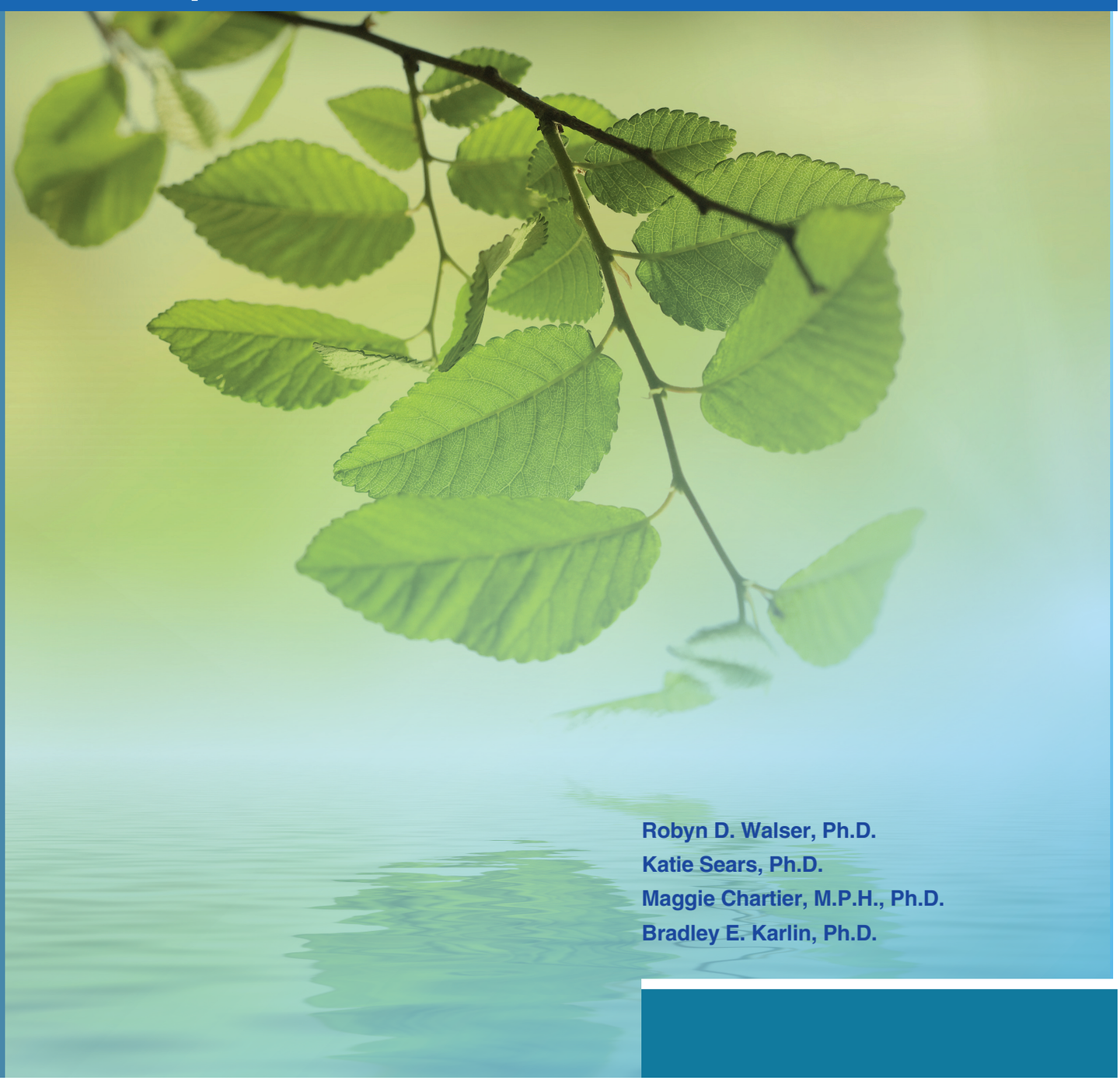
Acceptance and Commitment Therapy For Depression in Veterans

Therapist Manual



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Preface

When we pause to reflect on what it means to be human, we connect to our own experiences, both personal and shared, including those filled with simplicity and joy, amazement, and belonging. We also realize in those moments that life can be fraught with struggle and pain – that fundamental human experience also contains suffering. For many, this experience comes and goes, but for others suffering and pain may linger, even paralyze, in life-limiting ways. Depression is one of these types of life-impairing experiences that can have long-lasting effects. Acceptance and Commitment Therapy (ACT) is an effective intervention for many who struggle with depression. ACT is a behaviorally-oriented psychotherapy that addresses a person's relationship with cognitions, feelings, sensations, memories, and images and seeks to promote vitality and meaningful participation in life.

The Veterans Health Administration (VHA), the health care component of the U.S. Department of Veterans Affairs (VA), is disseminating and implementing ACT for Depression (ACT-D) as part of a broader initiative to make evidence-based psychotherapies for depression, posttraumatic stress disorder, and other mental and behavioral health conditions widely available to Veterans (Karlin & Cross, 2014). As part of this effort, VHA has developed a competency-based staff training program in ACT-D that includes foundational training in the theoretical and applied components of the treatment, followed by consultation on the implementation of the therapy. Program evaluation results associated with the VA ACT-D training program have shown that training and implementation of ACT-D in VHA has led to significant improvements in therapist competency in ACT-D and in patient outcomes (Walser, Karlin, Trockel, Mazina, & Taylor, 2013).

This manual was created to support implementation of ACT-D for Veterans within and outside of VHA. The therapy protocol presented in this manual was adapted specifically for use with Veterans and is based on research and clinical experience. The manual includes clinical examples and other content designed to promote the accessibility and usefulness of this resource. This manual provides straightforward steps for each session and includes highlighted boxes with *clinical definitions* and *things to know, Veteran spotlights* related to specific implementation issues with Veterans, *clinical watch* boxes that alert the therapist to important clinical issues, *theoretical underpinnings* that guide preparation for sessions, *example patient-therapist dialogue* and, lastly, *patient handouts.* This protocol is born out of a behavioral principles and a behavioral theory of language, and uses behavioral principles and individualized case conceptualization to support a functional understanding of behavior in order to best guide the clinical intervention for specific patients. It is important to note that while readers may have interest in implementing ACT for conditions other than depression, the focus of this manual and the dissemination of ACT in VHA is on the treatment of depression. It is also important to note that this manual is not a substitute for competency-based training in ACT-D, but can be a useful resource to those receiving or who have received specific training in ACT.

Although this manual seeks to clearly portray the "nuts and bolts" of the intervention, the protocol provides an overarching context for conducting the therapy by conveying the need to bring compassion to the human experience in the implementation. ACT-D endeavors to create both psychological and behavioral flexibility through processes that are based on behavioral principles and that are also applied with warmth, genuineness, and a true sense of understanding for the patient's circumstance. Helping Veterans to embrace ways of living that are meaningful and values-guided can be transforming, but it is important that this is done within a caring therapeutic relationship that embodies acceptance and hope for change.

Much of the change focus of ACT-D is on promoting living vitally with respect to personal values while simultaneously engaging a willingness to experience emotional and thought content whether it is evaluated as good or bad. ACT-D gauges therapy success via the *workability* of the patient's life in terms of interpersonal functioning, engagement in the world, seizing the moment and finding love, and promoting connectedness and belonging. It is our hope that you find this manual to be a helpful resource as you implement ACT-D and work with Veterans in pursuit of these positive change goals.

Introduction

ACT-D Overview

The experience of depression can profoundly affect a Veteran's life. The personal cost and emotional suffering related to depression can significantly impact interpersonal and daily life functioning, leading to further difficulties and a potential long-term decrease in functioning. Indeed, depression is one of the leading mental health diagnoses among Veterans seeking care in VHA (Karlin & Zeiss, 2010). Depression has a significant impact on life functioning, including problems ranging from loss of interest in pleasurable activities to isolation to failure in social and work situations (Fava & Cassano, 2008). Providing effective treatment for those suffering with depression can lead to personal re-vitalization and return to functioning. Acceptance and Commitment Therapy (ACT, said as one word; Hayes, Strosahl, & Wilson, 2012) is one such intervention that not only focuses on decreasing suffering, but also focuses on personal values in the service of bringing vitality and meaningful functioning to the Veteran's life.

Dr. Steven Hayes and colleagues developed ACT. It is considered a "third-wave" behavioral intervention and it is one of a number of "acceptance-based psychotherapies" developed in recent decades that focuses on promoting acceptance of internal experiences and taking committed actions consistent with personally chosen values. Other acceptance-based psychotherapies include Dialectical Behavior Therapy (Linehan, 1993) and Mindfulness Based Cognitive Therapy for Depression (Segal, Williams & Teasdale, 2012).

The clinical goals of ACT are exemplified in its very name. When using ACT, the therapist works to help the patient ***accept*** internal events (thoughts, emotions, sensations, images and memories) while also helping them make and keep behavioral ***commitments*** that reflect personal values. ACT-D includes a number of acceptance and mindfulness strategies and commitment and behavior change strategies to reduce depression and help patients move forward in their lives. Within the treatment, patients are explicitly guided to come into contact with two different ways of knowing the world and themselves. In addition to knowing things with the mind, an experiential sense of knowing is re-created. The latter provides a place where the patient can learn to relate to internal experience in a non-judgmental and open way. This work supports the patient in finding the freedom to be guided by values rather than the literal content of emotions and thoughts.

Part of the work done in ACT-D is about drawing the distinction between knowing with the mind and knowing with experience. There are two ways of knowing the world – through verbal knowledge and through experiential knowledge. **Verbal knowledge** is all that goes on "in the mind" – describing, planning, problem solving, imagining, creating, predicting, talking, reading, writing, communicating, and etc. It is all that we learn with the mind – it *is* language. **Experiential knowledge** is what we have learned through direct experience and practice. It is distinct from verbal knowledge. For example, learning to walk is experiential in nature – we were not instructed on how to walk, we moved around, crawled, wobbled, and fell down as we learned – it was by experience and practice that we came to walk. In fact, most of us learned to walk before we were verbal, before we were talking. This kind of experiential knowledge continues to grow throughout our life. However, once we become fully verbal, we tend to lose contact with much of this other kind of knowledge. We begin to live "in our heads." We become so involved with the world from a verbal perspective that we lose contact with what else we know – life experienced. For instance, a socially anxious patient might complain that he will "die of embarrassment" (verbal knowledge), however, experiential knowledge tells him that this is not so. The experience of embarrassment contains a certain set of physiological sensations that might look like blushing or sweating or feel like an increasing or rapid heart rate, however, these experiences pass and other experiences come along – actual death does not occur. We all may have had the thought that we "can't stand it another moment" – but even as we think these words, experiential knowledge tells us that we can. ACT-D actively works to help patients get back in touch with experiential knowledge, to observe and notice the ongoing and changing flow of their internal and bodily experience apart from what their mind is saying about the same. ACT-D patients are taught to see themselves as a context for ongoing experiential events that include all things occurring inside the skin – emotion, thinking, memories, images, and bodily sensations – without excessive involvement of the mind and misapplied or excessive control of these experiences. Simultaneously, patients work to clarify and define personal values and goals and are supported in taking specific behavioral actions that bring these values to life. These two processes are brought together in a flexible and interactive way to assist the patient in accepting and committing to values-based living.

Philosophical origins. ACT's philosophical origins rise out of functional contextualism and a solid theory of human language called Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). RFT has been well-researched and continues to grow as a viable explanation for understanding language and cognition or the "mind." The research in RFT informs the role that

language plays in human suffering. For an extensive description and understanding of the theory supporting RFT, see Torneke, 2010 and Hayes, Strosahl, & Wilson, 2012. The reader may also access additional information at: www.contextualscience.org the main website for ACT, RFT, and a broader community of scientists who are interested in contextual influences on behavior, mindfulness, and compassion interventions. Included on this website are links to an RFT tutorial and a review of functional contextualism, as well as information on the theory of language. This tutorial is highly recommended for those that plan to implement ACT-D.

Clinical Definition: *Functional Contextualism* (FC) as it is used in radical behaviorism is a philosophical world-view in which any behavior is interpreted as inseparable from its current setting or context. Additionally, the function of the behavior is the target of understanding and influence. FC defines truth and meaning in terms of pragmatism (i.e., what works) rather than absolute truth (i.e., what is).

In brief, RFT is a behaviorally based theory of language. It essentially holds that language is established through operant learning and that with a history of reinforcement children learn that a certain sound (e.g., "apple") refers to a particular object (e.g., a physical apple); children are reinforced for saying "apple" in the presence of an apple. This is directly trained, say "apple" when you see an apple. Additionally, a phenomenon that is fundamental to human learning of language and assists with explaining its complexity is *derived relational responding*. Here, human beings learn not only that a word is related to an object, but also that the object is related to the word. The relationship is bi-directional. This may seem overly simplistic, but this bi-directionality does not need to be directly trained. It is derived. Being able to derive relationships among words and events/objects sets the stage for a vast network of relational responding known as verbal behavior, or thinking itself. This kind of symbolic relating allows us to generate and expand knowledge across our lifetimes. It gives us the amazing capacity to create and develop, but also the grave capacity to compare and evaluate in negative and harmful ways. Indeed, all of the possibilities in derived verbal relations can move us to loftier places as well as lead us to sorrows.

