Grief and Hopelessness With ACT: Listen to Dr. DJ Moran Approach a Clinical Case

Welcome everyone! This is a Psychotherapy Academy interview with our ACT specialist, Dr. DJ Moran. I am your host, Dr. Jessica Diaz. Today, we will be discussing a clinical case with Dr. Moran. The idea is to give you, the therapist, tips and clarification about this therapy in real-world scenarios.

The hexagon model, as you may already know, includes 6 components: Acceptance, defusion, self-as-context, values, committed action, and contact with the present moment. Dr. Moran speaks about the trickiest of these concepts to grasp: self as context. But, don't despair! He also will give us a way to simplify it so it can be easier to understand.

I also described a clinical case for him, a widow with 2 young children who is overwhelmed with her life circumstances. He discusses important aspects: Empathy, fusion and defusion, the widow's reaction to Dr. Moran's interventions, and the average length of the therapy. We also explore what to do if the patient or client is unwilling to try and how to terminate the therapy. Oh, and how can we forget about countertransference? Dr. Moran has some advice on that, too. Sound interesting? Stay tuned!

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Psychotherapy Academy

Self as context: a tricky concept

I asked Dr. Moran in his experience as a trainer, what the most difficult concept to grasp is, to those new to ACT. He said that from the six components that they use from the hexagon model, one in particular stands out: self as context.

> **Dr. Diaz:** In all your years of practice, what would you say has been the most difficult concept to grasp?
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> **Dr. Moran:** Well, I appreciate you asking that because it's been my experience as a trainer, as a therapist and even someone who utilizes it, this approach myself the idea of self as context. Now, just to put this in a broader point of view, when people get introduced to training in Acceptance and Commitment Therapy, one of the ways we introduce ACT is by talking about the hexagon model.
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> We talk about how there are six points to Acceptance and Commitment Therapy, contacting the present moment, acceptance, defusion, self as context, committed action, values. And those six points -- I think it's simpler to understand committed action, values, mindfulness. I think sometimes people get a little confused with the ideas of defusion and acceptance.
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> But I think the real sticking point for some people is self as context. I think it's fairly esoteric. It's a little bit strange. It's essentially how are you going to come in contact with that core self, that observing you, that experience of just existing without necessarily getting caught up in your own labels, your own processes. Can you just be? Can you just realize you exist?
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> And I think trying to get that across to clients and people in workshops and even to resonate with that yourself at times can be a little thorny. So I think self as context can be tough for people to understand.
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> And I think what I try to do is simplify it, try not to get too caught up in the spiritual nature of it and just make it as practical as possible. I tell people, don't get wrapped up in your own language with your self-descriptions.
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> See if you could just notice that you exist right here in the present moment. And from that context, from that platform, you get to choose what you want to do with your life. You get to from this platform clarify what's meaningful to you. And from there, you

move forward and engage in some kind of measurable vital behaviors. That usually helps.

All right, so self-as-context is one of the most difficult concepts to grasp. From Dr. Moran's videos, we learned that the core self – the observing you – is a point of view from which all content – such as emotions and unhelpful thoughts – can simply be observed and accepted. As he said, try to notice that you exist in the present moment. From there, clarify what is meaningful. It is a bit tricky to grasp, indeed. As a reminder, the six components of the hexagon model are: acceptance, defusion, self-as-context, values, committed action, and contact with the present moment.

A Clinical Case: "You Can't Bring My Husband Back"

I posed Dr. Moran a case to try to understand a bit better how he would conceptualize a real-world patient. He addresses how to approach a widow who is overwhelmed with work and her children. Plus, she is a bit hopeless about her future.

So...

Here it goes.

> **Dr. Diaz:**
> We have Mary. She is 39 years old and she is a widow with two children who are 8 and 11. She blames doctors for the death of her husband. We can see her husband died at 38 years of age of an aggressive pancreatic cancer and it was diagnosed in the terminal stage. What she says is, "if they had given him the right treatment, he wouldn't have died". So now, she is overwhelmed with work, taking care of her two children, and is stuck in these thoughts. "This is unfair. I should not be alone doing all this. This is not what I bargained for in life. I wanted a typical family with a husband, two children, a dog and a house with a white picket fence. And if I wanted to remarry, I would not be able to find a quality man who would want me and my children".
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> "I mean, Dr. Moran, statistically, as you get older, all the good ones are taken. All that's left are players, men who want to cheat on their wives, gay men, men with children and I don't want other people's children or sorry widowers. I am doomed to be alone for a very long time. I will never have what I wanted in the first place".
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> She comes to therapy with you and says, "I don't know how you can help. You can't bring my husband back or make my life the way it was supposed to be".

