¶ 6.1

Lasting Sleep Problem

Clinician Assessment

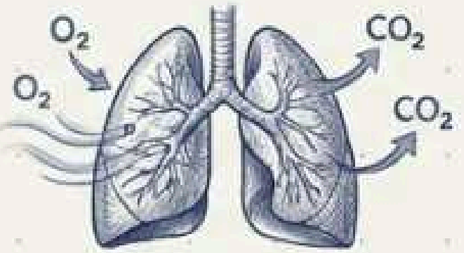


Duration & Pattern



Medicines & Daytime Effects

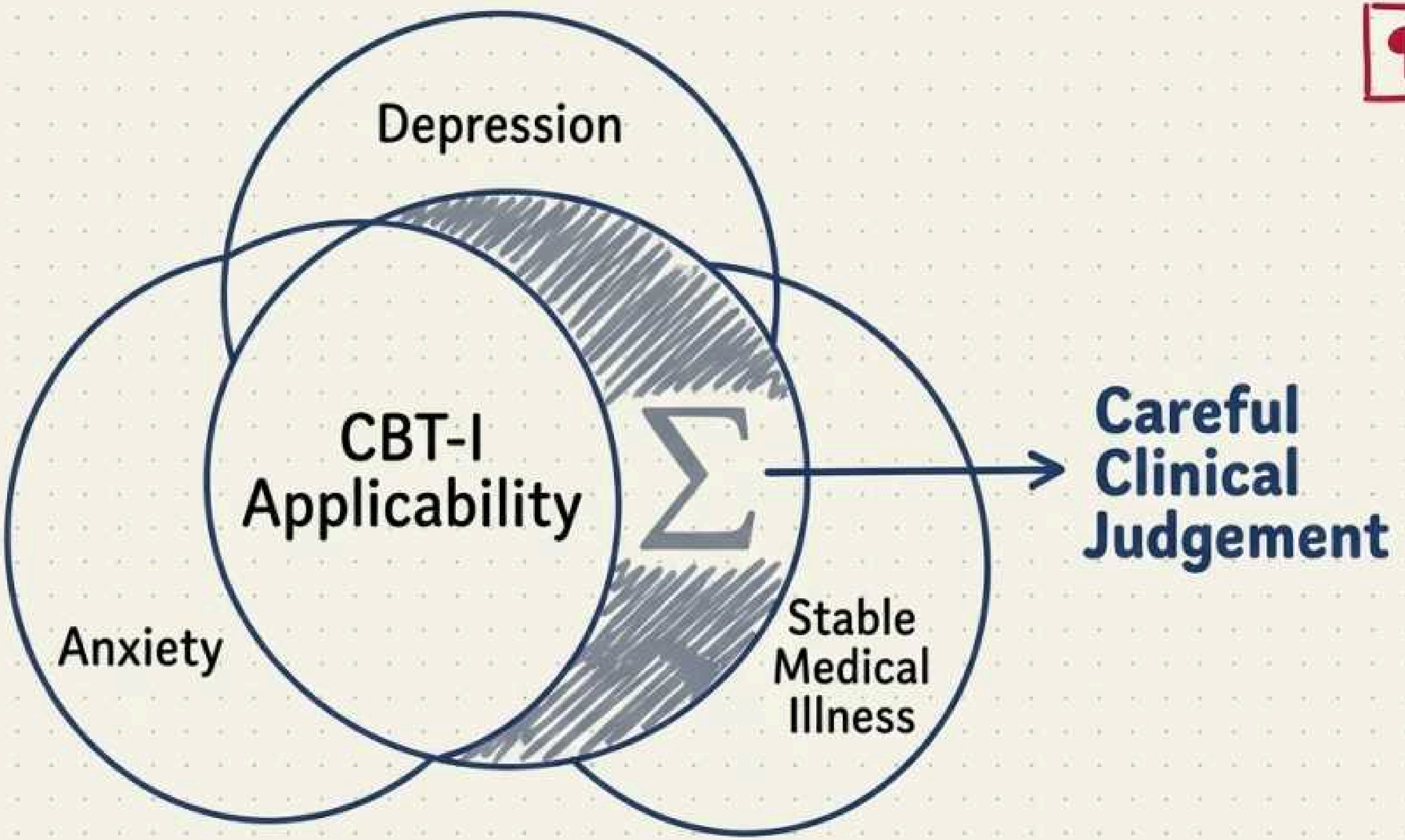
~~Self-Prescription / Checklist Diagnosis~~



Breathing in Sleep

This course helps you ask better questions. It cannot perform an assessment and must not be used as a DIY diagnostic checklist.

