

## Sleep, stress and trauma

Valentina Socci<sup>1</sup>, Rodolfo Rossi<sup>2</sup>, Dalila Talevi<sup>1</sup>, Claudio Crescini<sup>1</sup>, Daniela Tempesta<sup>1</sup>, Francesca Pacitti<sup>1</sup>

<sup>1</sup> Department of Biotechnological and Applied Clinical Sciences, University of L'Aquila, Italy;

<sup>2</sup> Department of System Medicine, University of Rome Tor Vergata, Italy;

### SUMMARY

*The potential impact of sleep and sleep disorders on stress responses has received increasing interest particularly in the context of Post-traumatic Stress Disorder (PTSD). This review aims at synthesizing current evidence concerning the link between trauma exposure, sleep, emotional regulation and stress. In the last decades, experimental investigations suggested a critical role of sleep on emotional memory formation and emotional reactivity; similarly, animal and human studies highlighted the relations between sleep and fear responses, supporting the notion that sleep disturbance plays an important role in PTSD-relevant processes such as fear learning and extinction. Although some crucial aspects of these interactions need further clarification, convincing evidence now suggests a complex physiological interaction of stress response and sleep. In the context of trauma-related disorders, sleep alterations have been suggested as core symptoms as well as risk and prognostic factors; importantly, sleep may also represent an important therapeutic target in mental health. However, evidence accumulated so far points to sleep disturbance as a marker not only of PTSD, but also of increased vulnerability to maladaptive stress responses. Novel models conceptualize sleep disturbance as a modifiable, transdiagnostic risk factor for mental disorders, with important theoretical and clinical implications.*

**Key words:** sleep disturbances, trauma, emotional processing, post-traumatic stress disorder

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### Correspondence

Francesca Pacitti

Department of Biotechnological and Applied Clinical Sciences (DISCAB), University of L'Aquila, via G. di Vincenzo 16/B, 67100 L'Aquila, Italy  
E-mail francesca.pacitti@univaq.it

### Conflict of interest

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### Introduction

In the last years, the potential relation between sleep and trauma has received increasing interest, particularly in the context of trauma and stress-related disorders such as Post-traumatic Stress Disorder (PTSD). In the last two decades, experimental investigations have progressively highlighted the importance of sleep for cognitive as well as emotional functioning<sup>1,2</sup>. A critical implication of sleep in emotional memory formation as well as emotional homeostasis is well documented, also leading to important implications for trauma-related disorders. Similarly, animal and human studies have probed the relationship between sleep, particularly Rapid Eye Movement (REM) sleep and fear responses, also providing strong support for the hypothesis that sleep disturbance plays an important role in trauma-related processes. Alterations of sleep pattern represent a typical behavioral consequence of acute stressful/traumatic exposure and a core symptom of PTSD. In this context, while sleep disorders could have a pathoplastic role in PTSD, the emotional hyper-reactivity associated with a traumatic experience itself may, in turn, affect subsequent sleep quality. A complex, bidirectional relation between sleep and stress/trauma emerges, whereby emotional processes can progressively affect and be affected by sleep disturbances. Overall, recent literature suggests that disturbed sleep can contribute to maladaptive stress and trauma responses and may constitute a modifiable, transdiagnostic vulnerability factor for poor psychiatric outcomes<sup>3,4</sup>. Importantly, sleep disturbance is a modifiable vulnerability factor, and sleep restoration through effective

targeted sleep treatments may accelerate recovery from trauma exposure and PTSD. Further clarifying the neural substrate and the behavioral implications of the relation between sleep and trauma is a critical issue for the development of innovative strategies for risk management and treatment.

The aim of this review is to summarize relevant evidence on the relations between stress exposure and trauma, sleep and emotional regulation. Potential critical implications of sleep in the context of stress exposure, trauma-related disorders and interventions will be discussed. Further, critical issues for future research will be suggested.

### Sleep disturbance in PTSD

Post-traumatic Stress Disorder is a psychiatric illness that can occur after the exposure to traumatic events. Lifetime prevalence of PTSD is estimated between 2.3%<sup>5</sup> and 6.1%<sup>6</sup> in civilians and 30% in veterans<sup>5</sup>. PTSD symptoms include four psychopathological dimensions, i.e. avoidance, negative affect, intrusions (including nightmares) and hyperarousal. In the 5<sup>th</sup> Edition of the Diagnostic and Statistical Manual of Mental Disorders<sup>7</sup>, sleep disorders are included among the criteria for PTSD as re-experiences of traumatic symptoms (nightmares, criteria B) as well as alterations in arousal and reactivity (sleep disturbance, criteria E). Difficulties in falling asleep, frequent awakenings, reduced sleep duration, restless sleep and fatigue represent typical complaints of PTSD patients. Particularly, nightmares and anxiety dreams, a Rapid-eye Movement (REM) sleep phenomenon, appear consistently associated with PTSD<sup>8</sup>, so that they are commonly considered a core symptom of PTSD<sup>9</sup>. Accordingly, disturbed sleep, particularly REM sleep disturbances and nightmares, have been considered as the hallmark of PTSD<sup>10</sup>. Although the presence of sleep disturbance is a diagnostic criterion for the disorder, a clear consensus regarding the link between sleep disorders and the development of PTSD is still lacking. Findings concerning objective sleep alterations in PTSD are contrasting. A meta-analytic review<sup>11</sup> showed more stage 1 sleep, less slow-wave sleep, and greater REM density in PTSD patients compared to controls. Conversely, REM sleep reduction or fragmentation has been observed both in the acute aftermath of trauma exposure and in subjects with PTSD several years after the onset of PTSD<sup>12,13</sup>. Nevertheless, insomnia and REM sleep fragmentation following traumatic events are predictive of later development of PTSD<sup>14</sup>. Also, self-reported sleep disturbances have been showed to increase the likelihood of developing PTSD following a natural disaster<sup>15</sup>, thus also indicating a potential proactive role of sleep disturbance on the PTSD vulnerability.

