SO... HOW TO GET FROM

HERE





FIRST THIS SEMINAR



CBT-I 2013 Cognitive Behavioral Therapy for Insomnia Thursday-Saturday, October 3-5, 2013, Monaco Hotel, Seattle, WA

Day One Thursday, October 3, 2013

The first day is dedicated to an orientation The primary focus of the second day will be to Sleep Medicine, the definition of the implementation of the core elements of insomnia, a review of basic etiology and eight-session CBT-I (Sleep Restriction, pathophysiology, and a review of treatment Stimulus Control, and Sleep Hygiene). approaches.

7:00 AM - 8:00 AM

Registration and Continental Breakfast / Exhibits

8:00 AM - 12:30 PM Welcome Announcements / Orientation Sleep 101: Overarching Framework Signs and Symptoms of Sleep Disorders Coffee Break / Exhibits Definition of Insomnia Etiology & Pathophysiology of Insomnia (Basic Models)

12:30 PM - 1:30 PM

Lunch (on your own) 1:30 PM - 5:00 PM

Treating Insomnia Part I (Review of Pharmacologic & CBT Options) Coffee Break / Exhibits Treating Insomnia Part II (Overview of CBT-I) Determination of Whether CBT-I is Indicated (vs Diagnosis-Based Assessment)

5:00 PM - 5:30 PM Additional time for above components Dedicated time for Questions and Answers Day Two Friday, October 4, 2013

7:00 AM - 8:00 AM Continental Breakfast / Exhibits

8:00 AM - 12:30 PM CBT-I Session-by-Session Review Orientation

Session I - Intake Evaluation Coffee Break / Exhibits

Session II - Treatment Initiation a) Sleep Restriction Procedures and Rationale b) Stimulus Control Procedures and Rationale

12:30 PM - 1:30 PM Lunch (on your own) 1:30 PM - 5:45 PM

Session III - Sleep Hygiene Sleep Hygiene Procedures and Rationale Coffee Break and Exhibits

Session IV, VI & VII - Titration and Compliance Coffee Break and Exhibits 6:00 PM - 7:00 PM Informal Get Together (Appetizer and Drinks)

Day Three Saturday, October 5, 2013 The primary focus of the third day will be Cognitive Therapy, Relapse prevention, Practice Management, and case examples.

7:00 AM - 8:00 AM Continental Breakfast / Exhibits 8:00 AM - 12:30 PM

Session V - Cognitive Therapy for Insomnia Focus: Catastrophic Thinking (Discussion on Alternative Cognitive Treatments)

Session VIII - Relapse Prevention Practice Management & Billing (Marnie Shanbhag, PhD)

12:30 PM - 1:30 PM Lunch (on your own)

1:30 PM - 5:45 PM Case Examples General Discussion

THE WORKSHOP IS INTENDED AS THE BEGINNING OF THE ROAD





FOLLOW UP STEPS INCLUDE READ MORE BROADLY SEE THE MOVIE(S) **OBSERVE 3-5 CASES CONDUCT 3-5 CASES WITH SUPERVISION PARTICIPATE IN A MINI-FELLOWSHIP ENGAGE WITH A PRACTICE CONSULTANT SEEK OUT CE OPPORTUNITIES**

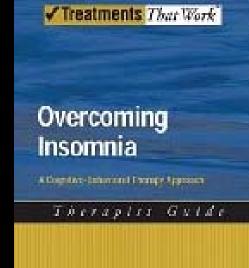
CHARLES M. MORIN AND COLIN A. ESPIE



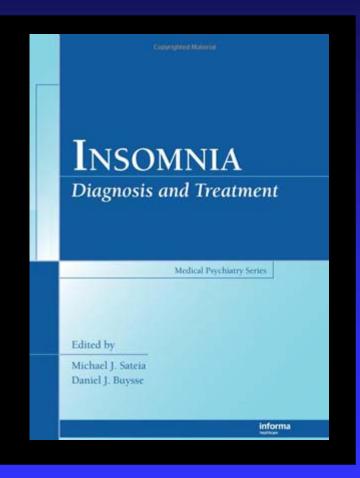
Cognitive Behavioral Treatment of Insomnia A session by Session Guide

