Chapter 8 – Eating & Sleep Disorders

DIAGNOSIS:

Death rate for eating disorders is highest for any psychological disorder, including depression.  
20% of people w/anorexia nervosa die as a result of the disorder; slightly more than 5% w/in 10 years.  
As many as half those deaths are suicides.

90% of severe cases are young females, usually from upper-middle-class or upper-class socioeconomic groups, who live in a socially competitive environment.

Criteria for Bulimia:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

   (1) Eating, in a discrete period of time (eg, within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

   (2) A sense of lack of control over eating during the episode (eg, a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type:

- **Purging type**: During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

- **Nonpurging type**: During the current episode of bulimia nervosa, the person has used inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Most bulimics are w/in 10% of their normal weight.
Criteria for Anorexia Nervosa:

A. A refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to a maintenance of body weight less than 85% of that expected, or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Specify type:

Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e. self-induced vomiting or the misuse of laxatives, diuretics or enemas)

Binge-Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e. self induced vomiting or the misuse of laxatives, diuretics or enemas).

Diagnostic Criteria for Binge Eating Disorder

A. Recurrent episodes of binge eating. An episode is characterized by:

1. Eating a larger amount of food than normal during a short period of time (within any two hour period)

2. Lack of control over eating during the binge episode (i.e. the feeling that one cannot stop eating).

B. Binge eating episodes are associated with three or more of the following:

1. Eating until feeling uncomfortably full
2. Eating large amounts of food when not physically hungry
3. Eating much more rapidly than normal
4. Eating alone because you are embarrassed by how much you're eating
5. Feeling disgusted, depressed, or guilty after overeating

C. Marked distress regarding binge eating is present

D. Binge eating occurs, on average, at least 2 days a week for six months

E. The binge eating is not associated with the regular use of inappropriate compensatory behavior (i.e. purging, excessive exercise, etc.) and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.
CAUSES:

Social—eating disorders are the most culturally specific psychological disorders identified.

Over-emphasis on thinness, especially in the past few decades. Study of Miss Americas and Playboy centerfolds shows the trend toward the ideal of thinness. (Most meet one of the criteria for anorexia—15% or more below normal body weight.)

Treatments

Drug treatments have not been shown effective for anorexia nervosa. Some evidence that Prozac may help prevent relapse, after weight has been restored.

Bulimia can be helped by tricyclic antidepressants and Prozac (ssri). Improvement measured by reduction in frequency of binge eating and percentage of patients who stop binge eating and purging. Useful for short-term but long-lasting effects.

Psychological treatments

Bulimia
Treatment of choice for bulimia is short-term cognitive behavior therapy targeting problem eating behavior and associated attitudes about the overriding importance and significance of body weight and shape.

CBT for Bulimia:
- Teach physical consequences of binge eating and purging, ineffectiveness of vomiting and laxative abuse, and adverse effects of dieting.

- Small amounts of food 5-6 times/day, at no more than 3-hour intervals, to eliminate the alternating overeating and restriction that are the hallmarks of bulimia.

- Alter dysfunctional thinking and attitudes about body shape and weight and eating.

- Coping strategies for resisting the urge to binge and purge; arranging activities to be with other people after eating, at the beginning stages.

CBT is most effective treatment we know, and works fastest. But IPT, which concentrates on interpersonal conflicts, not eating behaviors, has a slower but equaling good outcome over time (by 1 year).
Not everyone responds to CBT. Some of those may respond better to IPT or medication.

**BED:**
Anti-binge CBT has also been adapted for BED patients, with good success. IPT has been shown equally effective as CBT for BED (in contrast to bulimia). Self-help groups are just as effective, and less costly.

**Anorexia Nervosa:**
Most important initial goal is to restore weight to at least w/in low-normal range.

If below 70% of average or if lost very rapidly, inpatient hospital treatment used, because of very severe medical complications possible from such extreme weight-loss (esp. acute cardiac failure). (See Table 8.1 on page 319 for strategies to attain weight gain.)

Without a shift in attitudes about body shape and interpersonal disruptions in her life, will almost always relapse.

