

PERSONALITIES

Outline

- ⊕ Definition
- ⊕ Classification
- ⊕ Pathophysiology
- ⊕ Types of sleep disorders
- ⊕ Assessment
- ⊕ Management
- ⊕ Importance And Future

Definition

Parasomnias

- ⊕ Disorders characterized by *abnormal behavioral or physiological events* occurring in association with sleep, specific sleep stages or sleep-wake transitions.

Dyssomnias

- ⊕ Primary disorders of *initiating or maintaining sleep* or of *excessive sleepiness* & are characterized by disturbance in the *amount, quality or timing* of sleep.
- ⊕ Insomnia , Hypersomnia, Disorder of sleep – wake schedule.

DEFINITION

ICD 10

- ⊕ Abnormal episodic events occurring during sleep in childhood these are related mainly to development while in adulthood they are predominantly psychogenic
ie sleep walking sleep terrors and nightmares

DSM 5

- ⊕ Abnormal behavioral or physiological events occurring in association with sleep specific sleep stages or sleep wake transitions

STATE BOUNDARY VIOLATIONS SEEN IN PEREUSOMNIAS

- ⊕ Overlaps or intrusions of one basic sleep/wake state into another
- ⊕ Wakefulness, NREM sleep and REM sleep can be characterized as three basic states that differ in their neurological organization
- ⊕ Wakefulness: body and brain active
- ⊕ NREM sleep: much less active body and brain
- ⊕ REM sleep: pairs atonic body with an active brain

⊕ AROUSAL DISORDERS Momentary or partial wakeful behaviors suddenly occurring in NREM slow wave sleep Eg confusional arousal sleep walk sleep terror

⊕ TRANSITION DISORDERS Isolated sleep paralysis is persistence of REM atonia into wakefulness transition

⊕ REM behavior disorder Failure of mechanism of REM atonia where individuals literally act out their dream

ICD 10 NON ORGANIC SLEEP DISORDERS F51

⊕ Sleep walking Somnambulism F513

⊕ Sleep terrors Night terrors F514

⊕ Nightmares F515

DSM 5 CLINICAL DEFINITION

⊕ Nightmare disorder *dream anxiety disorder*

⊕ Sleep terror disorder

⊕ Sleep walking disorder

⊕ Restless leg syndrome

⊕ Parasomnia nos

⊕ Sleep disorder due to substance *Parasomnia type*

⊕ Sleep disorder due to GME *Parasomnia type*

ICSD CLASSIFICATION

DISORDERS OF AROUSAL FROM NREM SLEEP

- ⊕ 1 Sleepwalking
- ⊕ 2 Sleep terrors
- ⊕ 3 Confusional arousals

DISORDERS USUALLY ASSOCIATED WITH REM SLEEP

- ⊕ 1 REM sleep behavior disorder
- ⊕ 2 Recurrent isolated sleep paralysis
- ⊕ 3 Nightmare disorder

