



The Integration of Behavioral Medicine, Fatigue Management, and Sleep Disorders in an MS Population

Presenters:

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“The greatest revolution of our generation is the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives” William James

Presenters:

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Presenters:

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Sleep is the golden chain that ties health and our bodies together - [Thomas Dekke](#)

"I love sleep. My life has the tendency to fall apart when I'm awake, you know?"
— [Ernest Hemingway](#)

Learning Objectives

- Understand how behavioral medicine is integrated within a neurology clinic
- Be able to identify common psychological conditions in an MS population.
- Be able to identify treatment options for psychological conditions in MS
- Gain awareness of how standard behavioral treatments of sleep disorders can be modified in an MS population
- Appropriately utilize the tools and strategies that facilitate patient assessment in order to differential between cognitive problems, depression, and related psychosocial issues
- Incorporate the information obtained through appropriate assessments into the therapeutic plans of care for each area of concern.

Schedule

- 9:00-9:15: Introduction: Amy Sullivan
- 9:15-9:45: Integration of Behavioral Medicine in an MS Clinic: Building the MS patient experience: Amy Sullivan
- 9:45-10:30: Fatigue Management: Megan Clancy
- 10:30-10:45: Break
- 10:45-11:30: Sleep Disorders in an MS population: Michelle Drerup
- 11:30-12:00: Panel Discussion



Integration of Behavioral Medicine in an MS Clinic: Building the MS Patient

Amy Sullivan

Define This Person





Fatigue Management
Megan Clancy

Identifying and Managing Fatigue in Individuals with MS

MEGAN CLANCY, PH.D.
CLINICAL PSYCHOLOGIST

MS Fatigue

- Fatigue, or lassitude, is the most common symptom associated with MS
- >80% of individuals with MS
- Physical or mental tiredness
- Chronic or acute onset
- Pharmacologic, behavioral and multi-disciplinary treatment options

Effects of fatigue

- Decreased quality of life
- Employment
- Relationships
- Depression
- Anxiety
- Worsening MS symptoms

Living with Fatigue

- *“I feel like I hit a wall.”*
- *“I have nothing left to give when I get home after work.”*
- *“My husband thinks I’m lazy.”*
- *“I’m disgusted with myself.”*

Etiology of Fatigue in MS

- Primary symptom of MS
- Secondary or tertiary symptoms of MS
 - Medication side effects
 - Sleep difficulties (insomnia, nocturia, sleep apnea)
 - Heat
 - Stress
 - Depression
 - Physical exertion
 - Cognitive difficulties
- Other non-MS related sleep difficulties or symptoms

Assessing fatigue

- **Fatigue versus sleepiness**

- Patients with excessive daytime sleepiness (EDS) often will fall asleep easily if given an opportunity or at inappropriate times (e.g., while driving), report problems with alertness, especially in the afternoon and note errors in attention and performance
- Fatigue Severity Scale
- Epworth Sleepiness Scale



MaT4

Assessing Fatigue

- **Fatigue versus depression**

- Individuals with MS are at an increased risk for depression, in comparison to the general population, with estimates ranging from 26-51%
- Assess interest/activity level, mood
- Impact of fatigue on daily functioning
- Psychological consultation

First step: self-monitoring

- **Activity logs**
 - Track type and length of activities
 - Identify times or periods of increased or decreased fatigue and other symptoms
- **Sleep logs**
 - Record sleep time, nighttime awakenings, naps, etc.
- **Identify triggers (heat, stress, time of day, holidays, medication, etc)**

Exercise

- **The 'no pain, no gain' approach does not apply**
 - Work to a 3 (mild to moderate exertion) on a scale of 10
- **2-hour rule**
 - if a person doesn't feel as good two hours after exercising as she or he did before, then they probably did too much
- **10-minute rule**
 - if a person feels lousy after 5-10 minutes of exercise, take the day



Fatigue, Insomnia and Depression in MS

- Several studies have demonstrated significant relationships among insomnia, fatigue and depression for people with MS (Bamer et al, 2010; Fleming & Pollak, 2005; Merlino et al, 2009; Najafi, et al, 2013; Stanton, Barnes & Silber, 2006)
- Depression has been shown to worsen with sleep disturbances and sleep disturbances are often exacerbated by depression (Bamer et al, 2010)

