

BSS International Sleep Medicine Course 2026

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Sleep Disorders & Psychiatry

ISMC, Newcastle, September 2026

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This session maps to Chapter L of the ESRS catalogue

Penzel T, et al. Sleep medicine catalogue of knowledge and skills – Revision. *J Sleep Res.* 2021; 30:e13394.

Conflict of Interest Disclosures for Speakers

X

1. I wish to disclose the following potential conflicts of interest:

Type of Potential Conflict	Details of Potential Conflict
Grant/Research Support	Idorsia
Consultant	Advisory roles: Redefining Education on Sleep Therapy; TIMES trial; British Association for Psychopharmacology (professional body)
Speakers' Bureaus	None
Financial support	Speaker honoraria: TEVA; Idorsia; Leith Healthcare; Neurodiem; British Association for Psychopharmacology (professional body). Travel and accommodation from the International Sleep Medicine Course for this presentation
Other	Director, Sleep London (independent sleep medicine practice).

X

2. This talk presents material that is related to one or more of these potential conflicts, and the following objective references are provided as support for this lecture:

1. Riemann D, et al. The European Insomnia Guideline: An update on the diagnosis and treatment of insomnia 2023. J Sleep Res. 2023;32(6):e14035.

2. American Academy of Sleep Medicine. International Classification of Sleep Disorders, 3rd ed., Text Revision (ICSD-3-TR). Darien, IL: AASM; 2023

3. Tang M, Shen Z, Yu P, Yu M, Tong X, Jiang G. Comparison of efficacy and safety of dual orexin receptor antagonists lemborexant and daridorexant for the treatment of insomnia: a systematic review and meta-analysis. Psychopharmacology (Berl). 2025;242(8):1693–1711.

Why this matters

Outcomes

Poor sleep worsens treatment response, relapse risk, and distress.

Recognition

Sleep problems should be screened routinely, not dismissed as secondary symptoms.

Prescribing

Psychiatric medication can worsen or unmask sleep disorders and sleep treatments can affect psychiatric symptoms.

Management

Effective care requires integrated assessment and treatment of both sleep and mental health.

**By the end: name the symptom, spot the five missed disorders,
and review medication and safety.**

A two-way diagnostic mindset

When psychiatrists should think sleep	When sleep physicians should think psychiatry
Could this apparent psychiatric presentation be a sleep disorder?	Could this sleep complaint be the first clue to psychiatric illness?
Have I distinguished insomnia, sleepiness, fatigue, and circadian delay?	Are mood, anxiety, trauma, psychosis, or neurodevelopmental factors shaping the presentation?
Could medication or substance use be driving the sleep complaint?	Are behaviour, beliefs, or avoidance perpetuating the problem?
What does not fit a purely psychiatric formulation?	What does not fit a purely sleep-based formulation?

The sleep complaint is rarely the whole story.

Beyond depression: psychosis, bipolar, trauma and substances

Condition	Sleep disturbance
Schizophrenia spectrum	Sleep disturbance and circadian disruption are exceptionally common and often precede relapse. Action: <i>CBT-I is safe and effective in psychosis; do not withhold it¹</i>
Bipolar Affective Disorder	Sleep loss is both a prodrome and a precipitant of mania² Action: <i>ask "do you need less sleep, or can you not get it?" Reduced need is not insomnia.</i>
Trauma and anxiety	Nightmares and insomnia commonly persist after other PTSD symptoms remit Action: <i>treat the sleep disorder in its own right; do not wait for the PTSD to resolve. Image Rehearsal Therapy first³</i>
Substances	Insomnia predicts relapse in alcohol dependence — 60% vs 30% at five months⁴ Action: <i>ask what they use to get to sleep. Treating the insomnia is relapse prevention.</i>

**Insomnia is not a footnote in any of these.
It predicts relapse; and treating it improves the psychiatric outcome.**

1. Freeman D, et al. *Lancet Psychiatry*, 2017
2. Lewis KJS, et al. *BJPsych*, 2017
3. Morgenthaler TI, et al. *J Clin Sleep Med*, 2018
4. Brower KJ, et al. *Am J Psychiatry*, 2001

Which sleep–wake system is this drug pushing, and what does that mean for the patient’s 24-hour state?

