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Participant Experiences of Attending a Community CBT Workshop for Insomnia: A Qualitative Six-Year Follow-Up

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Objective/Background: Our aim was to qualitatively explore the experiences of people who attended a one-day sleep workshop six years previously. *Participants:* Of the 95 people who originally attended the workshop and a three-month follow-up, 14 individuals (mean age = 63.6 years) participated. *Methods:*

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Semi-structured interviews were used to explore: participants' experiences of insomnia since the workshop, memories of the techniques and information provided and the perceived impact of the workshop on their lives. Qualitative data were analyzed using the principles of Framework Analysis. *Results:* Interviews produced rich accounts of attributions of changes in sleep, the application of taught strategies and general experiences of the workshop. *Conclusions:* This research highlights which aspects of a large-scale intervention may be most helpful for individuals experiencing sleep difficulties and what factors may contribute to changes in sleep over time.

BACKGROUND

Insomnia is one of the most commonly reported symptoms in the United Kingdom; approximately 9–15% of the general population present with sleep difficulties of clinical severity (Ohayon, 2002). Insomnia symptoms have a wide-ranging impact and are frequently associated with cognitive impairments and poor daytime functioning (Fortier-Brochu & Morin, 2014; Kyle, Espie, & Morgan, 2010). Moreover, insomnia is strongly associated with a number of somatic and psychiatric disorders, most notably depression (Riemann & Voderholzer, 2003). Despite the high prevalence and reported impact of these symptoms, the majority of individuals with persistent sleep difficulties remain untreated, with only one third of people seeking help in primary care (Morin, LeBlanc, Daley, Gregoire, & Merette, 2006). Even for those who do consult, assessment and treatment of persistent insomnia is often viewed by patients as inadequate (Stinson, Tang, & Harvey, 2006). General practitioners often regard sleep hygiene advice as insufficient (Everitt et al., 2014), yet patients commonly report wanting to know more about sleep and behavioral strategies to address their problems (Andrews, Coviello, Hurley, Rose, & Redeker, 2013).

Cognitive-behavioral therapy for insomnia (CBT-I) is widely accepted as an effective treatment option for insomnia, with up to 80% of those with chronic symptoms reporting short- to medium-term improvement in the frequency and severity of their insomnia symptoms (Espie, Inglis, Tessier, & Harvey, 2001; Morin et al., 2006). CBT-I may be effective for improving insomnia symptoms secondary to physical health conditions (McCurry et al., 2014; Savard, Simard, Ivers, & Morin, 2005) and there is promising evidence that it may help to improve comorbid depression and anxiety symptoms (Manber et al., 2008).

CBT-I was originally developed to be provided in an individualized format (Morin, 1994). However, given the high prevalence rates of insomnia and limited services available, a five-tier, stepped-care model for delivering CBT-I has been proposed (Espie, 2009). The first step involves self-help methods, with the resource requirement gradually increasing according to time and expertise. There is a growing body of evidence for these less intensive interventions: CBT-I in self-help formats, such as bibliotherapy and audiotape, may be comparable to face-to-face treatments for improving self-reported insomnia severity, particularly when accompanied by telephone consultations (Ho et al., 2015; van Straten & Cuijpers, 2009). Group CBT-I is shown to be effective for improving diary-derived outcomes such as sleep efficiency (SE), sleep onset latency (SOL), and wake time after sleep onset (WASO; Bastien, Morin, Ouellet, Blais, & Bouchard, 2004; McCurry, et al., 2014), although the evidence base is smaller than for individual CBT. Brief, nurse-led CBT-I interventions delivered in primary care have been associated with significant improvements in sleep quality and clinical measures of depression and anxiety (Espie et al., 2007). The effects of these briefer therapies may also be maintained in the long term. Järnefelt and colleagues (Järnefelt et al., 2014) found that in a sample of people participating in a

nurse-led CBT group intervention, 62% reported moderate to large reductions in insomnia severity at 24-month follow-up.

A new approach to addressing treatment barriers is to deliver CBT-I in a day-long, psychoeducational workshop format, originally developed by Brown and colleagues (Brown, Cochrane, & Hancox, 2000). An exploratory study found that for a community sample of men with sleep difficulties, this approach was associated with improvements in both insomnia and depression symptoms (Archer et al., 2009). In a randomized controlled trial that Swift et al. (2012) conducted in 2008–2009, participants who attended a one-day, self-referral CBT workshop for sleep difficulties were compared with a control group on insomnia severity three months after baseline. The workshops were found to be clinically effective, with significant differences between the groups on measures of sleep and mood symptoms at a three-month follow-up (controlled effect size = 1.0). The authors concluded that one-day, CBT-I workshops are an accessible, clinically effective intervention for members of the public who self-refer for sleep problems. These findings highlight the importance of further research to explore what aspects of a one-day CBT workshop for sleep problems may be most useful for people.