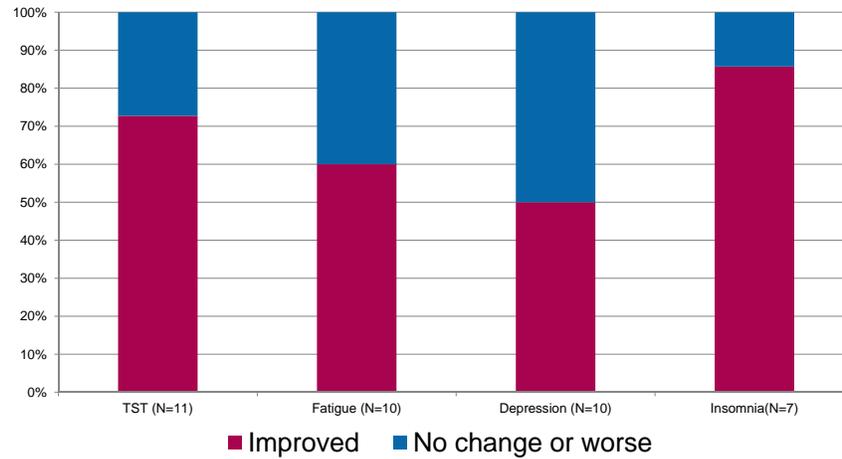
Fatigue, Depression and Insomnia

- A retrospective outcome data analysis was conducted for patients with Multiple Sclerosis (MS) who participated in individual or group CBT-I at the Sleep Disorders Center at the Cleveland Clinic Foundation (CCF) between January 2008-December 2013
- The clinical sample consisted of 11 individuals
- 10 females and 1 male
- Ages ranged from 36-69 ($M=52$, $SD = 11$).
- 8 patients identified as White and 3 patients identified as African American.
- The total number of visits ranged from 2-16 ($M = 8$, $SD = 4.8$).

Results

- Overall, patients reported improvement across all domains
- 73% of patients reported an increase in TST. Patients reported mean improvement in TST of 1.25 hours
- 60% of patients reported a reduction in fatigue
- **However, all patients continued to endorse a clinical level of fatigue**

CBT-I Outcomes



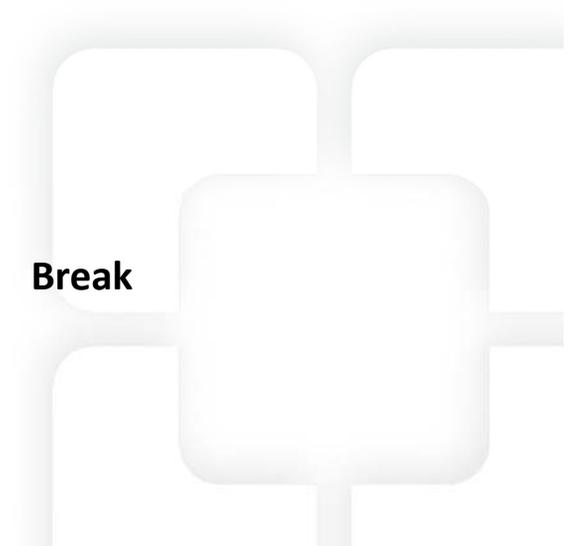
Practice Points

- Fatigue is the most common symptom in MS
- It may be the result of one or more factors – self-monitoring and proper assessment are key
- Fatigue in MS patients should be treated within a multi-faceted approach

Questions?



Break





Behavioral Sleep Medicine: Prevalence, Assessment and Treatment of Sleep Disorders in Multiple Sclerosis

Michelle Drerup, Psy.D., CBSM
Director of Behavioral Sleep Medicine
Clinical Assistant Professor of Medicine at CCLCM

Objectives

- Provide an overview of the association of sleep disorders with MS
- Review implementation and modification of BSM treatment interventions, including cognitive behavioral therapy for insomnia, in patients that have MS

Behavioral Sleep Medicine

- Branch of clinical sleep medicine and health psychology
- Focuses on the identification and treatment of the psychological factors that contribute to the development and/or maintenance of sleep disorders
- Specializes in developing and providing empirically validated cognitive, behavioral, and/or other nonpharmacological interventions for the entire spectrum of sleep disorders

Habitual Sleep Duration < 6 hours is associated with a variety of adverse consequences

- Decreased glucose tolerance
- Decreased leptin/increased ghrelin -> Obesity
- Increased inflammatory markers
- Mental health disorders, drug and alcohol abuse
- Increased health care utilization
- Occupational injuries and motor vehicle accidents
- Hypertension
- Cardiovascular events

MS and Sleep Problems

- Prevalence of sleep problems in MS are significantly higher (25% to 54%) than in general population or other chronic diseases, may affect women with MS more than men
- Bamer et al. (2008) large sample of MS population (n=1077) found 13.3% had mild, 21.5% moderate and 30% severe sleep problems
- Further attention and investigation needed given the potential impact of sleep disorders on the health and quality of life in individuals living with MS
- Sleep disorders ↑ risk of mortality, cardiac disease, obesity and diabetes, can contribute to depression, pain and fatigue – symptoms that are commonly seen in MS patients and often disabling

Sleep Disordered Breathing

- Pts may present with sleepiness, nocturnal apneas, choking episodes and snoring, with PSG evidence of 5+ apneas or hypopneas per hour (AHI)
- Obstructive apnea – associated with respiratory effort, 2 to 4% of adults
- Central apnea – lack of respiratory effort, rare
- OSA and MS comorbidity rates vary
 - Prospective series of 33 consecutive MS patients, at least 23 (70%) had OSA syndrome (AHI >15) (Trojan et al., 2008).

