Testing for Sleep-Disordered Breathing in Psychiatric Practice: Don't Sleep on It!

To the Editor: I wholeheartedly endorse Benca and colleagues' conclusion, in their recent review on obstructive sleep apnea (OSA) in psychiatric practice,[1] "Clinicians should not assume that all sleep-related symptoms are consequences of psychiatric illness or medication but should instead be cognizant of the potential for coexisting OSA that requires treatment." This view aligns with our 2002 hypothesis-generating review that challenged the nonspecific terminology "psychiatric insomnia" or "insomnia related to another mental disorder" for its failure to consider nosologically defined sleep disorders.[2] From the mid-1990s to early 2000s, my colleagues and I observed extensive, objectively measured, physiological sleep quality disruptions in psychiatric patients presenting with psychological sleep disorders, insomnia, or nightmares. Hence, Dr Christian Guilleminault and colleagues[3] as well as our research team published on 4 chronic insomnia patient cohorts totaling 703 adults, of whom 603 were objectively diagnosed (n = 427) or presumptively diagnosed (n = 176) with sleep-disordered breathing (SDB).[2] In earlier times[4] as well as more recently, several research groups[5-8] have observed high SDB prevalence among patients presenting with chief complaints of insomnia.

In 2003, our new center specializing in sleep disorders treatment for mental health patients was acutely exposed to the frustrating problem of continuous positive airway pressure (CPAP) failure. Like others, we presumed novel and intrusive stimuli of mask and pressurized air caused psycho-physiological maladaptation, largely aggravated by somatosensory amplification, not to mention the disincentivizing emotions of embarrassment and shame frequently triggered in psychiatric patients. Subsequently, we developed PAP-NAP procedures to create a systematic desensitization to mask and pressure for anxiety, depression, and posttraumatic stress disorder patients with coexisting insomnia or nightmares. The PAP-NAP approach was beneficial for many patients.[9]

Through the 2000s, we turned toward physiological disturbances caused by CPAP, primarily expiratory pressure intolerance (EPI), and observed how this uncomfortable, unpleasant stimulus carried an outsized clinical impact on CPAP failure with its notable associations to excessive sleep stage shifts, sleep fragmentation, lack of REM consolidation, and unresolvable respiratory effort-related arousals.[10] To address these objective changes due to EPI, in 2005 we transitioned virtually all of our PAP patients to bilevel mode, and by 2010 auto-bilevel mode, and finally by 2012 roughly two-thirds of our patients used auto-bilevel and one-third used ASV (adaptive servo-ventilation).[11] Research followed, demonstrating how advanced PAP technology rescues CPAP failure cases, improves outcomes, and increases adherence.[12–14] Recently, a randomized controlled trial proved ASV significantly and clinically superior to CPAP in treating chronic insomnia, yielding nearly thrice as many insomnia "cures," based on Insomnia Severity Index (ISI) scores (mean exit ISI with ASV = 5.89 vs CPAP = 10.19; ISI "cure" cutoff = 8; $P = .01$).[8] Although the total sample was small (n = 40), limiting significance findings, large effect sizes for ASV were demonstrated within-group compared to small-medium effects for CPAP on 3 validated scales measuring fatigue, quality of life, and daytime impairment, plausible outcomes consistent with growing evidence that independent sleep disorders therapy improves mental health.[14]

In sum, in our clinical experiences SDB is widespread in psychiatric patients and should be screened at intake; unfortunately, all such instruments were designed for classic sleep apnea and yield high false negative rates.[9] Our recommendation since 2005 assumes "guilty until proven innocent" with regard to the presence of SDB, as we test greater than 90% of mental health patients who present with a complaint of chronic insomnia or nightmares. It is our opinion that failing to test led many psychiatric patients to suffer inordinate harm for a decade or longer when pharmacotherapy remained their only sleep option.[15]

As we concluded in 2002 and now 21 years later, I would ask 2 questions: (1) In non-urgent cases, would it be advisable to objectively assess sleep and respiration prior to prescribing sedatives or sedating psychotropic medication? and (2) What are the potential liability issues that might arise when insomnia patients with SDB do not receive appropriate diagnostic testing?[2]

It is our belief that patients seeking sleep treatments from mental health professionals deserve answers to these questions.

Barry Krakow, MD

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Author Affiliations: Sleep Research, Sleep & Human Health Institute; Director of Sleep Medicine, Psychiatry Residency Training Program, Gateway Behavioral Health; and Department of Psychiatry and Behavioral Health, Mercer University School of Medicine, Savannah, Georgia.

Corresponding Author: Barry Krakow, MD, 211 Early St, Savannah, GA 31405 (bkrakow@sleeptreatment.com).

Relevant Financial Relationships: Dr Krakow recently published a book, *Life Saving Sleep: New Horizons in Mental Health Treatment.* He owns and operates the website www.barrykrakowmd.com, which offers sleep coaching services, training resources for sleep professionals, and books and videos for the treatment of sleep disorders.

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