Moreover, sleep-focused treatments can significantly improve both sleep and PTSD symptoms<sup>16,17</sup>.

A recent general population survey conducted in 24 countries reported a lifetime prevalence of trauma exposure of approximately 70%<sup>18</sup>. An even higher lifetime rate of traumatic events has been estimated in clinical populations, with a lifetime prevalence of 90%<sup>19</sup>. Particularly, compared to the general population, the exposure to interpersonal traumatic events such as physical and sexual violence is higher in individuals with a severe mental illness<sup>20</sup>, with a significant impact on personal and social functioning of patients with mental disorders<sup>21,22</sup>. Although the exposure to traumatic events is common in both clinical samples and general population, only a minority of individuals will develop PTSD. In addition to trauma exposure, increasing evidence suggests alterations in emotional memory processing and emotional modulation as critical to PTSD and complex PTSD development and maintenance<sup>23</sup>; in this context, evidence also exists in support of a causal role of sleep disturbance in such alterations.

### Sleep and emotional processing: implications for trauma-related disorders

In the last two decades sleep research strongly supported a crucial relationship between sleep and learning/memory consolidation<sup>2</sup>. Accumulating evidence suggests that sleep-related consolidation processes are essential for the long-term maintenance of emotional information<sup>1</sup>. Behavioral investigations showed that post-learning sleep selectively favored the retention of negative emotional texts compared to neutral texts and this emotional memory enhancement may persist for several years<sup>24,25</sup>. Similarly, napping may facilitate the consolidation and the post-sleep encoding of declarative emotional and neutral memories<sup>26</sup> or may promote preferential memory consolidation for negative emotional information<sup>27</sup>. Furthermore, sleep deprivation literature converges at indicating that the sleeping brain provides ideal conditions for episodic memory consolidation, while sleep loss negatively affects emotional memory processing<sup>1,28-31</sup>.

Importantly, accumulating evidence pointed to REM as the sleep stage specifically involved in emotional memory processing. Indeed, REM sleep stage is typically associated with reports of emotionally intense dreams<sup>32</sup>. REM sleep is accompanied by specific hyperactivity within brain areas implicated in memory functions during wake<sup>33</sup>. A large literature now suggests that the link between the REM sleep neuroanatomophysiology and the emotional domain is not coincidental<sup>34</sup>. During REM sleep, memories within

the neocortex are subjected to a plasticity-related cholinergic activity while remaining free from arousal-related noradrenergic interference, thus they potentially recombine each other and integrate into preexisting memory networks<sup>35</sup>.

However, while a crucial implication of sleep in all stages of emotional memory formation is well documented<sup>30,31</sup>, the specific impact of sleep on the next-day emotional reactivity is still controversial. According to Wagner and coworkers (2001) the REM sleep-mediated emotional memory consolidation is paralleled by the strengthening of the associated emotional charge. Consequently, REM sleep deprivation should prevent sleep-dependent neural reactivation assumed to be necessary for the consolidation of new memory traces, thus impairing the consolidation of a memory and of its associated emotional tone. In line with these assumptions, the use of sleep deprivation as a potential preventive therapeutic measure to hinder the long-term retention of traumatic events has been suggested<sup>24,25</sup>.

In contrast to the previous hypothesis, the 'Sleep to remember, sleep to forget' model<sup>34</sup> posits that the inherent neurobiological state of REM sleep could support a de-potentialization of the emotional charge of a memory. Specifically, during REM sleep the activation of brain areas implicated in memory function, such as the amygdala and the hippocampus, would support the overnight reprocessing and long-term retention of emotional memories ('Sleep to remember')<sup>36</sup>. Contextually, the suppressed adrenergic activity would gradually dissipate the autonomic charge associated with the emotional experiences ('Sleep to forget'). In this way, REM sleep could represent an 'overnight therapy' to adaptively preserve the salient aspects of a memory, dissipating at the same time the associated emotional tone, eventually promoting an accurate separation of the emotional charge from the declarative content of the mnemonic trace<sup>36</sup>. Neuroimaging as well as behavioral studies offer support to this assumption. Indeed, after sleep loss, an amplified limbic activation in response to negative emotional stimuli has been observed, in association with a reduced functional connectivity between the amygdala and the ventro-medial prefrontal cortex (vmPFC). These alterations are suggestive of a dysfunction of the vmPFC-amygdala circuitry and a lack of top-down control by the prefrontal cortex (PFC) on the limbic system<sup>37</sup>. Therefore, at the behavioral level, sleep loss may impose a more negative affective tone to memories<sup>38</sup>. Within this framework, REM sleep has also been indicated as a preventive therapeutic measure for emotional brain homeostasis to preserve an effective functional PFC-limbic connectivity<sup>36</sup>.

