MEDICAL PRACTICE

Today's Treatment

Psychological Medicine**Sleep Difficulties****I. OSWALD**

British Medical Journal, 1975, 1, 557-558

We devote a great part of our lives to sleep, and it is natural that patients who have complaints about their health or happiness should include sleep among them. A complaint of bodily discomfort can give grounds for seeking the doctor's ear, and so too a complaint that sleep is not satisfying. Both may have a concrete basis but either may be an expression of general dissatisfaction or a desire for comfort. The commonest complaint is of insomnia or of the poor quality or duration of sleep. The doctor cannot usually cure, but if the patient feels he has taken the trouble to listen and that he has understood the nature of the complaint, then he or she will feel a sense of having been helped.

Not Enough Sleep

There are big individual differences in sleep duration. A few people are happy and healthy on three hours a night, others would welcome ten. They need no medical intervention but their wives or husbands may prefer different bedtime habits and be glad of an opportunity for discussion. Likewise there are individual differences in ease of changing sleep routines. Some people find no difficulty when they fly to America or go on shift work, but others become both physically and emotionally exhausted by night shift working and would do better to find other jobs. They may need reassurance and support in the face of criticism and lack of understanding by others who sleep more readily.

Young people usually sleep easily, but advancing years bring troubles, especially for women. In fact once we pass 30 our intellectual grasp, our brain oxygen utilization, and our sleep all deteriorate in parallel, and the largest proportionate change is in sleep. It becomes more and more broken, and has less and less of the very deepest sleep with the slowest electrical brain waves. It is just an inevitable feature of ageing. Many patients are not pleased to be told it is their age, but now that we are leaving behind the era when bowel evacuation and laxatives were overvalued we might also try to educate patients away from thinking that eight hours of sleep and a hypnotic drug are essential. They should accept that short spells lying awake come naturally with greying hairs and less supple limbs and will not damage health.

NIGHTCAPS

It will sometimes be necessary to explain that alcohol is a cause of poor sleep. Evening drinks mean early morning restlessness. The nightcap is quickly metabolized, and minor withdrawal symptoms appear in the early morning and make later sleep less sound than it would have been had the alcohol not been taken. Better to have had a milk-cereal food drink, for it helps sleep to be less broken in the early hours of the morning. Coffee is another sleep disturber, and though two evening cups had no effect on the patient's sleep when she was in her twenties they might be doing so now that she is 40.

Middle-aged people usually take too little exercise. Physical exercise improves sleep, though it should be part of a routine and not just a sudden violent foray. Money spent on a good modern mattress and matching spring-base may not impress the neighbours as would a new set of chairs, and a few weeks may pass in getting used to the new support after the sagging old thing, but in the long run sleep will benefit and backache be made less likely.

University Department of Psychiatry, University of Edinburgh,
Edinburgh EH10 5HF
I. OSWALD, M.D., F.R.C.PSYCH., Reader in Psychiatry

WAY OF LIFE

There remain those people for whom simple advice is not enough. They are often worriers by nature or have problems in personal relations at home and at work. They often believe they spend the greater part of the night awake. Laboratory investigation invariably shows such patients sleep almost all night, but it is little use arguing. Before prescribing pills that may continue for years the doctor will want to take a thorough history. Is the complaint of insomnia part of general distress arising from discovery of the husband's girl friend or the arrival of a letter threatening court action over debts? Situations like these will not be altered by either hypnotics or antidepressants, and either drug may be taken in overdose. A prescribed hypnotic, like alcohol, may impair discretion sufficiently to make an overdose or a punch-up even more likely.

Is the insomnia part of a way of life, a symptom of years of inner tensions and marital friction? If so, to prescribe a sleeping pill will not help the patient but simply make her dependent on regular prescriptions. Once established on the drug, if she does without it for a night she will find her sleep more broken than ever and more troubled by vivid dreams. This confirms in her mind a need for pills, even though she has actually been experiencing withdrawal symptoms brought about by the drug. These comments apply equally to the many drugs available for the daytime relief of anxiety. They differ in little except dose from those used as sleeping pills.

In the course of the doctor's history taking it will become clear if the insomnia is something new in the patient's life. If it is not plainly due to some current crisis, the doctor will think of a possible depressive illness and will inquire especially about the kind of thoughts that run through the mind while the patient lies awake. The patient may complain of recently diminished interest, energy, and weight, about weeping and anxiety for no clear reason. Before prescribing either amitriptyline or sedatives the doctor should ask whether there have been ideas that life is no longer worth living and should assure the patient of ready support if feelings of depression become more severe.

