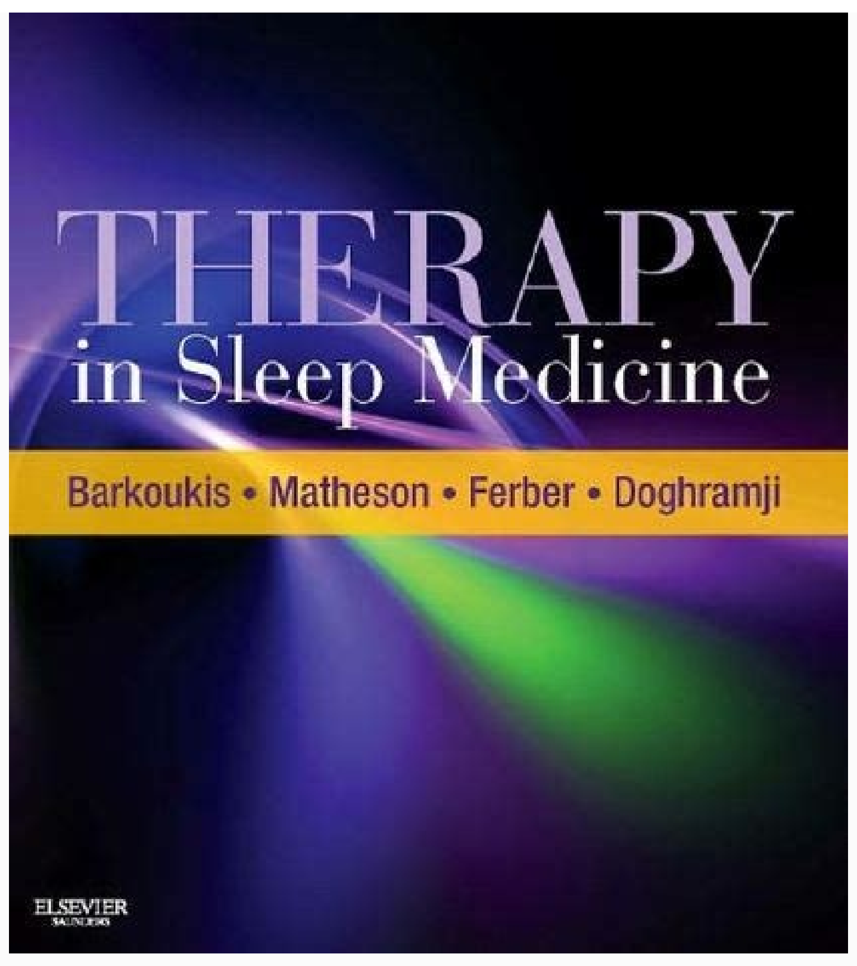
Parasomnias and dyssomnias pdf



THERAPY
in Sleep Medicine

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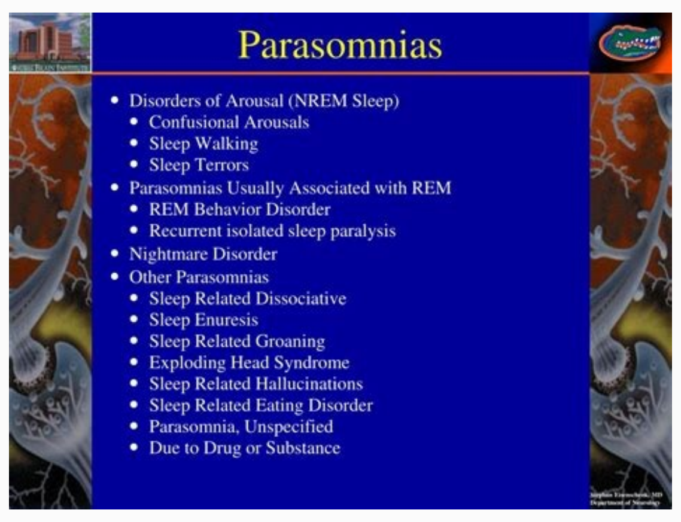

