About ACT

About ACT

Psychological Inflexibility: An ACT View of Suffering and Failure to Thrive

The core conception of Acceptance and Commitment Therapy (ACT) or (as it is usual called outside of a therapy context, Acceptance and Commitment Training ... also "ACT") is that psychological suffering and a failure to prosper psychologically is usually caused by the interface between the evolutionarily more recent processes of human language and cognition, and more ancient sources of control of human behavior, particular those based on learning by direct experience. Psychological inflexibility is argued to emerge from six basic processes. Stated in their most general fashion these are emotional inflexibility, cognitive inflexibility, attentional inflexibility, failures in perspective taking, lack of chosen values, and an inability to broaden and build habits of values-based action. Buttressed by an extensive basic research program on an linked theory of language and cognition, Relational Frame Theory (RFT), ACT takes the view that trying to change difficult thoughts and feelings in a subtractive or eliminative way as a means of coping can be counter productive, but new, powerful alternatives are available to deal with psychological events, including acceptance, cognitive defusion, mindful attention to the now, contacting a deeper "noticing" sense of self or "self-as-context", chosen values, and committed action. These six flexibility processes are argued to be inter-related aspects of psychological flexibility. Each of these in turn can be extended socially. For example, acceptance of emotions can extend to compassion for others; chosen values can extend to social values; a "noticing" sense of self to healthy social attachment; and so on.

The ACT Model

ACT is an orientation to behavior change and well-being that is based on functional contextualism as a philosophy of science, and behavioral and evolutionary science principles as expanded by RFT. As such, it is not a specific set of techniques or a specific protocol. ACT methods are designed to establish a workable and positive set of psychological flexibility processes in lieu of negative processes of change that are hypothesized to be involved in behavioral difficulties and psychopathology including

- cognitive fusion -- the domination of stimulus functions based on literal language even when that process is harmful,
- experiential avoidance -- the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences and takes steps to eliminate the form or diminish the frequency of these events and the contexts that occasion them, even when doing so causes psychological harm
- the domination of a conceptualized self over the "self as context" that emerges from perspective taking and deictic relational frames
- lack of values, confusion of goals with values, and other values problems that can underlie the failure to build broad and flexible repertoires linked to chosen qualities of being and doing
- inability to build larger and larger unit of behavior through commitment to behavior that moves in the direction of chosen values

and other such processes. Technologically, ACT uses both traditional behavior therapy techniques (defined broadly to include everything from cognitive therapy to behavior analysis), as well as others that are more recent "3rd wave" methods, and those that have largely emerged from outside the behavior tradition, such as cognitive defusion, acceptance, mindfulness, values, and commitment methods.

Research Support

Research seems to be showing that these methods are beneficial for a broad range of clients and positive psychological goals as well, not just in mental health areas but also in behavioral health, and social wellness areas. ACT teaches clients and therapists alike how to alter the way psychological experiences function rather

than having to eliminate them from occurring at all. This empowering message has been shown to help clients cope with a wide variety of clinical problems, including depression, anxiety, stress, substance abuse, and even psychotic symptoms; to step up to the challenges of diet, sleep, exercise, or the behavioral challenges of physical disease; to help address social problems such as stigma or prejudice; or to seek positive outcomes in areas like relationships, cooperation, business, social justice, climate change, gender bias, and so on. The benefits are as important for the clinician as they are for clients. ACT has been shown empirically to alleviate therapist burnout, for example. By focusing on processes of change what began as a way of dealing with mental health issues is now a model that is used to understand and change human behavior more generally.

How Do You Learn and Apply ACT to Your Practice?

The list of resources below are a great, easy-to-access way to learn more about ACT, it's theoretical and philosophical background. We recommend checking out these pages, as they will provide an important foundation of knowledge. We've also compiled a list of ways to learn about ACT by reading ACT books, as well as getting consultation from others as you begin to apply the work to your work and practice. This additional list of resources will help you do so as well. ACBS members are strongly encouraged to join the ACT for Professionals email listserv. Once on that listserv you can ask virtually any question, or raise virtually any issue, and thousands of ACBS members will read it ... and you can almost be guaranteed of interesting and helpful responses. We've found that members of this listserv are nearly eight times more likely to remain as ACBS members over the years than those who are not on the listserv, and we think the reason is that listserv members come to appreciate the value of being part of a helpful and values-based knowledge development community. If you are not sure, join and lurk for a while. If you do not like it, it easy to step off later on -- you can do so with a single click in your membership dashboard.
Steven Hayes July 2, 2005 - 4:32pm

Philosophical roots

Philosophical roots

Functional Contextualism

ACT is rooted in the pragmatic philosophy of functional contextualism, a specific variety of contextualism that has as its goal the prediction and influence of events, with precision, scope and depth. Contextualism views psychological events as ongoing actions of the whole organism interacting in and with historically and situationally defined contexts. These actions are whole events that can only be broken up for pragmatic purposes, not ontologically.

Because goals specify how to apply the pragmatic truth criterion of contextualism, functional contextualism differs from other varieties of contextualism that have other goals. ACT thus shares common philosophical roots with constructivism, narrative psychology, dramaturgy, social constructionism, feminist psychology, Marxist psychology, and other contextualistic approaches, but its unique goals leads to different qualities and different empirical results than these more descriptive forms of contextualism, seeking as they do a personal appreciation of the complexity of the whole rather than prediction and influence per se.

ACT itself reflects its philosophical roots in several ways. ACT emphasizes workability as a truth criterion, and chosen values as the necessary precursor to the assessment of workability because values specify the criteria for the application of workability. Its causal analyses are limited to events that are directly manipulable, and thus it has a consciously contextualistic focus. From such a perspective, thoughts and feelings do not cause other actions, except as regulated by context.

Therefore, it is possible to go beyond attempting to change thoughts or feelings so as to change overt behavior, to changing the context that causally links these psychological domains.

Further information on functional contextualism is available here
Steven Hayes January 11, 2006 - 11:03am

Theoretical roots

Theoretical roots

RFT: A Theory of Language and Cognition

ACT is based on Relational Frame Theory (RFT), which is a comprehensive basic experimental research program into human language and cognition. RFT has become one of the most actively researched basic behavior analytic theories of human behavior, with over 70 empirical studies focused on it tenets. In ACT, virtually every component of the technology is connected conceptually to RFT, and several of these connections have been studied empirically.

According to RFT, the core of human language and cognition is the learned and contextually controlled ability to arbitrarily relate events mutually and in combination, and to change the functions of specific events based on their relations to others. For example, very young children will know that a nickel is larger than a dime by physical size, but not until later will the child understand that a nickel is smaller than a dime by social attribution. In addition to being arbitrarily applicable (a nickel is “smaller” than a dime merely by social convention), this more psychologically complex relation is mutual (e.g., if a nickel is smaller than a dime, a dime is bigger than a nickel), combinatorial (e.g., if a penny is smaller than a nickel and a nickel is smaller than a dime then a penny is smaller than a dime), and alters the function of related events (if a nickel has been used to buy candy a dime will now be preferred even if it has never actually been used before).

The applied implications of RFT derived from the following key features:

1. Human language and higher cognition is a specific kind of learned behavior. RFT researchers have shown that arbitrarily applicable comparative relations (the nickel and dime situation just mentioned) can be trained as an overarching operant in young children; similar evidence has emerged with frames of opposition and coordination.
2. Relational frames alters the effects of other behavioral processes. For example, a person who has been shocked in the presence of B and who learns that B is smaller than C, may show a greater emotional response to C than to B, even though only B was directly paired with shock
3. Cognitive relations and cognitive functions are regulated by different contextual features of a situation.

The primary implications of RFT in the area of psychopathology and psychotherapy extend from the three features just described. RFT argues that:

1. verbal problem solving and reasoning is based on some of the same cognitive processes that can lead to psychopathology, and thus it is not practically viable to eliminate these processes,
2. much as extinction inhibits but does not eliminate learned responding, the common sense idea that cognitive networks can be logically restricted or eliminated is generally not psychologically sound because these networks are the reflection of historical learning processes;
3. direct change attempts focused on key nodes in cognitive networks creates a context that tends to elaborate the network in that area and increase the functional importance of these nodes, and
4. since the content and the impact of cognitive networks are controlled by distinct contextual features, it is possible to reduce the impact of negative cognitions whether or not they continue to occur in a particular form. Taken together, these four implications mean that it is often neither wise nor necessary to focus primarily on the content of cognitive networks in clinical intervention. Fortunately, the theory suggests that it is quite possible instead to focus on their functions.

RFT has proven itself successful so far in modeling higher cognition in a number of areas, and the neurobiological data collected so far comport with the theory. RFT is meant to be a comprehensive

contextualistic account of human language and cognition and thus its goals extend far beyond ACT or even the behavioral and cognitive therapies in general. Because all of the key features of the theory are cast in terms of manipulable contextual variables, it has readily lead to applied interventions in such areas as education.
Steven Hayes January 11, 2006 - 11:05am

Theory of Psychopathology

Theory of Psychopathology

Core Problem Processes

From an ACT / RFT point of view, while psychological problems can emerge from the general absence of relational abilities (e.g., in the case of mental retardation), a primary source of psychopathology (as well as a process exacerbating the impact of other sources of psychopathology) is the way that language and cognition interact with direct contingencies to produce an inability to persist or change behavior in the service of long term valued ends. This kind of psychological inflexibility is argued in ACT and RFT to emerge from weak or unhelpful contextual control over language processes themselves, and the model of psychopathology is thus linked point to point to the basic analysis provided by RFT. This yields an accessible and clinically useful middle level theory bound tightly to more abstract basic principles.

A core process that can lead to pathology is cognitive fusion, which refers to the domination of behavior regulatory functions by relational networks, based in particular on the failure to distinguish the process and products of relational responding. In contexts that foster such fusion, human behavior is guided more by relatively inflexible verbal networks than by contacted environmental contingencies. This is fine in some circumstances, but in others it increases psychological inflexibility in an unhealthy way. As a result, people may act in a way that is inconsistent with what the environment affords relevant to chosen values and goals. From an ACT / RFT point of view, the form or content of cognition is not directly troublesome, unless contextual features lead this cognitive content to regulate human action in unhelpful ways.

The functional contexts that tend to have such deleterious effects are largely sustained by the social / verbal community. There are several. A context of literality treats symbols (e.g., the thought, “life is hopeless”) as one would referents (i.e., a truly hopeless life). A context of reason-giving bases action or inaction excessively on the constructed “causes” of one's own behavior, especially when these processes point to non-manipulable “causes” such as conditioned private events. A context of experiential control focuses on the manipulation of emotional and cognitive states as a primary goal and metric of successful living.

Cognitive fusion supports experiential avoidance -- the attempt to alter the form, frequency, or situational sensitivity of private events even when doing so causes behavioral harm. Due to the temporal and comparative relations present in human language, so-called “negative” emotions are verbally predicted, evaluated, and avoided. Experiential avoidance is based on this natural language process – a pattern that is then amplified by the culture into a general focus on “feeling good” and avoiding pain. Unfortunately, attempts to avoid uncomfortable private events tend to increase their functional importance – both because they become more salient and because these control efforts are themselves verbal linked to conceptualized negative outcomes – and thus tend to narrow the range of behaviors that are possible since many behaviors might evoke these feared private events.

The social demand for reason giving and the practical utility of human symbolic behavior draws the person into attempts to understand and explain psychological events even when this is unnecessary. Contact with the present moment decreases as people begin to live “in their heads.” The conceptualized past and future, and the conceptualized self, gain more regulatory power over behavior, further contributing to inflexibility. For example, it can become more important to be right about who is responsible for personal pain, than it is to live more effectively with the history one has; it can be more important to defend a verbal view of oneself (e.g., being a victim; never being angry; being broken; etc) than to engage in more workable forms of behavior that do not fit that that verbalization. Furthermore, since emotions and thoughts are commonly used as reasons for other

actions, reason-giving tends to draw the person into even more focus on the world within as the proper source of behavioral regulation, further exacerbating experiential avoidance patterns. Again psychological inflexibility is the result.

In the world of overt behavior, this means that long term desired qualities of life -- values -- take a backseat to more immediate goals of being right, looking good, feeling good, defending a conceptualized self, and so on. People lose contact with what they want in life, beyond relief from psychological pain. Patterns of action emerge and gradually dominate in the person's repertoire that are detached from long term desired qualities of living. Behavioral repertoires narrow and become less sensitive to the current context as it affords valued actions. Persistence and change in the service of effectiveness is less likely.
Steven Hayes January 11, 2006 - 11:14am

Quick & Dirty ACT Analysis of Psychological Problems

Quick & Dirty ACT Analysis of Psychological Problems

- Most psychological difficulties have to do with the avoidance and manipulation of private events.
- All psychological avoidance has to do with cognitive fusion and its various effects.
- Conscious control belongs primarily in the area of overt, purposive behavior.
- All verbal persons have the "self" needed as an ally, but some have run from that too.
- Clients are not broken, and in the areas of acceptance and defusion they have the psychological resources they need if they can be harnessed.
- To take a new direction, we must let go of an old one. If a problem is chronic, the client's solutions are probably part of them.
- When you see strange loops, inappropriate verbal rules are involved.
- The value of any action is its workability measured against the client's true values (those he/she would have if it were a free choice). The bottom line issue is living well, not having small sets of "good" feelings.
- Two things are needed to transform the situation: accept and move.

Steven Hayes July 2, 2005 - 4:33pm

The Six Core Processes of ACT

The Six Core Processes of ACT

The Psychological Flexibility Model

The general goal of ACT is to increase psychological flexibility – the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends. Psychological flexibility is established through six core ACT processes. Each of these areas are conceptualized as a positive psychological skill, not merely a method of avoiding psychopathology.

Acceptance

Acceptance is taught as an alternative to experiential avoidance. Acceptance involves the active and aware embrace of those private events occasioned by one's history without unnecessary attempts to change their frequency or form, especially when doing so would cause psychological harm. For example, anxiety patients are taught to feel anxiety, as a feeling, fully and without defense; pain patients are given methods that encourage them to let go of a struggle with pain, and so on. Acceptance (and defusion) in ACT is not an end in itself. Rather acceptance is fostered as a method of increasing values-based action.

Cognitive Defusion

Cognitive defusion techniques attempt to alter the undesirable functions of thoughts and other private events, rather than trying to alter their form, frequency or situational sensitivity. Said another way, ACT attempts to change the way one interacts with or relates to thoughts by creating contexts in which their unhelpful functions are diminished. There are scores of such techniques that have been developed for a wide variety of clinical presentations. For example, a negative thought could be watched dispassionately, repeated out loud until only its sound remains, or treated as an externally observed event by giving it a shape, size, color, speed, or form. A person could thank their mind for such an interesting thought, label the process of thinking ("I am having the thought that I am no good"), or examine the historical thoughts, feelings, and memories that occur while they experience that thought. Such procedures attempt to reduce the literal quality of the thought, weakening the tendency to treat the thought as what it refers to ("I am no good") rather than what it is directly experienced to be (e.g., the thought "I am no good"). The result of defusion is usually a decrease in believability of, or attachment to, private events rather than an immediate change in their frequency.

Being Present

ACT promotes ongoing non-judgmental contact with psychological and environmental events as they occur. The goal is to have clients experience the world more directly so that their behavior is more flexible and thus their actions more consistent with the values that they hold. This is accomplished by allowing workability to exert more control over behavior; and by using language more as a tool to note and describe events, not simply to predict and judge them. A sense of self called "self as process" is actively encouraged: the defused, non-judgmental ongoing description of thoughts, feelings, and other private events.

Self as Context

As a result of relational frames such as I versus You, Now versus Then, and Here versus There, human language leads to a sense of self as a locus or perspective, and provides a transcendent, spiritual side to normal verbal humans. This idea was one of the seeds from which both ACT and RFT grew and there is now growing evidence of its importance to language functions such as empathy, theory of mind, sense of self, and the like. In brief the idea is that "I" emerges over large sets of exemplars of perspective-taking relations (what are termed in RFT "deictic relations"), but since this sense of self is a context for verbal knowing, not the content of that knowing, it's limits cannot be consciously known. Self as context is important in part because from this standpoint, one can be aware of one's own flow of experiences without attachment to them or an investment in which particular experiences occur: thus defusion and acceptance is fostered. Self as context is fostered in ACT by mindfulness exercises, metaphors, and experiential processes.

Values

Values are chosen qualities of purposive action that can never be obtained as an object but can be instantiated moment by moment. ACT uses a variety of exercises to help a client choose life directions in various domains (e.g. family, career, spirituality) while undermining verbal processes that might lead to choices based on avoidance, social compliance, or fusion (e.g. "I should value X" or "A good person would value Y" or "My

mother wants me to value Z"). In ACT, acceptance, defusion, being present, and so on are not ends in themselves; rather they clear the path for a more vital, values consistent life.

Committed Action

Finally, ACT encourages the development of larger and larger patterns of effective action linked to chosen values. In this regard, ACT looks very much like traditional behavior therapy, and almost any behaviorally coherent behavior change method can be fitted into an ACT protocol, including exposure, skills acquisition, shaping methods, goal setting, and the like. Unlike values, which are constantly instantiated but never achieved as an object, concrete goals that are values consistent can be achieved and ACT protocols almost always involve therapy work and homework linked to short, medium, and long-term behavior change goals. Behavior change efforts in turn lead to contact with psychological barriers that are addressed through other ACT processes (acceptance, defusion, and so on).

Taken as a whole, each of these processes supports the other and all target psychological flexibility: the process of contacting the present moment fully as a conscious human being and persisting or changing behavior in the service of chosen values. The six processes can be chunked into two groupings. Mindfulness and acceptance processes involve acceptance, defusion, contact with the present moment, and self as context. Indeed, these four processes provide a workable behavioral definition of mindfulness (see the Fletcher & Hayes, in press in the publications section). Commitment and behavior change processes involve contact with the present moment, self as context, values, and committed action. Contact with the present moment and self as context occur in both groupings because all psychological activity of conscious human beings involves the now as known.

A Definition of ACT

ACT is an approach to psychological intervention defined in terms of certain theoretical processes, not a specific technology. In theoretical and process terms we can define ACT as a psychological intervention based on modern behavioral psychology, including Relational Frame Theory, and evolutionary science, that applies mindfulness and acceptance processes, and commitment and behavior change processes, to the creation of psychological flexibility.
Steven Hayes January 11, 2006 - 11:19am

ACT Video Series - Six Core Processes of ACT

ACT Video Series - Six Core Processes of ACT

The Veterans Health Administration, part of the US Department of Veterans Affairs, has a video series about ACT that provides an introduction to the six core processes of ACT.

- Acceptance
- Defusion
- Being Present (Presence)
- Self as Context (Observing Self)
- Values
- Committed Action

Steven Hayes July 22, 2022 - 12:31pm

ACT Therapeutic Posture

ACT Therapeutic Posture

- Whatever a client is experiencing is not the enemy. It is the fight against experiencing experiences that is harmful and traumatic.
- You can't rescue clients from the difficulty and challenge of growth.
- Compassionately accept no reasons—the issue is workability not reasonableness.
- If the client is trapped, frustrated, confused, afraid, angry or anxious be glad—this is exactly what needs to be worked on and it is here now. Turn the barrier into the opportunity.
- If you yourself feel trapped, frustrated, confused, afraid, angry or anxious be glad: you are now in the same boat as the client and your work will be humanized by that.
- In the area of acceptance, defusion, self, and values it is more important as a therapist to do as you say than to say what to do
- Don't argue. Don't persuade. The issue is the client's life and the client's experience, not your opinions and beliefs. Belief is not your friend.
- You are in the same boat. Never protect yourself by moving one up.
- The issue is always function, not form or frequency. When in doubt ask yourself or the client "what is this in the service of."

Readings on this topic

Follette, V. M., & Batten, S. V. (2000). The role of emotion in psychotherapy supervision: A contextual behavioral analysis. *Cognitive and Behavioral Practice, 7(3)*, 306-312.

Pierson, H. & Hayes, S. C. (2007). Using Acceptance and Commitment Therapy to empower the therapeutic relationship. Chapter in P. Gilbert & R. Leahy (Eds.), *The Therapeutic Relationship in Cognitive Behavior Therapy* (pp. 205-228). London: Routledge.

Wilson, K. G., & Sandoz, E. K. (2008). Mindfulness, values, and the therapeutic relationship in Acceptance and Commitment Therapy. In S. F. Hick & T. Bein (Eds.), *Mindfulness and the therapeutic relationship*. New York: Guilford Press.

Steven Hayes July 2, 2005 - 4:34pm

ACT Therapeutic Steps

ACT Therapeutic Steps

- Compassionately confront the unworkable agenda, appealing always to the client's experience as the ultimate arbiter
- Support the client in feeling and thinking what they directly feel and think already—as it is not as what it says it is—and to find a place from which that is possible.
- In the service of that goal, teach acceptance and defusion skills.
- Help the client make a richer and less defended contact with the present moment, and with their own on-going thoughts, feelings, and sensations.
- Help the client contact a transcendent sense of self.

- Help the client become more consistently mindful.
- Help the client move in a value direction, with all of their history and automatic reactions.
- Help the client detect traps, fusions, and strange loops.
- Repeat, expand the scope of the work, and repeat again, until the clients generalizes.
- (and don't believe a word you are saying).

Steven Hayes July 2, 2005 - 4:35pm

Common Misunderstandings About ACT / RFT

Common Misunderstandings About ACT / RFT

Here are a number of common misunderstandings about ACT and RFT and CBS. I've listed only ones that I think are demonstrably false. Ones that could be true I have not listed since this page is about misunderstandings, not legitimate weaknesses. Comments follow each. If you know of others, let me know - Steven Hayes

- **ACT is just _____ (fill in your favorite: Buddhism, CT, BT, CBT, Logotherapy, a psychology of the will, Gestalt, existential, est, Morita, constructive living, solution focused therapy, Kelly role therapy, and so on and so on)**
  Resemblance is a fun game to play but I have yet to have anyone say these things in strong form (it is just _____) when they have really delved into the philosophy, theory, data, and technology. It is actually a positive sign when you see that others are pointing to somewhat similar issues. If multiple paths lead in a direction perhaps that is a direction worth exploring. If folks want to draw the connections above, it would be good to do them seriously and in print so people can understand the connections. The only ones I could see myself fully agreeing to is "ACT is just behavior analysis" ... or, properly understood, "ACT is just behavior therapy," but I'd quickly want to add "but that area itself has to be understood in a different way to say that." As far as roots, some of these are indeed influences on ACT. You could find some historical connections with CT, BT, CBT, Logotherapy, Gestalt, existential, and est for example. Maybe Buddhism if you mean "estern thought" -- as a child of the 60's it would be hard to avoid that. Probably a few more and as it expands lots of new things come in. ACT is a vast community now.

- **ACT is a cult**
  James Herbert has a great powerpoint on this site walking through why that comparison is unfair and inaccurate. Cults are closed off; they avoid criticism; they are hierarchical; they suppress open expression. ACBS is the exact opposite in all of these areas.

- **ACT is just the latest fad**
  ACT will ultimately die, as will we all, and it may indeed do so in a matter of decades or sooner, as what is worthwhile inside it become better understood and enters into the mainstream (that process of assimilation is happening at light speed right in front of our eyes), but if you mean that it is frivolous or insubstantial, that is just factually incorrect. When you last 35 years, do over 1000 basic and applied studies, and train over 50,000 people, "fad" is just not an applicable term. Is it? Inside the ACBS community we suspect that the applied and basic theory underlying ACT and RFT (etc) is wrong but that is because so far in science *all* theories have ultimately been shown to be incorrect. We just don't know where it is wrong yet ... but we are chasing that rabbit! Come help us prove ourselves wrong!

- **ACT is new on the scene**
  It is just under 35 years old. The first ACT workshop was given in 1982 at Broughton Hospital in North Carolina.

- **ACT is old on the scene and thus its outcome studies should be __ times more**
  When I first posted this page in the early 2000s I had to explain our slow start, but now the criticism is just so far out of date even that explanation seems unneeded. OK, here is the explanation I used to give: ACT followed a different development path linked to philosophy, basic research, and process measurement. There was a 14 year gap in outcome studies from 1986 to 2000. That gap should not be held against the tradition because the detour was linked to even higher standards and goals. During that time, functional contextualism, the psychological flexibility model, RFT, measures of psychological flexiblity, and a contextual behavioral science approach were created -- and it seemed responsible to do that before larding up with RCTs after the first 3 successful ones in the mid 1980s. ACT is willing to be held to RCT-linked standards but RCTs alone are not enough to create a progressive field. You need a theory and development strategy that works. Once we had that better worked out we did indeed come back to outcome studies. If you look at the outcome studies since 2000 it would be a hard case to make that ACT does not care about outcome data. In 2000 there were 3 RCTs in ACT but it began to pick up in the mid 2000s. When I first rewrote this page as 2011 began it was up to 37 RCTs. Wow. Now it is five years later and I'm rewriting the page again in early 2016. The number of RCTs is hard to say precisely because a new one appears every week or less and no one can keep up anymore and still have a life. My best guess is that it is sliding past 200 (I have 153 in a file but a new paper my students wrote for a class tells me that there are about 70 more studies I missed that are not in English). And meanwhile ACT has more and more consistent mediation outcomes than any approach in existence. Our guess is over 50 studies. And it is the ONLY psychotherapy with a vigorous basic science of cognition underneath it, with hundreds of studies on RFT. An entire book has been written on the ACT Research Journey (Hooper & Andersson, 2015: http://www.amazon.com/Research-Journey-Acceptance-Commitment-Therapy/dp/1137440163/ref=sr_1_1?s=books&ie=UTF8&qid=1459110186&sr=1-1&keywords=ACT+research+journey). So, really, anyone suggesting we are slack in terms of research just does not know what he or she is talking about. Counting all areas of CBS my best guess based on search engines is that there are over 2000 studies if you apply a liberal set of search criteria and about 1000 if you apply a strict set.

- **ACT seeks ridiculously high goals and thus is making grandiose predictions or claims.** Aspirations are not predictions or claims. Seeking a comprehensive account of behavior that would apply to all human action has always been the goal of behavior analysis as is shown in things such as Walden II. Why is a grand aspiration grandiose?

- **ACT works only with the well-educated**
  There are many trials indicating ACT is helpful for those who are poor, uneducated, intellectually disabled, children, those diagnosed with psychotic disorders, and so on and on. This criticism comes because the theory can be hard to understand (especially RFT). But we do not teach theory to client, we do therapy. That is different.

- **ACT works only for white middle class Americans**
  There are ACT studies from 15 countries includinging countries in Asia, the Middle East, and Africa. Successful studies have been done with poor urban black populations; unemployed poor Asian American populations; institutionalized South African blacks, etc. As of early 2016 there are 45 RCTs done on ACT in Iran; over 30 RCTs in Korea. The outcomes are equally good. The criticism is simply invalid.

- **ACT is not committed to science**
  Come on; wake up. Put in key ACT and RFT terms into the Web of Science or Google Scholar and look at what is out there dude. Download the studies. It after you do all that you repeat this claim that within arm's reach of me or you'd better be able to duck fast.
- **The ACT research base is weak**
  ACT has drawn a lot of interest from funded researchers and ACT funded studies are as good as any out there. There are a lot of them too (perhaps 50 RCTs of that kind) and the outcomes are often (not always) impressive. Yes, in some areas the research base is lean -- but ACT is not just for one problem area. In some areas, such as smoking or chronic pain, you'd have to distort the meaning of evidence to say that

they ACT research base is weak. And these are areas where people have worked for years to dial in how to move ACT processes. So overall the research base seems impressive given the scope of ACT work.
Having said that, we need to add three things. First, ACT draws a lot of interest from students, the developing world, or parts of the developed world without a grant infrastructure. These studies often have methodological issues (sample size; controls; etc) but jeez, how do they DECREASE what we know if they ADD to what we know from the best studies? Can someone please explain that to me? It happens IMHO only if people doing meta-analyses average methodology ratings. I'm sorry, that is just a dumb idea. Sure, weight findings study by study in light of methodological issues. But if a person in Liberia shows that ACT is helpful for problem x, and a huge grant-based study at a Western academic medical center with all of the bell and whistles showed that ACT is helpful for that same problem, *the one in Liberia added to what we know regardless of its weaknesses*. It showed that these approaches to not just apply to the western world, for one thing. It is fine to use the well controlled one to estimate effect sizes. But don't average the methodology ratings from the two and then say that the overall knowledge is weak in problem area x because the average methdology score is humble. Aaaagh. That is just *stupid*. Second, you need a string of studies in a given area with a given population to learn how to move psychological flexibility processes. If the technology has weak outcomes but did not move the processes, that is an unfortunate technology error, not a model failure. If you move the processes and the outcomes are poor that is a model failure. Yes, there are technology failures in ACT, but usually with new populations, settings, or modes of delivery. I know of no replicated model failures in 35 years of ACT / RFT / CBS research. Finally, some meta-analyses are biased. They are. Look at the overall pattern of meta-analyses and look carefully for responses to meta-analyses. For example, Ost claimed in 2008 that 13 ACT RCTs were weaker than 13 matched CBT RCTs; but then Gaudiano showed that effect was 100% due to grant funding, and furthermore 12 of the 13 ACT studies published mediational outcomes while 1 of the 13 CBT studies did so. An objective reader should reject Ost's comparison. You have to look at the criteria too. For example, if you rightly put "well defined population" on a list of methodological criteria, and then in small print insist on a DSM diagnosis as the only metric for a "well defined population," ACT will look methodologically weaker due to intellectually defensible choices that the reader might not realize is at play. CBS researchers generally despise the DSM. Including such a scoring approach behind an item will lead to a biased "criterion" (one that even NIMH has abandoned!). But the reader has to dig deep to sniff out bias liek that when it is there -- and sometimes not matter how much care, the reader will be bamboozled (e.g., if the ratings themselves have horrible kappas that are not reported). But the ACT community does not lay back on such things. We keep asking for the information and we keep trying to understand findings. As a reader: Keep your powder dry; be careful before leaping; look at the entire set of criticisms, responses, and meta-analyses; use your best judgment.

- **ACT is just a technology**
  It is a far more ... do your reading. It is a model linked to a philosophy, basic science, and a strategy of development.

- **ACT is just a philosophy**
  Ditto.

- **ACT is just acceptance**
  Ditto.

- **ACT is just commitment**
  Ditto.

- **ACT is just acceptance and commitment**
  Aw, come on. This kind of thing comes from folks reading the titles of books and studies instead of books and studies.

- **Acceptance is important because it is a way to change the content of emotion (so ACT is really about that)**
  The data suggest otherwise. Emotion do often change, but that change predicts behavioral outcomes more poorly than changes in the *functions* of emotions -- and sometimes good outcomes come without a change in emotion within the extant ACT literature.

- **Defusion is important because it is a way to change the content of thought (so ACT is really about that)**

Double ditto. Same point. Also decent data supporting it. Will thoughts change? Sure! RFT is all about changing thoughts and of course ACT changes thoughts.

- **The ACT model of cognition is no different than any CBT model -- it is just different in its terminology**
  If you believe that, have the courage to do your homework in detail and write it up in article form. Then be prepared to have others go after your ideas. We have so far responded to every single serious criticism in print in ACT or RFT, so anyone can read the criticisms and the response and judge the arguments. So far no one, I mean no one, has made the claim above in a careful scholarly article. But it is not the ACT world's obligation to prevent the claim from being made in the hallways of convention hotels or on listserves. Even here we do what we can, however. You are reading exhibit A in that area.

- **Defusion is just distancing as that concept is used in CT**
  They are indeed related. That is one of the real historical sources of ACT. But in ACT there are scores of such techniques, the are emphasized a great deal, and they are put to a quite different purpose than in traditional CT.

- **ACT is just mindfulness as that concept is used by Buddhists or _____ (fill in the blank)**
  ACT is clearly broader at the level of theory and technology. Mindfulness is itself a broad term that ican be vague if it is left at that level. That is why we have written 4-5 articles walking through the concept of mindfulness and trying to come up with a tighter analysis of it. When defined in the right way, ACT is a mindfulness-based approach but it is more than that as well.

- **Defusion is just exposure in a traditional sense**
  Research shows that defusion supports exposure. If you say it is exposure then you have expanded exposure to conver most contact of human beings with events and that is troublesome. Besides exposure itself is not well understood, and ACT folks have a flexibility and pattern-based account of exposure that comports with the ACT model.

- **Acceptance is just exposure in a traditional sense**
  Research shows that it supports exposure and appears to empower the impact of exposure. ACT is an exposure-based technology and we said in the first chapter on ACT in 1987. But the ACT view of exposure is that it is organized contact with previously repertorie narrowing events for the purpose of creating response flexibility. That is why our goal is teaching more flexible contact with private events and more flexible patterns of responding. We want patients to be able to label emotions; to feel them openly; and to be able to approach their values in action. The most recent work in traditional exposure in CBT is finally catching up that approach. We do not do exposure to reduce emotions (thought they usually are reduced) -- but it turns out that is not why exposure works even in traditional CBT.

- **ACT does not care about the relationship**
  We have a model of it; we teach it; we emphasize it. We have data showing that ACT gets high aliance scores; they predict outcome; but they are themselves explained in part by changes in acceptance/defusion/valued action. So no only do we care about the relationship, we care enough to be able to teach clinicans how to create powerful ones: create a psychologically flexibile relationship.

- **ACT eschews meditation and contemplative practice**
  Contemplative practice is often in our protocols (about 40% of the RCTs); Guided meditations is in nearly 100% of the protocols; ACT targets mindfulness at the level of process in multiple ways; it moves and is mediated by these processes; psychological flexibility impacts the brain or telomere length (etc) similarly. Now if you insist that mindfulness = sitting and following the breath, yes ACT is mostly not that. But if you insist on that narrow definition you now have to go to war with ancient mindfulness traditions too. Is a koan about mindfulness? Is chanting? This is why I resisted the word "mindfulness" in early ACT writing. I did not want to enter into arguments that were thousands of years old. ACT cares about mindfulness as a process.

- **You should not mix behavioral procedures with ACT**
  The model says you should. ACT is part of behavior therapy. With all due respect, you don't get to peel it away from its model just because that makes you uncomfortable in your sorting of things into cubby holes.

- **If you do mix behavioral procedures with ACT you now have a combined treatment**
  ACT is a model. Since the model says you should do this, it does not become a combination treatment to follow the model. In early ACT work we often deliberately hobbled the model so we could be heard by others (e.g., taking out formal exposure in studies on OCD). Times up. After 200 RCTs, no more hobbling the model to avoid science critics and their cubby holes.

- **The other aspects of ACT add nothing to the behavioral elements**
  We know that these other elements are helpful and that they can support the behavioral elements. If you mean that the other elements are inert, that is clearly untrue. We published a meta-analysis of the first 60 or so component studies and all of the components matter [Levin, M. E., Hildebrandt, M. J., Lillis, J., & Hayes, S. C. (2012). The impact of treatment components suggested by the psychological flexibility model: A meta-analysis of laboratory-based component studies. Behavior Therapy, 43, 741–756. DOI: 10.1016/j.beth.2012.05.003.] More formal component analysese are beginning to appear [Villatte, J. L., Vilardaga, R., Villatte, M., Vilardaga, J. C. P., Atkins, D. A., & Hayes, S. C. (2016). Acceptance and Commitment Therapy modules: Differential impact on treatment processes and outcomes. Behaviour Research & Therapy, 77, 52-61. doi:10.1016/j.brat.2015.12.001]. And we know that all of the aspects of the psychological flexibility model contribute to outcomes (McCracken and colleagues have a study on that in the chronic pain area).

- **The data on traditional CBT is far stronger**
  Well, duh. Your father's retirement account is bigger than yours too. ACT is part of the CBT / BT / BA family but its specific research program takes a large community to mount. The CBS community is focused on basic science, processes of change, micro-studies, prevention, social change, link to evolution science, and so on and on. But dig deeper. The vast majority of what is specifically supported in traditional CBT is stuff that ACT folks agree with anyway. If you insist on drag race studies --OK. Be patient. But you can't start outcomes studies in 2000 and expect 16 years later to have the same amount of data as the biggest dog on the block. But our research productivity is now obvious for anyone to see. If you know how to de searches

- **It is surely safe to mix ACT techniques with other techniques I'm more comfortable with while I wait passively to understand the model**
  Ah, no. Down that path lies chaos. It is such a poor model of scientific development. Understand first. Get the data. Then add anything that makes sense for good theoretical and practical reasons, not just because you feel like it. One great benefit we have in ACT: if the thinks you like to do already improve psychological flexibility (measure it regularly) than by all means include those things.

- **When I do that I should be able to rename it and get famous tomorrow because what I added (here you can pick any of the other misunderstandings -- relationship, emotion, mindfulness, etc etc) is obviously missing from the model**
  You can rename it and still come and talk at our conventions etc. We don't care about names. Some folks in the CBS community call ACT "Acceptance Based Behavior Therapy" for example. It turns out that psychological flexibility still mediates the outcomes. But branding helps people find the work so at least rename it for a good reason (e.g., sometimes it make it hard to do meta-analysises). It's up to you.

- **You can mix ACT with the cognitive elements of CT / CBT easily**
  With some, but be careful. Incoherence is not usually helpful and patients will detect the incoherence if it is there.

- **It is safe to do research on ACT without doing any training in ACT**
  Is it safe to do surgery that way? You cannot read a book and do this well. Get some training. It is cheap and available and non-proprietary. ACT folks will collaborate and consult. Reach out.

- **It is safe to criticize ACT based on what you've heard about it from others who are not expert in it**
  What is it about reading carefully that is so aversive?

- **ACT contains nothing new**
  If you've studied it thoroughly, just say it in print and say why you say that and let us all look at it dispassionately. If you've not done your homework yet, see above.

- **ACT is behavioral in an S-R sense**
  ACT is actively hostile to S-R psychology.

- **ACT is behavioral in a traditional behavior analytic sense**
  ACT / RFT is part of behavior analysis, but RFT changes everything. ACT is part of post-Skinnerian behavior analysis -- which is a new form. We call it "contextual behavioral science." Read the RFT book for why we say that.

- **For these reasons ACT is not oriented toward cognition**
  200 studies on cognition later, how can folks still say that?! Come to a training at least.

- **For these reasons ACT is not oriented toward emotion**
  Come to a training! Watch some tapes! Go look at my TEDx talk: www.bit.ly/StevesFirstTED

- **Because ACT is broadly applicable it is primarily based on a non-specific clinical process**
  The theory says why it is broadly applicable and the process data so far say it is successful due to specific process changes. We now have socres of mediational analyses out or in press.

- **Anything that works for such a broad range of problems must be bulls**t**
  The theory says why it is broadly applicable. Who are you to say a priori what nature is like?

- **There are not many outcome studies on ACT**
  About 200 RCTs and scores more controlled time series designs and counting.

- **ACT / RFT is a small minority**
  Maybe. But there are about 3000 folks on the ACT / RFT listserves and over 8000 in the association. ACBS is bigger than ABCT or ABAI. Its one of the the fastest growing associations of its kind out there. Besides, minority or not, we are speaking of ideas and data, not politics.

- **ACT proponents make excessive claims that go beyond the data**
  A quote would be nice.

- **ACT is hierarchical and you have to pledge allegiance to a leader to be involved with it**
  It's an open list serve; an open website; no certification of therapists; no cut goes to originators from members/trainers/etc; you can get our protocols for free; anyone can become a trainer. There are more ACT books by others than by the originators, by far. This is just so unfair. Its a cartoon, and an ignorant one at that.

- **ACT processes have not been studied**
  Download the list of studies and read them. We think our process data are stronger than just about any other approach in all of applied psychology, and our link to basic science is excellent.

- **RFT can't explain anything other models of cognition cannot explain**
  RFT researchers have explained phenomena that other approaches have had hard times with. For example, we are learning how to establish a sense of self, we know a lot about how metaphor works, we know a core process in human cognition. And it appears that RFT programs raise IQs more dramatically than anything else out there; it helps with acquisition of language in disabled children; it has better implicit measures than anyone; it can predict who will suceed for fail clinically; etc.

- **RFT is just jargon**
  How much have you carefully read so far? Until you read carefully you cannot distinguish jargon and a technical language. RFT has a techical language, but only when technical terms are needed. If you disagree, pick a technical term and show how it is the same as a common sense one. Maybe there was a slip.

- **ACT is just jargon**
  Same reaction as above.

- **No one can understand RFT**
  Do the RFT tutorial on this website. Yes the basic studies are damn hard to understand ... you are languaging about language and that is just confusing. But it is not beyond anyone reading this website. Physics is hard too -- so?

