# Sleep and Insomnia

THE TALKING THERAPIES UK SELF-HELP SERIES



# Sleep and Insomnia

An eight-module CBT-I programme for understanding sleep, breaking the cycle of insomnia, and rebuilding the kind of sleep you can rely on

A self-help workbook · 8 modules · about 8 weeks

**TALKING THERAPIES UK**

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First edition, 2026.

This workbook accompanies the Sleep and Insomnia programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 9. This printing was set on 15 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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# How to use this workbook

Insomnia is one of the most common difficulties adults bring to mental health services, and one of the most treatable. Cognitive Behavioural Therapy for Insomnia (CBT-I) is the first-line treatment recommended by the National Institute for Health and Care Excellence (NICE), the American College of Physicians, and the European Sleep Research Society for chronic insomnia in adults. It is more effective than sleep medication for long-term improvement, and its effects persist after the treatment ends, unlike medication which works only while it is being taken. The British Sleep Society and the British Association for Behavioural and Cognitive Psychotherapies both endorse CBT-I as the standard psychological intervention for insomnia. This eight-module programme teaches the standard CBT-I approach in a structured self-paced format. The model and the methods are those used by sleep services in the NHS and in private practice; the format is self-directed rather than therapist-led. Understanding insomnia. The first conceptual move is recognising that insomnia is not a problem of being unable to sleep. Insomnia is a problem of conditioned arousal: a state in which the bed and the bedtime routine have become associated with wakefulness and effort rather than with sleep. The body is fully capable of sleeping; the system has learned to be activated rather than relaxed in the situation where sleep should occur. Once you see this, the work changes shape: it is not about making yourself sleep, which cannot be done by direct effort, but about retraining the system to associate the bed with sleep and breaking the cycle of arousal that maintains insomnia. Stimulus control therapy. The most evidence-supported behavioural intervention for insomnia is stimulus control, a precise protocol developed by Richard Bootzin in the 1970s and refined since: only go to bed when sleepy, only use the bed for sleep, get up if not asleep within twenty minutes, get up at the same time every morning regardless of how the night went, and avoid daytime napping. The protocol is simple to state and demanding to implement, but it works: within four to six weeks of consistent application, most people see substantial improvement. Sleep restriction therapy. The second behavioural pillar is sleep restriction, which works by initially reducing the time spent in bed to match the actual time spent asleep, building a strong sleep drive, and then gradually expanding the sleep window as sleep efficiency improves. Counterintuitively, spending less time in bed produces more sleep, because the body adapts to the new schedule and develops the deep sleep that has been missing. Cognitive techniques. Sleep is heavily affected by cognitive patterns: catastrophic thoughts about the consequences of poor sleep (‘I will not be able to function tomorrow’, ‘this is going to ruin my health’), excessive monitoring of sleep state during the night, and rigid beliefs about how much sleep is necessary (‘I need eight hours or I cannot cope’). The cognitive modules work with these patterns using the same evidence-testing approach as CBT for depression and anxiety, calibrated specifically for sleep-related cognition. Sleep hygiene done properly. The popular advice about sleep hygiene (avoid caffeine, avoid screens, dark room, cool room) is mostly correct but tends to be misapplied. Sleep hygiene is the foundation of sleep, not the treatment of insomnia; treating chronic insomnia with sleep hygiene alone is like treating a chest infection with hand-washing. The programme covers the practical hygiene factors that genuinely matter, explains why some popular advice does not deserve the emphasis it gets, and integrates the hygiene work with the more powerful behavioural and cognitive interventions. Wind-down and arousal management. A substantial part of the programme is dedicated to the pre-sleep period, where arousal levels need

