

Sleep and Psychiatry

ESRS Catalogue of Knowledge and Skills, Chapter L — revision summary.

Companion to the session Sleep Disorders & Psychiatry, covering the material beyond what 30 minutes allows.

Structure follows Penzel et al.

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The two-way question. Could this apparent psychiatric presentation be a sleep disorder — and could this sleep complaint be the first clue to psychiatric illness? Ask what does not fit a purely psychiatric formulation, and what does not fit a purely sleep-based one. **Before labelling the problem, name the symptom:** insomnia, sleepiness, fatigue, circadian delay and clinophilia are not interchangeable.

L1 · Overview and core principles

- The relationship is bidirectional and often reciprocal — treating one side alone may leave an important perpetuating factor unaddressed.
- Poor sleep worsens treatment response, relapse risk and distress across every diagnosis.
- Screen sleep routinely; do not dismiss it as a secondary symptom that will resolve with the primary illness.
- Every psychotropic prescription changes sleep/wake. Review diagnosis, dose timing, alcohol, drugs and withdrawal state.
- Match the investigation to the question, not to what is locally available.
- Give and document driving advice whenever medication, sleepiness or nocturnal behaviours may impair fitness to drive.

L2 · Substance use disorders

- **Insomnia predicts relapse.** In alcohol dependence, 60% relapsed at five months with baseline insomnia vs 30% without [1].
- **Alcohol** suppresses REM early in the night with later rebound; withdrawal brings insomnia, fragmentation and vivid dreams, and can mimic RBD.
- **Benzodiazepines and Z-drugs** — rebound insomnia on withdrawal; withdrawal may unmask RBD-like behaviour.
- **Opioids** — central sleep apnoea in around 24% of chronic users [2], plus nocturnal hypoxaemia and ataxic breathing.
- **Cannabis** — withdrawal insomnia and vivid dreaming, worst in the first week; often the reason for resumption.
- **Stimulants** — sleep-onset insomnia and reduced total sleep; withdrawal hypersomnolence.
- **Caffeine and nicotine** are routinely under-asked.

Ask: “What do you use to get off to sleep?” Treating the insomnia is relapse prevention, not a comfort measure.

L3 · Schizophrenia spectrum

- Sleep disturbance and circadian disruption are exceptionally common and frequently precede relapse; a usable early warning sign.
- Sleep disruption can contribute causally to paranoia and hallucinations, alongside other bidirectional mechanisms.
- Digital CBT for insomnia reduced paranoia and hallucinations in a trial of 3,755 participants [3].
- Weight gain on clozapine and olanzapine — screen for OSA, and reconsider if sedation does not improve.
- Antipsychotics may aggravate restless legs and periodic limb movements; akathisia and RLS are readily confused.
- Sedation is not treatment of insomnia.

Action: CBT-I is safe and effective in psychosis. Do not withhold it.

L4 · Affective disorders

Depression

- Insomnia is a risk factor, a symptom and the commonest residual symptom; it predicts relapse and independently predicts suicidality.

- **Occult OSA in treatment resistance.** Among 125 patients with depression, insomnia and suicidal ideation — deliberately selected as low probability for OSA — 14% had an AHI above 10 [4]. Sleepiness and insomnia did not predict severity.
- Hypersomnolence should prompt review for atypical depression, bipolarity and seasonal pattern.

Bipolar disorder

- Sleep loss is both prodrome and precipitant of mania [5] — a modifiable relapse pathway.
- **Reduced need for sleep is not insomnia.** The distinction is diagnostic and frequently missed.
- Regularising sleep timing is relapse prevention; sleep and circadian rhythm form part of the maintenance plan.
- Take care with bright light and wake therapy without mood-stabiliser cover.

L5 • Anxiety and trauma-related disorders

- Nightmares and insomnia commonly outlast the other symptoms of PTSD and need treating in their own right.
- **Image rehearsal therapy** is a recommended first-line psychological treatment [6].
- **Prazosin** — the 304-patient PACT trial found no benefit over placebo [7]. Evidence is weaker than the older teaching suggests; conditional at best.
- PTSD and OSA co-occur frequently, and CPAP adherence is lower — address both, and expect to support adherence actively.
- Distinguish nocturnal panic from sleep-related breathing events and from NREM parasomnia; the history of recall and timing separates them.
- Anxiety maintains insomnia through arousal, sleep monitoring and safety behaviours — all CBT-I targets.

Action: do not wait for the PTSD to resolve before treating the sleep disorder.

