5 Acceptance and Commitment Therapy

This chapter will outline the detail and process of conducting a case formulation in Acceptance and Commitment Therapy (ACT – pronounced as a single word). The chapter will begin with a short description of the ACT model. Following this, the case of Molly will be discussed, and a preliminary formulation and treatment plan presented.

ACT is part of the wider family of cognitive and behavioural therapies, and is often considered to be part of the third wave of behavioural therapies. ACT builds upon classical and operant conditioning through a contemporary behavioural analysis of language and cognition (Relational Frame Theory; Hayes, Barnes-Holmes, & Roche, 2001). An account of the historical development of ACT can be found in Hayes, Strosahl and Wilson (1999) and a detailed introduction to Relational Frame Theory (RFT) can be found in Blackledge (2003) and Torneke (2010).

5.1 Defining Features

ACT rests on a small number of core principles: (1) psychological pain is normal and experienced by everyone; (2) pain and suffering are not the same thing; (3) we cannot deliberately get rid of our pain, and attempts to do so may actually amplify our suffering; (4) accepting pain is the first step towards reducing suffering; (5) psychological pain does not need to disappear in order to lead a life that one values; (6) distress is a function of context: There is nothing faulty, broken, or maladaptive ‘inside’ the client.

ACT makes a distinction between ‘pain’ and ‘suffering’: ‘pain’ is the normal emotional distress that one experiences in the course of life; ‘suffering’, on the other hand, is the additional distress experienced as a result of attempts to avoid or control pain. Consider a person who experiences a fear of rejection. Consequently they avoid relationships in order to reduce their fear (pain). However, as a result of avoiding relationships, the person may experience loneliness, isolation, and a life other than the one that they want to live. In this case, the pain of the fear of rejection is being managed by avoidance of relationships, which leads to the suffering of loneliness and isolation. From an ACT perspective our target is reducing suffering and building a better life through the acceptance of pain.

Because ACT is not focused on reduction of pain per se, we are not primarily interested in symptom reduction either (although this may be a secondary gain). Instead, we are interested in ‘growing the person’ rather than ‘shrinking the problem’. While it is tempting to wish to reduce the person’s problems and/or symptoms directly, ACT aims to ‘expand’ individuals so that they are enabled to live a life characterised by
whatever matters to them, whilst highlighting that one’s pain need not reduce or disappear in order for a meaningful life to be lived.

5.1.1 Experiential Avoidance and Psychological Flexibility

Experiential avoidance is defined within the ACT model as an active unwillingness to experience certain private events, such as thoughts, emotions, and physical sensations (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). ACT proposes that such avoidance not only amplifies those events but takes a person away from the life they wish to live. The ACT model makes a pragmatic distinction between helpful and unhelpful avoidance: If avoidance leads to an increase in pain, brings other problems into one’s life, or takes one away from the life that they want, then we would consider such avoidance to be unhelpful.

ACT seeks to replace experiential avoidance with psychological flexibility. Psychological flexibility is the ability to connect with the present moment – fully, as a conscious human being – and to engage in behaviour that is consistent with personally-identified values (Hayes et al., 1999). In a context where avoidance of psychological pain has not worked, is not working, and will not work, ACT advocates acceptance as an alternative strategy that can help individuals to take action in accordance with their values. Therefore, ACT could be summarised by the three statements: (1) accept those experiences that you cannot avoid, (2) choose where you want to go in life, and (3) take action to that end.

This is of course not as simple as it sounds. In ACT, as in all therapeutic interventions, we ask the client to go on a difficult journey with us, and this should not be underestimated or trivialised.

5.2 Core Processes

ACT proposes that there are six core processes that underpin psychological well-being and flexibility: acceptance; cognitive defusion; contact with the present moment; self-as-context; values; and committed action. These processes are conceptualised as being interconnected: they are not considered to be standalone processes to be worked through sequentially. Due to their interconnected nature, it is not uncommon for a typical ACT session to focus on several of these processes.

5.2.1 Acceptance

Acceptance from an ACT perspective is not resignation; it is does not mean tolerating the intolerable or giving in – these are fatalistic and passive responses. Acceptance
also does not preclude obvious workable solutions to problems, such as making beneficial changes to one’s environment. Instead, acceptance refers to an active and engaging stance that is true to its etymological root meaning: “take what is offered” (Hayes & Strosahl, 2004). In this context, acceptance is a stance of actively and non-judgementally embracing whatever thoughts, emotions, and physical feelings one experiences, when avoidance is not working. This is of course much harder than might be suggested by these few brief sentences. Often clients will come to therapy having tried for years to avoid painful thoughts and feelings. Some clients would rather be in abusive relationships than experience loneliness; some would rather be intoxicated or cut and burn themselves than think or feel. The difficulty of acceptance should not be underestimated.