Tenets of ACT. ACT is a principle-based intervention and is broadly applicable to all behavior including ineffective or maladaptive behavior. It is rooted in behaviorism and is interested in the function of behavior as well as the consequences that are shaping and maintaining behavior. For purposes of clarity, the type of behaviorism referred to in this manual holds true to the model that what human beings are *doing* is the focus of study and intervention. This is not simply the outwardly observable actions of a person, but also the behavior that occurs "inside the skin." Stated otherwise, thoughts, feelings, remembering, etc. are also considered behavior and are part of what human beings are doing and therefore are also the focus of study and intervention.

Two examples of relational frames and how they can serve or harm us:

1. Temporal or Causal Frames: "if/then" or "before/after":
   Serve: "If I save my money, then I will be able to go on that trip of a lifetime."
   Harm: "If I don't get over my childhood, then I will never be able to live a good life."
2. Comparative and Evaluative Frames: "better than," "bigger than," "faster than," etc.:
   Serve: "This apple is better than that candy bar. I will eat the apple."
   Harm: "Everyone is better than me. I must be worthless."

Based on this focus, ACT specifically targets psychological problems that emerge from behavioral rigidity or inflexibility (Hayes, et al., 2012). This is defined in ACT as the inability to persist or change behavior in the service of chosen values, usually due to the dominance of verbal processes. Examples of this kind of inflexibility might include a person "thinking" he is unable to take healthy action until his symptoms are eliminated (e.g., until he feels better); or it might include an individual "seeing" only one way to solve a problem (e.g., escape from pain via suicide); or "buying" a specific belief about himself (e.g., "I am a failure") and then basing his abilities on that belief. Rigidity and inflexibility are linked to other areas where problematic behavior can arise including excessive or inappropriate rule following (e.g., "There is only one right way to do things"), loss of contact with the present moment (e.g., spending excessive time thinking about the past), or over-identifying with only one aspect of the self (e.g., I am a victim, I am "broken," etc.). Inflexibility is often also found in an excessive effort to be in control, in an overly rigid

focus on being right, or in an inability to forgive or let go. Finally, rigidity and inflexibility may occur when an individual persists in a type of problem solving that doesn't actually lead to desired outcomes, or said otherwise, that doesn't work. One of the main goals of ACT, then, is to decrease rigidity and increase flexibility in the service of workability.

Empirical grounding of ACT. A growing body of research has shown ACT to be effective for depression, anxiety, and other mental and behavioral health conditions (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Lappalainen, Lehtonen, Skarp, Taubert, Ojanen, & Hayes, 2007; Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009; Substance Abuse and Mental Health Services Administration, 2010; Ruiz, 2010; Zettle & Rains, 1989). Beyond decreasing symptoms of depression, ACT has been found to reduce negative behaviors related to undesirable thoughts and feelings, and to reduce the strength of depressive thoughts (Zettle & Hayes, 1986; Zettle & Rains, 1989).

IN ACT, WORKABILITY IS ALWAYS TIED TO AN INDIVIDUAL'S PERSONAL VALUES

The processes of ACT have also been studied as mediators and moderators of change in outcome. Changes in ACT processes have been linked to changes in outcome (Hayes, et. al. 2006) and provide empirically based feedback that the mechanisms of change targeted in ACT are producing positive and predicted effects.

ACT processes. ACT maintains that a large part of psychological suffering is due to attempts to avoid internal negative experience or experiential avoidance (EA). EA is the process of being unwilling to contact, or remain in the presence of, certain negatively evaluated private experiences such as difficult thoughts, painful feelings and memories, and/or unpleasant bodily sensations. Moreover, the individual unwilling to feel is often cognitively "entangled" – fused with his or her mind (e.g., the thought and the individual are one and the same; "I *am* worthless;" see Clinical Definition below) – and fails both to notice the thought as a passing experience and to take the behavioral steps that are necessary for values-consistent living. The person engaged in this behavior is often suffering as their focus is on solving "the problem" of a difficult private experience. The Veteran is in a "battle" with their thoughts and emotions. Solving the problem of negative internal experience often involves efforts to seek *positive* feelings in order to replace or control negative ones – believing the former need to be in place *before* a "good" life can be lived. A life that is guided by values in the here and now is often sacrificed to this problem solving activity.

Clinical Definition: Cognitive fusion refers to the human tendency to get caught up in thought content in such a way that it comes to dominate over other, potentially more useful, sources of behavioral regulation. We tend to merge thought content with an automatic attribution of meaning, thus losing awareness of the ongoing (and imperfect) process of thinking itself (Luoma, et. al., 2007).

ACT is designed to target and reduce harmful experiential avoidance and non-acceptance while also encouraging patients to clarify values and engage life by making powerful life-enhancing choices. Given these treatment targets, ACT works by assisting patients to shift from viewing negatively evaluated internal experience as a problem to be solved to an "event" to be experienced (i.e., emotions and thoughts are not like math problems; they are more like sunsets; Wilson & Dufrene, 2009). ACT employs multiple core processes that are designed to decrease maladaptive behaviors and unhealthy attempts to avoid internal experience by focusing on increasing behavioral and psychological flexibility. Included among these processes are strategies that help the patient to identify and abandon problematic control and to accept negatively evaluated emotions and thoughts, treating them much like other emotions and thoughts, while also taking specific behavioral actions that produce meaningful life outcomes based on personal values.

There are six core processes in ACT. *Acceptance* is the process of fostering acceptance and willingness while undermining the dominance of emotional control and avoidance in the patient's response hierarchy. Undermining the language-based processes that promote fusion with "mind," needless reason-giving, and unhelpful evaluation that cause private experiences to function as psychological barriers to life enhancing activities is the process referred to as *Cognitive Defusion*. The third process, *Getting in Contact with the Present Moment,* is actively working to live in the present moment, contacting more fully the ongoing flow of experience as it occurs. *Self as Context* is the process whereby the individual makes contact with a deeper sense of self that can serve as the context for experiencing ongoing thoughts and feelings. It is distinct from the self that may be defined by the content

of those thoughts and feelings (conceptualized self), and thus helps to establish a position from which acceptance of private events is less threatening. The final two core processes are *Values* and *Committed Action.* These processes involve first identifying valued outcomes in living that help patients choose purposive life directions while confronting verbal processes that serve as barriers (e.g., avoidance, fusion) and second, taking committed action which involves building larger and larger patterns of behavior that reflect the patient's stated values. Each of the six core processes is designed to create and support psychological and behavioral flexibility. Psychological flexibility is defined as "contacting the present moment fully as a conscious human being, experiencing what is there to be experienced, and working to change behavior such that it is in the service of chosen values." The model is depicted in Figure 1. On the left side of the table are the pathological processes that lead to problems more broadly and are the responses to internal events and situations that can create long-term suffering. On the right side of the table are the ACT processes that are used in therapy to target and address these ineffective and problematic strategies.

TARGET PROBLEM: **Area of Rigidity/Inflexibility**	**ACT INTERVENTION:** **Process to Increase Flexibility**
Experiential avoidance; running away or escaping from difficult or painful emotions and thoughts	Acceptance
Fusion with the mind; arguing with mind; believing mind	Defusion
Living in the past or worrying about the future, lack of self-knowledge	Contact with the present moment
Attachment to the conceptualized self	Self-as-context: Conscious awareness; Experiencer vs. the experienced
A life focused on emotion, thought and symptom elimination or reduction	Values-focused life
Inaction and remaining stuck	Committed action: Making and keeping behavioral commitments that exemplify personal values
↓	↓
Psychological Inflexibility	Psychological Flexibility

Figure 1. Working on Acceptance and Defusion: How Control Is Part of the Problem

One of the main goals of ACT for depression is to help patients see that they "have" a mind, not that they "are" their mind. That is, when patients are struggling (and even when they aren't), they make no distinction between themselves and what they are thinking. It is as if they ***are*** their thoughts. A patient might say something like "I am broken" and rather than seeing this thought as a thought that he is experiencing, he sees it as something that is literally true – he is "entangled" (fused) with his mind. There are some specific ways, from the ACT perspective, in which patients get entangled with their minds and these can be represented in a single acronym: FEAR. FEAR stands for fusion, evaluation, avoidance, and reason-giving (Hayes et al., 1999). FEAR, incidentally, is not unique to patients or those suffering from depression or other psychological problems; the underpinnings of ACT hold that all human beings experience fusion with their minds. The FEAR processes apply to us all. That is, therapists are subject to the same vulnerabilities as those they treat.

WHILE ACT AS A THERAPY INVOLVES APPLYING THESE PRINCIPLES TO A TARGETED POPULATION, THESE UNDERPINNINGS DO NOT INTEND TO DRAW A DISTINCTION BETWEEN PATIENTS AND OTHER HUMAN BEINGS.

In FEAR. *Fusion* or *Cognitive fusion* refers to the process wherein human beings become "fused" with their minds. That is, individuals view their thinking as literal truth, and they respond to their verbal *constructions* of the world as if they *are* the world. For example, fusing (holding to be literally true) with the idea that "things will never change" can lead to a number of responses that are unhealthy, e.g., not getting into relationships, not taking care of daily life activities or health. *"Defusing"* involves seeing the words for what they are – a set of verbal constructions or sounds put together in a particular way (based on learning history) – and then "choosing" to respond in a way that is healthy, "outside" of the words. *Evaluation* is similar to fusion and is the act of holding verbal evaluations as literally true. Evaluation allows us to compare, make decisions, plan, and problem solve. These can be useful activities, but evaluation also allows us to judge in unhealthy and problematic ways. For instance, when the depressed individual says, "I am worthless," and evaluates that thought as "bad", he may decide that he needs to get rid of that thought in order for things to be better. He may get into a difficult and longstanding struggle to fix or eliminate the thought, or he may take no action at all towards making a change – simply giving up and no longer engaging the world in a healthy way.

Things to know: When individuals are fused with their thoughts, they often believe or feel as if they have no choice. However, from the ACT perspective, we always have a choice and *defusion* can assist with recognizing that choice is available.

Together, fusion and evaluations "bought" as literal truths can readily lead to experiential and behavioral *Avoidance*. Avoidance is defined as excessive and misapplied attempts to control internal experience (e.g., drinking alcohol to avoid anxiety). It can be harmful for several reasons. For one, it can narrow the range of behaviors that are possible as patients respond to their minds rather than flexibly responding to the current context. These responses can prevent healthy forms of exposure to emotions and other private experiences, as well as healthy actions in and interactions with the world. Avoidance can also strengthen responses that are problematic (e.g., excessive sleep to avoid or escape pain) and is characteristic of a number of psychological disorders, including depression. Indeed, there are at least two main problems in depression that can be linked to avoidance of psychological experience (Zettle, 2007).

Things to know: Avoidance activities often grow out of an individual's response to cultural notions that negative thoughts and feelings are problematic. These negative experiences are a "sign" that something is wrong or broken and they need to be fixed or changed in order to be normal. Avoidance often manifests as problematic control.

First, many Veterans with depression are socially withdrawn, have low energy, experience loss of interest in activities, become highly self-focused and often engage in efforts to discover why they are feeling the way they do. Depressed Veterans can also become lethargic or stop engaging in behaviors that would be helpful to them. This non-engagement can be viewed as experiential avoidance in that the patient escapes the "problematic" thoughts and feelings including discomfort, emotional distress, and perhaps fear of or actual experience of failure that may be associated with attempts to behaviorally engage with the world. For example, a depressed Veteran who experienced a series of job losses subsequently stopped trying to look for work. He did not want to continue to experience feelings of rejection. As a means to avoid rejection, he closed himself off from the outside world and, instead, sat at home worrying about finances and the possibility of future rejection. He became increasingly depressed and the feelings of rejection grew. He was behaviorally avoiding the activity of job hunting as well as psychologically avoiding the feelings of rejection and failure that accompany a job search. However, rather than alleviating his feelings of depression, his avoidance actually led to a greater desire to escape his emotional experience and an increase of symptoms.

Things to know: Avoidance (i.e., control) of internal experience is often paradoxical, leading to the sustainment and/or increase in the very emotions and thoughts that the individual is trying to eliminate.

Second, when patients become very depressed they often begin to report that they feel "nothing at all." They may say that they feel "empty" or "black." This may be an attempt to escape sadness or avoid feeling anything that seems threatening. This kind of avoidance can result when individuals appraise or evaluate internal experiences, such as sorrow or loneliness, as negative or "bad". These appraisals may be followed by strategies to avoid these painful experiences that, rather than help the patient feel

better, paradoxically increase the patient's distress and dysfunctional behavior. For instance, a Veteran who experienced intense loss (i.e., death of a brother) and a number of traumatic historical events reported in a "flat" tone that he "cared about nothing." Caring was too painful. It was easier to feel nothing than to feel the pain of loss. In his efforts to "not care," he isolated heavily, avoiding opportunities to connect with others and get support.

