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PTSD 101 Course

Transcript for: Acceptance and Commitment Therapy (ACT)

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Hello. Welcome to a presentation on Acceptance and Commitment Therapy: A Treatment for PTSD and Trauma-Related Problems.

My name is Dr. Robyn Walser, and I work at the National Center for Post-Traumatic Stress Disorder, Dissemination and Training Division. I have been involved in trainings and acceptance and commitment therapy since 1997 and have found the intervention useful across a number of diagnostic categories and am excited about the new and upcoming possibilities for the treatment of PTSD.

And, I am Sonja Batten. I am a clinical psychologist and I work as the Deputy Chief Consultant for Specialty Mental Health in VA's office of Mental Health Services. As with Robyn, I have been working with ACT since the mid-1990's and I am excited to have the opportunity to present today.

There are three main objectives of our presentation today. First, to provide you an overview and explanation of the theoretical underpinnings of ACT; second, to review the state of the empirical evidence for ACT; and third, to explore the six core processes that are used in ACT interventions and provide some introduction into their clinical application.

So, let's start with objective one. This is an overview of Acceptance and Commitment Therapy, both the description of the principles that underlie Acceptance and Commitment Therapy and the theoretical underpinnings.

We'd like to be clear about the state of affairs for using ACT with trauma survivors or individuals who have been diagnosed with Posttraumatic Stress Disorder. The first line treatments for PTSD are the cognitive-behavioral treatments, like Prolonged Exposure Therapy, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, or Stress Inoculation Treatment approaches.

ACT is not currently considered an evidence-based treatment for PTSD. But, with that said, we know that there is a lot of interest from the field about using ACT with trauma survivors. And, there are probably a few reasons for that. It may be because ACT has been shown to be effective for some of the problems that commonly co-occur with PTSD; things like depression, anxiety or chronic pain. It may also be that the interest comes from the appeal of the approach to some clinicians who feel that it fits with their

therapeutic style and how they like to approach the therapeutic relationship. Robyn and I will talk about that in more detail as we go through the presentation.

And, some people are drawn to the theoretical basis and the philosophy behind ACT, and we will provide more information about that as well.

So, what is ACT? Why is it so appealing, or intriguing, to people? Why is it different from other more traditional approaches to working with mental health problems? So, ACT is a behaviorally based treatment. It's time-limited, and it's often not packaged in a certain number of sessions or having to use a specific protocol all the time.

The overall goal is to help individuals really move forward with their lives, be able to engage in valued behaviors, do the things that are important to them, even when they have difficult thoughts or feelings or memories or bodily sensations. So, you don't have to wait to feel better in order to be able to live your life better. The idea is to teach people tools to be able to live the type of life that they want to live, regardless of what thoughts, feelings, bodily sensations, urges, all of those things that might be present. So, we will get more into details about how we do that in ACT later.

One of the other things about ACT is that it is transdiagnostic. It's really not that ACT, you know there's for depression and ACT for chronic pain and ACT for this and that. ACT is a principle-driven approach that can be used with a variety of different presenting problems or problems in living. So, it's really applicable for lots of problems that people go through in life and that can, of course, come across with many different diagnoses.

The processes, though, in ACT don't just target a specific psychological symptom like specific symptoms of anxiety or depression. It can really be used with a variety of kinds of symptoms or experiences and Robyn will talk more about that later.

So, but the real focus of ACT, fundamentally, is on living – living the life that you value, doing those things that are important and meaningful to you. So, for some people, that might be being a loving spouse, partner, parent, friend, being the type of employee or coworker that you want to be. And, the focus is not on decreasing symptoms in order to do that. And, that is one of the fundamental differences between ACT and some other approaches.

So, one easy way to remember the ACT model is using the acronym ACT. So, in addition to standing for Acceptance and Commitment Therapy, it may help to remember the following mnemonic. So, first, "A" for accept private events and we use the term private events to refer to those things that happen sort of inside the skin: your thoughts, your feelings, memories, physical sensations, urges. All of those things are what we call private events.

The "C" is for choose and commit to living consistently with your personal values. So, choosing the direction that you want to go that's important to you and committing to making those changes and steps in that direction.

And, then "T" for take action – so taking action then in those areas that matter to you, that are meaningful to you, that you committed to in the service of your values. So, really focusing on actual behavior change.

And, the ACT model relies heavily on learning through experience. It's not just the case that, if the therapist explains what it is that the client needs to do, that that's going to sink in or help the person move forward. Really, we want the person to have the experience of some of these concepts and

principles that we are talking about. And, that learning through experience in treatment, we often call those experiential exercises because we know that people learn better, and they learn faster, through direct experience rather than just being told about something. So, the ACT clinician really keeps that in mind and tries to take advantage of that sort of utility of experiential learning.

Another important component of the model is that, in ACT, we are not trying to target the symptoms themselves. We are not trying to change those private events. We are not trying to explicitly reduce anxiety, reduce depression, reduce pain. What we are trying to do is to try to control something that we probably actually have a little bit more choice about, which is our relationship with those private events. What do we do when those thoughts, and feelings, and memories come up? How do we change the function of a thought if you have the thought, you know, “I am worthless.”

