“The Role of Acceptance and Commitment Therapy in the Management of Behavior Maladjustment, Anxiety and Other Psychological and Organic Disorders”

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PeachTree Professional Education, Inc.
Richard K. Nongard, LMFT/CCH
7107 S. Yale, Suite 370 * Tulsa, OK 74136

Voice: (800) 390-9536
Fax: (888) 877-6020
www.FastCEUs.com
The Role of Acceptance and Commitment Therapy in the Management of Behavior Maladjustment, Anxiety and Other Psychological and Organic Disorders

3 CEU Credit Hours

Course Description:
This course overviews acceptance and commitment therapy (ACT), discussing its components, uses and evidence based outcomes for impacting client issues, altering destructive behavior patterns and emotional dissatisfaction.

Course Objectives:
At the conclusion of this course the professional will be able to:
1.) Create treatment plans using the six foundations of ACT Therapy
2.) Demonstrate techniques specific to ACT therapy that can assist clients
3.) Integrate ACT therapy into treatment of anxiety disorders
4.) Describe ACT therapy as an emerging evidence based psychotherapy
5.) Understand further applications of ACT therapy

Purpose of this course:
The purpose of this CEU course is to provide discussion relevant to the mental health counselor on the principles and uses of acceptance and commitment therapy with specific client populations.

Course Outline:
Part 1: Course organization, Documentation and Introduction.
Part 2: Reading of the course materials (this document)
Part 3: Administration and Completion of the Evaluation of Learning Quiz

3 Clock Hours / CE Credits

If you ever have any questions concerning this course, please do not hesitate to contact PeachTree at (800) 390-9536.

Your instructor is Richard K. Nongard, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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Introduction:

It is rather hard for humans to live a happy life. This is completely true and is highly endorsed by the shocking statistical findings that have plotted that the prevalence rate for mental disorders which approaches 30% of the population in America. Moreover, 20 million alcoholics live in the USA today, and more than 300,000 commit suicide each year. All this data leads to one conclusion; suffering is one of the basic characteristics of human life.

Most psychiatrists today believe that to live a happy life, an individual must overcome negative emotions and thoughts that can be the cause of psychological suffering. Although much effort is deployed to achieve happiness, some people still suffer from maladjustment, behavioral disorders and life dissatisfaction.

Acceptance and Commitment therapy (ACT) is a unique psychological therapeutic approach that aims at amelioration of psychological suffering. Acceptance and Commitment therapy (ACT) is a model that links psychological disorders and behavioral problems to psychological processes that normally occur, especially those which involve development and perception of human language. No matter how this model might not make sense, ACT doesn’t deny the existence of abnormal pathological psychological processes. Conversely, ACT presents a novel understanding of the components of psychological distress. The ACT model recognizes the potential destructive effects of the normal psychological processes. In other words, the normal psychological processes can trigger or amplify pathological psychological processes that can lead to suffering.

ACT is a model based on the assumption that most maladaptive behavioral patterns are caused by faulty attempts to suppress or avoid thoughts, emotions and/or sensations. The ACT approach is directed to teach patients the following:

a- To recognize and abandon control strategies which are internally oriented.

b- To accept the idea that difficult emotions and thoughts are almost always present.

c- To learn how to notice the emergence of hard psychological experiences without fighting them, arguing, or promoting them to reality.

d- To concentrate on positive behavior patterns that can yield favorable outcomes.
Since the early 1990s, ACT strategies have been extensively researched. Early studies have shown that ACT is a promising clinical approach. Results pointed to the useful role of ACT in reduction of the negative behavioral patterns that might be triggered by unhealthy thoughts and/or feelings. For instance, in 2000, Bond and Bunce successfully used ACT to treat worksite induced anxiety and stress. They managed to increase the acceptance to the environment stressors which yielded positive behavior at work. Some researchers have proven the efficacy of some strategies in the adjustment of behavior of selected individuals. Furthermore, ACT has been successfully used in the treatment of depression, dysthymia and bipolar disorders. More recently, psychiatrists have been using ACT to help psychotic patients learn to cope with their positive symptoms (auditory hallucinations and delusions).

Current evidence supports the effective role of ACT in the management of behavioral maladjustment and anxiety disorders. This data goes hand in hand with the present increasing emphasis on the role of emotional avoidance in the genesis of depression, behavioral and anxiety disorders. However, clinical studies are yet to be conducted to prove whether or not ACT would be an evidence based line of treatment for anxiety and other psychological disorders.

Outline of the Paper:

A- What is ACT?
B- Rule Governance and Relational Frame Theory: The Philosophy that Underlies ACT.
C- The six main processes of ACT
D- Clinical methods used in ACT
E- The role of ACT in the management of self-destructive behavioral problems.
F- The Use of ACT in the treatment of anxiety disorders and depression.
G- Anti-anxiety medications in conjunction with ACT
H- The role of ACT in the control of symptoms of psychotic patients
I- The role of ACT in the management of organic disorders
J- Competency of an ACT therapist
K- Conclusion
L- Recommendations
What is ACT?

Most of the psychological problems which human beings encounter originate in language and/or thoughts. However, no human being can live without developing and communicating by the means of language. To us, language either functions as a servant or a master. In this context, ACT is centered on training individuals to properly control language and thoughts. In other words, ACT is directed to render an individual the master rather than the slave of language using linear and logical language with emphasis on past experience as a guide for future experience.

The ultimate goal of ACT is achieving “psychological flexibility”, or the ability to fully cope with life through either changing or persistence, if doing so yields beneficial outcomes. ACT is a form of therapy that is based on the idea that regulation of language can help avoid the processes that might lead to psychological trauma.

ACT is based on the fact that rapid changes in an individual’s behavior normally occur. Generally speaking, ACT is directed towards altering the function of existing relationships while not attempting to abolish previously acquired psychological responses except after some progress is achieved. In a metaphorical context, ACT will not convince you to win a game that you have been losing throughout your life. Instead, ACT will offer you an alternative game that it is easier for you to win.

ACT is based on the use of non-linear forms of language. ACT therapists highly depend on metaphors, paradox, exercises and behavioral tasks. The relationship that is created between the patient and the therapist is pivotal to achieve favorable outcomes. This relationship is based on acceptance as the therapist attempts to model, practice and reinforce positive behavioral processes. Accordingly, ACT functions to avoid psychological processes and behavior that supports avoidance and fusion, while reinforcing behavior that supports defusion and acceptance. The ACT relationship is all about change or persistence of behavioral patterns that can lead positive results as regards psychological healthiness.

Rule Governance and Relational Frame Theory:
The Philosophy that Underlies ACT:

ACT has a solid foundation that is centered on the nature of human cognition and language. Its basic philosophy emerges from solid behavioral principles that are derived and guided by a coherent theoretical foundation; “relational frame theory”. This upside down approach was the successive therapy that paved the path for a considerable number of the first wave of effective behavioral therapeutic interventions. Actually, therapeutic strategies that emerged from this recipe, including experience exposure exercises for anxiety disorders, were
markedly successful (Barlow 2002). The theoretical, philosophical and empirical foundations of ACT are effectively integrated and have yielded a therapeutic technology that naturally emerges from them.

