INDIVIDUAL THERAPY PROTOCOL

ACCEPTANCE AND COMMITMENT THERAPY
FOR THE TREATMENT
OF POLYSUBSTANCE-ABUSING METHADONE CLIENTS

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Acceptance and Commitment Therapy Protocol for the Treatment of Polysubstance Abuse

Therapist Orientation

To become an ACT therapist, it is necessary to radically re-think some of the assumptions found in typical approaches to psychopathology and psychotherapy. The ACT Handbook therefore emphasizes theoretical discussion as well as procedures. The more thoroughly you grapple with the theoretical material, the more consistently you will be able to respond in an ACT-consistent fashion to the constantly shifting, idiosyncratic moments that occur during the course of therapy.

While this will require some commitment on your part, it is simply the case that ACT is a difficult form of therapy to do with integrity. Without supervised use, it is easy to make fairly major mistakes. In our experience, the usual form of such mistakes are a) inconsistencies in the use of the approach caused by the unsystematic mixture of acceptance and control based procedures and analyses, b) the tendency to lay "raps" on the client, or to want to be right about the analysis. This may show up in argumentation, traps in session, excessive reliance on the specific words in the manual, or an intensely verbal approach. And, finally, c) the use of these procedures in a dominating, controlling, one-up position, rather than in a compassionate, caring, equal level position. As is apparent in the ACT Handbook, we do not think that the struggles addicts have are fundamentally different than the struggles of any other human being. For the addict, these struggles are manifest in ways that can be profoundly disabling, and that are likely to garner much social censure. However, the core of the disorder, from an ACT perspective, is seen as a variant on the theme of what it means to be human being. ACT is best done from the perspective Martin Buber called "I and thou."

THE STRUCTURE OF TREATMENT

This treatment has considerably more structure than would likely be found in an ordinary clinical setting. This structure is imposed in order to increase the likeliness that we can make progress in the improvement of the quality of this treatment. Increasing quality involves systematic cycles of constrained practice, evaluation, and reorganization of practice in accord with the evaluation data. Consistency of approach will allow us to more easily say what worked and what didn't. The protocol contains the basic session structure, and order in which various ACT interventions and issues are introduced. Different and/or more flexible applications of ACT may be appropriate in some settings. However, for the purposes of this clinical trial it is critical that the therapists adhere strictly to the structure laid out in the protocol. This treatment protocol is designed for use with the ACT Handbook and ACT Skills Training protocol.

The protocol does not contain detailed descriptions of most intervention (e.g., experiential exercises, metaphors, homework assignments), nor does it contain extensive theoretical rationale. Detailed descriptions of the procedures and theoretical underpinnings can be found in the ACT Handbook. The therapist should be thoroughly familiar with both the particular structure discussed in the protocol, as well as of the general theoretical position from which the treatment is derived. Therapists are also advised to read the following list of articles

and chapters in order to gain the broadest understanding of ACT and its theoretical and philosophical underpinnings.
Sessions are organized around topics.

Each topic contains several key content areas, and sessions should include each content area. Some flexibility is allowed in terms of order of content area, relative to the particular context each individual client brings to therapy. However, no flexibility is allowed in terms of removing certain content areas, for the reasons mentioned above. For example, in working through the topic of Barriers to Emotional Acceptance, you must cover: (a) literality and language, (b) reason-giving, (c) reformulating language conventions, (d) behavioral syllogism, (e) process versus outcome. However, within this agenda, reformulating language conventions may be covered before reason-giving. Such changes must be done only as part of the therapist's assessment of the particular client, and may not be instituted in a way that compromises the necessary evolution of the concepts within topics.

This treatment will involve 32 individual sessions and 16 group sessions. The usual session frequency will be 2 individual and 1 group session per week. Missed individual sessions may be rescheduled as long as all treatment is completed within 119 days. Group sessions will be audio taped, and clients will be required to listen to the audiotape of any missed group sessions in order to make contact with material covered during that session. Clients may receive up to 2 emergency sessions over the course of treatment in addition to their regular individual sessions. Clients will be encouraged not to seek outside treatment during the course of active treatment in the study (i.e., 119 days). If a client's condition deteriorates sufficiently that the client, the therapist, or the supervisor deems outside treatment necessary, that individual will be independently evaluated for treatment outside the project. Clients may receive as many as 4 sessions of outside treatment (including the independent evaluation) without being removed from the project.

If more than 4 sessions of outside treatment are deemed necessary, the person will be considered inappropriate for the treatment provided in the project and will be given appropriate referrals. Missing more than 5 consecutive sessions will result in withdrawal from the project. Missing more than 12 sessions by the mid-treatment assessment date will result in withdrawal from the project. No more than one makeup session can be scheduled in a given week.

The basic treatment sequence for group therapy will involve a fixed 16-session sequence. Clients may enter the sequence at any point. Individual treatment will involve an introductory session and 10 core topics. All core topics should be done in the sequence laid out in the protocol. Optional topics may be introduced; however, no more than two sessions should be spent on any optional topic before returning to the sequenced core topics. These core topics are foundational in the ACT work. Introduction of too many optional topics without this foundation can be detrimental to the therapeutic process.

GENERAL SESSION STRUCTURE

Part 1: Review

Begin each session with an experiential centering exercise

The exercise should be one shared by the therapist and client and should be executed to accomplish two things: (1) it should set aside the clutter of day-to-day mindstuff and get the therapist and client "in the room," (2) it should focus the client and therapist on their shared task.

Review client's experience since last session

Inquire about any reactions to material from previous session

Inquire about any homework assignments

Inquire about reactions to any homework

If homework has not been done explore barriers to doing homework

Barriers should always be received in a nonjudgmental fashion. They should always be viewed as opportunities to examine the workability of whatever strategy the client used. The therapist should always remember that we will not serve the role of prosecutor for the client's crimes. The therapist should always take the position that if an agenda is unworkable, the client's life will let us know. The client does not need one more person in his or her life telling them what they ought to do. In addition though, the therapist never takes clients portrayals of reasons for doing something that does not work literally. The therapist should under no circumstances pretend, along with the client, that the unworkable is somehow workable if the reasons are sufficiently compelling.

Inquire about ways in which in-session material is impacting life functioning (e.g., intrapersonally or interpersonally in interactions with others at work, home or in social situations)

Part 2: New Material

Following the above review, new material should be introduced. Some core topics may be covered in a single session; however, others may take several. <u>The core topics should be done in sequence.</u> More flexibility is acceptable in the introduction of optional topics. Topics are laid out in this manual and are described in detail in the ACT Handbook.

Ideally, the new material will be integrated with examples from the particular client's life. The therapist should actively support the client in connecting new material with the client's life experience. The therapist should remember that ACT is aimed at disrupting problematic aspects of the verbal regulation of behavior. In other words, the point of therapy is not to introduce a different set of regulations. The client's life experiences are solicited in connection with these topics because we want the client to carefully examine and be guided by their own experience, rather than some new and "better" system of rules and beliefs.

Part 3: Homework and Behavioral Commitments

Various core and optional topics contain homework assignments. Many homework assignments can be found in the ACT Workbook. Some topics will also contain suggestions for behavioral

commitments on the part of the client.

Suggested readings:

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. F., & Strosahl, K. (In press). Emotional avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. **Journal of Consulting and Clinical Psychology.**

Hayes, S. C. & Wilson, K. G. (In Press). The role of cognition in complex human behavior: A contextualistic perspective. **Journal of Behavior Therapy and Experimental Psychiatry.**

Hayes, S. C. (1995). Why cognitions are not causes. **The Behavior Therapist, 18**, 59-60.

Hayes, S. C. (1994). Content, context, and the types of psychological acceptance. Chapter in Hayes, S. C., Jacobson, N. S., Follette, V. M. & Dougher, M. J. (Eds.), **Acceptance and change: Content and context in psychotherapy** (pp**.** 13-32). Reno, NV: Context Press.

Hayes, S. C. & Wilson, K.G. (1994). Acceptance and Commitment Therapy: Altering the verbal support for experiential avoidance. **The Behavior Analyst, 17**, 289-303.

Hayes, S. C. (1993). Rule-governance: Basic behavioral research and applied implications. **Current Directions in Psychological Science, 2**, 193-197.

Hayes, S. C. & Wilson, K. G. (1993). Some applied implications of a contemporary behavior-analytic account of verbal events. **The Behavior Analyst**, **16**, 283-301.

Hayes, S. C. (1992). Verbal relations, time, and suicide. In S. C. Hayes & L. J. Hayes (Eds.), **Understanding verbal relations** (pp. 109-118). Reno, NV: Context Press.

McCurry, S. & Hayes, S. C. (1992). Clinical and experimental perspectives on metaphorical talk. **Clinical Psychology Review**, **12**, 763-785.

Hayes, S. C. & Hayes, L. J. (1992). Some clinical implications of contextualistic behaviorism: The example of cognition. **Behavior Therapy**, **23**, 225-249.

Hayes, S. C. & Melancon, S. M. (1989). Comprehensive distancing, paradox, and the treatment of emotional avoidance. In M. Ascher (Ed.), **Paradoxical procedures in psychotherapy.** (pp. 184-218). New York: Guilford.

Hayes, S. C., Zettle, R. D., & Rosenfarb, I. (1989). Rule following. In S. C. Hayes (Ed.), **Rule-governed behavior: Cognition, contingencies, and instructional control.** (pp. 191-220). New York: Plenum.

Hayes, S. C., Kohlenberg, B. S. & Melancon, S. M. (1989). Avoiding and altering rule control as a strategy of clinical treatment. In Hayes, S. C. (Ed.), **Rule-governed behavior: Cognition, contingencies, and instructional control.** (pp. 359-385). New York: Plenum.

Zettle, R. D., & Hayes, S. C. (1987). A component and process analysis of cognitive therapy. **Psychological Reports**, **61**, 939-953.

Zettle, R. D. & Hayes, S. C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. **The Analysis of Verbal Behavior, 4**, 30-38.

Hayes, S. C. (1984). Making sense of spirituality. **Behaviorism, 12**, 99-110.

Zettle, R. D., & Hayes, S. C. (1982). Rule-governed behavior: A potential theoretical framework for cognitive-behavior therapy. In P. C. Kendall (Ed.), **Advances in**

cognitive-behavioral research and therapy (pp. 73-118). New York: Academic.

Hayes, S.C. (1994). Context, Content and the Types of Psychological Acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, M.J. Dougher (Eds.) **Acceptance and change: Content and context in psychotherapy** (pp. 1-13). Reno: Context Press.

Marlatt, G.A. (1994). Addiction and acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, M.J. Dougher (Eds.) **Acceptance and change: Content and context in psychotherapy** (pp. 175-197). Reno: Context Press.

Wilson, K.J. (1994). Mindfulness and Recovery from substance dependence. In S.C. Hayes, N.S. Jacobson, V.M. Follette, M.J. Dougher (Eds.) **Acceptance and change: Content and context in psychotherapy** (pp. 198-201). Reno: Context Press.

