

. . . a review of the literature—1960—1970

part II. sleep studies

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Similarities among dreams, hallucinations, and primary process thinking are often compared. Based on earlier ideas of William James and Hughlings Jackson, Feinberg and Evarts (1969) recently formulated three hypotheses associating dreams and hallucinations:

- Neurophysiological processes associated with dreams in the sleeping state are also associated with hallucinations in the waking state.
- Those mechanisms involved in the perception of visual hallucinations and dreams are the same mechanisms which underly normal vision.
- Dreams and hallucinations result from the elimination of an inhibitory process.

Since hallucinations are one of the most striking characteristics of some forms of schizophrenia, it is not surprising that considerable effort has gone into studying the physiology of sleep in schizophrenic patients. The most important stimulus for these efforts was the observation that there are periodic episodes of rapid eye movements (REM) during sleep (Aserinsky and Kleitman, 1953) and that these REM periods are highly correlated with dream reports (Aserinsky and Kleitman, 1955, and Dement and Kleitman, 1957). Normally, REM sleep alternates with the rest of sleep (nonREM sleep) in 90-minute cycles and occupies 20–25 percent of total sleep.

In an important series of experiments aimed at delineating a function for REM sleep, subjects were intentionally deprived of REM sleep for periods lasting from several days to over 1 year. This deprivation was accomplished by either awakening a subject every time a REM period began (as evidenced by EEG tracings) or by giving him one of the many psychoactive drugs which suppress REM sleep. When the subject was once again permitted to have REM sleep (regardless of which method of REM deprivation had been used), REM sleep periods took up a higher proportion of the night than they

had during baseline (preREM-deprivation) observations. This finding suggested a hydraulic model of REM sleep—i.e., that during REM deprivation the brain was capable of storing some “neurohormone” which discharged during the period of REM rebound (Dement and Fisher, 1963)—which, in turn, suggested that this increased REM pressure might tend to dissipate itself in a pathological manner (e.g., hallucinations) during waking hours.

While initial reports indicated that REM deprivation in normal subjects (Dement, 1960; Dement and Fisher, 1963; and Sampson, 1966) produced heightened anxiety, irritability, and difficulty in concentrating, subsequent better controlled experiments (Dement, 1964; Kales et al., 1964; and Dement, 1966) failed to produce gross psychological changes, although relatively subtle deviations were sometimes noted. Furthermore, no significant adverse effects were noted in a series of patients with depression (Wyatt et al., 1971) or narcolepsy (Wyatt, Fram, and Snyder, 1970) who had received phenelzine (a monoamine oxidase inhibitor which induces REM deprivation) for as long as a year. Because it seems unlikely that the brain could retain a constantly built-up “neurohormone” for a year, these findings tend to discredit the hydraulic model of REM sleep; nonetheless, this model has been an important impetus for many studies of schizophrenic sleep.

Some investigators have hypothesized that, if schizophrenic patients were found to have an abnormally high amount of REM sleep (Fisher and Dement, 1963), a corresponding tendency might exist for REM to manifest itself in some manner during waking hours (Rechtschaffen, Schulsinger, and Mednick, 1964). Most studies of chronic schizophrenic patients have not, however, demonstrated marked deviations from normal in amount of REM sleep (Dement, 1955; Koresko, Snyder, and Feinberg, 1963; Feinberg et al., 1964; Feinberg, Koresko,

and Gottlieb 1965; and Traub, 1970). While a number of investigators have noted markedly lower than normal amounts of slow-wave sleep in schizophrenic subjects (Caldwell and Domino, 1967; Caldwell, 1969; Feinberg, 1967 and 1969; Feinberg et al., 1969; and Kunugi, 1970, this finding's significance is unclear since depressed patients (Mendels and Hawkins, in press), some mental retardates (Feinberg, Braun, and Shulman, 1969), chronic brain syndrome patients (Feinberg, 1967), the normal elderly (Feinberg, Koresko, and Heller, 1967), and students under stress (Lester, Burch, and Dossett, 1967) also have decreased slow-wave sleep.

