Hello and welcome to Acceptance and Commitment Therapy (ACT) for chronic pain presented by Dr. Kathleen McChesney, the session is being recorded, if it is not already done so, please mute your microphone until the Q&A portion of the Workshop. We have posted assignment sheet and questions, that must be completed and returned to receive CNE CME, located in the files pod, please remember to download sign, and return sheet no later than September 9. If you look in the chat pod, you will see the emails. You can see the sign in sheet too.

In addition, screenshots will be taken throughout the session to your attendance in this workshop we will enable everybody, during the Q&A please place your questions in the chat pod, you will receive email evaluation, your answers are invaluable to the future of the Pain Care Skills Training, in addition to that survey you will receive CME, within the website, the survey from our program and from CME, these are two completely different items. For CME and CNE, we could take anywhere to 3 to 4 weeks to receive credit, you will receive an email to the system to complete the survey you will need to complete the survey in order to retrieve your certificate, please make sure you do this. If for any reason you have trouble viewing the slide presentation please exit out and come back in, we have found all of this is some of the problems, worst case, you can download the presentation from the files pod on the and follow along on your computer. If case persists, you can download and print from the files pod. Now I would like to turn it over to Dr. Kathleen McChesney.

Thank you Linda. I will extend my thanks to you and the team behind the curtain and the city of Oz thank you so much, for all your technical support and thank you everybody for your willingness to dial in I will make this as entertaining as possible. We live in an interesting world so virtually I will do as much of a tap dance to keep you all entertained as much as I can, thank you again, I have to go through initial slide. Linda whenever you're ready to put those slides up, I will start out with disclosures and disclaimers.

Next slide please.

Okay this certifies that I Kathleen McChesney have not nor do I have a spouse or partner any immediate family member who has in the past 12 months expected to have any upcoming relationship financial gift in kind with the industry or subject matter relevant to this presentation.

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Okay so the views expressed in this reflect myself, and do not reflect the policy of the Army, Navy, Air Force, the Department of the Defense or the US government. The goals for today, ideally this is a wonderful kind of historical foundation of what acceptance and commitment therapy is, ideally I hope you will come away with learning the philosophy and scientistic origins, and to understand the theories of how acceptance and commitment therapy understands diagnostic problems in living, and pathology. Also, how can we intervene using commitment methods towards behavioral change. The second half of the lecture I want to practice using the model, many people who are not familiar are often a bit

overwhelmed or taken back by the experimental exercises, I hope we can review some of these exercises and understand how we can better use them to bring about better change in the chronic pain population. Just a little bit a tidbit if you are familiar with the community perhaps you have heard this already, the founders of ACT, Steven Hayes and his colleagues, have actually made an emphasis that we call it ACT. For those of you unfamiliar you may call it ACT, not to use the acronym because it is so closely sounding like ECT -- We are not affiliated. If you are part of the community and would like to use it appropriately, please use the word ACT it's a way to use your familiarity. The print is a little small. If you are familiar with except Vince days intervention you may recognize we draw a distinction between physical aspects of pain in the mental and psychological and emotional aspects of pain, and we try to clarify with patients, some things may have been a part of your biological and physical experience, and yet how you choose to relate to that can influence your emotional suffering, and the help decrease your emotional suffering, I find this quite valuable.

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Talking about the philosophy, the origins of the background series of where it came from.

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So, ACT is considered a unique form of cognitive behavioral therapy, in many circles it is called a member of the third wave of cognitive behavioral therapy, it is a foundation that Sam's, stemming from contextual [Indiscernible - low volume] also a postmodern approach, and philosophy speaking, in environmental and chronological in context are taken into consideration. In order for it to be adopted within the scientific community, there was a need for us to figure out how we can Sure and conceptualizing, why we believe it is effective, this that is used in clinical trial is based on RFT, for those of you that have gone on to the website, I will get on that down the road, you may see there is EPT, RST, just so that you understand the acronym, it was one of the best methods to have that we can test our series applicable to the patient population from these new series pathology and how we can affluence, and how these all have been involved. The important thing to note there have been over 125 randomized clinical trials studying whether or not practices of acceptance and commitment therapy are effective. You can look that up if necessary. Essentially what we have found, it has been trialed for patients who suffer from depression. Dysphoria, and low self-esteem, anxiety, of different flavors if you will, psychosis, inpatient and outpatient. Substance use and smoking sensations, tested on eating pathologies weight loss, bariatric surgery patients as well as physical activations. Borderline personality disorder has been in clinical trials as well as occupational stress and burnout. More importantly I will focus on the evidence that focuses on the use of chronic pain. In addition to the medical conditions there has been studies on epilepsy, diabetes, tentative, and the list goes on. One of the things that is very important to note, it has proven to be as good as or better, then treatment of usual. They have the outcomes of the randomized clinical trials using ACT, rates as strong in efficacy.

Also ranked as being modest in efficacy for treatments of depression, obsessive compulsive disorder, just so you have an idea of the fact it does have some good grounding and consider an appropriate care.

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Basically, a pyramid of to organize the foundation of how ACT can be called the third wave, the bear at the bottom, radical behavioral is, that is all the rage. Based on recognizing that certain behaviors can be reported, rewarded, punished, reshaped, altered based on certain reinforcements and principles, those classical and operational I should say have been involved in foundation, as Tom many of us [Indiscernible - low volume].

How I think as a mediating thing to influence what I do, this is called cognitive behavioral is him, also shaping and altering and changing action or behavior. From there Steven Hayes actually at the time at the University of Nevada in Reno, was interested in the power of language. And what makes the human brain unique, the incredible power of how we form network of relations through the use of language, that can alter behavior mood, patterns of living, even if there is not any logic to it, contextualism, the frame theory from there, we have clinically how are we looking at the relational frame of how someone is thinking? We're looking at how this person behaves, how they function, how their behaviors serve them within the context of that in which they are living.

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You may want to consider that pyramid if you have a chance or printed out the actual slides, and I want to spend some time here on contextualism, based on pragmatism. Workability in other words, like I mentioned before, this is the key factor of ACT, what is the function of the behavior that the patient is doing? What is the patient serving with? How is observing the patient? This is a different direction from cognitive behavioral therapy, some may argue, that we are trying to alter one's understanding. To reach an ultimate shared truth. That is not is what is focused care, what we are driven, and how these behaviors are serving with the patient believes to be his or her truth within that context.

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Once again, what I would like from each of you to notice in the series, it is small on your slide, hopefully you can recognize in the dead center, this is the individual that we might be working with clinically, and this ball is actually a fear here moving in time, in a spear

This sphere multiple contexts as you can see, this person unlike the history of biomedical treatment, this individual is being seen as somewhat who has spiritual aspects. Mental cognitive aspects and physical. They are all interacting together, within the context, for many of you that have had experience working with patients we are very aware of how they behave in a clinic, and what we might observe them doing, the context of key here, how are they functioning in the home environment

around their circle of family, and the greater environment how are they functioning compared to their home environment, how are they relating to others in the world, these are key concepts I want you to think about, when you are thinking about the person as a sphere moving in time and responding to whatever it makes contact with as it bounces around in space. Psychological events are the interaction between this entire organism in the context in which it lives. It also includes history. As well as the perceived future as it is moving through space.

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What does this mean for us in terms of the patient? This is where Steven Hayes comes up with relational framed theory, it is empirically based psychological theory that describes the functional human language and cognition in that moving context. It is offering up a concrete approach and conducting the research that has enabled the credibility that was received through the APA. Essentially clinical knowledge can be obtained about contingency shaped behavior. In other words, as providers throughout the interaction and initial conversation with the patient in the room we can learn about how events in their history have rewarded or punished certain efforts to change, adapt or respond to their pain.

We can also find through the patient self-report, their thinking patterns. Whether or not the thinking patterns are actually influencing in a positive way, how they are moving, or actually disabling the person from living a rich and meaningful life.

Very Zygmunt, and a singular action.

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I want to introduce regarding the theory be time as you are thinking about -- As you are thinking about making a plan.

The building block of language, for any of us who have studied physiology of what happened when the patient experiences something painful, we are aware of multiple networks that fire off, doesn't just go to the cortex, it hit the amygdala, the thalamus, the visual center and our cortex and nine areas where pain is processed in the bay of the brain, very short period of time. To help the patient decide how to respond. That involves thinking. Thinking involves language, hence the bullet point number one, the building block of language, how the brain is relating perceived and interpreted events that are happening in the context and on the body. Number two Mac, language. -- Number two language. They help with her relationships are strong or rigged, if either of these happen. Language specifies the strength of length from one mental representation to another. In other words, if I put my hand on the stove it will burn. Therefore, if I do not want that have noxious experience, I won't put my hand on the stove, that is a relational frame. We've actually developed a number of different unique varieties of relational frames that can help folks adapt to their world and also hinder and cause greater disability. Some types of mental relations good experience versus bad experience, they are actually fostered sometime through no logic at all. That is clinical relevance. I want to give an example of that. I will grab right

here. I will grab a piece of paper, and I do this with my patients in groups all the time. What is this? If you have a piece paper and would like to take notes in front of the take a moment describe what this is. You may have come up with the number of things. That is absolutely fine. There is no wrong answer here. What we have learned in the matter of a few seconds. Alter your perceptions based on my actions. If you put the word trash or waste, take a moment and think about that phrase, and whether or not it falls on the spectrum of positive, emotional or negative emotional a valence, if I say that word trash, what can you come up within your network? It may be dirty.

