Sleep Disorders: A Major Factor in Psychiatry

Jan Fawcett, MD

Here's to a positive and meaningful 2015! This first *Psychiatric Annals* of the New Year, guest edited by Imran S. Khawaja, MD, FAASM, and Thomas D. Hurwitz, MD, quite appropriately features sleep disorders and the relationship to psychiatry. In the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*), sleep disorders have asserted their importance in psychiatry—perhaps more than ever before. This issue is a gem, in that it defines important sleep disorders for psychiatrists to identify. As will become clear, we need much more progress in the treatment of these disorders.

As a whole, the contributions take the position that sleep disorders should be considered complementary to psychiatric disorders, which often exist independently but contributing in a major way to coexisting conditions.

The first article by Susan Mackie, MD, and John W. Winkelman, MD, PhD, both from the Harvard Medical School, reviews "Insomnia"—a common condition associated with psychiatric disorders, particularly depression, schizophrenia, and panic disorder. They explain that patients with major depressive disorder (MDD) and schizophrenia, who also suffer from insomnia, are at a higher risk for negative outcomes such as suicide. Both panic attacks and severe insomnia have been found to be risk factors for suicide.[1] Unfortunately, most of our available pharmacologic treatments for insomnia are benzodiazepines or medications that affect the GABA receptors (gamma-aminobutyric acid-A); patients develop cross tolerance to these and now studies link their chronic use to the occurrence of Alzheimer's dementia.[2]

The next article on "Obstructive Sleep Apnea" outlines for mental health clinicians the importance of diagnosing this disorder. In our resident-teaching clinic at the University of New Mexico, we have seen two cases of "treatment-resistant depression" that remitted after the patient was referred for a sleep study, diagnosed, and successfully treated with continuous positive airway pressure treatment.

Elliot Kyung Lee, MD, FRCP(C), and Louis Kazaglis, MD, review the hypersomnolence disorders, noting that the *DSM-5* has changed to allow the diagnosis of these disorders in addition to psychiatric disorders. Lee and Kazaglis explain that narcolepsy is the first condition for which a laboratory measure—cerebrospinal fluid hypocretin—is a criteria for the diagnosis. Wow! How long have we been trying for that?

A behavior-rich series of sleep disorders, parasomnias, are reviewed by Michael J. Howell, MD, Khawaja, and Carlos H. Schenck, MD. Broken down into those occurring during rapid eye movement (REM), as well as non-REM disorders, these sleep emergent behavior ailments need to be diagnosed and managed.

The final article on restless leg syndrome, by Shehzad Niazi, MD, R. Robert Auger, MD, and Hurwitz, presents valuable information on approaches to treatment. This disorder is often missed in patients complaining of insomnia, so it is important to rule out in psychiatric patients.

We should be spending about one-third of our lives sleeping. In psychiatry, sleep disturbances are common, so it's important that we have the knowledge to diagnose these various disorders, treat who we can optimally, and refer patients when necessary for specialized treatment from a sleep disorders expert. If one can't get restful sleep, everything gets worse!

Jan Fawcett, MD, is a Professor, Department of Psychiatry, University of New Mexico School of Medicine. He was chairperson of the DSM-5 Mood Disorders Task Force.

Address correspondence to Jan Fawcett, MD, via email: psyann@Healio.com.

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