



Focussed Acceptance and Commitment Therapy

Contents of manual by Bruce Arroll © 2016

Chapter 1. Introduction

(included in course Introduction 1a)

Chapter 2. FACT basics - the first visit

(included in course introduction 1a)

Resources on FACT and ACT

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Chapter 1.

Glossary of terms

Creative hopelessness. This is the process in which the therapist validates the unworkable avoidance strategies of the client when s/he is stuck in the problem - solving mode of the mind. It is usually where experiential avoidance (defined below) is operating. The narrative is “That does not seem to be working for you” and the answer should be “no”. “Creative hopelessness” is an option for the therapist, not a feeling or state of mind in the client – and is a central task of the FACT consultation. It helps the client stop and let go of the struggle i.e. let go of the agenda of control (Harris, online adolescent course). This term does not suggest a hopeless future for the client. Another term for this is “confronting the struggle agenda”, which is preferred by Russ Harris. Yet another way to think of it is the patient is in a hopeless situation and you as the therapist can be creative and find ways to lead them to a more flexible place.

Mindful anchor. This is where the client sits with a powerful physical anchor e.g. hand on heart and both feet on the ground, while they notice and name their pain and then soften around it – let it go and expand. Clients may prefer to use a different metaphor. Having a visual metaphor enables the therapist to say: “If I have my video camera on you next week and see you are feeling stressed, what will I see you doing?” The idea is that the therapist can “see” the client carrying out the *mindful anchor* i.e. it is a behavioural action.

TEAMS. This stands for Thoughts, Emotions, Associations, Memories and Sensations. Uncomfortable TEAMS can be associated with experiential avoidance – that is, the client might respond to them by avoidance, suppression, distraction and escape. We have no ability to control the arrival of TEAMS and the unpleasant symptoms that are associated with them, so we must focus our energy on what we *can* control i.e. our immediate behaviour.

Experiential avoidance (also called experiential control) is the attempt to control or alter the form and frequency of situational experiences (TEAMS). This can be fed by an entanglement of language and cognition. From the brain’s perspective, there is essentially no difference between the cognitive process of escaping from a locked room and of escaping from an urge, for example, by using drugs. Avoiding painful TEAMS is a major source of human suffering. It leads to avoidance of painful situations, which involve friends and social gatherings, thus shrinking social and physical networks. One of the goals of FACT therapy is to expand the physical and psychosocial world.

Introduction

This is a work manual for therapists wishing to learn and develop their skills in ACT (acceptance and commitment therapy) and FACT (focussed acceptance and commitment therapy). This version of FACT has been developed primarily for use in primary care settings, but can be used in any high volume, time-limited consultation setting.

What is needed?

A standard approach to physical/mental health

What is needed is a simple, consolidated, uniform and evidence-based approach to human behaviour change that allows the clinician to apply the same treatment principles across a broad range of problems. FACT is such a treatment model (Strosahl, Robinson & Gustavsson, 2012).

What does ACT offer to psychology and regular healthcare?

FACT offers a focussed version of ACT. ACT is one of the “third wave” psychotherapies using processes that clinicians find useful. It is based on a philosophy called functional contextualism. Like all third wave psychotherapies, it includes a mindfulness component. Briefly, human behaviours are assessed for their functionality in specific contexts. A specific feeling, i.e. anger, is not per se problematic, but may become so in certain contexts (see p. 33–35, *ACT Made Simple* by Russ Harris). ACT is a trans-diagnostic model that allows a therapist to help people with physical and mental health issues such as depression, anxiety, pain, as well as with diabetes control and smoking cessation. It deals with the common underlying issues that cause these problems.

An initial FACT consultation can be completed in around 30 minutes, with shorter follow-up sessions. The number of sessions is not fixed, but is typically 2-3. The shorter FACT time frame makes it a better fit in regular health care settings where the demand is high and psychological resources are scarce. The developers of ACT are not proprietorial about their knowledge and openly encourage trained clinicians to try using some of the ACT processes.

FACT in a nutshell: In a limited number of brief therapy sessions, learn to accept the uncomfortable TEAMS, change the unworkable strategies, become flexible, start participating in activities and move toward a valued future through those activities. All actions need to be workable – that is: Is what you’re doing working, in the long run, to make your life richer and fuller?

1. Accept what you cannot change (acceptance part) – you cannot undo your history, but you can learn to hold it gently and not be defined by it.
2. Become psychologically flexible (i.e. learn to be aware and accepting of the pain that comes into our lives, while continuing to pursue what we value).
3. Identify values and commit to following them (commitment part). This may require a bold move and the ability to tolerate any discomfort that shows up. The aim is not to be symptom free, but to live a life that matters.

Strosahl et al. (2012) summarise the situation by saying that a “limited number of mental processes explain both human suffering and human vitality. There are three basic dimensions that determine both level of suffering and level of vitality:

- (i) awareness of the moment
- (ii) openness to private experience (flexibility)
- (iii) engagement in valued activities.

FACT explicitly holds that all human suffering, regardless of its form, is caused by deficits in one or more of these core processes”.

The solution becomes the problem

The client’s attempts to control their distressing TEAMS/private experiences results in constrained and unworkable patterns of behaviour i.e. they become stuck. The mind begins to “spin” and become busy, i.e. “the busy mind”. The problem-solving role of the mind is to make value judgements, which are great for avoiding traffic when crossing the road, but not so good if you are experiencing TEAMS. The theory behind this is Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001). The new perspective facilitates openness to these feelings rather than focussing on controlling them.

To lead a psychologically flexible life we need to value acceptance/willingness, rather than control. One aim of FACT is to connect the client with their personal values – these can be controlled, and it is acceptable to control/connect with them. The commitment part is taking actions that are values-based, flexible and expanding in scope. The aim of FACT is to help clients live a rich, full and meaningful life and not specifically to remove symptoms. Clearly, when living a values-based life, clients are likely to have fewer symptoms (Adapted from Strosahl et al., 2012).

The structure of this book is for action first and theory second.

If you wish to read some material on FACT theory, please turn to appendix [chapter XXX](#). (not in this version).

The diagnosis is the distraction (Strosahl et al., 2012)

A major issue in primary care for physical health is that complaints such as abdominal pain or headaches are likely to be largely influenced by psychosocial factors. This is frequently not taken into account and physical symptoms get investigated and psychosocial issues ignored. The same holds true for psychiatric diagnoses such as depression or anxiety, when the underlying behaviours and context are not always taken into account. FACT is an approach that enables the therapist to work with the underlying behaviours and reframe the “problem or diagnosis” to facilitate a more meaningful life while accepting the pain that goes with this.

