



SELF-MEDICATION & EMOTIONAL PAIN

Physical Pain, Sleep & Self-Medication

When substance use begins as an attempt to manage the body

The key idea

Self-medication may begin with physical pain, sleeplessness, fatigue or another bodily symptom rather than emotional distress. Short-term relief can become strongly reinforcing, particularly when the underlying problem remains untreated, difficult to treat or repeatedly interrupts everyday life.

When the starting point is physical

Not all self-medication begins with emotional pain. Someone may be trying to relieve back pain, headaches, nerve pain, gastrointestinal symptoms, muscle tension, sleeplessness, exhaustion or another bodily problem. If a substance provides rapid relief, repeated use can make practical sense from the person's immediate perspective even when it carries longer-term risks.

In everyday language

Sometimes the question is not 'What feeling are you trying to escape?' but 'What hurts, what keeps you awake, or what is your body struggling to do?' That distinction can completely change the support someone needs.

Pain can affect much more than the painful area

Persistent pain can affect movement, concentration, mood, sleep, relationships and work. It can also increase stress and reduce access to activities that previously helped someone cope. Pain and emotional distress can influence each other without either being imaginary or 'all in the mind'.

Why rapid relief becomes powerful

When a substance reduces pain quickly, the brain learns that using it changes an aversive state. That relief can reinforce repeated use. The risk can increase when pain is recurrent, healthcare has not found an adequate treatment, or the person feels they have few other ways to function.

Key distinction

Using a substance because someone is in genuine pain does not make dependence or addiction impossible. Equally, physical dependence on a prescribed medicine does not automatically mean a person has an addiction. These concepts need careful assessment rather than assumptions.

Prescription medicines and dependence

Some medicines used for pain, anxiety or sleep can cause dependence and withdrawal symptoms. NICE NG215 covers opioids, benzodiazepines, gabapentinoids, Z-drugs and antidepressants. These medicines have legitimate clinical uses, but prescribing should include discussion of benefits, risks and what to do if withdrawal becomes necessary.

Tolerance, dependence and addiction

Tolerance means that a previous dose produces less effect over time. Physical dependence means the body has adapted and withdrawal symptoms may occur if a medicine or substance is reduced or stopped. Addiction involves a broader pattern of impaired control, prioritisation and continued use despite harm. A person can be physically dependent without having an addiction.

Important clinical point

Do not abruptly stop a dependence-forming prescribed medicine simply because dependence has developed. Withdrawal may need to be gradual and individually planned with an appropriate clinician. The risks differ between substances and medicines.

Pain can also lead to non-medical substance use

When prescribed treatment feels inadequate, unavailable or produces unwanted effects, some people turn to alcohol, cannabis, illicit opioids or other substances. Understanding why does not make these options safe. Unregulated drugs can have unpredictable strength or contents, and combining sedating substances can substantially increase harm.

Mixing substances can increase risk

Alcohol, opioids, benzodiazepines and other sedating drugs can each impair alertness and breathing. Combining them can increase the risk of severe sedation, respiratory depression, overdose, falls and accidents. Prescribed medicines can also interact with alcohol or non-prescribed substances.

Safety note

If someone is unusually difficult to wake, has very slow or irregular breathing, is unconscious, has blue or grey lips/skin, or overdose is suspected, call 999. Do not assume they can simply 'sleep it off'.

Sleep: sedation is not the same as restorative sleep

Alcohol and sedating substances may make someone feel sleepy or fall asleep more quickly, but this does not necessarily mean sleep quality improves. Alcohol can fragment sleep and contribute to waking during the night. Repeated reliance can also create a learned belief that sleep is impossible without the substance.

The sleep–substance cycle

Poor sleep can increase the urge to use something at night. The substance may then disrupt sleep quality or create next-day tiredness. Stimulants or high caffeine intake may be used to compensate during the day, making it harder to settle at night and strengthening the cycle.

What this might look like

Someone drinks to fall asleep, wakes feeling unrefreshed, uses caffeine or nicotine heavily to function through the day, then feels too activated to settle naturally at bedtime and drinks again. Each part of the cycle can reinforce the next.

ADHD, sleep and self-medication

Sleep difficulties are common in people with ADHD, although they are not unique to ADHD. Restlessness, delayed sleep patterns, racing thoughts, inconsistent routines or co-occurring anxiety can all contribute. Alcohol, cannabis or sedating medicines may be used as an attempted 'off switch', while stimulants or nicotine may be used to counter daytime fatigue.

Fatigue and trying to stay functional

Long working hours, shift work, caring responsibilities, chronic illness, sleep disorders or persistent poor sleep can leave someone struggling to stay awake or concentrate. Stimulants, nicotine, caffeine or other substances may become functional tools rather than recreational ones. Treating the cause of fatigue matters.

What to explore

Ask about pain, sleep quality, snoring or breathing problems during sleep, restless legs, medication effects, shift patterns, caffeine, mental health, neurodevelopment, chronic illness and daytime sleepiness. Substance use may be one part of a larger health picture.

When pain and sleep affect each other

Pain can make it difficult to fall asleep, find a comfortable position or stay asleep. Poor sleep can in turn increase pain sensitivity, fatigue and emotional distress. A person may therefore be self-medicating several connected problems at once rather than one isolated symptom.

Treating the underlying problem matters

Reducing substance-related harm is important, but so is taking the original symptom seriously. Depending on the situation, useful support might involve pain assessment, physiotherapy, medication review, sleep assessment, treatment for a sleep disorder, psychological approaches to persistent pain or insomnia, occupational adjustments, pacing and specialist services.

For professionals

Avoid assuming that requests for pain relief or sleep treatment are automatically 'drug-seeking'. Take symptoms seriously while assessing medication history, current substance use, interactions, dependence risk and safety. Stigma can discourage people from disclosing use and make safe prescribing harder.

A safer plan needs to replace the function

If someone relies on a substance to sleep or function through pain, simply removing it can expose the untreated symptom underneath. A realistic plan considers both: reducing substance-related risk and developing effective ways to manage the pain, sleep problem or fatigue that made use valuable.

Reflection

What physical symptom appears before use? What does the substance allow you to do — sleep, move, work, eat, concentrate or rest? How long does the benefit last? What happens when it wears off? These answers can help identify what needs assessment or replacement.

References & Further Resources

Pain, sleep and substance use can overlap with many physical and mental-health conditions. These resources support further understanding but do not replace individual assessment, particularly where dependence, severe pain, significant daytime sleepiness or overdose risk is present.

NICE - Medicines associated with dependence or withdrawal symptoms (NG215)

Guidance on safe prescribing and withdrawal management for opioids, benzodiazepines, gabapentinoids, antidepressants and Z-drugs.

NICE - Chronic pain (NG193)

Guidance on assessment and management of chronic primary pain, including person-centred assessment and treatment options.

NHS - Insomnia

Information about insomnia, common causes, self-help approaches and when to speak with a GP.

NHS - Drug addiction: getting help

Information on local drug treatment, assessment, talking therapies, medicines, detoxification and harm-reduction support.

NHS - Alcohol-use disorder

Information on harmful drinking, dependence, withdrawal and treatment, including the risks of abrupt withdrawal in physical dependence.

NHS - Opioids

Patient information about opioid medicines, side effects, dependence and safe use. Individual medicine advice should also be checked with the prescriber or pharmacist.

How to use these resources

A GP, pharmacist, pain service, sleep service or local drug and alcohol service may be appropriate depending on the underlying problem. If prescribed medicines are involved, discuss changes with the prescriber rather than stopping suddenly. Suspected overdose, severe breathing difficulty or unconsciousness requires emergency help via 999.