Okay you may have put down another word associated with trash, like waste, dirty, unusable, finished. Done.

Those words also have meaning, and they also connect to an emotional valance.

Maybe you heard something like recyclable, it's not like that, what other words? Trees, reusable? Interesting enough those have balance in a more positive direction, this clinic of relevance and how people are describing their experience and impact of how they print leaves something is absolutely affecting their mood and their relationship to the pain and so forth. Interestingly enough, there is no wrong answer, you saw me do the same thing with paper. What we really try to foster is an understanding that we can describe it exactly as it is with as little emotional valance as possible, we are not trying to Pollyanna this saying it is a respectable, I could turn it into a basketball make origami out of it, were not trying to Pollyanna this. But to describe as they are moment by moment. A very mindful effort, in so doing, we can take extreme emotional endpoints, neutralize them or dial them down and away that is actually the most accurate way. You haven't seen what I decided to do with this piece of paper. To call it trash, implies what I should do with it. Before I have even done it. That is a good example of how relationship frame series, and the theory in particular, functions of one network, can alter the functions of this person's behavior, even if it makes no logical sense.

Okay relations are arbitrarily extrapolated and apply to events that might not necessarily be related.

Okay. Another example of how our emotional frame can influence our patient behavior. When we are working with the patient that who sees something they may say to you I motivated to get better, I want to make this change, really want to do this. Historically we have learned perhaps in the recent history, there with complaints of pain, and the treatment they want to receive did not result in positive outcome, and they might be coming to us resentful and angry because of prior treatment, that absolutely created frame to which the patient is wanting to trust you. That relational frame has power, we are able to identify that schema if you will, or that thought. That providers in the past have not helped me, then it will relate to a new scheme of things, where the person is a provider, in the past I haven't had help, the probability is high here. Not based on reality, not based on true experience, that

disconnect is almost a problem when we are trying to advocate for patients. I realize I'm babbling on that. Going on to another slide.

Here we are different categories of relational frames, I can break it down more specifically. One type of relational frame is called coordination, it is appropriate for those of you skilled with cognitive behavioral therapy, these are very similar to schemas or core beliefs. The difference, when we identify these relationship frames, not only do they have emotional valence, but we see they are directly related to how we can further come jumping to conclusions, removing us from reality. It takes us away from the present moment. Which is key for healing, coordination here. It is another way of saying the sameness, or fashion signs, I know that stars go with stripes. I know that red goes with white, it doesn't necessarily go with sharp truth, that is the emotional framework we developed.

And group distinction versus outgroup, you are with us or against us. That is another very popular if you will relation frame. Third, oppositional really opposing, this is against me as well. Comparison, this person is stronger, leaner, skinnier than I am. Number five. Here is a really big one particularly for those in the cognitive realm, if I move it hurts, so I am not going to move in order for it not to hurt. Those statements are very strong contingency frames, that can impact whether the patient will move, recovers, that type of thing, and then lastly, we have hierarchy. We definitely have that in the military right? How we relate, and how I relate to the captain, or the civilian [Indiscernible - low volume], and how we can behave behavior and the context what history has shown in the past.

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At some conclusions about relational frame theory, they are a central organizing principle of the experience and they are learned. Psychotherapy engages with and alters the function of that frame. We are not trying to erase it. Or change it. We are just trying to alter the function of how that serves the patient based on her perspective, number two Mac, problems in living is due to poor managed or poor developed relationship frames. In the cognitive behavioral sense, if I was hurt once by a provider, a poorly managed relational frame would be, as every provider hurts me, can you see the logic in that? Frames tend to dominate over behavioral regulation. Here is an interesting thing that will show up in our practice later on. Sometimes the and I managed with the relational frame comparable have behavior, through that experience we can have it thought of, take a moment right now ask yourself, have you ever had a god-awful profane thought? A terrible thought? You didn't vocalize it? You nodded and smiled. You carried about your business. Right. That right there, is an example of a healthy behavioral response, a flexible behavioral response is you are not automatically or impulsively blurting out the thought as if it was actually true, we help patients make that distinction, you can have a thought, not necessarily buy into it or respond to it. Number format people struggle between direct and verbal established functions or frames. I just described this problem. Sometimes patients have a really hard time with a password or an opinion, recognizing the difference between that, as networked, connecting versus

what their true experience is, and they're capable village he can show them, lastly this pulls people from the present and reduce our sensitivity to real life outcome from actual experience, for those who are clinically skilled, you may want to recognize one way is clinical depression, from anxiety and stress based thinking, based on the concept of time. If the patient is acknowledging and reporting negative thoughts that are based on things that happened in the past, that they cannot change, or that they are ruminating on reminiscing on, regretting? Wishing that they can go back. Being patient, is being pulled which we can't change. On the contrary, if we are working with the patient who is cognitive languages saying I will lose my career, I got to take care of my family. I don't think I can handle what is to come. Those are future based the way in the moment, recognizing those extreme frames, this will redirect the patient's thinking to what the current experiences showing in this moment.

Okay I will pause and see if anybody have any questions or comments on that? Please feel free to chat in the box. We will take a moment. Just to wrap this up, the domination of this verbal process see, the patient back responding to prescriptions and thoughts. Perceptions and thoughts. It makes them sensitive to realize capabilities and can be a major contributor to pathology.

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Again, my conclusion now is the fundamental take away, it is the same process, also causes those and current aspects of the environment. Just as I was saying, the ability to reflect upon the past can cause suffering. I'm not sure if anybody understand the song that came out, about a decade ago, it has Jamie -- Maybe if you had it ring game bows? What do I want my life to be like if we can open up the creamier part, and the cranium any negative experience I have, and without having too many deal breakers, the take away here, there are so many networks, so many ways in which neurons are firing, that it is impossible to be able to eradicate something that has been laid down through a life experience, rather than making this an assumption that we can simply rate that language, and pretend that it never existed, this is something that ACT claims we can do, we only can add on to our experience, working with patients and chronic pain, they are challenging because pain is a natural biological hardwired process, that has been built-in our brain ever since the dawn of time to procreate species, the discomfort associated with pain, these are all designed to warn us, according to the National Association for the study of pain, it is actually a danger signal to let us know about real tissue damage or potential tissue damage. There in line the challenge in working with patients who have developed chronic persistent pain the messaging center designed to let us know about potential danger is no longer serving that functional way, and an accurate message of real tissue damage. Our patients really get confused with that. Again, the takeaways here, while the mere presence of the framework, this is difficult, the function of that thought. The power of that thought with it shows up, I shouldn't move because it hurts, it can be altered, the way I relation and that experiences to help learn through that experience not all can hurt with equal harm.

Let's move onto the next slide please.

What is ACT. Assessment to help the approach in a contextual control based on the way they are at the time they are behaving, they assume the language is specifically at the court of certain disorder living, the court of human suffering. It uses logical and linear language when helpful and emphasizes direct experience BA, and the patient died, this can be more effect if in showing them you can have this thought and necessarily not believe it is true all the time. It takes a unique direction through cognitive therapy behaviors, and mindfulness -based exercises, commitment based behavioral processing. You might have heard through the community that we play with language. We may tell stories, that play with language, or have metaphors, or analogies, puns to stir up how silly language can be. Especially if it is altering how I move through my life. Most importantly, rather than focusing on ultimate truth on how someone should behave, it meets the patient where the patient is that, by helping identifying and clarifying his or her own value. In these activities they honor that valued direction regardless of what I believe would be the ultimate truth criteria, very interact give in very patient focused therapy, drawing technique away from traditional behavior therapy. Cognitive therapy absolutely, experiential therapy and uses resources outside of the mental health paradigm, like mindfulness, Zen Buddhism, and very humanistic in that respect.

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ACT is for such thoughts as feelings memories and sensations, as well as external events that are not amenable to direct control for what they are. Can I have an experience and still move in spite of that? Doesn't mean I have to like it. Doesn't mean I want to, can I be experiencing this hang onto it and still move in a direction that is honoring what I value in my life.

Choose a set of valued life direction, that will enlarge a sense of vitality and meeting with traditional cognitive methods. If I choose to go in this direction, what are the cost? What are the benefits? Am I trying to bargain with myself by thinking, it finally, if I can get my paint here and my pain down here, then I can pick -- If you want certainty to stay down before you can live your life, the choice versus obligation this is a huge discussion point we often use. Better to feel that freedom rather than choosing a direction, to the person based on their value. Rather than feeling obligated, because I have to, I should, they told me to pick and then lastly. Helping the patient take action. Engage in radical sometimes extreme behavioral change in spite of unwanted internal experiences by building experience of patterns. I will pause there. Again, if anybody has any questions. Please type them into the chat box. Just some final takeaways before we transition to a new subject if you are writing in a question, by all means keep going. This definitely asserts that it is an inherent, and built into the design of this condition we know through the central nervous system processing, it is not possible to eliminate internal language processing, we can only move forward and add on to our experience, we cannot un-ring a bell, if I say any meaning my knee, and you are listening then Moore comes up, and what does this have to do with this workshop? It is there.

