Acceptance & Commitment Therapy for Substance Abuse, Eating Disorders, Anxiety, Depression, Self-Injury, PTSD, Psychosis, and More

Sydney Kroll, PsyD

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MATERIALS PROVIDED BY

SYDNEY KROLL, PsyD, is a licensed psychologist with the state of Texas and has worked in various settings, including corrections, university counseling centers, behavioral health, and the VA hospital for the past 15 years. A doctoral graduate in clinical psychology from Baylor University, Dr. Kroll has utilized Acceptance and Commitment Therapy (ACT) in her clinical work with Veterans for the past decade and now in her private practice. In conjunction with her clinical experience, she has trained other professionals across the behavioral health spectrum in ACT, mindfulness-based psychotherapy, and other evidence-based practices. Currently, she serves on the Board of Trustees for both the Texas Psychological Association and Texas Psychological Foundation, as well as other local and state leadership roles.

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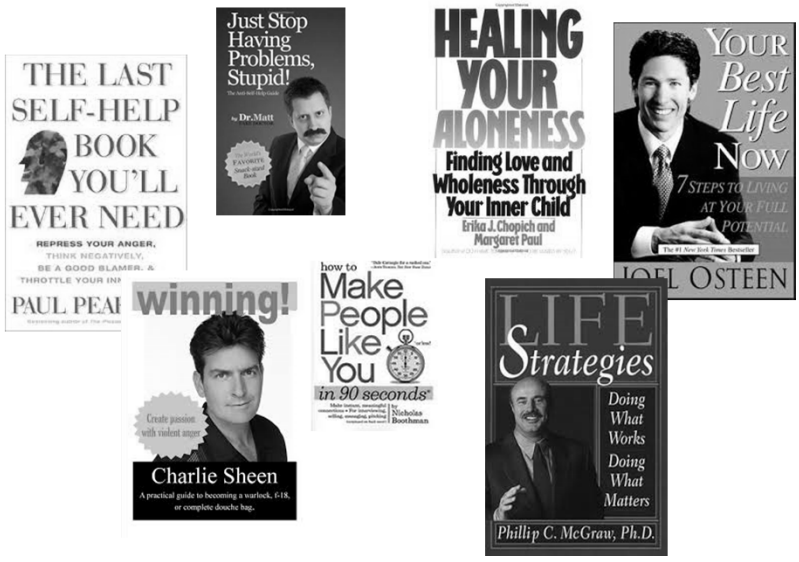
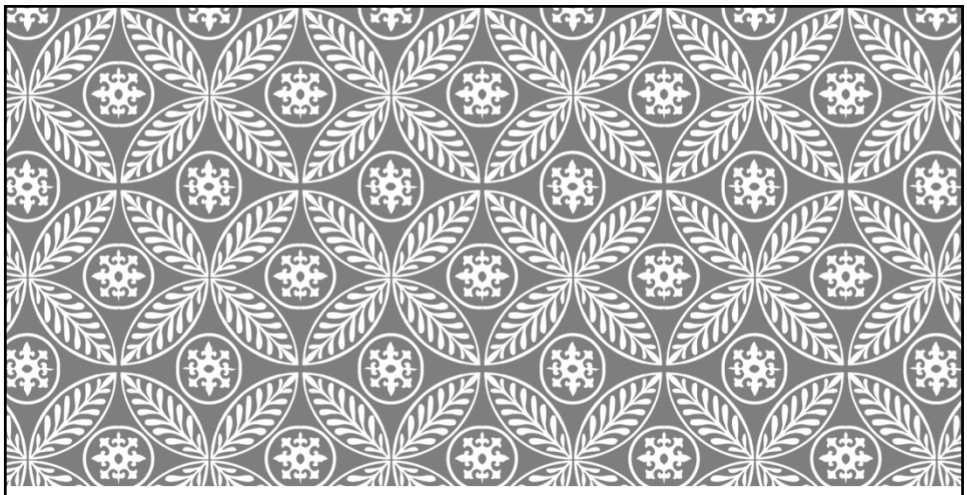
ACCEPTANCE AND COMMITMENT THERAPY FOR SUBSTANCE ABUSE, EATING DISORDERS, ANXIETY, DEPRESSION, SELF INJURY, PTSD, PSYCHOSIS, AND MORE

WHY IS IT SO HARD TO BE HUMAN?





SO WHAT'S NORMAL?

HOW IS ACT DIFFERENT?

ACT is a therapy approach that uses

- acceptance/mindfulness processes, and
- commitment and change processes
- to produce greater psychological flexibility

PARADIGM SHIFT

Origins of ACT

- Traditional behavior therapy, CBT, Gestalt therapy.
- Non-traditional therapy models (mindfulness, Zen Buddhism)

THIRD WAVE OF BEHAVIORISM

ACT is an approach to psychological intervention defined in terms of certain theoretical processes, not a specific technology. In theoretical and process terms we can define ACT as a psychological intervention based on modern behavioral psychology, including Relational Frame Theory, that applies mindfulness and acceptance processes, and commitment and behavior change processes, to the creation of psychological flexibility

ACT VS TRADITIONAL CBT

1. Philosophy- Functional contextualism vs elementalistic and integrative: irrational thoughts as contrary to fact vs as serving a purpose

2. Basic Theory- RFT

3. Applied Theory- in ACT, the primary source of psychopathology is the way that language and cognition interacts with direct contingencies to create psychological inflexibility

4. Clinical Methods- Goal of increasing psychological flexibility rather than symptom reduction

Example: How realistic is that thought?

RELATIONAL FRAME THEORY

According to RFT, the core of human language and cognition is the learned ability to arbitrarily relate events, mutually and in combination, and to change the functions of events based on these relations. There are neurobiological data showing that the brain lights up when performing RFT tasks much as it does when doing natural language tasks modeled by the theory.

Examples: near/far, big/little, more/less

PRACTICAL IMPLICATIONS OF RFT

1. Normal cognitive processes necessary for verbal problem solving and reasoning underlie psychopathology, thus these processes cannot be eliminated.

2. The content and impact of cognitive networks are controlled by distinct contextual features.

3. Cognitive networks are historical and thus are elaborated over time. Much as extinction inhibits but does not eliminate learned responding, the logical idea that cognitive networks can be logically restricted or even eliminated is generally not psychologically sound.

4. Direct change attempts focused on key nodes in cognitive networks tend to elaborate the network in that area and increase its functional importance.

DATA SHOW ACT TO BE EFFECTIVE WITH:

Depression (VA Roll-out)

PTSD (VA Roll-out)

Anxiety Disorders (OCD, panic disorder, social phobia)

Substance abuse

Eating disorders

Self harm

Hallucinations and delusions

Health Issues: smoking cessation, diabetes management, epilepsy, chronic pain, psychological adjustment of end-stage cancer patients

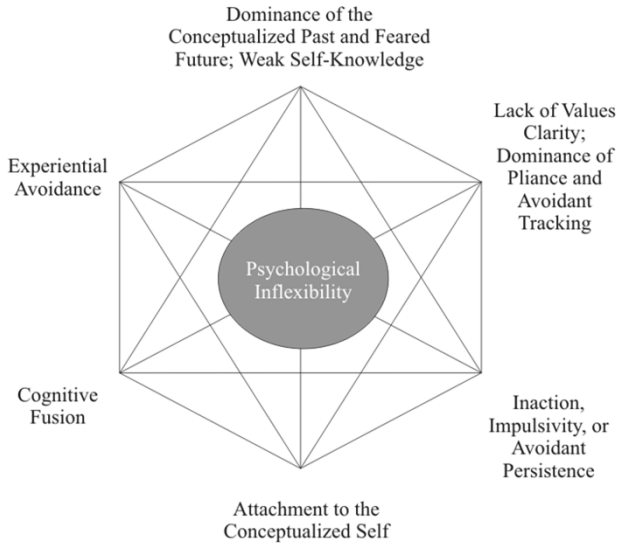
Also effective in increasing the skills of therapists, preventing burnout, reducing stigma toward patients

CHANGE IN TREATMENT AGENDA

What if the cause of your symptoms is not a thing (*e.g., a stressful event, a negative emotion, thought, or impulse*), but instead your avoidance of your experience (or emotions)?

Pain is inevitable, suffering is optional.

THE PRIMARY ACT MODEL OF PSYCHOPATHOLOGY



PSYCHOLOGICAL INFLEXIBILITY

The inability to modulate behavior in response to workability--- change when change is needed and persist when persistence is needed.

- Rigidity
- Can't follow Serenity Prayer

ACT sees two main causes of this:

- Experiential Avoidance
- Cognitive Fusion

EXPERIENTIAL AVOIDANCE

The attempt to escape or avoid negative internal experiences (*i.e., unwanted thoughts, emotions, memories, physical sensations, awareness of personality tendencies, etc.*), despite resulting psychological harm

- **Suppression**: active attempt to control and/or eliminate the immediate experience of a negative internal experience
- **Situational escape/avoidance**: active attempt to alter the situation associated with the appearance of a negative internal experience

Correlated with:

- anxiety, depression, overall psychopathology, poorer work, inability to learn, substance abuse, lower quality of life, trichotillomania, history of sexual abuse, high risk sexual behavior, BPD symptoms, thought suppression, alexithymia, anxiety sensitivity, long term disability, worry, etc.

EXPERIENTIAL AVOIDANCE

Amplifies negative private events and reinforces itself at the same time:

- Research on thought suppression strategies (e.g., illustrated by: *"don't think of a pink elephant" or imagining tasting a lemon)* shows that it later increases their frequency & the negative impact on behavior, and decreases the impact of exposure-based interventions
- Situational escape/avoidance requires thinking about the avoided event --- which then reinforces the strength of avoiding the imagined negative event ("I'm afraid of …")
  - If you're not willing to have it, you've got it.

ARTAX!

You have to fight against the sadness, Artax!

SUICIDE: THE ULTIMATE AVOIDANCE

ACT VIEW ON PAIN

Psychological pain is normal, it is important, and everyone has it.

You cannot deliberately get rid of your psychological pain, although you can take steps to avoid increasing it artificially (by not engaging in experiential avoidance).

Pain and suffering are two different states of being.

You don't have to identify with (i.e.: fuse with) your suffering.

Accepting your pain is a step toward ending suffering.

We are the only species that commits suicide --- the ultimate form of experiential avoidance

- Have you ever had a client die from feeling something in treatment? Have you known any who have died refusing to feel something?

COGNITIVE FUSION

Taking our thoughts literally and reacting to their content instead of responding to the realities of the current situation

- Happens all the time because we are verbal creatures.
- Becomes a problem when fusion dominates other sources of behavioral regulation because of the failure to pay attention to the process of thinking over the content.

Cognitive fusion is the major cause of experiential avoidance

ACT THOUGHTS ABOUT THINKING

"The mind" is not there to make you happy.

"The mind" (i.e., automatic verbal processes) evolved to protect you from danger (by categorizing, relating to the past and predicting future, comparing, worrying, evaluating, judging, explaining, planning how this or that action might work, etc.) .

But it relentlessly creates verbal representations of events ("languaging"), relating everything to everything --- often arbitrarily --- and sets up the illusion that a thought = the actual thing or event.

If thoughts are what they say they are (if we take them literally), then we are at the mercy of every arbitrary thought that arises.

We lose awareness that the verbal mind chugs along on auto pilot.

