

## **ACT With Depression & Chronic Suicidality**

The following pages are largely based on original materials by:  
Robert Zettle (on depression) and Kirk Strosahl (on suicidality).

(My thanks to both Robert Zettle and Kirk Strosahl for generously giving permission to use information from their original power-point presentations. In the following pages, most points are taken unchanged, directly from their original source material. A few points have been adapted and modified from the original source. And a very small amount is my own writing, adapted from standard ACT materials.)

### **ACT and Depression; some studies**

1. Zettle & Hayes (1986)
2. Zettle & Rains (1989)
3. Folke & Parling (2004)

#### **ZETTLE & HAYES (1986)**

Design:

18 depressed women randomly assigned to 12 weekly individual sessions of ACT vs. CT

Outcome Measures:

BDI: Both groups improved significantly but equivalently pretreatment-2 month follow-up

HRS-D: Both groups improved significantly  
ACT participants significantly less depressed than CT at follow-up

Process Measures:

ATQ-F: Significant but equivalent reductions

ATQ-B: Significantly greater reduction for ACT vs. CT participants at post-treatment

Reason-Giving: Only ACT participants reported significant reductions in validity ratings of “internal reasons” for dysfunctional behavior

#### **ZETTLE & RAINS (1989)**

Design:

31 depressed women randomly assigned to 12 weekly group sessions of ACT vs. CT

Outcome Measures:

BDI: Significant but equivalent reductions

HRS-D: Significant but equivalent reductions

Process Measures:

DAS: Significant reduction for CT only, in agreement with depressive beliefs

#### **FOLKE & PARLING (2004)**

Design:

Unemployed, depressed Swedish adults on sick leave randomly assigned to TAU (n =

11)vs. ACT (n = 13; 1 individual, 5 group sessions)

Outcome Measures:

ACT participants reported significantly less depression (BDI), higher levels of general mental health, quality of life, and functional ability

### **ACT and Depression: Assessment**

Aim to identify functions served by depression; contextual issues and processes that support its initiation, maintenance, and/or exacerbation

Leads to formulation of treatment plan

Often does not unfold in a logical, linear sequence

**Assessment of four broad contextual issues may uncover more specific issues and processes:**

#### ***1. The Story***

Ask clients to tell their “story”: “Tell me about the circumstances under which you became depressed.”

Types of cognitive fusion that may be identified:

Self-as-content (“I’m no good”)

Evaluation (“Life is terrible”)

Being right

Rigid rule-following

Emotional reasoning

Historical Reason-Giving: Supports “being right” and playing “martyr role”

Contemporary Reason-Giving: Supports disruption of value-directed activities

#### ***2. The Control Agenda***

“Tell me about what you have tried on your own, or through the help of others, to deal with your depression - and how has that worked for you?”

Common types of emotional control strategies that may be identified:

- Rumination: analysing, “making sense of it”
- Change in activity level
- Situational avoidance
- Wide variety of distraction methods
- Suicidal ideation
- Suicidal behaviour

#### ***3. The Functions/Contexts***

“Why is depression a problem for you? What’s so bad about it?”

Types of functions/contexts that may be identified:

- Avoidance: “I’m sick of feeling this way”

- Self-as-content: “I want to be normal” (evaluation)
- Lack of committed action: “When I feel this bad, I can’t even get out of bed to go to work.” (reason-giving)

#### **4. Values**

“What is your depression standing in the way of?”

“If depression was no longer a problem, what would you be doing differently; what direction would you take your life in?”

If necessary, identify goals and work back to values

#### ***Timing considerations:***

May be more useful to identify values earlier than later

Values serve as “anchors” against which to evaluate workability of goals and behavior  
values guide behavioral activation

#### **ACT and Depression**

Depression = “dirty discomfort” resulting from Experiential Avoidance & Cognitive Fusion

Unwillingness to accept the past => Guilt, Regret, Anger, Resentment, Rumination

Rumination functions as distraction from current unwanted Private Experience

*Primarily addressed by defusion, acceptance, present moment*

NB: ‘Leaves on a stream’ = opposite of rumination

#### **Rule following**

Rule: “I must appear to be successful to avoid feeling worthless.”

Appearing successful = Feeling worthwhile

Appearing successful = Being deceptive

Being deceptive = Feeling worthless

Results in “impostor syndrome”

Rule: “Do X, Y, and Z and you will be happy in life.”

But if stop rule-following = “I was wrong” = Worthless

*Primarily addressed by values clarification & promoting self-as context*

#### **ACT and Depression**

Initial depression may be maintained and exacerbated by withdrawal from pursuit of value-congruent goals

(Fusion with: “Can’t do it.” Avoidance of: anxiety)

Complicated by ruminative coping style that implicates conceptualized self (“What’s wrong with me?”)

