Chapter 7
Acceptance and Commitment Therapy ("ACT") for Problem Gambling

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Acceptance and commitment therapy (ACT; Hayes et al. 1999; Hayes and Strosahl 2005) is a behavioural treatment that was developed by Steven Hayes and is classified as one of the earlier 'third wave' psychological therapies. Third wave therapies are characterised by the inclusion of mindfulness interventions that can be used with the behavioural and cognitive treatments from the earlier two behavioural and cognitive waves. The treatment effectiveness of ACT for psychopathology that is commonly comorbid with PG, such as mood, substance misuse, and anxiety disorders has been documented (Ruiz 2012; Harris 2006). Some preliminary studies exploring ACT as a treatment for PG have also been reported (Dixon et al. 2016). This chapter provides the background to ACT, reports its current use for PG, and explores possible future uses for the PG population as demonstrated using a treatment case study undertaken at our clinic.

ACT theorists see the suffering we experience from painful events, such as loss, unexpected upset, and physically painfully experiences, as being amplified because of the way we interpret those events, rather than due solely to the events themselves. Inherent in the way that we interpret these events are our verbal abilities. Relational frame theory (RFT; Hayes et al. 2001) seeks to explain the importance of our verbal abilities in the above process and underpins ACT. RFT asserts that the relationships we interpret as existing between events are mostly formed as children and/or are built on social convention, rather than simply being based upon the physical properties of the events in front of us at any given time.

RFT states that the relationships between events develop as we age, creating a larger relational network of socially or culturally derived modes of living. Such a network is hypothesised to operate automatically in the background, structuring our world.

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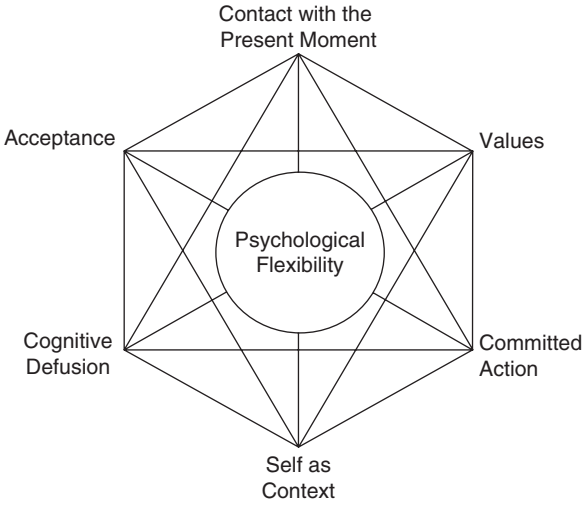

Fig. 7.1 ACT hexaflex containing the six core processes

Such a process can be maladaptive to a particular situation when the interpretation is automatic and not nuanced to the current situation can lead our interpretations to be maladaptive.

ACT is the therapeutic application of RFT that is designed to help patients develop greater levels of psychological flexibility (Louma et al. 2007). Increased flexibility in psychological processing may counteract the negative impacts arising from the automatic operation of the relational network described above. The processes in ACT that promote psychological flexibility are discussed below.

The overarching goal in ACT is to help patients be open to and willing to have their inner experiences whilst focusing attention on living a meaningful or value-consistent life, not on trying to escape or avoid pain. We have observed many cases where PGs have become overwhelmed with efforts to enable their gambling and maintain a perception of normality in other aspects of their life, and in the process they have sacrificed the pursuit of their values. Some examples include PGs who have stolen from their employers to fund their PG and set up elaborate over-confident behaviours that mislead their employer and their relatives, whilst gambling, and missing key family events. In these examples, the effort required to maintain the above deceit and the time spent gambling resulted in major diversions from their value-based living, which included connection with others, wisdom, and loyalty.

Core Therapeutic Processes

The six core therapeutic processes in ACT are designed to assist patients achieve greater levels of psychological flexibility. The core processes are outlined on the ACT hexaflex, which is contained in Fig. 7.1.