Parasomnias

- Disorders of Arousal (NREM Sleep)
  - Confusional Arousals
  - Sleep Walking
  - Sleep Terrors
- Parasomnias Usually Associated with REM
  - REM Behavior Disorder
  - Recurrent isolated sleep paralysis
- Nightmare Disorder
- Other Parasomnias
  - Sleep Related Dissociative
  - Sleep Enuresis
  - Sleep Related Groaning
  - Exploding Head Syndrome
  - Sleep Related Hallucinations
  - Sleep Related Eating Disorder
  - Parasomnia, Unspecified
  - Due to Drug or Substance

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Parasomnias, violence and the law

BY KENNETH J. WEISS, M.D., CLARENCE WATSON, J.D., M.D., DIMITRI MARKOV, M.D., ELENA DEL BUSTO, M.D., NICOLE FOUBISTER, M.D., AND KARL DOGHRAMJI, M.D.

In this review, we trace the parallel development of scientific understanding of parasomnias and the jurisprudence of violent behavior during sleep. Before sleep physiology was studied, it was generally self-evident that sleeping persons would not be criminally responsible. Though the problem of malingering was acknowledged in early American forensic psychiatry, the defendant with sleepwalking or sleep drunkenness was treated leniently. Over the past half century, sleep physiology has been examined and there is a developing nomenclature for sleep disorders. Though there is no clear-cut correlation between violence and sleep, several parasomnias have been implicated. We discuss contemporary concepts of parasomnias and suggest how expert witnesses might apply this knowledge to the difficult matter of assessing criminal intent and responsibility.

KEY WORDS: *Criminal responsibility, parasomnias, sleepwalking, violence.*

AUTHORS' NOTE: *For additional information about this article, please contact: Kenneth Weiss, M.D., 2 Bala Plaza, Suite 300, Bala Cynwyd, PA 19004. E-Mail: kenweiss@mail.med.upenn.edu. This article is based in part on the proceedings of a symposium delivered at the annual meeting of the American Psychiatric Association, in Washington, DC, in May 2008.*

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BOOKS

ple language, and technical terms are explained in a brief and clear fashion. The new headache classification of the International Headache Society is used where possible.

Dr Solomon is director of the headache unit at Montefiore Medical Center, New York, NY, and professor of neurology at Albert Einstein College of Medicine, New York. Steven Fraccaro is a writer and journalist who has successfully teamed with Dr Solomon to produce a text I believe our patients will find valuable. The book is divided into 10 chapters focused on particular headache types, including headaches in children and the elderly. Also presented is a chapter on when the patient with headache should see a physician. In describing individual headaches, case outlines are presented, making the clinical picture more real for the patient-reader.

Preventive and acute therapy are explained as is patient variability in response to medications and the importance of physician supervision and guidance. The point is emphasized that headache diagnosis is largely made on the answers given to the physician's questions and not on tests and laboratory investigations. Each chapter is well summarized.

Tension headache is dealt with clearly; the possible underlying mechanisms are described and the likely relationship between tension and migraine headache is discussed.

The point is well made that pain medication for occasional use may do considerable harm by converting periodic headache into chronic headache and, possibly, by causing liver and kidney damage. The chapter on cluster headaches, in particular, could be read with profit by many practitioners faced with treating this very difficult problem.

Twenty-six pages are devoted to trigger factors, at times repeating information contained in other chapters. However, concentrating this information into a single chapter is worthwhile, because the part played by a well-informed patient alert for trigger factors is vital for headache control. Prominence is given to diet, and the role of hormones and irregular body rhythms is described. Psychogenic headaches due to hysteria, depression, or delusions are described as uncommon. On the previous page, emotional stress is described as an important factor in headache. Some further differentiation here might be useful for the lay reader. The association with depression is well described. I was pleased to see a paragraph included on chronic paroxysmal hemicrania, probably an underdiagnosed headache.

