



DID YOU KNOW

- At least two-thirds of college students report occasional sleep disturbances.
- One third of those who reported sleep disturbances reported severe sleep difficulties.
- One study showed that only 11% of the students surveyed met the criteria for good sleep quality.
- The typical college student fails to make sleep a top priority.
- Only 40% of adults reported getting adequate sleep on a regular basis.
- 35% of adults reported experiencing at least one symptom of insomnia each night.

WHY DO I NEED SLEEP?

Sleep is essential for good health, mental and emotional functioning, and personal safety. The proper amount of sleep is usually determined by age. A college-aged person should get 7 to 8 hours of sleep each night. Insufficient sleep can be dangerous and lead to one or more of the following problems.

- **ANXIETY** - Studies found that people who get less than a full night's sleep feel more stressed, angry, sad and mentally exhausted. This pattern can lead to increased anxiety.
- **COGNITIVE DIFFICULTIES** - Insufficient sleep can cause deficits in attention, concentration, and critical thinking.
- **DEPRESSION** - Sleep difficulties such as insomnia or excessiveness sleepiness, may be signs of depression.
- **REDUCED PHYSICAL HEALTH** - Inadequate sleep can lead to a weakened immune system, and put you at risk for health related problems.

If you experience these problems for a prolonged period of time, you should consult with a health care professional.

Role of Sleep

Everyone has an optimal sleep requirement per night for normal functioning that can be anywhere from four to eleven hours. An average night's sleep is divided into multiple cycles of approximately 90-100 minutes. Each cycle is divided into REM (rapid eye movement) and four stages of non-REM sleep. REM accounts for about 20% of sleep while stages 3 and 4 make up another 10-20%. Stages 3 and 4 are the most refreshing, deepest, and most difficult period to awaken a sleeper.

WHY AM I SO SLEEPY?

There are a number of common causes for sleep deprivation. One or more of the following factors may disrupt the sleep cycle of students.

- **Not allowing enough time to sleep** - Studies show that college students obtain only an average of 6 hours of sleep per night. As a student, it is important to keep in mind that no matter how hectic your schedule gets, you should always set aside enough time for adequate sleep. Learn how to properly manage your time to allow for a good night's rest.
- **Stress** - All college students experience fluctuation in their stress levels. Balancing schoolwork, activities and a job can be overwhelming. Excessive worrying can contribute to stress and can keep you up at night. Practice relaxation techniques and learn about stress management skills to maintain normal stress levels.
- **Poor Sleep Hygiene** - College students often get less sleep during the week and attempt to make up for it during the weekends. It is important to remember that inconsistent sleep habits can lead to chronic sleep difficulties. Waking up at the same time each day is essential in sleep hygiene.
- **Medication** - If you are taking any medication, find out what the side effects are. If one of the side effects is preventing you from sleeping, consult with your healthcare provider about the best time of day to take medication or if it is necessary to change your prescription.
- **Lack of Exercise** - A person who does not get enough physical activity may experience low energy and will be less productive. Exercising early in the day can promote sleep at night. Do not worry if you cannot do anything too strenuous. A simple 30-minute walk or other form of light exercise will do the trick.

WHAT IS SLEEP HYGIENE?

Sleep hygiene refers to daily activities that promote normal, quality nighttime sleep and full daytime alertness. Here are some simple ways to improve your sleep hygiene:

- Develop a bedtime routine by doing the same thing every night before going to sleep. You will eventually associate your bedtime routine with sleeping. Give yourself about 30 minutes to get ready for bed. Avoid studying right up till bedtime.
- Avoid worrying in bed. Try journaling to help store your thoughts.
- Train your body to sleep at night by going to bed at the same time every day including weekends.
- Use the bedroom only for sleeping. Do not eat, talk on the phone, or do work in bed.
- Make sure that your bedroom is quiet and dark. Use earplugs or a fan to mask any noise that may interfere with your sleep.
- Get up and go to another room if you cannot sleep after thirty minutes. Sit quietly in another room for 20 minutes, drink warm milk, or listen to soothing music before going back to bed.
- Avoid or limit your use of caffeine, especially in the evening.
- Exercise earlier in the day and avoid exercising within a few hours of going to bed.
- Learn to better manage your time and the stress in your life.
- Avoid naps during the day if they interfere with establishing normal sleep patterns.
- Avoid eating a large, late evening meal or heavy fatty foods before going to bed.
- Prepare for the next morning by having your clothes picked out and your books together for the next day. This will save a lot of time and you will not be rushed in the morning.

SLEEP DISORDERS

Insomnia

Insomnia is characterized by the inability to fall asleep, difficulty maintaining sleep, or waking too early in the morning. The National Sleep Foundation's 2002 *Sleep in America Poll* found that 58% of adults in the US experience symptoms of insomnia a few nights a week. They also found that although insomnia is the *most common sleep problem* in 48% of older adults, they are less likely to experience frequent symptoms of insomnia than their younger counterparts.

