

# News Gram

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## Sleep Disorders

by Irwin Savodnik, M.D., Ph.D.

**A**MERICANS SPEND ABOUT ONE-THIRD OF THEIR LIVES sleeping or trying to sleep. Yet, sleep is a long-neglected area of medical research. Investigators often tire of what they are doing and head in other directions. But the need to understand what sleep is all about and what it has to do with the psychiatric functioning of a person remains. These days, sleep disorders have collectively become a hot number in the world of psychiatry. The field of workers' compensation can expect to see a widening array of sleep-related diagnoses as the effects of CA SB 899 sink in.

Sleep disorders are real – very real. They can be measured in a sleep laboratory with the assistance of routine medical devices such as an EKG, EEG and a respirometer. Unlike other psychiatric disorders, the presence of well-developed, highly reliable testing instruments will make it easier to establish or rule out a diagnosis without reference to subjective complaints. Also, the sleep disorders that will become commonplace in the insurance lexicon will not be merely the *result* of a psychiatric condition but a *cause* of one – as we shall see. The DSM-IV spends 57 pages on sleep. It is reasonable to expect that number to increase considerably by the time the DSM-V is published.

Let's take a look at a number of sleep disorders you are apt to encounter.

**Insomnia** – Everyone encounters difficulty falling and staying asleep at some time or other. However, a persistent pattern of such difficulty is another story. Insomnia can be divided into three different kinds according to whether the person has a problem falling asleep, staying asleep or awakening earlier than he or she ordinarily does. Difficulty falling asleep is most commonly associated with anxiety conditions. Muscular tension, airplane trips between numerous time zones and changes in the environment such as noise, loss of privacy or intrusive lighting can precipitate a pattern of disturbed or partial sleep associated with a lengthened period of falling asleep.

When it comes to staying asleep, the most common psychiatric condition associated with this problem is depression. However, alterations in the environment, posttraumatic stress disorder and schizophrenia are also implicated with this problem. Considering the role of stress in the workers' compensation system, it is a wonder that sleep disorders have not emerged sooner as a diagnostic and therapeutic issue to be dealt with.

**Hypersomnia** – While being sleepy during the day is most commonly caused by ordinary circumstances and activities, there are large numbers of people who sleep too much because of medical and psychiatric conditions. Once again, depression is occasionally associated with increased sleep, perhaps because sleep is a means of escape for such individuals. Sometimes the avoidance reactions associated with various conditions especially stress-related ones, will yield hypersomnolent responses. When drug-related hypersomnolent states are included in the list, the number of people with this condition turns out to be enormous. Also, sleepy people are dangerous people in the workplace. Those who operate machinery, order other people around or handle

technical problems are in an especially vulnerable position if they sleep too much.

In **narcolepsy**, the individual experiences an attack of refreshing sleep or even **cataplexy** which involves muscular weakness, even sudden collapse of the person.

**Sleep Apnea** – This condition has been receiving considerably more attention in recent years. A person with this condition will stop breathing during sleep. Eventually,

the sleep pattern is disturbed, enormous autonomic excitation occurs and blood pressure and heart rhythm are commonly affected. There is some support for the theory that essentially hypertension may be caused by sleep apnea. Episodes are usually 20-40 seconds in length. Three forms of the condition have been described: **Obstructive sleep apnea** is associated with snoring, brief, loud gasps and preservation of respiratory drive. Obese individuals are particularly inclined to develop this form of the syndrome. **Central sleep apnea** is not associated with any obstructive phenomena and is seen in older patients. There may be mild snoring as well. Apparently, many of these people have neurological conditions that affect ventilatory control by the central nervous system. **Central alveolar hypoventilation syndrome** results from impairment of ventilatory control causing low oxygen levels. This condition is seen mostly in people who are morbidly obese and do not adequately mobilize their diaphragms in order to draw air into their lungs. The waking correlate of this condition would be the Pickwickian syndrome.

As it turns out, there are many, many more sleep conditions that come to the attention of clinicians in various specialties. Psychiatrists, pulmonologists, cardiologists, among others, now recognize the dangers in neglecting the role of sleep disorders in the overall health (and employability) of their patients. People who sleep poorly are burdened with many more psychiatric and medical problems than those who sleep well. It is not clear what the total cost to the economy of sleep disorders actually is but if one recognizes that heart and lung disease, hypertension and psychiatric conditions are frequently related to these broad categories of disease, the macro-economic price of sleep dysfunction is in the hundreds of billions of dollars.

