

Sleep Diary Instructions - Core

General Instructions

What is a Sleep Diary? A sleep diary is designed to gather information about your daily sleep pattern.

How often and when do I fill out the sleep diary? It is necessary for you to complete your sleep diary every day. If possible, the sleep diary should be completed within one hour of getting out of bed in the morning.

What should I do if I miss a day? If you forget to fill in the diary or are unable to finish it, leave the diary blank for that day.

What if something unusual affects my sleep or how I feel in the daytime? If your sleep or daytime functioning is affected by some unusual event (such as an illness, or an emergency) you may make brief notes on your diary.

What do the words “bed” and “day” mean on the diary? This diary can be used for people who are awake or asleep at unusual times. In the sleep diary, the word “day” is the time when you choose or are required to be awake. The term “bed” means the place where you usually sleep.

Will answering these questions about my sleep keep me awake? This is not usually a problem. You should not worry about giving exact times, and you should not watch the clock. Just give your best estimate.

Item Instructions

Use the guide below to clarify what is being asked for each item of the Sleep Diary.

Date: Write the date of the morning you are filling out the diary.

1. *What time did you get into bed?* Write the time that you got into bed. This may not be the time that you began “trying” to fall asleep.

2. *What time did you try to go to sleep?* Record the time that you began “trying” to fall asleep.

3. *How long did it take you to fall asleep?* Beginning at the time you wrote in question 2, how long did it take you to fall asleep.

4. *How many times did you wake up, not counting your final awakening?* How many times did you wake up between the time you first fell asleep and your final awakening?

5. *In total, how long did these awakenings last?* What was the total time you were awake between the time you first fell asleep and your final awakening. For example, if you woke 3 times for 20 minutes, 35 minutes, and 15 minutes, add them all up ($20+35+15=70$ min or 1 hr and 10 min).

6. *What time was your final awakening?* Record the last time you woke up in the morning.

7. *What time did you get out of bed for the day?* What time did you get out of bed with no further attempt at sleeping? This may be different from your final awakening time (e.g. you may have woken up at 6:35 a.m. but did not get out of bed to start your day until 7:20 a.m.)

8. *How would you rate the quality of your sleep?* “Sleep Quality” is your sense of whether your sleep was good or poor.

9. *Comments* If you have anything that you would like to say that is relevant to your sleep feel free to write it here.

Sample

Consensus Sleep Diary-Core

ID/Name: _____

Today's date	4/5/11							
1. What time did you get into bed?	10:15 p.m							
2. What time did you try to go to sleep?	11:30 p.m							
3. How long did it take you to fall asleep?	55 min.							
4. How many times did you wake up, not counting your final awakening?	3 times							
5. In total, how long did these awakenings last?	1 hour 10 min.							
6. What time was your final awakening?	6:35 a.m.							
7. What time did you get out of bed for the day?	7:20 a.m							
8. How would you rate the quality of your sleep?	<input type="checkbox"/> Very poor <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good
9. Comments (if applicable)	I have a cold							

Sleep Diary Instructions (CSD-M)

General Instructions

What is a Sleep Diary? A sleep diary is designed to gather information about your daily sleep pattern.

How often and when do I fill out the sleep diary? It is necessary for you to complete your sleep diary every day. If possible, the sleep diary should be completed within one hour of getting out of bed in the morning.

What should I do if I miss a day? If you forget to fill in the diary or are unable to finish it, leave the diary blank for that day.

What if something unusual affects my sleep or how I feel in the daytime? If your sleep or daytime functioning is affected by some unusual event (such as an illness, or an emergency) you may make brief notes on your diary.

What do the words “bed” and “day” mean on the diary? This diary can be used for people who are awake or asleep at unusual times. In the sleep diary, the word “day” is the time when you choose or are required to be awake. The term “bed” means the place where you usually sleep.

Will answering these questions about my sleep keep me awake? This is not usually a problem. You should not worry about giving exact times, and you should not watch the clock. Just give your best estimate.

Sleep Diary Item Instructions

Use the guide below to clarify what is being asked for each item of the Sleep Diary.

Date.: Write the date of the morning you are filling out the diary.

1. *What time did you get into bed?* Write the time that you got into bed. This may not be the time you began “trying” to fall asleep.
2. *What time did you try to go to sleep?* Record the time that you began “trying” to fall asleep.
3. *How long did it take you to fall asleep?* Beginning at the time you wrote in question 2, how long did it take you to fall asleep.
4. *How many times did you wake up, not counting your final awakening?* How many times did you wake up between the time you first fell asleep and your final awakening?
5. *In total, how long did these awakenings last?* What was the total time you were awake between the time you first fell asleep and your final awakening. For example, if you woke 3 times for 20 minutes, 35 minutes, and 15 minutes, add them all up ($20+35+15= 70$ min or 1 hr and 10 min).
- 6a. *What time was your final awakening?* Record the last time you woke up in the morning.
- 6b. *After your final awakening, how long did you spend in bed trying to sleep?* After the last time you woke-up (Item #6a), how many minutes did you spend in bed trying to sleep? For example, if you woke up at 8 am but continued to try and sleep until 9 am, record 1 hour.
- 6c. *Did you wake up earlier than you planned?* If you woke up or were awakened earlier than you planned, check yes. If you woke up at your planned time, check no.
- 6d. *If yes, how much earlier?* If you answered “yes” to question 6c, write the number of minutes you woke up earlier than you had planned on waking up. For example, if you woke up 15 minutes before

the alarm went off, record 15 minutes here.

7. *What time did you get out of bed for the day?* What time did you get out of bed with no further attempt at sleeping? This may be different from your final awakening time (e.g. you may have woken up at 6:35 a.m. but did not get out of bed to start your day until 7:20 a.m.)

8. *In total, how long did you sleep?* This should just be your best estimate, based on when you went to bed and woke up, how long it took you to fall asleep, and how long you were awake. You do not need to calculate this by adding and subtracting; just give your best estimate.

9. *How would you rate the quality of your sleep?* "Sleep Quality" is your sense of whether your sleep was good or poor.

10. *How restful or refreshed did you feel when you woke up for the day?* This refers to how you felt after you were done sleeping for the night, during the first few minutes that you were awake.

11a. *How many times did you nap or doze?* A nap is a time you decided to sleep during the day, whether in bed or not in bed. "Dozing" is a time you may have nodded off for a few minutes, without meaning to, such as while watching TV. Count all the times you napped or dozed at any time from when you first got out of bed in the morning until you got into bed again at night.

11b. *In total, how long did you nap or doze?* Estimate the total amount of time you spent napping or dozing, in hours and minutes. For instance, if you napped twice, once for 30 minutes and once for 60 minutes, and dozed for 10 minutes, you would answer "1 hour 40 minutes." If you did not nap or doze, write "N/A" (not applicable).

12a. *How many drinks containing alcohol did you have?* Enter the number of alcoholic drinks you had where 1 drink is defined as one 12 oz beer (can), 5 oz wine, or 1.5 oz liquor (one shot).

12b. *What time was your last drink?* If you had an alcoholic drink yesterday, enter the time of day in hours and minutes of your last drink. If you did not have a drink, write "N/A" (not applicable).

13a. *How many caffeinated drinks (coffee, tea, soda, energy drinks) did you have?* Enter the number of caffeinated drinks (coffee, tea, soda, energy drinks) you had where for coffee and tea, one drink = 6-8 oz; while for caffeinated soda one drink = 12 oz.

13b. *What time was your last caffeinated drink?* If you had a caffeinated drink, enter the time of day in hours and minutes of your last drink. If you did not have a caffeinated drink, write "N/A" (not applicable).

14. *Did you take any over-the-counter or prescription medication(s) to help you sleep? If so, list medication(s), dose, and time taken:* List the medication name, how much and when you took EACH different medication you took tonight to help you sleep. Include medication available over the counter, prescription medications, and herbals (example: "Sleepwell 50 mg 11 pm"). If every night is the same, write "same" after the first day

15. *Comments:* If you have anything that you would like to say that is relevant to your sleep feel free to write it here.

Sample		Consensus Sleep Diary-M (Please Complete Upon Awakening)					ID/NAME: _____	
Today's Date	4/5/11							
1. What time did you get into bed?	10:15 p.m.							
2. What time did you try to go to sleep?	11:30 p.m.							
3. How long did it take you to fall asleep?	55 min.							
4. How many times did you wake up, not counting your final awakening?	6 times							
5. In total, how long did these awakenings last?	2 hours 5 min.							
6a. What time was your final awakening?	6:35 a.m.							
6b. After your final awakening, how long did you spend in bed trying to sleep?	45 min.							
6c. Did you wake up earlier than you planned?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6d. If yes, how much earlier?	1 hour							
7. What time did you get out of bed for the day?	7:20 a.m.							
8. In total, how long did you sleep?	4 hours 10 min.							
9. How would you rate the quality of your sleep?	<input type="checkbox"/> Very poor <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good	<input type="checkbox"/> Very poor <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good
10. How rested or refreshed did you feel when you woke-up for the day?	<input type="checkbox"/> Not at all rested <input checked="" type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested	<input type="checkbox"/> Not at all rested <input type="checkbox"/> Slightly rested <input type="checkbox"/> Somewhat rested <input type="checkbox"/> Well-rested <input type="checkbox"/> Very well-rested

Consensus Sleep Diary-M Continued

ID/NAME: _____

Sample

Today's Date	4/5/11							
11a. How many times did you nap or doze?	2 times							
11b. In total, how long did you nap or doze?	1 hour 10 min.							
12a. How many drinks containing alcohol did you have?	3 drinks							
12b. What time was your last drink?	9 :20 p.m.							
13a. How many caffeinated drinks (coffee, tea, soda, energy drinks) did you have?	2 drinks							
13b. What time was your last drink?	3 :00 p.m.							
14. Did you take any over-the-counter or prescription medication(s) to help you sleep? If so, list medication(s), dose, and time taken	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Relaxo-Herb Dose: 50 mg Time(s) taken: 11 pm	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:	<input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): Dose: Time(s) taken:
15. Comments (if applicable)	I have a cold							

DUKE STRUCTURED INTERVIEW SCHEDULE FOR DSM-5
AND
INTERNATIONAL CLASSIFICATION OF SLEEP DISORDERS, THIRD EDITION (ICSD-3)
SLEEP DISORDER DIAGNOSES

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Marci M. Loiselle, William K. Wohlgemuth, and Melanie K. Means

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

I'm going to be asking you some questions about your sleep. Before we begin, I have several checklists I'd like you to complete. (Give the participant the Checklist of Emotional Symptoms and read aloud the first question. Write participant's responses, and then give the participant the checklist to complete. Next, give participant the Checklist of Medical Conditions and Symptoms, and Checklist of Medications, Drugs, and Other Substances. When giving participant these checklists, read directions to them. Refer to these checklists when interviewing participants regarding sleep disorders related to medical conditions, emotional symptoms, and the use of medications, drugs, or other substances.)

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DEMOGRAPHIC INFORMATION

NAME: _____ DATE OF BIRTH: _____

AGE: _____ GENDER (check one): ___ F ___ M ___ other

MARITAL STATUS (check one):

ETHNIC BACKGROUND (check one):

___ Single

___ African American

___ Married

___ Asian/Pacific Islander

___ Live-in Partner

___ Hispanic

___ Divorced

___ Native American

___ Separated

___ White, not of Hispanic origin

___ Widowed

___ Other: _____

NUMBER OF CHILDREN: _____

EDUCATION & DEGREES HELD: _____

VOCATIONAL TRAINING: _____

EMPLOYMENT STATUS (check one):

WORK SCHEDULE (check one):

___ Full Time

___ Daytime Work

___ Part Time (Hours/Week) _____

___ Night Work

___ Retired

___ Rotating Shift (describe):

___ Unemployed

CURRENT OR PAST PROFESSION: _____

LIVING ARRANGEMENT (check one):

___ Living Alone

___ With Spouse or Partner

___ With Spouse/Partner and Children

___ With Family Member(s)

___ With Friend(s)/Roommate(s)

___ Other

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF EMOTIONAL SYMPTOMS

Have you ever been diagnosed with a psychiatric disorder or mental condition, or have you ever been involved in treatment with a mental health provider (e.g., psychologist, psychiatrist, social worker, etc.)? If so, please describe.

