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Chapter 1

What Is Acceptance and Commitment Therapy?

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Human beings use language to shape their world: to structure it and give it meaning. Language builds our skyscrapers, imparts the strength to our steel, creates the elegance of our mathematics, and forms our art's depiction of beauty. Language has been the source of so much human achievement that it is only natural that we look to it first to identify a problem and craft a solution. But it is precisely because language can be so useful that it can also be problematic. Language not only enables human achievements, but also our ability to project fearsome futures, to compare ourselves to unrealistic ideals and find ourselves wanting, or to torment our souls with the finitude of life itself. Language is at the core of the remarkable human tendency to suffer in the midst of plenty.

The internalized experience of language presents itself not as sounds or symbols, nor as responding of any kind, but as a form of immediate experience. This feature of language is part of its utility, but also is a reason that language and thinking can be dangerous. The skyscraper imagined seemingly "exists" in our mind's eye, as does the grim vision of a future without a lost loved one. Drawn into a symbolic world *about* human experience, an illusion is created that this world *is* human experience.

Various religions since the dawn of time have warned us of this inherent danger in language. The story of Adam and Eve provides an example. Once humans eat from the "tree of knowledge," we "know the difference between good and evil"—that is, we begin to make evaluations. We

can differentiate between being naked and clothed; we can evaluate being naked as "bad"; and we can experience "shame." We can construct causal analyses, and be right "right" or "wrong" in our ideas. In the biblical story Adam has an explanation for his sin: Eve lured him into eating the apple. And Eve has an explanation: the snake tempted her into doing so. These basic language abilities—such as naming and distinguishing, evaluating, and constructing causes for problems—are at the core of the evolutionary brilliance of human language. Without them, human progress would be impossible. They have, however, a dark side and once you eat from the apple there is no going back to non-verbal innocence.

Acceptance and Commitment Therapy (shortened to the word "ACT," said as a word, not initials; Hayes, Strosahl, & Wilson, 1999) is based on the view that language is at the core of many psychological disorders specifically, and human suffering in general. ACT is an intervention approach designed to bring language to heel, so that it can become a tool to be used when it is useful, rather than an unseen process that consumes the humans that host it. This approach is based on a growing line of basic behavioral research on human language and cognition called Relational Frame Theory (RFT: Hayes, Barnes-Holmes, & Roche, 2001). Both ACT and RFT come from a pragmatic philosophical tradition called functional contextualism.

ACT and, by scientific linkage, RFT, are not merely technologies. Together, they form an integrated approach, based on a theory and set of principles that vary in focus and level of analysis, from the most basic to the most applied. ACT is not a disorder specific treatment; rather, it is a general approach that can spur the development of many protocols, focused on particular problems, patient populations, or settings. ACT integrates scientific knowledge about contingency shaped behavior and verbal relations into a more effective therapeutic whole.

In this book, we will show how ACT can be applied to a broad range of human psychological problems, in a range of settings, with a variety of populations. The chief goal of this book is to orient clinicians in the field toward recent innovations in the application of ACT principles and interventions. Leaders in these various areas have been asked to speak to you the clinician and explain how these innovative treatments are conceptualized and delivered in practice. Our hope is that, after making contact with this information, you will come away with a much better sense of how to deliver ACT with the various clinical problems you encounter in your practice, whether it is in a mental health clinic, a substance abuse treatment program, a family services agency, a school based program, a chronic pain program, a primary care clinic or a medical hospital. We encourage you to try these new applications with your patients, to assess their effectiveness

and to integrate them into your practice if you and your patients are seeing good results.

In the first three chapters of the book we describe the ACT approach and put it into context. We will describe the core skills and competencies that comprise ACT technology and show how these principles can be used to formulate cases. In the eleven chapters that follow, we will then show how the ACT model can be applied to some major specific problems, populations, and settings.

Although the chapters will include some citations of the research literature, the scholarly arguments are deliberately simplified since the purpose is to consider the ACT model from a clinical perspective, and citations will be limited to the minimum. The book is also not meant to substitute for the original ACT book (Hayes et al., 1999). Specific citations will be given for specific metaphors or exercises drawn from that volume, but the text will not be reproduced.

In this beginning chapter we will answer a simple question: what is ACT? We will tell this story in a kind of reverse order, describing core ACT processes in order to give a concrete sense of the approach and providing a simple definition of it. Because the value of ACT is so much dependent on its underlying theory and philosophy, we will then back up and show how ACT is part of a broader shift within behavioral and cognitive therapy, and how its philosophy and theory drive the ACT model. This will also enable us to give a more technical definition of ACT.

The ACT Theory of Change: Acquisition of Psychological Flexibility

Although many of our psychological problems originate in thought and language, it is not possible or healthy for us to live without language. Language can function as either a servant or a master. Unlike most forms of therapy, which seek to change the content of problematic thinking, ACT seeks to help the client bring language and thought under appropriate contextual control, using logical, linear language when it helps to do so and letting direct experience be more of a guide when that is more effective. The goal is "psychological flexibility:" the ability to contact the present moment more fully as a conscious human being, and to either change or persist when doing so serves valued ends (Wilson & Murrell, in press). From a behavioral point of view, life itself should help shape more effective behavior over time, if the dead ends and cul-de-sacs can be avoided. ACT theory (which we will review later) suggests that it is excessive verbal regulation targeted toward the wrong ends that creates these cul-de-sacs.

All ACT interventions are aimed at greater flexibility in responding and greater sensitivity to the workability of action. Because all ACT components have the same ultimate target they can be introduced in a variety of orders. ACT is a general clinical approach, not just a specific technology because the issue of psychological flexibility and rigidity is manifested is almost every human problem.

ACT assumes that significant, rapid changes in client behavior are possible. In addition to being a pragmatic assumption, rapid change is assumed to be possible because of the route through which ACT targets language. In general, ACT seeks to alter the function, not the form, of relational networks, and consequently there is no need to remove these historically conditioned responses before progress is possible. Speaking metaphorically, rather than attempting to learn how to win a game one has been chronically losing, ACT changes the game to one that is much more readily won.

ACT tends to use a relatively non-linear form of language. ACT therapists rely heavily on paradox, metaphors, stories, exercises, behavioral tasks, and experiential processes. Direct instruction and logical analysis has a relatively limited role, although it does occur. Even ACT-related concepts are treated in a deliberately flexible manner: the point is not to establish a new belief system but rather to establish a more effective approach to language itself.

The therapeutic relationship is a primary means to establish these new behaviors. The relationship itself is accepting and values focused; the therapist seeks to practice, model, and reinforce what is being taught. Therapy is a social/verbal community in which the normal contingencies supporting fusion and avoidance are removed in favor of contingencies supporting acceptance, defusion, focus on the present moment, and other ACT-relevant behaviors. In an ACT therapeutic relationship, persistence and change linked to valued ends is at the very core of the relationship itself.