Nondrug therapies will be read by patients with interest. Overdiagnosis of "sinus headache," temporomandibular joint dysfunction, hypertension, and "low blood sugar" as causes for headache is discussed.

While 90% of headaches are due to migraine, tension-type headache, or cluster headache, hundreds of conditions may cause the remainder of headaches. Some of these are headaches due to sexual activity, exertion, cough, ice cream, and tight swim goggles!

The treatment of migraine in children is dealt with perhaps too conservatively.

This reviewer believes that preventive medication such as β-blockers should be given earlier in children rather than later. Although cyproheptadine (Periactin), which is recommended, may not have as many potential side effects, it is also a much less effective drug.

In the discussion concerning the elderly, only a sentence is given to distinguishing the aura of migraine from transient ischemic attacks. Further details might be in order to allay fears of stroke in older readers.

The final chapter deals with when to see a physician about headaches and an explanation of the role of the physician. Patients who read this section may have unduly high expectations of their physician unless the physician has had special training in headache. The role of the headache clinic is presented as a place of last resort, and the rare need for hospitalization is explained.

The book ends on an appropriate up-beat note and includes a useful list of references and a good index.

The Headache Book should be read not only by headache patients but also by medical students for its true common sense, accuracy, and balance as a good clinical introduction to the field. It could also be profitably read by primary care practitioners as a useful update of a problem so commonly seen in their offices.

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The International Classification of Sleep Disorders

By the Diagnostic Classification Steering Committee of the American Sleep Disorders Association, 396 pp, $59.95, Lawrence, Kan, Allen Inc, 1990.

The International Classification of Sleep Disorders is the product of 5 years' concerted effort on the part of the Diagnostic Classification Steering Committee of the American Sleep Disorders Association. This committee, chaired by Dr Michael Thorpy, worked in collaboration with sleep researchers, clinicians, and associations from all over the world to produce a definitive classification system of sleep disorders. The broad scope of this multispecialty and multinational project is readily apparent. The revision of the original *Diagnostic Classification of Sleep and Arousal Disorders*, published in 1979, involved surveying members of US and international professional sleep societies, and collating, evaluating, and responding to identified concerns.

The result is a comprehensive and usable classification system. In contrast with the four clusters of disorders of the original nosology, primary sleep disorders are now organized into two major groups: dyssomnias and parasomnias. The *dyssomnias* include those disorders producing a complaint of insomnia or daytime sleepiness and are further subdivided into intrinsic, extrinsic, and circadian rhythm disorders. The *parasomnias* include those disorders intruding into or occurring during sleep but not producing a primary complaint of insomnia or excessive sleepiness.

A third section, the "Medical/Psychiatric Sleep Disorders" (a helpful change from the *International Classification of Diseases* [*ICD*], *Ninth Edition* [*ICD-9*] use of the terms *organic* and *nonorganic*), comprises medical and psychiatric disorders commonly associated with sleep disturbance. "The Proposed Sleep Dis-