The last component of FEAR is *Reason-giving,* or giving verbal explanations for behavior (e.g., "I can't be in a relationship because I am damaged goods"). From the ACT perspective, reason-giving further amplifies both avoidance and rigidity, and tends to make treatment more difficult since many important "reasons" are unlikely to ever change. For example, if a difficult childhood is the reason for inaction (i.e., "I can't move forward *because* I was abused as a child"), then moving forward in life would seemingly imply that some other childhood would be needed in order to act differently (Walser & Hayes, 2006). Since no other history will be had, the patient is apparently stuck. Additionally, and in contrast to other models, ACT holds that reasons (i.e., thoughts) are not causes of behavior. Rather, they are understood to be critically important within the context of the social and verbal community that links them to behavior (Hayes, 1987). That is, particular stories and reasons are associated (often highly associated) with certain behaviors; however, they do not cause the behavior. From this standpoint, even if negative thoughts/reasons continue to occur, the patient can make choices that are about healthy living despite that the "reason" remains (e.g., choosing to take action even though the thought *"I am worthless"* doesn't change). In ACT, the target of change is not the thinking itself, but rather the relationship the patient has to their thinking. ACT-D specifically uses mindful awareness, defusion, and acceptance when working with depressive or negative thoughts in session.

Things to know: ACT holds that thoughts and behavior are highly correlated, but not causal. That is, having the thought, "I can't get out of bed," does not ***cause*** someone to stay in bed. Nor does the emotion associated with the thought.

ACT targets **F**usion, **E**valuation, **A**voidance, and **R**eason-giving by establishing willingness to experience thoughts and emotions, by supporting contact with the present moment, and by helping patients to defuse from problematic thoughts (and indeed, all thoughts as proves useful to engage effective living). Furthermore, ACT focuses on establishing an ongoing sense of self; or a "place" where thoughts, feelings, and sensations are experienced – i.e., self as *experiencer* (Hayes et al., 2012). Simultaneously, ACT targets supporting the patient in creating behavioral commitments designed to help live more consistently with personally held values. Overall, that ACT processes are designed to assist the patient in changing the relationship they have to their emotions and thoughts, viewing them as ongoing and changing experiences while also responding more flexibly to life events and challenges. Patients in ACT are led through several stages of therapy that bring them into contact with emotion and the present moment while also learning to observe their minds through exercises, meditation, and mindfulness techniques. Finally, defining personal values and making and keeping behavioral commitments are a large focus of the therapy. Implementing ACT helps the patient to see where effective life choices can be made, rather than remaining blocked by fusing with the mind and believing that thought and emotion must be different before positive action can be taken.

In therapy, the strategies of willingness, present moment, defusion, and self-as-context are used together to support acceptance and mindfulness processes. *Willingness* is an active stance (as opposed to being passive) of openness and acceptance in relationship to internal experiences. Both positively and negatively evaluated thoughts and emotions are able to be experienced with no need to make them come, go, or be different. The treatment consistently focuses on a conscious awareness of the here and now, or being in the *Present Moment. Defusion* strategies involve exercises that address the process of creating non-literal contexts in which language (i.e., thinking) can be seen as an active, ongoing, relational process that is historical in nature and present in the current moment. Strategies that center on experiencing events from "I/here/now", or the view of oneself in the now, are intended to support the development of *Self-As-Context*, or the place from which thoughts, emotions, memories, and sensations are observed; i.e., the observer self.

Things to know: Control, in this context, is excessive, misapplied, and focused on internal experience. There may be times when control is perfectly suitable for the context. It is therefore useful to assist the patient in discriminating between helpful internal control and harmful internal control.

Each of these processes is implemented and explored in the service of reducing experiential avoidance and increasing acceptance. Engaging in these processes increases flexibility by allowing emotion and mind to be present as they are – dynamic experiences, and to observe them without the quality of threat that they seem to carry when held literally. When the threat is decreased, avoidance and protection are no longer necessary – control of internal experience can be relinquished. From this perspective, the patient is guided to contact choice as a behavior that can be engaged while observing thoughts and emotions, rather than being "driven" by thought and emotion. This is not to say that patients cannot choose based on an emotion or thought, rather they are free to do so or not. Choice becomes an ongoing and readily available possibility that is free from any specific internal experience or any need to justify or explain; the question of what choices will be made arises. Here, it is most important to support patients in defining what matters to them, assisting them to connect with meaning and purpose, and supporting them in lining up their choices accordingly. Mattering is viewed as an activity and can only be done by the patient. Mattering is explored with the patient by helping them to clarify and define personal values. Specific behavioral goals or committed actions are set that yield fruit in valued areas or categories of living (e.g., family, friends, community, work, education, spirituality, etc.). These latter processes are about commitment and behavior change and are defined below:

- **Values:** personally important ways of living, instantiated by action, that can never be obtained as an outcome or object. Values are not divorced from human action and are better stated as verbs in ACT: valuing (e.g., loving, connecting, etc.).
- **Committed Action:** a series of well-defined actions (e.g., behavioral goals/steps) that move an individual in the direction of chosen values, regardless of what appear to be internal barriers such as negatively evaluated thoughts and emotions.

Things to know: Values should be used as "carrots not sticks." Values are not addressed in coercive ways to get patients to engage. Additionally, it is important to remember that patients are being asked to engage in committed action that is values consistent, not to engage in valued living. The latter has an implication that some kinds of living are more valued. This may be the case from a personal perspective, but values are there for each person to choose, including the patient.

Jointly, the six core processes are explored in session with the patient through use of metaphor, experiential exercises, mindfulness practice, talk therapy, and behavioral homework assignments. Appendix A includes a list of readings that more thoroughly describe the underlying theory, processes, and application of ACT. It will be important for the ACT therapist to grapple with multiple sources of information and reading material. It is recommended to continue to build an understanding of the theory and intervention by reading the below listed materials, listening to podcasts (visit contextualscience.org), attending additional trainings and workshops (see contextualscience.org), and seeking/developing peer support or consultation.

The General Flow of ACT-D

In the initial phase of ACT-D, it will be valuable to collect paper-and-pencil assessments and conduct a clinical interview. The assessment process is discussed in greater detail in a later section of the manual. However, it will be important to start the clinical process by asking Veterans about their **personal values.** A values assessment (see Appendix E for Values Assessment and Values Card Sort; also visit contextualscience.org for other examples) is completed to begin gaining clarity around what matters in each Veteran's life. After the initial assessment of values, explore with patients ways in which they have become stuck and unable to pursue some or all of their values. Then work with patients to deliberately undermine problematic and language-based control strategies. This is first done by exploring with patients the many ways in which they have tried to eliminate or change their negative memories, emotions, thoughts, and sensations (i.e., the content of internal experience). During this work, recognize that it is normal to employ these behaviors. That is, a person's cultural context supports the notion that psychological problems can be defined as the presence of unpleasant feelings, thoughts, memories and sensations. The presence of these unwanted experiences is often viewed as a sign that something is wrong and needs to be corrected. The presumption is that healthy living can only occur when these experiences are eliminated or reduced.

The Veteran working to correct these deficits by modifying the adverse factors that cause difficulty (e.g., low self-esteem resulting from critical parents, etc.) (Hayes, et. al., 2012) is doing so based on these cultural norms. Humans have been taught to problem solve negative experiences in order to have better self-esteem, more confidence, etc. in order to then have a better life. ACT tackles this very cultural norm as part of the problem. Patients are asked to explore how successful the attempts to control or eliminate this "problematic" content have been, particularly in terms of long-term outcomes. During this phase, it is routinely discovered that most elimination attempts involve efforts to try to control thinking and emotion in such a way that they no longer

occur or are substantially reduced. When these various control efforts are listed and described, it is revealed that the strategies to control internal experience haven't *truly* worked in any long-standing way. This stage of undermining excessive and misapplied control is called ***Creative Hopelessness*** and is part of building the path to openness and acceptance.

It is important to remember that this stage is a *creative* stage. The patient is "opened up" to try something different as an alternative to control. During this stage, it is essential to communicate that the strategy – control of private experiences – is hopeless, not that the patient is hopeless. In fact, there is great hope for the patient. In letting go of efforts to control internal experience the patient can begin to take control of their life. It is important to keep the type of hopelessness being worked on in this part of therapy in mind, and be clear with the patient. Communicate with the patient the hopelessness of the feel good agenda, while maintaining a solid sense of hope for the patient's capacity to make positive changes in their life.

Reducing control of private events is then explored in therapy. Point out how attempts to control internal events may actually prolong these experiences or paradoxically cause them to grow in intensity. ***Willingness*** to experience is offered as the alternative to control. Willingness is made possible by ***acceptance*** and ***defusion*** *(helping the patient de-fuse from the mind and/or mindfulness)* and by pointing to the sense of "self" that experiences – but is not defined by – any single experience. It is this larger sense of self that becomes the ***context*** for emotion, thought, sensation and memory (rather than being fused with the same). The patient learns that they are the place where internal experience occurs; they are not these experiences in and of themselves. For instance, we all have feelings that may last for a period of time, but they soon pass and other experiences (feelings) are there to be noticed and felt. The self that experiences these events remains constant.

The quality that is being created in therapy with the patient is one of being able to observe mind, emotion, and body as an ongoing process rather than discrete, literal, instances of thinking, feeling or sensing that must be responded to and changed. Once the patient is able to observe experience rather than automatically react to the content of the experience, new and more flexible ways of responding can develop. This sense of *observer self* is established through a series of experiential exercises, metaphors, and interventions that help the patient come in contact with ***self-as-context*** rather than *self-as-content*.

Finally, the work in treatment focuses on the additional concepts of ***values*** and ***choice***. Patients are taken through a series of exercises designed to help them clarify values and life goals that are personally important. ***Choice*** is approached as freedom of action that can occur in each moment, rather than needing internal experience to be a particular way (e.g., feeling "good") before choices and changes can be made. Furthermore, the focus is on making choices that are consistent with personal values regardless of the internal experience that is present at the moment. These internal experiences are still valid and important but no longer dictate behavior. Veterans are supported in coming to see themselves as whole human beings *with* on-going experiences (e.g., thoughts, feelings, memories, and bodily sensations) able to choose to live according to personal values at every step of the way.

To summarize, ACT-D is a compassionate therapy that views human beings as whole and acceptable as they currently are, with all of their historical experience, emotion, thought, and sensation. The key is to "hold" these experiences (gently observe and contact them without any effort to make them come or go), while also making flexible choices that are consistent with personal values or chosen life directions. This often has to do with making intimate personal connections, contributing in meaningful ways, and loving and playing in the world – accept and commit.

Figure 2. Hexaflex

Mindfulness and ACT-D[1]

Mindful awareness is explored, taught, and practiced in ACT. Awareness of the present moment is part of what makes acceptance possible. It will be helpful as an ACT therapist to have an understanding of mindfulness and to connect to how it can be helpful. Mindfulness is not a "thing" or a "technique," but rather a practice. The practice is non-theistic and therefore does not clash with any particular religious or spiritual belief system. Mindfulness is also about a person facing themselves and their lives as they are, without judgment. It is about awakening to the moment. Perhaps the greatest commonality between mindfulness practice and ACT is the idea that "acceptance precedes behavior change" (Germer, Siegel & Fulton, 2005).

Many definitions of mindfulness have been given by Buddhists and western clinicians who use mindfulness-based interventions with their patients. The word mindfulness is a translation of "sati" from the 2,500 year-old language of Buddhism. Sati connotes "awareness, attention, and remembering" (Germer et al., 2005). Essentially, being mindful means being awake and aware of the present moment as it is. Several western practitioners offer other definitions including the following: (a) paying attention, on purpose, in the present moment, nonjudgmentally (Kabat-Zinn, 2003); (b) awareness of present experience with acceptance (Germer et al., 2005); (c) awareness without judgment of what is, via direct and immediate experience (Linehan, 1993); and (d) nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise (Baer, 2003).

Nevertheless, defining mindfulness remains challenging because, as a felt experience, it is not easily translated into words. In some ways, it is easier to understand what mindfulness is not. Mindfulness is not passing your exit on the highway because you were "not there" for a while. It is not operating mechanically, on "autopilot" (Germer et al., 2005), or in reactive modes. Viewed this way, much of daily life is spent in a state of mind*less*ness. We get out of bed, wash up, brush our teeth, dress, drink that first cup of coffee and walk out the door in automatic mode, not necessarily noticing our moment-to-moment experiences (e.g., feeling the water on the skin during a shower or the sensation of clothes on the body, etc.) Operating in this manner is not automatically a good or a bad thing. There are times when a person needs to just "do" to get through the many demands of the day. However, in this mindless mode, we often miss out on more fully experiencing our lives. Additionally, when we are in automatic mode, we also miss the ongoing flow of experience. This has multiple costs, but key to ACT is recognizing that experience is constantly changing and is not a static affair. Mindfulness takes us off auto-pilot and assists us in connecting to the here-and-now, a place where vitality is alive and well.

Meditation practices are one aspect of mindfulness. However, there are a number of exercises rooted in daily life that are equally important in cultivating a mindfulness practice. Several of these exercises are described later in this manual. Additionally, the attitude a person brings to any form of mindfulness practice is also a central component of a mindful way of being. Kabat-Zinn (1990) identified seven attitudinal foundations of mindfulness practice: Non-judging, Patience, Beginner's Mind, Trust, Non-Striving, Acceptance, and Letting Go. Additionally, commitment, and purposefulness are necessary in cultivating these attitudes. Mindfulness practice is therefore not simply "meditating" or "doing an exercise," but it is also an attitude of openness and acceptance and a commitment to live more consciously.