The Six Core Processes of ACT

As is shown in Figure 1.1, psychological flexibility is established in ACT with a focus on six core processes: Acceptance, defusion, self as context, contact with the present moment, values, and committed action. Each of these processes helps establish change or persistence linked to chosen values. In the next chapter we will examine specific exercises and clinical steps that might promote these processes. In this chapter our focus is the model itself.

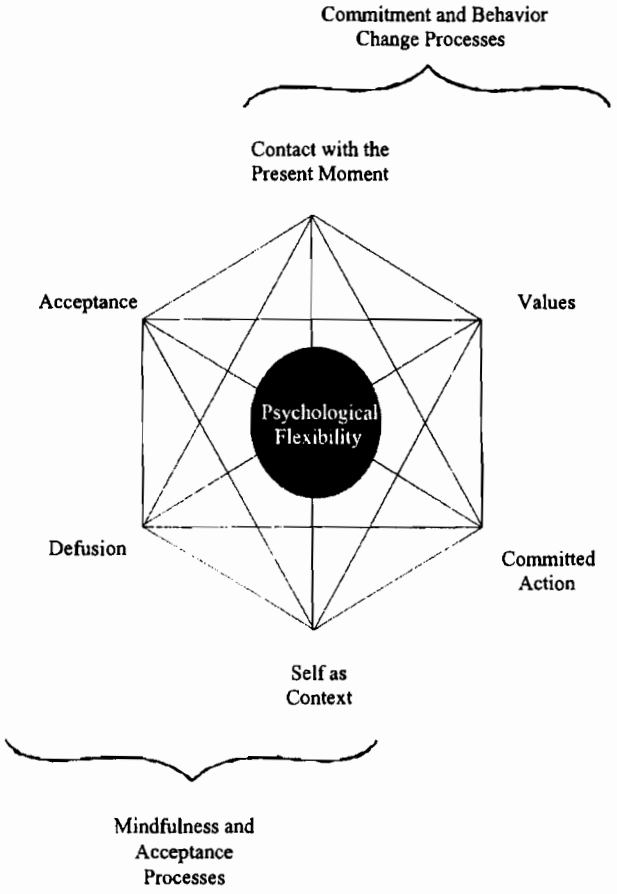

Figure 1.1. The facets of psychological flexibility according to the model of change underlying ACT.

Acceptance. Etymologically, acceptance means, "to take what is offered." Acceptance should not be confused with tolerance or resignation, both of which are passive and fatalistic. Acceptance involves taking a stance of non-judgmental awareness and actively embracing the experience of thoughts, feelings, and bodily sensations as they occur.

ACT promotes acceptance first by contacting the costs of control when control is inappropriately applied to private events. A major theme of many ACT interventions is, "Control is the problem, not the solution." Clients are

exposed in an immediate and experiential way to the paradoxical effects of control in the area of thoughts and feelings, and clear contrasts are drawn between the unworkable results of control in this area versus the enormous usefulness of this same repertoire in other areas of life. The pain of not being able to solve this conundrum is linked to an accepting message: this is not the client's fault—it is a rigged game that we all play and we can walk away from it. These issues are examined in a deliberately non-literal way—verbal persuasion and intellectual insight is avoided in favor of more experiential and evocative interventions.

As acceptance itself becomes a focus, clients learn—through numerous small steps, metaphors, and exercises—the distinction between acceptance and tolerance, and acceptance skills are practiced in the context of various difficult private events, usually in a roughly graded fashion. Techniques from experiential therapies, mindfulness traditions, gestalt therapy, and other areas are used to acquire acceptance skills. Clients learn through graded exercises that it is possible to feel intense feelings or notice intense bodily sensations without harm. Concrete behavioral targets that normally would not be pursued because of the private events they evoke are pursued in the context of acceptance of those events.

Cognitive Defusion

ACT aims to alter the context in which thoughts occur so as to decrease the impact and importance of difficult private events. Cognitive defusion works by changing the contexts that support detrimental functions that occur through relational learning so that the *process* of relating dominates over the *results* of that process. Cognitive defusion interventions include exercises that break down literal meaning through experiential means, inherent paradox, mindfulness techniques and similar procedures. As defusion skills are established, literal language itself is brought under better contextual control. Clinically, we want to teach clients to see thoughts as thoughts, feelings as feelings, memories as memories, and physical sensations as physical sensations. None of these private events are inherently toxic to human welfare when experienced for what they are. Their toxicity derives from seeing them as harmful, unhealthy, bad experiences that are what they claim to be, and thus need to be controlled and eliminated.

These techniques are also used to undermine the client's fusion with the conceptualized self. Difficult thoughts and feelings often present themselves as threatening to one's sense of self. For example, depressive thoughts may threaten the idea of the thinker as a normal person. The "self" that is threatened in this example, however, is the conceptualized self, a

collection of self-referential relations that generally are both descriptive (I am a male) and evaluative (I am a sick person that has problems with depression). The evaluative component of the conceptualized self is a particular threat to psychological flexibility. In ACT, networks of thoughts about the self rise up to the level of a "story" that contains within it both historical details (I was sexually abused as a child), cause and effect relationships (that event has caused me never to trust men) and explanations about contemporary behavior (because I don't trust men, I am not interested in pursuing relationships). There are an infinite number of relational networks that can be constructed around any set of events. Literally, there are thousands of potential stories that could be constructed based upon the same set of historical facts. Trying to form an "accurate" self-description that integrates one's entire learning history in a thorough manner is comparable to succeeding at a "connect the dots picture" of a Kandinsky painting where none of the dots are numbered. ACT defusion interventions not only try to reveal the hidden properties of language, but also the somewhat arbitrary way that humans try to make sense of inner events and build coherence among those events.

Self as Context: A Transcendent Sense of Self

While ACT sees excessive fusion with the conceptualized self as a threat to psychological flexibility, we consciously try to elevate contact with alternative types of self experience. One is the sense of self as the context in which private events such as thoughts, feelings, memories, and sensations occur. According to RFT, the theory that underlies ACT, deictic relational frames such as I-you; here-there; and now-then produce a perspective of "here-now" from which events can be reliably reported to the verbal community (Hayes, 1984; Hayes et al., 2001). Unlike all other events, however, "here now" is not thing-like. "Here now" is always the perspective from which events are directly experienced ("everywhere I go, there I am") and thus its limits cannot be consciously contacted for the person experiencing this process, because to contact events from the point of view of "here now" *is* consciousness. The ACT perspective is that a transcendent sense of self is built into verbal human beings and that it can be accessed through defusion and mindfulness processes. The great advantage of this sense of self is that it is a context in which the content of consciousness is not threatening. In other words, self-as-context supports acceptance. A number of core ACT interventions are aimed at helping clients directly experience the qualitative aspects of self as context. These include mindfulness/meditation, experiential exercises and metaphors.

