



Sleep Disorders

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1. Primary hypersomnia

Introduction

The defining feature of primary hypersomnia (also called idiopathic hypersomnia) is excessive sleepiness that has lasted for at least one month as manifested by prolonged sleep episodes at night or in the day. Excessive sleepiness during the day may result in long naps that fail to alleviate sleepiness, and other associated symptoms include prolonged sleep at night (which can last for 12 hours or more) as well as sleep drunkenness. Sleep drunkenness describes a drawn out transition from sleep to waking, during which the person is apparently in a state of inebriation, exhibiting partial alertness, disorientation, drowsiness, poor coordination, and even agitated or violent behaviour. Because the person does not feel well rested even after taking naps, they constantly struggle to stave off feelings of sleepiness. Hypnagogic hallucinations and sleep paralysis are rare, but may be found among those with primary hypersomnia. The onset of this disorder typically occurs before the age of 30 and continues on a chronic course unless treated.

Symptoms

According to the DSM-IV-TR, primary hypersomnia is characterised by the following symptoms:

- Predominant complaint is excessive sleepiness for at least 1 month (or less if recurrent) as evidenced by either prolonged sleep episodes or daytime sleep episodes that occur almost daily
- Excessive sleepiness causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Excessive sleepiness is not better accounted for by insomnia and is not due to insufficient amount of sleep

A subtype of this disorder is recurrent primary hypersomnia, in which there are periods of excessive sleepiness that last at least 3 days occurring several times a year for at least 2 years

Risk factors and causes

Thus far, no primary cause of primary hypersomnia has been identified. However, some factors that have been found to contribute to this condition include head trauma to the brain, use of prescription medications, drug abuse, or even a change in work schedule. Although some argue that the hypothalamus is implicated in this disorder, there is insufficient evidence to support this claim.

Treatment

Treatment may comprise of medication, therapy, and lifestyle changes. The types of drugs used include sodium oxybate, amphetamine, methamphetamine, and modafinil, which can help address excessive sleepiness. Therapy does not directly address the symptoms of primary hypersomnia, but is more concerned with providing the patient with support and guidance, and tackling the symptoms of possible comorbid psychological disorders. Lifestyle changes include exercising regularly, maintaining a healthy diet, and improving sleep hygiene, which may also help to alleviate the excessive sleepiness that characterizes primary hypersomnia.

2. Primary insomnia

Introduction

The defining characteristic of primary insomnia is sleeplessness that cannot be accounted for by any medical, psychological, or environmental reason, including drug abuse. In other words, there should be no identifiable cause that can help to explain the person's symptoms. Generally, the prognosis for this disorder, assuming that treatment is sought and adhered to, is good. However, as sleep is an important part of life, the lack of sleep caused by primary insomnia can lead to health complications, such as an increased risk of death, depression, anxiety disorders, and substance abuse problems. Furthermore, even without these more serious consequences, a consistent sleep deficit can be associated with poor health.

Symptoms

According to the DSM-IV-TR, primary insomnia is characterised by the following symptoms:

- Predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month
- Sleep disturbance or associated daytime fatigue causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Risk factors and causes

One factor that might trigger the onset of primary insomnia is a protracted period of stress. Initially, tension and anxiety related to the stress may disrupt sleep and cause awakening. As a result, for these people, sleep becomes associated with frustration and arousal, leading to poor sleep habits, which further exacerbates the problem of insomnia. For most people, the disrupted sleep is temporary and improves once their stress decreases, but in some cases, the pattern of poor sleep hygiene and disturbed sleep becomes cemented and reinforced, allowing the sleeplessness to continue on for years even after the initial stressor is no longer present.

Another possible cause of primary insomnia is an impairment in the area of the brain responsible for wakefulness and sleep, affecting the sleep-wake cycle. It could be due to a lesion present in the sleep system that keeps the person in a perpetual state of arousal.

Treatment

One of the main targets of treatment is an improvement in sleep hygiene so that the person is able to maintain a more regular sleep schedule. Aside from improving sleep habits, medication can be used to provide quick relief from symptoms. Drugs that help the person to sleep, such as hypnotics and benzodiazepines, have been used for short-term pharmacological treatment of primary insomnia.

