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MADISON NEUROLOGY LLC

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Insomnia Disorder

Patient education guide · Sleep Disorders · Madison Neurology LLC

What is it?

Insomnia disorder is persistent difficulty falling asleep, staying asleep, or waking too early — at least 3 nights per week for 3 months — despite adequate opportunity, with daytime consequences (fatigue, poor concentration, irritability). Chronic insomnia feeds itself: anxiety about sleep becomes the very thing preventing it. It is eminently treatable, and the best treatment is not a pill.

How does it happen?

Insomnia usually begins with a trigger (stress, illness, shift work, grief) and then perpetuates through conditioned arousal — the bed becomes associated with frustration and wakefulness. Contributing factors: irregular schedules, caffeine late in the day, alcohol (fragments sleep), screens in bed, untreated sleep apnea or restless legs, mood disorders, and certain medications.

Common symptoms

- Difficulty falling asleep (sleep-onset) or frequent/long awakenings (sleep-maintenance)
- Waking too early and unable to return to sleep
- Daytime fatigue, poor concentration, irritability, and low mood
- Dreading bedtime; 'trying hard' to sleep and failing
- Worrying about sleep during the day

How is it diagnosed?

Diagnosis is clinical, from the sleep history; a 1-2 week sleep diary clarifies the pattern. Evaluation screens for perpetuators and mimics (sleep apnea, restless legs, circadian disorders, mood disorders). Sleep studies are not needed for typical insomnia but rule out coexisting apnea when suspected.

How is it treated?

Cognitive Behavioral Therapy for Insomnia (CBT-I) is the first-line treatment recommended by every major guideline — more effective long-term than any sleeping pill. Its core: stimulus control (bed = sleep only), sleep restriction tailored to actual sleep ability, and restructuring catastrophic sleep thoughts. Digital CBT-I programs make it accessible without a specialist. Medications have a role short-term or in selected cases (dual orexin receptor antagonists — suvorexant, lemborexant, daridorexant — are modern, lower-dependence options; low-dose doxepin for maintenance insomnia), while older hypnotics are used cautiously. Caffeine cutoff, morning light, regular exercise, and limiting alcohol support all of it.

What does the future hold?

CBT-I works: 70-80% of patients improve meaningfully, with gains that outlast treatment because the skills are permanent. Relapses under stress are normal and respond to reapplying the techniques. Chronic insomnia that is properly treated does not have to be a life sentence.

Questions patients commonly ask

Q: Why is therapy recommended over sleeping pills?

A: Pills treat tonight; CBT-I fixes the mechanism — guidelines place it first because its benefits persist after treatment ends, without dependence.

Q: I've tried 'sleep hygiene' and it didn't work — how is CBT-I different?

A: Sleep hygiene alone rarely fixes chronic insomnia; CBT-I's active ingredients (stimulus control and sleep restriction) retrain the sleep drive directly.

Q: Will I become dependent on sleep medication?

A: Modern orexin antagonists have low dependence potential, but the goal remains skills-first: medication as a bridge, CBT-I as the foundation.

National support groups & resources

- **American Academy of Sleep Medicine — Sleep Education** — sleepeducation.org
- **American Sleep Apnea Association** — sleephealth.org
- **American Academy of Neurology — Brain & Life patient resources** — brainandlife.org

(Organization contact details were current at the time of compilation; please verify online.)

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