Being ACT at Every Step:
Weaving What Matters into Your Work in Complex Clinical Situations

JENNIFER PLUMB VILARDAGA, PHD

DUKE UNIVERSITY MEDICAL CENTER

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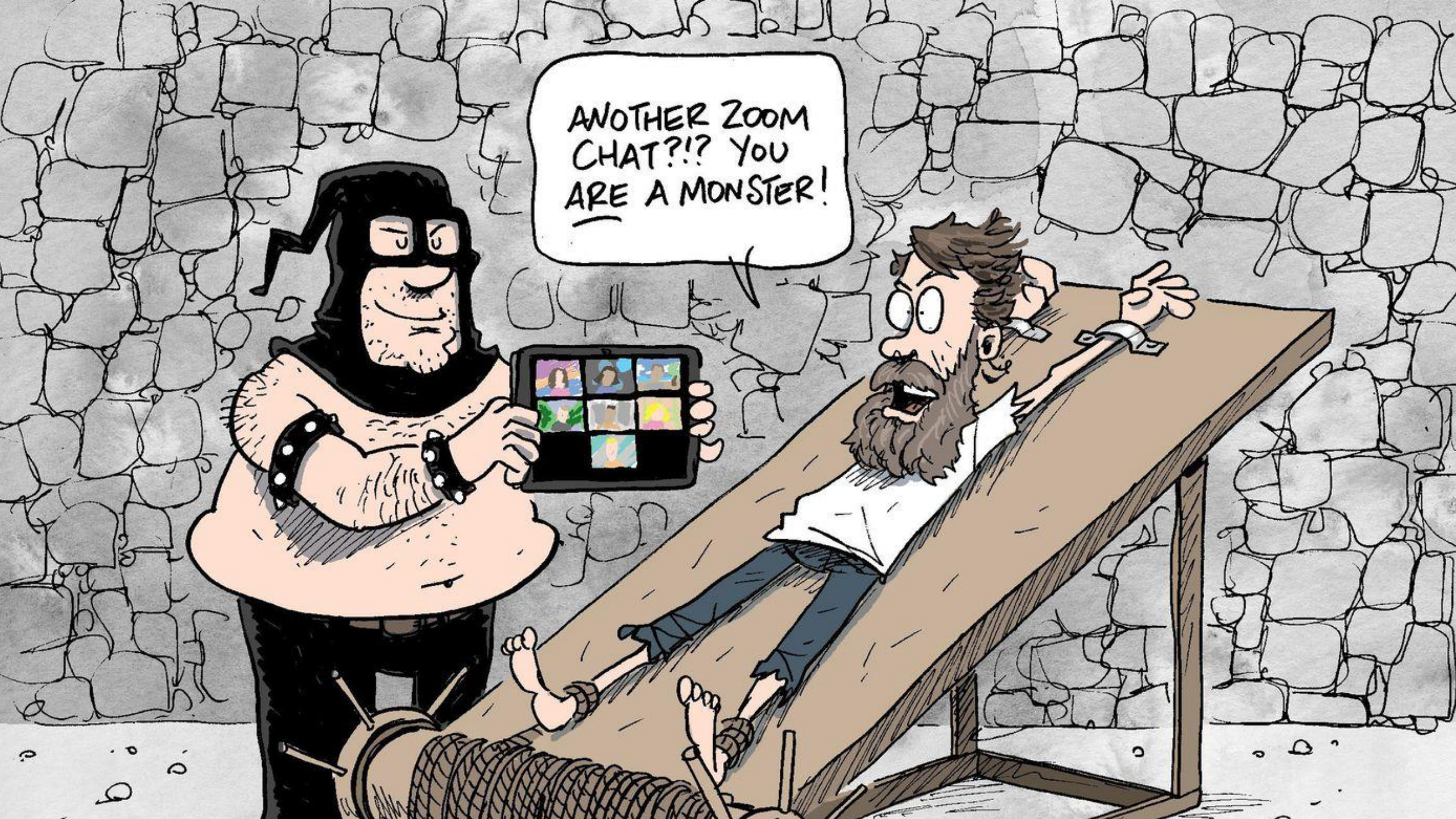
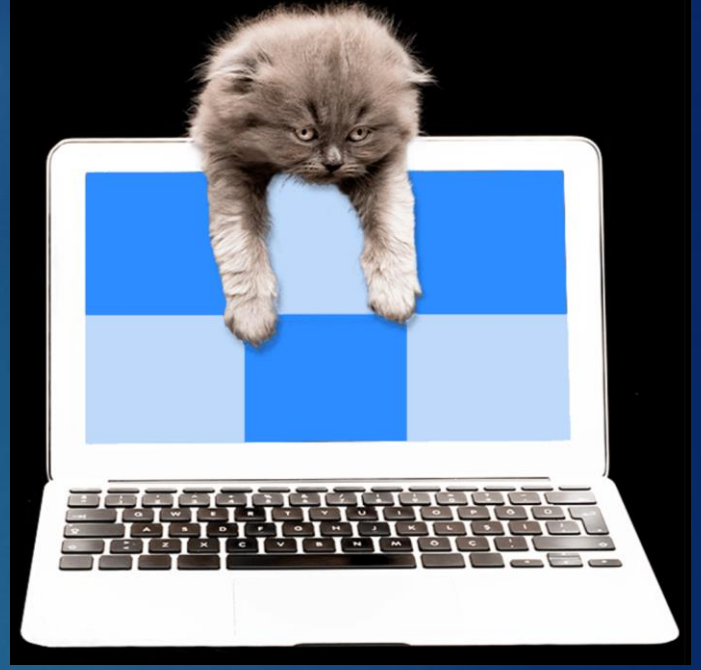
Yay for Global Connectivity!

