

DSM-5 Sleep-Wake Disorders Classification: Overview for Use in Clinical Practice

The goal of the DSM-5 sleep-wake disorders classification was, from the outset, to facilitate the differential diagnosis of sleep-wake complaints, given their ubiquity in psychiatric practice, and to clarify when referral to a sleep disorders specialist is appropriate.

The classification encompasses 10 disorders or disorder groups: insomnia disorder, hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, circadian rhythm sleep disorders, non-REM (NREM) sleep arousal disorders, nightmare disorder, REM sleep behavior disorder, restless legs syndrome, and substance- or medication-induced sleep disorder.

The core features of each disorder relate to the patient's dissatisfaction regarding the quality, timing, and amount of sleep with resulting daytime distress and impairment.

In some disorders (e.g., insomnia disorder), the DSM-5 Sleep-Wake Disorders Work Group took a lumping approach, while in others (e.g., narcolepsy/hypocretin deficiency) we used a splitting approach, reflecting the availability of validators derived from epidemiological, neurobiological, and intervention research. In all cases, however, the DSM-5 sleep-wake chapter provides both categorical and dimensional approaches to diagnosis and severity in order to facilitate measurement-based care in general mental health and medical or pediatric settings. The focus on measurement-based care is fundamental to the goals of the sleep-wake disorders classification.

*Sleep is by the brain, of the brain,
and for the brain.*

Clinical Relevance

Sleep disorders are often accompanied by depression, anxiety, and cognitive changes that must be addressed in treatment planning and management. Sleep disorders are also established risk factors for the subsequent development of common mental illnesses and may represent the prodromal expression of an episode of mental illness, allowing the possibility of early intervention to preempt or attenuate a full-blown episode.

In addition, sleep disturbances furnish a clinically useful indicator of medical and neurological disorders that often coexist with depression and other common mental disorders. Sleep-wake complaints can provide clinically actionable clues in breathing-related sleep disorders, disorders of the heart and lungs (e.g., congestive heart failure and chronic obstructive pulmonary disease), neurodegenerative disorders (Alzheimer's disease or Parkinson's disease), and disorders of the musculoskeletal system. Each of these is characterized by prominent sleep-wake complaints and each is frequently accompanied by depression and anxiety disorders.

Conversely, mental health clinicians should also understand that some medical disorders may not only disturb sleep (as in the examples above) but may themselves be worsened during sleep. Thus, some patients may experience apneas or ECG arrhythmias during REM sleep, confusional arousals with dementing illness, or REM sleep behavior disorder in alpha synucleinopathies such as Parkinson's disease.

Clinical Utility of Dimensional Assessment

In addition to diagnostic criteria for categorical assessment, the DSM-5 sleep classification also supports dimensional assessment for several reasons, primarily to capture severity and to facilitate measurement-based clinical care in the service of personalized medicine. Dimensional assessments are also useful for capturing behaviors that may contribute to the pathogenesis and persistence of sleep disorders, including poor sleep-wake hygiene practices. Finally, dimensional assessments of severity allow correlation with, and exploration of, underlying neurobiological issues such as genetic liability, hyperarousal, and circadian dysrhythmias. Particularly useful examples of dimensional measures amenable to office-based practice and bedside care include the NIH Patient Reported Outcomes Measurement Information System (<http://www.nihpromis.org>) and self-report inventories of sleep quality (e.g., the Pittsburgh Sleep Quality Index and the Insomnia Severity Scale).

Biological Validators of Diagnosis

The use of biological validators is now embedded in the DSM-5 classification of sleep-wake disorders, and this represents a major change from DSM-IV. Examples with particular relevance to clinical psychiatric practice, where the existence of laboratory measures is essential to diagnostic confirmation, include disorders of excessive sleepiness (e.g., narcolepsy/hypocretin deficiency), breathing-related sleep disorders, REM sleep behavior disorder, and some NREM parasomnia disorders of arousals.

A Practical Approach for Dealing With Comorbidity

The DSM-5 sleep-wake disorders classification has moved away from the causal attributions that were inherent in the logic of DSM-IV. In order to underscore the reality that patients in psychiatric and general medical practice frequently have sleep disorders that warrant an independent clinical condition, DSM-5 calls for clinicians to specify comorbid conditions, medical and psychiatric, that are present. The aim is simply to acknowledge the bidirectional and interactive effects between sleep disorders and coexisting medical and psychiatric illnesses.

An example from clinical practice will serve to illustrate this point. A psychiatrist may be treating a patient with major depression and prominent insomnia complaints. The DSM-IV classification would have specified "sleep disorder related to another mental disorder." In DSM-5, however, the clinician is asked to consider whether the patient has an insomnia disorder (or a disorder of hypersomnolence) in addition to a mood disorder. This question frequently arises in cases where treatment of the mental disorder has led to improvement, but sleep-wake disturbance persists. By diagnosing both major depressive disorder and, when appropriate, insomnia disorder or hypersomnolence disorder (i.e., concurrently specifying the two coexisting conditions), the management and treatment plan can address both issues. Unless the sleep complaint is also addressed, the patient will be at higher risk for failure to achieve remission and to suffer a relapsing, recurrent course of depression.

This conceptualization reflects a paradigm change that is now widely accepted in the field of sleep medicine and that holds great relevance for psychiatric practice. It moves away from the need to make causal attributions between coexisting disorders and only requires specifying clinical comorbidities that may have relevance to comprehensive treatment planning (1, 2).

Referral to Sleep Medicine Specialists

DSM-5 also provides guidance, in the text accompanying the diagnostic criteria, as to when referral to a sleep medicine specialist is appropriate. Such referral is indicated for severe daytime sleepiness, when patients may be placed in harm's way; if the patient has risk factors for sleep apnea (e.g., sleepiness during the day, snoring, and obesity); for unusual or dangerous behaviors during sleep (e.g., REM sleep behavior disorder); in cases of insomnia that do not respond to usual behavioral or pharmacological approaches; and finally, for atypical symptoms or treatment refractoriness.

Summary

Mental health clinicians should appreciate that sleep is a fundamental human behavior and that inadequate sleep has adverse medical, psychiatric, and psychosocial consequences. Sleep disturbances interact with common mental disorders; the two are mutually exacerbating, and both must be appropriately addressed to ensure optimal outcomes for our patients. Sleep is by the brain, of the brain, and for the brain.

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**CHARLES F. REYNOLDS III, M.D.
RUTH O'HARA, Ph.D.**

From the Department of Psychiatry and Behavioral Science, Sierra-Pacific Mental Illness Education and Clinical Center, Stanford University School of Medicine, Calif. Dr. Reynolds is Chair of and Dr. O'Hara is a member of the DSM-5 Sleep-Wake Disorders Work Group. Address correspondence to Dr. Reynolds (ReynoldsCF@upmc.edu). Commentary accepted for publication March 2013 (doi: 10.1176/appi.ajp.2013.13010058).

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