Sleep and Insomnia: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Sleep and Insomnia: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 7. This printing was set on 9 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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How to use this guide

This guide is for qualified practitioners who support clients through the Sleep and Insomnia programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: insomnia as conditioned arousal, the two processes that regulate sleep, the 3P model, the cognitive model, and how the eight modules are built
- Chapter 2, What the research shows: how common insomnia is and what it predicts, the evidence for CBT-I and for self-help versions of it, the evidence for sleep restriction in primary care and its short-term costs, and the limits of the evidence

CHAPTER 1

The model behind the programme

Insomnia is a problem of arousal, not of capacity

The programme starts from an account of chronic insomnia that the practitioner needs to share and to be able to explain simply. The person with insomnia has not lost the ability to sleep. What has happened is that the bed, the bedroom and the hour before bed have become linked with being awake, trying and worrying, so that the situation in which sleep ought to come now switches the brain on. The programme's description puts it plainly: the body is fully capable of sleeping, and the system has learned to be activated rather than relaxed where sleep should occur. Once a client sees this, the work changes shape. It is no longer an attempt to make sleep happen, which cannot be done by effort, but a matter of removing what has been keeping the brain alert and retraining the link between the bed and sleep.

Two processes regulate sleep

Module 1 teaches the two-process model of sleep regulation, first set out by Borbély (1982). Sleep pressure, Process S, builds with every hour of wakefulness and is discharged during sleep; the module explains it through adenosine, and through caffeine, which blocks adenosine's effect without stopping it building. The module says, correctly, that the main driver of sleep pressure is time spent awake rather than how mentally busy the day has been. The body clock, Process C, runs on a cycle of about twenty-four hours and is set chiefly by light, so that daylight soon after

waking anchors it and bright light late in the evening pushes sleep later.

