

3.6.1 Insomnia

Much of the relevant history in insomnia will already have been articulated in the description of a typical night. However, one should look for exacerbating and perpetuating factors for their insomnia. Clearly caffeine, nicotine and alcohol consumption are relevant here. Ask the patient to describe what strategies they have tried to tackle the insomnia and what impact medications have had on their sleep. Pain, asthma, gastro-oesophageal reflux and other physical complaints can impair sleep. It is informative to find out if they sleep better or worse when not in their own bed. Some patients have no difficulty falling asleep on the couch but struggle to sleep in their bed, and this may indicate that they have a conditioned response to the bed which wakes them.

Ask the patient why they feel they can't sleep. Is there an external, environmental factor such as noisy neighbours, a snoring bed partner or bright light that is preventing their sleep? If so, the problem may in fact be sleep deprivation due to an environmental factor rather than an inherent sleep disorder. Many patients will describe having an overactive mind at night, particularly once they get into bed. This is common in psychophysiological insomnia and can be a sign of a dysfunctional conditioned association of the bed with wakefulness.

3.6.2 Restless Legs Syndrome (RLS)

Given the degree of distress caused by restless legs, it is striking how few patients will spontaneously volunteer this symptom. Most RLS patients present with a complaint of insomnia. It is therefore critical that you specifically enquire about it. Restless leg patients will usually have difficulty describing the discomfort, but they are usually able to describe where in the body they feel it. This difficulty in describing the discomfort is also a useful way of differentiating it from cramps, which are usually described as such. In RLS, the discomfort can occur anywhere in the body but is most often localized to the lower limbs. A single question has been shown to have 100% sensitivity and 96.8% specificity for RLS in a neurology outpatient population (Ferri et al. 2007): 'When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement?'

In psychiatric patients on medication, particularly antipsychotics, it can sometimes be a challenge to differentiate between restless legs and akathisia as both can present with discomfort in the limbs and an irresistible urge to move the legs. Some akathisia patients will describe a mental unease which may be less common in RLS. Perhaps the best differentiator is the timing of the symptoms. Restless legs characteristically occur at night with a reduction, or complete absence, of symptoms during the day (as RLS gets worse, the onset of symptoms may occur earlier in the day, but there will still usually be a clear diurnal pattern). Akathisia severity is more likely to vary with the timing of the medication, being worse after taking a dose of that medication. Of course, there is no reason that a patient cannot have both akathisia and restless legs!

3.6.3 Circadian Rhythm Disorders

Circadian rhythm disorders are best diagnosed with the aid of a sleep diary (Appendix C) which can show the trend in sleep-wake times across several weeks. In the absence of a sleep diary, one should enquire about the patient's habitual bed and rising times and what times they fall asleep and wake up. In the most common circadian rhythm disorder—delayed sleep-wake phase disorder (DSWPD)—the patient will typically report being unable to initiate sleep until well after midnight and, if left to their own devices, would sleep late into the morning or afternoon.

Ask what would happen if they tried to change their bedtimes and rising times, for example, by going to bed earlier. Typically, in circadian rhythm disorders, it would have little or no impact on their sleep times. It is also critical to enquire about daytime symptoms and how they vary across the day. Patients with a DSWPD will feel worst in the mornings and progressively more alert as the day progresses; they feel most alert and energetic late at night when everyone else is going to sleep. Many patients will have tried hypnotics, and, even if they succeed in falling asleep earlier, the daytime symptoms will still follow the pattern described above. Of course, in advanced sleep-wake phase disorder (ASWPD), the patient will be most alert early in the morning and most sleepy at night, and their sleep times will be advanced. In a non-24-h sleep-wake rhythm disorder, the sleep time will rotate around the clock, usually getting progressively later each day.