This is also an issue when clients get a diagnosis of depression or anxiety and are put on antidepressants or antianxiety medication. Both the clinician and the client can get distracted by the medication (i.e. Is the drug still working? Are there adverse effects? When should/could the medication be stopped? Should we add a second one?), rather

than looking at the behaviour and persisting avoidance. Another way of viewing this is that the client's relationship to the TEAMS is the problem, whereas a diagnosis makes it a state or even a trait, which is not necessarily helpful to the individual (P. Bowden, personal communication, May 29, 2016; K. Strosahl, personal communication, 2016).

FACT is a trans-diagnostic approach

FACT is considered trans-diagnostic – this model focuses on underlying behavioural processes rather than specific diagnoses. The aim of FACT is to develop “psychological flexibility”. According to Strosahl (Auckland 2017) there are:

Three core processes underpin suffering:

(i) Cognitive fusion

(ii) Emotional avoidance

(iii) Behavioural avoidance

- (i) **Cognitive fusion** involves “over-identifying” with contents of the mind, such that mental “rules” exert undue influence on behaviour:

- Socially instilled rules about health and how to achieve it
- Cultural mores that suggest feeling bad is bad for you
- Problem solving operations that are focused on elimination and control
- Hidden beliefs about the normative state of being

Rule following results in rigid patterns of behaviour that don't change despite negative real world consequences

- (ii) **Emotional avoidance (EA)** involves being unwilling to make contact with unwanted, distressing private experiences (thoughts, emotions, memories, sensations)

- Active EA results in a “rebound effect” which makes avoided experiences seem more intrusive and uncontrollable;

Active EA cuts the link between direct results in the world and our resulting emotional responses. This creates increasingly rigid and unworkable behaviour patterns

(iii) **Behavioural avoidance** involves restricting access to, and participation in, situations, events or interactions that might “trigger” avoided material

- Avoidance of triggers also means avoidance of situations that “matter”
- Over time, patterns of avoidance naturally generalize and widen in life scope, leading to life problems festering
- In chronically avoidant patients, life meaning and purpose is entirely sacrificed in the service of avoidance
- Symptoms of distress are actually “feedback” loops from the real world that are ignored

The result is suffering and resistance to change

- Patients will approach challenging situations firmly believing that the prime directive is to control or get rid of distress; they will not hide this from you:
- They will try the same unworkable control/avoidance strategies repeatedly and will advocate for them
- Whatever the problem is, it will be getting worse because of the paradoxical effects of avoidance

The patient will be out of contact with his or her personal values for living, because these values require participating in situations that are likely to trigger feared and avoided experiences.

The ACT/FACT mission

- ACT seeks to undermine and reverse the cycle of rule following, emotional and behavioural avoidance that leads to suffering. The aim is not for an absence of symptom, rather:
 - Practicing acceptance/detachment undoes emotional avoidance
 - Being in the present moment and able to produce self-reflective cognition undoes unconscious rule following
 - Being connected with, and engaging in, valued action undoes behavioural avoidance

Clients are considered to be stuck and inflexible and the aim is to get them to be unstuck and flexible. Being stuck has the advantage of being a “functional” diagnosis, as you can become unstuck. Not making a formal diagnosis of depression/anxiety is another advantage. Such labels can cause later employment issues when applied to short-term stress situations that are not DSM 5 level diagnoses (R. Harris, Advanced online course, April 2016).

View the client through the lens of flexibility

Consider the client through a lens of flexibility and watch out for words like “should”, “never” “must” etc. (i.e. “we never cried in our family”). Most people live by rules they have acquired throughout their lives and often are unaware of how these can influence/control their lives. Rules are useful for the physical world, but less useful for our emotional world.

Constriction of activity precedes mental health problems, so check what TEAMS, people, or activities are being avoided.

It is very common for humans, when faced with adversity, to start avoiding situations that cause anxiety or stress (K. Strosahl, personal communication, 2016). This may be an internal avoidance of TEAMS or external avoidance of people or experiences. The mind cannot readily tell the difference between constructive and destructive safety: a lost job or a failed exam is just the same as a physical danger e.g. a sabre-toothed tiger for our caveperson brain. Fear of a tiger is a constructive reaction, while rumination and worry are destructive reactions. The natural defence mechanism of our “keep you alive” mind is a tendency to move away from difficulties i.e. to avoid discomfort. This is appropriate for our caveperson ancestors but is less often needed in the 21st century. Indeed, for modern humans, personal growth is more likely to come from “leaning towards our pain and suffering” (Epstein & Back, 2015), rather than leaning away from it. One could also say, “As the feelings get larger, the patient’s life gets smaller.”

Our problem-solving mind works well for sorting our tax returns, but not for fixing our emotional issues.

According to the ACT model, the mind has good problem-solving capacity. This is good for getting bills paid and fixing software problems. It is not good for fixing emotional issues. For this, we need other approaches such as acceptance, mindfulness and reversing the avoidance. These other options give our “busy minds” something constructive to do. The problem-solving function comes into its own when moving towards our values (see under **Values**).

The brain’s role is to keep us alive.

The mind can be our best friend and our worst enemy. The mind works best on “external” experiences e.g. crossing a road safely to keep us alive. It does not work well on “internal” emotional or physical experiences (TEAMS). It is likely to overreact to the internal ones, thinking it is keeping us alive by making us think that abdominal pain is a sign of cancer or a few negative thoughts mean the old depression or anxiety is back.

“Our minds are not built to think” (Benjamin Riley, *Economist*, July 22, 2017, p. 18), but are designed to keep us alive. They will tell us things such as “Don’t go the gym or do exercise,” yet when we do exercise, we feel better. Robyn Walser talks about learning to trust your experience in this case, rather than what your mind is telling you to do. Russ Harris has a great line where he says to the patient “Your mind would say that, wouldn’t it?” Another good line is “Thoughts are not facts.”

Workability: “Ask about what works, not what ought to work” (Strosahl, Robinson & Gustavsson, 2013).

“A workable life is one that is producing desired outcomes on an ongoing basis” (Robinson, Gould, & Strosahl, 2011, p. 42). Many clients think their actions are correct when, in fact, they are unworkable or unhelpful. Many people like to be right, rather than happy (Arroll et al., 2013). For example, a client who is unhappy with a banking transaction may argue with a bank teller, swear at them and storm out and feel satisfied

with this exchange. If and when they need banking services again, they may find they have burnt some bridges. Swearing and arguing with a bank teller is an unworkable action. It would have been more workable if they had stayed and sorted out the issue on the first occasion.

