

BSS International Sleep Medicine Course 2026

15th - 18th September | Newcastle



British Sleep Society



UK Multidisciplinary Sleep Professionals



Nederlandse vereniging voor
SLAAP- EN WAAKONDERZOEK
www.nswo.nl



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Conflict of Interest Disclosures for Speakers

☒

1. I do not have any potential conflicts to disclose.

☐

2. I wish to disclose the following potential conflicts of interest:

Type of Potential Conflict	Details of Potential Conflict
Grant/Research Support	
Consultant	
Speakers' Bureaus	
Financial support	
Other	

☐

3. The material presented in this lecture has no relationship with any of these potential conflicts, **OR**

☐

4. This talk presents material that is related to one or more of these potential conflicts, and the following objective references are provided as support for this lecture:

- 1.
- 2.
- 3.

Insomnia

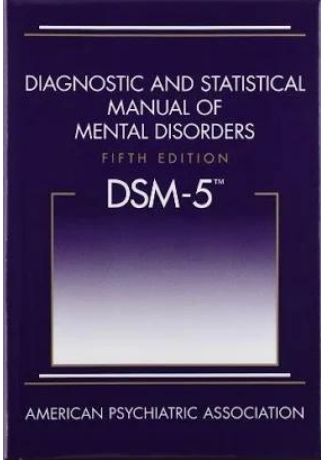
Intended Learning Outcomes

- Able to describe different approaches to defining insomnia
- The epidemiology of insomnia
- Most important aetiological models of insomnia

1 | History of Nosology of Insomnia

- Insomnia first in ICD-9 by WHO in 1975 (organic/ non-organic definition)
- Association of Sleep Disorders Centers (ASDC) (1979) with their Diagnostic Classification of Sleep and Arousal Disorders – insomnia falling with Disorders of Initiating and Maintaining Sleep (DIMS)
- American Academy of Sleep Medicine (former ASDC) narrower approach (splitting)
- APA route of primary vs secondary insomnia

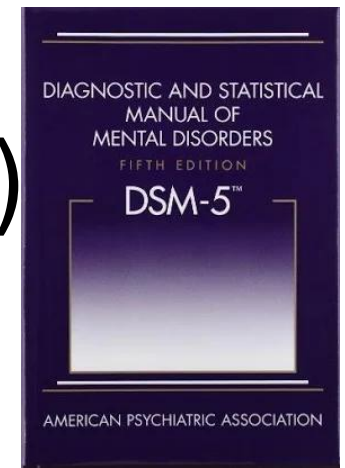
2| Current Systems | DSM-5 (APA, 2013)



- Eight criteria for **Insomnia Disorder**

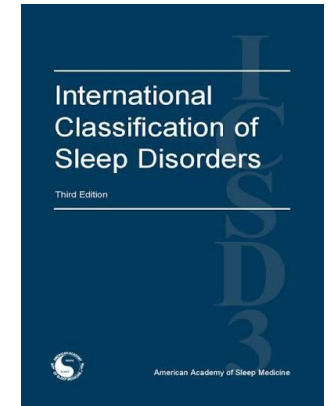
1. Dissatisfaction with sleep quantity or quality, with one or more of the following symptoms: difficulty initiating sleep, difficulty maintaining sleep, early-morning awakening
2. The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioural, or other important areas of functioning.
3. The sleep difficulty occurs at least 3 nights per week.
4. The sleep difficulty has been present for at **least 3 months**.
5. The sleep difficulty occurs despite adequate opportunity for sleep.
6. The insomnia is not better explained by, and does not occur exclusively during, another sleep-wake disorder (e.g., narcolepsy, breathing-related sleep disorder, circadian rhythm sleep-wake disorder, parasomnia).
7. The insomnia is not attributable to the physiological effects of a substance, such as a drug of abuse or medication.
8. Coexisting mental disorders and medical conditions *do not adequately explain the predominant complaint of insomnia*.

2| Current Systems | DSM-5 (APA, 2013)



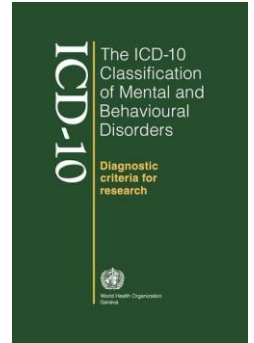
- If comorbidity present but not sufficiently explain the insomnia
It should be noted as Insomnia Disorder:
 - With other non-sleep disorder mental comorbidity
 - With other medical comorbidity
 - With other sleep disorder
- If all criteria met except the duration then is acute (short term insomnia) and should be categorised as “another specified insomnia disorder”
- Occurance criteria
 - Episodic episodes (1- and 3- month episodes)
 - Persistent episodes (3 months or longer)
 - Recurrent episodes (two or more episodes over 1 year)

2| Current Systems | ICSD-3 (2014)