ICSD CLASSIFICATION

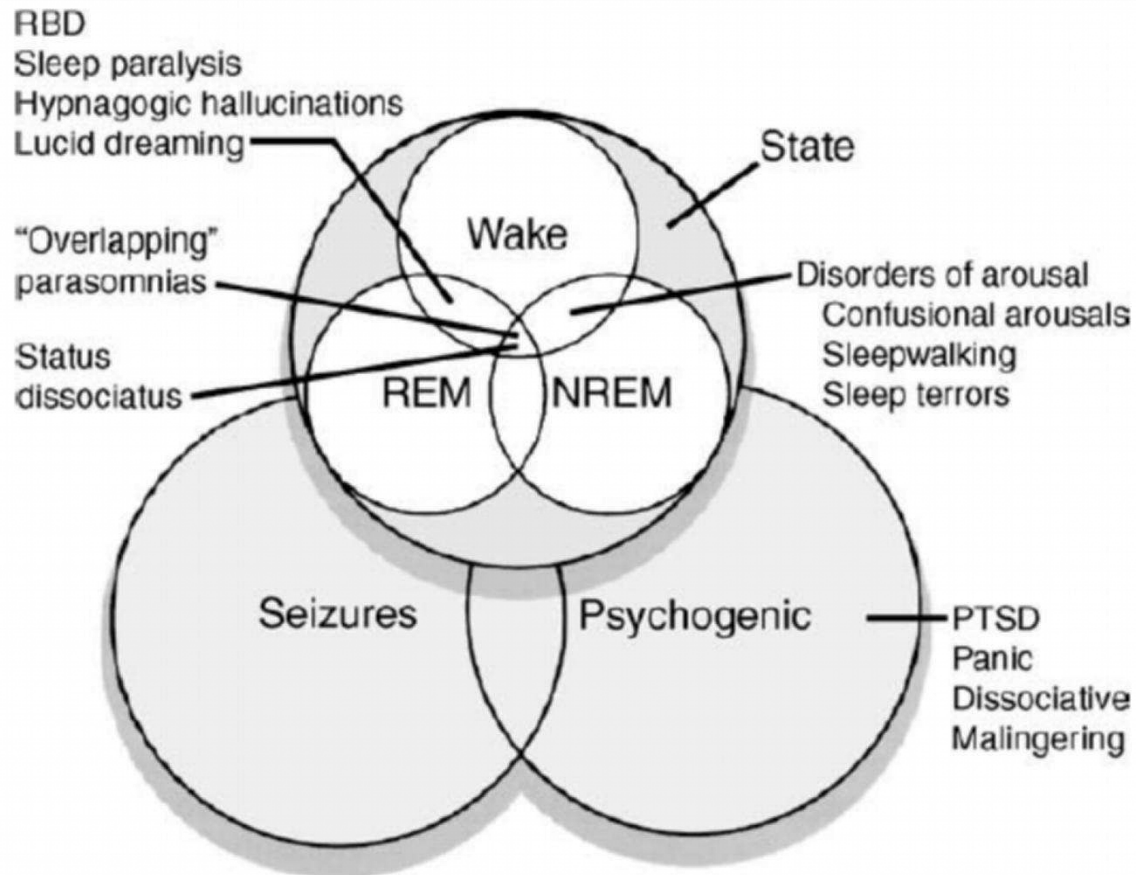
OTHER PARASOMNIAS

- ⊕ Sleep related dissociative disorder
- ⊕ Sleep enuresis
- ⊕ Sleep related groaning Catathrenia
- ⊕ Exploding head syndrome
- ⊕ Sleep related hallucinations
- ⊕ Sleep related eating disorders
- ⊕ Parasomnia unspecified
- ⊕ Parasomnia due to drug or substance use
- ⊕ Parasomnia due to medical condition

DEEPHYSIOLOGY

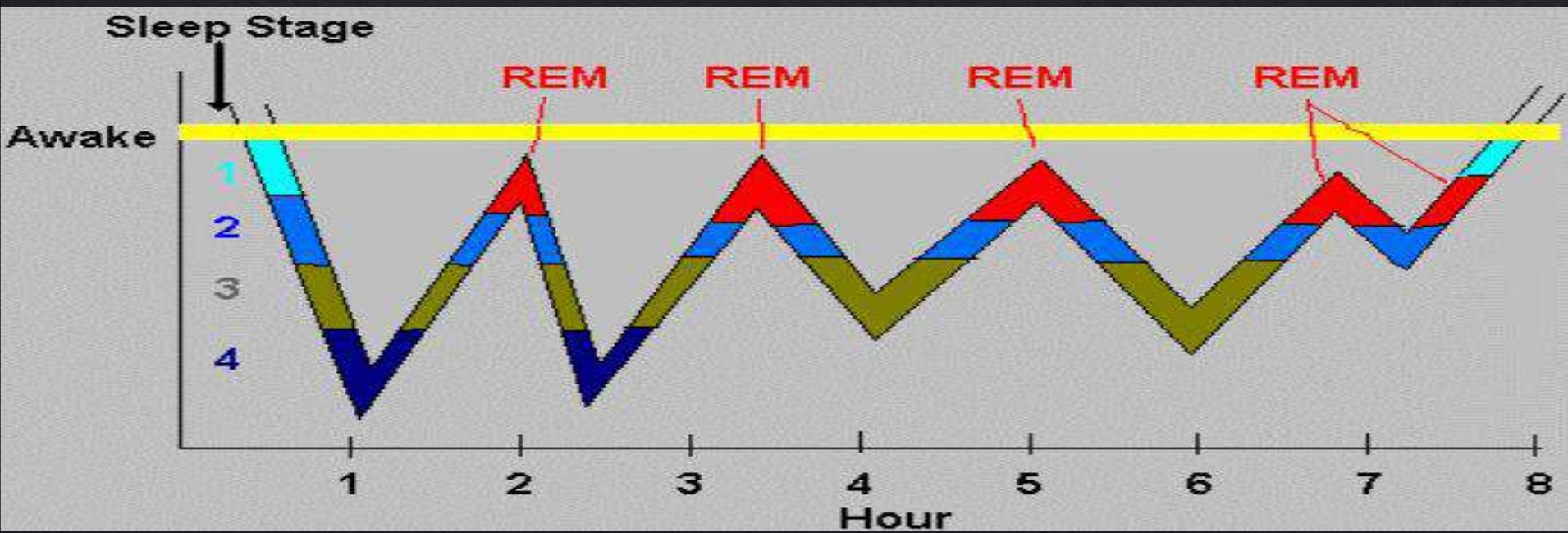
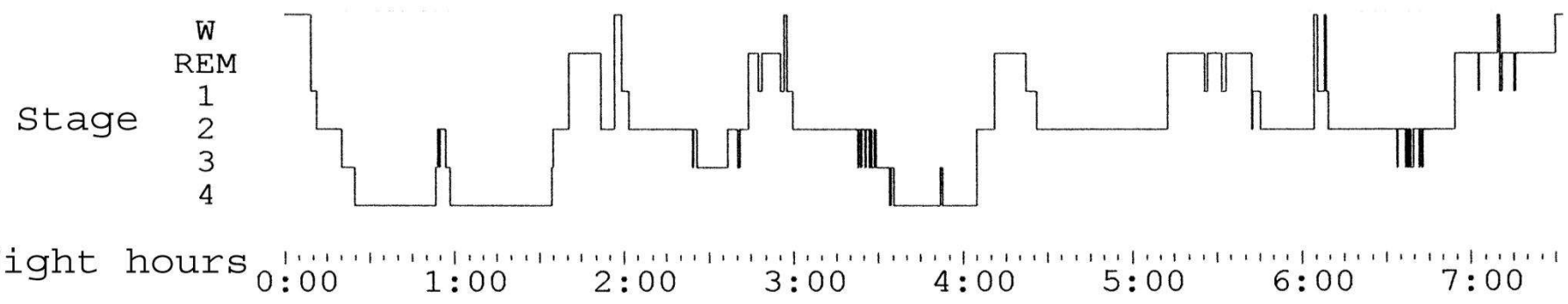
- ⊕ Sleep and wakefulness are not invariably mutually exclusive states
- ⊕ Various state determining variables of wakefulness NREM sleep and REM sleep may occur simultaneously or oscillate rapidly
- ⊕ The admixture of wakefulness and NREM sleep would explain confusional arousals
- ⊕ The tonic and phasic components of REM sleep may become dissociated intruding or persisting into wakefulness explain REM parasomnias

