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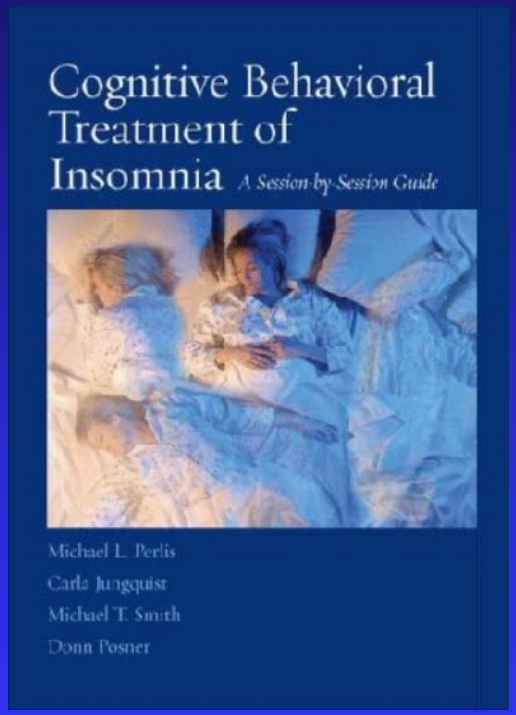

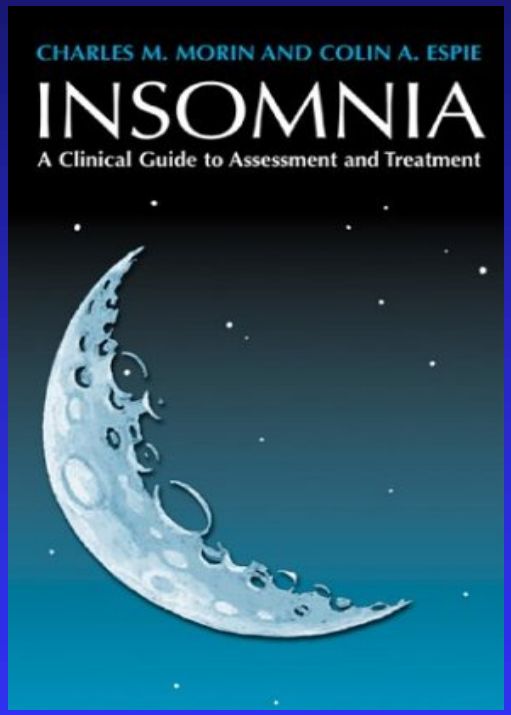

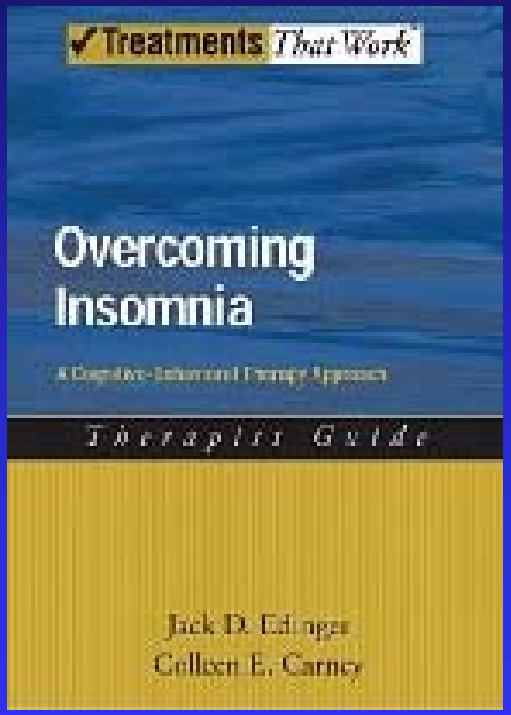

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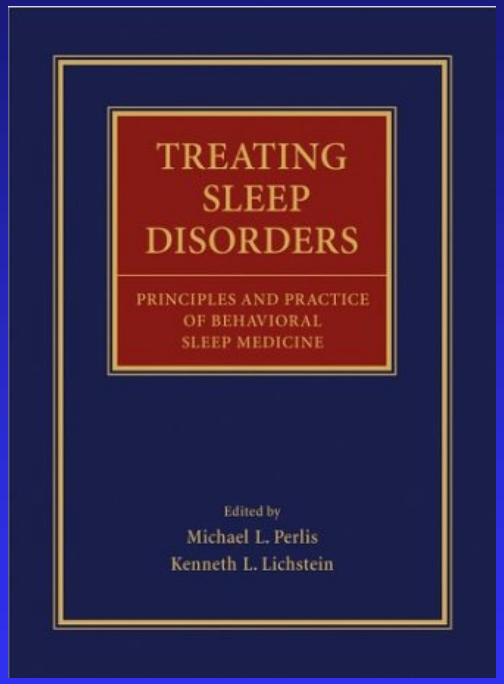