Two studies of chronic schizophrenic patients have shown contrasting abnormalities in amounts of REM sleep. Gulevich, Dement, and Zarcone (1967) found an *increased* amount of REM sleep in 13 chronic, nonmedicated, remitted schizophrenic patients, as compared to seven nonpsychotic controls, while Azumi (1966) demonstrated that REM time was *lower* in a group of 35 chronic, nonmedicated schizophrenics than in 33 normals. It seems probable that Azumi's chronic patients were more actively ill than those in the Gulevich group's study and possible that acutely ill schizophrenic patients might have even lower amounts of REM sleep. This possibility is supported by a study which revealed that short-term schizophrenic patients had significantly lower values for emergent stage 1 EEG ("REM time") and REM than did long-term patients (Feinberg et al., 1964). Abnormally low amounts of REM sleep were also seen in a study in which the sleep of six acute schizophrenic patients was monitored nightly during 10 psychotic episodes occurring over many months (Kupfer et al., 1970). The patients' behavior was monitored during this period, and each psychotic episode was divided into a waxing and waning phase. In the waxing phase of the illness, there was a decrease in both REM and nonREM sleep; the REM decrease, however, was proportionately greater than the nonREM decrease and lagged behind nonREM in returning to normal during the waning phase of the illness. The absence of a subsequent REM rebound in these patients was a surprising finding, particularly since psychotically depressed patients with

similar REM deficits evidence very large REM rebounds upon recovery (Snyder, 1969). Marked decreases in the amount of REM sleep have also been noted in smaller, less comprehensive studies of acute schizophrenics (Lairy, 1966; Lairy et al., 1965; and Stern et al., 1969); Vincent et al. (1968) did not observe any REM deficits in schizophrenics monitored with telemetry.

Studies by Zarcone et al. (1968), Zarcone and Dement (1969), and Azumi et al. (1967) support previous naturalistic observations that active chronic schizophrenic patients do not evidence compensatory REM increases following experimental periods of REM deprivation (although Zarcone et al. did observe greater than normal REM rebound in *remitted* schizophrenic patients). In the one study in which chronic patients *did* show compensatory REM increases (Vogel and Traub, 1968), REM deprivation had been accomplished by the use of amphetamine, a drug which suppresses REM sleep but is also associated with large REM rebounds when its use is discontinued. Moreover, the chronic schizophrenics in this study lacked florid symptomatology and may have been more similar to Zarcone et al.'s remitted patients than to their active patients. In none of these studies was there an increase in patient symptomatology during REM deprivation.

A recent study by Wyatt et al. (1970) suggests that schizophrenia may be characterized by a breakdown in the normal boundaries between the REM-sleep and waking states. These investigators report that spontaneous palmar skin potential fluctuations in seven of eight nonmedicated acute schizophrenics were more frequent in REM sleep than in other stages of sleep and equal in frequency to waking values. By contrast, normal controls showed a marked decrease in skin potential fluctuations during REM sleep. Since studies of cats have demonstrated that the skin potential is actively inhibited during REM sleep, the frequent fluctuations noted during the REM sleep of these acute schizophrenic subjects may represent a failure of normal inhibitory processes. The recent finding that autistic children's evoked potential amplitudes are *increased* (rather than decreased as is normally the case) during REM sleep

has been similarly interpreted (Ornitz et al., 1968).