Have you ever had or do you currently have (i.e. past month) any of the following symptoms? Please check the appropriate box (current or past) for all that apply.

CURRENT (past month)	PAST	SYMPTOM
		Depression
		Feeling "blue"
		Sadness
		Crying spells
		Loss of interest
		Appetite or weight changes
		Social withdrawal
		Low energy
		Suicidal thoughts or thoughts of death
		Decreased sex drive
		Hopelessness
		Mania
		Excessive energy or excitement
		A sense of having unusual powers
		Hyperactivity

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF EMOTIONAL SYMPTOMS (continued)

CURRENT (past month)	PAST	SYMPTOM
		Excessive frivolous spending
		Anxiety
		Trembling
		Excessive worry
		Palpitations
		Jumpiness
		Phobias
		Recurrent bothersome thoughts
		Irresistible urges to repeat certain actions over and over
		Recurrent nightmares or "flashbacks"
		Panic or intense fear of dying
		Choking
		Tension
		Dizziness
		Chest pain
		Sweating
		Hearing voices
		Seeing visions
		Feeling that others are plotting against you
		Great difficulty thinking and concentrating
		Beliefs that others are controlling your mind or reading your thoughts

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF MEDICAL CONDITIONS & SYMPTOMS

Have you ever had or do you currently have (i.e. past month) any of the following disorders or medical symptoms? Please check the appropriate box (current or past) for all that apply.

CURRENT (past month)	PAST	DISORDER/SYMPTOMS
		Heart Disease: Examples: Angina; Cardiac Arrhythmias (irregular heart beats); Congestive Heart Failure; Myocardial Infarction (heart attack)
		Pulmonary Disease: Examples: COPD; Emphysema; Cystic Fibrosis; Asthma
		Gastrointestinal Disorders: Examples: Stomach or Duodenal Ulcers; Reflux Disease (GERD)
		Neurologic Disorders: Examples: Huntington's Disease; Seizures; Spastic Torticollis; Blepharospasm; Dystonias; Parkinson's Disease; Alzheimer's Disease; Dementia; Sleep-disruptive Headaches
		Head Trauma: Examples: Blow to the head with loss of consciousness; Concussion
		Chronic Pain Disorders: Examples: Fibrositis/Fibromyalgia; Arthritis; Muscle Cramps; Chronic Low Back Pain
		Endocrine Disorders such as Thyroid Disease
		Metabolic Disorders such as Diabetes
		Kidney Disease: Examples: Kidney Failure with Dialysis; Kidney Stones
		Autoimmune Disorders such as Lupus
		Cancer
		HIV/AIDS
		Headaches
		Other. Please specify: _____

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF MEDICATION, DRUGS, AND OTHER SUBSTANCES

Have you ever used or do you currently use (i.e. past month) any of the following medications or substances? Please check the appropriate box (current or past) for all that apply.

PRESCRIPTION MEDICATIONS

CURRENT (past month)	PAST	MEDICATIONS/SUBSTANCES
		Antidepressants Examples – Elavil, Trazodone, Prozac, Zoloft
		Anti-anxiety drugs Examples – Valium, Xanax, Buspar
		Anti-psychotics Examples – Thorazine, Haldol, Risperidone
		Antihypertensives Examples – beta blockers, Clonidin
		Thyroid medication Examples – Thyroxin
		Antiasthmatics Examples – Theophyllin, Clebuterol
		Anti-Parkinson drugs Examples – L-Dopa, Sinemet, Requip
		Anticonvulsants Examples – Dilantin, Tegretol, Phenobarbital
		Headache medicines Examples – Cafergot, Imitrex
		Stimulants Examples – Ritalin, Cylert
		Sleep medicines Examples – Ambien, Trazodone, Amitriptyline, Benadryl
		Other – Specify _____

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF MEDICATION, DRUGS, AND OTHER SUBSTANCES, continued

OTHER DRUGS AND SUBSTANCES

CURRENT (past month)	PAST	DRUGS/SUBSTANCES
		Cannabis
		Marijuana
		Hashish
		Cocaine/Crack
		Heroin
		LSD
		Amphetamines
		Glue
		Diet pills
		Other – Specify: _____

COMMON BEVERAGES

CURRENT (past month)	PAST	DRUGS/SUBSTANCES
		Alcohol (used in large quantities or on a daily basis)
		Caffeinated beverages (coffee, tea, soft drinks) 4 or more cups per day or 2 or more cups after 6:00 p.m.

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF MEDICATION, DRUGS, AND OTHER SUBSTANCES, continued

EXPOSURE TO:

Have you ever been or are you currently (i.e. past month) exposed to any of these substances? Please check the appropriate box (current or past) for all that apply.

CURRENT (past month)	PAST	SUBSTANCES
		Lead
		Arsenic
		Mercury
		Copper
		Other poisonous substances Please specify: _____

FOOD ALLERGIES:

Have you ever had or do you currently (i.e. past month) have allergies to any of these foods or beverages? Please check the appropriate box (current or past) for all that apply.

CURRENT (past month)	PAST	FOODS/BEVERAGES
		Milk
		Wheat
		Shellfish
		Eggs
		Other foods or beverages: Please specify: _____

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

CHECKLIST OF UNUSUAL EVENTS AND BEHAVIORS OCCURRING DURING SLEEP

Have you ever had or do you currently have (i.e. past month) any of the following symptoms? Please check the appropriate box (current or past) for all that apply.

CURRENT (past month)	PAST	SYMPTOMS
		Recurrent disturbing dreams
		Night terrors (abrupt awakening with feelings of fright and confusion)
		Sleepwalking
		Strange sensory experiences upon awakening or falling asleep
		Memory changes or bizarre behaviors during the night
		Confusion and difficulty coming to your senses when awakened from sleep
		Painful leg cramps during sleep
		Paralysis or inability to move while in bed
		Behaviors that are aggressive to others or dangerous to yourself during sleep
		Acting out your dreams
		Grinding your teeth during sleep
		Eating/drinking during sleep
		Groaning during sleep
		Loud noises in your head upon awakening or falling asleep
		Bedwetting

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

MODULE 1:

INSOMNIA DISORDER

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 INSOMNIA DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Have you ever had a problem such as: <ul style="list-style-type: none"> • difficulty getting to sleep, OR • difficulty staying asleep, OR • problems waking up too early? 	1. Reports one of the following: <ul style="list-style-type: none"> (a) difficulty initiating sleep; (b) difficulty maintaining sleep; (c) waking up earlier than desired with inability to return to sleep 	? 1 2 3	? 1 2 3
2. Does this sleep difficulty cause you any problems in the daytime such as: <ul style="list-style-type: none"> a. fatigue/malaise? b. impaired concentration, attention or memory? c. impaired social, family, or vocational functioning or poor school performance? d. mood problems or irritability? e. daytime sleepiness? f. behavioral problems, e.g., hyperactivity, impulsivity, or aggression? g.. decreased motivation/energy/initiative? h. increased errors or accidents at work or while driving? h. tension, headaches, or stomach upset in response to sleep loss? OR i. excessive sleep concerns or worries? 	2. Reports (or caregiver observes) significant distress/impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning (at least one of the areas listed).	? 1 2 3	? 1 2 3

OR

(If individual does not indicate diurnal dysfunction) How would things be better if your sleep problem were eliminated?

CONTINUE ON NEXT PAGE.

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 INSOMNIA DISORDER (continued)

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
3. How many nights per week do you have sleep difficulties? _____ How many days per week do you experience associated daytime problems? _____	3. Requires that the sleep difficulty occurs at least 3 nights per week.	? 1 2 3	? 1 2 3
4. How long have you had the sleep problem? _____	4. Must be present for at least 3 months.	? 1 2 3	? 1 2 3
5. Do you have this sleep difficulty even if you give yourself enough time to sleep? Is your sleep environment comfortable and safe?	5. Requires that the sleep difficulty persist despite adequate opportunity for sleep.	? 1 2 3	? 1 2 3
6. In your opinion is the sleep difficulty you are having caused by or strongly related to: a. another sleep/wake disorder, b. a medical disorder, c. medication or substance use/abuse/withdrawal, or d. a mental disorder condition?	6. Not better explained by another sleep/wake disorder, medical disorder, physiological effects of a substance (e.g., a drug of abuse or medication), or psychiatric condition (i.e., coexisting mental and medical conditions do not adequately explain the predominant insomnia complaint).	? 1 2 3	? 1 2 3

NOTE: Determine present vs. past episode and course of disorder:

Episodic = 1+ months but < 3 months

Persistent = 3+ months

Recurrent = 2+ episodes within 1 year

**CONTINUE
ON NEXT
PAGE.**

NOTE: If there is significant distress or impairment, but full criteria for insomnia disorder are not met, consider the following:

Other Specified Insomnia Disorder: ? 1 2 3 ? 1 2 3

This diagnosis may be applied when there is a clear specific reason that full criteria for insomnia disorder were not met. For example:

1. **Brief Insomnia Disorder:** ? 1 2 3 ? 1 2 3
Symptom duration is <3 months.

2. **Restricted to nonrestorative sleep:** ? 1 2 3 ? 1 2 3

The main complaint is nonrestorative sleep, and there are no other symptoms such as difficulty falling or staying asleep.

Unspecified Insomnia Disorder: ? 1 2 3 ? 1 2 3

This diagnosis may be applied when it is preferable to *not* specify the reason that full criteria were not met for insomnia disorder (e.g., situations where there is insufficient information to warrant an insomnia disorder diagnosis).

**GO TO
NEXT
PAGE.**

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 RESTLESS LEGS SYNDROME

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you ever have a very strong urge to move your legs? Is this urge accompanied by an unpleasant sensation in your legs such as crawling, tingling, drawing, restlessness, or "electric" sensations?	1. Reports an urge to move the legs, usually accompanied or in response to unpleasant or uncomfortable sensations in the legs.	? 1 2 3	? 1 2 3
2. Does the urge to move and/or unpleasant sensations begin or worsen during periods of rest or inactivity?	2. Reports that the urge to move or unpleasant sensations begin or worsen during periods of rest or inactivity.	? 1 2 3	? 1 2 3
3. Are these sensations temporarily or completely relieved by moving your legs or walking?	3. Reports movement partially or totally relieves these sensations.	? 1 2 3	? 1 2 3
4. At what time of day do these symptoms occur? Do they occur or worsen in the evening or at night?	4. Reports that these symptoms occur or worsen in the evening or at night.	? 1 2 3	? 1 2 3
5. How frequently do these urges occur? How long have you been experiencing these symptoms?	5. Must occur at least 3 times per week and have persisted for at least 3 months.	? 1 2 3	? 1 2 3
6. What effect do these symptoms have on your life?	6. The symptoms are accompanied by significant distress/impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning?	? 1 2 3	? 1 2 3

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 BREATHING-RELATED SLEEP DISORDERS (SLEEP APNEA SYNDROMES)

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
<p>1. Based on what you know about yourself or on what others have told you, do you have any of the following symptoms?</p> <p>___ loud snoring</p> <p>___ gasping/choking in sleep</p> <p>___ breathing interruptions in sleep</p> <p>___ holding your breath while sleeping</p> <p>___ poor, unrefreshing sleep even after an adequate night's sleep</p>	<p>1. Endorses one or more of these symptoms. (<u>Note:</u> DSM-5 requires polysomnography results to verify and clarify breathing-related sleep disorder diagnoses.)</p>	<p>? 1 2 3</p>	<p>? 1 2 3</p>
<p>2. Are you very sleepy in the daytime? Do you feel your sleep is unrefreshing – do you wake up tired and not feeling restored by your sleep?</p>	<p>2. Yes to any of these questions.</p>	<p>? 1 2 3</p>	<p>? 1 2 3</p>
<p>3. Have you had an overnight sleep study? (<i>If yes:</i> Did the result of this study indicate the presence of any breathing-related sleep disorder, such as obstructive sleep apnea hypopnea, central sleep apnea, or sleep-related hypoventilation?)</p>	<p>Note: If the individual has had an overnight sleep study with polysomnography, consider:</p> <p><u>Obstructive Sleep Apnea Hypopnea:</u> Either: 1. Evidence of 5+ obstructive apneas or hypopneas per hour of sleep, and either (a) Nocturnal breathing disturbances, or (b) Daytime sleepiness, fatigue, or unrefreshing sleep despite adequate opportunity.</p>	<p>? 1 2 3</p>	<p>? 1 2 3</p>

CONTINUE
ON NEXT
PAGE.