We are like fish swimming in a sea of thoughts and cannot escape.

EXAMPLES OF COGNITIVE FUSION

Fusion with evaluations: *"bad chair"* (a judgment) comes to seem as real as *"big chair"* (a non-judgmental description).

Fusion with memories of past painful events: thinking about discussing trauma brings up the same emotions as occurred during the event, instead of being seen as an event that is occurring now.

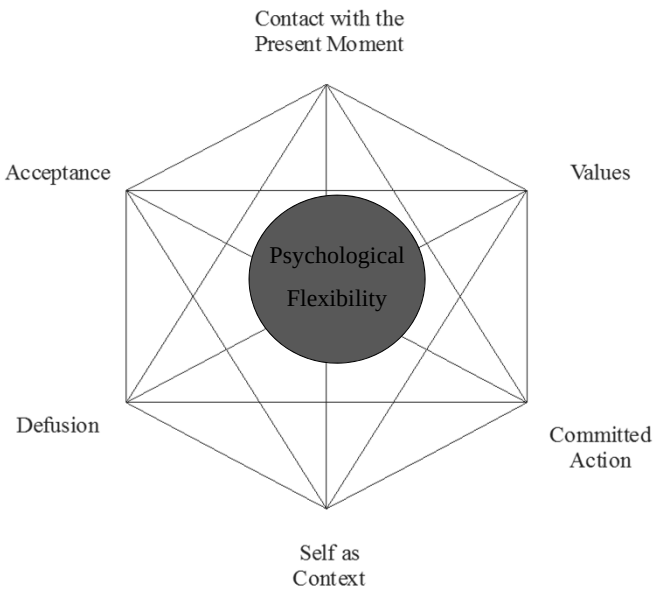
Fusion with imagined painful events: a worry about the future seems to accurately reflect the future, instead of seeing it as a process of worrying that is going on in the present.

Fusion with conceptualized past, present, or future: the thought *"life is not worth living"* seems to be an actual conclusion about life and its quality, rather than a verbal evaluative process that is going on right now.

TREATMENT COMPONENTS

Applying the Hexaflex model

The Primary ACT Model of Treatment



PSYCHOLOGICAL FLEXIBILITY

The ability to contact the present moment more fully as a conscious human being, and,

- based on what the situation allows,
- change or persist in the behavior
- in the service of chosen values.

This is the major goal of ACT (not symptom reduction).

ACCEPTANCE

"*To take what is offered*"

- Taking a stance of non-judgmental awareness, and
- actively embracing the experience of thoughts, feelings, bodily sensations, and personality traits as they occur.

First emphasize on the futility of the *control agenda*.

Interventions: Creative hopelessness, forced love or relaxation, not thinking of a jelly doughnut, various metaphors: Chinese finger cuffs, Shark Tank Polygraph, Person in the Hole, Feeding the Tiger/Paying off the Bully/Child's Tantrum, Tug of War with the Monster, Feedback Screech

WHY IS ACCEPTANCE SO HARD?

1) Because controlling works so well in other areas of life, (i.e., in the world outside your body), you assume it will work for your thoughts and feelings as well

2) You were taught that you should be able to control your thoughts and feelings

3) When you were young, the giants around you called "grown ups" seemed to be able to control their thoughts and feelings

4) While you were growing up, you received a constant stream of messages that good health and great happiness depended on the absence of negative internal experiences (especially from media)

5) Sometimes it appears that controlling our unwanted thoughts and feelings actually does work short term ("success" results in "imposter syndrome")

"WILLINGNESS" IS ACTIVELY ACCEPTING

The goal is to *feel* good, not to feel *good.*

Graded experiential exercises (using mindfulness, experiential, and gestalt techniques) to willingly expose clients to previously avoided internal experiences in the service of moving in the direction of personal values

Interventions: clean vs. dirty discomfort, willingness as an alternative, it is not wanting nor is it a feeling, eye contact exercises, Serenity Prayer, metaphors (Two Scales, Two Computers, Passengers on the Bus, swamp in the service of values; Physicalizing/Tin Can Monster exercises)

COGNITIVE DEFUSION

Deliteralization of thoughts about internal experiences by expanding your attention to seeing thinking as an ongoing process instead of responding to the content of thoughts.

Facilitates acceptance and broadens the client's repertoire through metaphors, paradox and mindfulness.

Interventions: teach me to walk, "orange, orange, orange" exercise, taking your mind for a walk, descriptions vs. evaluations, "I'm *having* the x that …", getting rid of "buts", thoughts on a card, talk radio, pop-up mind, cell call from hell, Cubby-holing, Mind Trains, Thoughts on Falling Leaves

COGNITIVE DEFUSION

Exposure to internal experiences, with the goal of seeing them as they are (i.e.: thoughts as thoughts).

Interventions: treat "The Mind" as an external event, "Thank your mind for that thought", having thoughts instead of thoughts having you, not "buying thoughts," "How old is this? Is this just like you? How has this worked? What is this in the service of?" Physicalizing & Tin Can Monster exercises

TRANSCENDENT SENSE OF SELF (SELF AS CONTEXT)

Three Senses of Self in ACT:

- 1) **Conceptualized self**: you as the object of summary verbal categorizations and evaluations that you take as literal truths, get attached to, invested in, and which come to distort and limit your experience of yourself, make you regard yourself like an object, and create pain that you get accustomed to
- 2) **Self as a process of ongoing self-awareness**: our fluid, continuous knowledge of our own experiences in the present moment
- 3) **Observing self**: an unchanging and boundary-less sense of self that has always been there (variously called a transcendent sense of self, spiritual self, big mind, wise mind, no-thing self, etc.). It is not experienced as a thing like an object, a feeling, or a thought is. It cannot even be looked at directly (because, who would be doing the looking at that moment?), but, independent of words, you know it exists.

TRANSCENDENT SENSE OF SELF (SELF AS CONTEXT)

Detaching from the *content* of internal experiences and connecting with the *context* within which those experiences occur

- Without this skill, internal experience can be very threatening, so this is a critical process to promote in ACT

Interventions: Observer Exercise ("Experientially, 'I' am not 'that'"), Mental Polarity exercise, Chessboard Metaphor, rewrite your "story," Mindfulness exercises, frequently asking "where are ***you*** in this experience?"

BEING PRESENT ("SELF AS PROCESS")

Effective, open, and undefended contact with the present moment
- "showing up," "standing with"

Mindfulness: the defused, nonattached, accepting, nonjudgmental, deliberate awareness of experiences as they happen.
- Increase presence, vitality, spontaneity, connection, and creativity

BEING PRESENT: MINDFULNESS PRACTICES

Basic:
- Tracking thoughts in time (past, present, future)
- Watching bodily sensations
- Defusing from implicit evaluations (good-bad, strong-weak)

Regular sitting practice/ breath

Mindful walking

Eating a raisin, drinking tea, etc.

Tai Chi, yoga, etc.

Starting sessions with brief breathing or sense awareness exercises

"Are you here? … What is showing up for you right now?"

VALUES

Chosen qualities of purposeful action, which can only be felt, experienced, and deeply desired, rather than dealt with like an object.

- Goal is to help clients to move in their valued directions

Questions:

- "What is this in the service of?"
- "What does your suffering tell you about what is ultimately important to you?"
- "If a miracle happened and your pain, problems, and barriers were gone, what would you be doing instead of all this?

Interventions: Your values are perfect, they are the compass heading, tombstone ("… he spent his life avoiding anxiety" … "he successfully avoided getting his heart broken by never falling in love"), eulogy, gardening and switchback metaphors

COMMITTED ACTION

Defining goals in specific areas based on values, then acting on those goals and making room for the inevitable psychological barriers.

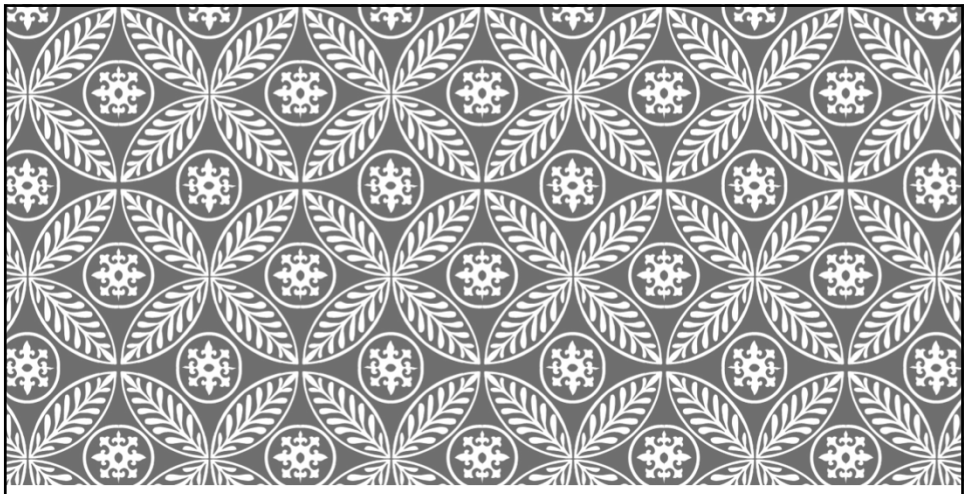
Build larger and larger patterns of effective action until they become self-sustaining and the therapist's role is done.

- No finish line: "goals are just a process by which the process can become the goal"

"You are response-able … behaving confidently is different from feeling confident"

"I know it would work for me in my life to do ___, and I'm willing to do it."

Interventions: Journey metaphors; open house, jumping from a piece of paper vs from a chair, mountain switch backs



BRINGING IT ALL TOGETHER

THE LIFE QUESTION

Starting from the place in which there is a distinction between you as a conscious, mindful human being on the one hand, and all of the private experiences you are conscious of and struggle with on the other hand,

(self-as -context)

are you willing to feel, think, sense, and remember all those private experiences,

(acceptance)

fully and without defense,

(defusion)

as you directly experience them to be, not as what your mind says they are,

(committed action)

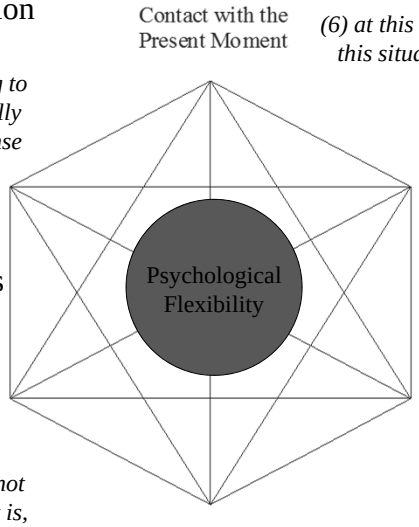
and do whatever it takes to move you in the direction of that which you truly value,

(values)

at this particular moment, and in this particularly situation?

(mindfulness)

ACT Question



(2) are you willing to have that stuff, fully and without defense

Acceptance

(6) at this time, in this situation?

