Defining the Disorder: Beyond a "Bad Night"



The Clinical Threshold. Without daytime impairment, a short or broken night is ordinary sleep variability, not not a disorder. The goal is separating lasting clinical problems from temporary distress.

DSM-5-TR: Quantifying Insomnia Disorder



Frequency: ≥ 3 Nights / Week

Filters out isolated late events or temporary examination nerves.

Duration: ≥ 3 Months



Establishes a chronic pattern rather than a temporary reaction.



Impact: Significant Distress

Meaningful impairment in social, occupational, or daily functioning.

Key Insight

A Pattern, Not a Single Night.

Insomnia is judged by long-term trajectories, meaning a single sleep diary cannot confirm the diagnosis.

Evolving Classifications: The Standalone Disorder

The Baseline: American Academy of Sleep Medicine (ICSD-3) aligns with DSM-5 on thresholds: ≥ 3 nights/week for ≥ 3 months.

Historical View: Primary vs. Secondary

Sharp lines were drawn between "pure" insomnia and insomnia as merely a symptom of another illness.

Action: Sleep treatment was delayed until the "primary" disease was cured.

Modern View: Independent & Co-occurring

Treated as a distinct disorder that stands on its own. Frequently co-occurs alongside depression, anxiety, pain, or medical diseases.

Action: Sleep treatment is initiated immediately alongside other therapies, not automatically postponed.

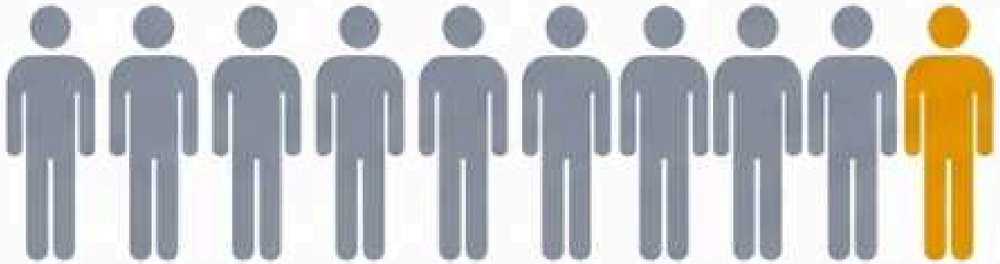
The Night-Time Pattern: Three Familiar Forms



Core Concept: These are descriptive forms, not separate diseases. Patterns can shift over time. All share a lasting mismatch between the wish to sleep, the opportunity to sleep, and reality.

The Public Health Scale: How Common is Insomnia?

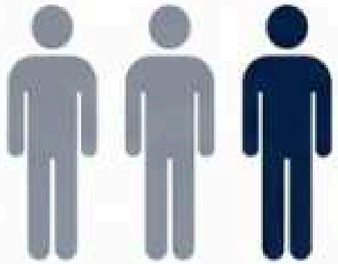
Chronic Insomnia Disorder



~1 in 10 Adults

10% of the population meets full, strict clinical criteria.

Occasional Poor Sleep



~1 in 3 Adults

33% of the population experiences periodic symptoms.

Demographics

Becomes more common in later adulthood (though not strictly an 'old age' problem).

The Treatment Gap

Despite high prevalence, a massive proportion of those suffering never receive structured psychological treatment.

Beyond the Night: Why Public Health Cares



Cognitive & Emotional Harm

Lowered mood, fatigue, and difficulty with attention and memory.