Therapy, particularly behavioural therapy, is also a component of treatment for primary insomnia. Typically, short-term cognitive-behavioural therapy is used to address poor sleep hygiene or any other factors that might be contributing to the person's insomnia, such as a stressful life event. Ultimately, the aim of therapy is to alter dysfunctional sleep habits and improve sleep hygiene. Cognitive therapy requires the patient to identify maladaptive thoughts that might be disrupting their sleep and modifying those thoughts by questioning their validity. This helps patients realise that their physical symptoms are at least partially attributable to psychological factors and can improve insomnia.

3. Narcolepsy

Introduction

Narcolepsy is a chronic sleep disorder that is characterised by excessive sleepiness, frequent sleep attacks during the day, and abnormal REM sleep. It usually begins during the person's teen or early adult years, and can result in a significant inability to function properly in various contexts. Although many people with narcolepsy have trouble sleeping at night, similar to those with insomnia, they are able to fall asleep very easily, even in the midst of carrying out an activity, such as talking or eating. Some rare symptoms of narcolepsy, possibly related to abnormal REM sleep, include hallucinations and sleep paralysis.

This condition also causes cataplexy, a symptom unique to narcolepsy and not seen in the other sleep disorders. Cataplexy is a sudden weakness in or loss of control over muscles that can be triggered by intense emotions. The muscles that are affected may only belong to a certain body part or the whole body, and the loss of muscle tone may last for a few seconds or minutes.

Symptoms

According to the DSM-IV-TR, narcolepsy is characterised by the following symptoms:

- Irresistible attacks of refreshing sleep that occur daily over at least 3 months
- The presence of at least one of the following:
 - Cataplexy, which involves brief episodes of sudden bilateral loss of muscle tone, most often in association with intense emotion
 - Recurrent intrusions of elements of REM sleep into the transition between sleep and wakefulness, as manifested by either hypnopompic or hypnagogic hallucinations or sleep paralysis at the beginning or end of sleep episodes

Risk factors and causes

Narcolepsy is a disorder of the nervous system, and has less to do with psychological factors per se. Although the exact cause of narcolepsy is not clear, it is likely to be associated with a genetic predisposition (e.g., a family history of narcolepsy) and

triggered by environmental influences (e.g., a virus), which then affect certain neurochemicals, ultimately leading to this condition.

Interestingly, people with narcolepsy tend to have lower levels of hypocretin (also known as orexin), a neurotransmitter responsible for regulating arousal, wakefulness, and appetite. This could be due to a deficit in the number of Hcrt cells, the neurons that produce hypocretin, and might account for the person's inability to maintain a normal schedule of sleep and wakefulness (i.e., excessive sleepiness during the day and inability to sleep at night).

Treatment

Although narcolepsy cannot be "cured", there are many ways in which professionals can help those suffering from narcolepsy to better cope with their condition. These methods include therapy, medication, and implementing changes in the person's way of life. Although each one can be effective in combating narcolepsy, a combination of treatment methods should be used for maximum benefit.

Although therapy does not directly address the purported causes of narcolepsy, it helps individuals to deal with the effects its symptoms might have on their lives and general wellbeing. For example, many people who have narcolepsy also suffer from depression, which could be associated with the impairment in functioning or distress brought about by the symptoms of the disorder. By talking to a psychologist or even a support group about the issues that they are facing, and receiving therapy and encouragement from people who are accepting and understanding of their condition, such depressive feelings may be prevented or alleviated.

Medication can be used to deal with the main symptoms of narcolepsy: excessive sleepiness at inappropriate times and cataplexy. The types of drugs administered to patients include stimulants, sodium oxybate, and antidepressants. Stimulants help them to maintain a state of alertness and wakefulness throughout the day. Sodium oxybate is a more potent drug that can be used for cases of severe cataplexy. It fosters deep sleep, reduces sleepiness during the day, and decreases the frequency of cataplexy. Finally, antidepressants help to improve cataplexy symptoms and regulate REM sleep, addressing problems related to REM sleep, such as hallucinations and sleep paralysis.

Maintaining a healthy way of life with regard to dietary habits, exercise, and stress management can, in addition to receiving therapeutic services and perhaps medication from a doctor, have a beneficial effect on their ability to manage their symptoms. Making these concrete lifestyle changes can help them better regulate their sleep cycle, and mitigate the symptoms of narcolepsy.