Qualitative investigations suggest that learning from others and sharing experiences may be the most salient experience of group CBT (Balabanovic, Ayers, & Hunter, 2013; Cramer, Salisbury, Conrad, Eldred, & Araya, 2011). This has been identified in several studies, including groups for people with psychosis (Dunn, Morrison, & Bentall, 2002; Messari & Hallam, 2003) and depression (Cramer, et al., 2011; Simmonds et al., 2013). CBT-specific techniques are also reported to be helpful in individual and group CBT. For example, participants have described that practical coping strategies help to promote a sense of control and increase their confidence to cope in the future (Nilsson, Svensson, Sandell, & Clinton, 2007).

Comparatively little is known about the value that people with insomnia derive from group CBT. In one study, 14 people with primary insomnia were interviewed about their experiences of taking part in a brief course of group sleep restriction therapy (SRT), a core component of CBT-I (Kyle, Morgan, Spiegelhalter, & Espie, 2011). Participants reported extensive adherence and adjustment issues, including a negative impact on daytime functioning and boredom during extra hours of wakefulness. Despite these initial difficulties, the majority of participants reported positive changes by the third week of treatment, corresponding to improvements in quantitative sleep parameters including total sleep time and reduced nighttime awakening.

Although the RCT conducted by our research group demonstrated the efficacy of CBT-I for reducing insomnia severity and secondary depressive symptoms (Swift et al., 2012), it provided limited insight into how participants experienced the intervention or perceived changes in their condition over time. Qualitative methods are increasingly being used to complement conventional outcome studies, offering valuable insight into how a psychological intervention is implemented, why an intervention fails or succeeds, and how it can be optimized (McLeod, 2011). The main objective of this study was to carry out a qualitative investigation using a sample of adults who had participated in the randomized controlled trial of a CBT-I intervention cited above (Swift et al., 2012). This large-scale workshop format has demonstrated success in improving insomnia and depression symptoms (Archer et al., 2009) and may last for up to two years (Brown et al., 2008). However, we do not know how participants explain the changes that have been observed over time and if these changes are associated with workshop-specific or more general factors. Thus, we sought to examine individuals' experiences of insomnia in the period since the workshop, their memories of the information and techniques provided, and the perceived impact of the workshop on their lives.

PARTICIPANTS

Our study sample was drawn from individuals who had previously participated in a randomized controlled trial of a CBT-I intervention in workshop format. In the original study (Swift et al., 2012), members of the general public were invited to refer themselves to the workshops, which offered a one-day program comprised of cognitive-behavioral methods aimed at improving sleep. The workshops, each for up to 30 people, were run in two centers in South West London. All individuals over the age of 18 years and living in one of five local boroughs were included. Participants were not required to be formally diagnosed with insomnia to participate and were only excluded if they reported to be currently undergoing psychological treatment for insomnia. Only one participant was excluded on the basis of this criterion.

In total, 151 individuals consented to participate in the original study, completed baseline data, and were randomized into experimental and waiting list control groups. The workshops started in December 2008 and a total of four workshops, two experimental, two control, were run. Three months after the workshop, participants were invited to attend a 2-hr group follow-up session, during which they also completed a second set of assessment measures. One hundred and twelve people returned follow-up assessments, meaning that the attrition rate from baseline to three months was 25.8% for the main outcome variables. The main findings from the parent study are included in [Table 1](#).

METHODS

Workshop Design

Workshops were run by two clinical psychologists with CBT expertise and experience with group facilitation. The workshops utilized cognitive-behavioral techniques adapted into a one-day educational program based on the work by Brown (Brown et al., 2000). The main aim was to help participants understand insomnia symptoms and to teach several practical techniques to improve their sleep. Details of the workshop protocol and content can be found in Swift et al. (2012).

Procedure

In the present study, direct contact with previous participants was not possible because ethical approval had not been obtained for follow-up after 3 months in the original study. An indirect recruitment approach was therefore adopted. Publicity was circulated over a two-month period to local community venues, health centers and libraries, and along residential roads in the surrounding areas. Flyers specified that the researchers wished to locate people who had attended the sleep workshops in 2008 or 2009 and included contact details for the researcher, but no explicit reference was made to locating those who may have noticed improvements or had continued to experience sleep difficulties. The study was approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee, King's College London (Ref. HR14/15-1700).

When participants made contact to indicate their interest, further information was sent out by post. The information sheet contained a statement clarifying that the researchers were simply interested to find out about people's general experiences over time. Participants were given time

TABLE 1
Main Findings From the Parent Study

Outcome/time point	Control group		Experimental group				Total		
	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>n</i>	<i>Mean</i>	<i>SD</i>
ISI									
Baseline	76	17.1	(5.4)	74	16.4	(4.6)	150	16.7	(5.0)
Follow-up (3-month)	63	16.2	(5.0)	49	10.8	(6.0)	112	13.5	(5.5)
Follow-up (6-year)	4	17.0	(8.3)	10	11.2	(4.8)	14	12.9	(6.2)
BDI									
Baseline	76	14.2	(8.4)	74	13.3	(8.0)	150	13.8	(8.2)
Follow-up (3-month)	63	15.3	(11.2)	49	10.7	(8.3)	112	13.0	(9.8)
Follow-up (6-year)	4	20.25	(18.4)	10	7.2	(3.8)	14	10.9	(3.0)
SE mean %									
Baseline	65	73.1	(15.7)	65	72.4	(15.0)	130	72.8	(15.3)
Follow-up (3-month)	58	75.3	(13.7)	46	83.5	(10.8)	104	79.4	(12.3)
SOL (mins)									
Baseline	65	40.2	(0.6)	65	39.0	(0.6)	130	39.6	(0.6)
Follow-up (3-month)	46	33.0	(0.5)	58	33.0	(0.6)	104	33.0	(0.6)
WASO (mins)									
Baseline	65	93.6	(1.1)	65	99.6	(1.1)	130	96.6	(1.1)
Follow-up (3-month)	46	86.4	(1.0)	58	45.6	(0.6)	104	66.0	(0.8)