The six core processes are summarised briefly below (Hayes et al. 2005):

Acceptance Acceptance is positioned as a preferred alternative to experiential avoidance. For example, many of our PG patients become distressed when they experience urges to gamble. They report that the presence of the urge in their thoughts carries with it a requirement to act on the urge, as that action will make the distress reduce in the short term. Acceptance in this context involves assisting the patient to increase their active awareness and tolerance of the experience of having gambling urges, without seeking to change their form or frequency. For example, some PGs are able to 'let go' of the drive to reduce their distress by negative actions when they are taught to take a position of observation and noting of the component parts of their distressing experience. Such a process then reduces the 'battle' between their long-standing historical agenda of trying to control or rid themselves of the unwanted urge and associated shameful feelings attached to the negative actions.

Cognitive Defusion Cognitive Defusion relies on the principle from RFT that the efforts to rid ourselves of unwanted private experiences increase distress within the relational network. The distress created then serves to make the 'event' (often in the form of a feeling or emotion) more important. Such a process is believed to narrow the behavioural repertoire, because the events are often connected to a rich historical network that is automatically activated, and reliance on this process is attached to a well-established reinforced pattern. The therapists in our clinic assist patients to see that alternatives to the automatic processes are available when they openly and willingly experience the urges. This approach provides a platform for new learning and ultimately involves less psychological distress than trying to avoid experiencing the gambling urge at all. Education is provided about learning theory to explain that urges may be triggered by an association with a mood state, time of day, or location, nothing more. That is, even though the experience is distressing the importance of the content in the message may be nothing more than an artefact, so current relevant information to the situation may deserve more weighting in the interpretation.

Defusion involves the process of understanding thoughts from a more useful perspective than the literal meaning of the words used to describe them. Defusion is concerned with reducing the largely automatic, unintended, and historical process of relating one event to another so that values can be introduced as an alternative more conscious approach of directing behaviour (Louma et al. 2007). Such a process facilitates the interpretation of the words in the form relevant to the current situation, not as what they mean more broadly in society or have meant to an individual in the past. For PGs, practicing defusion is promoted to create a looser relationship with the urge to gamble experience and to encourage greater flexibility of behaviour, that is, to make more adaptive and situationally relevant choices.

Self as Context Self as Context is largely concerned with raising awareness of the interpretations that we have developed about ourselves and built as we have grown up. Societal beliefs and experiences over our life create a sense of who each of us are in our own understanding. For example, 'I am smart', 'I am dumb,' or 'I am an

impulsive person who has poor discipline and difficulty acting like a supportive parent/partner'. There are often images, thoughts, and behaviours that support the conceptualisation of our identity. The same processes that build identity can trap our PG patients into destructive behaviours so that problematic patterns of living are maintained. ACT can help to decrease attachment to the maladaptive parts of the patient's conceptualised self, create a safe platform from which defusion and acceptance work can be deployed, and promote greater flexibility in the patient's interpretation of themselves (Louma et al. 2007).

Contact with the present moment Present moment awareness places attention on the learning opportunities afforded in the current situation. Such awareness can lead to enhanced flexibility, responsiveness, and access to the greatest number of learning opportunities. The alternative to present moment focus is attention resting in the past or future. Attention outside the present moment facilitates activation of the logical/rational drive of language and the relational framework that is in place. The activation leads to a greater vulnerability that maladaptive behaviours may re-emerge, via fusion or experiential avoidance. The theory establishing contact with the present moment as a useful ACT process does not deny the importance of reflection on past situations and planning for future events is a valuable part of life. Rather it states that individuals with problematic behaviours, such as PG, will have more choice and better outcomes if they have contact with the present moment at the times they experience an urge, and will be more productive and suffer less if they direct the planning or reflection process, rather than be held prisoner to the whims of their unconscious attention as it decides where to focus. A present moment focus is encouraged when urges appear, as well as at other times wellbeing is at risk, until the relational framework is altered in the more adaptive way through practice (see committed action).

