Project Sleep Podcast
"Untangling Sleep, Anxiety and Depression with Dr. Harris"
(Sleep Insights Series Episode 7)

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The Sleep Insight Series invites listeners to learn about this amazing adventure we take every night called sleep. Through these insightful discussions, we examine sleep, and our societies beliefs about sleep, from a variety of angles. We hope you'll learn some cool new facts and analogies that you can use to help us raise awareness about this under-appreciated one third of our lives. This is a written transcription of the podcast "Untangling Sleep, Anxiety and Depression with Dr. Harris" (Sleep Insights Series Episode 7) from Project Sleep. Transcription provided by Mirela Starlight.

Project Sleep is a 501(c)3 Nonprofit Organization, dedicated to raising awareness and advocating for sleep health, sleep equity and sleep disorders.

All guests and speakers express their own opinions. While medical diagnoses and treatment options are discussed for educational purposes, this information should not be taken as medical advice. Each person's experience is so unique, which is why it's so important to always consult your own medical team when making decisions about your own health.

Julie in intro: How do you know if you're having an occasional bad night's sleep, or an actual sleep disorder? And how do you untangle anxiety, depression and insomnia? In today's podcast, I speak with Dr. Shelby Harris, a clinical psychologist, behavioral sleep medicine specialist, and the author of "The Women's Guide to Overcoming Insomnia".

Julie: Hello everybody! I'm so excited because we have a very special guest with us, Dr. Shelby Harris. Hi Shelby, hi Dr. Harr—

Dr. Harris: Hi Julie! Thank you for having me, I'm excited to be here.

Julie: So I think to get started, this question that always kind of— something I'm always trying to think about, is how do we get people that don't yet know that they could have a sleep condition, how do we get them to know that? Because I know so many of the people that are probably tuning in, went years.
Um—

Dr. Harris: Yeah.

Julie: — like myself, where I thought I had a problem with my willpower, or I wasn't like meant for law school, 'cause I just couldn't seem to stay awake during the reading— and it seemed like it was just part of, a problem with me— before I realized it was a sleep issue, for so many years. And so, how do you know whether it's kind of like, a small problem— an occasional bad night's sleep, versus maybe something bigger?

Dr. Harris: Okay. So, I think that's a complicated question in that I think the first thing is that we need to at least— more and more physicians and doctors in general, need to be trained in sleep medicine or just recognizing sleep disorders. We think about it— primary care, they're taxed. They have so much that they're asking in just a general appointment, that sleep usually is at the bottom— and it's often if someone has their own complaint about sleep, they bring it up. And sometimes it doesn't get brought up because now with billing and everything it's just super fast with insurance— so, it's not the first thing people bring up. So we need to get doctors asking about it a little bit, or a lot more. And recognizing when things might be— recognizing just different disorders. Like you said with narcolepsy, narcolepsy is 15 years for average diagnosis, for a long time. Getting better, because people are learning more about it. But we need to be better still.

Dr. Harris: Now, with insomnia for example, I also— and any kind of sleep disorder, actually. Really it should be first of all, your Spidey sense. So if you feel that something is off, like you were saying— something is possibly off. Like you know your baseline, and if you feel like this is a continuous issue that keeps going— for a number of weeks, a number of months, and it's not getting better no matter what you do, usually the first thing we always try is basic sleep hygiene right. So make sure you're getting enough sleep, make sure you're not having a lot of alcohol, all that basic stuff. If that's not getting better and it's starting to impair your functioning, or it's happening multiple days a week, right— so consistency— so three or more days a week you're having some sort of issue with excessive sleepiness or you're not sleeping enough, and that's going on for a number of weeks, say a month or more— that's when you want to talk to a doctor. So a lot of people that I see will say, well I have a bad night here and there. I have a bad night here and there, that doesn't mean you have chronic insomnia. But if you have insomnia or hypersomnia, whatever the issue is, but it's happening multiple days of the week for a few weeks if not months or more, talk to your doctor. And if your doctor brushes it to the side, that's when that Spidey sense that I was talking about is like, there's something off. This is not my baseline. Maybe it's a sleep disorder. Maybe it's something else. Maybe there's some other deficiency going on— maybe it's diabetes, who knows. But talk to your doctor and if you feel like you get brushed off, go talk to someone else. You really need— you know yourself best.

Julie: I forgot to ask you also, how you got interested in sleep. I meant to start there. How did you get here, where— you know.

Dr. Harris: Okay, so it started at Brown. So Brown, yay—

Julie: Yay!

Dr. Harris: —has an awesome, awesome sleep researcher there. Which I didn't appreciate how amazing she was. Mary Carskadon. So I just sort of audited her class, I didn't actually take the

class (laughs) audited it. And I really just, it was sleep 101. It was like basic sleep. And I just thought it was really interesting. And then when I went to graduate school, or actually before I went to graduate school, I worked at the Brown med school for a year and I did addiction work. So I worked at the med school, going to rehabs— for people who were in rehab for alcohol issues. And what we did was we treated their insomnia— while, it was with medication approach, it was using trazodone. But we treated their insomnia while they were in rehab, and then we looked at— their sleep issues and if their sleep issues were well maintained, we found that people actually didn't have as much relapse with their addiction. Because they were sleeping better. So one of the big reasons that people will often relapse, initially, is because they're not sleeping. They start using substances again to go back to sleep. So if you treat the insomnia first, they actually start sleeping better. And that's when it made this thing go off in my head saying wow, such a small change— it's not that small— could make a change in someone's whole life. And that's when I started to really get interested in sleep even more, because I saw like what sleep could do for someone's whole life. And so going to graduate school I did my dissertation on it. And then I went to Montefiore and I worked in the Sleep-Wake Disorders Center, where Michael Thorpy and Neda Mosakhani who does a lot— who did a lot of narcolepsy work— they both trained me and really let me see the patient as a whole— and I had my own little carved out niche there, and I just fell in love with it and I've stayed with it forever because there's something about when someone's sleep gets better you see how much more it improves their life. So I love it.