Yet maybe some of us are feeling like…


ANOTHER ZOOM CHAT?!? YOU ARE A MONSTER!

Embracing the ZOOM



- Let's all take a moment, wherever we are in the world and just limber up. We are in for a LONG set of days in front of our screens….
- This is a real space with real people. Take care of you AND please stay muted when not talking; turn off camera as needed.
- Interactive! Please unmute and speak up.
- Virtual Hand Raise as well

What are your struggles?

- Take a moment to do the POLL
- Let's discuss what gets in the way of being as ACT consistent as you would like to be

When we put aside the ACT Toolkit

- **At a technological level,** we often need to focus on techniques that address other issues than psychological flexibility for your client/stakeholder

When we put aside the ACT Toolkit

- **At a philosophical level, we do not need to.**
- We will discuss today how to stay consistent with ACT at its core, and your values throughout your work

Contextual Behavioral Science

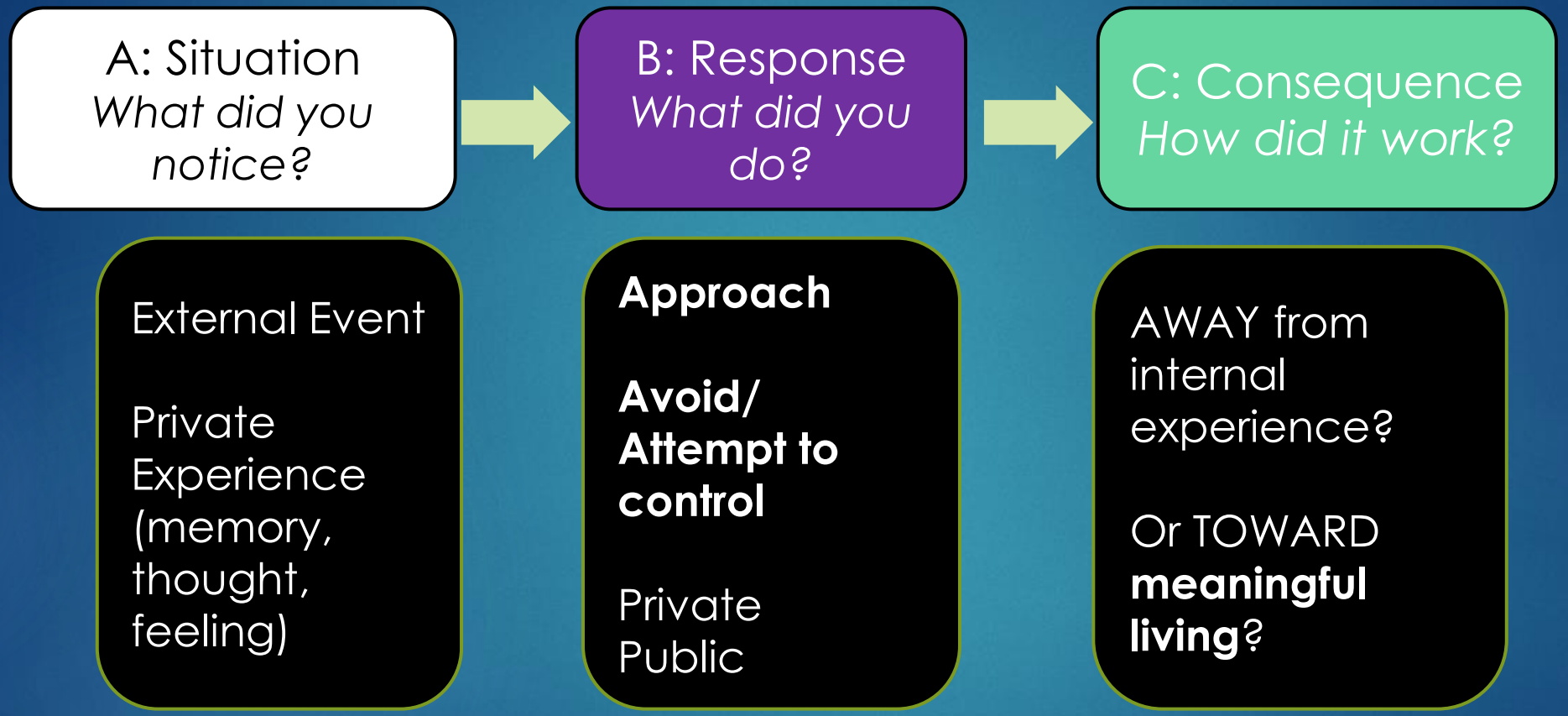
For the contextualist,

ideas are verified by human experiences,

with an idea's "meaning" essentially defined by its practical consequences,

and its "truth" by the degree to which those **consequences reflect successful action**.

Parallel Process – ABCs of Case Conceptualization



Asking these questions helps build a functional analysis

With our clients (help them learn this skill), and with ourselves behaving in the room

Model of Intervention:

Open (Acceptance, Defusion)
Aware (Present moment, Self)
Active (Values, Commitment)

In other words…

- WHAT we do may look like safety planning, boundary setting, documentation, procedures/policy completion, resource gathering, and such

- HOW we approach this can be completely in line with our values, and with sensitivity to the current context (private, public), and we can practice psychological flexibility with regard to that

Authoring & Amplifying Values

- **Tune In to what matters:**
  - Present moment practices to help you identify what matters in your heart
- **Turn Up the Volume:**
  - Not just the WHAT but the WHY
  - Bring present moment attention to What I am Doing AND Why I am Doing it*

- Practice. Ready to write.

**Behavior analysis caveat: Why do we things is under multiple sources of control. We are simply focusing on the chosen, value-guided part of this equation.*