Therapists at our clinic work to help patients be more flexible when deciding whether a past, present, or future perspective is most adaptive for each situation as it arises. For example, choosing to drink alcohol after work each day may have helped manage stress in the past, but it also raises the possibility of PG as discipline slips with alcohol intake. By developing a present moment focus and using mindfulness techniques, healthy adaptive ways to manage stress in the key moments after work can be encouraged as a genuine alternative to the automatic process of drinking and the subsequent engagement in PG.

Defining Valued Directions Defining values involves stepping back from day-to-day life to examine the greater possibilities that support the reasons patients have for being and their struggles. A key part of this process is to establish a framework for constructive action. Values are the response given to the question: 'In a world where you could choose to have your life be about something, what would you choose?' (Wilson and Murrell 2004, p135). In ACT, values are defined as verbally constructed, globally applied, desired, chosen life directions (Dahl et al. 2005). Again context remains important, so the concept of 'truth' implied in the values that are determined should be considered as helpful, or not, only in the particular situation at hand. In our clinic many PGs have responded well to the identification of their

values as they provide a 'road map' for them to access in moving their lives in more adaptive directions. Although the values are never finally achieved, the mindful, aware, and intentional process of working towards them is fulfilling and is very helpful in behaviour change away from PG.

Committed Action Committed Action involves creating stronger patterns of effective behaviour that move an individual closer to their chosen values. This process shares many similarities with goal setting components of traditional behaviour therapies. As with the 'first wave' strategies, committed action in ACT sees goals as tangible objectives that can and should be met and reset over time. The settng of tangible goals also helps establish treatment as not just a 'once-off' theoretical exercise, and that it is not just limited to the time spent in the therapy sessions. In our clinic we say that this process is where the 'rubber hits the road' so that actual change is engaged in or the barriers preventing the changed behaviour are identified and altered. The committed action process involves a cycle of ongoing review, reset, and re-engagement.

Research on the Use of ACT for Problem Gamblers

The empirical evidence in support of ACT as an effective therapeutic technique continues to expand (see Ruiz 2012 for a review). The evidence currently supports the use of ACT as an effective treatment option for substance use disorders (Twohig et al. 2007). As substance use disorders share aetiological similarities with PG (Petry 2005), ACT appears to offer promise for treating certain PGs, yet only a small number of brief experimental-based ACT approaches have been tested with PGs to date. Like the substance use literature for ACT, the initial results for using ACT for PG appear to be promising.

In the first investigation of ACT in a gambling setting, Nastally and Dixon (2012) found that gamblers' irrational beliefs decreased after exposure to a brief ACT intervention delivered via computer. The design had a small number of gamblers complete a slot machine activity before and after the intervention, and then they were asked to rate how close each slot machine outcome was to a win (1 not at all close, 10 very close to a win). The intervention used a PowerPoint slide show explaining the ACT components, similar to the description above. Following the intervention, the gamblers' subjective ratings of near-miss outcomes decreased.

In an associated study, Whiting and Dixon (2014) evaluated acceptance and defusion strategies on gambling behaviour, delivered via an imaginal desensitisation task. The design had 30 gamblers randomly assigned to 30 imaginal desensitisation trials (either imagining slot machine gambling 30 times plus dropping quarters in a laundry machine three times or imagining dropping quarters in a laundry machine 30 times plus slot machine gambling three times). After the desensitisation task, the gamblers were asked to play on a slot machine for as long as they desired. Results showed that participants who had practised accepting gambling

images and/or thoughts played less than participants who did not think about gambling images and/or thoughts.

The potential neurological impact of ACT was examined recently in college-aged PGs (Dixon et al. 2016). A randomised control design required 18 participants to complete two functional magnetic resonance imaging scans whilst the PGs imagined completing a slot machine activity. After the initial scan, 10 subjects were exposed to a total of 8 h of ACT delivered individually by a therapist, and the other 8 received no treatment. Using a mixed two-group (ACT, control), two-condition (wins, losses), and two-timeframe (pre, post) design, the self-report and behavioural aspects of the slot machine activity and the brain activation data were compared across time. Results indicated that at post-treatment, PGs in the ACT group reported higher rates of psychological flexibility and mindfulness than control gamblers. The brain activation patterns also differed significantly between groups for winning outcomes when compared to losing outcomes following treatment, in favour of those who received the treatment. These data suggest that psychological reconditioning of behavioural and neurological responses to various addictive stimuli are possible using ACT.