to be coming down rather than maintained or rising. This includes the practical wind-down routine, the management of the racing-mind problem that affects many insomnia sufferers, and the structured worry-postponement work for people whose insomnia is driven by night-time rumination. When sleep difficulties indicate something else. Not all sleep difficulty is insomnia. Sleep apnoea, restless legs syndrome, parasomnias, and the sleep disturbance that comes with depression or anxiety disorders all present differently and need different responses. The programme includes a clear guide to when sleep difficulties indicate something that requires medical or psychological assessment rather than self-paced CBT-I. Who this is for and what it is not. The programme is suitable for adults experiencing chronic insomnia (difficulty falling asleep, staying asleep, or both, for at least three nights per week for at least three months) where the picture is not complicated by an untreated sleep disorder, severe depression, an active anxiety disorder requiring its own treatment, or substantial substance use. If your sleep difficulty has emerged recently and is connected to a specific life event, the programme can still help, though shorter and more general stress-management approaches may be sufficient. If you suspect sleep apnoea, including loud snoring, witnessed pauses in breathing, or daytime somnolence despite a full night in bed, please see your GP before starting this programme; CBT-I assumes the breathing apparatus is functioning normally during sleep.

This workbook is the written form of the Sleep and Insomnia programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

### When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

## What this workbook will help you to do

- By the end of this module you will:
- Understand what sleep is doing for the body and mind, and why insufficient sleep has the costs it does
- Know the structure of a normal night's sleep and the two-process model of sleep regulation
- Understand the 3P model of insomnia and recognise the perpetuating factors that keep it going
- Have set three goals for what this programme should change
- Know how to keep a structured sleep diary in the format used in CBT-I research and clinical practice
- Understand sleep efficiency as the central single measure of sleep quality
- Recognise the four common patterns of insomnia and know which one (or combination) describes your sleep
- Have started a fortnight's daily sleep diary that the rest of the programme will use
- Know which lifestyle factors have the largest evidence base for sleep quality

PART 1

# Understanding Sleep

*What sleep does, how it is structured, and the two-process model that explains why insomnia gets stuck*

CHAPTER 1

## Welcome to the programme

This is an eight-module programme for understanding sleep and breaking the cycle of insomnia. The approach is Cognitive Behavioural Therapy for Insomnia, usually shortened to CBT-I, and it is the first-line treatment for chronic insomnia recommended by NICE, the British Sleep Society, and most contemporary clinical guidelines. The evidence base is extensive: across decades of randomised controlled trials, CBT-I produces durable improvements in sleep that match or exceed sleeping medication, with the additional advantage that the gains do not fade when the treatment ends and there are no withdrawal effects to manage. For most adults with chronic insomnia, CBT-I is what works.

The programme is not gentle in the way that some sleep advice can be. The two most effective single interventions in CBT-I (stimulus control in module four, and sleep restriction in module five) ask the client to do things that feel counter-intuitive and that often produce a worse week or two of sleep before producing a better four. People who push through the difficult phase typically end up with the kind of sleep they had been hoping for; people who back off when it gets uncomfortable typically continue with the same insomnia they came in with. This is worth knowing at the outset because the work is not light, and a clear-eyed sense of what the programme is asking matters from module one.

**A NOTE**

*A note on what the programme is not. It is a self-directed programme aimed at people whose insomnia is primarily psychological in origin: the kind that develops after a stressful period, that becomes self-sustaining through worry about sleep itself, and that does not have a clear medical cause. The programme is not the right approach if your sleep difficulty is due to obstructive sleep apnoea (loud snoring, witnessed apnoeas, daytime sleepiness despite adequate time in bed), restless legs syndrome (uncomfortable sensations in the legs that drive movement), narcolepsy, parasomnias such as sleepwalking or REM sleep behaviour disorder, or significant pain that prevents sleep. The final module of the programme covers when to step up; if any of the above describes your situation, a conversation with your GP about a sleep-clinic referral is the right next step rather than this self-help work.*

This first module sets out what sleep is, why it matters, and how insomnia gets stuck. The structure that follows is the standard CBT-I curriculum: assessment in module two, the lifestyle and environmental factors in module three, the two core behavioural interventions in modules four and five, the cognitive work in modules six and seven, and the maintenance plan in module eight.

