Instructor’s Manual

for

ACCEPTANCE AND COMMITMENT THERAPY: FACING THE STRUGGLE

with

STEVEN HAYES, PHD

Manual by
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psychotherapy.net
The Instructor’s Manual accompanies the DVD Acceptance and Commitment Therapy: Facing the Struggle with Steven Hayes, PhD. (Institutional/Instructor’s Version). Video available at www.psychotherapy.net.

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Acceptance and Commitment Therapy: Facing the Struggle with Steven Hayes, PhD

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS
Encourage viewers to voice their opinions. What are viewers’ impressions of what is presented in the interview?

4. CONDUCT A ROLE-PLAY
The Role-Play section guides you through exercises you can assign to your students in the classroom or training session.

5. HAVE STUDENTS OR TRAINEES WATCH OTHER TITLES IN THIS SERIES WITH SAME CLIENT
This video is part of a six-video series, Acceptance and Commitment Therapy with Steven Hayes, PhD. Watch the other videos in the series to give students the complete clinical picture of Acceptance and Commitment Therapy, demonstrated by a wide variety of clinicians and clients.

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Related Websites, Videos and Further Reading prior to or after viewing.

6. ASSIGN A REACTION PAPER
See suggestions in the Reaction Paper section.
Perspective on Videos and the Personality of the Therapist

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: The personal style of therapists is often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personality. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.
Acceptance and Commitment Therapy: A Summary of Approach

Acceptance and Commitment Therapy or ACT (pronounced as a word, not as separate initials) was developed in the late 1980s by Steven Hayes, Kelly Wilson, and Kirk Strosahl, and is considered part of the third wave of behavioral therapies—along with Dialectical Behavior Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT) and Mindfulness-Based Stress Reduction (MBSR)—all of which place a major emphasis on the development of mindfulness skills. It is an empirically-based therapy using acceptance and mindfulness strategies along with commitment and behavior-change strategies to increase psychological flexibility.

ACT is based on relational frame theory (RFT), a comprehensive theory of language and cognition that is an offshoot of behavior analysis. ACT differs from traditional cognitive behavioral therapy (CBT) in that rather than trying to teach people to better control their thoughts, feelings, sensations, memories, and other private events, ACT teaches them to notice and accept them—even previously unwanted ones. ACT helps the individual get in contact with a transcendent sense of self known as “self-as-context”—the self that is always there observing and experiencing but is separate from one’s thoughts, feelings, sensations, and memories. ACT aims to help the people clarify their personal values and take action on them, bringing more vitality and meaning to life and increasing psychological flexibility.

Western psychology has typically operated under the “healthy normality” assumption, which states that by their nature, humans are psychologically healthy. ACT assumes, rather, that the psychological processes of a normal human mind are often destructive. The core conception of ACT is that psychological suffering is usually caused by experiential avoidance, cognitive entanglement, and resulting psychological rigidity. These lead to a failure to take needed behavioral steps in accord with core values. As a simple way to summarize the model, ACT views the core of many problems to be due to the concepts represented in the acronym, FEAR:
• Fusion with your thoughts
• Evaluation (often negative) of experience
• Avoidance of your experience
• Reason-giving for your behavior

And the healthy alternative is to ACT:
• Accept your reactions and be present
• Choose a valued direction
• Take action

Core Processes and Treatment
The root goal of ACT is a change in one’s internal self-talk and one’s external behavior. ACT teaches clients to observe themselves having feelings and then accept those feelings, as fighting or avoiding emotions worsens their effect. ACT then focuses on a shift from the content of an experience to the context of an experience. ACT distinguishes between acceptance of things that cannot be changed—like our history—and those that can, such as leaving an abusive relationship.

There are six core processes of ACT:

1. Cognitive defusion: Learning to not be so controlled by one’s own thoughts, but rather to recognize thoughts without getting caught up in their content.

2. Acceptance: Allowing one’s thoughts and feelings to come and go without struggle and accepting the reality of one’s circumstances.

3. Contact with the present moment: Mindful awareness of the present on a moment-to-moment basis.

4. Self-as-context (observing self): Learning to access a continuity of consciousness that is unchanging—the “observing mind” or “observing self.”

5. Values: Defining what is most important to a person.

6. Committed action: Setting goals based on values and committing to them, despite contrary thoughts or emotions that might arise.
A basic ACT treatment using the six processes above might look as follows:

1. **Examine avoidant behaviors.** Clients have often struggled at great length with their problems and frequently enter treatment with a goal of eliminating painful thoughts or emotions. Avoidant behaviors are usually examined first. For example, what does the client do currently to avoid negative thoughts or feelings, or to escape them when they arise?

2. **Examine strategies that have not worked.** In struggling with and focusing on the presenting problem, clients often make the problem appear even worse. ACT helps clients differentiate between unpleasant inner experiences (feelings, thoughts, sensations) and psychological problems. Clients often confuse the two and assume that being healthy means eliminating these negative experiences. The ACT therapist works to challenge this belief by asserting that healthy, normal brains churn out negative feelings and thoughts all throughout the day. In other words, it’s just what the brain does. One’s job, then, is not to eliminate these feelings and thoughts—which is impossible—but to establish a more healthy relationship with them so they do not control or govern one’s actions. *(Cognitive Defusion, Acceptance)*

3. **Identify self-as-context, distinguished from self-in-content.** Similar to many mindfulness practices, clients are taught to get in touch with an observant self that watches and experiences yet is distinct from one’s inner experiences. This is done using a number of experiential mindfulness exercises, both in session and out. *(Contact with the Present Moment, Self-as-Context)*

4. **Determine values and choose goals.** Clients are taught the difference between deeper values (family, health, etc.) and the goals that might help them work towards those values (spend an hour a night exercising with the kids, etc.). Therapists help clients establish the willingness to regain control of life, rather than simply trying to control thoughts and feelings. A great deal of emphasis is placed on defining willingness and helping the client establish it. Clients are taught to take action towards their values, even when they “don’t feel like it.” For example, one may not feel
willing to go to the dentist, but one might willingly go anyway. *(Values)*

5. **Focus on commitment.** Clients commit to ending the war with their own emotional states. Clients integrate the practices of defusion, mindfulness, and acceptance into their daily lives. Clients continue to move forward on goals that are in line with their values and learn to take action on these goals in spite of sometimes having negative (and normal!) thoughts or feelings.

**Techniques Used in ACT**

ACT therapists are active and engaged in sessions. ACT frequently includes experiential work with the client in the therapy room, as well as “homework” between sessions.

ACT therapists have generated a tremendous number of metaphors for use with clients in explaining the various tenets of ACT, many of which can be found online or in the large number of published ACT guides for therapists. ACT also uses mindfulness strategies derived and adapted from a number of meditative traditions. As used in the therapy room, these strategies are stripped of any religious context and are used solely to help clients make contact with their “observing self” and practice mindfulness in various moments throughout the day.

ACT draws on experiential work guided by therapists in session, including techniques that “physicalize” negative thoughts or feelings, language exercises to help clients disconnect from the content of thoughts, and imaginative experiences led by the therapist (envisioning yourself at your own funeral, seeking wisdom from much older or much younger version of yourself, etc.) to help clients internalize parts of the model and/or define values and goals more clearly.

ACT therapists sometimes use worksheets and written assignments to help clients clarify their deeper values and set goals based on these values. As with CBT, clients might also use worksheets to track their progress and better understand any resistance or setbacks, so the therapist might help them identify problem areas and solutions.
Evidence:
ACT is considered an empirically validated treatment by the American Psychological Association with the status of “Modest Research Support” in depression and “Strong Research Support” in chronic pain. ACT has shown evidence of effectiveness in randomized trials for a variety of problems, including chronic pain, addictions, smoking cessation, depression, anxiety, psychosis, workplace stress, diabetes management, weight management, epilepsy control, self-harm, body dissatisfaction, eating disorders, burn out, and several other areas. ACT has more recently been applied to children and adolescents with good results. ACT has also been proposed for work with couples.

ACT is an actively growing therapy with a large number of clinicians and researchers regularly contributing new exercises and techniques. Though the basic principles and processes remain unchanged, the ACT community is eager for the continued development and innovation clinicians provide. If you are interested in further study, there are a number of helpful books and articles available online. As a still relatively new therapy with a growing research base, ACT is likely to be used in more and more settings as its efficacy becomes known and its popularity increases.


Facing the Struggle
In this video, you will first meet Steven Hayes, PhD, founder and originator of the ACT model, who will take you through the “Hexaflex” model, which outlines the six aspects of psychopathology as well as the core ideas ACT theory.

We see Hayes in an introductory session with Jerry, a client suffering from social anxiety. Hayes addresses the unique issue of informed consent in ACT, demonstrating how informed consent might include eliciting a client’s willingness to be confused or uncomfortable in the process of learning these very new tools. Jerry is reluctant to contact his own emotions and, as Hayes describes, he is “dug in” to his usual ways of thinking and behaving. Hayes has to work a great deal on creative hopelessness, helping Jerry see how his tactics have not been
working and opening him to the possibility of trying a new and different approach. Hayes gives commentary throughout, explaining why he uses particular interventions and their timing.

From there, you will watch Hayes and other ACT therapists work with various clients, including a mother with depression, a teacher with panic disorder, and a woman with chronic pain. You will learn the interventions used in the early stages of ACT therapy—such as psychoeducation and eliciting clients’ willingness to engage in the work of ACT—as well as how you might incorporate your own personal style into the model. Both clients and therapists new to ACT can feel confused at this stage of therapy, but this is a normal part of the process. Watching the other videos in the series leads you more deeply into the theory and application of ACT, so that by the time you watch the sixth video, “Psychological Flexibility,” you will have a complete understanding of all of the stages of ACT therapy.
Discussion Questions
Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. **Intro to this Video:** What do you think about the idea that people often feel they have to control their thoughts, feelings, and internal experiences in order to succeed in life? Does this seem like a helpful idea to you? Have you seen this to be true for yourself or others?

2. **Hexaflex:** Does the Hexaflex model of psychopathology resonate for you? What leaves you confused, or with questions and doubts? How does ACT appear similar or different from models you have learned in the past?

3. **Informed Consent:** What do you think of the idea that you need to conduct a different informed consent conversation when using the ACT model versus other models? Do you agree about the necessity of preparing a client for the possibility of being confused or upset during the course of therapy? What advantages or disadvantages do you see to doing so? What are your thoughts on garnering commitment for a certain number of sessions, as Hayes does?

