ABSTRACT

Introduction Insomnia has a remarkably negative effect on the work, quality of life and psychosomatic health of individuals, and imposes a substantial economic burden on society. Mindfulness-based interventions (MBIs) have proven beneficial in the treatment of insomnia. However, the effect of mobile or online-based (mHealth) MBIs requires further verification. This study will evaluate the effectiveness of an mHealth MBI, ‘Mindful Living with Insomnia’ (MLWI), relative to that of mHealth cognitive behavioural therapy for insomnia (CBT-I).

Methods and analysis The study is an mHealth, randomised controlled trial. Two hundred and fifty participants will be allocated randomly and equally to either the MLWI or CBT-I group. The intervention will involve 12 sessions over a 6-week course, with 2, 30 min sessions per week. The primary outcomes are sleep quality, severity of insomnia symptoms and sleep activity, according to the Pittsburgh Sleep Quality Index, Insomnia Severity Index and sleep tracker Mi Smart Band, respectively. The secondary outcomes are perceived stress, anxiety, depression and mindfulness. Outcomes will be evaluated at the baseline, end of the intervention period and at the 3-month follow-up. Data analyses will include covariance, regression analysis, $\chi^2$, t-test and Pearson’s correlations. Participants will be recruited from January to June 2022, or until the recruitment process is complete. The follow-up will be completed in December 2022. All trial results should be available by the end of December 2022.

Ethics and dissemination Full approval for this study has been obtained from the Ethics Committee at The Third Xiangya Hospital, Central South University, Changsha, China (21010). Study results will be disseminated via social media and peer-reviewed publications.

Trial registration number NCT04806009.

INTRODUCTION

Insomnia refers to persistent difficulty in initiating sleep, reduced sleep duration or disrupted sleep integrity or quality despite adequate sleep opportunities and environment, and can be cause of daytime functional impairment. Based on clinical manifestations, insomnia can be classified as affecting sleep onset or maintenance, or both, or neither. The latter refers to cases that do not meet the quantitative thresholds for onset or maintenance problems.

Insomnia can affect an individual’s emotional stability and ability to focus attention; can lead to interpersonal, social and career problems; and increases the risk of accidents. While insomnia causes distress in individuals, concomitantly it results in huge economic losses to society. Insomnia also increases the risk of mental and physical illness, being a common comorbidity of depression, bipolar disorder, anxiety disorder, substance abuse, and other psychiatric disorders, and diabetes, coronary heart disease and other chronic physical diseases.

Insomnia is a risk factor of oversedation, fatigue, cognitive impairment and dependence associated with pharmacotherapy. Thus, non-pharmacological therapies have attracted increasing attention from clinicians. Non-drug treatments for insomnia include acupuncture and psychobehavioural, light and music therapies, and transcranial
magnetic stimulation and electrical stimulation. Among the latter stimulation techniques, cognitive behavioural therapy for insomnia (CBT-I) is the most common. CBT-I has been shown as effective as drugs for the treatment of insomnia. Moreover, the therapeutic effects of CBT-I on insomnia in the workplace are also effective. However, implementing CBT-I requires highly trained therapists. Thus, having an effective, economical, and accessible intervention for insomnia is imperative, one that can be readily delivered by trained healthcare professionals and easily incorporated into existing healthcare systems.

Among non-pharmacological treatments, mindfulness-based interventions (MBIs) such as medication are particularly promising. MBIs are recommended by the National Center for Complementary and Integrative Health as a complementary psychological approach. The 2012 National Health Interview Survey reported that meditation among adults is very popular to supplement healthy activities, as the practice increased more than threefold from 4.1% in 2012 to 14.2% in 2017. The essence of meditation is mindfulness. Mindfulness involves focusing attention on current experience, with attention comprising thoughts, feelings and physical sensations, and practising an attitude of openness, curiosity and acceptance. MBIs are founded on the concepts of ‘being present’ and ‘not judging’ via a standardised and formalised mindfulness method. The practice of mindfulness can be formal or informal. Examples of formal mindfulness practice include sitting meditation, Tai Chi and yoga, while informal mindfulness can be applied during any daily activity such as household chores or walking. The advantage of mindfulness practice is that it can be conveniently performed at any place or time, with less dependence on therapists and venues. This has benefited the popularisation of mindfulness practices.

