

# INTRODUCTION TO ACCEPTANCE AND COMMITMENT THERAPY

Julian McNally

## PROGRAM OUTLINE

- About ACT: Definition, Research, Differences     ■ 40 minutes
- How does ACT work?     ■ 45 minutes
- How to do ACT     ■ 210 minutes
- How to learn more about ACT     ■ 15 minutes

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“How does ACT work?” will bleed into “How to do ACT” because sometimes demonstration trumps explanation.

## WHAT IS ACT?

- Behaviour-Focused
- Transdiagnostic
- Broad in scope



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Acceptance and Commitment therapy is a behaviour-focused, transdiagnostic model of therapy that is broad in scope and uses mindfulness and behaviour change processes to enhance clients' engagement, vitality and sense of life purpose.

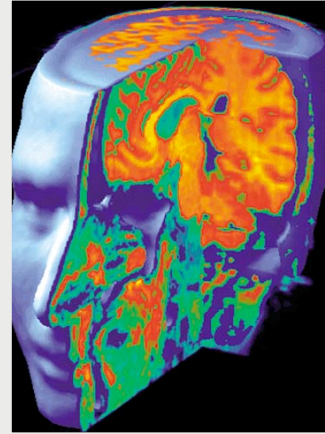
**Behaviour-focused:** The therapist detects and assesses maladaptive client behaviours and aims to influence them to be more consistent with client values. We're interested in what clients are doing (and not doing), how the doing relates to environmental and historical contingencies and what function the behaviours have.

**Transdiagnostic:** As we'll see when we look at the research, it applies to a wide variety of clinical and non-clinical problems. What this means is that the basic model encompasses principles that explain a broad range of pathological presentations. And in relation to diagnosis/ assessment, we examine behaviour in its context and for its function. Outside the context we can't know much. Without knowing the purpose or function of the behaviour, we can't say whether it's healthy (functional) or not.

**Broad in scope:** the same model of behaviour and communication applies to the researcher, the therapist, the client. This is a model of behaviour and communication that is broad in scope and applies to a wide range of clinical and non-clinical problems.

## MAJOR RESEARCH FINDINGS

- ≥ Treatment as usual
- Broad range of problems
- Results consistent with theory (mechanism is effective)
- Effects are longer lasting



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Examples: Chronic pain and pain tolerance analogues, panic disorder and panic symptom analogues, epilepsy, schizophrenia, work-site stress, stigmatisation of clients and counsellor burnout, drug addiction. See the ACT Pack for details.

Consistent with theory: Positive outcomes are mediated by acceptance, negative outcomes mediated by non-acceptance, fusion/believability of thoughts and remoteness from values.

In more than 40 studies with nearly 10,000 participants, psychological flexibility accounts for 16 to 33% of most psychological outcomes

There is evidence that the effects of negative thoughts, difficult feelings, maladaptive coping, emotional response styles, cognitive reappraisal, and perceived controllability, are all partially or fully mediated by psychological flexibility

## ACT Studies Examining Mediation (Hayes 2008)

Study	Problem	Comparison Group	Outcome Measure	Mediation Measure
Wicksell et al. (in press)	Chronic pain	Wait list control	Satisfaction with life scale	PIPS
Lillis et al. (under submission)	Weight Maintenance	Wait list control	BMI	AAQ for weight
Gifford et al. (under submission)	Smoking	Bupropion	One year smoking status	AIS
Lundgren et al. (in press)	Epilepsy	Supportive treatment	Seizure frequency and duration	AAQ-epilepsy.
Varra et al. (in press)	Resistance to use EBT	Education	Current use of EBT	STA believability and AAQ
Lazarone et al. (2007)	General Distress	Wait list control	GHQ	AAQ, KIMS
Gregg et al. (2007)	Diabetes	Education	Blood glucose level	AAQ-D and self-management
Lillis & Hayes, (2007)	Ethnic prejudice	Education	Positive action intentions	Acceptance and Flexibility
Lappalainen et al. (2007)	Depression, anxiety	CBT	SCL-90	AAQ
Hayes et al. (2004)	Stigma and Burnout	Education Control	CASA	SAB
Block et al. (2002)	Social phobia	Wait list control	Speaking time	Willingness
Zettle et al. (1986)	Depression	Cognitive Therapy	BDI	ATQ-B

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This is some of the range of problems we've found ACT effective with. Now let's look at some findings relevant to anxiety – both mediation and outcome studies included. Mediation because we want to make sure the processes we claim are relevant actually are. [Helps us counter the non-specific factors argument.]

## ACCEPTANCE & ACTION QUESTIONNAIRE (AAQ-I, 9 ITEM)

1. I am able to take action on a problem even if I am uncertain what is the right thing to do.
2. I often catch myself daydreaming about things I've done and what I would do differently next time.
3. When I feel depressed or anxious, I am unable to take care of my responsibilities.
4. I rarely worry about getting my anxieties, worries, and feelings under control.
5. I'm not afraid of my feelings.
6. When I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact.
7. When I compare myself to other people, it seems that most of them are handling their lives better than I do.
8. Anxiety is bad.
9. If I could magically remove all the painful experiences I've had in my life, I would do so.

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Although the AAQ is often said to be a measure of experiential avoidance, the original item pool focused on all major ACT processes

These 9–22 items (version II) cover a wide range of issues, including acceptance, defusion, and action.

The AAQ I and the soon to be released AAQ II seem to be measures of psychological flexibility more generally, emphasizing the parts of the model that we can tap easily within the existing language community.

