

Insomnia

A plain-English guide for you and your family

WHAT IS HAPPENING

Insomnia is when you have trouble falling asleep, staying asleep, or waking up too early — and it happens at least three nights a week for three months or more. You feel tired during the day, but your brain won't let you sleep at night. It starts when stress, worry, or a big life change flips on your brain's alarm system (the amygdala) and keeps it on. Night after night, lying awake teaches your brain that bed equals danger, not rest. Your stress-brake (the prefrontal cortex, the front part of the brain that calms you down) gets worn out and stops working well. The longer this goes on, the harder it is to break the cycle. During the day you feel foggy, moody, and exhausted because your brain never got the deep sleep it needs to recharge. The best first treatment is CBT-I, a short talk therapy that retrains your sleep habits and thoughts. It works better than sleeping pills in the long run and keeps working after you stop. If another condition (like depression, sleep pauses in breathing (apnea), or chronic pain) is part of the picture, treating that helps too. Sleep pills can help for a few nights in a crisis, but they don't fix the root problem and can become a trap if used too long.

What you might feel

- Trouble falling asleep at bedtime (taking more than 30 minutes most nights)
- Waking up in the middle of the night and lying awake for a long time
- Waking up too early in the morning and not being able to fall back asleep
- Feeling tired, foggy, or irritable during the day
- Worry or frustration about sleep itself
- Needing sleeping pills or alcohol to fall asleep
- Loud snoring, gasping, or breathing pauses noticed by a bed partner
- Uncontrollable leg movements or a crawling feeling in the legs at night

Call the doctor right away if...

- Loud snoring with witnessed pauses in breathing or gasping (suggests obstructive sleep pauses in breathing (apnea), which needs a sleep study and treatment to prevent heart problems and stroke)
- Sudden extreme daytime sleepiness or falling asleep at unsafe times like driving (may signal narcolepsy or severe sleep pauses in breathing (apnea))
- New insomnia with chest pain, severe headache, confusion, or thoughts of suicide (could be a heart problem, brain issue, or severe depression needing urgent care)
- Uncontrollable leg movements or crawling sensations that will not let you lie still (suggests restless legs syndrome or periodic limb movement disorder, which need specific treatment)
- Insomnia starting after a new medication or sudden medication stop (some drugs disrupt sleep or cause rebound insomnia)

What the care team will do

- Screen for obstructive sleep pauses in breathing (apnea) with the STOP-BANG questionnaire and refer for sleep study if score is 3 or higher before starting insomnia treatment
- Ask about suicidal thoughts using a direct question like 'Have you thought about hurting yourself?' and activate crisis protocol if the answer is yes
- Review all current medications, over-the-counter drugs, caffeine, and alcohol with times taken, and work with the provider to stop or retime any that disrupt sleep
- Give the patient a two-week sleep diary to record bedtime, wake time, time to fall asleep, and nighttime awakenings before the next visit
- Teach stimulus control instructions: use the bed only for sleep and sex, get out of bed if not asleep within 20 minutes, and return only when sleepy
- Refer the patient to a CBT-I program—digital, phone-based, or in-person—within two weeks and explain that it works better than sleeping pills long-term
- If the provider prescribes a dual orexin receptor antagonist or low-dose doxepin, teach the patient to take it 30 minutes before bedtime with at least 7 hours available for sleep and to avoid driving or operating machinery if drowsy the next morning
- Schedule a two-week follow-up to review the sleep diary, assess treatment response, and screen for worsening mood or new safety concerns

Medicines you may be given — and why

Cognitive Behavioral Therapy for Insomnia (CBT-I)

CBT-I is a structured program that teaches you new sleep habits and fixes thoughts that keep you awake. It works by retraining your brain to link bed with sleep instead of worry. You learn to go to bed only when truly sleepy, leave the bed if awake more than 20 minutes, wake at the same time every day, and replace anxious thoughts (like 'I'll never sleep') with calmer ones. This resets the connection between your bed and falling asleep, strengthens your natural sleep drive, and calms the alarm centers in your brain that fire at night. CBT-I can be done with a therapist in person, through a computer program, or with a trained counselor.

Suvorexant (Belsomra) or Lemborexant (Dayvigo)

Orexin is a brain messenger made in the hypothalamus (the brain's control center for sleep and wake) that keeps you alert and awake. Suvorexant and lemborexant block orexin from reaching its receptors, so the wake signal quiets down and your brain can shift into sleep mode. Unlike older sleep pills that force sedation, these drugs simply turn down the wake drive, letting natural sleep take over. They help you fall asleep and stay asleep without hangover grogginess the next day.

Doxepin 3-6 mg

At very low doses (3 to 6 mg), doxepin blocks histamine H1 receptors in the brain. Histamine is a wake-promoting messenger made in the tuberomammillary nucleus (a small cluster in the hypothalamus). By blocking histamine, doxepin turns down the wake signal and helps you stay asleep, especially in the second half of the night. At these tiny doses, doxepin has almost no effect on serotonin or norepinephrine (other brain messengers), so it does not cause the side effects seen with full antidepressant doses.

Melatonin 0.5-5 mg

Melatonin is a natural hormone made by the pineal gland (a tiny gland deep in the brain) when it gets dark outside. It signals to your suprachiasmatic nucleus (the master clock in the hypothalamus) that night has arrived, shifting your body into sleep mode. Melatonin supplements add extra melatonin to help realign your circadian rhythm (your internal 24-hour clock) when it is out of sync—for example, after jet lag, shift work, or if you are a night owl trying to go to bed earlier. Melatonin works best for circadian misalignment, not for anxiety-driven insomnia.

Zolpidem (Ambien), Eszopiclone (Lunesta), or Zaleplon (Sonata)

These drugs boost GABA (the brain's main calming signal) by binding to GABA-A receptors, especially the alpha-1 subtype that controls sedation and sleep onset. GABA-A receptors are

like dimmer switches all over the brain; when GABA attaches, chloride ions flow into neurons, making them less excitable and quieter. Z-drugs amplify this effect, turning down the brain's arousal networks and helping you fall asleep quickly. Unlike benzodiazepines (like temazepam), Z-drugs are more selective for the alpha-1 subtype, so they cause less muscle relaxation, less memory impairment, and less next-day hangover—though these side effects can still happen.

Where this information comes from

- American Academy of Sleep Medicine (AASM) clinical practice guideline for chronic insomnia 2021
- AASM clinical practice guideline for pharmacologic treatment of insomnia 2017
- Cochrane Database systematic review on cognitive behavioral therapy for insomnia
- NEJM clinical review on insomnia disorder 2020

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