Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/treating-insomnia-in-addicts/3758/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Treating Insomnia in Addicts

SLEEP DISTURBANCE AND ADDICTION DIAGNOSIS

From alcohol to nicotine to prescription opioids most substances of abuse can create sleep disturbances that continue even into abstinence, untreated sleep disturbance can be a significant relapse trigger, yet most FDA approved hypnotics are controlled substances. How can you break the cycle of insomnia in patients with addictive disease? Welcome to the Clinician's Roundtable. I am Dr. Leslie Lundt, your host, and with me today is Dr. Deirdre Conroy. Dr. Conroy is a Clinical Assistant Professor of Psychiatry at the University of Michigan.

DR. LESLIE LUNDT:

Welcome to ReachMD, Deirdre.

DR. DEIRDRE CONROY:

Thank you for having me.

DR. LESLIE LUNDT:

After you've made the diagnosis of insomnia in a patient that has a coexisting addictive disease, what do we do next?

DR. DEIRDRE CONROY:

Well it is important to address the addiction whatever it may be. If the patient is currently using the substance or is drinking that is really going to play a big role in whether the patient's sleep can improve, so whatever treatment they are involved with that would be the first step. Once that is under control or the patient has been receiving treatment formally or through a fellowship like Alcoholic Synonymous then you can jump in and start looking at the insomnia and really starting the treatment, the number of treatments that we have for insomnia.

DR. LESLIE LUNDT:

But what happens so often I think especially in primary care, a patient will come in and they really have no interest in stopping their drug or especially alcohol, so they are complaining of insomnia, they are still drinking, they do not want to stop drinking what do we do?

DR. DEIRDRE CONROY:

Well, you want to talk to the patient about that whether it is in your office at that time or recommending some of the options they may have available to them in the center whether there is an addiction treatment service. A lot of times in my practice I educate so I discuss the effects of alcohol or the substance on sleep and if their concern is about sleep then discussing that sleep disorder and its role in getting better is important for the patient to understand, which may also increase motivation including the patient in the decision making process is often quite helpful.

DR. LESLIE LUNDT:

So, it sounds like the common thing that happens in many offices of just giving them a prescription for Ambien may not be the best idea.

DR. DEIRDRE CONROY:

Not in all cases no. There are certainly other medications that may be better for them it is certainly an individual case basis.

DR. LESLIE LUNDT:

What treatment options are least likely to interfere with their sobriety?

DR. DEIRDRE CONROY:

Well we separate from pharmacotherapy to non-pharmacotherapy. In terms of a pharmacotherapy, there are few medications that have been researched quite a bit lately and one of them is medication called gabapentin or other name is Neurontin and not an antiepileptic drug that does not lower the seizure threshold that is important when you are considering alcohol-dependent patients with sudden withdrawal and this medication has been shown in some studies to help with the sleep and also prolong the rate of relapse. So, in some studies it took the patients longer to get back to drink and they did go back to drink it, but those that took this gabapentin medication did not relapse as soon as the others that didn't take the medication.

DR. LESLIE LUNDT:

But gabapentin is not FDA approved to treat insomnia, right?

DR. DEIRDRE CONROY:

That's right so it an off-label prescription medication, although in clinical practice lot of patients seem to tolerate it well and it's more appropriate for this patient population.

DR. LESLIE LUNDT:

So gabapentin is one in the real world. Sometimes we see trazodone being used or even quetiapine Seroquel. What do you think of both?

DR. DEIRDRE CONROY:

That's right, actually trazodone is prescribed most often for patients with insomnia in primary care settings and quetiapine is also prescribed frequently and both of these medications are used for their sedative properties and they are turned to by physicians treating the patients with addictions because there is less abuse potential as oppose to say a benzodiazepine like or non-benzodiazepine like Ambien as you mentioned so those are certainly quite effective for some of these alcohol-dependent patients.

DR. LESLIE LUNDT:

Which of the benzodiazepine or the more sedative hypotonic medications, you find to be the most troublesome in these addicted patients?

DR. DEIRDRE CONROY:

Well, any time you are dealing with the benzodiazepine in these patients it could increase the probability that something could go wrong like increasing the dose or even the rebound insomnia or the potential if you were to mix benzo with alcohol if the patient is still actively drinking that could contribute to some problem so in general the benzodiazepine.

DR. LESLIE LUNDT:

Do use patient contract in this population when they are on a prescription sedated hypotonic which may be abusable?

DR. DEIRDRE CONROY:

Some do. Some clinicians do, not all the time. The addiction psychiatrist in our centers occasionally will use the contracts if they are prescribing a benzodiazepine or if they anticipate that they will be prescribing them for a long period typically, these contracts can list the frequency of changing the dose, missed prescriptions or in some cases doctor shopping things like that, but not in every case.

DR. LESLIE LUNDT:

If you are new to our channel, you are listening to the Clinician's Roundtable on ReachMD, The Channel for Medical Professionals, I am Dr. Leslie Lundt, your host, and with me today is Dr. Deirdre Conroy, from the University of Michigan. We are discussing treating

insomnia in addicts. We have covered pharmacotherapy, let's talk for a moment about psychotherapy what options to be have there?

