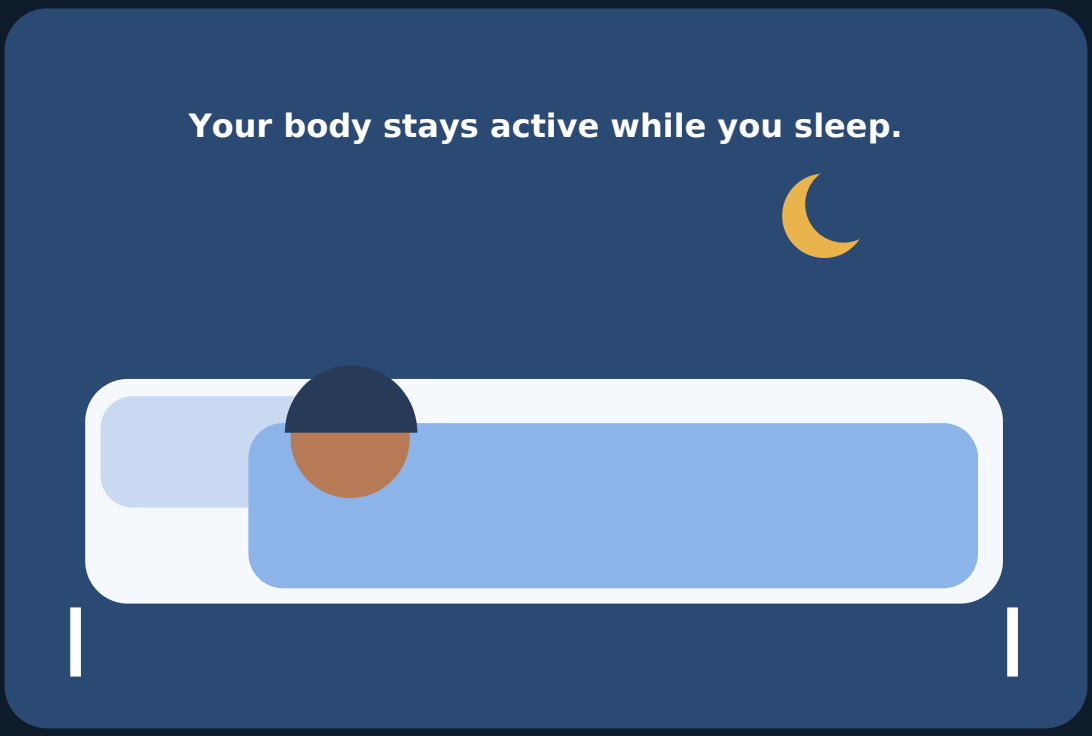
• A FRIENDLY GUIDE TO HEALTHY SLEEP

Sleep Made Simple

11 easy chapters for better sleep



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HI

A note from Dr. Javaid

I wrote this book to make sleep feel clear, useful, and less scary. You do not need a science degree to understand your own sleep. You only need good facts, simple words, and a plan that fits real life.

Medical note: This book teaches general health information. It cannot diagnose or treat one person. A sleep clinician should make care decisions after learning your history. If you may hurt yourself or someone else because you are sleepy, stop the unsafe activity and get help. For an emergency, call 911 in the United States or your local emergency number.

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What is inside

Eleven short chapters explain sleep, common sleep problems, and steps you can use.

MAP

How to use this book

Read from start to finish, or jump to the chapter you need. Boxes marked TRY give you a safe action. Boxes marked HELP show when to call a clinician. Source numbers point to the reference list.

Welcome

Sleep is easier to understand than it may seem.

Sleep may look quiet, but your brain and body stay active. Sleep helps you learn, manage feelings, grow, repair tissues, fight germs, and prepare for the next day.

Many body systems work together during sleep. Your body clock helps set the time. Sleep stages repeat through the night. Your breathing, heart rate, body heat, and hormones change in organized ways.

This book explains those ideas in eleven clear chapters. You will learn why sleep matters, what controls it, what can go wrong, how sleep is tested, and which steps are worth trying. You will also learn an important truth: a hard night is not a personal failure. Sleep is biology, not a grade.

4

The four parts of healthy sleep

Healthy sleep needs enough time, good quality, helpful timing, and a fairly steady pattern. It also means finding and treating a sleep disorder when one is present. One perfect night is not the goal. A healthy pattern is.

You will see a few long medical words. Each one will be explained right away. A glossary at the end gives you a quick place to look them up.

Let us get started.

CHAPTER 1

Why Sleep Matters

What your brain and body do while you sleep

Sleep may look quiet from the outside, but your brain and body stay active and prepare you for tomorrow.

Sleep	A natural state that changes brain activity, movement, breathing, and awareness.
Sleep health	A pattern of sleep that supports how you feel, think, grow, and stay safe.

Your body stays active

Sleep is not the same as turning off a lamp. Your brain stays active. Your breathing, heart rate, body heat, and hormones change in planned ways. Different parts of the night support different kinds of work.

Memory and learning

During sleep, the brain works with what you learned and felt during the day. It strengthens some memories and connects new facts with old ones. This is one reason a rested brain can learn and focus better.

Growth and repair

Sleep supports growth and body repair. It also helps the immune system, which protects you from germs. Children and teens need plenty of sleep while their brains and bodies are growing.

Mood and feelings

A tired brain has a harder time slowing strong feelings. After too little sleep, a small problem can feel huge. A child may look wild or cranky instead of sleepy. An adult may feel foggy, worried, or short-tempered.

Heart health and energy

Sleep helps the systems that manage blood pressure, blood sugar, hunger, and energy. Missing sleep again and again is linked with health problems such as high blood pressure, diabetes, obesity, heart disease, stroke, and depression. Sleep is one part of health, along with food, movement, medical care, safety, and relationships. [1]

FACT

A fair way to say it

Sleep supports health, but it is not magic armor. Good sleep cannot prevent every illness. Poor sleep also does not mean that illness is certain. It changes risk, and risk is not destiny.

How sleep loss shows up

Not everyone looks the same when sleep runs short. Common clues include:

- Heavy eyes, yawning, or falling asleep without meaning to.
- Slow thinking, forgotten details, or more mistakes.
- Irritability, sadness, worry, or poor control of feelings.
- More hunger or strong cravings.
- Poor school, work, sports, or driving performance.
- Needing a loud alarm, many snoozes, or lots of caffeine to get moving.

A person can feel used to short sleep while attention and reaction time are still worse. That is why the idea, 'I trained myself to need only four hours,' is usually a myth. Most people cannot choose a tiny sleep need through willpower.