Are our clients “insane” when they keep doing unworkable things? Someone once said that the definition of insanity is doing the same thing over and over again and expecting different results. By this definition, most or all of us would be insane. It is a human tendency to default to what we know. A case in point is people with primary insomnia – people who spend too long in bed (9 hours in bed, but sleeping for six hours). They may have a late night out and find they sleep wonderfully, but on the next night will attempt another 9 hours in bed in spite of the better sleep with the shorter time in bed. The tendency to default to the familiar is a safety mechanism: we are in the known, we feel included, we can trust those around us. However, the familiar may be following societal or family rules such as “We don’t cry in our family.”

According to Winston Churchill people occasionally “stumble over the truth, but most of them pick themselves up and hurry off as if nothing ever happened.” In terms of ACT, this is an example of rule-following. This following of the rules can conflict with our values and make us inflexible. In terms of Carl Jung, this pull of the familiar is to deal with our fear of death (although in ACT, we are less interested in the subconscious explanation for the action, than in the workability of the action).

The solution is the cause of the dysfunction.

Strosahl (2005) says that a patient’s problem is not causing the dysfunction, but rather the solutions being used to solve the problem cause the dysfunction. For example, shrinking of the external life (not seeing friends or not exercising, which reduce demand in the short term) is a solution that becomes a problem as the client becomes less resilient. This is the caveman equivalent of hiding in the back of the cave - where no resilience is required. The client needs to be at the front of the cave, with people out in the sun hunting game.

Creative hopelessness – these are “unworkable actions”

Creative hopelessness “means fully opening to the reality that trying too hard to control how we feel gets in the way of living a rich, full life” (Harris, 2009, p. 81). The therapist asks *Has what you have been doing helped to solve your problems?* The answer should be “No”, otherwise you are not in a therapeutic relationship, though denial may work in the short term. *Would you be willing to do something different?* The answer should be “Yes” or else you need to clarify the purpose of being together. *Are you willing to give up the struggle?* This can be used for mental health and physical health issues. For example, with patients with poorly controlled diabetes, the issue of what is being done to improve the situation can be raised. In many situations, patients will not be doing as much as they could be with lifestyle changes and careful management of their medication. (Occasionally their diabetes will be deteriorating as their pancreas fails to provide insulin and so for a small proportion of patients, behaviour change may not work.)

Values and actions

One aim of FACT is to get clients working towards their values, i.e. what is important to them in the long run, which will mean taking action that will change their relationship to their TEAMS in the service of their values.

The future is now: single sessions are possible.

In FACT, the first session is for assessment and to start treatment, as it may be the only chance to achieve change. It is not uncommon for clients to fail to attend a booked follow-up mental health clinic appointment. Clients should leave every session with a plan for behaviour change that has the potential to radically change their quality of life (Strosahl et al., 2012, p. 58).

The warm handoff

In medical clinic situations, where there is a dedicated mental health professional, a warm handoff is possible. This is when the therapist meets the client at the time of referral and starts therapy immediately. There is evidence that this procedure is associated with better outcomes (Collins, 2010). Given adequate resources, therapists may be available as needed or with a short wait for the client. If a full consult is not possible immediately, the client can at least be introduced to the therapist by their trusted primary care clinician. The warm handoff eliminates the Did Not Attend (DNA) rate, which is so common with mental health referrals (Strosahl, Robinson, & Gustavsson, 2015). This could be done in any medical clinical situation and does not necessarily need to be used with FACT.

Summary of FACT

A standard approach to both physical and mental health.

The aim is not to have an absence of symptoms, but to live a valued life.

FACT in a nutshell: In a limited number of brief therapy sessions, learn to accept what cannot be controlled, change the unworkable strategies, become flexible, and start participating in activities and move toward a valued future through those activities.

- * The diagnosis is the distraction.
- * Trans-diagnostic approach to diagnosis i.e. the client is stuck.
- * View the client through the lens of flexibility.
- * Constriction of activity precedes mental health (mood) problems.
- * TEAMS = thoughts, emotions, associations, memories and sensations.
- * Check what activity/people/situations and TEAMS are being avoided.
- * Our problem-solving mind works well for crossing a road, but not for fixing our internal emotional or physical issues. It makes value judgements on our TEAMS that are not helpful.
- * Pain is inevitable, but suffering is optional: a new understanding is needed to psychological pain.
- * Acknowledge that the client is working very hard and that what is bothering them is important to them i.e. they struggle because they care.
- * Ask what works, not what should be working. Creative hopelessness: what you are doing is not working. Would you like to try something different? This is the pivot point. Encourage client to lean into their fear/suffering or to carry their fear and suffering while moving towards their values.
- * Encourage warm handoffs - where therapist meets client at primary care visit.
- * The first visit is for assessment and starting treatment.

Chapter 2: FACT basics

2(a): The first visit

Summary in 7 steps	Introduce yourself and your role i.e. you are a capable person and my role is to work with you towards making a fuller life guided by your values.
A: FACT assessment	<ol style="list-style-type: none"> 1. Focussed questions.* 2. Creative hopelessness.* 3. Work-love-play checklist.*
“Find the pain”	Find the pain and/or the core belief: diagnosis is <i>being stuck</i> . Pain is a sign of caring.
B: Change relationship to experience.	<ol style="list-style-type: none"> 4. <i>No delete button</i> discussion. 5. Present-moment awareness and using the <i>mindful anchor</i>.
Find the pivot point.	The client agrees that their current effort to avoid pain in their life is not working and they are willing to try something else.*
C: Values and action(s)	<ol style="list-style-type: none"> 6a. Values* 6b. New actions.* 7. Likelihood of action * (readiness ruler).

Key: items marked * would be covered in all FACT interviews, while the others are optional along with additional optional activities that are described later in this manual.

Before you start:

Introduce yourself. Remember to state to the client that you see them as a capable person and that you are willing to stand with them in pursuit of a fuller life that is vital and meaningful. Your role is to help with problems of living to see what's working and what is not and to make the most of each visit. Also remember that the client may be fearful, as they will potentially be telling you things they may have never told anyone else. Therapy is a fear-provoking situation.

Narrative for introducing self (depending on who and where you are):

Hi, my name is Steve and I'm a Clinical Psychologist and I work as a Behaviour Health Consultant here at the clinic.

My role is to help you to improve your overall health, which includes not only your physical health, but your emotional and behavioural health as well.