Pursuit of values-incongruent goals => lack of fulfillment, discontentment

*Primarily addressed by defusion of reason-giving, values clarification, committed action, behavioral activation*

Depression may function to avoid contacting even more basic and threatening private experiences:

Fears of intimacy, rejection, failure

(“I’d rather not try at all than try and get hurt/get rejected/fail”)

*Can be addressed by all six clinical processes of ACT*

Depression may result from efforts to attain and maintain self-worth, self-esteem, etc.

Excessive fusion with positive self-as-content:

leads to hypervigilance for flaws, faults, and shortcomings that challenge the idealised self

Excessive fusion with negative self-as-content:

leads to ‘I’m useless/worthless/unlovable etc’

*Primarily addressed by promoting self-as-context, acceptance, defusion*

“Getting better” vs “being wronged”

(“Anyone who had to undergo what I’ve had to put up with would be depressed.”)

“Being right” vs “getting better”

Who would be made wrong, if you were no longer depressed? Who would be made right, if you were no longer depressed?

Possible additional function of suicidal behavior: revenge, “getting even”

*Address by defusion, acceptance, values, forgiveness*

### **ACT and Depression: a ‘loose’ structure to follow**

- Confronting the agenda (creative hopelessness)
- Control is the problem
- Willingness is the alternative (defusion, acceptance, present moment)
- Self-as-context
- Values and action

### **Start with:**

- Rapport: compassion, empathy, acceptance, equality
- Normalisation
- Commonality of depression
- Commonality of suicidal thoughts & behaviour
- Evolution of mind: normality of psychological suffering
- “Your mind’s not defective: it’s evolved to do what it’s doing”

### **Confronting the agenda/ control is the problem:**

- What have you tried? How has it worked? What has it cost?
- Zettle suggests titrating the level of this intervention – go more gently if client is suicidal
- Find out function of suicidality: “What would you accomplish by killing yourself?”
- “Has being suicidal helped improve your life in the long run? What have been the costs?”
- “Trying to get rid of these bad thoughts and feelings is not improving your life in the long run. How about we try a different approach?”

### **Willingness is the alternative:**

- Mindfulness : a set of skills that reduce the impact & influence of painful thoughts and feelings

### **Defusion skills typically come first:**

- I'm having the thought that
- Thoughts on cards
- Radio "Doom and Gloom"
- Chessboard metaphor

### **Fusion & defusion: psychoeducation**

- Fusion: a thought seems like *the absolute truth* or *a command that must be obeyed* or *something actually happening here and now* or *a threat* or *something very important that we must pay attention to*
- Defusion: a thought is just a thought. If it's helpful, we pay attention to it. If not, we let it go.

### **Defusion contd.**

- Reason-giving
- Factual description vs evaluation
- Good chair/bad chair
- Taking inventory
- Just noticing

### **Acceptance, present moment**

- Mindfulness of breath
- Mindfulness of emotions
- Mindful eating a sultana
- Informal mindfulness
- Anhedonia: it's like watching a movie, trying to see past the huge billboard that's resting on your lap, on which is painted with the words "*I'm not enjoying this*". You don't have to repaint the billboard; you can put it down beside your seat, and watch the movie.

### **Self-as-context**

- Observer exercise
- Sky & clouds
- Your mind: the world's greatest documentary maker

### **Values and action**

- Demons on the boat (passengers on the bus)
- What do you really want?
- If depression was no longer a problem, what would you be doing with your life?
- Magic wand

- Documentary
- 80 year celebration
- Values questionnaire

### **Values and action**

- Work from goals to values: What would that enable you to do? What's important or meaningful about that? How would others treat you? How would you be different?
- What's the smallest, simplest, easiest step you could take in that direction?
- Break goals into specific actions
- Engage fully in activity

### **How could the following be responded to in an ACT-consistent manner in treatment of depression?**

- A client remarks that he has lost hope and that perhaps therapy will help him find it again.
- A client says, "I don't see how this approach will work for me since my depression is 'biologically based'."
- A client states: "I'd try to be willing to have these feelings, but I don't know how to do it."
- A client states that her therapeutic goal is "to feel better about myself."
- A client complains of feeling criticized when his wife asked, "Can I help?" while he was putting up wallpaper.
- A client expresses doubt that forgiving a spouse who cheated on her in the past "would do any good."
- In attempting to identify values, a client claims, "I don't know what my values are anymore."
- In discussing goals and values, a client says, "I'm so tired of failing, I don't even want to set any goals for myself anymore unless I'm certain I can succeed in obtaining them."
- A client insists 'I'm worthless'.
- After an attempt by the therapist to defuse 'I'm worthless', client insists 'But it's true'
- Client claims they need to understand why they are depressed.
- Client says their depression is caused by the way others have treated them in the past ("Anyone would be depressed if they'd been treated like I was")

## **ACT with Chronic Suicidality**

Suicidal behavior is a learned response

Suicidal behavior is shaped and reinforced by internal and external rewards

Suicidal behavior is a problem solving response to problems that are viewed as:

Intolerable (Can't stand the pain)

Interminable (Don't see the pain ending)

Inescapable (Can't see a way to solve the pain)