CHOICE OF DRUG

If, finally, the doctor considers he must prescribe, what should the drug be? There are plenty to choose from. Self-administered overdoses, with drugs either recently prescribed or still lying around from last year, are common, so that whatever is prescribed should be safe, and it should not be a drug that teenagers in the home would filch for late-night parties. The benzodiazepines, such as nitrazepam, are not cheap but they are safe. Ethchlorvynol and barbiturates are unsafe, while proprietary cocktails containing several drugs are just expensive nonsense. Little or no criticism attaches to chloral.

The older patient who has had his pills for years is unlikely to be persuaded to stop them, but younger patients should have their attitudes shaped from the start by comments that these pills are to help them through temporary troubles and that they should be continued only for a few weeks. In the case of the elderly patient whose mental powers are failing, and who has alarmed his relatives by wandering around the house in the middle of the night, the usual hypnotics may actually be causing confusion, with severe disorientation and falls. Thioridazine 25-100 mg in the evening is more useful.

Too Much Sleep

Idiopathic narcolepsy, which starts at any age and persists for life, is commoner than usually supposed. The complaint is of episodes of irresistible sleepiness two or three times a day and lasting 10-15 min, after which all is well again for a while. The sleep attacks come on especially under circumstances conducive to sleep, such as sitting on a bus (followed by waking up at the terminus), in church or in the cinema, while eating a

quiet evening meal, or even when walking along the street. After perhaps some years cataplectic attacks are added, when for a few seconds sudden muscular weakness affects the whole or part of the body, having been provoked by a specific, fleeting emotion. It will be laughter for one patient (who learns to sit down for jokes), anger for another (whose children learn what happens when they provoke father), and for another a feeling of triumph (so that an opportunity for a winning smash at tennis is lost).

MANAGEMENT OF PATIENT

The families, friends, and employers have to be induced to understand that the sleep does not represent either lack of appreciation of their company or slothfulness in the patient. If possible it should be agreed that the patient deliberately take a 15 min nap in the lunch and tea breaks, as this will help avert sleep attacks at other times. The tricyclic drugs imipramine or clomipramine, 75-100 mg daily, have a specific action in preventing the cataplectic attacks (nothing to do with their antidepressant properties). But for most patients the sleep attacks are the bigger problem, and dexamphetamine sulphate 5 mg tablets in the pocket for such special occasions as weddings are a good idea. Though dexamphetamine in regular doses of 20-50 mg is often given, the greater the intake the greater the tendency for paranoid states to appear. My own patients seem to manage just as well without regular intake. The combination of a tricyclic drug with dexamphetamine is at least theoretically dangerous, yet some physicians do prescribe them together and apparently without hypertensive crises.

The onset of idiopathic narcolepsy is often accompanied by increase of weight, and obesity is a feature of other less common conditions of excessive sleepiness. There are patients who have attacks of irresistible sleep, often of 20-30 min, but without cataplexy and without the passage direct into paradoxical (R.E.M.) sleep that is a hallmark of idiopathic narcolepsy. They too often gained weight earlier in life when the sleep attacks began. Once again rearrangement of daytime routines and amphetamines can be advised. Then there are rare patients with recurrent spells of a drowsy state that last for weeks at a time, or with the Pickwick fat-boy syndrome who are sleepy by day because their nocturnal sleep is broken up by apnoea and explosive snorts in endless succession; they need specialist investigation. When it is mainly the relatives who have noticed recent drowsiness and when there is also a story of headache, vomiting, self-neglect, or memory failure, then an intracranial tumour, such as subdural haematoma, will be thought of.

Peculiarities during Sleep

Adults are less likely than are children to come to the doctor on account of night-terrors, sleepwalking, toothgrinding, bed-wetting, or rocking and rolling in sleep, but these disorders are still to be found. Enuresis lingering from childhood is best treated by the buzzer. Sleep walking, or night-terrors with blood-curdling groans or shrieks, will generally diminish as some anxiety-provoking events recede in time. Safety precautions or diazepam may be temporarily indicated. Talking in sleep is also commoner when daytime anxiety remains high but, like sleep-walking, tends to run in families, and the spouse or relatives should be reassured that nothing serious is betokened. Information about the normal nature of wet dreams should be part of health education for the pubescent boy. Even more a topic of common amusement and anguish is snoring. There are scores of treatments for snorers but, as always when treatments abound, I do not know of any that could really be recommended.

Sleep occupies nearly a third of our lives, modern research is confirming its importance for restoration or growth, but it continues an enigma, and its disorders merit a listening ear more often than they find a specific remedy.