Focusing on the essential role of human language is not specific for ACT only. This important role of language has been identified long ago in almost all human cultures. For instance, in the famous Book of Genesis, God had created the whole world through aid of his utterance. In several human cultures, the relationship between a given name and the thing and/or the person that is dominated by it is specifically not a sole arbitrary and an ideal association. Instead, it is rather a genuine and important link that bonds the two in a form that allows magic to be wrought on a man simply through his name just as through his nails, hairs or any other part of his physical person.

The great importance of language extends to include scientific and/or scholarly aspects. The twentieth century has been marked for the emergence of some psychological and philosophical schools which focused on the role of language in understanding different aspects of the human activity and the link between them and the external world (e.g. logical positivism, normal language philosophy, psycholinguistics and narrative psychology). Despite the fact that the vast majority of these approaches are very interesting, only few have been guided by organized clinical agendas; hence, the yielded analyses are often not relevant to the present clinical environment. Unlike some other forms of scientific research which involve language, ACT’s interest in the analysis of verbal behavioral patterns emerges from interests in the psychological health of human beings.

In spite of the fact that most of the practical approaches of ACT are derived from the link between behavioral therapeutic interventions and man’s potential movement, its foundation emerges almost totally from a context that is based on an analytic perspective. Regarding behavioral analysis, there has always been a somehow clear delineation between rule governed behavior and contingency shaped behavior, and the understanding of this delineation is of pivotal clinical importance. Contingency shaped behavior refers to behavioral patterns that have been developed through gradually shaping repetitive approximations, e.g. learning how to catch a ball via a process of trial and error. A great deal of human behavioral patterns are developed this way; however, some others are developed via verbally formulating different events and establishing relations between them. This form of behavior is referred to as “rule governed”.

Rule governed behavior is a form of behavioral pattern that is ruled by the specifications of different contingencies instead of making direct connections with them (Schlinger et al, 1987). This pattern of human behavior allows an individual to respond in a precise and effective way when contingency based behavior is harmless or fatal, e.g. when the consequences of behavior are
unnoticeable, small, remote, probabilistic or cumulative. For instance, an individual shouldn’t engage in a process in order to learn how to avoid dangerous high voltage electricity. Moreover, basic experimental studies have proven that delayed consequences are, in most cases, ineffective. Nevertheless, human beings sometimes respond to descriptions with remotely delayed consequences, for example “Treat your aunt decently and in 10 years she shall remember you in her will”.

Pliance is a form of rule governed behavior and refers to following a specific verbal rule which is linked to some previous social consequences that design the relationship between the verbal rule and the individual’s resultant behavior. For instance, if a child is instructed by his mother to “wear a coat - it is freezing outdoors” and the child reaction is based on previous experiences regarding pleasing or displeasing the mother, this is a form of pliance. Pliance is most probably the primitive form of rule following that human beings learn. Great evidence supports the fact that pliance is a form of pervasive rule governed behavior (Hayes, Zettle and Rosenfarb, 1989). Tracking is another form of rule governed behavior which is usually controlled by a form of correspondence that emerges between the verbal rule and the natural contingencies, whether social or non social. Natural contingencies emerge totally from similar forms of behavior which arise in a specific situation. (Hayes, Zettle and Rosenfarb, 1989)

A considerable number of researchers have concluded that whenever behavioral patterns are regulated by verbal rules, they become somehow insensitive to influence, that maybe imposed in the environment, which is not described by those rules. (Shimoff, Catania and Matthews, 1981; Hayes, Brownstein, Haas and Greenway, 1981; Catania, Shimoff and Matthews, 1981; Hayes, Brownstein, Zettle, Rosenfarb and Korn, 1986 and Hayes, Zettle and Rosenfarb, 1989). Studies have proven that when humans regulate their behavior using verbal rules, they often observe changes occurring in the environment less precisely than non humans do. To illustrate this, if a person is instructed to “push a button repeatedly quickly to gain points”, he/she would occasionally be reluctant to, due to the previous instructions, cease pushing the button when points can no longer be gained, or to push slowly when there is a need to slow the rate of pushing, or to change the pattern of pushing when this can increase the gained points (Shimoff et al., 1981; Mathews et al., 1977; Hayes, Brownstein, Haas and Greenway, 1986).

In a study conducted by Hayes, Brownstein, Haas and Greenway in 1986, subjects were taught a task by either experience or following a specific verbal rule. After some time, the requirements of the task were changed without alarming the subjects. 100% of the subjects who were taught by experience felt the change; while only 50% of the subjects were taught by following a change sensed the same change. This “insensitivity” proves that patterns of human
practices persist in spite of direct experiences and negative consequences. This led to the basic philosophical concept that inspires much of the therapeutic ACT interventions: “Developing behavioral patterns through direct verbal rules can yield psychological inflexibility”.

**The Six Main Processes of ACT:**

As illustrated in Figure 1, achieving psychological flexibility through ACT is pillared on the interaction between six main processes: defusion, acceptance, values, contact with the present moment, self as context and committed action. Each of the aforementioned processes aids in establishing persistence or change which is linked to certain chosen values.

Acceptance means “taking what is being offered”. Acceptance should be differentiated from resignation and tolerance which can lead to passive psychological consequences.

![Diagram](attachment:image.png)

**Figure 1:** Components of psychological flexibility in view of ACT (Hayes et al, 1999)

Acceptance is an attitude of awareness and active embracement of feelings, thoughts, experiences and feelings just as they occur. ACT supports acceptance by weighing the costs of effective control especially when control is erratically applied to some special events.
Defusion, or cognitive defusion, aims at modification of the context throughout which thoughts form and interact to alleviate the importance and impact of hard psychological experiences. Cognitive defusion comprises a group of exercises which analyze the literal meaning of language and thoughts through inherent paradox, experiential means, mindfulness techniques and other relevant procedures. Simply speaking, cognitive defusion is directed towards training an individual to see or perceive thoughts as thoughts, body sensations as body sensations, feelings as feelings and memories as memories. None of the previously mentioned private events are harmful when they are perceived as what they really are. However, psychological troubles emerge when these private events are thought of as unhealthy, harmful or intimidating experiences, so it is then when they should be eliminated.

Self as context is a main process in ACT which entails that an individual who is excessively fused with his/her conceptualized self has a threatened psychological flexibility. The perspective of ACT is that the sense of “self” evolves through verbal individuals and can be access by the means of mindfulness processes and cognitive defusion. The benefit of this concept of self is that it reflects a context throughout which the contents of consciousness are rendered non-threatening. Accordingly, the “self as context” concept supports acceptance. A considerable number of ACT interventions are focused on training individuals to experience “self as context” in a qualitative aspect. These interventions include experiential exercises, mindfulness/meditation and metaphors.