DEEP PHENOMENOLOGY



The overlapping nature of state and conditions associated with parasomnias.

NORMAL SLEEP ARCHITECTURE



TRIGGERS

⊕ *Prior sleep deprivation*

⊕ *Physical activity*

⊕ *Emotional stress*

⊕ *Alcohol*

⊕ *Medication induced*

⊕ *Menopause*

⊕ *Other sleep disorders sleep disordered breathing periodic limb movement*

SLEEPWALKING SOMNAMBULISM

⊕ Is a state of altered consciousness in which phenomena of sleep and wakefulness are combined

⊕ Repeated episodes of motor behaviour initiated in sleep usually during delta sleep in the first third of the night

ICD 10

A The predominant symptom is one or more episode of rising from bed usually during the first third of nocturnal sleep and walking about

B During the episode individual has a blank staring face is relatively unresponsive to the efforts of others to influence the event or to communicate with him or her and can be awakened only with considerable difficulty

C Upon awakening either from an episode or the next morning the individual has no recollection of the episode

D Within several minutes of awakening from the episode there is no impairment of mental activity or behavior although there may be a short period of some confusion and disorientation

E There is no evidence of an organic mental disorder such as dementia or a physical disorder such as epilepsy

D&M 5

A Repeated episodes of rising from bed during sleep and walking about usually occurring during the first third of the major sleep episode. While sleepwalking the person has a blank staring face is relatively unresponsive to the efforts of others to communicate with him or her and can be awakened only with great difficulty

B No or little eg only a single visual scene dream imagery is recalled

C Amnesia the episode is present

D The sleepwalking causes clinically significant distress or impairment in social occupational or other important areas of functioning

E The disturbance is not due to the direct physiological effects of a substance

F Coexisting mental and medical disorders do not adequately explain the episode of sleep walking

CLINICAL FEATURES

- ⊕ Individual arises from bed and ambulates without fully awakening
- ⊕ Engage in a variety of complex behaviors while unconscious
- ⊕ Disorder of arousal from deepest stages of sleep stage 3 and 4
- ⊕ Sleep deprivation and interruption exacerbate or provoke episodes
- ⊕ Patient can successfully interact with the environment

CLINICAL FEATURES

- ⊕ Once awake person will appear confused
- ⊕ Better not to grab or shake the person to wake up
- ⊕ May react violently if forced to wake up
- ⊕ Common in children age 4-8 yrs
- ⊕ In adolescence it disappears completely

DIFFERENTIAL DIAGNOSIS

- ⊕ **Psychomotor epilepsy** very seldom occurs only at night
- ⊕ During the epileptic attack the individual is completely unresponsive to environmental stimuli and perseverative movements such as swallowing and rubbing the hands are common
- ⊕ The presence of epileptic discharges in the EEG confirms the diagnosis although a seizure disorder does not preclude coexisting sleepwalking
- ⊕ **Dissociative fugue** must also be differentiated from sleepwalking
- ⊕ In dissociative disorders the episodes are much longer in duration and patients are more alert and capable of complex and purposeful behaviours
- ⊕ These disorders are rare in children and typically begin during the hours of wakefulness

POLYSOMNOGRAPHIC FINDINGS

⊕ Sleepwalking

- ⊕ Increased brief arousals from slow wave sleep
- ⊕ Preserved sleep EEG
- ⊕ Hypersynchronized delta activity
- ⊕ Autonomic activation following arousal

TREATMENT OF SLEEP WALKING

- No specific treatment
- Some patients may respond to BZDs and antidepressants
- Prevent injuries to sleep walker