Blondes have more -- Mary had a little? We have these things in our mind that have been planted years ago, and they serve us, we cannot undo what has happened we can only add on to our experience by choosing how we want to connect with that memory or thought. When it shows up, do I want to engage with that? To I want to just acknowledge, it is a stereotype or a limerick, that is where we do the work enhanced. Private events that are conceived and needing to be eliminated controlled, explained, or removed, rather than simply being experienced as passing human events. Fundamental concept for the active treatment in pain, helping to have absolute control all the time, may actually be futile, and the problem that is getting to know the way on how they want to relate to their bodies, we will often assert here. The struggle for control in certain events is the problem. Especially when these efforts are designed to avoid, reduce, minimize, or escape pain that is not changing, we help these patients tried to experience these internal experience, when these things occur we do not have to enjoy them, or embrace them willingly we certainly acknowledge and through mindful knowledge, and I will introduce you to these later on, next slide please.

Yes, I actually moving in here with any comments or questions, once again please feel free I feel like I need to have jeopardy music, let's go on to the next slide.

Complicated ladies and gentlemen, I encourage you to bring this into your skill, if you want to print this out, keep it on hand, this is one of the ways in which the creators of ACT have tried to map out, how we identify problems in living with our patients, which is called the Hexaflex. This helps guide the understanding where the patient might be struggling, that being said, there are six core areas to process. They begin with recognizing the history and context of what just walked into your room. The history is really an opportunity you as a clinician to learn what is happening in their history, what is going on in the context at the time that they are [Indiscernible] -- Occurred, which are acknowledged and validated what cognitive thought arose as a result of that? Let's take a look at the top here. In the top area, the top three are essentially things that you might not notice unless you are interviewing are having this clinical conversation. This is knowing the history of their injury and condition how it began, understand that context, is key, especially if we are looking at the biosocial model, what we will learn starting from the top left already this patient may become conditioned and maybe avoid engaging in certain areas of your life, and they are no longer doing things with loved ones, and now they have to hurry they can go -- They have to [Indiscernible - low volume], they can't go camping, they are stuck at the top center, and stuck in the sword -- Story of what got them to this point. And to be validated for what is happened to them not knowing where to go from here, for many patients. We often talk about grief and loss, your condition if it has and will potentially change your life and how you live in it, it is important to address grief and loss, maybe self-knowledge of who am I now? Now that I have this chronic pain condition, it's changing how I see myself, am I capable person, do I have confidence? Then on the top right as a result you may notice. They are not sure what is important to them anymore, because they have been focused on reducing, eliminating and controlling their pain, they may

have drifted away from looking inward and figuring out how I want to live my life, how do I want to be remembered and known for? Those are two things to control and focus on the pain -- These bottom three, these are things that you might be able to witness more clearly. You may have a conversation where you can see the patient is saying, I've always done this I will always do that. This is the way it's supposed to be. All the doctors are telling me this, and they are not listening to me. They are having that thinking that relational frame, and they bought into it 100%, they are not going to change. They may as a result of their condition. To really be stuck, and this attachment, and I was supposed to be strong and the leader and supposed to be hard-working. Look at me now. Now I'm a flat blob -- I'm a fat blob on the couch. As a result, they were locked into these beliefs as true. Every time I really move, I injure myself. You may have that conversation getting impulsive, it you hear this a lot they rind up -- windup making it worse. They are so afraid to move. Those patients that build up that inertia and hesitation that conflicts between hear how I see myself, and my experience and I can't do both, I'm stuck.

Let's move onto the next slide.

Let's note psychological rigidity is a big psychotherapy process, when we look at the word fusion what we mean by that in the ACT community language and processing that we buy into like I've been saying, we are locked into this, when we have this thought, it is 100% true and you will not talk me out of it. It may mean there's gotta be a cure, and we just haven't figured it out yet, when we are currently experiencing this tone and affect that is not true. Based on history, negative and positive reinforcements, the world governed behavior, I will take those roles I have, and they have been burned into my skull, if I be that person or do that task, now I have self judgement about myself, judgement about others. That is what evaluation, that is where evaluation comes in, negative providers, negative -- We have discussed -- If I do this and experience this lack of efficacy, if I experience this pain and anger, I don't want to Gill that way, so -- I don't want to feel that way, so I may quit going to the gym, or reason giving -- These are common things we will see. If people are really stuck psychologically and that rigid fusion if you will, lashed in - Last in the community it is a big deal and latched in. -- The treatment plan if you will and the office goals, and how the patient will loosen the relationships to those beliefs thinking flexible and the alternatives that are workable.

At the top right section of this Hexaflex, is helping the patient look at how their living their lives in this moment, not the past, not the hard future. How are your efforts really helping you with the life you want to live? I see you say you need this medication. How is that helping you? Reach the goals that you want or go for a walk, or not to nap during the day? Are you actually reaching those goals through the use of this? Let's look at their current behaviors. They look at change that our potential and exercises you can do with the patient. You can concretely identify some desires, what life do they like to see themselves in living, if they didn't have the pain, we can make great goals that way. The six key process here as a takeaway. They are identified and targets for fostering change and all are linked to helping the patient loosen the relationship with the thinking process changing the context of pain all pain doesn't

mean tissue damage some pain may be a false alarm, how do you want to respond to it in this moment? What is your option in this moment, moment by moment?

Distinguishing between choice and obligation while making excuses. It fosters engagement by helping that patient constantly ask themselves how is doing a behavior honoring my values? And clinical trials have shown us when people are living in line with the values as they know them. They are less likely to be depressed. When we identify patients who have a weak knowledge of values or who find themselves doing things and asking folks how did I get here? Why am I doing that? Chances are they are more likely to be depressed and is functioning in their context. Take a moment, a few moments to look at these different domains. Questions write them in the box.

I'm looking at the clock. I realize we have a couple more slides to go.

Next slide, please.

Again, underscoring the takeaway. The whole goal of using ACT processes is to establish and identify persistence and patterns of action that are for valued living. We do that through setting concrete goals as well as undermining cognition and relational frame that is not serving them effectively. Through the use of what we call defusing exercises. We will talk more about that later. It also fosters a willingness to face fears and acceptance to allow what cannot be controlled. Again, can you have this really uncomfortable experience and still take action? As small as it may be, toward something that really matters?

We actually use this a lot. If you've ever done any work in MA or AA this is the serenity prayer. It really, really ties up ACT in a lovely bow. God, grant me the serenity to accept the things I cannot change, the courage to change things that I can, and the wisdom to know the difference. Again, step one of ACT for chronic pain really involves showing and helping the patient learn from his or her experience. That constant and persistent effort to have absolute control over pain may be futile, and not serving them in the best way. Perhaps willingness to try an alternative method. And the practice of acknowledging the difference between what you can influence instead of control is where the conversation needs to go.

Just to underscore the differences between ACT and cognitive behavioral therapy, I think I've been making that throughout my talk. I will clarify here. Unlike cognitive behavioral therapy, ACT is actually antecedent focused. Instead of outcome focused. Usually, CBT is looking at the outcome after we do cognitive restructuring. ACT takes a different path. It actually says the ability to try to reframe a thought or rewrite or challenge it may actually be a waste of time. If the thought is going to be there, the thought will be there. What may be more important is to acknowledge the thought as it is but not get sucked into it and get attached to it. So, it's looking more at antecedent focused behaviors. I'm sorry. I said that wrong. CBT is antecedent focused, and ACT is outcome focused. Please accept my apologies. I think the nature of CBT and by all means please throw this out there, one of the goals of CBT is

to know what your dysfunctional thoughts are ahead of time. When it shows up we can do something about it. ACT is disregarding that as I mentioned. And it's really looking at the function of the thought. I stand corrected. We are looking at whether or not the person's relationship with that thinking style is serving them in a good way or not a good way. Or in a bad way. Functional [Indiscernible]. ACT approaches are based on an individual's chosen values, not the ultimate truth criterion. And the ACT therapist is seen not necessarily as an expert with the white coat but as a collaborator. I will often use analogies like we are in this boat together. I am rowing, but you were looking at me. I can't see where I am going although I have an idea, you were trying to give me instructions on where to turn and go. You might want to say you the patient have to row. I kind of give you directions but you have to help me. I need to give you that direction to help you get there. To as you saw the four in the 'Hexaflex' model interventions do not have to be linear. If you are the type of therapist that likes structure and first we do this and then we do that, ACT may not be the best fit for you. If you are more of a process oriented provider and want to grab something in the moment, that is really what ACT is about. If you can see when they talk, they are struggling with their identity we can go into the 'Hexaflex' and start talking about how they want to seek themselves in the self-knowledge and how well they understand this new chapter and how to say goodbye and the former chapter. If the patient comes in and says they won't do this because they will not let someone hurt them again will now we are looking at rigid thinking. You can go into that and work with them. That's why the 'Hexaflex' is designed that way. ACT interventions are process oriented and model our philosophy, that present focused care is where it is at rather than recalling stories and rewriting that versus looking at how will he help you in this moment based on your activity.

I believe we are at a great place to take a pause.

We can take a 15 minute break. Does that work? I have about almost 1110. I'm not sure. I am on the West Coast. We are at 2:00 on the east. How about everyone in their seats by 2:25. Does that sound fair? Perfect.

We will see you in a few. Be sure to stretch and hydrate. [Event is on a 15 min recess and will resume at 2:25 E.T. Captioner is on standby.]