CHAPTER 2

# What sleep is doing

Sleep is not the absence of activity. It is one of the most metabolically active states the body produces, with specific functions that nothing else in waking life can deliver. The functions are well-mapped in the contemporary sleep literature.

Memory consolidation. During sleep the brain replays the day's experiences, transferring relevant information from short-term to long-term storage and pruning what is no longer needed. The transfer happens primarily during slow-wave sleep (the deepest non-REM stage). People who sleep poorly retain less of what they learned during the day, and the effect is measurable in everything from exam performance to procedural skill learning to emotional memory.

Emotional regulation. During REM sleep the brain processes the emotional content of recent experiences, gradually decoupling memories from the emotional charge attached to them at the time. People who sleep insufficiently retain the emotional charge of difficult experiences for longer, find their mood more reactive to small triggers, and develop more anxiety symptoms over time. The relationship between sleep and mental health runs in both directions: poor sleep produces worse mood, and worse mood produces poor sleep, and the cycle entrenches when both are present.

Physical repair and growth. During slow-wave sleep the body releases growth hormone, repairs tissue, restores energy stores, and runs the maintenance work that the waking body cannot do at the same time as everything else it is doing. The repair includes muscle, bone, and the immune system. People who chronically under-sleep have measurably worse wound healing, greater susceptibility to infection, and a longer recovery from any given physical demand.

Glymphatic clearance. During sleep, particularly slow-wave sleep, the brain runs a fluid-clearance system that removes metabolic waste products accumulated during waking. The waste products include the protein fragments that, when they accumulate, are associated with neurodegenerative conditions over very long timescales. This finding is recent and the long-term implications are still being mapped, but the mechanism is now well-established.

Cardiovascular and metabolic regulation. Blood pressure drops during sleep and the cardiovascular system gets a recovery period that the daytime does not provide. Insulin sensitivity improves overnight. Hormonal balance is restored. Chronic short sleep is associated with measurable increases in cardiovascular disease, type 2 diabetes, and obesity, and the effect is dose-dependent.

The cumulative point is that sleep is functional rather than passive. The seven to nine hours that adults need are not optional time that can be reclaimed for productivity; they are the substrate on which everything else depends. People who chronically under-sleep are running a deficit that shows up across every domain of cognitive, emotional, and physical functioning, and the deficit cannot be made up by trying harder during the day.

A common pattern in clinical practice. The client reports that they have always been a five-or-six-hour sleeper and that this works fine for them. On exploration, they describe needing

three or four coffees to get through the morning, an inability to concentrate after lunch, a sense that work that used to be straightforward has become effortful, irritability with family that they put down to stress, weight gain that diet does not seem to shift, and frequent minor illnesses through the winter. None of these are connected, in their account, to sleep. Each of them is well-documented as a downstream effect of chronic short sleep. The “I get by” is doing a lot of work in that sentence; the data say they are not getting by, they are accommodating.

**A NOTE**

*Sleep need is largely fixed. Despite a popular myth that some people can train themselves to function on four or five hours, the research is clear that adult sleep need clusters tightly between seven and nine hours, with rare individuals needing slightly more or less. The people who claim to function on five hours are typically functioning worse than they recognise; performance metrics consistently show measurable impairment, even when the person reports feeling fine. The point of this programme is not to teach you to need less sleep; it is to help you reliably get the sleep you actually need.*

**A NOTE**

*The dose-response relationship between sleep and harm is now one of the most replicated findings in sleep medicine. Each hour of sleep lost below the seven-hour floor produces a measurable, additive increase in cardiovascular risk, cognitive impairment, and mood disturbance. The harm is not a step function that activates at some threshold; it is a gradient, and small amounts of additional sleep produce real benefit even when the gap to the optimum is large.*

CHAPTER 3

# How sleep is regulated, and how insomnia gets stuck

Sleep is regulated by two largely independent systems that interact to produce the timing, depth, and continuity of any given night.

