

**wFAST FACTS AND CONCEPTS #104**  
**INSOMNIA: NON-PHARMACOLOGIC TREATMENTS**  
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**Introduction** This *Fast Fact* addresses non-pharmacologic therapies for insomnia; *Fast Fact* #101 discusses patient assessment and #105 discusses pharmacologic treatment of insomnia.

**Non-Specific Treatments**

- I. **Improving Sleep Hygiene** Sleep hygiene education should be provided to anyone with insomnia. First, there is no arbitrary rule for how much someone should sleep. Generally, older patients need less sleep. Second, patients should be advised to keep a regular sleep schedule; this means going to bed and getting up at the same time. Third, patients should avoid long daytime naps, alcohol, and caffeine. These principles may be difficult for seriously ill patients, particularly maintaining a regular routine for hospitalized patients and avoiding naps for fatigued, seriously ill patients.

II. **Behavioral Treatments**

- Relaxation therapies: The patient can be taught to use various relaxation techniques just prior to bedtime such as progressive muscle relaxation, guided imagery, meditation, diaphragmatic breathing or hypnosis (see *Fast Fact* #211).
- Stimulus control therapy: This focuses on establishing a connection between the bed and sleep. It emphasizes not watching TV, reading in bed, or using bedroom for any other activity (except sexual activity).
- Sleep restriction therapy: This therapy requires patient motivation as it involves restricting the time allowed in bed depending upon the actual time spent in bed over the past 2 weeks and then going to bed 15 minutes earlier every night (increased weekly) until the target bedtime is achieved. Sleep compression therapy is a variant of sleep restriction but the reduction in sleep is made gradually.
- Cognitive behavioral therapy: This is a multi-component psychotherapy, and includes sleep restriction, stimulus control and cognitive therapy which focuses on identifying unwanted feelings or thoughts and replacing them with more positive thoughts. It is effective in treating chronic insomnia in the general population, in patients with chronic pain, and in women with metastatic breast cancer.

*The last two therapies are the only evidence-based psychological treatments for insomnia in older adults.*

- III. **Physical Exercises**: Although the data is limited, studies in elderly patients suggest significantly improved sleep duration and onset latency and minimal enhancement in sleep efficiency with community-based endurance training programs such as low impact aerobics, brisk walking, and Tai Chi Chih.

Choosing which therapy to use first depends mainly on provider experience and patient motivation. It is difficult to know how long non-pharmacologic therapy should be tried before attempting other measures. This depends on the patient, the severity of the insomnia, or the severity of the illness. Many studies which showed cognitive behavioral therapy to be effective used a treatment regimen of 7-8 weeks.

**Specific Treatments** *Obstructive sleep apnea* is treated with positive airway pressure (e.g., 'CPAP') ventilation at night. Although some patients report difficulty becoming accustomed to sleeping with the CPAP mask on, this therapy can dramatically improve symptoms. Surgery is sometimes indicated for obstructive sleep apnea. *Symptoms* from an underlying medical disorder can also contribute to insomnia. Adequately treating a patient's pain, nausea and vomiting (See *Fast Fact* #5), or dyspnea (See *Fast Fact* #27) should improve sleep.

*Spiritual and existential concerns* can be an important cause of insomnia in palliative care patients. Patients may be able to avoid these concerns during the day through the distraction of

daily activities but have difficulty ignoring them at night. Thus, it is important to directly address a patient's spiritual concerns, worries, and fears about dying during the day. Brief psychotherapy may be helpful.

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