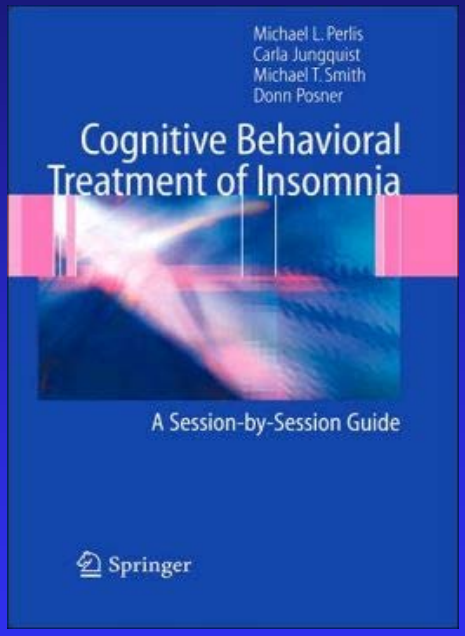
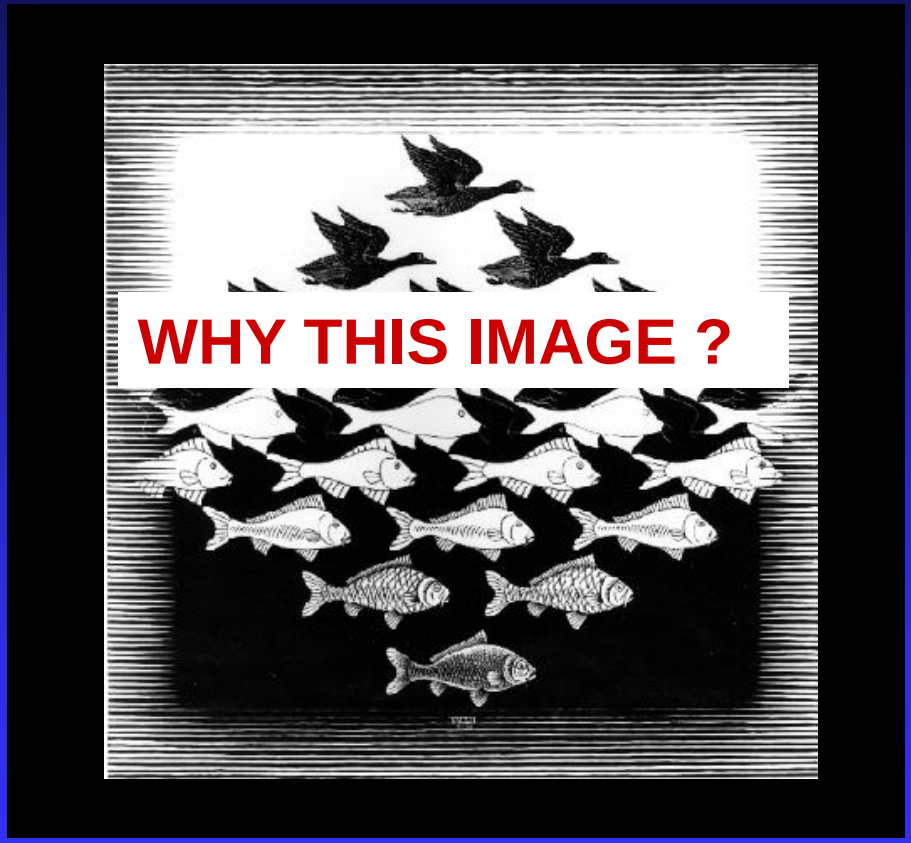
CBT-I TX OF INSOMNIA:

SESSION BY SESSION

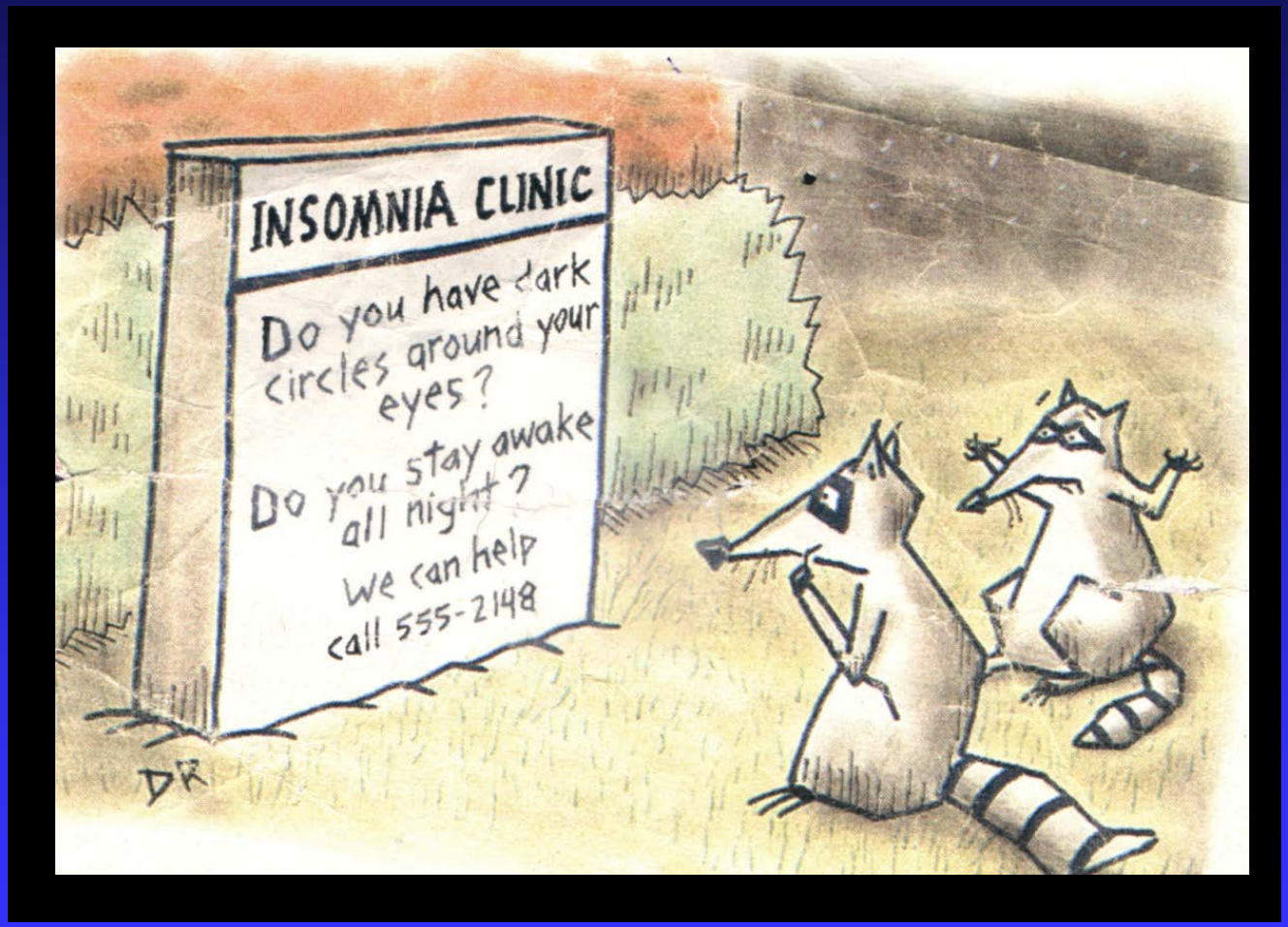
CONDUCT TX BY THE BOOK



ASSESSMENT



HERE'S WHY


INSOMNIA CLINIC
Do you have dark circles around your eyes?
Do you stay awake all night?
We can help
call 555-2148
DR

SESSION 1 – ASSESSMENT

BSM ASSESSMENT

Session One (Intake Evaluation; 60-120 min.)

Tasks
Introduce yourself to the patient
Complete Intake Questionnaires
Conduct Clinical Interview
Determine if patient is a candidate for CBT-I.
Determine other treatment options
Present An Overview of Treatment Options
Orient Patient to the Sleep Diary (and actigraph)
Field Patient Questions & Address Resistances
Setting the Weekly Agenda

INTRODUCTION

IN GENERAL

Despite the prevalence of chronic insomnia, people are often not inclined to seek treatment. They may think, or are told: "It'll go away on its own" or "just manage it" or "just learn to live with it."

The facts are:

- insomnia, when chronic (present for more than a month), is unlikely to "go away";
- most self-management strategies are not effective (i.e., "will power," "self control," naturopathic supplements, warm milk, tea, "night caps" with alcohol, etc.); and
- allowing insomnia to go untreated may negatively impact your quality of life, work performance, and increase your risk for
  - accidents and injuries
  - medical illness (e.g., hypertension)
  - psychiatric illness (e.g., depression)

Fortunately, there is no reason to suffer with insomnia. Effective treatments exist and there are clinicians who specialize in and are credentialed to provide specialty treatment for insomnia.

WHAT IS SPECIAL ABOUT THE PROGRAM AT PENN ?

The Behavioral Sleep Medicine (BSM) Program at Penn is comprised of researchers, educators and clinicians. This combination provides you with the assurance that our clinical services are the state of the art.

Our clinic offers the most effective and durable treatments available for insomnia including a form of evidenced-based cognitive behavioral therapy (CBT-I) that was standardized by our group and is taught to clinicians worldwide by members of our team. An evaluation by one of our sleep specialists will let you know if CBT-I is right for you.

Our group is comprised of clinicians who are certified by the American Board of Sleep Medicine, in both general Sleep Medicine and in Behavioral Sleep Medicine. This group, which brings together more than 50 years experience in insomnia research and treatment, can provide a variety of interventions for insomnia ranging from standard treatment with hypnotic medication, to treatment with CBT-I techniques, to combination strategies that may use both CBT-I and hypnotic or wake-promoting medications to improve your sleep.

In brief: the Penn BSM program and Insomnia Clinic promises to provide the best care possible by the most qualified individuals – so you can rest easy.

IS OUR PROGRAM FOR YOU ?

If you have trouble falling asleep, staying asleep, or waking up too early in the morning, we can help.

WHAT CAN I EXPECT ?

Your treatment will begin with an extensive evaluation including a review of your medical and mental health histories and an assessment of the factors that are likely to be related to your insomnia (sleep schedule, sleep duration, what you do and don't do when awake at night, etc.). Treatment will require that you complete a series of questionnaires during your first visit and daily sleep diaries before and during treatment. Depending on the situation you may also be asked to undergo an objective assessment of your sleep (via actigraphy and/or an overnight sleep study).

WHAT IS THE PREFERRED TREATMENT FOR INSOMNIA ?

The first line of intervention for insomnia is usually behavioral. Treatment is based upon the concept that chronic insomnia lasting from months to years is maintained by physical and behavioral factors that have little or nothing to do with what initially caused the insomnia. Accordingly, treatment targets the factors that have been shown to cause acute insomnia to take on "a life of its own."

HOW EFFECTIVE IS THIS THERAPY ?

There is a large scientific literature that shows that behavioral interventions are as effective as medication and, unlike medications, produce durable results that last after treatment is discontinued.

HOW LONG DOES TREATMENT TAKE ?

In most cases, 8 weeks.

INTRODUCTION

IN SPECIFIC

ASSESSMENT

IF THERE IS A MISMATCH BETWEEN SLEEP ABILITY AND SLEEP OPPORTUNITY, WE HAVE OUR INDICATION.

WHY DO AN ASSESSMENT?

WHAT IS ASSESSMENT FOR ?

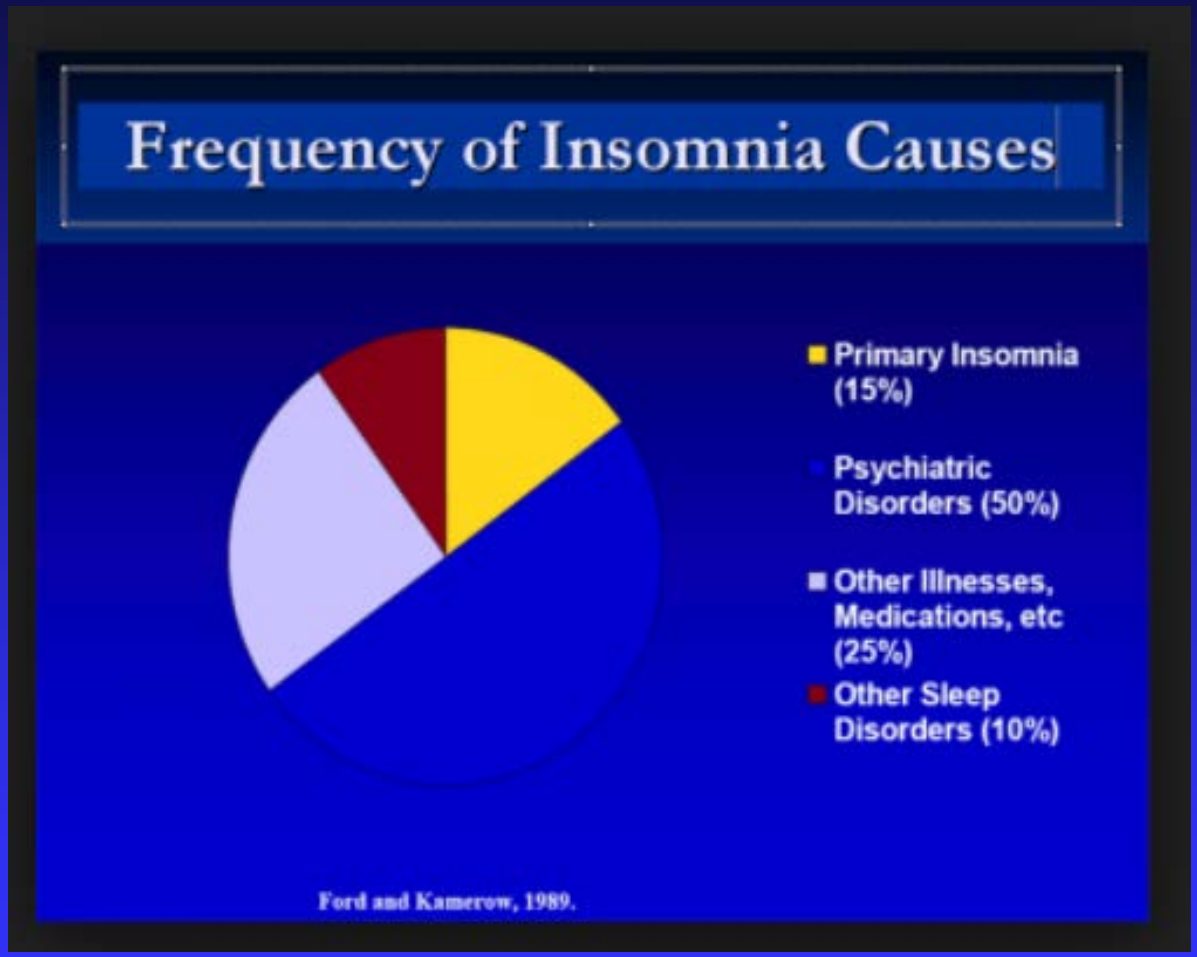
TO CONDUCT A DIFFERENTIAL DIAGNOSIS ?