4. **Techniques:** Hayes uses a number of specific techniques in ACT, some of which come from Solution Focused Therapy. What is your opinion of Hayes’ use of a version of the “miracle question” in this early session? What are your thoughts on the scaling questions Hayes uses? What about his use of the war metaphor? Do you think these techniques are helpful? Why or why not?

5. **Facing the Struggle with a “Dug-In” Client:** What do you think of Hayes’ choice not to challenge his client’s reluctance to discuss his emotions? Are there ways you might have worked differently?

6. **Creative Hopelessness:** What are your opinions on the idea of “creative hopelessness?” How did you feel about Hayes’ exploration of the client’s history of trying to solve his problems? What are your thoughts on Hayes’ various ways of approaching this client’s resistant behaviors? How did you find his encouraging the client to recognize that he needs to give up trying to solve his problem?
Would Hayes’ interventions and explanations leave you confused as a client? Do you believe this is his intention? If so, why? What do you make of the various metaphors Hayes uses with this client? Do you find the client to be as psychologically dug-in as Hayes describes?

7. **Psychoeducation and Therapy Process:** What are the differences you notice in Hayes’ approach with this second client? Given this client’s relatively short struggle with anxiety, what are your thoughts on the ways Hayes assesses for willingness and creates motivation?

8. **Relational Work:** What were your thoughts on the brief relational work incorporated by the Australian ACT therapist? How would you compare and contrast Hayes’ style versus the style you just saw (albeit briefly) from this new ACT therapist?

9. **Presenting a Valued Alternative in Chronic Pain:** What are your thoughts on the approach of this final ACT Therapist? Where in her work might you choose different techniques or interventions? What are your thoughts, in general, about the initial-stage ACT approach of helping a client see (or agree) that they have done everything they possibly can do and now must try something entirely new and different (creative hopelessness)?

10. **Personal Reaction:** How would you feel about having Hayes, or another therapist seen here, as your therapist? How would you feel about having an ACT therapist in general, in this early stage of therapy? Do you think Hayes or another ACT therapist could build a solid therapeutic alliance with you? Would one of these therapists (or the ACT method) be effective with you? Why or why not?
Role Plays

After watching the video, divide class into groups of two, consisting of one therapist and one client. After each role-play, have the pair debrief with one another, then switch roles and do the role-play again in the opposite position. Let participants debrief again in their pairs, then come back to share insights and experiences with the whole group. These role-plays can also be done in groups of three, with one person acting as observer and offering their insights, then rotating into one of the active roles. You may also do role-plays in a fishbowl environment, with a pair working in front of the class, and the class offering feedback at the end, or suggestions to the therapist during the role-play itself.

The students or trainees may do one or more of the following role-plays:

1. Have one participant role-play that he or she is a client coming for their first session with an ACT therapist. Have the ACT therapist help the client explore the problem that brought them to therapy, and explore all the methods they have used to fix, control, or avoid the problem in the past. See if the therapist can get the client to agree that everything they have tried has not worked, so they might be willing to try something completely different and new.

2. Have one participant role-play that he or she is similar to the first client in the video, who had trouble accessing or discussing emotional content (private experiences). Have this participant instead stay more in the logical language of thinking, rather than feeling. The other participant will role-play a therapist helping this client access and describe their feelings, as well as their thoughts. The goal is simply to help the client gain access, even briefly, into their emotional life; the therapist should not aim for a massive catharsis or emotional release. Professors might want to have students watch Hayes again in this segment and feel free to use interventions similar to his, if desired.

3. Have one participant role-play that he or she is a client, while the other is an ACT therapist explaining the Hexaflex model
to a new client (or to a fellow clinician, if preferred). Allow the therapist to look at the model while working. This is not an exercise in memorizing the model, but in demonstrating understanding by attempting to express the model in one’s own words.
Reaction Paper for Classes and Training

Video: ACCEPTANCE AND COMMITMENT THERAPY: FACING THE STRUGGLE

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.

- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

- **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about the ACT approach? What stands out to you about how ACT therapy works?

2. **What I found most helpful:** As a therapist, what was most beneficial to you about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. **How I would do it differently:** What might you do differently from Hayes when working with clients? Be specific about what different approaches, interventions and techniques you would apply.

5. **Other Questions/Reactions:** What questions or reactions did you have as you viewed the therapy sessions with the ACT therapists? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

WEB RESOURCES

“Acceptance and Commitment Therapy: Model, processes and outcomes” (article by Hayes, et al)

http://institutoact.es/descargas/b04/b043.pdf

Association for Contextual Behavioral Science

http://contextualscience.org/act

Steven Hayes

http://www.stevenchayes.com/

Act Mindfully Training in Acceptance and Commitment Therapy


“Embracing Your Demons: An Overview of Acceptance and Commitment Therapy” (article by Russell Harris)

http://tinyurl.com/ctnb2rn

Goodtherapy.org

http://www.goodtherapy.org/Acceptance_Commitment_Therapy.html

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

ACT in Action (6 Video Series)

Existential-Humanistic Psychotherapy with James Bugental, PhD

Cognitive-Behavioral Therapy with Donald Meichenbaum, PhD

Dialectical Behavior Therapy with Marsha Linehan, PhD

Mindfulness for Life: An Interview with Jon Kabat-Zinn, PhD
RECOMMENDED READINGS


Hayes: Welcome to ACT in Action, the six DVD series on Acceptance and Commitment Therapy. Acceptance and Commitment Therapy is an empirically supported psychological intervention that uses acceptance and mindfulness processes, and commitment and behavior change processes to produce psychological flexibility. My name is Steve Hayes. And I’m going to be host for this series.

In the program that follows, we’re going to walk you through some of the major methods and techniques of ACT, and try to show you how you can apply these directly to your clinical practice. ACT is a model, not just a set of specific methods or techniques. And in order to get on top of this model, you’re going to have to access more than just this DVD series.

So I’d caution you not simply to try to apply these techniques directly without further reading or training. But these videos will help you fill in the blanks and show you how to move from a conceptual understanding to an actual application of ACT in work with those who suffer.

You’re going to see in this DVD series a number of different therapists with different styles. We’ve done this on purpose to show you the different ways that this model can fit in to your clinical practice and your clinical style. I encourage you to look at all the DVDs to see the entire package so that you can explore this territory and see what might work best for you in your clinical work.

I do want to acknowledge that at times what you’ll see here might seem a little artificial. In the interests of training, at times we’re going to show you relatively constrained interactions that are deliberately depicting only specific techniques when other techniques might apply. At other times, you’ll be shown a more natural interaction style. It’s only when you see the entire package that you’ll be able to take full advantage of what’s in this DVD series.

So welcome. I hope this is of use to you. And if it is, we invite you to be part of this work, bringing your own best ideas to the open development community that we’ve tried to create. Please let us know
how we can best help you use this material to help you in your clinical work.

You can describe an ACT model using a hexagon, both for the psychopathology side and for the processes that are involved in treatment. If you first look at an ACT model of psychopathology, it begins with the idea that there’s an overextension of human language in which our basic problem-solving skills, using atemporal and evaluative reasoning strategies, get applied to the world within. And as a result, we begin to think that in order to move ahead, in the world of behavior in our lives, we have to control what we think and what we feel.

This leads to the core targeted processes in ACT—experiential avoidance, which is the tendency to try to regulate the form, the frequency, or situational sensitivity of private events as a method of behavior regulation, even when it doesn’t pay off in the form of successful life enhancement. All the elements of ACT are interlinked. Experiential avoidance is clearly linked to the other processes, in particular the one we call cognitive fusion, which is the tendency for our behavior to be regulated by verbal processes in an overextended way. Cognitive fusion refers to the entanglement with our own thoughts, looking to our own thoughts to do much more than they need to in terms of an orientation to how to live our life in a flexible way.

Continuing with the psychopathological side of these processes, language tends to take us out of the present moment. It’s very difficult even to notice what’s occurring in the present as we drift into the past or into the future through human language. Meanwhile what’s going on within us and without us is occurring only now. So we begin to lose contact with that. As we extend this fusion with our thoughts and evaluations, we extend it to an analysis of ourselves, our own stories and our own insides. We become entangled with a conceptualized self, and then ironically seek to defend that self from change, even when what we’re going into therapy for or seeking help for entails change in areas that are entangled with a conceptualized self.

In this set of processes of experiential avoidance—cognitive fusion,
loss of contact with the present moment, and entanglement with a conceptualized self—we put life itself on hold. And in particular, we tend to put away what it is that we really want in our lives, what we really want our lives to be about. And so we lose contact with our values, meaning, and purposes.

The meaning that we give to our lives is put on hold while this useless struggle is fought with a world within. The inability to engage in committed action, to follow a pattern of living that’s connected to what we most deeply want, even in times when it’s difficult or maybe painful, when it reminds you of some things that have happened in the past or raises fears about the future, is the sixth aspect that we target. And the core of all six of these processes, that which they all interrelate with and to, is what we call psychological inflexibility. Naturally, if these are the pathological processes that are targeted in an ACT model, in treatment it’s the inverse of these six processes that we’ll try to implement. Instead of experiential avoidance in ACT, we’ll teach and enhance acceptance skills, which are the skills needed to more fully be able to open up to what’s going on in terms of our own emotions, memories, thoughts, feelings, or bodily sensations. We teach people how to embrace those as a part of living, particularly when they occur in between the person and what it is that they want to be about or to do in the world of behavior.

In the same way that cognitive fusion presents a problem with cognitive entanglement, the flip side, cognitive defusion, presents an opportunity to see language processes unfolding in the moment. These defusion techniques are quite distinct. They’re characteristic of ACT. We tried to use cognitive defusion strategies to teach people to look at symbolic language processes as they unfold in the moment rather than looking from those language processes. This helps people take their thoughts a little less seriously and to see a distinction between the products of the human mind and what it is that’s being referred to by it. That’s done in a number of different ways. We interfere with the normal processes of language. And we teach people to step back and to observe themselves as they think, as you’ll see in this DVD series.
We use a number of methods to try to open people up to contacting more fully what’s happening in the present moment, both in the world without and in the world within. Knowing what you feel, knowing what you think, knowing where you sense is very important to ACT therapists, not because they then become targets for change directly, but because they become sources of information about the aspects of our history that are being brought into the present moment.