It is often very difficult to elicit a clear history of a circadian rhythm disorder in someone who has waking times imposed on them by outside commitments such as school or work. It is helpful to ask the patient to describe what happens when they are on an extended holiday and these commitments are removed. When external constraints are removed, most patients with a circadian rhythm disorder will revert to their innate sleep pattern and report an improvement in daytime symptoms. The Morningness-Eveningness Questionnaire (Horne and Ostberg 1976) (Appendix B), which asks the patient about their typical pattern of alertness in the day and preferred sleep pattern, can also be helpful to confirm the diagnosis.

3.7 Assessing Parasomnias and Other Night-Time Events

It is tempting to think that the diagnosis of parasomnias requires specialist investigations such as PSG with video monitoring, and it is true that these studies can be helpful. However, a good history will yield the correct diagnosis in most cases, and the studies are usually done purely to confirm the diagnosis or screen for any exacerbating factors such as OSA or PLMs. Furthermore, as these events can be sporadic, parasomnias are often not observed during a one-night PSG.

Parasomnias fall into two broad categories: REM sleep parasomnias and non-REM sleep parasomnias which usually arise from slow-wave (N3) sleep. Understanding the basic phenomenology and distribution of the different sleep stages across the night is vital in making a diagnosis. Slow-wave sleep is a very deep stage of sleep, with a high arousal threshold and very little dreaming or complex

mentation. It occurs primarily in the first half of the night and is increased in sleep deprivation. REM sleep is a lighter stage of sleep with a lower arousal threshold and is associated with detailed, vivid dreaming. It occurs primarily in the second half of the night. Therefore, in assessing unusual behaviours at night, one should determine the time of night they occur, how much the patient recalls about them, whether they recall vivid dreams or only vague fragments, whether they get out of bed and how organized the behaviour is (Table 3.2).

3.7.1 Sleepwalking

In sleepwalking, the diagnosis is generally very clear on history. The person typically gets out of bed and walks around the room or the home. They are able to turn door handles, open drawers, arrange objects, etc. fairly skilfully. However, although the individual actions are coordinated, the sum of the actions is often not. For example, the sleepwalker may open a drawer in the dresser, carefully rearrange the clothes and then urinate in the drawer or may eat a solid block of butter on a plate with a knife and fork. They may return to bed or continue sleeping in another location without waking up. If woken during an episode, they may describe feelings of confusion or panic, sometimes accompanied by hypnopompic hallucinations. As these episodes occur early in the sleep period, they may be witnessed by other members of the household, and therefore a collateral history is often available. If there is no one to give a collateral history, the patient will usually still be able to report symptoms and clues which are suggestive of sleepwalking, including waking up in a different place, finding household objects rearranged or unexplained bruises on the legs (from bumping into coffee tables, etc.).

Table 3.2 Comparison of non-REM and REM parasomnias

	Non-REM (slow-wave) sleep parasomnias	REM sleep parasomnias
Timing	First half of night	Second half of night
Arousal threshold	High	Low
Dreaming	Vague, fragmentary or none	Frequent, detailed, vivid
Recall of events on waking	Little or none	More frequent
Behaviour	Coordinated, may get out of bed, manipulate objects, etc. Eyes open	Uncoordinated, generally stay in bed. thrash around and hit out but rarely manipulate objects. Eyes closed
Onset	Often start in childhood, though nature of parasomnia may evolve through the years, e.g. it may start as sleep walking and progress to night terrors or sleep sex	Nightmares may start in childhood but can occur at any time; REM behaviour disorder starts in middle or old age

3.7.2 REM Sleep Behaviour Disorder

In contrast, REM sleep behaviour disorder (RBD) occurs in the second half of the night, is often violent in nature, appears less coordinated and is associated with vivid dreams and nightmares. It is very rare for the patient to leave the bed during an episode of RBD. In very extreme cases, they may jump out of the bed but will then wake immediately. Because they rarely leave the bed, it will often go undetected for many years if there is no bed partner to witness the events. However, a common presentation is when the patient throws a punch in their sleep and, in the process, throw themselves out of bed. They either wake up on the floor or hit their head on the bedside table on the way down! RBD can also lead to significant injury or even death of the bed partner. The author has encountered two patients who have been misdiagnosed with a personality disorder as they injured bed partners during their sleep and the psychiatrists, unaware of the RBD, presumed they were cases of domestic abuse.