TO ASSESS WHETHER THE INSOMNIA IS PRIMARY OR SECONDARY ?

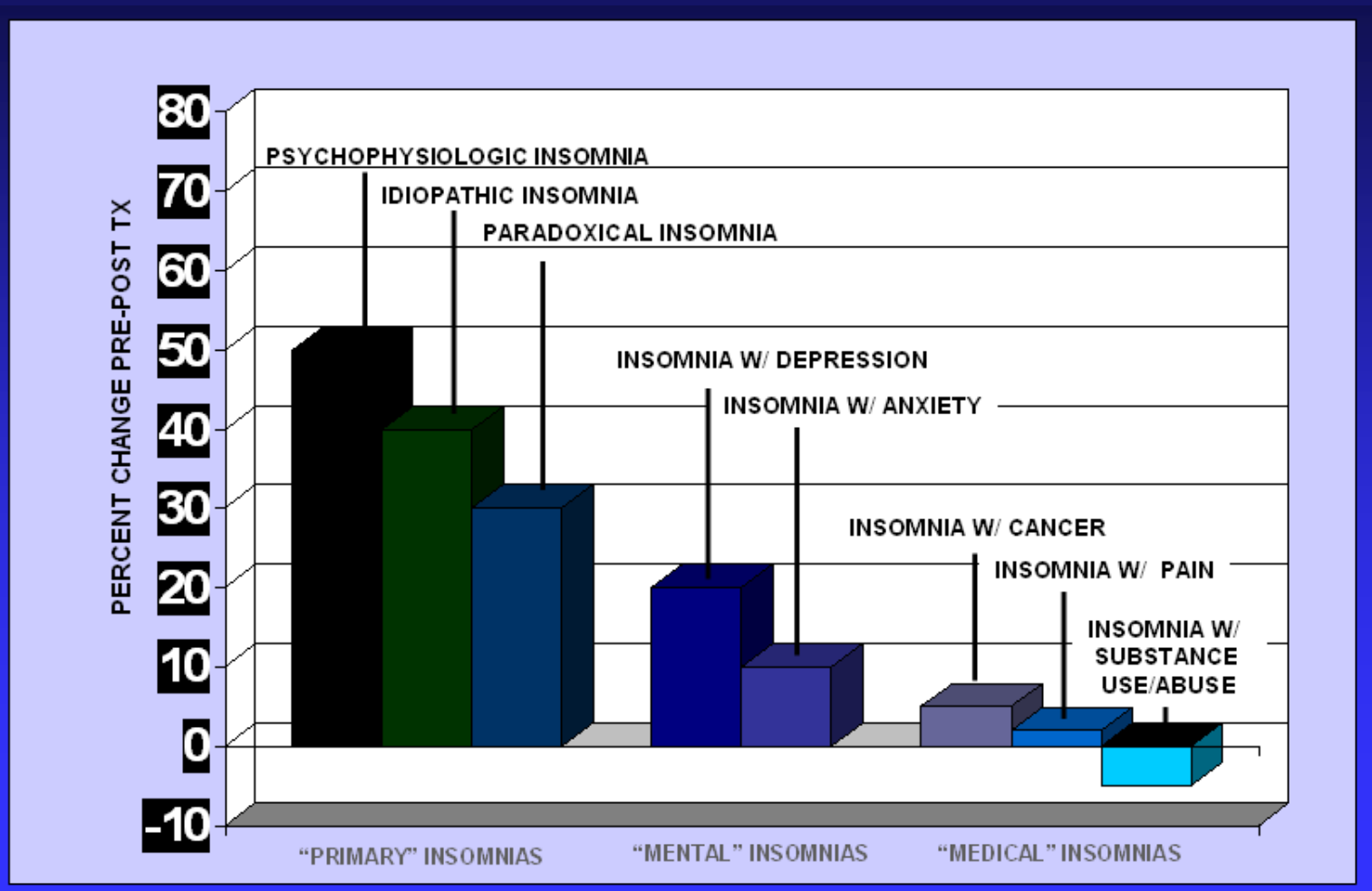
TO ASSESS FOR CONTRAINDICATIONS AND COMPLICATING FACTORS

TO ASSESS FOR INSOMNIA TYPES OR SUBTYPES ?

SO WHAT ABOUT “SI”



DOES TREATMENT OUTCOME VARY AS A FUNCTION OF INSOMNIA TYPE AND/OR COMORBID ILLNESS ?



DOES TREATMENT VARY AS A FUNCTION OF COMORBID ILLNESS ?

SHORT ANSWER:
NO.

LONGER ANSWER:
THE DATA TO DATE SUGGEST THAT

CBT-I IS EQUALLY EFICACIOUS FOR "PRIMARY AND SECONDARY" INSOMNIA

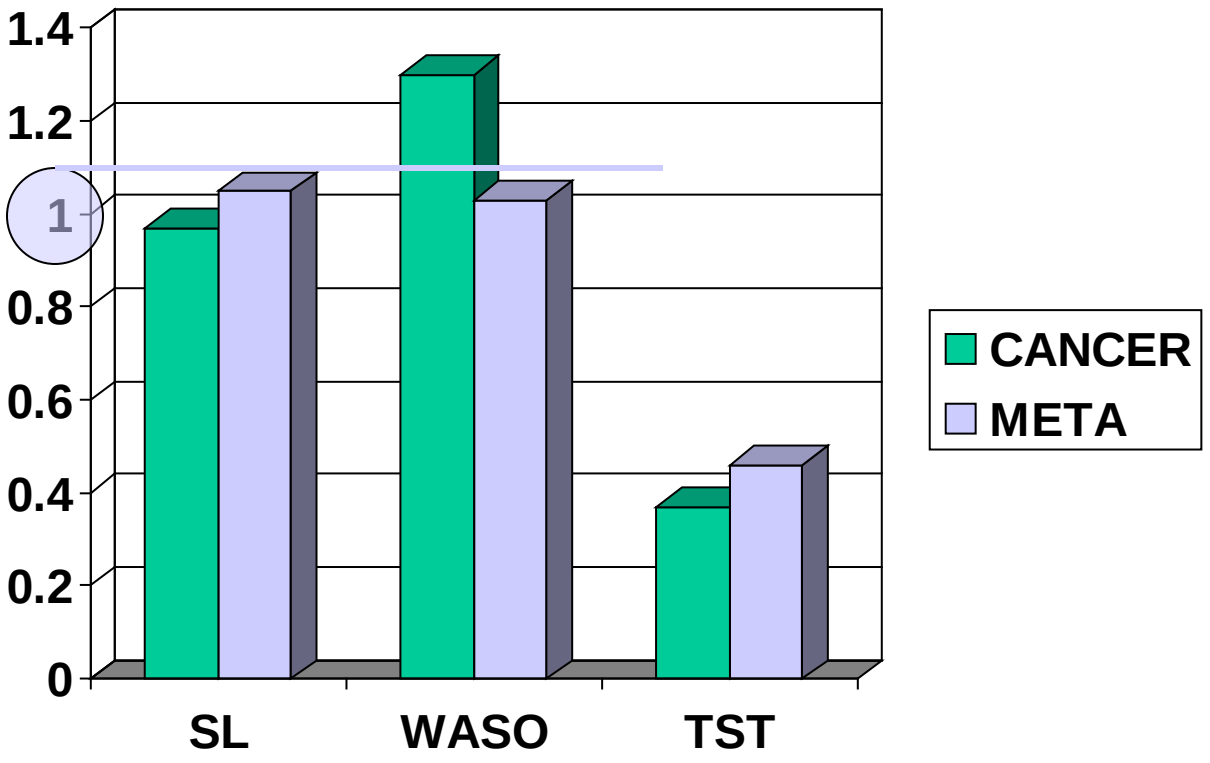
EARLY STUDIES OF "SI" WITH CBT-I

- Cannici et al., 1983
- Currie et al., 2000; 2004
- Dashevsky & Kramer, 1998
- Davidson et al., 2001
- De Berry, 1981-82
- Dopke et al., 2004
- Edinger et al., 2005
- French & Tupin, 1974
- Germain et al. 2006; 2007
- Kolko, 1984
- Krakow et al., 2001
- Lichstein et al., 2000
- Morawetz, 2001
- Morin et al., 1989
- Morin et al., 1990
- Perlis et al., 2001
- Quesnel et al., 2003
- Rybarczyk et al., 2002
- Stam & Bultz, 1986
- Savard et al. 2005
- Tan et al., 1987
- Varni, 1980

SLIDE ADAPTED FROM KEN LICHSTEIN

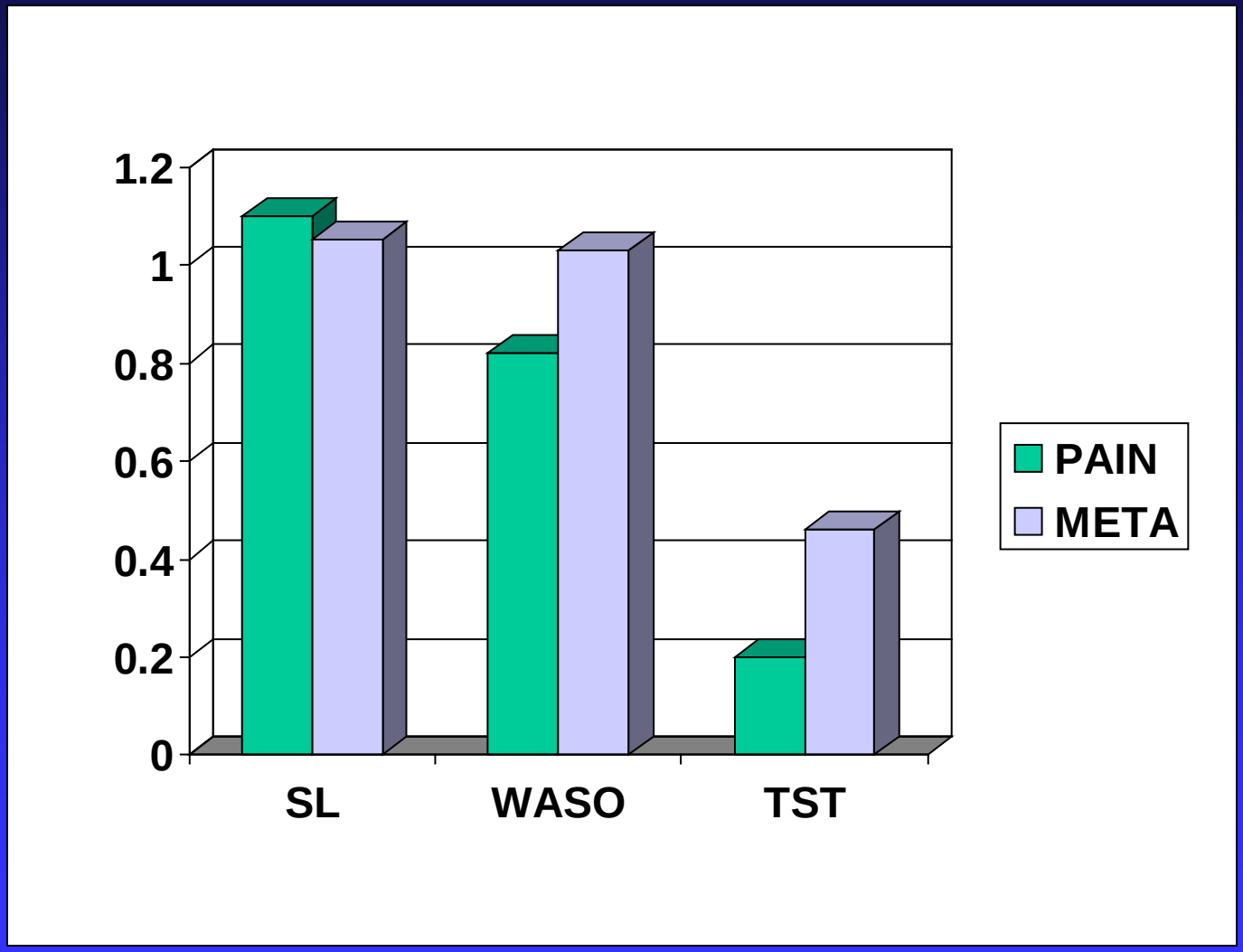
- Cancer
  - Cannici et al., 1983
  - Stam & Bultz, 1986
  - Davidson et al., 2001
  - Quesnel et al., 2003
  - Savard et al., 2005
- Various psychiatric disorders
  - Tan et al., 1987
  - Dashevsky & Kramer, 1998
  - Perlis et al., 2001
  - Krakow et al., 2001(PTSD)
  - Morawetz, 2001 (Depression)
  - Currie et al. 2004 (Alcoholism)
  - Dopke et al., 2004
  - Germain et al., 2006;2007 (PTSD)
  - Manber et al. 2008
- Various medical problems
  - Varni, 1980
  - Kolko, 1984
  - De Berry, 1981-82
  - Lichstein et al., 2000
  - Perlis et al., 2001
  - Rybarczyk et al., 2002
- Pain
  - French & Tupin, 1974
  - Morin et al., 1989
  - Morin et al., 1990
  - Currie et al., 2000
  - Edinger et al., 2005
  - Jungquist et al. 2010

