

Toward a Sleep Inclusive View of Mental Health Disorder Treatment and Prevention

Elaine Boland, PhD, DBSM

2026 PPA Convention

June 14th, 2026

Today's Talk

Why should psychologists care about sleep?



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graph TD; A[Why should psychologists care about sleep?] --> B[What do we know about how sleep impacts mental health and vice versa?]; B --> C[Is there nuance to the conversation about the risks of poor sleep?]; C --> D[Position statement from the National Sleep Foundation on Sleep and Mental Health]; D --> E[How psychologists can get more training in sleep interventions];
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What do we know about how sleep impacts mental health and vice versa?

Is there nuance to the conversation about the risks of poor sleep?

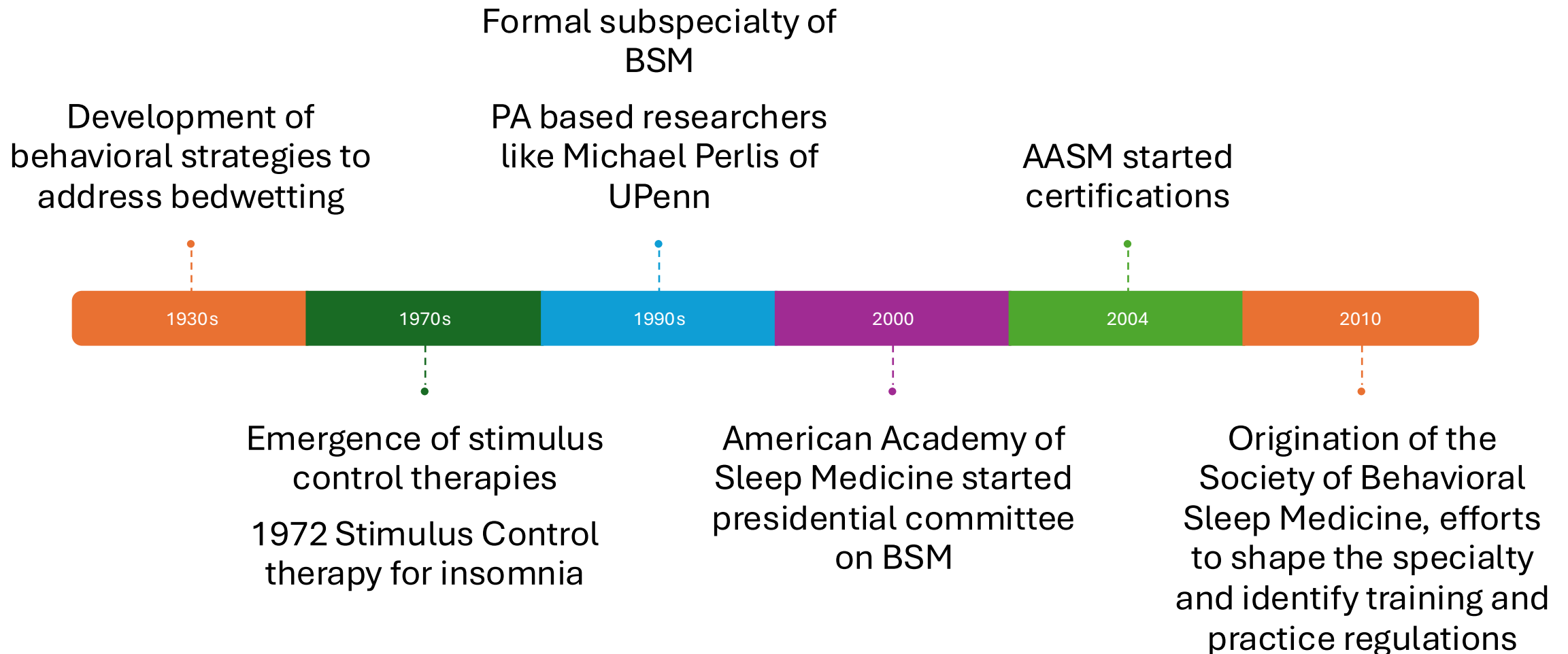
Position statement from the National Sleep Foundation on Sleep and Mental Health

How psychologists can get more training in sleep interventions

Why Should Psychologists Care About Sleep?



Evolution of Behavioral Sleep Medicine



Behavioral Sleep Medicine

- Behavioral interventions are often preferred by patients over medications
- 2018 study¹
 - treatments preferentially viewed if they conferred long term sleep benefits
 - patients actually wanted some outside time commitment (as opposed to none)
 - treatment onset of action had no influence on preference
- 2022 study of insomnia in primary care²
 - preference for behavioral intervention highest among those with severe symptoms;
 - medication most preferred by those with elevated anxiety;
 - preference for both was highest among those with elevated depression
- CBT-I is the first line approach recommended by numerous clinical practice guidelines as well as the American College of Physicians

¹Cheung et al., 2018; ²Perez et al., 2022

What do we know about how sleep impacts mental health (and vice versa?)

Sleep and mental health are reciprocal

Poor quality sleep can lead to:

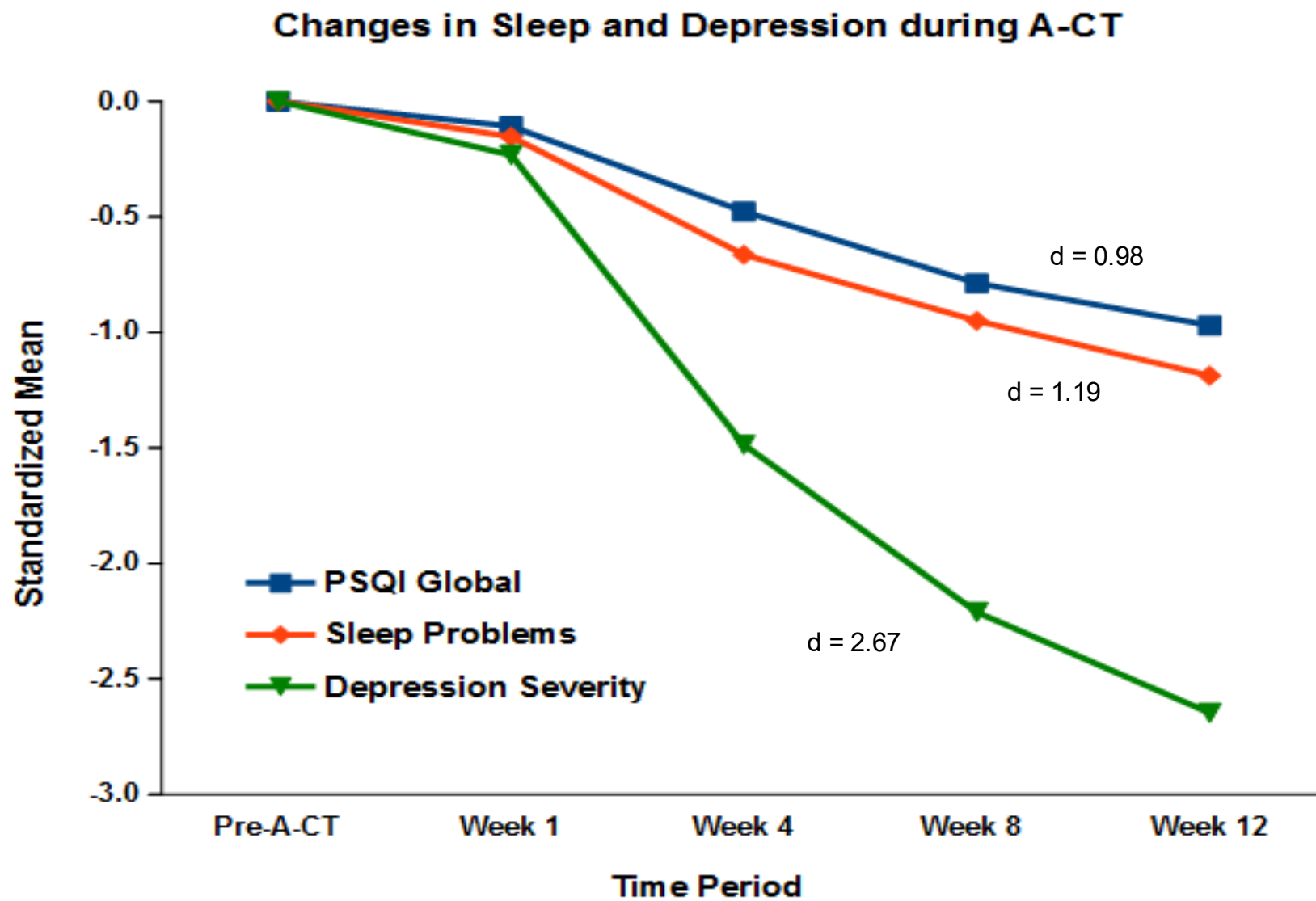
- Low, irritable mood
- Poor emotion regulation
- Impaired concentration
- Anxiety and worry
- Use of substances to “self-medicate”
- Exacerbated suicidal ideation