On the whole, investigations on the relationship between sleep and emotional reactivity produced contrasting

results, with evidence supporting both enhanced and diminished REM-related emotional reactivity, as well as no effect specifically associated with REM sleep<sup>1</sup>. Although the specific direction of the sleep-dependent emotional modulation needs to be further clarified, these results support the importance of sleep for appropriate emotional memory processing and next-day emotional reactivity.

## The complex relationship between sleep and trauma

Increasing evidence is providing important insight into the relationship between sleep and trauma. Such link is relevant in light of the robust relations between sleep disorders, adverse life events and mental disorders. While daytime affective symptoms can adversely affect sleep, there is growing evidence that sleep disturbances can reciprocally impact daytime symptoms<sup>39</sup>.

In the last years, fear conditioning paradigms in mammals<sup>40</sup> confirmed that sleep plays a critical role in the encoding and long-term retention of fearful memories. Research in this field showed that an experimentally induced fear response can affect subsequent sleep, as well as sleep manipulation can influence subsequent fear conditioning/extinction processes. Fear conditioning investigations have linked post-learning sleep to the consolidation of both fear conditioning and fear extinction in humans<sup>1</sup>. Although the specific direction of sleep-mediated modulation of fear remains unclear, sleep seems to promote the appropriate recognition of salient stimuli and the discrimination between fear and safety relevant stimuli, thus fostering the most appropriate response to the environment. This could be relevant since the dysfunctional persistence of fear conditioning and poor fear extinction has been implicated in the pathogenesis and maintenance of stress-related disorders and anxiety disorders. Indeed, dysfunctional fear expression in anxiety disorder may result from abnormally strong fear response or alterations of the inhibitory system modulating fear<sup>41,42</sup>. In this respect, a dysfunctional activation of brain areas implicated in fear extinction has been shown to differentiate trauma-exposed individuals with and without PTSD; at the behavioral level, such alterations were associated with impaired recall of extinction memory<sup>42-44</sup>. Importantly, in clinical populations such as spider-fearing women, sleep after exposure therapy may promote the retention and generalization of extinction learning with the potential to enhance the efficacy of the treatment, possibly preventing sensitization to threat and fear generalization<sup>45,46</sup>. Conversely, disturbed sleep may negatively influence the optimal processing of fear and extinction-related memory traces.

On the other hand, sleep disturbance represents a common behavioral consequence of acute and chronic

stress response<sup>47</sup>. In the animal model, different types of inescapable experimental stress were associated with subsequent REM sleep fragmentation; furthermore, conditioned reminders have been shown to produce similar stress-induced alterations in sleep architecture that may persist long after the initial stressful experience, while extinction learning seems to reverse these alterations<sup>48</sup>. Acute trauma-related hyperarousal itself could produce sleep disturbances that may lead, in turn, to a paradoxical hypervigilance response, thus perpetuating the stress response<sup>39</sup>. Moreover, sleep disruption may further impair the sleep-dependent memory processing, hindering an adaptive emotional regulation. Accordingly, at the neuroendocrine level, a complex mutually interactive physiology of stress response and sleep has been suggested, whereby traumatic experience may prevent a subsequent appropriate sleep-dependent emotional homeostasis (i.e. reduction in catecholamine levels, sympathetic tone, hypothalamic pituitary adrenal (HPA) axis and central corticotropin releasing factor (CRF)-ergic activity) resulting in an abnormal daytime stress response<sup>39</sup>. In the context of trauma-related disorders, these findings suggest that sleep alterations possess the potential to directly exacerbate initial symptoms and/or to impair the subsequent consolidation of appropriate extinction learning, thus contributing to the maintenance of maladaptive stress response.

### **Sleep disturbance: a transdiagnostic risk factor**

The importance of understanding the link between sleep and emotional processing is evident in light of the robust evidence demonstrating associations between sleep alterations and mental disorders<sup>3,49</sup>. Disturbed sleep represents both a core symptom and a potential pathophysiological factor of PTSD; however, in the DSM-5 sleep disturbance is a key symptom of many, if not all, psychiatric disorders. Accordingly, it has been suggested that sleep continuity disturbances imply a transdiagnostic imbalance in the arousal system that could represent a basic dimension of mental health<sup>3</sup>. As reported in epidemiological and prospective studies, pre-existing or peritraumatic sleep disturbance represents a risk factor not limited to PTSD, but also for mental disorders such as anxiety disorders, mood disorders and alcohol/substance use disorders<sup>50-54</sup>. Similarly, insomnia is a risk factor for incident depression<sup>55</sup>. In Major Depression, alterations in the sleep/wake cycle may emerge in a pre-morbid, symptoms-free age of life<sup>56</sup>; similarly, differences in circadian profiles can be found in subjects with Depression and Panic Disorders even before the clinical onset of the disorders<sup>57</sup>. The co-occurrence of sleep and psychiatric disorders tends to

attenuate treatment response; further, sleep alterations may increase the risk of relapse, thus suggesting an important prognostic significance of sleep disturbance in mental disorders<sup>58,59</sup>.