¶ 6.2



The Evidence: 2021 guidelines strongly recommend CBT-I, including for patients with comorbid conditions.

The Boundary: Comorbidity demands precise clinical judgment, not improvisation. It is not a reason for despair, nor an excuse to apply plans where sleep loss is unsafe.

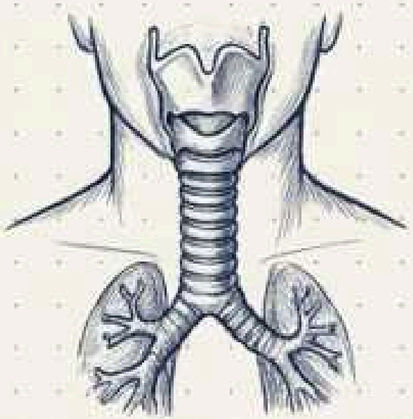
Absolute Safety Triggers: Seek Prompt Medical Care



Suicide / Severe Distress



Falling Asleep Driving / Dangerous Settings



Witnessed Gasping / Loud Snoring / Seizures



Prescribed Medicine Changes

Nothing in this course permits changing prescribed medicine without the responsible prescriber.

¶ 6.4

− What It CANNOT Do

- Train a therapist
- Certify a student in behavioral sleep medicine
- Replace a supervised clinical manual
- Give a personal sleep window
- Taper prescribed medications
- Promise next month's sleep results

+ What It CAN Do

- Make the disorder, treatment, and guidelines intelligible
- Ensure a later clinical conversation begins on firmer ground
- Prepare students for a future year of professional study

This is the modest, appropriate aim of an Anderson Academy Brief course.



