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How to Treat Insomnia in the Addicted Population

Sleep disturbances present daunting problems and difficulties for the treatment team and the patient especially when persisting after abstinence is achieved. They are troublesome in their own right, become a source of anxiety and depression, and increase the risk of relapse.

Assessment:

The first step in your work-up is to remember that insomnia may be related to a protracted withdrawal, may be a primary sleep disorder or may be a secondary disorder.

1. Rule out other illnesses such as psychiatric or medical disorders.
2. Is the patient taking sleep-impairing medications, such as activating antidepressants or Ritalin?
3. Does the patient use coffee or cigarettes? Other drugs, especially stimulants?
4. Does the patient understand and utilize the principles of good sleep hygiene?
5. Does the patient harbor dysfunctional beliefs about sleep?

The DSM-IV-TR diagnosis for insomnia involves one or more of the following:

1. Difficulty falling asleep or staying asleep.
2. Feeling that sleep is not refreshing for at least one month.
3. The sleep problem impairs daytime functioning.
4. The sleep problem causes clinically significant distress.¹

In terms of etiology, insomnia may be one of the causal factors in early drug use. Sleep problems in young boys, 3 to 5, predicted the onset of substance abuse by ages 12-14 to a high degree in one study. In another large study of adults, the incidence of new alcohol disorders after one year was double in those with persistent insomnia compared to those without insomnia.

If the patient has a primary sleep disorder, such as Restless Leg Syndrome, they should be referred to a sleep center for further work-up:

1. loud persistent snoring
2. cessation of breathing
3. frequent kicking during sleep

4. excessive daytime sleepiness

CBT, cognitive behavioral therapy, has been shown to be effective with chronic insomnia. There are several components to CBT, some of which may be especially relevant in any individual case:

1. Sleep Hygiene: Addresses those behaviors that may help or hinder sleep. Addiction patients can benefit from learning how substance use for sleep may exacerbate problems; how drug use and withdrawal impact sleep. The judicious use of caffeine and nicotine early in the day are part of SH; and do not exercise close to bedtime.
2. Sleep Restriction: This approach restricts the amount of non-sleep time spent in bed. SR temporarily prohibits napping; and encourages the insomniac to get out of bed after ½ hour; do something non-stressful such as meditating or light reading; and then try the bed again when feeling sleepy.
3. Stimulus Control: Psychologists use this term to describe an approach that redefines the bed as the place only for sleep. (They fudge the question about sex.) But all other bed-located activities should be discontinued, i.e., watching TV, reading, paying bills, newspapers, talking on the phone, etc.
4. Cognitive Therapy: This approach is based on the idea that incorrect thinking and beliefs about sleep provoke the inhibition of healthy sleeping. The therapist attempts to identify the irrational beliefs that provoke anxiety and sleeplessness. They then replace these beliefs with healthy ideas and behaviors. Some of the themes are: punishment b God for past wrongs, misconceptions about “old age,” if they don’t get normal sleep soon, they’ll “lose their ability to fall asleep forever,” etc.

You may wish to utilize pharmacotherapy under the following situations:

1. The patient’s mental or physical condition has not stabilized.
2. If some of the CBT instructions may exacerbate a co-morbid mental condition.
3. If the patient evidences low motivation for change.
4. If staff are not trained to administer CBT.

Some of the typical sleep difficulties caused by drug abuse are as follows:

Nicotine: Difficulty falling asleep, sleep fragmentation, less restful sleep, increased risk for Obstructive Sleep Apnea, and other sleep-disordered breathing.

Marijuana: Short-term difficulty falling asleep, decreased slow-wave percentage of sleep especially during withdrawal.

Cocaine: Prolonged sleep latency, decreased sleep efficiency, decreased REM sleep, hyper insomnia during withdrawal.

Stimulants (Amphetamines, Ritalin, etc.): Similar sleep effects as cocaine.

Opioids: Decreased slow-wave sleep, sleep disruption, nightmares, central sleep apnea.

Alcohol: Insomnia is a common complaint in active drinkers as well as those in recovery by over 50%.²

Pharmacotherapy for insomnia falls into two broad categories:

- I. Benzodiazepines (BNZ) (and the BNZ receptor agonists which do not have BNZ structure). The common medications for sleep are:
- Flurazepam (Dalmane) 15-30 mg
 - Temazepam (Restoril) 15-30 mg
 - Trizaolam (Halcion) ¼-1/2 mg
 - Eszopiclone (Lunesta) 1-3 mg
 - Zaleplon (Sonata) 5-20 mg
 - Zolpidem (Ambien) 5-10 mg
 - Zolpidem CR (Ambien CR) 6.25-12.5 mg

The newer drugs are alpha-1-selective BNZ receptor agonists, and do not have the BNZ molecule. However, they can be equally abused and are Schedule IV controlled substances to be used with extreme caution if at all in the substance abusing population.

If you decide to utilize one of the older non-selective BNZ's, one of the newer non-BNZ hypnotics or one of the tranquilizers as a sleep aid, a patient contract is very useful. This is a written contract signed by the patient that spells out:

- Frequency of visits, rules about early refills and telephone refills
- One prescriber and one pharmacy
- Abstinence from all other abused substances
- Random urine testing, pill counts
- Authorization to share info with significant others and other care providers
- Consequences for non-adherence

- II. Sedating drugs have been used off label for insomnia. The top of the list and the Most studied are: Gabapentin (Neurontin) and Trazodone (Desyrel). Also Quetiapine (Seroquel) and Mirtazapine (Remeron) have been commonly utilized in the addicted population for sleep. Gabapentin does not lower the seizure threshold, is not metabolized in the liver, does not require blood test monitoring for toxicity, and has low known abuse potential. Although patients taking Trazodone for sleep feel more tired the next morning, there has been demonstrated significant improvement in the sleep cycle. Quetiapine taken for sleep appeared to significantly reduce drinking days and craving.

Finally, non-prescription remedies occasionally have been useful: anti-histamines, valerian, and melatonin.

Non-Controlled (Off-Label) Sedating Agents for Insomnia

Ramelteon (Rozerem [melatonin receptor agonist]) 8 mg
Gabapentin (Neurontin [sedating anticonvulsant]) 300-1500 mg
Quetiapine (Seroquel[sedating 2nd generation antipsychotic]) 25-100 mg

Sedating antidepressants:

Amitriptyline (Elavil) 25-150 mg
Doxepin (Sinequan) 25-150 mg
Mirtazapine (Remeron) 7.5-45 mg
Nefazodone (Serzone) 50-150 mg
Nortriptyline (Pamelor) 10-75 mg
Trazodone (Desyrel) 25-300 mg

Abuse and addiction to drugs usually disrupts the sleep architecture. Sometimes, sleep disturbances precede abuse of drugs and alcohol. Once abstinence is achieved, disrupted sleep can become a risk factor for relapse. It is important to be aware of sleep difficulties in your patients and treat, while aware of the many constraining complexities. CBT, with or without medication is evidence-based treatment for chronic insomnia in the addicted population.

References:

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