Focussed Acceptance and Commitment Therapy

Contents of manual by Bruce Arroll © 2016

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Glossary of terms

Creative hopelessness. This is the process where the therapist validates the unworkable avoidance strategies of the client when s/he is stuck in the problem solving mode of the mind. It is usually where experiential avoidance (defined below) is operating. The narrative is "that does not seem to be working for you" and the answer should be no. It is an option for the therapist not a feeling or state of mind in the client and is a central task of the FACT consultation. It helps the client stop and let go of the struggle i.e. letting go the agenda of control (Russ Harris online adolescent course). It is not a hopeless future for the client. Another term for this is confronting the struggle agenda which is preferred by Russ Harris. Yet another way to think of it is the patient is in a hopeless situation and you as the therapist can be creative and find ways to lead them to a more flexible place.

Mindful anchor. This is where the client sits with a powerful physical anchor e.g. hand on heart and both feet on the ground while they: notice and name their pain then soften around it; let it go and expand. Clients may prefer to use another metaphor but having a visual one enables the therapist to say "I have my video camera on you next week and you are feeling stressed – what will I see you doing." i.e. the therapist can "see' the mindful anchor being done i.e. it is a behavioural action.

TEAMS. This stands for thoughts, emotions, associations, memories and sensations. Uncomfortable TEAMS can be associated with experiential avoidance and the client might respond to them by avoidance, suppression, distraction and escape. We have no ability to control the arrival of TEAMs and unpleasant symptoms that are associated with them so we must focus our energy on what we can control i.e. our immediate behaviour.

Experiential avoidance (also called experiential control) is the attempt to control or alter the form frequency of situational experiences (TEAMS). This can be fed by an entanglement of language and cognition. From the brain's perspective there is essentially no difference between the cognitive process of escaping from a locked room and those used to escape an urge by using drugs. Avoiding painful TEAMS is a major source of human suffering. The next step is to avoid painful situations e.g. friends, gatherings which shrinks the social and physical networks. One of the roles of this therapy is to expand the physical and psycho-social world.

Introduction

This is a work manual for therapists wishing to learn and develop their skills in ACT (acceptance and commitment therapy) and the focussed version FACT (focussed acceptance and commitment therapy). This version of FACT has been developed primarily for use in primary care settings but can be used in any high volume, time limited consultation settings.

What is needed?

A standard approach to physical/mental health

What is needed is a simple, consolidated, uniform and evidence-based approach to human behaviour change that allows the clinician to apply the same treatment principles across a broad range of problems. FACT is such a treatment model (Strosahl, 2012).

What ACT offers to psychology and regular healthcare?

FACT offers a focussed version of ACT. ACT is one of the "third wave" psychotherapies using processes that clinicians find useful. It is based on a philosophy called functional contextualism. Like all third wave psychotherapies, it includes a mindfulness component. Briefly, human behaviours are assessed for the functionality in specific contexts. A specific feeling e.g. anger is not problematic but it can become so in certain contexts. (refer to page 33-35 ACT made simple by Russ Harris). ACT is a trans-diagnostic model that allows a therapist to help people with physical and mental health issues such as depression and anxiety as well as pain, diabetes control and smoking cessation. It deals with the common underlying issues that cause these problems. An initial FACT consultation can be completed in around 30 minutes with shorter follow up sessions. The number of sessions is not fixed but is typically 2-3. The shorter FACT time frame makes it a better fit in regular health care settings where the demand is high and psychological resources are scarce. The developers of ACT are not proprietorial about their knowledge and openly encourage trained clinicians to try using some of the ACT processes.

FACT in a nutshell: Accept the uncomfortable TEAMS, change the unworkable strategies, become flexible, start doing activities and move toward a valued future through those activities, in brief, and a limited number of sessions. All actions need to be workable (by that we mean "Is what you're doing working, in the long run, to make your life richer and fuller?"

1. Accept what you cannot change (acceptance part) – you cannot undo your history but you can learn to hold it gently and not be defined by it.
2. Become psychologically flexible (i.e. learning to be aware and accepting of the pain that comes into our lives while continuing to pursue what we value.
3. Identify values and commit to following them (commitment part). This may require a bold move and able to stay with any discomfort that shows up. The aim is not to be symptom free but to live a life that matters.

Strosahl et al (2012) summarise the situation by saying that a "limited number of mental processes explain both human suffering and human vitality. There are three basic dimensions that determine both level of suffering and level of vitality:

(i) awareness of the moment
(ii) open-ness to private experience (flexibility)
(iii) engagement in valued activities. FACT explicitly holds that all human suffering, regardless of its form, is caused by deficits in one or more of these core processes."

The solution becomes the problem
The clients' attempts to control their distressing TEAMS/private experiences results in constrained and unworkable patterns of behaviour i.e. they become stuck. The mind begins to "spin" and become busy, i.e., "the busy mind". The problem solving role of the mind is to make value judgements which are great for avoiding traffic when crossing the road but not so good if you are experiencing TEAMS. The theory behind this is Relational Frame Theory (Hayes 2010). The new perspective facilitates openness to these feelings rather than focussing on controlling them. To lead a psychologically flexible life we need to value acceptance/willingness rather than control. One aim of FACT is to connect the client with their personal values – these can be controlled and it is acceptable to control/connect with them. The commitment part is taking actions that are values based, flexible and expanding in scope. The aim of FACT is to help clients live a rich, full and meaningful life and not specifically to remove symptoms. Clearly when living a values based life clients are likely to have fewer symptoms. (Adapted from Strosahl 2012)

The structure of this book is for action first and theory second.

If you wish to read some material on FACT theory please turn to appendix chapter XXX. (not in this version).