CBT-I FOR INSOMNIA IN CANCER SURVIVORS



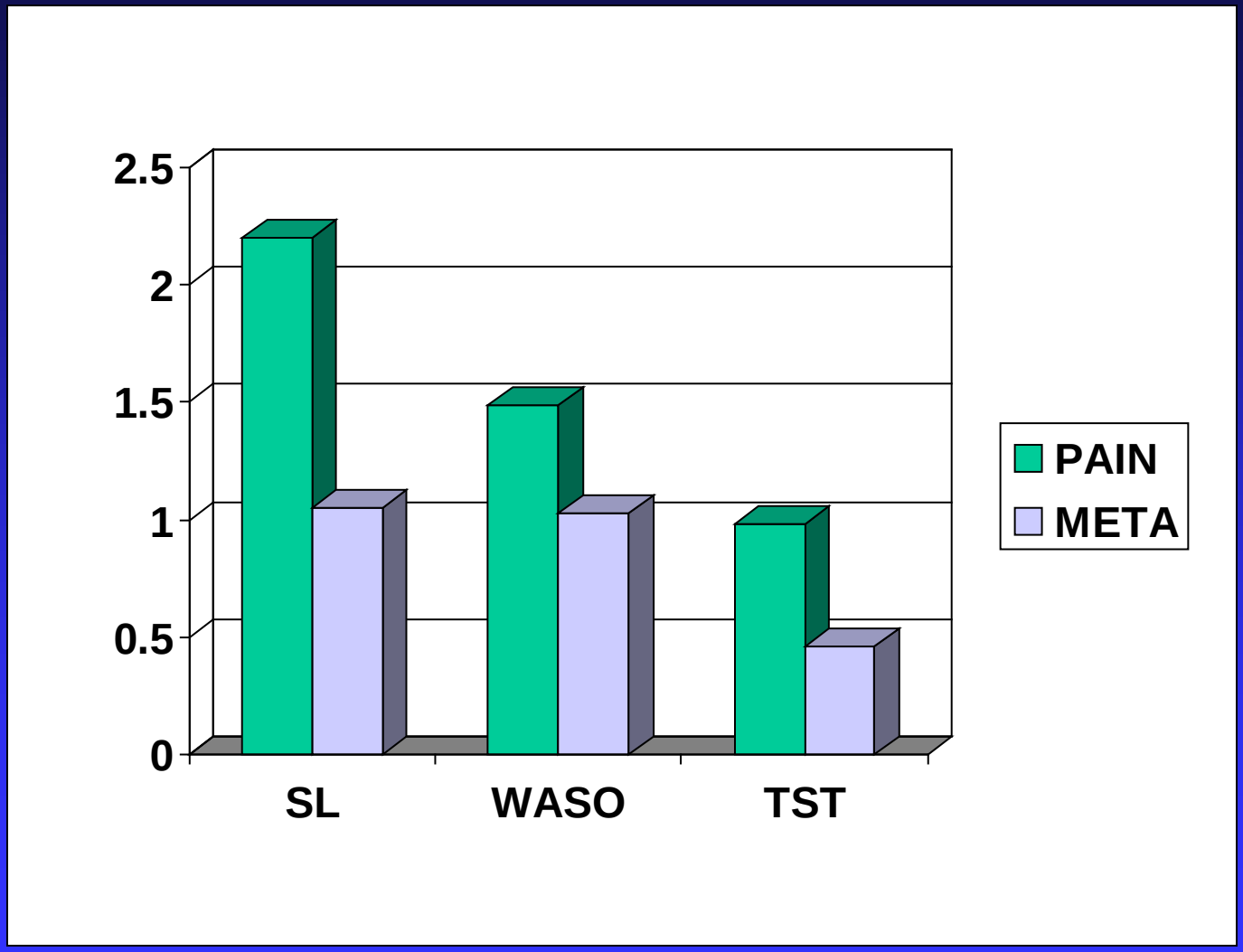
SAVARD ET AL. JCO 2005

CBT-I FOR INSOMNIA IN PATIENTS WITH CHRONIC PAIN



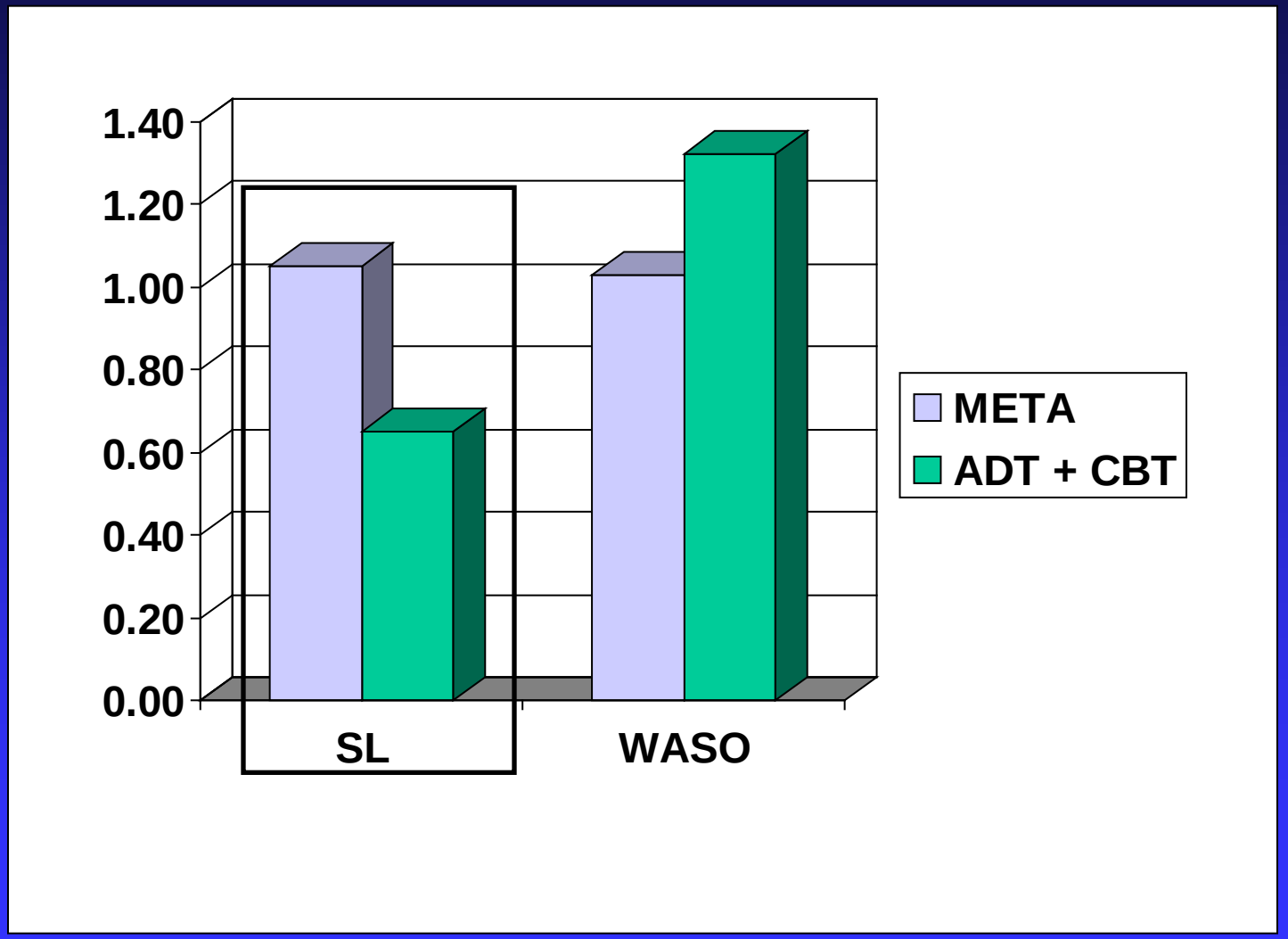
CURRIE ET AL. JCCP 2000

CBT-I FOR INSOMNIA IN PATIENTS WITH CHRONIC PAIN



JUNGQUIST ET AL. 2010

CBT-I FOR INSOMNIA IN PATIENTS WITH MAJOR DEPRESSION



MANBER ET AL. 2008

“BUT WAIT – THERE’S MORE !”

INSOMNIA AND DEPRESSION

Cognitive Behavioral Therapy for Insomnia Enhances Depression Outcome in Patients with Comorbid Major Depressive Disorder and Insomnia

Rachel Manber, PhD[1]; Jack D. Edinger, PhD[2]; Jenna L. Gress, BA[1]; Melanie G. San Pedro-Salcedo, MA[1]; Tracy F. Kuo, PhD[1]; Tasha Kalista, MA[1]

[1]Stanford University, Stanford, CA; [2]VA Medical Center and Duke University Medical Center, Durham, NC

Study Objective: Insomnia impacts the course of major depressive disorder (MDD), hinders response to treatment, and increases risk for depressive relapse. This study is an initial evaluation of adding cognitive behavioral therapy for insomnia (CBTI) to the antidepressant medication escitalopram (EsCIT) in individuals with both disorders.

Design and setting: A randomized, controlled, pilot study in a single academic medical center.

Participants: 30 individuals (61% female, mean age 35±18) with MDD and insomnia.

Interventions: EsCIT and 7 individual therapy sessions of CBTI or CTRL (quasi-desensitization).

Measurements and results: Depression was assessed with the $HRSD_{17}$ and the depression portion of the SCID, administered by raters masked to treatment assignment, at baseline and after 2, 4, 6, 8, and 12 weeks of treatment. The primary outcome was remission of MDD at study exit, which required both an $HRSD_{17}$ score ≤ 7 and absence of the 2 core symptoms of MDD. Sleep was assessed with the insomnia severity index (ISI), daily sleep diaries, and actigraphy.

EsCIT + CBTI resulted in a higher rate of remission of depression (61.5%) than EsCIT + CTRL (33.3%). EsCIT + CBTI was also associated with a greater remission from insomnia (50.0%) than EsCIT + CTRL (7.7%) and larger improvement in all diary and actigraphy measures of sleep, except for total sleep time.

Conclusion: This pilot study provides evidence that augmenting an antidepressant medication with a brief, symptom focused, cognitive-behavioral therapy for insomnia is promising for individuals with MDD and comorbid insomnia in terms of alleviating both depression and insomnia.

Keywords: Major depressive disorder, Insomnia, Cognitive behavioral therapy, Remission

Citation: Manber R; Edinger JD; Gress JL; San Pedro-Salcedo MG; Kuo TF; Kalista T. Cognitive behavioral therapy for insomnia enhances depression outcome in patients with comorbid major depressive disorder and insomnia. *SLEEP* 2008;31(4):489-495.

DIFFICULTY INITIATING AND/OR MAINTAINING SLEEP IS COMMON IN MAJOR DEPRESSIVE DISORDER (MDD) BUT IS OFTEN INADEQUATELY ADDRESSED. Subjective and objective (electroencephalographic) sleep disturbances are associated with slower and lower rates of remission from depression.[1-3] Depressed patients with abnormal sleep profiles have significantly poorer clinical outcomes with respect to symptom ratings, attrition and remission rates, and the stability of response to treatment than those with more normal sleep profiles.[3,4] Patients with MDD who experience sleep continuity disturbance and early morning awakening are also more likely to have suicidal ideation than those without such disturbances.[5] Collectively, these findings indicate that insomnia symptoms hinder response to antidepressant treatment.

Disclosure Statement

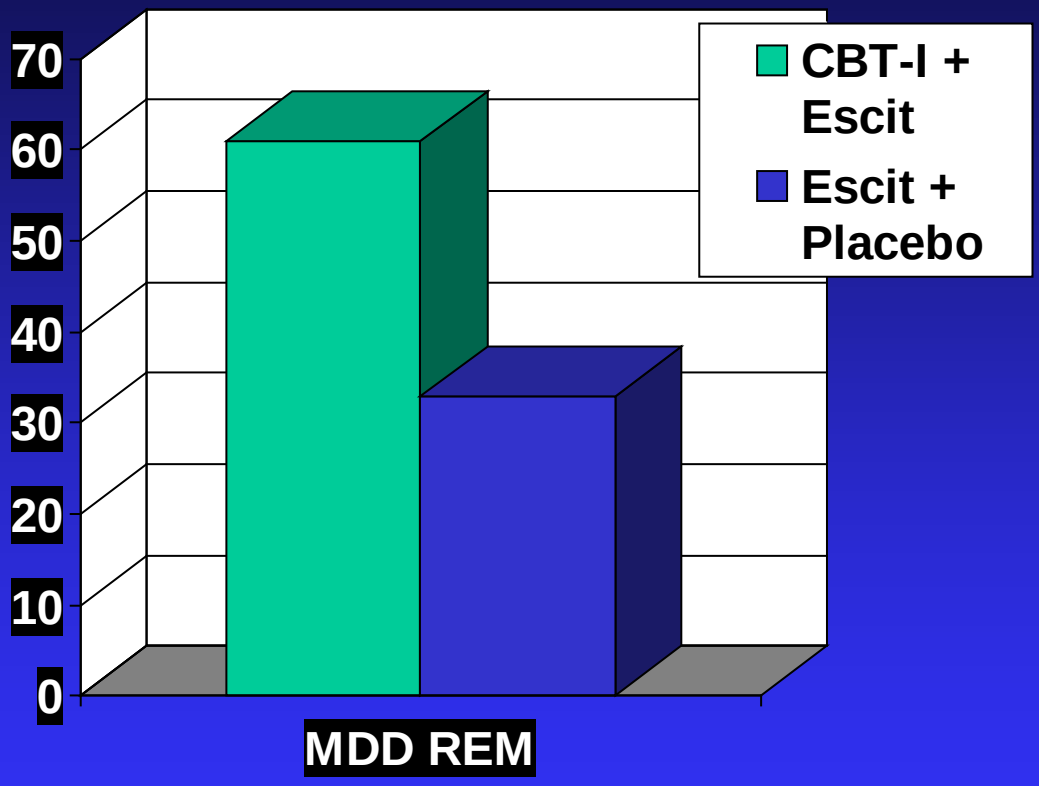
This was not an industry supported study. Forest Laboratory provided medication used in the study. Dr. Edinger has received research support from Respironics; has consulted for Respironics/MiniMitter Division; has participated in speaking engagements for Sleep Medicine Education Institute; and participated in a advisory panel meeting for Takeda. Dr. Kuo has received research support from Jazz Pharmaceuticals. The other authors have indicated no financial conflicts of interest.

