Chapter 2

An ACT Primer

Core Therapy Processes, Intervention Strategies, and Therapist Competencies

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The purpose of this chapter is to present a consolidated overview of ACT treatment interventions and therapy processes. In Chapter 1 we described the philosophy, basic theory, applied theory and the theoretical processes that collectively define ACT as a clinical system. In this chapter we will examine the concrete clinical steps used in implementing this model.

Since the ACT treatment model was first published in book form in 1999, there have been many innovative developments in the model, particularly as it has been applied to a variety of clinical problems and special populations. This type of innovation is exactly what is needed to grow the approach, and is a key reason for the publication of the present volume. At the same time, ACT is a relatively focused clinical model with a limited set of core processes. The components of psychological flexibility resurface in ACT protocols. One goal of this chapter is link the core processes to intervention techniques that ACT therapists (and their clients) have invented and put them into a user friendly system. Finally we will address a question that is being asked more and more: "What are the hallmarks of a good ACT therapist?" We will present a set of core competencies that any mental health professional wishing to learn ACT can strive for. The end result of reading this chapter is that you will better understand what is at the heart of ACT treatment, how the various ACT intervention target specific aspects of psychological inflexibility and the competencies you can develop to improve your clinical effectiveness.

Moving from FEAR to ACT

The simplest way to think about the essence of ACT is to remember the processes that eventually trap the client in an unworkable way of living. The ACT shorthand for these processes is the FEAR algorithm:

- *Fusion*: Excessive attachment to the literal content of thought that makes healthy psychological flexibility difficult or impossible, particularly in the way that it makes direct, undefended contact with unwanted private events (thoughts, feelings, memories, sensations) seemingly toxic and unacceptable, and in the way that it draws the focus of living away from the present moment into the past and the future.
- *Evaluation*: Provocative and evocative evaluations of self, others, the world in general and important components of human experiences such as personal history or contemporary private experiences, when evaluations are neither needed nor helpful
- *Avoidance*: A style of dealing with unwanted private events (thoughts, feelings, memories, sensations) and distressing external events that involves emotional avoidance, numbing or other methods of experiential control even when it has significant behavioral costs
- *Reason Giving*: The over use of seeming logical and culturally sanctioned justifications that "explain" and "rationalize" the use of unworkable coping strategies and make the individual less responsive to real contingencies in the environment

ACT involves attacking the processes that support FEAR and the goal of therapy is to replace FEAR based functioning with an alternative: ACT.

- *Accept*: Accept unwanted private experiences such as thoughts, feelings, memories, and sensations as well as external events that are not amenable to direct control for what they are, not what they appear to be.
- *Choose*: Choose a set of valued life directions that would enlarge one's sense of vitality, purpose and meaning.
- *Take Action:* Build larger and larger patterns of committed action that are consistent with these valued ends

The Six Core Clinical Processes of ACT

In Chapter 1 we described six processes that are central to the ability to persist or change in the service of valued action. Collectively, these

processes define the ACT intervention model. These processes are not unique to ACT—they appear in different forms in other treatment models. What is unique is that ACT treatment draws them together based in a consistent theory of the functional properties of human language and cognition. ACT treatment seeks to help the client:

- Foster acceptance and willingness while undermining the dominance of emotional control & avoidance in the client's response hierarchy (Acceptance)
- Undermine the language-based processes that promote fusion, needless reason-giving, and unhelpful evaluation and thus cause private experiences to function as psychological barriers to life promoting activities (Defusion)
- Live more in the present moment, contacting more fully the ongoing flow of experience as it occurs (Getting in Contact With The Present Moment)
- Make experiential contact with the distinction between self-as-context versus the conceptualized self to provide a position from which acceptance of private events is less threatening (Self-as-context)
- Identify valued outcomes in living that will legitimize confronting previously avoided psychological barriers (Values)
- Build larger and larger patterns of committed action that are consistent with valued life ends (Committed Action)

There are several important principles that go along with these six core clinical intervention processes. First, these processes are in practice highly interdependent and entering into the chain at any point is likely to stimulate the emergence of other processes. Practically speaking, this means that there is no "correct" order for addressing these core objectives. If you start by clarifying values and beginning to build patterns of committed action, it will likely stimulate issues like excessive reliance on emotional control, fusion with events that block behavior, or difficulties separating the spiritual or transcendent sense of self from the conceptualized content of consciousness. If you start by undermining excessive experiential avoidance, you will probably stimulate issues around fusion and loss of contact with self-as-context, and you will eventually have to put acceptance and defusion in the service of valued, committed action.

Second, your clients will exhibit unique profiles along these clinical dimensions—a topic we will address in the next chapter. Not all clients need work in all of these domains. Your client may be relatively functional in one or more areas but severely blocked in another area. This means that good ACT treatment involves considering the client's status in each of

these dimensions and then targeting the area(s) that need to be bolstered. As your client exhibits more psychological dysfunction, you can anticipate that more core processes are going to have to be targeted.

Third, a good ACT therapist needs to be highly proficient at providing interventions within any of these core processes. All therapists tend to have their favorite interventions and sequencing methods, but you should avoid the trap of a "one size fits all" approach. This principle has important implications for defining the core competencies of the competent ACT therapist and, consequently, training and supervising ACT therapists.

Fourth, many ACT interventions can be used to promote progress in one or more of these core process areas. Because ACT is a contextualistic treatment, the meaning of an intervention is entirely dependent upon the client's unique learning history and life situation. Understanding that the same metaphor, for example, can have many different meanings will help you be more flexible in the application of these strategies.

Acceptance and Willingness: Undermining the Dominance of Experiential Control

From an ACT perspective, experiential control is thought to be pervasive in the human condition. However, individual clients may be more or less invested in control strategies. Some clients may, as a result of their learning history, be more open to testing out the effects of acceptance in their own experience. Others may be so entirely fused with the catastrophic outcomes of feeling depressed or anxious that acceptance is not even in the realm of imaginable experience. For the latter clients in particular, we begin by undermining the control agenda. When the dominance of the control agenda has been weakened sufficiently, we use interventions that foster acceptance and willingness.

Undermining Control

The language community largely defines "psychological health" as the absence of distressing or unwanted private content. The dark side of this message is that negative private content is toxic and dangerous, and must be controlled in the name of psychological health. Inherent in this belief is the idea that healthy people can control and eliminate negative private content and thereby gain psychological health. This is what ACT describes as the "unworkable change agenda." Basically, this agenda means you first detect the cause of the negative content and then, by eliminating the cause, you eliminate the content. This verbally established problem solving strategy works well in the external world, but often backfires when applied

to events inside the skin. We are historical organisms and cannot simply eliminate our history and the experiences it contains. The more we try to squeeze out unwanted private content, the more dominant it becomes. Those suffering from clinical problems will often resort to destructive experiential avoidance strategies (i.e., alcohol, drugs, suicidal behavior, panic, depression) to try to make the change agenda work. This situation is further compounded as control focused reasons are put forward as causes of life restricting behavior (i.e., I didn't go to work because I was depressed; I can't trust men because I was sexually abused as a child). The change agenda says the cause must be controlled or eliminated before psychological health can appear, but since the cause specified in the relationship cannot be removed, the client is in a trap.

The basic goal of ACT in this core domain is to help the client see experiential control and avoidance for what it is, to get the client into experiential contact with the costs of using this strategy, and to open up to the possibility that this change agenda can never work. It is only out of that pain that the client is likely to be open to experimenting with the alternative, willingness. Some of the more basic ACT messages in this domain are:

- You are not broken, only trapped.
- You are not hopeless, but your change agenda is hopeless.
- Control is the problem, not the solution.
- The rule of mental events: The less you want of them the more you get.
- What have you tried? How has it worked? What has it cost you?
- Try to gain control of your feelings, lose control of your life.
- What would happen if you stopped the struggle?

There are various ACT experiential exercises, metaphors and self monitoring assignments that can be used to support your efforts in this domain. Some of the more commonly used tactics are presented in Table 2.1. Most of these interventions are described in some detail in the first ACT book (Hayes, Strosahl, & Wilson, 1999). Once the control agenda has been sufficiently eroded, an opening has been made for an alternative.