Acceptance is fostered by helping clients to experientially contact the costs of avoidance. It is hoped that clients see that, with respect to private events (thoughts, feelings, and sensations), avoidance or control is often the problem and not the solution. Clients are encouraged to confront the unworkability or costliness of avoidance and control in an empathic and non-self-blaming manner. The futility of avoidance, suppression, and control is highlighted so as to create space for new possibilities. Simple brief exercises and metaphors such as ‘Tug of War with a Monster’ (Hayes et al., 1999; p.101) can be used to make these points effectively. This metaphor presents the client with the conundrum that they are engaged in a ‘tug of war’ with their psychological pain (the ‘monster’). No matter how hard they struggle, the monster pulls harder, prompting ever greater effort from the client. What we want the client to realise is that the first step here must be to drop the rope. This is to help create a space in which alternatives to struggling can be experienced. This metaphor is similar to the concept of ‘trying to dig yourself out of a hole’: It does not matter how you got there, digging further certainly does not help you to escape; the first step is to lay down the shovel. It is important to recognise that avoidance can often be effective in the short-term, and clients may consequently have a strong reinforcement history for avoidance behaviour. Even for clients who recognise that their avoidance is not very effective in the longer-term, there may be a strong element of negative reinforcement at work in that their avoidance may be keeping larger threats and ‘scarier monsters’ at bay.

5.2.2 Cognitive Defusion

Humans have a tendency to respond to thoughts as if they are the ‘thing thought about’ as opposed to a verbal or visual representation of it. When remembering and thinking about a past negative experience, clients will respond (most likely at a lower level of intensity) in a manner similar to when they directly experienced the event itself (e.g., fear, anxiety, or shame), even though the tangible properties of the experience are no longer present; this phenomenon is known within ACT as cognitive fusion (for a more comprehensive discussion of this process from an RFT perspective, see Blackledge,
Thoughts are not problematic in and of themselves (Hayes & Strosahl, 2004), but may become a problem or a barrier to effective change if they are afforded weight or particular significance by the individual experiencing them. In ACT, we help the person to develop a different relationship with their thoughts by employing cognitive defusion exercises.

The purpose of cognitive defusion is to help clients view and experience their thoughts as not being 'literal truths' but rather psychological experiences that can be acted upon – or not. Whether the thought is 'true' is not considered to be the key issue; instead, the focus is on how one responds to the thought. In this regard, ACT is different from traditional forms of cognitive behavioural therapy (CBT) in that cognitive restructuring is not used and the thought is not engaged with or challenged at the level of content. For example, a client might report to the therapist that they think that no one likes them. The therapist would not ask for evidence for or against the thought, but might instead ask the client “if you buy into that thought, if you respond as if it is true, where does that take you?” Here an ACT therapist is attempting to get the client to reflect upon the ‘life-narrowing’ implications of acting on the thought as if it were true. Cognitive defusion interventions may utilise ‘physicalizing’ and externalising exercises to promote a shift in the context and function of thoughts. For example, a client may be asked to take a negative self-referential thought or label and to imagine putting the thought out in front of them on the floor and to begin to describe its ‘physical’ properties. The function of such exercises is to loosen the client’s attachment to their thoughts, re-contextualising the experience of thinking, and to begin to create space between the person and their thoughts. A further way of changing the contextual experience of thoughts is to use a technique borrowed from Gestalt psychology. A word with eliciting properties is repeated over and over, faster and faster until the person notices a change in the sensations elicited. Other techniques might be to say the negative thoughts in a silly voice (a favourite of the late great Albert Ellis). It should be noted that such changes in function are likely to be temporary and the purpose here is not to elicit a permanent change in the response to thoughts, or to belittle or ridicule the client’s thinking, but to practice responding differently to thoughts whilst refraining from attempts to change their content.

5.2.3 Contact With the Present Moment

The purpose of acceptance and cognitive defusion is to enable a client to ‘show up’ to the present moment in the service of connecting to personal values and living in accordance with them. Contact with the present moment is strongly connected to the process and stance of acceptance in that it functions to promote effective and undefended contact with whatever is happening in the ‘here and now’. This is important, because in order for a client to decide how best to respond to a given situation, the client must be present and in contact with it.
Clients are helped to label and describe experiences without excessive and unhelpful evaluation and judgement. Teaching clients to be present helps foster acceptance and to stay in the ‘here and now’ where workable solutions are to be found. This does not mean that clients are discouraged from remembering past events or from thinking forward to the future; it is when the ‘hold’ of such thinking takes the client away from living life in the present that it becomes problematic.

One of the main ways in which contact with the present moment is fostered is with a variety of mindfulness and orientation (or ‘noticing’) exercises. In such exercises, clients are simply orientated to whatever physical feelings, sensations, thoughts or emotions are showing up for them at a given time, without getting caught up in them.