OR

2. Evidence of 15+ obstructive apneas or hypopneas per hour of sleep, regardless of accompanying symptoms.

Specify severity based on the Apnea Hypopnea Index (AHI):

- **Mild:** AHI < 15
- **Moderate:** $15 \leq \text{AHI} \leq 30$
- **Severe:** AHI > 30

Central Sleep Apnea: There is evidence of 5+ central apneas per hour of sleep. ? 1 2 3 ? 1 2 3

Subtypes:

Idiopathic: Repeated apnea and hypopnea episodes during sleep caused by variation in respiratory effort, with no evidence of airway obstruction.

Cheyne-Stokes breathing:

5+ central apneas and hypopneas per hour resulting from periodic crescendo-decrescendo variation in tidal volume. Frequent arousal is also present.

Comorbid opioid use:

Respiratory rhythm generators in the medulla and differential effects on hypoxic vs. hypercapnic respiratory drive resulting from the effects of opioid use.

Sleep-Related Hypoventilation: ? 1 2 3 ? 1 2 3
There is evidence of episodes of decreased respiration associated with elevated levels CO₂ levels.

**CONTINUE ON NEXT
PAGE.**

Subtypes:

Idiopathic: The hypoventilation is not attributable to any identified condition.

Congenital central alveolar:

Congenital disorder with perinatal presentation of shallow breathing or cyanosis and apnea during sleep.

Comorbid sleep-related:

Hypoventilation is the result of medical condition (e.g., pulmonary disorder, neuromuscular or chest wall disorder, or medications).

Or, co-occurring with obesity (i.e., increased work of breathing due to reduced chest wall compliance and ventilation-perfusion mismatch and variably reduced ventilator drive (BMI typically >30; hypercapnia during wakefulness, without other evidence of hypoventilation).

Specify severity based on degree of hypoxemia and hypercarbia present during sleep, + evidence of resultant end organ impairment. Severity is greater if blood gas abnormalities present during wakefulness.

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MODULE 2:
SLEEP DISORDERS ASSOCIATED WITH
COMPLAINTS OF EXCESSIVE DAYTIME
SLEEPINESS – HYPERSOMNIA

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 HYPERSOMNOLENCE DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
<p>1. Do you often fall asleep or do you have to struggle to stay awake when you are in any of the following situations?</p> <p>___ Talking with others</p> <p>___ Driving</p> <p>___ Talking on the phone</p> <p>___ Standing</p> <p>___ Performing your work</p> <p>___ Other activities</p>	<p>1. Reports such sleepiness in one of more of the situations listed.</p>	? 1 2 3	? 1 2 3
<p>2. Do you sleep for long periods of time? (How often do you lapse into sleep during the day? How long do you sleep for generally? How do you feel when you are suddenly woken up?)</p>	<p>2. Reports excessive sleepiness despite a main sleep period lasting at least 7 hours, including at least one of the symptoms of (a) recurrent periods or lapses into sleep within the same day; (b) a prolonged main sleep episode of more than 9 hours per day that is nonrestorative, (c) difficulty being fully awake after abrupt awakening.</p>		
<p>3. When did this occur? (Determine duration and present v. past episode.)</p>	<p>3. The hypersomnolence occurs at least 3 times per week, for minimum of 3 months.</p>		

4a. Has your sleepiness caused you any problems in the daytime such as poor concentration, poor memory, reduced work performance, or irritability?

OR

4b. Has your sleepiness ever interfered in any way with your family or social activities?

4. There is significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.

? 1 2 3

? 1 2 3

NOTE: If there is significant distress or impairment, but full criteria for hypersomnia disorder are not met, consider the following:

Other Specified

Hypersomnolence Disorder:

This diagnosis may be applied when there is a clear specific reason that full criteria for hypersomnolence disorder were not met. For example, **Brief-duration hypersomnolence** (i.e., Kleine-Levin syndrome).

Unspecified Hypersomnolence

Disorder: This diagnosis may be applied when it is preferable to *not* specify the reason that full criteria were not met for hypersomnolence disorder (e.g., situations where there is insufficient information to warrant an hypersomnolence disorder diagnosis).

NOTE: Verify that the sleep disorder is not better explained by and does not occur exclusively during the course of another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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PAGE.**

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 NARCOLEPSY

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
<p>1. You said you were sleepy during the day. Do you often take naps during the day? Do you sometimes lapse into sleep without meaning to? How often does this happen? _____ How long has this occurred? _____</p>	<p>1. Must report excessive daytime sleepiness occurring at least 3 times per week over the past 3 months.</p>	? 1 2 3	? 1 2 3
<p>2. Do you experience sudden muscle weakness or paralysis when you become angry, amused, or emotionally excited? Does this weakness affect both sides of your body? How long do these episodes last? _____</p>	<p>2. Shows signs of cataplexy, defined as at least one of the following: (a) In individuals with long-standing disease, brief (seconds or minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that are precipitated by joking or laughter; or (b) In individuals within 6 months of onset (or children), spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.</p>	? 1 2 3	? 1 2 3

3. Have you had any of the following symptoms?

3. Not required by DSM-5 but helpful for confirmation.

? 1 2 3

? 1 2 3

___ inability to move while in bed

___ frightening images or visions while in bed

___ carrying out some activity without being fully aware of what you are doing

___ a broken or disrupted sleep pattern at night

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

MODULE 3:

CIRCADIAN RHYTHM SLEEP-WAKE DISORDERS

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDERS

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Have you ever had a sleep schedule that was... a) unusual or undesirable to you OR b) different from the sleep-wake patterns of most other people you know (for example, working at night and sleeping in the daytime)?	1. There is a persistent/recurrent pattern of sleep disruption that is primarily due to an alteration of the circadian system or a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by the contextual physical environment or social/professional schedule.	? 1 2 3	? 1 2 3
2. Does/did this sleep-wake schedule make it difficult for you to get enough sleep to feel rested and alert during the time you choose to be awake?	2. The sleep disruption leads to excessive sleepiness or insomnia, or both.	? 1 2 3	? 1 2 3
3a. Has your sleepiness caused you any problems in the daytime such as poor concentration, poor memory, reduced work performance, or irritability? OR	3 a. or b. The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	? 1 2 3	? 1 2 3
3b. Has your sleepiness ever interfered in any way with your family or social activities?			

NOTE: Individual must have a complaint of or met minimal criteria for insomnia or hypersomnia.

CONTINUE ON NEXT PAGE.

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, SHIFT WORK TYPE

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you ever have to work during the hours that most people typically sleep? How much sleep do you typically get during your main sleep period?	1. There is a report of insomnia and/or excessive sleepiness, as well as reduced total sleep time, associated with recurring work schedule that overlaps the usual time for sleep.	? 1 2 3	? 1 2 3
2. Are/were you ever required to work a night shift or work on rotating shifts?	2. Reports night shift or rotating shift work (i.e., job requiring unconventional work hours). [NOTE: The clinician may wish to consider other schedules if it is clear they disrupt sleep.]		
3. Did your sleep problem develop or did it worsen after you began this shift work? Do you think that the shift work is/was a major cause of your sleep difficulty?	3. Reports temporal relationship between shift work and sleep difficulty.	? 1 2 3	? 1 2 3
4. For how long have you had this shift-work related sleep problem?	4. Requires that symptoms are associated with shift work schedule for at least one month (<i>Episodic</i>). <i>Persistent</i> = 3+ months; <i>Recurrent</i> = 2+ episodes within one year.	? 1 2 3	? 1 2 3

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, IRREGULAR TYPE

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you tend to go to sleep and wake up at regular times? Do you ever nap during the day?	1. Reports a chronic or recurrent pattern of irregular sleep and wake patterns throughout the 24-hour period including at least one of (a) insomnia symptoms during the scheduled sleep period and/or (b) excessive sleepiness (napping) during the day.	? 1 2 3	? 1 2 3
2. Do you tend to take several naps each 24-hour day rather than sleeping 6 to 8 hours each night? (If yes) Do your naps appear at regular times? How many per day? How long are they? Do you experience insomnia symptoms when you attempt to sleep (such as at nighttime)?	2. There is excessive sleepiness during the day (demonstrated by naps). These naps do not occur at regular times.	? 1 2 3	? 1 2 3
3. For how long have you had this sleep wake pattern? _____	3. Symptoms have been present for at least 3 months.	? 1 2 3	? 1 2 3

NOTE: One- or two-week sleep log (and/or actigraphy) shows no major sleep pattern and multiple irregular sleep bouts (at least 3) during a 24-hour period.

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, DELAYED SLEEP PHASE TYPE

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you often have difficulty falling asleep as early as you would like? Do you often have to wake up much earlier than you would prefer? Do you have difficulty getting up in the morning in time for work, school, or other daytime activities?	1. There is a significant delay in the phase of the major sleep episode in relation to the desired or required sleep time and wake-up time.	? 1 2 3	? 1 2 3
2. When would you like to fall asleep? _____ When do you fall asleep? _____	2. There is a delay in the phase of the major sleep period in relation to the desired sleep and wake-up time (usually more than 2 hours). If the individual could maintain their desired schedule, any related sleep problems would no longer be present.	? 1 2 3	? 1 2 3
3. Would you say that one of your parents is more of a “night owl”?	3. There is evidence that one or both parents’ biological chronotype is delayed.		
4. For how long have you had this sleep difficulty? Did your parents/caregivers have difficulty waking you up in the morning in time for school as a child? Was it also difficult to get you to go to sleep at bedtime? Do you know whether you tended to stay up later at night as a baby (e.g., 9pm)?	4. Symptoms have been present for at least 3 months. There may be historical evidence of a delayed sleep schedule present during childhood.		

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

4. If you could always go to bed late at night and get up late the next day, would you get the amount of sleep you need? If it didn't matter what time you went to bed and got up, would you prefer to keep a late bedtime and late wake-up time?

4. When allowed to choose their preferred schedule, they will exhibit improved sleep quality and duration for age, and will maintain the delayed sleep phase schedule.

? 1 2 3

? 1 2 3

NOTE: Verify on the sleep diary (and/or actigraphy) this delay in the habitual sleep period. Monitoring should include both work/school days and free days.