So the first thing that comes to my mind if I had this patient in my office is well, Dr. Moran, what is the first thing you would say to Mary?

Dr. Moran:

Wow! This is a challenging case. Of course, what I want to do before actually addressing what the client is struggling with is really recontextualize what ACT is all about.

It is a context for therapeutic interventions and it's built off of doing a good functional analysis, making sure you understand what the client is struggling with. It also is going to embrace humanistic ideas, you know, building up a therapeutic alliance.

So in so far as answering the first thing I'd say, you know, it's not ACT-based.

It would just be a general therapeutic relationship-building endeavor for the first session and we're doing some kind of psychological assessment.

But the first intervention point that I could imagine doing is showing some kind of empathy, you know, validate what the person is struggling with. Again, that's not necessarily ACT right there. That's just a general way of doing a therapy.

So once established that I have a good relationship, a good assessment, I think I would focus on her concerns related to **fusion**.

Now, I don't want to put it in a particular order. I could pick any one of the six points on the hexagon and start with it. But what I heard in your description of what this woman is struggling with she was saying stuff that sounded like she's fused to content. “I should not be alone in all of this”. “This is unfair”. “This isn't what I bargained for”.

She has this idea that if she had another relationship the person is not going to be a good person for her, a widower, somebody who wants to cheat on their wives, men with children that she doesn't want. And it just kind of interesting.

I'd point out that the way language works for us, the way our mind works so to speak, it can be very helpful. It's helpful for us to describe our environment, evaluate whether it's good or bad, helpful or unhelpful and then to problem solve. I want more good and less bad. And the mind, our languaging just gets reinforced to do that to help. But sometimes, our thoughts, you can't control them because it's so well reinforced. But sometimes, our thoughts aren't all that helpful.

> And so what I might teach this person is the idea of **defusion**. Notice that your mind is telling you this stuff.
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> "If he would've gotten the right treatment, my husband would not have died". Okay. That may or may not be true.
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> "This is unfair." Okay. You have been taught by your culture, your parents, your guardians, your pastors, your teachers that life is supposed to be fair. There's a certain amount of fairness. We should be able to get what we want. And that might not always be true. Other people might not be suffering the same things that you're suffering and you can start to evaluate and compare.
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> But I would just tell the person, talk to the person, teach the person this is your mind being active. Of course, it's going to look for fairness if you're taught to do so. But just because you're saying life is unfair doesn't mean it has to impede you from doing things that are important to you.
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> Some of the things she was saying or at least that you were saying she would be saying, they sound like they might be obstacles to her following through on what's important to her.
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> So I might move beyond teaching her the idea of fusion and how it's holding her down to be able to defuse from things.

Ok, just to remind our listeners, from Dr. Moran's videos we learned that cognitive fusion occurred when a person was hooked by unhelpful thoughts. And defusion would be to look AT those thoughts rather than FROM them. In any case, it is a good idea to start by showing empathy.

Values

Let's listen to how Dr. Moran explores values, by asking Mary what she wants in her life.

> **Dr. Moran:**
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> And then I might move beyond that and say, what do you really want in your life? You're only going to be on this planet for a finite period of time. You can't choose all

the things that happen to you during your time on this planet. You wouldn't have chosen that your husband would pass away. You can't control the things that happen to you. But maybe what you can do is clarify what is important to you in your life and then see if you can move forward in committed actions moving towards these important goals, objectives, and values in your life.

And then I would assess what are the things that would impede you from moving forward on these things that you care about. I'd clarify what's important to her. Find out what's meaningful in her life. What was so important about her relationship with her husband? What were the values that were wrapped up in that relationship? And can they also show up in the present moment? I think that would be the way I would start to talk to this person.

So, we also need to find out what is important for Mary and what things are blocking her from moving forward. We also need to know how she reacts.