Developing Acceptance and Willingness

Acceptance is a kind of leap of faith—an active embrace of the present moment, fully and without defense. No one is willing all the time in all areas, thus, no matter how willing you are to be present in a given moment there is always more to do. What ACT attempts to do is to open a door to a process—life itself will show clients the value of the process as they engage

Table 2.1. ACT Interventions for Undermining the Dominance of Emotional Control

Intervention	Clinical commentary
Creative hopelessness	Is the client willing to consider that there might be another way, but it requires not knowing?
What brought you into treatment?	Bring into session client's sense of being stuck, life being off track, etc.
Person in the Hole exercise	Illustrate that the client is doing something and it is not working, but nothing else can work until the client stops digging
Chinese handcuffs Metaphor	No matter how hard the client pulls to get out of them, pushing in is what it takes
Noticing the struggle	Tug of war with a monster; the goal is to drop the rope, not win the war
Feed the Tiger Metaphor	Teaches client that the more emotional control strategies are used, the more they are needed in a ratcheting upward cycle
Driving with the Rearview Mirror	Even though control strategies are taught, doesn't mean they work
Clear out old to make room for new	Field full of dead trees that need to be burned down for new trees to grow; let go of things that don't work
Break down reliance on old agenda	"Isn't that like you? Isn't that familiar? Does something about that one feel old?"
Paradox	Telling client confusion is a good outcome highlights the fact that the old familiar logic may not work here
Feedback screech metaphor	Its not the noise that is the problem, it's the amplification caused by control strategies
Control is a problem	How the client struggles against unwanted experience = control strategies
The paradox of control: Rule of mental events	"If you aren't willing to have it, you've got it."
Illusion of control metaphors	Fall in love, jelly doughnut: Shows that even positive emotions or thoughts can't be controlled
Consequences of control	Polygraph metaphor: Shows that the higher the "stakes" for establishing control, the more uncontrollable the result

in it. In this portion of ACT treatment, you will teach your client about willingness as a choice to make undefended contact with psychological barriers in the serve of chosen values. Typical ACT interventions for developing acceptance and willingness are presented in Table 2.2. (Parenthetically, the techniques listed in all of these tables often have applicability to more than one core processes, but for the sake of clarity we have not listed the same techniques in multiple areas).

Table 2.2. ACT Interventions for Promoting Willingness and Acceptance

Intervention	Clinical commentary
Unhooking	Thoughts/feelings don't always lead to action
Identify the problem as useless struggle	When we battle with our inner experience, it distracts and derails us. Use examples.
Defining the impact of avoidance	Avoided experiences are allowed to function as barriers to heading in the direction of valued goals.
Experiential awareness	Learn to pay attention to internal experiences, and to how we respond to them
Skiing down the hill metaphor	Change orientation from rejection to embracing feared experience
Amplifying responses	Bring experience into awareness, into the room; "Can you make that feeling a little bigger?" You can approach and play with private experiences; experience often decreases in intensity in paradoxical fashion
Empathy	Participate with client in emotional responding; "What just showed up for you? Can you just sit with it without struggle?" Teaches client to hold still and notice, rather than avoid
The Serenity Prayer	Change what we can, accept what we can't.
Practice doing the unfamiliar	Pay attention to what happens when you don't do the automatic response
Acceptance homework	Go out and find what you fear and let yourself just be there without struggle
Mind-reading exercise:	Helps client just notice a variety of thoughts that are "pulled" when asked to think about a feared or unwanted experience
Journaling	Write about painful events
Tin Can Monster Exercise	Systematically explore response dimensions of a difficult overall event; teaches client to let go of struggle and instead just accept a difficult private experience
Distinguishing between clean and dirty emotions	Trauma = pain + unwillingness to have pain; pain is natural and non-toxic but the struggle to eliminate pain creates trauma
Distinguishing willingness from wanting	Bum at the door metaphor—you can welcome a guest without being happy he's there
How to recognize trauma	Are you less willing to experience the event or more? Teach client that experiences are not inherently traumatic, unless avoided or struggled with in some way
Distinguishing willingness the activity from willingness the feeling	Opening up is more important than feeling like it. You can do an act of willingness even though you don't like what you are exposed to

(*continued*)

Table 2.2. (*Continued*)

Intervention	Clinical commentary
Choosing Willingness: The Willingness Question	Given the distinction between you and the stuff you struggle with, are you willing to have that stuff, as it is and not as what it says it is, and do what works in this situation?
Two scales metaphor	Shows client that willingness level can be deliberately set, whereas private experience is automatic and uncontrollable
Tantruming kid metaphor	Teaches client that putting qualitative limits on willingness creates a paradoxical surge of unwanted experience
Distinguish willing from wallowing	Moving through a swamp metaphor: the only reason to go in is because it stands between you and where you intend to go
Sitting face to face, eye contact exercise	Shows how even little acts of willingness can elicit huge emotional barriers

While the quality of willingness is more all or none, the context in which it occurs can vary greatly. It is possible to be willing to feel one feeling, but not another; to be open in one situation and not another; for one time frame and not another. The ACT therapist finds a way to begin the process and walks with the client step by step until the action is well known, and the client is able to continue this process of growth in normal living. After that, the contingencies themselves take hold, which is probably why continued improvement in follow-up has been regularly found in ACT outcome studies.

The key therapeutic messages include:

- Willingness/acceptance is an alternative to emotional control and struggle
- What would you have to accept to move your life toward what you value?
- Focus on what you can control and change (your behavior) and accept what you can't
- Willingness is a choice, not a decision
- Willingness is not wanting; you don't have to want something to be willing to have it
- Willingness is an action, not a thought or feeling

Generally, the exercises, metaphors and behavioral tasks that help promote willingness/acceptance as an alternative to experiential control

can be tailored to fit the struggles the client has been facing. For example, one frequent ACT strategy is to elicit feared material in the therapy session and then to use various exercises (i.e., tin can monster, monsters on the bus) to help the client address that material directly with the assistance of the therapist. It is also important to emphasize that the qualitative attributes of willingness are present in the smallest act. Being willing for seconds can put the client in the same "space" as being willing for hours. This awareness helps you avoid over-reaching the clients tolerance level in the name of making some heroic change. This is not only likely to fail, but it may reactivate the client's avoidance strategies because of the perceived threat.

Some clients rapidly discover that willingness works and some don't. Generally, those who don't have significant problems with cognitive fusion.

Undermining Cognitive Fusion

The concept of cognitive fusion is central to the ACT model of human suffering. Fusion is the tendency of human beings to live in a world excessively structured by literal language. Language-based and direct functions become so fused, that humans often cannot distinguish a verbally-conceptualized and evaluated world from one that is being directly experienced. This is undesirable because it means that anything imported into human experience by language (e.g., conventional patterns of evaluation, the conceptualized past or future, emotional avoidance rules) will have its effects as if the effects are the product of nature itself.

Speaking technically, fusion is the dominance of particular verbal functions over other directly and indirectly available psychological functions. So for example, for the client who has the evaluation that anxiety is bad, anxiety, bad, and the "I" who has anxiety are inextricably fused. They are, psychologically, one thing in that moment. And, importantly, any other psychological functions that "I," bad, and anxiety might have will be obscured.

From a clinical perspective, when the client fuses with verbal content, that content can exercise almost complete dominance over the client's behavior. When fusion is combined with culturally supported messages that negative private events are toxic and the opposite of what a human being should expect, there is a very dangerous cycle that is set in motion. As the client tries harder and harder to eliminate and control private events that "must" be controlled, the more fused he or she becomes and a paradoxical ratcheting up of negative content occurs. From the client's point of view, this struggle for psychological health is life and

death. While we have never treated a client who died from experiencing negative thoughts, feelings, memories or sensations openly and without defense, we know of many a client who would choose to die rather than have them.

The general goal of this core ACT process is to help the client detect the hidden properties of language that produce fusion, to shake the client's confidence in implicitly trusting the "reality" of private experiences and to recreate the "space" that exists between thought and thinker, feeling and feeler. You will try to teach the client to catch language in flight, and by doing so see private events for what they really are, not what they advertise themselves to be. This will ultimately help the client use willingness and acceptance strategies on a more consistent basis because defusing from thoughts and evaluations reduces their capacity to function as psychological barriers.

There are three particularly pernicious forms of fusion that you will attack in this component of treatment: 1) Fusion between evaluations and events they are tied to; 2) Fusion with the imagined toxicity of painful events; 3) Fusion with arbitrary causal relationships that, collectively, form the clients "story"; and 4) Fusion with a conceptualized past or future. Key therapeutic messages during this core process are:

- Your mind is not your friend, nor is it your enemy
- Who is responsible here? The mind or the human?
- Your thoughts and feelings don't cause behavior
- The most dangerous thing about your past is that your mind will make it into your future
- Which are you going to trust, your mind or your experience?
- Is it more important to be right, or to be effective?