- **No one can understand ACT**
  You can. And "understanding" in a purely intellectual sense is not the point for clients anyway. Usually what therapists mean when they say this is that they are afraid that if they don't understand it thoroughly they can't do it effectively. Folks like Raimo Lappalainen have shown that ACT works even when delivered by beginning therapists who don't really understand it. In fact most of the outcome data on ACT was not done with experienced ACT therapists. It's a miracle these studies work at all -- but they do. Understsanding does help: we have studies

- **RFT has little to do with ACT**
  ACT and RFT co-evolved. There are many, many links are there and in both directions. It is not a matter of point to point correspondence and it should not be if we are right and applied and basic science should relate in a reticulated way.

- **ACT folks don't want CT people to be involved and they look down on them**
  Ask some CT people who got involved in ACT work what they think about how they were treated. Just ask.

- **We don't know which components work because there are no dismantling studies**
  ACT comes from an inductive tradition. Rather than wait decades for dismantling studies we've done over 60 technique building and micro-analytic studies (see the reference above) and every aspect of the model has at least some targetted research data. And we do have some studies that dismantle the methods to a degree (an example was listed above)

- **I hate the enthusiasm of students who do these workshops -- it scares me**
  We can all agree that enthusiasm is not the same as substance ... but suppose that enthusiasm is hostile to substance? Besides this concern itself sounds emotional so why let emotions substitute for data just because it is now *your* emotions we are talking about (*it scares me*) ? Be consistent. If enthusism creeps you out, try to make room for being creeped out, hang on to your legitimate skepticism, and follow the data.

- **I just don't like ACT**
  See above.

- **Talk of spirituality in ACT is creepy**
  It is treated as a naturalistic concept. ACT is not a religion.

- **I don't want to be told my values**
  ACT folks will never do that ... your values are your choice.

- **There is no data on ACT in groups**
  About a third of the RCTs on ACT are done in groups, so that means scores of studies.

- **ACT works through the same process as ____ (fill in your favorite)**
  Show me the actual research please. The reverse is much more likely to be true so far (the psychological flexibility model explains your favorite). But that is cool, no? Now that we know how things work we can chase the outcomes together.

- **ACT is not self-critical**
  Lurk on the list serve and see. Come to a WorldCon and see.

- **Steve Hayes is a jerk -- I saw him do a mean joke or a mean comment at ABCT or ABAI**
  ACT is not Steve Hayes -- there are scores of leaders in ACT / RFT. Besides, distinguish the message from the messenger. Some of us are confrontational about intellectual issues, but we don't go after people or traditions: just ideas. The list serve NEVER has flame wars, and that includes toward others. We are just playing hard. Why not? It is fun and can be helpful. Not everyone inside CBS plays the same way. if you hate folks who like to argue, go to ACT talks (etc) by softer folks. As for mean humor, sometimes roast humor can slip across the line a bit, but we tease those we respect. In the ACT community we use humor to remind us all that this work is not about the muckity mucks (including those inside ACBS) ... it is a shared enterprise and everyone is part of it who wants to be part and is willing to bring science based values and caring to the table. If you come to an ACBS conference you will see that the ACT / RFT leadership is outright ridiculed in the "follies" and it is just great fun. Anyone has access to the stage. Even cognitive therapists! :)

- **ACT is crazy (or my personal favorite variant since I'm writing this, Steve is crazy)**
  Ah, finally you are getting somewhere. But as that *Time* guy said in 2006 in the last line of the story on me and on ACT -- we may just be crazy enough to pull it off. If you are nutty enough to want to help us, come help us succeed!

Steven Hayes April 7, 2006 - 1:25am

Criticisms of ACT

Criticisms of ACT

Given the values of ACBS, there has been efforts from the beginning of the ACBS community to encourage responsible criticism, to give thoughtful critics a stage to speak to the group, of trying to respond thoughtfully in writing to knowledgeable critics, and of trying to resolve issues empirically where possible. Criticisms of ACT have appeared in published forms. The written criticisms of RFT (and to a lesser degree, functional contextualism) are extensive and in writing, as are the defenses. They can be found in the other sections of the website.

Self-Criticism

Part of the core of the ACT / RFT tradition is the openness to criticism, including self-criticism. At the LaSalle ACT Summer Institute (Philadelphia, 2005) James Herbert gave a really solid paper walking through many of the criticisms he knew about, under the title "Is ACT a fad?" He considers not just whether the criticisms are correct, but what those in the ACT / RFT community should do about them. You can look at that talk by clicking on the link below.

- Criticisms of ACT, ACT Summer Institute II (July 2005, PowerPoint file)

Published Criticisms and Responses: An Ongoing Conversation Below is a list of papers that have been published criticizing ACT as well as replies that have been published when available. If you know of other criticisms or replies please email us or add a child page to this page.

- Corrigan, P. (2001). Getting ahead of the data: A threat to some behavior therapies. *The Behavior Therapist, 24(9)*, 189-193.

This was the first strong criticism of ACT published. Corrigan argued that the ratio of non-empirical to empirical articles could be used to argue that third-wave CBT was ahead of its data.

A reply: Hayes, S. C. (2002). On being visited by the vita police: A reply to Corrigan. *The Behavior Therapist, 25,* 134-137.

The reply argued that the ratio of non-empirical to empirical articles could not be meaningfully used as a measure of getting ahead of data since there were many good reasons to write theoretical discussion pieces. Instead, actual claims that got ahead of the data had to be identified and none have been. Pat has been helpful to ACT researchers in various capacities over the years since that article.

- Corrigan, P. (2002). The data is still the thing: A reply to Gaynor and Hayes. *The Behavior Therapist, 25*, 140.

- Asmundson, G. J. G., & Hadjistavropolous, H.D. (2006). Acceptance and Commitment Therapy in the Rehabilitation of a Girl With Chronic Idiopathic Pain: Are We Breaking New Ground? *Cognitive and Behavioral Practice, 13*, 178–181.

- Hofmann, S. G., & Asmundson, G. J. G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review, 28*, 1-16.

- Hofmann, S. G. (2008). Acceptance and Commitment Therapy: New Wave or Morita Therapy? *Clinical Psychology, Science and Practice, 5*, 280-285.

  The theme of these two articles is that ACT and other mindfulness-based treatments is the same as CBT, and that ACT is the same as Morita Therapy. After these articles were written Stefan Hofmann was invited and funded to speak to the ACBS community in Chicago (2007). We had a great time in respectful dialogue. Read more about this criticism in non-peer-reviewed settings and the ensuing dialogue, click on the child page"ACT is Outright Taken from Morita Therapy" below.

- Öst, L. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46(3)*, 296-321.

  This article is in part based on *proactive* efforts by the ACBS community to encourage knowledgeable criticism. Lars-Goran Öst has been invited and funded to come to several ACT conferences beginning even before he was knowledgeable of ACT work, given that he was asked to play the role of an outside critic at the first World Conference in Linkoping, Sweden (2003). He was later also invited to London (2006), and Enschede, The Netherlands (2009), that last invitation coming after the article itself was available.

  The theme of Lar-Goran's criticisms have been that ACT research has methodological weaknesses, and that it is not as well done as mainstream CBT research. The latter was based on a comparison of ACT studies with a matched set of traditional CBT studies. His conclusion is that ACT is not an evidence-based treatment.

  Gaudiano reply: Gaudiano, B. A. (2009). Öst's (2008) methodological comparison of clinical trials of acceptance and commitment therapy versus cognitive behavior therapy: Matching apples with oranges? *Behaviour Research and Therapy, 47,* 1066-1070.

  Öst reply: Öst, L. -G. (2009). Inventing the wheel once more or learning from the history of psychotherapy research methodology: Reply to Gaudiano's comments on Öst's (2008) review. *Behaviour Research and Therapy, 47,* 1071-1073.

Gaudiano rejoinder: Gaudiano, B. (2009b) Reinventing the Wheel Versus Avoiding Past Mistakes when Evaluating Psychotherapy Outcome Research: Rejoinder to Öst (2009). Brandon has replied again in a piece self-published online (in an attempt to keep the conversation flowing without the confines of the lengthy peer-review process).

The theme of the replies was that errors were made in Lar-Goran's matching and coding process, resulting in a distorted comparison, and that ACT studies are not weaker when resulting differences in population and funding are weeded out. Further, it is noted that ACT is already listed by APA as an evidence-based treatment. Lars-Goran admits that the two sets of studies are not matched in areas such as funding, and that APA lists ACT as evidence-based, but holds to his original views.

- Arch, J. J., & Craske, M. G. (2008). Acceptance and commitment therapy and cognitive behavioral therapy for anxiety disorders: Different treatments, similar mechanisms? *Clinical Psychology: Science & Practice, 5*, 263-279.

  A reply: Hayes, S. C. (2008). Climbing our hills: A beginning conversation on the comparison of ACT and traditional CBT. *Clinical Psychology: Science and Practice, 5*, 286-295.

  The theme of the response was that ACT is part of the CBT tradition, but it is not possible to compare intellectual similarities until CBT says what it is. Efforts of the authors to do so were argued to change long standing mainstream views, which explain some of why the two could be argued to be very similar. Both the critical article and response agreed that there were good empirical issues to be explored.

  Reflective of the tone of this dialogue, several ACT researchers (Georg Eifert, John Forsyth, Steve Hayes, Mike Twohig) are doing work with Michelle Craske and her colleagues trying to study the issues raised. Michelle has been invited to speak at an ACBS World Conference. She was not able to come in 2009 but we hope to hear her in the future.

- Powers, M.B., Vörding, M.B., & Emmelkamp, P. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics, 8,* 73-80.

  A reply: Levin, M., & Hayes, S.C. (2009). Is Acceptance and commitment therapy superior to established treatment comparisons? *Psychotherapy & Psychosomatics, 78*, 380.

  Author response: Powers, M. B., & Emmelkamp, P. M. G. (2009). Response to 'Is acceptance and commitment therapy superior to established treatment comparisons?' *Psychotherapy & Psychosomatics, 78,* 380–381.

  ACT researchers have critically examined the method of the meta-analysis and have published a response to the study, with a revised analysis. A counter response by Powers and colleagues is also available. We invited Paul Emmelkamp to come to Enschede but he could not ... we hope to get him to an ACBS conference in the future.

Replies to Critiques in General: Articles Describing the CBS Strategy Extensive reviews of the issued raised in this article are out or in press, but they are too extensive to simply call them "replies." The theme of the articles (which you can read by clicking the link above) has been to describe the ACT approach, its knowledge development strategy and to show its distinctive features.
Steven Hayes January 15, 2010 - 5:27am

Criticism: "ACT is Outright Taken from Morita Therapy"

Criticism: "ACT is Outright Taken from Morita Therapy"
In June 2008 list serve post to the Academy of Cognitive Therapy, Bob Leahy, 2008 President-Elect of ACBT, made this claim: "Moreover, the claim for a new, unique model of treatment made by ACT does not seem

justified. As some of those on this Listserve know, many of the ideas and techniques that Hayes has advanced are directly taken from Morita therapy. *And without attribution.* See http://en.wikipedia.org/wiki/Morita_Therapy or http://www.clcma.com/morita1.htm Pay attention to the discussion about mindfulness, acceptance, character, values, etc. This was 1928. That's a long time ago. Does this remind you of anything? Is this a coincidence?" ********** This is a response written by Steve Hayes (on 6/29/08): The claim is false. Maybe folks in recent years have added things that I am unaware of ... ACT is a vast community .... but I am certain that no concepts or methods in the formative work on ACT came from Morita whatsoever. I never heard of Morita therapy until well after the ACT model was developed and published. I am not sure when I first heard of it but I do recall that the person knew Japanese and told me that the English translations are not very accurate and they had been made too much like CBT by Westerners. That decreased my interest in reading the secondary sources. The methods I saw in the limited reading I did (e.g., keeping depressed folks in sensory deprivation, etc) it just seemed way too far away from our work to be useful, especially since I recall seeing no controlled data. We have cited Morita several times as being relevant to the ACT work, however. For example in Hayes, S. C., & Ju, W. (1997). The applied implications of rule-governed behavior. Chapter in W. O'Donohue (Ed.), *Learning and behavior therapy* (pp. 374-391). New York: Allyn & Bacon, we said: "Conversely, the more traditionally non-empirical approaches, like Gestalt (Perls, 1969) and Morita (Morita, 1929), may be more consistent with the basic behavioral literature on rule-governance." Rather than a dark vision of scientific theft the more plausible reason for the connection is that many traditions have gathered together things that seem to work, and some of these overlap to a degree with ACT. ACT is a more bottom up, Western science account but it has arrived at places other traditions inhabit to a degree. That is particularly true with just about any Eastern tradition since all you really need to overlap a bit with where ACT ended up is mindfulness (which always includes acceptance somewhere) and some kind of right action (values). Because of the history of development, ACT partitions these broad chunks into technical processes that are linked to a basic account. That quality is part of what distinguishes ACT from these traditions. ACT is a model linked to a basic theory, clear philosophy, and successful applied technology. In other words, what is most new about ACT is that it is part of contextual behavioral science, with all of the progressive features this brings.
Steven Hayes June 29, 2008 - 6:49pm

Getting Beyond the Way of the Guru and Other Scientific Deadends

Getting Beyond the Way of the Guru and Other Scientific Deadends
ACT is drawing a great deal of attention and many of the folks now connecting with the work are not behavior analysts. In addition, behavior analysis itself is not necessarily evolving fast enough for visitors to see through to its core and to its potential without a bit of a roadmap. Many of the folks who visit this site would recoil from ACT's intellectual home base if dropped into an Association for Behavior Analysis convention, say, without a friend. Much of what is there will seem foreign or even hostile to an ACT / RFT perspective. But do the same with someone knowledgeable -- especially someone to help deal with the confusion because both mechanists and contextualists co-exist inside this tradition and to help find the right resources -- and the vast majority of those who connect with the ACT work will see the relevance of behavior analysis. If the ACT / RFT agenda is successful this problem will eventually resolve itself because RFT (especially) and perhaps to a lesser degree ACT will move the home base itself. But we are not there yet. The grand strategy here is this (this is not so much sequential and linear as it is an interconnected web): build the contextualistic wing of BA, build the RFT research program, build the ACT program, build the links between ACT and RFT, build the other applied extensions of RFT, use ACT to draw mainstream clinical to the work, expose mainstream CBT to the value of RFT, expose mainstream cognitive psychology to the value of RFT and use RFT to do hard work in that area, expose other areas of psychology (prevention, education, etc etc etc) to the value of ACT / RFT and use ACT/RFT to do substantial work in those areas, use the support for ACT and RFT to build support in academic departments for basic behavior analysis, bump behavior analysis itself along, end up with a revitalized form of behavior analysis inside the mainstream of psychology. Whew This is not politics, though it may look like it in some of its features. It makes sense only if you believe that for the good of humanity functional contextual psychology should play far more of a role in the future of psychology than it otherwise seems destined to, and that to do that it needs not just to be understood but to develop itself. But if you look at the list above you will see a problem. This agenda cannot work if the work begins and ends with ACT. The explosion of popularity of ACT is both a blessing and a danger. Folks come to the work and think it is just a neat technology. Some

immediately start to modify it based not on theory or development of needed processes but on comfort (I like doing X, X is not in there, I will do ACT + X). Some folks are doing ACT studies without ever having been to an ACT / RFT conference, or even an extended ACT training, etc. So just when we have a chance to leverage attention for even more dramatic change, we risk crumbling into incoherence. Once ACT is a technology only, it is done. Because then, how doe sit develop? If you just let the technology stay as it is you have: Option A. *The Way of the Empirically Supported Treatment Manual.* The technology is it. Sell the manuals. Validate them. Sell them some more. Then let them gather dust. If you are going to let it develop then you have other options: Option B: *The Way of the Guru.* A charismatic leader declares new things to be in or out. Yuck. Option C: *The Way of Politics.* Anything goes provided enough folks support it, thus create subgroups to support innovations/styles/techniques etc. Eventually this option becomes Option B, or ACT just splinters into nothingness and you are left just with a name and canonical texts. Option D: *The Way of Scientific Battleships.* Anything goes provided you have some data. The kitchen sink is useful, too, so don't forget to throw that in. And, way the way, where did those ideas you threw in come from in the first place? Ahhh. Hmmm. Brute force science linked to commonsense cannot see through to the essence of things. Precision, but no scope. Eventually this becomes a sequential version of Option A. There is another option. It is the way bieng followed in the ACT / RFT approach. ACT is a model, based on processes and techniques that modify those processes. The processes are linked to basic principles and a basic research program on those principles. All of that stands on a philosophy of science and on an intellectual and methodological tradition. This is Option E: *The Way of an Evolving Science.* But to do this, we have to take responsibility for it. Folks drawn into ACT, for example, need to take seriously the possibility that overtime they will need to learn more about RFT, and then about behavior analysis itself (even if they are, say, psychoanalysts, or existentialists, or cognitive therapists). If you force that too early or too rudely and it is a barrier. But ignore it altogether, and it is a recipe for ultimate irrelevance. Thus ACBS. Thus, the World Conferences. Thus this website. We cannot expect someone else to do it. Together, as a community, we have to work together to create a progressive science more adequate to the challenge of the human condition. - Steve Hayes
Steven Hayes April 24, 2006 - 4:29am

Books

Books

There are many books, audiobooks, and other materials to help you learn more about ACT, RFT, Contextual Behavioral Science, and related topics such as mindfulness and other third wave interventions.

There may seem like a lot of choices in some areas. And there are, which is a testament to how quickly the ACT/RFT/CBS work has grown.

admin May 11, 2009 - 8:09pm

ACT Books: General Purpose

ACT Books: General Purpose

(The following list of books is from the LEARNING ACT RESOURCE GUIDE: The complete guide to resources for learning Acceptance & Commitment Therapy by Jason Luoma, Ph.D. Updated July 2020 learningact.com)

The following list only includes ACT self help books in English. Click here for the list of books in 20+ languages.

BOOKS FOR LEARNING ACT

LEARNING ACT

- Acceptance and Commitment Therapy (Theories of Psychotherapy)

- Acceptance and Commitment Therapy, Second Edition: The Process and Practice of Mindful Change
- Acceptance and Commitment Therapy: 100 Key Points and Techniques
- Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change
- Acceptance and Commitment Therapy: Contemporary Theory Research and Practice
- Acceptance and commitment Therapy: The CBT distinctive features series
- Acceptance and Commitment Therapy For Dummies
- The ACT Approach: A Comprehensive Guide for Acceptance and Commitment Therapy
- The Act in Context: The Canonical Papers of Steven C. Hayes
- ACT in Practice: Case Conceptualization in Acceptance and Commitment Therapy
- ACT in Steps: A Transdiagnostic Manual for Learning Acceptance and Commitment Therapy
- ACT Made Simple: An Easy-To-Read Primer on Acceptance and Commitment Therapy (The New Harbinger Made Simple Series)
- The ACT Matrix: A New Approach to Building Psychological Flexibility Across Settings and Populations
- The ACT Practitioner's Guide to the Science of Compassion: Tools for Fostering Psychological Flexibility
- ACT Questions and Answers: A Practitioner's Guide to 150 Common Sticking Points in Acceptance and Commitment Therapy
- The Art and Science of Valuing in Psychotherapy: Helping Clients Discover, Explore, and Commit to Valued Action Using Acceptance and Commitment Therapy
- The Big Book of ACT Metaphors: A Practitioner's Guide to Experiential Exercises and Metaphors in Acceptance and Commitment Therapy
- Interventions for Radical Change: Principles and Practice of Focused Acceptance and Commitment Therapy
- A CBT Practitioner's Guide to ACT: How to Bridge the Gap Between Cognitive Behavioral Therapy and Acceptance and Commitment Therapy
- Committed Action in Practice: A Clinician's Guide to Assessing, Planning, and Supporting Change in Your Client (The Context Press Mastering ACT Series)
- A Contextual Behavioral Guide to the Self: Theory and Practice
- Contextual Schema Therapy: An Integrative Approach to Personality Disorders, Emotional Dysregulation, and Interpersonal Functioning
- The Essential Guide to the ACT Matrix: A Step-by-Step Approach to Using the ACT Matrix Model in Clinical Practice Essentials of Acceptance and Commitment Therapy
- Evolution and Contextual Behavioral Science: An Integrated Framework for Understanding, Predicting, and Influencing Human Behavior
- Experiencing ACT from the Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists (Self-Practice/Self-Reflection Guides for Psychotherapists)
- The Heart of ACT: Developing a Flexible, Process-Based, and Client-Centered Practice Using Acceptance and Commitment Therapy
- Innovations in Acceptance and Commitment Therapy: Clinical Advancements and Applications in ACT
- Inside This Moment: A Clinician's Guide to Promoting Radical Change Using Acceptance and Commitment Therapy
- Introduction to ACT: Learning and Applying the Core Principles and Techniques of Acceptance and Commitment Therapy
- Learning Acceptance and Commitment Therapy: The Essential Guide to the Process and Practice of Mindful Psychiatry
- Learning ACT for Group Treatment: An Acceptance and Com-mitment Therapy Skills Training Manual for Therapists
- A Liberated Mind: How to Pivot Toward What Matters
- The Little ACT Workbook
- Metaphor in Practice: A Professional's Guide to Using the Science of Language in Psychotherapy

- Mindfulness, Acceptance, and the Psychodynamic Evolution: Bringing Values into Treatment Planning and Enhancing Psychodynamic Work with Buddhist Psychology (The Context Press Mindfulness and Acceptance Practica Series)
- Mindfulness, Acceptance, and Positive Psychology: The Seven Foundations of Well-Being (The Context Press Mindfulness and Acceptance Practica Series)
- Mindfulness- and Acceptance-Based Behavioral Therapies in Practice (Guides to Individualized Evidence-Based Treatment)
- Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition
- Mindfulness and Acceptance in Social Work: Evidence-Based Interventions and Emerging Applications (The Context Press Mindfulness and Acceptance Practica Series)
- The Mindfulness-Informed Educator: Building Acceptance and Psychological Flexibility in Higher Education
- A Practical Guide to Acceptance and Commitment Therapy
- Talking ACT: Notes and Conversations on Acceptance and Commitment Therapy
- Values in Therapy: A Clinician's Guide to Helping Clients Explore Values, Increase Psychological Flexibility, and Live a More Meaningful Life
- The Wiley Handbook of Contextual Behavioral Science

ADVANCED PRACTICE IN ACT

- ACT Questions and Answers: A Practitioner's Guide to 150 Common Sticking Points in Acceptance and Commitment Therapy
- ACT Verbatim for Depression and Anxiety: Annotated Transcripts for Learning Acceptance and Commitment Therapy
- Advanced Acceptance and Commitment Therapy: The Experienced Practitioner's Guide to Optimizing Delivery
- Advanced Training in ACT: Mastering Key In-Session Skills for Applying Acceptance and Commitment Therapy
- Cognitive Defusion in Practice: A Clinician's Guide to Assessing, Observing, and Supporting Change in Your Client (The Context Press Mastering ACT Series)
- Getting Unstuck in ACT: A Clinician's Guide to Overcoming Common Obstacles in Acceptance and Commitment Therapy
- Inside This Moment: A Clinician's Guide to Promoting Radical Change Using Acceptance and Commitment Therapy
- Learning ACT: An Acceptance and Commitment Therapy Skills Training Manual for Therapists
- Learning ACT for Group Treatment: An Acceptance and Com-mitment Therapy Skills Training Manual for Therapists
- Metaphor in Practice: A Professional's Guide to Using the Science of Language in Psychotherapy
- Mindfulness for Two: An Acceptance and Commitment Therapy Approach to Mindfulness in Psychotherapy

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MORE ACT BOOKS

- Books for Specific Populations
- Books in 20+ Languages
- Self Help Books

admin May 11, 2009 - 8:12pm

ACT Books: Specific Populations

ACT Books: Specific Populations
ACT Books: Specific Populations

(The following list of books is from the LEARNING ACT RESOURCE GUIDE: The complete guide to resources for learning Acceptance & Commitment Therapy by Jason Luoma, Ph.D. Updated July 2020

learningact.com)

The following list only includes ACT self help books in English. Click here for the list of books in 20+ languages.

ANGER

Therapist guides

- Contextual Anger Regulation Therapy: A Mindfulness and Acceptance- Based Approach (Practical Clinical Guidebooks)

Client books

- Act on Life Not on Anger: The New Acceptance & Commitment Therapy Guide to Problem Anger
- The Moral Injury Workbook: Acceptance and Commitment Therapy Skills for Moving Beyond Shame, Anger, and Trauma to Reclaim Your Values

ANXIETY

Therapist guides

- Acceptance and Commitment Therapy: The Ultimate Guide to Using ACT to Treat Stress, Anxiety, Depression, OCD, and More, Including Mindfulness Exercises and a Comparison with CBT and DBT
- Acceptance and Commitment Therapy for Anxiety Disorders
- Acceptance-Based Behavioral Therapy: Treating Anxiety and Related Challenges
- ACT-Informed Exposure for Anxiety: Creating Effective, Innovative, and Values-Based Exposures Using Acceptance and Commitment Therapy
- The Clinician's Guide to Exposure Therapies for Anxiety Spectrum Disorders: Integrating Techniques and Applications from CBT, DBT, and ACT
- Trichotillomania: An ACT-Enhanced Behavior Therapy Approach Therapist Guide (Treatments That Work)

Client books

- The ACT on Anxiety Workbook
- The ACT Workbook for OCD: Mindfulness, Acceptance, and Exposure Skills to Live Well with Obsessive-Compulsive Disorder
- Anxiety Happens: 52 Ways to Find Peace of Mind
- Be Mighty: A Woman's Guide to Liberation from Anxiety, Worry, and Stress Using Mindfulness and Acceptance
- Cognitive Behavioral Therapy: How to Use CBT to Overcome Anxiety, Depression and Intrusive Thoughts + A Guide to Acceptance and Commitment Therapy and ACT Techniques
- The Confidence Gap: A Guide to Overcoming Fear and Self-Doubt
- In This Moment: Five Steps to Transcending Stress Using Mindfulness and Neuroscience
- Living Beyond OCD Using Acceptance and Commitment Therapy: A Workbook for Adults
- The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy (2nd Edition)
- The Mindfulness and Acceptance Workbook for Social Anxiety and Shyness: Using Acceptance and Commitment Therapy to Free Yourself from Fear and Reclaim Your Life
- Outsmart Your Anxious Brain: Ten Simple Ways to Beat the Worry Trick
- Social Courage: Coping and thriving with the reality of social anxiety
- Things Might Go Terribly, Horribly Wrong: A Guide to Life Liberated from Anxiety
- Trichotillomania: An ACT-Enhanced Behavior Therapy Approach Workbook (Treatments That Work)

- The Worry Trap: How to Free Yourself from Worry & Anxiety Using Acceptance and Commitment Therapy

CANCER

Client books

- Flying over Thunderstorms: Living Your Life with Cancer through Acceptance and Commitment Therapy

CHILDREN/ADOLESCENTS/PARENTING

Therapist guides

- Acceptance and Commitment Therapy: The Clinician's Guide for Supporting Parents
- Acceptance & Mindfulness Treatments for Children & Adolescents: A Practitioner's Guide
- ACT for Adolescents: Treating Teens and Adolescents in Individual and Group Therapy
- ACT for Treating Children: The Essential Guide to Acceptance and Commitment Therapy for Kids
- Challenging Perfectionism: An Integrative Approach for Supporting Young People Using ACT, CBT and DBT
- Mindfulness and Acceptance for Counseling College Students: Theory and Practical Applications for Intervention, Prevention, and Outreach (The Context Press Mindfulness and Acceptance Practical Series)
- Teen Anxiety: A CBT and ACT Activity Resource Book for Helping Anxious Adolescents
- The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection

Client books

- Acceptance and Mindfulness Toolbox for Children and Adolescents: 75+ Worksheets & Activities for Trauma, Anxiety, Depression, Anger & More
- The ACT Workbook for Kids: Fun Activities to Help You Deal with Worry, Sadness and Anger Using Acceptance and Commitment Therapy
- The ACT Workbook for Teens with OCD
- Becoming Mum
- Dark Agents, Book One: Violet and the Trial of Trauma
- Get Out of Your Mind and Into Your Life for Teens: A Guide to Living an Extraordinary Life
- The Gifted Kids Workbook: Mindfulness Skills to Help Children Reduce Stress, Balance Emotions, and Build Confidence
- The Joy of Parenting: An Acceptance and Commitment Therapy Guide to Effective Parenting in the Early Years
- The Mental Health and Wellbeing Workout for Teens: Skills and Exercises from ACT and CBT for Healthy Thinking
- The Mindfulness and Acceptance Workbook for Teen Anxiety: Activities to Help You Overcome Fears and Worries Using Acceptance and Commitment Therapy (Instant Help Book for Teens)
- Nuna and the Fog
- Parenting a Troubled Teen: Manage Conflict and Deal with Intense Emotions Using Acceptance and Commitment Therapy
- Parenting Your Anxious Child with Mindfulness and Acceptance: A Powerful New Approach to Overcoming Fear, Panic, and Worry Using Acceptance and Commitment Therapy
- Stuff That Sucks: Accepting What You Can't Change and Committing to What You Can

DEPRESSION

Therapist guides

- ACT for Depression: A Clinician's Guide to Using Acceptance & Commitment Therapy in Treating Depression

Client books

- The ACT Workbook for Depression and Shame: Overcome Thoughts of Defectiveness and Increase Well-Being Using Acceptance and Commitment Therapy
- The Mindfulness and Acceptance Workbook for Depression: Using Acceptance and Commitment Therapy to Move Through Depression and Create a Life Worth Living (2nd Edition)

DEVELOPMENTAL DISABILITIES

- Derived Relational Responding Applications for Learners with Autism and Other Developmental Disabilities: A Progressive Guide to Change

DIVERSE POPULATIONS

Therapist guides

- ACT for Gender Identity
- Mindfulness and Acceptance for Gender and Sexual Minorities: A Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies
- Mindfulness and Acceptance in Multicultural Competency: A Contextual Approach to Sociocultural Diversity in Theory and Practice (The Context Press Mindfulness and Acceptance Practica Series)

EATING DISORDERS/BODY IMAGE

Therapist guides

- Acceptance and Commitment Therapy for Body Image Dissatisfaction: A Practitioner's Guide to Using Mindfulness, Acceptance, and Values-Based Behavior Change Strategies
- Acceptance and Commitment Therapy for Eating Disorders: A Process-Focused Guide to Treating Anorexia and Bulimia
- A Clinician's Guide to Acceptance-Based Approaches for Weight Concerns: The Accept Yourself! Framework
- ACT for Anorexia Nervosa: A Guide for Clinicians
- Mindfulness and Acceptance for Treating Eating Disorders and Weight Concerns: Evidence-Based Interventions

Client books

- The Anorexia Workbook: How to Accept Yourself, Heal Your Suffering, and Reclaim Your Life
- Living with Your Body and Other Things You Hate: How to Let Go of Your Struggle with Body Image Using Acceptance and Commitment Therapy
- The Diet Trap: Feed Your Psychological Needs and End the Weight Loss Struggle Using Acceptance and Commitment

HEALTH/CHRONIC PAIN/INTEGRATED CARE

Therapist guides

- Acceptance and Commitment Therapy for Chronic Pain
- Behavioral Consultation and Primary Care: A Guide to Integrating Services
- Contextual Cognitive-Behavioral Therapy for Chronic Pain
- Mindfulness and Acceptance in Behavioral Medicine: Current Theory and Practice
- Psychological Treatment for Patients With Chronic Pain (Clinical Health Psychology)

- Real Behavior Change in Primary Care: Improving Patient Outcomes and Increasing Job Satisfaction
- Somatoform and Other Psychosomatic Disorders: A Dialogue Between Contemporary Psychodynamic Psychotherapy and Cognitive Behavioral Therapy Perspectives

Client books

- Better Living With IBS: A step-by-step program to managing your symptoms so you can enjoy life to the full!
- The Diabetes Lifestyle Book
- End the Insomnia Struggle: A Step-by-Step Guide to Help You Get to Sleep and Stay Asleep
- Living Beyond Lyme: Reclaim Your Life From Lyme Disease and Chronic Illness
- Living Beyond Your Pain: Using Acceptance & Commitment Therapy to Ease Chronic Pain

INTERPERSONAL/RELATIONSHIP ISSUES

Therapist guides

- Acceptance and Commitment Therapy for Couples: Using Mindfulness, Values, and Schema Awareness to Rebuild Relationships
- Acceptance and Commitment Therapy for Interpersonal Problems: Using Mindfulness, Acceptance, and Schema Awareness to Change Interpersonal Behaviors
- ACT and RFT in Relationships: Helping Clients Deepen Intimacy and Maintain Healthy Commitments Using Acceptance and Commitment Therapy and Relational Frame Theory
- The Interpersonal Problems Workbook: ACT to End Painful Relationship Patterns

Client books

- ACT with Love: Stop Struggling, Reconcile Differences, and Strengthen Your Relationship with Acceptance and Commitment Therapy
- The Mindful Couple: How Acceptance and Mindfulness Can Lead You to the Love You Want

LOSS/GRIEF

Client books

- The Reality Slap: Finding Peace and Fulfillment When Life Hurts

OCCUPATIONAL/COACHING

- Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy And Relational Frame Theory to Organizational Behavior Management
- Maximize Your Coaching Effectiveness with Acceptance and Commitment Therapy
- The Mindful and Effective Employee: An Acceptance and Commitment Therapy Training Manual for Improving Well-Being and Performance

PSYCHOSIS

Therapist guides

- Acceptance and Commitment Therapy and Mindfulness for Psychosis
- ACT for Psychosis Recovery: A Practical Manual for Group- Based Interventions Using Acceptance and Commitment Therapy
- Incorporating Acceptance and Mindfulness into the Treatment of Psychosis: Current Trends and Future Directions
- Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy, and Mindfulness Approaches within the Cognitive Behavioral

Therapy Tradition

RELIGION/SPIRITUALITY

Therapist guides

- Acceptance and Commitment Therapy for Christian Clients: A Faith-Based Workbook
- ACT for Clergy and Pastoral Counselors: Using Acceptance and Commitment Therapy to Bridge Psychological and Spiritual Care
- Faith-based ACT for Christian clients: An integrative treatment approach

SOCIAL WORK

- Mindfulness and Acceptance in Social Work

SPORTS/HUMAN PERFORMANCE

- The Psychology of Enhancing Human Performance: The Mindfulness-Acceptance-Commitment Approach
- The Winner's Mind: Strengthening Mental Skills in Athletes

SUBSTANCE ABUSE/ADDICTION

Therapist guides

- Acceptance and Commitment Therapy for Pathological Gamblers
- Acceptance and Commitment Therapy for Substance Abuse: A Clinician's Guide to Using Practical Mindfulness and Acceptance- Based Interventions for Alcoholism and Drug Addiction
- Investigating Acceptance and Commitment Therapy within Addictions
- Mindfulness and Acceptance for Addictive Behaviors: Applying Contextual CBT to Substance Abuse and Behavioral Addictions
- Mindfulness-Based Sobriety: A Clinician's Treatment Guide for Addiction Recovery Using Relapse Prevention Therapy, Acceptance and Commitment Therapy, and Motivational Interviewing

Client books

- Power Over Addiction: A Harm Reduction Workbook for Changing Your Relationship with Drugs
- The Wisdom to Know the Difference: An Acceptance and Commitment Therapy Workbook for Overcoming Substance Abuse

TRAUMA/PTSD

Therapist guides

- Acceptance and Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder and Trauma-Related Problems: A Practitioner's Guide to Using Mindfulness and Acceptance Strategies

Client books

- Dark Agents, Book One: Violet and the Trial of Trauma
- Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems
- The PTSD Survival Guide for Teens: Strategies to Overcome Trauma, Build Resilience, and Take Back Your Life (The Instant Help Solutions Series)

WORK/COACHING/BUSINESS

- Acceptance and Commitment Coaching (Coaching Distinctive Features)
- Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy And Relational Frame Theory to Organizational Behavior Management
- Maximize Your Coaching Effectiveness with Acceptance and Commitment Therapy
- Prosocial: Using Evolutionary Science to Build Productive, Equitable, and Collaborative Groups
- The Mindful and Effective Employee: An Acceptance and Commitment Therapy Training Manual for Improving Well-Being and Performance
- The psychology of enhancing human performance: The Mindfulness-Acceptance-Commitment (MAC) approach

YOGA

- Mindful Yoga-Based Acceptance and Commitment Therapy: Simple Postures and Practices to Help Clients Achieve Emotional Balance

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MORE ACT BOOKS

- Books for Learning ACT
- Books for Advanced Practice in ACT
- Books in 20+ Languages
- Self Help Books

admin May 11, 2009 - 8:30pm

ACT Books: Self Help

ACT Books: Self Help

Self-Help and Life Enhancement Resources

Please note that not all ACT self help books have been specifically empirically validated. A list of such studies is here and you can search for additional RCT studies here.

