TWO WEEK SLEEP DIARY

NSTRUCTIONS:

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 got 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.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				
	week 1																									
	week 2																									

Reid, K. J., & Zee, P. C. (2005). Circadian disorders of the sleep–wake cycle. In M. H. Kryger, T. Roth, & W. C. Dement (Eds.), *Principles and practice of sleep medicine* (pp. 691–701). Philadelphia, PA: Elsevier.

Rene, C. E., Rol, P., Grothmann, K., Kaase, H., & Terman, M. (1996). Bright light therapy in focus: Lamp emission spectra and ocular safety. *Technology and Health Care, 4*, 403–413.

Sateia, M. J., & Nowell, P. D. (2004). Insomnia. *The Lancet, 364*, 1959–1973.

Smith, M. T., Smith, L. J., Nowakowski, S., & Perlis, M. L. (2003). Primary insomnia: Diagnostic issues, treatment, and future directions. In M. L. Perlis & K. L. Lichstein (Eds.), *Treating sleep disorders: Principles and practice of behavioral sleep medicine* (pp. 214–261). New York, NY: Wiley.

Spielman, A. J., Saskin, P., & Thorpy, M. J. (1987). Treatment of chronic insomnia by restriction of time in bed. *Sleep, 10*, 45–56.

Suhner, A. G., Murphy, P. J., & Campbell, S. S. (2002). Failure of timed bright light exposure to alleviate age-related sleep maintenance insomnia. *Journal of the American Geriatrics Society, 50*, 617–623.

Vallieres, A., Morin, C. M., Guay, B., Bastien, C. H., & LeBlanc, M. (2004). Sequential treatment for chronic insomnia: A pilot study. *Behavioral Sleep Medicine, 2*, 94–112.

Verbeek, I., Schroeder, K., & Declerck, G. (1999). Evaluation of short-term nonpharmacological treatment of insomnia in a clinical setting. *Journal of Psychosomatic Research, 47*, 369–383.

Walsh, J. K., & Schweitzer, P. K. (1999). Ten-year trends in pharmacological treatment of insomnia. *Sleep, 22*, 371–375.

Williams, R. L., Karacan, I., Thornby, J. I., & Salis, P. J. (1972). The electroencephalogram sleep patterns of middle-aged males. *The Journal of Nervous and Mental Disease, 154*, 22–30.

Wohlgemuth, W. K., & Edinger, J. D. (2000). Sleep restriction therapy. In K. L. Lichstein & C. M. Morin (Eds.), *Treatment of late-life insomnia* (pp. 147–166). Thousand Oaks, CA: Sage.

Wu, R., Zhang, C., Deng, J., & Long, C. (2002). Comparison between cognitive-behavior therapy and medication on chronic insomnia. *Chinese Mental Health Journal, 16*, 677–680.

APPENDIX

Cognitive Behavioral Therapy Components to Treat Insomnia

Sleep hygiene instructions to the client (Haun, 1982; Morin, 1993)
- Sleep only as much as needed to feel refreshed.
- Maintain a regular sleep/wake schedule, even on weekends.
- Exercise regularly, but not close to bedtime.
- Eat regular meals, avoid going to bed hungry, and avoid excessive liquids in the evening.
- Plan time for worrying well before bedtime.
- Avoid trying to fall asleep, and turn the clock so the numbers are not showing.
- Make the bedroom free from light and noise, and set a comfortable temperature.
- Avoid long naps.
- Cut down on caffeine, alcohol, and smoking.

Sleep restriction prescription (Spielman et al., 1987)
- Client completes sleep diary for 2 weeks (provides information about bed/wake times, length of time to fall asleep, and number/duration of awakenings).
- Clinician calculates the average total sleep time according to sleep diary data.
- Clinician assigns time in bed equal to average total sleep time (no less than 4.5 hours/night).
- Clinician helps client to decide on appropriate bed/wake times for this amount of sleep.
- Each week, the client's average sleep efficiency (time asleep/time in bed) is calculated.
- If sleep efficiency is above 90%, clinician increases client's time in bed by 15 minutes; if below 85%, it is decreased by 15 minutes.
- Clinician continues to adjust time in bed until client reports satisfaction with sleep/daytime function, sleep efficiency is 85%–90%. Client's time in bed remains at last adjusted value.

Stimulus control instructions to the client (Bootzin, 1975)
- Keep a regular sleep/wake schedule every day, regardless of how much sleep you get.
- Use the bed and bedroom only for sleep (and sex).
- Sleep only in the bedroom, not elsewhere in the house.
- If awake, leave the bedroom.
- Return to bed only when sleepy.
- Recognize internal cues for sleepiness (e.g., yawning).
- Refrain from napping.

Cognitive restructuring (Harvey & Greenall, 2003; Smith et al., 2003)
- Client constructs list of all potential negative consequences of poor sleep (5–10 items).
- He/she rates the odds of each consequence actually occurring (*not likely to very likely*).
- He/she calculates how often sleep is poor and how often these consequences have occurred.
- Clinician displays the large discrepancy between beliefs (#2) and actual outcome (#3).

Paradoxical intention options for the client (Broomfield & Espie, 2003)
- At bedtime, relax with the lights out, but keep the eyes open.
- At bedtime, try to read for as long as possible.