It’s a matter of fACT: Unleashing radical functional contextualism in PCBH

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WHO WE ARE

Bridget Beachy, PsyD

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- Director of Behavioral Health, at a Community Health Center (CHC) in Central WA
  - **Roles**: BHC, administrator, primary supervisor for interns and fellows, faculty for FM residency

David Bauman, PsyD

- Principal Member, Beachy Bauman Consulting
- Behavioral Health Education Director at a CHC in Central WA
  - **Roles**: BHC, administrator, primary supervisor for interns and fellows, faculty for FM residency

We both live and breathe contextual approaches (e.g., (Focused) Acceptance and Commitment Therapy) and working in integrated primary care

We value what we do… and… we get emotional… well, Dave does…

Our values live through our presentations… the people that mean the most to us are with us today…

LOGISTICS

Zoom format – chat box

Our gratitude for you being here today…

OUR JOURNEY TODAY…

Attendees will be able to:

- describe core components of the Primary Care Behavioral Health model
- describe the PCBH GATHER approach to care
- describe the Four C's of Primary Care
- describe the core assumptions of a fACT clinician
- identify the three core pillars of fACT that lead to psychological flexibility
- describe the philosophy of functional contextualism
- delineate the components of the contextual interview (i.e., Love- Work-Play and 3Ts) when working with patients
- discriminate a patients' internal and external context based on the information gleaned during the contextual interview
- apply the contextualism philosophy to case conceptualization with patients with common mental and behavioral health conditions
- describe how learning information from the contextual interview can be applied to brief intervention in primary care

BEFORE WE "JUMP INTO THE DEEP…"

We are passionate about functional contextualism, and integrated behavioral health into primary care

We ~~may~~ will most likely say things that challenge some assumptions…

…And that is okay… that is our hope… we are here with you…

Our perspectives aren't truths…

- We wouldn't be very good functional contextualists if we believed that

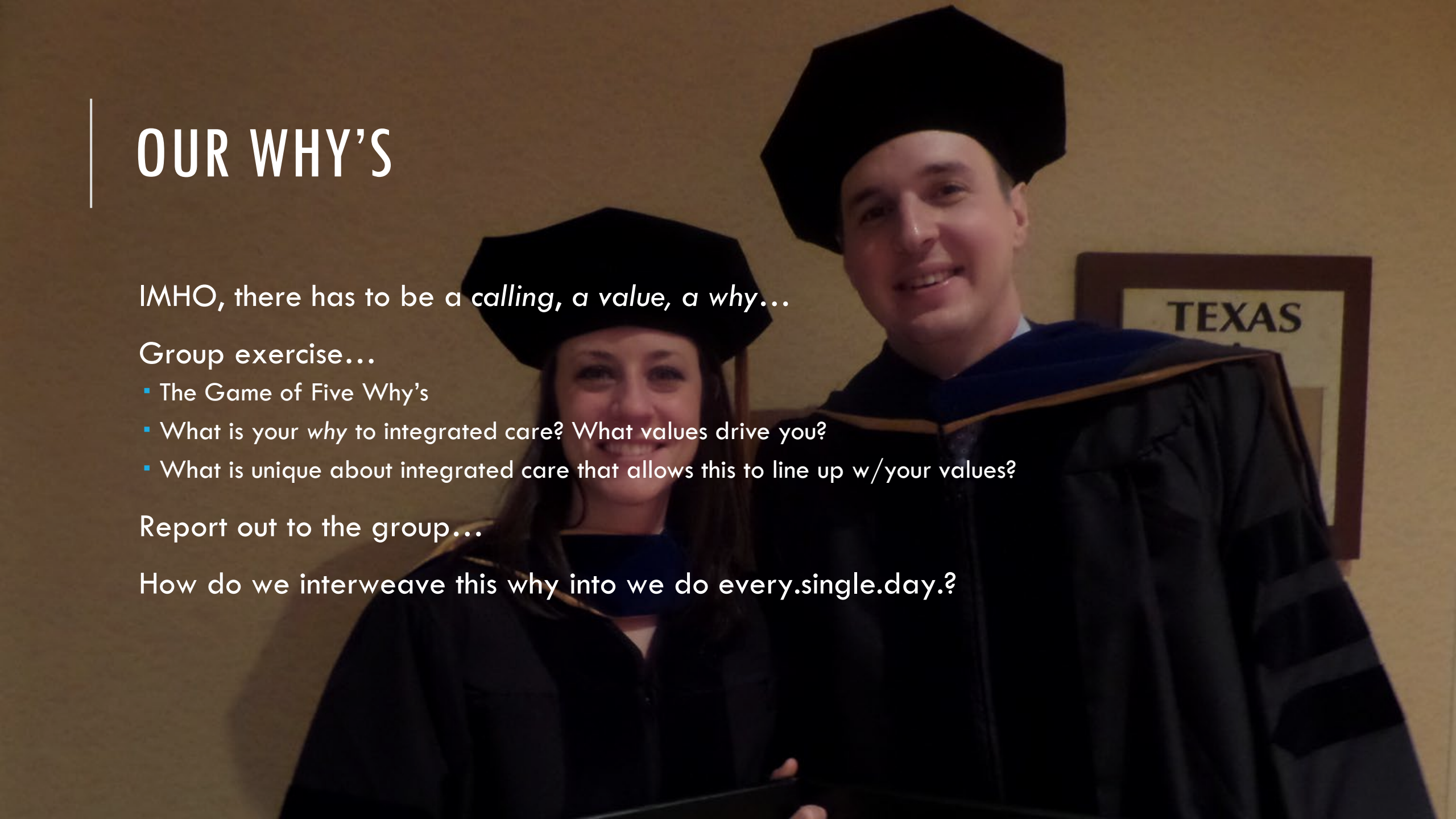
…Be kind on the journey…

INTEGRATED CARE CAN FEEL LIKE…

Anyone that says it's *easy*…

…probably hasn't done it…

OUR WHY'S



IMHO, there has to be a *calling, a value, a why…*

Group exercise…

- The Game of Five Why's
- What is your *why* to integrated care? What values drive you?
- What is unique about integrated care that allows this to line up w/your values?

Report out to the group…

How do we interweave this why into we do every.single.day.?

THE *WHY* OF PCBH

A lot of the stories (and accidents!)…

- Alexander Blount
- Neftali Serrano
- Kirk Strosahl and Patti Robinson
- Jeff Reiter

The biopsychosocial philosophy has been around for a while[1]

- Up-taken most by family medicine
- Influence on primary care

THE *WHY* OF PCBH

And… the data that you all are aware of…

What percent of adults have Any Mental Illness in a given year?[2]

Figure 51 Table. Any Mental Illness in the Past Year among Adults Aged 18 or Older: 2008-2019												
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	17.7+	18.1+	18.1+	17.8+	18.6+	18.5+	18.1+	17.9+	18.3+	18.9+	19.1+	20.6
18 to 25	18.5+	18.0+	18.1+	18.5+	19.6+	19.4+	20.1+	21.7+	22.1+	25.8+	26.3+	29.4
26 to 49	20.7+	21.6+	20.9+	20.3+	21.2+	21.5+	20.4+	20.9+	21.1+	22.2+	22.5+	25.0
50 or Older	14.1	14.5	15.1	15.0	15.8+	15.3	15.4+	14.0	14.5	13.8	14.0	14.1

THE *WHY* OF PCBH

But, where do they get treatment?[2]

Figure 74 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older: 2002-2019

Service Type	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
Any Mental Health Services	13.0+	13.2+	12.8+	13.0+	12.9+	13.3+	13.5+	13.4+	13.8+	13.6+	14.5+	14.6+	14.8+	14.2+	14.4+	14.8+	15.0+	16.1
Inpatient	0.7+	0.8	0.9	1.0	0.7+	1.0	0.9	0.8	0.8+	0.8+	0.8	0.9	1.0	0.9	0.9	1.0	1.0	1.0
Outpatient	7.4+	7.1+	7.1+	6.8+	6.7+	7.0+	6.8+	6.4+	6.6+	6.7+	6.6+	6.6+	6.7+	7.1+	6.9+	7.5+	7.9	8.3
Prescription Medication	10.5+	10.9+	10.5+	10.7+	10.9+	11.2+	11.4+	11.3+	11.7+	11.5+	12.4+	12.5	12.6	11.8+	12.0+	12.1+	12.2+	13.1

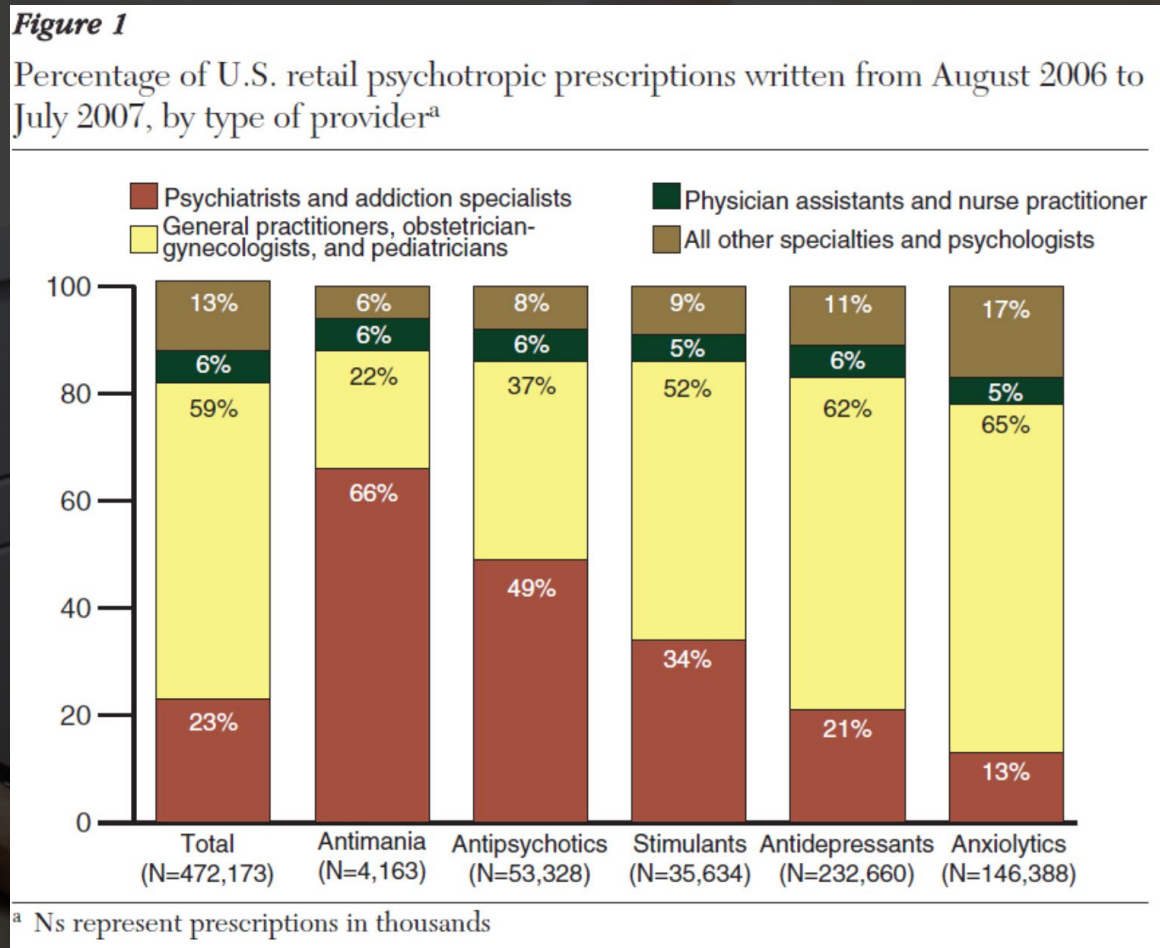
+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

THE *WHY* OF PCBH

That 13.1% of prescriptions… where are they coming from?[3]

Figure 1

Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider[a]



[a] Ns represent prescriptions in thousands

THE *WHY* OF PCBH

Well, just refer to SMH

- 20% of referred patients follow-through[4]

Why many don't go to specialty MH?[4]

- Lack of insurance
- Stigma
- View their problem as "physical"
- Inconvenience
- Better familiarity, comfort with PCP
- Prior negative experiences
- I don't want/need to go

THE *WHY* OF PCBH

We all know this data…

…which is why primary care continues to be the de facto mental health care system…[2,5]

THE *WHY* OF PCBH – LET'S DO IT!