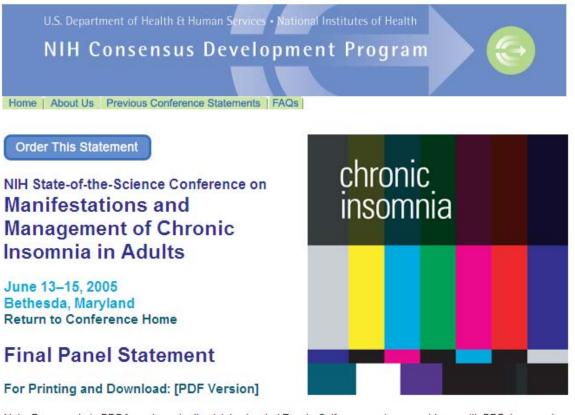


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http://consensus.nih.gov/2005/insomniastatement.htm

BSM Treatment Protocols for Insomnia

Introduction

Part I

Michael L. Perlis Department of Psychiatry and Nursing, University of Pennsylvania School of Medicine, Philadelphia, PA

Though Behavioral Sleep Medicine as a field is in its infancy (perhaps more accurately "in gestation") [1–3], the state of the science with respect to insomnia might be best likened to the fourth decade of life: the organism is fully mature but much remains to be learned, said, and done.

With respect to the maturity of the insomnia area, at this point in time there is a well-defined infrastructure that includes (1) a variety of conceptual models, (2) standardized definitions, (3) a general approach to assessment, (4) well-established therapies that are evidence based (with respect to both efficacy and effectiveness), (5) published treatment manuals and courses available for treatment dissemination and implementation, and (6) a new generation of treatments that hold the promise of even better clinical outcomes than those obtained presently. These issues are briefly reviewed below, followed by a short commentary about future directions for the insomnia field.

STATE OF THE SCIENCE

Conceptual Models

This aspect of behavioral sleep medicine is perhaps the most developed, starting with, in the early era sleep research and sleep medicine (1970s and 1980s), the Bootzin Stimulus Control Perspective [4] and the Spielman Three Factor Model [5]. Since the 1990s there has been a proliferation of theoretical perspectives on the etiology and pathophysiology of insomnia that includes ten human models and three animal models [6]. Taken together, these perspectives provide a rich panoramic view of the factors that (1) may serve to "predispose, precipitate, and perpetuate" insomnia as a disorder, (2) may account for the

Behavioral Treatments for Sleep Disorders. DOI: 10.1016/18978-0-12-381522-4.00047-X @ 2011 Haevier Inc. All rights reserved.

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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 Rafecas⁸

Neurology Department, Louisiana State University Medical Center, Shrevenort, College of Medicine, University of South Florida, Tampa, FL, Baptist Medic Hospital Sleep Center, Missoula, MT, Department of Medicine, VA Medical (Pediatrics and Neurology, Baylor College of Medicine, Houston, TX, *Sleep Disc

Summary: Chronic insomnia is the most common sleep complaint which health care i 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 t 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, actionaphy, or other alternative assess: 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 pa have not been shown to differentiate subtypes of insomnia complaints

Key words: Practice parameters: Sleep disorders: Insomnia: Sleep disturbance

BACKGROUND

nosed and poorly INSOMNIA IS A COMPLAINT OF POOR QUALITY cians alike, 10-13 SLEEP that is often associated with daytime sequelae It is widely rec including fatigue, irritability, decreased memory and contions which are as centration, and pervasive malaise which affects many ic sleep disorders, aspects of daytime functioning. The frequency of insomnia chological stresso complaints is high, and there is an abundance of epidemiotoward effective t logical data that suggest it is the most common sleep comment with establi plaint in the industrialized world.¹⁻⁵ However, despite the Determining the high frequency of this problem and the negative economic only by the absence

