SLEEP & STRESS

Does Bad Sleep Cause a Bad Mood?

Sleep and mood can unsettle each other, but the pattern in your own life offers clues about where to intervene first.

The morning-after version of you

You wake after a broken night and everything feels sharper: the noise, the unfinished work, the message you would normally shrug off. By afternoon, you are irritable with people you like. Then bedtime arrives, and you are anxious about doing it all again. It is easy to feel trapped in a loop-and to wonder which problem started it.

The honest answer is that either one can come first. Insomnia can leave you anxious, depressed or irritable, while depression, anxiety and other emotional distress can contribute to disturbed sleep. Long-lasting stress may also affect sleep, concentration, memory and mood. Sometimes there is no clean opening scene, only two difficulties now keeping each other company.

That does not make the question pointless. Timing still matters. If your mood reliably drops after poor sleep and lifts after better nights, sleep may be an important lever. If worry, emotional upheaval or low mood appeared first and your sleep changed afterward, the emotional problem may need direct attention. Those are clues, not proof of cause.

Quality matters alongside quantity. Interrupted sleep may reduce the time spent in particular stages of non-rapid eye movement sleep and rapid eye movement sleep. Poor-quality sleep can affect mental health, thinking and daily functioning even when the night looked long enough on paper. Most adults need about seven to nine hours, but need also varies with health, lifestyle, age and sleep patterns.

A loop, not a courtroom

You do not have to identify one guilty party before seeking help. Chronic insomnia is often secondary, meaning it is a symptom or side effect of another problem. Medical conditions, medicines, another sleep disorder, depression and anxiety can all sit behind it. Caffeine, tobacco and alcohol may contribute too. In other cases, insomnia itself is the primary problem and its origin is not well understood.

The loop can also begin with ordinary disruption. Work stress, family pressure or a traumatic

event can bring short-term insomnia lasting days or weeks. Travel, shift work, emotional upset and long-lasting stress can be involved in persistent insomnia. Once sleep is repeatedly difficult, anxiety about not sleeping may become part of what keeps the problem going.

Your body clock adds another possibility. Delayed sleep-wake phase disorder can make you fall asleep later than you want and struggle to wake on time, sometimes causing too little sleep, daytime tiredness or anxiety. Shift work disorder can produce insomnia, extreme tiredness and sleepiness at work because the required schedule conflicts with when your body needs uninterrupted sleep.

That distinction matters because "I cannot sleep" can describe several different patterns. Trouble falling asleep, repeated waking, waking too early and sleeping at the wrong biological time are not necessarily the same problem. Loud snoring, gasping, choking sounds or pauses in breathing point toward a possible sleep-related breathing disorder rather than mood alone.

For the coming week, your job is not to prove whether sleep or mood won the race.

What the evidence can-and cannot-untangle

The supplied evidence strongly supports an association in both directions, but it does not provide a universal rule about sequence. General clinical information identifies depression and anxiety as possible contributors to sleep disorders, while also describing anxiety, depressed mood and irritability as consequences of insomnia. That is why a single bad week rarely settles the question.

Research in narrower groups shows the same entanglement. A 2023 systematic review of 31 studies in women around and after menopause found that reflexology, yoga, walking and aromatherapy massage were associated with improvements in both insomnia and depression. Exercise and stretching more consistently improved sleep quality than depression. Those findings do not reveal which condition began first, and they do not automatically apply to everyone.

Supplements do not provide a shortcut to the answer. A 2021 meta-analysis covering eight cohorts and 812 menopausal women found that melatonin did not significantly improve sleep quality, anxiety or depression, although physical symptoms improved. Melatonin products can vary in purity and amount, may cause side effects, and may interact with medicines, so taking one is not a useful experiment for deciding whether sleep or mood is primary.

Other seemingly simple fixes have uneven support. A 2022 review of 13 studies involving 1,007 adults found that music may improve people's reports of sleep quality, but evidence was insufficient to determine its effect on insomnia severity or nighttime waking. Evidence for

relaxation alone is small and low quality, while guidelines have found too little evidence to recommend mindfulness by itself for insomnia.