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, ADVANCED SLEEP PHASE TYPE

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you seem to have difficulty staying awake as long as others do? Do you also wake up much earlier than others do?	1. There is a chronic or recurrent inability to stay awake until a desired or required conventional clock time and an inability remain asleep until a desired or required time for awakening.	? 1 2 3	? 1 2 3
2. When would you like to fall asleep? _____ When do you fall asleep? _____	2. There is an advance in the phase of the major sleep period in relation to the desired or required sleep and wake-up time (usually more than 2 hours).	? 1 2 3	? 1 2 3
3. For how long have you had this sleep wake pattern?	3. Symptoms must be present for at least 3 months.		
4. . If you could always go to bed early at night and get up early the next day, would you get the amount of sleep you need? If it didn't matter what time you went to bed and got up, would you prefer to keep an early bedtime and early wake-up time?	4. When allowed to choose their preferred schedule, they will exhibit improved sleep quality and duration for age, and will maintain a consistent but advanced sleep phase schedule.	? 1 2 3	? 1 2 3

NOTE: Verify on the sleep diary (and/or actigraphy) this advance in the habitual sleep period. Monitoring should include both work/school days and free days.

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 CIRCADIAN RHYTHM SLEEP-WAKE DISORDER, NON-24 HOUR SLEEP-WAKE TYPE

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you often have difficulty keeping a regular sleep schedule?	1. Reports such complaints. NOTE: There must also be a history of insomnia, excessive daytime sleepiness, or both, which alternate with asymptomatic episodes due to misalignment between the 24-hour light-dark cycle and the non-entrained endogenous circadian rhythm of sleep-wake propensity.	? 1 2 3	? 1 2 3
2. Do you seem to only be able to get enough sleep if you go to bed later and later and get up later and later with each passing day?	2. Reports a pattern of sleep and wake times that typically delay each day with a period longer than 24 hours.	? 1 2 3	? 1 2 3
3. How long have you had this problem? _____	3. Symptoms must be present for at least 3 months.	? 1 2 3	? 1 2 3

NOTE: Verify on the sleep diary (and/or actigraphy) this advance in the habitual sleep period. Monitoring should include both work/school days and free days.

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

NOTE: If condition is due to blindness, code as Other Physiological (Organic) Circadian Rhythm Sleep Disorders, Unspecified (Organic Circadian Rhythm Disorder, NOS)

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DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

MODULE 4:

PARASOMNIAS

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

MINIMAL CRITERIA FOR PARASOMNIAS

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Have any of the events or behaviors listed on this page ever occurred during your sleep? (Give “Checklist of Unusual Events and Behaviors Occurring During Sleep” and have them indicate all that apply). When did these events/symptoms occur? _____	1. Experiences one or more of the parasomnias listed.	? 1 2 3	? 1 2 3
		IF NO TO 1, STOP THE INTERVIEW.	
(NOTE: Questions 2 and 3 should be used to address severity level of parasomnia complaints. They are not necessary for diagnosis.)			
2. Do these events or behaviors cause you significant concern or embarrassment? Do you wish they would stop occurring during your sleep?	2. Reports a significant desire for the problem behaviors/events to cease.	? 1 2 3	? 1 2 3
3. Are these behaviors/events your main concern? Are you more concerned about the sleep disturbance or the daytime sleepiness they cause you?	3. The behaviors/events themselves rather than insomnia/hypersomnia resulting from them are the individual’s main concern.	? 1 2 3	? 1 2 3

**IF YES TO ITEMS,
CONTINUE TO NEXT
RELEVANT PAGE.**

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

INDEX OF PAGE NUMBERS FOR PARASOMNIAS

If participant endorses:	Check all that apply
Recurrent disturbing dreams	
Night terrors (abrupt awakening with feelings of fright and confusion)	
Sleepwalking	
Sleep related hallucinations	
Sleep related dissociative episodes	
Eating/drinking during sleep	
Confusion and difficulty coming to your senses when awakened from sleep	
Painful leg cramps during sleep	
Paralysis or inability to move while in bed	
Behaviors that are aggressive to others or dangerous to yourself during sleep	
Acting out your dreams	
Grinding your teeth during sleep	
Groaning during sleep	
Loud noises in your head upon awakening or falling asleep	
Bedwetting	

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 NON-RAPID EYE MOVEMENT SLEEP AROUSAL DISORDERS (SUBTYPE: SLEEP TERRORS)

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you awaken from sleep with intense fear, terror, or a feeling of being in danger of harm? Do you shout out or scream upon awakening?	1. Reports a sudden episode of terror during sleep typically beginning with an alarming vocalization (e.g. panicky scream).	? 1 2 3	? 1 2 3
2. Are these awakenings accompanied by sweating, rapid heart beat, or rapid breathing?	2. The episode is accompanied by autonomic arousal (e.g., mydriasis, tachycardia, rapid breathing, sweating).	? 1 2 3	? 1 2 3
3. How many episodes have you had? How frequently do these episodes occur?	3. Episodes must be recurrent.		
4. Is it difficult for others to wake you up during these episodes?	4. Inappropriate or absent responsiveness to the efforts of others to intervene, comfort, or redirect the person during the episodes.	? 1 2 3	? 1 2 3
5. Do you experience an inability to remember the episode when you wake up?	5. Partial or complete amnesia for the episode.		
6. Are you typically able to recall the dream after awakening from one of these episodes?	6. There is limited (e.g., a single visual scene) or no associated cognition or dream imagery).		
7. What effect have these symptoms had on your life?	7. DSM-5 requires that the symptoms cause clinically significant distress/impairment in social, occupational, or other important areas of functioning.		

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

**GO TO NEXT RELEVANT
PAGE OR END
INTERVIEW.**

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 PARASOMNIAS–NON-RAPID EYE MOVEMENT SLEEP AROUSAL DISORDERS (SUBTYPE: SLEEPWALKING)

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you get out of bed and walk around [sleepwalk] during your sleep? (If so) How often do these events occur?	1. Repeated episodes of rising from bed during sleep and walking about.	? 1 2 3	? 1 2 3
2. Has anyone told you that during these episodes your face is blank and staring?	2. DSM-5 requires that while sleepwalking the individual has a blank, staring face.		
3. Is it difficult for others to speak to you during or wake you up from these episodes?	3. DSM-5 requires relative unresponsiveness to the efforts of others to communicate with and great difficulty awakening the individual.	? 1 2 3	? 1 2 3
5. Do you experience an inability to remember the episode when you wake up?	5. Partial or complete amnesia for the episode.	? 1 2 3	? 1 2 3
6. Are these experiences typically associated with a dream? Can you ever recall what the dream was after waking up?	6. There is limited (e.g., a single visual scene) or no associated cognition or dream imagery).	? 1 2 3	? 1 2 3
7. What effect have these symptoms had on your life?	7. DSM-5 requires that the symptoms cause clinically significant distress/impairment in social, occupational, or other important areas of functioning.	? 1 2 3	? 1 2 3

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure

**GO TO NEXT
RELEVANT
PAGE OR
END
INTERVIEW.**

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 RAPID EYE MOVEMENT SLEEP BEHAVIOR DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you ever wake up from sleep speaking or moving around? How often do these episodes occur? Have you ever committed aggressive behaviors or acts that led (or could have led) you to injure yourself or someone else during sleep?	1. Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.	? 1 2 3	? 1 2 3
2. At the time you did this, were you having a dream or nightmare?	2. These behaviors are often (but not always) associated with simultaneously occurring dream mentation (individuals frequently report "acting out one's dreams").	? 1 2 3	? 1 2 3
3. Did your dream involve a chase, an attack, or a confrontation of some kind?	3. Behaviors are usually (but not necessarily) associated with dreams that involve a chasing, attacking, or confrontational theme.	? 1 2 3	? 1 2 3
4. During what part of the major sleep period do these episodes typically occur? When do they occur most frequently?	4. The behaviors occur during REM sleep period (typically more than 90 minutes after sleep onset), are more frequent during the later portion of the sleep period, and are uncommon during daytime naps. (If they have had a sleep study, PSG verifies REM sleep occurrence).	? 1 2 3	? 1 2 3

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

5. When you awaken from these episodes do you wake up fully and quickly become alert? Do feel very confused or disoriented after awakening?

5. DSM-5 requires that upon awakening from these episodes the individual is completely awake, alert, and not confused or disoriented.

? 1 2 3

? 1 2 3

6. What effect do these episodes have on your life?

6. The sleep disturbance causes clinically significant distress/impairment in social, occupational, or other important areas of functioning (which may include injury to self for the bed partner).

? 1 2 3

? 1 2 3

NOTE: Items 2 and 3 are not required for diagnosis.

NOTE: Verify that the sleep disorder is not better explained by another sleep disorder, medical/ neurological disorder, psychiatric disorder, or medication/substance use or exposure.

DUKE STRUCTURED INTERVIEW FOR SLEEP DISORDERS

DSM-5 NIGHTMARE DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. Do you experience distressing or disturbing dreams? (If so) What is typically going on in these dreams? Are you able to remember the dreams upon awakening? During what time of night do these dreams typically occur? (Do these bad dreams and awakenings usually occur in the second half of your night's sleep?)	1. Repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security, or physical integrity and that generally occur during the second half of the major sleep episode.	? 1 2 3	? 1 2 3
2. Once you awaken from such dreams, do you quickly become alert and realize that you just had a bad dream? Do you remember these bad dreams?	2. On awakening from the dysphoric dreams, individual rapidly becomes oriented and alert.	? 1 2 3	? 1 2 3
3. What effect have these symptoms had on your life?	3. The dream experience or sleep disturbance produced by awakening from it causes clinically significant distress/impairment in social, occupational, or other important areas of function.	? 1 2 3	? 1 2 3

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

DSM-5 SUBSTANCE/MEDICATION-INDUCED SLEEP DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
1. (Refer to answers provided above).	1. There is a prominent and severe disturbance in sleep.	? 1 2 3	? 1 2 3
2. You said that you were using [name of drug/substance]. When did you use this? How often had you used this? How long had you used this? <i>If prescription or over-the-counter:</i> Was your use in excess or over a longer time period than what your doctor prescribed / the recommended dosage?	2. There is current ongoing or past dependence on or abuse of a drug or substance known to have sleep-disruptive properties; or there is current ongoing use of or exposure to a medication, food, or toxin known to have sleep-disruptive properties in susceptible individuals.	? 1 2 3	? 1 2 3
3. Did your sleep difficulty develop or become much worse after you began using or abruptly stopped using this drug/substance? When you stopped using this substance for long periods of time, did your sleep problem get better?	3. The sleep disturbance is temporally associated with the substance use/abuse and/or acute withdrawal.	? 1 2 3	? 1 2 3
	4. The sleep disturbance must not occur exclusively during the course of a delirium.	? 1 2 3	? 1 2 3
NOTE: If the individual has met criteria for a sleep disorder during the interview, specify whether the Substance/Medication Induced Sleep Disorder is: <ul style="list-style-type: none"> • Insomnia type • Hypersomnia type • Parasomnia type • Mixed type (i.e., multiple types of sleep symptoms are present but no symptom clearly predominates) 	5. The sleep disturbance causes clinically significant distress/impairment in social, occupational, or other important areas of functioning.	? 1 2 3	? 1 2 3

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

DSM-5 OTHER SPECIFIED OR UNSPECIFIED SLEEP-WAKE DISORDER

<u>QUESTION</u>	<u>CRITERIA</u>	<u>PRESENT</u>	<u>PAST</u>
(Refer to information provided previously in interview).	1. There is significant distress or impairment, but full criteria for insomnia disorder are not met.	? 1 2 3	? 1 2 3
	Other Specified Sleep-Wake Disorder: This diagnosis may be applied when there is a clear specific reason that full criteria for were not met for insomnia disorder, hypersomnolence disorder, or any of the disorders in the sleep-wake disorders diagnostic class. For example, "repeated arousals during rapid eye movement sleep without polysomnography or history of Parkinson's disease or other synucleinopathy."	? 1 2 3	? 1 2 3
	Unspecified Sleep-Wake Disorder: This diagnosis may be applied when it is preferable to <i>not</i> specify the reason that full criteria were not met for insomnia disorder, hypersomnolence disorder, or any of the disorders in the sleep-wake disorders diagnostic class (e.g., situations where there is insufficient information to warrant a diagnosis).	? 1 2 3	? 1 2 3

END OF INTERVIEW.

