Practice Guidelines

Behavioral and Psychological Treatments for Chronic Insomnia Disorder: Updated Guidelines From the American Academy of Sleep Medicine

Key Points for Practice

- CBT for insomnia and brief therapies for insomnia improve sleep quality and increase remission in chronic insomnia disorder.
- Stimulus control, relaxation therapy, and sleep restriction therapy are components of CBT for insomnia that appear effective on their own.
- Sleep restriction can transiently increase fatigue and impair concentration and should be avoided in patients with high-risk occupations or with increased risk of mania or seizures.
- Typical sleep hygiene education is minimally effective in chronic insomnia disorder.

From the *AFP* Editors

Chronic insomnia is a common sleep disorder that causes impairment, and treatment historically has been limited to sleep hygiene recommendations. The American Academy of Sleep Medicine has updated its clinical practice guidelines on behavioral treatments for chronic insomnia disorder.

CBT for Insomnia

Cognitive behavior therapy (CBT) for insomnia has the best evidence for clinical treatment of chronic insomnia disorder. In CBT for insomnia, qualified therapists combine cognitive therapy strategies with stimulus control instructions and sleep restriction therapy. Often, CBT for insomnia also includes sleep hygiene education and relaxation therapy. It usually takes between four and eight sessions and requires the patient to keep sleep diaries to track adjustments and progress.

CBT for insomnia increases remission in chronic insomnia disorder compared with control while reducing sleep latency and increasing sleep time. Benefits appear to be durable over time and include a reduced need for medications. Harms of CBT for insomnia include transient increases in fatigue with irritability and cognitive disturbances. The sleep restriction element of therapy may be contraindicated for high-risk occupations and in patients predisposed to mania or seizures.

Shorter Therapies Based on CBT

BRIEF THERAPIES FOR INSOMNIA

Brief therapies for insomnia are abbreviated versions of CBT for insomnia that typically include one to four sessions. These brief therapies typically consist of education, stimulus control, and sleep restriction recommendations tailored to the patient based on pretreatment sleep diaries. Education focuses on sleep regulation and factors that influence sleep. Brief therapies for insomnia have moderate-quality evidence for increasing remission of chronic insomnia and improving sleep quality.

STIMULUS CONTROL

Stimulus control is a set of instructions to restore the association between the bedroom and sleep by ensuring patients go to bed only when sleepy, leave the bedroom when unable to sleep, and use the bedroom only for sleep and sex. Patients should wake at the same time every morning and refrain from napping to establish a consistent sleep routine. Stimulus control has low-quality evidence of increasing remission of chronic insomnia without evidence of improving sleep quality.

Coverage of guidelines from other organizations does not imply endorsement by *AFP* or the AAFP.

This series is coordinated by Michael J. Arnold, MD, contributing editor.

A collection of Practice Guidelines published in *AFP* is available at https://www.aafp.org/afp/practguide.

CME This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 15.

Author disclosure: No relevant financial affiliations.

SLEEP RESTRICTION THERAPY

Sleep restriction enhances sleep drive and consolidates sleep by limiting the time in bed to the average sleep duration from sleep diaries. Time in bed is then increased or decreased based on sleep efficiency thresholds until sufficient sleep duration and satisfaction are achieved. Sleep restriction therapy used by itself has low-quality evidence of increasing remission of chronic insomnia without evidence of increasing sleep quality. Harms of sleep restriction include transient increased daytime sleepiness and reduced concentration.

RELAXATION THERAPY

Relaxation therapy consists of structured exercises such as progressive muscle relaxation to release somatic tension and meditation to reduce cognitive arousal. Relaxation therapy has low-quality evidence of increasing sleep quality without evidence of increasing remission of chronic insomnia disorder.

OTHER THERAPIES

Sleep hygiene, a set of general recommendations about diet, exercise, substance use, and environmental factors that promote or interfere with sleep, is not recommended as a single-component therapy. In studies that included sleep hygiene as a control, sleep hygiene education was less effective than other treatments. In one study, sleep hygiene education was more effective than a wait-list control but less effective than CBT for insomnia.

The evidence is insufficient for the use of cognitive therapy (such as psychoeducation and Socratic questioning), paradoxical intention, mindfulness, biofeedback, and intensive sleep retraining as single interventions.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Uniformed Services University of the Health Sciences, Department of Defense, or the U.S. government.

Editor's Note: These recommendations expand on recommendations *AFP* summarized from the U.S. Departments of Veterans Affairs and Defense (https://www.aafp.org/afp/2021/0401/p442.html) that endorse CBT for insomnia in patients with chronic insomnia and recommend against sleep hygiene education alone. The American Academy of Sleep Medicine guideline further explores the literature and points out that fewer sessions and less expensive therapies also have evidence of benefit. A 2015 article on nonpharmacologic management of insomnia (https://www.aafp.org/afp/2015/1215/p1058.html) introduces all the treatments discussed but does not include the evidence from this guideline.—Michael J. Arnold, MD, Contributing Editor

Guideline source: American Academy of Sleep Medicine

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

Recommendations based on patient-oriented outcomes? Yes

Published source: *J Clin Sleep Med*. February 1, 2021;17(2):255-262

Available at: https://jcsm.aasm.org/doi/10.5664/jcsm.8986

Michael J. Arnold, MD
Uniformed Services University of the Health Sciences
Bethesda, Md.
Email: michael.arnold@usuhs.edu ■