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Shared Rest Time and Space… Restful or Restless?

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For many, sharing sleeping spaces and times can be a comforting and bonding experience. For others, having another person that close when trying to sleep and relax is not helpful and actually robs them of the deep refreshing sleep that is needed. One relationship leads to greater intimacy and closeness, while the other can create friction and frustration, due in part to sleep deprivation.

So what is SLEEP?

Sleep is not a period of absolute rest and stillness. Rather it is a very busy time for the maintenance crew within your body and brain to complete some important tasks and functions in order to keep everything running well and to help you function.

It is currently believed that there are two major forms of sleep states – Rapid Eye Movement (REM) and Non-Rapid Eye Movement (N-REM) sleep.

REM sleep refers to sleep that is relatively light and in which there is rapid eye movement with very limited body movement and a lot of brain activity, especially in a variety of cortical areas and the wiring in and out the hippocampus. REM sleep is when most *remembered* dreams occur and where typically we are immobilized by our brain to keep us safe as we apparently seek to rehearse newly learned tasks or actions, seek to figure out how pieces of information or feelings fit into a bigger picture, or try to work through challenges or puzzles in some fashion.

REM sleep is that phase of sleep that is closest to being awake and one of the easiest to disturb. Brain waves are mostly low amplitude and high frequency waves called alpha waves. Sleep generally occurs in waves, there are multiple cycles through the night. More and longer REM state sleep tends to occur later in the sleep period, later in the night or early morning. If a partner is on a different cycle or if that person is now moving during their REM phases of sleep, their partner is at high risk of having disturbed cycles as well. As dementia develops, the amount of time spent in REM sleep can decrease, or disappear. The ability of the brain to immobilize the body may decrease. That means a partner may find themselves hit or kicked during dreams or the person may injure themselves when moving around without awareness of real space and objects.

Non-REM sleep happens in phases that cycle from wakefulness, through N1, then N2, then N3 stages with a change to N2 and then the first REM sleep period. This pattern is repeated throughout the night with a shift from a longer N3 early in the night and shorter ones as the night progresses.

When a person moves from **wakefulness to N1**, their eyes close, their heart rate and breathing slows, their muscles start to relax with some twitching and brain waves start slowing. This phase typically only lasts seconds to minutes

As a person **enters N2** sleep, heart rate and breathing slow more, muscles relax more, and body temperature drops. Brain waves slow with short strong bursts of activity. It turns out that most people spend most of their sleep time in this state while going in and out of N3 and REM states.

As the person **enters the N3** state of sleep, their heart rate and breathing slow even more, muscles are totally relaxed, and it is extremely difficult to wake the person. After awakening from this state, the person typically reports feeling totally refreshed and alert. The brain waves in this state are delta waves, deep and long.

A typical time frame for the first sleep cycle looks something like this. N1 lasts 1-7 minutes, N2 lasts 10-25 minutes, N3 lasts 20-40 minutes, N2 reappears for 5-10 minutes, then REM lasts 5 minutes with a reappearance of N2 at that point.

As the night wears on, the time in each sleep state changes, with more time spent in N2 and REM sleep than in N3. Increasing age typically increases the risk of going from N2 to N1 to wakefulness in the middle of the night rather than simply going from N2-REM to N2.

So, what can happen if your sleep partner is not on your cycle? Their wakefulness or movements can disturb your efforts to move through your own pattern. It is also possible that your Circadian rhythms are no longer matching, which affects your falling asleep times and patterns as well.

Possible Options to Consider

Investigate changing the sleep area size and surface. A larger sleeping surface, changing from a full size to a queen or king size can allow proximity without as much contact once sleep is activated. Consider the use of a memory foam mattress that does not transfer the feel of the other person's movements nearly as intensely, allowing one person's lighter phases of sleep to happen without bothering their partner.

If one partner is experiencing nighttime wakefulness while the other is not, consider the possibility that a nighttime care partner is needed, so that the primary partner is rested and able to support and live well during daytime hours.

If there are physically active REM sleep patterns emerging, look at modifying the sleep area for increased safely of movement and decreased opportunity for falls, injuries, and the need for physical interventions.

If one person is seeking closeness and touch while the other is not, then consider snuggling with separate covers between you. Spooning can offer connection, while separate cocoons can provide a sense of space and personal protection as sensory

experiences can be altered and made less disturbing than with whole-body skin to skin contact.
For some partners, it becomes more comfortable and reasonable to use separate sleeping surfaces entirely or even separate sleeping spaces. The sense of vulnerability and confusion about relationships combined with personal histories that might include abuse, or fear of abuse, at night or in a sleeping area can create extreme distress and problems with sleep and interactions.

For a person in an Emerald state (lost in time and place), who has typically had a bed partner for most of their life and is now partner-less, seeking out a bed partner is fairly common and logical activity. Treating it as a sexual approach, can be both erroneous and problematic, as it doesn't address the person's need for the presence of another for comfort in sleeping. Creating a *comfort* partner, for going to sleep and monitoring for wakefulness during the night, can make all the difference in a restful and refreshing night of sleep for the person living with dementia. Consider the use of a body pillow, after an initial snuggle from on top of the comforter to provide a sense of touch, while providing time away for the care supporter.

If a person has helpers in their home, be aware that nighttime can engender a sense of danger and need for self-protection. Care providers who are fully accepted during the day, may create a sense of home invasion at night. It is a good idea to make sure possible weapons are fully secured or removed if around-the-clock care is being considered. There is no reason to create a risky situation that can become tragic due to lack of attention to a possible issue.

As I was researching and writing this article, I found there is almost nothing available on the internet or in recent publications related to sleeping arrangements and intimacy issues related to sleeping that frequently occurs for people living with various forms of dementia. For something that takes up about quarter to a third of our lives, it would seem that this area would be better addressed when dementia comes on board, but the main focus seems to be on controlling REM sleep disorders, trying to get the person to sleep more using medications or scheduling, and separate discussions on sexuality and intimacy. I have included three articles on the basics related to sleep. I wish there was more to offer to support partners and care providers, but little research or work has been done to date in this area of life with dementia.

Additional Resources

Natural Patterns of Sleep
Why Do We Sleep? Memory Processing and Learning
Brain Basics: Understanding Sleep