Alan Hu Foundation Mental Health Lecture Series

How Change Happens: Why Improvement in Our Mental Health Will Require Going Beyond Categories of Mental Illness

Webinar by Professor Steven C. Hayes, PhD

Foundation Professor of Psychology, University of Nevada, Reno

August 17, 2022

[00:00:00]
CHIH-CHING HU: Hello, everyone. Welcome to Alan Hu Foundation Mental Health Lecture Series. I'm Chih-Ching Hu, Co-Founder of Alan Hu Foundation and host for your webinar. Today Dr. Stephen Hayes will present "How Change Happens: Why Improvement in Our Mental Health Will Require Going Beyond Categories of Mental Illness."

[00:00:20]
First off, I want to thank Mental Health Association for Chinese Communities for providing simultaneous Chinese interpretation, and thank you, Penny Chen, for Chinese interpretation. Alan Hu Foundation's mission is to promote mental health, raise awareness and remove stigma surrounding psychiatric disorders, and support fundamental research for cures. Please consider making a gift to Alan Hu Foundation by scanning the QR code on the slide or using the donation link in the chat box. Thank you for supporting our programs to promote mental health.

[00:00:55]
Today it is our great honor and privilege to introduce Dr. Stephen Hayes. Dr. Hayes is a Foundation Professor of Psychology at the University of Nevada, Reno. He is the author of 47 books, including Get Out of Your Mind and Into Your Life (which for a time was the best-selling self-help book in the United States) and his new book, A Liberated Mind. An expert on the importance of acceptance, mindfulness, and values, methods he developed are distributed worldwide by the World Health Organization and other major agencies, and he is ranked among the most cited psychologists in the world. Today Dr. Hayes will debunk the idea that mental health is merely the absence of a mental disease.

[00:01:50]
Following the presentation, it will be in Q&A session. Please submit your questions using Zoom Q&A function. The presentation is for educational purpose only and is not intended for medical diagnoses. If you have any persistent symptoms, please seek for professional help.

[00:02:08]
With that, I'm going to turn to Dr. Hayes. Welcome, Dr. Hayes.

[00:02:13]
DR. STEPHEN HAYES: Well, welcome, and I'm pleased to be here with you. And to my friends around the world and especially in China, I haven't been there in a few years, but I, uh- uh, I'm glad that, uh, some of– there's going to be a Chinese translation.

[00:02:31]
I'm going to—let me go ahead and share my slides—um, tell a story that is focused on the sense that we have—I think most of us do—that something is wrong in the modern world, that something is– doesn't make sense. Something doesn't fit. And what can we do about this? And there's a sense of unease about our behavioral and mental health. Now, there's a sense of unease about our international relations and things of that kind, too, and that we maybe have better understanding for. But why is it that at the very same time, human beings are doing

better on almost every objective measure that you can think of—than ever in the history of the world—at the very same time that there's more suffering, especially among our young people, especially in the midst of plenty?

[00:03:38]
We can understand suffering when we're talking about deprivation and disease, but what about the condition in which our young people—even when they have the resources, the opportunities, the nourishment, the shelter, the physical things—still, we see rates of mental struggles rising and rising. And we know it's not just that we're socializing our young people to make complaints, that we're raising "a nation of wimps," to quote a- a book from some years ago; it's not that. Because even suicide attempts and successful suicide are rising especially among young people, and a recent study showed that, um, the 10-12 year old age group– it's risen just over the last, uh, several years by five fold.

[00:04:44]
That leads you to say, "something's wrong," and it's not that there's no treatment available. In terms of medications, for goodness sakes, I'm showing you a slide in which it's easy to find, uh, painkillers and antidepressants literally in the fish in the ocean—that's how much they're being used—but not associated with a drop in the prevalence of suffering among young people. And after these years of COVID, I think we have to think differently. Before, we were thinking, "Oh, one out of five people have a diagnosable mental disorder, and the four out of five should be supportive and not stigmatize them." Yeah, but I think now most of us have a sense that actually five out of five of the human population are struggling with issues that have to do with things like stress, anxiety, a sense of meaninglessness, sadness, loneliness, anger, a decreased sense of life satisfaction.

[00:06:04]
Now, we are used to thinking of this primarily in a disease model, but we don't really have psychiatric diseases, we have psychiatric disorders; they're syndromes, they're collections of things we see and things that are complained about—signs and symptoms. And for 40 years, we've lived inside that structure with the DSM and the ICD—these compendiums of particular collections, supposedly, of signs and symptoms.

[00:06:35]
Now, the dirty secret is, "not otherwise specified" is still the most frequent diagnosis; in other words, it doesn't fit any of the categories. But there's another problem which is the reason why we collected these things, and I'm going back now to 40, 45 years ago with the arrival of the DSM in our country: when Jerry Claremont, the head of ADAMA, first pushed—and then the NIMH, I believe—pushed on to us this idea that we will really only research diagnosable disorders with the idea that we will then find these functional entities. In other words, we will start with the superficial properties, and then we will find the "why": the hidden latent disease that explains where it comes from. What's the etiology? How does it develop? What is the "why" question there—the processes, the development maintenance? And how does it respond to treatment, and why these treatment– processes have changed. And when we've answered those "why" questions, finally, we would have a syndrome—a mere collection—turning into a disease.

[00:07:49]
In the history of psychiatry, as the years go by, we have to face that this has never happened. We've never had a syndrome turn into a psychiatric disease. And don't believe me, believe the American Psychiatric Association DSM-5 Work Group that said that in so many words.