Or

My role is to help you learn skills "to handle thoughts and feelings more effectively, so they have less impact and influence over you" (Harris, Depression and Anxiety online course, 2017).

We're going to meet for 20 to 25 minutes to get a snapshot of your life and see what's working and not working and work together to come up with a plan to make your life better. Sometimes people get what they need in a single visit; other times people return for a few visits to learn new skills. I will make a note in your medical record and I'll discuss with your Dr. X what we talked about today. If I have any concerns about your safety or the safety of others, I will help you get the help you need. Can you think of any questions at this time?

Lead-off consult

The lead-off consult is where patients/clients start to unload their distress. This may catch you off guard, as it can occur with any contact between two or more human beings. This section is to remind those in health care that enabling a patient to be seen, heard, and understood is almost certainly of major therapeutic benefit. You may or may not have training in mental health, but never undervalue the importance of listening to another human being. You may be a receptionist, nurse, doctor, physiotherapist or other health professional. Your listening is important, so don't avoid listening because you think/feel you are not well trained in mental health.

A: FACT Assessment

A1. Focussed questions (Strosahl et al., 2012)

As a reminder, the four focussed questions that can yield maximal information in the limited time available in brief interventions are:

1. What are you seeking?
2. What have you tried?
3. How has it worked?
4. What has it cost you? (What TEAMS are being avoided? What situations are being avoided? Who is being avoided?)

Validate that they have been working hard – very, very hard.

5. A fifth key question increases motivation to change and helps clients identify valued life directions that are within their reach.

What kind of life would you choose if you could choose? Or if you could change something next week what would it be? (David Kuhl, personal communication, 2016). Or what is the smallest thing you could change in the next week that would make a difference?

A2: Creative hopelessness

Has what you have been doing to help with your symptoms been working? The answer to this question should be “No”. Occasionally some clients may be very fused with their situation and may say “Yes”. Or if the client says *I try and keep myself busy*, ask *Does that help in the long term?* and again the answer should be “No”. Most clients will agree that what they are doing is not working. This is essential to establish in order to assist the client in choosing to make a change. This needs to be done sensitively, lest the patient feel judged, as they will have been trying very hard. The term *creative hopeless* is not said to the client, but merely describes their situation. One way to think of it is the patient is in a hopeless situation and you as the therapist can be creative and find ways to lead them to a more flexible place. Another way to think of the creative part is that this is often the time in the consultation to become creative. In the final analysis, it is about getting the client to stop the struggle.

A3: Work-love-play spirituality questions

This personal quality-of-life scale provides an overview of the client’s life and is known as the contextual part of the interview.

Looking back over the last week including today, can you rate how well you are doing in the following areas of your life. We call this the work-love-play checklist. Please circle the number that applies to you.

1. Work-occupation-school

Low										High
1	2	3	4	5	6	7	8	9	10	

2a. Love-friends

Low										High
1	2	3	4	5	6	7	8	9	10	

2b. Love-intimates

Low										High
1	2	3	4	5	6	7	8	9	10	

2c. Love-family

Low										High
1	2	3	4	5	6	7	8	9	10	

3. Play (recreation/hobbies/interests/sports)

Low										High
1	2	3	4	5	6	7	8	9	10	

4. Then ask about:

- Exercise
- Smoke
- Sleep
- Recreational drugs
- Alcohol
- Gambling issues
- Violence
- Citizenship/community
- Spirituality
- Trauma

Task: Give the work-love-play checklist to the client to fill out. This gives you time to make notes and plan therapy.

How to use the work-love-play scoring sheet:

Start in the section with the lowest score and find out what is happening there. Usually there is one lower than the others. If they are all low, e.g. all 1/10, you need to ask the client to elaborate. In general, ideas for therapy/behaviour change will come from the work-love-play questions.

Acknowledge the suffering.

Pain is inevitable; suffering is optional. The client needs a new understanding of the concept of pain. Acknowledge that the client is working very hard and what is bothering them is important to them i.e. they struggle because they care. Another way of reframing the pain is that it is a reminder of what they are about. Clients are very appreciative when you acknowledge that they are in pain because they care.

Finding the emotional pain

This is the main role of assessment (Strosahl, ACBS, Seattle, 2016). The pain is what drives the TEAMS. If the client cries, then ask *If your tears were words, what would they be saying?* It may be possible at this moment to identify the pain. If the client says they feel hurt, they are expressing a secondary emotion. You need to ask what is behind that, what is driving that. I sometimes ask *What is the issue that pushes your button?* Strosahl analogises it to being like a dentist finding all the pain in the mouth, so that treatment can be directed to it.

Shortcut to pain

The tables of “core beliefs” below are adapted from Judith Beck (1995). If the client is struggling to get to a core emotion or identify their pain, it may be helpful to ask them to look at the tables and select the core beliefs that apply to them. Virtually all humans have at least one of these core beliefs and some have many. The key message is that pain is expected in life, but suffering is optional: a new understanding/concept of pain is needed.

Note: This is not a standard ACT approach, but I find it useful in some situations.

Helpless core belief (problems of identity)

I am helpless	I am inadequate
I am powerless	I am ineffective
I am out of control	I am incompetent
I am weak	I am a failure
I am vulnerable	I am disrespected
I am trapped	I am defective (I do not measure up to others.)
	I am not good enough in terms of achievement

(Beck, 1995)

Unlovable core belief (problems of love)

I am unlovable	I am unworthy
I am unlikeable	I am different
I am undesirable	I am defective (so others will not love me)
I am uncared for	I am not good enough (to be loved by others)
I am unattractive	I am bound to be rejected
I am unwanted	I am bound to be abandoned
I am bad	I am bound to be alone

(Beck, 1995)

Summary of 3 possible ways to find pain

1. Client can identify their pain e.g. rejected.
2. If the client cries, then ask, “If your tears were words, what would they say?” This is when the client is connected with their pain.
3. Ask the client to select from the Core Belief tables.

Where are we now?

At this stage of the consultation you will have an idea of what the client is expecting and what their concerns are. You hopefully will have an overview of the balance of their lives and what TEAMS and life activities are being avoided. You will also have an idea of the core belief(s) or pain(s) that are driving the TEAMS.

B: Change relationship to experience

The core of a contextual behavioural science is putting the TEAMS into a different context, so the client can see their TEAMS differently (S. Hayes, ACT in Context, podcast #3, *The history and development of ACT*).

B4: The *No delete button* talk

In reply to “I just want to get rid of these awful feelings,” the therapist can reply *The problem with the human mind is that it has no delete button*. Any negative thought or experience is stored there and can be retrieved at any moment. This is a crucial safety task for the mind, as it cannot afford to forget something dangerous/negative that has happened in the past.