Numerous studies have reported the effectiveness of MBIs toward psychosomatic health, as they better sleep, reduce stress and depression, and improve well-being. A meta-analysis including 49 studies showed that MBIs are effective in treating insomnia and improving the sleep quality of healthy subjects and clinical patients. The 49 studies explored the effects of several mindfulness practices on insomnia: Mindfulness meditation significantly reduced the severity of insomnia, sleep latency, arousal level before sleep and waking times, and prolonged total sleep time; improved sleep efficiency and quality in individuals with chronic insomnia; and ameliorated insomnia in individuals with cancer, depression, anxiety and obesity.

However, studies on the application of MBIs for insomnia have been limited by focusing on secondary rather than primary insomnia; small population samples; and use of qualitative indicators rather than quantitative measurements. In addition, research on the effect of MBIs in patients with different types of insomnia is lacking. A new randomised clinical trial showed that MBIs are effective at improving subjective and objective sleep quality in older adults, but the generalisability to younger people remains undecided. Therefore, more rigorous scientific studies are needed regarding insomnia treatment through MBIs.

The development of information technologies has made possible the delivery of psychological interventions through the internet. Online interventions reduce costs and increase accessibility. The benefits of CBT-I accessed online are similar to that of in-person, group-based CBT-I, and can be successfully offered to a wide and varied range of insomnia sufferers. A real-world study also provided evidence that adjunctive digital CBT-I improved clinical outcomes and access to psychological therapy. A meta-analysis in 2016 indicated that online MBIs can improve mental health stress, depression, anxiety and well-being. Although there has been little evidence that online MBIs can improve sleep, rigorous studies using an active online-based control group, a large sample size, and both subjective and objective assessments are needed to explore their effect on insomnia.

Psychological interventions via mobile technologies (mHealth), such as smartphones, handheld tablets and other wireless devices are popular and an innovative mode of treatment delivery. In China, the WeChat app and its mini-programmes have dominated the browsing time of mobile phone users. Mobile learning using WeChat mini-programmes has become an important learning method. Considering the extreme shortage of insomnia interventions in China, or studies on the efficacy of MBIs for insomnia and online MBIs for mental health, we propose to design a population-based, widely accessible MBI via the WeChat mini-programme in China. This randomised controlled trial (RCT) will be conducted in this population to examine the effectiveness and feasibility of a 6-week MBI termed ‘mindful living with insomnia’ (MLWI) via the WeChat mini-programme, focusing on sleep and mental health. This study may provide valuable insights into bridging the huge gap between need and services received for insomnia in China.

METHODS

Patient and public involvement
Patients and the public were not involved in the development of the research question or in the design of the study. The general results (no personal data) will be disseminated on demand.

Study design
This study (figure 1) will be an mHealth, randomised, parallel-group, actively controlled trial. The trial will consist of a screening visit, a 1-week wash-out period and a 6-week intervention period. Two hundred and fifty participants will be randomised at a 1:1 ratio to either an intervention or control group. The intervention group will undergo a 6-week MBI via the WeChat mini-programme. The control group will receive a 6-week CBT-I via the WeChat mini-programme. Both groups will be given...
questionnaire surveys at three time points: 1 week before the intervention period (baseline); at the end of the respective 6-week interventions; and at the 3-month follow-up. Plans for important protocol modifications will be communicated to trial registration. Trial results will be disseminated through trial registration (ClinicalTrials.gov) or publication.

**Study objectives**

The primary study objective is to evaluate the feasibility, acceptability and efficacy of the MBI via the WeChat mini-programme for insomnia and identify the insomnia phenotype(s) that are the most responsive to it, relative to the control intervention (CBT-I via the WeChat mini-programme).

The secondary study objective is to determine the effects of the MBI via the WeChat mini-programme on stress, anxiety, depression, and mindfulness in individuals with insomnia.

