CHAPTER 8
EATING AND SLEEP DISORDERS
(p. 263-275)

EATING DISORDERS: OVERVIEW
(p. 269-270)

- Two Major Types of DSM-IV Eating Disorders
  - Anorexia Nervosa and Bulimia Nervosa
  - Severe disruptions in eating behaviour
  - Extreme fear and apprehension about gaining weight
  - Various scales to measure Eating Disorders and weight concerns (+1 +2)
- Serious disorder: high death rate from disease, suicide, ...
  - AN 5.86 12,000+ 14.2
  - BN 1.93 2,500+ 9.3

TABLE 8.2 Weight Concerns

<table>
<thead>
<tr>
<th>Statement</th>
<th>AN 12,000+</th>
<th>BN 2,500+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever lost or gained weight and then worried about your weight and body shape more than others with the same diet?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
<tr>
<td>2. How often do you worry about your weight and body shape?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
<tr>
<td>3. How often do you feel dissatisfied with your body shape?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
<tr>
<td>4. How often do you worry about your weight and body shape compared with other things in my life?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
<tr>
<td>5. How important is weight to your overall health?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
<tr>
<td>6. How important is weight to your overall health compared with other things in my life?</td>
<td>12,000+</td>
<td>2,500+</td>
</tr>
</tbody>
</table>

WEIGHT CONCERNS IN YOUNG GIRLS
(p. 271-272)

Table 2. Body mass index (BMI), weight concerns, and age for elementary and middle school samples

<table>
<thead>
<tr>
<th>Age</th>
<th>Elementary school</th>
<th>Middle school</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-13 yrs</td>
<td>17.6±3.1</td>
<td>19.9±3.1</td>
</tr>
<tr>
<td>14-17 yrs</td>
<td>14.0±13.1</td>
<td>21.7±4.6**</td>
</tr>
<tr>
<td>18+ yrs</td>
<td>10.1±8</td>
<td>25.8±27.7*</td>
</tr>
</tbody>
</table>

Arizona

<table>
<thead>
<tr>
<th>BMI</th>
<th>Weight concerns scale</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.6±3.1</td>
<td>14.0±13.1</td>
<td>10.1±8</td>
</tr>
<tr>
<td>19.9±3.1</td>
<td>21.7±4.6**</td>
<td>25.8±27.7*</td>
</tr>
<tr>
<td>12.9±9</td>
<td>32.9±23.8</td>
<td>12.8±9</td>
</tr>
</tbody>
</table>
**BULIMIA NERVOSA** (p. 270-271)

- **Binge Eating: Hallmark of Bulimia**
  - Binge: eating excessive amounts of food
  - Eating perceived as uncontrollable
- **DSM-IV Criteria and Subtypes of Bulimia (+1)**
  - Defined by compensatory behaviours
    - Purging subtype (2/3): vomiting, laxatives, enemas
    - Nonpurging subtype (1/3): excessive exercise, fasting
- **Associated Features**
  - Most within 10% of target body weight
  - Most over concerned with body shape, fear gaining weight
  - Most comorbid for other psychological disorders
  - Purging methods can result in severe medical problems

**ANOREXIA NERVOSA** (p. 273-274)

- **Extreme Weight Loss: Hallmark of Anorexia**
  - Defined as 15% below expected weight
  - Intense fear of obesity and losing control over eating
- **DSM-IV Criteria and Subtypes (+1)**
  - Restricting subtype: limit caloric intake via diet and fasting
  - Binge-eating-purging subtype: about 50% of anorexics
- **Associated Features**
  - Most show marked disturbance in body image
  - Most are comorbid for other psychological disorders
  - Methods of weight loss can have severe life threatening medical consequences

**BINGE-EATING DISORDER** (p. 274)

- **Binge-Eating Disorder: Appendix of DSM-IV**
  - Experimental diagnostic category (added to DSM-V?)
  - Engage in food binges, but not compensatory behaviors
- **Associated Features**
  - Many persons with binge-eating disorder are obese
  - Most are older than bulimics and anorexics
  - More psychopathology than obese people who do not binge
  - Similar concern as anorexics and bulimics about shape & weight
- **Other Subtypes of DSM-IV Eating Disorders**
  - Rumination disorder: regurgitate and re-chew food
  - Pica disorder: eat non-nutritional substances (e.g., clay)
  - Feeding disorder of infancy and early childhood

