

Question	Answer
What is the ideal number of patients in a group, please?	We have run groups from 8 - 40 patients. But an ideal size is around 8 - 10 patients.
Will you avoid the use of hypnotics during CBTi?	If the patient is already on hypnotics, we wouldn't necessarily stop them before the CBT (though some patients choose to). If they use hypnotics on an occasional basis they will naturally use them less and less as their sleep improves. If they use the medications nightly, we introduce a way to reduce medication using sleep scheduling (session 2). There is even some evidence that there may be benefit in giving hypnotics to patients going through the course and then tapering them afterwards: Morin, C. M., Vallières, A., Guay, B., Ivers, H., Savard, J., Mérette, C., ... & Baillargeon, L. (2009). Cognitive behavioral therapy, singly and combined with medication, for persistent insomnia: a randomized controlled trial. <i>Jama</i> , 301(19), 2005-2015.
If CBT-i works for 70% of people, what do you explain to the remaining 30%? Or what do you recommend doing next?	The first thing to do is check they have actually used the techniques and problem solve if they have struggled to use them. Sometimes they just need more CBT!! One can also look at supplementary therapies and there is a bit of evidence for Tai Chi, yoga, and various relaxation techniques such as autogenic training, mindfulness or heart rate variability coherence training. We would suggest using these in addition to the CBTi, not instead of it. But there will also be some patients who don't respond to non-medical interventions and ultimately need medication. This is more common in those patients with objectively short sleep, but they are a minority.
If CBT-i works for 70% of people, what do you explain to the remaining 30%? Or what do you recommend doing next?	Research studies show 70-80% of people have their insomnia fully or partially cured. However, audits show higher results. The people who do not benefit are usually the people who have dropped out part way through treatment or have something else going on in their life that is stopping them from engaging in the techniques. Those who complete it have a very high success rate

for the sleep diary, if we are looking for a subjective guide, do we just want guesses of how long they were awake for rather than clock-watching?	Yes absolutely - we tell them not to clock watch, it is a subjective estimation from the patient
Hugh, why include the 30 minutes of being awake before the alarm as time awake if the alarm time might just be the latest time of being asleep to avoid being late for work?	If they get up when the alarm goes off, we count it as time awake in bed. If they get up when they wake up, we do not count time after getting up
Older folks (eg. my parents!) tend to nap quite a lot during the day, should they not?	The rules are different for people without insomnia. If your parents are happy with their sleep, no need to change it. If they want to change their sleep at night, they will have to change the napping.
How adaptable is CBT-I for patients with neurodevelopmental conditions such as ADHD or autism, where sensory sensitivities, routines and irregular sleep patterns may be major contributors?	It is very applicable, but may require some minor modifications. For example, in ADHD it's advised to do the course over 6 - 7 sessions rather than 5 so you can make the sessions shorter, with slightly less content per session. But it is also important to remember that a lot of patients with neurodiversity have circadian rhythm disorders which require different treatments.
But if the patient is overestimating their periods of wakefulness, the calculation of sleep efficiency will be wrong?	It will be wrong and there is a good chance that, in the short term, they will overcompress their time in bed. They may sleep 7 hours, but think they sleep 6 hours and so will compress their time in bed to 6 hours. But this actually helps them to fall asleep really quickly and have consolidated sleep and they will hit the 90% threshold quickly. So over a couple of weeks any errors will naturally be ironed out.
Do we need to adapt the CBT-I for patients with trauma, who often tell me their sleep is interrupted by nightmares that wake them up and, at times, keep them awake?	The first thing to know is that there is a really good psychological therapy for nightmares in the form of imagery rehearsal therapy. But some of the CBT-I techniques can be helpful for nightmares as well, particularly progressive muscle relaxation. In terms of trauma, I have found that patients respond really well to CBT-I. Particularly in patients with a history of sexual abuse or trauma in a hospital setting, there is a powerful negative association with the bed, but feel that they have to stay in the bed at night because "they're supposed to". Sleep scheduling and stimulus control essentially release them

	from that. We are saying, if you are not asleep and not comfortable in the bed, you don't have to be there.
These patients have PTSD/complex PTSD.	It is effective in PTSD, but the best results are when combined with imagery rehearsal therapy if there are nightmares.
When you mention the first dose of light in the morning synchronising sleep, is normal daylight indoors enough ie opening curtains? Or do people need to go outside?	Ideally they should go outside, but if this is not possible or the weather is dreadful, then sitting near a big east facing window or using a SAD lamp is a decent plan B.
When you mention the first dose of light in the morning synchronising sleep, is normal daylight indoors enough ie opening curtains? Or do people need to go outside?	20 - 30 minutes should be enough. So lots of people will get this on their walk to the tube, their drive to work etc.
Is there any evidence that it works for patients with ADHD?	Yes, but the advice is to modify the techniques slightly (see question above)
Thanks Hugh. For how long? And sorry for the typos!	Good question - have amended my answer.
Could you tell us how you would deal with a wearable sleep monitor (iWatch/Fitbit for example) if we ask them for sleep diary?	A diary is better than a sleep monitor. But if they insist on using a monitor, ask them to fill out the diary BEFORE looking at the monitor data. If they are only using the monitor, then one has to look at the records and transfer the data into a diary.
if people aren't prepared to change their sleep hygiene routines and they are very poor, how do other treatments impact / should they be used	It is an opportunity to talk about how committed they are and if now is the right time to try the CBT. But, as most of the sleep hygiene techniques are not that important, I would rather they ignore sleep hygiene if it allows them to focus their energies on the other techniques.