[00:08:12]
And so the NIMH began not to fund more of this and started pursuing a different direction—I won't unpack that. It's called RDoC; it too has faltered, and for reasons that you can see when you simply look at these two graphs, in my opinion. This is just an average, typical, usual, randomized trial. It was between CBT and interpersonal

psychotherapy for depression. And that's– the only thing that characterized it that was any different: It was a reasonably large study with weekly measures of depression, and you saw the- the– both treatments were helpful, and the depression scores came down.

[00:08:56]
But look at the individual– in all of the individuals in these two groups—and here's what this smooth curve actually looked like when it was being lived. And so, the thing that's been hidden inside our top-down normative categories is that people are individuals. That doesn't mean they're alone and cut off—they're part of couples and families and communities and organizations—but they have particular needs, particular processes, particular ways, particular pathways. And the way that we have gotten used to thinking about these, we have hidden them, treating people as error terms towards the true score of these normative summaries. That's not fair to the individuals. Each person here is not an error term; they're human being. And when you dig deeper into our randomized controlled trials on these entities that we have been trying to understand, you def– you find that we are being– we are blurring the differences that will help us understand what to do. And there is a way forward; there is an alternative, and that's what I want to talk about today. And I'm going to give you some actual examples so you'll be able to apply it to yourself and get a sense of whether or not what I'm saying resonates with you as an individual.

[00:10:33]
Let me just give you an example of how much variability there is from one of the largest multi-site studies ever done of major depression, where 3700 individuals in this multi-site, huge, randomized controlled trial were studied: 3700 people in the STAR*D Trial of Major Depression. Now here's my question to you: The DSM has only a limited number of particular signs and symptoms—things you see and things people complain of—that lead to this diagnosis. In 3700 people, how many different combinations of those signs and symptoms did we have? How many different combinations? Do you suppose 100? 200? 300? And the answer is over 1000. And then you say, "Well, how many people had a combination that was so strange, so unusual, so idios- idiosyncratic that it was shared with only 1/100 of a percent of the total population, meaning that only four other people had the same combination?" And the answer is nearly half.

[00:11:55]
So here we have a category that purports to be about something that we're trying to understand and study so that we know how to help individual people and their individual life trajectories, and we've turned more than 1000 combinations into an error term that we don't even characterize or speak about—only the overall category. And most people are in such small portions that they have no chance to be heard, to be listened to. It's as if we ask people who are suffering to come in and fit into our schemes, and then we put our fingers in our ear, and we say, "but don't tell me the details." We wave our hands so we can hardly see their face. That's wrong, in my opinion. Every voice matters. Everyone deserves to be listened to and understood in their own terms. And that is the direction that the NIMH is trying to turn to with RDoC, but in a way that hasn't led to success, unfortunately—even the person who started it, Insel, has declared that it was not a success—and so I want to present another way forward to you today.

[00:13:12]
Now, I'm an old man with four children, and I've had them spaced so that I will have had children in the home for 55 straight years when little Stevie goes to college in two years. I'm ready. And every one of them loved mazes, and so I got very good at drawing them. I didn't draw this one, but I could have. And sooner or later, all of my children have learned there's a way to cheat when you're playing with mazes, and you may know what it is: You go to the part that says "finish," and you work backwards. The mazes are almost always easier to solve.

[00:13:51]
What if we took all of these data, these billions and billions of dollars that had been spent on randomized trials

for mental health disorders, and we looked at just those portions of studies where we measured processes of change (where we measured the pathway of how you get from the beginning to the end) and we looked at those who had a successful outcome, and we said, "What are the pathways"—we start from the end and we work backwards—"that lead to that?" And let's just look at the ones that occur frequently enough that it's a statistically significant pathway.

[00:14:29]
Now the way they do that in randomized trials is called mediation analysis. It's a very geeky area; I don't think it would be helpful to unpack the different statistical means. But I want to show to you the result of a three-year effort by myself; Stefan Hofmann, winner of the Humboldt Professor (the highest scientific award in Germany)– uh, Stefan Hofmann, who is now at the Philipps University in Marburg; Joe Ciarrochi, who's at Australian Catholic University; and our teams, especially Fred Chin and Baljinder Sahdra. What we did is we decided, if we're going to look at the pathways of change and try to organize them into the ones that are commonly found that actually lead to successful outcomes, that we would look at all of the studies with a properly done mediational analysis.

[00:15:25]
I'll say how it's done. I won't take you through the statistics, but basically, what you have to show is that treatment differentially moved a process, and that process—controlling for which treatment you're in, so it can't just be a marker of knowing that you're in the intervention group (another way to say it: it has to work even in the control group)—that process controlling for assignment to treatment predicted long-term outcomes (that so-called A-path from treatment to the process and B-path from the process to the outcome, controlling for treatment assignment). And when the- those two are, uh, multiplied (the coeffi– regression coefficients for them), you can determine, when you account for the pathway of change, can you understand at least some of why the positive impact of treatment on follow-up outcomes occurred?

[00:16:28]
We had no idea what we were getting into, and we decided to look at the entire world's literature on every single psychological intervention ever applied to any mental health outcome that had a wait list or treatment as usual control group. Why you would do that has to do with the underlying statistics, but it's the proper way to do it. And we started looking at almost 55,000 studies, and we had to look at them twice to get reliability. Uh, this, uh– Had we known it was going to take two and a half years and almost 50 staff members to be able to do this, I don't think we would have done it, but we did. And what I'm going to show you is only the pathways that have been replicated at least once. So in that whole 55,000 studies, we found about 700 times where the statistics were done properly, and of those, there were about 280 where they had measures of processes (of the things you do that lead to the positive outcome) such as connecting with your friends or having a good working alliance with your therapist—things of that kind—or learning to think more rationally, and so on. We ended up with 73 replicated measures in those 281 findings.