Submitted for publication September, 2007
Accepted for publication January, 2008

Address correspondence to: Rachel Manber, PhD, Department of Psychiatry and Behavioral Sciences, Stanford University, 401 Quarry Rd., Stanford, CA 94305; Tel: (650) 724-2377; Fax: (650) 725-8910; E-mail: Rmanber@stanford.edu

Sleep disturbance does not always resolve with antidepressant treatment. Sleep difficulties are also common residual symptoms in individuals who have responded to depression treatment.[6-10] Continued insomnia following the acute phase of antidepressant therapy poses a significant risk for relapse. For example, two-thirds of patients with persistent insomnia at the end of treatment with nortriptyline and interpersonal psychotherapy relapsed within one year after switching to pill placebo. In contrast, 90% of patients with good sleep at the end of the acute treatment remained well during the first year after discontinuing antidepressants.[11] Additionally, there are indications that insomnia may be a first-occurring prodromal symptom in previously depression-remitted persons.[12] Thus, insomnia is often more than merely a correlate or symptom of the depressive illness; it also affects the course of the illness, response to treatment, and when unresolved, it is a risk factor for relapse.

The prevailing model for the development of insomnia is based on the diathesis-stress model whereby a "stressor" precipitates insomnia in predisposed individuals. This model posits that, with time, conditioned insomnia develops and persists even after the stressor is removed. Specifically, as anxiety about not being able to sleep grows, it can lead to cognitive and/or somatic arousal that further interferes with sleep and perpetuates the sleep problem.[13] When these sleep difficulties become associated with significant distress or impairment of function in significant domains, all criteria for a diagnosis of insomnia are met and the individual experiences comorbid MDD and insomnia. Thus, insomnia is no longer simply a symptom of depression, but has become an independent disease process and a comorbid disorder that can subsequently hinder antidepressant response.



The New York Times

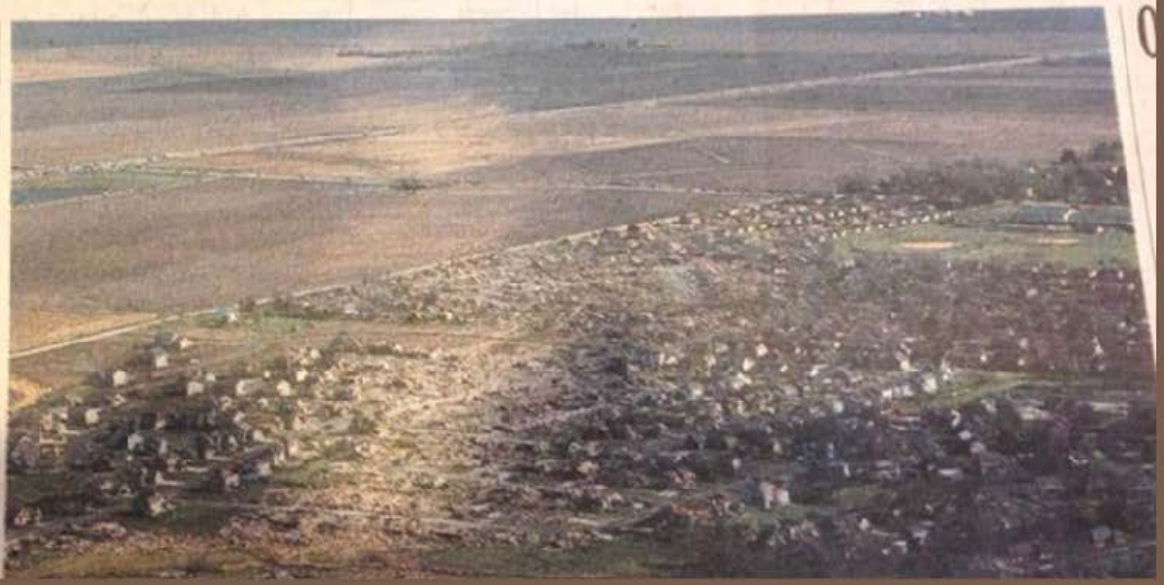
,325 © 2013 The New York Times TUESDAY, NOVEMBER 19, 2013

Sleep Therapy Seen as an Aid For Depression

Study Finds Big Benefit in Treating Insomnia

By BENEDICT CAREY

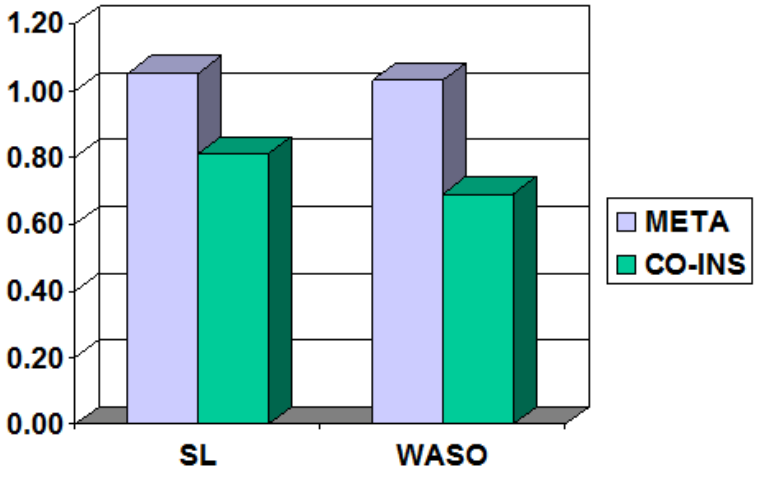
Curing insomnia in people with depression could double their chance of a full recovery, scientists are reporting. The findings,



“BUT WAIT – THERE’S MORE !”

A LOT MORE !!

COMORBID INSOMNIA
OVERALL



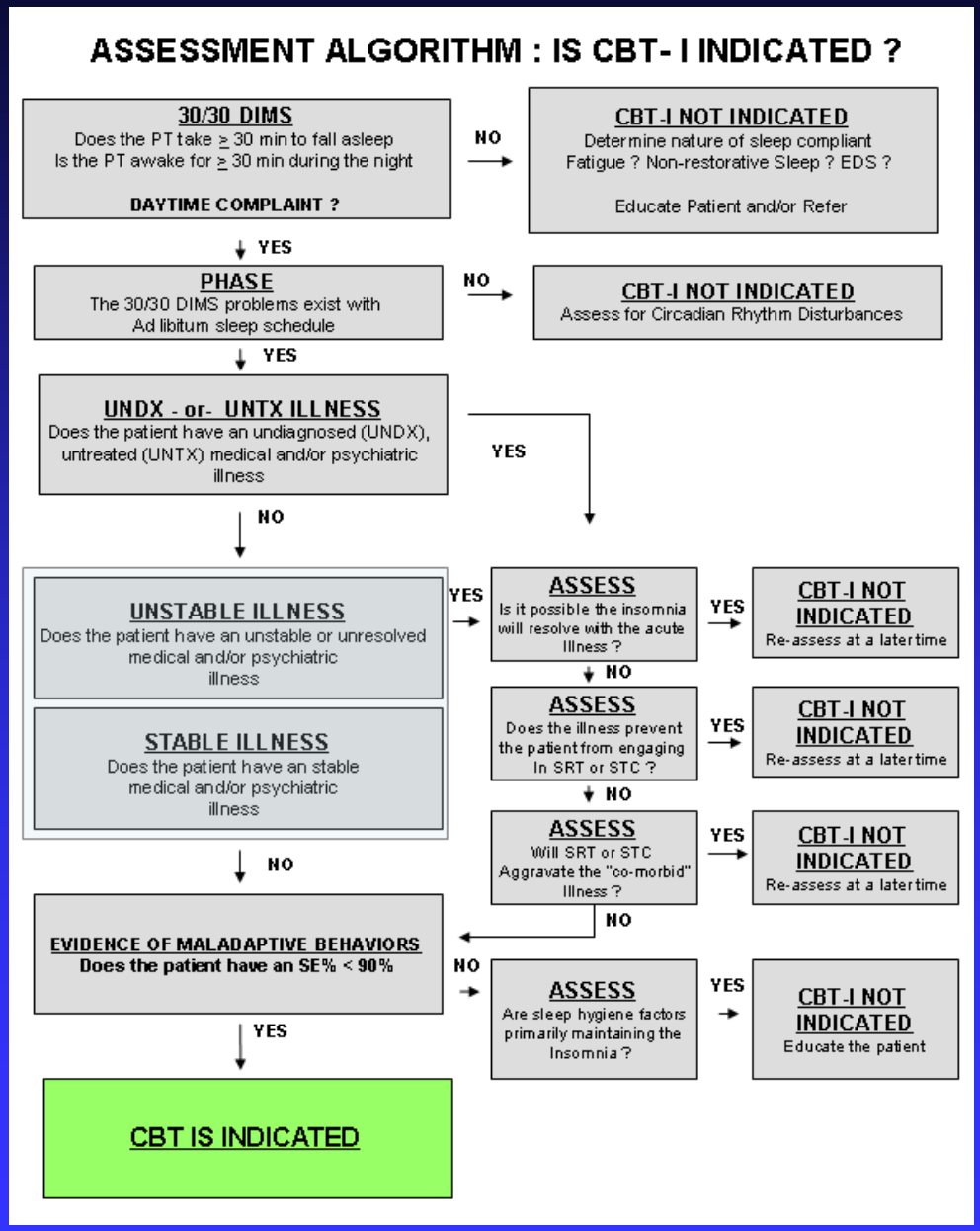
Wu et al (Ong Sr. Au.) 2015 PMID PMID: 26147487

SO THE PI vs. SI DISTINCTION IS NOT HELPFUL FOR DETERMING WHO IS A GOOD CANDIDATE FOR CBT- I ?

HOW SHOULD THIS BE APPROACHED ?

HOW ABOUT AN ALOGORITHM ?

WHO IS A GOOD CANDIDATE FOR CBT- I ?



ASSESSMENT

WHAT IS ASSESSMENT FOR ?

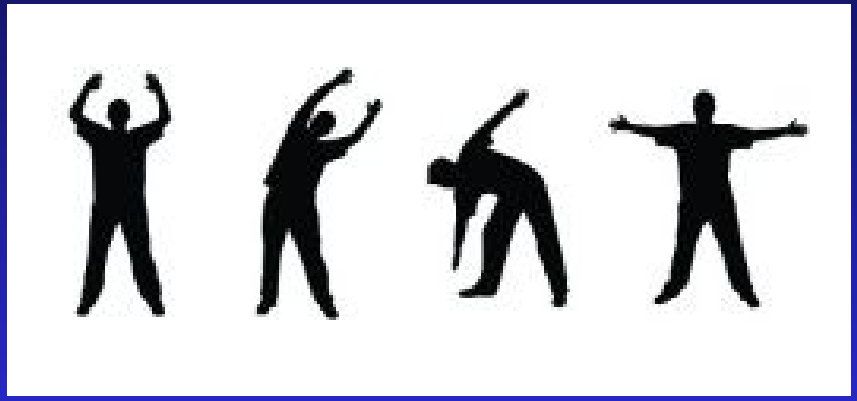
TO CONDUCT A DIFFERENTIAL DIAGNOSIS ?

TO ASSESS WHETHER THE INSOMNIA IS PRIMARY OR SECONDARY ?

TO ASSESS FOR CONTRAINDICATIONS AND COMPLICATING FACTORS

TO ASSESS FOR INSOMNIA TYPES OR SUBTYPES ?

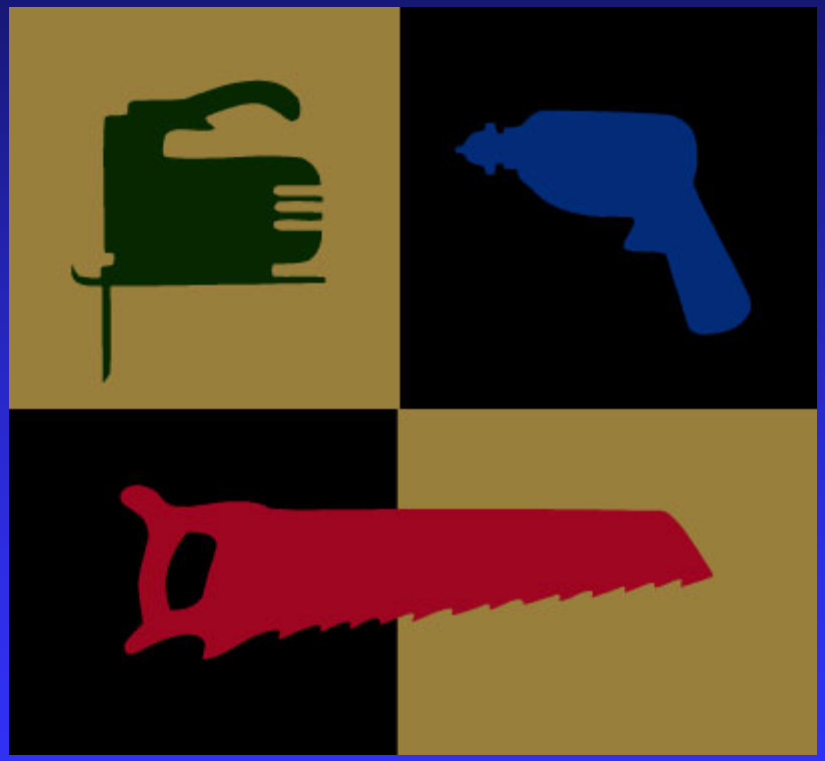
PRE-ASSESSMENT



WARMUP PEOPLE TO THE IDEA OF CANDID RESPONSES

BSM ASSESSMENT

TOOLS
PRE-CINIC VS. AT CLINIC



THE PATIENT – IN THEIR OWN WORDS

WHEN DID THE INSOMNIA START?

WHAT WAS THE TRIGGER?

WHAT DO THEY DO WHEN THEY HAVE INSOMNIA?

WHEN DID THEY FIRST SEEK HELP?

WHAT TXs WORK?

WHAT TXs DON'T WORK?