*"To get population reach – we need a **philosophy** to improve access to help us work with everyone & everything that walks into PC…"*

EBT for mental health disorders:

How long are typical visits?

How frequently do patients meet with providers?

How many visits do providers typically have with patients?

Now…what about for primary care providers?

So, just taking our SMH approach to PC is not the answer… we not only need to BE in PC but we need to change HOW we practice

Robust research base showing effectiveness of brief interventions[6]

- Even for intense mental health conditions (e.g., PTSD)

THE *WHY* OF PCBH

And… that is usually where the story ends… its about mental health and substance abuse….

Yet, close to half of all Americans have a chronic health concern (e.g., HTN, DM, heart disease, etc.)[7]

- Nearly 2/3 of all deaths in US are contributed to heart disease, cancer, stroke, COPD, & DM

What is one universal recommendation for chronic conditions?

What are the realities of treatment adherence in primary care?[8-9]

What does the research Adverse Childhood Events say?[10]

This isn't a mental health intervention… this is a healthcare intervention…

THE *WHY* OF PCBH

And… interventions are great… but, isn't that limited?

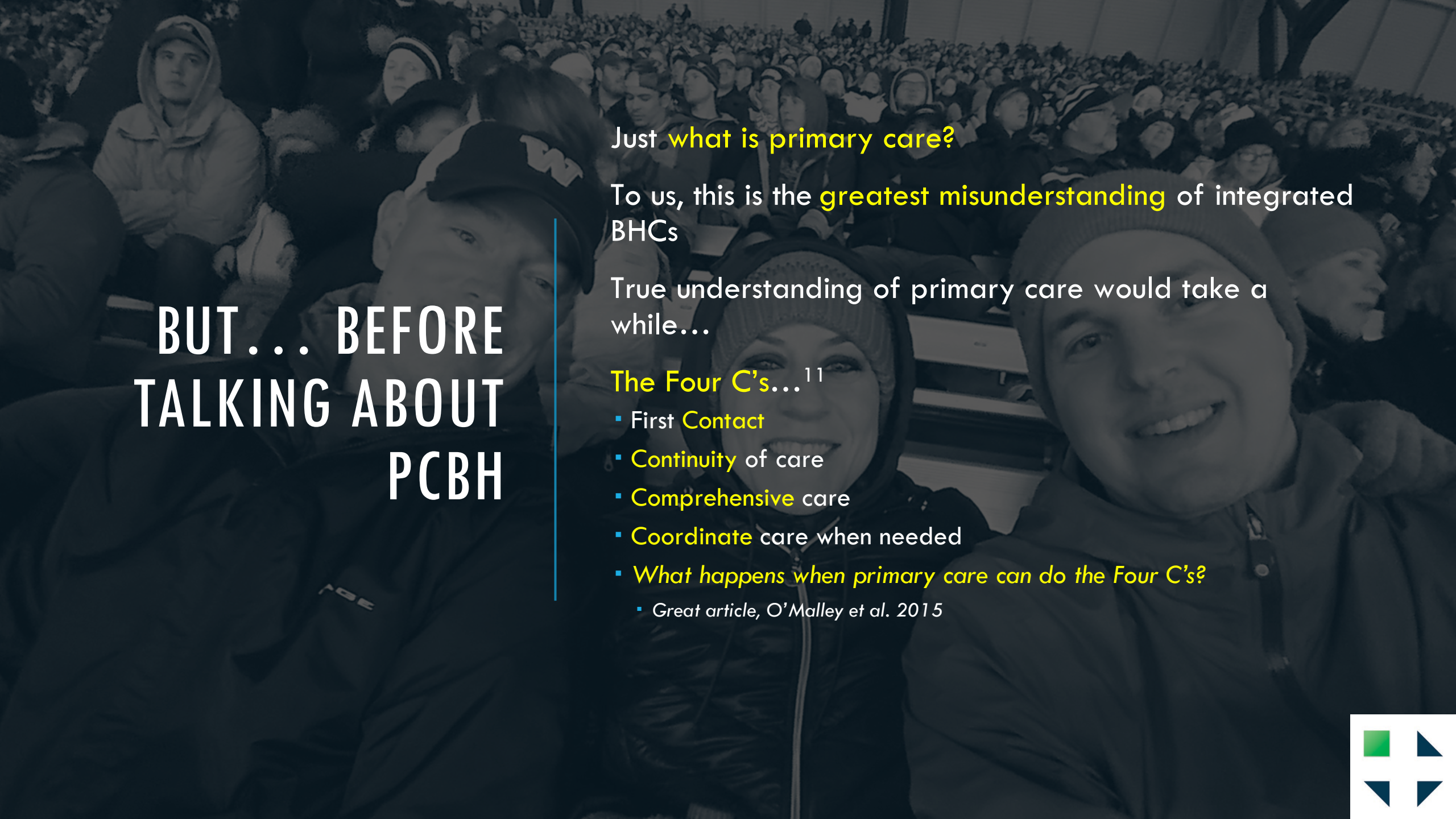
We want to influence our teams

We want to influence our system

We want to influence our communities

We need a philosophy that helps us do that…

And… that is what Primary Care Behavioral Health is all about… at least to us ☺



BUT… BEFORE TALKING ABOUT PCBH

Just what is primary care?

To us, this is the greatest misunderstanding of integrated BHCs

True understanding of primary care would take a while…

The Four C's…[11]

- First Contact
- Continuity of care
- Comprehensive care
- Coordinate care when needed
- *What happens when primary care can do the Four C's?*
  - *Great article, O'Malley et al. 2015*

FIRST CONTACT

Primary Care's Four C's

CONTINUITY OF CARE

Primary Care's Four C's

COMPREHENSIVE CARE

Primary Care's Four C's

COORDINATE CARE WHEN NEEDED

Primary Care's Four C's

OUR COMPASS GATHER

Great special edition on PCBH from the Journal of Clinical Psychology in Medical Settings[12]

G – Generalist

A – Accessible

T – Team oriented

H – Highly productive

E – Educator

R – Routine

GENERALIST

GATHER

ACCESSIBLE

GATHER

TEAM ORIENTED

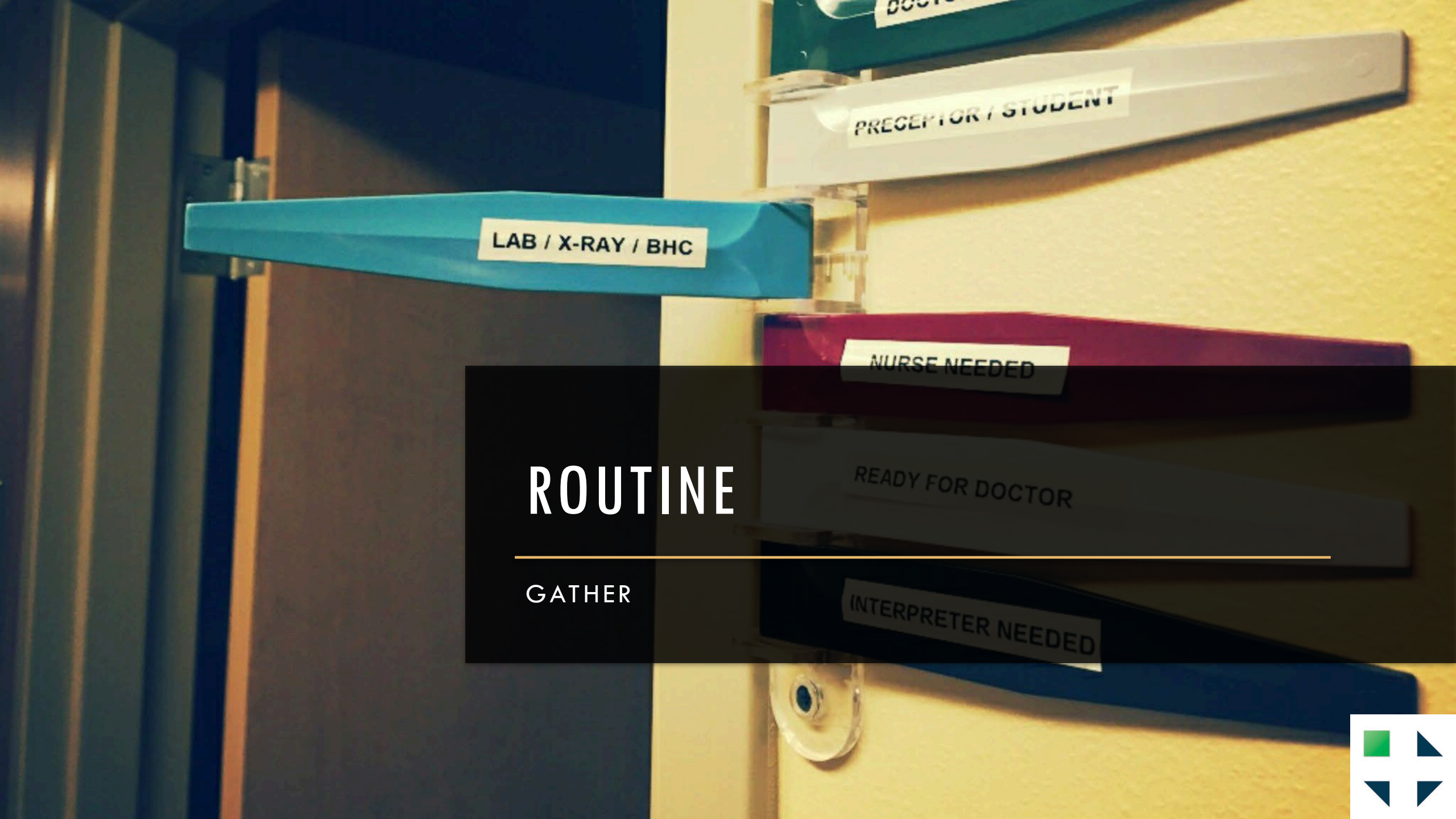
GATHER

HIGH PRODUCTIVITY

GATHER

EDUCATOR

GATHER



ROUTINE

GATHER

WHAT ALL THIS MEANS TO US…

We see ourselves as primary care providers, not necessarily behavioral health providers

By applying GATHER, we strive to help PC achieve the Four C's

This is our why… this is our value… this is our infinite goal…

How we do that? That's next…

QUESTIONS?

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AND...

