Understanding Trauma

Forensic and Military Cultural Aspects of PTSD and Effective Solutions

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Acknowledgements and Disclosures

- The views expressed in this presentation are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government, Federal Bureau of Prisons, or United States Pretrial or Probation Services.
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Conference Overview

- Defining PTSD
- Individual Consequences of cumulative exposure / complex trauma
- Impacts on relationship functioning and community reintegration
- Treatment options that work
- Post Trauma Growth

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What is Posttraumatic Stress Disorder (PTSD)?

What is PTSD?

- PTSD in a mental health condition that can occur after a person has been through a traumatic event.
- A traumatic event is something terrible and threatening that you see, or that happens to you.
  - ***Sudden and uncontrollable exposure to actual or threatened death, serious injury, or sexual violence.***

Defining Trauma

- A trauma has the following characteristics:
- ***It's a life-threatening event***
- ***It's uncontrollable***
- ***It's sudden***
- *It's an event you experienced yourself, observed happening to another person, or learned of it happening to someone close to you.*

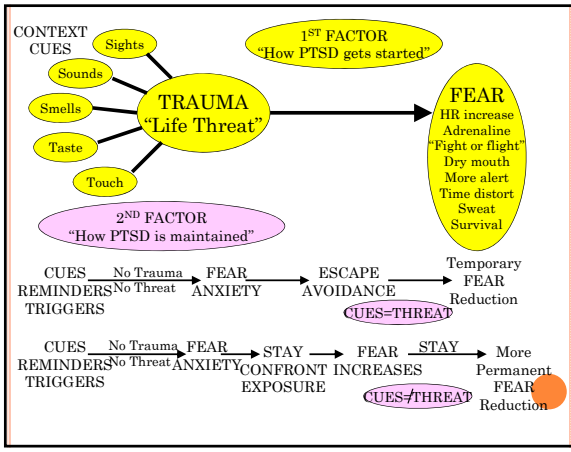
Examples of Traumatic Events

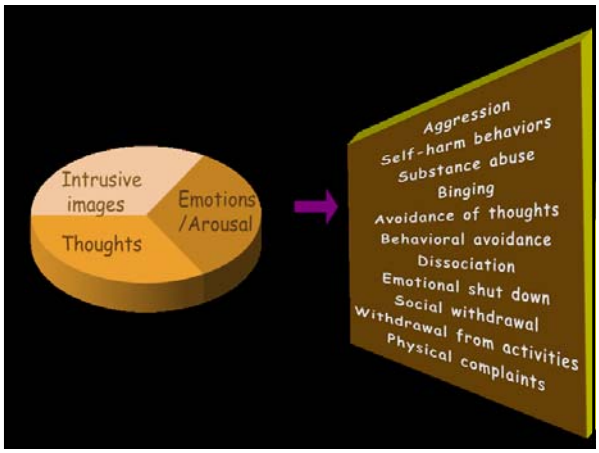
- Combat
- Sexual assault in childhood and adulthood
- Serious Accidents
- Natural disasters
- Sudden death of a loved one
- Witnessing or experiencing violence/physical assault
- Terrorist Attacks

10/8/2015

PTSD: Two-Factor Model

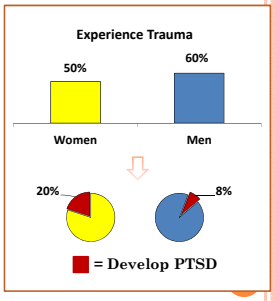
- How does PTSD develop?
- How is it maintained?



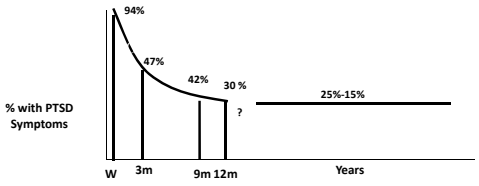


How common is trauma and PTSD?