For restricting anorexics, focus is on anxiety about becoming obese and losing control of eating, as well as undue emphasis on thinness as a determinant of self-worth, happiness, and success. Similar CBT treatment to that for bulimics.
Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep.
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Print out this test, fill in your answers and see where you stand.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing or Sleeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>____</td>
</tr>
<tr>
<td>Watching TV</td>
<td>____</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>____</td>
</tr>
<tr>
<td>Being a passenger in a motor vehicle for an hour or more</td>
<td>____</td>
</tr>
<tr>
<td>Lying down in the afternoon</td>
<td>____</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>____</td>
</tr>
<tr>
<td>Sitting quietly after lunch (no alcohol)</td>
<td>____</td>
</tr>
<tr>
<td>Stopped for a few minutes in traffic while driving</td>
<td>____</td>
</tr>
</tbody>
</table>

**Total score (add the scores up)**
(This is your Epworth score) ____
A score of 10 or more is considered sleepy.

A score of 18 or more is very sleepy (usually associated w/sleep disorder.

If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Scores of 17 (+/- 2 points) are associated with Narcolepsy and Central Nervous System Hypersomnolence.

Scores of 11 (+/- 2 points) are associated with obstructive sleep apnea.

Scores of 9 (+/- 2 points) are associated with periodic limb movements in sleep.

Scores of 6 (+/- 2 points) are associated with primary snoring.

Scores of 2 (+/- 2 points) are associated with insomnia.

Sleep deprivation leads to:
- Car crashes
- Poor memory
- Lack of physical coordination
- Poor health
- Loss of productivity on the job
- Doctors making errors (especially during internship, when they are very sleep-deprived)
- Engineers making errors
- Considered a major health crisis

**Dyssomnias & Parasomnias**
DYSSOMNIAS:

Diagnostic criteria for Primary Insomnia:

A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month.

B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The sleep disturbance does not occur exclusively during the course of narcolepsy, breathing-related sleep disorder, circadian rhythm sleep disorder, or a parasomnia.

D. The disturbance does not occur exclusively during the course of another mental disorder (e.g., major depressive disorder, generalized anxiety disorder, a delirium).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Can insomnia be a CAUSE (rather than just a symptom) of psychological disorders? Patients with persistent and untreated insomnia are at between 2 and 10 times the risk for new onset or recurrent episodes of major depression. There is also good evidence that insomnia is a risk factor for the development and/or recurrence of anxiety disorders and substance abuse.
# TABLE 1
Common Causes of Insomnia

<table>
<thead>
<tr>
<th>Medical causes</th>
<th>Psychologic causes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonprescription drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td>Depression</td>
</tr>
<tr>
<td>&quot;Diet pills&quot; (e.g., those including pseudoephedrine, phenylpropanolamine)</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Life stressors</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>Bedtime worrying</td>
</tr>
<tr>
<td>Methylphenidate (Ritalin)</td>
<td>Conditioning (associating the bed with wakefulness)</td>
</tr>
<tr>
<td>Theophylline</td>
<td>Mania or hypomania</td>
</tr>
<tr>
<td>Albuterol (Ventolin)</td>
<td></td>
</tr>
<tr>
<td>Quinidine (Cardioquin)</td>
<td><strong>Environmental causes</strong></td>
</tr>
<tr>
<td>Pemoline (Cylert)</td>
<td>Bedroom too hot or too cold</td>
</tr>
<tr>
<td>Dextroamphetamine (Dexedrine)</td>
<td>Noise</td>
</tr>
<tr>
<td>Pseudoephedrine (Novafed)</td>
<td>Eating, exercise, caffeine or alcohol use before bedtime</td>
</tr>
<tr>
<td>Phenylephrine (Neo-Synephrine)</td>
<td>Jet lag</td>
</tr>
<tr>
<td>Phenylpropanolamine (Entex)</td>
<td>Shift work</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitors</td>
<td>Daytime napping</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical conditions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary sleep disorders (sleep apnea, periodic limb movement disorder, nocturnal myoclonus, restless legs syndrome)</td>
<td></td>
</tr>
<tr>
<td>Pain from any source or cause</td>
<td></td>
</tr>
<tr>
<td>Drug or alcohol intoxication or withdrawal</td>
<td></td>
</tr>
<tr>
<td>Thyrotoxicosis</td>
<td></td>
</tr>
<tr>
<td>Dyspnea from any cause</td>
<td></td>
</tr>
</tbody>
</table>
Treatment

Initially, it is important not to compensate for the sleep loss by napping, staying in bed late, lying in bed not sleeping, etc, it is usually self-correcting within a short period of time.