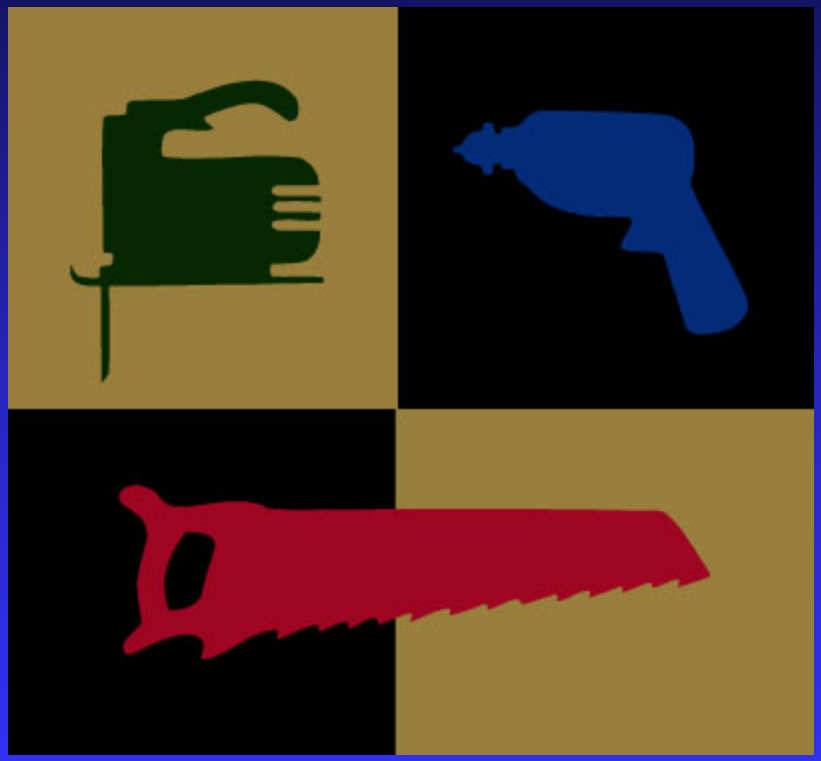
BSM ASSESSMENT

THE PATIENT – IN THEIR OWN WORDS

GWEN DESCRIBES

BSM ASSESSMENT

TOOLS



ASSESSMENT

Study Protocol Forms

All Forms:

To complete a form below, click on its title.

MED & PSYCH ASSESSMENT

1. Medical History Checklist
2. Symptoms Checklist
3. QIDS-SR
4. STAI-T

SLEEP ASSESSMENT

1. Sleep Disorders Checklist
2. Insomnia History Form
3. Sleep Medication History Form
4. Insomnia Severity Index
5. Daily Sleep Diary
6. Epworth Sleepiness Scale (ESS)

http://www.vistasleepassessment.com/

ASSESSMENT

Study Protocol Forms

All Forms:

To complete a form below, click on its title.

MED & PSYCH ASSESSMENT

1. Medical History Checklist
2. Symptoms Checklist
3. ~~QIDS-SR~~ **PHQ9**
4. ~~STAI-T~~ **GAD-7**

ASSESSMENT

MEDICAL HISTORY INFORMATION FORM

Current weight: _____ Name: _____
Current height: _____ Date: _____
Weight 5 years ago: _____ BMI: _____

List of medications:

Med	Dose	Schedule	Reason taking it

Put checkmark in the box:

- ☐ Head injury
- ☐ Hemorrhage
- ☐ Meningitis
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizures
- ☐ Stroke
- ☐ Shingles
- ☐ Chest pain
- ☐ Irregular Heart Rhythm
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Vision problems
- ☐ Blood clots
- ☐ Asthma
- ☐ Colitis
- ☐ Constipation
- ☐ Gastric Ulcer Disease
- ☐ Gastric bleeding
- ☐ Pancreatitis
- ☐ Heartburn
- ☐ Esophageal Reflux
- ☐ Cystitis
- ☐ Kidney Stones
- ☐ Menopause
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Kidney failure
- ☐ Blood disorders
- ☐ Chronic Pain
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Obesity
- ☐ Gout
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ HIV disease
- ☐ Psoriasis
- ☐ Hives or rashes
- ☐ Dental problems
- ☐ Grinding teeth
- ☐ Sleep Apnea
- ☐ Restless Legs
- ☐ Hepatitis
- ☐ Liver Disease

Other: _____

List Surgeries with dates: _____

ASSESSMENT

MEDICAL SYMPTOMS CHECKLIST

Have you had any of the following in the past week:
(If you check yes, state number of days and severity).

	# of Days	Severity Rating (1 low- 5 high) 1 2 3 4 5
_____Back pain	_____	
_____Foot or hand pain	_____	
_____Neck pain	_____	
_____Genital pain	_____	
_____Headaches	_____	
_____Chest pain	_____	
_____Deep muscle pain (in Limbs)	_____	
_____Jaw pain	_____	
_____Numbness	_____	
_____Bruising	_____	
_____Flushing	_____	
_____Swelling	_____	
_____Acne or Rosacea	_____	
_____Hives	_____	
_____Skin Discoloration	_____	
_____Warts/eczema	_____	
_____Fever		
_____Night Sweats	_____	
_____ Cold/Flu Symptoms	_____	
	_____	
_____Constipation	_____	
_____Diarrhea	_____	
_____Flatulence	_____	
_____Cramping	_____	
_____Bloating	_____	
_____Difficulty Swallowing	_____	
_____Sore throat	_____	
_____Dry mouth (cotton mouth)	_____	
_____Heartburn/GERD	_____	
_____Nausea/vomiting	_____	
_____Daytime Fatigue / Sleepiness	_____	
_____Insomnia	_____	
_____Malaise	_____	
_____Dizziness	_____	
_____Double vision	_____	
_____Eye strain	_____	
_____Fainting spells	_____	
_____Heart palpitations	_____	
_____Shortness of breath	_____	
_____Persistent cough	_____	
_____Wheezing	_____	
_____Vaginal infections	_____	
_____Urinary Tract Infections	_____	
_____Frequent Urination	_____	
_____Menstrual pain	_____	
_____Memory problems		
_____Concentration problems	_____	
	_____	
_____ Increase/Decrease in appetite	_____	
_____ Weight gain (> 5lbs)		
_____ Weight loss (> 5lbs)		
	_____	
_____Ringing in the ears	_____	
_____Toothaches	_____	
_____Other		

ASSESSMENT

Quick Inventory of Dep

1. **Falling Asleep:**
   - ☐ I never take longer than
   - ☐ I take at least 30 minutes
   - ☐ I take at least 30 minutes
   - ☐ I take at least 60 minutes
2. **Sleep During the Night:**
   - ☐ I do not wake up at night
   - ☐ I have a restless, light sle
   - ☐ I wake up at least once a
   - ☐ I awaken more than once
3. **Waking Up Too Early:**
   - ☐ Most of the time, I awak
   - ☐ More than half the time,
   - ☐ I almost always awaken
   - ☐ I awaken at least one hou
4. **Sleeping Too Much:**
   - ☐ I sleep no longer than 7-
   - ☐ I sleep no longer than 10
   - ☐ I sleep no longer than 12
   - ☐ I sleep longer than 12 ho
5. **Feeling Sad:**
   - ☐ I do not feel sad
   - ☐ I feel sad less than half t
   - ☐ I feel sad more than half
   - ☐ I feel sad nearly all the t
6. **Decreased Appetite:**
   - ☐ My usual appetite has not
   - ☐ I eat somewhat less ofter
   - ☐ I eat much less than usua
   - ☐ I rarely eat within a 24-h persuade me to eat
7. **Increased Appetite:**
   - ☐ My usual appetite has not
   - ☐ I eat somewhat less ofter
   - ☐ I eat much less than usua
   - ☐ I rarely eat within a 24-h persuade me to eat
8. **Decreased Weight (Within the Las**
   - ☐ My weight has not decre
   - ☐ I feel as if I've had a slig
   - ☐ I have lost 2 pounds or n
   - ☐ I have lost 5 pounds or n

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

r make decisions
anders
ake decisions
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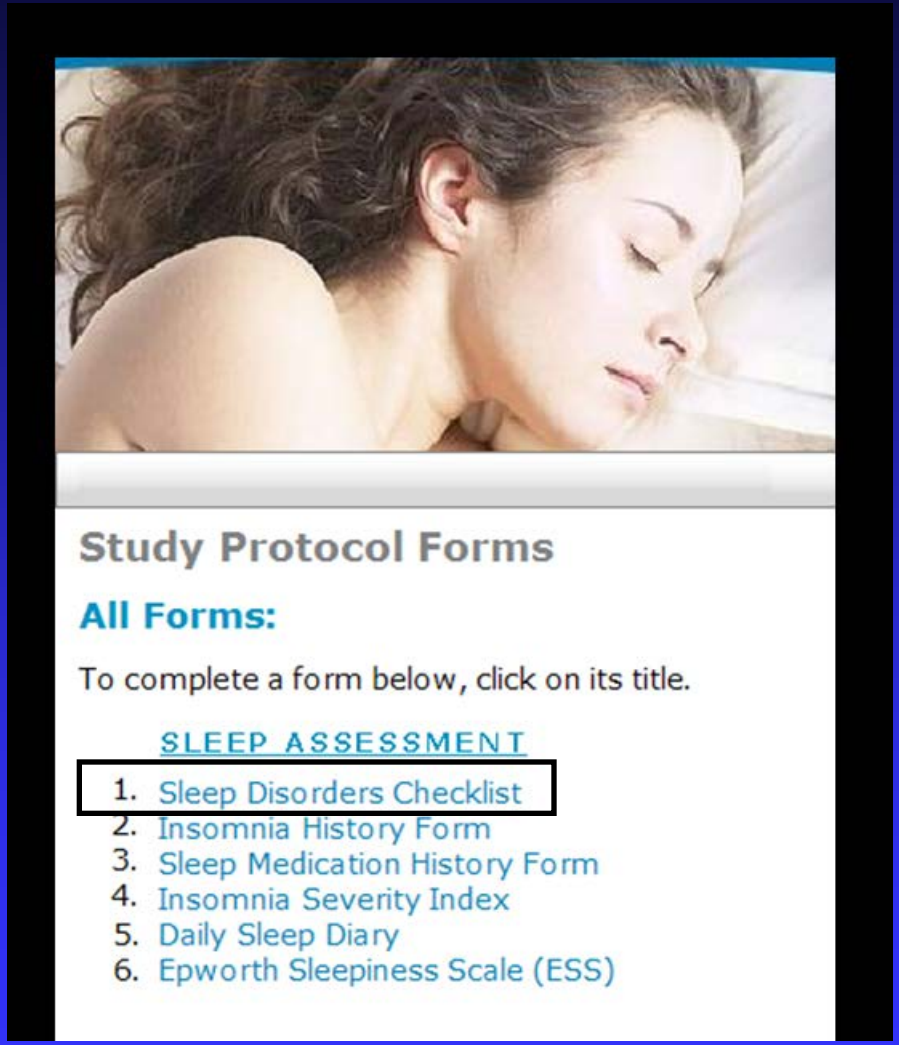
ressive Symptomatology (IDS)

ASSESSMENT

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "□" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

ASSESSMENT


Study Protocol Forms
All Forms:
To complete a form below, click on its title.
SLEEP ASSESSMENT
1. Sleep Disorders Checklist
2. Insomnia History Form
3. Sleep Medication History Form
4. Insomnia Severity Index
5. Daily Sleep Diary
6. Epworth Sleepiness Scale (ESS)

SLEEP HISTORY QUESTIONAIRE VERSION

SDS-CL-25 (V4)

Date: ___/___/___ ID/Initials ____ Age: ___ Sex: __ Height _____ Weight _____ Work Shift: __ n/a __ First (9-5pm) __ Second (4-12am) __ Third (12to 8am) Work Hours: __ 0 __ 10-20 __ 20-40 ___ > 40 Hours per week Do you regularly have a bed partner? (3 or more days/week) ___ (Yes/No) How much sleep do you typically get per night? ____ hours (e.g., 8.5 hrs) How much time do you typically spend in bed per night? ____ hours (e.g., 9.0 hrs) **Answer all questions for what has been typical for you for the last 3 months.**	0 NEVER	1 ONCE A MONTH	2 1-3 TIMES A WEEK	3 3-5 TIMES A WEEK	4 >5 TIMES A WEEK
1. My work or other activities prevent me from getting at least 7hrs of sleep					
2. My bedtime or waketime varies by more than 3 hours					
3. It takes me 30 minutes or more to fall asleep					
4. I am awake for 30 minutes or more during the night					
5. I wake up 30 or more minutes before I have to and can't fall back asleep					
6. I am tired, fatigued, or sleepy during the day					
7. I sleep better if I go to bed before 9pm and wakeup before 430am					
8. I sleep better if I go to bed late (after 1am) and wakeup late (after 9am)					
9. I am prone to fall asleep at inappropriate times or places					
10. I snore					
11. I wake up with a dry mouth in the morning (cotton mouth)					
12. My snoring is so loud, that my bed partner complains					
13. I have been told that that I stop breathing in my sleep					
14. I wake up choking or gasping for air					
15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them					
16. I have an urge to move my legs that is worse in the evenings and nights					
17. I wake up frequently during the night for no reason					
18. When angered, humored, frightened, I experience sudden muscle weakness					
19. When falling asleep or waking up, I experience scary dream like images					
20. When I am first awakening, I feel like I can't move					
21. I have nightmares					
22. For no reason, I awaken suddenly, feeling startled and afraid					
23. I have been told that I walk, talk, eat, act strangely or violently while asleep					
24. I grind my teeth or clench my jaw while I sleep					
25. My sleep difficulties interfere with my daily activities					

SDS-CL-25 (V4)

Date: ___/___/___ ID/Initials ____ Age: ___ Sex: __ Height _____ Weight _____ Work Shift: __ n/a __ First (9-5pm) __ Second (4-12am) __ Third (12to 8am) Work Hours: __ 0 __ 10-20 __ 20-40 ___ > 40 Hours per week Do you regularly have a bed partner? (3 or more days/week) ___ (Yes/No) How much sleep do you typically get per night? ____ hours (e.g., 8.5 hrs) How much time do you typically spend in bed per night? ____ hours (e.g., 9.0 hrs) **Answer all questions for what has been typical for you for the last 3 months.**	0 NEVER	1 ONCE A MONTH	2 1-3 TIMES A WEEK	3 3-5 TIMES A WEEK	4 >5 TIMES A WEEK
1. My work or other activities prevent me from getting at least 7hrs of sleep	●				
2. My bedtime or waketime varies by more than 3 hours			●		
3. It takes me 30 minutes or more to fall asleep					●
4. I am awake for 30 minutes or more during the night				●	
5. I wake up 30 or more minutes before I have to and can't fall back asleep			●		
6. I am tired, fatigued, or sleepy during the day				●	
7. I sleep better if I go to bed before 9pm and wakeup before 430am	●				
8. I sleep better if I go to bed late (after 1am) and wakeup late (after 9am)	●				
9. I am prone to fall asleep at inappropriate times or places	●				
10. I snore	●				
11. I wake up with a dry mouth in the morning (cotton mouth)	●				
12. My snoring is so loud, that my bed partner complains	●				
13. I have been told that that I stop breathing in my sleep	●				
14. I wake up choking or gasping for air	●				
15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them	●				
16. I have an urge to move my legs that is worse in the evenings and nights	●				
17. I wake up frequently during the night for no reason	●				
18. When angered, humored, frightened, I experience sudden muscle weakness	●				
19. When falling asleep or waking up, I experience scary dream like images	●				
20. When I am first awakening, I feel like I can't move	●				
21. I have nightmares	●				
22. For no reason, I awaken suddenly, feeling startled and afraid	●				
23. I have been told that I walk, talk, eat, act strangely or violently while asleep	●				
24. I grind my teeth or clench my jaw while I sleep	●				
25. My sleep difficulties interfere with my daily activities					●

SDS-CL-25

The SDS-CL-25, despite it brevity, allows for the assessment of ten sleep disorders, four functional outcomes of sleep, an estimate of preferred sleep phase and duration, and a retrospective estimate of sleep efficiency.