Well we don’t necessarily work with the person to try to change that thought or to not have the thought, “I am worthless,” because we don’t think that that’s a very effective way of relating to those experiences. Instead, we work with the person to help sort of recognize that our thoughts come and go throughout the day. They are not literally true and we don’t have to take them as literally true in sort of guiding our behavior. We can have our values guide behavior instead.

So, we don’t spend effort on trying to change the content, the form or the frequency of the thought. Instead, we try to change our relationship with those thoughts and feelings and we will give more examples of that.

And, so some strategies that we use, that Robyn will go more in depth about later, are things like mindfulness or being in the present moment, acceptance or being willing to experience those private events that show up for you, cognitive defusion or learning how to take a step back from your thoughts, and really using your values to guide behavior change and move your life forward in a way that’s meaningful.

So, it’s interesting, maybe, to learn a little bit about where ACT comes from. And, ACT really comes from a couple of different theoretical backgrounds. Most fundamentally, it is an outgrowth of behavioral theory and, although the term sometimes sounds scary to people, it is actually based on a radical behavioral understanding of human behavior which comes from Skinner’s radical behaviorism. And, what’s radical about radical behaviorism, though, is that it begins with the assumption that we can use the same behavioral principles that we use to understand overt outward behaviors. We can use those same principles to understand our thoughts and feelings and those other private events. So, that’s really what’s radical, is that we can use our basic behavioral underpinnings to understand private events.

And, so, really anything that is considered a behavioral intervention, because ACT is a behavioral approach to treatment, would be appropriate to use in ACT, including exposure therapy. So, the types of exposure therapy that are conducted in our evidence-based treatments for PTSD are also very appropriate to use in ACT. The important thing is finding interventions that work for that patient to help him or her live that more valued life that is providing more meaning and fulfillment.

The other important theory that’s relevant to ACT is Relational Frame Theory, or RFT, and ACT really came from RFT, which is a basic theory of language and cognition. It’s also a behavioral analytic account of verbal behavior, and when we use the term verbal behavior, we are describing those things that we do with our minds. If you think about what goes on in your mind over the course of the day, describing things, evaluating things, thinking, planning, reading, so I am not going to go into details and specifics of RFT, but maybe just a couple of points will be helpful to provide some context.

RFT sort of proposes that human language processes, although they can be very helpful, they can also lead to unnecessary suffering, and Robyn will go into more detail about this later – the good and the bad sides of language. But, briefly, you know, we are the only species that can look ahead and worry about the future, can look behind us and have regrets about the past. If you think about what a dog or a cat needs to be happy, you know, they probably need things like companionship, food, water, shelter, rest, things like that.

Many of us as humans may have all of those things and yet we find ourselves stuck. We find ourselves in pain or suffering even when we have all of those physical components of the environment in place. And, so we really think there is something fundamental about human language that has both a good side and a dark side. So, cognitive research has shown that we can only add to our cognitive networks, our language, add to the thoughts that may go through our minds over the course of the day.

One way we sometimes say this is, the nervous system only works by addition not subtraction. So, we can't really remove a cognitive network. We can't remove certain thoughts that automatically pop-up into our heads. So, that, we think, really makes it hard to change the content of the thought, because to think of the new thought – the one that you are trying to replace the old one with – you are inherently thinking about the old thought. So, there is a lot more to RFT, and for people who would be interested in learning more about that, we would encourage you to visit the Association for Contextual Behavioral Science website which is contextualpsychology.org and you can learn more about RFT.

So, now let's turn to objective two, and go through a brief review of the research on ACT.

So, now we will briefly summarize the state of the evidence for ACT. And, ACT has been applied to, and found to be efficacious for, a wide variety of physical and mental health problems. And, because the state of the evidence is particularly strong for depression and pain, the American Psychological Association Division 12 has listed ACT as an empirically supported treatment for those conditions and the Substance Abuse and Mental Health Services Administration, or SAMSA, also lists ACT in its national registry for evidence based programs and practices, and notes ACT's positive outcomes related to depression, obsessive compulsive disorder, psychosis-related rehospitalization and general mental health.

And, based on this research base, VA has recently rolled out ACT as a treatment for depression in our national dissemination efforts of evidence-based psychotherapies, and preliminary evaluations are showing positive outcomes. But, remember, as I mentioned earlier, one of the really unique aspects about ACT is that it is a transdiagnostic approach. So, it's designed to target common factors that we think are related to multiple types of problems in living or things that we would consider psychopathology.

So, ACT is really meant to have a broad applicability. It's not designed just to be used for one particular disorder. So, one of those things that we believe is sort of a functional dimension that underlies problems in living across a number of different concerns is what we call experiential avoidance. And, experiential avoidance is a process where a person is unwilling to experience thoughts or feelings or memories or bodily sensations and then take steps to try to change, avoid or escape those private events.