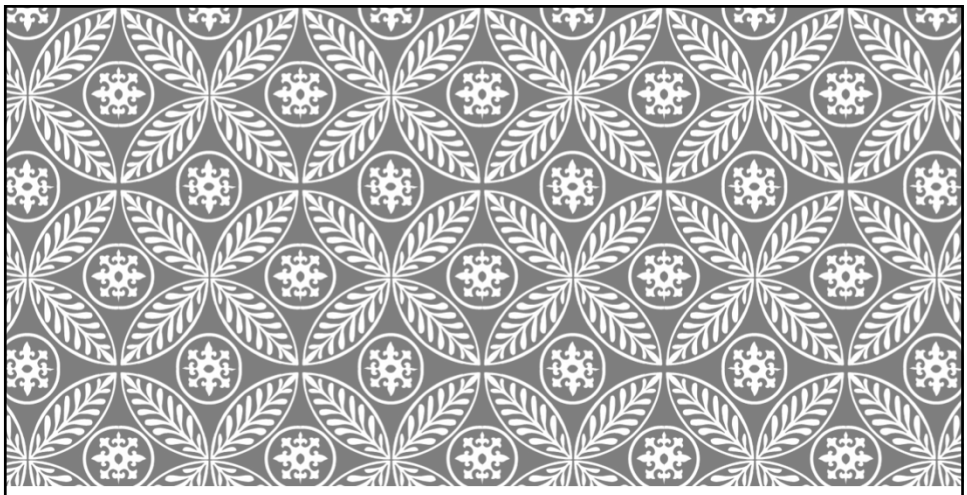
(5) of your chosen values

If the answer is "yes," that is what builds...

(4) and do what takes you in the direction

(3) as it is, and not as what it says it is,

(1) Given a distinction between you and the stuff you are struggling with and trying to change



PRACTICAL ISSUES

WHEN TO USE ACT

When other therapeutic approaches haven't worked

When simple, common-sense change methods fail

When there is experiential avoidance and fusion

When distress tolerance only goes so far

When the mind has caught onto the willingness, acceptance, or working-through processes and starts trying to use them to control internal experiences

POTENTIAL BARRIERS TO USING ACT

Dynamics of the clinician

* Relational model/ use-of-self

* Paradigm shift

Dynamics of the client

* Acute severity (sometimes)

* Concrete thinking/ poor abstract reasoning

Dynamics of the context

* Flexibility of goal setting

* Education of other clinicians

TRAINING RESOURCES

Association of Contextual and Behavioral Science (ACBS)

ACT trainings

Mindfulness trainings

- MBCT, MBSR
- Univ of Mass

CLIENT REFERENCES

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Kabat-Zinn, J. ***Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness.*** **Dell, 1990.**

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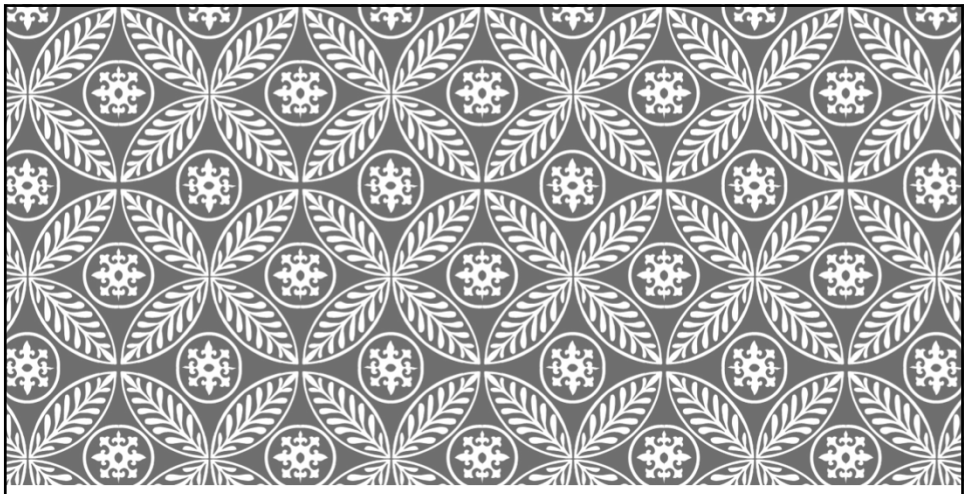


REVIEW OF CLINICAL MANUAL

QUESTIONS?

Acceptance and Commitment Therapy (ACT) for All Populations: A Practical Approach to a Revolutionary Treatment

Sydney Kroll, Psy.D.

- Slides-

Clinical Handbook

The Values of the ACT / RFT Community

What we are seeking is the development of a coherent and progressive contextual behavioral science that is more adequate to the challenges of the human condition. We are developing a community of scholars, researchers, educators, and practitioners who will work in a collegial, open, self-critical, non-discriminatory, and mutually supportive way that is effective in producing valued outcomes for others that emphasizes open and low cost methods of connecting with this work so as to keep the focus there. We are seeking the development of useful basic principles, workable applied theories linked to these principles, effective applied technologies based on these theories, and successful means of training and disseminating these developments, guided by the best available scientific evidence; and we embrace a view of science that values a dynamic, ongoing interaction between its basic and applied elements, and between practical application and empirical knowledge. If that is what you want too, welcome aboard.

ACT ANALYSIS OF PSYCHOLOGICAL PROBLEMS

- Psychological problems are due to a lack of behavioral flexibility and effectiveness
- Narrowing of repertoires comes from history and habit, but particularly from cognitive fusion and its various effects, combined with resultant aversive control processes.
- Key in this is avoidance and manipulation of private events.
- Clients are not broken, and in the areas of acceptance and defusion they have the basic psychological resources they need if to acquire the needed skills.
- The value of any action is its workability measured against the client's true values (those he/she would have if it were a choice).
- Values specify the forms of effectiveness needed and thus the nature of the problem. Clinical work thus demands values clarification.
- To take a new direction, we must let go of an old one. If a problem is chronic, the client's solutions are probably part of them.
- The bottom line issue is living a vital life, and FEELING good, not feeling GOOD.

THE ACT THERAPEUTIC POSTURE

Assume that dramatic, powerful change is possible and possible quickly

Whatever a client is experiencing is not the enemy. It is the fight against experiencing experiences that is harmful and traumatic.

You can't rescue clients from the difficulty and challenge of growth.

Compassionately accept no reasons -- the issue is workability not reasonableness.

If the client is trapped, frustrated, confused, afraid, angry or anxious be glad -- this is exactly what needs to be worked on and it is here now. Turn the barrier into the opportunity.

If you yourself feel trapped, frustrated, confused, afraid, angry or anxious be glad: you are now in the same boat as the client and your work will be humanized by that.

In the area of acceptance, defusion, self, and values it is more important as a therapist to do as you say than to say what to do

Don't argue. Don’t persuade. The issue is the client's life and the client’s experience, not your opinions and beliefs. Belief is not your friend. Your mind is not your friend. It is not your enemy either. Same goes for your clients.

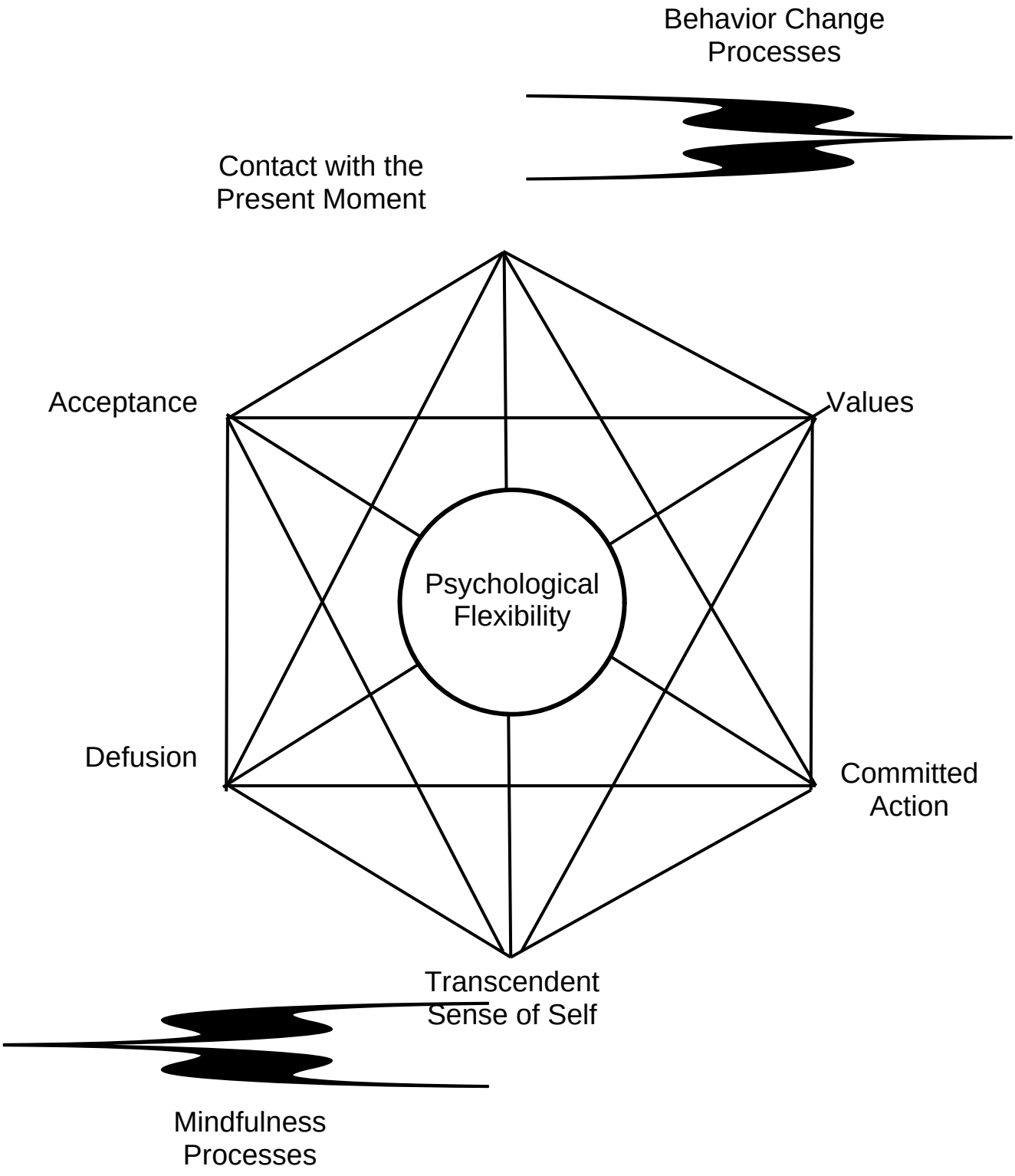
You are in the same boat. Never protect yourself by moving one up on a client.

When in doubt, ask yourself, “What is this serving?”

ACT THERAPEUTIC STEPS

1. Be passionately interested in what the client truly wants
2. Compassionately confront unworkable agendas, always respecting the client’s experience as the ultimate arbiter
3. Support the client in feeling and thinking what they directly feel and think already -- as it is not as what it says it is -- and to find a place from which that is possible.
4. Help the client move in a valued direction, *with* all of their history and automatic reactions.
5. Help the client detect traps, fusions, and strange loops, and to accept, defuse, and move in a valued direction that builds larger and larger patterns of effective behavior
6. Repeat, expand the scope of the work, and repeat again, until the clients generalizes
7. Don’t believe a word you are saying

Hexaflex Model



Core ACT Competencies

Use these as a self-assessment exercise. Also, the ACBS website has a questionnaire that follows this model to be used in training

Core Competencies Involved in the Basic ACT Therapeutic Stance

Collectively, the following attributes define that basic therapeutic stance of ACT.