Accepted for publication December 1999

Standards of Practice Committee American Academy of Correspondence: consolns of Procise Commisse, American Academy of Sleep Medicine, 5301 Bandel Road, Suite 101, Rochester MN 55001, Phone: 507.287.6006, Fax: 507.287.6008, Email: assrrightsomet.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

"Tmothy Morgenthaler, MD; ¹Milton Kremer, MD; ¹Cathy Alessi, MD; ¹Leah Friedman, MA, PhD; ¹Brian Boehlecke, MD; ¹Teny 8 Vishesh Kapur, MD; ¹Teofio Lee-Chlong, MD; ¹Lusith Gwens, MD; ¹¹Jeffrey Pancer, DDB; ¹¹Todd Swick, MD

¹Mayo Clinic, Rochester, MN; ²New York Medical Center, New York, NT, ⁴VA Greater Los Angeles Healthcare Syste California, Los Angelez, CA: "Stanford University School of Medicine, Stanford, CA: "University of North Carolim Memorial Hospital, Murphysbore, IL: "Interferenders Medical Center, Marfreedbore, TN: "University of Washingto Medical and Research Center, Denver, CO: "Redoc Island Hospital, Providence, RI: "Toronto, Canada: "Hospita orth Ca mineraity of Washin nto, Con-

Abstract: Insomnia is highly prevalent, has associated daytime conse-quences which impair job performance and quality of life, and is assoare individually effective therapies in ciated with increased risk of comorbidities including depression. These practice parameters provide recommendations regarding behavioral and psychological breatment 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 expedia Historian area blockers saturation in task to be dontant expensive was appointed by the American Academy of Steep Medicine to perform a comprehensive review of the scientific literature since 1999 and to gred the evidence regarding non-pharmacological treatments of insomnia. Recommendations were developed based on this review using evidencebased 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). Stru-lus control therapy, relaxion training, and cognitive behavior therapy

Disclosure Statement

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This was not an industry supported study. Dr. Morgenthaler has received research support from Itamar 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 speakeninstructor 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 Cephelon, Lilly, and Seprecor; is a consultant for Lilly, Cephelon, and Shire; and is a speaker for Johnson & Johnson, Cephalon, and Lily. 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 Ingel-heim. Drs. Kramer, Friedman, Boehlecke, Brown, Lee-Chiong, and Pancer have indicated no financial conflicts of interest.

Submitted for publication April 20, 2006

Accepted for publication April 30, 2106 Adress correspondence to: Timothy L. Morgentheler, MD, Mayo Sleep Disor-ders Center, Mayo Clinic, 200 First Street SW, Rochester, MN, 55905; Tel: (507) 284-3764; Fax (507) 266-4372; Email: morgarithelextimothy@mayo.

SLEEP, Vol. 29, No. 11, 2006

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, ND(1 Max Hirshkowitz, PhD)2 Milton Kramer, MD)2 Sheldon Kapen, MD(1 W. McDowell Anderson, MD)2 Dennis Salley, DDS)2 Richard B. Berry, MD)2 David Davis, MD⁻⁹ Stephen Johnson, MD⁻⁹ Ciete Kushida, MD, PhD:¹⁰ Daniel L. Loute, MD⁻¹¹ Merrill Wise, MD⁻¹² B, Tucker Woodson, MD

1VA Greater Los Anosies Healthcare System and UCLA School of Medicine, Senulveda, CA: "Bavlor College of Medicine and VA Medical Cente ¹¹PA Crimiter Lin Angeles Hendhaurs System and UCLL School of Mediano, Signibuda, C.J. Stopher Calling of Medianos and H-Mediatal Context Hendron, Z.C. Solitowicz, K. S. Santon, J. S. Santon, J. S. Santon, J. Santon, J. S. Santon, J. Santon, J. S. Santon, J. Santon, J. Santon, J. S. Santon, J. Santon,

764

ed with psychiatric disorders.

