Insomnia

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KEYWORDS

• Chronotype • Cognitive behavioral therapy for insomnia (CBT-I) • Hyperarousal
• Primary insomnia • Restless legs syndrome • Short sleeper
• Sleep restriction therapy • Stimulus control

KEY POINTS

- To the general public and in primary care, "insomnia" refers to the symptom of difficulty sleeping; to sleep specialists and researchers, it refers to a subset in which common specific causes have been ruled out.
- Acute insomnia should be treated by addressing the underlying cause (if possible) and with safe, effective sleep medication, in part to prevent the development of chronic insomnia.
- Chronic insomnia is best approached via history and/or questionnaires to identify common specific causes that have specific treatments.
- Restless legs syndrome, sleep apnea, and circadian rhythm disorders such as delayed sleep phase syndrome (night owl) are common causes of insomnia presenting in primary care.
- Cognitive behavioral therapy for insomnia is considered first-line therapy for chronic insomnia that is otherwise unexplained (primary insomnia) or is associated with chronic psychological or medical conditions.

EVALUATION AND TREATMENT OF INSOMNIA

Definitions and Presentation

Insomnia as experienced by people and reported to physicians is, simply, difficulty sleeping. Insomnia is typically described in terms of dissatisfaction with, and distress from, the quality or quantity of sleep obtained, despite attempts to obtain sleep. Insomnia is common, affecting most people at some point in a year and 10% to 20% of people chronically, and is commonly associated with a wide range of psychosocial, psychiatric, medical, and underlying sleep disorders. Both short-term and long-term insomnia can impair daytime functioning, and chronic insomnia is associated bidirectionally with adverse health and social outcomes. As with other symptoms such as dizziness or pain, treatment of the symptom without consideration of the underlying condition can be ineffective and misdirected.

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This article focuses on evaluation and treatment of the symptom insomnia as self-reported by patients in primary care settings. History is the key to uncovering underlying patterns and associated symptoms to determine factors contributing to the insomnia (Table 1). In sleep medicine practices, this typically includes a sleep diary and validated questionnaires, but with a framework in mind one can obtain a useful direct history from the patient (Fig. 1). Nocturnal polysomnography (PSG) does not diagnose insomnia, and it does not distinguish between satisfied sleepers and those with chronic unexplained insomnia.[1] However, when sleep is described as fragmented or

Table 1
Causes of insomnia

	Exogenous Factors (Environment/ Medications)	Medical Symptoms and Conditions	Psychiatric	Sleep Disorder
Acute	Change in environment (new sleep environment) Jet lag Clock change Sunday night insomnia	Acute physical symptoms: Pain Urinary frequency Cough Nasal congestion	Hypomania, mania Anxiety Stress	—
Acute or chronic	Environment Noise Temperature Disruptive presence Discomfort Substances—licit or illicit Alcohol (hours after ingestion) Stimulants Caffeine Nicotine Medications—systemic Armodafinil, modafinil β-Agonists Bupropion Ciprofloxacin Corticosteroids Decongestants Diuretics Stimulants Thyroid hormones (in excessive doses)	Dyspnea (lung disease, heart failure) Gastroesophageal reflux disease Nocturia (consider OSA) Menopause, particularly with vasomotor symptoms	Anxiety Stress Grief Depression	See list below
Chronic	See list above	Chronic pain Chronic renal failure (associated with OSA, RLS)	Depression Bipolar disorder Anxiety Posttraumatic stress disorder ADHD Conditioned insomnia	RLS Sleep apnea (obstructive or central) Primary insomnia Circadian rhythm disorder