[00:17:53]
So this is everything that we know. Now, it did stop at 2018 because that took us three years to do it, and so it's a little bit stale now, but I don't think it's fundamentally changed. I'm going to tell you the outcome, I'm going to give you a name for it, and then I'm going to walk through, in the rest of my talk, what that name meant and have you get a taste of it.

[00:18:21]
55% of all the findings that we could find in that set were due to psychological flexibility and the things that are included in it, including mindfulness. There were also reasonable strength of negative thoughts; parenting, social support, and the relationship and therapy; diet, sleep, and exercise; self-efficacy; and then a few little birds accounting for 1% or 2% of the findings. What is this big elephant with 55% of everything we know, uh, in terms of– or, at least, have found? Well, I'm going to tell you what it is, but first, I'm going to ask you to tell me what it

is. Because the fact is, you already know what I'm going to teach you here today. You don't know that you know that, because the organ between your ears is the part of you that isn't clear on this answer. But gut level, you are clear on this, and I'm going to try to start this talk by proving it to you.

[00:19:22]
Now, here's what I need from you. No worries, this will remain private. I'm going to revisit this a couple times in my talk, and I'm going to ask you to explore this territory, but I want you to pick something that's hard for you psychologically. Not just an external thing like, "Oh, I don't make enough money," but, no, something that has to do with emotions and thoughts or ability to step up to the challenges of your advert behavior, your psychological sense of well-being. Uh, pick something that's hard for you now, and ideally something that has a bit of a punch. Now use your wisdom: If you have a really difficult abuse history or something—and we're just working here without any ability of me to monitor, and so forth—don't push yourself harder than you should be. Pick something that fits the moment and your instinct tells you, "Now's a good time to have a look at that." When you get clear, then I'm going to ask you to start with a couple of questions.

[00:20:26]
Let's start with you at your worst. Take that issue, whatever you picked, and then imagine that your body is a sculpture and—like that game you played of statues, when you were children, and you would freeze—that you could put your body in a posture that would express what's going on inside by showing with your body posture from the outside what it was like to be you, with you at your worst with this issue, whatever that means to you. Now, if you're in a private place, I encourage you to actually do that: Put your body in this way. If you're with others and you're a little embarrassed, you can imagine doing it, but imagine it very clearly, and put your body in that position, mentally. And now take a little snapshot of what you would look like from the outside, if you're trying to show—like an artist might—of what was going on in your inside, with you at your worst.

[00:21:26]
Now hang on to the same issue—don't change the issue, at all, in terms of intensity or kind—and show me, with your body, you at your best. There are times when you handle this in a better way. It isn't always one way. So look a little deeper and find, "when other times?" and now show me with your body what it's like to be you at your best. And again, if you're with– by yourself, do it- actually do it. If you're with others, you can do it mentally. Now take a snapshot.

[00:22:04]
I have a pretty good idea what you look like at your worst. My suggestion would be probably your eyes closed or your head bowed. Your arms and hands might have come in. You might have even fallen to the floor, if you were free. This is, uh, a little grit– uh, you know, statuette that one of my students gave me when she- she got her PhD. Uh, Kara Bunting gave me this; I believe it's called The Suffering Buddha. And that's a characteristic collection of things that people do: your jaws may clench, your fists may become tight.

[00:22:45]
How about you at your best? My guess is your head came up, your eyes may have opened, your arms and hands may gone out, you may have stood up, you may have put your feet more broadly, you might have walked around the room.

[00:23:01]
Now, this isn't just a guess, because we've asked hundreds of people over- over the years this same question, and in a recent study, we actually took those snapshots and we scored them on three things, with naive raters. We told them nothing, and they didn't know which was the before, the after, the best, or the worst—all they had was several hundred photos, all mixed in a pile. And with each one, they had to rate the photo for the degree of openness, the degree of awareness, and the degree of active engagement. Why those three? I'll explain

in my talk.

[00:23:38]
And here's what we found: a very large effect. People at their worst—almost every single person, almost 95% of the people—showed a closed, less engaged, less aware posture (eyes closed, head down, arms and hands in) versus a more open and aware posture when they went from worst to the best, or vice versa. What that tells me: You already know everything I'm going to tell you. At least 95% of your peers did and could show it with their body, and I'm guessing you just did it yourself, and that you know that what works—as a whole human being—better is to be more open, aware, and actively engaged in your life.

[00:24:25]
Unfortunately, you have an organ between your ears that doesn't like that answer. When pain shows up, it wants to get rid of it. When a difficult thought shows up, it wants to change that thought. When a death happens, you're trying not to think about it. You wish that it weren't true. You ruminate over what you could have done to avoid it. That's the human condition of turning your life into a problem to be solved, like you might a math problem.

[00:24:59]
Psychological flexibility is this posture of being more open, aware, and actively engaged instead of this natural process of being avoidant, closed off, procrastinating, and waiting for life to unfold rather than taking it on a values-based journey.