Note. These findings from the parent study (Swift et al., 2012) are for all participants at baseline ($n = 150$), with three-month follow-up ($n = 112$) and six-year follow-up data for the current sample ($n = 14$). BDI, Beck Depression Inventory; ISI, Insomnia Severity Index; SE, Sleep Efficiency; SOL, Sleep-Onset Latency; WASO, Wake time After Sleep Onset.

to read and consider the information provided, after which the researcher made contact with each person by telephone to answer any additional questions. When participants confirmed that they would like to take part, an appointment was scheduled with the researcher to obtain consent and to complete the individual interview.

Instruments and Measures

Methodology

Qualitative interviews were used to investigate participants' experiences since attending the workshop. The average interview time was approximately 40 min (range 23–70 min) using a semistructured interview schedule (Appendix, see supplemental material). Interviews covered three main topics: (a) current experience of insomnia and changes over six years; (b) opinions on the techniques and information provided in the workshop and experiences of the workshop as a whole; and (c) the perceived impact of the workshop on their lives. Several prompts were included in the interview guide to pursue responses and to assist the recall of retrospective information. The interview schedule was used flexibly and efforts were made to address any questions that were unclear to participants. All interviews were conducted by one researcher (GB). Safety issues were addressed by familiarization with the university lone working policy, with telephone contact being made

with the other members of the research team before and after each meeting. Each interview was digitally recorded and then transcribed verbatim. Key impressions about the interview were systematically recorded to facilitate analysis and place the transcripts in context.

Additionally, two outcome measures were administered to provide descriptive changes in sleep and mood since the last three month follow-up: the Insomnia Severity Index (ISI; Bastien, Vallières, & Morin, 2001) and the Beck Depression Inventory (BDI; Beck & Beamesderfer, 1974).

Qualitative data analysis

All interviews were analyzed using the principles of framework analysis (Ritchie & Spencer, 1994) applied with the support of qualitative software (QSR NVivo 10). There were five key stages of analysis (Srivastava & Thomson, 2009):

1. Familiarization with the data

The first stage of analysis was concerned with gaining a sense of whole interviews prior to identifying recurring themes. During this stage, all interviews were transcribed by one researcher (GB) and emergent themes in the data were noted, with specific phrases or words being selected to form categories for stage 2. At this early stage, coding was completed using a paper-and-pen format. Contextual and reflective notes were written in the margins to record impressions made during the interviews.

2. Developing a thematic framework

The recurring themes identified in stage 1 were added to a set of framework matrices, applied with the support of NVivo 10. At this stage, there were five main themes based upon the a priori questions: (a) current status of insomnia and changes over time; (b) reasons for attending the workshop; (c) practical information and techniques; (d) emotional and cognitive changes; (e) the group experience; with several subthemes forming the draft framework. During this stage, regular discussions took place between the research worker (GB) and members of the research team (VL and JB) to (a) ensure that alternative viewpoints had been considered, (b) compare the labels applied to the transcripts, and (c) agree upon a set of codes to form the working analytical framework.

3. Indexing or coding the data

The working analytic framework was applied by indexing subsequent transcripts using existing categories and codes from the draft framework in stage 2. Transcripts were imported into NVivo and each transcript was read line-by-line, with data being indexed by coding the themes from the draft framework. Each code was assigned an abbreviation for easy identification. This initial framework was then adjusted to ensure that data fitted in only one theme and accurately reflected the research questions. At this stage, one theme that was considered as overlapping with existing themes was removed (reasons for attending the workshop).

4. Charting the emerging themes into matrixes

At this stage, a spreadsheet was constructed to generate a matrix and data were charted into the matrix. This involved summarizing the material by category from each transcript.

Summaries were linked back to full texts in the transcript by attaching sections of data to a reference or “node,” including where to locate it in the transcript. At this stage, regular meetings between GB and VL were scheduled to ensure consistency of data analysis and familiarity with the analytical framework. On average, this stage took half a day per hour-long transcript.

5. Synthesizing data to conceptualize thematic categories

This stage allowed for final comparison and refinement of themes and subthemes, checking against original transcripts to identify characteristics of the data, generate typologies and theoretical concepts (both prior concepts and those emerging from the data), and map connections between categories to explore relationships. During this final stage, interpretations of the data and their corresponding thematic categories were discussed regularly within the research team to allow alternative viewpoints and interpretations to be considered.