There are now 27 studies using the AAQ, involving 5,616 participants, So what is the AAQ telling us? [click]



## AAQ Scores Are Associated With ....

- Higher anxiety
- More depression
- More overall pathology
- Poorer work performance
- Inability to learn
- Sexual abuse
- Lower quality of life
- Trichotillomania
- History of sexual abuse
- High risk sexual behavior
- 3P symptomatology and depression
- Thought suppression
- Agoraphobia
- Anxiety sensitivity
- Long term disability
- Worry

**ALMOST  
EVERYTHING**

7/21/09

## AAQ AND PATHOLOGY MEASURES

- All reported correlations are positive for the model
- BDI (8 studies) .50
- SCL 90 (3 studies) .53
- BAI or STAI (3 studies) .49
- GHQ (3 studies) .40
- Overall effect size .42 – (CI: 0.40– 0.44)

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There are also now pathology-specific versions of the AAQ (e.g. for eating disorders and chronic pain). Changes in scores on them mediate outcomes in those studies too. Now let's look at some pathology analogue studies...



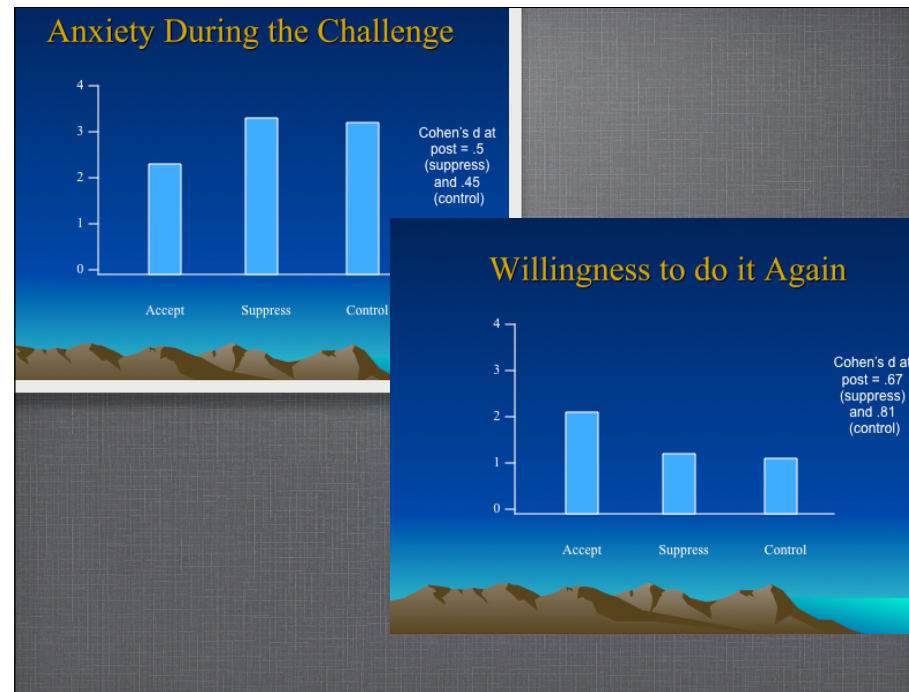
## ACCEPTANCE AND EXPOSURE

*Levitt, Brown, Orsillo, & Barlow, Behavior Therapy, 2004*

- 60 individuals with a primary diagnosis of panic disorder with or without agoraphobia randomly assigned to one of three groups (10 min audiotape): Acceptance, Suppression, Control (irrelevant distraction)
- 15-minute 5.5% CO<sub>2</sub> challenge (panic provocation)

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This is a typical panic disorder analogue, this time done with subjects who fit the diagnosis. Watch what happens...



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So anxiety is lower under Acceptance than Suppression, AND willingness increases...

## ACCEPTANCE VS. CONTROL TECHNIQUES WITH PAIN TOLERANCE

Hayes, S. C., Bissett, R., Korn, Z., Zettle, R. D., Rosenfarb, I., Cooper, L., & Grundt, A. (1999). *The Psychological Record*, 49(1), 33-47.

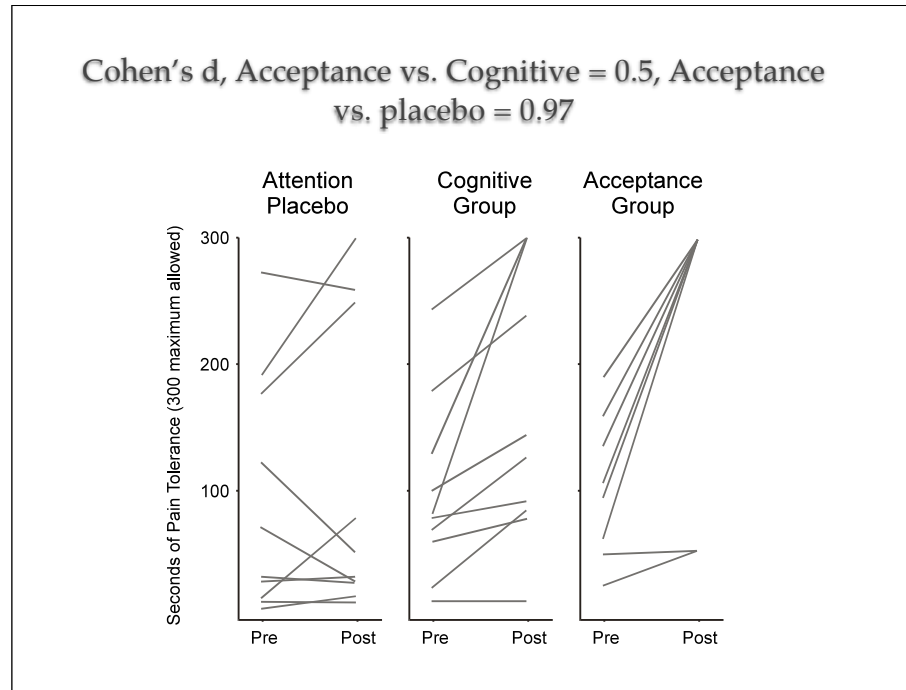
- 3 groups of subjects:
- ACT rationale plus acceptance and defusion practice
- CBT rationale plus practice
- Information about pain (placebo control)
- Cold pressor task (up to 5 minutes)

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cold pressor = water at 1 deg C. “You may remove your hand at any time, but stay as long as you can”.