[00:25:18]
Now, there are many treatments that move psychological flexibility. There's one that targets it from morning to night because the concept comes from it, and it's one that I developed 40 years ago, as I walked out of my own panic disorder. If you're interested in that story, google my name and "TEDx," and there are two TEDx Talks that you can see me walk through the psychological flexibility model and my personal history that led to the model and to the now nearly 1000 randomized trials on every area you can name. On acceptance and commitment therapy, or when it's done outside of psychotherapy, in business or sports, is called acceptance and commitment training; in either case, it's called ACT. It was developed– The very first workshop was 40 years ago this October, in 1982, and for a long time, there were very few randomized trials because I was working on processes of change and how to measure them on the underlying theory—philosophy of science—and the components that could move these things. And finally, in 1999, wrote the first book on ACT, and then has gradually become the overnight sensation that took 40 years to produce.

[00:26:41]
There are about 950 trials, we think, but we have another 30 or so just to enter. A new randomized trial happens every three days; by the end of this year, I think we'll pass 1000. And they're in every possible area that you can think of. If you allow your eyes to scan this, you'll see that it is not just mental health, but it's behavioral health—but not just that, it's social wellness and performance. You almost can't name something that human beings do where there aren't randomized trials of acceptance and commitment therapy or training. And I don't want to be a panacea—it's not a, you know, a solution to the world's problem—but it's a step forward of a process-oriented, radically transdiagnostic (almost to the point that it's universalist) approach that, yes, deals with most of the met– classic ment– excuse me, mental health disorders but was designed from the beginning to empower positive psychology, social wellness, reduce prejudice and stigma, increase your ability to step up to the challenges of physical disease, and on, and on.

[00:27:54]
Now, here's the way it's usually presented: the classic hexagon model of ACT. I'll use general terms rather than really specific ACT terms, but we focus on cognitive and emotional flexibility: of being able to be open to your

emotions, to learn from them without clinging, to be able to think different things and notice your thoughts with a sense of perspective. These are processes that last– like the photos, are things that help you be more open. We also work on attentional flexibility: being at a broad or narrow shift or stay, from a witnessing or noticing, more spiritual sense of self—pure awareness, you might say. And these are processes of awareness increasing—awareness of the now from the part of you that is conscious and aware. And finally, we delve into intrinsic meaning by choice: your values and how you can create, through behavioral flexibility, habits of values-based action, which is producing active engagement in a life worth living. So this is our model of the specifics of open, aware, and actively engaged processes that we call psychological flexibility.

[00:29:18]
Now, arguably, I believe, each of these—both on the negative and positive way, because each of these have a negative: emotional flexibility negatively is emotional avoidance, cognitive flexibility is cognitive entanglement, attentional flexibility is rumination and worry and rigid attention, and so on, through all six processes. That– I believe both the positive and negative forms—psychological inflexibility and psychological flexibility—represent underneath them a particular set of yearnings. I forgot this slide was here, but I just do want to say, these four processes are a pretty good operational definition of mindfulness, which is why it fits pretty well Jon Kabat-Zinn's definition, for example, which is why we include that in the data I showed you earlier. I believe that each of these involves a human yearning, and it's mishandled. We have challenges in life that, underneath it, has a need or a yearning, and when we mishandle it, it becomes a pathological process. When we are able to meet it in a healthy way, it becomes a positive process. That will be more clear as I walk through, with little brief examples, each of the six flexibility processes.

[00:30:50]
We yearn to belong. We want to be part of the group. When your mother's eyes met yours, when you were born, you would dump endorphins and op– natural opiates, as if to say, "Ah, I belong." And by the way, so did your mother. And by the way, also, so did—if you have dogs—your dog did; it's the only species that does that, and we've been co-evolving for 12,000 years. But this yearning for belonging can turn into something when our mind tells us will only belong if we're special—especially needy ("Help me") or especially able ("I will make this great again"). So whether it's narcissism or self-loathing, we hope that we'll be included—we'll be part of the group.

[00:31:50]
Now, let's see if we can, uh, do a little exercise to tap into this, uh, process. And here's what I would like you to do is we'll engage in a process of perspective taking, of looking from. I'll do it very briefly. Take that thing that you put your body into a shape—at you at your worst and you at your best—and take just a moment to connect with the pain and struggles that are associated with that issue. It's like reaching inside you and taking something painful and putting it in your lap. And now that it's there, imagine that you've left your body and you're looking back at yourself. And as you look at yourself, knowing full well you can't see it from the outside but this painful thing is in your lap, I have a couple questions for you. What do you think of that person called "you"? Is this a whole person? A lovable person? Do you like this person? Don't answer it immediately, but sort of sit inside that question.

[00:33:18]
And now, imagine going to the side of the room and looking back at yourself, but imagine that you could somehow see all the people—I don't know how many hundreds—who are all doing the same thing right now in imagination. You're part of a much larger group that, here for the magic of the Internet, is doing this at the same time, and each person has something painful in the lap. And seeing yourself from afar now and as part of a group now, I ask the same question: What do you think of that person? Is this a good person called "you"? Do you like that person? Do you love that person?

[00:34:00]
And now imagine that you realize, "Ah, this happened years ago. That strange guy—what was his name? Oh, Steve Hayes, that old bald guy, had me doing this exercise." But life has unfolded very, very well; it's 10 years from now, and you're in a much better place, and you're remembering what it was like to be you with this painful thing in your lap. And you have the thought, "I wish I could have known then what I know now." And through the magic of time travel, you can do that, because you can write yourself a little note: How should you be with yourself now, in a way that lightens the burden of what's in your lap? And allow something to form in your mind, just a sentence that maybe you could say to your younger self way back then, in 2022, when you had that thing in your lap. And whatever it is, write it in your memory, and then we'll come back from 10 years from now to the present time. We'll walk from the side of the room to in front of you. We'll take a final look at this person called "you." We'll spin around, we'll sit down, and we'll take what's in your lap and put it inside you.