RESULTS

Participant Demographics

Fourteen people responded and all agreed to take part in the study. This represented 12.5% of the 112 participants at three-month follow-up. Participant ages ranged from 40 to 85 years, with a mean age of 63.6 years ($SD = 12.8$). Demographic data for the current sample ($n = 14$) and those who were unavailable at six years ($n = 98$) are provided in [Table 2](#).

Qualitative Results

Our sample size was determined by the number of individuals who both indicated interest and confirmed that they would like to take part. That said, differences in opinion were purposefully sought and no new themes had emerged after coding the 10th interview. Following a rigorous coding protocol, a number of themes were generated, capturing participants’ descriptions of their sleep and changes over six years, their memories of information and techniques provided in the workshop, and their experiences of the workshop as a whole. As all participants were largely asked the same open-ended questions, we cite where relevant the number of participants to whom a particular theme applied. This gives an indication of the prevalence of themes; however, it should be noted that our analysis also examined their perceived importance and explanatory power. [Table 3](#) provides a summary of the main themes and subthemes. Supporting quotes are provided throughout the text.

Changes in sleep over time

Participants clearly stated that several significant life events, unrelated to the workshop, had influenced the course of their insomnia symptoms over the past six years. These were seen to have had either a positive or negative effect.

Bereavement and illness. Participants made clear attributions when discussing their experience of insomnia following the workshop. There were several references to bereavement and family illness, with over two thirds (9/14) of participants reporting to have lost a relative or

TABLE 2
Demographic Data for the Sample ($n = 14$) and Nonparticipants ($n = 98$)

Variable	Participants ($n = 14$)		Nonparticipants ($n = 98$)	
<i>Demographics</i>				
Age (years, <i>SD</i>)	63.6	(12.8)	64.8	(15.1)
<i>Gender (N, %)</i>				
Male	1	(7.1)	32	(65.4)
Female	13	(92.9)	66	(34.6)
<i>Ethnicity (N, %)</i>				
White or White British	12	(85.7)	83	(84.7)
Other	2	(14.3)	15	(15.3)
<i>Employment status (N, %)</i>				
Employed full/part-time	5	(35.7)	49	(50.0)
Retired	7	(50.0)	39	(39.8)
Unemployed	0	(0.0)	3	(3.1)
Other	2	(14.3)	7	(7.1)
<i>Civil status (N, %)</i>				
Single	4	(28.6)	21	(21.4)
Married/cohabiting	6	(42.8)	50	(51.0)
Separated/widowed	4	(28.6)	27	(27.6)

Note. All data is frequency, with the exception of mean age.

partner in the six years since attending the workshop. A common theme among these individuals was that worsening sleep problems were associated with grief and reduced coping ability.

This year particularly has been difficult, because my father died very suddenly . . . of course, my sleeping then went completely to pot. – *Participant 13 (Female, 59 years)*

Additionally, three participants described having to care for a parent with a neurodegenerative illness, such as dementia. This was linked by many to feelings of increased stress and worry, which affected their sleep.

I looked after my mum and dad. Mum had dementia and then dad got physically ill. . . . I decided that I would look after her . . . it all got a bit traumatic. – *Participant 6 (Female, 57 years)*

Work-related stress and the impact of retirement. Retirement was cited as a significant contributor to changes in sleep over time. Four of the seven retired participants had made the transition from full or part-time work to retirement status in the last six years. All of these individuals drew associations between this milestone and feelings of reduced worry about insufficient sleep, which they attributed to starting the day later and having more time to catch up on sleep, for example, by daytime napping.

Before I would kind of get up at four thirty in disgust and struggle through the whole day. Whereas now . . . it's partly the workshop, but it's also partly that I don't have to start the day at six thirty. – *Participant 8 (Female, 66 years)*

Conversely, the majority of those in full or part-time employment (4/5) discussed the effect of their sleep difficulties on daytime fatigue and subsequent functioning.

TABLE 3
Summary of Main Themes and Associated Subthemes

<i>Key themes</i>	<i>Subtheme 1</i>	<i>Subtheme 2</i>
Changes in sleep over time	Factors unrelated to the workshop: life events	Bereavement and illness Work-related stress and the impact of retirement Hormonal changes Sleep hygiene
Practical information and techniques	Valued practical strategies Consolidating knowledge Barriers to implementation and adherence	Stimulus control: “associating bed with sleepfulness” Sleep restriction: “pushing back sleep” Reinforcing “common sense” Practical constraints Side effects “It didn’t apply to me” The workshop promoting self-help
Cognitive and emotional changes	Taking control Feelings about sleep	Increased acceptance: “It’s just how I am” Reduced worry: “It’s not the end of the world” Nighttime waking: “Using the time” Time as a healer
The group experience	Group dynamics	Learning from others Group members dominating Social comparisons Equivalent experiences: feeling “less alone” Positive effects of social comparisons: “My problems aren’t that bad”

We’re expected and required to show up to work and to do things. We can’t have a little lie down in the afternoon just because we’re feeling a bit tired; but wouldn’t it be nice if we could! – *Participant 12 (Female, 54 years)*

Hormonal changes. For some female participants (5/13), menopausal symptoms, such as hot flushes and night sweats, were often linked to fluctuations in sleep and were seen as the “cause” of their sleep difficulties. Three women had experienced the menopause after attending the workshop and made a connection between hormonal changes and insomnia symptoms, which they attributed to worsening sleep over the last six years.