5.2.4 Self as Context (Over Content)

Self as context is strongly connected to the process of cognitive defusion in that both processes contend with the literality of language and other private content. Self as context processes are designed to help clients distinguish and separate out from their conceptualised selves (i.e., self as content). Key messages in any self as context work are (1) that you are not your thoughts, your emotions, or your memories; and (2) that there is a you, a bigger you (the context), wherein such things happen (i.e., where private content occurs). We want clients to experience – if only for a moment – that there is a place from which such things can be experienced, a place where such things cannot hurt them. An ACT therapist will help a client experience self as context in a number of ways. For example, through the use of mindfulness exercises where clients are helped to experience their thoughts and feelings as an observer. The therapist might also use simple metaphors to help the client make a distinction between themselves and their content. Such metaphors may include: “you are the house not the furniture, the chessboard not the pieces, the sky not the clouds”.

5.2.5 Values

Clients in therapy are often stuck in patterns of behaviour that are about controlling and eliminating unwanted private events rather than leading a life full of personal meaning. ACT seeks to help clients regain this life-direction; however, it is important to remember that many clients will not have given consideration to what they value or want out of life. Some clients arrive in therapy from a place where they have not been permitted to even think about such things, and some will therefore inevitably struggle to think about them now. Despite this, it can often be useful to enquire about values early in assessment and treatment. ACT, like many other psychological therapies, involves clients contacting experiences and physical places that they have been avoiding. Change is therefore difficult and there has to be some perceived
and anticipated benefit or reinforcement for making change. Whilst the client may be understandably focussed on reduction of symptoms, values work speaks to what this reduction is for (if you were to feel less anxious, what would you be doing then?). Values assessment also sends a message to the client that therapy will contain a space for the things that they love and care about, and a focus on how to begin having more of such things.

Values clarification in ACT takes place through questioning and experiential exercises. Clients can be asked questions like “if you could have your life stand for anything, what would you choose it to stand for?” Clients may also be asked to imagine a speech given about them at a ceremony honouring their life achievements; what would they like to hear?

It is important to make a distinction with clients between values and goals. The purpose of values is not necessarily the achievement of specific goals. Values can be thought of as signposts: A common metaphor used in ACT work is that living in line with one’s values is like traveling west. One never reaches ‘west’ as a destination, but can continue travelling west indefinitely. Many things can be experienced and achieved whilst travelling in ones chosen direction; it is the journey and not the destination that is important. From a behavioural perspective, values speak to the function of goals and give an idea to the therapist of sources of reinforcement for future behavioural activation. One of the advantages of understanding such functions is that it can help the therapist guide committed action (see below) towards a variety of goals. It can also help a client find new goals should one become unavailable to them. An extreme example could be the loss of a job or a cherished role through injury. While a person may not be able to continue in their previous role, if we know the value – i.e., the function of their role, and what it was that made the role important – we can help the client find other ways to stay connected to that value.

5.2.6 Committed Action

ACT is at heart a behavioural treatment and as such the previous five processes above serve to elicit actual change in the client’s behaviour to serve valued ends. All other processes in ACT therapy lead to this point, and the client, knowing that avoidance is not working, and knowing what they want from life, has to decide to commit to change and to actively implement it. Living and acting in line with one’s values is the context in which acceptance is worthwhile.

Like most effective behavioural exercises, committed action starts with smaller goals, similar to graded exposure or graded behavioural activation. Once a client has started on their path of values-guided behavioural change, it is expected that natural reinforcement will occur to maintain the change. It is important at this stage to prepare clients for problems that may surface and barriers that may arise. Often when a client commits to valued living they may predict failure and experience
anxiety (loss of contact with the present), or they may believe they will fail because they are inadequate (cognitive fusion and self as context). Clients can be prepared for this, by letting them know that their mind will not want change and may fight back, or that their anxiety or depression will fight for its survival (this represents a defusion metaphor in itself). Clients are asked to consider questions such as “what pain would you be willing to have in order to do what you love and care about?”

5.3 Evidence Base

ACT is an emerging and developing therapeutic approach and over the last 15 years has strengthened its evidence-base considerably. To date, ACT has been used successfully in the treatment of depression, anxiety, OCD, chronic pain, diabetes management, and psychosis, and its efficacy is discussed in a number of published positive reviews from Hayes, Luoma, Bond, Masuda, and Lillis (2006), Gaudiano (2009), Levin and Hayes (2009), and Ruiz (2010, 2012). More critical reviews have been published by Öst (2008, 2014) and by Powers, Zum Vörde Sive Vörding, and Emmelkamp (2009).

5.4 Formulation in Action

An ACT case conceptualisation will typically involve six activities on the part of the therapist (Hayes & Strosahl, 2004): (1) assess the scope and nature of the presenting problem; (2) identify the experiences that the client is attempting to avoid; (3) identify behaviours/methods that the client is using to facilitate their avoidance; (4) assess the factors that may be reducing motivation for change; (5) assess and identify any environmental barriers to change; and (6) consider factors likely to be contributing to inflexibility (e.g., fusion, self as content, domination of the past/future, values uncertainty, low levels of committed action).

