



Australasian Sleep Association position statement regarding the use of psychological/behavioral treatments in the management of insomnia in adults



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A B S T R A C T

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Insomnia disorder is a high prevalence condition with a high disease burden, which, left untreated, can increase risk of poorer health outcomes. Due to Insomnia's tendency towards having a chronic course, long-term treatment approaches are required to reduce the impact of Insomnia over time. After reviewing the available literature, The Australasian Sleep Association (ASA) recommends Cognitive Behavior Therapy for Insomnia (CBT-I) as a first line treatment in the management of Insomnia. The ASA notes that in addition to CBT-I, there is emerging evidence for the use of Mindfulness Based Therapy for Insomnia when used in combination with behavioural techniques (MBT-I). CBT-I should be used whenever possible, and medications should be limited to the lowest necessary dose and shortest necessary duration. CBT-I, whilst the most effective long-term treatment, does not work for everybody across all circumstances, so there will be circumstances in which other treatments are required (e.g., pharmacotherapy). Improving access to CBT-I is an important issue which will involve raising awareness of the effectiveness of CBT-I, increasing the number of trained practitioners, and the development of effective low intensity treatments that can be offered in the first instance.

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1. Background

1.1. Insomnia disorder definition

Insomnia disorder as defined in the Diagnostic and Statistical Manual fifth Edition (DSM-V, [2]) as longstanding (more than 3 months) subjective difficulty initiating asleep, maintaining sleep, or waking too early, accompanied by distress about the experience of daytime fatigue and its impact on day-time functioning. The difficulty occurs at least three nights per week, despite adequate opportunity for sleep. Adjustment Insomnia/Acute Insomnia is less than 1 month in duration.

1.2. Insomnia disorder subtypes

- The DSM-V outlines five insomnia subtypes: sleep initiation insomnia; sleep maintenance insomnia, early morning

awakening, a combination of these three core symptoms, or non-restorative sleep.

- The International Classification of Sleep Disorders-3 (ICSD-3, [1]) outlines four chronic insomnia subtypes: psychophysiological insomnia (insomnia that occurs due to a learned response of increased arousal whilst attempting to sleep), idiopathic insomnia (lifelong insomnia), paradoxical insomnia (sleep state misperception), and inadequate sleep hygiene (insomnia due to poor sleep habits).
- According the DSM-V and ICSD-3, to receive a diagnosis of insomnia disorder, the insomnia should be clinically significant on its own even though it may occur at the same time as another physical or mental condition.
- The primary and secondary insomnia distinction has been removed in the DSM-V and ICSD-3, in order to emphasise the mutually exacerbating nature of chronic insomnia with other mental and physical conditions. 'Insomnia disorder' is now recognized as a condition requiring independent clinical attention, regardless of other medical problems that may be present.

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- o Although the primary and secondary insomnia distinction is no longer used the most common diagnostic classification systems, they are defined here as these terms appear widely in the Insomnia literature.
- o Primary insomnia: Insomnia that is not directly attributable to a medical, psychiatric, or environmental cause. Primary Insomnia according to the ICSD may be psychophysiological insomnia (objectively verifiable impaired sleep), idiopathic insomnia (childhood onset), or paradoxical insomnia (sleep state misperception).
- o Secondary insomnia: Insomnia that is result of other causes such as (medical condition, medication or substance, mental disorder, inadequate sleep hygiene).

1.3. Prevalence and course

Insomnia is the most prevalent of all sleep disorders in the general population [31]. In terms of prevalence of Insomnia symptoms, population-based studies across various countries suggest that approximately 30% of adults report one or more of the symptoms of insomnia: difficulty initiating sleep, difficulty maintaining sleep, waking up too early, and in some cases, non-restorative or poor quality of sleep. Indeed, acute Insomnia prevalence rates are higher, at approximately 30% [3]. Prevalence of individuals meeting full criteria for insomnia disorder is estimated at 10% among the general population with increased rates in increasing age, female gender, and presence of medical or psychiatric illness. A recent Australian study estimated the prevalence to be 7% [14]. Importantly, chronic insomnia is a persistent, long-term disorder. For example, research has suggested that three quarters of individuals reporting insomnia at baseline still report having insomnia 1 year later and almost half reported having insomnia at three consecutive annual assessment points [26].