Before, it was grief, but now, it’s not grief it’s the menopause . . . so although it’s the same, it’s for different reasons. Maybe if I didn’t have the menopause, it would be better. – *Participant 9 (Female, 54 years)*

Practical information and techniques

Participants spoke at length when asked about the information and techniques that they had acquired in the workshop to help them cope with their insomnia. Discussions reflected the range of practical strategies that participants had found useful over the long term, and also highlighted perceived barriers to engagement and adherence.

Valued practical strategies. The majority of participants (12/14) found specific behavioral techniques, such as sleep restriction and stimulus control methods, very effective for improving sleep quality. The strategies that were most salient were calculating a sleep window, getting out of bed during nighttime awakenings, and removing electronic devices from the bedroom.

Leave the room if you can't sleep, go downstairs, but don't be warm . . . because then you get cold and you go back to bed quicker than you would have done. That was a good one for me anyway. – *Participant 6 (Female, 57 years)*

Of the 12 individuals who found these practical strategies useful, 10 concluded that being provided with basic information around sleep hygiene had allowed them to consider the impact of the environment on their sleep, leading them to make positive changes. This included avoiding caffeine and alcohol before bed, taking up exercise, and avoiding bright lights.

I got blocking curtains for the bedroom and it made a huge difference. You have to have darkness to go to sleep and I hadn't realized the importance. – *Participant 8 (Female, 66 years)*

Some participants (3/14) commented on the utility of using a sleep diary to record daily fluctuations in sleep. For these individuals, tracking their sleep had led to a greater sense of control and increased feelings of relaxation. Two participants described these changes in the context of learning new information about their own sleep patterns:

It was helpful, because when I kept the sleep diary, I realized that I was actually getting more sleep than I thought I was; and I think that just relaxed me a bit. – *Participant 7 (Female, 70 years)*

Consolidating knowledge. As well as finding new, practical strategies useful, participants described what they viewed as the more basic or simple information provided in the workshop that they already knew, with particular references made to sleep hygiene advice.

The bit about electronics and TV in the room . . . of course, I already know—but it wasn't unhelpful, it's just a reinforcement and a reminder. – *Participant 3 (Female, 40 years)*

Many participants referred to the educational components of the workshop as “common sense,” which, on the whole, was expressed in the context of positive attitudes toward the workshop.

Since then, they've all been talking about exactly what I was told in the workshop. You know, it's not rocket science, it's all there, everybody says it. – *Participant 6 (Female, 62 years)*

Participants commonly reported that hearing this information within the context of a formal treatment setting had consolidated or reinforced prior knowledge. In turn, this had encouraged them to put specific behaviors into practice, such as winding down before bed, buying a black-out blind or a new mattress, and keeping the room at a suitable temperature.

There were things that I read before, but it consolidated it. I tried to cut out lights and things like that from my room. But only when I came to the workshop did I really think about it in such a way that made me actually do the things. – *Participant 13 (Female, 59 years)*

Barriers to implementation and adherence

Despite participants finding much of the information and techniques useful, there were several factors associated with poor adherence to the taught strategies. These included practical

barriers, side effects, and general feelings around the application of the workshop material to their own problems.

Practical constraints. This theme captured the practical experience of implementing specific behavioral techniques, specifically, sleep restriction and stimulus control methods. The majority of those who had attempted these strategies (8/12) reflected on practical barriers to adherence. A common topic was the impact of room temperature when getting out of bed, a strategy associated with stimulus control. While two participants reported to have continued with the technique despite finding it difficult, four expressed reluctance to attempt the strategy, with particular references made to the impact of the winter months and being “forced” to go into a cold room, which many were unwilling to do.

I found that difficult. The workshop was in the winter and it’s cold getting up at night and I didn’t want to get up, so I tended to just stay where I was. – *Participant 11 (Female, 51 years)*

Side effects. Eight participants talked about both the actual and imagined impact of sleep restriction techniques. Reasons for unwillingness to try or continue with sleep restriction and stimulus control methods included daytime fatigue, boredom during extra hours of wakefulness, and perceived ability to cope with these side effects, attributed by some to their lack of motivation and self-discipline.

I’m not disciplined enough to not listen to the radio. I’m not disciplined enough to do that exercise of going to bed at one and then waking at five . . . to hell with that! *Participant 8 (Female, 66 years)*

The impact of sleep restriction on daytime functioning was frequently cited as a reason for discontinuation. The fear of increased daytime fatigue, particularly for those in full-time work, was viewed by three participants as a significant barrier to implementation.