Sleep Disordered Breathing

- Higher incidence of OSA in the MS population but further investigation needed
- Theoretical explanations for correlation between MS and sleep apnea that need further exploration:
 - symptomatic medications used in MS for pain or spasticity that may relax muscle tone in pharynx
 - inactivity from disability that may lead to obesity
 - brainstem lesions which regulate the motor neuron control of the upper airway

REM Sleep Behavior Disorder

- Pt exhibits disruptive and at times injurious behavior in REM sleep, lack muscle atonia that normally accompanies REM sleep, acting out dreams such as kicking, punching, etc
- Overall prevalence of RBD 0.38 to 0.5%, generally occurs in middle to older aged males
- Etiology: idiopathic or secondary to neurological disease, most commonly Parkinson's disease and Dementia with Lewy Bodies

REM Sleep Behavior Disorder

- RBD is thought to be associated with lesions in the pedunculopontine nuclei resulting in persistence of muscle tone during REM sleep. MS could lead to RBD via an inflammatory destructive lesion in the pons
- Use of clonazepam considered 1st line therapy for idiopathic RBD and has been effective at resolving RBD in MS patients
- SSRIs and other antidepressants can precipitate RBD, MS patients who are on antidepressants be considered at risk for the emergence of RBD

Restless Legs Syndrome (Willis-Ekbom disease)

- Urge to move legs usually due to uncomfortable sensation, urge in legs improves with movement, symptoms worsen at rest, symptoms often worsen in evening
- 2.5% to 18% of general population; twice more frequent in MS than in non-MS populations (Italian RES Study Group, 2008)
- Distinguishing RLS from other motor and sensory symptoms in MS can be challenging - for RLS make sure movements are voluntary, RLS maximal in evening
- RLS is 2nd to variety of disorders, especially those that cause an iron deficiency.
- RLS treated with dopamine agonist as first line therapy

Insomnia Disorder

- A. The predominant complaint is dissatisfaction with sleep quantity or quality made by the patient (or by a caregiver or family in the case of children or elderly).
- B. Report of one or more of the following symptoms:
- Difficulty initiating sleep; in children this may be manifested as difficulty initiating sleep without caregiver intervention
 - Difficulty maintaining sleep characterized by frequent awakenings or problems returning to sleep after awakenings (in children this may be manifested as difficulty returning to sleep without caregiver intervention)
 - Early morning awakening with inability to return to sleep
 - Non restorative sleep
 - Prolonged resistance to going to bed and/or bedtime struggles

(DSM-5, 2014)

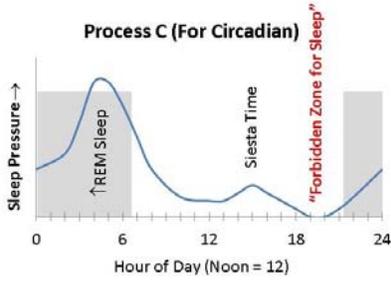
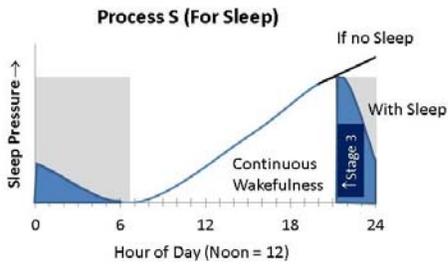
- C. The sleep complaint is accompanied by significant distress or impairment in daytime functioning as indicated by the report of at least one of the following:
- Fatigue or low energy
 - Daytime sleepiness
 - Cognitive impairments (e.g., attention, concentration, memory)
 - Mood disturbance (e.g., irritability, dysphoria)
 - Behavioral problems (e.g., hyperactivity, impulsivity, aggression)
 - Impaired occupational or academic function
 - Impaired interpersonal/social function
 - Negative impact on caregiver or family functioning (e.g., fatigue, sleepiness)

(DSM-5, 2014)

- D. The sleep difficulty occurs at least three nights per week.
 - E. The sleep difficulty is present for at least three months.
 - F. The sleep difficulty occurs despite adequate age-appropriate circumstances and opportunity for sleep.
 - Duration:
 1. Acute insomnia (<1 month)
 2. Sub acute insomnia (1-3 months)
 3. Persistent insomnia (> 3 months)
- (DSM-5, 2014)

Insomnia and MS

- Prevalence rates of insomnia with daytime impairment in general population 10-15%
- Several studies suggest higher rates of insomnia in MS - Insomnia present in 54% of 28 MS patients consecutively studied (Tachibana et al, 1994)
- Common reasons for insomnia reported by MS patients include:
 - Anxiety or racing thoughts
 - Pain
 - Urination



What regulates how well we sleep?