Mental health symptoms can lead to:

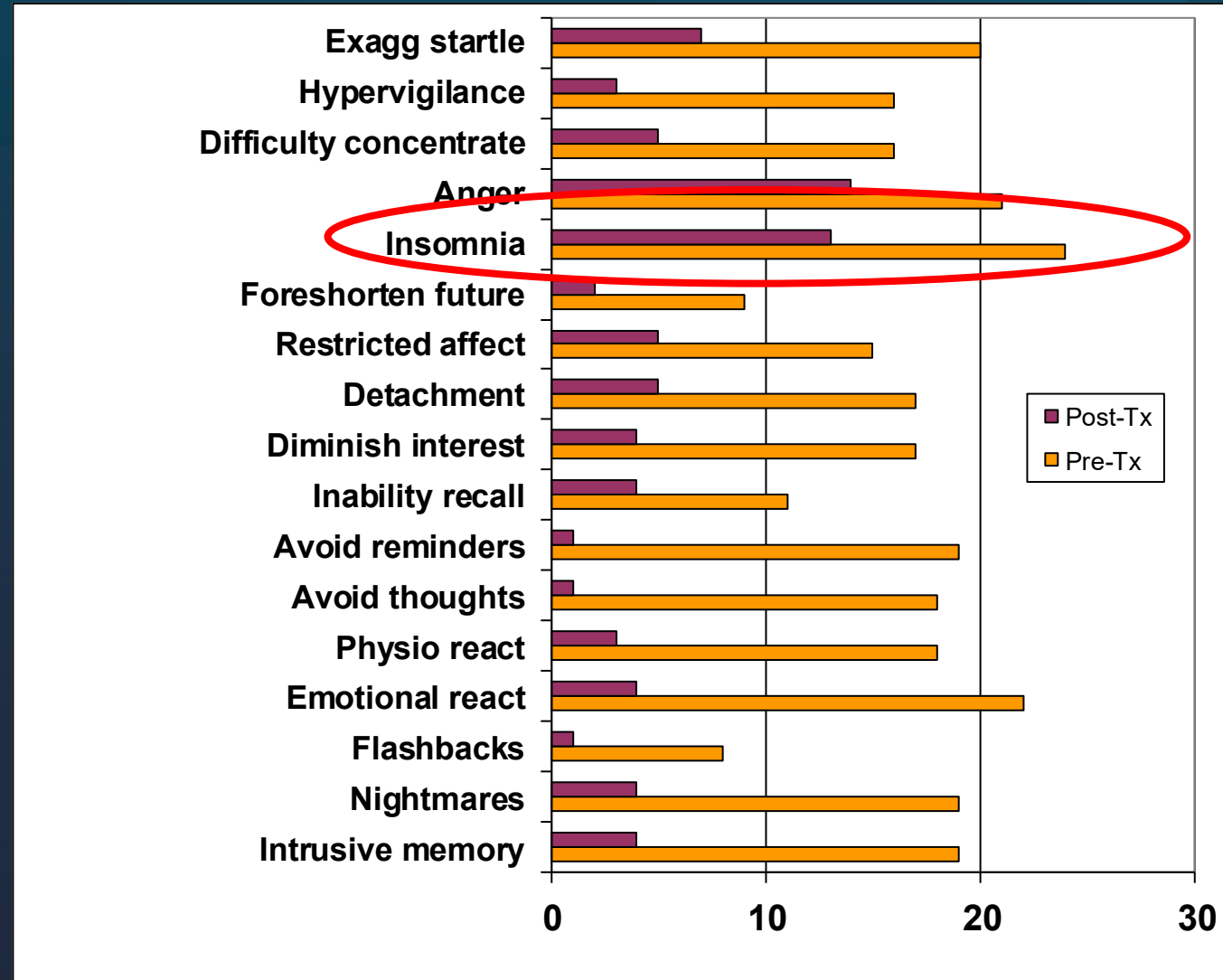
- Delayed sleep onset (e.g., due to rumination/mind racing)
- Excessive sleeping during the day, affecting sleep cycles
- Frequent awakenings, nightmares

An outdated view of sleep as symptoms of mental health disorders

Diagnosis	DSM-IV-TR criteria
Separation anxiety disorder	Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home* Repeated nightmares involving the theme of separation**
Alcohol withdrawal	Insomnia**
Amphetamine withdrawal	Insomnia or hypersomnia**
Caffeine intoxication	Insomnia**
Cocaine withdrawal	Insomnia or hypersomnia**
Nicotine withdrawal	Insomnia**
Opioid withdrawal	Insomnia**
Sedative, hypnotic, or anxiolytic withdrawal	Insomnia**
Major depressive disorder	Insomnia or hypersomnia nearly every day**
Dysthymic disorder	Insomnia or hypersomnia**
Bipolar disorder	Manic or hypomanic episode = decreased need for sleep** Depressive episode = insomnia or hypersomnia**
Posttraumatic stress disorder	Recurrent distressing dreams of the event** Difficulty falling or staying asleep**
Acute stress disorder	Reexperiencing of the traumatic event in dreams** Difficulty sleeping**
Generalized anxiety disorder	Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)**



Insomnia symptoms before and after PTSD treatment



Residual Insomnia in SUD



Sleep
Research
Society®

SLEEP, 2025, 48, 1–11

<https://doi.org/10.1093/sleep/zsae284>

Advance access publication 6 December 2024

Original Article

Original Article

Insomnia symptoms are associated with return to use and non-fatal overdose following opioid use disorder treatment