Safety & Societal Risk

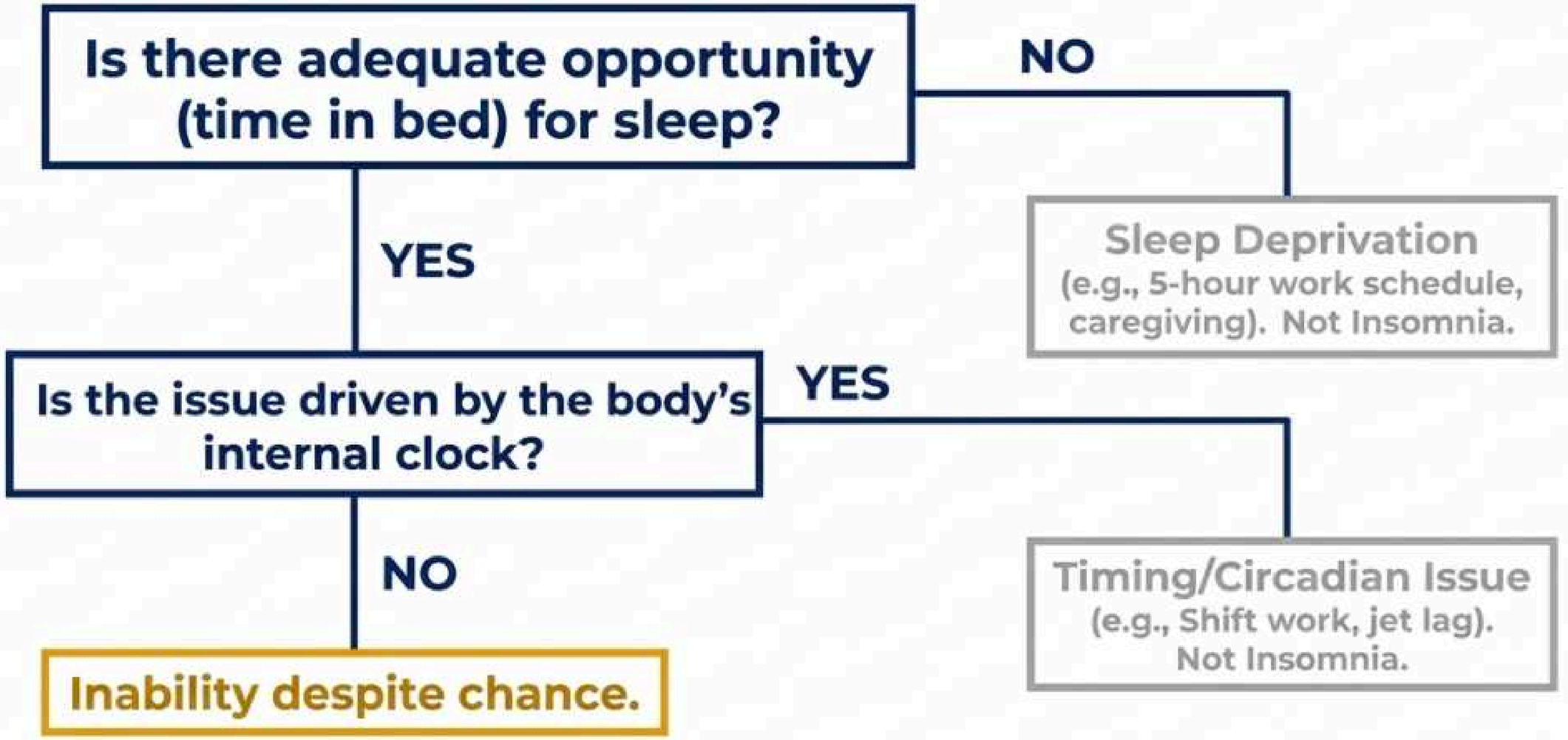
High risk of accidents (e.g., when sleepiness meets driving).

Long-term Associations

Linked in observational research to poorer quality of life and later depression (not necessarily a 1-way cause).

Takeaway: Lasting patterns with daytime harm require proper clinical assessment, not just a shrug or a slogan.

Differential Diagnosis: Opportunity vs. Inability



Conclusion: True Insomnia is the inability to sleep despite both adequate opportunity and normal timing.

Assessment First: Sleep Disorders That Mimic Insomnia



Obstructive Sleep Apnea

Respiratory disruption.

Unrefreshing sleep, loud snoring, gasping for air.



Restless Legs Syndrome

Sensorimotor disruption.

Movement problems making the start of the night miserable.



