MAINE PSYCHOLOGICAL ASSOCIATION

MAY 2019

Maine Psychologist Today

Welcome to the Maine Psychologist Today, MePA's new online newsletter!

President's Message

Dear Colleagues,

When I assess children, I take time to introduce myself, explain activities I enjoy, ice cream flavors preferred etc. I then begin my interview of the child, and on occasion ask them if they remember my name ("Mr. Collins"). They usually do not initially and so I offer 3 choices: "Is my name Mr. (their surname) or Mr. Gabinaginkos (HA! HA!), or Mr. Collins? They then get it, and usually remember. One day in Rangeley I performed my "usual" and then as we were leaving the testing area the student's mother happened to be waiting for him nearby, and so I introduced myself to her via stating to him: "Student: what's my name? I forgot it again!" The student rolled his eyes and said "Mr. Collins, just look at your name-tag on your shirt – It SAYS "Mr. Collins!" Grown-up lesson: sometimes the obvious is right before our eyes!

And now for two trivia questions:

1) When was the first president of MePA elected?

2) How many past presidents of MePA have been elected and how many can you name?

3) Can you name one of seven past presidents who has identical first & last initials?

Well guess what? A listing of past presidents is available "right before your eyes." Simply telephone MePA and request a copy from Sheila. You will likely find this very interesting! Two quick trivia answers: The first president was Norman Munn Ph.D. who was appointed in 1950, the year of my birth. There are a total of 51 prior presidents-I am # 52. I won't list the identical double initials past presidents, but YOU can find them via your own free copy!

On a more reflective note, we should all be very proud of our psychologist population; so many are so willing to volunteer services for the betterment of our state citizenry, as well as advance the effectiveness of availability of our services. Say…how might YOU like to be more directly involved in the above advancements via some form of MePA

committee or other volunteer activity? Hey, you MePA graduate students and early career psychologists…in what directions would YOU like to see us progress? Think about it ….

On a (to me) very sad note, our dear Sheila Comerford is officially retiring on August 1 after a 26 year tenure as our Executive Director. We are in process of advertising for Sheila's replacement, and the search committee is headed by Christine Gray, and includes John O'Brien, Linda Monahon, Elyse Corbett and Josh Kingsbury. Sheila, I offer to you the highest commendations for your effectiveness in keeping our organization moving, addressing multiple political and professional questions, and most importantly to me, mentoring me during my presidency. I am certain that I speak for our membership when I state that you are an extremely effective Director and your expertise, your sense of humor and your availability to all will be dearly missed.

And so dear Committees, Policy Council, graduate students, and regular members, let us keep up the pace! See you at the May 31st workshop on grief; and we will be listening to one another on the listserv!

Most gratefully,

Tom Collins

Welcome New Members!

Members
Heidi Wells, PsyD Portland
Laura Soden, PhD Portland
James McElligott, PsyD Freeport

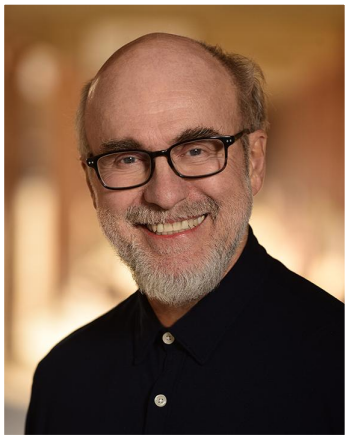
Retired
Peter Smith, PsyD S. Portland
Donna Hastings, PsyD Merrimack, NH

Affiliate
Audrey Gill Johnson, PsyD Arlington, MA

Student
Liv LiaBraaten, JD Lincolnville, ME

RLS and Insomnia? CBT-I Just Might Help

By Régis Langelier, Ph.D.



As many of you know, those of us who are "NightWalkers" have not only RLS, but also the insomnia that comes with it. All who endure RLS have some learned coping expertise; however, we also need new ways of thinking and strategizing for revitalization!

Now there is something proven to help: cognitive behavioral therapy for insomnia (CBT-I) – a treatment primarily given by specialized, doctoral-level psychologists. In 2016, the American College of Physicians finally recommended CBT-I as a first-line therapy for chronic insomnia,[1] officially endorsing the combined finding of data from multiple studies (meta-analysis).[2] CBT-I is proven to be the best treatment for chronic insomnia disorder, works as well as sleep medications and has the added benefit of fewer or no adverse effects. I use CBTI-I every day, and so can you.