In addition to their specific implication in PTSD, increasing evidence to date support the hypothesis that sleep disturbances may reflect a broad index of maladaptive stress responses to trauma exposure. The predictive relationship between sleep alterations and an increased risk for a broad range of subsequent disorders strongly suggests that sleep disturbances could be important indices of compromised resilience<sup>60</sup>. In further support of this, the presence of consolidated sleep in trauma-exposed individuals<sup>61</sup>, as well as sleep improvements during treatment for affective disorders<sup>62,63</sup>, are associated with better mental health outcomes. These findings therefore have important implication for the implementation of preventive and therapeutic strategies in mental health settings.

### **Conclusions and future directions**

In the last years, increasingly evidence supported an intimate relationship between sleep and trauma. A large number of experimental investigations have demonstrated a crucial role of sleep on the processing of emotional memories. Similarly, fear conditioning studies have implicated sleep, particularly REM sleep, in the adaptive consolidation of both fear and extinction memories, a process that could be specifically impaired in PTSD. Literature also suggests that treating sleep disturbances immediately after the trauma exposure may reduce the development or severity of PTSD via consolidation and generalization of extinction memories. However, some crucial aspect of the sleep-mediated overnight emotional modulation should be further clarified, with important theoretical and clinical implications for trauma-related disorders. Specifically, the role of sleep in emotional processing should be further addressed in clinical PTSD samples, in order to better elucidate the specific direction of such relationship. In this respect, while restoring REM sleep may be related to appropriate extinction learning in PTSD, it could also promote the initial consolidation of fear memories, thus exerting an opposite effect on the emotional reactivity in the early aftermath of a trauma. This suggest the individuation of a precise, strategic time window for sleep interventions as a critical issue for future research on trauma-related disorders.

Future studies investigating the link between sleep and trauma should advance our understanding on the specific impact of potential vulnerability or protective factors. For example, differences in REM sleep propensity could moderate the effects of stress and trauma exposure on behavioral and physiological

outcomes<sup>64</sup>. Sex-related differences in functional brain activity have been described in studies investigating emotional memory<sup>65</sup> and emotional reactivity<sup>66,67</sup>; also, physiological estrogenic fluctuations may influence some aspects of the emotional processing<sup>68</sup>. Moreover, a specific vulnerability of females to the detrimental effects of sleep loss<sup>69</sup> as well as to mood disorders<sup>70</sup> and sleep disturbances<sup>71</sup> has been reported, suggesting the need to further investigate the specific contribution of sex-related differences in modulating the relation between sleep and emotions.

Moreover, future studies investigating the relations between sleep, stress and trauma should further clarify the potential role of neurobiological markers such as brain-derived neurotrophic factor (BDNF). In this respect, alterations in BDNF levels have been linked with post-traumatic stress spectrum symptoms<sup>72</sup> and PTSD<sup>73</sup>. Moreover, changes in BDNF levels are associated with chronotype<sup>74</sup>, sleep loss and sleep quality<sup>75</sup>, with evidence also pointing to sleep as a key mediator in the relation between stress and BDNF regulation<sup>76</sup>, thus encouraging further research.

Future research should also be dedicated to a better understanding of the relations between sleep, trauma exposure and trauma-related disorders across different life stages. Retrospective studies suggested that

childhood trauma could be particularly associated with sleep disturbances later in life<sup>77,78</sup>. Also, sleep problems in children or adolescents predict subsequent anxiety and depression disorders<sup>79</sup>. Early adverse experiences may have long-lasting effects on REM sleep and brain development<sup>80</sup>. These findings also raise the possibility that trauma exposure and altered sleep patterns during critical developmental stages may crucially interact in representing a significant transdiagnostic risk factor for subsequent mental illness.

Taken together, evidence accumulated so far supports the notion that sleep disturbance represents a sensitive index of heightened vulnerability to maladaptive stress responses and compromised resilience. In the context of trauma-related disorders, evidence-based sleep interventions have the potential to significantly advance clinical care. More generally, sleep disturbances should be conceptualized as a modifiable risk factor for poor psychiatric outcomes and therefore an important target for prevention and early intervention; novel models emphasize the transdiagnostic nature of sleep disturbance as a dimension for brain and mental health<sup>3,4,81</sup>. Addressing sleep quality through accurate sleep assessment and interventions in populations at risk may represent an important preventive and therapeutic strategy in mental health.

