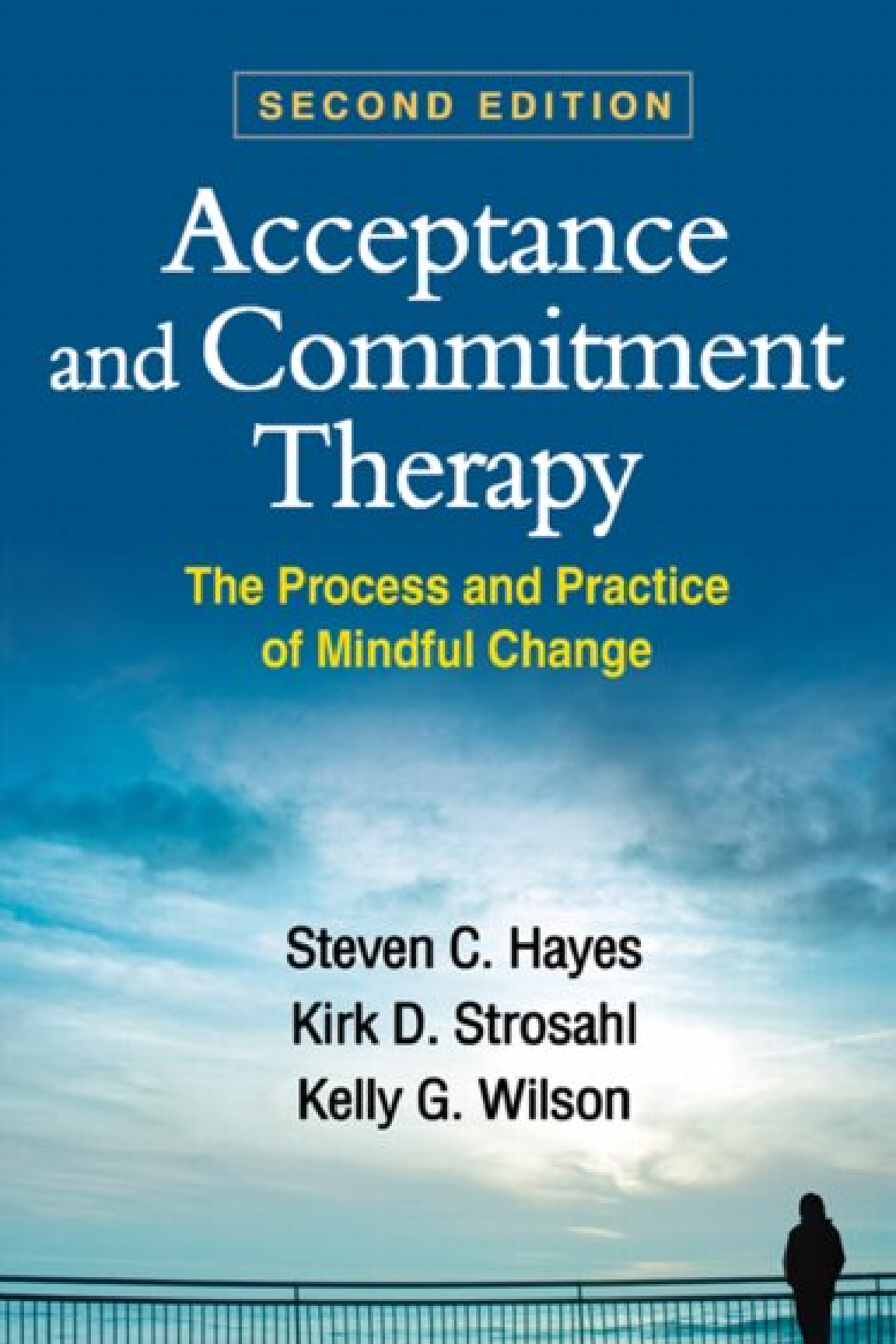
SECOND EDITION

Acceptance and Commitment Therapy

The Process and Practice of Mindful Change

Steven C. Hayes
Kirk D. Strosahl
Kelly G. Wilson



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To Barry and Trudy—
For helping ACBS through a critical time,
lifting the work and moving it forward.
Your vision was infectious, and I will always be grateful.

—S. C. H.

To my wife and lifelong soul mate, Patti.
Your keen intellect, constant encouragement, and support
and total acceptance of who I am—
with occasional requests for change—
have made me a better person.

To my brother Mark,
who has been gone barely a year now—
you will remain in my heart forever.

To my mom, Joyce, who at 93 is still reading novels,
playing the viola, and doing all the things that make up being alive—
what a role model you've been.

—K. D. S.

To my daughters Sarah, Emma, and Chelsea . . .
I love you to the moon and back.

—K. G. W.

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Preface

What Is New in This Edition

Acceptance and commitment therapy (ACT) was introduced in book form in the first edition of this volume in 1999. The underlying model was still underdeveloped, and we had not yet articulated our strategy of knowledge development. We knew that, but it was already well past time to put our then nearly 20-year-old "baby" out in front of the public. The first book on relational frame theory (RFT) was published 2 years later.

Something rather remarkable then occurred. Some very high-quality clinicians and researchers were attracted to the work and increasingly began to take responsibility for it. Clinicians were excited. RFT research quickened. A worldwide conversation began on the Internet, an association was formed, and other books were published. Regular national, international, and regional conferences were held, and existing societies began giving the work progressively higher visibility. Training innovations flowered. The research data began to flow in. Internationally, experts in several languages emerged. The development pace quickened, and the data, both basic and applied, increasingly guided refinements. Honest critics appeared, further refining the work.

The result has been considerable conceptual, technological, and empirical progress over the past dozen years. We were able to distill ACT down to six key processes and their interrelationships, revolving around a central concern, namely, psychological flexibility. Data increasingly showed that ACT works largely through the following psychological flexibility processes: defusion, acceptance, flexible attention to the present moment, self-as-context, values, and committed action.

As we had hoped, we began to see that ACT methods could be integrated with other empirically supported approaches and that psychological

flexibility fostered other important behavioral processes. The range of problems ACT methods were shown to be useful with was impressive, and the range of the psychological flexibility model was startling. The model that worked with depression also worked with smoking. The model that worked with heroin addiction also worked with diabetes management. The protocols varied greatly, of course, and the behavioral methods included were often specific to that particular usage. As a result, the number of ACT methods now exceeds what would fit into any single book—or even two or ten—but the model and its processes of change appear to be similar across a wide variety of behavior change areas.

For all of these reasons, the present volume has a different look and feel than the book we wrote more than a decade ago. This edition focuses on the *psychological flexibility model as a unified model of human functioning*. As the current volume has evolved, referring to this model as the "ACT model" (as we used to do) seemed a bit too confining because the model goes beyond any intervention approach. This book is less a step-by-step linear clinical manual than it is a guide to learning how to do ACT in a *natural* way. It is intended to be useful to those just beginning to explore the model as well as to those who are already well experienced in using it. Practitioners need to learn to see psychological flexibility processes *in the moment* and respond in a model-consistent way, and this book is intended to help them accomplish precisely that aim. Clinicians already know how to do some of what is in the ACT approach—so long as they use their methods in a way that is functionally consistent with the psychological flexibility model. Once that linkage is better appreciated, people can begin to try these methods now. Yes, there will need to be further training and guidance. But it can start now.

We have tried in this volume to make the proximal foundations of ACT—functional contextualism and RFT—easier to understand. Instead of suggesting that readers simply skip the difficult theory and model chapters (Chapters 2 and 3) if they like, we have worked hard to make them more readily accessible. We may have oversimplified (and we have certainly left out many details), but we want those who connect with the work to have a basic foundation from which further exploration is possible. There are hundreds of scholarly articles on ACT, its underlying model, and basic foundations—this volume is just a primer. We also make our development strategy—which we call contextual behavioral science (CBS)—more evident, especially in the concluding chapter. That might seem strange in a clinical book, but the purpose of ACT is not ACT *über alles*. We are not interested in brand names or personalities. Our purpose is *progress*. Further elaborating our model of knowledge development is how we are trying to accomplish that, as the best way to speed up progress is to have all hands on deck, whether they are clinicians, basic scientists, applied researchers, philosophers, or students. An open, values-based community embracing a

common mission can be far more productive than scores of professors in an ivory tower. If the development model is maximally well understood, it will be clear why we are not playing the empirically supported treatments game in quite the same way as usual (even though admittedly we are part of that tradition). Yes, we care about randomized trials—but we also care about much, much more than that. We want empirically supported *processes* to be solidly linked to effective *procedures* (Rosen & Davidson, 2003). We have a strategy for creating long-term progress, and we are determined to follow that strategy. It may work, it may not, but we invite the reader to join us in that journey.

Our assuming this perspective does not mean that a front-line clinician needs to be an RFT geek or needs to drop his or her practice and become a researcher. Clinicians and other practitioners are important to the development of this approach, and they have a right to demand much of behavioral science. We want to show precisely how progress in such areas as basic science as well as the philosophical underpinnings can help those with more practical interests also accomplish their purposes.

We can now enumerate some 60 books on ACT worldwide. The rate of publication of relevant empirical sources is soaring. This program of research and practical development has been examined at length in various review articles (e.g., Hayes, Bissett, et al., 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Öst, 2008), and even skeptical observers agree that we are making progress (e.g., Powers, Vörding, & Emmelkamp, 2009). Such substantive progress enables us to reduce the frequency of scholarly references in most sections of this book. The first edition contained some highly dense empirical and conceptual passages—chiefly to justify that serious academic attention be directed to our model—but the text's density made it harder for readers to understand or read with ease. Provided that those interested are willing to read beyond this single volume, point-by-point empirical justification no longer seems critical to our present purposes. We have included enough broad strokes for the reader to understand how we conceptually view the data and enough links for readers to find additional academic foundations with minimal additional effort.

Some of the ideas underlying ACT are rapidly becoming mainstream conceptions. Critics regularly now say this is what they meant all along. Perhaps that sense of revisionism rankles ACT authors with a long memory, but it need not deter new readers since that is how progress is made. On the other hand, taking a dollop of "acceptance" here and a dash of "defusion" there does not do justice to the ACT model or provide its full benefits. We want the entire model and its knowledge development strategy to be fully comprehended because that level of familiarity seems likely to yield greater progress in the long run than merely adopting the hot new techniques or concepts here and there, as if better treatment is a matter of fashion.

The ACT model is well known enough now to invite regular criticism. Our response to skeptics has been to invite them to our conferences; to try to respond to every major criticism but to do so with a sense of openness and reason, additional data, and further developmental efforts; and to create a community that stays open, cooperative, and nonhierarchical so that anyone can connect with the work, take what they find valuable, and help contribute whatever may be missing. ACT has not been created to undercut the traditions from which it came, nor does it claim to be a panacea. Our purpose as practitioners of ACT is to contribute as best we can to those who are suffering and to work to try to develop a practice of psychology more worthy of the challenge of the human condition.

After all, isn't that what we are all in this field to do? Soon enough all of our names will be forgotten, even by our descendants. It will not matter then who said what or when. What will matter is whether approaches exist that make a difference in the lives of the people the discipline exists to serve. We need to continue to learn what works best and to develop innovative ways to be of help. But to do that, we need to work together, continually creating better links between clinical creativity and scientific knowledge development, on the one hand, and processes that matter, on the other. What this book contains is a direct reflection of that agenda. We hope and trust that it serves this purpose.

Steven C. Hayes
Kirk D. Strosahl
Kelly G. Wilson

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PART I

Foundations and the Model

CHAPTER 1

The Dilemma of Human Suffering

Nothing external ensures freedom from suffering. Even when we human beings possess *all* the things we typically use to gauge external success—great looks, loving parents, terrific children, financial security, a caring spouse—it may not be enough. Humans can be warm, well fed, dry, physically well—and still be miserable. Humans can enjoy forms of excitement and entertainment unknown in the nonhuman world and out of reach for all but a fraction of the population—high-definition TVs, sports cars, exotic trips to the Caribbean—and still be in excruciating psychological pain. Every morning a successful businessperson arrives at the office, closes the door, and reaches quietly into the bottom drawer of the desk to find the bottle of gin hidden there. Every day a human being with every imaginable advantage takes a gun, loads a bullet into it, bites the barrel, and squeezes the trigger.

Psychotherapists and applied researchers are all too familiar with the grim statistics that document these realities. U.S. statistics, for example, show that lifetime prevalence rates for mental disorders are now approaching 50%, while even more persons suffer the emotional distress of problems with jobs, relationships, children, and the natural transitions that life presents to us all (Kessler et al., 2005). Nationwide there are nearly 20 million alcoholics (Grant et al., 2004); tens of thousands of people commit suicide each year, and countless others try to but fail (Centers for Disease Control and Prevention, 2007). Statistics like these apply not only to

those who have been beaten down over decades of living but equally well to adolescents and young adults. Almost half of the college-age population met the criteria for at least one DSM-related diagnosis within recent years (Blanco et al., 2008).

If we wished to summon up numbers to document the ubiquity of human misery in the developed world, we could do so almost indefinitely. Therapists and researchers often cite such statistics in one problem area after another when discussing the need for more clinicians, greater funding for mental health programs, or increased support for psychological research. At the same time, professionals and the lay public alike seem to miss the larger message these statistics communicate when taken as a whole. If we add up all those humans who are or have been depressed, addicted, anxious, angry, self-destructive, alienated, worried, compulsive, workaholic, insecure, painfully shy, divorced, avoidant of intimacy, and stressed, we are compelled to reach a startling conclusion, namely, that psychological suffering is a basic characteristic of human life.

Human beings inflict misery onto one another continually as well. Consider how easy it is to objectify and dehumanize others. The world community is literally staggering and reeling under the weight of objectification, with all of its attendant human and economic costs. We are reminded of that sad fact every time we have to partially disrobe to enter an airplane or have to empty our belongings onto a conveyor belt in order to enter a government building. Women make almost one-quarter less than what men make when performing the same work. Ethnic minorities often find it difficult to catch a taxicab in major cities. Skyscrapers are attacked by terrorists in planes as a symbol of what is hated; in retaliation, bombs are then dropped from on high because those thought to be evil may live below. People not only suffer, they inflict suffering in the form of bias, prejudice, and stigma in a way that seems as natural as breathing.

Our most popular underlying models of psychological health and pathology barely touch upon human suffering and its infliction on others as general human problems. Western behavioral and medical sciences seem to have a well-developed myopia for truths that don't fit neatly into their accepted paradigms. Despite overwhelming evidence to the contrary, we too readily conceptualize human suffering through diagnostic labels as though it were a product of biomedical deviations from the norm. We prefer to view objectification and dehumanization in ethical or political terms—as though prejudice and stigma were strictly an attribute of the ignorant or immoral among us rather than the readers and writers of books such as this one. There is "an elephant in the room" that no one seems to acknowledge. It is hard to have compassion for ourselves and for others. It is hard to be a human being.

HEALTHY NORMALITY: THE UNDERLYING ASSUMPTION OF THE PSYCHOLOGICAL MAINSTREAM

The mental health community has witnessed and generated the "biomedicalization" of human living. Western civilization virtually worships freedom from physical or mental distress. The wonders of modern medicine "convinced people that healing was the cause of health" (Farley & Cohen, 2005, p. 33)—not just physical health, but rather all forms. Distressing thoughts, feelings, memories, or physical sensations came to be viewed predominantly as "symptoms." Having a certain type and number of these is said to mean that you have some type of abnormality or even some type of disease. Labels often mask the significant role that behavior and the social environment play in determining people's physical and mental health. People who used to have discomforts triggered by their eating heavy meals laced with fatty foods nowadays simply have disorders that require them to take a purple pill. The lack of sleep that derives from the unhealthy behavioral choices people make in a 24/7 society are now treated as disorders that may be temporarily alleviated by either expensive CPAP (continuous positive airway pressure) equipment or one of the new sleep medications that together produce multibillion-dollar sales. The message that psychological problems should generally be treated much as one would a medical illness extends even to the very water supply of contemporary Western society—in that there are measurable amounts of antidepressants in our rivers and even in the fish that we eat (Schultz et al., 2010)! Even when they are properly prescribed, such medications have a clinically significant impact superior to the placebo only for the most extreme cases (Fournier et al., 2010; Kirsch et al., 2008), which are far too few to affect the water supply, were the drugs to be prescribed based solely on scientific merit.

The idea that suffering is best described in terms of bioneurochemical abnormality has a superficially appealing flip side, namely, that health and happiness are the natural homeostatic states of human existence. This *assumption of healthy normality* is at the core of traditional medical approaches to physical health. Given the relative success of physical medicine, it is not surprising that the behavioral and mental health community has adopted this assumption as well. The traditional conception of physical health is simply the absence of disease. It is assumed that, left to its own devices, the body is meant to be healthy but that physical health can be disturbed by infection, injury, toxicity, a decline in physical capacity, or disordered physical processes. Similarly, it is assumed that human beings are inherently happy, connected with others, altruistic, and at peace with themselves—but that this typical state of mental health can be disturbed by particular emotions, thoughts, memories, historical events, or states of the brain.

A corollary to the assumption of healthy normality is the assumption that *abnormal processes are at the root of mental and physical disorders.* These assumptions blossom into syndromal thinking and diagnoses. The identification of syndromes—collections of signs (things the observer can see) and symptoms (things the person complains of)—is the usual first step in the identification of a disease. Diseases are functional entities, that is, they are disturbances of health with a known etiology, course, and response to treatment. After syndromes are identified, the search begins to find the abnormal processes that are thought to give rise to this particular cluster of outcomes and to find ways to alter these processes so as to alter the undesirable results.

These assumptions and the diagnostic strategies they generate are broadly sensible within the area of physical health, although even there they have notable limitations. After all, health is not *merely* the absence of disease (World Health Organization, 1947), and common medical symptoms such as fever, cough, diarrhea, or vomiting have adaptive functions that can be overlooked when one focuses solely on the symptoms rather than their possible functions (Trevathan, McKenna, & Smith, 2007). Still, within broad limits, the assumption of healthy normality works in that the structure of the human body appears to be designed to deliver a reasonable degree of physical health as the natural result of biological evolution. If particular humans do not have genes adequate for physical health sufficient to ensure successful reproduction, evolution generally weeds out those genes or their expression over time. Physical signs and symptoms have often been useful as guides to the identification of diseases. Natural selection generally ensures that the structural development of an organism serves its self-preservative and reproductive functions. Deviations in structure, therefore, usually indicate malfunctions and are often useful in identifying specific diseases. For example, early in the HIV/AIDS epidemic, extremely rare forms of cancer led researchers to focus on a particular subgroup of persons, which in turn made discovery of the virus simpler. Natural selection alone does not ensure such a close connection between the form and function of behavior, and the biomedical diagnostic strategy risks being overextended when applied to psychological suffering.

THE MYTH OF PSYCHIATRIC DISEASE

Our current approach to psychological suffering is based on the idea that looking at topographical features (i.e., signs, symptoms, and collections of these) leads to truly functional disease entities that encompass *why* these features appear and *how best* to change them. The field of psychopathology

has been completely dominated by these assumptions and the analytic strategies that result. Few research psychologists and psychiatrists seem to be able to avoid adopting them. Be that as it may, psychiatric diseases are actually more myth than reality.

Given the extraordinary attention lavished on the abnormality model within psychology and psychiatry, it is surprising to note that virtually no progress has been made in establishing mental health syndromes as legitimate disease entities (Kupfer, First, & Regier, 2002). After relating the well-worn and dated example of general paresis, there are virtually no other success stories to tell. Unfortunately, this lack of success does not keep scientists from insisting that these psychological syndromes will soon represent discrete disease entities. We are just now turning the corner—so the story goes—and are on the verge of finding the gene, neurotransmitter, or neuromodulator that is responsible for the etiology of psychiatric disease. As the decades wear on, those with a memory should be granted the legitimacy of their original skepticism. A quick check of the World Health Organization (WHO) listing of diseases will unmask the story as the mirage that it is. None of the most common mental health syndromes has yet met even the most basic criteria to be legitimately considered as a disease state—even such dramatic disorders as the schizophrenias or bipolar disorders.

Every new edition of the DSM so far has contained a plethora of "new" mental conditions, subconditions, and dimensions of pathology. The draft version of the DSM-5 makes clear that this expansionist trend is still continuing. A growing portion of the human population will continue to come under the purview of the dominant psychiatric nosology. Diagnostic expansionism would be acceptable if it increased the overall effectiveness of our mental health system—*but it hasn't.* Instead, we are confronted with a classic Tower of Babel, in which new dimensions, concepts, and symptom lists are glued onto a poorly functioning nosology to disguise the failings of the overall enterprise (see Frances, 2010).

There are numerous deficiencies in the current diagnostic system, and we will touch on only a relative few right here. The "comorbidity" rates among disorders are so high as to challenge the basic definitional integrity of the entire system. For example, major depressive disorders have comorbidity rates that approach 80% (Kessler et al., 2005). Such astoundingly high rates are less a mark of true "comorbidity" than of a bad diagnostic system. Furthermore, the treatment utility (Hayes, Nelson, & Jarrett, 1987) of these categories is remarkably low, since the same treatments work with many syndromes (Kupfer et al., 2002). This observation undermines a major functional purpose of diagnosis, namely, increasing the effectiveness of treatment decisions. The system dismisses key forms of psychological

suffering (relationship problems, existential crises, behavioral addictions, and so on), and even its advocates agree that at times it seems to pathologize such normal processes of living as grief, fear, or sadness (Kupfer et al., 2002).

In prepaid mental health care settings (where "diagnosing up" to receive insurance coverage is no longer necessary), the large majority of clients receiving psychological treatment have no diagnosable condition at all (Strosahl, 1994). Even if clients can be given a label such as "panic disorder with agoraphobia" or "obsessive–compulsive disorder," therapy will still have to address such other problems as jobs, children, relationships, sexual identity, careers, anger, sadness, drinking problems, or the meaning of life. Tragically, as the DSM's vision of human suffering has expanded across the world and has increasingly pathologized normal human difficulties, the ability of non-Western cultures to deal with suffering in a way that maintains behavioral and social functioning has gone down, not up (Watters, 2010).

A syndrome focus has led us to develop treatment approaches that overemphasize symptom reduction and downplay functional and positive markers of psychological health. Often, the generalized effects of psychotherapy on functional status and quality of life are small, and the largest effects tend to be observed with symptom severity measures. Reductions in symptom frequency and severity are only moderately correlated with improvements in social functioning or broader measures of life quality. Yet, students of psychopathology are dutifully trained to know nearly every characteristic of nearly every syndrome category. Research journals in clinical psychology and psychiatry contain little else but research on syndromes; in most countries that fund mental health science, funding is almost entirely dedicated to the study of these syndromes.

The problem is not just the focus of syndrome thinking. Positive psychology, for example, redirects our focus by studying the strengths and virtues that enable communities and individuals to thrive. Thus, it resonates in many ways with the approach we develop and advocate in this volume. Positive psychology, however, cannot fully solve the deep difficulties inherent in the current system until it explores the core dimensional processes that create the patterns of human suffering we see right in front of our eyes. That is, we need an *explanation.*

The clinical establishment has been approaching the area of mental health specifically, and human suffering in general, using the assumption of healthy normality; as a result, it views distressing states of mind as signs of disorder and disease. If this strategy had led to vastly more effective forms of psychotherapy, there would be little reason for us to object. "Yes," we might then say, "human suffering is ubiquitous, but we must leave that to the priest, minister, or rabbi. Our job is to treat and to prevent clinical

syndromes. After all, this is what our clients want. And we do that very well indeed."

We cannot make such a statement. While the field has developed reasonably effective treatments for the most common "mental disorders," their effect sizes are modest, and in most areas there has been no appreciable increase in effect sizes for years. The evidence-based care revolution has revealed this problem over and over again, but few in the scientific community seem to be paying heed. So long as grant funds continue to flow into the university or research institute, everyone is content. So long as the scientific journals focus so single-mindedly on the disease model, no one will be the wiser.

Most experienced clinicians will readily express their deep skepticism about the current diagnostic system and their sense that the emphasis on disorder-based treatments is lacking in some very important respects. Practitioners generally perceive the discrepancy between what has been promised and what has been delivered. Clinicians often suggest that the academy is far too preoccupied with the form of mental health problems and insufficiently interested in the functions that these problems serve in the life of the client. Other critics point to the seeming disconnect between the clinical treatment of a particular disorder and the social, cultural, and contextual influences that give symptoms their meaning.

Even the progenitors of the psychiatric nosology are beginning to question the syndromal approach. When we give talks about the problems inherent in the syndromal approach, we sometimes omit the source of the quotes that follow below and then ask the audience to guess the source. Usually, someone in the audience will immediately call out "You!" But that is incorrect. The remarks that follow are excerpted from the report of the American Psychiatric Association planning committee for the fifth version of the DSM (Kupfer et al., 2002)—the same organization (acting in the same tradition) that built the Tower of Babel we are living in. The report could hardly be more damning. We have added italics to highlight some of the most disturbing admissions:

> The goal of validating these syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, *not one* laboratory marker has been found to be specific in identifying *any* of the DSM-defined syndromes. (p. xviii)

> Epidemiological and clinical studies have shown extremely high rates of comorbidities among disorders, undermining the hypothesis that the syndromes represent distinct etiologies. Furthermore, epidemiological studies have shown a high degree of short-term diagnostic instability for many disorders. With regard to treatment, lack of specificity is the rule rather than the exception. (p. xviii)

> Many, if not most, conditions and symptoms represent a somewhat arbitrarily defined pathological excess of normal behaviors and cognitive processes. This problem has led to the criticism that the system pathologizes ordinary experiences of the human condition. (p. 2)

> Researchers' *slavish* adoption of DSM-IV definitions may have *hindered* research in the etiology of mental disorders. (p. xix)

> Reification of DSM-IV entities, to the point that they are considered to be equivalent to diseases, is *more likely to obscure than to elucidate* research findings. (p. xix)

> All these limitations in the current diagnostic paradigm suggest that research exclusively focused on refining the DSM-defined syndromes may *never* be successful in uncovering their underlying etiologies. For that to happen, an as yet unknown paradigm shift may need to occur. (p. xix)

Despite the honesty of the workgroup report, the release of the DSM-5 drafts show clearly that those controlling our psychiatric nosology have not solved these problems (Frances, 2010).

The workgroup was right in its perception that a truly new approach is needed. This book is about how to foster a needed paradigm shift—in our clients, in our field, and in ourselves. That shift is in part assumptive, behavioral, and experiential, but it is also intellectual. The field needs a unified transdiagnostic model that is linked to a broader scientific effort to create a more useful and integrated psychology (see also Barlow, Allen, & Choate, 2004).

THE ACCEPTANCE AND COMMITMENT THERAPY PERSPECTIVE

The approach described in this book is called acceptance and commitment therapy, or ACT. *ACT* is always said as one word, not as individual letters, perhaps because A-C-T sounds rather like E-C-T (short for electroconvulsive therapy), which is hardly a favorable association[1] and more positively because the term reminds us that this approach encourages active involvement in living.

[1] Most of those in the field of psychotherapy use acronyms to identify treatment approaches. Not using initials thus has an immediate side benefit in that those who expound on the strengths and weaknesses of "Aay-Cee-Tee" are immediately exposed as not having done any serious training or reading in ACT. Readers will now know to take what these observers say with a gain of salt.

From an ACT perspective, human suffering predominantly emerges from normal psychological processes, particularly those involving human language. Even when physiological dysfunction is present (as in diabetes or epilepsy, for example), the dictum that "The good physician treats the disease; the great physician treats the patient who has the disease" is sound doctrine.

The foregoing observation does not mean that abnormal processes do not exist. Clearly they do. If a person suffers a brain injury and behaves oddly as a result, this behavior is not attributable solely to normal psychological processes (even though these processes may still be relevant in dealing with the consequences of the brain injury). The same observation may one day be shown to be true for schizophrenia, autism, bipolar disorder, and so on, although the actual evidence for a simple organic etiology in these areas is very limited, as is shown by the absence of specific and sensitive biological markers for these conditions (see the first "disturbing admission" by Kupfer et al., 2002, above). Even with such severe mental illnesses, however, the model underlying ACT holds that the ordinary processes embodied in self-reflective language and thought may actually *amplify* the core difficulties associated with such conditions (for more detailed evidence on this point, see Chapter 13). No matter how many voices a person hears or panic attacks he or she experiences, that individual is a thinking, feeling, remembering human being. How a person responds to, say, a hallucination may be more critical to healthy functioning than the hallucination itself, and from an ACT perspective that response is dominantly determined by normal psychological processes.

The Example of Suicide

There is no more dramatic example of the degree to which suffering is part of the human condition than suicide. Death by deliberate choice is obviously the least desirable outcome one can imagine in life; yet, a surprisingly sizable proportion of the human family at one time or another seriously considers killing themselves, and a shockingly large number of them actually attempt to do so.

Suicide is the conscious, deliberate, and purposeful taking of one's own life. Two facts are starkly evident about suicide: (1) it is ubiquitous in human societies, and (2) it is arguably absent among all other living organisms. Existing theories of suicide are hard-pressed to logically account for both of these facts. Suicide is reported in every human society, both now and in the past. Approximately 11.5 per 100,000 persons in the United States actually commit suicide every year (Xu, Kochanek, Murphy, & Tejada-Vera, 2010), accounting for nearly 35,000 deaths in 2007. Its

occurrence is virtually nonexistent among infants and very young children but begins appearing during the early school years. Suicidal thoughts and attempts are fairly common among the general population. A recent study commissioned by the Substance Abuse and Mental Health Services Administration found an imputed annual rate of serious suicidal ideation among some 8.3 million individuals, with annual suicidal attempts among young adults approximating 1.2% of that age group—with higher levels of incidence associated with substance abuse (Substance Abuse and Mental Health Services Administration, 2009). Studies of lifetime incidence suggest that about 10% of all people will at some time make an attempt on their lives, and an additional 20% will struggle with suicidal ideation and develop a plan and means to accomplish it. Yet another 20% will struggle with suicidal thoughts but without a specific plan. Thus, roughly half of the total population will experience moderate to severe levels of suicidality in their lives (Chiles & Strosahl, 2004). This is a shockingly high figure to explain if one is to view suicidality as "abnormal."

Also relevant to our discussion is the fact that suicide is totally absent among nonhumans. Several vaunted exceptions have been noted to this generalization over time, but on examination they turn out to be false. Norwegian lemmings are perhaps the most classic example. When their population density reaches a point that cannot be sustained, the entire group engages is a helter-skelter pattern of running that leads to the death of many of them—usually by drowning. But suicidality implies not merely death but also psychological activities inclining the individual toward personal death as a deliberate consequence of that activity. When a lemming falls into the water, it tries to climb out, and when it succeeds it stays out. But there are numerous documented cases of a person jumping from a bridge, surviving, and then immediately jumping from the same bridge again.

In humans, self-elimination can fulfill a variety of purposes, but its stated purposes are usually drawn from the everyday lexicon of emotion, memory and thought. For example, when suicide notes are examined, they tend to be messages emphasizing the immense burdens of living and conceptualizing a future state of existence (or nonexistence) in which those burdens will be lifted (Joiner et al., 2002). Although suicide notes frequently express love for others and a sense of shame for the act, they also commonly express that life is just too painful to bear (Foster, 2003). The emotions and most common states of mind generally associated with suicide include guilt, anxiety, loneliness, and sadness (Baumeister, 1990).

The phenomenon of suicide demonstrates the limits and flaws of the purely syndrome-based perspective on human suffering. Suicide is not a syndrome, and many people who kill themselves cannot be neatly categorized under any well-defined syndromal label (Chiles & Strosahl, 2004).

If the most dramatically "unhealthy" form of activity that exists is present to some degree in the lives of most humans but not among other sentient beings, we are drawn to an obvious conclusion, namely, that there must be something unique about being human that makes it so. Put more precisely, there must be a process at work that leads so readily to so much psychological suffering—one that is uniquely characteristic of human psychology. The research strategy underpinning contemporary psychopathology will not necessarily detect this process because it is not specifically focused on the mundane daily details of human actions. Even if we assigned nearly every person one or more diagnostic labels, no amount of progress in the study of psychopathology would diminish our obligation to address and further explicate the pervasiveness of human suffering. All human beings are hurting—just some more than others. In effect, it is normal to be "abnormal."

Destructive Normality

The ubiquity of suffering itself suggests that it originates within processes that evolved to promote the adaptability of the human organism. This observation is the core idea behind the *assumption of destructive normality*, the idea that ordinary and even helpful human psychological processes can themselves lead to destructive and dysfunctional results, amplifying or exacerbating whatever abnormal physiological and psychological conditions may exist.

When ACT was being developed during the 1980s, it was designed as a transdiagnostic treatment approach based on the common core processes that we thought might account for human psychological suffering. We started with some fairly simple and straightforward questions:

> How is it that bright, sensitive, caring people who have everything they need to survive and prosper in life must endure such suffering?
> Are there ubiquitous human processes that somehow are linked to widespread suffering?
> Can we develop a solid theoretical understanding of how suffering develops and then apply psychological interventions to neutralize or reverse the core processes responsible?

One key clue to finding meaningful answers to these challenging questions required only that we look in the mirror. Encased in the head's round protective shield was an organ with an extremely bright upside and an equally troubling downside.

It is humbling to note that this idea—that normal and necessary psychological processes function much like a double-edged sword—is basic to

many religious and cultural traditions, but it is much less appreciated in psychology and the other behavioral sciences. The Judeo-Christian tradition (and indeed most religious traditions, whether Western or Eastern) embraces the idea that human suffering is very much the normal state of affairs in life. It is worth examining this religious tradition as a concrete example of how far the mania for medical syndromes has taken us away from our cultural roots on these issues. Genesis, the beginning of all things, seems an appropriate place to begin our consideration of human language and human suffering.

The Origins of Suffering, according to the Judeo-Christian Tradition

The Bible is very clear about the original source of human suffering. In the Genesis story, "God said, 'Let us make man in our image, in our likeness'" (Gen. 1:26 [New International Version]), and Adam and Eve were placed in an idyllic garden. The first humans were innocent and happy: "The man and his wife were both naked, and they felt no shame" (Gen. 2:25). They are given only one command: "You must not eat from the tree of the knowledge of good and evil, for when you eat of it you will surely die" (Gen. 2:17). The serpent tells Eve that she will not die if she eats from that tree, but rather that "God knows that when you eat of it your eyes will be opened, and you will be like God, knowing good and evil" (Gen. 3:5). The serpent turns out to be correct, to a degree, because when the fruit is eaten, "The eyes of both of them were opened, and they realized they were naked" (Gen. 3:7).

This is a powerful story, one that is very instructive. When asked whether it is good to know the difference between good and evil, most religious people would surely say that having such knowledge represents the very epitome of moral behavior. That may be so, but the Genesis story suggests that having this kind of evaluative knowledge also represents the epitome of something else, namely, the loss of human innocence and the beginning of human suffering.

In the Biblical story, the effects of evaluative knowledge are immediate and direct. The additional negative effects from God's punishment come later. Adam and Eve were already suffering before God discovered their disobedience. When Adam and Eve discover that they are naked, they immediately "sewed fig leaves together and made coverings for themselves" (Gen. 3:7 [New International Version]), and then they "hid from the Lord God among the trees of the garden. But the Lord God called to the man, 'Where are you?' He answered, 'I heard you in the garden, and I was afraid because I was naked; so I hid.' And God said, 'Who told you that you were naked? Have you eaten from the tree?'" (Gen. 3:8–11). What happens next

is equally telling. Adam blames Eve for convincing him to eat from the tree, and Eve blames the devil.

There is something very sad about this narrative describing the first instance of human shame and blame. It touches something deep inside us relating to our own loss of innocence. Humans have eaten from the Tree of Knowledge: we can categorize, evaluate, and judge. As the story goes, our eyes have been opened—but at a terrible cost! We can judge ourselves and find ourselves to be wanting; we can imagine ideals and find the present to be unacceptable by comparison; we can reconstruct the past; we can envision futures that are not yet evident, and then we can worry ourselves to death over achieving them; we can suffer with the certain knowledge that we and our loved ones will die.

Each new human life retraces this ancient story. Young children are the very essence of human innocence. They run, play, and feel—and, as in Genesis, when they are naked they are not ashamed. Children provide a model for the assumption of healthy normality, and their innocence and vitality are part of why the assumption seems so obviously true. But that vision begins to fade as children acquire language and become more and more like the creatures adults see reflected every day in their mirrors. Adults unavoidably drag their children from the Garden with each word, conversation, or story they relate to them. We teach children to talk, think, compare, plan, and analyze. And as we do, their innocence falls away like petals from a flower, to be replaced by the thorns and stiff branches of fear, self-criticism, and pretense. We cannot prevent this gradual transformation, nor can we fully soften it. Our children must enter into the terrifying world of verbal knowledge. They must become like us.

The world's great religions were some of the first organized attempts to solve the problem of human suffering. It is telling that all the great religions have a mystical side and that all mystical traditions share a defining feature: they all have practices that are oriented toward reducing or transforming the domination of analytical language over direct experience. The diversity of methods is impressive. Silence is observed for hours, days, weeks, or years; unsolvable verbal puzzles are contemplated; one's breathing is monitored for days at a time; mantras are repeated endlessly; chants are repeated for hours on end; and so on. Even the nonmystical aspects of the great religious traditions—which do rely on literal and analytical language—often focus on acts that are not themselves purely analytical. Judeo-Christian theology, for example, asks us to have faith in God (the root of *faith* is the Latin *fides*, which means something more like fidelity than it does logical, analytical belief). Buddhism focuses on the costs of attachment. Different religions vary the details of the narrative, but the themes are usually the same. In their attempt to know, humans have lost

their innocence, and suffering is a natural result. Despite the excesses that religion is sometimes prone to, there is great wisdom in this perspective. By comparison, the relatively recent tradition of psychotherapy is just now catching up.

The Positive and Negative Effects of Human Language

The core of the ACT approach is built upon the idea that human language gives rise to both human achievement and human misery. By "human language," we do not mean mere human vocalization, nor English as opposed to French dialect. Likewise, we are not referring merely to social signaling, as when our pet dog barks for food or when a prairie dog emits a cry of alarm. Rather, we mean symbolic activity in whatever form it occurs—whether gestures, pictures, written forms, sounds, or whatever.

While there seems to be wide agreement that the earliest humans could use symbols (based on their burial practices, for example), the sophisticated use of these abilities is astonishingly recent. The earliest permanent and unquestionable records of sophisticated human symbolic activity seem to be cave drawings from only 10,000 years ago. The earliest evidence for written language as we know it is about 5,100 years old. The alphabet was invented only about 3,500 years ago. Even within the formal written record of human affairs, there is a clear progression of verbal abilities. Only a few thousand years ago, ordinary people may have experienced self-verbalizations as statements from Gods or unseen others (Jaynes, 1976), and in the earliest written stories "thinking for oneself" was viewed as dangerous (e.g., see Jaynes's [1976] analysis of *The Iliad* and *The Odyssey*). Nowadays, normal adults manipulate a variety of symbolic stimuli (both overtly and relatively covertly) from morning to night while simultaneously functioning in the world.

The progress of humankind can be related fairly directly to these same verbal milestones. The development of the great civilizations was fostered by written language, and the world's great religions developed not long afterward. The enormous expansion of the ability of the human species to alter their immediate environment through technology began with the gradual rise of science and has increased exponentially ever since then.

The resulting progress is astounding, outstripping our ability to appreciate the multifarious changes. Some 200 years ago the average human lifespan in the United States was 37 years; it now approaches 88! About 100 years ago, an American farmer could feed on average just four others; today, it is 200! Fifty years ago the *Oxford English Dictionary* weighed 300 pounds and took up 4 feet of shelf space; today, it fits on a 1-ounce flash drive or can be accessed via the Web from virtually anywhere!

This kind of familiar "gee-whiz" litany is easy to dismiss because the impact of today's human verbal abilities is so enormous as to be almost incomprehensible. But we cannot fully appreciate the human dilemma if we do not see the nature and speed of human progress clearly. Human misery and objectification can only be understood in the context of human achievement because the most important source of both of these is the same—human symbolic activity. Psychotherapists, better than most, know the dark side of this progress.

To ask individual human beings to challenge the nature and role of language in their own lives is tantamount to asking a carpenter to question the utility of a hammer. The same injunction applies to the readers of this book. You cannot be a good ACT therapist if you take words to be right, correct, and true rather than asking "How *effectual* are they?" This observation applies to the very words you are reading. Hammers are not good for everything, and language is not good for everything either. We must learn to use language without being consumed by it. We must learn to manage it rather than having it manage us—clinicians as well as clients.

The Challenge of Psychological Pain for Creatures with Language

When nonhumans are exposed to aversive stimuli, they react in a very predictable way. They engage in immediate avoidance behavior, emit distress cries, aggress, or collapse into a state of immobilization. These distress reactions are usually time-limited and tied to the presence of conditioned or unconditioned stimuli. Distress-related behavior will normally return to baseline levels once the aversive event is removed and autonomic arousal subsides.

Humans are very different creatures, chiefly owing to their ability to engage in symbolic activity. Humans can carry forward aversive events; create similarities and dissimilarities between events; and form relationships between historical events and current events based on constructed similarities. Humans can create predictions about situations that have not yet been experienced. Humans can respond as if an aversive event is present when it was withdrawn decades earlier. The powerful indirect functions of language and higher cognition create the potential for psychological distress in the absence of immediate environmental cues; yet, these are the very cognitive abilities that are most prized and helpful in human advancement.

It seems unlikely that the earliest humans evolved cognitive abilities primarily to ponder their self-adequacy or wonder where they were going in life. Human language was selected based on far more substantial consequences of life and death and social control. Humans are one of the most

cooperative species known. Indeed, social cooperation is probably a necessary context for the multilevel selection processes (within and between groups) that most plausibly originally led to human cognition (Wilson & Wilson, 2007). Individual adaptations (whether big teeth or better camouflage, for example) are generally selfishly advantageous, while larger social adaptations can be more altruistic because these adaptations provide advantages in the competition between groups. Cooperation is also a key contextual feature in the evolution of language because symbolic language is useful first and foremost to the larger community (Jablonka & Lamb, 2005). But while human cognition has led to a greater ability to detect and ward off threats to the group, to coordinate the behavior of the clan, and to ensure that propagation could occur, it has also given us cognitive tools we can turn mindlessly against our own best interests.

In the developed world, people are seldom faced with immediate threats to survival. They have the time and encouragement to think about practically anything: their history, their physical appearance, their place in life as compared to where they thought they would be, what other people think about them, and so on. The human culture of the civilized world has evolved in ways that takes advantage of our symbolic abilities. Language has evolved to include more and more terms that describe and evaluate various states of mind or emotion. As these terms evolve, experiences are able to be categorized and evaluated. As human beings increasingly look inward, life begins to seem more like a problem to be solved than a process to be fully experienced.

We can see this tendency to begin on the outside but ultimately to turn inward in the very structure and history of our modern languages. The earliest words in human languages almost always relate to externalities: milk, meat, mothers, fathers, and so on. It became possible to speak about the "world within" only much later, through the development of words that functioned as metaphors based on common external situations. This progression is readily seen in the etymology of dispositional words (Skinner, 1989). For example, "wanting" something comes from a word meaning "missing"; being "inclined" comes from a word meaning "to lean." Virtually every dispositional term is like that.

As we learned to turn inward, our verbal and cognitive abilities (our "minds") begin to warn us with alarms about past and future psychological states rather than only alarms about external threats. Normal instances of psychological pain become a central focus of our day-to-day problem solving—with toxic results. This process of applying a useful process to an inappropriate target is similar to the way that allergies involve the misapplication of a helpful process of bodily defense against intruding organisms toward the bodily processes themselves instead. Human suffering

predominantly involves the misapplication of otherwise positive psychological processes of problem solving to normal instances of psychological pain. In other words, our suffering represents a kind of allergic reaction to our own inner world.

It is not possible to eliminate suffering by eliminating pain. Human existence contains inevitable challenges. People we love will be injured, and people close to us will die—indeed, we are aware from an early age that in time we all will die. We will also be sick. Functions will diminish. Friends and lovers will betray us. Pain is unavoidable, and (owing to our symbolic inclinations) we readily remember this pain and can bring it into consciousness at any given moment. This progression means that human beings consciously expose themselves to inordinate amounts of pain—despite our considerable abilities to control its sources in the external environment. Even so, great pain is not in itself a sufficient cause for true human suffering. For that to occur, symbolic behavior needs to be taken a bit further.

The Sirens' Songs of Suffering: Fusion and Avoidance

In the classic Greek tale of *The Odyssey*, by Homer, Odysseus and his band of warriors seek to return to their homes in Greece following the end of the Trojan War. They sail through the treacherous Aegean Sea, facing many perils along the way, perhaps none more challenging than that encountered as they sail past the island of the Sirens. The Sirens are lovely creatures who stay hidden in the rocks along the shoreline, singing songs that promise knowledge of the future. The songs are irresistible because they speak to each sailor's longing to know, but those who linger through their enrapture inevitably meet their doom. Counseled by Circe about this imminent danger in advance, Odysseus orders his men to plug their ears with beeswax. Wishing to hear the Sirens' songs himself, however, he orders his men to lash him to the main mast and under no circumstances to untie him until the ship is well beyond the island's coastline. As the ship passes the island, Odysseus is so enchanted by the Sirens' songs that he begs and pleads with his men to untie him, but they refuse, knowing that he will jump overboard and die.

The story of Odysseus and the Sirens' songs speaks to humans' basic relationship to the dark side of their own mental powers and their entanglement with verbal knowledge. And, like the Genesis story, the story warns of the double-edged aspect of verbal knowledge. We can begin to understand the warning by focusing on two key processes: cognitive fusion and experiential avoidance—the "siren songs" of human suffering (Strosahl & Robinson, 2008).

Cognitive Fusion

Suffering occurs when people so strongly believe the literal contents of their mind that they become *fused* with their cognitions. In this fused state, the person cannot distinguish awareness from cognitive narratives since each thought and its referents are so tightly bound together. This combination means that the person is more likely to follow blindly the instructions that are socially transmitted through language. In some circumstances, this result can be adaptive; but in other cases, people may engage repeatedly in ineffective sets of strategies because to them they appear to be "right" or "fair" despite negative real-world consequences. People whose cognitions fuse are likely to ignore direct experience and become relatively oblivious to environmental influences. Quite often, people enter therapy because of the emotional wear and tear of such consequences, hoping for a reduction in symptom distress. But they have no intention of changing their basic approach because their approach is effectively invisible to them. It is as though they are imprisoned by the rules originating in their own mind. These rules are not randomly organized; rather, at the level of content, they follow a specific cultural directive about personal health and how best to achieve it. At the level of process, they are implicitly based on the assumption that verbal rules and deliberate problem solving are the best or even the only way to solve problems.

Consider, for example, dysthymic clients, who on a daily basis have internal dialogues that interfere with their direct experience of living. Most of the time, these thought processes involve "checking in" on whether they are "feeling good." If the client goes to a social gathering, not much time will transpire before self-reflective questions start arising. For example, clients may soon wonder, "Well, how am I fitting in?" The search for environmental cues begins. The individual scans the people nearby to see whether eye contact is being made, whether people are looking away, or whether he or she is being altogether ignored. Auditory stimuli are then checked, to see whether people might be saying demeaning or ridiculing things. The client engages in additional acts of self-reflection: "How well am I relating to these people?" "Am I really being myself?" "Am I just faking being happy and normal?" "Can they really see that I'm not as happy as I pretend to be?" "Why am I pretending around people anyway?" "I thought I was coming to this party to have some fun and to be happy, but I feel worse than ever now!" The internal drone caused by the client's self-monitoring of emotional causes and effects becomes so chronic that it becomes almost impossible for the client to engage in any activity without almost immediately destroying his or her sense of "being present," or spontaneous.

In a fused state, the dysthymic person follows the rule that there is a "right way to be" and that "right way" is happy. Attaining the right way to

feel becomes a constant struggle—one that many clients share. For the client with panic disorder, the chief struggle is against anxiety, thoughts of dying, losing control, or losing one's mind. To maintain control, the client must be vigilant in recognizing the early signs that undesirable reactions are occurring. The client must examine bodily sensations, thought processes, behavioral predispositions, and emotional reactions for signs of impending failure (or success). The solution to the struggle for feeling right seemingly lies in more vigilance, more scanning of the internal and external environment, and more control. But the client's self-imposed cycle of self-monitoring, evaluation, emotional response, control efforts, and further self-monitoring is not a solution to these disorders; rather, it *is* these disorders.

Disentangling people from their minds is one of the main aims of ACT, but this is much easier said than done, for clinicians and clients alike. People rely on their minds because language and thought are extremely effective vehicles in the everyday world. You should definitely pay attention to what your mind is saying when you are doing your taxes, repairing machinery, or trying to cross a street at a busy intersection. The problem is that we are not trained to discriminate when the mind is useful and when it is not, and we have not developed the skills to shift out of a fused problem-solving mode of mind into a descriptively engaged mode of mind. Minds are great when it comes to inventing new devices, constructing business plans, or organizing daily schedules. But, by themselves, minds are far less useful in learning to be present, learning to love, or discovering how best to carry the complexities of a personal history. Verbal knowledge is not the only kind of knowledge there is. We must learn to use our analytical and evaluative skills when doing so promotes workability and to use other forms of knowledge when they best serve our interests. In effect, the ultimate goal of ACT is to teach clients to make such distinctions in the service of promoting a more workable life.

Experiential Avoidance

Another key process in the cycle of suffering is *experiential avoidance.* It is an immediate consequence of fusing with mental instructions that encourage the suppression, control, or elimination of experiences expected to be distressing. For the client who engages in dysthymic patterns, the goal may be feeling the right way and avoiding feelings or thoughts that detract from this aim. For the client who demonstrates obsessive–compulsive patterns, the goal may be to suppress certain thoughts or to control feelings of doom. For the client with panic disorder, the paramount goal may be to avoid experiencing anxiety and thoughts of dying, losing control, or losing

one's mind. (All the while, amid treatment, the clinician may also be resisting impulses of feeling helpless, stupid, or lost.)

There is an inherent paradox in attempting to avoid, suppress, or eliminate unwanted private experiences in that often such attempts lead to an *upsurge* in the frequency and intensity of the experiences to be avoided (Wenzlaff & Wegner, 2000). Since most distressing content by definition is not subject to voluntary behavioral regulation, the client is left with only one main strategy: emotional and behavioral avoidance. The long-term result is that the person's life space begins to shrink, avoided situations multiply and fester, avoided thoughts and feelings become more overwhelming, and the ability to get into the present moment and enjoy life gradually withers.

Impact of the Siren Songs

Both cognitive fusion and experiential avoidance significantly affect whom we think we are. We become increasingly entangled in our own self-stories, and threats to our own self-conceptions become central. Possibilities that lay outside of our own official storyline have to be avoided or denied. This consequence is as true when the stories are awful as when they are self-deceptively positive. We inevitably avoid admitting to mistakes in order to save face but at the cost of learning from them. Persons struggling with panic disorder will often declare "I am *agoraphobic*"—as if their problems were meant to define who they are—and they will hang on to the specialness of their pathology or the uniqueness and explanatory power of their own tragic history as if it were their chief birthright. People often dive into their mental machinery much as sailors would dive into the sea (i.e., not without some degree of delight). However, they are swallowed up by waves of pride and smashed against cliffs of shame. Instead of broken bones, we have broken marriages. Like Odysseus's sailors awaiting the Sirens' mantic truths, opportunities pass us by like empty ships when they do not fit into our mind's narrative. When you are too busy being what your mind says you are, stepping outside of your normal habits becomes impossible, even when it would clearly be useful to do so.

Cognitive fusion and experiential avoidance also affects one's ability to attend flexibly and voluntarily to what is happening internally and externally. Deliberately attending to internal events that one wishes to avoid—or even to their external triggers—would defeat the purpose of experiential avoidance. Noticing events that might contradict a well-fused story might mean stepping outside of that story for a moment (horrors!). In order to avoid such untimely outcomes, one's attention must remain narrowly focused and inflexible. With time, a kind of life numbness sets

in. People go through the motions of daily life without much moment-to-moment contact with life itself. Life is put on autopilot.

The damage done by cognitive fusion and experiential avoidance is equally destructive to our sense of our life's direction and to our goal-oriented behavior. Our behavior comes to be more under "aversive control" rather than "appetitive control"—more dominated by avoidance and escape than natural attraction. Our most important life choices come to be based on how to not evoke distressing personal content rather than moving toward what we most deeply value. People lose their compass headings altogether because they are too busy monitoring the risk level of each event, interaction, or situation.

ACT: ACCEPT, CHOOSE, TAKE ACTION

In the ACT approach, a goal of healthy living is not so much to feel *good* as to *feel* good. It is *psychologically healthy* to have unpleasant thoughts and feelings as well as pleasant ones, and doing so gives us full access to the richness of our unique personal histories. Ironically, when thoughts and feelings become all-important, virtually dictating what we do—that is, when they "mean only what they *say* they mean"—then we often are disinclined to feel the feelings or think the thoughts openly and thus to learn from what they have to teach us. Conversely, when feelings are just feelings and thoughts are just thoughts, they can mean what they *do* mean, namely, that bits of our unique personal history are being brought into the present by the current context. Thoughts and feelings are interesting and important, but they should not necessarily dictate what happens next. Their specific role in each instance depends on the psychological context in which they occur, and that is far more variable than any normal problem-solving mode of mind can presuppose.

The constructive alternative to fusion is *defusion*, and the preferred alternative to experiential avoidance is *acceptance*. These are the processes taught and fostered in the ACT approach. Defusion and acceptance at their most basic levels are implicit in any psychotherapy because, at a minimum, the client and therapist soon learn to notice the thoughts and feelings that occur in order to make sense of the problem being addressed. In their more elaborated forms featured in ACT, defusion involves learning to be consciously aware of one's thinking as it occurs, and acceptance involves the active process of engaging with and at times even enhancing the rich complexity of one's emotional reactions as a means of furthering psychological openness, learning, and compassion toward oneself and others. These skills involve consciously experiencing feelings *as* feelings, thoughts

as thoughts, memories *as* memories, and so on. They allow one to dispassionately observe one's mind at work while simultaneously "embracing the moment," thereby remaining attentive to potentially important contextual clues or signals that might otherwise be missed.

As these skills are acquired, one's sense of attentiveness becomes more flexible, focused, and volitional, enabling one to better view oneself and others as part of an interconnected world. From that more mindful and flexible perspective, clients can more easily make the shift from avoidance and entanglement to increased engagement and behavioral expansion.

Avoidance is rarely engaged in as an end in itself. Successful avoidance is not an outcome goal, it is a process goal. If you ask a client *why* he or she should, say, avoid anxiety, the reply will usually refer to a hoped-for positive impact elsewhere in one's life. The client may believe, for example, that undue anxiety is undermining a potential promotion, hurting a relationship, or preventing him or her from traveling. Experiential avoidance strategies hold out the promise that important and desirable life outcomes will be obtained by ridding oneself of bad feelings. In ACT, however, such life outcomes are made more immediately relevant and achievable since practitioners can proceed directly to the issue of deeply held personal values and how to build one's life focused on them.

Successfully pursuing a life value becomes complicated by avoidance because the areas where we can be hurt the most are precisely those areas where we care most deeply. It can be quite comfortable to develop a pretense of "not caring." It is not possible to choose valued but risky life directions when our cognitions are fused because the logical mind seeks out guarantees of outcomes. In the context of greater psychological flexibility, however, the psychological pain that is inherent in difficult life situations can be accepted for what it is and learned from; one's attention and focus can then be shifted toward life-enhancing behaviors.

In the last few pages we have outlined the entire ACT model without stopping to explain fully why these processes exist or how they work. In part, this brief introduction is designed to give the reader a sense of what a process-focused transdiagnostic alternative to syndromal thinking might look like. The rest of this book is designed to put meat on these bones. It will be a journey that involves, first, clarifying theoretical assumptions, examining basic and clinical science, and then articulating specific clinical implications and applications.

We have organized this book so that first you come to understand the foundations of the work (Chapter 2). We believe that, far from being a dry exercise, connecting with the assumptions underlying ACT sets the stage for using the model in a vital way. We then explore psychological flexibility as a unified transdiagnostic model of human functioning and adaptability (Chapter 3). Next, the model is applied to specific case studies so that

you, the clinician, can begin to identify various psychological strengths and weaknesses in your clients and yourself from a contextual point of view (Chapter 4). Chapter 5 addresses the most powerful tool you possess as a therapist, namely, your relationship to yourself and to your clients. It shows how you can instigate, model, and support acceptance, mindfulness, and valued actions as an approach to the therapeutic relationship itself.

In Chapters 6–12 we examine through specific case study details how to engage clients and walk them through the core processes of ACT. Each chapter describes the clinical relevance of the core process, gives case examples of intervention methods, and offers advice about how best to integrate that particular process with the remaining ACT processes. In clinical practice, we have consistently found that working on one specific ACT process tends to elicit one or more of the other ones whenever they are relevant; so, it is important to learn how to see the signs of that happening. Each chapter gives you a brief list of therapeutic "dos and don'ts" to help you avoid some of the most common mistakes we are liable to make in our clinical work.

In Chapter 13, we look at the past and future of ACT and introduce you to the contextual behavioral science (CBS) approach to treatment development and evaluation. We examine in some detail the key principles of treatment development through which we are attempting to close the gap between science and clinical practice. If you are intrigued by the ACT approach, you should probably be equally interested in the scientific strategy that gave rise to it and that over time is extending its reach.

A CAVEAT

The Zen master Seng-Ts'an was fond of saying "If you work on your mind with your mind, how can you avoid great confusion?" Many human institutions (including Zen Buddhism prominently among them) have attempted to declaw the lions of human language. It is inherently difficult to use analytic language to declaw analytic language, requiring in effect that we learn to fight fire with fire without getting burned.

We are writing a book, not dancing or meditating. The readers of this book are interacting with verbal material. If human language is at the core of most human suffering, this circumstance presents an extreme challenge since our best attempts to both explicate and "understand" ACT will be firmly grounded in the language system itself and thus be subject to culturally instilled rule systems. To begin with a trivial example, this book will usually be read from front to back. This language structure can lead readers to assume that what comes first when we describe the ACT treatment model is the first stage of treatment and that the last component would

come late in the treatment. As it happens, this is not the case. Depending on the assessment made by the therapist, any core ACT process (regardless of its order of discussion in this book) might be the first process addressed in actual treatment situations.

At a more profound level, the ultimate goals of ACT are to undermine the hegemony of human language and bring our clients and ourselves back into broader contact with knowledge—including intuition, inspiration, and simple awareness of the world. These processes are no different for the therapist who reads this book trying to understand ACT than they are for the client who struggles to find meaning, purpose, and vitality in life. The language traps that ensnare us all will need to be identified. This proviso requires that the reader stay open to contradictions and learn to hold the sides of seeming contradictions lightly, rather than to view one side as wholly right and the other as wrong.

We at times use language in this book that is paradoxical and metaphorical, mostly in order to avoid becoming trapped in too literal a meaning. All of this verbal hocus-pocus may create some occasional confusion for the reader, for which we ask your indulgence. If we accomplish our larger goals, the confusion will have been both necessary and worth it.

In ancient societies, temples often feature a seemingly endless set of stairs leading up to a better vantage point—symbolizing, we suppose, the great effort needed to come to see things more clearly. At their base, these stairs are often flanked on each side by statues of fearsome creatures such as ferocious lions—perhaps symbolizing the frightful obstacles we sometimes need to surmount before letting go of familiar views in favor of new and unfamiliar ones. We can name those lions after the processes we just predicted will confront the reader in this volume—the one on the left is Paradox, and the one on the right is Confusion. We did not put two lions on the cover, but we could have.

ACT is not just a method or technique. It is a multidimensional approach linked to a basic and applied model and an approach to scientific development. It applies to clinicians as well as clients. At one level, our goal is to present a process-focused, unified, transdiagnostic account of human pathology and human potential. At another level, we invite you to explore a different conception of your own life and that of your clients.

CHAPTER 2

The Foundations of ACT

Taking a Functional Contextual Approach

Acceptance and commitment therapy has been developed over three decades by using a strategy of knowledge development that builds on and extends that of traditional behavior analysis. We designate the development model and methodology as a *contextual behavioral science* (CBS) approach, which advocates certain philosophical assumptions, particular kinds of theories useful to clinicians, and preferred ways of testing new clinical developments. CBS is considered central enough to ACT's work that the professional organization known as the Association for Contextual Behavioral Science (ACBS) is the international society that most promotes ACT's wider development.

Most of these matters are primarily of interest to researchers involved in basic science or treatment development and evaluation. We describe the CBS approach in greater detail at the end of the book (in Chapter 13). In this chapter, we cover only those aspects of philosophy and theory that are most relevant to a practicing clinician learning ACT.

We readily understand when practitioners are sometimes impatient with philosophy and theory. You usually want to move on immediately to the practical details of how to help others. You seek to discover new and specific techniques to use, and we understand your priorities as functionally practical, given your limited time for technical reading. But there is an important clinical reason to explore the basic foundations of ACT, namely, that *ACT asks its clients to take a new perspective on their own personal thinking habits.*

Clinicians cannot be highly skilled in establishing this new perspective with others if they know very little about it themselves. The normal assumptions built into human language are somewhat hostile to the new

perspective, as we will shortly demonstrate. It is far easier to be a skilled ACT therapist if you fully understand and can adapt to the unusually pragmatic assumptions on which it is based. It is also easier to experience ACT processes firsthand when fully invested in its underlying principles. For any practicing ACT therapist, exploring philosophical assumptions is not some dry academic exercise but rather the active promotion of the effective use of ACT itself.

Conceptually ACT's approaches and methodology are derived from a robust basic science tradition and a well-developed philosophy of science—something that in the main is not shared by other contemporary psychotherapies. When you fully comprehend the foundations underlying ACT, you can appreciate that its potential applications legitimately extend well beyond the therapist's office. It is this breadth of perspective that endows ACT with a special opportunity to function as a unified model of both human suffering and human resiliency. We begin our discussion with the basic assumptions of ACT, contrasting them, as we go, with more mainstream perspectives.

PHILOSOPHY OF SCIENCE: THE MAINSTREAM

As Kurt Gödel (1962) proved in the field of mathematics, it is impossible to have a symbolic system—in mathematics or anywhere else—that is not based on assumptions and postulates that go beyond the reach of that system. For example, in order to know what is true, you have to say what you mean by "true." Once you do that—out of nothing, so to speak—you can build a system of thought that seeks this kind of truth. Truth criteria *enable* scientific analysis—they are not the *result* of scientific analysis. Similar considerations apply to such key questions as "What are accepted as data?" or "What units best organize the world?" or "What exists?"

Philosophy of science is largely a matter of describing and choosing the assumptions that enable intellectual and scientific work. The goal of examining assumptions is not so much to *justify* them as it is to own them and weed out accidental inconsistencies. Phrased another way, the goals of philosophizing are nothing more (or less) than clarity and responsibility. The chief goal is to say "This is what I assume—precisely this."

Most psychologists and behavioral health professionals are relatively unclear about their philosophical assumptions. Not necessarily that they don't have any—they just might not know how best to articulate them or how they fit with one another. Ordinarily their assumptions are acquired implicitly from the commonsense use of language. There are other types of assumptions underlying behavioral science, but these are less likely to be acquired implicitly, which is our present focus.

In commonsense terms, the world consists of pieces or parts (e.g., mountains, trees, people) that can be described by language. This simple idea contains key assumptions about reality and truth. The real world is preorganized into parts, and truth is a matter of accurately mapping these parts with words. Consider the commonsense act of naming things. A child is taught "This is a ball." Within that sentence are assumptions, namely, that the ball is real and the name corresponds to it. There is also the assumption that the ball has knowable characteristics (e.g., it is round, it can bounce). These assumptions are foundational to at least two types of philosophy of science, both of which treat parts or elements as primary and view truth as a matter of correspondence between words and reality.

The commonsense act of naming underlies a philosophy of science called *formism* (e.g., such early Greek thinkers as Plato and Aristotle embraced this view). In this approach, truth is the simple correspondence between words and the real things to which they refer. The goal of analysis is to know the categories and classes of things. The key question is taken to be "What is this?", and it is answered by the precision and applicability of category definitions. In the behavioral sciences, some forms of personality theory or nosology are built on just such a set of assumptions.

The commonsense act of disassembling machines underlies a philosophy of science we prefer to term *elemental realism*. The British Associationists would be classic examples in philosophy. (*Mechanism* is the more common term, but that term leads to misunderstanding because it is used pejoratively in lay language.) For example, when a wind-up clock is disassembled, we observe that it has many constituent parts. These have to be reassembled according to an authoritative plan, and then the clock has to be wound in order to work. In this conception, truth is the elaborated correspondence between our models of the world and the parts, relations, and forces that the real world contains. The overarching goal of analysis is to model the world properly. The key question is taken to be "What elements and forces make this system work?", and it is answered by the predictive capacity of the model. The great bulk of intellectual work in psychology is ultimately based on elemental realism. In the behavioral sciences, information processing and most forms of cognitive neuroscience are good examples.

Ontology is the philosophical study of being, existence, or reality as such. Both formism and elemental realism view truth in ontological terms. Truth is based on either simple (formism) or elaborated (elemental realism) correspondence between our ideas about the world and what exists. It is assumed that the real world is knowable and is already organized into parts.

Consider how that idea plays out in therapy. A person comes into therapy saying, "I'm a terrible person. No one will ever love me." Clients quite

often attempt to justify such dysfunctional thoughts by making claims about what is real. "I'm not just thinking this," they say. "It is true." By "true" they very often do *not* mean that it helps to be guided by this particular thought. Often the thought they cling to has had exactly the opposite impact, functionally speaking. Instead, they mean that their words are true because they correspond with reality: "In some essential material sense, I am a terrible person, and thus I need to avoid developing relationships with others even though doing so does not lead to a vital life." Clients often seem entangled with their own ontological networks. Implicitly they challenge therapists either to undo these networks and prove them wrong or to admit that change is impossible.

Many forms of therapy try to address this problem by carefully testing or challenging the reality status or logical soundness of such thoughts, as if the problem were indeed getting the ontological claim right. This tactic can sometimes be helpful, but it is difficult to implement, frequently unsuccessful, and a largely unproven component of existing approaches (e.g., Dimidjian et al., 2006; Longmore & Worrell, 2007). It is difficult to abandon challenging the reality status or logical soundness of thoughts if one is a formist or elemental realist, regardless of the empirical status of these methods, because truth is a matter of correspondence between words and what is real. In these systems, we need to know what is real and teach our clients to do the same.

PHILOSOPHY OF SCIENCE: THE FUNCTIONAL CONTEXTUAL FOUNDATIONS OF ACT

ACT is fundamentally different from the foregoing approaches. It is based on a pragmatic philosophy of science called *functional contextualism* (Biglan & Hayes, 1996; Hayes, 1993; Hayes, Hayes, & Reese, 1988). *Contextualism* is Stephen Pepper's (1942) term for *pragmatism* in the tradition of William James. The core analytic unit of contextualism is the ongoing act-in-context; that is, the commonsense situated action of the organism (Pepper, 1942). It is doing as it is being done, in both a historical and situational context, such as in hunting, shopping, or making love.

Contextualism is a holistic approach; unlike the situation with formism or elemental realism, the *whole event* is primary, and the parts are derived or abstracted when it is useful to do so. The whole is understood in reference to context rather than assembled from elements. Consider a person going to a store to shop. This action has a proximal history (e.g., food is running low; a family dinner is coming up) and a situational context as it unfolds (e.g., now I'm turning left onto 12th Avenue to go to the grocery).

There is a wholeness and sense of extended purpose that integrates all of these. "Going to the store to shop" is a whole event that implies a place you are coming from and going toward, a reason to go, and a purpose to fulfill. If a road is blocked, another will be taken. The nature of the act is defined by its intended consequences, not its form (you could walk there or ride a bike—it is still "going to the store"). You know it is done when you get there.

In contextualism *everything* is thought of that way, including analyses used by clinicians and scientists. Going to the store to shop for food is "successful" when I get to the store and can buy what is needed. In the same way, analyzing an event is "successful" when I can do what I intended to do with that analysis. Truth is thus pragmatic: it is defined by whether a particular activity (or set of activities) helped achieve a stated goal. In this approach a "true" case conceptualization, for example, is a useful one. You know it is done when you get there.

Clarity about the goals of analysis becomes critical to contextualists because goals specify how a pragmatic truth criterion can be applied. Without a verbally stated goal, any behavior shaped by consequences would be "true" (see Hayes, 1993, for a detailed analysis of this point). This outcome would be nonsensical philosophically: it would mean that any instrumental behavior is "true," from addiction to a fetish. Once there is a verbally stated goal, however, we can assess the degree to which analytic practices help us achieve it. This option allows successful working toward a goal to function as a useful guide for science.

Successful working is the means by which contextualists evaluate events; goals allow this criterion to be applied. However, analytic goals themselves cannot ultimately be evaluated or justified—they can only be stated. To evaluate a goal via successful working would require yet another goal, but then that second goal could not be evaluated, and so on *ad infinitum*. Of course, we do have hierarchies of goals. This consideration causes mischief with clients all the time, as when process goals are linked to outcome goals. For example, a client will sometimes say his "goal" is to get rid of anxiety, but if you ask what would then happen he says, "If I was less anxious, I would be able to make friends." In other words, getting rid of anxiety was not an end goal per se but rather a presumed means to an end. The relationship between means and ends can be evaluated, but ultimate goals cannot be evaluated—only stated. Outcome goals must simply be declared and owned—naked and in the wind, so to speak. If having friends is of value to the client, then having friends is of value to the client.

The best-known forms of contextualism are probably various types of descriptive contextualism. These are designated as "descriptive contextualism" because they have as their goal a personal appreciation of the features

participating in the whole. Postmodernism, social constructivism, dramaturgy, hermeneutics, narrative psychology, Marxism, feminist psychology, and the like are examples. The distinctive features of *functional contextualism* as contrasted with these traditions (Hayes, 1993) are its unique goals: *the prediction-and-influence of psychological events with precision, scope, and depth*. In functional contextualism, psychological events are taken to be the interactions of whole organisms in and with a context considered historically and situationally. Functional contextualists seek primarily to "predict-and-influence" those interactions—the words are hyphenated because both aspects of this goal are sought at once. Clinically it does little good just to explain and predict things—we also have to know how to *change* things, and functional contextualists embrace that same perspective. Precision, scope, and depth are conceptual standards used to evaluate potentially acceptable explanations that serve our primary goals of prediction and influence. Precision refers to the specificity with which relevant variables are identified. Scope refers to the intellectual economy of a theory—the degree to which it can get more done with fewer concepts. And depth refers to the degree of coherence achievable with useful concepts developed at other levels of analysis (sociological or biological, for example).

Stated in more commonsense words, in psychology we want a science of applied analyses and interventions to be clear, simple, generally applicable, and to be integrated into the larger fabric of useful sciences. You could add the words *and nothing else* to this goal as a reminder that achieving practicality of this sort is not a means to an end but rather an end in itself.

The Whole Event: Act-in-Context

The philosophical concern for the whole event, viewed as an act-in-context, is reflected directly in the course of ACT therapy. What defines a behavioral event as a whole event? At one level it is set by the purpose of the persons doing the analysis, and at another it is set by the purpose of the behaving organism. It is not uncommon for ACT therapists to respond to a client's declarative statement describing his or her behavior by saying, "And that is in the service of . . . ?" The therapist might search for and perhaps note behavioral consequences at multiple levels (e.g., the therapeutic relationship; a sample of the person's general social behavior; an example of the dynamics of the individual's psychology). By focusing the client on the consequences of his or her action, the therapist is trying to both assess and spotlight its wholeness. ACT therapists are constantly trying to understand and influence the purposes that clients bring into their lives and how these purposes are played out, both in their external world and in the "world between their ears."

It should be noted that in a technical sense *behavior* is our preferred term for an act-in-context, whether considering overt behavior, emotional behavior, or cognitive behavior. Used in this way, *behavior* is not merely a code word for movement, glandular secretions, or publicly observable actions. The activity we are talking about is *any and all activity* that anyone (and sometimes only one person) can observe, predict, and influence. What does that exclude? It excludes hypothesized actions that *no one* (not even the client) can detect directly. Thus, thinking, feeling, sensing, and remembering are all psychological actions, while soul travel is not. Sometimes in this book we will speak in a way that fits lay usage, such as when we talk about emotions, thoughts, and behavior; but when being more technical we treat all forms of human action as acts-in-context, that is, as behavior in a psychological sense.

Context is a term used for the changeable stream of events that can exert an organizing influence on behavior. *Context* is not a code word for objects or things. It is a functional term. Context includes both history and situations as they relate to behavior. Since the organizing unit in contextual behavioral science is the act-in-context, it makes sense that *behavior* and *context* would be defined in terms of each other. To use the older but more precise behavioral language, it is not possible to have a response without stimulation or stimulation without a response. If a bell is rung but not heard, then the bell is not a stimulus in psychological terms—no matter what the decibel meter might read.

Pragmatic Truth: Practical Workability

In all forms of contextualism and in ACT, what is true is what works. Truth of this sort is always local and pragmatic. *Your* truth may not be *mine* if we have different goals. From this pragmatic point of view, the importance of a single consistent way of thinking about a situation begins to drift away. If what is important is not "truth" conceived abstractly as close correspondence between statements and reality—but rather getting things done—and if different ways of thinking or speaking have different consequences, then what is best will vary, depending on the context. Cognitive flexibility guided by workability, not just by the social demand for consistency, becomes far more important than getting the one true answer, whatever *that* is.

Seeing knowledge as intensely practical and not a matter of "truth" can seem strange until we link that idea back to more practical situations. Consider, for example, two different renderings of a building: one is an artistic drawing of the building in perspective, and the other is a blueprint of the building. Which is the "true drawing" of the building? Both are "representations," and the contextual approach would hold that there

is no "true drawing" in any objective sense. The truer drawing could be determined only in the context of the specific goals or purposes that apply. If one needed a drawing in order to identify the building while walking down a street, the perspective drawing would be the more useful and thus "truer"—in the sense that it is true for this purpose. Alternatively, if we wanted to know how to safely remodel the building, the blueprint would probably be a truer representation. Everyday language includes this sense of "true"—it is not entirely foreign. For example, when we say that an arrow was shot "straight and true," we mean that it was shot in a way that led to its hitting the target.

When the criterion for clinical success is workability toward the goal of "prediction and influence of psychological events with precision, scope, and depth," then we must have analyses that start with the changeable context of behavior. That is where practitioners are, that is, they are part of the context of behavior they wish to change. To significantly influence the client's actions, practitioners must be able to manipulate context, as it is never possible to manipulate someone else's actions directly (Hayes & Brownstein, 1986). B. F. Skinner expressed it this way: "In practice, all these ways of changing a man's mind reduce to manipulating his environment, verbal or otherwise" (1969, p. 239). If psychological principles start at this juncture, they can have direct relevance because they can help inform change agents about what to do. Contextual behavioral principles thus all have this quality: they are functional relations between changeable contextual features and the behavior they are integrated with.

The pragmatic view of truth is reflected at every level in ACT. ACT places great emphasis on specifying values at the individual level. When truth is defined by what works, the broader values and goals of the client assume paramount importance. All therapeutic interactions are evaluated as they relate to the client's chosen values and goals, and the issue is always workability—that is, whether they work in practice—not objective truth. Without values and goals being clearly specified, there is no way to assess what is functionally true or false.

ACT developers recognize this need for goals in their own work; that is why the goals of functional contextualism have been so clearly specified. The same bias is true of the client and the work of the practitioner serving the client. Prediction-and-influence of psychological events must necessarily be closely attuned to the client's values and goals to make any sense at all. This approach essentially places functional contextualism and its idea of truth firmly in the camp of multilevel evolutionary science (Wilson, 2007). Evolutionary thinking applies not just to biological genes but also to epigenetic processes, behavioral processes, and symbolic process within and across the lifetime of an individual (Jablonka & Lamb, 2005; Wilson,

Hayes, Biglan, & Embry, 2011). Human beings are evolving behavioral systems. At the level of contingencies of reinforcement and verbal meaning the selection criterion for that evolution should be very largely whatever the client cares most about.

As we have shown, the four major philosophical characteristics of functional contextualism described so far (the whole event, context, truth, and goals) are not empty abstractions when it comes to actual therapy; rather, *these assumptions are at the heart of ACT.* There is one more key feature of functional contextualism we want to emphasize. Superficially it is the strangest, but it can be transformative for clinicians and clients alike. In a deep sense it is why a focus on the philosophy of science underlying ACT is given such emphasis by ACT therapists and researchers.

Letting Go of Ontology, One Day at a Time

The pragmatic truth criterion carries with it certain epistemological consequences, that is, it determines how we justify our beliefs. In functional contextualism beliefs are justified based on the utility of holding them—where utility can be broadly construed, reflecting even one's whole lifetime or that of the species. Unlike correspondence theories of truth, the pragmatic truth criterion contains no element of ontology. It will not and cannot lead to claims about the nature of existence or reality as such. Pragmatically speaking, when we say a statement is "true," we mean that it facilitates the desired consequences (i.e., the epistemological requirement is satisfied). It adds *nothing* to those experienced consequences to then say "and the *reason* this works is because our views match what is exists or is real." For a pragmatist, such an ontological claim would be empty—a kind of intellectual posturing—and for a pragmatist, if it adds nothing, it *is* nothing. Thus, the functional contextualist simply has nothing to say about ontology, one way or the other.

If there is a single shift in perspective that supports learning and applying ACT, it is this: letting go of the ontological assumptions ingrained in the commonsense conception of language and cognition. That orphaning of ontology is part of why ACT is challenging, but it is also part of why it can be transformational.

Commonsense experience makes letting go of ontology difficult. The human mind objects, saying, "Parts are real, and they go together to create complexity. After all, there is a moon, a sun, and the earth. They are real." Contextualists assume only one world—the world we live in. It is fine to call it real if you want (contextualists are not idealists), but partitioning it into categories is a discrete action. That process of dividing up the world is put on steroids once human language gets involved, as we

discuss in greater detail later in this chapter. Some ways of dividing up the world work better than others—the consequences that arise from doing so are *not* necessarily arbitrary—but there may be many practical ways to go about the task.

Consider the claim "There is a moon, a sun, and the earth. They are real. They exist." In most ordinary contexts, it makes sense to call the sun the sun and to treat it as a *thing*, an object with spatiotemporal dimensions. But it is helpful at times for even *this* viewpoint to be held lightly. After all, where does the sun "truly" begin and end? Is the heat from the sun that falls on your face a portion of the sun? Is its gravitational pull on you also part of the sun? Where in the universe is the sun *not* existent? Isn't it a bit of an illusion to pull out cosmic scissors and snip around the yellow orb we see, name the "it" that we partitioned from the whole, and then conveniently forget about the scissors we ourselves wielded? If we sensed only heat, would we divide the world in the same way? What if we sensed only electrical charges or gravity?

Such philosophical ponderings echo throughout this volume, and learning to let go of ontological conclusions is a powerful ally in connecting with ACT. ACT focuses on the process of thinking, itself, so both clinicians and clients are urged to reassess thought as it unfolds and examine its practical workability in any given situation. Looking at thought from the point of view of workability instead of literal truth places thought into an alternative social/verbal context—one in which health, vitality, and purpose can more readily play central roles.

Letting go of ontological claims (and most especially any sense of essentialism) allows the ACT therapist greater flexibility in working with clients on their own terms without having to take on such pointless challenges as seeking to prove their unhelpful thoughts to be incorrect or untrue. Ontological claims made by a client or a therapist simply hold no interest. As a result, we have less need to struggle over who is "right," and instead we can proceed directly to what the client's experience says about what works. ACT is a-ontological, not anti-ontological. We are *not* saying that the world is not real, or that things don't exist. We are merely trying to treat *all* language (even about ACT and its assumptions) as acts in context so that we can take responsibility for our own cognitive actions and broaden behavioral flexibility so that workable practices can be selected based on the relationships of actions and outcomes that we experience.

This discussion may seem odd until the reader better understands the principles of ACT. We do not expect this section itself to do the work needed. But it makes the point that this book is not just trying to teach another technique but rather is about learning a new mode of mind based on radically pragmatic assumptions. That new mode of mind will not be

readily stuffed into a clinical bag of tricks where it can rest safely, as it tends to alter too many basic ideas about living.

The Fit between Functional Contextualism and the Clinical Agenda

Most clinicians want an analysis that does the following:

1. It explains why people are suffering,
2. It allows us to predict what people with particular psychological problems will do,
3. It tells us how to change the course of events so that this particular person with this particular psychological problem can achieve a better outcome.

These three goals (interpretation, prediction, and influence) are the clinician's *natural analytic agenda*. Clients, too, want these things from the professionals who counsel them. The individual client coming into psychotherapy usually wants to know, "Why am I like this, and what can I do about it?" Thus, clinicians have a natural need to interpret, predict, and influence psychological problems. Practical circumstance forces them to embrace certain analytical values.

These values are identical to those embraced by functional contextualists. For the functional contextualist, influence is not an afterthought or merely an applied extension of basic knowledge; rather, it is a metric for both applied and basic psychology. Thus, the practical concerns of the clinician are no longer totally divorced from the analytical concerns and assumptions of the researcher, even the basic researcher. This blending of concerns is one reason why developers of ACT now move so seamlessly from extremely basic research about such arcane matters as "What is a word?" to such extremely practical considerations as how best to sequence specific techniques in ACT. The changeable events that are involved in each investigation potentially apply to the full panoply of ACT methods and techniques.

Moving from Philosophy to Theory to Therapy

The a-ontological stance and heavy contextual emphasis of functional contextualism casts a new light on old issues. For example, suppose a client says, "I can't leave my home, or I will have a panic attack!" An elemental realist might wonder why the person is panicky, or how the person's panic can be alleviated, or whether the person's statement is credible or merely an overstatement. Functional contextualism suggests many other options. For example, the clinician might:

1. Think of this statement as a doing—as itself an action—and examine the context in which the client would say such a thing (e.g., "Is there something you hope will happen by telling me that thought?").
2. Note the demarcation of the world into units (leave home = panic) without ascribing reality status to the events described or to their supposed causal link (e.g., "That is an interesting thought").
3. Look for environmental contexts in which "panic" is functionally related to incapacity, with a view toward altering these contexts rather than necessarily trying to alter the panic itself (e.g., "Hmmm. Let's do this and see what happens. Say out loud, 'I can't stand up or I will have a panic attack,' and then while doing that, slowly stand up").
4. Look for environmental contexts in which "panic" is *not* functionally related to incapacity, with a view toward strengthening these contexts (e.g., "And have you ever had that thought and still left home? Tell me about those times").

   Or

5. See this statement as a part of multiple strands of action, and thus look for strands in which this same statement can be integrated into a positive process (e.g., "If a young child you loved very much told you she could not leave the house, what would you do?").

In other words, instead of entering immediately into the content of the client's thoughts, statements, and ideas, a functional contextualist views the act and its context and then harnesses functional analysis to the pragmatic goals of the clinician and client.

The contextual commitment of ACT extends to examination of the impact of thoughts or emotions on other actions. This philosophical cornerstone of ACT distinguishes it from many other therapeutic approaches. Rather than emphasizing only change in the *form* of private experience because these forms are presumed to be causal, ACT therapists emphasize changing the *functions* of private experiences. They alter the functions by changing the contexts in which certain types of activity (e.g., thoughts and feelings) are usually related to other forms (e.g., overt actions).

ACT seeks to implement treatment methods that are clear extensions of well-established behavioral principles, that is, principles about the normal actions of whole organisms. Exclusive reliance on behavioral principles (in the broadest sense of "behavior") is hardly a new idea. The entire field of applied behavior analysis is based on it, as was behavior therapy, which originally was defined as therapy based on "operationally defined learning theory and conformity to well established experimental paradigms"

(Franks & Wilson, 1974, p. 7). The set of behavioral principles has merely been augmented in ACT to include a contemporary behavioral account of cognition, specifically, relational frame theory. To that topic we now turn.

THE VIEW OF COGNITION UNDERLYING ACT: RELATIONAL FRAME THEORY

Emphasizing the importance of human language and cognition is not unique to ACT. The past century has witnessed the emergence of a number of schools of philosophy and psychology that focus on language as key to understanding human activity and the world that surrounds us (e.g., ordinary language philosophy, logical positivism, analytic philosophy, narrative psychology, psycholinguistics, and many others). While many of these approaches are quite interesting, their analyses are often not of obvious practical relevance. ACT is connected to a basic science account called relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). RFT is a functional contextual theory of human language and cognition that, for at least the past decade, has been one of the most active areas of basic behavior analytic research on human behavior. Because of its focus on changeable contexts, RFT is readily linked to practical concerns.

RFT aspires to provide a comprehensive psychological account of language and higher cognition by undertaking to explain some of our species' evolutionary success and seeking understanding of the cognitive roots of both human achievement and human suffering. RFT is a broad research program, with various books published on its essential aspects (Hayes et al., 2001) and how to apply it in clinical domains—not just in ACT, but in psychotherapy more generally (Törneke, 2010)—or in applied domains outside of clinical psychology, such as special education (Rehfeldt & Barnes-Holmes, 2009). The RFT research program is so vast that we will describe only those basic RFT processes that are needed to understand ACT. Before turning our attention to RFT, however, let's consider a bit of background.

Unlike many groups doing basic scientific research on language, ACT proponents' interest in the basic analysis of verbal behavior stems directly from an allied interest in both psychological well-being and applied work. We began with questions about how it might be that a conversation between a client and a therapist could possibly lead to pervasive changes in the client's life, and we became increasingly interested in experimental analyses of fundamental questions about human language. Thus, we started our basic research program with an attempt to understand an aspect of language pragmatics, that is, how verbal rules guide human behavior. We ended up with an analysis of the nature of human language itself.

At one time all behavior therapists were routinely taught such behavioral principles as discriminative control, respondent conditioning, and reinforcement. Then this curriculum largely fell away in most places where applied professionals were trained. It fell away in part because during the late 1970s the cognitive behavioral tradition abandoned the requirement that treatment be based on learning principles demonstrated in the lab. Instead, clients began being asked about their thinking, and their thoughts and cognitive styles were organized into various clinical theories of cognition. In some ways, that was the right choice at the time. Behavioral principles circa 1975 did not have an adequate way to deal with the problem of cognition. Unfortunately, basic cognitive science moved further from clinical concerns as the key emphasis turned toward relationships among mental events and ultimately to brain–behavior relationships—rather than the effects of changeable historical and contextual factors on cognitions and actions, and their various interrelationships. Thus, basic neurocognitive science simply could not authoritatively tell clinicians what to do (the later emergence of the "massive modularity" of evolutionary psychology shared the same weakness in practice). Clinical theories of cognition were seemingly the best alternative available.

We agreed with the need to change course but were suspicious of the long-term viability of a clinical model of cognition as an underlying theory. We conducted nearly a dozen studies during the late 1970s and early 1980s testing traditional cognitive models, none of which were supportive (for a single good example, see Rosenfarb & Hayes, 1984). As a result, we began to focus more and more on finding a new way of conducting a behavioral analysis of language and cognition (e.g., see Hayes, 1989b, for a book-length summary of that early work). These processes became the foundation for the early versions of ACT. When we found in small studies that ACT worked well (e.g., Zettle & Hayes, 1986), we took the research program in an unusual direction. Because our goal was not merely another manualized treatment but instead a process-oriented comprehensive model, we focused on the further development of a behavioral account of human cognition and language—and how that might relate to clinically relevant behaviors—and essentially stopped doing outcome studies altogether. This basic detour consumed nearly 15 years, but it led to RFT, which we now believe is a reasonably adequate approach.

In what follows, we begin with an account of what differentiates verbal and cognitive events from other psychological acts, extend that perspective to what verbal rules are, and then return to the subject of therapy. We use minimal referencing because detailed book-length treatments are available and our purposes here are highly practical. Throughout, we try to telegraph the clinical importance of these processes, and at the conclusion

of this chapter we summarize what we believe are the core implications of RFT for clinical practice and applied domains.

A Beginning Approach to Verbal and Cognitive Events

Virtually any definition of language and cognition quickly arrives at the idea that these domains involve systems of symbols, but what symbols are and how they came to be often remain hazy (e.g., see Jablonka & Lamb, 2005). If one seeks a bottom-up, process-oriented account of psychological functioning, that well-worn path is unlikely to add anything to the more clinical theories of cognition that already exist. This dilemma is precisely the issue over which general process learning theory foundered. Skinner, for example, defined a verbal stimulus merely as the product of verbal behavior, and verbal behavior was defined in a way that could not distinguish it from any animal operant behavior. Neither idea seemed progressive and as a result psychologists looked elsewhere (see Hayes et al., 2001, pp. 11–15, for an extended analysis of this point).

RFT begins with an extraordinary finding in behavioral psychology and posits a process account that expands that finding into all of language and cognition. Think of a triangle with a point facing upward (see Figure 2.1). Mentally place a different object at each of the three points—for example, a ball at the top point, a hammer at bottom left, and a leaf at

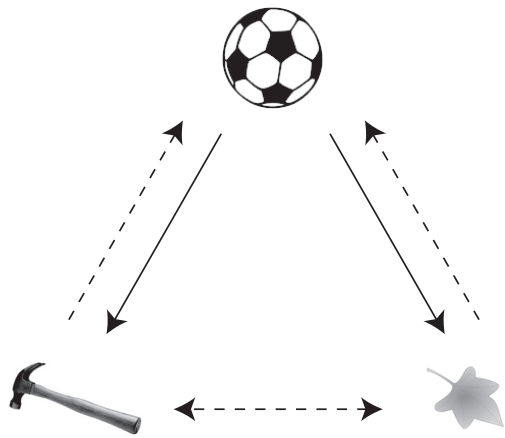

FIGURE 2.1. If a normal person learns to pick a hammer from an array of objects, given a ball as a sample; if he or she then picks a leaf from an array of objects, given the ball; the derived relations shown in dotted lines will likely be deduced by the respondent.

bottom right. Suppose that when shown the ball you had to learn to point to the hammer among a set of other objects; later on, when shown the ball, you were taught to point to a leaf and not to the other items. You have learned two "relations" (top → lower left; top → lower right). In more abstract terms, you learned two sides of the triangle, each in one direction. With only this training, if you were shown the hammer or leaf and had to pick either a ball or a donut, you would likely pick the ball. If you were then shown the leaf and had to pick either a hammer or a toy car, you'd pick the hammer, and vice versa. You would *derive* four relations you had not been taught (lower right → top; lower left → top; lower left → lower right; lower right → lower left). You would now know all sides of the triangle in all directions.

