Treatment of Chronic Insomnia in Adults: ACP Guideline

Key Points for Practice

- Cognitive behavior therapy should be the initial treatment option in persons with chronic insomnia.
- Data were insufficient to establish the comparative safety of one pharmacologic treatment over another.
- The choice to use medications should be based on shared decision making, and prescriptions should be limited to five weeks or less.

From the *AFP* Editors

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A diagnosis of chronic insomnia, also called chronic insomnia disorder, is based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., and the International Classification of Sleep Disorders. These indicate that symptoms occur three or more nights per week for three or more months and cause significant functional distress or impairment. The symptoms are not associated with other disorders, such as sleep or mental conditions. Only 6% to 10% of persons have insomnia with these criteria.

Treatment, which can include psychological or pharmacologic therapy, alone or combined, as well as complementary and alternative methods, is aimed at improving sleep, distress, and dysfunction. The American College of Physicians (ACP) has provided recommendations for treatment of chronic insomnia in adults.

Recommendations

Cognitive behavior therapy (CBT) should be the initial treatment option in persons with chronic insomnia. Although data were limited overall regarding psychological therapies, moderate-quality evidence indicated that CBT (e.g., in-person therapy, telephone and web-based therapy, self-help books) improved remission, response to treatment, wake after sleep onset, sleep onset latency, and sleep efficiency and quality. However, data were insufficient to establish whether one psychological treatment method was superior. In persons older than 55 years, who more commonly present with wake after sleep onset than sleep onset latency, moderate-quality evidence indicated that sleep index scores improved in those receiving CBT vs. those not receiving CBT. The harms of psychological treatment could not be established, although those that exist are probably mild.

If CBT is ineffective, the choice to use medications in the short term should be based on shared decision making that includes a conversation about the benefits, harms, and costs. Although most of the data were low quality, moderate-quality evidence showed that zolpidem (Ambien) improved sleep onset latency and total sleep time, and that compared with placebo, suvorexant (Belsomra) improved response to treatment, sleep onset latency, total sleep time, and wake after sleep onset, including in older persons. Doxepin improved some sleep parameters in older persons, including total sleep time, sleep onset latency, wake after sleep, and sleep index scores based on lower- to moderate-quality evidence.

The following therapies showed improvement in some sleep parameters based on lower-quality evidence: eszopiclone (Lunesta; general population and older persons), doxepin (general population), and ramelteon (Rozerem; older persons). Data were insufficient to establish the benefits of benzodiazepines, melatonin, diphenhydramine (Benadryl), and trazodone. Additionally, data were insufficient to assess the comparative effectiveness of medication use in general, including in older persons.

If prescribed, medications should be used for only five weeks or less. After this, the patient should revert to using tools acquired during CBT. Before deciding to continue medications, an evaluation for possible secondary causes of the insomnia (e.g., depression, substance abuse, restless legs syndrome) should be performed.

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If continued medication use is chosen, it should be reassessed periodically. Physicians should keep in mind that it is unclear whether medication use decreases the harmful health effects of insomnia, and that data are insufficient to determine the benefits and risks of their use in the long term.

Data were insufficient to establish the safety of a variety of pharmacologic treatments compared with each other. Observational studies indicate that hypnotics have been linked to serious adverse effects (e.g., dementia, fractures). The U.S. Food and Drug Administration provides labeling that outlines cognitive behavior changes and other adverse effects that may occur, and it recommends lower doses of these drugs in women and in older or debilitated persons, and short-term use in all persons. Because of greater medication sensitivity in older persons, physicians should monitor these patients more closely for adverse effects.

Data were insufficient to establish the safety and effectiveness of complementary and alternative methods for the treatment of chronic insomnia.

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