How is Mindfulness Helpful? There are many benefits of mindfulness practice. Before reviewing the benefits of mindfulness, it is important to clarify one aspect of the mindfulness exercises. Many patients will confuse mindfulness meditation with a "relaxation" exercise. Although mindfulness exercises can facilitate feelings of calm and peacefulness, sitting with the many thoughts and feelings of the mind and body can be challenging, even distressing. Since "non-striving" is an important attitude to bring to mindfulness practice, it is important to let go of ideas of finding peace or even reaching an enlightened state through mindfulness. Rather, the peacefulness gained through mindfulness practice is more about finding peace with all aspects of experience, the positive, the negative – including moments of suffering – and the neutral. When Veterans report feeling relaxed following a mindfulness exercise, remind them that it is a by-product of the practice, not an outcome or goal.

MINDFULNESS IS NOT SIMPLY DOING AN EXERCISE; IT IS ALSO ABOUT CULTIVATING AN ATTITUDE OF OPENNESS AND ACCEPTANCE.

[1] Major contributions to this section were provided by *Jennifer Egert, Ph.D.* and *John Billig, Ph.D.*

Still, mindfulness can be helpful to patients in many ways. When introducing the process and practice of mindfulness, it is important to include a rationale for this part of the therapy. Include as much of the following information in the rationale as possible.

Mindfulness practice can help to sharpen concentration, allowing greater focus in activities undertaken in life. It can help to cope with stress, anger and other forms of emotion. Much of the suffering we experience when we face stressful events comes from our struggle with accepting the reality of the event; or judgments about the event and how well or poorly we are coping with it. Mindfulness helps us to experience these events fully, as they are without self-judgment and added struggle against reality. In a similar way, mindfulness can facilitate finding peace with painful memories and experiences. By fully engaging in the present, we experience the events in our lives in a richer, fuller way.

Mindfulness practice also facilitates a broader perspective of life and a sense of connectedness often creating a greater empathy for and forgiveness of others. We come to see that suffering is a universal experience and this can facilitate greater acceptance of challenges in life. Perhaps one of the greatest benefits of using mindfulness with patients is affect tolerance. Through mindful practice patients often come to see thoughts and feelings as transient experiences. This can help to decrease identification with a momentary affective state. It is important to remember though, that decreasing identification with a momentary affective (or mind state) is not a form of dissociation. Rather than being detached when mindful, affect is experienced more willingly and fully in the mind and body – fully connected to the experience in the moment. Lastly, when affect is experienced in present moment context, rather than in the typical past and/or future representations of affect (or self-criticism) it can facilitate greater self-understanding, and therefore greater self-compassion.

It can also be helpful to include a summary of the research support for mindfulness as part of the rationale provided to the patient. A number of research studies have demonstrated both emotional and physical benefits of mindfulness programs. These benefits include improvement in symptoms of chronic pain conditions (e.g., Kabat-Zinn, 1982; Kabat-Zinn et al., 1985; Kabat-Zinn et al., 1986; Goldenberg et al., 1994), clearing of psoriasis (Kabat-Zinn et al, 1998), improvement in fibromyalgia (Goldenberg et al., 1994; Kaplan, Goldenberg, & Galvin-Nadeau, 1993) improved quality of life and sleep among cancer patients (Carlson, Speca, Patel, & Goodey, 2003), and improved brain and immune functioning (Davidson et al., 2003), as well as reduction of symptoms of anxiety (Kabat-Zinn, 1992) and depression (Miller, Fletcher, & Kabat-Zinn, 1995; Teasdale et al., 2000). For a more complete review, see Baer (2003), and for a meta-analysis, see Grossman, Niemann, Schmidt, and Walach (2004).

Mindfulness and the Clinician. In very similar ways, mindfulness practice can help the clinician to be more present in his or her own life, experiencing the same benefits intended for the patient mentioned above. Additionally, it can help build rapport and help to stay connected to the patient in the moment. Engaging in the same activities being requested of the patient is an excellent form of modeling and will assist in being able to more readily speak to the qualities of mindfulness practice. We have all experienced moments in session when our minds are focused on a deadline, a to-do list or something not related to what is happening in the session. Mindfulness practice will heighten awareness of moments during therapy of being distracted or taken away from the present and thus the patient. To refocus attention at that time can be quite useful. Mindfulness can also facilitate empathy for challenging patients, helping to recognize their suffering – along with becoming aware of the suffering of human beings. A study by Grepmair and colleagues (2007) demonstrated improved therapist ratings and greater patient symptom reduction for therapists who underwent mindfulness training. For an excellent discussion of mindfulness as clinical training, see Fulton's (2005) chapter in Mindfulness and Psychotherapy.

Lastly, there is a common belief among practitioners of mindfulness-based treatments that to teach mindfulness to patients, there is a need to have some personal experience with mindfulness. Germer (2005) notes that the extent to which a mindfulness technique should be introduced in therapy should be consistent with the extent to which the professional has personal experience with the technique (p. 115). A part of being trained in ACT-D is also being trained in mindfulness. It is helpful to practice mindfulness parallel to asking patients to do so. This is not meant as a deterrent to those not familiar with mindfulness, but rather an invitation to experiment with and to practice some of the exercises patients are using or being asked to use.

The Role of Mindfulness in ACT-D. Mindfulness is an integral part of ACT-D as it aids in connecting patients with the core concepts of defusion and self-as-context, namely developing awareness of the ongoing process of thinking and sensation in the here-and-now. This is possible when the present moment is contacted. Present moment awareness is emphasized throughout any ACT intervention. Most ACT manuals and protocols, including this one, contain a series of mindfulness exercises and guided meditations that are designed to map onto the material and support the patient in developing conscious awareness.

As a practitioner of ACT, there are several ways to incorporate mindfulness into your practice. Again, it will be important to begin by providing a rationale for use of mindfulness. Use the outlined points in the above section titled "How is mindfulness useful in ACT?" or the introduction to mindfulness in a later part of this manual to develop a rationale. As with many components of ACT, it is difficult to explain verbally prior to arriving there experientially, but providing sound reason for engaging mindfulness will assist in this process. Remember, some patients may feel comfortable with the idea of mindfulness or with meditation while others may resist the idea of mindfulness and dismiss it as a religious practice or as a "hippie thing" or "too new age." Others, especially trauma survivors, may have difficulty sitting with their eyes closed in a group or in your office. Prior to using a mindfulness exercise, check in with patients about their previous experiences with mindfulness and dispel any myths or misconceptions. Be sure to adapt the exercises to fit the patient's needs. This could mean significantly shortening the exercise to focus on only three breaths, for example, or conducting the mindfulness exercise with eyes open. Eating meditations, walking meditations, or mindfulness exercises that are focused on being present to daily activities work well with most patients, including those who may initially be ambivalent.

As the ACT-D intervention unfolds, there are several points where additional rationale for mindfulness may be presented. For example, in the discussion of willingness, many Veterans may feel it is too overwhelming to think about being willing to be open to their painful emotions. This is a good time to talk about contacting what is happening in the present moment, using mindfulness to experience what is happening *now*, not what their mind is telling them will happen if they let themselves experience.

There are a wide range of exercises that can be used with patients to facilitate mindfulness. Indeed, most general mindfulness exercises involve choosing an object of attention, be it the breath, the body, food, an activity, nature or sound and making an effort to maintain attention on that object. When thoughts or feelings take the attention away, instruct patients to notice what takes them away and then gently bring their attention back to the object. Other mindfulness exercises from mindfulness-based manuals, other ACT books, or web and written materials may be used, but should be vetted prior to implementation to be sure they are consistent with an ACT approach.

It should be noted that choosing a mindfulness exercise for a specific patient is not a "one size fits all" endeavor. For instance, for patients with a history of trauma or psychosis, internally focused exercises such as the breath meditation can be overwhelming as the patient is being asked to face distressing internal content head-on (Germer et al., 2005). Similarly, some patients may be better able to integrate into their lives exercises focused on daily experiences such as mindful eating and walking. Use your clinical judgment in helping your patients to find the "right" mindfulness exercises for them. Ask them to experiment and see what is most helpful (see Germer's chapter "Teaching Mindfulness in Therapy" in *Mindfulness and Psychotherapy* for a comprehensive discussion of choosing appropriate exercises for specific patients, 2005).

Depression, the Veteran, and ACT-D

Veterans may experience depression as the result of a number of life events, including significant change and adjustment, loss, or trauma. Veterans may become depressed as a result of their wartime, military, or post-military experience. During wartime, many Veterans may have witnessed or have been involved directly in a traumatic experience; some have endured tremendous loss; some have experienced traumatic brain injury or loss of limb(s), others have experienced a deep questioning of their values; often times it is a combination of events that impact the Veteran's emotional state. As a result of these life events, Veterans can experience a number of problems ranging from lost jobs and family to loss of engagement in life and hope about the future. Broadly speaking, Veterans with depression may be reacting inflexibly, understandably so, to a number of events that they have experienced and have come to evaluate negatively. Once they begin to experience sadness, worry, anxiety, or negative thoughts, the process of avoidance related to these experiences may begin. For example, in the effort to not feel negative emotion, a Veteran may find himself not caring or becoming detached from others. Being detached may be perceived or experienced as easier than the pain of caring for someone. This may be followed, however, by making less functional behavioral choices (e.g., decreasing pleasant activities with others). When people begin to act and feel this way, less *is* expected of them behaviorally as others and the patients themselves get "caught up" in looking for the antidote to the negatively evaluated emotions and thoughts that seem to cause the problem in the first place. Patients and others become convinced that the answer requires fixing these negative emotional experiences *first*, before they can begin to behave differently and more vitally. A vicious cycle may be set in motion, with further withdrawal ensuing the failed attempts to not feel pain.

Veteran Spotlight: Many Veterans have experienced significant loss associated with direct physical or psychological trauma, wartime events, life transitions, and/or pre-military experiences. Avoidance of negative feelings can be common and may take the form of not caring or chronic emotional detachment.

Getting Started: ACT-D and Assessing the Depressed Veteran

Prior to initiating ACT-D, it is important to consider the role of assessment in the ACT-D treatment process. Conducting an initial assessment/interview and developing an assessment plan will guide the therapist in developing a case conceptualization and implementing the intervention. All of the assessments completed should be used to inform the case conceptualization process. Several areas of assessment should be considered. In addition to using standard self-report assessments linked to diagnosis, quality of life, and values, also assess patients during the initial interview and throughout therapy with respect to ACT processes linked to behavioral change. Keep in mind that assessment in ACT-D is an iterative process that is designed to discover how the six core processes are functioning in and impacting the patient's life (Zettle, 2007). Completing a clinical interview will help to begin to conceptualize the case in an ACT-D consistent fashion. The general assessment and case conceptualization information provided below can be of assistance when considering self-report assessment and the types of questions to ask patients when conducting a clinical interview. The Case Conceptualization Form can be found in Appendix C.

Assessment: Self-Report and Clinical Interview Topics.

1. Self-Report Instruments. Several self-report instruments may be used with this protocol as part of the initial and ongoing assessment process. Whichever instruments are chosen, plan to routinely administer them across therapy, using the scores to inform progress and process, as well as to assist the client in understanding how things are developing in therapy. Highlighting and discussing potential reasons for positive change with the Veteran is recommended. If there is no change in scores or if scores worsen, explore with the patient why this might be the case in a compassionate and thoughtful manner. Exploring assessment progress with patients is meant to be motivational, not judgmental. Seek to identify if there are places where the patient remains stuck and tailor ACT strategies to address these issues.

Consider an assessment plan that includes regular monitoring of symptoms (e.g., assess depression symptoms at initial and every other session including final session) as well as regular monitoring of ACT-D consistent processes (e.g., assess avoidance/flexibility and mindfulness at pre, mid and final sessions; see Appendix E for suggested schedule of assessment). Finally, understanding life functioning and the strength of the therapeutic relationship can be helpful. Specific assessment suggestions are provided below, however, feel free to tailor the assessments to the needs of your practice.

The self-report instruments used in the ACT-D training program (see Walser, et. al., 2013) initially included the Beck Depression Inventory-II (BDI-II) and later shifted to the Patient Health Questionnaire- 9 (PHQ-9). Other instruments included the World Health Organization Quality of Life Scale – Brief (WHOQOL-BREF), the Working Alliance Inventory-Short Revised (WAI-SR), the Acceptance and Action Questionnaire – II (AAQ-II), and the Five Facet Mindfulness Questionnaire (FFMQ). The first two instruments assess level of depression while the second assesses quality of life, the third assesses the therapeutic alliance, and the latter two assess ACT processes. Symptom and quality of life measures are useful for informing the therapist of baseline functioning and change, while the alliance measure will inform the therapist about rapport, and the process measures about whether the specified processes being used to create change are effective. Brief descriptions of these measures (see Glossary for description of BDI-II) and website addresses are provided:

The Patient Health Questionnaire (PHQ-9): The Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a brief screening and diagnostic questionnaire that assesses symptoms of depression as specified by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; APA, 2000) and the fifth edition (DSM-5; APA, 2013). Patients are asked to rate how bothersome each of the nine items has been over the past two weeks on a Likert-type scale from 0 *(Not at all)* to 3 *(Nearly every day)*. Item 9 screens for suicidal ideation. A final item can be administered for the diagnostic portion of this measure, which asks, "How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" The items can be summed to form a severity score from 0 to 27. The cut-off scores of 5, 10, 15 and 20 represent mild, moderate, moderately severe, and severe depression, respectively, per the initial validation study (Kroenke et al., 2001). Consider administering the PHQ-9 at the start of each session. Briefly scan the patient's responses and discuss any significant changes (positive or negative) from the previous week, as well as follow-up on elevated responses to item 9. The PHQ-9 and information about it can be found at: http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.

