Chapter 4
Setting the Context for Therapy

Refined version to appear in Spanish in

Wilson, K. G. & Luciano, C. (2002). **Terapia de Aceptión y Compromiso: Un Tratamiento Conductual Centrado en los Valores.** (Acceptance and Commitment Therapy: A Values-Centered Behavioral Treatment.) Madrid: Editorial Pirámide.

5-16-02
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Establishing the Therapeutic Relationship

ACT is a densely interpersonal therapy. We say this, because ACT involves two features that are core components of interpersonal intimacy. One is vulnerability and the other is values. If you think about your most intimate relationships, you will probably find that these are at the center of them. The people with whom we are most intimate understand our fears and our hopes. When clients come to treatment, they tell us a bit about what they are afraid of. In the process of doing ACT we will be asking clients what they hope for.

The therapist has a responsibility to set the context of treatment at its outset. One feature of that context is to set the emotional tone of the treatment. Many therapists have been trained in traditions that insist on therapist opacity and distance. The reasoning behind this varies, but typically in the behavior therapy movement it has been proposed as a way to retain a "scientific" and "objective" perspective. Presumably this objectivity allows the therapist to understand the problems the client has in a way that leads to more effective interventions. However, again and again, in the scientific literature on factors that predict good therapeutic outcomes, therapeutic relationship emerges as a key element of successful therapy.

At the outset of treatment, the therapist has an opportunity to "say" what treatment will be about. What treatment will be about is said both in words and in action. Embedded in all of these introductory strategies are expressions of the therapist's values.

Power, competence, and the therapeutic relationship. Our culture has embraced a medical model in the treatment of psychological problems. Within this

model, the client comes to treatment assuming that they are "broken" in some important fashion and that the therapist is whole and competent. A power difference exists whether we want it to be so or not. This power difference can play out in ways that slow the progress of treatment. The client can play the one-down role in several somewhat destructive ways. They may play the compliant incompetent. In adopting the role of the competent provider, we run the risk of further reinforcing incompetence. Sometimes the larger and more competent the therapist appears, the smaller and less competent the client becomes. If improvements are not forthcoming the client may believe that they are even more hopeless than they thought when they entered treatment. "I can't even be fixed by the big strong therapist." The client may adopt the story that they are different, and that individuals of their type are beyond help. If therapy becomes difficult, the client may feel victimized by the therapist. The theory of psychopathology that underlies ACT is contrary to such whole/broken, strong/weak, well/ill, competent/incompetent dichotomies.

From an ACT perspective, much of what humans suffer from exists on a continuum, and the underlying pathological process is shared by every verbally-competent human being. The psychologically healthiest person on the planet suffers from some of the same "stuckness" that the client suffers. Much of what follows will level the relationship between therapist and client. There are a number of metaphors that can carry the various qualities of the relationship. In order to emphasize the similarity between therapist and client, we can use the two mountain climbers metaphor.

It is as if we are two mountain climbers. Each on our won mountain across a valley from one another. I may be able to see a path up your mountain, not because I have climbed your mountain, not because I am at the top shouting down to you, but because I am standing in a place where I can see things that cannot be seen when you are on that mountain. This is your therapy, but if it were mine, well….I have my own mountain to climb, and you might be able to say something helpful about the path I am taking up the mountain. My advantage here is not that I am bigger, better, or stronger. It is simply an advantage of perspective. On the other hand, there are things about your mountain that I cannot tell, that I will have to rely on you to tell me. For example, whether the mountain you are trying to climb is the "right" mountain or not is a matter of values. Only you can tell me that. Also, although I may be able to coach you along some path that I see, I cannot climb for you. You really have the more difficult job.

Physical and psychological posture in treatment. There are many schools of thought on the quality of interaction in psychotherapy. In classical psychoanalysis, the client did not even look at the therapist directly. In some behavioral interventions therapy takes on an entirely didactic quality—often complete with homework. The ACT therapist uses the interpersonal space with flexibility as a key therapeutic tool. During this phase of treatment, the therapist ought to be facing the client. They should be seated relatively close to the client. The therapist should listen as if the client was just about to reveal the keys to successful treatment. They will. At the beginning of treatment, the client knows something, without which you cannot treat effectively. They know their own experience. First, they know how they have suffered. They know how hard and how long they have tried. And second, they have some sense of a direction they want to take in their lives—what they value. Without this information, you will not know them and you will be unable to help them. When the client leaves the therapy session, it

should be entirely clear that their experience, their story, was the single most important thing in that therapy room.

Help me to understand your experience. The first thing we tell clients is "I need you to help me to understand your experience. If I am to be useful to you, I need to have some sense of what it has been like to be in your skin. I can't experience your experience directly, so my understanding will be imperfect. However, I need for you to do your best to transmit the details of your struggle.