Wulfert, E. (1994). Acceptance and the treatment of alcoholism. In S.C. Hayes, N.S. Jacobson, V.M. Follette, M.J. Dougher (Eds.) **Acceptance and change: Content and context in psychotherapy** (pp. 203-216). Reno: Context Press.

Gifford, E.V. (1994). Setting a course for behavior change: The verbal context of acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, M.J. Dougher (Eds.) **Acceptance and change: Content and context in psychotherapy** (pp. 218-222). Reno: Context Press.

Core Topic #1
Preparing to Begin
(1-2 sessions)

Goals:

Provide informed consent (this, of course, goes beyond the informed consent included in the intake materials)
Describe the course of treatment
Agreement on evaluation methods
Describe likely ups and downs of therapy
Discuss commitment to the course of therapy
Some ACT treatment basics
Introduce Comprehensive Substance Involvement Worksheet I

Metaphors & Exercises:

Roller coaster
Cleaning mud from a glass
Walking through the swamp

Critical Readings:

It is useful to get a full understanding of an ACT perspective on psychopathology at the outset of therapy. These issues may not all be discussed with the client, except as outlined in the protocol; however, they serve to orient the therapist to the perspective, and will shape interactions with the client.

ACT Handbook--Chapters 1 & 2
Hayes, Wilson, Gifford, Follette, & Strosahl (1996)

Informed Consent

Before ACT begins, the client must be prepared for it. It is an intrusive intervention and clients should not be subjected to intrusive interventions lightly. Clients have a right to know what they are getting into in therapy. This presents special problems for procedures that are designed to alter the function of verbal events, however, since our only effective mode of informing consent is to verbally describe therapy. In ACT the description of therapy is to some extent the therapy. A literal description of ACT is not very informative:

Therapist: Our goal is to deliteralize language and to increase the willingness to experience private events.
Client: OK. Sounds like it may help me feel better. I believe it may work.
Therapist: No, you don't understand ...

As a compromise, informed consent in ACT consists of general descriptions of operating principles and admission of the areas of ambiguity. In addition alternatives should be listed.

Therapist: I believe in letting clients know what will happen in therapy. I see two ways to go. Many therapists would work with you to change directly how you think and feel. That may be an option. However, since you have tried this general approach before, there is a second approach. It is more demanding, and it can be confusing. I can't fully describe this approach to you because to some degree explaining the therapy happens in the course of this therapy. But it is based on the idea that instead of helping you *win* the struggle you have been in it might work better to help you *step out of* that struggle. It is focused on the things that have kept you struggling and it seeks to change those things. It is pretty fundamental work, dealing with the *relationship* between you and your psychological experiences -- your emotions, thoughts, memories, and so on. It is not an approach to be entered in on lightly, but it has been helpful for some people with problems like yours.

If the client indicates an interest in ACT, a warning is usually given.

Therapist: As I said, we will get into fairly basic issues, including some that you might not have expected in therapy. My experience with this approach is that it can put you on a bit of a roller coaster. All kinds of different emotions might emerge: interest, boredom, anxiety, sadness, clarity, confusion, and so on. It is like cleaning out a dirty glass with sludge in the bottom: the only way to do it is to stir up the dirt. So some stuff might get stirred up. It is not that it is overwhelming -- it is just that you should be prepared to let show up whatever comes up.

Commitment to a Course

Because ACT can raise fairly fundamental issues, it is wise to get the client to commit to a course of treatment, and agree not to measure progress impulsively.

Therapist: A fundamental treatment like this is best done by carving out some space within which to work. Especially if we end up stirring up old issues sometimes it might look like we are going backward when we are really going forward. It is like exercise: sometimes good things hurt a bit. I believe that clients should hold therapists accountable: I'm not asking for a blank check. If we are moving ahead, you will know it and we will both see it in your life. It is just that we can't be sure of this on a week to week basis. So what I would like is a period of time -- say 10 sessions. Let's push ahead for that amount of time no matter what -- even if you really want to quit. Then we will stop and look. If at that time it looks as though we aren't moving, we will do something else. I'm not saying that everything you want done will be done in 10 sessions, or 5 or 4 or 20. I'm saying by then if it is helpful you will know that -- we both will know we are heading in a good direction. Then we can decide what to do next.

Other Warnings

ACT tends to be a fairly active form of treatment until the client is connected into the core of the work. Warn clients of that.

Therapist: One thing. I'm by nature a bit of a big mouth -- like most therapists I guess. This approach we have chosen challenges some basic issues and that means I may be a bit more active than you might have expected at first. This isn't one of those therapy approaches in which the shrink sits back and just says "uh huh." But two things you need to know about this fairly active or even intrusive style: first, it will change. Once you get on board with what we are doing, you will carry more and more of the load. Second, we can't do this if you back up from me. You can't be passive. We have to collaborate. If you don't understand, say so. If you disagree, argue. Put your reactions on the table -- it will speed everything up. Are we together on this?

Covering Some Basics

Differences from Some Other Treatments. Our clients will often have been in treatment and legal situations (sometimes a mix of the two) in which their personal integrity has been called into question. They have often been subjected to situations in which they were asked questions, for example about their drug use, where giving certain answers could result in the loss of treatment or even incarceration. When they have lied to remain in treatment, or to stay out of jail, those lies were used as evidence of their moral corruption and lack of motivation for treatment.

It should be made clear to the client that from this treatment perspective, we have no moral stand either for or against drug use. You might say something like:

Therapist: You may have had some experience with legal situations or even treatments where lying about drug use got you accused of being "in denial," of not really wanting to get clean, or of gaming the treatment center or the courts. We do not take that position here. We don't think it is a symptom of a disease when someone lies to stay out of jail. We take you at your word when you say you want to get clean. We also try to create an environment that allows you to be honest about your using, since that honesty will help you in your recovery, and will help us in developing better treatment. One way we do that is by not kicking anyone out of treatment for using drugs. (EMPHASIZE) You will not, under any circumstances, be excluded from treatment for using drugs. We need to know when you have used and will ask often. We have arranged with the methadone clinics that we will not provide them with data from your UA's or from your self-reports about drug use. Of course, if you came to a session really intoxicated, we'd reschedule – not because we want to punish you, but because it's hard to get much out of treatment under those conditions.

Alliance Building. By the time our clients have gotten in front of us, they have almost certainly tried many, many things in an attempt to get control of their lives. They are also likely to be in considerable distress. It is worthwhile for the therapist to try to get a sense of the client's struggle "from the inside." You might tell the client something like:

Therapist: Of course, I haven't had the same experiences as you, but to the extent possible, it will help me in providing your treatment if I can get a sense of your struggle from the inside – to get a sense of how the world is from inside your skin. Now, I'm not going to pretend that I know all of the ins and outs of heroin addiction, we don't share that experience. What we do share though is more fundamental. We're both humans, and as humans, we have access to the human struggle.

If you can hear the intensity of the client's struggle, acknowledge it. You might say something like:

Therapist: From what I can see, you are a person who has really struggled to make changes in your life. I can see the pain it causes you to have worked so hard and to find yourself still so stuck. It's a perplexing thing, and the good news is that this therapy seems best suited to folks who have tried all of the usual stuff – tried as hard as they could – but haven't gotten results – at least not in the long term.

It is critical that the therapist not pretend expertise. Therapists should, for example, avoid using drug use drug use slang that they are not comfortable using. Feigned expertise will be detected easily by actual experts (i.e., drug addicts). If you are not an expert on illicit drug use, it is acceptable to say so. For example:

Therapist: I haven't used heroin, and am not a big expert on illegal drug use – but then you didn't come to me for that expertise. You probably already know a lot of people who are experts, including yourself. You came to me for a different sort of expertise – and that I do have. My expertise is in helping people to move forward who have gotten stuck, and who have tried a lot of things to get unstuck. Your job will be to be the expert on your difficulties -- including substance abuse. My job will be to see how our approach applies to the particulars of your difficulties.

Acknowledging the Client's Contribution. Our clients are making a contribution to the generation of effective treatments for substance abuse. They have often been seen by others and by themselves as not making much of a contribution to society. They are making one here and we should acknowledge it and commend them for their commitment to helping make a difference both for themselves and potentially for others with similar difficulties.

Introducing the Comprehensive Substance Involvement Worksheet I (CSIW-I)

The final task in this session is the introduction of the CISW-I. We have found it useful, early in therapy, to get a client's use patterns fully on the table. We have instituted a systematic, comprehensive assessment of substance involvement (see Comprehensive Substance Involvement Worksheet: Part I in the ACT Workbook). Along with a detailed history of substance involvement beginning with the client's first recalled substance use, we collect information on patterns, amounts, frequencies, and modes of administration of various classes of substances. The therapist should go over the instructions of the instrument with the client. Be

sure that the individual understands the task and why doing it is important.

Core Topic #2
Making Contact with the Cost of Using
(2-3 sessions)

Goals:

Complete and review Comprehensive Substance Involvement Worksheet I
Facilitate client in becoming psychologically present to the cost of using
Explore any reactions that emerge in the process of completing the worksheet
Complete and review Comprehensive Substance Involvement Worksheet II
(<u>only</u> after Worksheet I is complete)

Metaphors & Exercises:

Taking inventory
Cleaning mud from a glass
Walking through the swamp

Readings:

ACT Handbook -- Chapter 4: Creative Hopelessness: Challenging the Normal Change Agenda
(Creative hopelessness is the topic of Core Topic #3; however, this work sets up creative hopelessness, and it is worthwhile for the therapist to bear the next topic in mind as they work through the cost of using. The therapist can begin to plant some seeds for the next topic while doing this topic.)

Getting in contact with use patterns and their cost

During this session, the therapist should carefully go over the CISW-I. We go over this homework for several reasons. First, we will be asking clients to do a lot of homework over the course of therapy. Clients are more likely to comply with homework if they see that we are interested in what they do and actually use that information. A second reason is that we need the information. The CSIW I & II set up the Creative Hopelessness work that will follow in the sessions covering Core Topic 3. As the therapist goes over the client's substance use history, they should particularly attend to changes in substance abuse that marked attempts to moderate or change drug use patterns that had begun to cause problems (such as changing modes of administration, changing drug type, etc.). The therapist should remain nonjudgemental. The therapist should resist starting from the position that these change efforts did not work. Unworkability will emerge on its own if the change efforts are followed out – after all, the client has come to treatment. It is fine for the therapist to acknowledge that things worked when they worked and in the ways that they worked. If we attack a client's change strategies we will be more likely to promote a defense of those strategies. In part, we are helping the client make contact more fully with the extent of their own drug use, but

we are also introducing a model of dispassionate and detailed examination of the workability of the client's various behavioral approaches to problem solving. This general strategy will be useful later.