**Setting**

The trial will be conducted at the Department of Clinical Psychology, The Third Xiangya Hospital of Central South University, in Changsha, China. All researchers in this project are required to have an educational background in psychiatry/psychology or information management and will be trained regarding research ethics and methods. This study is planned to begin in January 2022 and to last for approximately 1 year.

**Sample size**

Based on a previous study assessing the effects of online MBIs on sleep disturbances, a priori power analysis was conducted using G*power software. Assuming a moderate effect size (d=0.40), results indicated that analyses with 190 participants across 3 time points would yield a power of 0.8. To account for 20% attrition, we anticipated enrolling 238 participants. However, considering that online interventions often have a much higher drop-out rate than face-to-face interventions and also a high loss to follow-up, this study will have a final target sample size of 250 participants (125 participants in each arm), which will have sufficient power to detect a significant difference among the outcomes.

**Recruitment**

Participants will be recruited through advertisements posted in hospitals, universities, pharmacies and social media (ie, WeChat and internet bulletin boards) and by doctor referrals from outpatient clinics. Interested participants will be invited to attend an online screening by communicating with social media (mainly WeChat), which will be conducted by the researchers who are trained in psychiatry or psychology. Participants who fulfil the inclusion criteria will be informed about the procedures, responsibilities, benefits and possible risks of participation in the study and will be asked to sign digital informed consent forms to ensure that their participation is voluntary. Participants who enrol in this study can withdraw at any time. They will also be asked to provide contact information, and all personal information will be kept confidential on an encrypted laptop and used for research purposes only. Table 1 shows the schedule of enrolment, interventions and assessments. In addition, the researchers whose major is psychiatry or psychology will observer for severe psychological symptoms in participants by reviewing online consultation records, and will provide referral suggestions to a psychiatry clinic if necessary to ensure the safety of the participants.

**Eligibility criteria**

**Inclusion criteria**

1. Aged between 18 and 59 years old.
2. Able to read and write Chinese.
3. Obtained a Pittsburgh Sleep Quality Index (PSQI) of >5 at screening.
4. Able to access online services.
5. Willing to participate in the study.

**Exclusion criteria**

1. Unable to communicate.
2. With somatic disorders.
3. With mental disorders other than insomnia disorder.
4. Being treated with pharmacotherapy.
5. Already performing considerable mindfulness practices (>15 min/day).

**Randomisation and blinding**

Each participant who meets the eligibility criteria will be randomly assigned (in a 1:1 ratio) to either the mHealth MBI group or the mHealth CBT control group. After participants provide digital informed consent by clicking the ‘I agree to participate in this study’ button on the electronic detail page of the trial, a code will pop up on the page. By scanning this code, participants will be randomly assigned to either the intervention or active control group (in a 1:1 ratio) according to computer-generated numbers. Given that the participants will be told that they will either receive the MLWI intervention or CBT-I, their blinding will not be possible. The blinding of the researchers who are directly involved in interventions will also not be possible because of the differences in these two interventions. The following researchers will be blinded to the participants’ allocated groups until all data have been analysed: outcome assessors, statisticians, and data analysts. Before the trial, the researchers will be trained in the randomisation procedure and their individual responsibilities. The successful implementation and maintenance of the randomisation and blinding method will be validated.

**Interventions**

**Intervention group: MLWI via the WeChat mini-programme**

Participants in the intervention group will receive the MLWI intervention after installing the WeChat mini-programme. The MLWI intervention was developed by the principal investigator, a psychiatrist who has completed the programme for Training of Mindfulness Facilitation at the Mindful Awareness Research Centre at the University of California, Los Angeles. A similar face-to-face and group-based MBI has been verified as useful in helping nurses caring for people living with the HIV to manage stress and emotions, and improve their acceptance of others and attention.33

The MLWI intervention will involve 12 sessions over a 6-week course, divided into 2, 30 min sessions per week. Two new sessions of online lessons will be updated weekly during the 6 weeks. Each session will consist of a theoretical lecture, mindfulness practices, sharing common difficulties and coping strategies during mindfulness practices, and a homework assignment in the form of a video or audio recording. Embedded in the intervention will be mindfulness exercises in breathing, body scan, thoughts and emotions, meditation, movement and daily-life. In the intervention, the participants will also receive sleep hygiene education. Participants will be asked to conduct mindfulness practices for 5–20 min daily. **Table 2** summarises the content of the MLWI intervention.