Contact with the present moment is one of the main processes of ACT. ACT therapists train patients to notice and observe what is physically present in their environments as well as their private experiences. Moreover, ACT therapists teach their patients to describe and label their present without prejudice or excessive judgment. Accordingly, this would help in the establishment of sensing one’s self as a unique process of everlasting awareness of experiences and happenings. A variety of therapeutic techniques are deployed to increase the patient’s awareness of the present. Mindfulness is directed towards orientation of an individual to the world as they directly experience it, rather perceiving it as it is conceptualized in one’s thoughts. Mindfulness is an interaction between defusion, acceptance, contact with the present moment and self as context which are all processes of ACT. Contact with the present moment interventions can sometimes include cognitive and behavioral exposure techniques that are basic components of a wide range of behavioral therapeutic techniques. Nonetheless, the aim of these exercises in an ACT strategy is different as it emphasizes the great benefits of interaction with the present moment with the aid of a perfect psychological flexibility model.

Values are defined in view of ACT as selected qualities that relate to a purposive action. These qualities can only be exemplified rather than merely
processed as a physical object. In this view, ACT trains individuals to differentiate between reasoned judgments and choices and to be aware while selecting certain values. Patients are challenged to envision their lives throughout different aspects which include close relationships, work, family, personal growth, spirituality, health and friendship. Although ACT is focused on teaching individuals to accept, defuse and be aware while contacting the present, the ultimate of ACT is creation of a more purposeful happy life. As such, values function as the compass that directs ACT to yield an effective group of behavioral life patterns. A wide range of exercises are used by the ACT therapist to help an individual determine his/her fundamental values. Brainstorming and journaling are often used to reach this goal. The most common domains of human values include the following:
- Family relationships
- Romantic/marital relationships
- Friendship
- Career related relationships
- Leisure and recreation
- Religion/spirituality
- Citizenship/community
- Physical well being/health

**Committed action** is another important process that is often the result of recognition of faulty psychological processes and barriers that lead to avoidance and fusion. During ACT, commitment is a pivotal process that involves determination of one’s goals in a specific life aspect as he/she travels along his/her valued path. Thereafter, ACT involves working on these goals by means of anticipation and demolition of psychological barriers. As an individual learns to increase the size of life aspects addressed, more complicated committed actions are expected to be constructed. The target is to pillar healthy behavioral patterns that are supposed to work for an individual, rather than against him/her. The complex processes of acceptance, defusion, committed actions and values promote accepting the responsibility for adaptation, behavioral changes or persistence whenever necessary.

Figure 1 illustrates the interactive relationship between each and every component of ACT’s model of psychological flexibility. A total of 15 lines in Figure 1 represent the interactive relationships among the 6 components of psychological flexibility. Some of those relationships, which are represented by the 3 vertical lines, exhibit common functional properties. Acceptance and defusion are directly related because they both act through undermining harmful language and thought processes. Both contact with the present and self as context act through creation of effective awareness to what is really hear and now. Committed actions and values act through creation of positive language processes that can be translated into favorable behavioral changes. On the other hand, the relationships amongst defusion and acceptance on one hand, and committed action and values on the other (The intersecting “X”
shaped 2 lines in the middle of figure 1) can be considered dialectical relationships which function to construct language processes to serve acceptance and behavioral changes. The other 10 relationships can be considered to be bilaterally facilitative. For instance, defusion helps the patient to make healthy contact with the present. Similarly, effective contact with the present promotes defusion and aids in provision of materials which may be required during the process of sharpening the awareness to what is really happening here and now.

ACT is all about balance of strategies, in which easily changeable aspects are the target for change, while when change is impossible, acceptance and mindfulness should be the main therapeutic strategies. In the behavioral modification aspect of ACT, the intervention therapeutic strategies vary markedly as it depends on both the individual and his/her psychological problem. These interventions include problem solving, psycho-education, building of skills, exposure, behavioral homework and all other forms of interventions which were developed in the first and second waves of behavioral therapies. The main ACT processes of acceptance, contact with the present moment, defusion, self as context, values and committed action are often utilized to service interventions used in the first order strategies of behavioral change.

Clinical Methods:

ACT is not just a specific treatment protocol or a countable list of therapeutic strategies. Even for the same psychological problem, a wide variety of ACT protocols can be implemented. An effective package of ACT therapeutic interventions usually comprise a group of techniques that are created in view of concepts of acceptance, establishment of a healthy sense of self, defusion, connecting with the present and formulation of committed actions that are in direct link to the individual’s values. ACT’s clinical methods emerge from cognitive behavioral therapy, traditional behavioral therapy, gestalt therapy and experiential therapy. Moreover, throughout the six main processes of ACT, some traditions that are outside the range of mental health interventions are sometimes effectively utilized. These include Zen Buddhism, mindfulness and human potential movement.

The clinical stages of ACT are directed towards helping the patient deviate from focusing on the disturbing content of certain psychological experiences and shift to a healthy understanding of the true context of these disturbing experiences. This is formulated to help the patient achieve his/her valued lifetime goals.
The ACT therapist clinical interventional methods are formulated to achieve the following:

1- To undermine the patient’s agenda of unworkable changes.
2- To prove to the patient that this unworkable agenda is the product of strategies of avoidance and emotional control.
3- To help the patient determine and alleviate cognitive fusion.
4- To help the patient develop a healthy sense of his/her self that is different from literal disbeliefs and programmed reactions.
5- To help the patient determine his/her valued life paths and goals and identify the necessary actions to achieve them.
6- To help the patient engage in actions, thoughts, memories and actions which are parts of the journey to his/her ultimate goals.

The most important clinical methods of ACT include:

A- Use of metaphors:

A considerable number of ACT strategies are intentionally metaphorical. Metaphorical language has some beneficial features that serve the purpose of ACT. Metaphors are neither prescriptive nor specific. Moreover, it is almost always difficult for patients to show pliancy to metaphors. Pliance requires the rule giver (usually the social community) to monitor the relationships between a rule and the associated behavior. Simply speaking, metaphors are forms of stories; hence, it is usually never clear whether compliance or resistance would be the result. The patient realizes this fact as well and is usually aware that there is no clear distinction between a “good” and a “bad” response to a certain metaphor. This form of obscurity supports the coercive strength of the therapeutic relationship and inhibits self-destructive patient responses that are chained to unsuccessful social relationships that may have occurred in the past.

Metaphors are not simple, linear or logical forms or verbal interaction. Instead, they can be thought of as pictures. The underlying message behind a metaphor is often hard to wind up using a simple verbal or moral conclusion. On the contrary, metaphors offer a living picture that illustrates how things truly function in a given life aspect. Carefully constructed metaphors can be used as a form of experiential exercise, as if one had really lived a certain situation which is presented through a certain metaphor. In the setting of ACT, metaphors act through provision of a verbal/social context throughout which reliance on rationality is examined and the wisdom acquired from directly experienced life situations is highly valued.

What is interesting about metaphors is that they are usually easily remembered; thus, they can be utilized in several settings apart from those specific settings during which they are learned. Accordingly, metaphors are quite useful when the therapist is aiming at wider horizons of behavioral
change. Metaphors can be used to correlate paradoxical and/or complex situations to common sense—e.g. they allow the patient to examine the possibility that a paradoxical or a complex situation could be as simple as ordinary life situation. In other words, carefully constructed metaphors aid in rendering some of the surprising stages of the ACT plan more plausible. Furthermore, metaphors can help patients connect with ACT interventional methods without the need to reach them in a linear literal context.

