A BRIEF HX OF BEHAVIORAL SLEEP MEDICINE

Michael L. Perlis, Ph.D.

Associate Professor of Psychiatry
Department of Psychiatry
University of Pennsylvania

Director, The Upenn Behavioral Sleep Medicine Program

Visiting Professor: University of Glasgow & University of Freiburg

A CAUTIONARY PREAMBLE

HISTORY VARIES AS A FUNCTION OF THE HISTORIAN

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HISTORY VARIES
AS A FUNCTION OF THE
HISTORIAN

THE BIAS HERE IS TOWARDS EVENTS RELATED TO

IN GENERAL: INSOMNIA

IN SPECIFIC:

- TREATMENT R&D
- TREATMENT EFFICACY
- THEORY RE: ETIOLOGY
- EVIDENCE RE: INSOMNIA AS A RISK FACTOR

IF YOU HAVE IDEAS ABOUT OTHER LANDMARK STUDIES OR EVENTS THAT SHOULD BE INCLUDED HERE

PLEASE WRITE ME AT
mperlis@upenn.edu

BEHAVIORAL SLEEP MEDICINE

WHY THIS TERM ?

ELSEVIER

Journal of Psychosomatic Research 49 (2000) 343–345

Journal of Psychosomatic Research

Behavioral sleep medicine
An emerging subspecialty in health psychology and sleep medicine

Edward J. Stepanski[a,*], Michael L. Perlis[b,*]

[a]Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL, USA
[b]Department of Psychiatry, University of Rochester, 300 Crittenden, Rochester, NY 14642, USA

Received 15 March 2000; accepted 12 July 2000

Abstract

As the knowledge base in sleep disorders medicine has broadened, a subspecialty that we will refer to as "behavioral sleep medicine" area is emerging. This article will define this subspecialty area, provide some historical context for its emergence, current issues related to specialty training and clinical practice, and suggest needs for future research. The term "behavioral sleep medicine" was selected because it clearly denoted the two fields from which our subspecialty emerged (health psychology/behavioral medicine and sleep disorders medicine). It suggests much about our approach to training, clinical practice, and research, and it appropriately implies that the field is open to PhD sleep specialists, MD sleep specialists, and other health care providers with the relevant training. Formally, behavioral sleep medicine refers to the branch of clinical sleep medicine and health psychology that: (1) focuses on the identification of the psychological (e.g. cognitive and/or behavioral) factors that contribute to the development and/or maintenance of sleep disorders and (2) specializes in developing and providing empirically validated cognitive, behavioral, and/or other somatic therapeutic interventions for the entire spectrum of sleep disorders.
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Keywords: Sleep disorders; Health psychology; Sleep medicine

A historical context

It can be argued that clinical polysomnography and early sleep medicine evolved out of a branch of psychological science known as psychophysiology. In the late 1950s, a major effort was underway to explore and define cognitive, emotional, and behavioral processes using electrophysiologic techniques. The promise of this approach resided in the objectivity and replicability of the measurement strategy as well as the potential tie to the biologically based exploration of human behavior via medicine and the fledgling discipline of neuroscience. Many of those psychophysiology laboratories naturally gravitated toward the electrophysiologic study of sleep as the equipment was already available and the interest in altered states was strong. Examples of prominent early sleep researchers that have their historical origins in psychophysiology include Allan Rechtschaffen (University of Chicago), Wilse Webb (University of Florida), Harold Williams, Arthur Lubin (Walter Reed Army Institute of Research), and Laverne Johnson (Naval Health Research Center, San Diego). A further testament to the concept that sleep medicine is an outgrowth of psychophysiology resides in the very name selected for the first scientific sleep society: the "Association for the Psychophysiological Study of Sleep."

Beginning in the 1970s, sleep disorder centers were established as specialty clinics, generally in departments of psychiatry and neurology. These programs evaluated patients with a variety of sleep-related complaints, with 23.9% of all patients receiving a diagnosis obstructive sleep apnea (OSA) syndrome in 1978–1980 [1]. This pattern has changed over the past 17 years, and the proportion of patients evaluated in sleep disorders centers now diagnosed with OSA has nearly tripled to 67.8% in 1996 [2]. This shift is due primarily to the increased referrals of patients with suspected sleep-disordered breathing. How this shift in referral patterns has come to be is a matter of debate. Some may argue that OSA constitutes the

* Corresponding author. Tel.: +1-716-275-3046; fax: +1-716-275-1113.
E-mail address: michaelperlis@urmc.rochester.edu (M.L. Perlis).