**BULIMIA AND ANOREXIA: FACTS AND STATISTICS** (p. 274-276)

- **Bulimia**
  - Majority female, with onset around 16 to 19 years of age
  - Lifetime prevalence about 1.1% for females, 0.1% for males
  - 6-8% of college women suffer from bulimia
  - Tends to be chronic if left untreated
- **Anorexia**
  - Majority female and white, middle-to-upper-middle-class families
  - Usually develops around age 13 or early adolescence
  - Tends to be more chronic and resistant to treatment than bulimia
- **Statistics**
  - Develops at young age (+1)
  - Increase over recent decades (+2), especially for BN (+3), at time when weight of overall population is increasing (+4)
  - Emerging at earlier ages (+5)
INCREASING IN BULIMIA NERVOSA

CAUSES OF BULIMIA AND ANOREXIA: TOWARD AN INTEGRATIVE MODEL

OVERALL WEIGHT INCREASING

DECREASE IN BULIMIA NERVOSA

INCREASING IN BULIMIA NERVOSA

Risk

Definite and probable cases

CAUSES OF BULIMIA AND ANOREXIA:
TOWARD AN INTEGRATIVE MODEL

Integrative Model of Eating Disorders (+1 +2)

- Biological Factors:
  - Genetic predisposition to obsessions (about body),
    impulsive behaviors (eating), ...
  - Some twin studies consistent with genetic contribution
    (text), but not all (+3)

- Social Factors: Culture, Media, Peers, Family, ...
  - Culture & Media
    • Being thin = Success, happiness, esteem, ...
    • With proper nutrition, ideal difficult to achieve
    • Cultural imperative for thinness translates into dieting
    • Standards of ideal body size change over time (+4 +5 +6)
CAUSES OF BULIMIA AND ANOREXIA: TOWARD AN INTEGRATIVE MODEL


Social — Cultural and social emphasis on slender ideal, leading to body dissatisfaction and preoccupation with food and eating.

Biological — Possible genetic tendency to poor impulse control, emotional instability, and perfectionistic traits.

MZ = DZ?

Then and Now

Then and Now

Eating Disorders: more prevalent in Western (Euro) cultures
- Akan & Grilo (1995)
  
  Euro- > Asian- / Afr- Amer eating disorder, dieting, body dissatisfaction
- Low self-esteem, high public self-consciousness
- Allan & Gray (1993)
  
  White females higher
  Associated with depression, anxiety, low self-esteem
- Hamilton et al. (1985): dancers
  
  15-19% White vs. 0% Black
  Higher psychopathology, poorer body images

Body Shape and Eating Disorders
- Body weight historically sign of affluence, still viewed as more attractive in many cultures, although eating disorders / dieting on increase
- Contemporary West, Low body weight valued, especially by high SES
- Stigma associated with excess weight
  
  American students would marry embezzler, cocaine user, or shoplifter before an obese person (Venes et al., 1982)
  
  Affects likelihood of being hired, especially for Women, Salary, ...

INTEGRATED MODEL

- Family and Peers
  
  Family members (mothers) can promote excessive concerns about appearance, perfectionism, ...
  
  Peer groups may share similar ideals and concerns
  
  Results of sample study with young girls (+1) (and some other factors)
- Psychological and Behavioural Considerations
  
  Low sense of personal control and self-confidence, perfectionism, ...
  
  Misconceptions about normal growth and development around puberty, and what is attractive to others (+2)
  
  Food restriction can lead to preoccupation with food, which can have paradoxical effects on eating and weight (+3)
  
  Perceptual biases about body image prevalent (+4+5)