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**Table 1** Schedule of enrolment, interventions, and assessments by time points ($t_i$)

| Enrolment | Allocation | Postallocation | Close-out |
|-----------|------------|----------------|-----------|
| $t_i$     | $t_b$      | $t_{a}$ | intervention period | $t_p$ | post assessment | $t_f$ | follow-up |

| Enrolment                          | Allocation | Postallocation | Close-out |
|-----------------------------------|------------|----------------|-----------|
| Eligibility screen                | X          |                |           |
| Informed consent                  | X          |                |           |
| Allocation                        |            |                |           |

| Interventions                     | Allocation | Postallocation | Close-out |
|-----------------------------------|------------|----------------|-----------|
| MBI                               | X          |                |           |
| CBT-I                             | X          |                |           |

**Assessments:**

**Primary outcome measures**

- PSQI
- ISI
- Mi Smart Band

**Secondary outcome measures**

- PSS
- GAD-7
- PHQ-9
- FFMQ

CBT-I, cognitive–behavioural therapy for insomnia; FFMQ, Five Facets Mindfulness Questionnaire; GAD-7, Generalised Anxiety Disorder Questionnaire; ISI, Insomnia Severity Index; MBI, mindfulness-based interventions; PHQ-9, Patient Health Questionnaire; PSQI, Pittsburgh Sleep Quality Index; PSS, Perceived Stress Scale.
Push notifications from the WeChat mini-programme will be sent to participants every day to remind them about their regular attendance and mindfulness practices to enhance compliance. The participants can share their experiences and challenges during the 6-week intervention and at the 3-month follow-up in a WeChat group including all participants and some researchers. The outcome assessors, statisticians, and data analysts will not be in the WeChat group. The researchers will provide feedback to participants’ questions about cognitive or behavioural regulation practices.

**Control group: CBT-I via the WeChat mini-programme**

Participants in the control group will receive CBT-I after installing the WeChat mini-programme. The CBT-I was developed by a researcher who is a psychiatrist/psychologist and has many years of experience in CBT. The aim of CBT-I is to reduce sleep-related physiologic and cognitive arousal so that restorative sleep function can be re-established.

The CBT-I will involve 12 sessions over a 6-week course divided into 2, 30 min sessions per week. Two new sessions of online lessons will be updated weekly during the 6 weeks. Each session will consist of a theoretical lecture, cognitive or behavioural regulation techniques, a discussion of common difficulties and coping strategies during mindfulness practices, and a homework assignment in the form of a video or audio recording. Participants will be asked to conduct a cognitive or behavioural regulation technique for 5–20 min daily. Table 3 summarises the content of the CBT-I.

Push notifications from the WeChat mini-programme will be sent to participants every day to remind them about their regular attendance and cognitive or behavioural regulation practices to enhance compliance. The participants can share their experiences and challenges during the 6-week intervention and at the 3-month follow-up in a WeChat group including all participants and some researchers. The outcome assessors, statisticians, and data analysts will not be in the WeChat group. The researchers will provide feedback to participants’ questions about cognitive or behavioural regulation practices.