5.4.1 Assess the Scope and Nature of the Presenting Problem

Molly appears to have learned to avoid situations that elicit anxiety or other negative experiences. Her history with other people is also likely to have contributed to Molly developing negative self-labels, and importantly, to accept these labels as ‘true’ (self-as-content and fusion). Her attempts to avoid situations that elicit anxiety or negative thoughts/self-labelling appears to be hindering her ability to live her life in a way that is meaningful to her (i.e., a lack of valued direction or valued action).

Molly states that she “wants to get better”, “feel the opposite of how she does now”, “feel more confident”, and “make everyone proud”. From an ACT perspective this is a mix of both appetitive and avoidance goals. I would be keen to know what
“getting better” means for her: what would she be able to do if she were better? This is similar to the ‘miracle question’ often asked in Solution Focused Approaches (i.e., what would the client’s life be like if perceived problems were no longer present; De Jong & Berg, 2012). It is likely at this stage that the issue of wanting to be “more confident” would arise. In a similar manner, I would want to know what she would do if she were more confident and would hypothesise that Molly’s lack of confidence may manifest in predictions of future failure – indeed, she mentions twice that there is “no point” attempting to improve her situation. The anticipation of failure is likely to be emotionally distressing, and Molly may attempt to reduce her distress by eliminating the possibility of failure (e.g., by simply ‘not doing’). As these issues emerged during therapy, I would offer ACT-informed observations of Molly’s self-report. For example, if Molly describes an anticipation of future failure, I might respond thus:

Molly:  There is no point trying, it won’t work; it never does.
Therapist:  It sounds like every time you want something better or try for something better, your mind comes in and tells you it will be bad, not to bother. Then what happens?
Molly:  I begin to get worried, I feel anxious and scared and I think ‘what’s the point?’ so I don’t bother.
Therapist:  So when you believe what your mind tells you and you do what it says where does that leave you?
Molly:  Well, I feel less worried about the future.
Therapist:  But here and now?
Molly:  Here and now I just feel stupid and useless for not trying and I’m still stuck where I don’t want to be.

While in actuality, the above exchange rarely (if ever) happens so neatly, it hopefully illustrates the point. What I would be attempting to do through this process is to help Molly gain awareness of the cycle she is stuck in and the manner in which her avoidance not only keeps her away from a future that she wants, but also makes her more miserable in the present. The use of language such as “your mind comes in and tells you” is deliberate and is designed to facilitate defusion at a later stage by beginning to encourage Molly to consider her mind as almost like a separate entity – and one that is not necessarily acting in her best interests.

I also get a sense that Molly might be playing a ‘waiting game’ with her emotions. She might be waiting for things to get better or for her to feel different before she can move on with her life. This is of course understandable, given her experience of the world to date. I would, however, begin to explore with Molly the possibility that the waiting game may not work. I would want Molly to begin to consider that, rather than waiting for these experiences to disappear before she starts living her life, she can begin to live and take these experiences along with her.
5.4.2 Identify what Experiences the Client is Attempting to Avoid

Many of the experiences that Molly seems to be avoiding could be classified under a larger umbrella of fear of rejection/abandonment by her parents and her peers. Connected to this, Molly is also troubled by thoughts and beliefs about her own unworthiness, incompetence, and unattractiveness – and the expectation that she will fail at everything she does. She is also suffering from the impact of being sexually abused when she was nine years old. We would hypothesise that, due to the effects of classical conditioning, sex and sexual intimacy may now function as a conditioned aversive. As such, it seems that she is now avoiding intimate sexual relationships. It is also likely she is ‘fused’ with the memories of the abuse to an extent where thinking about the abuse, or thinking about sex, may elicit distressing emotional and physiological responses.

5.4.3 What Behaviours/Methods is the Client Using to Facilitate Their Avoidance?

There are a number of ways in which Molly has avoided or attempted to avoid these negative experiences. Molly’s avoidance seems to be facilitated by physically avoiding situations and contexts, and also by being overly compliant with her parents. It can be seen from the case description that Molly maintains a close proximity to her parents and does many things for them that they are capable of doing for themselves. I would hypothesise that, given her historical experiences within the family, Molly is attempting to avoid painful feelings relating to thoughts of being unlovable and taking second place to her sister.

Molly also avoids social contact with others and as a result lives a somewhat reclusive lifestyle. She has been let down by others in the past and fears their rejection and ridicule. As a result, she is likely to predict that other people will mistreat her or reject her in some way. Consequently, she avoids the anticipatory negative emotions by avoiding or minimising her social relationships; or by having them online where she may be able to maintain a larger degree of control over them. It is also likely that Molly’s avoidance of romantic and sexual relationships is a function of her sexual abuse experiences. Her descriptions of her relationship with Danny indicate that her difficulty in being intimate with him could be a function of her abuse experiences. Her reluctance to have further relationships could also serve the function of reducing her contact with these feelings.