PREDICTING WEIGHT CONCERNS IN YOUNG GIRLS

<table>
<thead>
<tr>
<th>Domain</th>
<th>Elementary School</th>
<th>Regression Coefficient ± SE</th>
<th>Spearmans Correlation</th>
<th>Middle School</th>
<th>Regression Coefficient ± SE</th>
<th>Spearmans Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance peers put on</td>
<td></td>
<td>26.93 ± 6.83***</td>
<td>0.39</td>
<td>39.50 ± 2.82**</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
<td>weight/eating</td>
<td></td>
<td>6.21 ± 2.49***</td>
<td>0.39</td>
<td>12.79 ± 2.10***</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>Seized about weight</td>
<td></td>
<td>13.68 ± 5.37*</td>
<td>0.37</td>
<td>21.52 ± 2.89*</td>
<td>0.36</td>
<td></td>
</tr>
<tr>
<td>Effects of being teased about</td>
<td></td>
<td>9.48 ± 4.20</td>
<td>0.36</td>
<td>13.64 ± 3.30**</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>weight</td>
<td></td>
<td>19.02 ± 10.12</td>
<td>0.30</td>
<td>13.84 ± 3.30**</td>
<td>0.32</td>
<td></td>
</tr>
<tr>
<td>Mother’s concern with weight</td>
<td></td>
<td>10.70 ± 3.04**</td>
<td>0.37</td>
<td>9.12 ± 2.45**</td>
<td>0.20</td>
<td></td>
</tr>
<tr>
<td>Father’s concern with thickness</td>
<td></td>
<td>9.93 ± 3.10**</td>
<td>0.37</td>
<td>6.96 ± 1.87**</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td>Body image</td>
<td></td>
<td>8.56 ± 2.20***</td>
<td>0.26</td>
<td>3.68 ± 1.51**</td>
<td>0.20</td>
<td></td>
</tr>
<tr>
<td>Perceived peer view</td>
<td></td>
<td>11.01 ± 2.66***</td>
<td>0.33</td>
<td>13.10 ± 1.86**</td>
<td>0.36</td>
<td></td>
</tr>
<tr>
<td>TV viewing</td>
<td></td>
<td>4.19 ± 2.53***</td>
<td>0.35</td>
<td>9.29 ± 2.12***</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Support from others</td>
<td></td>
<td>-9.28 ± 6.14</td>
<td>0.36</td>
<td>-6.01 ± 3.13*</td>
<td>-0.11</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td></td>
<td>1.22 ± 0.43</td>
<td>0.29</td>
<td>1.89 ± 0.21*</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Not English speaking</td>
<td></td>
<td>1.07 ± 0.24</td>
<td>0.17</td>
<td>3.32 ± 0.83*</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Body mass index</td>
<td></td>
<td>2.79 ± 0.87**</td>
<td>0.46</td>
<td>3.04 ± 0.85**</td>
<td>0.36</td>
<td></td>
</tr>
</tbody>
</table>

ESTIMATES ABOUT BODY SHAPE

- Female shape ideal
- Female shape attractive
- Male shape ideal
- Male shape attractive

FIGURE 6.4 Male and female ratings of body shape
Source: Based on Sundet, Sommers, & Schaufelein, 1990.

FIGURE 6.5 Cumulative hazard curves for the onset of obesity for self-labelled dieters versus self-labelled nondieters
Source: From Stice et al., 1999.
PERCEPTION OF APERTURE WIDTH RELATIVE TO SHOULDER WIDTH OF SUBJECTS

<table>
<thead>
<tr>
<th></th>
<th>M = 1.13</th>
<th>M = 1.32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control subjects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexic patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3.1: Strategies to Alter Weight Gain

1. Weight restoration occurs in conjunction with other treatments, such as individual and family therapy, so that the patient does not feel that eating and weight gain are the only goals of treatment.

2. The patient trusts the treatment team and believes that she will not be allowed to become overweight.

3. The patient’s fear of loss of control is contained; this may be accomplished by having her eat frequent, smaller meals (e.g., four to six times per day, with 400 to 500 calories per meal) so as to produce a gradual but steady weight gain (e.g., an average of half a pound (253 g) per week).

4. A member of the nursing staff is present during meals to encourage the patient to eat and to discuss her fears and anxiety about eating.

