Substance abuse and insomnia

Insomnia is a common complaint among people with substance use disorders. The relationship between sleep problems and substance abuse is bidirectional: People who have trouble sleeping may medicate with alcohol or illicit drugs or misuse prescription medications. And taking certain substances can interfere with sleep. This article reviews that relationship and presents information about the two evidence-based treatments for insomnia: prescription sleep medications and cognitive behavioral therapy for insomnia. Clinicians treating people with a substance use disorder or insomnia should be aware of the risks of comorbidity, and they should understand the risks and benefits of treatment for the insomnia.

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Editor’s note: This is the fourth of four articles in this issue, spanning pages 30-39, that address topics related to drug abuse and addiction.

Substance abuse is an ongoing and serious public health concern, as evidenced by the current opioid epidemic. For example, in the U.S., heroin overdoses tripled from 2010 to 2015, and in 2014, there were 28,000 deaths from heroin overdose.

Efforts to curb substance abuse include focusing on areas of health care that may reduce the spread of illicit drug use, drug abuse and misuse of prescription medications. Treatment of sleep disturbances is one such area worthy of attention.

Sleep disturbances are common in alcohol and drug users and appear to play an etiological role in substance abuse. In one study, nearly 70% of patients entering treatment for detoxification complained of sleep disturbances at admission. Alcohol and illicit drugs are being used to self-medicate insomnia symptoms, untreated insomnia has been linked to increased relapse rates for those in recovery from alcohol and drug dependency, and prescription sleep medications carry risks for abuse and dependency themselves. Abuse of illicit drugs and alcohol, as well as misuse of prescription drugs, have been linked to a variety of sleep disorders, including restless legs syndrome, sleep-disordered breathing, narcolepsy and circadian rhythm sleep disorders. While all of these disorders merit attention, this article focuses on the most common sleep disturbance, insomnia.

What is insomnia?
Insomnia involves difficulties with falling or remaining asleep or waking up too early in the morning. It can be a symptom or a condition. Up to half of the population experiences insomnia symptoms periodically, and estimates of people experiencing chronic insomnia during their lifetime range from 5% to 10% of the population.

Untreated, insomnia increases risks for medical conditions (eg, heart disease, high blood pressure and diabetes), psychiatric conditions (eg, depression and anxiety), daily functioning disturbances (eg, motor vehicle accidents and diminished work productivity), and alcohol and drug use and abuse. People more susceptible to developing insomnia include women, the elderly, and those with medical and psychiatric conditions.

Connections between substance abuse and insomnia
Insomnia and substance abuse interrelate in a variety of ways. For instance, alcohol consumption is among the most common strategies people use to manage insomnia symptoms. This is despite the fact that insomnia is both a common complaint among those dependent on alcohol and a risk factor for relapse among individuals in recovery from alcohol dependence. Likewise, marijuana is also used as a sleep aid, even though insomnia is a common complaint found in chronic marijuana users and a risk factor for relapsing among those in recovery from marijuana dependence. Insomnia is also a common complaint for cocaine users and can be present for up to three weeks after chronic cocaine users have been abstinent. Cocaine is seen as a cause for what some term “occult insomnia,” which is “degraded sleep accompanied by deteriorated cognitive functioning without the sensation of lack of sleep.”

Insomnia has also been found in opioid users while they go through methadone detoxification, as well as during the early part of abstinence.

Insomnia treatments
There are two evidence-based insomnia treatments: 1) prescription sleep medications (PSMs) and 2) cognitive behavioral therapy for insomnia (CBT-I). PSM and CBT-I have similar success rates, though they differ in their advantages and disadvantages.

PSMs have been available for years and their use is growing. According to the Centers for Disease Control and Preven-
tion, the number of prescriptions written for sleep aids in the U.S. tripled from 1998 to 2006. Among the most well-known PSMs today are the nonbenzodiazepine “Z-drugs,” which include zolpidem, zopiclone and zaleplon. The primary advantages of PSMs include their availability, their ease of use and the public’s awareness of them as a treatment option. At the same time, they are associated with potential health risks including misuse, abuse and dependency. In 2010, the Drug Abuse Warning Network (DAWN) found that there were 20,793 emergency room visits in the U.S. linked to zolpidem use, and overmedication was the cause of these visits in 33% of cases. It is also important to note that although the current generation of PSMs may not be as physiologically addictive as their predecessors, there are still risks for psychological dependence.

CBT-I is an effective and safe technique for treating chronic insomnia. It consists of multiple components including sleep restriction, stimulus control, cognitive re-framing, sleep hygiene, paradoxical intention, relaxation training and mindfulness-based therapy. CBT-I conceptualizes insomnia as a condition and addresses the underlying behavioral and psychological causes of it. This is one reason that gains from CBT-I tend to be durable. In fact, the American College of Physicians released guidelines in 2016 recommending that adults with chronic insomnia first attempt CBT-I and then consider PSM if the CBT-I is not effective. The stability of the improvements from CBT-I was one of the reasons behind this guideline.

The primary challenges of CBT-I include difficulty finding providers, improvements that are not immediate, and limited public awareness of it as a treatment option.

Conclusion

The opioid epidemic has heightened awareness within the health care community of the health risks associated with drug use. Insomnia and the treatment of insomnia appear to be factors that can affect use and abuse of substances, including opioids. Given the bidirectional relationship between substance abuse and insomnia, it is recommended that insomnia screenings in medical settings include questions that attempt to capture this potentially problematic comorbidity. Questions should gauge 1) whether alcohol or illicit drugs are ever used to treat insomnia, 2) whether illicit drugs are ever used to manage fatigue secondary to nighttime insomnia and 3) whether the patient shows signs of developing a tolerance or dependency to their PSM.

Ultimately, it is advised that physicians should base their treatment decisions on risk-benefit analyses personalized to the needs of each patient. Such analyses should consider both the advantages and disadvantages of available treatment options, including the risks for substance abuse and dependency.

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REFERENCES