ACT for Insomnia

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ACT Tips and Insights for Mental Health Practitioners

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Insomnia Matters

Improving sleep has a huge positive impact on mental health and wellbeing. We all know how hard it is to get through the day when we haven't slept well; and how refreshed we feel after a good night's sleep. No matter what the clinical issue may be, if insomnia is part of the picture, it's sure to make matters worse.

On the other hand, if sleep can be improved (and it usually can), that's likely to have significant positive effects and help clients cope better with their other problems.

Problems with Traditional ‘Sleep Hygiene’ Programs

‘Sleep hygiene’ basically means doing things to improve our quality and quantity of sleep, and reducing behaviours that interfere with it. The problem with most traditional ‘sleep hygiene’ programs is they tend to be extremely rigid and demanding. Typically, they have very strict rules that must be obeyed to the letter, and many people feel ‘under pressure’ when trying to follow them.

This is especially so when it comes to commonly recommended rules like these:

- Only go to bed when sleepy.
- Only use the bed for sex or sleeping.
- Do not nap during the day.
- If you’re not asleep within 15 minutes, get out of bed, go into another room, and do something relaxing, like reading a book.

These are hard rules for most people to follow. And for highly anxious clients, the idea of reducing the amount of time they spend in bed may itself become a source of anxiety. (This of course makes them even more anxious, thereby increasing their difficulty in sleeping). So it’s perhaps not too surprising that adherence rates for traditional sleep hygiene programs are low.

The good news is, ACT offers a much more practical and flexible alternative to traditional sleep hygiene programs - with none of the bullet-pointed rules above. The information that follows has been influenced by the ‘ACT for Insomnia’ program (ACT-I), created

by Guy Meadows. And if you'd like a deep dive into the topic of ACT for insomnia, check out Guy's popular self-help book: appropriately called The Sleep Book. Meanwhile, for a quick overview of the topic, read on.

Assessment

It's important to do a thorough assessment for insomnia, which includes:

- Comorbidity (for example, depression, PTSD, or anxiety disorders)
- Lifestyle factors (such as diet, exercise, drugs and alcohol)
- Sleep routines and bedtime habits
- Medical conditions (a medical check-up is advisable)
- Major life events (for example, a new baby, bereavement, relationship break up, work deadlines, any sort of major loss or crisis)
- Prescription medications (many have insomnia as a side-effect)
- All previous strategies used to try and improve sleep

Sometimes, when we ask about previous strategies, a client reports that they've tried 'mindfulness', and 'it doesn't work' or 'doesn't help'. Usually this means they've fundamentally misunderstood the concept.

In such cases, **here's what you'll need to do**.

The Sleep Control Paradox: What Has the Client Already Tried?

Trying hard to control sleep usually interferes with it. And most insomniac clients have already tried hard to control it, with little or no success.

So as part of our assessment, we want to explore all the different 'sleep control' strategies the client has previously tried. This may include relaxation techniques, herbal remedies, alcohol, marijuana, prescription medication, staying up late until exhausted, positive thinking, following strict rules from traditional sleep hygiene programs, practicing wind-down rituals, and so on.

Validate the Client's Experience

Once we've identified all the client's previous 'sleep control' strategies, we want to validate their experience. With great compassion, we may say something like this:

Therapist: It's clear that you have tried hard to improve your sleep. And most of the methods you've tried are widely recommended by friends or family or health professionals; in fact, just about everyone tries using at least some of those methods, at times. Unfortunately, even though some of these methods do work in the short term … in the long term, they're not giving you the results you want.

Highlight the Vicious Cycle

Following validation, a useful next step is to highlight the vicious cycle the client's been caught in:

Therapist: And that sucks, right? Despite all that effort, you're still suffering from insomnia. And there's a very good reason why. And it's *not* because you haven't tried hard enough. It's actually the opposite. The problem is, you're trying *too hard.*

Client: What do you mean?