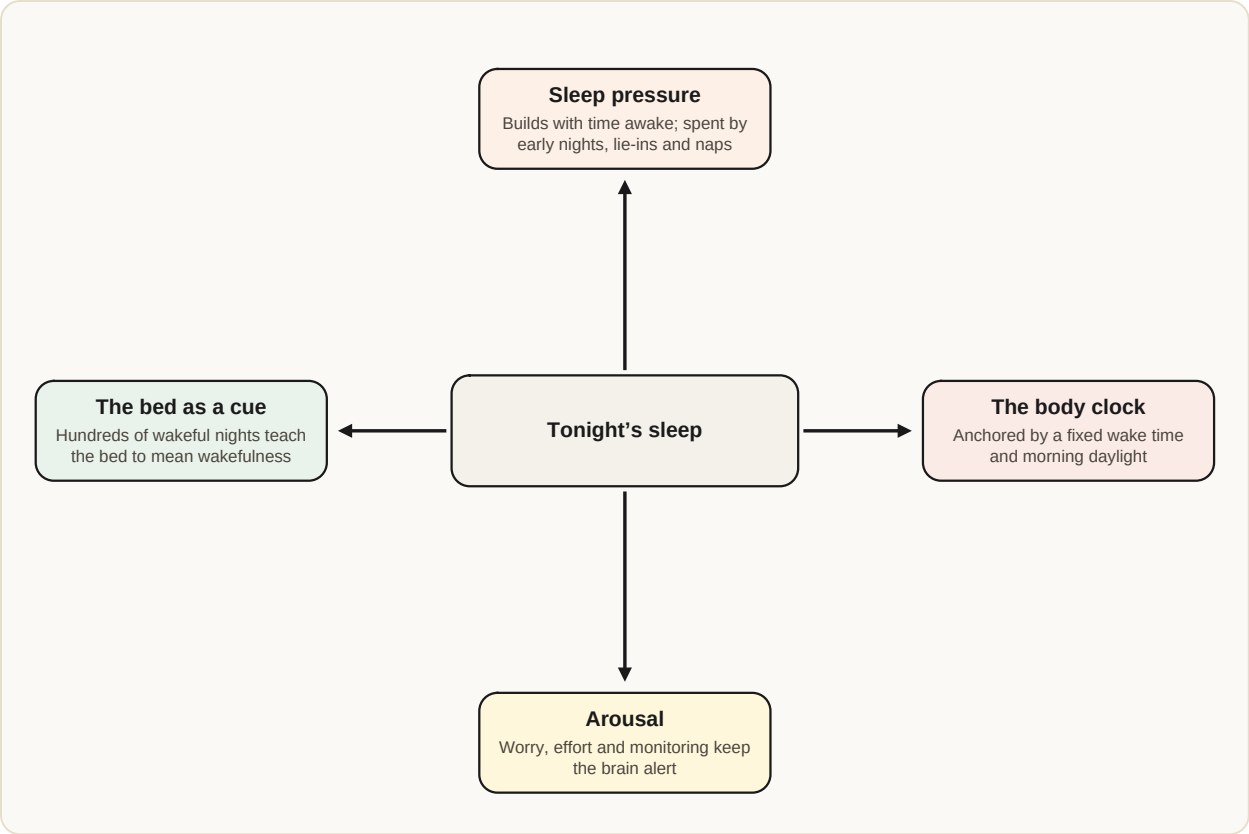


FIGURE 1.1 What decides tonight's sleep
Two regulating processes time sleep: the pressure that builds with time awake and the body clock set by light and a regular wake time. In chronic insomnia two further influences are added to them: arousal at bedtime, and a bed that has become a cue for being awake.

The model matters because nearly every perpetuating behaviour the programme removes works against one process or the other. Going to bed early and lying in after a poor night spend sleep pressure before the night begins and shorten the time it has to build; napping does the same in the afternoon; and sleeping at different times on different days unsettles the clock, which the module compares to a mild jet lag every Monday. The behavioural interventions in modules 4 and 5 are, in effect, the two processes put to work: a fixed wake time anchors the clock, and a window matched to the client's actual sleep lets pressure build to full strength before bedtime.

The 3P model

The clinical model the programme uses to explain how insomnia develops is the 3P model of Spielman, Caruso and Glovinsky (1987). Predisposing factors make a person vulnerable (a sensitive nervous system, a tendency to worry, a family pattern). Precipitating factors set the insomnia off (a stressful period, an illness, a bereavement, a new baby, a course of steroids). Perpetuating factors keep it going after the precipitant has passed: the early nights and lie-ins, the reading and scrolling in bed, the nightcap, the cancelled plans, and the dread of another bad night. The model's practical point is that chronic insomnia is usually maintained by what the person started doing in response to the poor sleep, which is within their control once it has been named, rather than by the event that started it. The programme's own example is M, a light sleeper whose insomnia began with a divorce and was still running three years later on early nights, phone use in

bed, antihistamines, naps and evening wine.

The cognitive model

Module 6 adds the cognitive model of insomnia described by Harvey (2002). Worry and unhelpful beliefs about sleep produce arousal and distress; the aroused person attends selectively to threats related to sleep, at night to the clock and the body and by day to signs of damage; this monitoring makes poor sleep seem worse than it is; and protective habits, which Harvey calls safety behaviours, both weaken sleep pressure and stop the beliefs from ever being tested. Running through all of it is effort, since trying to fall asleep is exactly the kind of goal-directed activity that keeps the brain alert. Harvey's model explains why some clients improve behaviourally and still dread bedtime, and why one bad night can feel like proof that nothing has changed.

How the programme works

The programme follows the standard curriculum of cognitive behavioural therapy for insomnia, usually shortened to CBT-I. Module 1 explains sleep, the two processes and the 3P model, and asks for three goals. Module 2 starts a fortnight of sleep diary and teaches sleep efficiency and the four common patterns of insomnia. Module 3 covers the foundation, sleep hygiene, in enough detail to change behaviour. Module 4 introduces stimulus control and module 5 sleep restriction, the two interventions with the strongest evidence. Module 6 works on beliefs and predictions with a sleep-thought record and a behavioural experiment, module 7 on the busy mind at night, and module 8 on keeping the gains and knowing when to step up.



FIGURE 1.2 The eight modules and what each works on
The programme follows the standard order of cognitive behavioural therapy for insomnia: understanding and assessment first, then the foundation, then the two behavioural interventions that do most of the work, then the thinking that keeps insomnia going, and finally a plan for keeping the gains.