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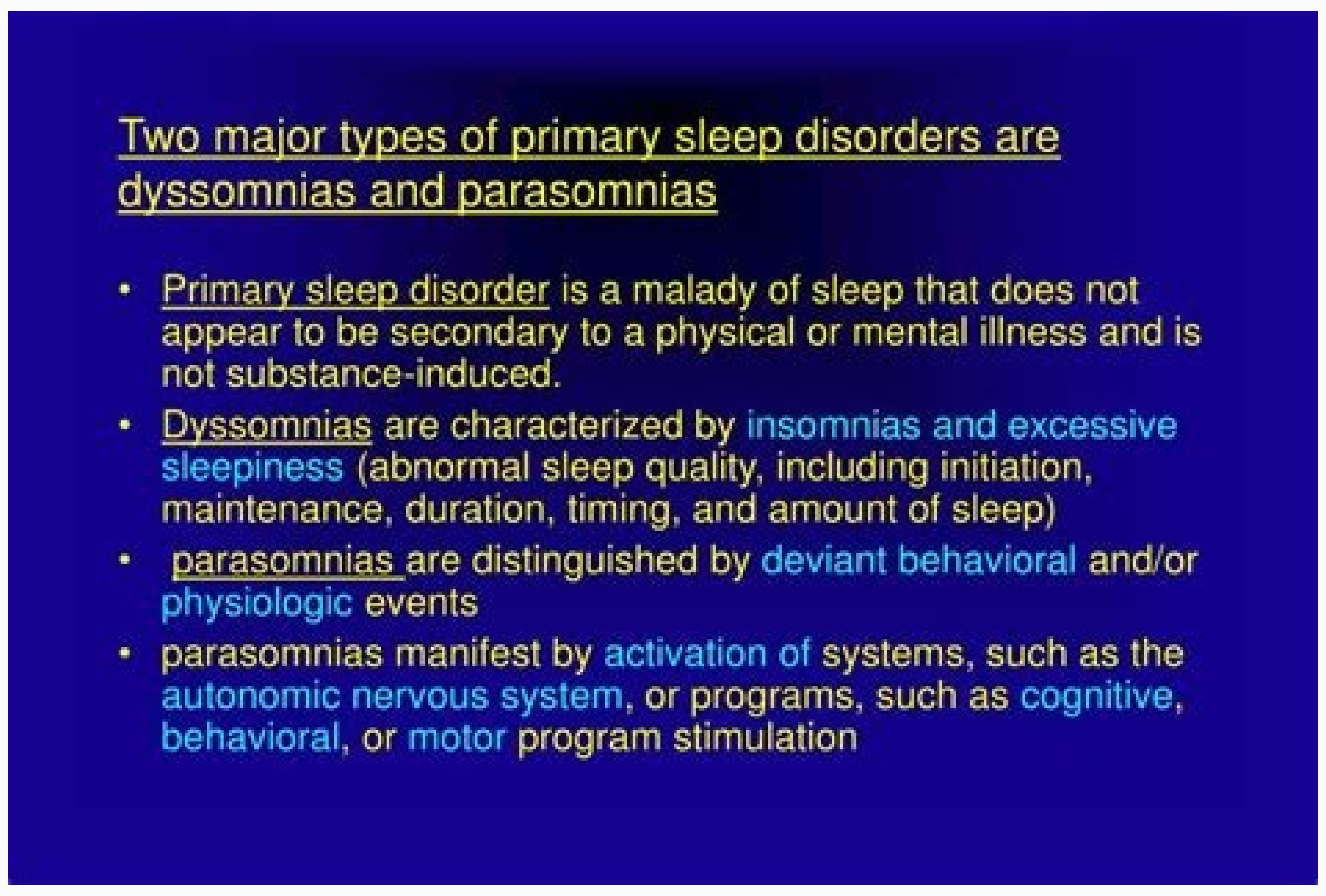

Two major types of primary sleep disorders are dyssomnias and parasomnias

- Primary sleep disorder is a malady of sleep that does not appear to be secondary to a physical or mental illness and is not substance-induced.
- Dyssomnias are characterized by insomnias and excessive sleepiness (abnormal sleep quality, including initiation, maintenance, duration, timing, and amount of sleep)
- parasomnias are distinguished by deviant behavioral and/or physiologic events
- parasomnias manifest by activation of systems, such as the autonomic nervous system, or programs, such as cognitive, behavioral, or motor program stimulation

What are parasomnias. Dyssomnias and parasomnias in early childhood. Difference between dyssomnias and parasomnias. Which sleep disorders are examples of dyssomnias.

