

Insomnia in Early Recovery

Kevin T. McCauley, M.D.

“You’ll never die from lack of sleep!”

You might hear this if you’re new in recovery and having trouble sleeping. If you do, I apologize. The statement is not only wrong, it’s cruel. Insomnia is *genuine suffering*. The patient is awake, night after night, and then drowsy in the daytime, snoozing in group therapy and often given “check marks” or “write ups” by treatment center staff for “not participating.”

I *never* hassle people who sleep in my lectures. And why is that? Well, there are a number of reasons (I may, in fact, be boring), but mainly because insomnia is a *normal symptom* of being newly sober. It’s one of the outward signs that the brain is slowly repairing itself. I *expect* to see it, and getting angry with a patient who manifests a normal symptom of being newly sober is a bit like getting angry with a heart attack patient because they had some chest pain. Doctors don’t get mad at patients for manifesting normal symptoms of their disease. It’s *dumb*.

Lack of sleep may not kill the patient, but insomnia - left unchecked - can lead to relapse – and that *can* kill the patient, or at least lead to a negative outcome that could have been prevented. Insomnia in the newly abstinent patient is something that I take very seriously. Insomnia is an *especially* severe problem for newly sober heroin addicts (personally, I believe that up to *a third* of all relapse to heroin surrounds the issue of sleep). To dismiss the patient’s suffering with a snappy (and dangerous) remark is to invite that patient to relapse. It is the responsibility of the clinician to provide tools that the patient can use to cope with their sleep disorder. Having said that - it is the responsibility of the patient to use those tools. They will work, I promise.

If all you do for treatment is handcuff the patient to a radiator and bring them Jack-in-the-Box twice a day for three months, believe it or not by the end of that “treatment” you *will* see some improvement in the patient’s addiction (however, when you come to unlock them they will stab you to death with that little plastic fork they give you to eat the apple pie). The reason for this (overall) improvement is that the brain will repair itself to some degree in that three months, and the symptoms of Post-Acute Withdrawal Syndrome will abate *just with time sober alone*. The point of treatment for addiction is to *support* that healing – not screw it up.

You see, for every brain cell we’ve got – every neuron that helps us do our thinking – we have *two* caretaker cells. That’s right, the bulk of our brain mass is essentially cells that are *janitors* – they clean up debris, repair connections, and help the thinking cells restore the natural balance of neurochemicals. The minute the addict puts down the bottle or the pipe or the needle, those cells go to work. Just in the five minutes that the addict takes to read this essay, repair has occurred. The trick of treatment is to get the addict as far out from their last episode of drug use as possible so that the maximal amount of repair can occur. This way the newly-sober addict stands a better chance of developing the short-term coping skills that will carry them into long-term sobriety.

I know you’ve heard that drugs will destroy your brain. I know you’ve seen the commercial with the egg in the frying pan (“This is your brain, this is your brain on drugs, any questions?”). Ha ha, very funny. But generally what we see when addicts put together long-term sobriety is not a bunch of sober imbeciles, but people who get their

memories and their attention and their thinking *back*. The brain *heals*. So the commercial is only telling you half the story. If it stays sober, the egg can un-fry, hop out of the frying pan back into its shell *and get on with its life*.

Sleep, I'm happy to tell you, is one of the first things to come back on-line as the brain repairs itself. Generally, between 60 to 90 days of sobriety (and often quicker if the patient is working Steps) I see patients experience what I call a "*Perfect Night's Sleep*." What is a "Perfect Night's Sleep?" Well, it looks like this: the patient turns out the light and puts their head on their pillow at 11pm, they are asleep by 11:03pm, they sleep exactly 7.5 hours without waking up in the middle of the night, they wake up spontaneously (without an alarm clock), refreshed and ready to take on the day. An afternoon nap is a nice treat, but it's not critical for functioning. That is a "Perfect Night's Sleep" and guess what? *That's the way most people sleep!* That's the way most people sleep every night and don't give it another thought. But very often the addicted patient has been struggling with sleep their whole life. And so when they experience a "Perfect Night's Sleep" right around 60 – 90 days of sobriety it can be a deeply emotional experience. Then, the next week they get another "Perfect Night's Sleep." And the next week - maybe two in row. By six to *nine* months of sobriety, the sleep problem is in the box. The resolution of insomnia is one of the first rewards of sobriety that is waiting for the addict – if they can just get some time away from drugs and alcohol.

This is why it is critical to avoid running to a sedative/hypnotic drug to manage insomnia in the addicted patient. Once detox is finished, and the addict is still experiencing insomnia, *behavioral* tools – things like "Sleep Hygiene" - are preferred over a prescription for Valium, or Ambien, or Sonata, or whatever for sleep disorders. We want to minimize the addict's risk of relapse secondary to insomnia, yes, but we also want the brain to heal. So we use behavioral tools, not pharmacological tools. I promise, these behavioral tools are *equally effective* at promoting sleep as the sedative/hypnotic drugs – they're just not quite as quick and easy as taking a pill.

You see, ninety percent of the time if a patient is suffering from simple insomnia, the doctor can prescribe one of these drugs for short-term relief and everything will be just fine. The patient takes the medication at bedtime - exactly as directed. The medication works perfectly. The patient's sleep disorder resolves and the remaining pills go stale in the patient's bathroom cabinet over the next ten years – never touched again. In nine out of ten patients you can do this and there's nothing to worry about. *It's the tenth patient – the addict - that has trouble*. For these patients something other than medications must be used.

Now this is where "Sleep Hygiene" comes in. Personally, I don't like the word "Hygiene" because it implies that the patient with insomnia is somehow "*Sleep Dirty*." And I don't like "*Sleep Discipline*" either. But Sleep Hygiene is a form of structured behaviors that, if practiced will clear up most sleep disorders, *without* medications. They work in non-addicted patients and addicted patients alike, but because of the danger of relapse in the addict with prescription medications they are especially important. I must tell you, they are not easy – certainly not as easy as taking a pill – but *they do work*.

To learn Sleep Hygiene best, I recommend that you find a doctor that is an expert in sleep disorders, undergo a sleep study, and work out a plan with that doctor that is right for you. If that is impractical right now, they you might start with two books (yes, I know, *more books!* Listen, I don't have stock in Amazon.com, there really is a legitimate

reason for all these books. It's called *bibliotherapy*, and hey, twenty dollars for a book is a lot cheaper than \$2000 for an inpatient detox). Here are the two books:

The Promise of Sleep. William Dement, M.D., Ph.D.

Desperately Seeking Snoozin' John Wiedman