4. Breathing-related sleep disorder

Introduction

Breathing-related sleep disorder is a diagnosis given when breathing-related difficulties are determined to be the cause of a person's sleep problems (e.g., insomnia or daytime sleepiness). These issues may include chronic or habitual snoring, upper airway resistance syndrome, frank obstructive sleep apnea (OSA), and obesity hypoventilation syndrome (OHS). Though merely failing to get a good night's rest might not seem like a major issue to most people, breathing problems, such as OSA and OHS, have been found to be associated with significant cardiovascular morbidity (including systemic hypertension and congestive heart failure) and higher mortality rates, which means that the effects of these breathing-related difficulties are much more serious than one might immediately assume.

Because of breathing problems, people with this disorder find it difficult to enjoy uninterrupted sleep at night, causing excessive daytime sleepiness. As such, they may find it difficult to stay awake while engaged in relaxing activities, such as reading a book. In some cases, it is even possible that they fall asleep while carrying out tasks that necessitate alertness such as talking and driving. People with this condition may also complain about insomnia, sleep that is not refreshing, and recurrent awakenings during sleep.

The DSM-IV-TR identifies three types of breathing-related sleep disorder: obstructive sleep apnea syndrome (the most common type), central sleep apnea syndrome, and central alveolar hypoventilation syndrome.

Symptoms

According to the DSM-IV-TR, breathing-related sleep disorder is characterised by the following symptom:

- Sleep disruption, leading to excessive sleepiness or insomnia, that is judged to be due to a sleep-related breathing condition

Risk factors and causes

One possible cause of obstructive sleep apnea syndrome is obesity, and symptoms tend to worsen as weight increases. However, other explanations for the blocked air passages implicated in this subtype include swollen tonsils, larger than average adenoids, and other abnormalities present in certain parts of the mouth or throat.

Central sleep apnea has a different etiology from the first type and is related to cardiac or neurological issues that prevent uninterrupted airflow. This type of the disorder is found most commonly among elderly patients.

The breathing dysfunction observed in central aveolar hypoventilation syndrome has been found to be associated with atypically low arterial oxygen levels, though the exact cause of the deficit in oxygen is unclear.

Treatment

Like most sleep disorders, an important component of treatment is improving sleep hygiene and working to ensure that patients get adequate rest through lifestyle and behavioural changes. This can be done with the help of a therapist who is also available to provide patients with any encouragement or support that they may need during the treatment process. Furthermore, patients with this condition should avoid sleeping in the supine position as well as consuming alcohol and sedative medications, as these products may contribute to upper airway issues during sleep.

In addition to these minor modifications, patients with breathing-related sleep disorders should be prepared to utilise well-planned weight management strategies and positive airway support or a dental appliance on a long-term basis. The surgical options available for breathing-related sleep disorders include procedures that enlarge the upper airway, enable bypassing the upper airway, and guarantee weight loss. In the circumstance that obesity is the underlying factor accounting for the sleep problems, bariatric surgery can be used when the patient does not respond well to weight management or pharmaceutical treatment attempts. One type of therapy that has been used with patients who have obstructive sleep apnea is nasal continuous positive airway pressure (CPAP) therapy. In this form of treatment, the patient wears a mask during sleep, which is connected to a high-pressure blower that ensures continuous airflow to the mask.

Pharmacological options for those affected by sleep apnea include respiratory stimulants (e.g., medroxyprogesterone acetate and acetazolamide) and tricyclic antidepressants (e.g., protriptyline).

5. Circadian rhythm sleep disorder

Introduction

Circadian rhythm sleep disorder involves a disruption in a person's circadian rhythm, the body's internal clock that controls the 24-hour cycle of organic processes that occur in plants and animals, including sleep and wake. The defining feature of circadian rhythm sleep disorder is a disruption in sleep patterns, which can either be continuous or occasional. The disruption in sleep patterns characteristic of circadian rhythm sleep disorder can either be due to a dysfunction in the body's internal clock or a discrepancy between the body's internal clock and the environment with respect to timing or length of sleep. Because of this disruption, people with circadian rhythm sleep disorder can experience insomnia and excessive sleepiness at inappropriate times, causing functional impairment in many areas of their lives, such as work and social situations.