Martin Hochheimer^{1,*}, Jennifer D. Ellis¹, Justin C. Strickland¹, Jill A. Rabinowitz², J. Gregory Hobelmann^{1,3} and Andrew S. Huhn^{1,3}

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Sleep disturbance can be an independent disorder

Insomnia

- Difficulty falling, staying asleep 3x/week, 3 months or longer; associated distress and impairment

Hypersomnia

- Excessive sleepiness despite 7h or more sleep duration; 3 months; significant distress or impairment

OSA

- Obstruction of the airway causing frequent breathing pauses and disrupted sleep

Circadian rhythm dysregulation

- Delayed Sleep Wake Phase Disorder
Advanced Sleep Wake Phase Disorder
Irregular Sleep Wake Disorder
Non-24 hour Sleep Wake Disorder

Significant comorbidities with MH disorders

Insomnia

- Up to 84% prevalence in depression¹; 30% to 100% in bipolar disorder depending on phase;² 36% to 91% in AUD³

Hypersomnia

- Up to 50% prevalence in depression;⁴ Up to 75% in bipolar disorder⁵

OSA

- Up to 31% in depression;⁶ Up to 75% in PTSD⁷

Circadian rhythm dysregulation

- Up to 9.6% in depression (delayed sleep phase);⁸ Up to 60% in bipolar disorder⁹

Evidence that improving sleep improves mental health



Sleep Medicine

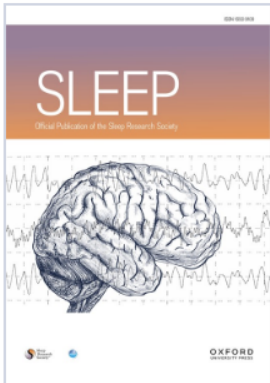
Volume 124, December 2024, Pages 650-658



CBT-I for prevention and early intervention in mental disturbances: A systematic review and meta-analysis

Laura Palagini^a  , Giulia Aquino^b, Gaspere Alfi^b, Leonardo Massoni^a, Matteo Gambini^a,
Mario Miniati^a, Donatella Marazziti^a, Dieter Riemann^{c d}, Angelo Gemignani^b, Pierre A. Geoffroy^{e f g}

Can improving sleep prevent mental health disorders?



Volume 46, Issue 6
June 2023

JOURNAL ARTICLE

Does insomnia treatment prevent depression? FREE

Elaine M Boland , Jennifer R Goldschmied, Philip R Gehrman

Sleep, Volume 46, Issue 6, June 2023, zsad104, <https://doi.org/10.1093/sleep/zsad104>

Published: 08 April 2023 **Article history** ▼



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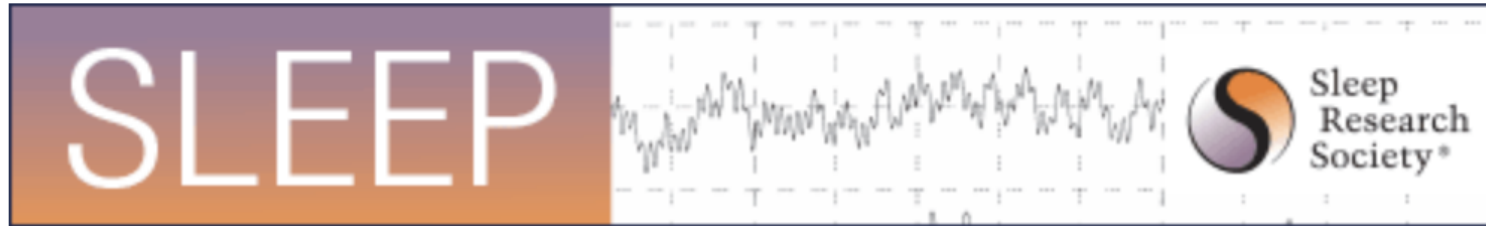


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Is there nuance to the conversation
about the risks of poor sleep?



► [Sleep](#). 2014 Jan 1;37(1):9–17. doi: [10.5665/sleep.3298](https://doi.org/10.5665/sleep.3298) [↗](#)

Sleep Health: Can We Define It? Does It Matter?

[Daniel J Buysse](#)^{1,✉}

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PMCID: PMC3902880 PMID: [24470692](https://pubmed.ncbi.nlm.nih.gov/24470692/)

Ru-SATED

Regularity – sleeping
and waking at roughly
the same time

Satisfaction –
subjective assessment
of good or poor sleep

Alertness –
maintaining
wakefulness/vigilance
during the day

Timing – is the
placement of sleep in
the 24h day optimal?

Efficiency – sleeping
for a large percentage
of time in bed

Duration – total
amount of sleep in a
24h period

Don't let 'sleepmaxxing' keep you up at night: Results from the 2025 American Academy of Sleep Medicine survey on sleep tracking

Author(s) [Logan Lutton](#)

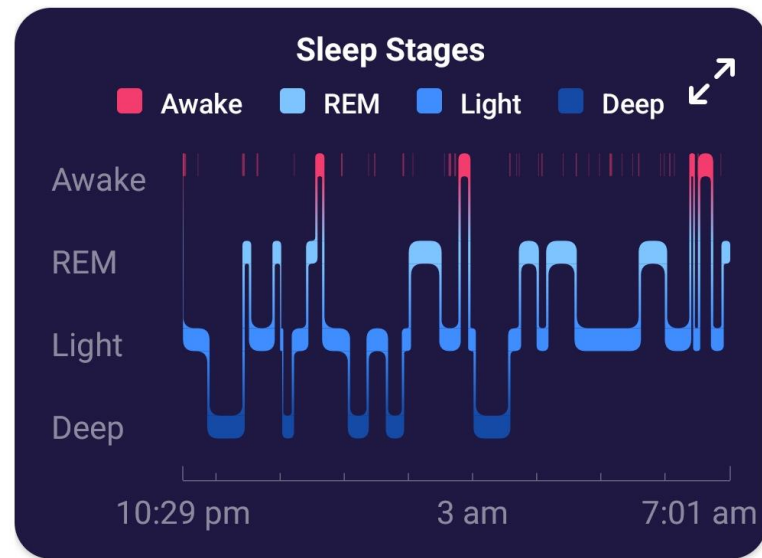
Listen



0:00 / 1:43



- Nearly half of Americans (48%) have used a sleep tracking device within the last year to monitor their sleep quality
- This is up from 35% in 2023.
- More than half (55%) are also adjusting their sleep behaviors based on what they learn.
- Anxiety over achieving optimal sleep metrics keeps 76% of Americans awake at night



Sleep health is not just sleep duration

JOURNAL ARTICLE

Is Cognitive Behavioral Therapy for Insomnia Effective for Improving Sleep Duration in Individuals with Insomnia? A Meta-Analysis of Randomized Controlled Trials [Get access >](#)

Wai Sze Chan, PhD ✉, Christina S McCrae, PhD, Albe Sin-Ying Ng, B.Soc.Sc

Annals of Behavioral Medicine, Volume 57, Issue 6, June 2023, Pages 428–441,

<https://doi.org/10.1093/abm/kaac061>

Published: 03 December 2022

Results

We found a small average effect of CBT-I on diary-assessed TST at post-treatment, equivalent to an approximately 30-min increase. Age significantly moderated the effects of CBT-I on diary-measured and polysomnography-measured TST; older ages were associated with smaller effect sizes. Contrarily, a negative, medium effect size was found for actigraphy-assessed TST, equivalent to an approximately 30-min decrease. Publication biases were found for diary data at follow-up assessments suggesting that positive findings were favored.