The World Health Organization also distributes an extensively validated free ACT self-help book *Doing What Matters in Times of Stress: An Illustrated Guide* and audio recordings to go with it: https://www.who.int/publications-detail/9789240003927

(The following list of books is from the LEARNING ACT RESOURCE GUIDE: The complete guide to resources for learning Acceptance & Commitment Therapy by Jason Luoma, Ph.D. Updated July 2020 learningact.com)

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Self-Help, Self-Improvement, and Skills Workbooks

ACT SELF HELP BOOKS

- Acceptance and Commitment Therapy: Principles of Becoming More Flexible, Effective, and Fulfilled
- The ACT Deck: 55 Acceptance & Commitment Therapy Practices to Build Connection, Find Focus and Reduce Stress
- ACTivate Your Life: Using acceptance and mindfulness to build a life that is rich, fulfilling and fun
- Break Free: Acceptance and Commitment Therapy in 3 Steps: A Workbook for Overcoming Self-Doubt and Embracing Life

- Cognitive Behavioral Therapy: A Guide to Self-Empowerment with CBT, DBT, and ACT: How to Build Brain Strength and Reshape Your Life with Behavioral Therapy
- The Courage Habit: How to Accept Your Fears, Release the Past, and Live Your Courageous Life
- The Diet Trap: Feed Your Psychological Needs and End the Weight Loss Struggle Using Acceptance and Commitment Therapy
- Escaping the Emotional Roller Coaster: ACT for the emotionally sensitive
- Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy
- Get the Life You Want: Finding Meaning and Fulfillment through Acceptance and Commitment Therapy
- The Happiness Trap: How to Stop Struggling and Start Living
- How to Be Nice to Yourself: The Everyday Guide to Self Compassion: Effective Strategies to Increase Self-Love and Acceptance
- The Illustrated Happiness Trap: How to Stop Struggling and Start Living
- Learning to Thrive: An Acceptance and Commitment Therapy Workbook
- The Mindfulness and Acceptance Workbook for Self Esteem
- The Mindfulness and Acceptance Workbook for Stress Reduction: Using Acceptance and Commitment Therapy to Manage Stress, Build Resilience, and Create the Life You Want (A New Harbinger Self-Help Workbook)
- The Power of Small: Making Tiny Changes When Everything Feels Too Much
- Reclaim Your Life: Acceptance and Commitment Therapy in 7 Weeks
- Sex ACT: Unleash the Power of Your Sexual Mind with Acceptance & Commitment Therapy
- Stress Less, Live More: How Acceptance and Commitment Therapy Can Help You Live a Busy yet Balanced Life
- Therapy Quest: An Interactive Journey Through Acceptance And Commitment Therapy
- Your Life on Purpose: How to Find What Matters and Create the Life You Want

Self Help Books for Specific Populations

ANGER

- Act on Life Not on Anger: The New Acceptance & Commitment Therapy Guide to Problem Anger
- The Moral Injury Workbook: Acceptance and Commitment Therapy Skills for Moving Beyond Shame, Anger, and Trauma to Reclaim Your Values

ANXIETY

- The ACT on Anxiety Workbook
- The ACT Workbook for OCD: Mindfulness, Acceptance, and Exposure Skills to Live Well with Obsessive-Compulsive Disorder
- Anxiety Happens: 52 Ways to Find Peace of Mind
- Be Mighty: A Woman's Guide to Liberation from Anxiety, Worry, and Stress Using Mindfulness and Acceptance
- Cognitive Behavioral Therapy: How to Use CBT to Overcome Anxiety, Depression and Intrusive Thoughts + A Guide to Acceptance and Commitment Therapy and ACT Techniques
- The Confidence Gap: A Guide to Overcoming Fear and Self-Doubt
- In This Moment: Five Steps to Transcending Stress Using Mindfulness and Neuroscience
- Let Go of Anxiety: Climb Life's Mountains with Peace, Purpose, and Resilience
- Living Beyond OCD Using Acceptance and Commitment Therapy: A Workbook for Adults
- The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy (2nd Edition)
- The Mindfulness and Acceptance Workbook for Social Anxiety and Shyness: Using Acceptance and Commitment Therapy to Free Yourself from Fear and Reclaim Your Life
- Outsmart Your Anxious Brain: Ten Simple Ways to Beat the Worry Trick
- Social Courage: Coping and thriving with the reality of social anxiety
- Ten Little Ways to Beat the Worry Trick: Outsmart Anxiety, Fear, and Panic

- Things Might Go Terribly, Horribly Wrong: A Guide to Life Liberated from Anxiety
- Trichotillomania: An ACT-Enhanced Behavior Therapy Approach Workbook (Treatments That Work)
- The Worry Trap: How to Free Yourself from Worry & Anxiety Using Acceptance and Commitment Therapy

CANCER

- Flying over Thunderstorms: Living Your Life with Cancer through Acceptance and Commitment Therapy

CHILDREN/ADOLESCENTS/PARENTING

- Acceptance and Mindfulness Toolbox for Children and Adolescents: 75+ Worksheets & Activities for Trauma, Anxiety, Depression, Anger & More
- The ACT Workbook for Teens with OCD
- Becoming Mum
- Dark Agents, Book One: Violet and the Trial of Trauma
- Get Out of Your Mind and Into Your Life for Teens: A Guide to Living an Extraordinary Life
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- Nuna and the Fog
- Parenting a Troubled Teen: Manage Conflict and Deal with Intense Emotions Using Acceptance and Commitment Therapy
- Parenting Your Anxious Child with Mindfulness and Acceptance: A Powerful New Approach to Overcoming Fear, Panic, and Worry Using Acceptance and Commitment Therapy
- Stuff That Sucks: Accepting What You Can’t Change and Committing to What You Can

DEPRESSION

- The Mindfulness and Acceptance Workbook for Depression: Using Acceptance and Commitment Therapy to Move Through
- Depression and Create a Life Worth Living (2nd Edition)

EATING DISORDERS/BODY IMAGE

- The Anorexia Workbook: How to Accept Yourself, Heal Your Suffering, and Reclaim Your Life
- Living with Your Body and Other Things You Hate: How to Let Go of Your Struggle with Body Image Using Acceptance and Commitment Therapy

HEALTH/CHRONIC PAIN/INTEGRATED CARE

- Better Living With IBS: A step-by-step program to managing your symptoms so you can enjoy life to the full!
- The Diabetes Lifestyle Book
- End the Insomnia Struggle: A Step-by-Step Guide to Help You Get to Sleep and Stay Asleep
- Living Beyond Lyme: Reclaim Your Life From Lyme Disease and Chronic Illness
- Living Beyond Your Pain: Using Acceptance & Commitment Therapy to Ease Chronic Pain

INTERPERSONAL/RELATIONSHIP ISSUES

- ACT with Love: Stop Struggling, Reconcile Differences, and Strengthen Your Relationship with Acceptance and Commitment Therapy
- The Mindful Couple: How Acceptance and Mindfulness Can Lead You to the Love You Want

LOSS/GRIEF

- The Reality Slap: Finding Peace and Fulfillment When Life Hurts

SPORTS/HUMAN PERFORMANCE

- The Psychology of Enhancing Human Performance: The Mindfulness-Acceptance-Commitment Approach
- The Winner's Mind: Strengthening Mental Skills in Athletes

SUBSTANCE ABUSE/ADDICTION

- Power Over Addiction: A Harm Reduction Workbook for Changing Your Relationship with Drugs
- The Wisdom to Know the Difference: An Acceptance and Commitment Therapy Workbook for Overcoming Substance Abuse

TRAUMA/PTSD

- Dark Agents, Book One: Violet and the Trial of Trauma
- Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems
- The PTSD Survival Guide for Teens: Strategies to Overcome Trauma, Build Resilience, and Take Back Your Life (The Instant Help Solutions Series

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MORE ACT BOOKS

- Books for Learning ACT
- Books for Advanced Practice in ACT
- Books for Specific Populations
- Books in 20+ Languages

admin May 11, 2009 - 8:48pm

RFT/Behavior Analysis Books

RFT/Behavior Analysis Books

- Dixon, M.R., Hayes, S.C., & Belisle, J. (2023). *Acceptance and Commitment Therapy for Behavior Analysts.* New York: Routledge.
- Ming, S., Gould, E., & Fiebig, J. (2023). *Understanding and Applying Relational Frame Theory: Mastering the Foundations of Complex Language in Our Work and Lives as Behavior Analysts.* Context Press.
- Fryling, M., Rehfeldt, R. A., Tarbox, J., & Hayes, L. J. (Eds.). (2020). *Applied Behavior Analysis of Language and Cognition: Core Concepts and Principles for Practitioners.* New Harbinger Publications.
- Villatte, M., Villatte, J. L., & Hayes, S. C. (2019). *Mastering the clinical conversation: Language as intervention*. New York: The Guilford Press.
- Törneke, N., Luciano, C., Barnes-Holmes, Y., & Bond, F. W. (2015). RFT for clinical practice: Three core strategies in understanding and treating human suffering. Chapter in *The Wiley handbook of contextual behavioral science*, 254-272.
- Dahl, J., Stewart, I., Martell, C., Kaplan, J. (2014) *ACT and RFT in Relationships: Helping Clients Deepen Intimacy and Maintain Healthy Commitments Using Acceptance and Commitment Therapy and Relational*

Frame Theory.

- Dymond, S., & Roche, B. (Eds.) (2013). *Advances in relational frame theory: Research and application.* New Harbinger Publications.
- McHugh, L., & Stewart, I. (2012). *The self and perspective taking: Contributions and applications from modern behavioral science.* Oakland: New Harbinger Publications.
- Törneke, N. (2010). *Learning RFT: An Introduction to Relational Frame Theory and Its Clinical Application*. Reno, NV: Context Press.

  - German Translation: Törneke, N. (2012). *Bezugsrahmentheorie : Eine Einführung.* Paderborn: Junfermann Verlag. (translated by Guido Plata)

  - Korean translation: Törneke, N. (2019). *Learning RFT: An Introduction to Relational Frame Theory and Its Clinical Application.* Hakjisa (translated by Lee, S.).

  - Spanish Transation: Törneke, N. (2016). *Aprendiendo TMR : una introducción a la Teoría del Marco Relacional y sus aplicaciones clínicas.* Úbeda, Jaén: Didacbook.
- Rehfeldt, R. A., Barnes-Holmes, Y. (2009). *Derived relational responding: Applications for learners with autism and other developmental disabilities.* Oakland, CA: New Harbinger Publications, Inc.

  - *Derived Relational Responding* offers a series of revolutionary intervention programs for applied work in human language and cognition targeted at students with autism and other developmental disabilities. It presents a program drawn from derived stimulus relations that you can use to help students of all ages acquire foundational and advanced verbal, social, and cognitive skills. The first part of Derived Relational Responding provides step-by-step instructions for helping students learn relationally, acquire rudimentary verbal operants, and develop other basic language skills. In the second section of this book, you'll find ways to enhance students' receptive and expressive repertoires by developing their ability to read, spell, construct sentences, and use grammar. Finally, you'll find out how to teach students to apply the skills they've learned to higher order cognitive and social functions, including perspective-taking, empathy, mathematical reasoning, intelligence, and creativity. This applied behavior analytic training approach will help students make many substantial and lasting gains in language and cognition not possible with traditional interventions.
- Dahl, J. C., Plumb, J. C., Stewart, I., & Lundgren, T. (2009). *The Art and Science of Valuing in Psychotherapy: Helping Clients Discover, Explore, and Commit to Valued Action Using Acceptance and Commitment Therapy.* Oakland, CA; New Harbinger Publications, Inc.

  - *The Art and Science of Valuing in Psychotherapy* is an applied volume in purpose, but includes an RFT account of each of the ACT processes, and in particular an in depth RFT perspective on personal values and the clinical interventions employed to enhance them and promote committed action.
- Ramnero, J., & Törneke, N. (2008). *ABCs of human behavior: Behavioral principles for the practicing clinician.* Oakland, CA: New Harbinger & Reno, NV: Context Press.

  - The *ABCs of Human Behavior* offers the practicing clinician a solid and practical introduction to the basics of modern behavioral psychology. The book focuses both on the classical principles of learning as well as more recent developments that explain language and cognition in behavioral and contextual terms. These principles are not just discussed in the abstract—rather the book shows how the principles of learning apply in a clinical context. Practical and easy to read, the book walks you through both common sense and clinical examples that will help you use behavioral principles to observe, explain, and influence behavior in a therapeutic setting.
- Miltenberger, R.G., (2008). *Behavior modification: Principles and procedures (4th Ed.).* Pacific Grove, CA: Thomson/Wadsworth.
- Woods, D. W., & Kanter, J. W. (Eds.). (2007). *Understanding behavior disorders: A contemporary behavioral perspective*. Reno, NV: Context Press.

  - *Understanding behavior disorders* presents a contemporary behavioral model of behavior disorders that incorporates the findings of current RFT and ACT research. Rich in possibilities for clinical work, this view of disordered behavior is an important milestone in clinical psychotherapy - an opportunity for behavioral clinicians to reintegrate their clinical practice with an experimental analysis of behavior.
- Cooper, J.O., Heron, T.E. & Heward, W.L. (2007). *Applied Behavior Analysis (2nd Edition)*. Prentice Hall.

  - *Applied Behavior Analysis (2nd Edition)* is great resource to get you ready for the BCBA exam and to understand basic principals.

- Baum, W. M. (2004). *Understanding Behaviorism: Behavior, Culture, and Evolution (2nd edition)*. Wiley-Blackwell.
- Pierce, W.D. & Cheney, C.D. (2003). *Behavior Analysis and Learning, 3rd edition.*Lawrence Erlbaum.
  - The "focus on research" and "on the applied side" sections in various chapters add an excellent generalization of concepts into interesting areas. There is a section on Bandura and the Bobo doll, review of Sidman's comments on coercion, review of the intrinsic/extrinsic reinforcement debates, a creativity section, respondent conditioning and heroin overdose, medical conditioning, and much more.
- Barnes-Holmes, Y., Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational frame theory: A post-Skinnerian account of human language and cognition. In H. W. Reese & R. Kail (Eds.), Advances in Child Development and Behavior, Volume 28 (pp. 101-138). New York: Academic.
- Baldwin, J.D. & Baldwin, J.I. (2000). *Behavior Principles in Everyday Life (4th Edition)*. Prentice Hall.
  - *Behavior Principles in Everyday Life (4th Edition)* is a really accessible account of behavioral principles. Great accompaniment to *ABCs of Human Behavior.*
- Dougher, M. J. (Ed.). (2000). *Clinical Behavior Analysis.* Reno, NV: Context Press.
- Chiesa, M. (1994). *Radical Behaviorism: The philosophy and science*. Cambridge Center.
- Leigland, S. (1992). *Radical behaviorism: Willard Day on psychology and philosophy*. Reno, NV: Context Press.
  Puts Skinner's work in context; links history/philosophy and the battles of minds as a background to RFT/ACT.
- Catania, C. (1992). *Learning*. Prentice Hall.
- Hayes, S. C. (Ed.). (1989/2004). *Rule Governed behavior: Cognition, contingencies, and instructional control.* New York: Plenum / reprinted in 2004 by Context Press.
  - One of the first full-length presentations of the ACT / RFT model is in three chapters in this book on the topic.
- Skinner, B.F. (1965). *Science and Human Behavior*. Free Press.

Community February 17, 2010 - 10:46pm

ACT Books in 20+ Languages

ACT Books in 20+ Languages

- **Click here for a list of ACT and RFT Books Translated in 20+ Languages**

Community December 1, 2021 - 1:59pm

General Purpose Books on Contextual Behavioral Science

General Purpose Books on Contextual Behavioral Science

General Purpose Books on Contextual Behavioral Science

- McHugh, L., Stewart, I., & Almada, P. (2019). *A Contextual Behavioral Guide to the Self: Theory and Practice.* Oakland, CA: New Harbinger.
- Wilson, D.S., Hayes, S.C. (2018) *Evolution and Contextual Behavioral Science: An Integrated Framework for Understanding, Predicting, and Influencing Human Behavior.* Context Press.
- Zettle, R. D., Hayes, S.C., Barnes-Holmes, D., Biglan, A. (2016) *The Wiley Handbook of Contextual Behavioral Science (Wiley Clinical Psychology Handbooks)* Wiley-Blackwell.

- Ramnero, J., & Torneke, N. (March 2008). *ABCs of human behavior: Behavioral principles for the practicing clinician*. Oakland, CA: Context Press / New Harbinger.

It's a basic behavior analysis book for clinicians/ M.D.s/ psychiatrists/ etc. who haven't had training in BA. Goes all the way up to RFT. Nice.

- Woods, D. W., & Kanter, J. W. (Eds.). (2007). *Understanding behavior disorders: A contemporary behavioral perspective*. Oakland, CA: Context Press/New Harbinger.

  This volume presents a contemporary behavioral model of behavior disorders that incorporates the findings of current RFT and ACT research. Rich in possibilities for clinical work, this view of disordered behavior is an important milestone in clinical psychotherapy - an opportunity for behavioral clinicians to reintegrate their clinical practice with an experimental analysis of behavior.

- Biglan, A. (1995). *Changing cultural practices: A contextualistic framework for intervention research.* Oakland, CA: Context Press/New Harbinger.

  This is begins to show how you might scale these issues to the level of cultural practices. If the ACT model is correct, we either alter the prevalence of psychological inflexibility or we fail to help the human condition. You can do that one at a time, or in formal prevention efforts, but either way it is the same bottom line. No change in prevalence = failure. So we need to think about how to measure this and approach this wisely throughout the work we are doing.

- Hayes, S. C., Hayes, L. J., Reese, H. W., & Sarbin, T. R. (Eds.). (1993). *Varieties of scientific contextualism*. Oakland, CA: Context Press/New Harbinger.

  If you get interested in the philosophical foundations of ACT, this will help you understand them.

- Leigland, S. (1992). *Radical behaviorism: Willard Day on psychology and philosophy*. Oakland, CA: Context Press/New Harbinger.

  Puts Skinner's work in context; links history/philosophy and the battles of minds as a background to RFT/ACT.

- Hayes, S. C. (Ed.). (1989/2004). *Rule Governed behavior: Cognition, contingencies, and instructional control.* New York: Plenum / reprinted in 2004 by Context Press and currently sold by Oakland, CA: Context Press/New Harbinger..

  One of the first full-length presentations of the ACT / RFT model is in three chapters in this book on the topic. This book is now available in paperback from Context Press.

admin May 11, 2009 - 8:54pm

FAP and CFT Books

FAP and CFT Books

FAP Books

- Gareth Holman PhD, Jonathan Kanter PhD, Mavis Tsai PhD, Robert Kohlenberg PhD, Steven C. Hayes (2017) *Functional Analytic Psychotherapy Made Simple.*
- Mavis Tsai, Robert J. Kohlenberg, Jonathan W. Kanter, Gareth I. Holman, Mary Plummer Loudon (2012) *Functional Analytic Psychotherapy (CBT Distinctive Features)*
- Mavis Tsai, Robert J. Kohlenberg, Jonathan W. Kanter, Barbara Kohlenberg, William C. Follette, Glenn M. Callaghan. (2008) *The Practice of Functional Analytic Psychotherapy.*
- Mavis Tsai, Robert J. Kohlenberg, Jonathan W. Kanter, Barbara Kohlenberg, William C. Follette, Glenn M. Callaghan (2008) *A Guide to Functional Analytic Psychotherapy: Awareness, Courage, Love, and Behaviorism.*

- Mavis Tsai, Robert J. Kohlenberg. (2007) *Functional Analytic Psychotherapy: Creating Intense and Curative Therapeutic Relationships.* (Published in 1991 and republished in 2007)

Translations of FAP Books

- *Italian:* Tsai, M. Kohlenberg, R., Kanter, J. W., Holman, G., Plummer Loudon, M. (2013). La psicoterapia analitico-funzionale (FAP). Caratteristiche distintive. (Ed. C. Orsini) Franco Angeli Edizioni.
- *Portuguese:* Holman, G., Kanter, J. W., Tsai, M., & Kohlenberg, R. (2022). Psicoterapia Analítica Funcional Descomplicada: Guia Prático Para Relações Terapêuticas (Rolim de Moura, P., Bastos Oshiro, C. K., & Villas-Bôas, A., Trans). Sinopsys Editora.
- *Spanish:* Kanter, J. W., Tsai, M., & Kohlenberg, R. J. (2021). La práctica de la psicoterapia analítico-funcional. (Ed J. Virues-Ortega) ABA Espanay.
- *Spanish:* Kohlenberg, R. J. & Tsai, M. (2021). FAP. Psicoterapia Analítico Funcional: Creación de relaciones terapéuticas intensas y curativas. Editociones Psara

Compassion Focused Therapy Books for Therapists

- Gilbert, P. & Simos, G. (Editors) (2022). *Compassion Focused Therapy: Clinical Practice and Applications.* Routledge.
- Kolts, R.L., Bell, T., Bennett-Levy, J., Irons, C. (2018) *Experiencing Compassion Focused Therapy from the Inside Out.*
- Kolts, R.L. (2016) *CFT Made Simple* - An excellent and very readable introduction to compassion-focused therapy, with a fantastic chapter showing how to use chair-work with highly self-critical clients.
- Tirch, D., Schoendorff, B., Silberstein, L.R. (2014) *The ACT Practitioner's Guide to the Science of Compassion* - This is the first book on the market to provide an in-depth discussion of compassion in the context of ACT and other behavioral sciences. It offers case conceptualization, assessments, and direct clinical applications that integrate ACT, functional analytic psychotherapy, and compassion focused therapy to enhance your clinical practice.
- Gilbert, P. (2010) *Compassion-Focused Therapy: Distinctive Features* - A key reference source for learning compassion-focused therapy. It's concise, filled with clinical wisdom, and a handy reference for thinking through how to work with shame and self-criticism.
- Gilbert, P. (2009). *The Compassionate Mind.* London: Constable.

Books based on Compassion-Focused Therapy for Clients

- *How to Be Nice to Yourself: The Everyday Guide to Self Compassion* by Laura Silberstein-Tirch (2019)
- *The Mindful Self-Compassion Workbook: A Proven Way to Accept Yourself, Build Inner Strength, and Thrive* by Kristin Neff and Christopher Germer (2018)
- *Self-Compassion: The Proven Power of Being Kind to Yourself* by Kristin Neff
- *Compassion Focused Therapy for Dummies* - From the publisher: Compassion Focused Therapy For Dummies is a wonderful resource if you are seeing—or thinking about seeing—a therapist who utilizes compassion techniques, or if you would like to leverage the principles of compassion focused therapy to manage your own wellbeing.
- *Mindful Compassion: How the Science of Compassion Can Help You Understand Your Emotions, Live in the Present, and Connect Deeply with Others.* This book by Paul Gilbert (creator of compassion-focused therapy) and Choden (a Buddhist monk) presents the principles of compassion-focused therapy in an accessible manner. A great book for people wanting to develop a kinder, more compassionate way of related to themselves and others.
- *The Power of Self-Compassion: Using Compassion-Focused Therapy to End Self-Criticism and Build Self-Confidence* by Welford and Gilbert. This book uses tools from Compassion-Focused Therapy to guide increased self-compassion and self-confidence.
- *An Open-Hearted Life: Transformative Methods for Compassionate Living from a Clinical Psychologist and a Buddhist Nun* is written in short chapters that make it easy to consume. Each

chapter can be read in one sitting, each has a brief exercise to put to use the concepts therein, and each covers one topic that is important to living a more compassionate life.
- *The Compassionate Mind Guide to Overcoming Anxiety* - This book is written primarily from the perspective of compassion-focused therapy, but also integrates techniques from acceptance and commitment therapy. This might be a particularly relevant book for people who are both anxious and highly self-critical.
- *The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions.* By C.K. Germer
- *The Compassionate-Mind Guide to Managing Your Anger* – A book based on compassion-focused therapy on how to bring compassion to the pain of anger and feeling threatened.
- *The Compassionate-Mind Guide to Recovering from Trauma and PTSD* - A book based on compassion-focused therapy on how to bring compassion to people who have survived trauma and abuse.
- *The Compassionate-Mind Guide to Ending Overeating* - A book based on compassion-focused therapy for people who binge or suffer from disordered eating.
- *The Compassionate-Mind Guide to Building Social Confidence* - A book based on compassion-focused therapy for people who are shy or suffer from social anxiety.

Mindfulness and other Third Generation Books

- Jonathan Feiner (2020). *Mindfulness: A Jewish Approach.* Mosaica Press.
- Christopher Germer, Ronald D. Siegel, and Paul R. Fulton, Editors (2016) *Mindfulness and Psychotherapy, Second Edition.*
- Ann F. Haynos, Evan Forman, Meghan Butryn, and Jason Lillis, Editors (2016) *Mindfulness and Acceptance for Treating Eating Disorders and Weight Concerns: Evidence-Based Interventions*
- Matthew D. Skinta and Aisling Curtin (2016) *Mindfulness and Acceptance for Gender and Sexual Minorities: A Clinician's Guide to Fostering Compassion, Connection, and Equality Using Contextual Strategies*
- Dennis Tirch, Laura R. Silberstein-Tirch, Russell L. Kolts (2015) *Buddhist Psychology and Cognitive-Behavioral Therapy: A Clinician's Guide*
- Paul Gilbert and Choden. (2014). *Mindful Compassion: How the Science of Compassion Can Help You Understand Your Emotions, Live in the Present, and Connect Deeply with Others.*
- Matthew S. Boone, Editor (2014) *Mindfulness and Acceptance in Social Work: Evidence-Based Interventions and Emerging Applications*
- Jason M. Stewart, Editor (2014) *Mindfulness, Acceptance, and the Psychodynamic Evolution: Bringing Values into Treatment Planning and Enhancing Psychodynamic Work*
- Jacqueline Pistorello, Editor (2013) *Mindfulness and Acceptance for Counseling College Students: Theory and Practical Applications for Intervention, Prevention, and Outreach*
- Todd B. Kashdan and Joseph Ciarrochi, Editors (2013) *Mindfulness, Acceptance, and Positive Psychology: The Seven Foundations of Well-Being*
- Steven C. Hayes and Michael Levin, Editors (2012) *Mindfulness and Acceptance for Addictive Behaviors: Applying Contextual CBT to Substance Abuse and Behavioral Addictions*
- Lance McCracken (2011) *Mindfulness and Acceptance in Behavioral Medicine: Current Theory and Practice*
- Steven C. Hayes, Victoria M. Follette, and Marsha M. Linehan, Editors (2011) *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition*
- Richard W. Sears, Dennis D. Tirch, Robert B. Denton (2011) *Mindfulness in Clinical Practice*
- Lizabeth Roemer and Susan M. Orsillo (2010) *Mindfulness- and Acceptance-Based Behavioral Therapies in Practice (Guides to Individualized Evidence-Based Treatment)*
- Ruth Baer, Editor (2010) *Assessing Mindfulness and Acceptance Processes in Clients: Illuminating the Theory and Practice of Change*
- Kelly G. Wilson PhD and Troy DuFrene (2009) *Mindfulness for Two: An Acceptance and Commitment Therapy Approach to Mindfulness in Psychotherapy*
- Kashdan, T. (2009). *Curious? Discover the missing ingredient to a fulfilling life.* New York, NY: Harper Collins.

- Flowers, S.H. (2009). *The Mindful Path Through Shyness: How Mindfulness and Compassion Can Free You From Social Anxiety, Fear, and Avoidance*. Oakland, CA: New Harbinger.
- Vieten, C. (2009). *Mindful Motherhood: Practical Tools for Staying Sane During Pregnancy and Your Child's First Year.* Oakland, CA: New Harbinger.
- Greco, L., & Hayes, S. C. (Eds.). (2008). *Acceptance and mindfulness treatments for children and adolescents: A practitioner's guide*. Oakland, CA: New Harbinger. Shows how the work in acceptance and mindfulness is impacting the treatment of children and adolescents. Several ACT chapters; also includes DBT, MBCT, MBSR etc
- Baer, R. A. (Ed.). (2005). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. New York: Academic Press. This book discusses the conceptual foundation, implementation, and evidence base for the four best-researched mindfulness treatments: mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT). All chapters were written by researchers with extensive clinical experience. Each chapter includes the conceptual rationale for using a mindfulness-based treatment and a review of the relevant evidence base.
- Orsillo, S. M., & Roemer, L. (Eds). (2005). *Acceptance and mindfulness-based approaches to anxiety: New directions in conceptualization and treatment*. New York: Kluwer Academic/Plenum. Includes conceptual and practical applications of ACT and other third-wave therapies to the anxiety disorders, with chapters covering ACT, DBT skills, and MBSR, as well as specific anxiety disorders, anxiety in children and basic research in anxiety and acceptance.
- Hayes, S. C., Follette, V. M., & Linehan, M. M. (Eds.). (2004). *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition*. New York: Guilford Press. Meet most of the major approaches in the third wave. Shows that ACT is not alone. Lots of good ideas for expanding your clinical work inside a third wave model. More theoretical though than immediately practical.
- Dougher, M. J. (Ed.). (2000). *Clinical Behavior Analysis*. Oakland, CA: Context Press/NewHarbinger. Situates ACT, Behavioral Activation, and other approaches in clinical behavior analysis. That is the tradition where this work comes from.
- Hayes, S. C., Jacobson, N. S., Follette, V. M., & Dougher, M. J. (Eds.). (1994). *Acceptance and change: Content and context in psychotherapy*. Oakland, CA: Context Press/New Harbinger. The first comprehensive third wave book. It carved out the domain we are now busy filling. Still relevant, despite its age.

admin May 11, 2009 - 8:56pm

Books (Archives)

Books (Archives) Community March 1, 2024 - 1:38pm

ACT Study Group for Beginners

ACT Study Group for Beginners

How This Came About

In February 2004 several beginners, interested but little experienced with ACT, found themselves on the ACT listserve. The idea arose for launching an on-line study group for beginners. Very soon 30 or more folks signed in, and the "ACT study group for beginners" was born.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). Acceptance and Commitment Therapy: An experiential approach to behavior change. New York: Guilford Press.

We began reading the book chapter by chapter, and discussing it on the listserve. The first, theoretical part was tough. Kate Partridge raised the idea of starting each discussion with a summary of a section of the book. The summarizing began on 04/13/04, when we reached the clinical part of the book.

What you find below is a uncensured, uncorrected collection of the summaries. They're meant for discussion, not for teaching purposes per se, but we are allowing them to become part of this website simply because we hope they might be useful to other beginners. People from 7 countries did parts of it: Australia, Belgium, Canada, Netherlands, Spain, United Kingdom, and the USA. (More countries participated in the discussion: Germany, Israel, Sweden, …) It was fun to participate, and very inspiring, … but sometimes hard too: we chose a fixed schedule of weekly reading, discussing, and sometimes summarizing … but we were willing and committed.

Part of the value in doing this probably cannot be achieved just by reading these products. This way we structured it beginners, hesitatant to take part in discussions between more experienced ACT-ors, had unique learning opportunities by taking part in the beginners' discussion. The "masters" could watch us and interfered when helpful, which also was stimulating. I can recommend the formula to other beginners and hesitating "lurkers". It might be worth while to start a second round. But that's up to others. Meanwhile, here are our written products.

Thanks to all beginners who participated, and to the listserve for the opportunity!
Francis De Groot July 2, 2005 - 4:35pm

ACT Book Summary: Pages 81-86

ACT Book Summary: Pages 81-86

Contributed by: Francis De Groot Part II: The clinical methods of ACT Chapters 3 to 9 present the ACT concepts and strategies. ACT = Acceptance and Commitment Therapy = Accept, Choose and Take action Goal: to move in the direction of chosen values, and accept the automatic effects of life's difficulties. Barriers: experiential avoidance & cognitive fusion Source of these barriers: verbal Act stages focus on shift from content of experience to context of experience Why?: to enable clients to pursue valued goals in life. During treatment metaphors, paradoxes, and experiential exercises are frequently used to undermine the traps of literal language and pliance. Metaphors:

- are not specific & proscriptive (less pliance)
- are more like pictures (more experiential)
- are easily remembered

Therapeutic paradox:

- not the classic therapeutic paradox to eliminate certain sympoms: e.g. "don't obey me". They rely on pliance
- = inherent paradox: functional contradictions between literal and functional properties of a verbal event: e.g. "try to be spontaneous"

Experiential exercises: To help contact potentially troublesome thoughts, feelings, memories, ...

- experience in a different context
- allows experience to be observed & studied experientially
- superior to discussing

Summary: More:

- pursuing of valued goals
- direct experience
- acceptance of negative experiences (thoughts, feelings, memories, bodily sensations, ...)

Less:

- literal language
- pliance

Use of: less "literalizing" verbal modalities: metaphors, paradoxes, experiential exercises Focus on: WHAT DOES YOUR EXPERIENCE TELL YOU? This also goes for therapists? Let's go for some tracking, not for pliance!
Francis De Groot May 1, 2005 - 1:13pm

ACT Book Summary: Pages 87 - 91

ACT Book Summary: Pages 87 - 91

Contributed by Kate Partridge Creative Hopelessness: Challenging the Normal Change Agenda [Comments in square brackets are from me. I know this summary is almost as long as the section itself, but doing it has really helped me understand it. Kate] Theoretical Focus Resistance to Change: Clients enter therapy because they have already struggled for a long time with "the problem", in many different ways (contemplation, planning, discussion, praying, reading, tapes, etc.) In spite of so much effort having been exerted, no solution to the problem has arisen. In this sense, the client is resistant to change. There are [at least] two reasons for this: 1) The client has not found the right way to fix the problem. 2) There is a fundamental flaw in the model for change, which is based on culturally sanctioned, language-based rules for solving problems. Culturally Sanctioned [Unconscious] Problem-Solving Rules:

- Psychological problems = the presence of unpleasant inner experiences (feelings, thoughts, sensations, etc.). The presence of these unpleasant experiences signal that "something is wrong and must be changed".
- "Healthy living" = the absence of these negative experiences.
- These experiences need to be eliminated by the correction of inner deficits (e.g., lack of confidence), through the understanding or modification of their causes (e.g., overcritical parents).

The underlying metaconcept is: "The problem is one of bad content; change the content and the problem will go away." ACT Assumption [Message of Hope and Liberation]: The Change Agenda Is Not Workable: The culturally sanctioned problem solving rules are like water to fish - they are taken so much for granted that to challenge them seems nonsensical. The ACT therapist works to undermine the sense of normality surrounding these rules, by showing that efforts based on these rules can actually be the source of problems, not their solution. The therapist asks: • "Which will you believe, your 'mind' or your actual experience of the unworkability of these rules?" [Not expressed in these words, naturally.] The therapist takes apart for the client the underlying logical assumption: 1) Identify the problem: "bad" thoughts and feelings. 2) Eliminate the problem: " " " " 3) Life will then improve. By drawing out multiple examples from the client's own history, the client can become experientially connected to what is often a long series of unsuccessful attempts to use this strategy. This can be quite painful. The therapist aims to organize most of the client's solutions into a general class of events that can be described as: "Control of private experience = Successful living." The client is (gently) encouraged to confront the reality of their multiple experiences of the unworkability of this assumption. This leaves the client often not knowing what to do next, in a state of "creative hopelessness". The state is "creative" because entirely new strategies can be developed with being overwhelmed by the old and previously unconscious rule system. Clinical Focus In this phase of ACT, the therapist focuses on the following issues:

- Client has tried everything, but the problem remains.
- The problem is not one of motivation, nor of specific tactics. The client is not to blame for being stuck.
- There is a paradox here: Working hard to solve the problem makes the problem seem worse. The solution is part of the problem. [I need some concrete examples here of how the solution makes things worse - KAP]
- The logic of the problem-solving system is flawed. A more valid and reliable source of problem-solving is the client's own direct experience and their feedback from life.

TABLE 4.1: ACT Goals, Strategies, and Interventions Regarding Creative Hopelessness. [There is no point in summarizing this useful table. It is on Page 91]. Informed Consent ACT interventions can be intense, and the client must be prepared for this by being provided with:

- general descriptions of operating principles [How general?]
- frank discussion of areas of ambiguity [What does this mean?]
- alternative forms of therapy that could be followed instead of ACT

Treatment involves the client in having to face previously avoided experiences. When this occurs, the client can start to question his/her commitment to treatment. Therefore, the client should be committed to meeting for a certain number of sessions, to expect ups and downs, and to hang in until a progress review occurs at a specified session. In this way, the client is guided away from impulsively dropping out of treatment.
Eric Fox May 1, 2005 - 1:18pm

ACT Book Summary: Pages 92 - 98

ACT Book Summary: Pages 92 - 98
Drawing out the system-developing the idea with the client that the process of trying to solve the problem-verbalized as actions taken by the mind or as "language", creates a logical trap that if directly described presents its own paradox of being linear, literal and analytical-the very process we are attempting to discredit. A less direct approach: What do you want? Outcome goals: Love others, have children, be content...Process goals: A technique (I think) that leads to outcomes. Example-Outcome goal: living well, Process goal: changing bad feelings. Linking these two by a technique such as drinking is an unworkable system. I'm confused about this. "Process" seems dynamic while "Outcome" seems static. Aren't "drinking" and "changing bad feelings" both processes? In other words, isn't "changing bad feelings" a strategy while drinking is a tactic (subset)? Anyway then-What has the client tried? This is where you identify with the client and follow along with his historic plan of solving his problems, clarifying with examples the process of attempts, and agreeing on their relative success of lack thereof(there should be lack thereof or the person wouldn't be here, right?). How has it worked? Using the "mind" metaphor to reify the process of producing inflexible and unworkable verbal rules that persist as technique in spite of experiential feedback that they aren't working. Also pointing out the false solution of "trying harder" when confronted with this reality. This (1) focuses on verbal understanding and (2) helps client look at mental reactions rather than through them. The essence of this section is creating the dichotomy of what your mind tells you versus what experience is telling you.
Eric Fox May 2, 2005 - 10:53pm

ACT Book Summary: Pages 98 - 105

ACT Book Summary: Pages 98 - 105
Confronting the System: Creative Hopelessness (this is a little long, but wanted to make sure I covered everthing adequately)

- Begins by noting that engendering creative hopelessness is the first ACT intervention (following thorough assessment of the client's 'presenting problem', change agenda, and strategies that have been tried to resolve it.
- Also notes (or warns) that doing this inevitably involves the use of human language, which is part of the trap the client is in anyway - the conundrum of attempting to side- step the trap of language, but needing to use language to deliver interventions. The therapist is thus just as susceptible as the client to the trap of literal language, and must be careful about too strongly believing or becoming fixed on the logic of words.
- This highlights the equality of therapist and client, with the therapist's only advantage that of having an outside perspective (the client would also have this advantage were the therapist's problems the topic of discussion).
- The therapist confronts the system by working outside it, using language only to meet certain ends, not to change beliefs or model more "rational" beliefs and thoughts. If those ends are not met, then the words are

not true, no matter how logical. So this takes us from the typical reliance on logic to relying on workability - this become our metric. The question for both clients and therapists is "does that work for you?".

Workability and Creative Hopelessness

- In the beginning of this section, the authors provide a caveat that it is written with severely affected clients in mind (although the tools are still useful in less severe circumstances).
- The work starts with confrontation, although of a different sort than typically thought. The confrontation is between the client's change agenda and the client's experience of the workability of that system. The message of the therapist and client being in the same boat as far as confronting this system (i.e. the therapist is not some expert who has all the answers) can be powerfully conveyed by the therapist sitting next to the client, with the system imagined as out in front, being confronted by both people together.
- The therapist is armed at this point with information related to strategies the client has tried in the past that haven't worked.
- Unworkability is gently suggested - the therapist highlights how hard the client has been thinking and working at the change agenda, and that consulting a therapist is another attempt to find a solution. Another powerful intervention here is to highlight that usually when we work this hard, things get accomplished, but that this situation seems different. All this effort has not resolved the issue.(this is a subtle way to highlight the role of the client's experience)
- This moves into a discussion of the notion that perhaps looking for solutions is part of the problem. That the client is stuck, and it's not because they are not clever enough to figure it out or are not trying. Perhaps it is because it can't work. The authors suggest that a way to make this more tangible to the client is to suggest that the client doesn't actually believe there is a solution - that anything offered by the therapist would likely just be refuted by the client based on the client' s experience that it would not work. So here, the idea that experience and mind tell the client different things, and that experience is more accurate is brought to the discussion.
- The authors break from the therapeutic dialogue here to discuss the importance of framing creative hopelessness as a positive thing. Being careful not to suggest that the client is hopeless or to engender hopeless feelings. But rather to introduce this idea as a starting point for giving up unworkable strategies and opening up for new possibilities to emerge.
- Several metaphors are provided, including the Man in the Hole metaphor, p. 101, to side-step the trap of language. This metaphor is flexible and can be used to address many issues a client might raise, such as:
    - giving up
    - belief in the need to delve into the past
    - responsibility
    - blame
    - continuing to look for solutions - this one actually seems really important and I think best highlights the goals of this part of therapy. The therapist really seems to stay away from promising solutions, but takes on a role of saying "I don't know". The goal at this point is batter down the tendency toward sense-making and to stay with the importance of the client giving up unworkable strategies, even without any promise of what will come next. This is a leap of faith and should be noted as such, since clients (like the rest of us) are definitely not used to not trying to make sense of things when there are problems in our lives.
    - illustrating the opportunity suffering presents for us to learn to disentangle ourselves from our own minds.

  The goal of this dialogue and the highlighting of what experience tells us, then, is to break apart the control-private-events-to-control-life-quality believe system. It is also to make contact with the client's knowledge of how the world works (rather than systems of logical language and rules that govern behavior). The authors highlight the importance of being mindful of this goal through this discussion.

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ACT Book Summary: Pages 105 - 110

ACT Book Summary: Pages 105 - 110

Chinese Handcuffs Metaphor illustrates that sometimes the counterintuitive solution is the one that works. Brief; can be used to reinforce the message of the more extended Man in the Hole metaphor or to introduce the therapy as part of an informed consent procedure. **Understanding: Belief versus Experiential Wisdom** Expressions of belief or disbelief on the part of the client are irrelevant and probably signify that the old control agenda is trying to claim any new territory opened up by metaphorical talk. The dimension of belief and disbelief is toward the nonexperiencing, derived stimulus functions end of the experiencing-nonexperiencing continuum. This includes the therapist's beliefs as well as the client's. **Persuasion is not an ACT move; consulting one's experience is. Confusing No Hope with Creative Hopelessness** 2 possible errors: confusing creative hopelessness with hopelessness as a negative feeling state or with hopelessness as a belief. Creative hopelessness is an action or a behavioral posture that results from experiencing the uselessness of deliberate control over unwanted thoughts and feelings, because this control cannot deliver the promised rewards. The over expansive track that maintains the control agenda is undermined. This prepares the way for a fundamentally new approach. However, talking about hopelessness is a sign of persuasion efforts on the part of the therapist. Hopelessness the feeling is often used as a move to coerce someone (God, a spouse, the therapist, oneself) to rescue the client from despair. Hopelessness the belief tends to be over expansive, in the sense that the person sees him or her self or life or situation as hopeless, rather than the more circumscribed control agenda. **Barriers to Giving Up the Unworkable System** It can be hard for clients to give up unworkable control strategies because previously avoided material quickly shows up in consciousness and there's no clear alternative. Metaphors that can be useful here include: Feedback Screech Metaphor, which illustrates how control moves amplify the inherent discomfort in living and make "tiptoeing around the stage" seem like a good solution; and Sports and Activities Metaphors, in which practice makes better, you have to "step up to the plate" or "get in the water," and overthinking interferes with the process. **Letting Go of the Struggle as an Alternative** Tug of War with a Monster Metaphor illustrates that letting go of the struggle with unwanted private experiences can be a more workable strategy than trying to win the struggle. Clients may want to know how to "let go of the rope" and describing the process would be a bit like describing how to swim or hit a baseball or drive a car: better learned by experience.