Dixon et al. (2016) commented that a successfully implemented ACT-based treatment for PGs could potentially make gambling less appetitive by disrupting existing relational networks between stimuli or by producing new competing relational frames that are in contrast to prior held frames. For example, patients exposed to a therapeutic intervention which alters relations targeted at larger value systems (e.g. if I gamble, then no bills get paid and gambling is the same as missing family time), then the patient might reduce gambling because those relational frames contain more aversive stimulus functions than before (Barnes-Holmes et al. 2004).

Whilst the above studies demonstrate some positive initial steps in using ACT for PG, the preliminary nature of the designs, methods used for detecting change, and low power of the studies means that the evidence-base for treatment use must be considered 'experimental' at this time. It is our anecdotal experience that some PG treatment practitioners draw comparisons between ACT and CBT interventions, suggesting that there is little difference in the practical application of these interventions. However, the differences in our practice of ACT and CBT are noteworthy, and the different emphasis appears to be favoured by certain clients who prefer acceptance-based over challenge-based interventions. In most cases the interventions are complementary, and the acceptance-based approaches appear to have good general acceptability in relapse prevention phases of treatment for PGs.

Case Study

A number of ACT interventions that we have used in the treatment of PGs are discussed below using the case study of a patient called Mark.

Mark was a 45-year-old accountant, who was diagnosed with a major depressive disorder 10 years prior to presenting to our clinic. Mark had been married for 20 years, had two children at high school, and previously owned a small accounting firm. He began gambling on horses in his late teens as he started attending licenced

premises. He had been gambling on EGMs over the previous 5 years at a level that had resulted in him losing his business. At assessment, he was working for another employer, had a poor relationship with his wife and children, and had symptoms consistent with depression (anhedonia, poor sleep, difficulty concentrating, weight increase). He reported that he had always been shy and that he had withdrawn socially since losing his business. He stated that 'I only feel remotely like myself when I'm in front of an EGM. At those times I don't feel weighted down'. He was gambling three times per week and spending the majority of the money he could access. Self-exclusion and past cognitive-focused treatment had been unsuccessful.

As indicated above, ACT aims to develop 'psychological flexibility' rather than target symptom reduction. Mark was able to identify 'events', or urges, that preceded his gambling episodes. In the first session Mark was asked to describe his urges in terms of specific thoughts, emotions, and physical sensations. He was also asked to describe triggers that preceded the urges, and he was encouraged to identify urges in very descriptive terms to outline any associated images or memories. Mark reported that he felt anxious, 'keyed up', and light-headed and had some tingling in his stomach, sweating palms, and thoughts that he 'must be due a decent payout', 'I'll feel ten feet tall if I walk through the door at home and have some money to show them', and 'I have no other way of breaking through this debt, I'm a failure'. His emotions cycled between excitement, anger, fear, and hopelessness. He also reported being able to hear the sounds of his favourite EGM.

The first intervention using ACT began following the assessment and PG-related psychoeducation (see Chap. 2) and utilised strategies from the acceptance and cognitive defusion core processes. The goal was to help Mark see the urges in a new way, namely, as electrical impulses in his brain and body, and the historical maladaptive PG responses to the impulses were held in place by his own language and frames about himself and societal views of PGs. The therapist helped Mark to willingly accept the urges as described above and educated Mark about defusion so that he didn't try to experientially avoid the distress of the urges. The focus was on highlighting the unworkable strategies being used by Mark not any deficits in him as a person.