Some of the more commonly employed ACT interventions used to pursue these clinical objectives are presented in Table 2.3. Note that there are at least four distinct levels of discourse within these interventions. One level works with the basic properties of language and thought in a direct way so as to reveal its highly automatic and programmable nature (i.e., milk, milk, milk; remember the numbers). The second level of interventions are designed to show how easily arbitrary relationships are formed at the conceptual level (why, why, why; autobiographical rewrite). These two levels are designed to help your client develop a healthy skepticism about the usefulness of the mind when it comes to "explaining" such things as personal history and/or contemporary states of mind. The third level of discourse is to attack the fusion of evaluations as human activities as opposed to evaluations as inherent properties of events (good cup, bad

Table 2.3. ACT Interventions for Promoting Defusion

Intervention	Clinical commentary
"The Mind"	Treat "the mind" as an external event; almost as a separate person
Mental appreciation: Thank your mind for that thought	Teach client how to separate self from minding and show aesthetic appreciation for the mind's products
Cubbyholing	Therapist labels private events as to kind or function in a back channel communication
"I'm having the thought that . . ."	Change language practice in session to include category labels in descriptions of private events
"Buying" thoughts	Use active language to distinguish thoughts and beliefs; makes evaluation a conscious choice, not automatic
Titchener's repetition (milk, milk milk)	Client repeats a difficult thought (I am damaged) over and over again until it ceases to sound like a thought
Physicalizing	Label; the physical dimensions of thoughts helps slow down attachment, recontextualizes experience of thinking
Put them out there	Sit next to the client and put each thought and experience out in object form; creates "distance" between event and perceiver
Sound it out	Say difficult thoughts very, very slowly
Sing it out	Sing your thoughts
Silly voices	Say your thoughts in other voices—a Donald Duck voice for example
Polarities: You are perfect, you are scum experiential exercise	Strengthen the evaluative component of a thought and watch it pull its opposite; helps highlight dialectical nature of language, self evaluations
Teach me how to walk	Try to instruct nonverbal behavior; shows limitations of language in understanding whole acts
Your mind is not your friend	Suppose your mind is mindless; who do you trust, your experience or your mind
Who would be made wrong by that?	If a miracle happened and this cleared up without any change in (list reasons), who would be made wrong by that?
Strange loops	Point out a literal paradox inherent in normal thinking
Thoughts are not causes	"Is it possible to think that thought, as a thought, AND do x?"
Choose being right or choose being alive	If you have to pay with one to play for the other, which do you choose?
There are four people in here: you, me, your mind and my mind	Opens therapy discussion on how to connect as humans when minds are listening

(*continued*)

Table 2.3. (*Continued*)

Intervention	Clinical commentary
Who is in charge here? You? Or your mind?	Treat thoughts as bullies; use colorful language to show that you distinguish between the client and the client's mind
Take your mind for a walk	Walk behind the client chattering mind talk while they choose where to walk; teaches client to have mental chatter and choose
How old is this? Is this just like you?	Step out of content and ask these questions
And what is that in the service of?	Step out of content and ask this question
OK, you are right. Now what?	Take "right" as a given and focus on action
Mary had a little	Say a common phrase and leave out the last word; link to automatic nature of thoughts the client is struggling with
Get off your buts	Replace virtually all self-referential uses of "but" with "and"; teaches client the dialectic of "both and"
What are the numbers?	Teach a simple sequence of numbers and then point out the arbitrariness and yet permanence of this mental event
Why, why, why?	Show the shallowness of causal explanations by repeatedly asking "why"
Create a new story	Write down the normal story, then repeatedly integrate those facts into other stories
Find a free thought	Ask client to find a free thought, unconnected to anything else shows the inherent paradox of language. To succeed requires linking to other thoughts
Do not think "x"	Specify a thought not to think and notice that you do
Find something that can't be evaluated	Look around the room and notice that every single thing can be evaluated negatively
Flip cards	Write difficult thoughts on 3 x 5 cards; flip them on the client's lap vs. keep them off
Carry cards	Write difficult thoughts on 3 x 5 cards and carry them with you
Carry your keys	Assign difficult thoughts and experiences to the clients keys. Ask the client to think the thought as a thought each time the keys are handled, and then carry them from there

cup; get off our buts). This set of interventions basically attacks the client's "attachment" to the evaluative functions of reason giving. The fourth level of interventions shifts attention toward the process of thinking, rather than the products of thinking (e.g., thank your mind for that thought; making the mind an "it"; leaves on a stream).

Getting in Contact with the Present Moment: Self as Process

Acceptance and defusion are in the service of "showing up" to the present moment, connecting with one's values, and living. Being present is revealed in qualities of vitality, spontaneity, connection, and creativity. When the therapy drifts into conceptualized content, often heavily evaluative and laden with verbal temporal relations of the past or future, the ACT therapist brings the process back into the present. This tends to undermine avoidance and fusion and grounds the clients experience in a continuing process of awareness of what is occurring now, and now, and now (what RFT has called self-as-process; Barnes-Holmes, Hayes, & Dymond, 2001).

The benefits of this focus are also felt in the therapeutic relationship and in the flexibility of the therapist. Attending to now requires a sensitivity to multiple levels of analysis when dealing with any bit of client behavior: the content of what the client is saying or doing; this as a particular kind of behavior occurring in the moment (e.g., thinking, feeling, remembering, sensing); this as a functional process occurring in the moment (e.g., emotional avoidance); this as an example of behavior outside of session; this as move in the therapeutic relationship occurring in the moment; and this as a general sample of social behavior. It is not possible to avoid content altogether, but by far the more important levels are often those that are outside of the literal story being told. The key therapeutic messages include:

- Life is not something that will be lived when you get rid of your problems—life is going on *now*
- There is as much living in a moment of pain as in a moment of joy
- Would you be willing to notice what is going on within you and between us now
- Thoughts and feelings often present themselves as about the past or future, but they are experienced now and from the point of view of now

Some of the more common behavioral tasks, metaphors and exercises are presented in Table 2.4. Amplifying the ability to notice what is present is a feature of mindfulness, and these exercises can be useful here. Interoceptive exposure, inventorying, and communications of feelings in a relationship are all examples of present focused interventions. There is overlap between self-as-context and self as process, because exercises that involve noticing that which is experienced in the present moment (self-as-process) will also be opportunities to point to the "you" that is noticing (self-as-context).

Table 2.4. ACT Interventions for Increasing Contact with the Present Moment

Intervention	Clinical commentary
Showing up for what is there	What is showing up for you right now? Brings client into the present; often used when affective shifts occur or when no affect is present
How are you feeling about this right now?	Therapy relationship interaction that brings the client into the immediate interaction with therapist relative to some provocative or evocative content
Just noticing exercise	Asks client to simply be aware of any thoughts, feelings, memories or sensations that are present
Mindfulness exercises	Controlled breathing, visualization exercises designed to get the client present; often useful to start sessions
Identifying when getting present is needed	Ask client to identify situations where being absolutely present is needed (i.e., applying first aid)
Tin Can Monster	Bring a feeling into the session and then help client see it in a new context
Experiential seeking	Getting present exercise that asks client to focus on sights, smells, sounds and other sensations in the room
Journaling continuous reactions	Asks client to journal in narrative fashion reactions to daily events, focusing on evocation of thoughts, feelings, memories and sensations
Leaves on a stream exercise	Client asked to notice each private event in an eyes closed exercise and place each event on a leaf floating down a stream; useful for creating simple awareness
Future-Past-Now	Client is asked to pull awareness into the exact moment when dialogue shifts to the past or the future
Practice being human	Try to get present with another person as a human, not an object; notice what you see and experience

Distinguishing the Conceptualized Self from Self-as-Context

Another core process in ACT is to help your client experience the distinction between the content of human private experiences and the context in which those experiences occur. Most clients have difficulty with detachment because they have insufficient skills for contacting an immutable sense of self that is available to us all. This is what ACT describes as "self-as-context." This is the context of simple psychological awareness and it has no boundaries. Self-as-context is the way we speak of the "I" that was and has always been there, has seen everything I have seen, and has been everywhere I have been. If a person cannot reliably make contact with this psychological space, then the products of daily human experience can be very threatening. If there is no distinction between the thought

and thinker, feeling and feeler, then the content of these events will invite struggle. Seen for what they are, just the products of a human history, there is no particular need to struggle. In targeting this process, you will use various metaphors, exercises and behavioral tasks to help the client develop this simple, but elusive awareness. The core therapeutic messages are as follows:

- You are not your thoughts, emotions, memories, roles
- There is a you that is not "thing like" that has been present your whole life
- When something is fearsome, notice who is noticing it
- You are perfectly made to experience your own experience
- The contents of your awareness are not bigger than you; you contain them
- You are a safe place from which you can have experiences for what they are

The various ACT interventions that have been developed to promote self-as-context are listed in Table 2.5. As you will notice, this is where some of the mindfulness and meditation components of ACT appear. Your client needs to make direct experiential contact with this space, so as to appreciate its unique non-verbalizable qualities. When the client is able to discriminate between conceptualized versions of self (the client's life story, self-evaluations, etc.) and the context in which these events occur (I am the person having these thoughts, feelings, evaluations, etc), a major step in building long term psychological flexibility has been achieved.

