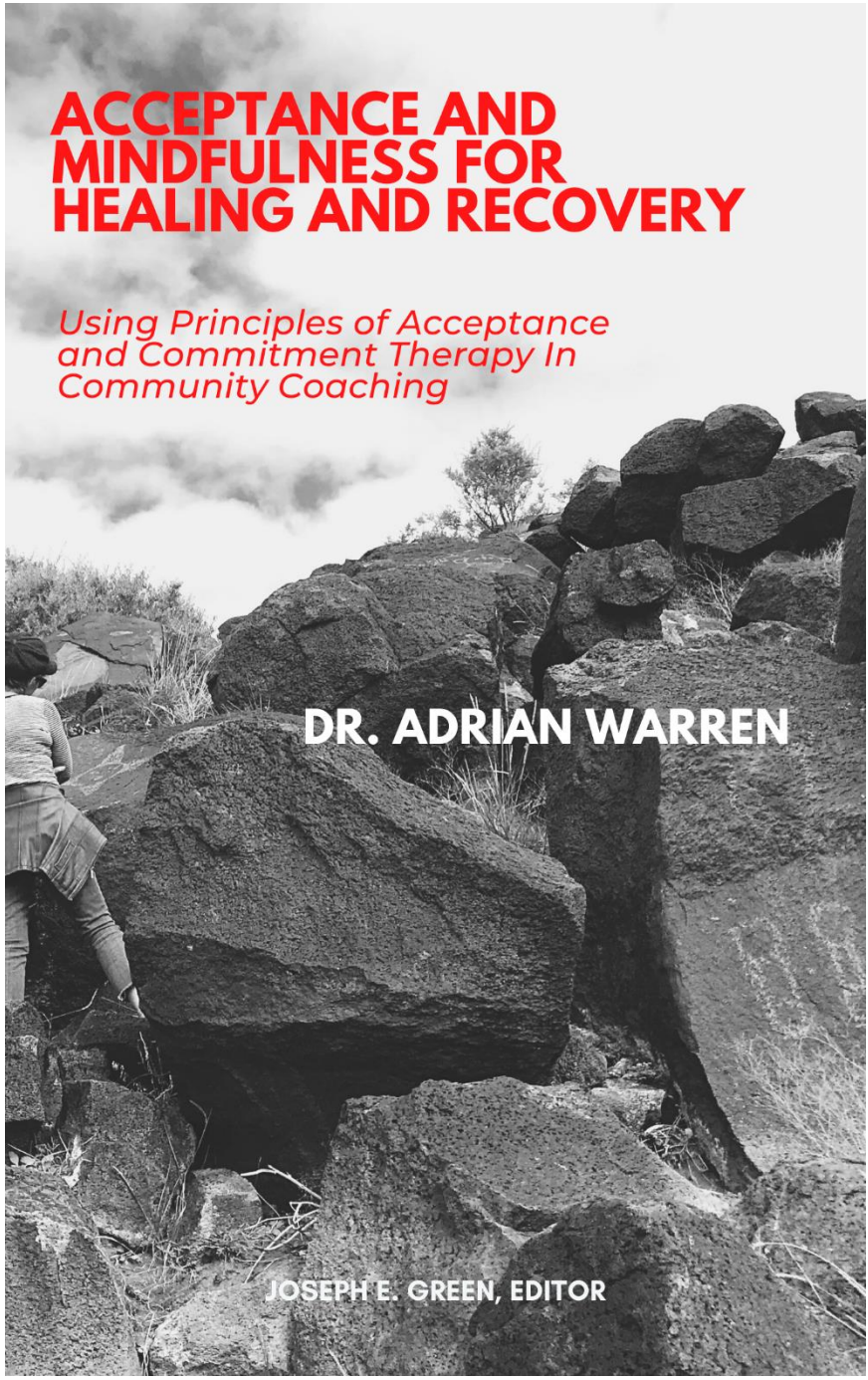
ACCEPTANCE AND MINDFULNESS FOR HEALING AND RECOVERY

Using Principles of Acceptance and Commitment Therapy In Community Coaching



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JOSEPH E. GREEN, EDITOR

ACCEPTANCE AND MINDFULNESS FOR HEALING AND RECOVERY

Listing Principles of Acceptance and Commitment Therapy in Community Coaching

Dr. Adrian Warren, LPC-S

Edited by Joseph E. Green

A NOTE ON USE AND LICENSING

The initial summary portion of this book refers to patients as it pertains specifically to a therapist-patient relationship. However, as this material is not restricted to clinical use, the rest of the book refers to clients and peers for case managers and recovery coaches. The material herein is designed to be helpful and non-exclusionary.

Contents

SUMMARY OF ACT

A Summary of Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is a theoretical framework that evolved out of traditional CBT. In contrast to CBT, though, an ACT therapist won't have their client/peer directly dispute irrational thoughts. Instead, they will accept that these thoughts are simply thoughts and explore where they come from. The ACT therapist is much more of a Kung-Fu master—turning the client/peers' irrationalities against themselves—than a boxer and punching through the irrational thoughts.

The founders of ACT built the model on six thought patterns that cause us problems and six counters to those patters for a total of 12 points to work on. The six negative patterns are: a) Experiential Avoidance; b) Cognitive Fusion; c) Attachment to Conceptualized Self; d) Inaction, Impulsivity, & Avoidant Persistence; e) Lack of Values Clarity; and f) Dominance of the Past. The six counters are: 1) Acceptance; 2) Cognitive Defusion; 3) Self as Context; 4) Committed Actions; 5) Defining Valued Directions; and 6) Being Present. Below, I've included all of the summaries from the curriculum to help provide an overall summary of the theory.

Experiential Avoidance

We live in a society that is partially built on the myth that we have an inherent right to feel good. From the media to the medical field, any time people don't feel good, they must fix it immediately. This isn't to say that we shouldn't address issues that make us feel poorly for extended periods of time; but we have to be careful what we address and how. For example, as we get older, some parts of our body just hurt. Sure, with proper diet and exercise, some of that can be minimized, but there is no way to completely halt or reverse the process of aging. The same is true of mental pain. Losing someone should hurt; getting attacked should produce fear. But we've become so accustomed to feeling good and the notion that we *should* feel good, that we assume all discomfort must be avoided.

So, then we begin to avoid, or mask, anything (including thoughts) that makes us uncomfortable. We develop elaborate rituals from drinking, to sex, to anger, to help us avoid thoughts that are unpleasant. The insidious thing is that this is very successful for a while. However, you can only distract yourself for so long before the thing you're avoiding comes rushing back. It's like the exercise where you tell someone "whatever you do, don't think about a pink elephant." They can successfully avoid and distract those thoughts for a time, but inevitably the elephant appears. This is what happens when we do everything within our power to avoid feeling unpleasant emotions—eventually the elephant re-emerges.

Acceptance

The contrast to experiential avoidance is the principal of acceptance. In traditional CBT, the practice is to change the thinking to change the feelings. In ACT, however, the practice is to accept the feelings as they are; explore the relationships among the thoughts and feelings without judgment; and (as we'll discuss more in defusion) begin to understand that thoughts are just thoughts and not necessarily TRUE. There is an understanding in ACT, as well as other theories, that the more we try to change something, the more it stays the same. A crucial step in healing is to simply accept thoughts and feelings as they are in the present without striving to change them.

Cognitive Fusion

Cognitive Fusion occurs when our words and our reality become one (e.g. *"I am sick", "I am a victim", or "I am broken"*). Particularly when they become one to the extent that we no longer realize we are seeing the world through a lens shaded with our thoughts. We tend to believe that our thoughts must be TRUE rather than assessing them and weighing the possibility that they may (or may not) be TRUE. We begin to see the world as a place for anger, anxiety, or depression. We create a thought cycle such as: *"I'm angry because I have PTSD. I yell because I'm angry. I yell because I have PTSD. I have PTSD because I'm broken. I yell because I'm broken. I am broken."*

Eventually the words we tell ourselves to make sense of what is happening around us begin to define us. Cognitive Fusion is ultimately an attempt at emotional control. There's a false concept that if we can only break the world down into simple interactions and truisms, then we will never be emotionally vulnerable again. Cognitive Fusion could also be called Rigid Thinking Habits.

Cognitive Defusion

There's an old concept in the study of thought and language that the map is not the territory (Korzybski). This is meant to suggest that no matter how detailed and nuanced our language is, words can only represent something—they cannot be the thing itself. This is very true when it comes to the thoughts and language surrounding memory. No matter how vivid the pictures, smells, sound, and words of a memory, they remain in the intangible realm of thought and language.

In Cognitive Fusion, we combine every thought, word, memory, and emotion into a cord that binds our life and functioning. In Cognitive De-fusion, we begin to pick apart those strands in order to free ourselves. Because language is how we define reality, we start defusion by changing language first. We change "am" to "have"; "I am depressed" to "I have depression." This seems like a simple change at first, but then we follow on to "I am angry" to "I feel angry about….because…" and the defusion continues.

Attachment to the Conceptualized Self

From a very early age we begin to answer questions about "who are you?" with "I am….." Over time those answers become more complex, but they are all built around the idea of "I AM." Some of the time those identity statements can be beneficial and give us a context in which to fit. When we remain open to the idea of "I am ..." changing, this is a healthy way of making sense of ourselves and the world around us. However, when this becomes rigid and we think "I am an alcoholic," "I am anxious," "I am a monster," all of the other complexities of am-ness are lost.

When we become attached to the am-ness of a singular label, we take on the identity of someone that is less than a complete human. Eventually all of our behaviors become focused on maintaining the limited identity. For many people trapped in a conceptualized self, the unknown dangers and challenges of embracing a full-fledged identity are overwhelming. It is easier to maintain a one-dimensional identity that is *known* than to explore a multi-dimensional *unknown*.

Self as Context

Many (but certainly not all) people have a tendency to focus on the external events happening around them in a memory. They lose a sense that they were actors in a situation, *even if all they could do was observe*. So it is that people often begin living a sense of helpless isolation because they feel caught up in the whirlpool of others' actions.

Now, we also have the opposite problem with some client/peers who feel that *everything* that happened is their responsibility or fault. This is actually a defensive reaction to the original feeling of helplessness. If they can somehow be responsible for everything that happened in the past, then they can control everything that happens in the future.

The goal in ACT is to find a healthy middle ground where we become accustomed (comfortable may be too much to ask for) to interacting with the past and present around us as observers and *limited actors*.

By exploring the world around us with an understanding that everything we observe is colored by our past experiences, we can begin to recognize that we have always used ourselves as the context for experiencing events. Once we understand that, we can begin taking appropriate responsibility for what we can influence and let the rest go.

Inaction, Impulsivity, & Avoidant Persistence

People tend to be very committed to maintaining the status quo. We are much more comfortable with the devil we know versus the angel we don't know. This is exceptionally true when it comes to maintaining psychopathology. We have short-term goals to limit or avoid pain and we will do virtually anything to attain those goals. We will drink, rage, hide, or even die to avoid a slight increase in or prolonged pain. We each take a different combination of Inaction, Impulsivity, or Avoidance to

reach these immediate goals. However, we can only attain the short-term goal if we sacrifice the longer-term goals of health, relationships, or quality of life.

Committed Action

In this area of Committed Action, ACT functions much like any other behavioral therapy. We are working with client/peers to take specific, concrete, measurable actions that support Defusion, Defining Values, Acceptance, and a Present-centered Life. The key to Committed Action is to help the client/peer identify appropriate homework and to fully understand all the whys that motivate the homework. We also want to make sure that homework is not seen as an end in and of itself; we want each assignment to have a practical purpose that supports the values they are re-creating and so that skills from the assignment are integrated into their lives.

Lack of Values Clarity

We all have values in our lives that inform, guide, or are used to judge our actions and decisions. Most people have those values imposed on them by family, religion, culture, or employment (especially the military, police, fire-fighters, etc.). We tend to accept those values as the RIGHT thing to do, and anything that is contrary to those values must be WRONG. Being bound by values is not inherently a negative thing. Many people find themselves aligning with these external values and living within them comfortably. For others, those values can be restrictive and stifling. We often evaluate what we *do* with our values and sometimes find ourselves lacking. However, we rarely evaluate our values themselves; nor do we make active choices on adopting or rejecting these values.

When we actively choose the values that define our lives, we have more power to assess our actions. Sometimes this assessment is much more painful because we've authentically adopted a value. But we have a greater ability to deal with consequences when we take ownership of process.

Defining Valued Directions

One of the key goals in ACT, to which many of the other processes are geared, is to help client/peers thoughtfully choose the values they want to live by. This can be an exceptionally challenging process for the client/peer and therapist because most of our values are entrenched in cultural and familial contexts. In ACT values are often seen as hindrances if they are externally imposed. When values are *informed by* or even *defined by* religion, cultural, family, etc., they can be healthy if we can explain *why* we have adopted them.

That explanation needs to contain a component of personal desire, though; it is not enough to say, "I want to be faithful to my spouse because the Bible tells me too." Instead, values need to be adopted because of a very personalized desire; "I want be faithful because I've seen how much it

hurts when someone cheats and I don't want to do that to my spouse or children. Ultimately, I don't want to hurt them because I'm a compassionate person and it will end up hurting me too."

When we actively choose the values we desire, we are then taking control of the values that define us and we begin holding ourselves to our own standards rather than seemingly arbitrary external standards.

Dominance of the Past/Future

Most of us have a hard time living in the present. We tend to ruminate over the past or fear (or dream about) the future. Many of our client/peers seem to get caught up doing both. We often form a picture of how things were in the past. For some people, the past seems better than it actually was and for other it seems worse. Because of our tendency to believe that our thoughts must be TRUE, we forget that our memory of the past (or fears of the future) only contain a small piece of an elaborate picture. Because we only experience time in one direction, it can be unsettling to acknowledge that our memories are not necessarily providing a firm foundation.

When people can't trust their memories, they often wonder what else they can't trust, and this can lead to existential questions. Instead, we want to explore the role of memory (and dreams/fears of the future) as one element of information in a much bigger picture.

Being Present

Being present is, perhaps, the simplest concept in modern psychology to explain, but the hardest to attain. As we've discussed, we tend to dwell in the past or in the future and tend to avoid the present. When we're unhappy we pull out all kinds of tricks to stay out of the present. However, it is particularly important to begin practicing a present-focused life in order to reduce the control the past and future exert on us.

Reference

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EXPERIENTIAL AVOIDANCE: Nightmares & Insomnia

ACT Theory

We live in a society that is partially built on the myth that we have an inherent right to feel good. From the media to the medical field, any time people don't feel good, they must fix it immediately. This isn't to say that we shouldn't address issues that make us feel poorly for extended periods of time; but we have to be careful what we address and how. For example, as we get older, some parts of our body just hurt. Sure, with proper diet and exercise, some of that can be minimized, but there is no way to completely halt or reverse the process of aging. The same is true of mental pain. Losing someone should hurt; getting attacked should produce fear. But we've become so accustomed to feeling good and the notion that we *should* feel good, that we assume all discomfort must be avoided.

So then we begin to avoid, or mask, anything (including thoughts) that makes us uncomfortable. We develop elaborate rituals from drinking, to sex, to anger, to help us avoid thoughts that are unpleasant. The insidious thing is that this is very successful for a while. However, you can only distract yourself for so long before the thing you're avoiding comes rushing back. It's like the exercise where you tell someone "whatever you do, don't think about a pink elephant." They can successfully avoid and distract those thoughts for a time, but inevitably the elephant appears. This is what happens when we do everything within our power to avoid feeling unpleasant emotions—eventually the elephant re-emerges.