Conclusions

CBT-I resulted in improvements in TST measured by sleep diaries and polysomnography (in adults). These improvements were not corroborated by actigraphy findings. Theoretical and clinical implications were discussed.

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Sleep disorders increase the risk of dementia, Alzheimer's disease, and cognitive decline: a meta-analysis

ORIGINAL ARTICLE | [Open access](#) | Published: 11 April 2025

Volume 47, pages 4899–4920 (2025) [Cite this article](#)

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[Zoltan Ungvari](#), [Mónika Fekete](#), [Andrea Lehoczki](#), [Gyöngyi Munkácsy](#), [János Tibor Fekete](#), [Virág Zábó](#),
[György Purebl](#), [Péter Varga](#), [Anna Ungvari](#)  & [Balázs Györrffy](#)

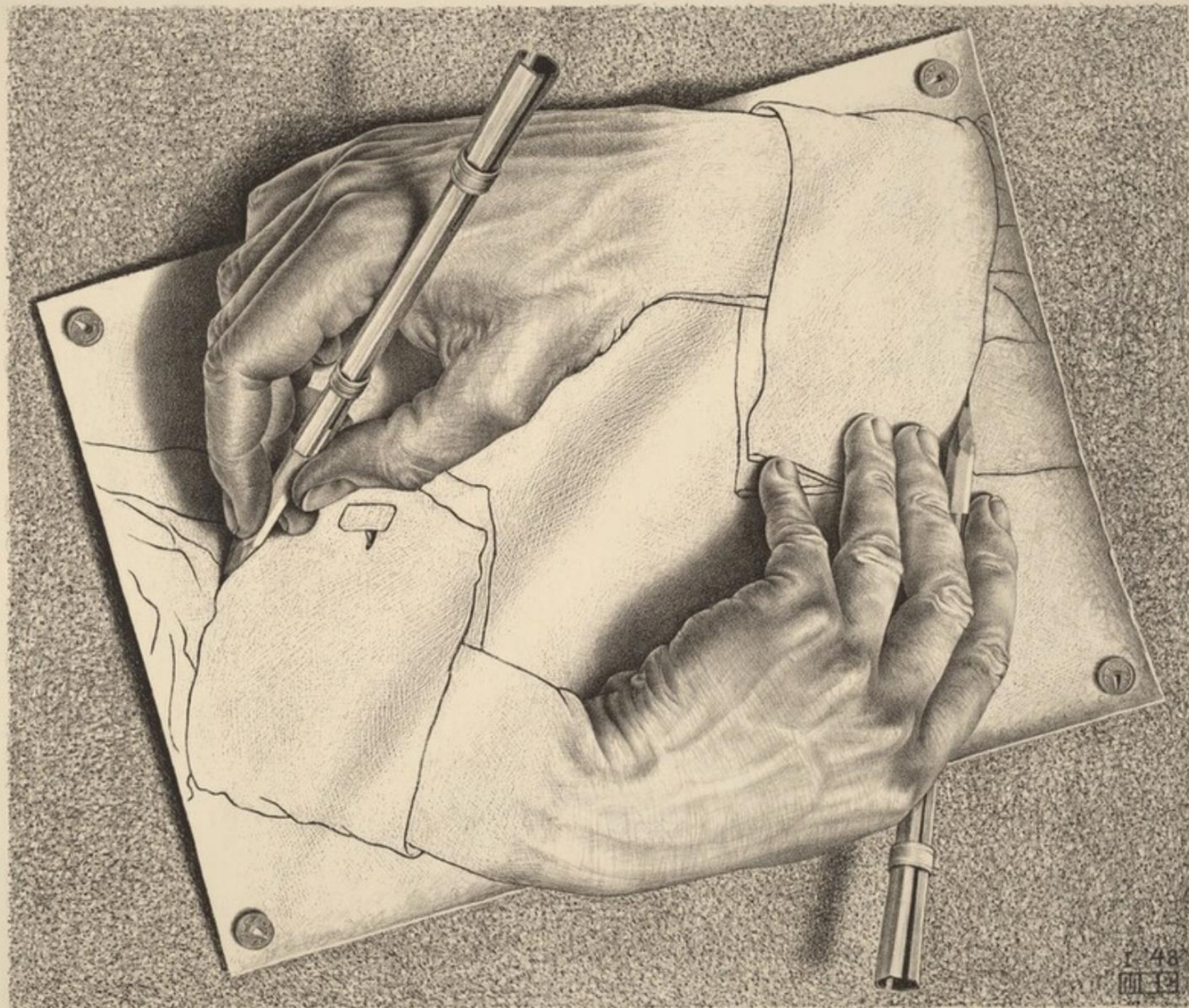
Sleep Disorders and Dementia

- Results showed:
 - Significant associations between all-cause dementia and obstructive sleep apnea, insomnia, and other sleep disorders
 - Obstructive sleep apnea increased the risk for AD
 - Insomnia was significantly associated with increased risk for both vascular dementia and AD
- But also...
 - Sleep was self reported not observed
 - Sleep disturbance often occurs with other disorders (hypertension, diabetes, depression) that are also independently connected to dementia

Sleep or distress?

The biological mechanisms underpinning the observed associations between sleep disorders and dementia are complex and multifactorial. Insomnia, characterized by difficulty initiating or maintaining sleep, is associated with chronic activation of the hypothalamic–pituitary–adrenal (HPA) axis [[108](#)], leading to elevated cortisol levels, systemic inflammation [[39](#),[40](#),[41](#),[42](#)], and chronic oxidative stress [[43](#)], all of which exacerbate neurodegeneration [[41](#),[42](#),[43](#), [108](#)]. Sleep deprivation further impairs glymphatic clearance of neurotoxic proteins [[109](#)], such as amyloid- β and tau, both of which are central to Alzheimer's disease pathology [[1](#), [34](#),[35](#),[36](#), [109](#),[110](#),[111](#)]. Obstructive

Dialectic of
sleep
improvement
and
acceptance



Advocacy: Translating Science into
Practice
Recommendations from the National
Sleep Foundation



Contents lists available at ScienceDirect

Sleep Health: Journal of the National Sleep Foundation

journal homepage: www.sleephealthjournal.org

Sleep health and mental health: A position statement from the National Sleep Foundation

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Recommendations for healthcare systems and providers

Recommendations for healthcare systems and providers

1. Integrate reliable sleep health screenings into regular medical and psychological evaluations to detect signs of poor sleep that may be affecting mental health.
2. Implement prevention, screening, assessment, and treatment of mental health issues that incorporate sleep as a critical component.
3. Develop institution-level procedures for using sleep data as part of routine data collection to flag risks for mental health issues and inform treatment of mental health.
4. Payers should incorporate sleep health and wellness into mental health offerings!

Insomnia Severity Index

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the *CURRENT* (i.e. *LAST 2 WEEKS*) *SEVERITY* of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your *CURRENT* sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
0 1 2 3 4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable Little Somewhat Much Very Much Noticeable
0 1 2 3 4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried A Little Somewhat Much Very Much Worried
0 1 2 3 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) *CURRENTLY*?

