

SLEEP WALKING IN ADULTS : TWO CASE REPORTS

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SUMMARY

Adults who present with sleep walking as a primary complaint is unusual. Two such cases are presented and their association with night terrors and sleep talking discussed. Psychosocial stresses exacerbate sleep walking and acts of violence during the episode can be potentially lethal.

INTRODUCTION

The phenomenon of sleep walking occurs mostly in children and has been regarded as benign. This complaint is usually mentioned in passing to the paediatrician during consultation for some other disorder. Adult sleep walkers are rarely reported or discussed. This is a report of two cases who presented sleep walking as the primary complaint.

CASE 1

CS, a 22 year old university undergraduate, was referred by his student health physician for shouting and walking in his sleep. Since the age of 12, he was noted to be talking and shouting in his sleep. Speech centered on incidents that occurred during the day, which became worse when he was under stress. He cannot remember walking and talking in his sleep. Stresses include examinations, interviews and meeting datelines. There were no biological disturbances

to suggest an affective disorder. There was no family history of sleep walking or sleep talking.

He shares a rented room with a fellow undergraduate on the 5th floor of a block of flats off campus. It was just prior to his semester examinations that his talking turned to shouting. He sleep walked every night so his roommate insisted that he be treated by the student health physician.

CASE 2

VR, a 65 year old married supervisor, complained of walking in his sleep associated with 'bad dreams'. This had been going on for more than forty years. He is able to fall asleep and shortly after has vivid dreams of being trapped in a flooded room or being attacked by robbers. His wife reported that he struggled in bed, mumbling, and would suddenly jump up and rush out of the room. At other times he would try to remove photographs from the wall and even move his bed shouting that it was flooded. He would turn violent if stopped at that time and on more than one occasion had tried to strangle his wife, thinking that she was a robber. He does not remember his actions but is able to recall his dreams which were repetitive.

There is no family history of similar complaints. He has tried alcohol in order to improve his sleep. There was initial response but later the dreams and sleep walking returned.

The episodes of struggling and walking get worse when he is under emotional stress. He is due for retirement and has difficulties with his son's proposed marriage to a particular woman.

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DISCUSSION

Sleep walking usually consists of simple, aimless activity like walking around a room, opening cupboard doors, and urinating before returning to bed. It lasts several minutes but sometimes up to half hour. It occurs during stages 3 & 4 of non REM sleep.¹

In children, it is held to be benign and transient, perhaps due to delays in maturation, and is frequently associated with enuresis. A major British text on Paediatrics by Arniel & Forfar has devoted a line to the condition.

In adults, sleep walking may be associated with sleep talking as in Case 1 or with night terrors as in Case 2. Night terrors occur during stages 3 & 4 of non REM sleep. It is accompanied by intense anxiety, autonomic discharge and vocalisations in moans and screams. The episode lasts 1 – 2 minutes and there is amnesia. The contents if the subject is awakened at the time are usually that of a simple frightening image.

This is in contrast to nightmares which are dreams that occur during REM sleep. Attempts at arousal during sleep walking usually result in marked disorientation. There is amnesia after the episode.

Sleep walking predominantly affects males. Emotional factors such as psychosocial stress play an important role in exacerbating the condition. In Case 1, it was examinations and meeting datelines, while in Case 2 he was experiencing family discord and imminent retirement.

Sleep walking is not associated with hysteria and is not a form of epilepsy. EEG studies on over 800 sleep records in epileptics have shown that the episodes of sleep walking are not associated with epileptic discharges.²

Management involves protection from injury. The undergraduate was advised to move to a room

on the ground floor urgently and to request his roommate to lock all doors/windows till he moves. There have been reported instances of sleep walkers falling off high rise buildings.

Stresses, if possible, should be reduced. It was not possible to stop university examinations faced by the first case but in the second, supportive psychotherapy and discussion of his difficulties were carried out.

Suppression of sleep in stages 3 & 4 could be tried. Benzodiazepines do this. Diazepam 10 mg was given to both patients at night and there was a marked reduction in attacks of sleep walking, night terrors and sleep talking. Benzodiazepines should be given in short courses, e.g. to tide over examination periods. There is however little in the literature that states how long the benzodiazepines should be continued.

It is possible for serious violence to occur during sleep walking. In the second patient, he would have strangled his wife if he were not aroused early. Three cases of serious violence have recently been reported in U.K. Sleep walking was suggested as a defence and accepted by the court.³ The risks as such exist for the second patient and it is prudent to keep weapons and dangerous objects away from the room. Strangely the wife of the second patient has continued to share the same bed with her husband after all three years.

REFERENCES

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