TRY

Check your sleep for one day

Tomorrow, write down three clues: how hard it was to wake, when your energy dipped, and whether you became sleepy during a quiet task. These clues can tell you more than asking only, 'Did I sleep well?'

Sleepiness is not laziness

Sleepiness can come from too little sleep, the wrong sleep timing, medicines, a health condition, or a sleep disorder. Telling a sleepy person to 'try harder' can miss the real problem. The right question is, 'What is getting in the way of healthy sleep?'

Remember these big ideas

- Your brain and body stay busy during sleep.
- Sleep supports learning, mood, growth, immunity, heart health, and safe reactions.
- Long-lasting sleepiness deserves a cause, not a label like lazy.

Quick check

1. Is sleep a time when the brain turns off?	Answer: No. Brain activity changes, but important work continues.
2. Can children look overactive when tired?	Answer: Yes. Tired children do not always look sleepy.
3. Does one bad night ruin your health?	Answer: No. Patterns over time matter much more.

CHAPTER 2

What Makes You Sleepy

Your body clock and sleep pressure work together

Two body systems help decide when you feel awake and when you feel sleepy. Sleep can be hard when they do not match your schedule.

Sleep pressure

Builds while you are awake

Like sand filling a bucket

BOTH MUST WORK TOGETHER

Body clock

Uses light and time cues

Like a 24-hour timer

BOTH MUST WORK TOGETHER

Body clock	A brain timing system that follows a cycle close to 24 hours.
Sleep pressure	The need for sleep that grows the longer you stay awake.
Melatonin	A hormone that helps signal that biological night has begun.

System one: sleep pressure

From the moment you wake, pressure for sleep begins to build. Imagine fine sand dropping into a bucket. More hours awake means more sand. A brain chemical called **adenosine** is part of this system. During sleep, the pressure falls. [2]

A nap can empty part of the bucket. That can be useful when you truly need rest. A long or late nap can also leave too little pressure at bedtime. The best nap plan depends on your age, schedule, and health.

What caffeine really does

Caffeine can sit on adenosine receptors and cover the sleepy signal for a while. It does not erase the need for sleep. It is more like putting tape over a fuel warning light. The low fuel is still there. Caffeine can remain active for hours, so afternoon or evening use can trouble some sleepers.

System two: your body clock

A small timing center in the brain uses light from the eyes to line up your body with day and night. Morning light says, 'Start the daytime plan.' Darkness helps the body prepare for night. Melatonin usually rises in the evening, while other wake signals rise toward morning. [2]

Light is not the only time clue. Meals, movement, work, school, and social activity also help set the pattern. Bright light late at night can push the clock later. Morning light often helps pull it earlier. The timing and strength of light matter.

NOTE

Melatonin is a time note

Think of melatonin as a note that says, 'Night is near.' It is not a hammer that knocks everyone out. The right dose and time depend on the problem. Ask a clinician before giving it to a child or using it for a health condition.

When the two systems disagree

You can be tired but not ready to sleep. This often happens after travel across time zones, night work, or a very late weekend. Sleep pressure says, 'I am worn out,' while the body clock says, 'It is still daytime.'

Teens are a special example. Their body clocks often shift later during puberty. Many teens do not feel sleepy as early as younger children. Early school times can then cut sleep short. This is biology, although late light and late screens can push the clock even later. [2]

Early birds and night owls

People have different natural timing. Some wake early with little effort. Others come alive later. A preference is not a disorder. It becomes a problem when a person's clock is far from the schedule they must keep and daily life suffers.

TRY

Help both systems work together

Wake at a steady time, get outdoor light early in your day, move your body, and keep late-night light low. These steps give the clock clear timing and let sleep pressure build in a regular way.

Remember these big ideas

- Sleep pressure grows with time awake and falls during sleep.
- The body clock uses light and other time cues.
- Caffeine can hide sleepiness, but it cannot replace sleep.

Quick check

1. What are the two sleep systems?	Answer: Sleep pressure and the body clock.
2. Does caffeine remove sleep debt?	Answer: No. It can cover the sleepy signal for a time.
3. Why may teens want to sleep later?	Answer: Their body-clock timing often shifts later during puberty.

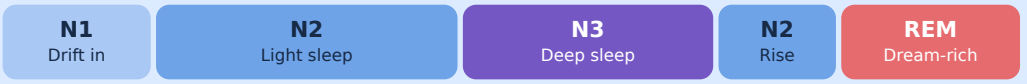
CHAPTER 3

The Stages of Sleep

Sleep moves through four stages during the night

Your brain moves through four sleep stages. Each stage has a different feel and a different pattern on a sleep study.

A simple map of one sleep cycle



The pattern repeats. Deep sleep is richer early. REM is richer late.
The exact shape and timing change from person to person and from night to night.

Non-REM	Sleep made of stages N1, N2, and N3.
REM	Sleep with rapid eye movements, active dreams, and very relaxed muscles.
Sleep cycle	A trip through sleep stages that repeats during the night.

N1: Falling asleep

N1 is the light step from awake to asleep. Thoughts may float. Muscles relax. You may feel a sudden jump, as if you tripped. A small sound can wake you easily. N1 usually takes only a small part of the night.

N2: Light sleep

In N2, you are clearly asleep. Heart rate slows and body heat falls. The brain shows special quick bursts and large waves on an EEG, which is a recording of brain electricity. Adults often spend more time in N2 than in any other stage.

N3: Deep sleep

N3 is deep, slow-wave sleep. It is harder to wake from this stage. Deep sleep is richer in the first part of the night. Growth and body repair signals are strong here. Sleepwalking and sleep terrors often begin from deep non-REM sleep.

REM: Dream-rich sleep

REM means **rapid eye movement**. The eyes move under closed lids, and the brain is active. Vivid dreams are common. Most large muscles become very relaxed, which helps keep the body from acting out a dream. REM periods tend to grow longer toward morning. [3]

DREAM

Dreams are not only in REM

Dreams can happen in non-REM sleep too. REM dreams are often more vivid and story-like. Scientists are still studying exactly why we dream.

The cycle repeats

A cycle often lasts about 80 to 100 minutes, and many people have four to six cycles in a full night. The pattern is not a perfect loop. Age, medicines, alcohol, illness, sleep loss, and many other factors can change it. Brief awakenings between cycles are normal, and most are not remembered. [3]

Cutting the last hours of sleep can remove some of the REM-rich part of the night. Cutting the first hours can remove some deep-sleep-rich time. Enough time for sleep gives all the stages time to occur.