Behavior analysts call this result, which was identified some 40 years ago and has roots extending back far beyond that, a "stimulus equivalence class" (Sidman, 1971). Once can apply this graphic example to a simple linguistic situation. A normal child is first taught to relate a particular written word to an oral name and then the same written word to a type of object. Given these two trained relations, all the other relations among this specific triangle of objects will likely emerge without further training. The untrained relations are what is meant by *derived stimulus relations*. For example, without explicit training in this specific case, the child will be able to say the name of the object. This is part of what we mean when we say that a child "understands" what a given word means. We can now be a bit more precise about the nature of a verbal stimulus: it has its effects because of the derived relations between it and other things.

What makes stimulus equivalence *clinically* relevant is that functions given to one member of an equivalence class tend to transfer to other members. Let us consider a simple example that extends this result to a more common language situation that might have clinical consequences (as depicted in Figure 2.2). Suppose a child who has never before seen or played with a cat learns that the letters C-A-T apply to these furry mammals and not others, and that the letters C-A-T are vocalized as "cat" (rather than "dog" or any other sound). Suppose next that the child is scratched while playing with a cat. The child cries and runs away. Later the child hears her mother saying "Oh, look! A cat!" Again, the child cries and runs away. This occurrence might seem surprising because the child had never been taught to fear the sound "cat." The same training history applied to a nonhuman would be highly unlikely to yield the same result. Fear of the cat is now elicited by an oral name, but the function of the oral name in this case is *derived*. Well-controlled studies have shown that the transfer of directly conditioned fear from cats to the oral name occur only if the child derives relations that were not directly trained. In other words, it is not enough for the child just to learn object → written word and written word

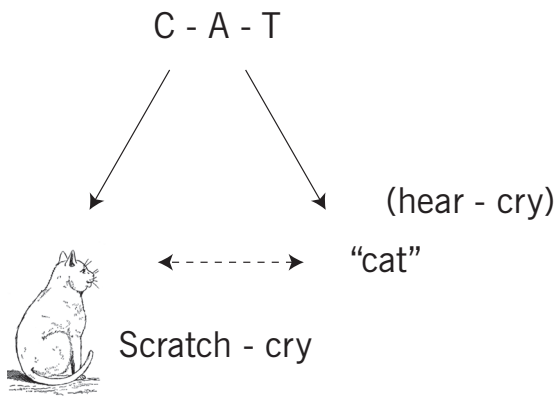

FIGURE 2.2. The child has learned the C - A - T → furry mammal relation and the C - A - T → oral name relation directly. Later the child is scratched by a cat and cries. Because the child derived a relation between the furry mammal and "cat," the new function transfers to other events in the relational network, and subsequently the child cries upon hearing the name even though there was no a history of aversive events occurring directly with regard to the name.

→ oral name. After all, many nonhuman animals could readily learn the same thing and would not show this effect. The child also has to *derive* the relations written word → object, oral name → written word, object → oral name, and oral name → object. That triangle needs to be formed. Only then will the functions of being scratched (i.e., fear and avoidance) transfer from the cat to the oral name.

These kinds of outcomes cannot be adequately explained by the simple and familiar processes of generalization that are built into contingency learning. If a baby learns to reach for an orange flap because there is food behind it and yet avoid a blue one because touching it sets off a noisy blare, the baby will probably be willing to approach a yellow one too, just a little more cautiously. Similarly, the baby will tend to avoid not just the blue flap but also a green one, though perhaps less emphatically. The baby's responses to orange and blue flaps were established through direct training. The observed responses to the yellow and green ones occur because humans and other animals with well-developed visual systems evolved in environments where orange coloration is closer to yellow than green and in which blue coloration is closer to green than to yellow. Such *stimulus generalization gradients* are based on formal similarity.

Such is not the case with stimulus equivalence. A child who cries upon hearing "Oh, look! A cat!" is not showing stimulus generalization in a formal sense because there is nothing about those sounds that is similar to

the actual animals. Likewise, simple principles of higher-order associative conditioning cannot readily account for the robustness of stimulus equivalence because one needs to appeal to backward conditioning and other procedures whose effects are far too weak to model these results. Indeed, that is precisely why associative verbal learning never provided a fully successful account of human language and cognition.

Even without explaining why stimulus equivalence happens or extending the finding to many other relations (both of which RFT attempts to do), this remarkable behavioral performance opens up new ways of thinking about behavior. For example, imagine a person suffering from agoraphobia having an initial panic attack while "trapped" in a shopping mall. Talk of a mall will now elicit fear—identical to the case of the scratched child—but so too will other events related to being "trapped." The range of things you can be "trapped in" is so broad as to defy a simple description based on formal properties, conceivably including an open field, a bridge, a marital relationship, talking on the phone, watching a movie, having a job, or even being inside your skin. All can now be a source of panic (if one is so inclined).

There is a vast literature on stimulus equivalence, but it is not enough to build a full theory of language around it, as even its originators have noted (e.g., Sidman, 2008, p. 331). Furthermore, stimulus equivalence is merely an outcome, not a process. RFT describes these kinds of relations in a general way and gives a process account of them. The process that RFT posits as giving rise to stimulus equivalence could readily apply to *any* type of relation among events. When the many other kinds of stimulus relations are added—different, opposite, hierarchical, sequential, causal, and so on—a single basic process can give rise to a vast array of cognitive abilities, and a general learning process account of cognition becomes possible. From the perspective of RFT, what links the kinds of situations in which a person may have a panic attack is not just their formal properties in a simple sense but rather the verbal or cognitive aspects of these situations.

Relational Frames

According to RFT, the essential core of language and higher cognition is the ability to learn and apply "relational frames." Relational framing is learned behavior that shows three main properties under arbitrary contextual control, namely, mutual entailment, combinatorial entailment, and transformation of the stimulus function.

Mutual entailment means that a relation learned in one direction also entails another in the opposite direction. If a person learns in a particular context that *A* relates in a particular way to *B*, then this entails some kind

of relation between *B* and *A* in that context. For example, if a person is taught that moist is the same as wet, that person will derive that wet is the same as moist. If a person learns that Sam is taller than Fred, he or she will also understand that Fred is shorter than Sam.

Combinatorial entailment means that mutual relations can combine. If a person learns in a particular context that *A* relates in a particular way to *B*, and *B* relates in a particular way to *C*, this arrangement also entails a relation between *A* and *C* in that context. For example, if a person is taught in a given context that Mike is stronger than Steve and Kara is stronger than Mike, the person will derive that Kara is stronger than Steve.

Finally, the functions of events in relational networks of this kind can be transformed in terms of the underlying relations. If you need help moving a heavy appliance and you know Mike is good at this, you will derive (given the information provided above) that Steve will be less useful and Kara will be more useful without necessarily being taught anything new about Steve or Kara.

RFT asserts that such qualities as these are features of an abstracted response frame that is initially acquired and brought under the control of arbitrary contextual features through reinforcement of approximations in multiple exemplar training. We are exposed to many examples that relate events in a particular way (e.g., "____ > ____"), usually initially based on their formal properties (e.g., an elephant is larger than a mouse; Dad is larger than Mom; a nickel is larger than a dime). As the particular kind of relating (such as comparison of size) is abstracted from multiple exemplars, it comes under the control of arbitrary relational cues such as "_____ is larger than _____." As that happens, anything can be put into the empty slots, given only the relational cues to do so, and the mutual and combinatorial relations will be derived.

Most parents have witnessed this process firsthand. In many countries some coins that are small in value are large in size. A nickel is quite a bit larger than a dime; a half-euro is larger than a euro. Any parent knows that when young children first learn that coins are valuable they usually prefer a nickel over a dime. That makes sense because children have learned a nonarbitrary comparative relation, that is, the nickel is physically larger. Most complex organisms can learn nonarbitrary relations (e.g., those defined by the formal properties of the related events), not just people. But at around age 4 or 5, children demonstrate a new skill set. They begin to prefer a dime over a nickel as they learn an *arbitrarily applicable* version of "larger than" that is no longer bound by the physical properties of the two items. A dime can actually be "bigger" in value than a nickel. Once learned in a general way, a child can be told "this is larger than that" and the other relational responses can be derived, no matter what the specific entities

may be. Once told that the sun is larger than the earth, even a child will derive the additional information that the earth is smaller than the sun, regardless of its appearance.

Naming is perhaps the simplest example of relational framing—it is the action that directly corresponds to stimulus equivalence, and it occurs first in language training. RFT calls this a "frame of coordination." A child is exposed to thousands of naming examples. If mother is "Mama," then pointing at her when one hears "Where's Mama?" is likely to bring approval from the nearby adults. Similarly if "dog" is D-O-G, then when D-O-G is read as "dog," approval is likely. In other words, learning a verbal relation in one direction predicts reinforcement for responding in the other direction. This type of sequence is how RFT hypothesizes that relational framing is actually carried out, that is, as a large set of multiple exemplars in natural language learning (see Moerk, 1990).

Once mutual entailment is robust, combinatorial entailment may occur fairly readily with simple forms of framing. For example, if the substance milk is "leite" in Portuguese and "milk" in English, then "milk" and "leite" may be readily related as synonyms. Initially, this correspondence may require direct training, but since some of the properties of actual milk (e.g., its taste, its physical appearance) may be readily observable by mutual entailment for both "milk" and "leite," combinatorial entailment may occur relatively easy.

The transformation of stimulus functions is implicit in all derived relations (the child may be able to see or taste "milk" upon hearing the word), but further training may bring it under tighter contextual control (a key area of applied implications, as we will see shortly). For example, we can focus on the color of milk and not its taste, or its taste and not its color, provided the right cues. The cues that control the transformation of stimulus functions (e.g., *taste* milk) are different than those controlling the type of relation (e.g., leite *is* milk). This finding is key to ACT, as we will describe shortly.

From the perspective of RFT, relational framing is the defining core feature of language and higher cognition. *An event that has effects because it participates in a relational frame is a verbal stimulus* (a "symbol"). Readers need to keep in mind, from here on out, that when we use the term *verbal* we do not necessarily mean words and when we use the term *cognition* we do not necessarily mean thoughts that occur in the form of words. When we say "verbal" or "cognitive," we mean "via training resulting in derived relations." Gestures, pictures, images, dancing, music—in some contexts, these can all be "verbal" or "cognitive" in this relational sense even without words playing a direct role.

RFT researchers have shown that training is required in relational framing skills for derived relations to occur (e.g., Barnes-Holmes, Barnes-

Holmes, Smeets, Strand, & Friman, 2004), including training in infancy (e.g., Luciano, Gómez-Becerra, & Rodriguez-Valverde, 2007). In a recent study (Berens & Hayes, 2007), we took young children and gave them many examples of arbitrary comparative relations. "This one is bigger than that one," we said, pointing at paper "coins" of various sizes. "Which one would you use to buy candy?" As the children received feedback, they gradually learned. They learned to derive a mutual comparative relation—if this was bigger than that, then that was smaller than this. They could then apply that knowledge to any set of defined related "coins" without additional training. As they learned to combine these comparative relations, they preferred the "large" ones to buy candy over the "small" ones. Every child in the study showed that this training generalized not just to new "coins" but also to new networks. For example, a child might learn to combine "This is bigger than that, but that is smaller than this other one over here" without any explicit training on that specific kind of network but only training in the comparative relational frame with other specific kinds of networks.

This finding can be made more obviously clinically relevant by linking it to research showing that comparative relational frames can alter all other behavioral processes. Dougher, Hamilton, Fink, and Harrington (2007) taught some adults and not others that the relationship between three arbitrary symbols on a computer screen was A < B < C. All participants then learned to press a bar at a certain rate when B was presented. Those who had not learned the symbols' relationships slowed down when A and C showed up. Those who had learned the arbitrary relationships also slowed down when A showed up, but they worked faster when C showed up. Their behavior reflected the derived relation that C is greater than B. At another point in the study, participants were shocked repeatedly when B was presented until they became quite aroused and fearful (as measured by a galvanic skin response) whenever B appeared. Those who had not learned the relationships showed little arousal when either A or C showed up. Those who had learned A < B < C also showed minimal arousal to A, but when C showed up they were far *more* fearful than they were when B itself was presented. Some participants even shouted out loud and ripped the wires from their arm—not because they had been shocked, but because that dreadful C stimulus had appeared. These participants had *never* been shocked in the presence of the C stimulus; yet, they were acting as if it is was far worse than a stimulus that had actually been paired over and over again with moderately painful shocks merely because C was arbitrarily said to be "greater than B."

Even such a simple example as this begins to link relational framing to clinical matters. If a nickel can be "smaller" than a dime—which it most certainly is not, except in an arbitrary sense—what is to prevent "great

success" from being small in comparison to an ideal? Many years ago, while struggling with a panic disorder, one of us (SCH) had an intense panic attack while giving a talk to three nurses, even though a week earlier he had given a talk to hundreds of people with far less difficulty. It would seem less surprising if you knew that the panic in the small crowd was viewed as "far more insane"—and thus far more threatening—than the anxiety in the large crowd, just as the participants in the study above showed *more* fear toward a situation that had previously been benign than toward one that had been directly paired with shock—merely because it was said to be "greater than" the latter. Relational framing is *arbitrarily applicable*, so there is nothing in the world of formal properties (e.g., the actual size of the crowd) to prevent these kinds of outcomes from occurring, despite the suffering they may cause.

To show what we mean by "arbitrarily applicable," think of two concrete objects. Mentally label them as *A* and *B*. Now, pick a number between 1 and 4. If you've done so, you can be told that the number indicates a relational phrase: 1 means "better than," 2 means "the father of," 3 means "unlike," and 4 means "similar to." Now answer this question: "How is *A* # *B*?" That is, "How is (say the name of the *A* object, followed by the relational phrase you chose by the number you picked, in turn followed by the name of object *B*)?

It may be an odd question, and you are very unlikely to have heard it before. Yet, in a few seconds you will come up with an answer. Very often, if you are clever, the answer will seem apt—sometimes so much so that the relation seems to be "in the objects," only waiting to be noticed. That has to be an illusion to a degree, since it does not matter what the objects or relations are for this effect to occur, and it cannot be that everything is related to everything else in all possible ways in a formal sense. There is a more plausible explanation, namely, that relations of this kind are arbitrarily applicable. Because of that property of human language and cognition, *we* can relate everything to everything else in all possible ways.

RFT can provide a robust model for any cognitive intervention strategy (Törneke, 2010), but so far this discussion of RFT has said little about ACT per se. For the connection to emerge more clearly, we need to return to a key feature of RFT, contextual control.

The Role of Contextual Features

RFT researchers have discovered that relational frames are regulated by two distinguishable contextual features: the relational context and the functional context. The relational context determines how and when events are related; the functional context determines what functions will be transformed in terms of a relational network. For example, in the sentence

"Sarah is smarter than Sam" the words *is smarter than* likely function for most readers to establish a relational context of comparison between Sarah and Sam. In the sentence "Imagine the taste of sour milk" the words *imagine the taste of* are likely to serve as a functional context that activates the perceptual experiences of sour milk, based on a frame of coordination between sour milk and written or spoken names.

The existence of two distinguishable forms of contextual control leads to important clinical implications, and ACT takes full advantage of them. Most verbally oriented therapy interventions are manipulations of the relational context. This type of manipulation is fine when information is needed by the client or when these manipulations are properly linked to efforts to create more cognitive response flexibility, such as with some forms of cognitive reappraisal. However, manipulating the relational context has major limitations in many other common situations. Since relational frames are learned and arbitrarily applicable, it is impossible to control the relational context so thoroughly as to keep unhelpful relations from being derived. For example, myriad cues can lead children to derive that they are not as attractive, lovable, intelligent, or worthwhile as they might be. Generally speaking, you can't save children from fears of inadequacy by making sure they never think they are inadequate. Dumping excessive praise on them, however well meaning, may create more harm than good. Furthermore, as with all learning, once relating occurs, it can be inhibited but it can never be fully unlearned. There is no process called "unlearning." Once a child derives "I am unlovable," that impression will *always* be ingrained in the individual, at least to some degree. Even if the impression diminishes to nearly zero strength, it will be more readily relearned, perhaps decades later.

The persistence of memory is why it is so hard to restructure cognitive networks efficiently. It is easy to add to networks—and ACT certainly does that in many areas—but it is hard to avoid unhelpful relations from being derived, and it is not possible to obliterate such thinking entirely from our mental history.

The functional context determines the *impact* of relational responding, however, and that, fortunately, is far easier to regulate in most cases. This is an idea that is put to good use in ACT. In imagination one can easily taste an orange … but we could also taste an ooooooooooo rrrrrrrrrrr aaaaaaaaaa nnnnnnnn gggggggggg eeeeeeeee … or taste an orange, orange, orange, orange, orange, orange, orange, orange, orange, orange, orange, orange, orange … or taste an "orange"—*said in the voice of Donald Duck*—or … taste one while singing "Home, home on the o-range." The psychological impact of these oddball variations are different than "taste an orange" and indeed these are all examples of defusion interventions that could be used in ACT.

It is not just that being aware of the distinction between a relational and functional context can create ideas for new clinical interventions. RFT also helps us see that if we are not careful the focus on a relational context can unintentionally modify the functional context in an unhelpful way. Consider, for example, a person struggling with psychotic processes who is asked to look at the rationality of a thought in order to better test whether it is real. This request amounts to a relational context intervention. The hope is that this intervention might alter the form of the person's verbal/cognitive networks (e.g., "No, I am not being chased by the Mafia—I'm a homeless person in Philadelphia"). This intervention could be helpful, but it could also make the thought more important and central, perhaps even causing it to impact behavior more, not less. Furthermore, since relational frames are bidirectional, if the rational thought is framed in opposition to the irrational one, it can evoke the relation in the opposite direction ("I'm a homeless person in Philadelphia—but then why is the Mafia chasing me?"). RFT suggests that any effort to change thinking is a double-edged sword and may be dangerous when put in the service of not thinking something, thinking less of something, or thinking only in one way. What is logically helpful is not necessarily the same as what is psychologically helpful.

We know from experience that some readers will challenge these ideas on the grounds that if they were correct some of traditional cognitive-behavioral therapy (CBT) would be harmful, not helpful, owing to its frequent inclusion of cognitive challenging. It is a fair point, but CBT is a large package, much of which is behavioral and much of which makes very good empirical sense. Furthermore, even some cognitive features of CBT (e.g., efforts to encourage cognitive flexibility, which are sometimes done in cognitive reappraisal interventions) make good sense from an RFT perspective. When the key element of cognitive challenging is focused on in component studies, however, it is *not* typically helpful (e.g., Jacobson et al., 1996; see Longmore & Worrell, 2007, for a meta-analysis) and indeed appears to be harmful for some subtypes of clients (e.g., Haeffel, 2010).

From a contextual behavioral point of view, most talking therapies are relational context interventions. Relational context interventions may elaborate, broaden, or interconnect relational networks, but they cannot eliminate previously learned cognitive relations. Elaboration is particularly useful when an existing relational network does not contain key relations, such as when a psychoeducational intervention is needed or when the person needs to learn how to generate additional response alternatives in order to be more cognitively flexible. ACT interventions often involve psychoeducational information about core ACT concepts, with the goal of elaborating a deficient or narrow relational network, and cognitive flexibility interventions are a regular ACT staple. For example, telling experientially

avoidant clients in the initial therapy session about their expected pattern of avoidance (or even drop out) once things get emotionally difficult can help maintain their engagement; pointing out how thought-suppression exercises can help reduce their unhealthy attachment to avoidant forms of coping. The caveat is that even technically correct psychoeducational and flexibility interventions can have unintended eliminative and avoidant functions (e.g., "If I can just understand this more thoroughly, then the problem will go away"), so special care must be exercised.

The realization that therapy is unlikely to help the client unlearn specific cognitions should not be turned into the idea that you, the clinician, should never try to change the clients' cognitions. Therapists can readily elaborate cognition, make it more adaptable, and indeed make it less likely to occur (ironically, one of the best ways to do that is just to find ways to treat certain thoughts as less important, which is a common technique in ACT). Many applied RFT research programs are entirely designed to elaborate on improving clients' cognition. RFT is already being used to train language abilities, strengthen problem-solving skills, and establish a stronger sense of self, for example (for a book-length description of such programs, see Rehfeldt & Barnes-Holmes, 2009). ACT contains relational context elements as well, even if it emphasizes interventions focused on a functional rather than purely relational context. For example, if the thought "I'm bad" creates entanglement and produces a negative effect, there is nothing wrong in principle with adding verbal forms to that habitual thought such as "I am having the thoughts that I am bad," or "Am I bad?", or "I am bad … except when I'm not." None of these additions will erase "I'm bad," but they may alter its functional impact by expanding the set of relational responses that occur that are relevant to it.

The Self-Perpetuating Nature of Relational Framing

Although framing is learned operant behavior, the contingencies that control it become so broad that it is very difficult to regulate. In early childhood, language is learned almost entirely through social conditioning. At the same time that language and thought are developing in children, they are learning social rules, mores, and beliefs that reflect contemporary cultural practices. This "social programming" is so entrenched within the language system that it is functionally invisible. Culturally promoted beliefs and practices—even those that are unhelpful—become very difficult for the individual to detect. Furthermore, as we mature throughout childhood, direct social consequences become less important as language is used for sensemaking, problem solving, and storytelling. Coherence and utility are enough to maintain verbal relations once they are established. Detecting that one is deriving coherent and explainable relational networks

(e.g., learning that one is "right" or "making sense") or that relating events is leading to effective outcomes (e.g., learning that one has "solved the problem") and similar processes provide continuous reinforcement for the process of relational framing. As a result, it is very difficult to slow down language and cognition once it is well established. Once language is learned, it is impossible to return fully to the nonverbal world, at least in our sense of the term *verbal*. Furthermore, once we think about things in a particular way, that way of thinking remains irremediably in our relational repertoire, even if it rarely recurs. The more an area has been thought about, the more derived relations are available to maintain and to reestablish a given network if newer practices weaken. This tendency helps explain why cognitive networks are extraordinarily difficult to break up even with direct contradictory training. RFT laboratories have shown that when old thoughts are extinguished they will quickly reemerge if new ways of thinking encounter difficulties (Wilson & Hayes, 1996). RFT labs have developed highly sophisticated new ways to measure cognition implicitly, showing that there are long-lasting and at times pernicious effects of certain types of relational conditioning (e.g., the Implicit Relational Assessment Procedure, or IRAP; Barnes-Holmes, Murphy, Barnes-Holmes, & Stewart, 2010).

These core ideas underlying RFT have received empirical support in a rapidly growing literature encompassing several scores of studies. We know that relational frames develop in infancy (e.g., Lipkens, Hayes, & Hayes, 1993), and they do so because of direct training (e.g., Luciano et al., 2007). Weakness in relational framing is associated with cognitive deficits such as poor problem-solving abilities or lower levels of intelligent behavior (O'Hora, Pelaez, Barnes-Holmes, & Amesty, 2005). Conversely, training in relational framing increases higher-order cognitive skills (e.g., Barnes-Holmes, Barnes-Holmes, & McHugh, 2004; Berens & Hayes, 2007), including IQ (Cassidy, Roche, & Hayes, 2011). The reader interested in delving deeper into this research literature can easily find good book-length reviews of recent developments in RFT (e.g., see Rehfeldt & Barnes-Holmes, 2009; Törneke, 2010).

Rule-Governed Behavior

Relational framing is a key evolutionary advantage of the human species that likely emerged in the context of social cooperation. Verbal stimuli can be combined into elaborate verbal rules that have the capacity to regulate behavior. Rule-governed behavior need not be based on contact reflecting direct consequences vis-à-vis the world; rather, it's largely based on verbal formulations of events and the relationships among them. According to Skinner (1969), rule-governed behavior is behavior that is

governed by the specification of contingencies rather than by direct contact with them. Rule-governed behavior allows human beings to respond in very precise and effective ways in cases where learning through direct experience might be ineffective or even lethal. For example, one would not want to engage in an incremental learning process to learn to avoid high-voltage electrical wires. Similarly, we know from basic experimental work that greatly delayed consequences are usually ineffective with nonhumans. Rule-governed behavior allows humans to respond effectively to enormously delayed consequences such as, "Be nice to your uncle, and in 20 years he will remember you in his will."

These rules are not without cost, however. When behavior is controlled by verbal rules, it tends to be relatively insensitive to changes in the environment that are not described in the rule itself (see Catania, Shimoff, & Matthews, 1989; Hayes, Brownstein, Haas, & Greenway, 1986a; Hayes, Zettle, & Rosenfarb, 1989, for reviews of this literature and Hayes, 1989, for a book-length treatment of this subject). When behavior is guided by verbal rules, humans often track changes in the environment with less precision than do nonhumans. For example, a person told to "push this button rapidly to make points" will be less likely to stop pushing when the points no longer are awarded (e.g., Hayes, Brownstein, Zettle, Rosenfarb, & Korn, 1986b).

This so-called insensitivity effect is important because many forms of clinically significant behavior exemplify this pattern: behaviors (both private and public) persist despite directly experienced negative consequences or their potential. This observation can be better understood by examining why rules are followed. RFT distinguishes between three types of rule following (Barnes-Holmes et al., 2001; Hayes, Zettle, & Rosenfarb, 1989): *pliance*, *tracking*, and *augmenting*.

Pliance (taken from the word *compliance*) involves following a verbal rule based on the history of consequences for the socially monitored correspondence between the rule and prior behavior. For example, a parent tells a child to "wear a coat—it is cold outside." If the child responds based on a history of following rules in order to please or displease the parent (not, in this case, to stay warm), that is pliance. At the clinical level, pliance can occur when the client does something to please the therapist, to look good, or to be right in the eyes of others—but does not really "own" the behavior and its link to personal values. Pliance tends to be relatively rigid, often predominating in people with inflexible behavioral patterns. It is an important form of rule-governed behavior in the development of children because tight contingencies can get rule following to occur; and by adding social consequences for rule following, the contingencies can be tightly linked to behavior. But among adults pliance is vastly overrated as a helpful form of verbal regulation and is often something that must be dealt with directly in therapy.

Tracking is following a verbal rule based on a historical link between such rules and natural contingencies (i.e., those produced by the exact form of the behavior in that particular situation). For example, if the child referenced above puts on a coat to get warm because in the past such rules ("wear a coat—it is cold outside") have accurately described the temperature and predicted the consequences of having or not having a coat, that behavior is based on tracking. Tracking puts the client into direct contact with the impact of behavior. Consequently, tracking produces more flexible forms of behavior than pliance, enabling people to adapt to the environment rather than merely bending to the social consequences of rule following unrelated to direct repercussions. However, because it is so helpful in many contexts, tracking can be overextended to situations that are not readily rule-governed. For example, trying to follow a directive to "be more spontaneous" is likely to lead to confusion. Spontaneity can no more be achieved solely by verbal instruction than can true artistry be achieved by "painting by the numbers."

Augmenting is rule-governed behavior that alters the extent to which some event will function as a consequence. In clinical terms, augmenting provides verbally formulated incentives for the client to behave in a particular way. There are two subtypes. *Formative augmentals* establish new consequences (e.g., Hayes, Kohlenberg, & Hayes, 1991). For example, if hearing the word *good* is reinforcing, then learning that the words *bueno* and *bon* also mean *good* can establish them as reinforcers as well. *Motivative augmentals* alter the strength of an existing functional consequence (e.g., Ju & Hayes, 2008). Advertisers use this form of rule-governed behavior when they try to evoke sensations verbally that their products could produce (e.g., "Aren't you hungry for Burger King now?"; see Ju & Hayes, 2008, for an experimental demonstration of how such advertisements work). Augmenting is a chief source of motivation for adults, and it is important to put it to good use in therapy.

Rule-Governed Behavior and Psychological Rigidity

These rule distinctions have held up fairly well over the past 20 years of laboratory research. The translation of these principles into clinical practice is actually quite direct, and in the following sections we address some of the more important implications.

The Clinical Impact of Pliance

Rule-induced insensitivity correlates fairly highly with undesirable forms of psychological rigidity as a pervasive behavioral pattern (Wulfert, Greenway, Farkas, Hayes, & Dougher, 1994). Pliance is a special source of this

rigidity (Barrett, Deitz, Gaydos, & Quinn, 1987; Hayes, Brownstein, et al., 1986a). The early stages of verbal regulation are typically characterized by social demands from rule givers. "No!" is normally one of the first words learned by children. Pliance of this kind is *intended* to reduce sensitivity to other environmental contingencies—if a parent is teaching a child not to go into the street based solely on the parent's demand, the parent does not wish to have the rule tested (e.g., by the child's going into the street to see what happens).

In adulthood, however, most of the effective behavior that might otherwise rely on pliance generally derives more efficiently from tracking and augmenting (see Sheldon, Ryan, Deci, & Kasser, 2004). Most of us can think of 40- and 50-year-olds who are still rebelling against their parents, even if they are long since dead. Pliance in such a circumstance needlessly narrows behavior and makes it less flexibly related to its natural consequences. Similarly, children may need to learn to show compassion by using parental praise to produce it, but an adult need not be stuck at this level; the adult can demonstrate compassion as an expression of chosen personal values (augmenting) and doing what works best with those values (tracking). The source of such caring may in part be social, but pliance turns human caring itself over to the opinion of others.

The Clinical Impact of Tracking

Tracking can also produce problems when people are following verbal rules that are untestable, not predictive, self-fulfilling, or are applied to situations that can only be contingency-influenced. ACT is skeptical about the broad application of direct cognitive change strategies as well as cautious about how easily healthy cognitive change strategies can be undermined; but there are good reasons at times to have clients test verbal rules and to develop tracks that do a better job of predicting consequences. Unfortunately many of the most pernicious types of rules are extremely difficult to test.

Consider rules that are self-fulfilling. In such cases the natural feedback loop between following a rule and the consequences that result is either absent or misleading. This circumstance can easily produce a strange loop. For example, tracking the rule "I am worthless" often leads to behavior that confirms the rule in a functional sense. If I pretend to be smart because I'm really worthless, praise from others seems empty. After all, I fooled them—and who can trust fools or care about their opinions? The end result is likely to be *continued* feelings of worthlessness despite the signs of objective success.

In areas where behavior needs to be established through direct experience, tests of the usefulness of verbal rules by detecting their consequences

is not enough; rather, they need to be compared to actions that are less rule-governed. We explain how that is accomplished in the chapter on defusion (Chapter 9) later in this volume.

The Clinical Impact of Augmenting

ACT tries to *strengthen* certain types of verbal regulation, including in particular augmenting, which can help behavior come under the control of delayed or probabilistic consequences. For example, ACT is heavily focused on the client's ultimate values. Values are chosen, stated, and clarified for their augmental functions, either formative or motivative. A client can more readily learn new and more effective actions and let go of old and ineffective ones when the larger purpose of doing so is based on the client's values, such as to loving, participating, sharing, or contributing to others. In contrast, escape- and avoidance-focused augmentals such as "Just don't think about your diabetes, and you will feel much better" typically contribute to poor outcomes. In ACT, augmentals linked to value-based outcomes should be strengthened; those linked to process goals (e.g., removing anxiety, increasing self-confidence) should be strengthened or weakened based on their impact on outcome goals (i.e., ones based on workability).

Overextension of Verbal Processes

RFT is a contextual theory, and contexts are the focus of clinical intervention in ACT. Certain contexts are often implicated when verbal or cognitive processes are overextended. The social/verbal community generally uses verbal symbols—events that have their functions because they participate in relational frames—in various contexts of literality. By a "context of literality," we mean social/verbal circumstances in which people are encouraged to interact with verbal stimuli based on their conventional meaning or supposed correspondence to what is "real." This context is central to many of the uses of language—reason giving, storytelling, sensemaking, or problem solving—and it is sometimes useful. When a parent screams "Watch out—a car!" the parent wants the child to jump as if the car is right there—that is, based on the correspondence between an arbitrary sound ("car!") and the imminent arrival of a large machine on wheels. Because problem-solving operations are perhaps the single largest beneficial use of language, we refer to the mode of mind established by these contexts of literality as a "problem-solving mode of mind" (see Segal, Williams, & Teasdale, 2002, for a related point of view).

Very few basic relational frames are needed to facilitate verbal problem solving. Consider an instance of verbal problem solving: "Given situation *X*, if I do *P*, I will get *Q*, which is better than *Y*." Only three types

of relational frames are absolutely needed: frames that coordinate words with events, before and after frames, and comparative frames. A problem-solving mode of mind constantly evaluates the current moment with reference to a goal, and the discrepancy is noted, triggering another round of this type of problem solving.

For an example of the process, suppose you are trying to find a museum in a large city. Say, given where you are, if you immediately turn to the right, you should get there. If instead you make a left turn, you will try to remember where you came from and will cycle repeatedly through the relational process until the discrepancy ("I want to get to the museum, and I'm not there yet") disappears ("I'm there!").

Problem solving is an amazing skill, but it is so pervasive and useful that human beings find it extremely difficult to discern when it is useful and when it is not. A problem-solving mode of mind is restricted, future- and/or past-oriented, sometimes rigid, judgmental, and highly literal. It is restricted because only relational responses that are relevant to the problem are considered legitimate; it is future- and past-oriented because those relational responses are aspects of problem analysis and the evaluation of possible problem solutions; it is sometimes rigid because it can readily address every human problem except the limits of verbal problem solving itself; it is judgmental because comparisons with a goal need to be made; and it is highly literal because symbols are treated as if they are tightly linked to their referents.

The problem with problem solving is that it is a mode of mind that does not know when to stop. It easily becomes overextended. It may crowd out intuition, inspiration, dispassionate description and observation, engagement, appreciation, wonder, emotional intelligence, or any other form of knowing and experiencing that is not temporal or comparative. Evolutionary contingencies (i.e., learning how to do what works) cannot operate in the absence of functional variation, and human lives readily become stuck in the lack of variation, unable to move ahead.

Let us consider the example of self-knowledge. Owing to the process of mutual entailment, whenever a human interacts verbally with his or her own behavior, the psychological meaning of both the verbal symbol and the behavior itself can change. This bidirectional property makes human self-awareness useful, but it also makes it painful. A person reporting past hurts and traumas will often cry—even (or perhaps *especially*) if the self-report has never been made before. The crying occurs because the report is mutually related to the event itself, not typically because the report itself has been directly associated in the past with aversive events.

We naturally apply a problem-solving mode of mind to aversive events. It is aversive to be verbally aware of aversive events, and the human mind is all too ready to solve this problem by avoiding, denying, or suppressing

aversive thoughts, feelings, memories, or bodily sensations. Thus, an indiscriminate, inflexible problem-solving mode of mind will feed what are arguably the two greatest repertoire-narrowing processes known in human psychology, namely, excessive rule governance and experiential avoidance.

Fortunately, we can create contexts in which language and cognition function differently. We can establish a different mode of mind—mindful engagement—that is more flexible and open to the consequences of action, whether direct or verbally embraced as meaningful. In this mode, language and cognition are put in the service of noting and appreciating the ebb and flow of external and internal events and flexibly focusing attention and action on intrinsically valued actions. For this approach to be possible, the contexts that feed literality and its problem-solving mode of mind need to be both detected and changed. How we can do that is one of the themes of this book. RFT will provide good guidance, as we shall see.

Clinical Relevance of RFT Findings

We can summarize a few core conclusions of applied relevance that emerge from the RFT research program as it applies to our present purpose. Some of these conclusions flow from the material we have already covered. A few will just be stated here and will be covered subsequently:

- Without relational frames humans cannot function normally. Clinicians have to deal with the verbal/cognitive system, often using verbal interchange, and thus we need theories that are precise and broad in scope that tell practitioners how to accomplish this task.
- Some of the client's clinical problems are attributable to poorly developed relational repertoires (e.g., weak problem solving; poor intellectual abilities; lack of empathy; failure to see the perspective of others) and can be remedied by verbal skill building. RFT can help specify the skills needed (e.g., see Cassidy et al., 2011).
- Relational networks work by addition, not by subtraction, and therefore it is impossible simply to eliminate a clinically relevant cognitive event. There is no learning process called "unlearning." Extinguishing past behavior or habits is a matter of new learning, inhibition, and response flexibility, not unlearning.
- As relational framing develops, it dominates over other sources of behavioral regulation because of its real-world utility, ubiquity, and the pervasive context of literality and problem solving that is maintained in part by the social/verbal community.
- The same properties of relational frames that permit effective

human problem solving also contribute to rigid rule following and experiential avoidance, which are powerful repertoire-narrowing processes.
- Relational framing under poor contextual control makes it difficult for humans to maintain flexible, focused, and voluntary attention to present experience.
- A literal problem-solving context is not the only context available in which verbal/cognitive processes can occur. A context of mindful engagement also can be created. Verbal functions will be different in this context.
- Learning to bring different modes of language and cognition under contextual control is a central task of ACT and of maintaining psychological health more generally.

CONCLUDING REMARKS

In this chapter, we have introduced some of the philosophical, theoretical, and scientific foundations of ACT. Our chief purpose was to give the reader a better understanding of the key tenets of functional contextualism and relational frame theory, which directly relate to the clinically relevant topics that we address throughout this book. In the next chapter, we introduce a unified model of human adaptive functioning and then build on core concepts from RFT, further introducing closely associated clinical concepts that have become the basis for ACT as it is practiced today.

CHAPTER 3

Psychological Flexibility as a Unified Model of Human Functioning

In this chapter we introduce a unified model of human functioning and adaptability and show its clinical relevance. We believe that the model's six core features are broadly responsible for human adaptability—or, said inversely, for human suffering. We also provide some links to the relevant science, relating work done in ACT and RFT labs with work done in other domains of psychological science that bear upon the subject. In the next chapter we will show how these same processes can be used to formulate case and plan interventions.

As we define it, a unified model is *a set of coherent processes that applies with precision, scope, and depth to a wide range of clinically relevant problems and to issues of human functioning and adaptability.* Think of a fountain that you may have seen at a city park, one that is capable of providing continuously different patterns of water displays. Some of the displays shoot high in the air, while others interact through carefully sequenced firings of different spouts. Each display you see is designed to be unique; that is what makes the fountain aesthetically appealing. At another level of analysis, the fountain is undergirded by a common set of pipes, a small number of pumps and motors, and a common circuit panel. All of this hidden plumbing and electrical equipment is the foundation for everything the fountain is able to do. A small number of processes are capable of producing nearly an infinite number of different displays.

Similarly, in ACT, our focus is not on the myriad displays of human suffering (symptoms and syndromes, or collections of symptoms) but rather on the processes that control the whole show. The psychological flexibility

model that underlies ACT is focused on a limited set of coherently related processes that contribute to human adaptability and its opposite, human psychopathology and suffering.

THE GOALS OF A UNIFIED MODEL

As discussed in Chapters 1 and 2, the acid test of any treatment model is its *ability to lead to clinically meaningful interventions*. It is possible to generate broadly applicable protocols—and the evidence suggests that ACT has done that—but that alone cannot meet our definition of a unified model. It is also critical to demonstrate the following: (1) the processes that purportedly explain the impact of treatment in fact do so; (2) the key human processes that the model argues are relevant to outcome are indeed relevant; and (3) the components of intervention that are asserted to be important *are* in fact important. In other words, clinical psychological models succeed or fail not just based on outcomes but also on *the identification of mediational processes, moderators of outcomes, and key components, all linked to ongoing basic and clinical research*.

A unified model must also show that these same processes differentiate functional from dysfunctional members of the population. It is not enough to show that *clinical* populations have a particular response style—one also needs to show that healthier segments of the population differ in some observable way on the same response style. Another way to express this requirement is that *the model of treatment and the model of psychopathology must be integrated and linked to common core processes.*

ACT is based on a dimensional approach to clinical assessment that emphasizes the continuous nature of human behavior. A dimensional approach can add to confusion, however, if there are too many dimensions and they are not of key importance and not organized into a coherent whole. Therefore, a unified model *must select among the many such processes available and organize a smaller subset into a coherent perspective.* It is easy to observe this phenomenon. Suppose we started to organize human psychology by dimensional features willy-nilly, in turn adding such things as age, degree of religious commitment, degree of self-esteem, the degree of external or internal orientation, and so on. By the time this list reached double digits, it would be too complicated to be clinically useful. Without an adequate *underlying theory*, there would be nothing to prevent any such approach from attempting to assess literally scores of dimensions. Functional dimensional classification requires that one focus on likely dimensions of clinical relevance as derived through basic science. The functional contextual approach seeks utility by limiting their number, linking them to basic processes, and organizing them into a coherent model. We now

believe that the ACT model has developed sufficiently well to satisfy all of these criteria.

AN OVERVIEW OF A PSYCHOLOGICAL FLEXIBILITY MODEL

The psychological flexibility model is inductive in its nature and linked to basic human processes derived largely from laboratory science. By design, it is simultaneously a model of psychopathology, a model of psychological health, and a model of psychological intervention. In a hexagon-shaped Figure 3.1, we represent the six processes that contribute to psychological inflexibility: inflexible attention; disruption of chosen values; inaction or impulsivity; attachment to a conceptualized self; cognitive fusion; and experiential avoidance. Figure 3.2 shows the corresponding six core processes that produce psychological flexibility: flexible attention to the present moment; chosen values; committed action; self-as-context; defusion; and acceptance. The model's shape and focus on psychological flexibility have led to the tongue-in-cheek label the "hexaflex." For good or ill, the label seems to have stuck. If it makes you smile a bit to use the term, do not worry—it makes us smile a bit too, despite its serious purpose.

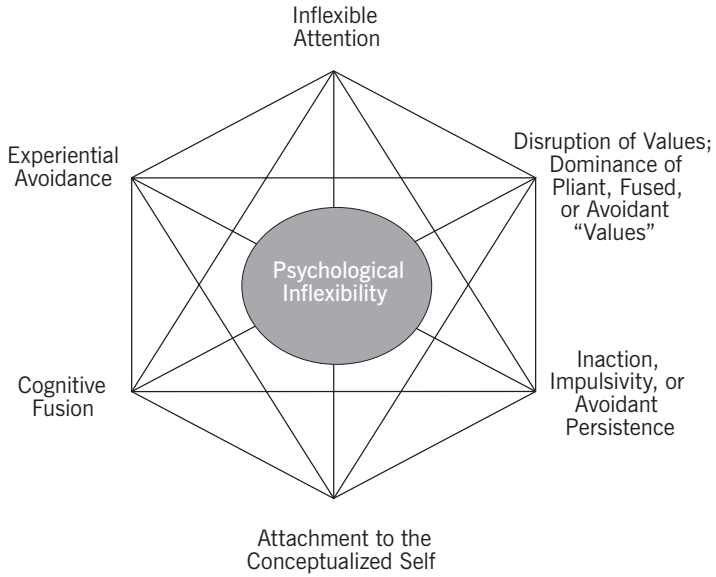

FIGURE 3.1. Psychological inflexibility as a model of psychopathology. Copyright by Steven C. Hayes. Used by permission.

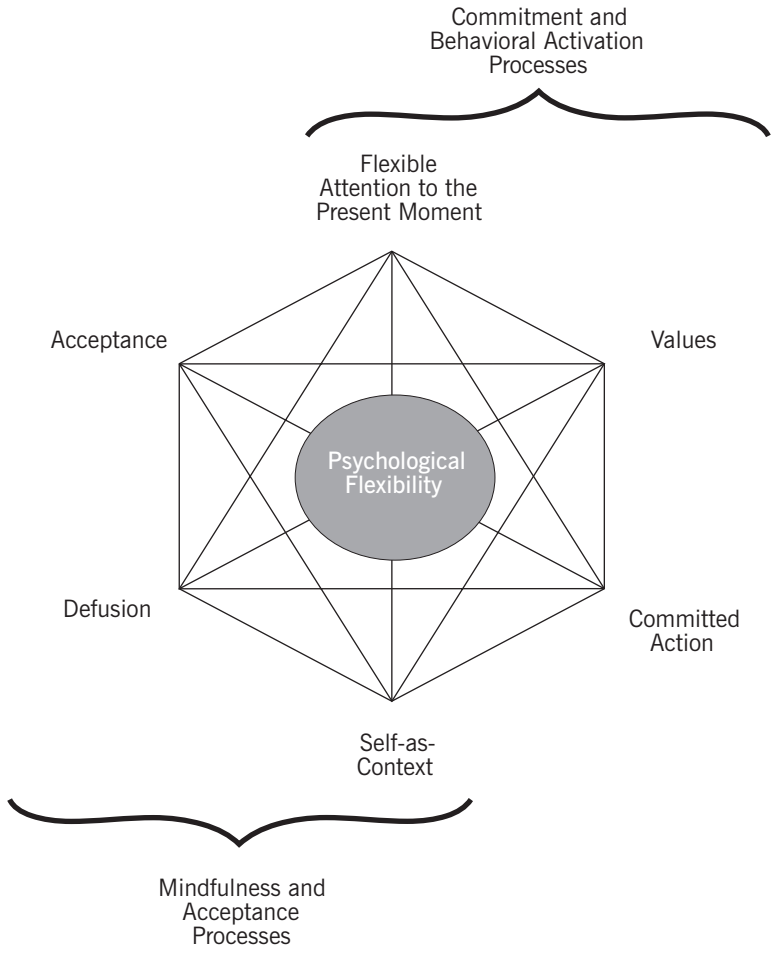

FIGURE 3.2. Psychological flexibility as a model of human functioning and behavior change. The four processes on the left are taken to be mindfulness and acceptance processes; the four on the right are commitment and behavior change or behavioral activation processes. All six working together are "psychological flexibility." Copyright by Steven C. Hayes. Used by permission.

Our major proposition is that these six core processes are responsible for promoting psychological flexibility and—in the absence of one or more of them—risks of psychological rigidity. Furthermore, it is our claim that psychological rigidity is a root cause of human suffering and maladaptive functioning. How many clients will you see in psychotherapy who are able to detach themselves from unworkable rules, to accept what cannot be changed inside and outside their skin, to live in the present moment and attend to what is relevant, to make contact with a deeper sense of self as a locus of perspective taking, and to choose and explicate closely held life values and organize their life's actions around those values? Few, if any, would be our claim.

The psychological flexibility model holds that pain is a natural consequence of living but that people suffer unnecessarily when their overall level of psychological rigidity prevents them from adapting to internal or external contexts (see Figure 3.1). Unnecessary suffering occurs when verbal/cognitive processes tend to narrow human repertoires in keys areas through cognitive entanglement and experiential avoidance. When people overidentify, or "fuse," with unworkable verbal rules, their behavioral repertoire becomes narrow, and they lose effective contact with the direct results of action. This response inhibits their ability to change course when existing strategies are not working. It also causes them to be more persistent in trying to analyze and understand their difficulty. Being "right" about what is wrong can become more important than living in a vital and effectual way. When people engage in experiential avoidance, their behavior comes under aversive control, that is, they are mainly trying to avoid, suppress, or escape from thoughts, feelings, memories, or bodily sensations. Avoidance causes further behavioral constriction and a gradual loss of contact with the positive consequences of responding. A cycle of avoidance can become dominant, in which the need to maintain avoidance increases as the "collateral damage" mounts (i.e., declining relationships, dashed hopes and dreams, etc.).

These patterns tend to overwhelm flexible attentional processes. For example, when people cannot get into the present moment in a flexible, fluid, and voluntary way and instead are preoccupied with the past or the future, they become easy targets for rumination, anxiety, depression, and the like. If they overidentify with their self-story or become rigidly attached to an unworkable view of self, they often end up behaving in ways that function as self-fulfilling prophecies. As a result, there is an unwarranted amplification of the impact of difficult aspects of one's prior history. These overly dominant processes also tend to interfere with the positive uses of human cognition, namely, constructing positive meaning and linking action to chosen consequences. Interference with these positive uses reduces motivation and inhibits values-based actions. When people

are out of touch with closely held personal values, their behavior is instead controlled by social conformity, attempts to please or placate others, or avoidance. When this behavior persists over time, major areas of life that produce a sense of health, vitality, and purpose stagnate. Instead, people begin to engage in withdrawal, self-isolation, or, conversely, they exhibit behavioral excesses such as drinking, drugging, cutting, overeating, chain smoking, and so forth. Collectively, these "negative hexaflex" processes can lead to a style of living that feels emotionally dead inside, as if the person is living on "autopilot," or a style filled with turmoil, angst, and self-focus. In either case, life is being lived, but it is not producing a sense of vitality, purpose, and meaning.

The psychological flexibility model seems on the surface to be extremely conventional: most human suffering is attributable to the mind, most psychopathology is indeed a "mental" disorder, and health requires learning to adopt a different mode of mind. What is unconventional is that ACT theorists approach mind with a technical appreciation of the nature of verbal and cognitive activity and a contextual behavioral approach to language. It is the *context* of verbal activity that is the key element in producing suffering—more so than the *content* of private experiences per se. It is not so much that people are thinking the wrong thing; rather, the problem is thought itself and how the wider community supports the excessive literal use of words and symbols as a mode of behavioral regulation.

The ultimate goal of ACT is to bring verbal cognitive processes under better contextual control and to have the client spend more time in contact with the positive consequences of his or her actions immediately in the present as part of a valued life path. The six "positive hexaflex" processes enumerated in Figure 3.2 collectively contribute to psychological flexibility and adaptive human functioning. These are the processes we try to enhance through ACT interventions.

Each of these core processes acts as a foil, or counteraction, to those that produce rigidity and suffering:

- To correct for the problem of overattachment to the contents of mental activity (fusion), ACT teaches the client to step back and see private events (thoughts, emotions, memories, sensations) for what they are (ongoing experiences to be had) and not what they say they are (literal truths that organize the world). This process is defusion. We "deliteralize" or weaken the functional dominance of literal, evaluative, rule-based responding. Thus, defusion is focused primarily on the verbal aspects of human experience.
- To correct the problem of experiential avoidance, ACT teaches the client to "make room for" unwanted private content without engaging in futile efforts to suppress, control, or escape from it and

moreover to explore the rise and fall of these difficult experiences with an attitude of genuine curiosity and self-compassion (acceptance). Thus, acceptance is focused particularly on the emotional aspects of human experience.

- To correct for the overattachment to and identification with one's self-story (attachment to a conceptualized self), ACT helps the client develop a stronger connection with self as an aspect of the "I–here–nowness" of experience. This observer perspective, or self-as-context, is used to provide a conscious foundation for exploring thoughts and feelings in a defused and accepting fashion.
- In place of rigid attentional processes that tend to carry people into the remembered past or imagined future, ACT attempts to establish flexible attentional processes that enable the client to come back to the present moment.
- If the problem is being disconnected from personal values or acting in ways that are inconsistent with one's values, ACT helps the client consciously opt for his or her values and connect with the positive qualities of the present that are intrinsically related to the situation (valuing).
- If the client struggles with an inability to act in effective ways or engages in impulsive acts or avoidant persistence, ACT helps the client link specific actions to his or her own chosen values (committed action) and helps the client build successively larger patterns of effective values-based actions, just as is done in traditional behavior therapy.

In actual clinical practice, clients seldom present with glaring deficits in all six of the core processes, which is why it is important to specifically assess each process before as well as on an ongoing basis throughout therapy. In actual practice, touching on one ACT core process almost invariably "activates" one or more of the other processes. From our perspective, this phenomenon presents the therapist with a golden opportunity, enabling him or her to use any identified strengths in the positive hexaflex to help the client correct identified weaknesses. Thus, as we elaborate further in Chapter 4, the hexaflex can simultaneously function as a case conceptualization and a planning or tracking tool.

THE CORE PROCESSES OF THE PSYCHOLOGICAL FLEXIBILITY MODEL

The six core processes of psychological flexibility—acceptance, defusion, the self-as-context, flexible attention to the present moment, chosen

values, and committed action—have emerged over nearly 30 years of basic and clinical research. Each plays a fundamental role in determining how well humans are able to adapt to the changing and often challenging circumstances of life. While each process is related to all the others, each is also more deeply interlinked with one process more than the others. It is useful to think of these three process pairs as response styles: Acceptance–Defusion, Present-Moment Awareness–Self-as-Context, and Values–Committed Action (see Figure 3.3). We use the terms *Open*, *Centered*, and *Engaged* to describe these core process dyads. Like a triad of pillars supporting a roof or three legs supporting a stool (Strosahl & Robinson, 2008), the three response styles have tremendous strength when properly aligned and functioning together. But if one or more legs is weak or out of alignment, the entire structure becomes wobbly and can collapse under even a very light load. Russ Harris (2008) embraces a similar idea in his "Triflex" model of psychological flexibility. The challenge of maintaining psychological flexibility is in creating an ongoing equilibrium among the three response styles and their components.

In the sections that follow, we address each of the six core processes of ACT, organized in terms of the three basic response styles—open, centered, and engaged—in that order. Later in this chapter we examine the

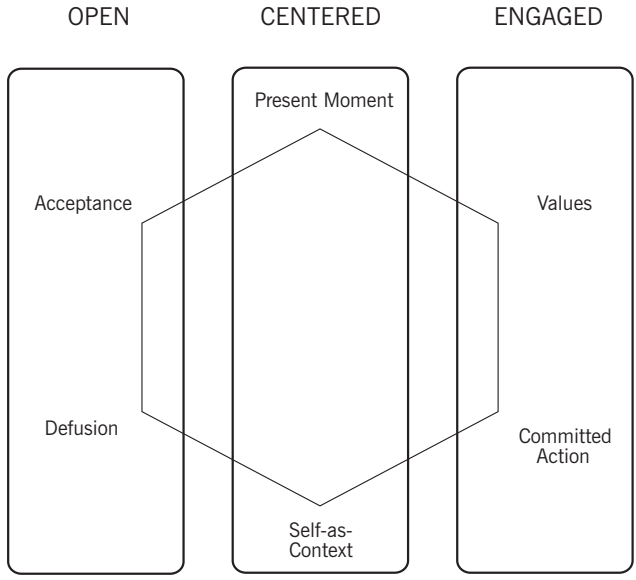

FIGURE 3.3. The three response styles that make up psychological flexibility. Copyright by Steven C. Hayes. Used by permission.

mediation, moderation, and outcome evidence for these processes and procedures.

Open Response Style: Defusion and Acceptance

Acceptance and defusion are key skills that support one's openness to direct experience. Defusion enables the individual to let go of needless entanglement with distressing, unwanted private events and experiences and to view them in a nonjudgmental way as merely ongoing mental activity. Acceptance unables the individual to engage the experiences more fully with an attitude of curiosity, to learn from them, and to make room for their occurrence. In the preceding chapter we discussed the verbal basis of two processes that can be repertoire-narrowing, namely, experiential avoidance and cognitive fusion. These two processes occupy the left-hand side of the negative hexaflex model (see Figure 3.1). If taking a rejecting and fused stance with respect to private experience is a cornerstone of pathology in the psychological flexibility model, being psychologically open is the remedy and a target for intervention.

Although discussions of ACT often begin with the subject of acceptance, we address defusion first because of the centrality of language and cognition in the psychological flexibility model and the key role of fusion in experiential avoidance.

Fusion and Defusion

Humans live in an intensely verbal world. This verbal emphasis is well recognized, but the exact processes involved are not often described. These processes, generally designated as "mental," are said to reside in our "minds." As a technical matter, when we speak here of "minds," we are referring to the individual's repertoire of relational (i.e., verbal or cognitive) activities, such as evaluating, categorizing, planning, reasoning, comparing, referencing, and so on. Although we use the word as a noun, *mind*, it is not a specific physical object. The "brain" is such a thing—replete with gray and white matter, midbrain structures, and the like—but the mind is a behavioral repertoire rather than a specific organ. *Minding* would be a more accurate, if cumbersome, term.

Verbal behavior is a wonderful tool for interacting effectively in and with the world, but it can overwhelm all other forms of activity. Once established, verbal relations occur with little continuous deliberate environmental support, since many of the consequences that maintain it—sensemaking, problem solving, storytelling, and so on—are virtually built into language and cognition themselves, once the skills are established. There is nothing in the world of human experience that "the mind" cannot reach. Even the

most obviously "nonverbal" event can readily become at least in part verbal for humans—simply by *thinking* about it.

In a technical sense, cognitive fusion is a process by which verbal events exert strong stimulus control over responding, to the exclusion of other contextual variables. Phrased differently, fusion is a kind of verbal dominance in behavioral regulation. Because the contexts that support verbal behavior are ubiquitous, we tend to behave verbally from morning to night, constantly describing, categorizing, relating, and evaluating. In our normal mode of mind, the functions of the world are fused with (etymologically, "poured together with") those deriving from thoughts and descriptions. As behavior becomes increasingly driven by derived stimulus relations, direct experience plays less of a role. Fusion makes it hard to distinguish between the two. We begin to respond to our mental constructions as though we are responding directly to a physical situation.

That is not necessarily bad. If we scream "Watch out!" to a person about to bump into something, there is little reason to want verbal stimuli to be balanced against other sources of behavioral regulation in that instant. Similarly, if you are preparing your taxes, allowing your mental focus to dwell entirely on the fit between the relevant numbers and the tax regulations does no harm. But when fusion is *not* helpful, it's important to have alternatives. Normal day-to-day living may never establish that alternative, since there is little to ensure that defusion skills are learned. *Bringing cognitive fusion under control by the client is one of the key purposes of the ACT approach.*

When we think a particular thought, what shows up are some of the stimulus functions of the events related to the thought. Suppose a client with panic disorder who is scheduled to give a presentation in a few weeks is becoming increasingly terrified. Suppose she (or he) imagines losing control while on stage in front of hundreds of people. In a fused state, this bad ending will seem immediately present and highly likely. The person may have fleeting images of going out of control or imagine the shock, horror, and derisive laughter her behavior would evoke in the audience. Anxiety is a natural response to immediately present aversive events, and as these fused thoughts occur, the thought itself may occasion panic symptoms. This reaction in turn perpetuates the imagined embarrassment even further. The fearful person who constructs a fearful environment and then fuses with that thought acts as though the fearsomeness of the world has been discovered, not constructed. The event imagined has not actually happened; however, the fusion of verbal symbols with the event allows some of the functional properties of the event to actually be present in a psychological sense. Without ever having to revisit the high-risk situation (e.g., the person may never have actually given such a presentation before), fusion enables the client to have already had a panic attack "while giving a

presentation." From an ACT perspective, it is not the thought itself that is the problem. Rather, the involuntary fusion with it and the resultant avoidance do the real damage.

To some degree, fusion is built into human language and its evolutionarily sensible functions. Language most likely evolved initially as a form of social control, cooperation, and danger signaling and then gradually expanded into a general problem-solving tool. As the saying goes, "It is better to miss lunch than be lunch." Language greatly expands our ability to detect and avoid danger and to marshal social support. It seems highly unlikely that language evolved to promote self-actualization, personal happiness, or aesthetic appreciation. No evolutionary advantage would be supplied by reminding organisms how safe and satisfied they are or by helping them to appreciate a beautiful sunset. A problem-solving mode of mind is a tremendously powerful tool. It at least partly explains why human beings took over the planet.

Unfortunately, this mode of mind is difficult to stop. Consider what happens when a person is lost. In that situation, the person looks to see how he or she got there and determines the distance between the current location and where he or she wants to be. Mark Williams (2006), one of the creators of mindfulness-based cognitive therapy, calls this approach a "discrepancy-based mode of mind." Most of the language functions involved in this process have little to do with the "here and now"; rather, they are based on prediction and comparison. Some of the thoughts we generate as part of this problem-solving process may be unproductive, but in this mode of mind the thoughts' content is more closely related to emotions and actions, and the thoughts' practical application is less of a focal point than their supposed truth. As a result, people get more entangled and live more in their heads. Indeed, the modern media seem to be encouraging a fused state of mind, as the public is increasingly exposed to emotionally charged judgmental talk. Perhaps as a result, our heightened access to electronic media predicts more stigma and bias (Graves, 1999).

Clinical Relevance of Fusion–Defusion

The foregoing types of fusion-related phenomena are the target of many forms of therapy. Indeed, they are precisely why the cognitive revolution occurred in behavior therapy in the first place. The main theorists of the time concluded that an undesirable thought → action relation should be modified by changing the form, frequency, or situational sensitivity of negative thoughts. While appreciating the severity of the problem, ACT recommends an alternative solution, namely, establishing more cognitive flexibility and undermining the contexts that automatically support thought → action relations. Cognitive flexibility is difficult to attain, short

of penetrating the illusion of language. This illusion, embedded in normal language processes, suggests that thoughts are what they say they are—that thoughts model reality, and so there is only one right and true answer to any given question.

As a clinical alternative to the traditional cognitive behavioral approach of identifying and reshaping the content of distorted thoughts, defusion methods attempt to alter the functional context of minding so that it is possible to appreciate the process of thinking and feeling, not just the content of those activities. In RFT terms, fusion involves contexts that enhance the transformation of stimulus functions for language and cognition. Think of defusion interventions as the clinical application of the opposite process. Defusion methods reduce the transformation of stimulus functions by altering the cues and contexts that support fusion. In order to alter the function, rather than the form, of thinking, defusion methods often help clients notice their act of verbally organizing the world in real time. Multiple or even contradictory thoughts might be noticed (or even deliberately fostered) without the necessity immediately to pick the correct one or to argue with the incorrect ones. Defusion gradually influences the content and style of thinking as well, although not through logical reprogramming but rather through exposure to new learning experiences being fostered by cognitive flexibility and openness.

Scores of cognitive defusion techniques have been developed, and we discuss many of them at greater length in Chapter 9. One classic ACT defusion technique we describe there is the *Milk, Milk, Milk* exercise, first used by Titchener (1916, p. 425). It consists, first, of initially exploring all of the physical properties of the single referenced word. For example "milk" is white, creamy, cold, and so on. The word is then repeated out loud and rapidly by both the therapist and client for about 30 seconds. In our example, the word *milk* quickly loses all meaning, and what is left over is a funny guttural sound. Try this on your own just to see what happens to your own relationship with the word *milk*. In clinical practice, we often follow this exercise with a similar one, this time using a single-word variant of a core clinical concern or troublesome thought that the person is ready to let go of (e.g., "mean," "stupid," "weak," "loser," etc.). If a clinically relevant thought is selected, research shows that the believability of the thought generally drops along with the distress it produces (Masuda, Hayes, Sackett, & Twohig, 2004; Masuda, Hayes, et al., 2009).

Why would this odd procedure work? It's because normal strings of words are a context in which words have meaning. Try this: if you do not know what "juzzwuzz" means, please clap your hands. We will wait for you. If you felt inclined to clap (or actually did), you are feeling the pull of cognitive fusion. "Clap" and "we will wait" are just ink on paper or electrons on a computer screen. In some contexts, "please clap your hands"

functions to produce specific hand actions, and even though this may not be a normal context for such actions (since reading a book for understanding does not normally require motor behavior), you can still feel the pull. There are ways to reduce the pull. If you say, write, or type "clap" 100 times fast, that function might be somewhat reduced. It might also be reduced if you noted that CLAP spelled backwards is PALC; or that upside down it resembles CTVb; or if you said it so slowly it took 10 seconds; or any of a dozen other procedures that might undermine the illusion of literality maintained by the language community and its practices. Our experience is that clients can readily generate new methods in therapy once the language illusion is penetrated and the nature and purpose of defusion are better understood. A recent study found a strong defusion effect on pain tolerance from having participants read a statement aloud while walking around the room. What was the statement? "I cannot walk around this room" (McMullen et al., 2008).

A context that supports giving verbal reasons for behavior tends to increase fusion, which is probably why reason givers are harder to treat (e.g., Addis & Jacobson, 1996). But we can reduce the incentive for reason giving in therapy. Even the positive psychological impact of cognitive reappraisal is dependent on psychological flexibility processes (Kashdan, Barrios, Forsyth, & Steger, 2006); so, even when we do need to deal directly with cognitive content, we can do so in a way that is sensitive to function and context. There are contextual alternatives to the cognitive problems we face as human beings.

Experiential Avoidance versus Acceptance

Relational frames are mutual or bidirectional. This characteristic readily turns self-knowledge into self-struggle because it is so automatic and natural to describe and evaluate our own history, physical sensations, thoughts, feelings, and behavioral predispositions. Verbal events related to aversive events are often experienced as aversive. Remembering a rejection is not itself a rejection, but we often take direct action against such private experiences, in effect turning them into the enemy. If clients are asked to look around a therapy room, they usually can find much to evaluate negatively with just a few minutes of effort. This ongoing stream of evaluation is applied as readily to ourselves as to our environment. But seeing an ugly door or an ugly rug does not affect us in the same way as does seeing an ugly thought or an ugly emotion because in the first instance you can leave the room. You can't leave your body or history. Language sets us up to struggle with the world within.

Experiential avoidance occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations,

emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form, frequency, or situational sensitivity of these experiences even though doing so is not immediately necessary. We introduced the term some time ago (Hayes & Wilson, 1994; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) to highlight the dangers of a psychologically closed, rigid, and defensive approach to the world within. It has since become commonplace in the psychological literature, with hundreds of studies having been conducted. Terms such as *emotional avoidance* or *cognitive avoidance* are sometimes used rather than the more generic term when these are the types of private experiences that the person seeks to escape, avoid, or modify.

There is a growing body of evidence demonstrating that experiential avoidance is associated with a startlingly wide variety of psychopathology and behavioral problems (for reviews, see Chawla & Ostafin, 2007; or, for psychological flexibility more broadly, see Kashdan & Rottenberg, 2010). A meta-analysis (Hayes et al., 2006) showed that levels of experiential avoidance as measured by the Acceptance and Action Questionnaire accounts for 16–28% of the variance in behavioral health problems generally. Experiential avoidance shares some attributes in common with several other concepts in the contemporary literature such as emotion dysregulation (Gratz & Roemer, 2004), distress intolerance (Brown, Lejuez, Kahler, & Strong, 2002), intolerance of uncertainty (Dugas, Freeston, & Ladouceur, 1997), cognitive and emotional suppression (e.g., Wenzlaff & Wegner, 2000), and mindfulness (Bear et al., 2008), among others. Researchers are busy distinguishing among such concepts and comparing their relative contributions (e.g., Kashdan et al., 2006; Karekla & Panayiotou, 2011), but thus far comprehensive reviews seem to agree that experiential avoidance integrates key aspects of behavior that cut across these other concepts (e.g., Chawla & Ostafin, 2007).

The costs and dangers of experiential avoidance have been implicitly or explicitly recognized in most systems of therapy. Behavior therapists recognize that "the general phenomenon of emotional avoidance is a common occurrence; unpleasant events are ignored, distorted, or forgotten" (Foa, Steketee, & Young, 1984, p. 34). Client-centered therapy emphasizes the importance of working with clients to enable them to become "more openly aware of their own feelings and attitudes as they exist" (Rogers, 1961, p. 115). Gestalt therapy holds that "dysfunction occurs when emotions are interrupted before they can enter awareness" (Greenberg & Safran, 1989, p. 20). Existential psychologists focus on avoidance of a fear of death: "to cope with these fears, we erect defenses … that, if maladaptive, result in clinical syndromes" (Yalom, 1980, p. 47).

We are not arguing that experiential avoidance is always toxic. In some circumscribed contexts (e.g., working as an emergency room nurse),

avoidance of private events may even be adaptive (Mitmansgruber, Beck, & Schüßler, 2008). Rather than the avoidance strategies themselves, it is their indiscriminate application that has a greater impact on human adaptability (Bonnano, Papa, LaLande, Westphal, & Coifman, 2004). The problem is that avoidance strategies are highly resistant to extinction (Luciano et al., 2008) because they are maintained by reductions in aversive internal states such as anxiety, fear, sadness, or anger. Unfortunately, these avoided experiences often then quickly return and are experienced as more distressing and dominant than before. Because avoidance behaviors are learned under conditions of such aversive control, they are more likely to be applied rigidly, independent of the current context (Folkman, Lazarus, Gruen, & DeLongis, 1986). Thus, while experiential avoidance might work in some constrained situations, the strategy is likely to become overlearned and applied to contexts where experiential avoidance is ineffective or even harmful. For example, acquiring wealth might not be intrinsically harmful, but it is when linked to experiential avoidance (Kashdan & Breen, 2007).

The mutual or bidirectional nature of relational frames makes experiential avoidance basic to human existence. Imagine that a survivor of sexual trauma is asked to describe that trauma. In so doing, there will be a transformation of stimulus functions between the report and the trauma. When the trauma survivor describes what happened, some of the original functions of the event will appear. Thus, the telling of the story will itself be experienced as aversive—it hurts to tell about painful experiences.

Human emotions that are negatively evaluated or that emerge from aversive events also tend to be avoided. Anxiety, for example, is a natural response to aversive events. In nonverbal organisms, anxiety is not itself bad because the response and the event that produces it are not mutually related. There is nothing in the animal experimental literature to suggest that nonverbal organisms naturally avoid their *responses* to aversive events; rather, they avoid the aversive events themselves (or situations that reliably predict them). Their emotional responses occur after aversive events or their correlates—they do not predict the arrival of these events. But human language is bidirectional, and that is enough to put a target on the back of any difficult emotion. Anxiety is bad. Getting rid of it is good.

The natural tendency toward experiential avoidance is also amplified by the verbal community. Seeing negative emotion in others is an aversive to each of us. Parents and others have long used pliance to reduce children's expression of negative emotion (because it is aversive), but often they say they are asking the child to change the emotion itself, not just its expression. For example, fearful children are told, "Go to sleep! There is nothing to be afraid of!" and will probably conclude that they can and should voluntarily eliminate fear. Negative emotions per se will be nominated as the bad actor. Children are told, regularly and often, that they

can and should control negative affective states. Even babies are often evaluated according to how little they express negative affective states (e.g., "She's such a good baby, she never cries"). Punishment and reinforcement are frequently doled out according to the ability to control and suppress at least the outward signs of aversive emotional states ("Stop crying or I'll give you something to cry about"). Siblings and schoolmates support the ongoing purposeful control of thoughts, memories, or emotions. Statements such as "Don't be a cry-baby" or "Just forget about X" will be backed up by a variety of socially mediated consequences (e.g., ridicule, being shamed, admiration for "sucking it up").

Modern media have greatly increased our exposure to horror and trauma while at the same time overtly supporting experiential avoidance strategies, whether in the form of a pill, a beer, a glitzy car, or simple escapism. What is going on here is the social extension of a psychological process. The process is not new—it is just promoted more effectively in the Internet age.

Clinical Relevance of Experiential Avoidance–Acceptance

The clinical relevance of the avoidance process is clear when one considers that most clients come to therapy complaining of emotions and, implicitly or explicitly, concerned that they cannot control them. Common clinical complaints such as "I can't control my depression" or "I'm too anxious" take this form. But the reality is that private events are poorly regulated, and the struggle to control or change them can easily be detrimental because it can become suppressive and repertoire-narrowing.

The conscious and deliberate avoidance of private events is highly likely to fail in several situations often encountered in clinical work, such as in the following examples.

1. *The process of deliberate control contradicts the desired outcome.* There are several examples of this situation in which avoidance produces the opposite of its stated goal. When subjects are asked to suppress a thought or emotion, they subsequently show an increase in this suppressed thought or feeling as compared to those not given suppression instructions (see Wenzlaff & Wegner, 2000). The rebound is greatest in contexts in which the suppression took place or, alternatively, while in the same psychological state that prevailed when the suppression originally occurred.

There is disagreement about why this phenomenon occurs, but suppression is well known to increase the salience of cues related to the suppressed item. In addition, suppression rules inevitably reference the item to be suppressed. "Don't think of red cars" contains the words *red cars*, and even mentioning them inclines one to think of them. Often suppression

rules contain explicit or implicit consequences that themselves bring the suppressed item to the fore. The warning or threat "Don't be anxious or else your life will be over" is likely to elicit anxiety in much the same way as a person walking up with a gun and saying, "Your life is over."

2. *The event to be controlled is not rule-governed.* Private events that are conditioned directly are not readily eliminated by verbal rules. In these circumstances, attempts at purposeful rule-based control may be futile because the underlying process is not verbally regulated. The event might change—but not necessarily in the intended way. For instance, suppose a person is extremely distressed about a memory of a difficult panic attack and tries to do everything to eliminate it. Memories are often spontaneous events triggered by a wide range of stimuli and are unlikely to go away, at least not in a healthy fashion. The strategies required to suppress such events entirely are nearly always self-destructive (i.e., alcohol- and drug-based numbing) and eventually produce difficulties in their own right.

3. *Avoidance is possible, but accomplishing it entails significant costs.* Suppose a memory is avoided by avoiding all situations that might give rise to it. This approach might reduce the frequency of the memory, but it might also horribly limit the person's life. For example, a survivor of sexual abuse or domestic violence might avoid *all* intimate relationships.

4. *The event is not changeable at all.* Sometimes experiential control is put in the service of unchangeable events. For example, a person may take the view that "I can't accept that my dad was killed" and will consume drugs to ease his or her grief. Grief is a natural reaction to such losses, but no amount of drug consumption will alter either the situation or the loss. No effort to reduce or alter private events is called for here. When an unchangeable loss occurs, the healthy thing to do is to feel fully what one feels. That process will include loss and grief. It may include many other things as well, such as laughter over the funny things that person did, or appreciation for what they created in life. The issue is one of flexibility.

5. *The change effort itself is a form of behavior contradictory to the goal of the change effort.* The behavior of controlling something itself has meaning. Sometimes what it means is the opposite of its purpose. A person trying hard to be more spontaneous is not really being spontaneous at all. Confidence is another good example, given that so many clients lack it, want it, and seem unable to achieve it. The etymology of the word *confidence* helps to show why. *Con-* means "with" and *-fidence* comes from the Latin *fides*, which is the root of the words *fidelity* and *faith*. "Confidence" literally means "with fidelity" or "with faith"—in short, it means being true to oneself. The act of running from scary feelings in the effort to feel more confident is not a confident action because that very act has no self-faith or self-fidelity. When frightening feelings are present, the most functionally confident action one can take is to feel them fully. In other words, experiential acceptance is the *behavior* of confidence.

The foregoing situations are all contraindications for deliberate control over experiential content as a coping strategy. Human emotional responses are just echoes of our own history being brought into the present by the current context. If our reactions are rooted in our history and our reactions are our enemies, then our own history has become our enemy. There are no good technologies for removing a person's history, at least not selectively. Time and the human nervous system move in one direction—not two—and new experiences are always *added*, never *subtracted*. In order to avoid automatic emotional reactions, we have to distort our lives in such a way as to be psychologically out of contact with our own histories. That is why experiential avoidance leads not only to restricted negative emotions but to a lack of positive emotions (Kashdan & Steger, 2006) and a lack of healthy emotional differentiation and flexibility (Kashdan, Ferssizidis, Collins, & Muraven, 2010). The alternative, though difficult to implement, is to turn around and embrace one's immediate experience in a nonjudgmental way and without struggle. This very act may in turn gradually alter emotions—but in an inclusive and open way in which all aspects of one's history are welcome to come along for the ride.

Acceptance, as we use the term, refers both to behavioral willingness and psychological acceptance. Willingness is *the voluntary and values-based choice to enable or sustain contact with private experiences or the events that will likely occasion them*. Psychological acceptance is *the adoption of an intentionally open, receptive, flexible, and nonjudgmental posture with respect to moment-to-moment experience*.

Without willingness, acceptance in the sense we mean it is unlikely to be present. Acceptance is not resignation or tolerance—it is an active process. Harris (2008) is sensitive to the distinction when he uses the term *enhancement* instead of *acceptance*. Indeed, we use that term clinically, especially to keep *acceptance* from leading to a passive quality (more like tolerance) that is not related to positive health outcomes (Cook & Hayes, 2010; Kollman, Brown, & Barlow, 2009). The linkage between *willingness* and *acceptance* is so great that these terms are often used as synonyms in the ACT literature, but a useful distinction can be made. For example, a client can be willing (e.g., a person suffering from social phobia may enter a social situation on purpose) and yet not practice acceptance (i.e., the person immediately tried to suppress anxiety when it appeared).

Acceptance is not readily rule-governed. Instructions to adopt an attitude of openness, curiosity, and flexibility normally carry a problem-solving purpose with them, which is exactly what acceptance is not. Clients may even initially try to use "acceptance" as yet another strategy to control or eliminate unwanted psychological events ("If I just let my experience be there long enough, it will go away"). When acceptance is linked to this kind of problem-solving mode of mind, it is not acceptance at all. That may be one reason why acceptance appears to require metaphors, exercises, and

shaping to be learned rather than instructions simply to be given (McMullen et al., 2008).

Centered Response Style: The Present Moment and Self-as-Context

It is not possible to be open and engaged in life without also being centered in consciousness and in the social, physical, and psychological present. The center column of the hexaflex functions like a hinge of conscious and flexible contact with "the now." Acceptance and defusion, on the one hand, and values and action, on the other, are based on the choices of a conscious person behaving in the present context. Therapy almost always begins with the centering of two people into a relationship. Conscious and flexible attention to "the now" empowers the person to activate defusion and acceptance skills when they are called for or to engage in value-based actions when they are needed. The ability to sweep back and forth between these is the touchstone of psychological flexibility, and it is empowered by centering processes.

Being Absent versus Flexible Contact with the Present Moment

The more time one spends in the problem-solving mode of mind, the less time one spends making contact with the "here and now." Clients who are not able to contact the here and now typically have difficulties in altering their behavior to fit the changing demands of their social context. Contact with the present moment involves attending to what is present in a focused, voluntary, and flexible fashion. Some external events exert so much stimulus control over behavior that contact with them is no longer fully voluntary, flexible, or focused. If a gun went off in the room you are in right now, the startle response would be quite predictable and inflexible. There might be a monk somewhere for whom that would not be true, but for most people it is. Fortunately, startle responses of that kind have little cost. Other external events can also induce inflexible responses, as any parent of a child mesmerized by a television show or video game can tell you. Internal thoughts, feelings, memories, bodily sensations, urges, and dispositions can have a similar dominating effect, and their impact on flexible attentional processes can be costly indeed. A key principle of human adaptability is that to respond effectively to natural contingencies the person must be psychologically present to make direct contact with those contingencies.

The only time that anything happens is in the present. The present is all there is. In that context, in a certain sense it is a bit odd to talk about "contact with the present moment" as if there is an alternative. The

present is always present; so, contact with anything is contact with the present moment. The alternative is a psychological one based on verbal functions: people can seemingly "disappear" from the moment and instead get "lost" in the process of minding. Symbolic meaning always lags at least a bit behind direct experience. Consider the words *I am speaking of now.* The "now" of me speaking is not the same "now" as a listener understanding the sentence or even the same as me finishing the sentence. Contrast this experience with direct perceptual experiences, which are always in the now. When we enter into the world of verbal meaning, we immediately risk losing contact with the present. That risk is much enlarged whenever language is used for problem solving.

Solving problems involves considering how the past led to the present in order to create a preferred future. Consider fusion with an emotional thought such as "Why do I feel like this?!" "Why" draws attention to the past and future, and not in a flexible way. An answer is demanded; possibilities have to be generated and weighed. "This" suggests the query is present-focused, but it is really referring to a present feeling in comparison to an imagined state that might be felt in some place and time ("this *and not that*"). Learning to attend to the present requires breaking through all of these automatic and habitual processes of attentional inflexibility. Rigid attention and failure to come into the present has been associated with many kinds of problems, including trauma (Holman & Silver, 1998), rumination (Davis & Nolen-Hoeksema, 2000), and pain (Schultze et al., 2010), among others.

It is common to think of attention as a thing that is allocated, much as money is spent, but in a behavioral sense attending is just interacting with something. It makes more sense to think of attention as a kind of general skill. It is possible to learn to interact with present events in a way that is focused, voluntary, and flexible irrespective of the specific events. Most people can interact this way with some things but not others, and often the difference is not voluntary but merely habitual. Psychological flexibility involves the ability to exercise attentional control even in situations that are complex, evocative, or intensely social in nature. Imagine a socially anxious person who is about to give a public speech and is mentally cycling through fearsome thoughts about potentially disastrous outcomes. The stimulus control of the thought is overwhelming, and a vast number of other events are crowded out. A present-moment focus might initially look more diffuse or varied, but opting for that alternative can set the stage for voluntary focus. The person might note a frightening thought, but at the same moment the person might also notice what it feels like to breathe in and out, or notice the rustling of the audience, or note the urge to make a difference and contribute to others. The thought is just one of several events occurring. The person might then be able to focus on what is

important—for example, on how to contribute by making a careful verbal argument in the next part of the speech. If frightening thoughts intrude, this same process of expansion, acknowledgment, and focus might enable more sustained attention to the speech.

There is evidence that such focused, voluntary, and flexible attentional processes can be taught and learned (e.g., Baer, 2003, 2006). Contemplative practice is, in part, training in a present-moment focus as we mean it here. For example, imagine a person who is closely attending to their breathing as part of a mindfulness exercise. A few seconds later, another event (say, a thought about what is happening at home) might grab one's attention, but then attention can be redirected gently to the breathing occurring now. A problem-solving mode of mind is not required to engage in this type of activity.

Minds hate unemployment. Anyone who has done a silent retreat that lasts for days knows how the mind will go on extinction bursts (a temporary increase in responding when a reinforcer is withdrawn), coming up with wonderful and creative ideas, or worries, or physical concerns, and so on—all demanding that they be given attention. In retreats of this kind, the person is told, when they notice such a mental rush coming on, to bring their attention back to their breath. In other words, steps are taken to keep that fused, problem-solving mode of mind on extinction. The mind can be almost diabolical in luring people into a fused problem-solving mode of mind. For example, the mind might kick in and say "I'm not doing it right" or (even more alluring at times) "Boy, I'm doing a good job meditating today!" These thoughts could be noticed and attention brought back to the breath but if the next response is "What was it my meditation instructor said earlier?" or "I hope I can keep getting better," then "the bird has already flown the coop"—that is, attention has been diverted from the present and noticing thoughts in the present when they occur and, instead, directed into a fused language stream. The solution to this conundrum is practice—practicing noticing and gently redirecting attention. Over and over again, small sequences of doing so teach attending as a general skill above and beyond the content of experience.

As a scientific matter, we know that acceptance and mindfulness methods can significantly alter basic attentional skills (Chambers, Chuen Yee Lo, & Allen, 2008; Jha, Krompinger, & Baime, 2007). Indeed, mindfulness-based cognitive therapy originally was going to be named "attentional control therapy," or ACT (how confusing that would have been!). Metacognitive therapy (Wells, 2008) has developed many clever methods for teaching attention regulation skills. ACT (acceptance and commitment therapy) providers are willing and eager to embrace these developments because they are entirely consistent with the psychological flexibility model (e.g., Paez-Blarrina et al., 2008a, 2008b).

Attachment to a Conceptualized Self versus Ongoing Awareness and Perspective Taking

Psychology has a long if somewhat murky history of attempting to develop and test theories of self-experience. Terms such as *self-concept* or *self-esteem* have been used in many ways, often tied to trait explanations of behavior. Generally, these theories emphasize self-experience as a kind of "thing"—much as one might treat personality attributes as a thing. Many therapeutic traditions emphasize the need to alter the self-concept as a way of promoting psychological health. This point of view implies that the self-concept is directly accessible via verbal behavior and is responsive to direct or rational interventions. For example, low self-esteem may be thought to be the result of illogical thinking (and so forth).

While our clients are often very familiar with their verbally constructed reports of self, they are much less familiar with ongoing self-awareness and even less in contact with the more spiritual aspect of self—the perspective-taking self based on the "I/here/nowness" of conscious experience. ACT distinguishes among three major types of "self-experience" (Barnes-Holmes, Hayes, & Dymond, 2001; Hayes & Gregg, 2000; Hayes, Strosahl, et al., 1999b). More types surely exist, but we are interested here only in those forms of self-relatedness that produce various types of self-knowledge. Those three types are the conceptualized self (or self-as-content), ongoing self-awareness (or self-as-process), and perspective taking (or self-as-context).

THE CONCEPTUALIZED SELF

When children begin to acquire language, they are taught to categorize themselves and their own reactions. They are boys or girls, happy or sad, hungry or not. Two things happen as a result of such training. First, children learn to differentiate and categorize their own reactions and behavioral dispositions—the basis of self-awareness—weaving the various features of their lives into integrated stories—the basis of a self-story. Second, they learn to make verbal reports from a consistent perspective and to distinguish that perspective from the perspective of others.

The conceptualized self is the direct by-product of training in naming, categorization, and evaluation. It is the type of self-relatedness that we are most likely to be fused with. We humans do not merely live in the world—we interact with it verbally and cognitively. We interpret it, build narratives about it, and evaluate it. Clients invariably have formulated their personal characteristics into what Adler designated a "private logic." They have told stories, formulated their life history, defined their dominant attributes, evaluated these attributes, compared their attributes

to those of others, constructed cause-and-effect relations between their history and attributes, and so on. As described in Chapter 2, the derived stimulus relations of language can readily dominate other behavioral processes.

In the problem-solving mode of mind, "self" is a kind of conceptualized object. People describe themselves in terms of their roles, history, dispositions, and attributes, such as "I'm a nice guy" or "I'm depressed" or "I'm handsome." A myriad of such statements come together as a kind of story (or set of stories) of who we are. "I am like the way I am because I was abused," or "I'm a critical person, like my father." A simple phrase, such as "I am a person who … ," can generate dozens, even hundreds, of these apparently accurate self-descriptions. While it is easier to speak of the conceptualized self in the singular, it is useful to remember that there are many versions constructed to fit the social purposes of various life contexts. For example, if urged to "Tell me a little bit about yourself," a person's self-story can vary widely, depending on whether the questioner is a human resource specialist at a job interview or a new acquaintance at a social get-together.

Many things are embedded in the self-stories we tell: evaluations, causes and effects, emotions, and reactions to the story. Many of these features are broad and difficult to change. Historically based explanations of cause-and-effect relationships, when viewed through language, are seen as "facts." Other members of the verbal community support these "facts"—in part because they too have a self-story based on "facts" that may be drawn from their histories. Over time, facilitated by fusion, we become wedded to the process of self-reflective categorization and evaluation, almost as if these stories define who we are. In this fused state, any threat to the story is a matter of life and death. We try to live up (or down) to this constructed view of ourselves. We hide our secrets from others or even ourselves. We try to live inside the stories, be they grand or horrific. We try to become what we say we are. The ego has landed!

Several factors promote the verbal dominance of this type of self-knowing. First, derivation is part of relational responding. Among other implications, this observation means that relational networks that are consistent are inherently more self-supportive because each part of the network can be used to derive other parts that may have been weakened over time. Cognitively impaired persons can readily confabulate on this basis, with fragments of a self-story that are known used to fill in gaps that are not known. Second, we have a massive history of learning to detect and maintain consistency. The goal of sensemaking is central to a problem-solving mode of mind, and it seems only "rational" to develop a consistent, socially conforming account of who we are and how we got to be that way.

Third, the social community not only demands story telling of this kind but also expects some correspondence between what occurred and what one says, and what one says and what one does. Consequences are doled out accordingly. The social community calls this "being right" or "knowing yourself." From an early age, being right and showing that you know yourself evokes powerful consequences. Fourth, phrases such as "I am a person who … " are assertedly about issues of being, as if "I am alive" and "I am kind" are the same sorts of statements. Via frames of coordination (instead of hierarchy so that the self *contains* these things), "I" comes to be in the same verbal class as these conceptualized attributes, a process spiritual traditions call "attachment."

Finally, when a person identifies with a particular self-conceptualization, alternatives to it are less likely to be seen. Inconsistencies can seem almost life-threatening. The relational frame here seems to be "me = conceptualization of me" and its entailed derivative "threaten conceptualization = eliminate me." Through these frames of coordination, we are drawn into protecting our conceptualized self as if it were our physical self. Perhaps for that reason, events that threaten the conceptualized self can evoke strong emotions and lead to heightened experiential avoidance (Mendolia & Baker, 2008), presumably because of the need to maintain consistency within the self-narrative.

In ACT, the conceptualized self (or selves) is seen as highly problematic in that it can interfere with psychological flexibility. Fusion with the conceptualized self can lead to an attempt to maintain consistency by distorting or reinterpreting events if they seem inconsistent with the self-story. If a person believes him- or herself to be kind, for example, there is less room to deal directly and openly with instances of cruel behavior. If a person believes him- or herself to be incompetent, there is less room to acknowledge skills. In this way, the conceptualized self fosters self-deception, which in turn makes it even more resistant to change since confronting that process means confronting the deception.

Mainstream empirical clinical psychology has often encouraged an emphasis on changing the conceptualized self on the grounds that people with mental health problems often judge themselves too severely. Unfortunately, such interventions can produce weak or counterproductive results. Indeed, comprehensive reviews of the scientific literature show that deliberately boosting positive self-image through therapeutic interventions or school programs is as likely to promote unhealthy narcissism as it is improved outcomes (Baumeister et al., 2003). In a particularly sad twist of fate, self-affirmations turn out to be helpful only for those who already have high self-esteem. If used indiscriminately by those who most need them, positive self-statements ("I am a lovable person") are actively

harmful (Wood, Perunovic, & Lee, 2009). In ACT, the goal is not to alter the content of the self-story directly but to weaken the attachment to it. It is that overbearing attachment, we argue, that creates harm because it makes behavior more narrow and rigid, reducing psychological flexibility.