### Process S: the sleep drive

The first system is the sleep drive, sometimes called Process S. From the moment you wake, a chemical called adenosine begins to accumulate in the brain. The longer you have been awake, the higher the adenosine, and the higher the adenosine, the stronger the felt pressure to sleep. When sleep eventually comes, adenosine is cleared and the sleep drive drops. By morning the drive is at its lowest and the cycle starts again.

This is the system caffeine works on. Caffeine blocks adenosine receptors, so the brain does not register the rising sleep drive even though the chemical itself is still accumulating. When the caffeine clears, the unmasked adenosine produces the felt crash. Caffeine has a half-life of around six hours in most adults, which means that an afternoon coffee is still affecting the brain at midnight; this matters more than people typically expect, and module three covers it in detail.

**A NOTE**

*Caffeine half-life is the number most people get wrong. A coffee at 3pm leaves around half its caffeine still active at 9pm and a quarter still active at 3am. For people sensitive to caffeine, an afternoon coffee is functionally equivalent to a low dose of caffeine taken at bedtime. If your sleep onset is poor, removing caffeine after midday is often the single highest-yield change you can make before any other intervention.*

**A NOTE**

*Process S responds to daytime activity. Adenosine builds up primarily with the amount of time spent awake and overall metabolic activity; both physical and mental activity can contribute, but the main driver is wake duration rather than the level of cognitive stimulation alone. People who are awake for longer periods, especially with sustained activity, tend to develop stronger sleep pressure. Physical exercise can increase sleep pressure, partly through metabolic mechanisms that involve adenosine.*

The sleep drive matters for insomnia because the drive needs time to build. Spending too long in bed (lying awake, going to bed too early, lingering in bed in the morning) reduces the build-up time and weakens the drive when sleep actually comes. People with insomnia often respond to a poor night by spending more time in bed the next night, hoping to catch up, and the response systematically makes the next night worse. Sleep restriction therapy in module five works by deliberately strengthening the sleep drive.

### Process C: the circadian rhythm

The second system is the circadian rhythm, Process C. The body's master clock, located in a small region called the suprachiasmatic nucleus, runs on roughly a 24-hour cycle and is set primarily by light exposure. Light in the morning signals the start of the active phase; darkness in the evening signals the start of the rest phase. The clock controls the timing of melatonin release (which begins about two hours before habitual bedtime), body-temperature variation across the day, hormone release, and many other physiological rhythms.

The circadian system matters for insomnia because it likes regularity. Sleeping at consistent times trains the system; sleeping at inconsistent times confuses it. People who sleep at very different times across the week (early on weekdays, late at weekends) effectively give themselves a mild form of jet lag, and the felt experience is poor sleep quality even when the duration looks adequate. The circadian system also responds slowly to changes; shifting your sleep window by an hour takes the system several days to adjust to, which is why the first few days of any sleep change feel worse before getting better.

### The 3P model of insomnia

The clinical model used in CBT-I to understand how insomnia develops is the 3P model, which identifies three sets of factors. Predisposing factors are the underlying tendencies that make a person more vulnerable to sleep problems: a sensitive nervous system, a tendency to worry, family history, certain personality traits. Precipitating factors are the events that trigger the sleep problem in the first place: a stressful life event, an illness, a job change, a bereavement, a period of jet lag, a course of corticosteroids, a relationship difficulty. Perpetuating factors are the behaviours and thoughts that keep the sleep problem going long after the original trigger has resolved.

The crucial insight is that the perpetuating factors are usually the cause of chronic insomnia, even when the original precipitating event was something quite different. A bereavement might cause two weeks of poor sleep, but the chronic insomnia that develops from there is often maintained by what the person started doing in response to the poor sleep. Going to bed earlier to try to catch up. Lying in bed longer in the morning hoping for more sleep. Drinking alcohol to fall asleep. Reducing daytime activity because of tiredness. Worrying about whether tonight will be another bad night. Each of these is understandable; each makes the insomnia worse over time.