Dr. Moran:

Now, the other thing I'm going to say before we move on to, you know, your feedback on this is this is psychotherapy. So it's hard for me to just case conceptualize and say, this is what I would do, without finding out the feedback from my client. Right? How they're going to react to what I'm saying. And since it's an interactive endeavor, maybe my plans for therapy would change depending upon my client's reaction to what I'm saying.

Treatment Specifics

Great Dr. Moran, so we must also pay attention to Mary's feedback. About how many sessions would this therapy take?

Dr. Moran:

I understand an interest in quantifying how many sessions would it take to actually have some kind of influence. And Acceptance and Commitment Therapy is built on this philosophy called functional contextualism. So I always err on the side of saying, you know, it all depends on how this client is functioning in this context. It's a little bit of an oversimplification of what the philosophy is. But it's hard for me to say this client should be able to get helped in X number of sessions. It all depends on the client's issues and how they function in this particular context. Having said that, the research

that I consume and I haven't read every article but a lot of the empirically supported treatment articles that are coming out, the randomized controlled trials, they're brief, you know, two or three months, eight to 12 sessions, some of them even briefer than that.

It looks like 8 to 12 sessions, 2 to 3 months, would be an average estimate of how long this therapy would take. Now, we as therapists know that sometimes the client or patient can grasp the concepts in their head, but not really feel them as true. In this case, how would an ACT therapist handle Mary saying something like, “I understand what you mean in my head, but I don’t feel it in my gut”?

Dr. Moran:

Well, I guess, you know, what I'd probably ask for is a little bit more clarification about what she is feeling in her gut so to speak. I want to get a better understanding of what she's driving at. And is she missing like a certain feeling? I don't feel it in my gut. What is she yearning for? What is she trying to feel? Because what I'd do is move into the area of acceptance. And we would define acceptance as actively contacting psychological experiences directly, fully without defending against them while behaving effectively. And I'd clarify for her, I don't know if what we're going to do in our psychotherapy is have you manage your feelings so they line up the way you want them to be in order for you to change the things that you're doing.

I would recontextualize what she is feeling and ask, in the presence of the way you feel, in the presence of the way you don't feel, if that makes sense, are you still willing to do the important things in your life? You have children. You yearn to have a relationship that might meet your needs and comport to your values. Are you willing to do the kinds of committed actions that that will require even in the absence of certain feelings and even in the presence of uncomfortable feelings? And if she says no because that's what it sounds like is happening here, if she says no, what I'd say is where is this agenda getting you? Why and how well is trying to control your emotions to fit a particular agenda, why is that on the table? And how well do you think that's going to work? And then I'd talk about the fact that it's probably not going to work.

So, we should clarify and recontextualize, if Mary expresses she is missing a certain feeling. What else can we do if Mary seems unwilling to try?

Dr. Moran:

I think that what I would say is what we're working on together is aim to help you with your values. As I mentioned before this phrase, you're only going to live on this planet for a finite period of time. You can't choose everything that's going to happen to you but maybe you can choose how you're going to respond to it. That's what I want to work on together. So I'm not going to forcefully say, if you don't try, nothing's going to work. This therapy is going to fail. But I am going to encourage them. You get to choose. We can make this therapy together about lots of different things.

Ok, encouragement may help.

ACT in Challenging Scenarios

We also know there can be other obstacles, right? Suppose Mary has a personality disorder or an intellectual disability. Then what?

Dr. Moran:

There's published research on helping out individuals with intellectual disabilities with Acceptance and Commitment Therapy that's out there. I can't cite a chapter and verse but there are folks who are helping out individuals who have as you mentioned lower IQ. I also try to promote the idea that what Acceptance and Commitment Therapy does is it integrates other types of interventions, treatment plans.
Going back to the idea of there being six points to a hexagon model as the way we introduce Acceptance and Commitment Therapy, one of those points is committed action. And I typically forward the agenda for therapy to have a treatment plan from another empirically supported treatment. If you're coming to see me as an ACT therapist to treat you for obsessive-compulsive disorder, I'm going to use exposure and ritual prevention. But if you're coming to see me because you're dealing with borderline personality disorder, I'm going to use DBT. What ACT does is it provides a framework or a platform for you to be able to help people with committed actions, with things like mindfulness and acceptance and defusion. But to get back to your question, if somebody has a personality disorder, I'm going to use the kinds of treatment plans that help out people with personality disorders. If it's borderline personality disorder, I'll do DBT with somebody.