Values

Of all the attributes that separate humans from other members of the animal kingdom, perhaps none is as important as our ability to conceive a purpose and then behave with regard to that purpose. Clients that are stuck in the trap of emotional control and avoidance slowly lose the "guidance mechanism" that leads to purposeful, enriching patterns of behavior. Their behavior becomes more and more "in the service of" controlling and eliminating unwanted private events or distressing external outcomes. The cost of this agenda over time is embodied in the ACT saying, "Work to control your feelings and lose control of your life." The ultimate goal of ACT is to help the client regain a sense of life direction that is consistent with his or her values and then begin acting in a way that is consistent with those values. In ACT, we are relatively uninterested in helping the client "get in touch with feelings, for feelings sake." There is nothing intrinsically

Table 2.5. ACT Interventions for Promoting Self as Context

Intervention	Clinical commentary
Observer exercise	Notice who is noticing in various domains of experience; brings attention back to self as source of experience
Therapeutic relationship	Model unconditional acceptance of client's experience.
Chessboard metaphor	Shows client that "good" and "bad" private events are just components of consciousness
Furniture in the house metaphor	Pretty and ugly furniture is all contained by and measured against the qualities of the house; shows client that unpleasant or negative content is not "bigger than" the human that has it
Confidence the feeling vs. confidence the action	Take actions that reflect inherent fidelity to self; teaches client that it is not the outcome of an act but the quality of self fidelity that is important
Riding a bicycle	You are always falling off balance, yet you move forward; metaphor for continuous experience of losing and regaining contact with self as context
Experiential centering exercise: Sequential expansion of perspective	Make contact with self-perspective in chair, on ceiling, from roof, from 100 miles up; shows that the same self awareness is present despite shifts in perspective
Practicing unconditional acceptance	Permission to be—accept self as is, as perfectly made and exactly as it should be
The you that you call you	Separates out what changes and what does not in human experience; thoughts, emotions, physical maturity change but consciousness never does
Two computers exercise	Teaches client that sitting back is the only way to contact self as context; up close the content is too threatening to let go
Programming process	Content is always being generated—generate some in session together; notice that there is someone observing this content
Self evaluations are different than the experience of self	Thoughts/feelings about self (even "good" ones) don't substitute for the direct experience of consciousness
Self as object of analysis	Describe the conceptualized self, both "good" and "bad"; shows client how evaluations shift and there is always an evaluator present
Getting back on the horse	Connecting to the fact that they will always move in and out of perspective of self-as-context, in session and out
Contrast observer self with conceptualized self	Pick an identity exercise

life enhancing about wallowing in one's own emotional soup. The reason for teaching clients to detach from "hot" events, to experience such events from the self-as-context, to let go of the struggle for emotional control is that private experiences function as barriers to valued actions. To pursue valued ends in life, the client has to be willing to have all of the negative content that goes along with being human. In this portion of ACT treatment, you will help the client begin to clarify valued life directions that will dignify making undefended contact with psychological barriers. The key therapeutic messages include:

- What do you want your life to stand for? And are you doing that now?
- In a world where you could choose a direction in your life, what would you chose?
- Are you willing to do what needs to be done to move toward valued ends?

Some of the more common behavioral tasks, metaphors and exercises are presented in Table 2.6. Note that in this part of ACT, whenever it occurs, there will normally be a formal attempt at values clarification. The original ACT book presents a values assessment protocol that has stimulated significant development of methods for assessing values and setting specific goals, actions and strategies. One such device is presented in the chapter on ACT in Medical Populations. There are several other values assessment questionnaires under development at the time of this writing, such as the Valued Living Questionnaire (see the Resource Appendix for more information on how to access these tools).

Building Patterns of Committed Action

What makes ACT a quintessentially behavioral treatment is that creative hopelessness, defusion, connecting with self, acceptance, contact with the present moment, and valuing must lead to actual concrete differences in the client's behavior that service those valued ends. The trap the client is in consists of highly elaborate patterns of action that lead nowhere except toward greater and greater emotional and behavioral avoidance. The goal of ACT is to help the client discover the nature of this trap, and to develop methods of dissolving it in the service of living. Eventually, the client has to "vote with his or her feet" or that time has been wasted.

At the same time, engaging in valued actions almost invariably triggers psychological barriers. No one effortlessly glides through life without hitting barriers. The key question asked by life at this point is, "Will you

Table 2.6. ACT Interventions for Values Clarification and Seeking Valued Ends

Intervention	Clinical commentary
Your values are perfect	Point out that values cannot be evaluated, thus your values are not the problem
Tombstone	Have the client write what he/she stands for on his/her tombstone
Eulogy	Have the client hear the eulogies he or she would most like to hear
What do you want your life to stand for?	Values intervention for a specific life dilemma that requires some type of response from the client
Values clarification	List values in all major life domains
Goal clarification	List concrete goals that would instantiate these values
Action specification	List concrete actions that would lead toward these goals
Barrier clarification	List barriers to taking these actions
Taking a stand	Ask client to stand up and declare a value without avoidance; helps promote intention to act
Is what you're doing in life now consistent with what you value?	Highlights discrepancy between current behaviors and valued life ends; can have a motivational impact
Traumatic deflection	What pain would you have to contact to do what you value
Pick a game to play	Define a game as "pretending that where you are not yet is more important than where you are"—define values as choosing the game
Point on the horizon	Picking a point on the horizon is like a value; heading toward the tree is like a goal
What if no one could know?	Imagine no one could know of your achievements: then what would you value?

experience the barrier and keep going, or will you stop?" It isn't so much whether this basic question will surface, but rather in what form, when, and how frequently. This core process often is the culmination of ACT because once patterns of committed action develop, life takes over and the therapist's role is done.

Committed action patterns start small, but part of the goal of this phase of ACT is to show the client how to build larger and larger patterns, so that habits of action serve the clients interests rather than compete with them. Maintaining a commitment for a moment is a start; doing so for a day is an improvement; and for a week is even better. It is not a problem that sometimes slips occur: it is precisely the moment in which barriers to building even larger patterns of committed action can be dissolved. Taking responsibility for the slip, and doing something different with it, allows a

pattern of "commit and slip" (or, far worse, "commit, slip, and quit") to turn into a pattern of committed actions that are broader, longer, deeper, and more elaborated.

So far as we know, there is no finish line to this process. No matter how "big" one gets, there is more "big" to get. Making commitments does not mean a commitment to never fail. Commitment involves living the value in the extended moment. This does not mean that we will not fail: it means that we are not leaving ourselves an out, and when we failed, we take responsibility for it and rejoin the commitment.

In this core process, the major goal is to help the client develop sustainable, value driven behavior patterns that involve approach toward successive moments of now. The key therapeutic messages during this phase are as follows.

- Goals are just a process by which the process can become the goal
- Behaving confidently is different than feeling confident
- You are response-able
- Focus on building larger and larger patterns of effective action
- If you slip, notice the pattern and return to your commitment
- Can you keep moving toward what you value, even when the obstacles surface?

During this phase, ACT makes significant use of a variety of "journey" messages, where the goal is not so much reaching an outcome as it is participating in the process of seeking an outcome. Some of the more common behavioral tasks, metaphors and exercises are presented in Table 2.7. Committed action can start with limited goals and just begin to enlarge upon the client's willingness to act. We are not so much concerned with the magnitude of these acts, as we are with the extent to which they help the client make experiential contact with value driven, approach oriented behavior. In fact, it is safe to predict that, for some clients, taking even a small step in the direction of vitality will immediately produce the same psychological barriers that have stalled the client in bigger venues. For example, the chronically stuck client may struggle with the very possibility of becoming a functional, contributing member of society, because this means the client's "story" will no longer be right. Another client may get frustrated and begin withdrawing when failure occurs with a seemingly straightforward value driven goal. Whatever the blockage, you must keep encouraging the client to "play" and to learn from the process, instead of being obsessed with the outcome. Whatever the client learns from contacting the process is exactly what the client needs to learn to grow as a human being.

Table 2.7. ACT Interventions for Promoting Patterns of Committed Action

Intervention	Clinical commentary
Relationship of goals and process	Committed action starts a process in which the process becomes the goal
Skiing down the mountain metaphor	Down must be more important than up, or you cannot ski; if a helicopter flew you down it would not be skiing; works against tendency of client's to be focused on outcomes of actions
Switchback metaphor	To reach the top of a mountain requires going in directions that seem wrong but in fact are the only way to the top; helps client anticipate barriers to committed action, avoiding misleading evaluations of "progress" toward life goals
Hikers on a path metaphor	On the path up the mountain, you might be convinced you are never going to get there; a person across the valley with binoculars can see you are going in precisely the right direction; teaches client to decrease emphasis on outcome and stick with commitments
Coke vs. 7 Up	Have client choose which one is favorite drink and then ask why, repeatedly to each reason given. Highlights that choosing is an act made with reasons, but not for reasons
Choosing not to choose	You cannot avoid choice because no choice is a choice; helps client appreciate that choosing actions is ever present
Responsibility and blame	You are response-able. That is different from being to blame. Teaches client that self blame has no relationship to being able to behave
Jump from a book or piece of paper	Teaches client that it is not the magnitude of a committed act that matters; it is the quality of committed action that matters; helps avoid setting heroic commitments with a high failure rate
Sticking a pen through your hand	Suppose getting well required this—would you do it; creates expectation that some painful content will have to be accepted to move toward desired life goals
Who would be made right if you got your life back?	Addresses right and wrong issues that some clients have that may lead to self defeating results with committed action
Fishhook Metaphor	Addresses need to release another person the client blames for life difficulties
Foregiveness: To give oneself the grace that came before	Specifies that the act of forgiveness is an act of grace toward self, not a denial of wrong doing
Confronting the little kid	Bring back the client at an earlier age to ask the adult for something
First you win; then you play	Choose to be worthy (because it cannot be "earned" or logically derived) then start with committed action
Taking responsibility for each act (e.g., I am the person that chose to stop drinking, drank on Thursday, then thought "What's the point in stopping, I can't do it" and gave up my commitment")	Linearly compile the client's successes and failures with a commitment in narrative self-description; helps keep client from giving up on a commitment because of a failure or sequence of failures

Even as committed action generates barriers that will require acceptance and defusion it will also generate vitality. One of the stories we create is that there is some accomplishment that will make us feel alive, virtuous and vital. However, it is in our movement, in the present moment, that we find vitality. What this means in practice is that any movement, however small, that is values-consistent will add vitality to our clients. Of course, the client who moves a tiny bit, may stop and reflect on the fact that they could have moved years before or could have moved more. Stalling out in such a reflection is a lapse out of the here and now and into the conceptualized world of "if only." There is no vitality in that world. The only solution is to notice the lack of vitality in that moment of morbid reflection, to rejoin our commitment, and then to notice the vitality in that moment of rejoining.