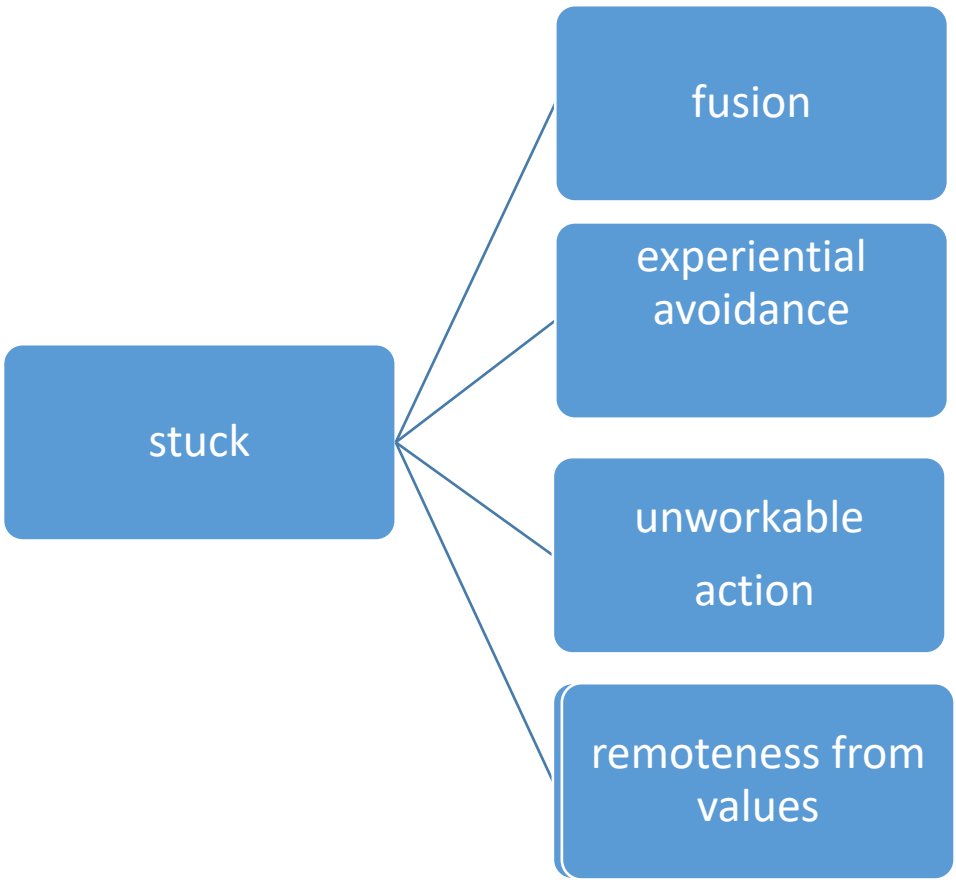
The diagnosis is the distraction (Strosahl)

This is a major issue in primary care for physical health e.g. abdominal pain or a headache when these are likely to be largely influenced by psychosocial factors. This is frequently not taken into account and physical symptoms get investigated and psychosocial issues ignored. The same holds for psychiatric diagnoses such as depression or anxiety (when the underlying behaviours and context are not always taken in to account). FACT is an approach that enables the therapist to work with the underlying behaviours and reframe the "problem or diagnosis" to facilitate a more meaningful life while accepting the pain that goes with this. It is also an issue for mental health where clients get a label of depression and anxiety and who get put on anti-depressant/anxiety medication. Both the clinician and the client can get distracted by the medication (i.e. is the drug still working or are there adverse effects and when should/could they be stopped and should we add a second medication) rather than looking at the behaviour and persisting avoidance. Another way of viewing this is that the client's relationship to the TEAMS is the problem where as a diagnosis makes it a state or even a trait and this is not necessarily helpful to the individual (Peter Bowden personal communication 29/5/2016). (Strosahl personal communication 2016).

FACT is a Trans-diagnostic approach
FACT is considered trans-diagnostic in that the models do not focus on specific diagnoses but the underlying behavioural processes. The aim of FACT is to develop "psychological flexibility". This refers to situations where people are "able to make room for the inevitable pain of life, more able to defuse from unhelpful thoughts, beliefs and memories; more able to take effective action in the face of emotional discomfort; more able to engage fully in what they're doing; and more able to appreciate each moment of their life no matter how they're feeling." Russ Harris ACT made simple page 30) Clients are considered to be stuck (and inflexible) and the aim is to get them to be unstuck and flexible. Being stuck usually means there are one to four components contributing to this state. Stuck = fusion ± experiential avoidance ± unworkable action ± remoteness from values. (Figure 1) Being stuck also has the advantage of being a "functional" diagnosis as you can become unstuck. It also

has advantages that a formal diagnosis of depression/anxiety is not made – those labels can cause later employment issues when applied to short term stress situations which are not DSM 5 level diagnoses. (Russ Harris Advanced online course April 2016).

Figure 1: Diagnostic schema



FACT does not aim for an absence of symptoms. The aim is living a meaningful life in the service of values. Pain is expected, suffering is optional. FACT targets some or all of these 4 components. The aim is not to make the TEAMS go away but to enable the client to live a more meaningful life in the service of their values.

View the client through the lens of flexibility
Consider the client through a lens of flexibility and watch out for words like should, "we never cried in our family, must etc." Most people live by rules they have acquired throughout their lives and often are unaware how these can influence/control their lives. Rules are useful for the physical world but less useful for our emotional world.

"Constriction of activity precedes mental health problems so check what TEAMS, people or activity(s) is being avoided"

It is very common for humans, when faced with adversity, to start avoiding situations that cause anxiety or stress. (Personal communication K Strosahl 2016). This may be an internal avoidance of TEAMS or external avoidance of people or experiences. The mind cannot readily tell the difference between constructive and destructive safety. A lost job or a failed exam is just the same as a physical danger e.g. a sabre-toothed tiger for our caveperson brain. Fear of a tiger is a constructive reaction while rumination and worry are destructive activities. The natural defence mechanism of our "keep you alive" mind is a tendency to move away from difficulties i.e. to avoid discomfort. This is appropriate for our caveperson ancestors but is less often needed in the 21st century. Indeed personal growth, for modern humans, is more likely to come from "leaning towards our pain and suffering" (Epstein and Back 2015) rather than leaning away from it. I have started using description that as the "feelings get larger the patient's life gets smaller."