Psychoeducation Literature

Night mares and insomnia often feed off of each other; we avoid sleep because of the nightmares, then our sleep is worse because we're over-tired. There can be many things other than fear of nightmares that lead to insomnia, though. After even 2-3 days of no sleep/poor sleep, the pursuit of a good night's sleep becomes consuming. When people begin to obsess over sleeping well their sleep actually tends to get worse. Anxiety-filled hours can be spent staring at the clock watching the night slip away. Then people will start doing anything to avoid insomnia and/or nightmares; they will seek extra medication (and side effects), drink, or use excessive amounts off stimulants the next day. Finally, a few nights of poor sleep become a self-reinforcing pattern.

We certainly want to make sure client/peers have a basic understanding of sleep hygiene—avoid caffeine in the afternoon/evening; not watching TV in bed; maintaining a regular sleep schedule; etc. However, sleep hygiene only goes so far—in fact, if concern about sleep leads to a dogmatic adherence to sleep hygiene, it can become counterproductive. Instead, with principles discussed more tomorrow, we want to start building an acceptance of the nightmares/insomnia and allow them to begin dissipating on their own. But, we want to do this in balance with overall health and treatment and not take acceptance to the opposite, unhealthy, extreme either.

Progress Notes

Psychoed: The group discussed the ACT principals of *Experiential Avoidance* and how trying to avoid unpleasant emotions, thoughts, or experiences often leads to an exacerbated experience of discomfort instead. We discussed how struggling with insomnia and nightmares can actually end up making sleep disturbances worse. Tomorrow will discuss the concept of *Acceptance* to let experiential discomfort naturally dissipate.

Psych Process: The group processed their own experiences with nightmares, insomnia, and how avoiding discomfort has led to increases in distress. They shared previous ineffective strategies for dealing with sleep disturbances and are looking forward to learning more about acceptance strategies tomorrow.

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Ong, J. C., Ulmer, C. S., & Manber, R. (2012). Improving sleep with mindfulness and acceptance: A metacognitive model of insomnia. *Behaviour Research and Therapy, 50*. 651-660.

Lesson Plan

Experiential Avoidance (10-15m)

- Discuss the concept that all discomfort should be avoided
- Discuss the ways we avoid behaviorally, cognitively, affectively, spiritually
- Discuss the rebound and reinforcement of discomfort when we try to avoid it

Nightmares & Insomnia (25m)

- Discuss various sleep disturbances and where they may come from and how some are natural reactions to stressors
- Discuss how strategies to avoid nightmares/insomnia often back fire and exacerbate the problem
- Discuss principles of sleep hygiene
- Discuss not becoming obsessive about sleep hygiene.

Socratic Questioning (10m)

- Ask about the RIGHT to a pain free life
- Ask about why avoidance backfires
- Ask about the consequences of avoidance

Therapist's Notes For Leading Process Group

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EXPERIENTIAL AVOIDANCE

Nightmares & Insomnia

Discomfort

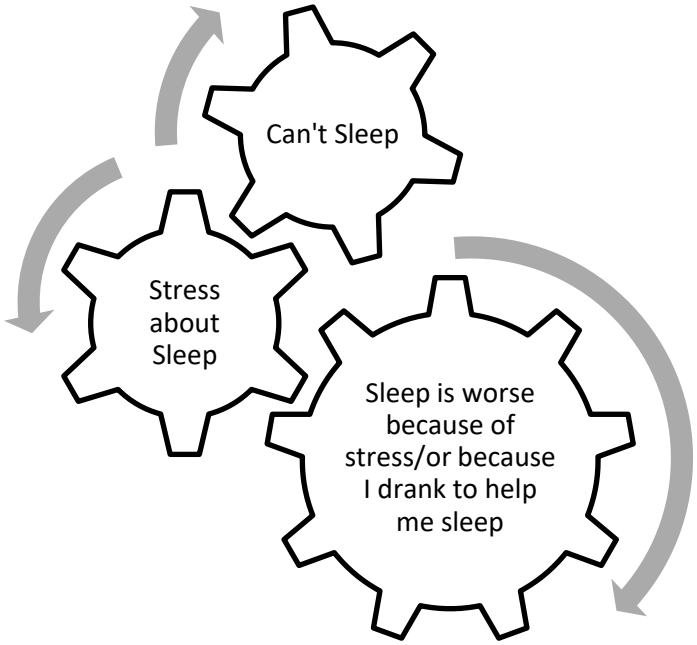
Avoidance

Consequences

Sleep Problems

Strategies that Backfired

Sleep Hygiene



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EXPERIENTIAL AVOIDANCE: Understanding Aggression

ACT Theory

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So then we begin to avoid, or mask, anything (including thoughts) that makes us uncomfortable. We develop elaborate rituals from drinking, to sex, to anger, to help us avoid thoughts that are unpleasant. The insidious thing is that this is very successful for a while. However, you can only distract yourself for so long before the thing you're avoiding comes rushing back. It's like the exercise where you tell someone "whatever you do, don't think about a pink elephant." They can successfully avoid and distract those thoughts for a time, but inevitably the elephant appears. This is what happens when we do everything within our power to avoid feeling unpleasant emotions—eventually the elephant re-emerges.

Psychoeducation Literature

Most people don't think of aggression as avoidance, yet aggression is almost always a reaction to a perceived threat—a threat to life, happiness, family, identity, etc. In ACT, the key to dealing with aggression is to understand what is being avoided by becoming aggressive. When we're faced with a threat we either fight, flee, or freeze. Today we're interested in the situations that cause us to fight. Particularly, we're interested in those situations where we fight back against a non-life-threatening stimulus.

Explore aggression as it's linked to shame, doubt, and a sense of not being in control of a situation. We also want to discuss how aggression is not always physical in nature but can take the form of emotional, verbal, sexual, financial, etc. control and manipulation.

Progress Notes

Psychoed: The group discussed the ACT principals of *Experiential Avoidance* and how trying to avoid unpleasant emotions, thoughts, or experiences often leads to an exacerbated experience of discomfort instead. Went on to discuss how aggression, particularly in a relationship, is often a means of avoiding some type of fear. Tomorrow will discuss *Acceptance* and Healthy Relationships.

Psych Process: The group processed their personal reactions and stories related to avoiding fears and using aggression to avoid dealing with things. There seemed to be mixed levels of insight, but some were starting to gain awareness.

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Lesson Plan

Experiential Avoidance (10-15m)

- Discuss the concept that all discomfort should be avoided
- Discuss the ways we avoid behaviorally, cognitively, affectively, spiritually
- Discuss the rebound and reinforcement of discomfort when we try to avoid it

Understanding Aggression (25m)

- Discuss wanting to understand the root of aggression vs. trying to simply stop a behavior
- Discuss aggression as a means of avoiding various types of fears
- Discuss aggression in response to non-life-threatening stimuli
- Discuss various types of aggression including physical, emotional, financial, etc.

Socratic Questioning (10m)

- Ask about the RIGHT to a fear free life
- Ask about why avoidance backfires
- Ask about the consequences of avoidance

Therapist's Notes For Leading Process Group

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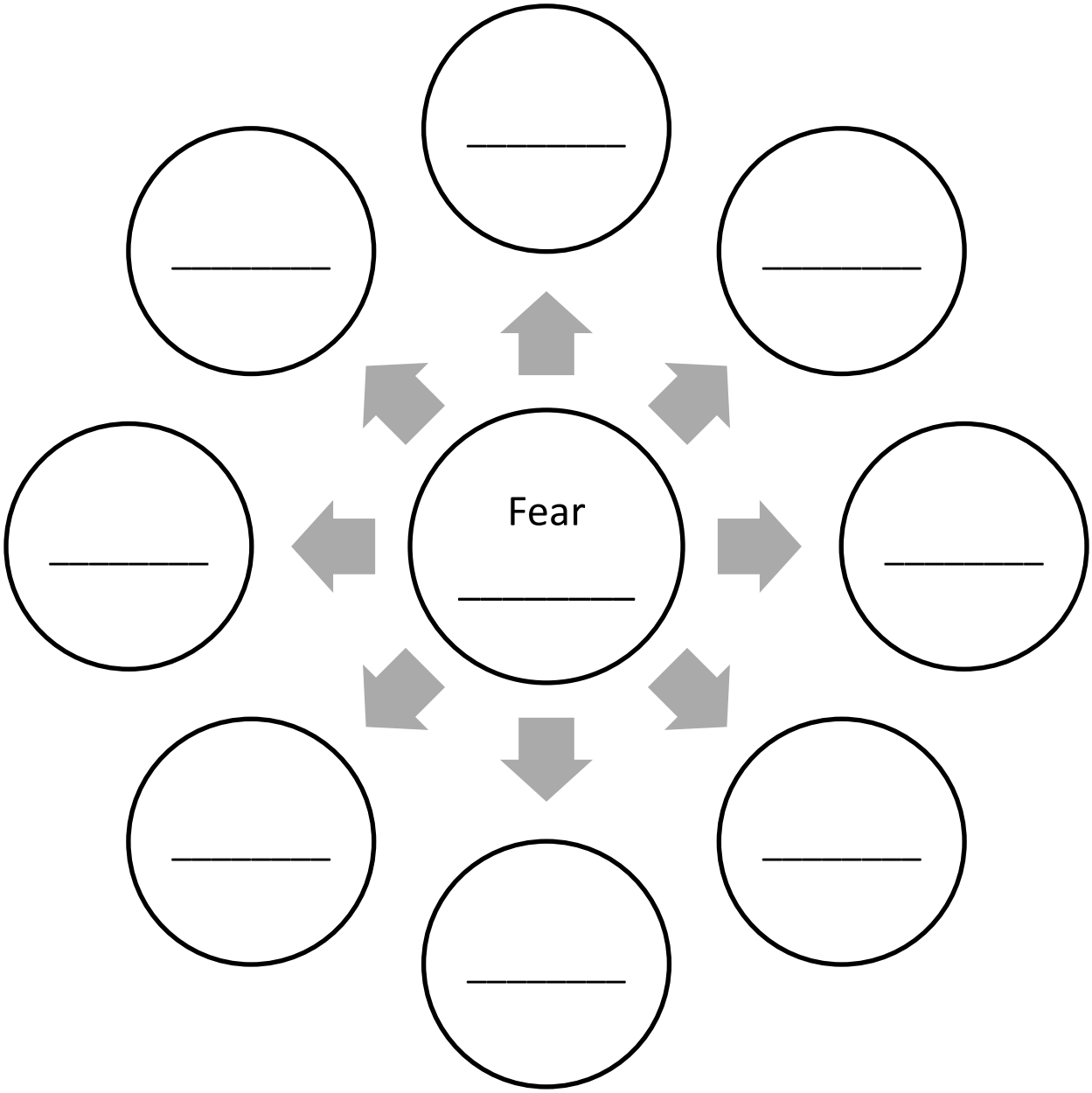
EXPERIENTIAL AVOIDANCE
Understanding Aggression

1. Identify one of your fears write it in the middle. Then, in the outer circles, write down ways you avoid that fear. Be sure to include a few types of aggression you use to avoid as well.



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ACCEPTANCE: Self-Esteem vs Self-Efficacy

ACT Theory

The contrast to experiential avoidance is the principal of acceptance. In traditional CBT the practice is to change the thinking to change the feelings. In ACT, however, the practice is to accept the feelings as they are; explore the relationships among the thoughts and feelings without judgment; and (as we'll discuss more in defusion) begin to understand that thoughts are just thoughts and not necessarily TRUE.

There is an understanding in ACT, as well as other theories, that the more we try to change something, the more it stays the same. A crucial step in healing is to simply accept thoughts and feelings as they are in the present without striving to change them.

Psychoeducation Literature

Most clinicians understand that there is a difference between self-esteem and self-efficacy. Most of our client/peers have only been exposed to self-esteem though. Self-esteem is an internal estimate of our worth as a human being; self-efficacy is an internal evaluation of our skill at a given tasks. Most of our client/peers are here trying to repair their self-esteem—that can be a lofty goal but is often unrealistic for people. The very nature of our work tends to dig up problems and their self-esteem often gets worse.

On the other hand, exploring self-efficacy can be extremely rewarding and productive. As we explore the concept of acceptance with client/peers, we want to help them accept their current level of self-esteem (no matter how bad), not try to change it. We also want to help them make objective determinations of their self-efficacies for the tasks they are dealing with in life—everything from job, to family, to treatment.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Acceptance* and the need to accept where they are in life and that life has changed. We discussed that this doesn't mean ambivalence or giving up, it just means taking the negative self-judgment out of the equation. We also discussed the differences between self-esteem and self-efficacy and how understanding self-efficacy can build self-esteem. Tomorrow will discuss *Cognitive Fusion* and how that is linked to avoidance.

Psych Process: The group processed their personal reactions to the concepts of Acceptance, Self-Esteem, and Self-Efficacy. They shared individual perceptions of self-esteem and explored more objective analysis of self-efficacy.

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Lesson Plan

Acceptance (20m)

- Discuss accepting an objective analysis about how things are in the present
- Discuss trying to change and ending up the same
- Discuss that acceptance is not apathy and never getting better

Self-Esteem vs Self-Efficacy (20m)

- Define Self-Esteem
- Define Self-Efficacy
- Discuss using Self-Efficacy to build Self-Esteem

Socratic Questioning (10m)

- Ask about what Acceptance means
- Ask about Acceptance vs Apathy
- Ask about Self-esteem vs Self-Efficacy

Therapist's Notes For Leading Process Group

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ACCEPTANCE

Self-Esteem vs Self-Efficacy

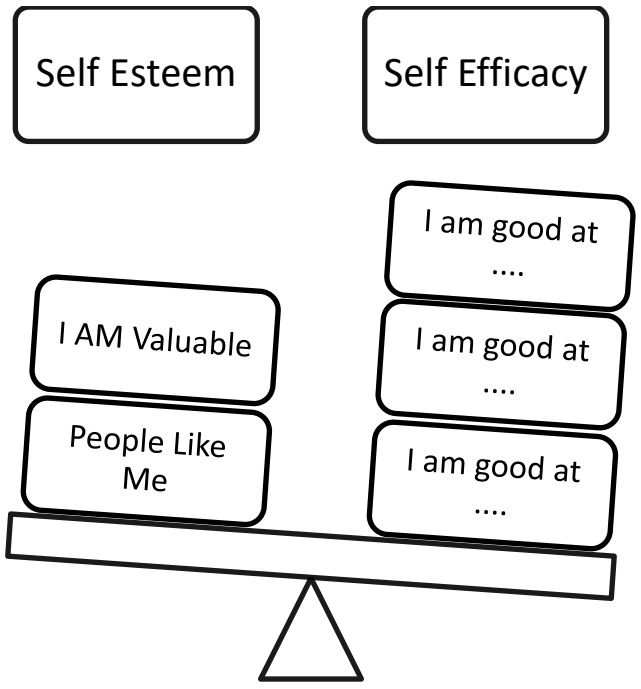
What is Acceptance

Trying to Change Makes us Stay the Same

Acceptance not Apathy

Self-Esteem

Self-Efficacy



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ACCEPTANCE: Healthy Relationships

ACT Theory

The contrast to experiential avoidance is the principal of acceptance. In traditional CBT the practice is to change the thinking to change the feelings. In ACT, however, the practice is to accept the feelings as they are; explore the relationships among the thoughts and feelings without judgment; and (as we'll discuss more in defusion) begin to understand that thoughts are just thoughts and not necessarily TRUE. There is an understanding in ACT, as well as other theories, that the more we try to change something, the more it stays the same. A crucial step in healing is to simply accept thoughts and feelings as they are in the present without striving to change them.

Psychoeducation Literature

Today's group is in direct response to the work from yesterday. Be sure you review yesterday's curriculum before going into group. Briefly discuss *Acceptance* as a principle in response to *Experiential Avoidance*. Then, have client/peers reflect on their fear and avoidances from yesterday. Finally, have the client/peers work on filling out the worksheet and looking at ways, especially in the context of relationships, work on accepting those fears. Have them break up into groups of 2-3 to work and then report back after they are done.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Acceptance* and the need to accept where they are in life and that life has changed. We discussed that this doesn't mean ambivalence or giving up, it just means taking the negative self-judgment out of the equation. We also looked at how accepting and facing our fears, especially in relationships, can be beneficial.

