

CO-OCCURRING CONDITIONS · 5.6

Autism and Sleep: The Biological Overlap

Sleep difficulty is one of the most consistent features of autism, in children and adults. The drivers are biological, sensory and behavioural together, and the evidence base for what helps is now reasonably mature.

FOR

Autistic adults and parents of autistic children

AUDIENCE AGE

All ages

REVIEWED

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PART OF

The NeuroFX resource library

IN SUMMARY

Autism and Sleep: The Biological Overlap

The link in plain terms

- **Sleep difficulty affects 50 to 80 percent of autistic children.** Similar or higher rates in autistic adults. The pattern persists from early childhood into adulthood and does not generally resolve with age.
- **The biology contributes substantially.** Multiple studies have found differences in melatonin production and circadian rhythm regulation in autistic samples. Lower or delayed evening melatonin onset is part of why sleep onset is so often difficult.
- **Sensory load matters more than in most populations.** Bedroom lighting, bedding texture, ambient sound, even pillow scent can all affect sleep. What disrupts one autistic person is irrelevant to another; the profile is individual.

How it shows up

- **Difficulty getting to sleep regardless of how tired the body is.** Long sleep latency is the most consistently reported feature. The mind does not switch off on cue, particularly where the day's transitions have been demanding.
- **Bedroom environment that has to be set up just right.** Small disruptions (a passing car, a temperature change, a new washing powder) can prevent sleep where a non-autistic sleeper would not notice.
- **Frequent waking and early morning waking.** Particularly in children. Difficulty returning to sleep after waking is common in autistic adults.
- **Bedtime resistance in children.** The transition from the day's structure to the unstructured space of bed is the hard part. Predictable bedtime routines, often visually represented, are one of the best-evidenced supports.
- **Co-occurring conditions amplify the picture.** Anxiety and ADHD are both more common in autism and both have their own sleep difficulty profiles. The combined sleep picture in AuDHD is usually harder than either alone.

What helps and where to start

- **Predictable bedtime routine and consistent timing.** A consistent sequence of activities in the same order. Regular bedtime and wake time, with weekend variation kept tight. The predictability is the active ingredient.
- **Sensory accommodations in the bedroom.** Weighted blanket, blackout curtains, white noise, specific fabric textures, controlled temperature. A sensory profile assessment can identify what matters for the individual.
- **Modified-release melatonin (Slenyto) for children where indicated.** The only paediatric melatonin preparation with a specific UK licence in autism, for ages 2 to 18 where sleep hygiene has been insufficient. The 2017 Gringras trial showed improvement in sleep latency and total sleep time over thirteen weeks.
- **Investigate apnoea and physical contributors where suspected.** Loud snoring, witnessed breathing pauses, severe daytime sleepiness all warrant sleep clinic referral. Treating apnoea can substantially improve daytime function. Reflux and constipation are also worth considering.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP if sleep difficulty is significantly affecting daily function, if you notice signs of obstructive sleep apnoea, or if persistent fatigue is not explained by anything else. Seek urgent help via 999 or A&E for any acute mental health crisis associated with severe sleep loss.

SOURCES

NICE CG142; NICE CG170; Souders et al. 2017 (Curr Psychiatry Rep); Gringras et al. 2017 (J Am Acad Child Adolesc Psychiatry); BNFc

NEXT STEPS**Speak to NeuroFX**

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neurofx.co.uk · **info@neurofx.co.uk** · **0333 533 3303**