5.4.4 Assess the Factors That May be Reducing Motivation for Change

While Molly gives indications of what she wants, there may still be factors inhibiting her motivation for change; in particular, her predictions of future failure. Molly’s
descriptions of her past indicate a number of aversive experiences, which have arisen while pursuing apparent valued ends. University did not work out; similarly, her job as a teaching assistant did not progress, and her current role at the library is also not as she would wish. Similarly, her experiences of sexual and romantic relationships have been negative. One of the biggest barriers to change for Molly will be her expectation that change is not possible or that she is not capable of change – and the anxiety and fear that this elicits. From an ACT perspective, Molly is heavily fused with her low opinion of herself and her expectations that she can only fail.

5.4.5 Assess any Environmental Barriers to Change

Superficially, Molly appears to have access to a number of resources, such as her job and her own accommodation, which may help to facilitate change. However, one external barrier to change for Molly is likely to be found in her relationship with her parents. If Molly is to make progress then it is likely that her relationship with her parents will need to change also. Despite being physically able, Molly’s parents have come to depend on her to run errands for them, and Molly reports that they make her feel guilty if she does not meet their demands. The reaction of Molly’s parents is likely to be an environmental barrier; from her description, I would predict that should she change the nature of her relationship with them (i.e., by doing less for them) then it is likely that they will put additional pressure on her to keep the status quo. In such a context, I would be mindful of the likely negative judgements Molly might make about herself, the feelings of guilt that might arise, and would target these in treatment.

5.4.6 Consider the Factors Contributing to Psychological Inflexibility

Factors contributing to inflexibility are presented in Table 5.1.
### Table 5.1: Sources of inflexibility for Molly

<table>
<thead>
<tr>
<th>Source of inflexibility</th>
<th>Presenting difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Areas avoided</td>
<td>Molly avoids socialising with others. She avoids contact at work (as she did her house mates when a student) and has few friends. She prefers to socialise online. Molly also avoids confronting her parents about their treatment of her and avoids telling them about her sexual abuse. Further to this, Molly avoids intimate sexual relationships and is no longer pursuing her dream of being a teacher.</td>
</tr>
<tr>
<td>Cognitive entanglement (fusion and self-as-content)</td>
<td>Molly believes that she is unlovable, unworthy, unattractive, and unable to succeed at what she wants. She also defines herself by her mental health problems: she is fused with the stigma of having been in the 'nuthouse' and believes that her parents must see her as a 'freak show'. Molly also feels 'dirty' and self-judgemental whenever she has sexual thoughts or sexual contact with another person.</td>
</tr>
<tr>
<td>Domination of the past/future</td>
<td>There is some evidence from the information provided that Molly finds it difficult to remain in the 'present moment'. For Molly the present moment and her current context seem to be dominated by aversive stimuli: She is relatively socially isolated, has negative relationships with her family, and is constantly reminded of past abuses (sexual abuse), rejections (boyfriends), and academic and occupational failures (university).</td>
</tr>
<tr>
<td>Values uncertainty</td>
<td>There is some evidence that Molly identifies some personal values, but these appear fairly limited to a specific area (e.g. work/teaching). Although wanting to be a teacher is a goal rather than a value, it is likely to be directed by some core values, and this would be explored further. Molly also presents with behaviours that appear to be values-driven but which may not be: She undertakes a lot for her parents who are quite capable, and it is possible that this is driven by a need to feel useful and loved by them, or more accurately, a need to avoid feeling unloved. Whilst efforts to evade 'feeling unloved' are of course understandable, the risk for Molly is that she gives her life over to avoiding such feelings – to the detriment of what she wants for herself. It would seem that her relationship with her sister and her friend Eve is a potential area for development.</td>
</tr>
<tr>
<td>Low levels of committed Action</td>
<td>Molly appears to engage in little values-guided activity at present and this would be a key area for development.</td>
</tr>
</tbody>
</table>

5.4.7 Intervention Objectives

The following outlines areas for potential intervention; however, it is not necessarily reflective of the order in which work would be undertaken, nor should it be
understood that the interventions would be implemented in a separate, serial manner. It is also worth remembering that the boundaries between assessment and intervention may be more blurred in ACT, and that aspects of normalisation and values work are likely to come up at various times during the assessment. Likewise, having the client discuss difficulties and unworkable change strategies inherently involves elements of exposure, defusion, and movement towards acceptance, and these aspects would be visited, and revisited, throughout my work with Molly.