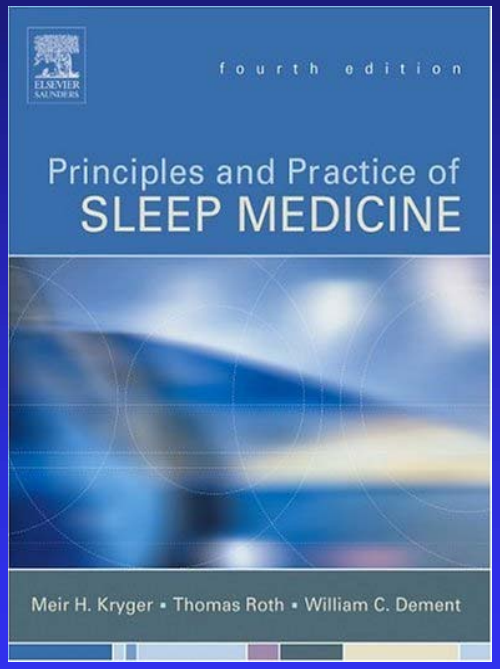

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PRACTICE PARAMETERS FOR THE EVALUATION OF CHRONIC INSOMNIA

Practice Parameters for the Evaluation of Chronic Insomnia

An American Academy of Sleep Medicine Report
Standards of Practice Committee of the American Academy of Sleep Medicine

Andrew Chesson, Jr.,[1] Kristyna Hartse,[2] W. McDowell Anderson,[3] David Davila,[4] Stephen ... Rafecas[5]

[1]Neurology Department, Louisiana State University Medical Center, Shreveport, [2]College of Medicine, University of South Florida, Tampa, FL, [3]Baptist Medi... Hospital Sleep Center, Missoula, MT, [4]Department of Medicine, VA Medical ... Pediatrics and Neurology, Baylor College of Medicine, Houston, TX, [5]Sleep Dis...

Summary: Chronic insomnia is the most common sleep complaint which health care ... patients are not, however, seen by sleep physicians but rather by a variety of primary ... concerning methods for effective assessment and subsequent differential diagnosis of ... basis for diagnosis and subsequent treatment has been the practitioner's clinical impress... tematic, evidence-based guidelines for diagnosis exist for chronic insomnia. This prac... dations for the evaluation of chronic insomnia based on the evidence in the accompan... these parameters by the sleep community, but even more importantly, hope the large n... this care can benefit from their use.
Conclusions reached in these practice parameters include the following recommendati... Since the complaint of insomnia is so widespread and since patients may overlook the ... tioning, the health care practitioner should screen for a history of sleep difficulty. This ... focused on common sleep disorders to identify primary and secondary insomnias. ... Latency Test (MSLT) should not be routinely used to screen or diagnose patients with ins... of insomnia does not preclude the appropriate use of these tests for diagnosis of specifi... apnea, periodic limb movement disorder, and narcolepsy that may be present in patier... dence to suggest whether portable sleep studies, actigraphy, or other alternative assessr... are effective in the evaluation of insomnia complaints. Instruments such as sleep logs, ... checklist, or psychological screening tests may be of benefit to discriminate insomnia p... have not been shown to differentiate subtypes of insomnia complaints.
Key words: Practice parameters; Sleep disorders; Insomnia; Sleep disturbance

BACKGROUND

INSOMNIA IS A COMPLAINT OF POOR QUALITY SLEEP that is often associated with daytime sequelae including fatigue, irritability, decreased memory and concentration, and pervasive malaise which affects many aspects of daytime functioning. The frequency of insomnia complaints is high, and there is an abundance of epidemiological data that suggest it is the most common sleep complaint in the industrialized world.[1-5] However, despite the high frequency of this problem and the negative economic ... as well as social ... noted and poorly ... cians alike.[10-13]

It is widely rec... tions which are as ... ic sleep disorders, ... chological stresso... toward effective t... ment with establi... Determining the ... only by the absen... by the multidime... which necessitate... etiologies. More... which have syste...

