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Sleep Experience and Sleeping Pills in Neurological Patients

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Information on patients' expectations, experiences and behavior concerning sleep can contribute to better management of diseases. Reports on normal subjects [Feinberg et al., 1967; Strauch et al., 1972] and on some aspects on psychiatric patients [Bochnik, 1966; Baekeland and Hartmann, 1971] have appeared. Data on neurological patients are still needed. We collected information on sleep behavior by questionnaires, containing 35 questions, which were distributed to successive patients at the neurological out-patient clinic of the University Hospitals, Zurich. The present results are based on the analysis of the first 480 questionnaires including answers about age, sex, employment, diseases, and personal habits, besides sleep-related questions. A considerable percentage of the patients reported poor sleep. The data for the five most frequent diagnoses are given in table I. As usual, the percentage of poor sleepers increased with age, and it was higher for
women than for men. Table I demonstrates that poor sleep is frequent in patients suffering from headache and neurosis, and particularly in patients having peripheral nerve affections accompanied by pain. A low incidence of poor sleep was seen in epileptics and, surprisingly, in patients with cerebrovascular diseases.

Roughly 50% of all patients who reported poor sleep felt that drugs could be helpful (table I). Noteworthy is the low level of drug ‘trusters’ amongst the neurotics as compared with epileptics (31 vs. 62%, p < 0.005). However, many patients who do not trust the efficacy of sleeping pills take them anyway, as can be seen from the difference between ‘pill-trusters’ and ‘pill-takers’ in table I. The diagnostic group of neurotics shows the highest difference, headache patients being second. Closer inspection of the data reveals that not all of the ‘trusters’ actually took medication. In other words, a certain percentage of all poor sleepers trust drugs, the others do not trust drugs; many of the ‘trusters’ as well as some of the ‘non-trusters’ actually take sleeping pills. About 80% of the ‘trusters’ take pills, the remaining 20% expect a prescription from the physician. The percentage of ‘trusters’ who actually take pills varies greatly between diagnostic groups, from 91% of the headache patients to 62% of the epileptics to 50% of the circulation patients. The percentage of ‘nontrusters’ who, nevertheless, take pills varies between 20 and 40%.

The patients took Valium® most often as sleep medication (about 40%); second was Mogadon® (about 20%); all other brands were named considerably less frequently. It became evident that barbiturates are used only rarely, almost exclusively by old patients.

Next, we shall briefly examine what our patients regard as ‘poor sleep.’ Average time to fall asleep was estimated about 8 min by epileptics who slept well, and about 14 min by headache patients who slept well. These estimates increased to about 35 min for poor sleepers of both groups. Nearly 70% of the poor sleepers complained about frequent intermittent nocturnal awakenings, vs. only about 10% of the good sleepers. Very often, long sleep latency and frequent awakenings were combined (about 55% of all poor sleepers).
Around 45% of the poor sleepers reported insufficient sleep durations, whereas almost all good sleepers felt that they had enough sleep, with the notable exception of young female headache patients (in this group, only 72% of those who reported good sleep also felt that they had enough sleep). We have not yet investigated the possible factors for shortened sleep durations. However, it appears that expectations concerning sleep duration are somewhat higher amongst poor sleepers: they spend an average of 8.4 h in bed, vs. 7.9 h for good sleepers. ‘Time in bed’ was computed from replies to the questions ‘At what time do you usually go to bed?’, and ‘At what time do you usually get up?’. The estimated sleep time of poor sleepers was on average about 1.5 h less than their time in bed, whereas sleep time for good sleepers was on average identical with time in bed. It is interesting that the estimate of sleep time of poor sleepers is only about 12% lower than that of good sleepers. This agrees well with the data of Karacan and Williams [1971] on insomniacs, who slept only 10% less than their normal controls.

Frequent recall of dreams was reported systematically more often by poor sleepers than by good sleepers (54 vs. 43%, p < 0.05). Here, sex was an important confounding factor, as women typically experienced frequent dreaming more often than men [see also Strauch et al., 1972]. Our results do not contradict the finding of decreased rapid eye movement (REM) percent time in poor sleepers [Monroe, 1967], since later recall of dreams may well be a function of duration of the time awake after the occurrence of a dream [Koukkou and Lehmann, 1968]. Frequent nocturnal awakenings were indeed typical for poor sleepers, as we have seen above.

In summary, the results of an examination of the first 480 questionnaires filled by neurological out-patients indicate that there is a considerable percentage of neurological patients who suffer from sleep problems. It appears that many patients do not believe that successful medication will be possible; however, a fifth of all who feel that drugs may help do not take medication. Why quite a few of the patients who do not believe in the efficacy of drugs nevertheless take drugs remains to be investigated.

Long latency to sleep onset, frequent awakenings, frequent dreams, increased time in bed, and somewhat decreased total sleep time are main characteristics of ‘poor sleep’. Its incidence varies markedly between diagnostic groups.

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Sleep Behavior of Senile-Arteriosclerotic Patients

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In order to control the success of drug treatment in severely sleepdisturbed senile-arteriosclerotic patients, EEG studies are of great value. However, due to obvious reasons, such studies can be carried out only