SELF-AS-ONGOING-AWARENESS

Self-awareness is important in therapy and closely allied with a healthy and psychologically vital life. This perception is true in part because much of our socialization about what to do in life situations is tied to an ongoing process of verbal self-awareness. Emotional talk is perhaps the clearest example. Anger, anxiety, or sadness are quite varied in the histories that give rise to them, but within each they are quite similar in their social and psychological implications. An individual who is not able to be aware of ongoing behavioral states cannot address the highly variable and volatile circumstances that daily life presents. Consider, for example, a young girl who has been sexually abused for many years by her father. Suppose that during this entire time period expressions of emotion associated with this aversive experience were reinterpreted, ignored, or denied by siblings, relatives, and parents. For instance, the perpetrator might have tried to convince the child that she actually was not upset when in fact she was upset, or that she should feel loved when in fact she emphatically did not feel loved. Given such a history, the child's ongoing self-awareness might be distorted or weakened, since many conventional verbal discriminations had been undermined; in other words, the child might not "know" how she felt—in the sense of being able to use words that accurately describe feeling states. Such a situation would not mean that she was not having intense emotional experiences but rather that she couldn't employ conventional verbal symbols to understand, communicate, respond to, and self-regulate her emotional experiences. In some deep sense, the person would be flying blind psychologically until this deficit was corrected (such as in the context of a therapeutic relationship that helped the person develop more normative self-awareness).

In terms of the psychological process involved, the basis for self as ongoing awareness is simply ongoing verbal description (what Skinnerians label as "tacts"). The conceptualized self involves integrating observations and descriptions into an evaluative self-story. In contrast, self-as-process is based on the simple relational actions of noting what is present, without fusion or needless defense. It is this latter sense of self that is fostered through ACT interventions.

From a behavioral point of view, self-awareness consists in responding to one's own responding. Skinner (1974) used the example of seeing. Most nonhuman animals "see," but humans uniquely also see that they see.

> There is a … difference between behaving and reporting that one is behaving or reporting the causes of one's behavior. In arranging conditions under which a person describes the public or private world in which he lives, a community generates that very special form of behavior called knowing. … Self-knowledge is of social origin. (p. 30)

The social/verbal community makes self-knowledge important by requiring answers to such questions as "How are you feeling? What do you like? What happened to you yesterday? Where did you go? What did you see?" As Skinner says, "It is only when a person's private world becomes important to others that it is made important to him" (Skinner, 1974, p. 31).

Clinically speaking, the skill of learning to describe what you feel or think can easily be impaired by living in emotionally impoverished environments that fail to pose any questions, or dysfunctional social environments that insist on providing answers that do not fit the person's experience, or environments that encourage experiential avoidance so that the individual primarily has distorted contact with distressing private experiences in the first place.

SELF-AS-CONTEXT

The final aspect of self-relatedness is the one that is most often ignored in Western culture, namely, self-as-context, or perspective taking. The psychological literature contains numerous terms and concepts that allude to this aspect of self: a transcendent sense of self, the observing self, noticing self, continuity of consciousness, pure consciousness, pure awareness, and others. Spiritual and religious traditions similarly cite a variety of relevant terms: spirituality, a "no-thing" self, big mind, wise mind, and so on. The multiplicity of terms used to describe this type of experience reflects how far removed it is from the problem-solving mode of mind. We are speaking of an aspect of self that metaphorically cannot be looked at but instead must be looked *from*. From the inside out, it is seemingly not an "it" at all, and having multiple names reflects the challenge of naming a process that has no "thing-like" properties that one can readily detect. It is not possible to contact fully the limits of consciousness consciously.

It is one of the paradoxes of life that the very existence of this sense of self—so key to psychological liberation—is but a side effect of the same language processes that create human suffering. Children begin to acquire self-awareness by being asked about themselves and others: e.g., "What did your sister eat yesterday?" They are asked about the present, past, and future; and about things happening here, there, and virtually everywhere. In order to give consistent verbal reports, children have to develop a sense of perspective—a point of view—and to distinguish their own from that

of others. Even as the content of these descriptions begins to weave a self-story—which can be limiting—the sense of perspective is growing—which can be liberating.

The key verbal relations in the development of perspective taking are "deictic," which means "by demonstration." Most verbal relations can be modeled initially by the formal properties of related events. You do not need to know the perspective of the speaker to instruct someone on which of two objects is physically larger, for example. When a child learns that "Dada" is bigger than the baby, the initial comparative relation is in the physical set. Only later will the child need to go through the harder task of making that relation arbitrarily applicable, as when learning that "Dada" is also much older than the baby. Deictic relations are not like that because they make sense only relative to a perspective; so, they have to be taught in a different way.

Consider the relation of "here" versus "there." Much to the confusion of young children, you cannot model "here/there" with physical objects. You have to learn it by demonstration. Suppose Mom has a box and the child has a ball. The child needs to learn to say "The ball is here, the box is there" even though Mom at the very same time would be saying "The box is here, the ball is there." If the child ran to where Mom was standing, "there" would suddenly become "here" and the place left behind would now be "there," not "here." This relationship is learned over hundreds if not thousands of examples; what is consistent across examples is not the *content* of the answer but rather the *context*, or perspective, from which the answer occurs. That is the case with all other deictic frames, such as I/you, we/they, and now/then.

Over the past few years RFT researchers have learned a great deal about how perspective taking happens, how to measure it, and how to produce it. The procedure used to teach deictic relational frames is quite clever. Take the three key deictic relations of I/you, here/there, and now/then. Deictic tests start with such simple questions as "I have a box and you have a ball. What do you have?" Then they progress to a question that demands contextual flexibility. An example of a simple-reversal question is "I have a box and you have a ball. If I were you and you were me, what would you have?" The questions can get more complex. An example of a double-reversal question is "Today I have a box and you have a ball. Yesterday I had a pen and you had a cup. If I were you and you were me, and today was yesterday and yesterday was today, what do you have today?" Even more complex questions are possible (e.g., triple reversals) by combining multiple deictic frames. Questions can be carefully worded to tap many different combinations of times, places, and persons as well as important types of content (e.g., objects, emotions, behaviors).

Research has shown that deictic relations assessed in this way gradually strengthen across childhood, becoming more useful in middle childhood

(McHugh, Barnes-Holmes, & Barnes-Holmes, 2004). They are key to understanding that other people have "minds" and that one's own perspective is different from the perspectives of others. Deictic frames have been shown to be central to "theory of mind" skills (McHugh et al., 2004), such as understanding deception (McHugh, Barnes-Holmes, Barnes-Holmes, Stewart, & Dymond, 2007a) or that others can have false beliefs (McHugh, Barnes-Holmes, Barnes-Holmes, & Stewart, 2006; McHugh, Barnes-Holmes, Barnes-Holmes, Whelan, & Stewart, 2007). Deictic relations are weak in clinical populations who have problems with sense of self, including those with autistic spectrum disorders (Rehfeldt et al., 2007). Adults with "social anhedonia," the inability to experience pleasure from social interactions, have difficulty with deictic framing (Villatte, Monestès, McHugh, Freixa i Baqué, & Loas, 2008, 2010). Deictic framing can be successfully taught, however, and when it is, perspective-taking and theory-of-mind skills improve (Weil, Hayes, & Capurro, 2011).

RFT theorists are able to model, measure, and train a perspective-taking sense of self because they have a precise sense of the verbal units that give rise to it. It is rather remarkable that children acquire these skills via the sloppy training history that is inside a natural language community. Usually deictic training is indirect. If you teach it with many "I" statements, "I" in some meaningful sense *is* the location that is left behind when all of the content differences are subtracted out. For example, notice what is consistent in answers to the questions "What happened to you yesterday? What did you see? What did you eat?" We normally answer, "I did such and such," "I saw so and so," and "I ate this and that." Similar training in "we/they" occurs in more allocentric cultures and languages. The "I" that is referred to is not just a physical organism—it is also a locus, place, or perspective. But RFT research has shown that "I" statements of this kind cannot create the proper discriminations unless they are accompanied by predictable and useful statements from others about their perspectives as well. Just as "here" does not exist without "there" or "now" without "then," or "we" without "they," "I" as a perspective needs the perspective of "you" to be fully formed.

Think of self-as-context as a kind of coming together of the major classes of deictic relations, such as I/you, here/there, and now/then. Figure 3.4 shows the idea. Like objects in elliptical orbits, children learn to imagine responding from here or there; in the now or in the then; from the point of view of "I" or the point of view of "you." As in the top panel of the figure, these actions overlap, but they are not fully integrated. When these classes of responding come together, a sense of perspective emerges as an integrated event. Once that occurs, all self-knowledge can occur from a conscious perspective of "I/here/now," as is represented metaphorically in the bottom panel. Even when we imagine, say, being behind the eyes of another person, we still have a sense of looking from an "I/here/

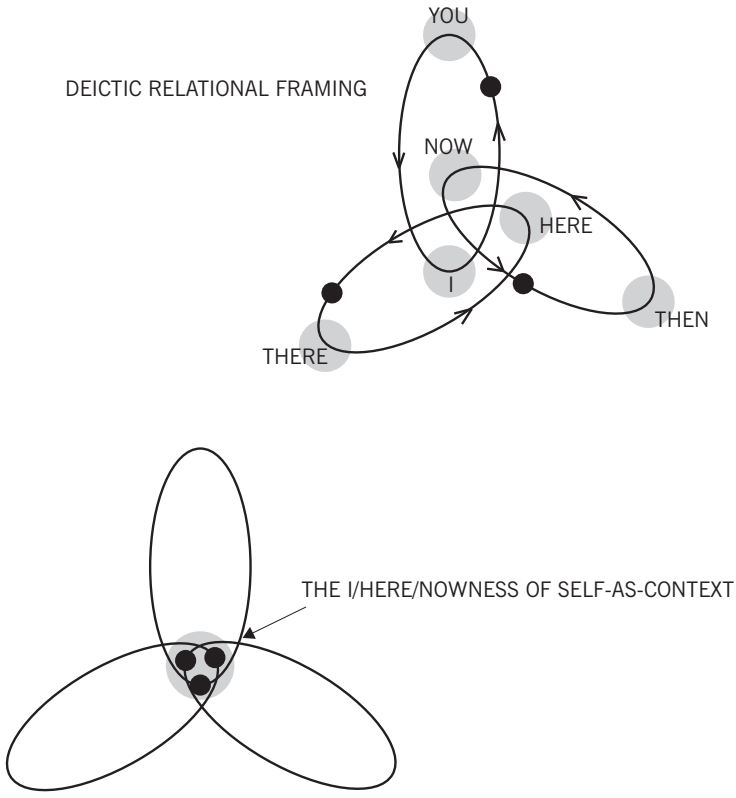

FIGURE 3.4. A graphic representation of how deictic relational frames go together to create "self-as-context"—a socially interconnected sense of self as a type of perspective taking. Copyright by Steven C. Hayes. Used by permission.

now" locus inside another person. Conscious content now is known in the context of a consistent locus or point of view that can integrate that knowledge. Infantile amnesia begins to drop away. Events are held in memory in a verbal temporal order. A conscious person shows up—not as the object of reflection but as a perspective from which knowing can occur.

Common clinical exercises begin to make more sense when the core properties of perspective taking are appreciated. A young adult with weak appreciation of his impact on others might be asked by a therapist, "Could you put yourself in that empty chair? If you were your mother, what would you want to say to you?" A socially inadequate child might be told, "Imagine you were Superman. What would Superman say?" Flexibility of perspective taking allows the integrated sense of "I/here/now" to be located without regard for time, place, or person. We can write letters to ourselves

from a distant and wiser future or try to see the world from behind another person's eyes. It is clinically important because it situates self-knowledge in a more expansive temporal, social, and spatial context. This flexibility increases the ability to respond to the consequences of actions that are delayed, that occur elsewhere, or that are felt primarily by others.

There are profound applied and theoretical implications of this sense of self and its cognitive basis. We note three here.

1. *Spirituality and a sense of transcendence.* As a sense of perspective taking is formed, a fundamental distinction is made between the content of a verbal event and the sense of locus from which observations are made. Once consciousness as perspective emerges, its limits can never be fully appreciated consciously. This dimension of human experience is unique in that it is not thing-like—it has no discernible edges, limits, or distinctions. Everywhere you go, there you are. Anything you know verbally, you were there to know it verbally. One can be conscious of the limits of everything except one's own consciousness.

These qualities give self-as-perspective a timeless, placeless, and transcendent quality. "Matter" is the stuff of which things are made (it came originally from a word meaning "timber"), and self-as-perspective is *not* thing-like. It is thus "immaterial" or "spiritual." We are arguing that the distinction between verbally known content and the self-as-context is the experiential source of the matter–spirit distinction that seems to have emerged in virtually all human cultures (Hayes, 1984). That distinction is an ancient one, originating long before the scientific perspective dominated human culture. Rather than rejecting this distinction, ACT and RFT recognize it as useful and scientifically sensible.

Spiritual and religious traditions have dealt the most with this sense of self, perhaps because of its transcendent qualities of perspective taking. Eastern traditions speak of spirituality, using terms like *everything/nothing*. Buddhism and Taoism promote the idea of an "uncarved block" that originates at birth. The uncarved block is the simple wholeness of consciousness itself and the "ground" for experience. Judeo-Christian traditions speak of spirituality as sharing in the divine (e.g., humans are made in the image and likeness of God; Gen. 1: 26), and the features of God (omnipresent, all-knowing, and so on) seem to be understandable as extensions of the "no-thing" qualities of self-as-context (Hayes, 1984).

Some intervention traditions (e.g., 12-step programs) advocate for the importance of spirituality but without a definition or interpretation of what spirituality entails beyond that given by the lay culture. ACT is an evidence-based therapy that likewise emphasizes the importance of spirituality, but ACT gives a basic account of its core features.

2. *Consciousness as social, expansive, and interconnected.* The finding that perspective taking emerges from deictic relational frames says something

profound about the nature of human consciousness. Self-as-context is not a sense of self that is alone and cut-off. We are not speaking of "I" in a self-focused, processive sense, as might be the case with a conceptualized "I." It is inherently social, expansive, and interconnected because framing is mutually and combinatorially entailed. I begin to experience myself as a conscious human being at the precise point at which I begin to experience *you* as a conscious human being. I see from a perspective only because I also see that you see from a perspective. Consciousness is *shared*. Moreover, you cannot be fully conscious here and now without sensing your interconnection with others in other places and other times. Consciousness expands across times, places, and persons. In the deepest sense, consciousness itself contains the psychological quality that *we* are conscious—timelessly and everywhere.

3. *Compassion and acceptance; stigma and defusion*. As described thus far, acceptance and defusion seem, superficially, to be intrapsychic issues, but self-as-context expands their nature. Because perspective taking is social, it is not possible to take a loving, open, accepting, and active perspective on yourself without doing likewise for others. Perspective taking inherently enables us to be conscious of our own pain, but it also enables us to be conscious of other people's pain, which in turn is doubly painful. Thus, compassion and self-acceptance are related inside the model. It is not possible to develop a habit of defusing from judgmental self-referential thoughts without practicing defusion from judgmental thoughts toward others. Fusion with judgments is an undiscriminating cannon, and sooner or later one's own qualities or features inevitably come under fire. In addition, the things we find irksome and worthy of strong judgment in others are often things that are relevant to aspects of our own history and behavior.

Our model helps explain the empirical finding that stigma and prejudice toward others are often associated with personal psychological distress in the stigmatized area. Interestingly, the linkage between distress and stigmatizing thoughts disappears when we adjust for the impact of fusion and experiential avoidance (e.g., Masuda, Price, et al., 2009). This finding suggests that prejudice itself is fueled by experiential avoidance of self-referential content. It also suggests that it is not so much the content of thought as it is that rigid attachment to those thoughts that causes the most trouble. This observation does not imply necessarily that we need to give up evaluation and judgment—they can still be useful tools in the problem-solving mode (e.g., "She is a *good* lawyer"). Like all such tools, however, we must embrace them gingerly and realize their limited utility.

A social, expansive, and interconnected sense of consciousness naturally orients acceptance and defusion in the direction of compassion rather than prejudice and bias. It expands ACT processes across times and places. It is hard to maintain the idea that values should apply only locally—that

concern for others should extend only to one's family and not to those suffering elsewhere, or should pertain only to this time and place and not to those in succeeding generations. This beneficial predisposition helps explain the expansive qualities of ACT work itself. It is not by accident that ACT has been applied not just to self-stigma among clients seeking treatment (e.g., Lillis & Hayes, 2008; Luoma, Kohlenberg, Hayes, & Fletcher, in press) but also to the stigmatization of racial and ethnic groups (Lillis & Hayes, 2008) and persons with mental disorders (Masuda et al., 2007). ACT even militates against the tendency of clinicians to stigmatize their own clients (Hayes, Bissett, et al., 2004) through a type of expansiveness built into the model of psychological flexibility that is at the heart of its approach to therapeutic treatment.

MINDFULNESS AND SELF-RELATEDNESS

The entrance of mindfulness into the behavior therapy community is one of the most notable features of the "third-wave" cognitive and behavioral treatments (Hayes, 2004). A virtual treasure trove of mindfulness-based methods has entered into the behavioral and cognitive therapies over the past decade. This development is a mixed blessing because we run the risk of adding yet another intervention that seems to "work," but without any coherent or progressive scientific explanation as to why. The extent of the science–practice disconnect in this area is sobering. Indeed, there is no agreed-upon definition of mindfulness in psychology. A review of the various definitions (e.g., Bishop et al., 2004; Kabat-Zinn, 1994; Langer, 2000) shows that they describe mindfulness as variously a psychological process, an outcome, or a general method or collection of techniques (Hayes & Wilson, 2003).

Mindfulness needs to be better understood at the basic behavioral as well as clinical level. The need is for greater understanding of "mindfulness" as an ongoing process, as a mediator or moderator of response to therapy, and as a life outcome in its own right. Defined in all these various ways, mindfulness is difficult to research adequately. As with most lay concepts that later become a disciplinary focus, we may never agree upon an authoritative definition, but such agreement per se is not the issue. Scientists and clinical researchers need to explicate their starting assumptions more fully so that the rest of the verbal community can actually track what is being studied. Within the psychological flexibility model, mindfulness is viewed as both open and centered. We have elsewhere (see Fletcher & Hayes, 2005) explored in some detail how the four processes in these two response styles provide a definition of mindfulness, and our views are supported by recent neurobiological evidence on mindfulness processes (Fletcher, Schoendorff, & Hayes, 2010). The subtitle of the present volume speaks of "the process and practice of mindful change" in this specific

sense: ACT therapists and clients attempt to bring the left four hexagon processes to bear on values-based behavior change.

Engaged Response Style: Values and Committed Action

While openness can make one's repertoire of actions more flexible, and centering can ground awareness in the present moment, what makes life meaningful are the connections with closely held values through daily life actions. Ultimately, psychological health is produced through effective working in the real world. Subsequently, effective working tends to produce a sense of vitality, life connectedness, and a sense of health and well-being. This sense of flow and engagement emerges as a person makes contact with reinforcing events in the present that are intrinsic to deeply meaningful life actions.

Waiting, Reacting, and Pleasing versus Valuing

Cognitive fusion and experiential avoidance exact other long-term life tolls. They produce diverse patterns of behavior that develop chiefly under conditions of aversive control. The individual can easily lose his or her sense of life direction that normally helps motivate, organize, and direct vitality-producing life actions. Clinically, this phenomenon often appears as a kind of aimlessness that typically involves complaints about life seeming mundane, empty, or meaningless and/or complaints about lack of motivation or failure to follow through on both short- and long-term goals. The "midlife crisis" is perhaps an example—in which the client, who typically possesses a good job, is married, has children, and enjoys all the accoutrements of middle-class success, suddenly breaks loose of his or her normal moorings to seek some deeper form of meaning from life. This breakway often is accompanied by some socially taboo behavior such as having an affair, suddenly quitting a good job, and so forth. In such cases, we are often seeing the delayed and life-suppressing effects of having for too long followed socially prescribed rules about how to live rather than staying in touch with one's values. As the time-honored saying goes, "Vision without action is a daydream; action without vision is a nightmare."

The emphasis on values distinguishes ACT from many other cognitive-behavioral treatments specifically and from a broad range of therapies more generally. It is only within the context of values that action, acceptance, and defusion come together into a sensible whole. In the language of rule governance, values are formative and motivative augmentals. They are one of the most important uses of human language.

"In ACT, values are freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish

predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioral pattern itself" (Wilson & DuFrene, 2009, p. 66). Wilson and DuFrene's (2009) formulation is dense and more easily understood when broken down into its key components.

FREELY CHOSEN VALUES

The emphasis in ACT is on values that clients experience as freely chosen rather than those that might be forced upon them by other people or by circumstances. This is a principal reason why ACT interventions focus on personal "choices" rather than using a "decision-making" approach. Choices are made *in the presence of* reasons for and against a particular action, but they are not *based on* those reasons. Decisions, on the other hand, tend to originate in the problem-solving mode of mind and can gain or lose resolve as reasons supposedly change. An implication of values being freely chosen is that their construction will play out in the healthiest sense when the person is contacting them in the here and now. Values like compassion for others or self tend to become manifest when a person is living in the present moment and making contact with the perspective-taking self, which is probably why values and compassion are a natural focus of most mindfulness traditions. Although "freely chosen" values are not socially forced, that does not mean they are not socially established or social in their focus. Free choice is not about individualism. It is about the psychological quality of ownership of actions.

VERBALLY CONSTRUCTED CONSEQUENCES

ACT interventions often focus on values construction and choice. The more common term is *values clarification*, but *clarification* can be misleading. It implies that there are preexisting, fully formed values that are waiting somewhere to be discovered. We prefer the term *construction* rather than *clarification*. We do so in order to highlight the active nature of valuing in ACT. Values, like minds, are not "thing-like" but rather are an ongoing process of verbal relating. For example, a client might not initially see a connection between having a fulfilling work career and being an effective parent. However, examining what the client would like to model for children as part of promoting their long-term life satisfaction might reveal such a verbally constructed link.

ONGOING, DYNAMIC, EVOLVING PATTERNS OF ACTIVITY

By "verbally constructed consequences of ongoing, dynamic, evolving patterns of activity," we mean that values give one the choice to engage

in certain patterns of behavior functionally defined by verbal behavior. The pattern chosen will be dynamic and evolving because it will be lived moment to moment as history and circumstance permit. Verbally constructed consequences are technically not reinforcing events because they may never be completed or even encountered. A person who values gender equity may never see it but may nevertheless work toward it as a constructed consequence or function of behavior. Reinforcers strengthen behavior when they are encountered, but values are never enacted in quite that way. What values do is they establish other events as reinforcers. That is why, technically speaking, values are augmentals.

INTRINSIC REINFORCERS PREDOMINATE

The events that values establish as reinforcers are described by Wilson and DuFrene (2009) as follows: "Predominant reinforcers … are intrinsic in engagement in the valued behavioral pattern itself." Values are not about the future so much as they are about living in the moment and doing things that embody personal values. These actions, by virtue of their connection to verbally expressed life desires, have reinforcing features. It is not the value per se that is reinforcing; it is the quality of action connected to values that is inherently reinforcing. In a sense, that quality of action is what is being freely chosen.

Suppose a person chooses to value being a loving father, that is, to be there for his children. If you explore what that might look like, a number of patterns of behavior can be described: spending time; being attentive; ensuring safety; encouraging learning. The process of loving will never be finished, and the patterns of action may evolve as the children and the father go through time together. If the father suddenly becomes bedridden, this value may be embodied in very different ways. The reinforcers are not off in some conceptualized verbal future. Rather, it is in the moment-by-moment process of telling stories, wiping noses, and comforting a skinned knee that the value of being a loving father is both practiced and reinforced. Trying to be a loving father because otherwise you might feel guilty—or because someone else would be disappointed if you failed—is not valuing in the sense in which we mean it. Indeed, the literature on values (e.g., Elliot, Sheldon, & Church, 1997; Sheldon & Elliot, 1999; Sheldon, Kasser, Smith, & Share, 2002) shows that only when the individual views values as a personal choice and not as a matter of social compliance or avoidance of guilt that values significantly correlate with favorable clinical outcomes.

To summarize, valuing focuses the client on generating psychological purpose and meaning and away from a problem-solving mode of mind. In Aristotelian terms, values function as "final causes" of behavior in that they

are the consuming purpose "for the sake of which" actions are undertaken. In a more technical sense, values provide the selection criteria that enable variation and selective retention to work as causal processes in the evolution of behavior. Values dignify the work of defusion and the acceptance of specific painful thoughts and feelings when such distressing experiences function as barriers to valued actions. ACT is not about endless emotional wallowing; rather, it involves "taking in" what one's history has to offer in the process of living a valued life. There is an extensive literature on values showing that significant behavior change can occur even with short-term values interventions (e.g., Cohen, Garcia, Apfel, & Master, 2006).

Inaction/Impulsivity versus Committed Action

The end result of fusion, avoidance, and loss of contact with values is a narrow, rigid pattern of ineffective responding. Behavioral rigidity can be characterized either by behavioral avoidance (inaction, passivity, withdrawal) or behavioral excesses (impulsive behavior, overuse of numbing behaviors such as drinking, drugging, bingeing, self-mutilation, etc.). The common thread among these behaviors is that they are designed to reduce or eliminate aversive states. Many times, the person will believe that feared outcomes and associated distressing private experiences can be prevented by avoiding a distressing situation entirely. In other cases, impulsive actions are taken that actually make situations worse; they are self-defeating. In still other cases, people will use "quick-fix" solutions that can have terrible long-term consequences. Regardless of their form, these actions' function is to limit aversive consequences rather than to seek something positive in life. Individuals who live this way experience a compression of life space that inevitably produces a variety of clinically significant symptoms such as depression, anxiety, addiction, and the like. Another way of saying this is that psychologically rigid individuals tend to have difficulty in initiating and maintaining actions that are sensitive to contingencies, thus reducing their ability to adapt to changing circumstances.

In the ACT model, the term *committed action* refers to *a values-based action designed to create a pattern of action that is itself values based*. In other words, there is a continuous redirection of behavior so as to construct larger and larger patterns of flexible and effective values-based behavior. Committed action is the antidote to the repertoire-narrowing effects of cognitive fusion and experiential avoidance. By implication, it is why ACT is a "hard-core" behavior therapy, in essence. By *commitment*, we are not speaking so much about a promise made about the future as we are the actual moment-by-moment living out of a behavioral pattern in which the person takes responsibility for its shape. When committed action slips, the additional commitment is to take responsibility for the slip and once again

direct one's efforts in a values-based direction. Individuals with the ability to direct and redirect behavior over time have an inordinate advantage over those who exhibit weak patterns of behavioral control. The cornerstone of psychological flexibility is the capacity to engage in highly organized and purposeful behavior that is sensitive to contingencies.

Committed action is an extension of values. Whereas a value involves the chosen consequences of ongoing patterns of activity and any values-based action is any action reinforced by these consequences, keeping a commitment means, in a moment-by-moment way, redirecting behavior toward larger patterns of behavior with a goal of sustaining these purposes. The moment the person sees a divergence and chooses to redirect his or her behavior so that it is values-consistent, the person is engaging in a committed act.

When we speak of action and behavior here, we do not necessarily mean physical acts. Commitment might well involve entirely private mental activities. One of Victor Frankl's commitments while in a Nazi concentration camp during World War II had to do with his wife. He decided in his own mind that love was something that made the suffering of the death camps worth enduring. He developed countless ways to keep his wife in mind even though he spent the entirety of his internment with no knowledge of whether she was alive, not knowing if he would ever see her again. He quotes the Song of Solomon: "Set me like a seal upon thy heart, love is as strong as death" (Frankl, 1992, p. 50). Frankl saw clearly the seduction of despair and instead chose to hold on to that image of his wife. Each time he did, he made a choice, a commitment to his value.

Unlike values, which may never be achieved as an object, concrete goals that are values-consistent can be achieved through committed action. ACT protocols generally involve the full range of goal setting and behavior change methodologies that are available in the larger therapeutic community in general and behavior therapy in particular. At the same time, existing behavioral approaches are often empowered by other aspects of the ACT model. There are some data suggesting that changes in other core processes "enable" the behavioral methods to work. For example, willingness and acceptance appear to help persons with panic disorder to be more open to exposure (Levitt, Brown, Orsillo, & Barlow, 2004) or chronic pain patients to change behavior (Dahl, Wilson, & Nilsson, 2004).

THE CORE OF THE MODEL: PSYCHOLOGICAL FLEXIBILITY

Psychological flexibility can be defined as contacting the present moment as a conscious human being, fully and without needless defense—as it is and not as what it says it is—and persisting with or changing a behavior in

the service of chosen values. We argue that the three response styles, comprising six core processes, together create psychological flexibility.

There are 30 directional relationships among the six core processes of the hexaflex. The lines depicted between the six components in Figures 3.1 and 3.2 are not for show; rather, each represents a theoretical claim of relatedness. Individual ACT processes do not make sense disconnected from the others in the overall model—any more than the double helix of DNA makes sense without pairs of nucleotides. For example, acceptance without values or action is a kind of tolerance or resignation. Values without acceptance or defusion are difficult to engender since caring and vulnerability go hand in hand, and experiential avoidance promotes numbness over vitality. Throughout this volume, core processes of the psychological flexibility model will be defined and refined with reference to the other points of the model, which makes sense, given their interrelatedness.

ACT Defined

ACT uses acceptance and mindfulness processes and commitment and behavioral activation processes to produce psychological flexibility. It seeks to bring human language and cognition under better contextual control so as to overcome the repertoire-narrowing effects of an excessive reliance on a problem-solving mode of mind as well as to promote a more open, centered, and engaged approach to living. The ACT approach is based on a functional contextual perspective on human adaptability and suffering, derived from behavioral principles as extended by relational frame theory. Although it contains techniques based on science, ACT is not just a technology. Functionally defined, it consists of any method that reliably produces psychological flexibility; theoretically speaking, any method based on the psychological flexibility theory we have described here could be called "ACT" if those employing the methods choose to describe it in that way.

Evidence for ACT and the Psychological Flexibility Model

Over the past decade, the number of published RFT and ACT studies has grown exponentially. In 1999, when this model was first described in a comprehensive fashion, RFT had not yet been presented in any book-length form; there were fewer than a handful of empirical studies on ACT; there were no well-established measures of ACT processes, nor any longitudinal or mediational studies on the relation of ACT processes to outcomes. All of that has changed. Even the most conservative categorization lists over 40 studies experimentally testing RFT processes (perhaps 100 more are related to RFT ideas), and yet not even one contains data

disputing the underlying rationale for the theory (Dymond, May, Munnelly, & Hoon, 2010). Ruiz (2010) found 22 correlational studies on the relation of psychological flexibility to depression (weighted $r = .55$), and 15 on anxiety (weighted $r = .51$), with more than 3,000 participants. Using correlational methodology, more that 30 longitudinal or mediational studies have examined the impact of ACT processes on long-term outcomes, and virtually every study fits within the expectations of the psychological flexibility model presented here. Levin, Hildebrandt, Lillis, and Hayes (2011) found 40 studies on ACT components, alone or in combination, with an average weighted effect size of $d = 0.70$ (95% confidence interval: .47–.93) on targeted outcomes. Ruiz found 25 outcome studies in clinical psychology areas ($N = 605$; 18 randomized trials), 27 in health psychology ($N = 1,224$; 16 randomized studies), and 14 in other areas such as sports, stigma, organization, or learning ($N = 555$; 14 randomized studies). Across all the existing literature, between-group effect sizes appear to be around .65 (Hayes et al., 2006; Öst, 2008; Powers, Vörding, & Emmelkamp, 2009; Pull, 2009). Nearly two-thirds of the randomized studies have had mediational analyses conducted, and all were successful at $p = .10$ or better, accounting for about half of the variance in outcome (Hayes, Levin, Vilardaga, & Yadavaia, 2008).

It is the breadth of problems addressed in these studies that is perhaps most startling. Such breadth is one of the main scientific requirements of a model that claims to be unified and transdiagnostic. There are controlled ACT studies on work stress, pain, smoking, anxiety, depression, diabetes management, substance use, stigma toward substance users in recovery, adjustment to cancer, epilepsy, coping with psychosis, borderline personality disorder, trichotillomania, obsessive–compulsive disorder, marijuana dependence, skin picking, racial prejudice, prejudice toward people with mental health problems, whiplash-associated disorders, generalized anxiety disorder, chronic pediatric pain, weight maintenance and self-stigma, clinicians' adoption of evidence-based pharmacotherapy, and training clinicians in psychotherapy methods other than ACT. The only sour notes so far are the use of ACT for more minor problems, where existing technology exceeded ACT outcomes on some measures (e.g., Zettle, 2003).

What is most important from the perspective of the psychological flexibility model is that when one or more of the core processes are changed—and they usually are—good outcomes are achieved. So far, that finding is without exception. That provides a target for the creativity of researchers and clinicians, who can the focus on *empirically supported processes*—not just empirically supported packages and manuals—a long-stated dream of empirically supported treatment (Rosen & Davison, 2003). Whether people call their work ACT no longer need be of interest. Indeed, one reason we are using the term *psychological flexibility model* is to emphasize

that this model goes beyond issues of either technology or the brand name. Even the term *psychological flexibility* is unimportant. What is important is whether the processes of acceptance, mindfulness, and values provide a coherent model of human suffering and adaptability, one that leads consistently to effective interventions and intervention components and to moderators and mediators of change. We will return to these issues in the last chapter of this book and look at the intellectual and strategic aspects of the psychological flexibility model and review more evidence for them.

CONCLUDING REMARKS

In this chapter, we introduced a model of psychological flexibility that involves six core processes organized within three major response styles. Although space does not permit an exhaustive review of the literature from every diverse research domain, we have attempted to note some areas of research that support the account. In addition, empirical data within the ACT and RFT research communities has been highlighted to show the promise of this transdiagnostic approach. We are not claiming to have an answer for every question that could be asked (or tested) with regard to the psychological flexibility model. The purpose of explicating the model in the first place is to provide interested practitioners and clinical and basic researchers with a framework that allows clinically important questions to be investigated. It is through this process of inquiry that we will ultimately discover the strengths and limitations of this approach. In the contextual behavioral science development model (see Chapter 13), that is exactly as it should be. We believe that the psychological flexibility model fits the requirements for a relatively adequate unified transdiagnostic account that can be use to foster human growth and alleviate human suffering. Starting with the next chapter, we will explore how that is done inside ACT.

PART II

Functional Analysis and Approach to Intervention

CHAPTER 4

Case Formulation

Listening with ACT Ears, Seeing with ACT Eyes

with Emily K. Sandoz

In this chapter, you will learn . . .

- How to explore the client's presenting problem.
- How to identify sources of psychological rigidity and flexibility.
- How to identify ACT-relevant processes in the therapeutic conversation.
- The key features of an ACT case formulation framework.

We begin this section on the ACT approach with a chapter on case formulation for one simple reason: it is often an important prerequisite for delivering effective ACT interventions that fit the needs of each client. Case formulation from an ACT perspective is the ability to analyze the client's presenting problems functionally and to reframe them within the psychological flexibility model (described in Chapter 3). We have witnessed many clinical situations in which the therapist is highly skilled in delivering specific ACT interventions but yet struggles with the "big-picture" understanding of the client's situation—and thus the direction of therapy is off the mark. If you, the practitioner, are able to listen with "ACT ears," you will be able to identify the verbal clues (readily available in most clinical interactions) that reveal what the client is really struggling with. These clues make it easier for you to select the most appropriate ACT intervention. Similarly, looking with "ACT eyes" enables you to tune into the subtle

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but highly significant nonverbal signals or behaviors (i.e., eyes dropping or saddening, clinched fists, lip biting, hand rubbing) that reflect the client's psychological attitude toward his or her difficult life situations and associated distressing private experiences.

We discuss the psychological flexibility model in this chapter in a clinical way, but the model itself is a model of human functioning, not just of psychopathology in a narrow sense. Case conceptualization in some special settings (e.g., corporate coaching) may require somewhat different tools than those we discuss here. Furthermore, in some settings, it is fine to do ACT work without a detailed case conceptualization for specific individuals (e.g., in large-scale organizational, public health, or educational work). Even in these situations, however, ACT ears and eyes will increase your effectiveness and make it less likely that you will apply ACT methods inappropriately. By and large, the general principles discussed in this chapter apply irrespective of differences in setting.

In the psychotherapy context, case formulation or conceptualization involves gathering the information you need in the initial interview, dissecting this information by using the psychological flexibility model, identifying an entry point in therapy, and modifying the formulation based on additional information gained as therapy unfolds. We focus in this chapter on the very direct relationship between assessment, case formulation, and treatment. To provide a needed element of structure to the case formulation process, we also introduce some ACT case formulation tools that you can readily use in your own clinical practice. While our emphasis in this chapter is on clinical interviewing strategies, we do not mean to diminish the importance of simultaneously using such formal assessment methods as self-report measures, behavioral simulations, and the like. In the interests of better communication, we use DSM syndromal terms at times even though we believe that when applied correctly the ACT unified model has greater treatment utility than current syndrome-based approaches.

THE CLINICALLY USEFUL CASE FORMULATION

While settings and clients vary widely, the aim of case formulation is always the same, namely, to orient the clinician to changeable intervention points of potential service to the client. If all case formulation were done in exactly the same context—say, a large interdisciplinary team at a research hospital, with a predefined battery of assessment hours programmed into the treatment regimen—we could offer a single method of case formulation that might have proven clinical utility. However, we know that this idealized arrangement is simply not the case. Some using this book may be

able to allot hours to the development and refinement of a case formulation, while others are faced with meeting a client in a primary care clinic or an emergency room and having to generate a working practical case formulation within 15 minutes. Some work with children and others with adults. Some work with intellectually disabled clients, while others work with highly functional people.

Whatever the reader's needs, we have a greater chance for making the case formulation clinically useful if we think about key flexibility processes in the broader context of the client (family history, culture, social contingencies) and the antecedents and consequences most influencing the "problem" behavior. An ACT approach is geared toward helping the clinician "get out of the box" quickly and think about human problems in a highly pragmatic way. Until the practitioner gets fully used to thinking functionally, behaviorally, and contextually, ACT will always be a rough fit—which is why practitioners who come to ACT from other theoretical orientations often need additional education and training in the broader aspects of contextualism.

Information Gathering on Presenting Problems and Their Context

The psychological flexibility model described in the present volume is at its core a contextual approach to understanding clients interacting within and through their environmental and private contexts. This statement suggests that the six processes of the model should not be viewed in isolation, but rather are highly sensitive to the surrounding social, cultural, environmental, and biological environments. Clinically relevant problems and solutions do not just unfold inside the organism; rather, they interact widely with the surrounding environment. For example, the benefits of teaching psychological flexibility to workers are undermined in a work environment that does not allow new ideas to be expressed and followed (Bond & Bunce, 2003). Values are sensitive to the cultural context—they may be allocentric or relatively individualistic. The psychological flexibility model is designed to be adaptable culturally by allowing cultural knowledge to be fitted to processes and principles known to be important to psychological health. This is a safer approach than cultural adaptation based on cultural knowledge alone, since cultures can support psychologically unhealthy processes, as well as healthy ones.

Because ACT assessment is focused on a small set of functionally relevant variables, ACT practitioners can significantly shorten the interview process relative to more traditional information collection exercises. That in itself is something that is highly desirable in the overburdened settings in which behavioral health services are often provided. There are two main

queries that typically "feed" the ACT case formulation process: What kind of life does the client most deeply want to create and live? What are the psychological and/or environmental processes that have inhibited or interfered with pursuit of that kind of life?

The Functional Analysis: Time, Trajectory, and Context

In the initial interview, the client normally presents with a particular problem focus, and the practitioner usually begins by analyzing these presenting complaints. The psychological flexibility model itself helps organize complaints into an analysis that is oriented toward their function, not just their form, frequency, or situational occurrence. Information about the course and context of the client's problems is needed to conduct this functional analysis.

The practitioner should understand the *timeline* of the problem. When did this problem first start? Has there ever been a time when the client didn't have the problem or it was markedly less pronounced? The problem's unfolding nature or *trajectory* also needs to be understood. Is this problem currently about the same in intensity, frequency, and duration as when it first appeared? Is it less serious than before or worse than before? Are the negative impacts of the problem widening or narrowing in the client's life space? Does it seem more controllable or less controllable over time? It is also important to note the private or public *antecedents* and *consequences* of the behavior. What triggers this problem in the client's external or internal world? What happens when the client engages in the behavior? How do positive and negative consequences arrange themselves over both the short and long term?

In addition to providing needed information, these questions are themselves an intervention merely because of how they are framed by the clinician. For example, suppose a person is taking street drugs and it seems possible to the ACT clinician that the client is using the drugs in part to regulate his or her anxiety. As the practitioner asks in gradually greater detail about the difficult experiences the drugs help regulate and the short- and long-term consequences experienced, the client's awareness of experiential avoidance and its costs may increase. This increased awareness, in turn, may set the stage for later ACT interventions.

It is usually helpful to inquire about the kinds of private experiences the client is struggling with. Knowing that the client looks uncomfortable when talking about some topic is not nearly as useful as knowing which specific thoughts, emotions, memories, or physical sensations are showing up at that point for the client. The clinician needs to show "appropriate inquisitiveness"—the ability to dig a little deeper into the client's private

experiences with respect to some subject area without getting lost in the resulting material. The clinician's goal is simply to touch upon relevant private processes to see how they might be interconnected. Later, this information will be used in both case conceptualization and treatment planning.

Many clinicians are likely to probe more for certain types of private experience than for others, and this tendency can create "holes" in the clinician's knowledge of the client. For example, a clinician with a strong background in cognitive restructuring might be more inclined to look for "sticky thoughts" and less inclined to inquire about memories and physical sensations the client is experiencing. In general, we recommend that the clinician always inquire about a wide variety of experiences in the client's private domain, including the associated thoughts, emotions, physical sensations, and memories experienced. This casting of a wide net enables the clinician to be in a position to pay appropriate attention to diverse aspects of the client's private experience that might be relevant. The external environment (including family members and significant others) should also be examined at length, along with possible relationships between the two spheres, internal and external.

It is also worth noting your own reactions during the interview. What types of thoughts, feelings, associations, memories, and physical sensations do you experience when interviewing the client? These can be useful as a guide. For example, if you are feeling angry without obvious reasons, it might be useful to explore how the client deals with issues of anger, hurt, or vulnerability, or how the client is currently feeling.

Values Interview: Love, Work, and Play

The case conceptualization must include the life context in which the client is operating and how the basic requirements of daily living are being met. Thus, it is important to get a snapshot of the client's life space across the relevant domains of valued living. Robinson, Gould, and Strosahl (2010) have suggested a "Work–Love–Play" assessment. All of the domains of valued living that we discuss in detail in our chapter on values (Chapter 11) can also be used at the outset to assess the client's strengths and weaknesses (Wilson & DuFrene, 2009). The time taken for this initial life snapshot assessment depends on the context. In typical outpatient psychotherapy, the interview might take up most of the first therapy session; in the context of a primary care exam or a visit to an emergency room, the assessment might take only a few minutes.

Irrespective of the particular setting, the practitioner should explore major domains of daily living in relationship to the client's presenting

complaints. Has the client stopped participating in relaxing present-moment-building activities? Is the client socially disconnected? How are things going at work and with peers at work? How is the client getting along with his or her life partner? or children? or friends? What does the client do for spiritual life? What kinds of health habits is the client practicing: is he or she drinking? drugging? smoking? overeating? exercising regularly?

During this phase of the interview, it is usually quite easy to reframe the client's rationale for the presenting problems in a values context. For example, consider a socially withdrawn person who says, "I don't want to be alone—I'm not a hermit in an empty house by choice—but when I get around people I don't know really well, I'm just not comfortable. They might not like me." The clinician might immediately recast the client's reply in this slightly different way:

> "Let me see if I have this right. It sounds like you actually care about people—you'd like to be connected and to be part of things—but you withdraw to lessen the anxiety you often feel around others, especially when you are thinking they might not like you, and that is leading to a sense of aloneness and emptiness. Does that seem like how it's been working?"

DETECTING PSYCHOLOGICAL FLEXIBILITY PROCESSES

If there is an art to therapy, it is the ability of the clinician to read what is happening during a therapy session. Some clinicians seem to be born with the ability to do this rather spontaneously, but for the rest of us a bit of structure is needed to help guide the process. Assessing the client's flexibility processes during the interview does not in itself constitute a case formulation. Rather, it provides the data for case conceptualization, treatment planning, and ongoing course corrections during therapy. In the sections that follow, we explore the psychological flexibility model and highlight the strands of a clinical interview that might indicate high or low levels of a particular core process. With each core process, we provide you, the clinician, with a behaviorally anchored scale representing low, medium, and high levels of flexibility in that area. We then return to the issue of integrating these processes into a coherent case conceptualization framework. Because the psychological flexibility model is both multidimensional and integrated, one could, in principle, begin at any point in the model and then observe other core processes that arise. We begin with assessing the "Centered" response style.

Assessing the Present-Moment Self-Domain: Can the Client Stay Centered?

The Centered response style incorporates present-moment awareness and self-as-perspective. To assess these processes, we need to know those two things at the most basic level:

1. Is this person viewing life as an experience at least somewhat distinct from the stories our minds might tell about it?
2. Is this person flexibly, voluntarily, and purposefully here in this moment?

In other words, to what extent is there a "you" and a "me" working here and now, attending in a flexible and focused way to the task at hand?

Assessing Present-Moment Processes

Assessing present-moment processes can come rather naturally in a clinical interview. All life occurs in the present moment—including discussions of the past and future. The critical assessment question is: Can the client contact events in the present in a way that is flexible, focused, voluntary, and purposive?

In the normal clinical interview, the issue of presence appears even with the simplest questions about what brought the person to therapy at this particular time. Questions about presenting problems described earlier provide an entry point to the assessment. Can the client direct attention toward when the problem started or times when the problem has worsened or improved and do so without being easily distracted or becoming fixated on particular content? The ability to do so is a marker for functioning in the domain of present-moment processes. Altering the pace of questioning by lingering over some topics and moving somewhat more rapidly through other topics can reveal the client's level of contact with the current context in a moment-by-moment way.

COMMON FAILURES OF PRESENT-MOMENT PROCESSES

Failures of present-moment processes may take a variety of forms. A common example is worry and rumination. Clients who exhibit high levels of worry and rumination may be capable of following a line of questioning. However, initial probes tend to reveal that their responses persistently lapse back into concerns about the future or a reexamination of past events. Attentional rigidity can be observed, for example, in a client diagnosed with Asperger syndrome who talks almost exclusively about, say, baseball

cards. Prompts to bring the client's attention to bear on particular subjects may be met with resistance and frustration. Other clients may become fixated on explanation or analysis as a means of avoiding particularly strong emotional content.

Distractibility is another variant that is seen regularly. The inability to maintain attentional focus is a central feature of certain diagnoses, such as attention-deficit/hyperactivity disorder (ADHD), but may also be present in clients struggling with anxiety and depression. In these cases, various sights, sounds, and topics draw the person readily off track. Clients with trauma histories often exhibit this sort of topic switching in the service of experiential avoidance. One should not confound the time period of the content being discussed with the capacity "to be present" in the sense that we mean it. For example, suppose a clinician asks about a very difficult event in the client's past, like the death of his or her spouse. The client might be able to shift awareness and bring careful attention to that event, memories of it, and how it feels now when being remembered, and then be able to move on to the next subject. Conversely, however, the client might brush the probe off and rush back to the previous topic or on to the next, or become so tightly connected to it that the ability to shift attention is lost. The client's inclination is often revealed by relative responsiveness to successive probes. For example, having made contact with some difficult event in the past, the clinician might ask what feelings are "showing up" as the event is remembered and how these might be different from what was felt when the event originally occurred. Transitioning fluidly from then to now, or from this topic to the next, indicates strength in present-moment processes even if the content discussed is "about the past." In the same way, then, merely bringing up the past or future voluntarily does not, in and of itself, indicate that the client has difficulty in dealing with present-moment processes.

Failures of present-moment processes are often revealed in the paralinguistic aspects of speaking and the attentional aspects of listening. When clients are psychologically present there is a sense of presence in their eyes, bodily postures, emotional tones, and responsiveness to the therapist's pace. When clients are attentionally rigid and out of contact with the present, they may be distracted by other events as they occur in the immediate environment (e.g., sounds outside the room) or may be unable to stay connected and responsive to the therapist's probes. Difficulties in these areas are often experienced by the therapist as a sort of disconnect with the client, where it almost seems as if client and therapist are not engaged in the same conversation. The conversation may seem dull or lifeless despite numerous attempts to elicit a variety of responses in the client. Indeed, the client may seem somewhat disconnected from the process of speaking—or,

conversely, so inflexibly connected that awareness of other aspects of the interaction seem to be lost.

Part of the assessment for present-moment processes is related to the pace of communication. If someone is experiencing something highly distressing, there is often a hurried, pressured quality to his or her speech. In instances such as this, the clinician might deliberately slow the pace and persist in that slower pacing. Some clients readily accede to therapists' changed pacing, but others do not. If the clinician asks a question very slowly, or gently asks the client to stop a moment and consider the question, is the client willing to modulate the pace of his or her own conversation appropriately?

EXTREME FAILURES OF PRESENT-MOMENT PROCESSES

At the extreme end of the continuum, the client might be entirely unresponsive to questions. Dissociating is a dramatic example. In such instances, the clinical requirements are to see where the client's attention is being focused, inquire about it, and probe to see whether the client's attention can be shifted to other related and even unrelated subjects. The practitioner may well attempt to see whether anything in the present environment is capable of provoking a response from the client. The client who is actively hallucinating provides another example. In this case, the flexibility and focus of attentional processes inside and outside of the problem area should be assessed. For example, we might ask about the hallucination ("Can you tell me what you hear?") or probe for attentional flexibility in other areas ("Who brought you to the session?").

Assessing Self-Processes

The assessment of self-relatedness is crucial to ACT case formulation. The classic self-problem seen in clinical settings is fusion with the content of verbal self-knowledge—such as "I am depressed" where "depressed" has the quality of a personal identity. This aspect of self—the conceptualized self—can be "positive" or "negative" or both, but its most dominant features are that it is rigid, evaluative, and evocative. When this form of self is dominant in the client's daily mental life, it tends to overwhelm all other forms of self-experience. Matters such as "being right," defending one's self-story, or understanding the origins of personal suffering become the most important goals. In general, ACT views this form of self-knowledge as not only highly flawed but also very much of a threat to the client's life vitality.

Another aspect of self is contact with the ongoing stream of private experience, or "self-as-process." This contact has to do with the ability to observe and describe experiences in the present moment. Statements such

as "I am feeling angry right now" reveal that the client is both aware of the content of ongoing awareness and aware of the distinct process of observing that content. This aspect of self-relatedness is a crucial part of "contact with the present moment."

A final domain of self-relatedness is characterized by the ability to note the content of consciousness from a particular perspective, or self-as-perspective. The "I/here/nowness" of consciousness itself is an aspect of self that transcends any particular content of awareness—it is the context of verbal knowing itself. RFT researchers have developed assessment tools to measure this sense of self (McHugh et al., 2004; Rehfeldt et al., 2007), but in clinical interviews assessment can be based on a person's ability to shift perspective from now to then, from here to there, and to assume the perspective of others. Often, this ability will be demonstrated in spontaneous verbal or nonverbal behaviors, for example, humorous comments made about a painful life situation or moments of silence in which the client appears to be "grounding" him- or herself.

A good way to assess for self-as-context is to examine the flexibility of perspective taking via the interview itself. A question like "What do you think I'm feeling now, hearing this?" probes for the ability to imagine the world as seen through the eyes of another, and thus clinicians can often detect deficits in perspective taking such as a certain lack of sensitivity or lack of connection to the client's own experience. Clients might be asked to imagine being older and wiser and giving themselves advice on how to proceed now in the midst of struggle. This approach probes for the ability to see the "me/now" from the perspective of "me/then." A wide variety of common clinical techniques (empty chair, role play, probing for what the person supposes others feel, or understanding and applying metaphors and stories) depend in part on self-as-context and can be used to help detect ACT processes in clinical interactions.

COMMON FAILURES OF SELF-PROCESSES

The prototypical problem in self-processes is fusion with verbal conceptions of self, such that the client cannot stay in contact with ongoing self-processes and cannot take perspective on difficult life problems. Fusion with the conceptualized self is revealed in the tendency to become absorbed in self-stories and to defend a particular self-image. It does not matter whether the story is "good" or "bad." When contradictory information or alternative interpretations are offered, the person finds a way to maintain the original thesis. It is not uncommon for such a client to respond with threats when the conceptualized self is challenged, as if to say "If I am not who I say I am, then who am I?"

Fusion with a conceptualized self can often be revealed by statements that take the form "I = problem." When the person is asked a question that would normally evoke "I" answers, the verbal response quickly devolves into fused content. Questions as simple as "What did you feel?" or "What do you remember?" can produce this type of effect. If fusion with the conceptualized self is very high, probes will invariably lead back to the self-relevant fused content, often integrated into the same general theme, regardless of areas actually probed.

Asking values-oriented questions is a good way to test for fusion with the self-story. The clinician might make such a simple request as "Tell me about some particular act you have done that would help me to understand you as a brother." This is a request the response to which would normally begin with "I." Suppose the client replies, "I loaned my brother my car 4 or 5 years ago, and he got in a wreck and never paid me for the damages. That's just like him." This type of response is inadequate because it does not really take into account the motives of the therapist (a form of perspective taking) and it has triggered a portion of the client's self-story, suppressing the client's contact with important social values.

At a much more severe level, some individuals may be wholly incapable of bringing attention to bear on anything the clinician asks. We may see no distance at all between the client-as-person and the hallucinations being experienced. Even such a question as "Are you hearing voices right now?" might be responded to with pleas such as "They are killing me! They are killing me!" rather than "I am hearing voices." In these circumstances, the client may be incapable of responding to "I" questions independent of the particular symptom being experienced. With the diminution of "I" will come also the diminution of "you," and such clients may have little or no awareness of the clinician's role, feelings, or perspective.

Assessing the Acceptance–Defusion Domain: Can the Client Stay Open?

Although some clients need little more than to get centered and present, reconnect with their values, and begin committed action, more frequently clients will have levels of avoidance and fusion that pose substantial obstacles to valued living. We earlier called fusion and experiential avoidance the "siren songs" of suffering. When the client's behavior patterns are developed under the aversive control contingencies that experiential avoidance entails, life becomes a game of avoiding personal experience, based on the belief that such experience is toxic and poses a direct challenge to personal health. It's a rigged game, of course, but it is made to seem winnable by the feel-good culture that promotes it.

When assessing this domain, the clinician needs to focus on the extent to which fusion and experiential avoidance are running the client's life. Is the client's existence organized chiefly by what he or she regards as unacceptable? Does the client permit disagreeable feelings or memories to largely dictate the direction of his or her life? To what extent does the client live in a world of "musts" and "shoulds" and "can'ts"? To what extent does the client live in a world of well-rehearsed excuses for why things are as they are—a world in which change is either impossible or for a time other than right now?

Often a type of stereotyped behavior characterizes the lives of clients who are under strong aversive control. Fusion and experiential avoidance are both indicated by constricted patterns of behavior. Verbally, this pattern is most evident in tone, pace, and content. The client may say essentially the same thing over and over again. The vocal quality may also lack range, both in tone and pace. For the depressed client, the tone may be low and pleading. The angry client's tone may be louder and clipped. Both depressed and angry clients show little variability or contextual sensitivity, even when prompted to do so. Finally, the content of the client's talk shows rigidity and narrowness.

Assessing Acceptance Processes

The central question in assessing acceptance is whether the client can actively embrace what occurs in direct experience—on a moment-by-moment basis—even when content is unwanted and distressing. Alternatively, which aspects of the client's private experience are functioning as obstacles to valued living? Clients typically seek help because they are experiencing some kind of pain in their lives. Inquiring in detail into what is painful and what the client does in the face of pain directly shapes acceptance-oriented interventions.

COMMON FAILURES OF ACCEPTANCE PROCESSES

When assessing acceptance, it is important to assess both avoided content and the client's avoidant behavioral repertoire. At times, the client directly labels what is unacceptable—panic attacks, bouts of depressed mood, negative thoughts about self, guilt, shame, cravings to drink or use drugs. When avoidant content can be described, the clinician can inquire further into the ways the client copes with these unacceptable events whenever they appear. Does the person prone to panic stay home? Does he or she avoid attending any events or engage in any activities that might trigger uncomfortable levels of anxiety/sadness/guilt? When in social situations,

does the client focus on monitoring his or her anxiety level rather than just being socially engaged? As the following narrative demonstrates, very simple probes relating to what the client does when the avoided content is present reveal much about avoidant repertoires.

THERAPIST: So, you said the cravings for a drink have been particularly bad lately.

CLIENT: Yes. It makes me crazy. I can't think straight.

THERAPIST: Sometimes they are better and sometimes worse?

CLIENT: Sure, sometimes I don't even think about it. Things go great. But then—there it comes and I can't think of anything else.

THERAPIST: To help me understand this, it would help if you could tell me about times when cravings are mild and times when they are really strong. So, when they are just mild, what do you do?

CLIENT: Well, I just try not to think about it. I just try to stay busy.

THERAPIST: Anything else?

CLIENT: Well, sometimes I worry—like what if they get worse or what if they never go away. What if I am 60 and still going crazy? I just don't think I can stand it! (*Pace picks up a bit, voice becomes more strained.*)

THERAPIST: Wow, it sounds like sometimes you start worrying and it sort of ramps up on you. Almost like you can watch it getting worse.

CLIENT: Yeah, it can get pretty bad.

THERAPIST: And, when it is really bad, what do you do?

CLIENT: I just don't know *what* to do! It makes me nuts. I end up yelling at people around me, yelling at my wife, yelling at people on the phone, driving like an idiot, yelling at traffic.

In this dialogue, the experientially avoidant pattern is trying not to think about drinking and trying to stay busy to distract attention away from urges. It is quite possible that the client's angry outbursts are a by-product of the aversive quality of the cravings; however, they may also function to distract the client from the unacceptable experience of craving, combined with thoughts about the cravings "never going away." The clinician might explore, without judgment, what happens to the cravings when the client gets really mad or gets into an argument. It is entirely possible that these outbursts stave off the aversive psychological states associated with the uncertainty of the cravings. Although there are some exceptions, a general

rule of thumb is that whatever reliably follows unacceptable content is most likely part of the chain of avoidant responding.

It can be valuable to assess when and where avoided content is worse. Patterns of avoidance in these instances may interfere with valued living. For example, a divorced father may try to avoid feeling remorse over his failed marriage when he sees his own child, or even observes other people with their children. Acceptance interventions targeting these relevant antecedents may help the client to open up more to parenting as a valued domain.

A significant source of information about both acceptance and experiential avoidance is the client's in-session behavior. The client may not know or may not be aware of what is being avoided and therefore cannot talk about it directly. This situation is particularly true of the chronic multiproblem client. While conducting the interview, the clinician may notice that topics have changed and realize only in hindsight that the client steered the conversation in a different direction. If the behavior recurs time and again, a pattern of avoidance is evident. Simply asking a client to visualize a difficult situation and noticing the thoughts, emotions, memories, and bodily sensations that arise can sometimes elaborate the avoided content in ways that the client might find difficult to discuss directly. Some clients will not be able to tolerate such exercises, even when kept very brief. This potential objection should not hinder the assessment, however, as it is itself an indicator of the level of avoidance. Another client might be able to follow instructions and visualize the scene but fail to remain in the exercise. Instead, he or she might engage the therapist in a conversation about the exercise to avoid making contact with the feared content. Yet another client might be able to settle into the exercise, describe the distressing content directly, and continue participating until instructed to stop by the clinician. All of these potential responses represent diverse points along the avoidance–acceptance continuum.

FORMAL MEASURES OF ACCEPTANCE

Formal measures of experiential avoidance and acceptance are by now quite popular and widespread. The best known is the Acceptance and Action Questionnaire (AAQ; Bond et al., in press; Hayes et al., 2004), a publicly available assessment scale that takes the client only a few minutes to complete. The AAQ does a very good job of predicting many forms of psychopathology (Hayes et al., 2006). A large number of more specific versions of the AAQ have been developed in such areas as smoking (Gifford et al., 2004), weight (Lillis & Hayes, 2008), psychosis (Shawyer et al., 2007), chronic pain (McCracken, Vowles, & Eccleston, 2004), epilepsy (Lundgren

et al., 2008), and diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007b), among others.

Given the great increase in acceptance, mindfulness, and other third-wave interventions, a wide variety of related measures have emerged that tap into acceptance processes. These include the Self-Compassion Scale (Neff, 2003); White Bear Suppression Inventory (Wegner & Zanakos, 1994); Cognitive-Behavioral Avoidance Scale (Ottenbreit & Dobson, 2004); Thought Control Questionnaire (Wells & Davies, 1994), Distress Tolerance Scale (Simons & Gaher, 2005), the Emotional Nonacceptance subscale of the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), or similar subscales on various mindfulness measures such as the Kentucky Inventory of Mindfulness Skills (Baer, Smith, & Allen, 2004) or the Five Facets of Mindfulness Questionnaire (Baer et al., 2008), among several others. The definitions of acceptance vary in all of these approaches.

Measures such as these can be used to inform case formulation. Even simple idiosyncratic measures have also been shown to be helpful, such as daily self-ratings of willingness made on a 1–10 scale (Twohig, Hayes, & Masuda, 2006). Clinicians practicing ACT should not be reluctant to improvise custom-made acceptance scales, so long as they promote the overall goal of informing case formulation.

Assessing Defusion Processes

In assessing defusion processes, the clinician should attempt to identify specific examples of fused content as well the impact of that content across the various domains of living. Repetitive, monotonic, categorical, and evaluative statements are common markers of fusion. Does the client return to the same content over and over again? Does the client readily tell a well-worn story about his or her condition, how it evolved, and what needs to change for life to move forward? The interrelatedness of ACT processes is particularly relevant when examining fusion. For example, the deadening repetitiveness of worry and rumination are examples of failures of present-moment processes, but the contents of worry and rumination constitute fused content. Likewise, fusion may well be encountered as a primary obstacle in a values assessment or when discussing difficulties with committed action.

COMMON FAILURES OF DEFUSION PROCESSES

Fused content is a common occurrence during the interview, both for the clinician and the client; so, it helps to know the seminal features of clinically problematic fusion. We can list several.

Comparison and Evaluation. Listen for excessive comparison and evaluation in the client's speech, as contrasted with description. The clinician can probe the strength of such patterns of fusion by asking the client to simply describe the troublesome situation and what it evokes without injecting evaluations. Clients with high levels of fusion may not be able respond at all or may quickly lapse, injecting personal evaluations into the ongoing narrative.

Complex, Busy, Confusing. Fused speech often has a very busy quality—as though the person is working very hard to figure something out. If fusion is running high, this stream of frantic problem solving is exceedingly difficult to interrupt.

Adversarial. Fused speech often has an adversarial quality. Sometimes this aspect can feel as though the person is actually arguing with him- or herself internally—trying to develop the strength of will to do or not do something. As the following dark humor narrative shows, the nature of human symbolic activity guarantees that there is never a "winner" in these internal debates; for every argument favoring one side of an argument, the human mind will usually be able to generate a counterargument.

ME: I should start an exercise program.

ME: But I don't like to exercise.

ME: But it would be good for me.

ME: But I am really too busy right now.

ME: But you are always too busy.

ME: But I have a chapter to finish.

ME: And, when is that not true.

ME: But this time I mean it. When I get back from Europe, I will start.

ME: Where have I heard that before?

And on and on it goes.

Justifying Speech. At times, fused speech sounds less like an argument and more like justification, explanation, or reason giving. The common factor is the relative impermeability and inflexibility of the conversation. Brief versions of some ACT defusion exercises can help you, the clinician, to assess how entrenched the reason giving is. For example, the clinician might write the client's reasons on $3'' \times 5''$ index cards and then ask the client to sit quietly while the clinician places one card at a time, face up, in

the client's lap. The client is asked to simply read aloud what is written on each card. The highly fused client will often break away from this exercise and begin to argue either about the purpose of the exercise itself or to pick up the process of defending reasons in midstream. Conversely, a client with very low levels of fusion might have little trouble just reading the various content statements aloud and might even make a comment about these statements seeming different when they are said aloud.

An additional element of justifying speech is a high level of verbal problem solving that fails to facilitate values-consistent action. Self-argument or reason giving is often solution-seeking behavior. Will I or won't I start an exercise program? Is there a good reason for me to be depressed? Is there a good reason for me to imagine the worst in my future? If the client is trying to convince you of something, or if you feel like arguing with the client, that inclination indicates that high levels of fused content are surfacing in the interaction. You need not attempt to refute these reasons. Instead, you should probe for flexibility and for experiential and behavioral avoidance that is the end result of fusion.

Perseveration. Similar to the way attention fixation poses a barrier to present-moment awareness, perseveration is often a hallmark of the fused client. In essence, the client loses the ability to flexibly shift between the topic that is dominating awareness and other topics of clinical importance. Valued domains of living can provide a sensible and practical method of assessing fusion. Because inflexibility is a hallmark of fusion, we can begin to ask a client about domains of living that are meaningful and then watch the direction that the talk takes in response.

In extreme cases, the client will be wholly unresponsive to the probe. In other instances, the client may respond partially to the probe in that the topic change is made, but the response pattern will tend to incorporate fused content. In yet other cases, the probe may only momentarily interrupt the repetitive pattern (e.g., of worrying about depression), which then immediately returns, often with the same tone and pace. A close look at the spoken content would likely reveal sentences, phrases, and thoughts that the client has repeated again and again.

FORMAL MEASURES OF DEFUSION

There is growing interest in developing structured measures of defusion. Defusion can be difficult to measure using self-report since the concept refers to one's relationship to thought rather than content, and self-report focuses mainly on content. There has been progress in this area, however.

One common way defusion is measured is to ask about the believability of a thought, above and beyond its occurrence. The two concepts are

not isomorphic. For example, "I am going to die" is believable to all, but a person can be defused from this thought or, alternatively, entangled with it. Distinguishing between whether a thought occurred and whether it was believable when it occurred is a readily understandable way to ask participants how they stand in relation to their own thoughts in particular areas.

Almost any cognitive measure that is focused on the content of thought can be rewritten to focus on the person's relationship to the thought when it first occurred. For example, believability ratings can be added to established measures such as the Automatic Thoughts Questionnaire (ATQ; Hollon & Kendall, 1980), asking not how often thoughts occur but whether they seem believable when they show up (it is an interesting historical fact that believability was originally part of the ATQ but was set aside by its developers before publication). This approach results in an "ATQ-Believability" measure. Such measures have been used successfully since the early days of ACT research (e.g., Zettle & Hayes, 1986) and have repeatedly mediated ACT outcomes (e.g., Hayes et al., 2006; Varra, Hayes, Roget, & Fisher, 2008; Zettle, Rains, & Hayes, 2011).

There are specific fusion/defusion measures in certain domains, for example, the Avoidance and Fusion Questionnaire for Youth (Greco, Lambert, & Baer, 2008) and the fusion subscale of the Psychological Inflexibility in Pain Scale (Wicksell, Ahlqvist, Bring, Melin, & Olsson, 2008). Some mindfulness measures also have subscales that measure fusion (Baer et al., 2004; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Various measures of reason giving, which were used in the earliest ACT research (Zettle & Hayes, 1986), have been refined in some specific areas, for example, the Reasons for Depression Questionnaire (Addis & Jacobson, 1996). RFT researchers are also making progress in developing implicit cognitive measures intended for repeated use with individuals that can be focused on specific forms of fused content (e.g., Barnes-Holmes, Hayden, Barnes-Holmes, & Stewart, 2008). A general measure of cognitive fusion is also under development (Dempster, Boulderston, Gillianders, & Bond, n.d., downloadable at *contextualpsychology.org/CFQ*).

Assessing the Values–Commitment Domain: Can the Client Engage Life?

The impact generated by difficulties in being open and centered is often felt in the arena of life engagement. The purpose of ACT is to help clients build ongoing patterns of values-consistent, committed actions by choosing valued life directions, by engaging in actions that are consistent with those values, and by consciously building larger patterns of values consistency. The psychological flexibility model suggests that doing so is based in part on openness and the ability to be centered. The exploration of values and

committed action often quickly reveals core issues, not just in this domain but in the other two (openness and centeredness) as well. It is a mistake to think, however, that intervening with values and committed action always requires work in the other areas. In some cases, simply getting the client into contact with his or her most closely held values and developing a simple committed action plan is all that is needed. Similarly, assessing difficulties with committed action may reveal something like a simple and easy way to remedy skill deficits in personal goal setting or self-directed behavior change. For this reason, it is always important to assess each core process individually and to include the results of that assessment in the case formulation.

Assessing Values Processes

The critical question in assessing values is: Does the client experience life as merely imposed or rather as something he or she can author in a meaningful and ongoing way? While the classic obstacles to appreciating and enacting one's values are generally fusion and avoidance, the failure to establish a values process can take a myriad of forms. We want to know something about the life the client is aiming to lead in order to orient and contextualize the ACT treatment. In the absence of a sense of life direction, there is little left to provide meaning to the client's pain and to the interventions designed to empower living.

COMMON FAILURES OF VALUES PROCESSES

The most common failure of values processes occurs when the client's psychological problems play such a central role that the client loses contact with valued domains of living. The client may not fully comprehend what is important in life because such matters have been put "on hold" while a war within is being fought. For example, a client may be so mired in anxiety or depression that he or she loses touch entirely with valued life directions. Life devolves into a daily attempt to control anxiety and depression and to figure out what is causing these unpleasant emotions in the first place. Ironically, strong attachment to solving the depression or anxiety problem can pull the client away from the very type of life the client is seeking.

Because fusion and avoidance are central obstacles to value-based living, the clinician must constantly listen for signs of fusion when assessing values orientation. Sometimes this need is indicated by the client directly (e.g., the client stating that he or she "has to" value something—and then linking that need to a fused reason). Other times more indirect evidence provides clues. When the clinician is directing the interview toward a discussion of the client's values, does the client persistently revert to a discussion of psychological difficulties? When valued domains are raised, does

the client begin to ruminate or worry about that area of living? Is the client defensive, claiming that life is going well in all valued domains? If asked to describe who he or she would like to be, can the client actively describe particular events in different valued domains?

Fused speech is dominated by categories rather than particulars and tends to be repetitive rather than fluid in tone. In the following session narrative, a female client endorsing parenting as a strong value is asked to describe a particular event in that domain.

THERAPIST: I can see on the Valued Living Questionnaire that parenting is very important to you.

CLIENT: Yes, the most important thing in my life.

THERAPIST: It would help me in our work if you could help me see that area really clearly. Perhaps you can tell me about some very specific things you have done with your son so that I can get a feel for this area.

CLIENT: Well, he is really important to me and I am just a mess. He needs me, and I can't even get out of bed in the morning. I just lay there, and I know I need to get up. I know I need to get moving, and I can hear my husband getting him ready for school, and I just can't get going.

Note in this example that the therapist asks for a specific example of parenting, but the client responds with a general reference to ongoing psychological difficulties and to past failures as a parent. Although the client's response seems sensible enough, it is in fact not responsive to the question asked. If a client is particularly fused, even several probes may fail to provoke a direct response to the question asked. Responsiveness to these probes reflects both an assessment and an intervention. If the therapist can assist in getting the client present with a single instance of valued living for an extended period of time, fusion is lessened at least momentarily. Then, the therapist might be able to assist the client in constructing goals consistent with the value.

Values are a matter of choice, not mere compliance; so, another failure of values processes arises when values are employed as a method of avoiding guilt or receiving social approval. These motives can sometimes be assessed in the interview. For example, the client who values education might be asked, "What if you received the education, but no one knew. Would that still be of importance?" When what looks like valuing is instead in the service of social compliance or experiential avoidance, questioning will reveal that the values are neither intrinsic to the action itself nor truly freely chosen.

FORMAL MEASURES OF VALUES

A number of values assessment processes and measures are available, such as the "Bull's Eye" (Lundgren, Dahl, Yardi, & Melin, 2008), the Personal Values Questionnaire (Ciarrochi, Blackledge, & Heaven, 2006, based on the work by Sheldon & Elliot, 1999), or the Valued Living Questionnaire–2, (VLQ-2; Wilson & DuFrene, 2009), which is discussed at length in Chapter 11. For the most part, these measures are relatively time-efficient, taking no more than 15–20 minutes to complete in most cases. The VLQ is an exception but specific versions of the VLQ-2 are emerging in such areas as chronic pain (Vowles & McCracken, 2008). When time permits, integrating structured values clarification instruments into the clinical interview can create even more clarity about values issues. Are there particular valued domains where the client shows more flexibility in speech or, alternatively, areas where there is a particularly strong sense of restriction? When a client shows reasonable flexibility in a valued domain, the clinician can move forward with elaboration of the values and with creating possible committed actions. When the client shows considerable restriction and high levels of fusion and avoidance, the therapist should come back to center and focus on present-moment work.

A tricky area occurs with cultures that foster allocentric values. Humans are a social species and in our experience most people in all cultures have strong social values. In allocentric cultures, however, the group good is fostered so strongly that it can be difficult to distinguish fused values from chosen social values. The pivot is not whether values are allocentric or individualistic—both can be values in an ACT sense—it is whether the person takes responsibility for these choices. More work remains to be done on how best to make these discriminations in different cultural conditions.

Assessing Commitment Processes

In assessing commitment processes, we are asking whether the client can construct and carry out particular behavioral acts that are values-consistent. The chief obstacles to commitment processes are fusion and avoidance, or the lack of motivation that can come when such actions are linked to the self-story and are not linked to values. The latter, in turn, leads to chronic patterns of self-defeating behavior. Problems with committed action can be evident in lack of action, lack of persistence, or behavioral excesses servicing the purposes of experiential and behavioral avoidance. The assessment process often reveals a spotty and loosely organized life situation. Important activities might characterize certain domains but not others, or they might occur occasionally but not regularly. Thus, even if the client

appears to have *some* behavioral skills, he or she still needs to engage seriously in building patterns of action that are larger, more integrated, and less sensitive to impulsive disruption. For example, if the client consistently allows patterns of committed action to be readily disrupted by certain emotions or thoughts, a gradual process of working through these points of vulnerability while maintaining commitments is definitely in order.

COMMON FAILURES OF COMMITMENT PROCESSES

The most common reasons leading to the failure of commitment processes are impulsivity, immobility, and persistent avoidance. The initial assessment of commitment processes often involves asking the client to cite examples of particular value-consistent actions he or she has taken in the past and others that might be contemplated in the future. The clinician can also ask the client to generate a list of possible committed actions—from very small committed acts that could be accomplished the very same day to ones that might be much more time-consuming. Some clients are able to generate plenty of examples with little prompting but seem to bog down when it comes time to act. Sometimes this reaction signals problems with fused content, while at other times it indicates skill deficits in personal goal setting. For this reason, the clinician needs to go all the way through the process of having the client make and keep particular commitments. What happens that stalls the process? Is the client failing to follow through because some feared content suddenly shows up? Does the client have the ability to break the planned behavior down into smaller units and take one step at a time? Is the client stopping the committed action at the first sign of any pushback from the environment? At a basic level, failures of committed action processes always point back to some other process, be it fusion or a specific skill deficit. It is very important to the case conceptualization process to be able to determine what factors are at work.

When fusion and avoidance are high, the client may be incapable of citing any specific examples of values-oriented actions, either past or future. As the following narrative demonstrates, a client may even lapse into worry, rumination, and fused patterns of speech upon being asked questions about making and keeping commitments.

THERAPIST: We were talking about the importance of parenting earlier, and I wonder if you could tell me a few actions you would like to take as a parent.

CLIENT: Well, I just want to be there for them.

THERAPIST: Sure but could you give me some specific things that you might do that really have the flavor of you being the mom you want to be.

CLIENT: Well, when they get home from school, I should be there. I mean, not just at home, but, you know, there like my mom was for me. But I just can't get going. I feel so stuck. It just makes me sick. And I worry about the effect this is going to have on them. It's like not having a mother at all—maybe worse. I just have to do something.

Note that the client's speech is littered with "have to" and "should." It also lacks detail. The client does not mention specific things her mother did—just "being there." The flexibility and fluidity with which clients can answer such questions is a critical assessment issue. If multiple prompts for specifics are met with fusion, it is likely that even the thought of taking action is paralyzing. If this type of interaction occurs, the therapist may as well take actual actions off the table and note whether the fusion softens a bit.

THERAPIST: I just want you to know that I absolutely *do not* want you to do anything different right now. I just want to get a sense of some small acts that would give me a feel for the mom you want to be. Later we can talk about *doing*. For now, I just want a look at the life you are longing for. So, you mentioned being there when your kids come home from school. And, you mentioned your mom. What kinds of things did she do?

CLIENT: It wasn't that much really. I can't remember. But I just remember her being there.

THERAPIST: Well, maybe you could help me see it. So, if you close your eyes for a moment and maybe you can see yourself coming home from school. Imagine standing in front of your childhood home and notice the outline of the building and the way the yard looks. And, picture yourself walking though the door, and your mother is there. Just imagine that you walk in and begin to notice the small things she does. And, just linger there a moment, breathing gently—just taking it all in. And now, could you open your eyes, and tell me what you saw.

CLIENT: She was in the kitchen. She had me sit down and made me a snack—these little sandwiches she used to make. And, I could see her moving around the kitchen and asking about my day, what I had learned and who I had played with.

THERAPIST: Nice.

CLIENT: She was just always there. It was no big thing, but I could count on her.

In this set of interactions, we have touched on potential committed actions in a fairly indirect and nonthreatening way. Because the woman referenced her own mother, her mother's acts serve as a sort of symbolic proxy for the committed actions she might like to take. Also, note that this exchange also involves asking the client to get centered—getting present in the small experiential exercise of coming home. A bit of getting present can help build flexibility around commitment processes when fusion and avoidance are high.

Immobility and impulsivity are usually easy to detect. It is often more difficult to detect patterns of avoidant persistence. These may present themselves in the guise of being values-based. For example, a workaholic dad may firmly believe that he is working to provide for his family, but only on closer examination is it clear that he is avoiding intimacy. Flexibility in pursuing values is key here. Committed action may thus at times look more like relaxation, play, or social connectedness than hard work.

The portion of the ACT model dealing with committed action varies the most, based on the specific problem behavior in question. So, any general advice about commitment processes has to be adjusted to the specific behavioral goals and methods being employed. For example, when dealing with smoking, committed action might involve tapering, scheduled smoking, mindful smoking, quit dates, stimulus control procedures, public commitments, and other procedures. When dealing with depression, committed action could involve behavioral activation, social involvement, resolution of family difficulties, exercise, or addressing work-related problems, and so on. When dealing with anxiety, committed action might involve graded exposure, increasing social activities, sleep hygiene, and so on. ACT is part of behavior therapy, and the functional analysis provided by the psychological flexibility model is meant to inform the larger set of functional issues specific to particular presenting problems.

Assessment Anchors

You can use a rough numerical method of tracking the six psychological flexibility processes by focusing on the ease of occurrence and contextual and behavioral flexibility of key response dimensions for each process. The dimensions are shown for each process on the Flexibility Rating Sheet shown in Figure 4.1. We can imagine a 10-point scale from zero (occurs very rarely or not at all) to 10 (occurs flexibly and as needed, functionally speaking), with the midpoint of 5 indicating that the response dimension occurs only sometimes (even when needed and useful) or only with encouragement. By estimating these numerical ratings during or following sessions, an overall assessment of psychological flexibility processes can be created by averaging the rows within areas. These ratings can, in

Process	Key Features of Client Behavior	0 None or very rarely	5 At times or with encouragement	10 Fluent and flexible
Present Moment	*Notes and makes use of internal and external events in the now*	0 5 10		
	Flexible attention—can persist or change as needed	0 5 10		
	Disentangled from past or future rather than worrying, anxiously predicting, or ruminating	0 5 10		
Self	*Contact with a transcendent sense of self*	0 5 10		
	Sees perspective of others and other times or places	0 5 10		
	Disentangled from conceptualized self	0 5 10		
	Uses perspective taking to enhance effective action	0 5 10		
	Shows genuine empathy and compassion	0 5 10		
Acceptance	*Takes open and curious approach to painful experiences*	0 5 10		
	Can enjoy positive emotions without clinging or showing excessive fear of loss	0 5 10		
	Active and flexible in the presence of difficult thoughts, feelings, memories, or bodily sensations	0 5 10		
Defusion	*Able to let go of being right or looking good*	0 5 10		
	Disentangles from stories and reasons in the interest of effective action	0 5 10		
	Evaluates thoughts primarily on the basis of workability rather than "truth" in a literal sense	0 5 10		
	Notices thinking as an ongoing process rather than merely the world structured by thinking	0 5 10		
	Thinking seems open, penetrable, and flexible	0 5 10		

(cont.)

FIGURE 4.1. Flexibility Rating Sheet. Use to rate key response dimensions of psychological flexibility processes.

		0	5	10
Process	**Key Features of Client Behavior**	**None or very rarely**	**At times or with encouragement**	**Fluent and flexible**
Values	*Clear sense of chosen values*	0 5 10		
	Values intrinsically rather than through compliance, avoidance, or fusion	0 5 10		
	Values provide meaning in the present	0 5 10		
	Differentiates values from goals	0 5 10		
	Open to vulnerability of choosing values	0 5 10		
Committed Action	*Sense of lightness, flow, vitality in actions*	0 5 10		
	Client willing to change directions in service of values	0 5 10		
	Action is linked to chosen appetitive purpose, not avoidance	0 5 10		
	Larger and larger patterns of effective action emerge over time rather than impulsivity, incapacity, or passive inaction	0 5 10		
	Client keeps commitments	0 5 10		

FIGURE 4.1. *(cont.)*

turn, feed into the specific case formulation described in the next section.

ACT CASE FORMULATION

The psychological flexibility model orients behavior change agents toward common functional processes built into human language and cognition. ACT case formulation is a direct extension of the psychological flexibility model. Case formulation involves specifying the following: (1) the external and internal events that have led to repertoire-narrowing processes and currently support these processes; (2) the ways that ACT processes interact to support the status quo; and (3) the degree of strength of repertoire-expanding processes that might be used to effectuate change. In other words, the clinician determines which processes are weakest, which of

these are most likely to be keystones, and which stronger processes can be used to foster change in the others. In each case their historical and situational context is considered. Assessment and treatment planning are intimately linked since treatment planning largely consists of the tactical considerations underlying how to target weaker areas.

Several newly developed innovative approaches to case formulation can be used to structure and streamline the case formulation and treatment planning processes. We describe a few of these tools here, but the rapid pace of development suggests an important caveat: our including particular tools in this chapter does not preclude your using other case formulation tools or inventing new ones that fit the particular demands of your clinical practice setting. Our purpose is just to demonstrate how structuring the process of case formulation can help clarify the relationship among core processes and reveal achievable treatment goals. In the remainder of this chapter, we describe three case formulation methods and supply case examples showing their specific application. All printed forms and tools in this book are readily downloadable at *www.contextualpsychology.org/clinical_tools*. We have found that, with regular use, these forms can provide helpful guidance in case formulation, treatment planning, progress monitoring, and individual or group supervision.

Hexagon Case Formulation Tools

The psychological flexibility model provides the basis for a functional dimensional diagnostic system—an idea first popularized by Wilson and DuFrene (2009). Since a key concept is that psychological flexibility is central to a unified model of human functioning and behavior change, by delineating the client's strengths and weaknesses through use of the hexagon model, key weaknesses can be targeted and key strengths emphasized. The simple graphics of the Hexaflex Case Monitoring Tool can be used to visualize the current state of the client's psychological flexibility and to track its development over time. Figure 4.2 depicts the Hexaflex Case Monitoring Tool as applied to Jenny, the client described below. The figure's hexagon is divided like a pie into six areas, representing the six processes. The concentric lines within the hexagon correspond to a 10-point scale for rating the strength of each process. The outermost line (unnumbered) represents 10, maximum strength. Zero, at the center of the hexagon (also unnumbered), represents maximum weakness. The central horizontal line gives the numbered rating for every other line. By averaging the rating numbers assessed for the key features in Figure 4.1, a client's overall rating within each process can be obtained. The overall rating can then be better comprehended by blackening the process's section outward to the assessed rating.

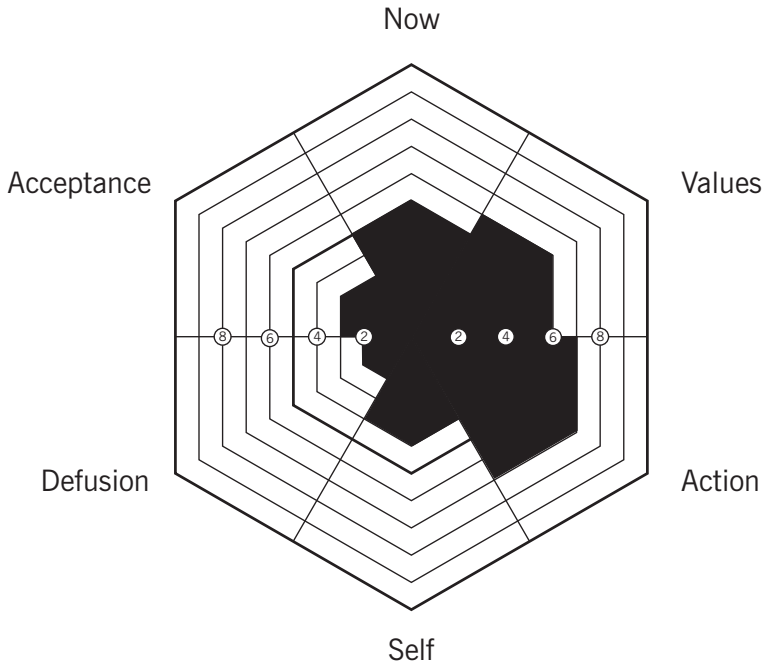


FIGURE 4.2. Jenny's ratings on elements of psychological flexibility, displayed on the Hexaflex Case Monitoring Tool.

Case Example: Jenny

Jenny[1] is a 52-year-old divorced white female who is complaining of family stress and depression. She has two adult sons who are living independently of her. She currently resides with her 88-year-old mother, for whom she is the primary caretaker. Jenny states that she has always been a "caretaker" and has had trouble asserting her own needs, particularly with her mother. Jenny describes her mother as very demanding and critical of her caretaking abilities. She notes that her mother was a devout Christian who taught her that taking care of her mother's needs was her primary duty, above all else. She also taught Jenny that thinking negatively about others or attending to her own needs above those of others meant that she was a bad person and not a good Christian. Jenny admits that she doesn't

[1]Jenny (treated graphically in Figures 4.2–4.4) is based loosely on a real client, but the description has been modified somewhat to ensure confidentiality. A recorded session with this client is available in DVD form (Hayes, 2009). Response anchors for psychological flexibility processes more detailed than those provided in Figure 4.1 can also be found at *www.contextualpsychology.org/clinical_tools* (after the user registers with the site).

want her mother residing at home and that she has a lot of "bundled up" emotions that she finds hard to express. She mentions feeling guilty and selfish several times when discussing her own desire for greater levels of independence, autonomy, and limit setting. She reports feeling depressed and is self-critical, particularly after any failed attempt to assert her independence in the face of her mother's criticism and relentless demands for attention. She mentions several times during the initial interview that she wants relationships that are genuine and honest. She has had a very hard time talking to her mother about what she wants. Jenny's AAQ score shows a high degree of experiential avoidance. The clinician's estimates of the strength of ACT processes for Jenny, on average, are shown in Figure 4.2. The biggest problems are with defusion (with a rating of 2) and acceptance (3)—the response style of openness. Values (6) and action (7) are relative strengths. The processes involved in being centered—now (5) and self (4)—are rated in the middle range. Closely surveying the graphic provides one a sense of each client's particular issues—the shape of the figure itself condenses a lot of information into a simple picture.

When thinking through the possible internal and external influences affecting the client's situation, a slightly different form can be used, as seen in Figure 4.3. Nicknamed "the turtle"—just because it looks like one—this tool was first developed by Japanese ACT expert Takashi Muto, who pointed out that the Japanese word for *hexagon* is derived from the sign for "turtle shell." Each of the six core processes is represented by a circle organized around the hexagon. Each circle, in turn, consists of a set of 10 progressively smaller concentric circles, representing the process's possible strength ratings. These can be filled in with the same scores depicted in Figure 4.2. The "turtle" is especially useful among supervision teams, among whom it can be readily distributed or blown up for a flip chart, enabling the entire team to visualize the case formulation.

In the case of Jenny, the clinician believes that the key feature is the repertoire-narrowing effects of fusion. This fusion, the clinician believes, was fostered originally by Jenny's mother, who taught her daughter only to serve her own needs, linking her demands to social compliance and to moral evaluations based on religious beliefs. As a result, the client feels threatened by the feelings of anger and guilt that emerge whenever she thinks of her own needs. She has bought into a conceptualized self that is negative and self-critical (including, for example, the self-conception that she is selfish). The clinician suspects that the client has additional fears in this area ("Deep down, I am not a good person"). Her other core process areas vary in strength but are at least moderately strong, particularly her values related to having caring, open, and honest relationships with her sons as well as her mother. Her ability to follow through behaviorally is good.

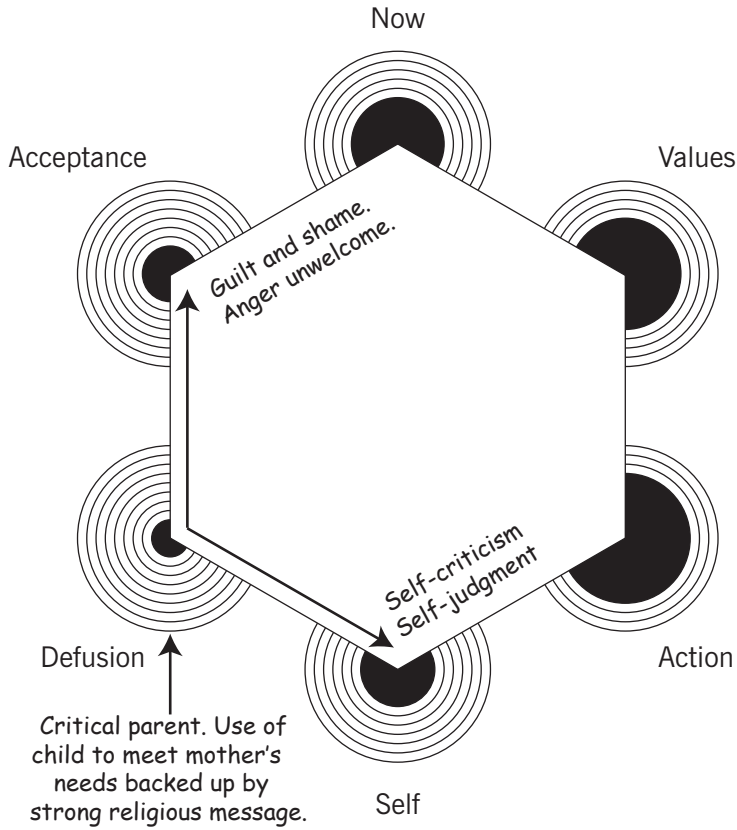


FIGURE 4.3. The initial case formulation for Jenny, displayed on the Turtle Case Formulation Tool.

