Introduction

I trained as a clinical psychologist in the late 1970s, qualifying in 1980, and began practising in the local primary healthcare services in NHS Lanarkshire in Scotland. It was in that context that a general practitioner (GP) asked me one day, likely in 1981, 'Colin, is there not anything you can do for folks who can't sleep?' I had to say that I didn't know. We hadn't had much, or even any, training on sleep problems. The GP concerned, along with many other professionals who referred patients, wasn't satisfied that a pill was the only, or even the best, answer to mental health conditions. I had been seeing people with depression, anxiety, and so on, but could insomnia be addressed using evidence-based psychological therapies? I was curious to find out.

What I discovered, and this also lay behind the GP's question, was that insomnia was a disorder that patients generally 'took something for' but that drug treatment was often problematic. Historically these drugs had been barbiturates, and at the time of his asking it was already becoming clear that the alternative, benzodiazepine hypnotics (BZs), whether shorter acting or longer acting, were not an ideal solution. My reading into whether effective behavioural treatment might be extended to insomnia revealed promising signs, and so I invited the GP to send me some patients, and I would see what I could do. I will spare you a detailed account of the subsequent 45 years, but suffice it to say that sleep problems, and insomnia in particular, became my principal clinical interest and research focus.

Coming right to the present day, it is enormously gratifying that we find ourselves in the position that cognitive behavioural therapy (CBT) has such a compelling evidence base that all contemporary clinical guidelines recommend CBT as the treatment of first choice for chronic insomnia. I am pleased to have contributed to that outcome. Not only does CBT 'work', but many patients and their doctors prefer this approach to medication. I believe it is right that people should have the choice of evidence-based treatments for any condition, and so it is of first importance that clinicians know how to assess and treat insomnia using CBT. Nowadays sleep is more on the curriculum for health practitioner education than it used to be, but there is often still a gap. Although we have a flourishing research literature on insomnia, and a number of treatment manuals for CBT is available, my reflection is that these are often insufficiently informative on *what to do* and *how to do it*. This was my main reason for writing this clinician's guide.

Crucially, I want to frame CBT in what I believe to be its greatest potential for good, which is that it is not *a* treatment for insomnia but an approach to treatment that offers scores of therapeutic choices. Although the analogy with pharmaceuticals is imperfect, it is clearly understood that we have numerous active agents within and across the medication classes of BZs, BZRAs (benzodiazepine receptor agonists), MRAs (melatonin

receptor agonists), and more recently DORAs (dual orexin receptor antagonists). We don't treat patients with pharmacotherapy; we treat them with a specific pharmaceutical agent. We may be taking a pharmacotherapeutic approach, but the treatment is a particular medicine. I have been using the term 'cognitive and behavioural therapeutics' (CBTx) to emphasise the rich repository of many evidence-based interventions that comprise the CBTx 'formulary', and this book is designed to enable you to make clinical judgements and selections based on CBT as an approach to treatment rather than as a treatment in itself.

My goal is to help you to discover the right CBTx treatment, for the right patient, at the right time, and so to personalise therapy in a time-efficient and treatment response-efficient manner. With this in mind, I emphasise and explain the importance of case conceptualisation as a clinical methodology. This helps us understand *why* a given patient has *insomnia*. As the subtitle to the book suggests, our job as clinicians is that of scientist-practitioner, to work collaboratively with the patient to identify what underpins and maintains their difficulties and to derive a treatment formulation that acts as a working hypothesis for selection of the optimal CBTx intervention.

Shared understanding normally benefits from the use of metaphor, and I offer you many illustrations of ways in which you can enrich communication and collaboration with patients attending your clinics. Likewise, I place considerable emphasis on treatment implementation and on being empathic with patients' struggles to put their best intentions into action. These are key levers to therapeutic progress. Throughout the book I have included tables, figures, and boxes, many of which provide not only material to explain and amplify the text but also practical tools that you will be able to use in your day-to-day work.

I have endeavoured to be comprehensive as well as practical. If you glance at the Contents, you will see that the book is laid out across five sections. Section 1 is on 'Sleep, Its Function, and Insomnia' and comprises three chapters addressing the fundamental questions 'What Is Sleep?' (Chapter 1), 'Why Does Sleep Matter?' (Chapter 2), and 'What Is Insomnia?' (Chapter 3). Section 2 then explores 'CBT and Its Application to Insomnia', answering 'Why Is CBT Relevant to Insomnia?' (Chapter 4) and 'unpacking' CBT by explaining cognitive and behavioural therapeutics as a construct and addressing the question 'What Is CBTx?' (Chapter 5). In Section 3 we turn to 'Assessing Insomnia from a CBTx Perspective' with the chapters 'How Do I Evaluate a Patient and Understand Their Presenting Complaints?' (Chapter 6), 'How Do I Incorporate Validated Scales and Measures into Clinical Evaluation?' (Chapter 7), and 'Should I Consider Objective Assessments of Sleep–Wake Functioning as Part of Clinical Evaluation?' (Chapter 8). My goal is to provide you with my insights and with the range of assessment tools that I use in my everyday work. In a similar vein Section 4 comprises five chapters on 'Treating Insomnia Using the CBTx Approach'. We start with 'How Do I Use This Book to Develop Personalised CBTx?' (Chapter 9), which will help you to develop skills in case conceptualisation and to navigate the subsequent three chapters. These are on specific classes of insomnia treatment, namely 'How and When Should I Deliver Behavioural Therapeutics?' (Chapter 10), 'How and When Should I Deliver Cognitive Therapeutics?' (Chapter 11), and 'How and When Should I Deliver Relaxation Therapeutics?' (Chapter 12). Each of these chapters comprises several component interventions in sufficient detail to guide your clinical work. This section concludes with Chapter 13, 'How and When Should I Incorporate Sleep Hygiene and Education?', which

I present as an adjunct to therapy rather than as an active treatment in its own right. Chapter 13 also summarises my '5 principles' of good sleep health', which I hope that you find useful as a patient-facing framework as well as in your public engagement with the importance of sleep. Finally, Section 5 on 'Implementing CBTx for Insomnia at Scale' comprises a single chapter, 'How Do I Design and Deliver a CBTx Service' (Chapter 14). Here I envisage you as a professional who is keen to develop a service in your territory, whether that be local, provincial, or even national. Consequently, as we close, we turn our attention to the bigger picture of population need rather than individual clinical work.

In closing this introduction, let me say that I very much look forward to working with you. I think you will get the most out of the book if you imagine that you and I are on the same team and that I can serve as a resource to you. In writing the book I have tried to anticipate the needs of your patients, as well as your needs as you seek to serve your patients well. Let's work together. Thank you for your interest in insomnia and for all your efforts to provide evidence-based care.