CBT rationale was ‘distract yourself from pain by thinking of a pleasant experience’. Appeals to logic and ‘common sense’ yes?

ACT rationale was ‘thoughts and feelings don’t control actions, people do’ and ‘you can’t successfully control thoughts and feelings anyway’.



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Note: These are individual subject scores.

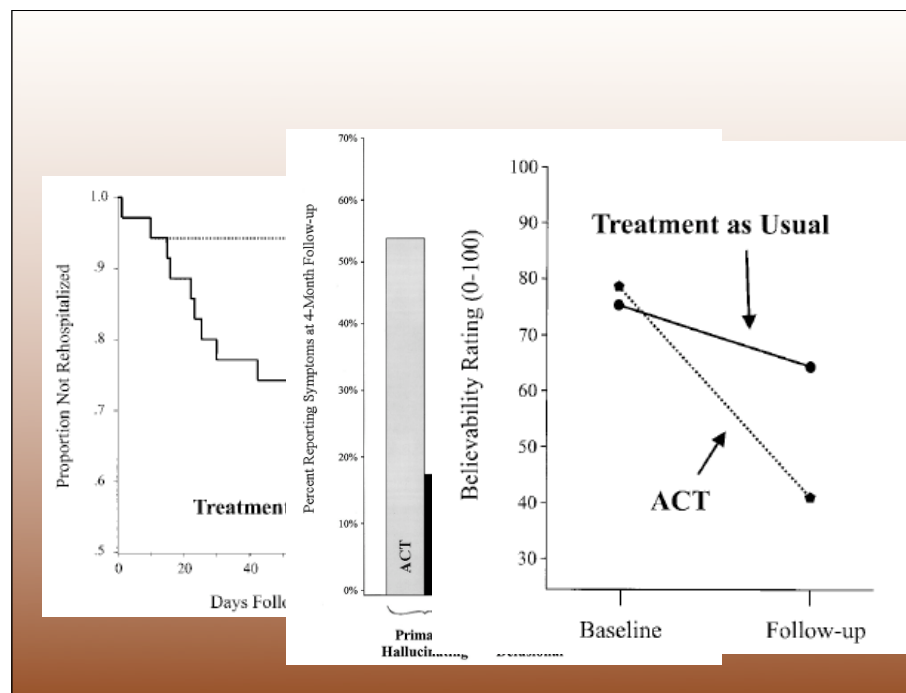
## COPING WITH PSYCHOTIC SYMPTOMS

Bach & Hayes, 2002

- 80 S's hospitalised with hallucinations and/or delusions randomised to either ACT or TAU
- 3 hours of ACT; all but one session in-patient
- ACT intervention focused on acceptance and defusion from hallucinations / delusions

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What is that creates anxiety for the psychotic patient? Isn't it the belief that the delusional experiences might be real? What do you do about that? Avoid contact with others, medicate, pace and talk to reassure your self, otherwise engage in a struggle with your experience. Most fearful thing is not to HAVE the delusion but to BELIEVE it. Will explain Defusion and Acceptance in the next section.



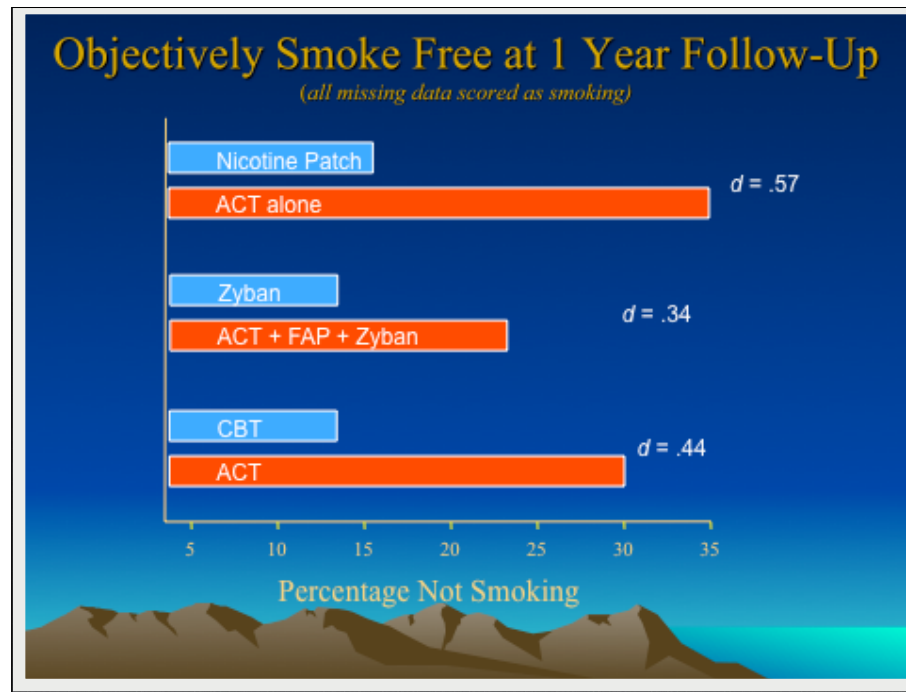
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Note:

Longer duration before hospitalisation for patients in the ACT treatment. So any differences between groups – e.g. maybe TAU was a more severe group, less medication? No to both and in fact, HIGHER frequency of symptoms for ACT group. So what mediates it – believability of delusions /hallucinations.