Eric Fox May 2, 2005 - 10:58pm

ACT Book Summary: Pages 110 - 114

ACT Book Summary: Pages 110 - 114

The chapter on creative hopelessness ends with a few therapeutic do's and dont's. I took the freedom to add some do's and don'ts from the list and one of my own 1. Am I hurting or helping the client seems to be a question that's often asked in workshops. Kelly Wilson suggests on this list (April 15th) that this is about the therapists' own experiential avoidance when sitting with the patients' pain. Empirical findings show that you don't have to be afraid that your patients will quit therapy, get deeply depressed or even kill themselves when they discover the futility of their struggle. In other words the message is essentially a hopeful one, and patients may feel relieved. CR may be the first step towards an increase of degrees of freedom of the patients' respondent behavior. 2. I suggest that as a therapist you have to face your own creative hopelessness in order to be able to sit with the patient when he or she is testing his rule sytem against experience. 3. Don't expect anything to change (yet), because any change can be linked to the intentional change agenda, and so become just another avoidance strategy. This is paradoxical. As I try to grasp it right now, experiential avoidance seems to be an escape reaction triggered (or conditioned) by a certain class of stimuli (Sd, like for instance the possibility of being criticized), and thus it's under antecedent control (see also Kelly Wilson's note on this). Each time I face this type of situation I feel stressed or aroused (CER), want to escape or avoid by procrastination, let's say (CAR). This is reinforced by nicely elaborated verbal rules (COV)(and each time I think I'm right is a reinforcement, a +S+). Moreover, i feel relieved in the short run because the criticism is avoided (-S-). If I try to change this chain of behavior without loosening the conditioned response, I may just get entangled in a more complex conditioned avoidance response. In terms of 'Mary had a little .... ' I will get even more 'lamb' connections on the dots. I guess the idea is that behavior change will result spontaneously when the link between the situation and your avoidance reactions will be weakened, for instance by an increase of awareness of the unworkability. And isn't hope just the same as finding more and new opportunities to achieve your goals? Just like the two Swedish colleagues I 'd like to try to describe these processes in behavior analytic terms, but feel very insecure about it. It seems to me very helpful in the process of understanding ACT, and also in grasping the patient's struggle. So

who wants to join or help in this enterprise? 4. Give homework to help people become aware of how they struggle, and what situations trigger it. Just do self monitoring, and not behavior change (see above) 5. The book (and the discussion on the list as well) seems to suggest that there should be a fixed order in therapy with CH as the starting point. I'd like to cite Kelly Wilson (April 15th) on this: " No you absolutely don't need to do CH like it says in the book. If it needs to be done, you will end up doing it. why? Well as you pursue values, it will appear as an obstacle--then you will do defusion of hopelessness, and the emergence of what we like to call creative hopelessness." 6. A very important do was formulated yesterday by Joanne Steinwachs. I'll just cite her contribution, can't do it better, as she's also including a beautiful metaphor. "I find it useful to begin the questioning with 'beginner's mind'. Perhaps what they tried did work out, in some way for them. Of course, if they're stuck in a framework of unworkable rules, then in the larger picture, it doesn't work, but sometimes talking to people about what they do and how it works in their idiosyncratic rule system illuminates the rule system both for them and for me. If I start with the agenda of discovering unworkability, then I can miss a lot of the nuances of trappedness, both for them and for me, and I feel like I move into a place of expert rather than co-explorer. I also feel that using "discovering unworkability" as my guide, respect and curiosity are harder to maintain as my base feelings towards the client. I can't do this if I've got the agenda of discovering unworkability. I have to hold the idea that the system DOES work for the client as a possibility. Usually, in my experience, clients have worked hard and creatively, their shtick does work in some way and it's often an elegant and creative adaptation to some crazy rule. I talk to people about the pre-Copernican world, and how astronomers were trying to describe the path of the planets, starting from the wrong assumption that the earth was the center of the universe. They came up with elegant and complex theories that sometimes could predict the position of the planet. Men spent their entire lives on these theories. To let them go took enormous courage and great pain. That conversation comes after I and the client understand the complex rules that govern their "planetary movement" and we've paid tribute to the fact that the rules can in some ways predict and control their experiences." Perhaps techniques as interviewing for solutions (De Shazer) can be useful here. Progress to the next phase can be seen when clients express doubts about their system of coping and avoidance. Personal work for the clinician is building on the work on page 80. Somehow this questioning is a bit too abstract for me-as-a-client. Me-as-a-client needs a bit more encouragement and support as to what is a problem, how can I analyze it in ACT terms, what level of detail is required to gain awareness or insight. I like to be as concrete and detailed as possible, and I try to find out what exactly is is what a client did (does), thought (thinks) and felt (feels) when using his or her strategies. Underneath abstract descriptions of an apparent intelligent strategy can hide a completely invalid schema (can I use such a term here?).
Eric Fox May 2, 2005 - 11:01pm

ACT Book Summary: Pages 115 - 118

ACT Book Summary: Pages 115 - 118
Control Is the Problem In ACT, attempts at controlling private events are thought of as part of the system that have brought the client into therapy. Four factors are identified that most clients bring into therapy (and, that have been wrestled with at various times in this forum):

1. "Deliberate control works well for me in the external world."
2. "I was taught it should work with personal experiences (e.g., 'Don't be afraid...')."
3. "It seems to work for other people around me (e.g., 'Daddy never seemed scared...')."
4. "It even appears to work with certain experiences I've struggled with (e.g., relaxation works for a while to reduce my anxiety symptoms)." It is emphasized that the examination of control strategies is based entirely on the clients experience, with workability as the unit of analysis, and that the therapist needs to be extremely careful not to dictate or demand that the client evaluate their control strategies as unworkable. Therapist techniques that are mentioned include using metaphors and experiential exercises to help the client develop increasing sensitivity to directly experienced contingencies. Also, the authors mention that asking questions rather than stating conclusions can be helpful in reducing pliance on the part of the client.

Eric Fox May 2, 2005 - 11:03pm

ACT Book Summary: Pages 119 - 125

ACT Book Summary: Pages 119 - 125

Giving the struggle a name - control is the problem Continuing to explore unworkable strategies (i.e., "digging" in the man in the hole metaphor) without interpretation. The goal here is to explore the form and function (immediate goals) of client's behaviors and hold these up against the change agenda. At this point in time there is no need to do any more than just touch and clarify these behaviors and their functions. Eventually the goal is to lump these responses into a single class "emotional control" **The rule of private events** The key lesson here is that purposeful control works in the successful manipulation of external events but that the same strategies do not work in controlling private events as these are governed by historical and automatic factors. The rule "if bad events are removed, then bad outcomes can be avoided" is not effective with regards to private events. On pages 120-122 is a good transcript showing a therapist bringing out the paradox of control:

- If I'm not willing to have it (e.g., anxiety), I have it
- If I don't get so uptight about being anxious, I will be less anxious
- If I am willing to have it in order to get rid of it, I am not willing to have it and I will have it again

Polygraph metaphor (page 123) is a core intervention in this stage of therapy - particularly useful for anxiety or mood disordered clients. In short the metaphor describes being hooked up to the most sensitive and accurate lie detector ever built. The task is simple, STAY RELAXED. An extra incentive is given, "stay relaxed or I'll shoot you". Not surprisingly, any hint of anxiety would escalate ("Oh my god, I'm getting anxious.") and BAM!, it's all over. There are three elements that can be drawn from this metaphor:

1. contrast between controllable behaviors (i.e., paint the wall or I will shoot you) versus behavior that is not regulated successfully by verbal rules (relax or I'll shoot you)
2. People carry their own polygraph with them all the time (their nervous system) and their own gun (self-esteem, self-worth). They are constantly monitoring for symptoms (e.g., anxiety) and firing the gun at themselves
3. How seemingly successful attempts to make situation work, don't work in the long term. For example, taking valium may help you relax initially but what about when it wears off?

Chocolate cake exercise (124) - particularly effective with clients struggling with obsessive thoughts or ruminations In short, don't think about delicious warm chocolate cake with icing and cream! (yum) Two things here:

1. either it is particularly difficult not to think about it (me included in this group)
2. or attempts to not think about it (e.g., "I thought about something else") actually require you to think about chocolate cake (you have to know what you are not thinking about)

Similar idea can be applied to physical reactions (e.g., salivation) "The key lesson here is for the client to make direct contact with the ineffectiveness of conscious purposeful control in these domains" (my own personal comments: I really like these ideas, and regularly use similar concepts no matter what therapeutic style I am incorporating. I think a lot of these ideas have filtered into the CBT framework, whereby automatic thoughts are treated more as uncontrollable private events and B (behavior change) is emphasized. The only trouble I have with some of this stuff is picking those clients that respond well to discussing these kinds of issues. This is totally my personal opinion, but I think many therapies suffer from some kind of intellectual bias, that is, techniques developed by well-educated, trained minds. I have trouble breaking down psych concepts to layman concepts. This is not a big issue at this stage, because the use of metaphors breaks down that barrier, but when it comes later to exploring the traps of language, I think this is so.
Eric Fox May 2, 2005 - 11:06pm

ACT Book Summary: Pages 125 - 132

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How Emotional Control Is Learned At this point in therapy, the client is coming to the realization that "control doesn't work". In the recovery business this is the same as "taking" the first step (12 step approach) where the client comes to the realization that they are "powerless." This can be a frightening step. As the book points out, the "thought that repeatedly applying a seemingly unworkable strategy proves there is something wrong with the client 'deep down inside.'" and this can be quite troubling. Again, in recovery we would say, that this is like "doing the same thing and expecting a different result." It is like the guy that thought he had figured out how to fly with a wing like contraption attached to his arms. He got up on his roof and ran straight off the end and flapped his arms like crazy. But, as you would expect, he landed with a thud and broke several bones in his body. After healing he thought, well I don't think I jumped high enough, or flapped my arms fast enough. That's what I have to do, jump higher and flap faster. I don't think I need to tell you what happened. Getting back to my assignment, at this point it would be easy for the client to blame them self for the predicament that they have gotten themselves into, however, as the book points out, all of the conditioning that got them here is actually very random. The trick now is how do we "come to believe"(step 2) this. The book suggests, "Experiential exercises are particularly useful for demonstrating how easy it is to condition a irrelevant and nonfunctional private response." The "'What Are The Numbers?" exercise is a good intervention at this point. In this exercise the book demonstrates the arbitrariness of reactions, thus hopefully helping the client see that ""I'm bad" is no more meaningful than "one, two, three."" The therapist would than help the client move into examining the apparent success of a control agenda. Which brings us to, **Examine The Apparent Success Of Control** At this point it is suggested that we help the client explore the "cost of using this change agenda in the wrong places." The therapist is helping the client "establish discrimination." Which always makes me think of the serenity prayer, **God grant me the serenity to accept the thing I can not change (or control), the courage (or willingness) to change (or control) the things I can, and the wisdom to know the difference ("establish discrimination").** I see this step as helping the client become more aware of when this control (change) agenda works and when it doesn't. The book gives a good dialogue of walking a client through this process. But as the client begins to get a sense of the unworkability of this control agenda, they can feel naked and vulnerable to the world, and desperately looking for someway to cover up. At this point all we want to do is help the client recognize what thoughts and feelings are showing up. This is not an easy task. The therapist needs to continually undermine the clients need to avoid the distressing thoughts and feelings and to help the client become more "willing" to experience these things in the here and now. All of this leads the client to "the alternative to control: willingness" which is next weeks homework. However, it brings me back to the serenity prayer, and how I see willingness (or courage), "to change the things that I can."
Eric Fox May 2, 2005 - 11:11pm

ACT Book Summary: Pages 132 - 135

ACT Book Summary: Pages 132 - 135
The Alternative to Control and the Two Scales Metaphor The objective here is to point to an alternative to the control agenda. Use willingness instead of acceptance-because it is often confused with resignation or tolerance/defeat. **Two Scales Metaphor**

- designed to look at concept of control and its relationship to distress
- Should be linked to clients' experience of their own futile effort to control distress, can link it to more mundane or less meaningful examples for the client (for example, trying to sleep during a bout of insomnia. The harder you try to fall asleep the less sleep you get. In supervision, we often use the Chinese finger trap example-the harder you try to get out of it, the less out of it you are- you get stuck.)
- Want to undermine the client's confidence in the control strategy and depathologize the struggle over control
- Not crazy, just using the wrong strategy

Metaphor Two scales--anxiety (or whatever fits for the client here) and willingness. Willingness has been low, anxiety has been high. Client came in with the goal of getting anxiety to be low. But what if there's this other scale that we haven't been using, haven't even seen, called willingness. Make a promise about what will happen if willingness is set high-anxiety will be low except when it is high and then it will be high. If you move willingness up, then anxiety is free to move around. Seems like the goal here is not describing acceptance or

distinguishing acceptance/resignation, but merely providing an alternative to their endless, futile struggle Can distinguish between mind/experience here. Mind tells you that if you demand anxiety to go down, then it will. However, experience says that this doesn't work "Suppose life is giving you this choice: You can choose to try to control what you feel and lose control over your life, or let go of control over discomfort and get control over your life" (p.135) Willingness is one thing that only you have control over. I can influence you feeling anxiety for example, but I cannot control how willing you are to have that anxiety. **Comment**: This was a perfect reading for me this week! I recently used ACT in my abnormal psychology class in the service of changing the stigma of the mentally ill and making a difference in my students' lives. I provided an alternative to their control agenda, but I spent a lot of time distinguishing between acceptance and resignation. I had one student in particular who would not "accept" the thing he hated most about himself (which was what I used in exposure and defusion exercises) because he refused to "just get over it and move on". I like using willingness instead of acceptance because it frames the whole concept in a different way. There's no question about what willingness is, acceptance can have different connotations. **Another thing**: When first reading this section, I thought "how can you describe willingness", "willingness to what...?" I think that my class would have benefited from my using the willingness to experience as opposed to acceptance. This seems much clearer to me.
Eric Fox May 2, 2005 - 11:12pm

ACT Book Summary: Pages 136 - 141

ACT Book Summary: Pages 136 - 141
The Cost of Unwillingness CLEAN DISCOMFORT: discomfort that comes and goes as a result of just living your life (= primary discomfort?) ---------- cannot be controlled DIRTY DISCOMFORT: emotional discomfort & disturbing thoughts created by efforts to control feelings = discomfort over discomfort (= secondary discomfort?) ---------- disappears when willingness is high and control is low ----------> clean discomfort stays when dirty discomfort disappears Box full of stuff metaphor: p. 136. Shows the additive nature of history; nothing is subtracted! You can only add to life. You can fill it up with things you want to avoid until you can't move anymore. Various reactions are put into the box = deliteralizing: treated as objects, dispassionate observation of reactions. **WATCH OUT!** Client's worldview can be put upside down! Clients can insist on using old strategies. This has to be supported. DON'T START LECTURING DON'T START INTELLECTUALIZING (& do all the talking; it's no question of trying to convince) DON'T START EXPLAINING & DISCUSSING CONTROL STRATEGIES (this keeps you within the existing language paradigm) DON'T FEEL PRESSURED TO MOVE INTO SUBSEQUENT STAGES with multiproblem clients (they need more time) DO ENCOURAGE CLIENTS TO NOTICE THE COMING AND GOING OF DISTRESS (when they cling to control strategies) DO STAY ON THE EXPERIENTIAL TRACK DO STAY WITH THE CLIENT's EXPERIENCE OF THE WORKABILITY OF CONTROL STRATEGIES Clients may be ready for the next stage when:

- willingness is appearing spontaneously in situations that used to elicit control
- clients report spontaneous examples of feeling feelings differently

Eric Fox May 2, 2005 - 11:15pm

ACT Book Summary: Pages 141 - 147

ACT Book Summary: Pages 141 - 147
Chapter 5 finishes with:

1. personal work for the clinician
2. a clinical vignette
3. appendices containing daily experiences diary, identifying programming exercise, feeling good exercise, rules of the game exercise and clean versus dirty discomfort diary. I'll deal with each of these in turn:

Personal work for the clinician Having identified a problem in your own life, explore the strategies that you have used or are currently using to solve this problem a) consider each strategy and designate it as either an

acceptance or control strategy b) examine the distribution of control and acceptance strategies. Is there a trend? c) For each control strategy, identify what it was that you hoped (hope) to control, avoid, manipulate, change or eliminate **Clinical Vignette** The clinical vignette describes a 45yo male with severe anxiety attacks at work and more recently at home. There is stress at work (high stress job), a recent move and relationship difficulties. The client uses deep breathing, distraction, hypervigilance to physical symptoms, avoidance of work and tranquilizers to cope with the anxiety. The question(s) for clinicians are: a) how would you conceptualize the client's major coping strategies and assumed goals? b) How would you discuss these solutions with the client? c) What would your goal(s) be in doing so The answers are as follows: a) strategies are primarily to reduce or control anxiety and appear not to work (long term) b) is anxiety serving another function? Are there areas in your life that you legitimately have reason to be anxious about c) Goal is to separate clean versus dirty anxiety (legitimate stressors versus the struggle, fusion) **Appendices Daily experiences diary** Client records uncomfortable moments, including feelings, thoughts and bodily sensations as well as efforts to handle these things Client and therapist can explore the use of acceptance versus control strategies. Therapist can reinforce strategies that reflect acceptance. **Willingness diary** Client provides a global rating for each day (e.g., emotion rating from 1-10). Client records the amount of effort put in to getting this to go away (rating 1-10) Client records how workable the day was (rating 1-10) Client and therapist explore the relationships between the struggle to controland the workability of the day. **Identifying programming exercise** Clients are encouraged to explore how a significant childhood event (or events) shaped or programmed who they are now to demonstrate how dysfunctional coping strategies are passed on. This is to demonstrate the arbitrary nature of learning events. **Feeling good exercise** Clients fill out a questionnaire tapping into a number of specific language rules that act as self-instructions (e.g., "the way to be healthy is to learn better and better ways to control and eliminate negative emotions") **Rules of the game exercise** Clients are asked to generate their favorite life sayings (e.g., no pain, no gain). Client and therapist can then explore sayings with reference to acceptance versus control strategies or on the basis of a number of other dimensions (e.g., black/white thinking, severity of consequence, good versus bad) **Clean versus Dirty discomfort diary** Client is encouraged to explore particular "high risk" situations in terms of clean discomfort (what immediately showed up in the way of thoughts, feelings etc) versus dirty discomfort (what emerged as a result of the struggle with these initial feelings)
Eric Fox May 2, 2005 - 11:17pm

ACT Book Summary: Pages 148 - 154

ACT Book Summary: Pages 148 - 154

Building Acceptance by Defusing Language

Here are some nuts and bolts followed by questions and critiques:

1. The distinction between process and content: language is a learned set of derived stimulus relations, while languaging is the action of deriving those relations.

2. Humans (therapists, clients, etc.) often don't make this distinction and often relate on (and become connected to) the content level. Taking these contents at "face value" (i.e., literally, tangibly) in turn, leads to powerful and predictable behavior patterns (that are often destructive) on the part of the client.

3. One of the main paradoxes in ACT is that language cannot be weakened by more language; however the essence of deliteralization is to take advantage of loopholes in the way language functions (by teaching the client to see that thoughts and feelings are just that-thoughts and feelings).

4. Page 152 contains a table (6.1) of ACT goals, strategies, and interventions to use regarding deliteralization.

5. One of the ways to begin addressing the paradox and function of language is to demonstrate to the client the limits of language in deciphering human experience (and to elicit their own examples). For example, there are two metaphors (found on page 153) that communicate how describing something is different from experiencing it. One metaphor is "finding a place to sit," which essentially describes how talking about a chair (its features,

uses) does not help when one wants to actually sit down. In other words, one cannot "sit" in a description of a chair. One can only sit IN an actual chair. A corollary of this metaphor is that one can describe the experience of swimming (how the water feels moving through it, its temperature, etc.). However, one cannot learn to swim in or by a description.

6. There is an assumption in ACT that "your mind is not your friend." Extrapolating from pre-human experience, one can see that the (human) mind was not developed to make humans or "prehumans" feel good. It was developed to keep humans from danger and was mostly comprised of negative content. Explain to clients the paradox "your mind is not your friend AND you cannot live without it."

7. Another assumption is that language is arbitrary and that once it is learned, it becomes relatively independent of immediate environmental support. This reminds me of my nanny's (successful) efforts to train my 20 month-old son to say "bling-bling" when he sees jewelry-now without her having to label it.

8. There is a provocative quote related to the usefulness of nonverbal (experiential?) knowledge at the end of this section on page 154: "If we suddenly had all nonverbal knowledge removed from our repertoires-we would fall to the floor quite helpless."

Comments/questions:

9. It has been my experience that, while clients appear "fused" to a lot of different ideas/contents, a great share of them come to my office without having specific terms/language to describe their experience. In fact they come ONLY with experience, which they have a difficult time describing in words. For example, an extremely anxious patient I had (with Posttraumatic Stress Disorder) wouldn't ever label himself as "anxious," rather he just knows he feels bad.

10. I don't know if behavior patterns follow from the premise that one does not make a distinction between the process of thinking and actual thought, and becomes fused with actual thought content, thereby leading directly to ingrained behavior patterns. I suppose one could explain this as troublesome behavior patterns becoming automatic due to conditioning (i.e., not being aware of the interaction pattern itself); however, I'm not sure if this is because one is fused to a verbal event.

11. Have any of these hypotheses been evaluated using individuals with various types of brain injuries (resulting in apraxia, aphasia, acquired deficits in language versus acquired deficits in motor ability, etc.)?
Eric Fox May 2, 2005 - 11:21pm

ACT Book Summary: Pages 154 - 158

ACT Book Summary: Pages 154 - 158
Deliteralizing Language Several exercises are described to help people improve their skill of looking at the process of language instead of looking from language.

- Thoughts are used to structure our perception of the world. We don't even notice that we look at the world from our thoughts, because we believe them in literal way. To look at the process of language involves focusing attention on language as language, cryptic as this may sound. A bit of defusion from literal 'understanding' can be achieved by watching the direct stimulus functions of language like sound, the feeling of your muscles, the sight, etc.
- An elegant way to watch your attention switch from the symbolic function of a word to some of its direct stimulus functions is by repeating a word over and over again for one or two minutes. This is the classic milk, milk, milk exercise (Titchener, 1916). Present it as an experiment or experiential exercise and help the client notice how the literal meaning of the word disappears and one can see the word as an instant of the language process.
- I like the notion of skill learning here. Deliteralization is a skill you can practice, it's not another rule to follow. One can play with direct stimulus properties and thereby loosen the 'grand illusion of language' by

realizing that the symbolized thing is not there at all. The only thing that's there is sound, movement, breathing and so on. And this is not a fact, but a skill, something you do.

Another skill that helps to defuse from nasty or frightening thoughts is practiced in the passengers on the bus exercise. In this exercise the relation between a person and his or her thoughts (or avoided inner experiences) is reframed. These are the elements of the metaphor:

1. You, the driver of the bus. You want to go places and do your job.
2. The passengers are your thoughts and all kinds of inner states. Some are nice, some ugly, scary, nasty.
3. The scary ones threat you and want to come up front where you'll see them.
4. You take this very serious and stop the bus (you don't go anywhere anymore) and try to make a deal with them: they'll keep quiet in the back of the bus, only when you do exactly what they tell you.
5. This means your route plan is greatly impaired and you're always on the watch inside the bus.
6. What happens is that you let these passengers control the whereabouts of the bus. You, the driver, are not in control at all.
7. Even though these passengers look scary, nasty, threatening etc. they can't take control (unless you let them). They can't make you do something against your will.

Eric Fox May 4, 2005 - 5:31pm

ACT Book Summary: Pages 158 - 168

ACT Book Summary: Pages 158 - 168

Summary: We are in Chapter 6, Building Acceptance by Defusing Language. Page 158 begins the section titled "Don't Buy Thoughts". The subject is the deliterization of language. The explanations, exercises and metaphors are designed to enable the client to become aware of and "assume" self as perspective and to focus that perspective on thoughts and feelings themselves as they are experienced. Comment: The ease or difficulty of this and degree of success may vary greatly from person to person, but those who find it most difficult may also reap the greatest benefits. The shift to looking at literal meaning from looking through literal meaning is subtle. "Having a thought" may be distinguished from "buying a thought" or "buying in". A common example is the shift from "I am a bad person" to "I am having the thought that I am a bad person". The idea is to expose the process of thinking often hidden behind the content of thinking. Mindfulness exercises include Zen-like meditation, Soldiers in the Parade Exercise, Leaves in the Stream Exercise, Contents on the Card Exercise, and Taking Your Mind for a Walk Exercise. The client/therapist dialogue (pgs. 159-161) illustrates a therapy situation using the Soldiers in the Parade. Note how you have to get the client to try this and then give you feedback as to what they are experiencing. The client is specifically reminded that thoughts like "This isn't working" or "I can't do this" should be placed on the soldiers' placards (along with "This therapist must be one of those nutty Gestalt guys I've heard about."). The therapist sort of anthropomorphizes the mind and speaks of it trying to "hook" the client on literal meaning. He also points out how the parade stops when the client "buys" or is "hooked" by a thought. I additionally had the thought in this section that while "Contents on Cards" and "Taking Your Mind for A Walk" may seem gamey or contrived, these might be necessary and effective with certain clients who experience very emotional fusions such as cluster B type folks(or the more politically correct "multi problem client"). **Undermining Reasons as Causes** A troublesome class of thoughts, reasons tend to disguise themselves as deterministic statements with a cause-effect function which they really may not have. Reasons often actually function as language community justifications. Personal history is often cited as a reason things can't change. This has always been a real pain for psychodynamic therapists (I speak from personal experience). Statements focusing on functional utility rather than literal truth are suggested as helpers, such as, "And what is this story in the service of"(Ouch! They may get angry!), "If God told you that your explanation is 100% correct, how would this help you?", etc. Another dialogue (pgs. 164-166) illustrates how reasons may be deliteralized to the clients' advantage without loosing their true function. An additional "tips" section is Disrupting Troublesome Language Practices (pgs. 166-168). A discussion of the etymology of the word "but", for example, reveals how it can be a psychologically limiting verbal behavior that may be changed to "and". "I want to go, but I am angry" could be "I want to go and I am angry" leading to behavior which may not be controlled by the language conceptualization of it. The "And/Be Out Convention" inset describes how this might be communicated to a client. I had the thought that this requires some careful listening to insert this timely intervention when it can be

most useful to the client. I will only comment that this is an extremely important section, drawn from RFT research and Zen and Gestalt traditions which are nuclear to ACT. It strikes me as needing a great deal of experience and/or training to be handy with it. I suspect that psychodynamically trained therapists, such as myself, have a harder time with it because we have to unlearn and learn at the same time.
Eric Fox May 4, 2005 - 5:34pm

ACT Book Summary: Pages 168 - 174

ACT Book Summary: Pages 168 - 174
Evaluation versus Description Evaluations masquerade as descriptions of things and events because language makes little distinction between them. Descriptions may be thought of as primary properties of things and events while evaluations are secondary properties, reactions to things and events. The authors point out that most clients bring negative self-referential evaluative self-talk directed toward themselves ("I'm a despicable human being") to therapy that would be difficult to accept if it described the essence of a person. The Bad Cup Metaphor illustrates this principle by pointing out the difference between essential properties of a cup (such as that it is made of metal or ceramic or whatever) and our evaluations of the cup (good cup/bad cup). As an aside, my husband, who is not a therapist, really related to the question of "If all the humans on earth died tomorrow, would this still be a good (or just, or moral, etc.) ____?" as a way of identifying evaluations. A second strategy for highlighting the kind of thought or speech someone is engaged in is to have them label each thought or sentence as a description, an evaluation, a feeling, a thought, a physical sensation, a memory, etc (Cubby Holing). Although this is awkward, it can be very effective at promoting defusion with private events.
Willingness: The Goal of Deliteralization The goal of deliteralization is to decrease the role of evaluation and strengthen the client's ability to take a non-judgmental, observer perspective so that they can begin to observe their own disturbing private events with less struggle and more willingness. Two exercises that give the client live experience with willingness are the Physicalizing Exercise and the Tin Can Monster Exercise. The Physicalizing Exercise has the client treat their unwanted content (depression, anxiety, addiction, etc) as an object, by describing its physical attributes (size, weight, color, density, etc). Then the client sets it aside and describes reactions to the "object" they described; they repeat the exercise with the reaction. They then go back and look at the first "object"; often it is less intense in some attributes (smaller, lighter, etc). The Tin Can Monster Exercise helps the client get in touch with their "observer you," then uses that perspective to explore several domains (physical sensations, thoughts, feelings, memories) associated with the problem area. The focus is on staying with the uncomfortable, unwanted content while letting go of the struggle to make it go away.
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ACT Book Summary: Pages 174 - 179

ACT Book Summary: Pages 174 - 179
Therapeutic do's and don'ts The goal of deliteralization is a hefty one. Chapter Six offers a dazzling array of ACT metaphors and exercises: confronting nasty passengers on the bus, endlessly saying milk, milk, milk, soldiers wandering around in a parade amongst the recesses of the mind, taking your mind for a walk, reasons as causes, avoid use of those 'buts," and practicing awareness of your experience, to name just a few. Deliteralization is an essential step in the ACT process, and yet its filled with perilous pitfalls for our heroic ACT therapist. First, there is the challenging task of entering the client's language system The therapist seeks to realize that it is a language system, while at the same time avoid the many opportunities presented to "fuse" with the system. This challenge occurs because we are using language to point out the dangers of language in an effort to convince a person to avoid being taken in by the power of their own words. Encouraging willingness and deliteralization by using words alone may result in an overuse of logic. Hence, words are always connected to metaphor (and hopefully experience) as a way of avoiding this pitfall. On the other hand, the use of metaphors presents another challenge in that the therapist may get totally caught up in the process of painting pictures. Telling stories and doing exercises keeps everyone awake, but the goal of willingness and deliteralization may get lost in the mix. Focusing on one metaphor per session at most (and any given metaphor may be useful for more than one session) is the best remedy. Most important, metaphors are adapted to fit a client's particular form of fusion. Context always is combined with content in the client's experience for the proper and judicious use of

metaphor. Next -- How to determine when its time to get out of Dodge City and move on to the next stage of ACT? First, we know there's progress when a person does not automatically respond to every troublesome thought (or emotion) with the same overwhelming and automatic connection. They cease to automatically fuse with their language system and instead are able to "wake up" and be aware of non-workable reactions, sometimes in the very midst of the process. Second, from this evolving stance of observer to their reactions, a person demonstrates an increased capacity for a willingness to experience content that would have previously brought automatic fusion. In other words, they do not always and automatically respond with well worn methods of control and avoidance. ACT would argue that this occurs when a person ceases to fuse and there is a "weakening of social/verbal context of control." The client is able to have more difficult experiences and demonstrates a willingness to set aside moves of experiential avoidance. From this point, the clinician is then advised to observe thyself in an exercise which eventually encourages one to "release" attachment to cherished notions of self, whether they be the best of things or the worst of things that you think about who you are. How difficult is it to release our attachment to these statements about self as "literal" realities of who we are? Perhaps this will develop an empathy for the challenges faced by our clients. Then we are presented with a clinical vignette about a 31 year old man with panic attacks whose life has become constricted because he avoids situations that produce feelings of anxiety and panic. How to conceptualize this situation? What strategies are we to use here? An ACT perspective would suggest that the client is confusing content with context by treating any appearance of a dreaded symptom of anxiety and panic as a harbinger of absolute danger ahead. An effective strategy would seek to use deliteralization exercises (e.g. Milk, Milk or Tin Can Monster) that encourage the person to step back and avoid the automatic literal response (disaster is here), and instead see these experiences as experiences -- nothing more and nothing less. Can the client allow these symptoms to occur without fusing? Then these symptoms can take their "natural course" without the rollercoaster wrought by cognitive fusion. **Finally, the chapter concludes with two exercises for client homework** The first seeks to analyze the extent to which reason giving pervades experiences outside the session. This will hopefully make the client more aware of how they use reason giving and to see reasons as merely content to be considered as useful only when they meet the criteria of workability. The second exercise is an awareness exercise which encourages a mindfulness and acceptance of present moment experience that helps one practice being in the role of observer. A useful and life long task indeed.
Eric Fox May 4, 2005 - 5:36pm

ACT Book Summary: Pages 180 - 187

ACT Book Summary: Pages 180 - 187
This is all open to feedback, of course, as I am never sure I have this stuff quite right. But then again, it's only a bunch of thoughts, so don't believe me anyway. Somehow this self stuff reminded me of a recent interview with Clint Eastwood (paraphrased from memory) --

- Int: So, we've talked a lot about what your critics think of you and your work, what your wife and ex-wives and children think. I have to ask, what do you think about Clint Eastwood?
- CE: I tend not to think about him very much.

ACT (181): In order to face one's monsters head-on, it is necessary to find a place where this is possible. I believe there is a Zen story (don't recall where I heard or read this) of a man who is alone in his house trying to eliminate all of his demon's. One after one, he faces them down, and they all disappear as he sees them for what they are -- except one. This is the largest demon of all, and as hard as the master-to-be tries, he cannot eliminate this demon. He cannot avoid the monster, he cannot talk the demon into going away, he cannot make a deal with the chimera. Finally, after he thinks he has attempted everything he could possibly do, he jumps right into the mouth of the demon, and it disappears. **ACT- Three Senses of Self** Conceptualized Self -- The me who I think I am Clients come into therapy, counseling, etc with varying goals regarding this self -- to defend the self, to fix the self, to find the self, to avoid the self ACT View for Success Regarding the CS -- to have the client voluntarily experience conceptual self suicide expurgate the boundaries of the self and (my thought) broaden the psychological world of the client to make room for all history and experience - to bring the clients to where they began and to see it again for the first time (I can't remember where I stole that one, either). Self as concept might make a statement like "I am a person who ....." and this statement is taken literally with many predicates, even

predicates which do not work. Examples "I am a person who breathes" compared to "I am a person who is sad, happy, " This universality can cause mucho problems. (Here's a reach) If I am a person who is sad, I may not notice the times when I am happy- they don't fit my self concept. On the other hand, if I am a person who is happy, what does it mean on an afternoon - when it is cold and wet and rainy in Minnesota, and it is June, and dammit, isn't supposed to warm and sunny now - when I am sad? With this concept we, and the community around us becomes very invested in my maintaining my "image" of being a certain kind of person; or

1. When I am x and I and my community do much better when I am x, I am pretty invested in remaining x, because if I act as Y there are consequences
2. Our history has taught us to see and maintain patterns.
3. We have equivalency statements that may not be equivalent "I am 5'10" (maybe 9") becomes the same as "I am alcoholic."
4. If I try to act outside of "who I think I am," it seems almost life (or self?) threatening. Note: I wonder about this with the "guys" I work with. Many are domestic violence offenders, and even though their physicality is usually not threatened, many lash out when their sense of "self" is threatened, the "manly man syndrome." OR "Eliminate conceptualization = eliminate me."

The self can be "maintained more easily simply by distorting or reinterpreting events if they are inconsistent with our conceptualized self." I am concurrently (as my bathroom bibliotherapy) reading a book - The Tao of Zen - there is a quote there that I somehow want to fit into this chapter. You decide - " For all Chinese philosophy is essentially the study of how [people] can best be helped to live together in harmony and good order ... [There is] nothing more dangerous than that theories and doctrines which belong to the world of language should be mistaken for truths concerning the world of fact." Our conditioned responses to and with language create the prison which many people go into therapy to theoretically escape, and get there and work hard to build stronger walls. Page 183 - "To escape a prison it is first necessary to see the prison itself." Most therapy to date has been designed to paint the walls of the prison with different thoughts and/or emotions, whereas ACT's design is for the client to see the prison from both the inside and the outside. **Ongoing Self Awareness** While the conceptualized self is a verbal trap, it is still necessary to have an idea of who you are and how you are when you are there. Without getting attached to the content, there still has to be a verbal self knowledge of life to engage with it. In this sense, it seems it is more like a surfer riding the waves, than a swimmer battling the water, or maybe, better yet, than a non-swimmer flailing in the waves. The surfer knows the water (language, words, content) is there, but does not get caught up in the depth, the swirls and eddies that come along moment to moment. A thought is just a thought, a feeling is just a feeling. The client is encouraged to engage some of these things descriptively, rather than evaluatively - to look at a thought, rather than through it. **The Observer Self** The "I" is a place, a locus, a perspective. It came about and is used to differentiate my experience from the experience of others? "I" am looking at my computer screen. "You" are not. The "I" sets up the context for description. (I think I have this right, or at least am making sense of it.) Spirit/Matter distinction which has emerged in all cultures. Spirit - a private event that cannot be experiences as a thing or object. Sense of self-as-perspective has same properties as spirit. This is important because we/I/You as context is the one place any of us can stand that is enduring. Even though we are constantly changing, we always have that sense of "being there," of seeing all that is in our life from behind these eyes. This important in the change process because there is something grounding about there being one part of us that will go through all of "this" unscathed, at least for the time we are aware of. With all of the threatening things that happen in therapy, life, etc, there is that sense of I that will remain. (I think) In ACT, it is important that the I/you-as- context will always be there, at night, in the clouds, through sleet and hail and thunder, wherever I am, whatever happens, there I go. Page 187 - "The trick lies in teaching the client how to be aware of content, to be aware of the awareness of content, and yet not be so preoccupied with content or attached to it as a matter of personal identity ... without objectifying these events or mistaking them for" the real me. Be careful not to pay too much "attention to that little man behind the curtain."
Eric Fox May 4, 2005 - 5:37pm

ACT Book Summary: Pages 187 - 192

ACT Book Summary: Pages 187 - 192

We're looking at the first part of the 'Clinical Focus' section of chapter 7 'Discovering Self, Defusing self'.

As will have been outlined earlier, this is an important part of ACT. The section begins with a brief outline of the core perspectives that are introduced here. Table 7.1 (p.188) provides the ACT goals, strategies and interventions regarding self.

Initially, it is helpful to 'Undermine Attachment to a Conceptualized Self'. Clients may vary in readiness to work on this area. The timeless struggle between content and context is presenting itself here. ACT promotes the idea that the problem may lie in attachment to beliefs, rather than in the beliefs themselves. This may be seen as a reversal of some views in which self-conceptualization and performance are linked. The 'Mental Polarity Exercise' can be used here to demonstrate the effects of attachment to evaluative thoughts. The description of the exercise also describes the etymology of the word 'perfect'. This is also a powerful and important point, that, in my view is worthy of detailed attention.

Next we have a section on 'Building Awareness of the Observing Self', that aims to help the client notice the process of consciousness and sense of perspective. A 'central ACT intervention', the Chessboard Metaphor, is then described in detail, and a helpful brief therapist/client transcript provided. The Chessboard metaphor can be physically acted out in therapy. Issues such as willingness can be demonstrated through observing how little effort it takes for the board to hold the pieces. An important phrase - " The point is that thoughts, feelings, sensations, memories etc are pieces on the board, they are not you" (p.192).

A couple of notes from a beginner: As p.189 notes, 'therapists and clients are in this language stew together'. It is therefore as important for therapists to work on attachment to their own conceptualized self(-ves), as for the client (a theme of the book). I especially like the brief paragraph on perfect (p.190). In this sense, who is not 'thoroughly made'? This perspective may also carry over to the judgments and evaluations we make of others.