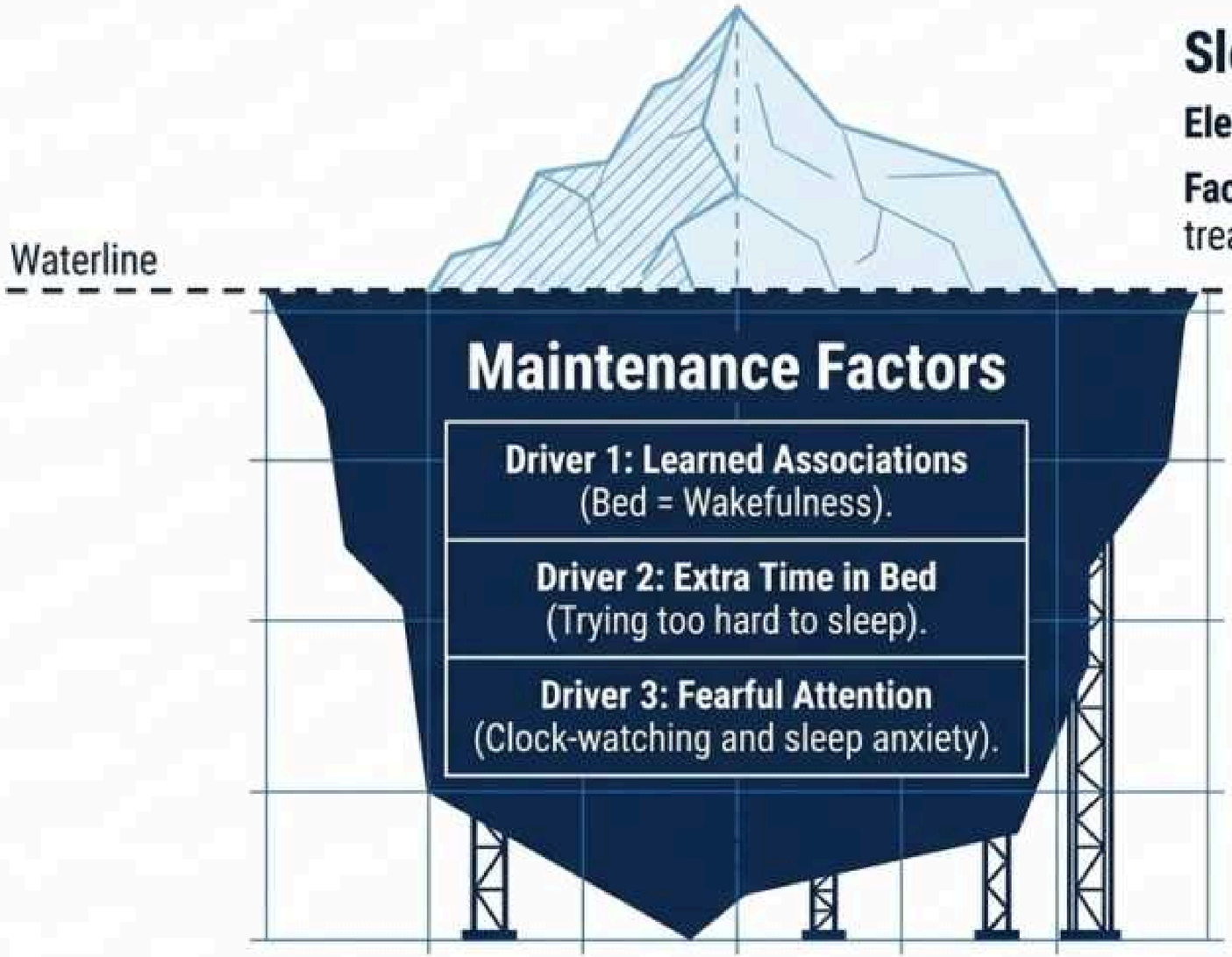
Medical/Neurological

Secondary disruption.

Disruptions to sleep architecture caused by underlying medical diseases.

A clinician must assess first. Therapy designed for insomnia (CBT-I) is not a universal fix for mechanical or neurological sleep disorders.

Why “Sleep Hygiene” is Not a Diagnosis (or a Cure)



Sleep Hygiene

Elements: Caffeine, alcohol, late screens, dark room.

Fact: Sensible advice, but insufficient as a standalone treatment for chronic insomnia disorder.

Many insomnia patients already practice perfect hygiene; the problem lies in the in the deeper behavioral and cognitive associations.