So just to clarify because I might've made it seem like I'll abandon ACT. I'm not going to abandon ACT. I'm going to use a DBT treatment plan in the context of Acceptance and Commitment Therapy. There are some folks out there who blend it together. I go

to conferences, ACT conferences and the title of some workshops are called ACTified DBT. So essentially, what we're doing is we're taking what's been shown to work and then we're going to supplement it with the ACT model.

All right, ACT can be used for different types of issues. And it can be combined with DBT or exposure, for example, if needed.

Countertransference

What about the following concern? Therapists are humans. What if in this context, a therapist were to feel Mary's issue was too close to his or her own problems? What would you recommend?

Dr. Moran:

Well, it sounds like what we might call countertransference and I know that's maybe not a CBT term or a behavioral analytic term but nevertheless I think it stands for what we're talking about. I would definitely encourage the person to make that they are in some kind of supervisory relationship. I mean, it could even be peer supervision. That might be helpful. And there's a really cool book that just came out and it's Experiencing ACT from the Inside Out and it's a neat book. And I think what it does is it helps people with this kind of thing. Like how are you going to deal with the struggles that sometimes come up as a therapist? So if you're dealing with some kind of countertransference issues or resonating with what the person is suffering with yourself and it impedes you from being able to do the best job possible, do a workable job at least with your client, I would seek supervision, peer supervision and check out this book, Experiencing ACT from the Inside Out.

Right. It is called countertransference and supervision for the therapist might help. Don't forget the book, Experiencing ACT from the Inside Out.
Another issue Dr. Moran, would you consider family therapy or therapy for the children? Is that a standard approach in ACT?

Dr. Moran:

ACT is a functional contextual approach, right? So how is this going to function in this particular context? Their father just died so I would imagine it might be a good idea

for the kids to have some kind of treatment whether it's brief bereavement. He died of cancer. Maybe a psycho-oncologist can be involved. Maybe there's some kind of treatment community around where he was getting the cancer treatments. So I would definitely, you know, try to support everyone involved. Whether or not I would have them into the mother's psychotherapy as part of it, eh, maybe. It all depends on how the kids are struggling with this life change.

Oh, that's good to know. Yes, by all means family therapy, or other kind of therapy for the children can be part of the treatment.

How to Terminate Therapy

Now, let's imagine Mary is doing well and therapy must finish. How do you go about doing that?

Dr. Moran:

You know, there are a couple of things on the table with something like that. You know, do I know that they're going to terminate at a particular time? Do they have pre-authorization of 12 or 16 sessions? If it's not that and the person just seems to be really engaged in their values, doing measurable committed actions, seems to be more psychologically flexible -- We could even measure that with the AAQ-2 in therapy, not that that's an outcome measure. But if they're doing new things, if they're doing the things that are important to them, then I might say, you know what, maybe what we could do is we'll take four weeks off and then we'll meet next month and then just titrate like that until we get to the point of view that maybe just come for booster sessions once every six months. That tends to be the style that we use at the clinics where I was a supervisor and as a therapist.

Great! It is good to know in ACT we have the resource of tapering off or spacing out sessions before terminating.

Closing Remarks

Dr. Moran, can you say a few words that can wrap up your approach in this clinical case?

Dr. Moran:

I mean, we're not going to try to get rid of some kind of symptomatology and have this person forget that they suffer as a widow and everything's going to be perfect in their lives and they're going to start dating like it's some kind of Hollywood movie or romantic comedy. What we're going to do is just really validate this person's pain and say, yeah, I get that this is difficult. And this is life on life's terms. And I'm not saying that in some kind of tough love manner but I'm trying to tell the person, hey, this might not seem fair to you and life might not be fair and you can still have a life of value, meaning purpose, vitality. And it's going to require some level of commitment. I understand you suffer and that's part of the human condition. We're not going to be able to eradicate pain. We do want to reduce suffering. You are feeling pain for something that is a very difficult thing that happened in your life. And you get to move forward from here, not move beyond it like you forget about the person you love but you get to move beyond the suffering and honor the fact that you had a great relationship, you have kids that you care about. And now, it's the next chapter in your life.

I like that! “The next chapter in your life”. I think that is definitely a phrase that can help people in therapy. Thank you so much Dr. Moran.

Summary

So, from this interview, there are some clinical pearls we can take with us.