Therapist: Well, if I can use a bit of jargon, what's going on here is that you're stuck in the vicious cycle of 'sleep control'. We call it a vicious cycle, because trying very hard to *control* our sleep usually interferes with it; and the

	harder we try, typically the worse it gets. See, what happens is, when we're not getting much sleep, we start to develop a 'sleep control' mindset. We go to bed thinking *'I have to get a good night's sleep! If I can't sleep, I can't function! I must get to sleep! I can't carry on like this!'* - and so on. Which is completely understandable. But the problem is, that 'sleep control' mindset creates stress, anxiety, pressure and worry – all of which makes it harder for us to sleep. So I'm wondering: would you be open to trying a very different approach; something that's radically different to everything else you've tried?
Client:	Sure. What is it?

Offer an Alternative

The next step is to offer the client an alternative approach. We have to be very careful how we do this, as it's easy for the client to misunderstand.

Therapist:	Well, it's a very different way of approaching sleep, and there's a fair bit to it. There's a lot to take in, so is it okay if we go through it step-by-step?
Client:	Sure.
Therapist:	Okay, well the first step is hard to get your head around, at least for most people. But here it is: *stop trying to control your sleep.* (Pause).
Client:	What d'you mean?

Therapist: I mean, basically, the idea is to treat your time in bed as an opportunity to *rest and restore yourself* – whether you're sleeping or not. So if you're in bed, but you're *not* sleeping, the idea is to use that time constructively: to do something that's restful and restorative.

Client: I told you, I've tried that. I've tried relaxation/mindfulness/calming/self-soothing techniques; they don't work.

Therapist: That's right. Because when you're doing those things, you're *trying hard to control* your emotions, *trying hard to control* how you feel, *trying hard* to get rid of anxiety and stress and tension, *trying hard* to feel more relaxed. And that's *hard work*. *Trying hard to control* how you feel is *not* restful or restorative. When someone who's a good sleeper goes to bed, do you know what they *try hard* to do?

Client: Err, no.

Therapist: Nothing. They just treat bed as a place of comfort and rest. They don't try to make sleep happen and they don't try to control their thoughts and feelings. The more we try to do those things, the harder it is to sleep; it just keeps that vicious cycle going.

Client: So what am I supposed to do, if I can't sleep? Just lie there, tossing and turning?

Therapist: No, not at all. The idea is to use that time in bed to do things that are restful and restorative. Can I take a couple of minutes to explain …?

Restful & Restorative Activities: Part 1

The next step is to outline what the client *can* do in bed, when they're *not* sleeping. Basically there are two kinds of activity they can do in bed:

1. **Mindfulness practices**

2. **Anything that's basically restful, soothing, or calming.**
   For example: cuddling, sex, masturbation, reading a book, listening to music (but nothing that's likely to stimulate you, like reading a thriller; and nothing that involves exposure to screens and blue light, like watching TV or scrolling on your phone).

Now at this point, a quick reminder: in ACT, the word ‘mindfulness’ is an umbrella term for defusion, acceptance, contacting the present moment, and self-as-context; it may refer to any one of those processes, or any combination of them.

At times, it may be better to avoid the term ‘mindfulness’, because there are so many common misconceptions about it. (For example, many people mistakenly think it’s meditation, Buddhism, or a relaxation technique.)

So instead of talking about ‘mindfulness’, you could use ACT terms such as unhooking, opening up, noticing, refocusing and expanding awareness. For example, you can use ‘unhooking skills’ as an umbrella term for any or all of the defusion, acceptance, self-compassion, self-as-context, or present moment ACT skills:

Therapist: Well, there are two main kinds of activity you can do in bed. One is practising your ‘unhooking skills’. For example .... (you now mention practices you’ve covered in earlier sessions, for example, leaves on a stream, listening in to thoughts, physicalising, body scans, kind hands, ‘making room’ for emotions, naming the story, noticing the breath, and so on).

If we leave addressing insomnia for later sessions, that usually makes it easier to work with, because the client already has ACT skills to draw upon.