Objective Measurement: The Insomnia Severity Index

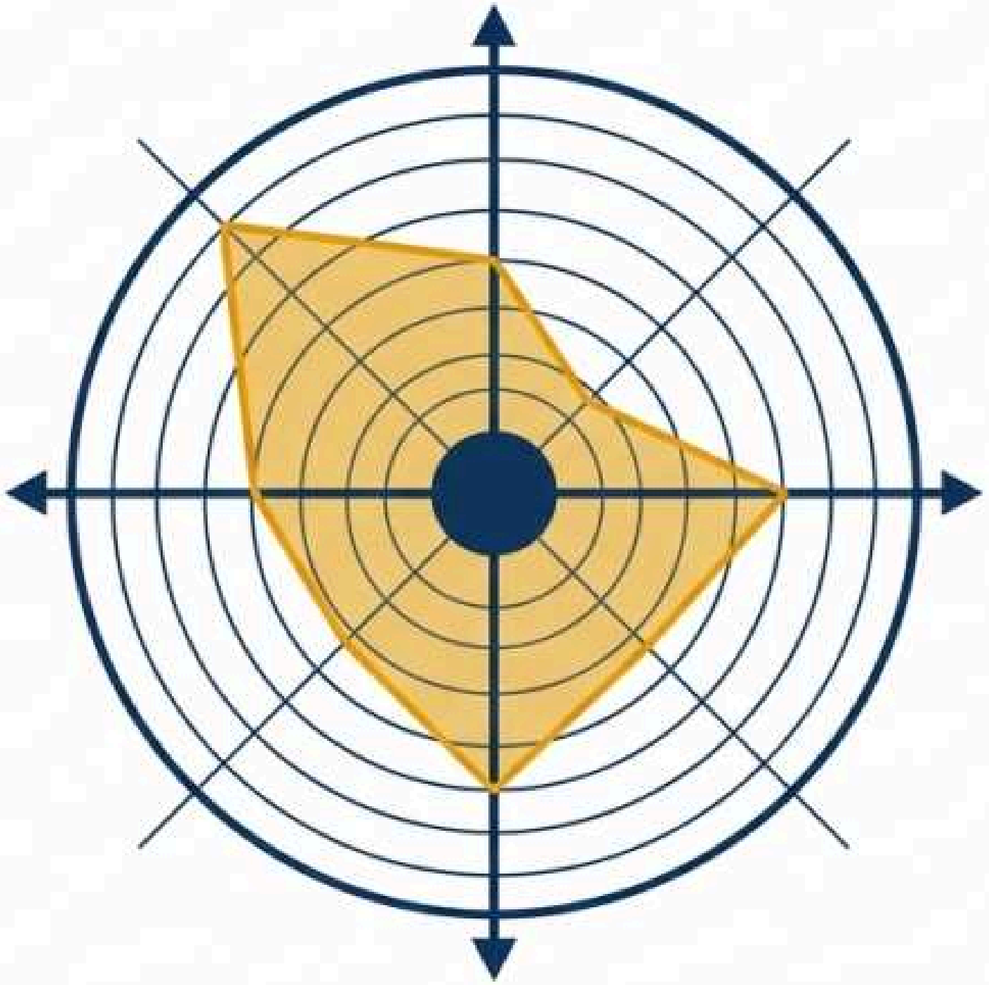
Developed by Charles Morin, the ISI complements sleep diaries and clock-time measures (e.g., time to fall asleep).

Severity

Severity of night-time difficulties.

Satisfaction

Satisfaction with current sleep patterns.



Interference

Interference with daytime functioning.

Noticeability

Distress or visibility of the problem to others.

Insomnia can be quantified repeatably. Treatment improvement is a matter of hard data, not just vague clinical impressions.

Navigating the Literature: A Student's Toolkit

Read This

Primary Source: Current Diagnostic Manuals
(Notice elements: opportunity, frequency, duration, daytime impairment).

Clinical Standard: 2021 Clinical Practice Guideline
(American Academy of Sleep Medicine - open scientific paper).