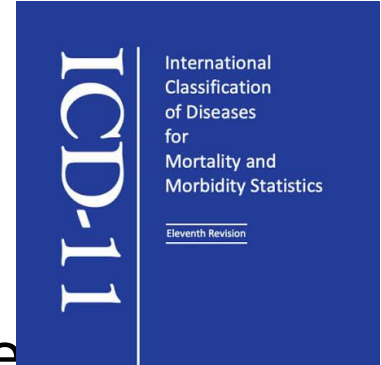
- Mirror of DSM-5 diagnosis of insomnia
- Principle complaint, daytime impairment, duration, frequency, occurrence despite opportunity to sleep and not better explained by other sleep disorder.
- In context of physical illness the clinician should attempt to determine how much explained by illness.
- Hypnotics should be removed to determine chronicity

2| Current Systems | ICD-10 (WHO,2010)



- Identified two types of insomnia:
 1. “Organic disorders for initiating and maintaining sleep”-G470)
 - Caused by another condition, thus management of that condition should resolve the insomnia
 2. “Non-organic insomnia” – F51.0
 - Broader , caveat that “insomnia dominates the clinical presentation”

2| Current Systems | ICD-11 (WHO,2022)



- Difficulty initiating or maintaining sleep and/or waking earlier than desired, occurring several times per week for ≥ 3 months despite adequate opportunity and circumstances for sleep, and associated with daytime symptoms or impairment.
- Short-Term Insomnia Disorder (7A01) for insomnia symptoms lasting less than 3 months.

3| Assessment tool

BMJ Open The Sleep Condition Indicator: a clinical screening tool to evaluate insomnia disorder

Colin A Espie,^{1,2} Simon D Kyle,³ Peter Hames,² Maria Gardani,⁴ Leanne Fleming,⁴ John Cape⁵

To cite: Espie CA, Kyle SD, Hames P, *et al.* The Sleep Condition Indicator: a clinical screening tool to evaluate insomnia disorder. *BMJ Open* 2014;**4**:e004183. doi:10.1136/bmjopen-2013-004183

ABSTRACT

Objective: Describe the development and psychometric validation of a brief scale (the Sleep Condition Indicator (SCI)) to evaluate insomnia disorder in everyday clinical practice.

Design: The SCI was evaluated across five study samples. Content validity, internal consistency and

Strengths and limitations of this study

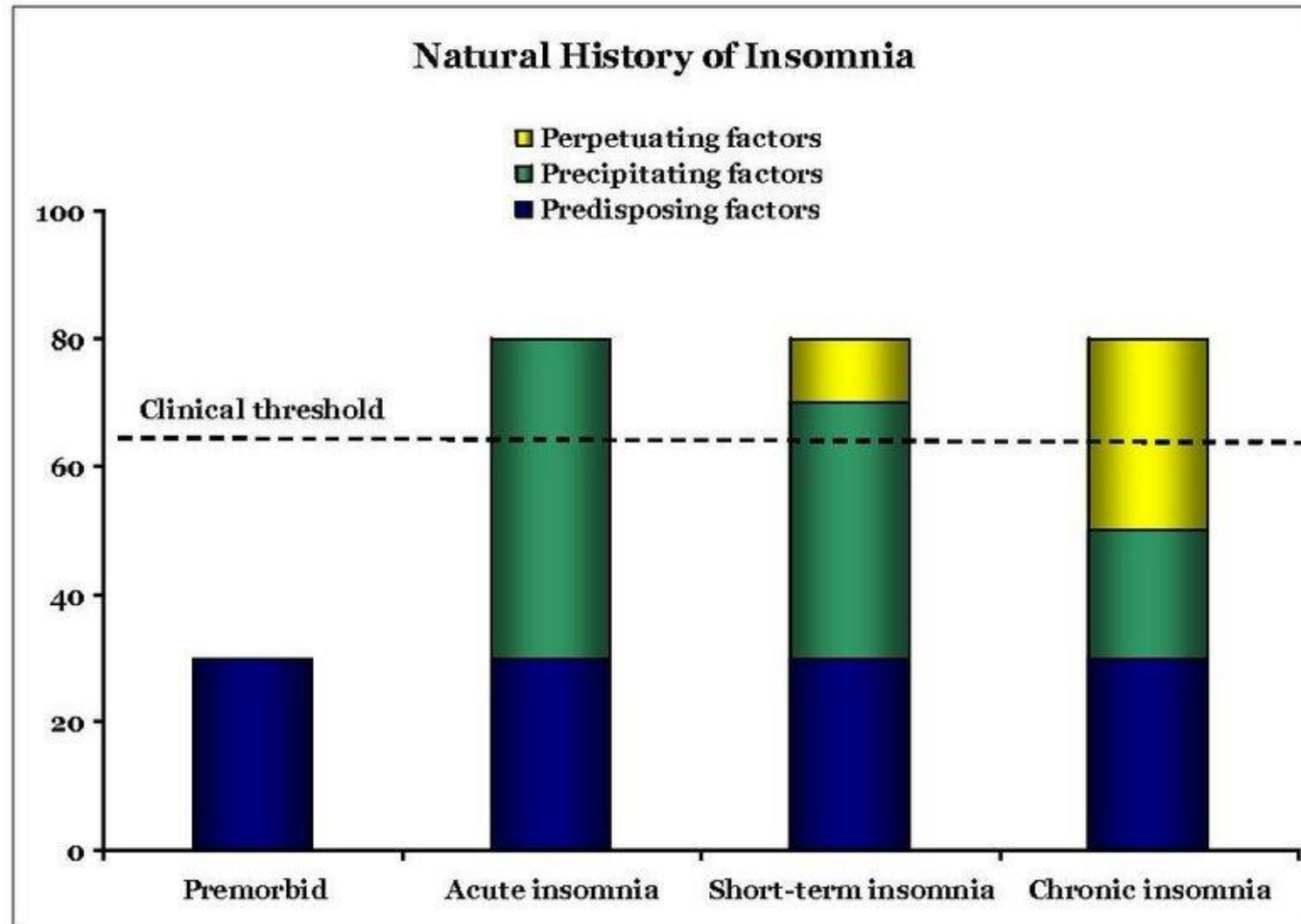
- Existing instruments used to evaluate insomnia lack specificity or do not permit assessment against the latest diagnostic criteria.
- This study describes the development and validation of a new instrument (the Sleep Condition

