

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



www.slaapgeneeskundevereniging.nl

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.

Assessment and Treatment for Insomnia

Intended Learning Outcomes

- Able to conduct a clinical interview of a patient with insomnia
- Able to select appropriate scales and conduct the diagnostic process for a patient with insomnia
- Understand the importance of clinical guidelines in insomnia treatment
- Cognitive behavioural therapy and other psychological treatment approaches

1 | Daytime and Night-time symptoms

- WASO, SOL, # of awakenings, early morning awakenings, SE, TST
- Questions should match these parameters
- Judge overall sleep quality
- Include 2 weeks of Sleep Diaries (example in later slide)
- Symptoms of hyperactivity of autonomous system (heart rate, palpitations etc)- “Do they get up when unable to sleep?”
- Evaluate cognitive aspect- “What is in your mind when you are unable to sleep?”
- Impaired cognitive functioning-tiredness, decrease attention etc

2| Clinical Evaluation

- Open interview to start and then semi-structured interview (sleep history, sleep experience over the past weeks etc)
- Include medical and psychiatric assessment *sleep history slides* (including blood tests for renal, hepatic and thyroid function)
- May include ECG, EEG or radiological methods (CT, MRI)
- **Circadian factors**, i.e. shift work, jet lag should be evaluated
- Intake prior or current over the counter, prescribed and/or illicit medications/ caffeine and alcohol

3| Questionnaires to assess insomnia

Measure	Construct	Items / timeframe	Scoring	Best suited to
Sleep Condition Indicator (SCI)	Insomnia disorder symptoms aligned with DSM-5	8 items Past month	0–32; lower = poorer sleep ≤16 suggests probable insomnia	Brief screening, population studies and repeated measurement
Insomnia Severity Index (ISI)	Perceived insomnia severity, distress and impairment	7 items Past 2 weeks	0–28; higher = greater severity 8–14 subthreshold; 15–21 moderate; 22–28 severe	Clinical screening and treatment outcomes, especially CBT-I
Athens Insomnia Scale (AIS-8)	Night-time symptoms and daytime impairment	8 items Past month	0–24; higher = greater severity ≥6 commonly indicates probable insomnia	Brief screening based originally on ICD-10 criteria
Pittsburgh Sleep Quality Index (PSQI)	General subjective sleep quality across seven domains	19 self-rated items Past month	0–21; higher = poorer sleep >5 commonly indicates poor sleep quality	Broad assessment of sleep quality and sleep patterns

Daytime effects, mechanisms and daily sleep

Measure	Construct	Items / timeframe	Scoring	Best suited to
Epworth Sleepiness Scale (ESS)	Propensity to fall asleep in everyday situations	8 items Usual experience	0–24; higher = greater sleepiness >10 generally warrants further assessment	Screening for excessive daytime sleepiness; not a measure of insomnia
DBAS-16	Dysfunctional beliefs, expectations and worries about sleep	16 items Current beliefs	Items rated 0–10; usually averaged Higher = more dysfunctional beliefs	Cognitive mechanisms and change during CBT-I
Glasgow Sleep Effort Scale (GSES)	Effort, monitoring and attempts to control sleep	7 items Past week	0–14; higher = greater sleep effort	Insomnia maintenance mechanisms and CBT-I process outcomes
Sleep Hygiene Index (SHI)	Behaviours and environmental practices that may disrupt sleep	13 items Usual behaviour	0–52; higher = poorer sleep hygiene	Potentially modifiable sleep behaviours; not insomnia severity
Consensus Sleep Diary (CSD)	Nightly sleep timing, latency, awakenings, duration and efficiency	Daily diary Usually 1–2 weeks	Derives SOL, WASO, TST, time in bed and sleep efficiency	Prospective monitoring in insomnia trials and longitudinal research

4 Sleep Diaries and Actigraphy

- Consensus Sleep Diary (Carney et al, 2012)
- Sleep diary very helpful for clinicians and patients to learn about their own sleep wake patterns and sleep-related behaviours
- Actigraphy
- Polysomnography



TWO WEEK SLEEP DIARY

INSTRUCTIONS:

- Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
- Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
- Put a line (l) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
- Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
- Leave boxes unshaded to show when you wake up at night and when you are awake during the day.



SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C	M			
2/2	Mon	WORK											I													
3/2	Tues	WORK											I													
4/2	Wed	WORK								A		I														
5/2	THURS	WORK								E		I														
6/2	FRI	WORK								A	A		I													
7/2	SAT	OFF		A						A	A	A		I												
8/2	SUN	OFF											I													

week 1

week 2

5| Current guidelines for treatment

Received: 16 August 2023 | Accepted: 21 August 2023
DOI: 10.1111/jsr.14035

REVIEW ARTICLE



The European Insomnia Guideline: An update on the diagnosis and treatment of insomnia 2023

Dieter Riemann^{1,2} | Colin A. Espie³ | Ellemarije Altena⁴ |
Erna Sif Arnardottir^{5,6} | Chiara Baglioni⁷ | Claudio L. A. Bassetti⁸ |
Celyne Bastien⁹ | Natalija Berzina¹⁰ | Bjørn Bjorvatn¹¹ | Dimitris Dikeos¹² |
Leja Dolenc Groselj¹³ | Jason G. Ellis¹⁴ | Diego Garcia-Borreguero¹⁵ |
Pierre A. Geoffroy¹⁶ | Michaela Gjerstad¹⁷ | Marta Gonçalves¹⁸ |
Elisabeth Hertenstein¹⁹ | Kerstin Hoedlmoser²⁰ | Tuulikki Hion²¹ |
Brigitte Holzinger²² | Karolina Janku²³ | Markus Jansson-Fröjmark^{24,25} |
Heli Järnefelt²⁶ | Susanna Jernelöv^{24,25} | Poul Jørgen Jennum²⁷ |
Samson Khachatryan²⁸ | Lukas Krone^{3,8,19} | Simon D. Kyle³ |
Jaap Lancee²⁹ | Damien Leger³⁰ | Adrian Lupusor³¹ |
Daniel Ruivo Marques^{32,33} | Christoph Nissen³⁴ | Laura Palagini³⁵ |
Tiina Paunio³⁶ | Lampros Perogamvros³⁴ | Dirk Pevernagie³⁷ |
Manuel Schabus²⁰ | Tamar Shochat³⁸ | Andras Szentkiralyi³⁹ |
Eus Van Someren^{40,41} | Annemieke van Straten⁴² | Adam Wichniak⁴³ |
Johan Verbraecken⁴⁴ | Kai Spiegelhalder¹

5| Current guidelines for treatment

TABLE 16 Recommendations for the treatment of chronic insomnia in adults of all ages

Treatment considerations

- Insomnia disorder should be actively treated whenever it presents (A)
- In the presence of comorbidities, clinical judgement should decide whether insomnia or the comorbid condition are treated first or whether both are treated at the same time (A)

CBT-I

- CBT-I should be provided as the first-line treatment for insomnia disorder in adults of any age, regardless of comorbidities (A)
- CBT-I may be delivered either in-person or digitally (A)
- Sleep restriction and stimulus control are the most active ingredients of CBT-I (B)

Pharmacological interventions

- A pharmacological intervention can be proposed if CBT-I is not effective (A)
- BZs and BZRAs can be used in the short-term treatment of insomnia (≤ 4 weeks) (A)
- Longer-term treatment (off-label use) with BZ or BZRA, either daily or preferably intermittently, may be initiated in some cases, and the advantages and disadvantages need to be discussed on an individual basis (B)
- Low doses of sedating antidepressants can be considered (off-label use) in the short-term treatment of insomnia; contraindications have to be carefully considered (B)
- Longer-term treatment of insomnia disorder (without comorbidities; off-label use) with low-dose sedating antidepressants may be initiated in some cases, and the advantages and disadvantages need to be discussed on an individual basis (B)

- Longer-term treatment of insomnia disorder with orexin receptor antagonists may be initiated in some cases, and the advantages and disadvantages need to be discussed on an individual basis (A)
- Because of insufficient evidence and possible risks, antihistamines are not recommended for insomnia treatment (A)
- Because of insufficient evidence and in light of their side-effects, antipsychotics are not recommended for insomnia treatment (A)
- Melatonin (fast-release, OTC or as a prescription drug) in general is not effective in the treatment of insomnia (A), if no circadian factors are involved
- Longer-term treatment of insomnia disorder with PR melatonin (in patients > 55 years) up to 3 months may be effective in some cases (B)