- The therapist speaks to the client from an equal, vulnerable, genuine, and sharing point of view and respects the client's inherent ability to move from unworkable to effective responses
- The therapist actively models both acceptance of challenging content (e.g., what emerges during treatment) and a willingness to hold contradictory or difficult ideas, feelings or memories
- The therapist helps the client get into contact with direct experience and does not attempt to rescue the client from painful psychological content
- The therapist does not argue with, lecture, coerce or attempt to convince the client of anything.
- The therapist introduces experiential exercises, paradoxes and/or metaphors as appropriate and de-emphasizes literal "sense making" when debriefing them
- The therapist is willing to self-disclose about personal issues when it makes a therapeutic point
- The therapist avoids the use of "canned" ACT interventions, instead fitting interventions to the particular needs of particular clients. The therapist is ready to change course to fit those needs at any moment.
- The therapist tailors interventions and develops new metaphors, experiential exercises and behavioral tasks to fit the client's experience, language practices, and the social, ethnic, and cultural context
- The therapist can use the physical space of the therapy environment to model the ACT posture (e.g., sitting side by side, using objects in the room to physically embody an ACT concept)
- ACT relevant processes are recognized in the moment and where appropriate are directly supported in the context of the therapeutic relationship

Core Competencies for ACT Core Processes and Therapeutic Interventions
Developing Acceptance and Willingness/Undermining Experiential Control

- Therapist communicates that client is not broken, but is using unworkable strategies
- Therapist helps client notice and explore direct experience and identify emotion control strategies
- Therapist helps client make direct contact with the paradoxical effect of emotional control strategies
- Therapist actively uses concept of "workability" in clinical interactions
- Therapist actively encourages client to experiment with stopping the struggle for emotional control and suggests willingness as an alternative.
- Therapist highlights the contrast in the workability of control and willingness strategies (e.g., differences in vitality, purpose, or meaning).
- Therapist helps client investigate the relationship between levels of willingness and suffering (willingness suffering diary; clean and dirty suffering)
- Therapist helps client make experiential contact with the cost of being unwilling relative to valued life ends (Are you doing your values; listing out value, emotional control demand, cost, short term/long term costs and benefits)
- Therapist helps client experience the qualities of willingness (a choice, a behavior, not wanting, same act regardless of how big the stakes)
- Therapist can use exercises and metaphors to demonstrate willingness the action in the presence of difficult material (e.g., jumping, cards in lap, box full of stuff, Joe the bum)
- Therapist can use a graded and structured approach to willingness assignments
- Therapist models willingness in the therapeutic relationship and helps client generalize this skill to events outside the therapy context (e.g., bringing the therapist's unpleasant reactions to in session

content into the room, disclosing events in the therapist's own life that required a willingness stance)

Undermining Cognitive Fusion

- Therapist can help client make contact with attachments to emotional, cognitive, behavioral or physical barriers and the impact attachment has on willingness
- Therapist actively contrasts what the client's "mind" says will work versus what the client's experience says is working
- Therapist uses language conventions, metaphors and experiential exercises to create a separation between the client's direct experience and his/her conceptualization of that experience (e.g., get of our butts, bubble on the head, tin can monster)
- Therapist uses various interventions to both reveal that unwanted private experiences are not toxic and can accepted without judgment
- Therapist uses various exercises, metaphors and behavioral tasks to reveal the conditioned and literal properties of language and thought (e.g., milk, milk, milk; what are the numbers?)
- Therapist helps client elucidate the client's "story" while highlighting the potentially unworkable results of literal attachment to the story (e.g., evaluation vs. description, autobiography rewrite, good cup/bad cup)
- Therapist detects fusion in session and teaches the client to detect it as well

Getting in Contact with the Present Moment

- Therapist can defuse from client content and direct attention to the moment
- Therapist models making contact with and expressing feelings, thoughts, memories or sensations in the moment within the therapeutic relationship
- Therapist uses exercises to expand the client's awareness of experience as an ongoing process
- Therapists tracks session content at multiple levels (e.g., verbal behavior, physical posture, affective shifts) and emphasizes being present when it is useful
- Therapist models getting out of the "mind" and coming back to the present moment
- Therapist can detect when the client is drifting into the past or future and teaches the client how to come back to now

Distinguishing the Conceptualized Self from Self-as-context

- Therapist helps the client differentiate self-evaluations from the self that evaluates (thank your mind for that thought, calling a thought a thought, naming the event, pick an identity)
- Therapist employs mindfulness exercises (the you the you call you; chessboard, soldiers in parade/leaves on the stream) to help client make contact with self-as-context
- Therapist uses metaphors to highlight distinction between products and contents of consciousness versus consciousness itself (furniture in house, are you big enough to have you)
- The therapist employs behavioral tasks (take your mind for a walk) to help client practice distinguishing private events from the context of self-awareness
- Therapist helps the client make direct contact with the three aspects of self-experience (e.g., conceptualizations of self, ongoing process of knowing, transcendent sense of self)

Defining Valued Directions

- Therapist can help clients clarify valued life directions (values questionnaire, value clarification exercise, what do you want your life to stand for, funeral exercise)
- Therapist helps client "go on record" as standing for valued life ends
- Therapist is willing to state his/her own values if it is relevant in therapy, and is careful not to substitute them for the client's values
- Therapist teaches clients to distinguish between values and goals
- Therapist distinguishes between goals (outcomes) and the process of striving toward goals (growth that occurs as a result of striving)
- Therapist accepts the client's values and, if unwilling to work with them, refers the client on to another provider or community resource

Building Patterns of Committed Action

- Therapist helps client value based goals and build a concrete action plan
- Therapist helps client distinguish between deciding and choosing to engage in committed action
- Therapist encourages client to make and keep commitments in the presence of perceived barriers (e.g., fear of failure, traumatic memories, sadness)
- Therapist helps client identify the impact being "right" might have on the ability to carry through with commitments (e.g., fish hook metaphor, forgiveness, who would be made right, how is your story every going to handle you being healthy)
- Therapist helps client to expect and to be willing to have any perceived barriers that present themselves as a consequence of engaging in committed actions
- Regardless of the size of the action, therapist helps client appreciate the special qualities of committed action (e.g., increases in sense of vitality, sense of moving forward rather than backward, growing rather than shrinking)
- Therapist helps client develop larger and larger patterns of effective action
- Therapist non-judgmentally helps client integrate slips or relapses as an integral part of keeping commitments and building effective responses

ACT Case Formulation

I. Context for case formulation

The goal of ACT is to help clients consistently choose to act effectively (concrete behaviors in alignment with their values) in the presence of difficult or interfering private events.

II. Assessment and Treatment Decision Tree

Beginning with the target problem, as specified by the client or significant others, refine these complaints and concerns into functional response classes that are sensitive to an ACT formulation and to the client's contextual circumstances, and link treatment components to that analysis

A. Consider general behavioral themes and patterns, client history, current life context, and in session behavior that might bear on the functional interpretation of specific targets in ACT terms. These may include:

1. General level of experiential avoidance (core unacceptable emotions, thoughts, memories, etc.; what are the consequences of having such experiences that the client is unwilling to risk)
2. Level of overt behavioral avoidance displayed (what parts of life has the client dropped out of)
3. Level of internally based emotional control strategies (i.e., negative distraction, negative self-instruction, excessive self-monitoring, dissociation, etc)
4. Level of external emotional control strategies (drinking, drug taking, smoking, self-mutilation, etc.)
5. Loss of life direction (general lack of values; areas of life the patient "checked out" of such as marriage, family, self-care, spiritual)
6. Fusion with evaluating thoughts and conceptual categories (domination of "right and wrong" even when that is harmful; high levels of reason-giving; unusual importance of "understanding," etc.)

B. Consider the possible functions of these targets and their treatment implications.

1. Is this target linked to specific application of the tendencies listed under "A" above
2. If so, what are the specific content domains and dimensions of avoided private events, feared consequences of experiencing avoided private events, fused thoughts, reasons and explanations, and feared consequences of defusing from literally held thoughts or rules
3. If so, in what other behavioral domains are these same functions seen?
4. Are there other, more direct, functions that are also involved (e.g., social support, financial consequences)
5. Given the functions that are identified, what are the relative potential contributions of:
   a. generating creative hopelessness (client still resistant to unworkable nature of change agenda)
   b. understanding that excessive attempts at control are the problem (client does not understand experientially the paradoxical effects of control)
   c. experiential contact with the non-toxic nature of private events through acceptance and exposure (client is unable to separate self from reactions, memories, unpleasant thoughts)

d. developing willingness (client is afraid to change behavior because of beliefs about the consequences of facing feared event.

e. engaging in committed action based in values (client has no substantial life plan and needs help to rediscover a value based way of living)

C. Consider the factors that may be perpetuating the use of unworkable change strategies and their treatment implications

1. Client's history of rule following and being right

(if this is an issue, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to a conceptualized self)

2. Level of conviction in the ultimate workability of such strategies

(if this is an issue, consider the need to undermine the improperly targeted change agenda, i.e., creative hopelessness)

3. Belief that change is not possible

(if this is an issue, consider defusion strategies; revisit cost of not trying; arrange behavioral experiments)

4. Fear of the consequence of change

(if this is an issue, consider acceptance, exposure, defusion)

5. Short term effect of ultimately unworkable change strategies is positive

(if this is an issue, consider values work)

D. Consider general client strengths and weaknesses, and current client context

1. Social, financial, and vocational resources available to mobilize in treatment
2. Life skills (if this is an issue, consider those that may need to be addressed through first order change efforts such as relaxation, social skills, time management, personal problem solving)

E. Consider motivation to change and factors that might negatively impact it

1. The "cost" of target behaviors in terms of daily functioning (if this is low or not properly contacted, consider paradox, exposure, evocative exercises before work that assume significant personal motivation)
2. Experience in the unworkability of improperly focused change efforts (if this is low, move directly to diary assessment of the workability of struggle, to experiments designed to test that, or if this does not work, to referral)
3. Clarity and importance of valued ends that are not being achieved due to functional target behavior, and their place in the client's larger set of values (if this is low, as it often is, consider values clarification. If it is necessary to the process of treatment itself, consider putting values clarification earlier in the treatment).
4. Strength and importance of therapeutic relationship (if not positive, attempt to develop, e.g., through use of self-disclosure; if positive, consider integrating ACT change steps with direct support and feedback in session)

F. Consider positive behavior change factors

1. Level of insight and recognition (if insight is facilitative, move through or over early stages to more experiential stages; if it is not facilitative, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to a conceptualized self)

2. Past experience in solving similar problems (if they are positive and safe from an ACT perspective, consider moving directly to change efforts that are overtly modeled after previous successes) 3. Previous exposure to mindfulness/spirituality concepts (if they are positive and safe from an ACT perspective, consider linking these experiences to change efforts; if they are weak or unsafe – such as confusing spirituality with dogma – consider building self-as-context and mindfulness skills)

