Behavioral Sleep Medicine

TEKST
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Owing to its roots in behavioral medicine, by 2000, cognitive-behavior therapy (CBT) had established a strong footing in sleep medicine, particularly in the clinical management of insomnia, pediatric insomnia, CPAP adherence, parasomnias (particularly nocturnal enuresis and nightmares), and circadian rhythm disorders. Comprehensive reviews of the history of behavioral sleep medicine are available elsewhere (Stepanski, 2003; Stepanski & Perlis, 2003)

But psychology and other social science disciplines were weakly represented in the American Academy of Sleep Medicine (AASM), and though the role of CBT in the assessment, prevention, and treatment of sleep disorders was well respected, low numbers of CBT providers placed this group within the category of endangered species. There was growing interest from several quarters to stimulate the viability of CBT in sleep medicine.

Behavioral sleep medicine was invented when Daniel Buysse, then president of AASM, created an ad hoc presidential committee of the same name in 2000 to broaden the role and stimulate the growth of psychology and related disciplines within sleep medicine. Three years later, this temporary committee was converted to a standing committee of AASM, and it stands to this day. The original committee was composed of Edward Stepanski (chair), Cynthia Dorsey, Jack Edinger, Kenneth Lichstein, Jodi Mindell, Michael Perlis, Paul Saskin, and Arthur Spielman. The precise charge to the committee was fourfold.

The Committee will work in conjunction with other Academy standing committees and with the American Board of Sleep Medicine to promote behavioral sleep medicine in four specific areas: 1. Accreditation [meaning certification] of behavioral sleep medicine practitioners; 2. Development of training programs for behavioral sleep medicine practitioners; 3. Development of educational programs on behavioral sleep medicine at professional meetings; and 4. Investigation of and recommendations for reimbursement of behavioral sleep medicine services.

In its early deliberations, the committee also took on the task of describing the boundaries of behavioral sleep medicine and adopted the following definition that is now seen in the training accreditation standards:

Behavioral sleep medicine comprises the behavioral dimension of normal and abnormal sleep mechanisms, and the prevention, assessment, and treatment of sleep disorders and associated behavioral and emotional problems through the application of established principles of behavior change.

In the six years that have followed the creation of the behavioral sleep medicine committee, the predictable conclusion that much has been accomplished and much remains undone is applicable. The field of behavioral sleep medicine has stabilized, and the foundation for steady growth has been laid. Evidence of this assertion is found in the characteristics of any subdiscipline that aspires to longevity: we have a flagship journal, *Behavioral Sleep Medicine*, that will publish its 5th volume in 2007; we have a textbook (Perlis & Lichstein, 2003); we have an exam since 2003 that is administered by AASM and that confers behavioral sleep medicine certification status (for health care providers in the US and Canada); we have a review process that confers the status of accredited training site at the levels of doctoral training, predoctoral internship/residency, and postdoctoral fellowship (in the US and Canada). At the time of this writing about 90 individuals have earned certification in behavioral sleep medicine and three behavioral sleep medicine training sites (University of Rochester Sleep Research Center, Rush University Hospital Sleep Disorders Center, and Stanford University Sleep Disorders Center) have been accredited.

Because the behavioral sleep medicine movement is stimulated, sponsored, and regulated by AASM, and because the umbrella of authority of AASM is limited to the US and Canada, it is likely that less progress has occurred in behavioral sleep medicine in other locales. In speaking with colleagues from other countries, I am given to understand that behavioral sleep medicine has not achieved broad recognition in most countries and is lagging with respect to certification/accreditation compared to the US/Canada. Organized, aggressive effort is needed to promote behavioral sleep medicine around the world. Such movements can succeed but they require thoughtfully orchestrated political/clinical/research initiatives that promise the harvesting of patient benefits. Active support and leadership from our physician colleagues has been indispensable and is probably a prerequisite for meaningful behavioral sleep medicine success.

Returning to the four original charges to the behavioral sleep medicine committee, substantial progress has been made with the first three, poor progress with the fourth: (1) a certification mechanism is in operation, (2) a training accreditation mechanism is in operation, (3) I have not yet spoken about this but behavioral sleep medicine clinical workshops are now available at numerous professional meetings and in many other venues throughout the US, and (4) the vagaries of the US healthcare system have proved to be a stubborn obstacle to funding behavioral sleep medicine services through our dominant mechanism, private insurance reimbursement.

This last point may represent an advantage that other countries enjoy with nationalized medicine. The financial viability of behavioral sleep medicine remains a struggle in the US. Perhaps other countries could make more rapid progress in this domain and wide

dissemination of behavioral sleep medicine services, yet an unrealized ambition in the US, could become a reality in other countries at a quicker pace.

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