If we choose to address insomnia in an early session before the client has such ACT skills to draw upon, we’ll need to say something like, ‘To improve your sleep, you’ll need to learn a few “unhooking skills”. These are methods for unhooking from difficult thoughts and feelings, so

they can't keep jerking you around. Once you learn how to do this throughout the day, you'll then be able to do it at night, in bed. But it will take a fair bit of daytime practice to get to that point.'

Restful & Restorative Activities: Part 2

After running through the above, we can continue:

Therapist: So that's one type of activity to do in bed, when you're *not* sleeping. The other type of activity is anything that's basically restful or soothing, like reading a book or listening to music. But nothing that exposes you to blue light - like watching TV or using your phone – because blue light exposure interferes with sleep. And also nothing that's likely to make you even more awake, like reading a gripping thriller or listening to music that revs you up. And also, nothing that's likely to tax your brain, like working or studying.

If the client now says something like, 'But I've already tried all that. It didn't help!', we may reply:

Therapist: Yes – yes, absolutely; you have! So, two things that are really important for you to know: One, this is just one small piece of the puzzle. There's a whole lot more to it – we're just getting started. Two: it's not surprising that it didn't help, because you were doing it with a 'sleep control' mindset: *'I have to get to sleep!'* And it's that very mindset that keeps you awake. And nothing we do here will help if you cling to that mindset. So you have to fundamentally shift it: make your bed a place

for rest and comfort; a place to treat yourself with kindness and caring – whether you're awake or asleep. So if you're sleeping, great; but if you're not sleeping, you're doing restful, restorative activities that are going to give you many of the benefits of sleep. And if you're anything like most of my clients, you're probably thinking, 'But lying awake isn't restful. I keep tossing and turning and worrying.'

Client: Yes! I was just about to say that!

Therapist: Of course. Because at the moment, when you're awake in bed, that's what it's like – tossing, turning, stressing out. Not restful or restorative. So that's where these unhooking skills come in. There are several specific unhooking skills that can help you to dramatically change that – so that lying awake in bed does become restful.

Client: But I don't want to lie awake! I want to sleep.

Therapist: Of course you do. We all do! But … if you get caught up in that 'sleep control' mindset … Well, you know what happens, right? Vicious cycle: the more you try to control your sleep, the worse it gets. So we're talking about doing something radically different.

At this point, it's often useful to introduce the classic 'struggling in quicksand' metaphor, to illustrate how doing what comes instinctively in a difficult situation can make it a whole lot worse. This isn't essential, but it's often helpful.

Watch Russ Harris discuss how letting go of the struggle with your own thoughts and feelings is similar to being stuck in quicksand.

Then the next step is:

Therapist: So the aim now is to make this radical shift. Instead of making your bedroom 'the place of sleep' – you make it 'the place of rest'. So if you're in bed, and you're not sleeping, the idea is to use that time effectively. Instead of tossing and turning and stressing and worrying, you do these other activities we've been talking about, which will make your bed a restful and restorative place.

And here's the bonus: most of the time, when you do these activities in bed, you will eventually fall asleep. That's not the aim of them – and if you start using them to try to make yourself sleep, then you're right back into that vicious 'sleep control' cycle. But it does often happen - and it's a nice bonus you can enjoy when it occurs. And of course, there will be nights when that doesn't happen, because this isn't some

miracle cure – but even on those nights when you're not sleeping, at least your time in bed will be a lot more restful and restorative than it is now.

What's Next?

What we do next will depend on:

a) the causes/factors underpinning the client's insomnia,

b) the other issues the client is dealing with, and

c) what we've already covered in earlier sessions.

With clients who already have some (genuine) mindfulness skills to draw upon (such as, from earlier ACT sessions, previous therapy, personal growth, or spiritual pathways), we can now begin to explore how they can practice these in bed when not sleeping.

However, with clients new to mindfulness, we need to quickly explain what it is. And it's soooo important that we keep our explanations short, sweet and simple; if we're not careful, it's easy to waffle on and bore, overwhelm, or confuse the client.

