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Starting off on the right foot in Acceptance and Commitment Therapy

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Abstract

This paper describes the initial phase of acceptance and commitment therapy (ACT). The paper begins with a review of ACT's theoretical orientation. Basic empirical support for ACT and its model is covered. A case description follows that highlights the initial phases of ACT. The paper concludes with practical recommendations for starting therapy using ACT.

Clinical impact statement:

Question: The goal of this paper is to present the manner in which ACT is initiated. Findings: There are specific theoretical elements of ACT that suggest certain approaches be taken at the beginning of therapy. Meaning: Before starting ACT with a new client, therapists should be familiar with the theoretical orientation of the therapy and the techniques needed to imitate it. Next Steps: Research on how to train these skills appears needed.

Theoretical Orientation

Acceptance and commitment therapy (ACT; pronounced like the word *act*) is a therapeutic approach grounded in contextual behavioral science, which has its foundations in behavior analytic psychology (Hayes, Barnes-Holmes, & Wilson, 2012). The philosophical stance underlying ACT is functional contextualism, which posits the “act-in-context” as the primary unit of analysis (Hayes et al., 2012, p. 3). From this perspective, actions cannot be viewed topographically, they must be looked at functionally. The context that determines function includes the observable and unobservable as well as past events (learning history) and present motivators. As such, from the start of treatment, the ACT therapist needs to be attuned to the ways in which context influences behavior and to use this framework to conceptualize clients’ experiences.

Because actions and experiences are inextricably influenced by context, there is nothing inherently wrong or abnormal about any internal experience; inner experiences are looked at by how they affect the individual’s functioning. Furthermore, the perspective ACT takes is that psychological struggles are usually rooted in normal psychological processes (Hayes, Strosahl, & Wilson, 2012). The verbal processes that have led us to create civilizations and continually improve our species are the same ones that contribute to our psychological challenges. Given this understanding of suffering, ACT therapists recognize that, as human beings, they too are privy to the same struggles as clients. This allows the therapist to offer insights from their experiences with internal events.

ACT aims to help clients flexibly learn from their experiences as well as from societal rules and expectations, as each has advantages and disadvantages. For example, most verbal communities espouse the message that inner events, such as thoughts and feelings, can and

should be controlled. This belief often leads individuals to engage in a struggle with such experiences in ways that often precludes valued living. Within an ACT context, such socially sanctioned assumptions are not treated as axiomatic, but rather, ideas whose utility with respect to therapeutic goals needs to be evaluated in relation to personal experience. If clients' experiences lead them to conclude that inner experiences cannot be controlled and that attempts to do so only cause suffering, then the therapist can work with clients to establish different, more effective responses to these private experiences. The disentangling of inner events and responses to them may be confusing for clients, and therapists can demonstrate this independent relation through their own speech and behavior in session.

The functional aspect of ACT must be defined with respect to an end; effectiveness is impossible to judge without a predetermined goal. In ACT, clients identify personal values, which form the basis of treatment goals. If an action brings clients closer to their values, it is effective. The overarching aim of ACT is to help clients develop a behavioral repertoire that allows them to move flexibly toward their values in the face of inevitable internal and external barriers — this skill set is termed psychological flexibility (Hayes et al., 2012). It can be helpful to explicitly state this functional orientation to clients at the start of therapy because it is different from the topographical or syndromal perspective often taken. Of note, some clients struggle to grasp this concept initially and ACT therapists may need to use directive questions to train clients to think of their behavior in terms of effectiveness. For example, rather than assess the form of the behavior (e.g., “What did you do this week?”), ACT therapists ask about the function of the behavior (e.g., “What effect did X behavior have with respect to your values?”, “How did doing X work for you [with respect to your values]?”).

Finally, practicing ACT requires a flexible approach that facilitates behavioral change in the direction of self-chosen values. Through doing so, the ACT therapist strives to create a context in which clients are more likely to view and interact with their inner experiences in way that works for their goals. One crucial aspect of ACT is the focus on processes of change as they occur in the moment. For example, ACT therapists notice when clients are being avoidant (e.g., “I need to calm down”) or fused (e.g., “I’m too afraid to do this”) in session and work with these processes directly — by eliciting, labeling, modeling, or reinforcing such behaviors in the context of the therapeutic relationship. Setting this tone early on in therapy can help to undermine the typical verbal structures and processes that maintain maladaptive behavior and precipitate effective behavioral change.

Clearly, ACT is not about applying techniques and metaphors formulaically. ACT therapists need to be able to recognize and respond appropriately to events in session in order to create a context for values-based change. Therapists also have to watch out for development of rigid rule-following (pliance) and avoidance-based behavioral patterns in therapy. For example, from a functional lens, homework completion is not necessarily effective if the client is doing so to avoid fear of criticism from the therapist—hopefully it is values-based. Ultimately, through fostering a space in which the therapist and client practice responding to inner experiences in a psychologically flexible way from the onset of therapy, therapists help clients expand their behavioral repertoire and more consistently select actions that serve their values.