? = insufficient information; 1 = Absent (no); 2 = Subthreshold (uncertain); 3 = Threshold (yes)

ISI

1. Please rate the current severity of your insomnia problem(s):

	None	Mild	Mod.	Severe	Very Severe
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		Moderately 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 functioning, ability to function at work/daily chores, concentration, memory, mood, etc.)?

Not at All	A little	Somewhat	Much	Very much
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	A little	Somewhat	Much	Very much
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

After a poor night's sleep, which of the following problems do you experience the next day?

Circle all those that apply.

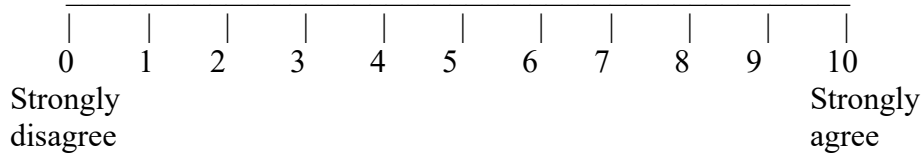
- Daytime fatigue: tired, exhausted, washed out, sleepy.
- Difficulty functioning: performance impairment at work/daily chores, difficulty concentrating, memory problems.
- Mood problems: irritable, tense, nervous, groggy, depressed, anxious, grouchy, hostile, angry, confused.
- Physical symptoms: muscle aches/pain, light-headed, headache, nausea, heartburn, muscle tension.
- None.

Study Number: _____

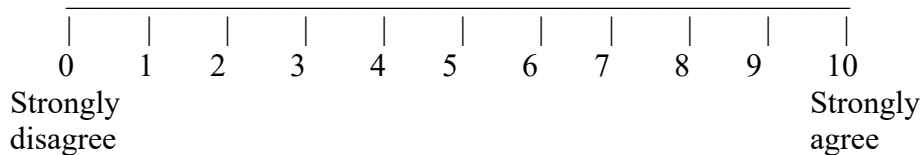
Beliefs and Attitudes about Sleep

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own personal belief. Please respond to all items even though some may not directly apply to your situation.

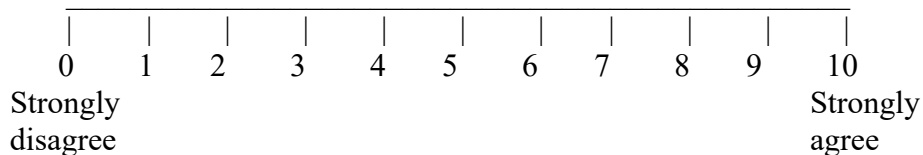
1. I need 8 hours of sleep to feel refreshed and function well during the day.



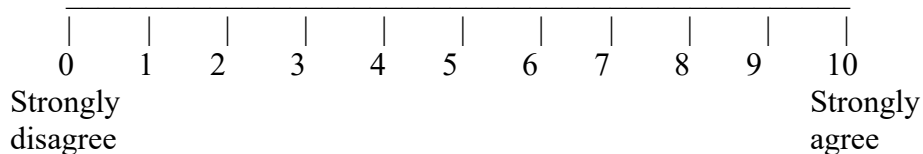
2. When I don't get the proper amount of sleep on a given night, I need to catch up the next day by napping or the next night by sleeping longer.



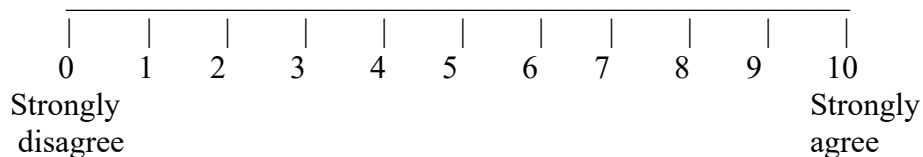
3. I am concerned that chronic insomnia may have serious consequences on my physical health.



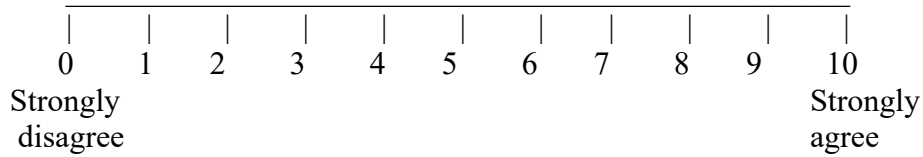
4. I am worried that I may lose control over my abilities to sleep.



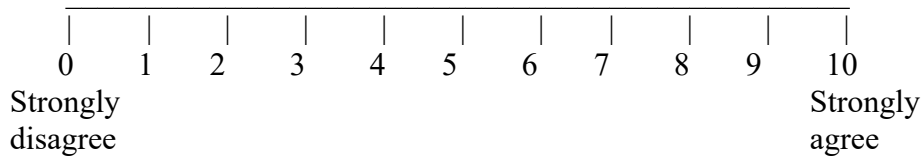
5. After a poor night's sleep, I know it will interfere with my activities the next day.



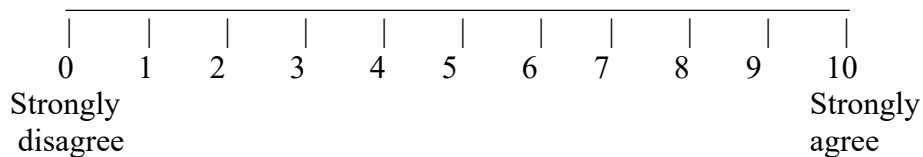
6. To be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.



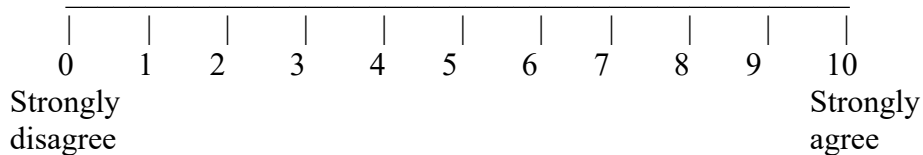
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.



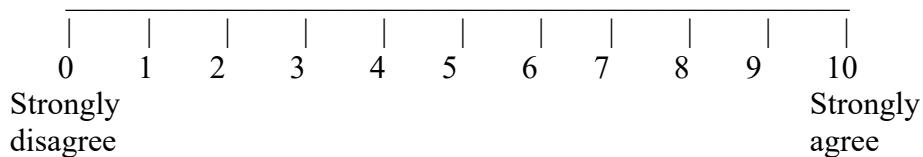
8. When I sleep poorly one night, I know it will disturb my sleep schedule for the whole week.



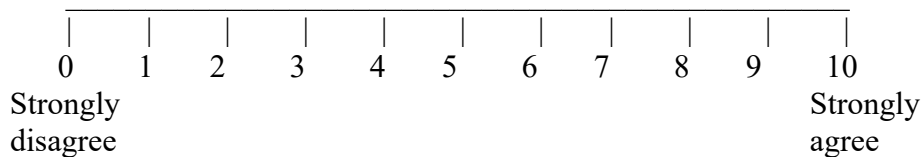
9. Without an adequate night's sleep, I can hardly function the next day.



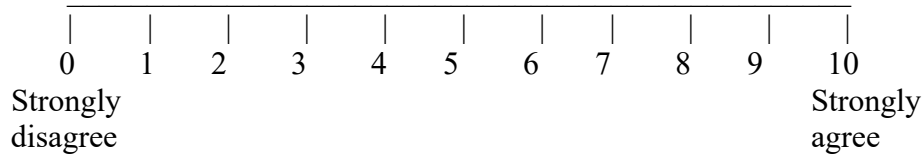
10. I can't ever predict whether I'll have a good or poor night's sleep.



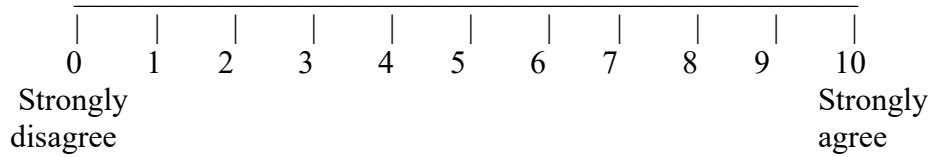
11. I have little ability to manage the negative consequences of disturbed sleep.



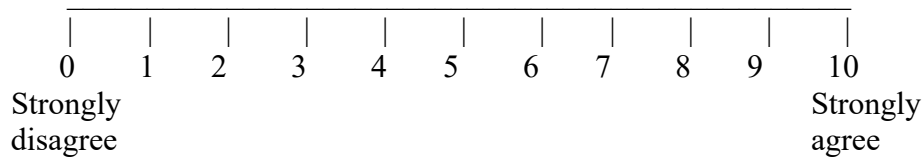
12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.



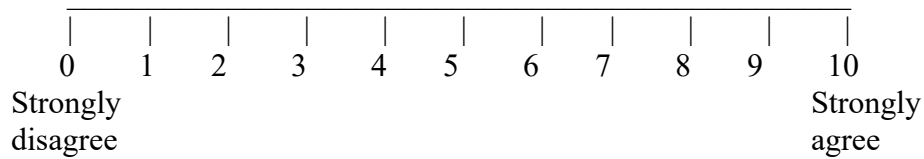
13. I believe insomnia is essentially the result of a chemical imbalance.



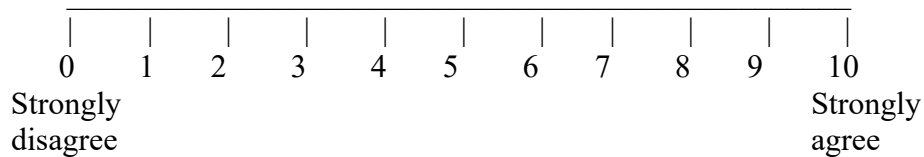
14. I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.



15. Medication is probably the only solution to sleeplessness.



16. I avoid or cancel obligations (social, family) after a poor night's sleep.



Case Conceptualization Form

Domains	Target	Resolution
<p>1. Sleep Drive: Are there any factors weakening the sleep drive?</p> <p>N.B. Low sleep drive can interfere with sleep onset and continuity as well as sleep depth/quality.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Time-in-bed is 30 minutes greater than average total sleep time? <input type="checkbox"/> Any evidence of dozing? <input type="checkbox"/> Any evidence of napping? <input type="checkbox"/> Any substances that block sleep drive (e.g., caffeine)? <input type="checkbox"/> Evidence of decreased physical activity in a 24-hour period? <input type="checkbox"/> Linger in bed greater than 30 minutes post-wake in the morning? 	
<p>2. Biological clock: Are there factors weakening the signal from the biological clock?</p> <p>N.B. Without regular habits congruent with one's chronotype, there will be weak alerting signals (e.g., fatigue) and social jetlag (e.g., sleep and mood problems).</p>	<ul style="list-style-type: none"> <input type="checkbox"/> An hour or more variability in rise time <input type="checkbox"/> An hour or more variability in rise time <input type="checkbox"/> Are they a night owl keeping an early bird's schedule, or reverse? 	
<p>3. Arousal: Any evidence of hyperarousal? Any behaviors engaged to "produce sleep" (i.e., sleep effort)?</p> <p>N.B. Sleep effort is related to and perpetuates anxiety—a state incongruous with sleep. Additionally, pairing wakefulness or negative activities with the bed will produce conditioned arousal.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Are there rituals to produce sleep even though sleep continues to be bad, e.g., no alarm clock, sleeping separate from bed partner, knockout shades, white noise machine/masks, tv or reading in bed...? <input type="checkbox"/> Are they worried about sleep? <input type="checkbox"/> Are they worried about other things (in bed)? <input type="checkbox"/> Are they wide awake upon getting into bed? <input type="checkbox"/> Do they stay in bed when awake? <input type="checkbox"/> Do they feel frustrated/anxious/distressed while awake in bed? 	