**Table 2 Content of MLWI by session**

| Theoretical instrument | Meditation practice | Homework |
|------------------------|---------------------|----------|
| 1 Physiological and psychological response to stress | Mindful eating practice | Bringing mindfulness to daily life |
| What is mindfulness? | Mindful breathing meditation | Mindful breathing meditation |
| Mindfulness history, application and science research | Mindful breathing medication | Mindful breathing space exercise |
| 2 Brain’s mode of action and existence | Mindful body scan | Bringing mindfulness to daily life |
| Mindful breathing space exercise | Mindful body scan | Mindful breathing space exercise |
| 3 Interpretation of insomnia | Mindful forest meditation | Mindfulness clock |
| Psychological regulation of insomnia | Mindful sleep meditation | Mindfulness meditation |
| Interpretation of thoughts | Mindful walking | Mindful walking |
| Interpretation of emotions | Mindful sea meditation | Mindful listening and speaking |
| Interpretation of STOP practice | Mindful meditation | |
| 5 Avoidance response | Mindful yoga practice | Mindful yoga practice |
| Allow emotions | Tai chi practice | Tai chi practice |
| Interpretation of RAIN practice | Mindful meditation | |
| 6 How to balance our life | Mindful voices and thoughts practices | Listing nourishing/consuming activities and balancing life |
| Seven attitude of mindfulness practices | Mindful dealing with difficulties practices | How to insist on daily mindfulness practices |

MLWI, Mindful Living with Insomnia; RAIN, Recognition, Acceptance, Investigation, None Identification; STOP, Stop, Take a breath, Observe, Proceed.

**ANALYSIS MEASURES**

**Compliance**

The researchers will inform the participants about the importance of attending each MLWI/CBT-I session and completing their homework, because learning and practising mindfulness-based or CBT skills is crucial for the effect of the intervention on their insomnia. Participants...
will be provided audio-video materials related to MLWI/ CBT-I to promote their adherence to daily practice. The compliance of participants will be measured in three ways: attendance rate, training time and assignment completion. The attendance rate and training time will be automatically recorded by an online intervention platform. Assignment completion will be reported by participants via the WeChat mini-programme.

**Outcome measurements**

**Primary outcomes: sleep quality, severity of insomnia symptoms and sleep parameters**

**Pittsburgh Sleep Quality Index**

The 19-item PSQI will be used to subjectively measure sleep quality and sleep disturbances during the previous month on a 4-point Likert scale of 0 to 3. PSQI can be divided into seven components: subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of medication and daytime dysfunction. A low global PSQI score indicates good sleep quality.\(^{10}\) Cronbach’s \(\alpha\) for the Chinese version of the PSQI is 0.84.\(^{35}\)

**Insomnia Severity Index**

The seven-item Insomnia Severity Index (ISI) is used to assess the current severity of insomnia symptoms, sleep dissatisfaction, daytime effects and distress concerning difficulties with sleep on a 5-point Likert scale (0=never; 1=occasionally; 2=sometimes; 3=often; 4=always). The total scores will range from 0 to 28. The cut-offs for subthreshold, moderate and severe insomnia are 8, 15 and 22, respectively. On the ISI, response to treatment and remission are defined by a change of \(\geq 7\) points from baseline and a reduction to a score of <8, respectively.\(^{36}\) Cronbach’s \(\alpha\) for the Chinese version of the ISI is 0.81.\(^{37}\)

**Mi smart band**

The Mi Smart Band is a very popular activity-based tracker in China.\(^{38}\) Participants will be given a Mi Smart Band as a gift for attending this study. Digital biomarker data, such as sleep duration and quality and daytime activity, will be assessed using the Mi Smart Band. The insomnia of participants will be classified into the following four types based on the monitoring data of the Mi Smart Band before the start of the respective intervention: sleep onset, sleep maintenance, combined sleep onset and maintenance, or neither sleep onset nor sleep maintenance. Sleep onset insomnia is defined as sleep onset latency (SOL) \(\geq 31\) min, and total wake time after sleep onset (WASO) <31 min. Sleep maintenance insomnia is considered SOL <31 min and WASO \(\geq 31\) min. Combined onset and maintenance insomnia is SOL \(\geq 31\) min and WASO \(\geq 31\) min. Neither sleep onset nor sleep maintenance insomnia is SOL <31 min and WASO <31 min. Data for sleep parameters including total sleep time, sleep onset, sleep offset and WASO and sleep efficiency will be measured and analysed.