5. The patient is encouraged to eat a variety of foods, including those that she may have previously avoided.

6. The patient is gradually taught to eat in a controlled manner, without the aid of others.

7. The patient is gradually taught to eat in a controlled manner, without the aid of others.

8. The patient is gradually taught to eat in a controlled manner, without the aid of others.

9. The patient is gradually taught to eat in a controlled manner, without the aid of others.

10. The patient is gradually taught to eat in a controlled manner, without the aid of others.

11. The patient is gradually taught to eat in a controlled manner, without the aid of others.

12. The patient is gradually taught to eat in a controlled manner, without the aid of others.

13. The patient is gradually taught to eat in a controlled manner, without the aid of others.

14. The patient is gradually taught to eat in a controlled manner, without the aid of others.

15. The patient is gradually taught to eat in a controlled manner, without the aid of others.

16. The patient is gradually taught to eat in a controlled manner, without the aid of others.

17. The patient is gradually taught to eat in a controlled manner, without the aid of others.

18. The patient is gradually taught to eat in a controlled manner, without the aid of others.

19. The patient is gradually taught to eat in a controlled manner, without the aid of others.

20. The patient is gradually taught to eat in a controlled manner, without the aid of others.

21. The patient is gradually taught to eat in a controlled manner, without the aid of others.

22. The patient is gradually taught to eat in a controlled manner, without the aid of others.

23. The patient is gradually taught to eat in a controlled manner, without the aid of others.

24. The patient is gradually taught to eat in a controlled manner, without the aid of others.

25. The patient is gradually taught to eat in a controlled manner, without the aid of others.

26. The patient is gradually taught to eat in a controlled manner, without the aid of others.

27. The patient is gradually taught to eat in a controlled manner, without the aid of others.

28. The patient is gradually taught to eat in a controlled manner, without the aid of others.

29. The patient is gradually taught to eat in a controlled manner, without the aid of others.

30. The patient is gradually taught to eat in a controlled manner, without the aid of others.

31. The patient is gradually taught to eat in a controlled manner, without the aid of others.

32. The patient is gradually taught to eat in a controlled manner, without the aid of others.

33. The patient is gradually taught to eat in a controlled manner, without the aid of others.

34. The patient is gradually taught to eat in a controlled manner, without the aid of others.

35. The patient is gradually taught to eat in a controlled manner, without the aid of others.

36. The patient is gradually taught to eat in a controlled manner, without the aid of others.

Table 3.2: Medical and Psychological Treatment of Bulimia Nervosa

Medical Treatment
- Antidepressants can help reduce binging and purging; not efficacious in long-term

Psychological Treatment
- Cognitive-behavior therapy (CBT) is treatment of choice
- Interpersonal psychotherapy similar long-term gains
- Weight restoration: first and easiest goal to meet (+1)
- Treatment involves education, behavioral, and cognitive interventions
  - Positive coping buffers against binging in people at risk (+2)
  - Treatment often involves family
  - Long-term prognosis for Anorexia poorer than for Bulimia

Table 3.3: Positive Coping Buffers Relation of Eating Disorder Symptoms to Binging

SLEEP DISORDERS: OVERVIEW

- Assessment of Disordered Sleep: Polysomnographic (PSG) Evaluation (+1)
  - Electroencephalograph (EEG): leg movements and brain wave activity
  - Electrooculograph (EOG): eye movements
  - Electromyography (EMG): muscle movements
  - Includes detailed history, assessment of sleep hygiene, and sleep efficiency

- Importance of Sleep (+2 +3)

- Two Major Types of DSM-IV Sleep Disorders
  - Dyssomnias (+4): difficulties getting enough sleep, problems in timing of sleep, complaints about quality
  - Parasomnias (+5): abnormal behavioral and physiological events during sleep
A polytomographic (PSG) evaluation assesses an individual’s sleep habits with various electronic tests to measure airflow, brain activity, eye movements, muscle movements, and heart activity. Results are weighted with a measure of sleep efficiency (SE), the percentage of time spent asleep.

**Sleep Deprivation & Attention**

<table>
<thead>
<tr>
<th>10-minutes periods</th>
<th>Normal Quiet</th>
<th>Deprived Quiet</th>
<th>Normal Noise</th>
<th>Deprived Noise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

**Dyssomnias: Overview and Defining Features of Insomnia**

- One of most common sleep disorders
- Difficulties initiating sleep, maintaining sleep, or nonrestorative sleep
- Primary insomnia: unrelated to any other condition (rare!)
- DSM criteria (+1)
- Facts and Statistics
  - Females report insomnia twice as often as males
  - Often associated with medical or psychological conditions
- Associated Features
  - Unrealistic expectations about sleep
  - Believe lack of sleep more disruptive than it usually is
Hypersomnia and Primary Hypersomnia

- Problems related to sleeping too much or excessive sleep
- Person experiences excessive sleepiness as problem
- Primary hypersomnia: Means hypersomnia unrelated to any other condition (rare!)