- Going through trauma is common.
  - 50% of women & 60% of men will experience a trauma in their lifetime.
- Most people who experience trauma do not go on to develop PTSD.
  - Only 20% of women & 8% of men who experience a trauma will develop PTSD.
- Facts about PTSD (based on U.S.):
  - About 7-8% of the general population will have PTSD at some point in their lives.
  - For some events, like ***combat*** and ***sexual assault***, more people

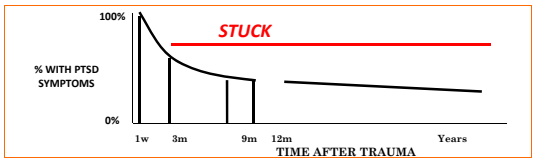


Typical Rate of Recovery



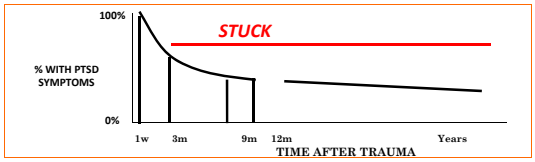
Data form Rothbaum et al., 1992

When does trauma become PTSD?



It is <u>normal</u> to have stress reactions after a traumatic event. Your emotions and behavior can change in ways that are upsetting to you. Even though most people have stress reactions following a trauma, they get better in time.

When does trauma become PTSD?



- For some people, symptoms of PTSD may continue to disrupt your life and make it hard to complete your daily activities. You may find it hard just to get through the day.
- You should seek help if symptoms:
  - last longer than three months
  - cause you great distress
  - disrupt your work or home life

Common Stress Reactions after a Trauma

- Fear or anxiety
  - Feel tense of afraid
  - Be agitated and jumpy
  - Feel on alert
- Sadness or depression
  - Have crying spells
  - Lose interest in things you used to enjoy
  - Isolate
  - Feel tired, empty, and numb

Common Stress Reactions after a Trauma

- Guilt and shame
  - Feel responsible for what happened
  - Feel guilty b/c others were injured or killed and you survived
- Anger and irritability
  - Lash out at your partner/spouse
  - Have less patience w/ your children
  - Overreact to small misunderstandings

Common Stress Reactions after a Trauma

- Physical Reactions
  - Stomach upset
  - Trouble sleeping
  - Pounding heart, rapid breathing, feelings edgy
- Behavior Changes
  - Drink alcohol, use drugs, or smoke too much
  - Drive aggressively
  - Neglect your health
  - Avoid certain people or situations
  - Reckless/Risky behavior

Symptom Clusters of PTSD

1. Re-experiencing Symptoms
2. Arousal Symptoms
3. Avoidance Symptoms

Re-Experiencing Symptoms

Re-experiencing Symptoms

- Intrusive experiences
  - Distressing, unwanted memories or thoughts about the trauma
  - Experiences may be images, sounds, smells, sensations or intense feelings
- Flashbacks
  - Feeling as if the trauma is happening again
  - Loss of connection to present moment (disrupts your perception of when/where you really are)
  - "Waking nightmare"

Re-experiencing Symptoms

- Nightmares
  - Recurrent, distressing dream of the event that cause high levels of anxiety or fear
  - May experience the same dream repeatedly, or different dreams with similar themes
  - Brain may be trying to process memory while asleep

Re-experiencing Symptoms

- Regular (non-traumatic) experiences enter our "experiencing brain" and are processed and edited by our "thinking brain"
  - Trauma prevents this from occurring in the moment
  - After the trauma, our brain tries to do this again, but sometimes this process can be "blocked"
    - Avoidance
    - Development of unhelpful thoughts and beliefs
  - Causes brain to repeatedly send message in form of intrusive experiences, flashbacks and nightmares

Arousal Symptoms

Arousal Symptoms

Marked by:

- Hyper vigilance- super awareness of surroundings i.e. feeling like you are constantly looking over your shoulder
- Startle Response- Intense reaction to an unexpected event i.e. "hit the ground" when you hear a loud noise