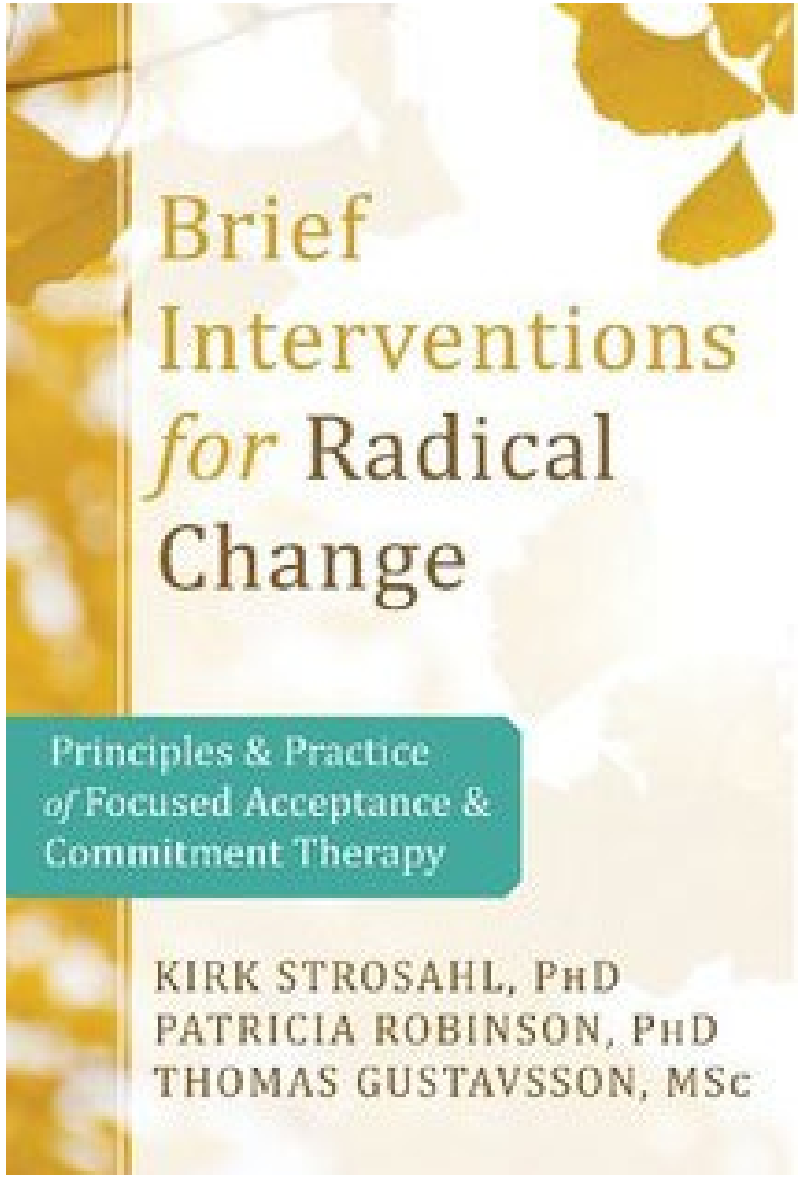
While GATHER[1] and the Four C's[2] will be our beacon, our ship will be largely be made out of Functional Contextualism and fACT

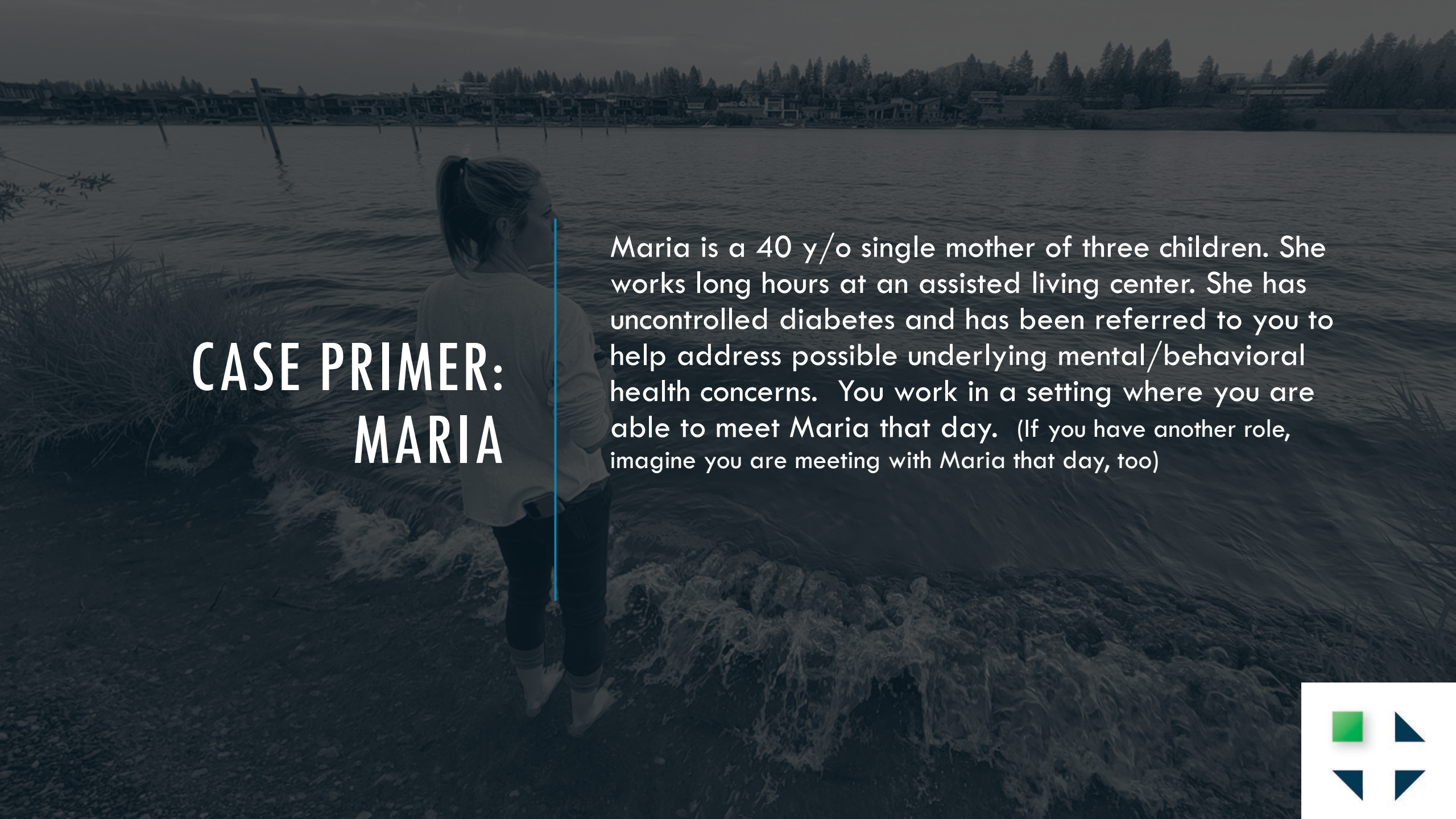
SOME ITEMS BEFORE WE GET STARTED…

- This is an overview & introduction to fACT…
  - Would be tough to do one webinar and say, "I got it!"… be kind…
- We don't DO contextualism/ACT/fACT
  - Patient with Chronic Pain? Oh, okay, now I am going to do an ACT intervention… *instead*…
- fACT **encompasses a philosophical shift**…a way of approaching and being with patients, not just "doing interventions"…today's didactic will be largely highlighting this shift
- Again, we are going to be challenging some things that we accept as truth – be open together! *Slaughter some sacred cows!*
  - Track and write down questions…
- True to the fACT philosophy – <u>we aren't going to wait</u> to get started!
- So here we go!

LET ME INTRODUCE YOU TO YOUR NEW BEST FRIEND[3]

https://www.youtube.com/watch?v=fXTJkWOVdCM&t=2916s





CASE PRIMER: MARIA

Maria is a 40 y/o single mother of three children. She works long hours at an assisted living center. She has uncontrolled diabetes and has been referred to you to help address possible underlying mental/behavioral health concerns. You work in a setting where you are able to meet Maria that day. (If you have another role, imagine you are meeting with Maria that day, too)

CASE APPLICATION OF CONTEXTUAL INTERVIEW: 40 Y/O MARIA, UNCONTROLLED DIABETES

Maria explains:

"I'm just so busy…these long hours to try to support my kids…their dads don't help at all…it's all on my shoulders. And, this month is the 5 year anniversary of losing my oldest. I just don't know what to do. It's hard to make my doctor's appointments, let alone remember to take my medications every day…or to even pick up my refills. The kids are such picky eaters and won't eat any of the healthier meals I've tried to make. I know they keep saying my sugars are high, but I honestly don't feel sick…so I guess it's easier to just not think about. Everyday I feel like I'm just hanging on, trying not to "lose it." I feel like if I just keep my head down and get done what I need to do that day, then I'll some how make it to the next day…I mean what can I really do as a single mom?"

CORE ASSUMPTIONS OF FACT[3]

Assume 1st visit may be the last (mode visits of psychotherapy?)

"f" is for "focused" – designed for clinicians to "jump-in," born out of population health principles…

Need to be efficient & effective at the same time

Challenges assumptions about duration & frequency of "treatment"… help meet the demands and realities of healthcare (fast paced) and… meet patients where they are …AND…most importantly…

Focused or brief is not a synonym for "surface level," "less than," or "sub-optimal"

Let me repeat:

Brief is not a synonym for "surface level," "less than," or "sub-optimal"

Okay, one last time:

Brief is not a synonym for "surface level," "less than," or "sub-optimal"

Now say it with me! Okay, just kidding, but you get the point…so if brief isn't that…*then what is it about?*

Meeting the demands of the masses!

BRIEF IS ABOUT…[3]

Starting the change process NOW (what better time?)

Inspiring hope about the change process (we don't have to "undo" to move forward)

Have them leave with something (reinforcing)

Talking in rapid change terms (rapid response research)

Being humble regarding not knowing who's going to make rapid changes (don't devalue the work done with patients)

Even those folks w/long-standing problems! Couldn't tell you how many times this has happened!

CORE ASSUMPTIONS OF A FACT CLINICIAN[3]

Symptom reduction is NOT the goal of treatment

Again (are we a broken record) people's symptoms make sense in context – and are not due to it being a disorder or a sign of psychopathology per se

People are NOT "broken"…even people with high levels of distress & symptoms…

Goal of treatment…join the patient on their journey to re-engage in life (more on this in a few slides)

It's their path - no need to argue with or persuade patients

"Lean in" to big emotions – both the patient's and your own

Every visit ends with something the patient will try in their life – remember it's about getting started NOW and trying something NEW!

THE PILLARS OF FACT THAT LEAD TO PSYCHOLOGICAL FLEXIBILITY[3]

fACT vs ACT (full discussion would probably be a full webinar – take away: many same concepts, extra emphasis on streamlining treatment; theory alert!)

According to your "new best friend"…fACT uses pillars vs processes to:

- Acknowledge the inter-connectedness of processes (if one pillar is flawed, the whole thing is greatly impacted)
- Simplify the psychological flexibility model to increase uptake amongst clinicians & patients alike
- Better support in session case conceptualization & treatment selection

Check out Contextualscience.org for resources on ACT!

TAKE HOME:
6 core ACT processes are condensed into 3 pillars

fACT 3 Pillars[3]

Open

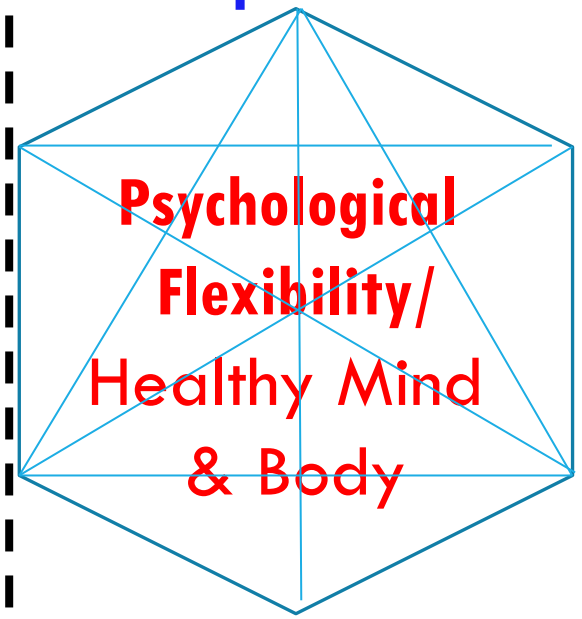
Acceptance/
Willingness

Defusion

Aware

Center

Present Moment/
Be present



Psychological
Flexibility/
Healthy Mind
& Body

Self as Context/
Perspective taking

Engaged

Values/
What's meaning-
ful

Committed
Action/Acting
on what's
important

DEFINITIONS: PILLARS OF PSYCHOLOGICAL FLEXIBILITY[3]

Rule of thumb: Start center, go left and then far right

OPEN

Able to accept distressing material without struggle

Behavior is shaped by direct results rather than rigid rules in our minds

Maria skill improvements - avoiding realities of diabetes, keeping head down, easier to not think about it "what can I do?"

