

SLEEP AND NEURODIVERGENCE · 12.2

Autism and Sleep: The Biological Overlap

Sleep difficulty is one of the most consistently reported physical health problems in autistic adults. Estimates put the rate at 50 to 80 percent over the lifetime, against general population rates of 10 to 30 percent. The biological overlap is real and reasonably well-characterised.

FOR

Autistic adults whose sleep is not working

AUDIENCE AGE

18+

REVIEWED

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PART OF

The NeuroFX resource library

IN SUMMARY

Autism and Sleep: The Biological Overlap

Why the biology makes it harder

- **Melatonin synthesis is often altered.** Tordjman 2013 documented reduced overall melatonin output, altered evening rise timing and altered circadian regulation in autism. Slenyto (paediatric prolonged-release melatonin) is licensed in the UK for autistic children on the strength of this work.
- **Sensory hyperarousal does not switch off at bedtime.** Noises, textures, light, temperature that were tolerable in the daytime become intrusive in a quiet bedroom. The same sensory system that processes input differently across the day continues into the night.
- **Wind-down is biologically longer.** Many autistic adults need 60 to 90 minutes of low-stimulation time before sleep. Cognitive carry-over from the day's social and sensory processing extends well past where sleep would otherwise begin.

What it looks like

- **Long sleep latency.** It often takes much longer than 30 minutes to fall asleep, even when tired. The mind continues processing the day.
- **Bedtime sensory friction.** The duvet that has been fine for ten years suddenly feels wrong. The hum of a fridge becomes the only audible thing. Generic "make your bedroom calm" advice often misses the specific input that is the actual problem.
- **Fragmented sleep and unpredictable restoration.** Multiple wakings, low sleep efficiency on trackers. The same number of hours can produce different next-day function in unpredictable ways.
- **Sleep and burnout are bidirectional.** Poor sleep accelerates burnout: sensory tolerance falls, masking capacity falls, emotional regulation falls. Burnout damages sleep. The loop is well-described.
- **Sleep is usually the last system to recover during burnout recovery.** Working on sleep without addressing the underlying load often produces partial improvement; working on load without addressing sleep often produces the same. The two work together.

How we can help

- **Sensory-targeted bedtime environment.** Identify the specific sensory inputs interfering at bedtime and address them concretely. Weighted blanket, white noise, blackout, temperature control, alternative bedding, ear protection.
- **Predictable routine and planned wind-down.** Same sequence into sleep, same approximate time. Build 60 to 90 minutes of low-stimulation time before bed deliberately.
- **GP for melatonin and sleep-disorder assessment.** Melatonin off-label for adults is a prescribing-clinician conversation. Specific things to ask about: sleep apnoea assessment, delayed sleep phase, autism-literate CBT-I via NHS Talking Therapies where available.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP if sleep is significantly disrupted and standard environmental adjustments have not helped over a couple of months. Specific things to ask about: sleep apnoea assessment, delayed sleep phase, and whether NHS Talking Therapies offers CBT-I in your area. For melatonin discussion, your prescribing clinician (or GP for adults not under a specialist) is the right route. NeuroFX is not a sleep medicine service but our autism clinicians can support the wider picture and write supporting letters where helpful.

SOURCES

Carmassi 2019; Tordjman 2013; Baker & Richdale 2017; Devnani & Hegde 2015; Cuomo 2017; NAS

NEXT STEPS**Speak to NeuroFX**

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