One, start by showing empathy for your patient or client! It is general advice for therapists, and an ACT therapist is not the exception.

Two, keep in mind the components of the hexagon model, and listen carefully to what your patient or client is saying, to give you an idea of which component you need to address first. In this case, Mary was fused to her thought content, and defusion was a clear way to start.

Three, pain is part of the human condition, but this therapy aims to move beyond the suffering, move forward from where you are. In this case, it was not the idea that Mary forgets about her deceased husband, but as Dr, Moran said, “honor the great relationship you had”, and move on to “the next chapter in your life”.

We'll remind our listeners that the course by Dr. Moran, "Demystifying ACT" is available for you on psychotherapyacademy.org. I am your host, Dr. Jessica Diaz. Thanks for listening! Stay tuned for part 2 of this interview!

Social Anxiety With ACT: Listen to Dr. DJ Moran Approach a Clinical Case

Welcome back everyone! This is Part 2 of the interview with Dr. Moran. I am your host, Dr. Jessica Diaz. Today, we have another clinical case for Dr. Moran. The idea is to give you, the therapist, tips and clarification about this therapy in real-world scenarios. As a reminder to our listeners, the hexagon model includes 6 components: Acceptance, defusion, self-as-context, values, committed action, and contact with the present moment. Dr. Moran will give you insights on a few of these today: Defusion, committed action, values, and contact with the present moment, with a mindfulness exercise included! He specifies not to try to get rid of anxiety, and what to do instead. We also include his views on the use of alcohol for anxiety, and if clinicians may make use of a co-therapist.

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A Scared Young Man: “Is This Like The Therapy I Already Tried And Did Not Work?”

Our clinical case is a young man with social anxiety, who tried traditional CBT without improving. He is afraid of eating in public, and his friends are tired of him never going out with them. Now, he is willing to try ACT, but he is scared it will be very similar to CBT. What would you do?
Listen carefully to the case and how Dr. Moran approaches it!

Dr. Diaz: Peter is 22 years old and he already tried traditional CBT for six months for his social anxiety. But according to him, he has not gotten better. He says he is afraid to go out in public.
“Oh, I look so stupid eating in a restaurant. What would people say if I spilled food on my shirt? I try not to walk anywhere because I know I look clumsy and people will laugh at me if I fall”.
So with his CBT therapist, he tried going to a party as a behavioral exercise but he was so nervous when he got there that he fainted making matters worse. He tried meditation but he says: “Oh, it makes me even more anxious”.
So now, he's unwilling not only to go to parties, but he doesn't want to run errands, he doesn't want to meet women, hang out with more than one friend at a time, or do group activities.
It is severely limiting his life. And his friends say: “They're getting tired of me saying no to going anywhere”.
So, he comes to your office willingly saying, “I read about ACT, and I wanted to try it out, but I'm scared Dr. Moran, because this is a form of CBT”.

Dr. Moran: Well, I guess there are a couple of things on the table and I don't know which to address first for the interview but I would say that sure, Acceptance and Commitment Therapy is under the umbrella of cognitive behavioral therapies. We publish in the same journals. We go to the same conferences. It comes from CBT. And I think it's different than traditional CBT and I would say to the client, I'd say, Peter, we're going to do something a little bit different. If we always do what we've always done, we're always going to get what we've always gotten. So I promise you what we're going to do here is not like traditional CBT. What we're going to try to do is not have you change your thoughts and I'd assess if that's what the CBT therapist in the past had them do. And if the person, Peter, says yes, I would say, all right, so we're not going to try to change the form of your thoughts. I'm not going to try to

> change what you think. I want to help you change the way you relate to what you're thinking. It's not changing what you think but how you relate to those thoughts.

So yes, ACT is under the umbrella of cognitive behavioral therapies. But, here we have a difference from traditional CBT. Like Dr. Moran said, we are not trying to change WHAT the patient or client thinks but HOW the person relates to those thoughts.

Defusion

From the previous interview we learned that if a client or patient is hooked on unhelpful thoughts, defusion is the way to go. With Peter, it would be useful as well:

> **Dr. Moran:**
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> And then I'd go into a psychoeducational perspective of what defusion is about. I might do that. You know, it all depends on what Peter is struggling with but I think that might be the beginning, introduction to Acceptance and Commitment Therapy for this client who's having a hard time coming to see me because they think it's still part of what CBT is all about. So that might be my step in that direction.