SLEEP TERROR DISORDER

⊕ Repeated abrupt awakenings from sleep characterized by intense fear, panicky screams, autonomic arousal

tachycardia, rapid breathing and sweating, absence of detailed dream recall, amnesia for the episode, and

relative unresponsiveness to attempts to comfort the person

A The predominant symptom is that one or more episodes of awakening from sleep begin with a panicky scream and are characterized by intense anxiety body motility and autonomic hyperactivity such as tachycardia rapid breathing dilated pupils and sweating

B These repeated episodes typically last 1 to 10 minutes and usually occur during the first third of nocturnal sleep

C There is relative unresponsiveness of efforts of others to influence the sleep terror event and such efforts are almost invariably followed by at least several minutes of disorientation and perseverative movements

D Recall of the event if any is minimal

E There is no evidence of a physical disorder such as brain tumor or epilepsy

A Recurrent episodes of abrupt awakening from sleep usually occurring during the first third of the major sleep episode and beginning with a panicky scream. Intense fear and signs of autonomic arousal such as tachycardia rapid breathing and sweating during each episode. Relative unresponsiveness to efforts of others to comfort the person during the episode

B No or little eg only a single visual scene dream imagery is recalled

C Amnesia the episode is present

D The episodes cause clinically significant distress or impairment in social occupational or other important areas of functioning

E The nightmares symptoms are not attributable to the physiological effects of a substance eg a drug of abuse a medication

F Coexisting mental and medical disorders do not adequately explain the episode of sleep terrors

CLINICAL FEATURES SLEEP TERRORS

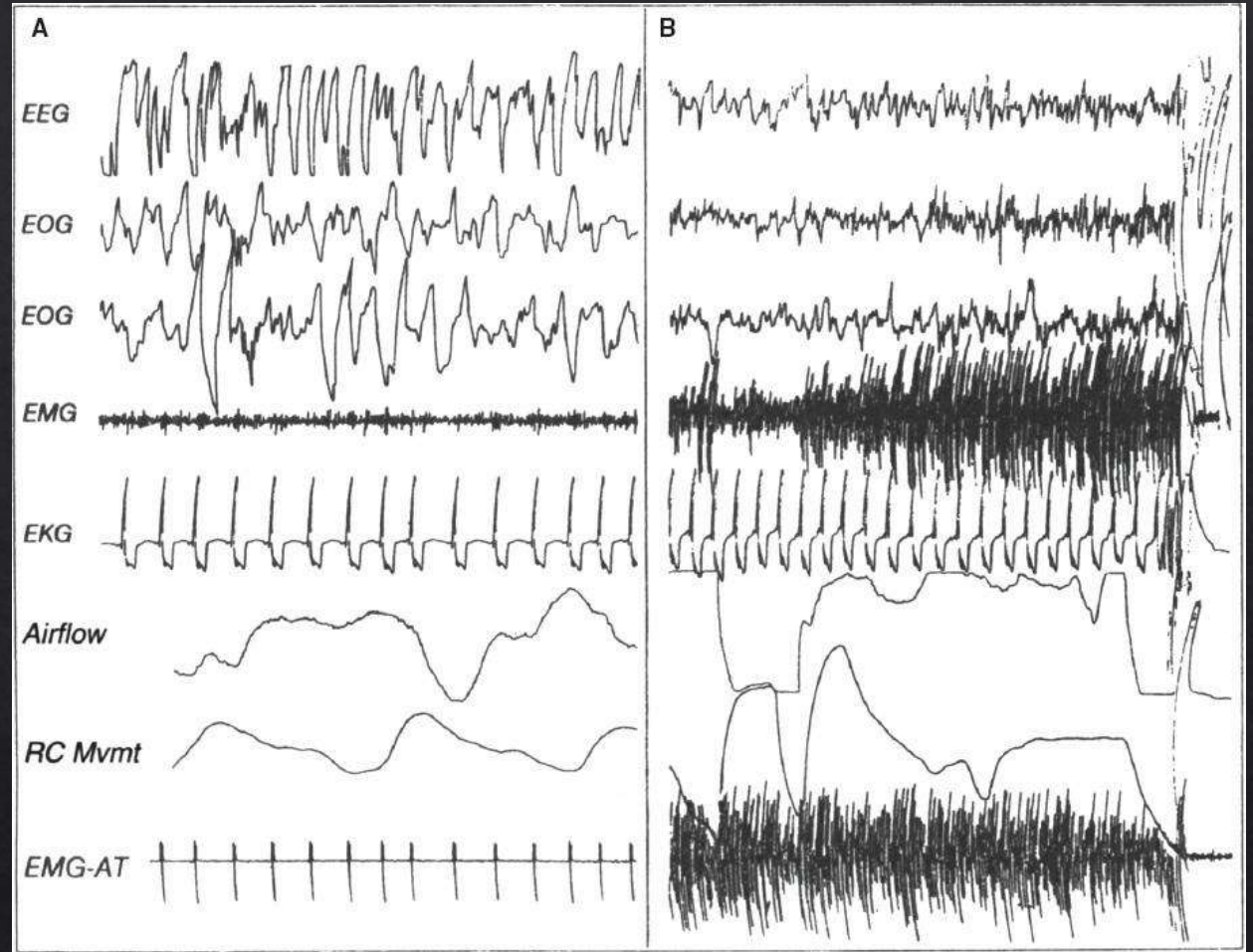
- ⊕ Occur primarily during delta sleep
- ⊕ Usually takes place during the first third of the night
- ⊕ Sleep terrors may also be called night terrors, pavor nocturnus
- ⊕ Incidence in children 1 to adults 1
- ⊕ 4-12 yrs resolves on its own
- ⊕ Boys > girls
- ⊕ Strong genetic component with high probability that one or both parents will have a history of sleep terrors, sleepwalking or another parasomnia