Our problem solving mind works well for sorting our tax returns but not fixing our emotional issues.
The ACT model of the mind is that it has a good problem solving capacity. This is good for getting bills paid and fixing software problems. It is not good at fixing our emotional issues. For this, we need other approaches such as acceptance, mindfulness and reversing the avoidance. These other options give our "busy minds" something constructive to do. The problem solving function comes intoits own when moving towards our values (see later under values).

The brain's role is to keep us alive.
Our minds can be our best friend and our worst enemy. It works best externally rather than internally for physical symptoms or emotions (TEAMS). The mind works best on outside experiences e.g. crossing a road safely. It does not work well for inside emotional or physical experiences and is likely to over react to them thinking it is keeping us alive e.g. abdominal pain is a sign of cancer or a few negative thoughts means the old depression or anxiety is back.

Our minds are not built to think" (Benjamin Riley Economist p18 22/7/17) but as above are meant to keep us alive. They will tell us things such as "don't go the gym or do exercise" yet when we do exercise we feel better. Robyn Walser talks about learning to trust our experience in this case rather than what our minds are telling us to do. "Listen to your experience not what your mind is telling you." Russ Harris has a

great line where he says to the patient "your mind would say that wouldn't it." Another sentence is that "thoughts are not facts."

Workability "ask about what works not what ought to work"
"A workable life is one that is producing desired outcomes on an ongoing basis."
Many clients think their actions are correct when in fact they are unworkable or unhelpful. Many people like to be right rather than happy (Arroll BMJ 2013). For example, a client who is unhappy with a banking transaction may argue with a bank teller, swear at them and storm out and feel satisfied with the interchange. If and when they need banking services again they may find they have burnt some bridges. Swearing and arguing with a bank teller is an unworkable action. It would have been more workable if they had stayed and sorted out the issue on the first occasion. (Strosahl and Robinson https://www.youtube.com/watch?v=8UCWzZRI_Vw)

Are our clients 'insane' when they keep doing unworkable things?
Quote: Insanity: doing the same thing over and over again and expecting different results. Albert Einstein

Or Winston Churchill "Men (and women) occasionally stumble over the truth, but most of them pick themselves up and hurry off as if nothing ever happened." In terms of ACT and rule following this isan example of rule following.

By this definition, most or all of us would be insane. It is a human tendency to default to what we know. A case in point is in those with primary insomnia – people who spend too long in bed (9 hours in bed but sleeping for six hours). They may have a late night out and find they sleep wonderfully but on the next night will attempt another 9 hours in bed in spite of the better sleep with the shorter time in bed. The tendency to default to the familiar is a safety mechanism as it means we are in the known, we may feel included and we trust those around us. However the familiar may be following societal or family rules such as "we don't cry in our family." This following of the rules can conflict with our values and make us inflexible. In the terms of Carl Jung, this pull of the familiar is to deal with our fear of death although in ACT we are less interested in the 'subconscious" explanation for the action than in the workability of the action.

The solution is the cause of the dysfunction
Strosahl (2005) says that a patient's problem is not causing the dysfunction, but rather the solutions being used to solve the problem cause the dysfunction. For example shrinking of the external life (not seeing friends or exercising which reduces demand in the short term) is a solution that becomes a problem as the client becomes less resilient. This is the caveman equivalent of hiding in the back of the cave- where there is no resilience. The client needs to be at the front of the cave with people, hunting game and in the sun.

Creative hopelessness – these are "unworkable actions"

Creative hopelessness "means fully opening to the reality that trying too hard to control how we feel gets in the way of living a rich full life." (Russ Harris ACT made simple p 81).The therapist asks "has what you have been doing helped to solve your problems? (The answer should be no otherwise you are not in a therapeutic relationship- note denial may work in the short term)." Would you be willing to do something different? (The answer should be yes or else you need to clarify the purpose of being together). Or are you willing to give up the struggle? This can be used for mental health and physical health issues such as a client with poorly controlled diabetes. For example with patients with poorly controlled diabetes the issue of what is being done to improve the situation can be raised. In many situations patients will not be doing as much as they can with lifestyle and taking their medication. Occasionally their diabetes will be deteriorating as their pancreas fails to provide insulin and so for a small proportion of patients behaviour change may not work.

Values and actions
One aim of FACT is to get clients working towards their values (what is important to them in the long run) which will mean taking action that will change their relationship to their TEAMS in the service of their values.

The future is now- single sessions are possible
In FACT the first session is meant for assessment and to start treatment as it may be the only chance to get change. It is not uncommon for clients to fail to attend a booked follow up mental health clinic appointments. Clients should leave every session with a plan for behaviour change that has the potential to radically change their quality of life (Strosahl 2012 page 58).

The warm handoff
In medical clinic situations where there is a dedicated mental health professional a warm handoff is possible. This is where the therapist meets the client at the time of referral and starts therapy then or at least the therapist being introduced to the client by their trusted primary care clinician. There is evidence that this is associated with better outcomes (Collins 2010). Given adequate resources, therapists may be available as needed (or with a short wait for the client). If a full consult is not possible immediately the client can at least be introduced to the therapist. The warm handoff eliminates the did not attend (DNA) rate which is so common with mental health referrals (Robinson book 2015). This could be done in any medical clinical situation and does not necessarily need to be used with FACT.

Summary of FACT

A standard approach to both physical and mental health.
The aim is not to have an absence of symptoms but to live a valued life.

FACT in a nutshell: Accept what cannot be controlled, change the unworkable strategies, become flexible, start doing activities and move toward a valued future through those activities, in brief and limited number of sessions. It does not aim for an absence of symptoms.

*The diagnosis is the distraction-
*Trans-diagnostic approach to diagnosis i.e. the client is stuck.
*View the client through the lens of flexibility.
*Constriction of activity precedes mental health (mood) problems.