The *no delete button* statement is one that clients always relate to. The mind can remember that you failed a math exam when you were 8 years old, that your mother yelled at you when you were 16, and that you crashed the family car when you were 21. At age 30 you have a difficult experience at work and can recall those previous dangers resulting in a negative spiral.

The *no delete button* talk needs to be handled sensitively so that the client does not feel hopeless about the negative thoughts from the past. This is an example of Relational Frame Theory – a conscious process of which only humans are capable. We understand that animals do not have this consciousness. The way to give our minds something constructive to do is to learn to hold those negative thoughts/feelings lightly. It is important that clients are aware that there is an antidote to the *no delete button* problem and that is to hold these TEAMS “lightly”. This is done through the present-moment awareness exercise below, using the *mindful anchor* (Steve Hayes, ANZ ACBS Wellington, 2015).

B5: Present-moment awareness

(Adapted from Strosahl, Robinson, & Gustavsson, 2015)

Five steps

1. Notice the negative TEAM/pain/core belief
2. Name it
3. Soften (apply some self-compassion to yourself)
4. Let go
5. Expand (which is only possible now that you feel different)

I have added a physical action to accompany the five steps from the book. This exercise is called the *mindful anchor*, as I ask the client to put their hand on their heart and feet firmly on the ground. We suggest you use this for all clients, though some may find it too “cheesy” and prefer their own metaphor. The powerful kinaesthetic anchor of touching the floor and heart helps to give the client a sense of safety. It also has the advantage that it is an observable behaviour. You can say to the client *If I film you with my video camera next week and you are feeling stressed, I will see you using this exercise to manage the stressful moments-* this operationalises an observable behaviour.

Keeping to the same *mindful anchor* means the therapist has to remember only one activity. The aim of this exercise is not to remove the pain, but to enable the client to live with and better tolerate their pain. In psychological terms, it is a form of exposure therapy and enables the mind to adapt to the TEAMS – thereby reducing the desire to avoid them. The mind needs to relearn how to respond to the TEAMS – to learn that they are not as dangerous as they at first seem. This way, the mind learns to do constructive, rather than destructive, work. A comment that I often make to clients is that the *mindful anchor* takes the stress from the mind (where it is uncomfortable) and puts it in their body (where it can be managed more easily).

Expand

When discussing Step 5, the narrative is about “What is now possible for the future given this new feeling?” Another narrative is “What constructive things are now possible?” – thus reinforcing the idea of training the mind to do constructive, rather than destructive or unconstructive, activity.

The client may think this is weird.

We have had clients find some of this a bit “flaky” or “weird.” The narrative for this is to remind them *What you have been doing up until now has not worked. There is a lot of evidence for this method (over 170 clinical trials) and our experience is that it works for many people.* The proviso can be given that if they are not getting results, then we have other options.

Possible narratives for *mindful anchor*

“The *mindful anchor* gives your mind something constructive to do, rather than spinning your wheels with problem-solving.”

“The mind needs to relearn that these TEAMS are not as dangerous as they at first seem.”

“The *mindful anchor* gets the stress out of your head and into your body, where it is easier to manage.”

What to do if they feel worse

You can ask them to put the feeling on a Xmas tree (as a method of moving the painful experience) or over there and make it smaller, different colour i.e. change the states/senses.

Where are we now?

At this point in the consultation, you will have the client agreeing that what they are doing is not working. You will have explained what you can and cannot do for them. They will have had the *no delete button* discussion and now have a tool to change their “busy mind” to a “wise mind” and to start sitting and observing their painful TEAMS. It is important to note that you are not trying to make the TEAMS go away. It is best to play down this expectation.

Pivot point

This can also be considered the pivot point of the consultation. “It starts with the distress the client is seeking help for and ends up as a discussion about core values, the costs of avoidance and the possibility of living a different kind of life” (Strosahl, Robinson & Gustavsson, 2012). You can say to the client *What you have been doing does not seem to have worked. Would you be willing to try something different?* The aim of therapy is to create behavioural variability by doing behavioural experiments.

C: Values and actions

Many clients will be working very hard to control their TEAMS. They are distressed because they are stuck. Looking at values is the next step to guide the future. It can be helpful to remind the client that their pain is the flip side of their values. They would not be hurting, if they did not care. It is important to realise values are a direction and not a goal.

Connecting the client to their values for emotional and physical issues

The way to find out a client's values is to ask *What is important to you (in the long run)?* Or *At your 70th birthday, what would you like people to say about you?* One way of connecting the client's behaviour to their values is to hold out your right hand and say *These are your values* and in your left hand hold their avoidant behaviours, such as smoking, not controlling their diabetes well, not contacting a friend. Ideally, showing the client the inconsistency between their behaviour and their values should enable them to adapt their behaviour to their values and achieve something workable.

Possible narratives for values

"What do you want to create?"

"What are the possibilities here?"

Another alternative is to use more motivating language such as:

"Taking the opportunity for greatness"

"When they go low, we go high." (Michelle Obama, 2016, Democratic National Convention USA)

Some clients may need to be inspired to "make a bold move" (Robyn Walser, Auckland, 2016 tour).

C6a: Values

Directions	Rating importance		On track	
	1= low	5= high	1= off track	5= on track +++
Being a valued friend				
Being a valued partner				
Being a valued sibling				
Being a valued son/daughter				
Being a valued family member				
Being a valued parent (if relevant)				
Being kind to myself – play and relax				
Being active in hobbies				
Being active in sport				
Being productive				
Being creative				
Developing myself				
Being a valued employee				
Being a contributing citizen				
Being a valued student				
Contributing to the earth				
Contributing to mankind				
Being spiritual (whatever that can mean)				

Adapted from *Sedley, 2015*.

C6b: New actions

I often preface the discussion of new actions by saying *You cannot make yourself feel better by sitting here – you need to start doing things*. It is always encouraging to see a positive head nod at this statement. Kirk Strosahl (Auckland, 2017) comments that it is about getting the client back in to the river of life and then they will start swimming again. The work-love-play checklist usually indicates some imbalance in life that is a good starting point. I ask the client why their score is low on a particular point and the explanation usually highlights an area for work. Since constriction of activity often precedes mental health problems, it can be very helpful to ask the client *What were you doing when you were last feeling well?* The response is often “Seeing friends and going

out". A first step is to try and enlarge the clients shrunken world and get them back to where they were. Ideally, pose questions, such as *Would you be willing to do this? Would you be willing to experiment with this idea?* rather than saying *You need to do this* or *You should do that*. The client needs to start different behaviours and it probably does not matter what they do. Doing something different changes the client's rule-following behaviour.