III. Building interventions into life change and transformation strategy

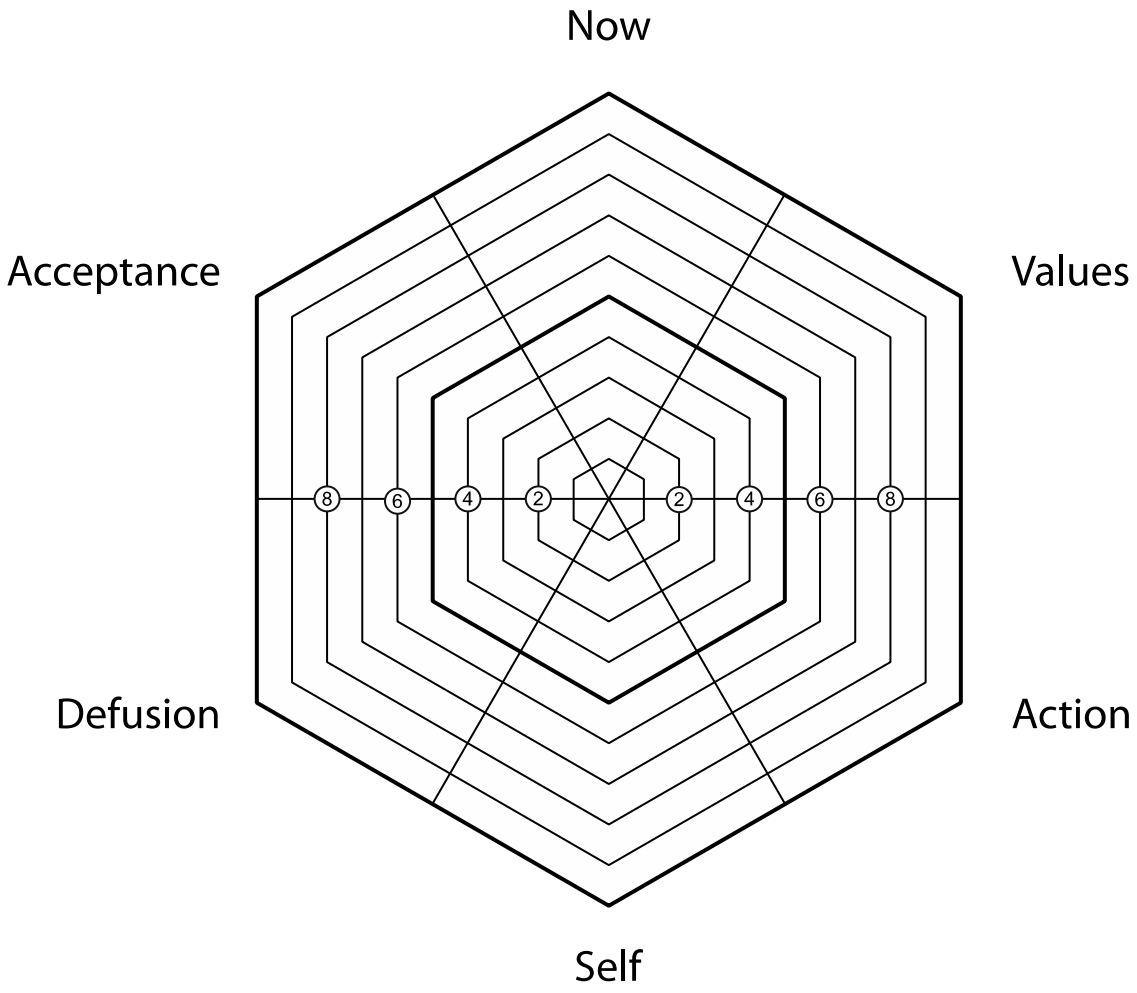
A. Set specific goals in accord with general values

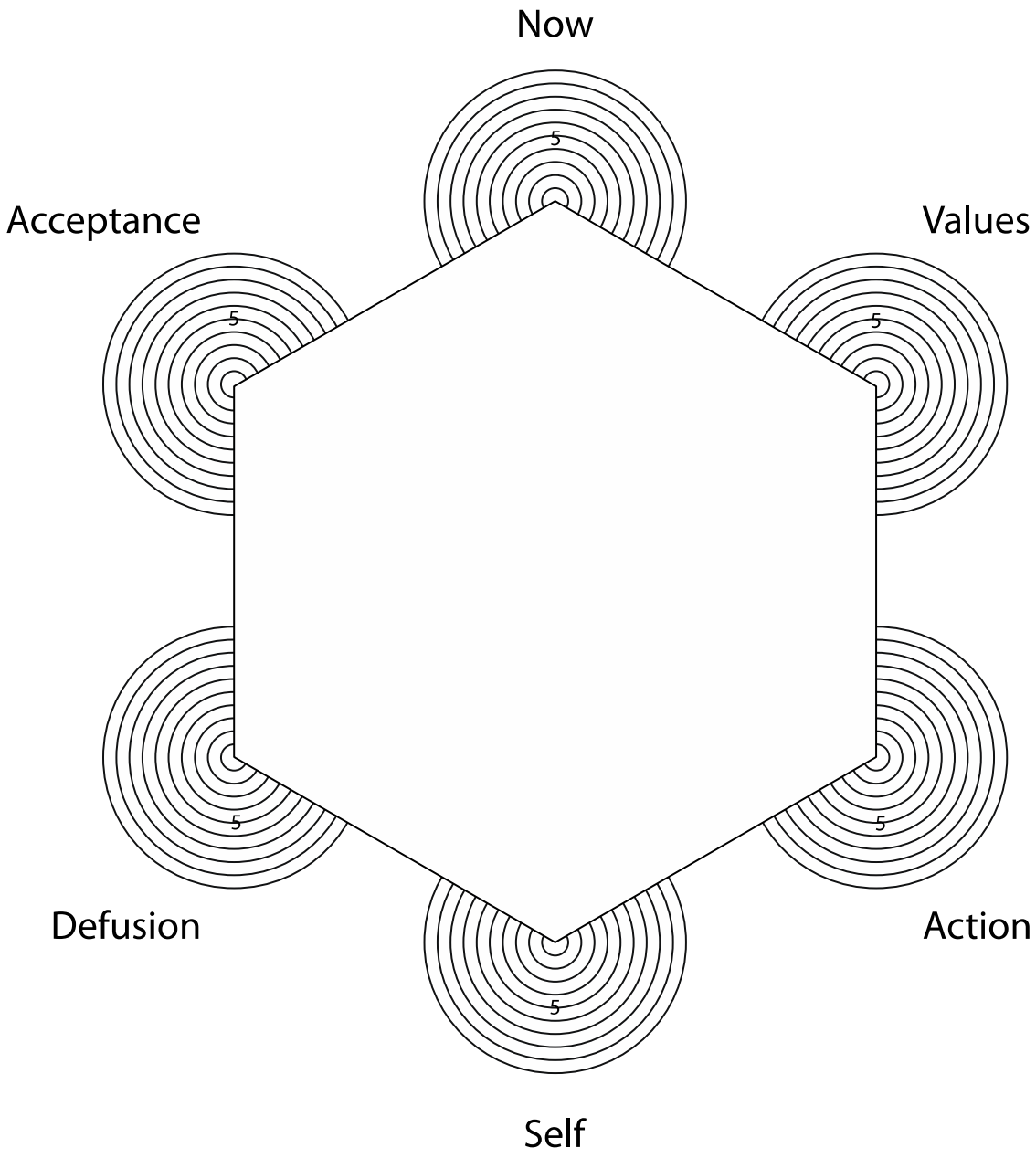
B. Take actions and contact barriers

C. Dissolve barriers through acceptance and defusion

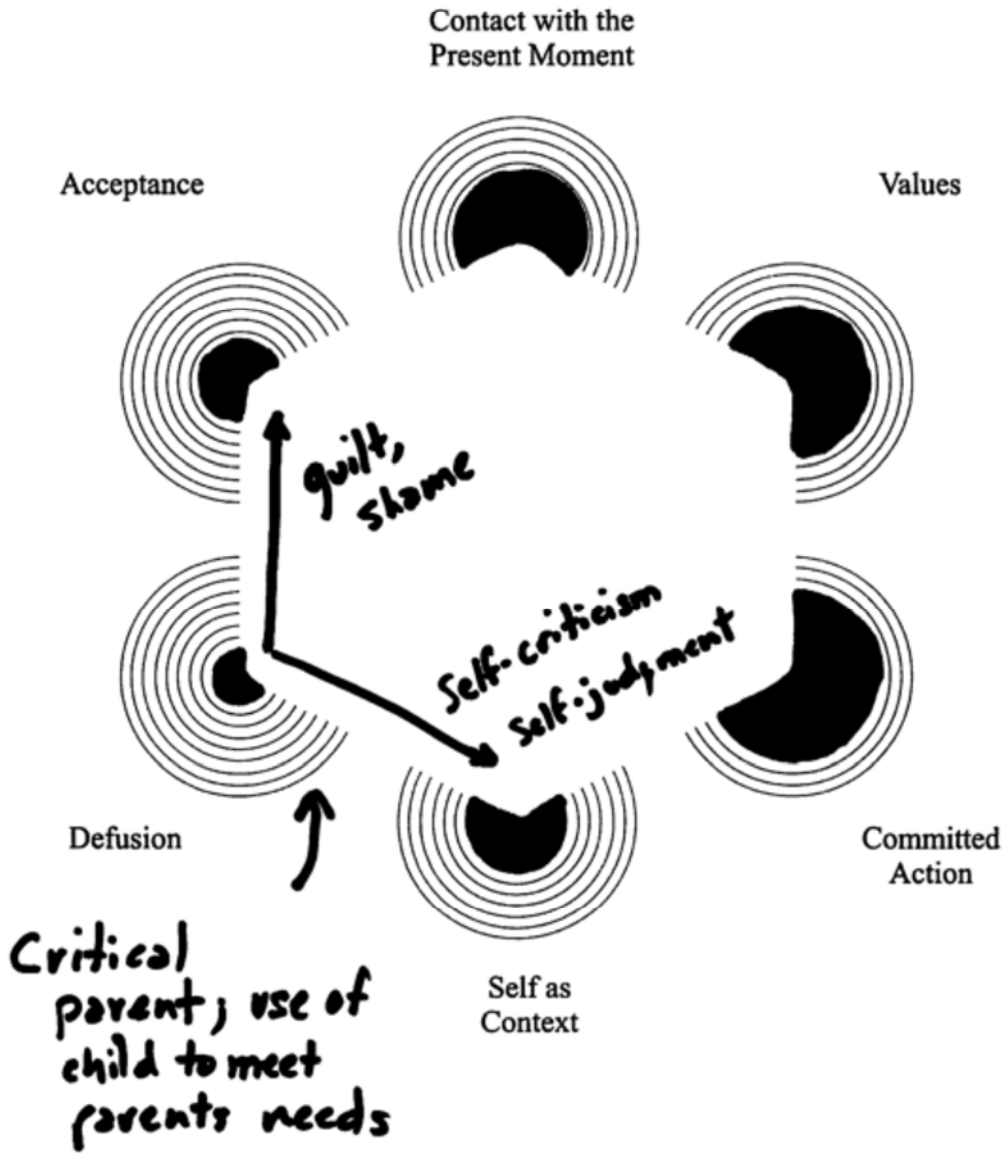
D. Repeat and generalize in various domains