If it continues, there are a number of strategies that can be used:

Medication

Benzodiazepines are prescribed to induce sleep. They are CNS depressants, have the effect of sedative/hypnotic.

- Problems:
  - Morning sleepiness (depending on half-life)
  - Side effects
  - Tolerance
  - Dependency
  - Rebound insomnia

Also nonbenzodiazepines, Zolpidem (such as Ambien) that have similar sedative/hypnotic effects, with less of the muscle-relaxant effect.

Medications are suggested for short-term use only (not more than 4 weeks).
What about alcohol? Will bring on sleep, but interfere with sleep later in the night.

The effect of ethanol on sleep can take several forms. These include:
1. Altering the time to fall asleep
2. Disrupting the sequence of sleep
3. Altering the total time of sleep
4. Diminishing the duration of particular types or stages of sleep.

Though it is true that drinking before bedtime may cause one to fall asleep sooner, it disrupts the second half of sleep. The person may have fitful sleep by awakening from dreams and having trouble returning to sleep. It is interesting that even if ethanol is drunk earlier in the day and has cleared the system, it still has the potential to disrupt sleep later in the night. This would suggest that ethanol acts on brain systems, which are still disrupted at a later, time.

Neurotransmitters (NTs) serotonin and norepinephrine are important in the regulation of sleep. Serotonin seems primarily associated with sleep onset and with regulation of SWS, while norepinephrine seems to regulate REM and arousal. Since it known that ethanol affects both serotonin and norepinephrine, possible mechanisms for the effects of ethanol on sleep are via ethanol’s action on these NTs.

Insomnia affects a higher percentage than found in the population at large. As a person consumes an excess amount of alcohol, the sedative properties of the substance lower significantly, and the alcohol no longer enables one to fall asleep quicker. In fact, consuming too much alcohol makes it increasingly difficult to fall asleep. Once sleep finally sets in for an alcoholic, the time spent in both SWS and REM modes is reduced, resulting in an overall reduction of sleep time. While studying recovering alcoholics during their periods of withdrawal, researchers observed an increase in the amount of time spent in SWS and REM sleep with a corresponding increase in the amount of time needed to fall asleep. However, although SWS and REM times were increased, they were not restored to their optimal levels. Research indicates that the damage an alcoholic does to his or her system while abusing the substance may be irreparable. In any case, sleep patterns are significantly affected for at least two years, if not for life.
Progressive muscle relaxation.

Paradoxical intention.

Stimulus Control:
1. Restrict bedroom activities to those that are conducive to sleep (rather than those that keep us alert or are associated with anxiety (doing schoolwork, watching the news, carrying on upsetting discussions).
2. If 15 minutes pass without falling asleep, get out of bed and try a relaxing activity.

Sleep Restriction - Only stay in bed for the total number of hours you usually actually sleep, whether you sleep during that time or not. Over time, your will become tired enough to actually sleep for 90% of the time in bed, at which point you can increase the time.

Instructions for Improvement of Sleep Hygiene

1. Establish a bedtime routine.
2. Establish a regular schedule for going to bed and getting up. Avoid daytime naps, which can disturb the normal sleep/wake pattern.
3. Decrease or eliminate the use of caffeine, especially after noon.
4. Do not use tobacco or alcohol near bedtime.
5. Avoid heavy meals close to bedtime. However, a light snack at bedtime may promote sleep, especially those that contain tryptophan.
6. Exercise regularly, but avoid vigorous exercise within 3 hours of bedtime. Relaxing exercise (like yoga) can be done in the hours before bed.
7. Keep the bedroom at a comfortable temperature and minimize light and noise. Make sure bed is comfortable, etc.
Diagnostic criteria for 307.44 Primary Hypersomnia

A. The 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.

B. The excessive sleepiness causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The excessive sleepiness is not better accounted for by Insomnia and does not occur exclusively during the course of another Sleep Disorder (e.g., Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia) and cannot be accounted for by an inadequate amount of sleep.