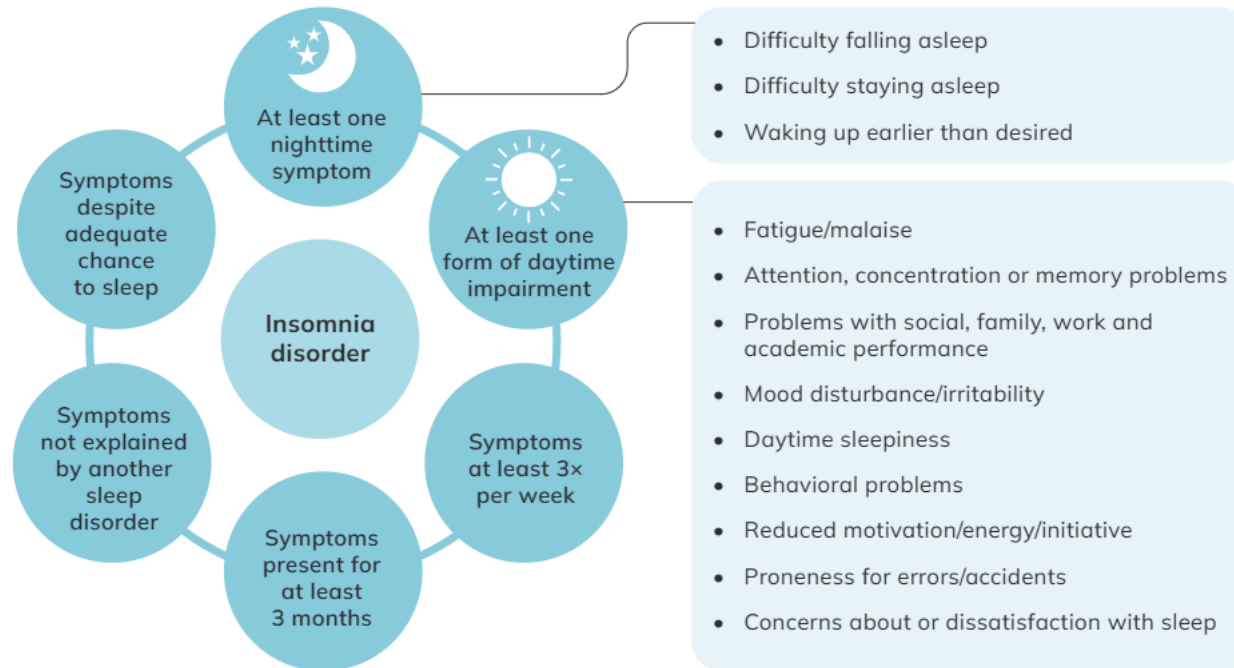
Other therapies

- Herbal remedies/phytotherapeutics are not recommended for the treatment of insomnia because of insufficient evidence (A). Light therapy and exercise regimes may be useful as adjunct therapies to CBT-I (B)

Abbreviations: BZ, benzodiazepines; BZRA, benzodiazepine receptor agonists; CBT-I, cognitive-behavioural therapy for insomnia; OTC, over-the-counter; PR, prolonged-release.

What does the guideline recommend?

How is insomnia disorder diagnosed?

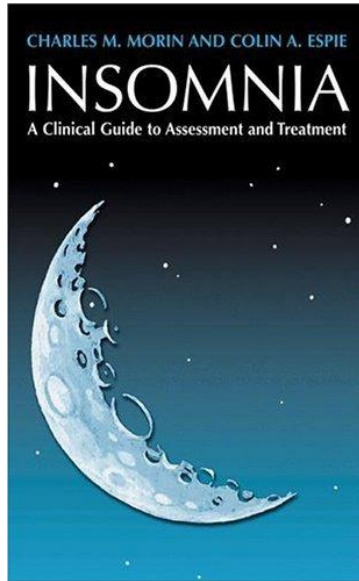


ICSD-3 criteria classify insomnia into 3 types:

1. Chronic insomnia disorder.
2. Short-term insomnia disorder.
3. Other insomnia disorder.

The ICD-11 tool follows the ICSD-3 classification with codes for chronic insomnia disorder, short-term insomnia and insomnia disorders, unspecified.

