Sleep-Wake Disorders in the DSM-5-TR

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Objectives

- Explore the symptoms and prevalence of the major sleep wake disorders in the DSM-5-TR
- Identify risk factors and treatment targets

- "Sleep-wake disorders encompass 10 disorders or disorder groups: insomnia disorder, hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, circadian rhythm sleep-wake disorders, non–rapid eye movement (NREM) sleep arousal disorders, nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/medication-induced sleep disorder"-DSM-5-TR

Prevalence

- Insomnia
  - 4%–22% of adults have symptoms that meet criteria for insomnia disorder
  - 40-50% of people with comorbid mental illness report insomnia symptoms
- Hypersomnolence: 5%- 33% of Americans
- Circadian Rhythm Sleep Disorder: 3%
- Obstructive sleep apnea: 15-30% of males and 10-15% of females
- Restless Legs 4-14%

Sleep Assessment Considerations

- Sleep latency
  - How long does it take to get to sleep?
- Wake after sleep onset (duration)
  - How long do you stay asleep before waking up?
- Number of awakenings
  - How many times do you wake up each night?
- “Sleep efficiency” Time spent asleep
  - How much time are you actually asleep each night (not just in bed)?

Sleep Changes: Lifespan

- Human sleep varies across the life span.
- Childhood and early adolescence are characterized by large amounts of slow-wave sleep; however, adults show increased wakefulness and N1 sleep and decreased deep sleep.
- Age must be considered in the diagnosis of a sleep disorder DSM-5-TR

Associated and Comorbid Features

- Sleep disorders are often accompanied by (DSM-5-TR)
  - depression, anxiety
  - cognitive changes
  - substance use and non–substance use disorders
  - other medical conditions.
- They may also represent early warning signs of an episode of mental illness providing opportunities for early intervention to stop or reduce the intensity of a full-blown episode.

Associated Features

- Sleep Disorders may be accompanied by a variety of other impairments including
  - Fatigue or, conversely, overaroused and “wired.”
  - Decreased energy
  - Mood disturbances.
  - Increased incidence of stress-related somatic symptoms: tension headache, muscle tension or pain, gastrointestinal symptoms
  - Increased risk of cardiovascular diseases

Suicidality

- Insomnia may increase the risk for suicidal thoughts, suicidal behavior, and death, even after adjustment for depression
- Nightmares increase risk for suicidal thoughts and behavior.
- 31.3% of college students with sleep problems had suicidal thoughts
- 82.7% of college students with suicidal thoughts had sleep problems.
- A consensus statement of the American Academy of Sleep Medicine concluded that in adolescence < 8 hours of sleep is associated with increased risk of self-harm, suicidal thoughts, and suicidal behavior. DSM-5-TR

Sleep Stages

- REM sleep is when dreams occur (10-60 minutes): 20%–25% of total sleep.
- NREM sleep stage 1 (dozing) is a transition from wakefulness to sleep: 5% total sleep
- NREM sleep stage 2 (10-60 min. increasing through the night): 50% total sleep
- NREM sleep stage 3 (20-40 minutes and reduces throughout the night) AKA slow-wave or “deep” sleep: 20% total sleep.
  - This stage is critical to restorative sleep, allowing for body recovery, growth, immune enhancement, memory consolidation. Sleep Foundation

Insomnia

- At least 3 nights per week for at least 3 months, despite adequate opportunity for sleep
- "A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:
  - Difficulty initiating sleep. Sleep latency > 20–30
    - *In children w/o caregiver intervention.*
  - Difficulty maintaining sleep, characterized by frequent awakenings after more than 20-30 minutes or problems returning to sleep after awakenings.
    - *In children w/o caregiver intervention.*
  - Early-morning awakening, 1 hour before the scheduled time and before total sleep time reaches 6½ hours, with inability to return to sleep.

Insomnia

- The sleep disturbance causes clinically significant distress or impairment …
- Insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder or attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- Coexisting mental disorders and medical conditions do not adequately explain the insomnia.
- Dx can be given even if comorbid with another condition that has sleep disturbance as a symptom.

Insomnia

- Diagnosis of insomnia is based on the individual's or caretakers subjective perception of sleep
- If the person complains of nonrestorative sleep occurs without difficulty initiating and/or maintaining sleep, a diagnosis of other specified sleep-wake disorder is made. DSM-5-TR

Hypersomnolence

- 3 times per week, for at least 3 months
- "Self-reported excessive sleepiness (hypersomnolence) despite a main sleep period lasting at least 7 hours, with at least one of the following symptoms:
  - Recurrent periods of sleep or lapses into sleep within the same day.
  - A prolonged main sleep episode of more than 9 hours per day that is nonrestorative (i.e., unrefreshing).
  - Difficulty being fully awake after abrupt awakening.
- Causes significant distress/impairment …
- Not better explained by another sleep disorder or attributable to the physiological effects of a substance
- Coexisting mental and medical disorders do not adequately explain the hypersomnolence. DSM-5-TR