DIFFERENTIAL DIAGNOSIS

- ⊕ Sleep terrors should be differentiated from **nightmares**
- ⊕ The latter are the common **bad dreams with limited if any vocalization and body motility**
- ⊕ In contrast to sleep terrors **nightmares occur at any time of the night and the individual is quite easy to arouse and has a very detailed and vivid recall of the event**
- ⊕ In differentiating sleep terrors from **epileptic seizures** seizures very seldom occur only during the night
- ⊕ An abnormal clinical EEG however favours the diagnosis of epilepsy

POLYSOMNOGRAM OF SLEEP TERROR

Autonomic hyperactivity in sleep terror



TREATMENT OF SLEEP TERROR

- ⊕ Sleep hygiene
- ⊕ Maintaining a "safe" sleep environment i.e. removing sharp or pointed objects that the sleeper could run into having these individuals sleep in ground floor bedrooms
- ⊕ BZD's suppress delta sleep and decrease arousal
- ⊕ Clonazepam 0.25 to 1mg

NIGHTMARE DISORDER

- ⊕ Recurrent dreams followed by awakening with *full detailed recall*
- ⊕ Predominant emotion fear anger embarrassment sorrow may occur
- ⊕ Typically occur in *latter third of night* increased proportion of REM sleep
- ⊕ Individuals predisposed *schizotypal borderline schizoid personalities schizophrenia*
- ⊕ "thin boundaries" individuals who are open trusting and often have artistic inclinations
- ⊕ No overt dream enactment

NIGHTMARE DISORDER

- ⊕ Lead to fear of going to sleep insomnia
- ⊕ Insomnia exacerbates nightmares
- ⊕ L DOPA beta blockers withdrawal from REM suppressant medications
- ⊕ Prevalence 5-8 adults
- ⊕ women men
- ⊕ Commonest psychiatric comorbidity PTSD
- ⊕ Associated with other psychiatric disorders like depression substance abuse disorders personality disorders

ICD 10

A Awakening from nocturnal sleep or naps with detailed and vivid recall of intensely frightening dreams usually involving threats to survival security self esteem the awakening may occur at any time during the sleep period but typically during the second half

B Upon awakening from the frightening dream the individual becomes rapidly oriented and alert

C The dream experience itself and the resulting disturbance of sleep causes marked distress to individual

DSM 5

A Repeated occurrences of extended extremely dysphoric and well remembered dreams that usually involve effort to avoid threats to survival security or physical integrity and that generally occur during the second half of the major sleep episode

B On awakening from the dysphoric dreams the person rapidly becomes oriented and

C The sleep disturbance causes clinically significant distress or impairment in social occupational or other important areas of functioning

D The nightmares symptoms are not attributable to the physiological effects of a substance eg a drug of abuse a medication

E Coexisting mental and medical disorders do not adequately explain the predominant complaint of dysphoric dreams

DIFFERENTIAL DIAGNOSIS

- ⊕ *Sleep terrors* In the latter the episodes occur during the first third of the sleep period
- ⊕ Marked by intense anxiety, panicky screams, excessive body motility and extreme autonomic discharge
- ⊕ In sleep terrors there is no detailed recollection of the dream either immediately following the episode or upon awakening in the morning

TREATMENT NIGHTMARE DISORDER

⊕ Self limited in children

⊕ Cognitive and behavioural interventions including systematic desensitization relaxation techniques as methods effective in reducing the frequency and severity of nightmares

⊕ Although SSRIs do suppress REM activity they also tend to lighten and fragment sleep

⊕ Sedative hypnotic anxiolytic agents do not suppress REM but may prevent arousals

	SLEEP TERROR	NIGHTMARES
STAGE OF SLEEP	NREM	REM
RECALL	Poor	Good
CONTENT	May be devoid of images or fragments of vivid frightening images	Elaborate increasingly frightening dream
AFTER EPISODE	Disoriented	Usually oriented

CONFUSIONAL EPISODES

- ⊕ Brief simple motor behaviors with little emotional expression or responsiveness to the environment
- ⊕ Mental confusion on arousal or awakening
- ⊕ May be accompanied by indistinct vocalization
- ⊕ Episodes are brief with dense amnesia for the episode
- ⊕ Cross sectional prevalence 4%
- ⊕ Comparable rates among men and women
- ⊕ Prevalence decreases with age