Not at all Interfering A Little Somewhat Much Very Much Interfering
0 1 2 3 4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score

Total score categories:

0-7 = No clinically significant insomnia

8-14 = Subthreshold insomnia

15-21 = Clinical insomnia (moderate severity)

22-28 = Clinical insomnia (severe)

STOP-BANG: Obstructive Sleep Apnea

STOP-Bang Questionnaire

Please answer the following questions by checking "yes" or "no" for each one

	Yes	No
S noring (Do you snore loudly?)	☐	☐
T iredness (Do you often feel tired, fatigued, or sleepy during the daytime?)	☐	☐
O bserved Apnea (Has anyone observed that you stop breathing, or choke or gasp during your sleep?)	☐	☐
H igh Blood P ressure (Do you have or are you being treated for high blood pressure?)	☐	☐
B MI (Is your body mass index more than 35 kg per m ² ?)	☐	☐
A ge (Are you older than 50 years?)	☐	☐
N eck Circumference (Is your neck circumference greater than 40 cm [15.75 inches]?)	☐	☐
G ender (Are you male?)	☐	☐

Score 1 point for each positive response.

Scoring interpretation: 0 to 2 = low risk, 3 or 4 = intermediate risk, ≥ 5 = high risk.

Epworth Sleepiness Scale – Excessive Daytime Sleepiness

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Use the following scale to choose the most appropriate number:

	0 no chance	1 slight chance	2 moderate chance	3 high chance
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public space	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Total Score:				

Consensus Sleep Diary

Consensus Sleep Diary-Core

ID/Name: _____

Sample								
Today's date	4/5/08							
1. What time did you get into bed?	10:15 p.m.							
2. What time did you try to go to sleep?	11:30 p.m.							
3. How long did it take you to fall asleep?	55 min.							
4. How many times did you wake up, not counting your final awakening?	3 times							
5. In total, how long did these awakenings last?	1 hour 10 min.							
6. What time was your final awakening?	6:35 a.m.							
7. What time did you get out of bed for the day?	7:20 a.m.							
8. How would you rate the quality of your sleep?	☐ Very poor ☒ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ Very poor ☐ Poor ☐ Fair ☐ Good ☐ Very good
9. Comments (if applicable)	I have a cold							

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: *On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.*

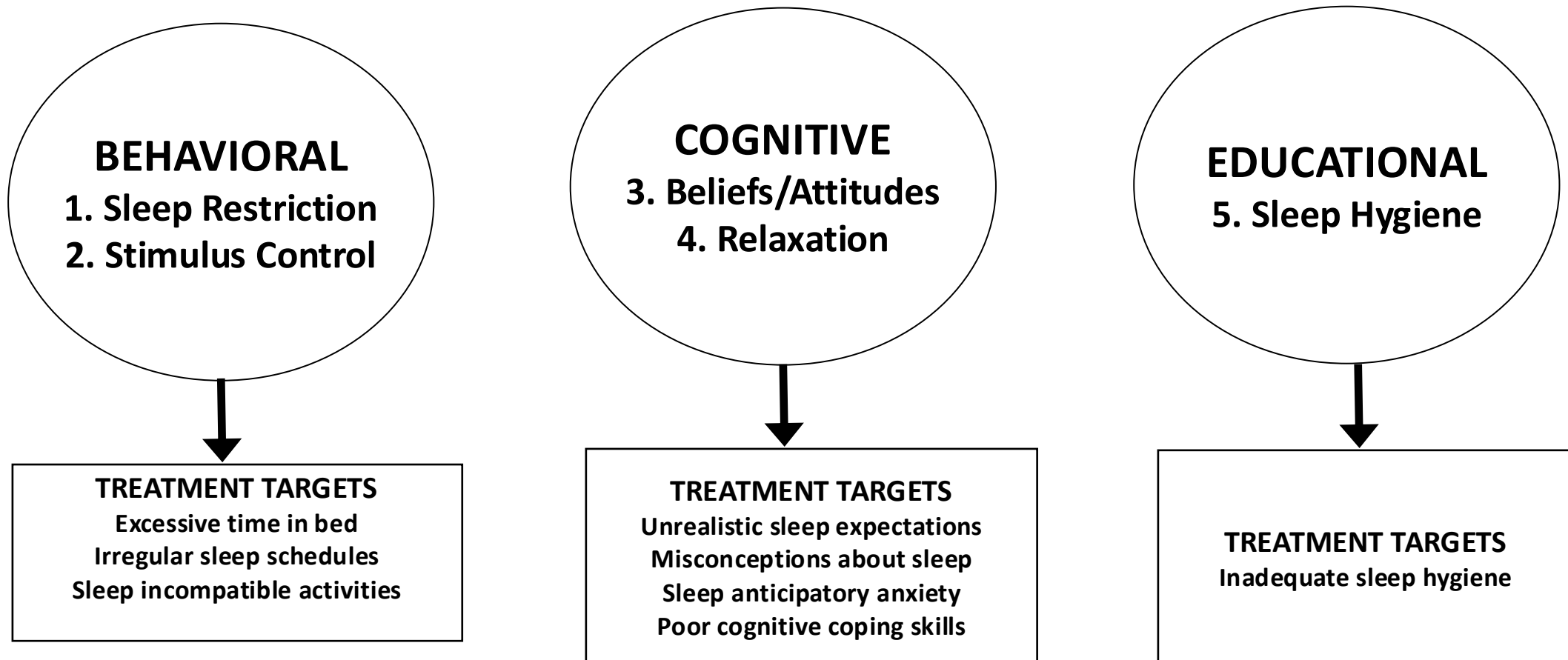
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Cognitive Behavioral Therapy for Insomnia (CBT-I)



Brief Behavioral Treatment for Insomnia

4 sessions

1st session 40 – 75 mins

- Healthy sleep practices, psychoeducation, sleep rules

2nd session ~20 mins

- Phone follow-up to address challenges, review progress, titrate sleep schedule

3rd session ~30 mins

- In person
- Make adjustments, review progress

4th session ~20 mins

- Phone follow-up
- Relapse prevention

“Single Shot” CBT-I

JOURNAL ARTICLE

Treating Acute Insomnia: A Randomized Controlled Trial of a “Single-Shot” of Cognitive Behavioral Therapy for Insomnia

[Get access >](#)