[00:35:19]
And, doing all that, the thing that I would ask of you is, "What is on your note?" And actually, write down a couple of words because at the end of this talk, I'm going to ask you what is on that note and do a little bit of a share. And it's my guess that you just shared something that's very wise from this wiser future, that you know something about how to do something that's healthy for yourself. Just as you showed with your body, you can show it with this little perspective taking exercise. And why is that relevant? Because this infant who looked out from behind his or her eyes and saw mama looking back is yearning to belong, and I'm claiming that your sense of consciousness or spirituality—this deeper, perspective taking sense of you—is part of what allows you to belong in a different way that doesn't lead to narcissism or self-loathing.

[00:36:25]
What else do we yearn for? Well, coherence. We want to understand. You're not but three years old before you're torturing your parents with "Why? Why, mommy, why?" We– But even young children will understand Goofy with horns on one shoulder and Goofy with a halo on the other. We enter into a world of men– er, mental chatter, where we're constantly criticizing ourselves and finding ourselves wanting blah, blah, blah, from morning till night. And what if we could learn how to take these scary voices within, that sometimes just dominate us and tell us that we're not worthy, that the world would be better off if we were to take our own life? Do you know that 98% of the human population admits to suicidal thoughts? And frankly, the other 2% are liars. That voice is sometimes very harsh, and yet if we could pull aside the curtain and realize where it came from—you might have even done this when you hear the words and you hear, "Oh, that was mommy. My mother used to say that to me." Or, "Oh yes, my boyfriend used to say that to me." You came by it honestly—"My teacher said that to me once"—and they echo down through the ages.

[00:37:53]
So take this thing that you're struggling with—I give you a Bitly link for one of my TED Talks where I give 12 examples of tools you can use for this, and I'm going to do a very quick one—so give me, in the thing that you showed with your body, a difficult thought that's inside that experience, and I want you to think that thought very, very clearly. And now I want you to think that thought in the voice of your least favored politician. And now I want you to think that thought in the voice of your favorite cartoon character. Be careful, this is not self-ridicule. What I'm saying is, the thoughts don't speak for themselves; you give them power, and there are ways of taking back the power—many, many ways that we've developed—that allow you to see the thought without entanglement in the thought. If we all heard in our head when we had a thought "I'm bad" something more like [unintelligible], it would be a lot easier to be human.

[00:39:14]
We yearn to feel. Your brand new baby—you're saying, "Don't put that in your mouth" because that baby is gonna taste, lick, explore, feel. It's only as judgment emerges that we start thinking we have to feel only good things. Life doesn't come in that form. People you love will pass away. Disappointments will happen—it's how you

learn. Do you know you fell down 100 times a day while learning to walk? If you don't have room for your errors, you don't have room to live, and so this voice within that tells you to avoid has given you an impossible task.

[00:39:56]
So once again, let's go to the thing that you showed me with your body about, and this time, just watch. Think of the difficult thing, whatever that issue is, and see if you can catch that there's something in your body that shows up that sort of goes, "no"—there's a little defensive thing that happens. And whatever that is, get that bodily sensation associated with the difficult thing, and decide in your mind that you don't want that. You want to get rid of that. That has to go away. That's really bad. "I don't want it. No, no, no, I don't like that feeling in my stomach. I don't like that feeling in my jaw. Go away, go away." Spend 10 seconds fighting with it, and see how your life feels. And now imagine that you were a child feeling that, and your task was to help the child be open to feeling it. And you're going to ask questions about what it feels like and where. Try to flip it to a "yes." "Oh, that feeling in your stomach—what does it feel like? Where is it?" And see if you can ask that question of yourself, in this way that generates kind of a self-kindness, that you're going to hold it like the way you might hold a dried flower. And as you do that with the very sensation- same sensation, see if it doesn't land differently in your psychology. And I ask you this question: I understand the history that gives you the feeling, and it's not your choice once it's in your history, but who's the person who's choosing this button [changes slide to "no" button] or that [changes slide to "yes" button]? And my guess: The answer is you. So do you have to do this [changes slide to "no"] with your own experience? What would it be like if you did something more like that? [changes slide to "yes"]

[00:42:05]
We yearn to be oriented. We want to know where we are. Even a little mouse in the corner will come out and explore. Your baby did that, you know, unattended; "Don't go near the stairs," you know, the mother says, "it's not safe," but the baby wants to know its environment. As we get our cognitive ability going, we- we can do that cognitively, and we can start ruminating about the past or worrying about the future and forgetting something, which is that we're always here, now. And what would it be like if we lived our life in the here and now?

[00:42:44]
And so, I want to do a 15-second mindfulness exercise in the present moment. Find anything in your environment here that you can pick up, and we're going to notice what it's like to pick that object up, but I want you to do it at 1/5 speed. If it would normally take a second, take five seconds. Reach out and pick up that object at 1/5 speed, and just notice your experience. And see if you didn't notice a few things that you know it might normally have missed. There's so much that is here and now that we're not attending to, and who knows if it's relevant? We will know when we get habits of greater awareness of the present moment.

[00:43:43]
We yearn to have self-directed meaning. Young children don't need to be taught this—"Not that way, mama. I want- I want to do it. Not that way." Really little ones are yearning for self-direction, but then we teach our young people these toxic ideas that meaning and purpose is to be found in external things and likes on your Instagram posts and being a YouTube influencer or instant cash falling from the sky. And what we need to do is connect to our deeper yearning for the kind of person we want to be and the kind of lives we want to live. We need to connect with our capacity to choose our own values, our own qualities; they're intrinsic to our behavior. They're not outcomes, and they're not predictions. What they are are choices of qualities, and I'm going to give you one of the fastest ways to know at least part of what your values are.