It's best to select just one core mindfulness process – usually either defusion or acceptance – and introduce it with a simple but powerful metaphor like 'hands as thoughts' for defusion or 'pushing away paper' for acceptance. For example:

Therapist: Okay, so there's a bunch of different skills involved and it'll be confusing if I try to go through them all at once. I think the most useful one to begin with is something called 'unhooking from thoughts'. Can I take you

through a little exercise to give you a sense of what's involved? (Therapist takes client through the **'hands as thoughts' exercise**.)

Or:

Therapist: Okay, so there's a bunch of different skills involved and it'll be confusing if I try to go through them all at once. I think the most useful one to begin with is something called 'making room for feelings'. Can I take you through a little exercise to give you a sense of what's involved? (Therapist takes client through the **'pushing away paper' exercise**.)

And after that? Well, let's take a look at the different options.

Undermine Experiential Avoidance & Emotional Control

With any mindfulness practice – especially defusion and acceptance techniques - we need to be crystal clear that the aim is *not* to make unwanted thoughts and feelings go away, but to open up and make room for them, and allow them to freely come, stay and go in their own good time. It's okay if they hang around; and it's okay if they go and then return. (Note how the final paragraph of the script for both 'hands as thoughts' and 'pushing away paper' makes this explicit.)

If a client is opposed to this, and just wants these thoughts and feelings to go away, we bring in 'creative hopelessness' to undermine experiential avoidance and the agenda of emotional control. (If you've forgotten what 'creative hopelessness' involves, **read this free eBook**.)

Defusion & 'Worry Time'

Both in the run up to bedtime, and when in bed, we encourage clients to utilise defusion techniques to handle sleep-interfering thoughts. Before bed, this may include simple defusion techniques based on noticing and naming: 'I'm having the thought that ….,' 'Aha! Here's the 'no sleep' story! I know this one!' 'Hello anxious thoughts; here you are again', 'Here's worrying', 'Thanks mind! I know you just want me to sleep better - and it's okay, I've got this handled.'

Once in bed, they can continue to use simple noticing and naming, or switch to meditative defusion techniques, such as 'leaves on a stream'. (About 10% of the population find visualisation hard or impossible, so a good non-visual alternative to 'leaves on a stream' is 'listening in to the mind'.)

If the client is doing a lot of worrying in bed, an ACT-congruent version of the famous 'Worry Time' strategy can be very useful. **Click here** for a client handout on the ACT-ified version of this method. (Obviously, 'Worry Time' should NOT be scheduled immediately before bed!)

Acceptance & Self-Compassion

We actively encourage clients to open up and make room for all difficult private experiences that show up in bed: thoughts, feelings, emotions, memories, urges and sensations. For unpleasant feelings and sensations in the body, useful acceptance techniques include 'physicalising', 'observe-breathe-expand-allow', and 'mindfulness of emotions'.

Watch Russ Harris explain the four 'A's of acceptance: Acknowledging, Allowing Accommodating and Appreciating.

Meditative self-compassion exercises, such as 'kind hands' or 'bowl of kindness' or 'loving kindness meditation' are good additions or alternatives.

Watch Russ Harris explain the importance of self-compassion and deconstruct this into six elements that interconnect and overlap with each other.

Contact with the Present Moment

When clients are in bed but not sleeping, we encourage them to do restful, restorative mindfulness practices – such as a mindful body scan or mindfulness of the breath. In Trauma-Focused ACT, a popular practice is Progressive Muscle Mindfulness (PMM). It's like Progressive Muscle Relaxation (PMR), but with one massive difference. The primary aim of PMR is to relax, but in PMM there is no emphasis on relaxation, and never any mention of the word 'relax.' In PMM, the aim is simply to notice the sensations in your body and allow them to be as they are. (**Here's a PMM script.**) This avoids problems that can occur with PMR, when people are 'trying to relax' but find they can't.

A good alternative to such exercises is to simply tune in mindfully to the experience of being in bed, consciously appreciating the warmth and comfort: the mattress supporting you; the warmth in your chest, arms and legs; the softness of the pillow beneath your head; the darkness behind your eyelids; the touch of the blankets on your chest; your body resting; and so on.