Think you may have COVID-19? Find out where you can get tested Need a vaccine or booster? Now scheduling for ages 6 months and up Coming to a Cleveland Clinic location? Visitation and mask requirements Parasomnias are disruptive sleep-related disorders. Abnormal movements, talk, emotions and actions happen while you're sleeping although your bed partner might think you're awake. Examples include sleep terrors, sleepwalking, nightmare disorder, sleep-related eating disorder and sleep paralysis. Treatment usually begins with non-medication options. Parasomnias & Disruptive Sleep Disorders A parasomnia is a sleep disorder that involves unusual and undesirable physical events or experiences that disrupt your sleep. A parasomnia can occur before or during sleep or during arousal from sleep. If you have a parasomnia, you might have abnormal movements, talk, express emotions or do unusual things. You are really asleep, although your bed partner might think you're awake. Are there different types of parasomnia? Yes. Parasomnias are grouped by the stage of sleep in which they happen. There are two main stages of sleep – non-rapid eye movement (Non-REM) sleep and rapid eye movement (REM) sleep. There are other parasomnias that fall into an "other" category. What is non-rapid eye movement (Non-REM) sleep? What parasomnias happen during this sleep stage? Non-rapid eye movement (Non-REM) sleep are the first three stages of sleep – from first falling asleep to about the first half of the night. Non-REM sleep disorders are also called arousal disorders. Non-REM parasomnias involve physical and verbal activity. You are not completely awake or aware during these events, are not responsive to others' attempts to interact with you and you usually don't remember or only partially remember the event the next day. Non-REM parasomnias usually occur in individuals between five and 25 years of age. Non-REM parasomnias often occur in people who have a family history of similar parasomnias. Parasomnias that happen during Non-REM sleep include: Sleep terrors: If you experience this sleep disorder, you wake up suddenly in a terrified state. You may scream or cry in fright. Sleep terrors are usually brief (30 seconds), but can last up to a few minutes. Other features of this disorder are a racing heart rate, open eyes with dilated pupils, fast breathing and sweating. Sleepwalking (somnambulism): If you're a sleepwalker, you get out of bed, move about with your eyes wide open, but you're actually asleep. You may mumble or talk (sleep talking). You may perform complex activities – such as driving or playing a musical instrument – or do strange things like pee in a closet or move furniture. Sleepwalking can be dangerous and lead to injuries because you're unaware of your surroundings. You can bump into objects or fall down. Confusional arousals: If you have this sleep disorder, you appear to be partially awake, but you are confused and disoriented to time and space. You remain in bed, may sit up, have your eyes open, and may cry. You speak slowly, have trouble understanding questions that are asked or responding in a sensible way. The episode may last from a few minutes to hours. Confusional arousals are common in childhood and tend to decrease in frequency with increasing age. Sleep-related eating disorder: If you have this sleep disorder, you eat and drink while you're partially awake. You may eat foods or food combinations you wouldn't eat if awake (such as uncooked chicken or slabs of butter). Dangers include eating inedible or toxic foods, eating unhealthy or too much food, or injuries from preparing or cooking foods. What is rapid eye movement (REM) sleep? What parasomnias happen during this sleep stage? Rapid eye movement (REM) sleep follows the three non-REM stages of the sleep cycle. During REM sleep, your eyes rapidly move under your eyelids and your heart rate, breathing and blood pressure are all increased. This is a time when vivid dreaming occurs. Your body cycles through and repeats non-REM and REM sleep about every 90 to 110 minutes. Parasomnias happen during the latter part of the night. If awakened during the event, it's likely you'd be able to recall part or all of the dream. Parasomnias that happen during REM sleep include: Nightmare disorder: These are vivid dreams that cause feelings of fear, terror and/or anxiety. You may feel a threat to your survival or security. If you are awakened during your nightmare, you'd be able to describe your dream in detail. You often have trouble falling back to sleep. Nightmare disorder is more likely to occur if you're under stress or experience a traumatic event, illness/fever, extreme