Jenny's very high level of fusion will likely be a focus of treatment, but her areas of strength will likely be allies in this process. In this case, the obvious strength is her values, assuming that Jenny confirms valuing of relationships that are open, honest, loving, and compassionate and is willing to take steps to promote these qualities. This course may then inform not only how to behave with her demanding elderly mother but also how to confront fused verbal barriers that can lead to poor limit setting and self-invalidation. For example, making room in awareness for automatic processes of self-judgment might be part of a values-based effort to listen carefully to her own experiences with less fused judgment. Listening to her mother in this way can also be part of the effort. The painful parts of her history can be an ally in this. Jenny may remember how ashamed she felt as

a young child when she was accused of being a bad Christian for not caring for her mother. The therapist might try to link defusion skills to that pain and to its source in yearnings for acceptance and a more positive relationship. For example, Jenny could be asked to recall a time when she struggled as a child and to have a conversation as an adult with that child. She may be asked to say some of the self-critical things she thinks now, such as "I'm a bad person," aloud in the voice of that child. This defusion intervention is designed to activate her self-compassion and self-acceptance, making possible the kind of relationships she values: ones that are open, honest, loving, and compassionate. The resulting treatment plan for Jenny is shown in Figure 4.4.

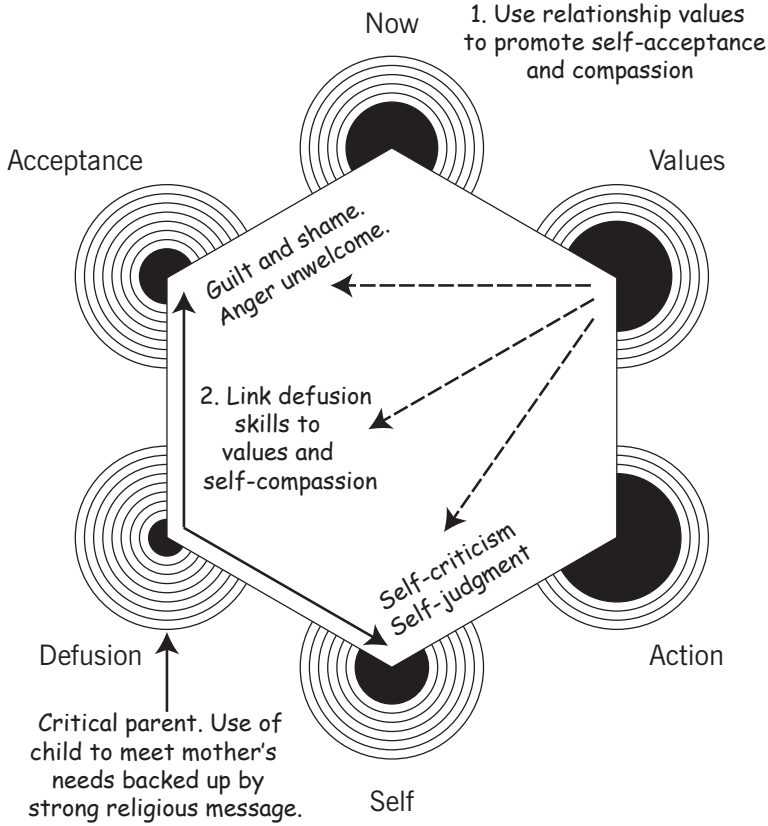


FIGURE 4.4. The initial treatment plan for Jenny, displayed on the Turtle Case Formulation Tool.

If the plan works, we should see changes in the processes that are targeted. As we measure changes in the client's defusion skills within and between sessions, the Hexaflex Case Monitoring Tool can be used to monitor treatment progress across a course of intervention.

The Psy-Flex Planning Tool

As we discussed at length in Chapter 3, an efficient and practical way to use the psychological flexibility model is to break it down into three basic response styles, each consisting of two core processes: Centered (present moment, self-as-context), Open (acceptance, defusion), and Engaged (values, committed action). Patricia Robinson (an experienced ACT clinician, researcher, and author) developed a simple method she calls the Psy-Flex Planning Tool, which is designed to condense clinical interview information into an easy-to-interpret visual format for ACT case formulation and treatment planning.

In the Psy-Flex case formulation method, each response style is represented by an arch that connects its two processes. After the client completes the clinical interview and any additional assessment exercises, the clinician rates him or her from low to high on each core process by marking the lines within each arch, as we have already done with the earlier tools. Below the arches are pivotal case formulation and treatment-planning questions for that response style. They focus the clinician on important processes that come into play, should that response style be the focus of intervention. Answers are formulated based on information gleaned from the clinical interview and other available information. For example, under the Centering Arch the clinician is asked to identify the barriers that are keeping the client out of flexibly contacting the present moment and what strategies might help promote present-moment experience. In addition, the clinician is asked to note specific interventions that might be effective in addressing any observed deficits in a core process. The following case example illustrates use of the Psy-Flex Planning Tool.

Case Example: Sandra

Sandra is a 42-year-old woman presenting with chronic worry and daily anxiety. She previously was diagnosed in another mental health setting as suffering from generalized anxiety disorder. She appears to maintain only partial attention to the world around her and describes herself as worrying constantly. During the interview, she frequently shifted from one life topic to another, apparently in response to an upsurge in negative emotion associated with any topic. Sandra has little contact with herself, outside of her

difficulties with anxiety. She had trouble in the interview simply stepping back and describing her worrisome thoughts without getting into negative self-evaluations or evaluations of the topic of her thoughts. She describes herself as a "worrywart" and responds to ambiguous events as potentially threatening or dangerous. Sandra is intolerant of the unknown, and her worrying seems to distract her from these powerful underlying fears. Sandra's worrying often involves categorizing potential events into "good" or "bad" and planning for how she might handle these events. Frequent sources of fusion are the "bad" things that could happen to her two daughters. Sandra values her role as a parent deeply. Sometimes she has been able to set her worries aside temporarily to serve her relationships with her daughters, who are 13 and 15. She is dissatisfied, however, with how frequently she allows her worries to dominate her attention and energy and notes that her daughters have sometimes commented that she is "not there" and seems distant. Sandra is now worrying about the impact of her worrying on her relationships with her daughters and husband.

As can be seen in Figure 4.5, this is a case in which the "opening" and "centering" arches dominate. Sandra needs training in both acceptance (making room for disturbing thoughts and images of the future) and mindfulness (staying focused on the moment instead of being pulled off into the future through worrying). This process can be greatly aided by her chief strength—her caring for her daughters. Instead of linking her caring about relationships to worry, she may be able to link that caring to the positive relationship behaviors that she values. To do this, she will have to make room for her propensity to experience thoughts, images, and associated emotions about possible future losses and setbacks. In other words, valued actions in relationship to her daughters could likely trigger fused content, distancing herself from the present moment. At that moment, it would be necessary for her to act in a more open and centered fashion if she is to behave in accordance with her values. Rather than targeting the most difficult of her fused content immediately, it makes more sense to begin low in a hierarchy of behaviors that will pull for fused content and then advance the degree of difficulty. Sandra can thus practice committed action in the face of less evocative fused content while staying present and connected to her values.

As is true with most contemporary ACT case formulation methods, the Psy-Flex Planning Tool can also simultaneously function as an in-session assessment exercise to help guide the clinician or as a progress-tracking device. Helpful aspects of this case formulation method include its framework for objectively and systematically evaluating the client's strengths and weaknesses in each core process and the requirement that the clinician think on paper by writing responses to the client's core issues.

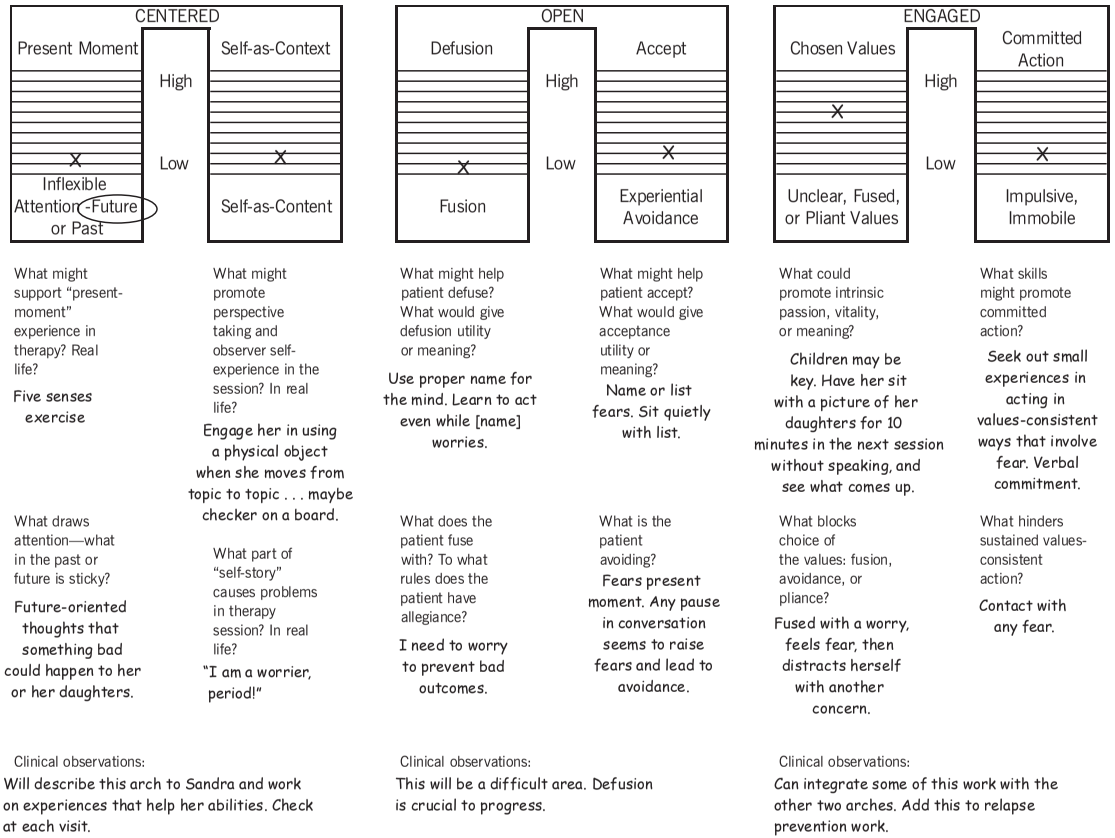


FIGURE 4.5. Use of the Psy-Flex Planning Tool to help formulate the case and plan treatment for Sandra. Copyright by Patricia Robinson, PhD. Used by permission.

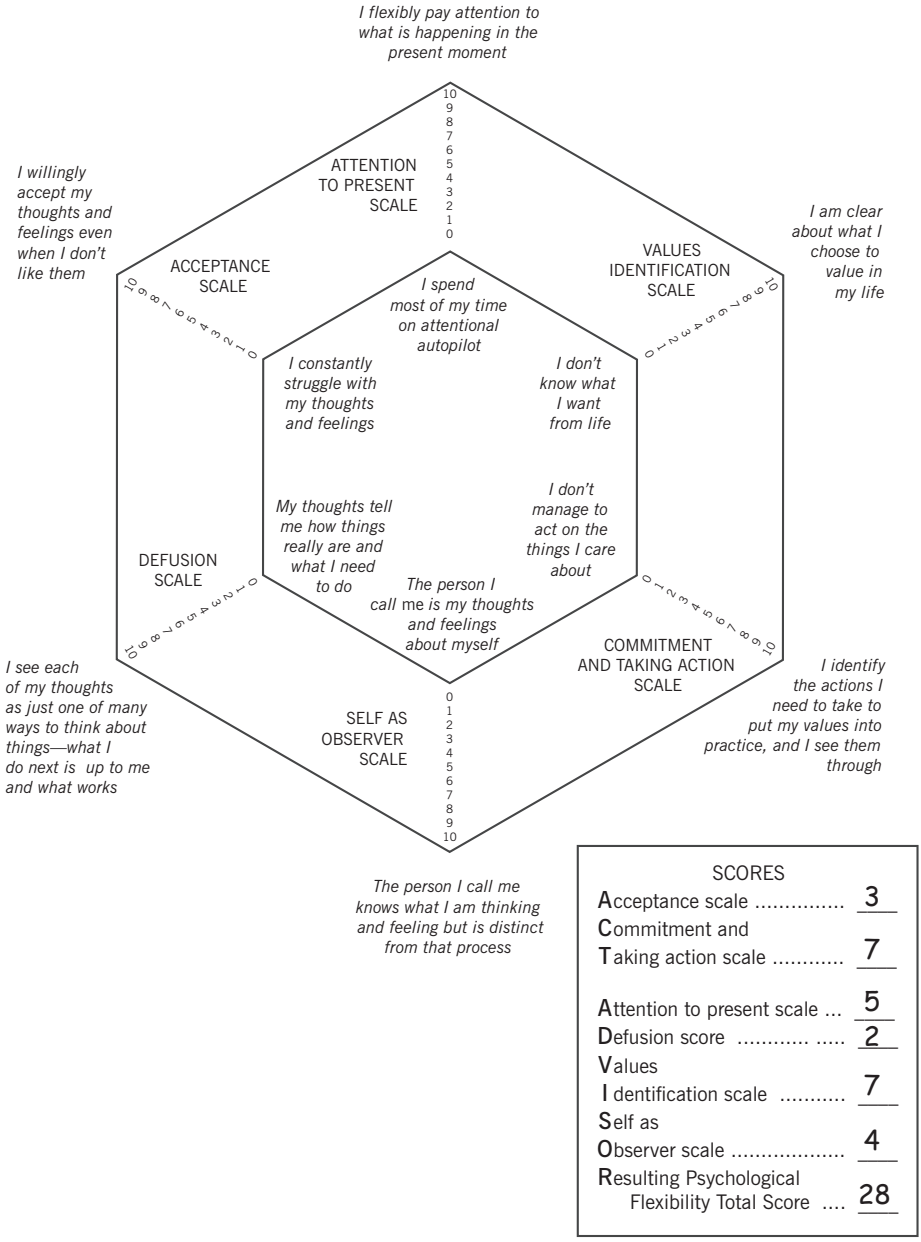
The ACT Advisor

David Chantry, an ACT clinician in the United Kingdom and editor of a interesting volume on ACT discussions (Chantry, 2007), created the ACT Advisor as a quick client assessment tool that can be used in any outpatient context. It is presented in Figure 4.6 (using our next case subject as an example). It can be helpful as a teaching tool and as a way of checking in with clients on their self-ratings of progress in therapy. The tool essentially requires the clinician and/or client to provide a numerical rating for each of the six core processes, using the acronym "ACT ADVISOR" as a mnemonic (ACT terms fit surprisingly well with the mnemonic—with the possible exception of the use of "identification" for a values clarity process that is more like choosing or taking ownership). A unique feature of the ACT Advisor is that the individual ratings can be added together to form an overall flexibility score ranging from 0 to 60. This score, as well as individual item ratings, can be reevaluated over time to provide a quantifiable measure of clinical change for case management use (it has not been evaluated for research use). The ACT Advisor tool may be helpful in settings where client interactions are brief and where treatment plans need to be generated quickly. The following is an example of a case formulation generated from a 10-minute interview using the ACT Advisor.

Case Example: Michael

Michael, a 27-year-old married white male, was admitted to an emergency room after having sustained multiple injuries during a physical altercation with a stranger outside of a bar. Michael reportedly works as a freelance writer. He avoided eye contact with the interviewer by repeatedly checking his watch and looking at the floor. His posture suggested physical tension, and he shook his leg nearly the entire time. Michael spoke in short bursts of rapid speech. His tone sounded annoyed and changed very little throughout the interview. Michael's speech was heavily laced with evaluations of himself as good versus bad. For example, he insisted repeatedly that he was "not a bad person" and had not behaved like "a man" when he initiated a physical fight with another man who had said something disrespectful toward him. This pattern of aggression has occurred in his marriage, and he stated there had been some episodes of marital violence. His wife has stood by him up to the present time, but he feels ashamed of his behavior toward her and worries that it will drive her away.

Michael indicated that being insulted and feeling ashamed were difficult for him to accept, and he responds to these feelings by demanding or forcing respect from the person he feels has hurt him. Afterward, the altercation leaves him feeling ashamed at having to demand respect instead of



SCORES	
Acceptance scale	3
Commitment and Taking action scale	7
Attention to present scale ...	5
Defusion score	2
Values Identification scale	7
Self as Observer scale	4
Resulting Psychological Flexibility Total Score	28

FIGURE 4.6. The use of the ACT Advisor to help track the psychological strengths and weaknesses of Michael. Copyright by David Chantry. Used by permission.

earning it. He described these categories of respect–disrespect as having absolute properties and exhibited little ability to imagine the thoughts or feelings of the other person in such a situation. His clearly stated belief is that "people are for me or against me—it's that simple."

Michael deeply cares about his work as a writer; he states that writing is the passion in his life. He writes positive self-help healing books, his goal ironically being to help others who lack self-confidence and life direction. His tone, posture, and affect changed slightly when he described his latest work and his hopes for how it might favorably affect people. He resisted acknowledging any difficulties with respect to his work but implied that he had had some problems with rejection of his work in the past. He was able to describe several strategies he has used in the past to curb his aggressive impulses, including taking long walks, reading scriptures, and physically removing himself from potentially problematic situations.

The clinician provided the ACT Advisor ratings seen in the lower-right portion of Figure 4.6. Fusion seems to be the prominent overall weakness for this client. His fused content includes rigid, black-and-white, right-and-wrong evaluations of how he should be treated. This perspective is further clouded by an additional fused thought that having to force people to respect him implies that he is not worthy of respect. His low acceptance score is based on his rejection of the feeling of shame that occurs when he makes contact with his ultimate "unworthiness." He responds to the messenger of this psychological insult with aggression, regardless of who the messenger is (whether his wife or a stranger at a bar). On the positive side of the equation, his values about helping others and wanting to be a better husband are strengths that can be used to help him work on defusing from his current conceptions and being more accepting of more positive evaluations. He also appears to possess some sense of perspective on his issues with being "respected," but that perspective quickly evaporates whenever he is confronted with his most evocative content. ACT defusion strategies will need to target the absolute nature of his fused content about respect–disrespect and his underlying sense of feeling unworthy. He might benefit from present-moment awareness strategies designed to help him "stay in his skin" in the presence of potentially evocative content.

CONCLUDING REMARKS

The psychological flexibility model is a dimensional psychology of the normal (Hayes et al., 1996). We all share the processes we have been discussing by virtue of being verbal human beings. The goal is not to "fix" people but rather to empower them. What the psychological flexibility model provides is a characterization of key features that can be changed, but it does not

specify how to link history to those features, nor precisely how to intervene in a step-by-step fashion. Much of the rest of this volume addresses these technical features of ACT in detail, using case examples, exercises, and guided discussions. Our goal in this chapter was to give the clinician an idea of the thousand faces this small number of core processes can present. If the processes can be experienced in the moment while actually conducting therapy, clients will teach clinicians over time what to do.

ACT uses both acceptance and mindfulness processes and commitment and behavior change processes to produce psychological flexibility. The approach is to use the client's strength within one process to target weaknesses within another; to use the client's values to provide meaning and focus in therapy; and to use the therapeutic relationship to model, instigate, and support ACT-consistent processes. As these processes build over time, some greater degree of psychological flexibility is created and is carried forward into meaningful behavior change. When the client can accomplish meaningful change on his or her own, therapy is over and life itself becomes the client's therapist. In the next chapter we explore how to use the therapeutic relationship to model, instigate, and support more psychologically flexible processes.

CHAPTER 5

The Therapeutic Relationship in ACT

In this chapter, you will learn . . .

- Why a strong therapeutic relationship requires psychological flexibility in both the therapist and the client.
- How to model the core processes of psychological flexibility inside the therapeutic relationship.
- How to identify and use positive leverage points in the therapeutic conversation to develop greater psychological flexibility in the client.
- How to avoid negative leverage points that can undermine the therapeutic relationship.

At first glance, some might assume that ACT is a highly mechanical and intellectual form of therapy simply because it is associated with behavioral principles and is an evidence-based approach. As it turns out, just the opposite is true. ACT, by its very nature, tends to be an intensive, experiential form of psychotherapy. Observers of ACT sessions often comment on how deeply moving the sessions are, noting with some surprise the strong sense of interpersonal connection that exists between the therapist and client as difficult issues arise and are addressed.

What explains this deep sense of connection between the therapist and client? It derives from the leveling of the relationship between the client and the ACT therapist, which in turn emanates from the psychological flexibility model itself. ACT is based on psychology of the normal. Both the client and the therapist are confronted by many of the same dilemmas just in the course of living. The same language traps that capture the

client also confront the therapist, not only in the therapist's professional role vis-à-vis the client, but also in his or her personal life. ACT purposely capitalizes on the common concerns between the client and therapist to help move clients and even therapists forward in their lives.

Establishing a truly therapeutic relationship has long been viewed as an important component in successful therapy, and indeed it is a significant mediator of positive outcomes. The same can be said of ACT as well. Unlike many forms of therapy, however, ACT contains a well-elaborated model of the therapeutic relationship that closely correlates with the core processes it targets. In this chapter we discuss how the psychological flexibility model is applied directly to the therapeutic relationship. We also examine how the therapeutic relationship can be used to address the positive and negative leverage points that become evident during implementation of ACT interventions.

THE POWER OF THE THERAPEUTIC RELATIONSHIP

Not all of the client's problems are specifically social, but all of the core processes that underpin psychological flexibility (or inflexibility) have a social dimension. Fusion and avoidance are in part socially acquired and maintained; the perspective taking sense of self is not just "I," but "I–you"; values are based in part on socialization; and psychological interventions are usually administered in a social format called "therapy." This direct connection between the social nature of problem areas and the process of psychotherapy gives clinicians a tremendous advantage because some of the person's problems and opportunities for growth are likely to appear in the consulting room itself, where they can be worked on directly. This social aspect is one of the most helpful lessons of functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), a sister technology which coevolved with ACT during the mid-1980s. Indeed, we use some basic FAP principles in our discussion of the nature and role of the therapeutic relationship in ACT.

Some of the skills that produce psychological flexibility cannot be learned through direct, literal rules but must be learned through experience. Behavioral psychologists call this kind of learning "contingency shaped," and in the consulting room they view the actions and reactions of therapists as key sources of instigation and support for contingency-shaped learning. The flexibility model greatly simplifies the clinician's task by framing specific problem areas as aspects of inflexibility and by favoring processes that increase flexibility. For one client, avoidance of intimacy might be a key focus, and for another it might be fusion with self-judgment—but the basic issues are the same.

Many ACT intervention methods are a kind of instigation: They are designed to destabilize response patterns that lead to inflexible and narrow repertoires and to establish alternatives repertoires that can be sustained by client-valued consequences. The therapeutic relationship provides a powerful ground for this kind of evolutionary change based on variation and selective retention of new social behaviors. Trying new things in a relationship can be anxiety-producing, even for highly functional clients. The mind demands predictability, and yet giving in to the urge to turn everything into a well-formulated verbally accessible rule is not a reliable route toward growth and connection. The therapy room provides a safe, accepting environment in which the client's anxieties can be incorporated and used to help shape greater flexibility linked to valued patterns. Therapy is a kind of petri dish, in which little "experiments" can seed and sustain processes that can lead to major personal transformation. At the heart of this process is the relationship shared by the client and therapist.

Powerful Relationships Are Inherently Psychologically Flexible

Think of an actual relationship in your life that is powerful, uplifting, moving, supportive, or perhaps even transformational. What is that relationship like? Do you feel constantly objectified and judged, or is there a deep sense that you are acceptable just the way you are? Does this person constantly try to be right and show you how you are wrong, or are your ideas and thoughts entertained with a sense of openness and curiosity? Is the person physically and psychologically "there" with you, or off into his or her own world, unable to be reached? Can this person sense how the world looks through your eyes? Is there a sense that you are deeply known, or do you feel as though your perspective is invisible or unimportant? Are your core values acknowledged and supported, or does the relationship seem disconnected from the deeper issues of what is meaningful to you? Is the relationship filled with actions large and small that are meaningful, or is it marked by a sense of repetition, automaticity, chronic passivity, or constant impulsivity?

We have just asked about the six psychological flexibility processes, and if you are like most people your answers as a set will tend to look like an affirmation of the psychological flexibility model itself. This type of response is not surprising because psychological flexibility is relevant to all forms of human action and change. Relationships that are powerful, uplifting, moving, supportive, or transformational are those relationships that are accepting, defused, attentive to the present, conscious, values-based, and flexibly active—that is, they are characteristic of psychological flexibility. As it applies to the therapeutic relationship, this characterization means that the psychological flexibility model can be a guide to the

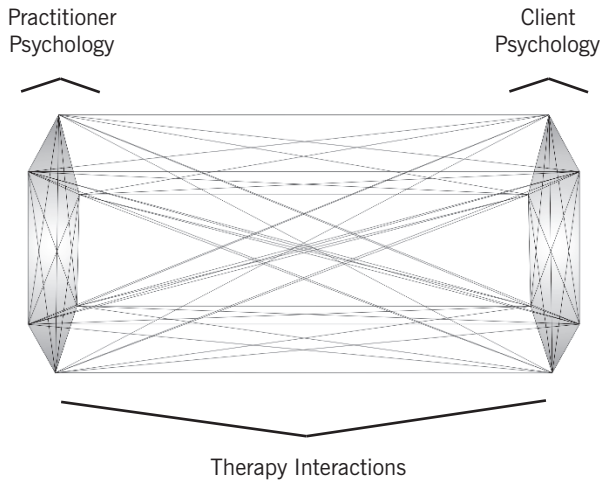


FIGURE 5.1. A model of the therapeutic relationship, cast in terms of psychological flexibility processes reflected in the practitioner, the client, and their interactions. Copyright by Steven C. Hayes. Used by permission.

creation of deeply and intimately transformative relationships. With some minor variations, the same may be said of prosocial groups, organizations, and communities.

This conception of the therapeutic relationship is depicted graphically in Figure 5.1. Any interaction between two human beings involves flexibility processes for each participant. In the therapeutic relationship, such interaction means that flexibility processes are not solely the *target* of intervention so much as they are the key *context* for effective therapy for the therapist. In addition, the figure makes the point that effective interactions in therapy instantiate flexibility processes. For example, an interaction can be accepting, defused, values-based, and a variety of other things—or their opposite. Exploring this idea is a key purpose of this chapter.

The ACT Therapist as Role Model

Consider a client who brings up a difficult area that is painful for not only the client but also the therapist. Perhaps a client is dealing with a deep sense of shame over sexual abuse she experienced as a child. This topic may also be difficult for the therapist in a myriad of ways. The therapist may have experienced similar events or witnessed them in his or her own family. The therapist might have no such history but simply be uncomfortable with judgmental thoughts toward perpetrators or survivors or, alternatively, be

unable to identify with the client's deep sense of shame. The therapist may fear for his or her own children and therefore be less capable of dealing objectively with these issues. None of these reactions is inherently harmful, but problems can develop if the therapist responds to such issues in a mindless, avoidant, fused, or psychologically inflexible way. If the pain is pushed away or avoided, if the therapist fuses with self-judgments, or if the fears become entangling, the client begins to disappear, and key therapeutic moments are lost or responded to in a less flexible fashion than warranted or advisable.

In this scenario, the client is going to sense that the therapist is struggling, has "checked out," or is being judgmental. The client will feel abandoned and disempowered because the therapist cannot be accepting, defused, attentive to the present, conscious, values-based, and so cannot act effectively in the presence of distressing content. Furthermore, what the therapist is modeling is contraindicated by ACT; that is, since modeling is a major contributor to contingency-influenced learning, the treatment will suffer. Not only will the client learn how to be inflexible from these interactions, but also the client might be motivated to rescue the therapist from the issues the client has raised—even possibly at the cost of the client's successful treatment. In addition, the burden of the work for the therapist is higher when flexibility skills are absent. Over time, the therapist who responds to the difficult content of therapy in a mindless, avoidant, fused, and psychologically inflexible way will be more stressed and vulnerable to burnout (Hayes, Bissett, et al., 2004; Vilardaga et al., 2011).

For all these reasons, it is important that the therapist not only *target* psychological flexibility processes in the client but also *model* these skills as well. This does not mean that ACT therapists must be icons of psychological flexibility to be effective. Indeed, even if the therapist is struggling with issues, knowing how hard it is to do this work puts the therapist in the same shoes as the client and tends to level interactions between the two. This sense of parity provides opportunities to increase empathy and to decrease one's inclination to brag about being "right" about ACT. What is key is that the therapist should actively embrace the importance of flexibility skills and be dedicated to working toward them both personally and professionally. That commitment can transform any personal difficulties into an even more powerful therapeutic alliance.

Suppose, for example, that an ACT therapist becomes confused during a session. The client may have said something that "hooked" the therapist at the level of literal content. The therapist begins to feel anxious, on the spot. There is a sense of danger in the room. The therapist is trying to think what to do next and searches for some ACT-consistent metaphor, exercise, or response. From an ACT perspective, the therapist is experiencing some emotions that are not 100% welcome (e.g., confusion,

anxiety, fear of looking incompetent). The client's verbalizations are being taken literally. The therapist's own evaluations (e.g., "I'm blowing it!") are being taken literally. As a result, the direction and flow of the session are upended. The therapist is performing for the client—trying to look competent. The two are no longer on the same level field.

Getting hooked like this is not a bad thing. It is not something that "good ACT therapists never do." Indeed, taking such an unrealistic attitude is itself an example of getting hooked on a thought. Getting hooked like this is something *all* people do, including people called "clients" and people called "therapists." The issue is not whether the therapist occasionally gets caught up short. It inevitably happens. Rather, the issue is what happens next. So, for example, the ACT therapist might sit silently for a while, observing his or her evaluations. After some silence, the therapist might say any one of the following (or hundreds of similar things):

- "I'm having some interesting mind chatter about this issue myself—in fact, why don't we just sit here for a minute or two and watch what our minds do in response to this."
- "Boy, am I getting hooked by this! Does it have you hooked too?"
- "I'm feeling anxious, confused, and incompetent right now. I don't want you to rescue me—I have room for it—but it is interesting how that pulls me to try to do something to make it go away. I know there is no growth there, though—so maybe we could just both be anxious for a moment and see what that is like."
- "I feel powerless when I buy my thoughts about this—like I have to do something but I don't know what to do. What shows up for you when you buy into your thoughts about this?"
- "Just to get some perspective on it, why don't we distill what you said down to a word or two and say it rapidly out loud over and over again—say, 30 times. I'll say it with you, and we can all feel slightly silly together. Then we will see what happens. Are you willing?"
- "This thing is heavy. For me, too. I'd like us to do a little exercise. It will be an eyes-closed kind of thing. We will put that thought out on the table, and I will take you through what your body does, what your emotions do, and what your mind does when that thought shows up. Are you willing?"

This list could continue indefinitely. Almost any technique imaginable could fit this moment, if the therapist is approaching the moment in an ACT-consistent manner. Conversely, "ACT techniques" could be employed in a way that is fundamentally inconsistent with the treatment model. For example, the therapist might fight with the anxiety, shove it down, and force out the words "Thank you, mind, for that thought" in a dismissive

tone of voice that subtly communicates the client was wrong to have said what he or she said. The therapist might perform for the client or use an ACT metaphor or exercise to avoid the discomfort of the moment and hide behind the role of being a therapist. Finally, the therapist might intellectualize the issue or, alternatively, try to dazzle and confuse the client with ACT psychobabble in order to be "one-up."

When therapists are confronted with painful material, they are in the same situation as their clients. Such a situation presents an opportunity for therapists to grow—just as, likewise, it represents an opportunity for clients to grow. By approaching painful content with an attitude suggesting openness and acceptance, therapists are less likely during that moment to buy into judgments about clients or turn therapy into mere advice giving or something to be "right" about. Clients will appreciate how hard it is to step up to emotionally charged material. These benefits are unlikely to accrue if therapists seem fused and avoidant. Therapists don't need to be totally free of "issues"; the motivation to try to improve is well enough to keep ACT on track. Research evidence confirms this point. In a study of beginning therapists, Lappalainen and colleagues (2007) found that those with just a dozen hours of training or less were significantly less confident doing ACT than traditional CBT; moreover, even though the inexperienced practitioners' worries went down less over time in ACT than in CBT, patients treated with ACT had better outcomes. Feeling uncomfortable doing ACT does not necessarily mean being ineffective at it; indeed, it could humanize or even empower the work.

It is not just that it is important to target, say, acceptance from an accepting place, it may also be especially powerful to do it in an accepting way—in a way that makes room for botched metaphors and miscommunications. Thus, the psychological flexibility model not only provides a functional roadmap for detecting areas of difficulty and growth; it is also a functional roadmap for evoking powerful social interactions in the therapy room, and consequating these to promote new flexibility skills.

Consider a person who was raised by emotionally avoidant and critical parents. Suppose the person adjusted to this lifelong treatment by becoming quite self-critical and even avoiding all feelings or signs of intimacy and connection for fear that rejection would follow. Continued fusion or avoidance would likely be sources of inflexibility. Suppose this client now begins to show more emotional openness in session. It is important that these early steps forward be reinforced and supported, but in an evolutionary sense it is important that the selection criteria for success also avoid dead ends ("adaptive peaks"). The psychological flexibility model provides guidance in all these areas. For example, suppose the therapist discusses an upcoming vacation and the client responds by expressing feeling upset. Given the client's history, this response might be a positive step forward

despite its negative emotional tone; it may show a greater willingness to feel emotionally connected even at the cost of distress and possible rejection. A wise therapist might react with acceptance, for example, by saying, "I'm moved by your willingness to let me see that you are upset at my leaving. It takes courage to do that, and it lets me know that this relationship is important to you. It is important to me too." Well-timed flexible responses by the therapist are likely to reinforce flexible client actions so that these processes of change can grow and be sustained.

If psychological flexibility skills underpin powerful therapeutic relationships, therapeutic alliance measures should be particularly high in ACT studies, and so far the evidence is consistent with this perspective (e.g., Karlin & Walser, 2010; Twohig et al., 2010). Furthermore, measures of psychological flexibility should reflect these processes, which also appears to be true. For example, when measures of client flexibility are allowed to compete with measures of the therapeutic alliance as predictors of ACT outcomes, changes in flexibility skills account for much of the variance that would otherwise be attributable to the therapeutic relationship (e.g., Gifford et al., in press). This is not because the relationship is unimportant in ACT but rather because the relationship is the means by which flexibility skills are imparted to the client. The best measure of relationships that are accepting, defused, present, conscious, values-based, and flexibly active in a functional sense may be the changes these relationships produce in the client's psychological flexibility. So far, this idea has not been examined outside of ACT. It would be a powerful test of a psychological flexibility model of the therapeutic relationship to assess whether it applies to other forms of intervention as well.

We have considered many aspects of the therapeutic relationship: its grounds for instigating change, its role as a model, and its role in instigating and reinforcing steps, going forward. These various points about the therapeutic relationship in ACT can be summarized in a simple acronym, **I'm RFT With it.** The acronym stands for **I**nstigate, **M**odel, and **R**einforce it—**F**rom, **T**oward, and **With it**. As shown in Figure 5.1, every interaction between the practitioner and client, from the very beginning of therapy, is an opportunity to support psychological flexibility. The best way to implement such flexibility is to embody it not as an expert, but as a fellow human being, and to create a relationship that embodies it as well.

Implemented properly, a good therapeutic relationship provides a humanizing dimension to the therapy sessions. The therapist comes to regard the client not as some diagnostic label but as a human being struggling with many of the same life issues as the therapist. This approach enables the therapist to step back from the verbal sparring that occurs during psychotherapy and to see words merely as words (even words about ACT theory!) and feelings as feelings, and to witness the behavior occurring during the session from the vantage point of an observer.

There are many ways in which the therapist can constructively build upon a genuine bond with the client. Conversely, there are many ways in which the therapist can defeat this bonding process through a personal lack of willingness to address issues that the client is being asked to address. In the remainder of this chapter, we examine the most critical of these positive and negative leverage points for the ACT therapist.

POSITIVE LEVERAGE POINTS IN ACT

It is their relative sensitivity to the client's ongoing behavior in the therapeutic conversation that differentiates effective from ineffective ACT therapists. This process does not consist in any simple mechanical application of metaphors, exercises, and concepts. When therapists are first exposed to ACT methodologies or techniques, they often respond very strongly to the specific interventions. Frequently they are attracted to the metaphors, the experiential exercises, the homework assignments, and the iconoclastic feel of challenging the mainstream verbal community. The process of ACT goes well beyond these interventions and strategies, however. The theoretical foundations come more slowly, especially for those without functional behavior-analytic training. The philosophical assumptions, willingness to let go of ontological claims, and the focus on workability are often difficult. But the personal work is perhaps the most challenging of all. For these interventions to function the way they are meant to function, the therapist must be willing to enter into a relationship with the client that is open, accepting, coherent, and consistent with ACT principles. The therapist cannot step outside of ACT and yet do ACT with integrity; what the therapist brings to the work and the relationship itself is key.

A defining feature of the effective ACT therapist is the perspective that both encapsulates and informs his or her work. This perspective is difficult to describe in words, and for a straightforward reason, namely, it is a viewpoint that is characterized by the deliteralization and defusion of language and the therapist's own self-acceptance, willingness, and commitment to "be there" for the client regardless of whether any therapist "buttons" are pushed. Because the issues addressed by ACT's impact on the therapist equally strongly, it is simply not possible to be sensitive to the client as viewed from an ACT perspective without applying these same perspectives to oneself.

Observer Perspective

The ACT therapist develops an almost intuitive disinterest in the process of rationalizing, explaining, and justifying through verbal behavior, instead preferring a mindful and experientially open approach to all private events.

In short, the therapist adopts an observer perspective. The therapist does not question the content the client is raising, out of defensiveness or condescension. Rather, the therapist observes what is present and considers how it functions. This approach, of course, closely parallels what the therapist is trying to teach the client to do in the midst of his or her life struggles. It makes intuitive sense that if the therapist is unable to model this ability to take an observer perspective on cognitive and verbal processes, then it is unlikely that same skill will be readily transferred to the client. An especially useful form of modeling occurs when the client can see that the therapist is risking something or allowing personal vulnerability into the room when avoidance would be an easy alternative.

Wisdom Is Gained by Approach, Not Avoidance

An additional characteristic of the effective ACT therapeutic relationship is the ability to see commitment to chosen values and resulting goals as something more than an exercise in seeking positive life outcomes. Often, the therapist's own personal experience with disheartening personal failures or personal setbacks in life must be called upon. The ACT therapist approaches obstacles, barriers, and personal setbacks as legitimate forms of growth and experience. Commitment involves coming into contact with these barriers and moving ahead—not by getting over or around them but rather by embracing and moving through or with them.

If the therapist's present life is characterized by avoidance of distressing content, then it will be much more difficult to model a healthy response. Again and again, the success of therapy boils down to the issue of whether the client (and therapist) is willing to approach and move through unpleasant obstacles in the cause of achieving a valued outcome. Therapists who have learned firsthand that overcoming personal obstacles creates a sense of health and vitality are much more likely to be able to impart this conviction to their clients.

Contradiction and Uncertainty

A defining characteristic of the ACT "field of play" is the willingness to sit in the presence of paradox, confusion, and contradiction without feeling compelled to use verbal behavior or verbal reasoning to resolve the differences. Life is full of contradictions, ironies, and things that cannot be explained entirely through deductive reasoning. Indeed, the trap that confronts most people actually comes back to the primary truth that building a vital life is not always a logical enterprise. If the ACT therapist has witnessed this experiential truth in his or her own life, there will be much less of a tendency to urge the client to begin determining which contradictions

need to be eliminated in order to proceed. In other words, the therapist will experientially connect with the fact that, while these contradictions admittedly exist, they need not be resolved in order to move forward.

In the area of uncertainty, the ACT therapist is asking the client to commit to an enterprise that carries significant risks of negative outcomes. It is called "life." The therapist can't guarantee that moving in a new direction will produce any particular outcomes for the client. The ACT therapist does not attempt to "rescue" the client from the fact that there are no guaranteed life outcomes. The process of living is like taking a very long road trip. The destination may be important, but the journey experienced day to day and week to week is what is invaluable.

We Are in This Stew Together

Many therapeutic orientations emphasize the need for the therapist to be separate and different from the client (e.g., more wise, professional, experienced, balanced, processing more ego strength, etc.). These approaches emphasize that good therapists should set good "boundaries," believing that the better the boundaries are defined as part of the therapeutic process, the more the client will benefit. This attitude can easily transform into the therapist's taking a "one-up" position on the client—in which the therapist presumes to know how to live a healthy life and the client must assume the role of learning from the teacher. If this boundary is crossed, and the therapist becomes merely a person "behind the curtain," the therapist has failed in some very fundamental way.

The ACT therapist has a ready alternative: both the client and therapist must make room for private experience and do what works best in each given situation. The successful ACT therapist's attitude is clear: "We are in this stew together. We are caught in the same traps. With a small twist of fate, I could be sitting across from you, and you could be sitting across from me—both of us in opposite roles. Your problems are a special opportunity for you to learn and for me to learn. We are not cut from different cloths, but rather from the *same* cloth." Assuming this type of attitude has two dramatic effects on the therapist's behavior and the therapeutic relationship that results.

Effect 1. An attitude of empathic, soft reassurance. When the therapist identifies with the client's struggles, problems that the client views as unique to his or her own life become much more universal issues. Whereas the client may feel oppressed by the conviction that he or she is alone with this problem, the therapist is able to respond with a genuine position of "soft reassurance." Normal reassurance can be demeaning when it implies that "I am strong and you are weak. I will help you." That type of attitude is inherently ACT-inconsistent. Soft reassurance, on the other hand, is the

support that comes when one person is willing to make contact with the other's sense of emotional pain and then validate and normalize it without despairing, rescuing, buying it, or running away from it. Exactly the same emotional, cognitive, and behavioral traps confront not just other people but the therapist specifically as well. A compassionate and empathetic view of the client's struggle is a fundamental attribute of the effective ACT therapist. This perspective cannot be communicated merely through metaphors, experiential exercises, and verbal games, and it cannot be readily faked. Whenever this point of view prevails, the exercises, metaphors, and other activities of ACT have a power and quality they do not otherwise possess.

Effect 2. Willingness to selectively self-disclose. A second effect of closely identifying with the client is the therapist's willingness to self-disclose whenever it is helpful. Self-disclosure is an essential aspect of developing powerful human relationships—including, in our opinion, therapeutic relationships. Not that the therapist should spend more time self-disclosing than the client does. Rather, self-disclosure flows as a natural and human process that is designed to serve the client. Once the client fully realizes that the therapist has struggled with some of the same issues that he or she is struggling with, a strong bond and sense of camaraderie often develop. This camaraderie is reassuring to the client and at the same time makes the therapist a more credible model of acceptance and commitment. Additionally, many of the client's fears about being different or abnormal are allayed when the agent of social control (i.e., the therapist) acknowledges having struggled with similar problems.

Openness to Spirituality

Spirituality can be a surprisingly difficult issue for empirically oriented clinicians. Many shy away from the whole topic completely—as though it were inherently untrustworthy or beyond the realm of therapeutic work. The ACT therapist who is willing to consider the spiritual side has more room to work and more moves to make to support the client's process of acceptance and change. Many therapists exposed to ACT who also have some prior personal history with Eastern religions or other mindfulness-based forms of personal growth perceive distinct parallels between these types of experiential activities and some of the processes that occur in ACT. In general, therapists with this type of spiritual background find it easier adapting to the space in which ACT is done—provided they know what is distinct about ACT in terms of its scientific and clinical attributes rather than mischaracterizing it merely as a form of Buddhism or the like.

Spirituality as a mode of intervention is highly valued in ACT. Spirituality does not necessarily imply the use of organized religion or even

theistic beliefs, but rather a view of the world that recognizes a transcendent quality to human experience, that acknowledges the universal aspects of the human condition, and that respects the client's values and choices. Through the deliteralization of language and the adoption of an observer perspective, ACT steps back from the personal aspects of struggle and examines it openly and nondefensively. It is an inherently spiritual process in the sense that this kind of perspective taking cannot be solely the product of logic but must also be based on one's firsthand experience of making contact with a transcendent sense of self.

The ACT therapist should not come to rely on spiritual or religious dogma, however. Indeed, spirituality and religion, as such, are discussed only when the client brings these issues into the therapy session. Nevertheless, ACT has an inherently and wordlessly spiritual quality to it. The ACT therapist needs to get over the initial resistance some have toward raising such issues as "Who *are* you?" and "What do you want your life to stand for?" Furthermore, if the client wishes to talk about these issues in spiritual or religious terms, there is no reason to resist that process if it is a route to connection with the key steps in ACT. Most ACT concepts have parallels in the major religious traditions, and so a translational link between religious beliefs and ACT concepts is not altogether problematic. Thus, for example, a Christian who understands the concept of faith might well be urged to do commitment exercises as "a leap of faith."

Radical Respect

One of the most important attributes of an ACT therapist is his or her posture of radical respect, in which the basic ability of the individual to seek valued ends is protected. In essence, ACT is inherently client-centered.

There is a great deal of implicit social influence lodged in therapy. Social influence harnessed to the goals of the client is one thing, whereas social influence as a substitute for the client's values and choices is entirely something else. Many therapists who use such words as *choice* and *values* subtly direct the client toward outcomes the therapist believes will benefit him or her. This tendency often occurs explicitly when therapists are working with clients engaged in such socially unacceptable behavior as domestic assault, chronic intoxication, or the like. Often the goal of the therapist with such clients is to eliminate the behavior, regardless of the goals the client may bring into treatment. The therapist, in response to a new episode of binge drinking by a client, might say, "Well, if it's your choice to go out and drink again, I hope you are willing to endure the consequences that are sure to follow." Here the therapist is basically saying, "Your choice is not the right choice—your choice should be to stop drinking. You deserve what is going to happen next because you made the wrong choice!" Using *choice*

in this way may shame the client into temporarily achieving the goal of sobriety, but it is really a form of coercive social control, not a values-based "choice" that emanates spontaneously from the client. A similar and equally perverse situation arises with clients of different cultural groups (or sexual identities, religions, etc.). Using the language of choice to coerce a client for any reason is fundamentally at odds with the therapeutic relationship that is envisioned in ACT.

In order to direct the client to what truly works for him or her, the ACT therapist has to be willing to assume a position that focuses on the client's actual experience rather than the therapist's preconceived ideas. The effective ACT therapist has to come to the therapeutic interaction with "clean hands"—otherwise, the client and the therapist have an unequal and subtly dishonest relationship. For example, ACT for agoraphobia involves no automatic presumption that the client must immediately start getting out of the house. After all, the ACT therapist is not playing a mind game with the client, but rather is engaged in a compassionate search for alternatives based on life experience and the therapist's radical respect for the client. There is no law against staying locked in your house. The important question is whether doing that best serves the client's life goals and values.

This experiential truth usually involves understanding that the formula for successful living is unique to each individual. There is no single right or wrong way to live one's life. There are only consequences that follow from specific human behaviors. This position is terribly difficult for new ACT therapists to maintain in the presence of socially undesirable behaviors. Taking this position, however, does not mean that the ACT therapist agrees with the client who claims something is working when, in fact, it is not. For example, if a drug addict is losing a spouse as the result of his or her drug use—and yet values that relationship highly—the ACT therapist has no duty to pretend that drug addiction has little effect on the client's valued end. Behind the eyes of even the most inveterate addict lies a human spirit that is trying to make something positive happen in his or her life. By acknowledging the vitality of this spirit and emphasizing that life is about making choices, the therapist is able to enter into an honest alliance. If a client values life outcomes that the therapist cannot work with, then the therapist should withdraw from therapy and refer the client elsewhere. That rarely happens, however, because deviant goals that are initially presented as chosen values in therapy are most often not truly chosen values at all. A client may *say* something like "I just want to get drunk," but when that response is explored further it usually turns out that this is just a means, not an end. It is not the role of therapists to supply values, but it is the role of therapists to test means, based on their technical and scientific knowledge and skills. Thus, 99% of supposed values conflicts turn out to be conflicts only on means, and there the therapist has a great deal to

offer in the way of alternatives—based on theory and evidence—by virtue of the role the client has asked him or her to assume.

Honoring Diversity and Community

The ACT therapist also respects and nurtures human diversity and responds in a customized fashion to the social context presented by each individual. The client is looking out at the world from a social context, and it is important to take the time to see the world through the client's eyes in a humble and open way. Perhaps this is no different than in other forms of therapy, but the unified model gives this idea special force in the areas of values and the transcendent sense of self. We will briefly examine the latter issue.

The client behind those eyes shares consciousness with the therapist, which means that it is not possible to accept one's own pain and to reject the pain of others without doing violence to the model. In the same way, owing to the deictic framing that underlies consciousness, "now" is inextricably related to "then" and "here" to "there." It is not possible to care about the world now and yet not care about the world we will leave to our children. It is not possible to care about the community here without being psychologically connected to the suffering of others far away.

We are arguing that, as a matter of basic processes, psychological flexibility includes caring about diversity and prosociality. Sexism, racism, environmental degradation, economic and social injustice—these problems surround the human community and in some small way they sit with us in each therapy session. Trying to see the world through the client's eyes means that every ounce of caring we can bring to issues of diversity and community is relevant to the therapy work we do.

A great deal remains to be learned about how to adapt ACT to diverse populations, but it is not by accident that ACT researchers have been in the forefront of using psychological methods to increase prosociality and to decrease prejudice and injustice in such areas as racial bias (Lillis & Hayes, 2008), sexual orientation (Yadavaia & Hayes, in press), prejudice against those with mental or behavioral problems (Hayes, Bissett, et al., 2004; Masuda et al., 2007), and a number of like causes. That does not mean ACT is culture or values free; rather, it provides a process-focused method of incorporating cultural adaptations (see Masuda, in press, for a book-length treatment of this topic).

Humor and Irreverence

Because the ACT therapist has experienced many of same pitfalls as the client, there is an opportunity to capitalize on one's shared experiences by taking a somewhat irreverent and ironic view of the client's situation. Irreverence is not the same thing as being condescending to the client. The

therapist's irreverence derives from appreciating the craziness and verbal entanglements that surround all human beings.

Many ACT concepts, techniques, or sayings are inherently irreverent. For example, an ACT therapist might say: "The problem here is not that you have problems … it's that they continue to be the *same* problems. You need some *new* ones!" If the other positive aspects of the ACT therapist's stance are well established, such a comment will not be seen as critical or pejorative. The therapist is poking fun at the system that squeezes down on *all of us*, not just the client. By using black humor or irony and treating problems somewhat irreverently, the ACT therapist is often able to get the client to question whether he or she might be taking his or her problems too seriously. The likely culprit is fusion with the belief that life is full of dangers, threats, and uncertainties and therefore is to be approached as a very serious proposition. Well-timed humor is inherently defusing. Perhaps that observation also helps to explain why ACT defusion methods are often themselves humorous.

Tracking Different Levels of the Client's Context

The psychological flexibility model can be applied to therapy experiences at three levels: the content and function of the specific issue the client raises; the issue as a sample of the client's social behavior outside therapy; and the issue as a statement in relation to the therapist. If a client raises an issue about a problem at home, it is worth examining it as an issue at home, that is, taking the client's verbal reports as being about something and dealing with their content and function. It is also worth noting that the issue might be an example of the client's social behavior more generally or that the issue might come up at a specific moment in the session with the therapist and might have a special function in that context. The effective ACT therapist invariably tracks the client's content on these multiple levels, always focusing on the levels that are of greatest importance. For example, if a client is talking about the pain of a dating relationship that ended with the client's feeling abandoned, the therapist also needs to track the possibility that telling a story like this might happen in other social contexts and consider what functions it might have. For example, it might fit into a more general view that the world is unfair and people cannot be trusted. The story might also be an indirect statement about the therapeutic relationship itself in that the client might be expressing fears that the therapist could abandon him or her or might be warning the therapist of dire consequences, should that occur. Clinical utility guides which level or levels are chosen to focus on in any given moment, but unless all the levels are tracked and considered within the psychological flexibility model, important sources of information might be lost.

NEGATIVE LEVERAGE POINTS IN ACT

ACT often involves an in-depth exploration of the client's innermost thoughts, feelings, values, or views of self, and yet it also involves forming a strong emotional and therapeutic bond with the client. Because of these considerations, the therapist must be mindful of the most common traps that lead to the misuse of ACT strategies.

ACT Is Not Merely an Intellectual Exercise

ACT embodies a complex set of philosophies, strategies, and techniques. Although the therapy attempts to undermine counterproductive forms of verbal control, most ACT principles and techniques must initially be communicated verbally. The philosophical ideas, basic theoretical research, clever sayings, metaphors, and exercises encompassed by ACT have an intellectual appeal for many therapists. It is crucial that this appeal not be converted into seeing ACT as solely or predominantly an intellectual exercise with the client. When verbal content is overemphasized, it results in the therapist engaging in verbal persuasion techniques to get the client to agree that the therapist is right and that the client has been "missing the boat" all along. This type of interaction is the antithesis of an effective ACT relationship in that it essentially reinforces the idea that there is a "correct" verbal formulation for how to live and the client has simply adopted the wrong one—as if the client is broken and the therapist is "oh, so wise."

It is not the job of the ACT therapist to convince the client to believe in ACT principles. If an ACT therapist says "Don't believe a word I'm saying," it has to be sincere (in other words, even this very invocation is not to be believed), and it has to apply equally to the therapist, not just the client.

When therapists begin overintellectualizing ACT, it is manifested in sessions by an excess amount of therapist verbalization (given the purpose of the session), relative client passivity, and the absence of nonverbal experiential exercises that could cut through the verbal entanglements. The overintellectualizing ACT therapist typically reacts with frustration when the client indicates that he or she is not following what the therapist is trying to say or accomplish. Then, to make matters worse, the therapist falls back on moralizing, lecturing, and further explaining.

This problem is one of the most common issues dealt with in ACT supervision. The therapist's own words often reveal the true source of the problem. In supervision, overintellectualizing therapists often say such things as "We *talked about* acceptance," or "We *discussed* the concept of commitment," or "I *brought up* the issue of his avoidance," or "I was *trying to show* the client that. … " The italicized words are suggestive of intellectualization. ACT is not about the adoption of concepts; rather, it is work in the

here and now. Yes, ACT involves issues and it uses words—but only as tools to get into contact with something that is directly experientially relevant to the client.

If an empowered life could be readily understood intellectually, no doubt the client would already be viewing life in the "correct" way. The painful irony is that intellectualizing the ACT perspective—and then idealizing it in therapy—is the single most likely way to prevent the client from developing it in a functional sense. When the client obviously does not understand or feels confused, it is useless and counterproductive for the therapist to spend time rationalizing logical premises or browbeating the client.

Intellectualization can be a difficult process to correct once it begins in earnest because the client often tacitly moves into the position of trying to please the therapist by adopting "correct" ACT answers. Meanwhile, the client's sense of vitality and connection with the therapy drains away. Whereas ACT in its proper application is compassionately confrontational, the intellectualized version of ACT tends to be accusatory and derisive.

The usual correction is to reduce the therapist's verbal domination of session time. As a curative rule of thumb to correct the situation, no more than 20% of the session should involve ACT principles and concepts in a distinctly verbal sense (and even this figure may be excessive). Instead, the therapist should use metaphors, exercises, and processes in the present moment—all linked to real-life events of direct relevance to the client. If stuck on intellectualization, the clinician should get additional supervision and have a clinical colleague watch a session or two. As things get back on track, these guidelines can be withdrawn and therapy can proceed more spontaneously.

A similar problem can occur when commitment to ACT techniques is getting in the way of doing ACT. Simple, genuine, natural responses have a place in therapy just as much as metaphors and exercises. It is quite possible to do an ACT session without any metaphors or exercises at all, based on natural interactions that embody ACT processes (e.g., a therapist modeling willingness by staying present with the client while a traumatic event is recounted). Function trumps form in every area, and having the flexibility to track and pursue functional changes is the mark of a good ACT therapist.

Modeling Psychological Inflexibility

Modeling psychological inflexibilty occurs most frequently with the more disturbed clients who can frighten or concern therapists with their high-risk behaviors such as suicidality, self-mutilation, bizarre behaviors, and the like. If the therapist cannot accept the client as a human being with

real-life legitimate and honorable dilemmas, then how is the client going to accept and move through these same dilemmas?

This problem can show itself in several ways during the course of ACT. The therapist can selectively reinforce the client's thoughts or behaviors that are socially desirable while ignoring or disputing experiences that are negatively evaluated. In other words, the therapist is modeling acceptance of positive events and rejection of negative events—precisely what the client was probably already doing before treatment.

Sometimes therapists respond to a negative set of behaviors, cognitions, and feelings by attempting to explore "where you learned that way of thinking." Asking the client where this particular set of thoughts and feelings might be coming from—as if to find out how to remove it—is a sure sign of trouble. The clinical use of the word *why* is almost always a mistake. It is an invitation to reason giving or storytelling, and it generally leads both the client and therapist to a dead end. It is generally more productive to ask the client to describe the internal events (including thoughts about one's history) that show up in association with the difficult material. The agenda is to see what is there—not to solve it, as though the person's life is a problem.

The way to address these difficulties is to acknowledge them, defuse them, and to return to the core of the work. The therapist should reconsider what personal values are involved in therapy and from that position go into the next session. Feelings of fear, disgust, or frustration about what is transpiring with a client are not, in and of themselves, bad. Such feelings do not mean what they say they mean. The solution is the same for the therapist as it is for the client. Properly learned from, this type of difficulty can be a good thing because it means that the therapist can more fully appreciate how hard it is to do what the therapist is asking the client to do. Bringing that sense of humility into the room can make therapy itself more effective and humane and places the therapeutic relationship on a more level plane.

Excessive Focus on Emotional Processing

A common misconception about ACT is that the central goal is to get clients "in touch with their feelings." This misconception ties into a very popular cultural conception regarding the need to release pent-up feelings and past frustrations. A second spin-off of this position is to believe that the client's entire psychological distress can be explained as a function of avoiding certain feelings. Therefore, the therapist's first maneuver may be to ask the client what he or she is avoiding in a more or less direct way. The implied assumption here is that if the client gets in touch with what is being avoided, life will automatically assume a positive direction.

Emotional avoidance is a central feature of ACT work—but only insofar as it blocks the client from pursuing a committed direction in life. The private events the ACT therapist is most interested in are those that surface once the client initiates valued actions. As the client moves toward establishing a process of vital living, negative avoided feelings, thoughts, and memories will in fact surface. Addressing these experiences is not some esoteric exercise in "getting in touch with your feelings" simply because emotion itself is thought to be inherently healthy. These experiences are grist for the ACT mill because the goal is behavioral flexibility and valued action.

The therapist may be tempted to jump onto the emotional avoidance bandwagon within minutes of starting the first session, but the language accompanying this choice often is indistinguishable from the language of other popular psychotherapies that emphasize emotional discovery for its own sake ("You just need to feel your feeling!"). Of all the errors an ACT therapist can make, this one is probably the most seductive because it is consistent with much of the contemporary literature and at times can appear almost indistinguishable from praiseworthy ACT work. Furthermore, it is hard for even experienced therapists to reliably distinguish and undercut this type of invitation to emotional wallowing as if clinical progress can be measured in tears per minute. The solution for this error is to come back to active exercises linked to values and behavior change. If the emotional work is worthwhile, it will be evident at that point.

Dealing with Your Own Issues

It is easy for the therapist to become stuck when the therapist and client stumble onto issues that are equally salient for them both. This difficulty might arise whenever the therapist has particularly strong moral beliefs about a certain set of client behaviors (i.e., suicidal behavior) or when the client's dilemma closely mirrors an issue that the therapist unsuccessfully addressed in his or her own life. The usual errors that result are avoidance of emotionally charged topics, advice giving, or excessive reliance on personal experience (e.g., "Don't do what I did!").

Even "good" ACT therapists have personal issues and feared psychological content. They have what is usually called "countertransference," and no amount of therapy or experience can eliminate the issue—because, after all, therapists *are* human beings. The psychological flexibility model itself suggests what should be done: acknowledge the issue (privately at first then to the client if that seems clinically useful); be more open with it psychologically; and focus on the values-based actions that can be taken in the service of the client. Sometimes personal issues have been engaged that won't be beneficial in helping to resolve the client's dilemma, and in

that case the goal is simply self-acceptance. In taking this course, the ACT therapist models exactly what the client is being asked to do, namely, persisting in taking valued steps forward, whatever feelings these may arouse. At other times, as well, one's personal connection to an issue suggests additional ways forward.

CONCLUDING REMARKS

In ACT, therapeutic relationships are strong, open, accepting, mutual, respectful, and loving. In short, the ideal ACT relationship is the epitome of psychological flexibility. At the same time, the therapeutic relationship per se is not viewed as an end purpose of therapy. Rather, it is a powerful vehicle for change. There are other powerful "delivery systems." Indeed, empirical evidence suggests that the ACT model can work even if no relationship is required, for example, via self-help books (Muto, Hayes, & Jeffcoat, 2011) or using computer-assisted treatment. In general, the effect sizes of these interventions are a bit less, however, since relationships are a powerful ally of change.

ACT work is personally challenging. That is the very nature of the work for any client, and it is thus unavoidable for the honest therapist. ACT can be a powerful intervention, but it is by its very nature intrusive, raising basic issues of values, meaning, and self-identity. The distinction between ACT topographically defined and ACT functionally defined has to do with the nature and purpose of the therapist's work. When developed properly, relationships in ACT are intense, personal, and meaningful. The boundaries of the therapeutic relationship are natural, nonarbitrary, and linked to workability. When done properly, this relationship models the purposes and nature of the ACT model itself.

CHAPTER 6

Creating a Context for Change

Mind versus Experience

In this chapter, you will learn . . .

- Why the act of coming into therapy is an extension of the client's change agenda.
- How to use the client's definition of *better* to call out the underlying change agenda.
- How to use the concept of workability to evaluate the client's past change efforts and the attendant emotional costs.
- How to address the key differences between what the client's mind says should work versus the results the client is actually getting.
- How to foster a creative sense of hopelessness, such that the client is willing to begin trusting his or her own experience rather than blaming him- or herself for any shortcomings.
- How to use information derived during the early sessions to decide which ACT core process to target first.

AN OPENING QUESTION: WHY NOW?

Experienced clinicians know that the important question "Why now?" should be running through their minds when first seeing a client. Why is the client presenting for help today and not a week, a month, or a year ago? What has shifted in the client's life such that the decision has been made to seek help?

Clinicians need to think about the significance of coming to see a therapist, given the cultural stigma for seeking mental health or chemical dependency treatment. Typically something significant has transpired to make the client want to cross this bridge.

Ordinarily, the client has worked, struggled, considered, planned, evaluated, contemplated, and dealt with the problem for some time. Usually, many different solutions have been tried without much success. The client might have talked to friends, discussed the situation with a family member or life partner, prayed, read a self-help book or two, talked with a rabbi, priest, or minister and, yes, even might have visited other therapists. The client might also have tried some not so helpful solutions such as avoiding friends and family, refusing to drive his or her car, drinking, taking drugs, overeating, self-mutilation, or the like.

We would label some of these responses as "positive" and others as "negative," considered individually. Considered as a class, however, these strategies are "birds of a feather" because they originate within the same culturally shaped agenda the client is following to solve the problem. Normally, the goal of such strategies is to control or eliminate psychological distress. Basically, the client is trying to find a way to feel better. Like pulling your hand off a red-hot burner immediately makes you feel better, clients carry this same definition of *better* into their psychological world. *Better* is being free from the actively painful emotion, thought, memory, or sensation the client is experiencing.

These responses are highly organized; they are not random. If they were random, the client would be far better off because unworkable solutions would be dropped quickly and more workable approaches would be discovered by trial and error. Just as biological evolution cannot work without variability and selection, healthy behavioral evolution is enhanced by psychological flexibility and a focus on workability. In a paradoxical way, ACT aims to help the client regain the ability to be more variable, to listen to results, and to be relentlessly experimental in approach. This progression cannot happen so long as the client is absorbed in and fixated on applying a verbal problem-solving mode of mind that emphasizes the importance of achieving an unattainable outcome.

In most cases, clients come into therapy with a sense that they are "stuck"—unable to produce or sustain positive momentum toward control or elimination of emotional distress. The client usually seeks therapy with the conviction that the therapist will provide an insight or a practical strategy that will enable the existing agenda to be accomplished. Seasoned clinicians know that, just because a client seeks help, it doesn't mean the client is willing to engage in real behavioral change. These clients are often described as "resistant," but in truth virtually all clients are resistant in a particular way.

CULTURALLY SHAPED RESISTANCE

If a person has exerted so much effort to reduce emotional distress and yet is still seeking help, one of two things must apply: either (1) the person has not found the right way to fix the problem, or (2) the "desired outcome" originated in a flawed and unworkable approach to the problem situation in the first place. Almost without exception, clients believe that it is the first circumstance that applies. ACT, however, starts from the viewpoint of the second alternative. Clients generally blame themselves for not finding the right formula and look to the therapist to validate the basic agenda and reveal the missing step that will make this approach work. The direction the therapist takes is expected to either ratify the culturally shaped change agenda or push the discussion in some unexpected direction. This is the crossroads that each clinician must address.

The ACT perspective, however, is that the conceptualized outcome, that is, the supposed solution, is often itself the problem. Most clients are intelligent, sensitive, caring individuals who, given a reasonable chance, would probably come up with an effective solution. The problem is that their cultural training does not give them a straightforward chance to succeed. Instead, the clients' problem-solving efforts are channeled by culturally sanctioned rules that describe how problems are to be identified, analyzed, and solved. These mental guidelines and cultural assumptions specify what psychological and life outcomes are important and how to achieve them. We earlier touched on the essential features of this flawed change agenda:

- Psychological problems can be defined as the presence of unpleasant feelings, thoughts, memories, bodily sensations, and the like.
- These undesirable experiences are viewed as "signals" that something is wrong with the client, and that something needs to change.
- Healthy living cannot occur until these negative experiences are eliminated.
- The client needs to get rid of negative experiences by correcting the deficits that are causing them (i.e., lack of confidence, mistrust in relationships).
- This is best achieved by understanding or modifying the factors that are the causes of difficulties in the first place (i.e., low self-confidence, resulting from overly critical parents; mistrust caused by sexual abuse).

Following this problem-solving approach creates toxic outcomes for many clients; nevertheless, these clients readily defend the validity of this approach. Clients often look at the therapist in disbelief when the therapist

directly calls into question the utility of this approach. They want the therapist to give them the silver bullet that will make yet another round of control-and-eliminate efforts successful.

THE ELEPHANT IN THE ROOM

The culturally promoted model of personal health and how to achieve it is at the heart of the predicament we face when trying to help a client that is suffering. It essentially suggests that uncontrollable internal events—such as painful feelings, distressing thoughts, scary memories, unpleasant images, or uncomfortable physical sensations—must be controlled or eliminated to achieve personal health. Instead of viewing unwanted internal experiences as signals that should be listened to and used to motivate effective action (the Latin root of *emotion* means "movement"), the cultural instruction is to kill the emotional messenger. Instead of recognizing that emotions are hardly ever "wrong" in a *functional* sense, the client has traditionally learned that negative emotions are "toxic" and therefore are the problem to be solved or eliminated. This simple but lethal cultural instruction sets off a domino effect of misdirected problem-solving efforts that frequently result in the client becoming stuck. So long as these problem-solving efforts are permitted to dominate over direct experience, the client continues to suffer. Because these traditional cultural rules are built into language itself, they do not naturally stand out for either clients or therapists.

The basic problem the therapist must somehow confront at the outset is that the client is fused, or overly identified, with the idea that health is the absence of emotional distress and that therefore deliberate control efforts will be successful in achieving it. The client does not see "the elephant in the room" and simply pointing out that one is there is not going to dissuade him or her from acting upon the existing change agenda. As with so many aspects of ACT, the therapist must use words in highly strategic ways to help the client move inch by inch toward recognizing the verbal trap that has been sprung.

How do we get the client to shift his or her attention from self-critical and agenda-strengthening explanations for why change efforts have failed (e.g., "I don't have enough willpower"; "I lack the necessary confidence"; "My abuse history prevents me from asserting myself"; "This is just another example of how I lose things that are important to me")? How do we get clients to begin questioning the legitimacy of the traditional change model itself (e.g., "Maybe the goal isn't to control how I feel or think or what I remember"; "Maybe the goal is to stand up for my values in this situation and take action even if I'm distressed"; "Maybe that is the way

to promote my sense of health and well-being")? If we had a silver bullet that could help the suffering individual step completely out of his or her cultural conditioning, this book would be but a fraction of its length. But, as with so many important life lessons, the client has to learn this one the hard way.

At the behavioral level, the act of entering therapy is an admission that—no matter how diligently the client has followed the "control-and-eliminate change agenda"—the expected results are not materializing. This lack of progress gives us, as clinicians, a distinct advantage in the interaction. If we keep coming back to the results the client is experiencing versus the results that the cultural change model promises, we have a built-in motivational tool. Normally, the client won't even recognize that unworkable mental rules are being followed. Establishing this point directly in a verbal interaction can work powerfully with some higher-functioning clients. And if the description of the problem is thorough, the therapeutic contract stage can be reached almost immediately. However, most clients—even those with considerable insight and motivation to change—will vigorously defend the idea that they will know they are healthy when they no longer experience significant personal pain. For this reason, exploration of mind versus experience is often the first order of business.

What follows in this chapter is a description of what normally precedes the development of a therapeutic contract. Occasionally, with particularly receptive clients, one can fast-forward through some of these steps, but usually not in full form. The exact timing and sequence depend on how forthcoming the client is during the problem description phase and how quickly the therapist must toward confront head-on the system that has thus far entangled the client.

WHAT HAVE YOU TRIED? HOW HAS IT WORKED? WHAT HAS IT COST YOU?

At the beginning of therapy, the immediate goals are to neutralize the client's fixation on following the traditional cultural rules and to begin sowing doubt about the effectiveness of the basic approach the client has been using. The best way to deal with this system is to continually refocus any discussion on what is working and what is not. The contrast between what the cultural rules say should happen and what is actually happening is the linchpin for creating a different context for change.

Typically the ACT therapist begins this process by drawing out the system that the client has been following, which involves focusing the dialogue on four key questions:

1. What does the client desire as the optimum outcome?
2. What strategy (or strategies) has the client already tried?
3. How has that worked?
4. What has been the personal cost of following this strategy (or these strategies)?

The theoretical rationale for this approach is important. The client is operating under the influence of an overarching "track" that goes like this: identify the problem ("bad" thoughts, feelings, etc.), eliminate the problem (eliminate "bad" thoughts, feelings, etc.), and then life will improve (e.g., "I will have fulfilling work, marriage. … ").

The goal of eliciting from the client the various strategies being employed is to help the client recognize their agenda and to make direct contact with the personal costs of following it. The goal is to get the client in contact with his or her experience of the workability of this approach, so that an openness to alternatives is created. We also want the client to begin to see the similarities among various coping strategies so that the discussion can shift to the general question of trying to control or eliminate private experiences. Drawing many instances into a larger class is useful because it makes it more likely that targeting extinction of some of them will lead to weakening of the entire class (Dougher, Auguston, Markham, & Greenway, 1994; Dymond & Roche, 2009). In essence, the ACT therapist is trying to group most if not all of the client's prior "solutions" into a "control of private experience equals successful living" class so that the validity of the entire class of "solutions" can ultimately be examined and dethroned. They are not working.

As the client makes contact with the unworkable nature of the internally focused "control-and-eliminate" agenda, he or she often does not know what to do next; we call this phase of development "creative hopelessness." During this period of transition, entirely new strategies can develop without being overwhelmed by previous rule systems. From a motivational perspective, it is also important that the client fully comprehend the considerable costs of continuing to follow an unworkable change agenda. Control-and-eliminate strategies are by no means harmless—they materially worsen the client's situation. Not only is the client inadvertently producing more psychological pain, but also the persistence of control strategies almost inevitably seeps into the external world as well. This is so because one chief experiential avoidance strategy is situational, or behavioral, avoidance. Whenever clients begin to engage in situational avoidance, real-world consequences inevitably follow. The marital relationship suffers, work performance deteriorates, and health-protective behaviors (such as eating well, sleeping well, exercising) decline. Thus, the client is

faced with the one-two punch of increasingly uncontrollable psychological distress and the negative consequences of avoidant behavior in the real world. It might be enough for some clients to simply see the unworkable nature of their coping strategies "in between the ears," but it helps more to make contact with the costs of these strategies in the material world. It is seeing what is not working that motivates the client to seek new solutions.

What Is "Better"?

The client has been struggling purposefully, not randomly. The best way to access the client's purposes is to get a sense of what the situation would look like if the underlying problem were resolved. In ACT, the client might be asked, "What would tell you that your life was working better? What would you be doing differently?" or "If a miracle were to happen and this situation were resolved, what would you notice that would tell you things are going better?" These questions allow the therapist to elicit the client's definition of the "solution" to whatever problem is present. Listening with "ACT ears" is very important here. Normally, the client describes a *process goal*—removing some unwanted private event that is seemingly preventing the client from getting on with his or her life ("I would wake up and not feel depressed"; "I could have intimate relations with my boyfriend without experiencing flashbacks"; "I wouldn't feel so worthless when someone criticizes me"; "I could get through the day without feeling urges to drink"). These responses tend to highlight the private experiences that the client is trying to suppress, control, or avoid. They also provide an entry point for a discussion about behavioral avoidance, that is, the client's attempts to avoid stimulating unwanted internal experiences by avoiding the situations, events, or interactions that trigger them. Since, by definition, these emotional obstacles remain as current concerns (that's why the client is seeking your help), the therapist can flip the question around and say something like:

THERAPIST: So, waking up and feeling depressed is one problem that you haven't been able to get on top of—is that correct? What happens next when you wake up and notice that you're depressed?

CLIENT: Well, I have to decide whether I'm going to go to work or not. If I'm really depressed, I just call in sick and go back to bed and try to disappear.

THERAPIST: So, one strategy you use to control your depression is to opt out of going to work to save your energy—is that correct?

This type of brief interaction begins to give the therapist a "snapshot" of the various emotional obstacles the client is trying to overcome.

The second goal of this set of questions is to briefly engage the client in a discussion about personal values and what the client would like from life. These visions of a better life are *outcome goals*. As we discuss later, some outcome goals are truly goals and others probably function more as values. This early interaction is not the full values assessment and goal planning that may occur further down the road in therapy. It is just attempting to touch on what the client would like to see happening.

THERAPIST: What would you be doing differently if you didn't experience flashbacks and anxiety attacks when you and your boyfriend are about to be intimate?"

CLIENT: I could relax, enjoy the moment of intimacy, and be responsive to his needs. I would be able to share with him how much I love him.

THERAPIST: It sounds like you have a very deep investment in making this relationship a reflection of what you want to be about as a life partner. That's very cool. It sounds like the impact of having flashbacks and anxiety is that they are trying to block you from realizing your dreams for this relationship.

In this case, the therapist is simply acknowledging the client's values and pointing to the fact that there is a conflict between what she wants and what she has to deal with in the way of emotional obstacles. This strategy is a kind of "thumbtacking." The therapist simply notes this important value and associated obstacles, and puts it on the bulletin board to be addressed later in therapy.

The system that usually is strangling the client involves his or her mistakenly linking outcome and process goals. Seldom does achieving a process goal guarantee that an associated outcome goal will be realized, but the traditional change agenda is based on this assumption. The therapist should be on the lookout for statements that express a direct connection between achieving a process goal and realizing an outcome goal. For example, in the following dialogue, the client is depressed, anxious, and in the middle of an unpleasant, drawn-out divorce that she initiated only after suffering through many years of a miserable relationship.

THERAPIST: What do you want from therapy?

CLIENT: I need to feel better about myself. Sometimes I think I almost hate myself. I am insecure most of the time. It goes back as far as

> I can remember—even as a little girl, I remember thinking that I was bad and I would never get it right. I think I've never really grown up and taken charge of what is happening to me. My marriage turns out to be a sham, my kids don't want to be with me—I've made a mess of it. For years, I just dealt with it by drinking, but of course that just made it worse. But now that I've stopped drinking, I realize how bad I feel most of the time—I think that if I knew how hard it would be, I'd never have been able to quit.

This answer presents a confusing mix of outcome and process goals, and it is uncertain whether the client is clear on which is which. The outcome goals include taking charge of her life, having a relationship that is valid and intimate, and having a good relationship with her children. These outcomes are blocked by various psychological obstacles: self-loathing, feeling insecure, feeling bad, and thinking "I'm bad." By asking this innocent question, the therapist has exposed the core of the clients' unworkable system: when the insecurity and bad feelings go away, the client will be able to live a more powerful and valuable life. Changing bad feelings is a process goal. Living well is an outcome goal. The answer also reveals some of the efforts that have been used to try to make this system work: the client "felt better" when drinking, but feeling better did not lead to a better life; indeed, drinking made her life much less livable. Achieving the process goal (feeling better) was actually negatively related to the outcome goal (living a rewarding life).

What Have You Tried?

Most clients are working within a system in which unwanted private experiences are seen as barriers to vital living. The therapist should spend some effort (even a great deal of effort, if that is what is required) trying to enumerate all of the various methods that have been used and the outcomes they have produced. While collected this information, the therapist should take an objective, nonjudgmental stance with respect to the client's various problem-solving efforts. The ACT therapist should get the client to describe each coping strategy in some detail and then link it back to the client's change agenda. For example, the following excerpt is an interaction with a chronic worrier:

> THERAPIST: What else have you tried to do?
>
> CLIENT: Well, sometimes I try to talk myself out of it. I say, "This is silly—you are making a mountain out of a molehill."

THERAPIST: In other words, criticize and chastise yourself. And the purpose of this criticism … ?

CLIENT: To get me to stop it.

THERAPIST: To get yourself to change—to stop worrying.

CLIENT: Yeah. … The things I worry about are silly. I mean some of the things that come into my mind are just nuts.

THERAPIST: And the idea is that if you could get rid of those worries—those thoughts—then the anxiety would be less and you'd be able to face your daily situation better.

CLIENT: Right, but it is pretty hard to convince myself to stop it. So, sometimes it works, but sometimes it doesn't.

THERAPIST: So, if you could just convince yourself that you don't need to worry, then it would work and things would start moving ahead. OK. So far we've got criticism, chastising, and attempts to convince yourself to stop. What else have you tried?

In this example, the therapist is functioning like a slightly cracked mirror, reflecting back the essence of what the client is saying but with a slight twist. By reframing solutions in terms of the client's desired outcome, the therapist is beginning to help the client recognize that (1) a number of solutions have been tried; (2) they are usually aimed at achieving process goals, with an assumed linkage to outcome goals; and (3) they share a common underlying strategy that is linked to control or elimination of unwanted private experience.

It is a good idea to include the therapy setting itself in this kind of exploration. The client can be invited to reveal how coming into therapy is itself another change effort. This suggestion can be helpful because it shows that the therapist is not defensive about simply being another part of the client's change agenda.

Here is an example from a session with the earlier depressed client who is in the middle of a divorce:

THERAPIST: And this coming in here—is it part of that effort to change how badly you feel as well?

CLIENT: Of course. I'm not sure what I will get out of this really, but if I could feel even a little better about myself, it would be worth it.

THERAPIST: So, you're hoping to remove some of the bad feelings and get more good feelings because then you would be able to move on.

CLIENT: (*Pauses.*) I guess so.

THERAPIST: So, this is another thing to try. Good. So, let's add this therapy to the list. It is another thing you've done to feel better.

CLIENT: I've tried almost everything I know to feel better.

THERAPIST: I'm sure you have. You have, indeed. And this—therapy—is yet another attempt.

CLIENT: You say it like there is an alternative.

THERAPIST: Well, I don't know. Right now I just want to be clear about what you have tried and how it has worked.

How Has It Worked?

The clinician is at a distinct advantage because of the following cardinal principle: if things were working "as advertised," the client would not be sitting in front of you right now. Something is amiss, and the goal is to help the client see what the basic problem is. In ACT, the therapist is engaging the client in a kind of contest between two main players. On the one hand there is the client's mind. On the other hand, there is the wisdom of the client's direct experience. The client has directly experienced certain outcomes. When clients suffer, it is because the mind and direct experience are in fundamental conflict. The mind says following a particular process strategy (e.g., improve self-confidence) will produce a desired outcome goal (e.g., getting people to like you), but the system is not delivering results. Instead of challenging the system, clients buy into the mind's explanations for why the strategy did not work (e.g., you didn't try hard enough to get self-confidence—you must be too weak to succeed). Because of the cozy relationship we have with our minds, it is very hard for most clients to recognize the game that is being played. Repeatedly bringing up the issue of workability is the only way to create initial doubt in most clients about the wisdom of following their mind. The basic state of affairs is that, try as they might, clients are not experiencing good results when they follow their mind's advice. That is why they end up coming into therapy. The challenge for the therapist is to expose these failures in a way that does not drive the client into a posture of defensive resistance. The following dialogue with the chronic worrier cited earlier demonstrates how to evaluate how well a rule system is working:

THERAPIST: OK. Let me ask you this. Your mind says that when you convince yourself that your concerns are silly, you will stop having those concerns, you will become less anxious, and then you will do better—right?

CLIENT: Right.

THERAPIST: OK. And how well does that work? What does your experience tell you?

CLIENT: Sometimes it works. But I can't always talk myself out of them.

THERAPIST: And even when it does work, if we expand the time frame a bit, would you say that over time, as you've followed the rules your mind has laid out for you, that your concerns overall are less or more?

CLIENT: . . . Overall, they are more.

THERAPIST: That seems like a paradox, doesn't it? I mean, you do what your mind says, sometimes it even seems to work, and then somehow it seems as though the concerns and worries are getting bigger, not smaller. They are more important, not less.

CLIENT: So, what should I do?

THERAPIST: What does your mind tell you to do?

CLIENT: Try harder.

THERAPIST: Interesting. And have you tried harder?

CLIENT: And harder and harder.

THERAPIST: And how has *that* worked? Has it paid off in a long-term or fundamental way, so that by doing it you have transformed the situation and it is no longer a problem? Or are you, unbelievably enough, sinking in deeper as you try harder and harder?

CLIENT: . . . I'm sinking in deeper.

THERAPIST: If we had an investment advisor with that track record, we would have fired him long ago. But here your mind keeps leading you into efforts that don't really, fundamentally, pay off, but it keeps following you around with its "blah, blah, blah," and it is hard not to give it one more try. I mean, what else can you do but what your mind tells you to do? But maybe we are coming to a point in which the question will be "Which will you go with—your mind or your experience?" Up to now, the answer has been "your mind," but I want you just to notice also what your experience tells you about how well that has worked.

Focusing on how the system is working does two things. First, it implicitly encourages the client to step back and "witness" the results of overidentification with the mind; in essence, this is the simplest form of defusion.

When the therapist uses the language of "your mind," the client is being coached to look *at* mental activity rather than looking at the world *from* the perspective of mind. It is easier to separate from self-talk when it is treated as an object-like event because language training emphasizes separating the roles of the speaker and the listener. Even though clients may express curiosity about what we mean by *mind* and may not immediately grasp the answer, they implicitly understand the process of speaking and listening. Second, discussing results in this objective, nonevaluative way is modeling a kind of acceptance for the patient. This is a powerful place to work from because, no matter how well defended the client is, the fact of being in therapy is itself undeniable evidence that something is not working. The pain of failure is our greatest ally in therapy. It changes the client's frame of reference and often is a precondition for seeking "out-of-the-box" solutions.

Although we are focusing now on the initial session or two with a new client, the principle of workability (i.e., "How is that working for you?") is a basic strategy for steering clear of dead-end interactions throughout therapy. Whenever an ACT therapist gets caught up in a client's fascinating but self-defeating life story, workability provides a reliable way to shift attention back to the contextual issues that are really more important. For example, if a client logically "explains" why things are the way they are, the therapist can pause and say, "And how has this approach of logically explaining why things will never change worked for you? What does your experience tell you? Has it given you an angle on this problem that gives you some room to move?"

What Has It Cost You?

The final element of the initial discussion of the client's situation is to mutually assess the cost of following the mind's recommendations. As noted earlier, control and avoidance strategies are anything but benign in their impact, but most clients view these adverse consequences as necessary "collateral damage" in their quest to control distressing and unwanted private events. In their view, extreme means are warranted to control them. In this initial discussion, the therapist is trying to shift the labeling from "collateral damage" to "main outcome." Not only does the control-and-eliminate agenda fail to neutralize distressing content, it also wreaks havoc with the client's psychological space and external world. By helping the client come to terms with this very real cost, the therapist is providing him or her with the motivational fuel needed to look for alternatives. As already noted, this initial discussion usually touches on the client's values at only the surface level, mainly because the discrepancy between the client's personal dreams and what is actually occurring creates a lot of anxiety. The

following interaction with the sexual abuse survivor introduced earlier highlights some key principles:

THERAPIST: I'm curious. You mentioned that your anxiety is at its height when your partner begins coming on to you when you get ready for bed at night. You also feel afraid and begin to remember what your uncle did to you. That must be a very scary and painful situation for you. So, what do you do to cope?

CLIENT: The only way I can get the anxiety under control is to leave and either take a walk or go into the TV room and zone out.

THERAPIST: That must be really difficult for you. I mean, you are basically forced to walk out on your partner, and this is a person that you've obviously got very strong feelings for. I'm wondering how this is affecting the two of you?

CLIENT: You have no idea how difficult it is for me! I just shake like a leaf afterward. I just don't know what to do! I also feel bad because my boyfriend is getting very frustrated with me. He has even suggested that we sleep in different rooms and is even talking about staying at his place more nights of the week.

THERAPIST: Wow, this is bad news! I guess another way to say this is that you purchase anxiety relief by giving up some of your dreams for this relationship—is that it?

CLIENT: Yes, as sad as that sounds … to let my own issues destroy this relationship.

THERAPIST: Well, it doesn't sound like your issues are doing the dirty work here. It is what you are doing when your issues show up that is wreaking havoc. In order to bring your anxiety down, you leave the bedroom. Given the cost you are experiencing, controlling your anxiety must be Job 1.

CLIENT: If I just stayed in the bedroom and let my anxiety go, I'm afraid that I would just freak out.

THERAPIST: Exactly, your mind is busy telling you that even worse things will happen to you if you don't get out of there pronto. Funny thing is, leaving the room produces even worse consequences, doesn't it? What does your mind have to say about you losing this relationship and the dreams you had for it?

CLIENT: I don't know how to answer that question.

THERAPIST: You mean your mind doesn't have an answer? Let me ask you this: What is most important to you here—not having anxiety in your bedroom or keeping your relationship with the man of

your dreams? Your mind is saying that anxiety is the most important thing in your life, but I'd like to know what *you* think is most important?

CLIENT: My relationship.

THERAPIST: And if you keep following your mind's advice about this situation, what do you think is going to happen?

CLIENT: He will get tired of this and leave me. I don't know what to do!

THERAPIST: Good … not knowing is a good place to be.

In this exchange, the therapist is undermining the notion that losing the relationship is simply justifiable collateral damage sustained in the service of the far more important objective of controlling anxiety and fear. The real cost is going to be an irreversible lifelong consequence. Discussions like this about the cost of control and avoidance cannot be allowed to devolve into criticism of the client. The therapist has to maintain his or her focus on drawing out the hidden consequences while simultaneously looking at the client with "soft eyes."

CREATING A TREATMENT AGREEMENT

The issues involved in informed consent and creating a treatment agreement vary between practice settings: outpatient psychotherapy, primary care, work site programs, and so on have different practical limitations. Generally there is a description of operating principles and processes; the nature and availability of alternative forms of therapy and evidence for these courses of action and are also important topics.

Because ACT can raise fairly fundamental and painful personal issues, it is wise to get the client to commit to a specified course of treatment and to agree not to measure progress prematurely. This approach usually involves agreeing to meet a certain number of times with the client and then reviewing results before proceeding with additional sessions. The client should be told to expect ups and downs and to understand that success should not be defined as the absence of personal pain.

A well-known ACT author and trainer, Russ Harris, has developed an accelerated way to arrive at an ACT therapeutic agreement. It involves casting the client's problem in relatively objective terms, validating the distress caused by the gap between what is occurring and what is desired, and taking note of the client's struggle with his or her thoughts and feelings and the relative absence of any values-based behavior. It concludes with an

agreement to pursue a fundamentally different alternative linked to lessening the impact of difficult thoughts and feelings and pursuing valued actions. This latter requirement is critical because, unless a firm contract is reached that is ACT-supportive, culturally supported ideas that are in opposition to ACT can readily embed themselves implicitly into the contract itself, in which case needless confusion and dissension likely ensue.

Externalizing the Problem

The client's original problem formulation contains not just ends—which are determined by the client—but also means or processes, which are not. "I'm depressed" normally implies that the client's depression *has* to go away. But on closer examination, that requirement is a means or process, not an end. If the client's depression *did* go away, what would the client be doing that would indicate life was more on track? The answer to that question reveals that getting rid of depression per se is not the outcome of greatest importance to the client.

By expressing the problem in more behavioral terms, the therapist can avoid this particular trap. A useful strategy is to express the client's problems as a matter of barriers and challenges that are a matter of history and circumstance. For example, a therapist might say, "So, let me see if I understand this correctly. You've faced a series of difficult challenges: First, you lost your job, then your father died, and now you have developed health problems. It's been increasingly hard for you to move forward in your life. Now, you are also having relationship difficulties at home." The trick is to express the client's problem fully—but without buying into the client's cause-and-effect formulation. In the problem summary it is important *not* to include diagnostic labels or the role of distressing thoughts or feelings, since the client will likely already have incorporated these into a cause-and-effect explanation of how the problem developed—*and that formulation is very largely what needs to change.* Some behaviors can be included in the problem summary, but the primary focus should be on the client's unique history and circumstances since, after all, these are the contextual features that most affect one's behavior.