Jason G. Ellis, PhD ✉, Toby Cushing, BSc, Anne Germain, PhD

Sleep, Volume 38, Issue 6, 1 June 2015, Pages 971–978,

<https://doi.org/10.5665/sleep.4752>

Published: 01 June 2015 **Article history** ▼

ACT for Insomnia



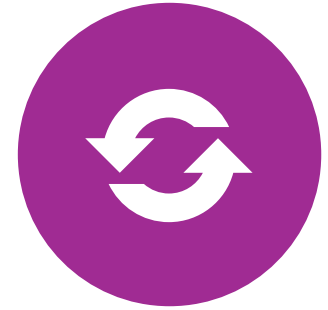
**REDUCE SLEEP-RELATED
ANXIETY**



**BUILD PSYCHOLOGICAL
FLEXIBILITY**

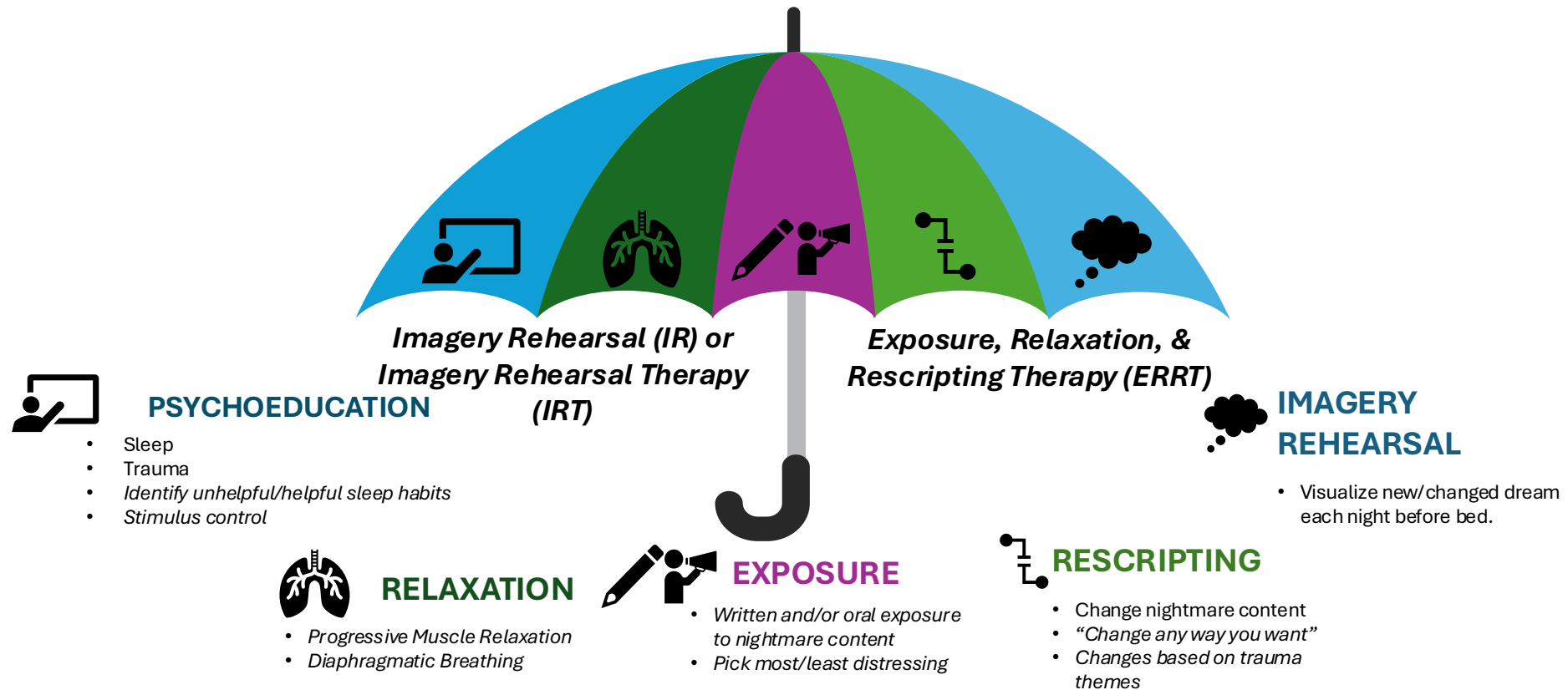


**FOCUS ON WHAT YOU
CAN CONTROL**



**COMMIT TO VALUE-
BASED ACTION**

Cognitive Behavioral Therapy for Nightmares (CBT-N)



CBT for Hypersomnia

Energy management and scheduling



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graph TD; A[Energy management and scheduling] --> B[Napping strategies]; B --> C[Psychosocial support]; C --> D[Cognitive reframing]; D --> E[Chronic disease coping];
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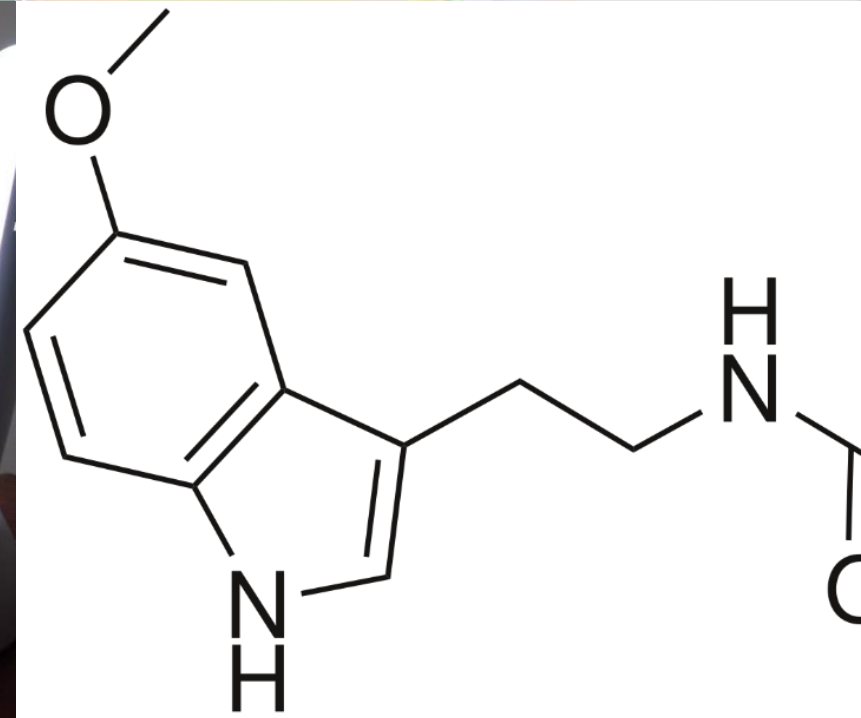
Napping strategies

Psychosocial support

Cognitive reframing

Chronic disease coping

Circadian Treatments: Bright Light and Melatonin



When behavioral sleep interventions “don’t work”

- Insomnia may not be maintained behaviorally
 - Evidence of increased metabolism; genetic factors; gut microbiota
- Medications are not the bad guys!
 - Recommendations for behavioral interventions first, not only.
- Focus on the distress
 - Change the goal – no longer focusing on sleep, focusing on changing the relationship to wakefulness
 - Help reduce worry and stress with nuanced information about the consequences of poor sleep