Do I recommend ACT for dementia clients? Let's wait until everyone is back in. Let's give it another minute or so.

For those of you who are settling back in, it's just about time for us to get back in. Now is a great time to post your question. I can open up with that while others are getting back into their seats. Do you have any particular announcement you would like to start us off with?

Just a reminder to download the CME sign in sheet. The email address is on the sheet. At the top of the sheet.

Again, another reminder to be on the lookout for the survey evaluation. Other than that, we are good.

Thanks again to the staff behind the curtain.

I appreciate all of the support. We could've not have done this without you and the team. We've been spending weeks if not months getting this together. Thanks to you for coming back. It is hard to sit through such a long lecture. Hopefully, you are getting some value out of this. I am willing to share my email at the end of this if anyone has any follow-up questions they would like to process later. I'm happy to make myself available. I want to address the questions in the chat box.

Do I recommend ACT for dementia clients?

It's a very important question. I cannot speak from professional experience, however, if you go to the website. So, in your Google window you can type contextual psychology.org. I was actually going to type it in here while I am doing this. That is the official website where you can train and learn and download videos and literature and find out more about clinical trials. What I can answer is there have been clinical trials conducted on the schizophrenia population. If we are trying to help folks who have disconnection with reality and thoughts and hallucination, there have been studies on schizophrenia and psychosis. I will lead you in a better direction. As far as I'm thinking, what is really valuable here is that ACT is a very flexible model. Although we have protocol, it's one of the virtues of using based on the philosophy, values are really a key component in helping foster motivation and desire to change. If you are working with a patient who has dementia and still has enough cognitive wherewithal to connect with a matter of the heart and how they want to have their final hours to be. If they are in hospice or they know they are not able to have a long future, I think it would be really important to have the clarification and then help foster them to take actions and long with those values especially if we know the time is limited. That's all I can offer at this time. I recommend we go to the website. And then the doodle in the photo was my carrier. Purebred. Her name was Magnolia. I called her Maggie. She crossed over the rainbow bridge about one year ago March. She still with me in spirit. If you've been analyzing the photos in the back of my room you may notice I have a portrait of her appear as well. Any other great questions?

I was checking in with the IT folks. We tend to keep it on so if anyone were to have a question or you wanted to have a discussion with someone, we did leave that. We did not want a formal setting for the entire group for the whole workshop, to mute everybody. Please let us know in the chat if you have any issues. Otherwise, we would like to keep it to please mute your own microphone. So, it can be un-muted and everyone can be enabled for the Q&A.

As I'm talking, I have no problem with you typing questions as I go. I don't mind and I am hoping I have a chance to respond to any queries you have. Let's move on.

Welcome back, everybody. Here's the section of my workshop and I'm hoping we could be more interactive. If you are gun shy her camera shy we don't have to have you show face and maybe you can engage in exercises. We will talk about using the app model to address change and to help you with case formulation and treatment intervention. If you have a capability of

printing out the case study, I would recommend you do that. We have it up although it's a lot of print. For those of who are visually challenged, we are going to talk about how to apply some of these spunky experiential, behavioral activation exercises. So, you don't feel awkward. I someone who has been doing training myself for many practitioners who are new to ACT, it's perfectly appropriate to feel awkward while in pure ACT form I will say embrace this. Thank your mind for whatever judging is happening. That is normal and can you have a negative self-evaluation to act out or carry out your goal if you know it's in the service of your value to be a good provider. Let's see if we can't move forward and improve that skill set.

When is the use of ACT appropriate? It's a very valuable question. Depending upon your acumen and comfort, I would say first and foremost from my experience building rapport and education would be the very first step in trying to hear the patient's story and validate that their pain is actually real and that our goal is to help them work in the domains in their lives that have been affected because the pain was not remitted. That says usually we are talking about if the pain condition has been experienced anywhere between three and six months minimum, they have in fact failed biomedical traditional methods like injections or medications. Physical therapy even surgery. Again, this is coming from a place that this is recognizing that the pain they are living with today is as good it's going to get. Maybe the person has exhausted all known current biomedical inventions. I've even thought, depending on the sophistication, they may benefit from cognitive therapy first. If that doesn't work, you can also try ACT. I would also recommend ACT in a group setting. Chronic pain is extremely isolating. When we don't feel well what do we do? We withdraw and pull away and go to the comfort zone and fall back on primitive coping ways and we don't want to be out and about socializing. Even though it may be difficult to garner in a group people find out that they are finally meeting people who are just like them or similar and they feel like they are finding out alone. That said, I think we will go to the next slide. I am going to recommend on the contextual psychology ORD website you can find the ACT for chronic pain group treatment manual that was written by Kevin. A wonderful, contemporary, he developed the protocol through another academic based in the UK. And we have used this frequently. It is what I am most experienced in using. I've been doing this group work since about 2007. So fundamentally speaking here, the treatment approach conceptually is to recognize that the patient who's been referred to you as a patient who has chronic pain and more importantly we will look at this as someone is experiencing persistent, non-acute pain. There is an unwillingness to have it. That's how we are looking at chronic pain. So, the topic we want to focus on is the topic that is part of the protocol of the ACT for chronic pain. I broke them down is different chapters. What's interesting is you do not have to go through the workbook chronologically.

The chapters are designed to be used and apply them based on the process of what's happening in the moment with the group. Don't feel bad if you skipped a subject or didn't do a bullet point by bullet point. Cut yourself some slack. Recognize that what shows up in the room is what needs to be addressed based on that 'Hexaflex' model. The topics we try to address the matter what week you do it and it is an eight week

program, is created hopelessness. This way of using exercises to underscore the fact that efforts to control, undermine avoid, reduce escape pain, and the outcomes of having pain, are actually serving to cause more suffering and are the problem in helping this person open up and have more flexibility in living. It will help the patient identify valued domains in their life that they rank as incredibly important. These are reasons for living. Why bother getting out of bed? What is it that helps you put one foot in front of the other when all else fails quick those questions like that usually help guide patients and giving you that information of what might make it worth living even if it means they have to bring the pain with them. There are sections where we talk about loosening the fixation on certain belief patterns. The loose fitting cognitive rigidity as an obstacle. Loosening up those rigid relational frames by engaging in and playing with words and light wishes show the patient how silly it is that we are buying into sounds out of a mouth to direct our behavior when it doesn't necessarily reflect the experience. We use mindfulness and mindlessness exercises to develop intentional actions. Again playfulness. How can we help the patient recognize the fundamental ways in which our thinking styles can undermine our best intentions. We often talk about the distinctions between control versus influence and that of course acceptance and willingness is a fundamental part of the process.

Lastly how do we maintain the game? How do we help you reduce the probability that you will have setbacks? No, it is perfect, and no one reaches acceptance some days are better than others. We absolutely emphasize relativity and how we respond moment by moment based on the cards you are dealt at this time. Sometimes that is hour by hour and day by day of the 'Hexaflex' let's take a quick moment to think about what are the and moment by moment. If you can recall or if you have the printout problems in living with psychological flexibility? Using this terminology, how might you think about a case and really look at how are they avoiding and what efforts are they making to try to control? Are they fused with pain related thoughts that are getting in the way of their best intentions?

And what are their goals in life? If you have a chance and I'm not sure - - can we have access to that case?

Give me one moment. Excellent.
I will grab my papers here as well.

Small print. We apologize. There's some great value with this. Take a few moments if you can read over this case example. This is a true case example of a patient I treated in our intensive program. He came to us with the onset of insidious low back pain.

Again, this can be downloaded, and they can put it on their own computer if they want to see it. It is in the file pod.

What I will be asking all of you out there in the virtual world is to type your answers in the chat box. Take notes on your own. Keeping in mind the prior slide that I want you to focus on is in what ways do you see they might be avoiding things. In what ways do you think they are

struggling for control over their pain? Both their emotional suffering and physical pain. At this point whether they may be fused with certain thinking or certain thought patterns. Let's start with that. Take a chance to read this and take notice. The first question I want to throw out there. The first question I want to throw out there, what areas of this patient's life is he no longer engaged in? Because of his pain and desire to control it?

Please keep your answer in the chat box. I will repeat the question. What areas of this person's life is he avoiding or no longer anticipating in, in order to try to reduce or control his pain?

I see a couple of people tripping typing in. Another way the same question can be asked if you want to extrapolate or predict. Are there certain emotions or sensations the client may be unwilling to consider? Are there certain memories the patient may be unwilling to experience?

Excellent. So, I will go ahead and scroll here and see where we are at. So absolutely he reduced his rhetoric this is a gentleman who used to do marathons. We're talking like 35 miles of trails. That's hard-core running. It has curtailed that.

I appreciate the comment. Running and then the activities which his children. If you have a chance to read further, he is no longer able to play with his little kids. And camping and things like that. Those are giving us some really interesting information. It's also giving me a little bit of a birds eye view of what are the areas of his life that matter X we often have to ask because of the pain how is your pain interfering in your family life? How is it inter-feeling in your work life and your personal life? And so, as an active duty service member you may have picked up on this.

They have a mentality, the Nike mentality. I just do it. I go. And so let's go on to the second question from that prior slide. At actually it is question number three. Does he have any fusion with pain related thoughts? Is he latched into a particular thought pattern about what he is supposed to do as a service member? Yes, wake and sleep cycles are probably disrupted. Good job.