tiredness or after alcohol consumption Recurrent isolated sleep paralysis: If you have this sleep disorder, you can't move your body or limbs during sleep. Scientists think the paralysis might be caused by an extension of REM sleep – a stage in which muscles are already in a relaxed state. This happens either before you fall asleep or as you are waking up. Episodes last seconds to a few minutes and are distressing, usually causing anxiety or fear. Sleep paralysis can be stopped if your bed partner speaks to you or touches you. REM sleep behavior disorder (RSBD): If you have this sleep disorder, you act out, vocalize (e.g., talk, swear, laugh, shout), or make aggressive movements (e.g., punching, kicking, grabbing) as a reaction to a violent dream. This sleep disorder is more common among older adults. Many people with this disorder have neurodegenerative disease, such as Parkinson's disease, Lewy body dementia, multiple system atrophy or stroke. Other parasomnias include: Exploding head syndrome: If you have this sleep disorder, you hear a loud noise or explosive crashing sound in your head as you're falling asleep or waking up. You may also see an imaginary flash of light or have a sudden muscle jerk. Sleep enuresis (bedwetting): This is not the bedwetting that occurs in young children. To be a parasomnia, this bedwetting must happen in children age five and older and must occur at least two times a week for at least three months. Sleep-related hallucinations: If you have this sleep disorder, you experience hallucinations as you're falling asleep or waking up. You may see things, hear things, feel things or feel movement that doesn't really exist. You may leave your bed to escape what you're experiencing. Sleep-related groaning (catathrenia): With this sleep disorder, you have repeat episodes of groaning noises (long groans followed by sighs or grunts) during sleep. Sexsomnia: Persons with this sleep disorder carry out sexual behaviors during their sleep. These may include intercourse, masturbation, sexual assault, fondling your bed partner or sexual vocalizations. Are certain parasomnias more common to a certain gender? Nightmares appear to happen more often in females. Sexsomnia is seen more often in males. REM sleep behavior disorder is more commonly reported in males over age 50. Sleep terrors, confusional arousals and sleepwalking occur in a similar number of males and females. Do parasomnias occur in children? Yes. Parasomnias are more common in children than in adults. Non-REM sleep disorders are more common in children than REM disorders. The most common parasomnias in children under the age of 15 are: Confusional arousal. Sleepwalking. Sleep terror. Nightmare. Parasomnias are seen more often in children who have neurologic or psychiatric health issues including epilepsy, attention-deficit hyperactive disorder (ADHD) or developmental issues. Causes of parasomnias can be grouped into those that disrupt sleep and other general health issues. Issues that disrupt sleep: Incomplete transition from being awake to the stages of sleep. Lack of sleep, irregular sleep-wake schedules (jet lag or shift work). Medications including those that cause sleep (benzodiazepines: zolpidem), treat depression (amitriptyline, bupropion, paroxetine, mirtazapine), treat psychotic disorders (quetiapine, olanzapine), treat high blood pressure (propranolol, metoprolol), treat seizures (topiramate), treat asthma/allergy (montelukast) treat infections (fluoroquinolones). Medical issues that disrupt sleep, such as restless leg syndrome, obstructive sleep apnea, pain, narcolepsy, sleep deprivation, circadian rhythm disorders, or periodic limb movement disorder. Lack of maturity of the sleep-wake cycle (in children with parasomnias). Other health issues: Fever. Stress. Alcohol or substance abuse. Head injury. Pregnancy or menstruation. Genetics. If there's a family history of parasomnias, you're more likely to have them. Inflammatory disease, such as encephalitis. Psychiatric illness, including depression, anxiety and post-traumatic stress disorder. Neurological disease, including Parkinson's disease, Lewy body dementia, stroke, multiple system atrophy, multiple sclerosis, brain tumors, migraines, and spinocerebellar ataxia type three. What are the symptoms of parasomnias? Each type of parasomnia has many unique features and triggers. However, some of the more common symptoms include: Difficulty sleeping through the night. Waking up confused or disoriented. Being tired during the day. Finding cuts and bruises on your body for which you don't remember the cause. Displaying movements, expressions, vocalizations or activities – as told to you by