### **Chronic Suicidality**

A pattern of suicidal behavior that is:

Pervasive (suicidal behavior becomes the dominant response to almost any stress, setback or emotional flare-up)

Persistent (suicidal behavior occurs across time despite negative consequences)

Resistant (difficult to extinguish in the response hierarchy because of its over-learned nature)

Unworkable (suicidal behavior decreases client's functional status and emotional resiliency)

- Persistent exposure to aversive thoughts, feelings, memories and sensations
- Inability to tolerate these experiences because of FEAR
- Excessive reliance on emotional control strategies
- Tendency to passive problem-solving (luck, waiting, depending on others)
- Aversive affect and associated suicidal cognitions are ratcheted upward
- Emotional control behaviors become increasingly "short term" oriented, furthering the spiral

### **The three prongs of effective treatment (Chiles & Strosahl, 1995)**

1. Psychotherapy: Develop effective problem solving skills, acceptance of and tolerance for distress, seek valued life goals that require living
2. Crisis Management: Create continuity of care, establish a functional alliance, teach social support seeking and self care skills, create humane limits
3. Case Management: Create uniformity in system response, reduce reinforcements for suicidal behavior, funnel responsibility to one provider

### **General flow of ACT with the high risk patient**

#### **Contain high risk behavior**

- Reframe the function of the behavior
- Neutralize the reinforcement field
- Study rather than judge the behavior
- Emphasize "response ability" rather than blame
- Develop a crisis and case management "frame"
- Use behavior as "grist" for the therapeutic mill
- Connect the patient with the "cost" of escape and avoidance in terms of valued life goals

#### **Attack the workability of suicidal behavior**

- Get patient to invest in the "story"
- Destabilize confidence in the "story"
- Institute workability as the yardstick

- Use creative hopelessness to release the patient from rational, but futile, control strategies
- Encourage stopping what doesn't work before looking for what does work

### **Substitute acceptance and willingness for emotional control**

- Introduce relationship of willingness, suffering and workability
- Distinguish decision and choice
- Work on components of FEAR
- Find small ways to practice willingness
- Use suicidal crises as opportunity to explore two alternatives: acceptance (willingness) vs.. control (struggle)

### **Institute committed action and behavior change**

- What do you want your life to stand for?
- Who would be made right if you got better?
- Address sense of victimization: pain vs.trauma
- Address confidence the feeling vs. confidence the action
- Relate sense of right & wrong with forgiveness
- Emphasize committed action as a process, not an outcome (titrate to fit clients readiness)

### **Typical ACT Moves**

- Is it more important to be right or to have a life?
- Life doesn't care
- What would you be doing in life if you weren't stewing in your suicidal thoughts all the time?
- The goal is not to feel good, but to feel alive: when you live a full life, you will feel the full range of human emotions.
- The greatest tragedy about your past would be turning it into your future!
- The clock of your life is ticking. Can you hear it?
- I don't know what will happen if you change. I do know what will happen if you don't.
- Your thoughts and feelings don't "cause" suicidal behavior! You do!
- What would happen if you just showed up for your life and let the chips fall where they may?
- Don't listen to me, listen to your experience.
- What do you need to do to make what you are going through honorable, purposeful and legitimate?
- You don't get to choose the deck of cards you've been dealt; you only get to choose how you play them.

### **Personal qualities of the effective therapist**

- Models an open, honest approach to suicidality
- Takes a matter of fact approach
- Communicates genuine caring and concern
- Creates a "collaborative set" with the patient
- Understands the difficulty of changing a well entrenched behavior
- Focuses on patient strengths, not psychopathology
- Willing to incorporate suicidality into treatment
- Understands we are "in this stew together"



- There, but for the grace of God, go I
- Open to what works, not what ought to work
- Instinctive mistrust of “insight & understanding”
- Does not promote culturally sanctioned rules
- Fully informed choice is the goal of therapy
- Does not promote personal agenda about suicide
- Willing to let life, not therapy, teach the client

### **Dealing With Downers**

*What are some ACT-consistent responses to:*

- I’m just tired of always having to struggle. I’d be better off dead.
- You don’t really know how I feel (said angrily)
- You don’t really care about me. You are just saying you do.
- If you are asking me to accept the way I feel, I’d rather kill myself instead
- If you felt the way I do, you’d be trying to kill yourself too.
- What you are asking me to do is just too hard.
- I don’t feel any better than when I started working with you (said challengingly)
- Why do you keep asking me what I want my life to be about? I can’t set goals in my life when I’m always suicidal.
- (In response to a values type question) I don’t have any values! I just try to make it through one day at a time.

### **Recommended Reading**

- Chiles, J. & Strosahl, K. (2005). *Clinical Manual For Assessment And Treatment Of The Suicidal Patient*. Wash. DC: American Psychiatric Publishers
- Hayes, S. & Strosahl, K. (2004). *A Practical Guide To Acceptance And Commitment Therapy*. New York: Plenum-Klewer Press.