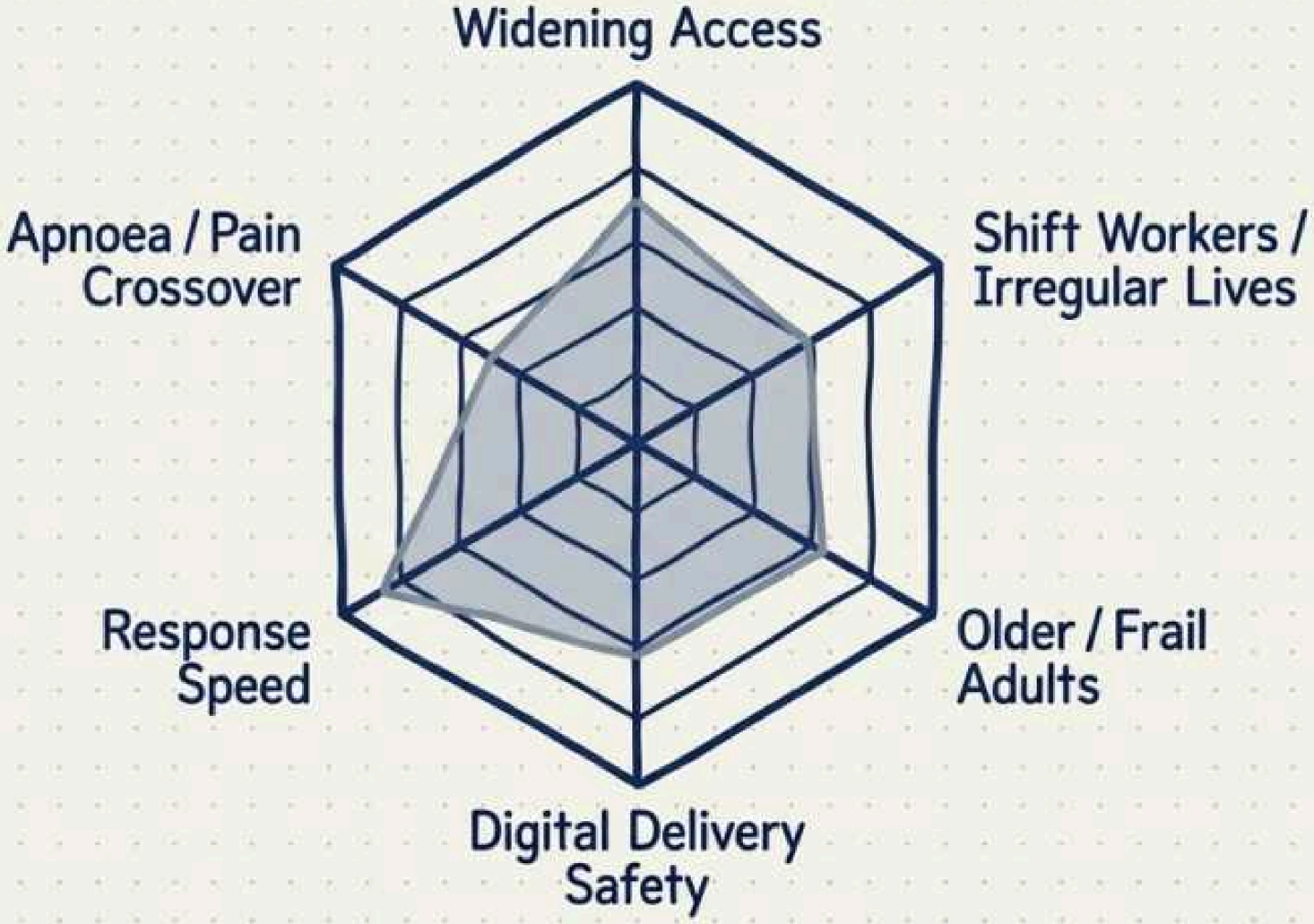
Vetting Practitioners

A professional title alone does not guarantee specific treatment expertise.

Qualified practitioners may be psychologists, physicians, or other clinicians who have taken specialized training.

Takeaway: Use this checklist as questions for your first clinical appointment, not as a ranking of names provided by this course.

¶ 6.6



The Evolving Science: A strong guideline recommendation summarizes present evidence; it is not a claim that the last paper has been written.

The Educated Reader: Welcomes new studies without discarding the present standard at the first headline, and acknowledges genuine gaps in under-represented groups.