Recent replication by Gaudiano and Herbert has shown similar results – 55% of TAU rehospitalised at 4 months vs. only 20 % for ACT group. What about against pharmacological interventions?





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ACT for smoking cessation: think about the savings in medical treatment and suffering if you keep just an extra 10% of people off smokes for a year.

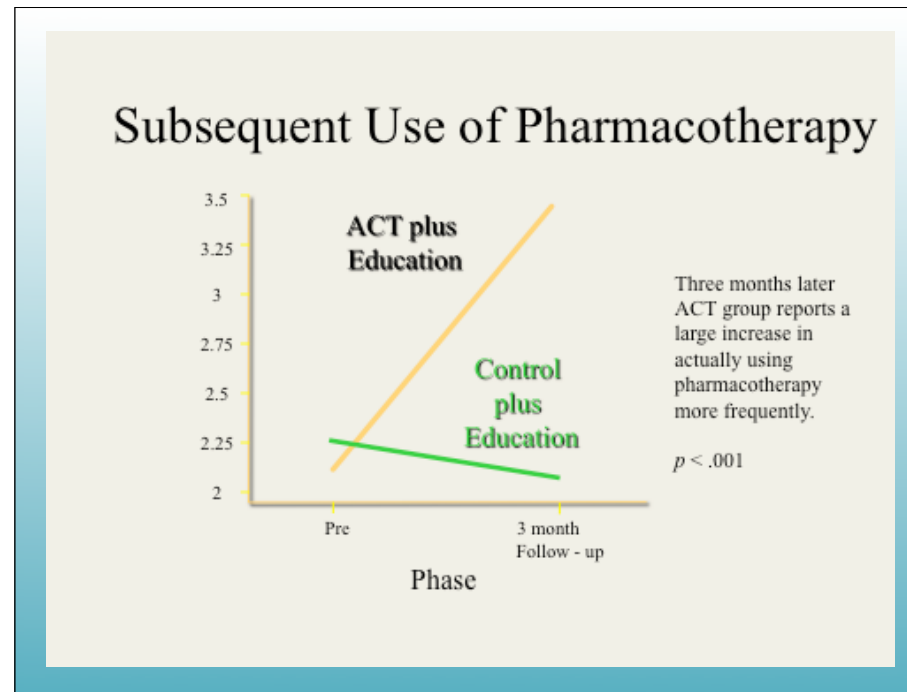
## Changing Counsellor Attitudes To Recommending ESTs

*Varra, Hayes, Roget & Fisher, 2008*

- 59 drug and alcohol counsellors randomly assigned to:
  - One day ACT workshop focused on defusing from the psychological barriers to learning new treatment approaches, and acceptance of the emotions they bring up
  - One day workshop on matters not linked to empirically supported treatments e.g. EAP policies (Control condition)
  - Both groups then do a two day educational workshop on empirically supported treatments in the drug and alcohol area focusing particularly on the use of agonists and antagonists

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This is important work because counsellors should be doing what works. If there are perceived barriers to doing that, it would be helpful to have an intervention that overcomes those barriers.

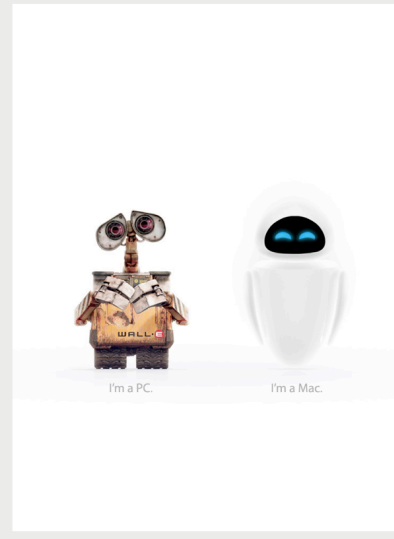


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1. Who perceives the barriers? The ACT group acknowledges the barriers, but fair enough, they just did a day's training focused on (defusing from) them.
2. although the ACT group starts off believing the barriers are more real than the control group, the intervention 'works' in reducing believability in the 'realness' of them.
3. What difference does this make? [Click] The ACT group reports greater willingness to use the ESTs. But then experimental subjects tell you what they think you want to hear. What we want to know is what difference in behaviour happened (cf. changing attitudes re prejudice,

## HOW IS ACT DIFFERENT?

- Philosophy: Functional Contextualism
- Derivation: Science then practice
- Examples: CBT, SFT