Accepted for publication December 1999
Correspondence: Standards of Practice Committee, American Academy of Sleep Medicine, 6301 Bandel Road, Suite 101, Rochester MN 55901, Phone: 507.287.6006, Fax: 507.287.6008, Email: aasm@aasmnet.org

SLEEP, Vol. 23, No. 2, 2000 1 Practice Parameters

PRACTICE PARAMETER

Practice Parameters for the Psychological and Behavioral Treatment of Insomnia: An Update. An American Academy of Sleep Medicine Report

An American Academy of Sleep Medicine Report

Standards of Practice Committee of the American Academy of Sleep Medicine

[1]Timothy Morgenthaler, MD; [2]Milton Kramer, MD; [3]Cathy Alessi, MD; [4]Leah Friedman, MA, PhD; [5]Brian Boehlecke, MD; [6]Terry ... [7]Vishesh Kapur, MD; [8]Teofilo Lee-Chiong, MD; [9]Judith Owens, MD; [10]Jeffrey Pancer, DDS; [11]Todd Swick, MD

[1]Mayo Clinic, Rochester, MN; [2]New York Medical Center, New York, NY; [3]VA Greater Los Angeles Healthcare Syst... California, Los Angeles, CA; [4]Stanford University School of Medicine, Stanford, CA; [5]University of North Carolin... Memorial Hospital, Murphyboro, IL; [6]Murfreesboro Medical Center, Murfreesboro, TN; [7]University of Washingto... Medical and Research Center, Denver, CO; [8] Rhode Island Hospital, Providence, RI; [9]Toronto, Canada; [10]Housto...

Abstract: Insomnia is highly prevalent, has associated daytime conse... quences which impair job performance and quality of life, and is asso... ciated with increased risk of comorbidities including depression. These ... practice parameters provide recommendations regarding behavioral and ... psychological treatment approaches, which are often effective in primary ... and secondary insomnia. These recommendations replace or modify ... those published in the 1999 practice parameter paper produced by the ... American Sleep Disorders Association. A Task Force of content experts ... was appointed by the American Academy of Sleep Medicine to perform a ... comprehensive review of the scientific literature since 1999 and to grade ... the evidence regarding non-pharmacological treatments of insomnia. ... Recommendations were developed based on this review using evidence-... based methods. These recommendations were developed by the Stan... dards of Practice Committee and reviewed and approved by the Board ... of Directors of the American Academy of Sleep Medicine. Psychological ... and behavioral interventions are effective in the treatment of both chronic ... primary insomnia (Standard) and secondary insomnia (Guideline). Stimu... lus control therapy, relaxation training, and cognitive behavior therapy ... are individually effective therapies in ... (Standard) and sleep restriction therap... cognitive therapy), biofeedback and pa... effective therapies in the treatment of c... was insufficient evidence to recommer... ery training and cognitive therapy as ... other specific approaches. Psychologic... effective in the treatment of insomnia ... of insomnia among chronic hypnotic u...
Keywords: Practice guidelines, predi... insomnia secondary, treatment, behav... cological, stimulus control therapy, re... cognitive behavior therapy, multicomp... tion, sleep hygiene education.
Citation: Morgenthaler T; Kramer M; ... for the psychological and behavioral ... An American Academy of Sleep Med... 1415-1419.

Disclosure Statement
This was not an industry supported study. Dr. Morgenthaler has received research support from Ilamar Medical, LTD. and ResMed, Inc. Dr. Alessi is a consultant for Prescription Solutions, Inc. Dr. Coleman is on the medical advisory board of Influent Medical, and is a consultant and speaker/instructor for Acclarent. Dr. Kapur has received research support from the Washington Technology Center and Pro-tech Services, Inc.; and has received research equipment from Respironics. Dr. Owens has received research support from Cephalon, Lilly, and Sepracor; is a consultant for Lilly, Cephalon, and Shire; and is a speaker for Johnson & Johnson, Cephalon, and Lilly. Dr. Swick has received research support from Sanofi-Aventis, Takeda Pharmaceuticals, Merck, Jazz Pharmaceuticals, Pfizer, Somaxon, Astellas-Pharmaceuticals, and Cephalon; and is a member of the speakers' bureau for GlaxoSmith-Kline, Jazz Pharmaceuticals, Sepracor, Cephalon, and Boehringer Ingelheim. Drs. Kramer, Friedman, Boehlecke, Brown, Lee-Chiong, and Pancer have indicated no financial conflicts of interest.