They may need some suggestions as to what to do, as they will be avoiding particular situations and people. This may induce stress. To deal with this stress, they will need to use the *mindful anchor*. The *mindful anchor* is analogous to using a moonboot to stabilise an injured ankle while the ankle heals. To assess for behaviour changes, you say *Next week, I will have a video camera on you and when you get stressed, what will I see you doing differently?* The answer should be "The *mindful anchor*". Real change is possible at this stage. Sometimes clients will need help with focussing and we suggest saying *If there were something you could change next week, what would it be?* (David Kuhl, personal communication, 2016) or *What is the smallest thing you could change by next week that would make a difference?* I always set up at least two tasks, but no more than four, to be attempted before the next meeting.

"Ultimately the goal is to help clients become aware they have a choice between continuing to use avoidance strategies and trying something completely different: accepting what is present inside and still actively moving in the valued life directions. This is at the heart of the process that promotes radical change. It starts with the distress the client is seeking help for and ends up as a discussion about core values, the cost of avoidance, and the possibility of living a different kind of life" (Strosahl et al., 2012, p. 80).

Possible narratives for new action

"Which pain is worth having? The pain of being stuck or the pain of growth, pursuing what is important? Which pain is more meaningful?" (Russ Harris, ACT for Adolescents)
 "What would you be doing if all your distress went away?"

C7: Likelihood of taking action

Near the end of each session, ask clients to rate the likelihood they will do what was planned in that session on a scale of 1 to 10, where 1 = not likely at all, and 10 = very likely. Generally, a rating of 7 or above is the target. A six or below should trigger further discussion about barriers to action that clients may anticipate. There might be a need to simplify the task or identify a new plan. I write out a task list (avoid using the term *homework*) and put the score beside it. I also record the plan in my computer notes, reading out loud as I type to reinforce for the client that s/he has tasks to attempt between each session (Russ Harris, Advanced course). Alternatively, you could ask the client to read the task list out loud to you for typing your notes. I have never had a client renegotiate at this point.

Does it matter what clients do?

Probably not – a new behaviour is needed. The key is to get the client doing something different and it may not matter what they are asked to do, so long as it makes sense to them. We had a client who had had minor knee surgery and his task was to walk 100 feet in the next week. He gave a likelihood score of 10/10 to this task, but ended up doing much more than this. Dr Martin Luther King, Jr. once said, “If I cannot do great things, I can do small things in a great way.” Asking clients to do a small amount of activity, such as one minute of brisk walking, is a strategy to get people moving. They are likely to find the activity self-reinforcing and do more.

Case conceptualisation

Case conceptualisation is standard practice for most psychological interviews. In their full form they can extend to five pages of summarised data (Luoma et al 2007). In a standard one hour long consultation there would be time to do this. There are two reasons for doing this. One is that it can help the therapist learn ACT theory in a deeper way and see the client’s behaviour through a functional lens. Second it can lead to more focused, consistent, and thorough intervention for the more difficult or multi-problem clients (Luoma et al 2007). Kuyken has challenged the activity concluding, “ There is no compelling evidence that CBT (cognitive behavioural therapy) enhances therapy processes or outcomes (Kuyken, 2006). In the FACT setting there is not usually time to spend on five pages of summarised data but Strosahl et al (2012) have developed a one page version called the Four Square Tool. The original version has an added acronym called CARE which describes the four segments: C= contextualise the problem (summary of work/love/play); A = avoidance rules (emotional and behavioural avoidance); R= reframe link between pain and values; E = experiment with approach behaviours. See fig 1. This can be done formally or in the mind of the therapist. It can be used to show clients the overall pattern of their lives and what interventions you think would be helpful. The direction of using the Four Square Tool is to go down the table then across then up i.e. C→A→R→E

Figure 1

Four Square Tool*

		Workability	
		Not Working (Less Meaning)	More Workable (More Meaning)
Behaviour	Public	<i>C for context</i> <i>Avoiding family and friend</i> <i>Withdrawn</i> <i>Not exercising</i>	<i>E for experiment with approach behaviours.</i>
	Private	<i>A for avoidance</i> <i>Avoiding feeling like a failure</i> <i>Avoiding family and friends</i>	<i>R for reframe link between pain and values. i.e. cannot have pain if we have things we value</i> <i>The flipside of pain is what matters to you.</i>

* For clinician use in case formulation and treatment planning

Where are we now?

We now have an overview of the client's issues and what they are doing and not doing and we know their pain. We may or may not have done a formal Four Square Tool and if done may have discussed with the client. The next step is to encourage them to start expanding their lives using the *mindful anchor* when experiencing TEAMS. This is the acceptance part of ACT. They need some tasks to do to reverse the avoidance process that has developed. We also know how likely they are to achieve this (on a scale of 1 to 10), so at the next visit we can assess their progress. You can also discuss tasks not done. This is the commitment part of ACT.

In summary, by the end of the first visit, two major issues should have been addressed.

1. The client needs to expand their world and start doing activities that they have done in the past (where helpful) or new activities requiring fresh ideas and approaches.
2. The client needs to use the *mindful anchor* to deal with their pain and any pain associated with expanding their lives. For some clients who are very fused and distressed, this exercise will not be enough. For these clients, other processes can be used (See later sections on *The three pillars: Open, aware, engaged*).

Termination of care

FACT is designed to be a brief therapy to get the client *progressing* toward their goals, whereas in traditional therapy termination occurs when the client has *met* their goals. This means FACT therapy can be limited to one to four visits. After that, the client can return to their regular health professional or cope on their own.

End of 7-step summary of FACT for primary care (overview on first page chapter 2)

Take-home points for first visit (approximately 20 to 30 minutes)

3 parts to the initial assessment.

A: FACT assessment (1) focussed questions (2) creative hopelessness (3) work-love-play sheet (find pain)

B: Change relationship to experience (4) *no delete button* talk (5) hand-on-heart/*mindful anchor* and present-moment awareness.

C: Values and action (6) Values and new actions (7) Likelihood of action.

*Focus on the lowest score on work-love-play sheet, unless something else is more important.

*Find the pain (3 ways of doing this)

*Creative hopelessness should prime client to doing something differently or at least highlight the futility of their struggle.

*The mind has *no delete button* so we need to hold our TEAMS lightly.