Competencies of the ACT Therapist

It is difficult to describe the core competencies of the ACT therapist. Why? Because the very space from which ACT originates leads to the development of new behavioral tasks, experiential exercises and metaphors in flight, session by session, moment by moment. This is why describing ACT simply as a finite set of tasks, exercises, metaphors and homework assignments does a disservice to those who are practicing it. If the goal of ACT is to help generate psychological flexibility in the client, then surely it has to involve the modeling of psychological flexibility by the therapist. ACT is more a set of functions or processes than techniques. Nevertheless, with such a rich set of treatment strategies to draw from, it is

silly to insist that technique is unimportant in producing good results. Too many qualified therapists have done too much work already within the set of processes defining ACT for this content to be irrelevant as a set of procedures focused on these processes, particularly by beginning ACT therapists.

In the end, we believe there are ways to differentiate "good" ACT treatment from "bad" ACT treatment. The distinction between good and bad is partly determined by how well the core processes just described are integrated into treatment. That involves knowledge of the core messages contained within each process as well as associated experiential exercises, tasks, metaphors, and out of session tasks. In addition, our experience in training suggests that the posture of the ACT therapist is quite distinctive and is easy to identify in the therapy room. The analogy we would draw is what it takes to be a good skier. There is a certain basic "skiing position" that all good skiers have. Without this position in place, it is impossible to make all of the specific maneuvers that will later be needed on the slope. At the same time, each specific maneuver has its own physical requirements and those must be made as well. Otherwise, the skier will fall at the time that specific maneuver is required. To go one step further, there are an endless number of ways good skiers "individualize" these specific maneuvers to fit their style of skiing. Similarly, the ACT therapist has to have a good basic ACT position, must be able to make specific ACT maneuvers based upon a thorough understanding of the core processes and must be able to individualize these maneuvers to fit the reality of each individual client. In this section, we will describe two sets of interrelated core competencies. One has to do with the general attitude, stance and demeanor of the therapist. The other has to do with understanding the core processes and delivering interventions that support those processes.

Core Competencies Involved in the Basic ACT Therapeutic Stance

The basic psychological stance of the ACT therapist is an especially important factor in providing good treatment. This involves being able to make contact with the "space" from which ACT naturally flows, as well as modeling certain facets of psychological flexibility that we seek to impart to the client. Like many treatment traditions, ACT emphasizes the importance of therapist warmth and genuineness. This stance emerges quite naturally from the core understanding of human suffering from an ACT perspective. When we see our clients trapped by language, we see

ourselves and the traps which generate our own pain. An "I and thou" perspective is the natural precipitant of this recognition. Collectively, the following attributes define that basic therapeutic stance of ACT.

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

Core Competencies for ACT Core Processes and Therapeutic Interventions

Once in the correct therapeutic posture, the ACT therapist must demonstrate competency in understanding the core processes and be technically facile in selecting and implementing interventions such as experiential exercises, metaphors, paradox, behavioral tasks and selecting home based practice. The key thing to remember in conducting ACT is that

simply applying these techniques in a vacuum is not consistent with good ACT practice. The techniques must "fit" with the contextual properties of the therapeutic interaction. For various areas of core competency, we will cite some typical ACT intervention strategies. At the same time, we encourage you to generate your own innovative exercises, metaphors, and tasks, particularly if they originate from the language system and experiential context of your client.

Developing Acceptance and Willingness/Undermining Experiential Control

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

(e.g., uses appropriate self-disclosure; brings difficult reactions to in session content into the room)

Undermining Cognitive Fusion

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

Getting in Contact with the Present Moment

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

Distinguishing the Conceptualized Self from Self-as-Context

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

Defining Valued Directions

- Therapist can help clients clarify valued life directions (values questionnaire, value clarification exercise, what do you want your life to stand for, funeral exercise)
- Therapist helps client "go on record" as standing for valued life ends
- Therapist states his or her own values that are relevant to therapy and models their importance
- Therapist teaches client to distinguish between values and goals
- Therapist helps client distinguish between deciding and choosing and applies this to values
- Therapist distinguishes between outcomes achieved and involvement in the process of living
- Therapist accepts the client's values and, if unwilling to work with them, refers the client on to another provider or community resource

Building Patterns of Committed Action

- Therapist helps client identify value-based goals and build a concrete action plan
- Therapist encourages client to make and keep commitments in the presence of perceived barriers (e.g., fear of failure; traumatic memories; sadness; being right) and to expect additional ones as as a consequence of engaging in committed actions

- Therapist helps client appreciate the qualities of committed action (e.g., vitality, sense of growth)
- Therapist helps client develop larger and larger patterns of effective action
- Therapist non-judgmentally helps client integrate slips or relapses into the process of keeping commitments and building larger patterns of effective action

Improving Your Skills as an ACT Therapist

There are many potential ways a therapist can improve skillfulness in integrating the basic ACT posture and improving technical skill in the application of the core processes. We have found that the following training strategies help cement "fluency" with core ACT concepts. Fluency is the ability to apply ACT concepts "on the fly," adapting strategies to the reality of the client, the language style of the client, and so forth. Any of these training experiences is better than no training experience and, similarly, the more of these training experiences you participate in, the more likely it is you will improve your skills as an ACT therapist. For ways of accomplishing the experiences listed below, consult the Resource Appendix at the end of the volume.

- Read both the original ACT treatment manual and this clinical handbook thoroughly (this will help you learn the basic tenets of the ACT model and its applications, less helpful with contacting the ACT space).
- Attend one or more ACT training workshops led by competent trainers (Basic exposure to the ACT space and ACT techniques).
- Attend an ACT intensive retreat (More intensive experiential contact with ACT space; will help you learn specific ACT techniques).
- Attend a mindfulness/meditation retreat or workshop (good for contacting the ACT "space," less useful with ACT techniques).
- Read ACT research literature.
- Attend conventions where ACT and RFT studies will be presented, and discuss them with presenters (common conventions in the United States are the Association for Advancement of Behavior Therapy and the Association for Behavior Analysis; for other conventions see the ACT website).
- Look at as many protocols as possible—even when the particular application is not one you work with. Looking at many applications will give you new ideas for your own applications and will help you

to see the principles at work independent of the particular presenting complaint.

- Read ACT transcripts, out loud, trying to get a feel for the normal flow of ACT interventions (to access these transcripts, go to the ACT website, mentioned last chapter. See also the list of other resources in the Resource Appendix).
- Join the ACT (and perhaps also the RFT) list serve (see ACT and RFT websites) and discuss questions you have there.
- Submit video tapes to an ACT center of excellence (good for getting feedback on your therapeutic posture and application of techniques; see appendix for the addresses of such centers and contact persons).
- Arrange clinical consultations with an experienced ACT therapist (Good for periodic feedback about both interventions; some help in the integration of the ACT posture).
- Arrange for extended supervision of your practice by an experienced ACT therapist (Best way to really learn both the ACT posture and become "fluent" in the application of techniques).
- Learn more about Relational Frame Theory, functional contextualism, and behavioral principles.
- Organize a discussion group/reading group/peer supervision group of professionals in your area interested in ACT.
- Talk about the group activities on the ACT online discussion group to find out things other groups have done.
- Use the list above of *Core Competencies for ACT Core Processes* and self-evaluate the degree to which you can engage in each skill. Self-identified areas of weakness can then become a focus in seeking additional training (for an instrument to use for this purpose see the ACT website).

Conclusion

These general ACT processes are not implemented in the abstract: they are implemented with real people struggling with real problems. In the chapters that follow we consider some of the kinds of problems people come into therapy wanting help for and will show the applicability of ACT to these problems. In so doing we are not buying into syndromal thinking: these groups of problems are simply guides to the general issues that emerge in real clinical practice with ACT.