L6 • Other psychiatric disorders

- **Autism** — delayed sleep-wake phase is common. Timed light and melatonin before sedatives.
- **Intellectual disability** — OSA is under-recognised; behavioural change or daytime irritability may be the only presenting signal.
- **ADHD** — delayed phase, restless legs and sleep-onset insomnia are all over-represented; review stimulant timing before adding a hypnotic.
- **Eating disorders** — separate sleep-related eating disorder (impaired awareness, often on a Z-drug) from night eating syndrome (fully aware) and from nocturnal binge eating.
- **Dementia** — irregular sleep-wake rhythm and evening agitation; dream enactment points to a synucleinopathy.
- **Personality disorder** — nightmares and insomnia are common; sleep deprivation worsens affective instability and self-harm risk.

Five sleep disorders not to miss in psychiatric practice

Disorder	How it is mislabelled	What to do
OSA	Fatigue and poor concentration read as depression; treatment resistance	STOP-BANG (0–2 low, 3–4 intermediate, 5–8 high) — sensitive but poorly specific here. Screen mood separately with HADS. Treat, then reassess mood. A screening score supports risk stratification; it does not diagnose OSA or replace clinical judgement.
RLS	Akathisia, agitation, anxiety	Check ferritin and iron studies first. For chronic persistent RLS, alpha-2-delta ligands are generally preferred; if dopamine agonists are used, discuss augmentation and impulse-control disorders, including gambling and hypersexuality, which can be misattributed to mania.
RBD	Marital conflict, depression, or a benign antidepressant side effect	Confirm on PSG. Make the bedroom safe: remove weapons and sharp/heavy objects; consider separate sleeping, barriers or a mattress on the floor where necessary. In well-characterised idiopathic RBD cohorts, phenoconversion has been estimated at 6.3% per year and 73.5% by 12 years [8]. SSRIs may unmask or exacerbate dream enactment; do not assume medication association excludes clinically important RBD.
DSWPD	“Insomnia”, school or work refusal, oppositionality	Diary and actigraphy. Timed light and appropriately timed melatonin. Sedatives worsen morning inertia without correcting the clock.

Hypersomnia with psychiatric disorder	Narcolepsy, or dismissed as laziness	≥3 months of daily sleepiness with concurrent psychiatric disorder, other causes excluded. Beware over-reading actigraphy and early-onset REM. Extended PSG ± MSLT is more informative.
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Psychotropics and the sleep/wake system

Promote sleep — benzodiazepines and Z-drugs (GABA-A); melatonin; trazodone and mirtazapine (5-HT_{2A}, H₁); antihistamines and doxepin (H₁); quetiapine and olanzapine (H₁, α-1); prazosin (α-1); daridorexant and other DORAs (orexin).

Promote wakefulness — SSRIs and SNRIs; modafinil, amphetamines (dopamine, noradrenaline); atomoxetine; pitolisant (H₃ inverse agonist); caffeine (adenosine antagonist); nicotine and cholinesterase inhibitors.

Watch for — SSRI-associated dream enactment and periodic limb movements; aggravation of restless legs by antipsychotics, mirtazapine and venlafaxine; cumulative anticholinergic burden; and withdrawal states masquerading as new sleep disorders. Sedation at night is not the same as restoring sleep.

Commonly confused pairs — the distinctions to be able to make

Pair	How to tell them apart
Insomnia vs reduced need for sleep	Insomnia: wants sleep, cannot obtain it, distressed, daytime impairment. Reduced need: refreshed and energised on little sleep, no complaint — think hypomania or mania.
Sleepiness vs fatigue vs clinophilia	Sleepiness: falls asleep unintentionally, relieved by napping. Fatigue: lacks energy but cannot fall asleep when lying down. Clinophilia: takes to bed for comfort or withdrawal rather than to sleep.
RLS vs akathisia	RLS: circadian — evening and night, urge localised to the legs, worse at rest, relieved by movement. Akathisia: present through the day, dose-related, generalised inner restlessness.
RBD vs NREM parasomnia	RBD: second half of the night, dream narrative may be recalled, eyes closed, rarely leaves the bed. NREM: first third, confused and amnesic, may leave the bed and walk, usually no recall.
Nocturnal panic vs apnoeic arousal vs nightmare	Panic: abrupt, full recall of fear, no dream narrative, arises from NREM; co-morbid daytime panic symptoms are common. Apnoeic arousal: choking or gasping, repeated through the night, settles quickly. Nightmare: dream narrative recalled, usually from REM, later in the night.
Hypersomnia with psychiatric disorder vs narcolepsy type 2	Psychiatric: long but unrefreshing sleep, high time in bed, mean sleep latency often normal, subjective-objective mismatch. Narcolepsy: mean sleep latency 8 min or less with 2 or more SOREMPs; naps are refreshing.
DSWPD vs sleep-onset insomnia	DSWPD: sleeps normally when allowed its own schedule; difficulty only at conventional times; the delay is stable. Insomnia: difficulty initiating sleep regardless of timing.

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Diagnostic criteria follow ICSD-3-TR. This summary is a revision aid and is not a substitute for the primary sources. © D O'Regan, 2026.