Being Present

ACT promotes effective, open, and undefended contact with the present moment. There are two features to this process. First, clients are trained to observe and notice what is present in the environment and in private experience. Second, clients are taught to label and describe what is present, without excessive judgment or evaluation. Together these help establish a sense of "self as a process of ongoing awareness" of events and experiences (e.g., now I am feeling this; now I am thinking that).

A wide variety of techniques are used to orient clients toward the present, having removed the two primary sources of interference with being present: fusion and emotional avoidance. Mindfulness practices are often used in ACT to orient clients to the world as they experience it directly, rather than the world as structured by the products of thought. The connection with mindfulness is not merely technical. Mindfulness has been defined as contacting events non-judgmentally in the here and now (Kabat-Zinn, 1994, p. 4). In that sense, mindfulness (like acceptance itself, broadly defined) can be thought of as a combination of acceptance, defusion, self as context, and contact with the present moment. All four of these processes are in ACT, and thus ACT can be thought of as a mindfulness-based therapy at the level of process, in addition to using mindfulness techniques. At the same time, ACT is not based in a religious or spiritual doctrine or traditions and the accoutrements of religious or spiritual practice are not part of ACT work per se. Many ACT therapists introduce mindfulness and meditation practices in their own lives, however, in part as a method of gaining an experiential understanding of the "space" within which ACT is done.

Contact with the present moment can also include the behavioral and cognitive exposure techniques that are so central to many behavior therapies. The purpose of these exercises in ACT is different, however. If experiencing is done in the service of getting a feeling like anxiety to diminish, it is tangled in a cognitively fused process in which anxiety is evaluated as undesirable. Instead, ACT emphasizes the value of contacting the present moment willingly, in the service of greater vitality and psychological flexibility.

Values

ACT defines values as chosen qualities of purposive action, which can only be instantiated rather than processed as an object. ACT teaches clients to distinguish between choices and reasoned judgments, and to

select values as a matter of choice. Clients are challenged to consider what they want their life to stand for in different life domains such as career family, intimate relationships, friendships, personal growth, health, and spirituality. In order for the client to face feared psychological obstacles, there needs to be a purpose for doing so. Just knowing how to accept, defuse, and make contact with the present is important, but ACT is a behavior therapy and, as such, we seek to help the client "get in motion" and build a more vital, purposeful life. Values function as the compass headings in building an effective set of life patterns.

A variety of exercises are used to help clients clarify their fundamental values. For example, the ACT therapist may ask the client to write out what he or she would most like to see on his or her tombstone. Journaling and brainstorming are used. Contacting directly how it feels to move in one direction or another is examined.

From the direction determined by the person's values, concrete goals and specific behaviors along a valued path are then defined. Obstacles that are likely to be encountered along the valued path are also identified. Usually these barriers are psychological ones which acceptance, defusion, and being present can aid the client in navigating.

Committed Action

Once the psychological barriers of avoidance and fusion are more recognizable and a general direction for travel is defined, making and keeping specific (and often public) commitments becomes useful. Commitments in ACT involve defining goals in specific areas along one's valued path, then acting on these goals while anticipating and making room for psychological barriers. By gradually increasing the size and breadth of the areas addressed, larger and larger patterns of committed action are constructed. The client is encouraged to be responsible for the patterns of actions that result. For example, if a commitment is kept and then abandoned, the larger pattern that is being built is to keep and then abandon commitments. The moment this is seen, the client has the choice to move back onto a valued path (strengthening this larger pattern) or to indulge in self blame and helplessness (strengthening this larger pattern). The goal is to construct behavioral patters that begin to work for clients, not against them. The processes of defusion, acceptance, values, and committed action help the client accept responsibility for behavioral changes, adapting and persisting when necessary. Thus ACT balances strategies, in which readily changeable areas are the focus for change (e.g., overt behavior), and acceptance/mindfulness is the focus in areas where change is not possible or helpful.

In the behavioral domain, the intervention tactics of ACT vary greatly depending on the individual client and individual problem. They can include psychoeducation, problem-solving, behavioral homework, skills building, exposure and any number of other interventions developed in first and second-wave behavior therapies. The core ACT processes of contacting the present moment, self as context, values, and building patterns of committed action are often employed in the service of first order behavior change strategies, and ACT protocols in these areas will use existing behavior change technologies as part of the overall approach.

Psychological Flexibility

Figure 1.1 is organized to reflect other aspects of the ACT model of psychological flexibility beyond its six core processes. Each process relates to and interacts with the other processes (a total of 15 relations), as is represented by the lines connecting all points in Figure 1.1. Some of these relations involve shared functional properties: the three vertical lines are all of that kind. Acceptance and defusion both undermine destructive language processes; self as context and contact with the present moment both involve increasing effective contact with the here and now; values and committed action both involve building out the positive aspects of language into patterns of behavior change. The relations among acceptance and defusion on the one hand, and values and committed action on the other (the horizontal "X" in the middle), are dialectical relations involving the dismantling and construction of language functions in the service of acceptance and change. All of the other 10 relations among these six processes are mutually facilitative. For example, defusion helps the client make contact with the present moment. Contacting the present moment supports defusion and provides access to material that requires it. Though we do not have time to do it here, it is worthwhile to think through each of these relations as a means of understanding the breadth of the ACT model.

The center of the diagram is the psychological space we seek: psychological flexibility. In essence, psychological flexibility is an answer to this question, which involves all six ACT processes:

- given a distinction between you as a conscious human being and the psychological content that is being struggled with (self as context) ...
- are you willing to experience that content fully and without defense (acceptance) ...
- as it is and not as what it says it is (defusion), AND ....
- do what takes you in the direction (committed action) ...

- of your chosen values (values) ....
- at this time and in this situation (contact with the present moment)?

In essence, life asks this question of us all, over and over again, moment by moment. If the answer to this question is "yes" in a given moment, psychological flexibility is increased. If it is "no," it is decreased.

What Is ACT?

We are now ready to begin to answer the question that is the topic of this chapter: "what is ACT?" We have already intimated that the six key processes in ACT can be chunked into two larger groups. Acceptance and mindfulness processes involve the four processes to the left of Figure 1.1 while commitment and behavior change processes involve the four to the right. Combining the two provides a working definition of ACT: Said simply, *ACT is a therapy approach that uses acceptance and mindfulness processes, and commitment and behavior change processes, to produce greater psychological flexibility.* The name "ACT" itself reminds us of these two collections of multiple processes that are central to this approach.