Chapter 3

ACT Case Formulation

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Because ACT is a contextual treatment, your attempts to conceptualize a presenting problem might be different from traditional case conceptualization models. The most important principle in contextual analysis is that you are not just assessing a particular symptom with a particular topography; you are also attempting to understand the functional impact of the presenting complaint. The same clinical complaint can function in dramatically different ways for clients. Thus, your case conceptualization and associated treatment plan may differ for clients with seemingly similar problems. For example, many patients are diagnosed with major depression, single episode (a categorical formulation) based on the number and severity of symptoms described by the patient (a topographical assessment). In clinical practice however, it is fair to say that no two depressed patients are alike. Each is unique in how their life space is organized, how depression affects their functioning (and vice versa) and how depressive beliefs and behaviors define the individual's sense of self and external world.

Understanding function in this way requires a focus on the learning history of the client as well as the current context in which events happen. An ACT therapist might be interested in a client's history of early childhood trauma, but in a way that differs slightly from more traditional approaches. The traditional conceptualization might use the trauma directly to explain current dysfunction. An ACT formulation would consider how this history might alter specific functional processes within the ACT model. For example, trauma might lead to a higher likelihood of emotional avoidance, since intensely negative experiences would set the stage for the use

of avoidance-based coping. If the trauma is sufficiently intense and occurs before deictic frames fully establish a sense of self-as-context through the "I-here-now" fames, this sense of self might itself be undermined as a method of emotional avoidance (as might be seen in, for example, dissociative disorders). The trauma might lead to fusion with crucial thoughts, such as "the world is unsafe" or "I deserved to be abused." The contextual viewpoint emphasizes the dynamic and interactive nature of all of these processes, considered at any single point in time. The client will bring a multitudinous learning history into the present that includes trauma but includes many other specific helpful and hurtful processes as well. How this history is functionally organized will alter how the client interacts with situational variables in a way that either promotes or defeats the client's best interests.

The ACT case conceptualization framework is unique in that it is specified how various processes may relate to psychological flexibility. Psychological flexibility involves the ability to defuse from provocative or evocative private content, accept private experience for what it is, stay in touch with the present moment, differentiate a transcendent self from the contents of consciousness, make contact with valued life ends and build patterns of committed action in pursuit of those ends. When psychological flexibility is present, the contingencies tend to shape behavioral effectiveness and individuals tend to move through life in a way that promotes vitality, purpose and meaning. In a contrasting sense, individuals tend to present for professional help when they are struggling in one or more of the six basic areas that define flexibility. This very simple principle has an important implication: you should assess for factors that promote psychological flexibility and factors that detract from it and consider the unique configuration of these promoting and detracting factors. Naming the form that suffering takes (depression, anxiety, addiction) is not as important in ACT as understanding how deficits in the various domains of psychological flexibility are contributing to the client's suffering. Similarly, the interventions you select will typically be designed to help promote more effective functioning in one or more of these domains, while being less focused on the elimination of pain per se.

While each client presents with a unique learning history, contemporary context and presenting problem, conducting an ACT case conceptualization generally involves five distinct activities:

1. Analyze the scope and nature of the presenting problem
2. Assess factors affecting the client's level of motivation for change
3. Analyze the factors that detract from the client's psychological flexibility

4. Assess factors that are promoting psychological flexibility
5. Develop a treatment goal and associated set of interventions

Table 3.1 presents a simple case formulation matrix that you might use to guide this process.

Analyze the Scope and Nature of the Problem

Your assessment should begin with an analysis of the presenting problem as formulated by the client, often leading to a reformulation in ACT consistent terms. In Table 3.1, we have identified a simple, core set of questions that will help you conduct an ACT consistent analysis of the presenting problem. A full functional analysis of client problems may go beyond these ACT-related factors, so we do not mean for the assessment and formulation of ACT-relevant processes to substitute for general clinical assessment, assessment of physical health, neurological assessment, assessment of family functioning, and similar factors. There are also cases in which ACT-relevant factors are not central. For example, a pure skills acquisition issue, if it entails no issues of experiential avoidance, cognitive fusion, or values, will not be usefully addressed by ACT formulations. As is being shown in ACT clinical trials, however, it is surprising how frequently ACT-specified factors are central to clinical difficulties.

Normally, your client will nominate a set of negative private events (negative feelings, thoughts, memories, sensations, physical symptoms, and so on) as the "problem." In the current nosology, clinical disorders are generally defined by the content of such complaints (depression, anxiety, hallucinations, and so on). While the form of the complaint will define the disorder in the usual taxonomy, it is the functions that the presenting problems reflect that will define the true disorder from an ACT perspective.

Generally clients will have this goal for therapy: If we can eliminate one or more of these private events, then my life would change in a positive direction. A client with an "anxiety disorder," for example, will usually come into therapy wanting to reduce or eliminate anxiety. If the clinician asks more about what would change if this were to happen, positive life goals tend to be stated such as: "Well, I would be able to travel" (or "I would be able to keep a job," or "I would be able to have relationships"). Answers such as this have rich meaning in an ACT model. They indicate that negative private content (e.g., symptoms of anxiety) is functioning as a barrier. They suggest that experiential avoidance (e.g., the attempts to get rid of the anxiety) and cognitive fusion (e.g., fusion with verbal formulations about how to live more positively, such as, "first feel better,

Table 3.1. A Simple ACT Case Formulation Matrix

Sources of Psychological Flexibility	Presenting Problem Analysis (Core Questions)	Analysis of Motivational Factors	Factors Contributing to Psychological Inflexibility	Factors Contributing to Psychological Flexibility	Treatment Implications
Acceptance	What private experiences (thoughts, feelings, memories, sensations) is the client unwilling to have? What patterns of avoidance are in place? Can the client "make room" for experience in an undefended, non-judgmental way?				
Defusion	Is the client overly attached to beliefs, expectations, right-wrong, good-bad evaluations of experience? Does the client confuse evaluations and experience?				
Contact with the Present Moment	Does the client exhibit ongoing, fluid tracking of immediate experience? Does the client find ways to "check out" or get off into their head? Does client seem pre-occupied with past or future or engage in lifeless story telling?				
Self as Context	Can client see a distinction between provocative and evocative content and self? Is client's identity defined in simplistic, judgmental terms (even if positive), by problematic content or a particular life story?				
Contact with Values	Can client describe personal values across a range of domains? Does client see a discrepancy between current behaviors and values? Does client describe tightly held but unexamined goals (e.g., making money) as if they are values?				
Patterns of Committed Action	Is client engaged in actions that promote successful working? Does patient exhibit specific, step by step pattern of action? Can client change course when actions are not working? Are there chronic self control problems such as impulsivity, and self defeating actions?				

then live better") may have a role in the rigid focus on unworkable solutions that chronic difficulties usually entail. They also suggest certain possible values (wanting to participate in the world, to have relationships, to make a contribution). These might both be a source of healthy pain (the pain of not living a life is often much greater than the pain of unwanted private events) and an ally in clinical change.

Superficially, ACT treatment targets are different than the client's presenting problem. Instead of "eliminating anxiety so that I can start to live" (the client's view of the presenting problem) you may eventually reformulate "the problem" in other ways (e.g., "warring with anxiety" or more specifically "not getting on about the business of living while needlessly warring with anxiety"). At a deeper level such reformulations must be consistent with the client's true goals. The therapeutic contract and consent to a treatment plan is no mere formality that for reason. We will address this issue later in this chapter.

From a contextual perspective, your interest as the therapist is to look beneath the presenting problem considered formally and to detect the functional processes that are interfering with living a more satisfying life. From an ACT perspective usually the two most important initial questions are 1) What private experiences is the client attempting to avoid? 2) What avoidance behaviors are being used and how pervasive are they? This perspective is perhaps obvious with problems like anxiety or depression, but it is important to look beneath even those complaints that look like straightforward values or even skills development issues. For example, suppose a client says his problem is "I have not been able to build meaningful intimate relationships in my life." You might ask: "If a miracle happened and this problem was totally solved, how would your life be different?" The client might answer: "Well, I would have a committed relationship. I might eventually get married and have a family." This answer would indicate that the client is speaking of a legitimate life goal that is not heavily encrusted with emotional avoidance. Contrast this with a different answer to the same question: "Well, I would feel a lot better about myself and this horrible loneliness would go away." In this case the client may have been using "relationships" to help avoid making contact with negative self-evaluations or a sense of loneliness or alienation. Further exploration might reveal that this very agenda has been part of why past relationships have not worked well. The client's view of the problem is that building relationships needs to be the focus, but they are being used as a process, not as a legitimate outcome in their own right. The ACT therapist may see emotional avoidance as the issue.

Another common occurrence is one in which a "presenting problem" functions to promote experiential avoidance of a more basic and even more threatening problem. For example, a person may present with "anxiety"

but the target may eventually be avoidance of anger, or a person may present with "depression" but the target may eventually be a failure to contact and act on core relationship and self-care values (e.g., as reflected in a failure to leave an irretrievably abusive and violent relationship).