I would normally go to bed at nine . . . and this was quarter-to-twelve, I did notice the following day . . . I didn’t feel as though I’d had my fair share of sleep, you know?– *Participant 3 (Female, 40 years)*

“It didn’t apply to me.” For two participants, the information and strategies provided in the workshop were considered to be unsuitable for their individual problem, leading to a general reluctance to implement the techniques from the outset. This was often associated with the type of sleep problem participants presented with at the time: difficulties with sleep initiation versus sleep maintenance.

I think little things like that, about forming habits before you go to sleep, were mostly for people who couldn’t get to sleep . . . it didn’t seem to make an awful lot of difference to my problem. – *Participant 4 (Female, 74 years)*

These participants also reflected on the severity of their own sleep problem and how this impacted on their perceived needs.

I found that it didn’t, err, attract people with bad insomnia, like me, it was just for people perhaps, you know, who couldn’t sleep occasionally, or something. – *Participant 14 (Male, 85 years)*

Cognitive and emotional changes

All 14 participants described modifications to how they perceived their present sleep. These were (a) regained control, (b) “using the time” during night time waking, (c) increased acceptance and reduced worry about sleep and, more generally, (d) reflecting on the passage of time.

Taking control. Six participants described experiencing an increased sense of control. While many reported that their sleep problems were ongoing, these individuals felt that they had been equipped with the tools to manage them more effectively. Five participants made connections between regaining control and taking responsibility for their own sleep, which was commonly linked to putting specific behaviors or techniques into practice.

It won't necessarily remove the sleep problem completely, but it gives me the opportunity to kind of take control of it in some way and just to be able to manage it as best I can. – *Participant 11 (Female, 51 years)*

Additionally, participants reflected on the role of the workshop facilitators, who were commonly viewed as providing guidance and encouraging participants to be more confident in applying the practical techniques beyond the workshop.

You gave us guidelines and pointed out things, gave us pointers, you know, like direction, well, it was there for us to take or not really, you know? – *Participant 2 (Female, 55 years)*

Feelings about sleep

Increased acceptance. Alongside these feelings of regained control, nine participants described experiencing increased acceptance. Even for those who described their sleep as being worse than it had been prior to the workshop, these individuals appeared to have shifted from a self-blaming or self-stigmatizing attitude to an outlook that recognized and accepted the impact of internal and external factors.

I know now that there are good days and bad days and that it will probably never end, but then, you know, eight hours is a mythical number—it doesn't mean that that's what everyone needs. – *Participant 11 (Female, 51 years)*

Reduced worry. One of the most dominant themes emerging from discussions was a sense of reduced anxiety and preoccupation about sleep. Participants reflected on the factors associated with this change, which included external influences such as retirement and fewer overall responsibilities. For others, the topic of worry was discussed in the context of increased acceptance, with the “it's just the way I am” phenomenon being explicitly linked to reduced worry about sleep.

I don't think there's anything wrong with me, it's just me, I know I've got a very active mind, with lots going on . . . it's knowing that, I think, has relaxed me and made me think, yeah, that's just how life is. – *Participant 12 (Female, 54 years)*

Some individuals (4/14) expressed how reduced worry had, essentially, led to significant improvements in their sleep overall, which many attributed to not lying in bed at night and thinking over their problems.

I remember feeling hopeful and more relaxed about going to bed and not worrying about sleeping. – *Participant 7 (Female, 70 years)*

Nighttime waking. Several participants had experienced a positive shift in the way in which they viewed problems of sleep maintenance. Middle-of-the-night and early-morning awakenings were described by six participants as “alone time” or a period to be productive, allowing for a more restful day. For all of these individuals, this had continued over the six years and appeared to facilitate both increased acceptance and reduced preoccupation or worry about continued sleep maintenance difficulties.

I get up and do ironing and things now . . . I might as well use the time that I’m lying here . . . use it productively and get up and do something. – *Participant 13 (Female, 59 years)*

Time as a healer. Despite participants attributing various external events to the severity and course of insomnia, for many, the natural passage of time was acknowledged as an important factor in fluctuating sleep patterns over the six years. Four participants described that being able to reflect on their experiences over the last six years had allowed them to gain a more philosophical view of their own sleep problem. This appeared to be associated with an increased level of acceptance, consequently relieving some of the worry and concern about lack of sleep.

Like everything in life, things change anyway; it’s not going to stay the same forever. And I think people, when they have insomnia, they think it’s just going to remain like that and they’re never ever going to get sleep again, but of course, they do—eventually. – *Participant 9 (Female, 54 years)*

The group experience

All 14 individuals discussed the role of the group environment in modifying their approach to sleep and, for many, the value of being part of a larger group was often the most salient memory of their experience. As well as enjoying the collective aspect of the workshop, the majority of participants felt that they had gained valuable knowledge and insight from talking and listening to others experiencing sleep difficulties.

Group dynamics

Learning from others. For the majority of participants (11/14), the concept of mutual learning and support was very important. This seemed to enable them to use the experiences of others to learn new information and skills beyond the content of the workshop.

I knew I wasn’t the only insomniac, but the other people told me the tricks they used to go to sleep and so that helped, you know? People all have different methods of nodding off. – *Participant 8 (Female, 66 years)*

Interestingly, a common theme arose from discussions with two participants who identified as having sleep maintenance problems. These individuals reflected on the utility of meeting others who also experienced middle-of-the-night and early awakenings, reporting that hearing methods from people with similar sleep difficulties had been particularly helpful for their own problem.