A single screening question for REM sleep behaviour disorder has been shown to have a sensitivity of 93.8% and a specificity of 87.2% in a sleep clinic population: ‘Have you ever been told, or suspected yourself, that you seem to “act out your dreams” while asleep (e.g. punching, flailing your arms in the air, making running movements, etc.)?’ (Postuma et al. 2012).

3.7.3 Nocturnal Epilepsy

If a patient has nocturnal epilepsy, this is likely to be detected when you are enquiring about sleepwalking and RBD. There is a great deal of variability in the presentation of nocturnal epilepsy, but there are a number of factors that would raise the suspicion of seizure activity. The presence of daytime seizures and classic signs of seizure activity such as tongue biting or incontinence should make one consider the possibility that unusual night-time events are epileptic in nature. Try to get an impression of how frequent the events are and whether they occur more than once a night. Slow-wave sleep parasomnias are often sporadic, while epilepsy tends to be more consistent, and multiple episodes per night make epilepsy the more likely diagnosis. Unlike parasomnias, the offset of seizures is often abrupt and may be followed by an awakening. Stereotyped movements are more likely with epilepsy, while organized activity and leaving the bedroom are less likely. However, some epileptic patients do experience nocturnal wandering as part of their condition, and so leaving the room does not preclude a diagnosis of epilepsy.

3.7.4 Confusional Arousals

Confusional arousals may occur independently or following an episode of sleep walking or a night terror. The patient reports being confused and disorientated. This usually resolves within a few minutes, either with the person waking up fully or going back to sleep. Partners may report that the patient says odd things and looks confused.

3.7.5 Sleep Terrors

Sleep terrors are sometimes reported by the patient's family rather than the patient. The patient may have little or no recollection of the events, but their dramatic nature can be distressing for bed partners and may adversely affect their sleep. A good collateral history is therefore very important. The bed partner will typically report that the patient sits up suddenly in the bed, their eyes are usually open wide and they will scream or cry. It can take several seconds or minutes for the patient to calm down, and they are generally very resistant to reassurance and consolation. In more dramatic episodes, they may jump out of the bed in a panic before coming to. Sleep terrors tend to occur in the first hour or two of the sleep period.

Where the sleep terrors are frequent, the patient is likely to be aware of some episodes. The disruption to their sleep may lead to daytime fatigue and sleepiness, and the unpleasant experience of the sleep terrors may lead to anxiety about sleep with secondary insomnia. They may report hypnopompic hallucinations during the episodes (see below).

3.7.6 Nightmares

Nightmares are frightening or deeply upsetting vivid dreams that often leave patients with a sense of loss, sadness or fear extending into the day. Patients who suffer from frequent nightmares may develop considerable anxiety about going to sleep leading to insomnia, sleep avoidance or choosing to sleep during the day. Of all the sleep disorders, nightmares are the strongest predictor of suicide (Bernert and Nadorff 2015), and so it is surprising how rarely they are asked about in routine psychiatric interviews. Taking a history of nightmares is complicated by the very different expectations that patients have about what normal dreaming entails. Some patients will be distressed by dream content that most people simply accept as part of normal dreaming. For example, it is common for people that we have not seen or thought about in years to appear in our dreams, yet some people find this very disturbing. However, one would not normally consider this a nightmare. Similarly, a very high proportion of normal dreams have a negative emotional tone, but this alone would not qualify them as nightmares.

Therefore, in order to determine if the patient is experiencing nightmares as opposed to negative or strange dreams, one needs to take a very detailed history. One can ask the patient if they feel the dreams are actual nightmares as opposed to anxious, unpleasant dreams, and some patients may be able to differentiate between the two. However, it is generally more useful to ask the patient to describe a typical dream; it is then much easier to get an impression of the content and emotional intensity of the dreams and determine whether they should be classified as nightmares.

Once again, as nightmares are REM phenomena, they are more likely to occur in the second half of the night.