



ACT for Insomnia

Dr Guy Meadows (PhD)



Acceptance and Commitment Therapy (ACT) offers a unique and gentle non-drug based approach to overcoming chronic insomnia. It seeks to increase people's willingness to experience the conditioned physiological and psychological discomfort commonly associated with not sleeping.

Such acceptance paradoxically acts to lessen the brain's level of nocturnal arousal, thus encouraging a state of rest and sleepiness, rather than struggle and wakefulness. Additional focus on valued driven behaviour also acts to avert unhelpful patterns of experiential avoidance and promote the ideal safe environment from which good quality sleep can emerge.

The application and merits for using ACT approaches such as acceptance and willingness, mindfulness and defusion and values and committed action for the treatment of chronic insomnia are discussed and compared to the traditional cognitive behavioural strategies.

Introduction

Sleep involves a slowing of psychological (e.g. decision making, problem solving and emotional readiness) and physiological (e.g. heart rate, breathing rate, blood pressure, bowel movements and muscle tone) processes at the end of the day. It is a natural act that can't be controlled and is characterized by an acceptance of the natural rise in sleep drive associated with nighttime and a willingness to let go of wakefulness.

By contrast, chronic insomnia is a difficulty sleeping that is characterized by a state of hyper arousal, which interferes with the natural ability to initiate or maintain sleep or achieve restorative sleep. Where insomnia is the primary disorder, the initial trigger is often resolved. But sleeplessness is maintained by a vicious cycle whereby poor sleep initiates worry about not sleeping, which in turn elevates arousal levels leading to further poor sleep. The adoption of unhelpful coping strategies and the movement away from valued living act to create an inflexible relationship with sleep.

Cognitive behaviour therapy for insomnia (CBT-I) is the most widely used treatment method. Its primary focus is based around symptom reduction via changing the cognitive and behavioural conditions that perpetuate the insomnia. It most commonly achieves this through a series of 1-hour interventions delivered over a 6 – 8 week period.

Whilst these interventions have been proven to be effective at reducing insomnia rates, some patients still struggle. Complaints typically focus around the non-workable nature of the process used and the continued need for patients to diarize their sleep and thoughts throughout the intervention.

Dalrymple et al. (2010) investigated how incorporating principles from Acceptance and Commitment Therapy (ACT; Hayes et al. 1999) into the treatment of insomnia could potentially enhance the adherence to and acceptability of such traditional CBT-I approaches. This opens up the debate as to whether ACT approaches alone could be an effective insomnia treatment.

The rationale for using ACT approaches within the treatment of insomnia and the practical ways in which it could be implemented into therapy sessions are discussed in this poster.

Acceptance

The vicious cycle of insomnia demonstrates that it is the unwillingness of patients to experience the unwanted thoughts, emotions and physical sensations associated with not sleeping and the ensuing struggle with them that heightens arousal levels and perpetuates sleeplessness. Most insomniacs can provide a long list of control-based strategies, including traditional CBT-I techniques, they have implemented and yet which have failed to improve their

sleep. This focus on symptom reduction, which if ineffective simply perpetuates the vicious cycle.

It could be more effective to teach patients to adopt a more accepting attitude towards what spontaneously arises when experiencing difficulty sleeping. The greater willingness to experience poor sleep results in fewer struggles, less arousal and paradoxically greater levels of sleepiness.

Practically, any initial insomnia assessment should include a detailed review of the failed techniques previously used to improve sleep. Lundh (2005) suggests that such an awareness of the futility of control-based strategies could then be used as a starting point from which to guide a patient towards alternative acceptance based approaches.

Mindfulness

Mindfulness is the ability to objectively and non judgmentally take notice of your internal and external experiences as they unfold. It can help insomniacs to stand back and observe their level of wakefulness or unwanted thoughts and emotional reactions without becoming overly entangled or judging them, a quality that is inherent in the normal act of falling to sleep.

Shifting patients towards an attitude of acceptance rather than the CBT-I focus on symptom reduction seen with many of the traditional relaxation strategies could be a way of short-circuiting the vicious cycle of insomnia.

Practically, insomniacs can be taught to mindfully notice their senses and the movement of their breath, which they can then practice during the day. At night such exercises can be used to help patients to notice and let go of their struggles and return back to the present moment (e.g. noticing the touch of the duvet on their toes or the gentle movement of their breathe). Care must be taken to highlight the potential risk and futility of using mindfulness as a tool to control the level of relaxation or sleep and to confirm the benefits of objective noticing (e.g. the use of the quicksand metaphor can be helpful at this point).

Defusion

Defusion describes the ability to see thoughts and emotions for what they are (e.g. naturally occurring cognitive and emotional responses) and create space for them to exist, rather than fusing with them or seeing them as something that needs to be removed, before sleep can be restored.

Such acceptance once again bypasses the need to struggle with such internal content by changing the patient's relationship with the content. It could be argued that such an energy efficient and low arousal approach is more nocturnally intuitive than the traditional CBT-I based cognitive restructuring, which requires patients to challenge their thoughts and then create new alternative and balanced ones in their place.

Practically, patients spend time identifying their unwanted thoughts, emotions, physical sensations and urges that show up when they don't sleep. They are then taught basic defusion exercises such as objectively describing, naming and welcoming unhelpful thoughts when they arrive in the night such as "I am having the thought that..." or "Hello, 'coping', 'medication' and 'ill health' thoughts". For emotions and physical sensations, patients can practice 'Physicalizing' exercises such as imagining them as objects and giving them a shape and colour.