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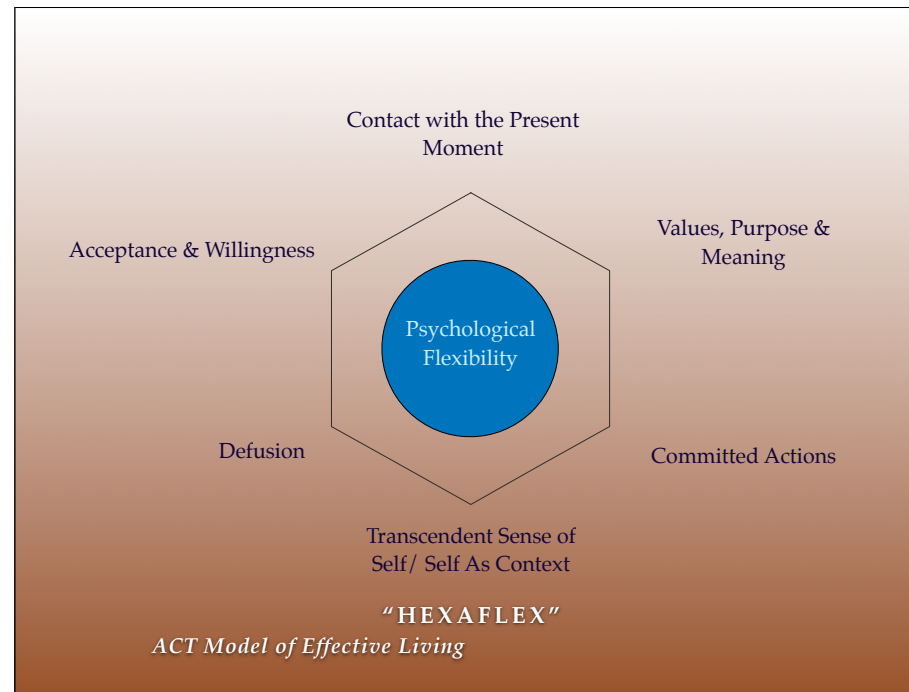
Philosophy. Compared to materialist philosophies that inform most other approaches to science and practice (e.g. mechanism), RFT does not pre-suppose the existence of mechanisms (like 'mind' and 'causes'). Focus instead is what works and how it works – search for effective components and a model that allows for prediction and influence with precision, scope and depth.

Science then practice. Hayes, Zettle and colleagues sought a model that works from the ground up to encompass all of human behaviour – including emotions and cognition as a form of behaviour rather than having to treat it with separate rules.

Other approaches aim to change internal experience, whereas we aim to change the context within which they occur – values & workability.

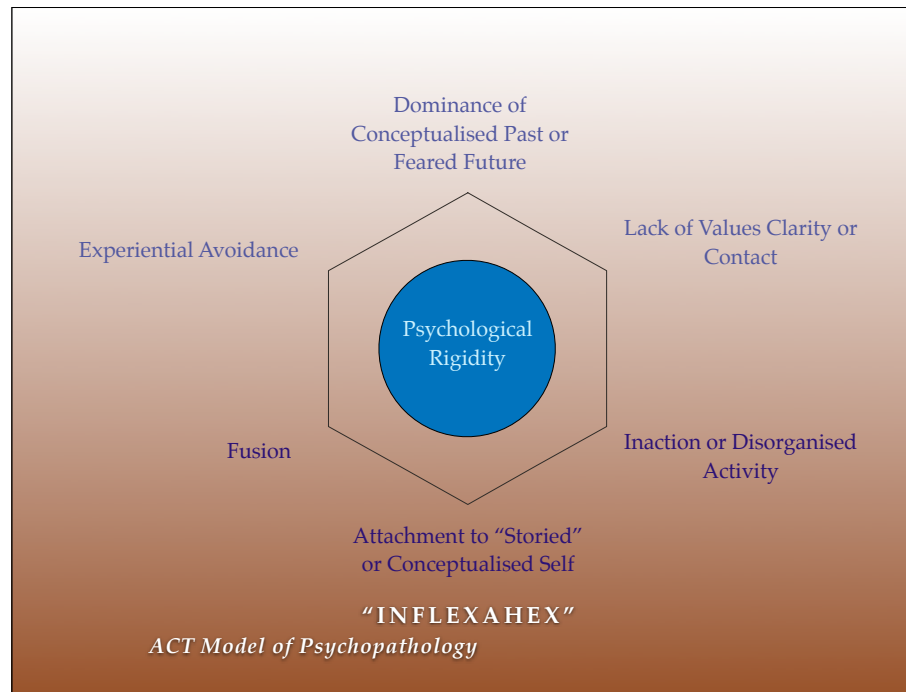
Examples:

- To CBT: accept vs. dispute thoughts, work on Ct's relationship with thoughts not with their content, feelings not evaluated as good/bad. MBCT/MBSR - accept to get over.
- To psychodynamic: theoretical level - same as per behaviour therapy – no need for explanatory phenomena that add nothing (e.g. transference = behaviour), clinical level – attention to values not meaning

