These outcomes are
particularly important because insomnia is not just a nighttime problem—it is a 24-hour problem that
affects functioning throughout the day. Improving the perception of control over one’s sleep is also critical
to reducing the psychological distress associated with insomnia, which may contribute to negative long-
term outcomes as much as poor sleep itself. CBT-i improves nocturnal sleep and some aspects of daytime
functioning (such as fatigue and distress), but there is less evidence about its effect on long-term health
outcomes. Given that persistent insomnia is a significant risk factor for adverse long-term medical
(hypertension) (7), psychological (depression), and occupational (disability) outcomes (8), evaluating
whether sleep improvements alter the course of these negative outcomes is essential. Such questions
remain largely untested and warrant further prospective, longitudinal research.

Beyond these matters of generalizability and clinical significance, there is also a critical translational issue
about the transportability of CBT-i to clinical practice. Despite robust scientific evidence of the
effectiveness and safety of CBT-i, along with strong professional endorsements that it should be the first-
line treatment for chronic insomnia (9), a major gap exists between the current state of the science and
actual clinical practice. Insomnia is often unrecognized and untreated. When treatment is initiated, it is
often with over-the-counter products with unknown risks and benefits or prescription medications (some
of which are not even approved for insomnia treatment) with known adverse effects. Cognitive behavioral
therapy is relatively unfamiliar to and underused by medical practitioners. How can we facilitate its export
from research settings to clinical practice?

Of course, such barriers as limited time and expertise complicate the management of insomnia with CBT-i
in primary care practices. However, new delivery models can overcome some of these barriers. For
example, although complicated cases may require referral to a behavioral sleep medicine specialist, in
many cases CBT-i can be effectively implemented in the context of a few (2 to 4) consultation visits or
telephone consultations with a physician, nurse or a psychologist. Use of print and digital self-help
materials may complement these consultations. These self-guided interventions can facilitate access to
CBT-i for a larger number of patients with insomnia, but they should be regarded as a complement to rather than a replacement for therapy.

Treatment with CBT-i inevitably requires more time and effort for both the clinician and the patient than prescribing a sleep medication. Although we lack an easy-to-swallow “CBT pill” for insomnia, the reality is that drug therapy alone does not address the underlying psychological and behavioral factors that perpetuate insomnia over time. Thus, investing in CBT-i provides behavioral guidance and self-management skills so that patients can manage some of the factors that contribute to their sleep difficulties. Over the long run, improving sleep and reducing the use of hypnotic medications is likely to improve patient well-being and decrease health care costs. Of course, CBT-i cannot be forced on patients who are not motivated or willing to engage in this therapeutic process. We need to be careful not to make assumptions about whether a patient will accept CBT-i. One should not underestimate patients’ interest in participating in their own care or the effect of a simple prescription for behavioral changes, such as regular sleep–wake schedules or restricting time in bed. Behavioral and attitudinal changes are essential to the effective management of chronic insomnia, just as they are for the management of other chronic health problems, such as hypertension, obesity, and diabetes. Drug therapy alone is not enough to address these problems, and the literature clearly shows that CBT-i produces more durable sleep improvements over time than medication (10).

Insomnia is a prevalent health problem with a heavy burden for the individual and society, yet there is little public education about the importance of healthy sleep. Although additional research is warranted to develop more effective, efficient, and accessible therapies, it is also necessary to broaden our perspective on insomnia and address sleep difficulties before they reach the level of a clinical problem. The design of public education campaigns to promote healthy sleep practices might reduce the incidence of insomnia and alter the course of negative outcomes among persons who already have it.

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Acknowledgment: The author thanks Dr. Lynda Bélanger for her comments on an earlier draft of this manuscript.

Grant Support: Preparation of this manuscript was supported in part by research grants from the Canadian Institutes of Health Research (MT-42504) and the National Institute of Mental Health (MH-091053).

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M15-1246.

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