The disorders include

Insomnia disorder
Advanced sleep phase syndrome & delayed sleep phase syndrome
Obstructive sleep apnea
Restless legs syndrome/periodic limb movement disorder
Narcolepsy
Nightmare disorder
Night terror disorder
REM sleep behavior disorder
Sleep-related temporomandibular joint disorder

The four functional outcomes of sleep include

Night-to-night sleep variability
Excessive daytime sleepiness
Fatigue
Daytime dysfunction

Resize font:

Welcome

The SDS-CL-25 (Sleep Disorders Symptoms Checklist) is a brief and comprehensive assessment for sleep disorders.

The SDS-CL-25 has been in development since 2005, and is currently in its second generation of validation. Articles related to the brief assessment of sleep disorders and the development of the SDS-CL-25 are accessible on the second page.

If you are a clinician, please feel free to use either the online or PDF version of this instrument. If you are a graduate student or post-doctoral fellow and wish to use this instrument as part of your research please contact Dr. Karen Klingman at klingmak@upstate.edu. If you are a federally funded investigator or industry based investigator please contact Dr. Klingman at klingmak@upstate.edu about licensing.

This project represents an active collaboration of Dr. Karen Klingman, Dr. Carla Jungquist and Dr. Michael Perlis.

To help us understand more about who is utilizing the SDS-CL-25, it would be greatly appreciated if you could provide us with your current location (Country and State). This is optional. To proceed please complete the complete the last question and click on the [Submit] button.

https://redcap.upstate.edu/surveys/?s=DT9REXW8DH

ASSESSMENT

Insomnia History Form

Subject ID#_____ Date: _____

1. How old were you when you first starting experiencing insomnia? _____

2. How many years ago did you start experiencing insomnia? _____

3. How old were you when the insomnia became chronic? _____

4. How long have you had insomnia? _____

4. Since you have been experiencing insomnia have there been any periods of time that you have not had insomnia for 2 or more weeks at a time? _____

_____

_____

_____

ASSESSMENT

Sleep Medication History Form

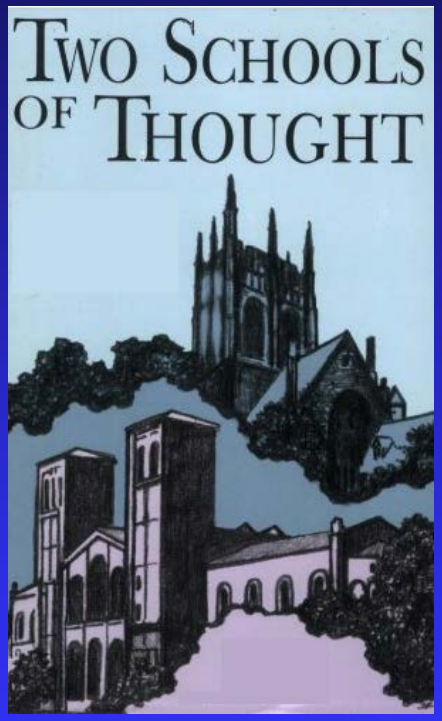
Please include all:

- **Rx** medications that have ever been taken
- **OTC** medications that have ever been taken

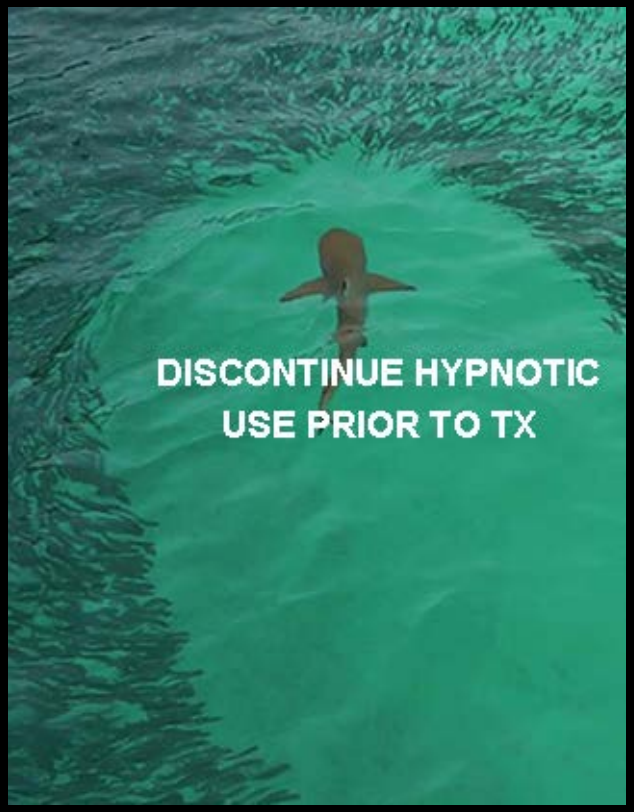
Medication	Ever Used	Start Date (or estimate)	Stop Date (or ongoing)	Effectiveness Rating Scale
Ambien/Zolpidem	○ Yes ○ No			Select rating
Ambien CR/Zolpidem Ext. R	○ Yes ○ No			Select rating
Dalmane/Flurazepam	○ Yes ○ No			Select rating
Doral/Quazepam	○ Yes ○ No			Select rating
Halcion/Triazolam	○ Yes ○ No			Select rating
Lunesta/Eszopiclone	○ Yes ○ No			Select rating
Prosom/Estazolam	○ Yes ○ No			Select rating
Restoril/Temazepam	○ Yes ○ No			Select rating
Rozerem/Ramelteon	○ Yes ○ No			Select rating
Sonata/Zaleplon	○ Yes ○ No			Select rating
Melatonin	○ Yes ○ No			Select rating
Unisom	○ Yes ○ No			Select rating
Benadryl	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating
	○ Yes ○ No			Select rating

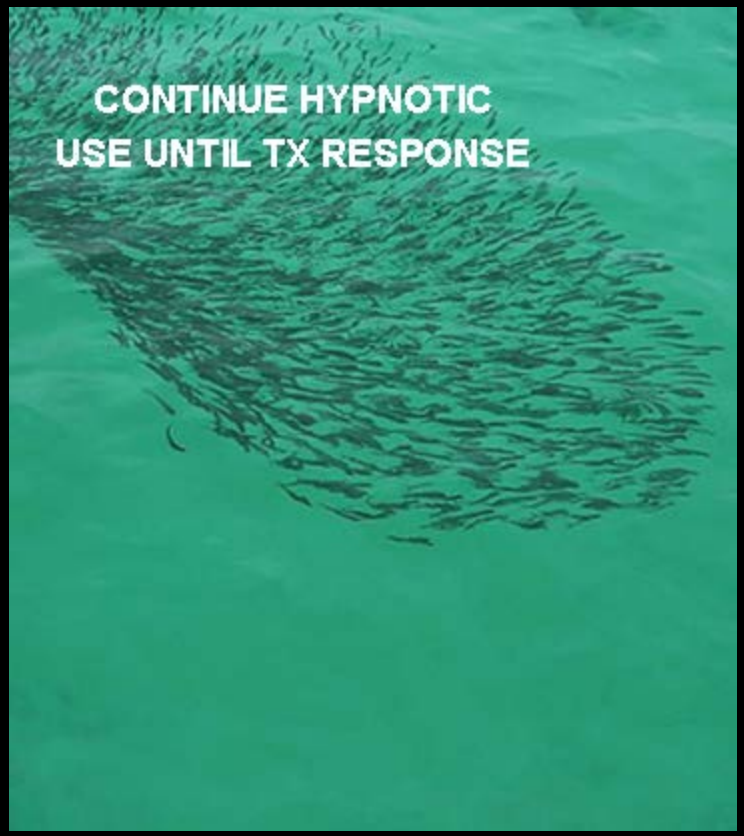
submit cancel

WHAT TO DO ABOUT HYPNOTIC USE



TWO SCHOOLS OF THOUGHT





IF HYPNOTICS WERE WORKING… THE PATIENT WOULD NOT BE SEEKING HELP

BETTER A SETBACK NOW THAN AFTER TX GAINS

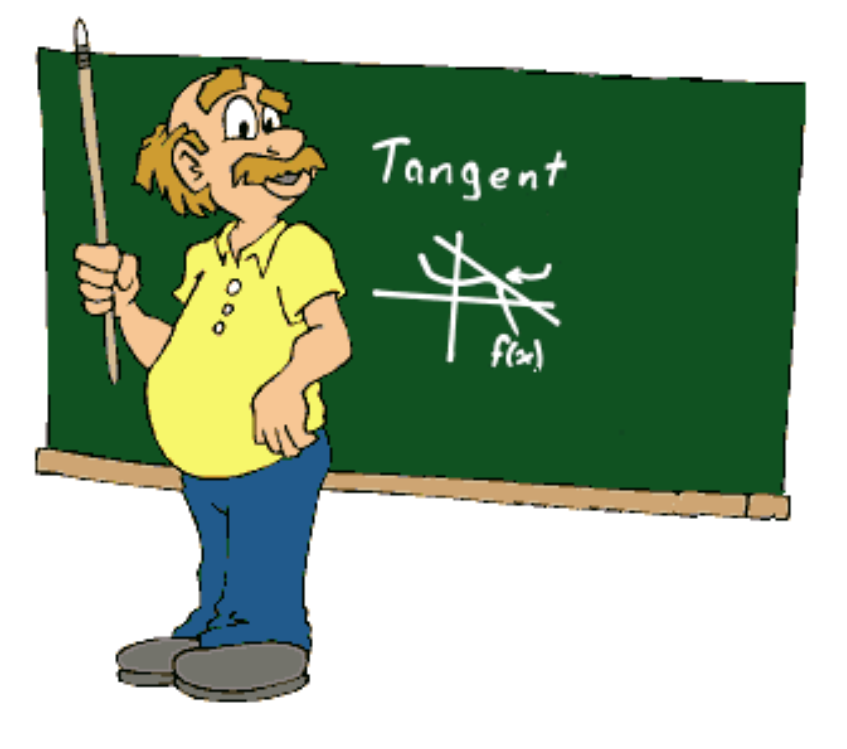
WORSENING UPFRONT SETS UP QUICKER AND LARGE TX GAINS

COLLABORATE WITH PRESCRIBING CLINICIAN

POSSIBLE DISCONTINUATION SCHEDULE

WEEK 1	7 days ½ dose
WEEK 2	7 days every other day ½ dose
WEEK 3	2 days (Fixed) ½ dose
WEEK 4	2ND Baseline week

VERY CONSERVATIVE



BACK TO ASSESSMENT

ASSESSMENT

Insomnia Severity Index (ISI)

Name: _____	Date: _____

1. Please rate the current (i.e., last week) **SEVERITY** of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2. How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.).