Elevated Sleep Drive – Process S
 Proper Circadian Timing – Process C
 Low physiological/mental arousal – Process A =

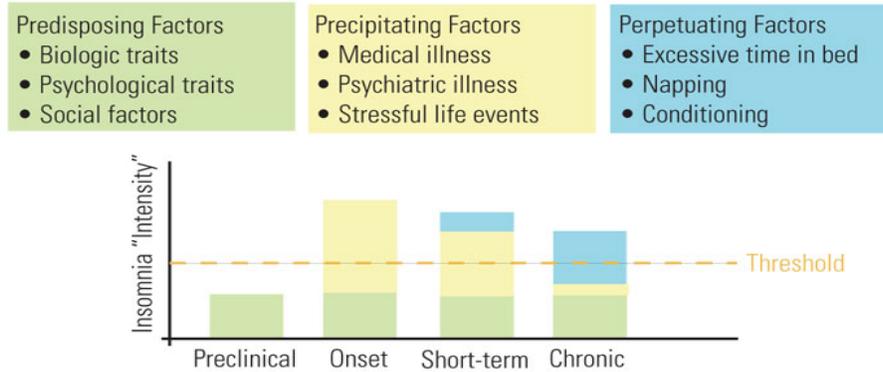


Low Sleep Drive – Process S
 and/or
 Improper Circadian Timing – Process C
 and/or
 High physiological/mental arousal – Process A =



Spielman Model: Three P's

FIGURE
A MODEL OF CHRONIC INSOMNIA²⁻⁴



Erman MK. *Primary Psychiatry*. Vol 14, No 7. 2007.

Cognitive-Behavioral Therapy for Insomnia (CBT-i)

- Multi-component treatment
 - Sleep hygiene education
 - Stimulus control *
 - Sleep restriction *
 - Relaxation therapy
 - Cognitive restructuring

Sleep Logs

- Prospective self report of one's perception of sleep and wake patterns
- Estimates of sleep parameters and variability in sleep/wake patterns
 - Time in Bed and Total Sleep Time
 - SOL (sleep onset latency), WASO (Wake after sleep onset)
 - Ratings of sleep quality, daytime sleepiness/fatigue
 - Sleep hygiene/lifestyle factors

Review of Sleep Logs with MS patients

- Important to go over sleep logs at beginning of session with patients to reinforce importance
- Can use this data for additional inquiry or track additional data
 - Track fatigue levels, daytime activity patterns with MS patients
 - You took a 2 hour nap in the afternoon this day and that night had more difficulty falling asleep. Why do you think that might be?
- Lack of comprehension
 - Important to make sure patients understand how to use it
 - Cognitive impairments with MS may serve as barrier – have fill out with spouse or caregiver

Stimulus Control

- 1) Establish a regular morning rise time
- 2) Go to bed only when sleepy
- 3) Get out of bed if not sleeping
- 4) Avoid excessive napping during the day

Sleep Restriction Therapy – “Sleep Efficiency Training”

Goal: Restore homeostatic sleep drive by restricting time in bed when not sleeping. Aim is to increase sleep quality

Step 1 – Use of sleep logs to obtain average sleep time (AST)

Step 2 – Limit time in bed (TIB) to AST +30mins

Step 3 – After 1 week implementation, adjust TIB based on initial response

↑ TIB **15** to 30 mins when Sleep Efficiency % \geq 85% but sleep need is not met

(Sleep Efficiency = Time in Bed/Time Slept)

↓ TIB by **15** to 30 mins when SE \leq 80%

Disadvantages of Sleep Restriction

- If a patient has an attachment to doing many activities (eating, arguing, reading, etc.) in bed, then the patient will need to redefine his/her relation to being in the bed (as with Stimulus Control Therapy). **May be major issue in MS patients**
- If the patient likes to have variable wake-up and bed-times, then this lifestyle may have to be given up. **Disability higher so less likely to have daytime schedule due to work**
- There will be a period of sleepiness in the early days of the therapy, so patient must be able to tolerate some discomfort for a later gain. **Fatigue high already with MS.**

April 2009

Sleep Restriction: Proceed with Caution!

- May be contraindicated in patients with history of mania, moderate to severe untreated obstructive sleep apnea, seizure disorder, parasomnias or those at significant risk for falls
- For MS patients recommend **Sleep Compression** – modified version of sleep restriction: Time in bed set at less than what pt is currently spending in bed, but more than actual amount of actual sleep

Sleep Hygiene Education

- Targets lifestyle and environmental factors affecting sleep
 - Not supported as stand alone treatment, often necessary but not sufficient
1. Exercise regularly but not too close to bedtime
 2. Make sure your bedroom is a comfortable (dark, cool, quiet)
 3. Avoid excessive liquids and heavy meals at night
 4. Cut down on caffeine and alcohol
 5. Don't take problems to bed
 6. Don't try or force yourself to fall asleep
 7. Turn the clock, so you don't see it
 8. Avoid naps
 9. Buffer zone before bedtime



Relaxation Strategies



Progressive Muscle Relaxation

Diaphragmatic Breathing

Visualization/Self-Hypnosis

Meditation

Biofeedback

Goal is to reduce or eliminate sleep-disruptive physiological and/or cognitive arousal

Cognitive Restructuring

- Identify, evaluate, and replace dysfunctional beliefs
- Targets
 - Unrealistic sleep expectations
 - Misconceptions about insomnia
 - Catastrophic thinking (losing job, health)
 - Helplessness/hopelessness
 - Performance anxiety

Cognitive Restructuring

Challenging Beliefs:

1. Is it 100% true you are not sleeping at all?
2. Is there evidence you can cope with sleep loss?
3. How does worry about sleep affect your chances of sleeping?
4. Are things improving or getting worse in the big picture?
5. Are there other things you can control that you are not thinking of in the moment?
6. Is there anything you can do to make being awake at night neutral or slightly pleasant?
7. What would you tell a friend in this situation?