Psych Process:

The group processed their cognitive and emotional reactions to the idea of accepting their fears, especially in the context of relationships. They talked about how it can be hard to face certain things with those you are close to.

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Lesson Plan

(10m)

- Discuss accepting an objective analysis about how things are in the present
- Discuss trying to change and ending up the same
- Discuss that acceptance is not apathy and never getting better

(30m)

- Have client/peers review their fears, avoidances, and aggressions from yesterday
- Have them break up into groups of 2-3 to work on the handout.
- Make sure they identify acceptance areas in relationship fears
- Have them report back on their work

Socratic Questioning (10m)

- Ask about acceptance vs. avoidance
- Ask about why we want to face our fears, especially in relationships

Therapist's Notes For Leading Process Group

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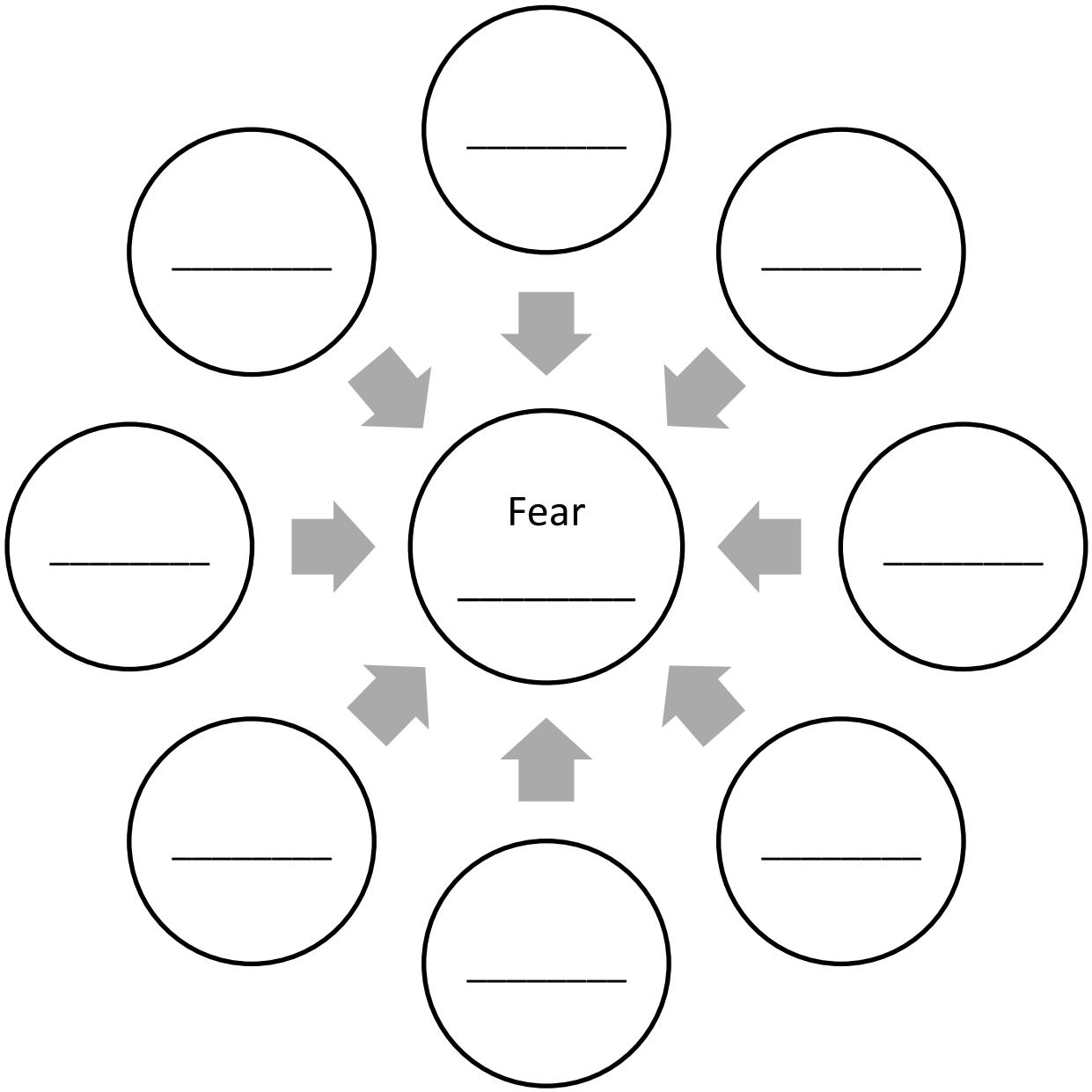
ACCEPTANCE
Healthy Relationships

1. Yesterday we looked at how we avoid fears including using aggression to avoid. Today we want to turn things around and look at ways of accepting fears. Write down the fear you used yesterday, then in the outer circles write down ways of accepting and facing that fear. Make sure you include a few relationship ideas of dealing with this fear in the context of relationships.



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COGNITIVE FUSION: Understanding Anger

ACT Theory

Cognitive Fusion occurs when our words and our reality become one (e.g. *"I am sick", "I am a victim", or "I am broken"*). Particularly when they become one to the extent that we no longer realize we are seeing the world through a lens shaded with our thoughts. We tend to believe that our thoughts must be TRUE rather than assessing them and weighing the possibility that they may (or may not) be TRUE. We begin to see the world as a place for anger, anxiety, or depression. We create a thought cycle such as: *"I'm angry because I have PTSD. I yell because I'm angry. I yell because I have PTSD. I have PTSD because I'm broken. I yell because I'm broken. I am broken."* Eventually the words we tell ourselves to make sense of what is happening around us begin to define us. Cognitive Fusion is ultimately an attempt at emotional control. There's a false concept that if we can only break the world down into simple interactions and truisms, then we will never be emotionally vulnerable again. Cognitive Fusion could also be called Rigid Thinking Habits.

Psychoeducation Literature

Anger typically occurs in an interpersonal context and stems from at least four related sources (a) thoughts, typically of judging or blaming, suggesting that other people (or the self) have violated or failed to meet personal needs, or firmly held ideas about right and wrong, rules about conduct, and so on; (b) strong belief in these thoughts, which are held as literally true, such that judgment and blame are treated as properties or qualities of self and other behavior (e.g., "that bastard screwed me over" is not simply a thought, but "bastard" and "screwed over" are seen as qualities of the person and their actions and intentions); (c) strongly believed-in thoughts catalyze unpleasant emotional responses, from feelings of hurt, fear, anxiety, tension, shame and guilt, and ultimately anger and rage; and (d) strong urges or impulses to resolve the welling discomfort are translated into actions, namely efforts to right the presumed injustice by struggling to control other people, particularly their behavior, in order to have one's needs met.

With problem anger, the terminal point in this sequence is often anger behavior, and this behavior tends to create more problems than it solves. Anger behavior is also largely ineffective in the long-term as a means to reduce or eliminate painful anger-feelings and associated feelings of hurt, shame, and guilt. (Eifert & Forsyth, 2011; p. 242)

Progress Notes

Psychoed:

The group discussed the ACT concept of Cognitive Fusion and how thoughts can shape our reality. They learned how repetitive thoughts about injustice, unfairness, how other people don't understand, can lead to anger and resentment. Tomorrow we will discuss Cognitive Defusion and how to begin breaking up these negative thought habits.

Psych Process:

The group processed their thoughts and experiences about the topics of Cognitive Fusion and Understanding Anger from the psychoed group. They discussed ways that they have formed rigid thoughts about family, friends, and employers, and how those thoughts have led to anger in their lives.

Eifert, G. H. & Forsyth, J. P., (2011). The application of Acceptance and Commitment Therapy to problem anger. *Cognitive and Behavioral Practice, 18*, 241-250.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Cognitive Fusion (10-15m)

- Thoughts and language shape our reality.
- Our thoughts must be TRUE.
- Because our thoughts are TRUE, the world really must be as bad as we see it.
- Instead, thoughts are only thoughts

Problem Anger (25m)

- Judging or blaming thoughts that someone (or self) have violated rules of conduct or failed to meet my needs.
- Strong belief that thoughts that arise during anger are TRUE (e.g. "He must have done it on purpose)
- Strong thoughts during anger create other unpleasant emotions (fear, shame, guilt, anxiety, etc.) which are then attributed to the target of the anger and reinforce the cycle
- Strong impulses to take action to control the behavior of the perceived source of the anger.

Socratic Questioning (10m)

- Ask About Rigid Thinking Habits
- Ask About Lenses
- Ask About Thoughts and TRUTH

Therapist's Notes For Leading Process Group

Eifert, G. H. & Forsyth, J. P., (2011). The application of Acceptance and Commitment Therapy to problem anger. *Cognitive and Behavioral Practice, 18*, 241-250.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Cognitive Fusion

Understanding Anger

Thoughts and Language Make Reality

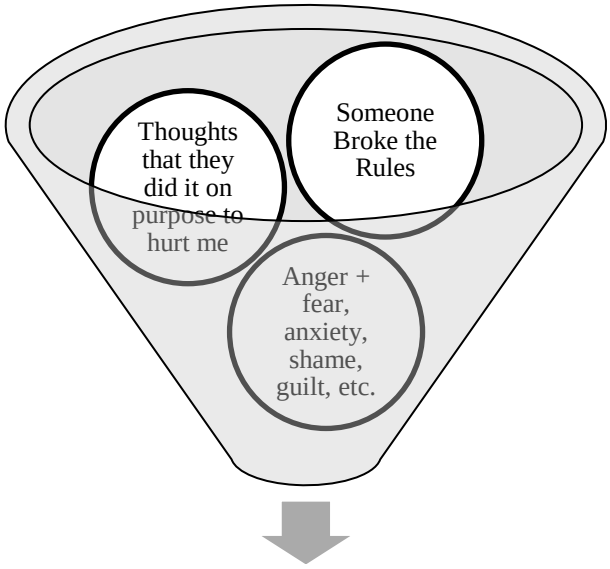
Thoughts & TRUTH

Who Broke The Rules

They Did it on Purpose

Anger+

I Must Make Them…



Impulse to Control the Other Person's Behavior by Force (Physical, Verbal, Emotional)

Eifert, G. H. & Forsyth, J. P., (2011). The application of Acceptance and Commitment Therapy to problem anger. *Cognitive and Behavioral Practice, 18*, 241-250.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

COGNITIVE FUSION: Understanding Anxiety

ACT Theory

Cognitive Fusion occurs when our words and our reality become one (e.g. *"I am sick", "I am a victim", or "I am broken"*). Particularly when they become one to the extent that we no longer realize we are seeing the world through a lens shaded with our thoughts. We tend to believe that our thoughts must be TRUE rather than assessing them and weighing the possibility that they may (or may not) be TRUE. We begin to see the world as a place for anger, anxiety, or depression. We create a thought cycle such as: *"I'm angry because I have PTSD. I yell because I'm angry. I yell because I have PTSD. I have PTSD because I'm broken. I yell because I'm broken. I am broken."* Eventually the words we tell ourselves to make sense of what is happening around us begin to define us. Cognitive Fusion is ultimately an attempt at emotional control. There's a false concept that if we can only break the world down into simple interactions and truisms, then we will never be emotionally vulnerable again. Cognitive Fusion could also be called Rigid Thinking Habits.

Psychoeducation Literature

After you spend the time on the concept of Cognitive Fusion, then begin to discuss how there's a concept in neuropsychology that "neurons that fire together, wire together." This means that, over time, different processes in our brain become linked together and eventually one neurological action won't happen without the other happening as well. There is a picture in the handout which illustrates that as various neurons are acting at the same time, they become more and more connected. In this way, thoughts, emotions, and physical reactions can all become linked together. Have the client/peers spend about 5 minutes identifying thoughts, feelings, and physical reactions they have fused, then have them talk about what they've discovered.

Progress Notes

Psychoed:

The group discussed the ACT concept of Cognitive Fusion and how thoughts can shape our reality. Tomorrow we will discuss Cognitive Defusion and how to begin breaking up these negative thought habits. We went on to discuss the concept of neurons wiring together and fusing thought, feeling, and physical reaction.

Psych Process:

The group processed their thoughts and experiences about the topics of Cognitive Fusion and Understanding Anxiety from the psychoed group. They discussed ways that they have formed rigid thoughts about family, friends, command, and employers, and how those thoughts have led to anxiety in their lives.

Codd, R. T., Twohig, M. P., Crosby, J. M., & Enno, A. (2011). Treatment of three anxiety disorder cases with acceptance and commitment therapy in a private practice. *Journal of Cognitive Psychotherapy: An International Quarterly, 25*(3), 203-217.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Cognitive Fusion (10-15m)

- Thoughts and language shape our reality.
- Our thoughts must be TRUE.
- Because our thoughts are TRUE, the world really must be as bad as we see it.
- Instead, thoughts are only thoughts

(25m)

- Discuss "what fires together, wires together"
- Discuss how thoughts, feelings, and physical reactions all become fused in the brain
- Let client/peers work on their handouts
- Discuss the handouts

Socratic Questioning (10m)

- Ask About Rigid Thinking Habits
- Ask About Lenses
- Ask About Thoughts and TRUTH

Therapist's Notes For Leading Process Group

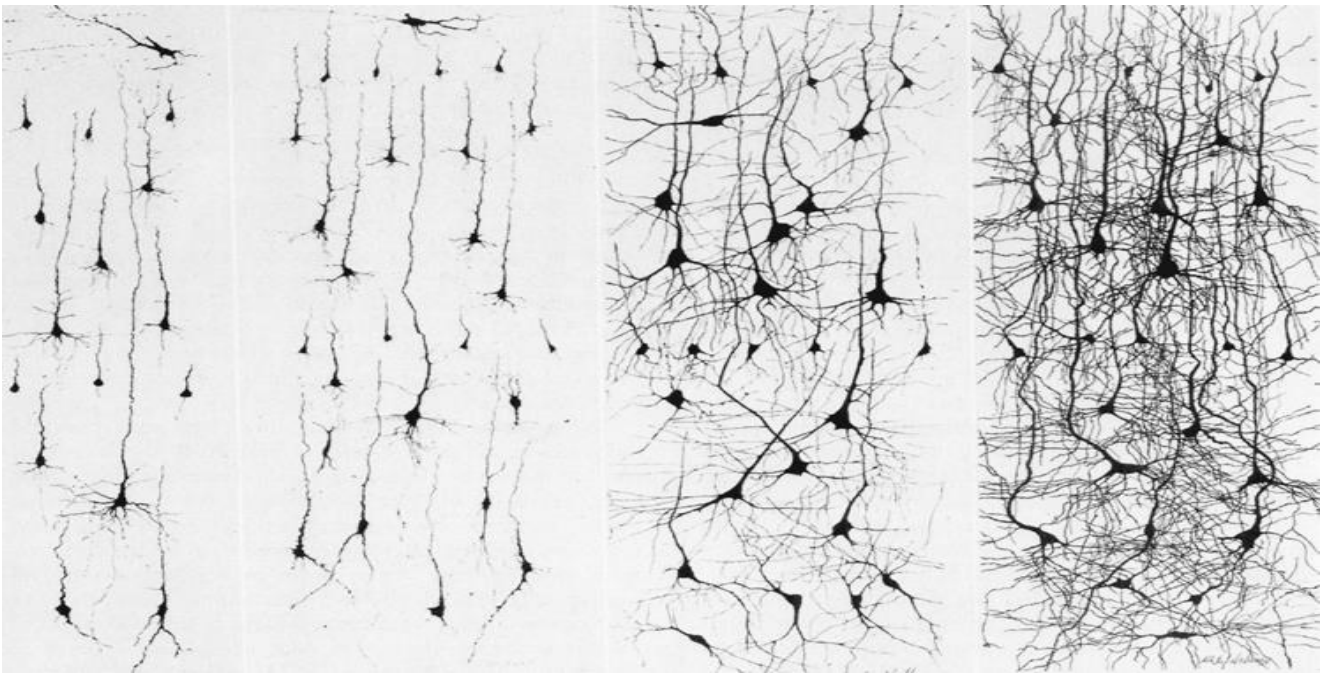
Codd, R. T., Twohig, M. P., Crosby, J. M., & Enno, A. (2011). Treatment of three anxiety disorder cases with acceptance and commitment therapy in a private practice. *Journal of Cognitive Psychotherapy: An International Quarterly, 25*(3), 203-217.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Cognitive Fusion

Understanding Anxiety

There's a concept in neuropsychology that "neurons that fire together, wire together." This means that, over time, different processes in our brain become linked together and eventually one neurological action won't happen without the other happening as well. The picture below illustrates that as various neurons are acting at the same time, they become more and more connected. In this way, thoughts, emotions, and physical reactions can all become linked together.