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

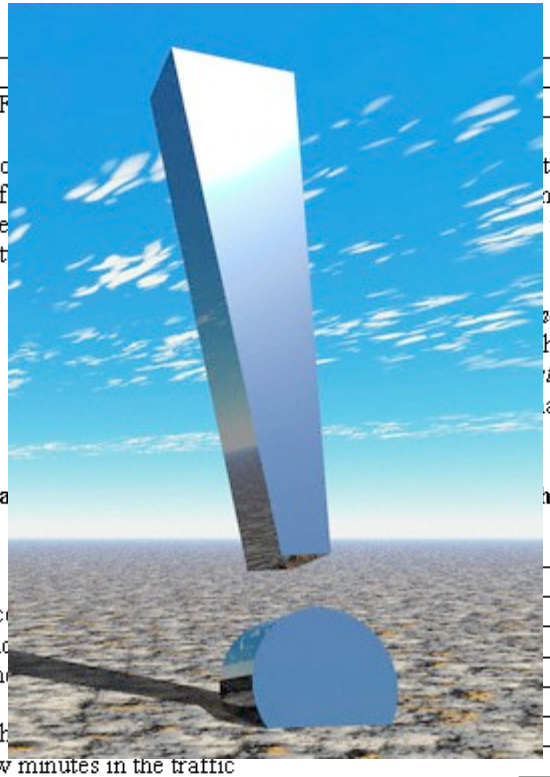
Not at all Noticeable	Barely	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How **WORRIED**/distressed are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4

ASSESSMENT

THE EPWORTH SLEEPINESS SCALE



Name: _____

Today's Date: _____

Your sex (male = M; female = F

How likely are you to doze off o to feeling just tired?
This refers to your usual way of me of these things
recently try to work out how the to choose the *most*
appropriate number for each sit

never doze
hance of dozing
te chance of dozing
ance of dozing

Situa **nance of Dozing**

Sitting and reading _____
Watching TV _____
Sitting, inactive in a public plac _____
As a passenger in a car for an ho _____
Lying down to rest in the aftern _____
Sitting and talking to someone _____
Sitting quietly after a lunch with _____
In a car, while stopped for a few minutes in the traffic _____

Thank you for your cooperation

ASSESSMENT

NAME: _____ DATE _____

COMPLETE IMMEDIATELY BEFORE BED CONCERNING HOW YOU FELT TODAY:

	MON	TUES	WED	THUR	FRI	SAT	SUN		MEAN
TYPICAL DAY? (YES/NO) *									
FATIGUE (NONE 0—1—2—3—4—5 A LOT)									
STRESS (NONE 0—1—2—3—4—5 A LOT)									
ALERT (NOT VERY 0—1—2—3—4—5 VERY)									
CONCENTRATION (GOOD 0—1—2—3—4—5 BAD)									
MOOD (BAD 0—1—2—3—4—5 GOOD)									
TIME SPENT EXERCISING (MIN.)									
TIME SPENT OUTSIDE TODAY (MIN.)									
NUMBER OF ALCOHOLIC BEVERAGES									
PRESCRIPTIONS TODAY (YES/NO)									
OTC MEDS TODAY (YES/NO)									
PAIN TODAY (NONE 0—1—2—3—4—5 A LOT)									
HEALTH (FELT FINE 0—1—2—3—4—5 BAD)									
MENSTRUATE TODAY (YES/NO)									
MENSTRUAL PAIN (NONE 0—1—2—3—4—5 BAD)									

** PLEASE INDICATE ON THE BACK OF THIS SHEET WHY ANY GIVEN DAY WAS NOT TYPICAL AND/OR WHAT MEDICATIONS YOU TOOK ON ANY GIVEN DAY.

COMPLETE IMMEDIATELY ON AWAKENING

	MON	TUES	WED	THURS	FRI	SAT	SUN		MEAN
TIME TO BED (CLOCK TIME)									
TIME OUT OF BED (CLOCK TIME)									
TIME TO BED (DEV FRM 11)									
TIME OUT OF BED (DEV FRM 7)									
(SL) TIME TO FALL ASLEEP									
(NUMA) NUMBER TIMES AWAKENED									
(WASO) WAKE AFTER SLEEP ONSET									
(TTOB) TOTAL AMOUNT TIME OUT OF BED									
(TST) TOTAL SLEEP TIME (MIN.)									
SLEEP QUALITY (GOOD 0—1—2—3—4—5 POOR)									
FATIGUE (NONE 0—1—2—3—4—5 A LOT)									

SE AND TIB TO BE AUTOCALCULATE

ASSESSMENT

NAME: _____ DATE _____

COMPLETE IMMEDIATELY BEFORE BED CONCERNING HOW YOU FELT TODAY:

	MON	TUES	WED	THUR	FRI	SAT	SUN		MEAN
TYPICAL DAY? (YES/NO) *									
FATIGUE (NONE 0—1—2—3—4—5 A LOT)									
STRESS (NONE 0—1—2—3—4—5 A LOT)									
ALERT (NOT VERY 0—1—2—3—4—5 VERY)									
CONCENTRATION (GOOD 0—1—2—3—4—5 BAD)									
MOOD (BAD 0—1—2—3—4—5 GOOD)									
TIME SPENT EXERCISING (MIN.)									
TIME SPENT OUTSIDE TODAY (MIN.)									
NUMBER OF ALCOHOLIC BEVERAGES									
PRESCRIPTIONS TODAY (YES/NO)									
OTC MEDS TODAY (YES/NO)									
PAIN TODAY (NONE 0—1—2—3—4—5 A LOT)									
HEALTH (FELT FINE 0—1—2—3—4—5 BAD)									
MENSTRUATE TODAY (YES/NO)									
MENSTRUAL PAIN (NONE 0—1—2—3—4—5 BAD)									

** PLEASE INDICATE ON THE BACK OF THIS SHEET WHY ANY GIVEN DAY WAS NOT TYPICAL AND/OR WHAT MEDICATIONS YOU TOOK ON ANY GIVEN DAY.

COMPLETE IMMEDIATELY ON AWAKENING

	MON	TUES	WED	THURS	FRI	SAT	SUN		MEAN
TIME TO BED (CLOCK TIME)									
TIME OUT OF BED (CLOCK TIME)									
TIME TO BED (DEV FRM 11)									
TIME OUT OF BED (DEV FRM 7)									
(SL) TIME TO FALL ASLEEP									
(NUMA) NUMBER TIMES AWAKENED									
(WASO) WAKE AFTER SLEEP ONSET									
(TTOB) TOTAL AMOUNT TIME OUT OF BED									
(TST) TOTAL SLEEP TIME (MIN.)									
SLEEP QUALITY (GOOD 0—1—2—3—4—5 POOR)									
FATIGUE (NONE 0—1—2—3—4—5 A LOT)									

AWAKENINGS BY TIME OF NIGHT
EMA VARIABLE

SE AND TIB TO BE AUTOCALCULATE

ASSESSMENT

LAB STORY

ASSESSMENT

SLEEP ENVIRONMENT QUESTIONNAIRE

1. I use an alarm clock five or more days a week.

True False Not Applicable

2. I keep the temperature in the bedroom so cold that I have 2 or more blankets on the bed to stay warm at night

True False Not Applicable

3. The blinds and curtains in the bedroom are so effective that at sunrise the room is so dark its hard to tell that the sun came up.

True False Not Applicable

4. I have spent real time and money making sure that my mattress and pillow are perfect for me.

True False Not Applicable

5. During the night, my bedroom is insulated so well that I rarely if ever hear outside noise from the road, neighbors, etc.

True False Not Applicable

6. House noise from the radiators, floor boards, etc. is so minimal that I am rarely aware of such sounds.

True False Not Applicable

7. My home is a safe place. My partner and/or pet and/or the locks and alarm system and/or concern and support of my neighbors provides me a level of comfort such that I rarely if ever worry about being safe at night.

True False Not Applicable

8. On three or more nights per week, I engage in two or more of the following behaviors in the bedroom: watch TV, read, plan, worry, work, clean, or eat).

True False Not Applicable

9. My pets rarely if ever keep me from falling asleep or wake me up during the night.

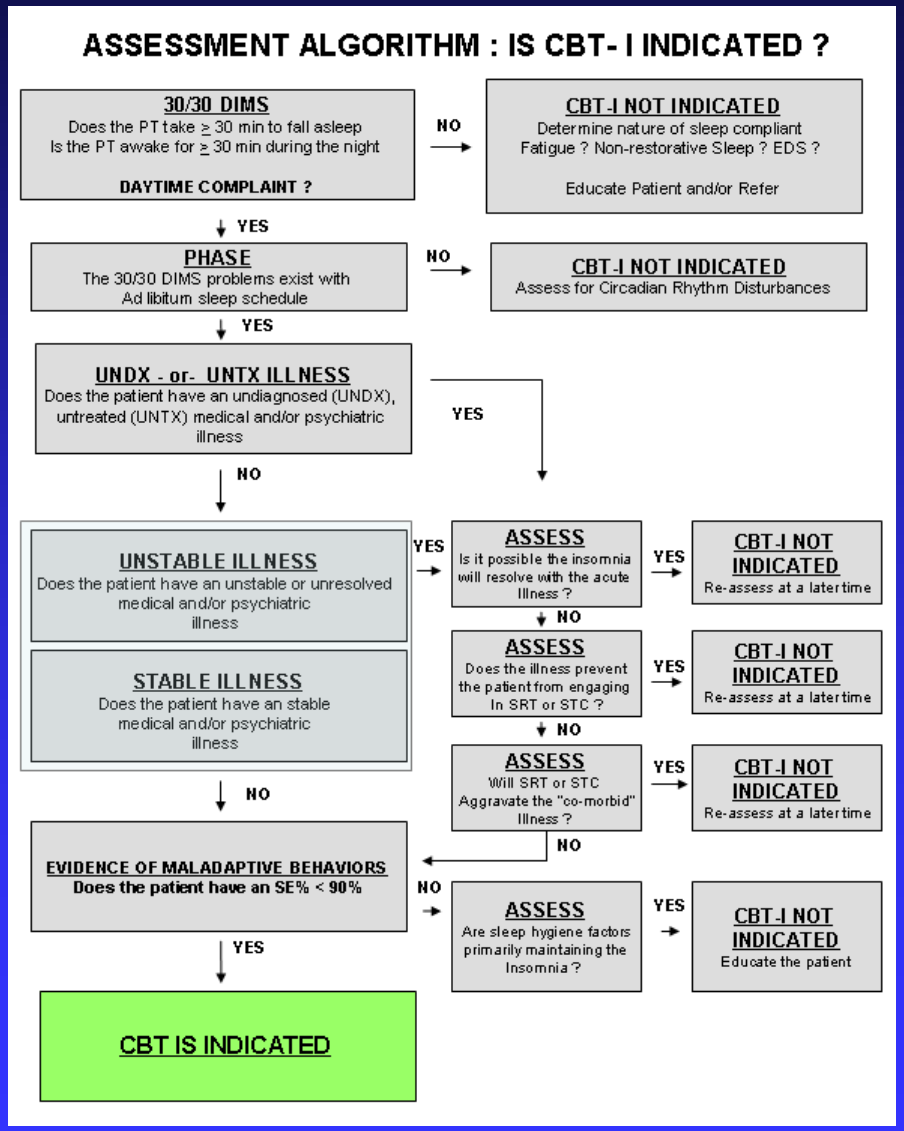
True False Not Applicable

10. My bed partner's sleep schedule or "habits" while in bed (reading, moving about, stealing the covers, snoring, etc.) rarely if ever disturb my sleep.

True False Not Applicable

NOW YOU HAVE ALL THE INFO

IS THE PATIENT
A GOOD CANDIDATE FOR CBT- I ?



SESSION-1 “TO DO LIST”

Tasks	
Introduce yourself to the patient	✓
Complete Intake Questionnaires	✓
Conduct Clinical Interview	✓
Determine if patient is a candidate for CBT-I.	✓
Determine other treatment options	✓
Present An Overview of Treatment Options	
Orient Patient to the Sleep Diary (and actigraph)	
Field Patient Questions & Address Resistances	
Setting the Weekly Agenda	

TREATMENT
OPTIONS/PROCESS

THE PATIENT NEEDS TO KNOW THE PLAN

1 WEEK OF BASELINE AND WHY (SANS CLOCK)

THAT THEY WILL DECIDE NEXT WEEK WHAT TX

OPTIONS

DELAY TREATMENT

BEGIN TREATMENT WITH SLEEP MEDS

BEGIN TREATMENT BY D/C SLEEP MEDS

IN THE BAG

SLEEP COMPRESSION, THE ISR PROCEDURE,
BRIGHT LIGHT, RELAXATION TRAINING,

CBT+M, MEDS ALONE

SESSION-1 “TO DO LIST”

Tasks	
Introduce yourself to the patient	✓
Complete Intake Questionnaires	✓
Conduct Clinical Interview	✓
Determine if patient is a candidate for CBT-I.	✓
Determine other treatment options	✓
Present An Overview of Treatment Options	✓
Orient Patient to the Sleep Diary (and actigraph)	
Field Patient Questions & Address Resistances	
Setting the Weekly Agenda	

ASSESSMENT

THE PRICE OF THERAPY IS SLEEP DIARIES

N

CON

	MON	TUES	WED	THUR	FRI	SAT	SUN	MEAN
TYPICAL DAY? (YES/NO) *								
FATIGUE (NONE 0—1—2—3—4—5 A LOT)								
STRESS (NONE 0—1—2—3—								
ALERT (NOT VERY 0—1—2—3								
CONCENTRATION (GOOD 0—								
MOOD (BAD 0—1—2—3—4—								
TIME SPENT EXERCISING (MI								
NUMBER OF ALCOHOLIC BEV								
PRESCRIPTIONS TODAY (YES								
OTC MEDS TODAY (YES/NO)								
PAIN TODAY (NONE 0—1—2—								
HEALTH (FELT FINE 0—1—2—								
MENSTRUATE TODA								
MENSTRUAL PAIN (NONE 0—								

** PLEASE INDICATE ON THE BA ONS YOU TOOK ON ANY GIVEN DAY.

COMPLETE IMMEDIATELY ON AWAKE ME)

						SAT	SUN	MEAN
TIME TO BED (CLOCI								
TIME OUT OF BED (CLOCK								
(TIB) TOTAL TIME IN BED								
TIME TO BED (DEV F								
TIME OUT OF BED (DEV								
(SL) TIME TO FALL ASLEEP								
(NUMA) NUMBER TIMES AWAKENED								
(WASO) WAKE AFTER SLEEP ONSET								
(TTOB) TOTAL AMOUNT TIME OUT OF BED								
(TST) TOTAL SLEEP TIME (MIN.)								
(SE) SLEEP EFFICENCY								
SLEEP QUALITY (POOR 0—1—2—3—4—5 GOOD)								
FATIGUE (NONE 0—1—2—3—4—5 A LOT)								

ASSESSMENT

ACTIGRAPHY

WHY NOT JUST USE THESE FOR TX !