[00:44:53]
Take this issue that we've been going back to repeatedly now, whatever it is that you picked—the one that you showed with your body, you at your worst and you at your best—and now pick a guide. Pick a hero. Pick somebody in your life that you know or look up to, who you have a sense manifests something in their life with regard

to that issue that you would like to learn and to put into your own.

[00:45:21]
These are a few of my heroes. That one at the bottom is my mother, just a year before she died. And I know why each one of these are heroes. There's qualities that they display in their life that make them heroes to me: the courageous quality that my mother showed with enormous suffering, where her mother was Jewish and her father became a Nazi sympathizer and would tell her things like, "Don't tell people you have tainted blood." I wish I didn't learn, though, as a teenager, yeah, but it softened her, and she was always for the underdog. She would always ask me not to judge people. So what did your hero– what hero did you pick? And if your hero could whisper, just like you did from a wiser future, just a few words about this thing you're struggling with, what would your hero say? And I ask you this question: Could you be your own hero? Could you do that? Could you manifest that, and could you learn how?

[00:46:42]
Because we yearn for competence. We yearn for the ability to show on our behavior these deepest desires. We didn't have to be taught that; I mentioned earlier you fell down on your diapered butt more than 100 times a day when learning to walk, and by the way, as a toddler, you walked more than 10 football fields. If you're a parent with a toddler, no wonder you're tired. But eventually, you didn't fall. Eventually, one foot got in front of the other, and no, it's not the Instagram vision that our young people somehow have that they're going to be promoted tomorrow and win the lottery and become, you know, YouTube influencers in the next 48 hours. No, it's the step-by-step journey of creating a life worth living. And so, having heard your hero, here's my question to you: Going forward from this one hour we're gonna spend together—I've got about five more minutes before we get to questions—what would you do if you could choose one thing that would somehow soften or step up to the challenge of this thing that you've been working on? And could you do that? Will you do that?

[00:48:11]
Now, my journey—this is psychological flexibility—is to try to understand how to put these processes in your life. And I'm thinking of it now more in an evolutionary idea, that each of these areas like acceptance and diffusion, attentional flexibility from this witnessing or noticing sense of self, our values and our values-based habits—and yes, things I haven't talked about much yet, but our health and our sociocultural belonging– Each of these require that we try different things, notice the winners (the things that move us forward), learn how to retain them, and to fit them into our life moments. So ACT is part of a larger attempt, I think, to evolve the human life.

[00:49:04]
Now, I showed you earlier all the processes of change. I've already talked to you in this talk about what we yearn for. There's a couple I haven't talked about at these other levels, but if we look at all of the processes of change and every single measure that has ever been shown to be a functionally important pathway of change, you can easily fit it into healthy variation (trying different things), processes of selection (doing things that work), practicing and producing habits, and fitting them to the present moment to the context. I can't walk through it in detail, but I can tell you when we do this—and I can send a link to an article, just came out in Behaviour Research and Therapy—if by psychological flexibility we meant being flexible (which means healthy variation that can be selected and retained because it fits the moment in all these areas) if we meant by psychological flexibility something that broad, it's more than 90% of everything that we know of our processes of change, leaving only healthy relationships and taking care of your diet, sleep, and exercise and your brain functions, and so forth, and then a few little birds left over.

[00:50:29]
So we know what works: We know how to create a life worth living. I won't have time to extend this to the social level, but it's not too hard to do it: our emotional openness becomes compassion for others, our cognitive flexibility becomes the ability to listen to the opinions of others, attention is joint attention, I think this spiritual

witnessing, noticing self becomes attachment—like that picture of a mother and a baby looking at each other—values become shared values, commitments become shared commitments and cooperation. I have only two slides, and so, miraculously, I'm only six minutes late. When you do this, you end up with a process-based model that accounts for almost everything that we know about how change happens—I'm not singing a song of ACT über alles; some of these methods that allow us to think that broadly are drawn from all of the deeper clinical traditions (CBT and systemic work, psychoanalytic work, humanistic work)—but when we do that, we can do something special. We can fit our methods into different cultures around the world, different religions around the world. There's something like 50 trials of modifying ACT to fit Islamic sensibilities. There's 200 randomized trials on ACT from the Islamic world and Iran, as– just as an example, or from other religious groups around the world.

[00:52:06]
And if I can finish with this example—so I've got about two minutes to finish: when the World Health Organization decided, "We need to do something about the impact of war," and specifically the thing that got them moving were– was the conflict in the South of Sudan that were leading to massive numbers of immigrants who were landing, especially in Uganda, with nothing except machete marks, their clothes, and their lives, sitting in dirt. I mean, they escaped with their lives, and that's about all they had, and had seen horrors along the way. And the question was what can we do, when we know that war makes everything go bad—not just mental health disorders, but people also can't sleep, they can't eat, they become angry for no reason, their relationships fall apart, everything goes sour? They tend to have more physical disease, they often have physical injuries from the war, they have traumas. And they came to me and said, "You know, you are developing the most radically transdiagnostic method we can find." I've given you a Bitly link for a WHO webpage—this is the WHO webpage. And I sent them off to a really good ACT developer named Russ Harris, who's better than me—because I'm a geek, and he's not so geeky—and we developed a cartoon book and a set of audio tapes; it's available in 21 different languages for free. I've given you the link. You can download it yourself. It's been tested now in five large randomized trials. It prevents the future development of mental health problems by 50% at follow-up. It has an impact on mental health problems as high as self-help in the developed world, and it's right now being deployed vigorously in the Ukraine.