WE NEED FLEXIBILITY… VALUED ACTION IS HARD

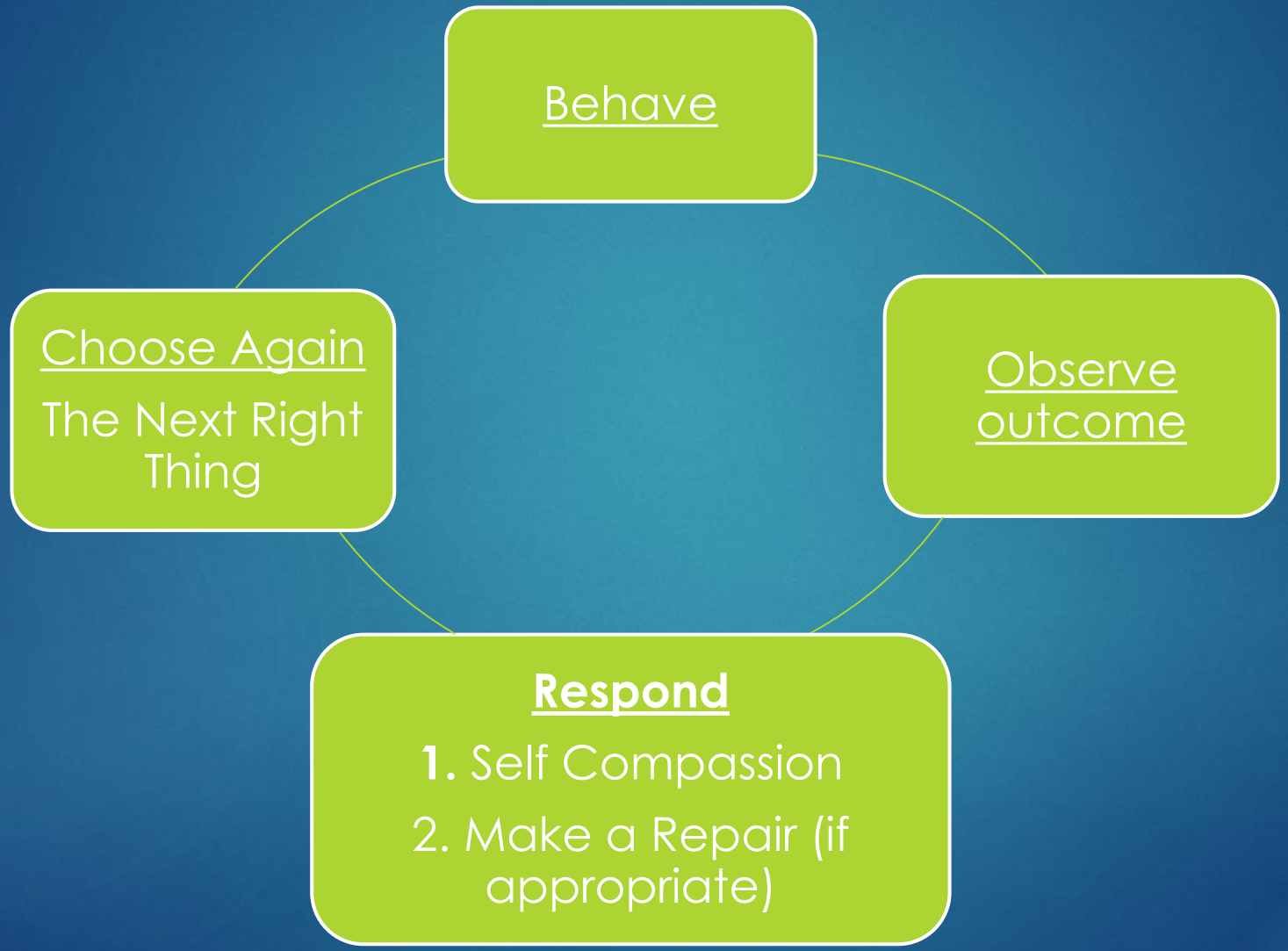
- Values as a metric for "failure", a reason for increased self-judgment or anger
- "IF I care about that, and I/they didn't live in line with that, I am/they are _____"

- Yet…

Valued action as an imperfect, ongoing process

- With openness and awareness, increase willingness to track our behavior, and make space for what shows up when we do not live in line with our values
- Practice genuine apologies/repairs. Respond to repairs with "Thank You."

Valued action as an imperfect, ongoing process



Self compassion

Opening up to our (shared) humanness

Can we practice re-committing – moving our feet?