CONFUSIONAL EPOISDES

⊕ Mildest form

⊕ Very common in young children

⊕ Child will typically partially awaken and sit up

⊕ Episodes are marked by confusion but usually the child backs down and resumes sleep

REM SLEEP BEHAVIOR DISORDER

- ✦ Involves a failure of atony during REM stage sleep
- ✦ Characterized by **loss of coordination of dreaming** **atonia** of skeletal muscle during REM sleep
- ✦ **Act out dreams** complex motor behavior like punching kicking screaming running
- ✦ **Agitated violent behavior leading to injury to self or bed partner**
- ✦ **Eyes closed unresponsive to environment**
- ✦ If awakened achieve rapid alertness
- ✦ Report dream to which behavior corresponds
- ✦ **Memory for dream content is good upon awakening**

DSM 5

- ⊕ A Repeated episodes of arousal during sleep associated with vocalization and or complex motor behavior
- ⊕ B These behavior arise during REM sleep and therefore usually occur 90 minutes after sleep onset are more frequent during the later portions of the sleep period and uncommonly occur during day time naps
- ⊕ C Upon awakening from these episodes the individual is completely awake alert and not confused or disoriented
- ⊕ D Either of the following
 - 1 REM sleep without atonia on polysomnogram
 - 2 H & O REMSBD and an established synucleinopathy diagnosis

DSM 5

- ⊕ E The sleep disturbance causes clinically significant distress or impairment in social occupational or other important areas of functioning
- ⊕ I The nightmares symptoms are not attributable to the physiological effects of a substance eg a drug of abuse a medication
- ⊕ G Coexisting mental and medical disorders do not adequately explain the episodes

NEUROLOGIC CONDITIONS CAUSING RBD

- ⊕ Bilateral peri locus coeruleus lesions
- ⊕ Diffuse hemispheric lesions
- ⊕ Bilateral thalamic abnormalities
- ⊕ Brainstem lesions
- ⊕ Parkinson's disease dementia
- ⊕ Lewy body dementia
- ⊕ Multiple system atrophy / Shy Drager syndrome
- ⊕ Narcolepsy
- ⊕ Progressive supranuclear palsy

SUBSTANCE ASSOCIATED WITH RBD

WITHDRAWAL

- ⊕ Alcohol
- ⊕ Amphetamines
- ⊕ Cocaine
- ⊕ Barbiturates
- ⊕ Meprobamate
- ⊕ Pentazocine
- ⊕ Nitrazepam

MEDICATION

- ⊕ Biperiden
- ⊕ Tricyclic antidepressants
- ⊕ MAO inhibitors
- ⊕ Serotonin reuptake inhibitors
- ⊕ Venlafaxine
- ⊕ Caffeine

POLYSOMNOGRAM

⊕ RBD

- ⊕ Polysomnography required to confirm Diagnosis
- ⊕ Elevated muscle tone
- ⊕ Increased phasic muscle activity in chin submentalis or limb ant tibialis EMG during REM sleep
- ⊕ Periodic limb movements
- ⊕ Otherwise typically normal polysomnograph

TREATMENT OF RBD

RBD

⊕ Clonazepam

⊕ First line drug

⊕ Dose Q5 2mg

⊕ Shorter acting benzodiazepines

⊕ Lorazepam 1 2 mg

⊕ Melatonin 3 15 mg

⊕ Pramipexole Q5 1 mg

⊕ Carbamazepine clonidine levodopa l tryptophan donepezil

RECURRENT ISOLATED SLEEP PARALYSIS

- ⊕ Inability to make voluntary movements during sleep
- ⊕ During sleep onset and awakening when individual is partially conscious and aware of surroundings
- ⊕ Distress increases when pt also has hypnogogic or hypnopompic hallucination
- ⊕ One of the tetrad of symptoms of narcolepsy
- ⊕ May or may not be accompanied by hypnagogia
- ⊕ May lead to experiences such as feeling a presence near them ghost or creature attacking them witch riding etc

RECURRENT ISOLATED SLEEP PARALYSIS

⊕ Irregular sleep sleep deprivation psychological stress shift work exacerbate sleep paralysis episodes

⊕ Occurs in 78% of young adults

⊕ If individual makes voluntary rapid eye blinking or is touched by another person episode terminates

⊕ Sleep hygiene and reassurance first line therapies

SLEEP BRUXISM

- ⊕ Sleep Related Bruxism is diagnosed when an individual grinds or clenches their teeth during sleep
- ⊕ ICD formerly classified sleep bruxism as a parasomnia but now lists it as a sleep related movement disorder
- ⊕ can produce abnormal wear on the teeth damage teeth provoke tooth and jaw pain and or make loud unpleasant sounds that disturb the bed partner
- ⊕ The etiology and pathophysiology of sleep bruxism remain unclear
- ⊕ treatment involves having the patient wear an oral appliance to protect the teeth during sleep
 - ⊕ There are two basic types of appliances used
 - ⊕ soft one mouth guard is typical used in the short term
 - ⊕ hard acrylic one bite splint is use longer term