Predisposing. M, in her early forties, has always been a light sleeper and a chronic worrier. Both parents reported the same. She has never been someone who falls asleep quickly. Precipitating. In her late thirties she went through a difficult divorce. Sleep was disrupted for three months by acute distress, recurring nightmares, and middle-of-the-night ruminations. Predictable, expected, would have resolved on its own. Perpetuating. In response to the months of poor sleep, M started going to bed at nine to try to bank more sleep, lying in bed reading on her phone for hours when she could not drop off, dosing herself with an antihistamine four nights a week, taking a daytime nap when she could, drinking two glasses of wine in the evening. The divorce settled; the sleep did not. Three years on, the precipitating event is long gone but the perpetuating behaviours have produced a self-sustaining insomnia. The work of this programme is to identify and dismantle the perpetuating factors, one at a time, in the right order.

CBT-I works because it targets the perpetuating factors directly. The original precipitating event has often resolved; the predisposing factors cannot be changed; but the perpetuating factors are entirely within the person's control once they are identified. The rest of the programme is essentially about identifying and removing the perpetuating factors from your sleep, week by week.

**A NOTE**

*A useful question for the start. Did your sleep problem start with something specific (a stressor, an illness, a life change), or has it been there as long as you can remember? Both are workable, but the answers shape what the programme will need to do. A recent-onset insomnia driven by perpetuating factors usually responds quickly. Long-standing insomnia with strong predisposing factors usually responds, but more slowly, and benefits from sustained practice.*

**WORKSHEET**

## Set three goals for the programme

Take fifteen minutes to set three concrete goals for what you want this programme to change. Specific goals work better than abstract ones; 'sleep through the night four nights a week' is workable, 'sleep better' is too vague to measure.

Set three goals. Specific, observable, and within reach. The goals do not need to be ambitious; modest goals that you actually achieve build momentum better than large abstract ones that drift.

**Goal 1**

**How I will know I am making progress on Goal 1**

**Goal 2**

**How I will know I am making progress on Goal 2**

**Goal 3**

**How I will know I am making progress on Goal 3**

CHAPTER 4

# Closing Module 1

You have a working understanding of what sleep is doing, the two-process model that regulates it, and the 3P framework that explains how insomnia gets stuck. You have three concrete goals.

## Looking ahead

Module 2 is the assessment module. Before any treatment can be effective, you need a clear baseline picture of your own sleep. The module introduces the sleep diary, which is the gold-standard tool for sleep assessment and the basis for the therapeutic interventions in modules four and five. The diary is a fortnight of light daily entries; it does not require detailed journalling, only honest tracking of the basic numbers.

## Practice for the week ahead

Notice your sleep without trying to change it yet. Pay attention to bedtimes, wake times, the felt quality of sleep, the times you wake during the night, and how rested you feel in the morning. The point is not to fix anything yet; the point is to know.

**A NOTE**

*The most common mistake at this stage is to start trying interventions before the assessment is in place. People read this module, recognise themselves in the perpetuating-factor list, and immediately try to fix three things at once. The improvement is usually short-lived because the changes were not calibrated to their actual baseline. Resist the urge for one more week. The sleep diary in module two is where the targeted work begins, and it works much better starting from a clear picture than from a hopeful guess.*

CHECK-IN

## Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |

| | | | | |
|---|---|---|---|---|
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**Total: _____ Date: _____**

*Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.*

*If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.*

*The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.*

CHECK-IN

## Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

*This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.*

WORKSHEET

## Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

**Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.**

PART 2

# Mapping Your Sleep

*The sleep diary, sleep efficiency, and the four common patterns of insomnia*

CHAPTER 5

## Why the assessment matters

Most people with insomnia describe their sleep in general terms: it is bad, it has been bad for months, they wake up exhausted, they cannot fall asleep, they wake up in the night. The descriptions are accurate at one level but not detailed enough to inform a treatment plan. Effective sleep treatment depends on knowing the actual numbers: when you go to bed, when you fall asleep, when you wake during the night, how long you stay awake, when you finally get up, and how you feel during the day. The numbers reveal patterns that the felt experience hides.