What a watch can and cannot see

A watch or ring can use movement and pulse signals to estimate sleep. It does not record brain waves like a lab study. Its stage labels may be useful for trends, but they are not a medical diagnosis. Do not let a score make you worried after a night that felt fine.

TRY

Watch the pattern, not one bar graph

Ask, 'How do I feel and function over many days?' That question is often more useful than chasing a certain number of REM or deep-sleep minutes on one device.

Remember these big ideas

- Non-REM sleep has N1, N2, and N3. REM is a fourth stage.
- Deep sleep is richer early, and REM is richer late.
- Short awakenings can be a normal part of a night.

Quick check

1. Which stage is deep sleep?	Answer: N3.
2. When is REM often richer?	Answer: Later in the night, toward morning.
3. Can a watch diagnose sleep stages?	Answer: No. It makes estimates without measuring brain waves.

CHAPTER 4

How Much Sleep Do You Need?

Sleep needs change with age

Sleep needs change with age. The right amount is a range, not a contest and not the same exact number for every person.

Sleep need	The amount of sleep that supports good health and daytime function.
Sleep debt	Sleep missed compared with what your body needs.
Sleep quality	How well sleep stays together and supports daytime life.

A useful starting guide

The American Academy of Sleep Medicine gives age-based sleep targets. These are for regular sleep, not one rare night. Baby and child totals include naps when noted. [4,5]

Age	Sleep in 24 hours
4-12 months	12-16 hours, including naps
1-2 years	11-14 hours, including naps
3-5 years	10-13 hours, including naps
6-12 years	9-12 hours
13-18 years	8-10 hours
Most adults	At least 7 hours each night

Newborns under 4 months have wide and changing sleep patterns, so the AASM table does not give one target for that age. Older adults still need sleep even when sleep becomes lighter or more broken. Illness, recovery, pregnancy, hard training, and past sleep loss may increase a person's need.

PLUS

More than a number

Healthy sleep is not only duration. Timing, regularity, quality, and the absence of an untreated sleep disorder all matter. Eight hours of badly broken sleep may not feel restoring.

How to estimate your own need

A sleep target is probably close when, on most days, you can:

- Wake with reasonable effort after a steady schedule.
- Stay alert through quiet parts of the day.
- Learn, remember, and manage feelings well.
- Exercise or work without a heavy wall of sleepiness.
- Drive safely without fighting to keep your eyes open.

Needing extra sleep after a hard week is a clue that you missed needed sleep. Sleeping longer can help after short-term loss, but a weekend cannot always undo a long pattern of short sleep. Large weekend shifts may also move the body clock, making Monday morning harder.

A simple sleep math check

Start with wake time because work and school often fix it. Count backward by the sleep amount you need. Then add time to wind down and fall asleep. If a teen must wake at 6:30 a.m. and needs about nine hours, lights-out needs to be near 9:30 p.m., not the time the bedtime routine begins.

KIDS

Do not grade a child by an adult number

A school-age child may need 9 to 12 hours. A teen may need 8 to 10. A seven-hour night that can be enough for some adults is usually too short for them.

What about naps?

Naps are normal for young children and can help adults in some settings. If a nap makes bedtime hard, try moving it earlier, making it shorter, or skipping it. A strong, new need to nap every day despite enough night sleep should be discussed with a clinician.

Remember these big ideas

- Children and teens need more sleep than most adults.
- Most adults should sleep at least seven hours on a regular basis.
- Daytime function helps show whether your sleep amount is enough.

Quick check

1. How much sleep should a 13-year-old usually get?	Answer: About 8 to 10 hours in 24 hours.
2. Is sleep duration the only part of sleep health?	Answer: No. Quality, timing, regularity, and disorders matter too.
3. What is sleep debt?	Answer: Sleep missed compared with what your body needs.

CHAPTER 5

Healthy Sleep Habits

Simple habits that can help you sleep better

You cannot force sleep like a push-up. You can build a steady routine that helps your brain and body get ready.

Sleep routine	A repeatable set of steps that prepares the brain and body for sleep.
Sleep environment	The light, sound, temperature, comfort, and safety of the bedroom.
Wind-down	A calm change from daytime activity to bedtime.

Start with the morning

1. Anchor the wake time

A fairly steady wake time is one of the clearest signals for the body clock. Try to keep it close even after a poor night. Sleeping very late may feel good at first but can push the next bedtime later.

2. Find bright morning light

Outdoor light early in your day tells the body clock that daytime has begun. Even a cloudy sky is often brighter than indoor light. Do not stare at the sun. People with eye disease or medicines that cause light sensitivity should ask a clinician about safe light plans.

3. Move during the day

Regular movement supports sleep and health. Pick something safe that you can repeat: walking, play, sports, yard work, or exercise. Very hard exercise close to bedtime wakes some people, while others sleep well after it. Notice your own pattern.

Watch late-day habits

Caffeine

Coffee, tea, energy drinks, cola, chocolate, pre-workout products, and some medicines can contain caffeine. If sleep is hard, avoid caffeine in the afternoon or evening. Some people need an even earlier stop time. [6]

Alcohol and nicotine

Alcohol may make a person drowsy at first, but it can break sleep later and worsen snoring or sleep apnea. Nicotine is a stimulant and can also disturb sleep. Neither is a good sleep treatment.

Food and fluids

A very large or spicy meal near bed can cause discomfort or reflux. Too much fluid may lead to bathroom trips. Hunger can also keep some people awake. Aim for a pattern that feels comfortable rather than a strict rule for everyone.

Get ready for bed

For the last 30 to 60 minutes, lower the speed of the day. Dim bright lights. Finish work. Choose a calm activity such as a warm shower, prayer, gentle stretching, quiet talk, or a paper book. Use the same few steps often enough that the brain learns what comes next.

Screens are not evil. Their light, exciting content, and ability to steal time are the problem. The CDC suggests turning off electronic devices at least 30 minutes before bed. If a device must be used, lower brightness and avoid upsetting or thrilling content. [6]

ROOM

Set up the bedroom

Make it dark, quiet, comfortably cool, safe, and supportive. Blackout shades, an eye mask, earplugs, or steady background sound may help. Keep a clear path to the bathroom to prevent falls.

Teach the bed one main job

If you often work, scroll, argue, or worry in bed, the brain may link the bed with being awake. Go to bed when sleepy. If you are awake long enough to feel upset, leave the bed when it is safe. Do something quiet in dim light. Return when sleepy. This is one part of insomnia treatment called stimulus control.

