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12-1-2006

Preface to the Psychiatric Clinics of North American, 2006

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Recommended Citation
Doghramji, Karl, "Preface to the Psychiatric Clinics of North American, 2006" (2006). *Department of Psychiatry and Human Behavior Faculty Papers.* Paper 1.
http://jdc.jefferson.edu/phbfp/1

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The Sleep-Psychiatry Interface

Karl Doghramji, MD

Complains regarding sleep and wakefulness are commonly voiced by patients suffering from a wide variety of psychiatric disorders. It is not surprising, therefore, that sleep and its disorders are of great interest to psychiatrists. Historically, however, scientific interest in sleep was initially fomented by Sigmund Freud in 1900, when he advanced the notion, in *The Interpretation of Dreams*, that dreams are a window into the mysteries of the mind. Since then, dream analysis has played a central role in psychoanalytic technique. The search for a physiological basis for psychic phenomena led Hans Berger, a German psychiatrist, to record the first human electroencephalogram 1924. This was the technological foundation for the milestone discovery of rapid eye movement (REM) sleep by Aesrinsky and Kleitman in 1953. The subsequent surge in research into electrophysiological sleep, triggered by this discovery, further advanced the role of sleep as a probe into psychiatric phenomena. We now know, for example, that the sleep EEG of individuals suffering from major depression adopts characteristic and predictable patterns. Such findings have led to theoretical formulations regarding the pathophysiological underpinnings of affective illness.

The interface between sleep and psychiatric disease took on additional dimensions following observations that changes in sleep and wakefulness can independently predict psychiatric phenomena. Several longitudinal studies, spanning the course of up to 40 years, indicate that current and persistent complaints regarding sleep and wakefulness predict future vulnerability to psychiatric illness. A constellation of sleep EEG patterns

in healthy individuals identifies vulnerability for depression and, in prior depressives, predicts future relapse; the correction of these EEG abnormalities in depressed individuals by certain antidepressants predicts subsequent antidepressant response. Furthermore, certain behavioral manipulations of sleep have a positive impact on depressive symptoms, and the correction of sleep abnormalities with certain hypnotic agents in depressives receiving antidepressant treatment can impart benefit for depressive symptoms above and beyond the benefit derived from treatment with antidepressants alone. Disturbances of sleep and wakefulness can no longer be viewed, therefore, solely as symptoms of, and markers for, psychiatric disease. Rather, the results of decades of research, along with emerging data, support the additional viewpoint that they can be independent contributors to psychiatric phenomena, related to psychiatric illness in a bi-directional fashion.

That sleep disturbances can be primary is highlighted by the fact that the recently introduced International Classification of Sleep Disorders, Second Edition, lists more than 80 primary sleep disorders, many of which feature psychiatric symptoms. The understanding of these conditions is, therefore, of crucial importance to psychiatrists. The clinical evaluation and treatment of these disorders is the professional focus of thousands of sleep medicine physicians, many of them also psychiatrists. Sleep medicine is now an accepted medical subspecialty, and all diplomats of the American Board of Psychiatry and Neurology are eligible to complete training and become board certified in this field.

The goal of this edition of the Psychiatric Clinics is to explore the multifaceted interface that exists between sleep and psychiatry, one that has been shaped by decades of research and clinical experience. We begin with a review of the neurophysiology of normal sleep and circadian rhythms. We then examine the sleep-related symptoms most commonly encountered by psychiatrists, insomnia and excessive sleepiness. We then elaborate upon commonly encountered sleep disorders that present with psychiatric symptoms, and specific psychiatric disorders that feature disturbances of sleep and wakefulness. We explore how sleep disturbances are affected by gender and age. Finally, we speculate as to how the future will define the multifaceted interface that exists between sleep and psychiatry.

I am indebted to the contributing authors of this edition. Many are luminaries in their individual areas of research and clinical work. Without them an edition of this scope would have been impossible. I am also grateful to my family, Laurel Jeanne, Mark, and Leah, for their loving support.