And, those can be steps that they take either overtly, like making choices to avoid certain situations or contexts, or things that they do sort of more internally; things like distracting yourself, checking out, emotional numbing, trying to think of other things. And, experiential avoidance has been conceptualized as really a fundamental process that we think is part of a lot of what we see as psychopathology. So, I will talk more about the research support for targeting experiential avoidance in a few minutes.

And, we really see that the goal—if we are able to decrease experiential avoidance in ACT—is to be able to increase psychological flexibility, and usually that would be associated with the processes that we talk about as acceptance or willingness.

So, because depression and chronic pain often co-occur with PTSD, I am going to start by reviewing the existing controlled research, the randomized controlled trials of ACT for those conditions. And, I think that given the VA's focus on ACT in its dissemination efforts for depression and the prevalence that we know is there of chronic pain in the Veteran population, hopefully this information will be particularly informative for clinicians in VA.

So, the randomized controlled trials examining ACT for depression have shown that, in general, ACT performs as well as cognitive therapy, or cognitive behavioral therapy, without significant between-group effect size estimates. They are sort of in the small to medium range. So, trials comparing ACT and waitlist conditions have also shown positive results with larger effect sizes, but we won't review those here.

Two randomized controlled trials have compared ACT to active treatments, not including treatment as usual for chronic pain and those studies have found medium to large, but non-significant, between-group effect size estimates. And, the outcomes on sick-leave utilization, impairment and satisfaction significantly favored ACT.

So, it is important to note that we want to look at a broad range of outcomes, not simply symptom based measures. So, ACT is considered an effective and acceptable intervention for depression and chronic pain, with effects on symptom outcome similar to those with active treatments. The trials for pain though, indicate that ACT is superior on non-symptom outcomes, so those differences we think suggest that ACT may have some particular advantages over existing treatments. You may work on the symptoms at a similar level but actually be able to impact some additional factors of living.

And, what we know, though, is that additional work is needed to explore those caveats and limitations and try to assess the potential role on improving patient treatment matching.

Next I'll talk a little bit about the state of the evidence for Posttraumatic Stress Disorder using ACT. And, it is important to note that, as of this time, there are no randomized controlled trials of ACT for PTSD.

ACT has, though, been applied to PTSD in some uncontrolled studies. There have been a couple of case studies that have shown ACT to be effective with PTSD. There is also a third study which was an open trial of ACT delivered in a group format and it found decreases in PTSD, depression and the impact of PTSD symptoms in 30 Veterans diagnosed with PSTD.

So, although right now interest is pretty high for ACT applied to PTSD and posttraumatic stress symptoms, we will have to wait a little longer to see if ACT will be as effective for PTSD as it is for anxiety, depression and other types of problems

Given the recent interest in ACT as a treatment for PTSD, it's exciting to note, though, that there are a number of important research studies underway that, hopefully, will provide us with more information in the coming years. For example, doctors Ariel Lang and Paula Schnurr and Dr. Barbara Hermann and her colleagues are both conducting trials of ACT.

Lang and Schnurr's study, which is a randomized control trial, specifically addresses the distress that's found in post concussive experience and it includes PTSD as an outcome measure. And, Dr. Herman's study, with her colleagues, is developing a manual of ACT to be used with comorbid PTSD and

substance abuse. We know that PTSD and substance abuse commonly co-occur and within the ACT model this is one of those situations where we think that experiential avoidance is likely a factor that contributes to both the PTSD and the substance use disorders. So, it will be interesting to see the outcomes of that study.

And, Dr. Walser and her collaborators are also looking at ACT as a front-line treatment for PTSD for Veterans who are not willing to do Prolonged Exposure therapy for PTSD. This is still in the proposal stage, but we are very excited about all of these investigations, and we're looking forward to seeing their results over time.

Although research on ACT for PTSD is in its early stages, we think it's really useful to look how ACT's main therapeutic target, experiential avoidance, is related to PTSD as a way to try to understand why we think there may be some potential for ACT as a PTSD intervention.

There have been a number of studies that have provided evidence that experiential avoidance is actually a significant factor in the development or maintenance of anxiety and mood disorders. And, the studies on depression and pain, that I reviewed earlier, have also shown that experiential avoidance can mediate outcomes in the ACT condition.

So, we think that the proposition that experiential avoidance may have a significant role in the development and maintenance of Posttraumatic Stress Disorder, that's been supported by a growing evidence base over the past several years.

Many of these studies have used the Acceptance and Action Questionnaire, or the AAQ, which is a self-report measure that's designed by the developers of ACT to assess experiential avoidance in a number of different populations.

So, some of those correlational studies with trauma populations have shown findings that we think support this model of understanding PTSD. So, for example, greater experiential avoidance has been associated with more severe PTSD symptoms in civilian survivors of the Kosovo War and for gay male and lesbian survivors of sexual assault.

One study found that individuals with current PTSD reported greater experiential avoidance than individuals who recovered from PTSD or never received a diagnosis, which suggests that experiential avoidance may play a role in PTSD.