RLS and insomnia pose daily challenges to well-being

RLS is a complex, neurological and torturous affliction. Just by itself, it creates fragmented and diminished sleep; constant fatigue (often an RLS trigger); sometimes an inability to relax during the day; disruption of life's pleasurable activities; impaired behavioral, emotional and cognitive functioning; and trouble with common activities such as driving, or attending a play or movie.

Insomnia is associated with one or more of the following symptoms: difficulty initiating sleep; difficulty maintaining sleep (characterized by frequent awakenings, or problems returning to sleep after awakenings); and early morning awakening with the inability to return to sleep. In chronic insomnia, sleep disturbance causes clinically significant distress or impairment in important areas of functioning, occurs at least three nights per week, and is present for at least three months. Chronic insomnia is linked to an increased risk of developing a number of physical and mental disorders, including but not limited to high blood pressure, heart disease, diabetes, chronic pain, work-related accidents, major depression, alcohol and substance abuse, and trouble with memory, concentration and performance.[3]

Population-based estimates indicate that in general, about one-third of adults report insomnia symptoms[3]; in comparison, the prevalence for people with RLS is much higher (48–60 percent).[4] Regardless of whether their RLS symptoms are relieved by medication, many patients continue to have sleep issues and other health problems. They also may be plagued by anxiety and depression, plus suffer from a sense of despair. RLS is invisible to our friends and others, as is insomnia. Often such unseen maladies contribute to feelings of isolation, to overwhelming stress, to chronic relaxation problems and to unique or quaint (soap under your pillow as a placebo?) coping strategies. Medications are not proven to be a universal answer. Coping and improvement are usually best achieved by medical evaluation and creating an individually tailored strategy that may include drug and/or nondrug treatments.

Poor sleep is partly learned and partly inherited. Factors known to contribute to sleep issues are age, pain, medical conditions, drugs, substance abuse, fear, financial insecurity, difficult work/living conditions, trauma, poverty and relationship problems – to name just a few common culprits. RLS and insomnia combined pose a much greater daily challenge to living well, and to achieving happiness!

Something proven to help: CBT-I

CBT-I is a set of strategies that helps modify thoughts, beliefs and behaviors that interfere with sleep and life. Although this therapy doesn't work as quickly as sleep aids (which remain the most popular treatment for insomnia, despite publicized concerns about safety and efficacy), CBT-I is an evidence-based therapy that can be effective and enduring, especially by increasing shuteye time in stages 3 and 4 of sleep (slow wave sleep, and deep sleep). CBTI-I improves mood and is particularly effective in mitigating excessive sleep effort – the common tendency to try too hard to make sleep happen. (Who hasn't experienced this?)

CBTI-I typically involves a sequence of eight or fewer sessions with a trained psychologist, and includes the following elements:

Sleep Assessment: The provider conducts a comprehensive evaluation and history of sleep problems, physical and mental health issues, substance use (including caffeine), daily sleep diary profiles, the Insomnia Severity Index score (mild to severe), and the Sleep Efficiency Index result (total time in bed actually spent asleep).

Sleep Education and Sleep Hygiene: This part of CBT-I addresses normal sleep and its stages, sleep regulators such as circadian processes, arousals from sleep, environmental conditions, and sleep hygiene recommendations. Screen time, Starbucks stops, and the nightly wine or beer are also added up on the "sleep trouble" scale.

Stimulus Control and Sleep Restriction Therapy.[5] These strategies aim to strengthen cues for sleep, reduce cues that interfere with sleep, reduce the amount of time spent awake in bed each night, and associate one's bed with falling asleep quickly. Stimulus control instructions are:

- Lie down intending to go to sleep only when you are sleepy.
- Do not use your bed for anything except sleep and intimacy.
- If you are unable to fall asleep within 20 minutes, then get up, go to another room and return to the bedroom when you are sleepy again. Do this as often as necessary throughout the night.
- Get up at the same time every morning, regardless of how much sleep you had during the night. This will help the body acquire a consistent sleep rhythm.
- Keep active during the day and avoid naps (except for a limit of 30 minutes when sleepiness might cause harm).

Sleep restriction is designed to increase the drive for sleep (i.e., tiredness) and is used in combination with stimulus control instructions and cognitive therapy.

Relaxation Training: This training reduces physical arousal and muscle tension, slows down the heart rate and breathing, and slows a racing mind. Approaches might include diaphragmatic breathing, visual imagery, and mindfulness-based stress reduction.