DR. DEIRDRE CONROY:

Well with the non-pharmacological options, there is cognitive behavioral therapy specifically for insomnia, which it's an empirically based treatment that works with the patient on behavior and thinking about sleep. This is something that works on all types of problems with sleeping whether that includes sleep hygiene, which can refer to what you do around sleep for example in this population patients may use alcohol before bedtime that would be addressed specifically and changing the way they think about sleep and early studies have shown that this treatment is specifically with the alcohol-dependent patients has been quite effective in helping them fall asleep and stay asleep and feel more rested during the daytime. So, it takes a while for the treatment to kind of kick in, but the effects are longer lasting and can actually be comparable to taking a medication after say 5 to 8 weeks of cognitive behavioral therapy.

DR. LESLIE LUNDT:

And much less likely to abuse I would imagine?

DR. DEIRDRE CONROY:

Oh yes and that's why that it is a desirable treatment for this patient population.

DR. LESLIE LUNDT:

Deirdre can non-psychologist to learn how to do CBT for insomnia?

DR. DEIRDRE CONROY:

Yes, they can. The number of different clinicians are now becoming skilled in cognitive behavioral therapy. There are courses that are offered through the American Academy of Sleep Medicine. There are apprenticeships that any kind of clinicians can do. The best that would be to shadow a clinician that is certified in behavioral sleep medicine and there is a list of all those clinicians on the American Academy of Sleep Medicine website so these sleep labs can open up their lab to having clinicians watch to see the patient progress and to offer the opportunity for them to be certified in doing this type of therapy.

DR. LESLIE LUNDT:

And what is the website?

DR. DEIRDRE CONROY:

www.aasmnet.org.

DR. LESLIE P. LUNDT:

When is CBT not appropriate?

DR. DEIRDRE CONROY:

Any time you have a patient with an unstable or untreated either medical or psychiatric illness and primarily the reason for that is if there is say for example untreated depression or anxiety or any kind of psychiatric disorder that may interfere with the progress of the cognitive behavioral therapy so that something that you want to either work with a psychiatrist or the prescribing physician or primary care physician, as they are undergoing that so that that does not impede their ability to improve.

DR. LESLIE P. LUNDT:

Let's say you are in primary care sees kind of everything imaginable, when is it appropriate to refer these patients out to either a sleep doctor or a psychologist?

DR. DEIRDRE CONROY:

The patients that report that they have had insomnia all their life and that they have tried the medications and they have tried the behavioral strategies those are the patients that I see most of usually when I see them they have gone through the list of the medications, they've read books, they will tell you the treatments back and forth, so it's really chronic insomnia patients, who have really tried all the options and still they have persistent sleeping problems.

DR. LESLIE P. LUNDT:

Now what about some of the more “natural therapies” for these patients like melatonin and sounds like we have tryptophan back again, as an option or valeriana root, there are so many difference things sold in the help with that, does any of that make a difference for these folks?

DR. DEIRDRE CONROY:

Well ya, and you had mentioned melatonin, now melatonin has now been FDA approved and the medication called Rozerem or Remelteon that is a melatonin-receptor agonist and it is approved for helping people, who have troubled falling asleep and that is actually an appealing option specifically for patients with a history of addiction because it is working on a different system so it is not a benzodiazepine, it is not working necessarily in a GABA system it is working in the melatonin system so that can be useful where actually there are no studies in the alcohol-dependent or substance abusing population, but that can be quite effective and there is also melatonin over-the-counter, which can work a little bit differently. The disadvantage of taking melatonin over-the-counter is that it is not FDA regulated, so the actual dose that you are getting may not be what it says on the bottle, you may get little bit more or less, but that is certainly can be effective in a lot of my patients actually say that it does help them in some ways. The other ones that you had mentioned like valerian, there are lot of sleepy time teas, you know there are many studies that I have examined objective improvements in sleep with these, some people will say does help them fall asleep, but this isn't something that is statically significant, so I usually take it on an individual basis some people will say that it works and other people say it will not.

DR. LESLIE LUNDT:

So, if it works probably not a bad thing, but don't count on it.

DR. DEIRDRE CONROY:

Exactly.

DR. LESLIE LUNDT:

Well, thank you so much for being on our show today.

DR. DEIRDRE CONROY:

Thank you for having me.

We have been speaking with University of Michigan psychologist Dr. Deirdre Conroy about treating insomnia in patients that have a coexisting substance abuse problem. I am Dr. Leslie Lundt, you are listening to ReachMD, The Channel for Medical Professionals. For a complete program guide and downloadable podcasts, visit our website at www.reachmd.com. You will even be able to hear today's interview. Thank you for listening.

You are listening to ReachMD XM160, The Channel for Medical Professionals.

I am Dr. Doug Weaver, host of heart matters on ReachMD. Join us this week with Dr. Doug Zeif, as we discuss sudden death and assays.

This is Dr. Jennifer Shu. This week we will be speaking with Dr. H. Gilbert Welch, Professor of Medicine and Community and Family Medicine at Dartmouth Medical School, co-director of the VA Outcomes Group in the Department of Veterans Affairs and White River Junction, Vermont. We will be talking about the effects of early screening and diagnosis of disease.

This is Dr. Mark Nolan Hill, this week we will be speaking with Dr. Paul Homans, a neurosurgeon for the Methodist Neurological Institute at the Methodist Hospital in Houston. We will be talking about minimally invasive spine surgery.

Download complete program information live streaming, ondemand podcasts and free CME at ReachMD.com. ReachMD online, on demand, and on air at XM160.

You are listening to ReachMD XM160, The Channel for Medical Professionals.