There were just one or two people who had the same problem as me ... I have never come across anyone that had the same problem before ... that's what I gained from it mostly. – *Participant 4 (Female, 74 years)*

Group members dominating. Despite the majority of participants taking a positive view of the workshop format, some others were more critical. Those who readily acknowledged being naturally shy or private people (5/14) discussed their experiences of group dynamics in relation to others whom they perceived as more assertive.

There are always some who seek the attention... I'm very aware of the need not to take up too much space, you know? I think we need to share that a bit. – *Participant 7 (Female, 70 years)*

These participants also felt that these individuals tended to dominate group discussions.

It was quite a big group and, er, there are always one or two people who dominate, and I found that irritating, but that always happens in groups, doesn't it? People who just talk and talk and talk about themselves. – *Participant 5 (Female, 79 years)*

Nonetheless, the overall consensus was that this had not impacted on their experiences of the workshop as a whole, and the positive aspects of the group environment appeared to outweigh this element.

Social comparisons

Hearing about other people's sleep problems during group discussions led many participants (13/14) to reflect on the nature and severity of their own sleep difficulties. These social comparisons took two main forms: equivalent experiences and positive effects of social comparisons.

Equivalent experiences. Many participants (9/14) reflected on their experiences of hearing from others who they considered to have similar problems to their own. This had resulted in them forming sideways comparisons with other attendees, with frequent references made to feeling less lonely or isolated. Many participants described feeling a sense of relief after the workshop, which appeared to be associated with normalizing their own experiences and reducing self-stigmatisation regarding their symptoms.

It was just ... being amongst, I can't say like-minded people, but people in the same situation, and just thinking that you're not a freak ... that actually, there are other people out there. – *Participant 12 (Female, 54 years)*

Positive effects of social comparisons. Hearing about others' sleep difficulties appeared to play a key role in the formation of downward social comparisons, that is, participants comparing themselves with others whose insomnia they perceived to be worse than their own. For many people (9/14), making these comparisons had helped them to form new perspectives about their own sleep difficulties, and was consequently linked to the development of a specific attitudinal change of feeling their own situation was not so bad:

I thought I had problems ... these poor souls. It put into perspective, you know? That your life isn't as bad as, say A, B or C over there. – *Participant 2 (Female, 55 years)*

CONCLUSIONS

The main objective of this study was to explore, using qualitative methods, participants' experiences of attending a CBT intervention for insomnia, delivered in workshop format. Specifically, we aimed to investigate the factors that individuals associated with changes in insomnia symptoms over time and the perceived impact of the workshop on their lives. The participants interviewed were taken from a sample of individuals who took part in a randomized controlled trial six years previously (Swift et al., 2012), which demonstrated that a CBT workshop is a clinically effective intervention for people who had not previously sought formal help for their sleep difficulties. The current findings enhance the clinical applications of the original study by identifying what aspects of the workshop were most useful and memorable for participants in the long term. To our knowledge, this is the first study to have explored participants' experiences of a CBT-I intervention after a period of six years. Much can be learned from these qualitative findings, which can be used to optimize future interventions and guide clinical practice.

The Course of Insomnia

The influence of life events and the wider social context featured heavily in interviews, indicating that general, nonworkshop-specific factors affect the course of insomnia over time. The majority of individuals who had retired since the workshop reported notable, positive shifts in their perceptions about sleep, including increased control and reduced worry, which supports existing accounts (Marquiae, Folkard, Ansiau, & Tucker, 2012). Yet several individuals identified that significant life events, including caregiving and bereavement, had led to worsening insomnia symptoms over time, which suggests that baseline insomnia severity is not the only variable determining the course of insomnia over time. This has several practical implications for clinical practice. Firstly, general practitioners should consider the role of the wider social context when patients consult about sleep problems. This will be particularly important for diagnosis and when selecting the most appropriate treatments for sleep problems in primary care. The findings also raise important questions regarding how common biopsychosocial changes such as fluctuating work-stress, menopausal symptoms, or bereavement can be integrated into a CBT-I workshop or similar intervention within the stepped-care framework. Incorporating relapse prevention techniques (a common component of CBT-I) into large-scale interventions could be particularly useful for enhancing long-term treatment outcomes for these subgroups.

Practical Information and Techniques

Participants regarded sleep hygiene advice to be one of the most salient and useful aspects of the workshop, which mirrors existing descriptions of patient treatment preferences (Andrews et al., 2013). Research has shown that sleep education may function as a first-line intervention in a stepped-care model for individuals who want to improve their sleep, but are unlikely to reach threshold for, or seek, more substantial clinical treatment (Irish, Kline, Gunn, Buysse, & Hall, 2015; Morin, LeBlanc, et al., 2006; Stinson et al., 2006). In the last few years, CBT has become an important treatment option within mental health care services, including the Improving Access to Psychological Therapies (IAPT) initiative in the UK. However, there are relatively limited numbers of stepped-care services offering specific provisions for the treatment and

management of insomnia. The current findings complement existing outcome studies, which show that CBT-I in workshop format is an accessible, economical, and clinically effective approach (Bonin, Beecham, Swift, Raikundalia, & Brown, 2014; Swift et al., 2012) when delivered as part of the original stepped-care model (Espie, 2009).