The Chessboard Metaphor is very useful - although I have had one or two clients wanting to sweep all of the pieces from the board (wipe the slate clean). John Billing gave us alternative metaphor on 16.06.04 (or 06.16.04, depending on which side of the pond you're on)

Eric Fox May 4, 2005 - 5:40pm

ACT Book Summary: Pages 192 - 198

ACT Book Summary: Pages 192 - 198
Experiential Exercise with the Observer Self Observer Self exercise: This is a "key" lengthy exercise that brings the person to the place where they are observing the changes that have occurred in their life from a perspective that seemingly does not change. *Phase1*: The exercise begins with general focusing and by noticing bodily sensations. From there it moves onto observing sensations of a recent memory; then to observing a further away memory, then lastly it moves to observing sensations of a distant memory. The main focus is on being aware of the self that was present at those past moments is the same self that is presently noticing; the observer self is a sort of common denominator; it's the soul prospective. It is also practice in "seeing seeing" where seeing is defined as what we feel, think, and sense. *Phase2*: Is similar to what occurred in Phase1, just the content has changed. The client is guided through observing the roles they play and the emotions and thoughts that they have; roles, thoughts, and emotions change, come and go but there is a you that is having them and has stayed the same while they have changed. The perspective of Observer Self is one where a person can more easily observe themselves engaging in the behaviors of thinking and sensing. Paraphrasing Skinner, "a person who is aware of his own behavior is in a better position to [influence] his behavior." *Pick an identity*: This is an exercise where a few semi-random statements about a self are picked from a box, randomly, and then the client uses these statements to take on that personality, with the help of some guidance. This equates to the client's real life experience of picking a few statements about themselves and becoming that person. This is an experience in flexibility where being flexible has not been utilized (much). *Faking it*: is a good example of how our minds' can give us the opposite experience of what we actually experience. "I feel like a fake because I am having a good time but I am not a person who has a good time; I'm depressed! Therefore I must be having a good time just to

make other's feel like I am having a good time (which of-course I couldn't be). Since I am a fraud this really sucks." The benefits of being able to observe these thoughts as thoughts and not truths should be obvious. Buying these thoughts will lead to one experience where the experience itself yields or is a much different experience.
Eric Fox May 4, 2005 - 5:41pm

ACT Book Summary: Pages 198 - 203

ACT Book Summary: Pages 198 - 203
Here is my attempt at the next couple of section called "Therapeutic Do's and Don'ts", "Progress To The Next Phase", "Personal Work For The Clinician: Is Your Self Getting In The Way?", and "Clinical Vignette". In the fist section "Therapeutic Do's and Don'ts", the authors caution clinicians about a couple of things. First "Reinforcing the Problem", in this section we a cautioned about joining in with the client's language, which will show "itself in the development of an excessive amount of logical, rational talk about why the client can't trust his or her thoughts, the lack of self-confidence, and so on." I usually see this rearing it ugly head when I realize that I am talking way to much, and at times trying to convince the client of something. At these moments the authors suggest we return the focus to "experiential exercises and metaphorical talk." We should also "Reaffirm for clients that there is no secret formula that delivers happiness in any consistent way." Because, inevitably we want to take our new found tools for living and turn them into shovels and start digging new holes. Next "Spirituality As An Experience, Not A Religion", warns of the dangers of seeing ACT as a religion. This is a pitfall that we have seen since the beginning of AA, where they warned of being swept up in a religious zeal. These new ways of living daily can bring with it a new found spiritual awakening, and as the book says "that is gravy." As therapist, we need to "emphasize the concept of workability for the client, not a belief system." Next "The Multiproblem Client And Self-Obliteration", in this section the authors deal briefly with the topic of more seriously dysfunctional individuals. I see this section as boiling down to two sentences from the section. One, "The destructive effects of trauma lie less in the event per se than in the escape and avoidance maneuvers used to compensate for the event.", and Two, "ACT strongly promotes the use of experiential and metaphorical exercises that undermine the need for avoidance with such clients." And isn't that the lesson to learn? This reminds me of a poem I once wrote; "Lost and Found I lost what I was looking for Because I was looking for what I hadn't found. I hope I find what I'm Looking for Before I've lost what I find that I found." Next "Progress To The Next Phase", how do we know when it is time to move on to the next stage? When clients start to speak of "looking at, rather than being caught up in, private experiences." The authors also state "Another critical sign at this stage is the ability to laugh at oneself in earnest." In my own life it shows when I spontaneously think of how I "dig my holes" and can laugh to myself as I say "Mark, step awayyyyyy from the shovel." Next "Personal Work For The Clinician: Is Your Self Getting In The Way?", this is where you break out your pad and pen, and get a chance to play along at home. In this section we are suppose to look at the "monsters" we have been avoiding in our own lives. This is not for the squeamish, but it can be truly freeing. I will share one of my "Monsters", but I suggest you use your own. "Remember to save your work." (My "Monster" is the internal circus that happens every time I am called Doctor.) 1. What emotion does this problem present that is most difficult for you to deal with? (When this happens, fear rushes through me, and I think someone is going to expect me to be something.) 2. What thought(s) does this problem present that is most difficult for you to deal with? (That I am unworthy, and inadequate) 3. What memory or personal history does this problem present that is difficult? (I have many memories of being told in High School that I wasn't college material, and that the best I could hope for was maybe getting in the military.) 4. Is there anything in these private experiences that, considered on their own terms, you cannot have and still live a vital life? If you can't have them or a part of them, just notice you are not having that part. (I don't think this issue for me rises to this level, however, there are times that it gets in the way of me making my opinion known.) 5. Are you willing to get into contact with these emotions, thoughts, memories right now? If so, practice having them in a new context. For example, if there is a horrible thought, say the thought out loud 50 times as fast as you can. If it's painful feeling, hold the feeling in your mind and mentally describe its shape, color, texture, temperature, or smell. Try to see it as a feeling and see yourself feeling it. If it's a painful memory, consider holding it in mind and separating out the physical sensations first, then put them "out there," then move on to the emotions and put them out there, then the images and put them out there. (I have found that when separating out the sensations, emotions, and images that I can move in to the present without the negative effects of these past experiences.) 6. As you consider each of these content areas,

notice also that a conscious person is considering them. Review items 1 to 5, but this time see whether you can also be aware of the person "behind the eyes" who is aware of what you are aware of. (Wow, that was a trip. You may need to be in a quiet place to try this, but it seemed as if I was invading my own body.) Finally "Clinical Vignette", here you are asked to "conceptualize the client's dilemma from an ACT viewpoint." This is a good exercise that folks can check out in the book starting on page 202.
Eric Fox May 4, 2005 - 5:42pm

ACT Book Summary: Pages 205 - 212

ACT Book Summary: Pages 205 - 212
What are values? 1. Values represent "verbally constructed global desired life consequences", different from goals in that they specify a more general direction and hence can not ultimately be satisfied, completed or achieved. For example the goal of completing this summary serves a larger goal of learning about ACT, that is consistent with my life value of continuing to learn as much as I can about psychology and its disciplines. Values typically elicit a number of goals, that is, values are "a verbal glue that holds sets of goals together". 2. Values are an action, not a feeling. Values are followed through behaviour, not through it necessarily "feeling right". 3. Values are a more stable form of "verbal rules" re-aligning a client in the present to a valued direction. Thoughts and feelings can be contradictory and inconsistent. 4. The main goal of ACT is help clients develop a "behavioural trajectory" that is vital and valued. 5. All of the techniques in ACT feed this main goal. Techniques such as defusion and acceptance are only useful in so far that they provide a means for a client to achieve a valued end. **Are values innate or learned?** 6. All clients have the capacity to define their life direction (i.e. develop values) 7. Verbal fusion and experiential avoidance are common barriers to following these values 8. Developing values is linked more to removing barriers (e.g., verbal fusion) rather than needing to teach valuing skills. 9. A lack of values in a client may reflect a chaotic, unpredictable environment, where the development of values/goals has met with frequently painful or disappointing consequences. 10. The social/verbal community requires that we have explanations or justification for our actions. Citing values may not appease this community, hence they are not always socially reinforced. **Why have them?** 11. People's behaviour is shaped by consequences, both experienced and verbally constructed. While learning histories provide a means of shaping behaviour over the short term, language provides the means by which behaviour can be shaped over longer periods (i.e., knowing that I will receive my degree at the end of 4 years keeps me studying, even though short term consequences can be somewhat aversive). 12. Values are part of this language process, specifying long term consequences for current behaviour. They can coordinate current actions over long time frames and since they are global, they require a person to do this on a day-to-day basis, different from specific goals in that they are not achievable per se. **Stance of the ACT therapist with regards to values**: 13. ACT therapists are asking clients a number of questions with regards to values: 1) What are your values (this will be explored with other people's summaries) 2) Can you act in a way that is consistent with your values, even when your thoughts or feelings tell you otherwise?" 3) What stands in the way of you acting in accordance with your values? 4) In pursuing a valued life direction, are you willing to have what emerges, what you encounter along the way? 5) Is there a difference between feeling a belief and acting on a belief? How will others know? (The "argyle socks exercise" is a useful way of addressing some of these questions)
Eric Fox May 4, 2005 - 5:43pm

ACT Book Summary: Pages 212 - 219

ACT Book Summary: Pages 212 - 219
This is a section I find very compelling and challenging. It has parts I can put into words but don't understand. It has other parts I understand, but can't put into words (Should the "buts" be "ands"?). At least it seems that way to me. I can put into words the difference between judgments and choices but can't seem to differentiate in practical examples. I have, for example, a vague feeling for where I want to go with the organization I manage. This feels like a value. I want everyone to be relatively happy and do a good job. That seems like a goal. What's my value here? I begin with "Choice" on page 212. Choice is distinguished from judgment-almost as a residual category (defined by what it isn't) of behavioral processes with certain characteristics that are used to select among alternatives. A selection among alternatives based on reasons is a judgment. Reasons are verbal formulations of

cause and effect which answer the question "why?". The formulations serve as a justification of sorts which may make reference to societal or personal outcomes or use quasi scientific historically based deterministic assertions. For example, "I eat fruits and vegetables because they clean out my system". A choice is a selection among alternatives that may be made with reasons but not for reasons. The live demonstrative exercise is to offer your fists and say, "Choose!". The client points to one. When ask "Why?", he may or may not formulate a reason; but most persons will realize that the reason is formulated after the act of choosing and therefore not functioning causally in the selection process. In a judgment, the weighing of pros and cons actually influences the outcome of the selection process. For example, "I was going to hire Mr. Smith because of his job skills. I decided not to hire him when I considered his poor health." Is it a judgment because my awareness of Mr. Smith's health problems precede my selection of Mr. Jones? Would it have been a choice if I met them both, wanted to hire Mr. Jones but didn't do so until I found out about Mr. Smith's health? Then there's this business on 213 and 214 about asking why a reason is true as a way undermining the causal relationship between the reason and the selection(in the mind of the client, that is). Or asking why a food is chosen and then when they say it tastes good you say you asked the person to choose and not their taste buds. Maybe this is over my head. The authors acknowledge that there is no "free choice" in a scientific sense. Is this then a question of creating the subjective illusion of "free choice" by impeachment of reason(or reason giving)? This seems to be the point of the paragraph at the end of this section. I can't quite grasp this. Help me Francis or Patty or Hank or someone. Valuing is always occurring as a behavior. The dialogue between Therapist and Client on page 215 is to show how choices are always being made and purposes fulfilled. The point here does not seem to be to elucidate how these selections among alternatives are choices rather than judgments even though the word "choice" is used. Perhaps this follows in some logical way from the previous section. Still the implication is that clients are not conscious of the selection among alternatives process being "choice making" and this dialogue will make them so. What do you want your life to stand for? The dialogue is with an independently wealthy client presumably because such an unfortunate is stripped of the illusion that working for a living guides life, I guess. Anyway, they do the exercise about attending the client's funeral and what he wishes everyone would say. The therapist comments that he doesn't expect them to say "...he was no fluke." I think this is to make the point that avoiding negatives is out as a value in the sense that we're after here(File it. Along with judgments and stuff determined by reasons). They're mainly trying to distinguish values, whatever they are, from the clients current real life actions. This section ends with Albert Schweitzer as an example of someone known by what he stood for rather than specific accomplishments and it recommends the values assessment homework assignment (pages 224-225). We'll get to that shortly. I wish I could've gone to Dr. Wilson's ABA workshop on this; but I chose Prof. Barnes-Holmes' RFT workshop (or was it a judgment? Does it matter how I think I arrived at the selection among alternatives?). *Choice and Commitment*. If actions are based on reasons and reasons change, then "true commitments" are better done as choices than as judgments. The heart of the ACT life strategy seems to be to develop a life direction in the behavioral sense relatively independent of thoughts and impulses of the moment. The marriage commitment is given as an example of a commitment that is undermined 50% of the time by divorce. The authors see the "cause" of divorce as the persons involved not knowing how to make commitments and marrying on the basis of judgments, decisions, and reasons-therefore not having made a commitment at all by our definition (right?). Is this logic circular? Does it follow that divorce can have no other cause? Maybe so-for our purposes. Anyway, the experience (private event?) of falling in and out of love is rather unpredictable compared to the "choice" quality of commitment. This frames things in a way that life can be lived differently for some than those who "believe" in love feelings as a guideline for action taking. They conclude that commitments are choices free of reasons and changeable verbal cover and suggest the Chessboard Metaphor and Gardening Metaphor as ways to illustrate conceptually.
Eric Fox May 4, 2005 - 5:45pm

ACT Book Summary: Pages 219 - 229

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These pages concern how to differentiate goals from values, methods to clarify values, ways to elicit actions related to values and how to evaluate barriers to valued action.

Outcome is the Process through which Process Becomes the Outcome

This section relates how needing to attain goals creates motivation and direction for action, but does not provide vitality in life. Attaining goals does not equal happiness or life satisfaction, as one is forced to live in a constant state of deprivation (interestingly, it is pointed out that the etymology of the word "want" is "missing").

The Gardening Metaphor describes how to stick it out with an initial choice (i.e., value) to see what happens (without believing that the "grass is greener on the other side," no pun intended). Another "goal" in this phase of therapy is to help clients see that the process of living equals the outcome of interest. The Skiing Metaphor describes this well. Your stated "goal" may be to get down to the lodge and you are planning to ski there. If someone whisks you off in a helicopter to bring you to the lodge, that would make you mad. It is the process of getting to the lodge (i.e., skiing) that is what is to be enjoyed.

Finally, process cannot be measured from moment to moment like goals. If one continually monitors progress toward specific goals, they may miss the " big picture" (i.e., what they have accomplished to date). Here the Path up the Mountain Metaphor comes into play. It highlights what is wrong with monitoring only "snapshots" of life. If you are hiking up a mountain, you may notice twists and turns, circling around (perhaps even going down the path in parts) ultimately to get up the mountain. You may think at any given time: "I'm doing well" (for instance on an up-path) or conversely: "I'm doing poorly" (on a down-path). Yet, an observer with binoculars across the way (looking down at the hikers) may notice steady, continuous progress toward the overall goal.

Values Clarification: Setting the Compass Heading

In this section, values work is further elaborated. The authors point out that doing values work can be an intimate experience between therapist and client, as oftentimes values are not something the client has ever articulate before to someone else. One of the "values" of "values work" is in the fact that values may help point out to clients what IS working in their lives (i.e., they may be leading valued lives in certain areas they hadn't even recognized). There are some values worksheets on page 224. There are three forms, including a values narrative form, values assessment rating form, and goals, actions, barriers form you can use with clients. The goal is to review the worksheets together and build on them. Values work may be a helpful assessment tool as well. In doing the values work, therapists can uncover possible "ulterior motives" for certain values. The authors give three examples:

1. when values statements are controlled by the presence of the therapist, the consequence can be therapist approval or lack of disapproval.
2. when values statements are controlled the presence of the culture more generally, the consequence can be the absence of cultural sanctions, broad social approval, or prestige.
3. when values statements are controlled by stated or assumed values of the client's parents, the consequence can be parental approval

This is not to say that these factors don't affect EVERYONE'S values, but the extent to which the client takes ownership of their values is important to assess. When a client is wedded to the consequences mentioned above, the therapist can ask the client what would happen if the stated consequences were not there (i.e., "What if your parents did not know you received a Ph.D.?"). Another point the authors make is that it is not uncommon for values to change in valence over the course of therapy. Sometimes (oftentimes) clients may leave certain (or many) domains completely empty. In this situation it can be helpful for the therapist to ask the client what values he/she held earlier in life.

Assessing Goals and Actions

After values work is underway, the focus is on developing goals and specifying the actions that can be taken to achieve those goals. A goal is define as a specific achievement, accomplished in the service of a particular value. Clients do homework in acting according to values either as a one-time deal or from a commitment to repeated and regular acts in the service of a given value. The therapist and client monitor for a close connection between action, goal, and value and try to "accumulate small positives." The authors assert that little steps consistently taken are more useful than heroic steps taken inconsistently. What to do about barriers? The authors mention that engaging in valued action almost always provokes a psychological reaction (often in the form of barriers). At

these times, clients may get stuck because they avoid taking values actions as a means of avoiding painful emotional barriers. The therapist then helps the client examine:

1. the type of barrier
2. ask if the barrier is something they can make room for and still act
3. find out what aspect of the barrier may actually help reducing your willingness to have it without defense
4. assess whether barriers are a form of emotional control or avoidance

Question

Although I am a big proponent of values work (or I wouldn't be doing this therapy), I am still struck by the similarity of values homework to "monitoring progress toward a goal," not noticing the process itself. In other words, the question "How well did you move toward this goal this week by these actions" seems like the very "snapshot" that is proposed as problematic in the initial part of this section. Any reactions?
Eric Fox May 4, 2005 - 5:46pm

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Willingness to have barriers and barriers to willingness: willingness is a value-based action, a choice: see the "Bubble in the road" metaphor p. 230. Therapeutic do's and don'ts:

- coercive use of choice: conflicts are possible between the therapist's and the client's values. Take care not to use "choice" as a way to blame the client.
- confusing values and goals: "I want to be happy" is not a value. It's no direction. It's something you can have or not have, like an object. Values cannot be achieved and maintained. Helping question: "What would you be able to do if that was accomplished?" Values are no means to an end.

Eric Fox May 4, 2005 - 5:49pm

ACT Book Summary: Pages 235 - 238

ACT Book Summary: Pages 235 - 238
Willingness and commitment: putting ACT into action ACT is not only about defusing and defining life values. Essentially ACT is all about living, action. This chapter focuses on the commitment part of ACT: "getting the client engage in valued actions while making room for their intended or unintended consequences". **Theoretical focus** Willingness & behavioral commitment = actively engaging in actions that may invite the presence of negative evaluated thoughts, emotions, and bodily states. This induces a confrontation with the unworkable aspects of old rule systems. Verbal and nonverbal aspects are important here. **Verbal**: formulating valued ends & intermediate goals **Nonverbal**: through action, actual movement, behavior can actual contingencies be met. Nonverbal behavior is necessary to find out what actually works. The difference with systematic exposure and behavior change lies in the focus on overt situations + on private events. The emergence of the old rule systems is helpful in the defusion process. **Goal of this phase** = to elicit behavior & to support the client's commitment to sustaining such change. **Comments**: - ultimately ACT is no talk therapy, it's behavior therapy. No behavior therapy without action. The proof of the pudding is in the eating. -old rule systems can be very though. Is it possible to change them in old people, with problem histories of tens of years?
Eric Fox May 4, 2005 - 5:50pm

ACT Book Summary: Pages 238 - 244

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Willingness and Commitment chapter **Clinical Focus** 1. The goal of clinical work in this section is to elicit behavior change and support the client's commitment to sustaining this change. 2. Therapeutic topics center around willingness and committed action. 3. There is a chart with goals, strategies, and interventions related to willingness and commitment on page 239. *My comments*: 4. The authors note that committed action is "funded by valuing." I find that description very helpful! **Experiential Qualities of Applied Willingness** 5. The experiential piece of willingness relates to increasing the client's ability to detect internal struggles and abandon them-even in the midst of the most difficult moments. 6. The authors differentiate willingness from wanting in that often clients feel that they have to want something to do it. They also often feel that if they withhold willingness to have X, X will go away (yet they experience just the opposite). 7. Joe the Bum metaphor (page 24) is used to illustrate willingness. * This metaphor underscores two characteristics of the fantasy of unwillingness: 1) If only invited and wanted guests came to the party, life would be grand. 2) Withholding willingness to welcome the unwanted guest will somehow promote peace of mind. *My comments*: 8. I am struck by how often we expect life to be rosy and don't want anything to happen to upset the applecart, when that's just a frightening way to live! **Willingness Has an All-or-nothing Quality** 9. There is an old Zen saying: "You cannot jump a canyon in two steps." The authors provide an experiential exercise on page 241 related to the simile: "willingness is like jumping." They discuss how the quality of jumping is the same whether one chooses to jump off of a book on the floor, off of a chair onto the floor, and off of a building to the ground. It is merely the context that changes and limits willingness. When you try to change the quality of willingness (for example, by trying to reach your toe to the ground from the book or chair), you destroy it altogether. *My comments*: 10. Maybe someday I'll be gutsy enough to jump off a chair in my office in the service of illustrating this point to a client-I'll have to commit to that J **Reconnecting with Values, Goals, and Actions** 11. At this stage, the therapist reviews the client's contemplated actions in each life domain. 12. While some domains may not be filled in, it is important to develop at least one high priority target and to keep the focus on willingness, not barriers. 13. A couple of therapist statements to illustrate the above are: "What stands in the way of you setting your willingness on high right now?" (the therapist noting the barriers the client cites) and "Has being unwilling worked to protect you over the long haul from those reactions?" **Committed Action as a Process** 14. It is not unusual for clients to avoid making a commitment because of the fear of failure to keep it. 15. There is a therapist-client dialogue on pages 243-244 demonstrating the difference between process and outcome (and how to help the client see this difference). *My comments*: 16. I think it's crucial in any behavior change undertaken by humans to realize (intellectually and experientially) that it is a process, and one will inevitably "fall off the wagon." I attribute this to "stress inoculation" or the Zen meditative notion of guiding one's wandering mind back to task.
Eric Fox May 4, 2005 - 5:52pm

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The section titled "Committed Action Invites Obstacles" begins with the idea that once we have a value-guided game plan, it is time to act. The Eye Contact Exercise is a live demonstration of action and a way to begin to behaviorally confront a common avoidance behavior. This exercise may elicit the reactions described. My experience has been also that many of the client's friends, relatives and acquaintances may perceive a change in the client as eye contact improves. Sometimes it gives them "the creeps". An action oriented, surprisingly powerful intervention. The FEAR and ACT algorithms are introduced as help aids in identifying barriers to willingness(Fusion with thoughts, Evaluation of experiences, Avoidance of experiences, and Reason giving for behavior) and maintaining focus on the game plan(Accept your reactions and be present, Choose a valued direction, and Take action). These can be printed on cards and carried. Live confrontational exercises in the therapy hour are suggested and the "Looking for Mr. Discomfort Exercise" is described on page 247. There's the business of renegotiating the clients relationship with "Mr. Discomfort" and possible use of earlier references to the Passengers on the Bus Metaphor. "Culprits" or likely suspects in failure to complete committed action sited in the book are actions not connected to client's valued ends(direction?) with possible influence by wishes of others, being hooked on literality bolstered by destructive reason giving, or taking a step that is too large or with insufficient preparation. There is also the tip in exposure exercises of identifying component experiences(bodily sensations, memories, emotions, thoughts) and being willing to have them rather than what it says it is or may become. There is also the technical tip of reminding awareness of external environment while encountering negative private experiences. This is helpful when the client "can't stand it" and resorts to devaluing the valued

end(direction?). The authors' use of "valued end" in this section bothers me as it seems to raise the specter of goals rather than the previously emphasized compass direction. The Swamp Metaphor on page 248 helps illustrate the idea of walking "through pain the service of taking a valued direction". The Expanding Balloon Metaphor considers the edge of the balloon as a growth zone where the question is asked: "Are you big enough to have this?" You may respond to each issue with a yes or no. Yes, you get bigger. No, you get smaller. No matter how big you get, there's always more "big" to get. It does not get easier (very important) as each issue may seem relatively as difficult. It may become habitual, however, which begins to provide a source of strength and confidence in the process. Figure 9.1 illustrates how avoided issues cause one to distort life around the issue until it is faced. The Take Your Keys with You Metaphor additionally helps deal with the relationship between avoidance and action. The keys represent difficult emotions, thoughts, reactions, sensations, etc. The client may pick up and carry the keys without them preventing the action and the keys may open doors(an illusion to insight?) The metaphor is given on page 250 and its use creates a tangible for the client to use in his outside therapy life. I'm surprised at how few comments there are on the summaries. These metaphors can restructure a persons' cognitive experience of life and facilitate behavior change. Is it a form of insight? Is that an important question? Is anyone else bothered by the "valued end" versus "valued direction" thing? Is it important? Why or why not? The idea that willingness never gets easier and can't be done piecemeal strikes me as important. I take an exercise class that seems to have this characteristic. It involves recurrent unpleasant private experiences, but doesn't seem to harm or traumatize me. The instructor reminds us, "If this was easy, everyone would be in here doing this." Is this an example of acceptance in service of health as a valued direction? I can tell you, it never gets easier. Do the FEAR and ACT algorithms que rule directed behavior? Could they have a down side?
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Primary barriers to committed action:

When a client resists committed action, often the client is struggling with how the action will alter his (or her) personal history; how the client has created in his own mind his place in his world. The client may also be grappling with the impact this history has had on his conceptualized self. The client has constructed a self perception of who he is. If he has been subjected to an abusive or otherwise harmful environment, his self perception embraces how he has been victimized by others.

Not surprisingly, the client is threatened with the possibility of positive change. This threat challenges both the client's self perception and the hope that an abuser may someday validate the client's self perception and make amends. For example, a client was physically abused as a child. He now perceives himself as a victim of physical abuse; the perception is intertwined with his identity. If he makes positive change, he may no longer appear as a victim to himself or his abuser. He loses his self perceived identity (as a victim).

Clients with history of painful events (especially in childhood) may have learned that life can be unpredictable and punitive. By limiting their exposure to painful thoughts, they mistakenly believe they can curb their sense of trauma. The opposite is often true. Psychological pain hurts but does not damage; whereas psychological trauma is pain without the willingness to experience the pain. This unwilling causes damage; the effect of the pain persist.

An exercise to teach the difference between psychological pain and trauma:

1. Ask the client to describe past painful and traumatic events in detail.

- distinguish between the original pain and,

- the client's reaction to the events.

2. Inventory the area of responses (i.e. physical reactions, emotional reactions, memories, thoughts, etc.)

3. Note the sense of trauma

4. As the client becomes aware of the reaction, ask the client to let go of the struggle with the reaction.

The client's willingness will shift the context of the events; this change will often reduce the client's tension related to the event. As a consequence, the client will be begin to distinguish between trauma and pain. The pain will remain; the trauma will disappear; positive change may occur. A client's reluctance and resistance can be expected. If so, the clinician should:

1. point out to the client the burdened caused by resisting the avoided content
2. have the client notice physical, emotional and cognitive responses that attach to the unwillingness
3. prompt the client to let go of the struggle with unwillingness and be willing to be unwilling
4. if the client is able to do this, ask the client to notice the difference between struggle and letting go
5. encourage the client to continue the process of letting go and bringing up avoided material.

Things to remember:

- The therapist must identify the functional connection between failing to be "right" about being a victim and remaining a victim who demands redress.
- If the client believes he must remain "broken" in order to prove someone else wrong, the client is stuck, not broken.
- Intervention is delicate.
- The events in question are not being disputed.
- What is being disputed is the necessity of living in a self defeating life in the service of waiting for the recognition and redress that seldom, if ever, comes.

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Guilt and Self-loathing (not in Las Vegas, not Hunter Thompson) Guilt = "I'm bad" is a stance that weakens the client's valuing ability. It is connected to past, dead behavior, and, when functionally connected to such a chimera, prevents the client from living in the present, in real time, and moving ahead with life.. In the example shown, the client implies that guilt/shame regarding past behavior is making a visit with a brother an extraordinarily stressful event. The client holds on to contradictory concepts, "I want to be close to my brother, so I cannot tell him the truth." The client is feeling numerous emotions, and seems to get that he is trying to bargain with them, and get them to the back of the bus. When he sees the cognitive dissonance (?), he appears to be able to also see the disconnect, which scares him. Therapist asks what is between him and honesty with his brother -- answer: fear, He can bring that to the front of the bus as well and is still able to drive. **Forgiveness** Clients often think fear is a change in stance where once they 'knew' someone was wrong, bad, untrustworthy, and to forgive is to say they are no longer these things, they are right, good, etc. The client has, in essence, changed their mind. It can also appear to be emotional avoidance -- excusing, denying, forgetting old angers. It is actually a gift to oneself, to give the self that which came before. It gives the for-giver the ability to regain the grace under which they can neutralize the injustices -within themselves. To paraphrase "the injustices of others can only be made permanent by the victim, not the perpetrator," or pain is unavoidable, but suffering is optional. Example used is the Gestalt "empty chair" exercise. It may be best to allow the client work on the pivotal, profoundly personal issue of forgiveness outside of the session, where the necessary privacy and time for self-reflection is available. **Behavior** When the client is nearing the end of the willingness and commitment phase, ACT begins to resemble other Behavior Therapy, while maintaining an ACT flavor. Skill building, couples work, role-playing et al, are used from an ACT perspective. **Termination** Termination comes when the client has reached a point where valued behavior change has been actualized for him or her. Therapy is not designed to be permanent -- Woody Allen "I have been in Analysis for twenty years. I think I will give it another ten and if that doesn't work, I will call it quits." It is to help the client get unstuck. When a client shows openness to change, a rating scale may be used to gauge further commitment to same. Termination may be tapered off, shorter for the

functional client, and longer for the multiple problem client. This phase is used to bolster key ACT principles (Oh how quickly we forget) and for relapse prevention. This, thinking of diClemente's stages of change, is the maintenance and transition stage. During this period, if the need to reenter therapy arises, the therapist will be aware of it during these phasing out visits.
Eric Fox May 4, 2005 - 5:58pm

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THERAPEUTIC DO'S AND DON'TS **Even in Relapse, Values are Permanent** When client is experiencing a relapse, the first thing therapist and client must know is if there's a change in client's values. Most of the times, there's not a change in values but on client's confidence to achieve them. When client experiences a relapse, there's probably inner conflictive talk about different rules and memories. If the therapist confirms that the client's values are the same, he can use a metaphor to say that even though obstacles may show up in the way, the way to arrive to the committed goal is the same. *omments*: What if the client's approach to his value allows him to foresee a "danger" (such as the non accomplishment of other values). On the other hand, the client might answer that if one is tired to drive to San Francisco it is not recommendable to do it, or that if he knows the road is blocked because of an accident, he should wait till another day or month. My comment might be silly but since my short therapeutic experience, clients are very good at refuting and turning over all kind of metaphors adjusting them to their immediate needs. **The Client Owns Committed Action** In this section, the authors emphasize the importance that the client follows his own values and not the ones that might be a non intentional influence of the therapist. **Noncompliance is not Failure** When client's behavior doesn't change, therapists use to think it's a failure, and when this happen, therapist pushes the client to act according to his own values (the ones of the client). That strategy doesn't lead to a good outcome, and client's behavior gets resistant or definitely avoidant. The best way to cope with that situation is to accept the client's struggle and non-action from the point of view of the client. *Comments*: It's interesting to me that in this situation the main problem is not the client's resistance, but the therapist resistance to accept the client's behavior. PERSONAL WORK FOR THE CLINICIAN: COMMITTED ACTION In this exercise, the therapist takes one value and establishes goals, actions and obstacles according to it. Then, the therapist thinks about which private events would show up once committed action begins and if he is decided to make room for them. *Comments*: it's very interesting to me the difference between ACT approach and CBT. In my clinical experience as a CBT I remember that after the assessment and before treatment, we had to write down together the client's goals, but most of the times, even though classifying them in different areas and making a hierarchy, there was a lack of certain "structure", not only in the result but also in the process of "outcoming" goals, so the goal sessions used to be quite unsatisfactory. CLINICAL VIGNETTE In this section, the authors expose an example of how a client can mislead committed action as a process, and as an outcome. The client relates "drinking again" to not to be a "loving and emotionally available husband", so he experiences negative private events. But he should consider "drinking again" as an obstacle which is part of the whole process, and not the outcome. The other point of the example to stand out is that the client misleads blame and responsibility. But considering "drinking again" as part of a process and not as an outcome, he would understand that he is able to choose again from now on. Three metaphors are provided. APPENDIX: CLIENT HOMEWORK Accepting Yourself on Faith Exercise The therapist differentiates between conclusion and assumption, and defines assumption (something we use to do other work). Then, after checking that the client validates himself making a conclusion, impels the client to choose the assumption that he is acceptable and valid. That's called Faith Exercise. When the client chooses to be acceptable, some contents such as self-doubt depend on the previous assumption and so they loose their meaning. *Comments*: I understand that assumptions are so frequent and necessary as breathing, and also, that approaching the problem of self acceptance might be easier and quicker that way. But I think that self validity can be approached from a filogenetical point of view. What we are is the outcome of millions of years of environmental and social selection. That has a great value per se, and is not an assumption. If we have being selected is that we are good. But on the other hand I understand that sometimes that's something difficult and maybe long to explain. What do you all think about it?
Eric Fox May 4, 2005 - 6:00pm

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The Effective ACT Therapeutic Relationship The chapter begins with the statement that the therapist stance towards the client and therapy is an important variable, and as a result therapy becomes an intense experience for both, client and therapist. Then, the problem of language traps is introduced as a process in which the therapist may fall down itself. The beginning of the chapter also announces the possibilities and limitations of all therapeutic relationships, their lights and shadows. *Comments*: the last passage of this page makes me think that in a therapeutic relationship, due to the fact that there's a short history of contingencies between client and therapist, words in that context have a great amount of relations, and so, the range of meanings is wide. For example, when talking to an old and close friend, some words, sentences or non verbal behaviors have an unique meaning. Usually it happens the opposite in therapy. **Positive leverage points in ACT** As a main feature of ACT stance it is presented its sensitivity: its open, accepting and coherent stance towards client. But the paradox of using rule governed behavior to direct and influence the therapist behavior is presented in a quick and clearly way. *Comments*: I ask myself which are the historical antecedents and conditions that lead to a sensitive therapist. Understanding the word "sensitivity" as a track to therapists is important, but I think that every kind of human relationship called therapy, shares (regarding other psychological models) the fact that therapy is an art, and art is a practice. And in that sense I think that the beginnings of all kind of therapy are mechanical, not only because of the model but mainly because of the lack of experience. **ACT in a functional sense** Then, the authors present an example of a therapist being caught up by the literal meaning of an internal event and the possible consequences of it. The point referred is not how to "resolve the problem" but how to accept the fact of experiencing this kind of thoughts. The therapist itself must become a living flesh example of individual being stuck by a rule ("Good therapists would know what to do in that case") that accepts its own inner events and commits to therapy goals. *Comments*: I like the fact that the possible interventions of therapist are not a memorizeable standardized list of sentences, just contingencied, spontaneous responses. Otherwise, I like the impel to consider therapy as a struggle DURING therapy and not a previously manufactured "solution". **Observer Perspective** Another of the positive leverages of ACT is an observer perspective that takes an extremely care in not rationalizing and justifying through verbal behavior our private events. The ACT model emphasizes the importance of the acquisition of this skill by the therapist, arguing that the way the therapist behaves during therapy regarding internal events is important to influence the way the client will behave itself. *Comments*: following the argument I agree that personal growing and maturity of the therapist is a fundamental variable in therapy **Wisdom is Gained by Approach, Not Avoidance** And as an end to my summary, the authors explain the difference between achieving goals and values and the stance of coping them despite of "secondary effects" hung on them. They say that therapist should show this stance during therapy, and furthermore, that they should have experienced such a coping stance. An effective ACT therapist is the outcome of that condition. *Comments*: I appreciate the difference between merely achieving goals and to live while achieving goals. I always thought that a goal oriented stance was not enough.

Eric Fox May 5, 2005 - 12:35am

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Contradiction and uncertainty: the willingness to entertain contradictory themes of uncertainties without feeling compelled to use verbal behavior or verbal reasoning to resolve them. Two things come to mind: *The test of a first-rate intelligence is the ability to hold two opposed ideas in mind at the same time and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise.* - F. Scott Fitzgerald And "Alice laughed: "There's no use trying," she said; "one can't believe impossible things." "I daresay you haven't had much practice," said the Queen. "When I was younger, I always did it for half an hour a day. Why, sometimes I've believed as many as six impossible things before breakfast." The phrase "field of play" seems apt to me. When I am in ACT mode with a client, it does feel like play, even if we're working on heavy painful stuff. Field of possibility is another way I think of it. No guarantees, no warranties-just living. My clients and I have a bus metaphor when we talk about the impermanence of life. Years ago, when I was making another appointment with a client, he told me he planned to be there, but as John Lennon said, "Life is what happens when you're busy making plans," and that either of us could be hit by a bus. He was right and I try to remember it. It seems to me that this awareness leads right into values work. If you have no guarantee that you will survive the day, how does that affect what you're doing right now? Tolerate

paradox, ambiguity, confusion and irony. I suppose you'd have to be a fan of Monty Python, then, hey? I still find the rescuing bit hard not to buy. Getting older helps. I'm beginning to realize on a gut level that I have no idea what happens next. Some days that's really hard. One woman and I were discussing the whole uncertainty thing and I got rescue-y. I suggested to her that it was like being a trapeze artist, and you just let go of one trapeze, fly through the air for a while and grab then next. She replied, "Right. Except for a few things: you've never seen a trapeze before, you're blind, all of your enemies are watching, your hair's on fire and you're naked." Point taken. Identification with the client: "We are not cut from different cloth, but from the same cloth." *This, to me, is perhaps the most precious thing about doing ACT*. Being trained in the psychodynamic camp, I always felt like a fraud. I knew that I wasn't necessarily stronger or more psychologically healthy, but the work seemed to need me to put on my therapist suit and pretend that I was. So the client would be wearing their client suit and I'd be wearing my therapist suit and we'd sit in the room and pretend not to notice when the suits slipped. Not as much fun as you might imagine. *Normal reassurance vs. soft reassurance*. How I make this distinction is this- normal reassurance has the flavor of the tense pat on the back and the underlying desire for them to stop talking. "It will be all right," is usually for me. I can feel the tenseness in my face when I'm being normally reassuring, and I can find myself wandering, thinking about grocery shopping and whatnot. When I'm doing soft reassurance, I'm often more uncomfortable, tending to see how close their suffering is to mine and I'm riveted. I can't hold anything else, just the awareness of how hard it is sometimes to be human. Often, I get teary, especially when I get in touch with the amazing courage it takes for some of my clients to just get out of bed in the morning. *Self-disclosure: An essential aspect of developing a human relationship*. Where I still struggle is with the workability of the self- disclosure. If I'm having a terrible day, I think the client can tell, but they're paying me to be present for them, although some of them would love to caretake me in the session, if only to avoid their stuff. It's messy, this edge, and I like precision. But I think the messiness is where the life is. Perhaps. *Therapeutic Use of Spirituality*. "A view of the world that recognizes a transcendent quality to human experience, acknowledges the universal aspects of the human condition, and respects the client's values and choices. " Stepping back from a personal struggle and examining it openly and non-defensively. Easier said than done. This is where the observer exercise comes in, for me. I've had the experience of transcendence with this exercise, and clients had described the same. When they can dip into that open hearted space and observe themselves from there, their faces and bodies soften. It's really wonderful to watch. This observer position is the most fluid position I can take in the session as well. That being said, it takes repeated effort and intention to come to this place. But when someone--myself or client--has had the experience of this observer self, they know that it's possible. There's a “there there” for them, if you will. Until the experience happens, there's no there for them to go to. At least as I see it. Radical respect: "There is no right of wrong way to live one's life. There are only consequences that follow from specific human behaviors." Another quote I've stolen from a client. "So the way I look at it, there's six billion and counting humans on the planet. There's probably not one right way to be a human being, so my job is to find the way I want to be a human being and choose things that get me there." In my experience, this defining of valued direction tends to evolve over time. Not many of the people I work with can immediately describe what matters to them. We tend to do successive approximation, and look for a non-verbal response, sort of an aha experience. Values work is the part of ACT I struggle with the most. Clinical use of humor and irreverence: "The therapist's irreverence comes from an appreciation of the craziness and verbal entanglements that surround human living." It seems to me that this can backfire if I'm not in radical respect. Radical respect seems to infuse all of the work with a client from the ACT perspective. RR for their values, RR for their history, RR for their choices. RR for how they show up in the room. Is RR the same as acceptance? It's great when the client begins using humor and irreverence with their stuff. Another steal: Client's doing a lot of reason giving, catches themselves and says, "Anyway, that's my story and I'm sticking with it." Then laughs. Very cool stuff.
Eric Fox May 5, 2005 - 12:37am

ACT Book Summary: Pages 275 - 288

ACT Book Summary: Pages 275 - 288
Negative leverage points in ACT *ACT is not an intellectual exercise* Overemphasizing verbal content and trying to convince clients is the antithesis of an effective ACT relationship. Better: - be "compassionately confrontational" - no more than 20% of the session involving explaining ACT principles - use metaphors and exercises *Modeling a lack of acceptance* This is especially difficult with more disturbed clients (suicidality, self-

mutilation, bizarre behaviors,...) Ways of nonacceptance: - selective reinforcement of socially desirable thoughts & behavior, while ignoring or disputing negatively evaluated experiences - using the language of choice in a socially coercive way: "It's your choice, and you're not making it!" - "Where did you learn that way of thinking?" Heavy emphasis on history & reason giving Solution: acknowledge it & let go of it. *Excessive focus on emotional processing* Misconception: clients should "get in touch with their feelings". This is true only insofar as avoidance blocks them taking a committed direction in life. No emotional rediscovery for it's own sake. This is the most seductive error. Solution: come back to active exercises linked to values and behavior change. *Countertransference* There will be issues that are as salient for the therapist as for the client. Resulting in: topic avoidance, advice giving, excessive reliance on personal experience. Solution: self-acceptance for the therapist • The therapeutic relationship: strong, open accepting, mutual, respectful, loving. It's not an end purpose per se. • ACT in context - Don't "believe" a word in this book - Important (different from many other clinical traditions): link with experimental research - "Are we using language or is language using us?" - It's our job to try to establish & support cultural practices inside & outside psychotherapy that ameliorate these destructive processes in a socially broader way (e.g. acceptance & cognitive defusion). Psychotherapy sometimes undermines valuable existing traditions (spiritual & non-rigid, non-punitive religious traditions). THE END *Comments*:

- some useful rules are given (esp. for beginners): no more than 20% explanation, back to exercise, ...
- excessive focus on emotional processing: I was exactly doing this the very moment I read this piece. Back to values and behavior!
- remaining questions: what about clients not seeking help, but needing it (involuntary treatment); how to integrate RFT with other problems (not having to do with avoidance): impulsivity, aggression, ...

Eric Fox May 5, 2005 - 12:40am

Book Translations (Archives)

Book Translations (Archives) Community December 2, 2021 - 6:07pm

Translated ACT and RFT Books

Translated ACT and RFT Books

This list is no longer being updated. Please click here for a list of ACT Books in 20+ Languages.

Translated ACT Books Organized by Language Community (see below for list by English title)

Chinese

- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
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Covati Katia Manduchi, Giovambattista Presti, Anna Bianca Prevedini, Elisa Rabitti, Massimo Ronchei, Francesca Scaglia, Giovanni Zucchi, Silverio Zucchi, Giovanni Miselli.