In the boxes below the picture identify some of the thoughts, feelings, and physical reactions that you have that seem to be "firing together".



Thoughts	Feelings	Physical Reactions

Codd, R. T., Twohig, M. P., Crosby, J. M., & Enno, A. (2011). Treatment of three anxiety disorder cases with acceptance and commitment therapy in a private practice. *Journal of Cognitive Psychotherapy: An International Quarterly, 25*(3), 203-217.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

COGNITIVE DEFUSION: Spiraling Up & Spiraling Down

ACT Theory

There's an old concept in the study of thought and language that the map is not the territory (Korzybski). This is meant to suggest that no matter how detailed and nuanced our language is, words can only represent something—they cannot be the thing itself. This is absolutely true when it comes to the thoughts and language surrounding memory. No matter how vivid the pictures, smells, sound, and words of a memory, they remain in the intangible realm of thought and language.

In Cognitive Fusion, we combine every thought, word, memory, and emotion into a cord that binds our life and functioning. In Cognitive De-fusion, we begin to pick apart those strands in order to free ourselves. Because language is how we define reality, we start defusion by changing language first. We change "am" to "have"; "I am depressed" to "I have depression." This seems like a simple change at first, but then we follow on to "I am angry" to "I feel angry about…because…" and the defusion continues.

Psychoeducation Literature

We've all observed how a series of bad choices and experiences can quickly lead to a spiral of negativity, shame, anger, and depression. We may have also observed how series of good choices and experiences can lead to feelings of happiness, contentment, and satisfaction. Most people have enough insight to have identified some of their major negative triggers and work in some fashion to avoid them. As a profession, therapists are generally pretty good at working to help client/peers identify those negative spirals and begin to break those habits.

However, we don't usually do such a good job on identifying the keys to upward spiraling. We may help client/peers identify some wellness activities and encouraging them to engage in them, but we don't usually put together a specific plan to strategically spiral up. What we want to do here is to help client/peers identify their negative spirals; but rather than simply avoid those triggers, we want to identify upwardly spiraling triggers and form a plan to seek those out.

Progress Notes

Psychoed:

The group discussed the ACT concept of *Cognitive Defusion* and how we want to begin pulling apart thoughts in order to stop being controlled by negative thinking patterns. We also discussed how thoughts and behaviors can lead to a negative spiral of consequences and how they could also lead to positive consequences. We worked on identifying ways to foster the positive consequences. Tomorrow will discuss *Attachment to Conceptualized Self*.

Psych Process:

The group shared their own thoughts and experiences about *Cognitive Defusion* and when their thoughts and actions have led to a series of negative consequences. They also worked to identify a plan to build positive chains of events.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Cognitive Defusion (10-15m)

- Words/thoughts represent reality, they are not reality themselves
- We work to pull apart "fused" thoughts and words and see how perceptions change

Spiral Up/ Spiral Down (25m)

- Discuss series of bad choices and triggers and how they lead to downward spirals
- Discuss how positive choices and events can lead upward spirals
- Have client/peers specifically identify and write down positive spirals they can begin during treatment
- Have client/peers identify and write down positive spirals for after treatment

Socratic Questioning (10m)

- Ask about how words/thoughts represent reality
- Ask about how we pull apart "fused" thoughts
- Ask about positive spirals and how they form

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

COGNITIVE DEFUSION

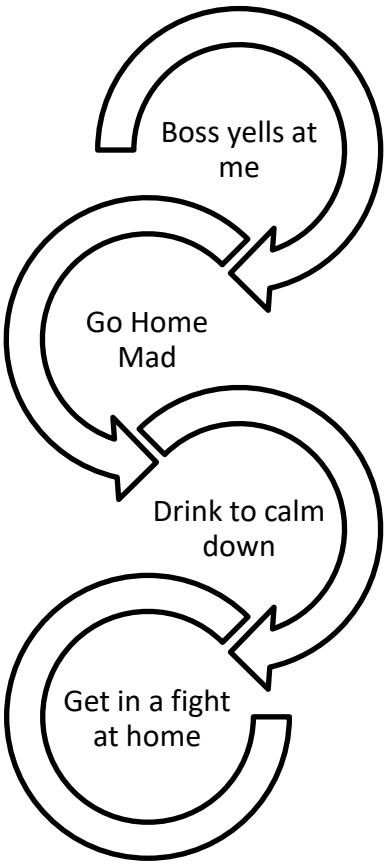
Spiraling Up & Spiraling Down

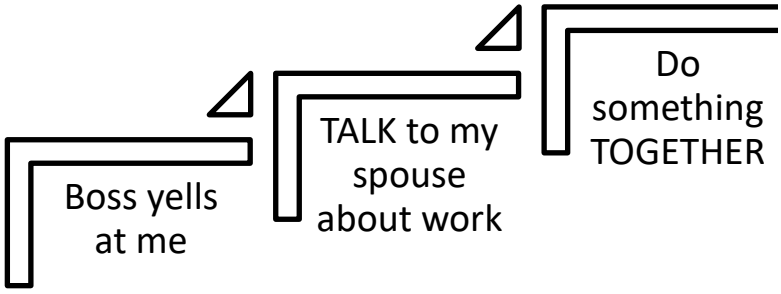
Thoughts are not Reality _____

Ways to De-Fuse Thoughts _____

Negative Spirals _____

Positive Spirals _____





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COGNITIVE DEFUSION: Challenging Negative Thoughts

ACT Theory

There's an old concept in the study of thought and language that the map is not the territory (Korzybski). This is meant to suggest that no matter how detailed and nuanced our language is, words can only represent something—they cannot be the thing itself. This is very true when it comes to the thoughts and language surrounding memory. No matter how vivid the pictures, smells, sound, and words of a memory, they remain in the intangible realm of thought and language.

In Cognitive Fusion, we combine every thought, word, memory, and emotion into a cord that binds our life and functioning. In Cognitive De-fusion, we begin to pick apart those strands in order to free ourselves. Because language is how we define reality, we start defusion by changing language first. We change "am" to "have"; "I am depressed" to "I have depression." This seems like a simple change at first, but then we follow on to "I am angry" to "I feel angry about….because…" and the defusion continues.

Psychoeducation Literature

Yesterday we looked at how neurons that fire together, wire together. Today we want to explore the counterpart to that idea: "neurons out of sync, fail to link." It's not quite as catchy, but it helps in remembering it. When we start pulling out one of the sets of neurons in the chain, then the whole linkage starts to fall apart. The cool thing is that we can start with any one of the parts; we can pull out the thinking part if that's easiest, or the feeling part, or the physical part. Different people respond to different types of therapies or techniques.

Have the client/peers work together to identify where they have overly tangled neuropathways and then have them start identifying which avenue (cognitive, affective, or physical) works best for them to start unlinking those chains.

Progress Notes

Psychoed:

The group discussed the ACT concept of *Cognitive Defusion* and how we want to begin pulling apart thoughts in order to stop being controlled by negative thinking patterns. They worked on identifying specific areas that they could begin untangling fused thinking.

Psych Process:

The group shared their own thoughts and experiences about *Cognitive Defusion* and when their thoughts and actions have led to a series of negative consequences. They discussed their insights on finding the best method of defusion for them.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Ojserkis, R., McKay, D., Badour, C. L., Feldner, M. T., Arocho, J., & Dutton, C. (2014). Alleviation of moral disgust, shame, and guilt in posttraumatic stress reactions: An evaluation of comprehensive distancing. *Behavior Modification, 38*(6), 801-836.

Lesson Plan

Cognitive Defusion (10-15m)

- Words/thoughts represent reality, they are not reality themselves
- We work to pull apart "fused" thoughts and words and see how perceptions change

(25m)

- Discuss the concept that when we start pulling out one strand of fused thinking that the entire chain starts to fall apart
- Have client/peers review the cognitive fusion work they did on identifying connections of thought, feeling, and physical reaction
- Have client/peers work as a group or small groups to begin thinking of ways/types of therapy that can help them pull out one of the areas

Socratic Questioning (10m)

- Ask about how words/thoughts represent reality
- Ask about how we pull apart "fused" thoughts

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

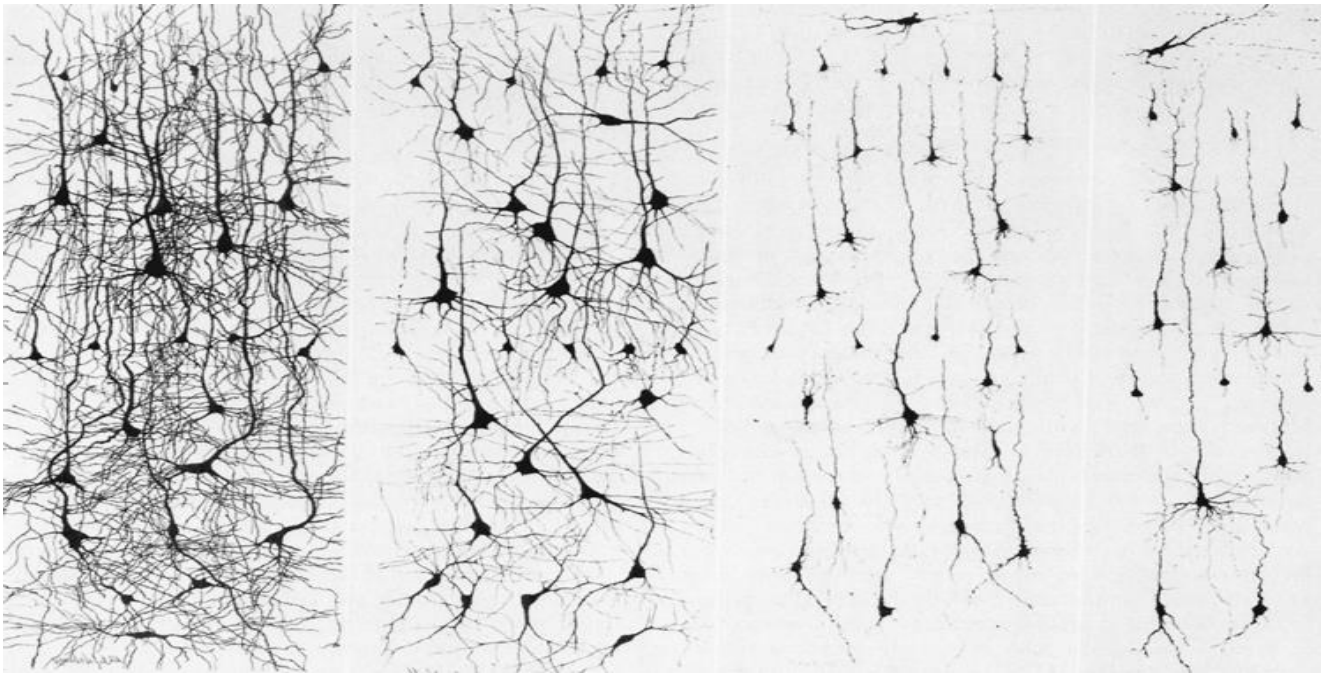
Ojserkis, R., McKay, D., Badour, C. L., Feldner, M. T., Arocho, J., & Dutton, C. (2014). Alleviation of moral disgust, shame, and guilt in posttraumatic stress reactions: An evaluation of comprehensive distancing. *Behavior Modification, 38*(6), 801-836.

COGNITIVE DEFUSION

Challenging Negative Thoughts

Yesterday we looked at how neurons that fire together, wire together. Today we want to explore the counterpart to that idea: "neurons out of sync, fail to link." It's not quite as catchy, but it helps in remembering it. When we start pulling out one of the sets of neurons in the chain, then the whole linkage starts to fall apart. The cool thing is that we can start with any one of the parts; we can pull out the thinking part if that's easiest, or the feeling part, or the physical part. Different people respond to different types of therapies or techniques. The biggest part is figuring out which one is right for you.

In the boxes below, write down a couple areas that you have that are wired together and then work together to think of ways to cut out pieces of the chain.



	Thoughts	Feelings	Physical Reactions
Wired			
Unwire			
Wired			
Unwire			

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Ojserkis, R., McKay, D., Badour, C. L., Feldner, M. T., Arocho, J., & Dutton, C. (2014). Alleviation of moral disgust, shame, and guilt in posttraumatic stress reactions: An evaluation of comprehensive distancing. *Behavior Modification, 38*(6), 801-836.

ATTACHMENT TO CONCEPTUALIZED SELF:
Grieving Losses from Traumatic Brain Injury

ACT Theory

From a very early age we begin to answer questions about "who are you" with "I am….." Over time those answers become more complex, but they are all built around the idea of "I AM." Some of the time those identity statements can be beneficial and give us a context in which to fit. When we remain open to the idea of "I am ..." changing, this is a healthy way of making sense of ourselves and the world around us. However, when this becomes rigid and we think "I am an alcoholic," "I am anxious," "I am a monster," all of the other complexities of am-ness are lost.

When we become attached to the am-ness of a singular label, we take on the identity of someone that is less than a complete human. Eventually all our behaviors become focused on maintaining the limited identity. For many people trapped in a conceptualized self, the unknown dangers, and challenges of embracing a full-fledged identity are overwhelming. It is easier to maintain a one-dimensional identity that is *known* than to explore a multi-dimensional *unknown*.

Psychoeducation Literature

When it comes to a memory of self and traumatic brain injury, the sense of disconnection can be even more problematic. There is a definite and real loss that goes along with TBI because the brain has literally changed. Some of the changes are subtle and some dramatic, but all of them represent a change from the historic sense of self. As people with TBI are trying to rebuild their lives, they must take time to grieve the old self. With advances in medicine and understanding brain plasticity, people can regain much of who they used to be; but there will be differences that must be accommodated. Many therapists and client/peers try to move straight into accommodation and moving on without spending sufficient time grieving the old self.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Attachment to the Conceptualized Self* which means holding on to old patterns of thoughts and behaviors and living in the past. We discussed how identifying as sick or broken traps you in that identity. We also discussed how to grieve the old self after a TBI as part of the healing process. Tomorrow will discuss the ACT concept of *Self as Context* to counter the attachment to the past.

Psych Process:

The group processed their personal reactions to Attachment to the Conceptualized Self and to TBI. Discussed ways they have lived in past and taken on negative identities. We discussed the importance of not trying to move on from the past without adequately grieving it.

