TOOLS FOR PRACTICE #418 | July 20, 2026

TOOLS FOR PRACTICE

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

Enough Evidence to Put One to Sleep: Cognitive behavioural therapy for insomnia

CLINICAL QUESTION

How effective is Cognitive Behavioural Therapy for Insomnia (CBTi)?

BOTTOM LINE

About 45% of patients receiving CBTi achieve remission versus ~10% on control at 6 weeks, with effects sustained for at least 6 months. Remote CBTi (self-guided or group-based, synchronous or asynchronous) works, but it is not clear if it is as good as in-person, individual sessions. CBTi may be better than sleep medications but studies too small to find statistical differences.

EVIDENCE

- Statistically significant unless stated.
- Focus on most recent/comprehensive systematic reviews of randomized controlled trials (RCTs) with patient-oriented outcomes [up to 36 RCTs, 1696 participants, ~6 weekly in-person individual sessions], control=waitlist, usual care, sleep hygiene education, or placebo.[1,2]
- At end of treatment (~6 weeks):
    - Response[1] (≥8 point improvement on 28-point insomnia scale): 53% versus 10% (control), number needed to treat (NNT)=3.
    - Remission (based on scale scores):[1] 45% versus 9%, NNT=3.

    - Other systematic review similar.[2]
    - Sleep indices:[2]
        - Time to fall asleep: 15 minutes faster [example: ~23 versus 38 minutes (control)].
        - Total sleep time: 10 minutes more [328 versus 318 minutes (control)].
        - Time asleep while in bed: 8% more [88% versus 80% (control)].
        - Number awakenings: 0.3/night fewer [0.8 versus 1.1 (control)].
- At ≥6 months:[1] Remission 42% versus 13% (control), NNT=4.
- Remote delivery (self-guided or group-based, synchronous or asynchronous via telephone/book/internet):
    - Remote better than control[1-7]
        - Example:[1] Remission (6 weeks): 28% versus 9% (control)].
    - Remote versus in-person: Inconsistent.[1,2]
        - Example: Remission (end of treatment): 45% (individual/in-person) versus 28% (internet) in one review;[1] no difference in another.[2]
- CBTi versus sleep medications: 4 RCTs, no meta-analysis:
    - CBTi numerically better but statistical differences inconsistent (possibly underpowered).[8-10] Examples:
        - Proportion with >85% time asleep in bed (6 months): 78% CBTi versus 40% zolpidem.[8]
        - Proportion who fell asleep within 30 minutes during treatment: 50% CBTi versus 36% zolpidem, not statistically different.[9]
    - CBTi plus medications versus CBTi: Inconsistent, often underpowered.[9-11]

CONTEXT

- CBTi has 4 main components: Sleep restriction therapy, stimulus control, sleep hygiene education, and cognitive therapy.
    - Sleep restriction therapy alone is effective; sleep hygiene education alone is not.[2,12]
- Patient and clinician resources available.[13]

REFERENCES

1. Takano Y, Okajima I, Osao M, *et al.* Sleep Med Rev. 2025;84: 102204.
2. Edinger JD, Anedt JT, Bertisch SM, *et al.* J Clin Sleep Med. 2021;17: 263-298.
3. Knutzen SM, Christensen DS, Cairns P, *et al.* JMIR Ment Health. 2024;11: e58217.
4. Scott AM, Peiris R, Atkins T, *et al.* J Telemed Telecare. 2025;31: 603-614.
5. Hwang JW, Lee GE, Woo JH, *et al.* NPJ Digit Med. 2025;8(1):157.
6. Leite IPA, Kakazu VA, de Carvalho LAT, *et al.* Clocks Sleep. 2025;7(4): 69.
7. Huang Y, Yan Y, Kwok JYY, *et al.* J Clin Nurs. 2026;35: 61-84.

AUTHORS

Adrienne J Lindblad, BSP ACPR PharmD
Jennifer Young, MD CCFP-EM
Jennifer Potter, MD CCFP

Authors have no conflicts of interest to declare.

8. Sivertsen B, Omvik S, Pallesen, S, *et al.* JAMA. 2006;295(24): 2851-8.
9. Jacobs GD, Pace-Schott EF, Stickgold R, Otto MW. Arch Intern Med. 2004;164(17): 1888-96.
10. Morin CM, Colecchi C, Stone J, *et al.* JAMA. 1999;218(11) :991-9.
11. Morin CM, Vallieres A, Guay B, *et al.* JAMA. 2009;301(19): 2005-15.
12. Allan GM, Lindblad AJ, Varughese J. Can Fam Physician. 2017;63(8): 613.
13. Sleepwell. Available at: https://mysleepwell.ca/. Accessed Jun 8, 2026.

TOOLS FOR PRACTICE PROVIDED BY

PEER Patients Experience Evidence Research

IN PARTNERSHIP WITH

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Tools for Practice are peer reviewed and summarize practice-changing medical evidence for primary care. Coordinated by **Dr. Adrienne Lindblad,** the articles are developed by the Patients, Experience, Evidence, Research (PEER) team, and supported by the College of Family Physicians of Canada. Feedback is welcome and can be sent to toolsforpractice@cfpc.ca. Archived articles can be found at www.toolsforpractice.ca