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 beatment. 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 unser-

Citation: Slandards of Practice Committee of the American Academy of Sleep Medicine. Precice parameters for using polysomnography to eval-uate insomnia: an update for 2002. SLEEP 2003;26(6):754-60.

tain, treatment fails, or precipitous arousals occur with violent or injurious

behavior. However, polysomnography is <u>not</u> indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associat-

sibly prefers the drug for the wrong reasons (e.g. because of euphorian properties). For this reason, polysomnography is a component of the standard procedure used to verify insomnia and assess treatment effica-

cy for research purposes.²⁹ Some clinicians in their search for objective diagnostic indices have Some clinicians in their search for objective diagnostic indices have used polysomergappity to evaluate patients with innovania. Monitering grave) on the very useful for making a diagnosis when innovania is acc-ondary to another condition. By contrast, using a lerge integrity measures to diagnose primary insomalit has a versel potential diamonia is ac-ondary to another condition. By contrast, using a lerge integrity measures to diagnose primary insomalit has a versel potential diamonia is ac-ondary to another condition. By contrast, using a lerge integrity measures a versel potential diamonia and the second potential diamonia in the origin of the diamonia of the second potential diamonia in the origin diamonia of the origin of the diamonia of the diamonia of the diamonia of the second poten-tial diamonia of the diamonia of the diamonia of the origin of the diamonia of the origin of the diamonia of the diamonia of the origin of the diamonia of the origin of the diamonia of the diamonia of the diamonia of the origin of the origin of the diamonia of the diamonia of the diamonia of the origin of the origin of the diamonia of the diamonia of the diamonia of the origin of the diamonia of the origin of the diamonia of the diamonia of the diamonia of the diamonia of the origin of the diamonia of the origin of the diamonia of the origin of the diamonia of t night effect disappears when the individual acclimates to the novel sleep onment. Second, insomnia typically varies in severity across night such that a single night may fail to properly characterize the full exter of the sleep problem.11.12 Third, patients with psychophysiological nia often paradoxically sleep well on their first night in the labo international often paradoxically sleep well on their flot night in the labo-ratory?" Fourth, some patients with incomia have sleep state misger-coption; that is, they have the complaint of insomnia in the absence of objective findings from polynomography.¹⁴⁴⁹ These four factors make it difficut to achieve diagnostic specificity with a single night or polynomography. For these reasons, cost for multiple nights in the laboratory are generally considered prohibitive unless a clear advantage over other procedures is provided.

over other procedures is provided. Thus, using polysomnography to diagnose primary insomnia is fraught with methodological pifalls detracting from its usefulness. As tranght with methodiogical partials detecting from its userliness. As such, using polycomagnethy for <u>regular</u>_initial evaluation of transient or chronic incommia is controversial and was not recommended in the 1995 American Sleep Disorden Association Practice Parameter Report.¹⁴⁴⁴ By contrast, diagnostic polycomagnethy was endored as mentimes appropriate in cases where a diagnostic in uservismic, by detep-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