Facts and Statistics

- About 39% have family history of hypersomnia
- Often associated with medical or psychological conditions

Associated Features

- Complain of sleepiness throughout day, but do sleep through night

Narcolepsy

- Daytime sleepiness and cataplexy
- Cataplectic attacks: REM sleep, precipitated by strong emotion
- DSM criteria (+1)

Facts and Statistics

- Rare: Affects about .03% to .16% of the population
- Equally distributed between males and females
- Onset during adolescence, typically improves over time

Associated Features

- Cataplexy, sleep paralysis, and hypnagogic hallucinations improve over time
- Daytime sleepiness does not remit without treatment

Breathing-Related Sleep Disorders

- Breathing-Related Sleep Disorders (DSM +1)
  - Sleepiness during day and/or disrupted sleep at night
  - Sleep Apnea: Restricted air flow, briefly stop breathing
    - Obstructive (OSA): Airflow stops, respiration works
    - Central (CSA): Respiration stops for brief periods
    - Mixed: Combination of OSA and CSA

Facts and Statistics

- OSA: M>F, occurs in 10-20% of population, increase (+2)

Associated Features

- Minimal awareness of apnea problem
- Snore, sweat during sleep, wake frequently, morning headaches
- Some episodes of falling asleep during day, accidents, ...
CIRCADIAN RHYTHM DISORDERS (p. 298-300)

- Circadian Rhythm Disorders
  - Disturbed sleep (i.e., either insomnia or excessive sleepiness during day)
  - Brain's inability to synchronize day and night
  - DSM (+1)
- Circadian Rhythms and Body's Biological Clock
  - Circadian Rhythms: do not follow 24 hour clock
  - Suprachiasmatic nucleus: brain's biological clock, stimulates melatonin
- Types of Circadian Rhythm Disorders
  - Delayed sleep phase type
  - Jet lag type: sleep problems related to crossing time zones
  - Shift work type: sleep problems related to changing work schedules

INTEGRATED MODEL OF SLEEP DISORDERS

- Integrated Model (+1)
- Biological Vulnerability
  - Disrupted biological clock and control of body temperature
  - Genetic predisposition
- Psychological factors
  - Temperament and Personality: difficult temperament
  - Stressful events: insomniacs more stressors and greater arousal before sleep
  - Sleep stress: bedroom becomes associated with anxiety

AN INTEGRATED MODEL OF SLEEP DISTURBANCE
Insomnia
- Benzodiazepines and over-the-counter sleep medications
- Prolonged use can cause rebound insomnia, dependence
- Best as short-term solution

Hypersomnia and Narcolepsy
- Stimulants (i.e., Ritalin)
- Cataplexy usually treated with antidepressants

Breathing-Related Sleep Disorders
- Medications, weight loss, or mechanical devices

Circadian Rhythm Sleep Disorders
- Phase delays: Moving bedtime later (best approach)
- Phase advances: Moving bedtime earlier (more difficult)
- Use of very bright light: Trick brain’s biological clock

Medical Interventions for Dyssomnias

<table>
<thead>
<tr>
<th>Sleep Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>This approach focuses on changing the sleeper’s unrealistic expectations and beliefs about sleep (“I must have eight hours of sleep each night.”) If I get less than eight hours of sleep it will mess me up). The therapist attempts to alter beliefs and attitudes about sleep by providing information on sleep physiology and the role of sleep, and helping the patient to restructure their thinking about sleep and a person’s ability to compensate for lost sleep.</td>
</tr>
<tr>
<td>Cognitive relaxation</td>
<td>Because some people become anxious when they have difficulty sleeping, this approach uses relaxation imagery to help with relaxation of bedtime or after a night of waking.</td>
</tr>
<tr>
<td>Graduated extinction</td>
<td>Used for children who have bedtime or bedtime or after a night of waking. This intervention helps the parent to teach the child to go to sleep at progressively longer periods of time, until the child falls asleep on his or her own.</td>
</tr>
<tr>
<td>Paradoxical intention</td>
<td>This technique involves instructing individuals in the opposite behavior from the desired outcome. Telling poor sleepers to lie in bed and try to stay awake as long as they can is counter-intuitive. For children, this might involve the child doing reality-distorting efforts to try to fall asleep.</td>
</tr>
<tr>
<td>Progressive relaxation</td>
<td>This technique involves relaxing the muscles of the body in an effort to introduce dozing.</td>
</tr>
</tbody>
</table>

Average Sleep Time & Age

TABLE 8.4 Good Sleep Habits

- Establish a set bedtime routine.
- Develop a regular bedtime and a regular time to awaken.
- Eliminate all foods and drinks that contain caffeine six hours before bedtime.
- Limit any use of alcohol or tobacco.
- Try drinking milk before bedtime.
- Eat a balanced diet, limiting fat.
- Go to bed only when sleepy and get out of bed if you are unable to fall asleep or back to sleep after 15 minutes.
- Do not exercise or participate in vigorous activities in the hours before bedtime.
- Do include a weekly program of exercise during the day.
- Restrict activities in bed to those that help induce sleep.
- Reduce noise and light in the bedroom.
- Increase exposure to natural and bright light during the day.
- Avoid extreme temperature changes in the bedroom (that is, too hot or too cold).