Having examined patterns of drug use in the CSIW I, we begin gathering a detailed history of the impact the client's substance abuse has had in a number of life domains including family relations, employment, and physical health, among others in the CSIW II. This work helps the client make contact with the damage substance involvement has produced and sets up work on the personal values their use has been violating. During the session in which the Comprehensive Substance Involvement Worksheet II is introduced, the therapist should carefully go over the worksheet and its instructions with the client. In order to be certain that the client understands the instructions, begin filling out the worksheet with the client. It is particularly important that the client provide some concrete examples in each of the applicable domains in the CSIW II. General descriptions are fine, but particulars are also needed. So, for example, the client may say that they were dishonest with their family. What we are looking for though, in addition, are several anecdotes that will give us the flavor of the deception. The client should be encouraged to write about a few instances that are characteristic. They should also be encouraged to write about instances that have a particularly strong emotional impact. The data produced by Pennebaker (1997) suggest that such emotional exposure through writing is, in and of itself, curative.

The Inventory Metaphor

As with the CISW-I, after the client has filled out the worksheet, the therapist should spend time in session exploring the client's reactions to filling out the worksheet. The therapist should be careful to neither to judge, nor to reassure. The therapist's job is simply to help the client become psychologically present to what is there. Tell the client that this part of the therapeutic process is like what happens when a store comes under new management. The first order of business is to take inventory. What's on the shelves? What's stored in the back room? Are there dented cans stacked in the alley? What about that old storeroom in the attic? This is nothing particular to the addict. It is a feature of human psychology that we tend to see, and remember what we've seen, selectively. Systematic stock-taking is necessary.

Topic #3
Confronting the System: Creative Hopelessness
(1-2 sessions)

Goals:

Inducing state of "creative hopelessness" regarding destructive attempts to win the good life by controlling private experience
Explore history of change efforts
Explore sense of being stuck
Introduce distinction between blame and responsibility
Introduce the "solution" as part of the problem
Appeal to experience, not logic
Begin breakdown of literality

Metaphors & Exercises:

Man in the hole metaphor
The rock climbing metaphor
Quicksand metaphor
Chinese handcuffs metaphor
Driving with the rear-view mirror metaphor
The rubber hammer metaphor
The feedback screech metaphor

Metaphors that emphasize the value and character of nonverbal knowing

The baseball metaphor (or dancing, or…fit to client's experience)
Finding a place to sit metaphor

Readings:
ACT Handbook -- Chapter 4: Creative Hopelessness: Challenging the Normal Change Agenda

For severe, multiple-problem, chronic, or personality disordered clients, more emphasis needs to be placed on clearing away the old system, so something new can happen. This section is especially designed for that kind of client. By the time the client has worked through the CSIW, they have usually come intimately in contact with the cost of their drug abuse in a variety of important life domains. The CSIW will alert therapist to the ways the client has used substances to avoid. In doing it, the therapist will also note other avoidance strategies. Before introducing the major creative hopelessness metaphors, the therapist should spend some time exploring other avoidance strategies, such as isolation, distraction, sleeping, etc. This constitutes

the preparation for clearing away an old and unworkable system. Clearing away the old system is, in part, a process of confrontation, but the confrontation is not between the therapist and the client. Rather it is between the client's system and the client's experience of the workability of that system. Thus, there should be no sense of one-upmanship.

The therapist is in the same boat, and while the client is hooked by his or her system, so are we all. The advantage of the therapist is not the advantage of the smart or together person talking with the dumb or broken person -- rather it is the advantage of the person outside the system over the person inside the system. It is an advantage of perspective. A metaphor we sometimes use for this is it is like a person sitting across a ravine from a mountain climber working up a cliff. The person watching might say over a radio "climb to the left -- you are climbing into a dead end" but if that same person were on the cliff, he or she may have no special wisdom. Thus, the confrontation we are speaking of is not a proud and personal confrontation.

The best way to confront an unworkable situation is to describe it as such. Recall that the therapist has already collected a long list of things the client has tried to eliminate emotional uneasiness, disquieting thoughts, or other psychological experiences. The therapist knows the major strategies ("more, different, better") which the client has tried in the past. These various ways the client has attempted to manipulate thoughts and feelings (e.g., drugs, alcohol, overt avoidance, sex, attacking others, moving away, social withdrawal, and so on) have not worked, the client knows that. What hasn't been faced is that the agenda itself is flawed.

Therapist: You have told me a lot of things you have tried to do, and it seems to me that you have tried to do just about everything that is logically there to be done. You've done all the obvious and reasonable things. You've thought hard, you've worked hard. You've looked for the angles. And now here you are in therapy once again ... still trying. But you've hired me. I work for you. So it is my obligation to point something out: this isn't working, right?

Client: I haven't figured it out yet.

Therapist: Here is another way to say what you just said: even trying to figure it out isn't working so far.

Client: Not yet.

Therapist: Not yet. And even in that "not yet" I hear "but it will. Surely it will." What if it won't? What if this whole thing is a set up?

Client: A set up?

Therapist: Don't you smell a rat here? It doesn't make sense. You're an intelligent person. You've worked on this problem. Sometimes it even seemed to be getting better. And yet, here you are in therapy again. Isn't it true *in your experience*, although it doesn't seem that it *should* be this way, that the more you've struggled with emotional discomfort and urges -- the more you have tried to get rid of them -- the more difficult it has become. They don't seem to respond to conscious control. As you have run away or escaped, these feared reactions haven't gotten smaller, they have gotten bigger.

Client: I don't know how to get rid of them. I'm hoping you can help. How should I get rid of them? What am I doing wrong?

Therapist: Those are important questions because they show what has been going on, but let's not get off on that issue quite yet. Let's start with what you know directly. You feel stuck.
Client: Right.
Therapist: It is not clear what to do next, but it doesn't seem like there is a way out.
Client: Exactly.
Therapist: So I'm here to say "you are stuck. There is no way out." .... Within the system in which you have been working there is only one thing that can happen: what has been happening. Just consider that as a possibility. Look, you know it hasn't been working. Now let's consider the possibility that it *can't* work. It isn't that you aren't clever enough, or work hard enough. It is a set up. A trap. You're stuck.
Client: So I'm hopeless. I should give up. Why am I coming in here?
Therapist: I don't know. But right now it's to try to see what hasn't been working. Anyway, I didn't say *you* are hopeless, I said *this* is hopeless. This whole thing that has been going on. This struggle that practically has you strangled is hopeless. And, yeah, if a struggle is hopeless its is time to give up on that struggle. It is a hopelessness, but a creative kind of hopelessness. If we give up on what hasn't been working, maybe there is something else to do.
Client: Then what should I do?
Therapist: Well ... first let's start from here. If this whole thing is a trick, a trap, we need to open up to that so that something different can happen. You came in here expecting some kind of trick, something to do, some solution I might have. You been trying to find the solution, you can't find it and maybe I have it. But maybe these so-called solutions are actually part of the problem. And check and see if this isn't so -- maybe this isn't true for you but just look and see if it is: *deep down* you don't believe that there *is* a trick. I trotted out one more clever idea from a shrink part of your mind would be going "oh, yeah. Sure." Your direct experience says this situation is hopeless. Your mind says of course there is a way out. There has got to be a way out. So which do you believe: your mind or your experience?

Several metaphors can be used by ACT therapists to help clients face the hopeless of winning through struggle. Some are quite short, such as the Chinese handcuffs and quicksand metaphors. These can be useful as supplements, when client needs additional ways of connecting with the issue, or as quick introductions useful in the earliest parts of treatment. Both of these metaphors capture, very quickly, the essence of the client's situation. Both of them point to the possibility that there is a counterintuitive solution to their problem. Both of them make contact with the lack of workability of common sense, logical solutions in some contexts. This is important, because the metaphors themselves provide a kind of reality check: things can sometimes be like this. The strange verbal game that goes on in ACT needs to make contact with the client's knowledge about how the world works: otherwise this looks like nothing but pointless psychobabble. ACT is a kind of psychobabble, but it is never pointless. It is coach talk. The metaphors help keep the client on track without having to wrap too many words around the core perspective.

These two short metaphors provide a quick introduction to the hopelessness of winning the struggle. The next metaphor is longer. It makes the same points, but it also provides many useful hooks for other issues that are relevant to this issue. The short metaphors are usually used spontaneously early in this phase as a way of orienting the client. Often they are not greatly elaborated. They are used to prepare the soil -- to break down some of the crusted over assumptions. The man-in-the-hole metaphor, however, is usually a centerpiece of this therapeutic effort. As you enter into these world of metaphors, the client will often not know quite what to do. There will be a sense of clarity -- as if some options not seen are opening up -- but as soon as the client tries to formulate this sense verbally the insight will slip away either to be replaced by disquiet and confusion, or by a pseudo-insight that amount to the same old thing.

Verbal "understanding" at this stage is almost always problematic, and at any stage of ACT is somewhat dangerous. It is problematic because this therapy approach is presenting a fundamental challenge to decades of socialization, belief, effort, and analysis. If the client "understands" this usually means that what is being done has entered into a pre-existing verbal network. When a response is put on extinction, as it decays other previously learned and extinguished responses reemerge -- a phenomenon known in the behavioral literature as "resurgence." Thus, it is easy, under the hammering of paradox and confusion, to weaken a dominant network verbal network so that it will temporarily give way to a less dominant network, but this less dominant network is -- by definition -- old. If that were what was needed why did it ever become less dominant in the first place? It too must have been abandoned because it didn't work. Thus, ACT seeks the development of truly new forms of responding, and furthermore they are responses that lie somewhat outside of normal, literal language. The therapist's ally in the effort to undermine problematic understanding is an attack on literal language, and a connection between these efforts and workability. Below are a few examples of some common responses to the man-in-the-hole metaphor:

Client: Oh, I see what you are saying. You're saying I just need to open up to my feelings.
Therapist: Isn't that like you? To say that? Haven't you thought similar things before? "I need to open up."
Client: Many times. I have tried to stay open and just feel what I feel.
Therapist: And so if that were the solution, wouldn't it have solved the problem before?

Here is another example:
Client: I guess you want me to make steps with the shovel. Dig a staircase.
Therapist: Clever idea. Have your tried to do that?
Client: I've tried everything.
Therapist: So that's not it. I guess the sides are too loose to make stairs. We are going to have to try something other than "everything."

And here is another:
Client: This is really neat. It reminds me of Zen Buddhism. I've always believed in the eastern traditions. It sounds like that is what you are driving at.

Therapist: And so just notice that thought that your mind gave you. And I want to say something in absolute confidence. 100% certainty. What you here me saying now. . . whatever it is . . . that's not it.
Client: I'm confused.
Therapist: Good.
Client: So why even think at all?
Therapist: So you can find out what I'm not talking about. ... And that thought? The one that is forming right now? Look and see it. That's not it either.