*TEAMS = thoughts, emotions, associations, memories and sensations.
*Check what activity/people/situations and TEAMS are being avoided.
*Our problem solving mind works well for sorting crossing roads but not fixing our internal emotional or physical issues. It makes value judgements on our TEAMS which are not helpful.
*Pain is inevitable suffering is optional- a new relationship is needed to psychological pain.
*Acknowledge that the client is working very hard and that what is bothering them is important to them i.e. they struggle because they care.
*Ask what works not what should be working. Creative hopelessness what you are doing is not working. Would you like to try something different? This is the pivot point. Encourage client to lean intotheir fear/suffering or to carry their fear and suffering while moving towards their values.
*Encourage warm handoffs-where therapist meets client at primary care visit.
*The first visit is for assessment and starting treatment.

Chapter 2: FACT basics- 2(a) the first visit

Summary in 7 steps	Introduce yourself and role. You are a capable person and my role is to work with you towards making a fuller life guided by your values.
A: FACT assessment	1. Focussed questions.* 2. Creative hopelessness.* 3. Work, love, play sheet.*
" Find the pain"	Find the pain and/or the core belief: diagnosis is being stuck. Pain is a sign of caring.
B: Change relationship to experience.	4. No delete button discussion. 5. Present moment awareness and using the mindful anchor.
Find the pivot point.	The client agrees that their current effort to avoid pain in their life is not working and they are willing to try something else.*
C: Values and action(s)	6a. Values*

	6b. New actions.* 7. Likelihood of action * (readiness ruler).

Key: items marked * would be done in all FACT interviews while the others are optional along with other optional activities that come later in this manual

TEAMS. This stands for thoughts, emotions, associations, memories and sensations. Uncomfortable TEAMS can be associated with experiential avoidance and the client might respond to them by avoidance, suppression, distraction and escape.

Just before you start: Introduce yourself. Remember to state to the client that you see them as a capable person and that you are willing to stand with them in pursuit of a fuller life that is vital and meaningful. Your role is to help with problems of living to see what's working and what is not and to make the most of each visit. Also remember that the client may be fearful as they will potentially be telling you things they may have never told anyone else. Therapy is a fear provoking situation.

Narrative for introducing self (depending on who and where you are)
Hi, my name is Steve and I'm a Clinical Psychologist and I work as a Behavior Health Consultant here at the clinic. My role is to help you to improve your overall health which includes not only your physical health but your emotional and behavioural health as well. We're going to meet for 20 to 25 minutes to get a snapshot of your life and see what's working and not working and work together to come up with a plan to make your life better. Sometimes people get what they need in a single visit; other times people return for a few visits to learn new skills. I will make a note in your medical record and I'll discuss with your Dr. X what we talked about today. If I have any concerns about your safety or the safety of others I will help you get the help you need. Can you think of any questions at this time? Or. "Learning skills to handle thoughts and feelings more effectively so they have less impact and influence over you. (Russ Harris Depression and anxiety online course 2017)"

Lead off consult.
The lead off consult is where patients/client start to unload their distress. This may catch you off guard as it can occur with any contact between two or more human beings. This section is to remind those in health care that enabling a patient to be seen, heard and understood is almost certainly of major therapeutic benefit. You may or may not have training in mental health but never under value the importance of listening to another human being. You may be a receptionist, nurse, doctor, physiotherapist or other health professional. Your listening is important and don't avoid listening because you think/feel you are not well trained in mental health.

A1. Focusing question

As a reminder, the four focusing questions that can yield maximal information in the limited time available in brief interventions are as follows: (Strosahl 2012)

1. What are you seeking?
2. What have you tried?
3. How has it worked?
4. What has it cost you?

    -What TEAMS are being avoided?

    -What situations are being avoided?

    -Who is being avoided?

(validate that they have been working hard, very very hard)

5. A fifth key question increases motivation to change and helps clients identify valued life directions that are within their reach:

Q? What kind of life would you choose if you could choose? Or if you could change something next week what would it be? (Kuhl 2016). Or what is the smallest thing you could change in the next week that would make a difference.

A2: Creative hopelessness

Has what you have been doing to help with your symptoms been working? The answer should be no. Occasionally some clients may be much fused with their situation and may say yes. Or if the client says I try and keep myself busy say “does that help in the long term” and again the answer should be no. Most clients will agree that what they are doing is not working. This is essential to establish in order to assist the client in choosing to make a change. This needs to be done sensitively lest the patient feel judged as they will have been trying very hard. The term creative hopeless is not said to the client but merely describes their situation. One way to think of it is the patient is in a hopeless situation and you as the

therapist can be creative and find ways to lead them to a more flexible place. Another way to think of the creative part is that this is often the time in the consultation to become creative. In the final analysis it is about getting the client to stop the struggle.

A3: Work love play spirituality questions

Personal quality of life scale work love play questions to get an overview of clients life. This is known as the contextual part of the interview.

Looking back over the last week including today can you rate how well you are doing in the following areas of your life. We call this the work-love-play checklist. Please circle the number that applies to you.

1. Work-occupation-school

Low
High

1	2	3	4	5	6	7	8	9	10

2a. Love-friends

Low
High

1	2	3	4	5	6	7	8	9	10

2b. Love-intimates

Low
High

1	2	3	4	5	6	7	8	9	10

2c. Love-family

Low
High

1	2	3	4	5	6	7	8	9	10

3. Play-recreation-hobbies-interests-sports

Low
High

1	2	3	4	5	6	7	8	9	10

4. Then ask about

Exercise
Smoke
Sleep
Recreational drugs
Alcohol
Gambling issues
Violence
Citizenship/community
Spiritual

Task: Give the work/love/play/spirituality sheet to the client to fill out. This gives you time to make notes and plan therapy.