AWARE

(show-up)

Able to experience the present moment

Able to take perspective on their situation

Maria skill improvements - Staying busy all the time

ENGAGED

Strong connection with values – knowing what's important/meaningful

Doing things that are important/ Meaningful

Maria: going to work, spending time w/kids, what else?

UNDERLYING THESE PILLARS IS A RADICAL PHILOSOPHY OF FUNCTIONAL CONTEXTUALISM

"Never in human history has there been as many medications and technologies available to help people manage their diabetes (or other health care concerns), yet the sequelae of poorly managed diabetes (or other conditions) continues to wreak havoc on patients and health care systems, alike…"[4]

We know what chronic conditions are…

We know how they develop…

We know how to treat them…

Yet…

A CONTEXTUAL APPROACH^3

Maybe… maybe we are focusing on the wrong things?

Instead of focusing on the weed that grows, maybe we focus on the soil?

- ACEs anyone?

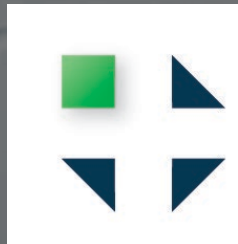
Maybe instead of dealing with what shows up at 5 PM, we focus on what is showing up at 8 AM

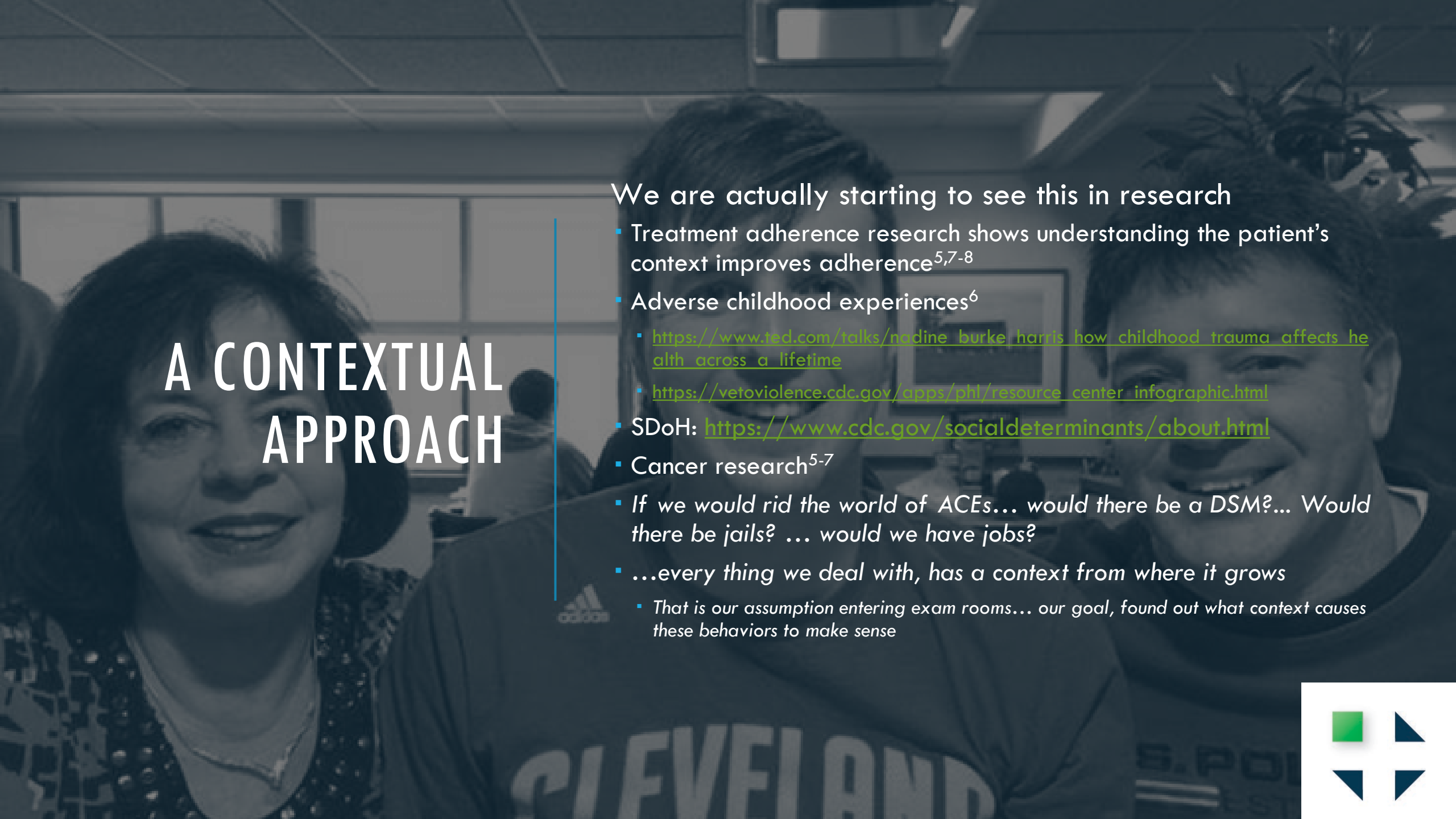
Remember when we said we would challenge assumptions… *hint, hint*

All of our diagnoses have contexts…

…even things that we think are purely biologically driven

- Bipolar, schizophrenia… they have a context





A CONTEXTUAL APPROACH

We are actually starting to see this in research

- Treatment adherence research shows understanding the patient's context improves adherence[5,7-8]
- Adverse childhood experiences[6]
  - https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime
  - https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
- SDoH: https://www.cdc.gov/socialdeterminants/about.html
- Cancer research[5-7]
- *If we would rid the world of ACEs… would there be a DSM?... Would there be jails? … would we have jobs?*
- *…every thing we deal with, has a context from where it grows*
  - *That is our assumption entering exam rooms… our goal, found out what context causes these behaviors to make sense*

RESEARCH ON ACT/FACT

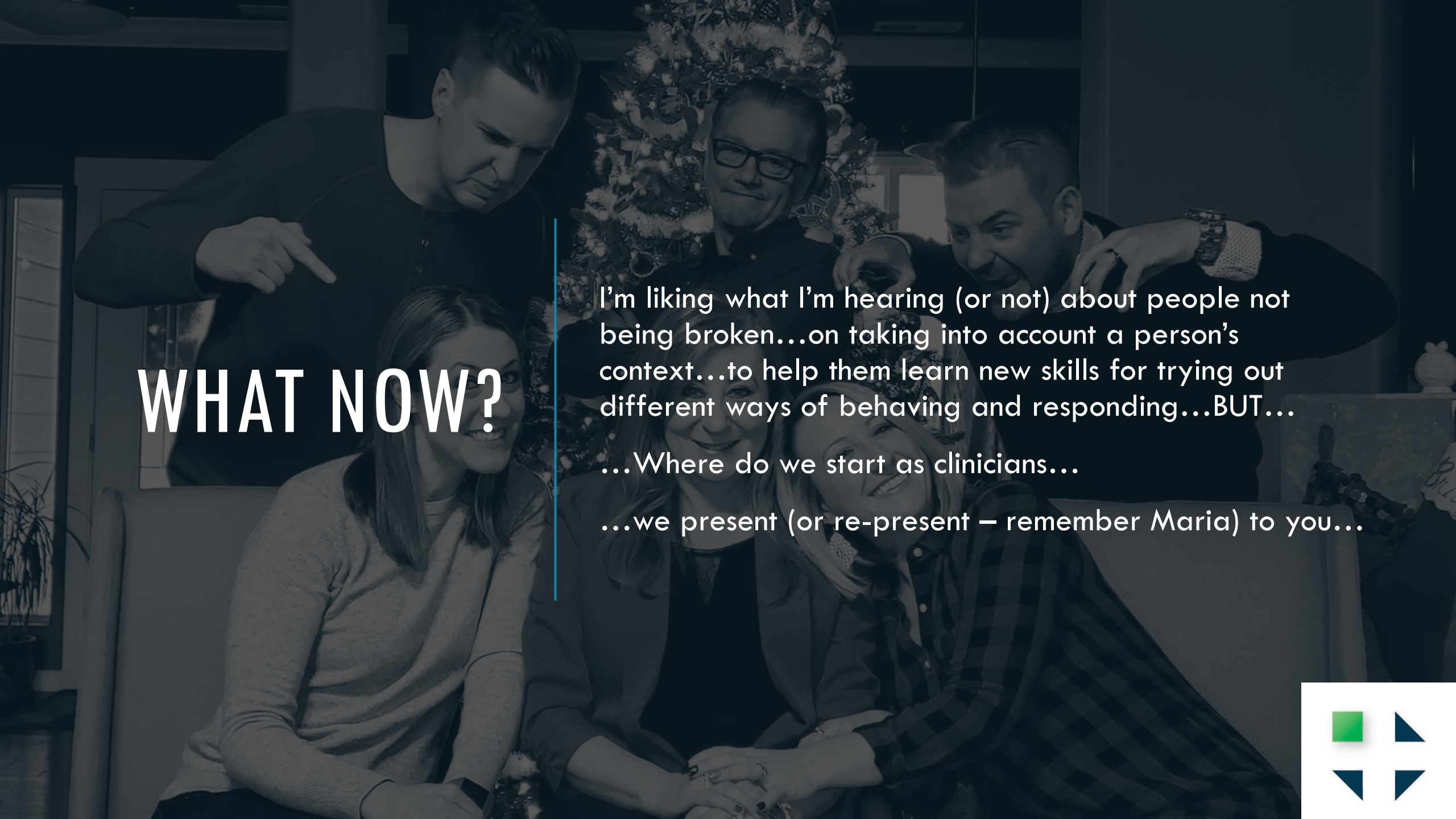
Number of meta-analysis on ACT and the support…[9-12]

Growing evidence for fACT…[11-12]

Growing evidence for brief interventions overall…[3]

- Recent meta-analysis showing promising results of a single session of ACT/fACT[13]

"In fACT, the focus is instead on living life in accordance with personal values, even if doing so produces symptoms. The goal is to help clients exchange responses that aren't working, and that often are producing paradoxically negative results, for workable behaviors." Strosahl, p. 53[3]



WHAT NOW?

I'm liking what I'm hearing (or not) about people not being broken…on taking into account a person's context…to help them learn new skills for trying out different ways of behaving and responding…BUT…

…Where do we start as clinicians…

…we present (or re-present – remember Maria) to you…

CONTEXTUAL INTERVIEW: LOVE, WORK, PLAY & HEALTH BEHAVIORS – ALL VISITS![3-4,8]

LOVE

- Living Situation
- Relationship
- Family
- Friends
- Spiritual, community life?

Work/School

- Income/Work/school situation

Play

- Fun/Hobbies
- Relaxation

Health Behaviors

- Exercise
- Sleep
- Sex
- Diet, supplements, medications?
- Substance use (caffeine, cigarettes, etoh, MJ, drugs)

The CI paints the picture of "walking a mile in someone else's shoes"…allows you to get a snapshot of their internal and external context! You're a detective…although it's a framework with practice it's very conversational…rapport building too!

FUNCTIONAL ANALYSIS: 3 T'S[3,8]

A lot of this info comes out during the contextual interview…but in case it doesn't…

Time

- When did this problem start? How often?

Trigger

- Anything happen recently to trigger this problem? Antecedents?

Trajectory

- What's the problem been like over time? Times it's worse? Better?

Workability

- Strategies for addressing the problem, how it has worked in the short or long run (value consistent)?