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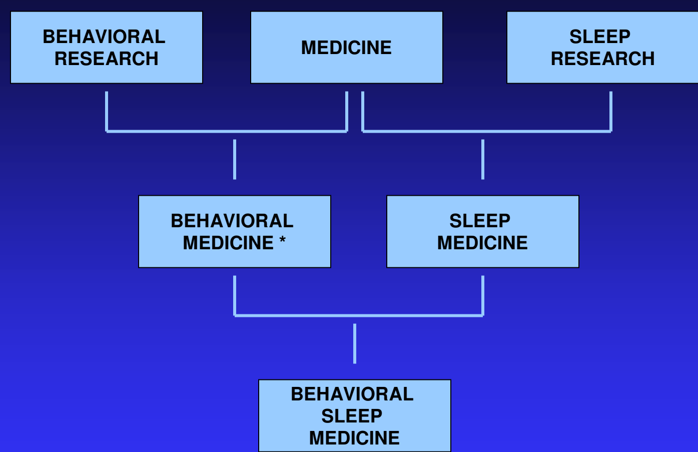
PII: S0022-3999(00)00171-9

The term "Behavioral Sleep Medicine" was selected because it clearly denoted the two fields from which our subspecialty emerged (health psychology/ behavioral medicine and sleep disorders medicine)".



* This is intended to denote both Behavioral Medicine and Health Psychology

DOES THE TERM DENOTE SOMETHING SPECIFIC ?

Formally, Behavioral Sleep Medicine refers to the branch of clinical sleep medicine and health psychology that:

(1) focuses on the identification of the psychological (e.g. cognitive and/or behavioral) factors that contribute to the development and/or maintenance of sleep disorders and

(2) specializes in developing and providing empirically validated cognitive, behavioral, and/or other nonpharmacologic interventions for the entire spectrum of sleep disorders.

CLINICAL RESEARCH MILESTONES
SOCIETAL AND EDUCATIONAL INITIATIVES

Questions After

CLINICAL RESEARCH MILESTONES


CLINICAL RESEARCH MILESTONES
1930s Jacobsen applies Progressive Muscle Relaxation to Insomnia
1930s Mowrer Bell-n-Pad Technique for Nocturnal Enuresis
1960s First Clinical Trials for insomnia (Relaxation)
1972 Bootzin applies stimulus control principles to Insomnia
1973 Borkovec conducts first Behavioral Therapy trials for Insomnia
1977 Hauri publishes Sleep Hygiene Rules in Current Concepts: The sleep disorders
1978 Bootzin conducts first systematic review of Insomnia Tx
1981 Czeisler and colleagues develop Chronotherapy
1981 Hauri publishes on the treatment of insomnia with SMR biofeedback
1985 Ferber publishes a guide on extinction to eliminate nighttime crying in infants
1985 Cartwright reports on positional Therapy


CLINICAL RESEARCH MILESTONES
1987 Spielman publishes the "3P' or Behavioral Model of Insomnia
1987 Spielman and Saskin develop Sleep Restriction Therapy
1988 Lask reports on Schedule Awakenings for Parasomnias
1989 Ford and Kamerow publish first paper on Insomnia as a risk for MDD
1990 Lack provides preliminary data on the role of circadian dysregulation in Insomnia
1992 Krakow reports on dream rehearsal Tx of nightmares
1993 Morin assesses Cognitive Behavioral Therapy for late life Insomnia
1993 Edinger reports on CPAP desensitization as a Tx for CPAP non-compliance
1994 Morin et. al and Murtaugh et al. publish first two Meta-analyses re: Tx of Insomnia
1995 Lichstein introduces Sleep Compression as an alternative to Sleep Restriction
1996 Edinger compares SRT to BZ treatment for PLMs