Willingness as self-compassion

- Willingness is All or Nothing: Jumping
  - Jumping = both feet off the ground at same time
  - Do. Or Do Not. There is no Try.
  - **Self-Compassion Move:**
  - ***We do get to decide from how high we jump!***
    - Work up to bolder actions starting with smaller success experiences

Clinical Challenge: Client Resource Issues

- What to do when your client presents with a pressing needs issue:
  - Instability of housing, food, finances, employment, legal status, or family

- **A common mistake:** Rigidity with applying ACT strategies (at the intrapersonal level) when societal resource/interpersonal issues may be more pressing

- **A common mistake:** Forgetting that ACT can inform how you relate to others in this place
  - There is a way to integrate ACT ideas with resource struggles

ACT Consistent Case Management

- If there is an immediate need, provide support for it if you can
  - Become aware of your local supports for these issues, share them, or make connections with those that have access to them
  - Finding balance between support, and overfocusing on fix-it agenda
- There is a role for psychological flexibility in how you and your client ***relate to*** these resource issues

ACT stance on addressing resource issues

- Assess the current and historical context in which these issues arise
- Honor society inequities and personal histories that contribute

- What are the external barriers to meeting these needs?
- What are the private factors facilitating or hindering these needs being met?
  - ACT case conceptualization for clients
  - Parallel process:
    - Do I have an opportunity to help them live better in response to challenging situations, even as I would like to help them change that (e.g., through advocacy, etc)?
    - If so, how do I want to show up to that?

Client is in unstable housing and needs financial support.

Scenario 1:

- Therapist: "Here is a list of places you can get support. I hope you call them, because these are serious issues and I'm sorry that you are dealing with them. OK, so for homework, let's discuss how control gets in the way of your values."

Scenario 2:

- Therapist: "I have a list of places to potentially help with these issues. Would you like to go over them together? Maybe together we can see what the next steps would be, and discuss what comes up as you consider utilizing them."

What happened in scenario 1:

- Therapist responded to content of request without assessment of function and without self-reflection.

What happened in Scenario 2:

- Therapist offers to join with the client in both the content of the need and the psychological responses that arise

ACT consistent boundaries

What happens when clients ask for things you are uncomfortable with? Some common scenarios:

- Letters for "getting out of" or "getting into" something
- Asking for more/different meetings than you are prepared to/able to provide

- Client conceptualization: What are the functions of this request?
  - Unsure? Ask.
- Self-reflection: FORM and FUNCTION
  - FORM: What am I struggling with about this request?
    - Timing of request, Nature of request, Compliance?
  - FUNCTION: Assess using the model- avoidance, fusion, self stories, values conflict. What shows up for you? What is useful and what can we make space for and move forward?

A client you have met once returns for second visit.

Scenario 1:

- Client: "My lawyer says you need to write me a letter stating that I am permanently disabled"

- Therapist: "I don't know you well enough to make that determination. Nor do I see that as my job to determine. I'm sorry."

What happened in scenario 1:

- Therapist responded to content of request without assessment of function and without self-reflection.

A client you have met once returns for second visit.

Scenario 2:

- Client: "My lawyer says you need to write me a letter stating that I am permanently disabled"
- Therapist: "Tell me more about this issue. I'd like to help where I can."

[client shares details of disability application]

- Therapist: "I care about being an ally for you, even though I haven't known you for long. And I hear that you are worried about your disability application.

Let me be transparent. Our treatment plan and my value for working with you is to help improve your overall functioning. That is at odds with the idea of permanent disability. However, I understand that the system we are in likes providers to make strong statements like that, and you get caught in the middle.

I *am willing* to write a brief, descriptive letter that includes your diagnoses, what I know from you and your medical records, the dates I've seen you, and our treatment plan. We can do that right now so you can see it. What do you think?

- Client: "OK I guess that would work".

What happened in scenario 2:

- Therapist seeks info, and buys time for case conceptualization of request
- Therapist self-reflects on discomfort of the idea of indicating a "permanent disability" and for a new patient.
- Therapist shares their values, and is responsive to the client's wishes, if not exactly as requested.
- Therapist can join with the client in this issue.

Clinical Challenge: Client Safety

- Suicidality and violence safety plans
- In what ways can they be ACT *in*consistent?