CASE APPLICATION OF CONTEXTUAL INTERVIEW: 40 Y/O MARIA: UNCONTROLLED DIABETES

Lives w/3 kids (19, 11, and 6 y/o)

Single

Then 19 y/o son passed away 5 yrs ago

Close w/mom and sisters (dad never involved)

Hard to find time for friends

Working long hours in assisted living

Christian, prayer but no church

No hobbies

Caffeine – coffee and soda all day

Denies cigs, etoh or substances

Convenience meals

Exercise at work/ADLs

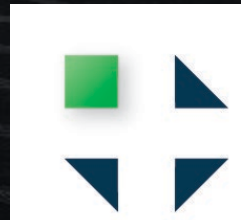
Sleep – difficult – variable hours

Time: Dx'd w/type 2 diabetes 3 years ago

Trigger: Forgets medications, too tired, stress

Trajectory: Non adherent (A1C continues to rise) since dx

Anything help? Maria starts to cry and says she "tries not to think about it"



AS WE ARE THINKING OF MARIA…THINK OF THREE DIFFERENT CONTEXTS

External

Internal

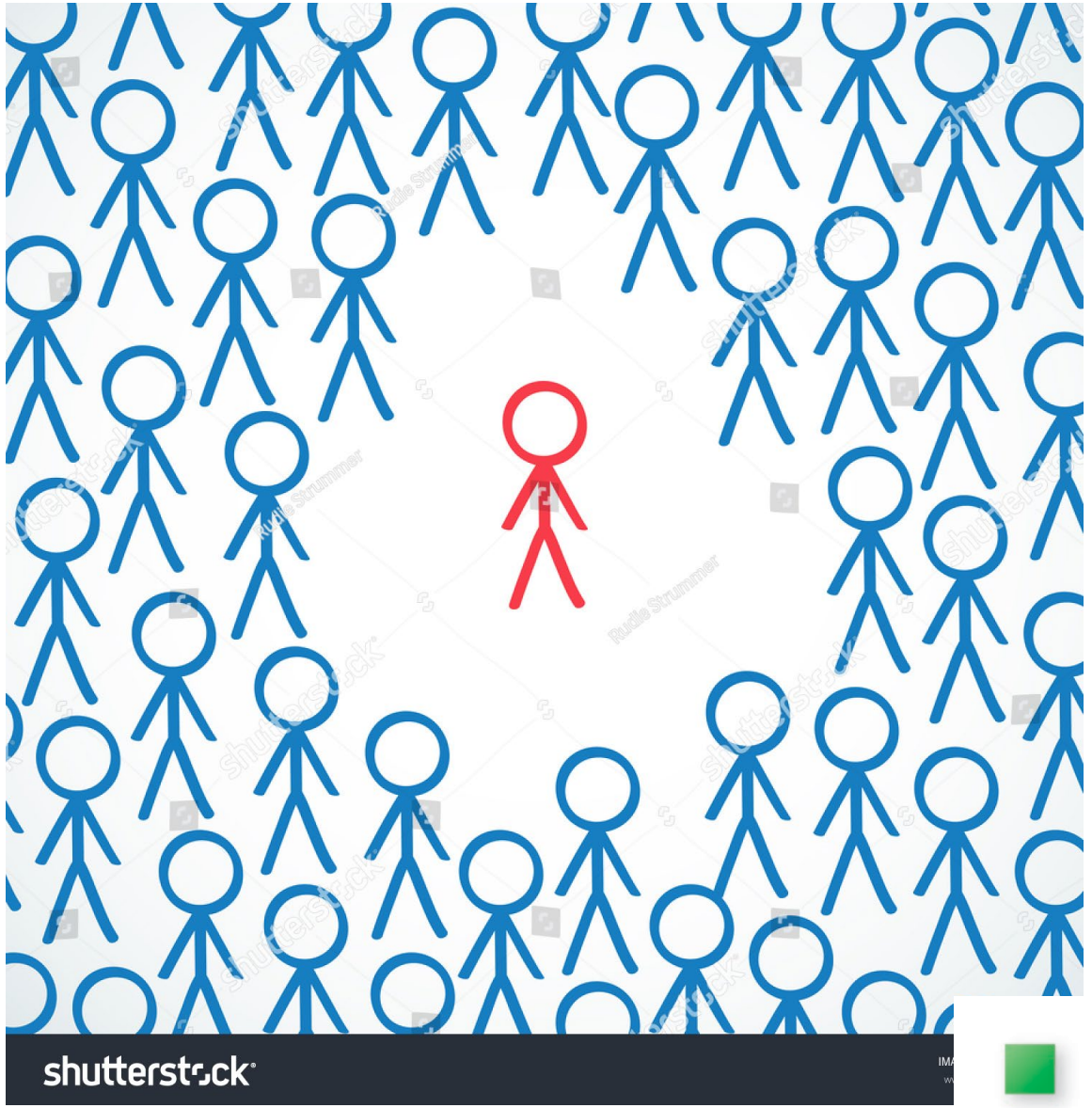
Relationship the individual has with each

EXTERNAL CONTEXT

Examples of external context?

How do we assess for the external context?

- Love, work, play, health behaviors



INTERNAL CONTEXT

Examples of internal context?

Two primary questions:

- How the individual sees themselves
- How the individual sees the world

How do we evaluate the internal context?

- Derived by answers to Love, work, play

THE RELATIONSHIP WE HAVE WITH EACH

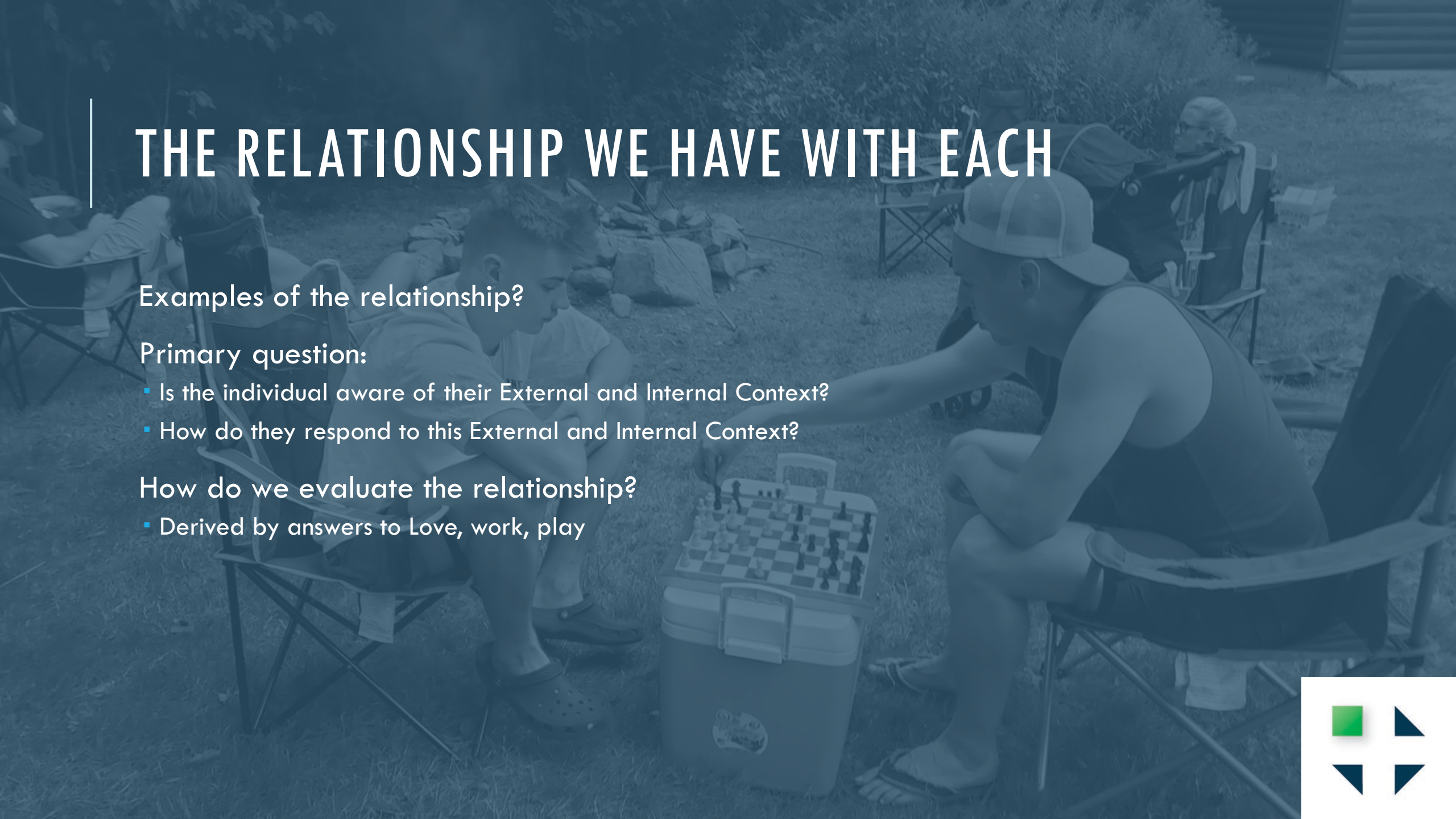
Examples of the relationship?

Primary question:

- Is the individual aware of their External and Internal Context?
- How do they respond to this External and Internal Context?

How do we evaluate the relationship?

- Derived by answers to Love, work, play



CASE APPLICATION: TAKE SOME NOTES

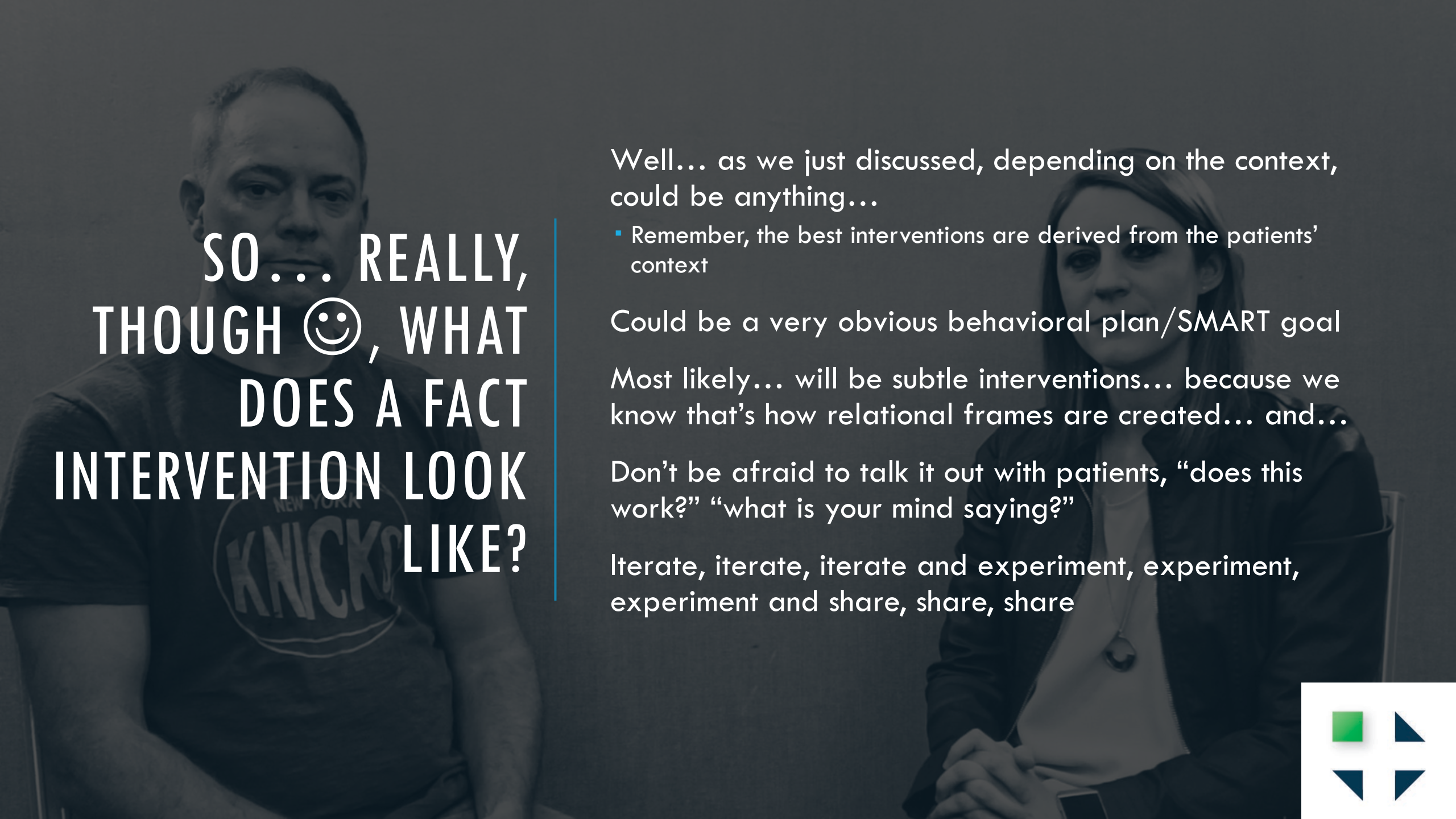
If you didn't know Maria's context, how would that have changed your approach?

