Original article

Sleep quality and emotional reactivity cluster in bipolar disorders and impact on functioning

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ABSTRACT

Objective: Bipolar disorders (BD) are characterized by sleep disturbances and emotional dysregulation both during acute episodes and remission periods. We hypothesized that sleep quality (SQ) and emotional reactivity (ER) defined clusters of patients with no or abnormal SQ and ER and we studied the association with functioning.

Method: We performed a bi-dimensional cluster analysis using SQ and ER measures in a sample of 533 outpatients patients with BD (in remission or with subsyndromal mood symptoms). Clusters were compared for mood symptoms, sleep profile and functioning.

Results: We identified three clusters of patients: C1 (normal ER and SQ, 54%), C2 (hypo-ER and low SQ, 22%) and C3 (hyper-ER and low SQ, 24%). C1 was characterized by minimal mood symptoms, better sleep profile and higher functioning than other clusters. Although highly different for ER, C2 and C3 had similar levels of subsyndromal mood symptoms as assessed using classical mood scales. When exploring sleep domains, C2 showed poor sleep efficiency and a trend for longer sleep latency as compared to C3. Interestingly, alterations in functioning were similar in C2 and C3, with no difference in any of the sub-domains.

Conclusion: Abnormalities in ER and SQ delineated three clusters of patients with BD and significantly impacted on functioning.

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1. Introduction

‘Core dimensional features’ can help characterizing Bipolar Disorders (BD), among which sleep disturbances and emotion dysregulation might be of particular importance. Perturbations of sleep (mainly quantity but also quality) belong to diagnostic criteria for both depressive and (hypo-)manic episodes [1]. Interestingly, these abnormalities of sleep continuity, regularity and quality also persist during periods of remission in BD, thus being considered as core trait dimensions. Indeed, insomnia symptoms are frequently observed in remitted patients with BD, with 55% of them who meet the strict diagnostic criteria for primary insomnia.

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and when combined with polysomnography, REM (Rapid Eye Movement) sleep was specifically involved in the dissipation of amygdala activity in response to previous emotional experiences [34]. Far from being exhaustive, these latter arguments suggested that sleep disturbances and emotional regulation deficits might be associated [16] in BD; maybe because they are underpinned by overlapping neurobiological systems and brain structures (mainly prefrontal cortex-limbic connections) [18]. However the research specifically in BD remains scarce.

Therefore, we hypothesized that abnormal sleep quality and disturbed emotional reactivity were associated dimensions that impacted on functioning in BD. Our main goal was to study the clustering of sleep and emotional reactivity disturbances in patients with BD during euthymia. We conducted a cluster analysis and explored whether the identified clusters differed for their sleep profile and various domains of functioning.

2. Methods

2.1. Population

The participants (n = 533) were adult outpatients with BD assessed within the French Network of Bipolar Expert Centres implemented by the FondaMental foundation (FACE-BD for FondaMental Advanced Centres of Expertise in Bipolar Disorders) [35]. The primary psychiatric diagnosis was made by trained psychiatrists or psychologists using the Structured Interview for DSM-IV Axis I Disorders (SCID) [36].

Inclusion criteria were: (A) a diagnosis of BD type I, II or NOS (Not Otherwise Specified) (1), (B) the absence of any major mood episode (of any polarity) according to DMS-IV criteria (1) at inclusion and within three months before the assessment, (C) baseline scores < 15 at the Montgomery-Asberg Depression Rating Scale [37] and at the Young Manic Rating Scale [38].

Therefore, patients were either in remission or with subsyndromal mood symptoms according to the criteria provided by the International Society for Bipolar Disorders (ISBD) Task Force report on the nomenclature of course and outcome in BD [39].

2.2. Assessments for sleep quality, emotional reactivity and functioning

Subjective sleep quality was assessed with the Pittsburgh Sleep Quality Index (PSQI). This 19-item self-questionnaire generated a total score ranging from 0 to 21 [40] and 7 sub-components (each ranging from 0 to 3): sleep quality (overall subjective sleep quality rated by the patient), sleep latency (time to fall asleep), sleep duration (number of hours of actual sleep), sleep disturbances (frequency of nightmares, snoring, abnormal awakening, or other problems during the night), sleep efficiency (ratio of the total time spent asleep in a night compared to the total amount of time spent in bed), use of sleeping medication (frequency of use per week to promote sleep) and daytime dysfunction due to sleepiness (trouble staying awake, lack of energy or enthusiasm). We used the validated French version [41]. A total score equal or above 5 is in favor of sleep disturbances with clinical significance.

Emotional reactivity was measured with the aforesaid component of the Multidimensional Assessment of Thymic State (Mathys), a validated French scale [42,43]. The Mathys is a visual analogic scale that explores five dimensions (emotional reactivity, cognition speed, psychomotor activation, motivation and sensory perception) that can vary from inhibition to activation. The Mathys evaluates a state rather than a trait of emotional reactivity. A subject is asked to assess his current emotional state compared to usual, and not in comparison to a normal euthymic
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