Interview

EMJ had the privilege of interviewing Hugh Selsick, who provided valuable insights into the complex interplay between sleep and psychiatric disorders, while also spotlighting innovative approaches for diagnosing and treating these conditions.

Hugh Selsick

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Q1 You have obtained a BSc in physiology, a BSc Honours in experimental physiology, and an MBBCh degree. How has your educational background shaped your career and passion for sleep medicine and psychiatry?

My science degrees were pivotal in fuelling my passions and setting out my career path. During my undergraduate physiology degree, I also did 1 year of archaeology, 1 year of zoology, and 2 years of psychology. These courses expanded my view of the world in a way that the very focused medical degree could not. But my science degrees also determined my trajectory in a more direct way: our physiology department had a sleep laboratory, and I signed up to be a subject in an experiment they were running. Whilst I was being wired up, the head of the laboratory told me about the different stages of sleep, and some of the sleep disorders. From that moment, I was absolutely hooked. I took a year out of medical school to do a postgraduate degree in physiology, where I was able to work in the sleep laboratory, and the rest of my training was always geared towards a career in sleep.

The higher training for psychiatry in the UK helped immeasurably, as we were given time each week to attend special interest clinics, which allowed me to work in sleep clinics and build my experience.

Q2 As the Chair of the Sleep Group, a special interest group in the Section Neuropsychiatry at the Royal College of Psychiatrists (RCPsych), can you detail the objectives and activities of this group?

I started the group after attending the American Psychiatric Association (APA) Conference in Toronto, Canada, in 2006, where there were numerous sessions on sleep, and they were all completely packed. Yet, when we ran a single sleep session at the RCPsych Conference in London, UK, only 15 people attended. I realised that there needed to be more awareness of sleep issues amongst psychiatrists, so I set up the sleep special interest group with the aim of raising awareness of sleep and sleep disorders amongst psychiatrists. We do this through webinars, contributing to college Continuing

Professional Development programmes, running sessions at congresses, and linking people together. Whether through our efforts, or a general increase in interest in sleep in our society, we have seen many more psychiatrists getting involved. The next time we ran a sleep session at the RCPsych conference, the hall was so full they had to turn people away, and we had to run the session a second time!

Q3 You are the lead clinician at the Royal London Hospital for Integrated Medicine, and the University College London Hospital's (UCLH) Insomnia Clinic, UK. Can you outline the clinic's approach to treating insomnia? Are there any innovative techniques or treatments used to combat this common sleep disorder?

All the patients who come to the clinic get a full sleep history taken. This is vital, as many patients who present with a complaint of insomnia turn out to have a different sleep disorder, such as restless legs, obstructive sleep apnoea (OSA), or a circadian rhythm disorder. Most patients with insomnia will go on to have group cognitive behavioural therapy (CBT) for insomnia, online or in person. For those patients who do not make sufficient progress with CBT, we may use medication or other psychological and behavioural interventions. For example, we are just starting to use intensive sleep retraining, and are also trialling a technique called heart rate variability coherence training, which has a small evidence base for use in insomnia but is very quick to deliver. We also do imagery rehearsal therapy for nightmares, and CBT for sleep paralysis.

Q4 You also used to practice in the Sleep Disorders Centre at Guy's Hospital, London, UK. What was your role at this centre, and how does it differ from your role at the aforementioned clinics?

At the Sleep Disorders Centre at Guy's Hospital, I saw a wider range of sleep disorders, with many more patients there suffering from narcolepsy, parasomnias, etc. But the most common condition I saw and treated was OSA. I often joke that I may have looked in more throats than any other psychiatrist in Britain! But treating OSA can be very rewarding, as the improvement in symptoms can be almost instantaneous.

> "I realised that there needed to be more awareness of sleep issues amongst psychiatrists."

Q5 Having specialised in insomnia and the relationship between sleep and psychiatric disorders, have there been any recent breakthroughs in these areas? Could you highlight any emerging research findings that show promise in improving patient outcomes?

There is a growing body of research demonstrating the bidirectional relationship between sleep disorders and psychiatric

disorders. What has become clear is that we should not view sleep disorders, and insomnia in particular, as a symptom of psychiatric disorders, but as a treatable risk factor for psychiatric illness. Also, there is evidence that where there are comorbid sleep and psychiatric disorders, treating the sleep disorder leads to improvements in the psychiatric condition as well.

"Sleep medicine is one of the last genuinely multidisciplinary fields."

Q6 Sleep disorders can have a significant impact on an individual's mental health and overall wellbeing. Based on your experience, can you spotlight any approaches that have proven to be most beneficial for your patients?

Ultimately, it depends very much on the sleep disorder. There is no question that CBT for insomnia markedly improves people's sleep and mental health. It is also critical to treat nightmares where they occur as, of all the sleep disorders, nightmares carry the highest suicide risk. Imagery rehearsal therapy and medications with α1 blocking properties are also very effective. I think it is important for prescribers to understand the role of centrally acting neurotransmitters in sleep-wake regulation, and the pharmacology of the drugs they are prescribing. This is to ensure that they select and time medications in a way that improves, rather than harms, a patient's sleep. For example, when treating a patient with insomnia and depression, one can choose an antidepressant that will treat both conditions, reducing the number of medications the patient requires.

Q7 Could you highlight the key challenges you have faced when diagnosing sleep disorders, particularly insomnia? How have you overcome these challenges?

The biggest challenges are lack of time and diagnostic resources. Teasing out whether a person has insomnia or a circadian rhythm disorder, for example, can take some time, a resource in short supply in the National Health Service (NHS). Technology has made it easier for us to get some patients to fill in questionnaires and sleep diaries before their appointments, which helps. Technology is also helping to tackle the problem of limited inpatient diagnostic resources, as we are now able to do more home studies, particularly when screening for OSA. Finally, better education on sleep medicine amongst referrers would be useful, so they can refer patients to the most appropriate service for their particular condition.

Q8 What are some points of emphasis you would recommend to healthcare professionals to be successful in specialising in sleep medicine and psychiatry?

I think to be a psychiatrist you have to be comfortable with uncertainty. We do not have any specific diagnostic tests for the conditions we treat, and we can never truly be confident about our risk assessments, even though this is a significant element of modern psychiatric practice. In sleep medicine, the best advice I can give is that there is no substitute for sitting in on as many clinics, with as many colleagues as possible. Sleep medicine is one of the last genuinely multidisciplinary fields of medicine. Observing how patients with sleep disorders are managed by neurologists, psychiatrists, respiratory physicians, otorhinolaryngologists, etc., will give you a whole range of different perspectives that will extend your knowledge beyond your own speciality.