TRY

Do not watch the clock

Clock checking turns time into a threat: 'Only five hours left!' Turn the clock face away. Your job is to rest and follow the plan, not to calculate all night.

A child's bedtime routine

Children do best with a short, calm, predictable routine. One example is bath, pajamas, brush teeth, two books, hug, and lights out. Set the screen rule before bedtime, not during a tired argument. A child who snores often, gasps, or struggles greatly despite a good routine needs medical review.

Try one change for seven nights

Pick only one or two actions. A huge list often fails. Try a steady wake time plus morning outdoor light, or an earlier caffeine stop plus a 30-minute wind-down. Track how you function during the day.

Remember these big ideas

- A steady wake time and morning light are strong body-clock cues.
- Caffeine, alcohol, nicotine, meals, light, and activity can affect sleep.
- A calm, repeated routine teaches the brain that sleep is near.

Quick check

1. Which time is a strong daily anchor?	Answer: Wake time.
2. Why can alcohol be a poor sleep aid?	Answer: It can break sleep later and worsen breathing problems.
3. What should you do if the bed becomes a place of frustration?	Answer: Leave briefly when safe, do something quiet, and return when sleepy.

CHAPTER 6

Understanding Insomnia

Insomnia is real, common, and treatable

Sometimes sleep stays hard even when a person has enough time and a good place to sleep. Trying harder can make the brain more alert.

Insomnia	Trouble falling asleep, staying asleep, or getting good sleep despite having a fair chance to sleep.
CBT-I	Cognitive behavioral therapy for insomnia, a treatment that retrains sleep thoughts and habits.
Stimulus control	Steps that rebuild the link between bed and sleep.

A sleep chance is important

A person who stays up to finish work may be sleep deprived, but that alone is not insomnia. With insomnia, the person has enough time and a suitable place for sleep, yet sleep is still hard. The problem also affects the day. It may cause low energy, poor focus, worry, or irritability.

Short-term insomnia can follow stress, grief, pain, travel, illness, a new baby, or a schedule change. Chronic insomnia lasts for months and keeps returning. It can continue even after the first trigger is gone.

The insomnia loop

After a terrible night, it makes sense to worry about the next one. But worry can make the brain scan for danger. Extra time in bed, clock watching, and trying hard to sleep can keep the alarm on. The loop may look like this:

LOOP

The insomnia loop

A hard night leads to fear about the next night. Fear leads to more effort, checking, and alertness. That makes another hard night more likely. The loop is learned, which means it can also be unlearned.

The leading treatment retrains the system

The AASM strongly recommends multicomponent CBT-I for chronic insomnia in adults. It is more than general sleep tips. It changes the habits, timing, thoughts, and alarm signals that keep the insomnia loop going. [7]

NEXT

Next: CBT-I

Chapter 7 explains who needs CBT-I, why it works, what happens during treatment, and which people need closer supervision.

Sleep hygiene can support CBT-I, but the AASM does not recommend sleep hygiene as the only treatment for chronic insomnia. A clean bedroom and no late coffee may not fix a well-trained alarm loop by themselves. [7]

What about medicine or supplements?

A clinician may use medicine for some people after weighing benefits, side effects, age, pregnancy, breathing disorders, other medicines, and fall risk. Some sleep medicines can cause morning sleepiness, memory problems, falls, dependence, or unusual behavior during sleep. Over-the-counter does not mean risk-free.

Melatonin may help certain body-clock problems more than it helps chronic insomnia. Product strength can vary. Do not combine sleep products or give them to a child without professional advice. CBT-I remains the usual first treatment for long-term insomnia. [7,8]

Look for a second problem

Insomnia can live beside sleep apnea, restless legs, pain, reflux, asthma, depression, anxiety, menopause symptoms, medicine effects, or another condition. Treating only bedtime may miss part of the puzzle.

HELP

Ask for help

Talk with a clinician when sleep trouble lasts for weeks, harms the day, or causes heavy worry. Get urgent help for suicidal thoughts, dangerous sleepiness, severe mood change, or behavior that may cause injury.

Remember these big ideas

- Insomnia happens despite a fair chance to sleep and affects daytime life.
- CBT-I is the leading treatment for chronic insomnia in adults.
- Sleep tips alone are not the same as full CBT-I.

Quick check

1. Is staying up by choice the same as insomnia?	Answer: No. Insomnia happens despite a fair chance to sleep.
2. What treatment has a strong AASM recommendation?	Answer: Multicomponent CBT-I.
3. Are over-the-counter sleep products always harmless?	Answer: No. They can have risks and interactions.

CHAPTER 7

CBT-I: Treatment for Insomnia

Who needs it, why it works, and what it includes

CBT-I does not force sleep or knock the brain out. It uses proven steps to make sleep steadier and reduce the struggle around bedtime.

Five main parts of CBT-I

The parts work together. Sleep hygiene alone is not full CBT-I.

CBT-I	A structured treatment that changes sleep habits, timing, thoughts, and body tension.
Sleep window	The planned time from getting into bed to final wake time.
Cognitive skill	A way to notice a scary thought, test it, and answer it more fairly.

Who needs CBT-I?

CBT-I is made for insomnia. A person may take a long time to fall asleep, wake for long periods, wake too early, or feel that sleep is poor. The key is that there is a fair chance to sleep, the problem keeps happening, and it harms daytime life. Chronic insomnia lasts for months, but help can begin before a person has suffered for years.

CBT-I can still help when insomnia lives beside pain, cancer, menopause symptoms, depression, anxiety, post-traumatic stress, or treated sleep apnea. The other condition may need its own care at the same time. Adult CBT-I is not copied word for word for young children; families need age-based behavioral treatment.

Situation	What it means
Good CBT-I fit	Sleep is hard despite enough chance, the problem keeps returning, and daytime life suffers.
Needs two plans	Insomnia lives beside apnea, restless legs, pain, depression, anxiety, menopause symptoms, or another condition.
Needs a different first step	The main problem is too little time in bed, a body clock at the wrong time, or untreated dangerous sleepiness.
Needs close guidance	There is bipolar disorder, seizure risk, pregnancy, fall risk, safety-sensitive work, or a complex medical history.

Why it works

Insomnia can train the brain in the wrong direction. Bed becomes a place for checking, planning, and trying. Extra hours in bed weaken sleep pressure. A changing wake time confuses the body clock. Fear keeps the alarm system alert. CBT-I reverses each lesson.

- It builds a stronger and more regular drive for sleep.
- It reconnects the bed with sleep instead of struggle.
- It makes the body clock more predictable.
- It lowers fear about a normal imperfect night.
- It gives the person a plan that does not depend on forcing sleep.