The World Health Organization Quality of Life Scale - BREF (WHOQOL-BREF; WHO, 1997) is a 26-item measure that assesses functioning in the following broad domains: physical health, psychological health, social relationships, and environment (Skevington, Lotfy, & O'Connell, 2004). Use the WHOQOL to determine if quality of life is improving across a number of domains. Consider administering the WHOQOL at baseline (session 1), during midpoint of treatment, and at the final session

(usually session 12). Higher scores indicate greater quality of life. For further information related to WHOQOL-BREF and to obtain permission to use this questionnaire, please send a message to WHOQOL@who.int

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) assesses key components of the working alliance between therapist and patient: (a) agreement on the treatment goals, (b) agreement on how to achieve the goals (task agreement), and (c) development of a personal bond between patient and therapist. Consider administering at baseline (session 1) and sessions, 3, 7, and 11. Higher scores indicate a better working alliance. There are a couple of ways to score the inventory. More information can be found at http://wai.profhorvath.com/. For additional information see http://onlinelibrary.wiley.com/doi/10.1002/cpp.658/abstract and https://www.niatx.net/PDF/PIPractice/FormsTemplates/Working_Alliance_Surveys.pdf

The Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2011) assesses the construct referred to variously as acceptance, experiential avoidance, and psychological inflexibility (i.e., or its opposite – flexibility – depending on how the instrument is interpreted). When first developed, the AAQ-I was a measure of experiential avoidance (e.g. non-acceptance/inflexibility), but as the ACT model matured, flexibility in responding – defined as the ability to fully contact the present moment, the thoughts and feelings it contains, without needless defense/avoidance and, depending upon the context, persisting or changing behavior in the pursuit of personal goals and values (Hayes et al., 2006) – became the overarching goal of ACT and thus what the AAQ-II measures. Patients are asked to rate how true each statement is for them on ten items ranging from 1 (never true) to 7 (always true). The AAQ-II can be explored as a process measure and may be administered at baseline (session 1), at every odd session thereafter (i.e., session 3, 5, 7, and so on), and at the final session (usually, session 12). Higher scores indicate greater psychological flexibility/acceptance depending on the scoring process used. For further information please visit: http://contextualscience.org/acceptance_action_questionnaire_aaq_and_variations. Additionally, a copy of the measure and scoring is included in Appendix E.

The Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, & Allen, 2004; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) is a 39-item questionnaire that assesses the respondents' general tendency to be mindful in daily life (e.g., "When I do things, my mind wanders off and I am easily distracted."). The FFMQ has 5 subscales: Observe, Describe, Act with Awareness, Non-judgment, and Non-reaction. It is scored on a 5-point Likert-type scale ranging from 1 (never or very rarely true) to 5 (very often or always true). The FFMQ is based on a factor analytic study including five independently developed mindfulness questionnaires and is considered to have good construct validity (Baer et al., 2008). This measure may be administered at baseline (session 1), midpoint and at or near the final session. Higher scores indicate greater mindfulness. Information about the instrument can be found here: http://asm.sagepub.com/content/15/3/329.short and a web search of the instrument will produce online and pdf versions.

In addition to these main measures, also consider administering the Valued Living Questionnaire (VLQ; Wilson, Sandoz, Kitchens, & Roberts, 2010), as well as the White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994). The VLQ is helpful in assessing the patient's values in 10 important domains as well as how consistently the individual is living according to those values. The VLQ may be used as an excellent clinical tool in working with and assessing values based behavior. The WBSI assesses the degree to which individuals work to suppress their thoughts. This can be thought of as a measure of avoidance of thinking or, in contrast, willingness to accept thoughts. Higher scores on each of these measures indicate greater improvement. Information about the VLQ can be found here: http://contextualscience.org/vlq_valued_living_questionnaire_0, and information about the WBSI as well as a printable free version of the instrument can be found here: http://contextualscience.org/WBSI_Measure and here: http://www.wjh.harvard.edu/~wegner/wbsi.html, respectively

2. Fusion with Depressive Thoughts. Patients with depression often develop rigid thinking, as they become ever more *fused* with the content of their minds. It is as if the patient *is* his negatively evaluated thoughts. During assessment, look for the places where patients have become rigid in terms of their evaluations of themselves, others and the world. This might include learning about how fused they are with the story of their life, or how much they "buy" automatic thoughts. It might also include assessing how much a particular thought evokes emotion. This kind of assessment is not done in the service of cognitive restructuring, but rather it is done in the service of seeing how stuck the patient is with respect to particular stories or thoughts. The goal would be to help the patient see these thoughts for what they are – thoughts.

3. Coping Strategies. It is important to identify both helpful and non-helpful coping strategies that the Veteran has utilized in the past. Helpful, ACT-consistent coping strategies (e.g., acceptance, past use of mindfulness, etc.) can be drawn upon as a strength. Also ask about problematic avoidance and emotional control strategies and about ways avoidance has made the problem

worse. For example, the Veteran may say that he does not want to be around people because it increases his anxiety and because he doesn't want others to react to him and his potentially painful emotional state. This isolation can be problematic and may actually increase the Veteran's depression. Assessing for misapplied and excessive avoidance and control involves asking and/or answering some form of the following questions:

a. Assess for internal control strategies: How much does the patient ruminate? Does the patient try to "escape" or avoid by suppressing thoughts? By daydreaming? Does the patient use distraction? Dissociation? Numbing?
b. Assess for external control strategies: How much does the patient use substances? Does the patient engage in behaviors that include withdrawing, working too much, or self-harm?
c. Observe in-session avoidance strategies: Does the patient avoid talking about certain aspects of his or her life? Is the patient resistant or argumentative? Does the patient shut down when asked certain questions?

4. Suicidal Ideation and Behavior. Assessing for suicidal ideation and behavior as a problem solving strategy or as an escape from emotional pain is also critical, though it is important to remember that not all suicidal behavior is about escaping emotional pain. For example, some suicidal behavior can be about escaping hopelessness or an attempt to evoke environmental change (Zettle, 2007). Therefore, it is important to assess the *function* of the suicidal behavior and then work to tailor the intervention based on what is learned. In the initial phases of therapy with a patient who is suicidal gauge the amount of creative hopelessness work that should occur. For some patients, it may be prudent to eliminate or use a *lighter* version of creative hopelessness. Good clinical judgment is required in order to keep the patient safe and to determine how to apply this technique as called for in the current situation. For more information on using the process of creative hopelessness with patients who may be at risk for suicide, see Zettle (2007). Suffice it to say, creative hopelessness can be done with a light touch, moving more quickly to control as the problem or skipped, but only if deemed important in the case of a suicidal patient. The goal isn't to create more feelings of hopelessness, it is to recognize the hopelessness of trying not to feel.

Clinical Watch: Remember - Creative hopelessness is not about the patient being hopeless; it is about the situation being hopeless. The "creative" part of this work is that something different is possible, that clearing out the old unworkable control agenda is needed to make room for what can be a very hopeful thing: **a better life.**

Suicide Risk Assessment and Safety Planning. It is essential to conduct a thorough suicide risk assessment and develop a safety plan (Stanley & Brown, 2008) if a patient appears to be at risk of suicide. Crisis intervention or referral for more intensive treatment should be arranged when clinically indicated. A suicide risk assessment may be warranted if patients endorse a 1 or higher on the suicide item (Item 9) of the PHQ-9, which is incorporated into the ACT-D protocol as described below. Other reasons for conducting a suicide risk assessment include the patient's report of suicide intent or plan, a recent suicide attempt, new or increased severity or frequency of suicidal ideation, threat or other behavior indicating imminent risk, uncertainty that the patient can control his impulse to harm self or others, an abrupt positive or negative change in clinical presentation, lack of improvement or worsening despite treatment, significant loss, or other negative life event. Thus, while it is recommended to complete the risk assessment early in the therapy process, it may be completed at any point in the treatment as indicated by warning signs or other risk factors as reported by the patient, as indicated by assessment measures or the medical record, or as indicated by direct observation of the patient's behavior.

Below is a list of risk and protective factors for suicidal behavior that are often considered in the context of a suicide risk assessment. Assess for these risk factors by the Veteran's verbal self-report as well as by other sources, such as completed measures, medical record, other therapists, or family members. Note whether each risk factor is present or absent. Although a detailed description of specific strategies for conducting a comprehensive suicide risk assessment is beyond the scope of this manual, additional information can be found in *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003).

Potential Risk Factors	
• History of single or multiple suicide attempts (lifetime and especially in the past 30 days) • History of non-suicidal self-injury behavior • History of aggressive or violent behavior toward others • Preparations to kill self (purchased a gun, wrote a suicide note) • Current wish to die, or wish to die outweighs wish to live • Current suicide ideation with intent to kill oneself • Current specific plan to kill oneself, lethal method currently or easily available • Reluctant to reveal suicidal ideation • Regrets surviving a previous attempt • Any recent stressful life event such as a job loss, break-up of a relationship, interpersonal conflict • Any abrupt negative or positive change in clinical presentation	• Current severe hopelessness • Current major depressive disorder • Current psychosis (especially command hallucinations to kill oneself) • Traumatic images • Current mania or other highly impulsive behavior • Relapse or current substance abuse (illicit drugs, alcohol, and/or medication) • Exacerbation of physical pain or other serious medical problem (e.g., Chronic Obstructive Pulmonary Disease) • Current agitation or acute anxiety • Current perceived burden to the family • Current homicidal or aggressive ideation, or • A problematic treatment history, including hopelessness, indifference, or dissatisfaction about current treatment, history of treatment noncompliance, current unstable or poor provider relationship, or other problem interfering with treatment

Potential Protective Factors	
• Current hopefulness • Current reasons for living • Current wish to live outweighs wish to die • Current perceived self-efficacy in the problem area • Current responsibility to children, family, others, or pets • Current living situation with dependents	• Current engagement in treatment and/or emotionally connected to the provider • Current supportive social network • Current fear of death, dying, or suicide • Current belief that suicide is immoral • Current lethal method of suicide unavailable • Current participation in religious or spiritual activities

Wenzel, Brown, & Karlin, 2011.

After risk and protective factors have been assessed, determine whether or not the patient is imminently or highly dangerous to himself. The reasons for this determination should be noted in the medical record. Next, choose an appropriate action plan given the Veteran's level of suicide risk. If the Veteran is determined to be at high risk for suicide, consult the local Suicide Prevention Coordinator, and place the Veteran on the High Risk List and start the Enhanced Level of Care process. This includes the development of a safety plan, higher intensity or frequency of treatment, hospitalization, or other treatment plan modifications. The Veteran may be hospitalized if it is determined that they are at a high or an imminent risk for homicide or suicide or are otherwise a danger to themselves and cannot be safely treated on an outpatient basis.

For any level of risk complete a safety plan with the Veteran. A safety plan is a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that Veterans can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides patients with something more than just a referral at the completion of suicide risk assessment. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, patients can determine and employ those strategies that are most effective in managing

acute distress. It is strongly recommended to consult the following manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version* (Stanley & Brown, 2008), for a full description of the safety plan protocol.

Finally, identify follow-up procedures. These may include continuation of care in the days or weeks following the suicidal crisis or plans to conduct a follow-up risk assessment (interview time and date are noted), examining the medical record (especially from any recent hospital admissions), contacting a provider or agency also responsible for the patients care, or contacting family members or other responsible individuals (especially to alert them of increased suicide risk) (Wenzel, Brown, & Karlin, 2011). It is encouraged to review resources on suicide risk assessment and prevention on the VA mental health website, which can be accessed at: http://www.mentalhealth.va.gov/suicide_prevention/index.asp. Finally, always provide at-risk Veterans with the Veteran crisis line telephone number: (800) 273-TALK (Veterans press 1).

5. Functional Analysis. Another vital task in assessment in ACT-D is to complete a functional analysis across time and behaviors. In the functional analysis, assess how a particular behavior or set of behaviors functions or accomplishes a particular outcome for the individual, rather than just looking at the topography or frequency of behavior(s). For instance, a depressed patient may believe that they need to "look inward" and figure out why they are feeling a certain way. The form of this behavior may look like self-contemplation and seem to be in the service of getting rid of depression. However, the function of the behavior may serve to keep the person isolated and withdrawn from activities that may actually be helpful. A way to think about this process is to understand how the behaviors are "working" for the patient in terms of desired goals. Assess *why the individual views being depressed as bad.* Asking about this will get to the function or the purpose of the current emotional state (Zettle, 2007).