Julie: Mmm. Hopefully more people will feel that way. I wish I'd taken a sleep class at Brown, like oh man I could've saved myself a few years. 'Cause I would've learned about narcolepsy probably, and cataplexy, and maybe I would've— but I was in the art history building, just all art history classes, and— avoiding all science, so.

Dr. Harris: I was a music major, mostly. I was a psychology major a little bit, and then— at the beginning, I finished that major— and then I actually played the upright base and I was like, orchestra and everything. But I just took the sleep thing just on the side, as for— random. Yeah, I've totally fell into it, and I'm so grateful— that I've kind of fallen into it a few times, that then it led me to the Sleep-Wake Disorders Center in Montefiore and then really solidified my love with it.

Julie: That's so cool. Okay, so, we need to have our Spidey sense up, and hopefully you know I think that is just really empowering, it's always empowering to hear a doctor say— if someone, if one doctor tells you, like kind of ignores you, to go to another. Because somehow that still feels like you're doing the wrong thing, and so, thank you for saying that because that's just really empowering. At any point of your journey, really.

Dr. Harris: 100 percent. And I try to educate my patients a lot, that I work with, when they're going to various physicians, and physicians are great! But, you have to advocate for yourself too. So if you feel like something's off, some of my patients are afraid to speak up sometimes, so I work with them on, okay, what are the issues that you're noticing are happening, let's make sure that you're at least communicating it, that you're not afraid to communicate it— because it might actually be received fine. But if it's not received well or it's brushed off, then let's talk about what the next step is for you to do.

Julie: Mm-hmm. So you've done a lot of media and education work. More than most sleep doctors and I really, really value that, because you're actually talking to the public. (laughs) You

know? So how did you get into doing that, and what do you feel like— you know, I just find it fascinating 'cause I think even just working with the media, and narcolepsy, I often have to be educating them about what narcolepsy really is. You can't just assume that they know, even if they do a little bit of research, so. I'm just interested about why you got into that area, and then what's your experience been like.

Dr. Harris: It totally fell in my lap, so when I got to Montefiore, Dr. Thorpy had done— he was a pretty, he's— very well known in the field. And he had started at— I'm trying to remember. He was doing like the Donahue show, if people— anybody remembers Donahue— he was like doing—

Julie: Yes!

Dr. Harris: —Donahue, and (laughing) all these things. 'Cause he'd been at the sleep center since the '80s or early '80s. So he was doing that stuff. All the media stuff. And when I came on, he saw that I was passionate, that I like to— I like to talk. And he was like, you know what? We had a PR department at Montefiore and they sent us sleep requests all the time from the media, and he was, at some point he was like, I'm done. I don't want to do this anymore. And he sent them to me! And it's interesting— I don't know, I just had a proclivity towards it, and then the more I started doing them, I didn't need the requests from Montefiore, it's just, you know, things live on on the internet. So then a reporter might just search for sleep doctor, or whatever, and then it just spiraled from there. I personally love it— 95% of the time— because I can clarify things, a lot of the things I get are more like, pop kind of psychology stuff like, "If you sleep in this position what does it mean about your personality?" Like that sort of stuff and then I can just kind of be like, listen I don't really do any of that, and there's no data behind it. So I can push that stuff to the side and I can kind of pick and choose. But I do it mostly because I want to educate people. So I'm very passionate about— insomnia, narcolepsy, what are the different treatments? I want people to learn that not everything is necessarily a medication— or that medication is the right approach. And the other thing I'm really big on is like trying to get people to just recognize if they have apnea, 'cause that's huge. And so many people just— have no clue about it. So, if people can at least have some awareness, to maybe bring it up to their doctor, that's— it's a win in my book, for doing all that media.

Julie: How did you ultimately decide— Shelby recently published a book—

Dr. Harris: 2019, it feels like—

Julie: Oh, yeah.

Dr. Harris: — end of 2019, I've lost track of time.

Julie: "The Women's Guide to Overcoming Insomnia". And— I was just curious, you know, taking on a book is a big deal. (laughs) Having done one, myself. And so you thought, when you looked into the future and said, I want to do this— how did you decide to take the approach of a women's guide and also insomnia?

Dr. Harris: So, the publishing house had approached me and said, we're interested in having you write a book about whatever you want. And I said you know what, I want to do something that talks to the public more so, than maybe an academic sort of book. So that's where I narrowed it down first, and I said insomnia's something I do day in and day out with that sort of treatment. And then they said but you need, try to have some niche. And then I thought about like, what is the majority of patients that I see? And I was like, women. And it's interesting when I was writing the book, over what, 2017, 2016— there was a little bit of research for women in insomnia, but it hadn't really exploded. Over the past year, now everything's like women and insomnia, women and insomnia— it really wasn't as big of a thing five years ago, six years ago when I started working on it. So I had some research and I was just like, you know what, I have so many women that either muscle through, they end up coming to me because this has been going on for 10 years and they powered through because they had no time to put themselves first, or they figured, you know what, this is normal, I shouldn't be sleeping anyways. Hormones are a problem, all these other issues. Or they put everyone else first, like not even just putting others first, they just at night would do everything else and not prioritize their sleep. And so I just felt like it was a niche area that I could speak to, also having a 10 year old and a five year old myself. So I know— and being in my 40's. I know what the hormones and all that stuff— so it really just spoke to me. And it's spoken to a lot of people, I'm really glad that it's been so well received.