Anger & PTSD

- Common response to trauma
- Natural survival response can help one to cope
- Responding with "full activation" can be problematic
- 3 factors that lead one to react with "full activation":
  - Arousal
  - Behavior
  - Thoughts/beliefs

Sleep & PTSD

- Why do people with PTSD have sleep problems?
  - The may be "on alert"
  - They may worry or have negative thoughts
  - They may use drugs or alcohol
  - They may have bad dreams or nightmares
  - They may have medical problems

Avoidance Symptoms

Common Stress Reactions After a Trauma

- Avoidance
  - You may avoid distressing memories, thoughts, or feeling about the traumatic event. Including:
    - Avoiding talking or thinking about the event.
    - Keeping very busy or avoiding seeking help because it keeps you from having to think or talk about the event.
  - You may try to avoid reminders (people, places, conversations, activities, objects, situations) that trigger memories of the traumatic event.

Avoidance Symptoms

- It is natural to want to avoid thinking about or feeling emotions about a stressful event
- Types of avoidance:
  - Emotional- when a person avoids thoughts or feelings i.e. denial
  - Behavioral- avoiding reminders of the trauma i.e. isolation, drinking or drugs

Consequences of Avoidance

- "Just try not to think about it"
  - May worsen symptoms
  - Short-term solution to long-term problem
  - Problematic if this becomes the primary means of coping with PTSD
- Not all avoidance is bad
  - Temporary distraction can focus thoughts and feelings on an intended purpose i.e. school or work

Common Stress Reactions After a Trauma

- Changes in mood/thinking
  - Negative beliefs about yourself, others, and the world (e.g., "I am bad," "No one can be trusted").
  - Unrealistic thoughts about the trauma that hinder your recovery and keep you stuck.
  - Frequent negative emotions (e.g., fear, horror, anger, guilt, or shame).
  - Loss of interest in activities you previously enjoyed.
  - Feeling detached from others.
  - You may find it hard to experience positive emotions like love and joy.

Common Stress Reactions After a Trauma

- Arousal
  - Unprovoked irritable or angry behavior (e.g., verbal or physical aggression).
  - Self-destructive behavior (e.g., dangerous driving, excessive alcohol/drug use).
  - Hypervigilance – remain alert and the lookout for danger
  - Startle Response- Intense reaction to an unexpected event (i.e., "hit the ground" when you hear a loud noise)
  - Difficulty with concentration.
  - Sleep problems.

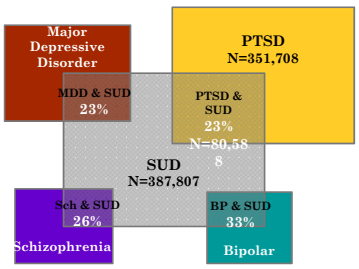
PTSD and the Family

PTSD and the Family

- Compared to Individuals without PTSD, those with PTSD:
  - Have more marital troubles and increased divorce rates.
  - Tend to have shorter relationships.
  - Share less of their thoughts and feelings with their partners.
  - Report more worry around intimacy issues.
  - Are more likely to have sexual difficulties and/or decreased sexual interest.
  - Have lower relationship satisfaction.

PTSD and Comorbid Disorders

Fiscal Year (FY) 2008 Prevalence of Co-Occurring Conditions in Veterans Seeking Treatment in Veterans Health Administration (VHA)



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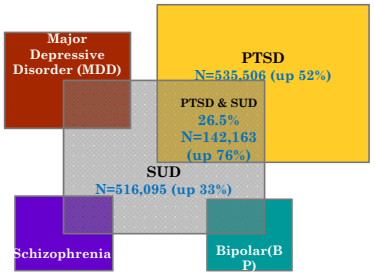
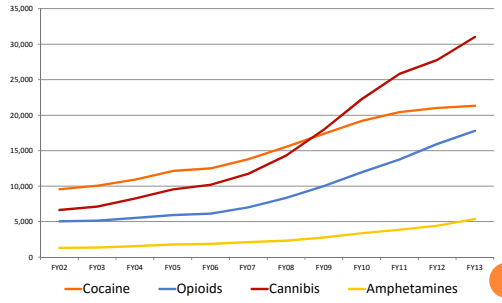


