

DSM-5/DSM-5-TR Disorders Associated With Sleep Problems

Clinical reference for conceptualizing how psychiatric symptoms can interfere with sleep. The emphasis is on mechanisms relevant to CBT-I rather than implying that every disorder includes a formal sleep-wake diagnosis.

I. Disorders and Their Sleep Mechanisms

DSM-5/DSM-5-TR disorder	How the disorder can interfere with sleep
Generalized Anxiety Disorder	Cognitive arousal: excessive worry, rumination, and anticipatory thinking can make sleep initiation difficult. Physiological arousal: sympathetic activation and muscle tension can interfere with sleep initiation and maintenance.
Panic Disorder	Physiological arousal: autonomic activation and fear of bodily sensations can interfere with sleep. Cognitive arousal: fear of a nighttime panic attack can produce hypervigilance and difficulty falling asleep.
Social Anxiety Disorder	Cognitive arousal: replaying social interactions, anticipating future situations, and self-evaluation can delay sleep.
Specific Phobia	Cognitive/physiological arousal: fear-related thoughts and autonomic activation may interfere with sleep when the feared stimulus is anticipated or encountered near bedtime.
Obsessive-Compulsive Disorder	Cognitive arousal: intrusive thoughts and compulsive mental activity can delay sleep. Behavioral factors: rituals may delay bedtime or produce repeated awakenings.
Posttraumatic Stress Disorder	Hyperarousal: elevated physiological arousal and hypervigilance interfere with sleep. Intrusive symptoms/nightmares: trauma-related thoughts and nightmares disrupt initiation and maintenance.
Acute Stress Disorder	Hyperarousal, intrusive thoughts, nightmares, and heightened vigilance can disrupt sleep.
Adjustment Disorder	Stress-related cognitive and physiological arousal can produce transient insomnia, particularly following a significant life stressor.
Major Depressive Disorder	Depressive rumination , altered circadian regulation, psychomotor changes, and changes in sleep drive can produce insomnia or hypersomnia. Early-morning awakening may occur.
Persistent Depressive Disorder	Chronic depressive symptoms may produce insomnia or hypersomnia , often accompanied by low energy and altered sleep-wake patterns.
Bipolar I/II Disorder — manic or hypomanic episode	Reduced need for sleep rather than simply insomnia. Increased energy, racing thoughts, behavioral activation, and decreased sleep drive allow prolonged wakefulness without equivalent subjective sleepiness.
Bipolar depression	Can produce insomnia or hypersomnia , with rumination, low mood, altered circadian rhythms, and reduced activity contributing to sleep disturbance.
ADHD	Cognitive/behavioral arousal: difficulty disengaging from activities, racing thoughts, poor time management, and delayed bedtime. Circadian delay may also contribute.
Borderline Personality Disorder	Emotional dysregulation and physiological arousal can interfere with sleep. Interpersonal crises, rumination, impulsive behavior, and trauma-related symptoms may further disrupt sleep.
Schizophrenia Spectrum Disorders	Circadian disruption, psychotic symptoms, cognitive arousal, and medication effects can interfere with sleep. Delusions or hallucinations may be particularly disruptive.
Delusional Disorder	Preoccupation with the delusional belief can produce cognitive arousal and hypervigilance , interfering with sleep.
Substance/Medication-Induced Disorders	Substances can alter sleep architecture, sleep drive, arousal, and circadian timing . Intoxication and withdrawal can have very different effects.
Alcohol Use Disorder	Alcohol may initially promote sleepiness but can produce sleep fragmentation, REM disruption, and withdrawal-related arousal , contributing to insomnia.
Stimulant Use Disorder	Direct physiological stimulation suppresses sleep and increases cognitive/physiological arousal. Withdrawal may produce hypersomnia.
Opioid Use Disorder	Can alter sleep architecture and contribute to sleep-disordered breathing ; withdrawal can produce autonomic arousal and insomnia.
Cannabis Use Disorder	May initially produce sedation, while chronic use and withdrawal can contribute to sleep disturbance and vivid dreams/nightmares .
Tobacco/Nicotine Use Disorder	Nicotine is stimulating and can increase physiological arousal ; overnight withdrawal may also disrupt sleep.
Somatic Symptom Disorder	Health-related cognitive arousal , symptom monitoring, and worry about bodily sensations can interfere with sleep.

DSM-5/DSM-5-TR disorder	How the disorder can interfere with sleep
Illness Anxiety Disorder	Persistent monitoring and interpretation of bodily sensations can produce cognitive and physiological arousal , particularly at bedtime.
Eating Disorders	Nutritional disruption, mood/anxiety symptoms, compulsive behaviors, and physiological consequences can disturb sleep.
Anorexia Nervosa	Malnutrition, physiological stress, anxiety, and excessive activity can interfere with sleep.
Bulimia Nervosa	Binge/purge behaviors, anxiety, mood symptoms, and physiological consequences can disrupt sleep.
Binge-Eating Disorder	Mood symptoms, nighttime eating, disrupted routines, and obesity-related sleep problems can contribute to sleep disturbance.
Autism Spectrum Disorder	Circadian abnormalities, sensory sensitivity, repetitive behavior, anxiety, and difficulty with transitions/routines can interfere with sleep.
Obsessive-Compulsive Personality Disorder	Perfectionism, preoccupation with tasks, and difficulty disengaging may produce cognitive arousal and delayed sleep.
Avoidant Personality Disorder	Social anxiety, rumination, and anticipatory worry can produce cognitive arousal at bedtime.
Dependent Personality Disorder	Separation anxiety, worry, and reassurance-seeking may interfere with sleep.

II. Mechanism-Based CBT-I Conceptualization

For CBT-I conceptualization, the DSM diagnosis identifies the broader disorder, while the sleep mechanism helps identify what is interfering with sleep and what may be maintaining the sleep problem.

1. Cognitive arousal

GAD — worry; OCD — obsessions and mental rituals; PTSD — intrusive thoughts; MDD — rumination; social anxiety — replaying interactions; illness anxiety — monitoring bodily symptoms; ADHD — racing or distractible thoughts; personality disorders — interpersonal rumination.

2. Physiological arousal

Anxiety disorders; PTSD and acute stress; panic disorder; stimulant effects; substance withdrawal; mania/hypomania.

3. Hypervigilance / threat monitoring

PTSD; panic disorder; psychotic disorders involving paranoia; illness anxiety; severe anxiety.

4. Behavioral activation / delayed bedtime

ADHD; mania/hypomania; OCD; autism; substance use; personality disorders.

5. Circadian disruption

Bipolar disorder; ADHD; autism; depression; substance use; schizophrenia-spectrum disorders.

6. Nightmares / trauma-related sleep disruption

PTSD; acute stress disorder; and other trauma-related conditions.

7. Altered sleep drive / reduced need for sleep

Mania/hypomania; stimulant use; some substance-induced states.

8. Hypersomnia / excessive sleep

Major depressive disorder; persistent depressive disorder; bipolar depression; substance withdrawal; and some eating or medical conditions.

Clinical note

Sleep disturbance may be a symptom of the underlying disorder, a consequence of treatment or substance use, a conditioned/behavioral problem that has become partially independent of the original disorder, or some combination of these. In CBT-I, assessment should therefore distinguish the precipitating condition from the factors currently maintaining insomnia.