Research Support

Several bodies of literature support the fact that humans are motivated to regulate or avoid aversive internal experiences through cognitive and affective strategies such as thought suppression, emotional suppression, avoidance coping, reappraisal, and self-deception (Chawla

& Ostafin, 2007). However, ACT posits that such attempts to avoid or escape these experiences (i.e. experiential avoidance; EA) can become overgeneralized and problematic due to the literal and evaluative functions of human language (Blackledge & Hayes, 2001), causing EA to become a pathological process contributing to the development and maintenance of various psychopathologies (Chawla & Ostafin, 2007; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance has been found to be related to almost all form of pathology or suffering, mediate various form of poor functioning, and mediate the outcomes of treatments that target it (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). As such, ACT seeks to alter this instinctual approach in human behavior and provide a new way of engaging with internal experiences. This is accomplished by affecting six core processes of change acceptance (allowing internal events to occur), defusion (experiences internal events as they are and not as cognition portrays them), flexible attention (the skill of adjusting attention as the situation demands), self as context (seeing the self as the context where internal events occur and not made up of those events), values clarity (knowing what is important), and behavioral commitment (engaging in actions consistent with ones values). Similarly, tests of the components within ACT show that there is support for each process on its own (Levin, Hildebrandt, Lillis, & Hayes, 2012). Lastly, the full ACT-based interventions have been found effective for treating a multitude of psychological disorders (A-Tjak et al., 2015; Hayes et al., 2006).

Case Example

ACT is process of change oriented, and there are many ways in which one might begin therapy. The following is one example of opening ACT with a client. Many aspects of this case have been altered to assure confidentiality of the individual presented. The client was a 25-year-

old White heterosexual cisgender female of middle class background who had recently completed college and worked as an administrative assistant. She presented at a psychology department outpatient clinic seeking treatment for anxiety as well as feeling “overwhelmed” by emotions and acting impulsively (e.g., binge eating, sexual hookups she regretted). She was diagnosed with Generalized Anxiety Disorder (GAD) and presented with subclinical depressive symptoms. She reported that her anxiety interfered with “enjoying life” and performing well at work, and that impulsivity interfered with taking care of her health and relationships. Her goals for therapy were for her anxiety and other emotions to be less overwhelming and to be able to cope with them better. Larger values-based goals included graduating from college and developing friendships and a romantic relationship.

Case conceptualization in ACT starts with determining the role of psychological inflexibility in the clinical presentation. Standardized measures such as the Acceptance and Action Questionnaire (Bond et al., 2011) work well, as do idiographic case conceptualization methods tools (Hayes et al., 2012). This client’s behavior indicated moderate to high experiential avoidance. She frequently attempted to double-check things and get reassurance to control anxiety at work, and when she experienced intense loneliness she would act impulsively in an attempt to take her mind off how she felt. She was moderately fused with worries, acting as if they were literally true most of the time. It was not clear initially if she was fused with self-concepts. She was low in present-moment awareness, frequently attending to worries and jumping between topics restlessly in session. She had relatively clear values such as doing well at school, but acted inconsistently with her values much of the time due to avoidance and impulsivity. In this case, it was clear that developing acceptance, cognitive defusion, and

present-moment awareness would be key to achieving the client's goals, and that values would be a strength to help motivate this work.

Some features of ACT may inform the initial intake. For instance, asking questions about experiential avoidance (“What do you do to try and get control over anxiety?”) and values (“How would you act differently if anxiety were no longer present?”) not only provides the therapist with useful information to begin treatment planning, but leads the client to begin attending to the function of their own behavior. Informed consent for ACT is an ongoing process, which changes as the client becomes more familiar with ACT. The initial informed consent should address what ACT involves, the benefits and challenges of ACT, discuss the roles of the therapist and client, and seek a commitment to the work with a specific time frame (Hayes et al., 2012). Informed consent was addressed in this manner with this client:

Therapist: There's an approach I think might be useful for you, called acceptance and commitment therapy or ACT. It's an evidence-based therapy that's been helpful for many people dealing with anxiety like yours. It's difficult to fully describe it in advance, because it's a bit like learning to ride a bike—you learn it largely by doing it. It's a bit different from many other types of therapy, in that rather than focusing on winning the battle with anxiety, ACT involves learning how to step out of the battle. It has two main pieces, learning skills to handle anxiety and other thoughts and feelings better, so they aren't a problem in your life, and clarifying what matters to you and doing more of that. Do you think that would be useful for you?

