



Case report: Adult parasomnia

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Introduction

A 43-year-old female presented to the Insomnia clinic with sleep disturbances that caused her to feel tired in the day and drowsy at mid-afternoon. She has a positive medical history for hypertension, hypothyroidism, cholesteremia and day time social anxiety disorder controlled by medication. The patient's neurological EEG study ruled out seizure disorder. Her BMI is 30.1. The patient denied OTC supplements/herbal use, cigarette smoking and recreational drug use. The patient drinks alcohol mildly—1-2 glasses per week. The patient lives with her boyfriend of three years and works as a legal secretary for a federal government office for seventeen years. Before this she worked fulltime as a clerk to support herself and her college and paralegal training. The patient works 10-12 hours days and because her accounts are at the federal level she is on call during the weekend and off times from traditional hours given the time changes. The patient expressed artwork hobbies, visiting with her family nearby and home improvement tasks. The patient has a network of close friends and her sister that she has frequent communications with and is a source of support to her.

Since childhood the patient has experienced Sleep terrors, Somnambulism and Confusional arousals. An all-night polysomnographic study followed by a multiple sleep latency test identified Sleep terror disorder and ruled out Sleep Apnea, Narcolepsy, Restless Legs Syndrome, Periodic Limb Movement disorder and Nightmare disorder. The Pittsburgh Sleep Quality Index indicated a sleep disturbance. Results from the two-week sleep log indicated a sleep efficiency average of 68% with recall of two minor wakeups for five minutes approximately, on average. The patient received an Ambien 5mg at hour of sleep prescription that she started after her initial interview, thus, the sleep onset latency times were nominal. She reported satisfaction with the use of the hypnotic and no side effects.

Discussion

The recurrent episodes of behaviors while sleeping are characteristic of Parasomnias [1,2]. The homeostatic sleep factors that determine sleep are influenced by behavioral factors of increased cognitive activity (i.e., worry, stress, rumination). The



sleeper partially awakens during various parts of the sleep to exhibit behaviors [2,3]. The behaviors vary from subtle such as teeth grinding, to vast expressions of dreams once the spinal skeletal muscle inhibition signals are freed [2]. Given the partial state of arousal, the sleeper is often amnesic for the events [1,2,3,4]. The interview findings were positive for the patient reporting Confusional Arousals and Somnambulism in her sleep history; - they did not occur during the PSG. Confusional arousals occur typically in children and teens, they are movements and vocalizations that may progress to agitation. The patient had sleep terror episodes during the assessment that were like the description of those experienced at home. The patient emits a piercing scream that is shriek-like, followed by screaming then the shriek-scream again in a rapid pattern for 8-9 cycles. There were two episodes of this at the assessment. The patient remained in bed during the episodes although the video captured several behaviors of moving to get out of the bed then only to recline into a fetal position to the scream as she was on her knee with arms flailing.

Following intake, the patient followed through with eight sessions of CBT focused psychotherapy. The patient was receptive to the psychoeducation focus to examining her schedule and setting up an essential work schedule balanced with a small time on her hobbies or contact to social support for stress management. There were some setbacks in her willingness to limit her work schedule –some of the setup backs were perceptual and some realistic. With examination and support she considered her hesitancy to minimize some of her work schedule without jeopardizing her job security. The patient was training in the use of mindfulness meditation to provide her with an effective means to manage her stress. The schedule change was done in preparation for setting up a resource of time for potential sleep deprivation secondary to scheduled awakenings therapy that was started after the six week of treatment. Sleep log data indicated an average sleep efficiency of 82% for weeks one through four of therapy, an 88% for weeks five and six and an average sleep efficiency of 79% for weeks seven and

eight. The three to four episodes that occurred four times per week on average and night the month before treatment were reduced to two per week in session weeks 8 through 10 and four weeks following that with no episodes. Psychotherapy evolved to include issues beyond the sleep disturbance and daytime sleepiness; 17 weekly sessions in total were completed. At the three-month follow-up, the patient has had two episodes over the last month and related this to her intensified worry over her sister newly diagnosed with a treatable breast cancer. The patient set up monthly follow-up sessions to learn more variations on the mindfulness meditation and receive support.

Conclusion

In conclusion, careful diagnosis of Parasomnias is essential [1,3]. Once diagnosed, this patient responded to assurance, education about the condition, training in mindfulness and psychotherapeutic exploration of her life to address the Sleep Terrors disorder. She expressed satisfaction with the psychotherapy intervention and utilized the resource when she needed it with new life events. Her daytime sleepiness and afternoon drowsiness were reduced. Of clinical note was the patient's ability per her self-report to understand her sleep condition and employ control on the condition rather than the reverse of that.

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