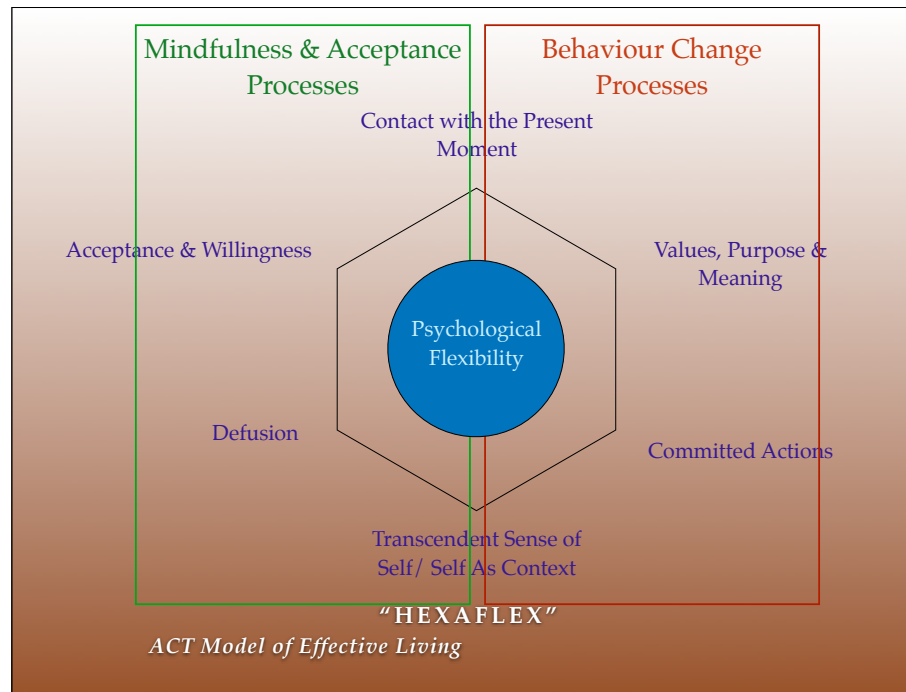


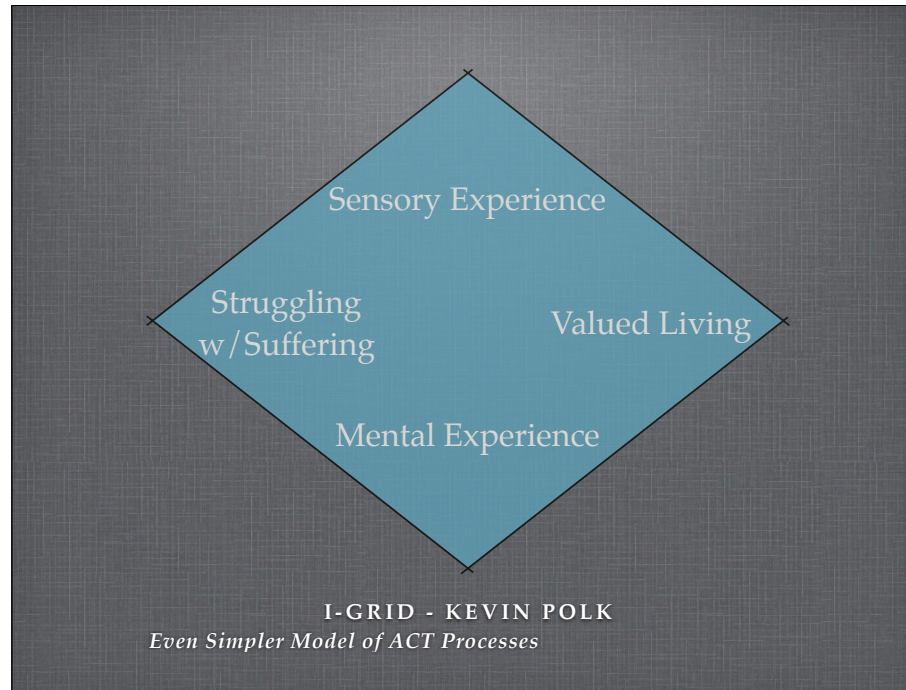
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Values are “are verbally constructed global desired life consequences”. Global because they are always available (for our attention), not so much desired as approved or appreciated for the pursuit itself not for the outcome of the pursuit. (Hank Robb)









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Healthy living = Acceptance of and response to sensory experience, with actions guided by values.

Pathology = Fusion and over-involvement with Mental Experience and actions directed into struggling with suffering

Then you just have the client do a Life Manual (Handout 3) and identify current and future actions as SwS or VL

If time – do this:

Simply draw The Grid for your client and explain that to the right are behaviors or actions *toward* values, important things like health, relationships, etc. To the left are behaviors *away* from unwanted mental experiences like anxiety and depression. Explain that all humans do both kinds of behaviors. Above the left line write the following:

I \_\_\_\_\_ for \_\_\_\_\_.  
action                      suffering

I \_\_\_\_\_ for \_\_\_\_\_.  
action                      value

Healthy living = Acceptance of and response to sensory experience, with actions guided by values. Pathology = Fusion and over-involvement with Mental Experience and actions directed into struggling with suffering