Client: I'm not sure how it would work, but yeah, if I could that would be great.

Therapist: Cool. There are a couple other things to know in advance. Because it's about learning new skills, it involves actively working and testing out new things, both in and

between sessions. Also, because ACT involves learning how to handle painful thoughts and feelings, there will be times when we might intentionally bring those things up.

Because of that, it can feel a bit like a roller coaster ride. Sometimes it might feel like the things you've struggled with are getting worse, when it's a step on the way to getting better. What I can say for sure is that I'll be there with you, and I'm committed to helping you move towards living the life you want. *[followed by discussion of time frame]*

Following informed consent, the next therapeutic task is generally to draw out the current system (Hayes et al., 2012). This involves building the client's awareness of their general stance towards the inner experiences they have been struggling with, which is typically one of control, as well as the range of specific behaviors they engage in that serve that function. As this awareness becomes clearer, it is connected to life workability, both how well it has worked to achieve control and how well it has worked relative to living a valued life. It is essential to bring a genuine curiosity and openness to this exploration and to normalize the client's control agenda.

Therapist: So you've tried medication, eating, yoga, shopping, distracting yourself, getting reassurance from other people, and thinking positive to make your anxiety go away. Is coming to therapy a part of that too?

Client: Yeah, I suppose so. At least in part. *[Therapist adds "therapy" to list]*

Therapist: How well have these worked in the short term, to get control over anxiety?

Client: A lot of them don't work. Getting reassurance from other people works for a little bit. Medication has helped too—it doesn't get rid of the anxiety but the low points aren't quite as low.

Therapist: And how well have they worked in the long term, to make anxiety go away and stay away?

Client: Stay away? None of them. But I don't know how I could function without them.

Therapist: It's like your mind keeps saying over and over, 'I need to get a handle on anxiety, and these should work.' And that's rational, isn't it? You've tried many things that "should" work. You're smart and you've worked hard at this. Normally, when you put this kind of effort in to solve a problem, it gets solved, right? But it seems like there's something different about this. As you've put more work into solving anxiety, has anxiety gotten bigger or smaller?

The effects of the control agenda on values may be drawn out further, or cognitive fusion may be targeted by exploring why the human mind is so focused on problem-solving and how well problem-solving works in different domains. Metaphors and experiential exercises are frequently used to bring clients in greater contact with the workability of control and the paradoxical effects of intentional control efforts. There is great flexibility in developing metaphors, and it may be most powerful if clients develop their own metaphors. In this case the "Struggling with Quicksand" metaphor was used (Hayes et al., 2012).

Therapist: When you fall into quicksand, most people instinctively try to tug and fight and pull themselves out. But the way quicksand works is, the more you pull and struggle, the more you sink. Your best chance to get unstuck is actually to spread out into it. When you fall into worry, or sadness, what's your first instinct then?

This summarizes much of the beginning of ACT, the following sessions would continue to develop acceptance and defusion. Once they are somewhat in place a brief discussion of values could occur and weekly behavioral commitments. Therapy would continue with behavioral commitment tied to values while building upon acceptance, defusion, self as context, flexible attention. ACT is commonly tested in 10-12 sessions.

Practical recommendations

This section will briefly review a set of brief practical recommendations for implementing these strategies with clients.

Informed consent and choice are key. ACT routinely asks clients to “lean into” difficult inner experiences they have been putting considerable effort into avoiding. Just like with exposure or other therapies, it is critical to obtain informed consent and to treat this as an ongoing process. One way to orient to this is to continue to return to the idea of client choice – whether they approach difficult experiences is their choice. As therapists, we can help clients orient to these choices and to what is at stake (e.g., “Would you be willing to feel anxious in the service of being there for your kids more?”). Therapists sometimes can lose sight of this component as they work longer with a client and engage in present-moment, process focused work, but catching choice points and pausing to ask the client whether they are willing to do an exercise that might be difficult is key.

Acknowledge things may get worse before they get better. Clients may notice unwanted thoughts and feelings arising more frequently or intensely at times as they learn to stop avoiding these experiences and practice how to be mindful and accepting of them. Addressing this ahead of time with clients can help ensure this is viewed as part of the process, rather than a sign that therapy is not working. Metaphors such as likening this process to a roller coaster, hiking with switchbacks, or a glass with sludge at the bottom can help, highlighting how sometimes things can go up and down or get stirred up, but that this is part of the process of change.