Similarly, opening up to what’s happening in the present moment in the world without is important. Knowing what the situation affords, what other people are doing, what they’re feeling, so you can better link your behavior to the opportunities that are afforded by the present moment. Instead of entanglement with a conceptualized self, ACT is going to work to open up contact with a transcendent or contextual self. This is the sense of looking at your experiences from I, here, now. It’s a place from which it’s possible to experience your feelings and your thoughts without threat that would otherwise be there when they’re taken literally, knowing you are you, and the deepest part of you is not going to be harmed by your own experience. We’re going to focus on values in ACT. We’re going to ask people very directly what it is that they want their life to be about, not just in the world of form or particular goals or even behaviors they want to see, but in the sense of purpose, direction, meaning.

We’re going to try to empower people to stand with these deepest desires, knowing full well that the places you really care about are precisely the places where you can be hurt. And so acceptance is linked inextricably to values. Committed action involves building patterns of behavior into larger and larger units. We know from basic research that as you build successful patterns of effective behavior, you become less sensitive to impulses that may bump you off a valued path. And then that may make it difficult to take difficult steps forward that nevertheless are important to your own vitality. And so ACT becomes part of the behavior therapy tradition in using virtually all of the behavior change methods that have empirical support, but being able to integrate them into acceptance and mindfulness and values as a context for working on these behavior change goals.
The core of this model is psychological flexibility, which is the ability to contact the present moment fully and without defense as a conscious human being, engaged in life as it is, not as what your mind says it is, based on what the situation affords, persisting or changing behavior in the service of your chosen values. That’s really the target of ACT psychological flexibility.

In the introduction to this DVD series, I defined ACT as a collection of acceptance and mindfulness processes on the one hand, and commitment behavior change processes on the other that have as their larger purpose increased psychological flexibility. The first four of these processes—acceptance, defusion, contact with the present moment, and a transcendent sense of self—are the acceptance and mindless processes. The four to the right of the hexagon model, contact with the present moment, once again, as a conscious human being, but now connected to your values and engaged in committed action. Those are the commitment and behavior change strategies. It’s called acceptance and commitment therapy because it brings together these two groups of processes. The two in the middle overlap because we’re always acting in the present moment as a conscious person.

So to summarize, these are the basic processes in the ACT model. I’m not going to walk through here the basic research and relational frame theory and behavioral principles that underlie each of these processes. But you do need to know that ACT is based on an extensive, basic, and applied research program that is increasingly showing that each of these processes is psychologically active, even though they’re all interrelated and can’t be fully understood without reference to the other. That’s why ACT is a model, not just a technique, not just a set of methods. It’s an approach. As you explore ACT, you’ll find that this is true. There’s a kind of richness to it that allows a lot of clinician creativity.

The great thing about that is when you understand the model, you can innovate within it, and yet be assured that what you’re doing is empirically supported in the sense that it’s based on principles that have empirical support. The treatment approach that you take is likely to be effective if it’s appropriately targeted, if your functional analysis
to the applied situation is correct. So let’s proceed now to how to do informed consent within an ACT approach.

So let’s examine the issue of informed consent from an Acceptance and Commitment Therapy point of view. It presents certain challenges. It’s similar in what you would want to walk through in the frequency of treatment, confidentiality limits, possible side effects, what the data show, as you might with any process of informed consent. What’s different is that ACT is going to target some of the basic language processes that we use to understand our world, creating a separation between the person and these cognitive processes.

You can’t simply layout ACT and expect the person to understand what it is, because that understanding will be based in the processes that we seek to change, so that person will not really know what to expect in the course of treatment that way. So you have to find more metaphorical or indirect ways to fully inform the individual of what’s likely to occur so that they can make some choices as to whether or not they’re willing to engage in a course of ACT.

In this section, we’re going to walk through this process with a socially anxious, lonely, withdrawn person. We’ll begin to frame the process of obtaining informed consent within an ACT approach.

Hayes: So you’re back seeing a therapist again.

Jerry: Again. I stopped because I didn’t feel that I was getting anywhere.

Hayes: Now is that true with each therapist? Sometimes I felt as though you were getting somewhere.

Jerry: Sometimes it felt at first as if maybe something new was happening. But in the end, things didn’t seem to change really.

Hayes: I think there’s a good point in there. Something new doesn’t happen here. What do you think is going to happen here? Do you know what I’m asking?

Jerry: Yeah. Why should this be more of the same?

Hayes: Right.

Jerry: In a sense, that means that something new should happen.
Something should be different from the experiences before.

**Hayes:** Yeah. And that’s what I want to put in front of you, the possibility of really going for that. I don’t think it’s right just to go into this blind. But it’s hard for me to really fully explain what it is we’re going to do. Because if we’re going to do something really new, it’s going to take a while to create that. You’ve worked pretty hard at this, haven’t you?

**Jerry:** Yeah, over the years.

**Hayes:** How many years has this been going on?

**Jerry:** Eight years.

**Hayes:** And during that time, how much effort do you think you’ve put into it? If you put it on a 1 to 10 scale, is it something where it’s not a central focus? Or it’s become a significant focus in your life?

**Jerry:** It varies in response to certain events or anxieties. I don’t know how much work I’ve put in. I’ve gone through all the motions. I’ve made the appointments. I’ve kept them. I’ve paid the bills.

**Hayes:** Let’s see if I can ask it this way. Would it be fair to say that part of what has been there for a while is that there’s been a sense of struggle with this problem, that you have been trying to figure out a way to outwit it or somehow defeat it or get beyond it. What would your words be? What is the core strategy here?

**Jerry:** I guess to find reasons, to find an answer.

**Hayes:** So to understand it.

**Jerry:** I’m a left-brained person. And I think in terms of solving problems.

**Hayes:** When I ask the question of how much effort, some of your effect is just thinking about it. So you’re thinking about this. Why is it like that? And when you say, I’m not sure I’ve given enough effort, you’re saying, maybe I haven’t really.

**Jerry:** Well, because there hasn’t been a result.

**Commentary:** Often one of the best ways to give a clear understanding of what it is that you’re going to do within ACT
is to use an organizing metaphor, because the metaphor can say a lot without having to literally be unpacked, avoiding the error of describing ACT literally and accidentally creating misunderstanding. In this next section, you’re going to see that done with a metaphor of fighting a war inside your own mind.

Hayes: Now here’s the thing. If we could think about it like this—imagine that you’ve been in a kind of a war, trying to figure out and outsmart and get the reasons, get it all worked out, like a mental war. Like if you had a really challenging problem, like you’re thinking about it. Very much like in school or something, like if you’re given a problem that’s hard to solve, does that feel close to what this is like?

Jerry: Yeah, I think it does, in a way. There’s this problem. And I’m usually good at problem-solving. I tend to think in innate, linear ways. And so I keep wanting to find a way to solve this problem. And what interferes is the fact that the problem is inside. It’s an internal problem. And it’s not something I can put my hands on and deal with.

Hayes: Well, and even that thought, what you just said there, that’s a familiar one, right?

Jerry: Yeah.

Commentary: Now we’re going to carry this metaphor forward and amplify it so that the choice to engage in ACT or not can be fully framed.

Hayes: So instead of going there, because we’ll go there later as to what to deal with, here’s what I want to put in front of you. Suppose we had two possibilities here. One possibility is to try in some other way to do basically what you’ve been trying to do when you’ve seen these other therapists. Conversely, would it be of interest to you if we could find a way of stepping out of that whole form? If we think of this sort of like a war going on, that there’s a battle, and that the normal way that we’ve tried to do this is to try to win that war, get those reasons, figure it out. What I want to put in front of you is would it be of interest to you if we might do here is something pretty different? That what we might do here is find a way to actually leave that war zone? It might still go on. It would be the difference between being inside a battle or being to the side of a battle, watching it going on. In one case, it’s more
like you have to win it before you can start living. Your life is on the line. It’s really important.

Conversely, if you could step out and watch it, your personal investment as to which side’s winning and which side’s up or down may not be so important. And meanwhile, life can happen. And the reason I’m expressing it that way is that it’s not something I can just lay out as a simple formula. We’re going to have to walk through this as to how it is to do that. And so I want you to feel as though this is something you really want to do. But it will be different. So what is your gut instinct on that?

Jerry: I guess, yeah. That sounds different to me. And I’m willing to try.

Commentary: As the person begins to make a choice, we need to continue to help the Client understand what it’s likely to involve. In the next short segment, we will orient the Client to expect this sense of confusion, upset, or disorientation that sometimes comes from altering language processes, once again through the use of a metaphor. This is one of several such issues. So our focus is more on how to work through this kind of thing than it is to present a full list of them here.

Hayes: So here’s some of the things that you have to expect if you’re willing to go in that way. And this is something that I know how to do. And if you wanted to do the other, I could either work with you on that or get you a good referral for that, because there’s a lot of folks who’d want to have another take on how to deal with these anxieties, for example, directly. But if you want to follow this path, there’s a few things you have to expect. One is you have to be willing for things to look confusing, to be stirred up. It’s kind of like if we had mud in the bottom of a glass. If we’re going to try to clean it out and really go after it, the immediate effect is going to be it’s going to look muddier.

Commentary: Now note that many other things could have been put in there. For example, you might predict premature termination, especially if the Client is particularly experientially avoidant. You might predict the emergence of confusion, the urge to understand, and the difficulty of doing that. Now we’re going to proceed to trying
to get a commitment, a therapeutic contract, an agreement that the patient is in charge and yet is committed to go through this process of treatment.

Hayes: What I would like from you is a certain number of sessions. And then we’ll stop. And then we’ll look. And you will tell me. I will not tell you whether or not we’re headed in the right direction. So I would suggest, based on what you’ve told me about your other courses of therapy, somewhere around seven sessions or so, eight sessions, somewhere in there. We’ll stop. It doesn’t mean we’ll necessarily be done. We’ll be able to make that judgment. But between then and now, part of the deal is, even if it looks like you’re going backwards—it’s confusing, you don’t understand it, what the heck, how could this possibly help—that you’re willing to get in here with your sole in the room. These.

Jerry: OK.

Hayes: If you’re willing to do that, I’m willing to walk through that with you, whatever it takes.

Jerry: OK.