B- Therapeutic paradox:

Paradox is a pivotal component of the clinical interventional methods of ACT. The psychological disorders that represent language traps are inherently paradoxical; hence, determination of these traps can render inherent paradoxes more prominent. ACT utilizes some forms of logical paradox to break down the incriminated language processes which might have yielded these traps. Apart from therapeutic strategies that deploy paradoxical interventions, ACT never utilizes constructed paradoxes.

A logical paradox is just like that the kind of paradox that can be encountered during a philosophy class. When using a logical paradox, some contextual cues are presented for a single verbal relationship; however, when that relationship is formulated, it is transformed to a contextual clue that links to another contradictory relationship. ACT often focuses on logical paradox, particularly in the beginning, as it aids in breaking down of literal language; hence, permitting wide loosening emergent stimulus relationships and amelioration of rule governed behavioral patterns in situations where they don’t belong.

Constructed paradox is a form of paradox that centered on the social needs to follow rules which create a kind of social system that triggers either following the rule or resisting it. Whether the patient reacts through complying with the rule or resisting it is of no importance, as either ways, the outcome is favorable. This form of paradox is what clinicians refer to as “therapeutic paradox” and constructed paradox is most commonly used in a high percentage of paradox based interventions. For instance, a rebellious adolescent with problems with the police can be advised by his therapist to disobey the therapist. The idea behind this is that the teenager will either break the rule and hence, become less aggressive, or follow the rule and hence, become less aggressive. Constructed paradox is not commonly used in ACT as it can result in delay of the change agenda; however, they can sometimes be effective in imposing prominent behavioral changes.

Inherent paradox is widely utilized in ACT. Inherent paradox is the result of functional contradiction which arises between the functional and literal properties of a certain verbal event. Inherent paradox usually involves verbal construction patterns which are linked to events that are not mainly governed by verbal rules. “Trying hard to be spontaneous” is an excellent example of
inherent paradox. Being spontaneous is linked to contingency-structured behavior which is entirely different from rule-governed behavior. However, attempting to do something on purpose is a form of rule following. Thus, attempting to be spontaneous undermines spontaneity itself.

Inherent paradox is of pivotal importance in ACT. Experiencing inherent paradox repeatedly during therapy can help undermine the influence of literal language through stressing on the fact that although literal language can be useful in some contexts, it is usually useless in others. This is an important goal of ACT, because unhealthy fusion with literal events is considered the major precipitating factor for creation of ineffective change patterns.

ACT’s view of the disturbances that lead to psychological troubles is itself inherently paradoxical. ACT is based on the concept that attempts to change negative psychological content is a great consequence to that very content. Moreover, reluctance to change is the greatest and most essential change that should be made. This concept is a typical inherent paradox.

C- Experiential exercises:

ACT utilizes experiential exercises extensively to help the patient interact with annoying (and usually avoided) feelings, thoughts, memories and physical sensations. Deliberately exposing patients to feared situations during therapy has several important benefits. It allows the patient to experience depressing and frustrating feeling, thoughts or memories within a rather “safe” context. These exercises can alter the verbal relationships that yield escape or avoidance. Demolition of the system of rules that lead to avoidance of certain experiences is on the top list of goals of ACT and repeated experiential exposure substantially catalyzes this process.

Triggering hard experiences, during experiential exercises, presents the opportunity to observe and study the patient's interaction with these experiences. Experiential exercises which stress on flaws in the verbal processes of the human language are far more superior to discussion of these same flows directly with the patient. Just like paradox and metaphor are, experiential exercises function to endorse a verbal and/or social context that repeatedly asks, “What does the past experience tell the patient?”
Competency of an ACT therapist:

Similarly to the vast majority of treatment strategies, ACT relies not only on the pivotal role of therapist genuineness and warmth, but also on the value of compassion. This view is essential for the effectiveness of the ACT intervention.

The following outlines the basic competencies and skills of an ACT therapist as referred to by Steven Hayes, Kelly Wilson and Kirk Strosahl during training of a group ACT therapists (Strosahl et al., 2004).

- **Being compassionate**: The ACT therapist should put himself/herself in the same shoes as the patient and communicate with the patient from a true, equal and caring point of view. The therapist should express a humanizing and compassionate attitude towards the patient’s pains. The therapist shouldn’t engage in judgments, criticism and communicating from a one-up position. This is the most important skill and its importance has been highly emphasized. It should be cleared that the ACT interventions can be exercised using a controlling, dominating and one-up position attitude instead of an attitude that is caring, compassionate and emerges from an equal leveled position. For example, a therapist can occasionally slip into the mistake of exercising metaphors in an examining attitude to delineate whether or not the patient understood a certain metaphor. This usually leads to negative results because the patient feels that he/she is “looked down upon”. When the therapist senses resistance during therapy, it is mostly due to falling in this pitfall. ACT is not about substitution of the patient’s beliefs (e.g. that anxiety should be controlled) with another (Controlling anxiety is the problem that worsens everything). Instead, it is about connecting with the patient’s suffering through a human link between the therapist and the patient that facilitates initiation of fundamental change.

- **Utilizing therapeutic techniques using a flexible creative approach**: The therapist should design therapeutic interventions that accurately fit the patient’s language and life experiences. Therapists are not to utilize predesigned ACT interventions. The therapist should sequentially tailor a patient’s interventions in line with his/her experiences and needs. At any moment during therapy, the course of treatment can be readjusted according to any needs which may emerge. For example, experiential exercises, new metaphors and behavioral tasks should be derived from the patient’s own context and experience. This skill is all about flexibility in designing treatment options. Metaphors are stories that can train the patient not to take the mind literally. Metaphors should be tweaked, embellished and modified according to the patient’s response to them. Furthermore, patients usually comment on certain metaphors by diversifying and/or expanding them. This is a favorable sign that implies
that the patients are actively participating in the intervention. The task of a therapist is to consider such comments and spin them along the path the patient points out to the therapist. The changes a patient applies to metaphors often reflect his/her experiences and thus, are more important than any modifications that could ever be made by the therapist.

- **Modeling Willingness and Acceptance.** The therapist trains the patient to accept his/her experiences willingly to hold difficult and/or contradictory feelings, ideas, and memories without feeling the need to resolve them.

A considerable number of therapeutic strategies consider resolution of the patient’s internal conflict as a primary goal; this is not the case with ACT. It is totally natural for humans to experience multiple hard or contradictory emotions and/or thoughts. The natural human response most often seeks some form of resolution in these circumstances. From an ACT point of view, this is totally unnecessary. The ACT therapist must always remember that the primary focus of the intervention is to adopt willingness and openness to one’s experiences. This would require the therapist to let the patient experience hard and/or contradictory emotions and thoughts for what they really are, while antagonizing any temptation to resolve these conflicts. The different aspects of human experience are totally normal and shouldn’t be fixed, interrupted and/or resolved.