Dropping Anchor: To Wake Up or Wind Down

You can use dropping anchor exercises in bed for two different purposes: to wake up or to wind down. If you want to use it to help people *wake up* and *get out of bed* – especially when they find that's hard to do because they're tired and sleepy following a restless night, **read this**. The document describes how dropping anchor is used to wake you up, make you as alert as possible – with lots of emphasis on active physical movement in bed and connecting with the world

around you. During the day, you can use similar versions of the exercise to disrupt rumination and worrying.

However, if you're in bed and you want to wind down into a restful and restorative state, you need to significantly modify the way you drop anchor. In the C (connect with your body) phase of an ACE cycle, you *don't* want to be actively moving and stretching; instead you lie still and connect with the gentle movement of the breath, or the feeling of your body pressing down into the mattress, the sense of your head sinking into the pillow. In the E (engage in current activity) phase, the aim is to tune into the warmth and comfort of the bed beneath you and the bedclothes on top of you. This is a good antidote to worrying and rumination.

Values & Committed Action

In the service of their values, we encourage clients to implement new behaviours likely to improve their sleep quality. The key to success here is, not surprisingly, flexibility. We want to encourage clients to experiment with the suggestions we give them and bring an attitude of openness and curiosity.

And don't turn them into RULES THAT YOU MUST ALWAYS OBEY. The idea is to experiment with them - adapt and modify them as necessary - and notice what difference they make, over time. We may say something like:

Therapist: I'm going to suggest a whole bunch of things for you to play around with. And I'm expecting most of these things to be helpful, but of course, nothing always works for everyone. So please, treat everything I suggest as an experiment - in the sense that we don't

know for sure what will happen. The idea is to carefully observe what happens, and if the results aren't as intended, be open to trying something different. With all of these strategies, treat them as the loosest of guidelines. They're not rules you have to obey. The idea is to modify and adapt everything so that we can make it work for you as well as possible.

What follows next are ten useful strategies we can encourage clients to flexibly experiment with. If you want these in the form of a client handout, **click here**.

Ten Useful Strategies for a Restful Night

Below you'll find a number of recommendations for things you can do that are likely to give you a more restful night and a better quality of sleep. No single strategy works for everyone - but most people find most of these strategies helpful. But be flexible with them: don't turn them into RULES THAT YOU MUST ALWAYS OBEY. Experiment with them - adapt and modify them as necessary - and notice what difference they make to your sleep quality over time.

1 Restrict stimulants before bed

- Avoid products containing caffeine (tea, coffee, chocolate) for at least four hours before bedtime.
- Avoid nicotine (cigarettes, vaping, nicotine patches, and so on) for at least one hour before bedtime, and when waking during the night.

2 Restrict alcohol and eating close to bedtime

- Don't drink alcohol around bedtime, because although it often promotes sleep at first, it can disrupt sleep later in the night.
- Don't eat large meals, especially those packed with fat and protein, immediately before bed.

3 Avoid 'blue light' for one hour before bed

- Exposure to blue light - from phones, computers, TVs - immediately before bedtime often impairs our ability to get off to sleep. So ideally, avoid looking at these devices for at least one hour before bedtime.
- Ideally, also avoid working or studying, for at least an hour; otherwise, your brain is likely to keep going over it in bed.

4 Create a 'wind-down ritual'

- Create your own 'wind-down' ritual to help prepare you for sleep. This may involve listening to relaxing music, reading a relaxing book, having a warm bath or shower, practicing a mindfulness or relaxation technique, or doing any other activity that helps you to 'wind down'.

5 Maintain regular sleeping hours

- The more regular your hours for getting up and going to bed, the better your sleep is likely to be. And the more irregular, the worse your sleep is likely to be.
- Sleeping in, or staying in bed longer than you should, is particularly disruptive to healthy sleep.

- Do your best to get up at the same time every day, even if you've had little or no sleep. In the short term, this means you'll have some difficult sleep-deprived days to get through. But in the long term, your sleep will improve.