Excessive Daytime Sleepiness

Excessive Daytime Sleepiness (EDS) disorder is a condition in which an individual feels drowsy during the day **even after getting enough sleep at night**. This disorder can significantly interfere with a person's ability to perform normal daily activities. People with EDS often suffer from low self-esteem, frustration and anger about being misunderstood and regarded as unintelligent and lazy.

Sleep Apnea

Sleep apnea is a breathing disorder characterized by brief interruptions of breathing during sleep. Early recognition and treatment of sleep apnea is important because it may be associated with irregular heartbeat, high blood pressure, heart attack, and stroke. People, who are overweight and snore loudly, or have high blood pressure, or have some physical abnormality in the nose, throat, or other parts of the upper airway are at a greater risk for developing sleep apnea.

Narcolepsy

Narcolepsy is a chronic neurological disorder that involves the body's central nervous system and is characterized by a triad of symptoms: sudden loss of muscle tone, sleep hallucinations, and uncontrollable daytime sleepiness during normal activities such as conversation, driving, sitting or standing. For people with narcolepsy the messages being sent from the brain about when to sleep and when to wake up often arrive at the wrong places at the wrong times. One in 2000 people suffer from narcolepsy and most of them report their first symptoms between the ages of 15 and 20.

Treatment for these disorders is usually tailored to the individual. Be sure to consult with your primary healthcare provider for a proper diagnosis and a treatment that is best for you.

HOW CAN I TELL IF I HAVE A SLEEPING DISORDER?

The following are questions to help identify sleep disorders. If you answered yes to any of these questions, then you may have a sleeping disorder and should consult your primary healthcare provider.

	Yes/No
1. Does it often take you more than 30 minutes to fall asleep at night?	_____
2. Do you wake up frequently during the night - or too early in the morning - and have a hard time going back to sleep?	_____
3. When you awaken, do you feel groggy and lethargic?	_____
4. Do you feel drowsy during the day particularly during monotonous situations?	_____
5. Has anyone told you that you snore loudly?	_____
6. Do you feel sleepy during normal daily activities such as watching TV, reading a book, or driving?	_____
7. Do you experience jumping or jerking movements in your legs that frequently prevent you from falling asleep?	_____

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KEEP TRACK OF YOUR PRECIOUS SLEEP

Keeping a diary of your sleeping habits is a good way to identify problems or conditions that could be interfering with your ability to get a good night's rest. The National Sleep Foundation's Sleep diary takes only a few minutes each day to complete. Complete the diary for a minimum of seven consecutive days and then review it to see if there are any practices that are contributing to your sleep problems.

A copy of the sleep diary is attached to the end of this handout. If there are some things that are worrying you, then consult your primary healthcare provider.

TIPS

- Determine how your sleep pattern affects your life.
- Use some suggestions from the sleep hygiene section.
- Use the attached sleep disorder diary to monitor your sleep patterns and determine what changes should be made.
- If problems persist, be sure to contact your primary health care provider at McKinley Health Center.

Resources

McKinley Health Center: Contact your primary healthcare provider

McKinley Health Center: Health Education Unit, Stress Management Educator, 333-2714

McKinley Health Center: Mental Health Unit, 333-2705

National Sleep Foundation: www.sleepfoundation.org

If you are a registered University of Illinois student and you have questions or concerns, or need to make an appointment, please call: **Dial-A-Nurse at 333-2700**

If you are concerned about any difference in your treatment plan and the information in this handout, you are advised to contact your health care provider.

Visit the McKinley Health Center Web site at: <http://www.mckinley.uiuc.edu>

National Sleep Foundation Sleep Diary

Fill out days 1-4 below and days 5-7 on next page	Complete in Morning							Complete at End of Day				
	I went to bed last night at:	I got out of bed this morning at:	Last night, I fell asleep in:	I woke up during the night: (Record number of times)	When I woke up for the day, I felt: (Check one)	Last night I slept a total of: (Record number of hours)	My sleep was disturbed by: (List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)	I consumed caffeinated drinks in the: (e.g. coffee, tea, cola)	I exercised at least 20 minutes in the:	Approximately 2-3 hours before going to bed, I consumed:	Medication(s) I took during the day: [List name of medication/drug(s)]	About 1 hour before going to sleep, I did the following activity: (List activity; e.g. watch TV, work, read)
DAY 1 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
DAY 2 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
DAY 3 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
DAY 4 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____



National Sleep Foundation Sleep Diary

Fill out days 5-7 below	Complete in Morning							Complete at End of Day				
	I went to bed last night at:	I got out of bed this morning at:	Last night, I fell asleep in:	I woke up during the night: (Record number of times)	When I woke up for the day, I felt: (Check one)	Last night I slept a total of: (Record number of hours)	My sleep was disturbed by: (List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)	I consumed caffeinated drinks in the: (e.g. coffee, tea, cola)	I exercised at least 20 minutes in the:	Approximately 2-3 hours before going to bed, I consumed:	Medication(s) I took during the day: [List name of medication/drug(s)]	About 1 hour before going to sleep, I did the following activity: (List activity; e.g. watch TV, work, read)
DAY 5 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
DAY 6 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
DAY 7 Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____

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