FEEDBACK

Issue3 2009

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President's Report

I have recently returned from the 32nd National AACBT Conference, which was held in Perth this year. It was an excellent conference, and very well attended, with about 300 participants including a large delegation from China who were very keen to learn about CBT activities in Australia. The scientific program was very busy, with many interesting and challenging presentations, and several thought provoking debates. One of the things that stood out for me at this year's conference was the theme in relation to evidence based interventions, and going back to careful empirical study of not only whether new or tailored interventions actually work, but also the mechanisms by which the interventions have their effects and the range of factors which can impact on intervention outcomes. In this context, there were also several presentations which highlighted some of the past and recent developments in CBT, and emphasised that the tradition in our area has been to study and explain human behaviour using the most well validated empirical and theoretical tools. Thus, many new theories and ideas can be encompassed under the umbrella of CBT, provided they meet the criteria that they explain human behaviour in an empirically validated way. As an interesting coincidence, the article in this issue of Feedback on ACT highlights some of these concepts as well, while critiquing some of the novelty in this particular approach.

After three days of being glued to a seat at the Convention Centre in Perth, it was a relief to attend the conference dinner, which as usual was a great social and networking event, and included observation of some great moves on the dance floor. One of the unique elements of AACBT conferences is in being able to gather a variety of people from all over the world and to feel like it's a big happy reunion. It is also a great opportunity for students to test their presentation skills in a very encouraging framework. Many of the 'veterans' of AACBT conferences fondly remember that their first ever presentation was at just such a conference. While there were many highlights to this year's conference, one is going to stay with me and with many others for a long time. The image of Prof Tom Borkovec and Dr Emily Holmes leading the audience in a rendition of "Don't Worry, Be Happy" as part of their effort in the Great Debate to persuade us that relaxation should not be banned in CBT. Both sides put in an incredible and highly entertaining effort, and in the end it was a very tight vote, but it was agreed that relaxation should stay.

Locally, since the last newsletter we have held two workshops, by Nikolaos Kazantzis on the effective use of homework in August and by Prof Tom Borkovec on managing generalised anxiety disorder in September. To finish off the year Prof Kim Halford has kindly agreed to present a brief seminar "On the successful treatment of couple therapy-phobia: How therapists can transcend fear and revulsion and come to enjoy couple work" which will be held on the 2nd of December in conjunction with the AGM. This event will be free for members and drinks and canapés will be served, so please mark it in your diaries.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)- A BRIEF VIEW

Michael Free

The theory and philosophy of Acceptance and Commitment Therapy were first formulated and presented in book form by Hayes, Strosahl, and Wilson in 1999. Acceptance and Commitment Therapy or ACT (pronounced "act", not "A-C-T") is based on "Relational Frame Theory" a behavioural theory of language which claims that our language structures can lead us to an inaccurate understanding of our world, thereby locking us into counterproductive ways of dealing with the world. An important part of this is that language leads us to understand a thing in terms of its *relation* to other things, which may detract from our ability to understand the first thing. More simply, according to ACT, our use of language leads to pain, and to rigid and stereotyped ways of dealing with that pain. Our rigid and stereotyped ways of dealing with pain are known as psychological inflexibility.

PSYCHOPATHOLOGY

Psychological inflexibility is the heart of psychopathology in ACT. Psychological inflexibility is produced by six factors: experiential avoidance; cognitive fusion; dominance of the conceptualised past and future and limited self-knowledge; lack of values clarity; inaction, impulsivity or avoidant persistence; and attachment to the conceptualised self.

Experiential avoidance involves attempting to control internal experiences, including thoughts and feelings. Humans have evolved ways of predicting and changing external experiences, and to our minds, our internal experiences are similar to our external experiences. We can pull the thorn out of our foot with our hand, but we have no mechanism to change the pain in our chest. Even controlling our thoughts is quite difficult. If we are asked not-to-think about something, such as the famous white bear, we find it very difficult. Finally, to add to our misery, properties of real life are transferred to verbal events. We can be frightened about something we dream up ourselves that does not exist and may never exist, such as going broke and losing our business, home, and family. We can even get anxious about developing anxiety associated with that scenario, so our distress can compound as time goes on.

Becoming obsessed with the idea of going broke is an example of cognitive fusion. In cognitive fusion the thought becomes confused with reality such that just because we have a thought, we think it reflects reality. Domination by content means we become involved in the content and never step back to evaluate whether it is true or not: the event and the interpretation of the event are fused. Another example of fusion is the 'event-action sequence', in which the role of choice is devalued, as in "I stayed in bed because I was depressed"= "Depression caused me to stay in bed".