Julie: So I think that one of the interesting things that I became educated about through your book is kind of the connection between anxiety, depression and insomnia. Tell us a little bit about that.

Dr. Harris: So, with the way we think about insomnia in the field, is the most traditional way. There's a newer way of thinking about it, is that there can be something that sets off anxiety, something that sets off depression. An event— the pandemic, who knows whatever it could be, it could be a medical diagnosis. It could be a good stress sometimes. But oftentimes there's things like depression, anxiety that are starting to happen. And then when you start to feel depressed or anxious you might start to have some sleep problems on top of that. And what happens is when you start having some sleep problems, because you're feeling down, a lot of people will— who are anxious, they find that they can't turn their brains off at night, or they wake up really early and their brains are— going like this. Or people who are depressed sometimes will just lay in bed ruminating a lot, or just nap a lot during the day and have trouble sleeping at night. At the beginning, yes the depression anxiety might really be fueling the insomnia. But what happens is, after a few months, all the behaviors that you start doing, like sleeping in or going to bed too early, or for people with insomnia, napping, which is totally different from say narcolepsy. Caffeine use, sleep aids, you know all that sort of stuff, that's actually stuff that's maintaining the insomnia for a lot of people.

Dr. Harris: So, what we try to do, what I try to do and what my book focuses on, is treating the things that people are doing— I want to say that it's an issue with common sense, so it's all the things that you're doing that are common sense to try and catch up on sleep. Worrying about it, going to bed early, sleeping in, whatever. That's the stuff that's actually getting you in trouble, more so. More than maybe the initial depression or anxiety that started it. So we try to treat them almost as two separate issues. So depression, anxiety with one treatment. Insomnia, very focused, behavioral— some cognitive treatment on the side. And that actually works very well. The problem is a lot of people have this assumption and— people still in like psychiatry, still have this assumption that, well just treat the depression. Treat the anxiety. And their insomnia or sleep issue— we see this with nightmares too— we see this across the board, a lot— their other

sleep issues will get better. But the reality is, the sleep issues don't usually get better, for many people— they're sort of this residual thing, because they didn't get targeted separately. So, really if you find you're in treatment for depression, treatment for anxiety, that's wonderful. Keep doing that, but if your insomnia's not getting better, really think about seeing someone for a targetted treatment to help it in that respect.

Julie: It's so interesting, thank you for sharing all that. I just feel like, I don't know— obviously it's not my personal experience, but I know other people that do have insomnia. Now, so many people, you talk about— I mean obviously you're a behavioral specialist and I know that's one of the areas where studies have shown consistently that the behavioral— cognitive behavioral therapy for insomnia is more effective long term, or as effective, or more long term than—

Dr. Harris: As effective initially, than most sleep aids— most sleep aids. But it shines long term. That's really— yeah.

Julie: How do you manage in a world where— knowing that so many people are going down sort of the medication path— maybe, I don't know if it's true, at a primary care level, so that primary care doctor feels empowered to treat it with sleep aids but then I guess that's maybe for some people short term, but then so many people end up taking those long term.

Dr. Harris: Yeah, I mean I think again it's complicated, but a lot of it— first of all CBT for insomnia, the behavioral— cognitive behavioral treatment. It's the first line treatment, by both the American Academy of Sleep Medicine and primary care society. So it's really should be the first line treatment. But there's a few issues. One there's not a lot of me— people who are true specialists in the field, there's some people who are like, say they do it here and there. But there's not a lot of people who are really specialists in CBT for insomnia, so a lot of primary care doctors have no idea what you're referring to. There are apps, there's books, there's stuff that's good to start with. But it's also education of the docs— so some docs just don't know about CBTI. Some docs know but patients who aren't sleeping are so— especially if it's a new onset sort of thing, they're so distraught by it a lot of times, that I don't blame the doc! They want to help their patient feel better. Right, so there's some of that pressure there too. And it's hard nowadays right, to say refer to me, and there might be a long waitlist some weeks, you know it depends. So it really varies. A lot of what I do is trying to get— educate docs, too, to like, lets do this first, here are different ways if you can't get in with someone, let's start with an app or a book or whatever. Or you come see me. That's all I did at Montefiore, a lot of times. Was a lot of education of the physicians there. But, it's also a lot of what I do is, like you were saying— people start it, and they can't get off of it. So a lot of what I do is doing CBT for insomnia, alongside whoever's prescribing the medication— and we very slowly work to get someone off, readjusting their program every time they step down. Sometimes people are surprised, they thought it was going to be harder than it was— than it actually was. Sometimes it's harder than actually they thought it was gonna be. So it varies, but that's a lot of what I do is getting people off of sleep aids, slowly over time. If anybody has questions on where to find someone who's a provider, the Society of Behavioral Sleep Medicine has a really good listing and you can also go to my website and email me and I'm happy to like direct you to the right place too.