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SLEEP, Vol. 29, No. 11, 2006 1416 Practice

1.0 INTRODUCTION

INSOMNIA IS A COMMON C... OCCUR IN ONE THIRD OF ... CHRONIC INSOMNIA IS AS... quality of life, impaired daytime ... time from work and higher health ... associated with an increased risk ... hypnotic medication.[3-4]

The diagnosis of insomnia is ... of difficulty falling asleep or sta... sleep associated with marked dis... pairment.[5,6] Insomnia-related con... daytime fatigue, problems with ... mood disturbance. Insomnia can ... mary insomnia (e.g. psychophys... insomnia, idiopathic insomnia, p... fied, etc.), or (what we term here ... insomnia is a symptom of or asso... cluding medical or psychiatric il... or another sleep disorder.[6,7] It is ... cause of insomnia in patients wit... However, insomnia, whether pri... bid illness, merits attention. Indic...

AMERICAN ACADEMY OF SLEEP MEDICINE PRACTICE PARAMETERS

Practice Parameters for Using Polysomnography to Evaluate Insomnia: An Update

An American Academy of Sleep Medicine Report

Standards of Practice Committee of the American Academy of Sleep Medicine

Michael Littner, MD;[1] Max Hirshkowitz, PhD;[2] Milton Kramer, MD;[3] Sheldon Kapen, MD;[4] W. McDowell Anderson, MD;[5] Dennis Bailey, DDS;[6] Richard B. Berry, MD;[7] David Davila, MD,[8] Stephen Johnson, MD,[9] Clete Kushida, MD, PhD,[10] Daniel I. Loube, MD,[11] Merrill Wise, MD,[12] B. Tucker Woodson, MD[13]

[1]VA Greater Los Angeles Healthcare System and UCLA School of Medicine, Sepulveda, CA; [2]Baylor College of Medicine and VA Medical Center, Houston, TX; [3]Maimonides Medical Center, Psychiatry Department, Brooklyn, NY and New York University School of Medicine, New York, NY; [4]VA Medical Center and Wayne State University, Detroit, MI; [5]College of Medicine, University of South Florida, Tampa, FL; [6]Englewood, Colorado; [7]University of Florida Health Science Center, Gainesville, FL; [8]Baptist Medical Center,Little Rock, AR; [9]St. Patrick Hospital Sleep Center, Missoula, Montana; [10]Stanford University Center of Excellence for Sleep Disorders, Stanford, CA; [11]Sleep Medicine Institute,Swedish Medical Center, Seattle, WA; [12]Departments of Pediatrics and Neurology, Baylor College of Medicine, Houston, TX; [13]Department of Otolaryngology and Communication Sciences, Medical College of Wisconsin, Milwaukee, WI.

Abstract: Insomnia is a common and clinically important problem. It may arise directly from a sleep-wake regulatory dysfunction and/or indirectly result from comorbid psychiatric, behavioral, medical, or neurological conditions. As an important public-health problem, insomnia requires accurate diagnosis and effective treatment. Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, polysomnography is *not* indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders.
Citation: Standards of Practice Committee of the American Academy of Sleep Medicine. Practice parameters for using polysomnography to evaluate insomnia: an update for 2002. *SLEEP* 2003;26(6):754-60.