So, just to remind our listeners, from Dr. Moran's videos we learned that defusion teaches people to have a different relationship with thoughts, and undermines unhelpful language processes. In the previous interview, Dr. Moran added that defusion would be to look AT those thoughts rather than FROM them.

What Have You Been Doing to Get Rid of Your Anxiety?

All right, so we use defusion. What else can we do? Listen in as Dr. Moran explores other options:

> **Dr. Moran:**
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> I might also talk to this client about creative hopelessness and that's the idea of looking at what this client, Peter, has been doing in order to try to get rid of his social anxiety. What has he been trying to do? And what was the agenda of CBT? Because the attempt to try to get rid of the way you feel, try to get rid of your sensations and emotions, oftentimes it exacerbates the problem. And so I'm wondering what the

exposure exercise was. When he went to a party with the supervision of his therapist, I want to know why he did it. Did he do it in order to what we call engage in habituation? Was it an exposure to try to get rid of the way he feels? Because if it is, that's not what the data are saying is a good way to do exposure.

To recap, we can investigate what Peter has been doing to get rid of his anxiety. Trying to get rid of sensations can worsen the problem. And isn't that what people naturally tend to do? So, what is a person supposed to do then?

Expand Psychological Flexibility or Diminish Symptoms?

To answer that question, we need to delve first into the type of exposure exercise he was doing. Why is that important? As we will see, there is a difference between inhibitory learning and habituation learning. What is that all about, Dr. Moran?

Dr. Moran:

We like inhibitory learning rather than habituation learning. Now, I don't want to get too crazy into a different type of psychotherapy but I'd want the exposure exercise to be about expanding his psychological flexibility, not about diminishing his symptomatology so to speak. I'm wondering if he's going to the party just so he stops having heart palpitations because I got bad news for you. It's not going to work like that. You're probably going to do better if you realize that you're going to have the heart palpitations but be present with them. Accept them. Acknowledge that they're there. Be willing to have what's showing up for you while you're doing the things that you care about. And I think that's been left out of this treatment.

Wow! So there may be a missing piece in Peter's previous treatment puzzle … did Peter go to the party to get rid of his heart palpitations? According to ACT, that is NOT the way to go. It is better to just accept that they are there and be present with them. Here we have the answer to the question then: Don't try to get rid of your anxiety, but be present with it. But we need more information...

Values

Don’t you wonder WHY Peter wants to improve? The answer has to do with Peter’s values. Let’s find out what this is about:

> **Dr. Moran:**
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> Why do you want to deal with your social anxiety a little bit better? What was the point of going on the exposure exercise? And I'd want to talk to the person about their values. What's important in your life? Because I'm wondering if you're stressing out so much because you really care about your social relationships and it's because you're so wrapped up in I have to do this right because you care about it so much that that attempt to try to do a great job and to try to control your emotions so everything works out perfectly, I think that's what leads to the problems for this person. So, I would recontextualize the way the person is looking at their issue and I would tell them that therapy, I would invite them to think this therapy is going to expand your abilities, not diminish your symptomatology.
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> I would never make any of my clients do anything, but that doesn't mean I wouldn't encourage and invite this person to consider going to a party as an exposure exercise, but I would first try to clarify why. Why would you even want to do this? What are your values? Is it because you care about relationships? Is it because you need -- It's not a matter of need. Is it because you really care about talking to people? Is it because you understand that social support helps people achieve great things? Is it because you want to have a family so you need to meet somebody who might want to start a family with you? I need to get a better understanding of this person's value system and what's important to them.

So, maybe Peter values social relationships, or he wants to meet someone to start a family, and he is trying to control his emotions.

Committed Action

If that is the case, it is better to work on expanding his abilities. But, how would an ACT therapist do that? Hint: It has to do with committed action. This is what Dr. Moran said:

Dr. Moran:

When they have clarified this is what motivates me, this is what upsets me that I'm not good at social situations, I'm going to say, okay, in the presence of this motivation, fueled by your values, what small committed action, what small step can we take in that direction? Not in order to get rid of your heart palpitations and your limb shaking and your jaw shaking, it's not about getting rid of it. It's about being willing to have it. You care about this stuff so much, social relationships. Is it okay? Does it provide you with the fuel to be willing to simply notice what's showing up physiologically and interoceptively with your anxiety. And then when you do that, let's engage in shaking people's hands, looking at them in the eye, you know, having a conversation, learning how to introduce yourself. Maybe what we'll do is some traditional behavior therapy and practice that in the office before he actually goes out and does this kind of thing. But the purpose is not just skills building and it's not symptom reduction. It is values expanding, psychological flexibility enriching. That's what we're after here. It's a little bit different than the traditional approach.