VHA Trends in Diagnoses by Drug for Veterans with PTSD and SUD



Resources that help

WHAT YOU CAN DO

DURING TREATMENT

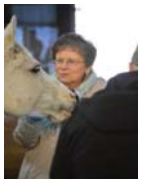
- Continue to use motivational strategies
- Continue to use measurement based approach
- Continue to assess progress, safety, and goals

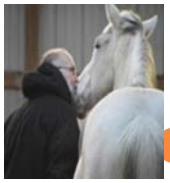
RESOURCES

- Resources for describing treatments - National Center for PTSD Factsheets
  - http://www.ptsd.va.gov/professional/treatment/overview/index.asp
  - AboutFace
- VA/DoD Guidelines for SUD and PTSD - www.healthquality.va.gov
- Internal VA Mental Health Sharepoint –
  - See Clinical Resources folder within SUD PTSD files http://vaww.national.cmop.va.gov/MentalHealth/default.aspx
- Integrated Smoking Cessation and PTSD Treatment
  - http://www.ptsd.va.gov/professional/continuing_ed/smoking-cessation.asp

EQUINE THERAPY "HORSE WHISPERERS"

- "I believe that kindness and patience and faith are more powerful than negativity. In fact, I'm sure of it, because I've seen it work with humans and animals alike."
- Buck Brannaman *Believe 2004*





WHY HORSES?

- Horses are prey animals and are particularly sensitive to things in their environment. People with MST feel like they are prey.
- Horses are herd animals. They seek relationships to feel safe, even with humans.
- Horses are also very sensitive to emotions and pick up and reflect the emotions of members of their herd. This includes the horse-human relationship. "My horse is my therapist."

"Horses have much to teach us about working with the human "emotional brain".

The techniques the Horse "Listener" uses are particularly helpful for Veterans who suffer from sexual trauma.

Monty Roberts
The Man Who Listens to

SEEKING SAFETY

PTSD and the Family

- PTSD can affect the lives of a individual's partner and children.
  - Partners of inidividuals with PTSD experience:
    - Lower levels of happiness
    - Less satisfaction in their lives
    - More demoralization (discouragement)
  - Children of Veterans with PTSD:
    - Have more behavioral problems.
  - Family members may experience a wide range of emotions about the individual's difficulties including:
    - Sadness/depression, worry, anger, fear, etc.

Cognitive Processing Therapy

- A 12 session protocol, developed in 1988
- Predominantly a trauma-focused cognitive therapy, with or without written accounts of worst traumas
- The protocol is very specific session-by-session and teaches the clients to challenge their own thoughts
- Can be implemented individually, in group or a combined format
- Recovery-focused based on collaboration and informed choice

COGNITIVE PROCESSING THERAPY (CPT) IS…

a short-term evidence-based treatment for PTSD	a specific protocol that is a form of cognitive behavioral treatment
predominantly cognitive and may or may not include a written account	a treatment that can be conducted in groups or individually

A Focus on Cognitive Theory of PTSD

- Throughout their lives, people are taking in information through all of their senses.
- We work to organize all of that information (words, categories, schemas, etc.) in an attempt to understand, predict and control.
- Most people are taught the "just world belief" (good behavior is rewarded and mistakes/bad behavior is punished) by parents, teachers, religions, culture.
- In the face of trauma, we often revert back to the just world belief.

A Focus on Cognitive Theory of PTSD

- These beliefs work as long as there is no contradictory information.
- The experience of trauma is so significant that you can't ignore it.
- Intrusive symptoms occur as a result of the inability to integrate the information effectively

So how does CPT work?