INTRODUCTION

INSOMNIA IS CHARACTERIZED BY A COMPLAINT OF DIFFICULTY INITIATING SLEEP, MAINTAINING SLEEP, AND/OR NONRESTORATIVE SLEEP THAT CAUSES CLINICALLY SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING. Insomnia is associated with a variety of morbidities including decreased quality of life, absenteeism, auto accidents, and increased general health care utilization. The term *insomnia* is used to describe a wide range of alterations in the amount and type of sleep loss or perceived sleeplessness. Etiologies include insomnia provoked directly by intrinsic sleep disorders, extrinsic sleep disorders, or circadian rhythm irregularities. Additionally, insomnia is associated with many psychiatric, medical, and neurological conditions. Insomnia may also be due to the use or misuse of either prescription or over-the-counter medications. In total, 55 of the nosological entities listed in The International Classification of Sleep Disorders[1] can have insomnia as a symptom. Epidemiological research reveals that insomnia affects 10-30 percent of the adult population.[2-4]

Overnight polysomnography (CPT 95810) is a standard tool in sleep medicine for evaluating sleep-related pathophysiology, sleep architecture, and sleep integrity. Some etiologies underlying insomnia have specific pathophysiology detectable with polysomnography (e.g. periodic limb movements). Other insomnias may manifest abnormal sleep architectural patterns (e.g. major depressive disorder) that while recognizable are diagnostically nonspecific.[5-7] Finally, sleep integrity can be directly measured with polysomnography. Measures such as latency to sleep onset, total sleep time, number of arousals and awakenings, and sleep efficiency are routinely calculated to characterize a night of sleep.[8,9] Disturbance in such measures objectively verify complaints of difficulty initiating and maintaining sleep. Furthermore, polysomnographic criteria can differentiate physiologically-based sleep disturbances from sleep state misperception and helps to evaluate whether the subject possibly prefers the drug for the wrong reasons (e.g. because of euphoriant properties). For this reason, polysomnography is a component of the standard procedure used to verify insomnia and assess treatment efficacy for research purposes.[10]

Some clinicians in their search for objective diagnostic indices have used polysomnography to evaluate patients with insomnia. Monitoring for specific etiology-related pathophysiologies (e.g. obstructive sleep apnea) can be very useful for making a diagnosis when insomnia is secondary to another condition. By contrast, using sleep integrity measures to diagnose primary insomnia has several potential drawbacks. First, most normal sleepers experience transient insomnia (or some degree of sleep disruption) the first time they sleep in the laboratory. This *first night effect* disappears when the individual acclimates to the novel sleep environment. Second, insomnia typically varies in severity across nights such that a single night may fail to properly characterize the full extent of the sleep problem.[11,12] Third, patients with psychophysiological insomnia often paradoxically sleep well on their first night in the laboratory.[13] Fourth, some patients with insomnia have sleep state misperception; that is, they have the complaint of insomnia in the absence of objective findings from polysomnography.[14-17] These four factors make it difficult to achieve diagnostic specificity with a single night of polysomnography. For these reasons, cost for multiple nights in the laboratory are generally considered prohibitive unless a clear advantage over other procedures is provided.

Thus, using polysomnography to diagnose primary insomnia is fraught with methodological pitfalls detracting from its usefulness. As such, using polysomnography for routine clinical evaluation of transient or chronic insomnia is controversial and was not recommended in the 1995 American Sleep Disorders Association Practice Parameter Report.[18,19] By contrast, diagnostic polysomnography was endorsed as sometimes appropriate in cases where a) diagnosis is uncertain, b) sleep-related breathing disorder or periodic limb movement disorder are suspected, c) a patient is refractory to treatment, d) violent behaviors are

SLEEP, Vol. 26, No. 6, 2003 754 PSG Insomnia Practice Parameters—Littner et al

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INSOMNIA

Recommendations for a Standard Research Assessment of Insomnia

Daniel J. Buysse, MD[1]; Sonia Ancoli-Israel, PhD[2]; Jack D. Edinger, PhD[3]; Kenneth L. Lichstein, PhD[4]; Charles M. Morin, PhD[5]

[1]Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA; [2]Department of Psychiatry, University of California San Diego and Veterans Affairs San Diego Healthcare System, San Diego, CA; [3]Department of Psychology, Veteran's Administration Hospital and Duke University, Durham, NC; [4]Department of Psychology, University of Alabama, Tuscaloosa, AL; [5]Department of Psychology, Université Laval, Québec, QC

Study Objectives: To present expert consensus recommendations for a standard set of research assessments in insomnia, reporting standards for these assessments, and recommendations for future research.

Participants: N/A.

Interventions: N/A.