## References

- 1 Tempesta D, Socci V, De Gennaro L, Ferrara M. Sleep and emotional processing. *Sleep Med Rev* 2018;40:183-95. <https://doi.org/10.1016/j.smrv.2017.12.005>
- 2 Gais S, Born J. Declarative memory consolidation: mechanisms acting during human sleep. *Learn Mem* 2004;11:679-85. <https://doi.org/10.1101/lm.80504>
- 3 Baglioni C, Nanovska S, Regen W, et al. Sleep and mental disorders: a meta-analysis of polysomnographic research. *Psychol Bull* 2016;142:969-90. <https://doi.org/10.1037/bul0000053>
- 4 Harvey AG, Murray G, Chandler RA, et al. Sleep disturbance as transdiagnostic: consideration of neurobiological mechanisms. *Clin Psychol Rev* 2011;31:225-35. <https://doi.org/10.1016/j.cpr.2010.04.003>
- 5 Yehuda R, Hoge CW, McFarlane AC, et al. Post-traumatic stress disorder. *Nat Rev Dis Prim* 2015;1. <https://doi.org/10.1038/nrdp.2015.57>
- 6 Goldstein RB, Smith SM, Chou SP, et al. The epidemiology of DSM-5 post-traumatic stress disorder in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *Soc Psychiatry Psychiatr Epidemiol* 2016;51:1137-48. <https://doi.org/10.1007/s00127-016-1208-5>
- 7 American Psychiatric Association. Diagnostic and statistical manual of mental disorders. American Psychiatric Association, 2013. <https://doi.org/10.1176/appi.books.9780890425596>
- 8 Ohayon MM, Shapiro CM, Ohayon MM, et al. Sleep disturbances and psychiatric disorders associated with post-traumatic stress disorder in the general population. *Compr Psychiatry* 2000;41:469-78. <https://doi.org/10.1053/comp.2000.16568>
- 9 Spoomaker VI, Montgomery P. Disturbed sleep in post-traumatic stress disorder: secondary symptom or core feature? *Sleep Med Rev* 2008;12:169-84. <https://doi.org/10.1016/j.smrv.2007.08.008>
- 10 Ross RJ, Ball WA, Sullivan KA, et al. Sleep disturbance as the Hallmark of post-traumatic stress disorder. *Am J Psychiatry* 1989;146:697-707. <https://doi.org/10.1176/ajp.146.6.697>
- 11 Kobayashi I, Boarts JM, Delahanty DL. Polysomnographically measured sleep abnormalities in PTSD: a meta-analytic review. *Psychophysiology* 2007;44:660-9. <https://doi.org/10.1111/j.1469-8986.2007.537.x>
- 12 Mellman TA, Bustamante V, Fins AI, et al. REM sleep and the early development of post-traumatic stress disorder. *Am J Psychiatry* 2002;159:1696-701. <https://doi.org/10.1176/appi.ajp.159.10.1696>
- 13 Habukawa M, Uchimura N, Maeda M, et al. Sleep findings in young adult patients with post-traumatic stress disorder. *Biol Psychiatry* 2007;62:1179-82. <https://doi.org/10.1016/j.biopsych.2007.01.007>
- 14 Babson KA, Feldner MT. Temporal relations between sleep problems and both traumatic event exposure and PTSD: a critical review of the empirical literature. *J Anxiety Disord* 2010;24:1-15. <https://doi.org/10.1016/j.janxdis.2009.08.002>
- 15 Mellman TA, David D, Kulick-Bell R, et al. Sleep disturbance and its relationship to psychiatric morbidity after Hurricane Andrew. *Am J Psychiatry* 1995;152:1659-63. <https://doi.org/10.1176/ajp.152.11.1659>
- 16 Galovski TE, Monson C, Bruce SE, et al. Does cognitive-behavioral therapy for PTSD improve perceived health and sleep impairment? *J Trauma Stress* 2009;22:197-204. <https://doi.org/10.1002/jts.20418>
- 17 Talbot LS, Maguen S, Metzler TJ, et al. Cognitive behavioral therapy for insomnia in post-traumatic stress disorder: a randomized controlled trial. *Sleep* 2014;37:327-41. <https://doi.org/10.5665/sleep.3408>
- 18 Benjet C, Bromet E, Karam EG, et al. The epidemiology of traumatic event exposure