This approach does not amount to substituting the clinician's goals for the client's. Therapists work *for* clients—they are "hired hands." They have the greatest expertise about which means best lead to which ends. Suppose someone called a plumber because there was a leak, and that person was mistakenly convinced that the toilet was leaking. The plumber might readily see that a pipe was burst. It would be unethical for the plumber to work on the toilet just because the client formulated the problem incorrectly. The problem is the leak, and the plumber has a professional responsibility

to seek out the leak's cause. Similarly, psychotherapists have a professional obligation to work on effective means rather than ineffective ones assumed by the client or the culture to be key processes of change. The client has a particular problem in living; the therapist has a professional responsibility to analyze the problem's source and resolution.

Validate the Gap

The client's distress and sense that life is not going well should be validated by the therapist. This validation of the client's experience helps normalize painful emotions and thoughts.

> "When you look at how you want your life to be versus how it is, you feel distressed. You feel depressed, and you become self-critical. But much of that seems very natural, given how large the gap is between how things are now and the kind of life you want for yourself."

Acknowledge the Client's Struggle with Thoughts and Feelings

It can be helpful to create an overarching metaphor for fusion, avoidance, and inflexible attention and to summarize the situation in a way that establishes a useful focus for intervention.

> "It sounds as though your mind keeps reminding you of how badly life is going. You feel sad. Your mind starts judging you. [Here add whatever else the client is doing, such as ruminating or feeling anxious.] It seems almost as if you have been drawn into a kind of "war within." As you've gotten caught up with difficult feelings and thoughts, they've become more and more central in your awareness. Often you've been actively struggling with depressed feelings and self-critical thoughts; at other times, they just drag you down. It's no fun trying to live inside a war zone!"

Point out the Costs

After acknowledging the client's current difficulties, elaborate on their implications and consequences:

> "And when you get all caught up in these thoughts and feelings, it sounds as though life is put on hold. You end up doing things that don't help much or that actually drain your vitality or even make

things worse over time. You sleep. You avoid. [Add whatever else the client is doing.] And actually these things do give you some relief for a short while. But in the long run, the kind of life you want has drifted further away. Things you hold dear have suffered. For example, you aren't spending time with friends much anymore. And you've given up on singing in the church choir. And because that makes things even more painful, the gap between where you are and where you want to be grows ever larger, the negative feelings become even more intense, and the struggle becomes more intense. Something is not working, but it is not clear what you should do. And so you've come to see me. Am I hearing this right?"

Create a Treatment Agreement

After reviewing the totality of the client's dilemma, seek to arrive at a treatment agreement:

"So, it seems we have two things to do. First, we need to find another way to handle these difficult thoughts and feelings so that they don't push you around. And second, we need to work to improve your life in these main areas [list the needed values and actions] so that the [list the obstacles] aren't allowed to rule your life or take away what you hold dear. So, what if we could work together on something truly different in those two areas? Instead of engaging in that war within, maybe we could work on stepping out of it, so that these self-critical thoughts and sad feelings not longer get in the way as much, and we could move on toward what you really care about. Would a truly different approach be worth exploring?"

If an agreement is reached, the client should be told that some aspects of the treatment may be confusing or seem contradictory to what he or she has learned about how to deal with personal distress, since, after all, this is meant as a new approach. Remind the client that it is not unusual for clients to question their commitment. The therapist should really emphasize that this type of fear is normal, and the client should feel free to bring up any doubts or fears in session. If the client exhibits avoidance or rigidity, these signs should be taken as an opportunity to try something different. For example:

"Also we know from preliminary testing that when you get distressed you tend to avoid—so that will probably occur in here too. If you start to feel anxious, for example, you might want to skip sessions or drop

> out—but that may be a sign that it is time to do exactly the opposite. It may be a sign that we are getting somewhere and that you need to bring that anxiety into this room so we can work on it."

It is also wise to remind the client that no pressure will be applied to make him or her engage in actions that the client is not ready to engage in. The client retains control over therapy at each step.

CONTROL IS THE PROBLEM, NOT THE SOLUTION

At this stage, it is important to "put a name to the agenda" that is strangling the client. Even within the first session or two, clients typically express a vague recognition that something they are doing is contributing to their suffering but are usually uncertain what it is. Each of the earlier steps provides an essential platform for moving from treating each unworkable solution individually to beginning to treat them as a class of responses. A core principle of the ACT approach is that attempts at controlling and eliminating unwanted private experiences are driven by cultural rules that specify health as freedom from unwanted and distressing private experiences. Most clients bring four presumptions into therapy that seem to support deliberate control as the preferred coping strategy in the domain of private events:

1. "Deliberate control works well for me in the external world."
2. "I was taught it should work with personal experiences" (e.g., "Don't be afraid … ").
3. "It seems to work for other people around me" (e.g., "Daddy never seemed scared … ").
4. "It even appears to work with certain experiences I've struggled with" (e.g., "avoidance works for a while to reduce my anxiety symptoms").

The world outside one's skin works according to verbally constructed rules that assert that "if bad events are removed, then bad outcomes can be avoided." From a cultural perspective, control-oriented problem solving is undeniably an important part of successful adaptation. The difficulty is that this basic approach malfunctions in the world of private experiences. Unfortunately, most clients start out with an unquestioned faith in the legitimacy and accuracy of this verbal rule. While control-oriented change strategies appear sensible, when they are applied to the wrong targets, they tend to engender or intensify the very experiences the client is trying to avoid. Private events are not mere objects to be manipulated—rather, they

are historical, automatic, and not responsive to attempts at suppression, avoidance, or removal. The costs associated with putting these experiences "in the closet" (namely, emotional avoidance, escape, and numbing) are greater than the damage done when the experiences are left unobstructed or unrepressed. In the case of the sexual abuse survivor, the therapist touches on this fact:

THERAPIST: So, you are at the proverbial "fork in the road" in your life. One fork is marked by a sign reading "Control your anxiety" and the other by one proclaiming "Live the relationship of your dreams!" Now, we know that your mind wants you to go down the first road, and you've tried that road very courageously, and you've persisted with it even though it is draining your partner to the point that he is talking about getting some distance from you. I'm wondering … do you feel that you are more in control of your fear and anxiety and flashbacks than you were, say, 6 months ago?

CLIENT: No—well, I guess it depends on what you mean by "control your anxiety."

THERAPIST: We know that, in the short run, leaving the bedroom helps you relieve your anxiety. We know that avoiding social situations helps you feel safer. We know that when you stay in your home, you are not as likely to trigger these anxieties. What I'm asking is when you think about the role of anxiety, fear, and flashbacks in your life, is that role getting bigger or is it getting smaller?

CLIENT: I have more anxiety and fear, and it's happening in more situations than it used to.

THERAPIST: So, what you are saying is that your strategies for relieving your fear and anxiety are actually creating more anxiety. Is it possible that you are in some strange loop here where the harder you try to control your anxiety, the more uncontrollable it becomes?

CLIENT: Well, all I know is that it is getting worse, not better, and it could be the case that I'm making it worse.

THERAPIST: Wow, that's weird! Your mind tells you that the way to cope with anxiety is to avoid situations that trigger it. But you are telling me that the actual result is that you have more anxiety to deal with in more situations.

Here, the therapist is simply expanding on the results of the "What have you tried, how has it worked, and what has it cost you?" assessment and introducing the idea that there is a general problem with the various types

of responses—perhaps as a whole category—that the client has been using. With many higher-functioning clients, pointing out this paradoxical result is all that is needed to instigate some immediate changes. To heighten the clinical impact of this discussion, the therapist should rely not just on verbal reasoning but also on metaphors and analogies. Metaphors can be powerful tools for speaking of the control issue—as, for example, with the Polygraph metaphor:

> "Suppose I had you hooked up to the best polygraph machine that's ever been built. This is a perfect machine, the most sensitive ever made. When you are all wired up to it, there is no way you can be emotionally aroused or anxious without the machine detecting it. So, I tell you that you have a very simple task here, namely, all you have to do is stay relaxed! If you get the least bit nervous, however, I will know it. I know you want to try hard, but I want to give you an extra incentive—so, I also have a .44 Magnum that I will hold to your head. If you just stay relaxed, I won't blow your brains out, but if you get nervous (and I'll know it because you're wired up to this perfect machine), I'm going to have to kill you. So, just relax! … What do you think would happen? … Guess what you'd get? … The tiniest bit of anxiety would be terrifying. You'd naturally be going, 'Oh, my God! I'm getting nervous! Here it comes!' Bam! How could it be otherwise?!"

This metaphor can be used to draw out several paradoxical aspects of the control and avoidance system as it applies to negative emotions. Modifying the language within the metaphor keeps the impact of the exercise intact while allowing the client's various issues to be addressed, as the following scripts suggest.

1. **Contrast behavior that can be controlled with behavior that is not regulated successfully by verbal rules.**

   "Think about this. If I told you, 'Vacuum the floor or I'll shoot you,' you'd immediately start vacuuming the floor. If I said, 'Paint the house or I'll shoot,' you'd soon be painting. That's how the world outside the skin works. But if I simply say, 'Relax, or I'll shoot you,' not only would the directive *not* work, but it would have the opposite effect. The very fact that I would ask you to do this would make you damn nervous!"

2. **Apply the metaphor to the client's own struggles with controlling distressing private experiences.**

   "Now, you have the perfect polygraph machine already hooked up to you: it's your own nervous system! It is better than any machine

humans have ever made. You can't really feel something and not have your nervous system in contact with it, almost by definition. And you've got something pointed at you that is far more powerful and more threatening than any gun—your own self-esteem, self-worth, the workability of your life. So, you actually are in a situation very much like this. You're holding the gun to your head and saying, 'Relax!' So, guess what you get! Bam!"

3. **Even seemingly successful attempts to use control and avoidance strategies don't really work in the long run.**

   "So, see if this isn't true: what you've done is that you've found that if you leave the situation [or whatever the client is doing: alcohol, avoidance, denial, etc.] for at least a little, then you can manipulate how you feel. But then it wears off, and it doesn't work anymore. Instead of seeing the whole game as a hopeless and useless enterprise—which it is—you've been trying to win it—and nearly killing yourself in the process!"

The Rule of Mental Events

As the *Polygraph* metaphor demonstrates, deliberate attempts to control or eliminate unwanted private responses are bound to backfire. Up to this point, the therapist has revealed how attempts at control and avoidance don't work in terms of what is promised by the client's mind. However, it is important that the client also understand that these strategies actually make matters worse because deliberate attempts to suppress or control emotions, thoughts, memories, images, or sensations actually create the opposite effect. In essence, the harder the client tries to squeeze out unwanted private thoughts, the more intrusive and dominant these become.

There is another strand in this discussion that is also a "thumbtack" for future discussions. This has to do with the client's attitude toward threatening or distressing private content. Without going into too much detail, the therapist can talk about a general posture of willingness or one of rejection toward unwanted but uncontrollable private experiences. The following dialuge shows how this topic is approached in a general way. To focus on ACT interventions, some of the following dialogues will be a bit heavy in therapist talk time (for a full transcript, see Twohig & Hayes, 2008).

THERAPIST: OK. I think I understand what you have been doing. Are there any other strategies you've tried to handle these distressing experiences when they show up?

CLIENT: No. That is about it.

THERAPIST: OK. Actually, there are probably a lot of others that will

percolate up as we proceed, but it is not important at this point that we know every one. We just need to get a sense of the range of things involved. What I would like to do today is to try to get a clearer sense of this set of things—I would like to have us get clearer about what agenda you have been following. And I want to give it a name—not to figure it out intellectually but just to have a way of talking about it in here.

CLIENT: You want us to have a name for the theme.

THERAPIST: Right. I believe that most of what you having been doing is quite logical, sensible, and reasonable, at least according to your mind and my mind. The outcome isn't what you hoped it would be, but really it seems to me that you've done pretty much the normal thing. You've really tried hard and fought the good fight. All these moves you just listed—aren't they the kinds of things people do?

CLIENT: Maybe not normal people, but people like me sure do. It's like that support group I go to. It is almost laughable. Every single person in there has the same story. I mean you can tell even before they open their mouth what the story will be.

THERAPIST: Exactly. Because we all know how the system works. Consider this as a possibility. Everyone's story is similar (and similar to yours) because what you are doing is what we are all trained to do. Human language has given us a tremendous advantage as a species because it allows us to break things down into parts, to formulate plans, to construct futures we have never experienced. And it works pretty well. If we look just at what goes on outside the skin, it works great. Just look around this room. Almost everything we see wouldn't be here without human language and human rationality—the plastic chair, the lights, the heating duct, our clothes, that computer. We are warm, it won't rain on us, we have light. If you give a dog or a cat all this stuff—warmth, shelter, food, social simulation—they are about as happy as they know how to be. But without humans they are outside in the cold. So we've solved the problems nonverbal critters face. Yet we can be miserable when they would be happy. What if there is a relationship between those two things? There is an operating rule for things outside the skin: if you don't like something, figure out how to get rid of it and get rid of it. And that rule works great in most areas of our life. But consider the possibility—just consider—that this rule does not work in the world between your ears. And the world inside your head is a pretty important one because it's where life satisfaction lies. In your experience, not in your logical mind, look at what's

been happening to you and see if it's not like this. In the world inside the skin, the rule actually is: if you aren't willing to have it, you've got it.

CLIENT: If I'm not willing to have it, I will … (*Pauses.*)

THERAPIST: Just look at it. For example, you've been struggling with anxiety, flashbacks, fear, and feeling shaky inside.

CLIENT: Oh, yeah.

THERAPIST: You are not willing to have them.

CLIENT: No way.

THERAPIST: But if it is really, really important not to have anxiety symptoms, then if you start to get anxious, that is something to get anxious about.

CLIENT: If I'm not willing to have it, I have it …

THERAPIST: Just to put a name on it, let me say it this way: In the outside world, our mind's fascination with prediction and control works great. Figure out how to get rid of something, give your mind the job and watch it go! But when it comes to unpleasant thoughts, feelings, memories, or physical sensations, conscious, deliberate purposeful control might have other effects.

CLIENT: You mean, if I don't get so uptight about being anxious, I'll be less anxious?

THERAPIST: But notice there is a paradox here. Suppose it really is true that "if you are not willing to have it, you do." What could you do with such knowledge? If you are willing to have it in order to get rid of it, well then … then you are not willing to have it and you will get it again. So, you can't trick yourself with this …

Very often clients will pick up on the word *control* in helpful ways: for example, "I've always had a problem when I wasn't in control" or "My husband says I'm a control freak" or "I'm a pretty controlling person." If that happens, the ACT therapist can harness these issues to the therapeutic agenda. For example, the therapist can respond, "We are *all* control freaks—we have minds that just can't let go of the idea that control is the solution for everything!"

It is often useful to show the paradoxical result of mental control efforts via experiential exercises or metaphors, such as the *Chocolate Cake* task:

"Suppose I tell you right now that, I don't want you to think about something. I'm going to tell you real soon. And when I do, don't think about

it even for a second. Here it comes. Remember, don't think of it. Don't think of … warm chocolate cake! You know how it smells when it first comes out of the oven … don't think of it! The taste of the chocolate icing when you bite into the first warm piece … don't think of it! As the warm, moist piece crumbles and crumbs fall to the plate … don't think of it! It's very important—don't think about any of this!"

Most clients get the point immediately, and may laugh uncomfortably, nod, or smile. Others may respond by insisting that they did not think about anything. As is illustrated in the following dialogue, the ACT therapist can use this exercise to further highlight the futility of mental control or thought suppression strategies.

THERAPIST: So, could you do it?

CLIENT: Sure.

Therapist: And how did you do it?

CLIENT: I just thought about something else.

THERAPIST: OK. And how did you know you did it?

CLIENT: What do you mean?

THERAPIST: The task was not to think of chocolate cake. So, what did you think of?

CLIENT: Driving a race car.

THERAPIST: Great. And how did you know that thinking of a race car allowed you to succeed at the task I gave you?

CLIENT: Well I was saying, "Great, I'm thinking of a race car … " (*Pauses.*)

THERAPIST: Yes. And continue on. I'm thinking of a race car, and I'm not thinking of …

CLIENT: Chocolate cake.

THERAPIST: Right. So even when it works, it doesn't.

CLIENT: It's true. I did think of cake but I pushed it out so fast I almost didn't think of it.

THERAPIST: And isn't this similar to what you have done with your anxiety symptoms?

CLIENT: I try to push them out of my mind.

THERAPIST: But see the problem. It looks like all you are doing is adding race cars to chocolate cake. You can't 100% subtract chocolate cake deliberately because to do it deliberately you have to

formulate the rule and then there you are because the rule contains it. If you are not willing to have it …

CLIENT: … you do.

THERAPIST: Does this look like your experience?

CLIENT: Just the story of my life …

THERAPIST: And look at what begins to happen. What comes to mind when I say "race car"?

CLIENT: Agh! … Chocolate cake.

The point can also be made by relating it to physical reactions. We might say to the client something like "Don't salivate when I ask you to imagine biting into a wedge of lemon. Don't salivate as you imagine the taste of the juice on your lips and tongue and teeth." These exercises help the client to make direct contact with the futility of trying to impose conscious purposeful control in these domains.

Undermining Confidence in Programmed Rules

An exercise that can be helpful is to note how easy it is to condition an irrelevant and nonfunctional private response. Watching how conditioning occurs is helpful because it undermines the credibility of content as a means to psychological health. There is something absurd about defining one's self-worth on the basis of particular feelings, thoughts, attitudes, and the like when these reactions are often established through accidental and whimsical circumstances that are totally out of the individual's control. The *What Are the Numbers?* exercise is an ACT intervention designed to demonstrate the arbitrary nature of personal history.

THERAPIST: Suppose I came up to you and said: "I'm going to give you three numbers to remember. It is very important that you remember them because several years from now I'm going to tap you on the shoulder and ask "What are the numbers?" If you can answer correctly, I'll give you a million dollars. So, remember, this is important. You can't forget these things. They're worth a million bucks! OK. Here are the three numbers: ready? … one, … two, … three." Now … what are the numbers?

CLIENT: One, two, three.

THERAPIST: Good. Now, don't forget them. If you do, it'll cost you a lot. What are they?

CLIENT: (*Laughs.*) Still one, two, three.

THERAPIST: Super. Do you think you'll be able to remember them?

CLIENT: I suppose so. If I really believed you I would.

THERAPIST: Then believe me. A million dollars. What are the numbers?

CLIENT: One, two, three.

THERAPIST: Right. Actually I fibbed. There's no million. You still know what they are, don't you?

CLIENT: Sure.

THERAPIST: Next week?

CLIENT: Sure.

THERAPIST: Even possibly next year?

CLIENT: Possibly.

THERAPIST: But isn't that ridiculous? I'm mean, just because some shrink wants to make a point here, you might go around for months or years or the rest of your life with "one, two, three." For no reason that has anything to do with you. Just an accident really. The luck of the draw. You've got me as a therapist, and next thing you know you have numbers rolling around in your head for God knows how long. What are the numbers?

CLIENT: One, two, three.

THERAPIST: Right. And once they are in your head, they aren't leaving. Our nervous system works by addition, not by subtraction. Once stuff goes in, it's in. Check this out. What if I say to you, it's very important that you have the experience that the numbers are not one, two, three. OK? So, I'm going to ask you about the numbers, and I want you to answer in a way that has absolutely nothing to do with one, two, three—OK? Now, what are the numbers?

CLIENT: Four, five, six.

THERAPIST: And did you do what I asked you?

CLIENT: I thought "four, five, six," and I said them.

THERAPIST: And did that meet the goal I set? Let me ask it this way: How do you know four, five, six, is a good answer.

CLIENT: (*Chuckles.*) Because they aren't one, two, three.

THERAPIST: Exactly! So four, five, six still has to do with one, two, three and I asked you not to do that. So, let's do it again: think of anything except one, two, three—make sure your answer is absolutely unconnected to one, two, three.

CLIENT: I can't do it.

THERAPIST: Me, neither. The nervous system works only by addition—unless you get a lobotomy or something. Four, five, six is just *adding* to one, two, three. When you're 80 years old, I could walk up to you and say "What are the numbers?" and you might actually say "One, two, three" simply because some dope told you to remember them! But it isn't just one, two, three. You've got all kinds of people telling you all kinds of things. Your mind has been programmed by all kinds of experiences. [The therapist can add a few possibilities relevant to the client, such as "So you think 'I'm bad' or you think 'I don't fit in.' "] But how do you know that this isn't just another example of one, two, three? Don't you sometimes even notice that these thoughts are in your parent's voice or are connected to things people told you? If you are nothing more than your reactions, you are in trouble. Because you didn't choose what they would be, you can't control what shows up, and you have all kinds of reactions that are silly, prejudiced, mean, loathsome, scary, and so on. You'll never be able to win at this game.

Seeing that reactions are programmed undermines the credibility of ever succeeding in a struggle against undesirable psychological content (because these reactions are automatically conditioned responses). Furthermore, it undermines the need for this struggle since private thoughts do not necessarily mean what they say they mean. The thought "I'm bad" is not inherently any more meaningful than "one, two, three."

WORKABILITY AND CREATIVE HOPELESSNESS

Of all the central ACT concepts, "creative hopelessness" is one of the most poorly understood and even controversial concepts. In common everyday language, hopelessness is not an acceptable state of mind. In many clinical models hopelessness is viewed as a dysfunctional state of mind that predicts high-risk behaviors such as suicide attempts or successfully completed suicides. This type of hopelessness involves being unable to see a meaningful future for oneself, along with the belief that one's suffering will continue interminably. Therapists often work hard to counter this type of hopelessness and to instill optimism about the future in the client.

Creative hopelessness is roughly akin to Paul Watzlawick's popular book on strategic therapy, *The Situation Is Hopeless, But Not Serious* (1993). If the client can give up on what *hasn't* been working, maybe there is something else to do. Thus, we are trying to help clients trust their own experience

and begin to open up to a transformational alternative. The goal is not to elicit a *feeling* of hopelessness or a *belief* in hopelessness; instead, the objective is to give up strategies *when the client's own experience says they do not work*, even if what comes next is not yet known. It is a generative, self-affirming act, and the feeling state that comes with it is often a kind of ironic hopefulness or an anticipation of new possibilities.

One way to confront an unworkable situation is to describe it as such. The therapist has already collected a long list of things the client has tried to control or eliminate: emotional uneasiness, disquieting thoughts, and/or other psychological experiences. The therapist knows the major strategies that the client has tried in the past. The various ways the client has attempted to manipulate thoughts and feelings (e.g., drugs, alcohol, overt avoidance, sex, attacking others, moving away, social withdrawal, and so on) have been listed and examined in great detail. The ultimate unworkability of those strategies has been gently and directly examined. What hasn't yet been faced is the possibility that the agenda itself is flawed. The following dialogue with the earlier cited sexual abuse survivor illustrates how the issue of creative hopelessness is introduced.

THERAPIST: So, let's sit down here and think about the dilemma you face. You have tried virtually everything at your disposal to control your anxiety, fear, and flashbacks. You've thought long and hard about how to do this, and you've tried very, very hard to get a handle on this thing. And the result you seem to be getting is that your anxiety is worse than ever. Not only that, but you are losing ground at your job, with your friends, and in your love relationship. I'm wondering, what do you see happening here as you look into the future?

CLIENT: More of the same. Even though I'm not helping my anxiety, I don't know what else to do.

THERAPIST: That is somewhat like treating a headache by hitting yourself on the head with a hammer. Someone points out to you that that strategy might not be a very good one for treating a headache and you say, "But it's the only treatment I know—so I'm going to continue."

CLIENT: (*Laughs.*) I hope it isn't that bad. I'm just saying that I'm at my wits' end with what to do here.

THERAPIST: What do you think is going to happen if you keep using the same strategies to control your anxiety and fear that you have been using?

CLIENT: Things will probably continue to get worse.

THERAPIST: Maybe you are being tricked here. You were brought up to believe that the road to happiness is to control your anxiety, fears, and memories, and then you will be able to function at work, with your friends, and with your partner. What if this is a set-up?

CLIENT: A set-up? What am I being set up for?

THERAPIST: Listen to your experience here, not your mind. Every day that you try to control and avoid your anxieties, those anxieties get worse and your life deteriorates. What if it isn't that you are not trying hard enough or that you have missed some strategy that will eventually allow you to succeed. You are a bright, sensitive, and caring person. If this approach was going to work, I think you would be the person to make it work. What if life is telling you something like this: this strategy will never work because it can't. It isn't that you did it wrong.

CLIENT: Well, what should I do, then?

THERAPIST: Well, I guess that is part of what we are here to learn, but let's start with your hard-earned knowledge. You *do* know something. You know what you *shouldn't* do. You've paid dearly for that knowledge, but it is precious if you are willing to be guided by it.

Using this kind of approach only loosens the grip of a control agenda. For deeply stuck clients, this issue can take a session or more and may need to be revisited repeatedly over the course of therapy. For younger and less stuck clients, or in prevention settings, it can look more like a straightforward psychoeducational intervention.

Metaphors can often make the point without provoking as much resistance because they provide a commonsense example that is more related to the client's experience than normal direct instruction. Research has shown that apt metaphors come from at least two sources. The target of the metaphor and the metaphorical vehicle itself have to share a dominant feature, and the metaphorical vehicle has to contain strong specific functions that are relevant to the missing elements or functions in the target situation the clinician is trying to change. A good metaphor takes what you already know, feel, or do and maps it onto a domain where adaptive behavioral functions are missing. In a sense, a metaphor is used to bypass normal analytical language in favor of more experiential learning. That quality allows the client to respond more to direct contingencies (tracking) than to what might please the therapist or be viewed by the therapist as right (pliance).

You can use these RFT insights to create new ACT metaphors on the fly (for an extended example, see Hildebrandt, Fletcher, & Hayes, 2007), but that is a topic beyond our present scope. Another way to use them is to increase the experiential qualities of metaphors. The *Person in the Hole*

metaphor is a core ACT intervention to use during the earliest phases of therapy. We present an example here in its experiential form, which is designed to make features of the metaphor more concrete and evocative. Any of the more didactic metaphors in this volume or elsewhere can be presented in this more experiential way once you see the main principles, which we place in brackets in the following clinical interaction with a client suffering from anxiety.

THERAPIST: I would like to engage you in a thought exercise so that we can understand your situation better. Imagine that you're placed in a field, wearing a blindfold, and you're given a little bag of tools. You're told that your job is to run around this field, blindfolded. That is how you are supposed to live life. And so you do what you are told. Now, unbeknownst to you, in this field there are a number of widely spaced, fairly deep holes. You don't know that at first—you're naive. So, you start running around and sooner or later you fall into a large hole. You feel around, and sure enough you can't climb out. It is muddy and slippery, and there are no escape routes you can find. Can you picture that in your mind? How do you feel in such a situation? [The therapist is using the present tense to make the situation seem more immediate. This strategy enables the client to more readily respond to the concrete aspects of the situation rather than having to deal with an abstraction.]

CLIENT: I would probably be shocked, pretty upset. [Often, when the client starts by answering in the conditional tense, the therapist can subtly bring him or her back to the present.]

THERAPIST: Yes, I can imagine that you feel upset falling in this hole. I would be, too! [The therapist validates the client's reaction and sends the message that this is a natural response.] So, imagine you are there. So, what do you do?

CLIENT: Well, I guess I want to get out of this hole, find a way out of here.

THERAPIST: You have the bag of tools you were given; so, maybe you want to find what is in there? Maybe there is something you can use to get out of the hole. You are blindfolded, but you feel around in the bag. There is a tool in that bag, but what you've been given is a shovel. It's seemingly all you've got.

CLIENT: This is not the most helpful tool for getting out of a hole …

THERAPIST: But suppose that you desperately want to get out of the hole, that you have been trying for hours to climb the muddy

wall with no success. … What would you think when finding the shovel?

CLIENT: That I could try to dig out. Maybe dig some stairs.

THERAPIST: OK, so you do that. You dig and dig. The dirt keeps slipping down. You keep trying to get it out of the way. You try to make little stairs. But it slips down, and when you start climbing, the stairs literally disappear under your feet, and you then have to dig them out. You are getting exhausted. You are sweaty, tired, breathing hard. And after all that digging somehow now you are in even deeper in the hole. Take time to feel what that would be like. [By emphasizing sensory qualities that are similar to anxiety, the therapist is making the connection more experiential.] What are you feeling?

CLIENT: I'm feeling desperate. This is getting me nowhere.

THERAPIST: It looks like this is getting you even deeper. … All this effort and all this work and the hole has just gotten bigger and bigger and bigger. No way out. And isn't that your experience? What I wonder is if you've come to me thinking "Maybe he has a really huge shovel—a gold-plated steam shovel." Well, I don't. And even if I did, I wouldn't use it because digging is not a way out of the hole—digging is what makes holes. So, maybe the whole anxiety-control agenda is hopeless—it is a trick. You can't dig your way out; that just digs you in. [The therapist intentionally mixes terms from the metaphor and from the actual situation lived by the client so as to implicitly underline the equivalence between the two situations.]

This metaphor is extremely flexible. It can be used to deal with many beginning issues. In the interaction with the client, the therapist can build out the metaphor to address the specific issues that the client raises or that the therapist thinks are pertinent. It is also useful to try to integrate these client responses into the ongoing metaphor, as demonstrated by some of the following scripts:

1. **Maybe I should just put up with it.**

   "You've tried other things. You've tried to tolerate living in a hole. You sit down and twiddle your thumbs and wait for something else to happen. But you observed that it doesn't work and besides, it's just no fun living your life in a hole. So, when you say 'Put up with it' or 'Give up,' what I hear is that you are really staying with the same agenda (digging your way out) but no longer trying because

it doesn't work. I'm suggesting something else. I'm suggesting changing the agenda."

2. **I need to understand my past.**

   "Another tendency you might have would be to try to figure out how you got in the hole. You might tell yourself, 'Gee, I went to the left and over a little hill, and then I fell in.' And of course that is what happened; you are in this hole because you walked exactly that way. Your exact history brought you here. But notice something else. Knowing every step you took does nothing to get you out. And besides—remember, you are blindfolded—even if you had not walked exactly that way and you'd gone somewhere else instead, you might have fallen into another hole because there are lots of holes to be found. So, you found anxiety, someone else found drug abuse, someone else found bad relationships, someone else found depression. Now, I'm not saying your past is unimportant, and I'm not saying we won't work on issues that have to do with the past. The past is important, but not because figuring it out let's you escape emotional pain. It is only when the past shows up here and now that we need to work on it. And it will show up in the context of you moving on with your life. When it does, we will work on it. But dealing with the past, the dead past, isn't a way out of the hole."

3. **Am I responsible for these problems?**

   "Note that in this metaphor you are responsible. Responsibility is recognizing the relationship between what we do and what we get. Did you know that originally the word *responsible* was written 'response able'? To be responsible is simply to be able to respond. So, yes, you are able to respond. And, yes, your actions put you in the hole, and your actions can get you out. Response-ability is acknowledging you *are able to respond*, and were you to do so, the outcome would be different. If you try to avoid responsibility, there is a painful cost: if you cannot respond, then truly nothing will ever work. I'm saying digging is hopeless, not 'You are hopeless.' So, don't back away from responsibility—if you have an ability to respond, then there are things you can do. Your life can work."

4. **Should I blame myself?**

   "Blame is what we do when we are trying to motivate people to do something—to change or to do the right thing. But you look plenty motivated to me. Do you need more motivation? Do you need to buy 'I'm at fault'? Blame is like standing at the edge of the hole and throwing dirt on top of the person's head and saying,

'Dig out of here! Dig out of here!' The problem with blame in this situation is that it is useless. If the guy in the hole has dirt thrown down on his head, it won't make it any easier to get out of the hole. That doesn't help. When your mind starts blaming you, does buying it strengthen you or weaken you? What does your experience tell you? So, if you buy blame from your mind, go ahead, but then be response-able about that. If you buy into that you will be doing something that your experience tells you doesn't work."

5. **What is the way out?**

   "I don't know, but let's start with what isn't working. Look, if you still have an agenda that says 'Dig until you die,' what would happen if you were actually given a way out? Suppose someone put a metal ladder in there. If you don't first let go of digging as the agenda, you'd just try to dig with it. And ladders are lousy shovels—if you want a shovel, you've got a perfectly good one already."

6. **The need to give up first.**

   "Until you let go of the shovel, you have no room to do anything else. Your hands can't really grab anything else until that shovel is out of your hand. You have to let it go. Let it go!"

7. **A leap of faith.**

   "Notice you can't know whether you have any options until you let go of the shovel; so, this is a leap of faith. It is letting go of something not knowing whether there is anything else. In this metaphor you are blindfolded, after all—you'll only know what else is there by touch, and you can only touch something else when the shovel is out of your hands. Your biggest ally here is your own pain. That is your friend and ally here. It is only because this current strategy isn't working that you'd even think about doing something as wacky as letting go of the only tool you have."

8. **The opportunity presented by suffering.**

   "You have a chance to learn something most people never will—how to get out of holes. You would never have had a reason to learn it if you hadn't fallen into this hole. You'd just do the rational thing and muddle through. But if you can stay with this, you can learn something that will change your life. You'll learn how to disentangle yourself from your mind. If you could have gotten away with it—more or less—you'd never have done that."

Metaphors such as the *Person-in-the-Hole* disrupt the client's tendency toward problem solving and sensemaking ("I must deserve to suffer"; "I lack the self-confidence I need to succeed," etc.). These are powerful and useful repertoires—they cannot be shed entirely or for long. They

overwhelm the client's experience of the negative results of the control-and-eliminate agenda. Again and again during the initial discussions with the client, the ACT therapist engages the seeming contradiction between the client's change agenda and real-life results. However, even momentary direct contact with real-world contingencies provides a wedge that can be used to break apart the problematic control-private-events-to-control-life linkage of process and outcome goals.

Where to Start?

In Chapter 4, we described a relatively simple and straightforward approach to case conceptualization and treatment planning, based on the unified model of psychological flexibility. At the macro level, we have the three basic response styles to establish: being open, centered, and engaged. At the micro level, there are the six core processes that define these major response styles.

Therapists new to ACT sometimes assume that they must follow a sequence of interventions regardless of the client's specific strengths and weaknesses. The reality is that many clients have a specific "Achilles heel" and will respond quickly to a targeted intervention in that area. For example, higher-functioning clients with mental health or substance use problems or clients with lifestyle change issues (i.e., smoking, diabetes self-management, weight control, fitness) may only require brief ACT work focused on a single response style, and perhaps only with a single core process. The therapist should not assume that all core processes need to be targeted with every client.

The initial discussions with the client should help point the therapist in a specific direction, using one or more of the case formulation methods that we discussed in Chapter 4. Take the example of the sexual abuse survivor we introduced earlier in this chapter. We would assess her as being relatively strong on the *engagement* dimension because she clearly has very well developed values about what she wants in terms of relationships. What she lacks in this dimension are committed acts of intimacy, in which she stays with her male partner even though she is afraid. At the same time, she is aware that this is the action she would like to take in an ideal world. In terms of the *centered* dimension, she is pretty self-aware and can stay present in the interview. The problem in this area is that she can't stay present when provocative private experiences show up and instead she acts impulsively. Her Achilles heel lies in the *open* dimension. She is fused with evaluations about the toxic nature of her anxieties, flashbacks, and fears such that she is unwilling to accept them for what they are. Instead, she tries to control their appearance by avoiding the actions that will trigger them. The main job of the therapist in this case is to help her defuse from her

toxic evaluations and use nonjudgmental acceptance instead. As is true with most ACT interventions, targeting one process will have ramifications for the other processes. If she learns to accept the presence of flashbacks, anxiety, and fear, then she may be able to stay in the present moment and focus her energy on committed actions that promote the intimacy she so values.

In subsequent chapters, we use the following conventions in describing clinical strategies that target one or more core processes. These conventions follow the spatial layout of the hexaflex diagram in which the "aware" dimension (including present-moment awareness and self-as-perspective) is the Center and starting point:

- Go Left: Focus on either increasing acceptance (left high) or increasing defusion (left low)
- Go Right: Focus on connecting with chosen values (right high) or behavioral activation and commitment (right low)
- Go to Center: Focus on getting flexibly present (center high) and taking perspective (center low).

In the following chapters, we examine these response styles and specific processes in greater detail. Given the nature of a book, we do this in a linear sequence, but in actual therapy the process of going left or right, or coming home to the center, is more like a dance. We do our best to capture that quality in what follows.

CONCLUDING REMARKS

In this chapter, we have discussed several important intervention principles and strategies designed to help clients make direct contact with the negative results of trying to control or eliminate distressing private experiences. For most clients, this type of recognition is needed before the client will be open to alternatives, such as willingness and acceptance. These interventions can be flexibly applied to fit the particular needs of each client; some clients will require more interventions than others. Their purpose is to begin to undermine repertoire-narrowing processes so that new actions and new consequences can begin to move the client. Once a context for change is created, it is time to get down to business and begin working with specific core processes. We next demonstrate how to apply ACT interventions designed to strengthen each core process. We examine how interventions in one core process area might interact with other core processes. Finally, we offer some practical tips on what to do and what to avoid when working on each core process.

PART III

Core Clinical Processes

CHAPTER 7

Present-Moment Awareness

with Emily K. Sandoz

> . . . she felt the stab of time like she never had before. Even if she didn't leave him, it would still go smash eventually—so that there was no evening ever when one would not feel the same melancholy, a kind of nostalgia for the present itself, slipping away like water down a drain.
>
> —Robinson (2000, pp. 91–92)

In this chapter you will learn . . .

- The basic skills that enable present-moment awareness.
- How to address and treat the failures of present-moment processes that interfere with effective living.
- How to promote contact with the present moment during sessions.
- How to read the client's progress in present-moment processes.

PRACTICAL OVERVIEW

In a basic sense, all of the ACT core processes are linked to present-moment processes. In order to benefit from treatment, clients have to be there—not just physically but mentally. If they are to learn and be shaped by life events, their full "presence" is required. This chapter looks at the role of present-moment awareness and how to develop it with ACT interventions. First, a cautionary note: none of the ACT core processes is "superior" to the others. The fact that the first chapter in this section is on present-moment processes does not mean that this would necessarily be the first process you would target as you begin therapy with a client. The decision about where

to start is always made on a case-by-case basis. We have chosen to begin with "the now" in part because this is a process that is relevant throughout treatment. The now is where acceptance and defusion are possible, and the now is where valuing and committed action have their greatest relevance.

Present-moment processes are about living flexibly in the here and now. They do not mean "present," as opposed to "past" or "future." "Past" and "future" are simply ways we talk about change—it is only a trick of language that makes it seem as though time is a thing, like a string holding a strand of beads. "That happened in the past" or "that will happen later" sounds a lot like "this is a chair" or "that is a beach ball," as if time holds the past and future, just as space can hold the ball or chair. ACT practitioners, however, assume that the past is gone forever and the future is not here yet. In this perspective, time is not a thing—it is just a measure of change. There is now and now and now. The rest of human experience consists of stories or memories of the past and constructions of the future. The memories, stories, and constructions are present—the past and future never can be.

The difficulty with such problems as worry and rumination is not that the client is living in the past or the future; rather, it's that the stories of the past and future garner so much attention that the client misses things that are going on all around him or her. As the epigram that begins the chapter laments, the present moment slips down the drain. These stories of the past and future are like the magician's "other hand." When a magician is performing a trick, one hand typically works overtime to grab the audience's attention. While this hand is distracting us, the other hand makes the really important things happen. While clients are fixated on their past and future, going over them time and again, life slips away. Important things happen that are missed.

Since there is no past and future, present-moment processes are really about the skillful intentional allocation of attention. In the most general sense, the ability to allocate our attention with both focus and flexibility gives us the best chance to be shaped by, and to shape, the world around us. Mere physical exposure to events is often not enough. Active, engaged moment-by-moment responsiveness is what's needed!

There are two common overlapping categories of failure in present-moment processes. Failures in the first category are the result of skill deficits in focused attending. This deficit may be especially common with younger clients or with others who have simply not had the life experiences that would naturally develop an active repertoire of responses. For example, individuals with developmental disabilities (including autism and Asperger syndrome) often lack the skills need to stay focused on the present. The second and more common type of failure is the result of rigid attentional control. In this case, the individual has the ability to come into

the present but can't sustain it, usually because something else distracts his or her attentional focus (Stahl & Pry, 2005). For example, depressed patients who ruminate excessively about past setbacks might get glimpses of the present moment, but their attention is then quickly drawn back into focusing on the past. Similarly, anxious patients experience the same fate as they drift off into ruminating about some future catastrophe. Both types of present-moment process failures require interventions that promote the ability to return to the now. These interventions, whatever their form, can rightly be called *mindfulness strategies*, although ACT developers originally avoided the term (on the grounds that we were actually engaged in teaching people how to get *out* of their minds and into the now).

PRESENT-MOMENT PROCESSES AND THEIR RELATION TO MINDFULNESS-BASED INTERVENTIONS

ACT is part of a larger group of acceptance and mindfulness-based therapies, often referred to as "contextual CBT" (Hayes, Villatte, Levin, & Hildebrandt, 2011), that utilize a variety of methods to cultivate better attentional control and present-moment awareness. As these develop, we expect to see additional innovation and cross-fertilization. Metacognitive therapy (MCT) is focused on developing attentional flexibility and changes in metacognitive beliefs (Wells, 2000), for example, and all of the methods of attentional training in MCT can be used as part of ACT without notable modification.

Present-moment processes, among all components of the ACT model, connects most closely to these other emerging mindfulness-based interventions. However, from an ACT perspective, all of the processes on the left side of the hexaflex are involved in mindfulness (Fletcher & Hayes, 2005; Wilson & DuFrene, 2009). Jon Kabat-Zinn's definition of *mindfulness* from his landmark book *Full Catastrophe Living* (1990) provides a solid starting point for seeing its connection to the larger body of work: "Paying attention in a particular way: on purpose, in the present moment, nonjudgmentally" (p. 4). Present-moment processes, acceptance, and defusion processes are all clearly and directly implicated in Kabat-Zinn's definition.

Not in the definition, but certainly throughout the teaching in *Full Catastrophe Living*, is the theme of noticing the busyness of mind—noticing our tendency to judge, cling to past concerns, and refuse entry into the present moment. The processes of evaluation and prediction, which organize behavior and take us out of the present moment, are captured best by the fusion aspect of the ACT model. Some of the fusion we encounter involves stories about ourselves—what is wrong with us, how we should be different, better, smarter, kinder, and the like. Taking an open, accepting,

present moment–focused posture and allowing thoughts, emotions, memories, and bodily sensations to come and go without having to do anything about them leads to the emergence of a sense of self that is distinct from the contents of consciousness—self-as-context or a transcendent sense of self.

We know that treatments such as metacognitive therapy, mindfulness-based stress reduction (Kabat-Zinn, 1990), and mindfulness-based cognitive therapy (Segal et al., 2002), which incorporate contemplative practice, can have a major impact on mental health. A recent meta-analysis of 39 studies involving treatments featuring formal mindfulness practices found effect sizes in the moderate range for participants overall in anxiety (Hedges' $g = 0.63$) and mood symptoms ($g = 0.59$) and large effects for anxiety ($g = 0.97$) and mood ($g = 0.95$) among those diagnosed with anxiety and mood disorders (Hofmann, Sawyer, Witt, & Oh, 2010).

Most ACT protocols do not include formal meditation practice, but they are replete with experiential exercises, metaphors, and other interventions that promote mindfulness. As our scientific understanding of the place of mindfulness processes in ACT has grown both theoretically and practically (Hayes, Follette, & Linehan, 2004), a number of newer ACT protocols have included contemplative practice (see Forsythe & Eifert, 2007; Hayes & Plumb, 2007; Hayes & Wilson, 2003; Wilson & DuFrene, 2009).

CLINICAL APPLICATIONS

In this chapter, we focus on the specifics of present-moment processes, turning to topics of the self, acceptance, and defusion in later chapters. We examine in some detail the qualities of attention we want to cultivate in our clients. We then explore two common types of failures of present-moment processes and describe some methods of treating them. We also briefly address some of the dos and don'ts of working with present-moment processes, including formal contemplative practices within ACT.

Skill Deficits in Present-Moment Processes

Some degree of present-moment process training occurs in the social environment of most humans. Children require some amount of flexible, focused attention to function well in school and at home. Correction and shaping comes in various forms. We ask children, "What do you hear? Do you hear Daddy?" and then we listen carefully. "What do you see?" Some shaping involves correction in the form of reprimands and other feedback. The object is to train the child to notice not only what is going on (focusing attention), but also *what else* is going on (breadth of attention) and then

to adapt the breadth and focus of his or her attention appropriately to the situation (flexibly allocated attention). In any given instance, these instructions and feedback are specific ("Stevie, listen to your mother!"), but a more general attentional skill is learned through exposure to a variety of circumstances, which helps make specific stimuli more or less salient. It is easy to take the general skill of attentiveness for granted, as most of us rarely encounter training that focuses on attentiveness per se. Attentional skills span the full spectrum of possibilities, however, and most normal populations vary greatly in their strengths and deficits in this area.

Significant deficits in basic attentional skills most likely occur in children, individuals with developmental disabilities, or persons with severe behavioral disorders. Severe deficits can also result from an inadequate ongoing shaping environment. Among children, the underdevelopment of attentional skills may simply reflect not having lived long enough to have experienced the requisite social training and shaping. Severe deficits can also occur because individuals may have behavior problems (i.e., hallucinations, mania, paranoia) that preclude the sorts of interactions that help sustain effective attention to the moment; behavior problems may also focus the social environment on behavioral management rather than the development of flexible, focused attentional abilities. More moderate deficits typically occur because attentional training per se is rarely part of normal experience unless the individual happens upon mindfulness practices or other methods of attentional training.

Sources of Attentional Rigidity

As we noted in Chapters 3 and 4, optimal attentional processes are flexible, fluid, and voluntary. They cannot be assessed or monitored solely by relying on the content of the client's verbalizations. For example, a client could be focused entirely on the present in a formal sense (e.g., constantly noticing bodily sensations or asking about the therapist's reactions) and not have a good repertoire of present-moment processes in the sense that we mean them here. Telltale signs of failed present-moment processes include an unhealthy narrowing of attention, such as being fixated on a particular topic, difficulties with shifting attention to a different topic, or persistent skipping from topic to topic. Other signs include rapid, automatic talking, emotional blunting, and such nonverbal behaviors as dropping eye contact or looking away or down. These signs indicate that the client is "checking out" rather than "checking in." Because the present moment is a dynamic and ongoing process, the therapist also needs to be constantly "checked in" and closely attending to both the client's verbal and nonverbal behaviors.

If present-moment processes exist in some contexts and not others, their failure to appear may be related to other sources of psychological

rigidity. Fusion and avoidance, in particular, restrict the operation of present-moment processes. Fusion with a story from the past or the future (worry and its backward-looking twin, rumination) and experiential avoidance connected to that fusion can easily induce attentional rigidity, even in a person with normal attentional skills. Worry and rumination both carry a functional promise (Wilson & DuFrene, 2009) in that worry promises to prepare the worrier for the future while rumination promises that past mistakes will not be repeated. These promises are not kept, however; indeed, just the opposite is true (Borkovec, Alcaine, & Behar, 2004). Heightened worry and rumination are negative predictors of good psychological adjustment.

CLINICAL APPLICATIONS

Presenting the Rationale for Present-Moment Work

Prior to any attentional training, clients need to know why it is important to develop flexible attentional control. It can help to ask if they can think of times in their lives when they were so busy or preoccupied that they missed out on important things.

Therapists might also begin with the oft-quoted advice to "Stop and smell the roses," which is both widely known and widely ignored. There always seems to be a reason not to take time for contemplation and enjoyment right now, to put it off until later. Unfortunately, "later" never seems to arrive. If we leave it up to life to make time for us to stop, we are going to be sorely disappointed. Most clients will understand and accept this rationale for working on improving their present-moment processes. After announcing the rationale, the therapist can let the client know a bit more about what to expect. Introducing "problem solving" and "sunset" modes of mind to clients touches on important and readily understandable aspects of experience (Wilson & DuFrene, 2009).

> "One of the things we will be practicing here is stopping and noticing what we are experiencing. Sometimes there is a lot going on around us, but it goes unnoticed. So, we will specifically *practice noticing* because it is a skill we all can develop. We never know exactly when there will be other things going on or where we will want to use this skill, and so we will just practice it here and there in our work together. I will also ask you to try it out on your own out in the world. Think of it this way: there are two modes of mind that we use. One is a *problem-solving* mode of mind. This mode of mind is superautomatic—and that is a good thing! When it comes to avoiding fast-moving cars or judging the validity of a sales pitch, being on your toes is very helpful. Watch how it works. Two plus two is (pauses)? Three minus one is (pauses)?

[These last two questions are said quickly.] This mode of mind helps us categorize and evaluate things, often so quickly we don't even recognize what is happening. The problem with a problem-solving mode of mind is that it's so automatic that it often gets applied where it is not useful—or it gets applied too soon.

"There is another mode of mind that we are interested in, which can be thought of as a *sunset mode of mind*. When you see a problem you solve it, but what do you do when you see a sunset? or a beautiful painting? or when you hear a beautiful piece of music? This mode of mind mostly notices and appreciates. One thing we can all see in our own lives is a tendency to get so caught up in problems and in the problem-solving mode of mind that we miss a lot of sunsets.

"We will practice the sunset mode of mind in session in a few different forms. One thing we might do is start a session with a couple of minutes of eyes closed, just settling in. During these times we will practice letting go of the cares of the day for a few minutes and noticing something as simple as the inflow and outflow of our breath. Sometimes we encounter circumstances that are difficult for us to deal with. This makes us want to scramble as fast as possible to problem-solve. But sometimes scrambling around causes more problems than it solves. So, another thing we will do is slow way down and drop into this sunset mode of mind when problems show up. This doesn't mean we won't do any problem solving. *We will*, but we won't do it in a *knee-jerk* way. We will problem-solve *mindfully*. We will also drop down into a sunset mode of mind when something sweet comes along. So, I may hear you say something that is really meaningful to you—a part of your values—and I may ask you to take a few moments of stillness to just appreciate that sweetness.

"One thing I have noticed over the years I have done this work is that if you slow down a little you often find that sweet and sad mix together pretty often. It is pretty hard to find anything sweet in your life that does not have some sadness mixed in. The problem-solving mode of mind wants us to turn away from sadness, and sometimes when we do that we also turn away from sweetness. So, I invite you to check that out with me as we move along in our work together."

Conducting a brief 1- or 2-minute mindfulness exercise at the beginning of treatment sessions (e.g., monitoring one's breath intake and release; mentally scanning one's bodily sensations; taking in several deep breaths; focusing on all five senses) supports the development of attention to the present moment both within and without. It has the added benefit of emphasizing the importance of mindful awareness during therapy sessions and can greatly increase the efficiency of treatment because it fosters the transition from "small talk" to serious therapy work.

Attentional Training for Skills Deficits

If the goal is to remediate attentional deficits, a variety of clinical interventions can be modified because attention is an aspect of all forms of noticing. For example, standard behavior therapy procedures such as progressive muscle relaxation, where a person tenses and releases different muscle groups, can provide practice in noticing, moment by moment. The key is to teach the client focus, breadth, and flexibility. Thus, during the procedure, the person can be asked to occasionally shift attention to notice whatever thoughts are present and then to gently shift attention back to whatever part of the body is being tensed and relaxed. Mindfulness exercises, such as a body scan (Kabat-Zinn, 1990), can also be an excellent means to teach this sort of attentional regulation. Sometimes these strategies are taught with the express purpose of helping the client "let go" of his or her need to control stress, anxiety, and other bad feelings. Although present-moment exercises can produce relaxation, that is not their main purpose. Rather, the purpose is to cultivate present-moment awareness, to heighten attentional focus, and to create flexibility in how and where attention is directed. Such skills are not acquired all at once; they must be practiced over time. Clinicians should remember that the goal is one of shaping and thus should start small, reinforcing as one goes to approximate progressively more complex behaviors. The practitioner needs to notice where the client is moment by moment and to tailor the duration of any exercise, based on the client's response.

If clients appear not to have sufficient attention skills, the therapist should notice and distinguish specific sensory experiences (sound, sight, touch, taste, smell) and focus on one and then another. A specific set of sensations can be picked out, and then attention shifted, narrowed, and broadened (e.g., focusing on only the bass line in a piece of music, then shifting attention to the horns, then to both at the same time). Clients might be asked to stop every so often to "just notice," or "just watch." It is not difficult to implement small 30-second to 1-minute exercises during psychotherapy sessions. For example, the client might be asked to close her eyes and just notice how her body feels in this moment, whether there is any tension in her body, whether her breathing is normal, and then gently open her eyes and come back to the work being done. Asking the client to practice these same methods outside of therapy sessions promotes development of a skill that can be used in a wide variety of typical life situations.

Attentional training can be included in almost any ACT protocol. The critical process element in the training is bringing clients' focus to bear on noticing what is present, then gently shifting their attention and practicing narrowing and broadening of their focus until clients can use

their attentional skills as an instrument. Adult outpatient clients who are struggling with mindfulness exercises may benefit from starting with such things as a mindful walk, where they practice noticing colors, shapes, people, and objects.

Even very small children can answer questions about what they are noticing within and without. Stopping, noticing, and answering can be made into a game. The breadth of impact of even simple attentional training is noteworthy, even in developmentally disabled populations. It is not correct to think that such populations cannot benefit from psychotherapy—especially from such methods as ACT that may initially seem too abstract. In point of fact, exactly the opposite is true—because mindfulness and coming into the now is *not* an abstract analytical activity. For example, teaching developmentally disabled, adolescents with conduct disorder, or chronically mentally ill patients to focus awareness on the soles of their feet positively impacts aggression and other social behaviors (Singh, Lancioni, Singh Joy, et al., 2007; Singh, Lancioni, Winton, Adkins, Singh, et al., 2007; Singh, Lancioni, Winton, Adkins, Wahler, et al., 2007). ACT also has been shown to work with other developmentally disabled populations (Pankey, 2007). In a gardening project with developmentally disabled adults supervised by one of us (KGW), clients were repeatedly asked questions that required them to stop and notice. "How does the soil feel in your hands right now?" "Stop a moment and tell me what sounds you hear." Over time, these requests seemed to lead fairly quickly to notably greater attentional flexibility.

Interventions for Attentional Rigidity

As noted earlier, a client may have attentional skills but be unable to use them. In these cases, fusion and avoidance may be narrowing the client's repertoire of actions. Exercises in defusion and acceptance (see Chapters 9 and 10 for more detailed discussions) can aid in developing a present-moment focus. Conversely, asking a client to really focus on how content is experienced in the present moment can itself have defusion and acceptance effects. For example, a client might be completely fused with the thought "Why am I so anxious?" You could ask the client to close his or her eyes, to touch on this question, and then, beginning with his or her toes, try to notice any feelings of tension or anxiety. Proceeding in small increments up and through the body, the client could be asked to notice where anxiety is felt more as well as less acutely and, in particular, the sensory details at the edges of those regions. Since this kind of detailed moment-by-moment engagement is probably not normally evoked by the thought "Why am I so anxious?", this exercise should both defuse the thought and bring the client more fully into the moment.

Slowing Down

Clients often enter the session on the heels of a stream of activity that is fast and mindless. The therapist's vocal pacing can be an important tool in facilitating the client's present-moment processes. Pace is an important component of many skill repertoires and their automatic functions. Changing pace, particularly slowing down, can break up old patterns and allow their functions to be seen. For example, if the client seems to be rushing, you may be able to find out why by altering the pace. If you slow clients down enough, whatever they are chasing will become clearer, and whatever is chasing them will catch up.

Fused and avoidant behavior can seem like running, in a figurative sense. Clients are running away from what cannot be tolerated—just as they run to keep up with their stories of the world, of what can be tolerated, and of what must be done to manage it all. The pace is like glue holding elements together. Often, disrupting the pace can disrupt the functional properties of the repertoire, such that what is being avoided or fused with "catches up" with the patient. Consider the following clinical example:

CLIENT: It just feels like the whole world is closing in around me. I have a thousand deadlines at work, and there is just no way I can get caught up. Every time I think I am getting ahead, more stuff gets dumped on me and I am right back where I started. I just don't know how much longer I can take this!

THERAPIST: So, the difficulties are mostly at work?

CLIENT: No, it's everywhere. I have a pile of unpaid bills on my desk at home. I don't know what is wrong with me. I have enough money to pay them, but I just can't seem to get it done. I have a dozen messages on my answering machine at home—calls I haven't returned. My friends must think I'm just nuts. I can't take care of business or friends. I can't even take care of myself. I bought a membership at the gym and never go. I bought a bike and it sits in the garage. I don't know what's the matter with me! I have always been like this, and I don't see it ever changing. Just on and on.

THERAPIST: Wow! That is a lot. It makes me tired just thinking about it.

CLIENT: Sorry, yeah, I know.

THERAPIST: No, no. That's cool. It just seems like we are ripping through this list so fast that I'm worried I may be missing important things—things that are important for you. I just feel like I can't keep up. Would it be OK if we just slowed down a little? I want to make sure that I am really hearing you.

The therapist's last response, above, is said in a relatively slow and deliberate fashion. The therapist begins to change the pace in what appears to be the client's very well established, persistent, and pervasive pattern. There is a rhythm to it, and changing the rhythm can allow new things to happen.

The therapist sets the new pace by speaking and pausing long enough so that both can really listen to each word that is said. The pauses function like negative space in a work of art: they direct attention to what is said by both the therapist and the client.

THERAPIST: Would it be OK to go back over what you just said more slowly? I think I hear really important things in there that whipped by too quickly for me to really absorb them.

CLIENT: Sure, I guess.

THERAPIST: So, let's start with the first thing you said—about work. (*pause*) Tell me about a specific thing that is going on at work, a specific deadline.

CLIENT: I don't know. There are a million of them.

THERAPIST: Sure, but just pick one, one particular thing. (*pause*) How about yesterday?

CLIENT: A lot of things.

THERAPIST: OK, let's just take that. When you said "a lot of things," I could hear a sense of despair in that. Can we bring our attention to that one thing for a moment?

CLIENT: I guess.

THERAPIST: (*spoken slowly with a few seconds' pause at the ellipses*) OK, so if you could just let your eyes gently close and allow yourself to settle into your chair. … And perhaps you could begin by bringing your attention to your own breath. … See if you can begin to allow really full breaths. Not forced … but just allowing your belly to expand … and your chest to gently rise … and perhaps as your chest rises, you can allow your shoulders to drop slightly and to soften … and now just take a moment and see if you can allow yourself to gently come to rest in your own breath. You work very hard and I wonder if you could just allow yourself the gift of stillness for just a moment. (*15- to 20-second pause*) Gently noticing the rise and fall of each breath, and when you find your attention drawn away, allow it to return easily to your own breath. Cool around your nostrils as you inhale, warming in those same places as you exhale.

Now, I am going to repeat the words you just said to me, very, very slowly. And I want you to listen very carefully to each individual word: "A … lot … of … things … " (*5- to 10-second pause*) And breathe. And see if you can notice what happens in your body, any subtle changes as I say the words: "A lot of things" (*said without pauses, but slowly, deliberately, allowing the weight of the words to be expressed in voice and then pausing again for 5–10 seconds*). Without opening your eyes, in just a few words, spoken softly, tell me where you feel the impact in your body. Here come the words: "A lot of things."

CLIENT: In my chest.

THERAPIST: Tightness?

CLIENT: Yes.

THERAPIST: Would you take just a moment and see if you can notice where you feel that sensation strongest and gently place your hand near that spot?

CLIENT: (*Places hand on solar plexus.*)

THERAPIST: Just allow your hand to rest gently in that spot. I would like you to see if you can feel the rise and fall of your breath in your hand. See if you can notice the sensations in the places where your hand meets the rise of your breath. … See if you can feel the beating of your own heart. … If you find your awareness drifting, just notice the sound of my voice, notice that I am right here, sitting with you … and come gently back to the sensations. … Just stay with those sensations for a moment, noticing each, resting there a moment, and then noticing others. See if you can notice those tensions, resistances, those no's you hold in your body, and see if you can allow those to soften for just a moment. See if you can notice what it feels like to gently release those resistances even for just a few moments. See if you can imagine breathing softness into those resistances. (*20- to 30-second pause*)

Now, let me ask you a question. There is a "you" at work that is a whole human being. And that same "you" is here right in this moment and is noticing all of this. I want you to imagine that you could offer this softness, this gentleness, to yourself at work … as a gift. What might that gift mean to you? How might it change work for you?… In a moment I will ask you to open your eyes, and I want you to see if you can bring a bit of that softness and pace into our conversation about work. … And now I want to invite you to open your eyes, and let's come back to talking about your work.

The foregoing sequence contains multiple elements of the psychological flexibility model and shows how a present-moment focus spreads out naturally to include other core processes. The processes activated during this interaction are defusion, acceptance, self, and present-moment focus work: the mindfulness quartet from the perspective of the psychological flexibility model. It will be useful to examine each of these processes in more detail.

Undermining Fusion

The client's speech patterns are indicative of high levels of fusion. At the start of the transcript, the therapist repeatedly probes for specific things that are overwhelming the patient and receives repeated categorical yet nonspecific answers: "everything," "everywhere," "a lot," "always," and "forever." The client's expressions of distress also have a very well-worn and automatic quality. If the therapist probed as to whether the client has had these thoughts before, the answer would be "yes." This grinding fusion takes the client out of the present moment. The therapist can attack this situation in two different ways. One would be to continue to push for something specific (i.e., "Give me an example of one thing that is bothering you"). The second approach—and the one taken by the therapist—is to seize a generality, "a lot of things," and move into a highly specific series of sensations noticed on a moment-by-moment basis. The client's attention was directed toward breath, then the thought "a lot of things," then bodily reactions experienced in relation to "a lot of things," back to the therapist's voice, and so forth. Varying and repeating the words said, lingering with the words, engaging in imagined responses—all are likely to reduce fusion and increase flexibility of attention in the present moment.

Promoting Acceptance

Experiential avoidance is often connected to fusion, with both inducing attentional rigidity. The above mindfulness intervention contains a number of acceptance-oriented elements. The therapist coaches the client to soften, to let go of resistance, to metaphorically offer the gift of stillness. These suggestions are all designed to stimulate acceptance of what is present in the client's context in this exact moment.

Contacting Self

Self elements are somewhat less prominent in the above exercise; however, the therapist gives the instruction to notice "the you that notices."

Instructions to notice "the you that notices" are most potent when delivered on the heels of a stream of different things noticed: elements such as I/you noticing, as when the therapist instructs the client to notice the therapist's voice, to notice the therapist "here with you." All of these suggestions facilitate the emergence of an active *you noticing*.

Contacting Values

The values element is added to the end of the exercise in the form of questions that ask the client to consider a kinder, gentler relationship with work. At least two values elements are being activated by the therapist. First, there is the direct value of work; and, second, there is a value of self-compassion embedded in the instructions to soften and give oneself a metaphorical gift.

Present-moment process work rests on the relatively straightforward idea that learning happens best when the learning occurs in the present and is experienced directly. If the therapist senses that fusion and avoidance are at very high levels, even while doing values work, touching down on the processes of the centered response style is a solid fallback position. The above example of a present-moment intervention can be used with any problem brought in by a client. It can last as long as 20 or 30 minutes or be as short as 4 or 5 minutes. Different elements of the psychological flexibility model—or different emphases on the same elements—could be activated through slight alterations of the intervention. For example, more questions could be focused on perspective taking or values. The constant element is the focus on present-moment processes. Sometimes slowing down around an item of fused content such as this frees up the subsequent conversation.

If it appears the client has "disappeared" into a fused and/or experientially avoidant state, the therapist should initiate some brief work on present-moment processes like the above exchanges. Start with benign content, such as having the client slow down and simply focus on breathing. This can be followed by having the client notice what is showing up in the way of thoughts, feelings, memories, and physical sensations. In effect, the therapist slows the client down and helps redirect attention to what is happening within the moment-to-moment awareness.

Creating Continuity between Sessions

Short or long exercises focused on present-moment processes make excellent homework assignments and can help the client practice in naturally occurring life contexts. If a client already engages in some form of prayer,

meditation, yoga, or other mindfulness practice, these can be natural opportunities to add noticing and focusing skills. Sometimes, the client might agree to practice a particular in-session exercise at home such as breathing and noticing for 5 minutes, twice daily. The message to the client is that present-moment processes are skills and the only the way they are developed is through practice. Without practice, it is very difficult to flexibly direct one's attention in stressful life situations. The client should be encouraged to view this way of being as a permanent "lifestyle" modification rather than as a panacea that is only used in stressful life situations.

For ease of home-based practice, many ACT protocols now routinely include simple "getting-present" exercises in audio form that can be played on iPods or similar devices. Clients can be encouraged to use small exercises of this kind on their own. For example, they can be asked to set an alarm a few times each day to pause, let go of distractions, and to notice the sensations of 10 breaths—inflow and outflow. Clients may also be asked to slow down and notice their sensory experiences as they engage in simple ordinary tasks, such as dish washing or ironing. To make it less likely that the exercises will be put in the service of controlling or eliminating bad feelings, clients should be encouraged to do the exercises both when they are distressed *and relaxed*. Although extended present-moment activities like formal yoga or meditation activities are likely to be beneficial, even small amounts of present-moment and mindfulness exercises can be helpful. Indeed, the meta-analytic evidence on mindfulness methods shows that they are helpful even in very small doses and even when participants do not practice them regularly (Hoffman et al., 2010).

INTERACTIONS WITH OTHER CORE PROCESSES

Work on present-moment processes can be done as freestanding interventions, but as we've discussed previously, promoting present-moment processes often stimulates work on other processes. The following sections briefly review additional interactions between present-moment and other processes.

Present-Moment Processes and Self

Fused thoughts about the self are a common problem. As we have already discussed, fusion in general can take a person out of contact with the present moment. Many present-moment exercises ask a client to track emotions, thoughts, and bodily states on a moment-to-moment basis, and then

to connect with a sense of self that transcends these various contents of consciousness. As is the case with fusion more generally, present-moment processes are a good antidote for fusion with self-stories that are being held too tightly by the client.

Present-Moment Processes and Defusion

Some defusion exercises do not have the mindful qualities of the exercises and interventions described in this chapter, but brief present-moment exercises can be appended to them, and thus in the chapters that follow it will be helpful to remember the possible relevance of these applications. Consider, for example, a word repetition exercise in which the client is asked to repeat a bit of fused content over and over again very, very rapidly until the words begin to lose their capacity to constrain behavior (e.g., "I'm terrible"). This method has been shown to be clinically helpful in some contexts (e.g., Masuda et al., 2004) and is covered later, but punctuating rapid repetition with brief periods of stillness and awareness of breath can provide a terrific sense of contrast and awareness. In some contexts, the transition seems to lead to a more defused stance toward the process of thinking without necessarily having to defuse from a particular set of thoughts.

Similarly, many ACT exercises train clients to contact psychological content and simply to describe it without adding or subtracting anything. When clients are asked to simply name emotions as emotions, thoughts as thoughts, and so forth, they are basically mindfully observing the ongoing stream of cognition, emotion, and sensory experience. The therapist can alter the pacing and present-moment focus of attention to enhance the impact of the naming convention.

Present-Moment Processes and Acceptance

In a certain sense, there is always a bit of acceptance and defusion built into any *Just Noticing* exercise. Using a good deal of present-moment work in the context of difficult thoughts and emotions can facilitate acceptance and can help the client to notice *what else* is present even when strong emotions are felt. Painful private experiences tend to draw and fixate attention—indeed, this effect is probably, in part, evolutionary in origin. Present-moment work that shifts between painful events and more benign sensations such as the rise and fall of one's breath can help the client practice shifting attention. The experience of shifting attention in the midst of unwanted and distressing private experience also teaches clients that attending is embedded in everything we do. Likewise, coaching from the

therapist to open up and take a more accepting posture can foster greater attention toward one's values and what is important in the moment. When a client is overwhelmed by the prospect of acceptance, a mindful moment of stillness around something like breathing can provide enough psychological space to begin the process.

Present-Moment Processes and Values and Commitment

The development of the psychological flexibility model has helped to illuminate the interrelationships between values, commitment, and other behavioral activation work on the one hand and mindfulness processes on the other. There is a reciprocal interaction between present-moment processes and values and commitment work. Sometimes small values components can be used to facilitate present-moment work. For example, when doing present moment–focused work with a difficult emotion, a mindfully framed values question can foster the willingness to stay present and connect with what matters to the client.

> CLIENT: It is just too hard to think about my daughter. I have just given her too many disappointments.
>
> THERAPIST: If sitting in stillness with these hard things … for just a moment … could help you move toward being the father you want to be … would you be willing? (*said slowly, deliberately, with pauses*)

In this response, the therapist invokes the values question to motivate willingness to be present. Also, the pacing of the question is conducive to moment-by-moment noticing, and present-moment processes are fostered.

THERAPEUTIC DOS AND DON'TS

Emphasize the Purpose of Mindfulness Strategies

Nothing in ACT is opposed to a peaceful state of mind; however, there is a danger in present moment–focused interventions being seen solely as a tool for producing emotional relief. Mindfulness has been taken up by popular culture as the royal road to feeling "healthy." Although meditating on one's breath and gently releasing thoughts and emotions that arise are likely to produce positive feeling states, that is not their purpose in most contemplative traditions; it is also not their purpose in ACT. Present-moment processes are not a "feel-good" tonic. Therapists

should consistently characterize present-moment work as designed to both increase and broaden the client's ability to flexibly allocate attention. The point is to counter rigid attention fixated on certain thoughts, emotions, memories, or sensations. Present-moment processes are sources of health, not because they eliminate negative, unwanted content, but rather because they create a "space" in which negative content can be experienced without it dominating attention and behavior. Present-moment processes, well established, allow the client to act (or not act) in a "want to" rather than a "have to" manner.

Be Sensitive to Possible Client Bias against "Mindfulness"

Therapists also need to be aware of the poor fit between the language of mindfulness and the experiences and biases of many clients. Many clients follow fundamentalist religious traditions that are skeptical or even hostile toward anything that smacks of Eastern spirituality or New Age ideas. If this is an issue, it might be better to refer to mindfulness practice as "attention training" or the like. Suggest, for example, that valued living sometimes requires flexible and focused attention and that practicing these skills can prepare us to respond when life calls. This approach is better than allowing clients to think they are being encouraged to be Buddhists or to live the life of a monk. Some ACT methods and ideas parallel those of Buddhism (Hayes, 2002; Shenk, Masuda, Bunting, & Hayes, 2006), but ACT is not Buddhism and many clients are fearful that therapy might import unwanted relgious ideas. The therapist should therefore respect the ethnic and cultural diversity of each client and custom-tailor the language of each intervention to match the preferences of the client.

Model and Apply Skills to the Therapeutic Relationship

It can be helpful for therapists to model a present-moment focus, and therapists should not forget to apply these skills to the therapeutic relationship itself. Of all of the major psychological flexibility processes, a present-moment focus is probably the hardest to maintain during therapy sessions. Therapists too are susceptible to "checking out" in response to painful emotional content, fatigue, entanglement with clinical problem solving, and a multitude of other factors. A good rule of thumb is "When in doubt, first get centered!" This helps the therapist slow down and make contact with any barriers that have showed up, rather than engaging in "knee-jerk" responses that might be counterproductive. Staying inside present-moment work in order to *avoid* being more active as a therapist or in order to avoid emotionally difficult content is not helpful, however. Getting centered is step 1, not an end in itself.

READING SIGNS OF PROGRESS

The client's ability to engage in present-moment processes should grow over time; therefore, therapists need to learn to read signs of progress. The initial present-moment exercises may require more time and structuring than originally anticipated by the therapist. As the client progresses, certain in-session techniques such as repeatedly asking the client to focus on breathing, or making verbal requests of the client to come into the moment, may be gradually phased out. As each client makes progress, you may note greater ease in his or her stopping, slowing, or changing the direction of a session when that seems helpful, or that the client persists with exercises or difficult content when that is needed. Such changes normally demonstrate that attentional flexibility is being acquired. Generalization of skills is indicated when the client spontaneously initiates deliberate stopping, slowing, or altering the direction of sessions. As attentional flexibility increases, the present moment becomes an ever-present and firm foundation for awareness and action.

CHAPTER 8

Dimensions of Self

Form is only emptiness; emptiness only form.
—Zen Saying

In this chapter you will learn . . .

- How the problem-solving mode of mind affects self-experience.
- How the three aspects of self-experience interact to promote or undermine psychological flexibility.
- How to undermine attachment to the conceptualized self.
- How to promote contact with self as perspective taking.
- How to create a distinction between the client and the client's self-story.
- How to read and address self-problems.

PRACTICAL OVERVIEW

The ability to keep centered by taking perspective and staying present is a main source of psychological health and flexibility. We need to use that ability when the regulatory functions of minding become overextended. We need to have a place of sanctuary that protects us from entanglement with toxic self-evaluations, mindless rule following, and socially supported but self-destructive coping responses. That sanctuary is the simple experience of being aware that we are the ones who contain and look at our private experience.

ACT views human suffering as the result of the overextension of arbitrary verbal relations and the relative weakness of a larger sense of self that can contain the mental clutter. There are two central processes that must be addressed to correct this imbalance. One is to reduce the dominance

of the problem-solving mode of mind, which is focused primarily on sense-making, prediction, and storytelling. This mode of mind is inherently reactive because it evolved to respond to environmental inputs in an automatic overlearned fashion (Strosahl & Robinson, 2008).

ACT seeks to promote a different kind of minding, one that is located in the present moment and is centered within simple awareness itself. Awareness itself supports the ability to stay nonjudgmental and simply let the products of mind be present. The attentional flexibility that underpins being "in the now" is much more possible when there is a distinction available between thoughts and the thinker, emotions and the feeler, memories and the person remembering, and so forth.

We are used to screening mental inputs for their immediate relevance. It is a function that is used so pervasively that we simply take it for granted, and without it humans would be in a constant state of "information overload." For example, when crossing a busy intersection, we might be aware of fragrant smells emanating from a nearby restaurant, but that is not nearly as important as noticing the speed of oncoming cars. But when it comes to the subjective elements of minding—self-evaluations, comparisons, predictions of what is yet to come, to name a few possibilities—we can lose the contextual relationship between what we are aware of and who is aware of it. As a result, we lose the ability to screen these inputs for their relevance and too easily fall prey to the content of these inputs. In essence, we are on automatic pilot.

ACT asks a lot of the client. It asks that verbal defenses be reduced. It asks that psychological monsters be faced. No one can be expected to face psychological pain if self-destruction (even if metaphorical) seems to be the likely result. In order to face one's monsters head-on, it is necessary to find a place from which this is possible. The solution requires that the client learn to stay in the present moment and to make contact with a larger sense of self that is not threatened by the content. This ability to center (stay present and take perspective) can be thought of as a hinge that links to the ability to stay open (defuse from content, accept what is present) and to engage life (choosing values and engaging in committed actions).

Alternatively, imagine it in this way. Life is like driving a car. Sometimes it rains, and mud gets splattered onto the windshield. In order to see ahead, the windshield wiper needs to be turned on. Experiential avoidance and cognitive fusion are like having a windshield wiper that is frozen in place by ice—rigid and inflexible. Acceptance and defusion free up our actions so that we can fully participate in the present and gravitate toward our own values and committed actions. The sweeping motion of a wiper may clear the windshield, but a moment later if the storm is sufficiently furious the windshield may cloud up again and more will be required. The pivot point of this process is a transcendent sense of self. The processes of

defusion and acceptance permit life energy to move into the present, where it can be transformed into vital action, but consciousness itself allows all of this to be the action of a conscious human being.

ACT therapists take the view that vitality, purpose, and meaning occur when the person voluntarily and repeatedly engages in a kind of conceptual suicide, in which the boundaries of the conceptualized self are softened and there is a more open approach to experiences that are but echoes of one's history. The ACT phrase for this is "kill yourself every day." When we emphasize contact with direct experience through an observing self, we foster more flexible attentional processes, which in turn allow an ongoing process of self-awareness and awareness of the environment to emerge. We restore for clients what they already have been given but have lost as a result of the domination of language and thought: consciousness itself as a place to observe their private war without being *in* the private war.

Defending the Conceptualized Self

Clients often come into therapy heavily fused with and prepared to defend a verbally constructed view of self that is rooted in the problem-solving mode of mind. In some cases, clients have so little contact with other forms of self that they don't know what they are feeling or experiencing and can't separate themselves from the contents of their minding. In ACT, entanglement with the conceptualized self is largely seen as problematic because it narrows our repertoire of actions needlessly. Fusion with the conceptualized self can lead to distortion or reinterpretation of events that are inconsistent with the conceptualized self. Clinically, therapists of various schools deal with this process when working with negative self-concepts, but it can be equally problematic with positive self-concepts. If a person believes him- or herself to be kind, there is less room to deal directly and openly with behavior more readily called "cruel." In this way, a conceptualized self can foster self-deception, which in turn makes it more resistant to change.

Ironically, most people come into therapy wanting to *defend* their particular self-conceptualization even if it is loathsome, harmful, or the apparent reason for seeking treatment in the first place. Familiar repeated ideas about oneself—both positive and negative—are treated as things to be right about. Initially, most clients are so thoroughly trapped in this conceptual prison that they do not know that—and won't believe that—they are imprisoned. The conceptual world in which they live is a given, and within that world certain thoughts are rational and others are irrational; certain emotions are good, and others are bad; certain beliefs show high self-esteem, while others show low self-esteem; and so on. This kind of categorization is quite familiar to our clients. It's what they have been doing

all their lives (therapists, too!). Rather than help them win this conceptual war—as most therapies try to do—ACT therapists work to help clients distinguish themselves from their conceptualized content, however good or bad that content may be. This approach supports behaviorally healthy variation and flexibility—the story of self is inherently more rigid than on our actual repertoire need be. From an evolutionary standpoint, repertoires evolve by fostering variation and then selectively keeping those that work toward valued patterns. ACT helps that occur—allowing behavioral patterns to evolve in a positive direction based on life itself.

Promoting Continuous Self-Awareness: Self-as-Process

While ACT assumes that it is inherently constraining to tie one's identity to conceptualized content of any kind, it also assumes that healthy living requires continuous and flexible verbal self-knowledge of the present moment. ACT interventions seek to develop flexible attending and immediate self-awareness. Evaluations of private content in the moment are not important; rather, that is the purview of a problem-solving mode of mind and its endless attempts to categorize, evaluate, and predict. The issue is not whether a thought, or sensation, or memory is good or bad. Instead, the ACT clinician encourages clients *to see what they see as they see it*, without unnecessarily judging or justifying what is present. This approach helps identify and weaken the social contingencies that lead to self-deception in the service of preserving a conceptualized version of self ("I'm never angry at people—so, this emotion can't be anger"). The irony is that when the evaluated content of self-awareness is no longer so much at issue, fluid and useful self-awareness is more likely to be fostered ("I'm feeling angry right now in response to the remark she made"). ACT clinicians model this sense of self—what has been termed "self-as-process." When doing so is useful, they are ready to describe what is going on in therapy, in clients, or in themselves—directly and uncritically. They are able to instigate and support this sense of self by asking questions of the client at key moments and by maintaining a posture of openness to what is noticed. Many ACT exercises train clients to contact psychological content and simply to describe it without adding or subtracting anything.

Promoting a Perspective-Taking Sense of Self: Self-as-Context

In Chapter 3 we reviewed some of the RFT evidence that a sense of perspective emerges not just from "I" but also from other perspectives such as "you" and that the deictic relations of here–there and now–then are key to perspective taking. In a basic sense, seeing from "I–here–now" is

an *action* of perspective taking because there is no static mental position from which perspective is guaranteed. This is an ongoing fluid process; "I-ing" might be a more accurate though more cumbersome description of this process. A person with a rich history of being asked questions about person, time, and place will more readily abstract what is invariant in the answers, namely, perspective taking itself. A person with an impoverished history will have more difficulties contacting this sense of self. Thus, ACT, like other experiential traditions, encourages the use of "I" statements and fosters such statements in a wide variety of contexts. It is important not merely to talk about problems but also aspirations—not just because it is a whole person in the room but also because doing so establishes more flexible perspective taking.

Distorted learning histories can give rise to countless kinds of problems in perspective taking. For example, a client who, as a child, was constantly forced to describe wants, states, and desires based on what others wished to hear quickly learns that "I" is less "from here" than "from there." Certain kinds of clinical conditions show such a phenomenon. The person whose sense of wholeness or personhood dissolves when his or her therapist goes on vacation—or when a partner is no longer present—is evidencing a loss of sense of self that has been tied too closely to the perspectives of others. The child reared in a violent, abusive, dysfunctional family will often learn to split off various aspects of self-awareness in order to survive the mental turmoil that he or she has no ability to symbolically process and integrate. This fragmented sense of self-awareness may later lead to dissociative states under conditions of negative emotional arousal.

The deep insight RFT provides is that "I" shows up at the moment that "you" shows up, and the resulting flexibility in perspective taking is key. Many ACT exercises require that the client adopt different perspectives for that very reason. For example, clients may be asked to go to a "wiser" future and look back at themselves now, perhaps even writing a letter to oneself about how to engage with the current situation in a healthy way. The client might be asked to put him- or herself into an empty chair and talk to him- or herself from the perspective of another. Upon hearing a new bit of clinical material, the client might be asked what he or she supposes you, the therapist, might be thinking.

It is not too difficult to help clients recognize the essential connection between the person they are today and the person they were last summer, the person who once was a teenager and the person who once was 4 years old. People can often remember being behind the same eyes in earlier times and can contact that "person" even now. Contact with this perspective-taking sense of self is critical to acceptance work because it provides a sanctuary in which there is no existential threat from entering into the pain and travails of life. This perspective enables the person to know in

a truly experiential way that no matter what comes up, the "I" is not threatened. This is not because the "I" is permanent but rather because the "I" is not thing-like. Instead, it is the perspective from which verbal activity is observed. To borrow a metaphor from Baba Ram Dass, behind the cloud of language is a small bit of blue sky. There is no reason for humans to blow the clouds away every moment in order to be reassured that there is blue sky. It envelops and contains the clouds themselves. Contact with this aspect of self is thus contact with a sense of personal wholeness, transcendence, interconnectedness, and presence.

The therapeutic relationship in ACT is often intense, and there is a sense of shared values and vulnerabilities between the therapist and the client (see Chapter 5). Self-disclosure is common; the therapist models an openness to addressing the difficulties inherent in perspective taking in the presence of the overly dominant problem-solving mode of mind (e.g., "When I get hurt, like you, I find it difficult to just step back and let the hurt be there, and instead see it as part of me"). This makes sense for many reasons within the ACT model, but in this context it is worth noting that one of the ways that a person learns about "I–here–now" perspective taking is to learn about the perspectives of others, including the clinician.

CLINICAL APPLICATIONS

There are three primary clinical goals to shoot for when working with this core process. One is to undermine the client's attachment to the conceptualized self. The second is to help the client develop and/or improve the ability to notice the continuous flow of experience. The third is to help the client increase the availability and flexibility of perspective taking.

The signs suggesting that self-work is needed are a sense of lifelessness or self-righteousness and a rushed or automatic quality in daily existence, both of which reflect a sense of attachment to the conceptualized self. Resistance and discomfort in a session will sometimes emerge as issues are contacted outside of the usual self-narrative. The content of clients' experiences may feel almost life-threatening, as if there is nothing more to them than their self-stories. There may be a lack of sensitivity to the perspective of others, including the therapist or others in the person's environment. A hyperattentive concern for the views of others or a feeling of anomie when left alone may indicate problems with self as "I-ing." A lack of a sense of spirituality or connectness to others, discomfort with ambiguity, personal rigidity, a sense of emptiness inside, and/or problems with dissociation can all be indicators of the need to develop the ability to make contact with a larger sense of self.

Undermining Attachment to the Conceptualized Self

As is true with any ACT process, some clients are ready to begin tackling the thorny issues related to self, while others are not. Occasionally clients have worked on these issues for some time, or they may quickly grasp the issue of self and immediately make headway with it. The ACT orientation toward self and suffering also explains why this approach may work with a broad variety of clinical problems. In a sense, the struggle between content and context is timeless and inextricably tied to the "human condition"—it is a struggle thousands of years old. The therapist and client are in this language stew together, and an intense therapeutic bond develops between them owing to this fact.

The early work that is designed to undermine one's attachment to one's conceptualized self can be fairly straightforward. Clients often believe that therapy will help eliminate bad and limiting self-beliefs and immediately create pure and unadulterated self-confidence. They expect the therapist to make the necessary repairs, like a plumber fixing leaky or rusting pipes. The ACT therapist introduces the idea that the goodness or badness of beliefs may not be a problem, per se, but that the problem may consist of one's *attachment* to the beliefs.

To begin the process of disengagement, the therapist can provide the client with several examples of the ways by which attachment to even very positive beliefs can blind a person. For example, a person who is attached to the idea that the world is a place that is full of goodness is more likely to be preyed upon by the unscrupulous. Someone who is committed to the idea that he or she is a good parent may be blind to the ways in which he or she may actually be harming the children. The therapist may ask the client to examine some relevant personal experiences and try to come up with situations where attachment to both positive and negative ideas has been detrimental.

The *Whole, Complete, Perfect* exercise is an excellent experiential exercise for addressing attachment. The client often does not appreciate the powerful dialectical properties of language and the arbitrary way this characteristic can affect one's self-conceptualizations. The client's assignment in this exercise is to notice that any positive identity statement automatically draws its opposite and (if you choose to extend the exercise) that extremely negative identity statements also automatically attract their opposite. The point is that peace of mind is elusive at the level of content, and thus an attachment to private evaluative thought content immediately produces a sense of unease and threat. In this eyes-closed exercise, first do a brief centering exercise such as the following:

> "Before we get started, would it be OK if we spend a moment to get centered and help you get into the room? Good. OK, let's get settled and

> put everything down. Take a nice, deep breath, and notice how it feels to breathe in … [*pause*] … and when you are ready just do it again … [*pause*] … And now do it again, but at the top of the breath I want you to notice that you neither breathe in nor out—there is a kind of flat spot before breathing out. See if you can notice that, and notice where it begins and ends … [*pause*] … [Other things to attend to could be added here, such as attention to sounds, sensations, and so on.]"

Next, ask the client to notice what comes up in the mind as you say a few words. Then, say just four words slowly:

> "I'm whole … complete … perfect."

After a few minutes, end the exercise and begin a discussion of the client's experience with it. Ask what came up, which word was harder, and so on. Usually, the more positive the word, the more negative the client's experience—for example, "I may be whole, but I'm not perfect!" You can add a similar set of more negative words, and the client will often begin to silently argue with extremely negative ones as well. Again, the point is that there is no peace of mind at the level of content because one polar extreme attracts its opposite. Peace of mind has to be found elsewhere.

Parenthetically, it can be worthwhile to tell the client about the etymology of *perfect*. The first part of the word (*per*) comes from a term that means "thoroughly." *Fect* comes from the same root as the word *factory*, and it means "made." In contemporary usage, "wholeness" and "perfection" seem to be issues of evaluation; yet, if to be perfect is to be thoroughly made, perhaps perfection is more a matter of presence or wholeness. No second contains more life than any other second. Any moment is always absolutely whole, even a moment in which the thought arises that "I am missing something."

It is also worth noting something else. Almost no one doing this exercise notices the word *I'm*. In this exercise, the therapist does not say, "See what it is like to believe these words about yourself: I'm whole, complete, perfect." There is no instruction to apply these attributes to oneself. Nevertheless, 99% of those doing the exercise will apply the four words that way, and almost no one will at first notice that he or she need not have done this. That is worth noting—usually after unpacking most of the process—as another example of how seductive and automatic control by thoughts can be.

Another common intervention is to use the *Storyline* written exercise. This exercise asks clients to describe in writing the key historical events that have shaped their lives and made them into what they are today. After about a page is written, ask clients to underline all the objective facts (e.g.,

"I had a panic attack during my senior prom"), circle all psychological reactions (thoughts, feelings, memories, sensations, urges, dispositions, and so on—such as "I thought I was going to die"). Then ask them to write the story again with all the underlined and circled content remaining, but with a different theme and ending.

When reviewing the new story, assure yourself that all the elements are in place and that the ending and theme are different. There is no need to "compare" the new story with the old one in terms of which is better or more accurate. The clinician should emphasize that the purpose is not to show that the original story is wrong or to find a better story, but just to notice how the mind works, even when we are not watching. After completing this conversation, ask the person to write yet another story using only the underlined events (i.e., the objective facts) and this time applying any kind of different psychological reactions or evaluations/judgments. Again, the debriefing is more focused on the client's experience in doing the exercise than what the content of the new story says. The client might say something like "I tried to think of another way to describe how horrible it was." In response, the therapist might say, "Interesting. Let's work together right now to see if we can't come up with a different adjective or description. Let's just see if we can get your mind to do that." Overall, the *Storyline* exercise promotes a type of defusion process that helps undermine attachment to the conceptualized self-story and that makes the ongoing process of making judgments more explicit and distinguishable. If the client and therapist could tolerate it, hundreds of stories could be written about the same set of objective events, and we have personally worked with clients through several rounds of this exercise. It is important not to lecture or give the client the "moral of the story" when doing this exercise. The meaning we want the client to take away is implicit in the task. For example, if the client says something like "So, what you're trying to show me is that my life history is just a story, and I shouldn't believe it, correct?", the therapist might reply, "This is just an opportunity to see how our minds make sense of things and what kinds of things go into a personal story. It's also a chance to notice how we get attached and invested in certain aspects of a life story when in fact there are many ways to think of things. That is not a good or bad thing, just something we want to be aware of." Parenthetically, this classic ACT exercise shows that ACT is *not* opposed to cognitive reappraisal as a form of cognitive flexibility. What ACT is resistant to is the idea that the content of thinking is necessarily key and thus that the primary emphasis should always be on removing bad content and replacing it with good cognitive content. That idea applies in some limited situations (e.g., ignorance), but it is vastly overplayed and is less reliably helpful than changing the functions of thoughts and the person's relationship to cognitive processes.