ACT is not a specific protocol or finite collection of therapeutic strategies. Even within a specific problem area, multiple ACT protocols can readily be generated. An ACT consistent intervention package includes a wide variety of techniques in the general domains of acceptance, defusion, establishment of a transcendent sense of self, being present and mindful, chosen values, and building larger and larger patterns of committed action linked to those values. Which of these are used in addressing a given problem in a given client is based on an ACT case formulation, either with the individual or the class of patients or both. ACT draws techniques from traditional behavior therapy, cognitive behavior therapy, experiential therapy, and gestalt therapy, as well as from traditions outside of the mental health paradigm (i.e., mindfulness, Zen Buddhism, human potential movement). But what unifies these in ACT is the philosophical and scientific framework that gives it life. We turn now to that topic, and to the history that gave rise to the ACT model.

ACT and the Third Wave of Behavior Therapy

ACT is part of the behavior therapy tradition, and it will help in an understanding of ACT to back up and look at that tradition in broad terms. Behavior therapy began as an alternative approach to less empirical and

research-oriented therapeutic traditions. Traditional behavior therapy was committed to the development of clearly defined empirical treatments that were based on well-established basic learning principles. Instead of vague clinical concepts, behavior therapists focused directly on overt problem behaviors, and manipulated direct contingencies (both operant and classical) in an attempt to reduce the severity of or eliminate behavioral problems. In other words, behavior therapy was rooted in the philosophy of promoting "first order change." If an individual avoided social situations, increasing time in social situations or decreasing anxiety about social situations was the target and it was approached directly. If behavioral deficits were apparent, straightforward attempts were made to detect the nature of skill deficits and remediate them through direct training. Psychoanalytic theorists were afraid that such direct behavioral interventions would not get at the root of the patient's problem, but "symptom substitution" turned out to be a far smaller issue than they imagined. Compared to the techniques available at the time, the use of behavioral principles to create first order change worked very well and the first wave of behavior therapy established itself as a well accepted empirically oriented clinical approach.

But something was missing. Both behavior analytic (operant) and neobehavioral (S-R) theories had difficulties handling the problem of thinking, and lacked interventions that could remediate the negative influence of private experiences on human behavior. About thirty years ago, cognitive methods burst onto the scene to address these shortcomings. Some early behavior therapists argued that cognition had been dealt with all along, but the objection fell on deaf ears because clinicians felt that thinking should have a more *central* role in the analysis and treatment of many psychological programs.

The theory of cognition that prompted this evolution was not very sophisticated, however. Treatment innovations were usually based on a common sense approach to human thinking. Clients with particular problems thought particular and unhelpful things. These would be documented and targeted directly, much in the same way overt behavioral problems had been targeted in the previous generation. For example, clients would learn to detect irrational cognitions and dispute them; to notice cognitive errors and logically correct them; to extract core beliefs and conduct behavioral experiments to evaluate their validity. Information processing research models were sometimes linked to the treatment rational, but usually this was an add-on and few of the techniques really required the link.

Because the underling model was more common sense than basic, this "second wave" of behavior therapy undermined the original idea that interventions would emerge from basic scientific principles. In its place came an almost obsessive focus on the outcomes of randomized controlled

trials. If a manualized treatment worked in randomized clinical studies, there was only limited interest in determining *why* the treatment worked, and even less in linking these components back to basic science principles. Furthermore, while more emphasis was placed on cognitive processes, the "first order change" emphasis of traditional behavior therapy was not modified. If an individual avoided social situations, the original targets of increasing time in social situations or decreasing anxiety about social situations were simply expanded to include changing irrational thoughts about what might occur in those situations. Cognitive methods were just added to the list of interventions available, under the rubric of "cognitive behavior therapy" (CBT).

The second wave of behavior therapy is now more than 30 years old. It has had unprecedented success, as is exemplified by the number of CBT procedures on the lists of empirically supported treatments (Chambless et al., 1996). However, there are nagging empirical and theoretical issues that have created a need to move forward in the development of empirically based clinical interventions.

First, the theoretical models that explain cognitive behavioral interventions have not held up well in scientific tests. There are multiple lines of evidence that reveal the problem. Clinical improvement in CBT often occurs well before procedures thought to be central to its success have been implemented (Ilardi & Craighead, 1999). Measures of cognitive change often fail to explain the impact of CBT (e.g., Burns & Spangler, 2001), particularly in predictive studies of treatment outcome (e.g., Bieling & Kuyken, 2003). Component analyses of CBT (e.g., Jacobson, Dobson, Truax, Addis, Koerner, Gollan, Gortner, & Prince, 1996; Zettle & Hayes, 1987) have led to the disturbing conclusion by highly respected cognitive behavioral researchers that there may be "no additive benefit to providing cognitive interventions in cognitive therapy" (Dobson & Khatri, 2000, p. 913). Improvements in the general clinical effectiveness of well established CBT interventions have been hard to come by, especially with clinical problems that have been well researched.

Problems like this set the stage for change, but it requires more to actually produce it. It requires innovation. Over the past decade, new treatment models have appeared that place more emphasis on the *function* of problematic cognitions, emotions, memories, or sensations rather than their content, form or frequency. These "second order" change methods attempt to alter the function of these human experiences by focusing on contextual and repertoire building interventions such as contacting the present moment, and meditation/mindfulness. The positive empirical effects of treatments such as ACT (Zettle & Hayes, 1987), Mindfulness-Based Cognitive Therapy (MBCT: Segal, Williams, & Teasdale, 2001) and Dialectical

Behavior Therapy (DBT: Linehan, 1993; see Hayes, Masuda, Bissett, Luoma, Guerrero, in press, for a recent outcome review of both DBT and ACT) have provided support for these changes and there has been an explosion in interest in treatments of this kind (see Hayes, Follette, & Linehan, in press, for a book length review of most of these new treatments). A third wave of behavior therapy has been launched (Hayes, in press).

The Intellectual History of ACT

Acceptance and Commitment Therapy (Hayes et al., 1999) and Relational Frame Theory (Hayes et al., 2001) have played a central role in stimulating the third wave of behavior therapy. The visibility of ACT/RFT is only now becoming significant because of the development strategy we employed, but we think that our development strategy is now bearing fruit. It is worth a brief review, primarily so that readers can understand why there is much more to ACT than a mere description of its technology, and why is it only now becoming well-known and well-researched even though it claims to be an empirical behavioral therapy and is already 20 years old (a fact that has drawn strong criticism—e.g., Corrigan, 2001).

In outline form ACT and RFT were developed in the early 1980's. The first publication that began to out the ACT/RFT model was published in 1984 (Hayes, 1984) in an article that argued that a monist approach to spirituality was both theoretically important and practically useful. The first controlled study of ACT (Zettle & Hayes, 1986) and the first description of the clinical intervention package (Hayes, 1987) were published a few years later. Then ACT outcome research deliberately stopped. Why?