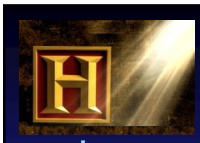
CLINICAL RESEARCH MILESTONES

- 1997 Perlis publishes the Neurocognitive Model of Insomnia
- 1999 Aloia publishes on Motivational Therapy for compliance with CPAP
- 2000 Perlis publishes that CBT-I outcomes in clinic are comparable to RCT norms
- 2000 Bastien publishes on the familial incidence of Insomnia
- 2000 Lichstein publishes on the efficacy of CBT-I for "Secondary Insomnia"
- 2001 Lichstein publishes a paper challenging the concept of "Secondary Insomnia"
- 2001 Edinger publishes first large scale placebo controlled RCT on CBT-I
- 2002 Smith et al. publish a meta-analysis on the relative efficacy of CBT-I vs Hypnotics
- 2002 Harvey publishes on the role of selective attention & safety behaviors in Insomnia
- 2002 Espie publishes the Psychobiological Inhibition Model of Insomnia
- 2003 Suka publishes first paper re: insomnia as a risk for hypertension

CLINICAL RESEARCH MILESTONES

- 2003 Edinger reports on abbreviated cognitive-behavioral insomnia therapy (ACBT)
- 2005 Smith Shows CBT-I reverses CNS abnormalities as assessed with SPECT
- 2006 Pigeon et al. publishes on the role of sleep homeostasis dysregulation in Insomnia
- 2007 Edinger publishes a dose response assessment of CBT-I
- 2007 Harvey publishes on the effects of Cognitive Therapy (CT only) for Insomnia
- 2007 Germain reports on brief behavioral Tx for PTSD-related sleep disturbances
- 2007 Harris et al. publish on the Intensive Sleep Retraining procedure for Insomnia
- 2008 Altena shows that CBT-I reverses diurnal cortical hypoactivation as assessed with fMRI
- 2008 Stone recommends that non restorative sleep not be considered as Insomnia
- 2008 Manber reports that CBT-I enhances depression outcomes in patients with MDD & Insomnia
- 2009 Morin Publishes on the Natural Hx of Insomnia

SOCIETAL AND EDUCATIONAL INITIATIVES



SOCIETAL AND EDUCATIONAL INITIATIVES

- 1983 NIH SOS conference characterizes Insomnia as “only” a symptom
- 1990s SRS Insomnia special interest group & AASM PhD focus groups are established
- 1996 Morin publishes first Insomnia treatment manual
- 1998 Stepanski & Perlis coin the term Behavioral Sleep Medicine
- 2000 Buysse forms the Presidential Committee for Behavioral Sleep Medicine
- 2000 Stepanski & Perlis publish first Hx review of Behavioral Sleep Medicine
- 2000 AASM Review & SOP papers on the evaluation of Chronic Insomnia are published
- 2001 APA Monitor publishes article on the “Need for Sleep Psychologists”
- 2003 Lichstein & Perlis publish first text book dedicated to Behavioral Sleep Medicine
- 2003 BSM Comm creates and administers first AASM BSM exam (Chair: E. Stepanski)
- 2003 Lichstein establishes the Journal of Behavioral Sleep Medicine

SOCIETAL AND EDUCATIONAL INITIATIVES

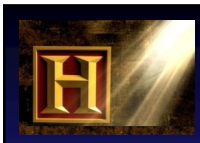
- 2004 AASM sponsors first Behavioral Sleep Medicine course
- 2005 NIH SOS conference identifies CBT-I as a first line Tx for chronic insomnia
- 2005 Perlis, Jungquist, Smith & Posner publish a session by session guide for CBT-I
- 2005 Pittsburgh Consensus Conference on standards for Insomnia Research (Chair: D. Buysse)
- 2005 BSM Committee establishes one year BSM fellowships (Chair: W. Pigeon)
- 2005 Behavioral Insomnia of Childhood reclassified as a V code
- 2006 AASM SOP Review on the Behavioral Treatment of Ped Insomnia
- 2006 AASM "White paper" re: evidence for Psych & Behavioral Tx of Insomnia is published
- 2006 AASM "White paper" re: SOP for Psych & Behavioral Tx of Insomnia is published
- 2006 BSM Committee establishes Mini-fellowships (Chair: W. Pigeon)
- 2006 University of Rochester sponsors an annual CBT-I seminar (Course Director: Perlis)