**Mindful anchor* for present-moment exercise, so that this can be “seen” with our video camera next week to enable observation of a change in behaviour.

*For values ask *What is important to you in your life?* Remind them that their pain is the flip side of their values and what is important to them.

*What tasks are clients willing to undertake to change their situation? It may not matter what it is, so long as it makes sense to the client and they are willing to do it. Making a change means they are departing from their rule-governing behaviour.

*Agree on tasks and check the likelihood scores are $\geq 7/10$.

*Always set more than one, but no more than four tasks to be attempted before the next session.

The killer narratives

Empathy

1. One of the tasks of an adult is to learn to forgive oneself and forgive one's parents (they did their best according to their skills) (anonymous UK author)
2. The feeling is big because the ability to respond is small or impaired (Jacob Moreno of psychodrama fame)
3. We all need to cultivate the voice of kindness in our heads. (Paul Gilbert)
4. "Think about what you would say to your best friend if they were feeling this way, be kind to yourself, be your own best friend." From self-compassion by Kristin Neff
5. "It hurts because it matters" "It's two sides of the same coin" (Kirk Strosahl)
6. The worst is over (from book of that name by Judith Acosta)

Motivating for a change in behaviour

7. Waiting is costly (Robyn Walser)
8. Perhaps it is time for a bold move (Robyn Walser)
9. You are the boss, I am merely your advisor (it's up to you to make the changes). It makes no difference to me if you change but it may make all the difference to you if you do. BA & LME
10. Trust your experience not what your mind is saying (Robyn Walser)

For those with low motivation

11. You cannot sit here and make yourself feel better. You have to start doing things. (BA)
12. You are hiding in the back of the cave. There is no resilience there. You need to get out to the front of the cave looking for lions to hunt, people to talk with and sunshine. (BA)
13. Your life has shrunk and one of my roles is to work with you to expand it. (BA)
14. Your life is like a puppet on strings. Your (anger) is the puppeteer and commanding your life. Is there some way we could cut those strings. (Robyn Walser)
15. I am willing to make a stand for you are you willing to make a stand for yourself (LME)
16. If you stay on your default settings (like a computer) what is the predicted future going to be (the same) (LME).
17. You won't feel like exercising initially but you need to keep at it – the benefits will come later. (BA)
18. Thoughts are not facts. (Robyn Walser)
19. "You've been working really hard to make things better. It looks like it's not working that well. Are you ready to try something different?" (Kirk Strosahl)
20. You don't need to be defined by your past (Robyn Walser)

Living with ease

21. Be open to outcome not attached to outcome (LME)
22. Be committed but not attached (LME)
23. Don't look back it is not where you are going (Buddhism)
24. Accept what you cannot change and commit to what you can. (Bed Sedley)
25. You have too much accelerator and not enough brake. (BA)
26. There is no delete button in the human brain. What do you do with negative thoughts/experiences; you need to hold them lightly. (Steve Hayes)

Understanding the condition (for clinicians)

27. The solution becomes the problem (Kirk Strosahl)
28. Life constriction accompanies mental distress (Kirk Strosahl)
29. The diagnosis is the distraction (Kirk Strosahl)

Opportunities for greatness and hope

30. Message on your forehead – what message do you want to send to the world (BA)
31. Its all invented any way so why not invent something that works (Ben Zander)
32. Do you want to be right or be happy
33. When they go low we go high (Michelle Obama)
34. Look for opportunities for greatness (BA)
35. We need to get you back in to the river of life (Kirk Strosahl)

(the names/initials after each line is the person to whom I heard it from first- they may not be the actual creator)

BA= Bruce Arroll

LME= Landmark Education course

References:

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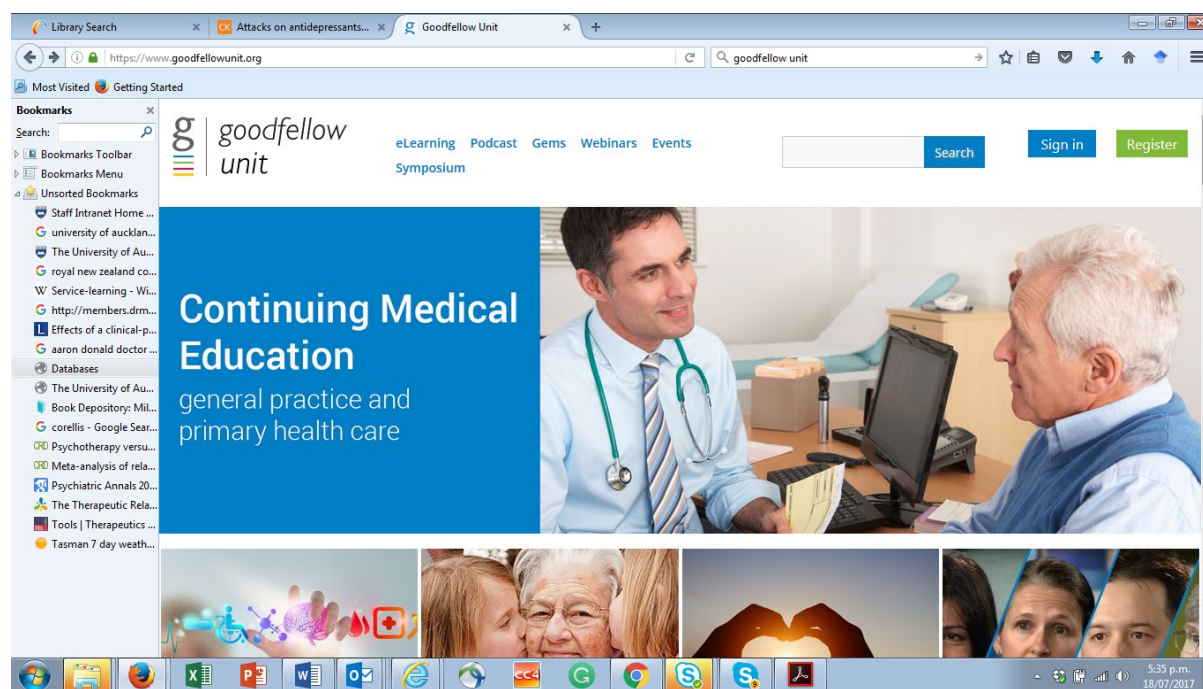
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FACT Learning Resources

A summary of FACT learning resources are on <https://brucearroll.com>. It includes this manual and two videos. Under the Goodfellow unit resources are a 22 minute podcast, a 1.5 online learning course with certificate and 1.5 hour webinar with Dr Kirk Strosahl co-founder of ACT and co-founder of FACT.