Review diagnosis, dose timing, alcohol, drugs and withdrawal.

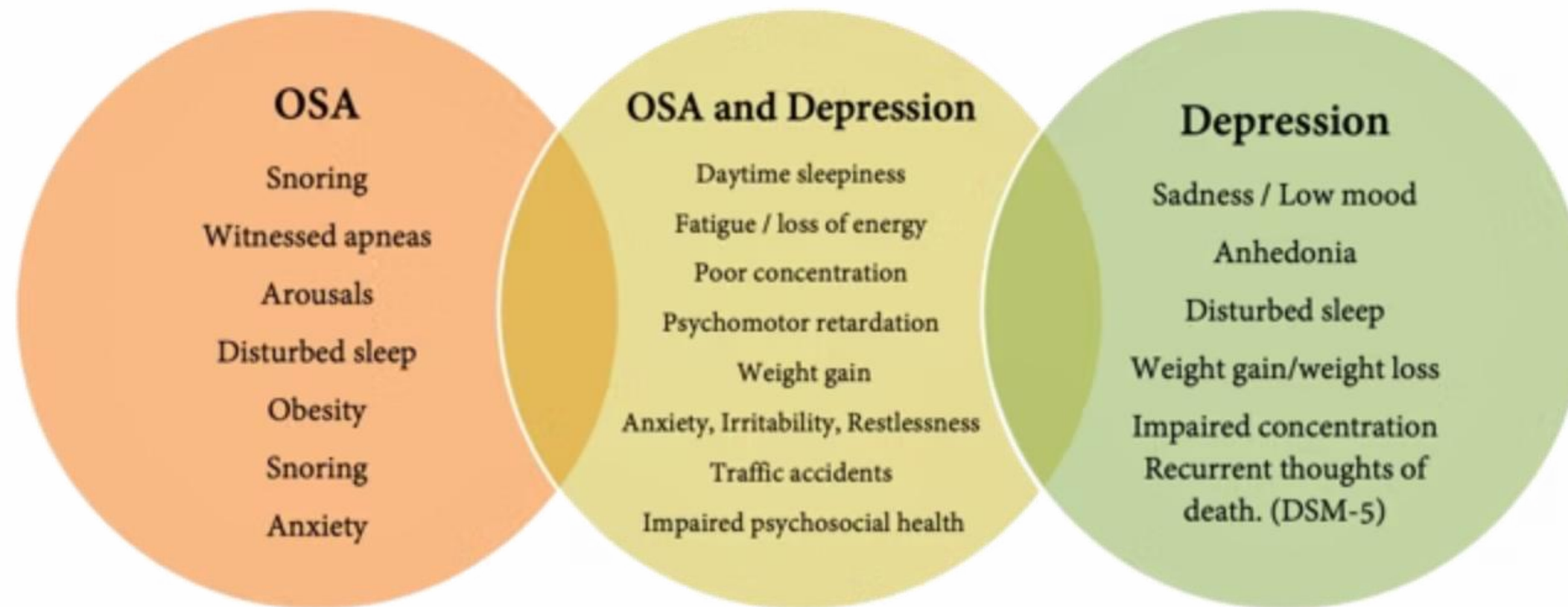
	Endogenous Neurotransmitter	Drugs promoting wakefulness	Drugs promoting sleep
Sleep promoting	GABA		Benzodiazepines, Z-drugs (e.g. zopiclone)
	Melatonin		Melatonin
	Adenosine	Caffeine (antagonist)	
Wake promoting	Noradrenaline	Atomoxetine, Amphetamines	Prazosin (antagonist)
	Dopamine	Amphetamines, Modafinil	Quetiapine (antagonist)
	Serotonin	Selective Serotonin Reuptake Inhibitors (SSRIs)	Trazodone, Mirtazapine, Olanzapine
	Histamine	Pitolisant	Antihistamines, Doxepin, Mirtazapine, Trazodone, Quetiapine, Olanzapine
	Acetylcholine	Cholinesterase inhibitors, nicotine	Tricyclic antidepressants, e.g. clomipramine
	Orexin		Daridorexant & other orexin antagonists

Review the timing of activating antidepressants individually.