The first reason was philosophical. Both the first and second wave of behavior therapy were committed to first order change methods, but ACT is a contextual treatment and focuses as well on second order change methods. ACT is interested in the *function* of clinically problematic behaviors (e.g., What is this thought, emotion, impulse, behavior in the service of? Under what conditions does it function that way?), not *form* alone (e.g., is this thought logical? How often does it occur?). This is a significant philosophical departure from the implicit philosophies underlying much of both the first and second waves of behavior therapy. It seemed to us that when interest in these new forms of therapy really hit, we would need to have our philosophical ducks in row or their potential to advance the field could be frittered away in a chaotic embrace of eastern thought, or more experiential techniques, without the construction of a coherent approach. Hence, a multi-year detour was taken to get clear about the philosophical assumptions that support the radically functional change methods that characterize ACT (e.g., Biglan & Hayes, 1996; Hayes, Hayes, & Reese,

1988; Hayes, 1993). We will give a brief introduction to this philosophy shortly.

The second reason was similar but more theoretical. CBT weakened its link to basic science for a good reason: no principles of human language and cognition were available that provided a good framework for CBT packages. Information processing accounts largely failed to specify the contextual variables that clinicians might directly manipulate to improve treatment outcomes. They were used because little else was available, but the lack of clarity about contextual variables meant that the linkage to clinical practice was necessarily weak since what clinicians do is always (by definition) part of the context of client action. Basic behavioral principles were very successful with direct contingency control, but by themselves were not adequate to understand human cognition.

Sensing the need to provide a basic science underpinning human cognition that would have clinical utility, we turned to building a contextual theory of language and cognition. We wanted a concrete, experimental approach that could be useful to *all* contextual approaches, not just ACT. Relational Frame Theory (Hayes et al., 2001) was the result.

There are now scores of RFT studies comprising an extended program of research at multiple sites around the world. In our opinion, the result is a theoretically consistent set of principles of cognition that augment the available science on contingency shaped learning and classical conditioning principles, and that provide a foundation for a new wave of applied analyses and technological development. We will give a brief introduction to this theory shortly.

With those two problems addressed, we began to develop a model of psychopathology that flowed from these foundations (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). We will describe that model below.

Finally, we began to do clinical outcome research again. When we relaunched our outcome program we first wanted to see if this model was as broadly applicable as the theory said it should be, so we started with an effectiveness study that showed that training in ACT produced clinicians who were generally better at producing good outcomes across the range of clients clinicians face (Strosahl, Hayes, Bergan, & Romano, 1998). The ACT manual was published a year later (Hayes et al., 1999). And then, like a dam breaking, the outcome research began to flow. By the end of 2004 more than 35 case studies or controlled trials will have appeared on ACT, covering almost every area of applied work (see Hayes, Masuda, et al., in press). This research program is occurring world-wide. It is producing good outcomes, sometimes startlingly so (e.g., Bach & Hayes, 2002; Dahl, Nillson, & Wilson, in press). Just as important, the ACT/RFT model of change seems to be holding up in these studies (e.g., Bach & Hayes, 2002; Bond & Bunce,

2000). Several studies have shown an independent impact for various ACT components such as acceptance (Hayes Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999; Levitt, Brown, Orsillo, & Barlow, in press) and defusion (Masuda, Hayes, Sackett, & Twohig, in press).

ACT is not a traditional behavior therapy, nor is it a classic cognitive behavior therapy. It is a behavior therapy that is based upon a philosophy of science, a basic theory of the functions of language and cognition, a theory of psychopathology and behavior change, and a core set of processes within which treatment protocols can be developed. ACT is part of a broader approach that seeks nothing short of the development of a more unified and useful discipline. Even though this book is a clinical guide, we think a short review of those features of ACT is worthwhile and will help make the rest of the book understandable. Because we are being very brief, however, this material will feel a bit dense. If it is not fully understood, we would suggest moving on and returning later. More familiarity with ACT itself will help its underlying theory and philosophy be understood, not just vice versa.

Philosophy and Basic Science Foundation

Philosophy: Functional Contextualism

ACT is rooted in radical behaviorism, but we have rarely talked about it that way. Radical behaviorism is almost universally misunderstood, and includes conflicting perspectives under its broad umbrella. Rather than struggle under this dual burden indefinitely, we have defined the philosophical base of our approach and worked out its applied implications, using terms that allow a fresh look. Some of the unique features of ACT make a lot more sense if its underlying philosophy is understood. We will spend only a couple of pages on it here—just enough to get the flavor of the work—but readers with a more philosophical bent can pursue the matter in the works cited.

You need assumptions to develop a logical or empirical system, but they can't really be justified, only owned. If two people start with different assumptions they may end up in different places achieved by different means, but that does not mean that one is right and one is wrong. Metaphorically it is like the difference between starting from New York and heading as far west as possible on foot, versus starting from New Orleans and heading as far north as possible by boat. Neither journey is "correct" or "better" in any absolute sense. It would be silly for our two travelers to criticize each other because they are each heading in different directions, or

are using different means of transportation. After all, those differences are built into the very purpose of the chosen journeys. But both journeys imply certain consistencies when considered on their own terms. For example, if the person starting from New York unknowingly starts heading east, the "as far west as possible on foot" journey will not be successful. If the New Orleans traveler takes a bus and not a boat it will be difficult to know how far north the rivers and streams go. In these cases, criticism is warranted and may be useful.

In the same way, philosophy does not prove anything: it simply specifies assumptions (e.g., where are you starting from; where are you going), and makes sure they aren't in conflict (e.g., are your methods and measures in harmony with your goals). This is a good idea clinically. If disagreements about a system of therapy occur, they might be based on disagreements about assumptions and therefore more a matter of understanding differences than of legitimate and useful criticism. Conversely, if systems of therapy bog down it might be because assumptions are in conflict or they are not being adhered to, and in that case criticism might be both warranted and helpful.

ACT is based on a variety of pragmatism known as functional contextualism (Hayes et al., 1988; Pepper, 1942). Common sense actions (we will use the example of "going to the store") are a kind of abstract model for contextualistic interpretations. These kinds of events imply an interaction between a person and a setting, and they are whole events, with a history and a purpose, no matter how expansively or minutely they are viewed. For example, "going to the store" implies a reason for going, a place to go, a means to get there, and so on, all mixed together. If the whole is lost, the features lose their meaning. Small actions, like gripping the steering wheel, and larger sets of actions, like following a map route, can all be features of "going to the store," but they make no sense if they are seen in isolation. If we brought people into the lab and repeatedly made them grip a steering wheel we would no longer be studying "going to the store," because the context of that action would have been lost.