Self-as-Ongoing-Process: Strengthening Continuous Self-Awareness

Discussing self as conceptualized content at an intellectual level can be useful for some higher-functioning clients, but most of the time the therapist must help the client make experiential contact with "I/here/now" as a perspective from which consciousness arises. One important way this is done is to ask questions that require an "I" answer. If self-as-context is a kind of abstraction across multiple exemplars and needs to be distinguished from the conceptualized self, it is important that the questions be broad and flexible. Failing to ask across dimensions can confuse content with context. For example, asking only about problems can feed an identification the client may have with these specific problems. Artificially creating "self-esteem" by only talking about positive things can create another attachment—this time to "positive" content—that can invite further struggle.

An advantage of the ACT approach is that it strengthens self-as-process—the ongoing, flexible, and voluntary awareness of the world within. For example, a person struggling with a difficult thought might be asked what his or her body feels like, how old he or she feels; to put into postural form what he or she feels an urge to do when this thought comes up; or to see whether he or she can open their eyes and come into the present even while noticing that thought. In other words, flexible attentional control is critical to the development of the simple awareness that is a core feature of perspective taking. At times, ACT can resemble existential or humanistic therapies, with its intense interest in the person's immediate experience. This resemblance is not the same as an interest in the evaluative content of the person's story. There is a sense of openness and vulnerability that can come from "I" statements that are honest, present, and flexible. That is what is being pursued.

If the person's sense of self has become excessively externalized in an unhealthy way, the clinician may need to return frequently to the client's immediate experiences, effectively slowing them down so that they can be explored further. A person can subjugate "I" into "you" so thoroughly that the "I–you" relation is not a relation at all. This tendency is as corrosive to the development of a transcendent sense of self as failing to ask "I" questions at all. Just as a person with impoverished deictic training might not know "If I were you and you were me, what would you be feeling?", so too a person with excessive externalization of self may fail the same test.

Self-as-Context: Strengthening Contact with Perspective Taking

Since "I" is relational, it can be used to modify perspectives. This type of modification is accomplished by exploring the perspectives of others in the

client's life or through well-timed therapist self-disclosures (for the client's benefit, not the therapist's), but it can also be explored within the person's own sense of perspective. Here is an example of a brief mindfulness exercise that might be used at the beginning of a session to help promote perspective taking. The following begins with a brief centering exercise similar to the start of the *Whole, Perfect, Complete* exercise described earlier. The client is asked to notice various sensations such as one's breath or ambient sounds. The exercise then continues with the following:

> "Now, as you notice these things, I want you to *notice* that you are noticing these things. You are here now, aware of what you are aware of. If you are not sure, just take time to notice a sensation or an image. . . .
>
> "And notice you are noticing it. . . . Don't try to grab that part and look at it—you'd be looking from another place. Just touch this awareness lightly and notice that you are here, aware, in this moment of your life. . . . Now I want you to think about all the things that might happen in our session today—we may look at what has been happening; at what is hard or joyful; what you fear and what you hope; your pain and your values. Don't get all entangled in them now—just note that these issues are here, and give them a moment to bubble around you. . . . And then I want you to imagine that you a looking back at this moment many years from now. You can see yourself sitting in this chair, aware of all the pains and fears and hopes and aspirations. Imagine that you've made progress and you are wiser. Don't overthink this, but see if you can contact that sense of awareness—of looking back at yourself now. Try to let go of any judgments and just hold that person you see in a kind way in your consciousness. If this could actually happen, what advice would you give yourself about how to engage this session that we are about to have? Don't answer that quickly . . . just sit inside that question for a few moments. . . . See if there is anything you might have to say to yourself if that could actually occur. If there is, just note what it is. See if you can connect with a self of caring and self-compassion. Is there something you have to say? Connect with that message, almost as if you are about to speak it out loud. And now come back inside your body. . . . Picture where I am. And when you are ready to begin, just open your eyes and take the next few minutes to write down the message that came to you.

An inductive exercise like this can be used to set a context of consciousness for clinical work. The perspective-taking skills of looking across time, place, and person may help establish greater perspective taking. The many exercises being developed in contextual CBT for increased compassion toward others and oneself can all fit readily inside this part of ACT (e.g., see Gilbert's [2009] "compassionate mind therapy").

Metaphors are particularly useful in highlighting the differences between the context and content of consciousness. A classic ACT intervention is the *Chessboard* metaphor.

> "It's as if there is a chessboard that extends infinitely in all directions. It's covered with different-colored pieces, black pieces, and white pieces. They work together in teams, as in chess—the white pieces opposing the black pieces. You can think of your thoughts, feelings, and beliefs as these pieces; they sort of hang out together in teams too. For example, 'bad' feelings (like anxiety, depression, resentment) hang out with 'bad' thoughts and 'bad' memories. Same thing with the 'good' ones. So, it seems the way the game is played is that we select which side we want to win. We put the 'good' pieces (like thoughts that are self-confident, feelings of being in control, etc.) on one side and the 'bad' pieces on the other. Then we get up on the back of the white queen and ride to battle, fighting to win the war against anxiety, depression, thoughts about using drugs, whatever. It's a war game. But there's a logical problem here, and it's that from this posture huge portions of yourself are your own enemy. In other words, if you need to be in this war, there is something wrong with you. And since it appears that you're on the same level as these pieces, they can be as big or even bigger than you are—even though these pieces are *in* you. So, somehow—even though it is not logical—the more you fight, the bigger they get. If it is true that 'if you are not willing to have it, you've got it,' then as you fight them they get more central to your life, more habitual, more dominating, and more linked to every area of living. The logical idea is that you will knock enough of them off the board that you eventually dominate them—except your experience tells you that exactly the opposite happens. Apparently, the black pieces can't be deliberately knocked off the board! So, the battle goes on. You feel hopeless, you have a sense that you can't win, and yet you can't stop fighting. If you're on the back of that white horse, fighting is the only choice you have because the black pieces seem life-threatening. Yet, living in a war zone is no way to live."

As the client connects to this metaphor, it can be turned to the issue of the self.

> THERAPIST: Now, let me ask you to think about this carefully. In this metaphor, suppose you aren't the chess pieces. Who are you?
>
> CLIENT: Am I the player?
>
> THERAPIST: That may be what you have been trying to be. Notice, though, that a player has a big investment in how this war turns

out. Besides, who are you playing against? Some other player? So, suppose you're not that either.

CLIENT: . . . Am I the board?

THERAPIST: It might be useful to look at it that way. Without a board, these pieces have no place to be. The board holds them. What would happen to your thoughts if you weren't there to be aware that you thought them? The pieces need you. They cannot exist without you, but *you* contain *them*, they don't contain *you*. Notice that if you're the pieces, the game is very important; you've got to win, your life depends on it! But if you're the board, it doesn't matter if the war stops or not. The game may go on, but it doesn't make any difference to the board. As the board, you can see all the pieces, you can hold them, you are in intimate contact with them, and you can watch the war being played out in your consciousness, but it doesn't matter. It takes no effort.

The *Chessboard* metaphor is often physically acted out in therapy. For example, a piece of cardboard is placed on the floor, and various attractive and ugly things are put on top (e.g., cigarette butts, pictures). The client may be asked to notice that the board expends no effort in holding the pieces, a metaphor for the lack of effort that is needed to contact simple awareness, with the physical act of the board holding things as a metaphor for willingness to engage with, and acceptance of, feared content. The client may be asked to notice that at the board level only two things can be done: hold the pieces and move them all around. We cannot move specific pieces without abandoning the board level. While the board's job is effortless, the pieces are engaged in a total war. Furthermore, the board is in more direct contact with the pieces than the pieces are to one another—so, simple awareness is not about detachment or dissociation. Rather, when the client becomes attached to a thought or struggles with an emotion, other pieces, while scary, are not genuinely being touched at all. In group work, the chessboard can be acted out by the whole group.

If the client connects with the metaphor, it is useful to reinvigorate it periodically by simply asking the client, "Are you at the piece level or at the board level right now?" All the arguments, reasons, and so on that the client brings in are examples of pieces, and thus this metaphor can help defuse the client from such reactions. The notion of board level can be used frequently to connote a stance in which the client is looking *at* psychological content rather than looking *from* psychological content. You, the clinician, might hold your palms out together face up when talking about consciousness as a kind of unstated physical metaphor for what is being discussed.

Clinicians need to learn how to listen for metaphors and construct exercises that fit the client's experience. One client may talk about how waves move through the ocean, but they do not move the ocean, itself. Another might talk about how boats travel across a lake, but the lake remains. Such spontaneously generated "word tags" can then be used to reintroduce the notion of perspective taking during difficult clinical moments. Metaphors work when they are rich, sensory, and apt. It is best to use those that emerge from the clients' experience, language, and imagery, and when they do they can replace the "canned" ACT metaphors.

The ACT clinician is sensitive to the fact that discussions about self-concept and consciousness can quickly become overly intellectual. The metaphors just described point to the issues involved, but they don't actually create that distinction experientially. So, if the client asks, "What should I do differently, then? How can I stay at board level?", it is best not to directly answer the question. A good response is "We will help with that as we go forward. But right now, just notice that it is impossible not to struggle with thoughts and feelings if you treat them as defining who you are." We need to help the client make direct contact with the experience of simple awareness as the defining context for psychological content.

The *Observer* exercise (a variant of the "self-identification exercise" developed by Assagioli, 1971, pp. 211–217) is designed to begin to establish a sense of self that exists in the present and provides a context for cognitive defusion. The exercise is usually carried out with eyes closed (clients who are uncomfortable with that can cover their eyes or merely look down at a particular place on the floor). The therapist induces a state of relaxed focus and gradually directs the client's attention to different domains with which people can become identified. Each is examined in turn, and at key moments the therapist focuses attention on content with the instruction to notice that someone is noticing this content. These instructions can create a brief but powerful psychological state in which there is a sense of transcendence and continuity: a self that is aware of content but is not defined by that content.

> "We are going to do an exercise now that is a way to begin to try to experience that place where you are not your programming. There is no way you can fail at the exercise; we're just going to be looking at whatever you are feeling or thinking—so, whatever comes up is just right! Close your eyes if you feel comfortable to do so, get settled into your chair, and follow my voice. If you find yourself wandering, just gently come back to the sound of my voice. For a moment, now, turn your attention to yourself in this room. Picture the room. Picture yourself in this room and exactly where you are. Now begin to go inside your skin and get in touch with your body. Notice how you are sitting

in the chair. See if you can notice exactly the shape that is made and the parts of your skin that touch the chair. Notice any bodily sensations that are there. As you see each one, just acknowledge that feeling, and allow your consciousness to move on. (*pause*) Now, notice any emotions you are having, and if you have any, just acknowledge them. (*pause*) Now, get in touch with your thoughts, and just quietly watch them for a few moments. (*pause*) Now I want you to notice that, as you noticed these things, a part of you noticed them. You noticed those sensations … those emotions … those thoughts. And that part of you we will call the 'observer you.' There is a person in here, behind those eyes, that is aware of what I am saying right now. And it is the same person you've been your whole life. In some deep sense, this observer you is the you that you call 'you.'

"I want you to remember something that happened last summer. Raise your finger when you have an image in mind. Good. Now, just look around. Remember all the things that were happening then. Remember the sights … the sounds … your feelings … and as you do that see if you can notice that you were there then noticing what you were noticing. See if you can catch the person behind your eyes that saw, and heard, and felt. You were there then, and you are here now. I'm not asking you to believe this. I'm not making a logical point. I am just asking you to note the experience of being aware and to check and see if it isn't so that in some deep sense the you that is here now was there then. The person aware of what you are aware of is here now and was there then. See if you can notice the essential continuity—in some deep sense at the level of experience, not at the level of belief. You have been you your whole life.

"I want you to remember something that happened when you were a teenager. Raise your finger when you have an image in mind. Good. Now, just look around. Remember all the things that were happening then. Remember the sights … the sounds … your feelings. … Take your time. And when you are clear about what was there, see if you just for a second catch that there was a person behind your eyes then who saw, and heard, and felt all of this. You were there then too, and see if it isn't true—as an experienced fact, not a belief—that there is an essential continuity between the person aware of what you are aware of now and the person who was aware of what you were aware of as a teenager in that specific situation. You have been you your whole life.

"Finally, remember something that happened when you were a fairly young child, say, around age 6 or 7. Raise your finger when you have an image in mind. Good. Now just look around again. See what was happening. See the sights … hear the sounds … feel your

feelings … and then catch the fact that you were there seeing, hearing, and feeling. Notice that you were there behind your eyes. You were there then, and you are here now. Check and see if in some deep sense the 'you' that is here now was there then. The person aware of what you are aware of is here now and was there then.

"You have been you your whole life. Everywhere you've been, you've been there noticing. This is what I mean by the 'observer you.' And from that perspective or point of view I want you to look at some areas of living. Let's start with your body. Notice how your body is constantly changing. Sometimes it is sick, and sometimes it is well. It may be rested or tired. It may be strong or weak. You were once a tiny baby, but your body grew, and it has been continually changing as you have aged. You may have even have had parts of your body removed, like in an operation. (Your cells die and are renewed constantly; on average they are 7–10 years old.) Your bodily sensations come and go. Even as we have spoken, they have changed. So, all this is changing, and yet you have been there your whole life. That must mean that, while you have a body, you do not experience yourself just as your body. This is a matter of experience, not of belief. Just notice your body now for a few moments, and as you do this, every so often notice you are the one noticing. [*Give the client time to do this.*]

"Now, let's go to another area: your roles. Notice how many roles you have or have had. Sometimes I'm in the role of a [fit these to the client, e.g., 'mother … or a friend … or a daughter … or a wife … sometimes I'm a respected worker … other times I'm a leader … or a follower' … etc.]. In the world of form, I'm in some role all the time. If I were to try not to be, then I'd be playing the role of not playing a role. Even now, part of me is playing a role … the client role. Yet, all the while notice that you are also present. The part of you you call 'you' … is watching and aware of what you are aware of. And in some deep sense that 'you' never changes. So, if your roles are constantly changing, and yet the you that you call 'you' has been there your whole life, it must be that while you have roles, you do not experience yourself to be your roles. This is not a matter of belief. Just look and notice the distinction between what you are looking at and the you that is looking.

"Now, let's go to another area, emotions. Notice how your emotions are constantly changing. Sometimes you feel love and sometimes hatred, calm, and then tense, joyful–sorrowful, happy–sad. Even now you may be experiencing emotions … interest, boredom, relaxation. Think of things you have liked and don't like any longer, of fears that you once had that now are resolved. The only thing you can count on with emotions is that they will change. Though a wave of emotion

comes, it will pass in time. And yet, while these emotions come and go, notice that in some deep sense that "you" do not change. So, while you have emotions, you do not experience yourself to be *just* your emotions. Allow yourself to realize this as an experience, not as a belief. In some very important and deep way, you experience yourself as a *constant*. You are you through it all. So, just notice your emotions for a moment, and notice also that you are noticing them. [*Observe a brief period of silence.*]

"Now, let's turn to the most difficult area—your own thoughts. Thoughts are difficult because they tend to hook us and pull us into them. If that happens, just come back to the sound of my voice. Notice how your thoughts are constantly changing. You used to be ignorant—then you went to school and learned new ways of thinking. You have gained new ideas and new knowledge. Sometimes you think about things one way and sometimes another. Sometimes your thoughts may make little sense. Sometimes they seemingly come up automatically, from out of nowhere. They are constantly changing. Look at your thoughts even since you came in today, and notice how many different thoughts you have had. And yet in some deep way the you that is aware of what you think is not changing. So, that must mean that while you have thoughts, you do not experience yourself to be just your thoughts. Do not believe this. Just notice it. And even as you realize this, notice that your stream of thoughts continues. And you may get caught up with them. And yet, in the instant that you realize that, you also realize that a part of you is standing back, watching it all. So, now watch your thoughts for a few moments—and, as you do, notice also that you are noticing them. [*Observe a brief period of silence.*]

"So, as a matter of experience and not of belief, you are not just your body … your roles … your emotions … your thoughts. These things are the content of your life, while *you* are the arena … the context … the space in which they unfold. Notice that the things you've been struggling with and trying to change are not you. No matter how this war goes, you will be there, *unchanged*. See if you can take advantage of this connection to let go just a little bit, secure in the knowledge that you have been you through it all and that you need not have such an investment in all this psychological content as a measure of your life. Just notice the experiences in all the domains that show up, and, as you do, notice that you are still here, being aware of what you are aware of. [Observe a brief period of silence.]

"Now, again picture yourself in this room. And now picture the room. Picture … [Describe the room]. And when you are ready to come back into the room, open your eyes.

After this exercise, the clients' experience is examined, but without analysis and interpretation. It is useful to see if there were any particular qualities of the experience of connecting with the "you." It is not unusual for clients to report a sense of peace or tranquility. Life experiences invoked in this exercise, many of which are threatening and anxiety-promoting, can be received peacefully and calmly (i.e., accepted in a posture of psychological willingness) when they are viewed as bits and pieces of self-content, not as defining the self per se.

A minority of clients will be disturbed by self-as-context work, however, fearing that they will disappear into a black hole if they directly contact simple awareness because of its seeming lack of discernible edges. Often, these clients have weakened the continuity of consciousness itself as a method of experiential avoidance; so, in effect, the exercise is challenging a basic form of self-protection. In these instances, an emphasis on simple perspective taking and present-moment awareness (as well as working to reduce fusion and avoidance) can allow self-work to go on productively.

It is usually worth touching the active implications of this experience, if only briefly. The therapist can link the client back to experiences with the *Chessboard* metaphor. For example:

> "There is one other thing that the chessboard, as a board, can do other than hold the pieces. It can take a direction and move, regardless of what the pieces are doing at the time. It can see what is there, feel what is there, and still say, 'Here we go!' "

Once a perspective-taking sense of self is touched, it can be brought back into the room readily. Virtually any opening exercise or mindfulness method can include a request to "notice who is noticing that." It is usually best, however, not to overinterpret or intellectualize this sense of self—at least not until the client has contacted it and knows what is being talked "about." This sense of self will not yield to examination and analysis because it is metaphorically where we look *from*, not what we look *at*. Clients can get completely confused in the attempt to label or understand this version of self through verbal means. This sense of confusion often means that the client is trying to reconcile the process of simple awareness with the conceptualized self—for example, "My problem is that I don't know how to take perspective on things." If this situation occurs, one method to counter it is to take the client into the "my problem is" chatter and then just ask, "And who is noticing that?" In other words, try to leave this sense of self at the level of experience rather than telling a big story about it or "understanding" it to be the main point. The ACT therapist is helping the client develop a wordless knowledge that there is more to us than just our verbalizations.

INTERACTIONS WITH OTHER CORE PROCESSES

Perspective taking can be added to any other core process merely by touching it (e.g., "And notice who is noticing."). But there are other relationships among the core processes worth exploring.

Self and Present-Moment Processes

Self-work is inherently focused on helping the client develop flexible attentional processes applied to the present moment, and it is sometimes difficult to distinguish between present-moment work and self-as-context work. That is one reason they are organized together into a single response style within the psychological flexibility model. For the sake of simplicity, think of perspective taking as the psychological space in which simple awareness "emerges"; think of present-moment awareness as the voluntary shift of attention that allows one to come into second-by-second contact with life. Self as process is a kind of present-moment awareness, but the target is ongoing experience. Perspective taking facilitates these distinctions and the ability to move flexibly among them.

Self and Defusion and Acceptance

This same method can be used to leverage progress with perspective taking into areas requiring defusion or acceptance. For example, if the clinician is using ongoing awareness and perspective-taking exercises, content can be brought in that would normally cause avoidance or fusion, and it is much more likely that these results will not occur. For example:

> "And just notice these bodily sensations, and be aware for a brief moment that you are aware of them—they are not aware of themselves. And as you do that, form a thought in your mind and imagine seeing it far across a room, written on a piece of paper. You can barely read it. It says 'I'm a bad person.' Just leave it over there, and notice that the person aware of that thought and the words on the paper are not the same thing."

If that was helpful, the person could be asked to imagine walking over and looking at the paper, and then walking away again—all with dialogue that would help maintain a sense of perspective taking. The reverse is also true. Fusion or avoidance can sometimes be a trigger to come to the centered response style, especially when the client is failing to make progress. The rule "When in doubt, come home to the center" is a good one for beginning ACT therapists learning to do the therapeutic dance called ACT.

Self and Values or Committed Action

Valuing and committed action eventually bring the client into contact with psychological barriers. Often that requires shifting toward openness strategies, but sometimes just a brief contact with centering processes is enough to keep balance and maintain momentum.

Just as often, self-work naturally stimulates values and action work. It is no accident that many spiritual and religious traditions hold that a stance of awareness naturally leads to a state of compassion for self and others and a profound appreciation of the interconnectedness of all things. This observation may be true because attachment to the conceptualized self draws the person out of contact with the surrounding world. Humans are naturally social creatures, but the direction that a person's social vision takes is heavily influenced by social conditioning and cultural practices. In a state of attachment to the conceptualized self, the client is usually following socially inculcated plys and therefore does not make contact with closely held values. Making contact on a repeated basis with simple awareness very often opens a door into a different world where the client is free to follow benevolent motives toward him- or herself and others. This choice cannot be forced, but when it occurs it can be transformational. It is not uncommon for self-work to lead to very basic discoveries about the important of giving and receiving love. If the client has been holding his or her own awareness in abeyance—perhaps for fear of acting on it—what emerges during self-work leads naturally to values choices and their action implications. This change normally involves clarifying the person's values about marriage, intimacy, parenting, being a friend, and identifying specific actions the person can take to realize these connections.

THERAPEUTIC DOS AND DON'TS

Reinforcing the Problem

A key temptation confronting the therapist is the urge to join the client's language system and begin inadvertently reinforcing the conceptualized self. This tendency usually shows itself in the development of an excessive amount of logical, rational talk about why clients can't trust their thoughts, lack of self-confidence, and so on. In another form, clinicians or clients can become attached to stories about spiritual awakenings or awareness of the "now" and end up buying into a subtly comparative or fused sense of self (a kind of prideful attachment to how dedicated they are to being aware, "unlike others").

One way to counter this temptation is to focus on more experiential processes and their link to actual behavior change. The client may

misinterpret this process as well, however, and assume that the therapist's message is that happiness emerges once the client appears not to care about a particular version of the conceptualized self. It is important to reaffirm for clients and therapists alike that there is no secret formula that delivers happiness in any consistent way. The objective is to be present with what life gives us at any given point in time and to more toward valued behavior. Clients often turn back on themselves in their language and begin evaluating "how well they are staying at the board level"—as if this were something that could be achieved and never lost. In other words, experiences with the larger sense of self provide new opportunities for the problem-solving mode of mind to loop the client back into a spiral of fused self-evaluations (usually negative but sometimes positive). The ACT clinician should be watching for these subtle self-evaluation processes, which function only to provide more content for the conceptualized self.

Using Spirituality, Not Promoting It

For decades, the psychotherapeutic community has shunned spiritual practice as outside the purview of the therapist's office. Discussion of such issues was tantamount to a breach of the client's personal boundaries. Fortunately, this attitude is giving way to the realization that spirituality, in all of its many forms, is an essential element of vital living. While not always the case, spirituality usually requires, or enables, some form of perspective taking. There are plenty of religious writings in different cultures that deal with the problems of self-conceptualization and the advisability of seeking a deeper form of self-meaning. Religion got there first in the attempt to undo some of the damage of "eating from the tree of knowledge." We acknowledge that some clients or therapists may fall for the rule-governing aspects of religious doctrine, and this tendency may make the them more rigid. At the same time, we should not "throw the baby out with the bath water" and automatically assume that religious or spiritual practice is something we could never align our own practices with.

With these caveats in mind, it is important that the clinician avoid advocating any religious view per se. ACT is not about changing spiritual beliefs, but rather about initiating a process of identifying *what works for the client*. Although many ACT philosophies may be consistent with the messages of different religions, the clinician needs to focus on and emphasize the concept of workability for the client, not any particular belief system.

It is perfectly acceptable to use religiously based stories or terms that the client already connects with when working on issues of the transcendent self. For example, acceptance is much like grace in a Christian religious context, and that connection can be used to show how acceptance is a free, unearned, loving choice and not something that is earned by good

content. That connection may be made easily since *grace* comes from the word *gratis*, or *free*. Similarly, *confidence* comes from the same root word as *faith* and means "self-fidelity" or "self-faithing." For some clients it may be helpful to encourage the client to take actions of "self-faithing" rather than waiting for "confident" feelings to emerge (about the least self-faithing thing one can do).

The Multiproblem Client and Self-Obliteration

More seriously dysfunctional clients sometimes engage in a kind of self-fragmentation in an attempt to adapt to overwhelming personal trauma or chronic negative environmental stress. Such clients are victims of language-based processes designed to filter out the painful consequences of traumas or chronic distress. The destructive effects of trauma lie less in the event per se than in the escape and avoidance maneuvers that emerge to defend the client from the emotional impact traumas. The most destructive form of emotional avoidance that an individual can experience is a fragmentation of self as an ongoing process, which occurs through dissociation, suppression, or denial. In extreme cases, these fragments become attached to versions of the self as conceptualized content, and—voilà—seemingly different and pervasive behavioral patterns suddenly appear. Such clients often have a conceptualized self that evokes anxiety or fearfulness when exposed to present-moment experience. Chronically dysfunctional clients may also complain of numbness, a sense of boredom, emptiness, or a sense of impending darkness or self-annihilation. The client may communicate a fear that, when asked to be present with thoughts or feelings, some form of psychological death will occur. In metaphorical terms, the client fears falling into a black hole and never returning. Since self-as-perspective is not thing-like, it can appear to be literal nothingness or annihilation. In a sense the client is right because the observing self does annihilate the attachment to a conceptualized self. As mentioned earlier, ACT therapists often suggest that clients "kill themselves everyday," but it is the conceptualized self, not self-as-perspective, that needs to be continuously killed off (only to reemerge and be killed off again).

In ACT, there is no assumption that clients lack the ability to develop perspective taking or are incapable of developing a cohesive self-awareness. In dissociative disorders, for example, there is only one person in the room. The client's behavior is being affected by fragmented content about various conceptualized selves, disrupting his or her ongoing self-awareness of disturbing private content. What clients have in common is the indiscriminate occurrence of emotional avoidance strategies, regardless of whether they work in the client's life or not. The therapist can carefully observe the client's words and actions and work on bringing the client "into the room"

once rapport and safety have been established. We encourage the use of experiential and metaphorical exercises that undermine dissociative (i.e., avoidant) processes. These interventions can undermine the use of fragmentation as an emotional avoidance strategy and help the client build the "I" and a cohesive sense of self-awareness.

READING SIGNS OF PROGRESS

Ordinarily, work with the observing self is progressing well when the client reports a sense of observing (rather than being caught up in) private experiences. Clients in such instances use language that suggests they see themselves as separate from their mind. This development is particularly noteworthy when it occurs spontaneously, indicating that it comes out of the client's experience rather than mimicking something the therapist has been saying. Another critical sign at this stage is the ability to laugh at oneself in earnest. In Zen Buddhism, this ability is referred to as "the all-knowing smile". It really reflects the client's sense of amusement at how seductive self-related processes are—but from a point where this can be laughed at as a forgivable element of human nature. A great source of human suffering is the tendency to take ourselves too seriously, and taking oneself more lightly through the application of humor, irony, and paradox is generally a healthy life sign. Finally, these developments are all the more promising once the client begins using these centering processes spontaneously in his or her daily life.

CHAPTER 9

Defusion

> DANIA, Fla., June 16 (AP)—A 6-year-old girl was killed today when she stepped in front of a train, telling two siblings and a cousin that she "wanted to become an angel and be with her mother." … The authorities said … her mother … had a terminal illness.
>
> —*New York Times*, June 17, 1993

In this chapter, you will learn …

- How fusion with verbal content can lead to suffering.
- How to make clients aware of the limitations of language.
- How to target evaluative language that interferes with the capacity to experience directly.
- How to use nonverbal and experiential exercises to promote defusion.

PRACTICAL OVERVIEW

As the above-cited newspaper excerpt shows, even a 6-year-old can imagine that she would enter a better world after stepping in front of a train. "Because of *X*, if I do *Y*, it will produce *Z*, which is good." A 6-year-old can fill in those blanks. Doing so is necessary to verbal problem solving, but the problem-solving mode of mind does not know when to stop. It can readily change a human life into a problem to be solved instead of a process to be lived, even if it kills the person as a result!

The fundamental challenge of being human involves learning when to follow what your mind says and when to simply be aware of your mind while attending to the here and now. When we get "mindy," ongoing verbal analytical processes carry us away into what they are related to instead of what they *are*. We interact with thoughts as representations of the internal and external world, losing contact with thinking as an ongoing action

and thereby losing contact with the many other present sources of stimulation. This aspect of human experience is a 24/7 reality for us all. We all have "minds" that virtually never shut up and are continuously evaluating, comparing, predicting, and planning. The word machine humming in our heads is a powerful and useful tool, but it is also destructive when it mindlessly carries us away.

As we discussed in Chapter 3, fusion is the pouring together of verbal/cognitive processes and direct experience such that the individual cannot discriminate between the two. By its nature, fusion narrows our response repertoire in certain domains. When fused, we formulate a situation symbolically and then organize our behavior to fit the demands of the rules that we are programmed to follow. These rules are socially inculcated into us and thus appear to be the "normal, rational thing to do." The problem is that rule following overwhelms contact with the direct antecedents and consequences of behavior. In a fused state, a person can follow the same rule over and over again and never really recognize that the desired results are not occurring because each failure to achieve those results evokes even more rule following. Because verbal rules are so useful in so many domains, they become socially supported and selected as our preferred operating mode in most aspects of daily living. This creates a tendency for persons to habitually and automatically fuse with their word machine. If the process was voluntary and had to be "willed," we could elect to fuse or not, depending on the utility of doing so. Unfortunately—until one learns to make fusion a conscious choice—the process is not only automatic and habitual but also invisible. We do not typically get an "alert" from our language system that tells us we are too enmeshed with it.

When fusion is present, thinking regulates behavior without any additional input. When the situation involves distressing, unwanted private experiences, fusion almost automatically leads to experiential avoidance because, in a fused state, the person invariably follows rules that suggest these experiences are "unhealthy" and must be controlled or eliminated. Fusion makes it impossible for the person to simply witness the presence of unwanted thoughts, feelings, memories, or sensations. Left as an automatic process, fusion results in a stance that is the opposite of psychological openness.

In order to bring fusion under contextual control, ACT teaches clients how to separate ongoing cognitive process from its cognitive products. Metaphorically, this is tantamount to pulling the "human" (the listener) apart from the "mind" (the speaker). This intervention tactic is called "defusion"—an ACT neologism that means making closer contact with verbal events as they really are, not merely as what they say they are. (One occasionally sees the term spelled "diffusion" in the ACT literature, but this is because computer-based spelling checkers are altering the correct term

during manuscript preparation, and it is slipping by human proofreaders). Defusion does not eliminate verbal meaning—it just reduces its automatic effect on behavior such that other sources of behavioral regulation can better participate in the moment. The goal is to bring language to heel—not by making its form different but rather by changing its functions and bringing them under greater voluntary contextual control. Stated another way, the goal of defusion is learning to adopt a stance of voluntary cognitive flexibility. When fusion is safe and desirable, such as when curled up in bed reading a novel, the person can voluntarily engage in it without needless interruption. When fusion is not helpful, such as when dealing with a habitual stream of self-criticism, the person can voluntarily step back, separate from the mind, watch its ongoing processes ("I'm aware of thinking *X*"), and not be caught in its products ("I am a bad person"). Acquiring the ability to defuse takes practice, and that practice can only begin outside of the normal evaluative mode of mind. The comedic comment is right on target: "I used to think my brain was my most important organ—until I noticed which organ was telling me that."

ACT work is done almost entirely in a defused psychological space. For example, during the very first moments of the initial session when a client is talking about struggling with negative thinking, the therapists might say, "So, it sounds as if your mind is saying that … " This kind of verbal construction promotes defusion without any grand announcement of its purpose because it asks the client to look at his or her own thoughts as though they might be the verbal statements of others. The essence of the work is simply stepping back from the meaning of verbal processes and beginning to witness them from the point of view of an observer. The therapist models this stance repeatedly by using ACT-consistent talk. For example, the therapist might ask what else shows up, or what else is on that tape, or what else does the client's mind have to say, or how old is that thought, or where does that feeling show up in the person's body? These are all defusing interactions. They subtly change the rules of normal verbal interactions. Metaphors and exercises are also used. ACT therapists might ask clients to watch their thoughts drift by like leaves on a stream; troublesome thoughts might be sung aloud as if in an opera; they might be said very slowly or said in a Donald Duck voice or be put on the floor in one's imagination and given a color, size, shape, temperature, and texture. Mindfulness techniques might be used to allow thoughts to be noted nonjudgmentally and in the moment. Defusion can occur through metaphors, such as when thoughts are discussed as if they are colored glasses, or cartoon bubbles over one's head, or statements on our T-shirts. Defusion can occur just by talking about thoughts as thoughts, by asking a client if it is OK to have a difficult thought, or by arranging for the relationship between thoughts and behavior to be weakened through behavioral exercises.

Fusion is maintained by the relational contexts established within a social or verbal community: the demand for reason giving and storytelling, the demand for sensemaking, consistency, and coherence, and the demand for planning, reasoning, and problem solving. In ACT, the therapist's job is to undermine these contexts by speaking and acting in unexpected and nonliteral ways. Once we have helped the client establish some defusion skills, we can strengthen the process of stepping back from the mind when it is useful to do so. Fusion itself is not the enemy—it is just a function of language and is incredibly useful in the right circumstances. Similarly, defusion is not an end, in and of itself—it is just a useful skill to have at certain times in certain situations. ACT can help teach the client how to use this skill and how to distinguish when fusion is helpful and when it is not.

CLINICAL APPLICATIONS

A good way to undermine the client's confidence in language is by demonstrating its limits. Language is the one tool in the human toolbox that appears to be good for all jobs. The therapist's goal is to expose this as an oversimplification. Language and thought are useful mainly in solving problems in the external world; the subjective representational nature of verbal knowledge makes it a very dangerous force in the "world between the ears." Language has a very limited capacity to apprehend and decipher personal experience; however, we are taught from childhood onward that it is the grand tool for developing self-understanding. There are many ACT exercises that reveal the limitations of private verbal ("mental") behavior. Prior to initiating them, it is helpful to discuss the issue of minding with the client in a way that creates a new framework for these experiences. The following vignette provides an example of how this task might be accomplished.

> "You've probably guessed by now that I'm not a big fan of minds. It's not that I don't think minds are useful, it's just that you can't really live your life effectively between your ears. Minds evolved to give humans a powerful way of detecting threats to our survival; so, it is not surprising that a large percentage of mental content is negative, critical, or warning of danger. Your mind is doing what it is designed to do—but it's also giving you little room to breathe! So, in here we are going to have to learn how to back out of the chatter whenever that's most helpful. Your mind is not your friend, *and* you can't do without it. It's a tool to be used. We need to learn how to use it, but right now it's using *you*."

Being verbally knowledgeable and verbally right is powerfully and frequently reinforced within human culture. The arbitrariness of human language means that, once it is learned, it becomes relatively independent of immediate environmental support. The combination of these two factors leads to the indiscriminate overextension of language, often without the client's even being aware of it. The *Finding a Place to Sit* metaphor helps make this point experientially.

THERAPIST: It is as if you needed a place to sit, and so you began describing a chair. Let's say you gave a really detailed description of a chair. It's a gray chair, and it has a metal frame, and it's covered in fabric, and it's a very sturdy chair. OK, now can you sit in that description?

CLIENT: Well, no.

THERAPIST: Hmmm. Maybe the description wasn't detailed enough. What if I was able to describe the chair all the way down to the atomic level. Then could you sit in the description?

CLIENT: Client: No.

THERAPIST: Here's the thing, and check your own experience: Hasn't your mind been telling you things like the world is this way and that way, and your problem is this and that? Describe, describe. Evaluate, evaluate, evaluate. And all the while you're getting tired. You need a place to sit. And your mind keeps handing you ever more elaborate descriptions of chairs. Then it says to you, 'Have a seat.' Descriptions are fine, but what we are looking for here is an experience, not a description of an experience. Minds can't deliver experience—they just blab at us about what has just transpired. So, we'll let your mind describe away, and in the meantime you and I will look for a place to sit.

Another useful strategy is to appeal to the client's own experience in areas where words are not only insufficient but even detrimental. Some tasks are very well regulated by rules, such as finding one's way to the grocery store—go to the first stop light, turn left, and so forth. However, for some other activities, rules are not at all helpful. This awareness can be developed experientially by asking the client to explain motor actions during therapy. For example, if the client picks up a pen, the therapist can ask for an explanation of how this is done. When the explanation is given (e.g., "Reach for it with your hand"), the therapist can see if this works by telling his or her own hand to reach. Of course, the hand will not hear and will not reach. The behavior was nonverbal first and only then became verbally

governed. Yet, language itself claims to know how to do virtually everything, from reaching for a pen to developing a relationship. Verbal knowing rests atop nonverbal knowing so completely that an illusion is created that all knowledge is verbal knowledge. If we suddenly had all nonverbal knowledge removed from our repertoires, we would fall to the floor quite helpless!

Deliteralizing Language

Having made an initial assault on the limits of language as a stand-in for actual experience, the therapist needs to provide the client with the experience of language stripped of its symbolic functions. The *Milk, Milk, Milk* exercise (cited earlier, in Chapter 3) was first used by Titchener (1916, p. 425) to try to explain his context theory of meaning. It is a playful way to demonstrate that a literal, sequential, analytical context is required for language stimuli to have any literal (that is, derived) meaning.

THERAPIST: Let's do a little exercise. It's an eyes-open one. I'm going to ask you to say a word. Then you tell me what comes to mind. I want you to say the word *milk*. Say it once.

CLIENT: Milk.

THERAPIST: Good. Now what came to mind when you said that?

CLIENT: I have milk at home in the refrigerator.

THERAPIST: OK. What else? What shows up when we say "milk"?

CLIENT: I picture it—white, a glass.

THERAPIST: Good. What else?

CLIENT: I can taste it, sort of.

THERAPIST: Exactly. And can you feel what it might feel like to drink a glass? Cold. Creamy. Coats your mouth. Goes "glug, glug" as you drink it. Right?

CLIENT: Sure.

THERAPIST: OK, so let's see if this fits. What shot through your mind are things about actual milk and your experience with it. All that happened is that we made a strange sound—"milk"—and lots of these things showed up. Notice that there isn't any milk in this room. None at all. But milk was in the room as far as your mind is concerned. You and I were seeing it, tasting it, feeling it—yet, only the word was actually here. Now, here is a little exercise, if you're willing to try it. It's a little silly, and so you might feel a little embarrassed doing it, but I am going to do the exercise with you,

so we can be silly together. What I am going to ask you to do is to say the word *milk* out loud, rapidly, over and over again, and then notice what happens. Are you willing to try it?

CLIENT: I guess so.

THERAPIST: OK. Let's do it. Say "milk" over and over again.

[The therapist and the client say the word for 1 minute, with the therapist periodically encouraging the client to keep it going, keep saying it out loud or go faster.]

THERAPIST: OK, now stop! Where is the *milk*?

CLIENT: Gone. (*Laughs.*)

THERAPIST: Did you notice what happened to the mental aspects of milk that were here a few minutes ago?

CLIENT: After about 40 times they disappeared. All I could hear was the sound. It sounded very strange—in fact, I had a funny feeling that I didn't even know what word I was saying for a few moments. It sounded more like a bird sound than a word.

THERAPIST: Right. The creamy, cold, gluggy stuff just goes away. The first time you said it, it was as if milk was actually here, in the room. But all that really happened was that you said a word. The first time you said it, it was really meaning-full; it was almost solid. But when you said it again and again and again, you began to lose that meaning, and the words began to be just sounds.

CLIENT: That's what happened.

THERAPIST: Well, when you say things to yourself, isn't it also true that these words are just words? The words are just smoke. There isn't anything solid in them.

This exercise demonstrates quite quickly that it is not that hard to establish contexts in which the meaning of even familiar verbal processes can be significantly weakened. This exercise can also be done with a negative thought that is troubling a client if the thought can be shortened to a couple of words. For example, the sentence "I'm bad" can be said as rapidly as possible over and over for at least 45 seconds. Several studies have demonstrated that this word repetition exercise rapidly reduces the believability of negative self-referential thoughts and the psychological distress associated with them (e.g., Masuda et al., 2004, 2010; Masuda, Hayes, et al., 2009; Masuda, Price, et al., 2009). Clients often report that the emotion linked to a given word (e.g., *death*) decreases as an effect of repeated exposure—but emotion reduction is not the purpose of this exercise. We do not ask our clients to repeat again and again every word that triggers a

difficult emotion. This approach would be endless and probably not useful, as the verbal relation between these words and the actual painful events they refer to never totally disappear. Learning to see the direct stimulus functions of words does not eliminate their derived functions, nor would we want that to happen. This type of intervention *adds* to the functions (e.g., hearing the sounds of the words; feeling what it feels like to say them) and makes it easier to observe the *process* of verbal relations without fusing entirely with its products.

At ground level, human verbal intelligence is an interlocking system of ongoing relational actions. Other therapy models try to get the client to be properly skeptical about the truth of words (e.g., seeing and challenging irrational thoughts). In RFT terms, the emphasis is put on manipulating the relational context. Unfortunately, that approach may increase the functional context as well (e.g., thoughts may become even more important). ACT, rather, reveals the ongoing process of relating symbolically so that clients can see it for what it is. In RFT terms, the emphasis is put on manipulating the *functional* context. As that occurs, thinking often does gradually change (changing the functional context gradually alters the relational context for language)—but without much downside risk.

Thoughts as Passengers

Another way to defuse language is to objectify it, allowing thoughts to become things or people. Physical metaphors can be used to accomplish this objectification to great effect, since we naturally see external objects and other people as separate from ourselves.

The *Passengers on the Bus* exercise is a core ACT intervention aimed at deliteralizing provocative psychological content through objectification. It contains within it the entire psychological flexibility model.

> "It's as if there is a bus and you're the driver. On this bus we've got a bunch of passengers. The passengers are thoughts, feelings, bodily states, memories, and other aspects of experience. Some of them are scary, and they're dressed up in black leather jackets and they've got switchblade knives. What happens is, you're driving along and the passengers start threatening you, telling you what you have to do, where you have to go. 'You've got to turn left,' 'You've got to go right,' etc. The threat that they have over you is that, if you don't do what they say, they're going to come up from the back of the bus.
>
> "It's as if you've made deals with these passengers, and the deal is, 'You sit in the back of the bus and scrunch down so that I can't see you very often, and I'll do what you say, pretty much.' Now, what if one day you get tired of that and say, 'I don't like this! I'm going to throw

those people off the bus!' You stop the bus, and you go back to deal with the mean-looking passengers. Notice that the very first thing you had to do was stop. Notice now, you're not driving anywhere, you're just dealing with these passengers. Plus, they're real strong. They don't intend to leave, and you wrestle with them, but it just doesn't turn out very successfully.

"Eventually you go back to placating the passengers, to try and get them to sit way in the back again where you can't see them. The problem with that deal is that you have to do what they ask. Pretty soon, they don't even have to tell you to 'Turn left'—you know as soon as you get near a left turn that certain passengers are going to crawl all over you. Eventually you may get good enough that you can almost pretend that they're not on the bus at all. You just tell yourself that left is the only direction in which you want to turn! However, when they eventually do show up, it's with the added power of the deals that you've made with them in the past.

"Now, the trick about the whole thing is the following. The power that the passengers have over you is 100% based on this: 'If you don't do what we say, we're coming up and we're making you look at us.' That's it! It's true that when they come up they look like they could do a whole lot more. They've got knives, chains, etc. It looks like you could be destroyed. The deal you make is to do what they say so they won't come up and stand next to you and make you look at them. The driver (you) has control of the bus, but you trade away the control in these secret deals with the passengers. In other words, by trying to get control, you've actually given up control! Now notice that, even though your passengers claim they can destroy you if you don't turn left, it has never actually occurred. These passengers can't make you do something against your will."

The therapist can continue to allude to the bus metaphor during therapy. Questions such as "Which passenger is threatening you now?" can help reorient the client who is practicing emotional avoidance during the session.

In groups and during workshops, we have found that physical representations of this predicament are extremely effective. Several persons can be selected to represent different thoughts, emotions, sensations, or memories that the client has been struggling with. The "passengers" can be asked to line up behind the client, who is then instructed to name a valued life direction. That direction is then given concrete form (e.g., "So, over here is being with your children even though you have issues with your ex"). The client is asked to confront passengers one at a time and to note what they pull for. The audience members playing the specific thought

or feeling have often been selected because they understand something about it, and they are coached to express out loud how it is. If the driver wants to argue with the passenger, an argument is structured. After a few moments the leader may ask "Is this how it is?" and "How is this working?" or even "And what about your kids?" If the driver says that the passengers need to go away, the leader says, "Oh, they can … just turn this way and they won't be seen," and turn the driver away from the destination. By the time each passenger has been confronted, the driver may head backward and be even more frustrated. The process is then repeated. This time the driver puts a hand on each passenger's shoulder (as a symbol of connection to one's own history), hears each one out, and is asked to invite each one on board as an expression of willingness ("Is there room for this passenger?"). If that choice can be negotiated with each passenger, the driver then grasps an imaginary steering wheel and begins driving while the "passengers" begins threatening the client with feared obstacles. The goal of the passengers in this game is to get the client to let go of the steering wheel and begin to talk back or argue with one or more of them; the driver is asked to experience what it is like to drive with the chatter and with an eye on the road instead of fighting the chatter.

Having Thoughts, Holding Thoughts, Buying Thoughts

Mental activity in the form of thoughts, feelings, memories, images, and associated physical sensations is an ongoing aspect of being alive. The mind never stops feeding us material. However, we also have a built-in ability to *selectively attend* to mental products. If we did not, we would be paralyzed. We constantly attend to certain products and not others; it just happens instantaneously and naturally. It is part of our basic operating system. We can access it voluntarily if it suits a particular purpose by shifting attention from looking at the world *through* the lens of language (fusion) to looking at the verbal processes themselves.

The ACT therapist wants to help the client learn to distinguish between having a thought, holding a thought, and buying a thought. Having a thought is simply being aware of the presence of a psychological event (primarily thoughts, but also emotions, memories, images, sensations and so on, since all have verbal functions in an RFT sense). Holding a thought is the action of withholding judgment and evaluation while not attempting to manipulate the form of the verbal product. Buying a thought is moving into overidentification with the thought or fusing with it. In ACT, we train the client to have a thought and hold it *without buying it*. The notion of buying thoughts highlights the basic conundrum the client must face. The "problem" is not in the content of private events; the issue is not what the feeling is, what the thought says or what the memory is about. These

verbal processes are conditioned, arbitrarily applicable, historically determined events. The problem is that overidentification with the content of the product creates behavioral rigidity and inflexible attention. When the client buys representations of the world, the ongoing verbal process is hidden behind the content of thinking. The client has shifted attention from context (awareness of a process) to content (what the representation says). Normally, provocative private content is to blame for this important shift of attention. The concept of buying a thought metaphorically establishes this as a voluntary act, much as one buys a cup of coffee. When a client appears to be struggling with some life event, situation, or interaction, the therapist can elicit various aspects of the private content and ask, "So, what happened when you bought that thought (feeling, memory)?"

Phishing

Not all psychological content is created equal, and this observation explains why most people are able to shift their attention from minute to minute despite being bombarded by information from the mind. It is useful to establish the point with clients that some psychological topics are "hotter" than others. If therapists can teach clients to recognize the early warning signs that hot content is being dangled by the mind, they can take preventive measures. The process is much like the phishing done by Internet scam artists (Strosahl & Robinson, 2008).

THERAPIST: The initial ploy in phishing is actually quite simple: you are sent an e-mail message that results in a powerful emotional response on your part. For example, you are informed that someone appears to be using your credit card illegally. The e-mail message asks you to stop this illegal activity by submitting your Social Security number, credit card number, date of birth, driver's license number, or the like. Of course, this information will not be used to catch the culprit—it's so the scam artist can use your credit card or steal your identity. But in the negative emotion of the moment, people act impulsively and only later realize that the entire situation was a set-up. What if your mind sometimes acts like that 'phisher'? It can put an upsetting message in front of you and get you to impulsively attach to a thought, feeling, memory, or sensation. Your mind will tell you that what it has to say is the absolute truth and requires a response. Like the phisher on the Internet, your mind is pulling you in, based on the raw negativity of the "intelligence" you are being given. Once you are hooked, you are going to suffer!

CLIENT: So, how do I stop myself from being pulled in like you are talking about?

THERAPIST: Well, what would you do if you were being phished on the Internet? Slow down. Step back. Don't impulsively dive in on what your mind is feeding you. And, just like these Internet messages, see if you can notice the common qualities of these lures. They are often black-and-white, negative, provocative, urgent. They encourage you to avoid or drop out of your life in some way. You will often receive this bogus information in the form of 'I' statements, which create the impression that these are thoughts you've already bought into, when in fact this is just your mind speaking to you. The mind is not the same as you. You are the human being. Your mind is a verbal tool, not your master. But it is a very noisy servant and tricky to deal with at times.

Don't Go Dancing

Once a person enters a fused state, a "dance" starts. This dance often involves clients' engaging in ruminative processes that supposedly will help them "win" the battle with the mind. It goes much like the kid's game "Who Can Make the Biggest Number?" The mind will put a zero on the end of whatever number the client comes up with. A simple, easy-to-understand form of defusion is learning not to engage in minding. This approach requires clients to contact their direct experience of futility with such battles, much as in the early "creative hopelessness" stages of ACT (covered in Chapter 6).

THERAPIST: What you've told me so far is that when you really get going with your anxiety your mind starts to give you all kinds of stuff to chew on. But the more you chew on it, the more entangled you get. What does your experience tell you? Do you usually win this contest with your mind?

CLIENT: No way! I just go round and round with myself until I'm exhausted emotionally. That's the only time I can stop.

THERAPIST: So, doing this thing with your mind. … has this given you some hoped-for leverage or insight or a new approach for how to improve your life? Has it given you something useful over all these months of doing it?

CLIENT: The only thing it does is make me crazy! I've truly begun to question whether I have some mental problem that won't ever go away.

THERAPIST: So, actually, your mind is telling you that you might have some incurable mental problem. Sounds like it wants to dance with you right here, right now.

CLIENT: Yeah, it just slips these doozies in front of me and off I go!

THERAPIST: Well, you know, your mind is very bored, and it wants to go dancing because—for it—dancing is fun. Dancing is a big problem to solve. For you, dancing is hell.

CLIENT: Yeah, hell is a good word for what I feel like inside.

THERAPIST: So, you've explored this entire game … the whole complex of your mind's game with you. Your experience is that you never win; your experience is that dancing with your mind is like dancing with the devil. Your mind baits you over and over again in order to get you to dance with it. Do you need to get in there again and try to sort this thing out with your mind, or might you just respectfully decline the invitation to go dancing? I mean, you could step back and decline to get on the dance floor. It's your life, isn't it?

Practicing Mind Watching

Various meditative and mindfulness exercises are useful in helping the client acquire the skill of simply watching thoughts, feelings, memories, and the like. This type of practice can establish useful skills without learning them inside the provocative content the client is struggling with. Learning how to defuse is a general skill; so, it is perfectly OK to first practice on more innocuous content. The *Soldiers in the Parade* exercise and its variants (i.e., *Leaves on a Stream*, *Watching the Mind Train*) are designed to help establish this critical skill and to help clients distinguish between fusion and defusion so that they can get a better sense of what it feels like to be hooked.

THERAPIST: I'd like us to do an exercise to show how quickly thoughts pull us away from experience when we buy them. All I'm going to ask you to do is to think whatever thoughts you think and to allow them to flow, one thought after another. The purpose of the exercise is to notice when there's a shift from looking *at* your thoughts to looking *from* your thoughts.

I'm going to ask you to imagine that there are little people, soldiers, marching out of your left ear and marching down in front of you in a parade. You are up on the reviewing stand watching the parade go by. Each soldier is carrying a sign, and each thought you have is a sentence written on one of those signs.

Some people have a hard time putting thoughts into words, and they see thoughts as images. If that applies to you, put an image on each sign being carried by the soldiers. Certain people don't like the image of soldiers, and there is an alternative image I have used in that case: leaves floating by in a stream. You can pick the image that seems best for you.

CLIENT: The soldiers seem fine.

THERAPIST: OK. In a minute I am going to ask you to get centered and begin to let your thoughts go by written on placards carried by the soldiers. Now, here is the task. The task is simply to watch the parade go by without having it stop and without you jumping down into the parade. You are just supposed to let it flow. It is very unlikely, however, that you will be able to do this without interruption. And this is the key part of this exercise. At some point, you will have the sense that the parade has stopped, or that you have lost the point of the exercise, or that you are down in the parade instead of being on the reviewing stand. When that happens, I would like you to back up a few seconds and see if you can catch what you were doing right before the parade stopped. Then go ahead and put your thoughts on the placards again until the parade stops a second time, and so on. The main thing is to notice when it stops for any reason and see if you can catch what happened right before it stopped. OK?

CLIENT: OK.

THERAPIST: One more thing. If the parade never gets going at all and you start thinking "It's not working" or "I'm not doing it right," then let that thought be written on a placard and send it down into the parade. OK? Now, let's get comfortable, close your eyes, and get centered. (*Takes the client through a centering exercise for 1 or 2 minutes.*) Now, allow the parade to begin. You stay up on the reviewing stand and let the parade flow. If it stops or you find yourself in it, note that, see if you can notice what you were doing right before that happened, get back up on the reviewing stand, and let the parade begin to flow again. OK, let's begin … Whatever you think, just put it on the cards. … (*for about 2 to 3 minutes, allowing the client to work*).

Be sure to allow clients enough time, and use very few words. Try to read the client's reaction, and observe for other cues, adding a few comments as needed, like "Just let it flow, and notice when it stops." Don't dialogue with the client. If the client's eyes open, calmly ask that they be closed and the exercise be continued. If a client starts to talk, gently suggest that that

thought be put on a placard, saying something like "We will talk more about this when the exercise is finished, but for now there is no need to talk with me. Whatever you think you want to say, let that thought be written down and let it march by, too."

THERAPIST: OK, now we will let the last few soldiers go by, and we will begin to think about coming back to this room (*helping the client reorient for 1 or 2 minutes*). Welcome back.

CLIENT: Interesting.

THERAPIST: What did you observe?

CLIENT: Well, at first it was easy. I was watching them go by. Then I suddenly noticed that I was lost and had been gone for about 15 seconds.

THERAPIST: As if you were off the reviewing stand entirely.

CLIENT: Right. The whole exercise had stopped.

THERAPIST: Did you notice what had been happening right before everything stopped?

CLIENT: Well, I was thinking thoughts about how my body was feeling, and these were being written on the cards. And then I started thinking about my work situation and the meeting with the boss I have on Friday. I was thinking about how I might be anxious telling him some of the negative things that have been going on, and next thing you know it's a while later and I'm still thinking about it.

THERAPIST: So, when the thought first showed up—"I'm going to be meeting with the boss next Friday"—was that thought written on a placard?

CLIENT: At first it was, for a split second. Then it wasn't.

THERAPIST: Where was it instead?

CLIENT: Nowhere in particular. I was just thinking it.

THERAPIST: Or it was just thinking you. Can we say it that way? At some point you had a thought that hooked you. You bought it and started looking *at* the world *from* that thought. You let it structure the world. So, you started actually working out what might happen, what you will do, and so on, and at that point the parade has absolutely stopped. There is now no perspective on it—you can't even see the thought clearly. Instead, you are dealing with the meeting with the boss.

CLIENT: It was like that. It was.

THERAPIST: Did you get that thought back on the placard?

CLIENT: Well, at some point I remembered I was supposed to let the thoughts flow, so I wrote the thought out and let a soldier carry it by. Then things went OK for a while until I started thinking that this whole exercise is kind of silly.

THERAPIST: And did you just notice that thought, or did it think you?

CLIENT: I bought it, I guess.

THERAPIST: What happened to the parade?

CLIENT: It stopped.

THERAPIST: Right. And check and see if this isn't so. Every time the parade stopped, it was because you bought a thought.

CLIENT: It fits.

THERAPIST: I haven't met anyone who can let the parade go by 100% of the time. That is not realistic. The point is just to get a feel for what it is like to be hooked by your thoughts and what it is like to step back once you're hooked.

It is useful to have clients engage in daily practices designed to strengthen the posture of having and holding private experiences. This type of exercise might include having the patient practice 5 minutes of deep breathing three or four times a day with the goal of simply noticing what shows up in between the ears. The *Soldiers in the Parade* exercise can be recorded and practiced nightly. Clients can make daily ratings of the degree to which they were "mind watching" and write down what they noticed, much like the bird watcher who keeps a log of each new species observed. These will help establish a posture of dispassionate curiosity—one of the hallmarks of defusion.

Naming the Mind

When the client comes to realize that human minds emit a more or less constant stream of evaluative "chatter," we can begin to pit the interests of the mind against the interests of the person. It can help just to name the evaluative problem-solving mode of mind as if it were a person. Some therapists whimsically ask clients to give it a name, which is then used for the rest of therapy (e.g., "What does Bob have to say about that?" or "So, has Bob been throwing a tantrum since you've taken these steps forward?"). *Treating the mind almost as though it were a separate entity is a very powerful defusion strategy.*

If naming the mind does not seem to fit the client's personal style, it could be given a descriptive label such as the "Reactive Mind" (as was

done in Strosahl & Robinson's [2008] *Mindfulness and Acceptance Workbook for Depression*). The therapist can then say things like "So, what was your reactive mind bullying you about this time around? Who am I talking to right now—you or your reactive mind?" This helps the person create some healthy distance between the thought and the thinker and makes it possible to step back from the issues that having a mind creates. The other benefit of labeling the analytical, evaluative aspects of mental activity is that eventually the therapist will propose that there are other aspects of mind that are vastly more helpful, and using these labels will help the client make needed distinctions between different modes of minding.

The *Take Your Mind for a Walk* exercise can provide a powerful experience of how busy, evaluative, and obstructionistic the mind can be. In this exercise, the therapist goes for a walk with the client. The goal is for the client to simply walk at whatever speed and in whatever direction the client desires. There is no destination set; it is just an exercise in random walking. The client is to play the "human," and the therapist will play "the mind." While walking, the therapist verbalizes the sort of evaluative second-guessing chatter that the client gets from his or her mind on a daily basis. Often, it is helpful for the therapist to use provocative content or distressing themes that have arisen in therapy. The goal for the client is to keep walking despite this steady stream of negative chatter. If the client stops or tries to talk back to the mind, the therapist immediately says, "Never mind your mind!" This is a signal that the client has been pulled into the distressing content and needs to defuse from this content and just keep walking.

Undermining Reasons

A particularly burdensome class of sensemaking is called "reason giving." At the situational level, reasons are often used by the client to offer social justification for some undesirable action or lack of action (e.g., "I didn't go to work today because I was too depressed"). These self-generated rules tend to combine to create a "self-story" with a predictably negative effect. Situation-specific reasons often create the impression of a causal link between private states of mind (e.g., depression) and observable behaviors (e.g., not going to work)—missing the context that has established these links between psychological actions. Self-stories function like metarules and force large patterns of context and behavior into a self-sustaining cognitive network. Clients often come in with elaborate descriptions of things that have happened in their lives that have left them somehow broken and unable to move forward, for example.

It is helpful to sensitize the client to the pernicious effect of verbal reason giving. It is one thing to deliteralize single words and play interesting

games with the client's verbal operating system, but it is quite another to step back from well-worn, treasured stories of how life has removed all opportunity for the client's living a vital, meaningful life. Defusing "reasons" and self-stories are particularly important for clients who continually use insight into, and understanding of, past history in ways that are self-defeating.

During sessions, clients often try to explain the cause of their problems or begin citing personal history as a reason why things can't change. There is no point in directly challenging the accuracy of the story or trying to identify life events that run contrary to the story in the effort to arrive as a better life story. Instead, the therapist can best undermine this behavior by focusing attention on its functional utility rather than its truth. It can be helpful to ask things like this:

- "And what is that story in the service of?"
- "And does that description of your past help you move ahead?"
- "Is this helpful, or is this what your mind does to you?"
- "Are you doing a solution, or is this just your way of digging?"
- "Have you said these kinds of things to yourself or to others before? Is this old?"
- "If you've said this before, what do you think will be different now by saying it again?"
- "If God told you that your explanation is 100% correct, how would this help you?"
- "OK, let's all have a vote and vote that you are correct. Now, what?"

The following transcript demonstrates how the ACT therapist uses various interventions to undermine reason giving with a client who is struggling with urges to relapse into drug use.

THERAPIST: So, let's do an exercise. Tell me why you used [drugs] last Tuesday.

CLIENT: (*pause*) Well, I was mad about that stuff that happened at work.

THERAPIST: Why else?

CLIENT: Well, I don't know, I suppose I don't have any support group. You know, to talk about this stuff.

THERAPIST: OK, why else? I mean, those sound like really true reasons. Could you give me some fake reasons?

CLIENT: What do you mean?

THERAPIST: You know, make some up. What reasons could you make up?

CLIENT: Someone forced me to do it?

THERAPIST: Why else?

CLIENT: I accidentally took the pills thinking they were aspirin.

THERAPIST: OK. Can you imagine anyone giving these reasons?

CLIENT: Sure.

THERAPIST: Probably several of them in combination. And if you asked several people—Mom, Dad, you know—you'd get a whole list of reasons. And some might even contradict one another. Hmmm. Something is suspicious here, if the reasons are actually causing you to do things.

CLIENT: What do you mean?

THERAPIST: Well, what about the reasons you just used?

CLIENT: Because of work, you mean?

THERAPIST: Sure. Right. But has anything bad ever happened at work like that when you didn't use?

CLIENT: Well, yeah.

THERAPIST: But if the reason caused it, why didn't you use then?

CLIENT: Well, there were other reasons not to use.

THERAPIST: And they were somehow stronger than the other reasons, right? But here's the suspicious part: what if I asked if there were reasons not to use last Tuesday. Could you think of any?

CLIENT: Sure, I mean, of course.

THERAPIST: Like if we did that exercise again, you know, good reasons, bad reasons, Mom's reasons, Dad's, smart reasons, goofy reasons, you know … well, could you have given equally long lists for each perspective?

CLIENT: Mmm, well, it might take a while.

THERAPIST: Say, we tried it right now. Could you tell me a reason to use? I mean, sure you could, and if I asked for a reason not to, you could come up with those too. And do you suppose that for any reason to use, you couldn't also come up with a reason not to?

CLIENT: Well, sure.

THERAPIST: And I'll bet you've done that too. Sat and thought of lists of reasons why to and not to … and then you either used or you didn't. And where did all the reasons on the opposite side go, once you picked a direction? What if it's the case that we just have this infinite storehouse of reasons that we can draw on for whatever we do. Could it be? And could it be that, although these things go together a lot—doing and giving reasons for doing—that one

doesn't really cause the other. My guess is that you have been trying to generate enough reasons—really good ones—in order to cause yourself to not use. I mean, isn't it really true that you've got some really powerful reasons to stop using? Why else would you be doing this excruciating therapy? I mean, you have great reasons! Could you imagine any stronger reasons than getting your kids back?

CLIENT: Well, no.

THERAPIST: So, isn't this suspicious? You've believed that you do this and that for *X* and *Y* reasons. But here we have just uncovered two pieces of evidence that this isn't how it works! One is we seem to have an unlimited supply of reasons and, two, you've already got about the most powerful reasons imaginable for not using and you still used!

Some of this looks superficially like traditional cognitive methods, but it is worth noting how even in those areas the ACT therapist keeps coming back to the function rather than the form of cognition. The point in attacking reason giving is not to do away with reasons, nor should the therapist browbeat the client about the arbitrary nature of reason giving and sensemaking. As a human being, the client will always develop reasons, and sometimes they might actually be useful. In the world outside the skin, developing reasons for events is the crown jewel of the problem-solving mode of mind. It pays off handsomely when applied to the right situation. At this juncture, we merely want the client to be aware of this verbal process as a process and to have and hold the reason, much like having and holding an evaluation, emotion, or memory.

Disrupting Troublesome Language Practices

A number of verbal conventions used in ACT are designed to disrupt well-formed language practices and simultaneously to create some distance between the client and the client's mind. These verbal conventions replace common ways of speaking that foster problems of various sorts. In RFT terms, these are relational context manipulations focused on generic cognitive forms that determine the functional impact of specific cognitions.

Be Out

A major target of the assault on normal verbal conventions is the client's use of the word *but*. *But* is commonly used to specify exceptions, carrying with it an implicit statement about the organization of psychological events. Consider the statement "I want to go but I am anxious." This simple

statement carries a deep message about the role of feelings in human action and points to a conflict. Two things are present: wanting to go and anxiety. Furthermore, although wanting to go would normally lead to going, anxiety seems to cancel this effect of wanting to go. Going cannot occur with anxiety.

The etymology of the word *but* reveals this dynamic quite clearly. The word is from the Old English "be-utan," meaning "on the outside, without." In Middle English this became "bouten" and was gradually phonetically weakened to *buten*, *bute*, and thus *but*. The Old English word *be-utan* is itself a combination of "be"—meaning something like the modern word *be*—and "utan," which is a form of "ut"—an early form of our modern word *out*. Etymologically speaking, *but* means "Be out." It is a call for whatever follows the word to go away or else threaten whatever preceded the word. It says two reactions that coexist cannot coexist and still be associated with effective action. One or the other must go. The difficulty we experience with clients who have finely tuned "yes, but" language responses nicely demonstrates how paralyzing this posture can be. In ACT, using the word *but* is attacked directly. The therapist should introduce a verbal convention that substitutes the word *and* for the word *but* when *but* artificially creates a relationship of opposition between emotions or thoughts, on the one hand, and some other emotions, thoughts, or even actions, on the other hand.

THERAPIST: I would like for us to try something different when we are talking together. I'm going to ask you to use the word *and* instead of the word *but* when you form a sentence. This may seem a bit awkward at first, and you may notice that you have to slow your thinking down to make sure you are not slipping in a *but*. Don't worry, though, if one does slip through—I'll stop you and have you use the word *and* in its place.

CLIENT: Why are you doing this? It seems kind of weird.

THERAPIST: Most of the time, we don't even think about the words we are using. *But* is a good example. We just throw it in the mix whenever there is a pause or we don't quite know whether we are willing to go somewhere or do something. I'm interested in hearing how changing from *but* to *and* affects the feel of our conversation for you. At another level, I guess we could say that I'm going to help you get off your *but*s.

This is a convention that greatly opens up the verbal and psychological perspective within which clients and therapists can work. *And* is a descriptive, not a proscriptive term, and thus can be associated with many courses of action. All possibilities are open. It is safe for the client to notice and report even the most undesirable reactions since there is no need for

desired reactions to somehow vanquish them. "I love my husband, *but* I get so angry with him" can make anger a very dangerous feeling for someone committed to a marriage. "I love my husband, *and* I get angry with him" carries little such threat, and in fact, implies an acceptance of the experience of anger within the experience of love. *And* is also more experientially true since many thoughts and feelings can occur within an individual. *And* makes sense whenever the process of thinking and feeling itself is at issue since whatever was observed and noted was, after all, observed.

Evaluation versus Description

Evaluations present an especially thorny fusion problem. Distinguishing between evaluation and description is critical because most clients enter therapy fused with evaluations about personal history, current situations, events, or interactions. The most provocative evaluations, and the ones clients are most likely to fuse with, involve four polarities: good versus bad, right versus wrong, fair versus unfair, and responsibility versus blame. Many evaluative thoughts that clients exhibit in therapy are self-referential. "I am broken, defective, bad," or similar such pejorative statements are common.

Held as truths, these evaluations become toxic for the client. They are not seen as evaluations but rather as descriptions of the essence of the situation or person to which they are applied. There is no way to wiggle off the hook that is set in this way. If you are a "bad person," the only way you can correct this is to end being a person altogether. Unfortunately, some of our clients do just that! Therefore, it is important to insert a wedge into the verbal process of evaluation such that the client can step back and differentiate intrinsic properties from properties that are injected by the mind.

Even superficial probing often reveals that clients are responding to their own self-evaluations as if they were descriptions. Our language makes almost no distinction between the primary properties of events themselves and the secondary properties that are injected by the responder. This creates a significant problem. Not only is the client fusing with verbal products, but also the fusion itself confuses primary properties and injected properties. Incidentally, this process, as extended to the societal level, makes it possible to justify killing people of various religious backgrounds because, for example, they are "all terrorists." The *Bad Cup* metaphor can be employed to show how evaluations can masquerade as descriptions.

> "There are things in our language that draw us into needless psychological battles, and it is good to get a sense of how that happens so that we can learn to avoid them. One of the worst tricks language plays on us is in the area of evaluations. For language to work at all, things have to be what we say they are when we're engaging in the kind of talk that

is naming and describing. Otherwise, we couldn't talk to one another. If we describe something accurately, the labels can't change until the form of that event changes. If I say 'Here is a cup,' I can't then turn around and claim it isn't a cup but instead a race car unless I somehow change the cup. For example, I could mash it into raw materials and use it as part of a race car. But without a change in form, this is a cup (or whatever else we agree to call it)—the label shouldn't change willy-nilly.

"Now consider what happens with evaluative talk. Suppose I say, 'This is a good cup' or 'This is a beautiful cup.' It sounds the same as if I were saying, 'This is a ceramic cup' or 'This is an 8-ounce cup.' But are they *really* the same? Suppose all the living creatures on the planet die tomorrow. This cup is still sitting on the table. If it was 'a ceramic cup' before everyone died, it is still a ceramic cup. But is it still a good cup or a beautiful cup? Without anyone around to have such opinions, the opinions are gone because good or beautiful was never a built-in part of the cup. *Beautiful* is the word produced in the interaction between the person and the cup. But notice how the structure of language hides this difference. It looks the same, as if 'good' is the same kind of description as 'ceramic.' Both seem to add information about the cup. The problem is that if you let *good* be that kind of descriptor, it means that *good* has to be what the cup is, in the same way that *ceramic* is. That kind of description can't change until the form of the cup changes. And what if someone else says, 'No, that is a terrible cup!' If I say it is good, and you say it is bad, there is a disagreement that seemingly has to be resolved. One party has to win, and one party has to lose: both can't be right. On the other hand, if *good* is just an evaluation or a judgment, something you're doing with the cup rather than something that is in the cup, it makes a big difference. Two opposing evaluations can easily coexist. You could think the cup is beautiful, and I could think it looks awful. The fact that we have different opinions does not create some impossible state of affairs in the world—like claiming the cup is both ceramic and metal at the same time. Rather, this reflects the simple fact that events can be evaluated as good or bad depending on the perspective taken by each person. And, of course, it is possible that one person could take more than one perspective. On Monday, I thought the cup looked awful. On Tuesday, I had a change of heart and thought it was beautiful. Neither evaluation is a concrete fact; neither needs to win out over the other."

Cubbyholing

Sometimes it is useful to interrupt the ongoing flow of a conversation to call out the various elements of the verbal operating system as they make

their appearance. This practice has the effect of dropping the client out of the world of content and into the world of verbal process. In cubbyholing, the therapist labels the *kind* of verbal product that the client is producing rather than responding to the content of the product. Descriptions, evaluations, feelings, thoughts, memories, and the like can simply be labeled as an aside, and the conversation can continue.

Once this process is well understood, the client can be asked to do the labeling as part of the normal conversation itself, not as an aside. For instance, a client might restate the phrase "I'm a bad person" as "I'm a person and I'm having the evaluation that I'm bad." "I'm anxious" is restated as "I am having the emotion called anxiety." "I'm terrified of this memory" is restated as "I am a person who is having a memory of being abused by my father, and the emotion I'm experiencing is fear." By its very awkwardness, this language change helps break apart the verbal process and the corresponding verbal product. We are literally prying apart the thought and the thinker via the same operating system that produces the fusion of thought and thinker in the first place.

In this section we have given a few examples of defusion strategies, but ACT therapists and their clients have generated hundreds more in the process of therapeutic work. It is easy to acquire scores more in the rapidly growing ACT literature, but they are also easy to generate once you see the principles involved. Slow down the automatic use of language products, and instead derive nonanalytic methods that enable the client to see their form, appreciate their nature, and examine their utility. The normal contexts of sensemaking, literal meaning, reason giving, and problem solving can be changed in therapy by altering their paralinguistic contexts (i.e., noting the limitations of language, establishing different kinds of observations, and creating paradoxes). In short, the therapist can break the rules of the language game and establish new ones inside therapy.

INTERACTIONS WITH OTHER CORE PROCESSES

Defusion and Acceptance

It is not uncommon for defusion work to lead to acceptance work. That progression is more likely to occur when provocative private content is at issue. For example, the *Take Your Mind for a Walk* exercise can sometimes be upsetting to the client if the therapist is using salient therapy material during the walk. The therapist could gently instruct the client to make room for some distressing thought and not attempt to evaluate or change the thoughts in any way during the walk. If the client has previously exhibited low levels of acceptance, it is a good idea to titrate the provocation level. Since acceptance of distressing content is measured by its quality, not quantity, it is OK to practice defusion with content that is less evocative.

The therapist needs to take a measured approach here; otherwise, the client's lack of acceptance will also inhibit the client's ability to learn new defusion skills.

Defusion and Self or Present-Moment Processes

When defusion is being practiced with highly provocative personal material, the therapist might notice that the client is "zoning out," is looking down or away, seems emotionally nonresponsive, or is "pie-eyed." These are signs that the client might be slipping out of the present moment in the service of avoiding contact with distressing content. If this happens, the therapist can move into the present moment or a perspective-taking sense of self. For example, the therapist might gently ask, "What just showed up for you? Can you get back in the room with me for a minute? Can you stay right here, right now, with me?" It is OK to slow the process down and just wait for the client to acquire some balance.

Defusion and Values or Committed Action

Most of the time, problems with fusion convert into various forms of valueless activity and behavioral avoidance. As we mentioned earlier, one of the main impacts of fusion is that it overregulates flexible, engaged action. When the goal is to avoid triggering or to control distressing content, there is almost an inevitable impact of expansive forms of behavior. Thus, having the client connect with personal values and desired actions can function as a "back door" into defusion. Connecting with personal values and identifying specific actions to be taken sets the stage for real-life practice with defusion strategies. In these situations, defusion does not need to be understood intellectually—it is a way of loosening the grip of the problem-solving mode of mind so that values can better be pursued—but rather it is experienced behaviorally. The client is exposed to valued life situations and actions that trigger unwanted distressing content. Defusion strategies can be practiced *in vivo,* and by doing so the value of defusion strategies will then be more readily apparent to the client.

THERAPEUTIC DOS AND DON'TS

Being Literal about Defusion

The biggest challenge faced by the therapist promoting defusion is to enter the client's language system while maintaining awareness of it as a language system and to avoid the many invitations to fuse with the system. Practically speaking, therapists cannot use words to convince clients to defuse; at the same time, they must show clients how to defuse via a conversation that is

based on words. The hope is that the client's direct experience with defusion will overcome the seeming illogic of these moves. It is easy to get lost in this process. A key sign of trouble is the therapist's beginning to overuse logic with the client. Of course, logic is a language-based operation, and so it is highly likely that the use of logic will only feed the client's existing verbal system. Although it is necessary to use words to conduct therapy, we generally like to see them embedded in metaphors and used to support direct experiential exercises.

A variant of this issue arises when clients get interested in the logic of defusion. After real gains have been made with defusion, it might be safe to have such a conversation; before that time, it is a dangerous conversation to be lured into. Fused stories about what defusion is and how to do it are still a form of fusion and can even trigger negative content. Actions like repeatedly explaining defusion to the client, trying to convince the client of the need to defuse, or just talking *about* defusion rather than demonstrating it via experiential exercises and metaphors signal danger.

Metaphor Abuse

Equating the use of metaphors with conducting ACT is the flip side of the foregoing problem. Although ACT has specific techniques and strategies, the therapist has to be sensitive to the context of each session and then pick and choose what is most likely to work. Cramming five or six metaphors into a session without a context is often just as useless as using logic to convince the client to defuse. With new ACT therapists, it is common to see the therapist using techniques without attending to the functions of the client's verbal behavior. The client does not necessarily relate to what the therapist is doing whenever the therapist rambles on with multiple metaphors and exercises. Done properly, ACT is about *connecting* with the client, seeing the client's particular forms of fusion and avoidance, and tailoring metaphors and exercises to destabilize those forms. Of course, the therapist is always welcome to develop new metaphors or exercises based on the client's history, personal struggles, preferences, and the like.

Humor Rather Than Derision

Defusion is counterintuitive, often ironic, and paradoxical. For these reasons, many defusion exercises use humor (e.g., saying difficult thoughts in silly voices). While humor adds power to defusion methods, it needs to be timed and presented in such a way that the client does not feel ridiculed. The point is not to make fun of difficult thoughts or make fun of the client for having them. The point is to liberate the client from the death grip of language and cognition. There is genuine humor in the incongruity of

words trapping human beings, but liberation will not be encouraged by judgmental and derisive "humor." If the therapist is unsure of how to time or apply a humorous communication, it is advisable to address a less provocative issue that the client has been struggling with.

Defusion for the Sake of Defusion

As we noted earlier in this chapter, fusion itself is not a bad thing—nor is defusion always a good thing. This perspective suggests that it is important to pick the right targets for defusion, especially during the initial stages of treatment. Defusion methods works best in the context of valued goals or actions that are inhibited because of barriers created by the overextension of normal language processes. If a painful thought, feeling, memory, or sensation does not seem to be functioning as a barrier, there is no reason to see fusion as an issue. For example, if a victim of domestic violence is involved in another unsafe relationship, defusion from the word *safe* might actually be harmful for the client. What functions as a barrier—and thus as a target for defusion—however, cannot be determined just on the basis of positive or negative content. Defusion from the words *I'm great* might be just as liberating as from the words *I'm bad* if positive self-affirmations have a repertoire-narrowing function with a given client.

READING SIGNS OF PROGRESS

When work on defusion is successful, conditioned private reactions are seen as less compelling. Sacred cows such as "urges to drink," "suicidal impulses," or "obsessive thoughts" seem a lot less mysterious and romantic when this shift occurs. Generally there are two distinctive markers that suggest the client is acquiring these skills. First, the client is spontaneously recognizing troublesome reactions. The client may stop in the middle of a therapeutic interaction and say, "I'm making up reasons right now," or "I just noticed I was thinking 'I'm bad.' " The client appears to be noticing reactions at the level of an observer rather than at the level of a person fused to those reactions. A second marker of progress is the "feeling in the room." Defused psychological spaces feel lighter, more open, more ambiguous, more relaxed, and more flexible. Because these changes emerge over time, sticking with defusion work demands a certain amount of faith on the part of the therapist because of the lag time between intervention and observed impact. It often takes some time for clients to "get it," but when they do the therapy process tends to accelerate.

CHAPTER 10

Acceptance

We can't control the wind; we can only adjust the sails.
—POPULAR SAYING

In this chapter, you will learn . . .

- How experiential avoidance results in psychological rigidity and acceptance promotes flexibility.
- The qualities of acceptance that make it a powerful clinical tool.
- How to use metaphors and exercises to teach the client willingness.
- How to use in-session exposure to promote acceptance.
- How to make the shift from in-session acceptance to real-world acceptance.

PRACTICAL OVERVIEW

Almost everyone has read or heard the famous serenity prayer commonly used in 12-step programs:

> God grant me the serenity to accept the things I cannot change,
> the courage to change the things I can,
> and the wisdom to know the difference.

The reason this simple prayer is so widely known is that it addresses a basic conundrum of our daily existence. What do we do when life delivers us the "slings and arrows of outrageous fortune"? How do we deal with the pain of birth, death, divorce, rejection, illness, and myriad other life

events we have no control over? How to proceed in the face of such pain is an important question that each of us faces over and over again in the process of pursuing a vital life. This prayer says it takes a certain kind of "wisdom" to live life well. We must learn what can be controlled and what can't and then redirect our energy accordingly. The fact that some things can't be controlled is a hard pill to swallow because, by inference, we are left to "swallow" the private impact of these things. It takes courage to exercise control when we can because this too can create distressing private content. So, it takes both wisdom and courage to live a vital life, and our culture offers little guidance on how to do this.

As we discussed in the previous chapter, fusion "fuels" avoidance and makes acceptance difficult, if not impossible. This is because fusion creates the illusion that experiences are what they say they are. Our emotions, thoughts, images, and memories become thing-like and verbally accessible. Consider emotion. Of all the private experiences that go into being human, emotions are among the most heavily evaluated private experiences we have. This makes sense because the evaluative terms applied to emotion help give them conventional functions with a conventional valence, allowing emotional talk to express our needs and wants to others. Walk into a room full of people and declare "I'm thirsty," and you are likely to mobilize almost immediate social support in accessing water. Emotions set people into motion—as the very etymology of the word suggests—and evaluation suggests the conventional direction that this motion should take. Unfortunately, these evaluations do not serve social functions alone—they also encourage struggle with the internal world. If anxiety is "bad," it presumably should be gotten rid of.

When distressing content shows up, the person has an immediate choice as to what stance to take. Some immediate ways to "feel better" are to escape, avoid, or attempt to suppress the unwanted private event. The immediate relief associated with escaping an aversive emotion, situation, or interaction is such a powerful reinforcer that almost all human beings are experiential avoiders to some extent. Human behavior is controlled by immediate contingencies, even if the long-term effects are dismal. Experiential avoidance is a clear example of precisely this kind of behavioral trap.

The Impact of Avoidance

There are three notable costs of experiential avoidance. First, diminishing contact with how the present connects with our history diminishes our experiential intelligence. Remaining in contact with our history makes our own actions more sensible, creating a context that enables us to read what is working and what is not. For example, it is not *bad* when a person

with a history of sexual or physical abuse feels nervous in circumstances that evoke memories of the abuse. Properly handled, such nervousness is a major way to avoid any additional abuse and also to connect with how deeply one values trusting and respectful relationships. Naturally, such feelings are a challenge. The person may feel anxious with even healthy intimacy, for example. But if the person tries to remove or escape these feelings, he or she risks entering additional abusive relationships, on the one hand, or being unable to have meaningful relationships, on the other. Paradoxically, when these feelings become overemphasized as content, that is precisely when they can no longer be used sensibly to guide behavior.

The second cost of avoidance is that we may not even be aware that we are avoiding, which in turn means we have no opportunity to consider whether or not avoidance is what we really want. Clients with severe trauma histories and dissociative coping styles are but one example of how severe this dysfunction can become. As a result, life is under less voluntary control—it becomes a little less free.

Finally, avoidance fosters real-life collateral damage because it thwarts the evolution of the client's behavior toward more positive and valued patterns. Avoidance of feelings leads to avoidance of particular actions and situations—but often growth and valued-based living require these actions and therefore will produce these situations.

Acceptance as an Alternative to Avoidance

Acceptance, as we mean it, is *the voluntary adoption of an intentionally open, receptive, flexible, and nonjudgmental posture with respect to moment-to-moment experience.* Acceptance is supported by a "willingness" to make contact with distressing private experiences or situations, events, or interactions that will likely trigger them.

Acceptance should not be confused with self-absorption. An open posture to psychological experiences is not an end in itself. Psychological health is not attained by doing nothing but feeling one's feelings or sensing one's sensations from morning to night. It does not mean dropping everything and remembering in detail every memory that flits by in consciousness. Acceptance, as ACT practitioners mean it, has a *flexible* and *active* quality such that psychological events are noted and seen—even at times enhanced—moment to moment so that these events are available to participate in behavior if it makes sense for them to do so.

Acceptance can sometimes have an unhealthy connotation. Indeed, the term is sometimes used as a kind of weapon against others ("You just have to grow up and accept it!"). Used in that way, *acceptance* means bucking up, tolerating, resigning oneself, or putting up with a situation—a passive

form of acceptance does not necessarily predict positive health outcomes (Cook & Hayes, 2010). *Acceptance* also does not mean wanting or liking something, wishing it were here, or judging it to be fair, right, or proper. It does not mean leaving changeable situations unchanged—it means to embrace experiences as they are, by choice, and in the moment. Some ACT authors have used the word *enhancement* instead of *acceptance* to keep the spotlight on this quality (Harris, 2008). It means to stand with your self psychologically and embrace what is present at the level of experience.

As the serenity prayer suggests, there are circumstances where change is possible and, equally well, ones where attempts at change are going to backfire. Suffering is likely when people become confused about which circumstance is which and/or they have not learned acceptance skills that can be applied even when difficult experiences need to be embraced. What the prayer does not say is that, even when events *can* be changed, doing so produces events that *can't* be changed. For example, changing behaviors is always possible, but new behavior often feels uncomfortable or awkward or may remind us of vulnerabilities or past hurts. Because personal history is not changeable—except the history not yet written—and spontaneous feelings, thoughts, memories, and sensations change only gradually, acceptance skills are needed to follow through with change itself.

Acceptance Is an Ongoing Process

An important feature of acceptance is that it is an ongoing voluntary process; it never remains constant. Acceptance is part of an open stance taken toward life, but that general stance needs to be lived out moment by moment. Thus, acceptance includes acceptance of the rise and fall of acceptance itself. We can get better at it, but we will never be perfect at it.

Acceptance Is Not Giving In

One unfortunate connotation of the word *acceptance* is resignation or defeat. In fact, the opposite is true: change is empowered by embracing the present moment and accepting what will occur in the process of change. Consider a wife in a domestic violence situation. Acceptance is very relevant, but it does not mean acceptance of the abuse. Instead, it might mean accepting the painful fact that if nothing is done the abuse will most likely continue. It may mean acknowledging the toxic emotional impact of the abuse and the painful gap between valued intimacy and what is present. It might mean facing the fearful thoughts as part of the process of terminating or fundamentally changing an unworkable relationship. But it does not mean giving in.

Acceptance Is Not Failure

Acceptance is not an admission of personal failure; rather, it is a recognition that a particular strategy has not or cannot work. Metaphorically, *acceptance* means abandoning digging as a way out of a hole. *Acceptance* and *workability* are close allies. When life workability is low, abandoning unworkable strategies is a necessary first step; but taking that course of action means accepting what experience has been teaching us all along—namely, that our current approach to life is not working.

Acceptance Is Not Toleration

Acceptance is not merely tolerating the status quo. Toleration is a conditional stance in which a certain amount of distress is allowed for a period of time, usually in exchange for something else of value—but without real openness to the experience itself. Most of us practice this type of toleration when we go to the dentist. Acceptance is active, not passive. It suggests that there is something meaningful in feeling what is there to be felt.

Acceptance Is a Function, Not a Technique

As is true for all of the psychological flexibility processes, acceptance is not a technique, but a functional process. The therapist is gently and persistently opening the door so that the client can more directly contact personal experience. The methods matter, but where they come from is more important. ACT therapists might ask their clients to sit without speaking for a few moments to make greater room for a feeling; they may ask what clients feel inclined to do; they may ask clients to open up to what is hard for clients to look at; or they may smile and nod when even more pain enters the session room. Such interactions are not likely to work very well as techniques. They work inside a natural openness that is persistent, transparent, and respectful. A client with a phobia of snakes might actually be helped by having a snake thrown in his or her lap! At the same time, acceptance work is not about ripping away defenses unexpectedly or measuring the client's progress in tears per minute. Rather, it is a process of learning (often very gradually) about making it more possible for clients to experience what is present in a truly open way.

Acceptance Is Relevant to the Therapist as Well

The posture of acceptance is as important for the therapist to assume as it is for the client. If it were not, there would be no way for acceptance to be natural and effective. When therapists are only conditionally accepting,

clients will keep their most threatening personal content off the table. This reaction might prevent the therapist from experiencing psychological pain, but it shrinks the acceptance space in which the client and the therapist must operate. This observation does not mean that ACT therapists have to be "kings and queens" of acceptance. Rather, it means that "they are working on it" and are willing to step forward to face their own material if it promotes the interests of the clients they serve.

Acceptance Is a Values-Based Choice, Not Wallowing

Acceptance is not a matter of "have to." There are consequences for a lack of acceptance, but since there can be no guarantees acceptance requires a kind of values-based leap into what is present whenever it *is* present. Feeling what one is feeling is not an end in itself—that is wallowing. Rather, clients are being asked by life itself to feel, think, sense, or remember what comes up in the process of living a valued life. That requires both behavioral willingness and acceptance skills, deployed as a values-based choice.

CLINICAL APPLICATIONS

Clients exhibit a wide range of prior history with acceptance-based concepts; it is useful to gather information about any prior experience that can be usefully harnessed for the therapy. Some clients have previously meditated; some have read self-help books; some have "let go and let God"; some have participated in athletic sports that require extreme attentional focus; and so forth. If a client successfully quit smoking 5 years ago, it is worthwhile to find out what the client did to suppress his or her urge to smoke that might remain relevant even today. If the client experienced a painful divorce in the past, it is important to hear what the client did to handle the sense of grief, loss, and abandonment that was present. Such considerations as these might give the therapist important clues as to how "acceptance-ready" a client likely is. In addition, the therapist might acquire some "language tags" from the client. These are metaphors the client uses in describing efforts to accept something in the past. The skillful therapist is good at co-opting the tags to refer to ACT-consistent elements and adapting them to the current problems the client is facing. It is easier to use acceptance methods the client found beneficial in the past. Listening with "ACT ears" gives the therapist a good idea of how familiar or foreign the concept of acceptance is going to be for the client.