1. <u>Unhealthy sleep behaviors:</u> What unhealthy sleep behaviors are present? Consider amount and timing, etc.).	<input type="checkbox"/> Excessive or late caffeine? <input type="checkbox"/> Alcohol? <input type="checkbox"/> Marijuana? <input type="checkbox"/> Short-acting sleeping pills? <input type="checkbox"/> Nocturnal eating? <input type="checkbox"/> Vigorous evening exercise?	
2. <u>Medications:</u> What medications might impact the patient's sleep/sleepiness? Consider carryover effects, tolerance, and psychological dependence.		
3. <u>Comorbidities:</u> What comorbidities impact the patient's sleep and how? Consider sleep, medical and psychiatric conditions. (e.g., difficult adjustment to CPAP treatment for sleep apnea, pain, PTSD-related hypervigilance).	<input type="checkbox"/> Sleep apnea, if yes, is it adequately treated? <input type="checkbox"/> Restless Leg Syndrome, if yes, is it adequately treated? <input type="checkbox"/> Periodic Limb Movement, if yes, is it adequately treated? <input type="checkbox"/> Chronic pain, if yes, is it adequately treated? <input type="checkbox"/> Comorbid psychiatric disorder, if yes, is it adequately treated? Affects sleep? Others?	
4. <u>Other:</u> Consider sleep environment, care taking duties at night, life phase sleep issues; mental status, and readiness for change.	<input type="checkbox"/> Sleep environment optimal? <input type="checkbox"/> Care taking or on-call duties at night? <input type="checkbox"/> Cognitive or learning issues? <input type="checkbox"/> What stage of readiness for change? <input type="checkbox"/> Any resistance to engaging in short-term behavior changes?	

Notes:

From Manber & Carney (2015). Treatment Plans and Interventions for Insomnia: A Case Formulation Approach.

The Guilford Press. PERMISSION FOR CLINICAL USE ONLY

RestBell Assessment Form

Name: BIN HUANG
Sex: MALE
Age: 78 YEARS OLD

Relationship status? WIDOWED
Children? 3 ADULT
Occupation? RETIRED PHYSICIAN

Nature of presenting problem:

Write down their Insomnia Severity Index score 24

It is scored by adding up the items. Daytime items aren't scored. Anything above 10 is clinically significant <14 is moderate severity.

"What is the most distressing part of your sleep problem?"

☐ Difficulty initiating sleep; ☒ Difficulty maintaining sleep;

☐ Waking up too early;

☐ It is difficult to wake up:

"How many nights per week is the sleep problem experienced?" 7

"When did the current episode of insomnia start?" 7 YEARS AGO

"What do you think caused the insomnia? It's ok if you have no idea." CANCER?

"What kinds of treatments have you tried, if any, for this most recent bout of insomnia?"

ESZOPICLONE, HERBS

"What treatments and medications have you tried for insomnia in your lifetime?"

SAME AS ABOVE

Daytime effects:

☒ Energy/fatigue

☒ Concentration/functioning

☒ Mood

☒ Daytime activity levels

Other _____

Enter the Fatigue Severity Score here: 6.6

It is calculated by summing the items and dividing by 9. A score above 4 is suggestive of a problem with fatigue.

History:

"How old were you when you first suffered from chronic insomnia episode?" 71

"Since then, what has been the course of your insomnia across your lifetime? Has it been chronic or it comes and goes? When it goes away, is it because of treatment? Resolution of stressors?"

FIRST REAL EPISODE WAS 7 YEARS AGO AND IT WORSENER WHEN HE RETIRED AND THEN WORSENER AGAIN AFTER HIS WIFE'S DEATH

"Does anyone else in your immediate family suffer from insomnia? If yes, what sorts of treatments have they tried?" : NO

Sleep habits (Focus on previous or most recent typical week; describe range; obtain weekday/weekend times):

Beginning of Sleep Period:

"What time do you typically get into bed?" 9

"What time do you typically turn out the lights with the intention of sleep?" 9:30

"How do you decide when to go to bed?" Is it because a tv show ended? Do they determine it based on the clock (e.g., they always go to bed at 11 PM)? Do they determine it based on feeling sleepy? Do they fall asleep by accident and then wake up and go to bed?

"FEEL BORED, CAN'T FIND SOMETHING TO WATCH"

"FEEL LIKE I SHOULD REST"

"Tell me about what you do after dinner and right up to bedtime." WATCH TV, READING

☒ "Do you have any fears pre-bed or in-bed fears, such as the dark or worrying?"
NO

☒ "Do you doze off in the evening, either accidentally or on-purpose with a nap?"
NO

"How long does it typically take you to fall asleep?" 1 HOUR

"What do you do when you cannot get to sleep (e.g., what kinds of thoughts/behaviors)?"

TRY TO RELAX, TAKE AN EXTRA SLEEPING PILL

☐ Rumination ☐ General worry ☐ Sleep worry ☒ Physical tension

Middle of the night:

"On average, how many times do you wake up in the nights once you initially fall asleep?" 1-2

"On average, how much time do you spend awake, once you have woken up in the night?" 1 HOUR

"What do you do when you awaken in the middle of the night (e.g., thoughts/behaviors)?"

TRY TO KEEP EYES CLOSED

☐ Rumination ☐ General worry ☐ Sleep worry ☒ Physical tension

End of the night:

"On average, what time do you finally wake up in the morning (without going back to sleep)?" 4AM

"Is that because of an alarm clock?" ☒ No ☐ Yes

"On average, what time do you finally get out of bed?"

7 AM

"Does your body tend to wake up earlier than planned/acceptable? ☐ No ☒ Yes, by how much? (mins)"

23 HOURS

"Do you have difficulties waking up at an intended time? In other words, if you have set your alarm, do you have difficulty getting out of bed at that time?" ☒ No ☐ Yes

"On average, how much do you typically sleep?"

4 HOURS

If they say, 0, ask "Not even one minute any night, any day of the week?"

N/A

"Before this sleep problem began, what was your sleep like? How did it take to fall asleep? Did you wake up the middle of the night and if so, how long? Did you have trouble getting out of bed in the morning? How much time did you sleep? When was this period?"

NO PROBLEMS. I SLEPT 8 HOURS, DIDN'T WAKE UP
SLEPT UNTIL 7 AM

Sleep medication(s)/aids:

Name	Dose	When Taken (@ BT, Middle of night; PRN)	How long?	Helpful?
ESZOPICLONE	1-2 MG	30 MIN BEFORE BED	1 YEAR	YES

Napping:

"Are you able to nap if you were given an opportunity?" ☐ No ☒ Yes

If yes, "How many times per day and per week, would you have a nap?"

7

"How long are your naps typically?"

30 MIN.

"Is there a particular time of day in which you would likely take a nap?"

AFTER LUNCH

"If you could take a nap, what time of day would you like to take a nap?"

AFTER LUNCH

Sleep Environment:

"Is there anything unusual about your sleep environment (e.g., does your bed partner snore loudly? Do your kids wake you up? Do any pets share your bed? Is there sound or light in your environment when you are trying to sleep? Is the temperature comfortable for you as you sleep)?"

NO

Other Behaviors that can Impact Sleep: (Include time and frequency. For substances also include amount.)

"How much and at what time do you consume caffeinated products such as tea, coffee, sodas, energy drinks, chocolate?"

2-4 BLACK TEA

Do you use any tobacco products such as vaping/smoking? If yes, how much and at what time do you consume tobacco products?" NO

"How much and at what time do you consume alcohol per day?" NO

"How much and at what time do you consume marijuana or cannabis products per day?" NO

"Do you use any drugs such as cocaine? If so, which ones, how much per day and at what time?" NO

"How often and at what time do you exercise? How would you describe the exercise?"

NO

"Do you eat close to bedtime or during the night? If yes, what do you tend to eat, how much and at what time? Do you have a medical condition that requires you to eat at night?" NO

"How would you describe your overall physical activity level? Would you say you are under-active, relative to what you would like to be? Over-active (you should probably slow down)?"

less active than usual, very tired

Notes on Cognitive Hyperarousal

Write in their score on the DBAS16 7.1 Obtained by adding up each item and dividing by 16.

What were some of the beliefs that were endorsed at a 8 or above?

Medication is only solution; insomnia is a chemical imbalance

Everything else endorsed as a 7

High degree of unhelpful beliefs.

Circadian tendencies:

"Would you say that you are more of a

✓ Morning type? _____ Evening type _____ or neither type?"

Other Sleep Disorders

Circadian Rhythm Disorders

If extreme score on MEQ, = 61 slight morningness

"Do you seem to have difficulty staying awake as long as others do? Do you also wake up much earlier than others do?" NO

"When would you like to fall asleep?" 10 PM

"When do you fall asleep?" 10 30 PM

"If you could always go to bed early at night and get up early the next day, would you get the amount of sleep you need? If it didn't matter what time you went to bed and got up, would you prefer to keep an early bedtime and early wake-up time? Tell me about your ideal bedtime and waketime": 1030 PM; 7 AM

If the answer is a time that is 3 am or later for an ideal bedtime, or 8 pm or earlier for an ideal bedtime, and they get out of bed about 8 hours later feeling refreshed, AND their score on the MEQ is shifted towards extreme eveningness or morningness, do not use CBT-I.

If you could keep this schedule, would you no longer have a sleep problem?" NO

If the answer is yes and their schedule is shifted towards extreme eveningness or morningness, do not use CBT-I.

Have you ever had a chance to maintain this idea schedule (e.g., on days off, holidays, etc.)? If so, did your sleep problem get better?" He uses this schedule currently and has insomnia

If the answer is yes and their schedule is shifted towards extreme eveningness or morningness, do not use CBT-I.

"Have you ever had a sleep schedule that was unusual or undesirable to you, or different from the sleep-wake patterns of most other people you know (for example, working at night and sleeping in the daytime)?"

"Was this unusual schedule because of shift work or cross-time-zone travel?" He was on-call periodically when he worked.

"Have you ever been diagnosed by a doctor with Circadian Rhythm Sleep-Wake Disorders related to jetlag, shift-work, non-24, Delayed or Advanced Sleep Phase?" NO

Excessive Daytime Sleepiness

Epworth Sleepiness Score: 6

Scored by adding the items. If it is above 10, this is clinically significant and they should be referred for a sleep study.

"Do you have trouble staying awake during the day unless you use extreme measures to stay awake?" NO

"Do you fall asleep despite these measures?" NO

"Do you need a nap, otherwise you will fall asleep involuntarily?" NO - could fight it

People with insomnia are tired but because of hyperarousal, they don't fall asleep during the day. When sleepiness is present, it is suggestive of some other problem, and they should be referred for a sleep study.