And a final example of the same sort:
Client: I'm not exactly sure what you are driving at.
Therapist: I'm just asking you to look at your own experience. Just look.
Client: So I'm not supposed to feel upset about myself. I've been blowing this all out of proportion.
Therapist: That's an interesting thought. And notice I didn't say that. I definitely didn't say "you are blowing this all out of proportion." I said "don't believe a word I'm saying." Right?
Client: So why even talk? I won't get anything out of it.
Therapist: That a great one. Thank your mind for that one. Beautiful. And this is rather like you, isn't it? This is the kind of thing you do. So just notice that you are doing it again. And notice that this is yet another formulation of the world -- as you move from one to the other.
Client: So what should I do?
Therapist: Start from here.
Client: You mean if I start from here I can put the past behind me.
Therapist: Great. Great thought. And how has that worked in the past?
Client: I've never been able to do it.
Therapist: Good. So what else comes up?
Client: It sound like what ever I say will be wrong.
Therapist: Super! And that has the odor of antiquity about it doesn't it? Old stuff. How old would you say you feel right now?
Client: About 9.
Therapist: And feeling that whatever you do is wrong. What else?
Client: Are you just trying to blow my mind?
Therapist: Well, I know both you and I have a mind in the room so there are actually four of us in here. It is really fine if your mind stays around -- they seem to do that and I imagine mine isn't leaving -- it is just that I want to talk with the human in the room, not only the mental machinery. We can notice what our minds have to say without disappearing into them. This therapy is not a belief system or a new philosophy -- you've already got plenty of those.
Client: (long pause). I don't know what to say. As soon as I start to think or say anything I think "there I go again" and then another thought shows up.
Therapist: Neat. Stay with that experience for a bit.

It is critical that the therapist not engage in this kind of discourse from a position of "one up." To do so is dangerous and potentially abusive. The therapist has to be vulnerable and at the same time on point. The "point," however, is not a verbal point. There is no verbal "right answer" to anything in ACT. Even if the client says something that closely corresponds to an ACT perspective (e.g., "You're saying I just need to open up to my feelings") it is the job of the ACT therapist to detect what that verbalization is *functionally* and to speak to that *function*. The point is to stay with what experience is like when thoughts are experienced *as* thoughts rather than as a structured set of experiences.

When a verbal formulation is adopted it structures the world, so much so that only the structured world can be seen in that instant. The whole point of ACT is to weaken the excesses of literal language and the implicit assumptions and agendas that it contains. Thus, the ACT therapist really means it when she says "don't believe a word I am saying" but this does not at all mean "disbelieve what I am saying." The ACT therapist is attempting to open up a realm that it orthogonal to believe and disbelief. Thus, it is not that the client's formulations are wrong and the therapist's are right. The therapist's formulations are also just ongoing verbal behavior, and if the therapist acts on the basis of belief or disbelief in *these* formulations, contact with the client's actual experience will be diminished. This is the space in which it is possible to confront the client's verbal system and remain vulnerable. It is that razor's edge in which language itself is given no firm place to stand on either side of the therapeutic interchange

Clients often come into therapy blaming themselves for their difficulties. From an ACT perspective, we make a critical distinction between blame and responsibility. Always make this distinction in the context of the man-in-the-hole metaphor (see ACT handbook on blame versus responsibility).

Another area where clients will need help is with the idea that therapy will be present focused and action focused. Much of our socialization about therapy suggests that it must involve delving into the deep dark past. ACT therapists move fairly quickly into the idea that the task is to let go of unworkable past solutions and begin to live life with vitality and effectiveness. Here is a metaphor that helps in that effort:

Driving the Car with the Rear-View Mirror Metaphor

If a client is in a great deal of emotional pain (e.g., panic, severe depression) the next metaphor can touch how scared the client becomes of feelings associated with suffering:

The Feedback Screech Metaphor

Additional metaphors:

The Rubber Hammer Metaphor
The Tug-of-War with a Monster Metaphor
The Baseball Metaphor

Concerns

Leaving Therapy

Therapists exposed to the ACT perspective at first are often concerned that clients at this stage will react with horror, will leave therapy, or will otherwise engage in dramatic and negative actions. In nearly fifteen years of experience in developing this model, with many hundreds of clients and many dozens of therapists, I am unaware of anyone who as left therapy at this point. No one has committed suicide, or entered into a deep depression. Quite the contrary. Although clients frequently express concern, anger, or destructive hopelessness, these are merely verbal maneuvers -- they are mind stuff. If the ACT therapist does this phase well, the net result is greatly calming (not that creating calm is our purpose -- this is merely the effect).

The mistake is to think that we are adding something to the client's distress. In fact, repeatedly the ACT therapist brings the client back to his or her own experience and validates that experience. This is not a mind game in which we are trying to produce something that was not there before. We are instead trying to make contact *with what the client is already in contact with.* Most clients experience this with an odd sense of relief. It is odd because the literal content seems so severe ("yes, you are stuck") but it is relief both because it fits the clients experience and because the client is taken off a hook. The message from the therapist is very positive, even though it is superficially negative: This is not your fault. You are not to blame (though you are response-able). You have been caught up in a trap that has caught most if not all other humans and now you have a chance to confront that head on and really learn something that many people never will learn. Your experience is valid. It is OK to start from exactly where you are already -- nothing needs to change first. Face the futility of the struggle, and new things can happen.

Hopelessness

Therapist can make two kinds of errors in the area of hopelessness: confusing creative hopelessness with hopelessness the feeling or with hopelessness the belief. Creative hopelessness is neither. It is a stance, or a behavioral posture that occurs when all the purposive behavior oriented toward a desired outcome -- in this case emotional control -- is disconnected from that outcome on the basis of the experienced lack of workability. If this disconnection is comprehensive, it begins to undermine the verbal construction of a means-end relationship to that desired outcome.

Hopelessness the feeling is, oddly, associated with a firm grasp on the old agenda, often in the secret hope that someone, magically, will rescue the person and produce the desired outcome. Put into words, hopelessness the feeling is "It is so sad I can't ever get what I want. Please help me." It is, frankly, a rather childish position in which some imagined external agent (God, the therapist, reality, fairness) will have pity on this poor suffering mass of protoplasm on the basis of the extent of its misery and hopelessness. Hopelessness the feeling is not at all a creative state because the client hasn't really faced the futility of the agenda itself, and thus the possibility of doing entirely new things. Hopelessness the feeling is not response-able.

Hopelessness the belief in one form is irrelevant to the ACT work. We are not asking clients to *believe* that the situation is hopeless -- we are asking them to contact their own experience of the futility of the struggle even while their verbal programming does whatever it does -- belief, disbelief (the most usual reaction), both, or neither. In a second form, hopelessness the belief usually moves over into the area of "I am hopeless," not "this isn't working."

Client Expectations of Improvement

Usually, at the end of this phase (which in a normal outpatient setting could take anywhere from part of one session to two sessions -- with one session being the mode) we make clear that we expect nothing "positive" to happen as a result of what we have done so far, and that we do not suggest any behavior change yet on the part of the client. In fact, positive things often do happen, but positive movement at this phase is tricky because it can lead to an immediate re-engagement with the destructive agenda the client has been pursuing. It is an irony that progress made from abandoning a verbally-established agenda will immediately be claimed by our verbal side as evidence that the agenda is workable. The "no change" expectation is prophylactic.

Therapist: In this next week I want to be clear that I'm not telling you to do anything different. Don't change your behavior -- don't try anything new. I don't expect that what we have done here will be of any help that you will detect. If you notice positive things, file them away so that we can talk about them but in all likelihood if such things occur they don't have anything to do with this work.

Homework:

It is a good idea to give homework, but not behavior change. We cannot trust behavior change until we undermine the agenda and provide a place from which to work.

Therapist: One thing you can do between now and when we get back together is to try to become aware of how the struggle has been carried out. See if you can notice all the things you normally do: all the ways you dig (*see man-in-the-hole metaphor*). Getting sense of what digging is for you is important because even if you put down the shovel you will probably find that old habits are so strong that the shovel is back in your hands only instants later. So we will have to drop the shovel many, many times. You might even make a list that we can look at when we get back together: all the things you have been doing to moderate, regulate, and "solve" this problem. Distraction, self-blame, talking yourself out of it, avoiding situations, and so on.

The "clearing the field" phase in ACT sets the occasion for later work. It confronts the client's verbal system, but it does not do so literally, or in an effort to replace it with a better verbal system. Rather, we begin to distinguish verbal content from the person, and we begin to open up to direct contact with the world as a major source of "know how" (not necessarily "know that"). All of the many unworkable things clients do to "fix" things are challenged (but again, not literally). It is not that the client has no knowledge about how to make things work -- to the contrary the client has a great deal of such knowledge but it is not in verbal form and would not be especially helpful if it

were. Thus, were are “clearing the field” of the trees created by language so that more robust experiential plants can have light and air.

Topic #4
Excessive Emotional Control Is the Problem
(1-3 sessions)

Goals:

The problem is "emotional control" (it's not that emotional control *hasn't* worked; rather, the problem is that it *can't* work)
The present goal of therapy: to experience the scope of the problem, not to necessarily do anything different at this time
The 95% versus 5% rule
Introduce "If you aren't willing to have it, you've got it."
If control is the problem, why haven't we let go of it?

Metaphors & Exercises:

More use of man in the hole metaphor
The polygraph
Jelly doughnuts
Fall in love

Critical Reading:

ACT Handbook -- chapter 5

Giving the Struggle a Name

Usually the client will have noted some things that are normal and typical "digging" moves (homework from the last phase). These should be explored, without interpretation or an attempt to understand them but if a real interest in the exact nature of these maneuvers. The therapist will ask questions to elucidate the nature of the client's struggle, as a set up to the next step.

Therapist: So what else did you notice.
Client: Well, when I was about to go into the department meeting I noticed checking several times to see if I still had my kit in my bag. I knew it was in there -- I always have it anyway -- but I checked it maybe four times within five minutes right before the meeting.
Therapist: What do you think the checking was in the service of?
Client: I guess reassuring myself that it was there.
Therapist: So that you could ...
Client: Well, so that I could always go fix if things got too bad.
Therapist: So one thing you noticed is that before you go into the department meeting you make sure you have a way of dealing with anxiety that might show up there. And you check for the kit to reassure yourself that you have that way out.
Client: Right.

Therapist: Can I say it this way: being sure to have access to liquor is one way you dig.
Client: Yeah.
Therapist: And that is in the service of keeping the anxiety away.
Client: For sure.
Therapist: Great. What else did you notice?

At this point, no big deal is made of any of this -- it is touched on, clarified, formulated in fairly common-sense terms, and then just left on the shelf. But this is important, because the immediate goal of the next phase is to gather this set of events into a single class: conscious, deliberate, purposeful control. The monster's name is CONTROL. It's manifestation is ESCAPE and AVOIDANCE.