[00:54:06]
And my point here is, when we do– when we chase a vision of mental health that is not just about syndromal diseases but about processes of change that can empower human lives, where every voice matters, we're able to fit our methods to the needs of the individual, and we can treat not just the one out of five problems but the five out of five problems that all of us now are facing in the modern world, where we're constantly exposed to a diet of judgment, of pain, and of a sense of unease that comes from a world that's changing this rapidly. That's why our young people are suffering. We can't do it simply by treating them as if they're all syndromal entities—it's not the case that 100% of human beings have a specific mental disease, but we all have processes of change that can lead to that or lead to positive outcomes if we know how to manage it.

[00:55:10]
And so that's, uh, my talk. I do want to say, WHO said things that only my critics say I ever say about ACT—I would never say anything this bold: a "guide…for anyone who experiences stress, wherever they live and whatever the circumstances." My critics would thump me over the head if I ever said such a thing, but WHO did say such a thing about Self-Help Plus, which is their ACT self-help protocol.

[00:55:40]
Uh, so that is my talk. I think we need to change the narrative about mental health in the world. We need to do it in schools, in the churches, in the businesses, and in the clinics, and give people the processes of change knowledge they need to create a more empowered human life. I mentioned here, if you want to follow me—and late people are welcome to do it—simply go to my website and say, "Yes, please send it to me," and I'll send

you a newsletter. I don't spam, hardly sell anything; if you ever get tired of it, it's a one click opt out. And I thank you for the attention, and I can take questions.

[00:56:20]
CHIH-CHING HU: Thank you so much, Dr. Hayes, for the wonderful presentation. Yeah, um, we only have a few minutes left, so maybe two, three questions?

[00:56:32]
DR. HAYES: Yeah.

[00:56:33]
CHIH-CHING HU: Okay, uh, first one: Would you encourage mental health sufferers to focus on small-scale or large-scale changes? What approach does the evidence suggest leads to better outcomes?

[00:56:48]
DR. HAYES: Well, small changes repeated produce large changes, and large changes can overwhelm you. It's more important that they be true to the process, so it'd be like if you had a tennis coach: it's better to hold the racket properly and practice your stroke, and even if you're not thumping it over the net, okay. Keep working, you'll get better. So I would rather focus on trying to learn and dig into the wisdom of your own body that you showed and learn how to deploy that wisdom of being more open with yourself, kinder with yourself, more in the present moment consciously, more mindful, more focused on your values. And small steps repeatedly; nobody's keeping score, there's not a speedometer glued to your forehead, you're not a horse to be whipped.

[00:57:41]
So that's what I would encourage, and there's some very nice self-help groups out there—I mentioned the free thing. If you go to groups.io, there's a group called ACT for the Public: about 2,000 people who, for 12 years, have been meeting and supporting each other—very sweet group—and so you can get this for free. You can get the one-step-at-a-time, kind support from others on the Facebook groups, and so forth. Look for it, and you'll find it with "psychological flexibility," "ACT"—it will bring you to it. And the many books—there's something like, um, 150 books on ACT and probably four, five million copies in print, so, uh, by– Do be careful of counterfeit books—they're now on the Internet, unfortunately—that are sometimes teaching bad things, so look for real authors who are known people in the ACT world.

[00:58:42]
CHIH-CHING HU: Okay, next question: What can people practice daily as part of an effective mental health hygiene routine?

[00:58:51]
DR. HAYES: Well, it turns out that all six flexibility processes are like sides of a box; they're all important. So I like thinking of it as kind of like a tool kit—a psychological flexibility tool kit. There's hundreds of methods, and you can get them on the Internet for free—I've given you some examples of, you know, my TEDx Talks, for example, with diffusion methods. Find one that resonates to you—just one or maybe two. So, for example, if you have your thoughts like this and you want them– if you find saying a thought repeatedly in a single word helpful to you, then do that. If it's singing the song, do that. If it's saying it in a Donald Duck voice, do that. If– There's many things you can try; keep that in your tool kit, so you end up with at least one practice in each of the processes that you're repeating. At the point at which you get good at it, add one more. When you get to three or four, that's probably enough, and at that point, you can let the ones that are least helpful go away and add others.

[00:59:53]

And it's a lifetime journey—no matter how much the onion is peeled, there's more onion to go. And I'm no shining star of psychological flexibility; I've been at it for 40 years, and, you can ask my wife, I'm still not very good at it. But excuse me for living what I always say to my love is, "Yes, but you remember how I used to be," and she always says, "That's true, you're much better." So I think that's what we aspire to is progress.

[01:00:22]
CHIH-CHING HU: Right. Next question: Are psychological flexibility and cognitive flexibility the same?

[01:00:30]
DR. HAYES: Cognitive flexibility is an important element of psychological flexibility, and one of the message I have– initially, ACT, when it appeared, looked like it was an opponent to CBT and some of the cognitive methods, which is never– was never true—it was written up in Time magazine as if it was a big war. It was fine. It was why my self-help book went to the best-selling self-help book: because Time wrote it up, but they wrote it up as a war between myself and my dear colleague, the late Aaron Beck, which is not true. It never was a war.