WE CONFUSE RELIABILITY FOR VALIDITY

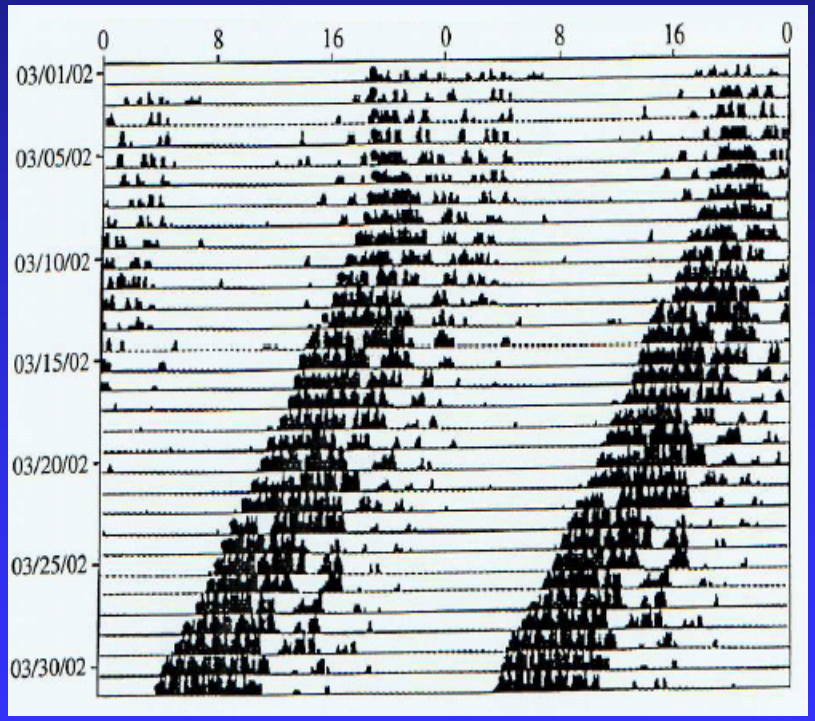
NOT A MEAUSURE OF PATIENT EXPERIENCE

SO WHY USE THEM AT ALL ?

ASSESSMENT

ACTIGRAPHY

CIRCADIAN DISTURBANCES



ASSESSMENT

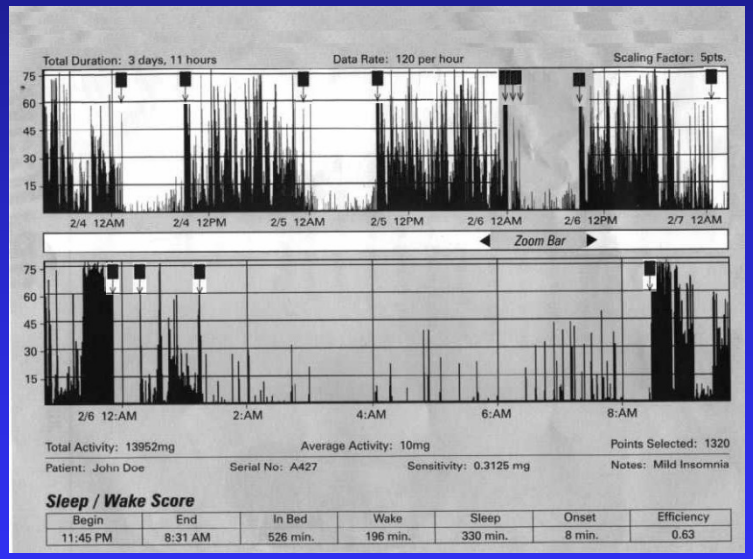
ACTIGRAPHY

SUB-OB DETECTION

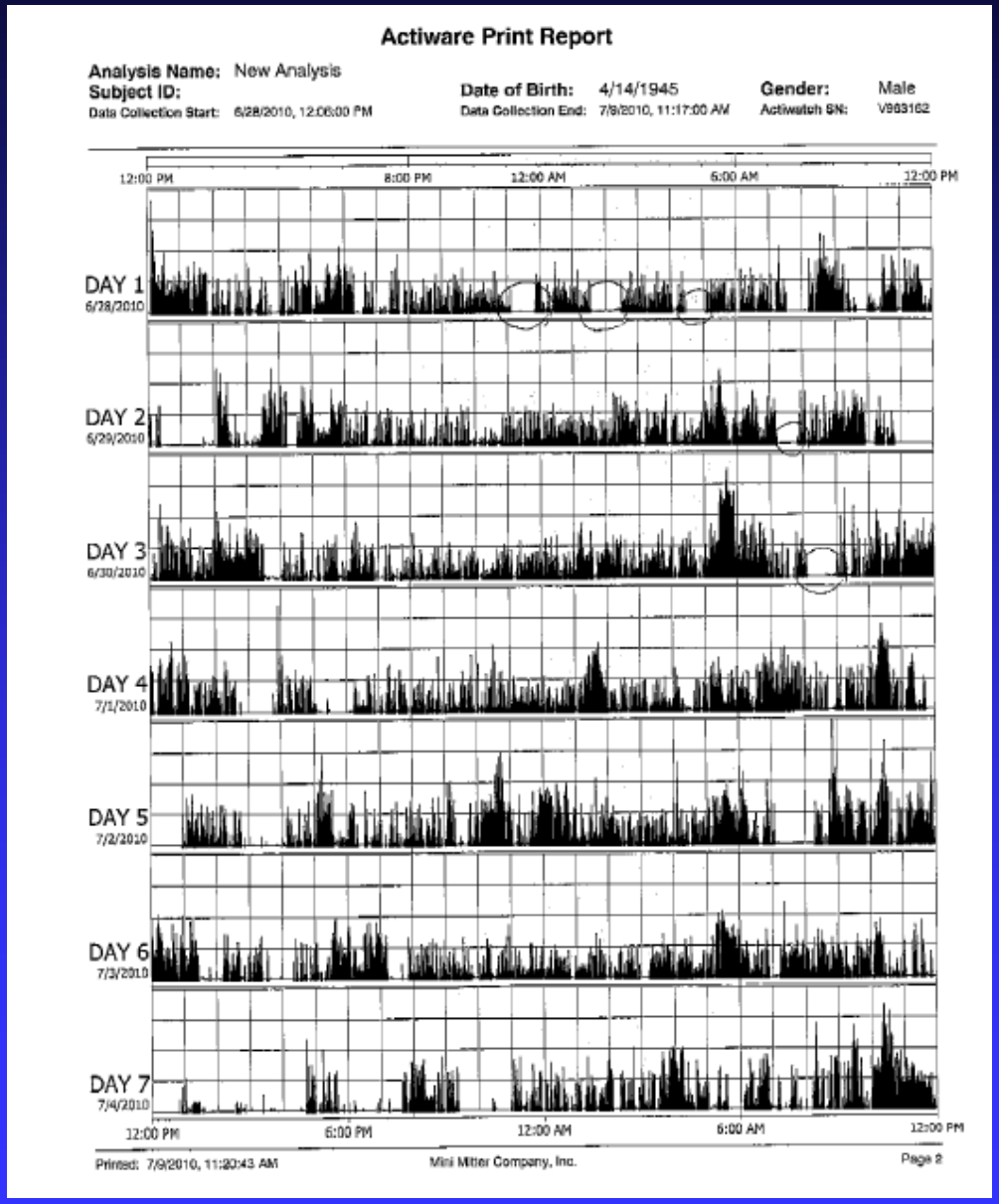
COMPLETE IMMEDIATELY ON AWAKENING (PLEASE CACULATE TOTAL TIME IN BED AND TOTAL SLEEP TIME)

	MON	TUES	WED	THURS	FRI	SAT	SUN
TIME TO BED (CLOCK TIME)	10:00	11:00	12:00	11:00	10:00	12:00	11:00
TIME OUT OF BED (CLOCK TIME)	6:00	6:00	6:00	6:00	6:00	8:00	8:00
(TIB) TOTAL TIME IN BED	480	420	360	420	480	480	420
TIME TO BED (DEV FRM 11)	-60	0	60	0	-60	60	0
TIME OUT OF BED (DEV FRM 7)	-60	-60	-60	-60	-60	60	60
(SL) TIME TO FALL ASLEEP	35	55	45	35	60	65	20
(NUMA) NUMBER TIMES AWAKENED	2	1	3	3	4	2	1
(WASO) WAKE AFTER SLEEP ONSET	20	65	60	35	45	55	35
(TTOB) TOTAL AMOUNT TIME OUT OF BED	0	0	0	0	0	0	0
(TST) TOTAL SLEEP TIME (MIN.)	425	300	255	350	375	360	365
(SE) SLEEP EFFICENCY	88.5	71.4	70.8	83.3	78.1	75.0	86.9
SLEEP QUALITY (POOR 0—1—2—3—4—5 GOOD)	0	1	2	3	0	1	1
FATIGUE (NONE 0—1—2—3—4—5 A LOT)	5	4	3	5	5	4	5

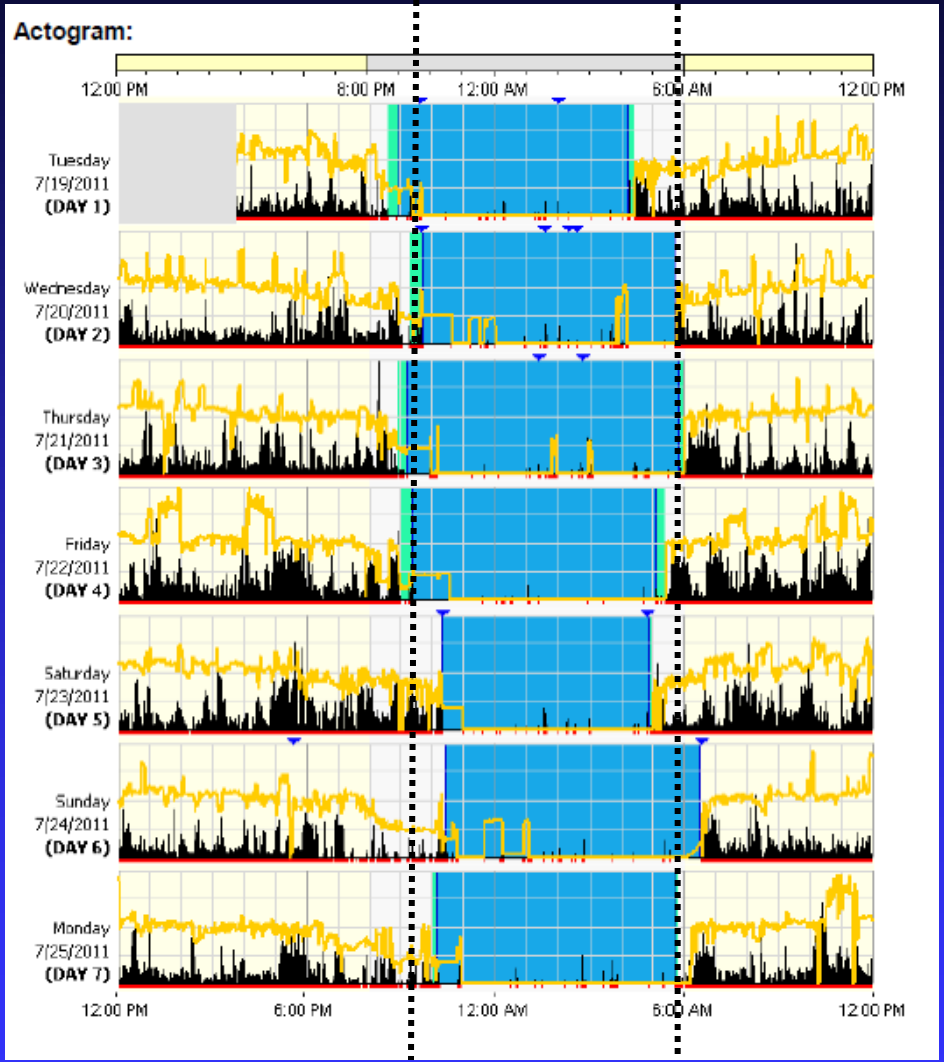
- VS -



SOMETIMES IT IS AS THEY SAY



LIGHT, TIB, AND SLEEP



ISSUES: BIOCALIBRATION

ACTIVITY LEVEL – LIGHT LEVELS

ASSESSMENT

ACTIGRAPHY

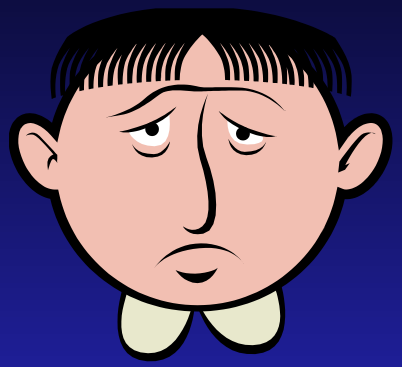
COMPLIANCE

THE NANNY CAM EFFECT

SESSION-1 “TO DO LIST”

Tasks	
Introduce yourself to the patient	✓
Complete Intake Questionnaires	✓
Conduct Clinical Interview	✓
Determine if patient is a candidate for CBT-I.	✓
Determine other treatment options	✓
Present An Overview of Treatment Options	✓
Orient Patient to the Sleep Diary (and actigraph)	✓
Field Patient Questions & Address Resistances	
Setting the Weekly Agenda	

QUESTIONS & RESISTANCES



WHY DO I HAVE TO WAIT A WEEK TO START TX ?

CAN WE DO A PART OF TX THIS WEEK ?

WHY CAN'T I CONTINUE MY SLEEP MEDICATION ?

CAN YOU AT LEAST EXPLAIN WHAT TX WILL BE ?

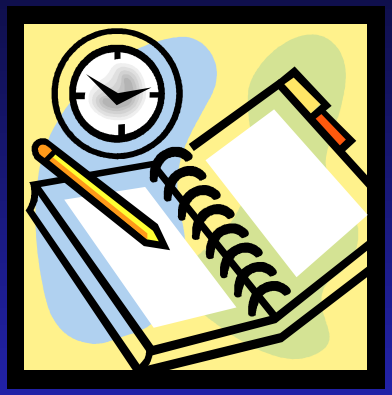
AREN'T I SUPPOSED TO GET A SLEEP STUDY ?

WHY AM I NOT SEEING A REAL DOCTOR ?

SESSION-1 “TO DO LIST”

Tasks	
Introduce yourself to the patient	✓
Complete Intake Questionnaires	✓
Conduct Clinical Interview	✓
Determine if patient is a candidate for CBT-I.	✓
Determine other treatment options	✓
Present An Overview of Treatment Options	✓
Orient Patient to the Sleep Diary (and actigraph)	✓
Field Patient Questions & Address Resistances	✓
Setting the Weekly Agenda	

WEEKLY AGENDA



NEXT WEEK

REVIEW YOUR SLEEP DIARY DATA

DECIDE IF YOU WISH TO PURSUE TX

IF YES
CHART YOUR SLEEP DIARY DATA
SELECT TX APPROACH
BEGIN TX PROCESS

BREAK

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