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**Table 3  Content of CBT-I by session**

| Theoretical instrument | Cognitive/behavioural regulation skills | Homework |
|------------------------|----------------------------------------|----------|
| **1** | What is cognitive model? | Distinguish ideas and facts | Calendar of thoughts |
| What is CBT? | Distinguish situation, thoughts, emotion, behaviour and physiological response | Calendar of event-emotion-thinking |
| **2** | Cognitive behaviour model of insomnia | Elicit, confirm automatic thinking | Drawing your cognitive model of insomnia |
| **3** | Interpretation of sleep and insomnia | Sleep hygiene education, stimulus control and sleep restriction | Automatic thinking categorisation and modification tool table |
| **4** | Interpretation of emotions | Relaxation training for sleep | Relaxation training for sleep |
| **5** | Physiological and psychological response to stress | Emotion ruler | Recording your emotions in daily life |
| Understanding depression, anxiety, anger | Imaginary exposure skill | Imaginary exposure practice |
| **6** | Identifying intermediate belief | Arrow down skill | Finding supportive or unsupportive proofs of your automatic thinking when you face challenges |
| **7** | Inspection and correction of intermediate belief | Developing new belief though Socratic questions | Recording your intermediate belief |
| **8** | Identifying core belief | Rational emotion role-play | Core beliefs worksheet |
| Developing new core belief | Shifting attention practice | How to use cognitive and behaviour skills to deal with future challenges |

CBT-I, cognitive–behavioural therapy for insomnia.
Secondary outcomes: stress, anxiety and depression

Perceived stress

The 14-item Perceived Stress Scale (PSS) is used to assess all thoughts, feelings, and stressful situations experienced during the past month on a 5-point Likert scale (0=never; 4=always). A high total score indicates high perceived stress. The Chinese version of the PSS has been well validated (Cronbach’s α=0.78), and a score ≥25 indicates severe stress.

Anxiety

Anxiety will be assessed using the Generalised Anxiety Disorder Questionnaire (GAD-7). GAD-7 comprises seven items for assessing the level of general anxiety. All items are rated on a 4-point scale (0=never; 3=always), with high total scores indicating high levels of anxiety. A cut-off score >6 indicates anxiety symptoms. The Cronbach’s α for the Chinese version of GAD-7 is 0.89.

Depression

Depression will be assessed using the Patient Health Questionnaire (PHQ-9). The PHQ-9 is used to measure depression in primary care and other medical settings. The PHQ-9 consists of 9 items, and all items are rated on a 4-point scale (0=never; 3=always), with high total scores indicating severe depression. The cut-offs for mild, moderate, moderately severe, and severe depression are 5, 10, 15 and 20, respectively. Cronbach’s α for the Chinese version of the PHQ-9 is 0.86.

Mindfulness

Level of mindfulness will be assessed using the Five Facets Mindfulness Questionnaire (FFMQ). All items are rated on a 4-point scale (0=never; 3=always), with high total scores indicating high levels of mindfulness. The FFMQ comprises 39 items which range from 1 (never or very rarely true) to 5 (very often or always true). The higher the total score, the more mindful the individual is. Cronbach’s α values for the subscales observing, describing, acting with awareness, non-judging and non-reactivity are 0.75, 0.84, 0.79, 0.66 and 0.45, respectively.

Data collection, management and monitoring

Data will be collected online by Wenjuanxing, a Chinese online market research website that provides a professional online questionnaire survey or data collection service. Data from the electronic questionnaires assessing sleep/stress/depression/anxiety/mindfulness and the Mi Smart Bands will be collected at three time points: preintervention (1 week before the first session), post-intervention (1 week after the last session) and at the 3-month follow-up. Demographics, including age, gender, education level, employment status, marital status and other information will be collected at the baseline. The questionnaires will be required to be completed within approximately 40 min. Outcome assessors will be available to answer questions for questionnaires by WeChat and Mi Wristband data will be sent to outcome assessors.

The participants’ confidentiality will be protected by storing all data in password-protected files on a designated computer and limiting access to the data to only the principal investigator and data analysts. Furthermore, once the study has been completed, all the data will be destroyed.