Functional contextualism thus views psychological events as an interaction between whole organisms and a context that is defined both historically (e.g., prior learning histories) and situationally (current antecedents and consequences, verbal rules). Analyzing it (e.g., by the scientist or clinician) is itself a whole event, also with a history and purpose. Just as going to the store is defined by its purpose and is finished as an event when one gets to the store, so too from a contextualistic viewpoint the actions of a client are considered useful only to the extent that they foster valued ends, *and* scientific or clinical analyses are considered "true" only in so far as they accomplish their specified purposes. This is an unusual and pragmatic sense

of truth, that differs from more typical approaches to "truth" that consider it to be a matter of correspondence, not workability. To understand this approach to truth, imagine having a picture of a house, a map to it, and a blueprint of its construction. If we ask "which is the right view of the house?" we would have to know the purpose. If the goal is getting to the house, the map would work well but the blueprint would not. If the goal is strengthening the foundation, the blueprint picture would work well but the picture would not.

Functional contextualism is precise about its purpose: it seeks the prediction-and-influence of psychological events, with precision, scope, and depth (Hayes & Brownstein, 1986). Other forms of contextualism (e.g., feminist psychology, social constructionism, narrative psychology) seek other ends (Hayes, 1993) so their analyses look different even though they share the same basic philosophy. "Prediction-and-influence" is hyphenated to indicate that this is one goal, not two. Analyses of variables that lead only to prediction, and not to influence, are relatively uninteresting from a functional contextual viewpoint. Analyses are sought that have precision (only certain terms and concepts apply to a given phenomenon), scope (principles apply to a wide range of phenomena), and depth (principles cohere across scientific levels of analysis, such as biology, psychology, and cultural anthropology).

Many features of the ACT/RFT tradition make sense given these various assumptions and goals. First, ACT is linked to an ongoing basic research program while most psychotherapies are not, because there is a commitment to analyses with precision, scope and depth, and that requires a basic account. Second, ACT tends *not* to view thoughts or feelings as causal in a mechanical sense. In order to achieve the goal of prediction-and-influence, directly manipulable events are essential (by definition, "influence" requires change or manipulation), and in a situated action it is only contextual variables that can be manipulated directly by therapists or others (Hayes & Brownstein, 1986). This helps explain why in ACT thoughts and feelings are viewed as important and related to overt behavior but it is always context (e.g., the social supports for emotional avoidance), not thoughts and feelings in isolation, that are its therapeutic targets. Third, values and goals are always critical in ACT because they provide the measure of success and thus pragmatic truth. ACT clients are often encouraged to abandon interest in the literal truth of their own thoughts or evaluations and instead embrace a passionate and ongoing interest in how to carry all of these reactions forward into a the process of living according to their values. If a client tells a story of past difficulties the issue will not be "is the analysis correct?" or even "does this story comport with the evidence?" but "what is this way of speaking in the service of?" or "does such talk move my

life in a vital direction" or "can I just have that thought and move forward in the world of behavior?" Similarly, ACT and RFT researchers have no interest in the *ontological* truth of their own theories and instead embrace a passionate and ongoing commitment to developing analyses that make a difference in the lives of human beings. Fourth, there is considerable flexibility in the use of language both in the clinic and the RFT laboratory, when different ways of speaking are found to be useful. ACT and RFT are focused on discovering what is useful, not what is "objectively" true. Concepts tend not to be reified, and there is an intensely pragmatic quality both inside ACT sessions and in the research program that surrounds it. The clinical contexts justify the use of some ways of speaking (e.g., free choice) that would be anathema in the laboratory and vice versa, yet no inconsistency is implied. This quality helps explain why from the beginning of ACT and RFT rigorous behavioral theory has been intermingled with discussion of topics like spirituality or meaning (e.g., Hayes, 1984).

Basic Theory: Relational Frame Theory

Relational Frame Theory (Hayes et al., 2001) is a comprehensive functional contextual program of basic behavioral research on human language and cognition. The research on RFT is growing very quickly and there are few areas of the theory that have not been tested in some form or another. ACT theory and associated treatment strategies are thoroughly integrated with RFT at the level of basic science. ACT targets language processes that have been shown to directly control human behavior in the RFT laboratory.

At the core of RFT is the premise that humans learn to relate events under arbitrary contextual control. All complex organisms respond to stimulus relations that are defined by formal properties of related events (what are called "non-arbitrary relations"). For example, a non-human can readily learn to choose the larger of two objects, regardless of which particular objects are compared. Humans are able to bring relational responding under contextual control and apply it to events that are *not* necessarily related formally in that way. These kinds of relational responses are "arbitrarily applicable" meaning that the particular relation can be specified by social whim or convention. For example, having learned that "x" is "smaller than" "X," humans may later be able to apply this same relation to events under the control of certain arbitrary cues (such as the words "smaller than"). A very young child will know that a nickel is bigger than a dime, but a slightly older child will have learned that a nickel is "smaller than" a dime by social attribution, even though in a formal sense it is not.

For behavior to be considered verbal in RFT, it must demonstrate three main properties: mutual entailment, combinatorial entailment, and

transformation of stimulus function. Mutual entailment means that if a person learns that A relates in a particular way to B in a context (the context is termed "C_{rel}" for "relational context," then this must entail some kind of relation between B and A in that context. For example, if a person is taught that moist is the opposite of dry, that person will derive that dry is the opposite of moist. Combinatorial entailment means that mutual relations can combine. For example, if a person is taught in a given context that Mike is stronger than Steve and Kara is stronger than Mike, the person will derive that Kara is stronger than Steve. Finally, the functions of events in relational networks of this kind can be transformed in terms of the underlying relations. Suppose you need help moving a heavy appliance and you know Mike is good at this. In this context (the context is termed "C_{func}" for "functional context"), it will be derived that Steve will be less useful and Kara will be more useful as a helper, without necessarily having used either Steve or Kara to move items before.

When all three features are established with a given type of relational responding, we call it a "relational frame." Frames of coordination (i.e., sameness), distinction, opposition, comparison, time, and hierarchy are examples. From an RFT perspective, relational framing is considered to be the core process in all human language and cognition (Hayes & Hayes, 1989).

What makes relational framing clinically relevant is that the functions of one member of a relational network can alter the functions of other members. Suppose a child is playing with friends and gets trapped inside a wooden box. The child gets very frightened and cries. Some of that fear and anxiety could years later transform the functions of other events where one could be "trapped," such as in a difficult class or in a relationship. There are few formal similarities between a relationship and a wooden box; what links these responses is not their formal properties but the derived relations among them in a verbal network.