Barriers to Implementation and Adherence

Participants frequently associated their reluctance to adopt strategies with actual or perceived adjustment issues, such as daytime fatigue and work commitments. Links were drawn between these barriers and early termination of behavioral strategies, as well as general unwillingness to put certain techniques, such as stimulus control, into practice. These findings support existing exploratory accounts of CBT-I strategies (Kyle et al., 2011). In terms of the possible psychological mechanisms underlying these differences, research has demonstrated links between adherence to behavioral strategies and cognitive factors, such as dysfunctional attitudes and self-efficacy. Participants' beliefs about their capacity to execute taught strategies has been found to predict adherence to behavioral techniques such as sleep restriction and stimulus control (Cvengros, Crawford, Manber, & Ong, 2015; Eidelman et al., 2016; Hebert, Vincent, Lewycky, & Walsh, 2010; Ruitter-Petrov, Lichstein, Huisingh, & Bradley, 2014). These considerations are very important for future research and clinical practice, given that adherence to CBT-I methods is a key predictor of posttreatment sleep outcomes (Vincent & Hameed, 2003). Taken together with existing research, our findings highlight the value of robust referral and screening practices in stepped-care services. Individuals who report low self-efficacy from the outset may need more direct clinical support if offered lower intensity treatments. Moreover, identifying the barriers that affect implementation of taught strategies poses the question of how vital, evidence-based treatments, such as stimulus control and sleep restriction, may be taught or explained more effectively to patients. For those who express a preference for brief psychological interventions, such as a workshop, developing methods to increase engagement and adherence may include discussions around anticipated side effects, practical barriers, and use of motivational strategies to help overcome these challenges following the workshop. Utilizing the experiences of individuals who have previously attended a workshop, for example by inviting ex-participants to facilitate these discussions, could be particularly powerful for increasing patient engagement with, and adherence to, taught CBT-I strategies.

The Group Experience

Participant's views about the workshop format reflected the multiple factors previously associated with social experiences of group CBT interventions (Cramer et al., 2011; Simmonds et al., 2013). Similar to the results presented in an earlier phenomenological study (Balabanovic et al., 2013), participants consistently linked social comparisons with others to more positive views about their own sleep. Subthemes also highlighted the complexity of group dynamics. For some individuals, being shy or introverted led to detachment from the group, which mirrors previous investigations into the study of group phenomena (Bion, 2013). Studying the group dynamic will be vital for evaluating large-scale interventions such as a workshop. Although learning from others and sharing ideas appear to be particularly salient and useful aspects of CBT-I in workshop format, inevitably, a large-scale treatment approach will not appeal to every patient. The current findings highlight the

importance of patient preference when offering a psychological treatment for insomnia. In developing the format and content of existing workshops delivered in stepped-care services, the addition of small-group discussions or paired exercises may be particularly useful for more reserved patients who are at risk of becoming lost in larger group discussions.

Important methodological limitations must be considered. Firstly, the current study used self-selected and snowball sampling techniques. It is possible that using this recruitment strategy could have resulted in selection bias; that is, for those who made contact and agreed to take part, memories and experiences of the workshop were more salient. Moreover, individuals in the current sample may have experienced some benefit of the intervention, thus demonstrating greater motivation to participate in the follow-up study.

Secondly, the sample size was small and the majority of participants were female. Thus, the findings may not represent the experiences and attributions of other participants in the original trial. Future research using larger samples is now needed to examine the clinical effectiveness and generalizability of this approach in the long-term. Incorporating qualitative methods into clinical trials would also be useful and could be used to complement traditional outcome studies of CBT-I.

Lastly, it should be acknowledged that during the face-to-face interviews, participants may have felt obliged to describe their experiences of the workshop more favorably. However, this was accounted for in two ways: firstly, the research worker carrying out the interviews had no previous involvement with the original trial. Secondly, during the design of the interview schedule, every attempt was made to ensure that questions were as open and nondirective as possible. Participants were also informed that the main aim of the research was to explore their experiences and beliefs. Participants were open to discussing both positive and negative experiences, which was taken as an indication of low demand characteristics.

By employing a qualitative framework, the research presented here provides a rich account of the lived experiences of participants who have undertaken a one-day CBT workshop for sleep difficulties. The findings expand existing research examining this large-scale approach and may be used to guide the development and implementation of similar programs in the future. There is increasing emphasis on the utility of hybrid models and implementation research to provide more holistic accounts of patient experience. The current study highlights the value of incorporating outcome and process data to provide valuable insight into the effect of an intervention and the mechanisms through which improvements are achieved. Complementing traditional outcome studies with qualitative methodologies in this way can inform the development of accessible, evidence-based treatments for members of the general public experiencing insomnia symptoms.

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SUPPLEMENTAL MATERIAL

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