- **Focusing on the patient’s experiences.** The therapist should always refer issues back to what the patient’s experiences denote. The therapists should never attempt to substitute patient’s experience with his/her opinions of them. Opinions are just another form of verbal evaluative response that can hurdle experiential knowing. This is of high importance when it comes to creative hopelessness and helping the patient to realize the ineffective of his/her change agenda. The therapist should be aware that the aim of ACT is to enable the patient to fully contact the experience of his/her experience, unchanged, just as it is. The therapist should foster an attitude of psychological flexibility and abandon rule governed behavior while encouraging a more experientially guided behavior. Patients already have a huge number of opinions regarding their experiences and how they should respond to them. The therapist should not add to those any more opinions.

- **Cognitive Insight:** The therapist needn’t explain the underlying meaning of metaphors and/or paradoxes to establish insight. The therapist should always focus that the aim of using metaphor and paradox is loosening the rigid verbal regulation process of the patient’s behavior. Explanations are forms of verbal responses which can undermine the primary process of loosening the rigidity of verbal regulation. A therapist should enable the patient to relate his/her experiences differently through metaphor and paradox. There is no need to explain metaphors in details for this to happen. It is sufficient for the patient and the therapist to analyze the
patient’s responses to the metaphors and the message underlying them. After the patient realizes a certain point, a therapist can help him/her express what has been understood verbally. Insight, or the sense of perspective and distance, may yield as the patient discovers that his/her quality of life is beginning to improve when he/she stops to do what his/her mind tells him/her to do. Nevertheless, this insight is not always necessary for a meaningful change to occur.

- **Therapist’s self disclosure:** The therapist should be willing to self disclose personal experiences when they can illustrate specific therapeutic points. Judicious presentation of the therapist’s personal experience helps in conveying to the patient the idea that the therapist is a human being who suffers and thus, can struggle too. Moreover, the therapist can express experienced emotions and thoughts in response to what the patient does or says in a therapeutic session. Depending on the situation, it can be sometimes appropriate to point out the experience just as it is (for example, “I feel sad for what you have just said”). Such disclosure can promote establishment of a strong therapeutic relationship, while setting a good example of the importance of being open and honest regarding one’s experiences.

- **Pinpointing clinically related behavior:** ACT related processes should be recognized and, whenever appropriate, directly correlated in view of therapeutic relationships. No one argues that patients seek therapy because of issues they confront in their lives. It is easy for a therapist to be centered on problems a patient is having in his/her life while failing to detect clinically related behavioral patterns as they are uncovered during therapeutic sessions. During therapeutic sessions, a patient might do a clinically relevant response or action which should be recognized and encouraged by the therapist. This should also be applied to actions and processes that need to be influenced. This approach is also used in Functional Analytic psychotherapy (FAP) (Kohlenberg and Tsai, 2001) and it is not uncommon for ACT therapists to utilize FAP methods to center on clinically relevant behavior patterns which show up during the sessions. Evaluation, fusion, escape, avoidance and reasoning are examples of general processes that are can be encountered when working with patients with anxiety and/or depression. The best way to influence and alter these forms of clinically relevant behavior is to do so directly when they show up during the treatment session. This should be done without any judgment, blame or arguing.
The role of ACT in the management of self-destructive behavioral problems:

Recent studies and meta-analyses have spotlighted an astonishingly high prevalence rate of self-destructive behavioral problems. (Lundh, Karim and Quilisch, 2007). In spite of the fact that many researches have been conducted in the field of self harming behavioral patterns, self harming behavior has still no satisfying definition. The most widely accepted definition entails that self harming behavior is any intentional direct attempt to mutilate, destroy or alter parts of one’s body without having the intention of committing suicide.

Self harming behavior, or deliberate self-harm (DSH), is explained using the experiential avoidance model (EAM) in view of the ACT basic processes. Experiential avoidance is considered a form of functional response, i.e. it represents a range of behavioral patterns which are different in some aspects yet similar in others that they can yield similar reactions and/or outcomes. The EAM was based on an integrated protocol of research on DSH, different emotions and experiential avoidance. The model was established on research data which imply that the primary controller of DSH is negative reinforcement. In other words, emotional imbalance is a key factor in the development of DSH.

ACT was used in treatment of self-harming behavior in view of functional analysis of these behavioral patterns using the basic components of psychological flexibility. ACT is aimed to ameliorate experiential avoidance and enforce behavioral patterns that can invite the patient to paths that he/she would consider valuable and meaningful. As with any ACT based interventional program, proper management of self-harming behavior necessitates proper functional analysis of the patient’s behavior in certain contexts. Context is a group of behavioral patterns that can be recognized by one or more person, as well as the setting in which these behavioral patterns occur. The functional approach of ACT dictates that the therapist should focus on the function of specific behaviors, rather than their topography. The intervention is based on the hypothetical model which suggests that self harming behavior can lead to self destruction, when the behavioral function fail to build a vital value based life.

Proper functional analysis of self harming behavior should include precipitating factors, maintenance factors, triggering behavioral patterns and the specific context within which the negative behavior occurs. This analysis is essential to construct a successful treatment plan. A major determinant of the success of ACT in the achievement of positive behavioral change is creation of a healthy space where interaction between the therapist and the patient can successfully occur. The therapist sometimes responds to patient’s negative behavior with interest and acceptance in an attempt to break the cycle of destructive behavioral patterns; thus, creating an adequate space for learning new valuable experiences. The therapist should validate the psychological suffering of the patient and act as a convincing values’ advocate. The ultimate goal of
ACT in this aspect is to help the patient to fuse with natural contingencies that lead to a proper choice of valued behavioral patterns. Moreover, the therapist should train the patient to set himself/herself from slavery to aversive stimuli. Throughout treatment sessions, the therapist shouldn’t get involved in any discussions regarding being good or bad, right or wrong. This functional strategy should be established so that it would smoothly flow throughout the interventional plan. Whenever applicable, all the patient’s responses during the ACT interventional plan

For example, if an individual is referred to an ACT therapist for cutting behavior, the therapist shouldn’t exhibit any interest in the cutting behavior. Alternatively, the therapist should show deep interest in what the patient wants by this behavior, what the patient is afraid of and how the therapist can help to ease the patient’s life. In this situation, it is almost useless to tell the patient to stop cutting himself/herself as definitely, many have told him/her to stop doing so and still he/she failed to develop a positive favorable change. ACT should be centered on creation of a fresh start which is based on connecting with the present”, reinforcing valued behavior and endorsing psychological flexibility.

The role of ACT in the management of anxiety disorders and depression:

Psychiatrists generally believe that the process of emotion regulation is considered an adaptive process that can, under certain circumstances, lead to unfavorable outcomes. For example, an individual who suffers from anxiety disorder can worsen his condition, if he/she either lacks the right emotional regulation skills, or condition himself/herself to acquire counterproductive compensatory emotional techniques such as escape, avoidance, inhibition and suppression (Gross, 2002). Similarly, from an ACT perspective, the process of emotional regulation can impose a negative psychological impact.