Julie: For people that might have other sleep conditions, I think that's what's always drawn me to be in contact with you, is that often I think for something like narcolepsy people are very medication-focused and medications are super important but that there could possibly be other things that we could be doing and I'm still learning about some of those best practices from

other communities and seeing what could work for narcolepsy possibly. Of course I think for me social support is so important— that people have— know other people with narcolepsy so they don't feel alone. And so there's social support, but probably some cognitive behavioral stuff too, so. What's your take on a multidisciplinary approach to something like narcolepsy?

Dr. Harris: That's where I basically was born into sleep medicine, right, so that is the model with which I was taught. So Montefiore had the narcolepsy center, the Narcolepsy Institute. That dated back to— I think the early or mid-eights, with Neda Mosakhani. And she saw a lot of narcolepsy patients, ran groups, a lot of our patients from the New York area, a lot of patients from the Bronx. But she saw patients for— they had a monthly group that went on for years! And they did that with Dr. Thorpy. And it was the perfect model to show that not everything is medication based. And then when I came in I started to provide more of the CBT kind of approach, too. So we had the psychosocial— Neda did so much stuff for just, employment issues that people were having— she had, she was a wealth of knowledge. And, then I did a lot of work with patients that might've had depression, anxiety, negative thoughts about narcolepsy that might be impacting their life, and acceptance. And also sometimes not always acceptance— challenging some of the thoughts you're having. Because not every thought we have is based in reality. So teaching people to look at their thoughts, is this a realistic thought? Is it something that I can change, and if I can change my thought or the way I approach my thoughts about this disorder or whatever— it's impacting in my life, maybe that will help my mood in general. So I did a lot of that. And then I also did, you know it totally depended on patient but, I would do— napping strategies, I would do caffeine strategies, diet strategies, exercise, light expos— all that sort of stuff too, so. I came at it from that way, and Montefiore was amazing in that we just saw the patient as the whole patient. So, that's— in my opinion there's no other way to really approach, especially narcolepsy.

Julie: Right, but that's so not what people mostly get. I mean, it just is heartbreaking to constantly hear stories, for most people they get a prescription and they leave an office and— go on their way. And it's just, it's heartbreaking that that multidisciplinary approach isn't really what most people are getting. So, what kind of— I'm especially interested about what you said about napping. I think it's really, always like a— it's still a big challenge for me. I feel like it's really tough to know— I don't schedule my naps, maybe I should. And because I don't, I kind of let the day happen and then if I happen to be in a place where I'm still home and it makes sense to take one, then great. But then I'm often on my way to tennis and I get sleepy, you know, and then it's like, do I pull over and have to delay by 15 minutes with my best friend who's gonna be there and we only have an hour to play— and so I just kind of push through. What are your thoughts about napping strategies?

Dr. Harris: I think— like I say, it really depends on the patient. I am a fan of them when they're useful. Some people don't find them particularly helpful and they find it more like a frustration in a life, to be able to do— not even that— they just can't find time to do it, that it causes more frustration than anything. But if it does help you then you have to arrange your life, in a way, it's not ideal— to try and figure out how you can do it. But also know that it's not possible to do it every single day, probably, like you were saying, right. But then it also really depends on per person, some people really do so well with the 90 minute, 90 minute to two hour long nap. Is that really always possible. Some people need just a 30 minute nap. It really varies. But the thing that I do try to encourage is, I'm a big fan of circadian rhythm, and the body clock. So if you go to bed at the same time, you wake up at the same time— you can kind of see how much bang for your buck you'll have overall, if you're consistent with certain things. And the napping is

one thing that really can help if you do it at more of a consistent time. But then you can play around with the amounts of time, and know if you can't do it, then— it is what it is. It's not ideal.

Julie: Alright, let's talk about circadian rhythms and stuff because— I had a big moment reading your book where you were talking about body clocks and the environment and about how our body clocks thrive on consistent— I've heard about circadian rhythms, I've heard about body clocks. But reading your book for the first time, I realized we are connected to our environment, all of us, in a way I hadn't really realized. I think I thought, Julie Flygare decides what Julie Flygare does, and I'm an individual and I— you know, of course narcolepsy has been humbling and realize that I need my sleep. But as far as the timing and making sure I get sunlight during the day, and then not having light at night. I'm always kind of like, whatever to all that stuff because I'm like, I've got enough problems, I'm gonna deal with them the best I can. But tell us a little bit about our body clocks and why that's important.

Dr. Harris: So like you were saying, Julie Flygare can do whatever she wants, right. We all think we're special. Guess what? We're not. But we're all— we're all humans, we all have these body clocks that are set. I mean, the reality is— before electronics came around, before alarm clocks, before this kind of concept of a weekend versus weekday— insomnia rates and just sleep disorder rates— I mean, different sleep disorders, but— insomnia in general was not anywhere near like what it is now. And I think for, in general, to get your body on a good rhythm when it comes to falling asleep and waking up in the morning, we need consistency. That's how the cells in your body thrive. They know your clock, they know when to do certain things, they all have different functions. Your brain, in the pineal gland, it releases melatonin to help you sleep. And it does it at around the same time, a few hours before you go to bed. If you have varying bedtimes, varying wake times, your body doesn't release the chemicals that it needs to release to be able to sleep on a consistent basis. Now granted it's different for say, narcolepsy and say, apnea— but there's still this idea that we should be sleeping when it's ideally dark out, but that's not always possible for people that work shift work, whatever. But it really is the thing that keeps peoples'— especially if it's not insomnia, that's what keeps insomnia at bay, for many people. Is consistency.

Julie: And probably, it sounds like even eating. Like the eating time should be consistent, and probably not—

Dr. Harris: Ideally.