- How would you help Maria?
- What more would you want to know?
- What would be your next step? Can you help her? Do you think she'll return?

What would I do? There's obviously no "right or wrong":

- Validate, validate, validate
- It makes sense she feels the way she does
- Strength based approach
- More info – hobbies, what happened with son?
- SMART goals – based on what she's willing to try

See it's not about *doing* fACT…it's a shift in philosophy…



SO… REALLY, THOUGH ☺, WHAT DOES A FACT INTERVENTION LOOK LIKE?

Well… as we just discussed, depending on the context, could be anything…

- Remember, the best interventions are derived from the patients' context

Could be a very obvious behavioral plan/SMART goal

Most likely… will be subtle interventions… because we know that's how relational frames are created… and…

Don't be afraid to talk it out with patients, "does this work?" "what is your mind saying?"

Iterate, iterate, iterate and experiment, experiment, experiment and share, share, share

SOME EXAMPLES OF THESE EXERCISES…

Direct and subtle

MOVIE EXERCISE

Who has heard of it?

How it came about?

When to use?

How to do?

fACT Pillars:

- Aware
- Open
- Engage

Overview - https://www.youtube.com/watch?v=NtDMg3ba0rA&list=PLvLh_YdubBs5l1Nt4s44-KcqRysQpTBhl&index=2

Example - https://www.youtube.com/watch?v=M2cUHd1oaLU&list=PLvLh_YdubBs5l1Nt4s44-KcqRysQpTBhl&index=6

PROGRAM EXERCISE

Who has heard of it?

How it came about?

When to use?

How to do?

fACT Pillars:

- Aware
- Open
- Engage

Example: https://www.youtube.com/watch?v=wrdZQDOo6EQ&list=PLvLh_YdubBs5l1Nt4s44-KcqRysQpTBhl

PEANUT BUTTER JELLY MOMENTS

Who has heard of it?

How it came about?

When to use?

How to do?

fACT Pillars:

- Aware
- Open

DRIVING IN THE PRESENT

Who has heard of it?

How it came about?

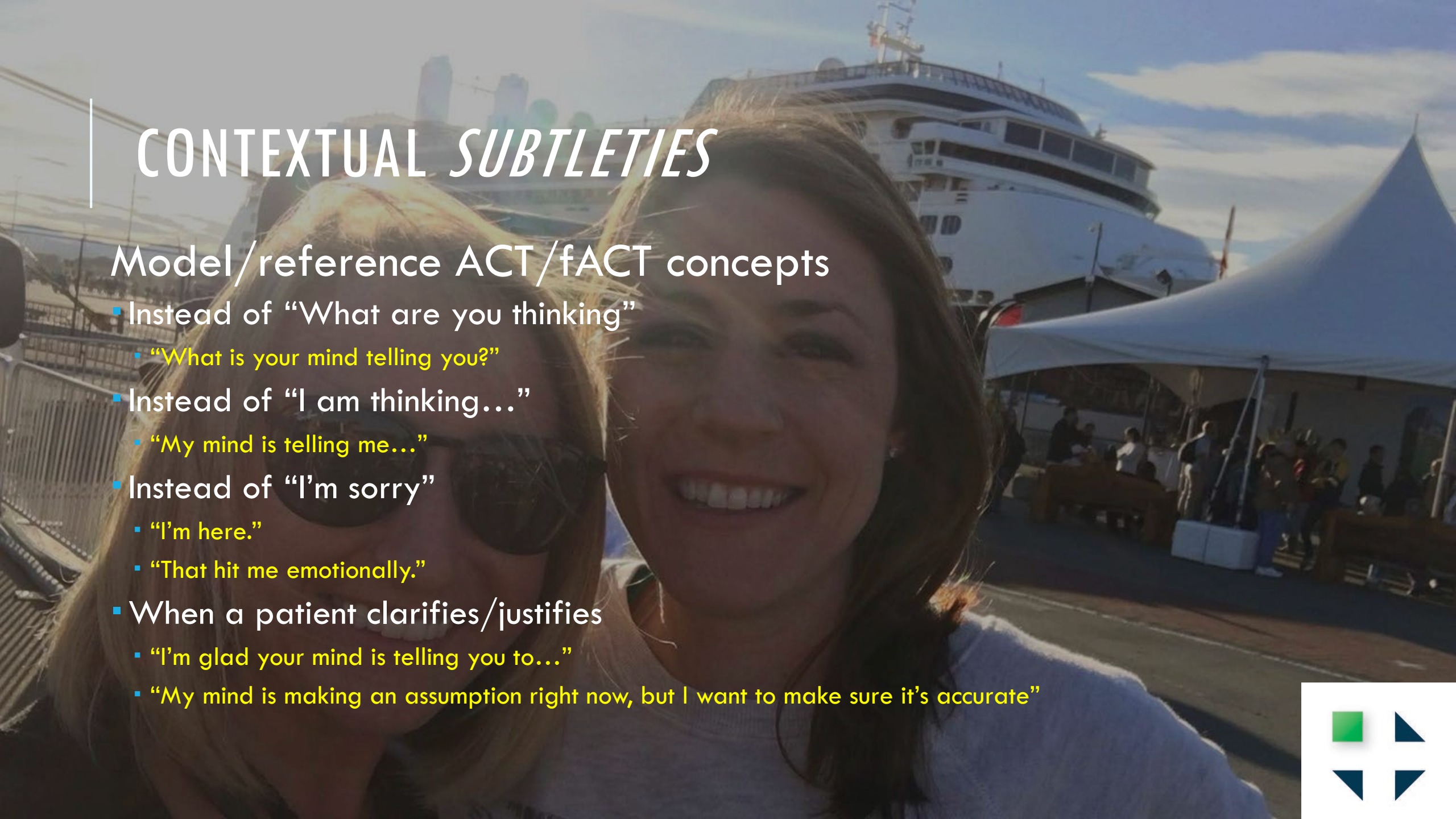
When to use?

How to do?

fACT Pillars:

- Aware
- Open

Example: https://www.youtube.com/watch?v=CNJvQudMhFM&list=PLvLh_YdubBs5I1Nt4s44-KcqRysQpTBhI&index=4



CONTEXTUAL *SUBTLETIES*

Model/reference ACT/fACT concepts

- Instead of "What are you thinking"
  - "What is your mind telling you?"
- Instead of "I am thinking…"
  - "My mind is telling me…"
- Instead of "I'm sorry"
  - "I'm here."
  - "That hit me emotionally."
- When a patient clarifies/justifies
  - "I'm glad your mind is telling you to…"
  - "My mind is making an assumption right now, but I want to make sure it's accurate"

CONTEXTUAL *SUBTLETIES*

Model/reference ACT/fACT concepts

- Stay in uncomfortable moments
  - "I can see the emotion that comes up, what is it?"
  - "What TEAMS are showing up right now?"
  - "I can see your struggle right now, can we allow the emotion to be with us?"
  - "If you weren't feeling this way, that would be *weird*."
  - *"If 1000 people went through this…"*
- Inquire about the function
  - "What might be a function of that behavior?"
  - "Why would it be beneficial for your mind to tell you that right now?"
- Notice values and that it doesn't mean life will be great moving towards values
  - "Both situations will probably suck, so, maybe we don't decide on what sucks less, maybe we decide on what moves us closer to who we want to be."
  - "Maybe it is not a **but**; maybe it is an "**and**" in that both things can be present"
  - "If we judge success on how you are feeling, we will fail eventually… however, if we judge success on what you do, that's a winnable game."