Hypersomnolence

- People with hypersomnolence generally
  - Fall asleep quickly and have a good sleep efficiency (> 90%).
  - Feel sleepiness developing over a period of time, rather than experiencing a sudden sleep "attack."
- Unintentional sleep episodes typically occur in sedentary situations but can manifest in high-attention situations such as at work or while driving.
- The persistent need for sleep can lead to automatic behavior (like driving) being carried out with little or no recall.
- 40% of individuals with hypersomnolence disorder may have sleep inertia (AKA "sleep drunkenness") DSM-5-TR

Hypersomnolence

- For some individuals with hypersomnolence disorder, the major sleep episode lasts 9 hours up to 20 hours.
- Sleep is nonrestorative and is followed by difficulty awakening.
- Most people with hypersomnolence disorder take daytime naps nearly every day regardless of the nocturnal sleep duration.
- Note: Many people with hypersomnolence can reduce their sleep time during work days, but weekend and holiday sleep is greatly increased (by up to 3 hours). DSM-5-TR

Hypersomnolence

- People with hypersomnolence disorder may have
  - A family history of hypersomnolence
  - Symptoms of autonomic nervous system dysfunction including POTS, recurrent headaches, reactivity of the peripheral vascular system (Raynaud's phenomenon), and fainting. DSM-5-TR

Circadian Rhythm Disorders

- A persistent or recurrent pattern of sleep disruption that caused by an alteration or misalignment of endogenous circadian rhythms and the sleep-wake schedule required by the individual.
- Sleep disruption leads to excessive sleepiness or insomnia, or both.
- Causes clinically significant distress

- Irregular sleep-wake
- Non-24-hour sleep-wake type
- Shift work type

Restless Leg Syndrome

- 3 times per week and have persisted for at least 3 months
- An urge to move the legs, usually accompanied by or in response to uncomfortable and unpleasant sensations in the legs, characterized by all of the following: The urge to move the legs
  - Begins or worsens during periods of rest or inactivity.
  - Is partially or totally relieved by movement
  - Is worse in the evening or at night than during the day (DA levels fall through the day)

Restless Leg Syndrome

- Causes significant distress or impairment
- Not attributable to another mental disorder or medical or behavioral condition or the physiological effects of a drug of abuse or medication DSM-5-TR
- Antipsychotics are a common cause of RLS
- Low iron is also associated with RLS

OSA

- Either 1 or 2

  1. Evidence by polysomnography of at least five obstructive apneas or hypopneas per hour of sleep and either of the following sleep symptoms:
     - *Nocturnal breathing disturbances: snoring, snorting/gasping, or breathing pauses.*
     - *Daytime sleepiness, fatigue, or unrefreshing sleep despite sufficient opportunities to sleep that is not better explained by another mental disorder (including a sleep disorder) and is not attributable to another medical condition.*

  2. Evidence by polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep regardless of accompanying symptoms. DSM-5-TR

Development and Course

- The onset of insomnia symptoms can occur at any time during life, but the first episode is more common in young adulthood.
- In women, the incidence of insomnia increases with childbirth or menopause and may persist even after other symptoms (e.g., hot flashes) have resolved.
- Hypersomnolence disorder usually begins in late adolescence or early adulthood, with a mean age at onset of 17–24 years(extremely rare to appear in children) and a gradual progression over weeks to months

Risk Factors / Treatment Targets

- Anxiety
- Negative cognitive style
- Higher stress reactivity
- PTSD
- Noise, light, or uncomfortably high or low temperature
- High altitude may predispose to insomnia and periodic breathing difficulties during sleep.
- Heritability may be highest for insomnia disorder
- Obesity and male sex.
- Poor sleep hygiene practices (e.g., excessive caffeine use, irregular sleep schedules)
- Alcohol or other substance use

Treatment Targets

- Excessive attention and efforts to sleep, especially in which the individual has frequently spent sleepless nights, in people with insomnia or circadian rhythm disorders may contribute to the worsening of insomnia symptoms
- Individuals with persistent sleep disruption may also acquire
  - maladaptive sleep habits (e.g., spending excessive time in bed; following an erratic sleep schedule; napping)
  - cognitions (e.g., fear of sleeplessness; apprehensions of daytime impairments; clock monitoring)

Summary

- Sleep disorders impact millions of Americans and increase the risk of a variety of health and mental health issues
- Sleep disorders can have both physical (viral, nutritional, medication, neurological) and behavioral causes.
- People presenting with sleep disorders should be referred to a medical doctor for an assessment
- Behavioral Health Clinicians can assist with addressing sleep hygiene (lifestyle factors), emotional regulation, negative cognitive styles, and negatively conditioned stimuli