State your values explicitly. When we say that the therapist should express their values explicitly, we don't mean their religious or political beliefs. We mean their values as they relate to the therapeutic context. There are several values implicit in ACT and we believe that it is worthwhile making them explicit:

Therapies are always laden with values. Sometimes the behavior therapy movement has tried to pretend a values-free position, but it is a simply not so. Even taking the time and trouble to try to "remove" depression or anxiety, one is expressing the value that it is better to be without depression and anxiety than to be with them. ACT is also a values-laden therapy. In ACT we try to be very explicit about the values that drive the treatment. ACT is a treatment that works from a very particular assumptive posture. Here are the core facets of that posture:

1. ACT assumes that, at some level, people hope, aspire, dream, wish for a life that is broader, richer, and more meaningful.
2. ACT assumes that under any and all conditions it is possible to live a life in the direction of one's core values
3. ACT assumes that some of the barriers to living a valued life are imposed by the social-verbal context.
4. ACT assumes that this social verbal context can be altered in ways that can broaden a person's ability to choose a valued direction in their life.
5. Finally, the ACT therapist is committed to helping clients achieve the richest life (in terms of the client's own values) that is possible.

This is a fundamentally optimistic philosophy. It assumes the improvability of the human condition.

Be humble. We never tell clients that we are sure we can help them. There may be data on percentages helped, but typically clients come with their own unique convergence of difficulties. There is no "average" client, and clients do not care about what happens to the average client, they care about their own prospects. Clinical trials cannot speak with authority regarding individual cases within the clinical trial, because the analyses are at the level of the group. They certainly cannot speak with authority to individuals outside the clinical trial. We tell clients explicitly that we intend to be useful to them and that we care about being useful to them. We tell them about the available data and its limits. ACT has accrued a reasonable database as a therapy and it is based upon behavioral principles that have been shown to be robust across a wide variety of behaviors and situations. The ultimate question for the client, though, is will the treatment improve my life. Only that client and that client's own experience can speak with authority to this issue. We make a commitment to the client to stop at regular periods in order to assess their sense of the progress of treatment. We tell them that they will be the ultimate judge of the success of treatment. This is especially appropriate since they were the judge of whether they needed treatment.

Make a contract. ACT is a client-centered treatment in the sense that it is the client's values that direct the therapy. A solid therapeutic contract is consistent with this approach. The client should never feel that the treatment is being done to them. Like any good contract it should be explicit as possible. There should be no "fine print," or unmentioned details. If we make a good contract with the client, we will be working in partnership. In ACT, a therapeutic contract will evolve over time. At the outset of treatment, it may be fairly minimal. For example, in the treatment of a client with chronic anxiety problems:

> I have begun to get a sense of the pain you are experiencing. It has the feel of something that has been hanging around for a long time. You have tried a lot of different things to manage. From what you have told me, your anxieties have improved at times, only to return later. The other thing that I have gotten from what you have said is this sense of restriction in your life. It is as if anxiety is squeezing the life out of you. What I am proposing is a course of treatment that is aimed at helping you to expand your life in ways that are consistent with what you care about. This will almost certainly mean that you will feel profoundly uncomfortable. Also, I cannot guarantee that we will be able to move ahead—but we might. What I do promise you is that I will stay with you as we move ahead in the treatment, and that we will only move into pain where it serves your values. We cannot properly do this unless you say yes to it. So I'm asking: Are you willing to give this a try?

If the client agrees, there is much less chance that as treatment becomes painful, the client will feel victimized by the therapist. Nietzsche said that a man can stand almost anyhow if they have a why. Data tell us that people and animals prefer aversives that they control to aversives that they do not control. The "why" is supplied by the client's own values and control exists in their uncoerced agreement to proceed.

If successful, you will feel awful. If you went to a dentist with a bad tooth, and the dentist looked around in your mouth, poked, prodded and scraped, but only touched

teeth that were healthy, the appointment would be painless, but not particularly useful. If the dentist took your money for that appointment, he may have kept you comfortable, but he stole your money. You walk away with the same troublesome tooth. We use metaphors such as this to illustrate to clients that illustrate the pain inherent in addressing problems. We do not undersell it. If it turns out to be less painful, no one will complain. But if it turns out to be very painful, which it well may, they should know at the outset. This should be part of the contract the client has made with you. When the treatment gets painful we ask: If this pain was between you and the life you want, could you be willing?

Core Features to Be Included Throughout Treatment

Therapy can be very confusing. However, there are core principles that can be safely brought to bear, regardless of any confusion or uncertainty. Four features ought to be present in each session. The therapist should carry a mental checklist that they review before a session is completed. If therapists find themselves disoriented, concerned, confused, angry, or otherwise lacking useful direction, these four components can provide a safe refuge. It may not be impossible to go wrong implementing them, but it is difficult. The features are values, exposure, defusion, and empowerment. Different phases of treatment will focus on these four areas; however, the ACT therapist ought to reinforce their importance from the first session through the last.

Values

Although there are phases of treatment in which the exploration of values is the focus of treatment, they ought to be touched upon in every session. In the description above, occurring in the first few sessions, the values component may be as simple as suggesting to the client that treatment will be directed by the client's values. Even if those values are obscured by a long battle with anxiety, depression, alcoholism, or the like, the therapist can still suggest that the therapy will be about revealing this obscured personal sense of life-direction. Don't leave the session without this being clear. The treatment is about you and a life you value.

