When the drugs make sleep worse

Mental health

Malcolm Falconer

Up until two years ago I had never experienced insomnia. I had always fallen asleep in less than five minutes of my head hitting the pillow. I developed insomnia after I spent a year on a medication that had nasty side effects.

I am not sure which caused what, but I ended up with depression and a sleep problem. The specialist who prescribed the original medication then prescribed antidepressants and a hypnosedative to assist sleep. I was very relieved when both worked reasonably well. When I stopped taking the nasty medication causing the side effects, I also stopped the antidepressants and the sleep medication. No problems with the SSRI (selective serotonin reuptake inhibitor) medication – I stopped on a dime and had no withdrawal problems at all. The sleep medication was another story.

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I stopped taking it and then didn't sleep properly for six months; this is rebound insomnia. David Codyre, a psychiatrist from East Tamaki PHO, explains this as the loss of "sleep architecture". The medication had replaced the structures by which I normally fell to sleep. I was no longer "falling asleep" through the veil of consciousness to unconsciousness, falling down through the levels into the various stages of sleep.

On a hypnosedative a "drug sleep" is induced. I now had to rebuild the path to normal sleep. This is what I now warn patients about when they take hypnosedatives. You get to go to sleep but there is a price to pay.

Insomnia has many causes

How best to manage insomnia is well articulated in the best practice guidelines available at www.bpac.org.nz. Insomnia affects about one in three adults intermittently and about one in 10 adults chronically. Most of these cases have an underlying diagnosis, eg, depression, anxiety, grief, PTSD (post-traumatic stress disorder), a crisis, dementia, psychosis, etc. Travel, shift work and physiological disorders, or, as in my case, taking a medication, can also result in insomnia.

Insomnia is extremely debilitating for those who have acute and chronic conditions. Untreated, it can lead to a deterioration of the predisposing condition. For instance, psychosis, depression and anxiety will not respond well to medication until insomnia is stabilised. For most people, hypnosedatives stabilise the insomnia. However, just as the current best practice for depression and anxiety treatment is to use talking therapy/CBT (cognitive behaviour therapy) as an alternative to, or in conjunction with, SSRI medication, so too the best practice guidelines for sleep maintenance also recommend using medication as a last resort.

The guidelines clearly state that the primary goal is to reduce or treat any underlying problems and so prevent progression from transient to chronic insomnia – and to improve the patient's quality of life. The guidelines also clearly recommend management of insomnia using non-drug options if possible. Education about sleep hygiene and stimulus control are recommended for everyone with insomnia, regardless of whether they require further treatment with behaviour therapy drugs.

Sleep tips to ensure blissful shut-eye

ASLEEP is a mnemonic for remembering sleep hygiene tips.

A – Alcohol, caffeine and nicotine should be avoided. Try to encourage patients to avoid stimulants if they have sleep problems, but particularly in the hours prior to sleep.

S – Sleep and sex should be the only uses of the bed. If you can't sleep don't force it – it will just elevate sleep anxiety – get out of bed, go to the lounge and read a book. This is to avoid conditioning the bed as a place of sleep anxiety.

L – Leave laptops, televisions and paperwork out of the bedroom. Some studies have found electromagnetic fields affect sleep, so any device, clock, etc, with a blue or green light should be obscured. Anything other than a red light affects melatonin production.

E – Exercise regularly but not within two to three hours of bedtime. Breathing, muscle twitch and physiological anxiety states are all helped by exercise, preferably to a level where breathing becomes ragged enough that singing is difficult.