Julie: —right before bedtime. Okay, so this is I think right up your alley. I love reading about different parts of psychology or whatever, so I read about willpower.

Dr. Harris: Okay.

Julie: They were talking about how willpower, is a thing that go— that you only have so much every day. I can't remember— but you have a certain amount, and when you use it up it's like, kind of gone. So your willpower gets less and less throughout the day, as the day goes on.

Dr. Harris: Uh huh.

Julie: I forget which chemical, but so— I thought about that and that makes me realize, maybe that makes going to bed at the right time and shutting down from my phone and not eating a bowl of ice cream— I know I also have narcolepsy and I'm a pretty sleepy person and probably make some bad decisions around sugar at night. But in general I just thought like, if our willpower goes down throughout the day, how do we then— how can we prepare to like, set ourselves up to make better decisions at night, when our willpower is the lowest?

Dr. Harris: That's a great question, and I think it makes so much sense, right. You have like just fewer defenses against all the things that you wanna do at night, right. I'm a fan, just from a behavioral stand point— and I've done this with myself— I'm a fan of picking one thing to change at a time. Instead of saying tonight's gonna be the night that I'm gonna go to bed, I'm not gonna do all these things, I'm gonna do— it's too much. But it might be a little bit easier to be kind to yourself, do what you normally do, but say tonight I'm going to aim for one Netflix show. As opposed to three. And I'm gonna stop it at that point and get in bed at a certain time. Or just aim for one. Or just, or— for some people it's just turn off the auto play where it goes from show to show. That one step alone is really hard for some people to do. 'Cause then they have to make a decision if they're gonna watch another one. So it's sometimes just something small like that. Right, 'cause the idea of like I'm going to avoid all sugar at night is a hard one. But maybe pick I'm gonna try to go to bed at this time tonight. Or I'm gonna cut off electronics, as opposed to an hour before, if that's hard for someone, start with just 10 minutes before. Because that, even if you don't have a lot of willpower that that point, it might be a little easier. And once you get that under your belt for a few days, or a week or so— it's not an issue any more. It's automatic. Then you add on something else, and then you add on something else—

Julie: Okay. That sounds reasonable! I feel like I could do that. I think for me I need to just work on consistency, I think that's probably a big one as far as— and still let myself do whatever I want, but just the timing.

Dr. Harris: Yeah, I'm not immune to all of this stuff too! I get sucked into all of it myself. Right. So, and I sometimes will notice, okay, I'm doom-scrolling a little bit too much, or whatever. It's like I have to back myself off. But sometimes it's hard to just cut myself off fully. So one thing at a time, or if I'm eating way too much at night, I'll say you know what, I'm just going to cut off maybe the ice cream for a little while. You just have to do it slowly, it's really how behavior change works the best.

Julie: What about for children. Do you treat children and do children— I think that's probably the area where I've seen actually, there's been some more attention to other approaches besides medication, like that somehow— I mean maybe that's just from knowing the Boston group pretty well, at Children's— but do you have any sort of different techniques you use, for kids that are diagnosed with sleep disorders?

Dr. Harris: It depends on what the sleep disorder is. So I am board certified, I've worked with babies, through I always say like, three months through— my oldest patient was 92. So I've had the whole range. I do a good amount of sleep work with like babies, toddlers, preschoolers— and even like nine and 10 year olds. I have a lot of nine and 10 year olds right now. But it's more that it's more insomnia sort of stuff with them— I am not though, a child psychologist. So a lot of times when it's sleep issues like that, like insomnia and stuff, like I have to have my mom next to me— it's a lot of parent training. So that's what I'm doing a lot more of. If there's an underlying significant anxiety or depression disorder, then I usually refer— or like a significant separation

anxiety— then I refer out to a child psychologist. But a lot of times a lot of it's parent training, right, let's do some reward charts, right. With the really young kids then I do some modified, just— whatever we need to do based on the age to get them sleeping through the night and sleeping better, there's a bunch of different ways that we'll do it. With narcolepsy I don't see that many kids. But I did— when I was at Montefiore, I was on the FDA approvals for Xyrem. So— I saw a good number of kids in the studies there, where we were working with them. But it was really more of a drug focused kind of approach. We just didn't really see many kids with narcolepsy there.

Julie: Well I think they probably have a lot of the same things, you know. A lot of the social isolation and the challenges we've been talking about— but maybe they might have more scheduling— they have often a more regimented schedule 'cause of school.

Dr. Harris: Yeah.

Julie: Than I do as an adult.

Dr. Harris: Yeah, and I see a lot— a lot of adolescents. Like, young adolescents too, even older— who have circadian rhythm issues. So there's the consistency, right. So they are extreme night owls. So that's something I've seen for years, but it's gotten worse with the pandemic. Sometimes it's gotten better, if they don't have school where they've got to get to early anymore. But that's an area that we treat a lot. It's interesting with kids, from my perspective we try to treat everything behaviorally first, and then go to melatonin or whatever else the treatment might be— it's different with adults a lot of times. Although that being said, melatonin is used like candy a lot of the times, for kids. And it has a place for sure but it shouldn't be the first line thing that we should always try. Just like adults with insomnia. Not always a quick fix.

Julie: Yeah. Do you have any wind down tips for night owls in recovery?