For Screens, is bluelight not so much of the problem from your point of view?	Not really. Our circadian rhythm is relatively insensitive to blue light at night. There was a well publicised study about 10 years ago that showed reading on a tablet delayed sleep onset. What was missed in most of the reporting is that it delayed sleep onset by 8 minutes which is not clinically significant. Also, a lot of the studies that have shown some disruption from night time screen use kept subjects in a dim environment with no access to screens or daylight all through the day. This is clearly not a good representation of what happens in reality.
do you find there is a lot of variation in adult sensitivity to screens and blue light exposure in time leading up to bed? If so what might be responsible for that?	There can be a bit, but not much. One factor is age - yellowing of the cornea with age may reduce the transmission of blue light. I think a lot of the variability though is down to how much light exposure one gets in the day. If you get very little light exposure in the day, then light at night may have some effect. If you are getting plenty of light exposure in the day, then night light exposure seems to be less disruptive. So encourage patients to get outdoors!
What is the evidence/ your views for how helpful/ unhelpful wearables are for people with insomnia?	We now talk about a condition called orthosomnia where people develop increased anxiety about their sleep because of what their watch is telling them. I think the technology is improving and may become more useful over the next few years. The one time I have found it helpful is where a patient feels they are getting little or no sleep but their watch says they are - sometimes patients find this reassuring. In the USA the Samsung smartwatch does have FDA approval to screen for moderate/severe OSA.
You've mentioned completing the sessions in a group is ideal, I was wondering if there was data around if 1:1 vs group was any worse in terms of results (or if it's just in terms of how much CBT-I can be offered in the same timeframe?) I work in addictions psych and a number of my patients are fairly resistant to the idea of any sort of group work due to the chance of running across people with whom they've had previous issue when they've been in the throes of substance/alcohol use	There is evidence that individual may be better - see: Yamadera, W., Sato, M., Harada, D., Iwashita, M., Aoki, R., Obuchi, K., Ozone, M., ... Nakayama, K. (July 07, 2013). Comparisons of short-term efficacy between individual and group cognitive behavioral therapy for primary insomnia. <i>Sleep and Biological Rhythms</i>, 11, 3, 176-184.

Curious about how UK seasonal changes in light levels/hours and clock changes (as we're about to experience soon) might typically impact on wake/sleep times and subjective feelings of sleepiness in people you see in sleep clinic, and whether you recommend any adjustments to sleep schedule based on this? Other than using light therapy in morning in winter months, any other recommendations for adjusting to significantly varied light hours seasonally for energy levels/mood purposes?	In terms of the clocks changing, we advise people just to carry on as normal and stick to the same clock times for bed and rising. This is because, if work starts at 9am in the summer, it starts at 9am in the winter. There are some patients who like to get up earlier in the summer and later in the winter and that's fine. They can shift their rising and bed times at the change of seasons as long as they not changing night on night or changing it every week.
In treating PTSD nightmares and insomnia would there be a sleep protocol to use the IRT first and then manage residual insomnia with CBTi or use both as often the fear from the patient is that increasing the exposure to sleep increases the chances of more nightmares what would be the suggestion if the trauma focused intervention hasn't worked or they are on a long waiting list for T-F CBT or EMDR and the sleep issues are the most disabling?	Yes, if the nightmares create a fear of sleep then treating them first is a good idea. In our IRT course we sneak in a few CBT-I techniques as well so they may experience some insomnia improvement along the way.
Non pharmacological options rather than medication that is	In particular, progressive muscle relaxation works for insomnia and nightmares.
IN those with substance use disorders, is abstinence a prerequisite before commencing treatment?	Not necessarily, though they need to be realistic that the substances may impact on their sleep. Sometimes the substance misuse is driven by the insomnia and so treating the insomnia would be an integral part of the overall care package.
Hugh, I am sorry I am a little unclear about what you meant by the '5 hour floor' during the sleep scheduling session. I think you mentioned that the earliest sleep time need not be changed if the 5 hour floor is met.	When we set an earliest bedtime, if the patient feels they are sleeping less than 5 hours, we set the earliest bedtime at 5 hours before their rising time. If they then have a sleep efficiency of below 85% we wouldn't move their earliest bedtime 15 minutes later - we would keep it at 5 hours before the rising time.