Symptoms

According to the DSM-IV-TR, circadian rhythm sleep disorder is characterised by the following symptoms:

- Persistent or recurrent pattern of sleep disruption leading to excessive sleepiness or insomnia that is due to a mismatch between the sleep-wake schedule required by a person's environment and his or her circadian sleep-wake pattern
- Sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

This disorder has three subtypes: delayed sleep phase type, jet lag type and shift work type. Delayed sleep phase type refers to a persistent pattern of late sleep onset and late awakening times, with an inability to fall asleep and awaken at a desired earlier time. Jet lag type involves sleepiness and alertness that occur at an inappropriate time of day relative to local time, occurring after repeated travel across more than one time zone. Shift work type is defined by insomnia during the major sleep period or excessive sleepiness during the major awake period associated with night shift work or frequently changing shift work.

Risk factors and causes

Circadian rhythm sleep disorder can be attributed to various factors, including shift work, pregnancy, changes in time zone, medications, and changes in routine. Most of the time, the cause depends on the type of circadian rhythm disorder being experienced. The jet lag type is generally caused by a discrepancy between the person's current circadian cycle and that necessitated by a different time zone. People who often travel to places with different time zones have the greatest likelihood of suffering from this type of disorder.

Shift work sleep disorder is associated with a mismatch between a person's natural circadian cycle and the cycle he or she is forced to have due to shift work. People who work a night shift but follow a regular sleep schedule when they are not working are particularly susceptible to this problem. Those who tend to work different shifts are also vulnerable as they experience a constantly changing sleep schedule as well. Eventually, the irregular sleep cycles caused by shift work and inability to adapt to them leads to shift work sleep disorder.

DSPS is often a result of intentionally staying up later than usual due to certain responsibilities, such as rushing to meet a deadline. It can be attributed to an environmental stressor that causes the person much distress. Delaying sleep eventually leads to chronic sleep deprivation and the establishment and maintenance of later sleep onset. Because it is usually difficult to adjust sleep cycles once such a pattern is established, the delayed sleep pattern continues and can cause problems in the long run.

Treatment

Many treatment options are available to those with circadian rhythm sleep disorder, and treatment should be tailored to each individual's specific type of disorder and impairment to maximize benefit. Some treatment modalities include behavioural therapy, bright light therapy, medication, and chronotherapy. Behavioural therapy involves instilling healthy sleep habits, such as maintaining a consistent sleep schedule, exercising regularly, and avoiding caffeine or stimulating activities close to bedtime. This could help the patient better regulate his or her sleep routine to prevent sleepiness at inappropriate times or insomnia at night.

Bright light therapy can be useful in advancing or delaying sleep, thereby recalibrating the circadian rhythm, so as to adjust irregular sleep routines. In this form of treatment, timing is crucial and is typically set by a sleep specialist. It employs a high intensity light and the period for which the patient is exposed to the light ranges from 1 to 2 hours. Chronotherapy involves a gradual advancement or delay (1 to 2 hours a day) of sleep onset in order to adjust the sleep-wake cycle. Once the desired sleep and wake timings are established, the patient works to maintain that sleep schedule.

The pharmacological aspect of treatment uses melatonin, wake-promoting agents, and short-term sleep aids to modify the patient's current sleep schedule, creating a more regular routine. Melatonin is a hormone that is readily available and has been effective in addressing problems related to jet lag.

6. Nightmare disorder

Introduction

Nightmare disorder, sometimes known as dream anxiety disorder, indicates the presence of recurrent dreams during which the person's experiences some threat to their safety, security or self-esteem and becomes frightened, causing him or her to wake up. Nightmares are dreams that induce intense feelings of fear in an individual. These dreams can be elaborate and lengthy, and typically increase in intensity as they progress, exacerbating the person's sense of fear. Usually, as the climax of the threat or danger in the dream approaches, the person wakes and is able to recall details of the dream as well as what was so frightening about it. Because of the associated feelings and physical sensations of anxiety, the clarity with which the person awakes, and his or her ability to vividly recall images from the nightmare, the person is rarely able to easily calm down and go back to sleep.

When the person is having the nightmare, he or she may make some noise (e.g., moan) or exhibit slight movement, though this is not always the case. The person's waking is accompanied by an intense sense of fear and symptoms indicating anxious arousal, such as increased heart rate and sweating. In addition, the person becomes completely awake and quickly oriented, rather than confused. Sometimes, the person may avoid going back to sleep due to the fear of having another nightmare or the residual symptoms of anxiety may prevent the person from relaxing enough to fall asleep. Consequently, these people might display signs of mild sleep deprivation, such as attentional problems, irritability, and excessive daytime sleepiness.