How the modules are built

Each module has an introduction, one to four teaching sections, worksheets, a closing summary with practice for the week ahead, and a reflection, “Taking this forward”, which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. Module 5, the longest, adds a quiz on the rules of sleep restriction and a set of when-then plans, and module 6 a sorting exercise. The check-ins come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8. Take the GAD-7 at assessment too. None of the three measures insomnia itself, so where your service uses it, add the Insomnia Severity Index at assessment, at the fourth contact and at the last. In a community sample a score of 10 or more best identified clinical insomnia, and in a clinical sample a fall of about eight points went with moderate improvement as judged by an independent assessor (Morin et al., 2011). The worked examples in this guide follow one composite client, Rhys, through all eight contacts.

Talking about sleep and health

Module 1 makes a strong case for the importance of sleep: memory, emotional regulation, repair, metabolism, and a dose-response relationship between short sleep and harm. The case is made to motivate the client, and for many clients it does. For a client whose insomnia is already driven by fear of what poor sleep is doing to them, the same passages can feed the worry that keeps them awake, which is exactly the catastrophising module 6 later asks them to test. The practitioner can hold both truths. Sleep matters, and long-term short sleep is associated with poorer health in large population studies; but those associations come from populations followed over years, not from the nights of one person, and an ordinary poor night does no lasting harm. After a short night the next night’s sleep tends to be deeper, which is the body’s own compensation. Clients also commonly underestimate how long they slept and overestimate how long they lay awake, compared with recordings of their sleep, for reasons that include the worry and monitoring the programme works on (Harvey and Tang, 2012). It helps to say early on that the diary is a record of experience rather than a laboratory measurement, that it is the right measure for the programme’s calculations, and that the aim is sleep the client can rely on, not a perfect number.

What the practitioner adds

The programme carries the teaching. The practitioner’s part in insomnia has three particular demands. The first is to hold the line on methods that feel wrong. Stimulus control and sleep restriction both make most people’s sleep worse for a week or two before it improves, and both contradict the common-sense remedies the client has been using for years; a contact that wavers in the first fortnight usually loses the treatment. The second is safety. Sleep restriction makes people sleepier for a time, some clients must speak to their GP before starting it, and insomnia sometimes turns out to be something else: sleep apnoea, restless legs, a circadian rhythm disorder, or depression. The third is to keep the client’s thinking about sleep accurate rather than reassuring. Telling a client not to worry does nothing; helping them test the prediction that a poor night ruins the next day does a great deal. Chapter 5 shows how a thirty-minute contact can keep its attention on all three.

CHAPTER 2

What the research shows

How common insomnia is

Insomnia is among the commonest complaints in primary care. In a review of the epidemiological studies, about a third of the general population reported at least one symptom of insomnia, and about six per cent met the criteria for an insomnia diagnosis; the prevalence was higher in women than in men (Ohayon, 2002). The diagnostic criteria used today require difficulty starting or keeping sleep, or waking too early, on at least three nights a week for at least three months, with distress or impaired daytime functioning, despite adequate opportunity to sleep (American Psychiatric Association, 2013). The programme's description uses the same thresholds.

What insomnia predicts

Insomnia is not only a symptom of other difficulties. In a meta-analysis of 21 longitudinal studies, people with insomnia who were not depressed at the start had about twice the risk of developing depression as people who slept well (Baglioni et al., 2011). Sleep disturbance is also associated with suicidal thoughts and behaviour: in a meta-analysis, the relative risk of suicidal ideation, attempts and suicide ranged from about two to three in the unadjusted studies, the associations remained significant after adjustment, and depression did not account for them (Pigeon, Pinquart and Conner, 2012). For the practitioner this means two things: that treating insomnia well is worthwhile in its own right, and that a client with insomnia needs the risk questions at every contact like any other client, however much the programme is about sleep.