Research is also starting to look at how experiential avoidance may relate to specific associated behaviors that come along with PTSD. For example, experiential avoidance was associated with aggressive behavior, above and beyond PTSD severity and trait anger, in one study of men with a history of interpersonal violence.

A number of other studies have found experiential avoidance to be a significant predictor, and significant mediator, of psychological symptoms, including PTSD, following war-related or interpersonal trauma, as well as after disasters.

In some of these studies, experiential avoidance was a more robust predictor of PTSD severity over time than trauma severity and initial distress, or than PTSD severity and diagnoses.

So, it's important to note that research is really needed to address important questions about experiential avoidance, things like whether experiential avoidance is a unique predictor of PTSD or a predictor of general psychological distress among trauma survivors, if it predicts PTSD over and above the avoidant

symptom cluster in the current PTSD diagnostic criteria, whether experiential avoidance can prospectively predict PTSD, and if experiential avoidance is a process that is uniquely affected by ACT or whether other treatments may also result in changes in EA or experiential avoidance.

So, all that is to say that the existing body of evidence does point to the role of experiential avoidance in mood, anxiety, and posttraumatic stress disorder. So, given the many studies showing that effects of ACT on outcomes in non-PTSD clinical trials is mediated by experiential avoidance, we really think that there is a clear rationale for applying ACT to PTSD.

So, now I am going to turn it over to Robyn for the remainder of the presentation and she will now present objective three.

Now let's turn to the six core processes used in ACT and look at how some of them might be applied clinically. Before we explore these processes individually it will be helpful to briefly revisit verbal behavior to provide a context for the interventions used.

Remember, verbal behavior is language and it is what we are doing with our minds. Language is useful. It helps us to communicate. It allows us to do what we are doing right now – to hear and understand. Communication plays a role in everything from technology to intimacy. Language also helps us to predict and plan. I can conceptualize something that I might want to have in the future, such as a vacation or a house and plan accordingly. I can organize and save my money now as a means to obtain those things that I am after.

Language also helps us to solve complex problems. If I lock my keys in the car I can think of a number of problem solving strategies to open the car and recover my keys. For instance, I might call a locksmith, I might call someone and ask them to bring the extra pair, I might break the window, or I might even try to use a hanger. I can put my mind to work and fix the problem of being locked out of my car.

We also use language to develop rules that regulate behavior. For example, look both ways before you cross the street. These kinds of rules are very useful and thank goodness we don't have to learn the behavior of looking both ways the hard way. Rules can guide us and help us to live well in societies. So you can see, there are many benefits to language.

However, language also has a dark side. We can construct futures that don't actually exist in the moment or exist at all. For instance, we are the only species that is fully aware of our own deaths and can take actions around this eventuality. This kind of knowledge can lead individuals into very difficult places. Much suffering can come with this knowledge as individuals struggle with personal meaning.

Through this same process, we can create idealized futures. For instance, you might imagine what it would be like to win the lottery and all of the great benefits that would come from that. In this same way, you can create this future by adding something, money. You can also create an imagined future if you subtract something. People will imagine entirely different futures based on something being removed from their past. Clients might imagine that if a trauma were no longer in their history -their life might be better. The difficulty is that history only goes one direction – trauma can not be removed.

Furthermore, we can evaluate nearly anything and this process of evaluation can be good. It's healthy for me to be able to assess that dark alleys at night might be dangerous. However, when we apply these same kinds of evaluations to experiences inside the skin and evaluate emotional content as dark alleys that are dangerous, this can be problematic.

As noted, rules can be helpful, but we can develop rules for acting that are harmful and ineffective. For instance, we might create a rule that people cannot be trusted and fall into a kind of paranoia about others.

One final example of how language can be problematic is how the excessive use of language makes it difficult to maintain contact with the present moment. We are so busy in our heads worrying about the future or the past that we fail to see what is happening right here and now; we live in our minds instead of in our lives.

This over-reliance on language changes our relationship with internal experience. We become overly identified or entangled with the content of our mental life. This over extension not only includes loss of contact with the present moment and inflexible rule following, it also creates a tendency to take stories about the self to be literally true and it moves us away from knowledge gained through experience. This kind of entanglement can lead to a behavioral narrowing or a loss of response flexibility. What we are doing with ACT is helping individuals to come back into contact with experiential knowledge. In ACT we work with clients to disentangle them from their minds.

If it is the case that we are entangled, How do we get there? ACT uses the acronym FEAR to out line the situation. FEAR stands for Fusion, Evaluation, Avoidance and Reason Giving. Let's take a look of each in turn.

Fusion is the first process that can cause problems. Cognitive fusion occurs when a person holds their thoughts to be literally true. For example, imagine a lemon. Imagine what it looks like, feels like, smells like and tastes like. You can interact with the lemon and even respond to it as if it were really there, even though you are only imagining it. People do this with thoughts, they interact with them and respond to them as if they literally exist. So the thought, "I am broken," is no longer seen as a thought, but rather is seen as something that literally exists in the person. In ACT, we work with people to de-fuse, to see the thought as a thought.

