THE BALANCE

Sleeping Medication Dependence

Private treatment

A guide for individuals and families

Dedicated to one client at a time

MALLORCA / ZURICH

English / September 2026

01 / WHAT TO KNOW BEFORE TREATMENT

What to know before treatment

01 Sleeping medication dependence can arise during prescribed use, while tolerance and medication-use disorder are related but distinct patterns requiring individual assessment.

02 Treatment uses medically governed medication reduction alongside assessment of insomnia, mental health, pain, substance use, sleep disorders, routines, and travel demands.

03 THE BALANCE offers one-client residential care in Mallorca and Zurich, with coordinated prescribing, psychotherapy, CBT-I where appropriate, and continuing-care planning.

One client

A private residence and a team organized around you.

Coordinated care

Clinical disciplines work within one individual plan.

Continuity

The next steps are considered throughout treatment.

02 / UNDERSTANDING YOUR NEEDS

Understanding your needs

Dependence, Tolerance, and Sleeping-Pill Use Disorder

Physical dependence can occur during prescribed use and may produce withdrawal if the medicine is reduced too quickly. Tolerance means that the same dose has less effect over time. A medication-use disorder involves a broader pattern of impaired control and continued use despite harm.

Which Medicines Are Included?

The term sleeping medication can include benzodiazepines, Z-drugs, sedating antihistamines, certain antidepressants, antipsychotic medicines, melatonin products, and other prescribed or nonprescribed agents. They differ in evidence, risk, and withdrawal profile.

The assessment identifies every product, brand, dose, timing, formulation, prescriber, pharmacy, and over-the-counter supplement. International clients may know a medicine under a different trade name or use products that are unavailable in the country of treatment.

03 / ASSESSMENT BEFORE A RECOMMENDATION

Assessment before a recommendation

Medication dependence cannot be treated adequately without asking why sleep remains difficult. Causes may include chronic insomnia, anxiety, depression, trauma, bipolar-spectrum illness, pain, menopause, circadian disruption, sleep apnea, restless legs, stimulant use, alcohol, or environmental factors.

Assessment and Treatment Planning examines sleep timing, routine, naps, travel, devices, caffeine, substances, physical symptoms, medication, and psychiatric history. A sleep study or specialist assessment may be required.

Safety and the appropriate setting

Some sedative-hypnotic medicines can produce significant withdrawal, including rebound insomnia, anxiety, agitation, perceptual changes, confusion, or seizure. Risk depends on the medicine, dose, duration, pattern of use, medical history, and use of alcohol, opioids, or other sedatives. Admission depends on the medicine, dose, duration, withdrawal history, other substances, neurological and respiratory risk, psychiatric state, and available monitoring. Seizure risk, delirium, severe polysubstance withdrawal, overdose, or medical instability may require hospital care.

04 / CARE BUILT AROUND YOU

Care built around you

Cognitive Behavioral Treatment for Insomnia

Cognitive behavioral therapy for insomnia, often called CBT-I, is an established psychological treatment that addresses sleep-related behavior, timing, conditioned arousal, beliefs, and routines. It may include stimulus control, sleep scheduling, cognitive work, and relapse prevention.

CBT-I should be adapted when bipolar disorder, epilepsy, severe daytime sleepiness, eating disorders, or another medical condition affects sleep. It is not simply a set of generic sleep-hygiene tips.

Anxiety, Trauma, and Fear of Not Sleeping

Some clients become highly vigilant about sleep and interpret a difficult night as evidence that they will be unable to function. Others use medication to avoid nightmares, trauma-related arousal, or panic at night.

Psychological treatment can address these fears and the underlying condition while medication changes remain medically governed. Trauma processing should not be rushed during severe sleep deprivation or unstable withdrawal.

Setbacks During Medication Reduction

A difficult night or temporary increase in anxiety does not automatically mean that the plan has failed. Equally, persistent or severe deterioration should not be dismissed as something the client must endure. The responsible prescriber reviews the pattern and may slow or pause a reduction.

From assessment to a shared plan

The recommendation explains the proposed setting, priorities, team and pace, and how the plan will be reviewed with you.

05 / THE EXPERIENCE OF CARE

The experience of care

A calm private setting can create room for treatment, rest and reflection. The residence, schedule and practical support are organized around one client at a time.

A private place to pause

Personal space, discreet coordination and a daily rhythm shaped around clinical needs.

Care with room to recover

Individual appointments are balanced with rest, meals, movement and time to process.

Practical support

A personal care manager helps coordinate the schedule and everyday arrangements.

Care and residence imagery from THE BALANCE admissions guide. The residence is confirmed individually.

Mallorca

Private residential care in a restorative island setting.

Zurich

Private residential care with Swiss clinical coordination.

London

Selected assessment, transition and continuing-care support.

06 / FROM ASSESSMENT TO EVERYDAY LIFE

From assessment to everyday life

01

A confidential conversation

Admissions listens to your circumstances and explains the clinical review process.

02

Assessment and a recommendation

The team considers suitability, priorities, setting and the individual plan.

03

Personalized treatment

Care is reviewed and adjusted as your needs and capacity change.

04

Transition and continuing care

A handover connects treatment with the people, routines and support needed at home.

Preparing for home

Sleeping medicines may be controlled or differently regulated across countries. Before discharge, the client needs a realistic plan for prescribing, pharmacy access, travel documentation, quantity limits, and follow-up. Remote prescribing cannot be assumed across jurisdictions. A local physician or psychiatrist may be necessary after the client returns home. See International Continuing Care.

07 / CONSIDERING THE NEXT STEP

Considering the next step

Can sleeping pills cause dependence?

Yes. Physical dependence and tolerance can develop with some sleeping medicines, including during prescribed use. A broader medication-use disorder involves impaired control and continued use despite harm.

Should I stop sleeping medication immediately?

No. Abrupt discontinuation can be unsafe for some medicines and patterns of use. A prescriber should assess the medication, dose, duration, other substances, and withdrawal history.

How long does sleeping-pill withdrawal take?

There is no universal timeline. The medicine, dose, duration, co-used substances, sleep condition, and individual response determine the plan, which may continue after residential treatment.

Can insomnia be treated while medication is reduced?

Yes. The underlying sleep problem should be assessed and may be treated through CBT-I, psychiatric or medical care, routine changes, and management of pain, anxiety, trauma, or other contributors.

Begin with a conversation

Speak privately with Admissions about your circumstances and the options available. An enquiry carries no obligation to proceed.

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Full condition page

If you or someone else is in immediate danger, seek local emergency care. Do not wait for routine admission or travel.

General information; individual care follows assessment.