D. The disturbance does not occur exclusively during the course of another mental disorder.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

Recurrent: if there are periods of excessive sleepiness that last at least 3 days occurring several times a year for at least 2 years

Diagnostic criteria for Narcolepsy

A. Irresistible attacks of refreshing sleep that occur daily over at least 3 months.

B. The presence of one or both of the following:

(1) cataplexy (i.e., brief episodes of sudden bilateral loss of muscle tone, most often in association with intense emotion [like laughing or startle])

(2) recurrent intrusions of elements of rapid eye movement (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

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition.

What causes narcolepsy?

Most cases of narcolepsy in humans are due to a lack of a chemical in the brain called hypocretin. This chemical was unknown before 1998, so this is very new research. Most patients with narcolepsy do not produce hypocretin in a deep part of the brain called the hypothalamus. If you don’t produce hypocretin, it would appear that other chemicals that cause alertness cannot function properly.

Research studies have shown that most narcoleptic patients don't have hypocretin in their spinal fluid, and it is possible that this may become a diagnostic test for narcolepsy in the not-too-distant future. What we don’t know is why patients with narcolepsy don’t produce hypocretin. We think this is probably due to an attack of the body's immune system against the cells that produce it, but this is still speculative. But we are engaged in research projects to try to establish this.
Treatment

Symptoms are treated, not the cause. Medications like Ritalin or amphetamines are given to increase alertness. For cataplexy, they give antidepressants, because they decrease REM sleep. (Norepinephrine associated with REM, serotonin with SWS.)
Diagnostic criteria for Breathing-Related Sleep Disorder

A. Sleep disruption, leading to excessive sleepiness or insomnia, that is judged to be due to a sleep-related breathing condition (e.g., obstructive or central sleep apnea syndrome or central alveolar hypoventilation syndrome).

B. The disturbance is not better accounted for by another mental disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition (other than a breathing-related disorder).

Coding note: Also code sleep-related breathing disorder on Axis III.

Obstructive Sleep Apnea:
Typically, the frequency of waking episodes is somewhere between 10 and 60. A person with severe OSA may have more than 100 waking episodes in a single night.

Risk Factors
The primary risk factor for OSA is excessive weight gain. The accumulation of fat on the sides of the upper airway causes it to become narrow and predisposed to closure when the muscles relax. Age is another prominent risk factor. Loss of muscle mass is a common consequence of the aging process. If muscle mass decreases in the airway, it may be replaced with fat, leaving the airway narrow and soft. Men have a greater risk for OSA. Male hormones can cause structural changes in the upper airway. Other predisposing factors associated with OSA include:

- Anatomic abnormalities, such as a receding chin
- Enlarged tonsils and adenoids, the main causes of OSA in children
- Family history of OSA, although no genetic inheritance pattern has been proven
- Use of alcohol and sedative drugs, which relax the musculature in the surrounding upper airway
- Smoking, which can cause inflammation, swelling, and narrowing of the upper airway
- Hypothyroidism, acromegaly, amyloidosis, vocal cord paralysis, post-polio syndrome, neuromuscular disorders, Marfan's syndrome, and Down syndrome
- Nasal congestion
  ...
- Obesity, particularly upper body obesity, is the most significant risk factor for obstructive sleep apnea.
- There is a 12 to 30-fold higher incidence of obstructive sleep apnea among morbidly obese patients compared to the general population.
- Among patients with obstructive sleep apnea, at least 60% to 70% are obese.

Central Sleep Apnea - temporary ceasing of respiration due to rare neurological dysfunction.

Treatment:
If not severe, sleep hygiene to avoid becoming sleep deprived, and avoiding alcohol (which can add to loss of muscle tone), raising the head of the bed, etc.
Medications to prevent the loss of muscle tone associated with REM sleep (tricyclics).
Device to keep the airways open—CPAP (continuous positive airway pressure).
Oral appliances to move tongue and mandible forward.
Surgery to correct obstruction.
This Dyssomnia is diagnosed when the individual's own (endogenous) sleep-wake schedule is not synchronized with the schedule imposed from their environment, resulting in Insomnia and sleepiness which may occur regularly but at the inappropriate time.