Therapist: OK. I think I understand what you have been doing? Any others that you noticed.
Client: No. That is about it.
Therapist: OK. Actually, there are probably a lot of others that will percolate up as we proceed, but it is not important at this point that we know everyone. We just need to know enough to have a sense of the range of things involved. What I want to do today is to try to get a clearer sense of this set of things -- I want to have us get clearer about what digging even is anyway. And I want to give it a name -- not to figure it out intellectually but just to have a way of talking about it in here.
Client: You want us to have a name for the theme.
Therapist: Right. You know I was saying last time that most of what you having been doing is quite logical, sensible, and reasonable. The outcome isn't maybe, but really it seems to me that you've done pretty much the normal thing. And all these digging moves you just listed. Aren't they the kinds of things people do?
Client: Maybe not normal people, but people like me sure do. You know that support group I go to every month? It is almost laughable. Every single person in there has the same story. I mean you can tell even before they open their mouth what the story will be.
Therapist: Exactly. This is how the system works. Consider this as a possibility. It is similar because what you are doing is what we are all trained to do. It's just that it doesn't work here. Human language has given us a tremendous advantage as a species because it allows us to break things down into parts, to formulate plan, to construct futures we have never experienced before, and to plan action. And it works pretty well. If we look just at the 95% of our existence that involves what goes on outside the skin, it works great. Look at all the things the rest of creation is dealing with and you'll see we do pretty well. Just look around this room. Almost everything we see in here wouldn't be here without human language and human rationality. The plastic chair. The lights. The heating duct. Our clothes. That computer. And so on. So we are warm, it won't rain on us, we have light -- with regard to the stuff non-humans are struggling with we pretty much have it made. You give a dog or a cat all this stuff -- warmth, shelter, food, social simulation -- and they are about as happy as they know to be.
Client: What's your point?
Therapist: Well, I'm just saying that really, really important things -- important to us as a species competing with other life forms on this planet -- have been done with human language.

There is an operating rule: *if you don't like something figure out how to get rid of it and get rid of it.* And that rule works great in 95% of our life. But not in the world inside the skin. That last 5%. It is a pretty important 5% because it is where satisfaction lies, but it is only a small proportion of our total lives. But suppose that same rule worked just terribly in that last 5%. In your experience, not in your logical mind, check and see if it isn't so: in the world inside the skin, the rule actually is, *if you aren't willing to have it, you've got it.*

Client: If I'm not willing to have it, I've got it...

Therapist: Just check it out. For example, you've been struggling with cravings.

Client: Big time.

Therapist: You are not willing to have them.

Client: No way.

Therapist: There is a funny thing about cravings though, that a lot of people notice. You seem to get fewer cravings when you have absolutely no possible access to drugs. So, say someone is in jail. Detoxing in jail is generally easier than detoxing at home. Detoxing at a detox center is usually easier too. There isn't any access. Now imagine trying to detox at home when you have a whole bunch of dope right there in front of you. Think you'd get any cravings? It is almost like the more important it is to not have cravings, the more cravings you get.

Client: If I'm not willing to have it, I've got it...

Therapist: Weird, huh? Just to put a name on it, let me say it this way: in the manipulable world, conscious, deliberate, purposeful control works great. Figure out how to get rid of what we want to get rid of and do it. But in the areas of consciousness, history, self, emotions, thoughts, feelings, behavioral predispositions, memories, attitudes, bodily sensations, and so on, it often isn't helpful. In these situations, the solution isn't deliberate control, the problem is control. If you try to avoid your own history and what it brings automatically into the situation you are in an unwinnable struggle. Dig, dig, dig.

You can be certain that the list of digging items developed earlier will mostly be interpretable as methods for the control and avoidance of private events: especially emotions, thoughts, memories, and bodily sensations. You can see, for example, why the ACT therapist at the beginning of the section carefully formulated the access to drugs this way: 1. you make sure you have a way of dealing with anxiety that might show up there. 2. You check for the drugs to reassure yourself that you have that way out. 3. Access to drugs is one way you dig. 4. And that is in the service of keeping the anxiety away. In short: using is a method of emotional avoidance.

Very often clients will pick up on the word "control" is helpful ways: e.g., "I've always had a problem when I wasn't in control" or "my husband says I'm a control freak" or "I'm a pretty controlling person." If that happens, use these connections to build out the main point.

It can be helpful to point out right away that understanding "if you are not willing to have it, you've got it" will not be of any use to the client given the normal agenda.

"If you aren't willing to have it, you've got it."

Therapist: Notice there is a paradox with this. Suppose it really is true that "if you are not willing to have it, you've got it." What could you *do* with such knowledge. Now let's see ... ah, I want to

get rid of it but if you are not willing to have it, you've got it. So, therefor, if I am willing to have it I'll get rid of it! That's it! If I am willing to have it I'll get rid of it! But if I am willing to have it in order to get rid of it, then I'm not willing to have it and I have it again. So you can't trick yourself. "If you are not willing to have it, you've got it" can't be used harnessed to the old agenda. You can't dig with it ... or at least if you do nothing positive or different will happen.

The next metaphor is, like the "Main in the Hole" metaphor, one of the core metaphors that very often is helpful. It is especially good for clients with comorbid anxiety or mood disorders, and illustrates the problem of emotional control with "negative emotions."

The Polygraph Metaphor

Other metaphors are also useful to deal with positive emotions. These need to be dealt with because often the client has to idea that even if negative emotions can't be controlled, it is quite possible to control positive emotions, and thus maybe by putting positive emotions into the situation, the negative emotions will disappear.

The Fall in Love Metaphor

In this phase of ACT we are trying to show how weak deliberate control is when applied to the world of private events. Depending on what the client is struggling with, it might be helpful to develop this point with regard to thoughts, memories, or other domains of psychological events. Here is one for thoughts, for example, that is usually helpful and is especially so if the client is dealing with obsessive thoughts or ruminations.

The Jelly Donut Metaphor

Finally, this issue should be related to urges to use. Clients have often struggled mightily with urges to use. What their mind tells them is that if they cannot make these urges go away, or at least lessen, they will eventually use. Always ask the client whether this strategy has worked. They will usually say that it has worked in a limited sense. However, it cannot have worked in a real, lasting, fundamental sense, or else the client would not be in treatment. It is important to validate the incredible effort the client has invested in controlling urges.

The therapist should also explore the clients actual experience with suppressing urges, to see if it may not be a possibility that trying to suppress them make actually be increasing them. The therapist need not insist that this is so. Tentativeness creates less resistance. We might say something like: "Is it possible that this is so?" We also point out that in other areas of their life where they have invested this much effort they have succeeded in making fundamental changes. We ask if it doesn't seem a bit fishy that this does not seem to have worked out here. Another way to introduce the possibility is to ask the client: "In your experience, have your urges to use gone up or down over the years? Are they better or worse than they were 5 years ago or 10?"

Clients as severe as the ones being seen in this project will certainly have, in their own experience, the seeds of this fact. *It is important that they make contact with the paradox of control efforts in their experience, rather than as a compellingly logical argument.* The client knows quite well that emotional control and avoidance hasn't worked. What clients have usually not face is that it *can't* work. These various metaphors expose the client to the fundamental unworkability of this system of deliberate, conscious, purposeful (i.e., verbally regulated) control as applied to private events.

Topic #5
Emotional Willingness
(2-3 sessions)

Goals:

introducing the possibility of willingness as an alternative
distinguishing willingness from wanting
distinguishing willingness the activity from willingness the feeling
emphasize that willingness cannot have control as an underlying agenda
link the cost of unwillingness to values assessment

Critical Reading:

ACT Handbook -- chapters 4, 5 & 6

It is generally useful to talk about clients' emotional reactions to the material from the previous session, or (better yet) feelings they are experiencing at the moment in session that are "undesirable" (e.g., anxiety, depression, anger, confusion, etc.). For example, you might say something like: "When you have that feeling, what do you do with it? Do you try to get rid of it? Is it possible that struggling to get rid of the emotional discomfort and disturbing thoughts is *itself* very discomfort provoking? Eventually you get through it, and it *looks* as if the reason you got through it was because you were struggling with it, but doesn't that seem a little bit fishy? If that were the case, then why is the discomfort you have still hanging around? Clearly, struggling doesn't solve the confusion." Try to relate these control efforts to their pattern of substance dependence.

It can be helpful to give clients some literal understanding of how they first learned conscious control and avoidance as applied to private events. This is part of the general effort to illuminate the spectacular lack of success of control as applied to private events, without making the client feel stupid for buying into this agenda; which is, after all, spectacularly successful in other domains (such as the physical world) and ubiquitous.

Introduce the ways emotional control is established:

These four factors seem to glue deliberate control into the domain of private events:

1) It works in other areas of your life
2) You were told it should work here (e.g., "Don't be afraid...")

3) It seemed to work for other people around you (e.g., “Daddy isn’t scared...”)
4) It even appeared to work here.

These means of establishing the control agenda often lead people to present themselves in ways that are inconsistent with their experience of themselves. Metaphorically, everyone walks around looking like John Wayne. It is sometimes useful to tell the client that among all the clients you have seen, you have never met John Wayne. When the door to the therapy room closes, we find that the big strong looking folks are just as scared as the rest of us. Will I be liked? Will I fit in? Will I measure up? Point out that even John Wayne isn’t John Wayne. Empathize with the client if they are able to get present to the burden of the pretend game of total emotional and cognitive control. The following metaphor emphasizes aspects of this dilemma.

Introduce the self-esteem sandwich metaphor

Introduce issue of confidence

Useful metaphors :

These two metaphors further emphasize the problem of control efforts applied to private events. The second, introduces the possibility of willingness as an option.

Programming:
remember these three numbers
Two scales: anxiety and willingness
Clean and dirty anxiety, clean and dirty depression, clean and dirty urges

It is important to help the client understand what is meant by willingness from an ACT perspective. The following distinctions should be introduced and examined with the client:

distinguish willingness from wanting
distinguish willingness as an activity from willingness as a feeling

Finally, it should be emphasized that for willingness to be useful it must be genuine. Being willing in order to make thought or feeling or urge go away is not willingness at all. The following metaphor illustrates this point.

The Kid in the Candy Store Metaphor

Willingness and values:

The therapist should spend some time exploring the particular ways in which unwillingness has interfered with the client living out the values uncovered in the values assessment sessions. It is important to insure that the client make contact with this cost in very

specific ways, rather than as an abstract generality. If the client is unwilling to examine these costs, the therapist should, in a very empathetic way, point to the cost showing up in that very moment. Try to help the client notice by using this particular example of unwillingness the unworkability of unwillingness.

(**Warning)** While examining the cost of unwillingness, be sure to emphasize that we are not suggesting that the client ought to rush out and change anything, or to be shamed for their unwillingness. Point out that they have probably been shamed by themselves and others and that has simply not worked. Point out to the client that our task at this point is only to examine the system in which they are living and to see how it works (or doesn't). Point out that within this system, willingness is not really possible. Future sessions will involve finding a place from which willingness is a real possibility. For now though, just noticing is the job to do.

