Correction: Effects of E-aid cognitive behavioral therapy for insomnia (eCBTI) to prevent the transition from episodic insomnia to persistent insomnia: study protocol for a randomized controlled trial


This article was previously published with errors. The corrections are listed below:

1. Throughout the article, all ‘episodic insomnia’ should be read as ‘acute insomnia’, and all ‘persistent insomnia’ as ‘chronic insomnia’.

2. Below is the updated ‘methods and analysis’ section in the ‘Abstract’:

   This is a pragmatic two-arm multicentre, randomised controlled trial comparing eCBTI with treatment as usual (TAU) in outpatients. Two hundred patients with acute insomnia (as defined by DSM-5) will be recruited. Participants will be randomly assigned to receive 1 week eCBTI via a smartphone application, or to receive TAU. Treatment effects will be assessed at 1 week and 3 months after intervention. The primary outcome of the study is the incidence of chronic insomnia. Secondary outcome measurements include the Insomnia Severity Index, Dysfunctional Beliefs and Attitudes about Sleep Scale, Pre-sleep Arousal Scale and Epworth Sleepiness Scale. Additionally, the Hospital Anxiety and Depression Scale and the Short-Form 12-Item Health Survey will be used for measurement of mood symptoms and quality of life.

3. Below is the updated second paragraph of ‘Insomnia disorder’ section under ‘Background’:

   Based on the course of illness, insomnia is classified as ‘chronic insomnia’ (lasting 3 months or longer) or ‘acute insomnia’ (lasting less than 3 months). It is worth mentioning that acute insomnia is a common social phenomenon, and most people would have experienced it, especially in response to situational stress or rapid changes in the circadian rhythm. Acute insomnia is often considered as a normal biopsychological response with no significant impairment; acute insomnia attracts less research attention than chronic insomnia. Few longitudinal studies have investigated the natural course of insomnia. In the only two prospective studies conducted by Ellis et al specifically focusing on acute insomnia, the annual prevalence of acute insomnia was reported to be 36% and about 40% of the patients with acute insomnia eventually developed chronic insomnia. These two studies showed a high prevalence of acute insomnia and a high susceptibility of developing long-term insomnia in those with acute insomnia, which indicated that acute insomnia could be a key transitional stage in the course of chronic insomnia. The findings suggested a need for developing timely, active intervention to prevent the conversion of acute insomnia into chronic insomnia.

4. Under ‘the current study’ section, the second sentence is ‘Moreover, we aim to investigate whether this programme can improve insomnia symptoms, sleep-related symptoms, anxiety, depression and quality of life in individuals with acute insomnia’.

5. Under ‘the current study’ section, the first point of ‘The secondary hypotheses’ is ‘The eCBTI intervention can improve insomnia symptoms and sleep-related symptoms in patients with acute insomnia’.

6. The updated ‘Primary outcome measures’ section under the ‘Outcome measures’ in ‘Methods/design’ is below:

   Incidence of chronic insomnia: the diagnosis of chronic insomnia according to DSM-5 was determined at week 12.

7. The updated ‘Secondary outcome measures’ section under the ‘Outcome measures’ in ‘Methods/design’ is below:

   The change in insomnia symptoms will be measured by the Insomnia Severity Index (ISI), which assesses the severity, nature and impact of insomnia. The Ford Insomnia Response to Stress Test, was used to identify sleep disturbance and predisposition to chronic insomnia. The subjects’ general sleep hygiene and practices will be measured with the Sleep Hygiene and Practices Scale. The Dysfunctional Beliefs and Attitudes about Sleep Scale will be used to measure sleep-related beliefs, potential treatments, expectations and attitudes towards causes. Problems of sleep initiation will be assessed with the Pre-Sleep Arousal Scale. We will also assess the patient’s daytime sleepiness using Epworth sleepiness scale (Chen et al), the generic health outcomes from the patient’s perspective using the Short Form 12-Item Health Survey, and anxiety and depression levels using the Hospital Anxiety and Depression Scale. Participants in the treatment group will be also...
asked to complete a self-reported questionnaire to assess their treatment adherence and perceived helpfulness using the Treatment Adherence Scale.39

8. Below is the updated ‘Statistical analysis’ section in the ‘Methods/design’:

Intention to treat (ITT) 41 will be used for the main efficacy analysis and per protocol (PP) for the consistency test. The ITT group consists of all randomised participants regardless of adherence to treatment assignment. Per protocol group refers to all ITT participants who completed the eCBTI programme and assessments at baseline, week 2, and week 12. In the ITT analysis, the last observation carried forward method will be used to analyse any missing therapeutic data. Mean with SD for continuous variables, and frequency with a percentage for categorical variables will be reported. Independent t-test and non-parametrical analyses, where appropriate, will be applied to compare the differences between the two groups. Repeated measurement analysis will be used to compare the changes of symptoms (e.g., ISI Score) following treatment and at 3 months follow-up. Chi Square test was used to compare the incidence of chronic insomnia at week 12 between two groups. Statistical analyses will be conducted using SPSS analytics software V.22.0. Alpha will be set at 0.05 for all tests (two-sided).

9. A new reference has been added below and it is cited in the updated ‘Secondary outcome measures’ section under the ‘Methods/design’.


10. Author to provide updated figure 1.

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![Image: STID research flowchart](http://bmjopen.bmj.com/)