Exposure

ACT is a behavioral treatment and relies on an understanding of basic behavioral processes. One can think of experiential avoidance as a sort of "experience phobia" (Wilson, 1997). The behavioral prescription for phobic avoidance is exposure. Behavior analysts have focused on two aspects of exposure that are important, but not sufficient in understanding the role of exposure in therapy. Classical conditioning analogues of phobias emphasize conditioned elicitation and conditioned avoidance. Suppose, for example, we expose a rat to a tone followed by a shock on repeated trials. Two outcomes are likely. First, the rat will show conditioned elicitation in the presence of the tone. The rat may show increased autonomic arousal. It may freeze, defecate, urinate, etcetera. And, second, the rat will work to avoid the tone. Experimental work on exposure and it's effects have carefully examined decrements in conditioned elicitation and conditioned avoidance over repeated unreinforced trials.

In ACT we focus less on these particular outcomes and more on the client's range and flexibility in responding. The rat's behavioral repertoire becomes very narrow with respect to the conditioned stimulus. Similarly, people can become quite narrow in their range and flexibility in response to aspects of their own experience such as "negative"

thoughts, emotions, memories and bodily states, among others. The sexual abuse survivor may become distressed and dissociate when memories of abuse occur during sex. The drug addict may engage in very rigid patterns of drug seeking and use in response to aversive withdrawal states and cravings.

In ACT we are not so much interested in eliminating these from the client's repertoire as we are interested in broadening the array of potential responses. We don't want the snake phobic to be unable to flee the presence of a snake. We do want to be able to impact the fact that they must flee. Psychological content that emerges in the context of the pursuit of valued life goals, and which precipitates unhealthy avoidance, should be targeted for exposure. The nature of the exposure work will not merely be remaining in the presence of the feared psychological content, but in building more elaborated response repertoires with respect to that content. We begin where the client is able to begin. In the chapters that follow we will examine a variety of therapeutic strategies including metaphors, experiential exercises, and verbal conventions that can make avoidance one among an array of responses, rather than the client's sole response to painful or frightening aspects of their expeience.

Defusion

Defusion refers to a set of techniques, but also to a general posture adopted by the therapist. In the preceding chapters on the theory of verbal behavior underlying ACT, we have described the ways that verbal functions so dominate our responding that no other functions of a stimulus are available (refering back to a specific page here might help, c.f., Hayes & Wilson, 1993; Wilson & Hayes, 2000; Wilson & Blackledge, 2000; Wilson, Hayes, Gregg, & Zettle, 2001). For example, a thought may be responded to as what it says it is, but it can also be responded to as a thought. To provide a concrete example, if an addict has the thought "I can't stand these cravings," and responds only to the literal content of that thought, they must do something to alter that state of affairs. Typically, this means using more drugs to alleviate the insufferable state. However, the thought could also be experienced and noticed as a thought in an eyes-closed experiential exercise. This posture is akin to certain forms of meditation. The thought could be said out loud a hundred times rapidly. It could be written on a card and placed in the person's wallet. The person could tell four stories about a person who had that thought: one that turned out tragically, one that turned out absurdly, one that turned out boringly, and one that turned out heroically. The point of these exercises is two fold. First, they provide repertoire-building exposure as described in the previous section. And second, these interventions break up the dominant verbal functions that make such a thought so life restricting.

As a general principle and posture for the ACT therapist, we never back up from frightening psychological content, when that content is in between the client and a life the client desires. This is especially true of bedrock feelings of hopelessness. As will be described in the chapter that follows, the ACT therapist is encouraged by pain and hopelessness, because pain and hopelessness are connected to client values and their values will direct treatment. Expressions of pain and hopelessness, either mild or severe, should be examined for their connection to the life the client wants. Pain is always dignified by its connection to values. In doing so, the therapist models and facilitates the client in developing new responses to old problematic psychological content.

Empowerment

ACT is a client-centered treatment. It relies on the client's values to give it direction, on a dense understanding of the client's experience and struggle to provide the content for intervention, and on the client's commitment to growth and development to make therapeutic gains possible. The ACT therapist works persistently to undermine the therapist's perceived power to change the client, and systematically emphasizes the client's contributions to treatment progress. A session should not go by that does not acknowledge and solicit the client's input into the direction and pace of treatment. Of course, client's will often suffer from an unwillingness to take responsibility for their treatment and their lives, or a belief that they are incapable of such. If the therapist responds to this acted out incompetence by taking control and responsibility, they have confirmed the client's worst fears. The ACT therapist is a consistent source of active confidence that the client can and will take a direction in treatment. This expressed both in word and in deed. We tell our clients that we believe that they can and will take a direction and we actively rely on it in treatment.

What have you accomplished in this phase of treatment?

1. The client should understand that you care about understanding them and their experience.
2. The client should understand that while the therapist brings something important to the treatment, the client and their values will ultimately direct the treatment.
3. The client should have a sense that psychological discomfort will likely be a marker that therapy is headed in the right direction.