Is this sleepiness, fatigue, depression—or all three?

OSA is common, masked by psychiatric symptoms, and often missed.

- OSA is associated with higher rates of depression, anxiety, and suicidality¹.
- Risk is especially high in psychiatric inpatients, people with intellectual disability, and those taking sedating medication^{2,3}.



Screen for OSA

STOP-Bang · 0–2 low · 3–4 intermediate · 5–8 high risk
Sensitive, but poorly specific in psychiatric populations

Screen mood separately

HADS⁴ · self-rated, quick, contains no sleep items
8–10 borderline · 11+ probable case

Then treat

Treating OSA may improve psychiatric symptoms, daytime function and treatment response⁵

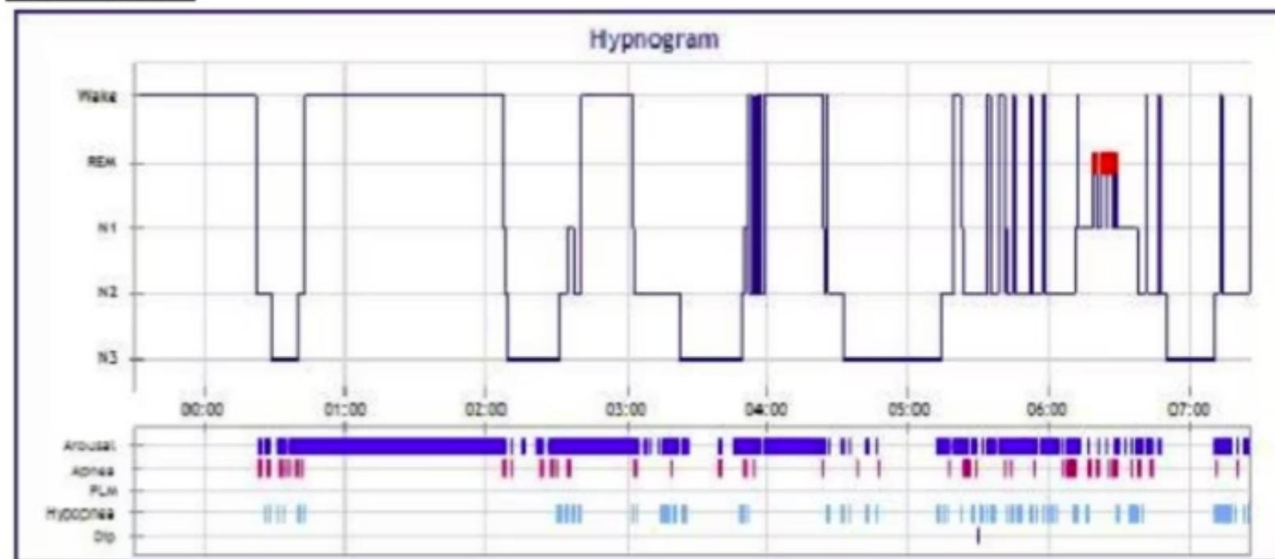
Use a validated OSA screen and a separate mood screen; do not assume one explains the other.

1. Mi C, Front Psychiatry, 2024
2. Knechtle B, J Clin Med, 2019
3. Riha RL, Thorax, 2024
4. Law M, J Clin Sleep Med, 2014
5. Colvonen PJ, Curr Psychiatry Rep, 2018

Case example: hidden OSA in resistant depression

- 51-year-old man referred from the National Affective Disorders Unit.
- History of treatment-resistant depression.
- STOP-Bang score: 6/8 (sleeps alone; not aware of snoring or apnoeas).