How to use the work love play scoring sheet. Start with the lowest score
We start in the section with the lowest score and find out what is happening there. Usually there is one lower than the others. If they are all low e.g. all 1/10 you need to ask the client to elaborate. In general ideas for therapy/behaviour change will come from the work/love/play questions.

Acknowledge the suffering
Pain is inevitable suffering is optional- a new relationship is needed for pain.
Acknowledge that the client is working very hard and what is bothering them is important to them i.e. they struggle because they care. Another way of reframing the pain is that it is a reminder of what they are about. Clients are very appreciative when you acknowledge that they are in pain because they care.

Finding the emotional pain

This is the main role of assessment (Strosahl ACBS Seattle 2016). The pain is what drives the TEAMS. If the client cries then ask "if your tears were words what would they be saying?" This is a moment when the pain may be able to be identified. If the client says they feel hurt they are expressing a secondary emotion. You need to ask what is behind that, what is driving that. I sometimes ask "what is the issue that pushes your button?" Strosahl analogises it to being like a dentist in finding all the pain in the mouth so that treatment can be directed to it. If they cannot get to a core emotion it may be simpler to ask to look at the core belief checklist and choose their core beliefs (virtually all humans have at least one and some have many). The key issue with pain is that pain is expected in life; suffering is optional- a new relationship to pain is needed.

Short cut to pain

From Judith Beck "Cognitive Behaviour Therapy basics and beyond" xx edition copyright 1995 Judith Beck PhD. If the client is struggling to identify their pain you can ask them to look at the following two boxes and tick the core beliefs that apply to them. Please note this is not a standard ACT approach but I find it useful in some situations.

Helpless core belief (problems of identity)

I am helpless	I am inadequate
I am powerless	I am ineffective
I am out of control	I am incompetent
I am weak	I am a failure
I am vulnerable	I am disrespected
I am trapped	I am defective (I do not measure up to others.
	I am not good enough in terms of achievement

Unlovable core belief (problems of love)

I am unlovable	I am unworthy
I am unlikeable	I am different
I am undesirable	I am defective (so others will not love me)
I am uncared for	I am not good enough (to be loved by others)
I am unattractive	I am bound to be rejected
I am unwanted	I am bound to be abandoned
I am bad	I am bound to be alone

Summary of 3 ways to find pain

1. Client can identify their pain e.g. rejected. Or.
2. If the client cries – then ask "if your tears were words" what would they say- this is when the client is connected with their pain. Or.
3. Ask them to check the core belief sheet.

Where are we now
At this stage of the consultation you will have an idea of what the client is expecting and what their concerns are. You hopefully will have an overview of the balance of their lives and what TEAMS and life activities are being avoided. You will also have an idea of the core belief(s) or pain(s) that are driving the TEAMS.

B: Change relationship to experience

This is the core of a contextual behavioural science in that the "TEAMs" is put intoa different context i.e. the client can see their TEAMs differently (ACT in Context podcast #3 The history and development of ACT with Steve Hayes.

B4: No delete button talk
In reply to "I just want to get rid of these awful feelings." You reply "the problem with the human mind is that it has no delete button. Any negative thought or experience is stored there and can be retrieved at any moment. This is a crucial safety task for your mind as it cannot afford to forget something dangerous/negative that has happened in the past. The "no delete button" sentence is one that clients always relate to. The mind can remember that you failed a math exam when you were 8 years old, your mother yelled at you when you were 16 and you crashed the family car when you were 21. At age 30 you have a difficult experience at work and can recall those previous dangers resulting in a negative spiral. The "no delete button talk" needs to be done sensitively so that the client does feel hopeless about the negative thoughts from the past. This is an example of Relational Frame Theory – a process that only conscious humans can do. We understand that animals do not have this consciousness. The way to give our minds something constructive to do it to learn to hold those negative feelings lightly. It is important that clients are aware that there is an antidote to not having a no delete button and that is to hold these TEAMS lightly. This is done through the present moment awareness exercise below using the mindful anchor. (Steve Hayes ANZACBS Wellington 2015)

B5: Present moment awareness (this is adapted from the book Inside this moment Strosahl, Robinson and Gustavsson 2015). I have added a physical action to accompany the five steps from the Inside this Moment book. This exercise is called the mindful anchor as I ask the client to put their hand on their heart and feet firmly on the ground (we suggest you use this for all clients- some may prefer their own metaphor). It has the powerful kinaesthetic anchor of touching the floor and heart which assists safety. It also has the advantage that it can be seen externally so that when you say: If I were filming you with my video camera next week and you were feeling stressed, you would be able to see and describe your response to those stressful moments. If the client finds it too "cheesy" they may wish to use a metaphor of their own. Keeping to the same mindful anchor means the therapist has to remember only one activity. The aim of this exercise is not to remove the pain but to enable the client to live with ease and better tolerate their pain. In psychological terms it is a form of exposure therapy and enables the mind to adapt to the TEAMS thereby reducing the desire to avoid them. The mind needs to relearn that they are not as dangerous as they at first seem- to do constructive work rather than destructive work. A comment that I often make to clients is that the mindful anchor takes the stress from the minds (where it is uncomfortable) and put it in their body (where it can handle it better).

Five steps from the Inside this moment book (Strosahl et al)

Notice the negative TEAMS/pain/core belief

Name it

Soften (apply some self-compassion to yourself)

Let go

Expand (what is possible now you feel different)

Expand: At the point of discussing "expand" the narrative is "what is now possible for the future given this new feeling." Another narrative is "what constructive things are now possible"- this reinforces the idea that you are training the mind to do constructive rather than un-constructive activities.

The client may think this is weird.
We have had clients find some of this a bit 'flaky or weird." The narrative for this is to remind them: what you have been doing has not worked. There is a lot of evidence for this work (over 170 clinical trials) and our experience is that it works for many people. The proviso can be given that if they are not getting results then we have other options.

Narratives for mindful anchor
"The mindful anchor gives your mind something constructive to do rather than spinning your wheels with problem solving."