5.4.7.1 Normalisation
One of the first treatment goals or strategies I would introduce for Molly would be a normalisation of her experience. Molly seems stuck in a cycle of avoidance that is consuming her life to the extent that I do not have a full sense of where she wants to go: what she wants her life to ‘stand for’, in ACT parlance. Even though she will undoubtedly be experiencing many negative self-appraisals and be engaged in counter-productive avoidance strategies, I would want Molly to know that this is a normal response to her situation. I would begin to highlight areas of ‘fusion’ and begin to reflect these back using defusion techniques (e.g., ‘what is your mind telling you?’). In addition to normalising her experience, by beginning to talk about her mind in this way, we are attempting to create some distance between Molly and her ‘private content’. Whilst not advocating a dualist position, we are pragmatically helping Molly to separate out and step back from her psychological content, and I would deliberately speak in these terms throughout the assessment and intervention. The second aspect of the normalisation stage would be to consider the avoidance strategies that Molly is using. Again, I would have a discussion around the pull of avoidance, and how it is ultimately ineffective when it comes to our private experiences. I would be extremely careful that Molly does not feel blamed for being stuck, and this conversation would be had in the context of an understanding that avoidance is something that we all practice. The function of these discussions would be to highlight to Molly that she is not intrinsically or internally broken, but that she is currently stuck as a result of how she has been taught to ‘play the game’ (e.g. that aversive experiences need to be avoided or overcome before meaningful action can be undertaken). I would conclude by highlighting that, while the road ahead will be a difficult one, I will do everything I can to help her to get her life moving again.

5.4.7.2 Values
Whilst the majority of the work on values and associated behavioural activation goals would come later in therapy, I would typically also start to discuss values early on. When asked about ‘values’ early in therapy, many clients are unable to answer. This might be because they simply don’t know: They have been so busy surviving that they have not had the opportunity to think about it. In other cases, clients may have had
to subjugate their own needs to those of others; or may have an active history of being punished for attempting to live their own values. Most (if not all) of these experiences are likely to apply to Molly in some way, affording her little opportunity to clarify personal values. Consequently, Molly may be somewhat perplexed and resistant when asked about her own values. Despite this, my experience suggests that it is an important area to explore at an early stage for the following reasons: (1) I want Molly to know that she has the possibility of a brighter future guided by the things that she cares about; (2) I want Molly to know that the difficult journey I am going to ask her to take is going somewhere important to her; and (3) I want Molly to know that, whilst therapy will involve discussion about and contact with things that are painful, there will still be space for the things that she loves, cherishes, and values.

5.4.7.3 Acceptance
When working with Molly, I would help her to contact and to appreciate the costs of her struggle, and the unworkability of avoidance. This should be done in the context of the normalisation described above. It is important that Molly is not blamed for being stuck; the message that she is doing as life has taught her comes to the fore, and there is no blame to be apportioned. This does not, however, preclude Molly from experiencing self-judgmental thoughts about her situation. In fact, the case material as presented would lead me to hypothesise that these experiences would occur for Molly. This is why the language of defusion should run through the assessment and the intervention, allowing the therapist to identify such negative judgements and to externalise them as the ‘mind’ being unhelpful. An important aspect of acceptance-focused work is to examine the larger cost of avoidance, in that it can take us away from our values and our goals. This is why I often find it useful to have the conversation on values early on; it creates a context in which there is a benefit to at least considering acceptance as a workable alternative to avoidance.

5.4.7.4 Contact With the Present Moment
There are indications that Molly’s ability to contact the present moment is undermined by the dominance of the past. She conveys the ongoing impact of previous difficulties – her relationship with her family, being seen as second best to her sister, the experience of being sexually abused, failed relationships, and problems with work and education. I get a sense that these past events have come to occupy Molly and interfere with her ability to take effective action in the here and now. Using mindfulness techniques, I would want Molly to be able to differentiate between ‘then’ and ‘now’, in an attempt to lessen her fusion with the past, so as to foster values-consistent action in the present.
5.4.7.5 Defusion and Self-as-Context
This part of therapy is where ACT takes a more distinctive approach to other interventions within the broader cognitive and behavioural family. As mentioned in the summary above, the emphasis in ACT is on acceptance of private events rather than change or elimination of them. In this element of the treatment I would work with Molly to loosen the control that such experiences have on her. This would hopefully lead to Molly being able to see her thoughts ‘as thoughts as opposed to facts’. The content of the thought is not challenged or evidence tested, but Molly is instead asked to consider how useful the thought is for her life plan (this again points to the utility of developing knowledge of her values at an early point in therapy).

A large part of this work would focus on her experiences of sexual abuse and the negative judgements that she makes about herself in relation to these experiences. In this element of treatment, I would of course not be seeking to stop her thinking about the abuse, or even to reduce the occurrence of abuse-related memories, but more to reduce the impact of remembering when it does inevitably occur. We can see from her descriptions of connecting sex to labels such as “dirty” that there is a dominant impact of her abuse experiences in the present. At a purely technical level, the impact of these experiences would be tackled in the same manner as other negative private content. The scope and nature of the abuse would form part of the initial assessment, in as much as she is willing to discuss it, and it may be that such work is left to later in the treatment.