Constructive Worry Activity

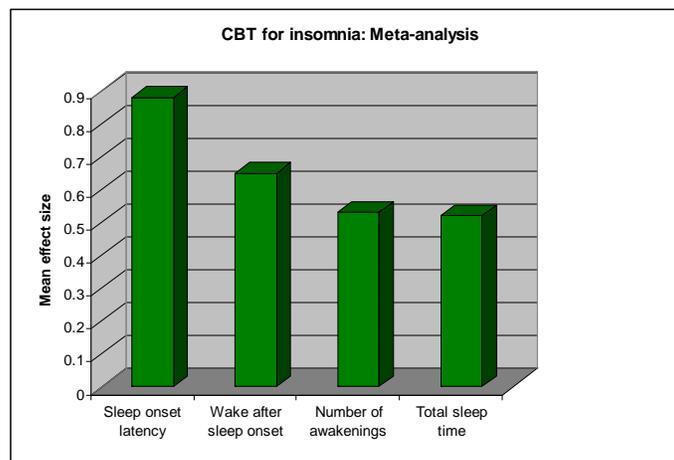
Worry

If I don't get at least 6 hours of sleep tonight I won't be able to function tomorrow

Action or Coping Plan

- Remind myself that despite my sleep problem, I have still been able to do my job well
- Recent feedback from supervisor has been positive despite insomnia
- I may feel tired and more irritable but I actually function relatively well on a few hours sleep

Efficacy of CBT for Insomnia



Generalizability of Outcomes

- Insomnia in primary care settings (Espie et al., 2007; Edinger & Sampson, 2003; Germain et al., 2006).
- Insomnia associated with medical (pain, cancer) and psychiatric (depression, substance abuse) conditions (Currie et al., 2004; Lichstein et al., 2000; Manber et al., 2008; Savard et al., 2005; Taylor et al., 2007)
- Insomnia in older adults (Lichstein et al., 2001; McCrae et al., 2007; Pallesen et al., 2003)
- Hypnotic dependent patients (Morgan et al., 2003; Morin et al., 2004; Soeffing et al., 2008)

Cognitive Behavioral Therapy for Insomnia

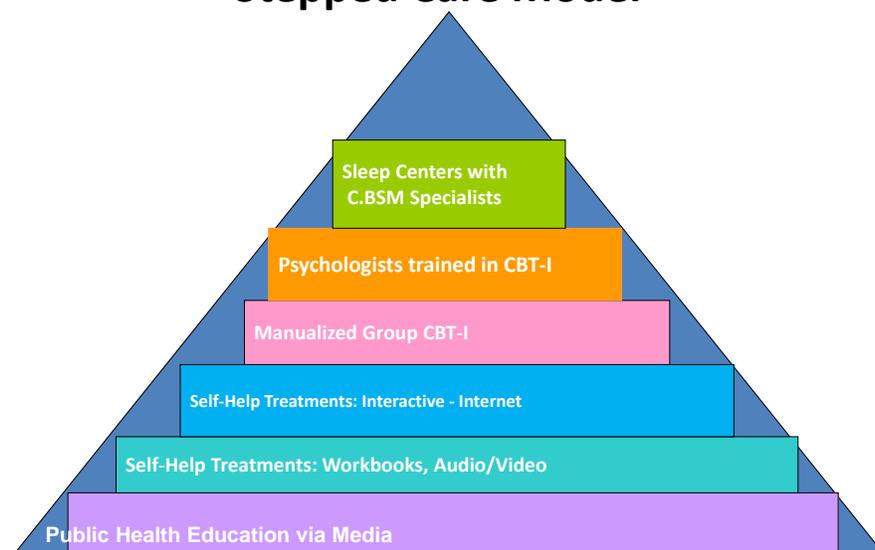
- Very effective for psychophysiological insomnia as well as comorbid insomnia
- Benefits outlast those of pharmacologic agents
- CBT-I is usually delivered by a therapist in 4-8, 50-60 minute individual sessions

Barriers to Treatment

- Unfortunately, majority of those suffering from chronic insomnia go untreated
- Most people who seek treatment are only offered prescription sleep medication
- Relative inaccessibility of CBT-I? – lack of awareness, not enough trained clinicians, lack of accessibility due to mobility, transportation and financial restrictions

CRITICAL NEED TO MAKE CBT-I MORE ACCESSIBLE TO
GENERAL PUBLIC

Taking a Broader Health Perspective: Stepped Care Model



Innovative and Cost Effective Strategies: Internet based self help programs

- Internet interventions have been based on well-established face to face cognitive behavioral therapy incorporating the primary components of treatment.

EFFICACY OF AN INTERNET-BASED BEHAVIORAL INTERVENTION FOR ADULTS WITH INSOMNIA

ONLINE TREATMENT OF INSOMNIA

Logging on for Better Sleep: RCT of the Effectiveness of Online Treatment for Insomnia

Study Objective: Despite effective cognitive behavioral treatments for chronic insomnia, such treatments are underutilized. This study evaluated the impact of a 6-week, online treatment for insomnia.

