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Drugs for poor sleepers?

Some people have always been poor sleepers, but nowadays there are more of them—because there are more elderly people. Patients have always wanted sleep inducing drugs, from Shakespeare's drowsy syrups to the benzodiazepines of today. If doctors accept recent criticisms of benzodiazepines are they justified in always withholding the drugs? I think not.

Patients who say that they have hardly slept a wink for a month or that they always take two hours to fall asleep are inaccurate. Monitoring with an electroencephalogram shows that such people are usually asleep within 20 minutes and sleep for six hours. Indeed, the impressive finding in the laboratory is the overlap in the amounts of sleep between those who complain and their matched controls. Yet, though the expert can say for how many minutes a patient slept, he can say almost nothing about the restorative intensity of the sleep. The patient maintains something is amiss; the expert cannot say he or she is wrong.

When matched groups are compared with the electroencephalograph people who complain of poor sleep do on average get half an hour less and do wake up more frequently than people who say that they sleep well. The poor sleepers are also hotter by night and by day,[1-3] which would imply a higher rate of catabolism—and the greater need for restoration; yet their sleep is somewhat shorter and more broken. Evidently they are not mere complainers: they know something that we cannot fully measure. Also we do not know why people who say they habitually have under six hours a night when followed up for nine years should have had a mortality rate 1·3 times higher than expected.[4 5]

The simple guides to better sleep are regularity in time of getting up in the morning, not smoking, minimising alcohol intake, taking regular exercise, forgiving your enemies, and deliberately planning happy thoughts at bedtime.[6 7] Irregular times of evening food should be avoided—these disturb sleep—while the milk and cereal drink Horlicks at bedtime really does bring benefit.[8] But none of these recipes rivals the potency of a modern hypnotic drug.[9]

What about alternative techniques? Biofeedback training sessions use the tension in the muscles to produce a rate of clicks that informs the listener that she is or is not relaxing. Poor sleepers average high scores for tension and anxiety. Can training in relaxation improve their sleep? Nicassio *et al* trained poor sleepers in progressive relaxation or gave biofeedback or bogus biofeedback (the rate of clicks varying without relation to muscle tension).[9] The genuine biofeedback and the progressive relaxation were no more effective than the bogus biofeedback. Hauri assessed 165 poor sleepers and thought that 54 might benefit from biofeedback.[10] Yet after an average of 25 hours of training neither subjectively nor in the laboratory was there an overall advantage compared with one hour of simple counselling.

The subjective and laboratory evidence that modern hypnotics improve sleep is extensive. Statements that benzodiazepines do not long remain effective may be refuted[11 12]: tolerance certainly occurs, but it is only partial. The trouble is that with regular dosage the brain adapts its machinery to provide the partial tolerance. If the drug is then abruptly stopped a rebound occurs because of the changes in the brain, so sleep is temporarily worse than it would have been had the drug never been taken.[11] Once these facts are understood the drugs can be used accordingly.

A recent leading article in the *BMJ* asserted that benzodiazepines should not be prescribed at times of bereavement or divorce,[13] but I think that it would be inhumane to pursue such a policy rigorously in the face of distress. Certainly patients should be told that hypnotics should be taken only in small dosages during short periods and preferably not every night. Time sorts out human troubles, the dosage may then be cut, and the drug stopped, rebound sleep troubles being balanced out by the amelioration of stress.

Many people keep a few sleeping pills at home for the odd occasion when experience suggests that the day's events will cause a troubled night. Today's hypnotics are safe and are as much modern facilities as telephones or videos. In Britain an effective hypnotic may now be purchased over the counter as Sominex (promethazine), and sufficient for several nights. I do not see why short acting benzodiazepine hypnotics should not be similarly available in Britain—where any adult is free to buy a bottle of vodka. Doctors need not always be intermediaries. If asked to prescribe they can take the opportunity to educate.

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