Purpose: To provide guidelines for the treatment of patients diagnosed with primary chronic insomnia.

Definition of insomnia: Insomnia is a condition characterized by difficulty falling or remaining asleep for a period of three or more weeks. Primary insomnia is a DSM-IV sleep disorder classification, which indicates that disturbed sleep is mainly primary in origin and not the direct cause of another medical, sleep disorder, or mental health condition. The patient may have other medical or mental health disorders but they do not play a central role in causing the sleep disturbance.

Causes: Causes of chronic insomnia are multifactorial, in which genetic predisposition, medical conditions, medications, sleep disorders, psychological conditions, conditioning, and poor sleep hygiene interact alone or together to predispose, precipitate, and perpetuate chronic insomnia. One of the most common causes of chronic insomnia, regardless of its precipitant, is conditioning, in which bedtime and the sleep environment is paired with frustration and wakefulness. A patient who experiences conditioned insomnia frequently verbalizes dread and anticipatory anxiety about sleep or fear about their ability to sleep.

Treatment: First, treat all underlying or predisposing conditions that may be contributing to the insomnia such as sleep apnea, restless leg syndrome, depression, or anxiety. Also identify and eliminate (when appropriate) OTC /prescriptions medications caffeine and other stimulants that may be contributing factors.

If underlying conditions are ruled out or treated and insomnia still remains a problem then nonpharmacological interventions should take precedence over pharmacological interventions for the treatment of chronic insomnia. Medications used to treat insomnia may cause daytime drowsiness and other adverse effects such as confusion, falls, and fractures. Long-term use of medications for treatment of insomnia may also result in dependence and tolerance.

Research increasingly supports sleep hygiene and other behavioral changes having long term benefits in treatment of insomnia. Medications have not been shown to have long term benefits.
**Sleep Hygiene**
There are several safe things one can do to help get a good night’s sleep. The most effective is to improve sleep “hygiene” or habits.

- Go to bed and wake up at around same times each day, even on weekends. Avoid naps.
- If you cannot fall asleep within 15 to 30 minutes after going to bed, get up and read or do some other relaxing activity until you feel tired.
- Reduce stress. Do something relaxing in the evening before bedtime.
- Avoid caffeine (especially after noon), alcohol, tobacco, and medicines that keep you awake.
- Alcohol and recreational drugs actually make insomnia more likely.
- Try drinking less water in the evening to avoid waking up to go to the bathroom during the night.
- Get regular exercise for 30-60 minutes at least 3 times a week, but do it at least 4-6 hours before bedtime.
- Reserve the bedroom only for sleep and sexual activity, not for watching TV or other activities
- Negative envisioning. Instead of trying to go to sleep, try to stay awake!
- Avoid disturbing content in books or media immediately prior to sleep. Plan 30 minutes of pleasant or relaxing activity prior to going to bed.
- The computer can act as a stimulant. Discontinue working or playing on the computer one hour prior to desired sleep onset.

**Cognitive Behavioral Therapy** remains the gold standard of insomnia therapy and is the only modality shown to have benefits beyond the time of treatment.

**Pharmacological Therapy**
If underlying conditions are ruled out or treated **AND** if the member has had an adequate trial and failure of sleep hygiene measures and other behavioral modifications, then pharmacological therapy may be considered.

**Recommended drug therapy**
1. Trazodone (Desyrel)
   a. Starting dose: 25-50mg at bedtime increasing as needed by 50mg increments to no more than 200mg at bedtime.
   b. Geriatric dose: 25mg at bedtime increasing as needed to no more than 100mg at bedtime. Trazodone is contraindicated in members with orthostatic hypotension.
2. Mirtazapine (Remeron)
   a. Starting dose: 15mg at bedtime increasing as needed by 15mg increments to no more than 30mg at bedtime. At doses of greater than 30 mg, adrenergic effects start to predominate. Geriatric patients should start on 7.5 mg at bedtime.