Evaluations work in the same way as fusion. They are viewed to exist in the object being evaluated. When we hold evaluations in this way, it is as if they exist in the individual and then they seem to need to be problem solved or eliminated, fixed in some way in order for the individual to be considered okay or normal. Here again, we work with the individual to help them see an evaluation as something that they are doing, not something that literally exists in the person.

Avoidance is the social training of cognitive and emotional control. We are taught from a young age that if you don't like something figure out how to get rid of it and get rid of it. This works fine in the world outside the skin, however, trying to avoid a thought or a feeling can actually cause the thought or feeling to persist or even increase in frequency. For instance, if it is really important to for you to not think a thought or have a memory, you have to contact the thought or memory in order to figure out how to make it go away. In order to know that you don't want to think it, you have to think it. There is an inherent paradox in the system. The harder you try to avoid a thought or feeling, the more likely it is that it will stay.

Lastly we have reason-giving. Reason giving is about believing that our verbal explanations are a justification for our actions. For instance, if I say, I didn't do it because I didn't feel like it, not feeling like it becomes the cause of my not doing it. This can be extended broadly. For instance, trauma survivors might say I can't live my life because I have PTSD. PTSD is causing the not living. In ACT we make the case that giving reasons as a cause for behavior might not be so for multiple reasons.

There are multiple variables involved in why we do what we do. There is your thinking, what is present, context, history, feelings. We are complex beings and to hold a reason as a cause of behavior misses a much bigger picture. ACT seeks to undermine reason-giving so trauma survivors are free to make healthy choices outside of reasons.

There are six core processes that ACT uses to disentagle people from their minds and to help them take action that supports vital living. Let's explore those now.

To broaden and simplify, there are acceptance and mindfulness processes that use a unique set of experiential and mindfulness exercises to promote acceptance of self and others. And there are a set of commitment and behavior change processes that guide the client in defining personal values while also supporting efforts at making and keeping commitments related to those values.

All of these processes are in the service of psychological flexibility.

Let's explore each of these processes more fully; but first, it is important to mention the ACT therapeutic stance. The ACT therapist is quick to acknowledge that problems that are dealt with in session are common to the human condition.

We are not fundamentally different from our fellow travelers. The therapist also works from the assumption that the client is not pathological or broken. And the therapist takes the stance that the client has the capacity to live a vital, meaningful life. Lastly, the therapist works with the client from an equal, vulnerable, genuine and compassionate position.

Turning to the individual processes, we can look at what happens in the initial sessions. In these sessions, the therapist is working to set the stage for implementing the core processes. Many psychological problems and in particular with PTSD, include personal attempts to alter the intensity, form, frequency, or duration of unwanted thoughts, memories or feelings. The client is often seeking more good feelings, better thoughts, a different history. This struggle is conceptualized as experiential avoidance. Clients tend to persist in avoidant behaviors for two reasons.

First, attempts at distracting oneself from emotions or thoughts often result in their immediate reduction, which negatively reinforces the process. However, this immediate relief is often only temporary and the client has to persist in the more, better and different agenda. And second, we live in cultural contexts that support the elimination or reduction of negatively evaluated internal experience. Feeling good is upheld as a goal of good living. The work done in creative hopelessness specifically undermines this process. The therapist works with the client to explore how they have tried to fix the problem, yet it remains. The therapist also notes that the problem is not one of specific tactics. Clients have often tried the right things it is just that trying to problem solve internal experience is not like trying to problem solve other areas of their life.

The creative part of this exploration occurs when the workability of efforts the client has been using to rid themselves of negative emotional content is viewed honestly and the client begins to open up to the possibility of truly new ways of living. Typically, clients feel that if they had a different history, one without sexual abuse, disaster trauma, or war trauma for instance, then their problems would be solved and they would no longer be in emotional turmoil. They would feel better. However, as they try solutions over and again, the behavioral relevance of their painful history is only magnified and a search for still more "solutions" continues.

With ACT, the solutions the client has been trying are viewed as part of the problem and are labeled as control. These very control efforts are explored as barriers to successful solutions to clients' problems in

living. That is, conscious, purposeful efforts to get rid of, escape, or avoid negative thoughts and feelings may actually be preventing clients from behaving in ways that are consistent with what they value. In this stage of therapy the focus is on how efforts to control may not only prove ineffective, but these very efforts may lead to increased difficulty.

Let's take a moment and look at a demonstration of creative hopelessness.

Dr. Walser: All right, so Chris, one of the reasons that you have come to see me is that you want to address the PTSD, these experiences that you have been having following your experience in Iraq. And what I want to understand a little better is: What are the emotions and thoughts that you have been struggling with, specifically?

Patient: I guess, I mean, ever since I came back I feel like I don't fit in. Like in my old life, but I feel like there's not a spot for me to fit in even in a new life. And I just look around and I think a lot of people have just normal lives and I don't know how to do that.