Topic #6
Distinguishing the Person from the Programming
(1-3 sessions)

Goals:

a lot of behavior is automatic: it is programmed
reasons aren't causes
·*you* are not your thoughts and feelings (rather, you are the context in which they are played out)
development of a "self"-perspective which is beyond evaluation
the focus is on experience, not logic

Critical Reading:

ACT Handbook -- chapters 5 & 6
Making Sense of Spirituality, Hayes, 1984

Just as emotions and thoughts reflect the immediate content of our verbal behavior, so too our histories function as repositories of language. We carry these repositories around, and they are extremely useful to us. However, like thoughts and feelings, histories aren't controllable, they just are what they are. Time only moves in one direction. We can't go back and rewrite the past. Therefore the domain of memory and historical events is also a domain which calls for acceptance and not control.

In general, human beings tend to identify with the programming that they have accumulated throughout their histories. This programming becomes verbal in nature as soon as language abilities are acquired. By the time clients come into therapy, they have accumulated extensive historical events which they are carrying around in the form of programming, or rules , i.e., the way the world works, the way they can and should work in the world, their fundamental worth as a person, etc. While this ability to extract rules from events is extraordinarily useful, it carries with it a dark underside. Where the individual identifies with their programming exclusively, it limits the range of their available response options . It does this in two ways: by creating insensitivity to alternatives, and by setting up a context where avoidance of negative or bad memories becomes essential.

The point here is to help the client identify with their sense of consciousness and continuity as a way of decreasing the perceived danger of emotional responses. We will define a naturalistic sense of spirituality that can be an ally in therapy. It may be helpful to describe this as the client developing an expanded relationship with their self. From the perspective of self-as-context, versus self-as-programming, all aspects of their inner experience are acceptable.

Where no part of inner experience must be avoided, then choices about how to behave can emerge from what is valued and useful, rather than from avoidance and attempts at control.

Useful metaphors:

These three metaphors describe, in different ways, the ways in which our history provides us with an accumulation of programming, and the ways we can fruitfully (or unfruitfully) interact with it. They are intended to highlight both the existence of the programming, and the fact that there is an overarching perspective *from which* this programming is experienced. It is useful to do multiple metaphors covering the same point. Some clients connect with certain metaphors, and not with others. In addition, the different metaphors highlight different aspects of a phenomenon. For more discussion of the function of metaphors, see "Clinical and experimental perspectives on metaphorical talk," McCurry & Hayes, 1992.

Two computers Metaphor
The Box with Stuff in it Metaphor
Chessboard Metaphor

Useful exercises:
The following exercises provide an experiential window on the issues alluded to in the metaphors. The first points to the ways in which the "pieces" alluded to in the Chessboard Metaphor tend to connect to one another, and how identification with them pulls the client away from the perspective of the board. It also gives an experiential view of the inevitable interconnections among all possible events for a languaging organism.
The second exercise often proves to be a powerful experience for clients. They often report a strong sense of peace. It should be pointed out that the exercise is not intended as a method for making "bad" thoughts and feelings go away. Rather, if done properly, the exercise allows the client to fully accept their thoughts and feelings: any experience of peace is a byproduct of this process. The point is to make experiential contact with the place from which thoughts, feelings, urges to use and the like need not be believed, acted upon, run from, etc. The client should be helped to notice the different aspects of the experience: the lack of struggle, their visceral experience, and anything else they describe.

Find a free thought
Observer exercise

Topic #7
Barriers to Emotional Acceptance
(3-5 sessions)

Goals:

introduce literality
introduce verbal conventions: labeling thoughts and feelings *as* thoughts and feelings, not what they *say* they are
Getting off our buts: "but" and "and" convention
"reasons": the arrogance of words
process vs. outcome and taking a direction
what do you want your life to stand for?

Critical Reading:

Applied Implications, I and II, Hayes & Wilson, 1994,
ACT Handbook, Hayes, Strosahl & Wilson, Chapters 5 & 6

As a species, language offers us the blessings and the curse of knowledge. The power of language has pros and cons: there is a "light side" and a "dark side" to the force. On the positive side, look at the influence it gives our species over the environment. On the dark side, we are the only species who commits suicide.
The dark side is dominant when we believe that feelings and thoughts *literally are what they say they are*. For example, "The truth about me is that no one could ever love me", or "When I feel this way I have to use." This occurs when we identify with our programming, instead of identifying it for what it is. The process of deliteralization is the process of identifying thoughts and feelings as what they are rather than what they way they are. If thoughts and feelings are what they say they are -- literal reality, e.g., " I am going to be alone forever and no one will ever love me," -- then avoidance and struggle become necessary.
The content of the literalized or "bought" programming will vary depending on the individual clients. The client's persistent problematic thoughts feelings will come up as a repeated theme over the course of therapy. The goal at this point is simply to establish the process of deliteralization, in order to create a repertoire that will allow the client to discern the difference between themselves and their thoughts/feelings, and to begin to recognize when they are buying their programming. This will begin to sensitize them to the signals that useless struggle is beginning.

Reformulating Language Conventions

At this point, we are beginning to create a set of conventions designed to keep the focus of the therapy clearly in mind: we can relate to our thoughts and feelings by identifying them as such, in the interests of accepting them rather than struggling with them. This is the purpose of all the

conventions. For example, the use of "and" rather than "but." "But" says that two reactions that both exist cannot co-exist, e.g., "I am angry at my mother but I really lover her," versus "I am angry at my mother *and* I really love her."
Another essential convention is the labeling of thoughts and feelings as such. This verbal convention is awkward, sometimes extremely so. Nevertheless it creates a great deal of space within which clients can work on their problems without disappearing into them.

1. Typical client verbalization: "This whole relationship stinks. It's sad really. There is just no way to pull it back together."
Reformulated client verbalization: "I'm having the evaluation that this relationship stinks. I have sad feelings associated with that thought, and then I have the thought that there is no way to pull it back together."

2. Typical client verbalization: "No one could live like I do. I am too anxious. It is miserable."
Reformulated client verbalization: "I'm having the thought that no one could live like I do. I have feelings of anxiety and I have the thought that they are too much. I evaluate it as miserable."

The artificiality of these verbal constructions is a problem initially. If the therapist is persistent, however, most clients can -- within just a half an hour or so -- get the hang of it. Typically, there is no need to be watchful about the conventions after a short while. Just an hour or two of consistent application will get them firmly established and available for use as needed. Then they can be called upon whenever the client is getting all tangled up in the content of private events. The conventions help create enough distance between the person and their own reactions so that these reactions can be seen *as* reactions, rather than the world being seen *through* these reactions.

The key components of the reformulation are:

1. "I" statements. The particular behavioral events must be phrased in the first person.

2. A clear label of the behavioral process. The main ones in most clinical work are thoughts, feelings, evaluations, bodily sensations, and memories.

3. Doing or having, not being. There is a subtlety in here that we do not deliberately teach to clients, but that nevertheless is usually learned. Respondent behavior is usefully viewed as something you have. Operant behavior is usefully viewed as an action you chose. In both cases, however, these actions or reactions are not who you are. The issue is doing or having, not being. Thus, the construction "I am angry" is almost always harmful. It places an emotion as a quality of being. "I feel angry" or "I have a feeling of anger" are much safer because they distinguish between the person and the event.

Useful verbal practices:

I'm having the thought that
but/and
Distinguish description and evaluation
Distinguish description from the events described
Distinguish process versus outcome

Useful metaphors:

These metaphors describe the results of confusion about the relationship between thoughts, feelings, and behavior. This misconception can be expressed in a simple syllogism:

1. Behavior is caused
2. Reasons are causes
3. Thoughts and feelings are good reasons
4. **THE CONCLUSION:** If you what to change the outcome, change the thoughts and feelings

The thrust of the metaphors is that literalization without awareness forces one into a position of struggle and avoidance. There is a tremendous cost to this posture toward one's private experience, in terms of freedom of movement and the accomplishment of valued goals.

Monsters on the bus
Little Dutch boy
The sign at the mountain
The colored shield over the head
Sign on the bus - setting a direction

Useful exercises:

The first two exercises below may seem "silly." However, it is important to get clients connected to the power of language, which is hard to do given how steeped in language we are. It is therefore critical to help them make contact with deliteralization at a basic level, before they begin to work with deliteralizing "hot" thoughts/feelings. The final exercise emphasizes the reason for doing this: directing your life toward valued ends. This is the "prize" which is always the goal of therapy.

Tichener's milk, milk, milk exercise
Tell me how to walk
What do you want you life to stand for?

Topic #8
Moving from Emotional Acceptance to Behavior Change
(3-5 sessions)

Goals:

Distinguishing between choice and decision
Identifying the characteristics of acting in alignment with goals: doing versus trying
Willingness as a choice and as an act
Disrupting the believability of perceived barriers to behavior change
Acceptance as the commitment to behavior change

Critical Readings:

Acceptance and the treatment of alcoholism, Wulfert, 1994
Setting a course for behavior change: The verbal context of acceptance, Gifford, 1994

Noticing Things That Keep Us In The Struggle With Our Own History

The point here is to empower clients to make behavior changes, building on a foundation of the acceptance of private events. Part of this process will be identifying the perceived barriers to behavior change. For example, noticing things that keep us in the struggle with our own history, i.e., unacceptable thoughts and feelings regarding ourselves, our past, etc. As the literalized or fused thoughts and feelings which are functioning as barriers are identified, the particular dimensions which require acceptance will become clear: namely, what shows up for the client when they choose to work toward their goals? For example, "If I stop using I will have to face what I have done to my life," etc. Once thoughts and feelings have been divested of their "unacceptable" status, then there is no good reason to avoid action. There are two main components to this topic: acceptance, and choice. They are unavoidably linked, as the willingness to choose implies the willingness to accept what shows up.

Choosing Willingness: The Willingness Question

The key question, the bottom line of all these weeks can be stated as follows: **"Out of the place from which there is a distinction between you and "that" ("that" meaning the stuff you struggle with, the thoughts or feelings or evaluations that come forward when you're doing something), are you willing to feel that, think that, experience that, as it is, not as it says it is, *and*, do what works for you in the situation?"** Tell client that this is the core of what we are doing in therapy; this is a question that will never stop being asked. Remind client that

willingness is a verb, an action, a process, not an outcome. Willingness is a *choice to do* something and, in that context, to have happen whatever is going to happen.

Tell client that what we are talking about in here is really an act of faith; there is no reassurance we can give that everything is going to be different. Say “We don’t know what will happen if you are willing to experience your urges, anxiety, or anger, or resentment, or whatever thoughts and feelings come up in the process of living your life. It’s like jumping out of an airplane with a parachute!” No one can take such an action except the client. Tell client that one of the things that can help facilitate willingness to experience discomfort is if you break it down into components, little pieces that can be looked at separately, rather than all at once.