- Challenging avoidance
- Dissipation of natural emotions
- Change in thinking about meaning of event changes manufactured emotions instantly
- Clients learn to not over-generalize their thinking about a single bad event to all people or to themselves (just because an event has bad consequences, it doesn't have to have big implications)

Cognitive Processing Therapy

- Sessions 1-4
  - Education and Impact statement
  - Client learns about connections between events, thoughts, and feelings.
  - Client writes detailed accounts of the incident including sensory details, thoughts, and feelings (if CPT-C then no account).

Cognitive Processing Therapy (continued)

- Sessions 5-7: Cognitive therapy
  - Challenging questions for a single belief
  - Learning about patterns of faulty thinking (Problematic Thinking Patterns)
  - Challenging Beliefs Worksheet

Cognitive Processing Therapy (continued)

- Sessions 8-12: Over-accommodation
  - Modules and worksheets challenging beliefs regarding:
    1) Safety
    2) Trust
    3) Power / Control
    4) Esteem
    5) Intimacy
  - Client rewrites impact statement

Take home message

- CPT is:
- Effective in group, individual, or combination
- Effective with complex cases

Prolonged Exposure
Empirical Research

Rationale for PE

- Promotes emotional processing: Learn new, corrective information – trauma memories and related situations are not dangerous
- Discriminate trauma memories from trauma
- Reduce excessive fear and gain perspective on trauma
- PTSD commonly impacts core beliefs about self and world; PE focuses on modifying negative beliefs that maintain PTSD
  - "No one can be trusted"
  - "I am incompetent/weak"
  - "The world is unsafe"

Role of Avoidance

- Avoidance reduces trauma reexperiencing and hyperarousal in short term but prolongs in long term
- Avoid trauma memories → never challenge trauma-related beliefs
- Avoid public → never challenge safety concerns
- Maintains trauma structures
- Avoidance and negative reinforcement: Leaving or initially avoiding feared situation leads to relief, thus strengthening avoidance behavior

Rationale (continued)

- Two types of exposure

1. Imaginal exposure
   - Emotional processing of trauma memory
   - Learning – Memory is painful but not dangerous
2. In vivo exposure
   - Do real-life activities that are avoided
   - Learning – Many situations are safer than I thought

PE Protocol

- 9-15 sessions; averages 10 sessions
- 90-min sessions
- 1: Assessment, treatment overview, PTSD psychoeducation, breathing retraining
- 2: In vivo Exposure (continue throughout)
- 3-5: Imaginal exposure
- 6-9: "Hot Spot" exposure
- 10: Final imaginal exposure, wrap-up

Example of typical PE session (session 4 on)

- Review homework (10 min)
  - In vivo exercises & trauma tape listening
- Conduct imaginal exposure (30-45 min)
- Process imaginal exposure (15-20 min)
- Discuss/implement in vivo exposure (10-20 min)
- Assign homework (5-10 min)
  - Continue breathing practice
  - Listen to trauma tape daily
  - Complete in vivo exercises

Prolonged Exposure (PE) Therapy

- Imaginal exposure: Patients recount the traumatic memories during sessions and listen to the tape-recorded recounting between sessions
- In vivo exposure: Patients confront safe trauma-related situations and objects between sessions, beginning with less fearful situations and moving on to more fearful ones

Foa et al. 1991, 1999, 2005; Resick et al, 2002; Rothbaum et al, 2005

PE is a treatment for *PTSD*

- While PE focuses on trauma, it is specifically designed to treat PTSD
- Not everyone who experienced trauma has PTSD
- PE will not be (as) effective for those who do not meet diagnostic criteria for PTSD
- Potential Problems
  - Lack of/low reexperiencing – poor target for imaginal
  - Low avoidance – few avoided situations for in vivo
  - Not sufficiently distressed to adhere – distress motivates exposure therapy; if patient not very distressed, why would s/he bother?