“The mind needs to relearn that these TEAMS are not as dangerous as they at first seem.”
“The mindful anchor gets the stress “out of your head” and intoyour body where it is easier to manage.”

What to do if they feel worse
You can ask them to put the feeling on a Xmas tree or over there and make it smaller, different colour i.e. change the states/senses.

Where are we now
At this point in the consultation you will have the client agreeing that what they are doing is not working. You will have explained what you can and cannot do for them. They will have had the “no delete button exercise” and now have a tool to change their “busy mind” to a “wise mind” and start sitting and observe their painful TEAMS. It is important to note that you are not trying to make the TEAMS go away. It is best to play down this expectation.

Pivot point
This can also be considered the pivot point of the consultation. “It starts with the distress the client is seeking help for and ends up as a discussion about core values, the costs of avoidance and possibility of living a different kind of life.” (Strosahl, Robinson and Gustavsson 2012). What you have been doing does not seem to have worked. Would you be willing to try something different? The aim of therapy is to create behavioural variability by doing behavioural experiments.

C: Values and actions

Many clients will be working very hard to control their TEAMS. They are distressed because they are stuck and looking at values is the next step to guide the future. It can be helpful to remind the client that their pain is the flip side of their values. They would not be hurting if they did not care. It is important to realise values are a direction and not a goal.

Connecting the client to their values for emotional and physical issues
The way to find out a client’s values is to ask “what is important to you (in the long run)?” Or at “your 70th birthday what would you like people to say about you?” One way of connecting the client behaviour to their values is to hold out your right hand and say these are your values and in your left hand hold their avoidant behaviours (could be not contacting a friend, smoking or having poorly controlled diabetes) and show them the inconsistency. Ideally this should enable clients to connect their behaviour with their values and achieve something workable.

Values narratives
A variation is to use more motivating language such as:

-“taking the opportunity for greatness” (when they go low we go high- Michelle Obama 2016 Democratic National Convention USA)

- what do you want to create ?
- what are the possibilities here?

Some clients may need to be inspired to “make a bold move” (Robyn Walser Auckland 2016 tour)

C6: Values

Directions	Rating importance	On track
	1= low 5= high	1= off track 5= on track +++
Being a valued friend		
Being a valued partner		
Being a valued sibling		
Valued son/daughter		
Valued family member		
Valued parent (if relevant)		
Kind to myself –play and relax		
Being active in hobbies		
Being active in sport		
Being productive		
Being creative		
Developing myself		
Being a valued employee		
Being a contributing citizen		
Being a valued student		
Contributing to the earth		
Contributing to mankind		
Being spiritual (whatever that can mean)		

Modifed from "Stuff that sucks" a book for adolescents by Ben Sedley child psychologist in Wellington.

C6: New actions

"you cannot make yourself feel better sitting here – you need to do things"

I often preface the discussion of new actions by saying that "you cannot make yourself feel better by sitting here – you need to start doing things." It is always encouraging to see a positive head nod at this statement. Kirk Strosahl (Auckland 2017) comments that it is getting the client back in to the river of life and then they will start swimming again. The work love play sheet usually indicates some imbalance in life and that is a good place to start. I ask the client why their score is low on a particular point and the explanation usually highlights an area for work. In line with the above comment "Constriction of activity precedes mental health problems" it can be very helpful to ask what were you doing when you were last feeling well. The comment is often I was seeing my friends and going out. A first step is try and enlarge the clients shrunken world and get them back to where they were. Ideally asking questions such as "would you be willing to do? …" rather than "you need to do." Or would you be willing to experiment with an idea. The client needs to start different behaviours and it probably does not matter what they do. Doing something different changes the client's rule following behaviour. They may need some suggestions as to what to do as they will be avoiding particular situations and people. This may induce stress. To deal with this stress they will need to use the mindful anchor. The mindful anchor is analogous to using a "moon boot" to stabilise an injured ankle while the ankle heals. To assess the different behaviours we say that we (the therapist) have a video camera on you (the client) next week – what will we see you doing differently and that way we can see a behaviour change. When you get stressed what will we see you doing (the answer should be the mindful anchor). Real change is possible at this stage. Sometimes clients will need help with focussing and we suggest saying "if there were something you could change next week what would it be?" (Kuhl 2016) or what is the smallest thing you could change by next week that would make a difference. I always have at least two tasks but no more than four tasks to be attempted before the next meeting.

From Strosahl 2012 p80 "Ultimately the goal is to help clients become aware they have a choice between continuing to use avoidance strategies and trying something completely different: accepting what is present inside and still actively moving in the valued life directions. This is at the heart of the process that promotes radical change. It starts with the distress the client is seeking help for and ends up as a discussion about core values, the cost of avoidance, and the possibility of living a different kind of life." (Strosahl 2012 p 80)

Useful Narratives: Which pain is worth having; the pain of being stuck or the pain of growth pursuing what is important. Which pain is more meaningful (from Russ Harris ACT for Adolescents). Another is what would you be doing if all your distress went away.

C7: Likelihood of action

Likelihood of taking action

Near the end of each session, ask clients to rate the likelihood they will do what was planned in that session using a scale of 1 to 10, where 1 = not likely at all, and 10 = very likely. Generally, a rating of 7 or above is the target. A six or below should trigger an additional interaction about barriers to action that might be showing up for clients. There might be a need to either identify a new plan or to reduce the task (make it smaller, simpler or easier) from the original plan. I write out a task list (avoid the term homework) and put the score beside it. I also write this into the computer note speaking it as I write it to reinforce the fact there are tasks between each session.

(Russ Harris Advanced course). Alternatively is ask the client to read it out aloud so that I can type it in to the computer notes- I have not had anyone renegotiate

Does it matter what clients do- probably not- a new behaviour is needed

The key is to get the client doing something different and it may not matter what they get asked to do so long as it makes sense to them. We had one client who had had minor knee surgery and he agreed to walk 100 feet in the next week and it was 10/10 he would do this. In fact he did much more than this. There is a saying from Martin Luther King Jr "If I cannot do great things, I can do small things in a great way." Asking clients to do a small amount of activity e.g. 1 minute of brisk walking is a strategy to get people moving. They are likely to find that self-reinforcing and do more.

