

CASE REPORT

Isolated Sleep Paralysis in a Case of Panic Disorder

Avinash De Sousa

ABSTRACT

We present herewith a case of isolated sleep paralysis (ISP) which entails a transient, generalized inability to move or speak, i.e., usually seen during the patient's transitions between sleep and wakefulness. We report the case of a 33-year-old man with recurrent ISP and panic disorder. The patient sought help after nearly 6 years of symptoms as he thought that the symptoms were part of his nocturnal panic attacks. Isolated sleep paralysis is seen in conjunction with multiple anxiety disorders and the symptoms may mimic anxiety, thereby confounding the diagnosis. It is prudent that clinicians keep in mind sleep paralysis as a differential diagnosis in anxiety disorders as all cases of freezing at night may not be nocturnal panic attacks.

Keywords: Panic attacks, Panic disorder, Sleep, Sleep paralysis.

How to cite this article: De Sousa A. Isolated Sleep Paralysis in a Case of Panic Disorder. *Ind J Priv Psychiatry* 2017;11(2):36-37.

Source of support: Nil

Conflict of interest: None

INTRODUCTION

Sleep paralysis is a condition characterized by a transient, generalized inability to move or speak, i.e., usually seen during the patient's transitions between sleep and wakefulness.¹ It is a symptom of narcolepsy and may be seen with excessive daytime sleepiness, cataplexy, and hypnagogic hallucinations as per the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision criteria.² Isolated sleep paralysis is a rapid eye movement sleep parasomnia and is a recurrent phenomenon.³ Epidemiological data have reported the occurrence of ISP with anxiety disorders where it may mimic the symptoms of an anxiety disorder and thus may not be diagnosed.⁴ We report here a case of a patient with recurrent ISP and panic disorder where the episodes of ISP were mistaken by the patient as nocturnal panic attacks and help was not sought for over 6 years.

CASE REPORT

A 33-year-old married man working as a teacher presented to the psychiatry outpatient department with chief complaints of episodes of inability to move his limbs at night while asleep since the past 6 years. The patient had all these episodes during his sleep at night and the event lasted 15 to 20 minutes whereby he was unable to move his limbs or turn in bed or even call for help, all of which he would desperately want to do each time but was unable to do so. He had panic disorder for many years and was on treatment. He thought that these episodes were nocturnal panic attacks. These episodes had him feeling extremely fearful and anxious. Even though things returned to normal in 20 to 25 minutes he would have anxiety for an hour after these episodes. He could very clearly hear his wife calling out and speaking to him but was never able to respond to her. The episodes would usually occur when he was about to get up from sleep at 5.30 AM. He reported the first such episode 6 years ago but they progressed from one attack a month to weekly and then thrice weekly to each night at the time of presentation. He did not have other symptoms suggestive of narcolepsy and slept 6 to 7 hours a night. He described his sleep quality as fine but the episodes would cause him anxiety. He would have panic attacks once or twice a week during the day and was on Escitalopram 10 mg and Clonazepam 0.25 mg at night and when needed for the same. He had no issues with the panic attacks as he would consume a mouth-dissolving Clonazepam when they ensued and the attacks subsided in 5 minutes. He denied symptoms suggestive of other parasomnias and other major psychiatric disorders. No family history suggestive of the same existed. There was no history of any form of substance use ever by the patient. His general and systemic examination was within normal limits and on mental state examination he was absolutely normal. All routine blood tests done a month ago by the patient were normal. Using International Criteria of Sleep Disorders⁵ we reached a diagnosis of chronic ISP over and above his existing panic disorder. We psychoeducated him and his wife about sleep paralysis and sleep hygiene. We increased the dose of Clonazepam to 0.5 mg at night and the dose of Escitalopram was increased to 20 mg. In 2 weeks he reported a stoppage of all symptoms and he is currently symptom free on the same dose of medication for 2 months.

Research Associate

Department of Psychiatry, Lokmanya Tilak Municipal Medical College and Hospital, Mumbai, Maharashtra, India

Corresponding Author: Avinash De Sousa, Research Associate, Department of Psychiatry, Lokmanya Tilak Municipal Medical College and Hospital, Mumbai, Maharashtra, India
Phone: +919820696828, e-mail: avinashdes888@gmail.com

DISCUSSION

The patient had symptoms of recurrent ISP occurring in the absence of any symptoms of narcolepsy and also had panic disorder. The episodes in sleep paralysis are more likely to occur during awakening from sleep as in our case.⁶ Hallucinatory experiences both in visual and auditory modes are common in ISP but our case had no such features.⁷ Most cases reported that they are aware of other people present in the room and can hear their voices and other noises around, but usually complain of complete inability to move any part of their bodies including an inability to speak out as in our case.⁸ Appropriately diagnosing a case of ISP is important for psychiatrists as the fright and anxiety reported by patients may mislead the clinician into diagnosing such patients with anxiety disorders or nocturnal panic attacks.⁹ Selective serotonin reuptake inhibitors have been the mainstay for treating sleep paralysis and our case also responded to Escitalopram when the dose was increased.¹⁰ Recurrent ISP is a rare disorder that may be easily misdiagnosed as some psychiatric disorder. It is important for psychiatrists to be aware of ISP as a diagnostic entity.

REFERENCES

1. Sharpless BA, Barber JP. Lifetime prevalence rates of sleep paralysis: a systematic review. *Sleep Med Rev* 2011 Oct;15(5):311-315.
2. Morgenthaler TI, Kapur VK, Brown TM, Swick TJ, Alessi C, Aurora RN, Boehlecke B, Chesson Jr AL, Friedman L, Maganti R, et al. Practice parameters for the treatment of narcolepsy and other hypersomnias of central origin. *Sleep* 2007 Dec;30(12):1705-1711.
3. Ramsawh HJ, Raffa SD, White KS, Barlow DH. Risk factors for isolated sleep paralysis in an African American sample: a preliminary study. *Behav Ther* 2008 Dec;39(4):386-397.
4. Otto MW, Simon NM, Powers M, Hinton D, Zalta AK, Pollack MH. Rates of isolated sleep paralysis in outpatients with anxiety disorders. *J Anxiety Disord* 2006;20(5):687-693.
5. International Classification of Sleep Disorders, Revised. Diagnostic and coding manual. Chicago, IL: American Academy of Sleep Medicine; 2001.
6. De Jong JT. Cultural variation in the clinical presentation of sleep paralysis. *Transcult Psychiatry* 2005 Mar;42(1):78-92.
7. Cheyne JA, Girard TA. Paranoid delusions and threatening hallucinations: a prospective study of sleep paralysis experiences. *Conscious Cogn* 2007 Dec;16(4):959-974.
8. Munezawa T, Kaneita Y, Osaki Y, Kanda H, Ohtsu T, Suzuki H, Minowa M, Suzuki K, Higuchi S, Mori J, et al. Nightmare and sleep paralysis among Japanese adolescents: a nationwide representative survey. *Sleep Med* 2011 Jan;12(1):56-64.
9. Sharpless BA, McCarthy KS, Chambless DL, Milrod BL, Khalsa SR, Barber JP. Isolated sleep paralysis and fearful isolated sleep paralysis in outpatients with panic attacks. *J Clin Psychol* 2010 Dec;66(12):1292-1306.
10. Sutton EL. Psychiatric disorders and sleep issues. *Med Clin North Am* 2014 Sep;98(5):1123-1143.