It is of considerable interest that the new California law covering workers' compensation issues has taken note of sleep disorders. By acknowledging the importance of this category of disease, the law implicitly sanctions – even encourages – the inclusion of sleep disorders in the panoply of conditions that humble the human body and the person within. —IS



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## SAVODNIK'S PICKS

*A Monthly Review of Dr. Savodnik's Favorite Books-On-Tape*

### The Tightrope

by Desmond Bagley

PSYCHIATRISTS AND PHILOSOPHERS OFTEN consider the problem of human identity. What, after all, is it that tells us someone is who he is? Some physical feature, usually, like the mouth or eyes, or hair or just the sound of his voice. Sometimes, it's a turn of phrase no one else could utter in just the same way. Other times, it's the redolence of one's presence. A woman's perfume or the click of her heel on the wooden floor.

But what is it that identifies a man to himself? That's an even trickier question. We're often mistaken when we think we see someone we know and then learn that we've formed the wrong impression. But that's not the case when it comes to our respective identities. It is exceedingly rare for a person to look in the mirror and ask, "Who is that staring at me"? Which is exactly what happens when Giles Denison awakens one morning and does not recognize the man in the mirror.

He touches his face, sees that it's his, but has never seen it before. He looks down at his once lean torso and perceives a paunch. And his hair. It's receded. He's not who he thinks he is. Or is he?

Denison turns away and looks back. Sorry. You're still not yourself – and whoever you are, you don't have a clue. No, it wasn't the liquor last night, nor anything he ate. As best he can figure, Denison had an ordinary night, nothing peculiar, nothing out of sorts. Now, though, he's turned into a different person, or at least, is the same person who looks terribly different.

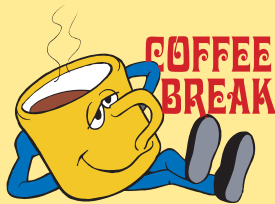
Think now, man, who are you. What do you remember? At this point, the face in the mirror turns icy pale. His knees feel rubbery and his skin becomes moist and cold. You have fallen down. That's what

you've done. Fallen through space and time. Out of your own body, your own existence – your identity.

That's how Desmond Bagley, in *The Tightrope*, begins his novel about a man whose face is a mystery. From the first page, the reader can't quite figure out what has happened and how Denison will get out of his predicament. Nor is Bagley inclined to provide much in the way of hints. Any reader or listener of this book will have a field day trying to figure out how to make sense of what is going on. Eventually, Denison begins to learn a few things about himself, retrieves a memory or two and may even figure out who he looks like. Each discovery, though, is a struggle to make and it requires more than human persistence to have a sense of what may have occurred in the few days prior to his rude awakening.

Of course, the police arrive just in the nick of time. And so does a woman or two. Then there is the question of why he looks so much older, why he was chosen to impersonate or look like or merely suggest the identity of some who is or was so terribly different from him. It's an intriguing idea turned into an exciting story. We are led back to the original question. What is it that makes a person look, sound, think and feel the way he does – especially, when the person one is is also the person who recognizes who one is. It is of more than passing interest that there is a neurological syndrome consisting of an inability to recognize one's own face – prosopagnosia, it's called. Well, Denison doesn't exactly suffer from that syndrome but he's awfully close.

The story is a chase, on the one hand, and a search on the other. You can sit on either side of the narrative and see things differently each time. Bagley has done a fine job tweaking our imaginations with a mystifying, exciting, even breathtaking book about who and what we think ourselves to be. —IS



## THE COFFEE BREAK QUIZ

A man who does not recognize that his left arm is paralyzed most likely suffers from:

- A. Prosopagnosia
- B. Alexithymia
- C. Anasognosia
- D. Schizophrenia

ANSWER: C.  
Anasognosia is the inability to recognize disease in oneself. Prosopagnosia is the inability to recognize faces. Alexithymia is a failure to read one's own emotional state. There is evidence to suggest schizophrenics may respond differently to painful stimuli but not in the manner described above.