Dominance of the conceptualised past and future and limited self knowledge are two sides of the same coin. Dominance by the conceptualised past may lead a person to ruminate over past errors. Alternately a person can spend a counterproductive amount of time fantasising or worrying about the future. A similar pattern can apply in the interpersonal sphere… a person can spend an inappropriate amount of time obsessing over minor interpersonal hurts rather than looking for intimacy. These three factors mean that the person's attention is directed outward, and forward and backward in time. The person does not acquire rich and detailed information about themself and tends to repeat old behaviour and chase meaningless goals rather than consider new possibilities.

Attachment to the conceptualised self is another example of how language can be both productive and counterproductive. Language can help us construct an identity or concept of ourself, but we then become limited by that very same construct. A person tends to construe themself in terms of the labels they have been given, or decided for themself on the basis of past experiences. The person then behaves in accordance with the label, but may also be limited by that label. Examples are "I am a battered wife", "I am an alcoholic", "I am an agoraphobic".

According to ACT, another source of counterproductive behaviour is *lack of values clarity*. Values refer to the principles a person uses to determine or select goals and choose acceptable actions to achieve those goals. They are used to guide life, and evaluate courses of action. Values are chosen qualities of life. According to ACT people in general do not consciously choose and refine their values, but act in accord with more ad hoc principles that have a more short term compass than values do, thereby reducing their chance of long term success and happiness.

A final important quality that leads to psychopathology in the ACT view, is the tendency of people in pain to be *inactive, impulsive and to persist with their avoidant strateg(ies).* Such people display an inability to behave effectively with regard to chosen values. Furthermore, such people emphasise short-term goals and de-emphasise long term happiness. Many of the short term goals are relatively trivial, behavioural repertoires are small, and the generally avoidant strategies ill-chosen and ill-applied, but are persisted with.

Therapy

In an elegant symmetry, ACT has six Core Therapeutic processes that derive from the above model of psychopathology. They are: being present, acceptance of private events, cognitive defusion, defining valued directions, committed action, and self as context. Therapists use a number of strategies to engage these processes.

Being present, or *present moment awareness*, counteracts dominance of the conceptualised past and future. Rather than having ones awareness focussed on the past or future, ones awareness is focussed in the present moment. It is a mindfulness technique in as much as it involves being aware of what is in your mind. According to Hayes, being present is more direct, less conceptual, less fused, and more responsive. Part of being present is "self as process", which involves observation of oneself in ongoing, defused, non-judgmental, descriptions of thoughts and other private events.

Acceptance of private events is an alternative to experiential avoidance, and is supposed to counteract experiential avoidance. Similar to being present it involves the active and aware embracing of private events, which previously were seen as toxic and thus includes aspects of exposure. Rich, flexible interaction with the previously avoided experience, willingness, and flexibility are encouraged.

Cognitive defusion counteracts cognitive fusion. Thoughts are isolated from their relationships and seen to be just what they are: word patterns or images that occur in consciousness. Language is seen as merely language. Clients do not have to rid themselves of negative feelings and distorted thoughts as they do in traditional Cognitive Therapy.

Self as Context counteracts attachment to the conceptualized self. In ACT, instead of seeing oneself as a label, one is encouraged to see oneself as the continuous and transcendent aspect of the central locus, the "I" from which events are experienced; the observer/experience.

Defining valued directions is the antidote to the lack of clarity of values that is seen as pathological. Clients are encouraged to discover and articulate their values. Unlike some of the other aspects of ACT treatment, values clarification and commitment is a language based activity, and, in this area, language is strengthened. Values are essentially choices. They are seen as very important in ACT because they actually give direction to the application of the other aspects of ACT treatment. "Truth" is also important in ACT. Truth is what is useful in empowering us to live rich, meaningful lives guided by our values, but truth in ACT is contextualised. Instead of truth of beliefs, the emphasis is on establishing what they are in service of - are they likely to be helpful in leading toward a life that reflects chosen values?

The final therapeutic process in the set is *Committed Action*. Once values have been determined, behaviours are planned that lead to achievable concrete goals that are consistent with those values. Larger and larger patterns of effective action are linked to chosen values. The behaviour is developed using standard behaviour therapy techniques such as shaping, modelling and the like.