Commentary: Among the other things that could have been done in this section, we could have focused more on the up and down quality of progress in ACT, or on the therapist’s commitments and values. Now there’s another aspect of informed consent that we will still need from an ACT point of view, in addition to warning Clients of what it’s likely to be like, and things of that kind. And that is to focus more positively on what therapy is for. This needs to happen. And some of it needs to be front-loaded. Because if it’s not simply about removing pain, getting rid of thoughts and feelings and so forth, when you do you stop and look to see whether or not you’ve progressed, you’re going to have to have some sort of positive guide to go by. If you’re doing ACT in such a way that values work is front-loaded, this is going to be an extensive piece here. But even if you’re not doing that, you need enough values front-loaded that they can be looked at to evaluate progress in a fully pragmatic way which fits with the underlying philosophy of ACT.
I also like warning Clients that sometimes early on ACT can be a bit talkie, because you’re trying to change how the person interacts with their own psychology. And this is my own particular style of doing ACT. So it leads to a more active role for the therapist. But I want Clients to understand that this is a temporary process. And increasingly, as it goes along, they’re going to have to take more and more responsibility for the content of these sessions.

Hayes: So there’s only two other things that we really should have before we go on. One is just, not really a warning, but just an acknowledgement. For us to really do something that different, I’m probably going to have to be a little more controlling or a little more chattery, or a little more active than I ultimately want to end up being. Because we have to get some new things in the room here. And I think it’ll go more quickly if you allow me to do that. And what I want you to know is probably five, six sessions out from here, the quality of this is going to change. So if you’re thinking, “man, he’s talking a lot,” you’re right. I’m talking a lot.

The other is I said we’re going to stop and kind of look. What is the metric that we really want? If you really were making progress here—and I’m going to artificially do something. If we take off the table for now, for reasons that we’ll get into later, anxiety. Imagine that just, poof. Magically that’s solved. How are going to know that things are really moving forward? What are we going to see? What would you be seeing? What would I be seeing?

Jerry: Well, some degree of comfort, I guess, in what we’re doing.

Hayes: And outside of here? If I weren’t so anxious, what I would be doing is?

Jerry: Oh, for me?

Hayes: Yeah.

Jerry: I’d be feeling better. I would be probably more socially involved.

Hayes: So we’ll see some change in actual engagement, connection, involvement. Is that the territory?

Jerry: Hopefully, yeah.
Hayes: So when we stop and look, we can see whether or not your gut instinct is that you’re headed towards that, and use that as a compass to see whether or not we’re going in the right direction.

Jerry: Yeah.

Hayes: Good. Let’s do it.

Jerry: All right.

Commentary: And now we are going to walk Jerry, a chronically, socially anxious, withdrawn, lonely person, gradually into the process of facing the struggle that he’s been in. You should note the focus on avoidance and how it shows up in different ways.

There’s a sense of defusion, which is there from the very beginning in ACT. There’s an attempt gradually to open to the level of experience, and to take some care in avoiding rigid cognitive entanglements and formulations.

Hayes: So why don’t you just characterize for me the core of some of the things that you’ve been struggling with.

Jerry: A part of the problem is that in encountering new people or situations, I can appear to be comfortable in a glib kind of way. And yet I don’t really want to make contact. I don’t want to get involved beyond just the mechanics and the pleasantries of establishing myself in some way.

Hayes: So you’re pulling back?

Jerry: Yeah.

Hayes: And what are you feeling when you’re pulling back?

Jerry: Just a sense of avoidance, that I don’t want to complicate my life. But it’s OK to go through the motions, to pretend that I’m really there.

Hayes: And in addition to the—would it be fair to call it a sense of numbness, or disconnection? I’m trying to get to what it actually—

Jerry: OK. Disconnection—not numbness so much as the sense that I’m putting up a good front, but I’m faking it. That whoever this is, whoever these people, whoever this person is that I’m encountering, if
they look too closely, there’s nobody home. And so I put up barriers.

**Commentary:** You can notice how this is quite heavy, mind-y, talky. We’re going to need to go down to a deeper level gradually over time. It’s worth noticing how hard it is for this Client to go to the level of emotion and to talk about it directly.

He most easily moves up to the level of thoughts. Pushed for feelings, he refuses to go there, almost until there’s no alternative. Now that’s not going to be directly challenged at this point. But it will be noted and filed away. We’ll come back to it at a later time. But it’s obvious in the very beginning that it’s occurring.

**Hayes:** And so when you’re pulled to avoid those social situations, what’s going on with you inside? What are you feeling, for example?

**Jerry:** I guess the first thing I feel is why am I here? Why did I put myself in this situation where I’m going to feel uncomfortable and vulnerable?

**Hayes:** So you start having some thoughts like that of judgmental, self-critical?

**Jerry:** I don’t know what I expected to happen that would be any better. But I wish I just wasn’t there.

**Hayes:** OK, good. And what else? Anything else going on for you in these moments?

**Jerry:** Well, I guess what follows on that is how do I get out of here? Can I say whatever I have to say and then find an excuse to leave?

**Hayes:** So you start feeling pulled to do something. And if you were to do those, if you did get out of there, what’s going to happen? And when I get out of here, I’m going to?

**Jerry:** Go home.

**Hayes:** And then I will?

**Jerry:** Turn on the TV, shut out the world.

**Hayes:** And I will feel?

**Jerry:** Safer.

**Hayes:** So a sense of danger.
Jerry: Yeah.
Hayes: Fear?
Hayes: Yeah, people. OK, good.

Commentary: I clearly could have pushed harder on feeling there. But early on, this is not necessary. It’s pretty clear what the process is. And it’s going to be a core focus of the work later on. In this next piece, I’ll suppose that we’ve done enough assessment of this kind to move on into a phase that’s commonly called creative hopelessness. Creative hopelessness is a phrase that sometimes has created some problems because it sounds too much like an emotion. Oddly the emotion, typically, by the time you’re finished with this process, is not hopelessness at all. It’s hopeful. You really need both words to understand what it is that we’re talking about. It’s a kind of opening up that occurs when there’s a sense of validation, opportunity, new horizons. It comes from letting go of your attachment to the things that you’ve been doing that your direct experience tells you have not been working.

So really, in this phase of ACT, what we’re talking about is a kind of self-validation fostered by validation of the Client’s experiences directly of workability. This can be seamlessly linked to intake and assessment work. And you can notice how easy it is to transition naturally into this segment. It’s also worth noticing the use of humor, defusion, and a sense of acknowledgement and validation—and all of that in the context of a focus on workability.

Hayes: What have you tried to do to solve this problem? Not just therapy. I’m asking also just in general.

Jerry: Exploring the past.

Hayes: Why don’t we just go one at a time. So what would be the kind of thing that would be very much a Jerry-like thing to do when you explore the past? What does that look like?

Jerry: I guess looking back at situations in which I felt more comfortable, when I was younger.
Hayes: So you can compare this to then. OK, good.

Jerry: And again, trying to—

Hayes: And this is usually not as good as then, I imagine. Then was better.

Jerry: Then was better. And again, in making that comparison, I guess, again, the approach of problem-solving. What was really better?

Hayes: Yes, you’re trying to figure it out. You really want to know that. Is that like you? You’ve got a mind that really wants to understand.

Jerry: What’s changed? Why is now worse than—

Hayes: Yeah, why is that? So it isn’t just that you’re exploring the past just aimlessly. You’re exploring the past to try to understand it.

Jerry: Look for clues.

Hayes: Look for clues, like a detective almost. And how has that worked for you? How does that whole process—let’s just focus just on this one thing. Walking through the past, how has that worked for you?

Jerry: Well, sometimes I’ve thought that there were logical connections that made some sense intellectually. Never changed what’s happening now.

Hayes: So you’ve made some connections. Might even have been some—well, is it fair to say some fun in there, some entertainment, some interest? I mean, there’s some interesting things you probably thought about.

Jerry: Yeah.

Hayes: So it wasn’t that it didn’t have any positive qualities.

Jerry: No, it looked promising.

Hayes: It was hopeful.

Jerry: Yeah. And so I could do a little mental narrative about how things were then, and what may have changed.

Hayes: But then I want to come down to this point. Here you are seeing a shrink again. So in the grand scheme of things, would you say
that this problem is becoming smaller and smaller, less and less important?

Jerry: No.

Hayes: Or it’s becoming bigger, more central, more enmeshed?

Jerry: And that it’s more persistent.

Hayes: More persistent.

Jerry: And because I haven’t found satisfactory answers, it becomes more pressing, more demanding.

Hayes: So here’s the thing. When we say something like this, minds don’t like it, because there’s always two sides to every story. But let’s just come down to the simple reality, is that your experience has told you something. That when you go back and try to figure it out in the past to get to the why, although there’s some positive things in there, bottom line, it doesn’t seem as though it’s delivering the goods. Is this the kind of life that you want to live? The life you’re living now, is it the kind of life you want to live?

Jerry: No, I want to change it.

Hayes: So bottom line, would it be fair to say is that apparently that’s not, so far, an ultimate solution?

Jerry: Yeah, it’s like you can’t go back. You can’t recreate.

Hayes: So let’s put that one off to the side. It’s kind of interesting. But it doesn’t seem to be ultimately a solution. Some positive things. What else? What else have you done to solve this problem?

Jerry: Well, just kind of exercises to ostensibly reduce the anxiety—meditation of one kind or another, physical relaxation.

Hayes: Relaxation, good. You bought the tapes.

Jerry: Yeah.

Hayes: You have the tapes.

Jerry: And those, in a sense, while they’re reassuring or comforting, I guess, it doesn’t seem to carry over very much into real life situations.

Hayes: So here’s the thing. What we want to do is we want to come
down to what your actual experience is, because there’s a whole lot of voices out there—your own inside your head, but from many places saying what’s supposed to work. What I want to get to is what your actual experience has been, so inside the various things you’ve done to try to meditate and relax. And there may be some value in there. It sounds like there’s some positives in there for you. Nevertheless, your experience is telling you something.

Jerry: Yeah. In real situations, where I’m confronted with new people, new situation, I’m not relaxed.

Hayes: So if we had to go just with what your experience is saying, would it be fair to say that, bottom line, those things have not delivered the goods?

Jerry: They haven’t solved the problem.

Commentary: You could see at the end there how not being anxious and being relaxed has been the focus of the struggle. And that’s really the problem, from an ACT point of view. But we’re not going to go there yet. This Client’s not going to be moved easily. But instead, we’re going to stick with the same strategy. In this next section, it’s worth noticing the use of defusion, which will be used continuously throughout. And also notice how I goose his mind just a little bit. I begin to identify the process that he uses to stay in his head and actually begin to point to it.

