



Implementing CBTI at the Veterans Health Administration

Commentary on Manber et al. Dissemination of CBTI to the non-sleep specialist: protocol development and training issues. *J Clin Sleep Med* 2012;8:209-218.

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There has been considerable research indicating that the prevalence for insomnia is high, that cognitive behavior therapy for insomnia (CBTI) is an effective treatment, and that it maintains its effectiveness during follow-up periods for as long as two years.^{1,2} Despite this, there have been difficulties in disseminating CBTI so that more individuals would benefit.

The article by Manber et al. in this issue on the training and dissemination effort taking place at the Veterans Health Administration (VHA) is ambitious and tackles some of the most difficult aspects of disseminating effective treatments. The VHA is the largest integrated health care system in the United States and is in the midst of undertaking an evidence-based psychotherapy dissemination program³ for a number of disorders including depression, PTSD, and now insomnia treated with CBTI. With regard to CBTI, VHA mental health clinicians who are already credentialed to treat mental health problems are being recruited for training and supervision in CBTI.

There are many noteworthy aspects of this training program, but one that stands out is the commitment to what the authors call, "case conceptualization." This commitment to personalized assessment, etiology, and the mechanisms underlying effective treatments is praiseworthy. There is sometimes a danger in attempts to disseminate treatments by simplifying or abbreviating them. In the process of doing so, we may lose sight of insuring that the mechanisms for the treatments' effects are retained.⁴ Not infrequently, the treatment of insomnia is made more difficult when it is complicated by the presence of comorbidities that are common in returning veterans, and simplified versions of the treatment may not work under those conditions.

To emphasize a personalized approach in the VHA program, a case conceptualization form was developed that prompts the training clinicians to identify items that affect possible etiological factors. This includes descriptions of activities that may have weakened homeostatic drive, activities that may have weakened circadian drive, and evidence of both sleep-interfering hyperarousal and sleep-interfering behaviors. In addition, those being trained are taught to attend to the role of comorbid disorders and the effects of ongoing medication. Further, the Spielman model of predisposing, precipitating, and perpetuating factors of insomnia⁵ is integrated into treatment planning.

The material discussed in the paragraph above is part of a training experience that begins with a workshop. As described

in the article there is considerably more covered during the workshops. The Manber et al. article provides detail on a number of issues that had to be decided to keep a balance between the time commitments of busy professionals and the methods of expanding the clinician's expertise to include CBTI.

The workshop, although important, may not be the most important pedagogical technique described. Equally important, if not more so, all trainees see patients using the CBTI approach and are supervised by behavioral sleep medicine clinicians. Such a mentoring approach is common in many training environments. It would seem to be essential in any attempt to build clinician competence.

The short-term process results look excellent. The long-term test of the program will depend on whether the authors meet their goal of training 1000 VHA clinicians to implement CBTI, whether the clinicians' commitment to treating insomnia with CBTI can be sustained, whether the training experience serves as a gateway to becoming expert in the full range of behavioral sleep medicine clinical activities, and whether competency as measured by patient outcomes is achieved.

A strength of the program is that this CBTI dissemination effort has the potential to impact a growing societal problem in treating insomnia that is comorbid with other medical and emotional problems. Perhaps the success of the VHA CBTI program will be encourage other integrated health systems, such as HMOs, to implement their own programs.

CITATION

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REFERENCES

1. National Institutes of Health State of the Science Conference Statement on Manifestations and Management of Chronic Insomnia in Adults, June 13-15, 2005. *Sleep* 2005;28:1049-57.
2. Bootzin RR, Epstein, DR. Understanding and treating insomnia. *Annu Rev Clin Psychol* 2011;7:435-8.
3. Zeiss AM, Karlin BE. Integrating mental health and primary care services in the Department of Veterans Affairs Health Care System. *J Clin Psychol Med Settings* 2008;15:73-8.
4. Shoham V, Insel TR. Rebooting for whom? Portfolios, technology, and personalized intervention. *Perspectives Psychol Sci* 2011;6:478.
5. Spielman AJ. Assessment of insomnia. *Clin Psychol Rev* 1986;6:11-26.

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DISCLOSURE STATEMENT

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