sleep state misperception and helps to evaluate whether the subject pos-

PSG Insomnia Practice Parameters-Littner et al

www.aasmnet.org/PracticeParameters.aspx?cid=109

INTRODUCTION INSOMNIA IS CHARACTERIZED BY A COMPLAINT OF DIFFI-CULTY INITIATING SLEEP. MAINTAINING SLEEP. AND/OR Constructional and the second NONRESTORATIVE SUFER THAT CAUSES CUNICALLY SIGNE mia, r medicine for evaluating sleep-related pathophysiology, sleep architeo-ture, and sleep integrity. Some etiologies underlying insomnia have specific pathophysiology detectable with polysomnography (e.g. perio citic pathopyuotogy detectaties with polysionmography (e.g. peniodi link movements). Other incomains any munifest altoneauti sleep archi-tectural patterns (e.g. major depressive disorder) that while recognizable are diagnostically monoscilicit.¹⁷ Finally, teles integrity can be directly measured with polynomeography. Measures such as latency to sleep oncest, total sleep time, multier of renorals and architeging, and sleep efficiency are routinely calculated to characterize a night of sleep.¹⁴ hid illness marits attention India Practice Disturbance in such measures objectively verify complaints of difficulty initiating and maintaining sleep. Furthermore, polysomnographic cri-teria can differentiate physiologically-based sleep disturbances from

1415-1419 1.0 INTRODUCTION INSOMNIA IS A COMMON (OCCUR IN ONE THIRD OF CHRONIC INSOMNIA IS AS quality of life, impaired daytim time from work and higher health associated with an increased risk otic medication.²⁴ The diagnosis of insomnia is

(Standard) and sleep restriction thema cognitive therapy), biofeedback and p effective therapies in the treatment of c

was insufficient evidence to recomme

ery training and cognitive therapy as

other specific approaches. Psychologic effective in the breatment of insomnia i

of insomnia among chronic hypnotic ut Keywords: Practice guidelines, pract insomnia secondary, treatment, behar cological, stimulus control therapy, re

cognitive behavior therapy, multicom; tion, sleep hygiene education.

Citation: Morgentheler T; Kremer M; J

for the psychological and behavioral

An American Academy of Sleep Med

of difficulty falling asleep or str sleep associated with marked dis

pairment.** Incomnia-related cor daytime fatigue, problems with mood disturbance. Incomnia can mary incomnia (e.g. psychophys unia, idiopathic inco fied, etc.), or (what we term here ia is a symptom of or ass cluding medical or psychiatric il or another clean disorder #7 It is cause of insomnia in patients wit However, incomnia, whether pri-

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www.absm.org/bsmspecialists.aspx

CONDUCT 3-5 CASES WITH SUPERVISION

2012 CBT-I Seminar: October 19th-21st, Bethesda, MD

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Home » General Resources » Peer Supervision

Group Supervision

Weekly case review webinar

Practitioners who are new to CBT-I, and Behavioral Sleep Medicine in general, are likely to have ongoing questions about the nuances of treatment implementation. In order to provide ongoing support we will be offering a weekly case review seminar that is offered over the internet. For one hour each week, participants can take part in the webinar from any computer with internet access and a phone. Participants will have the opportunity to present and ask questions about their own cases, as well as

Register Now

>

Click here to register for the 2012 CBT-I Course

Support our Work

http://www.med.upenn.edu/cbti/GroupSupervision.html

ADVANCED TRAINING



ADVANCED TRAINING



Advanced CBT-I 2014

Thursday-Saturday, April 17-19 2014, Loews Hotel Center City Philadelphia, PA

Day One Thursday, April 17th

Lecture on alternative delivery systems (phone, internet, skype)

Lecture on alternative measurement of sleep (actigraphy, zeo, etc.)

Lecture on adjuvant and/or alternative treatments (e.g., bright light, ISR and sleep compression)

Lecture on interpreting PSG reports

Lecture on interpreting Clinical Chemistries reports

Lecture on combo Tx (Meds and CBT-I)

Lecture on Med Titration

Day Two Friday, April 18th Lecture on treating complex cases

Case Presentations by Donn and MLP

Case Presentations by attendees

Day Three Saturday, April 19th Review of classical resistances Role Plays (2-4 hours)

For more information about the course, please visit http://www.med.upenn.edu/cbti

CONTINUING EDUCATION OPPORTUNITIES



Society of Behavioral Sleep Medicine Behavioral Sleep Medicine Course

Date: April 2-3, 2011 | Location: National Office • Darien, IL (Chicago suburb) Course Chair: Ryan Wetzler, PsyD, CBSM | CME and CE Credits for Psychologists: 10.00 Advanced Registration Deadline: March 4, 2011

Course Overview

During this timely and comprehensive course, leading clinicians and researchers in sleep medicine will provide an overview of the application of psychological principles to the evaluation and treatment of sleep disorders.