Hayes: So let’s just put that one. Now we got two of them out there. What else?

Jerry: Well, maybe role-playing.

Hayes: Pretending.

Jerry: Pretending.

Hayes: Maybe you could act your way through this.

Jerry: But that’s a prepared situation that’s sort of predictable and with confronting someone who I know is going to be there, or that I can somehow relate to.

Hayes: So you do that when you know?
Jerry: Yeah, with a role-playing therapist or partner. But again, it’s not the real thing. It’s not confronting somebody—

Hayes: Oh, I see what you mean. In organized role-plays with your partner or therapist, you try to play out how would it look if you really—OK.

Jerry: But that’s a synthetic situation. In a situation like that, I’m willing to be accessible to, or to be exposed to that person, because that’s the function.

Hayes: Got it.

Jerry: But it doesn’t change the situation.

Hayes: So if you were to go just with what your direct experience is, not what you’ve been told or what you believe or what your mind tells you, would it be over here with these other two?

Jerry: Yeah, I think so. Because it doesn’t apply, again, to a real, spontaneous confrontation with someone new who just might have a can opener into my mind.

Hayes: Right, OK. What else? We’re getting a little row here.

Jerry: Wow.

Hayes: What is your mind doing right with what I’m asking you?

Jerry: It’s sort of skimming back in terms of therapies. I don’t know what else really has been relevant or irrelevant to this process.

Hayes: I’m interested, though—I was asking the question, what is your mind doing right now? Why do you think I’m asking?

Jerry: Is this a written test? You want an essay? Multiple choice?

Hayes: Are you trying to figure out the answers to the test?

Jerry: Yeah, trying to identify other therapy experiences that I can somehow relate to you. And nothing else—

Hayes: But not just even that. And if you were able to do that really well, you’re here seeing a new shrink, right?

Jerry: Right.
Hayes: And I haven’t exactly told you what we’re doing in here. Did you notice?

Jerry: That’s true.

Hayes: Other than some broad metaphor. And here we’re sort of walking through this. So what is your mind doing? What’s the purpose of this? What’s the purpose of this?

Jerry: What are you selling me?

Hayes: Yeah, what am I selling you?

Jerry: Because we’re crossing out these other attempts.

Hayes: This is one thing I want to make sure, 100%, you’re with me on this. Your experience you’re telling me is crossing them out.

Jerry: Yeah.

Hayes: If that’s not true, then you don’t let me ride over this. Because I don’t want to cross out anything that your heart and soul doesn’t cross out because you lived through it. You with me on this?

Jerry: Well, sure. I can acknowledge those experiences for what they were. But it still comes down to the fact that they have not solved the problems for me.

Hayes: And as I ask this, are you trying to figure out what this is about, what we’re doing right now? I just had that sense.

Jerry: Yeah. Yeah, again, it comes back to what’s going to be different this time.

Commentary: And so you’re seeing more of the same. But we need to be patient. After a bit more, I’m going to try to close the deal. The focus here is going to be on workability, the Client’s direct experience, defusion, and validation. And finally, he will begin to clear the field.

Hayes: And let’s just take that one. Do you find your mind going there? What’s going to be different this time? Probably not just in therapy. In fact, didn’t you say something like that, when you go into a social interaction? I believe you told me what comes up in your mind is, what’s going to be different?
Jerry: Yeah. Yeah, yeah. That maybe this time things will be more comfortable.

Hayes: Yeah, exactly. Let’s look at that one. Let’s say that whole process of wondering, of wondering is this the time it’s going to be more comfortable? And almost, is there a sense of hope in there?

Jerry: Yeah. Yeah, keep trying.

Hayes: Keep trying?

Jerry: Yeah.

Hayes: That goes on the list, doesn’t it?

Jerry: Sure.

Hayes: Because you haven’t given up. It’s not like you’ve walked away from people.

Jerry: No. And again, it’s kind of like looking back in time. Because there was a time when I could be comfortable in new encounters, new situations.

Hayes: So that ends up being like the other one. Let’s understand.

Jerry: So there’s the hope that maybe out there somewhere there is a situation that—

Hayes: And even coming to see me, that’s part of that move, isn’t it? And maybe I’ve got something up under these sleeves here. But yet, so far, would we have to say that even that one is over here in this list? It’s kind of like the first one, frankly.

Jerry: Yeah.

Hayes: I think we just need to look at this directly. It’s kind of like there’s four of use in here. There’s you. There’s me. There’s your mind. And there’s my mind. And the problem here is our minds are listening, talking, analyzing, et cetera. But I want to get down to the two people here and what your actual experience is. Because you’re telling me that these things have not delivered the goods for you. Like no bluff, just between you and the person in the mirror, this is not it. Suppose it were the case not just that it hasn’t, but that it can’t. You know that sense that you have? Don’t let me put words in your mouth.
But there’s a sense in here that you’re kind of stuck on this problem?

Jerry: Yeah.

Hayes: What if it were the case that really what’s going on here is that you are stuck on this problem. Watch what your mind’s about to do with what I’m saying. Just watch what your mind’s about to do with this. Go ahead and say what you’re about to say. But just also watch it.

Jerry: As a problem-solver, I don’t like to admit that there’s a problem I can’t somehow find a solution to. But maybe there are problems that can’t be solved.

Commentary: But even now, you can sense that he’s still attached and entangled. So even that will go on the list. As we gradually begin to clear the field more and more, I’m trying to orient him towards something that is truly new.

Jerry: At some point, maybe I have to give up.

Hayes: Interesting. Have you tried to do that before?

Jerry: No, not really. No, I mean, there have been periods of time when I’ve just avoided situations—

Hayes: That is a kind of giving up.

Jerry: —that are threatening. But then sooner or later, I want to challenge it again.

Hayes: So do you hear me saying right now that I’m suggesting that maybe this is an unsolvable problem and you need to give up? Because you notice, I didn’t say that.

Jerry: Well, it raises that possibility.

Hayes: Except, I do want to be clear. I didn’t say that.

Jerry: No, you didn’t. You just asked me.

Hayes: Look, if you always do what you’ve always done, you’re always going to get what you’ve always got.

Jerry: That’s very basic.

Hayes: Moms Mabley.
Jerry: Logical principle.

Hayes: You’ve been going through one after another, after another. And even in this moment, as I say this, your mind’s trying to figure this out. Is that fair?

Jerry: Yeah.

Hayes: Is that like you?

Jerry: Yeah.

Hayes: So that’s probably not where we need to go.

Jerry: No

Hayes: If it’s like you, you’ve already done that. If that were it, you wouldn’t be in here seeing me. You said it. One of the first things you said to me when I started to say we were going to—you said, it’s going to have to be something new. Figuring it out, is that new?

Jerry: No.

Hayes: No. So let’s not do that. Can we at least agree that we’re not going to do more of what has led here?

Jerry: Yeah. That implies there’s something other to do.

Hayes: I hope so. I hope so. But maybe not what’s coming up right now. There’s for of us here. There’s you. There’s me. There’s your mind and my mind. What your mind is giving you. Would it be fair to say this? You’re a pretty logical person. Have you tried to do the things that your mind has told you? It’s told you a lot of things. Isn’t it fair to say that you’ve been listening and following its advice? Not always, not always. But it’s not like you’re just.

Jerry: No.

Hayes: No. You’re thinking. You’re reasoning. You’re planning, and trying to figure it out.

Jerry: Trying different tools.

Hayes: Trying different tools, exactly. So maybe that is another one of these.

Jerry: Yeah.
Hayes: And what you’re thinking right now, listening to me right now, maybe that is another one of these. Maybe what you hear me saying right now is absolutely not what I’m saying right now. Because what you’re hearing me say right now, is it brand new?

Jerry: No.

Hayes: With me on this? So what are we going to do? What are we going to do if nothing we can do will do?

Have you tried the logical, reasonable, sensible things?

Jerry: Yeah. I thought so.

Hayes: Isn’t that this list?

Jerry: Yeah.

Hayes: And look at where it’s led.

Commentary: You see how he becomes confused. I haven’t always saved him from that. I’ll just watch what he does with it, and watch how he keeps looping back to an avoidance strategy, a way of dealing, really trying to get rid of his own experiences. The Client becomes perplexed. It seems important to open up to that sense of confusion when he does, rather than viewing it as a barrier, and focus instead on issues of workability. He might notice how defusion opens up new territory. But then the mind comes behind it and tries to turn it into more of the same. And so there’s this quality of one step forward and a half step back that is characteristic of all of the early work that we’re likely to be doing in this part of ACT, as the mind grapples with something that truly is beyond the capacity of the mind to understand, literally.

Hayes: So how are you feeling just hearing all this, looking at all this?

Jerry: I guess I’m still looking for something new. Like, what have you got?

Hayes: Yeah, exactly. So there’s a pull. Well, is it fair to say your mind’s pulling out into the future, like what’s he got here? Does he have something new for me?

Jerry: Right.
Hayes: Except it’s worth noticing that that’s another one. We already went through the list, right? That would be on the list, wouldn’t it?
Jerry: Yeah.
Hayes: It’s pretty familiar, isn’t it?
Jerry: Right.
Hayes: That’s kind of a Jerry thing.
Jerry: Another remake of the same old movie.
Hayes: Yeah, another scene of the same movie.
Jerry: So I guess perplexed is the word. All of the forms of thinking about it are not fruitful. So there’s got to be a way of not thinking about it that somehow makes sense. Now I don’t know what that is.
Hayes: And it’s worth noticing even that is another round. That’s another scene of the movie. It’s clever, though. It’s good. It’s good. But then I’ll not think about it. But of course, we’re thinking about not thinking about it. You were saying the word perplexed. And I think you used the word confused a little earlier. Is it OK to feel that? What do you feel like to be with that?
Jerry: It feels OK on the assumption that there’s something out there that will clarify things.
Hayes: As a temporary state of affairs, if it’s removed quickly.
Jerry: Or sooner or later.
Hayes: The Greeks, when they built their temples, as all cultures did, they usually put them high. I don’t know any that put them low. They put them high. I suppose the metaphor is, you get up, you can see. And they usually have a lot of steps to get there. And the ones that were really important had a lot of steps, a lot of effort to get there. And right down at the bottom were these scary creatures. They still have it. If you go to the Supreme Court, you’ll see these lions. Supposedly. I don’t know if the story’s apocryphal. But the one on the left was called paradox. And the one on the right was called confusion.
Jerry: Interesting.
Hayes: So maybe it’s something like that. Maybe confusion is not
a bad thing, if you’ve done the logical, reasonable, sensible, normal things, and here we are seeing another shrink. You ever get the sense that you’re kind of in a rigged game?