Generally speaking, attempting to regulate one’s emotion can yield negative consequences, both psychologically and experientially, when the context of the situation doesn’t require it, or when the process itself is unworkable. Individuals suffering from anxiety often bear the feeling that “they shouldn’t be feeling or thinking the way they do”. This leads to lack of action, because the patient thinks that he/she should feel and think differently to take certain action. Throughout this process, anxious individuals may spend their lives focusing on how to regulate their fear and anxiety, rather than taking action and doing what they should be doing. That’s why a patient suffering from an anxiety disorders often expresses a form of experience phobia. This pivotal conclusion applies to individuals with anxiety, fear as well as other negative psychological states such as depression.
From an ACT point of view, pathological anxiety is present when an individual:
- Doesn’t accept the fact that he/she is liable to experience certain unpleasant thoughts, emotions, physical sensations and/or memories.
- Is reluctant to be interact with the aforementioned thoughts, emotions, physical sensations and/or memories as they really are.
- Take intentional actions to decrease the intensity and frequency of situations that are expected to precipitate those experiences.
- Insist to react as previously mentioned even though it imposes negative influence on one’s life (Hayes et al., 1996).

The aforementioned behavioral patterns and the verbal cognitive processes which are guiding their control are pivotal when understanding the underlying factors that trigger and control anxiety disorders in an ACT treatment approach. Normally, any human being can experience some form of anxiety. However, anxiety becomes pathological when an individual denies its existence, when one refuses to experience it, when actions are planned to avoid its occurrence and when such actions undermine one’s life and hurdle the path to his/her valued goals.

ACT intervention in anxiety disorders focuses on undermining the patient’s need for excessively unnecessary emotional regulation. The path is guided by convincing the patient that “controlling emotions is not the solution; it is the problem itself”. ACT should promote willingness, experiential flexibility and openness to live all sorts of human experiences, rather than evaluating them as pleasant and unpleasant ones. This is Acceptance attitude sets the anxious patient free and invites him/her to take action to improve their lives in view of their precious values. When the patient learns to embrace every emotional experience, the self need to regulate emotions eventually, in most cases, becomes nonsensical.

Although ACT leads to alleviation of symptoms of patients with anxiety disorders, it is not the main therapeutic target for this form of therapeutic intervention. Alternatively, the main aim of ACT in anxiety disorders is what we refer to as “broadband outcomes”. Broadband outcomes are centered on helping the patient to move on with his life in directions which they genuinely value and care about.

For example, a mother who has well established deep and valuable relationship with her son may let her efforts to control her anxiety get in the way of such special connection. In this situation, the focus of ACT would be to remove hurdles that prevent her from having a normal relationship with her son, especially excessive emotional regulation strategies. Throughout ACT intervention, reduction of anxiety may occur, although it is not the primary goal of the intervention. When treating anxiety, ACT is much about promotion of the development of a fully functioning individual who is able to live in
consistency with his/her meaningful goals and values. Creation and maintenance of commitments which are guided by one’s values and goals is an indispensable part of ACT’s therapeutic approach to anxiety disorders. A valued life highly dignifies the therapeutic approach and renders the efforts spent in therapy worthwhile.

The ACT treatment program, proposed by Hayes in 2004, for treatment of anxiety disorders consisted of 12 therapeutic sessions each lasting about one hour. Both the number of sessions and the duration of each session are flexible i.e. with some patients, the ACT therapist can move a little faster, while with other patients more time and sessions are needed to achieve the delineated therapeutic goals. The therapist should be careful not to move rapidly through the treatment scheme. Here is an outline of the 12 sessions:

**Session 1** is focused on helping the patient to generally understand the nature, origins and purpose of his/her anxiety. The therapist should also stress on explaining to the patient what can worsen their anxiety. Moreover, the ACT therapist should start introducing the patient to the experiential, participatory and active nature of the ACT treatment plan and its idea of living a valuable and meaningful life rather than focusing on emotional regulation and reduction of anxiety.

**Sessions 2 and 3** are designed to evaluate and analyze the strategies which had been used by the patient to cope with his/her anxiety. The goal of this stage is to undermine the patient’s anxiety control strategy and pillar an ACT guided treatment motivation by highlighting:

- The futility and obvious ineffectiveness of the past emotion control efforts and avoidance behavioral patterns.
- That willingness of the patient to take action towards his/her anxiety is the key to solving the problems and starting positive life changes.
- The power of value guided behavior as an effective tool in the management of anxiety.

**Sessions 4 and 5** should focus on mindfulness and acceptance as means of learning to view undesirable anxiety related reactions exactly as they are. The primary goal of this stage is to introduce the patient to a variety of reactive responses when exposed to anxiety. In other words, the ACT therapist should promote the concept of psychological flexibility in an attempt to broaden the patient’s narrow list of responses such as suppression, escape and avoidance. The patient should discriminate between what they can control and what they can’t control within their lives. These sessions steadily add blocks to the concept of a valued life as a healthy alternative to the patient’s previous unhealthy anxiety control strategies. This alternative is formulated to help the patient focus on issues that really matter in his/her life through choosing the most valued directions to his/her ultimate goals of life and to help recognize potential barriers. Collectively, sessions 1 to 5 are formulated to build an
acceptance oriented context which furnishes the path for the remaining therapeutic sessions which will aid in training the patient to move out of the tight circle of mindful observation to the wide horizons of engaging in committed actions that are driven by values derived from the patient’s own environment.

*Sessions 6 and 7* present the patient to experiential exposure exercises, value oriented actions, defusion and establishing commitment to advance in valued directions that lead to the goals of life. The idea of these exposure exercises is to allow the patient to experience mindful observation, cognitive defusion and acceptance with coexistence of anxiety induced response patterns. The cognitive defusion elements in the therapeutic sessions shouldn’t discuss the validity and/or the details of the patient’s negative evaluation of himself/herself. In other words, experiential exposure exercises should be prioritized to train the patient to respond to the experience rather than evaluating it in terms of thoughts and emotions. During this stage, reduction of anxiety is not a pre-designed goal, yet it can be a product of effective experiential exercise sessions.

*Sessions 8 through 12* are focused on training the patient to start moving through the designed path by committing to action. During this stage, behavioral activation is utilized to help the patient start doing what he/she has a heart for, with emphasis on keeping honest commitments which are guided by one’s meaningful and rich values. The patient is taught to overcome any barriers by valued actions.

**Anti-anxiety medications in conjunction with ACT:**

Researches haven’t detected any contraindication for the use of medications in conjunction with ACT in the treatment of anxiety disorders; however, the history of previously and presently used medications should be investigated in detail early during the therapeutic intervention. For example, in view of adoption of creative hopelessness, a therapist needs to carefully investigate the reason why the patient is using anxiolytic pharmaceutical agents. Is the patient taking such medications so as not to live the experience of anxiety? If this is the case, this should be addressed by the therapist in a context of experiential mindfulness and acceptance related actions. A patient who routinely resorts to taking benzodiazepines for his/her panic attacks and/or anxiety is likely to do so when he/she becomes willing to live the experience of anxiety for what it is really, not what he/she says it is.