Dr. Harris: So night owls, how extreme of a night owl. So if you find that no matter what you do, you can't go to sleep earlier and you want to go to sleep earlier, there are treatments for that circadian rhythm issue. Right, so it's like, I can't go to sleep until four in the morning but everyone's in bed at 10— then there are things you can do with someone— like someone like myself, to try and get you going to bed earlier. 'Cause it sounds like you're trying to force yourself to wind down a little bit, and you can't find anything to make yourself sleepy. That's what it sounds like. I mean wind down really varies, like it doesn't matter about the time— whatever time you go to bed, we always try to encourage a half hour to an hour of wind down. So that means dim lights, let the melatonin come out naturally in your brain, to help make you sleepy. That's the whole point of it. But it varies on everyone. Like some people really like to read, some people want to do— I have a lot of patients who are doing puzzles right now, like jigsaw puzzles, sorts of things. Knitting is popular. Meditation apps. But you just want to be careful because if you have the phone then you're staring at a blue light. So just take it, put it to the side. Audio books are really good. And I have like all these younger patients who are watching The Office left and right— The Office and Friends. Super popular. And they all want to watch it but I'm trying to get them away from the screens. So if they have to and they want it, like steps at a time, right, to move away and change your behaviors. Then get blue block— they're not like ideal, but you can get blue blocking glasses or get a filter for your computer that

will help to block some of the blue light. So you have to find something that works for you, because if you resent it you're still not going to go to sleep. But then if nothing's working, and you have a very late night owl kind of issue, then you might want to see someone because we can do things to try and get your circadian clock moved a little bit earlier.

Dr. Harris: Circadian issues are basically the idea that your body clock is off. That's the idea behind it. So there's the two most common ones, are the night owls, delayed sleep phase— so that's when you go to bed late, and you wake up late. But you get a full amount of sleep and you sleep throughout the night, it's just shifted. The other set is you go to bed really early and you wake up really early. And that's if anybody here has a— or is themselves— it's a lot of times we see in older adults— so if you have an older adult who complains, I wake up at three in the morning every night and I can't go back to sleep. All you do is ask them, well what time do you go to bed? If they're going to bed at 7 p.m., that's a phase issue, it's not insomnia. They're getting a full nights sleep. A lot of those patients get put on ambient and stuff in the middle of the night, they shouldn't be because it's a different problem. So, the delayed one we see a lot in adolescence. And that's when we really see it, and it's interesting because of the late school start times or the online school for a lot of people hasn't been as much of an issue, but before the pandemic I was giving talks to schools all the time about the problem with too early of a school start time because you're waking up, you are sleepy, right— and your brain is just not functioning in the way it should be, when you're sleepy. And we're testing kids, we're testing people at a time when they're still half asleep, essentially. So that's a big area that I think hopefully if schools go back to an early time that hopefully my field will be able to get them to really rethink it. And then, the other thing is like sometimes with circadian delayed people, sometimes they just pick a career that actually fits with their issues and then it's not a disorder anymore. Some people just choose freelance work. Or they choose to work as an actor, or something like that, where they— or a writer— where they can work late and it doesn't really matter, and it doesn't cause a disruption in their life. A sleep issue is an issue when it causes a disruption in your life.

Julie: Well, yeah, I think it's interesting when you don't know, though— like I have a feeling— I have a good friend that I think it's circadian, so like a delayed circadian— but the social dynamics of that, if you don't have a diagnosis.

Dr. Harris: Yeah.

Julie: Are really— how you know, especially if you have kids and, you could be up and you could take care of the kids in the middle of the night but then nine or 10 in the morning, and you're not doing great and— so it could be interesting even, the conversations could possibly change in that household if you knew what you were dealing with.

Dr. Harris: Uh huh. 100 percent. Yeah. But yeah, it's like, you have to think like, is it— it really is only diagnosable, that sort of stuff, as a disorder if it's causing an issue. So a lot of patients will come to me and say, well I just wanna sleep on a more normal schedule. It's like, but why? What's your reason, what's your why. And they have to have a real reason for it, otherwise the treatments not going to follow through.

Julie: Yeah, that makes sense. I'm curious about your thoughts about— you know there's a lot of people always think of technology as solutions, and I've seen this happen to friends, that they

think that their sleep is off and so they're gonna get a Fitbit and it's gonna— they're going to be able to track their sleep, and therefore solve their sleep.

Dr. Harris: Yep.

Julie: I think that's problematic in how these things are marketed, in a little bit more of a solution way— but what are you tracking, and— I have heard some thoughts about, even that these can cause extra anxiety about sleep, though, so I was curious—

Dr. Harris: Yeah, you hit it— you hit the nail on the head. Right, so— I mean I have one too, right, and I've tested them. The idea is that— I always look at the trackers as being really good for people who can sleep, but they don't make sleep a priority. So you're someone who's working 90 hours a week, you're falling asleep, you're getting into bed at three in the morning, you're getting up at six. And you're just— chronically sleep deprived, but that's based on your own choice or lifestyle. So I think they're really good for helping make someone more aware of just how little sleep and what time they're getting in bed, 'cause they're really just movement trackers. That's essentially— I mean they have some other fancy stuff that they do, but— some track heartrate, stuff. But that's when I think they're valuable, to give someone that lightbulb moment. There's two areas of sleep medicine right, there's the area of treating sleep disorders, and then I do a lot of wellness stuff, too. So I am a big fan of like, if people are good sleep— if they don't have an actual sleep disorder but they don't make sleep a priority and they can actually get sleep— they need to start making it a priority 'cause it's gonna start helping the rest of their life. That's when these are good.