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    - Korean translation: McCurry, C. (2011). 불안한 아이 수용과 마음챙김으로 키우기. Sigmapress (translated by Lee, S.).
- Forsyth, J. P. & Eifert, G. H. (2008). The Mindfulness and Acceptance Workbook for Anxiety Workbook: A guide to breaking free from anxiety, phobias, & worry using Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Korean translation: Forsyth, J. P. & Eifert, G. H. (2008). 마음챙김과 수용중심 불안장애 치료의 실제. Sigmapress (translated by Lee, S., Han, H., Jung, E.).
- Törneke, N. (2010). Learning RFT: An Introduction to Relational Frame Theory and Its Clinical Application. Reno, NV: Context Press.
    - Korean translation: Törneke, N. (2019). Learning RFT: An Introduction to Relational Frame Theory and Its Clinical Application. Hakjisa (translated by Lee, S.).

Norwegian

- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Norwegian Translation: Hayes, S. C., Strosahl, K., & Wilson, K. G. (2018) Aksept og verdibasert adferdsterapi (ACT) Mindfull endring - prosess og praksis. Oslo: Arneberg Forlag.
- Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Norwegian translation: Hayes, S. C., & Smith, S. (2015). Slutt å gruble begynn å leve. Oslo: Arneberg Forlag.

Persian

- Vowles, K. E., & Sorrell, J. T. (2008). Life with chronic pain: an acceptance-based approach (therapist guide and patient workbook).
    - Persian translation: Vowles, K. E., & Sorrell, J. T. (2008). زندگی با درد مزمن: رویکرد مبتنی بر پذیرش. zendegi ba darde mozmen: roykarde mobtani bar paziresh (rahnamaye darmangar va ketabe kare bimar). translated by F. Mesgarian. Tehran: Arjmand.

Polish

- Hayes, S. C. (2019). A liberated mind: How to pivot toward what matters. New York: Penguin/Avery.
    - Polish translation: Hayes S. C. (2020). Umysł Wyzwolony. Zakończ wewnętrzną walkę i żyj w zgodzie ze sobą. Sopot: Gdańskie Wydawnictwo Psychologiczne.
- Hayes, L. L., & Ciarrochi, J. (2015). The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection. Oakland, CA: New Harbinger.
    - Polish translation: Hayes, L., Ciarrochi, J. (2019). TRUDNY CZAS DOJRZEWANIA. Jak pomóc nastolatkom radzić sobie z emocjami, osiągać cele i budować więzi, stosując terapię akceptacji i zaangażowania oraz psychologię pozytywną. Gdańsk: GWP.
- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Polish translation: Hayes, S. C., Strosahl, K., & Wilson, K. G. (2015). Terapia akceptacji i zaangażowania (2nd edition). Krakow, Poland: Jagiellonian University Press.
- Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Polish translation: Hayes, S. C., & Smith, S. (2014). W pulapce mysli: Jak skutecznie poradzic sobie z depresja, stresem I lekiem. Gdansk: Gdanskie Wydawnictwo Psychologizne.

Portuguese

- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Portuguese translation: Hayes, S. C., Strosahl, K., & Wilson, K. G. (2021). Terapia de aceitacao e compromisso: a processo e a practica da mundanca consciente (2a editcao). Translation edited by Sandra Maria Mallmann da Rosa. Porto Alegre, Brazil: Artmed.

Romanian

- Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Romanian translation: Hayes, S. C., & Smith, S. (2013). Ieși din scenariile minții și trăiește-ți viața. (Trans. K. Szabo). Lași, Romania: Editura Poliram.

Russian

- Hayes, S. C. (2019). A liberated mind: How to pivot toward what matters. New York: Penguin/Avery.
    - Russian translation: Hayes S. C. (2021). Освобождённый разум. Moscow: Бомбора (Bombora).

Serbian / Bosnian / Croatian / Montenegrin

- Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Serbian / Bosnian / Croatian / Montenegrin translation: Hayes, S. C., & Smith, S. (2017). Centar za Kongnitivno-Bohejvioralnu Terapiju. Banja Luka, Bosnia Hercegovina: My Books / Centar za kognitivno-bihejvioralnu terapiju.

Spanish

- Villatte, M., Villatte, J., & Hayes, S. C. (2015). Mastering the clinical conversation: Language as intervention. New York: Guilford.
    - Spanish translation: Villatte, M., Villatte, J., & Hayes, S. C. (2019). Gerente la conversación clínica: El lenguaje como intervención. Madrid: Madrid Institute of Contextual Psychology.

- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Spanish translation: Hayes, S. C., Strosahl, K., & Wilson, K. G. (2014). Terapia de aceptacion y compromise: Proceso y practica del cambio (2nd edition). Translation edited by Ramiro Alvarez. Bilbao, Spain: Desclee de Brouwer.
- Twohig, M., & Hayes, S. C. (2008). ACT verbatim: Depression and Anxiety. Oakland, CA: New Harbinger; Reno, NV: Context Press.
    - Spanish translation: Twohig, M., & Hayes, S. C. (2019). ACT en la practica clinica para le depression y la ansiedad. Bilbao, Spain: Desclee de Brouwer.
- Harris, R. (2008). The Happiness Trap: How to stop struggling and start living. Boston, MA: Trumpeter.
    - Spanish translation (2008): Las Trampas De La Felicidad. Grupo Editorial Patria.
- Harris, R. (2011). The Confidence Gap. Boston, MA: Trumpeter.
    - Spanish translation (2012): Cuestión de Confianza. Santander. Sal Terrae.
- Hayes, S.C. (2005). Get Out of Your Mind and Into Your Life. Oakland, CA: New Harbinger Publications.
    - Spanish translation (May 2013): Sal de tu mente, entra en tu vida. Bilbao. Desclée de Brouwer.
- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Spanish translation (2014) Terapia de aceptacion y compromise: Proceso y practica del cambio (2nd edition). Translation edited by Ramiro Alvarez. Bilbao, Spain: Desclee de Brouwer.

Swedish

- Hayes, S.C., Strosahl, K.D., Wilson, K.G. (2012). Acceptance and Commitment Therapy: The Process and Practice of Mindful Change (second edition). New York: The Guilford Press.
    - Swedish translation: Hayes, S. C., Strosahl, K., & Wilson, K. G. (2014). ACT – Acceptance and Commitment Therapy i teori och tillamping: Vagen till psykologisk flexibilitet (2nd edition). Stockholm, Sweden: Natur Och Kulture.
- Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.
    - Swedish translation: Hayes, S. C., & Smith, S. (2007). Sluta grubbla Borja leva. (Trans. A. Ghaderi). Stockholm: Natur och Kultur.
- Harris, R. (2008). The Happiness Trap: How to stop struggling and start living. Boston, MA: Trumpeter.
    - Swedish translation: (2009): Lykofallan. Stockholm, Sweden.

Translated ACT Books by English Title

Translations of Hayes, S. C. (2019). A liberated mind: How to pivot toward what matters. New York: Penguin/Avery.

- **German Translation:** Hayes, S. C. (2020). Kurswechsel im Kopf: Von der Kunst anzunehmen, was ist, und innerlich frei zu werden. Beltz Verlag.
- **Polish Translation:** Hayes S. C. (2020). Umysł Wyzwolony. Zakończ wewnętrzną walkę i żyj w zgodzie ze sobą. Sopot: Gdańskie Wydawnictwo Psychologiczne.
- **Russian Translation:** Hayes S. C. (2021). Освобождённый разум. Moscow: Бомбора (Bombora).

Translations of Luoma, J., Hayes, S. C., & Walser, R. (2017). Learning ACT: An Acceptance & Commitment Therapy skills-training manual for therapists (2nd ed). Oakland, CA: Context Press / New Harbinger Publications.

- **Italian translation:** Luoma, J., Hayes, S. C., & Walser, R. (2019). Il manuale del terapeuta ACT: Apprendere e allenare le abilita dell' Acceptance & Commitment Therapy (2nd ed). Rome, Italy: Giovanni Fioriti Editore.

Translations of Polk, K. L., Schoendorff, B., Webster, M., & Olaz, F. O. (2016). The essential guide to the ACT matrix: A step-by-step approach to Using the ACT matrix model in clinical practice. Oakland, CA: New Harbinger Publications.

- **French translation:** Polk, K. L., Schoendorff, B., Webster, M., & Olaz, F. O. (2017) *Guide de la matrice ACT.* De Boeck Sup.

Translations Villatte, M., Villatte, J., & Hayes, S. C. (2015). Mastering the clinical conversation: Language as intervention. New York: Guilford.

- **French translation:** Villatte, M., Villatte, J., & Hayes, S. C. (2019). Maîtriser la conversation clinique: Le langage en therapie. Malakoff: Dunod Editeur.
- **German translation:** Villatte, M., Villatte, J., & Hayes, S. C. (2020). Beherrschung der klinischen Konversation: Sprache als Intervention. Stuttgart: W. Kohlhammer GmbH.
- **Italian translation:** Villatte, M., Villatte, J., & Hayes, S. C. (2020). Il dialogo clinic: Funzione, valore e centralita del linguaggio in psicoterapia. Milan: Franco Angeli.
- **Korean translation:** Villatte, M., Villatte, J., & Hayes, S. C. (in press). Imsang daehwa maseuteohagi : Gaeib-euloseoui eon-eo. Seoul: Life and Knowledge Publishing.
- **Spanish translation:** Villatte, M., Villatte, J., & Hayes, S. C. (2019). Gerente la conversación clínica: El lenguaje como intervención. Madrid: Madrid Institute of Contextual Psychology.

Translations of Hayes, L. L., & Ciarrochi, J. (2015). The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection. Oakland, CA: New Harbinger.

- **Polish translation:** Hayes, L., Ciarrochi, J. (2019). TRUDNY CZAS DOJRZEWANIA. Jak pomóc nastolatkom radzić sobie z emocjami, osiągać cele i budować więzi, stosując terapię akceptacji i zaangażowania oraz psychologię pozytywną. Gdańsk: GWP.

Translations of Hayes, S. C., Strosahl, K., & Wilson, K. G. (2012). Acceptance and Commitment Therapy: The process and practice of mindful change (2nd edition). New York: Guilford Press.

- **Dutch translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2012). Acceptance en Commitment Therapie: Veranderingen door mindfulness, het process en de praktijk. (2nd edition). Amsterdam: Pearson Education Publishers.
- **Danish translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2013). Acceptance en Commitment Therapy: Psykologisk fleksibilitet og mindfulnessprocessor (2nd edition). Translator: Bjorn Nake. Copenhagen, Denmark: Hans Reitzel Publishers).
- **Italian translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2013). Teoria e pratica del l'Acceptance and Commitment Therapy. (2nd edition). Translation edited by Cesare Maffei. Translators: Nidia Morra and Nicolò Gaj. Milan, Italy: Rafaello Cortina Editore.
- **Spanish translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2014). Terapia de aceptacion y compromise: Proceso y practica del cambio (2nd edition). Translation edited by Ramiro Alvarez. Bilbao, Spain: Desclee de Brouwer.
- **Swedish translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2014). ACT – Acceptance and Commitment Therapy i teori och tillamping: Vagen till psykologisk flexibilitet (2nd edition). Stockholm, Sweden: Natur Och Kulture.
- **German translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2014). Akzeptanz & Commitment Therapie: Achtsamkeitsbasierte Veranderungen in Theorie und Praxis (2nd edition). Paderborn, Germany: Junfermann Verlag;

- **Norwegian translation:** Hayes, S. C., Strosahl, K., & Wilson, K. G. (2018) Aksept og verdibasert adferdsterapi (ACT) Mindfull endring - prosess og praksis. Oslo: Arneberg Forlag.
- **Japanese translation:** (Suginami City, Japan: Seiwa Shoten
- Chinese translation
- **Polish translation:** (Krakow, Poland: Jagiellonian University Press)
- **Hebrew translation:** (Haifa, Israel: Ach Publishers)
- **Korean translation:** (Soule, Korea: Sigma Press)
- **Portuguese translation:** (Porto Alegre, Brazil: Artmed)

Translations of Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). Acceptance and Commitment Therapy: An experiential approach to behavior change. New York: Guilford Press.

- **German translation**: Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2004). *Akzeptanz- und Commitment-Therapie: Ein erlebnisorientierter Ansatz zur Verhaltensänderung*. München: CIP-Medien. (transl. by Rainer F. Sonntag & Danielle Tittelbach)
- **Dutch translation**: Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2006). *ACT. Een experiëntiële weg naar gedragsverandering. Nederlandse bewerking* (trans. By Ando Rokx). ISBN 90 265 1758 0 Verschijnt zomer 2006 Prijs: C.a. € 50, -
- **Korean translation**: Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2009). *수용과 참여의 심리치료*. Sigmapress (translated by Moon, S-W & Kim, E.). Click here to buy this book.

Translations of Hayes, S. C., & Strosahl, K. D. (2004) (Eds.). A practical guide to Acceptance and Commitment Therapy. New York: Springer-Verlag.

- There is a **Korean translation** in press from Hakjisa Publisher
- **Japanese translation** (in press). Akashi Shoten Co.

Translations of Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004) (Eds.). Mindfulness and acceptance: Expanding the cognitive behavioral tradition. New York: Guilford Press.

- **Dutch translation**: Hayes, S. C., Follette, V. M., & Linehan, M. M. (Eds.). (2006). *Mindfullnes en acceptatie. De derde generatie gedragstherapie* . (Trans. By Ando Rokx). Nederlandse bewerking. ISBN 90 265 1759 9 Verschijnt zomer 2006 Prijs: C.a. € 50, -
- **Japanese translation**: Hayes, S. C., Follette, V. M., & Linehan, M. M. (2005.) *Maindofurunesu ando akuseputansu; Ninchikodo-ryoho no shinjigen*. (Trans. by Y. Haruki, T. Muto, Y. Ito, & Y. Sugiura). Tokyo: Brain-shuppan.
- **Korean translation:** Hayes, S. C., Follette, V. M., & Linehan, M. M. (Eds.). (2005.) Mindfulness and acceptance: Expanding the cognitive behavioral tradition. Seoul: Meditation Counseling Research Institute. [2009]
- **Chinese translation:** Hayes, S. C., Follette, V. M., & Linehan, M. M. (Eds.). (2005.) Mindfulness and acceptance: Expanding the cognitive behavioral tradition. Shanghi: Ewen Publishers. [2011]

Translations of Hayes, S. C., & Smith, S. (2005). Get out of your mind and into your life: The new Acceptance and Commitment Therapy. Oakland, CA: New Harbinger. (Winner of the Association for Behavioral and Cognitive Therapies Self-Help Book of Merit Award, 2010)

- **Danish translation**: Hayes, S. C., & Smith, S. (2008). *Slip tanketyrraniet – tag fat på livet*. (Trans. T. Bøgeskov). Copenhagen: Dansk Psykologisk Forlag.
- **Dutch translation**: Hayes, S. C., Smith, S. (2006). *Uit je hoofd, in het leven. Een werkboek voor een waardevol leven met mindfulness en Acceptatie en Commitment Therapie*. (Trans. A. Rokx). Amsterdam: Uitgeverij Nieuwezijds.
- **Finnish translation**: Hayes, S. C., & Smith, S. (2008). *Vapaudu mielesi vallasta ja ala elää*. (Trans. Päivi and Raimo Lappalainen). Tampere, Finland: Suomen Käyttäytymistieteellinen.
- **German translation**: Hayes, S. C., & Smith, S. (2007). *In abstand zur inneren wortmaschine: Ein selbsthilfe- und therapiebegleitbuch aud der grundlage der Akzeptanz- und Commitment-Therapie*. (Trans.

G. Kluger). Tübingen, Germany: dgvt-Verlag.
- **Italian translation** (2010): Hayes, S. C., & Smith, S. (2010). *Smetti di Soffrire, Inizia a Vivere.* (ed. IT P. Moderato trans. ACT-Italia) Milano: Franco-Angeli. www.act-italia.org
- **French translation:** Hayes, S. C., & Smith, S. (2013). Penser Moins pour etre heureux: Ici et maintenant, accepter so passé, ses peurs et sa tristesse. Paris, France: Groupe Ayrolles.
- **Chinese translation:** Hayes, S. C., & Smith, S. (2010). Zǒuchū nǐ de tàidù, zài nǐ de shēnghuó: Xīn Acceptance and Commitment Therapy. Chongqing, China: Chongqing University Press.
- **Korean translation:** Hayes, S. C., & Smith, S. (2010). 마음에서 빠져나와 삶 속으로 들어가라 새 수용전념치료. Seoul: Hakjisa Publishers.
- **Japanese translation**: Hayes, S. C., & Smith, S. (2008). *Anata no Jinsei wo Hajimeru tameno Workbook: Kokoro tono Atarashii Tsukiai kata, Acceptance and Commitment* (Trans. T. Muto, H. Harai, M. Yoshioka, & M. Okajima). Tokyo: Brain Shuppan.
- **Second Japanese translation:** Hayes, S. C., & Smith, S. (2010). Anata no Jinsei wo Hajimeru tameno Workbook: Kokoro tono Atarashii Tsukiai kata, Acceptance and Commitment (Trans. T. Muto, H. Harai, M. Yoshioka, & M. Okajima). Tokyo: Seiwa Shoten Publishers.
- **Swedish translation**: Hayes, S. C., & Smith, S. (2007). *Sluta grubbla Borja leva*. (Trans. A. Ghaderi). Stockholm: Natur och Kultur.
- **Romanian translation**: Hayes, S. C., & Smith, S. (2013). Ieși din scenariile minții și trăiește-ți viața. (Trans. K. Szabo). Lași, Romania: Editura Poliram.
- **Bosnian translation:** Hayes, S. C., & Smith, S. (in press). Centar za Kongnitivno-Bohejvioralnu Terapiju.
- **Croatian translation:** Hayes, S. C., & Smith, S. (in press). Centar za Kongnitivno-Bohejvioralnu Terapiju.
- **Montenegrin translation:** Hayes, S. C., & Smith, S. (in press). Centar za Kongnitivno-Bohejvioralnu Terapiju.
- **Serbian translation:** Hayes, S. C., & Smith, S. (in press). Centar za Kongnitivno-Bohejvioralnu Terapiju.
- **Polish translation:** Hayes, S. C., & Smith, S. (n press). Gdansk: Gdanskie Wydawnictwo Psychologizne.
- **Spanish translation:** Hayes, S. C., & Smith, S. (2013). Sal de tu mente entra en tu vida: La nueva Terapia de Aceptación y Compromiso. Bilbao, Spain: Editorial Desclée De Brouwer.
- For the visually impaired (or just those who like audio books) there is an Audio book version: New York: Tantor Audio (2012)

Translation of Eifert, G. H., McKay, M., & Forsyth, J. P. (2006). Act on life not on anger: The new Acceptance and Commitment Therapy guide to problem anger. Oakland, CA: New Harbinger.

- **Dutch translation**: Eifert, G. H., Forsyth, J., & McKay, M. (2006). *Boosheid de bass: ACT: een nieuwe methode om ergernis en frustratie in de hand te houden*. The Netherlands: Thema.

Translation of Harris, R. (2008). The Happiness Trap: How to stop struggling and start living. Boston, MA: Trumpeter.

- **Spanish translation** (2008): Las Trampas De La Felicidad. Grupo Editorial Patria.
- **Chinese translation**: 羅斯．哈里斯（2009）。快樂是一種陷阱。台北：張老師文化。
- **French translation:** (2009): Le piège du bonheur. Montréal : Éditions de l'Homme.
- **Japanese translation:** 幸福になりたいなら幸福になろうとしてはいけない: マインドフルネスから生まれた心理療法ACT入門 (単行本) (Japanese) Tankobon Hardcover – December 17, 2015
- **Dutch translation:** (2010): De valstrik van het geluk. Bohn Stafleu van Loghum.
- **Swedish translation:** (2009): Lykofallan. Stockholm, Sweden.

Translation of Harris, R. (2011). The Confidence Gap. Boston, MA: Trumpeter.

- **Spanish translation** (2012): Cuestión de Confianza. Santander. Sal Terrae.

Translations of Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). Learning ACT: An Acceptance & Commitment Therapy Skills-Training Manual for Therapists. Oakland, CA: New Harbinger & Reno, NV: Context Press.

- **German translation** (2009): *ACT-Training. Reihe Fachbuch, ACT für die klinische Praxis; Acceptance & Commitment Therapie: ein Handbuch. Ein Lernprogramm in zehn Schritten*. Translators:Theo Kierdorf, Hildegard Höhr. (ISBN: 978-3-873877-00-9).
- **Japanese translation** (2009): *ACT wo manabu*. (Trans. H. Kumano, F. Takahashi, & T. Muto) Tokyo: Seiwa-shoten. www.seiwa-pb.co.jp
- **Dutch translation:** Luoma, J., Hayes, S. C., & Walser, R. (2009). Leer ACT. Vaardigheden voor therapeuten (Trans. L. Berkhuizen, P. van der Kaaij, & J. A-Tjak). Houten, The Netherlands: Bohn Stafleu van Loghum.
- **Korean translation:** Luoma, J., Hayes, S. C., & Walser, R. (20012). Bae-u-gi ACT. Soule, Korea: Hakjisa Publishers.

Translations of Bach, P., & Moran, D. (2008). ACT in practice: Case conceptualization in Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.

- **Japanese translation** (2009): *ACT wo jissenn-suru*. (Trans. T. Muto, M. Yoshioka, K. Ishikawa, & A. Kumano) Tokyo: Seiwa-shoten. www.seiwa-pb.co.jp
- **Chinese translation**: 帕特里夏·A.巴赫（Patricia A.Bach）、（美國）丹尼爾·J.莫蘭（2011）。接受與實現療法：理論與實務。重慶：重慶大學出版社

Translation of Ramnero, J., & Torneke, N. (2008). ABCs of human behavior: Behavioral principles for the practicing clinician. Oakland, CA: Context Press / New Harbinger.

- **Japanese translation** (2009): *Rinshou-koudou-bunnseki no ABC*. (Trans. T. Muto, N. Yoneyama, & J. Tanaka-Matsumi) Tokyo: Nihon-Hyoron-sha. www.nippyo.co.jp

Translations of Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational Frame Theory: A Post-Skinnerian account of human language and cognition. New York: Plenum Press.

- **Japanese translation:** Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2009). Relational Frame Theory: A Post-Skinnerian account of human language and cognition. Tokyo: Seiwa Shoten.

Translation of Forsyth, J. P. & Eifert, G. H. (2008). The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy. Oakland, CA: New Harbinger.

- **Chinese translation**: 約翰．福賽思（John.P.Forsyth）、格奧爾格．艾弗特（Georg H.Eifert）（2010）。晚安，我的不安：緩解焦慮自助手冊。四川：四川人民出版社。

Translation of Robinson, P. J. & Strosahl, K. D. (2008). The Mindfulness and Acceptance Workbook for Depression. Oakland, CA: New Harbinger.

- **Chinese translation**: 科尔克．斯特尔萨拉，派翠西娅．罗宾逊（2010)。抑郁的自我疗法：用接受与实现疗法走出抑郁。华东：华东师范大学出版社。

Jen Plumb October 14, 2009 - 5:34am

Examples of Books on ACT and RFT

Examples of Books on ACT and RFT

This is a partial list as of 2014

General ACT Books: Professionals

Luoma, J., Hayes, S. C. & Walser, R. (2007). Learning ACT. Oakland, CA: New Harbinger. [A step by step learning companion for the main ACT book below. Very practical and helpful]

Hayes, S. C., Strosahl, K., & Wilson, K. G. (2012). Acceptance and Commitment Therapy: The process and practice of mindful change (2nd edition). New York: Guilford Press. [This is still the heart of the ACT literature. It is where it started]

Wilson, K. G. & Dufrene, T. (2009). Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy. Oakland, CA: New Harbinger. [A book on ACT that emphasizes mindfulness and the therapeutic relationship]

Hayes, S. C. & Strosahl, K. D. (2005). A Practical Guide to Acceptance and Commitment Therapy. New York: Springer-Verlag. [Shows how to do ACT with a variety of populations]

Twohig, M., & Hayes, S. C. (2008). ACT verbatim: Depression and Anxiety. Oakland, CA: New Harbinger; Reno, NV: Context Press. [Good example of ACT in actual practice]

Chantry, D. (2007). Talking ACT: Notes and conversations on Acceptance and Commitment Therapy. Reno, NV: Context Press. [This is an edited version of the ACT listserv from July 2002 through August 2005 compiled by a therapist, for therapists. Functions as a quick reference on a wide range of ACT topics (acceptance, anxiety, behavior analysis, choice, clinical resources, contextualism, etc)]

Ciarrochi, J. V. & Bailey, A. (2008). A CBT practitioner’s guide to ACT. Oakland, CA: New Harbinger. [Does what the title says it does]

Batten, S. (2011). Essentials of Acceptance and Commitment Therapy. London: Sage. [Broad introduction to ACT]

Harris, R. (2009). ACT made simple. Oakland, CA: New Harbinger. [Easy place to start with ACT]

Hayes, S. C. & Lillis, J. (2012). Introduction to Acceptance and Commitment Therapy. Washington, DC: American Psychological Association. [Books specifically for students learning about ACT]

General ACT Books: Clients

Hayes, S. C. & Smith, S. (2005). Get out of your mind and into your life. Oakland, CA: New Harbinger. [A general purpose ACT workbook. RCTs show that it works as an aid to ACT or on its own, but it will also keep new ACT therapists well oriented]

Harris, R. (2008). The happiness trap. New York: Shambala. [Very accessible ACT book for the public]

Trauma: Professional book

Walser, R., & Westrup, D. (2007). Acceptance & Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder & Trauma-Related Problems: A Practitioner's Guide to Using Mindfulness & Acceptance Strategies. Oakland, CA: New Harbinger. [A very practical and accessible approach to using ACT to treat post-traumatic stress disorder (PTSD) and acute trauma-related symptoms.]

Trauma: Client book

Follette, V. M., & Pistorello, J. (2007). Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems. Oakland, CA: New Harbinger. [Applies the principles of ACT to help readers cope with the after effects of traumatic experience. Straightforward, practical, and useful]

Depression: Professional book

Zettle, R. (2007). ACT for Depression: A Clinician's Guide to Using Acceptance & Commitment Therapy in Treating Depression. Oakland, CA: New Harbinger. [An solid book from one of the founders of ACT on one of the most pervasive problems human beings face.]

Depression: Client book

Strosahl, K. & Robinson, P. J. (2008). The Mindfulness & Acceptance Workbook for Depression: Using Acceptance & Commitment Therapy to Move Through Depression & Create a Life Worth Living. Oakland: New Harbinger. [Great workbook on ACT for depression]

Anxiety: Professional book

Eifert, G. & Forsyth, J. (2005). Acceptance and Commitment Therapy for anxiety disorders. Oakland: New Harbinger. [Good book with a protocol that shows how to mix ACT processes into a brief therapy for anxiety disorders].

Anxiety: Client book

Forsyth, J., & Eifert, G. (2007). The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy. Oakland: New Harbinger. [Solid workbook for anxiety]

Worry: Client book

Lejeune, C. (2007). The Worry Trap: How to Free Yourself from Worry & Anxiety using Acceptance and Commitment Therapy. Oakland, CA: New Harbinger. [A guide to the application of ACT to worry and generalized anxiety.]

Chronic pain: Professional books

Dahl, J., Wilson, K. G., Luciano, C., & Hayes, S. C. (2005). Acceptance and Commitment Therapy for Chronic Pain. Reno, NV: Context Press. [Describes an ACT approach to chronic pain. Very accessible and readable. One of the better clinical expositions on how to do ACT values work.]

McCracken, L. M. (2005). Contextual Cognitive-Behavioral Therapy for chronic pain. Seattle, WA: International Association for the Study of Pain. [[Describes an interdisciplinary ACT-based approach to chronic pain

Chronic pain: Client book

Dahl, J. C., & Lundgren, T. L. (2006). Living Beyond Your Pain: Using Acceptance and Commitment Therapy to Ease Chronic Pain. Oakland, CA: New Harbinger. [Uses ACT principles to help those suffering from pain transcend the experience by reconnecting with other, more valued aspects of their lives.]

Anger: Client book

Eifert, G. H., McKay, M., & Forsyth, J. P. (2006). ACT on life not on anger: The new Acceptance and Commitment Therapy guide to problem anger. Oakland, CA: New Harbinger. [The first book to adapt ACT principles to dealing with anger. It teaches readers how to change their relationship to anger by accepting rather than resisting angry feelings and learning to make values-based responses to provocation. Has been tested successfully in a small randomized trial.]

Caregivers: Client book

McCurry, S. M. (2006). When a family member has dementia: Steps to becoming a resilient caregiver. Westport, CT: Praeger Publishers. [Although not directly on ACT or mindfulness, this book for caregivers does include a significant emphasis on acceptance, as might make sense given that the author is on of the early ACT therapists from UNR.]

Eating disorders: Client book

Heffner, M., & Eifert, G. H. (2004). The anorexia workbook: How to accept yourself, heal suffering, and reclaim your life. Oakland, CA: New Harbinger. [An eating disorders patient workbook on ACT.]

Diabetes management: Client book

Gregg, J., Callaghan, G., & Hayes, S. C. (2007). The diabetes lifestyle book: Facing your fears and making changes for a long and healthy life. Oakland, CA: New Harbinger. [You cannot tell from the title but this is a book applying ACT to diabetes management.]

Organizational issues: Professional book

Hayes, S. C., Bond, F. W., Barnes-Holmes, D., & Austin, J. (2007). Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy and Relational Frame Theory to Organizational Behavioral Management. Binghamton, NY: Haworth Press. [This was a special issue of the Journal of Organizational Behavior Management that was bound into book form. Don't buy it expecting a smooth presentation of the applicability of ACT and RFT to organizational issues -- it is a collection of journal articles gather into a book. But it is still worthwhile if I/O is your area and you are wondering how ACT and RFT might apply.]

Human performance: Professional book

Gardner, F.L., & Moore, Z.E. (2007). The psychology of enhancing human performance: The Mindfulness-Acceptance-Commitment (MAC) approach. New York: Springer.
[This book provides theory and empirical background, and a structured step-by-step, protocol for the assessment, conceptualization, and enhancement of human performance with a variety of high-performing clientele including executives, athletes, artists, and emergency/military personnel].

Trichotillomania: Professional book

Woods, D. W., & Twohig, M. P. (2008). Trichotillomania: An ACT-enhanced Behavior Therapy Approach Therapist Guide. New York: Oxford University Press.

Trichotillomania: Client book

Woods, D. W., & Twohig, M. P. (2008). Trichotillomania: An ACT-enhanced Behavior Therapy Approach Workbook. New York: Oxford University Press.

Behavioral Medicine: Professional book

McCracken, L. (2011). Mindfulness and Acceptance in Behavioral Medicine. Oakland, CA: New Harbinger.

Assessment: Professional book

Baer, R. (2010). Assessing Mindfulness & Acceptance Processes in Clients: Illuminating the Theory & Practice of Change. Oakland, CA: New Harbinger.

Primary care settings: Professional book

Robinson, P. J., Gould, D. A., & Strosahl, K. D. (2011). Real behavior change in primary care. Oakland, CA: New Harbinger.

Irritable Bowel Syndrome: Client book

Ferreira, N. B. & Gillanders, D. T (2012) Better Living with IBS: A step-by-step program to managing your symptoms so you can enjoy life to the full! Exsile Publishing, New South Wales.

Psychosis: Professional book

Morris, E. M. J., Johns, L. C., & Oliver, J. E. (2013) (Eds). Acceptance and Commitment Therapy and mindfulness for psychosis. London: Wiley-Blackwell. ISBN: 978-1-1199-5079-0

Sleep: Client book

Meadows, G. (2014). The sleep book: How to sleep well every night. London, UK: Orion.

Steven Hayes March 31, 2014 - 11:34am

Persian

Persian

This list is no longer being updated. Please click here for a list of ACT Books in 20+ Languages.

Vowles, K. E., & Sorrell, J. T. (2008). Life with chronic pain: an acceptance-based approach (therapist guide and patient workbook).

Persian translation: Vowles, K. E., & Sorrell, J. T. (2008). زندگی با درد مزمن: رویکرد مبتنی بر پذیرش. translated by F. Mesgarian. Tehran: Arjmand.

fatemeh April 20, 2013 - 12:57pm

Original Non-English ACT Books

Original Non-English ACT Books

This list is no longer being updated. Please click here for a list of ACT Books in 20+ Languages.

Original Non-English ACT Books

Danish (Dansk)

- Grønlund, C. & Møller Rasmussen, S. (2015). Rundt om ACT : muligheder og metode i acceptance and commitment therapy. Frydenlund.

    - This first Danish-written anthology on ACT (Acceptance and Commitment Therapy) goes in depth with the method's many application possibilities - seen through the eyes of Danish therapists.
- Ramussen, S. & Taggaard Nielsen, O. (2010). Introduktion til ACT. Copenhagen: Dansk Psykologisk Forlag.

Dutch (Nederlandstalig)

- A-Tjak, J., & De Groot, F. (Eds.). (2008) . Acceptance and commitment therapy: Een inleiding voor hulpverleners. Houten: Bohn Stafleu van Loghum. (ISBN 978 90 313 5894 6. NUR 777)
    - An original edited volume about ACT.
- Jansen, G. (2006). Denk wat I wilt doe wat I droomt: op weg naar waardevol leven. Amsterdam: Uitgeverij Nieuwezijds.
    - An ACT-related book in Dutch. Some discussion between ACT and Cognitive Therapy in this book, but it is not possible to make such discrimination out of a language community. The book definitely puts a number of ACT concepts forward for consideration.

Finnish (Suomi)

- Lappalainen, R., Lehtonen, T., Hayes, SC, Batten, S., Gifford, E., Wilson, K.G., Afari, N., & McCurry, S.M. (2004). Hyväksymis- ja omistautumisterapia käytännön terapiatyössä (Applying Acceptance and Commitment Therapy (ACT): A Clinical Manual). Tampere, Finland: Suomen Käyttäytymistieteellinen Tutkimuslaitos (The Finnish Institute for Behavioral Science).
    - An ACT clinical manual in Finnish.

French (Français)

- Dionne, F., & Veillette, J. (2021). Apprivoiser la douleur chronique avec ACT: un guide de pratique en 10 modules. Paris, France : Dunod.
    - La douleur chronique constitue un enjeu de santé publique important et pose plusieurs défis cliniques et personnels pour le praticien. La thérapie d'acceptation et d'engagement (ACT, Acceptance and Commitment Therapy) propose des stratégies thérapeutiques originales et efficaces pour améliorer la qualité de vie des gens souffrant de cette problématique.
    - Son objectif n'est pas de modifier les symptômes, mais de faire évoluer le rapport du patient à leur égard, de la lutte vers l'acceptation active de la douleur, et l'engagement dans des activités en cohérence avec ses valeurs personnelles.
- Monestès, J. L. (2010). Changer grâce à Darwin. La théorie de votre évolution. Paris: Odile Jacob.
    - Darwin nous a appris comment l'évolution avait façonné notre espèce. Mais sa théorie peut aussi être utile à chacun d'entre nous au quotidien !
    - Cet ouvrage explique comment les mécanismes naturels qui ont fait leur preuve pour l'espèce humaine peuvent aider chacun de nous à évoluer dans sa vie : nous pouvons favoriser une sélection de nos comportements, et ne plus laisser le hasard gérer notre destin.
    - Il propose de nombreux outils pratiques fondés sur la thérapie d'acceptation et d'engagement et les thérapies cognitives et comportementales : dépasser les obstacles au changement, créer de la variation, développer sa curiosité au monde, mais aussi, quand il le faut, accepter les choses comme elles viennent, ne rien changer, cesser de vouloir contrôler l'incontrôlable….
    - Un « darwinisme personnel » pour faciliter votre propre évolution !
    - This book presents a selectionist approach of behaviors. It proposes advice and tools to commit in direction of values and to walk through acceptance, by using concepts from Darwinism and ACT.
- Schoendorff, B. (2009). Faire Face à la Souffrance, Choisir la vie plutôt que la lutte avec la Thérapie d'Acceptation et d'Engagement.
    - The first book on ACT in French. It is a bibliotherapy book based in part on the I-view model of Kevin Polk and Jerold Hambright.
    - This is the first book on ACT in French. It's a self-help book based on Kevin Polk and Jerold Hambright's I-view.

- Monestès, J. L. (2009). Faire la paix avec son passé. Paris: Odile Jacob.
  - Nos souvenirs, particulièrement les plus douloureux, nous incitent à la lutte pour éviter leur réapparition. Ce livre sur la mémoire développe de nombreux concepts de l'ACT et les applique aux souvenirs des événements que nous aurions préféré ne pas vivre.
  - It is our natural tendency to struggle when we are confronted to hurting memories. We would prefer to erase them if we could. This book on memory uses ACT concepts to deal with memories of events we would rather not have lived.

German (Deutsch)

- Wengenroth, M. (2008). Das Leben annehmen. So hile die Akzeptanz- und Commitmenttherapie (ACT). Bern, Germany: Huber.
  - An original German, ACT-based self-help book. Very good buzz about this book by ACT experts.

Polish (Polish)

- Baran, L., Hyla, M., Kleszcz, B. (2019). Elastyczność psychologiczna. Polska adaptacja narzędzi dla praktyków i badaczy. Wydawnictwo Uniwersytetu Śląskiego.

Portuguese (Português)

- Saban, M. T. (2015). Introdução à Terapia de Aceitação e Compromisso. Belo Horizonte: Ed. Artesã.
- Lucena-Santos, P., Pinto-Gouveia, J., & Oliveira, MS (Eds.) (2015). Terapias Comportamentais of Terceira Geração: Guia para profissionais. Novo Hamburgo: Sinopsys Editora
  - An original book including but not limited to ACT. Specifically, this book is a professional guide on third-wave behavioral therapies (Mindfulness-based Cognitive Therapy, Functional Analytic Psychotherapy, Behavioral Activation Therapy, Behavioral Activation, Mindfulness-Based Stress Reduction and Compassion Focused Therapy)
- Boavista, R. (2012). Terapia of Aceitação e Compromisso (ACT): Purpose uma possibilidade para a clínica comportamental. Santo André: ESETec Editores Associados.
  - In this book Rodrigo RC Boavista does a book review that contemplates philosophical assumptions, theoretical foundations, model of psychopathology and a few application scenarios of the ACT therapeutic approach.

Japanese (日本語)

- Muto, T. (Ed.) (2017). 55歳からのアクセプタンス＆コミットメント・セラピー（ACT）超高齢化社会のための認知行動療法の新展開 [Turning 55 years old in super-aging society: Living oldness with Acceptance and Commitment Therapy]. Kyoto: Ratik.
- Kumano, H. & Muto, T. (Eds.) (2009). Tokushuu-gou: Akuseputansu ando komittoment serapi. in the "Kokoro-no-Rinshou a la carte" Magazine for clinicians. Tokyo: Seiwa-shoten.
  - Title translation: Special volume: Acceptance and Commitment Therapy.
- Kumano, H. (2009). 21 seiki no jibun sagashi project: kara no ori kara dete, machi ni dekakeyou. Tokyo: Sanga.
  - Title translation: The "Pursuit of myself" project in 21 century: Breaking the prison of conceptualized myself.
- Muto, T. (Eds.) (2006). Akuseputansu ando komittoment serapi no bunmyaku: Rinshou-kudu-bunseki no maindofuru-na tenkai. Tokyo: Brain-shuppan.
  - Title: Some contexts of Acceptance and Commitment Therapy: Mindfulness in Clinical Behavior Analysis .

Korean (조선말, 한국어)

- Lee, Seonyoung (2017). 꼭 알고 싶은 수용-전념 치료의 모든 것: ACT와 친해지기. Soulmate. Seoul.

Spanish (Español)

- García Higuera, JA (2007). Curso Teraperutico de Aceptación I y II. Madrid: Paradox.
  - An ACT self help book with lots of exercises.
- Barraca, J. (Ed.). (2005). The mente o la vida. An aproximation to the Terapia of Acceptance and Compromise. Bilbao: Desclée de Brouwer.
  - An original edited ACT book in Spanish.
- Wilson, KG, & Luciano, C. (2002). Acceptance and Commitment Therapy: A behavioral treatment focused on values. Madrid: Pirámide.
  - An original ACT book in English ACT authors.
- García Higuera, JA (2003). Terapia psicológica en el tartamudeo, from Van Riper to the terapia of acceptance and compromiso.Barcelona: Editorial Ariel. Visit this site web para más información.
  - An ACT book dedicated to stuttering and its psychological treatment.
- Luciano, C. (Ed.). (2001). Terapia of Acceptance and Compromise (ACT) and the Traastorno de Evitación Experiencial. A síntesis of casinos clinics. (Ed.) Valencia: Promolibro.
  - An original ACT book in Spanish with a series of very creative single case studies.

