

Change in Dysfunctional Beliefs About Sleep in Behavior Therapy, Cognitive Therapy, and Cognitive-Behavioral Therapy for Insomnia

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As part of a larger randomized controlled trial, 188 participants were randomized to behavior therapy (BT), cognitive therapy (CT), or cognitive-behavioral therapy (CBT) for insomnia. The aims of this study were threefold: (a) to determine whether change in dysfunctional beliefs about sleep was related to change in sleep, insomnia symptoms, and impairment following treatment; (b) to determine whether BT, CT, and CBT differ in their effects on dysfunctional beliefs; and (c) to determine whether the treatments differ in their effects on particular kinds of dysfunctional beliefs. Beliefs, sleep, insomnia symptoms, and sleep-related psychosocial impairment were assessed at pre-treatment, posttreatment, and 6- and 12-month follow-up. Greater change in dysfunctional beliefs occurring over the course of BT, CT, or CBT was associated with greater improvement in insomnia symptoms and impairment at

posttreatment and both follow-ups. All groups experienced a significant decrease in dysfunctional beliefs during treatment, which were sustained through 6- and 12-month follow-up. Compared with the BT group, a greater proportion of participants in the CT and/or CBT groups endorsed dysfunctional beliefs below a level considered clinically significant at posttreatment and 12-month follow-up. The results demonstrate the importance of targeting dysfunctional beliefs in insomnia treatment, suggest that beliefs may be significantly modified with BT alone, and indicate that cognitive interventions may be particularly powerful in enhancing belief change.

Keywords: insomnia; beliefs; sleep; cognitive-behavioral therapy; behavioral experiments

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Insomnia is the most common sleep disorder worldwide and one of the most common presenting complaints in primary care (Morin, LeBlanc, Daley, Gregoire & Mérette, 2006; National Institutes of Health, 2005; Simon & vonKorff, 1997). Chronic insomnia involves a persistent disturbance in sleep as well as daytime impairment and distress. It is associated with increased rates of disability, health care utilization, and medical and psychiatric comorbidity (e.g., Roth, Soubrane, Titeux, Walsh, &

Zoladul Study Group, 2006). Cognitive-behavioral therapy (CBT) for insomnia is an empirically supported treatment for chronic insomnia (e.g., National Institutes of Health, 2005) and has moderate to large effects on several measures of nighttime wakefulness, including sleep onset latency and wake after sleep onset (e.g., Morin & Benca, 2012; Morin, Culbert, & Schwartz, 1994; Smith et al., 2002). Although CBT is an effective treatment for insomnia, additional research is needed to clarify how the behavioral and cognitive components of the treatment affect proposed disorder-maintaining mechanisms.

Dysfunctional beliefs about sleep have been implicated in insomnia, and they are included as a core component of many theoretical models of insomnia (e.g., Espie, 2002; Harvey, 2002; Morin, Stone, Trinkle, Mercer, & Remsberg, 1993). Compared with healthy sleepers, individuals with insomnia endorse a higher level of dysfunctional beliefs about the consequences of poor sleep, uncontrollability and helplessness related to sleep, sleep-promoting behaviors, and the causes of insomnia (Morin et al., 1993). Such beliefs have been proposed to lead to increased worry and safety behaviors, and they likely perpetuate insomnia via a number of pathways (Harvey, 2002). For instance, dysfunctional beliefs about sleep-promoting behaviors can lead to problematic behaviors (e.g., staying in bed for 8 hours regardless of how much sleep is obtained), beliefs about the consequences of poor sleep may lead to catastrophic thinking about insomnia and changes in daytime routine (e.g., canceling daytime activities due to poor sleep), and beliefs about the uncontrollability of sleep may lead to feelings of helplessness and hopelessness (e.g., Carney & Edinger, 2006; Morin, Blais, & Savard, 2002). Initial research supports the assertion that dysfunctional beliefs about sleep perpetuate insomnia and are an important target for intervention. Indeed, previous findings suggest that greater change in dysfunctional beliefs over the course of insomnia treatment is associated with greater improvement in subjective sleep report (Carney & Edinger, 2006), improvement in daytime impairment (Jansson-Frömjark & Linton, 2008), and better maintenance of treatment gains (Edinger, Wohlgemuth, Radtke, Marsh, & Quillian, 2001; Morin et al., 2002). Additionally, research suggests that treatment effects on the different types of dysfunctional beliefs may vary, and that individuals who hold a high level of dysfunctional beliefs regarding the consequences of poor sleep and helplessness related to insomnia may be particularly good candidates for CBT (Sanchez-Ortuno & Edinger, 2010).

Thus, initial research findings suggest that dysfunctional beliefs about sleep are an important mechanism maintaining insomnia, that these beliefs

can change with treatment, and that belief change enhances the maintenance of treatment gains. Nevertheless, additional studies are needed for a number of reasons. First, the number of studies focused on belief change in insomnia treatment is relatively small, and the findings that belief change may lead to improved sleep and decreased impairment need to be replicated. Second, to our knowledge, no studies of CBT for insomnia to date have included the use of behavioral experiments as part of the intervention to target unhelpful beliefs. Behavioral experiments engage the patient in a hypothesis testing and data collection experiential exercise that allows him or her to take the position of an objective observer and test potentially dysfunctional beliefs. The behavioral experiment approach has been proposed as the cognitive therapy (CT) intervention most likely to elicit belief change (Bennett-Levy et al., 2004; Harvey & Eidelman, 2011; Ree & Harvey, 2004). It is possible that behavioral experiments related to sleep and daytime functioning could enhance change in dysfunctional beliefs and thereby lead to improved treatment outcomes for individuals with chronic insomnia. Third, and perhaps most important, the manner in which CBT for insomnia leads to belief change is unclear. Although CBT, relaxation strategies, and hypnotic medications have all been shown to improve sleep, CBT leads to significantly greater change in dysfunctional beliefs as compared with these other insomnia treatments (Edinger et al., 2001; Morin et al., 2002; Wu, Bao, Zhang, Deng, & Long, 2006). This specific effect of CBT on beliefs suggests that improvement in sleep (which also occurs with relaxation and pharmacological approaches) is not enough for belief change to occur. As a next step to extend this developing knowledge, there is a need to clarify whether the cognitive components, behavioral components, or both need to be present in order for CBT to result in belief change. Research focused on CBT in other disorders, including depression and various anxiety disorders, has suggested that explicitly cognitive interventions may not be necessary for belief change to occur (e.g., Borkovec, Newman, Pincus, & Lytle, 2002; Jacobson et al., 1996; Longmore & Worrell, 2007). For instance, Borkovec and colleagues (2002) have proposed that behavioral interventions can lead to widespread change in all of the systems involved in maintaining a disorder. Thus, it may be the case that weekly behavior therapy (BT) for insomnia, which incorporates purposeful behavioral change accompanied by self-monitoring, may ultimately lead to belief change, although beliefs are never explicitly discussed or challenged. However, to the

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