Clinical Challenge: Client Safety

- Understanding the function of suicidality/violent ideation can provide a conceptualization of how to move forward
- Short term safety can allow longer term psychological flexibility growth

Clinical Challenge: Client Safety

- While in ACT we highlight difference between thoughts and actions…
- Imperative that we also assess and discuss with clients what to do *when thoughts feel like they are driving or could drive one's actions*
- **Safety Planning is completely in line with ACT. Do what works to keep people safe in the moment!**
  - Remember, distraction and avoidance etc. are not inherently bad. Simply want to be aware of *when, how often, and why we are using them.*

ACT is compatible with other evidence-based suicide management strategies

- One example is **Collaborative Assessment and Management of Suicidality** (CAMS; Jobes, 2012; 2016)

- Allows a conversation about the empirically-derived individual **drivers of suicide** (not just 'suicide risk factors'), helps determine the level of risk, and sets up safety planning
  - ACT can then be used to treat the drivers of suicide

- NOTE: No-Suicide Contracts DO NOT WORK
  - DO ask for commitment to use the Safety Plan
  - DO ask for commitment to attend therapy

Example Suicide Drivers – Personal/Psychological	**Example Suicide Risk Factors – Statistical**
	Static
Emotional Pain	Mental Health or SUD diagnoses
	Suicide Attempt History
Self-Hatred	Chronic Pain/Illness
	Family Member Completed Suicide
Psychological Stress	Dynamic
	Current SI, intent, or plan; Recent suicide behavior
Hopelessness	Social isolation/limited positive emotional support
	Impulsivity
Agitation/Urge to Act	Access to lethal means
	Current financial or legal problems
	Drug or alcohol use

CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rank	Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)
_____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
_____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
_____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
_____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
_____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

SSF- Initial Session part 2

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

_____

- Consistent with ACT perspective to look at both reasons for living AND reasons for dying… a defusion move in and of itself.

CAMS SUICIDE STATUS FORM–4 (SSF-4) TRACKING/UPDATE INTERIM SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will *not* kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

In the past week:

Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Section B (*Clinician*):

Resolution of suicidality, if: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

Complete **SSF Outcome Form at 3rd consecutive resolution session**

Patient Status:

TREATMENT PLAN UPDATE

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				

Do ACT here

A Note on Violent Ideation

- What is the function of anger?
  - Anger often a response to recognition of a transgression of our values
  - Anger often co-occurs with "softer" emotions of fear, hurt, disappointment, sadness, loneliness, etc.
- Short term goal, offer alternative behavior options to promote everyone's safety and freedom
- Case conceptualization - long term goal of working with clients to identify the psychological drivers of anger, and cultivate flexibility with responding to it
- Session #13 (right after this) with Hank Robb on Righteous Indignation

SAFETY PLANNING tips

1. Early Warning Signs of Crisis
2. Things I Can Do to Cope Differently
3. People I can call to either
    1. Help me manage the crisis
    2. Distract me from the crisis, reduce my isolation
4. Ways to Reduce Access to Lethal Means
5. Emergency Mental Health Contacts/Procedures
6. Where I will Keep This Safety Plan

Clinical Challenge: Institutional Requirements

- Therapeutic methods supported by your clinic that are not entirely ACT consistent; change/control-oriented, cognitive disputation
  - Examples from your work?
- **A common mistake:** Trying to ACT-ify models that are theoretically inconsistent
  - This CAN be helpful, if done thoughtfully, but can also create confusion
  - Examples of ACT-informed exposure work in Session #60 on Friday, and Session #112 on Sunday

Models inconsistent in theory or goal

- Are there commonalities with ACT? Does this complement ACT in some way?
- Are they tools that support some important improvement in symptoms?
  - Definition of experiential avoidance is when using this strategy *creates a problem*
    - Control, avoidance, distraction are not inherently bad
    - Later return to psychological flexibility as an explicit goal?
- Can we bring psychological flexibility to how we use those?
- What are your therapist values for utilizing these strategies?

Clinical Challenge: Institutional Requirements

- A facet of burnout based on institutional demands that require behaviors that are not in line with your values
  - In extreme forms, can be a kind of **Moral Distress** (Dean, Talbot & Dean, 2019)

- Simply being a part of a system that has high demand for documentation or other work that takes away from your autonomy or patient care time

Clinical Challenge: Institutional Requirements

- Case Conceptualization of this struggle… What shows up for you?