SOCIETAL AND EDUCATIONAL INITIATIVES

- 2006 AASM establishes a bi-annual "Insomnia course" (Course Director: Edinger)
- 2007 Pigeon et al. publish "The Future of Behavioral Sleep Medicine" in JCSM
- 2007 The ABSM exam is discontinued in favor of the ABMS exam
- 2008 APA Monitor publishes article "Wake up to a new practice opportunity"
- 2008 AASM initiative to increase availability of CBT-I
- 2008 AASM proposes to open the CBSM to Masters level clinicians
- 2008 BSM Com. Chair (Pigeon) & Insomnia Section Head (McCrae) call for reconsideration
- 2008 Perlis & Smith publish "How can we make CBT-I and BSM more widely available"
- 2008 Clinical Guidelines for Evaluation and Management of Insomnia published in JCSM
- 2008 Smith Surveys Membership re: the "Masters proposition"
- 2009 BSM Consensus Conference

SO HERE WE ARE

LET'S SEE WHAT KIND OF CONSENSUS WE CAN REACH.



THE SPECIFIC EVENTS THAT BRING US TO OUR PRESENT CROSS ROADS

JCSM
Journal of Clinical Sleep Medicine

EDITORIAL

How can we make CBT-I and other BSM services widely available?

Michael L. Perlis, Ph.D.[1] Michael T. Smith, Ph.D.[2]

[1]University of Rochester, Sleep & Neurophysiology Research Laboratory, Rochester, NY; [2]Johns Hopkins University, Behavioral Medicine Research Laboratory and Clinic, Baltimore, MD

Following several presentations and discussion panels regarding cognitive-behavior therapy for insomnia (CBT-I) during the 2007 annual meeting of the Associated Professional Sleep Societies in Minneapolis, it seems to many of us that the budding field of behavioral sleep medicine (BSM) is at a critical juncture.

Six events have occurred that bring us to the present crossroad. First, as result of the vision and generosity of the American Academy of Sleep Medicine (AASM), there is (as of 2004), a credentialing board for BSM that is underwritten and administered by the academy.[1] Second, the research literature regarding CBT-I has matured to a point where the 2005 NIH State of the Science panel acknowledged that this form of BSM is to be considered a first-line therapy for chronic insomnia.[2] Third, sleep medicine (with the change in the board-certification process from the American Board of Sleep Medicine to the American Board of Medical Specialties) has recently been redefined as a medical subspecialty and, as a result, BSM is not formally a part of sleep medicine. Fourth, with the revamping of AASM sections to be aligned with disease states (vs areas of specialty), BSM is no longer identified as a section within the Academy. Fifth, the recent AASM Comprehensive Academic Sleep Programs of Distinction initiative does not reference BSM nor require that centers within this program have BSM services.[3] Sixth, and finally, it now appears that there is a substantial push to alter who should provide CBT-I (core-BSM "physician extenders" vs BSM specialists) and how treatment should be conducted (fewer and shorter sessions). Although each of the last 4 events is relevant for the continued growth of BSM as an allied field and an interdisciplinary component of sleep medicine, the last and most recent event urgently needs to be addressed.

The push to make CBT-I more available by diversifying who can provide it and how it is provided is largely based on the following belief: (1) There are not enough credentialed BSM specialists to provide treatment for the millions of patients with insomnia, (2) reimbursement for BSM services is complicated and garners too low a level of reimbursement, (3) CBT-I can be conducted by anyone with a minimal amount of training, and (4) BSM specialists have little to offer sleep disorders centers beyond the treatment of insomnia (which can hardly keep one busy enough to justify a part-time equivalent or full-time equivalent salary).

Before addressing these issues specifically (and providing a series of recommendations), it is worth addressing the global perspective. Twenty to 30 years ago, sleep medicine itself was faced with many of the same daunting issues (e.g., too few specialists, problems with reimbursement, and a lack of evidence that sleep medicine alone could sustain a dedicated clinical enterprise). Yet, at that time, there was no call to populate the field with non-MDs to conduct polysomnography studies and evaluations (although this was allowed via the American Board of Sleep Medicine) nor was there a call to make polysomnography assessment studies half or one-third night studies to reduce the burden of the assessment process. Instead it was recognized that these issues required time and work to resolve and that only in this way could a clinical specialty be established. What has changed? Why is there such a sense of urgency and a rush toward solutions that can only diminish the effort to establish BSM as a subspecialty of sleep medicine (and behavioral medicine). Whatever the answer, it cannot be one that accepts that sleep medicine is, and should continue to be, a multidisciplinary field.