Hypnogram:



Apnoea Hypopnea Index (AHI) 36 events per hour; Arousal Index 47 events per hour.
CPAP led to depression remission



Journal of Psychiatric
Research
Volume 116, September 2019, Pages 147-150



Prevalence of obstructive sleep apnea in suicidal patients with major depressive disorder

William V. McCall^{a,*,} Ruth M. Benca^{b,} Meredith E. Rumble^{c,} Doug Case^{d,} Peter B. Rosenquist^{a,} Andrew D. Krystal^{e,}

- RCT of 125 patients with MDD with suicidality
- Selected for lowest probability of OSA (*exclusion*)
- 14% had significant OSA (*1 in 7*)
- Daytime sleepiness/insomnia did not predict OSA severity.

Screen independently of mood; neither insomnia nor sleepiness rules it out.



Restless Legs Syndrome (RLS) & Psychiatry

Is this RLS or medication-induced akathisia?



Aggravating Medications

Antipsychotics, some antidepressants (mirtazapine, venlafaxine), antihistamines



Suicide Risk

RLS severity correlates with deliberate self-harm and suicide risk



Psychiatric Comorbidity

Higher rates of anxiety, depression, PTSD in RLS patients



Clinical Strategy

- Screen for RLS before prescribing potentially aggravating psychotropics.
- Screen for mental health disorders before using dopamine agonists.
- Treating RLS may improve mild depressive symptoms.

Distinguish it from akathisia; check iron and review aggravating medication.

REM Sleep Behaviour Disorder (RBD) & Psychiatry



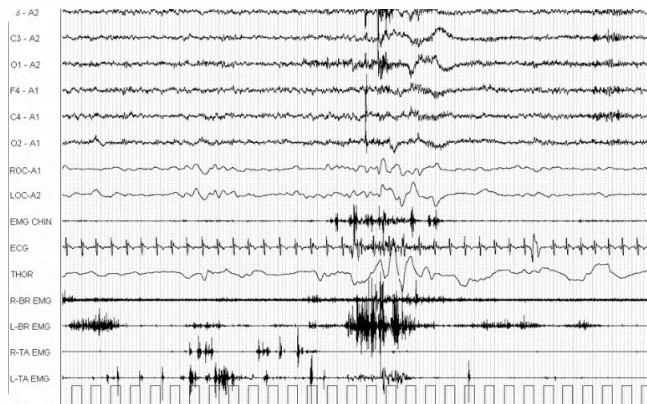
Loss of REM Atonia

Normal muscle paralysis during REM sleep is impaired



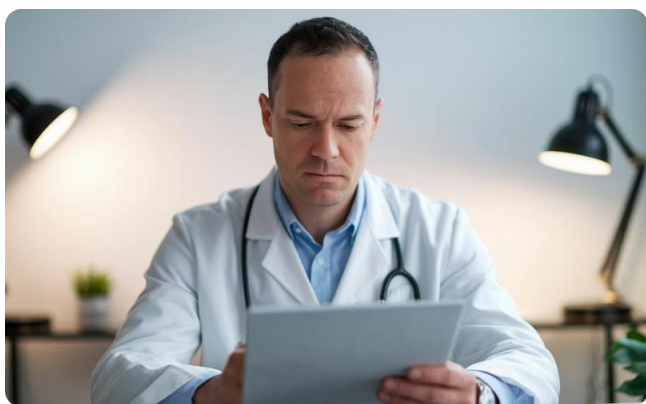
Dream Enactment

Patients physically act out dream content



Diagnostic Confirmation

Polysomnography shows REM without atonia



Prodromal synucleinopathy

6.3% phenoconvert per year; 73.5% by 12 years³

<i>If you see this</i>	<i>Do this</i>
OSA can produce RBD-like behaviour	Treat the OSA; behaviour may resolve
Alcohol or benzodiazepine withdrawal	Take a substance history before diagnosing
SSRIs can unmask subclinical RBD	Review; don't assume it's benign

Make the bedroom safe — sleep apart, mattress on floor, remove hazards
Follow up — monitor for parkinsonism and cognitive decline

Is this dream enactment, withdrawal, untreated OSA, or NREM parasomnia?