Cognitive Techniques, or cognitive restructuring: This therapy addresses misconceptions about the causes and consequences of insomnia, unrealistic sleep expectations, and negative automatic and sometimes catastrophic thoughts about sleep. It is important to challenge those thoughts and beliefs by identifying more realistic substitutes for them. In this therapy, negative thoughts (make your own list) such as "I am never going to fall asleep" or "I won't cope tomorrow" or "I have no control over this racing mind" are treated, challenged and restructured by realistic thoughts: "I always fall asleep eventually" or "I will be tired tomorrow but will get through it as always" or "I am not alone – at least two in five people with RLS have sleep trouble." Time is scheduled during the day to address anticipated worrisome bedtime thoughts and to practice relaxation. CBT-I providers typically provide handouts on cognitive techniques for patients to take home with them.

CBT-I considerations

A combination of CBT-I and RLS medication might be necessary to address the sleep disturbances and reverse RLS symptoms. This combination can make the difference between frustrating torture, and some measure of success. With conditions such as depression, studies[2] show that compared with antidepressant medication alone, CBT-I in conjunction with these medications can significantly reduce depressive symptoms and increase insomnia remission rates.

Sleep restriction therapy has been found effective for older adults (not for children) but is contraindicated for specific types of depression (e.g., bipolar disorder) and may at first increase anxiety. For this reason, sleep restriction therapy is optional for individuals who have post-traumatic stress disorder. Skip sleep restriction therapy if it doesn't seem right for you.

Finally, although CBT-I can be conducted in groups or online, research to date on CBT-I outcomes has focused on in-person treatment.[2]

In summary, CBT-I offers an effective, evidence-based protocol to improve sleep profiles for children and adults who have RLS. If you would like to explore this therapy, talk with your health care provider about whether this treatment may be right for you.

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[1] Qaseem, A, "Management of Chronic Insomnia Disorder in Adults: A Clinical Practice Guideline from the American College of Physicians." *Annals of Internal Medicine*, July 19, 2016.

[2]DeAngelis, T, "Behavioral Therapy Works Best for Insomnia, *Monitor in Psychology*, October 2016, Vol 47, No 9, American Psychological Association," Washington, D.C.

[3]*DSM-5 Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, American Psychiatric Association, Washington, D.C., 2013.

[4] Lee, HB, Buchfurer, MJ, Allen, R, Hening, WA, *Clinical Mana*

[5] Bootzin, R.R., Epstein, D.R., (2011), Understanding and Treating Insomnia, *Annual Review of Clinical Psychology*, 7, 11.1-11.24

Régis Langelier, Ph.D., ***rplangelier@gmail.com***, *is a practicing; licensed psychologist in southern Maine offering CBT-I in-person and by remote consults. He is a behavioral medicine specialist, and a past clinical associate professor of psychiatry at the University of Vermont, Burlington. Langelier formerly served as treasurer of the RLS Foundation Board of Directors, was a support group leader for 10 years, and currently volunteers as an RLS support contact*. He can be reached at The Saco Island Mill Langelier, Inc.

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The Maine Psychological Association presents…

Navigating through Loss and Grief:

How Continuing Bonds, Creativity, Religion/Spirituality and Culture Contribute to the Journey

Featured Speaker

Lorraine Mangione, Ph.D.

Friday, May 31, 2019

8:45am-noon
University Events Room
7th floor Glickman Library
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3 CE credits

$ 59 for MePA members, $ 79 for non-members $30 for students
Register Now at mepa.org

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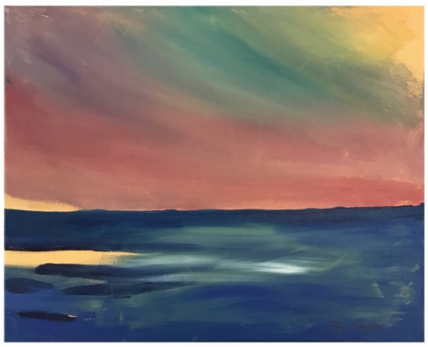

Deep Calm

INNER -OUTER CONTEMPORARY CLIMATES

Artist/Psychologist Régis Langelier, Ph.D.

Come ponder the relationship between nature's contemporary statements and the corresponding human conditions of: Anxiety;Insomnia;Fury;Calm. Sea,Mountain,Fire,Borders,Desert and Coastline are depicted with mixed media .East and Southwest are featured in this interactive exhibit of 25 stimulating paintings.

**RECEPTION- Saturday, June 1, 2019. 1pm-3pm*

Contact 207.351.5352
Ask for: Sea Oats Art
rplangelier@gmail.com

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