The AASM gives multicomponent CBT-I a strong recommendation for chronic insomnia in adults. Sleep hygiene by itself is not full CBT-I. [7]

Before you begin

A clinician first checks for other causes and safety concerns. Loud snoring, gasping, restless legs, sudden sleep attacks, dream acting, a very late body clock, medicine effects, pain, and mood symptoms can change the plan. A medication should not be stopped suddenly unless the prescriber gives a taper plan.

SAFE

Get clinician guidance before changing time in bed

Close supervision is important with bipolar disorder or recent mania, seizures, pregnancy or early postpartum sleep loss, serious fall risk, major daytime sleepiness, untreated sleep apnea, safety-sensitive work, or a complex medical or mental health condition.

How a full CBT-I program works

1. Map the pattern

For one or two weeks, record bedtime, estimated time to fall asleep, wake-ups, final wake time, naps, and daytime sleepiness. The diary is an estimate. It is not a minute-by-minute test. This map helps the clinician see how much time is spent in bed and how much is spent asleep.

2. Set one wake-time anchor

Choose a wake time that fits real life and keep it fairly steady every day. Get up at that time even after a rough night unless a clinician changes the plan for safety. Morning light and daytime activity help support the anchor.

3. Re-link bed and sleep

Go to bed when sleepy, not only because the clock shows a certain time. Use the bed mainly for sleep and intimacy. If you are awake and becoming frustrated, leave the bed when it is safe. Sit somewhere quiet in dim light. Return when sleepy. Do not use a clock to decide whether exactly 20 minutes have passed.

4. Build a safe sleep window

The clinician uses the diary to choose a planned window for sleep. The wake time stays fixed, and bedtime becomes the other edge. The first window is often closer to the time the person is truly sleeping than to the long time spent in bed. This builds sleep pressure and reduces long awake stretches.

CASE

Example, not a prescription

A fictional adult lies in bed for 8.5 hours but sleeps about 6.5 hours. A trained clinician may begin with a shorter, safe window, keep the wake time fixed, and review sleepiness and sleep efficiency each week. The window is then moved or widened in small steps. The exact limit must fit the person.

This part is often called sleep restriction, but the aim is to restrict awake time in bed, not to keep a person sleep deprived forever. Some clinicians use a gentler method called sleep compression, which shortens the window slowly. The window grows as sleep becomes more solid.

5. Answer the alarm thoughts

CBT-I does not demand happy thoughts. It looks for a fair thought that is accurate and less alarming. A person can write the scary prediction, check the evidence, and write a balanced answer.

Alarm thought	A balanced answer
I must sleep right now.	I cannot force sleep. I can follow the plan and let sleep arrive.
Tomorrow will be a total disaster.	Tomorrow may be harder, but I have handled tired days before.
I need to check the time.	The clock adds pressure. I can turn it away and notice sleepiness instead.

6. Practice a downshift

Slow breathing, gentle muscle relaxation, mindfulness, or calm imagery can lower tension. These are practice skills, not sleep tests. If a person thinks, 'Relaxation must make me sleep,' the exercise can become another form of pressure. The goal is to rest the alarm system.

7. Support the plan

Morning light, regular activity, an earlier caffeine stop, and a calm wind-down support CBT-I. They are helpers, not the whole treatment. Naps may be limited for a time if they weaken nighttime sleep pressure, but safety and medical needs come first.

8. Review and widen

The diary is reviewed each week. When sleep becomes more solid and daytime safety is acceptable, the clinician may widen the sleep window in small steps. If sleepiness becomes unsafe or mood changes sharply, the plan is paused and reassessed. A course often lasts about six to eight weeks, but some people need more or less time. [8]

What progress looks like

Early in treatment, a person may feel sleepier because time in bed is shorter. Over time, falling asleep may become easier, awake time may shrink, and fear of a hard night may fade. The goal is better sleep and better daytime life, not a perfect night every night.

STORY

A fictional example

Maya began spending ten hours in bed because she feared being tired. She often slept only seven. Her clinician used a diary, a steady wake time, stimulus control, a safe sleep window, and thought skills. Maya learned that getting out of bed was not giving up. It was retraining the bed to mean sleep. This story is fictional; results differ.

Therapist, group, or digital program?

CBT-I may be given by a trained behavioral sleep medicine clinician in person, by video, or in a group. A tested digital program can improve access for some adults with a simpler case. A person with high risk, another sleep disorder, major mood symptoms, or a poor response needs more direct clinical care.

Does medicine have a role?

Sometimes, but CBT-I remains the first choice. In 2026, the AASM favored CBT-I plus an insomnia medicine over medicine alone, yet favored CBT-I alone over starting CBT-I and medicine together. Both recommendations were conditional and based on low-certainty evidence. Benefits, side effects, other conditions, and the person's goals guide the choice. [18]

Remember these big ideas

- CBT-I is for repeated insomnia that affects daytime life.
- A full program uses a diary, wake-time anchor, bed-sleep re-linking, a safe sleep window, thought skills, and review.
- High-risk patients need a trained clinician to adapt the plan.

Quick check

1. Is sleep hygiene alone full CBT-I?	Answer: No. CBT-I combines several active treatment parts.
2. Why is wake time kept steady?	Answer: It anchors the body clock and helps sleep pressure build regularly.
3. What is the sleep window meant to reduce?	Answer: Long awake time in bed, not healthy sleep forever.

CHAPTER 8

Understanding Sleep Apnea

Signs, testing, and treatment

In sleep apnea, breathing becomes too shallow or stops again and again during sleep.

This loop can repeat many times and break sleep into tiny pieces.

Apnea	A pause in breathing.
Obstructive apnea	A pause caused by a blocked or narrowed upper airway.
PAP	A machine that uses gentle air pressure to hold the airway open.

Two main kinds

Obstructive sleep apnea

Obstructive sleep apnea, or OSA, is the common kind. The throat becomes too narrow or closes while the chest still tries to breathe. Airflow falls. Oxygen may drop. The brain wakes for a moment to reopen the airway. The person often does not remember these tiny wake-ups.

Central sleep apnea

In central sleep apnea, the brain's breathing signal pauses. The airway may be open, but breathing effort stops. Heart disease, certain medicines, high altitude, and other conditions can play a part. Some people have both kinds. Treatment depends on the cause.