5.4.7.6 Goal Orientation and Committed Action
During this phase of therapy I would begin by returning to the concept of values in more detail. Molly has reported good relationships with her sister and her friend Eva and there is a strong sense that ‘being a teacher’ has been of value to her in the past. This in particular is evident from her working as a classroom assistant. However, as part of our assessment and treatment, we need to make a distinction between Molly’s own values and goals versus those that may come from her family’s expectations of her. If Molly pursuing a career in teaching was an example of the latter, then this may indicate a degree of aversive control and suggest that her aspirations in this domain may be more about avoiding the disapproval of her family.

It is unclear whether Molly wishes to have another romantic or sexual relationship; however, the manner in which she discusses this area of her life indicates issues that require further exploration. She provides reasons as to why it would be ‘pointless’ to pursue future relationships, rather than stating this is something she does not want or value. This seems to me to be the expression of a value or goal being blocked, as opposed to something that is not valued. In this phase of therapy, I would help Molly to identify goals in line with her values, and collaboratively build a graded hierarchy of value-based activities for her to engage in during therapy.
5.4.7.7 Treatment Summary
1. Normalise and contextualise her experience; highlight that she is not ‘damaged’ or ‘broken’, but rather ‘stuck’;
2. Identify and clarify her values and associated goals, and begin to identify the internal and external barriers to pursuing them;
3. Use cognitive defusion and self-as context strategies to loosen the control and dominance of private experiences;
4. Use mindfulness to facilitate exposure to private experiences and encourage present moment awareness;
5. Build patterns of committed action relevant to her values, employing skills training (e.g., assertiveness with her parents) where needed.

5.4.8 Measuring Effectiveness

Given that ACT as an approach is not focused on symptom reduction, how do we therefore measure the effectiveness of our interventions? Within an ACT model, we measure success by how much a client is reengaged with and living the life that she/he wants, loves, values, and cares about. In Molly’s case, I would hope that she would be able to assert her needs with her parents, doing less for them and more for herself. I would hope to see spending more time in the company of others, and perhaps with her friend Eva in particular. I would also hope to see Molly happier in her current job, or pursuing a career more relevant to her personal values. A final area in which I would hope to see Molly make progress would be in respect to the impact of the sexual abuse on her life, particularly its apparent effect on her ability to form new intimate relationships. If developing a new relationship was identified as being consistent with Molly’s values, then we would look for evidence of this when assessing therapeutic gains.

Kerry Beckley

5.5 ACT Formulation: Critical Commentary

ACT aims to pragmatically facilitate a person to cope in the here and now, by accepting life as it is and building towards a more value-orientated future. The evidence-base thus far appears to demonstrate moderate effect sizes for a range of less complex mental health problems. However, Öst (2008) conducted a meta-analysis of RCTs of third wave behavioural therapies and concluded that ACT could not be considered an empirically supported treatment. ACT has been criticised for not using diagnostic categories in half of the studies of clinical effectiveness, and some studies also appear to have less methodological stringency in comparison to more general CBT RCTs in terms of: reliability and validity of outcome measures, number of therapists and level
of therapist training, statistical analysis, presentation of results, equality of therapy hours, diagnostic adherence, and checks on treatment adherence.

The central tenet of 'growing the person' as opposed to 'shrinking the problem' is an attractive clinical prospect but it is not one which, by itself, is proven to be effective with more complex and sustained mental health presentations such as personality disorder. Arguably, this idea is not solely the domain of third wave behavioural therapies, and parallels can be drawn with the behavioural pattern-breaking aspects of Schema Therapy (ST; Young, Klosko & Weishaar, 2003) in the growth of the Healthy Adult Mode. Both approaches make use of meta-cognitive interventions to weaken the relationship between deeply rooted ideas of self and others. The approaches appear to differ most in terms of the assumed aetiology of the client’s difficulties, the importance of content and language in terms of creating opportunities for change, and the explicit use of the therapeutic relationship within therapy.

There is, however, a significant degree of similarity in the formulations of Molly presented from apparently opposing theoretical positions. ACT uses the term ‘avoidance’ as an overarching concept which would encompass all three coping strategies seen in the ST model. Both approaches would view past experiences in terms of their reinforcing attributes; ST would place less assumption on Molly ‘knowing’ what she really wants, but would understand her schema-reinforcing actions as ways of sustaining a sense of self and other that is familiar. The use of defusion within the therapy exchange parallels the idea of separating the ‘Punitive/Demanding’ Parent Modes from the person; in contrast to ST, ACT uses this separation to enable clients to question and be more sceptical of their thoughts. However, it is not clear what happens next if this is not effective. ST would consider that intervention by the therapist is crucial: the therapist would align with Molly to enable her to have an experience of someone standing up to her internalised critical self, whilst supporting her in weakening the influence it has on her.

