Buproprion, however, tends not to have this effect and indeed appears to be an effective treatment for PLMs.

Summary

Mood disorders and depression in particular, are associated with insomnia and hypersomnia. In vulnerable individuals problems sleeping should be noted; enabling better sleep can bring significant relief and help cope with the illness.

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Sleep and Depression

Canadian Sleep Society

Sleep disruption is a very common finding in patients with psychiatric difficulties. A large community study found that a much higher proportion of people with insomnia or hypersomnia (sleeping more than usual) have a major psychiatric illness when compared to people who do not have these sleep complaints. Furthermore, when someone has insomnia early in life he or she is more likely to develop depression in later life. Over 70% of patients who are acutely ill with a psychiatric condition have insomnia and unfortunately the sleep disruption may not improve even when the illness is in remission.

Do psychiatric disorders cause sleep disorders?

There is no doubt that sleep disruption often appears when a psychiatric illness develops. This is not surprising since the increased arousal and anxiety that often accompanies such illnesses will make it more difficult to sleep. However, there is evidence that the opposite may be true, that is, insomnia may trigger psychiatric illness or make someone who is vulnerable more likely to have an episode of illness. It may be the case that mental health and sleep are controlled by common brain mechanisms. When these mechanisms are altered or become disrupted, both sleep problems and psychiatric illness may occur.

How do mood disorders affect sleep?

Depression is the most common mood disorder. Approximately 1 in 4 women will suffer from an episode of depression at some time during their lives. The number for men is less but a significant proportion will also suffer from this condition. An episode of major depression is diagnosed when there is a history of feeling sad or not being able to enjoy things as much as usual for at least 2 weeks (often it is much longer than this). This feeling is accompanied by several other symptoms such as having difficulty paying attention and concentrating; loss or significant increase in appetite; insomnia or hypersomnia; having recurrent thoughts about wishing that one were dead or thinking about ending one's life; not being able to get pleasure out of things previously found pleasurable.

What causes depression?

There are likely many causes. One is a genetic vulnerability. A strong history of depression in a family increases the likelihood that one will have a similar condition. Depression can also result from certain medical conditions such as hypothyroidism, stroke, head injury and HIV. There is evidence that ongoing sleep disruption contributes to depressed mood. Certain medications, for example prednisone and interferon, are known to cause depression. One's social situation is another important factor, for example, if one is living in poor housing with little income and few social supports, or in an abusive relationship, then there is an increased risk for becoming depressed.

What happens to sleep during depression?

Insomnia co-occurs with depression more than with any other illness, either medical or psychiatric. Sleep disruption (insomnia or hypersomnia) is one of the symptoms that is used to determine whether or not someone is depressed. It is often one of the first signs of an episode of depression, often preceding the onset of low mood and dissatisfaction in people who have recurrent depression. Typically, people have difficulty getting off to sleep, have many awakenings across the night and awaken in the very early morning and cannot get back to sleep. They feel very tired in the daytime and this makes the other symptoms of depression difficult to tolerate. There are some people for whom depression results in them sleeping much more than they normally would. When the sleep of people with a depression is recorded in the sleep clinic, we find that they have a delay in falling asleep, less deep sleep and poor sleep quality. They often have more REM sleep (rapid eye movement sleep, which is when dreaming occurs) and it occurs earlier in the night.

How is the sleep problem in depression treated?

The main focus of treatment must be treating the underlying condition, namely the depression. This is done through the use of antidepressants and/or psychotherapy. There are many antidepressants available nowadays and most people are able to find adequate relief from their difficulties. The response to an antidepressant varies greatly from person to person. There are certain antidepressants that almost always make one sleepy and the doctor treating a patient for whom insomnia is a problem may choose one of these in order to help treat the sleep problem. Some doctors, when starting an antidepressant, may also give the patient a short-term supply of a sleeping medication such as zopiclone or lorazepam (especially when anxiety is also causing difficulties). Such medications should be used in the short-term only and should be discontinued when the depression starts to respond to the antidepressant. There is no doubt that enabling someone to sleep if they have been depressed and not sleeping well for some time, can bring significant relief and helps them cope with their illness and even get better.

Psychotherapy is another effective way of treating depression. Whenever someone is very depressed, the doctor will usually encourage the use of antidepressant medications first as it can be difficult to take advantage of therapy when one is feeling so low. Psychotherapy can be long-term, looking at the factors from the past that may have resulted in or made one vulnerable to depression, or short-term, focusing more on the current situation and teaching one strategy to deal with the negative thoughts that often accompany depression.

As mentioned above, it may be the case that sleep may not go back to "normal" even when the depression has improved. It is important to pay close attention to sleep hygiene factors, such as eliminating caffeine and keeping a regular sleep-wake schedule. Learning and practicing relaxation strategies can be very beneficial. It may be helpful to do some therapy, such as cognitive behavioural therapy, aimed specifically at treating the insomnia. The more one can work on such strategies when one is well the easier it will be to put them into practice should the depression recur in the future. When there is a history of depression alterations in sleep may signal its recurrence. Getting the insomnia under control as soon as possible will likely improve the course of the illness. Given the strong associations between sleep disruption and depression, it may even be worth considering restarting treatment for the depression at this point before it advances to a higher level of severity.

Do antidepressants affect sleep?

Most antidepressants change sleep. As noted above, some such as mirtazapine are beneficial in that they are sedating and they can, therefore, be taken at night to treat insomnia. Some antidepressants, for example buproprion, often make one feel more alert and awake. Hence, they are useful when the patient suffers from hypersomnia. Some people find it is more difficult to get to sleep, and complain of sleep disruption, when they first start taking the medication. These disruptive effects usually last for 4-6 weeks and if they persist another medication should be tried or a sleep-promoting agent added.
The recording of sleep in the sleep clinic shows that antidepressants have the greatest effect on REM/dreaming sleep, decreasing the amount. Patients sometimes notice that they dream more vividly after starting an antidepressant and in rare cases, nightmares can be problematic. Excessive dreaming may occur during withdrawal from an antidepressant.

Unfortunately, antidepressants can cause or worsen restless legs syndrome, periodic leg movements (PLMs) during sleep, and sleep bruxism (teeth-grinding), often resulting in fragmentation of sleep.