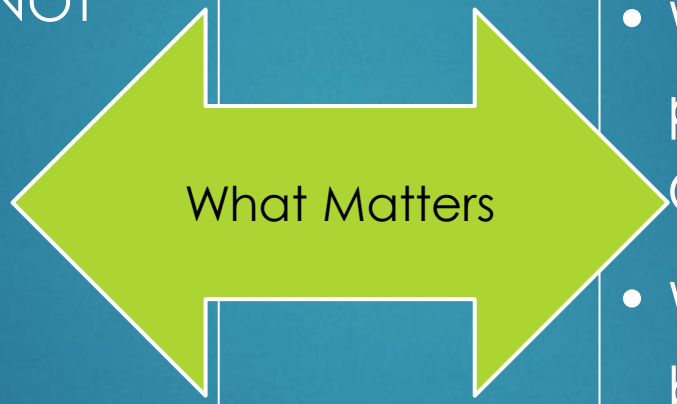
- What are your values for your work environment? Let's really spend some time here.
  - When do we speak up and when do we stay silent?
  - What is that under the control of?
  - How do you want to be? What are you willing/unwilling to experience if you speak up?

- In our pain we find our values… can we increase our willingness to contact those experiences so that we can orient toward values?
  - For example: Show up to the people you work for/with, Advocate for them, Support the people around you

Turning energy from struggle to purpose – in our pain we find our values

STRUGGLE SPACE

- We spend energy trying to NOT HAVE what we HAVE
- We FIGHT our experience
  - Deny, Dismiss, Discount
- We RUN AWAY
  - Disengage
- **Reduction of Emotion is the Guide**



PURPOSEFUL SPACE

- We use present moment practices to soften, breathe, and CHOOSE the 'Next Right Thing'
- We notice what happens, we breathe, and choose again
- **Increase in Meaning is the Guide**

Clinical Challenge: Burnout

- Particularly relevant given
  - The global impact of COVID, and significant health disparities for BIPOC and communities with resource limitations
  - The global environmental crisis
  - Political climates due to these and other difficult social factors
    - BIPOC, gender, & LGBTQ+ inequities worldwide

Clinical Challenge: Burnout

- There is more need than we can handle – and it will likely continue
  - Physical and emotional self-care is MUCH harder and dependent on connectivity resources
    - Less basic health prevention visits
    - Outdoor activity not safe or possible for many
  - Financial strain /unemployment
  - Chronic underlying stress; compounded for BIPOC/LGBTQ+ individuals
  - Work itself is often more stressful

Clinical Challenge: Burnout

- Parallel process for us as clinicians

- Creative Hopelessness Model
  - We are Response – Able

- Openness to experience more important than ever
- Mindfulness exercises to sharpen awareness, yet soften into it
- Watching for opportunities to turn toward values rather than away from our emotions

- Staying connected in our new virtual world
- How can we make these actions meaningful?
- Identify one small thing you can do to feel connected with a loved one even if you can't see or hug them
- Reflect on when and how often you engage in virtual activities designed to keep you engaged
  - Speak up for changes in your workplace – less meetings? More emotional check ins? More support for other life activities?
- Pivoting from virtual to other forms of life engagement when needed

- Returning to an exploration of values, when other sources of values expression are not available
- What values are being **amplified** for you right now in this global climate?
- What might be possible if we listen to that?

Honoring our emotional experiences

Flexibility in values expression

Embrace new values-guided actions

Shared Humanity and Self-Compassion

- It is rare that the whole world struggles with the same experiences all at the same time; us, our clients, our families and friends. Yet here we are. The ultimate parallel process.
- Lovingkindness toward each of us on our journeys within this time is critical.
- We are not all in the same boat – some of us have yachts, while others are drowning
- **Yet we are all afloat in the same sea.**
- ***I see you. You see me. We see each other. Open up. Feel the world's pain. Move our feet.***

Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.

Viktor E Frankl

QuoteAddicts

Q+A

Inspiration

- May we all seek to embrace all that our (public and private) history teaches us
- And continue to move our feet toward what matters

Thank you!

- Jennifer.plumb.Vilardaga@duke.edu