Visual Representations of Client Progress

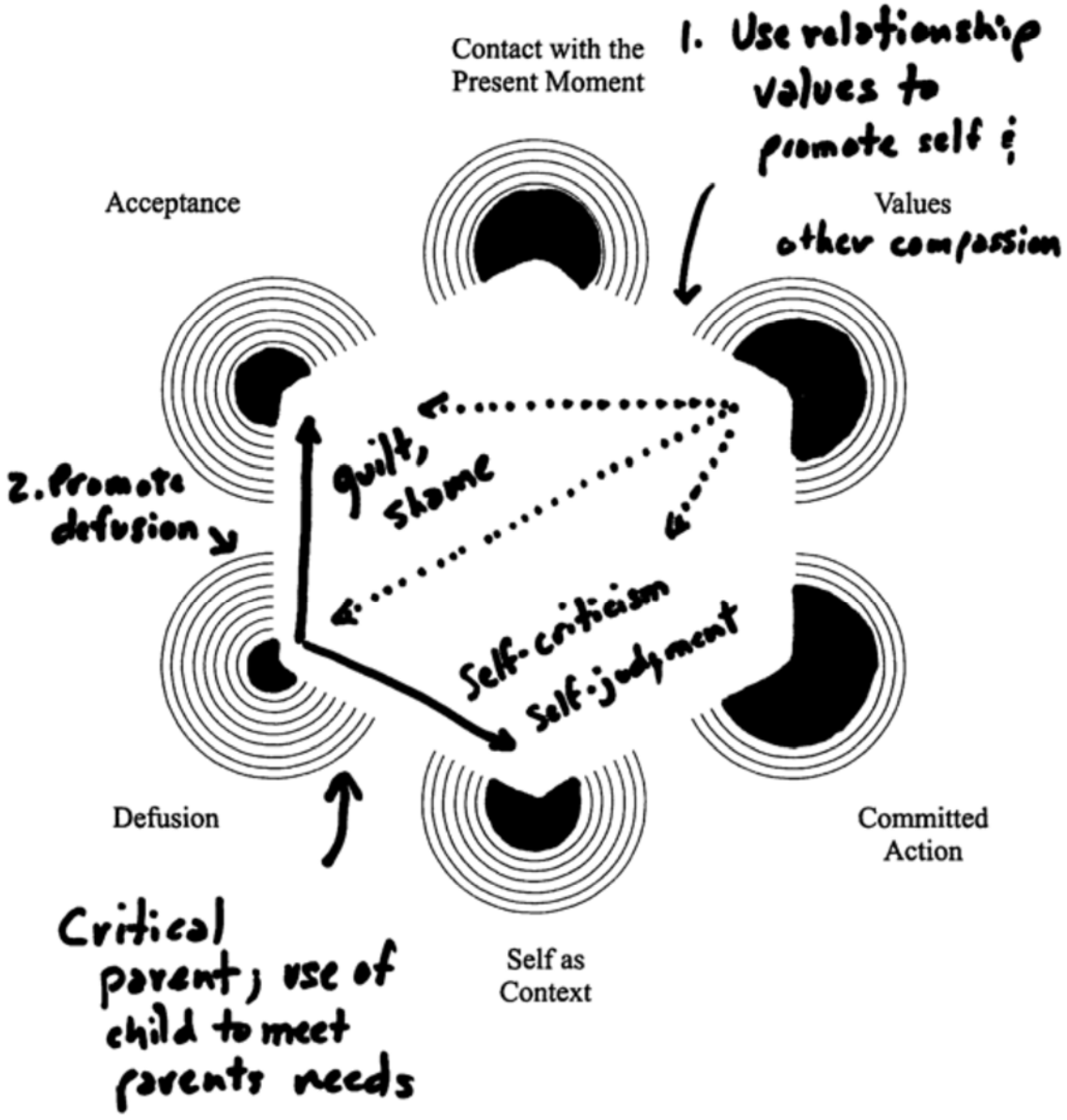



Now
5
Acceptance
Values
5
5
5
5
Defusion
Action
5
Self

Examples


Contact with the Present Moment
Acceptance
Values
guilt, shame
Self-criticism
Self-judgment
Defusion
Committed Action
Critical parent; use of child to meet parents needs
Self as Context

Treatment plan



A Few Examples of ACT Components

(*Compiled by Elizabeth Gifford, Steve Hayes, and Kirk Strosahl, public domain ACBS website*)

Facing the Current Situation ("creative hopelessness") / Control is a Problem

Purpose: To notice that there is a change agenda in place and notice the basic unworkability of that system; to name the system as inappropriately applied control strategies; to examine why this does not work

Method: Draw out what things the client has tried to make things better, examine whether or not they have truly worked in the client's experience, and create space for something new to happen.

When to use: As a precursor to the rest of the work in order for new responses to emerge, especially when the client is really struggling. You can skip this step in some cases, however.

Things to avoid: Never try to convince the client: their experience is the absolute arbiter. The goal is not a feeling state, it is what the Zen tradition calls "being cornered."

Examples of techniques designed to increase creative hopelessness:

Creative hopelessness	Are they willing to consider that there might be another way, but it requires not knowing?
What brought you into treatment?	Bring into sessions sense of being stuck, life being off track, etc.
Person in the Hole exercise	Illustrate that they are doing something and it is not working
Chinese handcuffs Metaphor	No matter how hard they pull to get out of them, pushing in is what it takes
Noticing the struggle	Tug of war with a monster; the goal is to drop the rope, not win the war
Driving with the Rearview Mirror	Even though control strategies are taught, doesn't mean they work
Clear out old to make room for new	Field full of dead trees that need to be burned down for new trees to grow
Break down reliance on old agenda	"Isn't that like you? Isn't that familiar? Does something about that one feel old?"
Paradox	Telling client their confusion is a good outcome
Feedback screech metaphor	Its not the noise that is the problem, it's the amplification
Control is a problem	How they struggle against it = control strategies (ways they try to control or avoid inner experience).
The paradox of control	"If you aren't willing to have it, you've got it."
Illusion of control metaphors	Fall in love, jelly doughnut, what are the numbers exercise
Consequences of control	Polygraph metaphor
Willingness vs. control	Two scales metaphor
Costs of low willingness	Box full of stuff metaphor, clean vs. dirty discomfort

Cognitive Defusion (Deliteralization)

Purpose: See thoughts as what they are, not as what they say they are.
Method: Expand attention to thinking and experiencing as an ongoing behavioral process, not a causal, ontological result
When to use: When private events are functioning as barriers due to FEAR (fusion, evaluation, avoidance, reasons)

Examples of defusion techniques

'The Mind"	Treat "the mind" as an external event; almost as a separate person
Mental appreciation	Thank your mind; show aesthetic appreciation for its products
Cubbyholing	Label private events as to kind or function in a back channel communication
"I'm having the thought that …"	Include category labels in descriptions of private events
Commitment to openness	Ask if the content is acceptable when negative content shows up
Just noticing	Use the language of observation (e.g., noticing) when talking about thoughts
"Buying" thoughts	Use active language to distinguish thoughts and beliefs
Titchener's repetition	Repeat the difficult thought until you can hear it
Physicalizing	Label the physical dimensions of thoughts
Put them out there	Sit next to the client and put each thought and experience out in front of you both as an object
Open mindfulness	Watching thoughts as external objects without use or involvement
Focused mindfulness	Direct attention to nonliteral dimensions of experience
Sound it out	Say difficult thoughts very, very slowly
Sing it out	Sing your thoughts
Silly voices	Say your thoughts in other voices -- a Donald Duck voice for example
Experiential seeking	Openly seek out more material, especially if it is difficult
Polarities	Strengthen the evaluative component of a thought and watch it pull its opposite
Arrogance of word	Try to instruct nonverbal behavior
Think the opposite	Engage in behavior while trying to command the opposite
Your mind is not your friend	Suppose your mind is mindless; who do you trust, your experience or your mind
Who would be made wrong by that?	If a miracle happened and this cleared up without any change in (list reasons), who would be made wrong by that?
Strange loops	Point out a literal paradox inherent in normal thinking
Thoughts are not causes	"Is it possible to think that thought, as a thought, AND do x?"
Choose being right or choose being alive	If you have to pay with one to play for the other, which do you choose?
There are four people in here	Open strategize how to connect when minds are listening
Monsters on the bus	Treating scary private events as monsters on a bus you are driving
Feed the tiger	Like feeding a tiger, you strengthen the impact of thoughts but dealing with them
Who is in charge here?	Treat thoughts as bullies; use colorful language
Carrying around a dead person	Treat conceptualized history as rotting meat
Take your mind for a walk	Walk behind the client chattering mind talk while they choose where to walk
How old is this? Is this just like you?	Step out of content and ask these questions
And what is that in the service of?	Step out of content and ask this question
OK, you are right. Now what?	Take "right" as a given and focus on action

Mary had a little ….	Say a common phrase and leave out the last word; link to automaticity of thoughts the client is struggling with
Get off your buts	Replace virtually all self-referential uses of "but" with "and"
What are the numbers?	Teach a simple sequence of numbers and then harass the client regarding the arbitrariness and yet permanence of this mental event
Why, why, why?	Show the shallowness of causal explanations by repeatedly asking "why"
Create a new story	Write down the normal story, then repeatedly integrate those facts into other stories
Find a free thought	Ask client to find a free thought, unconnected to anything
Do not think "x"	Specify a thought not to think and notice that you do
Find something that can't be evaluated	Look around the room and notice that every single thing can be evaluated negatively
Flip cards	Write difficult thoughts on 3 x 5 cards; flip them on the client's lap vs. keep them off
Carry cards	Write difficult thoughts on 3 x 5 cards and carry them with you
Carry your keys	Assign difficult thoughts and experiences to the clients keys. Ask the client to think the thought as a thought each time the keys are handled, and then carry them from there
Wearing your badges	Put feared negative self-evaluations in bold letters on your chest
Bad news radio	Practice saying sticky negative thoughts as if they came from a radio station in your head you cannot not turn off. It's bad new radio! All bad news! All the time!
Pop up ads from hell	Imagine that you mind sends thoughts like internet pop-up ads
Mr. Hands	Imagine your thoughts are spoken by South Parks "Mr. Hands"
Mr. Bush	Imagine your thoughts are spoken by President Bush (alter to fit politician you are skeptical of)

Acceptance

Purpose: Allow yourself to have whatever inner experiences are present when doing so foster effective action.

Method: Reinforce approach responses to previously aversive inner experiences, reducing motivation to behave avoidantly (altering negatively reinforced avoidant patterns).

When to use: When escape and avoidance of private events prevents positive action

Examples of techniques designed to increase acceptance:

Unhooking	Thoughts/feelings don't always lead to action
Identifying the problem	When we battle with our inner experience, it distracts and derails us. Use examples.
Explore effects of avoidance	Has it worked in your life
Defining the problem	What they struggle against = barriers toward heading in the direction of their goals.
Experiential awareness	Learn to pay attention to internal experiences, and to how we respond to them
Leaning down the hill	Changing the response to material – toward the fear not away
Amplifying responses	Bring experience into awareness, into the room
Empathy	Participate with client in emotional responding
In vivo Exposure	Structure and encourage intensive experiencing in session
The Serenity Prayer	Change what we can, accept what we can't.
Practice doing the unfamiliar	Pay attention to what happens when you don't do the automatic response
Acceptance homework	Go out and find it
Discrimination training	What do they feel/think/experience?
Mindreading	Help them to identify how they feel
Journaling	Write about painful events
Tin Can Monster Exercise	Systematically explore response dimensions of a difficult overall event
Distinguishing between clean and dirty emotions	Trauma = pain + unwillingness to have pain
Distinguishing willingness from wanting	Bum at the door metaphor – you can welcome a guest without being happy he's there
How to recognize trauma	Are you less willing to experience the event or more?
Distinguishing willingness the activity from willingness the feeling	Opening up is more important that feeling like it
Choosing Willingness: The Willingness Question	Given the distinction between you and the stuff you struggle with, are you willing to have that stuff, as it is and not as what it says it is, and do what works in this situation?
Focus on what can be changed	Two scales metaphor
Caution against qualitatively limiting willingness	The tantruming kid metaphor – if a kid knew your limits he'd trantrum exactly that long; Jumping exercise – you can practice jumping from a book or a building, but you can step down only from the book – don't limit willingness qualitatively
Distinguish willing from wallowing	Moving through a swamp metaphor: the only reason to go in is because it stands between you and getting to where you intend to go
Challenging personal space:	Sitting eye to eye

Self as Context

Purpose: Make contact with a sense of self that is a safe and consistent perspective from which to observe and accept all changing inner experiences.