Clues in adults

- Loud or uneven snoring.
- Breathing pauses seen by another person.
- Choking, snorting, or gasping during sleep.
- Morning headache, dry mouth, or repeated bathroom trips.
- Unrefreshing sleep, poor focus, or daytime sleepiness.
- High blood pressure that is hard to control.

Quiet sleep does not rule out apnea, and snoring alone does not prove it. People of any body size can have OSA. Risk can come from jaw or throat shape, large tonsils, nasal blockage, family traits, age, weight, alcohol, sedating medicines, or sleeping on the back.

Clues in children

A child may snore, breathe through the mouth, sweat, sleep in odd positions, wet the bed, toss around, or pause breathing. During the day, the child may be overactive, moody, or have trouble learning. Large tonsils and adenoids are common causes. Regular child snoring deserves attention.

WHY

Why treatment matters

Untreated sleep apnea can lower sleep quality and oxygen. It is linked with problems in attention, mood, blood pressure, heart rhythm, heart and blood vessels, blood sugar, and driving safety. A link does not mean every person will develop every problem. [12]

A diagnosis needs more than a quiz

Symptoms and risk questions help decide who should be tested, but they cannot diagnose OSA by themselves. The AASM recommends objective sleep apnea testing. Depending on the person, this may be an overnight lab study or a home sleep apnea test. A doctor should review the full story and the test. [9]

Treatment options

PAP therapy

CPAP and APAP are types of positive airway pressure. A mask sends gentle air that acts like an air splint. PAP is very effective when used. The AASM recommends PAP for adults with OSA and excessive sleepiness. Education, early troubleshooting, and follow-up are important parts of treatment. [10]

Oral appliance

A custom, adjustable oral appliance moves the lower jaw forward to make more airway room. A sleep physician may prescribe one for an adult who cannot use CPAP or prefers another treatment. A qualified dentist should fit and monitor it, and follow-up sleep testing should confirm that it works. [11]

Other parts of care

- Weight management when excess weight is part of the cause.
- Side-sleeping treatment when apnea is mostly on the back.
- Avoiding alcohol or sedating medicines near bed when medically safe.
- Treating nasal blockage when present.
- Selected surgery or nerve stimulation after a specialist review.
- For some children, removal of tonsils and adenoids.

FIX

A mask problem is a fix-it problem

Leaks, dry mouth, a stuffy nose, swallowed air, pressure discomfort, and fear of the mask are common. Do not quietly quit. The clinician can change mask style, fit, moisture, pressure settings, or the type of PAP. Use PAP for all sleep unless your care team says otherwise.

STOP

Driving rule

Do not drive when you are fighting sleep, nodding off, drifting lanes, or missing exits. Pull over safely and rest. Untreated sleep apnea can raise crash risk.

Remember these big ideas

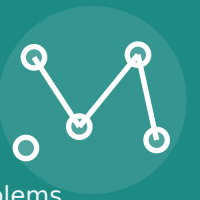
- OSA is repeated airway narrowing or closing during sleep.
- Snoring is a clue, not a complete diagnosis.
- Testing, treatment, and follow-up should work as one plan.

Quick check

1. Can a thin person have OSA?	Answer: Yes. Airway shape and other factors matter too.
2. What does PAP do?	Answer: It uses gentle air pressure to hold the airway open.
3. Should a quiz alone diagnose OSA?	Answer: No. Objective sleep testing is needed.

CHAPTER 9

Other Sleep Disorders



Restless legs, narcolepsy, unusual behaviors, and body-clock problems

Not every sleep problem is insomnia or apnea. The pattern of a symptom can help a sleep clinician find the cause.

Disorder	Common clue	Best next step
Restless legs	Urge to move at rest, worse at night, eased by movement	Review iron, medicines, and symptoms with a clinician
Narcolepsy	Strong sleepiness, sleep attacks, or emotion-triggered weakness	Sleep specialist testing
Parasomnia	Walking, terror, eating, or dream acting during sleep	Make sleep safe and seek review if risky or new
Clock disorder	Sleep works at the wrong time for school, work, or life	Track timing and get a planned light/schedule treatment

Parasomnia	An unusual action or experience during sleep or while waking.
Cataplexy	Brief muscle weakness triggered by a strong feeling while a person stays aware.
Circadian disorder	A problem caused by sleep timing that is out of step with daily life.

Restless legs syndrome

Restless legs syndrome, or RLS, creates an urge to move the legs. It often comes with crawling, pulling, tingling, or aching. It starts or worsens during rest, is worse in the evening or night, and improves for a while with movement. A leg cramp is different because a muscle becomes tight and painful.

Low iron stores can play a part even when a person is not anemic. Kidney disease, pregnancy, and some medicines may matter too. The 2025 AASM

guideline places special importance on checking iron and removing factors that worsen RLS. Medicine choice has changed because some older dopamine medicines can make symptoms start earlier and spread over time, a problem called augmentation. Do not start iron on your own; too much can be harmful. [13]

Leg kicks are not always RLS

Periodic limb movements are repeated leg jerks seen during sleep. A person can have them without feeling the awake urge of RLS. The movements only become a disorder when the full clinical picture supports it and other causes are ruled out.

Narcolepsy

Narcolepsy is a brain disorder that causes strong daytime sleepiness. A person may fall asleep at unwanted times. Some have cataplexy, such as knees buckling with laughter. Sleep paralysis can make a person unable to move for a short time while falling asleep or waking. Dream-like sights or sounds can also spill into wakefulness.

Narcolepsy is not laziness and cannot be diagnosed from sleepiness alone. A careful schedule, an overnight study, and usually a next-day nap test are used. Treatment may include planned naps, school or work support, safety steps, and medicine chosen by a sleep specialist. [14]

Parasomnias

Sleepwalking and sleep terrors

These usually rise from deep non-REM sleep. They are common in children. The person may look awake but be confused and remember little. Protect stairs, doors, windows, and sharp objects. Keep sleep regular. Do not shake or frighten the person unless needed for safety.

REM sleep behavior disorder

In REM sleep behavior disorder, the normal muscle quieting of REM is lost. A person may shout, punch, kick, or leap while acting out a dream. New dream acting in an adult needs medical review because injuries can occur and the condition can be linked with certain brain diseases. Remove weapons and dangerous objects, pad nearby furniture, and protect the bed partner. [15]

Body-clock disorders

A person with delayed sleep-wake phase may sleep well from very late night to late morning but struggle with an early schedule. An early type has the opposite problem. Shift work, jet lag, blindness, and irregular routines can also disturb timing. Treatment may use carefully timed light, darkness, melatonin, and schedule changes. Wrong timing can move the clock the wrong way, so get guidance for a major problem.