Pain is absolutely interfering with sleep.

I love it when it says multiple attendees are typing. Yes brilliant. I appreciate that.

Yes. Yes. And the cognition pushing through pain results in paying for it later. Absolutely. He may be struggling with a mentality that is common in our active-duty population. Pain is weakness leaving the body. Who here by a show of hands wants to be week? Nobody. I won't show that I am weak. I need to show that I can control this, and it is not a problem. I'm going to avoid showing my pain. I'm going to avoid displaying any pain behavior. I'm going to suck it up and push through. That behavior is serving a function. That behavior of sucking it up is likely serving a function of making sure he is still valued and respected as a member of his community. Let's look at his rank. He's a chief master at arms. If he

were to show weakness, how might that influence how others see him? It could go in a bad way.

Yes. His wife also has chronic pain. And here we are, family life. The context in which he is living moving through his context. He also has to be able to juggle home life with small children and a wife who has chronic pain. He may be having some relational evaluation and comparison. Her condition may be worse than mine, I need to step up. Or if I don't do this, if I don't do this, I'm going to be a dirt bag by my leadership. I need to support my family. If I don't stay in this job, I may lose my job. These are all schemas. You can call them stuck points you can call them negative cognition.

Let's move on. I have added here for your own take away, a case conceptual document. We won't go there yet. It's also a fantastic way to guide your thinking process using this new lens through ACT. Going back to question number four. What life direction do you think at this point he is hoping to go toward? What do you think his values are? That we may want to tap into to see if we can energize him to take better care of his body and to find that balance to care for his pain? What value domains do you think we could help him connect with?

Excellent. Love to see the typing.

Yes, family is huge for this guy. Time. If you had a chance to read the back page, what is really interesting here is he could be avoiding or controlling his pain through alcohol. Many of our folks do it. However, thank you, Linda. However, he's not drinking. Why? Multiple family members with drug and alcohol addiction exist in his family in the second paragraph. He was born and raised among a dysfunctional family. Secondary to drug addiction. He reported having a challenging trial to where he not only witnessed all of this drug abuse but he was living on the streets. Drinking alcohol is not an option for him to control his pain. Clearly it underscores that his only way of coping with stress emotional upset was to run and to run long distances. Another way of coping was is he using healthy diet methods? Not so much. So, for him to have a tightknit honorable family with healthy coping skills is a great avenue you can try to clarify with him. Moving down further you will see out of the kindness of his heart he adopted three children from foster care to try to create his own family. A pretty cool guy. That being said, let's move on.

If you could, go back to the 'Hexaflex'. I'm not sure what slide that is but it's the 'Hexaflex' slide of change. You have the ability to get back there? If not, I can read them to you guys. Can you see the numbers to tell me which one?

Okay. Back go back one. There it is. Perfect. So those of you out there if you are on board and wanting to do this study go ahead and type in the box. If you could happen to any of these domains there's no wrong answer. Given how you are thinking about this patient and where you want to do some great therapy.

What domains do you think you want to tackle? To kind of get going with this patient?

I love seeing multiple participants replying. Keep going. If you can see how much he values family perhaps one avenue could be clarifying his values. Making sure he is about how much his family is important him it. If the ability to play with his kids is something, he wants to do is a goal that could be an excellent way to garner rapport and get him motivated and to think if he can get some behavioral movement in a very carefully paced manner. I love all of the language. Increases awareness of his care and functioning to get to acceptance. Instead of being stuck. Okay.

Contact with the present moment. Engaging in movement while exploring sensation. I like how you are thinking with that. There is this interesting blend of traditional behavioral exposure if you will I like to use the word distress tolerance. Can we actually get this patient to start to do some movement or experience and lean into some sensations while he is in a relaxed, calm, meditative state. He can lean into that and learn how he can increase his tolerance in spite of what his mind may be saying about it. That experience of being in a meditated state while mentally focusing on the pain is actually engaging the patient distress tolerance so they can build a greater sense of self-efficacy. I would fit that in with some of the present moment awareness. Excellent.

So, I'm also wanting to acknowledge how these used to be. We can use this by identifying some of these cognitions. Using some interesting questioning to undermined some of the futility in his thinking. An example of that could be if you always do what you've always done you will only get what you've always got. If you keep running, what do you keep getting? Is there another way we can help you figure this out? Is running 35 miles the only way to cope with stress? Let's see if we can't help introduce to use some alternative ways. Let your experience help guide you. That is a big piece. What does your experience show you when you are willing to try this? That is a big ACT intervention. To undermine the language directed activity.

In the interest of time, I'm going to bring some conclusion to this. Take notice, if you have the second handout, it is the ACT initial case conceptualization form. Linda posted it for us. Thank you so much. I would like for each of us to kind of go through and you don't have to answer anything in the box per se but it's another way of echoing what I just guided through. You can use this when you're trying to think about your case. What would be the goal for this particular gentleman? He clearly doesn't want a medical board. That's good. Thank goodness. We have a patient who wants to stay in service. He wants to continue to provide. Provide first three adopted children. He wants a stable source of living considering the poverty and insecurity he came from. He can use those in a valued way. What is it about being in the Navy that you truly value? And its these concepts like security, health insurance, how he sees himself, head of the household and provider for his wife and children. What steps can he take even if they are baby steps that demonstrate to him and others that he's living in line with the identity. That will tap to birds. The value domain and the family domain and a lot of domains.

One of the things about this patient that was interesting, and I wouldn't expect you to pick up on this by my case study he was very stoic. He really had very limited contact with his emotional range. And another goal of ACT is to slow an individual down long enough so they can have greater access understanding themselves and the relationship between their thoughts and how that may feel in the body. Mindfulness can do that. We talked about avoidance. Environmental barriers. He can't just get up and do PT. He has to go home. I think we also talked about items four and six. What are some motivational factors? We just reviewed that. Number six, factors contributing to his inflexibility. Suck it up and push through. You are an MA. Of course, your back will hurt. Just accept it and deal with it. That is very rigid.

Any questions? I'm going to pause here.

Hopefully, this handout is something you can use to try to better understand your patient. I would argue this handout and the 'Hexaflex' of change are wonderful guides to help you see where you may want to intervene. All right. If there are no other comments let's move on.

I will say we will have more slides after the break.

There's only way to become good practitioners. We can lead until the cows come home but we need to have virtual role-play. Let's change the slide.

As practitioners it is so important to recognize how much our internal dialogue. Let's move forward acknowledging what is believable and true and still engaging in some of these exercises what I would like to ask of you out there, if anyone was willing to type in a good question. For example, breakdown for me and quick terms what are typical problems in living you have seen in your pain patients. Not wanting to go to work. Problems with marriage. Sleep problems. If you can type that in the chat box, give me an idea here. What are some common problems in living that often present with your pain patients? Then I will ask the rest of the group to look at the 'Hexaflex'.

I appreciate the entry. This is a loaded question. Let's see what shows up. If I don't get that what I might do is lay out an example myself.

I do see some people typing. What I will do in order for the interest of time is I'm going to say let's fall back on that case study. We all have it. I did see some good feedback. Let's fall back on the case study. You don't need to change the slide, Linda.

Let's go to the next slide.

If we have an individual who we are trying to let them know that the current efforts to try to have absolute control over the pain. The efforts to escape their pain and their anger at the medical system for not solving their pain. And they say no one is listening to me. Nothing is working. I need more medication. Can you raise my meds or can I get another injection? I do see those offers there. Thank you. We will be there in just a second.

With this particular patient we are trying to work with how to undermine the dominance of emotional control. I'm going to role-play for you the story that we made you to emphasize how the struggle for control is often like falling into quicksand. It can be useless and futile. What I will often say is okay it is story time. Let's talk about a recent event where maybe you were walking and minding your own business and as you turn the corner unbeknownst to you, you fall into a giant pothole. The hole is huge. It's like 12 feet high and 10 feet wide. You are like oh my gosh. I am stuck. How do I get out of this whole? You shout help, help. Can someone help me out of this whole? A passerby notices and they walk by and they say you have fallen in a whole, are you okay?

I need help. Can someone help me? Let me see if I can get you help. I will be right back. I brought you a shovel. Here you go. And you're sitting there going I don't want to dig any deeper. Will this make it worse? Help. Can someone help me get out of this hole?
Another passerby comes over. Oh my gosh are you okay?
I fell in a hole and I have to get to work. Can you please help me?
I know just the right solution.
I've brought you this new titanium special edition shovel from Sears.
Okay. Usually when I am doing this, I am riling up the audience. Maybe we will get some stairs. Maybe you can have someone throw a rope. Rope is not an option.
Someone help me. You fell in a hole. Yes, I did.
You need some help? Yes, I do.
Hold on. I will be right back. I got you this really cool 24 karat gold jewel encrusted shovel with some gems in it. I think it will be the bomb. Here you go.

What's wrong with this picture? What is wrong with this picture?