A data monitoring committee that is independent from the sponsor and free from competing interests will include the principal investigator, statisticians, outcome assessors and data analysts. Outcome assessors will be trained to collect good quality data, promote participant retention and complete follow-up. Data analysts will be trained on data entry, coding, security and storage. The training will be conducted by the principal investigator and statisticians.

Participants will be encouraged to report any adverse event, such as unfavourable or unintended signs or symptoms of diseases that arise during the trial. Psychiatrists in the research team will evaluate if the adverse events are associated with the intervention. If there is no association and the participants’ psychosomatic statuses are suitable for attending the intervention, they will be invited to continue participating in the study. Otherwise, the research team will recommend that the participants withdraw from this study and seek help from other healthcare providers.

Statistical analysis

All data will be collected automatically online. A user-specified Excel file will be downloaded from the database. No interim analyses will be performed. When all data have been obtained, it will be analysed using SPSS V.22.0 by the trial statistician who will be blinded to the intervention assignment. Between-group differences in numeric socio-demographic data and other measures at pretreatment will be assessed via independent t-tests and χ² tests. Variables that are significantly different between groups will be treated as covariate(s) in the analyses of treatment effects. Significant differences in multivariate analysis of variance (ANOVA) will be assessed with repeated-measures ANOVA to compare the participants’ outcomes (ie, PSQI, ISI, Mi Smart Band, PSS, GAD-7, PHQ-9 and FFMQ). All tests will be two tailed. A two-sided p<0.05 will determine statistical significance.

DISCUSSION

Insomnia has a remarkably detrimental effect on the work, quality of life and psychosomatic health of individuals and imposes a substantial economic burden on society. An estimated 33% of the general population suffer from insomnia symptoms, and 6%–10% meet the diagnostic criteria for insomnia disorder. A meta-analysis in 2017 reported an insomnia prevalence of 15% in China. Due to the large population of China, there are many individuals with insomnia. However, there are few qualified psychiatrists or psychologists, and innovative measures are needed to deliver mental health support with high efficiency.

CBT-I is the preferred non-drug therapy for the treatment of insomnia according to the American Academy of Sleep Medicine.
Mind-body movement practices including yoga and tai chi have also been investigated as treatments for insomnia. The most recent systematic review and meta-analysis on yoga for sleep quality and insomnia in women indicated that yoga did not significantly alter the severity of insomnia. Several RCTs have suggested that tai chi for sleep can improve sleep quality, particularly among older adults. However, an evaluative study showed that tai chi was less effective than CBT-I for chronic insomnia disorder.

MBIs are particularly promising non-pharmacological treatments. Mindfulness practice focuses attention on the present and allows stressful, obsessive and intrusive thoughts, beliefs and emotions to pass. Thus, mindfulness practice can change cognitive processes and behavioural patterns associated with insomnia and reduce the over- arousal of sympathetic nerves. This reduces redundancy and emotional responses and promotes an unbiased reappraisal of important experiences, resulting in better sleep. A meta-analysis in 2019 reported that MBIs are effective in treating insomnia and improving the sleep quality of healthy subjects and clinical patients. However, highly rigorous scientific research with a large sample size and objective assessment indicators is needed to explore the efficacy of MBIs for primary insomnia.

Intervention research via online resources can increase the timeliness, convenience, and interaction of intervention training, which is more in line with the particularity of psychological intervention. This study will involve use of the WeChat app and its small programmes, which have become an integral part of daily life for a vast number of users in China. Given the need of intervention, which can be delivered to more people suffering from insomnia in China, highly rigorous research on exploring the efficacy of mHealth MBI is crucial.

Considering the extreme shortage of insomnia interventions in China, or data on the efficacy of MBIs for insomnia, or online MBIs for mental health, we propose to design a population-based and widely accessible MBI via WeChat in China. This article described the design and methodology of a parallel group RCT to test differences in sleep between individuals receiving the MBI and CBT-I. This study should provide valuable insights into bridging the huge gap between need and services for insomnia interventions in China.

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