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# MAKING SLEEP A PRIORITY

Making sleep a priority is a mental health care necessity.

At every level in South Africa, we need better public education and awareness regarding good sleep, bad sleep and sleep disorders. Public policy and societal change are at stake here, as are organisational performance markers, productivity and educational implications. Research has unequivocally quantified that excessive daytime sleepiness, as a consequence of sleep deprivation or sleep disorders, leads to compromised performance, mood degradation and mental health disorders, increasing suicide risk (e.g. anxiety, depression and stress disorders).

Social withdrawal and interpersonal conflict are also common outcomes. The converse is also true. Mental health illness can be the precipitator. Fatigue is an adjunct disability, linked to functional disorders and chronic medical illness, yet frequently is the consequence of a perfectionistic ideology, perpetuating neglected sleep.

Sleepy drivers are a hazard on our roads compromising alertness. Add alcohol or drugs to the mix and the potential for fatal accidents rises. On the one hand, undiagnosed psychiatric illness increases risk factors for sleep disorders, yet on the other, medication prescribed for illness, may exacerbate drowsiness and compromise sleep, if not timed correctly. These considerations must be consciously and responsibly managed by health care practitioners. A diagnosis of severe daytime sleepiness is enough justification to pull drivers off the roads and pilots out of the sky. There are currently such policies in place after much work from experts and global recommendations.

Sleep is both physiologically restorative (cell rejuvenation, growth, healing) and neuroprotective. The recently discovered glymphatic System, or 'brain garbage disposal unit', is proposed to clear macroscopic waste such as soluble proteins and metabolites out of the central nervous system during sleep. The flow of cerebrospinal fluid and interstitial space increases, washing away harmful waste for excretion.

Biologically, sleep is an instinctual need and fundamental to physiological survival. Whilst a vast amount of the population require a total sleep time of 7.5-8 hours, on either side of this norm are the rare population of short sleepers (5-6 hours) and the long sleepers (9-10 hours). Famous individuals, such as Churchill, boasted a maximum of four hours, but failed to share the 2-3 hour nap he had in the afternoons! Sleep-need and age is different.

Longer sleep in adolescents, allows developmentally appropriate growth acceleration and frontal lobe maturation. Physiological markers such as circadian rhythm regulate sleep consolidation.

Coupled with total sleep need, is the chronotype entrenched in each sleeper. The early bird person versus the late night, owl person. are refined by brain systems, hormones, neurochemicals, light and dark, environmental cues and individual lifestyle generating and modulating peaks and troughs of alertness. Optimal competency for an early bird is in the earlier part of the day, preferring an earlier bedtime, whereas

a night owl often peaks much later in the morning and can work late into the night. This phenomenon should determine daily routines and has the potential to drastically impact on productivity, learning, exercise times and quality of life. Individuals who care for their sleep are acutely aware of this sleep-phase typology and adjust their lifestyles accordingly to optimise health and daytime alertness.

The current facts surrounding adolescent-young adult sleep need are important considerations:

- A natural 'phase delay' occurs with sleep onset around 10-11 pm
- Sleep need averages around 8-10 hours
- Teens tend to have irregular sleep patterns typically staying up late and sleeping late on the weekends and during holidays, which can affect their sleep phase and degrade the quality of their sleep. If extended, a full blown sleep disorder can be created (Phase Delay Syndrome), making it impossible to function in the mornings and cause social, occupational and interpersonal difficulties
- Sleeping appropriately will facilitate attention, concentration, new learning, memory and stress responses
- Teens must be evaluated for sleep disorders

Sleep and cognition are closely related. It follows that sleep is protective for learning.

Considering the above it seems highly pertinent that policy for education in high schools should be evaluated in relation to sleep. A simple step to start school at 8.30 am instead of 7.30 am (recommended by the American Academy of Sleep Medicine), may have far reaching consequences for academic achievement. Sleep has been traded for academic success. Some countries have implemented these strategies, reporting decreased rates of depression and increased academic success in students.

In my experience, nothing has caught the public eye and generated conscious awareness (and panic) of the importance of sleep, as much as the papers purporting that poor sleep could lead to Mild Cognitive Impairment (MCI – a precursor to dementia) and dementia/Alzheimer's. Studies suggest a link with fragmented sleep and poor disposal of amaloid metabolites in Alzheimer's disease, suggesting the glymphatic system may be compromised in this population. Furthermore, rumours that the use of hypnotics could lead to dementia (studies needing further replication) abound. I noted an influx of people with sleep disorders (particularly insomnia disorder) to my practice soon after this research was made public.


Perhaps fear of degrading temporally to a state of extreme mental incapacity, may have woken up the nation to the brevity of neglecting sleep? I hear people bragging about how they get by with very little sleep. Perhaps it is time to stop wearing sleep deprivation like a badge of honour? I can also attest to the fact that many healthy high functioning young adults view sleep as a time waster, later 'hitting the wall' (burnout). After years of poor sleep practice, they may require extended admission for psychiatric illness, leave from work, and begin a long, slow journey back to health, simply because they didn't prioritise sleep. I propose this is a sleep disorder in itself, likened to an eating disorder (starvation). Likewise, neglecting sleep problems when psychiatric illness is the root cause, or simply prescribing hypnotics without a proper sleep evaluation, is also neglectful.

Behavioural treatment, particularly for insomnia should be the first line of treatment according to a white paper released by the USA College of Physicians in 2018. Working collaboratively in a multi- disciplinary team will increase the likelihood of good outcomes.

Mental health practitioners must prioritise opportunities to get our nation sleeping well. Firstly, by practicing what they preach and secondly, by seeking training and supervision in standards of practice for sleep medicine and concomitant treatment protocols. Changes in sleep are frequently a precursor to neuropsychiatric illness. Teaching people how to sleep well, not just by reciting sleep hygiene, but by working with the dysfunctional belief systems perpetuating poor initiation and maintenance of sleep, is the key to altering perceptions of sleep. The care of a patient should be a 24-hour sleep-wake priority, with both equally weighted. The narrative of the patient, describing their measure of distress, and their lived experience of the sleep struggle, is as important as symptomatology.

Matthew Walker delivers a message right to heart of any nation in the conclusion to his book *Why we sleep* (2017; ISBN 978-0-141-98376-9):

I believe it is time for us to reclaim our right to a full night of sleep, without embarrassment or the damaging stigma of laziness. In doing so, we can be reunited with that most powerful elixir of wellness and vitality, dispensed through every conceivable biological pathway. Then we may remember what it feels like to be truly awake during the day, infused with very deepest plenitude of being. MHM

***References available upon request***