A series of animal and human pharmacological studies have suggested a model which may ultimately prove more useful for explaining REM abnormalities in schizophrenia than the previously discussed hydraulic model. This alternative model stems from recent investigations of parachlorophenylalanine (PCPA), an inhibitor of tryptophan hydroxylase (the rate-limiting enzyme in serotonin synthesis). When Dement et al. (1969) administered PCPA to cats, monophasic sharp waves (which normally occur almost exclusively in REM sleep) were produced in both nonREM-sleep and waking states. Because of their spike-like appearance and location in the pons, geniculate, and occipital regions, these sharp waves are referred to as PGO spikes. Along with PGO spiking, daily PCPA administration was associated with a marked diminution of both REM and nonREM sleep and with aberrant behavior in the waking state—rage, hypersexuality, hyperphagia, and activity reminiscent of humans undergoing hallucinations. Attempting to explain these responses to PCPA, Dement et al. postulated that the PGO spikes acted as internal stimuli which were too disturbing to allow the cats to sleep. These investigators also considered the PGO spiking responsible for the production of "hallucinatory" behavior in the cats. The diminution of REM and nonREM sleep associated with PCPA administration tended to be a relatively transitory phenomenon, for REM and nonREM sleep time generally returned to normal levels after approximately 1 week of diminution.¹ PCPA-induced abnormalities in behavior and PGO spiking, however, continued unabated. After administration of either 5-hydroxytryptophan (which bypasses the PCPA enzymatic block) or chlorpromazine all PCPA-induced changes were reversed.

Data also exist on the effects of PCPA in man. Recently, Wyatt (1970) and his associates (1969) reported on the sleep of 11 patients who had been given PCPA for its possible

therapeutic effects. While the decrease in non-REM sleep seen in cats did not occur, all 11 patients showed diminished REM sleep over a 2–3-week period. When the drug was discontinued, REM required over 3 weeks to return to normal levels. Again, compensatory increases in REM sleep time did not occur in the period following PCPA-induced REM deprivation. For this reason, it was concluded that PCPA irreversibly blocks tryptophan hydroxylase in human brain, resulting in a decrease in the synthesis of serotonin (believed to play a fundamental role in REM production). Supporting this interpretation was the finding that, when the enzymatic block was bypassed by oral administration of 5-hydroxytryptophan, REM sleep returned to normal levels. Because possible methods for measuring the presence of PGO spikes in man have only recently been proposed (Wilson and Nashold, 1969; Pivik and Dement, 1970; and Rechtschaffen et al., 1970), they have not yet been used with patients receiving PCPA; hopefully, data on this subject will become available in the near future.

The psychological effects of PCPA administration in man are unclear. In an early study, PCPA (in a dose up to 3 g./24 hr.) was given to prisoner volunteers without significant psychological effects (Cremata and Koe, 1966). When PCPA was later administered to patients with carcinoid tumor (4 g./24 hr.), however, such psychological symptoms as depression, confusion, hallucinations, and anxiety were present in four out of five subjects (Engelman, Lovenberg, and Sjoerdsma, 1967). Subsequently, in a more careful, double-blind study of seven patients with carcinoid tumor, behavioral changes (as measured by a psychiatric interview and rating scale) were significantly correlated with the period of highest PCPA dosage (Carpenter, 1970). The behavioral changes noted in this study included depression, anxiety, restlessness, irritability, crying, agitation, withdrawal, and lack of interest. The fact that maximum PCPA dosage was generally smaller than in the earlier study of carcinoid patients and that particularly labile patients were not given the drug may explain the absence of hallucinations or clear delusions in these patients. It is possible that higher amounts of PCPA

¹It is interesting to note that the cats, like the REM-deprived schizophrenics discussed on p. 46, did *not* evidence REM rebound in the period following PCPA-induced REM deprivation.

might have produced effects similar to those seen in cats who received PCPA in amounts greater than 50 mg./kg./day (the highest dosage of PCPA that has yet been administered to man).