Kangas, M. & McDonald, S. (2011). Is it time to act? The potential of acceptance and commitment therapy for psychological problems following acquired brain injury. *Neuropsychological Rehabilitation, 21*(2), 250-276.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Attachment to Conceptualized Self (20m)

- Discuss what "I Am..." means
- Discuss ways we live in our past selves
- Discuss how labels become or sole identities

Grieving TBI (20m)

- Discuss how parts of the old self are sometimes lost with TBI
- Discuss how brain plasticity works and can work around many of the losses, but not all
- Discuss the importance of grieving the old parts not just trying to move on

Socratic Questioning (10m)

- Ask about multidimensional selves
- Ask about what labels do
- Ask about why we need to grieve old selves

Therapist's Notes For Leading Process Group

Kangas, M. & McDonald, S. (2011). Is it time to act? The potential of acceptance and commitment therapy for psychological problems following acquired brain injury. *Neuropsychological Rehabilitation, 21*(2), 250-276.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

I AM …

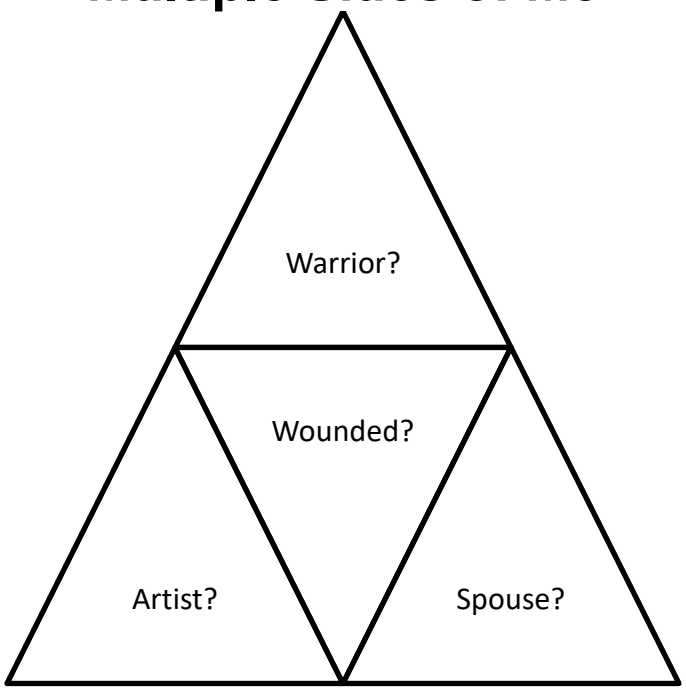
What Labels Do

Many Parts of Me

What is Lost with TBI

The Importance of Grieving

Multiple Sides of Me



Kangas, M. & McDonald, S. (2011). Is it time to act? The potential of acceptance and commitment therapy for psychological problems following acquired brain injury. *Neuropsychological Rehabilitation, 21*(2), 250-276.
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ATTACHMENT TO CONCEPTUALIZED SELF: Moral Injury

ACT Theory

From a very early age we begin to answer questions about "who are you" with "I am….." Over time those answers become more complex, but they are all built around the idea of "I AM." Some of the time those identity statements can be beneficial and give us a context in which to fit. When we remain open to the idea of "I am ..." changing, this is a healthy way of making sense of ourselves and the world around us. However, when this becomes rigid and we think "I am an alcoholic," "I am anxious," "I am a monster," all of the other complexities of am-ness are lost.

When we become attached to the am-ness of a singular label, we take on the identity of someone that is less than a complete human. Eventually all of our behaviors become focused on maintaining the limited identity. For many people trapped in a conceptualized self, the unknown dangers and challenges of embracing a full-fledged identity are overwhelming. It is easier to maintain a one-dimensional identity that is *known* than to explore a multi-dimensional *unknown*.

Psychoeducation Literature

Moral Injury (MI) is the concept that when a person is forced by circumstance to commit an action that is against his or her moral standard, then an emotional and cognitive injury often occurs. There is a clear relationship to PTSD and the two are often co-morbid, but MI is a distinct phenomenon and not merely a sub-category of PTSD. They key trait is that there is a moral, spiritual, and/or existential component to MI.

For most people with MI, guilt and shame over the event become highly interwoven. The guilt is often appropriate because they did, in fact, do something wrong. But the shame becomes overwhelming. Remember that guilt is the emotional sense that goes along with the thought "I *did* something wrong;" while shame is the emotion that goes with the thought "I *am* wrong as a human being." Guilt can be a very pro-social emotion and drive people to making improvements in their world. Shame, however, is toxic and rarely has any positive effects.

When people are bystanders to horrific acts, they often still have guilt and shame, but they also develop feelings of anger, disgust, and contempt for others. While there is some appropriateness to these feelings being directed at the person responsible, these emotions are often generalized to the entire population of the person who committed the act. This can cause significant problems when someone attributes blame to an entire race, or other group of people. Interestingly, blame is considered to be a means of decreasing shame which could indicate that people are actually mostly ashamed of standing by and allowing something to happen.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Attachment to the Conceptualized Self* which means holding on to old patterns of thoughts and behaviors and living in the past. We discussed how identifying as sick or broken traps you in that identity. Discussed the concept of moral injury and how shame can be a crippling emotion.

Psych Process:

The group processed their reactions to self-identity and shame from moral injury. They worked on identifying areas where guilt was appropriate, but shame was more prevalent instead.

Farnsworth, J. K., Drescher, K. D., Nieuwsma, J. A., & Walser, R. B. (2014, 18(4)). The role of moral emotions in military trauma: Implications for the study and treatment of moral injury. *Review of General Psychology*, 249-262.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Attachment to Conceptualized Self (10-15m)

- Discuss what "I Am..." means
- Discuss ways we live in our past selves
- Discuss how labels become or sole identities

Moral Injury (25m)

- Discuss what Moral Injury is and how it is related, but different, to PTSD
- Discuss the difference between Shame and Guilt
- Briefly discuss Anger, Disgust, & Contempt
- Have client/peers start identifying where they feel Shame and where they feel Guilt

Socratic Questioning (10m)

- Ask about multidimensional selves
- Ask about what labels do
- Ask about why we need to grieve old selves

Therapist's Notes For Leading Process Group

Farnsworth, J. K., Drescher, K. D., Nieuwsma, J. A., & Walser, R. B. (2014, 18(4)). The role of moral emotions in military trauma: Implications for the study and treatment of moral injury. *Review of General Psychology*, 249-262.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

ATTACHMENT TO CONCEPTUALIZED SELF

Moral Injury

What is Moral Injury _____

Guilt _____

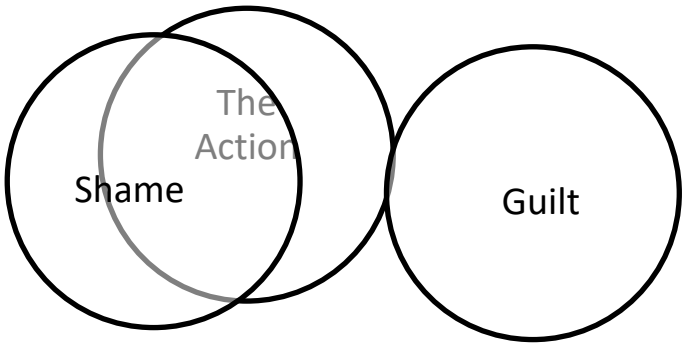
Shame _____

Anger _____

Disgust _____

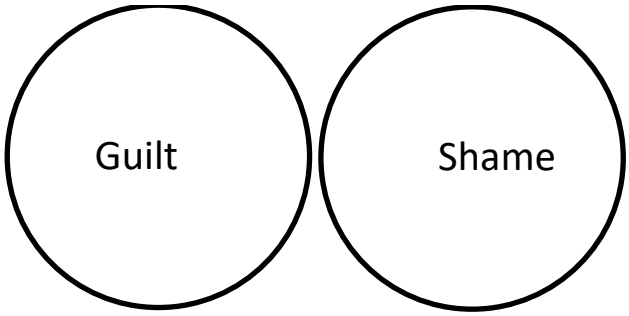
Contempt _____

In every action where someone else is hurt, most people have a reaction of guilt or shame. If you remember back to Cognitive Fusion, when guilt and shame happen at the same time it can be hard to tell the two apart. When someone is suffering from a moral injury, they become overly attached to the shame reaction especially.

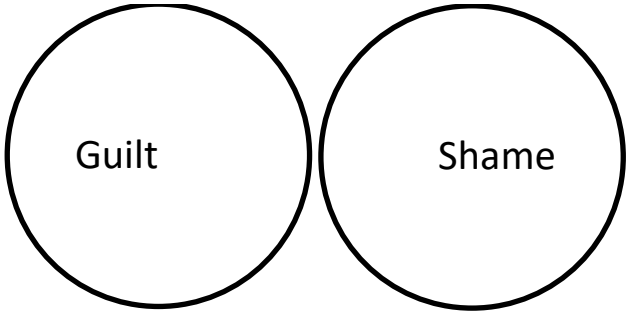


Farnsworth, J. K., Drescher, K. D., Nieuwsma, J. A., & Walser, R. B. (2014, 18(4)). The role of moral emotions in military trauma: Implications for the study and treatment of moral injury. *Review of General Psychology*, 249-262.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Identify some of the things that you may have done in the past where someone was hurt. Then, draw "The Action" circle over the response that you're having the most. It's ok to overlap some but try to decide which one is more accurate.



Name of the action:_____



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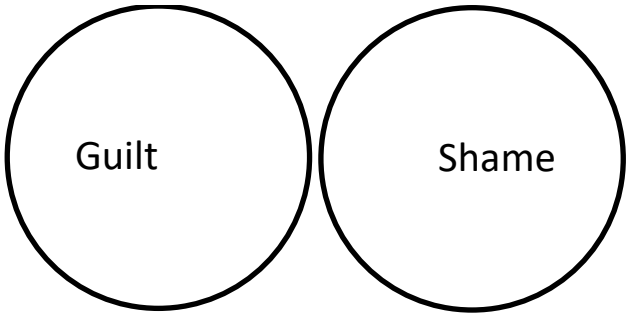

Name of the action:_____

Farnsworth, J. K., Drescher, K. D., Nieuwsma, J. A., & Walser, R. B. (2014, 18(4)). The role of moral emotions in military trauma: Implications for the study and treatment of moral injury. *Review of General Psychology*, 249-262.
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SELF AS CONTEXT: Understanding Rebounds

ACT Theory

Many (but certainly not all) people tend to focus on the external events happening around them in a memory. They lose a sense that they were actors in a situation, *even if all they could do was observe*. So it is that people often begin living a sense of helpless isolation because they feel caught up in the whirlpool of others' actions.

Now, we also have the opposite problem with some client/peers who feel that *everything* that happened is their responsibility or fault. This is a defensive reaction to the original feeling of helplessness. If they can somehow be responsible for everything that happened in the past, then they can control everything that happens in the future.

The goal in ACT is to find a healthy middle ground where we become accustomed (comfortable may be too much to ask for) to interacting with the past and present around us as observers and *limited actors*.

By exploring the world around us with an understanding that everything we observe is colored by our past experiences, we can begin to recognize that we have always used ourselves as the context for experiencing events. Once we understand that, we can begin taking appropriate responsibility for what we can influence and let the rest go.

Psychoeducation Literature

The idea of rebounds is similar to the idea of relapse. However, instead of returning to the problematic situation, person, or substance we turn to something that is functionally the same though technically different. For example: if we open a tube of toothpaste and squeeze it all out on the counter we have a problem; then suppose we scoop it all up and stuff it back in and then someone comes along and squeezes it all out again—that's relapse. In rebound, we stuff it all back in, screw the lid on tight; then someone comes along and squeezes and squeezes until it bursts out the bottom. We still have a mess, we now have a busted tube, but technically it happened in a different way.

When we try to deal with relational, psychological, or substance related problems by stuffing things back in place, we're going to either relapse or rebound. Often the rebound is actually more damaging to overall recovery. Noticing how we've rebounded in the past can help us identify weak areas to shore up.

Progress Notes

Psychoed:

The group discussed the ACT concept of *Self as Context* and how we want to learn to see our role in events, where we have power to change things, and where we can only observe. Discussed how we don't want to be attached to the conceptualized self, but rather the realistic self. Worked on how understanding ourselves can help prevent rebounds, both relationally and behaviorally.

Psych Process:

The group processed their thoughts and experiences about the topics of *Self as Context* and *Understanding Rebounds* from the psychoed group. They discussed previous rebounds and the reasons for them.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Self as Context (20m)

- We are the only consistent character in our memories
- We make sense of the past by understanding the extent *and* limits of our ability to act and finding sense of balance between control and lack of control
- Once we can conceptualize a balance for the past, we can act on that balance in the future

Understanding Rebounds (20m)

- Discuss relapse vs. rebound
- Discuss how rebounds can actually be worse
- Identify rebound patterns

Socratic Questioning (10m)

- Ask how we identify the extent of our role in the past
- Ask what "limited actors" are
- Ask how rebound can be worse than relapse

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

SELF AS CONTEXT

Understanding Rebounds

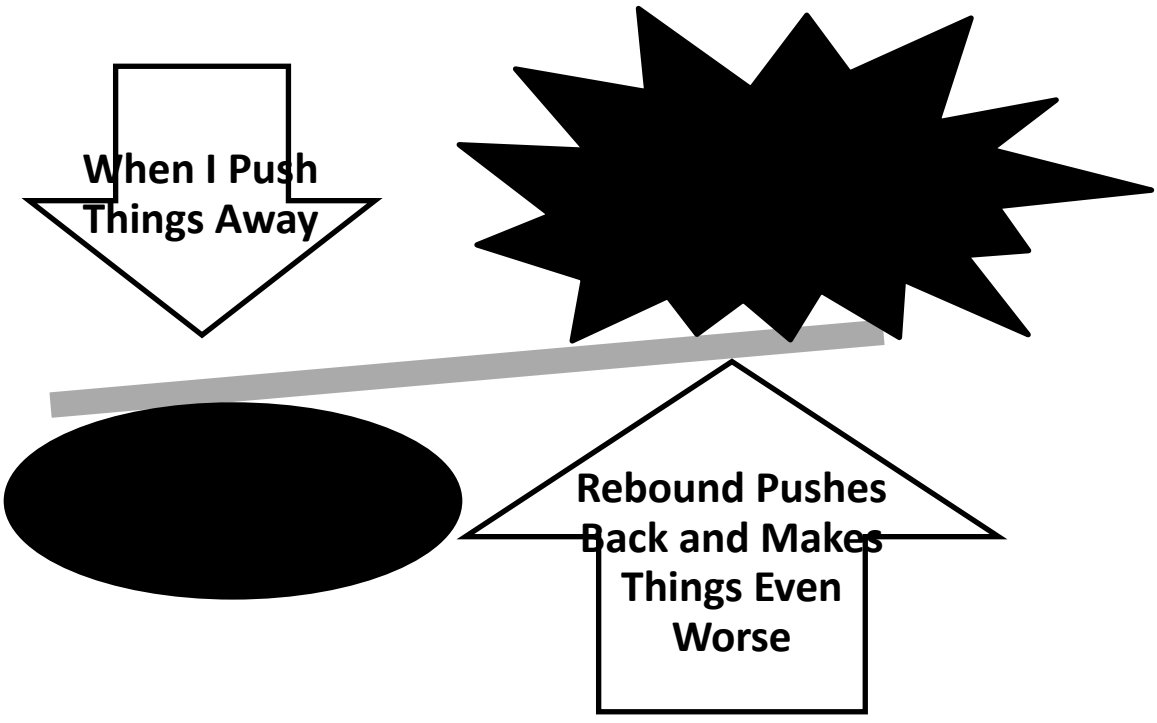
I was Always There

Where I had Control

And No Control

Relapse can be Bad

Rebound is Usually Worse



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SELF AS CONTEXT: Healthy Boundaries

ACT Theory

Many (but certainly not all) people tend to focus on the external events happening around them in a memory. They lose a sense that they were actors in a situation, *even if all they could do was observe*. So it is that people often begin living a sense of helpless isolation because they feel caught up in the whirlpool of others' actions.

Now, we also have the opposite problem with some client/peers who feel that *everything* that happened is their responsibility or fault. This is a defensive reaction to the original feeling of helplessness. If they can somehow be responsible for everything that happened in the past, then they can control everything that happens in the future.

The goal in ACT is to find a healthy middle ground where we become accustomed (comfortable may be too much to ask for) to interacting with the past and present around us as observers and *limited actors*.