Design: This was a randomized controlled trial with online treatment and waiting list control conditions.

Participants: Participants were 118 adults with chronic insomnia.

Setting: Participants received online treatment from their homes.

Intervention: Online treatment consisted of psychoeducation, sleep hygiene, and stimulus control, relaxation, sleep restriction, and cognitive-behavioral therapy, cognitive therapy, and help with medication tapering.

Measurement and Main Results: Post-treatment, there was a 30% reduction in total sleep latency, a 30% increase in total sleep time, and a 30% increase in sleep efficiency.

Conclusion: Online treatment for insomnia is effective and well-accepted.

EVALUATION OF ONLINE CBT FOR CHRONIC INSOMNIA DISORDER

A Randomized, Placebo-Controlled Trial of Online Cognitive Behavioral Therapy for Chronic Insomnia Disorder Delivered via an Automated Media-Rich Web Application

Study Objective: Despite effective cognitive behavioral treatments for chronic insomnia, such treatments are underutilized. This study evaluated the impact of a 6-week, online treatment for insomnia.

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GO! to Sleep
Cleveland Clinic Wellness

Get Out of Bed, Sleepyhead



As you know by now, people with insomnia often spend a significant amount of time in bed not sleeping or getting poor-quality sleep. They often complain of not getting enough sleep — but, understandably, they don't necessarily want more of the kind of sleep they're currently getting. So what's the trick?

The first, most important step is to stabilize your sleep into a more reliable pattern. To do that, you have to practice sleep restriction. As I explained earlier in this lesson, sleep restriction consists of decreasing the amount of time spent in bed so that your time in bed matches the amount of time you actually spend sleeping. Once you've managed to do that, you can start extending your time in bed by 15 minutes each week, as long as you're actually sleeping during that extra time in bed. Don't worry — I won't decrease your "sleep opportunity" to less than four hours.

In order to extend your time in bed by those 15-minute increments, you must achieve an average sleep efficiency of at least 85 percent for one week. Sleep efficiency is the ratio of time you actually spend sleeping versus how much time you allow for sleep. For example, a person may allow for six hours of sleep but sleep only four and a half of those hours. That means the person is sleeping 75 percent of the time they're in bed trying to sleep.

As you can see, it's important that you allow enough time for sleep each night but not too much time. The amount of time you schedule for yourself in bed each night should fit your own current sleep schedule. To figure out the right amount of time for you to allow for sleep, use the information from your sleep log. Look at the Progress section to find the average number of hours you slept so far since the start of the program.

Even though the information is provided for you, I want to explain how it's calculated. To figure out your average total sleep time, you add up all the minutes you slept since starting the program (for our purposes, that equals 17 nights' worth of sleep). Next, you divide that number by 17. The result is your average total sleep time, per night (divide by 60 to convert the minutes into hours). Here's an example based on seven nights of sleep:

Lesson 1

- Sleep Basics
 - 1 Waking, From A to Zzzz
 - 2 Sleep: It's Not All a Dream
 - 3 Sleep Dissection 101
 - 4 Sleep is Not A Waste of Time
 - 5 Insomnia and its Causes
 - 6 Embrace Change
 - 7 Pills and the Snoozing Biz
- Lesson 2
 - 1 Lifestyle Habits & Sleep Hygiene
 - 2 The Practice of Relaxation
 - 3 Stop the Insomnia Train
 - 4 Grabbing Some Daytime Z's
 - 5 Blame Starbucks?
 - 6 Two Habits You'll Want to Quit
 - 7 Magic Foods & Exercise Myths
 - 8 Making Sleep a Routine Thing
- Lesson 3
 - 1 Stimulus Control & Sleep Schedule
 - 2 Are You Prone to Insomnia?
 - 3 Making Your Bed Equal Sleep
 - 4 Want to Sleep? Stop Trying So Hard
 - 5 Get Out of Bed, Sleepyhead
 - 6 Let Your Body Relax Your Mind

Go! to Sleep Features

- Designed as an alternative treatment strategy for caregivers to have in their toolbox for the treatment of insomnia
- Online sleep log, individualized feedback based on sleep log data so user can implement sleep restriction plan
- Access to downloadable audio recorded relaxation exercises
- Progress charts to track improvements
- Go to Sleep doc: new feature of physician portal to track patient progress/outcomes

GO! to Sleep iPhone App

Get GO! to Sleep on Your iPhone

Following the program is easier than ever with our smartphone app. You can log your sleep, track your progress and read daily tips no matter where you are.