Jen Plumb October 14, 2009 - 5:05pm

Samtaler som forandrer - behandlerens guide til ACT i teori og praksis

Samtaler som forandrer - behandlerens guide til ACT i teori og praksis

Drømmer du om at lære de effektive, evidensbaserede og håndgribelige strategier, som skaber vilde og varige forandringer for dine klienter og for dig selv? Samtaler som forandrer er behandlerens guide til ACT i teori og praksis. Bogen er skrevet af Rikke Kjelgaard, en af Danmarks største kapaciteter inden for ACT (Acceptance and Commitment Therapy). Her får du som behandler en grundig introduktion til ACT med masser af kliniske eksempler og øvelser. Du bliver præsenteret for de grundlæggende begreber og for modellens bærende principper. Du får en gennemgang af kerneprocesserne i ACT samt eksempler på, hvordan disse processer udspiller sig i det terapeutiske møde. Du følger med i en række samtaler som netop demonstrerer kerneprocesserne. Du lærer at lave sagskonceptualisering, at skabe fleksibilitetsprofiler, og du lærer, hvordan du designer dine egne metaforer. Du får desuden en række generelle tips til, hvad du skal gøre – og hvad du skal undgå at gøre – for at skabe samtaler, som forandrer.

Rikke February 13, 2024 - 12:56pm

Self-Help Books in Non-English Languages

Self-Help Books in Non-English Languages

This list is no longer being updated. Please click here for a list of ACT Books in 20+ Languages.

Original Non-English Self-Help Books

German

- Waadt, M. (Author),& Acker, J. (2018). *Das Selbsthilfebuch gegen Burnout: Mit Akzeptanz und Achtsamkeit den Teufelskreis durchbrechen*. Berne, CHE: Hogrefe AG.
- Wengenroth, M. (2008). *Das Leben annehmen. So hilft die Akzeptanz- und Commitmenttherapie (ACT)*. Bern, Germany: Huber.

Danish

- Ramussen, S. & Taggaard Nielsen, O. (2010) Introduktion til ACT. Copenhagen: Dansk Psykologisk Forlag. 2nd printing (2012).

Dutch

- Bohlmeijer, E., & Hulsbergen, M. (2009). *Voluit leven*. Amsterdam, NLD: Boom.

French

- Schoendorff, B. (2009). *Faire face à la souffrance, choisir la vie plutôt que la lutte avec la Thérapie d'Acceptation et d'Engagement.* Paris: Retz.

  Le premier livre sur l'ACT en français. C'est un ouvrage de bibliothérapie qui se base en partie sur le modèle I-view de Kevin Polk et Jerold Hambright.

Portuguese

- Bittar, E. (2011). *Nao sou feliz ... e agora? O que fazer quando todas as formulas fracassem?* Uberlândia, Brazil: Imagine.

Spanish

- García Higuera, J. A. (2007).*Curso Terapéutico de Aceptación I y II.* Madrid: Paradox.

  An ACT self help book with 4 audio CDs with lots of exercises.

admin September 8, 2009 - 3:00pm

Other Self Help Books (2006-2009)

Other Self Help Books (2006-2009)

OTHER SELF HELP BOOKS

- Kashdan, T. (2009). *Curious? Discover the missing ingredient to a fulfilling life.* New York, NY: Harper Collins.
- Flowers, S. H. (2009). *The Mindful Path Through Shyness: How Mindfulness and Compassion Can Free You From Social Anxiety, Fear, and Avoidance.* Oakland, CA: New Harbinger Publications.
- Vieten, C. (2009). *Mindful Motherhood: Practical Tools for Staying Sane During Pregnancy and Your Child's First Year.* Oakland, CA: New Harbinger Publications.
- McKay, M., & Sutker, C. (2007). *Leave Your Mind Behind*. Oakland, CA: New Harbinger.
- McCurry, S. M. (2006). *When a family member has dementia: Steps to becoming a resilient caregiver*. Westport, CT: Praeger Publishers. - Although not directly on ACT or mindfulness, this book for caregivers does include a significant emphasis on acceptance (the author is one of the early ACT therapists from the University of Nevada, Reno and studied with Steve Hayes).

Community March 1, 2024 - 1:38pm

ACT /RFT Reader's Update 2008 - 2011 (Archives)

ACT /RFT Reader's Update 2008 - 2011 (Archives)

The ACT/RFT Reader's Update was published from 2008 - 2011. For up-to-date lists of ACT/RFT publications, go to the ACT Randomized Controlled Trials page, the State of the ACT Evidence page, the list of ACT Books, and the Publications section.

The ACT /RFT Reader's Update is an electronic newsletter provided for your information and perusal. This online newsletter provides summaries of recent, ACT and RFT articles (or related articles) published in peer-reviewed journals. In addition, citations for the latest books, book chapters, and unpublished dissertations will be listed.

Our main aim with this update is to keep the ACT/RFT community informed. We hope to include information that is relevant, scientifically sound, and of interest in the ACT/RFT community. Our purpose is not to recreate the abstract of these articles, but to provide a broader summary of the article. However, are goal is to keep the "busy" reader in mind, and therefore, we will work to keep the summaries brief.

Reviewers include:
Robyn Walser, PhD
Christi Ulmer, PhD
Maggie Chartier, MPH, MS
Ian Stewart, PhD
Miguel Rodríguez Valverde, PhD

admin January 11, 2008 - 7:24pm

ACT/RFT Readers Update 2011

ACT/RFT Readers Update 2011

Dear Contextual Science Community,

We are happy to be putting out our full 2011 ACT/RFT Reader's Update. In this Update we review assessment, chronic pain, experiential avoidance, pilot studies, RCT's, relational frame theory and several research reviews. We hope you find the information helpful. Please take a look at the attached and find what interests you.

It has been interesting times at the Update, with change in editorial/writer staff (a big welcome to Katherine Young, Jeannette Tappe, Tam Nguyen and Aimee Zhang) and other unanticipated delays with this issue, we have been pressed to finish up and post.

We are also looking forward to including and perhaps featuring articles found in the **Journal of Contextual Behavioral Science**. We hope everyone is enjoying the journal and finding it useful. What a great contribution to ACBS! http://contextualscience.org/JCBS

Lastly and importantly, we are looking forward to **ACBS World Conference in Sydney, Australia, July 8-12**. The World Conference is always exciting, engaging and fun! Many great ideas for projects, studies and papers are generated at the conference and it will be sure to provide ACT/RFT Reader's Update staff with plenty more to review! http://contextualscience.org/wc11

Warm Regards,

Maggie Chartier, Psy.D., MPH
Barbara Mazina, B.A.
Tam Nguyen, Ph.D.
Katie Sears, Ph.D.
Ian Stewart, Ph.D.
Jeannette Tappe, M.A.

Thuy Tran, B.A.
Robyn Walser, Ph.D.
Katherine Young, M.S.
Aimee Zhang, B.S.
ACBS staff April 10, 2013 - 12:11pm

ACT/RFT Reader's Update 2010

ACT/RFT Reader's Update 2010

Dear ACT Community,

We are excited….and relieved to put out two Reader's Updates this round. Please log in to download the attachments from this webpage.

It is really great to see all of the work and writing that is being done in the areas of ACT, RFT and mindfulness. It is keeping us busy and energized as reviewers. Find in the Update, summaries designed to provide you with a quick overview of topics and issues, with links in the document to more detailed information.

In Update "10finalb" you will find summaries, references and abstracts on acceptance, addiction, assessment, case studies, children/adolescents, chronic pain, experiential avoidance and RFT.

In Update "10finalcd," in addition to some of the same topics above, you will find summaries, references and abstracts on anxiety and depression, RCT's and research reviews. In this issue we also wanted to feature RFT. It is the first summary presented in the Update. Ian Stewart has done an excellent job. He has thoughtfully put together information in a effort to keep us abreast of research this area. A big thanks to Ian!

We are diligently working on the next issue: Coming soon to a list-serve near you!

Finally, if you know of any articles, studies or other information that we should include in our next issue and may not be easily findable by regular search engines, please let us know. Also, be sure to let us know if we missed something.

Enjoy!

Reviewers and Editors

Maggie Chartier

Barbara Mazina

Katie Sears

Ian Stewart

Thuy Tran

Robyn Walser

Douglas Long June 21, 2012 - 5:33am

ACT/RFT Reader's Update: Articles from early 2010 (November, 2011)

ACT/RFT Reader's Update: Articles from early 2010 (November, 2011)

Dear Colleagues,

Welcome to this edition of the ACT/RFT Reader's Update.

In this issue, as in all issues, we provide a summary of the literature published related to acceptance and commitment therapy, mindfulness and relational frame theory. We link summaries to particular topics and provide a review of the articles. Feel free to read the summaries and find the links to the references and abstracts related to the summaries right in the document. For a taste of what is in the Update, we summarize 3 articles on acceptance approaches to treatment, 3 on addiction that compare CBT to ACT, 1 on assessment by Wilson – the VLQ is alive and well -, 2 case study designs looking at the treatment of GAD and cancer, 3 articles on mindfulness based approaches with children and parents, 4 articles on experiential avoidance, 5 on mindfulness including how mindfulness works with managing emotions, intrusive thoughts, stress reduction and substance use. Finally, we have 3 on RFT reviewed by Ian – Thanks Ian!

We have sorted and distributed articles to our reviewers for the first half of 2011. We are looking forward to the next round.

Please let us know if we missed anything that we should include or inform us of dissertations, etc.

Thanks and Enjoy!

Kind Regards,

Robyn D. Walser, Ph.D.

Douglas Long November 20, 2011 - 6:32pm

ACT/RFT Reader's Update: Final 2009 Review (July, 2010)

ACT/RFT Reader's Update: Final 2009 Review (July, 2010)

Science and Practice: ACT /RFT Reader's Update: Final 2009 Review

Welcome to the ACT/RFT Reader's update. This is the last issue reviewing the literature on ACT and RFT from 2009. We will be publishing updates for 2010 in late summer, fall and winter.

To kick off the issue, we want to extend a thank you to Dr. Chad Drake who has been with the Update since its inception. We thank Chad as he closes the "Update chapter of his life" and wish him much success in his new and fun endeavors. Thanks Chad!

In this issue, we summarize articles on assessment, ACT and diagnostic populations, experiential avoidance, behavioral health, RFT, mindfulness and "The Great Debate".

The attached PDF includes a Table of Contents that allows you to "click" directly to the summary of multiple articles covering a topic and/or references and abstracts that you may be interested in. In addition, citations for the latest books, book chapters, editorials, and unpublished dissertations are listed.

Our aim with this update is to provide information that is clinically relevant, scientifically sound, and of interest in the ACT/RFT community. We have worked to keep the "busy" reader in mind and hope that you find the Update useful.

** If you are a graduate student working on an ACT/RFT study and would like to have us include your dissertation or thesis citation in this update,please send us an email backchannel.

**If you have published an editorial you would like us to include that citation, please send us an email back channel.

We hope you will find our e-mail updates of interest and value.

Our editors and reviewers include:

Robyn Walser, PhD
Maggie Chartier, PhD, MPH
Katie Sears, PhD
Thuy Tran, BS
Chad Drake, PhD
Elizabeth Gifford, PhD
Ian Stewart, PhD
Christi Ulmer, PhD
Miguel Rodríguez Valverde, PhD
Darrah Westrup, PhD

Jen Plumb July 9, 2010 - 9:28pm

ACT/RFT Reader's Update (December, 2009)

ACT/RFT Reader's Update (December, 2009)

Science and Practice: ACT/RFT Reader's Update
December, 2009

Acceptance and Values-Based Action in Chronic Pain: A Study of Treatment Effectiveness and Process Cognitive-behavioral approaches to pain management have an established record of empirical support. However, as true with other behavioral problems, the mechanism by which improvement occurred is inconsistent with the theoretical underpinnings of CBT. In a recent paper, Vowles and McCracken add to their ongoing line of research in acceptance-based approaches to the treatment of chronic pain. In their paper, they present their findings of an inter-disciplinary treatment program based in Acceptance and Commitment Therapy, with a focus on acceptance and values-based action. One-hundred seventy-one participants completed the program which consisted of 3 to 4 weeks of inpatient treatment for about 30 hours per week. Participants improved across almost all domains, including pain, depression, pain-related anxiety, disability, medical visits, work status, and physical performance, and effect sizes for these improvements were medium to large. Analysis of reliable change revealed that 75.4% of participants improved in at least one key domain assessed. In contrast with CBT-based approaches to pain management, improvements across these domains were associated with ACT's proposed mechanisms of action, namely, acceptance of pain and values-based action. The authors conclude that these findings provide support for the ACT model of treatment for chronic pain, and the processes associated with improvement – acceptance and values-based action.

> Vowles, K., & McCracken, L. (2008). Acceptance and values-based action in chronic pain: a study of treatment effectiveness and process. *Journal of consulting and clinical psychology, 76(3)*, 397-407.

Rule-Governed Behavior and Psychological Problems Humans, uniquely among animals, can come to understand and respond to linguistic rules, both effective ones and not so effective ones. The effective ones help us to learn and adapt to our environment. The ineffective ones can cause maladaptive behavior and diminish our lives considerably. This paper presents a functional analysis of patterns of rule-governed behavior (RGB) and shows how rules can contribute to psychopathology. Rules have been described as antecedent stimuli that alter the functions of stimuli in our environment. They allow us to respond to that environment in complex and efficacious ways. But what are rules? Relational Frame theory suggests that we humans learn to respond in accordance with abstract relational patterns based on cues (e.g., SAME). Rules are essentially combinations of

cues that specify particular relations between environmental stimuli and between environment and behavior and thus allow us to respond in new ways ('transformation of function'). The paper describes three functional patterns of RGB. These are pliance, tracking and augmental rule following. Pliance is RGB under the control of a history of socially mediated reinforcement for coordination between behavior and antecedent verbal stimuli (rules). A typical example might be a child obeying the rule 'Don't touch my laptop' because their parent has given them this rule and because their parent has previously provided consequences for following or not following rules. Tracking is RGB under the control of a history of coordination between the rule and the way the environment is arranged independently of the rule. An example might be a child obeying the parental rule 'Eat your breakfast because it will give you more energy' because in the past the child has experienced the effect of other rules that have been accurate in their description of the environment. If this rule also shows coordination (i.e., the child finds an increase in energy when they eat breakfast), then this will further strengthen tracking behavior. Augmenting is RGB due to relational networks that alter the degree to which events function as consequences. The example given is 'Eat your vegetables to be a big strong boy'. If this rule makes vegetable eating more reinforcing then it might be described as augmenting. Each of these patterns has its advantages and its disadvantages, including maladaptive behavior. It's useful for children to learn pliance since this allows them to acquire useful adaptive habits, but doing things just because one is told to can make one insensitive to one's environment. Tracking allows independence from social whim, but tracking can also lead to ineffective behavior; for example, tracking short term reinforcement can mean one misses longer term reinforcement. Augmenting is the most advanced form of rule governed behavior and as such it can interact with and reinforce either of the other two functional patterns resulting in strongly adaptive or maladaptive patterns. Experiential avoidance can be a product of the latter while valuing, an important part of the antidote to EA, is an example of the former. Törneke, Luciano and Valdivia (2008) have provided an excellent description of RGB and its relationship to psychopathology.

Törneke, N. Luciano, C. & Valdivia Salas, S. (2008). Rule-Governed Behavior and Psychological Problems. *International Journal of Psychology and Psychological Therapy, 8 (2)*, 141-156.

Brief Review: A Parametric Study of Cognitive Defusion and Believability The effects of the "Milk, milk, milk" exercise are dependent upon the length of the intervention: Reducing distress in respect to private events has been a major emphasis of traditional behavioral and cognitive behavioral therapies. The inclusion of mindfulness interventions in some contemporary therapies like ACT has shifted this focus from distress reduction to changing the behavior regulatory functions of distressing private events. One means of examining this change is by asking clients about the believability of their thoughts. Defusion interventions represent efforts to disrupt this behavior regulation, and the "milk, milk, milk" exercise is the intervention examined in this article. Two studies examined the effect of this exercise on the emotional discomfort and believability of a negative, self-relevant word identified by the participant as sufficiently problematic. Each study varied the amount of time spent repeating the word – 0, 3, or 20 seconds in study 1 and 1, 10, or 30 seconds in study 2. A rationale for the procedure and training with the word "milk" was provided before each intervention. Results showed that emotional distress reduced significantly within 3-10 seconds, while believability reduced significantly only after 20-30 seconds. The difference in timing for these reductions suggests that discomfort and believability are functionally distinct behaviors. The authors suggest extending defusion exercises until the believability of thoughts, rather than just emotional distress, diminishes.

Masuda, A., Hayes, S. C., Twohig, M. P., Drossel, C., Lillis, J., & Washio, Y. (2009). A parametric study of cognitive defusion and the believability and discomfort of negative self-relevant thoughts. *Behavior Modification, 33*, 250-262.

Brief Review: Relational Frame Theory and Social Categorization The Matching-to-Sample procedure can transform the functions of arbitrary stimuli in the Implicit Associations Test: This study examined the acquisition of obesity stigma to arbitrary stimuli. More specifically, the matching-to-sample (MTS) procedure was used to provide relational conditioning sufficient to generate a transformation of stimulus functions for stigma to images

of either horizontal or vertical lines. The Implicit Associations Test (IAT) was used to detect this transformation of functions. Fifty undergraduate psychology students engaged in a series of five computerized tasks: (1) an IAT containing evaluative words and images of horizontal and vertical lines, to confirm a lack of pre-existing bias, (2) an established IAT for detecting implicit evaluative bias toward obesity, to confirm the presence of pre-existing bias, (3) two MTS tasks providing relational conditioning sufficient to generate the transfer of positive and negative evaluative functions to images of horizontal and vertical lines, (4) the same IAT used in step 1, to assess for the acquisition of bias, and (5) the same IAT used in step 2. Results confirmed no pre-existing bias at time 1, a large and significant predicted bias at time 2, and a small and significant predicted bias at time 4. The results of this study are discussed in respect to an RFT account of the development of stigma and social categorization and contrasted with a more mainstream, cognitive account known as the Social Knowledge Structure.

> Weinstein, J. H., Wilson, K. G., Drake, C. E., & Kellum, K. K. (2008). A relational frame theory contribution to social categorization. *Behavior and Social Issues, 17*, 39-64.

Revised/Reviewed by: Walser, R., Chartier, M., Sears, K., Drake, C., Valverde, M., Stewart, I., Ulmer, C., & Westrup, D. **Read the ACT RFT Reader's Update: References & Abstracts, 2008 in an interactive PDF, attached below.**

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ACT/RFT Reader's Update (Fall, 2008)

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Science and Practice: ACT /RFT Reader's Update Fall, 2008

Welcome to ACT/RFT Reader's Update:

In our second issue we summarize 5 articles recently published in peer-reviewed journals. The references to full citations and whether they are available for download on the ACBS website is also included. Citations for the latest books, book chapters, and unpublished dissertations are listed at the end of the update. If you don't see your recently published article….hang on, we continue to work on future issues and have a fair number of articles that are being reviewed and summarized for our coming issues. However, if you are publishing or have recently published please make us aware by either sending us the reference or pdf. Thanks.

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This issue of Science and Practice: ACT/RFT Readers Update contains 5 summaries:

ACT ARTICLES AND RELATED TOPICS

Acceptance and commitment training reduces prejudice and promotes diversity-oriented behaviors in college students

Despite increased efforts at promoting diversity in recent years, prejudice continues to result in diminished quality of life for ethnic, racial and religious minorities across numerous life domains. Interventions designed to reduce prejudice have been moderately successful with short-term improvements, but do not seem to promote sustained equitable attitudes and behavior. In fact, in some instances, the interventions actually result in an increased bias. ACT may be particularly applicable to prejudice due to its focus on intransigent and difficult cognitions. Luoma and Hayes compared a brief ACT Training protocol to an education-based prejudice awareness training intervention for reducing racial and ethnic prejudice in college students. Material was presented to students using a counterbalanced within-group design such that the impact of each approach could be evaluated independently. The outcome measure, developed for this study, consisted of items assessing the following: awareness of bias; acceptance and flexibility; thought control and defusion; and positive actions. Student responses suggest that the ACT training produced greater reductions in prejudice across most dimensions, and that only ACT training promoted greater intention to engage in diversity-oriented behaviors. Changes in these positive intentions were partially mediated by acceptance and flexibility, and defusion processes explained more variance in positive intention outcomes than acknowledgement of bias. The authors suggest that the combined findings of this study and a previous ACT-based study on prejudice lend preliminary support to an ACT-RFT based model of understanding and reducing prejudice. The findings are also consistent with the theory underlying acceptance-based approaches stating that it is the relationship with thought rather than the content of thought that matters. Limitations of the study include the use of an unvalidated outcome measure, the potential self-selection bias of students who choose to enroll in a class on the psychology of racial differences, the potential for bias of the interventionist in favor of ACT, and a short follow-up interval. Future studies are proposed using a more intensive intervention and assessing longer-term outcomes. Given the need for empirically supported approaches to address prejudice, the findings of the current study are promising. In terms of clinical application, the authors propose that similar processes are likely in play with regard to mental health stigma, and that cognitive processes that promote prejudice are themselves psychologically damaging.

Read the Article:

Lillis, J., & Hayes, S. C. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice: A pilot study. Behavior Modification, 31(4), 389-411.

ACT and CT for anxiety and depression, a randomized controlled effectiveness trial

For some period of time there has been discussion and even argumentation between those who hold true to cognitive models of intervention (e.g. Beckian) and acceptance models of intervention (e.g. Hayesian). Forman and colleagues take a closer look. They explain that Cognitive Therapy (CT) has a mixed record of success in producing theoretically-consistent mediation of treatment outcomes while Acceptance and Commitment Therapy (ACT) has a relatively impressive, though preliminary record, of the same. Given that only a handful of studies have directly compared these treatments and that all contained methodological shortcomings the authors undertook that task of comparing each therapy's ability to produce mediation and positive outcomes among an outpatient sample of college students in a well-controlled trial. Services were provided by clinical psychology doctoral candidates working at a student counseling center. Outcome measures included self-reports of symptoms (BDI-II, BAI, OQ-45) and self-reports of quality of life (QOLI, SLS). Two mediational measures were administered (KIMS, AAQ). The study also included measures of treatment fidelity, therapist allegiance, and participant expectancies of treatment. Results showed that all measures were comparable between treatments, and that each treatment generated large effect sizes. Mediational analyses showed that the observing subscale of the KIMS more strongly (though nonsignificantly) predicted outcomes for CT, while the AAQ and the acting with awareness and acceptance subscales of the KIMS more strongly (and significantly) predicted outcomes for ACT. The authors reported that "changes in "observing" and "describing" one's experiences were more strongly associated with outcomes for those in the CT group relative to those in the ACT group, whereas

experiential avoidance, acting with awareness, and acceptance were more strongly associated with outcomes for those in the ACT group" (p. 792). Although, the authors concluded that "these findings support the notion that CT and ACT are functionally distinct from one another" (p. 792), it was never explained why the capacity to observe and describe one's private experiences is a fundamental component of CT but not ACT.

Read the Article:

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of Acceptance and Commitment Therapy and Cognitive Therapy for anxiety and depression. Behavior Modification, 31, 772-799.

RFT ARTICLES

How does multiple-exemplar training and naming establish derived equivalence in an infant?

Stimulus equivalence at its simplest can be described as follows. Imagine I train someone in the following two relations between physically different arbitrary stimuli: Pick stimulus B when you see stimulus A, and pick stimulus C when you see stimulus B. If given the opportunity, a verbally able human might subsequently go on to demonstrate further relations, without being trained to do so, including picking A when he sees B, and picking B when he sees C (i.e., reversing the trained relations, referred to as symmetry), picking C when he sees A (i.e., combining the trained relations, referred to as transitivity) and picking A when he sees C (a combination of symmetry and transitivity). This pattern of derived responses has been called stimulus equivalence, because it appears that, suddenly and unexpectedly and without being trained to do so, the person is treating a number of physically different stimuli as mutually substitutable for or equivalent to each other. There is growing interest in stimulus equivalence research as only verbally able subjects seem to be able to show this pattern readily, suggesting a link between equivalence and language. But what is the nature of this link? How are the two connected? The present paper discusses two theoretical approaches that claim to account for this link - Relational Frame Theory (e.g., Hayes et al., 2001) and Naming Theory (Horne & Lowe, 1996). More importantly, however, the paper reports a series of experiments involving training an infant in relational responding that provide important additional evidence pertaining to the debate between these approaches. More specifically, the results add to evidence in favour of the RFT account, while demonstrating a phenomenon that directly contradicts Naming Theory. This study is a significant empirical contribution for a number of reasons (i) It demonstrates the use of multiple exemplar training to establish generalized contextually controlled receptive mutual entailed relational responding; (ii) it provides the youngest empirical example of coordinate (sameness) combinatorial entailed relational responding (equivalence) ever recorded; and (iii) it provides extremely important evidence vis-a-vis the Naming Theory / RFT debate by providing empirical evidence that directly contradicts a core tenet of Naming Theory while being consistent with RFT.

Read the Article:

Luciano, C., Becerra, I. G., & Valverde, M. R. (2007). The role of multiple-exemplar training and naming in establishing derived equivalence in an infant. Journal of the Experimental Analysis of Behavior, 87(3), 349-365.

Can the Implicit Relational Assessment Procedure be faked? First evidence says no.

The Implicit Relational Assessment Procedure (IRAP) is a computer-based task for the assessment of implicit cognitions recently devised within the theoretical framework of RFT. It is a latency-based response measure that intends to assess the participants' existing verbal-relational networks (i.e. beliefs). It works by requiring participants to respond as quickly and accurately as possible across trials when presented with particular relations (among sample and target stimuli) that may be consistent or inconsistent with their beliefs (i.e. relational networks). The idea is that participants will be faster when required to respond to stimulus relations that are consistent (e.g. categorizing words like love or peace as pleasant, and words like vomit or death as unpleasant) than to stimulus relations that are inconsistent with their verbal histories (e.g. categorizing vomit or death as pleasant, and love or peace as unpleasant). This idea is supported by empirical evidence from several

recent studies. As with other implicit measures, like the Implicit Association Test (IAT), one of the strengths of the IRAP is that it may be less sensitive than questionnaires and other explicit measures to assess deliberate attempts to conceal information about one's own socially sensitive attitudes. This study attempted to see to which extent this is the case (i.e. whether the IRAP can be faked). Three groups of participants underwent two consecutive exposures of the IRAP task with the same stimuli (the words pleasant and unpleasant as samples, the words similar and opposite as response options, one set of six pleasant target words, and one set of six unpleasant target words). Between both exposures, one group was informed about how the IRAP works. Another group received the same information and was told to fake the IRAP, without a specific strategy to do so. The third group received the same information and were also provided with a strategy, namely slowing down on consistent trials and going fast on inconsistent trials. Results showed no evidence of faking in any condition. All groups showed an IRAP effect in the second exposure regardless of the instructions or strategies received. According to a post-task questionnaire, only two participants in the third group reported using the specific strategy they had received. All in all, participants found it difficult to fake the IRAP, even if provided with specific strategies. This contrasts with previous findings with the IAT, which can be successfully faked when explicitly told how to do so. This observed resistance to deliberate attempts to fake performance renders the IRAP a solid procedure for the assessment of implicit cognitions.

Read the Article:

McKenna, I., Barnes-Holmes, D., Barnes-Holmes, Y., & Stewart, I. (2007). Testing the Fake-ability of the Implicit Relational Assessment Procedure (IRAP): The First Study. International Journal of Psychology and Psychological Therapy, 7, 253-268. (in English)

What can RFT add to the study of pain?

The current study focuses on an RFT interpretation of the way that pain takes part in complex behavioural episodes for humans. It is a theoretical/conceptual study that reviews functional-contextual approaches to the study of private events specifically related to pain and with a special emphasis in recent research in verbal behaviour, behaviour-behaviour relations, and transformation of psychological functions. The review is divided into four parts. The first summarizes the philosophical assumptions of functional-contextualism and its implications for the study of pain (e.g. the extent to which explanations of pain allow for effective action as the criterion against which these explanations should be tested). The second focuses on the classical behaviour-analytic point of view, where pain experiences have been conceptualized as private events that exert discriminative control over subsequent behaviours (e.g. abuse of pain-killers, inactivity, social isolation, etc.). This discriminative function (behaviour-behaviour relation) is the product of specific histories of reinforcement along the individual's development, in direct-contingency terms. This view is illustrated with the presentation of the contributions of Schoenfeld and, more specifically, of Fordyce. RFT is proposed as a more comprehensive framework for the behaviour ral study of pain, a framework where verbal (derived) histories can be included as part of the explanation. In line with this, pain-related clinical problems are conceptualized as a form of experiential avoidance disorder, where it is the verbal functions of pain, rather than pain itself, that limit the individual's life (i.e. the consideration of pain as a literal barrier for engaging in valued actions). This is described in the third part of the article. Finally, the last part of the article presents a general overview of ACT and describes its implications for the treatment of pain-related problems.

For more information, read the original article in Spanish:

Gutiérrez Martínez, O., & Luciano Soriano, C. (2006). Un studio del dolor en el marco de la conducta verbal. International Journal of Clinical and Health Psychology, 6, 169-188. [A study of pain in the framework of verbal behavior: from the contributions of W. E. Fordyce to Relational Frame Theory (RFT)]

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BOOKS

Ciarrochi, J. V., & Bailey, A. (2008). A CBT practitioner's guide to ACT. Oakland, CA: New Harbinger.

BOOK CHAPTERS

DISSERTATIONS

Barthold, C., & Hoffner, C. (2007). Factors affecting the generalization of 'wh-' question answering by children with autism. Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 68(4-A): 1403.

EDITORIALS AND COMMENTARIES

Hayes, S. (2007). Hello Darkness. Psychotherapy Networker, Sept/Oct. 46-52.

Hummelen, J. W., & Rokx, T. A. J. J. (2007). Individual-context interaction as a guide in the treatment of personality disorders. Bulletin of the Menninger Clinic, 71(1): 42-55.

Muran, J. C. (2007) Commentary: Language, Self, and Diversity. In S. C. Hayes (Ed.), Dialogues on difference: Studies of diversity in the therapeutic relationship) pp. 275-279. Washington, DC, US: American Psychological Association.
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ACT/RFT Reader's Update (Winter, 2007)

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Welcome.... to the first issue of the ACT /RFT Reader's Update, an electronic newsletter provided for your information and perusal. This online newsletter provides summaries of recent, ACT and RFT articles (or related articles) published in peer-reviewed journals. In addition, citations for the latest books, book chapters, and unpublished dissertations will be listed. This will be an ongoing project, and new article summaries will be distributed via email every 4 months. You can identify these email summaries by the subject title "ACT/RFT Readers Update". Our main aim with this update is to keep the ACT/RFT community informed. We hope to include information that is relevant, scientifically sound, and of interest in the ACT/RFT community. Our purpose is not to recreate the abstract of these articles, but to provide a broader summary of the article. However, are goal is to keep the "busy" reader in mind, and therefore, we will work to keep the summaries brief. Additionally, we had to start somewhere, so we are only including summaries of some of the most recent articles.....and our next issue will include more from 2007 (such as ACT and diabetes and social anxiety disorder). We will conduct regular searches, however, if we missed your publication (from mid-2007 until now), please let us know. ** If you are a graduate student working on an ACT/RFT study and would like to have us include your dissertation or thesis citation in this update, please send us an email backchannel. **If you have published an editorial and you would like us to include that citation, please send us an email back channel. We hope you will find our e-mail updates of interest and value. If you have questions, please **contact Robyn Walser, Robyn.Walser@va.gov or Maggie Chartier, maggie_chartier@yahoo.com** Our reviewers include: Robyn Walser, PhD Christi Ulmer, PhD Maggie Chartier, MPH, MS Ian Stewart, PhD Miguel Rodríguez Valverde, PhD This issue contains 8 summaries. Please find references at end of summary and references listing at end of document: **ACT ARTICLES AND RELATED TOPICS** Acceptance and pain in children.... The literature supporting the use of cognitive-behavioral interventions for chronic pain in adults is fairly extensive. Nevertheless, considerably less empirical support is available for psychological approaches to pain in children. Even more limited is the literature on psychological approaches to idiopathic (of unknown cause) chronic pain in youths. Acceptance-based approaches have been implemented into behavioral pain treatments in adults, and have been found to be associated with better outcomes. The authors of a recent study investigated the impact of an ACT intervention with an exposure component for increased functioning and school attendance in 14 adolescents experiencing idiopathic chronic pain. The intervention was administered in individual therapy sessions tailored to the individual patient, but generally followed a format that included education, ACT, and exposure. Parents were also seen in separate sessions to provide guidance on an intervention-consistent parental coaching role versus a caretaking role. The number of sessions varied across patients. Post-intervention data

revealed large effect sizes for improvements in the primary outcomes (functioning and school attendance) in addition to the secondary outcomes (pain intensity, pain interference, and catastrophizing). Interestingly, pain intensity and interference decreased following this intervention despite the absence of intervention components targeting pain reduction. Limitations of the study included lack of a control group, variability in session number and therapeutic skills, and absence of a measure of the proposed mechanism of action (psychological flexibility). Despite the limitations, this pilot study contributes to a nascent area of research on the treatment of chronic pain in youths, and suggests a potential role for ACT-based interventions in this population. Read the Article: Wicksell, R. K., Melin, L., & Olsson, G. L. (2007). Exposure and acceptance in the rehabilitation of adolescents with idiopathic chronic pain - A pilot study. *European Journal of Pain, 11*(3), 267-274. _____ Hair pulling and experiential avoidance... Trichotillomania (TTM) is estimated to be present in up to 3.4% of the population and is associated with significant psychosocial difficulties. Previous research has identified several specific cognitions and affective states that are associated with the tendency to engage in hair pulling. A recent internet-based study investigated the potential relevance of the stance of the TTM sufferer towards aversive thoughts and emotions in hair pulling severity. More than 700 individuals reporting a diagnosis of TTM completed an anonymous online survey assessing: DSM-IV TTM criteria; hair pulling severity, urge, behavior and consequences; shame; self-perceived appearance; and fear of negative evaluation; and experiential avoidance. In spite of the waning criticism of internet-based research, the sample characteristics suggest that is was similar to those of studies completed in clinical settings, and the reported internal consistencies of the employed measures suggested that participants provided meaningful responses. As found in previous research, hair pulling behavior was associated with greater negative cognitions. However, in the current study, these associations were either significantly reduced or eliminated when experiential avoidance was introduced as a mediator. Under the premise that aversive cognitions are functionally related to hair pulling behavior, clinicians commonly target thought content using a cognitive restructuring approach to TTM. However, the findings of the current study suggest that targeting avoidance may result in a greater degree of behavior change. Replication of this study is needed in a clinical sample and should include longitudinal data to explore causal pathways plus a larger battery of private events should be investigated. Despite the need for additional study, the findings of the current study implicate experiential avoidance as a potentially critical factor in the understanding and treatment of TTM. Read the Article: Norberg, M. M., Wtterneck, C. T., Woods, D. W., & Conelea, C. A. (2007). Experiential avoidance as a mediator of relationships between cognitions and hair-pulling severity. *Behavior Modification, 31*, 367-381. _____ Preliminary findings suggest that ACT is useful for coping with psychological distress related to breast cancer. A recent article in the Spanish journal of psychooncology (Psicooncología) suggests that psychological problems resulting from diagnosis, treatment, and possible sequels of breast cancer, can be analysed as a form of an experiential avoidance disorder. The authors explored the application of an acceptance-based psychological intervention to these problems in a Spanish sample, comparing it with a more traditional intervention based on cognitive-control. Twelve women (ages 42 to 50) that had been diagnosed and treated for breast cancer took part. Half of them were randomly assigned to treatment with a brief adaptation of Acceptance and Commitment Therapy. This acceptance-based protocol focused on the clarification of personal values, the detection and acceptance of psychological barriers to acting towards those values, and on the continued practice of cognitive defusion through experiential exercises and metaphors. The other six women were treated with a brief adaptation of the official cognitive-behavioral program of the Spanish Association Against Cancer. This protocol focused on analysing the relationships among disease-related thoughts, feelings, and actions, and in the modification of those cognitions and emotions through several strategies (e.g. identification and management of automatic dysfunctional emotional reactions, emotional ventilation techniques, breathing and relaxation techniques for anxiety control, etc.). The general aim was to promote a sense of personal control over problematic private events, and to encourage a positive coping style. Overt behavioral components (exposure and activity planning) were explicitly excluded from this protocol. Both interventions were administered in eight sessions (two initial individual sessions, five group sessions, and a final individual session), with pre- and post - treatment assessment, and up to 12-month follow-ups. Post-treatment effects were similar for both conditions, but after one year, ACT was significantly more effective, with improvements in anxiety and depression scores, quality of life scores, and affected valued life areas. Despite the key limitation in terms of generalizability due to the small sample size, the results are promising and these findings point to ACT as a potentially effective treatment for disease-related psychological distress in long-term medical conditions. Read the Original Article in Spanish: Páez, M. B., Luciano, C., & Gutiérrez, O. (2007). Tratamiento psicológico para el afrontamiento del cáncer de mama. Estudio comparativo entre estrategias de aceptación y de control cognitivo. *Psicooncología, 4*,