Where are we now

We now have an overview of the client's issues and what they are doing and not doing and we know their pain. The next step is to encourage them to start expanding their lives using the mindful anchor when experiencing TEAMS. This is the acceptance part of ACT. They need some tasks to do to reverse the avoidance process that has developed. We also know how likely they are to achieve this (on a 1 to 10 scale) so at the next visit we can assess their progress. You can also discuss tasks not done. This is the commitment part of ACT.

In summary then there are two major tasks of treatment at the end of the 1st visit

1. The client needs to expand their world and start doing activities that they have done in past (where helpful) or new activities where fresh ideas and approaches are needed.
2. Mindful anchor to deal with their pain and any pain associated expanding their lives. There will be situations where this is not enough for clients who are very fused and distressed and there are other processes that can be used (see later sections on the three pillars open aware and engaged).

Termination of care

FACT is designed to be a brief therapy where getting the client progressing toward their goals whereas in traditional therapy termination occurs when the client has met their goals. This means therapy can be just one or two visits or four at the upper limit. After that they can be returned to their regular health professional or back to life.

End of 7 step summary of FACT for primary care (overview on first page chapter 2)

Take home points- for first visit approximately 20 to 30 minutes
3 parts to the initial assessment. A: FACT assessment (1) focussed questions (2) creative hopelessness (3) work, love, play sheet (find pain) B: Change relationship to experience (4) no delete button talk (5) hand on heart mindful anchor and present moment awareness. C: Values and action (6) Values and new actions (7) likelihood of action. *Focus on the lowest score on work love play unless something else is more important. *Find the pain.(3 ways of doing this) *Creative hopeless should prime client to doing something differently or at least highlight the futility of their struggle. *The mind has no delete button so we need to hold our TEAMS lightly. *Mindful anchor for present moment exercise so that this can be "seen" with our video camera next week so can see a change in behaviour. *For values ask "what is important to you in your life." Their pain is the flip side of their values and what is important. *What tasks are clients willing to do to change their situation? It may not matter what it is so long as it makes sense to the client and they are willing to do it. Making a change means they are leaving their rule governing behaviour. *Agree on tasks and check the likelihood scores are ≥ 7/10. *Always set more than one up to four tasks to be attempted before the next session.

Resources on ACT

To access the free online Goodfellow Unit course on Focussed Acceptance and Commitment therapy (duration 1.5 hours)

1. Go to goodfellowunit.org and sign in if already registered.
    a. If you are not registered you will need to register (green box on screen shot below)-this is free and you have access to the majority of Goodfellow Unit resources.
2. Then click eLearning at the top of the page (see screen shot below).
3. Then scroll down to focussed acceptance and commitment therapy (this is also free)-it takes 1.5 hours and you can get a certificate confirming you have done the course.

References for this manual

Arroll B, Goodyear-smith, Moyes S, Kenealy T. Being right or being happy: pilot study. BMJ 2013; 347 doi: https://doi.org/10.1136/bmj.f7398 (Published 17 December 2013) Cite this as: BMJ 2013;347:f7398

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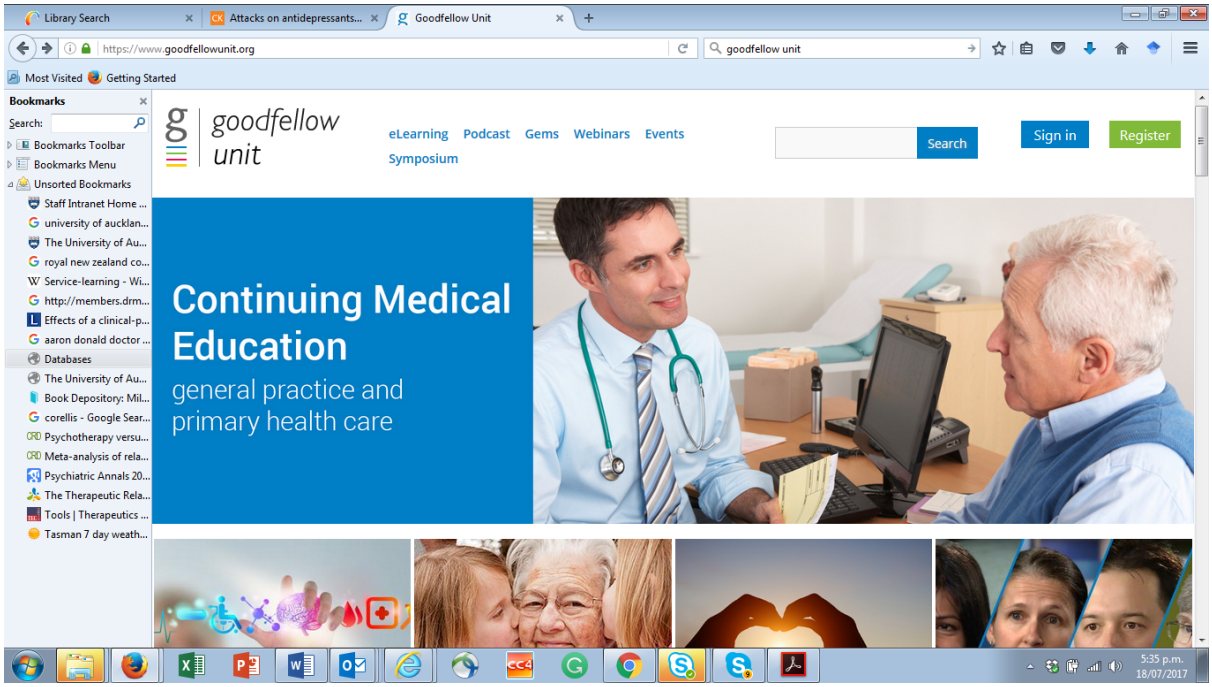
Epstein RM, Back AL. Responding to Suffering.
JAMA. 2015;314(24):2623-2624. doi:10.1001/jama.2015.13004

Kuhl 2016 From a personal communication with Professor David Kuhl from the University of British Columbia.