A PERSONAL COMMENT

As a long time diehard/dyed in the wool cognitive therapist and behaviour therapist, it has taken me a long time to come to any grip at all with ACT, despite reading several books and attending several workshops, including one by Hayes himself. While the above may be a gross oversimplification, I hope that it has been helpful to others.

So what does ACT have to offer that is new, different, or useful. The concepts are certainly not original. Fennell and Teasdale talked about depression about depression in 1987, Rachman talked about thought-action fusion in 1997 or earlier and Linehan introduced mindfulness, an ancient Buddhist technique, to mainstream cognitive therapy in the late 1980s. Much of traditional cognitive therapy can be seen as defusion. What the thought-record or the ABC analysis does is encourage defusion, since it involves disengaging the thought from its surroundings. In my own work (Free 2007) I talk about one's identified thoughts as becoming 'propositions' to analyse. The impact of labelling is also recognized in traditional cognitive therapy, as is the importance of avoidance and inertia (See Beck 1976 pp 91, 218, 274 for just some examples). Other aspects of ACT also seem very similar to metacognition as articulated by Wells (e.g. Wells 2000), and the equivalent of committed action is also part of traditional cognitive therapy. Obtaining an explicit commitment to change is part of REBT (see Dryden and Branch 2008, p 119) and CT (Free 2007, p176). There are many views of what CBT is, but one is the idea that once the therapist has used cognitive techniques to change the person's thinking, then the traditional behavioural techniques are used to change behaviour or increase their behavioural repertoire, again this is part of my own approach (Free 2007, see pp 173 and following)

There are also resonances of the ACT schema with other approaches to psychotherapy. Bandler and Grinder in Neuro Linguistic Programming talked about increasing behavioural alternatives as an important aim of therapy. Their concept of "congruence" has some similarities with the ACT approach. Finally, discussion of values has been recognized since the 1960s and the work of Truax, Carkhuff and Berenson as an important aspect of psychotherapy. Lewinsohn in his Coping with Depression program has a section on goals and values (See Lewinsohn, Munoz, Youngren and Zeiss 1986 pp 185-204).

Thus it seems difficult to find any aspect of ACT that is really original. Instead what we see is a number of principles that can be found in other therapies that are put together in an elegant and symmetrical package, with what is possibly an underlying unifying theory. (It is of course beyond the scope of this short article to analyse the theory). What this does is create a shift of emphasis rather than a new therapy. The six areas of pathology and six associated therapeutic principles are relatively easy to either incorporate into therapeutic practice, or to use by themselves as the underpinnings of a reasonably comprehensive therapeutic practice.

Themes that seem come out of ACT are:

- The entrapping nature of relational meaning,
- Fusion vs mindfulness.
- Rigidity vs alternatives
- The centrality of values

ACT also has a slightly different way of working than traditional cognitive therapy in as much as it is more process based than content based. This may suit some therapists and some clients. From the point of view of a practising cognitive therapist I see a number of aspects of ACT as useful. The first is the idea of fusion/defusion. Although, as noted, defusion is done in CT, it is not emphasized as much as it is in ACT. Secondly, the ACT approach does point towards the importance of shifting attention *from* the outside world, the interpersonal world and the past and future *to* oneself. The questioning of labels, and of the idea that you must always behave the same way as you always have done and act in accordance with your label, is empowering. As a fairly content oriented cognitive therapist it is useful for me to be reminded of process, and while I do frequently discuss values in therapy as a legacy of my training in the late 1970s, I have not articulated that as part of my therapy up till now. Which I think goes to show that there is some wisdom in any therapy which is based on a genuine desire of the originator to come up with a better way of conceptualising what we do with clients both for our own benefit and to pass on to others, whether that therapy is psychoanalysis, ACT, REBT, mindfulness, Neuro Linguistic Programming or cognitive therapy.

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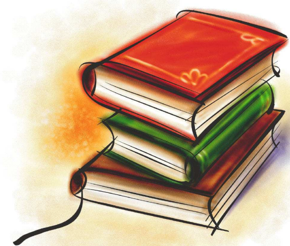
AACBT Qld Resource Library



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Workshop Review: Tom Borkovec – CBT Approaches for Managing Generalised Anxiety Disorder, Saturday 12th September, 2009.

On Saturday, 12th September, 2009 AACBT Qld hosted a one-day workshop titled 'CBT approaches for managing Generalised Anxiety Disorder', presented by the world renowned Professor Tom Borkovec. Tom has spent many years studying anxiety and its treatments, primarily from the base of the Pennsylvania State University, USA. The workshop was well-received with approximately 32 participants registered prior to the day and with all registrants attending.