Knowing when to end PE

- Let the numbers tell the tale
  - Have PCL scores dropped sufficiently?
    - 50 is cut-off for PTSD DX; however aim for lower scores
  - Have SUDS levels routinely decreased ~ 50% for both in vivo and imaginal exposures?
- Look for other signs of improvement; PCL *isn't* everything
  - See signs of habituation during imaginal?
    - Tells story with less intense affect, shows behavioral signs of being more relaxed
    - Reports that it seems more like a memory, less like reliving
  - Is patient more engaged with life?
    - Doing more; being more spontaneous; greater emotional range and engagement?

EMDR

- In VA, most attention has been given to CPT and PE, but
- EMDR is still a recommended first line psychotherapy
- Supported by evidence as reviewed in literature

Strongly Recommended in PG

- Strongly recommend that patients who are diagnosed with PTSD should be offered
  - One of the evidence-based trauma-focused psychotherapeutic interventions that include components of exposure and/or cognitive restructuring; or
  - Stress inoculation training. [A]

EMDR: Some History

- Introduced by Shapiro in 1989
  - Reportedly following a personal experience involving distressing memories
- Applied to a series of clinical cases; 1st quasi-controlled experiment by Shapiro (1989)
- Substantial improvement in the quality of research
- Outcomes of treatment have been generally positive
- EMDR classified as empirically supported

Adaptive Information Processing (Shapiro & Maxfield, 2002)

- Objective of EMDR is to assist patients to access and process traumatic memories while bringing them to an adaptive resolution (Shapiro, 2001)
- "If distressing memories remain unprocessed, they become the basis of current dysfunctional reactions"
- Suggestion is that EMDR vis-à-vis the use of eye movements or other "dual attention" stimuli facilitate this information processing
- "As the image becomes less salient, clients are better able to access and attend to more adaptive information, forging new connections within the memory networks (Shapiro & Maxfield, 2002, p.935)"

Description of EMDR

- Incorporates the following 8 stages:
  - Patient history and treatment planning
  - Preparation
  - Assessment
  - Desensitization and reprocessing
  - Installation of positive cognition
  - Body scan
  - Closure
  - Reevaluation

(Shapiro, 2001; Shapiro & Maxfield, 2002)

Preparation

- Therapeutic alliance is developed and fostered
- Patient education regarding trauma is provided
- Treatment is reviewed and explained
- Suggestions are made for coping with trauma reactions
- Perspective-taking in the face of trauma reactivation is also taught

Assessment

- Careful assessment of the trauma memory
- Patient is asked to:
  - Identify targets in memory and associated negative cognitions
  - Identify an alternative positive cognition
  - Rate the validity of the positive cognition
  - Identify emotions that are associated with the trauma memory
  - Rate the subjective level of disturbance associated with the traumatic memory
  - Identify trauma-relevant physical sensations and their respective bodily locations

Desensitization and Reprocessing

- Patient asked to hold the distressing image in mind, along with the negative cognition and associated bodily sensations
- While tracking the therapist's fingers across the patient's complete field of vision in rhythmic sweeps of one full back and forth sweep per second
- At the end of approximately 20 seconds (or 20 back and forth sweeps) the patient is asked to "blank it out"; meaning let go of the memory, take a deep breath
- And to note and provide feedback to the therapist as to any changes in image, sensations, thoughts or emotions that might have occurred
- In successive tracking episodes, the patient concentrates on whatever changes or new associations have occurred

Installation of Positive Cognition

- Once the disturbing images have been desensitized
  - SUDs scale report by the patient indicates little or no distress (0-2 points on the 11 point scale)
- Patient instructed to hold the positive/desired cognition in mind while tracking the therapist's fingers
- Patient not asked to report on changes in thoughts, feelings and images during this phase
- Rather to report on changes in the validity of cognition
  - Utilizing a 7-point scale where 7 is completely valid and 1 is not valid at all

Body Scan

- Patient requested to identify any continuing bodily tensions or discomfort
- If these are reported, the patient is asked to attend to them each in turn as they track the therapist's fingers