Revisiting that inner experiences are hard to regulate. Clients will likely come to therapy with a long history of experiential avoidance and an expectation that they will learn more effective ways to change and eliminate unwanted inner experiences in therapy. Although the

costs of such a “control agenda” is often addressed at the start of therapy, this will likely be an ongoing theme to return to. For example, clients might notice that a mindfulness exercise leads to fewer thoughts or a sense of calm, or that unwanted thoughts and feelings were less present following therapy. Unabated, this can obstruct progress in ACT as clients practice acceptance-based strategies for non-accepting reasons. Sometimes this can be detected by a client noting a strategy “didn’t work,” and when asked “how did you know it didn’t work,” the sought after outcomes were to feel better or otherwise change inner experiences. An established, impactful metaphor that captures past discussion of the costs of experiential avoidance can provide a relatively quick way to address this process in-the-moment (“Oh so were you ‘digging’ again?” – meaning engaging in experiential avoidance like trying to dig your way out of a hole).

Acknowledge differences in therapist and client perspective. ACT introduces a set of concepts related to thoughts and feelings that typically diverge from what clients are taught to believe in their culture. More broadly, clients regularly have concerns about differences with their therapists that relate to experiences and backgrounds (e.g., age, culture, problems like addictions). These perceived discrepancies between a therapist and client’s experiences can sometimes raise concerns for clients (e.g., “do they really understand me and can they help me?”). ACT is arguably well-suited in these cases as it so strongly emphasizes client experience and de-emphasizes any hierarchical, expert role of the clinician. Metaphors like the “two mountains” are often used at the start of ACT to address this directly, noting that the client is climbing their own mountain, is the one who knows that mountain the best, and the therapist is admittedly on a different mountain, but from that perspective can see things to call out that the client might not notice on their journey.

Emphasizing client experience. Particularly when first learning ACT, there can be a pull for therapists to simply explain and convince clients of concepts related to how inner experiences work and how best to respond to them, which at best continues a cycle of intellectualizing experiences and acting on verbal rules, and at worst creates a polarized process of arguing for one side versus the other with clients. Sidestepping such intellectual debates and instruction is critical in ACT, which can be done by continuously returning to client experience. ACT therapists routinely say things like “I don’t want you to believe what I say” or “don’t take my word for it” in an effort to de-emphasize such rule giving, while instead asking clients to look to their experience to see if a metaphor or concept fits for them (e.g. “based on your experience, how has this worked for you?”). This also helps to introduce defusion by having clients focus on experience rather than “what their mind tells them.”

Emphasizing workability, particularly in relation to values. Coming back to what works is one of the most critical “moves” in ACT, orienting to the client’s experience with regards to what helps them achieve their goals, rather than what they believe or have been told “should” work. This necessitates a common understanding of workability, which is ideally defined in terms of valued action (e.g., “doing what matters,” “living a fulfilling, meaningful life”). There are no “hard and fast” rules with ACT in terms of what is or is not effective, or what therapists or clients should or should not do. Instead, the question to return to is “does this work?”

Emphasizing function in therapy. For therapists, workability means that *what* you do is not so important as *how* it works (i.e., the function it has on the client). Using a classic ACT metaphor that functions to engage in an intellectual debate is probably not the function you want to have. Therapists should think of implementing ACT with fidelity in terms of producing ACT

functions in therapy interactions, rather than whether certain classic metaphors or exercises were covered or not (as these may or may not function as intended with any given client).

Watch for these processes and model ACT. As therapists get more adept at ACT, they become increasingly flexible in terms of identifying and using opportunities as they naturally arise to elicit, model, and reinforce acceptance, mindfulness, and other ACT processes. Early in training, relying on protocols and techniques can be the most efficient way to begin developing competency in ACT, but we also recommend keeping an ongoing eye towards when ACT processes show up in the moment with clients. One particularly fruitful place to watch is to notice your own experiences in the room – are there times you are unwilling to have a thought or feeling, when you are fused with a thought, and so on. These can shift therapeutic interactions to be more effective (e.g., catch a moment of over intellectualizing and shift to being mindful), and also for strategic self-disclosure where you can model how to notice processes like avoidance and practice acceptance (e.g., “I notice I get sad too when you talk about this, and I have this pull to try to come up with the right thing that will make that sadness and hurt go away. What if instead we just took a moment to appreciate and notice where you are at right now, even though it’s a very hard place to be.”).

Working with clients through the six ACT processes. The ACT model specifies a set of six, interrelated psychological processes, each of which is theorized to be critical to addressing presenting problems. That said, these processes cannot all be taught at once, and thus there is a natural tension and challenge in terms of sequencing and scaffolding the training of ACT skills (e.g., when to introduce values and can you fully clarify values when a client is highly fused with what they “should” be doing; can you be accepting when you are not mindful and how can you be mindful without accepting). At the very least, this means being aware that clients will not

fully understand ACT component skills or develop mastery with them until they have learned all six ACT processes. As therapists develop more competency and flexibility with ACT, they become increasingly adept at moving between these six ACT processes to help support this process (e.g., briefly touching on defusion and values while introducing acceptance).

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