To summarize, first explore Peter's values. Then, committed action, or, what small step can you take in the direction of your values? In this case, Peter probably values social interaction and social support. What steps can Peter take towards this? He can start by shaking people's hands or looking at them in the eye, for example.

What About a Co-Therapist?

But suppose Peter needs some extra help. As you may already know, in other therapies the figure of a co-therapist is used to help with some of these exercises. Would you consider a co-therapist for this case?

Dr. Moran:

Yeah. I think co-therapy is an adequate way to do some interventions. I wouldn't have that as an agenda at this point in my life. I will say that one of the greatest experiences for me in my ACT development was having Patty Bach, a friend of mine and just a great ACT therapist. She's a great member of the ACBS, Association for Contextual Behavioral Sciences community, I did co-therapy with her, learned a lot that way. I don't know if I would specifically require a behavioral technician or a co-therapist to help me with somebody with social phobias, social anxiety but you could. I mean, you know, if somebody wanted to do something like that, if it functioned in the context, I don't see any reason why not to do that.

Great! So now we know that ACT does not rule out a co-therapist.

Mindfulness

As you know, meditation and mindfulness exercises are sometimes used for anxiety. I mean, who hasn't seen pictures of someone meditating in a peaceful-looking place? We know from Dr. Moran's videos, that mindfulness exercises are very useful in ACT. But, Peter said that meditation makes him more anxious. So, what do we do here, Dr. Moran? His answer may surprise you:

> **Dr. Moran:**
>
> I would wonder about how this person is learning what mindfulness is about, how it's done, what the process is, what the outcomes are from an ACT point of view, right? So, I don't want to speak for mindfulness. I don't know a lot about Eastern philosophy and traditional ways of doing meditation, so I'm not speaking for that. But, if I am using mindfulness interventions in therapy, I would make sure that I'm telling the person that this is not about diminishing your anxiety. It's helping you relate to it differently. There's a weird phrase that I hear a lot in the ACT community and I hope it goes over well on a podcast but the therapy, Acceptance and Commitment Therapy is not going to make you FEEL better. It's going to make YOU feel better. What I mean by that, it's not going to improve your positive emotions so to speak, feel better. But, it's going to let you have whatever emotions are there as fully as you can experience them. That's what I mean by that weird redundancy. It's not about feeling better. It's about feeling better.

Ok, so mindfulness within the ACT point of view, is not about diminishing your anxiety but relating to it differently. Wait...what? I don't know about you, but I always thought of mindfulness or meditation as a way to relieve anxiety. Hey, here it helps by helping the person relate to their anxiety in a different way. So, Dr. Moran, give us an example of how you would do this? Listen in as he explains his method:

> **Dr. Moran:**

> The mindfulness exercise, if somebody says, oh, it doesn't make me less anxious, it makes me feel my anxiety, I'd say, okay and notice that. Just notice the anxiety. Notice the heart palpitations. Notice that your limbs are shaking. Notice that your armpits are sweating and just be present with it. And then when you start saying stuff like oh my gosh, I'm anxious. This is a negative emotion. I got to get rid of my negative emotions. Realize that that is your subcultural training. You were taught that by your guardians. You were taught that by society. You're not supposed to feel the negative emotions. You got to feel the positive emotions. Just notice the thoughts. I have to get rid of this anxiety. I'm not good at meditating. If I am noticing my heart racing, I must not be doing this meditation the right way.