Closure

- Patient provided with coping techniques such as relaxation skills or positive visualization to address emergent distressing emotions or memories
- Journaling regarding thoughts, dreams, and feelings is also emphasized as needed

Reevaluation

- Therapist evaluates whether treatment goals are being met and maintained, at each session
- Additional sessions are scheduled as needed to target further trauma memories and/or skill development

Comments on Stages

- Stages 4 – 6 are unique to EMDR
  - Desensitization and reprocessing
  - Installation of positive cognition
  - Body scan
- Other stages may be applicable to many other forms of therapy
  - Patient history and treatment planning
  - Preparation
  - Assessment
  - Closure
  - Reevaluation

Summary of Evidence

- EMDR is an efficacious treatment for PTSD
- Recent comparisons of EMDR to PE indicate that EMDR appears to be roughly as effective as PE
- These conclusions also noted in other PGs:
  - National Institute for Clinical Excellence (NICE)
  - Australian Centre for Posttraumatic Mental Health
  - International Society for Traumatic Stress Studies (Spates et al., 2009)

(ACPMH, 2007; NICE, 2005; VA/DoD, 2003)

Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change

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Presented December 6, 2007 as part of the Office of Mental Health Services MST Support Team's monthly MST Teleconference Training Call Series

The Situation

- **Most humans are hurting**
- **Pervasiveness to human suffering-depressed, addicted, angry, suicidal, anxious, avoidant of intimacy, stress, divorce**

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The Issue

- **To sensitize you to the role that language plays in human suffering**

The Target

- To make experiential contact with previously avoided private events without excessive verbal involvement and control – and to make powerful life enhancing choices.

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The Assumption of Healthy Normality

1. Underlying assumptions of psychological mainstream
   1. **Psychological health is the natural homeostatic state**
   2. **This state is disturbed by illness or distress – *problematic***
      1. ***Example of suicide***
2. By dividing the world into normal and healthy versus abnormal and disturbed – we have failed to see that most humans are hurting.
3. Normal to abnormal.
4. Why? The answer must lie in the ordinary.

Verbal Knowledge: Language

- *Verbal knowledge is our blessing and our burden*
- We have knowledge:
  - What goes on in the mind (construct, plan, ideas)
  - Relational Frame Theory
    - Theory of human language and cognition
    - Based on principles of learning
    - What we are doing with our minds: describing categorizing, relating, evaluating, talking about, writing, reading, thinking, solving, etc.
    - Generalized operant
    - Relating as a class of behavior
    - www.contextualpsychology.org

Good……

- Language is useful:
  - Communicate
  - Predict and plan
  - Solve complex problems
  - Develop rules to regulate behavior
  - Learn from people and cultures that no longer exist

.....AND BAD

- Only species aware of our own death
- Create an idealized future
- Evaluation
  - Form negative opinions about ourselves and others
  - Construct hateful and prejudice beliefs
- Obsess or relive traumatic events
- Develop rules for acting that are harmful and ineffective
- Excessive use of language makes it difficult to maintain contact with the present moment

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OUR "MINDS" DO NOT KNOW WHAT IS GOOD FOR US

- As noted, we can verbally construct needs, dangers, and futures and take action based on these constructions
- We also struggle for no reason and hold on when we should let go
- We live in a derived,verbally regulated reality rather than to experience the world as it unfolds in the here and now
- Language is overemphasized as the means to achieving well-being

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GENERALLY WHAT THESE FEEL DIFFERENT CHANGE AGENDAS INCLUDE:

MORE, BETTER, DIFFERENT

If a client comes to us they have generally not found the right way to fix their problem:

They say, "Why am I failing?"