For these reasons, you should avoid buying into or challenging the initial formulation presented by the client. Take an open, data gathering stance in which you assess the client's learning history, current situational triggers, the domains of avoided private events and specific behavior avoidance patterns.

Motivation

Initially, it is not only important to understand the scope and nature of the presenting problem, but also the extent to which the client is in touch with the costs of unworkable patterns of behavior. In the ACT assessment sequence, motivation is contingent upon whether the client is sufficiently open to the view that current behavior patterns are not working to consider suspending them and trying out alternatives.

There are a variety of factors that can negatively impact the client's motivation, even in the presence of significant psychological suffering. In the case formulation matrix presented in 3.1, we would encourage you to form an assessment of factors that might promote or decrease the client's motivation to change. Note that many motivational barriers may be present in more than one domain of psychological flexibility. So, for example, a suicidal patient might insist that thinking about suicide "works" to relieve pent up emotional distress, as does avoidance of situations involving the potential for interpersonal rejection. The patient also presents a "rationale" based on personal history for why changing this pattern of behavior will never work. In terms of motivational barriers, there is the pay off for not accepting unwanted private experiences (the Acceptance Domain) and a set of closely held reasons for why this pattern cannot change (the Defusion Domain). As we have stressed repeatedly in the first two chapters, the domains of psychological flexibility exist in a reciprocal, interactive relationship. If you start an intervention in one area, it will ordinarily "pull" content from other areas. Hence, you are not necessarily in a situation where you have to pick the "right" intervention for the "right" domain. The assessment of motivational factors just gives you a "snapshot" of the important treatment factor and, usually, you will pick one or more ACT interventions to counter-act these negative forces.

Some of the more common motivational barriers are listed below, along with a brief suggestion for how to address them clinically.

- *Client's history of rule following and being right.* If this is an issue, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to the conceptualized self.
- *High level of conviction or behavioral entanglement with unworkable strategies.* This is usually seen as an insistence on doing the same thing even though the client admits it doesn't seem to work. If this is an issue, consider the need to undermine the improperly targeted change agenda, using creative hopelessness interventions.
- *Belief that change is not possible combined with a strong attachment to a story that promotes this conclusion.* This is often seen in chronically distressed clients or clients with history of repeated trauma. If this is an issue, consider using defusion strategies, especially attacking the attachment to the story; revisit the cost of not trying in terms of valued life goals; arrange behavioral experiments to test whether even small changes can occur.
- *Fear of the consequences of change.* This is often seen in clients that are hiding in unsatisfying relationships or jobs for fear of the unknown. If this is an issue, consider working on values clarification and teaching qualities of committed action, choice and decision; work on acceptance of feared experiences under conditions of change.
- *Domination of a rigid, content-focused self-identity in which changing would pose a threat to a dearly held set of self beliefs.* This is often seen in "therapy wise" clients or clients with a history of treatment failure. If this is an issue, consider undermining the story using various defusion strategies such as the autobiography rewrite; consider values work to get the client to make contact with the "cost" of holding to the story.
- *Domination of the conceptualized past or future.* This is often seen in clients complaining of excessive worry, regret, or anticipatory fear that functions to block effective behavior. If this is an issue, consider self-as-process and self-as-context work, including "just noticing" interventions, and experiential exercises to help make contact with the moment. Link this to defusion work so that temporal thoughts can be caught and observed without belief or disagreement.
- *Short term effect of ultimately unworkable change strategies is evaluated as positive.* This is often seen in addictive behaviors, chronic suicidality, or chronic pain. If this is an issue, consider values clarification and creative hopelessness work tied to what have you tried, asking how has it worked, what has it cost you?

- *Social support for avoidance and fusion.* This is often seen in trauma victims, "disabled" clients of all kinds and may involve relationships, family, and financial or institutional reinforcement. If this is an issue, early values clarification work can be used to highlight the cost of not changing.

Factors Contributing to Psychological Inflexibility

The next step in ACT case formulation is to assess the factors that are contributing to psychological inflexibility. You will probably already be developing hypotheses about this area just based upon your assessment of motivational determinants. These same determinants will often "cross over" to other columns in the case conceptualization matrix (indeed, one reason we did not try to fill out many of the columns in Table 3.1 is that the same questions and issues can appear in many cells). Generally, you will want to assess the nature, strength, and contextual control over of various forms of psychological inflexibility and establish any important interrelationships. Assessment areas may include:

- General level of experiential avoidance (e.g., core unacceptable emotions, thoughts, memories, bodily sensations; low levels of intimacy)
- Level of overt behavioral avoidance displayed (e.g., what parts of life has the client dropped out of, what activities/pursuits are not occurring that would occur if the problem were solved)
- General levels of poor persistence and self-control problems that might be behavioral indicators of avoidance (e.g., procrastination, under performing, poor health behaviors, impulsive behavior)
- Level of internally based emotional control strategies (e.g., negative distraction, negative self instruction, excessive self monitoring, dissociation)
- Level of behaviorally focused emotional control strategies (e.g., drinking, drug taking, smoking, self-mutilation, suicide attempting, over eating)
- Weak life direction (e.g., general lack of values; lack of effective involvement in work, intimate relationships, family, friends, exercise/nutrition, hobbies, recreation and leisure, spiritual practice; important goals that the patient has "checked out" of due to emotional avoidance or fusion)
- Fusion with evaluating thoughts and conceptual categories (e.g., domination of "right and wrong" even when that is harmful; high levels of reason-giving; overuse of "insight" and "understanding," self-loathing, comparisons with or critical attitudes towards others)

As you conduct your assessments over time, we would encourage you to profile findings within the rows of the case conceptualization matrix presented in Table 3.1. This will make it easier for you to select target areas that might result in greater clinical impact. In addition, changes in the case conceptualization matrix over time can give you a good read on how the various sources of inflexibility are interacting.

Since ACT emphasizes that these sources of psychological inflexibility are common for clients, it is easy to stop once you have detected one or two good examples. It is worthwhile to take the time to address each area with as much detail as time permits, because you are trying to understand the person in context. Creating this "snapshot" will provide you with valuable clinical information both about the pervasiveness of ACT-relevant processes and how the client conceptualizes these problems. For example, the client may have frequent conflicts at work. Suppose you see readily that part of this is due to the client's avoidant coping styles. The client may be afraid of addressing and resolving work related problems in an open and healthy way because of the emotional reactions that process will produce. Seeing this clearly, you may forget to ask whether there is also a connection between this problem and the domination of "right and wrong" thinking. That could be a big mistake since successfully targeting acceptance of the emotional reactions to openly resolving work related problems could then open up work relationships to attempts by the client to make others see the wrongness of their views—perhaps causing more severe work conflicts. The early stages of therapy may not be the time to address these difficulties with an intervention, but if you know the lay of the land you can formulate your ideas about what might lead to what and design intervention accordingly.

Factors Contributing to Psychological Flexibility

Nearly all clients bring into therapy an array of strengths that will help promote greater psychological flexibility. Most clients have had some level of contact (however briefly and infrequently) with acceptance, letting go of disturbing private experiences, moments of being in the present, standing up for a value, or engaging in a committed act. It is important to be aware of these factors and their potential for offsetting factors that detract from psychological flexibility. For example, some clients have exposure to both mindfulness and acceptance concepts based upon previous spiritual practice or participation in one of the many human potential programs. If these experiences have been positive for your client, this might be a strength you want to build upon. The client already knows something of the concept and it may be easier to select interventions that capitalize upon

this. Conversely, if previous experience is problematic—such as confusing spirituality with dogma, or using mindfulness meditation as a means of experiential avoidance—you will need to be especially cautious or your interventions will be harnessed to unhelpful processes. For example, when you address self-as-context and mindfulness skills, you will have to find ways to distinguish what you are saying from what the client has used these tactics for in previous life situations.

It is also important to assess the skills your client possesses that can promote effective working in the external world. Does your client articulate a set of values that you can mobilize to help drive a behavior change plan? Does your client possess special educational, social or vocational skills that you can activate in the pursuit of making life work better? Consider whether your client possesses the skills to build an effective plan of value-based committed action. If these skills need to be developed further, you might target skills training directly in such areas as interpersonal effectiveness, time and stress management, personal problem solving, relaxation and recreation, or conflict resolution.