Often times there is a dialogue about have you ever had the experience where you are trying to tell what's going on and you're trying to ask for help, and no matter what you are given and what is provided you are still in the same hole. You are still stuck. It's a great opportunity to try to undermine that rigid thinking of how do I get out of this? Another method of undermining the struggle for control. I know my slide says emotional control. It's also a struggle for physical control. We often use what I call the Chinese handcuff. So, they are a tool that is often used -- for those of you who understand what that is, the finger cuffs. What we have them do as we passed them out and say put your fingers in there. Has anyone ever used these before? What is the purpose of this? I will try to get my finger out. What happens when you try to get your finger out? It locks down it does. It locks down. And it's really hard to get it out. I literally had some of these infantry guys like rip it apart. That is worth talking about. What are you willing to do to get out of that? Are your efforts to escape this so strong that you will bust through things may be destroy things, hurt things in order to have some relief. I take it a step further and say let's pretend where your fingers are touching is an acute experience. It's a flareup. Some of them are insightful folks. You will have to wiggle it around. You have to get closer to it. It leads me to say you mean we have to make more contact and get closer to the pain in order to have mobility? What does that mean? Does that mean we have to pay attention and see it? And listen to

it? How does that make it looser? Let's explore that and I will talk to them about that.

Another way to recognize how efforts for control are futile to the chronic pain patient is to literally do a cost-benefit analysis. I will throw it up on the chalkboard and say let's brainstorm a list of everything you've done. Everything you've done to try to get rid of your pain, fix your pain, escape your pain, bargain with your pain. I don't care if it's drugs. I don't care if it's drying or staying in bed all day. It could also be medication. Radiofrequency and surgery. Yoga painting. Let's list all of the things and I emphasize this.

Look at all of the things you have done. Look at all the resources that are there. I have no doubt you guys have done as much is you have possibly can at this point to try and manage it. I have every bit of faith in knowing you are probably still researching more alternatives. And let's look at the short-term benefits of each. The short-term cost of each. The long-term benefits of each. The long-term cost of each. At the end of the day the question remains is the purpose of the treatment is it to reduce or remove pain negative impact, how successful has this been? What is interesting and we know certain methods can be very effective. Certain medications enable more function. Certain forms like yoga are evidence-based methods. We are not trying to undermine the patient's work. We are trying to have a discussion about workability. What patients really appreciate is this emphasis on although I may have some benefit, all of these methods are temporary. If you can foster a conversation on that, now you have traction. If this is temporary, again you have done just about everything I can tell is available. Now what?

How many of these methods have enabled you to live the life you want to live? The value based question. Let's move on in the interest of time.

I will use some of these examples that people typed in which I really, really appreciate. There's some difficulty in sound there I think.

Some of the problems that you guys are experiencing is conflict management and communication problems. Yes. Okay. I want to try to speak to that. Let's start with that. Communication difficulties and conflict management. One of the things we try to offer that is definitely a cognitive behavioral intervention. It might not necessarily be an act but it involves both. I might have brought your attention to this earlier. When we engage in mindfulness, by definition, the act of engaging in mindfulness is the practice of being fully present, moment by moment, without judging. And one of the things that we are aware of when we engage in mindfulness is it's not necessarily designed to lower heart rate and to lower rage or to reduce cardiovascular hypertension. Not in its purest definition. If you are engaging the patient in mindfulness, you are helping the patient see their pain as it is in that moment, while they are sitting calmly. It brings to mind the ability for the patient to sit with the negative experience and learn that their identity as a whole person is more than just their pain. They are able to practice this tolerance.

Often times through practices of mindfulness you will successfully get down regulations of the stress response and that is key. Even if it's taking a time out from anger outbursts, practices can be used effectively and enable the patient in the process of having an argument or panic attack or disagreement to say I need five minutes. Can you give me five minutes? And find a place. I don't care if it's the head or the cab of their car or the garage. If they can go someplace where they can practice mindfulness and breathing, they may be able to down regulate and get some perspective and then choose not to be impulsive. Choose an impulsive response. Here's another metaphor I used in order to help loosen up problems where our values - - problems where our belief system impacts our value. It's the bum. Joe the ball my column. In a nutshell I like to use it. You live in a neighborhood that happens to be urban and there are several homeless people. This bum, Joe, you recognize has been around for a while. He looks pretty crusty. You can smell them before you see them. He doesn't bother you and he's actually courteous. He will say hello but mind his own business. I will embellish this story. It's Labor Day weekend that's coming up. You are excited because you just got a brand-new Viking barbecue and you're totally excited. Maybe they are on replay because of COVID. A buddy of yours got back from Japan totally excited and you will have a get together. You will have delivery barbecue. You will be socially distant. Everyone will wear their mask. You are hosting a party and the day arrives totally excited. A couple of your friends keep popping over and people start coming in and you have the polls fired up. Everything's cool. And there is a knock on the door and it is Joe the bum. You're like Joe what you doing here? I heard you are having a party. Come on in. You are saying sorry, Joe. This is a private party. I'm sorry you can't come in.

Shut the door. You can actually smell a little bit because he has that fog in his wake. And a couple of your friends are like who is that? You are saying well I'm sorry he's a guy that lives in the neighborhood. You are okay. We are okay. Let's get back to the game. You put the game back on and you get the lights on and your spring that off and you wash your hands and your friends are a little like whatever. Right at like one of the great moments and the best places you've seen is occurring, there's another knock on the door. Your friend gets to the door before you do and sure enough guess who it is? It's Joe. He comes right on in and he starts helping himself to the chips and the M&Ms in the nuts and the drinks.

And his gnarled hands with the tobacco stains digging in the potato chips. And he's filling his face because he's famished turkeys hungry. He's doing all the stuff and some of your friends are like what just happened? You are like Joe, did you not hear me? I need you to leave. You need to go now. Now you are getting angry. That was a violation that was not okay. Your friends are like taking a back because you were shouting at him.

They kicked Joe out and he's gone. You locked the door and tell your friends I am really sorry but do not let this guy in. Do not let him in. I need to calm down. Your roommates are like take a chill. Go take a timeout. Your friends are like okay. They're putting the show back on. Now you have missed out on a few of those plays. Some of your friends are

like wondering what is going on. And before you have a chance to get out and rejoin the group you hear someone scream because someone has just jumped in through the window in the back bedroom. Now they are really upset. It's Joe. What do you do in this scenario? And I foster conversation on that it never ceases to amaze me there's always a number of people who recognize with Joe represents and then there are a number of people who haven't quite made that connection again the group setting is a fantastic way for them to talk with each other. However, the fascinating way to get folks to recognize what would it be like if you were to allow Joe to come and go? Some people say I would give him a plate and tell him to eat outside. Some people would put contingencies on him. And it raises the question of how much we want to bargain with our pain. Are we willing to accept our pain? It takes us away from why this whole event happened in the first place. What was the primary intention of this day?

It was to share good memories with friends. And given what I laid out and you are able to reflect upon is the more intrusive this person or your pain is, the more fixated you get on controlling it. The more you bargain and negotiate, and you make contingencies, you are not spending time with your friends.

Wasn't this really about being able to be with your friends?

That is a wonderful analogy of what would it be like to have him just be there? It sucked. It absolutely is terrible. Can you have that there and be present to watch the game? And crack jokes. And have a few toasts with beers. I mentioned before you see the serenity prayer. I will foster conversation about that. To practice doing the unfamiliar. This is the fun one. We will do interesting undermining verbal exercises I can't get out of the share there's no wire I can get out. It undermines language. Can you have the experience and remain contrary to the language? You can. There's a recent book published by another couple of colleagues of mine they created a book. I'm sure it's curious on the website.

Let's go to the next slide.

Here’s that really difficult thing. When we talk about latching onto language and how people get very rigid and stuck to that schema or that stuck point or that dysfunctional thought. How do we help people not react impulsively as if everything that happens in here is the truth? The traditional method in cognitive behavioral skills is to identify this function thought and challenge its validity using the questioning and then to reframe and help the patient re-create a new thought they can use as a mantra or as a way to redirect their approach in living. It has shown to be effective. It's one of our gold standards. ACT will take a different approach. As I mentioned earlier, rather than spending time tearing a thought apart and focusing on how that is not okay, it says sometimes the mind creates things and is helpful and sometimes it's really not helpful. I will play with that. Have you ever seen an obese person wearing the most unusual tightfitting spandex? Yes. We have some thoughts about that. Absolutely. And do you shout them out? Maybe some people do. Or do you keep them to yourself?

Sometimes our mind is our friend. Sometimes our mind is not our friend. The important thing for us to recognize is our mind has a mind of its own. I will also say things like in here is a very interesting one. The paper on the floor that I got you to defuse if your language like the automatic thought we might have traditionally is that the wrinkled up piece of paper is trash. When we introduce concepts of that's just one way of looking at it. Is there another truth is there something we can say that is just as accurate but not as negative? How else might we want to think about this. It will expand the flexibility of thinking outside the box. That is the purpose of the paper on the floor.

I will also do something that is very common which is - - for those of you in front of me I am reusing my paper. Grab a blank sheet of paper. If you are engaging in learning. Take your handy-dandy piece of paper and you will poke a hole. Kind of like that. It doesn't have to be perfect. You see it?

I want you all to do this.

Go ahead and poke a hole in a piece of paper. What I want you to do when you are ready is hold it up to your face just like this I want you to imagine that you had to walk away from your computer with it up here and walk outside of your building and fine your automobile and the way which you get on your subway. I want you to locate where that station or your car is pick you have to keep it up like this the whole time. I asked the group what is running through your mind right now? This is stupid. I feel I can idiot. I bet you do. It will be hard. Do I have to look through the hole? Yes.