CBT-I works

The strongest evidence is for multicomponent CBT-I. In a meta-analysis of 20 randomised trials with 1,162 adults with chronic insomnia, face-to-face CBT-I shortened the time taken to fall asleep by about 19 minutes and the time awake after first falling asleep by about 26 minutes, and raised sleep efficiency by about ten percentage points; total sleep time changed little at the end of treatment, the changes seemed to be sustained, and no adverse outcomes were reported (Trauer et al., 2015). The finding about total sleep time is worth knowing, because many clients measure success by hours. The early gains of CBT-I are in how quickly sleep comes, how continuous it is and how much of the night in bed is spent asleep; the window then widens, and longer sleep tends to follow over the months after treatment.

Clinical guidelines agree. The American College of Physicians recommends that all adults with chronic insomnia disorder receive CBT-I as the initial treatment (Qaseem et al., 2016). The American Academy of Sleep Medicine makes a strong recommendation for multicomponent CBT-I and conditional recommendations for stimulus control and sleep restriction as single components, and advises against sleep hygiene on its own as a treatment (Edinger et al., 2021). The European Insomnia Guideline recommends CBT-I as the first-line treatment for chronic insomnia in adults of any age, including digital forms (Riemann et al., 2023).

Self-help CBT-I

Self-help forms of CBT-I have their own evidence. In a meta-analysis of 20 randomised trials, self-help CBT-I improved sleep, beliefs about sleep, and anxiety and depressive symptoms compared with waiting list or routine care; the effect sizes for sleep efficiency, time to fall asleep and time awake in the night were 0.80, 0.66 and 0.55, the dropout rate did not differ from that of therapist-delivered CBT-I, and subgroup analyses supported the added benefit of telephone support (Ho et al., 2015). The last finding is the case for the practitioner's contacts. In England, the National Institute for Health and Care Excellence (2022) recommends a digital CBT-I programme, Sleepio, as a cost-saving option for treating insomnia and insomnia symptoms in primary care, for people who would otherwise be offered sleep hygiene advice or sleeping pills. The largest trial of a digital programme randomised 3,755 university students with insomnia; at ten weeks it had reduced insomnia substantially, with smaller reductions in paranoia and hallucinations that were mediated by the change in sleep (Freeman et al., 2017).

Insomnia alongside other conditions

Most clients do not have insomnia on its own. In a meta-analysis of CBT-I for insomnia occurring with psychiatric and medical conditions, 36 per cent of those treated were in remission from insomnia at the end of treatment, against 17 per cent in the comparison conditions; the effects on sleep were medium to large, and the comorbid condition itself improved a little, more in psychiatric than in medical conditions (Wu et al., 2015). A co-occurring condition is therefore a reason to adapt the programme and to make sure the other condition is being looked after, not in itself a reason to withhold the work.

Sleep restriction in primary care, and its costs

The method module 5 teaches was developed by Spielman, Saskin and Thorpy (1987). Its effectiveness in the setting closest to guided self-help has been tested in England. In the HABIT trial, 642 adults with insomnia disorder in general practice were randomised to brief sleep restriction therapy delivered by practice nurses or to sleep hygiene advice; at six months the mean Insomnia Severity Index score was 10.9 against 13.9, the incremental cost per quality-adjusted life year was £2,076, and no serious adverse event was judged to be related to the treatment (Kyle et al., 2023).

The same research group documented the short-term cost. In a laboratory study of sixteen patients, total sleep time measured by recording fell during the first weeks of sleep restriction, by an average of 91 minutes on the first night and 69 minutes on the twenty-second; lapses of attention increased, and self-rated sleepiness was raised in the first three weeks, all returning to normal by three months while the insomnia improved (Kyle et al., 2014). This is why module 5 lists the people who should speak to their GP before starting, and why the practitioner's questions about driving and safety-critical work are not a formality.

What the research does not show

No trial has tested this programme in its present form. The programme applies the components with the strongest evidence in the order most services teach them, with practitioner support, which is the arrangement the self-help evidence favours. It is designed for chronic insomnia that is

not caused by another sleep disorder, and it is not a treatment for sleep apnoea, restless legs syndrome, narcolepsy or a circadian rhythm disorder. Where the picture is complicated by severe depression, bipolar disorder, an active anxiety disorder or substance use, the programme can still help, but the other condition needs its own care, and the stepping-up guidance in Part 2 and in module 8 is the safeguard.