THERE ARE NOT ENOUGH CREDENTIALED BSM SPECIALISTS TO PROVIDE TREATMENT FOR THE MILLIONS OF PATIENTS WITH INSOMNIA.

First, while it is estimated that 10% to 15% of the population suffers from chronic insomnia, it is unclear what proportion of this population is actively seeking help. Thus, the assumption that the demand far exceeds the supply remains to be formally documented. What is clear is that most accredited sleep disorders centers do not have full-time or part-time clinicians who special-

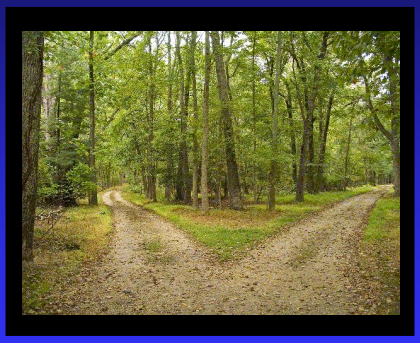
Disclosure Statement
Dr. Perlis has received research support from Cephalon and Sanofi-Aventis; has consulted for Elan-King Pharmaceuticals, Gerson Lehrman, Clinical Advisors, and MediCorp; has participated in speaking engagements for Sanofi-Aventis; has received use of equipment from Respironics; and has financial interests in Internet Didactic Services. Dr. Smith has received research support from Gaiproor.

Submitted for publication August, 2007
Accepted for publication October, 2007
Address correspondence to: Michael L. Perlis, UR Sleep and Neurophysiology Research Laboratory, University of Rochester, Department of Psychiatry, 300 Crittenden Blvd, Rochester, NY 14534; Tel: (585) 383-4017; Fax: (270) 512-4628; E-Mail: Michael_Perlis@URMC.Rochester.edu

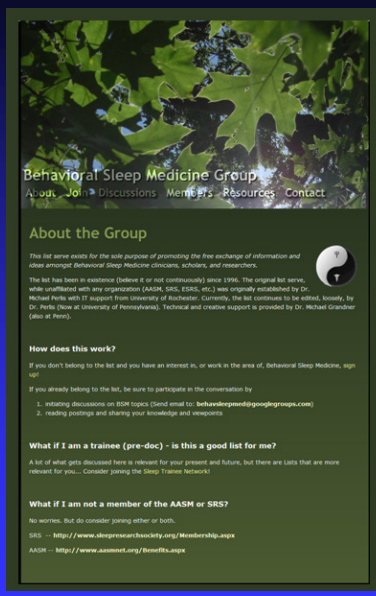
THE EVENTS THAT BRING US TO OUR PRESENT CROSS ROADS

- The establishment of the BSM exam and the CBSM credential via the AASM
- The 2005 NIH SOS panel states that CBT-I should be considered 1st line therapy for insomnia
- The ABSM is dissolved and BSM is no longer formally a part of Sleep Medicine
- The AASM reclassifies / renames the BSM section "the insomnia section"
- The AASM does not require "flagship" sleep disorders centers to provide BSM services
- The AASM seeks to re-define what CBT-I Tx should be and who should provide it
- The AASM switches the annual BSM exam to a bi-annual offering
- The AASM rules that masters level clinicians may sit for the BSM exam
- The AASM "tables" the call for detailed eligibility criteria for MA clinicians (exam & practice)
- The AASM "tables" the call for a phase in of a requirement for SDCs to have BSM's on staff

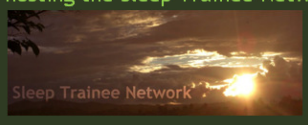
S0
WHERE TO FROM HERE ?



THAT'S WHAT WE NEED TO DECIDE



The NEW Behavioral Sleep Medicine Group!

- Now hosted through Google Groups
- New Website
  - http://www.behavsleepmed.com
- Also hosting the Sleep Trainee Network
  - 

- Still Moderated by Dr. Michael Perlis
  - With help from Dr. Michael Grandner

mperlis@upenn.edu

The University of Pennsylvania

Michael Perlis PhD
Director, Upenn Behavioral Sleep Medicine Program
mperlis@upenn.edu