It would be hard to look through the whole you know what, I can't see what's on my side. That is absolutely right.

What if I were to tell you to take that piece of paper and straighten out your arm all the way. I want you to do the same thing. I want you to leave the computer and walk through the building. I want you to exit the building and go find your car. Where your bus stop. Or your ride. Yes, your arm is very tired. I can see a little bit more. You can see a little bit more. It's still weird.

People will think you are weird. Absolutely. If you could choose between finding your car like this or finding it like this, what would you prefer?

I'm telling you nine times out of 10 I get this. Why? Why is that easier? I have a better view of what's around me. Okay. What do you think the paper represents?

Has it ever felt like your anger or rage and depression and pain are so up in your face you can't see clearly? But if you could just get a little bit of distance just a little bit it's attached to my hand. It's a part of me. If I could just get some space. Now I have some choices. I can see out my window. Now I can see my kitchen and see my way out of this room. Even though it is still here is still connected. I have a little bit more perspective. I will use that to help people practice the skill of

defusing visually from what they might see. We have the concept of the my. In certain mindfulness I will practice a similar thing where we talk about sometimes you feel like your head is in the screen. And you're living with pain and you could feel like you are immersed. What would be like to visually imagine you are on a chair with wheels and you can roll your chair back and now you are at arm's length. Let's roll it back even further. Now you are all the way in the back of the room. Your pain is there and is tugging at you. However, you have a view of the bookshelf of the plans and the window the mental practice is really a way to defuse and disconnect and give that person understanding. That the pain is a passing experience. This too shall pass.

Act intervention for increasing contact at the present moment. We did talk about mindfulness. If you are working with patients who have a lot of intrusive thought or maybe you have people who have core movement pain and trauma where they are often triggered into having flashbacks or they are afraid in doing mindfulness practices that they will lose contact or drift off or disassociate. It's not uncommon. I will often tell folks you don't have to have your eyes closed to practice mindfulness. It doesn't have to be a sedentary practice. Again, by definition to be fully present moment by moment without judging.

And that can mean walking mindfully. I am feeling my heel make contact. I feel my foot and now the ball of my foot and my toes. While my other leg is lifting up and moving. I feel how I have to balance so closely on one foot before I put the other one down.

You can do a slow, walking mindfulness. People who are able to swim are drifting in thought. If you have the intention of being fully present with your senses as you are focused you can say to yourself I am reaching up and I am grabbing an apple and putting it in my pocket. I feel cool water and put in my cop it pocket. I'm drifting - - come back. Describing moment by moment is a way to keep us in the present moment.

There's a wonderful exercise called five, four, three, two, one. I called the grounding exercise. It's effective. Essentially what it entails is - I will do this with the patient it's been successful virtually and in person. If you are starting to feel like you are spacing out or starting to have a hallucination or a flashback I want you to keep your eyes open and right now using your own language so you hear yourself say it, I want you to name five things out loud that you can see currently in your environment. I see my phone. I see my laptop. I see my coffee mug. I see my pen and paper. Five things you can hear. I see my voice and my fans. I hear the birds I hear my [Indiscernible]. I hear my voice again. And they can repeat some of those things.

I think you can touch or feel I feel my butt in the chair and my feet in my socks. I feel perspiration. I feel my hair on my face. Again, five things they see or hear and five things they touch.

And then you count down. Four things you see and hear and touch. The things you see in three things you hear and three things you touch and two and one. And often times the patient will experience and report feeling present. Really in contact with what is happening now. I found it

to be very successful. We also tried to identify when a patient is hovering in the past like I should have, could've, why deny? I wish and I regret. And we go I think your mood for that. Your brain wants to go there. What are the options now?

What is available now if you could choose.

I also deal again. We have a lot of people who have occupational uncertainty. My career is over. What is the evidence you have to support that?

Has anyone given you a paper that you have to sign? Would it be fair to say you are feeling afraid?

Let's talk about what the options are right now?

There's also this concept of in order to break that rigid thinking of I am either fit and doing my job or I am unfit and a dirt bag but no one wants to be the dirt back. So, we see people who overdo it who reinjure or suffer tremendously. The use of that kind of thinking either or sets us up for black and white, good and bad and white and wrong evaluation. That often drives unhealthy, dangerous behavior. We encourage the patient to play with words. I will call them out in session. How about we try the word and. I'm in pain and I am going to work.

I am pistol off and I am laughing at myself.

I am really not looking forward to this meeting and I am going to go anyway.

I feel like crap and I came to therapy.

It's all inclusive. It enables the patient to recognize. They could have more than one experience and still take action toward a valued direction. This is really challenging. It's kind of in the service of helping the patient recognize things are not permanent. You may be really suffering now and yet if there's one thing we could count on. And so we tried to encourage that perspective as being something moving through time. If you want to call it like a Star Wars analogy, I think the philosophy would allow you to play with that. I mentioned having this to get perspective. Sometimes we do silly role-playing like I know you are really, really fatigued and exhausted and depressed. What would it be like, show me?

Show me like even if you are totally exaggerating. What would it look like? As if you were joyous? And see what they do in the room. There's a clear distinction and its function. Does the chosen behavior serve a function that enables them to live more flexibly with the cards they were dealt? That's the key.

And then lastly there is the metaphor. It's a rather complex one but I will break it down. Imagine your life is a chessboard. However, unlike the game this chessboard extends infinitely in all directions. Your goal in the chess game is to conquer the Queen. To capture the Queen.

And so, we divide this lifespan on the chessboard into good and bad.

We put all of the enemies on one side and we put all of the good things and the heroic things on our side. We want to conquer. We want to win. So, we go through this battle and we fight, and we charge and sometimes sacrifice aspects of our own team. In the service of winning and conquering over the bad. And this paralleled a lot of the lives. And so, I will say something to the extent of if your goal is to hop on that horse to valiantly conquer that which is not wanted, that which is evil and painful wrong. You will charge. Let us keep in mind this board is infinite. I will ask all of you in the audience, what if this is a story whereby you can't necessarily be the bad guy you don't want to. Nobody wants to identify with the bad guy.

You can't necessarily completely only identify with the good guy. Because we recognize we have within us and within our lives both positive things and negative things. Likes and dislikes. My hair is driving me nuts. It's a part of me.

If I can't only be the enemy and I can't only be the ally, my life is this entire chessboard. Who am I?

As I asked this question, I will ask you. In this analogy if my life was this chest game who am I? Who can I be?

If you think you know the answer type it in the chat box. Have I stunned the audience? If you are trying to foster perspective diffusion and cognitive flexibility. Is to say you are the board.

Why are you the board? Well through the course of our life which we really do not know when it will end, that's why it's infinite, we may come into contact with positive memories and experiences and we may come into contact with very painful and dark and hurtful experiences. If we think about this if I am only on one slide that means I am rejecting a whole aspect of myself which is part of my identity. It means I'm unwilling to handle anything which will make my life very challenging and very small.

And the cool thing about being the board is that I can actually observe and watch both sides battle. I don't have to engage in it. I simply am the platform on which this happens. I don't have to hop on the horse. I am not obligated to fight and conquer and in so doing, I am not necessarily losing contact with any member on any side. I am simply the environment on which these experiences take place. Many patients appreciate it. And it opens up an opportunity for them to see how they don't have to buy into the battle for control.

They can see it as it is and then choose whether or not they want to ride a horse that day or just watch the battle. And they are infinitely connected with every player unlike if you are only on one side.

Let's move onto the next slide.

For values clarification, this is actually a really nice easy way to get involved in an ACT intervention. It's a miracle question for those of you who are more familiar with solution based types of intervention. The magic wand question. I like it because I get giggles from our Marines. We are all known for being wizards. I will say you know what, I will ask you a question.

Let's say I am a real able to waive my wand when you go to bed tonight something amazing will happen. The first thing you notice is tomorrow morning is that your life has changed. It's amazing. Your pain is gone. Completely. What would you be doing that you are not currently doing? And that answer will yield some very interesting questions. Some of them may go back to well I would be going to the gym. What else? What else would you do? I would probably be traveling. What else would you be doing? My job. Okay. What else?

It's a great way to tap into other domains. If you are not getting much back, what is possible? It happens a lot. Many people who are unhappy have thrown all of their eggs into one basket. They through all of their energy and all of their activity into either the health domain, I value being pain-free as the definition of health, or they are throwing all of their eggs in the work domain. That needs some unpacking. We need to ask them are you interested in falling in love someday? Would you like to live your life how would you like to live it when you retire? Or if the Navy doesn't work with you? You may get some interesting responses. Many people bring their children into it, it being a loving parent and having parents. Another fantastic way of clarifying value is called the tombstone or the life achievement award. The tombstone question is very heavy. We need to use clinical discretion at applying this particular question. Essentially when you're trying to really get some clarification it starts with a mindfulness exercise where you guide the patient to literally visualize that they are observing their own funeral. There is a eulogy being given. Everyone who has ever loved them or cared about them is going to speak on their behalf about the life you lived and the life that you strove for and if you want to be remembered and commemorated. If these people were going to speak about the life you lived, how would you want to be remembered? Many people find this extremely powerful. What you will find out and it has never failed me, you will find out they want to be remembered as a loving family member. As productive and intelligent and talented and supportive. All of these wonderful things. I have never had anybody say I want to be remembered as someone who conquered my pain. And I say that. Think about how much energy and time you are putting into that if that's not necessarily what matters most in the grand scheme of how you want to be remembered.