Methods and Results: An expert panel of 25 researchers reviewed the available literature on insomnia research assessments. Preliminary recommendations were reviewed and discussed at a meeting on March 10-11, 2005. These recommendations were further refined during writing of the current paper. The resulting key recommendations for standard research assessment of insomnia disorders include definitions/diagnosis of insomnia and comorbid conditions; measures of sleep and insomnia, including qualitative insomnia measures, diary, polysomnography, and actigraphy; and measures of the waking correlates and consequences of insomnia disorders, such as fatigue, sleepiness, mood, performance, and quality of life.

Conclusions: Adoption of a standard research assessment of insomnia disorders will facilitate comparisons among different studies and advance the state of knowledge. These recommendations are not intended to be static but must be periodically revised to accommodate further developments and evidence in the field.

Keywords: Insomnia, diagnosis, polysomnography, sleep diary, actigraphy, questionnaires

Citation: Buysse DJ; Ancoli-Israel S; Edinger JD et al. Recommendations for a standard research assessment of insomnia. *SLEEP* 2006;29(9):1155-1173.

INTRODUCTION

INSOMNIA IS THE MOST COMMON SLEEP COMPLAINT IN THE GENERAL POPULATION. RECENT RESEARCH HAS ADDRESSED A WIDE RANGE OF ISSUES related to this condition, including epidemiology, consequences, pathophysiology, and treatment. However, understanding the results of the research and translating these results into clinical practice have been hindered by the absence of standardized definitions, assessments, and reporting standards. For instance, a recent review of epidemiologic studies showed that the reported prevalence of insomnia in the general population can range from 2% to 48%, depending on the definition of insomnia.[1] Studies examining the clinical and physiologic characteristics of insomnia have used definitions ranging from the very broad (e.g., self-defined "good vs poor sleepers"[2]), to the very narrow (e.g., individuals with "sleep-state misperception," which can only be defined with polysomnography[3,4]).

Reviews of treatment studies demonstrate similar problems. For instance, Nowell and colleagues identified 198 studies comparing drug therapy with placebo in insomnia, but only 22 could be included in a final meta-analysis.[5] The authors needed to make several inferences regarding the diagnosis of primary insomnia because most studies failed to specify insomnia duration, clinically significant distress, or the means by which psychiatric or medical causes of insomnia were excluded. Holbrook and colleagues[6] identified 89 double-blind trials for their meta-analysis but excluded half of these, noting, "the methodologic quality of the studies was not uniform… The diversity in outcomes used and the methods of summarizing… prevented the pooling of many trials." Likewise, Smith and colleagues initially identified 194 treatment studies of primary insomnia but included only 21 in their final meta-analysis. Many primary sources were excluded because means, standard deviations (SD), and test statistics were not reported. A recent review of behavioral and psychological treatment studies for insomnia[7] also identified a wide range of diagnostic methods, specific diagnoses, and specific outcomes, with 16 of 53 eligible studies excluded from the review for reasons including the failure to document an insomnia diagnosis. In summary, consistent diagnostic, baseline, and outcome measures have not been used in published insomnia studies. Inconsistency of reporting methods and outcome data has further limited the ability to compare findings across studies.

This paper reports the findings of an expert consensus process to develop recommendations for standard assessments and reporting standards in insomnia research studies. This process included a conference held on March 10-11, 2005, in Pittsburgh, Penn, with 25 experts in insomnia research in attendance. The specific aims of this process and the accompanying conference, reflected

Disclosure Statement

This manuscript is based on a conference supported by unrestricted grants from Pfizer, Sanofi-Aventis, Sepracor, and Takeda. Dr. Buysse has served as a consultant for Actelion, Cephalon, Eli Lilly, GlaxoSmithKline, Merck, Neurocrine, Neurogen, Pfizer, Respironics, Sanofi-Aventis, Servier, Sepracor, and Takeda. Dr. Ancoli-Israel has served as a paid consultant, scientific advisory board member and/or speaker for Acadia, Cephalon, Inc., King Pharmaceuticals, Inc., Merck, Neurocrine Biosciences, Inc., Neurogen, Inc., Pfizer, Inc., Sanofi-Aventis, Sepracor, Inc., Somaxon, and Takeda Pharmaceuticals North America, Inc. Dr. Edinger has received research support from Respironics; and has participated in speaking engagements supported by Axis Healthcare, Sepracor, and Fission Communications. Dr. Lichstein has received research support from Respironics/Mini Mitter. Dr. Morin has received research support from Sanofi-Aventis and Organon; and is a consultant and/or a member of the advisory board for Sanofi-Aventis, Pfizer, Neurocrine, Takeda, Shire-Biodem, and Sepracor.