Useful verbal practices:

Choice, willingness, commitment, and acceptance are all or nothing by definition. If it is the case that there are conditions on one, there are conditions on them all, and there is no way out of the loop of literality. Given the ubiquity of reason-giving in the culture (see control as problem), it is important to be consistently clear in our language conventions with our clients.

Distinguish choice from decision
Distinguish willingness from "wanting" or evaluation
All or nothing

Useful metaphors:

These metaphors are oriented around identifying that clients have what it takes to make positive changes in their lives. The question is willingness, not capability. Willingness is an action, a choice, not a condition that happens as a result of "getting fixed."

Bum at the door
The tantruming kid
Try versus do
Vanilla versus chocolate
The need for willingness emerges in the context of commitment:
    like walking through a swamp
Picking a point on the horizon
The pen through the bottom of the board
Like playing a game
The problem is not problems -- its the same old stinky problems

Useful exercises:

The second exercise below can be particularly powerful for clients, in part because there is a kind of emotional exposure that supports the acceptability of whatever shows up. The therapeutic relationship itself is also an exercise in this sense: whatever shows up for clients in terms of thoughts, feelings, beliefs, etc. is never to be invalidated or challenged by the therapist. This unconditionality on this level is essential, because it models the proper relationship for the client to have toward their experience. The issue is not the content of their thoughts or feelings or memories, rather, it is what they choose to do with it.

Choosing: coke versus 7-Up
Challenging personal space: sitting eye to eye
Return to Goals, Acts, and Barriers Worksheet from the Values Assessment

Core Topic #9
Values and Goals
(2-4 sessions)

Goals:

Introduce Values Assessment Packet
Therapist describes values assessment homework to client.
Client completes values assessment homework.
Therapist and client discuss values in each domain and generate brief values narratives.
Therapist generates Values Assessment Rating Form
Client rates values narratives on Values Assessment Rating Form.
Therapist looks for valuing activities in both in-session and out-of-session behavior.
Explore any reactions that emerge in the process of completing the Values Assessment Packet
Therapist and client collaborate to generate goals, actions and barriers related to the client's stated values.

Metaphors & Exercises:

More map making

Critical Reading:

Values reading--
ACT Handbook -- Chapter 7: Valuing

Rule-governed behavior readings (pay particular attention to discussions of pliance)
Hayes & Ju, in press
Hayes, Kohlenberg & Melancon, 1989
Hayes, Zettle, & Rosenfarb, 1989
Zettle & Hayes, 1982

A Values Oriented Treatment Approach

ACT is a thoroughgoing values oriented intervention. ACT differs from some emotionally-focused approaches in that it has no commitment to feeling painful emotional states for their own sake. Neither does ACT attempt to move the client toward emotional acceptance in order to reduce the frequency or intensity of emotional responses. In this way it differs from techniques such as flooding or systematic desensitization. From an ACT perspective, acceptance of negatively

evaluated thoughts, memories, emotions, and other private events is always in the service of ends which are valued by the client. Valued directions both direct and dignify this therapy. Therapists should refer to the ACT Handbook for a thorough discussion of values from an ACT perspective.

In some variants of ACT, such as brief treatment or treatments targeting specific problems, the protocol would move immediately to the development of the Goals, Barriers, and Actions forms and then directly on to willingness exercises related to those goals, actions and barriers. In this variant, we generate Goals, Barriers, and Actions forms in order to provide material for the next sections on Creative Hopelessness and Control as the Problem. In later sections, having established a place from which valued action is possible, we will return to Goals, Barriers, and Actions, and to a more indepth examination of an ACT perspective on Values. (For those familiar with previous protocols, this is a combination of approaches used in the treatmnent development project, which placed all the values work at the front of the treatment, with the old approach used in Comprehensive Distancing for agoraphobia, which placed the values work later in the therapy.

More Map Making

It may be useful to revisit the map making metaphor used in the previous core therapeutic area. Tell the client:

Therapist: This next piece of work will be a little like the map making we did the last few sessions. The difference is that before we were mapping the past and the present – where you have been, and where you find yourself now. Now we are going to map possible futures. What we are looking for is this: In a world where you could choose a direction in your life, what would you choose? We are going to map values next. As before, we are not recommending <u>any</u> changes at this time. We are just mapping the territory.

Assessment of Client Values

The following contains a description of a complete values assessment process (the actual worksheets are contained in the ACT Workbook). The therapist should carefully go over the instructions for the values assessment with the client. As with the substance involvement worksheets, the therapist should begin work in a few domains with the client in order to insure that they understand the task.

<u>Values assessment homework (given to client).</u>

The following are areas of life which are valued by some people. Not everyone has the same values and this worksheet is not a test to see if you have the "correct" values. Try to describe your values as if no one would ever read this worksheet. As you work, try to think about each area in terms of both concrete goals you might have, and also in terms of more general life directions. So, for instance, you might value getting married as a concrete goal and being a loving spouse as a valued direction. The first example, getting married is something that could be completed. On the other hand, the second example--being a loving spouse--does not have an end. You could always be more loving, no matter how loving you already were. Work through each of the life domains. These

domains overlap. You may have trouble keeping family separate from marriage/intimate relations. Do your best to keep them separate. Your therapist will provide assistance when you discuss this goals and values assessment. Clearly number each section, and keep them separate from one another. You may not have any valued goals in certain areas. You may skip those areas and discuss them directly with your therapist. It is also important that you write down what you would value if there were nothing in your way. We are not asking what you think you could realistically get, or what you or others think you deserve. We want to know what you care about, what you would want to work towards, in the best of all situations. While doing the worksheet, pretend that magic happened and that anything is possible.

1. Marriage/couples/intimate relations. In this section we would like you to write down a description of the person you would like to be in an intimate relationship. Write down the type of relationship you would want to have. Try to focus on your role in that relationship.

2. Family relations. In this section describe the type of brother/sister, son/daughter, father/mother you want to be. Describe the qualities you would want to have in those relationships. Describe how you would treat these people if you were the ideal you in these various relationships.

3. Friendships/social relations. In this section write down what it means to you to be a good friend. If you were able to be the best friend possible how would you behave toward your friends? Try to describe an ideal friendship.

4. Employment. In this section describe what type of work you would like to do. This can be very specific or very general. (Remember, this is in an ideal world.) After writing about the type of work you would like to do, write about why that appeals to you. Next, discuss what kind of worker you would like to be with respect to your employer and coworkers. What would you want your work relations to be like?

5. Education/training. If you would like to pursue an education, formally or informally, or to pursue some specialized training, write about that. Write about why this sort of training or education appeals to you.

6. Recreation. Discuss the type of recreational life you would like to have, include hobbies, sports, leisure activities, etcetera.

7. Spirituality. We are not necessarily referring to organized religion in this section. What we mean by spirituality is whatever that means to you. This might be as simple as communing with nature, or as formal as participation in an organized religious group. Whatever spirituality means to you is fine. If this an important area of life write about what you would want it to be. As with all of the other areas, if this is not an important part of **your** values, skip to the next section.

8. Citizenship. For some people participating in community affairs is an important part of life. For instance, some people feel that it is important to volunteer with the homeless or elderly, lobby governmental policymakers at the federal, state, or local level, participate as a member of a group committed to conserving wildlife, or to participate in the service structure of a community service group. If these sort of community oriented activities are important to you, write about what direction you would like to take in these areas. Write about what appeals to you about this area.

9. Physical well-being. In this section, include your values related to maintaining your physical well-being. Write about health related issues such as sleep, diet, exercise, smoking, etcetera.

10. Therapy. In this section, write about what you would like to accomplish in therapy. What do you hope to do, or to become in therapy? What sort of client would you want to be?

In-session values work.

The following worksheets are to be completed by the therapist and the client. After the client completes the homework section, the therapist and client should discuss each domain. The therapist's job is to clarify the direction inherent in what might be fairly concrete valued ends. The therapist's should also be assessing for variables controlling client's statements about valued ends. The therapist should attempt to intervene on relatively pure pliance-type responses (see Zettle & Hayes, 1986 from suggested readings for a discussion of pliance). The following are examples of forms of pliance which may be seen:

1. Values statements controlled by the presence of the therapist, in conjunction with the client's assumptions about what the therapist would like to hear. Relevant consequences would be signs of therapist approval and/or the absence of therapist disapproval.
2. Values statements controlled by the presence of the culture more generally. Relevant consequences would include the absence of cultural sanctions, broad social approval or prestige.
3. Values statements controlled by the stated or assumed values of the client's parents. Relevant consequences are parental approval--either actually occurring and/or verbally constructed.

It is difficult to imagine a client who would have values which were not controlled in part by all of the above variables. The key is whether removal of the specified pliance-type consequences would significantly affect the occurrence of the responses. This task will necessarily be accomplished imperfectly at the outset of therapy. Some issues of pliance may be side-stepped by asking the client to talk about the value while imagining the absence of the relevant consequence. To illustrate, consider a client who says that they value being well educated. The therapist might ask if the level of valuing (or the value itself) would change if they had to live the value anonymously: "Imagine that you had the opportunity to further your education, but you could not tell anyone about the degrees you had achieved. Would you still devote yourself to achieving it?" Or, what if mom and dad would never know you pursued an education:"Would you still value it?" The converse question might also provide some insight into controlling variables. So, for instance, the therapist might ask: "What if you were to work very hard for a degree, and mom and dad knew and were proud, but the day after you received the degree you forgot every thing you had learned. Would you still value it to the same degree?" As clients play in imagination with possible arrays of consequences as suggested here, they may be chagrinned to find that they are really valuing prestige or approval rather than the stated content of the value domain. Some values are likely to change over the course of therapy as the client and therapist sort through variables controlling particular values. Valuing the above consequences is itself a value and one may choose whether or not they will value the values of others with their feet. In this context, clients may discard certain valued directions and adopt others.

We have asked the client to generate values in various life domains. The therapist may have to assist the client either in generating the directions inherent in specific life goals, or conversely in generating specific goals from more global directions. Clients may also list ends which are not possible. So, for example, a woman might say that she wanted to regain custody of a child which

was given up for adoption 10 years ago. In these instances, try to find the underlying value, and goals that might be achievable if one were moving in that direction. After discussing and refining the values narratives, the therapist should generate a Values Assessment Rating Form by transcribing the refined narrative to that form.

Topic #10
Accepting Responsibility for Change
(2-3 sessions)

Goals:

Acceptance in the service of effective action
Discuss the difference between pain and trauma
Willingness to abandon the role of victim
Blame versus response-ability revisited
Looking for emotional discomfort and disturbing thoughts
Problems viewed as opportunities

Critical Readings:

ACT Handbook, Chapter 6 & 7

Sessions on this topic contain a large number of experiential exercises. They constitute a major prelude to actual work making and keeping commitments to the client's valued ends. The critical exposure is, after all, to the emotionally and cognitively difficult situations in their live *outside* the therapy room.