6|Cognitive behavioural therapy for insomnia



Sleep hygiene



Recommendations on bedroom factors (e.g., temperature, light, noise, bed comfort) and lifestyle (e.g. caffeine, alcohol, clock watching) that may interfere with sleep

Relaxation techniques



Teaches how to relax the mind and body through muscle relaxation and deep breathing

Sleep restriction



Sets limits on time spent in bed

Stimulus control



Reestablishes a positive connection between bed and sleep

Cognitive therapy



Learning how to deal with worries and negative thoughts and attitudes that impact sleep

6|Cognitive behavioural therapy for insomnia| Sleep Hygiene

- Do:
 - Regular rising time
 - Exercise earlier in the day
 - Light bedtime snack
 - Comfortable sleep environment
- Don't:
 - Caffeine past noon
 - Napping past 2 pm
 - Nicotine near bedtime
 - Heavy meals before bedtime
 - Alcohol near bedtime
 - Exercise near bedtime

6|Cognitive behavioural therapy for insomnia| Relaxation

- Techniques to induce physical and mental calm
- Progressive muscle relaxation
- Guided imagery
- Practice twice daily (during the day and at bedtime to combat arousal)

6|Cognitive behavioural therapy for insomnia| Stimulus Control

- Avoid no sleep behaviours in the bedroom
- Go to bed when 'sleepy tired'
- **Exit the bedroom if you are not asleep at 15 min**
- Guidance on practices that aid adherence (planning ahead)

6|Cognitive behavioural therapy for insomnia| Sleep Restriction

- Insomnia shows low Sleep Efficiency (SE)
- $SE = \text{Total Sleep Time} / \text{Time in Bed} \times 100$
e.g. $80\% = 380 / 470 \times 100$
- Sleep schedule is *fixed* within a bedtime and rising time (based on sleep diary and previous $TST \leq 5$ hours)
- Sleep boundaries are adjusted based on the SE ($<85\%$ and $>90\%$)
- Promotes sleep continuity, reduces wakefulness in bed and increases sleep efficiency

6|Cognitive behavioural therapy for insomnia| Cognitive Therapy

- Psycho-Education on the role of cognitions
- Identify possible maladaptive cognitions
- Challenge the authenticity of maladaptive cognitions
- Modify the cognitions

e.g. "I will never get to sleep"

- Correcting attentional bias & reducing safety behaviours
(cancelling meeting friends)

6|Cognitive behavioural therapy for insomnia| Brief Therapy

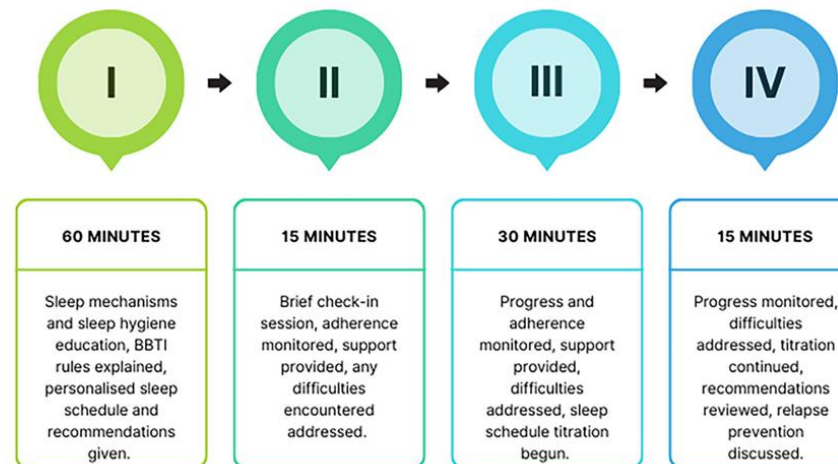
- Edinger et al (2007) Dose-response effects of cognitive-behavioral insomnia therapy: a randomized clinical trial. *SLEEP* 30:203-212
- Buysse et al (2011) Efficacy of brief behavioral treatment for chronic insomnia in **older adults**. *Arch Int Med* 171:887-895
- Ellis et al, (2015) Treating Acute Insomnia: A Randomized Controlled Trial of a "Single-Shot" of Cognitive Behavioral Therapy for Insomnia. *SLEEP* 38(6):971-8.

Brief Behavioural Treatment for Insomnia after ABI

- 6 Participants (1 woman)
- 41–70 age range (median 51.5)
- TBI (3 participants)
- Stroke (1 participant)
- Tumour (1 participant)
- Anoxia (1 participant)



BBTI Sessions Outline



Gardani et al, 2024, Journal of Sleep Research