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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 crossroads. 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 (non-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 beliefs: (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 MediaCorp; 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 Sepracor.

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Wallace Mendelson, MD
Gary Zammit, PhD

Update on Behavioral Therapy for Insomnia
Arthur Spielman, PhD
Kenneth Lichstein, PhD

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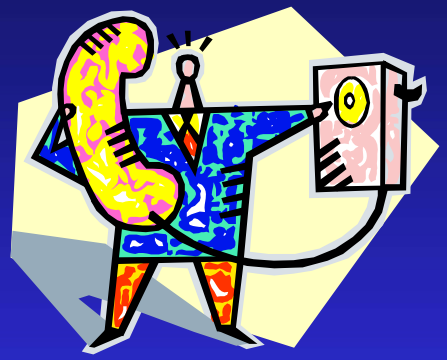

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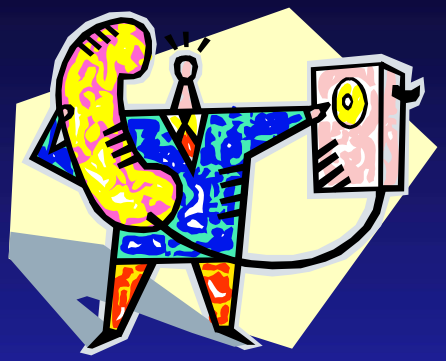

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Certified Behavioral Sleep Medicine Specialists

The American Academy of Sleep Medicine (AASM) administers an annual certification examination in behavioral sleep medicine. Individuals who pass the exam earn the designation of C.B.S.M. (Certified in Behavioral Sleep Medicine).

To pass the exam an individual must display a comprehensive understanding of the diagnosis and treatment of the full range of sleep disorders. Certification also confirms an individual's expertise in the application of behavioral and cognitive methods of prevention and treatment.

These individuals have earned certification from the AASM in behavioral sleep medicine:

NAME	CITY	STATE	COUNTRY	DATE
Sunoj Abraham, M.D., FCCP, D, ABSM, FACP	Hernando	FL		June 18, 2006
Mark S. Aloia, Ph.D.	Providence	RI		June 18, 2006
Sonia Ancoli-Israel, Ph.D., D, ABSM	San Diego	CA		June 4, 2003
Michael W. Anderson, Ph.D., D,ABSM	Prairie Village	KS		June 4, 2003
Carolyn Andrews, Ph.D.	Skokie	IL		June 8, 2008
J. Todd Arnedt, Ph.D.	Providence	RI		June 4, 2003
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CBT-I SEMINAR

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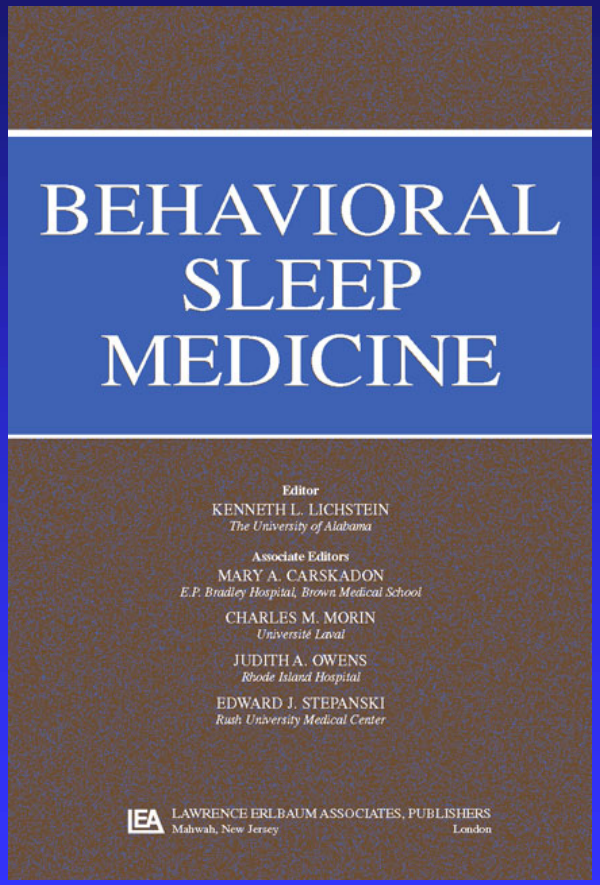

“BUT WAIT – THERE’S MORE !”