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Institutional Settings

Sleep questions as part of every intake



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graph TD; A[Sleep questions as part of every intake] --> B[Tracking of sleep over time]; B --> C[Integrated Care settings];
```

Tracking of sleep over time

Integrated Care settings

- recognize sleep as a trigger for behavioral health triage

Recommendations for Educational and Government Organizations

Recommendations for educational and government organizations

1. Include content about sleep health and mental health in K-12 and college health education, medical school and health-related graduate education, and training/certification programs for other health professionals.
2. Implement sleep-focused mitigation programs specifically aimed at populations at higher risk for inadequate sleep and mental health issues (e.g., trauma victims, first responders, military personnel, postpartum parents, high school students) and among medically underserved communities to reduce potential long-term risks.
3. Dedicate resources to reduce disparities and help ensure equitable access to interventions and treatments that benefit both sleep health and mental health.

Education



Include sleep courses in our graduate programs!

Often limited to portions of health psychology courses



Can instruction in CBT-I be as standard as instruction in CBT?



Practicum placements for sleep are limited – can they be expanded?

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Mitigation

- Advocating for early screening in children and teens
 - School psychologists/parents
- Education programs in schools and high-risk populations

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3. Dedicate resources to reduce disparities and help ensure equitable access to interventions and treatments that benefit both sleep health and mental health.

Reduce Sleep and Mental Health Disparities

- Contributing factors:
 - SES
 - Racism
 - Discrimination
 - Neighborhood segregation
 - Geography
 - Social patterns
 - Access to healthcare
 - Cultural beliefs

Recommendations for Policy Makers

Recommendations for policy makers

1. Develop policy around sleep and mental health promotion in residential and inpatient facilities serving a variety of clients and patients.

General Sleep Recommendations aimed at improving sleep health, and therefore, mental health

2. Implement later school start times in accordance with expert recommendations (8:30 AM or later), especially for high school students, to align with the natural sleep rhythms of adolescents.
3. ~~Implement regular, scheduled nap periods for daycare, early learning, and pre-school programs to provide adequate 24-hour sleep opportunity for young children.~~
4. Recommend and implement work hour policies that prioritize sleep, especially for jobs that are at risk for sleep deprivation or disruption and those industries that serve the public (e.g., transportation, first responders, utilities, and healthcare).
5. Develop policies to promote sleep health and mental health in the armed forces, both active and inactive duty.
6. Eliminate clock change and daylight saving time in favor of permanent standard time.
7. Update and improve the built environment to incorporate sleep-health promoting principles (e.g., lighting, noise, temperature, activity, safety).

School start times

Teen Sleep Issues and School Start Times, Part I

Gail R. Karafin, EdD, Public Policy Chair, School Psychology Board, gkarafin@verizon.net



Dr. Gail R. Karafin

The research on the benefits of a healthy lifestyle and the consequences of an unhealthy one cannot be disputed. One of the main components of a healthy lifestyle is getting adequate sleep. Yet sleep is something frequently neglected in our society, especially among adolescents. Continually getting too little sleep can have serious consequences, including emotional,

behavioral, and performance problems. In addition, many mental disorders, such as depression, anxiety, mania, schizophrenia, post-traumatic stress disorder, and attention-deficit/hyperactivity disorder, can include sleep disturbance. This can complicate diagnosis and treatment with teens.

The National Sleep Foundation and many pediatric sleep specialists recommend the following sleep amounts relative to a child's age:

Age of Child in Years	Needed Hours of Sleep
1-3	12-14
3-6	10-13
6-11	9 ½ -12
11-18	9-9 ½

The four most common sleep disorders in children are (1) obstructive sleep apnea, (2) periodic limb movement disorder, (3) delayed sleep phase syndrome and circadian schedule disorders, and (4) narcolepsy. A more prevalent problem is not a sleep disorder, but a behavioral issue: poor sleep hygiene.

Circadian rhythm in teens

All living organisms appear to have rhythmic patterns at the cellular level known as circadian rhythms. The human body has an internal clock that is normally set by daytime sunlight and evening darkness. Teens experience delayed phase sleep problems where the natural circadian rhythms have an extended day and they are excessively sleepy in the mornings. That means, as all parents know, teenagers tend to stay up later and sleep in later. Adolescents report being unable to fall asleep in time to get the amount of rest needed given their wake-up schedule. Ironically in most school districts, high school has the earliest start time, which compounds the problem for teens who are struggling with circadian rhythm shifts and delayed sleepiness. There also is the effect of modern technology: the hypnotic and addictive use of electronic devices late into the night frequently delays the onset of sleep. Adolescent chronic sleep deprivation results in a form of perpetual pseudo-jet lag.

Physical consequences of sleep deprivation

There are a number of consequences associated with sleep deprivation. Chronically getting too little sleep disrupts many aspects of physical health, including hormone regulation, glucose metabolism, insulin resistance, inflammation processes, heightened pain perception, cancer, and reduced immune function. Although many early studies on sleep deprivation focused on total deprivation, more recent attention has addressed the more common problem of "partial sleep loss" or shortened sleep. This occurs when one cuts sleep short by an hour or two. Levels of leptin, a hormone that regulates hunger and appetite, drop during partial sleep deprivation. This can have effects on dietary choices, obesity, diabetes, high blood pressure, and cardiovascular disease, now referred to as cardiometabolic disease. Circadian