Dream enactment mislabelled as depression or relationship conflict

Patient Profile

Late 50s male accompanied by wife with two-year history of unusual sleep behaviours occurring in early morning hours.

Clinical Progression

Started with sleep talking, progressed to shouting. GP suspected depression; commenced Sertraline. Deterioration - arm and leg movements, never left bed but has fallen out. Recently wrapped blankets around wife and hit her repeatedly. Referred couples' therapy.

Patient Experience

No recollection of episodes but recalls vague dream of fighting intruders. Patient is distressed and mortified by his behaviour.

Treat dream enactment as a safety issue; exclude mimics and confirm vPSG.

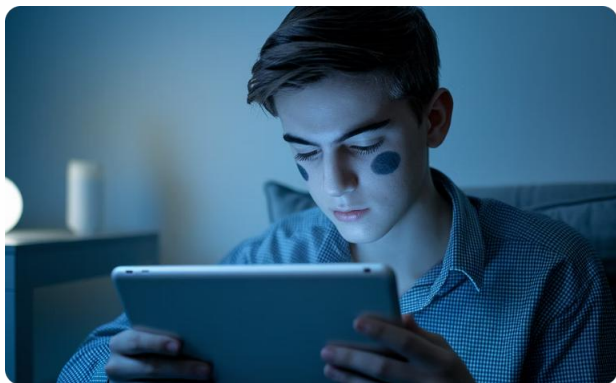
Is this insomnia, or a delayed biological clock?

DSWPD is common in adolescents, over-represented in autism, and often overlaps with psychiatric disorder.



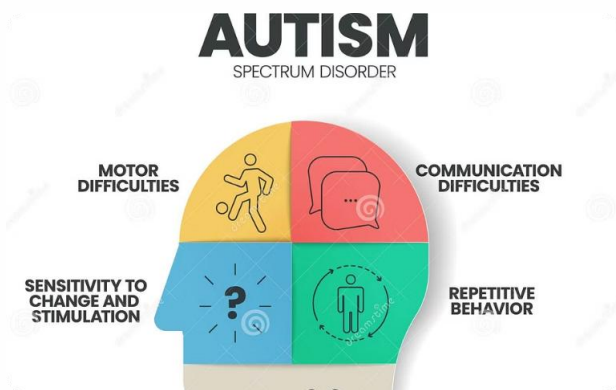
Delayed Sleep-Wake Phase Disorder (DSWPD)

Sleep timing is delayed relative to the desired schedule, causing sleep-onset difficulty at conventional bedtimes.



Adolescent Impact

Common in adolescents (1–16%); often worsened by screen use and behavioural change.



ASD Association

DSWPD is overrepresented in adults with ASD.