In some conditions, using anxiolytic drugs can interfere with the ACT therapeutic interventions. Anti-anxiety drugs can decrease the intensity, frequency and duration of the difficult content which associates anxiety
disorders. This is exactly the outcome a patient is looking for "My emotion regulation strategies are effective at last". This is rather problematic from an ACT point of view, because it conveys the message that controlling one's internal world is possible if he/she tries hard enough. This is entirely wrong as concluded in many studies. ACT is entirely centered on fusing with problematic hard content without defense. Because anti-anxiety drugs can prevent the patient from establishing full contact with problematic content, this can undermine the efficacy of the ACT intervention. A patient can never make full contact with certain content, as long as the pharmaceutical agents are changing the properties of that content. That’s why relapses often occur when the anti-anxiety drugs are discontinued.

Presently, there is no firm protocol for the use of anti-anxiety medications in conjunction with ACT for the treatment of anxiety related disorders and panic attacks. However, significant evidence suggests that ACT is more useful in helping the patients cope with their problems, rather than taking a pill to “turn off” the patient’s symptoms.

The role of ACT in the control of symptoms of psychotic patients:

Approximately 4% of patients with schizophrenia, who were initially fully controlled by medications, fail to remain so mostly due to re-emergence of delusions and/or auditory hallucinations (Breier, Schreiber, Dyer, & Pickar, 1991). These symptoms are the most common cause of rehospitalization in patients who are considered seriously mentally ill (SMI). Psychosocial interventional strategies are often utilized to help those patients cope with the residual symptoms.

The firstly used psychosocial programs were designed to teach the patients effective methods to alleviate the intensity, frequency or believability of auditory hallucinations and delusions. Those therapeutic methods included verbal challenges, experiential testing, reduction of perception and expression of symptoms, focusing and distraction as well as a variety of other therapeutic strategies.

The potential role of ACT has been derived from the recognition of the role of suppression and avoidance on the exacerbation of psychotic symptoms. (Morrison, 1994; Morrison, Haddock, & Tarrier, 1995) have suggested that active coping strategies which are based on suppression can increase the severity and frequency of anxiety, intrusive thoughts, auditory hallucinations and autonomic arousal in patients with schizophrenia, especially the seriously mentally ill. Furthermore, following research data supported the fact that patients who cope by developing distraction based strategies are less likely to tolerate auditory hallucinations. In an ACT perspective, avoidance and suppression maybe the key factor to understanding the reason why delusions
are attributed to external uncontrollable factors. Suppression and avoidance might be the cause of what is refereed to as “introspective alienation” which is relatively common in SMI patients. Accordingly, ACT can have a potent effect on the negative behavioral influence and believability of delusions and hallucinations without the risk of worsening cognitive entanglement or paradoxically affecting thought suppression.

In 2002, Hayes conducted a randomized control trial to investigate the use of ACT to decrease the incidence of rehospitalization in patients with schizophrenia. Patients who participated in the thesis received four 45-50 minutes ACT sessions. The sessions were individual ones that were conducted by psychology interns who were considered by the author as competent ACT therapists:

- **The 1st session** started within 72 hours of the patient’s approval to participate and was mainly centered on simple explanation of the ACT approach. Throughout this session, the ACT therapist focused on the patient’s previously developed strategies to cope with positive psychotic symptoms and the attitude of noticing perceptions and thoughts instead of reacting towards them. The “take your mind for a walk” exercise illustrates an example of the main aim of this session. The ACT therapist acts as the mind of the patient who would go for a walk. The therapist should walk behind the patient verbalizing a continuous commentary on the items and events they meet describing, instructing, evaluating, analyzing, recommending actions and predicting events. Throughout the exercise, the patient is instructed to only notice what his/her brain says, without trying to interact with it and to choose how he/she should behave without paying attention to what the mind says. This form of cognitive defusion practice allows the patient to connect with the true nature of thoughts and to act without focusing on the literal aspect of these thoughts.

- **The 2nd session** started within 72 hours after successful completion of the first session. The session was centered on teaching the patient how to accept his/her symptoms, although he/she might not like them. The polygraph metaphor is an example of the exercises held through this session. This test is used to delineate the uselessness of attempts to control one’s emotions, thoughts and/or physical sensations. The patient is instructed to imagine that they are connected to a polygraph device that can spot any anxiety. Then, the patient is instructed to imagine that he/she would be harmed if he/she developed anxiety; however, the device would detect if he/she becomes anxious. The main aim of this exercise is to allow the patient to experience that attempting to control anxiety usually leads to more anxiety.

- **The 3rd session** started within 3-5 days after successful completion of the 2nd session. This session was focused on establishing valued goals and selecting the context within which the responses to the patient’s
symptoms would be less or more workable. In such circumstances, the ACT therapist can ask the patient to select coping strategies, which were utilized in the past, and analyze how using them can interfere with the ultimate goals. For instance, some patients cope by yelling at the heard voices, while others resort to the use of certain illicit drugs; however, using such strategies can hurdle the ultimate goal of maintaining an independent housing environment. The patients are guided to select coping strategies which wouldn’t come in the way of their valued goals.

- The fourth session was held 72 hours after discharge of the patient from the inpatient care unit. In most conditions, the last session was held just before the patient is discharged; however, occasionally, when the period of hospitalization is short, the fourth session was held during the initial 72 hour period following discharge. Throughout this session, all the concepts and ideas which were discussed during the past sessions were summarized.

Research data revealed that ACT therapy was effective in reducing the need of hospitalization of a group of psychotic patients suffering from positive symptoms of psychosis (auditory hallucinations and delusions) by 50% along a period of 4 months. The decreased rate of hospitalization of patients who received ACT was attributed to the patients’ heightened acceptance of their symptoms. The pattern of results that were produced in Hayes’s study had been previously shown in acceptance literature. (Teasdale, 1997; Zettle and Hayes, 1987). The decreased rate of hospitalization of those patients was due to acceptance of symptoms rather than decreased incidence of their occurrence.

The role of ACT in the management of organic diseases:

The ACT therapeutic model is now implemented to control, or rather alleviate, certain physical symptoms such as seizures and pain. From an ACT point of view, allowing symptoms to control an individual is both pathological and logical to some extent. It is now widely agreeable that pleasant emotions, health states and cognitions promote good behavior, while unpleasant emotions, health states and cognitions promote bad behavior.

Some medical disorders which can result in chronic pain and/or seizures readily fit into the perspective of experiential avoidance emphasized by ACT. Due to certain properties of our language, we always try to shift away from thoughts of an unpleasant event such as seizures or pain, very much as if we attempt to shift away from the unpleasant event itself. Moreover, whenever pain and seizures accompany events such as demands, stresses, social situations and work activities, all of these events will be avoided in thoughts as well as real
life actions. Generally speaking, all of the actions that are to be used to control these symptoms would also be “intoxicated” by these aversive symptoms.