"Have you ever been diagnosed by a doctor with Obstructive sleep apnea (OSA)?" **NO**

☐ previously diagnosed Severity _____

sleep study last year was negative

☒ not previously diagnosed: ☐ suspected ☐ not suspected

Treatment:

☐ not or inadequately treated ☐ adequately treated

"What kind of treatment have you tried for OSA?" na

Write their STOPBANG score 3 If there are 3 or more "yes", then refer.

sent info to doctor already studied

"Have you ever been diagnosed by a doctor with Restless Leg Syndrome?" ☒ Does not meet criteria ☐ Meets criteria

"Do you ever have a very strong urge to move your legs? Is this urge accompanied by an unpleasant sensation in your legs such as crawling, tingling, drawing, restlessness, or "electric" sensations?" If no, skip to nightmares. ☒ No ☐ Yes

If yes, "does the urge to move and/or unpleasant sensations begin or worsen during periods of rest or inactivity?" If no, skip to nightmares. ☐ No ☐ Yes "Does moving your legs improve the symptoms?"

☐ No ☐ Yes Moving legs often improves the symptoms.

If yes, to the questions above, they need a referral for Restless Leg Syndrome assessment.

"Do your restless legs interfere with your ability to fall asleep? If yes, how many nights per week?"

If it interferes with sleep onset at least half the nights, they should get treatment before you can reasonably expect CBT-I to be helpful.

Nightmare Disorder

"Do you experience regular nightmares?" ☒ No ☐ Yes

If yes, "How often do you have nightmares?" _____

"Do your nightmares prevent you from falling back to sleep? If you did not have nightmares, would you not have insomnia?" ☐ No ☐ Yes

If the answer is Yes, they should receive nightmare treatment instead of CBT-I.

"Do you experience any unusual behaviors during the night that disrupt sleep such as seeing strange things on the wall that you know aren't there? ☒ No ☐ Yes Waking up feeling paralyzed? ☐ No ☐ Yes

Do you experience sudden muscle weakness or paralysis when you become angry, amused, or emotionally excited?"

The presence of two or more of these symptoms (e.g., visual hallucinations in bed, sleep paralysis, and cataplexy) with daytime sleepiness is suggestive of narcolepsy and requires a sleep study. Sleep paralysis, on its own, is genetically higher in Chinese adults, and is not suggestive of narcolepsy if it is not associated with any other feature.

Co-Occurring Mental Disorders

"I am going to read a list of symptoms, and please tell me if any of them have been a problem in the past month?"

- ☒ Depression, feeling "blue" or down, extreme sadness, crying spells, loss of interest
- ☒ Appetite or weight changes
- ☐ Excessive energy or excitement
- ☐ A sense of having unusual powers
- ☐ Hyperactivity
- ☐ Anxiety, tension, trembling, excessive worry, heart racing
- ☐ Recurrent bothersome thoughts along with irresistible urges to repeat certain actions over and over
- ☐ Recurrent nightmares or "flashbacks"
- ☐ Panic or intense fear of dying
- ☐ Hearing voices or seeing visions, feeling that others are plotting against you, a belief that others are controlling your mind or reading your thoughts

"Have you been diagnosed with any of the following conditions: Bipolar disorder? Major depression? Panic Disorder? Post-Traumatic Stress Disorder, an Anxiety Disorders, Schizophrenia?"

Depression - since last year

If yes, "what treatments have you tried for this condition?"

Nothing - believes its related to insomnia and doesn't want the depression treated "its pointless"

Co-Occurring Medical Disorders

"I am going to read a list of symptoms, and please tell me if any of them have been a problem in the past month:"

HYPERTENSION

- ☐ Heart Disease (e.g., Angina; Cardiac Arrhythmias (irregular heart beats); Congestive Heart Failure; Myocardial Infarction (heart attack))
- ☐ Pulmonary Disease (e.g., COPD; Emphysema; Cystic Fibrosis; Asthma)
- ☐ Gastrointestinal Disorders (e.g., Stomach or Duodenal Ulcers; Reflux Disease (GERD))
- ☐ Neurologic Disorders (e.g., Huntington's Disease; Seizures; Spastic Torticollis; Blepharospasm; Dystonias; Parkinson's Disease; Alzheimer's Disease; Dementia; migraines)
- ☐ Head Trauma (e.g., Blow to the head with loss of consciousness; Concussion)

- ☐ Chronic Pain Disorders (e.g., Fibrositis/Fibromyalgia; Arthritis; Muscle Cramps; Chronic Low Back Pain)

- ☐ Endocrine Disorders such as Thyroid Disease
- ☐ Metabolic Disorders such as Diabetes
- ☐ Kidney Disease such as Kidney Failure with Dialysis; Kidney Stones
- ☐ Autoimmune Disorders such as Lupus
- ☐ Cancer
- ☐ HIV/AIDS

If yes, "what treatments have you tried for this condition?"

Diuretics since age 67

"What medications do you currently take, including supplements, over-the-counter or prescribed? How often and dose?"

HYDROCHLOROTHIAZIDE 12.5 MG/D EVERY DAY
ESZOPICLONE 1 MG (sometimes 2 MG) 3-4 NIGHTS AS NEEDED

"Anything else I should know about your sleep or your medical history?"

"What is your goal for treatment? Keep in mind the goal should be measureable, so that you would know that you are satisfied with treatment"

FALL ASLEEP QUICKLY AND STAY ASLEEP
FEEL MORE ENERGETIC

If the goal is not realistic (e.g., they set a daytime goal rather than a sleep goal or they want to sleep the way they slept 20 years ago, as if aging never occurred), not specific (e.g., I want to feel better), revisit these goals in cognitive therapy.

When asked about how to measure the above, he said
fall asleep within 5-10 minutes and be awake 0-5 minutes
during the night - sleeping for 8 hours every night
He resisted corrective information about normative sleep
values, insisting this is the way I used to sleep!

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

6

Situation	Chance of dozing
Sitting and reading	<u>1</u>
Watching TV	<u>2</u>
Sitting inactive in a public place (e.g. a theater or a meeting)	<u>0</u>
As a passenger in a car for an hour without a break	<u>0</u>
Lying down to rest in the afternoon when circumstances permit	<u>3</u>
Sitting and talking to someone	<u>0</u>
Sitting quietly after lunch without alcohol	<u>0</u>
In a car, while stopped for a few minutes in the traffic	<u>0</u>

Thank you for your cooperation

STOPBANG

Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes ☒ No

Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?

Yes ☒ No

Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep ?

Yes ☒ No

Do you have or are being treated for High Blood Pressure ?

Yes ☒ No

Body Mass Index more than 35 kg/m²?

Yes ☒ No

Age older than 50 ?

Yes ☒ No

Neck size large ? Is your shirt collar 16 inches / 40cm or larger?

Yes ☒ No

Gender = Male ?

Yes ☒ No

3

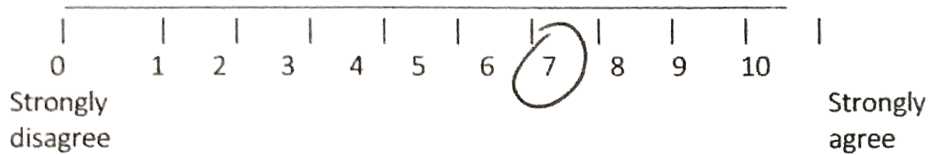
Yes = 1; Add them up.

Dysfunctional Beliefs and Attitudes about Sleep (DBAS16)

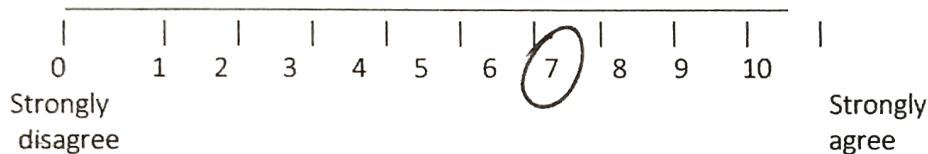
7.1

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own personal belief. Please respond to all items even though some may not directly apply to your situation.

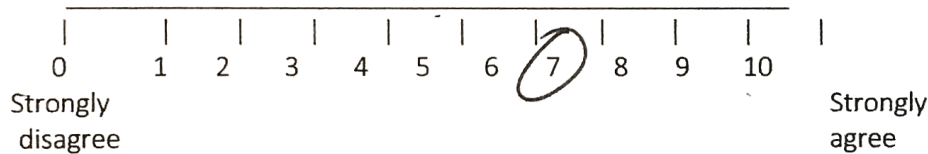
1. I need 8 hours of sleep to feel refreshed and function well during the day.



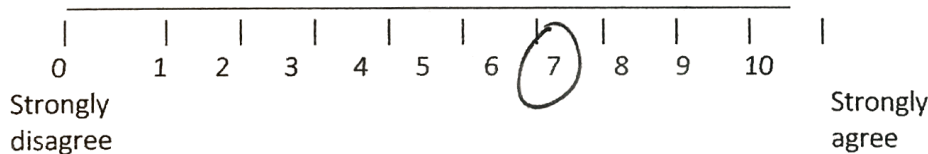
2. When I don't get the proper amount of sleep on a given night, I need to catch up the next day by napping or the next night by sleeping longer.



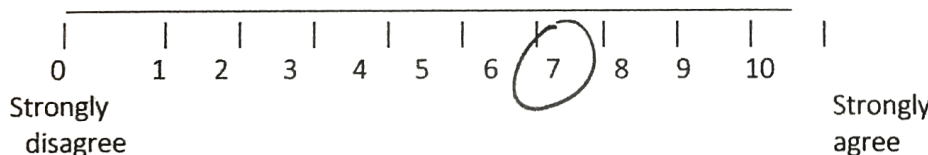
3. I am concerned that chronic insomnia may have serious consequences on my physical health.



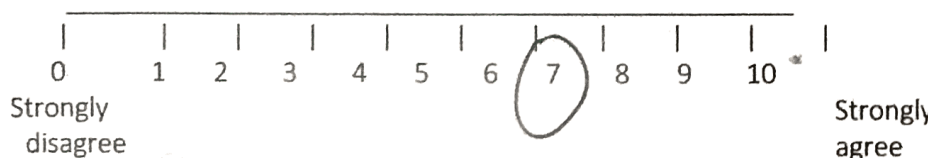
4. I am worried that I may lose control over my abilities to sleep.



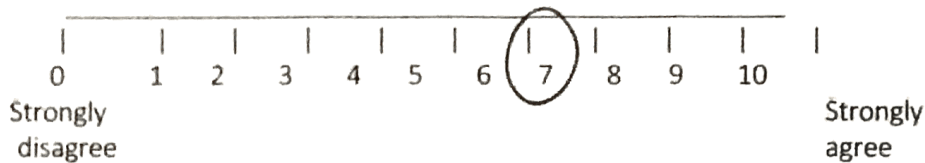
5. After a poor night's sleep, I know it will interfere with my activities the next day.



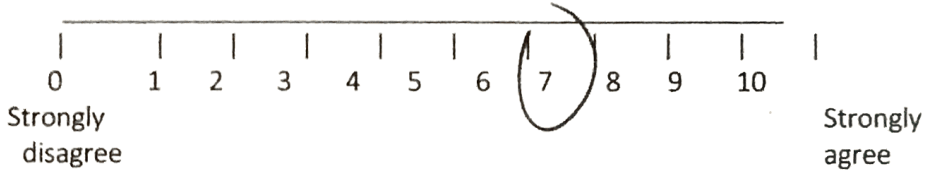
6. To be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.



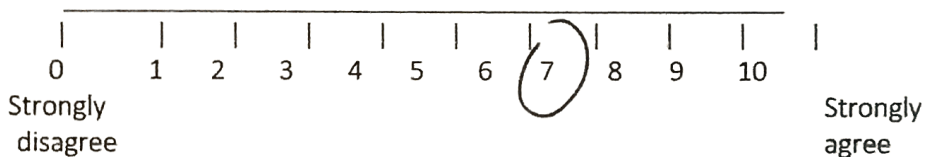
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.