By exploring the world around us with an understanding that everything we observe is colored by our past experiences, we can begin to recognize that we have always used ourselves as the context for experiencing events. Once we understand that, we can begin taking appropriate responsibility for what we can influence and let the rest go.

Psycho-education Literature

One very important way of using past experiences to define future interactions is by learning to set healthy and realistic boundaries. There are many different metaphors for exploring the concept of limits among people. Most of them could be appropriate, but we're going to explore one that many client/peers may not have been exposed to.

Most of us are familiar with the concept of a boundary being a wall between two people. We understand big, strong walls as being overly rigid; we understand short crumbling walls as being too diffuse. Instead, what if we thought of the space between people as a *territory*? It would be a neutral space where two people come together for an interaction and then depart when that interaction is done.

In this space people learn to bring in as much of themselves as is comfortable and appropriate, but they can also leave back aspects that they're not ready to share.

Progress Notes

Psychoed: The group discussed the ACT concept of *Self as Context* and how we want to learn to see our role in events, where we have power to change things, and where we can only observe. Discussed how we don't want to be attached to the conceptualized self, but rather the realistic self. The group went on to discuss how an important part of their role in future events is to maintain appropriate boundaries without cutting everyone off.

Psych Process: The group processed their thoughts and experiences about the topics of *Self as Context* and how boundaries have been effective and ineffective in their lives. They worked to identify specific people and situations that they need to work on in regards to boundaries being too loose or rigid.

Austin, W., Bergum, V., Nuttgens, S., & Peternelj-Taylor, C. (2006). A re-visioning of boundaries in professional helping relationships: Exploring other metaphors. *Ethics & Behavior 16*(2), 77-94.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Self as Context (10-15m)

- We are the only consistent character in our memories
- We make sense of the past by understanding the extent *and* limits of our ability to act and finding sense of balance between control and lack of control
- Once we can conceptualize a balance for the past, we can act on that balance in the future

Healthy Boundaries (25m)

- Explore the concept of boundaries as walls--too solid, too loose
- Explore the concept of a territory between human interactions
- Explore what aspects of themselves they many bring into the territory they share with other people.
- Explore what they may want to leave out

Socratic Questioning (10m)

- Ask someone about a past event where he/she may have had less control than originally thought
- Ask someone about future events where he/she can exercise some control
- Ask someone to explain the difference between *boundary* and *territory* in his/her own words

Therapist's Notes For Leading Process Group

Austin, W., Bergum, V., Nuttgens, S., & Peternelj-Taylor, C. (2006). A re-visioning of boundaries in professional helping relationships: Exploring other metaphors. *Ethics & Behavior 16*(2), 77-94.
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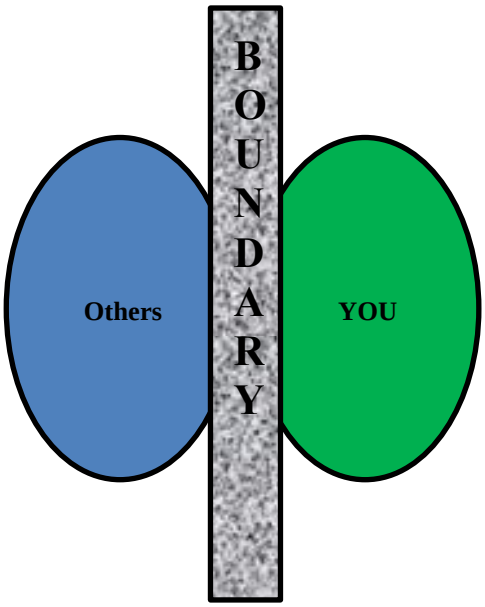
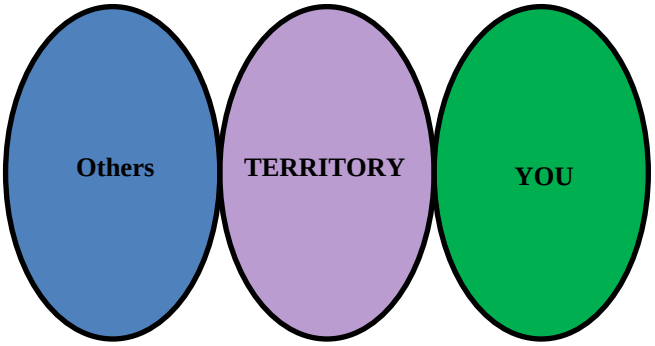
SELF AS CONTEXT

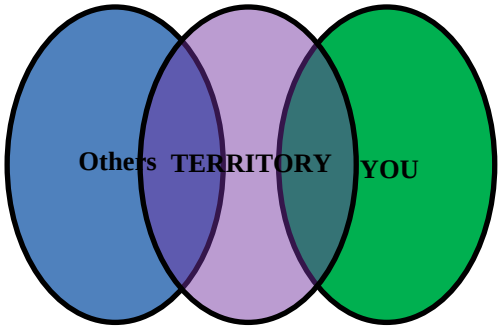
Healthy Boundaries



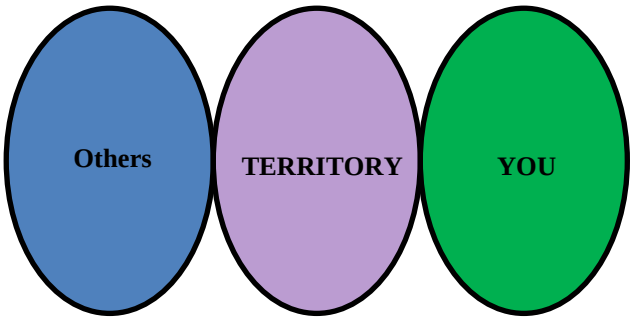
BEFORE INTERACTION



DURING INTERACTION



AFTER INTERACTION



CONCEPTUALIZED SELF VS. SELF AS CONTEXT: Personality & Career

ACT Theories

From a very early age we begin to answer questions about "who are you?" with "I am….." Over time those answers become more complex, but they are all built around the idea of "I AM." Some of the time those identity statements can be beneficial and give us a context in which to fit. When we remain open to the idea of "I am ..." changing, this is a healthy way of making sense of ourselves and the world around us. However, when this becomes rigid and we think "I am an alcoholic," "I am anxious," "I am a monster," all of the other complexities of am-ness are lost.

Conceptualized Self

When we become attached to the am-ness of a singular label, we take on the identity of someone that is less than a complete human. Eventually all of our behaviors become focused on maintaining the limited identity. For many people trapped in a conceptualized self, the unknown dangers, and challenges of embracing a full-fledged identity are overwhelming. It is easier to maintain a one-dimensional identity that is *known* than to explore a multi-dimensional *unknown*.

Self as Context

Many (but certainly not all) people tend to focus on the external events happening around them in a memory. They lose a sense that they were actors in a situation, *even if all they could do was observe*. So it is that people often begin living a sense of helpless isolation because they feel caught up in the whirlpool of others' actions.

Now, we also have the opposite problem with some client/peers who feel that *everything* that happened is their responsibility or fault. This is a defensive reaction to the original feeling of helplessness. If they can somehow be responsible for everything that happened in the past, then they can control everything that happens in the future.

The goal in ACT is to find a healthy middle ground where we become accustomed (comfortable may be too much to ask for) to interacting with the past and present around us as observers and *limited actors*.

By exploring the world around us with an understanding that everything we observe is colored by our past experiences, we can begin to recognize that we have always used ourselves as the context for experiencing events. Once we understand that, we can begin taking appropriate responsibility for what we can influence and let the rest go.

Career

When it comes to career counseling, we want to explore times and jobs in the past that still may be trapping us and how different facets of our "AMness" or personality can help us identify careers we may align better with.

Progress Notes

Psychoed:

The group discussed the ACT concept of *Self as Context* and how we want to learn to see our role in events, where we have power to change things, and where we can only observe. Discussed how we don't want to be attached to the conceptualized self, but rather the realistic self. Discussed the importance of having an accurate picture of self is important in finding a good career fit.

Hoare, P. N., McIlveen, P., & Hamilton, N. (2012) Acceptance and commitment therapy (ACT) as a career counselling strategy. *International Journal of Education and Vocational Guidance 12*, 171-187.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

ACT Self Concepts (20-30m)

- We are the only consistent character in our memories
- We make sense of the past by understanding the extent *and* limits of our ability to act and finding sense of balance between control and lack of control
- Once we can conceptualize a balance for the past, we can act on that balance in the future

Career & Self (15-20m)

- Discuss previous jobs that may not have been a good fit, but that they feel like they have to stick with that experience
- Discuss multi-faceted personality
- Discuss how various facets may make more sense with different careers

Socratic Questioning (10m)

- Ask how either/both ACT concepts seem different and similar today than they did earlier in the week.
- Ask how they see multiple parts to personality
- Ask how personality impacts career

Therapist's Notes For Leading Process Group

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CONCEPTUALIZED SELF VS. SELF AS CONTEXT

Personality & Career

Where I had Control _____

_____

And No Control _____

_____

I AM … _____

_____

Many Parts of Me _____

_____

Career & Personality _____

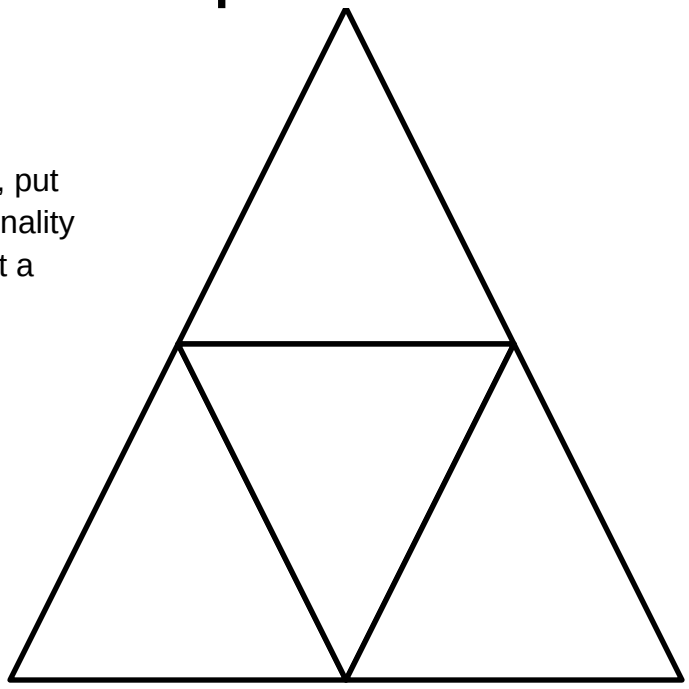
_____

_____

_____

Multiple Sides of Me

1. In the 3 outside triangles, put down parts of your personality
2. In the middle triangle, put a career or 2 that may fit



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COMMITTED ACTION: What am I Good at?

ACT Theory

In this area of Committed Action, ACT functions much like any other behavioral therapy. We are working with client/peers to take specific, concrete, measurable actions that support Defusion, Defining Values, Acceptance, and a Present-centered Life. The key to Committed Action is helping the client/peer identify appropriate homework and to fully understand all the whys that motivate the homework. We also want to make sure that homework is not seen as an end in and of itself; we want each assignment to have a practical purpose that supports the values they are re-creating and so that skills from the assignment are integrated into their lives.

Psychoeducation Literature

Today in the Psych Ed we want to focus on the strengths and assets that the client/peers already have. We're setting aside most of 35 minutes for them to work on identifying strengths, skills, and experiences that they have that could serve them well in more fitting careers.

For most of them, they'll run out of ideas after the first few minutes. After they've slowed down, have them divide up into groups of 2-3 and start helping each other identify more strengths. If they slow down again and there is still a lot of time left, encourage them to keep looking; often some of the best strengths come out after the easier ones are exhausted.

Also, don't let them turn the time into general talking/processing. There is a process group for this topic as well. In the process group, have them talk about Committed Actions they can take to utilize or enhance the strengths they identified during Psych Ed.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Committed Action* as a means of countering *Inaction, Impulsivity, and Avoidance*. Discussed the importance of committing to concrete, obtainable goals in order to make true progress. They worked to identify several specific strengths, skills, and experiences that could help them in their ideal careers.

Psych Process:

The group continued to process the topic from psych ed and further expanded their exploration Committed Actions they can take to utilize and/or enhance their career strengths.

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Lesson Plan

Commited Action (10-15m)

- Have the group briefly review their understanding of *Impulsivity, Inaction, & Avoidance* (IIA)
- Define and discuss how *Committed Action* is the counter to those tendencies
- Don't spend more than a few minutes on IIA or CA as they've already had both topics this week.

Career (What am I good at?) (35m)

- Instead, make a connection using CA to start making specific plans for future career
- Spend the bulk of the session having client/peers identify skills, traits, training, and experience that they have.
- Don't let them derail the session by identifying "killing," "blowing @#$& up," etc. Set the expectation that they are to identify strengths that will apply outside the military.
- Remember, they still have a process group on this; spend the bulk of the time simply identifying.

Therapist's Notes For Leading Process Group

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COMMITTED ACTION

Career: What am I Good at?

Psychoeducation

1. **Identify as many skills, strengths, and/or experiences as you can that will help you in your ideal career.**

Character/Personality Strengths	Skills/Training	Experiences

Process

2. **Choose of a few of those items from above and think about Committed Actions you can take that will build on the strengths you already have.**

Skill/Strength/Experience	Committed Action to Build on it

Hoare, P. N., McIlveen, P., & Hamilton, N. (2012) Acceptance and commitment therapy (ACT) as a career counselling strategy. *International Journal of Education and Vocational Guidance 12*, 171-187.
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DEFINING VALUED DIRECTIONS:
Career—What do I Hate?

ACT Theory

One of the key goals in ACT, to which many of the other processes are geared, is to help the client/peer thoughtfully choose the values they want to live by. This can be an exceptionally challenging process for the client/peer and therapist because most of our values are entrenched in cultural and familial contexts. In ACT, values are often seen as hindrances if they are externally imposed. When values are *informed by* or even *defined by* religion, cultural, family, etc., they can be healthy if we can explain *why* we have adopted them.

That explanation needs to contain a component of personal desire, though; it is not enough to say, "I want to be faithful to my spouse because the Bible tells me too." Instead, values need to be adopted because of a very personalized desire; "I want be faithful because I've seen how much it hurts when someone cheats and I don't want to do that to my spouse or children. Ultimately, I don't want to hurt them because I'm a compassionate person and it will end up hurting me too."

When we actively choose the values we desire, we are then taking control of the values that define us and we begin holding ourselves to our own standards rather than seemingly arbitrary external standards.

Psychoeducation Literature

By the time people have reached the point of a major career transition, they have often identified many things that they never want to deal with again. It is important for us to help client/peers explore both the positive and negative aspects of various jobs and careers. However, there are negative parts to every job; we don't want people to dismiss potentially good jobs because certain aspects remind them of unpleasant things from their pasts.

We want to have client/peers identify which things they identify as negative career attributes because they conflict with their *values*; and which things they identify due to situations that were bad in the past. Values conflicts will almost always lead to a negative employment outcome (quitting/fired) while annoying idiosyncrasies can usually be ignored or overcome.

Progress Notes

Psychoed:

The group discussed the ACT concept of *Defining Valued Directions* and the importance of actively choosing what we value rather than it being imposed. They discussed how understanding values can be very important in choosing a career and place to work. They discussed the negative consequences that arise when values are violated.

Psych Process:

The group continued to process their personal reactions and insights to exploration of values and career choices. Discussed certain things that they never want to deal with again, and things that are unpleasant, but not necessarily worth leaving a job over.

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Lesson Plan

Defining Values (5-10m)

- Briefly discuss the importance of understanding our values and where they come from.
- Remember that most people will have had the topic of values the previous week and/or will have it next week, so you don't need to spend a lot of time on this section.