Continue assessing the patient's behavior in terms of function across the therapy. This should include looking for both patterns of behavior and behaviors that are problematic or keep the patient stuck in the current unworkable situation and then evaluating them in terms of their function. The ultimate goal is to work with the patient such that behaviors function to support values-based living. Understanding the function of the patient's behavior will help determine which ACT processes to apply, when. For instance, if the patient is engaging in behaviors that function as avoidance of emotion then focus on the process of acceptance; or if the patient's behavior is ruminative and is serving to try to control anxiety, then both present moment and defusion might become more of a focus. Incorporating, the processes across the protocol, while also balancing the implementation of the protocol, should stay linked to the patient's behavior and its function.

6. Values Assessment. ACT has a particular focus on personal values and living a more vital life with respect to those values. Assessing for the patient's values will help to guide your therapy. In addition to having the patient complete the Values Worksheet (see Appendix D), the patient can be asked a number of questions about their personal values and the life they would like to lead. Some questions that are helpful in clarifying the patient's values include: "What do you care about?" "If you could lead any life, what would that life be?" "What actions have you stopped taking that are consistent with your values?" Further, identifying avoidance behaviors that are linked to inaction around values-based behaviors is important in order to determine what actions can be actively re-engaged. Working with the patient to take active steps in his life that are linked to valued ends can be very helpful. When the patient engages in these kinds of behaviors, he may actually begin to experience a reduction in the negative effects of inaction and dysfunctional, avoidant strategies. And, although this is not the explicit goal of ACT-D, the patient may also begin to experience a decrease in negative appraisals or problematic thoughts. This is the result of engaging in meaningful life activity, rather than trying to eliminate the thoughts or avoid experiences.

7. Behavioral Goals. Finally, there is a significant focus on identifying the individual behavioral goals for treatment. These goals are not derived by the therapist and prescribed to the patient; rather, the patient is asked to spend some time thinking about what he or she values and what goals and actions would be associated with those values. Some of this will take place in the context of the therapy, and some will be elucidated through the use of the Values Worksheet (see Appendix D-2). The values form is worked on in session, particularly during the first phase of treatment, but is also followed and updated throughout treatment. The patient and therapist work through a few examples and then the patient is asked to continue to work on the completing the form outside of the session. This form should be revisited and revised across the therapy. This and other values work will help define what patients want their lives to be about in a number of domains, what their goals are, and what specific behavioral actions they can take toward these goals. Once this information is obtained, the patient defines barriers to implementing the goals and actions. Work together to address these barriers.

ACT-D Case Conceptualization with Veterans

The ACT-D case conceptualization is fully grounded in theory, principles, and core processes that guide the therapist in supporting behavior change. By *behavior*, it is important to remember that *we mean everything the person does including thinking, feeling, and overt behavior* and, using this understanding to implement ACT consistent strategies. The goal with the conceptualization is to examine the patient's history and current context and to note how these are associated with the target problem(s) and how and they might be creating inflexibility. Work to understand the unique circumstances that have given rise to the patient's personal struggle and problems. Assess these according to the six processes in ACT and their corresponding pathologies. As mentioned, a functional analysis of behavior should be conducted, which involves looking to see what the antecedents and consequences are for any problematic behavior(s) – or, stated differently, the functional analysis will aid in understanding how the behaviors are "working" in the patients' life. [For more detailed discussion of behavioral principles and how they are applied in psychotherapy, see Ramnero and Torneke's (2008) book, *The ABC's of human behavior: Behavioral principles for the practicing clinician.*]

In sum, it is critical to establish a context for case conceptualization. In ACT-D, the goal is to help patients consistently choose to act effectively and according to their values. Identify the case conceptualization framework by using the clinical interview and self-report assessment strategies to evaluate the patient's current psychological functioning and to assess progress over the course of treatment.

The clinical interview is another strategy used to guide the case conceptualization. In the clinical interview, the patient is asked, in addition to the assessment above, a number of questions to understand how the ACT principles apply to the individual patient. The clinical interviewing should be designed to understand the private experiences the patient is attempting to avoid (e.g., sadness, anxiety, thoughts of worthlessness) as well as ways in which the patient is failing to act in ways consistent with his life values. The clinical interview can be important in gathering information not only about symptoms and current problems, but also about the contextual circumstances of the patient (e.g., current life issues, living conditions), the general behavioral patterns in which the patient engages, and, again, the kinds of in-session behaviors relevant to the case. All of this information can then be used to refine complaints and concerns into an overall ACT-D-consistent conceptualization.

The ACT Case Conceptualization form can be used to record the information gathered during the assessment phase that is relevant to conceptualizing the case in more detail. The case conceptualization should involve identifying ACT behavioral targets (summarized from Lillis & Luoma, 2005; for further information see Bach & Moran, 2008). Overt behavioral avoidance can be identified by asking the patient questions like, *"What parts of your life have you dropped out of?"* Identify external and internal emotional control strategies which can be guided by questions such as, *"What external strategies (drinking, drug taking, smoking, self-mutilation, etc.) do you use to avoid your emotions?"* and *"What internal strategies (distraction, self-monitoring, etc.) do you use to avoid your emotions?"* Attending to the patient's behavior in session can aid in detecting additional avoidance or emotional control behaviors (e.g., topic changes, aggressiveness, resistance, dropout risk, etc.).

Assessing factors that may be related to the patient's motivation for change is another important piece of the case conceptualization. This involves asking questions to assess what cost avoidance has in the patient's life (e.g., decreased interaction and connection, loss of important goals and activities), as well as the experience the patient has with the futility of his current efforts to control unwanted experiences. Similarly, assessment should attempt to elucidate the extent to which the patient has clarity about and is in contact with their personal values. An additional factor that may impact motivation for change is the importance of the therapeutic relationship. Does the patient feel "heard" and understood in treatment? Is the therapist able to take a compassionate and nonjudgmental stance and be empathic? In general, the process of case conceptualization should consider the compatibility of the therapist's and patient's goals and the rapport between them.

Treatment is also impacted by circumstances external to the therapy environment and conceptualizing a case should consider any external barriers to therapeutic change. One way of accomplishing this is to ask the patient questions about his or her home environment. What is it like? Is it supportive or non-supportive? What are the patient's current financial circumstances? Are there potential costs to making changes in one's life such as loss of friends, loss of disability benefits, loss of special status, or other risks?

The case conceptualization can also be informed by assessment of factors that contribute to psychological *inflexibility*. Assessing this aspect requires both asking the patient directly in the clinical interview as well as observing instances in session that demonstrate examples of the non-acceptance of thoughts, emotions, memories, and sensations. The degree of *fusion*

experienced, including the ways in which the patient becomes entangled in evaluative thoughts, is overly attached to beliefs, expectations, and right and wrong, or is engaged in overuse of insight and understanding should be evaluated. Relatedly, understanding the ways in which the patient is fused with *self-as-content* and holds their identity too literally should be a focus of assessment. Asking questions that help to understand the ways in which the Veteran is entangled with their life story and the ways in which fusion with that story are keeping the patient stuck is helpful. As well, asking the patient how they might be defining their life by being fused with a particular kind of content (e.g., "I am too overwhelmed") is essential.

Assessment and case conceptualization in ACT-D also involves understanding the degree to which the patient is out of contact with the present moment by being preoccupied by the past or future or is unable to see the ongoing flow of experience. It is also important to have a good understanding of the degree to which the patient is out of contact with their personal values or if there is lack of clarity about personal values. In addition to assessment of personal values, assessing the patient's ability or inability to build patterns of committed action is also critical. For example, is procrastination an issue? Are compulsive behaviors (e.g., angry actions) problematic? Are self-defeating actions (e.g., staying in bed) part of the problem?

While focusing on the importance of assessing areas that may be problematic for a patient, it is also important to assess the patient's ability to be flexible and responsive. This will aid in understanding the patient's strengths and building on them to support the therapeutic process. Identifying these strengths may involve assessing the Veteran's positive experiences with mindfulness practice in the past, exploring episodes where "letting go" worked for the patient, exploring times when the patient was able to be intensely present to the moment, and exploring times in the past where the patient took a course of action that although painful or difficult, was consistent with their values.

Using Assessment Information to Build the Case Conceptualization. The assessment information is used to build the case conceptualization and develop an initial treatment plan. Remember, case conceptualization should be considered a dynamic process. New information in the therapeutic work should be considered in light of the working conceptualization, and the case formulation adjusted accordingly. Given the assessment and conceptualization, ask: What parts of ACT-D need to be emphasized and which of the following treatment processes will be the primary areas of focus for an individual patient:

1. Generating creative hopelessness.
2. Understanding that emotional control is the problem.
3. Developing willingness.
4. Experiential exposure to the non-toxic nature of private events through acceptance and defusion.
5. Generating experiences of self-as-context to facilitate experiencing of feared events in the present moment.
6. Making contact with the present moment/mindfulness.
7. Exploring values.
8. Engaging in committed action based on chosen values.

After completing the initial case conceptualization, be sure to refine and rework it while moving through the therapy and the protocol. The information gained from ongoing assessment and each session will guide updates. The case conceptualization should be referred to weekly in order to stay focused on the overall goals and direction of the intervention.

The Protocol

The Big Picture

Most humans are hurting or will be at some point in their lives. Suffering, as distinguished from pain, appears to be a uniquely human problem (also see Hayes, et al., 2012 for further discussion). That is, other animals may experience pain, but they don't seem to get stuck in the process of suffering in the same way humans do. For instance, if a man and a dog were standing outside in the rain, they both might be cold and wet and ready to be inside. Imagine that the dog and the man are waiting at the front door of a home for a long period of time in these circumstances. Finally, someone comes to open the door. The difference between the dog and the man is that the dog will curl up by the fire, "free" from what was happening when it was out in the rain and cold, the man however, may not be free. He may continue to complain about the cold and how no one was there to let him in and about how awful the whole experience seemed to be. Man has the unique capacity, through verbal processes, to "live" in his past or to live in the future, depending on the circumstance. In fact, humans – through language – have many unique capacities.

Language is good in many ways. It helps us to connect, communicate, plan, problem solve, learn and know. Nonetheless, language can also be harmful. For instance, humans, through language, are fully aware of their own deaths and thus can suffer existentially as a result. Humans can construct futures that have never been experienced and then compare themselves to those constructs (e.g., "If I had only not had that terrible childhood, my life would be so much better now"). Humans evaluate with language, a healthy process for survival and planning, but an unhealthy process when turned inward (e.g., "I am worthless"). Humans also judge, wish, and desire in ways that can be helpful but also destructive; and, even the very process of problem solving, when misapplied, can wield harmful effects. We have come to be so dependent on language that we have lost that we are in the process of "languaging." That is, we have *become our minds* rather than seeing that we have minds. We have lost our wholeness – that larger sense of self that is the place where thinking, feeling, sensing, remembering and experiencing occur – "being" itself. Living as if we are our minds carries its own set of problems. Simply said, our minds are not always our friend.

The mind is not our enemy either. There is much utility in knowing and understanding. Verbal knowledge (i.e., mind) has led to tremendous problem solving and has created everything from electricity to intimacy. However, there is a dark side to verbal knowledge. We are taught through culture and language to strive for happiness and good feelings or good thoughts. We are taught that the good life is the happy life. If feeling unhappy, this is a problem that requires fixing. Indeed, the unlikeable emotions and thoughts – the ones that are considered abnormal or dysfunctional, are a problem; and, problem solving begins. This useful strategy applied in the environment outside of ourselves is turned toward what we consider problematic internally (e.g. If you do not like sadness or anxiety or if you do not like a thought or memory, figure out how to get rid of it and get rid of it). We try to *control* our internal experience in efforts to be acceptable and happy.

Control in most areas of our lives is quite effective and allows us to manage much of what is happening. However, when we take this strategy and try not to feel and think by controlling our feeling and thinking, we might actually, paradoxically, be causing the negative thoughts and feelings to linger or increase in intensity. For example, if you don't want sadness and you are trying to control it, you must already have sadness. If you don't want to think "I am worthless" you have to contact the thought, "I am worthless" in order to try not to think it. You get caught in the paradox of trying not to think a thought or have a feeling that you must already have in order for you to know you don't want to have it. This can cause the problem to grow, rather than shrink, and the struggle to suppress or eliminate these internal events can become the suffering itself.

This effort to try to control private experience is termed experiential avoidance in ACT-D and can lead to a life fraught with the struggle (i.e., suffering) to eliminate or decrease unwanted emotions and thoughts. The goal of ACT-D is to tackle suffering not to eliminate unwanted experiences. Indeed, from the ACT-D perspective, engagement in efforts to control can pull a person away from other important life activities, potentially increasing their suffering. Humans are designed, naturally, to experience emotion – both the kind that they evaluate as positive *and* the kind they evaluate as negative. Battling these natural experiences may very well define suffering itself. Furthermore, simply through the process of evaluation, a person's mind has become involved with their emotional experience – sorting them into good and bad categories – to be kept and to be eliminated categories. But what if it is the case that emotion, evaluated as good or bad, is there to be felt rather than desired after or pushed away. And, also notice that emotion and thought experience are constantly changing, even in very subtle ways. Through careful observation, emotions and sensations can be "seen" to increase and decrease in intensity, as they rise and fall to be followed by other emotions or sensations. Same with thoughts, they come and go and come and go again. Sometimes they are focused on problem-solving and sometimes they seem to be loosely floating around from event to event. Sometimes thinking is slow, carefree and sometimes

chaotic and racing. However, when we "get captured" by our mind, it can pull us away from this kind of process. It is as if we become our thoughts and lose the broader sense of a whole self that has a history, feels, thinks, senses, remembers, engages, chooses, and lives in the world. The whole of a person is lost to a struggle with parts of their self, parts that have been evaluated as not okay. The struggle then isn't in the person having and feeling negatively evaluated emotions – it is in the implication that they can't have these because the emotions seem to mean something about them. Years of a life can be lost to trying to not feel, to not think, to not sense, to not be.