LOG

Record, but do not stage a video

If a safe camera already captures an unusual event, a short clip can help the clinician. Never delay help or put someone in danger to make a recording. Write down the time, what happened, medicines, alcohol, fever, and how the person acted after waking.

HELP

Seek prompt help

Call a clinician for injuries, violent dream acting, repeated nighttime wandering, possible seizures, sudden emotion-linked weakness, or sleepiness that causes near-crashes. Call emergency services for a current serious injury, breathing emergency, or event that does not stop.

Remember these big ideas

- RLS has a clear rest-evening-movement pattern.
- Narcolepsy is a brain disorder, not a lack of effort.
- New or dangerous sleep behaviors need evaluation and a safer bedroom.

Quick check

1. What often eases RLS for a short time?	Answer: Moving the legs.
2. What is cataplexy?	Answer: Brief muscle weakness triggered by emotion while awareness remains.
3. Why should adult dream acting be checked?	Answer: It can cause injury and may signal a neurologic condition.

CHAPTER 10

Sleep Tests: What to Expect

The right test answers the right question

A good sleep evaluation starts with the story. Sensors add evidence, but no single number knows the whole person.

What an overnight lab study can watch

- **Brain** sleep stages
- **Eyes** REM sleep
- **Chin** muscle tone
- **Heart** rate and rhythm
- **Breath** air and effort
- **Oxygen** blood level
- **Legs** movement
- **Sound** snoring

Polysomnography	A detailed overnight lab sleep study, often called PSG.
Home apnea test	A limited home test used to look for OSA in selected adults.
Sleep diary	A daily record of sleep timing, symptoms, naps, and sleep-related habits.

The first tool is a conversation

A sleep clinician asks what happens at night and during the day. The story may include bedtime, wake time, naps, work shifts, snoring, breathing pauses, leg feelings, unusual actions, medicines, caffeine, alcohol, mood, pain, and other health conditions. A bed partner or parent may notice clues the sleeper misses.

A one- or two-week diary can show patterns. It may track when you got in bed, when you think sleep began, wake-ups, final wake time, naps, sleepiness, and substances that affect sleep. An activity watch used by a clinic, called actigraphy, can add movement and timing data over many days.

The overnight sleep study

Polysomnography is painless, although the wires can feel strange. Sensors record brain waves, eye movements, chin muscle tone, heart rhythm, airflow, breathing effort, oxygen, leg movement, body position, and often snoring. These signals show sleep stages and help find breathing, movement, and behavior disorders. [16]

The home sleep apnea test

A home sleep apnea test usually records fewer signals, such as airflow, effort, pulse, and oxygen. It often cannot tell exactly when a person is asleep because most devices do not record brain waves. It is best for certain uncomplicated adults who have a strong chance of moderate to severe OSA. It is not a general test for every sleep disorder.

If a home test is negative, unclear, or technically poor but concern remains, the AASM recommends a lab study. A lab study is also preferred in several complex medical situations. The clinician should choose the test before the box is mailed. [9]

ASK

A normal test does not erase a strong story

Sleep changes from night to night, and every test has limits. If symptoms remain, ask whether the test answered the right question, captured enough good data, and needs follow-up.

Daytime nap and alertness tests

The multiple sleep latency test, or MSLT, measures how quickly a person falls asleep during several daytime nap chances and whether REM appears unusually fast. It is used in the right setting for narcolepsy and some other causes of severe sleepiness. It usually follows an overnight lab study and requires careful preparation.

The maintenance of wakefulness test, or MWT, measures the ability to stay awake in quiet daytime sessions. It may be used when alertness is important for safety. These tests are not simple pass-fail exams and must be interpreted with sleep schedule, medicines, and the overnight study.

Numbers are clues, not the whole case

- **AHI:** breathing events per hour of measured sleep.
- **Oxygen level:** how low it went and how long it stayed low.

- **Arousal:** a quick brain shift toward wakefulness.
- **Sleep efficiency:** the part of time in bed that was spent asleep.
- **Sleep stages:** how the night was shared among N1, N2, N3, and REM.

Two people with the same AHI can have different symptoms, oxygen patterns, health risks, and treatment needs. A clinician joins the numbers to the person.

Treatment is a follow-up process

The first treatment is not always the final fit. PAP data may guide mask or pressure changes. An oral appliance needs dental checks and repeat sleep testing. CBT-I changes as sleep becomes steadier. Light treatment needs correct timing. Medicine needs review for effect and side effects.

TECH

Wearables are trend tools

A consumer watch, ring, mattress sensor, or app may help you notice timing. It should not rule in or rule out apnea, narcolepsy, seizures, insomnia, or a sleep stage disorder. Bring useful trends to the visit, but bring your symptoms too.

Remember these big ideas

- The history chooses the test; the test does not replace the history.
- A lab study measures more signals than a typical home apnea test.
- Follow-up proves whether treatment is working in real life.

Quick check

1. Does a home apnea test check every sleep disorder?	Answer: No. It is a focused OSA test for selected adults.
2. What test often follows an overnight study for narcolepsy?	Answer: The MSLT.
3. Is AHI the whole diagnosis?	Answer: No. Symptoms, oxygen, health, and other data matter.

CHAPTER 11

Your Better Sleep Plan

Simple steps you can use

You cannot command sleep, but you can support it. Protect enough time, notice warning signs, and ask for help when you need it.

Sleep plan	A small set of actions chosen for one person's needs and schedule.
Pattern	What repeats across many nights, not what happens once.
Red flag	A clue that should lead to medical help or an immediate safety step.

Step 1: Name the daytime goal

A useful goal is not, 'Get a perfect sleep score.' Try, 'Stay alert in my afternoon meeting,' 'Wake for school with less struggle,' or 'Stop dozing while reading to my child.' Daytime goals keep the plan tied to real life.

Step 2: Protect enough time

Use the age guide from Chapter 4. Count back from wake time and leave room to wind down. If the schedule allows only six hours but your body needs eight, no pillow, tea, or app can make six become eight.

Step 3: Choose two strong levers

Pick two actions you can repeat for one week. Good choices include a steady wake time, morning outdoor light, an earlier caffeine stop, a short wind-down, or moving a late nap. Avoid changing ten things at once because you will not know what helped.

My one-week sleep experiment

Wake time: _____

Bedtime window: _____

Morning light plan: _____

Last caffeine time: _____

Wind-down plan: _____

Bedroom change: _____

Goal: Notice patterns. Do not chase a perfect score or a perfect night.