From an ACT point of view, the path to psychological comfort in patients suffering from chronic pain involves directing patients towards living a life that is filled with more values while identification of their attempts to experiential avoidance. When utilizing ACT in control of chronic pain, less focus is directed towards reduction of the pain and greater focus is directed towards improving the patient’s ability to effectively embrace more valued life patterns. A considerable number of studies have proven that experiential avoidance is a major determinant of chronic pain. The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) was modified to be used with patients with chronic pain. This has shown two primary aspects of the concept of acceptance of pain; willingness to feel the pain and engaging in valued life events despite the presence of pain. Acceptance of painful conditions is usually associated with reports of lessened pain intensity, less depression, less pain induced avoidance and anxiety, less psychosocial and physical disability and better work performance.

Several studies have proven the efficacy of ACT in yielding better behavioral tolerance of pain and discomfort. Hayes et al. (1999) proved that a 90 minute ACT training session produces better behavioral tolerance to pain and discomfort as compared to pain control attempts using distraction as in behavioral therapy pain management strategies. The same results were obtained by Gutierrez, Luciano, Rodriguez and Fink (2004). These researchers concluded that an ACT based acceptance and defusion intervention yielded a higher increase in the tolerance to pain as compared to cognitive based interventions, especially in patients with more severe degrees of pain.

More recently, an ACT interventional protocol that incorporated a behavioral approach was utilized in the treatment of a group of patients with refractory epilepsy in South Africa (Lundgren, Dahl, Melin and Kies, 2006). During the 1 year follow up period, all patients who were subjected to ACT interventional sessions were seizure free, while only 2 of the control group were seizure free. Collectively, ACT interventional sessions yielded approximately a 90% decline in the rate of seizures at some point during the 1 year follow up period. The quality of life of patients who received ACT was markedly improved as regards physical health, psychological health, intimacy of social relationships and environmental health.
Conclusion:

Acceptance and Commitment therapy is considered one of the most recent behavioral therapy plans that are based on mindfulness. ACT has been proven to be effective in the treatment of a wide variety of psychological and medical conditions. ACT is based on the simple fact that some of the human psychological processes are destructive and can lead to suffering. Controlling symptoms is not the target of ACT because attempts to control symptoms are often ineffective and lead to psychological troubles. The ultimate goal of ACT is to enable the patient to live a rich meaningful life while learning to accept the pain that is invariably a part of life itself. ACT is all about taking effective actions which are guided by one’s richest values. Mindful actions are the sole way to establishment of a meaningful life. Attempting to establish such a life is usually hurdled by many barriers that are in the form of undesirable and unpleasant private experiences (thoughts, emotions, physical sensation, memories and urges). ACT teaches individuals some mindfulness skills that are effective in handling such private experiences.

ACT is used in the management of a wide range of behavioral and psychological problems. ACT has been successfully used in the management of patients with self destructive behavior. ACT is primarily used as a therapeutic approach in patients with anxiety related disorders. Recent reports have also reported the effectiveness of ACT in the control of positive symptoms of psychotic patients (auditory hallucinations and delusions). On the other hand, few reports have proven that ACT may be even valuable in the treatment of some organic medical disorders such as epilepsy and chronic pain disorders.

ACT therapeutic interventions are advancing at a rather accelerating rate and the yielded therapeutic developments are highly bound to the advancements in basic and conceptual acceptance research (Hayes, 2004). This protects against some forms of fragile psychotherapeutic trends that can attract followers without producing favorable noticeable outcomes.

ACT is a form of behavioral therapy. Despite the fact that ACT utilizes some techniques that are used in some Eastern and Western schools of psychotherapy, ACT is strongly pillared to psychology at practical and conceptual levels. From a conceptual point of view, ACT is derived from new developments in the behavioral analysis of verbal processes. From a practical point of view, ACT focuses on value guided behavioral change and value guided actions which are the basics of good behavioral therapy interventions. General optimism is now felt towards the effectiveness and strengths of ACT which will serve as basic foundations for future growth and advancement of ACT at a rapid rate.
Recommendations:

Extensive research need to be conducted to prove whether or not ACT is an evidence based line of treatment for different psychological problems, namely anxiety. Moreover, the effectiveness of ACT as compared to other cognitive behavioral intervention programs should be investigated in details. Researches have to be conducted to investigate the efficacy of ACT alone as compared to ACT plus anti-anxiety drugs as treatment plans for patients with anxiety disorders and/or panic attacks.
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“The Role of Acceptance and Commitment Therapy in the Management of Behavior Maladjustment, Anxiety and Other Psychological and Organic Disorders”

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The purpose of the following Evaluation of Learning questions is to:
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ANSWER THE 20 EVALUATION OF LEARNING QUESTIONS – TRUE/ FALSE.

T F 1. I have read all of the required reading material for this course.

T F 2. Acceptance and Commitment therapy (ACT) is a unique psychological therapeutic approach that aims at amelioration of psychological suffering.

T F 3. ACT is a model that is based on the assumption that most maladaptive behavioral patterns are caused by faulty attempts to suppress or avoid thoughts, emotions and/or sensations.

T F 4. ACT strategies have not yet been researched but are promising.

T F 5. Current evidence does not yet support the effective role of ACT in the management of behavioral maladjustment and anxiety disorders.

T F 6. ACT is based on the fact that rapid changes in an individual’s behavior normally occur.

T F 7. Pliance is a form of rule governed behavior and refers to following a specific verbal rule which is linked to some previous social consequences that design the relationship between the verbal rule and the individual’s resultant behavior.

T F 8. A considerable number of researchers have concluded that whenever behavioral patterns are regulated by verbal rules, they become somehow insensitive to influence, that maybe imposed in the environment, which is not described by those rules.

T F 9. Acceptance means “liking everything that has happened”.

T F 10. Self as context is a main process in ACT which entails that an individual who is excessively fused with his/her conceptualized self has a threatened psychological flexibility.

CONTINUED →
“The Role of Acceptance and Commitment Therapy in the Management of Behavior Maladjustment, Anxiety and Other Psychological and Organic Disorders”

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(CONTINUED)

T  F 11.  Contact with the present moment is only a small part of ACT.

T  F 12.  Values are defined in view of ACT as selected qualities that relate to a purposive action.

T  F 13.  Committed action is another important process that is often the result of recognition of faulty psychological processes and barriers that lead to avoidance and fusion.

T  F 14.  The clinical stages of ACT are directed towards helping the patient deviate from focusing on the disturbing content of certain psychological experiences and shift to a healthy understanding of the true context of these disturbing experiences.

T  F 15.  ACT does not use metaphor, instead preferring only clear communications with no ambiguity.

T  F 16.  Paradox is a pivotal component of the clinical interventional methods of ACT.

T  F 17.  ACT is based on the concept that attempts to change negative psychological content is a great consequence to that very content.

T  F 18.  ACT intervention in anxiety disorders focuses on undermining the patient’s need for excessively unnecessary emotional regulation.

T  F 19.  Acceptance and Commitment therapy is considered one of the most recent behavioral therapy plans that are based on mindfulness.

T  F 20.  ACT is a form of behavioral therapy.
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