ACT-D reconnects us to being. It holds the notion that human beings are 100% acceptable as they are with all of their history, emotions, thoughts, and memories whether evaluated as good or bad (this does not mean that ACT supports problematic behavior, (e.g., violence, these kinds of behaviors are not acceptable and should be addressed). ACT-D engages a "first you win then you play game" – you are whole and acceptable *now*, rather than a "first you lose then you play game" – you have to eliminate negative experience in order to be whole and acceptable. ACT-D, in part of its technology, steps outside of language (mind) and helps to create a place where the patient can learn to observe experience, whether categorized as positive or negative, and then choose to act on it or not. ACT-D also focuses on getting patients back in touch with values-based life activity *now*, rather than waiting to feel good before those activities can be engaged.

The overall "story" and implementation of ACT-D includes working patients through the recognition of the problem of language when it is misapplied (e.g., problem-solving internal events) and then creates a place where acceptance and observation of internal experience is possible. This is all done in the service of values-based living. The steps in the protocol align with this story and can be broadly told to the patient.

The following is an example of this type of conversation with a patient;

Therapist: "Throughout the process we have explored a number of things. First we talked about all of the efforts you made to feel better and then we talked about how that wasn't working and we gave it a name: *control* (improperly applied to internal experience). We then explored an alternative to control: *willingness to experience or acceptance*. We worked on building the willingness muscle by developing a sense of self that is larger than your thoughts, emotions, and sensations, a *sense of you that is a context*, an experiencer of these events (emotions, thoughts, etc.) – a place where thoughts, feelings, memories, and sensations occur. From that place, where you are larger than, and not just simply your thoughts and feelings, you are free to make choices. So, we explored *values* and talked about *getting your feet moving* in a direction that was consistent with those values, as a choice – accept and commit."

Clinical Watch: When talking about "control" as the problem, you will want to be clear about what you mean. Let a patient know that you want them to be in control of their own life. When we are speaking about letting go of control it is specific to the excessive and misapplied control of internal experience.

Getting Started with ACT-D

ACT is a principle-based intervention and is broadly applicable to human suffering in its various forms. As noted, it has been researched across a number of diagnoses and has demonstrated positive outcomes (Hayes, et. al., 2006). This manual, however, was created using the ACT approach applied to the problems experienced by Veterans who are struggling with depression (and depression with co-occurring anxiety). Clearly, not every individual who experiences depression is the same and individuals diagnosed with depression should not be treated as a homogeneous group. This treatment may not be appropriate for every individual who has or is experiencing depression. Individual assessment should guide treatment intervention decisions. Some key events to look for when considering this intervention include, but are not limited to: experiential avoidance and inaction, being "stuck" in the past, being overly bound to ineffective rules (loss of flexibility), long-standing and/or difficult to treat depression, and multiple treatment failures.

Therapist Orientation

The theory underlying ACT is as important as the intervention itself. The more thoroughly therapists grapple the theoretical material, the more able they will be to respond in an ACT-consistent fashion to the constantly shifting, idiosyncratic moments that occur during the course of therapy. Additionally, it is important for therapists to have training in ACT. Much of what is learned

during training in ACT will allow the manual to be more accessible. To implement ACT well, it may be necessary to re-think some of the assumptions found in typical approaches to psychotherapy and psychopathology. For instance, several theoretical and training traditions view thoughts as causing problematic emotions and behaviors and therefore these are the primary target for intervention. ACT assumes a relationship between thoughts and behaviors. However, thoughts are not considered to be causal and efforts to change the form or frequency of thoughts are abandoned in the service of changing their function.

As a part of the process of learning ACT-D, refer to a list of references and theoretical readings in Appendix A. It is recommended to read these while continuing to learn the ACT–D approach. Ongoing consultation and supervision are also highly recommended. Weekly consultation with an ACT-D training consultant, for a period of six months, is included as a core component of the VA ACT-D Training Program. It is simply the case that ACT can be challenging to do with integrity, as it is easy to slip into giving the patient messages of control related to private experience. Mistakes typically occurring early in training and implementation can take the form of (a) inconsistent use of the approach caused by the unsystematic mixture of acceptance- and control-based procedures (paying attention and careful use of language are helpful in remaining consistent) and (b) the use of ACT in a "technique-like" way that is either dominating, controlling, or mired in excessive use of language that places the therapist in a one-up position, rather than in a compassionate, caring and equal position. Also, exercises and metaphors can be "dropped" into therapy without context or without being linked to the patient's personal experience. This tends to make the exercises and metaphors "flat" and ill-fitting. It is important to link the exercises and metaphors together and to link all of this to the patient's experience.

Clinical Watch: It is important to keep in mind that the pain and internal difficulties of the individuals who have come to see a therapist are not fundamentally different from the pain and internal difficulties of any other human being – including the therapist.

A final caution: It is generally not recommended to read directly from the manual in session. This can be a barrier between the therapist and the patient and disconnect the therapist from the relationship. It is critical to know the materials before the session. Also, take care not to read exercises in session. Commit to understanding this material before a session and then use your own words to lead the exercises or metaphors. It is important to bring your therapeutic style to the work. If prompts would be helpful in the initial stages of learning the therapy, take just a few notes (e.g., 3 to 4 key phrases, headings, or topics; create a "cheat sheet") and refer to them if needed. A patient will know if you are stuck in your 'mind' – concentrating on doing things 'right' rather than responding to the patient contingently.

Therapeutic Stance

Just as it is important to grasp the theoretical material, it is equally important to engage ACT-D personally. ACT-D asks a therapist to be willing to experience also, just as is asked of the patient. Therapists, like patients, sometimes find themselves avoiding feelings and thoughts in harmful and ineffective ways. To do this therapy competently, you need to work with your own anxieties in the same way you are asking the patient to work with theirs: open up to them, get in contact with personal values, and actively engage the goals that are consistent with those values. Being able to be present to your own internal states is part of doing this therapy well. Also, taking actions that are consistent with moving the patient forward – even if you are feeling anxious – is crucial. For instance, when a therapist has the thought in session, "I don't want to do that," it may be a cue that that is the very thing that needs to be done. Use good judgment, of course; whatever is done should always be in the service of the patient's wellbeing and within ethical bounds. Conversely, the things that you as therapist might automatically think to do (e.g., reassure, comfort, reason with) may be the things that would not be helpful to do in this treatment. Only a functional analysis along with a conceptualization of what will be effective for the patient will tell if it is the appropriate thing to do.

Several of the core competencies in ACT-D that characterize the therapeutic stance, include speaking to the patient from an equal, vulnerable, compassionate, genuine, and sharing point of view while respecting the patient's inherent ability to move from unworkable to workable responses; a willingness to self-disclose when appropriate and when it serves the interest of the patient; and modeling acceptance (Luoma, Hayes, & Walser, 2007) for the patient. Broadly speaking, the therapist models psychological flexibility. This is not always easy to do. Therapists bring their own histories, interpersonal limitations, and idiosyncrasies into the therapy room. Catching all instances of flexible and *in*flexible behaviors made by the patient can be challenging given our own personal quirks. Rather, take a general stance that reflects psychological flexibility and instantiates this process over time. Additionally, as an ACT therapist, bring the core processes to bear in the moment. That is, exemplify and work to promote in-

the-moment acceptance, defusion, and values-based behavior. Luoma, Hayes, and Walser (2007), Pierson and Hayes (2007), and Wilson and Murrell (2004) provide additional information about ACT and the therapeutic relationship. Read these articles and book to better understand the core stance in the ACT therapeutic relationship.

Clinical Watch: One of the key processes inside the therapeutic relationship involves maintaining a stance of *compassion* toward your patient – sitting with him or her in their pain in an open and accepting way, while continuing to encourage vital movement.

The Structure of ACT-D

This 12-session protocol contains the basic structure for implementing ACT-D with individuals (or groups for more advanced clinicians already trained to deliver ACT-D with individuals) who are experiencing depression alone or depression with co-occurring anxiety. The protocol was developed for the VA ACT-D Training Program and is designed to speak to the application of the therapy and the nature of the therapist using ACT, while also considering the Veteran with depression. The three prongs of patient, therapist, and therapy are ideally balanced across the therapeutic relationship. The protocol is set up sequentially, but flexibility is still allowed within the manual. Although 12 sessions are presented here, it is recognized that the therapy could take more or less time for an individual patient. For some Veterans, the protocol presented in this manual may require up to 16 sessions to be fully implemented, for others, it may take only 10 sessions. Any of the sessions below can be stretched across time allowing for thorough coverage of the exercises, metaphors, and therapeutic work that may need to be done with an individual Veteran with specific needs. This manual specifically provides Veteran examples to demonstrate the various ACT-D techniques and it provides Veteran-specific references throughout the manual so that you can more thoroughly read about and digest the materials supporting ACT-D and its theoretical underpinnings, as well as consider Veteran needs and context.

This manual provides considerably more structure than may be found in some clinical settings. This structure is provided in order to improve overall understanding and knowledge of the intervention while learning its application. Furthermore, increasing the quality of implementation involves some degree of consistent and structured practice, tailored to the needs of the individual patient.

Session topics are generally organized around the six core processes with each session containing several key content areas. Although sessions should include each of these content areas, as mentioned, some flexibility is allowed depending on the individual and your assessment of the patient and what is happening in the session. For instance, you may decide to cover one of the core concepts for a longer period of time. Or decide to extend the treatment up to 16 sessions if needed and as noted. Such changes must be done as a part of your assessment of the particular patient and should not be instituted in a way that compromises the integrity of the therapy. You may also choose to use other therapy techniques in addition to ACT-D (e.g., motivational interviewing, behavioral activation), although it is important not to deviate from the core assumptions of ACT-D. These are foundational, and the simultaneous use of conflicting theoretical interventions can be problematic for the therapeutic process.

Importantly, should you determine that the patient's condition is deteriorating sufficiently such that the patient, the therapist, and/or a supervisor or consultant deems different or more intense treatment is necessary (i.e., hospitalization), appropriate actions should be taken and referrals should be made.

Finally, *preparation is key to successful implementation.* It is strongly encouraged to fully read through the section for each session while learning the therapy prior to entering the therapy room.

Clinical Watch: Preparation is key to successful implementation. It can be easy to get lost if you fail to prepare. You may fall back on old knowledge under these circumstances, which can lead to an inconsistent or confusing session.

Expanding the Protocol from 12 to 16 Sessions. Any of Sessions 1-11 can be expanded to accommodate the exercises/metaphors and patient interaction and/or situation. For instance, during Session 6 (Willingness/Defusion), it may be felt that more time is needed to explore the material and work with the patient. Do not feel the need to rush through the session. For instance, in

Session 7, content may be continued from Session 6 and completed before moving on to the material in the "official" Session 7. This may need to be done at several places in the protocol. Except under unusual circumstances, therapy should be able to finish by Session 16.

Things to know: It may not be necessary to complete every exercise and metaphor provided as long as you have created the intended experience for the patient and have a strong sense that they are connecting to the material and making progress.

Clinical Watch: One of the key processes that occurs inside the therapeutic relationship involves maintaining a stance of *compassion* toward your patient – sitting with him or her in their pain in an open and accepting way, while continuing to encourage vital movement.

All exercises and metaphors utilized in sessions should be related to the patient's experience. Spend time processing the exercises and exploring how what is done in session is relevant to the person's life and struggles. Work to tie the material together across sessions, linking the processes together in an overarching story, while also linking sessions, metaphors and exercises, and then linking the full process to the patient's experience. Not all exercises and metaphors will "click" with the patient and the focus should be on those that work. If an exercise does not seem to fit for the patient, perhaps spend a bit of time exploring the meaning; however, there are plenty of other exercises and metaphors to move on to, or work with the patient to develop their own. Patients often have excellent ACT-consistent metaphors that are helpful. Keep in mind that spending a great deal of time explaining is generally not helpful. Take care to titrate explanations; remembering that explaining is a very verbal process and we are working to get patients to come into contact with experiential processes, too. The piece of information to keep in mind is that the process is more important than any metaphor or exercise.

Finally, given that a values assessment is conducted in the beginning of therapy, remember to link what you are doing in all sessions to these values. Bring values-based living to play in the sessions whenever appropriate. Be careful not to "hit the patient over the head" with values, though. Referring to values is not designed to be coercive or judgmental. It is a gentle and compassionate process that is about living the life a person wants to live in the time that they have to do it.

How to Use the Session by Session Information. Each of the 12 sessions includes a structure that is described more fully below, (e.g., start session with mindfulness, review homework, introduce new topic, and assign homework for next session). Three of these categories remain fairly consistent across the protocol: mindfulness (although different mindfulness exercises will be conducted), review of homework (from prior session) and setting the homework for the next session (different homework assignments are given each time). It is important to pay particular attention to the material in the Topic section. Some sessions will have one topic section and others will have more. It is expected that all of these different topic areas will be covered in a single session – unless otherwise indicated by therapy progress and additional time is needed.