Step 4: Track lightly

Each morning, note bedtime, estimated sleep time, final wake time, and major wake-ups. Each afternoon, rate sleepiness and function from 0 to 10. Do not calculate in bed. A diary should lower confusion, not create a new worry.

Step 5: Check for a sleep disorder

Healthy habits may not fix a sleep disorder. Ask for a clinical review when you notice:

- Loud regular snoring, breathing pauses, choking, or gasping.
- Sleepiness despite enough time for sleep.
- Falling asleep while driving, working, eating, or talking.
- Insomnia that lasts for weeks and harms the day.
- An evening urge to move the legs that delays sleep.
- Sudden weakness with laughter or another strong feeling.
- Walking, eating, fighting, or acting out dreams during sleep.
- A child who snores often, pauses breathing, or has major daytime behavior or learning changes.

Step 6: Make safety immediate

Sleepy driving cannot wait for a future appointment. Warning signs include heavy eyelids, repeated yawning, drifting, hitting a rumble strip, missing an exit, or forgetting the last miles. Pull over in a safe place. A short nap or caffeine may help for a short time, but the real fix is enough sleep and treatment of the cause. [17]

911

Emergency line

Call 911 in the United States, or your local emergency number, for severe trouble breathing, chest pain, a serious injury, a seizure-like event that will not stop, or any immediate danger. This book is not an emergency tool.

Step 7: Review and adjust

After one or two weeks, look for a direction, not perfection. Did daytime sleepiness improve? Is wake time steadier? Is the plan realistic? Keep what helps. Change what does not. If strong symptoms remain, take the diary to a clinician.

Four questions for a sleep visit

1. What problem are we trying to explain?
2. Which test or treatment fits that problem, and why?
3. How will we know the plan is working?
4. What should I do if the first plan is uncomfortable or fails?

GO

Your final step

Treat sleep as a health signal, not a character test. Protect time. Keep your schedule steady. Notice breathing, movement, behavior, and daytime alertness. Ask for help early when something does not seem right.

Remember these big ideas

- Choose a daytime goal and two repeatable actions.
- A pattern matters more than one strange night or one device score.
- Dangerous sleepiness and breathing problems deserve prompt action.

Quick check	
1. How many habits should you change at first?	Answer: One or two strong, repeatable actions.
2. What should you do when fighting sleep while driving?	Answer: Pull over safely and rest. Do not keep driving.
3. Who can help with your sleep plan?	Answer: Your family and health care team can help.

Good night. Better day.

Sleep Safety Guide

Some clues can wait for a routine visit. Some cannot.

NOW

Act now

Do not drive or operate dangerous equipment if you are fighting sleep. Move to safety. Call emergency services for severe breathing trouble, chest pain, a serious injury, a long seizure-like event, or immediate danger.

SOON

Call promptly

Contact a clinician for breathing pauses, choking or gasping in sleep, near-crashes from sleepiness, sudden muscle weakness with emotion, violent dream acting, repeated unsafe wandering, or severe mood change.

VISIT

Make an appointment

Ask for a sleep review when insomnia lasts for weeks, snoring is regular, sleep is not refreshing, legs will not stay still at night, or daytime sleepiness continues despite enough sleep time.

Bring these clues

- A one- or two-week sleep diary.
- A full medicine and supplement list.
- A bed partner's or parent's observations.
- PAP, oral appliance, or wearable trends if you already use them.
- Your main daytime goal and your biggest safety concern.

A clear story helps the sleep team choose the right question, test, and treatment.

Sleep Dictionary

Plain meanings for the medical words in this book.

Adenosine	A brain chemical linked to the pressure to sleep.
AHI	The average number of apneas and hypopneas per hour of measured sleep.
Apnea	A pause in breathing.
APAP	PAP that adjusts pressure within a set range.
Arousal	A quick brain shift toward wakefulness, often too short to remember.
Body clock	The inner timing system that helps organize sleep and wake.
Cataplexy	Brief muscle weakness triggered by emotion while awareness remains.
Circadian rhythm	A body pattern that repeats about every 24 hours.
CPAP	PAP that provides continuous positive airway pressure.
CBT-I	Cognitive behavioral therapy for insomnia.
Deep sleep	Stage N3, also called slow-wave sleep.
EEG	A recording of the brain's electrical activity.
Home sleep apnea test	A limited home test for OSA in selected adults.
Hypopnea	A partial drop in airflow that meets sleep-test rules.
Insomnia	Trouble with sleep despite a fair chance, with effects during the day.
Melatonin	A hormone that helps signal biological night.
MSLT	A daytime nap test used in the right setting for severe sleepiness.
N1	The light transition from wake to sleep.
N2	A stable non-REM sleep stage that fills much of the night.
N3	Deep non-REM sleep.
Narcolepsy	A brain disorder that causes strong daytime sleepiness and other REM-related symptoms.
Non-REM	The N1, N2, and N3 stages of sleep.

Oral appliance	A mouth device that can move the jaw to make more airway room.
OSA	Obstructive sleep apnea, caused by repeated upper-airway narrowing or closure.
PAP	Positive airway pressure used to keep the airway open.
Parasomnia	An unusual action or experience during sleep or while waking.
Polysomnography	A detailed overnight lab sleep study.
REM	Rapid eye movement sleep, with active dreams and low large-muscle tone.
RLS	Restless legs syndrome, an urge to move that follows a rest-evening-movement pattern.
Sleep cycle	A repeating trip through non-REM and REM stages.
Sleep debt	Sleep missed compared with what a person needs.
Sleep efficiency	The percent of time in bed that is spent asleep.
Sleep pressure	The need for sleep that rises with time awake.
Stimulus control	A CBT-I method that rebuilds the link between bed and sleep.

Medical source guide

Facts were checked against AASM guidance and official federal health resources.

These sources support the medical content. The wording, examples, activities, and diagrams in this book are original. Guidelines help clinicians make decisions, but they do not replace judgment for one patient.

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About the author

Making sleep medicine easier to understand.

Adnan A. Javaid, MD, FCCP, is board-certified in Pulmonary Disease and Sleep Medicine. He leads Lung and Sleep Wellness Center in North Carolina, where he helps children and adults understand breathing, sleep, and the link between good nights and better days.

Dr. Javaid created this book for patients, families, teachers, and anyone who wants accurate sleep knowledge without a wall of medical language. His goal is simple: make the science clear enough to use.

END

The last word

Sleep is not lost time. It is an important part of health. Protect it, pay attention to warning signs, and get help when sleep problems do not improve.

SLEEP MADE SIMPLE
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