Symptoms

According to the DSM-IV-TR, nightmare disorder is characterised by the following symptoms:

- Repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely frightening dreams, usually involving threats to survival, security, or self-esteem
- On awakening from the frightening dreams, the person rapidly becomes oriented and alert

- The dream experience, or the sleep disturbance resulting from the awakening, causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Risk factors and causes

It is unclear what exactly causes a person to have nightmares, but several factors that may contribute to their occurrence have been identified. Some possible causes include psychological disorders (e.g., PTSD and depression), stress, and medications. Having a late-night snack can also cause nightmares as it increases metabolism and consequently, brain activity. Medications that can increase the likelihood of having a nightmare include antidepressants, narcotics, and certain blood pressure drugs. Nightmares can also be a symptom caused by withdrawal from medications or substances, including tranquilisers and alcohol. Being deprived of sleep can also lead to more nightmares, which may perpetuate the cycle of sleep deprivation. A family history of nightmares also increases the risk of recurrent nightmares in an individual.

Treatment

If nightmares appear to be caused by a psychological disorder, then the underlying disorder is targeted to alleviate nightmare-related difficulties. However, if there seems to be no identifiable cause, therapy can be used to aid people in coping with the common themes of their dreams, thereby reducing the distress associated with their nightmares. Another form of therapy is imagery rehearsal treatment, in which patients rehearse the way in which they would like their nightmares to play out while awake in order to modify their dreams. As stress can contribute to the frequency of nightmares, stress management is another way to help deal people with nightmare disorder. Psychotherapy is also helpful in decreasing stress by recognising the significant stressors in patients' lives and helping them to manage them in a more adaptive fashion. Maintaining good sleep hygiene is another way to alleviate nightmares associated with sleep deprivation as it can help to improve patients' sleep patterns.

7. Sleep terror disorder

Introduction

Sleep terror disorder is defined by repeated episodes during which the person suddenly awakes in a terrified state, exhibiting physical symptoms of fear, such as sweating, quick breathing, and rapid heart rate. An average episode lasts less than 15 minutes and in most cases occurs only once a night. However, sleep terror episodes have been found to occur in clusters as well, with some people reporting more than 40 attacks in the same night. In most cases, the frequency of these attacks is once per week or a few per month. Sleep terrors are also sometimes known as night terrors. However, because these episodes can also occur during daytime naps, “sleep terrors” is the preferred term. Although this condition is more commonly found in children, it is present in adults as well, especially when it is preceded by emotional stress.

Once awake, people with this disorder may not respond to attempts to calm them down or wake them up and tend not to remember much about their dream. Even though they wake from sleep, they may remain confused and poorly oriented. In fact, most of the time, they are able to go back to sleep once the episode is over without waking completely. It is also possible for some people to experience hallucinations before they become fully awake. Interestingly, people with sleep terror disorder do not recall their sudden awakening the next morning.

The prognosis is good for children with this disorder as it usually improves completely by adolescence without any intervention. Adults also tend to respond well to pharmacological treatment and psychotherapy.

Symptoms

According to the DSM-IV-TR, sleep terror disorder is characterised by the following symptoms:

- 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
- No detailed dream is recalled and there is amnesia for the episode
- Episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Risk factors and causes

Although no one factor has been found to cause this disorder, several potential explanations have been proposed. They include inadequate sleep or poor sleep, life stress, fever, genetic predisposition, and physical health problems. Having a family history of the disorder increases the likelihood of developing sleep terror disorder by 10 times. Some have argued that the cause of sleep terror disorder in children has to do with delays in neurological development, which make the brain fall behind sleep cycles.

Treatment

Like many of the other sleep disorders, a popular treatment option is maintaining good sleep hygiene, which includes following a consistent sleep schedule. However, if the sleep terrors appear to be caused by underlying psychological problems, psychotherapy may be helpful in alleviating the symptoms of this disorder. Stress management and learning coping mechanisms may also help with the attacks.

Although medications are hardly used in the treatment of sleep terror disorder, benzodiazepines (e.g., Valium) may be effective in improving symptoms. Benzodiazepines are hypnotic (sleep-inducing) drugs that are believed to help prevent sleep terror attacks by functioning as a nervous system depressant. Tricyclic antidepressants can also be useful as a short-term treatment for severe cases. It should be noted that medications are typically reserved for adult patients.