Dr. Walser: All right, so one thing that shows up is, "I don't fit in." What are some of the emotional experiences that are present that you struggle with?

Patient: I feel anxious all the time and...

Dr. Walser: So anxiety would be on that list.

Patient: And I think, I mean, I don't know what depression is, right? But, I feel down like that. I don't know what to do with myself. I feel kind of like a nervous energy all the time.

Dr. Walser: Good.

Patient: And I think, I get confused about what I am going to do with that. Right?

Dr. Walser: All right. So we can see this list building, right? We've got don't fit in, we've got confusion, nervous energy, anxiousness, depression, maybe sadness---is what, does that fit?

Let's create another list. I want to ask you all the different things that you have tried to fix that stuff we just listed.

Patient: Well I guess when I first got back---I don't know if it fixed anything, but I certainly... I drank a lot and tried to, just sort of, not be here, you know, not be in my head.

Dr. Walser: So, drinking. Checking out.

Patient: Yeah, and you know, I tried to get back with my old group of friends and stuff, and I think I was partying a lot, which was sort of giving me something to do that wasn't very real. You know?

Dr. Walser: Partying, trying to figure out things to do. What else? Anything that you have tried? It can be good or bad things.

Patient: I tried to think---to kind of settle down and find, you know, I've dated a couple of girls and I was trying to be a normal guy... job, maybe get a wife or something. I tried finding a job that would keep me busy.

Dr. Walser: Okay.

Patient: I spend a lot of time by myself. I spend a lot of time on the computer, you know, just playing games and stuff, and, I don't know, just sort of getting away, from getting away from people and killing time.

Dr. Walser: There's this kinds of list of things and as this list grows, I start to wonder how well it's working.

Patient: Yeah, I do. I mean...

Dr. Walser: There's this funny thing here where you've got some good solutions like, "I'll distract myself. I'll get involved. I'll hang out with friends." It's not like these are bad strategies. Some of them may not be so good.

Drinking is probably not the best strategy because it can get excessive or problematic, but it sounds like you've tried a number of things to try and fix this stuff. To try and get it under control. And we are kind of coming to this place where here you are sitting here in front of me, where something about this isn't working.

Patient: Yeah, I don't think much of anything is working.

Dr. Walser: There is something fishy here. Like you are trying some pretty normal stuff and yet here you are still with this set of problems. So it kind of has this quality. It's as if you were blindfolded, given a bag of tools, picked up in a helicopter, and set down in the field of life, and told to go live your life. And you did. But unbeknownst to you in this field there's some fairly large and pretty deep holes. And if you're wandering around in a field blindfolded, sooner or later you are bound to fall in.

And you are a smart guy, right? You have these strategies about thinking about how to get out of your experiences that you don't like. You take out the blindfold, you open up your bag, but what you discover is when you reach in to get the tool to help you get out, you find a shovel. When you are given a shovel, what do you do?

Patient: I start digging.

Dr. Walser: Start digging, right? So, you might dig fast and you might dig slow. So there are all different kinds of ways that you might try to dig your way out of a hole. All these different strategies that you have listed to try and fix the problems of anxiety and not fitting in. And what I am suggesting here is that there is a funny quality to this. All these different strategies that you have listed to try and fix the problems of anxiety and not fitting in. And what I am suggesting here is that there is a funny quality to this. I mean, if these strategies were going to work, if digging were going to work, you'd be out of a hole. You would be out. You wouldn't be sitting here in front of me right now.

Willingness or acceptance is offered as an alternative to control. As mentioned, control typically narrows the trauma survivor's repertoire such that it is focused on eliminating the symptoms of PTSD. This process can lead to personal struggle and suffering. Willingness broadens the range of response alternatives so that other outcomes can be pursued. That is, if the client lets go of the struggle to have good feelings, he or she can pursue activities that are about having a good life.

The therapist works to create a context where the client is given the opportunity to experience ALL private events fully and without defense. It is noted that willingness is not wanting or liking. The client is not asked to like any particular emotion or even want it. Rather, the question is posed, would they be

willing to be open to it, to feel it, if it meant that they could gain control of their life. Finally, willingness is highlighted as an active process that is chosen in the service of personal values.

Although the therapist is working with the client to be present to difficult internal content – to be willing to feel it – it is important to note that this is in the service of decreasing suffering. As human beings, we will all experience pain at some point in our lives. It is natural to respond to trauma with painful feelings. Suffering occurs when the mind steps in and begins to evaluate those feelings as problematic and judges the self negatively for having those experiences.

The work in willingness is to help the client decrease suffering by showing up to internal experiences as they are; thoughts, feelings and memories. This must be done compassionately. Being mindfully aware is not intended to diminish experience or distance one from experience – as in disconnecting or dissociation – rather it is a gentle observing, a presence to and acknowledgment of experience.

Let's take a moment and view a demonstration of a willingness exercise.