CONTACT WITH THE PRESENT MOMENT

*Exercise 1*

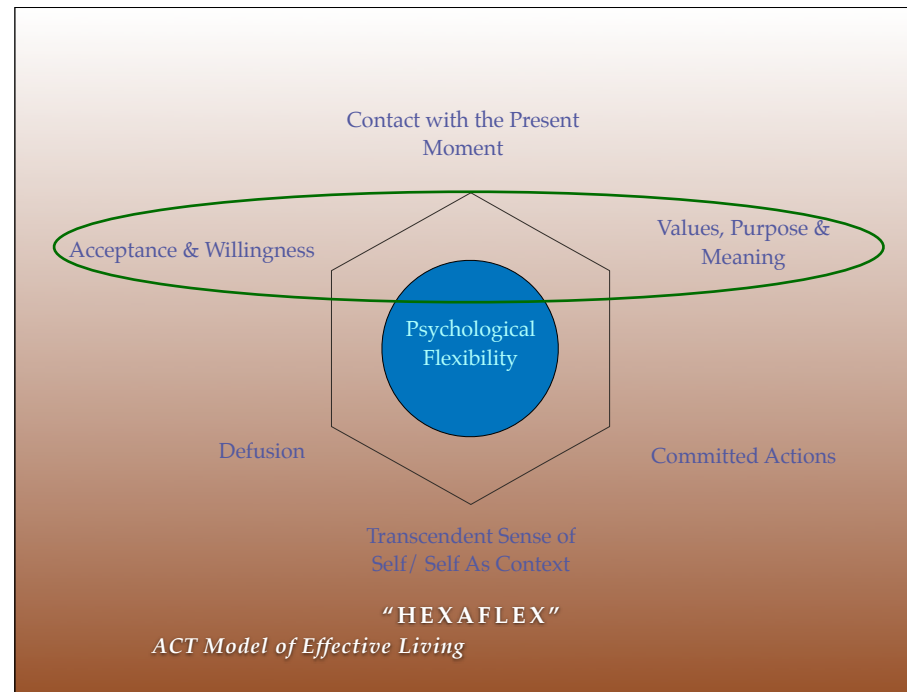
**BREAK!**

## WHEN TO USE AND WHEN NOT TO USE MINDFULNESS EXERCISES

- You feel stressed or stuck
- Client is agitated, “mindy” or circular
- Give yourself time
- When your client has a pulse!
- Psychosis
- Severely drug-affected
- Unsafe environment, including prior trauma

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1. Stressed? Allows you to get present and choose from alternatives how to respond best.
2. Agitated, “mindy” or circular (going round in circles)? Gives them a chance to calm down – grounds them. Helps them defuse if “mindy” or contact observing self if they’re retelling/ re-living their story.
3. Give yourself time? Allows you to make better decision. We need only 1, not 2 agitated people in order to have a counselling situation. We need 2 non-stressed individuals in order for effective learning to take place.
4. Pulse? First do no harm, and except for the following caveats, anyone will benefit.
5. Psychosis – e.g. auditory or command hallucinations – may be unable to distinguish sounds from your voice, your voice from hallucinated voices. Try with eyes open and more tactile commands – you can feel the phone, etc. “tell me what you can see – describe it in detail”.
6. Drug-affected? May nod off or have difficulty following. Not harmful, just not helpful.
7. Unsafe environment? Safety is first priority. If intrusive re-experiencing is happening, may not be able to hold them over the phone. Probably need assessment if acute, but can ground with instructions for Psychosis if they will stay on the line.



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Workability & Values to start. Identify motivation for change:

1. Workability – fed up with getting nowhere, open to trying a different approach even if it doesn't make sense. Quicksand. Finger-cuff. Give examples of Workability questions: What have you been struggling with? What have you tried? How has that worked? And yet it's still there...
2. Values – Life beyond symptoms, struggle and relief. Examples of Values questions: MQ – life without this problem. Where was your life headed before this came along? What is this stopping you from doing? Why is that important to you?

## YOUR TURN!

Pair up - one is "A" the other is "B"

- Decide individually if you'll **be** a client or **consult** on a client
- If **being a client**, your partner is the **counsellor**
- If **consulting**, your partner is your **supervisor**
- Use the "Guide to initial ACT session" for questions - 2, 3 & 4
- Observe and resist urge to "fix" or make better
- Hasten slowly



***“PAIN IS MANDATORY,  
SUFFERING IS A CHOICE”***

Julian McNally (I think)



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vs. inevitable and optional

Here's what Pain looks like...

And here's what our minds do to create suffering. Think of the demons as thoughts.

*"IF YOU'RE UNWILLING TO HAVE IT  
YOU'VE GOT IT"*

Hayes, Wilson & Strosahl



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The essence of Acceptance and Willingness is that if you're willing to have it, it probably won't bother you. If you're unwilling to have it you get to keep it and suffer while keeping it.

Now, try not to think about a flying pink elephant. [Click] – this is what I want you not to think about.

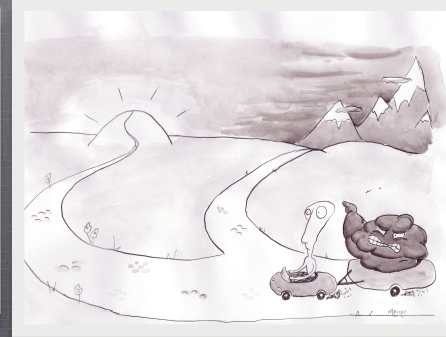
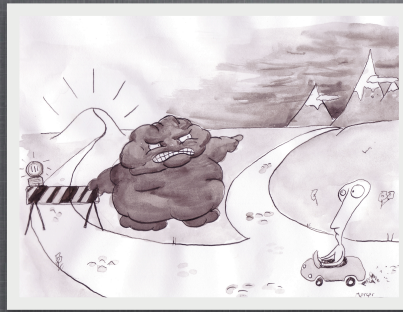
How did you go? ["What are the numbers?" and "Mary had a little..." if necessary.]

Why Accept? Not to get rid of, but in service of pursuing valued direction.

BREAK

## DEFUSION

Can you have your thoughts and feelings for what they are and not for what they say they are?