Psychological Treatments

- Various psychological approaches (+1)
- Relaxation and Stress Reduction
  - Reduces stress and assists with sleep
  - Modify unrealistic expectations about sleep (+2)
- Stimulus Control Procedures
  - Improved sleep hygiene: bedroom for sleep and sex only (+3)
  - For children: set regular bedtime routine
- Effectiveness (+4)
- Combined Treatments
  - Insomnia: short-term medication plus psychotherapy best
  - Lack evidence for efficacy of combined treatments with other Dyssomnias
THE PARASOMNIAS  (p. 303-305)

• Nature of Parasomnias
  – Problem not sleep itself
  – Problem is abnormal events during sleep, or shortly after waking

• Two Types of Parasomnias
  – Those that occur during REM (i.e., dream) sleep
  – Those that occur during non-REM (i.e., non-dream) sleep

THE PARASOMNIAS: OVERVIEW OF NIGHTMARE DISORDER (p. 303-305)

• Nightmare Disorder
  – DSM (+1)
  – Occurs during REM sleep
  – Distressful and disturbing dreams
  – Interferes with daily life functioning and interrupt sleep

• Facts and Associated Features
  – Dreams often awaken sleeper
  – More common in children

• Treatment
  – May involve antidepressant medication or relaxation training

PARASOMNIAS: SLEEP TERROR DISORDER (p. 303-305)

• Sleep Terror Disorder
  – Occurs during non-REM sleep (DSM +1)
  – Recurrent episodes of panic-like symptoms
  – Incubus: Refers to sleep terror disorder in adults
  – Pavor nocturnus: Sleep terror disorder in children

• Facts and Associated Features
  – More common in children; often noted by piercing scream
  – Child not easily awakened and has little memory of it
  – Genetic component (+2)

• Treatment
  – Often involves wait-and-see
  – Antidepressants or benzodiazepines for severe cases
  – Awakenings prior to sleep terror can eliminate problem (+3)

GENES AND SLEEP TERRORS

• Genetic Factors
  – Guilleminault et al (2003): 35% of children with both Sleep Terrors and sleep disordered breathing have at least one immediate relative with parasomnia
  – Kales et al (1980): 96% had one or more relatives in pedigree with Sleep Terrors or Sleepwalking
  – Owens et al (1999): 60% risk if both parents affected
**WAKING TREATMENT**

- Behavioral Intervention “Waking Treatment”
  - Sleep Terrors usually occur around the same time each night
  - Track timing for several nights
  - Fully wake up 15-30 mins before expected
  - Allow to sleep again after 5 minutes
  - After week, stop waking.
  - If terrors return, repeat waking for one more week
  - 90% effective in study of 50 children (Oakey)

**THE PARASOMNIAS: OVERVIEW OF SLEEP WALKING DISORDER**

- Sleep Walking Disorder: Somnambulism
  - Occurs during non-REM sleep
  - Usually during first few hours of deep sleep
  - Person must leave bed

- Facts and Associated Features
  - Problem more common in children
  - Difficult, but not dangerous, to wake someone during episode
  - Seems to run in families
  - Problem usually resolves on its own without treatment

- Related Conditions
  - Nocturnal eating syndrome: Person eats while asleep

---

**DSM-IV-TR Table 8.10 Criteria for 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.


**SUMMARY OF EATING AND SLEEP DISORDERS**

- All Eating Disorders Share
  - Gross deviations in eating behaviour
  - Fear or concern about weight, body size, appearance
  - Heavily influenced by social, cultural, and psychological factors

- All Sleep Disorders Share
  - Interference with normal process of sleep
  - Interference results in problems during waking
  - Heavily influenced by psychological and behavioural factors

- Incidence of eating and sleep disorders is increasing
- More effective treatments for eating and sleep disorders are needed