RESTLESS LEGS SYNDROME

- ✦ RLS is characterized by the irresistible urge to move the legs when at rest or while trying to fall asleep. Patients often report crawling feelings in their legs.
- ✦ Moving the legs or walking around helps alleviate the discomfort.
- ✦ Uremia neuropathies and iron and folic acid deficiency anemias can produce secondary RLS.
- ✦ RLS is also reported with fibromyalgia, rheumatoid arthritis, diabetes, thyroid diseases, and COPD.
- ✦ dopaminergic agonists like pramipexole and ropinirole are FDA approved and represent the treatment of choice.

SLEEP RELATED DISSOCIATIVE DISORDER

- ⊕ Dissociative Identity Dissociative fugue Dissociative NOS
- ⊕ History of violence trauma and or psychiatric illness
- ⊕ Individuals with dissociative disorder has nocturnal episodes of dissociation
- ⊕ More common in women with h/o past trauma
- ⊕ During EEG established wakefulness
- ⊕ On transition from sleep to wakefulness to several minutes after wakefulness
- ⊕ Behaviors complex violent self mutilating abuse re enactment or fugue
- ⊕ May occur in 1/4th of pts with dissociative disorder

SLEEP RELATED ENURESIS

- ⊕ Bed wetting individual urinates during sleep while in bed
- ⊕ Primary and secondary
- ⊕ Secondary asse with nocturnal seizures sleep deprivation urological abnormalities
- ⊕ Occur in REM or NREM sleep
- ⊕ Sleep is normal
- ⊕ Common in children present in 12 adolescents 05 adults
- ⊕ Formal urologic examination not required
- ⊕ Rule out nocturnal seizures

Sleep related enuresis

- ⊕ TCA Imipramine Desipramine
- ⊕ Desmopressin intranasally

SLEEP RELATED GROANING

- ⊕ *Catathrenia* groaning during sleep intermittently during REM or NREM
- ⊕ Prolonged often loud often socially disruptive groaning sounds during expiration
- ⊕ Can occur at any stage during the sleep cycle
- ⊕ Begins in childhood
- ⊕ No association with psychiatric disorders
- ⊕ Parasomnia vs sleep disordered breathing

Treatment

- ⊕ Continuous positive airway pressure
- ⊕ Upper airway surgery
- ⊕ Oral appliance treatment

EXPLODING HEAD SYNDROME

- ⊕ Abrupt arousal occurring in transition from wake to sleep with sensation of loud sound like an explosion or sensation of bursting of head
- ⊕ Not associated with pain
- ⊕ Wakefulness and REM sleep
- ⊕ No known neurological consequences
- ⊕ R^o seizure

Treatment

- ⊕ Clomipramine
- ⊕ Nifedipine

SLEEP RELATED HALLUCINATIONS

⊕ *Hypnogogic and Hypnopompic*

⊕ *Classically visual may include auditory tactile at onset or offset of sleep*

⊕ *Represent REM intrusion into wakefulness*

⊕ *Prevalence*

⊕ *Hypnogogic 37*

⊕ *Hypnopompic 125*

SLEEP RELATED HALLUCINATIONS

- ⊕ Complex nocturnal visual hallucinations less common
- ⊕ Visual hallucination of animal or person after full awakening from sleep may remain for several minutes disappear when illumination is increased
- ⊕ May be related to neuropsychiatric condition DLBD or only anxiety

SLEEP RELATED EATING DISORDER

- ⊕ Inability to get back to sleep after awakening unless the individual has something to eat or drink
- ⊕ Predominantly affects infants and children
- ⊕ In adults nocturnal feeding can be conditioned to awakening
- ⊕ Eating may become obsessional several small meals
- ⊕ Unaware of the activity weight gain

TREATMENT OF SRED

SRED tailored to individual patient

- ⊕ Short to intermediate acting benzodiazepines or non appetite stimulating sedatives trazodone
with h₁ or Sleepwalking
- ⊕ Antidepressants SSRI bupropion
- ⊕ Topiramate decrease frequency of nocturnal eating decrease weight gain

PARASOMNIA NOS

⊕ REM sleep behavior disorder

⊕ Sleep paralysis

⊕ Parasomnia is present but unable to determine whether it is primary due to a general medical condition or substance induced

PARASOMNIA DUE TO SUBSTANCE USE

⊕ Alcohol

⊕ Drugs worsening parasomnias: biperiden, TCAs, MAOIs, caffeine, venlafaxine, selegiline, serotonin agonists

⊕ Medications known to provoke nightmares: L-DOPA and beta blockers

⊕ Nightmares caused by drug-induced REM sleep rebound: eg. withdrawal from REM-suppressing drugs like methamphetamine