If schizophrenics are characterized by a deficiency in serotonin metabolism, as predicted by the sleep studies, it does not necessarily follow that these patients must have low brain serotonin concentrations. An hypothesis concerning the mechanism of action of LSD, for example, suggests that this hallucinogen blocks serotonin receptor sites, thereby increasing brain serotonin concentrations (through a feedback mechanism) and decreasing concentrations of serotonin's metabolite, 5-hydroxyindoleacetic acid (5HIAA) (Aghajanian, Foote, and Sheard, 1968). Smythies, Benington, and Morin (1969) have also speculated about the blocking of serotonin receptors by hallucinogenic drugs. Thus, depending on its cause, a functional deficiency in serotonin metabolism could be associated with either an absolute increase or decrease in brain concentrations of serotonin or its metabolites. Symptomatic of the uncertainty surrounding this subject is the fact that Woolley, who initially postulated a serotonin deficit in schizophrenia (Woolley and Shaw, 1954), later reversed himself and predicted a serotonin excess in this disorder (Woolley, 1962).

The results of studies of serotonin concentrations in schizophrenia are not uniform, and, of course, these levels can only be measured peripherally. Feldstein, Hoagland, and Freeman (1959) found no differences between chronic schizophrenic and normal blood serotonin concentrations, although low concentrations were noted in acute psychotic patients. By contrast, Jus, Laskowska, and Jimmy (1958) reported low blood serotonin concentrations in chronic schizophrenics. Ljungberg (1963) observed higher urinary 5HIAA concentrations in patients with "fatal catatonia" than in other psychotics, and Banerjee and Agarwal (1958) found high urinary 5HIAA concentrations in schizophrenics. These findings must be contrasted with those of Buscaino and Stefanachi (1957) who noted low urinary 5HIAA concentrations in schizophrenics, of Leyton (1958) who reported

urinary 5HIAA excretion to be low in 20 percent of the schizophrenic patients he examined, and of Frago Mendez and Lopes do Rosario (1959) who found no difference in urinary 5HIAA between normals and schizophrenics.

To test the possibility that schizophrenics are unable to synthesize adequate amounts of serotonin, Lauer et al. (1958) administered tryptophan to both schizophrenic patients and normal control subjects. While they found no increase in 5HIAA excretion in the schizophrenic urine, there was a 100 percent increase of 5HIAA in the urine of normals. Neither Kopin (1959) nor Shaw, Lucas, and Rabinovitch (1959) were able to confirm this finding in their respective studies of adult and childhood schizophrenics. More recently, Christodoulou and Papaevangelou (1966) found no difference in the urinary 5HIAA excretion of schizophrenic and normal subjects to whom they had administered diets high in protein and carbohydrate.

In studies more closely related to brain function, Bowers, Heninger, and Gerbode (1969), Ashcroft et al. (1966), and Chase, Schnur, and Gordon (1970) found lower 5HIAA cerebrospinal fluid concentrations in schizophrenic patients than in either neurological patients or normal controls. Persson and Roos (1969), however, found no difference between schizophrenic and normal 5HIAA concentrations. In each of these studies, psychoactive drugs were administered within a few days of the 5HIAA determination, and the effect of these drugs is not clear (Chase, Schnur, and Gordon, 1970).

Attempts to treat schizophrenia with serotonin or its precursor, 5-hydroxytryptophan, have been generally unsuccessful (Woolley, 1962; Klee et al., 1961; Hoagland, 1958; and Pollin, Cardon, and Kety (1961). However, both Sherwood (1955), who injected 15–75 ug. (2–3/wk.) of serotonin intraventricularly to four chronic schizophrenics, and Ljungberg (1963), who gave unspecified dosages of 5-hydroxytryptophan to nine "fatal catatonics," reported "great improvement" in the patients they had studied.

Studies of serotonin deficits in schizophrenia are subject to the same general criticisms that have been directed to investigations of other

possible biochemical defects in schizophrenia—i.e., failure to adequately control for experimental biases related to such factors as diet, drugs, and hospitalization. Thus far, the serotonin hypothesis—like so many others—has not been consistently supported by experimental evidence.