Robinson PJ, Reiter JTBehavioral Consultation and Primary Care: A Guide to Integrating Services 2nd ed. 2016 Edition

Strosahl K, Robinson P, Gustavsson T. *Brief interventions for radical change: principles and practice of focussed acceptance and commitment therapy* 5674 Shattuck Avenue, Oakland, CA 94609: New Harbinger Publications 2012.

Strosahl K, Robinson PJ, Gustavsson T. Inside this moment. A clinician's guide to promoting radical change using acceptance and commitment therapy 5674 Shattuck Ave Oakland CA 94069: Context press. An imprint of New Harbinger Publications Inc. 2015.



(Nine Videos on Focused Acceptance and Commitment therapy (FACT) done by Bruce Arroll at the University of Auckland)

https://www.youtube.com/playlist?list=PLiXC7JOP_RV3dSrtYr1OWPMTc0GuDNsZF&feature=em-share_playlist_user

look at 8,1,7,3,5,4,2,9,6, in that order

Order to consider

Video number	What each one contains
8	Bruce Arroll talks on FACT for 31 minutes and describes 3 patient with diabetes
1	BA interviews patient with mixed depression/anxiety and goes thru the 7 steps outlines in the manual- about 11 minutes
7	BA demonstrates work love play a few minutes. This is the contextual part of the discussion. Duration a few minutes.
3	The futility discussion with chronic pain patient. Duration a few minutes.
5	Open – demonstration of defusion using a Russ Harris and a Robyn Walser technique. Duration a few minutes.
4	Aware and the second pillar of open-aware-engage. Duration a few minutes.
2	Engage – getting a patient to take action on their diabetes by linking their values to their poor control of their diabetes. Duration a few minutes.
9	Engage – Duration a few minutes.
6	Second case of patient with depression and drinking heavily about 10 minutes

Fact resources online

Webinar with David Bauman and Bridget Beechy from Washington USA

https://vimeo.com/183028615

Three videos of FACT (including Kirk Strosahl and Patricia Robinson)

Clinical cases

https://www.youtube.com/playlist?list=PLvLh_YdubBs5l1Nt4s44-KcqRysQpTBhl

Interview with Kirk Strosahl and others on being a primary care behavioural health consultant

https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ

Steve Hayes TedX https://www.youtube.com/watch?v=GnSHpBRLJrQ Mental Brakes to Avoid Mental Breaks

ACT learning resources in New Zealand

Join Association Contextual Behavioural Science (ACBS) society. They ask for a voluntary amount $US10 to $70. There are lots of resources here which are free. (This is the ACT society). This includes videos, audios and written material.

Focussed Acceptance and Commitment therapy in order of preference for books

1. Strosahl K, Robinson P, Gustavsson T. *Brief interventions for radical change: principles and practice of focussed acceptance and commitment therapy* 5674 Shattuck Avenue, Oakland, CA 94609: New Harbinger Publications 2012.
2. Strosahl K, Robinson PJ, Gustavsson T. Inside this moment. A clinician's guide to promoting radical change using acceptance and commitment therapy 5674 Shattuck Ave Oakland CA 94069: Context press. An imprint of New Harbinger Publications Inc. 2015.

3. Robinson PJ, Gould DA, Strosahl K. Real Behaviour change in primary care; improving patient outcomes and increasing job satisfaction 5674 Shattuck Avenue Oakland CA 94609: New Harbinger Publications, 2010.

General ACT introduction

1. Luoma JB, Hayes, S.C, Walser RD. Learning ACT. An acceptance and commitment therapy skills-training manual for therapists. 5674 Shattuck Avenue Oakland CA 94609: New Harbinger Publications Inc. 2009.
2. Harris R. *ACT made simple. An easy-to-read primer on Acceptance and Commitment Therapy* 5674 Shattuck Avenue Oakland CA 94609: New Harbinger Publications Inc. 2009.

Great book on mindfulness and a concise summary of ACT

1. Wilson Kelly G. Mindfulness for two (this is not a couples book). New Harbinger.

Books for clients

1. Harris R. The happiness trap. Constable & Robinson let. 3 The Lanchesters. 162 Fulham Palace Road London W6 9ER- this is a self-help manual
2. Hayes SC, Smith S. Get out of your mind and into your life. The new acceptance and commitment therapy. 674 Shattuck Avenue Oakland CA 94609: New Harbinger Publications Inc. 2009. This is a self-help workbook.
3. Book for teenagers " Stuff that sucks: by Ben Smedley by Robinson Great Britain 2015. Ben is an ACT therapist in Wellington NZ.

Blog quick tips for ACT therapists
https://www.newharbinger.com/blog/quick-tips-therapists

Online courses with Russ Harris an Australian GP who wrote the happiness trap - better than face to face courses. Online courses enable you to integrate learning in to practice.

1. Introduction course -about $500 for 8 weeks- 3 hours per week.
2. Advanced course about $500 for 8 weeks- 3 hours per week.
3. https://www.praxiscet.com/ courses and online in the USA.
3. Many other courses.

Face to face courses in New Zealand

1. Elizabeth Maher face to face courses in many centres and at many levels. http://www.mindfulnesscbt.org/
2. Russ Harris face to face- Bruce Arroll likes the online course and Russ Harris thinks more learning takes place with the online format. http://www.actmindfully.com.au/
3. Ben Sedley on ACT for teenagers https://www.compass.ac.nz/index.php?route=product/product&product_id=398

Podcasts (go to iTunes or google play store)

1. ACT in context
2. Taking hurt to hope. Joanne Dahl
3. Functionally speaking by Daniel Moran

Conferences

ACBS international 24th July 2018 in Montreal