Very early in clinical work, it is useful to expose clients to the idea that letting go of futile struggles may be a viable option. This level of progress does not usually require full use of creative hopelessness; the starting point

in most cases is to have clients make experiential contact with the unworkability of their previous approaches and to consider the alternative of giving up on them. As we discussed in Chapter 6 when using the *Person in the Hole* metaphor, the ability to recognize that a cherished strategy is destined to fail is really an acceptance move. Another acceptance metaphor, the *Tug of War with a Monster*, was generated by a courageous client with agoraphobia. She abandoned a 20-year struggle with panic and started living instead—doing all the things she had always wanted to do (starting a business, going to school, leaving a destructive marriage). She was able to make these changes by including anxiety as a legitimate component of her life. She described her breakthrough in this way:

> "I realized I was in a tug-of-war with a monster. It was big, ugly, and very strong. In between me and the monster was a pit, and, as far as I could tell, it was bottomless. I thought that if I lost this tug-of-war I'd fall into this pit and would be destroyed. So, I pulled and pulled, but it seemed that the harder I pulled, the harder the monster pulled back. I felt like I was getting closer and closer and closer to the pit. And through therapy I just realized that it was not my job to win this tug-of-war … my job was to drop the rope."

"Dropping the rope" is a perfect metaphor for how one begins the process of acceptance. Sometimes clients ask "How do I do that?" after hearing this metaphor. As with the *Person in the Hole*, it is best not to answer directly. The therapist can instead say something like "Well, I don't know exactly know how to answer that right now. But the first step is simply to realize that—so long as you hang onto that rope—you can't try anything else."

Depending on how the client reacts to this and other acceptance metaphors, they can be used as a language in ACT sessions. If a client comes in with a new struggle, the therapist might describe it as "digging." If a client is facing a new challenge, it might be talked about as "an opportunity to drop the rope." This use of metaphors helps the client see the consequences of actions rigidly maintained by verbal rules. If a client creates a metaphor that fits well, the wise ACT therapist will go with it and integrate it into their therapeutic work together.

Willingness as an Alternative to Control

Clients need an alternative to their control-and-eliminate agenda. Willingness and acceptance are that alternative. Willingness is a values-based choice to expose oneself to an unpleasant thought, emotion, memory, or sensation or to feared situations or feared content. Clients become willing to make this choice as they become aware of their values and of

how avoidance has blocked valued actions. Willingness is a prerequisite for acceptance. In other words, willingness is what gets you in front of unwanted experience; acceptance is what you do with that experience. The following dialogue is with the sexual abuse survivor we first met in Chapter 6. She experiences severe anxiety at the prospect of being intimate with her partner and avoids it by leaving the room. In the earlier dialogue, the therapist drew out the likely cost of the client's avoidance while clarifying that she valued keeping the relationship over not having anxiety.

THERAPIST: You asked me earlier about what you could do instead of leaving the bedroom when you begin to freak out. The strategy you've been using is to escape the situation and gain control of your fear and anxiety. If running from your anxiety is one strategy, the alternative must be to stay there with your anxiety.

CLIENT: You mean, just stay in the bedroom and watch myself go through the roof?

THERAPIST: Thank your mind for that thought—it was a doozy! Consider this: you have *no* direct experience with what will happen to you if you stay in the bedroom when you begin to freak out, right? All you have is your mind telling you that you are going to melt down.

CLIENT: No, I've never tried staying there. It is just too intense.

THERAPIST: So, here is your predicament: if you aren't willing to even stay in the bedroom, how will you ever discover whether there is another way to address your fear? All you are learning when you run is how to run better—how to zig-zag to get a few more seconds of anxiety relief. But apparently you can't outrun your anxiety and fear for long. It tracks you down from behind.

CLIENT: Are you saying that the only way I can get rid of my anxiety and fear is to stay in the bedroom?

THERAPIST: I don't know what will happen to your anxiety, to your flashbacks, to your fear if you stay in there. It might even get worse—who knows? The point of staying in the bedroom is not to get rid of these things; that is what you've been trying to do by leaving the bedroom. I'm guessing that if you stayed in the bedroom with the intent of staring down and eliminating your anxiety and fear, that things would not go very well.

CLIENT: So, what is there to gain other than a whole lot of pain?

THERAPIST: That's the strange loop we're in. If you're not willing to stand with your anxiety and fear, you can't discover what it feels like to simply stand with it. Then it will continue to just bully you

the way it has been all these years. Which path do you want to take? Being pushed around by anxiety and missing out on the important things in your life, or taking a chance on standing with your anxiety even though you are not sure what you will do when you get there?

CLIENT: I have to try something different, although I don't want to!

THERAPIST: OK, I propose we run an experiment. The next time your partner comes onto you in the bedroom and you notice that your anxiety has shown up, would you be willing to hold tight for 2 minutes? During that 2 minutes, I just want you to try to hold still. Don't try to control the anxiety … just let it do whatever it does, and I want you to just observe it. Try to see what it is actually like. Be curious! After 2 minutes, if you need to, you can run like a screaming banshee from the bedroom, or you can choose to linger longer in the presence of anxiety.

CLIENT: Just 2 minutes, huh? That isn't long. I'm willing.

In this exchange, the therapist's suggestion is not designed to obtain the traditional effect of exposure (a decrease of the anxiety). The purpose here is to experience the emotion, with no attempt to control it, and to engage in a new response in its presence (e.g., curiosity). We deal with these issues in greater detail in Chapter 12. There is no specific rule about the duration of an acceptance exercise, but it makes sense to start small. The key point is to help the client open up to the sensations and thoughts that may come.

Applying one's willingness to promote actions that are consistent with chosen values is a central goal of ACT. There are several manifest qualities of behavioral willingness that make it a unique form of chosen action.

Willingness Is Not Wanting

Clients sometimes confuse willingness with wanting. It is not uncommon for a client to say, in response to the willingness question, "No. I really don't want that." This confusion is not helpful. *Want* means "missing" (e.g., "For want of food, he died"), and, yes, no one misses panic, urges, depression, and so on. That is not the question, however. Sometimes, clients get phished with the idea that if they withhold willingness and avoid situations long enough, feared content will eventually go away on its own. An ACT client once said it this way: "I used to hold back willingness as if my life depended on it. I figured God or someone would rescue me if I held out long enough. It was as if reality or some force would care that I was in pain and would come and take it away. Finally, I saw that only one thing could

happen if I was unwilling and that lots of things could happen if I was willing. So, now I'm willing as if my life depends on it—because actually my experience tells me that *it does*!"

Metaphors are a very effective way of making the point that the client is not at liberty to choose what content shows up in any given situation or how it presents itself. The *Joe the Bum* metaphor helps make this point experientially.

> "Imagine that you got a new house and you invited all the neighbors over to a housewarming party. Everyone in the whole neighborhood is invited—you even put up a sign at the supermarket. So, all the neighbors show up, the party's going great, and here comes Joe, who lives behind the supermarket in the trash dumpster. He's stinky and smelly and you think, "God, why did *he* show up!" But you did say on the sign "Everyone's Welcome." Can you see that it's possible for you to welcome him and really, fully, do that without liking that he's there? You can welcome him even though you don't think well of him. You don't have to like him. You don't have to like the way he smells, or his lifestyle, or his clothing. You may be embarrassed about the way he's dipping into the punch or the finger sandwiches. Your opinion of him, your evaluation of him, is absolutely distinct from your willingness to have him as a guest in your home.
>
> Now, you could also decide that even though you said everyone was welcome, in reality he's *not* welcome. But as soon as you do that, the party changes. Now you have to be at the front of the house, guarding the door so he can't come back in. Or, if you say 'OK, you're welcome' but you don't really mean it—you only mean that he's welcome as long as he stays in the kitchen and doesn't mingle with the other guests—then you're going to have to be constantly making him do that and your whole party will be about that. Meanwhile, life's going on, the party's going on, and you're off guarding Joe. It's just not life-enhancing. It's not much like a party. It's a lot of work! What if all the feelings, memories, and thoughts that you don't like and that show up were just more bums at your door? The question is: What posture would you take with them? Are they welcome? Can you choose to welcome them in even though you don't like the fact they came? If not, what's the party going to be like?"

The metaphor reveals two central characteristics of the fantasy that underlies unwillingness. First, if only invited *and* wanted guests came to the party, life would be grand. Second, choosing not to welcome the unwanted guest will somehow promote your peace of mind. The reality is the opposite. In fact, most clients have noticed that when they try hard to stop one

reaction from joining the party, other undesirable reactions follow along right behind—what one ACT therapist called "the bum's chums."

Willingness Has an All-or-Nothing Quality

The client may promote the idea that willingness can be achieved via sequential incremental steps. While the size of a "willingness" can vary, its *quality* does not change. Willingness is a "whole act," and the *Jumping* exercise makes this point.

> "Willingness is like jumping. You can jump off lots of things. [The therapist takes a book and places it on the floor and stands on it, then jumps off.] Notice that the quality of jumping is to put yourself in space and then let gravity do the rest. You don't jump in two steps. You can put your toe over the edge and touch the floor, but that's not jumping! [The therapist puts one toe on the floor while standing on the book.] So, jumping from this little book is still jumping. And it is the same action as jumping from higher places. [The therapist gets up on the chair and jumps off.] Now this is jumping too, right? Same quality? I put myself out into space, and gravity does the rest. But notice, from here I can't really put my toe down very well. [The therapist tries awkwardly to touch the ground with his toe after getting back up on the chair.] Now if I jumped off the top of this building, it would be the same thing. The jump would be identical. Only the context would have changed. But from there it would be impossible to try to step down. There is a Zen saying, 'You can't cross a canyon in two steps.' Willingness is like that. You can limit willingness by limiting context or situation. You get to choose the magnitude of your jump. What you can't do is limit the nature of your action and yet still have it work. Reaching down with your toe is simply not jumping. What we need to do here is to learn how to jump: we can start small, but it has to be jumping from the very beginning or else we won't be doing anything fundamentally useful. So, this is not about learning to be comfortable, or gritting your teeth, or gradually changing habits. This is about learning how to be willing."

Willingness Is Safely Limited Only by the Size of the Situation

Even with the caveat that heroic steps are not required to apply willingness, any notion of letting "monsters" in the room can be frightening to clients. Clients do not know what will happen if they let go of their familiar patterns of action and reaction. Clients might appreciate the value of willingness, but yet they want to keep their risks limited. The client with agoraphobia

might say, "I'm willing to put up with my heart racing, but if I start to feel dizzy or sick, I'm leaving." There are ways to limit willingness safely, but most of the normal actions taken to limit it are destructive. The client cannot really embrace willingness fully by changing its quality because then the client is not simply limiting willingness but, rather, destroying it. Willingness can only safely be limited by time and situation. In the earlier cited dialogue with the sexual abuse survivor, the therapist permits the client to limit the amount of time she spends in the bedroom while at the same time specifically requesting that she be fully open and curious during the required 2-minute period. Similarly, a client with panic disorder can start practicing willingness and acceptance at the local convenience store before making a major trip to the mall. What can't be limited is the quality. Being half-willing is like being half-pregnant: it just isn't possible.

The Costs of Unwillingness: Clean and Dirty Pain

There is an important distinction to be made between pain that is *clean* and pain that is *dirty*. *Clean pain is the original discomfort we feel in response to a real-life problem*. It doesn't feel good necessarily, but ultimately it is a normal, natural, and healthy experience. In contrast, *dirty pain is the pain we get when we needlessly struggle to control, eliminate, or avoid clean pain*. Most people, if given the choice, would gladly return to just feeling their clean pain if they could somehow walk away from the dirty pain that they habitually become entangled in. Unfortunately, that wish contains the process that led to the dirty pain to begin with. In the following dialogue, the therapist explores the distinction with the sexual abuse survivor.

THERAPIST: I'd like to pick apart the situation you are facing in a different way to see if this makes sense to you. If I don't make sense, just say so and I'll stop blabbering. You have this history of being sexually victimized by your uncle. This is an absolutely despicable thing for an adult to do to a child. It is awful, and it has left you with some scars. You feel very anxious whenever the issue of trust or intimacy surfaces with any man. You experience flashbacks when you get anxious. You feel nervous in ambiguous social situations, as would any sane person with the same history as yours. While these emotional experiences are definitely unpleasant, they are not unhealthy or damaging to you. They are what they are. So, let's call this group of reactions your clean pain. By that, I mean they are just the normal emotional responses that sexual abuse survivors experience. Does this make sense to you?

CLIENT: Yeah … but what are you getting at?

THERAPIST: Well, it seems like we have two sets of emotional responses to account for. One set is your clean pain; the other is what you do to manage the pain. This group of responses includes your evaluations of your pain. For example, one thought you have is that your anxiety proves you are too unstable to be in a relationship. Another thought says that you can't be intimate with your boyfriend if you have a flashback during sex. Another is that controlling your anxiety is more important than being truly present with your partner. You have other evaluations about not wanting to experience apprehension in social settings, about how your anxiety is ruining your friendships, and so on. When you look at these responses overall, what impact do you think they have on your overall level of anxiety and fearfulness?

CLIENT: They make it much worse.

THERAPIST: OK, so let's call this group of responses your "dirty pain"—because they increase your distress level but are not actually part of the original reactions that you carried away from your sexual abuse. In other words, you add dirty pain on top of the original clean pain. Does this make sense?

CLIENT: So, you're saying my reactions to being anxious are also a problem?

THERAPIST: Well, let's see if they are a problem or not. I've drawn a big empty circle on this piece of paper, and I want you to do this for me. (*Gives client a pen and paper.*) Assuming that empty circle represents all of the pain that you are experiencing in your life right now, I want you to cut me a piece of pie that shows how much of your suffering is coming from the clean pain—you can express this figure in percentage points if you want to. If the full circle contains 100 points of suffering, how many of those points are coming from the clean pain?

CLIENT: I'm thinking it is about 50% because having flashbacks and nightmares is no fun at all, and feeling unsafe in a lot of situations is very difficult emotionally.

THERAPIST: OK, so you also have some evaluations about flashbacks and nightmares that might actually be a part of the dirty suffering group—but let's leave them in the clean group for now. If I'm following you, you are going to assign 50% of the cause for your suffering right now to the dirty stuff, right?

CLIENT: Right, about half of this is what I go through in reaction to my trauma experiences.

THERAPIST: Good, I have a proposition for you. What if I told you that we could cut your suffering level in half. Would you be interested in that?

CLIENT: Oh, in half—I never thought about it this way.

THERAPIST: The deal is that if you want to cut it in half you have to be willing to have the clean pain as it is, not as your evaluations say it is. You have no control over the clean pain. You do have control over whether you join it with the dirty pain. It is like you are adjusting a music amplifier with two big knobs. The one on the left is labeled "your history," and it is fixed at a certain level. You can't turn it at all. The one on the right is labeled "willingness to have your history as it is," and that one you can dial up or down. When you dial your willingness level down, your dirty pain increases. However, when you set the willingness level on high, your dirty pain goes down. You have been putting your energy into trying to get the left knob to turn, and, in doing so, you have forgotten that there is a second setting you *can* adjust.

Often, the therapist will follow up this type of discussion with some type of homework assignment, such as the *Willingness–Suffering–Vitality* exercise. In this exercise, the client makes daily ratings of levels of willingness, suffering, and vitality. It is often useful to instruct the client to keep notes about any spontaneous actions that seemed to spark higher levels of willingness. The therapist can then begin to incorporate these willingness-producing actions (e.g., listening to music, painting, reading a prayer out loud, etc.) into the client's daily lifestyle.

A powerful way to promote willingness and acceptance is to bring unacceptable content into the room during therapy. The goal is to stimulate distressing private experiences, get the client to defuse from them, and simply make room for them. The therapist and client may go to a setting outside the therapy office if that helps to stimulate discomfort. For example, a client with agoraphobia can meet the therapist at the local mall. A client with obsessive–compulsive symptoms can meet with the therapist at home and go through hoarded trash. Alternatively, props (e.g., letters, pictures) that elicit difficult emotions can be brought to the session to enhance direct exposure. There is a built-in contradiction in this type of exercise. On the one hand, the client tends to see feared experiences as coming on their own and being uncontrollable. On the other hand, the in-session work requires the client to voluntarily confront feared material. This tacitly suggests to the client that some control in the moment may be possible—but not in the way the client is expecting. The client wants to be

in charge of whether automatic, conditioned responses appear, but that alternative is not possible. However, it is possible to sit with these difficult responses, notice them for what they are, and, by doing so, to avoid needlessly escalating or prolonging them.

Acceptance Is Not Just Exposure Therapy

In ACT, exposure is the *organized presentation of previously repertoire-narrowing stimuli in a context designed to ensure repertoire expansion*. Acceptance interventions are qualitatively different from classical exposure therapy even though they share some similarities in form. This poorly understood distinction can readily lead to certain clinical errors. While holding still in the presence of anxiety is certainly exposing the client to anxiety, classical exposure is done in order to reduce arousal (Farmer et al., 2008). In acceptance, the goal is not to rid the client of anxiety. In fact, the ACT therapist explicitly states that it is not clear what will happen to any given distressing thought, feeling, memory, or sensation if the client simply allows it to be fully present. It may get worse, better, or remain the same.

The purpose of acceptance exercises is not to reduce emotional arousal but to learn to stand in the presence of private experiences while functioning in a more free, flexible, and values-based way. That is the perspective that ACT encourages, and many researchers are beginning to look at exposure in that way, based on the evidence from research on the processes of change (e.g., Arch & Craske, 2008). If that is the understood definition and purpose, then acceptance (and the entire psychological flexibility model) can indeed be thought of as a form of exposure; for that very reason, ACT theorists have always argued that ACT is a kind of exposure-based therapy (Hayes, 1987). For example, defusion makes it possible to contact a thought as it is rather than what the thought refers to; similarly, acceptance makes it possible to contact an emotion as it is rather than what it historically evokes; and so on. These processes foster the key variable in exposure, namely, the expansion of the client's repertoire in the presence of previously repertoire-narrowing events. We are interested in exposure in a functional sense, not in a procedural sense.

Acceptance is not a trick designed to "accept something out of existence." Although acceptance methods typically produce symptom reduction, their stated purpose is not to reduce symptoms. Through acceptance, we attempt to change the contextual relationship between the client and the pain the client is experiencing so as to increase psychological flexibility. Paradoxically, when you can stand up to your pain and examine it with openness and curiosity, it often becomes much less onerous. In some instances it doesn't. But in either case life can open up.

In-Session Acceptance Exercises

When conducting exposure-based acceptance exercises, it is helpful to label them in ways that are a bit playful, such as the *Looking for Mr. Discomfort* exercise. Clients can be asked if they are ready to look for Mr. (or Mrs.) Discomfort. If they are unwilling, earlier issues need to be covered again (e.g., "OK … and let's look at the cost of that" or "You can for sure do that, but what are the values you'll be putting aside?"). When describing the purpose of exposure exercises, the scene should be set carefully.

> "We're going to go out and find Mr. Discomfort, to try to call him forth, talk to him, and find out what's going on in your relationship with him. If discomfort does not show up, that's OK. Our goal is just to experience being willing to have him here. If he shows up, and at any time you find that you are not willing to stay and see what happens, that's OK, too. We're going to do some things that may push your discomfort buttons a bit. However, there will be no tricks, nothing to startle or surprise you; any steps we take I'll suggest first, and you can choose to go along with them or not. Notice that this exercise will not be limited by time; these hot buttons could get pushed any time, so it will not be a matter of getting through this exercise. Clock watching won't apply. If you are just going to endure this, you are digging. We'll quit only once the work is done. When Mr. Discomfort shows up, we will try to renegotiate your relationship with him. We're going to try to call up the passengers from the back of the bus, to see if we can examine and change the nature of the relationship you have with them. We'll be looking at all the dimensions of that relationship, with the goal of helping you let go of the struggle and keep your hands on the wheel."

In the exposure session, ask the client to look for emotional discomfort and disturbing thoughts. If client begins to experience discomfort, get a description of what the discomfort is in great detail. Look for specific components: bodily sensations, emotions, memories, thoughts, and so on. For each element, ask the client, "Just see if you can let go of the struggle with [a specific disquieting thought, feeling, memory, or physical symptom] for just a moment, if you can be willing to have it, exactly as it is, not as it says it is or as it is threatening to become." If the client begins to sink into panic, sadness, or some other negative state, suggest that the client direct attention back into the external environment. Ask the client to remain aware of the negative private experiences but also to notice the other things happening in the external environment.

The *Physicalizing* exercise is borrowed from the Gestalt tradition, its goal being to convert subjective experiences into physical objects with perceptual properties. It starts with a disturbing reaction: an emotion, a bodily state, an obsessive thought, an urge to use drugs, or whatever is relevant to the particular case. The therapist asks the client to imagine the disturbing element as if it were an object. The characteristics of the object are then explored.

THERAPIST: Now, I want you to imagine yourself placing this depression outside of you, putting it 4 or 5 feet in front of you. Later we'll let you take it back, so if it objects to being put outside let it know that you will soon be taking it back. See if you can set it out in front of you on the floor in this room, and let me know when you have it out there.

CLIENT: OK. It's out there.

THERAPIST: So, if this feeling of depression had a size, how big would it be?

CLIENT: (*pause*) Almost as big as this room.

THERAPIST: And if it had a color, what color would it be?

CLIENT: Dark black.

THERAPIST: And if it had a speed, how fast would it go?

CLIENT: It would be slow and lumbering.

This process continues with questions about power, surface texture, internal consistency, shape, density, weight, flexibility, and any other physical dimensions the therapist wishes to choose. Have the client verbalize each response, but do not get into a conversation. After getting a fairly large sample, go back to a few earlier items and see if anything is changing (e.g., what was big may now be small). Especially if the psychological situation hasn't changed much, ask the client whether she or he has any reactions to this thing that is big, black, slow, and so forth. Often, the client will report being angry with it, repulsed by it, will not want it, will be afraid of it, will hate it, or something of that kind. Get the core strong reaction, and then ask the client to move the first object slightly to the side and to put this second reaction out in front, right next to the initial object. Repeat the entire *Physicalizing* exercise with the second reaction. Now take a look back at the first. Usually, when the second reaction is physicalized, the first will be thinner, lighter, less powerful, and so on. Sometimes these attributes can be turned on and off like a switch: whenever the second reaction is taken literally and used as a perspective from which to examine the first reaction, the first becomes more powerful. When the second reaction is

deliteralized by being viewed as an object, the initial reaction diminishes in intensity.

If the items do not change, the therapist can either look for another core reaction that is holding the system in place or simply stop the exercise. The therapist should never suggest that any particular outcome was expected if it did not occur. Just commenting on a reaction as though it were a physical object—without struggling with it—changes its qualities profoundly. This simple experience can change the context of that reaction when it occurs again in real life. It may be the same reaction, but it is seen differently, even if the client still struggles with it. A popular variant with ACT therapists is the *Tin Can Monster* exercise. It usually starts with a particularly painful or difficult feeling, thought, or memory. In this example we use "panic."

THERAPIST: Facing our problems is like confronting a giant monster who is made up of tin cans and string. The 30-foot monster is almost impossible to face willingly; if we disassemble him, however, into all the cans and string and wire and bubble gum that he's made of, each of those pieces is easier to deal with one at a time. I'd like us to do a little exercise to see if that isn't the way it works. Start by closing your eyes. [The therapist adds the usual coaching necessary to get the client centered, focused, and relaxed.] OK. Let's start out by recalling something that happened last summer. Anything that happened is fine. When you have something, just let me know.

CLIENT: I went to the lake with my family. We are in a boat.

THERAPIST: Now I want you to see everything that was happening then. Notice where you are and what is happening. See if you can see, hear, and smell just like you were back then. Take your time. [The therapist can elicit enough verbal responses to make sure that the client is following and can build on these to encourage the client to get into the memory.] And now I want you to notice that you were there. Notice that there was a person behind those eyes, and though many things have happened since last summer notice also that that person is here now. I'm going to call that person the "observer you." From that perspective or point of view, I want you to get in touch with this feeling of panic that can show up at work. Let me know when you have it.

CLIENT: (*pause*) I have it.

THERAPIST: Now I want you to watch your body and see what it does. Just stay in touch with the feeling, and watch your body, and if you notice anything, let me know.

CLIENT: I have tightness in my chest.

THERAPIST: Now I want you to see if it is possible to drop the struggle with that tightness in your chest. The goal here is not that you like the feeling but that you're having it just as a specific bodily event. See if you can notice exactly where that feeling of tightness begins and ends. Imagine that the tightness is a colored patch on your skin. See if you can notice the shape it makes. And, as you do that, drop any sense of defense or struggle with this simple bodily sensation. . . . If other feelings crowd in, let them know we will get to them later. Let me know when you are a little more open to the tightness.

CLIENT: OK.

THERAPIST: Now I want you to set that reaction aside. Bring the feeling of panic back into the center of your consciousness, and again watch quietly for what your body does. See if there is another reaction that shows itself. As you watch, stay with that "observer you"—the part of you behind your eyes—and watch from there. Let me know when you see a reaction, and tell me what it is. [The therapist repeats for two or three bodily reactions. If the client denies having any, stay with it for a while.]

Now, this time just go back and get in touch with that feeling of panic that you've felt at work, and let me know when you are in touch with it.

CLIENT: Got it.

THERAPIST: OK. So, continue to look for things your body does, but this time just look very dispassionately at all the little things that may happen in your body, and we will just touch each and move on. So, with each reaction just acknowledge it, like you would tip your hat to a person on the street. Sort of pat each on the head, and then look for the next one. And each time see if you can welcome that bodily sensation without struggling with it or trying to make it go away. In a sense, see if you can welcome it, like you would welcome a visitor to your home.

After this sequence is done with bodily sensations, do the same thing with any behavioral domain of interest: actions the person feels constrained to attempt, thoughts, evaluations, emotions, social roles that come to mind, and so on. The more distressing the experiences covered, the better. Stay with one specific set of reactions at a time. If working on the predisposition to run away, for example, don't let the client also work on thoughts, other

actions, emotions, and so on. If you are unsure of what the client is doing, have the client explain, but do not get into a conversation. Constantly come back in creative ways to the issue of letting go. Usually the last domain is memories because they can be especially powerful emotionally. Here an additional metaphorical component helps:

> "OK, now for the last part here, I want you to imagine you have all the memories of your life on little snapshots in a picture album. First I want you to flip back through the album until you reach that memory last summer. And once again, see if you can recall that sense of being a person aware of that scene. Do you have it? Good. Now I want you to reconnect with that feeling of panic. When you are well connected, start flipping back through the picture album. If you find yourself gazing at a picture, even if it doesn't make sense that it might be related to panic, tell me what it is that you see."

When a memory is contacted, ask the client such questions as "Who else is in the picture? How old are you? Where are you? What were you feeling and thinking at the time? What are you doing?" Have the client answer questions briefly, but do not enter into a conversation.

> "Now, I want you to find a place in that memory where you might have avoided what was present. See if you avoided your own experience in some way. And take this opportunity now to drain out any sense of trauma in that memory by seeing if you are willing to go now where you would not go psychologically then. Whatever your reactions to the memory, just see if you can have that exactly as it is, have exactly what happened to you as it happened. That doesn't mean you like it—but you are willing to *have* it! [Repeat this with two or three memories.] OK, when you're ready, I want you to close the album and picture this room as it was when you shut your eyes and began the exercise. When you can picture it and are ready come back, just open your eyes and come back to the present.

This exercise is time-consuming, but it can be very powerful. It allows for prolonged exposure to feared experiences in a safe context. The therapist should help the client to notice the "hooks" that decrease willingness and the quality of the reactions when those experiences were bought as opposed to when they were not bought. Without extensive interpretations, the ACT therapist notes all reactions, big and small, with a sense of interest in the process and nonevaluative openness to the content.

Have and Move

As work on willingness and acceptance progresses, the issue at hand changes from standing with disturbing content in the psychological sense to learning to "inhale" unwanted experiences and to move in valued directions. This progression harkens back to the original purpose of bolstering acceptance, namely, that it is only by taking an open, accepting posture toward distressing content that a person can pursue valued life directions. Acceptance allows distressing content to be present without it serving as a barrier to valued action. Two themes seem particularly helpful to this shift in focus. The first is that the person is "bigger than" the experiences inside their skin—that private events are merely accoutrements that the human takes along on the journey of life. The *Expanding Balloon* metaphor is an excellent example of this message.

> "Think of yourself as an expanding balloon. At the edge of the balloon is a zone of growth where the same question keeps being asked: 'Are you big enough to have *this*?' No matter how big you get, you can always get bigger. When an issue presents itself, the same question keeps being asked, and you can say 'yes' or 'no.' If you say 'no,' you get smaller. If you say 'yes,' you get bigger. If you keep answering 'yes,' it does not necessarily get any easier because the issues that show up may seem just as difficult as earlier ones. Saying 'yes' does become more of a habit, however, and your experience provides a reservoir of strength. If a difficult problem arises, you might think, 'No, I don't want that problem to be next,' but life presents each new issue as your situation evolves, and it may not be possible to choose the sequence of the challenges."

There are many other metaphors available that help the client "scale down" private content in relation to a larger notion of self. For example, the therapist can have the client represent specific complexes of thoughts, feelings, or memories as deck chairs on a huge cruise ship and then ask, "In the big picture, what is most important to how this ship runs? Is it that some of the deck chairs are funky-looking, or is it how the engine and drive line to the propellers are working?"

The second theme at this juncture is that the client can't leave history behind. The nervous system works by addition, not subtraction (as noted earlier). It is not possible to unlearn a historically conditioned response. The only thing one can do is to add new responses that change the contextual meaning of the old responses. For example, *observing* pain rather than *being* the pain represents a contextual shift. It repositions the relationship between the client and the client's pain. In ACT, we want the client to take

the pain "along for the ride," so to speak. The *Take Your Keys with You* metaphor makes this point in physical terms.

> Ask whether the client carries keys and whether you can borrow them. Put the keys on the table, and say "OK, suppose these represent the things you've been avoiding. See this key here? That is your anxiety. See this key? That is your anger at your mother." [The therapist continues fitting major issues to the client's keys.] The keys are then placed in front of the client, and the client is asked, "What are you going to do with the keys?" If the client says "Leave them behind," say "Then two things happen. First, you find that, instead of leaving them behind, you keep coming back to make sure they are left behind—so, then you can't go. And second, it is hard to live life without your keys. Some doors won't open without them. So, what are you going to do with your keys?"
>
> The process continues, waiting for the client to do something. Most clients are a bit uncomfortable when actually picking up the keys. For one thing, the whole exercise seems a bit silly (which in itself is another "key"), and, second, the keys are symbols of "bad" things. In that context, actually picking them up is a *step forward*, and the therapist should keep presenting the keys until they are picked up without therapist encouragement. If the client says "I would feel silly picking them up," point to a key and say "That feeling? That's this one, here! So, what are you going to do with the keys?" When they are finally picked up, say something like "OK. Now the question is: Where will you go?" And note that the client can go in any direction whatsoever and still have the keys. Also note that other keys will keep showing up—that answering the question affirmatively now does not mean that the same questions won't be asked over, and over, and over by life. A nice between-session homework assignment is for the client to associate every use of a key to "letting go" of the struggle with distressing private experiences.

In this metaphor, the keys on the client's key ring represent different difficult emotions, memories, thoughts, or reactions. The metaphor highlights two important aspects of these "keys." First, picking up the keys and carrying them does not prevent the client from going anywhere. Second, carrying these keys willingly can open doors that might otherwise be locked. The old saying "Your pain is your strength" suggests that going through darkness and emerging on the other side teaches us to trust, to feel compassion, and to do the right thing. Conducting this exercise with the actual keys the client uses also gives the client a physical touchstone or reminder of important goals (where they are going), the means of going

(willingness), and what they must carry with them to move (their history and the reactions it may produce). Since we use our keys many times in a day, they serve as a frequent reminder outside of therapy sessions.

INTERACTIONS WITH OTHER CORE PROCESSES

Acceptance and Defusion

Acceptance and defusion work are so closely intertwined that they sometimes seem interchangeable during treatment. It is not always clear whether the client's primary issue is one of a low acceptance level or high fusion. Most of the time, low acceptance and low willingness signal that the client is fused with some unacceptable private material. Common signs indicating the need to move into acceptance work include a heightened sense of rigidity that emerges when particular emotional material comes up; words suddenly become halting or rushed; the body tenses; topics change unexpectedly; stories begin to be told immediately following quivers in the client's lips or voice; or the pace of the client's speech quickens. In such cases, the therapist can use a statement like "So, what is your reactive mind giving you now?" that open up territory to explore.

Acceptance and Valuing

Acceptance work naturally feeds values and committed action work. When the practice of acceptance becomes widespread in the client's life, the resulting self-compassion leads to thoughts about larger life directions. At this level of development, the client begins to engage in spontaneous applications of willingness and acceptance to valued actions. There's a shift of focus to vital living and a sense of lightness, vitality, and potential. Old issues that need to be addressed are sometimes spontaneously raised. For example, past hurts in therapy may be raised in a flexible way that moves the therapeutic relationship forward. It is a sense of interest in living that marks a broadened behavioral repertoire as mindfulness and acceptance work move people naturally from the "laboratory" of therapy into everyday life.

Acceptance and Committed Action

Acceptance is done in the service of committed action and involves practicing acceptance in real life. The client and therapist work to identify potential barriers to action, perhaps rehearsing them in session or using various exposure exercises to decrease their valence. The client then "experiments" with whatever committed actions have been agreed to and

then debriefs the therapist at the next session on his or her successes and failures in furthering acceptance processes. The therapist needs to take a low-key and patient approach here because acceptance is not always automatically going to be the outcome. The client may even backslide relative to his or her commitments whenever evocative material must be avoided. This temporary setback is just more "grist" for the therapeutic mill in the sense that real barriers to vital living are at least showing up rather than self-stories or well-worn historical material being regenerated.

Acceptance and Self or Present-Moment Processes

Acceptance requires that the client always stay present and not drift off as part of an avoidance maneuver. Therefore, many acceptance interventions begin by getting the client into the present moment. This may be done by using some type of structured exercise (e.g., deep breathing for 5 minutes) or done spontaneously when the therapist senses the presence of evocative material that the client is struggling to accept ("I noticed you just started biting your lip—what just showed up for you?"). Similarly, accessing the perspective-taking ability of self is critical to retaining an accepting posture. Questions to the client like "Are you big enough to have what is *inside of you* right now?" create an instructional set to expand awareness to assimilate what is going on. There are many other ACT interventions that ask the client to expand awareness and just observe what is present. In this sense, acceptance and self-processes continuously interact in and out of session.

THERAPEUTIC DOS AND DON'TS

Too Much Verbiage

Acceptance is shaped by direct contact with contingencies. Talking about acceptance is not going to help the client acquire the skills of acceptance. Therapists new to the ACT approach may "explain" acceptance and then have to "explain" it yet again—as though it can be fully verbally modeled. When therapeutic progress is slow, beginning ACT therapists often feel a strong temptation to go back and explain the basic propositions of the approach to the client again, as though the client were failing because he or she did not understand ACT ideas well enough.

A much better approach is to be more experiential. Acceptance cannot be fully described in a literal sense. Metaphors, analogies, and experiential exercises shape our knowledge and provide a conduit for the acquisition of skills. It is important to look for in-session opportunities to actually practice acceptance rather than merely talking about it.

Therapist-Generated Pliance

It is important for the ACT therapist to look at the struggling client with "soft eyes" and remember that acceptance is a values-based choice. It does little good to try to convince clients logically that they need it. Just as it would be painful to lead a desperately thirsty horse to water only to find him refusing to drink, it is painful to see a lack of acceptance when transformation is only inches away, were the person more willing. Acceptance cannot be coerced or gained through compliance. If the client has a hard time making the choice, the therapist needs to keep faith with the client and him- or herself, which in practice means both opening up to the pain of the situation and modeling patience and trust in the client's capacity to change. Reassurance is generally not helpful, but it is helpful to take small jumps, provided they are actually jumps. Even a small jump may later turn out to be a huge leap.

Compassion and Sabotage

The flip side of pushing and convincing is that sometimes therapists are tempted to protect clients from the harsh reality of the choice to be present with whatever is present. For example, there may be an urge to protect a trauma survivor from painful memories. Underneath that urge is a bought thought—some histories are just too much to live with. Often, this type of compassionate sabotage is a signal that some hot button has been triggered in the therapist. If the therapist has never accepted the triggered issue, the temptation will be to make sure the client doesn't either. True compassion is helpful, but clients do not need to be protected from life—rather, they need to be further empowered to live it in the present. The only certain way to remove the content of a painful history is to remove oneself from obsessing over the past. That takes courage on the part of the client, but it takes courage on the part of the therapist as well.

READING SIGNS OF PROGRESS

Although clients certainly vary in their acceptance levels early in treatment, in general they struggle with the notion of accepting what is going on inside, and they *really* struggle with the idea of voluntary exposure to life events, situations, or interactions that will trigger personal pain. This will be manifest in both the language clients use (i.e., "I can't allow myself to remember, it is just too painful"; "I just want to feel nothing") and in persistent patterns of situational avoidance (i.e., low willingness). When progress starts to occur, it is usually noted in these same two areas. Clients

begin to spontaneously use language that suggests they are adopting a more open and accepting stance toward feared content (i.e., "I realize this is not going to disappear and I'm going to have to deal with it, even if I don't like it"; "It was painful to have the argument with him, and I told myself to just let the pain be there and say what I wanted to say"). Clients will often spontaneously engage in willingness actions that haven't even been discussed in therapy. This is a sign that the acceptance move is beginning to generalize to other challenging life situations. Inside the session, acceptance creates a light, open, and casual atmosphere, as opposed to the tense, self-focused, serious tone of initial sessions. Clients begin to "get it"; they get the experiential knowledge that a stance of acceptance toward the outside and inside worlds breeds a softness and compassion. "Giving in" no longer means "giving up"; it opens up an entirely new set of self and other possibilities that is truly liberating for the client to experience, and the therapist to be a party to!

CHAPTER 11

Connecting with Values

> If we don't decide where we're going, we're bound to end up where we're headed.
>
> —Chinese Saying

In this chapter, you will learn . . .

- How values can be used to create a sense of life's meaning and direction.
- How values differ from but are linked to life goals.
- The distinction between the act of choosing and the act of deciding.
- How to support the client's construction of valued directions.
- How to help clients distinguish between valuing as behavior and valuing as a feeling.
- How to separate values from unfulfilling social and community pressures.

PRACTICAL OVERVIEW

ACT assumes that each client already possesses everything that is needed to live a rich and meaningful life. For most clients, however, the ability to see and follow a valued direction has been impaired by verbal fusion and experiential avoidance. Thoughts about the past, emotions, bodily states, and the like do not stimulate life-enhancing action, especially when they are viewed in the context of literality, control, and reason giving. Thoughts and feelings often lead in contradictory directions, and they invite a focus on irrelevant process goals (e.g., getting rid of certain feelings, having only

certain thoughts). Chosen values provide a far more stable compass reading. Values can motivate behavior even in the face of tremendous personal adversity. Clients are hurting, yes . . . valueless, no. Once awakened, valuing can become a powerful part of a vital life.

An example of this simple idea is found in Victor Frankl's book *Man's Search for Meaning*. Frankl describes a point in time near the end of World War II when he had discovered a way to escape from the concentration camp where he had been imprisoned. He describes making one last round of the patients in his makeshift hospital. He comes to a patient whom he had hoped to save but who was dying. The patient looked up at Frankl and said, "You too are getting out." Frankl describes experiencing a terrible sense of turmoil. He went to his colleague, with whom he had planned to escape, and said that he would stay and care for his patients. As he returned to his work, Frankl reported feeling a sense of peace unlike any he had ever experienced (Frankl, 1992, p. 68).

If Frankl could experience a sense of purpose and peace in one of the most horrific environments ever devised by humankind, then our clients, no matter what history they carry, are capable of living a life that is rich and meaningful. By rich and meaningful, we do not mean painless. We do not mean rich and meaningful by the standards of our materialistic culture. We mean rich and meaningful by our clients' own standards.

We believe that suffering is ubiquitous in the human condition. If you live long enough, people you love will die, careers will end, your body will age. What helps dignify living, given the certain knowledge that everyone, in time, will suffer? If we ask clients what they would do if they could finally lay their psychological pain down, we often hear things about family, career, social engagement, self-development, and the like. However, the problem-solving mode of mind tells us that these things cannot be had *until* psychological pain is mastered. This presumption naturally leads to overfocusing on process goals (i.e., reducing depression, anxiety, flashbacks, the urge to drink or to drug oneself, increasing self-confidence, etc.), with the longer-term result being that clients lose their connection to more significant life missions. This disconnection can become so pervasive that clients literally do not "know" what they believe in or want their lives to stand for. It is not uncommon in clinical practice to ask a client something like "What would you be doing in your life if you didn't have to spend all of this energy on controlling your *X* (depression, drinking, etc.)?" and to hear back "I don't know." A major goal of ACT is to help clients construct a sense of life direction that may have been lost in their struggle to end their daily suffering. They might well find that even the smallest steps in the direction of championing one's values can bring new vitality to a life where a deadening sameness has long reigned.

CLINICAL APPLICATIONS

In ACT, values are freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioral pattern itself" (Wilson & DuFrene, 2009, p. 66). We reviewed the components of this definition in Chapter 3 and unbundled their meaning. Perhaps the things to most remember in clinical work are, first, that even though values are socialized, they have a quality of being freely chosen rather than appearing forced by other people or by emotions that need to be avoided; and, second, that they establish intrinsic appetitive consequences. Values are not off in the distant future. They have an appetitive nonavoidant quality in the now despite their temporal extension; it is as if meaning in the present stretches out through time.

In a sense this process establishes a new kind of contingency within the multi-level evolutionary theory inside ACT: not just contingencies of reinforcement but, rather, contingencies of meaning based on relational conditioning and the cognitive processes it establishes. Once that new selection criterion is fully in place, behavioral systems begin to evolve naturally in its direction. Evolution of behavior occurs with any reinforcer, but many reinforcers lead to adaptive peaks. For example, experiential avoidance is reinforced, but it does not lead anywhere. Values work allows behavioral systems to evolve toward chosen qualities and patterns.

Valuing as Action

The ACT therapist makes several distinctions when discussing the issue of values. Among the most important is distinguishing values as feelings from valuing as actions. These two aspects are often thoroughly confused for the client. The example of valuing a loving relationship with one's spouse is instructive. One's feelings of love may wax and wane across time and situations. To behave lovingly (i.e., respectfully, thoughtfully, etc.) only when one has feelings of love (and to behave in the opposite way when negative feelings show up) has problematic effects on a marriage. Yet, this is precisely the difficulty we find ourselves in when values are confused with feelings, since feelings are not fully under voluntary control and tend to come and go.

This issue is essentially the same one we discussed earlier in the context of emotional control and emotional reasoning. The cultural context that supports the association between feelings of love and acts of love is the same cultural context that supports the client with agoraphobia staying home in the presence of high anxiety and the alcoholic's drinking in the

presence of strong urges. If the client bases living entirely on the absence of emotional or cognitive obstacles, then valued directions cannot be pursued in a committed fashion since sooner or later some formidable obstacle will be encountered. As the client walks along the path of life, emotional obstacles inevitably arise, and life asks, "Will you have me?" If the answer is "No," then the journey must stop. In the area of values, this means that we need to learn to value even when we don't feel like it, to love even when we are angry, and to care even when we despair.

A useful way to distinguish feelings and actions is to start with things that the client has no strong feelings about. The following dialogue is an example.

THERAPIST: Let's do a silly little example. Do you care how many people wear argyle socks?

CLIENT: No, why should I?

THERAPIST: OK. Well, what I want you to do is really, really develop a strong belief that college boys have to wear argyle socks. Really feel it in your gut. Really get behind it!

CLIENT: I can't.

THERAPIST: Well, really try. Feel overwhelmingly strongly about this. Is it working?

CLIENT: No.

THERAPIST: OK. Now I want you to imagine that even though you can't make yourself feel strongly about this, you are going to act in ways that make argyle socks important to college students. Let's think of some ways. You could picket the dormitories that have low percentages of argyle sock wearers, say. What else?

CLIENT: I could beat up college students not wearing them.

THERAPIST: Great! What else?

CLIENT: I could give away free argyle socks to college students.

THERAPIST: Super. And notice something: although these things may be silly actions, you could easily do them.

CLIENT: And would be forever remembered as that stupid guy who wasted his time worrying about argyle socks!

THERAPIST: Yes, and perhaps because of your commitment to it, as the person responsible for bringing argyle socks back into fashion. But also notice this: if you behaved in these ways, no one would ever know that you had no strong feeling about argyle socks at all. All they would see is your footprints . . . your actions.

CLIENT: OK.

THERAPIST: Now, here is a question. If you did this, would you in fact be making argyle socks important in your life?

CLIENT: Sure.

THERAPIST: OK. So, what stands between you and acting on the basis of things that you *really do hold* as important? It can't be feelings if they are not critical even when we are dealing with something so trivial.

Here the ACT therapist is focusing on valuing *the action*. Efforts at conscious control work in the arena of behavior but are a problem in the arena of private experiences. It makes much more sense to focus on what can be directly regulated (overt behavior) rather than on events that cannot easily be controlled (private events). By starting with a trivial matter, the client can see that choosing to hold something as important is not necessarily an emotional issue. This realization may make it somewhat easier to talk about more personally relevant material without conflating feelings and values outcomes.

Valuing as Choice

Values are useful because they help humans select among alternatives. In humans, selecting among alternatives almost always occurs in the presence of the problem-solving mode of mind, which is useful for generating reasons for and against a particular course of action. Reasons are verbal formulations of causes and effects. They are attempts to answer the question "Why should I do or not do *X*?" To have a precise way of speaking about it, we call selecting among alternatives based on reasons *decisions*. Decisions are explained, justified, linked to, and guided by verbal decision-making processes such as predicting, comparing, evaluating, or the weighing of pros and cons.

In order for valuing to occur, it is critical that values *not* be confused with decisions and judgments—values must instead be *choices*. A choice is a selection among alternatives that may be made *with* reasons (if reasons are available) but not *for* reasons. Choices are *not* explained, justified, linked to, or guided by verbal evaluations and judgments. To say that choice is not done for reasons does not mean that there are no historical facts that give rise to a given choice. Rather, it means that the verbal formulations a given person constructs with regard to a choice do not cause the specific choice to be made. Defined in this way, animals can *choose* but they cannot *judge*. It seems unlikely that humans, merely because they have added verbal behavior, cannot do what an animal can do quite naturally.

ACT attempts to steer clear of the confusion between chosen action and logically derived action. The following suggested script demonstrates how the ACT therapist can broach the issue of judgment and choice:

> "To deal with this issue of valuing, I want us to distinguish between choices and decisions. These two are often confused. A decision is a selection among alternatives courses of action made for a reason. A 'reason' is a formulation of cause and effect or of pros and cons. When I say 'for a reason,' I mean that the action is linked to the reason, guided by the reason, explained by the reason, or justified by the reason. So, for example, you may decide to invest in a stock because the company has good management, a new product that you think will be successful, and a strong record of growth. These reasons guide, explain, and justify the purchase of the stock. Choices are something else. A choice is a selection among alternatives that is not made specifically for given reasons, although it is usually made in the presence of reasons (because we are such verbal beings)."

To help the client see the distinction between choices and decisions, the clinician can first explain the distinction intellectually in this way and then put two hands out in front, each in a fist as if holding something, and say, "Quick, choose one." The clinician then asks, "Why did you choose that hand?" Because the choice is trivial, the most common reaction is "for no reason." (If a reason is given, this trivial choice or a variant can be repeated even more quickly so that the client does not have time to generate reasons). If the client did not choose it for a reason, the clinician can then ask in some amazement, "Is that possible? Can you just *choose* things? And you got away with it—the sky did not *fall*?"

The clinician can then ask the person to do exactly the same thing while thinking of various reasons for picking the left hand or the right one. For example, the person can be encouraged to think "the right one is better" and then simply to choose one or the other. If that hurdle can be passed, the clinician can say that each hand represents a slightly more important alternative faced by the client (e.g., the left hand is "I will buy that table," and the right is "I will not"), and the client is asked simply to choose one or the other, now *with* reasons (since anything of importance naturally prompts an analysis of alternatives) but not *for* reasons. In this fashion, the bar can be gradually raised into an area of values while still maintaining the action as one of choice, not judgment.

If the person keeps raising reasons that address *why* the choice is being made, one strategy is to ask why each reason is true. After one repeats this question two or three times, the usual answer is "I don't know." This response can then occasion an examination of the "reasonableness" of

many such judgments. How reasonable can it be to select among alternatives when those reasons are barely skin-deep? For example, suppose we ask a client why he or she drinks Coke instead of Pepsi. The answer is usually something like "because I like the taste." If we then ask "Why do you like the taste?", usually the pause preceding any credible answer will be very long. Eventually the answer we get is something like "I just do."

In another variant, the client can specifically be asked to make a choice among two alternatives (e.g., types of food). The therapist can then ask "Why did you choose that?" This is a trick question. If the person answers by giving reasons and the action occurred *for* these reasons, then it was a decision, not a choice. The therapist can repeatedly refuse to accept the person's reason as an answer: "But I did not ask *your taste buds* to choose—I asked *you* to choose. And besides you could have noticed that you liked this food while you chose the other, true?" After continuing to press this line of questioning for awhile, clients will often switch to more accurate answers such as "just because" or "for no reason," indicating they now understand the distinction between choices and decisions.

This distinction is important in ACT not merely because it is the only way to learn how values function but also because ACT is about changing the agenda behind clinically significant behavior that often is reasonable but ineffectual. In that sense, willingness versus control is ultimately a choice, not a decision or judgment.

Choice has other benefits. For example, it helps the client avoid paralysis when reasoned action does not work. Similarly, it helps the therapist avoid getting entangled with the content and logic of the client's life story. Most of all, however, the distinction is needed so that clients can engage their values without needing also to invoke justifications and explanations that inevitably draw them back into the same socially sanctioned behavior patterns that produced their problems to begin with. The only issues left are what one does and what happens as a result. Used correctly (and not coercively), choices can help a client to be "response-able."

Choices are not "free" in the sense of being unaffected by an individual's history. In fact, choice itself is a historically situated act. Choices are "free" in the sense that there is no coercion, no "have to" driving the choice. If behavior were related to reasons in a strictly mechanical sense, then the mere presence of certain predictable reasons would constitute the necessary and sufficient conditions for the behavior to occur. This deterministic approach to causation is demonstrably false. Humans are capable of being loving even when there are many good reasons not to be. For example, one could consider the establishment of a commission on reconciliation in South Africa as an act of love toward past offenders and oppressors, even though there were more than ample reasons to show hatred and seek retribution against their many acts of racist criminality.

Purpose Is Everywhere

Purpose is always present in the client's life. It cannot be avoided, no matter how shut down and numbed out the client is. Why is this so? Because most behavior is purposeful, regardless of whether there is an experienced sense of direction. The clock of life is always ticking, and it only goes in one direction: from one moment of now to the next moment of now. Any behavior that is historical involves a history of such moments, and any behavior that is mindful and purposeful involves a verbally constructed future as well. In a very real way, most behavior *is* purposeful—either experientially or verbally, or both. That is true even if the client's overriding thought pattern is: "I'm not really in charge of my life. It is in charge of me. I can't do anything different because I'm trapped in my situation."

While purpose is everywhere, values (as we have defined them) are not. Clients often feel coerced in their lives, believe they are victims of life, or simply feel as though they are adrift. When they are living out of contact with the present moment, they are, in effect, on autopilot. In these circumstances, social training by itself is more than capable of organizing highly complicated sequences of behavior (e.g., working every day, doing laundry, watching TV, going to church, etc.). The question, therefore, is not what the client is doing, but how it is being done. The same behaviors that are "numbing" while one is on autopilot can reflect vast reservoirs of vitality when accomplished in pursuit of one's personal values. In the following dialogue, the ACT therapist attempts to highlight how the client's behavior might well reflect certain purposes—even when the client is unaware of it. Of course, a purpose is not the same thing as a value. An additional component is needed, namely, choice. But acknowledging that the client's behavior might indeed reflect certain purposes sets the stage for this discussion.

THERAPIST: I think what you are telling me is that you are not aware of the choices you are making each and every day. So, it seems to you as though you aren't acting according to any purpose because you are not aware of having these purposes. If that were actually possible, wouldn't it follow that each day your activity would be completely random? You would be walking around bumping into walls, putting your socks on your hands, brushing your teeth with the toilet brush, going to the wrong place of work, and so forth? Let me ask you: Is your life actually that random, or does it just feel like you are not choosing your actions?

CLIENT: Well, I'm not *that* out of it, so I guess it mostly feels like I'm not in control of what's happening to me. I don't have any way to change things.

THERAPIST: And choosing to believe what your mind is giving you here—that you are trapped—you proceed to behave like a trapped person, right?

CLIENT: Uh huh.

THERAPIST: I'm not asking you whether you believe you are trapped. What I'm asking is: Are you able to direct your behavior? And then I want to know: Are you able to choose the direction?

It is important not to browbeat the client about this but rather to gently cut through the illusion that choices are not being made and purposes are not being fulfilled. The question is: *Which* purposes? When we examine the ways that behavior functions, what it produces, we find its purpose. Often our clients will find that the purposes they are serving are relatively ineffectual and provide, at best, only short-term relief from some type of aversive consequence. For example, a client involved in a unfulfilling marriage might dutifully do "all the right things" around the home so as to maintain a peaceful, albeit distant, relationship with the spouse. This temporary relief is purchased at an expensive price because there is little if any chance that the relationship will evolve into anything more gratifying so long as the most painful issues remain closeted. In ACT, we try to turn the discussion to the question, If you could choose a purpose here, what purpose would you choose?

What Do You Want Your Life to Stand For?

One of the most powerful ACT "horizon-setting" exercises is called *What Do You Want Your Life to Stand For?* The following dialogue involves an independently wealthy client who is distressed by his aimlessness:

THERAPIST: If you're willing, I'd like us to do an exercise that might have some very interesting and surprising results, or it may simply help get you in touch with something you've known all along. Let's just see what happens.

CLIENT: OK, I'm willing to give it a try.

THERAPIST: This is what I call the *What Do You Want Your Life to Stand For?* exercise. I want you to close your eyes and relax for a few minutes and put all the other stuff we've been talking about out of your mind. (*Assists the client with relaxation for 2–3 minutes.*) Now, I want you to imagine that through some twist of fate you have died, but you are able to attend your funeral in spirit. You are watching and listening to the eulogies offered by your wife, your children, your friends, the people you have worked with, and so

on. Imagine just being in that situation, and get yourself into the room emotionally. (*Pauses*) OK, now I want you to visualize what you would like these people who were part of your life to remember you for. What would you like your wife to say about you as a husband? Have her say that. Really be bold here! Let her say exactly what you would most want her to say if you had totally free choice about what that would be. (*Pauses and allows the client to speak.*) Now what would you like your children to remember you for as a father? Again, don't hold back. If you could have them say *anything*, what would it be? Even if you have not actually lived up to what you would want, let them say it as you would most want it to be. (*Pauses and allows the client to speak.*) Now what would you like your friends to say about you as a friend. What would you like to be remembered for by your friends? Let them say all these things—and don't withhold anything! Have it be said as you would most want it. And just make a mental note of these things as you hear them spoken. [The therapist may continue with this until it is quite clear the client has entered into the exercise. Then the therapist helps the client to reorient back to the session, e.g., "Just picture what the room will look like when you come back and when you are ready just open your eyes."]

CLIENT: That was weird … trying to imagine being dead but being there. Sometimes in the past I've thought about suddenly dying. Usually I imagine how blown-out everyone would be—how tough it would be on Debbie and the kids!

THERAPIST: So, projecting yourself to the point of dying feels like pretty serious business.

CLIENT: Yeah, it seems to kind of dwarf all my problems! At the same time, I get really down on myself because it seems like my life is wasting away.

THERAPIST: I'm curious … when you heard the eulogies, what stood out in the way of things you wanted to be remembered for?

CLIENT: When Debbie said I had been a loving, faithful, attentive husband and a father who always provided for his children. Chuck, the guy I've probably known the longest, said I had been there for him when he needed me the most, when he quit drinking. This actually happened 2 years ago.

THERAPIST: Did anyone stand up and say "Here I remember Richard—he spent his entire life trying to prove he was no fluke"?

CLIENT: (*Laughs.*) No.

THERAPIST: Did anyone say "Here lies Richard—he made over $2

million in his career and because of that he is eternally worthy"?

CLIENT: (*Laughs.*) No. What are you trying to tell me?

THERAPIST: Nothing really . . . just notice that a lot of things you berate yourself about and struggle with have no connection to what you want to be remembered for. It just seems that you've squeezed yourself mercilessly in the name of things you may not even value.

CLIENT: That's pretty scary if that's true!

THERAPIST: Yes, it is, and it's not about what's true! It's about what works and what doesn't.

In a variation on this exercise, the client can be asked to write a short eulogy on an imaginary tombstone. Often this exercise reveals wide discrepancies between the client's values and his or her current actions.

THERAPIST: When people die, what is left behind is not so much what they had as what they stood for. For example, have you ever heard of Albert Schweitzer?

CLIENT: Sure. A doctor in Africa, right?

THERAPIST: Right. Now, why should you know about this guy? He's dead. Probably most of the people he treated are dead. But he stood for something. So, in that same way, imagine that you can write anything you want on your tombstone that says what you stood for in your life. What would you like your epitaph to say, if it could be absolutely anything? Think about it for a minute.

CLIENT: "He participated in life and helped his fellow human beings."

THERAPIST: Cool . . . now, let me ask you: When you look at what your life is currently standing for, is it standing for that? Are you really participating in life and helping your fellow humans?

CLIENT: No—I'm not sure I can!

THERAPIST: I hear you. So, you're on the way to an epitaph like "Spent his entire life wondering whether he had what it took to live it . . . and died unsure."

In some settings or with some clients, use of the *Funeral* or *Tombstone* exercise is perhaps too evocative of mortality issues—which is not the point here—but it is easy to devise less evocative versions. For example, in

worksite interventions the funeral might be changed to a retirement party, and the tombstone epitaph to any engraving on the back of a gift watch. Many variants on this theme exist in the ACT literature.

"Bull's Eye" Intervention

A simple but elegant intervention at this point is based on the *Bull's Eye* exercise developed by Tobias Lundgren and colleagues (2011). Most members of our culture are familiar with the concept of a bull's eye target, either from playing darts or engaging in archery. The goal of these sports is to put the dart or arrow in the middle of the target, the bull's eye, where the most points are awarded. Generally speaking, fewer points are awarded as the dart or arrow strays away from the center of the target. The therapist quickly draws a series of five to seven concentric circles on a piece of paper and then begins the discussion.

THERAPIST: So, notice that I've drawn a target on this piece of paper. Are you familiar with a target like this?

CLIENT: Yeah, I used to play darts as a kid, and we used a target similar to this.

THERAPIST: Well, we are going to use the target to measure a different kind of marksmanship here—basically, the degree to which you are aiming your life in the direction you want it to go. You've discovered that one of your main life values is to feel like you are participating in life and also helping others who are in need. Remember that the center of the target is called the "bull's eye"; that is what you want to hit when you play darts, right?

CLIENT: Right, and it didn't happen very often for me, but it was very cool when it did!

THERAPIST: And the rings continue outward, and you get fewer points for putting the dart in those rings, remember? Right now, what I want you to do is to think about this value you've expressed, and I want you to place a mark on this target that reflects the degree to which you are living your values at this point in time. A mark in the center means you have hit the bull's eye; you are participating in your life to the fullest extent possible, and you are living out the value to help others in need. A mark away from the center means you might be living your values sometimes or maybe not at all, depending on where you put your mark. So, right now, I want you to think about where you are in your life at this exact moment and put a mark on the target for me. [The therapist hands a sheet

of paper to the client, and the client makes a mark in the outermost ring and hands the paper back to the therapist.] So, it looks like you have marked yourself pretty far from the bull's eye, meaning that you don't feel you are living consistent with your values right now—is that correct?

CLIENT: Yeah, this is pretty upsetting because I feel I'm capable of more than this. I'm just not doing it! Putting a mark on the target is like going on record as saying I'm failing at this.

THERAPIST: Thank your mind for those rosy, warm thoughts. There is a much more important purpose here than declaring yourself a winner or a loser. It is to figure out where you actually are in your life. You can only start from where you are, not where you'd like to be. So, as unpleasant as this might be, it is a vital first step in the process of choosing to do something different, if that is what you choose to do.

CLIENT: OK, so I'm out here in this ring, and I want to be in here in this ring. How do I get there?

THERAPIST: Maybe think of this as an ongoing process. You don't stay in one ring forever; even if you hit bull's eye, you don't get a certificate from life that says "Bingo! You are at the center, and you don't have to ever do anything else to stay there!" So, just notice that your location on the target will fluctuate all the time; this is just a way of checking in and seeing where you are. Nothing more, nothing less. If you don't like your location, you might choose to do just one thing differently that might move you one ring closer to the bull's eye. It's kind of like steering an ocean liner: you can't turn on a dime, but you can nudge the rudder slightly and over time it will make a big difference in the ship's direction.

CHOOSING VALUED DIRECTIONS: SETTING THE COMPASS HEADING

The process of making close experiential contact with one's values is one of the most intense, intimate clinical experiences in ACT. People know intuitively that what they care about most deeply is also where they can be hurt and thus may very rarely allow these areas to be seen by others. After values work, the therapist is likely to become privy to information that has never have been shared with anyone else. Used properly, this very intimacy can serve as the basis for the hard therapeutic work of implementing value-based behavior change.

In ACT, the values assessment process serves a variety of assessment and intervention purposes. First, the client may become aware of long-suppressed values. This process is motivational in the sense that the client may find major discrepancies between valued life directions versus current behaviors. We refer to this gap as the "values–behavior" discrepancy, and it is often the galvanizing force in the behavior change process in ACT. Second, discussions about values, if managed properly by the therapist, create a positive strengths-based feel to the therapeutic conversation. Most people possess altruistic motives in life: they want to be good lovers, good spouses, good parents, good friends, and so forth. These motives are basic to the social nature of human beings. The process of values assessment can help move the therapeutic conversation from focusing on flaws, deficits, and problems to highlighting the perfect and pristine foundations of the client's life. In a world filled with imperfection, a person's values are perfect. A person's values may not be what someone else thinks they should be, but they are always perfect and complete within the person, him- or herself. Many clients come into therapy with a sense that deep down, at the most fundamental level, they are somehow terribly flawed. It is difficult to imagine anything more fundamental than a person's values, and it can be both empowering and uplifting to find that one has a flawless foundation. After reviewing values with a client, an ACT therapist might ask, "Is there anything at all that is missing from these values? Could they be improved in any way?" If the client can think of anything that could be improved, the improvement is accomplished by this very awareness. In this basic sense, everything the client comes up with is perfect.

A final benefit of values construction is that it can trigger a realization that life is happening *now*—it is not far off in the future somewhere. The clock is ticking, but not in a bad way. As strange as it sounds, there is limited (at best) social support for constantly thinking about one's values in comparison to how one is living life at the moment. We are encouraged to stay "checked out" on this issue because it would be a definite threat to the contemporary social order if the masses "checked in" and began to actually question the utility of widely promulgated, socially constructed "values." The unusual flavor and tone of ACT values work help the client get "located" in the present, which often leads to concrete discussions about specific behaviors that can be changed or modified. Most of the time, these behaviors will not be elicited by the surrounding social milieu but instead will have to come from within.

ACT researchers and practitioners have developed a wide array of values tools. Entire volumes have been dedicated to values work within the ACT perspective (e.g., Dahl, Plumb, Stewart, & Lundgren, 2009), and different settings and clinical styles afford diverse approaches to

values work. In this chapter we describe one generally applicable clinical approach, but readers with more specific needs should consult Dahl and colleagues (2009) and other ACT sources for less time-consuming alternative approaches.

The values process that we describe further is a relatively structured one that is useful as a kind of extended exercise (for quick assessments the *Bull's Eye* is more useful). The steps are:

1. The therapist describes the values assessment process to the client.
2. The client completes the *Values Assessment* worksheet (see Figure 11.1), either during a session or as a between-session homework assignment. This assessment form helps the client "go on record" with the themes that have emerged during the in-session work. The values enumerated will be referenced repeatedly during the remainder of ACT; so, the therapist needs to go over the values construction work with the client to verify that the key visions of the client are accurately recorded. That process of review is accomplished through the next steps.
3. The therapist and the client discuss the values cited in each domain and together generate brief values narratives for each domain that simplify, focus, and encapsulate the free-form values statements from the worksheet (see Figure 11.2, Values Narrative Form). Typically the therapist's main task is to help the client distinguish goals from values and to describe values in terms of directions, not merely concrete ends. Thus, the therapist brings his or her technical knowledge of values from an ACT perspective to the process of refining the client's narratives into values narratives that satisfy the definitional requirements of values.
4. When the narratives are finished, the client generates ratings by filling in the Valued Living Questionnaire–2 (VLQ-2; Wilson et al., 2010), which is shown in Figure 11.3. (It can be helpful to the clinician as a kind of exercise also later to conduct a similar set of ratings.) The purpose of the two sets of ratings (clients and therapists) is in part to help identify areas where the clinician and the client are not communicating, which provides guidance for areas that might need additional clarification through discussion.
5. The client's values assessment worksheet (from step 2) is reviewed by the therapist and client together and then modified in a collaborative fashion. The therapist's job during this process is to clarify the direction inherent in what might be fairly concrete valued ends.

The following are areas of life that are valued by some people. Not everyone has the same values, and this worksheet is not a test to see if you have the "correct" values. Describe your values as if no one will ever read this worksheet. As you work, think about each area in terms of concrete goals you might have and also in terms of more general life directions. So, for instance, you might value getting married as a concrete goal and being a loving spouse as a valued direction. The first example, getting married, is something that could be completed. The second example, being a loving spouse, does not have an end. You could always be more loving, no matter how loving you already are. You could also work toward being a loving spouse even if you are not married or even in a relationship. For example, there might be ways you could prepare yourself so that an intimate relationship would be more likely or more successful. Work through each of the life domains. Some of the domains overlap. You may have trouble keeping family separate from marriage/intimate relations. Do your best to keep them separate. Your therapist will provide assistance when you discuss this goals and values assessment.

Clearly number each section, and keep them separate from one another. You might not have any valued goals in certain areas. You may skip those areas and discuss them directly with your therapist. It is also important that you write down what you would value if there were no obstacles in your way. We are not asking what you think you could realistically get or what you or others think you deserve. We want to know what you care about, what you would want to work toward, in the best of all situations. While doing the worksheet, pretend that magic happened and that anything is possible.

Note: In clinical use add spaces below each category below.

1. **Family relations (other than marriage or parenting).** In this section, describe the type of brother/sister, son/daughter, father/mother you want to be. Describe the qualities you would want to have in those relationships. Describe how you would treat these people if you were the ideal you in these various relationships.

2. **Marriage/couples/intimate relations.** In this section, write down a description of the person you would like to be with in an intimate relationship. Write down the type of relationship you would want to have. Try to focus on your role in that relationship.

3. **Parenting.** What sort of parent would you like to be, either now or in the future?

4. **Friendships/social life.** In this section, write down what it means to you to be a good friend. If you were able to be the best friend possible, how would you behave toward your friends? Try to describe an ideal friendship.

(cont.)

FIGURE 11.1. *Values Assessment* worksheet.

5. **Career/employment.** In this section, describe what type of work you would like to do. This description can be very specific or very general. (Remember, this is in an ideal world.) After writing about the type of work you would like to do, write about why it appeals to you. Next, discuss what kind of worker you would like to be with respect to your employer and coworkers. What would you want your work relations to be like?

6. **Education/training/personal growth and development.** If you would like to pursue an education, formally or informally, or undertake some specialized training, write about that. Write about why this sort of training or education appeals to you.

7. **Recreation/fun.** Discuss the type of recreational life you would like to have, including hobbies, sports, and leisure activities.

8. **Spirituality.** We are not necessarily referring to organized religion in this section. What we mean by spirituality is whatever that means to *you*, whether it is as simple as communing with nature or as formal as participation in an organized religious group. Whatever spirituality means to you is fine. If this is an important area of life, write about what you would want it to be. As with all of the other areas, if this is not an important part of your values, skip to the next section.

9. **Community life.** For some people, participating in community affairs is an important part of life. For instance, some people feel that it is important to volunteer for work with the homeless or older adults, to lobby government policymakers at the federal, state, or local level, to become a member of a group committed to conserving wildlife, or to participate in the service structure of a self-help group, such as Alcoholics Anonymous. If these sorts of community-oriented activities are important to you, write about what direction you would like to take in these areas. Write about what appeals to you about this area.

10. **Health/physical self-care.** In this section, include your values related to maintaining your physical well-being. Write about such health-related issues as sleep, diet, exercise, smoking, and the like.

11. **The environment/sustainability.** In this section, include your values related to values you might have in the area of sustainability and caring for the planet and especially the natural environment.

12. **Art/aesthetics.** In this section, include your values related to such pursuits as art, music, literature, craftsmanship, or any other form of beauty in the world that is meaningful to you—whether considering things that you make yourself or things that others make and that you mainly appreciate.

FIGURE 11.1. *(cont.)*

The therapist generates a brief narrative for each domain, based on discussion of the client's values assessment homework. If none is applicable, write "none." After generating all the narratives, read each to the client and further refine it. Continue this process, simultaneously watching out for pliance-type answers, until you and the client arrive at a brief statement that the client agrees is consistent with his or her values in a given domain.

Domain	Valued Direction Narrative
Family Relations (other than couples or parenting)	
Marriage/Couples/Intimate Relationships	
Parenting	
Friendships/Social Relations	
Career/Employment	
Education/Training/Personal Growth and Development	
Recreation/Fun	
Spirituality	
Community Life	
Health/Physical Self-Care	
The Environment/ Sustainability	
Art/Aesthetics	

FIGURE 11.2 Values Narrative Form.

Below are areas of life that are valued by some people. We are concerned with your quality of life in each of these areas. There are several aspects that we ask you to rate. Ask yourself the following questions when you make ratings in each area. Not everyone will value all of these areas, or value all areas the same. Rate each area according to your own personal view.

Possibility: How possible is it that something very meaningful could happen in this area of your life? Rate how possible you think it is on a scale of 1–10. 1 means that it is not at all possible and 10 means that it is very possible.

Current Importance: How important is this area at this time in your life? Rate the importance on a scale of 1–10. 1 means the area is not at all important and 10 means that the area is very important.

Overall Importance: How important is this area as a whole? Rate the importance on a scale of 1–10. 1 means the area is not at all important and 10 means that the area is very important.

Action: How much have you acted in the service of this area during the past week? Rate your level of action on a scale of 1–10. 1 means you have not been active at all with this value and 10 means you have been very active with this value.

Satisfied with Level of Action: How satisfied are you with your level of action in this area during the past week? Rate your satisfaction with your level of action on a scale of 1–10. 1 means you are not at all satisfied and 10 means you are completely satisfied with your level of action in this area.

Concern: How concerned are you that this area will not progress as you want? Rate your level of concern on a scale of 1–10. 1 means that you are not at all concerned and 10 means that you are very concerned.

(cont.)

FIGURE 11.3. Valued Living Questionnaire–2. From *Mindfulness for Two.*

	Possibility	Current Importance	Overall Importance	Action	Satisfied with Action	Concern
1. Family (other than couples or parenting)						
2. Marriage/Couples/ Intimate Relation						
3. Parenting						
4. Friends/Social Life						
5. Work						
6. Education/Training						
7. Recreation/Fun						
8. Spirituality						
9. Community Life						
10. Physical Self-Care (diet/exercise/sleep)						
11. The Environment (caring for the planet)						
12. Aesthetics (art, music, literature, beauty)						

FIGURE 11.3. *(cont.)*

Addressing Pliance and Counterpliance

The therapist should also constantly assess other factors that may influence the client's value statements, particularly those involving pliance and counterpliance. The therapist should be on the lookout for, among other indicators, the following signs that pliance or counterpliance might be influencing the process:

- Values statements controlled by the presence of the therapist, in conjunction with the client's assumptions about what might please the therapist. Relevant consequences would be signs indicating the therapist's approval and/or the absence of the therapist's disapproval.
- Values statements controlled by the presence of the culture more generally. Relevant indicators would include the absence of cultural sanctions and broad social approval or widespread prestige.
- Values statements controlled by the stated or assumed values of the client's parents. Relevant consequences would be parental approval—either actually recorded and/or verbally constructed.
- Values statements that have a "have to" quality that might indicate either fusion or avoidance.
- Values statements that are heavily laden with rumination about the past and/or worry about the future.

It is difficult to imagine a client who would have values that were not controlled in part or at times by all of these variables. The key question is whether removal of the relevant influence would significantly affect the potency of the value as a source of life direction. The task of assessment cannot be completed in only one discussion. The issue of "ownership" of the value is likely to resurface time and again. Some of these issues might be best addressed by asking the client to talk about the value while imagining the absence of a relevant social consequence.

To illustrate, consider a client who endorses the value of being well educated. The therapist might ask if the level of valuing (or the value itself) would change if it had to be enacted anonymously: "Imagine that you had the opportunity to further your education but you could not tell anyone about the degrees you had achieved. Would you still devote yourself to achieving it?" Or, "What if Mom and Dad would never know you pursued an education—would you still value it?" A different tack might also provide some insight into controlling variables. So, for instance, the therapist might ask: "What if you were to work very hard for a degree, and Mom and Dad knew and were proud, but the day after you received the degree you forgot

everything you had learned. Would you still value it to the same extent?" As the client considers various imagined consequences, he or she may be chagrined to find that parental approval is the "straw that stirs the drink." In this case, "becoming well educated" is not a value at all but rather a goal in the service of some other value (i.e., "being loved by and loving those who are in my life"). Once this value is clarified, it is written down as a desired end. It is not uncommon for some values to change in valence over the course of therapy or even as a function of the initial assessment.

Missing Values

The VLQ-2 asks the client to generate responses covering many separate life domains. Often, clients may come in with forms showing one or more domains left blank, or unresponded to. With more dysfunctional clients, all the domains' response slots might be empty or might contain only very superficial answers. Here, the therapist needs to patiently discuss each domain in order to elicit responses from the client. Often, it helps to go back earlier in the client's life and look for examples of dreams, wishes, or hopes that have disappeared because of negative life events. At other times, the therapist may have to assist the client either in identifying hidden values that underlie his or her specific life goals or, conversely, in generating specific goals based on well-described but ungrounded values.

It is not unusual for clients to list specific life goals that cannot be achieved. For example, a woman might say that she wanted to regain custody of a child she gave up for adoption 10 years earlier. In these instances, the therapist tries to find the underlying value and goals that might be achievable if one were moving in that direction. Another variation of this problem exists when the client focuses on unattainable life goals as evidence that irreparable damage has been done and yet there are no real meaningful life outcomes available in that domain. This latter possibility is more difficult to address clinically because values are now being employed in the service of the status quo, whereas the client's perspective is that no change or only superficial change is possible. In such circumstances, it is often useful come into the present moment and have the client identify the specific feelings that appear in him or her whenever this sense of permanent loss is encountered. The therapist might ask the client to identify the value at the source of the pain (e.g., "I wanted to be a good mother and felt my meth addiction would eventually damage my child; that's why I put her up for adoption"). Sometimes the source of the pain is a closely held value that the client followed at great personal cost. The therapist can help the client "connect" to the expression of this value without necessarily taking a pollyannaish stance on what has happened.

INTERACTIONS WITH OTHER CORE PROCESSES

In many ACT protocols, values work comes late in the intervention, leading some to assume that once acceptance and defusion work have been done, one can move on to values without too much attention given over to mindfulness processes. Yet, mindfulness processes in ACT often remove experiential barriers to values work and enhance contact with values and the client's ability to evolve and act on valued patterns of action.

Values and Defusion

Attention to fusion is particularly critical in working with values. People often come to therapy with well-worn stories about their values. Common variants include fused content like "The world is just not like that" or "No matter what you do, the world will slap you down" or "No one hires people my age." Clients cite their own history of difficulties as evidence that there is no sense in even trying to act in accordance with their values, for example, despairing that "My relationships always fail" or "My children will never give me another chance." We refer to this negative content as "values fusion."

Inflexibility is the hallmark indicator of values fusion. This inflexibility may take several forms, including inaction despite strongly espousing certain values, denial that one even possesses values, and/or a complete refusal to even consider certain domains as subject to values. Another variation of values fusion involves a rigid attachment to a particular positive outcome or strong avoidance of a negative outcome, resulting in the client's losing his or her flexibility to move ahead in the valued domain.

There are times in values work where fusion appears to work in the service of values. This circumstance can be particularly insidious since values fusion may actually produce *some* good outcomes (e.g., "If I'm nice to everybody, then everybody will be nice to me, and I will feel cared for"). The problem lies in the inflexibility and insensitivity that fusion produces. The high-water mark in values work is defused valuing. A value can be held lightly but yet pursued vigorously. The advantage of defused valuing is that the client is better able to perceive when letting go of a particular valued act is the best way to serve the same value over the longer term. Sometimes doing something that is, on the surface, contrary to the value functionally *serves* the value. Allowing children to make *some* mistakes can be hard on parents but is vital for the children's learning experience. Inflexible adherence to a rule about keeping your children from any harm can lead to overprotectiveness and stifle children's need to develop their own autonomy.

Therapists may be tempted to press ahead with values work as something the client "should do," especially when there is a clearly valued

direction the client would like to take. Doing so likely generates even more values fusion on the part of the client. If clients *should* be willing to act, then that imperative can become one more thing for clients to club themselves with—one more piece of evidence that "I am bad." Instead of pressing on with values work, the emergence of inflexible persistence, inaction, or persistent values confusion should prompt the therapist to assess and treat fused content. At that point, the work can move back to values.

Values and Self

The most common obstruction to values work in the domain of self is overattachment to the storyline of the conceptualized self, as with such statements as "It's too late for me—I have already made too many mistakes that cannot be redeemed" or "There is some flaw that I have that makes achieving anything in this domain impossible" (e.g., "I am not smart enough," "good enough," "enthusiastic enough," or "lovable enough"). Sometimes the flaw is not known but is asserted with great certitude: "I don't know what is wrong with me, but look at my life!" The emergence of such themes should cue in the therapist to do work that involves bolstering the client's present-moment awareness and the observing self. Very often, attachment to self-stories functions to shield the client from caring about important life outcomes. The storylines of "not trying," "bound to fail," and "Look at what happens when something is important!" must give way to discussions about the feelings that show up at the exact moments those stories appear and the ability to look at the self-stories as a listener, not as a participant.

Values and Acceptance

It is common for individuals to evince instances of experiential avoidance related to values. There is a constant interplay between values and vulnerabilities. When we are aware of what someone values, we know how to hurt him or her. If a person values your regard, your disrespect is painful. This characteristic of interaction cuts across valued domains. An artist might avoid painting a particular subject or person because of the pain that would arise if he or she failed in his or her artistic expression. Writer's block often shares this quality. When people go through a painful relationship failure and a resulting divorce, they may avoid situations and activities that could lead to the development of another intimate relationship. The avoidance produces some short-term relief but over time leaves the person out of synch with values about intimacy. As with fusion, the marker for such avoidance is the client's inflexibility during in-session discussions of these issues and in the avoidance of life situations where he or she could act in ways more consistent with the value. When the therapist sees repetitive

behaviors, such as repeated false starts, worries, and rumination about acting on a value, it is time to shift the focus from values work to a focus on acceptance-oriented interventions. Sometimes even brief acceptance work can free the client to act in ways that are more consistent with their values.

Values and the Present Moment

The inability to move in a valued direction often involves failures in present-moment processes. With more intractable clients, conversations about valued directions devolve into ruminative rehashing of past failures and/or obsessive worrying about the way forward or about all of the potential obstacles that might arise. The divorced parent may spend so much time ruminating over past failures as a parent that contact with the simple sweetness of being a parent is lost. In repeated attempts to think through the past and head off any possible negative futures, the person misses opportunities to act on the value of parenting in the present moment.

When the therapist notices these failures of present-moment processes, it is time to intersperse mindfulness and present moment–focused interventions (e.g., What just showed up for you as we talked about your values about being a parent? Would you be willing to just hold still and let those feelings, memories and evaluations be here?). Fusion and avoidance have a very difficult time surviving in the present moment. They are best suited to the past and future and thrive in past/future conversations. Of course, talking about living one's values is inherently about living, going forward. Planning for the future and learning from the past are part of that. However, therapists should aim for interventions that move flexibly between future plans and mindful appreciation of valued domains in the present moment.

Values and Commitment

One of the aims of values work is to generate potential actions that are consistent with one's values. Given this, it is somewhat ironic that making and keeping commitments can be one of the greatest obstacles to values work. When we work on values with clients, the action implications of those values also emerge. When valued domains have been neglected or violated for a long time, the very idea of choosing actions in those areas—or even that such choices are in the offing—can generate significant fusion and avoidance. As a rule of thumb, therapists should spend considerable energy on understanding the psychological valence of values before moving into discussions about committed action. In essence, the therapist needs to understand the psychological implications of getting the client to take action in

a valued domain. How does this action tie into the client's self-story? What are the potential sources of fusion if the client begins to make moves in this area? When therapists encounter significant difficulties with values work, it is often useful to explicitly take commitment off the table. The following session transcript shows how such a conversation might develop.

CLIENT: I just don't think I can take another rejection. The divorce was awful! The idea of asking someone out … well, I just can't do it!

THERAPIST: So, as we talk about intimate relations, you start thinking about dating?

CLIENT: Well, yes, that's where this is going, isn't it? I mean when my wife left, I knew why. I would have left me too if I could have! I haven't changed. It will just happen again. And, how would I even do it? Go on one of those online dating services? I just … I'm just not ready.

THERAPIST: Wow! That's a lot. Overwhelming! As you were talking, it felt to me like you were just being smothered by the complexity and impossibility of it all. I feel a little reluctant to even ask anything about this area … about intimacy. If you want me to stop, I will, but can I ask just a couple questions? And, if you say "no" at any moment, I am with you. We will stop. That is my commitment to you. It is just that it seems like there is something in the middle of all this pain that is important to you and I don't want to neglect it … to just skip over it like nothing happened.

CLIENT: Well, yes, of course it is important. There is nothing more important to me.

THERAPIST: So, is it OK? Is it OK for me to ask a couple of questions? And I promise I will go slow and leave the option to stop open at every step.

CLIENT: Sure … I mean, I have to face this stuff.

THERAPIST: Hmmm. I don't know. I don't like "have tos" very much. I sure don't want to be one more person in your life joining the choir and telling you what you *have to* do. What about this—because it is so apparent to me how important this is—I don't know that I can really *get you* without having some appreciation of the way this value moves you. So, how about this—how about if for a little while we just set aside whether this is possible or how to make it happen. That is another conversation, and we can have that conversation on another day. But today, right here and now, would you be willing to just help me get what intimacy means to

> you? I don't mean an explanation. I don't want to understand it as much as I want to appreciate it. More like, what you would do with a painting than what you would do with a textbook. The textbook is something where you check off all the facts. With the painting you just witness it, appreciate it, spend a little time with it. Would you be willing to help me see a moment of intimacy that you have known or that you long for? Like I said, we can talk about what and whether to do anything about it later, but for now, would you be willing to just help me get a felt sense of what this means to you?

Sometimes it is easier to make contact with values when committed action is at least momentarily set to one side. Working this way can titrate the acceptance and defusion work that will ultimately make committed action possible. ACT is at its core a behavioral treatment. Its ultimate goal is to help the client develop and maintain a behavioral trajectory in life that is vital and valued. *All* ACT techniques are eventually subordinated to helping the client live in accord with his or her chosen values. This statement means that even such key ACT interventions as defusion and acceptance are, in a sense, secondary. For example, while ACT is emotionally evocative, it differs from some emotion-focused approaches in that there is no interest in confronting painful or avoided private experiences for their own sake. Instead, acceptance of negative thoughts, memories, emotions, and other private events is legitimate and honorable only to the extent that it serves ends that are valued by the client. Helping the client identify valued life directions (treated in this chapter) and implement them in the face of emotional obstacles (the next chapter) both directs and dignifies what ACT asks of clients.

THERAPEUTIC DOS AND DON'TS

Coercive Use of Choice

There is a potentially dark side of the therapeutic intimacy that develops when valuing is on the table. Often it moves both the therapist and client into the realm of moral judgments. Morals are social conventions about what is good, while values are personal choices about desirable ends. To be maximally effective, the ACT therapist must be able to work conscientiously with the client. Some clients present with histories or current problems that are morally repugnant to the therapist, such as battering, addiction, repetitious suicidal behavior, and child molestation, to name but a few. Values assessment work often exposes these areas; yet, the ACT therapist cannot be drawn into the role of "moral detective," using the

social influence of therapy to openly or implicitly coerce the client into conforming to broadly held social values. The therapist makes the same move the client is asked to make, namely, to see valuing as essentially a personal exercise.

For example, when working with an alcoholic in the ACT model, there is no assumption that being intoxicated on a daily basis is incompatible with living life in a direction valued by the client. Since the values and direction are the client's to choose, it is actually a legitimate outcome for a client to choose to abuse alcohol. Language and the culture of "political correctness," of course, make it seem like this choice is definitely the "wrong one" to make because the interests of society are not served by sanctioning alcoholism. Therapy is a verbal enterprise, and it therefore is inextricably intertwined with social control functions. The therapist must avoid falling into the trap of using choice as a way to blame the client.

The language of "free choice" is a powerful language, but it should not be used to coerce the client. This coercion usually occurs when the therapist assumes an attitude like "Well, of course, if you choose to continue drinking, that is your choice. You have to make those choices. I can't do it for you. Just remember that it's the choice you made when it comes time to endure the consequences." Although this posture may be technically correct (it is the client's choice and only the client can live out the consequences), the psychological attitude is "The choice you are making here not only disappoints me, but you are morally wrong for making it."

Both disappointment and moral judgment are things that the therapist should notice and hold lightly. These reactions are data for the therapist. It is entirely likely that the client has gotten this reaction from others and even has many of these reactions internally. Gently noticing these reactions and inquiring about them can sometimes paradoxically help people make clearer, less defensive contact with their own choices. It is worth bearing in mind that if moralizing and judgment were likely to change problem drinking, there would be very few alcoholics in this world.

On rare occasions, a client may present with values that are so divergent from the therapist's that a collaborative working relationship cannot be established. In these cases, the therapist should refer the case elsewhere. In the vast majority of cases, however, client and therapist values are sufficiently similar that a basic schism over valued life directions will not develop.

Confusing Values and Goals

A common problem in values work is the therapist's failure to detect goals that are presented as values by the client. For example, the client might say, "I want to be happy." This sounds like a value, but it is not. Being happy is

something you can have or not have, like an object. A value is a direction—a *quality* of action. By definition, values cannot be achieved and maintained in a static state—they must be lived out. When goals are mistakenly taken as values, the inability to achieve a goal seemingly cancels out the value. A practical way to avoid this confusion is to place any goal or value statement produced by the client under the following microscope: "What is this in the service of?" or "What would you be able to do if that was accomplished?" Very often, this exercise will reveal the "hidden value" that has not been stated.

Some "values" are really means to an end, in which case they are not values at all. One way to think of values is as *means values* versus *ends values.* Means values are things that are valued because they can produce certain ends. For example, a person might value being wealthy; however, wealth is valuable because it allows for other values to be pursued, such as security for oneself and one's children or a desire to help others who are less fortunate. The hidden value here is caring for self, family, and the less fortunate. Another common means value is promoting personal health. Staying healthy might feel better than the alternative, but the real value in protecting health is that it enables us to do things that are valued in life, such as traveling, giving away one's daughter at her wedding, spending the "golden years" with a life-long partner, and so on. Ends values, by way of contrast, are life outcomes that are valued for their own sake even though they might also trigger other valued outcomes. For example, one may value parenting, and parenting may produce social recognition and praise by peers. However, it is unlikely that one would cease to value parenting if social recognition were not forthcoming. Contrast this with money as a value. If money ceased to produce material goods—say, through the complete devaluation of a currency—acquiring money would cease to be a value.

Experiential avoidance is a good example. The means–end relationship is revealed if the therapist asks, "What would avoiding anxiety be in the service of?" or "What would you be able to do if you could avoid anxiety?" The client might answer that it would then be possible to live a more valuable life. The therapist could then ask, "If you weren't anxious, what would you be doing that would tell you that you were living a more valuable life?" Avoiding anxiety is a pseudovalue, and much of the impact of ACT comes simply from sorting this out and moving more directly to actions linked to values. When the values implicit in current actions are made explicit, the client often rejects them. For example, the client would probably not choose a tombstone epitaph that read "Here lies Fred. He spent his life avoiding anxiety."

Contemporary society is dominated by a focus on object-like outcomes (i.e., goals that are attained). In most cases, the first time the client completes the values exercise what he or she produces looks more like an

exercise in goal definition than an exercise in choosing valued directions. The therapist's job is to detect this confusion of process and outcome and help the client connect specific behavioral goals to values.

Order of Values Work

We have stressed repeatedly that the order in which ACT core processes are addressed in this book bears no relation to their ordering in therapy, and values work is an excellent case study of this point. Some ACT therapists like to use values work upfront during the initial sessions of therapy. The rationale for this approach is that getting clients "in touch" with their values as well as the cost of inflexible behavior on valued life outcomes is one good way to motivate clients to stay in therapy and make changes. Some intractable clinical problems (i.e., chronic drug or alcohol addiction) might be good candidates for this approach, especially when the main issue is keeping the client involved in the therapy. There are "softer" versions of a full values construction approach, in which the initial session involves a conversation about the client's life desires and what the impact of the "problem behavior" has been on those desires. In practice, there is a constant fluid dynamic among the core processes such that early discussions of values can immediately give way to a present-moment intervention (e.g., "What just showed up for you as we talked about your life principles and how they've been affected by your depression?"). The "art" of ACT (if there is one) is the ability to seamlessly move between the core processes in response to what is happening with the client in session.

In general, we discourage taking a "one-size-fits-all" approach to the positioning of any ACT process. It is not the case that every course of therapy should start with values work. There is nothing magical about values work in and of itself. It is how it is tied to and linked in with the other core processes that matters. There are many clinical situations in which a rigid adherence to conducting values work upfront could actually be counterproductive, such as with a multiproblem client with failures of self-processes and very high risk avoidance behavior (i.e., cutting, suicidal behavior). Upfront values work with such a patient might produce increased self-loathing and the sense of being criticized and rejected by the therapist for failing to live up to any identified values.