Target Audience

Psychologists, physicians and other healthcare providers seeking to augment their knowledge of the role of psychology in the evaluation and treatment of sleep disorders.

Course Objectives

Upon completion of the course, participants will:

- · Review the history and future of the field of behavioral sleep medicine
- Explain sleep diagnostic tests and commonly utilized behavioral sleep evaluation procedures
- Apply a cognitive behavioral approach to treating chronic insomnia and other sleep disorders
- · Adapt cognitive behavioral treatment approaches to those experiencing co-existing anxiety, depression and other conditions
- Discuss basic circadian science and apply this knowledge to managing circadian rhythm sleep disorders
- Develop approaches to assisting patients dependent on sleep agents
- Apply cognitive behavioral approaches to managing common pediatric sleep disturbances
- Develop strategies to managing nightmares and other parasomnias
- Discuss basic behavioral sleep billing procedures
- · Discuss the role of behavioral sleep specialists in the management of sleep apnea

Preliminary Schedule and Topics

| Saturday, April 2, 2011 | | | | |
|-------------------------|---|--|--|--|
| 12:00 pm - 1:00 pm | Registration | | | |
| 1:00 pm - 2:00 pm | History and Scientific Underpinnings of Behavioral Sleep Medicine | | | |
| | Kenneth Lichstein, PhD, CBSM | | | |
| 2:00 pm - 3:00 pm | Behavioral Sleep Medicine Evaluation Procedures and Billing Considerations | | | |
| | Ryan Wetzler, PsyD, CBSM | | | |
| 3:00 pm - 3:15 pm | Break | | | |
| 3:15 pm - 4:15 pm | Cognitive Behavioral Treatment of Chronic Insomnia | | | |
| | Rachel Manber, PhD, CBSM | | | |
| 4:15 pm - 5:15 pm | Cognitive Behavioral Approaches for Insomnia in those with Anxiety, Depression, and other Co-existing | | | |
| | Conditions | | | |
| | Rachel Manber, PhD, CBSM | | | |
| | | | | |
| Sunday, April 3, 2011 | | | | |
| 7:30 am – 8:00 am | Continental Breakfast | | | |
| 8:00 am - 9:00 am | Evaluation and Treatment of Hypnotic Dependence | | | |
| | Kenneth Lichstein, PhD, CBSM | | | |
| 9:00 am - 10:00 am | Evaluation and Treatment of Circadian Rhythm Sleep Disorders | | | |
| | Helen Burgess, PhD | | | |
| | | | | |

Questions? Call the SB SM at 630-737-9706.

Break

10:00 am - 10:15 am

Continued on next page

www.behavioralsleep.org/Course.aspx

WORKSHOP AND SEMINAR OFFERINGS

HAPA Annual Convention Toronto, Ontario, Canada August 6-9, 2009

Workshop Description

o, Ontario, Canada August 6-9, 2009

Behavioral Sleep Medicine: Evidence-Based Treatments

for Sleep Disorders (Workshop Code: #108)

Thursday, August 6, 2009

Back by Popular Demand!

An overwhelming number of patients have sleep problems, which can be disconcerting to clinicians without the training to treat these disorders. An abundance of evidence supports several psychological treatments of sleep disorders such as insomnia, parasomnias, and circadian rhythm disorders. There is a growing need for practitioners with expertise in these techniques. The main goal of this INTRODUCTORY workshop is to educate clinicians about how to provide and be reimbursed for, empirically validated treatments for common sleep disorders (e.g., insomnia).