Jerry: Yeah. Sometimes I just get the feeling that none of you guys know anything more than I do. Sometimes I get the feeling that maybe my particular problem, my particular discomfort is, in some way, different or unique. And you just don’t have the experience to deal with it. It’s frustrating.

Hayes: So you’re a unique case. And we just don’t have the knowledge that—

Jerry: Maybe.

Hayes: And in there is that if we did have the knowledge, if we knew how to figure it out—you’ve been trying to figure it out. If we knew how to figure it out, we’d know what to do.

Jerry: I need somebody smarter than me.

Hayes: Right. But there’s also a little voice in there—maybe there isn’t anyone.

Jerry: Yeah.

Hayes: That’s what you said, right? In fact, maybe there really isn’t. Maybe this isn’t a matter of smarts.


Commentary: I’m satisfied that there is a little opening up there. And I’m going to try to capture some of that territory by giving a simple metaphor for what’s been happening, to give it some form and some focus. But it’s worth noticing that I won’t simply say, and that’s what the problem is. Because the Client’s verbal processes would turn that into more of the same.

Hayes: Maybe it’s something more like this. That maybe these results are the results that come from this. Look, it would be like if you were standing out in a bunch of quicksand, like right out of a Tarzan movie. I’m told that apparently that it never really was like that. But let’s just imagine it was, like what you learn at Boy Scouts or something, like in the Tarzan movies. You’re standing out in there. And what your
mind’s telling you to do is get out, right? So how are you going to get out? If you haven’t been to Boy Scouts, the logical thing to do is?

Jerry: Well, you would try to move. You would try to walk out of it. But intellectually, you know that that’s the bad thing to do.

Hayes: Exactly. Because you lift one foot, how much do you weigh? The same as you did a second before. How much surface area is on that mud? Half, right? So guess where you’re going?

Jerry: Sinks.

Hayes: Yeah, exactly. So then your mind tells you, try the other foot.

Jerry: Yeah. And that’s no better.

Hayes: That’s no better. And maybe these things in a row here are kind of like that. This is the try the other foot. Do you know what the Boy Scout solution is?

Jerry: I was never a Boy Scout. I avoided that. But my pragmatic brain would say something like stretch out and—

Hayes: Increase the surface area.

Jerry: Yeah, increase the surface area and sort of swim or backstroke or something to get across.

Hayes: So maybe there really is something like there, where the logical, sensible, reasonable things are just not paying off.

Commentary: Now we’re going to move to a little later part of that same session. I’m using a different metaphor here to give some form to the struggle. I’m going to be fairly relentless. I think this Client is fairly well dug in and will need a push to become more flexible and more open. So this part may be, frankly, somewhat painful to watch. And it might not be obvious at this point that it’s even helpful at all. But I think it will set up the work later on. So let’s watch to see how that works.

Hayes: Maybe like this. Suppose you’d been blindfolded, given a little tool bag to carry. And you’re told, Jerry, this is life. Run around. And so you ran around. And some time, several years ago, you fell into a hole of this social anxiety, withdrawal, fear that you’ve been living
in. It’s a deep enough hole that there’s no apparent way out. And so you wait a while to be rescued. Nobody comes. So you see if you can tolerate it, put up with it. It’s not a good place to be. Sooner or later it occurs to you—still blindfolded—to get inside that bag and see what’s in there. Now suppose what was in there was a nice, sturdy shovel. And so you did what we do with shovels. You start digging. And you dig in one way, or another way, or another way, and probably others we haven’t even mentioned. It’s like you dig with big scoops and small scoops and fast scoops and slow scoops, and fancy ones and plain ones. And here we are. This hole is getting smaller or bigger?

Jerry: Bigger.

Hayes: It’s getting bigger. That’s weird. You think about it. Because in every other area of your life, the external part of your life at least, this much effort. And if we were talking about painting your house, your house would be painted. But it’s getting bigger. So just consider the possibility that that’s the situation you’re in. And you’re in here basically thinking, or at least the mind part of you is thinking, maybe this guy really understands this, but probably not, enough to show me how to really dig my way out. Except maybe this is not a dig problem. Maybe this is not a dig-your-way-out type problem.

Jerry: Maybe it’s not a hole. Maybe it’s a wall.

Hayes: Interesting. Clever.

Jerry: Who put it there?

Hayes: Maybe if we went to the past, we could figure it out.

Jerry: Probably not. Been there, done that.

Hayes: Dig, dig, dig, dig, dig. This is the Jerry method of digging. What’s coming up for you right now, consider the possibility. Just watch. What if it were the case that what’s coming up right now are Jerry methods of digging? You’ve been through a few rounds of it. If you actually were in that situation—here you are. If you saw somebody in that situation, what would you say the first thing is they need to do.

Jerry: Well, the most obvious thing is yell for help.
**Hayes:** You’ve done that.

**Jerry:** Yeah.

**Hayes:** Guess who I am? Help. No? I’m not? Am I wrong?

**Jerry:** Yeah. And now you’ve posed a very practical problem to me. Here I am in the bottom of the hole with this shovel. Now my solution would be to start digging a series of steps.

**Hayes:** Good. Suppose when you try to do that, it just collapses down. It’s like that kind of dirt that—now you’ve got even more to get out of the way. You’ve tried that, actually, haven’t you? You’ve tried to dig your way out. That’s part of that, if I can get a logical angle, something firm to stand on. If I understand why. It’s logical. That’s a good, logical answer. And yet here you are. And if you actually go into the experience, isn’t it sort of like that? I mean, actually you’re in a situation like that. I mean, it’s a metaphor. But it’s not a silly metaphor. Am I wrong?

**Jerry:** Sure. It’s a problem. And I’ve tried a number of tactics to solve it. And they’ve failed. Or at least they haven’t been applicable or something.

**Hayes:** Right. So what are we going to do? Here we are.

**Jerry:** Again, this begs the question, is there no way out? Is it not a soluble problem? Curl up in the hole. Be happy.

**Hayes:** Yeah. Have you tried that, just sort of put up with it?

**Jerry:** Yeah, again—

**Hayes:** Try to rationalize it.

**Jerry:** For periods of time, right.

**Hayes:** Does that word?

**Jerry:** No. Ultimately I want to get out.

**Hayes:** So I’m with you here. Look, I am not about…And you’re trying to justify, explain, rationalize living in a hole.

**Jerry:** Right.

**Hayes:** And not a whole lot of life going on in there. Fair to say?
Jerry: Right.

Hayes: OK, so no. I mean, if you want to, I don’t know how I’ll help you do it. If you really want to do it, I guess I’ll get out of the way and watch it happen. But I don’t suspect there’s much vitality in there. What’s this guy got to do? If you actually were up there, and you were watching somebody, what would you do? If you were watching someone else, what would you do?

Jerry: If I were up there watching somebody else stand in the hole—

Hayes: Yeah, stuck.

Jerry: Go get a ladder.

Hayes: Suppose you did that. You pass the ladder down. And here’s what the guy does with it.

Jerry: That’s crazy.

Hayes: I don’t know. Blindfold. If it’s really set, I think that’s pretty close to the situation we’re in here. I think it’s more important, number one, until you do something else, you don’t have the ability to put your hands on the ladder. What are you going to grab it with, number one? Number two, you think this is going to work any better? Heck, you already got a shovel going. You need a really bad one. Ladders are not very good shovels.

I bet you, if you were honest with yourself, is this the part of you that thinks that here you’ve come to get the Steve Hayes gold-plated steam shovel, like I’m going to dig your way out. And if it would work, I would. And as far as I know, it’s not going to work. If I were to help you do all these other things you’ve done up there, as far as I know, it would work about as well as it has worked. That part of you that says, maybe there’s someone who really knows, that’s that same deal you’re trying to figure it out, get me to figure it out. If figuring it out would help you, I’d do it. I suspect it’s more that that. So we’re going to have to do something that’s really, really frightening for you.

Jerry: What’s that?

Hayes: Especially with, or at least for—you don’t know what’s going to happen next. You said, I’m willing to be confused as long as it gets
clear soon. Suppose it’s no guarantees. I’ll tell you, we’ve only got one ally in here that’s really powerful. Here’s our ally. It’s your pain. Is this the life that you want to be living?

Jerry: No.

Hayes: Do you need any more experience with that part of it? Or have you had enough? Is this enough? Have you suffered enough?

Jerry: Yeah, I think so.

Hayes: Because this is scary. The only thing that would embolden you to do that is you have had enough. And if you haven’t, I’ll try to get you a good referral. I’ll try to get some other folks who say they can help you dig your way out. But I don’t see it.

Commentary: In this last segment, I’m going to try to tie this process up and to get it linked to an openness to move forward into something that’s truly new and that could really make a difference in this client’s life.

Hayes: So our ally in here is your own sense that enough is enough. Because otherwise why do something as odd as that, not knowing what would happen? Minds really don’t like this. I mean, they really don’t like it. They want to know what the answer’s going to be, do it on a guarantee. But I’m not giving you a guarantee. Except, I’m going to give you one guarantee. I bet you if you keep digging, it will keep working just like this.

Jerry: Yeah, I believe that. So we don’t dig.

Hayes: Well, we could.

Jerry: Don’t want to.

Hayes: Done enough of that?

Jerry: Yeah.

Hayes: So part of what we’re going to do is learn how that—because digging shows up in 1,000 different forms. It’s very creative. Minds are like unbelievably creative organs. And they’re figuring it out, trying to control it. All of which, one or another, may be another form. Some of the stuff that you’ve done, if you think about it within that metaphor,
it makes some sense. This thing of going back into the past, it would be like this. It would be like, back there, there was a rise. And there was a rock. And I went this way. And then I went way. And if I just knew that, I’d know why I’m in this hole. And the hoot is, it’s actually right. You would know.

**Jerry:** But does it matter?

**Hayes:** That’s the point. That’s the thing. Suppose you actually could know. Because probably the reason you’re in this hole, as opposed to some other, is because of every single step you took. And all the experience you’ve had, et cetera, sitting on Mount Olympus, if we could just watch the little—and what would that do in terms of being here?