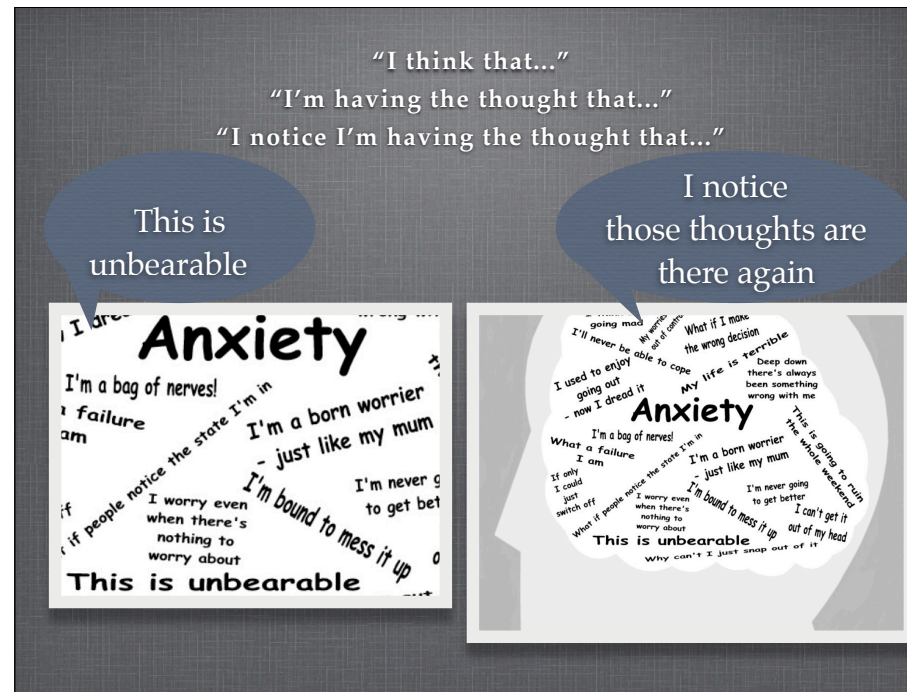
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Sometimes your thoughts are like bullies. If you pay them heed, you end up going in a direction that's not truly yours.

Really, though, they just show up for the ride. They can say turn left and you can still choose to turn right.

[If needed, demonstrate other defusion exercises.]





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### 3 Step defusion of troublesome thoughts

1. I think that this suffering is unbearable
2. You could say though, that I'm having the thought that this suffering is unbearable.
3. You could also NOTICE that you are there having the thought.
4. It looks like the thought appears out of nowhere. Just like when you open your eyes, there is the world.
5. As soon as that "unbearable" thought appears, so does everything else associated with it. [RFs]
6. But there is a mind there having the thoughts. In a sense you contain them, so you are not them...
7. ...and can observe your mind having them. [Then go on to choose value-consistent actions in their presence.]

You can use this kind of illustration with a client



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Think about a sour, juicy lemon cut in half. Imagine squeezing a couple of drops of juice onto your tongue and feeling the sharp bite of that sourness... who's salivating. Now say "Lemon" x 30 secs. What happened?

Exercise is not used to defuse, but to demonstrate that it's possible to displace the derived stimulus functions of saying "lemon" with direct ones



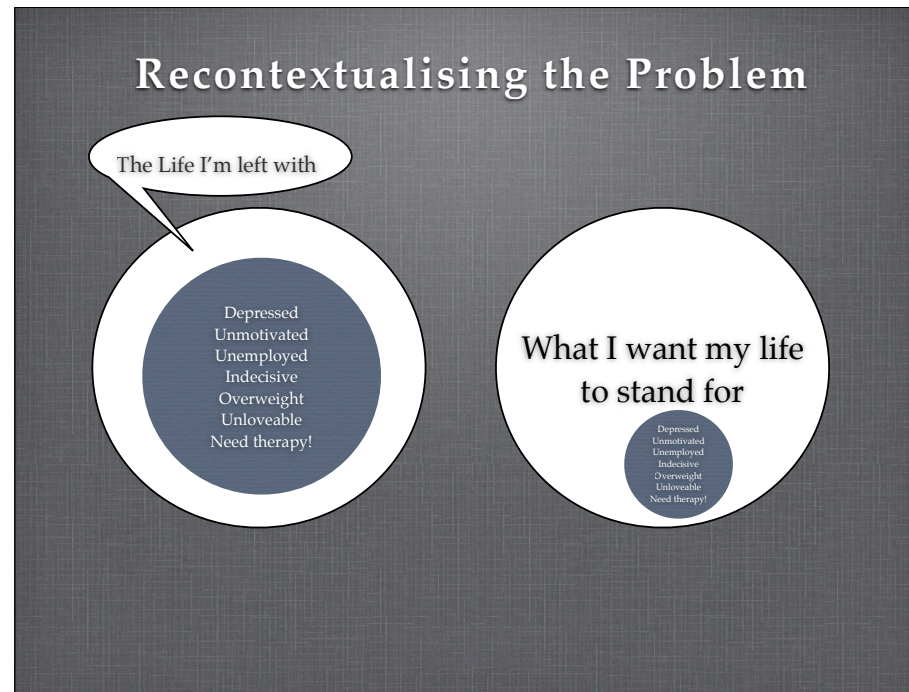
## SIMPLE SELF-AS- CONTEXT METHOD

1. Notice an experience
2. Notice that you're noticing it

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...or for 2, notice that you're having it. Where is the you that is having it?

Try this now



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What you pay attention to grows. [Demonstrate if needed]. This is why the gratitude diary works – focuses attention on what the person values most in life. Do you want life to be what you have left once you've dealt with the grey stuff?

So the question for the client is “What are the patterns of action that are going to be consistent with that white space in your life?” [Rainer video – then H6]

## HOW TO LEARN MORE

- Join ACBS for USD1.00! at [www.contextualpsychology.org](http://www.contextualpsychology.org)
- Join the listserves at Yahoo! Search for “groups” and “acceptanceandcommitmenttherapy”
- Stay tuned to these for the ACT-ANZ Conference 13-15 November at Melbourne University
- Russ Harris’ website, workshops and newsletter at [www.actmindfully.com.au](http://www.actmindfully.com.au)
- My website and workshops (2010) at [julianmcnally.com](http://julianmcnally.com)

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ACBS = get resources

Listserve = join the conversation, belong to a community

Conference = 1 & 2 but more so

Russ & Julian = training and supervision