Career & Values (30-35m)

- Have the group identify 1-2 things that they hate when they are working.
- Explore whether those are value-based hates or personal preference hates.
- Discuss how we can often overcome or tolerate personal preference dislikes in an otherwise good job, but that value-based problems will probably get worse
- Have them work in pairs or small groups on the worksheets to identify more things they don't like.

Socratic Questioning (10m)

- Ask someone the difference between value-based and personal preference dislike
- Ask someone why it's hard to overcome a value-based problem at work

Therapist's Notes For Leading Process Group

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DEFINING VALUED DIRECTIONS

Career: What do I Hate?

Something I Hate: _____

Circle one: **Value** **Pet Peeve**

Describe: _____

Something I Hate: _____

Circle one: **Value** **Pet Peeve**

Describe: _____

Something I Hate: _____

Circle one: **Value** **Pet Peeve**

Describe: _____

Something I Hate: _____

Circle one: **Value** **Pet Peeve**

Describe: _____

Something I Hate: _____

Circle one: **Value** **Pet Peeve**

Describe: _____

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INACTION, IMPULSIVITY, & AVOIDANCE:
Understanding Alcohol & Other Addictions

ACT Theory

People tend to be very committed to maintaining the status quo. We are much more comfortable with the devil we know versus the angel we don't know. This is exceptionally true when it comes to maintaining psychopathology. We have short-term goals to limit or avoid pain and we will do virtually anything to attain those goals. We will drink, rage, hide, or even die to avoid a slight increase in or prolonged pain. We each take a different combination of Inaction, Impulsivity, or Avoidance to reach these immediate goals. However, we can only attain the short term if we sacrifice the longer-term goals of health, relationships, or quality of life.

Psychoeducation Literature

One of the most common traits of people with various addictive issues (Alcohol, drugs, sex, pornography, food, nicotine, etc.) is that they tend to engage in a thinking/behavior pattern called *Delay Discounting* (DD). People with impulsive tendencies will choose $5 today over $10 tomorrow.

Some key concepts to remember and translate though, is that it seems that most people with mental health concerns also have some type of co-morbid addiction/impulse control issue. They may have no problem with alcohol, cigarettes, or gambling, but they do struggle with food, love, or videogames.

It's thought that maybe the impulsivity is a *result* of the brain's reaction to addiction rather than a *cause* of the addiction. As the neuro-receptors become habituated to the addictive stimulus, they require more stimulation more rapidly to engage. Under ACT, we're more conceptualizing that the addiction itself is more a result of Avoidance than anything else. As people find various ways of avoiding unpleasant thoughts, memories, and emotions, a cycle of addiction is fostered.

Progress Notes

Psychoed:

The group discussed the ACT theories of *Inaction, Impulsivity, & Avoidance* and how it relates to alcohol and other addictions. Discussed how people in psychological pain will go to great lengths to avoid the pain and this can include everything from drug use to thrill seeking. Talked about the neuro-biology of addiction and the concept of delayed gratification. Tomorrow will discuss the ACT concept of *Committed Action* as a counter to today's topic.

Psych Process:

The group shared their personal reactions and feelings about today's topic. Explored more about personal addictive tendencies and areas where they were impulsive. Worked on building awareness of how addiction and impulsivity are means of avoidance.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Morrison, K. L., Madden, G. J., Odum, A. L., Friedel, J. E., & Twohig, M. P., (2014). Altering impulsive decision making with an acceptance-based procedure. *Behavior Therapy, 45*, 630-639

Lesson Plan

Inaction, Impulsivity, & Avoidance
(10-15m)

- Discuss maintaining the status quo, even when it's not good
- Discuss ways people engage in *Inaction*
- Discuss ways people engage in *Impulsivity*
- Discuss ways people engage in Avoidance

Understanding Alcohol & Other Addictions
(25m)

- Discuss *Delay Discounting*
- Discuss several different types of addictions
- Discuss the idea of impulsivity as a result instead of a cause
- Discuss addiction as a form of avoidance

Socratic Questioning
(10m)

- Ask someone to explain Delay Discounting
- Ask someone to explain impulsivity as a result instead of a cause
- Ask someone to talk about addiction as avoidance

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Morrison, K. L., Madden, G. J., Odum, A. L., Friedel, J. E., & Twohig, M. P., (2014). Altering impulsive decision making with an acceptance-based procedure. *Behavior Therapy, 45*, 630-639

INACTION, IMPULSIVITY, & AVOIDANCE

Understanding Alcohol & Other Addictions

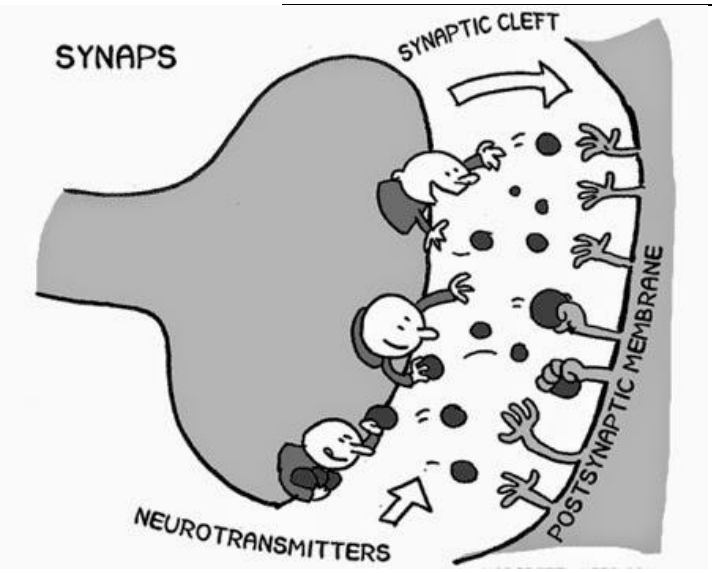
Inaction

Impulsivity

Avoidance

Delay Discounting

Addiction & Avoidance



Normally the brain should function like this. However, once an addiction begins, it is like dumping a million extra balls into the gap there. At first, it's great and everyone is sure to catch a ball. However, then their hands are full and they just start getting hit with the balls instead of catching them.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.
Morrison, K. L., Madden, G. J., Odum, A. L., Friedel, J. E., & Twohig, M. P., (2014). Altering impulsive decision making with an acceptance-based procedure. *Behavior Therapy, 45*, 630-639

COMMITTED ACTION: Healthy Coping Skills

ACT Theory

In this area of Committed Action, ACT functions much like any other behavioral therapy. We are working with client/peers to take specific, concrete, measurable actions that support Defusion, Defining Values, Acceptance, and a Present-centered Life. The key to Committed Action is helping the client/peer identify appropriate homework and to fully understand all the whys that motivate the homework. We also want to make sure that homework is not seen as an end in and of itself; we want each assignment to have a practical purpose that supports the values they are re-creating and so that skills from the assignment are integrated into their lives.

Be sure to talk about Committed Action as the counter to Inaction, Impulsivity, & Avoidance.

Psychoeducation Literature

Rather than a session on all the positive coping skills that client/peers *could* be using, we want to focus today on identifying the strengths and healthy coping skills already in their lives. Have everyone identify at least 2 skills they can use in public situations and at least 2 they can use when they are home.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Committed Action* as a means of countering *Inaction, Impulsivity, and Avoidance* from yesterday. Discussed the importance of committing to concrete, obtainable goals in order to make true progress. They also worked to identify 2 tangible healthy coping skills they can use while in treatment and 2 they can use when they get home. Tomorrow they will discuss *Lack of Clear Values*.

Psych Process:

The group continued to process the topic from psych ed and further expanded their exploration of healthy coping skills and the principle of making committed actions for their wellbeing.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Commited Action (10-15m)

- Have the group briefly review their understanding of *Impulsivity, Inaction, & Avoidance* (IIA)
- Define and discuss how *Committed Action* is the counter to those tendencies
- Discuss the importance of homework and coping skills being specific, concrete, obtainable, and beneficial

Healthy Coping Skills (25m)

- Have the group identify specific problems areas related to IIA here at s and at home. They can do this in groups of 2-3 or as an entire group
- Then have each person identify at least 2 healthy coping skills *they already have* that they can use at Missions, and 2 they can use at home. They can do this in groups of 2-3 or as an entire group
- You will probably have to help them identify skills they already possess unless it is a very function group all towards the end of treatment
- Make sure they take the time to identify really beneficial skills, not just the first that they think of.

Socratic Questioning (10m)

- Ask a few people to share one of their problems areas and coping skills
- Ask people to explain the relationship between IIA and Committed Action

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

COMMITTED ACTION

Healthy Coping Skills

1. Please Identify at least 1 problem area in public situations and at least 1 at home.
2. Please identify at least **2** healthy coping skills you have that you can use in public situations and at least **2** you can use at home. Remember, we want you to identify skills you *already have* not new ones you may still be learning.

Problem Areas	**Healthy Coping Skills**
Public Situations	
Inaction:	**1.**
Impulsivity:	**2.**
Avoidance:	**3.**
Home	
Inaction:	**1.**
Impulsivity:	**2.**
Avoidance:	**3.**

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LACK OF CLEAR VALUES: Relational Aggression

ACT Theory

We all have values in our lives that inform, guide, or are used to judge our actions and decisions. Most people have those values imposed on them by family, religion, culture, or employment (especially the military, police, firefighters, etc.). We tend to accept those values as the RIGHT thing to do, and anything that is contrary to those values must be WRONG. Of course, being bound by values is not inherently a negative thing. Many people find themselves aligning with these external values and living within them comfortably. For others, those values can be restrictive and stifling. We often evaluate what we *do* with our values and sometimes find ourselves lacking. However, we rarely evaluate our values themselves; nor do we make active choices on adopting or rejecting these values.

Psychoeducation Literature

One of the many places that unclear values manifest is in *relational aggressions*. We want to start thinking in terms of relational aggression rather than domestic violence. Domestic violence is a narrower term that most people associate with physical violence or, maybe, extreme emotional abuse.

If a client/peer hasn't been involved in that physical violence, then s/he may dismiss the need to understand relational aggression. Relational aggression is a broader term that applies to act or reaction that seeks to force or coerce the other party in a relationship (spouse, parent, friend, etc.) to do what you want. That aggression can be overt—physical violence, yelling, threatening; or it could be more subtle—manipulating; withholding money, affection, or sex; picking fights, etc.

We want to explore what values we hold that make it seem temporarily OK to engage in relational aggression. For most people there is some type of value, rule, or standard that seems congruent with aggression on the surface. When we examine those values more closely though, we often realize that there is really no justification for that relational behavior.

Progress Notes

Psychoed:

The group discussed how we all have values that guide our lives, but that for many of us those values are externally imposed and not really understood or believed. Discussed how those unclear values can lead to relational conflict with everything from arguments to physical violence to killing. Tomorrow will discuss personally defined values and goals.

Psych Process:

The group discussed some values they have had in their lives that were externally imposed and times in their lives where they have been involved in relational aggression as aggressor, victim, or both.

Eifert, G. H. & Forsyth, J. P., (2011). The application of Acceptance and Commitment Therapy to problem anger. *Cognitive and Behavioral Practice, 18*, 241-250.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist*. Oakland, CA: New Harbinger Publications, Inc.

Zarling, A., Lawrence, E., & Marchman, J. (2015). A randomized controlled trial of acceptance and commitment therapy for aggressive behavior. *Journal of Counseling and Clinical Psychology, 83*(1), 199-212.

Lesson Plan

Lack of Clear Values (15-20m)

- Talk about various things that we value
- Talk about where those values come from
- Talk about externally imposed values vs consciously chosen values
- Talk about some of the problems that can arise due to unclear values

Relational Aggression (20-25m)

- Talk about the difference between domestic violence and relational aggression
- Explore the many ways that most of us have been on one side or the other (or both) of relational aggression
- Discuss how relational aggression may be rooted in misapplied values

Socratic Questioning (10m)

- Ask about where values come from
- Ask about externally imposed values
- Ask about how unclear values may lead to relational aggression

Therapist's Notes For Leading Process Group

Eifert, G. H. & Forsyth, J. P., (2011). The application of Acceptance and Commitment Therapy to problem anger. *Cognitive and Behavioral Practice, 18*, 241-250.

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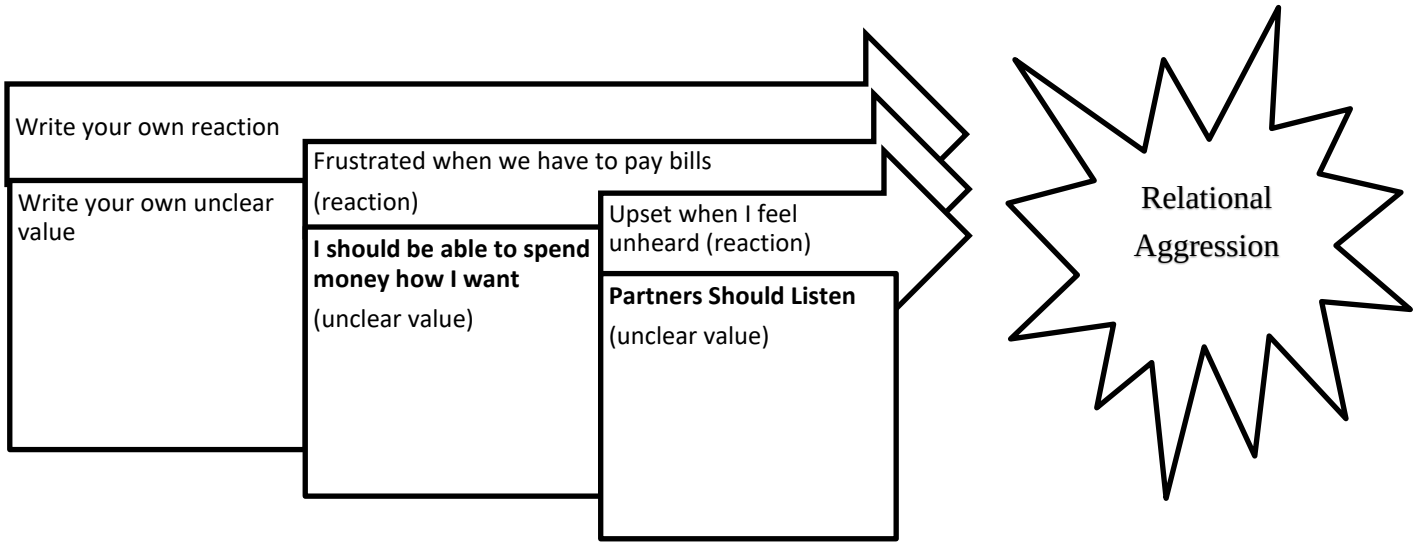
LACK OF CLEAR VALUES

Relational Aggression

Externally Imposed Values

Consciously Chosen Values

Relational Aggression



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DEFINING VALUED DIRECTIONS: What do I Believe in?

ACT Theory

One of the key goals in ACT, to which many of the other processes are geared, is to help client/peers thoughtfully choose the values they want to live by. This can be an exceptionally challenging process for the client/peer and therapist because most of our values are entrenched in cultural and familial contexts. In ACT, values are often seen as hindrances if they are externally imposed. When values are *informed by* or even *defined by* religion, cultural, family, etc., they can be healthy if we can explain *why* we have adopted them.

That explanation needs to contain a component of personal desire, though; it is not enough to say, "I want to be faithful to my spouse because the Bible tells me too." Instead, values need to be adopted because of a very personalized desire; "I want be faithful because I've seen how much it hurts when someone cheats and I don't want to do that to my spouse or children. Ultimately, I don't want to hurt them because I'm a compassionate person and it will end up hurting me too."

When we actively choose the values we desire, we are then taking control of the values that define us and we begin holding ourselves to our own standards rather than seemingly arbitrary external standards.