All right, so we tell Peter in this case, to notice his anxiety and his negative thoughts. Don't try to get rid of everything you label as negative, rather, just notice it. This is intertwined with committed action and defusion, but how? Let's listen to Dr. Moran explaining that:

> **Dr. Moran:**
>
> Notice all of those thoughts as if they were clouds in the sky on a windy day very distant from you and blowing away and bring yourself back to whatever committed action you set yourself out to do during this mindfulness exercise. I don't know what it is, your breathing, doing a yoga pose, gazing at a candle, whatever it is that you're doing as a mindfulness exercise. It's going to require you coming up with some kind of commitment to breathe, to do a yoga pose, to gaze at a candle. Keep that committed action as your primary focus. Be maximally influenced by your committed action. And when you have sensations, feelings and emotions, accept them. When you have thoughts, cognitions, self-denigrating talk, notice them as if they were leaves on a stream. Defuse from them and then contact this present moment by bringing yourself back to your committed action.

Remember then to keep your committed action as a focus and defuse negative thoughts.

Is Alcohol Allowed?

What about alcohol intake? Some people say it makes them relax. Would you allow that, if Peter in this case, is NOT an alcoholic?:

Dr. Moran:

Goodness gracious. I sure hope so, right? I mean, you said that they weren't alcoholic so I don't want to ban the use of alcohol. I'll be screwed, right? I mean, I like to have a beer. There's nothing necessarily wrong with that. The person doesn't have a clinically relevant concern around it. You know, this is maybe a justification, maybe it's a rationalization but alcohol is part of the world and people can use it in a healthy manner. And if it helps people loosen up, you know, it does reduce our inhibitions at times at a party. If somebody doesn't have a health problem with it, a behavioral health or a medical health problem with it, I would not look at it as an issue. You know, as long as you're using it responsibly, you're not driving and it's not leading you to black out or gamble your money away or get involved in a relationship that is going to go awry or problematic, then I don't see any reason why we can't have a beer or a scotch or a whiskey or something along those lines. Heck, you know, at conferences, they often have an expo and they often have parties and we're not looking at that as some kind of clinically relevant issue at the time.

So, yes, a client may use alcohol as long as it is responsibly, and if there is no clinical issue. That will surely surprise some of us!

Concluding Thoughts

Any words to wrap up this case?

Dr. Moran:

I want to be cautious about talking about Acceptance and Commitment Therapy as if it were an intervention, as if there were an ACT tool that you would use for this particular issue right here. I don't have a tool. It all depends on how my relationship and my understanding about treatment plans are going to fit this particular issue. So yeah, I could make up an answer and say this is what I would do for Peter. But I want to be reluctant about saying something like that so folks listening to this don't get a sense that ACT is a set of techniques. It's a platform for how you're going to conceptualize and then, and then develop some kind of intervention for it.
I think one of the great things about Acceptance and Commitment Therapy is it has a transdiagnostic approach. So if we've only talked about social anxiety and somebody's bereavement issues and anger and depression, we've only talked about two. But the cool thing about it is that it's transdiagnostic. So if we didn't have examples about trichotillomania, we didn't have examples about workplace stress,

we didn’t really have examples about obsessive-compulsive disorder, that doesn't mean it wouldn't be helpful and workable in those clinically relevant concerns. It is. What Acceptance and Commitment Therapy does is it helps us relate to our own private events differently, relate to our language differently, clarify what's purposeful and meaningful for us, integrate other types of evidence-based approaches and really support people moving forward in life given their human condition. And that's what's neat about ACT. It's not for a particular diagnosis. I think it can be widely applicable. And I really appreciate the opportunity to talk to you about it today, Jessica.

Thank you, Dr. Moran. It is our pleasure to have interviewed you. There is so much we can learn here. Where can our listeners get more information?

Dr. Moran:

To the folks who are listening, if you really want to learn more about it, I would check out the Association for Contextual Behavioral Sciences. It's a great resource. Contextualscience.org is the website. And it's a worldwide, international organization that promotes the idea of reducing suffering and improving quality of living for people with applied behavioral science. And it's a great clearing house to learn about Acceptance and Commitment Therapy and functional contextualism.

Thank you so much Dr. Moran! Remember then, contextualscience.org is a website where you can obtain more information on ACT. Don’t leave just yet! Our takeaway clinical pearls are:
1.- ACT does not try to change WHAT the person thinks but HOW they relate to those thoughts.
2.- Do not try to get rid of your client’s anxiety; rather, the person must be present with it and learn to relate to it differently.
3.- After clarifying values, take small steps towards what the client wants with committed action.

We’ll remind our listeners that the course by Dr. Moran, “Demystifying ACT” is available for you on psychotherapyacademy.org. I am your host, Dr. Jessica Diaz. Thanks for listening!