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INVITED COMMENTARY

ONLINE FIRST

Time to Disseminate Cognitive Behavioral Treatment of Insomnia

The efficacy of cognitive behavioral treatment for insomnia (CBTI) is supported by over 3 decades of research.^{1,2} Evidence is accumulating that it is effective not only for primary insomnia but also for patients with insomnia and complex comorbidities including psychiatric disorders, chronic pain, and cancer.³⁻⁵ Despite a wealth of data showing efficacy, CBTI has not been available in most practice settings, including many specialized sleep centers whose focus is on the assessment and treatment of sleep apnea. CBTI may be misperceived as being analogous to weight-loss treatment for obesity-related sleep apnea; that is, it is theoretically superior to all alternatives, but the obstacles to

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implementation seem overwhelming. CBTI involves initial demands for substantial behavioral changes that seem difficult to address in the context of most primary care settings. How does one help patients make changes in their sleep-wake activities that often are entrenched by years of habit? How does one refer patients for effective behavioral treatment? Unfortunately, CBTI remains limited to specialized sleep centers with trained behavioral sleep medicine specialists. Most primary care settings lack access to these resources, and there are concerns about stigma related to referrals to mental health treatment.

Behavioral sleep medicine rightfully claims great success in creating a treatment that in a few weeks achieves

efficacy comparable with that of sedative hypnotics⁶ and over the long term achieves greater satisfaction as reported by patients.⁷ In an ideal health care system, one would expect behavioral treatment for insomnia to be widely disseminated because of the data showing efficacy, the cost savings that would accrue from reduced pharmacy costs, and reduced morbidity from sedative hypnotic-related falls and injuries. The message repeatedly finds its way into the scientific literature but not into practice settings.

CBTI has slowly evolved in the past decade in response to concerns about the need to move from efficacy to effectiveness oriented clinical trials. There have been successful demonstrations that the number of sessions can be reduced,⁸ that it can be delivered in group format in primary care settings,⁹ and that it can be adapted for internet based treatment.¹⁰ In this issue of the *Archives*, Buysse et al present encouraging results from a brief intervention for insomnia that was delivered in a primary care setting by a masters-level mental health nurse practitioner with no prior experience in sleep medicine. The treatment involves an initial 45- to 60-minute visit, a second 30-minute visit, and two 20-minute telephone calls over a treatment period of 4 weeks. The patient is given a workbook and individualized behavioral instructions and is taught to monitor their sleep with a sleep diary. The 4-week time period for assessing outcomes is shorter than most CBTI trials, based on the idea that participants might request medication therapy if shorter-term gains were not

obtained. Buysse et al also reasoned that shorter-term treatment, if proven effective, would have a greater likelihood of being acceptable for wider dissemination. The results from the trial by Buysse et al show effects on sleep outcomes similar to those which have been published in other CBTI trials in older adults as well as trials with sedative hypnotic therapy.¹¹ Furthermore, the enrolled participants were atypical compared with those in many prior studies of primary insomnia in that they were older and had complex comorbidities including sleep apnea and psychiatric disorders.

The basic elements of CBTI are that patients learn to stabilize their sleep-wake schedule by fixing a wake-up time, going to bed only when sleepy, limiting the use of the bedroom for sleep and intimacy, and eliminating wake time spent in bed—either by arising out of bed if unable to sleep, or restricting the time window for being in bed. Patients may initially feel tired and sleep deprived during the first few weeks of treatment, but over time they consolidate their sleep and achieve outcomes equal and superior to those achieved with sedative hypnotic drugs. Furthermore, there is evidence from a growing number of studies that additional gains are measurable at 6 months.¹²

The slow entry of CBTI into primary care may be related to multiple factors related to the dissemination of sleep medicine into medical school curriculum. Clinicians are often taught to treat insomnia as a constitutional symptom that has a complex differential diagnosis. Initial interventions are often aimed at finding and treating what are viewed as primary causes of insomnia, such as depression or pain syndromes. In the past few years, attempts have been made to view insomnia as a comorbid condition that warrants separate individualized treatment. This is based in part on a behavioral model of chronic insomnia which posits that prolonged awakenings during the sleep period may become entrenched by conditioning factors and maladaptive behaviors, such as habitual rumination while lying in bed.¹³

The model for insomnia treatment presented by Buysse et al makes particular note that the treatment can be delivered by a nurse practitioner with no prior training in behavioral sleep medicine. Several sleep specialists have suggested a stepped model of care in which initial treatment can be offered to relatively uncomplicated patients with insomnia much in the same way that depression is often first handled in the primary care setting.¹⁴⁻¹⁶ Referrals to sleep specialists would be considered in more complicated patients or in those who were not responsive to initial treatment.

So who will do this? Clinics that specialize in the care of older patients may be a good starting point. CBTI has been proven to be effective for helping older patients discontinue sedative hypnotic use.^{17,18} This is particularly attractive in older subjects who arise frequently in the night, are at risk for hip fracture, and who may be showing early signs of cognitive impairment.

Perhaps dissemination will be driven by integrated health care systems that have to manage all the costs related to health care, including clinician time and phar-

macy costs. The demonstration project from Buysse et al is a welcome addition and hopefully will lower the threshold for disseminating an effective treatment.

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