Psychoeducation Literature

There can be a lot of power for the positive in religion and spirituality. There can also be the potential for a lot of harm when people simply accept what they're told (especially when they are younger) and not evaluate their beliefs for themselves. Yesterday we spent time looking at how unclear values can lead to relational aggression. Today we want to explore the religious/spiritual/philosophical basis of our values and begin making choices about what to keep and what to begin to discard (unfortunately, evaluating spiritual beliefs can be very difficult).

Progress Notes

Psychoed:

The group discussed the ACT concept of *Defining Valued Directions* and the importance of actively choosing what we value rather than it being imposed. They went on to discuss how this is especially important, but difficult, when it comes to religion and spirituality as they guide so much of our lives. Tomorrow will discuss *Dominance of the Past/Future*.

Psych Process:

The group processed their emotional and cognitive reactions to exploring the role religion and spirituality has played in guiding their lives—both good and bad. They discussed how difficult it is to try to objectively evaluate things you were taught at an early age.

Bingaman, K. A. (2015). When acceptance is the road to growth and healing: Incorporating the third wave of cognitive therapies into pastoral care and counseling.
Hayes, S. C. (2002). Buddhism and acceptance and commitment therapy. *Cognitive and Behavioral Practice, 9*(1), 58-66.
Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Defining Valued Directions (15-20m)

- Briefly have the group discuss what they remember from *Lack of Clear Values*
- Discuss *why* we want to actively define our own values--make sure to discuss the personal reason for values

Spirituality & Religion (20-25m)

- Talk about how many of our values come from our (and/or our parents') religion/spirituality or philosophy
- Discuss the reasons that it can be so uncomfortable to critically evaluate religion
- Spend at least 15 minutes having the group discuss values from their religious/spiritual tradition that they want to keep
- Spend a few minutes having the group discuss values that they might be thinking about discarding

Socratic Questioning (5-10m)

- Ask someone to explain the importance of clear values
- Ask someone to explain why it's hard to critically evaluate religion

Therapist's Notes For Leading Process Group

Bingaman, K. A. (2015). When acceptance is the road to growth and healing: Incorporating the third wave of cognitive therapies into pastoral care and counseling.

Hayes, S. C. (2002). Buddhism and acceptance and commitment therapy. *Cognitive and Behavioral Practice, 9*(1), 58-66.

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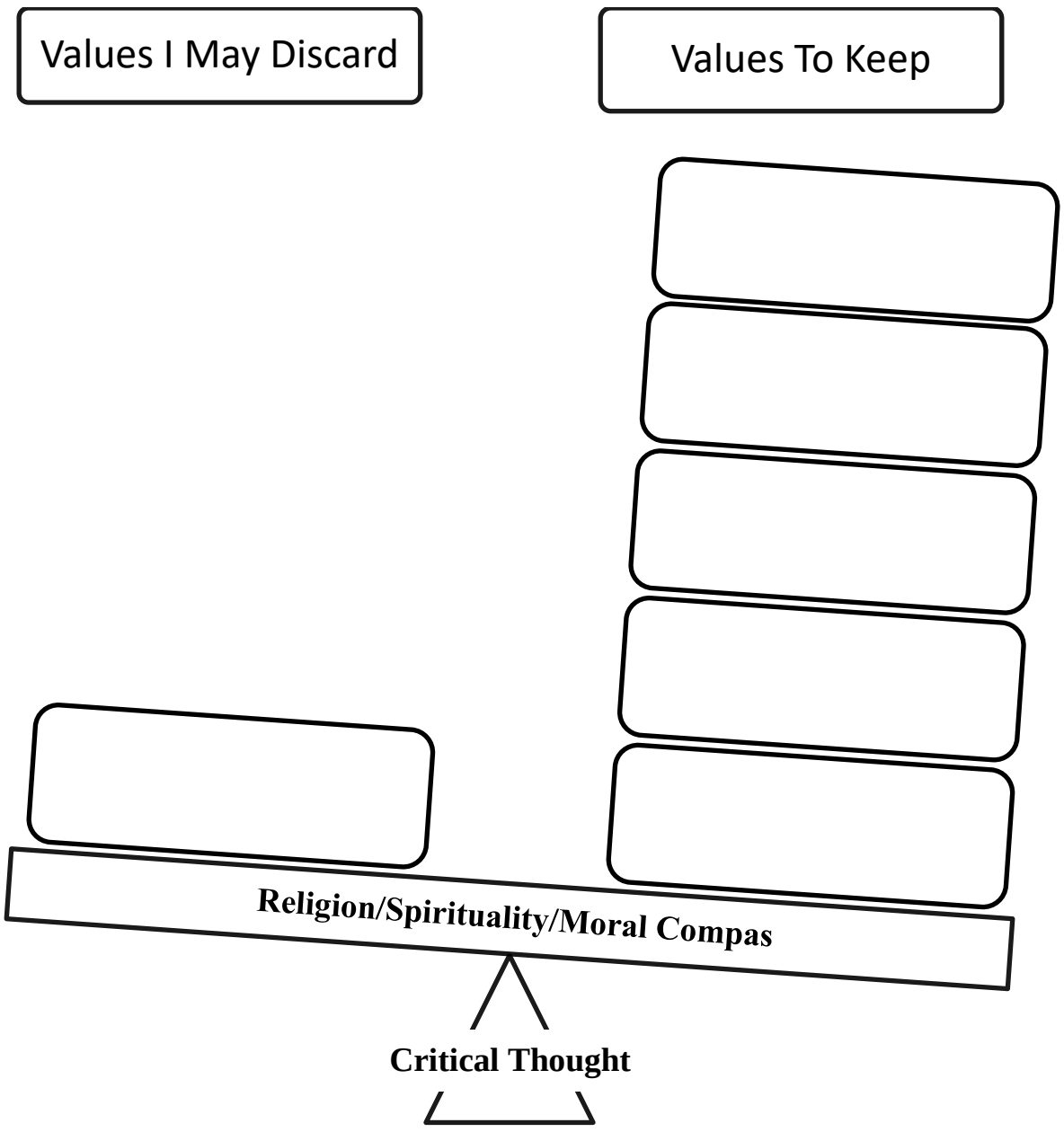
DEFINING VALUED DIRECTIONS

What do I Believe in?



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DOMINANCE OF THE PAST/FUTURE: Grief & Loss

ACT Theory

Most of us have a hard time living in the present. We tend to ruminate over the past or fear (or dream about) the future. Many of our client/peers seem to get caught up doing both. We often form a picture of how things were in the past. For some people, the past seems better than it actually was and for other it seems worse. Because of our tendency to believe that our thoughts must be TRUE, we forget that our memory of the past (or fears of the future) only contain a small piece of an elaborate picture. Because we only experience time in one direction, it can be unsettling to acknowledge that our memories are not necessarily providing a firm foundation.

When people can't trust their memories, they often wonder what else they can't trust and this can lead to existential questions. Instead, we want to explore the role of memory (and dreams/fears of the future) as one element of information in a much bigger picture.

This dominance of the past and future is especially prevalent in times of grief. We are constantly remembering who or what we've lost, and we're constantly trying not to imagine the future without them. We expend a lot of effort to avoid staying in the present with our emotions. We start telling ourselves stories that begin with "if only…"; "I should have…"; "Why not…"; anything to pull ourselves out of the present.

Instead, we need to simply accept what we feel without judgment; accept that there will be times when it's too much for us and we need distractions and *this is OK as long as we don't push away the grief every time it comes back*; have compassion for those around us *and ourselves*; make choices about the present and future based on the values that really matter to us.

Progress Notes

Psychoed:

The group discussed the ACT principle of *Dominance of the Past/Future* and how it especially applies to grief and loss. They explored how thoughts and memories of the loss can control us and keep us from actually experiencing the grief and starting to feel better. Discussed acceptance of the unpleasant emotions, and ways to start handling grief. Tomorrow will discuss *Being Present*.

Psych Process:

The group processed their emotional and cognitive responses to the topics of Past/Future and grief. Discussed their reflections on making plans based on their values rather than their emotions. Discussed ways they've been trapped in the past.

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Lesson Plan

Past/Future (10-15m)

- Discuss how things that hold us in the past are actually only *memories (thoughts)* of those things
- Have client/peers talk about whether thoughts are REAL
- Discuss how it feels to think about memories as being uncertain

Grief (25m)

- Discuss how we use stories about the loss to keep us from feeling the grief
- Discuss some of those stories that client/peer have used themselves
- Discuss how the stories actually keep us trapped in the past/future which makes grief take longer
- Discuss Accepting what we feel; Accepting that it can be overwhelming; Compassion; Values-based choices
- Have client/peers start filling out values-based choices worksheet

Socratic Questioning (10m)

- Ask someone to explain how thoughts aren't real
- Ask someone what happens when we tell ourselves stories about the past/future
- Ask someone what Compassion is
- Ask someone what Values-based choices are

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

DOMINANCE OF THE PAST/FUTURE

Grief & Loss

What are Memories

Past

Future

Stories

Compassion

Values-Based Decisions

Value	Decision:
Me:	
Family:	

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BEING PRESENT: What Defines Me?

ACT Theory

Being present is, perhaps, the simplest concept in modern psychology to explain, but the hardest to attain. As we've discussed, we tend to dwell in the past or in the future and tend to avoid the present. When we're unhappy we pull out all kinds of tricks to stay out of the present. It is especially important though, to begin practicing a present-focused life in order to reduce the control the past and future exert on us.

Some theories and philosophies aim at living only in the present moment; ACT however realizes that living only in the present may be unattainable for many people. Instead, ACT seeks to help people live in the past when reflection and learning is important; live in the future when planning is important; and live in the present when simply living is the most important.

We want to understand that the past *is* important—many things from the past help define us—but we also want to understand that the present and future are also important. We want to work with client/peers to identify things from the past that define them, then we want to challenge them to add things from the present and future that also help to define them.

Progress Notes

Psychoed:

The group covered the ACT concept of *Being Present.* The group discussed how being present is a simple concept, but very hard to actually achieve. Discussed various ways to practice it and how understanding what emotions, thoughts, and experiences define us can help us to stay in the present. Tomorrow will discuss *Committed Action*.

Psych Process:

The group processed their cognitive and emotional reactions to the challenging topic of Being Present. Discussed how challenging it can be at times. They also discussed their insights into what defines them and what/who has influenced those definitions.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

Lesson Plan

Being Present (10-15m)

- Discuss the concept of *Being Present* and acknowledge how challenging it can be.
- Explore various ways to practice presence

What Defines Me? (25m)

- Talk about how we have allowed different people and experiences to define us
- Talk about how those definitions influence our daily life
- Work with client/peers to complete the worksheet, then discuss

Socratic Questioning (10m)

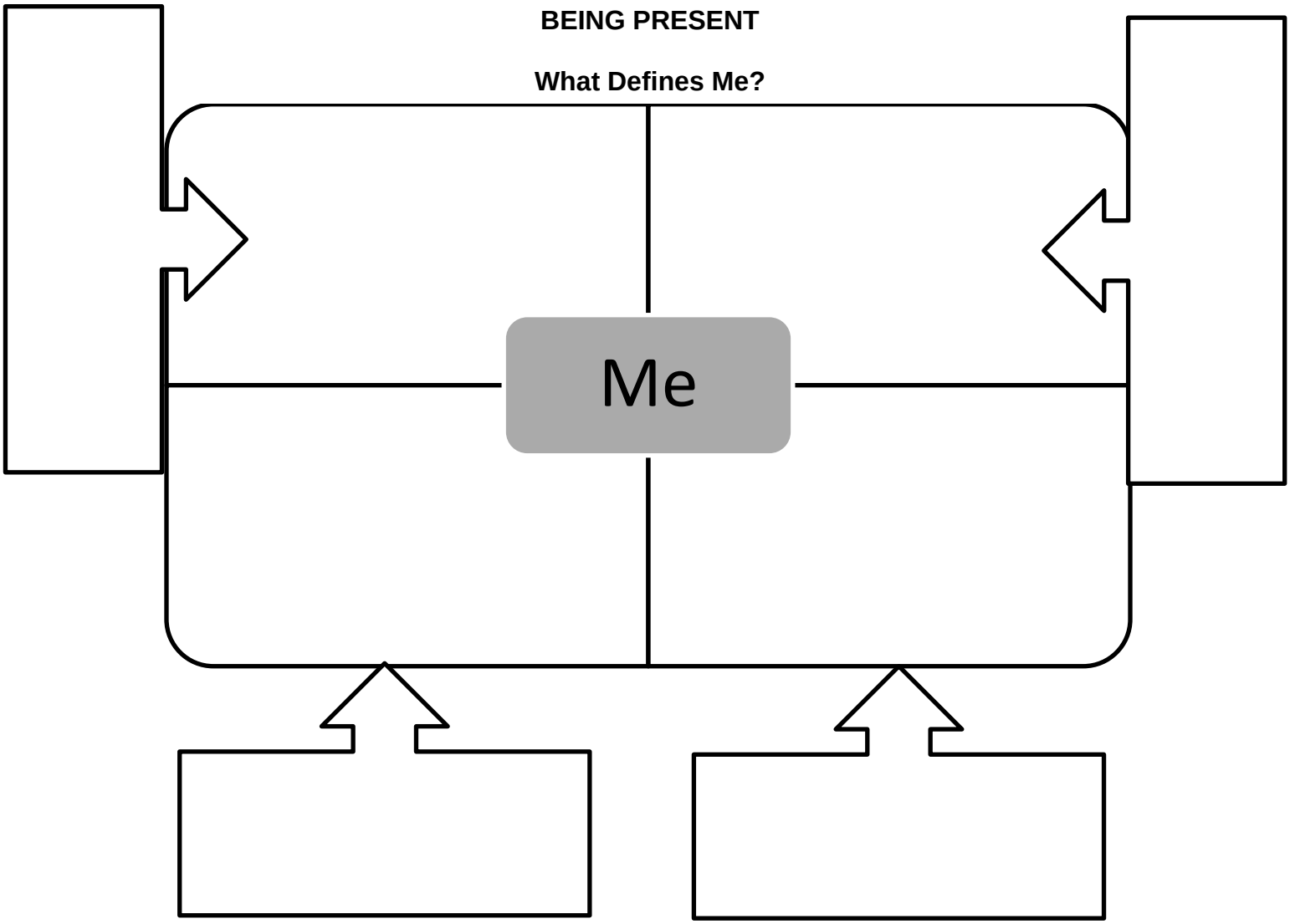
- Ask someone what it means to "Be Present"
- Ask someone how people and events define us
- Ask someone how those definitions help/hinder being present

Therapist's Notes For Leading Process Group

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapist.* Oakland, CA: New Harbinger Publications, Inc.

BEING PRESENT

What Defines Me?



In the inside boxes, write down some of the thoughts, feelings, or experiences that define you.

Then, in the outside boxes, write down where they may have come from.

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Zarling, A., Lawrence, E., & Marchman, J. (2015). A randomized controlled trial of acceptance and commitment therapy for aggressive behavior. *Journal of Counseling and Clinical Psychology, 83*(1), 199-212.

About the Author

Adrian S. Warren, PhD, is a Licensed Professional Counselor specializing in individual, couples and family counseling with an emphasis on Existential and Hypnotherapy, and maintains a private practice in San Antonio, TX.

With over 11 years' experience as a counselor and 16 years of experience in mental health, he is currently working as a private practitioner and counselor educator. Among his areas of expertise are hypnotherapy, LGBT issues, past traumas, and military families.

In addition, Dr. Warren has presented at National and State conferences and to general audiences speaking on the topics of Hypnotherapy, LGBT Issues, Countertransference and Supervision, and Creativity in Counseling.

Dr. Warren is an interactive, Existential counselor. His therapeutic approach is to provide support and practical feedback to help clients effectively address personal life challenges. He integrates complimentary methodologies and techniques to offer a highly personalized approach tailored to each client. With compassion and understanding, he works with individuals to help build on their strengths and attain the personal growth they're striving for.

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