Valued Sleep Actions

A normal sleeper has a strong relationship with their bed and bedroom, meaning they can fall to sleep or return back to sleep very quickly and with little effort. In contrast, an insomniac has a negative sleep association meaning they become cognitively and emo-

tionally alert at the point of trying to sleep (e.g. conditioned bedtime arousal). The adoption of unhelpful coping strategies in order to control sleep (e.g. going to bed early, sleeping in the spare room or sleeping during the day), not only perpetuates poor sleep, but also results in a reduction in valued living (e.g. not being able to go out at night, share a bed with a partner or schedule early appointments), something that patients cite as one of the main reasons for struggling with sleep in the first place.

CBT-I approaches the problem by asking patients to follow a series of strict rules known as Stimulus Control Therapy (SCT), see table 1. The aim is to limit the time patients spend in the negative state or engaging in non-sleep activities, in the hope of developing a positive association, whereby sleep onset occurs rapidly on getting into bed. Whilst SCT is widely used, many patients complain that its strict nature is counter intuitive and goes against normal valued sleep actions, see table 1. The result is that anxiety and arousal levels associated with the bedroom and sleep are unhelpfully heightened.

Practically, teaching patients to commit to making behavioural changes in line with their sleep and life values, whilst being willing to experience the unwanted elements of the negative association between sleep and bed. The aim is that by promoting a healthy and flexible approach to sleep, any negative associations and therefore arousal levels are reduced, creating a platform from which natural sleep can emerge effortlessly.

Restricting Sleep

Sleep is regulated by an internal body clock and a sleep homeostat, to keep it on time and create its cyclical drive. A normal sleeper keeps a fairly regular pattern by going to bed and getting up at roughly the same time four days per week and a little later on the weekend. A common coping strategy of many insomniacs is to change their sleep wake cycle in the hope of getting a little more sleep (e.g. going to bed earlier, lying in later or catching up during the day). Whilst such action may make cognitive sense, they do in fact worsen nocturnal sleep by lowering the sleep efficiency (SE), the percentage of time spent in bed asleep. CBT-I approaches this problem using Sleep Restriction Therapy (SRT), which restricts the time in bed to actual sleeping time only so as sleep drive increases, so will sleep consolidation, which can then be steadily titrated back to a normal level. Whilst such an approach can be effective, some patients struggle with the concept of spending less time in bed. Many insomniacs also present with sleep anxiety and so any suggestion of restricting the amount of time in bed is often met with increased levels of anxiety and alertness, thus counteracting any of the positive benefits of an increase in sleep drive, possibly explaining the low adherence rates (Harvey et al. 2002).

Practically, it is therefore advised that patient anxiety levels be considered before the implementation of sleep restriction. If anxiety levels are found to be high, then treatment should be focused on increasing patient willingness to experience the anxiety, before then considering sleep restriction at a later date (e.g. assuming reduced anxiety levels did not lead to improved sleep).

Conclusions

This poster puts forward the rationale for using Acceptance and Commitment Therapy for Insomnia (ACT-I) and its potential benefits over traditional cognitive behavioural treatments. It suggests that acceptance and mindfulness based approaches are intuitively, psychologically and physiologically more in tune with the natural process of deactivation associated with falling to sleep.

It places importance on the act of adopting valued sleep actions, whilst being willing to experience the heightened cognitive and emotional processes that present in response to not sleeping. Ultimately it seeks to promote a high level of sleep flexibility, thus leading to less struggle and arousal, improved sleep quality and energy conservation and enhanced quality of life.

Table 1

Valued Sleep Action	CBT-I	ACT-I
Go to bed when either tired or sleepy	NO Go to bed only when sleepy	YES Both states allowed
Allow normal bedroom activities	NO Use the bed for sleep and sex only	YES Allow calm non sleep activities such as reading in bed
Stay in bed, if awake at night	NO If not asleep within 15mins, go to a spare room & read	YES Focus on resting and welcoming discomfort
Allow a flexible sleep-wake cycle	NO Go to bed and get up at exactly same time everyday.	YES Allow natural variation (+/- 30m - 1hr)
Allow daytime naps	NO Avoid all daytime napping	YES Allow a short (<20mins) daytime nap

References

Dalrymple, K.L., Fiorentino, L., Politi, M.C., & Posner, D., (2010). Incorporating Principles from Acceptance and Commitment Therapy for Insomnia: A Case Example. *J Contemp Psychother*, 40: 209-217.
Harvey, L., Inglis, S.J., & Espie, C.A. (2002). Insomniacs' reported use of CBT components and relationships to long term clinical outcome. *Behaviour Research and Therapy*, 44: 1-25.
Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and commitment t: An experiential approach to behaviour change*. New York: Guilford Press.
Lundh, L.G., (2005). The Role of Acceptance and Mindfulness in the Treatment of Insomnia. *J of Cog Psychother*, 19: 29-39.

Additional Information

Dr Guy Meadows (PhD) is a sleep physiologist who runs The Sleep School a private sleep clinic in London focusing on the use of Acceptance and Commitment Therapy in the treatment of Insomnia.

the Sleep School

CONTACT

guy@thesleepschool.org

www.thesleepschool.org