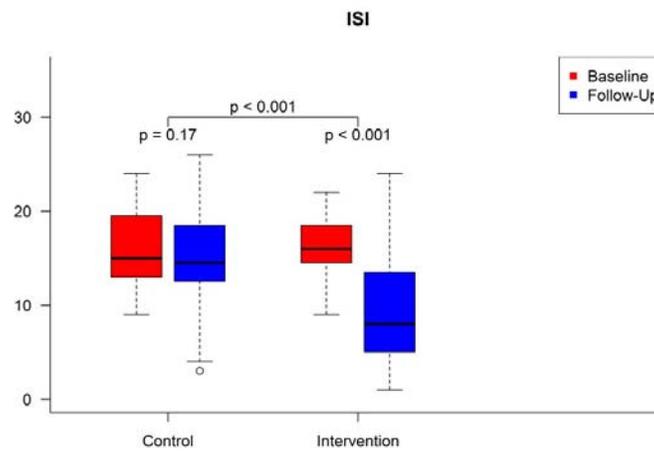
Web-based therapy for insomnia : A randomized clinical trial and observational cohort

- To investigate the efficacy of a web-based online CBT-I intervention via a randomized controlled trial
 - Primary outcomes: Change in Insomnia Severity Index (ISI)
 - Secondary outcomes: Pittsburgh Insomnia Rating Scale (PIRS) and Perceived Stress Scale (PSS)
- To examine the effectiveness of the intervention by testing its use in an open trial of participants with comorbid insomnia

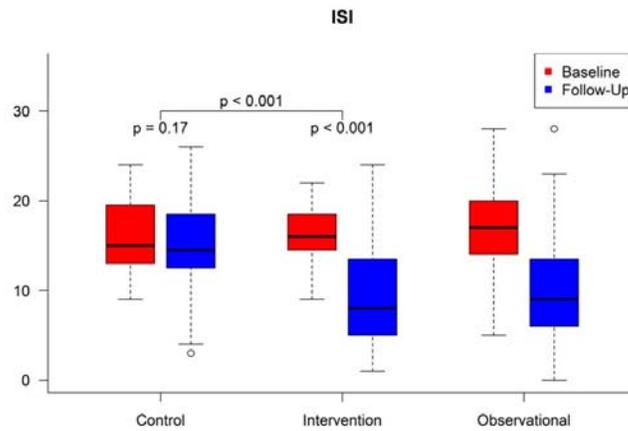
Abstract presented at Sleep 2014, submitted for publication

Adam M. Bernstein, MD ScD¹; Didier Alexandre, PhD²; Jonathan Doyle¹; James Bena, MS³; Gina Gendy, MD; Susan Fay; Lu Wang, MS³; Katrina Zell, MA, MS³; Reena Mehra, MD MS⁴; Douglas Moul, MD⁵; Nancy Foldvary-Schaefer, DO, MS⁶; Michael F. Roizen, MD⁷; and Michelle Drerup, PsyD¹

RCT Pre-Post changes: ISI scores



Pre-Post changes in ISI scores: comorbid insomnia group



Ongoing Research for Go! To Sleep

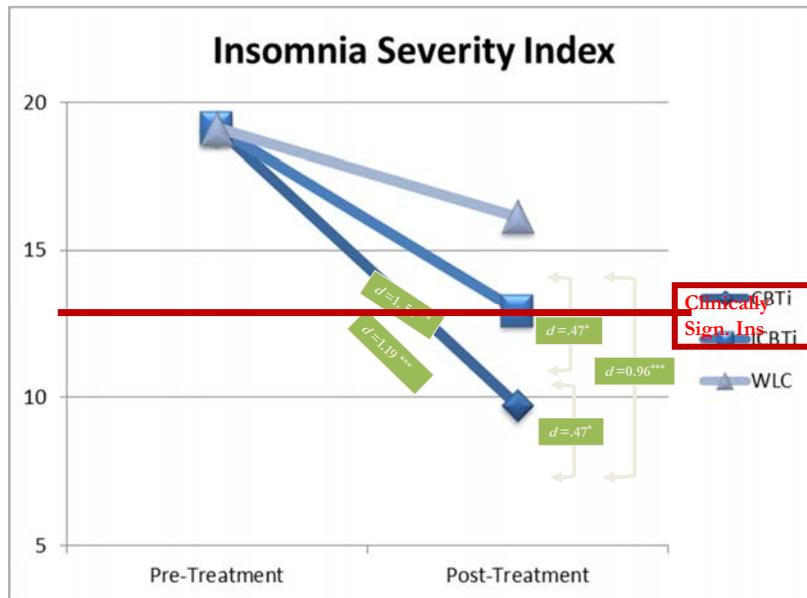
- Parkinsons Disease
- Post-partum women
- Cardiovascular risk
- High risk cancer population

CBT-I Group “Sleep Skills Group”



- 4 session CBT-I group therapy program for individuals with insomnia
- Group members provide social support and motivation for each other

MyCare Online - CBT-I online visits



Taylor, D.J., Peterson, A., Pruksma, K.E.,* Young, S., Mintz, J., the National Center for Telehealth and Technology, & the STRONG STAR Consortium (June, 2014). *Comparing Internet and In-Person Brief Cognitive Behavioral Therapy of Insomnia*. In D.J. Taylor & A. Peterson (Chairs) Cognitive and Behavioral Interventions for Insomnia in Military Populations. Symposium presented at the Annual Meeting of the Associated Professional Sleep Societies, Minneapolis, MN.