Summary (Part 2)

Because of obvious parallels between dreams and hallucinations, the physiology of sleep in schizophrenic patients has evoked substantial investigative interest. Particular attention has been directed to possible abnormalities of rapid-eye-movement (REM) sleep—periodic episodes which are highly correlated with dreaming and which usually occupy 20–25 percent of total sleep time. Although most studies of chronic schizophrenics have not found marked abnormalities in amount of REM sleep, both *acute* and *actively symptomatic chronic* patients reportedly evidence lower than normal amounts of REM sleep. Thus, decreased REM sleep appears to be associated with the waxing phase of the schizophrenic disorder. But since experimentally induced REM deprivation has generally failed to produce gross adverse psychological effects in normal subjects, the significance of this finding is unclear. Another unusual characteristic of actively ill schizophrenics is their failure to evidence compensatory increases in REM sleep time (REM rebound) following periods of REM deprivation. Various theories have been offered as explanations for these and other abnormalities in the sleep of schizophrenics—the two most important being the hydraulic model of REM sleep and the REM-sleep/serotonin-deficit hypothesis. Thus far, however, none of these theories has been consistently supported by experimental evidence.

Conclusion

This review has focused on several major areas of the biochemical investigation of schizophrenia. How many of these areas focus on postulated aberrations of biogenic amines is immediately apparent. The Frohman factor, for example, is thought to alter red-cell uptake of amines, and the physiological sleep abnormali-

ties which characterize acute schizophrenia have been induced in both animals and man by manipulating brain serotonin concentrations. This focus of interest is not surprising since, when we look at our academic psychiatric centers, a very large percentage of biological researchers are studying one or another aspect of biogenic amines. Whether this convergence of interest will prove to be of practical importance in the prevention and treatment of schizophrenia remains to be seen.

The transmethylation hypothesis of schizophrenia has excited considerable investigative interest and has generally been studied using the “precursor-load” strategy. Both methionine and betaine seem to make schizophrenic patients more psychotic, but because toxic and schizophrenic psychoses have not been clearly differentiated, the significance of this psychotic worsening is difficult to assess. Furthermore, although methionine loading has increased brain concentrations of S-adenosyl-methionine (the putative methyl donor) in rats (Baldessarini, 1967), no such increases have yet been found following methionine loading in man. Given the schizophrenic’s postulated “abnormal” ability to form, or inability to metabolize, methylated substances, methionine loading should theoretically cause differential reactions in schizophrenic and nonschizophrenic subjects; but since the methionine precursor-load strategy has only twice been carried out in nonschizophrenic subjects (Alexander et al., 1963), this important aspect of the transmethylation hypothesis cannot be meaningfully evaluated.

On the grounds that they are methyl acceptors which theoretically should lower brain concentrations of aberrant methylated substances, nicotinic acid and NAD have been used to treat schizophrenics for almost 20 years. Nevertheless, no evidence exists that nicotinic acid or NAD, in fact, perform this function in man, and current evidence of their therapeutic efficacy in schizophrenia is, at best, equivocal.

During the last 8 years, DMPEA (or “pink spot”) has attracted as much worldwide attention as most of the other biochemical substances in the study of schizophrenia com-

bined. This interest probably stems from Osmond and Smythies' (1952) identification of DMPEA as a possibly provocative compound with regard to the transmethylated hypothesis. Over the years, the study of DMPEA has been plagued by repeated failures of one investigator to replicate another's experiments—failures which, for the most part, appear to result from inadequate biochemical methodology leading to type A, B, and C errors (see figure 1 and the discussion on pp. 11–12). DMPEA's presence in urine has been demonstrated through mass spectrometry (Stabenau, Creveling, and Daly, 1970), but whether it is formed in the body or is obtained from preformed plant foods (e.g., tea) is not yet clear. The fact that DMPEA's presence in or absence from the urine correlates with the addition or removal, respectively, of tea from the diet of normal subjects is suggestive but not conclusive evidence that tea is the source of DMPEA in schizophrenics. It is also possible that DMPEA occurs in one particular subgroup of schizophrenics (e.g., acute schizophrenics) but is generally absent from other types of schizophrenics.