Dr. Harris: The watches are— there's research that's been coming out that essentially shows that (laughs) this is not so accurate for— like they'll say, you got this much deep sleep, this much late sleep— like, no. You need to have a sleep study for that sort of stuff, right. They're not so exact in that aspect. And I think what happens if you have some sleep issues already, all it's going to do is make you hyper focused on it. I have patients do a sleep diary for me every week, when they come to see me. There's a version of it on my website, there's a version in my book— I much rather care about what someone— subjectively thinks about their sleep, than what the watch says. And I have patients that will come in with just like, printouts of Fitbit data, I'm like no. I want to treat your perception. If you feel like you woke up 10 times for an hour, that's a problem. But if you start reporting that you're only up once for a short amount of time, then I know you feel like you're getting better— that's all we care about. I don't care about what the watch says. So really if you have a sleep disorder, trash the watch. Don't trash it, but just don't wear it at night. It will make it worse for you. Yeah. I mean I do use it sometimes for those circadian rhythm though people. Like just to kind of see what time they fall asleep, and then wake up. But I'm not looking at the middle of the night stuff. I don't find it helpful.

Julie: Thank you for addressing that. We always want to find hope, in different places, and I think that there's a— something sexy about technology solving our sleep, and so thank you for explaining 'cause it could be useful for some people, and—

Dr. Harris: Right. But even that being said like, I'm a fan of— like I'm doing something with my best friend, I'm like, sleep and your bedroom. I'm a fan— I will do stuff to make— I want you to enjoy your room. You've done a lot, you want to make it a place that you enjoy. You want to have all that sleep hygiene around you, but if something is marketed as, this will fix your chronic

sleep problem— question it, initially. Right? But things that you wanna have, like a basis like— good bed, good sheets. All that stuff. This though is not gonna necessarily get you there.

Julie: I do think that weighted blankets are pretty cool and so what are your thoughts about those and I don't think they're really talked about very much. I think people— there's more talk about the technology than weighted blankets. So what are those used for?

Dr. Harris: Whatever makes you comfortable, is great. You want to be comfortable for sleep. But don't expect it to solve all the problems, right. Weighted blankets— so weighted blankets are great, in that there's been research on them for kids with autism and some ADHD, 'cause it's this kind of like pressure feeling, that kids sleep better with that, typically. You have to weight it properly, usually about 10% of your body weight. The problem is there's really not that much— there's a little bit on like adults with anxiety but there's really nothing for sleep, it's fascinating! I bet'cha in the next few years there'll be a lot of stuff coming out. But there's really not much. That being said, anecdotally, I have so many patients that sleep with them— who have a lot of anxiet— it's more the patients with anxiety, I find, that really like them. Just gives them that sense of— touch, pressure, and just calm. That's great. Few caveats, though. If you get hot at night, they're not always great, so you want to find a cooling one. And then the other caveat is if you get used to sleeping with a weighted blanket, good luck trying to sleep without it. So you're going to have to carry a weighted blanket with you to places where you travel to. (laughs) So, that's the one thing you have to keep in mind, right, so.

Julie: I love those caveats, though. I think those are really important, (laughs) so.

Dr. Harris: Like anything you train yourself to sleep with, like a sound machine, right— that's like, you need to have a sound machine, for a long time— it's something that has to be broken, it's not an easy habit to get rid of. They're not bad, but it's just something you have to think about, for the future, when it comes to sleeping.

Julie: Mm-hmm. What about sleep and menopause, and tell us about sleep and aging.

Dr. Harris: The sleep and aging. So. Don't expect as you get older to sleep like you did necessarily when you were 17. There's like two different things going on, so as you get older— what typically happens is, you don't need drastically less sleep. So, that's a big misnomer that we hear a lot. Just normal sleep in general. So you don't drastically need a lot less, what tends to happen when you get a lot older— to like late or middle age, older aspect— you'll start taking a nap usually. And so the sleep at night is a little less because you're napping during the day more. And sleep at night becomes less deep. So you don't have that same restorative, deep, deep, deep sleep. And that's something that I try to educate patients on a lot because, a lot of times people want to just be knocked out at night and they resort to like, Ambien, and other medications but that's not necessarily gonna give you normal sleep either. Right, what should normal look like. But if you're waking up a lot to pee, like some of that's normal but then there's a fine line as to how much of it's excessive, that's where you want to talk with your doctor, how long you're up for at night.

Dr. Harris: Menopause, hormone changes in women— perimenopause, it starts usually in like early to mid-forties for many women, it's a period of a number of years until you have a cessation of your period for at least a year. That's when you hit menopause. So that transition,

from perimenopause to menopause, lots of hormonal fluctuations, and that's when people start to have night sweats— they'll wake up with a hot flash in the middle of the night, they find that— a lot of women I work with will wake up in the morning or early morning because their mind is racing. That's stuff that really can impact sleep, but there are medications, there are supplements that you can try, my book talks about all of them. And CBT for insomnia has some data behind it. I work with women all the time who are going through menopause to try and make some behavioral and cognitive changes for them to help them sleep better. So there are definitely things you can do. And that's one of the other reasons I didn't mention, that I thought to write the book is that, so many women are like just suffering. And sometimes it's really hard, menopause is really hard. But there are treatments that can help. It shouldn't be suffering in silence for years.

Julie: So important. And so— I'm not like, I'm getting close to 40 and I'm just not ready?