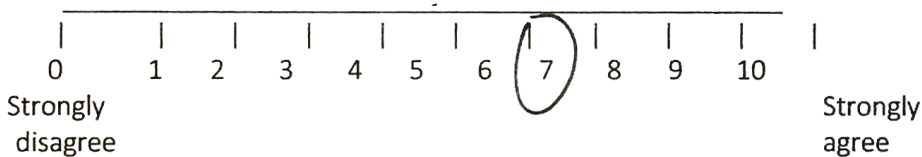
8. When I sleep poorly one night, I know it will disturb my sleep schedule for the whole week.



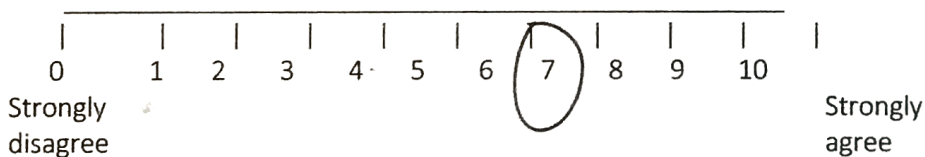
9. Without an adequate night's sleep, I can hardly function the next day.



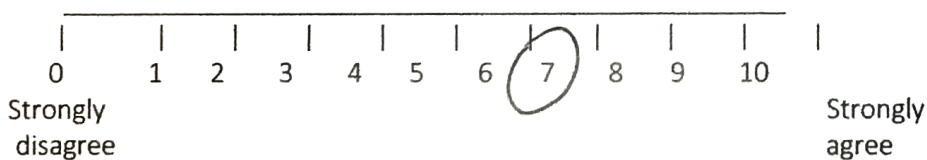
10. I can't ever predict whether I'll have a good or poor night's sleep.



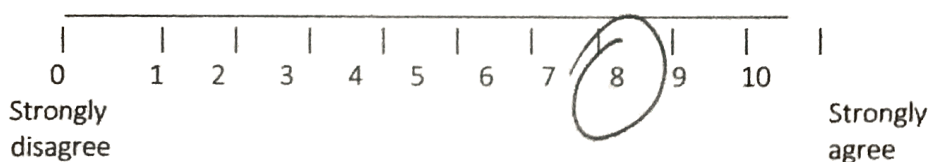
11. I have little ability to manage the negative consequences of disturbed sleep.



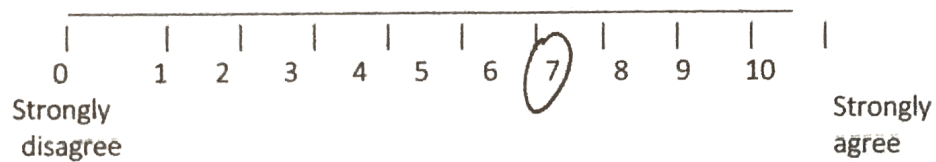
12. When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.



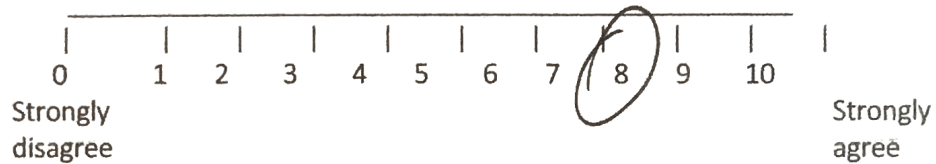
13. I believe insomnia is essentially the result of a chemical imbalance.



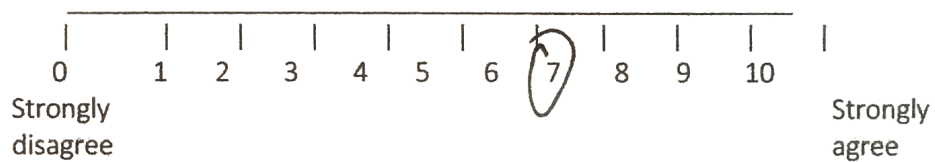
14. I feel insomnia is ruining my ability to enjoy life and prevents me from doing what I want.



15. Medication is probably the only solution to sleeplessness.



16. I avoid or cancel obligations (social, family) after a poor night's sleep.



<p>6. <u>Comorbidities</u>: What comorbidities impact the patient's sleep and how? Consider sleep, medical and psychiatric conditions. (e.g., difficult adjustment to CPAP treatment for sleep apnea, pain, PTSD-related hypervigilance).</p>	<p>Depression may contribute to the time-in-bed and low activity → AVOIDING ACTIVITY and SOCIAL hurts Insomnia may be causing the depression sleep too ↳ may relate to low activity levels</p> <p>Plan?</p>
<p>7. <u>Other</u>: Consider sleep environment, care taking duties at night, life phase sleep issues; mental status, and readiness for change.</p>	<p>HIS BELIEF THAT INSOMNIA IS BIOCHEMICAL ONLY AND HIS SLEEP DOCTOR WANTS TO DISCONTINUE PILLS MAY NEGATIVELY AFFECT MOTIVATION?</p> <p>Plan?</p>

Case Formulation Summary Form

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Domains	Patient specific factors contributing to insomnia or interfere with adherence
1. <u>Sleep Drive</u> : What factors may be weakening the patient's sleep drive? (e.g., extended time in bed, dozing off in the evening, daytime napping, sedentary life)	lots of TIB ; naps ; lingering little activity Plan?
2. <u>Biological clock</u> : What factors may be weakening the signal from the patient's biological clock? (e.g., irregular wake and/or out of bed time, time in bed window that is not congruent with the patient's chronotype).	Wakes up naturally around 4:30 am - phase advance? early bird tendency Plan?
3. <u>Arousal</u> : What manifestations of hyperarousal are evident? Consider the following: 3a. <u>Cognitive arousal related to sleep</u> (e.g., sleep effort, safety behaviors, and maladaptive beliefs and attitudes about sleep). 3b. <u>General hyperarousal affecting sleep</u> (e.g., worry in bed about life stressors). 3c. <u>Conditioned arousal</u> : Has the bed become associated with arousal rather than sleep? Specify predisposing (e.g., high trait anxiety), precipitating (e.g., stressful life event), and maintaining factors (e.g., extended time spent in bed).	- some doubling-up and noncontingent use would be better use of sleep meds - to sleep self efficacy "I feel like I should rest" - napping is a nurturing behavior - beliefs are perhaps unhelpful (high DBAQ) - Beliefs insomnia is biochemical and medication is the only solution - may think there is little he can do. - loneliness and boredom may contribute to an early bedtime? lots of wake time in bed - conditioned arousal Plan?
4. <u>Unhealthy sleep behaviors</u> : What unhealthy sleep behaviors are present? Consider caffeine, alcohol, nocturnal eating, timing of exercise, etc.).	Up to 4 black teas (caffeinated) as late as 6 pm Plan?
5. <u>Medications</u> : What medications might impact the patient's sleep/sleepiness? Consider carryover effects, tolerance, and psychological dependence.	Diuretics contribute to an awakening to urinate Sleeping pill use is not contingent Plan?

MEQ=61
slight morningness

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Domains	Patient specific factors contributing to insomnia or interfere with adherence
1. <u>Sleep Drive</u> : What factors may be weakening the patient's sleep drive? (e.g., extended time in bed, dozing off in the evening, daytime napping, sedentary life)	lots of TIB ; naps ; lingering little activity Plan?
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4. <u>Unhealthy sleep behaviors</u> : What unhealthy sleep behaviors are present? Consider caffeine, alcohol, nocturnal eating, timing of exercise, etc.).	Up to 4 black teas (caffeinated) as late as 6 pm Plan?
5. <u>Medications</u> : What medications might impact the patient's sleep/sleepiness? Consider carryover effects, tolerance, and psychological dependence.	Diuretics contribute to an awakening to urinate Sleeping pill use is not contingent Plan?

MEQ=61
slight morningness

"he shouldn't have to ask."

Case Formulation Summary Form

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Domains	Patient specific factors contributing to insomnia or interfere with adherence
1. <u>Sleep Drive</u> : What factors may be weakening the patient's sleep drive? (e.g., extended time in bed, dozing off in the evening, daytime napping, sedentary life)	lots of TIB ; naps ; lingering little activity Plan? TIB restriction and schedule activity SC to eliminate naps and wait until sleepy
2. <u>Biological clock</u> : What factors may be weakening the signal from the patient's biological clock? (e.g., irregular wake and/or out of bed time, time in bed window that is not congruent with the patient's chronotype).	Wakes up naturally around 4:30 am - phase advance? early bird tendency Plan? Decrease lingering in morning because his body won't sleep - SC set rise time MEQ=61 slight morningness
3. <u>Arousal</u> : What manifestations of hyperarousal are evident? Consider the following: 3a. <u>Cognitive arousal related to sleep</u> (e.g., sleep effort, safety behaviors, and maladaptive beliefs and attitudes about sleep). 3b. <u>General hyperarousal affecting sleep</u> (e.g., worry in bed about life stressors). 3c. <u>Conditioned arousal</u> : Has the bed become associated with arousal rather than sleep? Specify predisposing (e.g., high trait anxiety), precipitating (e.g., stressful life event), and maintaining factors (e.g., extended time spent in bed).	Unrealistic beliefs about sleep even in the face of normative information. - some doubling-up and noncontingent use would be better use of sleep meds - to sleep self efficacy "I feel like I should rest" - napping is a nurturing behavior - beliefs are perhaps unhelpful (high DBAQ) - Believes insomnia is biochemical and medication is the only solution - may think there is little he can do. - loneliness and boredom may contribute to an early bedtime? lots of wake time in bed - conditioned arousal! Some rigidity about social/family life - he "shouldn't" have to ask. Plan? Cognitive therapy to test whether sleep effort is helpful and to test whether the "shoulds" get in the way of him seeing his family and friends.
4. <u>Unhealthy sleep behaviors</u> : What unhealthy sleep behaviors are present? Consider caffeine, alcohol, nocturnal eating, timing of exercise, etc.).	Up to 4 black teas (caffeinated) as late as 6 pm Plan? switch to decaf/other beverage after lunch
5. <u>Medications</u> : What medications might impact the patient's sleep/sleepiness? Consider carryover effects, tolerance, and psychological dependence.	Diuretics contribute to an awakening to urinate Sleeping pill use is contingent Plan? Switch to noncontingent sleep medication use. Stimulus Control for prolonged bathroom-related awakenings.

<p>6. <u>Comorbidities</u>: What comorbidities impact the patient's sleep and how? Consider sleep, medical and psychiatric conditions. (e.g., difficult adjustment to CPAP treatment for sleep apnea, pain, PTSD-related hypervigilance).</p>	<p>Depression may contribute to the time in-bed and low activity → AVOIDING ACTIVITY and SOCIAL hurts sleep too. Insomnia may be causing the depression ↳ may relate to low activity levels</p> <p>Plan? Discuss depression treatment options; bereavement support; behavioural activation Present a unified case conceptualization</p>
<p>7. <u>Other</u>: Consider sleep environment, care taking duties at night, life phase sleep issues; mental status, and readiness for change.</p>	<p>HIS BELIEF THAT INSOMNIA IS BIOCHEMICAL ONLY AND HIS SLEEP DOCTOR WANTS TO DISCONTINUE PILLS MAY NEGATIVELY AFFECT MOTIVATION?</p> <p>Plan? Focus in Cognitive Therapy.</p>