First described 10 years ago, the "mauve factor" now appears to be a group of substances (including a pyrrole derivative). Neither its significance to schizophrenia's etiology nor its differential occurrence in schizophrenics, as opposed to normals, has been established.

Studies of bufotenine, like those of DMPEA, have suffered from inadequate biochemical methodology and either poor or nonexistent controls. While the recent finding in human brain of an enzyme capable of N-methylating serotonin to bufotenine (Mandell and Morgan, 1970) is presumptive evidence of bufotenine's existence in man, and while it may be present in greater concentrations in schizophrenics than normals (Sireix and Marini, 1969, and Fischer and Spatz, 1970), conclusive evidence of bufotenine's hallucinogenic properties in man has yet to be brought forward. Since bufotenine probably does not cross the blood brain barrier, its role in schizophrenia will be hard to demonstrate.

One of the most consistent findings in the biochemical investigation of schizophrenia has

been that there is some abnormality in the schizophrenic's ability to handle histamine. It is therefore surprising that only four studies of the histamine-schizophrenia relationship have been carried out in the last 10 years. A possible explanation for this neglect is the fact that, although histamine is in part metabolized by methylation, none of its metabolites are considered hallucinogenic, which, of course, does not jibe with the widely accepted transmethylated hypothesis. Only recently, in fact, has any theoretical hypothesis about histamine's relationship to schizophrenia been formulated (Cowen, 1969, and Pfeiffer et al., 1970).

Studies of taraxein, serum factors, and other substances thought to be involved in immune systems have presented a confusing array of results, most of which have not been replicated in experiments carried out by researchers other than the original investigator. This failure to replicate may stem from the complexity of immunological systems and protein chemistry and from psychiatric researchers' general unfamiliarity with them. Until independent investigators are able to consistently replicate each other's findings, the importance of taraxein and comparable substances will remain in doubt.

Although there is considerable evidence of the Frohman factor's presence in schizophrenic patients, its chemical structure and function remain an open question. Recently, Ryan et al. (1968) found a substance in the plasma of non-schizophrenic, chronically hospitalized patients which was quite comparable to that found in schizophrenic patients (i.e., the Frohman factor) but different from that found in normal controls. From their study, it appears that some correlate of hospitalization—rather than schizophrenia, *per se*—may produce the Frohman factor.

Most of the better known and established biochemical views of schizophrenia are discussed above, but new areas of interest are constantly developing and old ones reopening. Three suggestive new findings, for example, are that the sex of the fetus may determine the presence of puerperal psychosis (Taylor and Levine, 1969), that hexanoic acid is present in the sweat of schizophrenics (Smith, Thompson,

and Koster, 1969) and that 6-hydroxydopamine may be formed by schizophrenics (Stein and Wise, 1971). The generalized theory that excessive or deficient concentrations of substances normally present in the human body (i.e., the "orthomolecular theory") are involved in the schizophrenic process (Pauling, 1968) is an organizational research strategy frequently applied to schizophrenia.

While it is relatively new and untested, the REM-sleep/functional serotonin-deficit theory is promising in that it combines data from physiology and biochemistry, provides an animal model, proposes a functional relationship between dreams and hallucinations, and can be used in conjunction with other hypotheses involving a disturbance of serotonin metabolism. Despite this theory's attractiveness, no adequately controlled studies have demonstrated differences between schizophrenic and normal serotonin metabolism and no properly controlled study has shown clinical improvement in schizophrenic patients in whom serotonin concentrations have been elevated.

The biochemical investigation of schizophrenia has been hampered by the complex, inaccessible nature of the brain. To date, peripheral tissue examination has not unlocked secrets of practical importance to schizophrenia, and attempts at direct examination of the brain have not yet been successful. The discovery of enzyme defects in diseases of glycogen storage, amino aciduria, and lipid storage affecting the brain points toward more rewarding findings to come. Moreover, research methodology is constantly improving, and this, too, will aid in our further investigative efforts.

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