The audience was riveted throughout the whole day with Tom's charismatic presentation holding their attention better than I have witnessed in a workshop of any kind before. Tom's style of presenting was a successful combination of personalised anecdotes, review of prominent research and researchers, as well as the future outlook of anxiety as a disorder and its treatments. He also made a point of living up to his advertised promises, such as performing a 'magic trick', quoting relevant and meaningful song lyrics at random, and showing a videotaped 'cure' for GAD. Tom's overwhelming knowledge of anxiety, research regarding anxiety, and treatments for anxiety was blindingly obvious and definitely contributed to the clarity of information he presented. Although it is true that he reviewed some basic anxiety research and simple CBT techniques with regard to anxiety in general, the way that he framed this information to include the findings of current research and link it to evidence-based practice of today was remarkable.

On a personal note, Tom was very approachable and willing to engage with attendees during the breaks and after the workshop had concluded. Given the calibre of Tom's own body of research and the widely recognised contributions he himself has made to the field of anxiety disorders, this was an additional delight. Some may say it was the icing, on an already very satisfying cake.

Michelle Combo

ACBS ANZ

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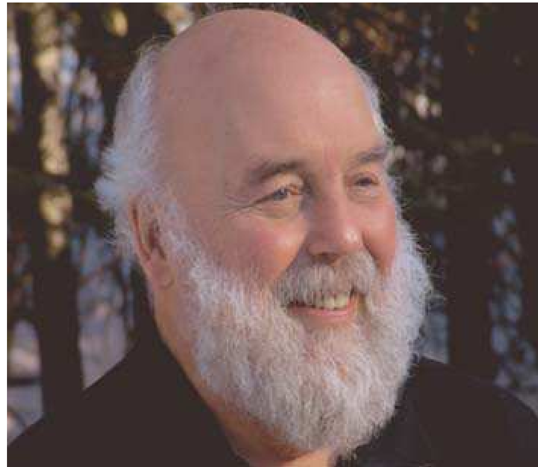

TO PRESENT A TWO-DAY WORKSHOP

Emotion-focused Couple Therapy: The Dynamics of Emotion, Love, Power and Forgiveness

Friday 19th and Saturday 20th February 2010 Brisbane

Registration and venue details to be finalised.

\What is Emotion-focused Couple Therapy (EFT)?

EFT for couples is a short term (8-20 sessions), manualised approach to couples therapy formulated in the early 80's by Les Greenberg and Sue Johnson. Research suggests that EFT for couples can move couples from distress to recovery in 10-12 sessions. EFT is based on understanding the role of emotion and emotion regulation in marital and individual distress Change strategies and interventions are specified. EFT has been validated by 20 years of empirical research. There is also research on the change process and predictors of success. EFT views marital distress as maintained by absorbing states of negative affect and constricted patterns of interaction such as criticize/withdraw and pursue /distance. These patterns prevent the safe emotional engagement necessary for secure bonding.

THIS WORKSHOP IS DESIGNED TO HELP YOU:

Understand the phenomenon of marital distress in the context of emotion and its role in intimacy and attachment as well as influence and identity.

Learn to differentiate between adaptive attachment and identity oriented emotions and negative emotional reactions.

Learn steps to promote forgiveness or letting go and reconciliation

Deal with issues related to rebuilding trust

To foster a more secure emotional bond between partners

Les Greenberg - Biography

Dr. Greenberg's work has received international critical acclaim. Professor of Psychology at York University in Toronto, he is the primary developer of emotion focused therapy for individuals and for couples. More recent books include Emotion-focused therapy: Coaching Clients to work through their Feelings (2002), Emotion-focused therapy of Depression (2006) and Emotion-focused Couple therapy: The Dynamics of Emotion, Love and Power (2008). Dr. Greenberg received the 2004 distinguished Research Career Award of the International Society for Psychotherapy Research, of which he was a past President. He recently was awarded the Canadian Psychological Association Professional Award for distinguished contribution to psychology as a profession and the Carl Rogers award of the Division of Humanistic Psychology of the American Psychological Association.

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Dr Michael Free is a well known Brisbane Clinical Psychologist with 30 years of experience, in a wide variety of settings. He is the author of “Cognitive Therapy in Groups”, the second edition of which was published by John Wiley and Sons in 2007. He is in full-time private practice in Chapel Hill and Ipswich.

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