This workshop is designed to help you:

- Discuss the prevalence of sleep disorders treatable with behavioral and cognitive interventions,
- 2. Apply the theorized etiology of these disorders in developing a treatment plan,
- 3. Provide empirically validated treatments for these disorders in adults,
- 4. Provide empirically validated treatments for these disorders in children,
- Develop a practice specialty in behavioral sleep medicine through collaboration with local sleep disorders centers,
- 6. Apply effective billing methods for behavioral sleep medicine services, and
- 7. Prepare to become certified in behavioral sleep medicine.

Leader: Daniel J. Taylor, PhD, University of North Texas, Denton, TX



CONFERENCE OFFERINGS



44th Annual Convention

Cognitive Behavior Therapy:

Unifying Diverse Disciplines With a Common Thread

WORKSHOP

Hands-on Training in CBT for Insomnia in Those with Anxiety Disorders, Depression, and other Comorbid Conditions

Instructors: Manber & Carney

CLINICAL ROUND TABLE 11

Providing CBT Behavioral Sleep Medicine in Primary Care Settings: Relevance to Clinical Necessity

Chair: Rachel Manber Panelists: <u>Anne.Bartolucci</u>, Shannon Sullivan, Kathy Sexton-Radek, Jason Ong, Christina Nash, Bret Kuhn, Jacqueline Kloss, Shelby Freedman Harris

SYMPOSIUM 20

Modifications of CBT for a Diverse Spectrum of Older Adults with Comorbid Conditions

Chairs: Patricia Haynes, Jennifer Martin Discussant: Richard Bootzin

SYMPOSIUM 33

An Introduction to Behavioral Sleep Medicine

Chair: Robert Meyers Discussants: <u>Christina McCrae</u>, Daniel Taylor, Michael Smith, <u>Michael Perlis</u>,

SYMPOSIUM 44

Sleep Across Axis I Disorders

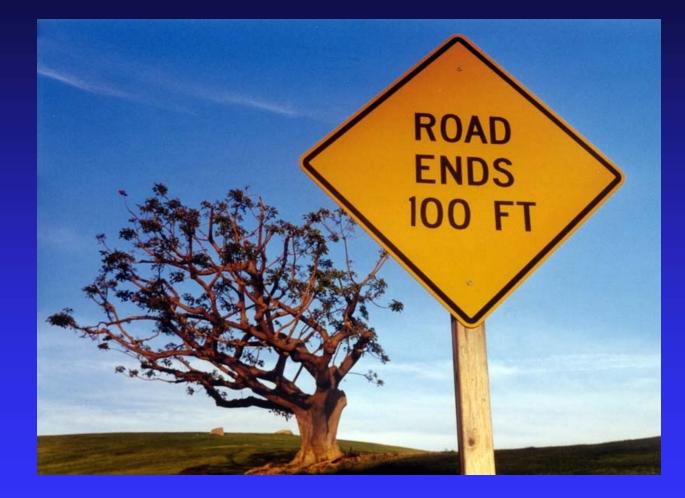
Chair: Lisa Talbot Discussant: Allison Harvey

SYMPOSIUM 61

Sleep and Internalizing Disorders in Children and Adolescents

Chairs: Courtney Weiner Donna Pincus Discussant: Ron Dahl

<u>SIG MEETING</u> Insomnia and Other Sleep Disorders Friday, 3:30 p.m. - 5:00 p.m., Union Square 8





Mental Health





Behavioral Treatments for Sleep Disorders

A Comprehensive Primer of Behavioral Sleep Medicine Treatment Protocols

Michael Perlis, Mark Aloia and Brett Kuhn

hn (AP)

TREATING SLEEP DISORDERS PRINCIPLES AND PRACTICE OF BEHAVIORAL SLEEP MEDICINE

> Edited by Michael L. Perlis Kenneth L. Lichstein

About Membership Events Training Resources Contact

About the Group

History of the Group

How this Works

About the Group

This list serve exists for the sole purpose of promoting the free exchange of information and ideas amongst Behavioral Sleep Medicine clinicians, scholars, and researchers.