- worldwide: results from the World Mental Health Survey Consortium HHS Public Access Author manuscript. *Psychol Med* 2016;46:327-43. <https://doi.org/10.1017/S0033291715001981>
- <sup>19</sup> Floen SK, Elklit A. Psychiatric diagnoses, trauma, and suicidality. *Ann Gen Psychiatry* 2007;6:12. <https://doi.org/10.1186/1744-859X-6-12>
- <sup>20</sup> Mauritz MW, Goossens PJJ, Draijer N, et al. Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *Eur J Psychotraumatol* 2013;4(Suppl). <https://doi.org/10.3402/ejpt.v4i0.19985>
- <sup>21</sup> Talevi D, Imburgia L, Luperini C, et al. Interpersonal violence: identification of associated features in a clinical sample. *Child Abus Negl.* 2018;86:349-57. doi:10.1016/j.chiabu.2018.08.017
- <sup>22</sup> Talevi D, Pacitti F, Costa M, et al. Further exploration of personal and social functioning: the role of interpersonal violence, service engagement, and social network. *J Nerv Ment Dis* 2019;207:832-7. <https://doi.org/10.1097/NMD.0000000000001036>
- <sup>23</sup> Longo L, Cecora V, Niolu C, et al. Dissociative symptoms in complex post-traumatic stress disorder and in post-traumatic stress disorder. *Journal of Psychopathology* 2019;25:212-9.
- <sup>24</sup> Wagner U, Hallschmid M, Rasch B, et al. Brief sleep after learning keeps emotional memories alive for years. *Biol Psychiatry* 2006;60:788-90. <https://doi.org/10.1016/j.biopsych.2006.03.061>
- <sup>25</sup> Wagner U, Gais S, Born J. Emotional memory formation is enhanced across sleep intervals with high amounts of rapid eye movement sleep. *Learn Mem* 2001;8:112-9. <https://doi.org/10.1101/lm.36801>
- <sup>26</sup> Cellini N, Torre J, Stegagno L, et al. Sleep before and after learning promotes the consolidation of both neutral and emotional information regardless of REM presence. *Neurobiol Learn Mem* 2016;133:136-44. <https://doi.org/10.1016/j.nlm.2016.06.015>
- <sup>27</sup> Payne JD, Kensinger EA, Wamsley EJ, et al. Napping and the selective consolidation of negative aspects of scenes. *Emotion* 2015;15:176-86. <https://doi.org/10.1037/a0038683>
- <sup>28</sup> Atienza M, Cantero JL. Modulatory effects of emotion and sleep on recollection and familiarity. *J Sleep Res* 2008;17:285-94. <https://doi.org/10.1111/j.1365-2869.2008.00661.x>
- <sup>29</sup> Van Der Helm E, Gujar N, Walker MP. Sleep deprivation impairs the accurate recognition of human emotions. *Sleep* 2010;33:335-42. <https://doi.org/10.1093/sleep/33.3.335>
- <sup>30</sup> Tempesta D, Socci V, Coppo M, et al. The effect of sleep deprivation on the encoding of contextual and non-contextual aspects of emotional memory. *Neurobiol Learn Mem* 2016;131:9-17. <https://doi.org/10.1016/j.nlm.2016.03.007>
- <sup>31</sup> Tempesta D, Socci V, Dello Iorio G, et al. The effect of sleep deprivation on retrieval of emotional memory: a behavioural study using film stimuli. *Exp Brain Res* 2017;235:3059-67. <https://doi.org/10.1007/s00221-017-5043-z>
- <sup>32</sup> Cipolli C, Ferrara M, De Gennaro L, et al. Beyond the neuropsychology of dreaming: Insights into the neural basis of dreaming with new techniques of sleep recording and analysis. *Sleep Med Rev* 2017;35:8-20. <https://doi.org/10.1016/j.smrv.2016.07.005>
- <sup>33</sup> Nir Y, Tononi G. Dreaming and the brain: from phenomenology to neurophysiology. *Trends Cogn Sci* 2010;14:88-100. <https://doi.org/10.1016/j.tics.2009.12.001>
- <sup>34</sup> Walker MP, van der Helm E. Overnight Therapy? The role of sleep in emotional brain processing. *Psychol Bull* 2009;135:731-48. <https://doi.org/10.1037/a0016570>
- <sup>35</sup> Walker MP, Stickgold R. Overnight alchemy: sleep-dependent memory evolution. *Nat Rev Neurosci* 2010;11:218. <https://doi.org/10.1038/nrn2762-c1>