Both formulations highlight Molly’s fear of abandonment/rejection, linked to her own sense of unworthiness and failure. The ACT formulation goes further in its consideration of the impact of sexual abuse. Although the hypothesised impact has merit, it may be premature in its assumption that Molly finds sex distressing, given the other factors which contribute to her avoidance of close relationships. Molly’s barriers to change are formulated in similar ways: that her repeated experiences of failure have resulted in her predicting that her future holds more of the same. However, the ACT formulation extends further by explicitly predicting that Molly’s parents may present an environmental barrier to change (negative external feedback as she begins to do less for them). ST would place more emphasis on the development and maintenance of a stable sense of self and other, that is resilient to the demands placed on us by others.

Both treatments similarly take the form of a set of principles, rather than a set of interventions, which are undertaken in a linear fashion. Like ST, ACT attempts to normalise avoidance (given Molly’s history) and uses strategies to create distance
between Molly and her ‘private content’. The therapeutic language in both models, although different in content, is crucial in achieving this. The idea of being ‘stuck’ because of how she has been taught to ‘play the game’ parallels the ideas in ST of strategies which previously had protective value to survive trauma, but now continue as though the client was still in that set of circumstances.

The ACT formulation highlights the role of the therapist as facilitator, but there is far less emphasis on the therapeutic relationship. For individuals who have significant difficulties in the relational domain, this appears to be a weakness of the outlined intervention. Molly’s template of ‘other’ as rejecting/uninterested is likely to permeate the therapeutic relationship and impede the aims of the intervention unless explicitly worked with.

ACT places emphasis on the space to consider values in therapy, which may differ somewhat from ST’s emphasis on unmet needs, but in essence they are aiming to achieve the same outcome. Those who work in an integrative way with both approaches have highlighted how this more explicit focus on ACT principles and interventions can augment aspects of ST: suggesting that, with more complex presentations, change-focused work may first be necessary, before acknowledging that some things cannot be changed and should therefore be accepted (Roediger, 2012). A strength of the ACT model is the importance of keeping Molly’s values central to the therapeutic narrative and how this can be utilised in developing value-based tasks for homework. It makes intuitive sense that a client would be more likely to engage in activities which aim to enhance enjoyment and purpose, than to directly work on a task which aims to reduce something they actively avoid. This is also true of the measurements of success, which ultimately reflect Molly’s values rather than symptom reduction – which may or may not lead to improvements in her quality of life.

Aidan J P Hart

5.6 Author Response

This seems to a reasonably fair summary and critique of the model and formulation as presented in the chapter. There are two areas of the critique I would like to address: the issue of sexual abuse and the therapeutic relationship.

I would accept that the focus in the formulation on sexual abuse may indeed be premature, and I acknowledge that more information is certainly required. A formulation is of course a working hypothesis that is always subject to revision. As such, it might be that the formulation is revised with respect to sexual abuse, if further exploration suggests that this experience does not appear central to Molly’s current difficulties.

In my experience of delivering ACT training, a question often asked is how an individual could be expected to simply ‘accept’ abuse. By including the sexual abuse
in the formulation, I was attempting to offer an example of how one might conceptualise this experience within the ACT assessment, formulation, and treatment framework. This is not to say that it would always be included in this manner, or indeed at all.

The main aspect of the critique I would like to address is the point about the therapeutic relationship. ACT by no means minimises the importance of the therapeutic relationship in facilitating client change. From a pragmatic point of view, if the client does not trust or value the therapist, or if the therapist is experienced negatively, then therapy will inevitably be impeded. The therapeutic relationship is important, first and foremost, because if the client is not in the room with the therapist, and does not return for further sessions, then the therapist cannot help them. It is important that a humanising, supportive, and safe environment is created that helps maximise the client’s commitment to change whilst minimising any coercion on the part of the therapist (Hayes & Strosahl, 2004). This is not a new concept from a behavioural point of view, and can be found in the notion of the therapist as a ‘non-punishing audience’ (Skinner, 1953; see Chapter 3).

The importance of the therapeutic relationship is not just limited to keeping the client in the room, however, but is central to every aspect of the ACT process. The relationship in ACT is a fully collaborative one. A key message is that the therapist is not immune to the processes of experiential avoidance, fusion, etc. To that end, the therapist will often talk about ACT processes with the client in the context of “we” rather than exclusively “you”. In an ACT intervention, the therapist will communicate hope and optimism for change, and a passionate interest in helping the client to pursue their values. The therapist will also use the context of the therapeutic relationship to model ACT-relevant processes – and experiential exposure in particular.

A final reason why the therapeutic relationship is important is connected to the fact that a large part of ACT is dedicated to breaking down patterns of avoidance and exposure to feared interoceptive and exteroceptive stimuli; this is often difficult for the client to engage in, and a meaningful and trusting therapeutic relationship is essential. In my experience, in the context of a strong empathic therapeutic relationship, clients will go to the difficult places that are necessary as part of the therapeutic journey, and will forgive you most mistakes you may make along the way. Without the foundational bedrock of a good therapeutic relationship, then the rest of the model becomes largely unworkable.

References