6 Exercise during the day

- Do regular physical exercise during the day. Even mild exercise helps - and anything is better than nothing.
- Getting out into the sunlight during the day also helps sleep at night.
- But don't exercise vigorously (to the point of sweating) for at least one hour before bed.

7 Make your bedroom favourable to sleep

- Make your bedroom as conducive to sleep as possible. Keep it clean, tidy and well-aired (not stuffy), and choose a mattress, sheets and pillows that are comfy. Block out light and noise in the bedroom. Make sure your phone is on silent. If necessary, wear an eyepatch or ear plugs in bed.
- Avoid extreme room temperatures. Most people sleep best in room temperatures of approximately 65 degrees Fahrenheit (or within the range of 60 - 67 F), or 18 degrees Celsius (or within the range of 15.6 - 19.4 C).

8 Limit daytime naps to half an hour or less

- Many people find a short nap - up to half an hour, in the late afternoon is helpful. But longer naps than that usually impair sleep quality at night.

9 Limit Activities in Bed to Sleep, Sex, Relaxation or Practising Your Unhooking/Noticing/Making Room Skills

- When in bed, limit your activities as much as possible to sex or sleeping. You can also do something relaxing, such as reading a book or listening to peaceful music. You can also practice unhooking/noticing/making room exercises (also known as 'mindfulness skills') or self-compassion exercises.
- Alternatively, you can gently tune in to the warmth and comfort of your bed: notice the mattress supporting you; the warmth in your chest, arms and legs; the softness of the pillow beneath your head; the darkness behind your eyelids; the touch of the blankets on your chest; your body resting; and so on.
- But don't do things in bed that expose you to blue light (for example, watching TV, using your phone), or wake you up (such as reading a gripping thriller), or tax your brain (like working or studying).
- You also want the bedroom itself to be strongly associated with rest and sleep. So avoid doing other forms of activity in the bedroom such as watching TV, working, eating, doing yoga, lifting weights, and so on.

10 Don't Try To Force Sleep

- If you're in bed, and you're not sleeping, trying to make yourself sleep is a recipe for failure. So instead, the idea is to use that time effectively. Instead of tossing, turning and worrying, practice your unhooking/noticing/making room skills, and/or self-compassion skills. That way, although you're

not sleeping, you're resting. And, as a bonus, you're developing useful skills which can help you with many other problems.

The good news is, unhooking/noticing/making room practices and self-compassion practices are usually restful and restorative - and a much better alternative to tossing, turning, stressing, worrying, and so on. Plus, often when you do these practices in bed, you will eventually fall asleep. That's not the aim of them, but it is a nice bonus. So enjoy this bonus when it happens - and when it doesn't happen, at least you'll get the benefits of a comfortable rest.

Ups and Downs

It's important to emphasise, this isn't a quick fix, but we do expect to see significant improvements over time – often within the space of a few weeks, and sometimes straight away. And of course, there will be ups and downs: days (or weeks) where sleep and rest is much better, and other days (or weeks) where it's not so good. So it's important to be patient; to ramp up self-compassion during rough patches, and come back to values, over and over again, to sustain motivation.

How You Spend Your Days Affects Your Nights

It's also important to explore how what we do during the day affects our nights. If we're spending our days living by our values and focusing on/engaging in what we do, that's going to be much more conducive to a restful night than a day full of fusion and avoidance. So as therapy progresses, and the client makes values-based lifestyle changes, improves their relationships, lives mindfully, practices self-

compassion, and so on, we expect all of that to contribute to better sleep.

Wrapping Up

Well, here's hoping you found something useful within these pages. We're all going to have disrupted sleep at times – so these strategies apply to us just as much as they do to our clients. (Just like everything else in ACT.) As usual, please freely share this document and the resources linked within it – and modify and adapt everything to suit your way of working and the clients you work with.

Good luck with it all,

Cheers, Russ Harris

About Russ Harris

Internationally bestselling author, medical doctor, psychotherapist, life coach, and consultant to the World Health Organisation. Russ Harris has directly trained over 80,000 psychological health professionals in the ACT model. He provides exceptional learning experiences on Psychwire.com.

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