- <sup>36</sup> Goldstein AN, Walker MP. The role of sleep in emotional brain function. *Annu Rev Clin Psychol* 2014;10:679-708. <https://doi.org/10.1146/annurev-clinpsy-032813-153716>
- <sup>37</sup> Yoo SS, Gujar N, Hu P, et al. The human emotional brain without sleep – a prefrontal amygdala disconnect. *Curr Biol* 2007;17. <https://doi.org/10.1016/j.cub.2007.08.007>
- <sup>38</sup> Tempesta D, De Gennaro L, Natale V, et al. Emotional memory processing is influenced by sleep quality. *Sleep Med* 2015;16:862-70. <https://doi.org/10.1016/j.sleep.2015.01.024>
- <sup>39</sup> Pace-Schott EF, Germain A, Milad MR. Sleep and REM sleep disturbance in the pathophysiology of PTSD: the role of extinction memory. *Biol Mood Anxiety Disord* 2015;5:1-19. <https://doi.org/10.1186/s13587-015-0018-9>
- <sup>40</sup> Milad MR, Quirk GJ. Fear extinction as a model for translational neuroscience: ten years of progress. *Annu Rev Psychol* 2012;63:129-51. <https://doi.org/10.1146/annurev.psych.121208.131631>
- <sup>41</sup> Mineka S, Oehlberg K. The relevance of recent developments in classical conditioning to understanding the etiology and maintenance of anxiety disorders. *Acta Psychol (Amst)* 2008;127:567-80. <https://doi.org/10.1016/j.actpsy.2007.11.007>
- <sup>42</sup> Milad MR, Orr SP, Lasko NB, et al. Presence and acquired origin of reduced recall for fear extinction in PTSD: results of a twin study. *J Psychiatr Res* 2008;42:515-20. <https://doi.org/10.1016/j.jpsychires.2008.01.017>
- <sup>43</sup> Milad MR, Pitman RK, Ellis CB, et al. Neurobiological basis of failure to recall extinction memory in post-traumatic stress disorder. *Biol Psychiatry* 2009;66:1075-82. <https://doi.org/10.1016/j.biopsych.2009.06.026>
- <sup>44</sup> Shvil E, Sullivan GM, Schafer S, et al. Sex differences in extinction recall in post-traumatic stress disorder: a pilot fMRI study. *Neurobiol Learn Mem* 2014;113:101-8. <https://doi.org/10.1016/j.nlm.2014.02.003>
- <sup>45</sup> Pace-Schott EF, Verga PW, Bennett TS, et al. Sleep promotes consolidation and generalization of extinction learning in simulated exposure therapy for spider fear. *J Psychiatr Res* 2012;46:1036-44. <https://doi.org/10.1016/j.jpsychires.2012.04.015>
- <sup>46</sup> Kleim B, Wilhelm FH, Temp L, et al. Sleep enhances exposure therapy. *Psychol Med* 2014;44:1511-9. <https://doi.org/10.1017/S0033291713001748>
- <sup>47</sup> Han KS, Kim L, Shim I. Stress and sleep disorder. *Exp Neurobiol* 2012;21:141. <https://doi.org/10.5607/en.2012.21.4.141>
- <sup>48</sup> Sanford LD, Suchecki D, Meerlo P. Stress, arousal, and sleep. *Curr Top Behav Neurosci* 2015;25:379-410. [https://doi.org/10.1007/7854\\_2014\\_314](https://doi.org/10.1007/7854_2014_314)
- <sup>49</sup> Bersani FS, Iannitelli A, Pacitti F, et al. Sleep and biorythm disturbances in schizophrenia, mood and anxiety disorders: a review. *Riv Psichiatr* 2012;47:365-75. <https://doi.org/10.1708/1175.13027>
- <sup>50</sup> Gehrman P, Seelig AD, Jacobson IG, et al. Predeployment sleep duration and insomnia symptoms as risk factors for new-onset mental health disorders following military deployment. *Sleep* 2013;36:1009-18. <https://doi.org/10.5665/sleep.2798>
- <sup>51</sup> Bryant RA, Creamer M, O'Donnell M, et al. Sleep disturbance immediately prior to trauma predicts subsequent psychiatric disorder. *Sleep* 2010;33:69-74. <https://doi.org/10.1093/sleep/33.1.69>
- <sup>52</sup> Mellman TA, Hipolito MMS. Sleep disturbances in the aftermath of trauma and post-traumatic stress disorder. *CNS Spectr* 2006;11:611-5. <https://doi.org/10.1017/s1092852900013663>
- <sup>53</sup> Carito V, Ciafrè S, Tarani L, et al. TNF- $\alpha$  and IL-10 modulation induced by polyphenols extracted by olive pomace in a mouse model of paw inflammation. *Ann Ist Super Sanita* 2015;51:382-6. <https://doi.org/10.4415/ANN-15-04-21>