AVERAGE TEEN CIRCADIAN CYCLE



Getting sleepy

Melatonin, the sleep hormone, rises about an hour later in teens than adults. The blue light from electronic devices can suppress melatonin, disrupting your sleep.

11 PM



The big dip

Your energy is at its lowest. Depending on your internal clock, you might not feel fully awake until 9 a.m. or even 10 a.m.

3 AM TO 7 AM



Afternoon slump

You feel blah, and you might crave a snack. In your adult years, you'll see this energy dip earlier, from 1 to 3 p.m.

2 PM TO 5 PM



Energy up

Your body temperature rises throughout the morning, so your alertness and sharpness increase.

10 AM TO 1 PM

Recent PA Legislation and Legislative Action

[PA Education Committee Hearing on Later School Start Times](#). On April 4, 2024, PA Senate Education Committee Chairman David Argall presided over a hearing to better understand the later secondary school start times movement. RASNC Co-founder and Co-Chair Amy Goldman was asked to provide testimony, as were sleep medicine experts Drs. Indira Gurubhagavatula and Joanna Fong-Isariyawongse. The aforementioned physicians have successfully lobbied for the introduction of [House Bill 1848](#), listed below, and are trying to get the Senate to take up that bill or write a companion piece of legislation. Hearing Recording [CLICK HERE](#). Wissahickon School Board Resolution [CLICK HERE](#).

[HB 1848](#) (Rep Cooper, Briggs, Mihalek and Brennan) - proposed mandated **secondary school start time for 8:15 AM** or later as a result of strong lobbying efforts of sleep scientists and years of data. If passed, legislation would be effective in 2026-27. Hoping to pair this legislation along with another one that reduces the distance for mandated bussing from 10 miles beyond district boundaries to help make school start time changes easier. Referred to the Education Committee of the House on November 14. **Related resources:** PA Joint State Government Commission Report SLEEP DEPRIVATION IN ADOLESCENTS: THE CASE FOR DELAYING SECONDARY SCHOOL START TIMES (October 2019) - Full Report [CLICK HERE](#) & Summary [CLICK HERE](#).

[HB 312](#) (Rep. Diamond) - proposed amendment to the Act of April 13, 1887 that established uniform standard of time in PA to be **permanent standard time** and the elimination of daylight savings time in PA. Referred to the State Government Committee on March 10th. This standard of time enhances the benefits of later school start times by having biological clocks aligned all year long with natural circadian rhythms and reducing the duration of morning darkness.

Recommendations for Policy Makers

Recommendations for policy makers

1. Develop policy around sleep and mental health promotion in residential and inpatient facilities serving a variety of clients and patients.

General Sleep Recommendations aimed at improving sleep health, and therefore, mental health

2. Implement later school start times in accordance with expert recommendations (8:30 AM or later), especially for high school students, to align with the natural sleep rhythms of adolescents.
3. Implement regular, scheduled nap periods for daycare, early learning, and pre-school programs to provide adequate 24-hour sleep opportunity for young children.
4. Recommend and implement work hour policies that prioritize sleep, especially for jobs that are at risk for sleep deprivation or disruption and those industries that serve the public (e.g., transportation, first responders, utilities, and healthcare).
5. Develop policies to promote sleep health and mental health in the armed forces, both active and inactive duty.
6. Eliminate clock change and daylight saving time in favor of permanent standard time.
7. Update and improve the built environment to incorporate sleep-health promoting principles (e.g., lighting, noise, temperature, activity, safety).

► J Clin Sleep Med. 2024 Jan 1;20(1):121–125. doi: [10.5664/jcsm.10898](https://doi.org/10.5664/jcsm.10898) 

Permanent standard time is the optimal choice for health and safety: an American Academy of Sleep Medicine position statement

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The case for permanent standard time

- Reduced sleep in spring
- Shifts associated with increased heart attacks, strokes, hospital admissions due to atrial fibrillation, increased production of inflammatory markers, increases in motor vehicle accidents¹
- Evidence that the body doesn't adjust to DST
- Ongoing circadian misalignment

How can psychologists get more training
in behavioral sleep medicine
interventions?

Resource: Society of Behavioral Sleep Medicine

Member Resources

- Practice Guidelines, Position Statements
- Scope of Practice
- DBSM Information
 - like ABPP for psychologists

Education

- SBSM [Reading List](#)
- Online Courses/Webinars
- FYI: Students

Public Resources

- What is BSM?
- Community Education Videos
- Hot Topics in Sleep Behavior
- Adult/Childhood Sleep Disorders

Consultation

- Get support on cases
- List of BSM providers

Resource: American Academy of Sleep Medicine

Practice Standards (much available to public)

[Practice Standards - American Academy of Sleep Medicine – Association for Sleep Clinicians and Researchers \(aasm.org\)](https://aasm.org/practice-standards)

- Practice Guidelines
- Position Statements
- Consensus Statements
- Quality Measures
- Choosing Wisely

Practice Guidelines

This page lists active AASM clinical practice guidelines and clinical guidance statements, formerly called position papers, on the use of diagnostic and treatment options for patients with sleep disorders.

Most Recently Published

Recommended protocols for the Multiple Sleep Latency Test and Maintenance of Wakefulness Test in children: guidance from the American Academy of Sleep Medicine

Circadian Rhythm Sleep-Wake Disorders

Diagnostics

Hypersomnias

Insomnia

Parasomnias

Pediatrics

Sleep-Related Breathing Disorders

Sleep-Related Movement Disorders

Other Resources/Training

University of Arizona

- [BSMinar - University of Arizona Behavioral Sleep Medicine Seminar \(sleephealthresearch.com\)](https://sleephealthresearch.com/BSMinar)

University of Pennsylvania

- [Continuing Medical Education | The Penn Sleep Centers | Perelman School of Medicine at the University of Pennsylvania \(upenn.edu\)](https://www.upenn.edu/perelman-school-of-medicine/continuing-medical-education/)

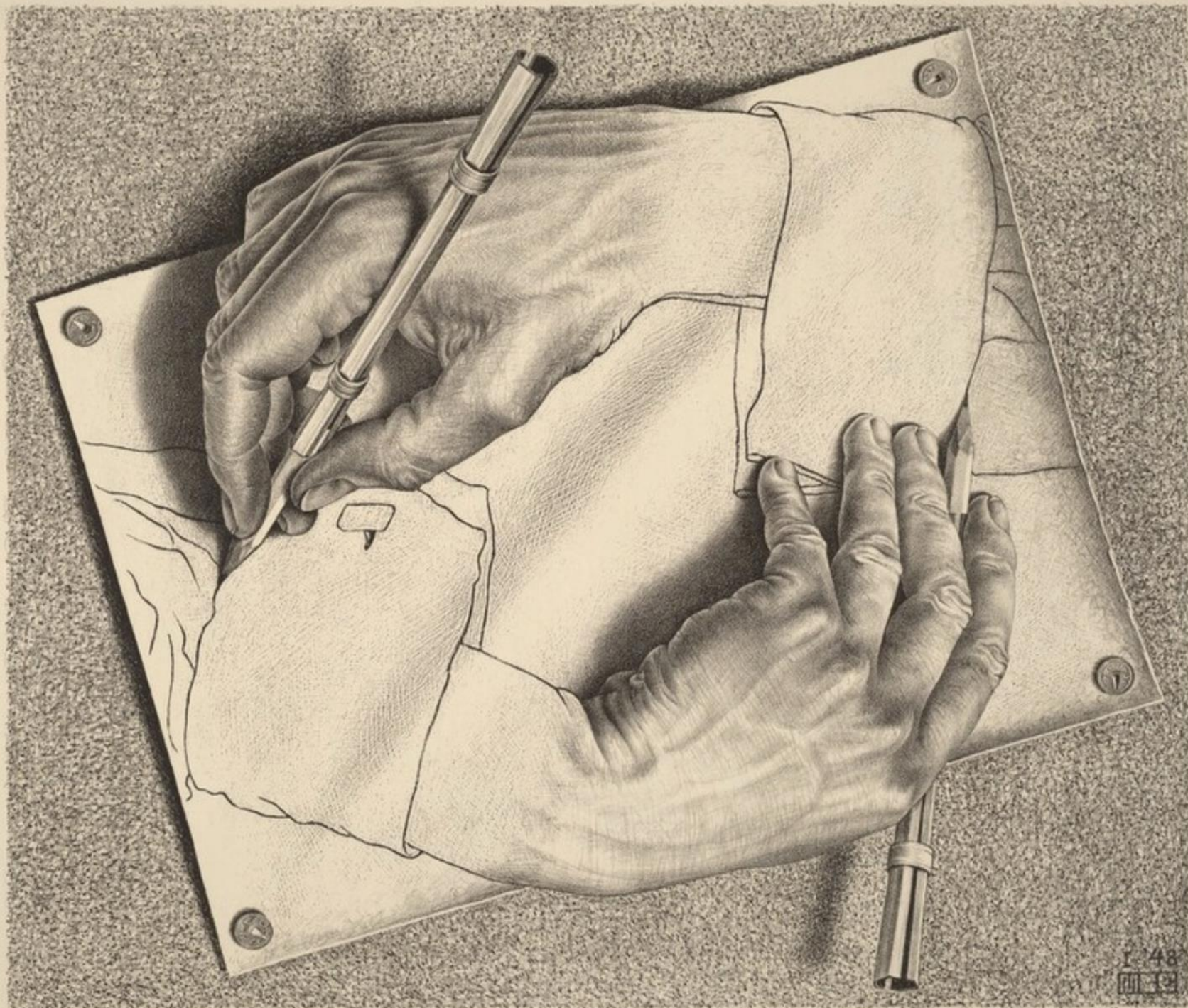
CBT-I Web

- <https://www.cbtweb.org/>

CBT-N Web

- <https://www.cbtnightmares.org/>

Toward a
Sleep
Inclusive
View of
Mental
Health Care



Thank you!

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