FAQS AND REFERENCES

1. How Efficacious is CBT-I (i.e., what's the clinical trial data)? - Very.

Morin C.M., et al. (1994) Non-pharmacological interventions for insomnia: a meta-analysis of treatment efficacy. Am. J. Psychiatry 151, 1172-1180.

Murtagh D et al. (1995) Identifying Effective Psychological Treatments for Insomnia - A Meta-analysis. JCCP, 63, 79-89.

2. How Effective is CBT-I (i.e., is there case series data in "real" patients)? - Very.

Lichstein K.L. et al.(2000) Psychological treatment of secondary insomnia. Psychology of Aging 2, 232-240.

Perlis M., et al.(2000) Behavioral treatment of insomnia: A clinical case series study. J. Behav. Med. 23, 149-161.

3. How does CBT-I compare to Pharmacotherapy? – The therapies are comparable.

Morin C.M., et al. (1999) Behavioral and pharmacological therapies for late-life insomnia: a randomized controlled trial JAMA 281, 991-999.

Smith M.T., et al.(2002) Behavioral treatment vs pharmacotherapy for insomnia - a comparative meta-analysis. Am. J. Psychiatry 159, 5-11.

Jacobs G.D. et al. (2004) Cognitive behavior therapy and pharmacotherapy for insomnia - A randomized controlled trial and direct comparison. Arch. Intern. Med. 164, 1888-1896.

Sivertsen B., et al. (2006) Cognitive behavioral therapy vs zopiclone for treatment of chronic primary insomnia in older adults - A randomized controlled trial. Journal of the American Medical Association 295, 2851-2858.

4. Does the NIH have a position on what's the best for the treatment of insomnia ? – Yup.

http://consensus.nih.gov/2005/2005InsomniaSOS026html.htm
This is available on web cast. http://videocast.nih.gov/PastEvents.asp?c=1&s=81

5. Does the AASM have a position on what's the best for the treatment of insomnia? – Yup.

Chesson A.L., et al. (1999) Practice parameters for the non-pharmacologic treatment of chronic insomnia. An American Academy of Sleep Medicine report. Standards of Practice Committee of the American Academy of Sleep Medicine Sleep. 22, 1128-1133.

Chesson A., et al. (2000) Practice parameters for the evaluation of chronic insomnia. An American Academy of Sleep Medicine report. Standards of Practice Committee of the American Academy of Sleep Medicine Sleep. 23, 237-241.

Morgenthaler T. et al. (2006) Practice parameters for the psychological and behavioral treatment of insomnia: An update. An American Academy of Sleep Medicine Report. Sleep. 29, 1415-1419.

Morin C.M., et al. (2006) Psychological and behavioral treatment of insomnia: Update of the recent evidence (1998-2004). Sleep. 29, 1398-1414.

6. How does one know who is an appropriate candidate for CBT-I ?. See for example,
Smith M.T. et al. (2006) Who is a candidate for cognitive-behavioral therapy for insomnia? Health Psychol. 25, 15-19.

7. Are there books me and mine can read on how to do CBT-I - Yup.

Insomnia: A Clinician's Guide to Assessment and Treatment Eds. Morin & Espie. Plenum Pub Corp. 2000
Cognitive Therapy for Insomnia: A session by session guide. Perlis, Jungquist, Smith & Perlis, Springer-Verlag. 2005.

8. Are there training courses available on CBT-I? - Yup.

General: http://www.aasmnet.org/SleepEdSeries.aspx
Specific: www.urmc.rochester.edu/cpe/CBT-I/

9. Is it possible to arrange for peer supervision for one's first CBT-I cases. Yup.
It is likely that any of the individuals with the CBSM would be willing.
See, http://www.aasmnet.org/BSMSpecialists.aspx

10. Is it possible to be credentialed in CBT-I. Yup.
There is a certification exam. See, http://www.aasmnet.org/BSMExam.aspx

11. How does reimbursement work for CBT-I. Ask:
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