**A NOTE**

*The perception-clock-time gap. A common surprise from sleep diaries is that the actual numbers differ substantially from what the person had been describing. The person who described themselves as sleeping four hours turns out to be sleeping six and a half on average. The person who described being awake for hours each night turns out to be awake for forty minutes that feel like hours. The person who described their sleep as completely random turns out to have a fairly consistent pattern of difficulty in the second half of the night. None of this is the person being inaccurate; it is the difference between subjective time at three in the morning and clock time. Both matter, but the diary lets the treatment work on the actual structure of sleep rather than on the felt experience of it.*

A second reason the assessment matters is that the central CBT-I interventions in modules four and five are calculated directly from diary data. The sleep window prescribed in sleep restriction therapy is computed from your average total sleep time; without an accurate baseline, the calculation cannot be done. Skipping the assessment phase, or doing it half-heartedly, undermines the treatment that follows. The two weeks of diary in this module are not preliminary; they are the foundation on which the rest of the programme is built.

**A NOTE**

*Two weeks, not three days. A small number of diary entries can mislead because any single night is influenced by the day before in ways that wash out across a fortnight. People who keep three days of diary often see numbers that do not generalise; people who keep fourteen days see the actual pattern of their sleep. The fortnight is the minimum, not a recommended target.*

CHAPTER 6

# The sleep diary and sleep efficiency

A sleep diary is a brief structured record of each night's sleep, completed each morning shortly after waking. The standard CBT-I diary tracks a small number of items, deliberately, because the simplicity is what makes it sustainable. Detailed journalling tends to be abandoned within a few days; brief structured tracking continues for weeks.

**A NOTE**

*Estimates, not precision. Do not check the clock during the night. The diary asks for honest approximations of how long it took to fall asleep, how many times you woke, and how long you spent awake. Clock-watching during the night is itself one of the perpetuating factors that worsens insomnia (it activates the alerting system and gives the worry-about-sleep mechanism something to feed on). The diary works best when you guess in the morning rather than measure during the night. Treat estimates within ten or fifteen minutes as accurate enough.*

The fields that matter are these.

Time you went to bed. The clock time at which you got into bed with the intention of sleeping. Not the time you started getting ready; the time you were actually in bed.

Time you tried to fall asleep. The time at which you turned off the lights and stopped reading or doing anything else. Often the same as the previous answer; sometimes different.

Estimated time it took to fall asleep. Your honest estimate of how long you lay awake before sleep came. Estimates are fine; do not look at the clock to check.

Number of awakenings during the night. How many times you came to consciousness, even briefly. Brief awakenings that you returned to sleep from quickly count.

Estimated total time awake during the night. The total amount of time you spent awake after first falling asleep but before final waking. Again, an estimate; do not check the clock.

Final wake time. The time at which you stopped trying to sleep and decided to start the day, even if you did not actually get out of bed at that moment.

Time you got out of bed. The time you actually left the bed.

Subjective sleep quality. A 1-to-5 rating of how restful the sleep was, regardless of the duration.

Daytime sleepiness. A 1-to-5 rating of how sleepy you felt during the day.

From these fields, two important measures can be calculated.

Total Sleep Time (TST) is the actual time you were asleep, in hours and minutes. It is calculated by taking the total time in bed and subtracting the time it took to fall asleep, the time spent awake during the night, and the time between final waking and getting up.

Time In Bed (TIB) is the total clock time between getting into bed and getting out of bed, including

all the awake time.

Sleep Efficiency (SE) is the ratio of TST to TIB, expressed as a percentage. A sleep efficiency above 85% is in the normal range. An efficiency in the 75–85% range is mild insomnia. Below 75% is moderate-to-severe insomnia. The number is the central single measure of sleep quality used in CBT-I, because it captures the relationship between time spent in bed and time actually asleep, and it directly informs the sleep-restriction calculation in module five.