> To join, just enter your email: Join the list!

Read more about the history of the group.

Learn how to be involved in the group.



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2010 Application for Membership

Society of Behavioral Sleep Medicine • 2510 North Frontage Road, Darien, IL 60561-1511 Phone: 630-737-9706 • Fax: 630-737-9790 membership@societyofbehavioralsleepmedicine.org • www.societyofbehavioralsleepmedicine.org

memoryanp@societyoneansistementencorg - www.societyoneansistementencorg

Biographical Data

| Last Name: | First Name: | | | | Middle Initial:Suffix: |
|----------------------------------|---------------------|-----------------|---------------------|-----------------|------------------------|
| Title: | | Degrees/Ce | rtifications | | CBSM: Yes No |
| Date of Birth:// | _Gender: 🗖 Male | Female | Are you licensed: 🗖 | Yes 🗖 No State: | Type: |
| Addresses (Please provide both o | ddrawa and check pr | oferred mailing | gaddress) | | |
| Professional Address | | | | | |
| Business Name: | | | | | |
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| Phone: | Fax: | | E-m | nail: | |
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Membership is on a calendar-year basis (January 1, 2010–December 31, 2010); 2010 membership will be effective June 1, 2010. All applications for membership must be approved by the SBSM membership committee; applicants will be notified of their application status following this review.

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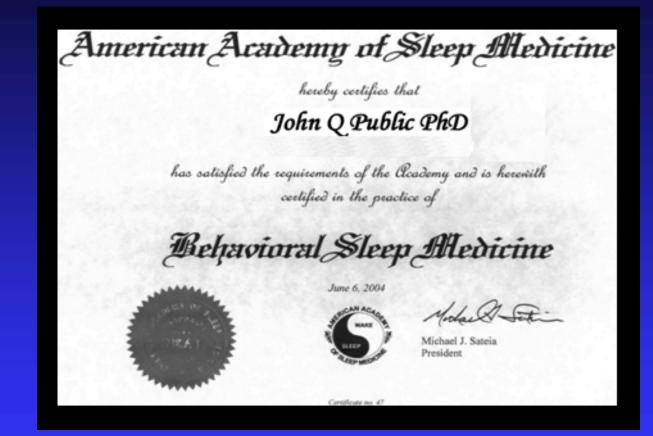
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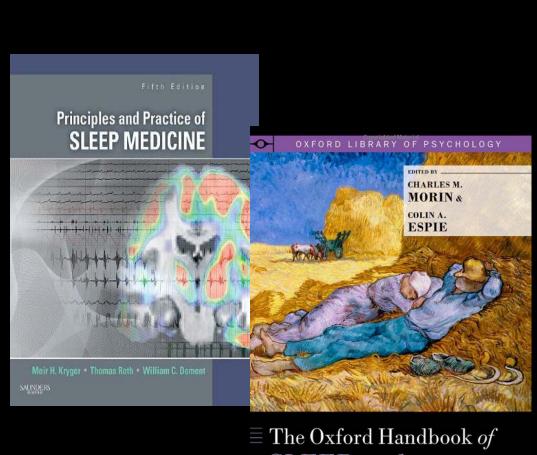
VOLUME 12, 2014 Included in this print edition: Number 1 (January-February) Number 2 (March-April)



www.behavioralsleep.org/resources/MembershipApplication.pdf



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| mailed in June of each year. | |
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Send me a printed copy of future membership directories: 🗆 Yes 💿 No

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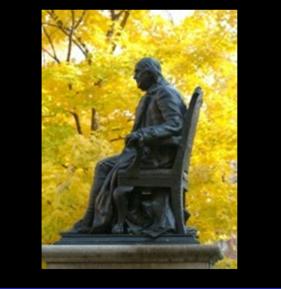
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Michael Perlis PhD Director, Upenn Behavioral Sleep Medicine Program mperlis@upenn.edu