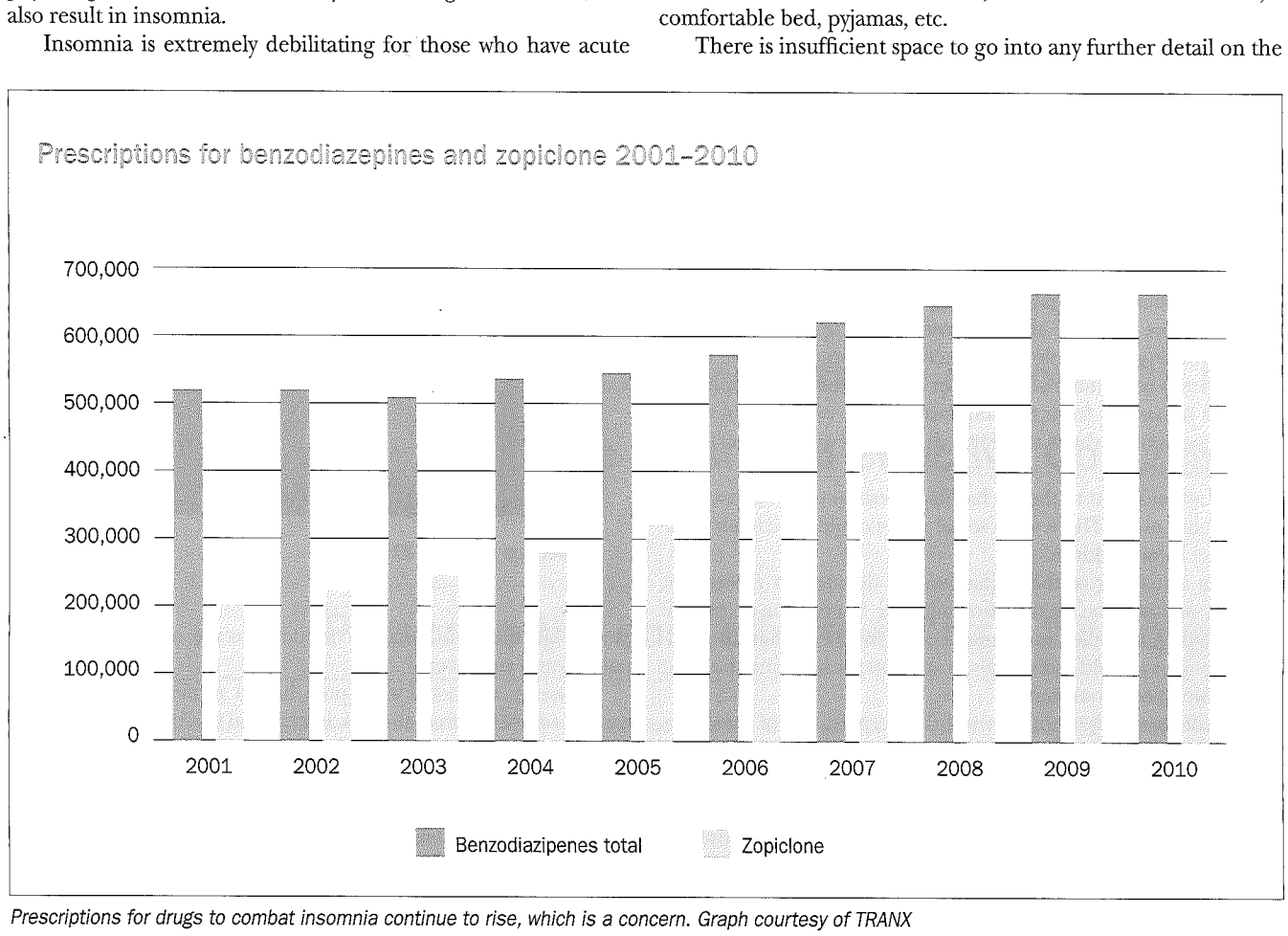
E – Early rising is good. Avoid sleeping in or daytime naps. The sleep neurotransmitter explanation is much more complicated than this article permits but, basically, the circadian rhythm is governed by the "sleep" hormone (melatonin) and the "wake" hormone (adenosine) being distributed in a familiar 24-hour cycle, and once this routine is compromised it takes time to restore it.

P – Plan for bedtime. Create necessary and sufficient conditions for sleep, eg, a hot bath, a warm Horlicks or other bedtime drink which doesn't have caffeine, a low stimulus environment, a comfortable bed, pyjamas, etc.

There is insufficient space to go into any further detail on the multitude of behavioural strategies that can help with sleep. There are good resources available online – www.calm.auckland.ac.nz is a good place to start.

I am not against sleep medication prescribing. Sleep deprivation is a serious symptom and must be stabilised or the consequences for any underlying condition can be severe, sometimes even life-threatening.

However, the treatment of sleep disorders using hypnosedatives has increased steadily over the years. The graph supplied is produced by TRANX Drug and Alcohol Services Incorporated (TRANX) and is based on Pharmac's statistics. It shows, while prescriptions for benzodiazepines have levelled off, zopiclone scripts are climbing steadily. While information on quantities isn't indicated and shorter scripts are the norm, the trend is nonetheless a cause for concern.



Prescriptions for drugs to combat insomnia continue to rise, which is a concern. Graph courtesy of TRANX

Key points

- Rebound insomnia is a problem when sedatives are withdrawn.
- Sedatives undo a person's "sleep architecture", and restoring this takes time.
- Insomnia is a chronic problem for one in 10 adults.
- Clocks with blue or green lights can interfere with melatonin production and therefore with sleep.

Sleep doesn't always come easily, but hypnosedatives can worsen the problem in the long term. Despite this, their use is on the rise

Sleep medication use on the rise

TRANX is a regional addiction service that specialises in addiction to benzodiazepines and other hypnotics. TRANX has observed an upward trend in referrals. It treats patients who have unwittingly become heavily chemically dependent on their sleep medication.

The service is replicated in some other regions of New Zealand under different guises. TRANX works with both patients and their GPs to wean people off dependence on the drugs. The process is never easy and rarely fast. Without going into detail about the timelines involved – because this depends on dosage, length of time taking the drug and the underlying medical condition – the rule of thumb is it takes a month for every year a person has been on a hypnosedative for the person to come off it.

TRANX recommends GPs switch patients off all other forms of hypnotic drugs and substitute diazepam only, and then steadily reduce the dose of diazepam. For more information, go to www.tranx.org.nz

For those GPs who can't access TRANX or a similar service, Matua Raki, the national addiction workforce development group, has produced a handy folder entitled *Substance Withdrawal Management: Guidelines for Medical and Nursing Practitioners in Primary Health, Specialist Addiction, Custodial and General Hospital Settings.* The section on benzodiazepine and other hypnotic withdrawal is particularly useful. Contact Matua Raki at www.matuaraki.org.nz if you would like access to this resource.

Malcolm Falconer is a consultant psychologist from Auckland