As children develop, the number of relational frames and range of contextual features that govern them expands. Beginning with the simple frames of coordination, difference, and opposition, more complex frames of time, cause, hierarchy, and comparison are added. Deictic frames such as here-there or I-you establish a sense of self or perspective. These relational networks are constructed and brought to bear on new situations through analogies, stories, metaphors, and rules. Problem solving tasks make use of frames of coordination, hierarchy, time or contingency, and comparison ("because x has y features, if I do x then a beneficial q will happen"). Verbal formulae are used to control other people: first for concrete benefits from the rule giver (pliance), then to orient the listener toward contingencies

in the environment (tracking), and finally to create abstract consequences and values (augmenting).

What we are saying in a just few paragraphs is supported by scores of studies and detailed analyses (see Hayes et al., 2001 for a book length summary). It is not our purpose to summarize the research on RFT here—it is far too vast. As it applies to the foundation of ACT theory, however, we can summarize a few core conclusions from the RFT research program:

- Relational frames are learned behavior processes that are a central organizing principle of human experience. Psychotherapy necessarily involves engaging with and, when necessary, altering the functions of various relational frames.
- Some of the more common skill deficits noted in our clients (weak problem solving; lack of tolerance for emotional distress, impulsivity) are due to poorly controlled or improperly developed relational repertoires.
- Relational frames tend to dominate over other sources of behavioral regulation such as contingency shaped learning because of their general utility in so many areas of human endeavor, their tendency to broaden their impact through the transformation of stimulus functions, the arbitrariness of the cues that control them, and the ubiquitous cultural drive to use language to control the behaviors of individual members of the social unit.
- As a verbal repertoire develops, humans tend to treat transformed functions (the functions of events based on their participation in relational frames) as if they are direct (based solely on the formal features of events). People have difficulty making a distinction between direct functions and verbally established functions, and thus fail to notice how much they live in a verbally transformed world. For example, the "disgusting" qualities of drinking a fresh glass of one's own saliva will be thought to be in the properties of the saliva itself and not in our thinking about it—a view that is obviously false since we all daily drink quarts of our own saliva simply by swallowing without any such disgust reaction.
- The symbolic, temporal, and evaluative nature of relational frames makes it difficult for humans to stay in direct contact with the present moment. The domination of verbal processes over other sources of behavioral regulation ("cognitive fusion") can make the person less sensitive to real life outcomes and can be a major contributor to psychopathology.
- The same properties of relational frames that permit effective human problem solving (e.g., that allow us to define a problem, detect

and alter the cause) also allow us to be in pain regardless of the current formal features of our environment (e.g., by remembering past loses or hurts), and to exacerbate our pain needlessly (e.g., by continuously comparing our situation to the ideal; by fearing the future). This negative effect cannot be controlled by eliminating the verbal relations that produce it because these relations are necessary in positive human functioning.

- Because humans are unable to control pain simply by controlling the situation they often focus on negative experience itself. The attempt to regulate distressing private events in the same way as one alters external problems (i.e., through direct, rule-governed attempts to control) often increases the intensity, frequency, or behavioral impact of these private events. This process is a root cause of human suffering in general and psychopathology in particular.
- Relational networks work by addition, not by subtraction, and thus it is difficult to alter the content of historically conditioned verbal relations via clinical interventions. For that reason, a content focused change process is often unlikely to succeed in the case of undesirable private events.
- While the presence of relational frames and their content is difficult to control, the negative function of relational framing can be contextually controlled to a large degree, even when negative relational networks remain intact. It is not necessary to control, eliminate or avoid negatively framed events in order to change their behavioral functions. Said another way, it is often more clinically important to focus on the functional context (C_{func}) as compared to the specific relational context (C_{rel}) in designing effective clinical interventions.

The ACT Theory of Psychopathology: Psychological Rigidity

Language is repertoire broadening, when considered from the overall point of view of non-verbal behavior. Temporal relational frames allow "the future" to be considered in a different way, so verbal organisms can plan and problem-solve in a way that non-verbal organisms cannot. Comparative frames allow consequences to be considered verbally, and thus relative and probabilistic events can have more influence ("eating food x may reduce the probability of disease more so than eating food y"—a comparative process impossible without language). The combination of time and comparison allows rules about future events to induce more self-control and sensitivity to the delayed consequences of action. The repertoire broadening effect of human language is part of why such a slow and weak creature

as human beings have been able to compete with other animals who are far stronger, faster, and better defended.

There is a large and important domain where language *narrows* behavioral repertoires, however. This occurs particularly in situations where the problems are produced by the excesses of language and thought. ACT is not so much interested in training minds as in liberating humans from their excesses; not so much interested in building relational repertoires, as bringing them under appropriate contextual control. We want to teach clients to use relational repertories (rule following) when they work and to use other sources of behavioral regulation when they do not.

From an ACT perspective, ubiquitous human suffering and psychopathology are dominantly the result of the repertoire narrowing effects of language in two key areas: cognitive fusion and experiential avoidance. These two processes result in psychological inflexibility, which is the inability to modulate behavior in response to how useful it is—changing behavior when change is needed and persisting when persistence is needed—so as to accomplish desired ends.

Cognitive Fusion

Cognitive fusion refers to the human tendency to interact with events on the basis of their verbally ascribed functions rather than their direct functions, while being oblivious to the ongoing relational framing that establishes these functions. The event and ones thinking about it become so fused as to be inseparable and that creates the impression that verbal construal is not present at all. A bad cup is seemingly bad in the same way that a soft chair is soft. A worry about the future is seemingly about the actual future, not merely an immediate process of construing the future. The thought "Life is not worth living" is seemingly a conclusion about life and its quality, not a verbal evaluative process going on now. The effect is repertoire narrowing because verbal relations in essence restructure our contact with events in such a way as to maintain the verbal network itself. For example, acting on the basis of "life is not worth living" will tend to produce a life that is less vital, intimate, meaningful, or supportive—a set of events that will tend to confirm the thought itself.

Part of the resistance to change that seems to occur with human language may have evolved culturally. Language is a primary means by which cultural practices are propagated. When members of a language community learn culturally supported rules, these often protect the interests of society more so that the individual. Our most basic beliefs about what goes into a "good" life plan (i.e., get a good job, get married and have a family, be a good provider at home) can often be turned into life suppressing rule

following (e.g., don't stop this job no matter how unsatisfying it is because you have to provide for your family; healthy people don't get divorced, so stay in this entirely unrewarding relationship). If, however, these culturally supported rules could be easily noted, challenged, and changed, cultural practices themselves would be far more difficult to pass from generation to generation.

Behavior controlled by the rules contained in relational frames tends to be relatively sensitive to consequences surrounding rule following but relatively insensitive to direct, programmed consequences of other kinds (see Hayes, 1989 for a book length review). What this means clinically is that people can continue to engage in rule governed behavior even if aspects of the results produced are consistently bad. Cognitive fusion will hide the true source of the problem, which contributes to its persistence.