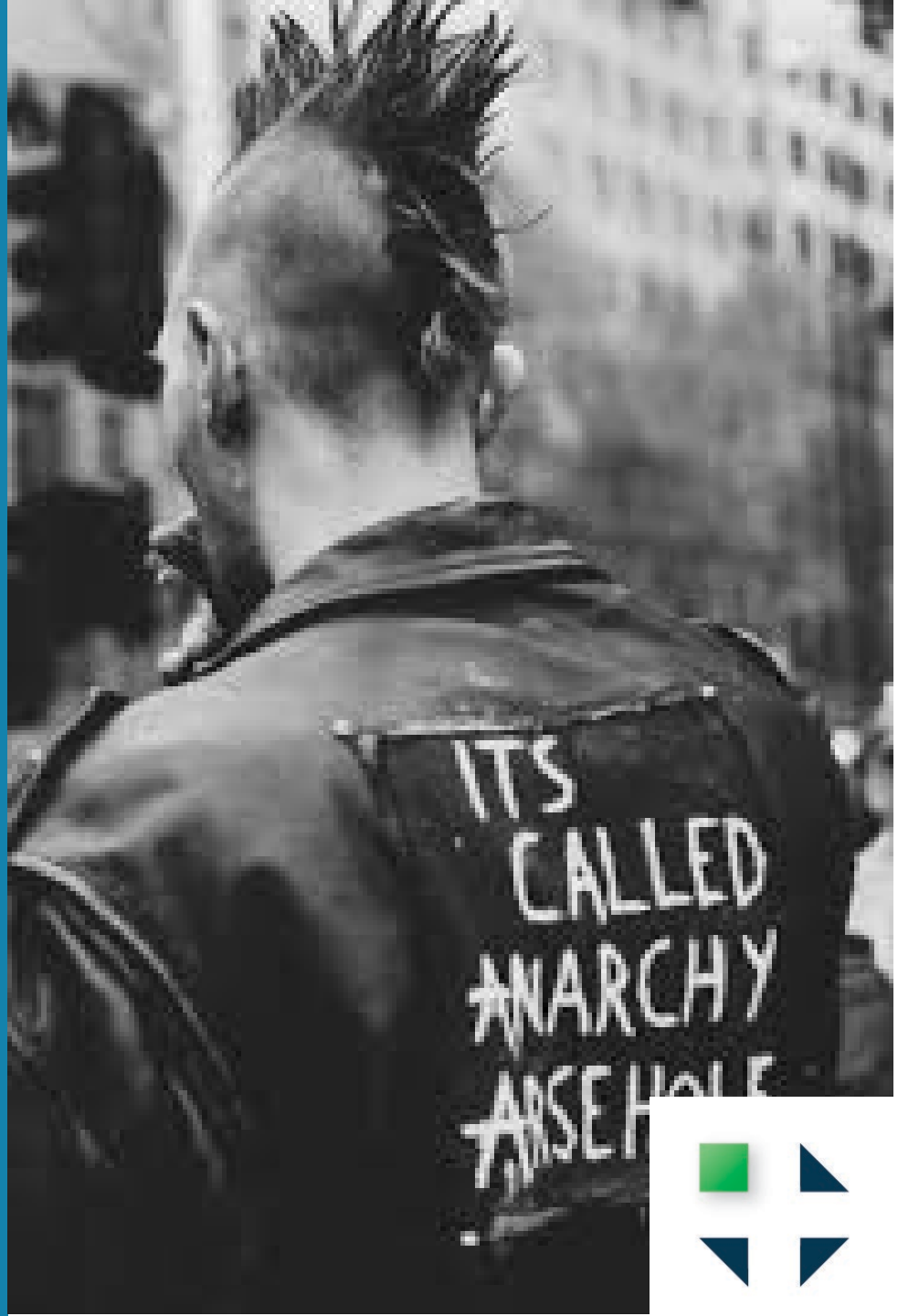
MORE CONTEXTUAL *SUBTLETIES. . . .*

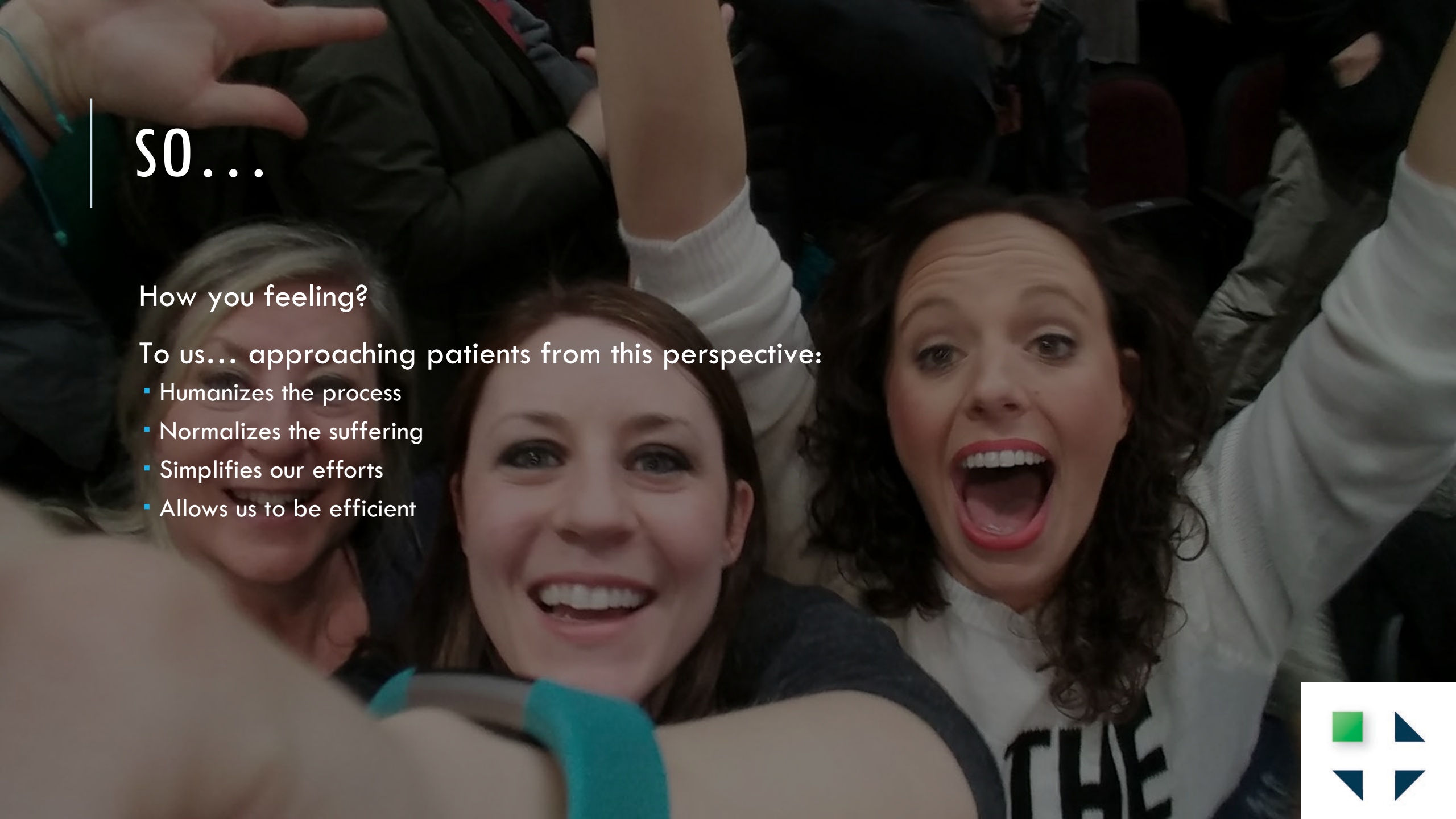
Kirkisms:

- "I am not sure what will happen if you change, but I know what will happen if you don't."
- "Keep your cards close to your chest" (take it all in)
- "You will always have to pay the piper" (there is always a cost to everything)

Other "isms"

- "Mindfulness is not about ridding anything; it is about being with everything"
- "If we were good at changing the way we think or feel, we would change the way we think or feel."
- "What *behaviors* would show that you are being kind towards yourself?"





SO…

How you feeling?

To us… approaching patients from this perspective:

- Humanizes the process
- Normalizes the suffering
- Simplifies our efforts
- Allows us to be efficient

AS WE END…

Even with these techniques, strategies, skills… we will still fall short at times…

- And, maybe that is the point

Be kind, be compassionate, and above all, be **LOVE**…

…never underestimate how you can engineer a context… even like this presentation…

…and create contexts that allow patients to thrive and move towards their values

BONUS context video: https://www.youtube.com/watch?v=toawBMszpKk&t=179s

…We so appreciate you all… thank you for joining us today on this journey…

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YouTube: https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ
& https://www.youtube.com/user/commhealthcw/videos

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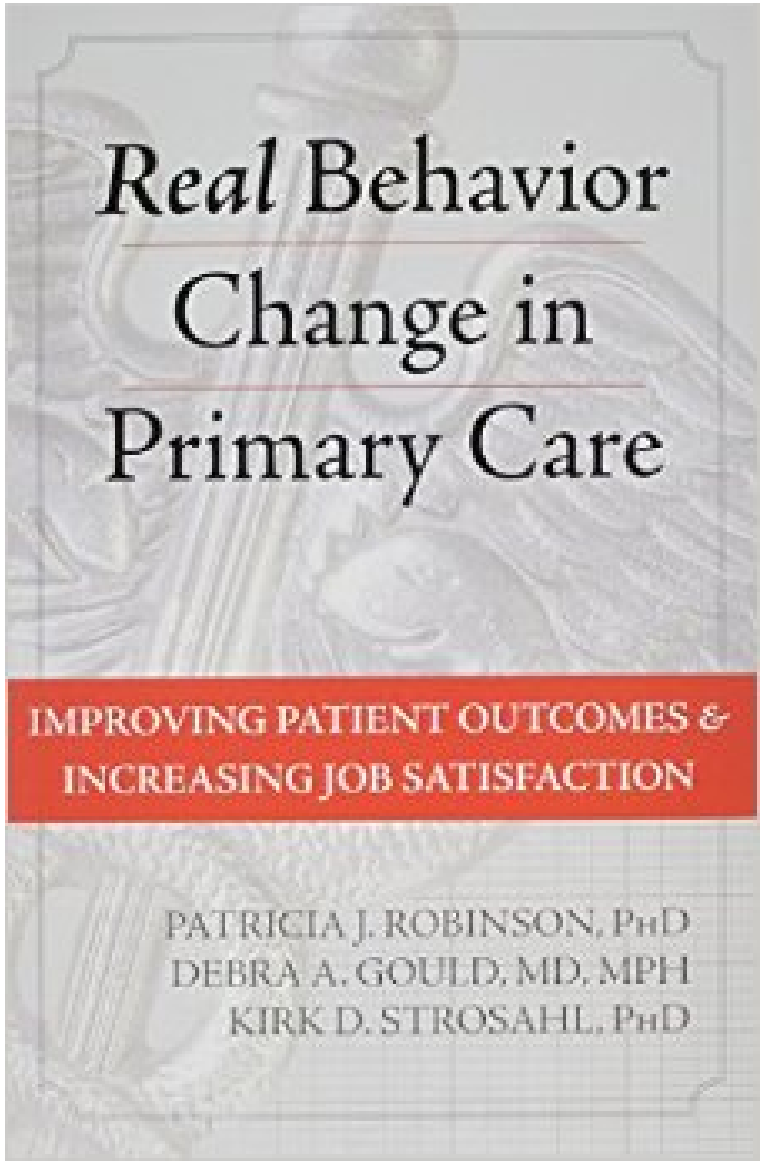
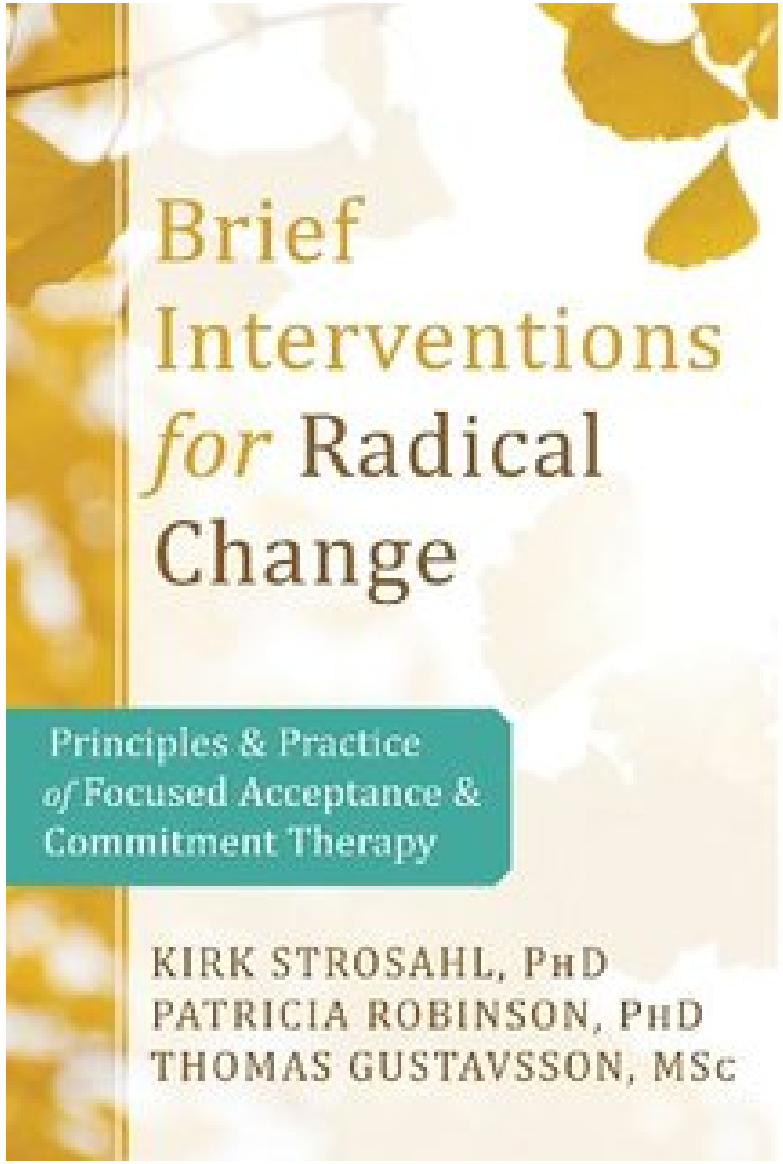
RESOURCES & BONUS SLIDES


Real Behavior Change in Primary Care
IMPROVING PATIENT OUTCOMES & INCREASING JOB SATISFACTION
PATRICIA J. ROBINSON, PhD
DEBRA A. GOULD, MD, MPH
KIRK D. STROSAHL, PhD


Brief Interventions for Radical Change
Principles & Practice of Focused Acceptance & Commitment Therapy
KIRK STROSAHL, PhD
PATRICIA ROBINSON, PhD
THOMAS GUSTAVSSON, MSc

FOCUSING QUESTIONS (STROSAHL ET AL., 2012; P. 70)

Must collect highly productive data

After contextual interview…

Well-designed interview sequence

- *What are you seeking?*
- *What have you tried?*
- *How has it worked?*
- *What has it cost you?*

FLEXIBILITY PROFILE EXERCISE

OPEN	AWARE	ENGAGED
Strengths	Strengths	Strengths
Skill Deficits	Skill Deficits	Skill Deficits