Method: Mindfulness and noticing the continuity of consciousness

When to use: When the person needs a solid foundation in order to be able to experience experiences; when identifying with a conceptualized self

Examples of techniques designed to increase self as context

Observer exercise	Notice who is noticing in various domains of experience
Therapeutic relationship	Model unconditional acceptance of client's experience.
Metaphors for context	Box with stuff; house with furniture; chessboard
"confidence"	con = with; fidence = fidelity or faith – self fidelity
Riding a bicycle	You are always falling off balance, yet you move forward
Experiential centering	Make contact with self-perspective
Practicing unconditional acceptance	Permission to be – accept self as is
Identifying content as content	Separating out what changes and what does not
Identify programming	Two computers exercise
Programming process	Content is always being generated – generate some in session together
Process vs outcome	Practice pulling back into the present from thoughts of the future/past
ACT generated content	Thoughts/feelings about self (even "good" ones) don't substitute for experience
Self as object	Describe the conceptualized self, both "good" and "bad"
Others as objects	Relationship vs being right
Connecting at "board level"	Practice being a human with humans
Getting back on the horse	Connecting to the fact that they will always move in and out of perspective of self-as-context, in session and out.
Identifying when you need it	Occasions where "getting present" is indicated (learning to apply first aid)
Contrast observer self with conceptualized self	Pick an identity exercise
Forgiveness	Identify painful experiences as content; separate from context

Valuing

Purpose: To clarify what the client values for its own sake: what gives your life meaning?
General Method: To distinguish choices from reasoned actions; to understand the distinction between a value and a goal; to help clients choose and declare their values and to set behavioral tasks linked to these values
When to use: Whenever motivation is at issue; again after defusion and acceptance removed avoidance as a compass
Examples of values techniques

Coke and 7-Up	Define choice and have the client make a simple one. Then ask why? If there is any content based answer, repeat
Your values are perfect	Point out that values cannot be evaluated, thus your values are not the problem
Tombstone	Have the client write what he/she stands for on his/her tombstone
Eulogy	Have the client hear the eulogies he or she would most like to hear
Values clarification	List values in all major life domains
Goal clarification	List concrete goals that would instantiate these values
Action specification	List concrete actions that would lead toward these goals
Barrier clarification	List barriers to taking these actions
Taking a stand	Stand up and declare a value without avoidance
Pen through the board	Physical metaphor of a path – the twists and turns are not the direction
Traumatic deflection	What pain would you have to contact to do what you value
Pick a game to play	Define a game as "pretending that where you are not yet is more important than where you are" -- define values as choosing the game
Process / outcome and values	"Outcome is the process through which process becomes the outcome"
Skiing down the mountain metaphor	Down must be more important than up, or you cannot ski; if a helicopter flew you down it would not be skiing
Point on the horizon	Picking a point on the horizon is like a value; heading toward the tree is like a goal
Choosing not to choose	You cannot avoid choice because no choice is a choice
Responsibility	You are able to respond
What if no one could know?	Imagine no one could know of your achievements: then what would you value?
Sticking a pen through your hand	Suppose getting well required this – would you do it
Confronting the little kid	Bring back the client at an earlier age to ask the adult for something
First you win; then you play	Choose to be acceptable

Example Values

Love
Kindness
Fun
Honesty
Interdependence
Independence
Sincerity
Transcendence
Connection
Responsibility
Thoughtfulness
Patience
Persistence
Stability
Tolerance
Humor
Organization
Flexibility
Adventure
Affection
Creativity
Community
Ethical
Peace
Diversity
Cooperation
Competition
Comfort
Spirituality
Mentorship
Gentleness Efficiency
Friendship
Growth
Privacy
Tolerance
Variety
Consistency
Sensitivity
Strength
Spontaneity
Respect
Beauty
Optimism
Skepticism
Simplicity
Conservation
Loyalty
Trust
Tenacity
Intimacy
Freedom
Change
Joyfulness
Equality
Empathy
Nurturance
Public Service
Knowledge
Curiosity
Inspiration
Discovery
Passion
Tranquility
Accountability
Tenderness
Justice
Leadership
Integrity
Harmony
Empowerment
Sharing
Reflection
Discretion
Influence
Uniqueness
Wisdom
Collaboration
Self-reliance
Artistry
Confidence
Safety
Sophistication
Serenity
Merit
Compassion
Genuineness
Acceptance
Innovation
Courage
Devotion
Whimsical
Cleverness
Resourcefulness
Luxury
Lightheartedness
Encouragement
Faithfulness
Nature
Truth

Resources

ACT is listed as an evidence-based treatment by the Clinical Division of the American Psychological Association (http://www.div12.org/PsychologicalTreatments/treatments.html) and by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its *National Registry of Evidence-based Programs and Practices* (NREPP). The NREPP listing can be found at http://174.140.153.167/ViewIntervention.aspx?id=191

The main website for ACT and for Relational Frame Theory is the one maintained by the Association for Contextual Behavioral Science: www.contextualscience.org. Upcoming workshops are always posted there. Dues are "values based" meaning you pay what you think the work is worth and what you can afford. The resources there are invaluable. Your membership automatically includes a high quality Elsevier journal called the *Journal of Contextual Behavioral Science.* There are over 6,700 members worldwide. There is also an email list serve for ACT. Once you are an ACBS member you can join the list through your membership settings.

Workshops: There are ACT trainers all around the world.

ACBS World Conference held annually. Details are on www.contextualscience.org

Critical ACT Books

"Must haves" for learning ACT.

Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford Press. [This is still the ACT bible but it should no longer stand alone.]

Hayes, S. C. & Strosahl, K. D. (2005). *A Practical Guide to Acceptance and Commitment Therapy.* New York: Springer-Verlag. [Shows how to do ACT with a variety of populations]

Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders.* Oakland: New Harbinger. [Great book with a super protocol that shows how to mix ACT processes into a brief therapy for anxiety disorders]. Fall 2005 ACT handout 2

Hayes, S. C. & Smith, S. (2005). *Get out of your mind and into your life.* Oakland, CA: New Harbinger.

How to Learn ACT

Read 3 or 4 key books; Join ACBS and the list serves; Attend a workshop or a ACT convention; Work thru a general ACT self-help book looking at your own processes (i.e., *Get out of your mind*); Review ACT DVDs; Form a Peer Consultation Group; apply ACT following a protocol several times; Apply ACT with supervision but without a formal protocol to a few clients; Do a presentation on ACT.

A Few Helpful ACT Books and DVDs

General ACT Books: Professionals

Luoma, J., Hayes, S. C. & Walser, R. (2007). *Learning ACT.* Oakland, CA: New Harbinger. [A step by step learning companion for the main ACT book below. Very practical and helpful. Great book.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (2011). *Acceptance and Commitment Therapy: The process and practice of mindful change* (2nd edition). New York: Guilford Press. [This is still the heart of the ACT literature. It is where it started]

Wilson, K. G. & Dufrene, T. (2009). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy.* Oakland, CA: New Harbinger. [A book on ACT that emphasizes mindfulness and the therapeutic relationship]

Hayes, S. C. & Strosahl, K. D. (2005). *A Practical Guide to Acceptance and Commitment Therapy.* New York: Springer-Verlag. [Shows how to do ACT with a variety of populations]
Twohig, M., & Hayes, S. C. (2008). *ACT verbatim: Depression and Anxiety.* Oakland, CA: New Harbinger; Reno, NV: Context Press. [Good example of ACT in actual practice]
Chantry, D. (2007). *Talking ACT: Notes and conversations on Acceptance and Commitment Therapy.* Reno, NV: Context Press. [This is an edited version of the ACT listserv from July 2002 through August 2005 compiled by a therapist, for therapists. Functions as a quick reference on a wide range of ACT topics (acceptance, anxiety, behavior analysis, choice, clinical resources, contextualism, etc)]
Ciarrochi, J. V. & Bailey, A. (2008). *A CBT practitioner's guide to ACT.* Oakland, CA: New Harbinger. [Does what the title says it does]
Batten, S. (2011). *Essentials of Acceptance and Commitment Therapy*. London: Sage. [Broad introduction to ACT]
Harris, R. (2009). *ACT made simple*. Oakland, CA: New Harbinger. [Easy place to start with ACT]
Hayes, S. C. & Lillis, J. (2012). *Introduction to Acceptance and Commitment Therapy.* Washington, DC: American Psychological Association. [Books specifically for students learning about ACT]

General ACT Books: Clients

Hayes, S. C. & Smith, S. (2005). *Get out of your mind and into your life.* Oakland, CA: New Harbinger. [A general purpose ACT workbook. RCTs show that it works as an aid to ACT or on its own, but it will also keep new ACT therapists well oriented]
Harris, R. (2008). *The happiness trap*. New York: Shambala. [Very accessible ACT book for the public]

Trauma: Professional book

Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder & Trauma-Related Problems: A Practitioner's Guide to Using Mindfulness & Acceptance Strategies.* Oakland, CA: New Harbinger. [A very practical and accessible approach to using ACT to treat post-traumatic stress disorder (PTSD) and acute trauma-related symptoms.]

Trauma: Client book

Follette, V. M., & Pistorello, J. (2007). *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems.* Oakland, CA: New Harbinger. [Applies the principles of ACT to help readers cope with the after effects of traumatic experience. Straightforward, practical, and useful]

Depression: Professional book

Zettle, R. (2007). *ACT for Depression: A Clinician's Guide to Using Acceptance & Commitment Therapy in Treating Depression.* Oakland, CA: New Harbinger. [An solid book from one of the founders of ACT on one of the most pervasive problems human beings face.]

Depression: Client book

Strosahl, K. & Robinson, P. J. (2008). *The Mindfulness & Acceptance Workbook for Depression: Using Acceptance & Commitment Therapy to Move Through Depression & Create a Life Worth Living.* Oakland: New Harbinger. [Great workbook on ACT for depression]

Anxiety: Professional book

Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders.* Oakland: New Harbinger. [Good book with a protocol that shows how to mix ACT processes into a brief therapy for anxiety disorders].

Anxiety: Client book

Forsyth, J., & Eifert, G. (2007). *The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy.* Oakland: New Harbinger. [Solid workbook for anxiety]

Worry: Client book

Lejeune, C. (2007). *The Worry Trap: How to Free Yourself from Worry & Anxiety using Acceptance and Commitment Therapy.* Oakland, CA: New Harbinger. [A guide to the application of ACT to worry and generalized anxiety.]

