TRIMS Therapy Notes

Texas Research Institute of Mental Sciences

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Sleep disorders and their psychiatric significance

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Evaluation of sleep may become a routine part of patient assessment in this decade as data collected in sleep laboratories, with assistance from bioengineers and computer scientists, help clinicians to understand the mechanisms of sleep and its disorders.

The Association of Sleep Disorders Centers, formed in 1975, has published a *Diagnostic Classification of Sleep-Arousal Disorders* (1979). In four main sections, it defines disorders of initiating and maintaining sleep (DIMS), disorders of excessive somnolence (DOES), disorders of sleep-wake schedules, and dysfunctions associated with sleep, such as abnormal behaviors that appear during sleep (parasomnias).

Initiating and maintaining sleep

DIMS, a heterogeneous group of conditions formerly known as insomnias, are common sleep disorders. DIMS should be regarded as nonspecific signs of a disorder; like fever, the problem should be traced to specific causes and treated directly. So-called "short sleepers," however, who normally require less sleep than the average person, should not be treated.

DIMS associated with a personality disorder are usually difficulties in falling and staying asleep. Many of the symptoms are related to the patient's unsuccessful attempt to control anxiety. Other nonaffective, nonpsychotic disorders associated with DIMS include hypochondriasis and obsessive-compulsive personality disorders.

DIMS are frequently found in patients with affective disorders. Although patients suffering from unipolar depression have either normal or moderately increased sleep latencies, their sleep is characterized typically by repeated awakenings that lead eventually to waking in the early morning. The patients' cardinal complaint is waking up too early and not being able to go back to sleep.

The sleep pattern of manic or hypomanic patients differs from that of depressed patients. Manic or hypomanic patients do not try to fall asleep again once awakened, and they feel refreshed after two or three hours of sleep. These patients' most striking feature is that they seldom complain of disturbed sleep; they maintain a high arousal level until they are completely exhausted.

The major psychosis associated with DIMS is schizophrenia. Zarcone (1979) noted that sleep studies of schizophrenic patients have yielded inconsistent results. Inability to fall asleep remains, however, the most prevalent sleep disturbance in acute schizophrenia; once asleep, the patients may spend close to normal amounts of time in bed.

DIMS may be associated with intake of such psychoactive substances as drugs and alcohol, drug and alcohol withdrawal, and with several other psychophysiological problems.

Excessive somnolence

Disorders of excessive somnolence (DOES) may also be associated with affective and functional disorders, but they are by far the most characteristic symptom of patients in the depressed phase of bipolar manic-depressive illness. Borderline personality disorders, conversions and dissociative disorders, hypochondriasis, and some forms of schizophrenia may also be associated with DOES.

Other significant causes of DOES are such primary sleep disorders as sleep-induced respiratory impairment (sleep apnea), narcolepsy, nocturnal myoclonus, and restless-leg syndrome. Infections, hormonal imbalances, trauma, and occasionally food allergies are among rare causes of DOES.

Disturbed sleep-wake schedules

In these disorders onset and maintenance of sleep are normal, but the patient cannot sleep when he or she wants, needs, or expects to. These disorders may be induced exogenously by, for example, time-zone changes, "jet lag," or work-shift changes, or they may be produced endogenously by disturbances in chronological rhythm, which are advanced- or delayed-sleep phase disorders or non-24-hour sleep-wake schedules.

Long-lasting DIMS and DOES may secondarily cause sleep-wake schedule problems. Patients with affective disorders often have disturbed 24-hour

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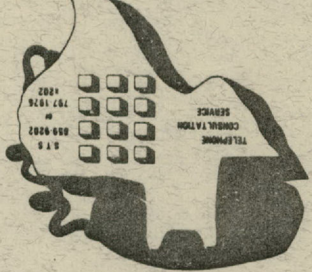

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sleep-wake patterns, whereas acute schizophrenic patients act like persons with a delayed sleep phase: they cannot fall asleep until 3 or 4 a.m. and then sleep until late morning. Some patients with bipolar illness also may extend their periods in bed late into the morning.

Parasomnias

These are undesirable physical phenomena that happen either only during sleep, as in somnambulism, or they are, like asthma, exacerbated by sleep.

Painful erections, for example, appear during specific sleep stages. Other problems—such as bruxism (grinding of the teeth)—occur during various sleep stages. Yet another type may occur during the transition between sleep and arousal or wakefulness and sleep; one of these is familial sleep paralysis, which is the inability to move either at sleep onset or upon waking up. It may be a mild form of narcolepsy.

Usually, however, these disorders occur during the first part of the night when sleep is deepest. They are common in childhood, and their persistence into adult life should be regarded as a possible indication of psychopathology.

Although not all sleep problems are signs of psychopathology, clinicians should be alert to patients' complaints of sleep difficulties as a possible sign of psychiatric disturbance. The *Diagnostic Classification of Sleep-Arousal Disorders*, along with advances in sleep laboratory research, will help psychiatrists to understand Shakespeare's "Sleep that knits up the raveled sleeve of care ...Balm of hurt minds, great nature's second course, Chief nourisher in life's feast."

—*Cyrus Sajadi, M.D.*

Diagnostic Classification of Sleep-Arousal Disorders. Sleep 2 (1), 1979.

Zarcone, V.P. Jr. Sleep and schizophrenia. *Psychiatric Annals* 9:29-40, 1979.