**A NOTE**

*An example calculation. You went to bed at 11pm. You took 45 minutes to fall asleep. You woke twice during the night and were awake for 30 minutes total. You woke for the day at 7am and got out of bed at 7:15. Time in bed: 8 hours 15 minutes (495 minutes). Total sleep time: 495 – 45 – 30 – 15 = 405 minutes (6h 45m). Sleep efficiency: 405 ÷ 495 = 82%. This is mild insomnia by sleep-efficiency criteria. The treatment in module five will work directly with this calculation.*

### The four common patterns of insomnia

Sleep diaries typically reveal one of four patterns, or a combination. Read each below and notice which one (or which combination) best describes your sleep across recent weeks.

Difficulty falling asleep at the start of the night. The classic picture is lying awake for an hour or two before sleep eventually comes. The mechanisms are usually a combination of physiological hyperarousal (the body is too alert), cognitive activity (the mind is busy), and sometimes a circadian misalignment (going to bed earlier than the body's natural sleep timing). Most common in people with anxiety, busy minds, and stressful evenings.

Falling asleep is fine, but waking during the night and struggling to return to sleep. The classic picture is waking at three or four in the morning, lying awake for an hour or more, and either getting up or falling back asleep just before the alarm. The mechanisms are often related to sleep architecture (the second half of the night is naturally lighter sleep, so any disturbance is more disruptive), worry that activates on waking, and sometimes alcohol or food in the second half of the night.

Waking earlier than intended and being unable to return to sleep. Sometimes appears similar to sleep-maintenance insomnia, but distinguishes by waking unusually early (before five in the morning, say) rather than in the middle of the night. Particularly associated with depression and with circadian phase advance, both of which need different responses. If this is your dominant pattern and you have not yet been assessed for depression, that conversation with your GP is worth having alongside this programme.

Sleeping for what seems like a normal duration but waking unrefreshed, with low energy throughout the day. Often involves disturbed sleep architecture (less deep sleep than the duration would suggest, more frequent micro-arousals than the person is aware of) and is sometimes associated with undiagnosed sleep apnoea, particularly when accompanied by snoring or witnessed pauses in breathing. If this is your pattern and either you or your partner notice snoring or interrupted breathing, a GP conversation about sleep-clinic referral should happen before the behavioural work in this programme.

The patterns are not mutually exclusive; many people have a combination. The diary in this module helps you identify which pattern, or combination, describes your sleep specifically. The treatment in later modules can then be tuned to that pattern.

WORKSHEET

## Begin a fortnight of sleep diary

For the next fourteen days, complete the diary every morning shortly after waking. The estimates do not need to be precise; honest approximations are what the treatment will work with. Resist the temptation to look at the clock during the night to make the entries more accurate; clock-watching during the night actively worsens insomnia and is one of the perpetuating factors that module four addresses directly.

Complete every morning. Two to three minutes per entry. Fourteen consecutive days, including weekends; the weekend numbers are part of the picture. The fields below match the standard CBT-I sleep diary used in research and clinical practice.

Use one column of the grid for each day. It has room for 7 of the 14 days the exercise asks for: copy it for the rest.

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Time I got into bed (e.g. 23:00) | | | | | | | |
| Time I tried to fall asleep (lights off) | | | | | | | |
| Estimated time to fall asleep (minutes) | | | | | | | |
| Number of awakenings during the night | | | | | | | |
| Estimated total time awake during the night (minutes) | | | | | | | |
| Final wake time (e.g. 06:30) | | | | | | | |
| Time I got out of bed | | | | | | | |
| Subjective sleep quality (1 = very poor, 5 = very restful) | | | | | | | |
| Daytime sleepiness (1 = none, 5 = severe) | | | | | | | |
| Caffeine consumed yesterday (cups, and times of day) | | | | | | | |
| Alcohol consumed yesterday (units, and times) | | | | | | | |
| Daytime naps (duration and time) | | | | | | | |

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Anything else worth noting (stressors, illness, unusual events) | | | | | | | |

### The end of the sample

This is a free sample of “Sleep and Insomnia”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.