**Jerry:** No help.

**Hayes:** I don’t see how it would give us much help. Later on in the work we do, it might be important to go back, because there’s some things in there I think we can learn. But for this purpose, it’s more important just to get with what it’s like to be right here and open up to the possibility that there’s no way out by digging. So something’s going to have to happen first, with no guarantees.

**Jerry:** That’s hard. That’s hard, because my brain immediately wants to know, OK, what’s the next step?

**Hayes:** Mine too.

**Jerry:** Yeah.

**Hayes:** In fact, it’s in here saying, what are we going to do to help Jerry? Blah, blah, blah. It’s doing the same thing. The human condition, you know.

**Jerry:** Sure. We’re problem-solvers. That’s how we survive one way or another.

**Hayes:** You betcha.

**Commentary:** I do want to note that with really dug-in clients, this process can take some time. A full session can sometimes be spent on it, or even more, occasionally, if you have the time to give. We will continue this work and see where it leaves us with the same client on
other DVDs in the series. But in the rest of this DVD, we’re going to be looking at applying some of these same basic methods and other ways and with other kinds of clients.

The next segment is with a different client, Claire. We’re at a similar place in treatment. Claire’s never been in therapy before. She’s depressed, anxious, worried, self-critical, married with small children. She has difficulty sleeping, difficulty in getting going. She’s just not nearly as dug in as Jerry. She’s less avoidant. She’s more emotionally open than he has been. So in this case, we can walk through the acceptance of where we start in this creative hopelessness phase in a way that looks more like psychoeducation than what you just saw. So let’s just see how that’s done.

Hayes: So Claire, what have you actually done so far to try to solve this problem?

Claire: Well, when I can’t sleep, I will take a sleeping pill, over the counter thing. Or usually I try to distract myself. I’ll watch TV. Or I’ll talk to friends. And that works sometimes. But then I don’t get the sleep that I need.

Hayes: Let’s just look at these things one at a time. You’ve used some sleeping meds. Have you used meds in another ways, tranquilizers during the day? Or is it pretty much just at—

Claire: It’s just at night when I can’t sleep.

Hayes: Just at night when you can’t sleep. And what is your sense of that? How does that actually work for you? In what ways is it helpful? What ways isn’t it?

Claire: Well, it definitely knocks me out. But then the next morning, I’m usually really groggy. And I’m kind of afraid that I’m going to become dependent on them, because it sort of happens more and more.

Hayes: You’re starting gradually using more.

Claire: But I mean, at least I get some sleep.

Hayes: So it has some benefits for you. It sounds like if you were to look long-term, what’s your guess? Is this a solution to this problem?
Claire: I don’t think so.

Hayes: It’s just more managing it. But with some risks, right? Some things you’ve worried about and so forth. So we could probably say helpful, but probably not ultimately. How about the distraction kinds of things that you’ve done? Let’s look at those. Again, how does that really work?

Claire: Well, if I’m really nervous because I have a test the next day, I’ll try to hook up with a friend and talk for a while about something else, so that I don’t have to think about it. And it usually gets my mind off of it. But then I have to go to bed. And my friend’s not there. So that’s when I have trouble sleeping. Or I wake up the next morning. And sometimes it just hits me, because there’s nothing distracting me when I first wake up. I mean, it really works when I’m doing it. But I just can’t do it all the time.

Hayes: So it doesn’t fit all situations. I’ll be interested, do you sometimes anticipate this? Like if you are looking ahead, that you might be anxious in a setting and wondering, is a friend going to be available, if you need one, or things of that kind?

Claire: Yeah. I can usually find a TV show or something that I like. But yeah, sometimes my friends get a little tired of holding my hand that way. And so sometimes I worry about that a little bit, that they’re not going to be—

Hayes: I’m interested also in the TV shows. Are they as good a distractor as they were from the beginning? Or are you finding that you have to add more things over time?

Claire: It depends on the show. But now that you say it, it’s become such a habit that it becomes of a piece. The anxiety sort of works in while I’m watching the TV.

Hayes: That’s interesting. That’s worth noticing. So let’s see if we can summarize that. There’s some real benefits that you can notice. But there’s some problems with implementing it, and this last one, and some indications, again, that maybe this thing is not getting better and better over time. But even in the places where it’s worked, it’s getting a little more routine. Maybe it doesn’t work quite as well.
Maybe over time, what do you think? If you were to guess—let’s just focus on this one, like five years from now. Do you think distraction is going to solve whatever it is that’s going on in this anxiety piece that you’re trying to distract yourself from? What would you predict?

Claire: I don’t think so. That’s sort of why I came here to see you.

Hayes: That’s why you came here. So you can see a trend, right?

Claire: Yeah. And it takes up a lot of time and energy.

Hayes: Usually I would say to somebody, your biggest ally in all of this is really your own sense of pain, of actually watching how this has worked directly. Because what you’re experiencing is early. You have not been struggling with this for very long. And this is the first time you’ve been in a treatment, yeah?

Claire: Yeah.

Hayes: But I think it’s worth looking at what your experience is telling you. Let’s just think about this logically. If you had something that you were really afraid of, let’s say something in the external world, something that is very normal—fear of snakes or spiders. Let’s say snakes. And let’s say what you then do is make sure that there’s no National Geographics in the house, because they might have pictures of snakes. And you don’t watch the Adventure Channel or the National Geographic Channel. And you don’t go to the zoo. And you start making a list. Do you suppose that if you did that that your fear of snakes would be getting less? Or is it actually growing as you do this? In other words, is it that snakes are being eliminated as a fear? Or is it more that you’re just not contacting it because you’re avoiding it in all these ways, but it actually maybe stays a fear? You see what I’m saying?

Claire: Yeah. I may not experience it, because I don’t see the snakes. But I also never get to challenge it.

Hayes: Exactly. And if you were to guess, just to sort of guess, would you guess that over time doing that would actually tend to expand and grow? Or would it shrink? In other words, would snakes now maintain their importance as something that’s frightening and actually grow? Or would they shrink over time and become unimportant if you were
doing a lot of these kinds of avoidance things?

Claire: Well, it seems like if I spend so much time avoiding snakes and trying to get snakes out of my life, I’ll be thinking about snakes a lot. It might even make it worse.

Hayes: Exactly. So here’s the deal. We have a little bit of a problem here, because you have not been around the block on this yet. But what you just told me is exactly what the data show. It’s what my clients tell me. It’s what experience tells me. And with enough time, what you’re doing right now, for example, the distraction, the distraction that you’re already experiencing, it’s getting a little less potent. It’s now working its way in. In fact, I bet you, if you’re honest with yourself, sometimes when you think about watching the TV, it reminds you of the anxiety. True? Has that ever happened to you? Are you finding the arrow going back in the other direction?

Claire: Yeah, especially certain shows. Yeah, you’re right.

Hayes: Ones that you use. I could walk you through the scientific literature on this. This is how it works. And the challenge for us here is have you had enough with the small taste that you’ve done here that you’re willing to take a different approach? Because part of you is going on to say, well, I’ve tried the pills. And I’ve tried distraction. And they’re not working too well. But gee, how about—and it’ll be something that’s on that same list. You could go to lots of therapists out there that would try to help you find a way to feel differently about this, think differently about this, use various coping strategies and so forth. And what you agreed to last time, when I was walking through whether or not you really wanted to use this approach, is really a different approach. So I’m going to have to not just rely on your pain, you’ve got some of that, but also on your head. Do you think more of what you’ve been doing, a different strategy and another strategy, another strategy, but at its core the same deal, which is, let’s find a way to get rid of this anxiety and then avoid contacting it, diminishing it, very much like in the snake phobia. Let’s find a way to stay away from it.

Is it your thought that you’ll be able to do that in such a way that it will disappear? Or is it your instinct that going more down the road
you’re going down is probably not going to lead to any different ends than you’ve experienced so far? I need a little bit of your head and not just your gut on this, because frankly, you’re lucky in a way, because you have a chance to catch a pattern early that most people that I work with find ultimately doesn’t work. But you’re going to have to tell me whether or not this is enough, or if you really want to play with it some more, and maybe come back later if it doesn’t work. Do you see what I’m saying? Because if we’re going to do something really different, that means abandoning what seems more logical. Distraction’s a pretty darn logical thing. It even works, sort of.

Claire: For a while.

Hayes: For a while. So I don’t know.

Claire: Well, it kind of feels scary to do something really different. But what I’m doing isn’t working. And that’s why I’m here. So let’s try it.

Hayes: Let’s do that.

Commentary: Another approach that can help us in this phase is the use of the therapeutic relationship itself, and focus on the present moment. In this next segment, there’s a very brief piece of work from a leading Australian ACT therapist, Anne Bailey Ciarrochi, with a panic disordered teacher. She’s walking through the process of avoidance, and links it back to avoidance in the relationship itself. It gives a nice example of how to do that, of how to bring it into what’s going on in the therapy room itself.

Ciarrochi: You know, you’ve mentioned there’s been fluctuations in the intensity over the years. And sometimes it appears that some strategies have kind of worked. Would that be right? And maybe the ice works for a little while?

Client: I guess strategies to get me through the moment kind of work. But I guess, in the long term, it’s not. I guess that would be the most honest way to put it. In the very moment, if I’m sitting there for an hour, and I’ll be eating ice or whatever, I can talk and do my thing. But it’s under great distress. I’m sitting there just freaking out inside.

Ciarrochi: It just never goes away, does it?
Client: No. So I would say, overall, no.

Ciarrochi: So it’s like you’re stuck. Because no matter what you do—

Client: I just feel trapped when I’m standing there, because I’m stuck in front of people. And I’m in a role that I have to play. And I’m chewing ice, which is a ridiculous way to get through a social situation. Or sitting there not really talking with friends while I’m at dinner, or my husband, because I’m sitting there downing glass after glass of wine, which I don’t even really like, just to feel better in the moment. So it’s just like Band-Aid fixes, but not something real.

Ciarrochi: God, so it’s just going nowhere.

Client: No, it’s not.

Ciarrochi: And it kind of feels like right now we’re kind of stuck, too, doesn’t it? Like I don’t know, I’m feeling like we’re kind of trying to—

Client: Yeah. I’m kind of like, yep. It’s the same feeling. Even when I talk about it, I feel stuck. What are we going to do about it? What can anybody else tell me how to, you know?

Commentary: This next segment is with a chronic pain patient, Teresa. Chronic pain presents an interesting model, because unlike many other problems, most people who are experiencing chronic pain are very likely to experience pain for the rest of their lives. But that allows us to look at this creative hopelessness process in a simpler, cleaner way.