**Diagnostic criteria for Circadian Rhythm Sleep Disorder**

**A.** A 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.

**B.** The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**C.** The disturbance does not occur exclusively during the course of another Sleep Disorder or other mental disorder.

**D.** The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify type (code):*

- **Delayed Sleep Phase Type:** 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:** 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:** insomnia during the major sleep period or excessive sleepiness during the major awake period associated with night shift work or frequently changing shift work

- **Unspecified Type**

Pathway from the eyes to the superchiasmatic nucleus of the hypothalamus. When light hits the retina, information is sent to the hypothalamus that regulates the sleep/wake cycle (production of hormones—cortisol upon awakening, serotonin to sleep, melatonin during the night). (Circadian rhythm also affects digestion, etc.) Melatonin is produced by the pineal gland when it is dark.

**Treatment**

Phase delays are easier than phase advances.

Melatonin may be helpful for circadian rhythm disorders, but it does have side-effects. Probably not useful for other types of sleep disorders.

Phototherapy, the use of bright light to reset the circadian biological clock.

One *lux* is equal to one lumen per square metre.

<table>
<thead>
<tr>
<th>Illuminance</th>
<th>Abbr.</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 lux</td>
<td>Moonlight</td>
<td></td>
</tr>
<tr>
<td>400 lux</td>
<td></td>
<td>A brightly lit office</td>
</tr>
<tr>
<td>Lux</td>
<td>klx</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>400</td>
<td>1</td>
<td>Sunrise or sunset on a clear day.</td>
</tr>
<tr>
<td>1000</td>
<td>1</td>
<td>Typical TV studio lighting</td>
</tr>
<tr>
<td>1000</td>
<td>1</td>
<td>Approximate minimum level required to reset the biological clock in humans</td>
</tr>
<tr>
<td>32000</td>
<td>32</td>
<td>Sunlight on an average day (min.) (100,000 lux max sunlight)</td>
</tr>
</tbody>
</table>
PARASOMNIAS:

Diagnostic criteria for Nightmare Disorder

A. 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. The awakenings generally occur during the second half of the sleep period.

B. On awakening from the frightening dreams, the person rapidly becomes oriented and alert (in contrast to the confusion and disorientation seen in Sleep Terror Disorder and some forms of epilepsy).

C. 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.

D. The nightmares do not occur exclusively during the course of another mental disorder (e.g., a Delirium, Posttraumatic Stress Disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Occur during REM sleep. Not much study of the “cause” and “treatment” of them. Seem to decrease w/age.

Diagnostic criteria for Sleep Terror Disorder

A. Recurrent episodes of abrupt awakening from sleep, usually occurring during the first third of the major sleep episode and beginning with a panicky scream.

B. Intense fear and signs of autonomic arousal, such as tachycardia, rapid breathing, and sweating, during each episode.

C. Relative unresponsiveness to efforts of others to comfort the person during the episode.

D. No detailed dream is recalled and there is amnesia for the episode.

E. The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Night terror occurs most often in young boys, although it can occur in girls and in adults. It is fairly common in children 3 to 5 years old, and much less common after that. Night terror may
run in families. It can occur in adults, especially with emotional tension and/or the use of alcohol.

Occur during NREM sleep. Seems to have a genetic component.

Sometimes “scheduled awakenings” are used with persistent and frequent sleep terrors—waking the child up 30 minutes prior to the usual time of the terror.
Diagnostic criteria for 307.46 Sleepwalking Disorder

A. Repeated episodes of rising from bed during sleep and walking about, usually occurring during the first third of the major sleep episode.

B. 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.

C. On awakening (either from the sleepwalking episode or the next morning), the person has amnesia for the episode.

D. Within several minutes after awakening from the sleepwalking episode, there is no impairment of mental activity or behavior (although there may initially be a short period of confusion or disorientation).

E. The sleepwalking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Occurs during NREM. Deepest sleep, so hard to awaken. Not dangerous.

Much more common in children than adults. Seems to have a genetic component.

Don’t know what causes them. Usually associated with stress, sleep deprivation, or use of sleeping medication.

Nocturnal eating syndrome, they eat in their sleep!