In terms of bed use, is there any exception when you caught a cold for example? for the rest purpose in such situation?	live answered
Should we first explain to them the concept of classical conditioning with examples like the dog salivation example?	I think this is really important. Patients think the point of the 15 minute rule is to make themselves feel sleepy and expect that it should make them sleep well on the night they do it. We need to make it clear that this is not how these techniques work and that they work slowly. If they understand that the techniques are not designed to improve their sleep in the short term, but are designed to change a deeply ingrained association leading to improved sleep after a few weeks, they are more likely to stick with it.
Kindly share a recommended textsbook or journal paper on CBT-i	live answered
Can CBT-I work in inpatient population? Or would they be very unwell to do that	See: Novak, C., Packer, E., Paterson, A., Roshi, A., Locke, R., Keown, P., ... & Anderson, K. N. (2020). Feasibility and utility of enhanced sleep management on in-patient psychiatry wards. BJPsych bulletin, 44(6), 255-260.
Specific approach in shift worker or night work?	live answered
Does the royal college have a CBT-i special interest group that meets regularly ?	No - the newly minted United Kingdom Insomnia Network may be offering something like this.
any thoughts on app such as Sleepio, and on devices such as 8sleep mattress cover?	Automated CBT-I programs can be effective, though not as effective as working with a therapist. They will often reject any patients with psychiatric comorbidity, but are fine for uncomplicated insomnia. Mattresses which monitor and advise on sleep are not validated, but mattresses that can provide cooling in the night can be helpful.
Is Sleepio a good app option? Also interesting the idea around sleep hygiene advice not being all that effective - do you think this relates to delivery, or patient struggling to engage with something that's less specific/assertive/pragmatic/based on hard numbers, when compared to CBTI ?	Sleepio is not yet commissioned in England, only in Scotland. It may be commissioned in the rest of the UK in the future, and NHS England are looking at this currently. In the meantime, Sleepful is a free app

How much admin time do you need to write on the patients' individual clinical records after each session + preparation time before each session etc. Asking in terms of Job Planning. Thank you	It is useful to have a short phrase summarising the session that you can copy and paste into all patient notes for that session, and only add something specific to the patient if important. We would job plan 1.5 hrs per group and 30mins for admin time, so 2 hours per group. Plus time to do the initial assessments with people before the group.
Thank you. If you could share Kristy Anderson's email, that would be appreciated	If you are interested, send me your email at hugh@selsick.net and I'll send it on to Kirstie.
if there is time, could you talk more about sleep in trauma and how to manage it, which are best techniques and how we can help in routine OP clinics	Patients with trauma often respond well to CBT-I. It can be an enormous relief for patients. Especially being given 'permission' not to stay in bed when they feel anxious or triggered in bed
What about people with insomnia who are required to travel long haul/accross time zones frequently with work?	Again, be realistic - sleep doesn't like having your body clock moved to a different time zone and sleeping on planes is hard. If crossing only a couple of times zones and only for a short period, then try stay on UK time. So if you go to Italy which is 2 hours ahead and your rising time in the UK is 7am, get up at 9am Italy time (which is 7am UK time). If you are travelling across more time zones or for more than a day or two then switch to the local time. So if you travel to New York, which is 5 hours behind, for a week, get up at 7am New York time. Then switch back to 7am UK time on your return. The same applies to the earliest bedtimes.
What does the 'assessment' for the program entail? thank you	There are those who say that anyone with an insomnia complaint can go into CBT-I and those who don't get better should be referred for a more detailed sleep assessment. Our approach is to do an assessment first to screen for any other sleep disorders like restless legs or circadian rhythm disorders that might mimic insomnia and to check if the patient will function well in a group or if there are comorbidities, personality traits or language barriers that might suggest individual therapy is better. I will include two chapters on sleep assessment in the post course pack.
What are the strongest predictors of CBT-I treatment response	live answered

Would you ever advise someone to focus on their breathing or is this more difficult than the techniques you provided?	live answered
Psychiatrists may speak about sleep 10-20 times per week with patient. How many of these patients should have cbt-i?	live answered
Do patients ever ask for the 'evidence base' for things we might say to them in the course of a CBT I program?	live answered
If they are doing imaginary and if a worry/ anxious thought comes up, what should we advise?	live answered
For patients with trauma histories, can relaxation imagery inadvertently trigger unwanted memories, and how should we adapt the technique	live answered
What outcome measures would you suggest to demonstrate improved sleep please? Is it mainly the patient's subjective response of whether they slept well or not? And how often do we do these measures?	live answered
If we are thinking of developing a sleep clinic, what screening tools would you recommend that clinicians in the community/inpatient can use to screen for insomnia in their patients and then refer to the sleep clinic?	live answered
How do you manage patients who do not engage in the program i.e. not turn up to some sessions; not do homework; being disruptive in the group etc.? Thank you	live answered
Can you please give advice on how to set up a CBT-I service in the trust? I am currently a ST5 registrar and so far, I am not aware of anyone in my trust who practise CBT-i and apart from the knowledge from this course, I have not got any expertise/experience on how to deliver CBT-i. Any advice on who should I approach/supervision etc?	live answered

what about Pitsburg Sleep Quality Index for evaluation	live answered
Do patients suffering from Insomnia due to pain, drugs and alcohol issue benefits from CBT-I	live answered
Are there any private CBTi clinics or services you would recommend?	live answered
Are your cbt I zoom sessions open to NHS patients outside of London	live answered
Can you say anything about managing orthosomnia in pt's?	live answered