Chronic pain: Professional books

Dahl, J., Wilson, K. G., Luciano, C., & Hayes, S. C. (2005). *Acceptance and Commitment Therapy for Chronic Pain.* Reno, NV: Context Press. [Describes an ACT approach to chronic pain. Very accessible and readable. One of the better clinical expositions on how to do ACT values work.]

McCracken, L. M. (2005). *Contextual Cognitive-Behavioral Therapy for chronic pain.* Seattle, WA: International Association for the Study of Pain. [[Describes an interdisciplinary ACT-based approach to chronic pain

Chronic pain: Client book

Dahl, J. C., & Lundgren, T. L. (2006). *Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain.* Oakland, CA: New Harbinger. [Uses ACT principles to help those suffering from pain transcend the experience by reconnecting with other, more valued aspects of their lives.]

Anger: Client book

Eifert, G. H., McKay, M., & Forsyth, J. P. (2006). *ACT on life not on anger: The new Acceptance and Commitment Therapy guide to problem anger.* Oakland, CA: New Harbinger. [The first book to adapt ACT principles to dealing with anger. It teaches readers how to change their relationship to anger by accepting rather than resisting angry feelings and learning to make values-based responses to provocation. Has been tested successfully in a small randomized trial.]

Caregivers: Client book

McCurry, S. M. (2006). *When a family member has dementia: Steps to becoming a resilient caregiver.* Westport, CT: Praeger Publishers. [Although not directly on ACT or mindfulness, this book for caregivers does include a significant emphasis on acceptance, as might make sense given that the author is on of the early ACT therapists from UNR.]

Eating disorders: Client book

Heffner, M., & Eifert, G. H. (2004). *The anorexia workbook: How to accept yourself, heal suffering, and reclaim your life.* Oakland, CA: New Harbinger. [An eating disorders patient workbook on ACT.]

Diabetes management: Client book

Gregg, J., Callaghan, G., & Hayes, S. C. (2007). *The diabetes lifestyle book: Facing your fears and making changes for a long and healthy life.* Oakland, CA: New Harbinger. [You cannot tell from the title but this is a book applying ACT to diabetes management.]

Organizational issues: Professional book

Hayes, S. C., Bond, F. W., Barnes-Holmes, D., & Austin, J. (2007). Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy and Relational Frame Theory to Organizational Behavioral Management. Binghamton, NY: Haworth Press. [This was a special issue of the Journal of Organizational Behavior Management that was bound into book form. Don't buy it expecting a smooth presentation of the applicability of ACT and RFT to organizational issues -- it is a collection of journal articles gather into a book. But it is still worthwhile if I/O is your area and you are wondering how ACT and RFT might apply.]

Human performance: Professional book

Gardner, F.L., & Moore, Z.E. (2007). *The psychology of enhancing human performance: The Mindfulness-Acceptance-Commitment (MAC) approach.* New York: Springer.

[This book provides theory and empirical background, and a structured step-by-step, protocol for the assessment, conceptualization, and enhancement of human performance with a variety of high-performing clientele including executives, athletes, artists, and emergency/military personnel].

Trichotillomania: Professional book

Woods, D. W., & Twohig, M. P. (2008). *Trichotillomania: An ACT-enhanced Behavior Therapy Approach Therapist Guide.* New York: Oxford University Press.

Trichotillomania: Client book

Woods, D. W., & Twohig, M. P. (2008). *Trichotillomania: An ACT-enhanced Behavior Therapy Approach Workbook.* New York: Oxford University Press.

Behavioral Medicine: Professional book

McCracken, L. (2011). *Mindfulness and Acceptance in Behavioral Medicine.* Oakland, CA: New Harbinger.

Assessment: Professional book

Baer, R. (2010). *Assessing Mindfulness & Acceptance Processes in Clients: Illuminating the Theory & Practice of Change*. Oakland, CA: New Harbinger.

Primary care settings: Professional book

Robinson, P. J., Gould, D. A., & Strosahl, K. D. (2011). *Real behavior change in primary care.* Oakland, CA: New Harbinger.

Irritable Bowel Syndrome: Client book

Ferreira, N. B. & Gillanders, D. T (2012) *Better Living with IBS: A step-by-step program to managing your symptoms so you can enjoy life to the full!* Exsile Publishing, New South Wales.

Psychosis: Professional book

Morris, E. M. J., Johns, L. C., & Oliver, J. E. (2013) (Eds). *Acceptance and Commitment Therapy and mindfulness for psychosis*. London: Wiley-Blackwell. ISBN: 978-1-1199-5079-0

DVDs

Hayes, S. C. (Ed.). (2007). *ACT in Action DVD series.* Oakland, CA: New Harbinger. [A set of six DVDs on the following topics: Facing the struggle; Control and acceptance; Cognitive defusion; Mindfulness, self, and contact with the present moment; Values and action; and Psychological flexibility. The tapes include several ACT therapists from around the world in addition to Steve, including Ann Bailey-Ciarrochi, JoAnne Dahl, Rainer Sonntag, Kirk Strosahl, Robyn Walser, Rikard Wicksell, and Kelly Wilson. As the marketing folks say: you've read the books, now see the movies.

Hayes, S. C. (2008). *Acceptance and Commitment Therapy.* Washington, DC: American Psychological Association [Therapy skills DVD using real client].

A 90 minute ACT tape from the 2000 World Congress is available from AABT (www.aabt.org). It costs $50 for members and $95 for non-members. It shows Steve Hayes working with a client (role-played by a graduate student – Steve did not, however, meet the "client" or know their "problem" before the role playing started so it appears relatively realistic). Recommended, however the mike was not properly attached for the "client" and she is a bit hard to hear.

AABT also markets a taped interview with Steve Hayes about the development of ACT and RFT as part of their "Archives" series. Cost is the same as above.

Applied theory

Hayes, S. C., Follette, V. M., & Linehan, M. (2004). *Mindfulness and acceptance: Expanding the cognitive behavioral tradition.* New York: Guilford Press. [Shows how ACT is part of a change in the behavioral and cognitive therapies more generally]

Greco, L. & Hayes, S. C. (2008) (Eds.). *Acceptance and mindfulness treatments for children and adolescents: A practitioner's guide.* Oakland, CA: New Harbinger. [Similar to the above but for children and adolescents.]

Hayes, S. C., Jacobson, N. S., Follette, V. M. & Dougher, M. J. (Eds.). (1994). *Acceptance and change: Content and context in psychotherapy.* Oakland: New Harbinger.. [Some of the fellow travelers. This was the book length summary of the 3rd wave that was coming. Still relevant]

Basic Theory

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001) (Eds.), *Relational Frame Theory: A Post-Skinnerian account of human language and cognition.* New York: Springer-Verlag. [Not for the faint of heart, but if you want a treatment that is grounded on a solid foundation of basic work, you've got it. This book is the foundation.]

Hayes, S. C. (Ed.). (1989). *Rule-governed behavior: Cognition, contingencies, and instructional control.* New York: Plenum. (2007) Reprinted by Context Press.

Rehfeldt, R. A. & Barnes-Holmes, Y. (Eds.) (2009). *Derived relational responding.* Oakland, CA: New Harbinger. [Great for language training programs, and work with children]

Torneke, N. (2011). *Learning RFT.* Oakland, CA: New Harbinger. [Clinically accessible book on applying RFT]

Philosophical Foundation

Hayes, S. C., Hayes, L. J., Reese, H. W., & Sarbin, T. R. (Eds.). (1993). *Varieties of scientific contextualism.* Reno, NV: Context Press. [If you get interested in the philosophical foundation of ACT, this will help]

There are several additional books on contextualism (see the Context Press list at New Harbinger's website) and a new book on functional contextualism that is coming within the next year or so.

A Few Theoretical and Review Articles Relevant to ACT (more on ACBS website)

Gaudiano, B. A. (2011). A review of acceptance and commitment therapy (ACT) and recommendations for continued scientific advancement. *The Scientific Review of Mental Health Practice, 8,* 5-22. A well-balanced scholarly review of ACT, its underlying theory, and scientific status. Makes really good recommendations for development. This is a great review to give to "science skeptics" (especially traditional CBTers) and to use in graduate classes.

Longmore, R. J., & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavioral therapy? *Clinical Psychology Review, 27,* 173-187.
A comprehensive review of the evidence in three keys areas that question the idea that trying to change the form of thoughts is helpful. It finds little evidence that specific cognitive interventions significantly increase the effectiveness of CBT or that cognitive change is causal in the symptomatic improvements achieved in CBT. It does not find enough evidence to conclude that there is an early rapid response to CBT (before cognitive methods). Overall, the review supports the view of the basic ACT criticism of traditional CBT.

Williams, J. C. & Lynn, S. J. (2010). Acceptance: An historical and conceptual review. *Imagination, cognition, and personality, 30,* 5-56. Good historical review of the acceptance concept.

Hayes, S. C., Luoma, J., Bond, F., Masuda, A., and Lillis, J. (2006). Acceptance and Commitment Therapy: Model, processes, and outcomes. *Behaviour Research and Therapy, 44,* 1-25.
[A meta-analysis of ACT processes and outcomes. Reviews all AAQ and ACT clinical studies]

Ruiz, F. J. (2010). A review of Acceptance and Commitment Therapy (ACT) empirical evidence: Correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology and Psychological Therapy, 10,* 125-162. [A meta-analysis of ACT processes and outcomes].

Hayes, S. C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, L. F. (2004). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy, 35,* 35-54. [Tutorial review of the empirical evidence on ACT, DBT, and FAP]

Hayes, S. C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35,* 639-665. [Makes the case that ACT is part of a larger shift in the field.]

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Emotional avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal*

of Consulting and Clinical Psychology, 64, 1152-1168. [This reviews the data relevant to an ACT approach to psychopathology, as of the mid-90's. Still relevant]

Salters-Pedneault, K., Tull, M. T., & Roemer, L. (2004). The role of avoidance of emotional material in the anxiety disorders. *Applied and Preventive Psychology, 11,* 95-114. [A more recent review of much of the experiential avoidance literature]

Cavanagh, K., Strauss, C., Forder, L., & Jones, F. (2014). Can mindfulness and acceptance be learnt by self-help? A systematic review and meta-analysis of mindfulness and acceptance-based self-help interventions, *Clinical Psychology Review, 34,* 118-129. Meta-analysis of 15 RCTs (7 with ACT). Significant benefits in comparison to control conditions on measures of mindfulness/acceptance, depression, and anxiety with small to medium effect sizes.

Assessment instruments

Go to the ACBS website for a nearly 100 page pdf there of all the ACT measures available. Here are just two examples:

Gillanders, D. T., Bolderston, H., Bond, F. W., Dempster, M., Flaxman, P. E., Campbell, L., Kerr, S., Tansey, L., Noel, P., Ferenbach, C., Masley, S., Roach, L., Lloyd, J., May, L., Clarke, S., Remington, R. (2014) The development and initial validation of The Cognitive Fusion Questionnaire. *Behavior Therapy, 45,* 83-101. DOI: 10.1016/j.beth.2013.09.001

Trompetter, H. R., ten Klooster, P. M., Schreurs, K. G., Fledderus, M., Westerhof, G. J., & Bohlmeijer, E. T. (2013). Measuring values and committed action with the Engaged Living Scale (ELS): Psychometric evaluation in a nonclinical sample and a chronic pain sample. *Psychological Assessment, 25*(4), 1235-1246. doi:10.1037/a0033813