About the Editor

William Vaughn McCall

William Vaughn McCall is the Case Distinguished Professor and Chairman of the Department of Psychiatry and Health Behavior at the Medical College of Georgia, of the Georgia Regents University (USA). He is board certified in general psychiatry, geriatric psychiatry and sleep disorders medicine. His research interests include depression, electroconvulsive therapy, quality of life, insomnia and suicide. His research has been continuously supported by the National Institute of Mental Health since 1995, and he is author of more than 300 publications, including more than 160 peer-reviewed journal articles.

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Foreword

Insomnia moves front and center among sleep disorders

William Vaughn McCall

The importance of a good night's sleep has led some to suggest that sleep could be considered a vital sign, along with temperature, pulse, blood pressure and respiratory rate. Indeed, sleep is much like the 'canary in the coal mine' – when a patient is sleeping poorly, it often indicates an underlying health problem. This reasoning underscores the rationale for this book on the topic of secondary insomnia, also known as comorbid insomnia.

While chronic, isolated insomnia can be found apart from any other medical or psychiatric condition, it is the exception rather than the rule [1]. Free-standing chronic insomnia had been called primary insomnia in the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association [2], but this term is now replaced by the term 'insomnia disorder' (with no mental or medical comorbidity) in the fifth edition of the Diagnostic and Statistical Manual [1].

It is now recognized that the majority of adults with 'insomnia disorder' in fact have a concurrent psychiatric or medical disorder, and it is often difficult if not impossible to know whether the insomnia is due to the comorbid condition, whether the insomnia caused the comorbid condition or if the two are completely unrelated. The recent trend is to give both the insomnia and the comorbid condition equal attention.

One of the more curious aspects to the development of treatments for insomnia is the fact that insomnia treatments are first developed in

individuals with primary insomnia (insomnia disorder with no mental or medical comorbidity) and only later tested in individuals with comorbid conditions. This has certainly been true for the research and development plans for hypnotics such as zolpidem, zaleplon and eszopiclone, each of which gained approval by the US FDA through testing in patients with primary insomnia. Testing of these hypnotics in individuals with both insomnia and mental illness did not occur for years after the initial FDA approval.

The same general pattern of development has been seen for psychological therapies, such as cognitive–behavioral therapy for insomnia (CBT-I). CBT-I is highly effective in primary insomnia and, when available, is often preferred over pharmacotherapy for insomnia. However, comparatively less is known regarding the efficacy or effectiveness of CBT-I in individuals with comorbid psychiatric or medical illness.

The general feeling among sleep physicians is that insomnia, regardless of whether it is primary insomnia or comorbid insomnia, is undertreated. The reasons for this are not totally clear, but I suspect that many physicians view insomnia as trivial, complicated to treat (at least with CBT-I), and fraught with potential complications such as falls and addiction resulting from the prescription of controlled hypnotic medication. We now know that insomnia is not trivial, as it contributes to both poor quality of life and suicide risk in individuals with comorbid psychiatric disorders [3,4], and treatment of insomnia leads to improved quality of life in individuals with insomnia with comorbidities [5]. In the future, we have hope that newer psychopharmacology approaches will be as effective as benzodiazepine agonist hypnotics, but will work through a different mechanism that has no/low risk for abuse.

In the meantime, we hope that information on insomnia and its treatment, as found in the following chapters, will promote the health and access to effective care of those individuals suffering with primary or comorbid insomnia.

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