Chronic Insomnia

The treatment that works best is not a drug · and the advice most often given does not work at all

CBT-I is first-line
sleep hygiene alone is not treatment

⚠ THE TWO THINGS PRACTICE GETS BACKWARDS

⚠ SLEEP HYGIENE ALONE IS NOT TREATMENT

What patients are most often handed carries a **recommendation AGAINST use as a single-component therapy** -it lacks efficacy versus real behavioral treatment. **Adjunct only.** Offering a leaflet, then reaching for a hypnotic when it fails, is the commonest sequence in practice and **it skips the treatment with the best evidence entirely.**

CBT-I COMES FIRST, BY GUIDELINE

ACP recommends CBT-I as initial therapy, with drugs only if CBT-I alone is insufficient. Its advantage is **DURABILITY**: hypnotics work while taken, CBT-I changes the behaviors sustaining the insomnia so benefit persists after it ends. **⚠ Adding a drug is not automatically better** -guidance suggests **against combination** versus CBT-I alone. **Access, not evidence, is the barrier**, which is why digital CBT-I matters.

"SECONDARY INSOMNIA" IS OUTDATED

Insomnia alongside depression, pain or cancer was assumed to resolve once the primary problem was treated. **It frequently does not.** Treat it **in its own right and CONCURRENTLY** -that often improves the comorbid condition too, and treating insomnia in depression improves depression outcomes. **Waiting leaves a treatable problem untreated indefinitely.**

CBT-I COMPONENTS *and which one actually does the work*

Component	What it involves, and why
SLEEP RESTRICTION the active ingredient	**Limit time in bed to roughly the time actually slept**, then extend as sleep efficiency improves. Counterintuitive and resisted, but **the mild sleep deprivation consolidates sleep and rebuilds sleep drive. ⚠ Warn about first-week sleepiness and caution about driving**; use carefully in bipolar and seizure disorders, where sleep loss destabilizes
Stimulus control	**Re-associate the bed with sleep.** Bed for sleep and sex only; go to bed only when sleepy; **get out of bed if awake beyond ~20 min** and return only when sleepy; **fixed wake time daily**; no naps. The point is breaking the conditioning where the bedroom itself triggers arousal
Cognitive therapy	Targets the catastrophizing that maintains the cycle ("if I don't sleep I can't function tomorrow") -that anxiety is itself arousing and self-fulfilling. Corrects the belief that eight solid hours is required
Relaxation · hygiene	Progressive muscle relaxation and paced breathing for the racing mind. **Sleep hygiene is adjunct only** -sensible advice that does not treat the disorder alone

EXCLUDE THESE BEFORE TREATING

Consider	Why
⚠ Obstructive sleep apnea	**Screen BEFORE prescribing any sedative** -snoring, witnessed apneas, obesity, unrefreshing sleep. The most consequential miss here, because **hypnotics can worsen apnea and blunt arousal responses**
Restless legs	Urge to move the legs, worse at rest and in the evening, relieved by movement. Presents as trouble falling asleep, treated completely differently. **Check FERRITIN** -iron deficiency drives it
Circadian disorders	Delayed phase (younger) or advanced phase (older) is a **timing mismatch, not insomnia**. The clue: **sleep is normal when the schedule is unconstrained** -ask about weekends and holidays
Depression · anxiety	Strongly bidirectional. **Early-morning wakening** classically accompanies depression. Screen deliberately and treat both
Drugs & substances	Stimulants, activating antidepressants, corticosteroids, beta-agonists, decongestants, late diuretics, caffeine, nicotine. **And treat what is WAKING them** -nocturia, pain, reflux, orthopnea, hot flashes- rather than sedating through it. **⚠ ALCOHOL is the common self-treatment that makes it worse** -shortens latency, then fragments the second half of the night
Diagnosis itself	Clinical: **≥ 3 nights/week for ≥ 3 months + daytime consequences + ADEQUATE OPPORTUNITY**. Someone sleeping 5 h because they work two jobs has **insufficient opportunity, not insomnia**. A **1-2 week sleep diary** is the most useful instrument. **Polysomnography is NOT indicated** for uncomplicated insomnia

TWO THINGS THE WARDS GET WRONG *where residents actually write the order*

⚠ THE INPATIENT HYPNOTIC ORDER

A sedative started for hospital insomnia is a delirium risk, and is frequently continued at discharge, becoming a long-term prescription nobody intended. **Most inpatient insomnia is situational** -noise, light, overnight observations, an untreated symptom. **Fix the environment and the cause first**: cluster overnight care, minimize night-time vitals and draws where safe, reduce noise and light, and treat pain, nausea, dyspnea or nocturia. **⚠ If a hypnotic was started in hospital, address it explicitly in the discharge summary** with a stop date, or it becomes permanent.

SLEEP EFFICIENCY: THE NUMBER THAT DRIVES IT

Sleep efficiency = time asleep ÷ time in bed × 100. It is how sleep restriction is titrated, and it turns a vague plan into a protocol. **Set time in bed to average actual sleep time, with a floor of ~5-5.5 h**, keep the **wake time fixed**, and review weekly with the diary: **if efficiency exceeds ~85-90%, extend time in bed by 15-30 minutes**; if it stays low, hold or reduce. **Sleep improves before total sleep time does**, which is worth telling the patient so they do not quit in week two.

MEDICATION, IF NEEDED

⚠ Z-DRUG BOXED WARNING (2019)

Zolpidem, eszopiclone and zaleplon carry a boxed warning for **COMPLEX SLEEP BEHAVIORS** -sleep-walking, sleep-driving and other acts while not fully awake, causing serious injury and death. Two details prescribers miss: **these have occurred after a SINGLE dose at the LOWEST recommended dose**, so a low dose is not protection; and **a prior episode is now a CONTRAINDICATION** to further use. Also next-morning impairment, tolerance, rebound, and **falls and fractures in older adults**. Lowest dose, shortest course, **exit plan agreed at the time of prescribing**.

THE ALTERNATIVES

Orexin antagonists (suvorexant, lemborexant, daridorexant) **block wake-promoting orexin rather than sedating**, and **PRESERVE sleep architecture including REM** where benzodiazepines and Z-drugs suppress it; fewer safety concerns than GABA-A agents. **Contraindicated in narcolepsy. Low-dose doxepin** for sleep MAINTENANCE. **Ramelteon** for onset, no dependence. **Trazodone** widely used off-label on thin evidence. **⚠ AVOID benzodiazepines** and **⚠ antihistamines** (diphenhydramine, doxylamine, most OTC sleep aids) -both on **Beers**; tolerance develops within days and the anticholinergic burden brings confusion, retention and falls. **Ask specifically: patients don't report OTC aids as "medicines." Melatonin** is weak for insomnia, better for circadian problems.

PEARLS & PITFALLS

- **⚠ Deprescribing needs a warning delivered in advance.** Abrupt stopping causes **rebound insomnia worse than baseline**, which the patient reasonably reads as proof they need the drug. **Taper gradually, tell them the rebound is coming and temporary, and start CBT-I before or alongside the taper** -not after.

References: American College of Physicians clinical practice guideline on management of chronic insomnia disorder in adults · American Academy of Sleep Medicine guidance on behavioral and psychological treatments for chronic insomnia and on combination treatment · FDA boxed warning for complex sleep behaviors with eszopiclone, zaleplon and zolpidem (2019) · AGS Beers Criteria.

Educational aid; verify against current guidance, local formulary and patient factors.

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