To access the free online Goodfellow Unit course on Focussed Acceptance and Commitment Therapy (duration 1.5 hours), see screenshot below.

1. Go to goodfellowunit.org and sign in if already registered.
 - a. If you are not registered, you will need to register (see green box, upper right corner). This is free and you have access to the majority of Goodfellow Unit resources.
2. Click eLearning at the top of the page.
3. Scroll down to Focussed Acceptance and Commitment Therapy. A certificate can be issued on completion.



Podcast with Bruce Arroll <https://www.goodfellowunit.org/podcast/acceptance-and-commitment-therapy-bruce-arroll>

Nine Videos on Focused Acceptance and Commitment therapy (FACT) by Bruce Arroll at the University of Auckland

https://www.youtube.com/playlist?list=PLiXC7JOP_RV3dSrtYr1OWPMTc0GuDNsZF&feature=em-share_playlist_user

Consider watching in this order:

Video	Content
8	Bruce Arroll (BA) talks about FACT and describes 3 patients with diabetes (31 minutes)
1	BA interviews a patient with mixed depression/anxiety and demonstrates the 7 steps of FACT (11 minutes)
7	BA demonstrates the work-love-play questions in the contextual part of the interview (<5 minutes)
3	The futility discussion with a chronic pain patient (<5 minutes)
5	Open: demonstration of defusion using a Russ Harris and Robyn Walser technique (<5 minutes)
4	Aware: the second pillar of open-aware-engage (<5 minutes)
2	Engage: getting a patient to take action on their diabetes by linking their values to their poor control of their diabetes (<5 minutes)
9	Engage (<5 minutes)
6	Second patient with depression and drinking problem (10 minutes)

FACT resources online

Webinar with Kirk Strosahl <https://www.goodfellowunit.org/events/webinar-fact-radical-change-possible-patients-brief-primary-care-visits>

Webinar with David Bauman and Bridget Beechy from Washington, USA

<https://vimeo.com/183028615>

Videos about FACT

Clinical cases

https://www.youtube.com/playlist?list=PLvLh_YdubBs5l1Nt4s44-KcqRysQpTBhl

Interview with Kirk Strosahl and others on being a primary care behavioural health consultant

https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ

Steve Hayes, TedX: *Mental Brakes to Avoid Mental Breaks*

<https://www.youtube.com/watch?v=GnSHpBRLJrQ>

Books on FACT (in order of preference)

1. Strosahl, K., Robinson, P., & Gustavsson, T. (2012). *Brief interventions for radical change: Principles and practice of focussed acceptance and commitment therapy*. Oakland, CA: New Harbinger.
2. Strosahl, K., Robinson, P., & Gustavsson, T. (2015). *Inside this moment: A clinician's guide to promoting radical change using acceptance and commitment therapy*. Oakland, CA: New Harbinger.
3. Robinson, P. J., Gould, D. A., & Strosahl, K. D. (2011). *Real behaviour change in primary care: Improving patient outcomes and increasing job satisfaction*. Oakland, CA: New Harbinger.

ACT Learning Resources in New Zealand

You can join the Association for Contextual Behavioral Science (ACBS), the ACT Society, by donating between \$US10 to \$US70. There are lots of free resources here, including videos, audio files and written materials.

General ACT introduction

1. Luoma, J. B., Hayes, S. C., & Walser, R. D. (2009). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists*. Oakland, CA: New Harbinger.
2. Harris, R. (2009). *ACT made simple: An easy-to-read primer on Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger.

Great book on mindfulness with a concise summary of ACT

Wilson, K. G. (2009). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy*. Oakland, CA: New Harbinger.

Books for clients

- Harris, R. (2008). *The happiness trap*. Boulder, CO: Shambhala
(self-help manual)
- Hayes, S. C., & Smith, S. (2009). *Get out of your mind and into your life: The new acceptance and commitment therapy*. Oakland, CA: New Harbinger.
(self-help workbook)
- Sedley, B. (2015). *Stuff that sucks*. London, UK: Little, Brown Book Group.
(Written by an ACT therapist from Wellington, NZ, for teenagers)

Blog quick tips for ACT therapists

<https://www.newharbinger.com/blog/quick-tips-therapists>

Online courses: Can be better than face-to-face courses because they enable you to integrate learning into practice.

1. With Russ Harris, the Australian GP who wrote *The Happiness Trap*.
<https://psychwire.com/harris/courses>
Introductory course - about \$500 for 8 weeks - 3 hours per week.
Advanced course - about \$500 for 8 weeks - 3 hours per week
2. <https://www.praxiscet.com/>
courses and online in the USA.
3. Plus this free intro "course " from Steve Hayes
<http://www.stevenchayes.com/>

Face-to-face courses in New Zealand

1. With Elizabeth Maher (available in many centres and at many levels).
<http://www.mindfulnesscbt.org/>
2. With Russ Harris
https://www.actmindfully.com.au/workshop_types
3. With Ben Sedley
<http://www.bensedley.com/Workshops.html>

Podcasts (go to iTunes or Google Play Store)

1. *ACT in context*
<https://contextualscience.org/podcast>
2. *Taking hurt to hope*
https://contextualscience.org/joanne_dahls_radio_program_act_taking_hurt_to_hope. Joanne Dahl
3. *Functionally speaking* by Daniel Moran
<https://itunes.apple.com/nz/podcast/functionally-speaking/id285977716?mt=2>

ACT Conferences/courses in 2018-2019

1. FACT training seminars: I will be running a one-day FACT training seminar in the next 6 months in Auckland, Hamilton, New Plymouth, Wellington, Christchurch, Dunedin and Canberra Australia
2. Auckland 22nd March 2019 pre-conference workshop for Goodfellow Symposium 9 to 4.30 <https://www.goodfellowunit.org/symposium/programme>

The following are all part of Grow.co.nz <https://www.grow.co.nz/page/focused-acceptance-and-commitment-therapy/> All workshops: 9am – 3.30pm

Christchurch 14th Nov 2018, Dunedin 28th Nov 2018, New Plymouth 27th Feb 2019, Auckland 8th March 2019, Wellington 12th March 2019, Hamilton 3rd April 2019

Others

3. The Canberra training day is a pre-conference workshop before the ANZACBS conference (this is the annual Australasian Acceptance and Commitment Therapy conference)
<http://anzact.com/2019-anzacbs-conference/>
4. Elizabeth Maher <http://www.nz-act-training.com/contact-us>