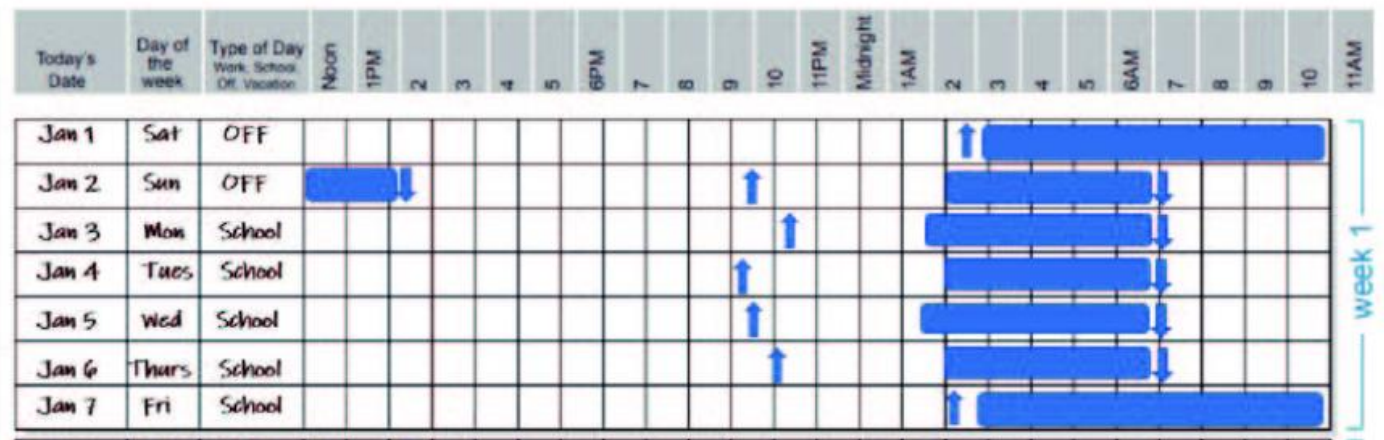


Psychiatric Comorbidity

About 70% of adults with DSWPD have a comorbid Axis I psychiatric disorder.

1. Narala B, Curr Opin Pediatr, 2024
2. Baker EK, J Autism Dev Disord, 2017
3. Futenma K, Front Psychiatry, 2023
4. Nesbitt A, J Thorac Disease, 2018

Case Study: DSWPD in ASD



Sleep Pattern

22-year-old with intellectual disability and ASD unable to sleep until 2am.

Consequences

Difficult to wake, missing daytime activities, irritable and hyperactive



Living Situation

Supported accommodation at risk due to nocturnal disturbance



Failed Interventions

Previous trial of sedating hypnotic was unsuccessful

Clue: Stable delayed phase on diary and collateral history; better function on a later schedule. Sedatives worsened morning inertia without correcting the clock.

Use a diary/collateral history; treat timing, not simply sleep onset.

Hypersomnolence Associated with a Psychiatric Disorder

Diagnostic Criteria: Requires ≥ 3 months of daily sleepiness, concurrent psychiatric disorder, and exclusion of other causes

Associated features:



Excessive Sleep Pattern

Long nocturnal sleep, daytime sleepiness, frequent naps, and non-restorative sleep.



Symptom Focus

Patients demonstrate excessive preoccupation with their hypersomnolence symptoms



Hidden Comorbidity

Psychiatric comorbidity may only emerge after repeated or prolonged assessment.



Functional Impact

Additionally: Poor attendance, social withdrawal, apathy, and low energy are common.

Differential: Depression (atypical); BPAD; SAD; functional/somatic disorders; trauma-related disorders; NDDs; schizophreniform disorders; PDs.

Practical Clinical Tips

Assessment & Language Considerations

- *Clarify the symptom:* is it sleepiness, and/or tiredness, and/or clinophilia?
 - Ask about psychiatric history, family history, prior psychotropics, and therapy.
 - Ask about alcohol/drug use.
 - Ask whether the patient links symptoms to mental health.
 - Screen with HADS and the Hypersomnia Severity Index.

Interpretation of Sleep Studies

- Be wary of over-interpreting actigraphy
- Be wary of over-interpreting early onset REM in the PSG
- *Extended PSG may be more useful:* e.g. 48-hour PSG with *ad libitum* sleep +/- MSLT

Clarify whether this is sleepiness, fatigue or clinophilia before interpreting sleep tests or settling on a psychiatric formulation.

What Changes Monday Morning?

Sleep and psychiatry are interdependent.

Look for the five misses.

OSA · RLS · RBD · DSWPD · hypersomnolence.

Name the symptom.

Insomnia, sleepiness, fatigue, circadian delay and clinophilia are different problems.

Review medicines and substances.

Sedation is not necessarily treatment.

Protect safety.

Driving, bed-partner risk and dream enactment deserve documentation.

Collaborate when it does not fit.

Treat sleep and psychiatric illness as interacting targets.

Thank You

*Sleep is central to psychiatry, and vice versa.
Treating the sleep complaint alone is rarely enough.*

❏ Questions?