75-95. [Psychological treatment for coping with breast cancer. A comparative study of acceptance and cognitive-control strategies]. _____ Can brief training for new therapists in ACT and CBT be effective? Many psychotherapy effectiveness trials use experts in the therapies they are testing. In this Finnish study, the authors wanted to first reduce this professional bias common in many head-to-head trials, by using graduate-level therapists. They explored level of training, regardless of therapeutic intervention, required to achieve significant psychological effects in treated individuals. Therapists were taught both CBT and ACT, through a combination of lectures, reading, and case supervision. Each therapist delivered a CBT treatment and an ACT treatment. The only criteria for entry into the study was a desire for individual therapy, thus a range of diagnoses were represented in the study population of 28. The techniques used within each model were based on a functional analysis case formulation model, and as such there was some overlap in techniques. For example, both interventions set treatment goals, used behavioral activation and exposure; and the treatments were problem, not syndrome focused. Overall, ACT showed significantly larger effect sizes at post and follow-up for symptom improvement. Both groups showed improvements on symptom reduction, but the ACT group was "virtually indistinguishable" from community norms. CBT showed more rapid improvement in self-confidence than ACT, and ACT improved acceptance of private experience more than CBT. When controlling for self-confidence, acceptance remained a significant predictor of improved outcome on the SCL-90 at both post and follow-up assessment. There were no differences between the two on client satisfaction or client willingness to recommend the therapy. There were also no differences post treatment in the therapist comfort with therapy or how much they felt they had helped their clients, although therapists reported more discomfort and confusion about learning and delivering ACT. So the answer is, yes. Brief training in either ACT or CBT with novice therapists produced moderately good psychological effects. The authors emphasize in their discussion of the limitations that this was not an effectiveness trail comparing the two therapies, but rather an effectiveness trial focusing on the issues of brief training and competency. Read the Article: Lappalainen, R., Lehtonen, T., & Skarp, E. (2007). The impact of CBT and ACT models using psychology trainee therapists: A preliminary controlled effectiveness trial. *Behavior Modification, 31*(4), 488-511. _____ Do we need to challenge thoughts in CBT? The title says it all. In this review of CBT component analyses, the authors investigate the 'three anomalies of CBT' put forth by Steve Hayes in a previous paper. These are that component analyses do not show added value of cognitive interventions; that there is often early rapid improvement in CBT prior to cognitive intervention; and that changes in cognitive mediators (thoughts/beliefs) don't seem to precede symptom changes. The authors found 13 component analysis for Cognitive Therapy (CT) in the treatment of depression and anxiety, published since 1980 in English. There were no significant differences between conditions that targeted cognitive process only or primarily and comparison groups that often included behavioral activation (BA). In many cases, BA was found to be as effective as CT and/or Automatic Thought (AT) interventions. To quote the authors, "the case at issue is not that CT performed poorly, but that BA performed so well." They discussed preliminary findings from a long-term large-scale project that has been presented at conferences (but not yet published) in which BA performed as well as antidepressant medication, and that both were superior to CT. For anxiety disorders, cognitive interventions have not been found to be more effective than disorder-specific exposure techniques. In addressing the second anomaly the authors concluded that that early responding has insufficient evidence to support CT. And as for the third, it appears that there is insufficient evidence to support cognitive mediation as a mechanism of change in therapy. The authors conclude that, almost without exception, among component analysis studies, there was no difference in effectiveness between the behavioral and cognitive components of CBT. The cognitive interventions appeared to add no additional value to behavioral interventions. The authors called CT theorists and researchers to task, requesting further investigation of the fundamental tenets of CT therapy. Read the Article: Longmore, R. J., & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavior therapy? *Clinical Psychology Review, 27*(2),173-187. **RFT ARTICLES** Training more-than/less-than relations can facilitate derived comparative relations in young children ... One critical assumption in RFT is that relating events is operant behavior. This is a challenge to demonstrate empirically, since relating is theorized to develop early in life. Examining relatively complex relations among older, more manageable subjects is one means of avoiding certain difficulties in this analysis. This study was conducted with four normally functioning females between four and five years old. The design of the study involved a multiple baseline across participants in groups of two. Stimuli were paper slips displaying arbitrary pictures. Sessions were conducted between 1 and 3 times weekly, each lasting between 40 and 60 minutes. Participants required between 2 and 6 months to complete the study. All participants displayed deficiencies in more-than/less-than relating before training and demonstrated derived performances after sufficient training. Two of the four participants required non-arbitrary

training among differing stacks of pennies before demonstrating criterion responding in training with arbitrary stimuli. In summary, these results provide evidence supporting the contention that relating events is an operant class, and that a repertoire of relating among non-arbitrary events may be a prerequisite for arbitrarily applicable derived relational responding. Read the Article (available for download on the ACBS website): Berens, N. M., & Hayes, S. C. (2007). Arbitrarily applicable comparative relations: Experimental evidence for a relational operant. *Journal of Applied Behavior Analysis, 40*, 45-71. _____ Combinatorial entailment in young children is facilitated by multiple exemplar training... RFT is built on the basic tenet that relating events is a generalized operant. In other words, the ability to derive relations among arbitrary stimuli develops from explicit training with multiple exemplars in early life. Consistent with this assumption, a former study found that derived symmetrical relations among the majority of a sample of 4-5 year old children were contingent upon explicit training with multiple exemplars. The current work contains two studies, each incorporating a multiple baseline design. Participants were two female and two male children between the ages of 4:6 and 4:10 years/months. The first study examined the repertoire for symmetrical relations using the procedures of the former study. Participants received conditional discrimination training for an action (e.g., clapping, waving) given an object (e.g., doll, truck). Subsequently they were tested for symmetrical relations between the action and the object. All children successfully derived symmetrical relations without encountering exemplar training. The second study examined for equivalence relations, building upon the training provided in the first study. A new set of actions (e.g., touching forehead, touching shoulder) were trained in respect to the objects. Subsequently the children were tested for equivalence relations between the actions trained in the first study and the new actions. Three of the four children required exemplar training for equivalence before demonstrating derived equivalence. These results support the developmental trajectory hypothesized in RFT, and suggest a means of remediation for delayed or absent relational abilities. Read the Article: Gomez, S., Lopez, F., Martin, C. B., Barnes-Holmes, Y., & Barnes-Holmes, D. (2007). Exemplar training and a derived transformation of functions in accordance with symmetry and equivalence. *Psychological Record, 57*, 273-294. _____ RFT and Perspective-taking in children with high-functioning autistic spectrum disorder . The current research involves using a test of perspective taking based on the Relational Frame Theory to (i) compare normally developing children and autistic children and (ii) demonstrate how perspective taking skills may be trained when they are deficient. According to RFT, language essentially involves relating things in accordance with particular learned patterns referred to as relational frames. Perspective taking is one specific pattern of relating or 'relational framing' in which the relating depends on the perspective of the person who is doing the relating. According to RFT, there are three core relational patterns or frames involved in perspective taking: I-YOU, HERE-THERE and NOW-THEN. This article reports on two experiments focusing on perspective taking in normal and autistic subjects. In the first experiment they use an RFT-based test of perspective taking to compare two groups of 9 children each. One of these groups is composed of normally developing children while the other is composed of high functioning autistic children. Results from this first experiment were that (i) there was a significant difference between the means scores for the normal and autistic groups of children on both the clinical tests; (ii) across both groups, most errors in the perspective taking test were made on reversed relations and there was a significant difference between performance on the simple and reversed level tasks; (iii) the two groups - normally developing and autistic - differed significantly as regards to performance on the reversed relations tasks but not as regards to performance on either of other two task types; (iv) there was a correlation across all subjects between performance on the NOW-THEN reversed relations task and Daily Living Skills scores. The researchers suggest that despite a small sample size, the results provide support for the RFT account of perspective taking as deictic relational responding in that autistic children did perform more poorly than the normally developing children in the relational perspective-taking tasks provided. They performed significantly more poorly in the reversed relational tasks than in the simple tasks. They did not perform significantly more poorly in the double reversed relational tasks than in the simple tasks. However, as the researchers point out, this may be because these tasks may be answered correctly without necessarily responding appropriately in accordance with deictic relations. In the second experiment, the researchers used the RFT tasks employed in Experiment 1 combined with appropriate feedback (cartoon animations for correct responses) to train up perspective taking ability in two of the children from the normally developing group from the first experiment. The results showed that the relational pattern involved in perspective taking could indeed be trained up as RFT would predict. They suggest that this implies that the RFT account of perspective taking is a useful one, and that RFT-based perspective taking tasks such as those used in the current experiments may be used in future work to train up perspective taking in autistic children. Read the Article: Rehfeldt, R.A., Dillen, J.E., & Ziomek, M.M.(2007) Assessing

Relational Learning Deficits in Perspective-Taking in Children with High-Functioning Autism Spectrum Disorder. *Psychological Record, 57*(10), 23-47. **BOOKS** Gregg, J. A., Callaghan, G. M., & Hayes, S. C. (2007). *Diabetes lifestyle book*. Oakland, CA: New Harbinger Press. Follette, V. M., & Pistorello, J. (2007). *Finding life beyond trauma*. Oakland, CA: New Harbinger Press. Hayes, S. C., Bond, F. W., Barnes-Holmes, D., & Austin, J. (2007). *Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy And Relational Frame Theory to Organizational Behavior Management*. Binghamton, NY: Haworth Press. Lejeune, C. (2007). *The Worry Trap: How to Free Yourself from Worry & Anxiety using Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Press. Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists*. Oakland, CA: New Harbinger Press. Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder: A Practitioner's Guide to Using Mindfulness & Acceptance Strategies*. Oakland, CA: New Harbinger Press. Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using acceptance and commitment therapy in treating depression*. Oakland, CA: New Harbinger Press. Also: Check out the ACT in ACTion DVD set. Available at newharbinger.com **BOOK CHAPTERS** Pierson, H., & Hayes, S. C. (2007). Using acceptance and commitment therapy to empower the therapeutic relationship. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 205-228). New York, NY: Routledge/Taylor & Francis Group. Twohig, M. P., Pierson, H. M., & Hayes, S. C. (2007). Acceptance and Commitment Therapy. In N. Kazantzis & L. L'Abate (Eds.), *Handbook of homework assignments in psychotherapy: Research, practice, prevention* (pp. 113-132).New York, NY: Springer Science + Business Media. **DISSERTATIONS** Pellowe, M. E. (2007). Acceptance and commitment therapy as a treatment for dysphoria. *Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 67*(9-B), 5418. Braekkan, K. C. (2007). An acceptance and commitment therapy intervention for combat veterans with posttraumatic stress disorder: Preliminary outcomes of a controlled group comparison. *Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 67*(12-B), 7365. **EDITORIALS** Curran, J., & Houghton, S. (2007). Moving beyond mechanism. *Mental Health Practice, 10*(8), 20-23. Blackledge, J. T. (2007). Disrupting verbal processes: Cognitive defusion in Acceptance and Commitment Therapy and other Mindfulness-based Psychotherapies. *The Psychological Record, 57*(4).
admin September 28, 2008 - 1:38pm

ACT with Special Populations or in Specific Settings

ACT with Special Populations or in Specific Settings

ACT is a general model of the language and cognition processes involved in reducing psychological suffering and promoting human well-being. As such, it is not a specific set of techniques. Any ACT intervention is an instance of a general psychological strategy which is designed to be flexibly applied. ACT can be applied in short interventions done in minutes or hours, as well as in interventions which take many sessions. ACT can be used in groups, individual sessions, classroom settings, couples therapy, bibliotherapy, workplace trainings, and much more. Be sure to check out our collection of ACT treatment protocols and list of books for Specific Populations.

There are several Special Interest Groups (SIGs) focused on specific populations and settings. This is a partial list of SIG topics. *To see the full list of Special Interest Groups, click here.*

- Addictions
- Aging
- Asian Culture
- Autism
- Cancer
- Children, Adolescents & Families
- Coaching
- College/University Student Mental Health
- Educational Settings
- Forensic and Corrections

- Gender and Sexual Diversity
- Leadership and Organizational Behavior Management
- Military Personnel
- Occupational Therapy
- OCD
- Pain
- Perinatal
- Primary Care
- Psychosis
- Sport and Human Performance
- Veterans Affairs (VA)

admin November 28, 2007 - 11:23pm

Fellow Travelers

Fellow Travelers

The third generation of cognitive behavior therapy (CBT) has been defined this way:

> *Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones. These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioral and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions, in hopes of improving both understanding and outcomes.* (Hayes, 2004)

The most unique characteristic of the third wave interventions is the degree of emphasis on contextual and experiential change strategies, including acceptance, defusion, mindfulness, relationship, values, emotional deepening, contact with the present moment, and the like. The purpose of experiential and contextual strategies of this kind is to rapidly alter the function of problematic psychological events, even if their form or frequency does not change or changes only slowly. Mindfulness-based and acceptance technologies show that focus quite clearly. For example, Segal, Teasdale, and Williams (2004) state: “Unlike CBT, there is little emphasis in MBCT on changing the content of thoughts; rather, the emphasis is on changing awareness of and relationship to thoughts.”

It is worth noting that this step is being taken both by techniques that are quite behavior analytic and thus philosophically contextualistic in their rationalization (e.g., Behavioral Activation, ICBT, DBT, ACT, FAP), and by techniques that are quite cognitive in their rationalization (e.g., MBCT, Metacognition).

This is important, because it means that the mainstream itself is changing and there are new opportunities for connection and communication across old boundaries. In a kind of dialectical synthesis of a previous thesis and antithesis, the new wave therapies seem to be healing old wounds and divisions between behavioral and cognitive perspectives. Evidence for this view can be found in the synergies between technologies across of the spectrum of third wave interventions, and in the ways that each of these new approaches has breadth across these divisions regardless of its home of origin. The third wave interventions are not a rejection of the first and second waves of behavioral and cognitive therapy so much as a transformation of these earlier phases into a new,

broader, more interconnected form. Thus, while the implications may be revolutionary, the processes giving rise to these developments are evolutionary – as might be expected in an explicitly empirical tradition.

We invite child pages to be added in any of the methods and approaches that are part of a more contextual approach (simply click the "add child page" link at the bottom of the relevant page).
Steven Hayes August 14, 2005 - 11:37am

Fellow Travelers FAQ

Fellow Travelers FAQ

ACBS Members: To suggest a question for someone to answer, click on the "add new comment" link at the bottom of this page and enter your question. To provide a question and an answer to this FAQ, click on the "add child page" link at the bottom of this page.

Eric Fox August 16, 2005 - 2:00pm

What characterizes the so-called third wave behavior therapies?

What characterizes the so-called third wave behavior therapies?

”Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form, and thus tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones. These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems, and to emphasize the relevance of the issues they examine for clinicians as well as clients. The third wave reformulates and synthesizes previous generations of behavioral and cognitive therapy and carries them forward into questions, issues, and domains previously addressed primarily by other traditions, in hopes of improving both understanding and outcomes.” (quote from Hayes, 2004).

These are very broad characterizations and there is no clear dividing line between various historical aspects of the behavior therapy tradition.

Steven Hayes July 31, 2005 - 9:50am

How does Relational Frame Theory (RFT) relate to traditional CBT-theories?

How does Relational Frame Theory (RFT) relate to traditional CBT-theories?

That question is a huge one. RFT seeks a broad understanding of cognition. In the long run it could be more important than ACT because if it works the whole of psychology could change.

RFT is developmental, contextual, and behavioral. It gives you ideas about what to change to make things happen. It is so basic that it goes all the way down to animal behavior and human infants; and yet so broad in scope that it has clear implications for our understanding of social processes or such human activities as religion.

We have never had an empirically adequate behavioral, contextual account of cognition. Now we have at least the beginnings of one and it seems to be braking down the artificial barriers between cognitive and behavioral science.

The theories underlying CBT and CT are not like that. They have relatively low scope and they emerged typically from clinical concerns. They do not pretend to be the functional equivalent in cognition for what “behavioral principles” are in non-verbal behavior.

You have to be impressed with what the traditional behavior therapists were able to do with traditional behavioral principles, in part because these principles emphasized manipulable contextual variables. Imagine what we might do with a theory of cognition that emphasized manipulable contextual variables, if the theory was relatively adequate. Maybe a lot.

Steven Hayes July 31, 2005 - 9:54am

ACT, evolutionary biology and severe mental illness

ACT, evolutionary biology and severe mental illness

Originally submitted by user dixonph on 7/30/2014:

Edward Hagen's paper: Delusions as Exploitative Behavior
http://bit.ly/1ppVlnu echoes themes of ACT theorists. ACT is held by the founders as a possible aid for even severe psychotic disorders. Contextual behavior theory is not mentioned as such in Hagen's paper. I don't know if Hagen is involved with mental illness treatments, or ACT specifically. The paper seems to be very much in line with ACT principles. That is why I mention it here. I see a connection.

If even severe mental illness is an evolutionary adaptive survival mechanism manifested as a result of a failed social context, then how can ACT help reintegrate the modern sufferer into more successful social connections?

Can there be communities where ACT functions to create an experience of acceptance and support for sufferers even outside the therapeutic setting?

I am looking to see if Edward Hagen is involved with ACBS/ACT. His paper states that he believes anti-psychotic medication will not really help someone with what is called delusional disorder (semi-plausible delusions, continued day to day routine functioning), which is distinct from the bizarre delusions of schizophrenia. He also mentions the harmful side effects of the medications.

I am interested in the potential for ACT in supportive community for mental health sufferers.

Any known efforts among ACT practioners?

Jennifer Krafft March 9, 2016 - 6:45pm

Differences/Similarities between ACT/DBT

Differences/Similarities between ACT/DBT

ACT and DBT could be considered **sister/brother technologies**. Both have been described as part of the "third wave" of cognitive-behavioral therapies, which also includes therapies such as mindfulness-based cognitive therapy and integrative behavioral couples therapy (and potentially the new modern behavior analytic form of behavioral activitation by the deceased Jacobson and colleagues that seems to be outperforming cognitive therapy for depression in two trials). This new set of therapies, all of which have a commitment to empirical evaluation and science, tend to differ in important ways from traditional CBT. For example, the third wave tends to pay more attention to secondary change in the area of thoughts and feelings. Traditional CBT tries to help people directly change thoughts and feelings, sort of an in-with-the-good out-with-the-bad approach to cognitive and emotional content. These third wave approaches focus on helping people to change their relationship to these private experiences, rather than trying to change the form, situational sensitivity, or content of these experiences. Emphasis then tends to turn to being effective in one's life and away from working to feel GOOD. Another way to put this is that these therapies tend to help people learn how to FEEL good, rather than to try to feel GOOD. Anyways, there are papers written about this new set of therapies and their similarities and differences for those who want more info.

Here's a little about what I see as **differences/similiarities between DBT and ACT,** with the disclaimer that I am far from an expert on DBT. DBT and ACT both emerge from a behavioral tradition. Both share the similarity of emphasizing acceptance, mindfulness, and effectiveness of action. In at least those domains they are quite similar. In terms of the theory that underlies them, they are quite different. ACT is closely tied to a modern behavior analytic theory of language and cognition called Relational Frame Theory (RFT), which underlies the approach, and also to traditional behavior analytic principles such as reinforcement. The first clinical trials on ACT were published several years before DBT (in 1985-86 with depression), but then Steve Hayes decided that ACT needed a firmer theoretical foundation and this lead to about 15 years of research and dozens of studies on RFT before the next application of RFT (an ACT clinical trial on psychosis) was published in 1999. My experience with DBT is that its focus has been on developing a technology that is practical, pragmatic, and manualized, with less of an emphasis on developing a comprehensive theory of human behavior. ACT is very closely tied to the broader tradition of behavior analysis and could be considered a form of clinical behavior analysis while DBT seems to be more closely tied to traditional behavior therapy.

In terms of **overlap in specific techniques** between ACT and DBT, the overlap appears limited. There seems to be very little overlap in terms of the specific techniques, exercises, and metaphors used in session (with the exception of general mindfulness exercises).

In terms of the **evidence base,** DBT undoubtedly has a stronger evidence with more replication in the more limited areas that it has been tested (e.g., parasuicidality/substance abuse), while ACT has been examined in a wider variety of clinical trials, with less replication, with more disorders (e.g., chronic pain, substance abuse, depression, workplace settings, anxiety, and a dozen or so other), probably due to the broader scope of its underlying theory.

[this is exerpted from an email to a listserv in Oregon and I thought others might be interested in this. Feel free to modify or comment on any disagreement/inconsistencies/extensions]
Jason Luoma February 10, 2006 - 2:39pm

Glossary

Glossary

Glossary of Terms

(en español)

Emily September 15, 2008 - 7:35pm

Cfunc

Cfunc

A context that controls the transformation of stimulus functions. Pronounced "cee funk." (Note: the "func" portion of this term typically appears as subscript, which is difficult to implement in HTML).

Emily September 15, 2008 - 8:08pm

Crel

Crel

A context that controls framing events relationally. While these can include nonarbitrary features of the relata in some circumstances, the same relational behavior must also be controlled by arbitrary contextual cues in other circumstances in order to define the response as arbitrarily applicable. Pronounced "cee rel." (Note: the "rel" portion of this term typically appears as subscript, which is difficult to implement in HTML).

Emily September 15, 2008 - 9:05pm

acceptance

acceptance

Acceptance is defined in ACT as "actively contacting psychological experiences -- directly, fully, and without needless defense -- while behaving effectively." (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1163)

Emily September 15, 2008 - 7:41pm

analytic-abstractive theory

analytic-abstractive theory

Organized sets of behavioral principles emerging from coherent sets of functional analyses that are used to help predict and influence behaviors in a given response domain.

Emily September 15, 2008 - 7:43pm

arbitrarily applicable relational responding

arbitrarily applicable relational responding
Learned relational responding that can come under the control of arbitrary contextual cues, not solely the formal properties of relata nor direct experience with them.
Emily September 15, 2008 - 7:48pm

arbitrary

arbitrary
By social whim or convention. It is arbitrary, for example, that English speakers use the word "apple" to refer to a particular type of fruit. Speakers in other language communities choose entirely different words to refer to that type of fruit.
Emily September 15, 2008 - 7:50pm

augmenting

augmenting
A form of rule-governed behavior controlled by relational networks that alter the degree to which events function as consequences. The rule itself is called an augmental.
Emily September 15, 2008 - 7:56pm

behavior analysis

behavior analysis
A natural science of behavior that seeks the development of an organized system of empirically-based verbal concepts and rules that allow behavioral phenomena to be predicted and influenced with precision, scope, and

depth. By studying the current and historical context in which behavior evolves, behavior analysts strive to develop analytic concepts and rules that are useful for predicting and changing behavior in a variety of settings. The most well-established behavioral principles of this sort are those related to classical and operant conditioning, such as B. F. Skinner's principles of reinforcement. The core analytic unit of behavior analysis is the operant (or multiterm contingency). An operant analysis defines behavior in terms of its relation to antecedent events and consequences, and learning is understood to be a function of the inherent interdependence between these features. This contextual approach to studying behavior has resulted in a robust science with many powerful applications in nearly every area of human endeavor. Behavior analysis is supported by a philosophy of science known as functional contextualism. See the Association for Behavior Analysis (www.abainternational.org) and the Cambridge Center for Behavioral Studies (www.behavior.org) for more information.
Emily September 15, 2008 - 7:58pm

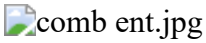
behavioral principles

behavioral principles
Ways of speaking about behavioral interactions that are high in precision and scope. Reinforcement theory is based on a set of principles that meet these criteria.
Emily September 15, 2008 - 8:01pm

combinatorial entailment

combinatorial entailment

A defining feature of relational frames that refers to the ability to combine mutually related events into a relational network under forms of contextual control that can include arbitrary contextual cues. Combinatorial entailment applies when in a given context A is related in a characteristic way to B, and A is related to C, and as a result a relation between B and C is now mutually entailed. The specific form of the network does not matter. It would be as correct to say that combinatorial entailment applies when in a given context A is related in a characteristic way to B, and B is related to C, and as a result a relation between A and C is now mutually entailed. Combinatorial entailment can be represented by the formula below.



Emily September 15, 2008 - 8:17pm

complete relational network

complete relational network

Networks of events containing Crel terms that set the occasion for the relational activity necessary to specify a relation between the events in the network.

Emily September 15, 2008 - 8:51pm

contextual psychology

contextual psychology
Contextual Psychology refers to the study of organisms (both human and non-human) interacting in and with a historical and current situational context. It is an approach based on contextualism, a philosophy in which any event is interpreted as an ongoing act inseparable from its current and historical context and in which a radically functional approach to truth and meaning is adopted. This website is devoted to the development of a progressive psychological science based on functional contextualism, a variant of contextualism focused on the construction

of practical, scientific knowledge. This scientific form of contextual psychology is virtually synonymous with the field known as behavior analysis.
Emily September 15, 2008 - 8:55pm

contextualism

contextualism
Although this term has more general meanings, as applied in RFT it refers to a philosophy of science based on the root metaphor of an going historical act in context as its analytical unit, and utilizing a truth criterion of successful working as tied to a specific set of analytic goals.
Emily September 15, 2008 - 8:58pm

continuity assumption

continuity assumption
The assumption that more recent life forms contain the features of older life forms within the same evolutionary stream.
Emily September 15, 2008 - 8:59pm

coordination

coordination
The frame of coordination is perhaps the most common type of relational responding. It incorporates the relation of identity, sameness, or similarity. This relational frame is probably the first to be abstracted sufficiently to enable its application to become arbitrary, in part because it is the only relation in which derived and trained relations are the same, regardless of the number of stimuli that participate in relational networks consisting purely of this response frame. Naming is an example of the frame of coordination at its simplest.
Emily September 15, 2008 - 9:01pm

deictic frames

deictic frames

Deictic relations specify a relation in terms of the perspective of the speaker such as left/right; I/you (and all of its correlates, such as "mine"; here/there; and now/then. Some relations may or may not be deictic, such as front/back or above/below, depending on the perspective applied. For example, the sentence "The back door of my house is in front of me" contains both a spatial and deictic form of "front/back." Deictic relations seem to be a particularly important family of relational frames that may be critical for perspective-taking. An example is the three frames of I and YOU, HERE and THERE, and NOW and THEN. These frames are unlike the others mentioned previously in that they do not appear to have any formal or nonarbitrary counterparts. Coordination, for instance, is based on formal identity or sameness, and "bigger than" is based on relative size. In contrast, frames that depend on perspective cannot be traced to formal dimensions in the environment at all; instead, the relationship between the individual and other events serves as the constant variable upon which these frames are based.

Emily September 15, 2008 - 8:13pm

depth

depth
Depth means that analytic concepts relevant to one level of analysis (e.g., the psychological level) cohere with (or at least do not contradict) well-established and workable concepts at other levels of analysis (e.g., the

anthropological level).
Emily September 15, 2008 - 10:03pm

distinction

distinction
The frame of distinction also involves responding to one event in terms of the lack of a frame of coordination with another, typically also along a particular dimension. Like a frame of opposition, this frame implies that responses to one event are unlikely to be appropriate in the case of the other, but unlike opposition, the nature of an appropriate response is typically not defined. If I am told only, for example, "this is not warm water," I do not know whether the water is ice cold or boiling hot. When frames of distinction are combined, the combinatorially entailed relation is weak. For example, without additional disambiguating information, if two events are different than a third event, I do not know the relation between these two beyond the fact of their shared distinction.
Emily September 15, 2008 - 10:04pm

families of relational frames

families of relational frames

Relational frames can be roughly organized into families of specific types of relations. This list is not exhaustive, but serves to demonstrate some of the more common frames and how they may combine to establish various classes of important behavioral events.

- *frames of coordination*
- *frames of opposition*
- *frames of distinction*
- *frames of comparison*
- *hierarchical frames*
- *deictic frames*
- other families: other families of relations include spatial relations such as over/under and front/back, temporal relations such as before/after, and causal/contingency relations such as "if...then"

The foregoing families of relational frames are not final or absolute. If RFT is correct, the number of relational frames is limited only by the creativity of the social/verbal community that trains them. Thus the foregoing list is to some degree tentative. For example, TIME and CAUSALITY can be thought of as one or two types of relations. It is not yet clear if thinking of them as either separate or related may be experimentally useful, relative to the goals of RFT. Thus, while the generic concept of a relational frame is foundational to RFT, the concept of any particular relational frame is not. The purpose in constructing a list of frames is to provide a set of conceptual tools, some more firmly grounded in data than others, that may be modified and refined as subsequent empirical analyses are conducted. To see some brief examples of common families of relational frames, please watch the video families below.

Emily September 15, 2008 - 10:07pm

formative augmenting

formative augmenting

A form of rule-governed behavior controlled by relational networks that establish given consequences as reinforcers or punishers.

Emily September 15, 2008 - 11:52pm

frames of comparison

frames of comparison

The family of comparative relational frames is involved whenever one event is responded to in terms of a quantitative or qualitative relation along a specified dimension with another event. Many specific subtypes of comparison exist (e.g., bigger/smaller, faster/slower, better/worse). Although each subtype may require its own history, the family resemblance may allow the more rapid learning of successive members. The different members of this family of relations are defined in part by the dimensions along which the relation applies (e.g., size; attractiveness; speed). Comparative frames may be made more specific by quantification of the dimension along which a comparative relation is made. For example, the statement "A is twice as fast as B and B is twice as fast as C" allows a precise specification of the relation within all three pairs of elements in the network.

Emily September 15, 2008 - 11:58pm

frames of coordination

frames of coordination
The frame of coordination is perhaps the most common type of relational responding. It incorporates the relation of identity, sameness, or similarity. This relational frame is probably the first to be abstracted sufficiently to enable its application to become arbitrary, in part because it is the only relation in which derived and trained relations are the same, regardless of the number of stimuli that participate in relational networks consisting purely of this response frame. Naming is an example of the frame of coordination at its simplest.
Emily September 16, 2008 - 12:06am

frames of distinction

frames of distinction

The frame of distinction also involves responding to one event in terms of the lack of a frame of coordination with another, typically also along a particular dimension. Like a frame of opposition, this frame implies that responses to one event are unlikely to be appropriate in the case of the other, but unlike opposition, the nature of an appropriate response is typically not defined. If I am told only, for example, "this is not warm water," I do not know whether the water is ice cold or boiling hot. When frames of distinction are combined, the combinatorially entailed relation is weak. For example, without additional disambiguating information, if two events are different than a third event, I do not know the relation between these two beyond the fact of their shared distinction.

Emily September 16, 2008 - 12:09am

frames of opposition

frames of opposition

Opposition is another early relational frame. In natural language use, this kind of relational responding involves an abstracted dimension along which events can be ordered and distinguished in equal ways from a reference point. Along the verbally abstracted dimension of temperature, for example, cool is the opposite of warm, and cold is the opposite of hot. The specific relational frame of opposition typically (but not necessarily) implicates the relevant dimension (e.g., "pretty is the opposite of ugly" is relevant to appearance). Opposition should normally emerge after coordination because the combinatorially entailed relation in frames of opposition includes frames of coordination (e.g., if hot is the opposite of freezing and cold is the opposite of hot, then cold is the same as freezing).

Emily September 16, 2008 - 12:13am

framing events relationally

framing events relationally

Framing events relationally (or "framing relationally" or "relational framing") refers to a specific type of arbitrarily applicable relational responding that has the defining features in some contexts of mutual entailment, combinatorial entailment, and the transformation of stimulus functions. Framing events relationally is due to a history of relational responding relevant to the contextual cues involved; and is not solely based on direct non-relational training with regard to the particular stimuli of interest, nor solely to nonarbitrary characteristics of either the stimuli or the relation between them. The action of framing events relationally is often referred to in the noun form of "relational frame." Various families of relational frames, or ways of framing events relationally, have been identified.

Emily September 16, 2008 - 12:17am

functional contextualism

functional contextualism
A specific form of contextualism with the a priori analytic goals of the prediction-and-influence of behavioral events, with precision, scope, and depth. "Prediction-and-influence" is hyphenated here to emphasize its fundamental inseverability in functional contextualism, even though in practical terms it is possible only to reach one goal and not the other. Functional contextualism supports the science of behavior known as behavior analysis.
Emily September 16, 2008 - 12:27am

generalized operant

generalized operant
Operants are purely functional units of analysis, organized by their common antecedent, consequential, and motivational sources of control. However, because topographical and functional classes of behavior-environment interactions often overlap, operants are sometimes thought of in topographical terms. The word "generalized" (or similar terms, such as "purely functional" or "overarching") is used to emphasize that this particular operant is not usefully thought of in topographical terms.
Emily September 16, 2008 - 12:36am

hierarchial frames

hierarchial frames

Hierarchical relations or hierarchical class memberships have the same diode-like quality of frames of comparison, but the combinatorially entailed relations differ because the hierarchical relation itself is the basis for a frame of coordination. For example, if Tom is the father of Simon and Jane, then Simon and Jane are known to be siblings. If Tom is taller than both Simon and Jane, however, the relative heights of Simon and Jane are unknown. Hierarchical relations are essential to many forms of verbal abstraction.

Emily September 16, 2008 - 12:38am

listening with understanding

listening with understanding

The responses of listeners that are based on framing events relationally.

Emily September 16, 2008 - 12:40am

motivative augmenting

motivative augmenting

A form of rule-governed behavior controlled by relational networks that alter the degree to which previously established consequences function as reinforcers or punishers.

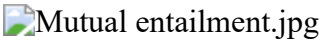
Emily September 16, 2008 - 12:55am

mutual entailment

mutual entailment

A defining feature of relational frames that refers to its fundamental bidirectionality under forms of contextual control that can include arbitrary contextual cues. Mutual entailment applies when in a given context A is related

in a characteristic way to B, and as a result B is now related in another characteristic way to A. Mutual entailment can be represented by the formula below.


Mutual entailment.jpg
Emily September 16, 2008 - 1:00am

opposition

opposition

Opposition is another early relational frame. In natural language use, this kind of relational responding involves an abstracted dimension along which events can be ordered and distinguished in equal ways from a reference point. Along the verbally abstracted dimension of temperature, for example, cool is the opposite of warm, and cold is the opposite of hot. The specific relational frame of opposition typically (but not necessarily) implicates the relevant dimension (e.g., "pretty is the opposite of ugly" is relevant to appearance). Opposition should normally emerge after coordination because the combinatorially entailed relation in frames of opposition includes frames of coordination (e.g., if hot is the opposite of freezing and cold is the opposite of hot, then cold is the same as freezing).

Emily September 16, 2008 - 1:03am

pliance

pliance

A form of rule-governed behavior under the control of a history of socially-mediated reinforcement for coordination between behavior and antecedent verbal stimuli (i.e., the relational network or rule), in which that reinforcement is itself delivered based on a frame of coordination between the rule and behavior. Stated another way, pliance requires both following a rule and detection by the verbal community that the rule and the behavior correspond. Mere social consequation does not define pliance. The rule itself is called a ply.

Emily September 16, 2008 - 1:11am

pragmatic verbal analysis

pragmatic verbal analysis

Framing events relationally under the control of abstracted features of the nonarbitrary environment that are themselves framed relationally. Stated in other words, pragmatic verbal analysis involves acting upon the world verbally, and having the world serve verbal functions as a result.

See below for an illustration of RFT's interpretation of pragmatic verbal analysis/problem solving.

Emily September 16, 2008 - 1:13am

precision

precision
Precision means that there are relatively few ways to explain or describe a given phenomenon with a set of analytic concepts. The fewer ways a given phenomenon can be explained or described with a set of concepts the better.
Emily September 16, 2008 - 6:53pm

problem solving

problem solving

Although problem-solving has both non-verbal and verbal connotations, in a verbal sense problem-solving refers to framing events relationally under the antecedent and consequential control of an apparent absence of effective actions. When the particular problem involves the stimulus functions of the nonarbitrary environment, verbal problem-solving can be said to be pragmatic verbal analysis that changes the behavioral functions of the environment under the antecedent and consequential control of an apparent absence of effective action.

See below for an illustration of RFT's interpretation of pragmatic verbal analysis/problem solving.

PragmaticVerbalAnalysis

02:14

admin September 16, 2008 - 6:56pm

relata

relata
Events that are in a relational network.
Emily September 16, 2008 - 7:49pm

relational frame

relational frame

A specific type of arbitrarily applicable relational responding that has the defining features in some contexts of mutual entailment, combinatorial entailment, and the transformation of stimulus functions. Relational frames are due to a history of relational responding relevant to the contextual cues involved; and is not solely based on direct non-relational training with regard to the particular stimuli of interest, nor solely to nonarbitrary characteristics of either the stimuli or the relation between them. While used as a noun, it is in fact always an action and thus can be restated anytime in the form "framing events relationally." Various families of relational frames have been identified.

Emily September 16, 2008 - 7:50pm

relational network

relational network

A relational frame is the smallest relational network that can be defined, although the term network is usually used to refer to combinations of relational frames, such as A is more than B, B is the same as C, C is less than D.

The term network is also used to describe relations between or among relational frames, such as, if A is more than B, and C is more than D, then the relation between A and B participates in a frame of coordination with the relation between C and D.
Emily September 16, 2008 - 7:54pm

relational responding

relational responding

Responding to one event in terms of another. See below for an illustration depicting the difference between relational responding and non-relational responding.

Emily September 16, 2008 - 7:56pm

rule-governed behavior

rule-governed behavior

a.k.a., RGB

In its most general terms, behavior controlled by a verbal antecedent. However, behavior controlled by verbal antecedents is more likely to be termed "rule governed" if the verbal antecedent forms a complete relational network that transforms the functions of the nonarbitrary environment.

See below for an illustration of RFT's interpretation of rule-governed behavior.

Emily September 16, 2008 - 7:58pm

scope

scope

Scope means that a broad range of phenomena can be analyzed with a given set of analytic concepts (the broader the range the better, so long as precision is not compromised).

Emily September 16, 2008 - 8:01pm

strategic problems

strategic problems

Those verbal problems in which the problem solver has placed the desired goal or purpose into a relational frame.

Emily September 16, 2008 - 8:02pm

thinking

thinking
Although thinking has both non-verbal and verbal connotations, in a verbal sense it is a reflective behavioral sequence, often private, of pragmatic verbal analysis that transforms the functions of the environment so as to lead to novel, productive acts.
Emily September 16, 2008 - 8:05pm

tracking

tracking

A form of rule-governed behavior under the control of a history of coordination between the rule and the way the environment is arranged independently of the delivery of the rule. The rule itself is called a track.

Emily September 16, 2008 - 8:06pm

transfer of stimulus functions

transfer of stimulus functions

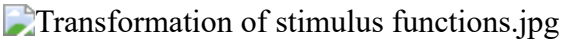
A specific type of transformation of stimulus functions between two relata when they participate in a frame of coordination.

Emily September 16, 2008 - 8:11pm

transformation of stimulus functions

transformation of stimulus functions

A defining feature of relational frames that refers to the modification of the stimulus functions of relata based on contextual cues that specify a relevant function (Cfunc) and the relational frame that these events participate in (Crel). The transformation of stimulus functions can be represented by the formula below.


Transformation of stimulus functions.jpg

Emily September 16, 2008 - 6:49pm

valuative problems

valuative problems

Those verbal problems in which the goal is to place a desired goal or purpose into a relational frame.

Emily September 16, 2008 - 8:15pm

varieties of relational frames

varieties of relational frames

Relational frames can be roughly organized into families of specific types of relations. This list is not exhaustive, but serves to demonstrate some of the more common frames and how they may combine to establish various classes of important behavioral events.

- *frames of coordination*
- *frames of opposition*
- *frames of distinction*
- *frames of comparison*
- *hierarchical frames*
- *deictic frames*
- other families: other families of relations include spatial relations such as over/under and front/back, temporal relations such as before/after, and causal/contingency relations such as "if...then"

The foregoing families of relational frames are not final or absolute. If RFT is correct, the number of relational frames is limited only by the creativity of the social/verbal community that trains them. Thus the foregoing list is to some degree tentative. For example, TIME and CAUSALITY can be thought of as one or two types of relations. It is not yet clear if thinking of them as either separate or related may be experimentally useful, relative to the goals of RFT. Thus, while the generic concept of a relational frame is foundational to RFT, the concept of any particular relational frame is not. The purpose in constructing a list of frames is to provide a set of conceptual tools, some more firmly grounded in data than others, that may be modified and refined as subsequent empirical analyses are conducted. To see some brief examples of common families of relational frames, click on the video below.

RelationalFamilies

01:11

Emily September 16, 2008 - 8:16pm

verbal behavior

verbal behavior

The action of framing events relationally.

Emily September 16, 2008 - 8:21pm

verbal stimuli

verbal stimuli

Stimuli that have their effects because they participate in relational frames.

Emily September 16, 2008 - 8:23pm

The Three Earliest ACT Protocols

The Three Earliest ACT Protocols

Sleuthing exactly when the first ACT protocols were written is tricky due to the passage of time, and the fact that computers did not exist so duplicate records meant carbon paper copies on onion skin kept in files and packed in cardboard boxes as moves occurred or new jobs were secured. Thus the reasoning for dating is included below.

The first ACT protocol was likely written by Steve Hayes in late Spring of 1981. At that time the name was "Comprehensive Distancing". An attachment to this page contains that very first protocol ("1981 Big D Manual S C Hayes") which is only 3 pages long. But its clear from the "manual" (an outline really) that the students knew the metaphors and exercises. Steve thinks his "night on the carpet" (www.bit.ly/StevesFirstTED) was during the 1980-81 winter break and that he came back to the lab ready to push hard on studying what he had experienced. He thinks he remembers conducting a workshop in the lab soon after and the "manual" was written after that in the 1981 Spring semester.

The next protocol was written soon after in 1981. Here is how we know that: the study was an analogue study on pain tolerance and it was presented at the Association for the Advancement of Behavior Therapy (now AABT) in 1982:

Hayes, S. C., Korn, Z., Zettle, R. D., Rosenfarb, I., & Cooper, L. (November 1982). *Rule-governed behavior and cognitive behavior therapy: The effects of comprehensive cognitive distancing on pain tolerance.* Paper presented at the meeting of the Association for Advancement of Behavior Therapy, Los Angeles.

That means the study was finished by about March of 1982 so it could be submitted.

But Rob Zettle (Steve Hayes's first doctoral student) thinks he likely used that pain manual to help write the manual for his dissertation on Cognitive Therapy vs ACT for depression. One reason to think that: the onion skin carbon copy of that pain protocol was only found in February 2024 (!) while looking for the first "Big D" manual, and Rob found it not in the files for the pain study, but in the cardboard box of files for his dissertation ... as if the protocol was relocated for his reference.

Rob recalls running two subjects for his dissertation project in Greensboro before he left for his internship at the Center for Cognitive Therapy in Philadelphia in the summer of 1982. For that reason he thinks he was writing that protocol in the Fall 1981. His dissertation was conducted with the cooperation and support of Aaron Beck (note, ACT was never "at war" with Tim Beck!) and was defended in 1984 under the title "Cognitive Therapy of Depression: A Conceptual and Empirical Analysis of Component and Process Issues" (ProQuest Dissertations Publishing, 1984, 8509189). Incidentally in the context of the recent move toward ACT as a form of "Process-Based Therapy" it is worth noting the title of this first randomized controlled clinical trial on ACT! ACT was *always* a form of process-based therapy -- it's just now we have a name for that view.

The pain study was put in a file drawer, not because it was bad but because it was good, and Steve thought it would be more prudent to work out the issues of process measures, components, basic principles of rule-governance and relational framing, and philosophy of science issues before emphasizing outcomes alone.

That took far longer than anyone thought at the time and thus the pain study was only published in 1999, 17 years after it was finished: Hayes, S. C., Bissett, R., Korn, Z., Zettle, R. D., Rosenfarb, I., Cooper, L., & Grundt, A. (1999). The impact of acceptance versus control rationales on pain tolerance. *The Psychological Record, 49,* 33-47.

An unfortunate historical note is that the pain manual was lost -- although Steve remembered seeing it more than once over the years, it was simply not in Steve's box of materials about the pain study when ACT began to be studied again for outcomes in the late 1990's. This meant that the two labs that were first interested -- Dermot Barnes-Holmes and Bryan Roche -- had to wander in the wilderness trying to replicate it. Both labs eventually did, but it took years to dial in the preparation, so progress was needlessly delayed and effort was wasted. That is

one reason why finding the actual manual (25 years after its publication and 42 years after the study itself!) is of such historical importance.

Rob Zettle has written a history of this era and later eras of ACT development. The article describing these early days and more is attached below.

Steven Hayes February 29, 2024 - 8:23pm