1.4. Burden

Sleep is an important component of health and has a large negative impact on quality of life, affecting how well people think, work and interact with others (e.g., Ref. [17]). Individuals with insomnia experience fatigue, mood disturbance, and distress [25], have greater absenteeism rates, 60-percent greater healthcare costs as compared to the general population, (e.g., Refs. [36,39]) and an increased risk of accidents [7]. There is also an increased risk for depression, anxiety, suicide, and substance use, with Insomnia being an independent risk factor. The economic burden in Australia is estimated to be \$5.1 billion per year [14].

2. The use of cognitive behavioral treatments in insomnia disorder

The main treatment goals in insomnia are: (1) to reduce nocturnal hyperarousal, (2) to improve sleep quality and quantity, (3) to reduce insomnia related daytime impairments, (4) reduce the distress and anxiety associated with poor sleep. Psychological/behavioral treatment approaches assume that physiological and cognitive hyperarousal (tension and worry) contribute to the evolution and maintenance of poor sleep. Poor sleep results in unhelpful sleep habits (e.g., irregular sleep routine, excessive caffeine use, long daytime naps) that maintain insomnia over time. Cognitive Behavior Therapy for Insomnia (CBT-I) is a multicomponent treatment that consists of an educational component, cognitive interventions (correcting unhelpful beliefs, reducing worry, reducing cognitive hyperarousal) and behavioural interventions

(sleep restriction, stimulus control) which work to reduce arousal and behaviours/routines that interfere with sleep.

Meta-analyses and systematic reviews support the efficacy of CBT-I interventions for insomnia in both younger and older adults [5,18,40,43]. Dismantling studies suggest that both Cognitive maximises both acute and long term effects [13]. Research investigating the combination of CBT-I and pharmacotherapy suggests this is effective as long as the pharmacotherapy is short-term and adverse effects of medications are assessed [24,26,28]. As far as stand-alone treatments are concerned, CBT-I has the best efficacy [43]. The acute effects of CBT-I are comparable with or superior to those of hypnotic medications and are maintained for up to 3 years of follow-up [23]. There is emerging evidence that mindfulness-based treatment for insomnia (MBT-I) is also efficacious [11,33,34].

Outcome studies support the use of both individual and group CBT-I treatments [18,27,30]. There is also evidence for the effectiveness of telephone, printed self help, and online cognitive-behavioural therapy (for reviews see Refs. [16,41,42,46]). One randomized controlled trial of individual face-to-face versus online CBT-I exists and this suggested superiority of face-to-face treatment [20]. There is evidence to suggest that brief, weekly telephone support [15] or personalised motivational feedback emails [21] may enhance outcomes for online treatments. Telephone, printed self help, and internet-based options (with personalised support where possible) are recommended by the ASA as part of a stepped-care approach, or in places where face-to-face treatments are unavailable or too costly, or when there is a low level of complexity in the insomnia disorder [4,9,16,44].

A proportion of Insomnia patients have circadian rhythm abnormalities that can result in sleep onset insomnia (delayed sleep phase) or early waking insomnia (advanced sleep phase). Careful timing of exposure to bright light in the morning or evening, respectively, may be a behavioural intervention that is useful in such cases [19,22].

2.1. Recommendation that CBT-I is a first line treatment

The ASA recommends treatments with either Level I or Level II evidence. The Australian National Health and Medical Research Council [29] and the Oxford Centre for Evidence Based Medicine [35] use the following classification system when assessing evidence for specific treatments.

Level I

- Evidence obtained from a systematic review of all relevant randomised controlled trials (meta-analyses).

Level II

- Evidence obtained from at least one properly designed randomised controlled trial.

The ASA recommends CBT-I as a first line treatment of insomnia disorder as it has extensive level I evidence. It is universally accepted as the best treatment modality for insomnia disorder, in the long term.

2.2. CBT-I description

The table below provides a summary of the core components of CBT-I (Table 1).

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