Mindful breathing techniques were used to allow Mark to notice the thoughts and emotions that were circling within him. Mark related well to the analogy of engaging in a championship wrestling match versus observing an uninteresting, non-provocative television commercial (Louma et al. 2007). It was put to Mark that if he relied on experiential avoidance in the current case, it would highly likely lead to and continue to maintain PG as a short-term strategy to reduce the distress associated with the urges, thus reinforcing the relational network. For homework, Mark was asked to spend time each day devoted to imagining his thoughts as being written on a karaoke screen with a bouncing ball on top of them, so the thoughts could be seen merely as language passing through his consciousness.

During the next phase of treatment, Mark was introduced to a mindfulness technique, to promote a greater level of focus on the present moment. It is our experience that in this phase of treatment that many clients report an understanding of mindfulness that includes the goal of 'clearing your mind of everything', which we describe as being closer to mindlessness than mindfulness. Mindfulness in the ACT

treatment context involves increasing the awareness of what the internal and external experience is at the current point in time, and to recognise the ‘pull’ to either the past or future. In our clinic, therapists help patients learn this skill for better decision-making and behavioural repertoire expansion beyond automatic PG behaviours. One example of an experiential exercise involved Mark mindfully eating a sultana. This required him to slowly chew the sultana whilst noting the texture, weight, and flavour. Mark was told that when thoughts arose that took his focus from the sultana, he was to try and note the distracting thoughts and then reengage in focusing on the sultana eating experience, without criticism of himself. The session debrief focused on Mark drawing parallels to the language he used to describe his thoughts in the sultana exercise and when he was having urges, as well as the level of detail and enjoyment he experienced eating the sultana in the experiment compared to any other time he could remember. The therapist discussed how he may be able to start to accept the urge related thoughts, as he did with the intrusions in the sultana exercise, rather than trying to ignore or overly engage with them. Homework involved nominating times during the day that he was to deliberately activate his five senses to notice the present moment and to try and practise accepting whatever was detected in those times.

As Mark’s mindfulness practice developed, the therapist introduced the concept of self as context, as described above. The previous mindfulness exercises were used to demonstrate that there were two distinct entities involved when being mindful: (1) the internal experience that was observed and (2) the ‘self’ that did the observing. The aim was to help Mark realise that no internal experience is inherently dangerous, controlling, or threatening and that his ability to control his internal state may be merely an illusion created by the use of problem solving language that is so effective in the external world. The therapist explained to Mark that understanding self as context meant that whilst his relational frame (1 above) was likely to provide information, it is distinct from his ‘self’ (2 above), and that learning to access both perspectives in situations was the goal.

The next sessions moved the focus of treatment to Mark’s values. Mark was taken through the Values Compass exercise (Eifert and Forsyth 2005) to help distil his values and his surrent resource allocation to each of them. For homework Mark was asked to write the speech for his 80th birthday party as would be written by his wife. He was told to write it as if he had lived a value-based life. This exercise identified reliability, knowledge, and service to others as key values that were present at times when he had felt most satisfied in life. A discussion was then initiated in which the therapist and Mark agreed how his limited resources of time, attention, and energy were currently organised in service of the values he had just stated. The outcome was to develop committed actions to re-balance the pursuit of his values.

The final phase of the core ACT treatment was devoted to reviewing the previous content of sessions and tying key components together with associated ‘committed action’. The focus was on establishing goals that were consistent with Mark’s values. Mark set the goal of going for a 15-min walk each lunchtime and after work before he commenced his journey home for the next month and then review whether he would change that activity to keep him engaged. He also set the goals of practicing techniques from past sessions on alternate days for 1 month, as well as tightening

his stimulus control measures around access to money. We agreed that the next round of goals would be for him to offer his services informally as a mentor to one of his work colleagues and that he would schedule 30 min a week into his calendar to review updates on tax management from the professional body for accountants. Appropriate clarity was created around these goals so they could be measured, and reality testing was done to ensure they were reasonable and achieveable. A follow-up session was organised, where goal-setting review was placed as agenda item 1. Relapse prevention strategies involved deepening the skills discussed above.

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