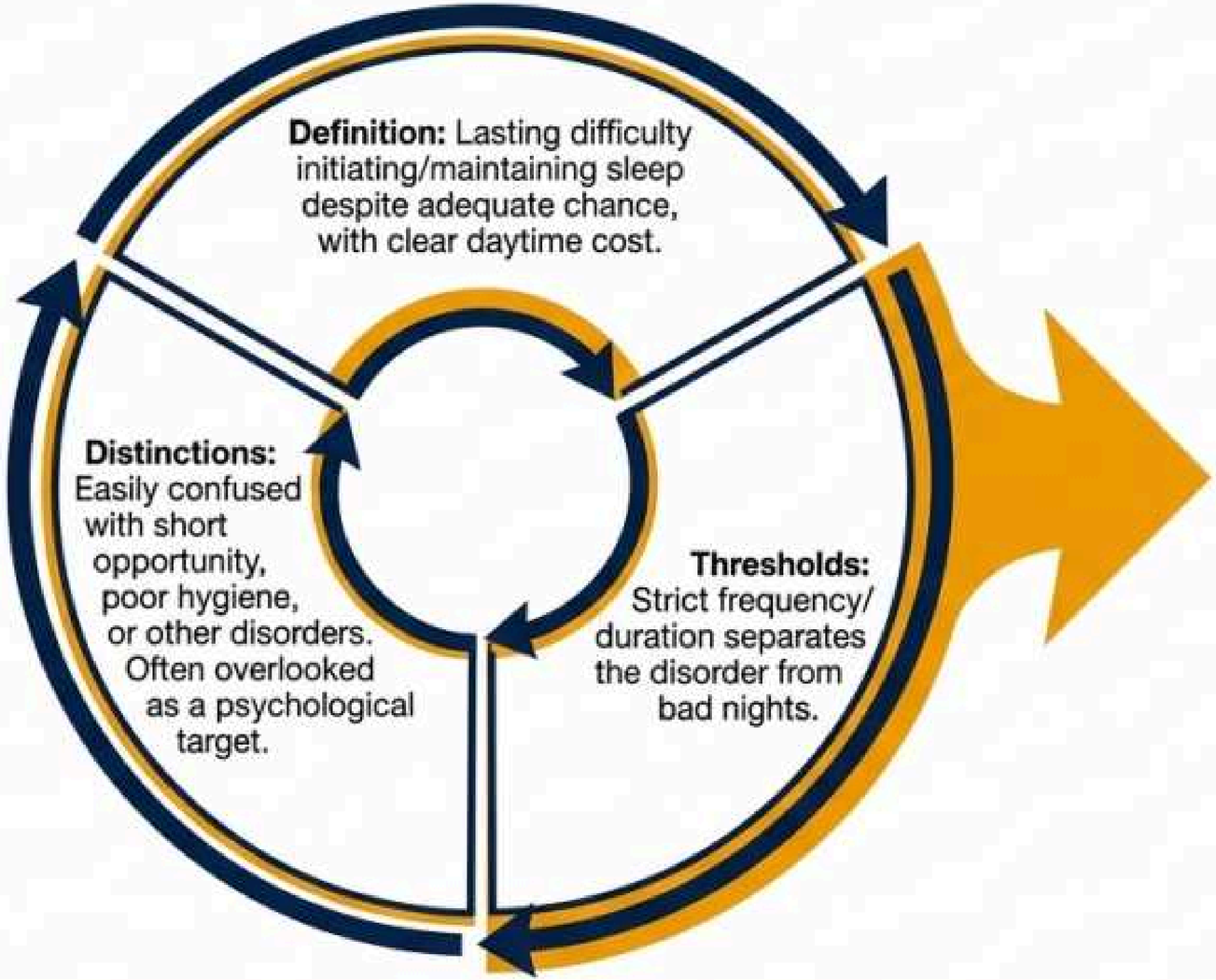
Physiological Foundation: Physiology 120 B
(Normal sleep stages and body clocks).

Not This

Avoid popular articles that promise "a cure by Friday" or simple lists of tips.

Rely on careful, short analyses of the diagnostic idea. Rigor beats tips.

Synthesis: What Insomnia Is (And What's Next)



The Core Question:
Why does the difficulty so often continue after the original trigger has passed?

(Exploring the transition from acute reaction to chronic maintenance)