Dr. Walser: We have been talking about willingness as an alternative to control and one of the things you have mentioned is that being willing feels overwhelming. Like to experience your emotional states when you are getting in that anxious place, like it will just be way too much.

Patient: Yeah.

Dr. Walser: And, so part of what I want to do is look at willingness in a different way, through a different process. When I was a kid, we used to make these tin-can dolls out of tin-cans and string essentially. You would cut the tops and the bottoms out of them and you would have string them together and you would have a coffee can for a head and then you would string the cans together to make arms and legs. Make sense?

Patient: Yeah.

Dr. Walser: Yeah, kind of a rattle-y doll. And the way that things work when we are feeling overwhelmed is as if that rattle-y tin-can doll is actually a giant tin-can monster, right?

Patient: Okay.

Dr. Walser: Like it's huge and it's noisy and it feels like if you were to try to encounter it in any way, that it will be too much – too much noise. So, part of what I want to do is move us to a place where actually we are just looking at the individual cans and see if willingness is possible in those places.
So I am going to ask you to do is kind of go that place where you start thinking about feeling your anxiety, like being open to your anxiety.

Patient: Uh huh.

Patient: And as you start to go there, what do you notice about your body? What do you notice happening, just off the top?

Patient: It's like an overwhelming feeling. It's an anxious, "I don't want to go there" kind of feeling.

Dr. Walser: Okay, okay. So like the tin-can monster like shows up in the room, all that noisy stuff shows up in the room. So, what I want us to do is kind of bring it down to a place where we are just looking at the individual cans. I will just walk you through this and ask you to attend to some different tin cans. So,

in that place of overwhelm, I want you to connect up with this and just notice what you feel in your chest. Just describe that sensation.

Patient: It's like tight. It's like heavy I guess is the way...

Dr. Walser: So, it's tight and heavy. What I want to ask you to do is to stay with that experience. Just let yourself feel the tightness and feel the heaviness. See if you can feel the edges of it, where it starts and stops. Let yourself be present to that.

Patient: Uh huh

Dr. Walser: Is it possible that willingness is available here to experience? We will just start in this place. So, part of what I would like you to do in this process, when you are thinking about kind of that whole tin can monster, see if you can bring your attention down to the individual cans in this process of introducing yourself to willingness.

While willingness or acceptance is used to decrease suffering by letting go of the struggle with private events, defusion more specifically targets the social and contextual supports for thoughts as causes of behavior. It is essentially designed to disarm the power of thoughts. The therapist supports the client in becoming de-fused. In other words, the therapist helps the client to see that she has a mind, not that she is a mind.

The therapist also works with the client in such a way such that the ongoing process of thinking is more evident. For instance, the client is taught to be mindfully aware of thinking. The ability to dispassionately observe the ongoing process of thinking is established. Mindfulness exercises are often incorporated into session and assigned as homework.

The defusion work done in session provides the opportunity to interact with language in non-literal ways. There are a number of strategies that are used to support defusion. For instance, the therapist might ask the client to adopt a verbal convention wherein he talks about the experiences he is having in the moment rather than stating the experience literally. The client might be encouraged to say" I am having the thought that this will never stop" or "I am having the evaluation that I am damaged." as opposed to "this will never stop" and "I am damaged" – both of which have static qualities and are products of thinking. Helping the client the client to recognize that he is having something in the moment supports the defusion process.

The therapist also introduces present moment experience as a way to increase flexibility. In present moment work we are asking the client to be here now. Trauma survivors diagnosed with PTSD can spend an inordinate amount of time describing their past or worrying about the future. The current moment is often lost to this kind of mindiness.

Under these circumstances behavior can be disproportionately influenced by the past. A trauma survivor may make rules about trust or safety, based on past experiences that are not effective in the present context, that is mind or languaging tends to narrow the focus of attention to particular thoughts, evaluations, or descriptions to the exclusion of other potentially important aspects of the environment. Present moment exercises are instituted to broaden the context beyond verbal content. Working with the client on present moment opens the door for additional contextual variables to influence behavior.

An explicit emphasis on self-as-context can be particularly helpful for the trauma survivor. In this process a distinction is drawn between one's self and internal phenomena such as thoughts, feelings, and bodily sensations. Clients are helped to come into contact with the perspective "I/here/now". From this place

clients are helped to recognize the continuity of consciousness, and to observe ever-changing internal experiences.

The self is recognized as a place where life events unfold. We call this sense of self the observer; it is beyond evaluation, has no mechanical qualities and it is found in experience not in logic. It is a felt sense. This concept is particularly powerful for individuals who have experienced trauma. It provides them with the means to reconcile with the fact that although something horrible has happened to them, that they are larger than that experience. They can observe that experience as a part of their history and that they are a place where the memory occurs. They are not any single memory or set of memories. They are larger than the memory. From this place memories are not as threatening and powerful lives can still be lived even if the memory continues to occur.

Let's take a moment and look at an example of how we might demonstrate self-as-context.