your bed partner – that you don't remember. Your sleep medicine specialist will ask you and your sleep partner about your sleep symptoms. You will also be asked about your medical history, family history, alcohol use and any substance abuse. You'll be asked about your current medications. You may be asked to keep a sleep diary and your bed partner may be asked to keep track of your sleep events. Other sleep disorders tests include: Sleep study (polysomnogram): This is a sleeping laboratory in which you'll be monitored as you sleep. Your brain waves, heart rate, eye movements and breathing will be recorded as you sleep. Video will record your movements and behavior. While some sleep studies can be done at home, an in-lab study will be recommended if there's concern for parasomnia. Video electroencephalogram (EEG) or sleep EEG: These tests help your healthcare provider see and record your brain activity during a brain event. Neurologic exam, CT or MRI scan to detect degeneration of the brain or other possible neurologic causes of your symptoms. Treatment starts with identifying and treating other sleep problems and any other health issues as well as reviewing medications that may trigger the parasomnia. General management strategies for both Non-REM and REM sleep disorders are to: Follow good sleep hygiene habits (get 7-9 hours of sleep/night; turn off lights, TV and electronic devices; keep room temperature cool; avoid caffeine and strenuous exercise near bedtime). Maintain your regular sleep-wake schedule. Have a consistent bed time and wake up time. Limit, or don't use, alcohol or recreational drugs. Take all prescribed medications as directed by your healthcare provider. Other treatments for non-REM sleep disorders: Medication is not usually prescribed for non-REM parasomnias. However, when they are used, benzodiazepines are the medications of choice for parasomnias that are long lasting or potentially harmful. Tricyclic antidepressants are also sometimes tried. Psychological approaches (such as hypnosis, relaxation therapy or cognitive behavioral therapy, psychotherapy) are also considered. Other treatments for REM sleep disorders: Clonazepam and melatonin are the medications commonly used to manage REM sleep disorders. Your healthcare provider will discuss the best treatment options – medications and/or psychologic approaches – for your specific type of parasomnia considering your unique health history and medical issues. Safety precautions Another discussion you and your healthcare provider will have are suggestions to keep your sleeping environment safe. Tips include: Lock or remove any dangerous or sharp items from the bedroom. Secure tableside lights. Use floor pads to prevent injuries from falls. Pad the edges of bedside furniture. Use plastic bottles and cups if water is needed at the bedside. Install alarms on windows and doors for sleepwalkers. Sleep in separate beds if the person with parasomnia displays aggressive behaviors – like punching or kicking. How are parasomnias in children treated? Non-REM parasomnias are most common during childhood and normally end during adolescence. Usually all that’s needed is calming reassurance from the parents that everything is okay. Medications are rarely needed, but if they are, they’re typically only prescribed for three to six weeks. Medications typically tried include benzodiazepines or anti-anxiety drugs. Although some causes of parasomnias are less likely to be prevented, such as those due to neurological diseases, mental health issues or heredity, others may be prevented by following some of the same management approaches discussed in this article. These include getting seven to nine hours of sleep a night sticking with consistent bedtime and wakeup times, and limiting alcohol and recreational drug use. (See the treatment section for more tips.) Also, ask your healthcare provider to review your current medications. Many can disrupt sleep. If this is the case, perhaps different drugs can be prescribed. You should talk to your doctor if you or your family member experiences any abnormal sleep-related behaviors, especially those associated with injuries or sleep disruption. Last reviewed by a Cleveland Clinic medical professional on 04/29/2021. References National Institute of Neurological Disorders and Stroke. Brain Basics: Understanding Sleep. (Accessed 4/22/2021. American Academy of Sleep Medicine. Parasomnias – Overview and Facts. (Accessed 4/22/2021. Sleep Foundation. Parasomnias. (Accessed 4/22/2021. Sateia MJ. International classification of sleep disorders-third edition: highlights and modifications. 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