Dr. Harris: It's gonna come. But yeah, the other thing with hormone changes, too is that— think about sleepiness, right— so there are issues that can happen before a woman— like every month, before she has, she like menstruates or whatever. That week before, typically either causes insomnia for some people, or it causes excessive sleepiness. So if you notice that there's something going on that's off with your sleep, that week before, I'm always a fan of tracking it. That's where you might wanna talk to your doctor too because there are treatments that you can do to help with it.

Julie: Wow. And what do you think about age and sleep disorders? I've heard a lot of different things, I've heard it really can vary. Similar to pregnancy and narcolepsy, like some people feel less sleepy, some people feel more sleepy, their symptoms get worse. So what do you think about narcolepsy and aging.

Dr. Harris: Narcolepsy and aging, I just haven't seen as— personally haven't seen as many older adults. So I can't speak to it so much from what I've seen— I have seen a number of patient— it's mixed, right. I've seen some patients report that it's gotten a little bit better over time, but I haven't seen someone for a long, long, amounts of time to see them really later in life. Yeah, from what I've seen it does tend to dissipate a little bit, the severity of it.

Julie: Yeah, I've also heard that maybe people when they're retired, kind of find their— kind of like what you were saying about finding a job that works for your sleep schedule—

Dr. Harris: That's interesting, right, so you can kind of work around it a little bit more. But then, that being said, now narcolepsy, there's a lot of people that when they retire they develop insomnia. So your sleep cycle, your body clock, you're like, you know what? I don't have to get up at the same time I got up at for 50 years. So I'm just gonna do whatever, and if I have a bad night of sleep, I'll sleep in. I'll do all these other things. And that can worsen sleep too. So I see more insomnia patients that come to me and they're like 50, 60, 70's, because they have new onset insomnia.

Julie: Wow. And then what about poor sleep quality? I mean that's kind of what I was going to ask you about, I've been thinking a lot about analogies because we use this analogy— Project Sleep's been using it 'cause I remember reading it in an article that Jerry Seigel wrote a long time ago, like 2000 I think? And he said that the sleepiness of narcolepsy was similar to being

awake for 48-72 hours, that was like the call to sleepiness. And so we've been using that for a while, and then recently I was kind of like— I mean, I think what people get out of that is, wow. Wow. That just seems really extreme.

Dr. Harris: Yeah.

Julie: But I'm not sure that people get it in a sense of like, that they could actually know what that feels like, because I don't know any people who really stay up for 48-72 hours. So I was kind of thinking about— trying to think of other ways, and one thing that came to mind me, and then people say something like, well wake up in the middle of the night and try to do your taxes, without any coffee, or something.

Dr. Harris: It is hard, right, to say— it's like you've been up for three days. So, what— but it's what are all the things that chronic sleep deprivation really do affect, right. It's memory, its irritability, it's just— stress tolerance, all that sort of stuff, so I think that people need to connect with that aspect too, but it's like how do you get at that, right. So, maybe not even just like, sleep quantity, right— I think definitely there's people who misuse Ambien, or any of the sleep aids, and then they end up doing things and they have no recollection, it's like automatic behaviors, right. They're doing things, they drive, they get in car accidents, all this sort of stuff! Because part of their brain is literally shut off. So they took it too early in the morning and they got up when they just really should have been sleeping and they weren't. That's I think a good way to think about it. You're going through life in like a fog with automatically doing things without connecting or really thinking about it, but then the other way to think about it is like, newborn-hood right, like newborn-dom. But there's a bit of that, stress tolerance is not there, you're not thinking clearly— like some times for some people, that can connect to them too. But its a hard concept, I do agree with you, it's a hard concept for people to get, other than the wow, three days awake? But the Ambien thing, or any kind of medication, where it turns off a part of your brain, and then you just do automatic things without realizing or knowing what you're doing, that's I think pretty powerful for some people.

Julie: Yeah, you know as a community I want to keep thinking of analogies and ways for people to try to understand. But I think that's a really— parts of your brain, I just can't get through to that. Like I had an ex-boyfriend where I'd just say, I'm literally tired, like we're coming home from a movie, all I can do is just be a body, but still just trying to engage with me, trying to like have a conversation and I'm just not gonna be a nice person, I'm just not there. At least I could say that, which is the best I could do. (laughs)

Dr. Harris: Yeah, if you have a newborn, some people are— more power to them, they're like— fully in it, and they're great. That was not me. Right, I was super sleep deprived, recovering from having a baby— it's more of like just doing everything, like okay I've gotta change a diaper, I've gotta feed, I've gotta— but there's no other— you can't— you have no brain space for anything else. That's it! And then I gotta go sleep. On and off.

Julie: Before we close I just want to hear a little bit from you as closing thoughts on self-care, which is a very hot topic.

Dr. Harris: I always liken it, and this has been so cliche but I always liken it to that— when you're on an airplane, and the oxygen comes down— you have to put on your mask first. If

you're not good for yourself, I mean I will be no good to my patients, I'll be no good to my family— so the things that I know that make me a better person, just day to day. Getting enough sleep. For me, exercise, which I figured out 12-13 years ago. That helps to regulate me a lot. Like I need to make those things a priority in my life and I know there are days that I won't get it in. But that— that's my lifeline, and that will help me be a better person in the whole wide world. And it's not selfish. I mean I've seen that quote all over the place where it says, self-care is not selfish. But it's true! It will just make you better to everyone else to help and do what you need to do in your life. Prioritize yourself.

Julie: Well perfect. Alright, bye for now, thanks Dr. Harris!

Dr. Harris: Thank you, bye Julie.

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