Treat the knot where it is tightest

When insomnia has become long term, cognitive behavioral therapy for insomnia (CBT-I) is usually recommended as the first treatment option. It addresses several parts of the loop: nervousness about not sleeping, relaxation, sleep habits, time spent awake in bed and the link between bed and sleep. It can be delivered in person, by telephone or online by an appropriate healthcare professional.

This is more substantial than collecting bedtime tips. CBT-I may include going to bed only when sleepy, leaving the bed when you cannot sleep and reserving the bed for sleep and sexual activity. It also uses a structured approach to time in bed. Because that element involves a specific plan that changes as sleep improves, it belongs with a trained provider rather than an improvised schedule.

Basic conditions still matter. A cool, quiet, dark bedroom and consistent sleep and waking times can support sleep. Electronic light may disrupt the sleep-wake cycle. Alcohol may make falling asleep easier but tends to produce lighter sleep and more waking. These measures can reduce avoidable disturbance, but they should not be used to explain away persistent low mood or a possible sleep disorder.

This stops being only a lifestyle question when sleep trouble lasts a month or longer, repeatedly interferes with daytime functioning, or comes with persistent depression, anxiety or major emotional distress. Regularly taking a long time to fall asleep, repeated waking with difficulty returning to sleep, excessive daytime sleepiness, or reported gasping and breathing pauses are also reasons to discuss the pattern with a healthcare provider.

Map one week with a notebook

On Monday, start a simple record using a notebook and pen. Each morning, write down whether you struggled to fall asleep, woke repeatedly, woke too early or felt unrefreshed. Later, add a few plain words about your mood and functioning: irritable, anxious, low, steady, sleepy, unable to focus. Do not turn it into a verdict or a score.

Look for order rather than perfection. Did worry or low mood rise before the difficult night? Did irritability appear mainly the day after broken sleep? Did both shift after a work change, travel or emotional shock? Also note clues that do not fit a mood explanation, including an urge to

move your legs, sleeping at markedly unwanted times, or a bed partner reporting loud snoring, gasping or pauses in breathing.

A healthcare provider assessing insomnia will ask about both medical history and sleep history, may perform an examination and may recommend a sleep study. Your notes cannot diagnose the problem, but they can make that conversation more concrete. Bring them if the pattern persists, daytime sleepiness makes driving unsafe, or your sleep or mood is disrupting ordinary life.

For the coming week, your job is not to prove whether sleep or mood won the race. It is to catch the sequence while it is happening. A notebook and pen will not fix the loop, but they can show you where it tightens-and give you something specific to take into a conversation about loosening it.

Where this comes from

- Sleep Disorders

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/sleepdisorders.html
- Insomnia

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/insomnia.html
- Sleep Disorder Treatments | NHLBI, NIH

  National Heart, Lung, and Blood Institute · https://www.nhlbi.nih.gov/health/sleep-disorder-treatments
- Circadian Rhythm Disorders Types | NHLBI, NIH

  National Heart, Lung, and Blood Institute · https://www.nhlbi.nih.gov/health/circadian-rhythm-disorders/types
- Psychological and Physical Approaches for Sleep Disorders | NCCIH

  National Center for Complementary and Integrative Health · https://www.nccih.nih.gov/health/providers/digest/psychological-and-physical-approaches-for-sleep-disorders
- Effects of different physiotherapy modalities on insomnia and depression in perimenopausal, menopausal, and post-menopausal women: a systematic review.

  BMC women's health, 2023 · https://pubmed.ncbi.nlm.nih.gov/37422660/
- Passiflora incarnata in Neuropsychiatric Disorders-A Systematic Review.

  Nutrients, 2021 · https://pubmed.ncbi.nlm.nih.gov/33352740/
- Evening wear of blue-blocking glasses for sleep and mood disorders: a systematic review.

  Chronobiology international, 2021 · https://pubmed.ncbi.nlm.nih.gov/34030534/
- The relationship between preoperative sleep disturbance and acute postoperative pain control: A systematic review and meta-analysis.

Sleep medicine reviews, 2025 · https://pubmed.ncbi.nlm.nih.gov/39504912/

- Effects of exogenous melatonin on sleep quality and menopausal symptoms in menopausal women: a systematic review and meta-analysis of randomized controlled trials.

  Menopause (New York, N.Y.), 2021 · https://pubmed.ncbi.nlm.nih.gov/33784263/