Cognitive behavior therapists are well aware of this. Classic CBT interventions often are designed to teach people to notice, test, and evaluate their thoughts and then to change the content of those that are irrational, over-generalized, excessive, untestable, and so on. This model is based on the assumption that it is the presence of dysfunctional thoughts that produces poor outcomes and thus they need to be modified: "cognitive therapy is best viewed as the application of the cognitive model of a particular disorder with the use of a variety of techniques designed to modify the dysfunctional beliefs" (Beck, 1993, p. 194). For reasons that we will explain later, there are substantial problems in that solution, which can itself be repertoire narrowing.

The problem with language-based problems, as we noted in the RFT section above, is that the ubiquitous nature of language and language-based solutions hides their nature and existence. Verbal processes are so fruitful in some areas that humans tend to apply them to all areas. The transformation of stimulus functions enabled by language allows humans to interact with verbally construed events (e.g., what is imagined or feared) as if these events were concrete non-verbal events (e.g., something that is "real"). Humans interact more with the products of thinking than with the processes that underlie thinking. The contextual cues supporting relational responses are arbitrary and ubiquitous—thus there is literally nothing that cannot evoke verbal responses and verbal responses, once formed, can be tied to almost any other verbal response. Language amplifies the impact of arbitrary social consequences which is one of the main consequences produced by language—it may be more important to be "right" than to be effective. Language helps us make sense of the "world," which can make it difficult when excessive attempts to understand is itself part of the problem. For these reasons and several more, language-based problems tend to have a life of their own, producing a notable inability to engage in

forms of behavior that are not based in logical, linear language processes. Despite its utility in other ways, language contains within it repertoire narrowing tendencies.

Experiential Avoidance

Experiential avoidance is the attempt to escape or avoid the form, frequency, or situational sensitivity of private events, even when the attempt to do so causes psychological harm (Hayes et al., 1996). There are two main forms of experiential avoidance: suppression and situational escape/avoidance. Suppression is the active attempt to control and/or eliminate the immediate experience of a negative private event such as an unwanted thought, feeling, memory or physical sensation. For example, the alcoholic may increase consumption in response to the unpleasant outcome of a marital conflict in an attempt to "numb" guilt, shame, or depression. The patient with schizophrenia is filled with sadness inwardly but maintains a flat and expressionless façade. The borderline patient, in response to perceived criticism and the fear of abandonment, uses an angry outburst to quell the criticism.

Situational escape/avoidance is the attempt to alter the antecedent contextual features likely to be associated with the appearance of an unwanted private experience. The patient with agoraphobia stays at home to avoid the anxiety attack that is sure to come if the grocery store is visited. The depressed person avoids a family reunion in response to the idea that he/she will be boring and unlikable. These experiential avoidance strategies have been found to result in poorer outcomes in a broad range of disorders (see Hayes et al. 1996 for a review).

Humans construct rules of the form "If I do x, I will feel y, and that will have effect z." For example, the panic disordered person says "if I don't go to the restaurant I will not be anxious, and that is good" or the person with OCD says "If I forget to wash my hands then I will contaminate my family and they will get sick and die, and that is bad." Unfortunately, rules of this kind have self-amplifying properties. Trying not to think of something evokes thinking of it. Trying not to feel something bad to avoid a bad outcome also relates the present moment to that bad outcome and thus the present moment evokes or elicits bad feelings. There is extensive research showing that deliberate attempts to suppress private events increases their occurrence and behavioral impact (e.g., Cioffi & Holloway, 1993; Wegner, Schneider, Carter, & White, 1987) and decreases the effectiveness of exposure based strategies (Feldner, Zvolensky, Eifert, & Spira, 2003). Both suppression and avoidance based strategies will come to cue the feared or unwanted private event since they are based on (and thus strengthen) the

underlying relational frames ("don't think of x" will serve as a contextual cue for "x" and for some of the functions of the actual event "x" refers to). Relational networks do not change readily and even direct, contradictory training may not break them up (Wilson & Hayes, 1996).

The process of experiential avoidance is also heavily reinforced by our "feel good" culture. The culture promotes the idea that healthy humans do not have psychological pain (stress, depression, memories of trauma, and so forth), and that the absence of negative private events is a state to be desired. Avoidant solutions (alcohol, drugs, mindless sex) are modeled in television shows, commercials, and other media.

Indeed, feeling good is often at the very heart of much of the mental health model. The very names of our disorders and treatments reveal this connection. We diagnose "disorders" based upon the presence of particular configurations of private events and experiences (self critical thoughts, suicidal thoughts, feelings of fatigue are part of "depression") and we construct treatments that are designed to eliminate these symptoms, ostensibly with the goal of returning the person to "good health".

In some areas, we have learned not to buy into this misguided culturally promoted view of health. For example, it was once considered ethical to try to remove or change homosexual thoughts, urges, and arousal. Our homosexual clients were obviously suffering; they said they were suffering because of these private events; and we as a field went along and tried to remove these events. Many therapists now consider this approach unethical. Instead, therapists work with homosexual clients to help them make room for their own feelings and thoughts and to function positively. One of the basic messages in ACT is that we ought to be looking at this issue in all of our clients. Is it the symptom itself that is harmful, or is it the culturally supported rules about what to do with such symptoms?

The result of cognitive fusion and experiential avoidance is psychological rigidity. Humans persist when they need to desist, and desist when they need to persist. They desist and persist for the wrong reasons and using the wrong means. For example, when persons experience a profound loss they tend to persist at avoidance, suppression, problem solving, and understanding in an attempt to avoid feeling the loss when the situation may call for simple contact with the loss, while engaging in effective and needed actions in the context of that loss. When faced with a self-control challenge, humans tend to focus either on the undesirable feelings that self-control initially induces (thus undermining persistence and fostering emotional indulgence) or they attempt to suppress or avoid those feelings in order to persist (but also producing second level responses such as emotional numbing or stress). Emotional indulgence on the one hand and suppressive persistence on the other form a poisonous choice that modern

society and its culture of "feel goodism" seems to be forcing on us all. The impact of this culturally sanctioned model on the ability of individuals to live effective lives has been horrific. ACT presents a middle path that is neither indulgent nor suppressive.

What Is ACT?

So we return now to the central topic of this chapter. We are ready for a more elaborate definition of ACT. *ACT is a functional contextual intervention approach based on Relational Frame Theory, which views human suffering as originating in psychological inflexibility fostered by cognitive fusion and experiential avoidance. In the context of a therapeutic relationship, ACT brings direct contingencies and indirect verbal processes to bear on the experiential establishment of greater psychological flexibility through acceptance, defusion, establishment of a transcendent sense of self, being present, values, and building expanding patterns of committed action linked to those values.* It is to ACT technology that we now turn.