SLEEP DISORDERS DUE TO GMC

- ⊕ *Degenerative neurologic diseases*
- ⊕ *Cardiovascular disease*
- ⊕ *Endocrine hypo or hyperthyroidism*
- ⊕ *Viral and bacterial infections*
- ⊕ *Respiratory disorders*
- ⊕ *Pain from musculoskeletal disease*

ASSESSMENT

CLINICAL EVALUATION

History Practice parameters by GRC&M

- ⊕ Describe characterize behavior in details
- ⊕ Age of onset time at night frequency regularity duration of episodes
- ⊕ Risk of injury to self others property
- ⊕ Distress caused to patient and family
- ⊕ Sleep disturbance
- ⊕ Presence of other sleep disorders
- ⊕ Use of medication substance

CLINICAL EVALUATION

- ⊕ Clinical examination including complete Neurological examination
- ⊕ Common uncomplicated non injurious parasomnias like typical disorders of arousal nightmares enuresis can be diagnosed by clinical evaluation alone
- ⊕ Need for EEG should be based on clinical judgment and likelihood that patient has sleep related seizures

CLINICAL EVALUATION

⊕ Formal evaluation indicated for behaviors

⊕ Potentially violent or injurious

⊕ Extremely disruptive to other household members

⊕ Excessive day time sleep

⊕ Associated with medical psychiatric or neurologic symptoms or findings

⊕ NREM parasomnias if new onset in adult without childhood h & t & r & treatable causes of arousal eg sleep disordered breathing or nocturnal seizures

MANAGEMENT

GENERAL PRINCIPLES

Children

- ⊕ May not require pharmacologic treatment
- ⊕ Intermittent self limiting poses little risk to child does not negatively affect daytime functioning
- ⊕ Reassurance that they lack psychological significance
- ⊕ Regular sleep wake time
- ⊕ Avoidance of sleep deprivation

GENERAL PRINCIPLES

- ⊕ Voiding before bedtime
- ⊕ Treatment of underlying sleep disorders eg sleep apnea restless leg syndrome may decrease frequency of episodes
- ⊕ Improve safety of sleeping environment eg locking door window keeping stairways well lit to reduce potential harm
- ⊕ Anticipatory awakening
- ⊕ Sleep hygiene

GENERAL PRINCIPLES

Adults

1 Sleep hygiene

2 Modifying predisposing and precipitating factors

Identify medication causing or contributing to disorder

RBD & RITCA MAOI & RED zolpidem

3 Improving safety of sleeping environment

⊕ Locking doors and windows

⊕ Limiting objects in bedroom safety of bed partner

⊕ Sleeping on mattress on floor on groundfloor

4 Pharmacotherapy

IMPORTANCE IN PSYCHIATRY

- ⊕ Parasomnias can be misdiagnosed and inappropriately treated as a psychiatric disorder
- ⊕ Parasomnias can be a direct manifestation of a psychiatric disorder eg dissociative disorder
- ⊕ The emergence and or recurrence of a parasomnia can be triggered by stress
- ⊕ Psychotropic medications can induce the initial emergence of a parasomnia or aggravate a pre existing parasomnia

IMPORTANCE IN PSYCHIATRY

- ⊕ Parasomnias can cause psychological distress or can induce or reactivate a psychiatric disorder in the patient or bed partner on account of repeated loss of self control during sleep and sleep related injuries
- ⊕ Familiarity with the parasomnias will allow psychiatrists to be more fully aware of the various medical and neurological disorders that can be associated with disturbed sleep related behaviour and disturbed dreaming

IMPORTANCE IN PSYCHIATRY

- ⊕ Parasomnias present a special opportunity for interlinking animal basic science research including parasomnia animal models with human sleep behavioural disorders
- ⊕ Parasomnias carry forensic implications Psychiatrists may be asked to render an expert opinion in medico legal cases pertaining to sleep related violence

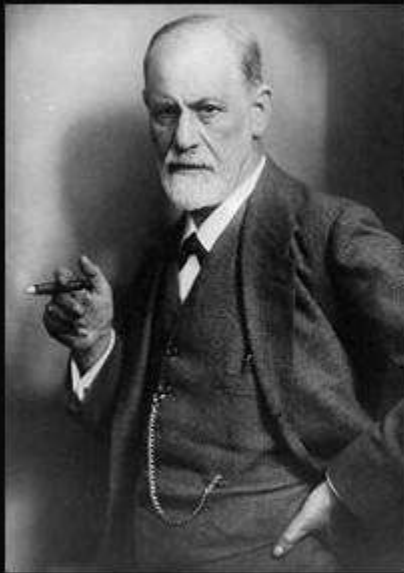
FUTURE DIRECTION

- ⊕ Development of clear indications for pharmacotherapy
- ⊕ Need for RCTs to evaluate treatment efficacy safety and outcomes especially for newer drugs
- ⊕ Insight into association of parasomnias with psychiatric disorders
- ⊕ Follow up studies especially of childhood parasomnias
- ⊕ Forensic implications of parasomnias objective evidence based guidelines

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THANK
YOU



Dreams are often most profound when they seem
the most crazy.

(Sigmund Freud)

izquotes.com