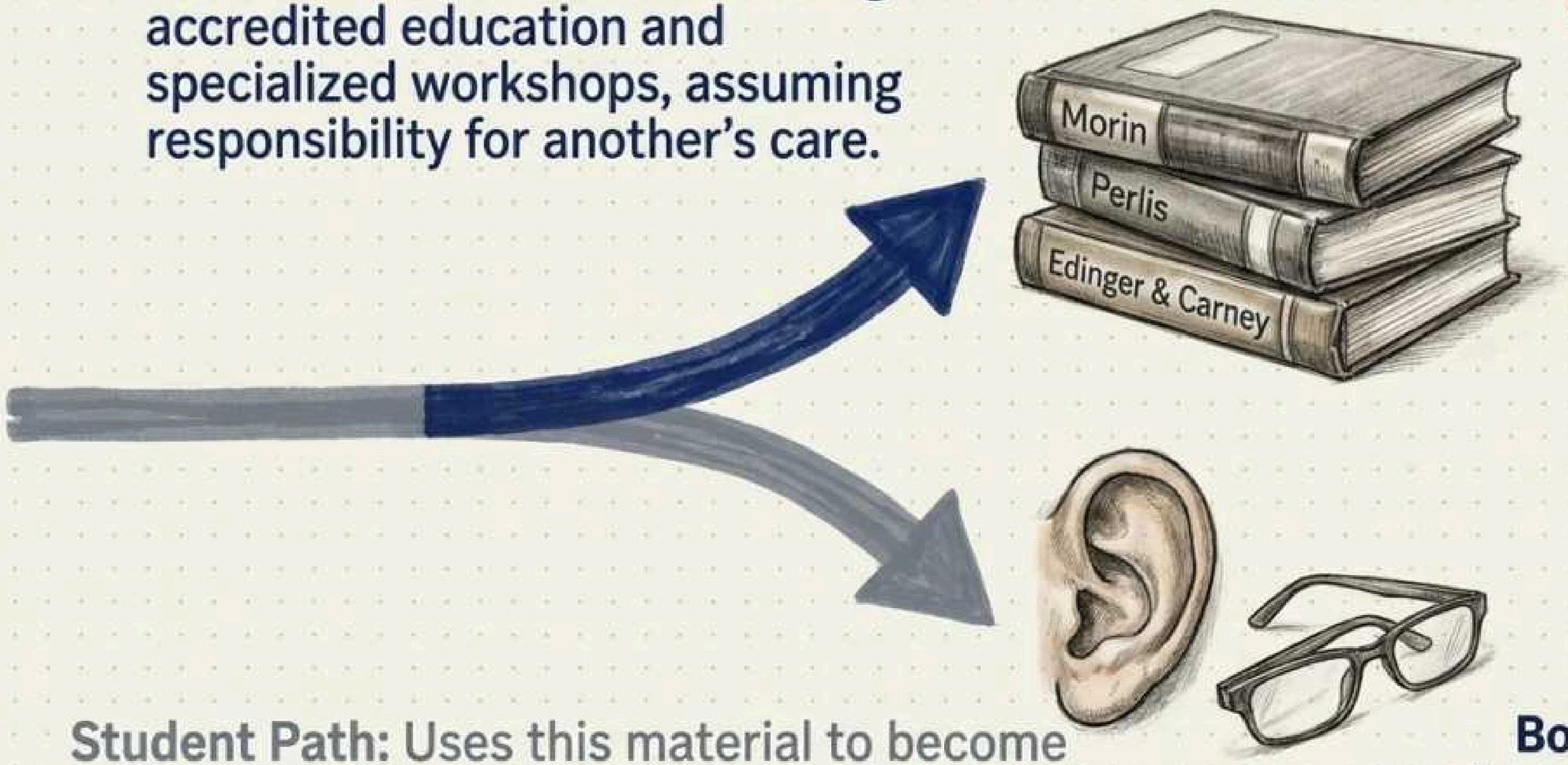
¶ 6.7



When meeting a new claim, ask: What is asserted? What evidence, in what population, with what safety screening supports it?

¶ 6.8

Professional Path: Runs through accredited education and specialized workshops, assuming responsibility for another's care.

