Sleep Medicine and Psychiatry

Roobal Sekhon, D.O.
Common Diagnoses

• Mood Disorders:
  – Depression
  – Bipolar Disorder
• Anxiety Disorders
• PTSD and other traumatic disorders
• Schizophrenia
Depression and Sleep: Overview

• Depression is strongly associated with sleep complaints with up to 70% of patients reporting sleep complaints.

• Symptoms of depression are often bidirectional with sleep disorders.

• Depression is seen in 15-20% of patients in the United States.
Depression: Clinical Features

• Insomnia in depression often associated with early morning awakening but can be seen as middle of the night awakening, inability staying asleep or difficulty falling asleep.
• Greater association with suicidality when comorbid with insomnia.
• Insomnia can be a prodromal symptom and is often the last symptom to remit.
Depression: Clinical Features

• Hypersomnia seen in subset of patients.
  – High risk for depression when insomnia and hypersomnia are both reported.
• Often comorbid with OSA. Sleep disordered breathing symptoms can mimic depression.
  – 10-50% depending on the study/population.
• RLS symptoms can be precipitated by medications used to treat depression
Depression: PSG findings

• Increased REM sleep time, density and reduced REM latency.
• Decreased SWS in percentage and total amount.
• Decreased total sleep and fragmented sleep with prolonged sleep latency.
Depression: Effects of Therapy

• Most commonly used medications are serotonergic and noradrenergic.
• Medications often suppress REM sleep.
• Can worsen insomnia, usually not seen with TCAs, mirtazapine etc.
• Treatment of patients with OSA and depression with CPAP is often helpful in treating depression as well.
Bipolar Disorder: Overview

• Sleep Disturbance is a hallmark of bipolar disorder, particularly in the manic phase.
• Seen in approximately 3% of the population.
• May be triggered by sleep disorders and symptoms may be bidirectional as with depression.
• Substance abuse rates may be high.
Bipolar Disorder: Clinical Features

• Similar to depression in that insomnia is a common finding.
• However, hypersomnia, reports of excessive daytime sleepiness are more common in Bipolar disorder.
• Cardinal feature is the ability to maintain energy and wakefulness with little or no sleep during mania.
• Sleep disturbances often precede manic episodes
Bipolar Disorder: PSG Findings

- REM latency is increased and there is decreased overall time in REM sleep.
- Sleep onset latency and the number of awakenings after sleep onset are increased.
- Sleep efficiency is decreased.
- Slow wave sleep may be decreased in bipolar disorder.
Bipolar: Medications

• Therapy is done with various medications including mood stabilizers, antidepressants and antipsychotics.
  – Mood stabilizers generally cause sedation. Lithium can increase SWS, total sleep time and decrease REM.
  – Antidepressants are often stimulating and can trigger mania in patients who aren’t on mood stabilizers.
Bipolar: Therapy

• Treatment of underlying sleep disorders such as OSA, insomnia etc is helpful to the patient.
• Care should be taken in using bright light therapy as it may trigger a manic episode.
• Regular sleep wake cycles can be helpful in prevention of future manic episodes.
• Increased sleep time has been shown to be indicative of response to therapy.
Anxiety: Overview

• Anxiety disorders are very common and have a life time prevalence of 25-30%.

• Sleep disturbance is part of the criteria for generalized anxiety disorder.

• They also commonly co-occur with a variety of sleep disorders, particularly insomnia.
Anxiety: Clinical Features

• Cardinal sleep disturbance in GAD is difficulty falling or staying asleep, or restless, unsatisfying sleep.
• Nocturnal panic attacks can be seen in panic disorder.
• Anxiety symptoms may be the underlying cause in many insomnia patients.
• RLS and OSA are seen in higher amounts in patients with insomnia.
Anxiety: PSG Findings

• Increased sleep latency and wake time after sleep onset.
• Reduced sleep efficiency as well as reduced total sleep time.
• Sleep panic attacks often occur in NREM sleep in stage 2 or slow wave sleep.
Anxiety: Therapy

• The aim of therapy is generally to decrease arousal and medications acting on the serotonin, noradrenergic, histamine as well as GABA neurotransmitters are often used.
• Cognitive Behavioral therapy as well as other therapies are widely used.
• Therapy should be carefully selected, especially when taking into account interactions between other psychiatric and/or sleep disorders.
PTSD: Overview

• PTSD is almost always associated with sleep disturbances, particularly nightmares and insomnia.
• Lifetime prevalence of PTSD is 5-10%.
• Was previously grouped under anxiety disorders until DSM IV. Now under traumatic and stress related disorders in DSM 5.
• Substance abuse rates are high.
PTSD: Clinical Features

• In the DSM 5, sleep in PTSD is listed separately under 2 categories.
  – Alteration of arousal and reactivity: Sleep disturbance that began or worsened after the traumatic event.
  – Intrusive symptoms/re-experiencing: Nightmares.

• PTSD is associated with RLS as well as sleep disordered breathing at levels higher than the general population.
PTSD: PSG Findings

• PSG results in PTSD have been varied and at times contradictory.
• Increased REM sleep with increased REM density are often seen.
• Nightmares are more commonly REM related.
• Sleep latency, awakenings, efficiency, motor activity etc. generally needs more clarification.
PTSD: Therapy

- PTSD, particularly where nightmares are present, responds well to evidence based behavioral therapy.
- A variety of medications including antidepressants, prazosin, second generation antipsychotics etc have been used.
- Comorbid psychiatric, sleep and substance abuse disorders should be treated.
Schizophrenia: Overview/Clinical Features

- Schizophrenia occurs in about 1% of the population.
- Sleep disorders are common in schizophrenia.
- Sleep disturbance may be a trigger for agitated psychosis.
- Sleep disordered breathing is seen at rates higher than the general population.
Schizophrenia: Clinical Features

• Insomnia is common in patients in schizophrenia as are disturbed sleep wake cycles.

• Sleep hygiene is often poor in patients due to psychiatric as well as socioeconomic issues.

• Hypnagogic hallucinations and nightmares occur often in patients with schizophrenia.

• Substance abuse may play a role.
Schizophrenia: PSG

• Poor sleep efficiency with decreased total sleep time and increased sleep latency.
  – Associated with positive symptoms.
• Decreased REM latency.
  – Associated with increased symptoms and poor outcomes.
• Decreased slow wave sleep.
  – Has been associated with negative symptoms and poor long term outcome.
Schizophrenia: Therapy

• First and second generation antipsychotics are generally used to treat schizophrenia.

• Generally atypical (second generation) antipsychotics increase SWS as compared to baseline and 1st generation medication.

• Side effects of medications include weight gain, augmenting RLS symptoms or periodic leg movements.
Psychiatry and Sleep: Summary

- Significant overlap exists between sleep disorders and psychiatric illness.
- Bidirectionality is often present.
- Treatment of psychiatric illness requires consideration of comorbid sleep disorders and vice versa.
- Effects of psychiatric medications on sleep disorders should be considered when deciding treatment.