In June 2005, the National Institutes of Health consensus conference report concluded that cognitive behavioral therapies are effective for the treatment of insomnia and called for efforts to make the treatments more available in the community. Among the barriers to making treatment more available has been the expense of providing multiple individual sessions by doctoral-level trained clinicians. The study by Germain and colleagues in the current issue challenges the assumptions about the number of treatment sessions and the level of clinician training required for effective treatment.

Germain and colleagues report encouraging preliminary findings of a 2-session individual brief behavioral treatment for insomnia (BBTI) in older adults. The first session of 45 minutes provided instructions from stimulus control and sleep restriction therapies tailored individually from the patients’ baseline sleep diaries. The insomniacs followed the instructions for 4 weeks. A 30-minute booster session to review the instructions, discuss adherence, and modify sleep schedules if needed was held 2 weeks after the first session. In comparison to an information-only control condition (IC), the brief treatment produced improvement consisting of large effect sizes on the Pittsburgh Sleep Quality Index (PSQI) and on the sleep diary measure of sleep latency, and moderate effect sizes on wake after sleep onset, sleep efficiency (SE), and clinician ratings of depression.

To evaluate the clinical significance of the improvement, the investigators operationally defined response to treatment and remission. Their definition of response was either an increase in SE of 10% calculated from sleep diaries or a reduction of 3 points or more on the PSQI. Remission of the insomnia was defined as meeting the criteria for response and having SE >85% after treatment or a PSQI score of ≤5. Seventy-one percent of the BBTI patients met criteria for response compared with 33% of the IC patients, and 53% of the BBTI patients met criteria for remission compared with 17% of the IC patients.

In prior evaluations of cognitive behavioral treatments for insomnia, the average number of treatments has been 5.7 sessions. In both the study by Germain and colleagues with older adults and an earlier study by Edinger and Sampson with a broader age range, significant improvement in sleep was produced by following a 2-session protocol. Edinger and Sampson had a 3-month follow-up during which treatment gains were maintained.

In the preliminary study by Germain and colleagues, there was no follow-up assessment. Follow-up assessments are critical for a complete evaluation of treatments for chronic insomnia. Interventions may produce initial improvement that is not maintained. Indeed, the maintenance of gains during follow-up periods as long as 2 years has been a primary benefit of cognitive behavioral treatments when compared to pharmacotherapy.

Regarding the level of clinician training required for this treatment protocol, Germain and colleagues employed a masters-level nurse practitioner who had been trained to deliver the intervention, not a doctoral-level clinician. Previously, Espie and colleagues had trained nurses to effectively provide a multi-session treatment for insomnia. The use of masters-level clinicians raises the question of the role of the doctoral-level clinician. Should it be primarily one of training and supervising clinicians along with developing and evaluating treatments? Or is there a direct service role for the psychologist, physician, or doctoral-level nurse that cannot be met by masters-level clinicians? Included might be assessing and diagnosing the problem, reviewing and managing medication in addition to behavioral treatments, integrating the treatment of comorbid problems, and providing further assessment and treatment for individuals who do not improve from brief protocols. For all of these activities, however, examples could be provided of masters-level clinicians successfully engaging in them under varying degrees of supervision.

Only a small proportion of those with insomnia complaints are seen by insomnia specialists. To meet the broader societal need, we can expect continuing effort in the development of treatments that are less expensive, more efficient, and more accessible to the general public. These include group treatments, self-help books, audio- and videotapes, television programs, and Internet treatments. For many of these, there is a trade-off between effectiveness and the numbers reached by the intervention. Brief individual therapy has the promise of being able to provide the clinician attention and feedback that is likely to lead to a higher degree of efficacy while at the same time being more econom-
cal and thus accessible to an increased number of sleep disturbed individuals.

REFERENCES