Dr. Walser: So, one of the things we have been talking about is your relationship with your emotions and thoughts. And, there are different kinds of relationships we can have through them and sometimes it looks like a game of chess. So, let's set this up. The object of the game is to win the war by getting your opponent's pieces off the board.

So, let's set-up this game as it relates to some of what is going on inside of you, like that war that is going on inside of you, so to speak. We're going to start with the chess pieces you would like to see win this game. So, give me a few thoughts about yourself that are positive thoughts.

Patient: I think I am a pretty good dad, I think I'm...

Dr. Walser: Good dad.

Patient: I think I am usually pretty funny.

Dr. Walser: Funny, okay.

Patient: Umm, you know, I think I am reliable.

Dr. Walser: Reliable. So now we have the team that we hope would win. If we were to look at it, that's the team that we would like to see win. Now, let's create the team that we would like to see the team lose. That other side, that struggle side.

Patient: Right.

Dr. Walser: So give me some of the thoughts and emotions that show up.

Patient: Umm.

Dr. Walser: There.

Patient: Overwhelmed with emotion.

Dr. Walser: Overwhelmed, okay.

Patient: Anxious.

Dr. Walser: Anxious, anxiety.

Patient: And, uhh un-confident I guess.

Dr. Walser: Not confident, perfect.

Patient: Not good enough.

Dr. Walser: Not good enough.

Patient: Scared a little bit.

Dr. Walser: Scared. Okay good. So, now we have the pieces in our game. We've got the side that you would like to win and the side that you would like to lose. And, the way it works is that one of these guys makes a move. Let's say, Not Confident makes a move or Scared makes a move.

And, we don't like that, right? We want those pieces off of the board. So, what we do next is call up the good pieces. Let's, you know, move those into positions where they can overcome these and kick them off the board.

You know, lets strategize and problem solve in such a way that this piece could be gone.

Patient: Okay.

Dr. Walser: Make sense?

Patient: Yeah.

Dr. Walser: But let's imagine that this board kind of stretches out in all directions and no matter how many of these pieces you try to replace with one of these, these never leave. Like, it turns out to be a chase rather than a victory. So, there is constantly this battle happening and I wonder if there is a way to step out of the battle. Like, if there is any other place that you could be in this game.

Patient: Just sort of like watching it outside of it.

Dr. Walser: So you would be watching it outside of it. Kind of like a player like out here.

Patient: Sure.

Dr. Walser: But the player is still invested in moving the pieces, right? Like where are these pieces going to be. Anything else that you can think of?

Patient: There is the board.

Dr. Walser: The board. All right, take a look at this. So, the board holds the pieces, it's in contact with the pieces, yet it is not the pieces. So, what if there is a place here, in this game where you are not these things. You are not these things either, alright. You are the place where the game is played. You are the context in which these experiences show up. So you are in contact with them, you are aware of them but the board is not the piece. The board is much larger than that. And notice this about the board that, it can carry the pieces, it can hold the pieces and the war can go on but it does not interfere with the board's movement in life.

Patient: hmmm.

Much of what we have explored so far in ACT has been oriented on mindfulness and acceptance. Let's turn to values. The concept of valued living is introduced as a foundation for making choices that are about building meaningful lives. Values are clarified and defined to orient the therapist and client in session and to orient the client to a life direction.

Values create a sense of life meaning and purpose. However, values are never attainable and they are a process not an outcome. If you hold the value of being loving, there is always more loving to do.

Additionally, values are defined by behavior, not by private content, that is values come to life in actions, not feelings. You can take valued actions that are loving in nature, even when you may not feel loving at the time. Participating in a family function because a survivor chooses connection as a value can be done even if anxiety is present during the experience. Finally, values are instantiated in the moment through behavior. This leads us to the final process, committed action.

Committed action rounds out the therapy – the client is asked if they are willing to be present to their experience, to clarify and contact their personal values and to move in a direction that brings these values to life. Committed action then, is about values congruent behavior. The behaviors can range in nature but should be specific or clearly defined. Actions can include things that are small like getting a cup of coffee with a friend or large like moving to another state to be close to a family member. Valued actions are only limited by creativity, but involve movement and routine implementation.

The overall goal of ACT is to help individuals engage and persist in behavior even when undesirable private events make that journey difficult. Thus, willingness is a primary condition of committed action. It is also the case that taking action will inevitably invite unwanted experience. Living according to our values sometimes invites pain. So, while committed action may appear to be one of the end points of therapy, it often is just the beginning. The barriers of fusion, evaluation, avoidance and reason giving can emerge and the client's ongoing work of acceptance and defusion will be essential in building larger and larger patterns of behavior that are values consistent.

As we end this presentation, we can return to the essence of the ACT work. Flexible use of each of these core processes is the heart of the therapy. ACT uses mindfulness and acceptance processes plus commitment and behavior change processes to promote psychological flexibility – the harbinger of health. Said in another way, ACT works with clients to support them in holding their internal experience while moving in valued directions, hold and move, accept and commit.

Thank you for joining this presentation.