Emotional Exposure

While many therapies focus on emotional exposure, ACT does so with a particular goal firmly in mind. Emotions aren't sought for their own sake: rather, significant feelings that the client has a history of avoiding are targeting because of the ultimate behavioral benefits for the client.

Identifying the difference between pain and trauma supports the client in stepping into difficult feelings or thoughts that are impeding effective action. If active emotional exposure has not been occurring in the service of changing behavior, at this point it is critical to focus on the significant barriers to effective action, and the undesirable feelings/thoughts/experiences the client is avoiding by choosing not to act effectively.

Responsibility versus Victimization

There may be imagined costs to abandoning the posture of victimization for the client. In particular, the abandonment of victimization may imply that the client is in fact responsible for

their past and present actions. To accept responsibility requires a nonblaming posture on the part of the client toward themselves. Blame itself is a literalized thought which may require deliteralization. Identifying with the self-as-context is itself an unconditionally accepting relationship with the self at the level of private experience. It is from here that clients may lean into their grief about the costs of not having taken responsibility, and acknowledge that they are capable of behaving responsibly currently. The point here is to see that we have an investment in the normal way of speaking and doing. Responsibility is a two edged sword.

Useful verbal practices:

It may be useful to revisit some of the material regarding why the culture teaches control, as we are bucking the system in order to encourage clients to feel exactly what they believe they shouldn't be feeling. On the other hand, clients who have been exposed to therapeutic cultures may on the other hand value the emotional experience for its own sake. ACT does not make that move either. Emotional exposure is encouraged in the service of expanding the possibilities for the client's life.

Distinguish pain and trauma
The nature of right and wrong

Useful metaphors:

Jumping
Match in the gas tank
Corpus delicti
Rat in the maze

Useful exercises:

Who would be made wrong by that?
Tin can monster
What size is it?
What does the little kid want
Choosing love and acceptance: operating from the basis that you are OK
Taking your mind for a walk

Topic #11
Extending Emotional Willingness into Real Life:
Making and Keeping Commitments
(3-5 sessions)

Goals:

making a behavioral commitment and following through
finishing unfinished business
forgiveness and self-acceptance: right and wrong revisited
reasons are not causes
willingness continued
the role of guilt and values in controlling behavior

Critical Readings:

ACT Handbook, Chapter 7

Willingness

Tell client that reason-giving is one of the seemingly big obstacles to willingness. Ask the client again, "What stands between you and complete willingness? Whatever reasons are given (other than "nothing stands in the way") can be discussed in the context of reasons not being causes. Remind client that willingness is not an emotion, but a choice to have what you already have. The only thing that stands between the client and 100% willingness, is choosing to have it be so. "Why be willing? Because it works! It's the same reason that you breathe in and out, or that you don't run into a wall." Point out, however, that even saying "It works" is a reason, a thought, and that there may be times when he or she will choose to be willing when it doesn't appear to be working. Ultimately, it is up to the client to check out his or her own experience; ask, "In your experience, has *not* being willing worked?"

Commitment

Commitment homework and exercises will constitute a central focus for the remainder of therapy. Areas to be systematically dealt with in terms of commitments are:
1) employment/education issues
2) recreational activities/social interaction issues
3) family/marital issues
4) integrity/cleaning up past and present circumstances at variance with "what the client wants to stand for"

The client should expand previous talk about "what they want their lives to stand for" in terms of specifics in the above five domains. Virtually all clients will have some issues in these areas. Have the client select one of these domains and share what they want to stand for in that area of their lives. The client should be asked to make some specific behavioral commitment in the discussed area. Wherever possible the client should generate his/her own homework. The therapist should feel free to challenge clients if their agenda seems to be in the service of avoidance rather than growth. Resistance should be processed in terms of willingness, avoidance and how those work in the client's lives. The week following these commitments should be in part devoted to processing what showed up for clients (both those who followed through with their commitments and those who didn't). Again process the feelings and thoughts that were occasioned by the homework in terms of willingness, avoidance and working toward goals. Suggested exercises/homework assignments might include:

1) investigating reentering school, applying for new jobs, asking for a raise, talking to a career counselor
2) joining a softball team, attending church, asking someone out on a date, going dancing, having a friend over for dinner, going to an NA meeting
3) setting aside special time to spend with your spouse, calling or visiting a child from a former marriage, calling or visiting parents
4) arranging to make payments on back taxes/child support/bills, making amends in severed friendships and family relations

Tell client that there is an issue that underlies the question of willingness, and that issue is, *Can you make a commitment and keep to it?* Is it possible for you to say, It would work for me in my life to do this, and therefore, I'm doing it. And then to do it. And if you slip, or fail at the attempt, turn right around and do it again. Is commitment--which is a choice--a possibility, not only in the area of emotional discomfort and disturbing thoughts, but in other areas of life as well? Tell the client that we are not talking about living up to someone else's standards (e.g., church, mom, husband, etc.), but rather talking about living up to *any* standards. We are also not talking about something that will necessarily feel good. If feelings or thoughts are seen to be the reason for making decisions, then keeping a commitment becomes impossible, because you can't control your thoughts and feelings. Discuss how a commitment may define a set of situations or circumstances in which the commitment applies, or when a behavioral exception will be made (for example, a commitment to not eat dessert for the next six months may include the exception that when I'm at mom's house on my birthday, I will eat it.) Point out also that a commitment should not be made unless one is 100% sure you intend to keep it, *and* it will happen that you won't be able to keep it always. The question is, Are you willing to make a commitment, knowing that you're not going to always live up to it; are you willing to feel what you're going to feel when you fail to keep your commitments *and* still make the commitment?

Commitment for the upcoming week

Say, "Are you willing to do what would work to expand and enhance your life *and* to have whatever thoughts and feelings may arise when you do it?" If client says, "No", discuss the reasons he or she gives, reframing them as thoughts, feelings, etc. If client says, "Yes", ask, "What specifically could you do this week that would help enhance your life?" Proceed as in previous session to define a specific behavior the client is to perform during the upcoming week.

Tell clients that commitments are based upon life values that a person has. Say, "We talked about values before, when we talked about what you would like your life to stand for. People often are afraid to make commitments because they are afraid that they will be unable to live up to the standards they set for themselves, to live up to their values. However, commitment is a process, not an outcome: it's an acknowledgment that you are heading in a direction, despite the fact that sometimes you find yourself off the path." Ask client to talk about his r her values, what (s)he would like his life to stand for. Point out that the criteria they use to compare themselves with other people, or to criticize themselves for failing at something are the values they hold. Note that we aren't necessarily going to try to change their values, but only to help see if they are satisfied with their goals, or if they are "working" in the client's life. If client says he or she does not *know* what would work, point out that "working" is something experience teaches us: "How does a bunny-rabbit know what works?" Reassure the client that once they have seen the distinction between their observer-self and their thoughts and feelings, they can never go back; despite the fact that they (and we) inevitably get pulled back to piece-level and break our commitments, we are still response-able, able to begin again to take a direction with our life that will work.

Tell client that we are absolutely not encouraging them to feel *guilty* over past failures to live up to their commitments. Note that there are a lot of thoughts that go with guilt, such as "I'm bad", and "I never do what I'm supposed to do", and "What's the matter with me", etc. Guilt literally says, "There's something wrong with you or you wouldn't do 'X'" That's why guilt has a way of actually creating the very behavior that it claims it is going to prevent; it puts you in a weakened position, a posture that says, "Since you're so weak you're never going to be able to change, don't expect yourself to do anything different". So, for example, when I feel guilty over breaking a diet, I may think "I'll never be able to stick to this diet" and as a consequence, give up sticking to it. Note that guilt is made up of thoughts and feelings and evaluations; the client needs to be able to separate these evaluations from what *is*. Guilt is something you're *doing*; these thoughts and feelings and evaluations are not *you*.

Useful Exercise:

Do role-reversal exercise with the client: "Suppose I was the client and you were the therapist. I tell you that I'm going to do [some commitment]. The next week, I come back and say I didn't do it, I just *couldn't* do it because I was too anxious or depressed, too tired, didn't want to, etc. Now if you were me, what would you say to this person sitting in front of you?

Remind client that in the context of willingness, the *form* of discomfort or depression, resentment, anger, etc. will probably not change. Whatever it is that the client is calling "terrible" may still be happening *and* the client may still be saying to themselves, "This is terrible". In other words things may look exactly the same, but the function they serve to control one's life will be different. Remind group that their own best ally in accepting this difficult perspective is the pain they've suffered in the past as result of lack of acceptance.

Forgiveness and self-acceptance

Say to client "In the past few weeks we've talking some about how our unwillingness to 'have what we have' often seems to be related to our desire to be *right* in some way. This being right, however, is at a high cost." Remind group that the question is, Are you going to be right, or are you going to be alive? In other words, fullness of living may require risking being wrong in some of our choices and actions. Identify an issue for which this conflict over being right seems to be salient for a client in the group, and then ask him or her, "What would happen if you gave up this struggle with being right about (____)?" Letting go of the struggle with being right probably involves *forgiveness* of self or others. Tell client that forgiveness may appear to be equivalent to emotional avoidance, i.e., to excusing/denying/ forgetting old angers, hurts, etc. True forgiveness, however, is really the opposite of avoidance. It is a choice, not a decision; something that is not earned, but freely given (literally, it is a choice to *give* what was there *before* whatever damage occurred). In order to truly forgive, to make that choice, first one must fully feel whatever he or she is feeling, and then do what is there to be done. Only then is it freely possible to choose to forgive.

Optional Topics

It is possible to spend the entire 32 sessions working on the core topics, and then working on behavioral commitments and emotional exposure as described in Core Topic #11. The therapist should explore these commitment and exposure exercises in a wide variety of the areas discussed in the Values Assessment component of treatment. Some clients may have particular issues that warrant exploring some of the alternate topics listed below. In addition, certain topics may emerge in later stages which require a revisitation of previous topics. Finally, integrating therapy with group skills training may be undertaken at this point. Broader discussion of some of these topics can be found by looking in the index of the ACT Handbook.

Sample Topics for Commitment and Emotional Exposure Work:

Sessions on these topics should be homework intensive. The therapist should use the Values, Goals, & Barriers Worksheet from the Values Assessment Packet. The sessions should involve commitments to homework assignments relevant to these topics. The client and therapists should discuss the outcomes of these assignments in subsequent sessions. Working in these various areas can provide a practice ground for the client to try out new skills and to be coached through what are certain to be mixed results. Working and failing at times is a critical emotional exposure exercise. The therapist should always focus on the process of taking a direction in these life domains rather than the particular outcome. Failures are inevitable and the client needs to practice what needs to be done when that happens.

Dealing with slips
Dealing with others who urge using
Dealing with social conflicts
Work relationships
Health related behaviors (e.g., exercise and diet)
Family relationships
Sex
Money
Parents
Socializing with others
Dealing with being alone
Dealing with boredom
Dealing with criticism