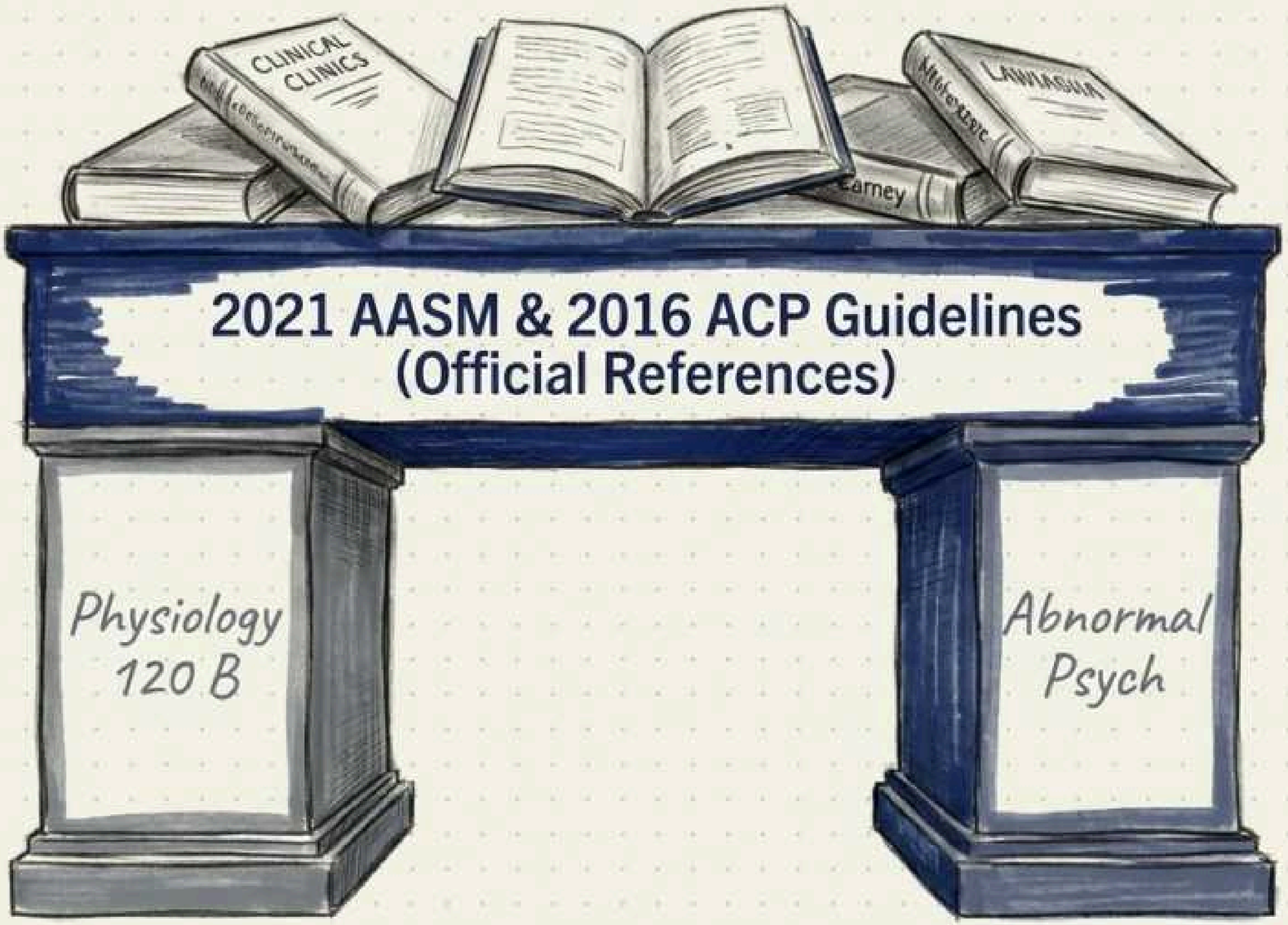


Student Path: Uses this material to become better patients, relatives, and readers, without stepping onto the clinical track.

Both uses are honorable; they must never be confused.

¶ 6.9

Deeper Context
(Not Self-Treatment Scripts)

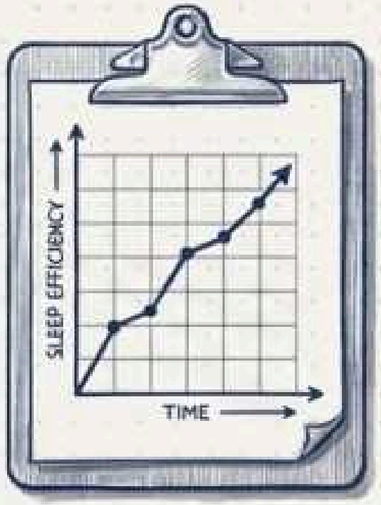


Actionable Advice:
If in clinical training, seek supervision before applying any method. If seeking personal help, take these outlines as questions for a clinician, not a plan to run alone.

¶ 6.10

[Compassion] + [Empirical Evidence] ≠ Character Flaw





The Tone of Treatment: Insomnia is real, maintained by intelligible processes, and responds to specific, studied treatment. Compassion and evidence belong together. Neither is served by a casual protocol, and neither is served by neglect.

¶ 6.11

1. **Definitions**
   (Impairment vs. ordinary bad nights)
2. **Spielman's Factors**
   (Learned arousal & unhelpful thinking)
3. **Stimulus/Restriction**
   (Rationale & clinical individualization)
4. **Cognitive/Hygiene**
   (Proper ranks; hygiene is not a sole treatment)
5. **Trial Traditions**
   (Morin, Edinger, Perlis & 2021 recommendations)
6. **Assessment & Limits**
   (Safety, reading claims against evidence)



Questions welcome at garyanderson at mail dot grokbot dot com or on X at garyanderson.