Once you see the connection between facing the struggle and the issue of values, the same approach can be taken with almost any emotional struggle. And it can be applied to a much wider variety of Clients, not just those who are in chronic pain. And that’s an example of what you’re going to see here.

There’s an expression in ACT that in your pain, you find your values. And in your values, you’ll find your pain. You’re going to hear that a few times in this DVD series, because it’s one of the powerful insights that comes from ACT work. In this next segment, JoAnne Dahl, who’s a leading ACT researcher and clinician from Sweden, is going to show how this can be done.
Dahl: What brings you here today?

Teresa: Well, I went to see Dr. Smith again last week. And he told me you’d just been appointed. So I’m very pleased to hear that, because we’ve been without a psychologist for such a long time. And he said he thought you might be able to help. So here I am. I’ll try anything.

Dahl: You’ll try anything? And how do you think I could help you?

Teresa: I thought that’s your job. Well, I went to Input 20 years ago. And I learned a lot there. Maybe you remind me of what I did there. I’ve got this pacing. When my beeper goes off, I stand up every two minutes. Maybe some more of that. I really don’t know. I’m here to find out what you can do. This was helpful. I still do this.

Dahl: It sounds like you’ve been doing a lot of trying to solve this problem.

Teresa: Yeah. I go to physio. I go swimming when I can help it. And I just had to give up work a year ago. And I thought that would make it better. And it did for about a month. But it’s just the same again now. But I can’t go back to work, I can’t with this stress. At least I can sometimes walk the dog now. I don’t have the stress. But I’ve done a lot of things.

Dahl: You know, Teresa, I can see there’s a sadness in your eyes about losses, work.

Teresa: I had a great business. It was great. I was the best dog trainer.

Dahl: What’d you like about that? I see your eyes light up. What was great about that?

Teresa: I love teaching. And you know, they didn’t know how much I was hurting. They didn’t know. But I just had to come home. And I just lay on the floor.

Dahl: What did you love about that job?

Teresa: I love being on stage. I loved helping people. I loved the dogs. I love that I go to town and people always come up and say, here’s my dog. Look how he is.

Dahl: I’m curious about those losses. You miss something in your
work that you loved very much. You loved working with people. And you loved the dogs. And you don’t have that now.

**Teresa:** No, I don’t.

**Dahl:** How does that feel?

**Teresa:** I’m relieved. I like not to be so stressed. But once the pain is a bit better, you see, if the pain got better, I was planning that I could do things that I really like, if I wasn’t so stressed and the pain would go.

**Dahl:** Teresa, that was not really my question.

**Teresa:** I’m sorry.

**Dahl:** The sadness in your eyes about losing your job, how does that feel?

**Teresa:** I lost my job. I gave it all up, and for nothing. I just got fatter and fatter and fatter. And I sit at home. And it hurts more. I’m no better off. My husband can’t stand me anymore. I’m too fat to take my own dog out. Some days I can do it. Some days it’s OK.

**Dahl:** So let me get this straight. You gave up your job to make the pain better. And now the pain’s worse. And you lost your job. And you’ve gained weight. And you can’t go with your dog like you used to. And you think your husband hates you.

**Teresa:** He can’t stand me anymore.

**Dahl:** He can’t stand you.

**Teresa:** Because I can’t do anything. There’s days I can’t get out of bed. And he has to do all the cooking and the cleaning. And he walks the dog. And he’s just had it up to here with me.

**Dahl:** Sounds like you’ve had it up to here with you.

**Teresa:** I’ve had it up to here with me. I’ve had this for 20 years. I’ve had this all my life. We wanted a family. We were hoping I would get well enough if I gave up the job. Maybe I could get fit.

**Dahl:** So it sounds like you’ve given up so much, Teresa. And things have just gotten worse. So I can feel that must be a frustration that you want it so much. And you’ve given up one thing after another.
Teresa: I wouldn’t go back to work. I couldn’t stand the stress. They tell you always to go back to work, don’t they?

Dahl: Are you thinking that I’m going to—

Teresa: That’s what they did at Input. And I did it. I did it for 10 years. I can’t do anything now.

Dahl: How does that feel for you when you say I can’t do anything now?

Teresa: It’s horrible. I hate this body. I didn’t want to be like this. This wasn’t how it was supposed to be. This wasn’t what I’d planned. I’d do anything to get rid of the pain and just do stuff like everybody else does.

Dahl: You know what, Teresa? I wonder what you were thinking when you sat outside in that waiting room before you came in here, with all the experience you have of all of the failed therapies and all the things you’ve done that have just made things worse. What were you really thinking out there when you were in the waiting room coming in to see me?

Teresa: Oh, I’m a real fighter. I always think the same. I always think, this time is going to work.

Dahl: You were hoping. When you think about all your experiences, you really think that I could help you, Teresa?

Teresa: If I didn’t think that, I’d just give up. What else is there? That one day you or the physio or Dr. Smith—I need help. And nobody’s really helped me. So maybe you can help me.

Dahl: What if I put it like this, Teresa. What if I said that on the one hand, I could offer you pain free the rest your life?

Teresa: I’d take it. I don’t care what the other one is. I’ll take it.

Dahl: And the funny thing is, Teresa, you already know how to do this. There are alcohol and drugs. You can be intoxicated all the time. There’s morphine pumps that you can have pumped in your body.

Teresa: The doctors won’t give me that. They won’t even give me Valium.
Dahl: But it is possible to lay in bed and take drugs and be pain free. That’s one way. And another choice is that you could have the pain you’re having, more or less, maybe a little more, and—

Teresa: It can’t get more.

Dahl: —get closer to those things you were talking about, the joy of doing something that you really like doing, getting closer to your husband again, being able to go walk the dogs. All the life that you long for.

Teresa: It’s not an again with my husband. I’ve always had pain.

Dahl: But Teresa, what about these choices? We got pain free, but you lose your life. Or pain and get back what you’re longing for.

Teresa: Right. Now I’ve got half of both. I’ve got the pain. And I’ve got no life.

Dahl: What if you got just these two choices?

Teresa: I don’t think I can take either of those two choices.

Dahl: And not taking them is also what you’ve been doing. Because you know what, Teresa? I don’t think you came here to get rid of your pain.

Teresa: Of course I came here to get rid of my pain.

Dahl: But if that’s what you really wanted, you know how to do that. I think you came back here because you want your life back.

Teresa: I don’t think you know how hard it is.

Dahl: No, I don’t, Teresa I don’t. But what I see in your eyes is a longing, is a woman who longs to get her life back, not just to be pain free.

Teresa: How? How? And this body is fat. It hurts. It doesn’t move. I can’t do anything. I can’t even drive my car.

Dahl: The how part, Teresa, is something we could work with. But what I want to hear from you is that choice. Do you want this? Or do you want your life back with the pain?

Teresa: You’re saying you can’t help me.
**Dahl:** Well, this part you already know how to do. If you’re willing to have your pain, I could work with you in getting your life back.

**Teresa:** I said I’m a fighter. I’d try anything. I guess it can’t get any worse, can it? It can’t get any worse.

**Dahl:** So what is your choice?

**Teresa:** I try what you say. I’ll try. I don’t think I can do anything. But OK, I’ll try it your way.

**Dahl:** Not my way.

**Teresa:** I don’t know what to do. I’ve tried everything.

**Dahl:** Yeah, but it’s your way.

**Teresa:** I haven’t had much success with any other way I’ve tried, have I?

**Dahl:** No. And what you tried there is stopping your job, and taking all the meds.

**Teresa:** And physio, and chiropractic. And I go to a special person to get these vitamins that you still can’t get on the NHS. I’ve asked my GP. I’ve changed GPs. I used to have private meds. Then it ran out. It expired. They won’t pay for it anymore.

**Dahl:** We can make a long list of all the things you’ve done. And Teresa, you’ve been a great patient. You’ve done what they told you to do. You’ve tried everything in the book, and in the service of getting rid of the pain first, and then getting your life back. But what happened? What’s your summary or conclusion if you look back on all the things you’ve done?

**Teresa:** I’m just getting worse—everything.

**Dahl:** And you know what, Teresa? I don’t want to be on that list of things that you’re disappointed about.

**Teresa:** You think this can be different?

**Dahl:** But not getting rid of your pain.

**Teresa:** I’m not sure you understand how hard it is.

**Dahl:** I don’t, Teresa. But I’m willing to be with you, if you are willing
to—

**Teresa:** Nobody else believes me. Nobody else believes me. They all think I’m making it up. My family think I’m making it up. But at least I feel that you believe me. My husband thinks I’m making it up. They all think I’m just lazy. I’m not lazy. And if I start doing things, maybe that will just prove that they were right, that I was just being lazy.

**Dahl:** So is life going to be about being right or getting your life back? You need to choose, Teresa.

**Teresa:** I have no choice. I’ll choose. I’ll choose. OK? OK I’ll do it. I’ll do it.

**Dahl:** I mean, it’s letting go of what you’ve been trying to do and doing something else.

**Teresa:** I still find it kind of hard to see what else I can try to do, because I tried everything.

**Dahl:** Yeah. That thought comes up quite a lot.

**Teresa:** Because it’s a true thought. It’s a true thought.

**Commentary:** In this first DVD, “Facing the Struggle,” you’ve heard some about an ACT model. You’ve seen how to do informed consent. And you’ve seen some of the different approaches that could be used to get through the process of having clients face the struggle that they’re in, the so-called creative hopelessness phase, which really is a process of validation and acknowledgement that the client has done all that they can do. And helping them to see that opens us up to something that is truly new. If you always do what you’ve always done, you’ll always get what you’ve always got. And this early stage of ACT opens up clients to a new agenda. You’ll see how that’s carried forward into other kinds of work in the other DVDs in the series.
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**Therapeutic Issues**

ADD/ADHD
Addiction
Anger Management
Alcoholism
Anxiety
Beginning Therapists
Child Abuse
Culture & Diversity
Death & Dying
Depression
Dissociation
Divorce
Domestic Violence
Eating Disorders
Grief/Loss

Happiness
Healthcare/Medical
Infertility
Intellectualizing
Lew & Ethics
Parenting
Personality Disorders
Practice Management
PTSD
Relationships
Sexuality
Suicidality
Trauma
Weight Management

**Population**

Adolescents

Latino/Hispanic
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