In very severe cases, treatment also deals with prevention. Prevention typically involves waking patients up before the time their sleep terrors usually occur to avoid the sleep terror experience altogether. To prevent self-injury during a sleep terror episode, it is also good to ensure that their sleeping environment is safe, perhaps by rearranging the layout of the room or furniture.

8. Sleepwalking disorder

Introduction

Sleepwalking, or somnambulism, is a sleep disorder, which causes people to walk or perform other activities while seemingly still asleep. Sleepwalking episodes usually occur during the deep stages of sleep, and might be accompanied by incoherent talking. The person is unable to respond during the episode and has trouble recalling it later on. After a sleepwalking episode, it is possible for the person to return to bed. This disorder is more common in children and generally improves by late adolescence, but may stay with a child till adulthood. Sleepwalking can be manifested as slow, calm walking around a confined area or agitated running as if attempting to flee. During an episode, the person's eyes are open but look glassy and blank, as if the person is looking right through you. Each episode may be very short-lived, lasting for a few seconds to a few minutes, but episodes that last for 30 minutes or longer have been reported. The average length of an episode is 5 to 15 minutes long.

The greatest danger associated with sleepwalking has to do with the injuries that could be sustained during an episode. Besides that, this condition does not seem to be related to any other long-term complication. However, it should be noted that disrupted sleep for an extended period of time can be associated with academic or behavioural problems. Generally, the prognosis for this disorder is very good.

Symptoms

According to the DSM-IV-TR, sleepwalking disorder is characterised by the following symptoms:

- 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
- On awakening, the person has amnesia for the episode

- Within several minutes after awakening from the sleepwalking episode, there is no impairment of mental activity or behaviour, although there may initially be a short period of confusion or disorientation
- Sleepwalking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Risk factors and causes

There appears to be a genetic contribution to sleepwalking. Thus, having a family member with the disorder increases the likelihood of developing sleepwalking disorder. In addition, it is more common for both identical twins to have sleepwalking disorder than a set of fraternal twins.

Environmental factors can also play a part in the development of this condition. Sleep deprivation, an inconsistent sleep schedule, stress, magnesium deficiency, alcohol intoxication, and drugs (e.g., sedatives/hypnotics, neuroleptics, stimulants, minor tranquilisers, and antihistamines) have been associated with the onset of sleepwalking disorder. Some medical issues appear to be related to sleepwalking as well. They include arrhythmias (abnormal heart rate), fever, gastroesophageal reflux (condition in which food or liquid is regurgitated from the stomach back into the oesophagus), nighttime asthma, nighttime seizures or convulsions, obstructive sleep apnea (condition in which breathing is disrupted during sleep), and psychological disorders, such as posttraumatic stress disorder, panic disorder, and dissociative disorders. Physiological factors such as the length and depth of slow-wave sleep, which is typically greater in young children, during pregnancy, and during menstruation have all been associated with an increased frequency of sleepwalking.

Treatment

If the cause of sleepwalking is found to be a physical or psychological condition, the underlying disorder should be the target of treatment, rather than the sleepwalking itself. Pharmacological treatments, which include benzodiazepines (which help to relax muscles), tricyclic antidepressants, and clonazepam, have been effective in treating this disorder. In most cases, medication can be discontinued after 3 to 5 weeks without symptoms returning.

Long-term treatments for this disorder are psychological in nature and include relaxation techniques, mental imagery, and anticipatory awakenings. Anticipatory awakenings involve waking the person about 15-20 minutes before the anticipated time of the sleepwalking episode and maintaining his or her arousal for the amount of time that the episodes usually last to prevent them from occurring. Avoiding or minimising the consumption of alcohol or other central nervous system depressants, fatigue or insomnia, as well as stress, anxiety, and conflict may be helpful in preventing sleepwalking episodes. Hypnosis can also be used to get patients to wake up once their feet touch the ground.

People with this disorder should maintain a safe sleeping environment that does not contain any harmful or sharp objects, sleep on the ground floor (if possible) or the lower bunk of bunk beds to avoid potential injury from falls, lock all doors and windows, remove obstacles from their bedroom to prevent tripping, cover glass windows or doors with heavy curtains, and place alarms or bells on their bedroom doors or windows.