- 54 Quartini A, Pacitti F, Bersani G, et al. From adolescent neurogenesis to schizophrenia: opportunities, challenges and promising interventions. *Biomed Rev* 2017;28:66-73. <https://doi.org/10.14748/bmr.v28.4452>
- 55 Baglioni C, Battagliese G, Feige B, et al. Insomnia as a predictor of depression: a meta-analytic evaluation of longitudinal epidemiological studies. *J Affect Disord* 2011;135:10-9. <https://doi.org/10.1016/j.jad.2011.01.011>
- 56 Bersani G, Liberati D, Rasa A, et al. Premorbid sleep, appetite, energy, and cognitive circadian profile in patients with depressive disorders. *Eur Psychiatry* 2010;25:461-4. <https://doi.org/10.1016/j.eurpsy.2010.01.002>
- 57 Bersani G, Bersani FS, Prinzivalli E, et al. Premorbid circadian profile of patients with major depression and panic disorder. *Riv Psichiatr* 2012;47:407-12. <https://doi.org/10.1708/1175.13031>
- 58 Marcks BA, Weisberg RB, Edelen MO, et al. The relationship between sleep disturbance and the course of anxiety disorders in primary care patients. *Psychiatry Res* 2010;178:487-92. <https://doi.org/10.1016/j.psychres.2009.07.004>
- 59 Buysse DJ, Tu XM, Cherry CR, et al. Pretreatment REM sleep and subjective sleep quality distinguish depressed psychotherapy remitters and nonremitters. *Biol Psychiatry* 1999;45:205-13. [https://doi.org/10.1016/s0006-3223\(98\)00198-x](https://doi.org/10.1016/s0006-3223(98)00198-x)
- 60 Germain A. Sleep disturbances as the hallmark of PTSD: where are we now? *Am J Psychiatry* 2013;170:372-82. <https://doi.org/10.1176/appi.ajp.2012.12040432>
- 61 Seelig AD, Jacobson IG, Donoho CJ, et al. Sleep and health resilience metrics in a large military cohort. *Sleep* 2016;39:1111-20. <https://doi.org/10.5665/sleep.5766>
- 62 Manber R, Edinger JD, Gress JL, et al. Cognitive behavioral therapy for insomnia enhances depression outcome in patients with comorbid major depressive disorder and insomnia. *Sleep* 2008;31:489-95. <https://doi.org/10.1093/sleep/31.4.489>
- 63 Harvey AG, Talbot LS, Gershon A. Sleep disturbance in bipolar disorder across the lifespan. *Clin Psychol Sci Pract* 2009;16:256-77. <https://doi.org/10.1111/j.1468-2850.2009.01164.x>
- 64 Spookmaker VI, Sturm A, Andrade KC, et al. The neural correlates and temporal sequence of the relationship between shock exposure, disturbed sleep and impaired consolidation of fear extinction. *J Psychiatr Res* 2010;44:1121-8. <https://doi.org/10.1016/j.jpsychires.2010.04.017>
- 65 Cahill L, Haier RJ, White NS, et al. Sex-related difference in amygdala activity during emotionally influenced memory storage. *Neurobiol Learn Mem* 2001;75:1-9. <https://doi.org/10.1006/nlme.2000.3999>
- 66 Stevens JS, Hamann S. Sex differences in brain activation to emotional stimuli: a meta-analysis of neuroimaging studies. *Neuropsychologia* 2012;50:1578-93. <https://doi.org/10.1016/j.neuropsychologia.2012.03.011>
- 67 Pompili A, Arnone B, D'Amico M, et al. Evidence of estrogen modulation on memory processes for emotional content in healthy young women. *Psychoneuroendocrinology* 2016;65:94-101. <https://doi.org/10.1016/j.psyneuen.2015.12.013>
- 68 Gasbarri A, D'Amico M, Arnone B, et al. Electrophysiological and behavioral indices of the role of estrogens on memory processes for emotional faces in healthy young women. *Front Behav Neurosci* 2019;13:234. <https://doi.org/10.3389/fnbeh.2019.00234>
- 69 Killgore WDS, Muckle AE, Grugle NL, et al. Sex differences in cognitive estimation during sleep deprivation: effects of stimulant countermeasures. *Int J Neurosci* 2008;118:1547-57. <https://doi.org/10.1080/00207450802323970>
- 70 Payne JL. The role of estrogen in mood disorders in women. *Int Rev Psychiatry* 2003;15:280-90. <https://doi.org/10.1080/0954026031000136893>
- 71 Zhang B, Wing YK. Sex differences in insomnia: a meta-analysis. *Sleep* 2006;29:85-93. <https://doi.org/10.1093/sleep/29.1.85>
- 72 Stratta P, Sanità P, Bonanni RL, et al. Clinical correlates of plasma brain-derived neurotrophic factor in post-traumatic stress disorder spectrum after a natural disaster. *Psychiatry Res* 2016;244:165-70. <https://doi.org/10.1016/j.psychres.2016.07.019>
- 73 Angelucci F, Ricci V, Gelfo F, et al. BDNF serum levels in subjects developing or not post-traumatic stress disorder after trauma exposure. *Brain Cogn* 2014;84:118-22. <https://doi.org/10.1016/j.bandc.2013.11.012>
- 74 Tirassa P, Iannitelli A, Sornelli F, et al. Daily serum and salivary BDNF levels correlate with morning-evening personality type in women and are affected by light therapy. *Riv Psichiatr* 2012;47:527-34. <https://doi.org/10.1708/1183.13096>
- 75 Schmitt K, Holsboer-Trachsler E, Eckert A. BDNF in sleep, insomnia, and sleep deprivation. *Ann Med* 2016;48:42-51. <https://doi.org/10.3109/07853890.2015.1131327>
- 76 Giese M, Unternaehrer E, Brand S, et al. The interplay of stress and sleep impacts BDNF Level. *PLoS One* 2013;8. <https://doi.org/10.1371/journal.pone.0076050>
- 77 Kajeepeeta S, Gelaye B, Jackson CL, et al. Adverse childhood experiences are associated with adult sleep disorders: a systematic review. *Sleep Med* 2015;16:320-30. <https://doi.org/10.1016/j.sleep.2014.12.013>
- 78 Brindle RC, Cribbet MR, Samuelsson LB, et al. The relationship between childhood trauma and poor sleep health in adulthood. *Psychosom Med* 2018;80:200-7. <https://doi.org/10.1097/PSY.0000000000000542>
- 79 Gregory AM, Caspi A, Eley TC, et al. Prospective longitudinal associations between persistent sleep problems in childhood and anxiety and depression disorders in adulthood. *Orig Publ J Abnorm Child Psychol* 2006;33:157-63. <https://doi.org/10.1007/s10802-005-1824-0>
- 80 Lupien SJ, McEwen BS, Gunnar MR, et al. Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nat Rev Neurosci* 2009;10:434-45. <https://doi.org/10.1038/nrn2639>
- 81 Ceccanti M, Iannitelli A, Fiore M. Italian Guidelines for the treatment of alcohol dependence. *Riv Psichiatr* 2018;53:105-6. <https://doi.org/10.1708/2925.29410>