[01:01:04]
So– But it turns out that it's not "detect, challenge, dispute, and change your thoughts." No, it's "be able to think a range of thoughts, take what's useful, and leave the rest." That's cognitive flexibility. So you want to encourage the ability to think broadly, to have many options, to be able to shift to the ones that work better. And diffusion—what we call diffusion, which is stepping back and noticing these– some of these methods I've mentioned—is part of it, but also, so is learning how to generate alternatives. Being– And so some of the methods that you're more familiar with in ACT will help with that, but if you only have cognitive flexibility and not, for example, emotional flexibility, your cognitive flexibility may say, "You should really do this," and then your emotional part says, "but I don't like how I feel when I do that." Well, that's a problem; they all fit together. Take values: If your values say, "Really, I want to be in an intimate loving relationship, but I don't want to be vulnerable," good luck with that. It doesn't come that way, because of course you're woundable, because you hurt where you care—that's what vulnerable means—and a person you love could die, could go away, could betray you; that's possible. If you want to protect yourself from all pain, you have to protect yourself from all life. So you need all six skills, and cognitive flexibility is a very important one, but it's one of six.

[01:02:33]
CHIH-CHING HU: All right, the next question: How might you see schools implementing this kind of philosophy to support students?

[01:02:41]
DR. HAYES: Uh, say it again. I missed some words.

[01:02:44]
CHIH-CHING HU: How might you see schools implementing this kind of philosophy to support students?

[01:02:50]
DR. HAYES: Ah, yes, yes, yes. Well, it's thundering into our schools in many, many different ways. In elementary school, of course, we've seen mindfulness methods enter in, but I think we're also seeing some of—which is good for attentional flexibility and emotional openness—but I think we're also seeing some work on, uh, cooperation, sharing, caring, being there for others. And so I really like the ones that are building things like "help for the poor," or "What can we do for the downtrodden?" or things of that kind. Children need to be socialized to care, and if you can build that– Our, our religious and spiritual traditions have done that for forever, but they're weakening, and so we have to put other things in other places.

[01:03:39]

Uh, it's also the case we need to put these methods into the schools that teach people to be therapists, and thankfully, that's happening; a process-based focus gives you the freedom to not be just one thing. You don't have to be just an ACT person or just a Gestalt person or just an analytic person, you can use whatever techniques or kernels or methods fit the needs of the individual. And we're developing new measures that allow us to look within the individual of how these processes combine and come up, essentially, with an idiosyncratic diagnosis, much the way that personalized medicine is done. If you take an area like cancer, when we were botanizing cancer and just saying, what the shape of the lesion– you know, what it looked like, what color it was, it didn't help. When we got into the lab and started understanding oncogenes and epigenetic regulation of cell growth, and so forth, the outcomes kept getting better. And if you have a cancer diagnosis and you're sophisticated, very likely, you're wanting to go to one of the leading centers that does personalized medicine– can look at your specific epigenome, your specific genetic makeup, and so on to fit the interventions to you particularly. That's what we need to do with mental health.

[01:05:01]
And it's not as complicated as it sounds; I think it will actually be much simpler than these many, many different syndromal diagnoses, and we have measures and statistics—if you get on my list, I will share some of those with you. And a little bit of that is in the article I mentioned of where we're going with this idiographic process-based focus to diagnosis and treatment that allows all of the different schools of thought to come together without having this archipelago of, you know, kingdoms, where in this form of psychotherapy you do it this way and in that form you have to do it that way. I hope we can go beyond that era.

[01:05:45]
CHIH-CHING HU: And, Dr. Hayes, we are running late. Can we have, uh, one last question?

[01:05:49]
DR. HAYES: Yes, please.

[01:05:50]
CHIH-CHING HU: All right. So how do therapists integrate the CBT and the ACT?

[01:05:56]
DR. HAYES: Well, ACT is part of the CBT tradition, and thankfully, the era—that I thought was driven more by reporters than anything else—a seeming war has passed away, and now we're definitely into an era of cooperation. My closest colleague and the person who, uh– one of my best friends is Stefan Hofmann—I mentioned his name earlier. When ACT first arrived—he's a major CBT person and a winner of the Beck Award, and so forth—he wrote articles like "ACT is old wine in new bottles," and very harsh articles. We are now working together very happily around Process-focused CBT, and ACT methods—as well as the other mindfulness methods, plus our traditional CBT methods—are part of it.

[01:06:50]
So what I would encourage professionals wanting to do that– to look at how focus on processes of change will allow you to use the whole range of methods that come, yes, from traditional CBT but also from behavior therapy that came before—still has important methods there: exposure, and so on, skill development, the so-called third wave (mindfulness, values, acceptance, self-compassion). And use the full range of tools to serve the individual clients that you have without having to feel as though you're violating some prohibition to be– think of CBT as that broadly. And so I have books—three or four—out on Process-based CBT and how to move beyond the DSM in this ideographic way, and I would encourage the person who asked that question to explore those books and journal articles to see how we're doing it.

[01:07:50]

CHIH-CHING HU: All right. Thank you for that information, and thank you for sharing your wisdom with us, Dr. Hayes. So we are going to close the webinar, and, uh, thank you, everyone join our webinar. We hope to see you again on September 21st for webinar with Dr. Robert Friedberg on the topic about CBT, and please take a moment to fill out a short survey. I will leave the donation QR code for a few more minutes, and thank you for donating to support mental health.

[01:08:23]
And with that, I'm going to close the webinar. Goodbye. Goodbye, everyone. Take care and stay well.

[01:08:31]
DR. HAYES: Goodbye, my friends. Peace, love, and laugh.

[01:08:34]
CHIH-CHING HU: Yeah, thank you. Thank you, Dr. Hayes. Bye.