Cultural Insensitivity

Values work done well is inherently culturally adapted since the client sets the agenda and is the final expert. That being said, therapists need to learn about cultural differences and to listen carefully to clients. Values are part of socialization, and cultures differ in the values they encourage.

Especially if specific values are characteristic of cultures other than the therapist's, it can be important to consult with others familiar with that social group to avoid communicating that certain choices are not really values merely because they are different.

READING SIGNS OF PROGRESS

Progress in values work is signaled when the client and therapist have a mutually agreed-upon set of behavior-motivating life directions that are accompanied by specific immediate and intermediate-term life goals and action strategies. In addition, the client should indicate a willingness to form an action plan to embody these values and goals. At that point it becomes clear that the client is pursuing closely held personal beliefs and is not simply "inhaling" the mores and beliefs of the surrounding social milieu without taking personal responsibility for values choices. Values work is usually (but not always) connected to committed action in the sense that the ultimate goal of ACT is to help the client live a value-consistent life. To use an orientation metaphor, values assessment is more about careful appreciation of the map and also of the surrounding terrain. Values assessment is like taking a compass heading. Commitment action work, by contrast, is designed to identify and undertake specific actions that move a person in a valued direction, specific goals that tell one whether if movement has truly occurred, and, finally, about the potential barriers to action that arise as the actual journey begins. To those issues we now turn.

CHAPTER 12

Committed Action

> [Upon booking passage to Mumbai:] Concerning all acts of initiative (and creation), there is one elementary truth the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, providence moves too. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents, meetings and material assistance, which no man could have dreamt would have come his way. I learned a deep respect for one of Goethe's couplets: "Whatever you can do or dream you can, begin it. Boldness has genius, power and magic in it!"
>
> —MURRAY (1951)

In this chapter, you will learn . . .

- How to deepen the distinction between choice and decisions.
- How to help clients work with values to create specific life goals.
- How to define actions that are used to accomplish these goals.
- How to work with "hooks" that undermine committed action.

PRACTICAL OVERVIEW

Despite its well-elaborated interests in cognition and emotion, at the end of the day ACT is a relatively hard-core form of behavior therapy in two senses of that term. First, it is a therapy that is based on behavioral principles in a thoroughgoing way. Theoretically its roots are deeply embedded in behaviorism, behavior analysis, and functional contextual philosophy. Second, its bottom line is behavioral. The ultimate goal is to develop patterns of behavior that work for the client, and nothing less will be counted as a success. By *working*, we mean that the client is taking actions that move his or her life in a valued direction. Ultimately, clients have to "vote with

their feet," and the footsteps are committed actions. The *C* in *ACT* and the acronym itself express the fundamental importance that ACT places upon behavioral change. If a client does not change his or her behavior, then all of our efforts working on defusion–acceptance, present moment–self-as-perspective, and values are for naught.

One of the major misunderstandings about commitment is that it often seems like a promise made about the future. In therapy, it can take this form: "Can you make a commitment to do this behavior between now and when we meet again?" The client says, "Yes, I will make that commitment." Although making such a statement might be part of a commitment, it is not the most important part. In fact, commitment is not really about the future at all. It is about taking a specific action *in situ*, a situated act in the context of external and internal forces. If a person comes to a fork in the road, commitment occurs in the very moment a person takes a step in one of two directions. The person is saying, "I'm going this way rather than that way." Each step taken in the direction of "this way" is part of the commitment to go "this way rather than that way." In the chapter-opening quotation, Murray makes his statement on the heels of booking passage to Mumbai, where his trip to climb the Himalayas will begin. The ascent of those mountains begins in the booking of that ticket. It is his first step that says "I am climbing." He is no longer planning to climb; he is climbing.

Defining Commitment in ACT

In an important sense, commitment is properly part of the expression of personal values. What would a value be, absent any action taken on its behalf? Committed action consists of particular acts in particular moments, whereas a value involves freely chosen, verbally constructed qualities of ongoing action. Values-based actions are those that are deliberately designed to embody a particular value and are intrinsically reinforced. For example, if a person feigns love for another solely in hopes of receiving a gift, the action is not likely loving in any true functional sense because it is reinforced (if at all) by money, not merely by signs that a loved one is cared for. In a sense, values are adverbs because a quality of action serves as the intrinsic reinforcer. "Behaving lovingly" can be a value, for example. "Having someone love me" is more a goal than a value.

Commitment, as it is used in ACT, also involves a process of deliberately constructing larger and larger patterns of behavior. Thus, in ACT, *committed action is a values-based action that occurs at a particular moment in time and that is deliberately linked to creating a pattern of action that serves the value.* Keeping a commitment means, in a moment-by-moment way, behaving consistently with values as part of an extended and ever-expanding pattern of action.

Committed actions are not the same as promises, predictions, or historical descriptions. Although they extend into the future, they occur in the here and now. That quality of an *extended present* is attributable to functional rather than the purely surface features of committed actions. A person can stay married for decades and never be committed to a loving marriage; conversely, a person may be committed to a loving marriage but later get divorced. The commitment depends on the source of reinforcement in the present, linked to particular choices.

Committed actions are never perfect and never constant. And yet, the very moment one sees a divergence between actions and a value, and chooses again to act to embody and grow that value, that very action is a committed action.

Committed actions can involve entirely private mental activity. One example is Victor Frankl's commitment, in a concentration camp, to love and care for his wife—even though he had no control whatsoever over any behavior that could communicate love and caring to her directly.

In this chapter we examine a number of important topics that typically arise in work on commitment processes. Commitment deepens the distinction, introduced in values construction, between choosing and deciding. In this chapter we show how the distinction is relevant to values-based actions. We discuss how to work collaboratively with the client to develop action strategies that embody expressed values. We address the process of anticipating and addressing barriers to committed action that inevitably arise and, in fact, make sense of all of the work done on acceptance, defusion, present-moment awareness, and self as perspective. We also address how to integrate "traditional" behavior therapy interventions such as exposure, skills training, stimulus control, response prevention, behavioral activation, and homework within an ACT-consistent framework.

CLINICAL APPLICATIONS

Clients typically come into therapy feeling the sting of failure and defeat. They have undoubtedly resolved to try different strategies to address their problems and often have found it difficult to persist in the face of obstacles. In some cases, their behavior reflects a commitment to avoid obstacles rather than to live according to personal values. We can often observe this attitude in the behavior the client brings into the sessions. If we assume that all behavior is organized and the client is not just engaging in random behavior, what values could we infer from observing the function of the behavior? In a very real sense, this is the "life meaning" that currently is being generated by the client. Unfortunately, the client often is so busy explaining, analyzing, and justifying behaviors that this important fact

is overlooked. We have to bring the client into contact with the fact that every behavior at every moment is generating some meaning and is tied to some purpose. Living in an intensely symbolic world does not alleviate the situation—it merely expands the variety of behaviors that are relevant to choice. The clock is ticking, our behavior is ongoing even while we sleep, and our behavior is reflecting our purposes regardless of what our minds are telling us.

Choice and Commitment

Committed action is a choice to behave in a particular way on purpose. Clients often have a hard time with the concept of choice because it is an emotionally cluttered word in our culture. Clients talk about having made "bad choices" as if it is essential to make "good choices." What they normally mean by "bad choice" is that the outcome of an action was aversive. The ACT therapist tries to circumvent this moralistic and evaluative use of the word. We don't blame clients for the choices they make. We try to help them understand that choice is available, and if closely tied to values it can be a powerful place to stand. If the client related well to the *Chessboard* metaphor (see Chapter 8), the therapist can link the issue of choice to that metaphor:

> "It's like the chessboard. There are only two things the board can do: hold all the pieces and move them all. Choosing a course of action is like saying to the pieces 'We are moving *here*.' That's a choice—it is not up to the pieces to agree or to argue it out. The board is going in a particular direction because you choose to do so. To do that, you have to be in a place that the pieces can come along. They are not in charge. So, being willing to 'have what you have' is what makes choice of action possible. Within the *Chessboard* metaphor, the direction taken is the value, while the choice to move in that direction in a behavioral way is part of committed action."

The *Gardening* metaphor can also be used to highlight how choice allows one to maintain a fixed course in the face of difficult, provocative, or confusing feedback.

> "Imagine that you selected a spot to plant a garden. You worked the soil, planted the seeds, and waited for them to sprout. Meanwhile you started noticing a spot just across the road that also looked like a good spot—maybe even a better spot. So, then you pulled up your vegetables and went across the street and planted another garden there. Then you noticed another spot that looked even better. Values

are like where you plant your garden. You can grow some things very quickly, but some things require time and dedication. So the question is 'Do you want to live on lettuce, or do you want to live on something more substantial—potatoes, beets, or the like?' You can't find out how things work in gardens when you have to pull up stakes again and again. Now, of course, if you stay in the same spot, you'll start to notice its imperfections. Maybe the ground isn't quite as level as it looked when you started or the water has to be carried a good distance. Some things you plant may seem to take forever to come up. It is times like these that your mind will tell you that 'you should have planted elsewhere,' 'this will probably never work,' 'it was stupid of you to think you could grow anything here,' and so on. The choice to garden *here* allows you to water and weed and hoe even when these thoughts and feelings show up. You are building a larger pattern. You are not just watering—you are watering *your garden*. You are not just hoeing, you are hoeing *your garden*."

This metaphor is also useful in guiding clients toward more committed actions. For example, if a client values a more loving marital relationship, this metaphor could encourage the client to be more active in that area. Bringing coffee to your spouse might in some ways be like hoeing—but it is not the coffee per se that is important. It is the linkage to the larger *relationship*—that is, the marriage or the garden—that makes sense of these individual moments of action and that gives them the power to lead to larger patterns of values-based behavior.

Goals Are the Process through Which Process Becomes the Goals

One reason clients get stuck is because they believe attaining goals is the key to happiness and their satisfaction with life. They try to get what they want in order to be happy. This way of living is in some ways oppressive because it is functionally connected to a state of deprivation. Trying to be happy by achieving goals is living in a world where what is important is constantly missing, present only in the hope that it will someday arrive. The thing that you most need (i.e., having what you want) is constantly never present. While this sense of deprivation may create motivation and directed action, it squeezes out any sense of vitality. Little wonder that goals and values are constantly confused with each other!

At the level of process, the inflexibility and "stuckness" result from fusion, avoidance, and a failure of present-moment processes. If "outcome X = good," then "absence of outcome X = bad." In such a state, the present moment itself is to be avoided, since the present, by definition, is "the absence of X." Ironically, intimate contact with the present moment may

be exactly what is needed to produce *X* in the deeper sense of an ongoing evolving pattern.

The best answer to the dilemma is to use goals only as a means to engage in the change process and to point one's efforts in a consistent direction. The clinician's focus should remain riveted on staying with the process in a moment-by-moment way and constantly defusing verbal messages. This approach does not mean that the client's preferred outcome is not desired. It just means that the outcome or absence-of-outcome exerts less rigid control over the client's behavior. When the process of living itself actually becomes the primary outcome of interest, we are no longer living in a verbal world of constant deprivation. When the purpose of life becomes truly living, we always have it *right here, right now.* Bringing up the *Skiing* metaphor is another way of dramatizing the vitality-producing aspects of rightly focusing on process.

> "Suppose you go skiing. You take a lift to the top of the hill, and you are just about to ski down the hill when a man comes up and asks where you are going. 'I'm going to the lodge at the bottom,' you reply. He says 'I can help you with that,' and immediately grabs you, throws you into a helicopter, flies you to the lodge, and then disappears. So, you look around kind of dazed, take a lift to the top of the hill again and are just about to ski down it when that same man grabs you, throws you into a helicopter, and flies you to the lodge again. You'd be pretty upset, right? You'd probably say, 'Hey, I want to ski!'
>
> "Skiing is not just getting to the lodge. Any number of activities can accomplish that for us. Skiing is a particular process of getting there. But notice that getting to the lodge is important to skiing because it allows us to do that process. Valuing down over up is necessary in downhill skiing. If you try to put on downhill skis and ski uphill instead of down, it just doesn't work! There is a paradoxical way to express this: outcome is the process through which process can become the outcome. We need outcome goals, but the real point is that we participate fully in the journey."

Most clients in contemporary society are far too outcome-oriented in that much if not most of their social training consists of simply applying materialistic standards of "success" to themselves almost by rote. They constantly monitor how well they are doing and how successful they are compared to others, and they constantly imagine themselves achieving a better state of mind than their current one or lamenting past instances whenever their actions, or failures to act, play out badly. They often pull up short on potentially invigorating life initiatives whenever the anticipated outcome is not achieved precisely "on time."

Behaving is a way that is directed does not mean that we have to monitor progress from moment to moment every step along the way. In fact, this preoccupation with outcome monitoring inevitably diminishes the vitality. If we keep looking to see how happy we are in life, we will be very unhappy. Indeed, at times, we have to keep the faith even when a valued direction takes unexpected turns. The *Path Up the Mountain* metaphor can be employed to help the client understand the hazards of constantly monitoring immediate progress toward concrete goals rather than connecting with valuing as a process. More than that, this metaphor shows that even painful or traumatic phases in life can be integrated into a positive overall path if we learn from them.

> "Suppose you are taking a hike in the mountains. You know how they construct mountain trails, especially if the slopes are steep. They wind back and forth; often they have 'switchbacks' where you literally walk back and forth, and sometimes they will even drop back down below a level you'd already reached earlier. If I asked you at any given point on the trail to evaluate how well you are accomplishing your goal of reaching the mountain top, I would hear a different story every time. If you were in switchback mode, you would probably tell me that things weren't going well, that you were never going to reach the top. If you were in a stretch of open territory where you could see the mountain top and the path leading up toward it, you would probably tell me things were going very well. Now, imagine that we are across the valley with binoculars looking at people hiking on this trail. If we were asked how they were doing, we would have a positive progress report every time. We would be able to see that the overall direction of the trail—not what it looks like at a given moment from ground level—is the key to progress. We would see that following this crazy, winding trail is exactly what leads to the top."

Developing Values-Based Goals and Actions

After undertaking and completing the values construction and clarification process (described in the preceding chapter), the client is asked to develop goals and specify actions that can be taken to achieve those goals. Inevitably, barriers to committed action will arise and need to be addressed. This work on goals, actions, and barriers to action stands on the foundation of the client's values. It is the most applied aspect of the ACT approach and also the most critical because ACT is primarily about acting on and in the world.

A goal is defined as a specific achievement sought in the service of a particular value. For example, if the client values contributing to society,

we might ask about specific ways this value could be put into action—say, by getting involved in a local charity or volunteering somewhere. The client then defines actions that would likely achieve the goal. The client might decide to call the Red Cross, to give money to the United Way, or to volunteer at a local soup kitchen. The therapist and client try to generate acts that can take the form of homework. In some cases, these may involve single instances; at other times, they may involve a commitment to repeated and regular acts. Typical goals and actions might include:

1. *Career*: investigating reentering school, applying for new jobs, asking for a raise, talking to a career counselor, doing your job well
2. *Leisure*: joining a softball team, attending church, asking someone out on a date, going dancing, having a friend over for dinner, going to an AA meeting
3. *Intimacy*: setting aside special time to spend with a spouse, calling or visiting a child from a former marriage, calling or visiting parents, making amends in severed friendships
4. *Personal growth*: arranging to make payments on back taxes/child support/bills, learning a foreign language, joining a meditation group

An important aspect of effective goals-action work is to monitor the relationship between the action, its associated goal, and the associated value. Will this action, if taken, actually produce the goal or help lead to it? Is the action feasible and within the client's range of abilities? Does the client understand the temporal relationship between the action and the goal? Some actions are like seeds in the *Garden* metaphor. They need to be "put into the ground" and allowed time to sprout. Other actions produce immediate results, such as quitting an unsatisfying job for the goal of pursuing a new career. Figure 12.1, the Goals, Actions, and Barriers Form, can be used in helping clients to develop goals and actions connected to their values.

When developing committed action plans, it is often wise to encourage the client to accumulate small positives in the action–goal arena. Taking little steps consistently has a greater impact than heroic steps done inconsistently. The emphasis is on actions that feel like "steps in the right direction," that is, actions experienced as consistent with the client's values and stated goals. The aim is to increase the client's efficacy in building ever greater patterns of committed action. At the same time, the therapist models a very effective form of personal problem solving that can generalize to other settings and situations the client might face.

Work on commitment is the part of the ACT model that varies the most with specific problem behaviors. For example, committed action for

Given the valued direction listed, work with the client to generate goals (obtainable events) and actions (concrete steps the client can take) that would manifest these values. Using interviews and exercises, identify the psychological events that stand between the client and moving forward in these areas (taking these actions; working toward these goals). If the client presents public events as barriers, reformulate them in terms of goals, and place them beside their relevant value (they may differ from the initial row that raised this issue). Then look again at actions and barriers relevant to these goals as well.

Domain	Valued Direction	Goals	Actions	Barriers
Family Relations (other than couples or parenting)				
Marriage/Couples/Intimate Relationships				
Parenting				
Friends/Social Relations				
Work				
Education and Training				
Recreation/Fun				
Spirituality				
Community Life				
Physical Self-Care (diet, exercise, sleep)				
The Environment (caring for the planet)				
Aesthetics (art, music, literature, beauty)				

FIGURE 12.1. Goals, Actions, and Barriers Form.

smoking might involve tapering, scheduled smoking, mindful smoking, quit dates, stimulus control procedures, public commitments, and other procedures. When dealing with depression, committed action could involve behavioral activation, social involvement, resolution of family difficulties, exercise, or addressing work-related problems. When dealing with anxiety, committed action might involve graded exposure, increasing social activities, or sleep hygiene. The key point is that ACT is part of behavior therapy, and the functional analysis provided by the ACT model is meant to inform the larger set of functional issues specific to particular presenting problems. Committed actions tend to be extended by time, place, or specific actions. A commitment to resolve a drug addiction involves many specific actions. Behavioral science can provide a great deal of information about how to construct such patterns that work. The link between committed action in ACT and traditional behavior therapy is that the latter can help specify the larger patterns that can be built to foster valued qualities of action.

Identifying and Undermining Barriers to Committed Action

Effective behavioral goal setting requires a candid analysis of the barriers that the client is likely to encounter that may forestall action. Usually, barriers function as obstacles because they trigger unwanted, distressing private events. Barriers might involve negative psychological reactions or pressure from outside sources. The client who contemplates resigning from an unfulfilling job will most likely encounter thoughts like "You're making a big mistake. What if you don't find your dream job—then what'll you do?" Contained in this relatively simple thought are potential examples of fusion, failure of present-moment processes, and avoidance. Also, such negative anticipatory emotions as fear, anxiety, or shame may show up. External barriers that trigger pliance or counterpliance may also present themselves. The client's spouse may disagree with the decision, may resent the subsequent restrictions in lifestyle as money gets tighter, or may accuse the client of being "selfish" rather than self-sacrificing.

These external barriers can lead to still more negative private events and more avoidance. The client may also come to realize that pursuing one course of valued action (e.g., striving for a more satisfying or challenging work life) collides with another valued course (e.g., building intimacy in primary relationships). The point is that engaging in valued action always stimulates psychological content in one way or another. Particularly when this content is negative, it can function as a barrier to action. Our clients do not get stuck in life solely by chance. They get stuck because they avoid taking valued actions as a means of avoiding painful emotional barriers. If previous ACT work has been successful, the client is ready to recognize

the barriers for what they really are, not what they advertise themselves to be.

Can the client identify barriers to valued action in each domain? This work will naturally involve moving between values and commitment work and work on other processes of the hexaflex—self-as-perspective, defusion, acceptance, and present-moment processes. Making commitments activates the problematic aspects of these other processes, which are then revisited in the service of keeping these commitments. As barriers are identified and discussed, the therapist helps the client to consider the following:

1. What type of barrier is this? Are negative private events or external consequences in conflict with some other value? Are there issues with pliance or counterpliance?
2. Is this barrier something you could make room for and keep acting?
3. What aspect of this barrier is most capable of reducing your willingness to have the barrier without defense?
4. Are any of these barriers just another form of experiential avoidance?

Willingness to Have Barriers and Barriers to Willingness

Willingness was addressed earlier (in Chapter 10) in the context of acceptance processes. With commitment work, it is time to reintroduce willingness with a new twist. The emphasis in Chapter 10 was on helping the client open up to difficult internal states. In the context of commitment, willingness is the choice to act in a values-based way while knowing full well that doing so triggers feared content. It may be revealed in the patient with panic symptoms who nonetheless chooses to walk into the shopping mall, well aware that anxiety and fear await. It is revealed in the unhappy spouse sitting down with a life partner to discuss basic problems in a marriage, knowing that rejection by the other is possible. Why would anyone voluntarily evoke painful personal content from the environment like this? The answer is that no one would—unless it served an overarching life purpose. Willingness—the action—is dignified by the presence of values, and it makes the embodiment of those values possible.

One major barrier to commitments is the fear of failing to keep them, combined with fusion with a story that past failures in commitments mean that future commitment is impossible. In fact, the pain of not committing to what ones cares about is a powerful ally to the pain of past failures—but only if these twin sources of pain can be taken in and enhanced through defusion, acceptance, and behavioral willingness.

The *Bubble in the Road* metaphor expresses the linkage between willingness and the ability to take a valued direction.

> "Imagine that you are like a soap bubble. Have you ever seen how big soap bubbles can collide with smaller ones, and the little ones are absorbed into the bigger one? Well, imagine that you are a soap bubble like that and you are moving down a path you have chosen. Suddenly, another bubble appears in front of you and says 'Stop!' You stand there for a few seconds. When you move to get around, over, or under the bubble, it moves just as quickly to block your path. Now you have only two choices. You can stop moving in your valued direction, or you can collide with the other soap bubble and continue on with it inside you. This second move is what we mean by 'willingness.' Your barriers are largely feelings, thoughts, memories, and so on. They are really inside you, but they seem to be outside. For example, the smaller bubble can say, 'You can't commit to this path because in the past you've failed to keep your commitments.' 'Willingness' is not a feeling or a thought—it is an action that answers the question the barrier asks: 'Will you have me inside you by choice, or will you not?' In order for you to take a valued direction and create a new behavioral pattern, you must answer 'Yes,' but only *you* can *choose* that answer. For example, can you have the fear of failing in your commitments *and* make the commitment?"

The ACT therapist weaves these topics together to fit the client's situation: willingness, choice, valuing, actions, and barriers. Living a powerful and vital life is not really possible without the willingness to surmount barriers; a set of valued directions that make dealing with these barriers purposeful; and a choice to act in the face of unpredictable consequences.

Commitment work highlights the iterative quality of ACT. Committed action is like peeling an onion. If you peel a layer off of an onion, what you find is another layer. It is tempting to see committed action as a simple formula: Constructed Value → Committed Action. If being a loving spouse emerges as a client's key value, it implies a series of committed actions. However, ongoing committed action likely also reveals other ways the value could be lived. In this way, committed action feeds back into values, causing the client to further elaborate what it means to be a loving spouse. The elaboration might in turn generate new committed actions. In a similar way, all ACT processes feed into one another and back again. An elaborated value may bring a person into psychological contact with failures to live that way in the past. To the extent that the failures are painful, they may require acceptance. A client might make contact in a very painful way with his or her own myopia with regard to the value. The thought "How

could I be such an idiot?" might become an important target for defusion work. Strong attachments to a history of failure might take the client out of contact with the present moment. Clients frequently recycle through ACT processes like this as new commitments are made and kept. Clinical progress almost certainly will mean revisiting all other ACT processes, each time within a different contextual field of play.

COMMITTED ACTION AND TRADITIONAL BEHAVIOR THERAPY APPROACHES

Given the dynamic growth pattern of the contextual wave of the behavioral and cognitive therapies of which ACT is a part, there is always going to be confusion about how the "new" relates to the "traditional." For example, ACT has been construed by some as being opposed to traditional behavioral approaches; to others, ACT is basically the "same wine in a different bottle." In fact, virtually all classical behavioral interventions are compatible with ACT. As we stated at the beginning of this chapter, ACT is in essence a hard-core behavior therapy—but featuring thoroughgoing analysis and an approach to cognition that is based on behavioral thinking. In what follows, we address the ways in which committed action fits in readily with many traditional behavioral interventions.

Exposure

As we noted in passing in Chapter 10, ACT is an exposure-based intervention—based on a contextual view of the essence of exposure. The goal of traditional exposure is symptom reduction or elimination, whereas in ACT the goal is psychological flexibility in pursuit of committed action.

To some degree repertoire expansion can be pursued by fostering emotional, cognitive, and behavioral flexibility per se. For example, during a traditional exposure session in a mall with a person suffering from agoraphobia, an ACT practitioner would observe that the client is open to new behavior and have the client identify the person close by with the silliest hairdo, or discuss what the soles of his or her feet feel like, or deliberately do the opposite of what his or her mind is suggesting to do (e.g., if he or she is afraid of having a panic attack and looking foolish, march straight into the nearest clothing store together and immediately order a hamburger!). Such oddball tactics are designed to increase the flexibility of psychological actions in the presence of previously repertoire-narrowing stimuli. If we have done some previous values work with the client, however, the choice of experimental actions can be linked more closely to values-based actions and committed action. For example, the person struggling

with agoraphobia can be asked to commit not to leave the mall until he or she buys a gift for a loved one.

Even the most conventionally organized *in vivo* exposure activities play an important role in ACT. For example, exposure can be used as a form of practicing staying in the present moment regardless of distressing content. During exposure, the client can practice defusion and seeing thoughts for what they are. Staying in a painful situation can be done with an eye toward personal values and taking actions consistent with those values. Patterns emphasizing even more flexible actions can be acquired as part of a formal commitment. The key is that exposure in ACT is not about symptom reduction. It's about fostering psychological flexibility in the presence of previously repertoire-narrowing stimuli in the service of doing what is to be done.

One of us (KDS) worked with a 38-year-old married mother of three children who had experienced debilitating and chronic anxiety for over a decade. Her fear of anxiety, preoccupation with it, and avoidance of situations that could produce it had wreaked havoc in her life. The following conversation occurred in the initial interview.

THERAPIST: Let me see if I've got this straight. Your stance on anxiety is that you won't tolerate it, you will be on guard for it at all times, and you will avoid doing anything that might trigger it—is that right?

CLIENT: That's about it. Sounds pretty weird and depressing, doesn't it?

THERAPIST: I'm guessing the depressing part is all the activities you want to do with your kids and they ask you to do—but you don't do. You skip out on them because you might become anxious if you went out with them.

CLIENT: I feel like I'm failing them as a mother. I can see how disappointed they are when I tell them I won't go to a movie, I won't go to the park with them, I won't take them shopping. I make their dad do all of those things.

THERAPIST: And you told me your kids mean everything to you! If it weren't for them, you mentioned you might have done yourself in a long time ago when the anxiety got the best of you. So, I can see that you have this beautiful value of wanting the very best for your kids and you want to find a way to live that out to the fullest. Unfortunately, Mrs. Anxiety is telling you what you can and can't do rather than letting your values do the talking.

CLIENT: Exactly, I hadn't really thought about it that way, but that's exactly what has happened. My anxiety is making the choice for me.

THERAPIST: And the result is you feel like you are letting your kids down. You are living the opposite of what you believe in. If we could just think small here, what action *could* you take that would tell you that you were beginning to be the mother and friend that you want to be? We don't have to get grandiose and change everything at once, but just something little; something that would tell you that you were getting back on track. Of course, to take even this little step, you will have to disobey Mrs. Anxiety. Anything you pick is going to expose you to some level of anxiety; you are going to be anxious, you might even get very anxious and at that very moment, you get to choose what you want your life to be about—being the mother you always dreamed of being or trying to live without anxiety. Which direction do you want to go in?

CLIENT: I'm scared to hear myself say this . . . but I want to be Mom! My youngest son loves soccer, and I haven't let him sign up for a team because driving him to practice will make me really anxious. I hate driving by myself; I usually need my husband to be in the car if I'm going anywhere.

THERAPIST: So, imagine you are driving in the car with just your son. What will show up?

CLIENT: I can feel my heart beating faster; that's the first sign I get when the anxiety hits.

THERAPIST: What else?

CLIENT: I feel like I'm short of breath and there is a pain in my chest. I start to feel dizzy. I am worried that I can't drive right, so maybe I should pull over. I feel sick to my stomach. I want to go home so I can be safe. I feel like I'm in danger!

THERAPIST: I just want you to sit still with all of this. Don't move; just let it wash over you without doing anything with it.

CLIENT: This is really uncomfortable.

THERAPIST: Right, it is. I know it is! Can you imagine having all of this stuff show up and then just keep driving the car to the soccer sign-up? This trip is not about anxiety and what to do with it; it is about being the mother you want to be, even if it means being anxious.

This vignette shows how ACT can recast exposure work in terms of the fit with valued life patterns. Each exposure exercise is itself is an act of commitment. In fact, each step this client takes, however small, can be an act of commitment in the service of her values. It takes a tremendous amount of courage to confront one's own fears and stay focused on what matters.

This client returned for a follow-up session in 2 weeks. She brought along a piece of notebook paper. Every line on the first side of the paper was filled with an activity she had engaged in during the preceding 2 weeks, many of which hadn't happened in years! Beside each activity, she made a rating of her anxiety level while doing the activity. The anxiety scores ranged from 5 to 10, with many ratings being 8 or 9. However, the anxiety scores had not declined during the 2-week period with any regularity, despite numerous exposures. The following conversation took place about that fact.

THERAPIST: I notice that you did all these activities, and your anxiety a lot of times was very high. How did you pull that off?

CLIENT: It felt really good to do these things. It made me feel healthy inside—like I am living again! The anxiety is really, really uncomfortable, and I hate it! But this is what I want in my life: I want to be there for my kids and my husband, not a house-bound person who is afraid of her own shadow. I hope the anxiety will go away sometime—that would be nice. But I'm going to do these things anyway, regardless of how I feel! I've even decided to take my husband to a movie on our anniversary next month. We have never been to a movie since we met 12 years ago!

Pharmacotherapy

Even some pharmacotherapy approaches can be set in the context of values and commitment. ACT is often thought to be opposed to medications, but medications based on good science with proper controls can be an important ally. ACT has been used in randomized controlled trials to help providers become more open to using what that good science says in the area of pharmacotherapy for substance use (Varra et al., 2008). The same message applies to clients. For example, monitored Antibuse can be effective in maintaining abstinence from alcohol, but it is often experienced as demeaning by clients. In a case treated by one of us (KGW), a values and commitment approach was taken. The client had a long history of relapsing into dangerous and destructive bouts of alcohol consumption. In an effort to save his marriage, the alcoholic husband agreed to take Antibuse each day, with adherence being monitored by his wife. The following clinical conversation addressed his sense of feeling demeaned by the whole process.

CLIENT: I told Sue I would take the Antibuse every day and she could watch me do it.

THERAPIST: And she said she would give the marriage another chance if you did that?

CLIENT: Yes.

THERAPIST: How are you feeling about that, Tim?

CLIENT: Well, it is the only way she would stay. Without that, she said she just couldn't take another chance. You know, with the kids and all.

THERAPIST: Feels a little like you *have* to do this?

CLIENT: She will leave if I don't.

THERAPIST: Well, this worries me some. I mean there are a couple of ways this could go. Every morning, you could sit down at the breakfast table and she would be there and you would be saying to yourself, "This sucks. Why do I have to do this? She's watching me like I am a little kid or something." And, in all likeliness she would pick up on that, and it would make her mad. Like—"Hey, this isn't my fault! Don't blame me!" And even if it all goes unsaid, there it is, driving a wedge between you.

CLIENT: Well, I'm OK with doing it. I mean, I don't trust myself!

THERAPIST: See, that's exactly what I mean. Now the Antibuse is driving a wedge between you and you. Here is another idea. Try this on for size. Remember when you and Sue got married? Just stop a minute, and let your eyes go closed, and see if you can picture her on that day.

CLIENT: Sure. It was an amazing day! Scary and lucky, and I don't know how to say what it meant to me.

THERAPIST: Well, you did say it that day, though—didn't you? You stood up in front of all those people, in front of Sue. And you looked into her eyes. And you said, "I do." Remember?

CLIENT: Sure.

THERAPIST: Let me ask you to do this, Tim. Would you mind just taking a second to close your eyes, let yourself settle in your chair, and just take a moment and let yourself notice the gentle inflow and outflow of each breath. (*Pauses for about 30 seconds with small coaching to notice breath.*) Tim, I want you to see if you can picture yourself and Sue at the altar. See if you can remember looking into Sue's eyes. (*Pauses long enough to allow the client to visualize.*) Can you see her there, Tim? Can you just linger a moment with those eyes you looked into all those years ago. Just let yourself drink this in for just a moment. (*Pauses.*) You stood there and you made a commitment to be her husband Tim. See if you can

hear your own words, "I do." And now breathe and let your eyes come gently open, Tim. Could you see that moment (*spoken softly, slowly*)?

CLIENT: Yes, I could see her. I was right there.

THERAPIST: Forever, right? You know … "For richer, for poorer, in sickness and in health."

CLIENT: Yes.

THERAPIST: What about this, Tim? What if each morning you sat down at the breakfast table with Sue. And you just took a moment to look her in the eyes and just said one more time, "I do." And then, take your meds. Is there a way, Tim, that each time you take them you can let it be a sort of reaffirmation of those vows you took?

In the ACT model, even mandatory treatments, including therapy and/or medications—be they court-ordered, health-ordered, or spouse-ordered—can be set in the context of a closely held value, with the direct followthrough framed as a committed action.

Skills Training

Skills training has always been a mainstay of behavior therapy, and it is an important component of ACT as well. We would maintain, without being pedantic, that all cognitive and behavior therapies are actually forms of skills training. Challenging a distorted thought in a given situation is a skill; changing self-talk when anxious is a skill; learning to maintain eye contact and to smile when meeting a new person are skills; mindfulness and present-moment awareness are skills; perspective taking is a skill. This interpretive framework is what gives behaviorism its distinct advantage over other approaches. Problems don't originate from unseen forces like unconscious conflicts—rather, they originate from *skill deficits*.

Virtually any skills training can be set in the context of values and done mindfully as an act of commitment. Each act, moment by moment as one walks through the skills training, can serve as commitment and recommitment to the client's larger values served by the training. The awkwardness one feels and the self-chatter one faces when learning new skills become the focus of acceptance and defusion, which should empower learning and deploying skills (for positive evidence on that point, see Varra et al., 2008).

These components need not add significantly to the time needed to execute the skills training: rather, skills training can simply be done inside an ACT space, which might even increase the efficiency of skills work. For example, in doing social skills training, a mindful moment touching on

the value served, a sincere, present moment–focused "Yes, I accept this task in the service of my values" can alter the client's relationship with training and make it more likely that the training will actually have a significant impact on future behavior.

Homework

Homework is a traditional staple of behavior therapy with known benefits. Skills taught during therapy sessions need to be integrated into the client's life context. Without some form of between-session practice, there is no reason to believe this type of integration will occur naturally. Homework, from an ACT perspective, is used to activate obstacles and barriers so that the client can learn the skills needed to persist in the face of barriers in the natural situation. The ACT therapist creates homework assignments in collaboration with the client that are explicitly linked to the client's values and in which performance of the homework constitutes committed action in the service of those values. With a depressed client, we might do valued event scheduling in a way that is reminiscent of behavior activation therapy. With a socially anxious client, we might ask him or her about a place to visit that would be anxiety-provoking and that would serve as a committed step in the direction he or she wants to take. An individual who is in a dead-end job but is afraid of failing might be invited to look into online courses or to seek vocational counseling at a local community college. Each step can be explicitly carried out as a commitment to broadening valued action.

Contingency Management

Contingency management strategies are frequently used in a variety of treatment settings, where patients typically gain privileges or other prizes by achieving certain treatment objectives. Level systems, token economies, vouchers for clean urine specimens, and take-home methadone doses all provide good examples. These strategies may seem at odds with ACT, since staff members are typically in a position to both dictate behavior and to provide reinforcement for appropriate performance. This shortcoming only becomes a serious problem, however, when staff members are overwhelmed and contingency management measures become punitive. Linking contingency management directly to patients' values can encourage rather than supplant self-regulation as well as provide some protection against lapsing into a punitive use of an effective treatment strategy. While it may require somewhat more effort, treatment is more likely to be successful when external contingencies and freely chosen values can be aligned.

Stimulus Control Strategies

There are a host of stimulus control strategies that are entirely sensible and useful within an ACT framework. For example, if a person being treated for obesity empties his or her house of bad food choices, that can be done as self-punishment, or it can be done, mindfully, purposefully, and as a step in a valued direction. Emptying the house is not done "so I can't eat bad foods," but instead so that "I create a healthy environment in which to live." Relapse prevention relies heavily on stimulus control strategies. Learning to recognize cues for heavy drinking and arranging to stay out of situations that produce those cues may seem like avoidance. However, that line of thinking need not merely constitute avoidance. An alcoholic client who decides on abstinence might forgo spending time in bars. A person who wanted to moderate their drinking might stop spending Friday nights with particularly hard-drinking friends. Such actions, however, need not be seen as merely avoidant. There is nothing in ACT that says people need to spend their lives finding and accepting difficult experiences. Furthermore, there is no particular virtue in tempting fate. When valued action places the client in harm's way, the appropriate committed action is to note feared content for what it is, accept it on a moment-by-moment basis, and behave in accordance with one's values. An equally appropriate committed action is to arrange one's environment so that feared content is not triggered any more than is necessary, or to seek out new activities that best serve one's values and goals.

Behavioral Activation

The easiest behavioral method of all to integrate with ACT is behavioral activation because the entire right side of the hexaflex is all about it. Modern behavioral activation methods (e.g., Dimidjian et al., 2006) are 100% compatible with ACT and given their relative simplicity and empirical support it is not uncommon for ACT therapists to use a course of behavioral activation alone before launching a more extensive ACT intervention.

This brief overview does not do justice to how fully to integrate an ACT approach with behavioral methods. That undertaking is not possible in a single volume. The psychological flexibility model has such breadth (and, besides, behavioral steps vary by area) that fully explicating how to integrate these methods is tantamount to fully explicating applied psychology from a contextual behavioral point of view. Our key point is that ACT plus behavioral methods is not an "addition" to ACT. Rather, ACT is designed as a *context* for the use of behavioral methods. In other words, developing psychological flexibility is properly the focus of how to do behavioral and cognitive therapy.

INTERACTION WITH OTHER CORE PROCESSES

Commitment and Fusion

Fusion is almost certainly one of the major obstacles to committed action. There are several variants, including fusion with "reasons" as the basis of committed action. If an action is based on reasons and the reasons change, then the decision itself logically must be altered. In some deep sense, this possible eventuality means that commitments are better done as choices rather than on the basis of rational decision making. Reasons often point to things that a person cannot control directly. Thus, one's level of commitment can potentially ebb and flow as the number and relevance of reasons shifts. If commitments are to be ours, not the world's, we want to locate the source of commitment in a province that is ours to control.

Marriage shows the distinction between choosing and decision making quite clearly. Marriage is a commitment—yet, half of all marriages end in divorce. How could this be? In part it occurs because people do not know how to make commitments. They try to make them on the basis of judgments, decisions, and reasons, not as a genuine choice (as we mean it). In so doing, they put their commitments greatly at risk. Suppose, for example, that a man marries a woman "because she is beautiful." If his spouse then has a horribly disfiguring accident, the reason for loving her and wanting to be with her is not longer valid. Even if the man does not want to react in that way, he may have a hard time dealing with what logic tells him, since the original action was based on, linked to, explained by, and justified by this reason—and the reason has now changed. This kind of thing happens all the time when people marry and later find that they no longer have the same feelings of love toward their spouse. Marrying because of feelings of love is considered quite reasonable in our culture because love is dominantly thought to be a feeling, not a kind of choice. But feelings of love are extremely unpredictable. We speak of love as if it were an accident: we say that we fall into and out of it, for example. It should not be a surprise, then, when we fall into and out of marriages in much the same way.

If the client can learn to make choices in valued areas, things work differently. Consider how much more likely it is to keep a marriage vow if marriage is based on a *choice* to marry and love is considered to be a *choice* to value the other and hold the other as special. These actions are a-reasonable, not unreasonable. Commitments based on choices insulate the individual from some of the weaknesses of rule-governed behavior. Held as a choice, nothing can happen that justifies and explains abandoning a commitment since the choice itself does not need to be justified and explained. If any reasons "that came along for the ride" later change, the choice itself doesn't have to changed because the choice was not driven by those reasons. This absence of verbal "cover" is itself a powerful contingency

that helps commitments be kept. If they are going to change (as in the choice to divorce), that absence of cover can help keep the larger set of values front and center (e.g., divorcing in a way that respects the other person, protects the children, and so on).

We see fusion in its most generic form when reasons (or the falling away of reasons) become obstacles to committed action. Several other variants of fusion will be discussed in the sections below because they are particularly relevant to other facets of the hexaflex.

Commitment and the Present Moment

A difficulty arises when clients make commitments as if the commitment is about the future rather than about the here and now. The future is constructed—it does not actually exist. If we become fused with thoughts about the way the future *must* go, we may become hypervigilant. If we spend too much time imagining the future, we may miss opportunities to act in the present moment. In a very similar way, fusion with the past can also undermine commitments. The client who spends all of his time reliving past failures is in a worse position to act in the present.

Worry and rumination are known predictors of poor outcomes. From an ACT perspective, both are examples of rule-governed behavior under aversive control. Because of this, clients become insensitive to important inputs and lack the flexibility necessary to keep commitments under changing conditions. Thus, present-moment processes are key allies to committed actions.

Commitment and Acceptance

Lack of acceptance of feared content can also present enormous obstacles to commitment. To the extent that we determine a set of experiences, thoughts, emotions, behavioral predispositions, or bodily states to be unacceptable, we have set limits on our capacity to make and keep commitments. It is difficult to think of any truly meaningful domain of living where difficult thoughts and emotions are not just likely, but certain, to arise. Career choices generate anxiety about the choices made. Marriage proposals generate anxiety about the future of the marriage. Losses in any of these areas sadden, disappoint, and call up memories of mistakes made and thoughts about the broader implications of the setback for other areas of living. All three authors of this book are parents, and we know many others who are parents as well. We do not know anyone for whom parenting has not—at least at times—been one of the most painful experiences in life. It has been said that becoming a parent is like having your heart placed on the outside of your body. There is some truth to this.

In an important way, making commitments means being willing to live with one's heart outside of one's body. A cultivated capacity to be willing to suffer psychologically, in the service of one's values, makes commitment possible. To the extent that we can teach this kind of acceptance, we can free clients to make and keep commitments.

Commitment and Self

Fusion with a conceptualized self can likewise present serious obstacles to movement. For example, a client fused with the thought "I am a loser and never finish anything" may never start a project. A self-story that is based on childhood victimization may result in the person's never trusting anyone. Since commitments often involve making oneself vulnerable, the person may not be willing to really let go and be vulnerable. By contrast, a client who is able to see self-stories *as only stories* is in a much better position to observe thoughts and emotions that arise when making commitments and to persist even when persistence is painful.

Commitment and Values

Valuing is the core ACT process most closely linked to commitment. Commitments consist of the moment-by-moment links between actions and values in the service of larger values-based patterns. Absent clarity of and contact with values, committed actions cannot be sensibly guided and recalibrated over time. In this case, behavior is left to wander from one "feel-good" option to the next. There is an iterative process between values and commitment that can be exercised in treatment. As a person constructs a valued pattern, new potential forms of committed action become apparent. Likewise, once one makes and keeps a set of commitments for a period of time, the world they inhabit often changes. Acting with kindness toward one's spouse over time is likely to alter the spouse's behavior. Changes in a spouse's behavior, in turn, may then reveal different directions that the relationship might take—different valued patterns. Constructing values and living commitments feed one another, hopefully creating a virtuous cycle.

THERAPEUTIC DOS AND DON'TS

Even in Relapse, Values Are Permanent (until They Are Not)

It is not unusual for a client to lose focus on a commitment and then lapse into defeatism, as if this somehow implies the client has defective values. When clients present this phenomenon in therapy, the question

the therapist asks is "Which of your values changed during this relapse?" It is important to get the client to answer this question very specifically. Usually none of his or her values has changed. Basic values are more often refined than changed. One's confidence in achieving valued patterns, however, can change a lot. The client is undoubtedly struggling with troublesome thoughts ("I'm a failure, I should give up"), feelings (shame, anger), and memories (past failures like this), and the most important question becomes, "So, what now?" The ACT therapist might say something like this:

> "Unless your values have changed, the answer to 'What now?' is the same as 'What before?' If you were to move in the direction you value right now—right at this moment, here in therapy—what would you do? If you are committed to heading west and you find that you have taken a wrong turn and have backtracked 10 miles, is there anything that prevents you from turning the car around and again heading west? If you were in a car headed west toward San Francisco, and your mind was telling you that the car will break down, the road will be closed ahead, or that you will fall asleep at the wheel and get in a wreck, would you continue to drive west? If west is where you want to go, get in the car and start driving!"

This does not mean that values cannot change. Values are a choice, and choices can and do change—but they change by *one's explicit choice*, not merely by assessing that a temporary relapse may have occurred!

The Client, Not the Therapist, Owns Committed Action

Commitment work involves asking the client to engage in potentially life-altering behavior. Therefore, it is important to make sure that the client is fully cognizant of the wide range of potential consequences of valued actions. The potential problem here is that the therapist's personal agenda for the client may be unduly influencing the client's choices. The client, seeking the therapist's approval, buys into actions without appreciating the gravity of these actions. The ACT therapist needs to carefully monitor and guard against this injection of his or her own values. It is sometimes useful to ask, "If I stopped working with you tomorrow for some weird reason and another counselor were sitting here with you, would you be standing by these actions with 100% certainty? Are there ones you'd have less certainty about?" The therapist needs to be absolutely clear that what has shown up are the client's values and goals. If there is any doubt whatsoever, it is time to go back to the process of choosing values again.

Not Doing Anything Is a Choice Too

A potential trap that often envelops the therapist is the tendency to regard change in the client's behavior as a requirement for the therapy to be considered a "success." When the client's commitment waivers or the client goes back to old avoidance behaviors, the therapist begins to pressure the client to follow through on goals and actions. This is akin to the common parenting practice of merely changing the volume, not the message: if the kid doesn't behave when you say it softly, then say it loudly. While this approach may work for a few children (precious few!), it certainly doesn't work too well with clients. In other words, the harder the therapist pushes on the client (acts of nonacceptance on the part of the therapist), the more resistant the client usually becomes. At its worst, this process can devolve into mutual confrontation, "resistance" interpretations, and even precipitous termination by the client. It is important for the therapist to realize that, no matter how carefully the stage is set for the client to choose valued actions, it is a choice only the client can make. Choosing not to go forward with a plan is a legitimate choice—so long as it is actually a choice. The gentlest and most honest way to work with a client in such circumstances is to completely validate the client and the dilemma he or she is facing. The therapist might say, "If this were my life and I was seeing the consequences you are seeing, I could well imagine myself choosing not to go forward."

Sneaky Pliance

Pliance is always a risk with commitment work just as it is with values interventions, and it can show itself in any number of ways. When committed action has been absent and where there has been a substantial social impact, clients may be prone to regard committed acts as "have tos": "I *have to* do this for my children [or spouse]" are common themes, as is also "I should do something for my children because of all the mistakes I've made." This type of "motivation" is likely to break down quickly, once significant barriers to action are encountered. An excellent strategy as with pliance of any kind is to retrace the commitment back to the client's values and then ask, "If you never made a single mistake as a parent—that is, if you were the absolute best parent ever put upon the face of the earth—would this action be something you would *still* value?"

Addressing Emotional Turmoil

Making commitments is almost certain to call up a host of frightening thoughts, emotions, and memories. These difficult psychological states often remove us from the present moment, are experienced as things to be

avoided, and cause us to lose contact with that sense of self that transcends content.

Often the more important the action is from a values point of view, the more distressing and unwanted are the private experiences that show up. At key choice points, it is a good idea to place the committed action process on "pause" and simply have the client make contact with both the good and the bad of the commitment process. Inquire as to whether the client's values have changed or are experienced differently. Use defusion and acceptance strategies to help the client deal with this emotional storm gently, while noticing thoughts *as thoughts*, memories *as memories*, and emotions *as emotions*.

READING SIGNS OF PROGRESS

Early in therapy, discussions about commitment may result in high levels of fusion and avoidance. These discussions will typically feature such fusion and avoidance markers as words like *have to*, *can't*, *always*, and *never*. Clients may also produce a lot of *I don't knows* and other disfluencies when asked to generate possible committed acts. The focus may be on predictions about whether commitments will be kept or on fears that they will not be. Clients who are further along will show more fluidity and flexibility in their capacity to generate small and large examples of committed acts and in their ability to accept the painful emotions, memories, and thoughts that arise when doing commitment work. This litany includes the painful processes of failing to keep commitments, learning from that pain, and returning revitalized to the process of making and keeping needed commitments. Ultimately signs of progress on commitment will be apparent in ever-widening patterns of committed action in the client's life and flexibility in dealing with the emotional and cognitive implications of that ever-widening pattern.

PART IV

Building a Progressive Scientific Approach

CHAPTER 13

Contextual Behavioral Science and the Future of ACT

Given enough time, scientific theories are found to be wanting. So far, that is without exception, and we have no reason to believe that psychological flexibility as a model or ACT as a method, as they are now understood, will ultimately escape the ash bin of history. The point is not to create a theoretical or clinical monument to immortality. The point is to create progress in our scientific understanding of human behavior across multiple domains.

In this volume we have presented a set of methods, a model, a set of principles, and a philosophy that we believe may be progressive. That is a lot, but for those with eyes trained toward the horizon it should not be enough. We need a solid development strategy if the goal is to create a comprehensive psychology more worthy of the extraordinary challenge of the human condition. In other words, we need a way to discard today's useful half-truths and generate better ideas and then later to discard those ideas for even better ones. The aim is to construct a positive sequence of development. That is difficult to do in applied science. Suffering is present now, and the need is urgent—without a plan, clinicians and clinical researchers alike will often grab at whatever is available. That impulse is understandable, but long term progress demands more. It demands a strategy that can work.

The ACT community believes it has such a strategy, which we call a *contextual behavioral science* (CBS) approach. Indeed, the ACT community is really the CBS community. That is the name of its international society (the Association for Contextual Behavioral Science, or ACBS; *www.*

contextualpsychology.org), and that is the heart of the work. Without the RFT researchers, the contextual philosophers, the evolutionists, the disseminators, the research strategists, the community builders, and clinicians working in concert, ACT becomes nothing but an interesting technology that gradually will be assimilated into the same trends the field has been suffering with for decades.

Applied science cannot be built successfully on the foundation of data alone, and most especially not on data about techniques applied to syndromes or disorders. It cannot be built by loose theorizing backed up by pretty-looking brain images. It cannot be built without the creation of a strong and effective psychology.

The exciting conclusion the CBS community has reached is this: behavioral science and application is a collective. Applied and basic psychologists are in the same boat together; practitioners and researchers are on the same vessel; prevention scientists and treatment developers will move ahead or sink to the bottom together.

A CBS APPROACH

CBS is a *naturalistic, inductive approach to system building in the behavioral sciences that emphasizes the evolution of historically and situationally embedded action, extending that unit across levels of analysis and into knowledge develeopment itself.* Extended from traditional behavior analysis, it emphasizes several key steps (see Hayes, Levin, Plumb, Villatte, & Pistorello, in press-a; Vilardaga, Hayes, Levin, & Muto, 2009). We briefly note each step below to provide a kind of overview and then reexamine each a bit more deliberatively.

1. *Explicate philosophical and analytic assumptions.* CBS is a monist, inductive approach based on functional contextualism, a set of philosophical assumptions that view knowing as a pragmatic activity based on variation and selective retention.

2. *Develop a basic account with contextual principles organized into analytic abstractive theories.* CBS is based on evolutionary science and, in a more proximal way, on behavioral principles as augmented by relational frame theory. The basic science agenda in CBS is being tested behaviorally and neurobiologically across a wide range of basic science topics.

3. *Develop models of pathology, intervention, and health, each tied to the basic account.* Psychological flexibility is a unified model of human functioning linked in each of its key aspects to behavioral principles as augmented by RFT and viewed within the context of evolution science.

4. *Build and test techniques and components linked to processes and principles.* ACT is an intervention approach built from specific methods that are

known to move key processes of change from the viewpoint of a psychological flexibility model.

5. *Measure theoretical processes and their relationships to pathology and health.* Measures of psychological flexibility and its elements are being developed continually and are examined for their relationship to the overall model. Treatment utility, conceptual utility, and coherence are the key aspects of measurement advances, not mere psychometric consistency.

6. *Emphasize mediation and moderation in the analysis of applied impact.* The links between intervention methods and theoretically important processes are key; therefore, analytic methods that focus on processes of change are also key, such as studies of mediation and moderation. Dozens of such studies have been conducted to test key aspects of the psychological flexibility model as a transdiagnostic approach.

7. *Test the applied research program across a broad range of areas and levels of analysis.* The applied goal of CBS is broad—far beyond ACT (for example, the applied utility of RFT in education is key to the ultimate success or failure of CBS; see Rehfeldt & Barnes-Holmes, 2009, or Cassidy et al., 2011). ACT itself cannot be contained by traditional clinical psychology. It has already been applied to an amazing range of problem areas, many of which (prejudice, learning, organization functioning, etc.) will never be treated in the pages of the DSM.

8. *Conduct early and continuous testing of effectiveness, dissemination, and training strategies.* As befits CBS's pragmatic philosophy, training, dissemination, and effectiveness are placed early in the research program. Pragmatically speaking, methods need to be evaluated in terms of their ability to achieve outcomes by changing practices in real-world settings. It does no good to humanity to create the intervention equivalent of a gold-plated limousine that cannot be driven on the unpaved backroads of our underfunded and overworked prevention and treatment delivery systems.

9. *Create an open, diverse, and nonhierarchical development community.* The bold agenda of CBS requires an entire community to embrace it, and the psychological flexibility model has been used to suggest how that might be done. By extending the model to organizational work, the CBS community has grown enormously over the past few years.

In this chapter we examine each of these key steps briefly in order to assess the degree to which progress is being achieved.

Explicate Philosophical and Analytic Assumptions

In Chapter 2 we spent some time on philosophy of science issues and on the nature of functional contextualism, a type of psychological pragmatism that extends Skinner's "radical behaviorism" (Hayes, Hayes, & Reese,

1988). We defined the core unit of contextualism as the act-in-context and its truth criterion as "successfully working"; and then we further distinguished functional contextualism by its goal, namely, prediction and influence—with precision, scope, and depth—of whole organisms interacting in and with a context considered historically and situationally (Hayes, 1993).

Every aspect of ACT, RFT, and CBS more generally is touched by these assumptions. Consider, for example, the idea that thoughts and feelings are not causes of action. Contextualists view causes as ways of speaking about how to accomplish ends—they do not exist as discrete entities independent of context. For one thing, each "cause" has to assume a context in which a relation holds. A gas leak may "cause" a basement water heater to explode, but no one will mention the necessary presence of oxygen—it is assumed. When welding combustible metal in a vacuum, you might say "losing the vacuum caused the explosion," but no one will mention the spark from the welding—again, it is assumed. An explosion requires fuel, oxygen, heat, and an ignition source, but none individually is a cause of the explosion; rather, all of them together *are* an explosion.

In much the same way, ACT theorists reject the idea that thoughts and feelings cause actions because such an idea assumes a context in which these relations hold; and until that context is specified, the goal of prediction *and influence* of behavior cannot be obtained. Once it is specified, the very fact that it holds only in a particular context shows that thoughts, feelings, and actions are all dependent variables, not changeable contextual features that might be "independent" variables. Mental causation is thus viewed as inherently incomplete until the contextual variables are specified that in principle would allow for the goal of "influence" to be met (Biglan & Hayes, 1996). ACT theorists are interested in the historical and situational contexts that give rise both to thoughts *and to their mutual relation to emotions and actions*. It is the italicized portion of the preceding sentence that is most often missed in traditional models, and it is a key clinical focus of ACT.

A caution is in order about assumptions, however. There is an enormous temptation to use philosophy to bludgeon those outside one's own philosophical camp (e.g., contextualists harrumphing about elemental realists). This inclination is an especially delicious form of useless activity. If you criticize the *assumptions* and *values* of your intellectual adversary, you do so by virtue of analysis based on your own, usually hidden, assumptions and values. It is the adult equivalent of the children's taunt "nah, nah, nah, nanaah, nah." This taunting can be great fun, but it is dishonest.

By definition, assumptions are not the *results* of analysis—they enable analysis. One cannot honestly say, in effect, "My assumptions and values meet my standards better than your assumptions and values meet my

standards; therefore, my assumptions and values are best." All one can honestly say is that "these are my assumptions. Descriptively (not evaluatively) here is what happens when you have these instead of those." Similarly, when alternative assumptions are encountered, the differences can either be pointed out nonevaluatively or one can temporarily take on the assumptions of the other to see if they are being applied consistently or to see what consequences they have relative to their own purposes. Anything else is dogmatism.

To be honest, Skinner was dogmatic in this way, claiming that the purposes of science were prediction and control (Skinner, 1953, p. 35) rather than simply stating that these were *his* goals as a scientist. James was dogmatic in the same way, for example, in arguing for the utility of religious experience but without linking that evaluation to a priori goals. The assumptions of functional contextualism are not right, true, or correct. Instead, they are just "where we stand." We want to say what they are and take responsibility for them.

Critics of ACT often miss this point in their own psychology, and as a result their criticisms can be dogmatic. Almost always elemental realists argue for the truth of their position, failing to see the very assumptions that allow them to make the argument in that way. Criticisms of ACT based on these philosophical differences often devolve into tangential and useless arguments. For example, time is wasted struggling about whether thoughts are behavior (a merely definitional matter) or whether thoughts cause actions (ditto—it depends on what you mean by *cause* and the role that term and concept plays philosophically). An unexpected criticism of this kind (given how much time has been spent in the CBS community building an experimental program in cognition) is the idea that ACT somehow challenges whether cognition exists or is important, instead of merely departing from an elemental realist position. These kinds of conversations are counterproductive because they hide the real issue, namely, assumptions.

There is another reason to specify assumptions: it helps build bridges to friends who speak in different ways or who address phenomena at other levels of analysis (e.g., biological, sociological, anthropological) but share foundational assumptions. As we have mentioned throughout, CBS shares the assumptions of thoroughgoing forms of evolutionary science. Indeed, one can think of functional contextualism merely as one way to deal with philosophy of science based on the principles of variation and selective retention. As in evolution itself, successful working is the outcome of importance, and all other concepts and terms are subordinate; but, unlike mindless processes of evolution, we can link successful working to the criteria we select, both as a scientific matter and as clinical matter. This book is not the place to unpack these ideas fully, but we expand on them to some extent in the next two sections.

Develop a Basic Account with Contextual Principles Organized into Theories

A great deal of time was spent in developing RFT, owing to a commitment to the idea that principles focused on changeable contextual features (that is, on history and situation) were needed to understand human cognition. RFT argues that derived relational responding emerges from a combination of a genetically evolved capacity and a history of reinforcement by a social community. This entirely evolutionary way of analyzing human language and cognition is based solely on variation and selection at phylogenic and ontogenic levels.

RFT is a theory, but it is not a hypothetico-deductive one. It is rather an analytic/abstractive theory, a kind of superset of functional analyses. A verbal event is simply one that has its psychological functions because it participates in a relational frame, a learned unit of responding. This elegantly simple definition brings good order to the line of cleavage between verbal and nonverbal events. For instance, verbal rules are "verbal" because their effects depend on their elements being in relational frames. Gestures, signs, and pictures are "verbal" if their effects depend on their participation in relational frames, but they are "nonverbal" if that is not the case. Human "minds" are a way of speaking about our relational framing repertoire.

The tricky part is that, defined in this way, most human behavior is verbal, at least to a degree. Derived relational responding changes how other general learning processes operate, and it thus broadens the focus when analyzing human behavior. If we look at a tree and see a T-R-E-E, a "plant" that "photosynthesizes" and has particular "cell structures" and so on—then the tree is functioning as a verbal stimulus for the observer. It is hard for humans to avoid the derived nature of stimulus functions in their world because even "nonverbal" stimuli quickly become verbal in part when they enter into relational frames. Much of what we know we "know" only verbally.

The word *know* in English has an interesting etymology. It comes from two quite distinct Latin roots: *gnoscere*, which means "knowing by the senses," and *scire*, which means "knowing by the mind." In the usual human conception, knowing by the mind (knowing things consciously) is familiar and safe. It is unconscious, nonverbal processes that seem strange and hard to understand. In a CBS approach, it is the other way around. Knowing by direct experience, or contingency-shaped behavior, is something psychologists understand quite well. Verbal knowledge, or "knowing by the mind," is difficult to understand.

Relational frame theory views verbal knowledge as the result of networks of highly elaborated and interconnected derived stimulus relations.

That is what "minds" are full of. These relational responses enable forms of activity that could not occur otherwise, but when they are unrestrained by context they are at the root of human suffering.

Informed by the unit of analysis in RFT, ACT methods emphasize altering the functions of language by changing its context. The social/verbal community called "psychotherapy" works in part because it can establish new contexts in which existing cognitive relations have a different function.

The topic of CBS and evolution is important enough for a brief discussion of how the effort to develop RFT fits with the history of behavioral psychology and biological perspectives. In the 1970s, general process learning theory became unpopular in part because of the failure to negotiate the issue of how ontogenetic selection can be nested inside genetic evolution. A good example is Seligman (1970), who, based on such issues as taste aversion (Garcia, Ervin, & Koelling, 1966), suggested the irrelevance of general process accounts: "We have reason to suspect that the laws of learning discovered using lever pressing and salivation may not hold" (Seligman, 1970, p. 417). Language and cognition were treated similarly: "Instrumental and classical conditioning are not adequate for an analysis of language" (p. 414). Seligman was one example of many. As this process snowballed, the conclusion was reached that "*all* the results of the traditional conditioning literature are due to the operation of higher mental processes, as assumed in cognitive theory" (Brewer, 1974, p. 27; emphasis added). The cognitive revolution was on, in force.

Although these supposed biological limits on learning theory pushed behavioral psychology aside, selectivist accounts in psychology did not warm to the new cognitive approach either. Evolutionary psychologists eventually moved into the cul de sac of massive sets of hypothesized specialized genetic adaptations (Tooby & Cosmides, 1992). Such an approach has been difficult to link to clinical concerns and as a basic matter have further distanced mainstream psychology from biological evolution.

A CBS perspective views human language to be the result of phylogenetic and ontogenetic selection processes, each viewed purely in selectivist terms. RFT provides a plausible general process approach at the ontogenetic level into which more specialized processes can be fit. After all, despite the cynicism of evolutionary psychology about general processes, it has to be remembered that evolution itself is such an account.

The utility of derived relational learning conveys adaptive advantages in the context of a cooperative species, but in this volume we argue that the processes of fusion and experiential avoidance have been oversupported, leading both to repertoire narrowing and to inappropriate selection criteria. Thus, the goal of ACT is to induce healthy variation and flexibility, to maximize effective contact with the present environment, and to allow

purpose and intention to enter into behavioral selection and retention processes. This view is entirely consistent with evolutionary science (Jablonka & Lamb, 2005; Wilson, 2007), and the future seems certain to include a growing alliance between ACT, CBS, and evolutionary science (for examples of that effort, see Monestès, 2010; Vilardaga & Hayes, in press; Wilson, Hayes, Biglan, & Embry, 2011).

Develop a Model of Pathology, Intervention, and Health Tied to Behavioral Principles

The psychological flexibility model is designed to be practitioner-friendly. One of the characteristics of a CBS approach to knowledge development and utilization is recognition of the need for "middle-level terms" linked to technical accounts. Every such term in the psychological flexibility model is linked to RFT and behavioral principles, but the use of middle-level terms means a practitioner need not know the full breadth of behavioral principles or the inner workings of RFT to begin to apply it clinically.

The reader has seen in this volume the dance between accessible language inside ACT and the tighter theoretical analysis that exists at another level. It is relatively easy to specify the psychological flexibility model in a loose and accessible way. The six processes used in this book are middle-level terms: self-as-context, the present moment, defusion, acceptance, values, committed action. They are designed to be accessible.

Underneath the hood, however, there is a bottom-up account that is entirely technical. The careful reader has seen it peeking through these pages periodically. At the point that clinicians become seriously interested in ACT, they naturally begin to try to understand RFT, behavioral principles, and functional contextualism. It deepens their clinical work to do that. Entire books have been written on how to scale RFT and behavioral principles to the clinical level (e.g., Törneke, 2010). Any system that demands technical knowledge of that kind as a portal of entry is doomed to irrelevance. Any system that fails to be based on technical knowledge of that kind is doomed to a lack of coherence and progressivity. The CBS strategy attempts to avoid both of these possible pitfalls.

There is a final point worth mentioning. It seems now to be widely accepted that evolutionary contingencies occur at multiple levels: between individuals and between groups (Wilson, 2006). Individual adaptations are locally advantageous and inherently promote selfishness; group adaptions are locally disadvantageous but tend to promote cooperation (Wilson, 2007). The latter conclusion can be shown experimentally.

Suppose you own an egg farm and you want to produce a lot of eggs. In the egg farm, hens live nine birds to a cage. In one condition you allow only the best egg layers on the farm to reproduce; in the other, you allow

only the best cages of nine birds to reproduce. In the former condition, all birds are good layers; in the latter, some birds are very weak egg layers. Ask yourself this question: After five or six generations, which breeding strategy will lead to more eggs? The surprising but informative answer is that the system focused on entire cages will be more successful by far (e.g., Muir, Wade, Bjima, & Ester, 2010). The reason is that the individual selection criterion leads to constant fighting within the cages, high bird death rates attributable to the attacks, and high levels of stress for the surviving birds. Individual hens that lay a lot of eggs are not necessarily good team players. Indeed, they may be successful in part because they can intimidate other birds and acquire more food at the expense of their cage mates. Conversely, cages that are productive environments for eggs are cages where the hens know how to get along. After five or six generations, the birds are calm and cooperative.

In an analogous way, many different features of human experience are competing at any one moment, separated out from one another by human language itself. Our urges, actions, feelings, and thoughts are all housed together in one collective called a human being. Psychological inflexibility processes such as experiential avoidance, cognitive fusion, or the conceptualized self establish individualistic selection criteria that invite in-fighting and attacks on the self. Experiential avoidance means that sadness is unwelcome. Fusion means that ambiguity and confusion is unwelcome. A conceptualized self means that material that contradicts the narrative is unwelcome.

Acceptance and mindfulness processes are like saying to an entire cage of psychological chickens, "Everyone in here belongs—now, let's lay some eggs!" In essence, ACT attempts to place the selection criterion (values-based action) at the level of the entire person (the experiential collective), and in-fighting is put off-limits by removing the individualistic benefits that keeps fighting going (e.g., "being right" inadvertently feeding fusion, temporary reductions in unwanted feelings inadvertently feeding experiential avoidance). The ACT approach aims to promote internal cooperation and wholeness, and it comports with what evolutionary science tells us is key to the development of altruism and cooperation in collective systems.

Build and Test Techniques and Components Linked to Processes and Principles

The psychological flexibility model provides the conceptual scaffolding for creating and deploying treatment technologies and components in ACT. Researchers have conducted many small studies on ACT components and have examined their links to specific processes of change. This approach is a sensible strategy. Tests of entire packages are not well suited to examine

the links between various components, processes, or principles, and large-scale dismantling studies are also expensive, few, and often delayed for many years, limiting their impact.

In each of the major areas of the psychological flexibility model, data exist on small components or methods. These areas include defusion (e.g., Masuda, Hayes, et al., 2009), acceptance (e.g., Levitt, Brown, Orsillo, & Barlow, 2004), self-as-context (Williams, 2006), attentional flexibility in the now (e.g., Langer & Moldoveanu, 2000), and values (Cohen et al., 2006). Furthermore, the psychological flexibility model has been shown to be broadly useful, far beyond ACT per se (e.g., Bonnano et al., 2004; Moore & Fresco, 2007).

Every ACT process has at least one study, and most have several. Some of these studies are, in effect, small clinical trials. For example, Levitt and colleagues (2004) found that patients with panic disorder exposed to ACT methods were more willing to participate in exposure to panic sensations. ACT methods have been compared to traditional CBT methods, psychoeducational methods, distraction, suppression, and relaxation, among other potential influences. Some studies have focused on key treatment issues. For example, McMullen and colleagues (2008) found in an well-controlled study that, while an ACT rationale was effective in increasing pain tolerance as compared to distraction or no instructions, it was vastly more so when ACT metaphors and exercises were added. Masuda, Hayes, and colleagues (2009) found that a word repetition-based defusion exercise reduced the distress and believability of negative self-evaluative thoughts. The authors also discovered that believability came down more slowly than distress, with the reduction greatest when the word repetition exercise was about 30 seconds long.

These very pragmatic and yet conceptually interesting studies provide incremental evidence that the processes specified in an ACT model generate components that work in a coherent fashion. Effect sizes for the specific comparisons vary, but they are almost uniformly positive.

The link between technique and theory is so central that it makes little sense to view ACT as a technique alone. ACT is the application of the psychological flexibility model. Looking at ACT as a mere collection of techniques greatly limits its possible value and may actually make it harder to deliver effectively.

For one thing, even well-developed treatment approaches evolve. The ACT community worldwide encompasses thousands of practitioners, researchers, and students. Almost every week someone adds, subtracts, or refines the technical elements of ACT within an overall ACT model. As more and more therapists develop an interest in the approach, this process seems to be accelerating. Many flavors of ACT have evolved to fit various problems or settings. When working in an organization with four or five

sessions as a limit for an entire case, some elements of the approach are emphasized and others are greatly diminished as compared to outpatient settings, in which more sessions are generally allowed. ACT can be done outside of therapy per se, where it is often called acceptance and commitment training (a name deliberately chosen to also be designated as "ACT"). ACT looks quite different in organizational settings (Flaxman & Bond, 2010) as compared to ACT for excessive pornography viewing (Twohig & Crosby, 2010). ACT for chronic pediatric pain (Wicksell, Melin, Lekander, & Olsson, 2009) looks different than ACT for psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). If ACT is *just* a technique, which one is it?

When ACT is approached solely as a technique, there is also a tendency to apply it "by the book." In randomized controlled trials it is necessary to use manuals to train ACT therapists—but experienced ACT therapists learn to modify the procedures to fit the needs of the particular client at the particular moment. That is exactly why we have organized this book as we have. If ACT were just a set of techniques defined topographically, we would have to claim that an experienced therapist dancing elegantly through model is not doing ACT while a new therapist going by the book is doing the real thing. That is nonsense. The effective ACT therapist uses ACT as *functionally defined*, not merely as *topographically defined*.

The look and feel of ACT cut across the stale divisions that we have lived with for so many decades within our field. We think ACT offers something to mental health professionals from all the traditions. It takes the deepest clinical issues seriously, and it is following a careful model of development.

The much-discussed schism between science and practice is not attributable to a lack of interest among clinicians in what science has to offer; rather, it reflects a disconnect between the natural agenda of clinical researchers and clinicians. Clinicians need a limited set of principles, linked to techniques, that tell them which components are important, when they should be used, and which processes of change are critical. That is not what clinical science is giving them because there is no incentive in academia for such a process of simplification. Research careers are on the line, tenure is at stake, and publications need to be piled on top of one another. This type of situation encourages expansionism, not the principle of parsimony.

Technology alone can work quite well in limited circumstances. There is nothing wrong with writing food recipes. But psychotherapy and behavior change in general are *not* limited situations. We need to do more than collect a recipe book of psychological procedures: we need to understand human suffering and how best to treat it. We need a theory of human capacity and how best to enhance it. And for that we need a strategy that

can lead to simplification, not fragmentation. We need unified transdiagnostic models that really work so that a practitioner can learn a smaller set of related things instead of a nearly infinite set of apparently unrelated things. That was the goal of ACT from the beginning: an approach capable of addressing a broad range of human concerns, based on a clear philosophy and a solid basic science understanding of adaptive and maladaptive functioning.

Measure Theoretical Processes and Their Relationships to Pathology and Health

The goal of functional contextualism requires not just that predictions and methods of influence be precise but also that they have scope. Scope requires good theory, not just good technology. It is one thing to build methods based on principles and processes. It is another to test the links among principles, theory, and treatment components/packages. For that goal to be accomplished, one must have measures of the key processes thought to be involved in psychological difficulty and be able to examine their relations to psychopathology and behavior.

There is a reason that theories in psychology rarely go away once they become popular. Once a theory is formed, it is hard to falsify because any test stands on how concepts are applied and measured. Consider a concept like *reinforcement*. There is a very tight link between observations, measurement, and this term. If an event does not function as a reinforcer, it is nearly impossible to lay the blame on the precision of the definition of the term or how it was measured. It is very different with other terms normally used in psychology. If, say, a measure of self-esteem fails to show a predicted outcome, there is always room to question the measures of self-esteem or the conditions under which these measures were collected. In a CBS strategy, the deliberate use of middle-level terms raises the same danger, but the CBS strategy tries to limit it by linking these terms to basic behavioral processes and by tightening the link between theoretical terms and the conditions of measurement so that empirical problems can be attributed to the theory rather than to worries about the conditions under which it was tested (Hayes, 2004).

Measures of ACT-relevant processes are being developed at great speed. This volume would be outdated quickly if existing measures were fully covered, and we have mentioned just a few in the main part of the book. The grandfather of ACT measures is the Acceptance and Action Questionnaire (AAQ ; Bond et al., in press; Hayes, Strosahl, et al., 2004). The AAQ examines acceptance, defusion, and action. The general measure is not content-free—its components include measures of anxiety and depression—but it

assesses experiential avoidance and psychological flexibility fairly broadly and predicts many form of psychopathology successfully (Hayes et al., 2006). With targeted protocols the AAQ can be too broad, and as a result many versions of the AAQ have emerged that ask about specific problem thoughts, feelings, or actions linked to specific areas of functioning. The number of specific forms is now very large, including chronic pain (McCracken et al., 2004), epilepsy (Lundgren et al., 2008), diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), weight (Lillis & Hayes, 2008), psychosis (Shawyer et al., 2007), smoking (Gifford et al., 2004), and substance abuse (Luoma, Drake, Kohlenberg, & Hayes, in press). Measures exist to assess defusion in various areas (e.g., Varra et al., 2008; Wicksell et al., 2008; Zettle & Hayes, 1986). Values measures are also beginning to appear (e.g., Lundgren et al., 2008; Wilson, Sandoz, Kitchens, & Roberts, 2010). Mindfulness measures are proliferating and are known to tap into key ACT processes (Baer et al., 2004, 2006). Researchers are also learning to see ACT processes in behavior shown in psychotherapy sessions (Hesser, Westin, Hayes, & Andersson, 2009) or to develop implicit measures of ACT processes (e.g., Levin, Hayes, & Waltz, 2010). Measures of perspective taking are changing how we think of the sense of self (e.g., McHugh et al., 2007).

The model's processes so far have done very well indeed in explaining psychopathology and human adaptability. Hardly a week goes by without a researcher publishing a study relevant to the basic claims of the psychological flexibility model. Beyond mere correlations, psychological flexibility seems to systematize things in ways that help organize various areas of the literature (for empirical and conceptual reviews, see Boulanger, Hayes, & Pistorello, 2010; Hayes et al., 2006; Kashdan & Rottenberg, 2010).

Psychological flexibility moderates distress tolerance and task persistence in experimental tasks (Cochrane et al., 2007; Zettle, Petersen, Hocker, & Provines, 2007). But inflexibility is not a mere correlate of pathology—rather, it is a vulnerability factor that predicts poor outcomes longitudinally, controlling for how the person was doing at the point of original assessment (e.g., Bond & Bunce, 2003; Marx & Sloan, 2005). Psychologically rigid persons respond poorly to challenging life experiences, such as having a family member with dementia (Spira et al., 2007) or being in a war zone (Morina, 2007). They have fewer positive events over time and fewer positive emotions, and they experience lower life satisfaction (John & Gross, 2004; Kashdan et al., 2006). Experiential avoidance and psychological flexibility actually mediate the impact of various emotion regulation strategies (e.g., Tull & Gratz, 2008). For example, Kashdan and colleagues (2006) found that the impact of coping strategies such as cognitive reappraisal on the relationship between anxiety and life outcomes was fully mediated by experiential avoidance and psychological flexibility.

Emphasize Mediation and Moderation in the Analysis of Applied Impact

Mediation and moderation examine the utility and coherence of the relationship between theory, technology, and outcomes. It is not important to CBS that ACT always be more successful than other approaches—indeed, it has not been (e.g., Forman, Hoffman, et al., 2007), found that ACT was not better in dealing with food urges when the person was not dominated by food). What is important is that the model be able to account for the differences so that researchers and clinicians are given a target for how to develop empirically supported procedures linked to empirically supported processes (Rosen & Davison, 2003). ACT researchers have been committed to the exploration of mediation and moderation more consistently and for longer than any other empirical clinical tradition. That assertion may seem like a bold statement, but it is fairly easy to document.

Nearly two dozen formal mediational analyses of ACT now exist, including those that are analyzed and being written up but are not yet published. Successful ACT mediators include general or specific measures of acceptance and psychological flexibility (e.g., Gifford et al., 2004; Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007; Lappalainen et al., 2007; Lillis & Hayes, 2007; Lundgren et al., 2008); defusion (e.g., Gaudiano, Herbert, & Hayes, 2010; Hayes, Stroshal, et al., 2004; Lundgren et al., 2008; Varra et al., 2008; Zettle & Hayes, 1986); and values (e.g., Lundgren et al., 2008), among others. Across all studies so far available, just under half of the follow-up differences in outcomes are mediated by posttreatment levels of psychological flexibility or its components (Levin et al., 2010). These results are not just seen in ACT versus a wait list. For example, Zettle, Rains, and Hayes (2011) examined group forms of ACT versus Beck's cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979). ACT produced better outcomes that were mediated by differential levels of cognitive fusion. Furthermore, in every case so far reported, when alternative mediators drawn from other perspectives were applied to ACT interventions, they did not work or did not work as well as those drawn from psychological flexibility theory.

There has been a lot of misunderstanding about the meaning of mediation. Statistically speaking, successful mediators require a relationship between treatment and the mediator as well as a relationship between the mediator and outcome, *controlling for treatment.* This requirement means that, unlike traditional correlationally based process analyses, mediation cannot occur simply owing to socialization to a treatment model and its language because such mediators will not relate to outcome, controlling for treatment. In other words, if the mediator is not related to outcome even in the control group, successful mediation is unlikely.

Mediation is rarely a matter of causation, however. In psychology by far the most common mediators are process measures provided by clients (self-report, behavioral, neurobiological, etc.). These are theoretically important dependent variables. However, as we pointed out in Chapter 2, thinking of dependent variables as causal can slow down the search for changeable independent variables (Hayes & Brownstein, 1986). Instead, what mediation analyses provide is an opportunity to detect functionally relevant pathways.

It needs to be pointed out that most ACT meditational studies (but not all; e.g., Gifford et al., 2004; Lundgren et al., 2008; Zettle & Hayes, 1986, as reanalyzed in Hayes et al., 2006; see Hayes et al., 2006) have measured mediators after outcomes have changed, which means that mediators could have changed owing to outcomes changing and not vice versa. Meditational analyses that do not violate temporality are especially useful in detecting functionally relevant pathways, but it is wrong to dismiss the importance of meditational analyses that *do* violate temporality. That is because, with all the statistical advantages a violation of temporality provides, meditational analyses should be consistently successful in such cases. Thus, for any given intervention method, the vast majority of outcome studies should show successful mediation by a small set of concepts. If that is not the case, there is something wrong either with the theory or with the measurement of its concepts. Both failures are the responsibility of treatment advocates to correct, not treatment critics. So far as we are aware, ACT is the only popular current clinical method that can pass this test.

Moderation has also been examined in the ACT literature, but more work needs to be done. Moderators identify who responds to what treatment. Masuda and colleagues (2007) found that psychoeducation was less effective in targeting stigma toward mental illness when individuals reported higher levels of experiential avoidance, as compared to ACT. Forman, Hoffman, and colleagues (2007) found that outcomes for an ACT intervention for food cravings, as compared to a traditional CBT model (drawn from Brownell, 2000), differed depending on an individual's level of sensitivity to food in the environment. Individuals who were dominated by food did better when exposed to ACT than with either CBT or no treatment.

Test the Research Program across a Broad Range of Areas and Levels of Analysis

A psychological flexibility model putatively applies not just to specific clinical disorders but to human functioning more generally. An idea of that kind cannot be tested by randomized controlled trials focused on a narrow range of disorders. There are unified protocols available that focus

on several anxiety disorders or on anxiety and mood disorders, but we know of no approach that has been applied to as broad a range of problem areas in as little time as ACT. As a demonstration of that point, consider only the randomized controlled trials (RCTs) or controlled time series studies that have been published in these three top-ranked journals: the *Journal of Consulting and Clinical Psychology*, *Behaviour Research and Therapy*, and *Behavior Therapy*. After publication of the first ACT manual (Hayes, Strosahl, et al., 1999), the first RCT in these journals appeared on coping with psychosis (Bach & Hayes, 2002). During the 8 years since, these journals have seen controlled studies on coping with diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007); chronic pain (Dahl et al., 2004); worksite stress (Flaxman & Bond, 2010); treating and preventing stress, anxiety, and depression in international students (Muto, Hayes, & Jeffcoat, 2011); polysubstance abuse (Hayes, Bissett, et al., 2004); back pain (Vowles et al., 2007); skin picking (Twohig et al., 2006); smoking cessation (Gifford et al., 2004); trichotillomania (Woods, Wetterneck, & Flessner, 2006); reducing prejudice toward people with psychological disorders (Masuda et al., 2007); coping with psychotic symptoms (Gaudiano & Herbert, 2006); obsessive–compulsive disorder (Twohig et al., 2006, 2010); problematic Internet pornography viewing (Twohig & Crosby, 2010); reducing stigmatizing attitudes and burnout of substance abuse counselors (Hayes, Bissett, et al., 2004); and helping counselors overcome the barriers to learning and using evidence-based pharmacotherapy (Varra et al., 2008). Approaches that have drawn very heavily from ACT have also appeared in these journals on generalized anxiety disorder (Roemer, Orsillo, & Salters-Pedneault, 2008) and borderline personality disorder (Gratz & Gunderson, 2006). Considering just these three journals over the past 8 years, there have been evaluations of ACT with groups and individuals; ACT applied in a self-help format; ACT with inpatients and outpatients; and ACT with dominantly ethnic minority and dominantly ethnic majority clients; prevention studies and intervention studies; studies with patients, therapists, and students; population-based studies; and studies with interventions lasting less than 2 hours or more than 40 hours. If the entire ACT literature is considered, far more diversity is evident, but this extended example makes the point: we know of no approach in psychology that has been applied to as broad a range of problem areas in as little time as ACT.

Overall the between-group effect size in the ACT literature is medium ($d = 0.66$ at post and $d = 0.65$ at follow-up; Hayes et al., 2006). Three independent meta-analyses have arrived at broadly similar values (Öst, 2008; Powers et al., 2009; Pull, 2009). Some authors have noted that there are relative weaknesses in ACT research (Öst, 2008) as compared to mainstream CBT. That is true to a degree, but it disappears if the amount of grant funding is factored in (Gaudiano, 2010); so, the weakness comes primarily from

the relatively short history of the literature. Furthermore, Öst's (2008) analysis used criteria that ignored the relative strengths, namely, that ACT research is being deployed in entirely new areas not previously touched by empirically supported intervention methods and is dramatically more focused on the processes of change (Gaudiano, 2010).

Where has ACT been shown to be weaker than comparative methods in terms of outcomes? The data are still limited, but in general this deficiency has applied mainly to more minor problems (Zettle, 2003) or to less entangled and less avoidant clients (Forman, Hoffman, et al., 2007). There is a great deal yet to learn about how to disseminate ACT for prevention or in more normal populations, and we expect to see some further outcome weaknesses in such areas, until the technology evolves. There may be other special populations that require modification of the model, but so far when outcomes are weak it does not appear to be owing to a weakness in the model per se but rather to the technology (Follette, 1995, explains how to make this distinction empirically). There has not yet been a reported case in which psychological flexibility processes moved differentially but outcomes were not differential. There *are* cases in which psychological flexibility processes did not differ, and in those the outcomes were less consistently superior (e.g., Zettle, 2003). In some ways, the whole point of a CBS strategy is to find those failures so that further development can occur. The best way to do that is to push the model as far as it can go and be prepared to innovate when deficiencies are encountered, which they will be.

Conduct Early and Continuous Testing of Effectiveness, Dissemination, and Training Strategies

Contextual behavioral scientists are not trying to find out what is "true" in an ontological sense and then determine if that knowledge is useful; rather, knowledge is taken to be true because it is useful. Since effectiveness and dissemination are key outcomes, CBS researchers have emphasized them from the beginning. Indeed, the first ACT study in the modern era was an effectiveness study (Strosahl, Hayes, Bergan, & Romano, 1998) showing that training clinicians in ACT produced better overall outcomes in an outpatient setting. Since then, several additional effectiveness studies have appeared (e.g., Forman, Herbert, et al., 2007; Lappalainen et al., 2007; Vowles & McCracken, 2008, 2010).

Studies have also been done on how ACT influences instructional techniques in other methods (e.g., Luoma, Hayes, & Walser, 2007; Varra et al., 2008). It has also been shown to be useful in multiple cultures (e.g., Lundgren, Dahl, Melin, & Kees, 2006) and in ethnic minority populations (e.g., Gaudiano & Herbert, 2006; Muto et al., 2010). These areas are all fertile fields for additional developments in the future.

Create an Open, Diverse, and Nonhierarchical Development Community

ACT and RFT are being developed by an open, diverse worldwide community of clinicians, basic scientists, applied scientists, scholars, and students. The CBS community has distinctive features: it is heavily international, involves professionals from many backgrounds, attempts to limit hierarchy, and has traditions of sharing methods, protocols, and tools for free or at very low cost. The creation of a broad and diverse development community of that kind is a necessary feature of the CBS approach. It is necessary because inductive science can be very slow, and when linked to a broad agenda only a whole community can make progress in a reasonable time. Only a wide range of ideas, settings, backgrounds, professions, and cultures makes it likely that the blind spots will be identified rapidly, as knowledge is contextually situated. For example, if widespread dissemination and effectiveness are to be key concerns, line clinicians need to be involved from the very beginning. Everything in an evolutionary perspective suggests that groups have more of a chance to create cooperation if they focus on benefits for the whole group rather than on individual competitive success. In empirical clinical science that basic rule of evolution is violated the moment a treatment developer tries to control development of an approach (e.g., deciding what elements to add and subtract; certifying therapists; dictating to others what is or is not proper within an approach). Instead, ACT and RFT development is being encouraged and supported by the Association for Contextual Behavioral Science. Only a few years old, ACBS has 4,000 members, more than half of whom reside outside of the United States.

The CBS community has taken many steps to remain open and flexible. The ACBS has eschewed certification of therapists. ACT trainers are "recognized" by a free process of peer review and must sign a values statement in which they agree to make their protocols available for low or no cost. Most protocols are posted on the website and can be downloaded for free after payment of dues. Dues are "values-based," meaning they are set by the members themselves (the floor is $1). Whether protocols that comport with a psychological flexibility model are branded "ACT" is considered optional. No one is required to check their orientation at the door. Except for science values and contextual assumptions, everything else is up for grabs.

It is not difficult to explain why the CBS community is like this. It is a scaled-up version of psychological flexibility. In place of defusion is the sharing of ideas and an invitation of criticism; in place of acceptance is openness, permeability, and lack of unnecessary hierarchy; in place of flexible contact with the present moment is shared data and a commitment

to evidence and exploration; in place of a transcendent sense of self is trying to understand the perspective of others; in place of individual values and committed action are open and stated organizational values and the attempts to link all concrete actions of the community to them.

Those outside of the CBS community are sometimes worried about its expansive goals and enthusiasm. Expansive goals are fully consistent with the original vision of basic behavioral science, which was to develop principles that could have a chance of scaling into issues of human complexity. Skinner provided an example: he was but a fledgling animal researcher when he wrote his utopian novel *Walden II* (1948). That might seem arrogant or even frightening, but it is neither. It is a worthwhile exercise regularly to think about how to use behavioral science knowledge to organize society because it reminds us of its ultimate goal. Doing so is not a claim to knowledge until research has actually been done at that level. In the same way, the CBS tradition is committed, as its website notes, to the "creation of a psychology more adequate to the challenge of the human condition." That is an aspiration, not a claim to knowledge.

The enthusiasm comes because people are excited to find a model that applies to themselves, is broadly applicable to their clients, is based on a serious basic research program, and is reflected in the community itself. Enthusiasm is a force for good if it is kept linked to science values. Those linkages are reflected in the CBS community itself, and in some small way we hope this book has been a worthy example.

CONCLUDING REMARKS

The scientific progress of a contextual behavioral science approach needs to be assessed over time, but so far the results seem promising. The philosophical foundations are fairly well established. The basic science work in RFT is evolving rapidly and is increasingly affecting both mainstream basic (e.g., De Houwer, 2011) and applied domains, including ACT itself. The psychological flexibility model is taking off and aspects of it are spreading throughout contextual forms of CBT (Hayes, Villatte, Levin, & Hildebrant, 2011) and into social and personality psychology. Component and process evidence is good and getting better. Outcomes are good and incredibly broad—which is impressive, considering how early in development ACT is. In most cases, outcomes appear to be as positive as those achieved with more established interventions, and in some cases the outcomes appear to be better. A very large and highly energetic development community has formed worldwide that is drawing diverse groups of people together.

Ten years ago, the first edition of this book could only present a hope. This second edition presents the achievement of a more mature model

and a set of methods that any fair observer will agree is helpful to many. Further progress will be determined by how the development community responds to criticisms and problems that may emerge and by how thoroughly, carefully, and creatively the existing opportunities are explored. Young researchers, clinicians, theorists, and students will determine the future by where they invest their energy. In the interests of those whose lives we serve, we hope this book has made such an investment seem wise and worthwhile.

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