In general, we tend to look for certain types of psychological assets that, if mobilized properly, can "jump start" the patient toward more effective living. These might include:

- Prior positive experience with mindfulness, spiritual practice or human potential concepts
- Episodes in life where "letting go" of urges, self defeating thoughts, uncontrollable feelings led to greater personal efficacy (i.e., Alcoholics Anonymous, smoking cessation, getting through a death)
- Moments in life when the client felt intensely present and in contact with life, even if the experience involved negative affect
- Prior experiences where laughing at oneself, seeing the irony or humor in a situation seemed to decrease the gravity associated with it
- Times in the past when the client took a course of action that was painful but was consistent with their values
- Prior experiences with setting personal goals, taking step by step concrete steps to achieve them
- Prior experiences with starting in one life direction and ending up going in another more positive direction

Select a Set of Treatment Goals and Associated Interventions

The two main outputs of the case conceptualization process are: 1) A set of treatment goals mutually agreed to by you and your client, and

2) A set of interventions that you intend to use to achieve those goals. This requires you to eventually discuss your impression of the "presenting problem" with the client and to get the client's informed consent to proceed with a course of treatment designed to achieve those goals. Some ways to talk about ACT as treatment model in the pursuit of achieving informed consent are presented in the first ACT book (Hayes, Strosahl & Wilson, 1999).

The process of establishing mutually agreed upon treatment goals is complicated by the fact that an ACT conceptualization of the "problem" can and often is very different from the client's conception of the problem. For example, a therapist attending an ACT workshop recently asked, "how can I do ACT in an anxiety disorders clinic? People come to us to get rid of anxiety. It is not my place to challenge that goal."

It is helpful to distinguish outcome goals (the ultimate ends therapy should produce) and process goals (the means that will produce those ultimate ends). In our clinical nosology and in our culture more generally we have deeply confused the two, so it is not surprising that clients do likewise. The ultimate outcome goals are up to the client (though of course clinicians are free to decline to work for goals that they view as unethical). As noted earlier, if a client does not justify a goal by an appeal to yet another goal, it is probably an outcome goal. Process goals, however, are in large part a scientific and professional matter. Knowing *how* to produce ends is part of what the clinician must do for the client. Clients do not usually know, for example, that emotional avoidance is horrifically ineffective, and thus that it might be relatively unhelpful to ask clinicians to enter into a therapeutic agreement to "get rid of anxiety."

Clients have both outcome goals (the lives they want to live) and process goals (how they might get there). Almost always clients have been unsuccessfully seeking specific process goals before coming into therapy. Despite that failure, they will generally ask you to help them do more of the same in therapy (itself a reflection of a kind of psychological rigidity). It is not required that clinicians agree to this plan, and generally ACT treatment goals do not.

The following analogy highlights the distinction between process complaints masquerading as treatment goals and true outcome goals. Suppose a person calls a plumber because there is water on the floor. When the plumber arrives the homeowner insists that in order to stop the water leak the plumber needs to work on a natural gas pipe located behind a cabinet. In this case, both the plumber and the person calling for help hold the same outcome goal (stopping the water leak). Despite that commonality of purpose a responsible plumber will decline to do what the consumer asks precisely because working on a gas line will not stop the leak and it would

be both dangerous and a waste of time and money to open up a natural gas line. It should not be assumed that the consumer has the skills to diagnose the problem or to understand how to correct it: that is probably part of why a plumber was called in the first place. The plumber might explain that this pipe does not hold water (perhaps because it is black, not galvanized; or it goes to the stove, not the sink), and may provide an alternative process account (e.g., the leak is coming from a hole in the hot water heater). If the consumer insists on the plumber opening up a live gas line anyway, the plumber should probably decline to assist in this risky and useless course of action.

Clinicians are in this exact situation all the time. Quite often, the client is interested in achieving a process goal that is shaped by cultural forces (e.g., "feel goodism") but may not serve the client's long term interests. In this case, you may need to initiate a discussion about this type of psychological "plumbing problem" and how it can be fixed. In our experience, in the vast majority of cases what clients *really* want is to live a satisfying and effective human life, and they are encouraged to hear that there may be a more direct path to that goal that can begin now.

A feature of ACT is the huge variety of clinical interventions that are available to you the therapist and the relatively tight link between these interventions and the functional model that is at the core of this work. We have covered some of these interventions in the preceding chapter and we placed it in an unusual position (before the assessment chapter) because we thought it would help to have these in mind as you consider the case formulation processes that lead to their selection. When you have identified legitimate treatment goals in partnership with the client, we would encourage you to select interventions for the domains of psychological flexibility that you will target and record in the case conceptualization matrix. Just for the sake of demonstration, we have listed a variety of typical intervention goals below and a characteristic reason or two that they might be selected:

1. Generate creative hopelessness (client has not faced the unworkable nature of the current agenda)
2. Understand that emotional control is the problem (client does not understand experientially the paradoxical effects of control)
3. Experiential exposure to the non-toxic nature of private events through acceptance and defusion (client is afraid to change behavior because of beliefs about the consequences of facing feared events)
4. Generate experiences of self-as-context to facilitate experiencing of feared events in the present moment (client is unable to separate self from reactions, memories, unpleasant thoughts; client needs safe place from which to engage in exposure)
5. Make contact with the present moment/mindfulness (client lives in conceptualized future, e.g., worry; client is not contacting reinforcements already present in the environment)
6. Values exploration (client does not have a substantial set of stated values or is out of contact with their values)
7. Engage in committed action based on chosen values (client needs help to rediscover a value based way of living; client's behavior is not generally productive or well-directed and client could use help in maintaining consistency of life direction; client has little motivation to engage in exposure)

ACT Specific Measurement Tools

Multiple methods of assessment may be useful to help with the case formulation as well as to determine response to treatment in a standardized way. It is important that you define the mutually agreed upon "outcomes" of treatment, then select a reliable, quantifiable way to measure achievement of these goals. In addition to your case conceptualization interview, the administration of standardized assessment tools may be useful. This could involve generic outcome and/or process measures or more specific ACT-relevant measures. One caution in using generic outcome measures such as symptom inventories is that they usually measure symptom form (number; severity) but not symptoms function (believability; psychological impact). Furthermore, often these symptoms are private events that are thought to be related to outcomes (which may be true in a typical context, but not necessarily in the kind of extraordinary contexts ACT helps establish). Very commonly, there is no measure of actual overt outcomes. For example, anxiety presence will be measured while neither the function of anxiety nor the overall level of life functioning will be addressed. In essence, this is the professional version of the "plumbing problem" above, in which the field itself insists on measuring gas lines instead of water leaks. This can create a misleading impression about treatment response. For example, in one study of ACT with hospitalized psychotic patients, the ACT intervention produced a *smaller* reduction in the number of patients admitting to hallucinations and delusions among psychotic patients than usual hospital treatment (Bach & Hayes, 2002). However, ACT patients were 50% less likely to be re-hospitalized than patients treated as usual, they reported their symptoms as being significantly less believable than patients treated with usual care, and rehospitalization was particularly low for those admitting to symptoms in the ACT condition but

not in the treatment as usual condition. In essence, symptoms functioned completely differently in ACT (presence and believability in essence were measures of acceptance and defusion and were both positively related to overt behavioral outcomes), but if believability of symptoms and rehospitalization measures were unavailable it would have looked as though ACT was less effective and treatment as usual based purely on symptom occurrence.

In general, the best ACT process measures seem to focus on measuring client perceptions of the literal believability (that is, are they what they say they are) of clinical symptoms, and the degree of willingness to experience them while continuing to behave effectively. These kinds of cognitive fusion and acceptance measures have regularly been empirically linked to positive clinical outcomes in ACT. Measures of this kind are not difficult to construct. For example, patient diaries for those suffering with particular disorders can be used to gather lists of thoughts, feelings, bodily sensations, and the like that are linked to ineffective actions in particular domains. The ACT approach asks second order questions about these events. Instead of rating their frequency, clients will rate their believability when they do occur, or the willingness to experience these events and still behave effectively. There will soon be many measures of this kind.

There are also generic ACT measures. The Acceptance and Action Questionnaire (AAQ; Hayes, Strosahl, Wilson, Bissett et al., in press) seems to measure factors related to acceptance and committed action. The initial validation study yielded both a 9 and 16 item version of the instrument. A second validation study (Bond & Bunce, 2003) led to a slightly different 16 item version.

In population-based studies, the AAQ seems to work well as a measure of acceptance, and several studies have used the instrument successfully to show the role of experiential avoidance in stress, trauma, anxiety, depression and the like (e.g., Marx & Sloan, in press). In general, either of the AAQ-16 versions work better as a process measure than the 9-item version. An AAQ-2 is currently under development that is designed to tap into the broader concept of psychological flexibility.

Values assessments are also under development (Wilson & Murrell, in press). It is not yet clear if this will also function as a mediator of clinical response. No specific measures of self-as-context or contact with the present moment are available, but a number of mindfulness measures now exist that seem to tap into these domains.

Developing measures of second order change processes is a very rapidly developing area of ACT work, and the best way to keep up on current developments is through the world wide community of ACT practitioners and researchers. They can be accessed through several

means listed in the resource appendix, but they especially include the ACT and RFT websites (www.acceptanceandcommitmenttherapy.com and www.relationalframetheory.com) which provide materials of this kind. Sections in these websites are devoted to assessment, intervention innovation, protocols, training, email list serves, and other issues of relevance to any practitioner interested in ACT and its underlying theory.