VIDEOS

Contextual interview and intervention demo:
https://www.youtube.com/watch?v=NRZ7WLsj25w&t=183s

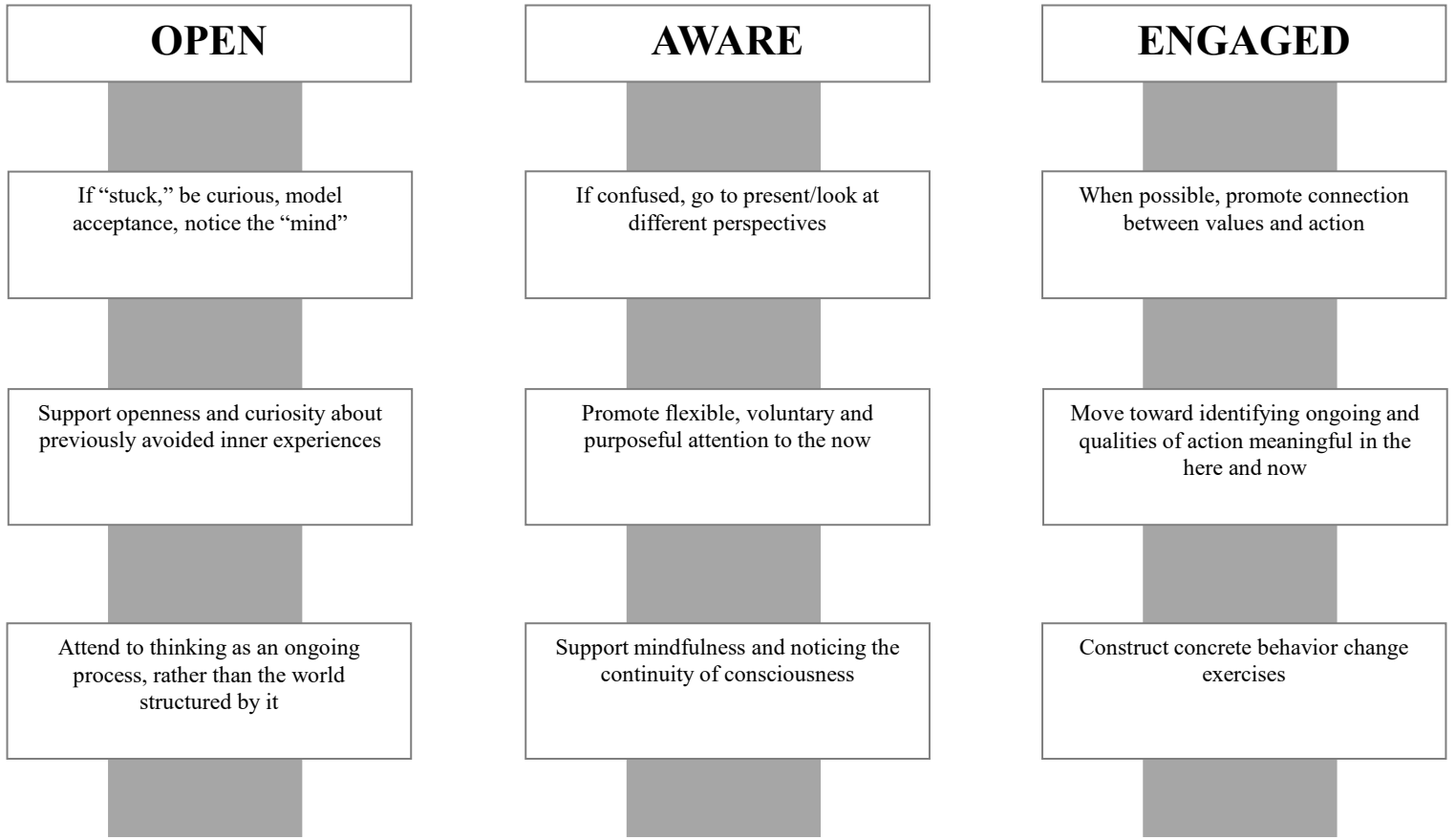
Dr. Strosahl's
https://www.youtube.com/watch?v=Qa_qH0DiAh4&t=28s

Program metaphor:
https://www.youtube.com/watch?v=wrdZQDOo6EQ&t=14s

Contextual interview and brief visit for headaches demo
https://www.youtube.com/watch?v=vuTrmRFDt9s&t=74s

Contextual interview and brief visit for diabetes demo:
https://www.youtube.com/watch?v=JKFWsb8RtW0&t=150s

FACT DANCING (STROSAHL ET AL., 2012)



METAPHORS / INTERVENTIONS FOR EACH PROCESS

OPEN

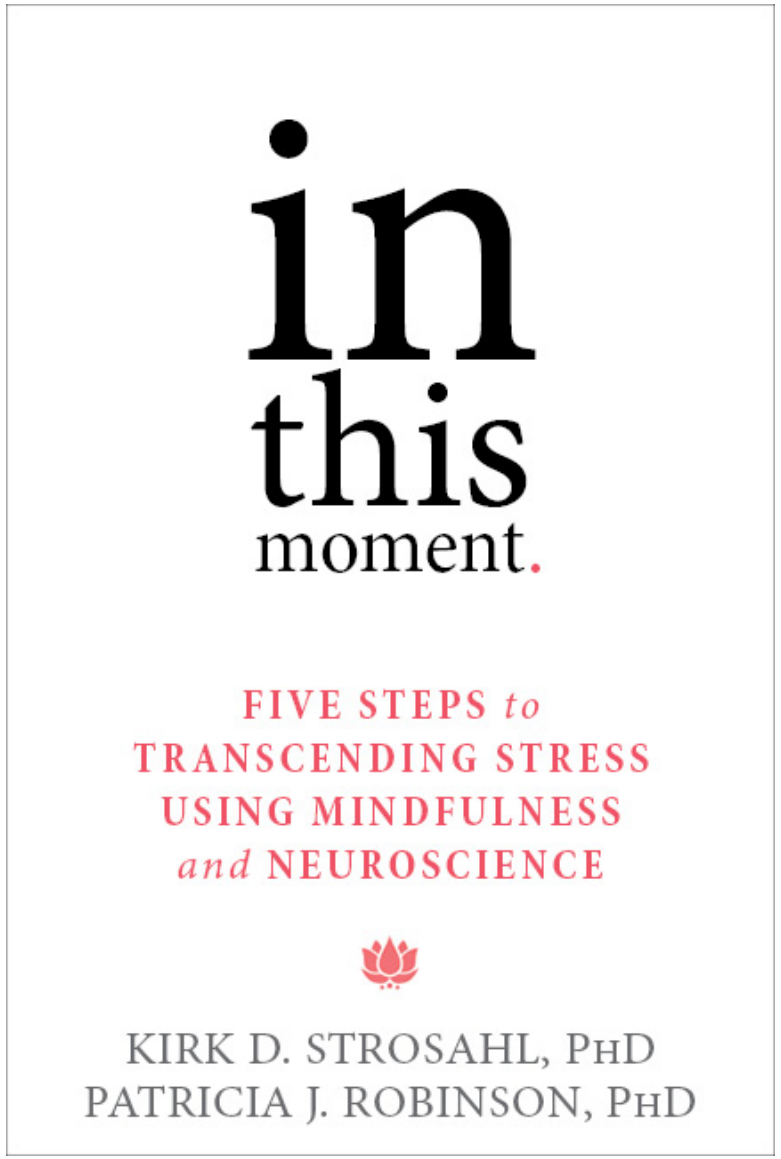
- Acceptance
  - Tiger metaphor
  - Book chapter
  - Quick sand
  - Chinese finger trap
  - Unwelcome party guest
- Defusion
  - TEAMS sheet
  - Leaves on a stream/clouds in the sky
  - Velcro
  - Zoomed in, Zoomed out?
  - Prison bars
  - “Menu of options”

AWARE

- Present Moment
  - Timeline – now, past, present
  - Name 3 things you see…hear, smell, taste, feel?
  - Deep breathing via balloon metaphor (here – inhale; now – exhale), focus on one item in room
  - I am having the thought…. The feeling…. The sensation…
- Self as Context
  - Monitor, person looking at screen
  - Imagine you are 5, 15, 25 y/o
  - Self stories – who witnessed the writing or telling of the story?
  - Miracle questions – what would be different about you? What would I see? What are you doing?
  - Chess metaphor

ENGAGED

- Committed Action
  - “Try to pick up the pen”
  - Response-able vs responsible
  - Bull’s eye action steps
  - Passengers on a bus
- Values
  - Bull’s eye value identification
  - True north
  - Retirement party


in
this
moment.
FIVE STEPS to
TRANSCENDING STRESS
USING MINDFULNESS
and NEUROSCIENCE
KIRK D. STROSAHL, PhD
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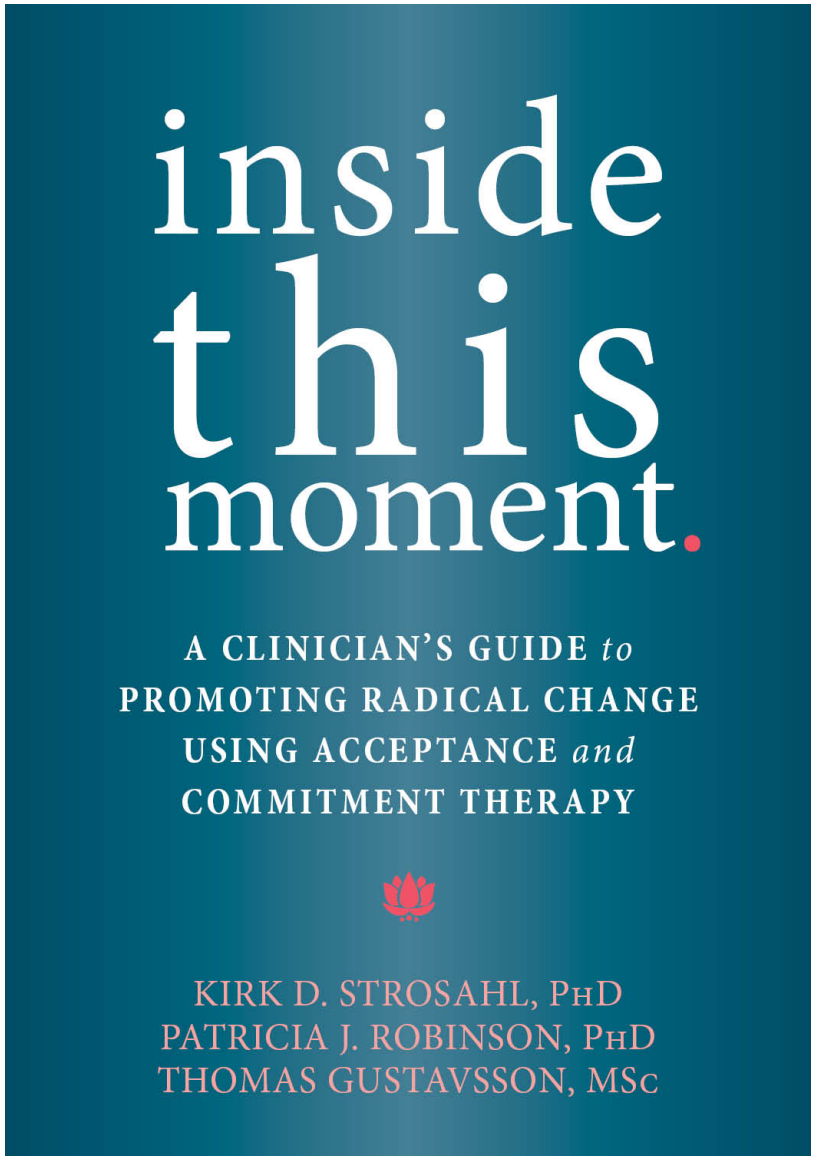
inside
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A CLINICIAN'S GUIDE to
PROMOTING RADICAL CHANGE
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