Would it not serve you better to consider how you can continue to take action in order to honor these other domains that really matter to you? Family, parenting, mentor ship, brotherhood, teaching, learning, studying, help. There are so many aspects of health. Let's unpack some of these other domains that can tell you that you will live long enough to walk your child down the aisle or witnessed the birth of a grandchild. The alternative if you are hesitant to using the tombstone analogy would be to talk about a this is your life achievement party or this giant banquet. And you are being honored with an award. And this is how people

speak to you. Sometimes that takes some heaviness out of it. Especially based on the sensitivity of your patient it's just as effective.

We often talk about your values are a compass. They are the direction in which you want your life to go. They give you direction. Our values are usually grounded in morality, virtue, some of the fundamental beliefs that help us live lives that are worthy and honorable. And so, if you can imagine and I will draw this on the board. I will say imagine your life is as a bus driver. And you have a lot of baggage on that bus. And you will have a lot of passengers on the bus. And the interesting thing about this is in this scenario it has no doors. Nevertheless, you are trying to go west. I will say this because we are out in California. Let's say you get to the beach. Are you done heading west? If your value is to go west? You can go to Catalina Island. Okay. I'm to go to Catalina Island. Now my done valuing West. You can go to Hawaii. I'm going to go to why. When I get to Hawaii and my done valuing West?

And the takeaway from this is your values are never done. They keep us going. They are the passion and the energy that help us thrive. Right beneath the value domain is the goal. The goals are the signposts on the road that tell us we are heading in the right direction. If I am in D.C. and I hit the Grand Canyon, at least I know I am heading west. I found this massive crevice in the earth and I am doing the right thing. I'm not done honoring West. So, I'm going to keep going until I see Vegas, baby. I'm still moving west.

I'm going to keep going until I hit San Diego or Hawaii. And so forth and so on. When we do this, we will also talk about the passengers. Passengers made tried to [Indiscernible] us. They are the internal obstacles. Those passengers represent pain, insomnia, fear, anger, and they are talking and talking and yelling. I will even say some of these throw spit wads that you. There something interesting about being a bus driver. There is always that yellow line that divides the driving cab from the passengers. They are not allowed to cross the line. Even though you want to boot those passengers off the bus, you might lose your job as a driver. If every person you gave a ride was an A-hole, you wouldn't be a successful driver. You have to tolerate. You have to accept that they are there. And just because they are there doesn't mean you have to answer to them. You can keep driving in spite of the noise. So, we use that as a way to help guide them. We might identify with some of the passengers are.

A wonderful way to clarify how much the values mean. And also, to help them internally get into contact with some of the unwanted not just the sensation but the emotional stuff that goes with those unwanted sensations. All right. I'm pausing for questions.

If there are no questions let's move on. We are actually at a great place here where we are wrapping up and I recognize virtual time online is tiring to sit for this length of time. I cannot help but emphasize even though you went through this talk with me it is so helpful to go to an ACT boot camp. Where you can engage in better role-play. And practice having dialogue. I know our patients are challenging and they will throw us curveballs. They may drag us down a total diversionary hole. They

will distract. We have to redirect we have to be able to show compassion and understanding and still help them change. The website is a huge resource. We believe in transparent access to learning. They used to have value based fees and unfortunately given issues they have now put the bar at a relatively respectable number. You can still gain a lot of valuable information. There are all so - also some fantastic links. The ask for chronic pain group protocol. I also have the living beyond your paints self-help ACT based workbook. You can see an alternative that is still using the same format control is the problem. Let's get them to creative hopelessness where they realize their efforts to control are putting them on a merry-go-round and let's step outside of that and think about willingness and we talk about acceptance and we clarify values and once they are clarified you can set goals.

And then once you set those goals you can really offer that behavioral reinforcement, cognitive behavioral reinforcement and use and interweave throughout your session mindfulness practice to help them internally with creating a different relationship with their body. That is what we are about. If you want to learn more about the fundamentals of ACT, again a boot camp is essential and they have constant smaller workshops and no matter what continent you are on they have an international conference every year that I think - I think that's it for me. We may be done relatively early. I do want to open up the room for any questions, comments, feedback, and now is a perfect time for us to explore any areas that were too fast or too complicated. If everyone would like to enable their WebCams and say hello. We have some shy birds out there.

It's a long time to sit.

Hello. >> Do you want to unmute?

Areas.

Nice to meet you. >> I know it's hard.

Nice to meet you.

I have one question about mindfulness exercise.

Please go ahead.

Which ones do you find particularly useful? Which ones are particularly useful in a group session?

So great question. I'm not sure if you find it on my mindfulness workshop which will be tomorrow, but I like to for people who are brand-new to mindfulness. I usually like to start out with a practice that starts out short timewise. May be a 2 to 5 minute practice. Many people are so uncomfortable, and they have never slow down long enough to even sit. You will see some pretty interesting stuff show up. A lot of fidgetiness and emotional resistance. Some people hate it.

If you're doing it consecutively, at least once a week in session, you will see people actually begin to settle in or crave or appreciate it. I

almost always start more with simple things like a body scan. Getting familiar with how their body feels. And then I might advance or progressed into a guided thing like imagery and then I may go into more diffusion exercises. So much of it will depend on where you are on the 'Hexaflex'. I'm going to recommend the textbook by [Indiscernible] Afri and Jill's daughter. They have published an excellent textbook on the book of metaphors. There may be some mindfulness practices in there. There is another book that I referred to a lot called inside this moment.

Okay that is the first one.
The other one is inside this moment, I think by Strozol, I will have to get back to you.

Okay.

Wonderful books on weave mindful practices into your work hope that was helpful any other questions I can clarify further, do I see any place for group therapy with ACT?

This is actually what I like doing, I've been doing ACT groups with pain since 2007, and then in 2011 I came over to the off duty side. I found it to be extremely valuable because living with pain is isolating, when they are finally opening up to will, and willing to talk to their experiences it's nice to help that they're not alone, and helps with that feeling of being heard and validation. In all honesty many of our folks once they correct, they connect and request, befriend other people and are still in contact today.

Are the AA principal similar to act? >> Not necessarily.

You will have to forgive me, I am less familiar with the specifics and the foundations of AA, however rather than take action on past mistakes I would argue that ACT is very present focused. It encourages the patient to look at the short and long-term benefits of their behaviors and what that has been, on their current quality of living. Whether or not certain chosen actions are serving them in a way that is helping them live a happy life, healthy life, there has been a number of books for people in recovery. I would absolutely recommend that you go on the website. That you look at the books written for ACT treatment and substance abuse for addiction, and using ACT subsequent trials, that has shown it being used for abuse, and has been successful, finding alternative ways to cope. Not being impulsive, and reactive to uncomfortable emotional sensation, all of these are involved I could imagine in the AA treatment, and the complement each other rather than parallel if that makes sense?

Admitting alcohol, -- Your thinking of the hexagon where would you put that in, Kathleen I'm responding to when you're looking at the Hexaflex there, and you're looking at alcoholism, where would you like to put that into the Hexaflex? It could be weak self-knowledge, it could be an ability to have flexibility and thinking at the top present moment. I hadn't thought about that. If we are looking at things like triggers, urges, we know urges that are negative emotions, or neutral emotions, boredom, anger, depression, those often trigger urgent to use. That awareness using mindfulness to delay that gratification is one option. In

the grand scheme of how one identifies, that can also be considering, how do you want to be remembered as a person? You want to be remembered as an alcoholic? Or do you want to be remembered as someone that did other things? I take think on cognitive behavioral methods things you can distract, substitute, replace, delay, that impulse of gratification, I do think if you are working on direct tolerance that's a great method to intervene.

Have I answered your question?

Again, if we look at the Hexaflex theory of change, one of those things that the treatment can do using ACT, if the valued domain of sobriety, then what are the goals that they can continue to set? In order to organize their approach, I want to get that chip for sobriety, or I want to be a mentor, those are goals and then action specifically connected to those goals, that means I will go to meetings, three per week, I will consult with my mentor about how I can be a mentor, it is the ACT model defining the specific actions toward a goal. It is online, in line with the value.

Any other questions these are fantastic by the way? I really appreciate the interactive aspect, it's a hard to be talking to my laptop.

I'm also going to say too, people have afterthoughts, I'm going to put in my email here, in the event as you are going through this, those of you who are watching this later and cannot ask your live question. -- ask a live question. I'm putting in my email pick it is Kathleen.McChesney -- on the global Outlook, if you got my first and last name you will find me quick. I will put one more shout out, any more questions at this time?

Any more thoughts? Anymore curiosities or comments at this time? There it is, I'm just going to do one more shout out to the beginning, if anybody needs anything to download, any CME, the sign in sheet from the files part pick you can do so please pick that is all for me that means you guys can wrap up for the afternoon, that is a thank you for coming to the workshop, if we do this next year, introduce yourselves I would love to chitchat afterwards, extending my thanks to Linda, Mitchell, and everybody on the program, thank you so much for your patience, stay safe everybody, and take care.

[Event Concluded]