

**Psychiatry · Educational evidence summary**

Anticholinergic burden and insomnia treatment

This psychiatry article focuses on anticholinergic burden and insomnia treatment.

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Three ways of describing a sleep medicine

A medicine used at night can be described by its evidence for insomnia, its classification in an anticholinergic scale, and a geriatric prescribing criterion. These descriptions may look inconsistent if their questions are not stated. The insomnia evidence asks about defined sleep outcomes in a studied population. The scale categorizes a medicine using source-specific methods. A geriatric criterion addresses potentially inappropriate use in a specified context.

This comparison explains how those layers fit together. It is not a ranking of sleep medicines and does not provide a treatment plan. The aim is to avoid translating “used for sleep” into either automatic reassurance or automatic prohibition.

What insomnia trial evidence is measuring

Trials may evaluate sleep onset, sleep maintenance, total sleep time, or another defined outcome. Evidence for one outcome should not be casually generalized to all of them. A nighttime effect that is subjectively noticeable is also not automatically evidence of improvement in the outcome a guideline considered.

The AASM's 2017 pharmacologic guideline made a weak recommendation for doxepin for sleep maintenance and a weak recommendation against diphenhydramine for chronic insomnia. Its recommendations were linked to the studied doses and outcomes, not to an anticholinergic burden cutoff. [AASM pharmacologic insomnia guideline, 2017](#)

That example illustrates why an efficacy assessment cannot be reconstructed from the scale column. A medication can have a specific evidence-supported role while still requiring attention to its preparation, dose, population, and adverse-effect profile. The full treatment assessment extends beyond whether it helps someone become drowsy.

What an anticholinergic scale contributes

A source-specific scale can make an exposure contributor visible in the medication history. It does not usually describe the individual's sleep pattern or measure the next morning's functioning. A category may also be ingredient-level rather than a dose-response model.

Therefore, a change in dose need not change the displayed source value even though the clinical exposure history has changed. Conversely, a different source value does not prove that the person's



current sleep medicine has become more harmful. It may reflect a different publication or classification method. Both situations require the method and version to be retained.

Why the doxepin qualification matters

The 2023 Beers antidepressant criterion distinguishes doxepin above 6 mg per day. That is a dose-qualified statement for older adults. It should not be stripped of its dose condition or used to overwrite an ingredient's score in another source. [AGS Beers Criteria, 2023](#)

When the dose is unknown, the correct next step is to clarify the total daily dose before interpreting that criterion. It is not appropriate to assume the higher-dose condition applies because the ingredient is present, or to assume it does not apply because the prescription was described as “for sleep.” The indication label cannot replace the missing dose.

Over-the-counter products still require ingredient identification

Products marketed for nighttime use can be recognized by a brand name rather than their active ingredients. A medication review should identify the actual formulation and whether another product duplicates an ingredient. The relevant evidence attaches to those ingredients and products, not to the marketing description.

This step is particularly helpful when an occasional sleep product is absent from the formal prescription list. The review should record actual frequency and timing. A product kept in a cupboard, a single recent dose, and nightly use are not interchangeable exposure histories, even when all involve the same ingredient.

A comparison without an unsupported winner

Suppose two medicines are being discussed for a sleep-related concern. First state the question: sleep onset, sleep maintenance, daytime experience, or medication tolerability. Then examine the relevant treatment evidence. Separately, retrieve the exact source observations and any qualified geriatric criteria.

The resulting summary may contain a source difference without identifying a universally preferable option. That is an honest result. The anticholinergic evidence does not contain every consideration relevant to sleep care, including the reason for the sleep difficulty, other treatments, co-medications, and the person's prior experience.

No averaging across scales can solve this problem. An average would change the measurement while leaving the missing treatment context unresolved. A clearer comparison describes what each source contributes and what remains outside its scope.

Evaluate the next day as a separate outcome

If the concern is morning concentration or daily function, name that outcome explicitly. A report of improved sleep and a report of unwanted next-day effects can coexist. Neither should be erased because the other is easier to summarize.

Similarly, a lower burden classification after a treatment change does not itself demonstrate that sleep or daytime function improved. The treatment goal, observed experience, and source evidence need parallel documentation. This makes follow-up interpretable and prevents a category change from becoming a surrogate for every outcome that matters.



A compact comparison note can preserve three separate entries: the sleep outcome and population addressed by a guideline, the medicine's observation in a named anticholinergic source, and any applicable geriatric qualification. Leave a field unresolved when its information is unavailable. Do not let an empty source cell acquire the meaning of a favorable trial result, or let an unfavorable burden category erase evidence about sleep maintenance. This separation allows the prescribing discussion to consider all three questions without falsely treating them as one scale.

Boundaries of this comparison

The cited insomnia guideline concerns adults; the Beers criterion concerns older adults. Neither supplies a pediatric rule, and neither establishes patient-specific safety from the ingredient name alone. This article also does not evaluate every available insomnia intervention or recommend starting, stopping, or changing medication.

The useful conclusion is that the apparent contradiction often disappears once the questions are separated. Efficacy for a particular sleep outcome, an anticholinergic source category, and a dose-qualified geriatric criterion can all be reported accurately on the same page.

References

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Explore the evidence

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