

# Preface



Kenneth L. Lichstein, PhD, CBSM  
*Guest Editor*

By 2000, owing to its roots in psychosomatic medicine, behavioral medicine, and behavior therapy, behavioral/cognitive science and its therapeutic application, cognitive behavioral therapy (CBT), had established a strong footing in sleep medicine, particularly in the clinical management of the insomnias, continuous positive airway pressure (CPAP) adherence, parasomnias (particularly nocturnal enuresis and nightmares), and circadian rhythm disorders. Comprehensive reviews of the history of behavioral sleep medicine (BSM) are available elsewhere.<sup>1</sup>

BSM was invented in 2000 when Daniel Buysse, then president of the American Academy of Sleep Medicine, created an ad hoc presidential committee to broaden the role and stimulate the growth of psychology and related disciplines within sleep medicine. In its early deliberations, the committee took on the task of describing the boundaries of BSM and adopted the following definition that is now seen in the training accreditation standards:

“BSM 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 decade that has followed the creation of the BSM committee, the predictable conclusion that much has been accomplished and much remains undone is applicable. The field of BSM has stabilized, and the foundation for steady growth has been laid. At the time of this writing, about 130 individuals have earned certification in BSM, and nine BSM training sites have been accredited. Practical matters of insurance reimbursement and

growing the number of certified BSM practitioners, to achieve adequate dissemination, are enduring challenges.

The scientific underpinnings of BSM have grown rapidly and are, by now, prodigious. This issue summarizes the state of adult BSM science. The issue is organized in two clusters of articles. The first cluster, varied BSM targets, is a series of articles on disorders, strategies, and critical issues. The first article, by Matthews and Aloia, is on the topic of CPAP adherence. Adherence to medical regimens is one of the enduring, paramount obstacles to effective healthcare, and the article examines this obstacle with respect to the most important treatment for sleep apnea. The second article, by Pigeon and Yurcheshen, explores periodic limb movement disorder/restless leg syndrome. These disorders are typically managed pharmacologically, but this article is a call to action to expand the range and power of behavioral interventions for these disorders. The third article, by Cvenegros and Wyatt, addresses circadian rhythm disorders. This article elucidates this complex web of processes and available strategies for taming these disorders when circadian rhythm drifts off. The fourth article, by Hasler and Germain, targets nightmares. This area has made great progress in recent years, and this article highlights effective interventions for nightmares, whether or not they are associated with posttraumatic stress disorder. The fifth article by McCurry, Gibbons, Logsdon, Vitiello, and Teri investigates sleep disturbance in caregivers. Home-based caregivers of dementia patients, often older adults themselves, are a special group of individuals whose sleep needs are significant and often overlooked. The sixth article by Vorona, Chen, and

Ware examines sleep deprived physicians. It demonstrates with startling clarity the serious hazards to physicians and their patients when healthcare providers do not obtain adequate sleep.

The second cluster, the insomnias, is comprised of articles on varied aspects of the premier topic in BSM. The first two articles by Kaplan, Talbot, and Harvey and by Perlis, Gehrman, Pigeon, Findley, and Drummond investigate the two main theories of insomnia mechanisms: cognitive and neurobiologic. The third article, by Espie and Kyle, is on the major topic of primary insomnia. This article presents a broad survey of the research and clinical procedures of insomnia unaccompanied by overt medical and psychiatric comorbidities. The fourth article by Rybarczyk, Lund, Mack, and Stepanski is on comorbid insomnia. Having shed its untouchable status when it was referred to as secondary insomnia, this article documents significant progress in directly treating comorbid insomnia emphasizing the most prevalent types of comorbidity—depression, cancer, and pain. The fifth article by Bélanger, Belleville, and Morin tackles dependence in long-term hypnotic use. This article describes the hazards of hypnotic use and effective rescue with CBT for insomnia when hypnotic use becomes problematic. The sixth article by McCrae, Dzierzewski, and Kay discusses late-life insomnia.

Insomnia in older adults is more frequent, severe, and disabling than in younger adults. This article presents a comprehensive approach to understanding and managing late-life insomnia.

Last, I express my deep appreciation to my colleagues, who invented time to prepare these articles amidst densely packed schedules that yield time grudgingly. I am proud to be associated with these high quality scholarly pieces that may serve the dual purpose of advancing BSM a bit further and expanding the availability of effective, safe treatments for people experiencing sleep disorders.

Kenneth L. Lichstein, PhD, CBSM  
Sleep Research Project  
Department of Psychology  
The University of Alabama  
Box 870348  
Tuscaloosa, AL 35487-0348, USA

E-mail address:  
[Lichstein@ua.edu](mailto:Lichstein@ua.edu) (K.L. Lichstein)

## REFERENCE

1. Stepanski EJ. Behavioral sleep medicine: a historical perspective. *Behav Sleep Med* 2003;1(1):4–21.