"I am failing because I need more _____"

Will power, emotional control, confidence

Or "less _____"

Anxiety, urges, depression, stress, worry

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Our Relationship With Private Events

- **People become identified with the content and process of their mental life to a large extent:**
  - **Vietnam era vet**
- **Disentangling people from their "minds" is one of the main goals of ACT**

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FEAR: Fusion, Evaluation, Avoidance & Reasons

- **Fusion or Literality:** cognitive fusion occurs when a person holds their thoughts to be literally true. Lemon
- **Evaluation**: evaluation exists in the object
  - Given into, argued with, undone, put out of one's mind
- **Avoidance:** or Social training of cognitive and motional control
  - avoid that which should be avoided - nonhappiness
  - "Just forget about X", "Get on with it", "I can't control my depression"

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- Reason-giving: (believing one's stories) refers to verbal explanations and justifications that clients give for their actions.
  - Behavior is caused
  - Reasons are causes
  - Thoughts and feelings are good reasons
- Reasons become accepted as legitimate causes for dysfunctional actions

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Is there ANOTHER way?

- In the place of literal meaning, there are **multiple meanings** (your thinking, what is present, context, history, feelings)
- In the place of evaluations – own your evaluations and **do what works**
- In the place of reason-giving – honest ignorance and **commitment to a course**
- In the place of emotional control – **emotional acceptance**

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Accept and Commit

The **Acceptance and Commitment Therapy (ACT)** approach assumes the position that clients can learn to accept their own emotions and deliteralize their own thoughts such that they do not have a significant negative psychological impact, even if these emotions and thoughts continue to occur.

Rather than change the form or frequency of the thought – ACT seeks to change the function.

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6 Core Processes

1. Foster acceptance and willingness while undermining the dominance of emotional control and avoidance in (Acceptance).
2. Undermine the language-based processes that promote fusion, needless reason-giving, and unhelpful evaluation (these can cause private experiences to function as psychological barriers to life promoting activities) (Defusion).
3. Live more in the present moment, contacting more fully the ongoing flow of experience as it occurs (Present Moment).

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Core Processes Continued

4. Make experiential contact with the distinction between self-as-context versus the conceptualized self to provide a position from which acceptance of private events is less threatening (Self-as-Context).
5. Identify valued outcomes in living that will legitimize confronting previously avoided psychological barriers (Values).
6. Build larger and larger patterns of committed action that are consistent with valued life ends (Committed Action).

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- Or using a unique set of experiential and mindfulness exercises that promote acceptance of self and others, while working to define personal values and also to support efforts at making and keeping commitments related to those values.

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The Question?

Out of the place from which there is a distinction between you and the things you have been struggling with and trying to change, are you willing to experience those things, fully and without defense, as they are and not as what they say they are, and do what works for you in this situation according to what you value?

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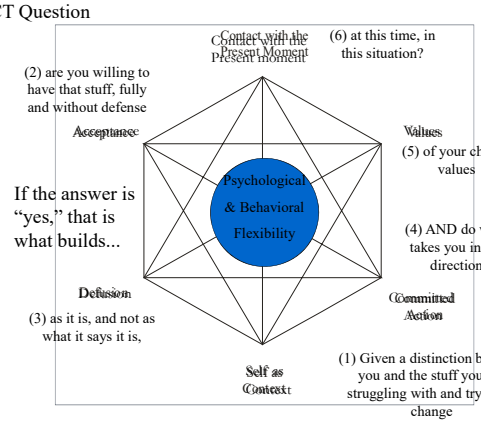
ACT Question



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The Application and Technique Part

Five Main Goals of ACT:

1. **Creative hopelessness**
2. **Control of private events as the problem**
3. **Willingness/Letting go of the struggle**
4. **Self as context rather than content**
5. **Commitment and behavior change**

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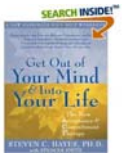
Books

- New Harbinger



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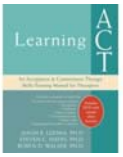

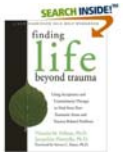

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- http://www.contextualpsychology.org
- http://www.contextualpsychology.org/all_publications
- New Harbinger:
  - ACT: PTSD, Anxiety, Depression, Chronic pain, anger
  - Get out of your mind and into your life
  - Learning ACT
  - DVD's on ACT

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