Efficacy of CBT-I in MS

- No studies (outside our retrospective study) have been done treating insomnia in MS patients
- Baron, Cordon, Jin & Mohr (2011) indirectly treated insomnia in 127 MS patients with depression
 - Used a 16-week CBT-based telephone therapy
 - Treatment including cognitive restructuring of depressed beliefs, increasing positive behaviors and stress management skills
 - Found a reduction in insomnia prevalence (≥ 3 times per week) from 78% to 43% at post-treatment
 - Improvement in insomnia related to decreased anxiety and depression

Case Example

- Tina is a 25-year old woman diagnosed with MS 2 years ago. Before being diagnosed she had her life ahead of her, with dreams and goals. Now, she can only manage 2 classes a semester in college and gets down about not being able to graduate for another 2 years. Overwhelming fatigue stops her in her tracks, and she is not involved in clubs and organizations like she used to be. The past 6 months she has had a lot of difficulty going to sleep, and lies awake in bed for 1-2 hours because of sharp pains in her legs.

Special considerations for insomnia treatment in MS

- Symptoms to keep in mind when treating MS patients:
 - Fatigue – common symptom complaint and very disabling
 - Urinary incontinence
 - Numbness or pain in limbs
- May be treating depression along with insomnia
 - Addressing irrational or unhelpful beliefs about insomnia and themselves, disease or functioning
 - Important to remember that fatigue may be related to depression

Practice Points for MS and Sleep Disorders

- Sleep disorders in MS patients are common compared to general population
- Sleep disorders may masquerade as complaints of fatigue – the most common and disabling symptom of MS
- As in the general population, insomnia in MS patients should be treated in a multi-faceted approach. The clinician must modify treatment based on other comorbid disorders.

Future Research and Clinical Considerations

- Evaluate utility and efficacy of stepped care approach for insomnia
- Does one size fit all? Additional efficacy studies on abbreviated CBT approaches in underserved populations (e.g., rural settings, community health centers, varied education levels)
- Consider complex comorbidities such as MS (physical and mental health problems)



Cleveland Clinic

Every life deserves world class care.



Common Questions and Concerns: Ask the Panelists

- Remember who you are as a provider, why you went in to this field to begin with
- Walking in the patient's shoes
- Understanding their fear
- Helping them create a better life

Could a Greater Miracle Occur Than
for Us to Look Through The Eyes of
Another for A Moment? Thoreau

- http://www.youtube.com/watch?feature=player_embedded&v=cDDWvj_q-o8

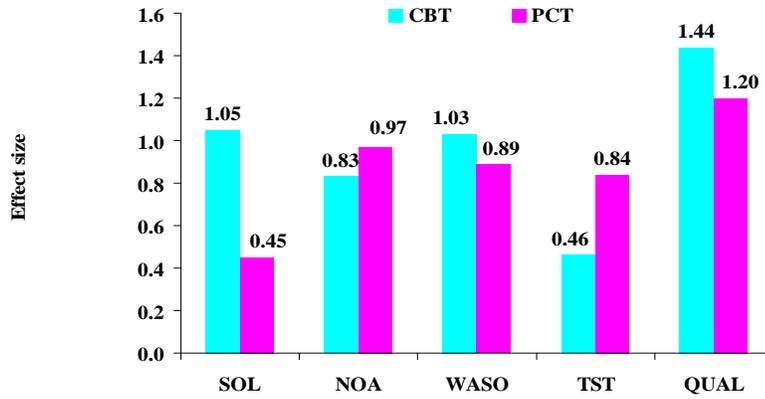
| @ Amy MB Sullivan, Psy.D. |
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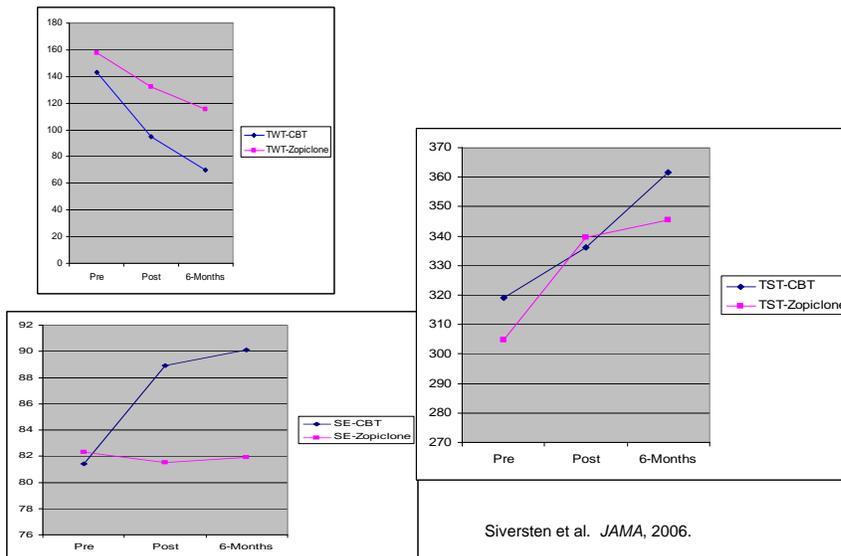
Every life deserves world class care.

How does CBT-I compare with sleep medication in the short-term?



Smith et al. *Am J Psychiatry*, 2002, 159; 5-11.

How does CBT-I compare with sleep medication in the long-term?



Siversten et al. *JAMA*, 2006.