Item	Score				
	4	3	2	1	0
Thinking about a typical night in the last month ...					
1. ... how long does it take you to fall asleep?	0–15 min	16–30 min	31–45 min	46–60 min	≥61 min
2. ... if you then wake up during the night ... how long are you awake for in total? (add all the awakenings up)	0–15 min	16–30 min	31–45 min	46–60 min	≥61 min
3. ... how many nights a week do you have a problem with your sleep?	0–1	2	3	4	5–7
4. ... how would you rate your sleep quality?	Very good	Good	Average	Poor	Very poor
Thinking about the past month, to what extent has poor sleep ...					
5. ... affected your mood, energy, or relationships?	Not at all	A little	Somewhat	Much	Very much
6. ... affected your concentration, productivity, or ability to stay awake	Not at all	A little	Somewhat	Much	Very much
7. ... troubled you in general	Not at all	A little	Somewhat	Much	Very much
Finally ...					
8. ... how long have you had a problem with your sleep?	I don't have a problem/<1 mo	1–2 mo	3–6 mo	7–12 mo	>1 yr

4| Epidemiology

- The population prevalence of insomnia disorder is 10-12%, with older adult rates > 20%
- More than one-fifth of patients seen in general practice clinics have insomnia
- In the UK insomnia is the foremost of all mental health complaints
- Not only is insomnia common, it is also a major risk factor for new-onset and/or recurrent psychiatric illness, particularly Major Depression.
- patients with chronic insomnia are 2 - 10 times more likely to develop new onset depression (first and/or recurrent episodes) than patients without insomnia
- Some data suggests that patients with insomnia are also at greater risk for alcoholism and anxiety disorders

5| Main Aetiological Models| 3 P-Model



5| Main Aetiological Models| 3 P-Model

- Predisposing factors:** Some psychological or biological characteristics increase vulnerability, or predisposition, to sleep difficulties (e.g., female gender, anxiety, hyperarousal, genetics). Social factors (e.g., conflicting sleep schedule with partner, child rearing).

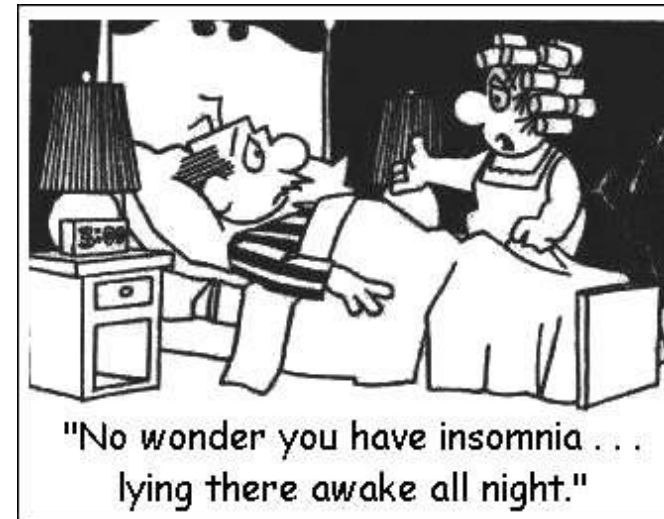
- Precipitating factors:** These are the life events and the medical, environmental or psychological factors that “trigger” insomnia (e.g., divorce, death of a significant other, illness, medication, familial or occupational stress).

- Perpetuating factors:** These elements maintain or exacerbate sleep difficulties. They are typically behaviours (e.g., extending time spend in bed to try to sleep more, naps) and/or beliefs and thoughts (fear of sleeplessness, excessive worries about daytime consequences) that people adopt in order to cope with sleeplessness.

5| Main Aetiological Models| Cognitive Model

- The majority of people with insomnia report that they can't get to sleep because of mental events
- Arousal (cognitive) and sleep are mutually exclusive

e.g. uncontrollable worry, intrusive thoughts, a mind that won't stop turning things over



5| Main Aetiological Models| AEI or Psychophysiological Model of insomnia