As appropriate, listed under the topic sections are information and bulleted outlines that review what to cover in each session. These topic sections also include theoretical and application information, therapist preparation materials, examples of patient and therapist dialogue, and written metaphors and exercises. The therapist's job is to be thoroughly familiar with the topic sections and implement them in the session while integrating the metaphors and exercises as appropriate. Some topic areas also contain *Clinical Topic* information. These sections provide valuable information regarding conducting ACT. Finally, the protocol also includes text boxes with Veteran Alerts, Clinical Definitions and Clinical Watch materials. These, too, are useful in thinking about theory, application, and working with Veterans.

Things to know:

1. In each session you will want to relate the metaphors and exercises to each patient's particular issues. You will want to find ways in which the exercises are relevant to each patient. If you do not link the exercises and metaphors directly to patient experience, they may feel "dead" or "heartless."
2. You will want to pull the patient's struggle in as much as possible. Metaphors and exercises are NOT designed to be delivered in a mechanical fashion. They are meant to be lively and linked to what is happening in the session. At times a particular exercise is not needed because it just doesn't fit with what is happening. It is okay to leave a metaphor or exercise out as long as you are cautious in doing so, and are focused on implementing the targeted process.
3. In an effort to implement with more ease (without being mechanical) you will want to process exercises with the patient as appropriate. There should be a transition into new exercises rather than delivering one exercise after the next as if following a recipe. Providing rationales that are appropriate to the exercises and processing the experience is considered an important part of implementing the therapy successfully. The goal is to flexibly implement the model while exploring and adapting to the patient's needs.
4. Finally, you need to understand the purpose of the exercises and metaphors and what process they are demonstrating. This will help with delivery and also assist you in being able to explore the process more fully in session.

Overview of ACT-D Sessions

A list of the 12 ACT-D sessions is found below. From this overview you can see that several of the processes are covered in detail in at least two sessions. Processes like values and committed action are covered throughout the 12 sessions as patients are asked to do homework (committed actions) linked to values starting early in the protocol. Finally, in covering the material in the sessions, a fair amount of example dialogue is provided to describe what should be done in the session. This is done in the place of just simply describing exercises. These examples are guides. It is better to try to "own" the material by finding the more personal ways in which to deliver it.

Session 1: Informed Consent; Formal and Informal Assessment; Rapport Building
Session 2: Values Assessment/Goals of Therapy
Session 3: Creative Hopelessness
Session 4: Control as the Problem
Session 5: Willingness: Building Acceptance, Defusing Language – Part I
Session 6: Willingness: Building Acceptance, Defusing Language – Part II
Session 7: Self-as-Context – Part I
Session 8: Self-as-Context – Part II
Session 9: Values – Part I
Session 10: Values – Part II
Session 11: Committed Action
Session 12: Termination

General Structure of Each Session

As noted, preparing for each session is essential. In doing so, it is important to read the entire session thoroughly and carefully review the exercises and metaphors introduced and how they are tied to the overall approach. Reflecting on the prior session and the session that will follow is also suggested. This grounds interventions in a broader story of the approach and will help to make sense of the metaphors and exercises in terms of individual preparation. From time to time, if new to ACT, a patient may ask, "Why this exercise?" Being able to speak to the broader work will be useful. Saying things like, "I don't know why" undermines the therapeutic process.

After reading the session material, be sure to understand the "gestalt" of the session. This perspective will serve as a helpful guide when applying the material with a patient. Each session in the manual is guided by the following general structure and is extrapolated to the therapy room: therapist preparation; conduct assessment; open session with mindfulness; review experiences

and reactions since last session and review homework; introduce new material (includes main focus of session and clinical topics, metaphors and exercises, and example clinical dialogue); and assign homework/behavioral commitments. Each of these is explored in more detail below.

1. ***Therapist preparation:*** At the beginning of each session is a short overview of theory and/or practical matters related to the session including the session's purpose/function. This part of the session is designed to remind and ground the therapist in overall goals and underlying processes for the session. It will be helpful to return to this section from time to time as a guide to remaining ACT-consistent. Lastly, each session contains a "Clinical Topics" section. These are short descriptions of valuable information to bring into therapy as appropriate. The Clinical Topics section is provided at the end of the session topic material, rather than in the therapist preparation material, as these topics are viewed as part of the actual information reviewed in session, not simply preparatory material.
2. ***Administer assessment:*** Have the patient complete the self-report measures as chosen or indicated (see above section on Assessment). At regular intervals, explore progress on these measures with the patient.
3. ***Begin each session with a mindfulness exercise:*** Read the *Mindfulness and ACT* section (page 17) in the introduction to this manual to help develop a rationale and brief introduction to mindfulness before beginning the protocol. Additional ideas for rationale are also stated below. Plan to deliver a rationale early in the therapy (Session 1). This rationale may need to be delivered only once, but feel free to restate the rationale as needed.
   a. Begin each session with a mindfulness exercise. The purposes of the exercise are to bring the therapist's and patient's attention "into the room" as a preparation for the session; and to help the patient practice mindful awareness as a part of the overall treatment intervention.
   b. Mindfulness rationale. In addition to the material covered earlier in this manual in the *Mindfulness and ACT* section (see page 17), be very specific about why the use of mindfulness is important to the treatment. Consider using the following example:

Therapist: "As we go through the treatment, we are going to be working on several things that may prove helpful. We know that people who are struggling with depression can get stuck in worrying about the future or be painfully stuck in the past. Mindfulness helps us to practice living more fully in the moment; to be present to this place and time rather than places that can cause additional suffering. We will also be working to help you see yourself as larger than your thoughts and emotions – to get freedom from them. Mindfulness helps with this task and, through awareness we can begin to contact a sense of self as an experiencer of emotions, thoughts and sensations rather than being defined by them. Being aware and mindful also allows and creates a space where values based choice is possible. When we are lost in the past or future, we tend to be more impulsive or to make choices based on worry or fear or feelings. Being present reduces that possibility – awareness is key to choice-making that is based on what you want to stand for versus what your feelings or worries want. Lastly, mindfulness has some additional wonderful benefits. It reduces stress and improves health. For instance, we have research showing that it reduces blood pressure and improves immune functioning. These are great perks to practicing mindfulness."

   c. Mindfulness exercises should be conducted with appropriate pace and tone. Allow for the patient to attend and be present "with" the particular focus of the exercise by adding space between comments. Pacing can be challenging. If new to mindfulness there may be a tendency to move through the exercises too quickly, stating one instruction after the other with no time between statements for the patient to process the request. Practice pacing and slow down. It will make for a better mindfulness exercise. Tone should generally be soft. It is important not to rush mindfulness exercises, as the intent of the exercise can be lost under this circumstance. It is strongly recommended, to personally engage in mindfulness practice on a routine basis to better understand the practice.
4. ***Prior Session and Homework Review***
   a. Review patient's experience/reactions since last session. Keep this part of the session short as it can quickly take over the session and take it off course. Also, it leaves little time for the other work needing to be done in the session.

Clinical Definition: Workability refers to the pragmatic truth criterion of contextual approaches; that is, focusing on *what works* to fulfill a particular goal rather than the "absolute truth" or intellectual reason-giving for a certain behavior. Workability should also be tied to values, just because something works, doesn't necessarily mean it *should* be done.

5. ***Introduce New Material (Topic)***
   a. Review/explore the core topics with the patient.
   b. Some of the core components can be covered in a single session. Others will take more than one session. As noted, spread the content of the sessions out as needed up to 16 sessions, based on the specific conceptualization for each case.

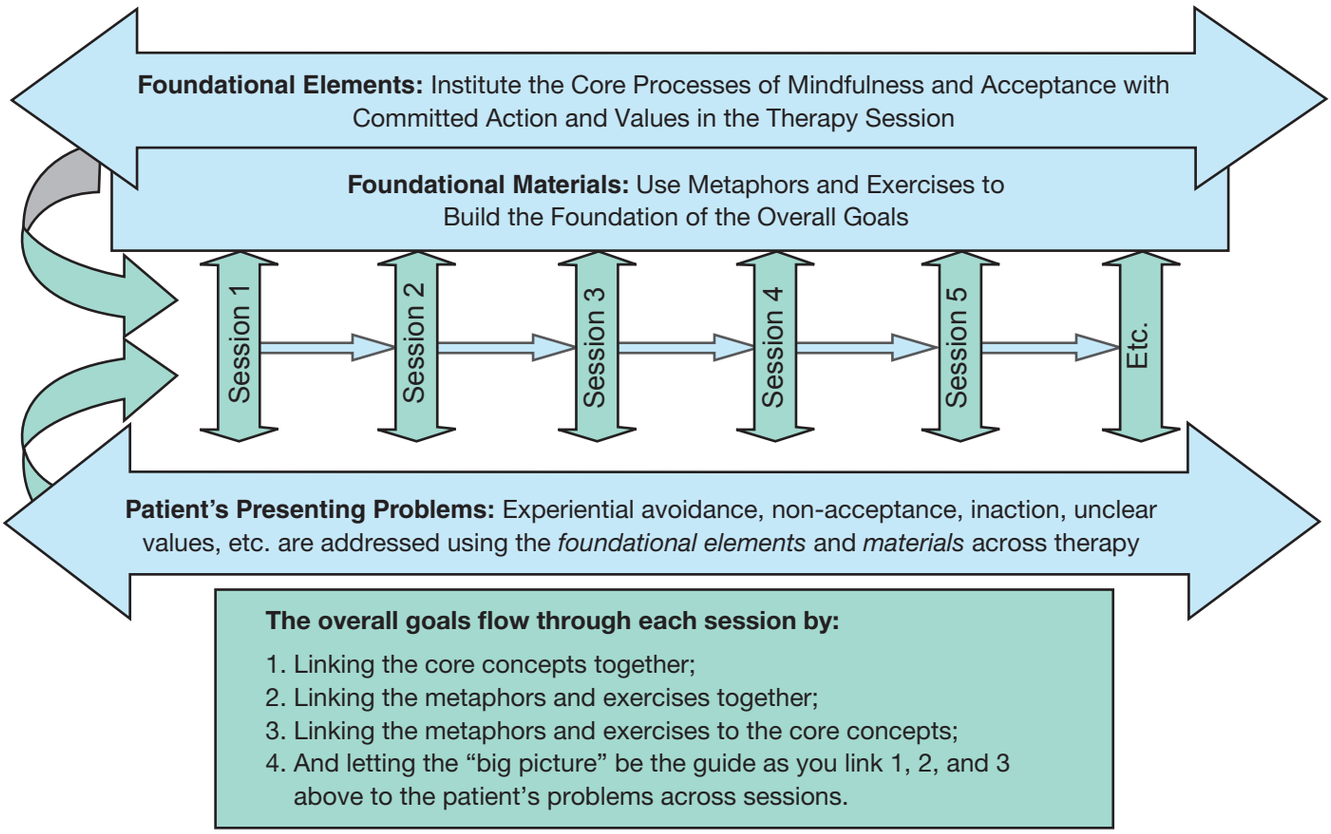
Things to know: Appendix A-1 contains additional supportive readings for each session. This appendix includes references with page numbers for easy location of materials that can guide your understanding and provide supplemental information that may be used to enhance sessions.

   c. Use the material sequentially, but feel free to expand on sessions if needed. Also, you may use other core components not addressed in a specific session flexibly and in a way that is appropriate to the patient's situation. For example, in a session designed to focus on willingness, discussion may lead to a focus on values or self-as-context. Moving flexibly in this manner is appropriate when it makes the most of natural opportunities to introduce concepts concurrent with the patient's in-session experience or in relation to recent events/homework.
   d. Try to integrate the new material into examples from the patient's life. The notion is to apply the concepts in such a way as to be personally relevant to the patient, using the concepts in a way that speaks to their personal experience. Directly solicit the patient's experience and use the core interventions as a means to inform the patient about how internal experience is ongoing and flowing, not static. Increased flexibility is possible under these circumstances. One of the ways in which ACT works to create flexibility is by targeting and disrupting problematic rule-governed behavior. If there is a reliance on giving new rules to replace the old ones, then therapist and patient will be back in problematic rule following, (e.g., replace the rule, "get rid of the bad," with "just accept"). Acceptance can then be misused – the patient presumes that they just need to accept and the negative experience will go away. An appeal to the patient's experience will help them to see that emotion comes and goes; it is not eliminated when accepted.

Clinical Definition: Rule-governed behavior is behavior that is under the control of verbal rules. Rules are useful to guide us socially and keep us from danger and certain kinds of problems. However, rules can also be problematic themselves when we don't interact with them flexibly. For instance, "I have to control my negative thoughts and feelings to find real intimacy" as a rule can retard intimacy and, interestingly enough, is the opposite of intimacy.

   e. Link the exercises to the overall goal of the therapy: To help patients accept internal experience through defusion and mindfulness (helping them to see that they have a mind, not that they are a mind) while choosing lives committed to personal values. If links are not made back to the overall process, the exercises will take on a disconnected and disjointed feel, they will seem academic rather than therapeutic; as if doing the exercise for the exercise' sake. It may be best to think about this graphically:

Figure 3. Graphic Conceptualization: Flow of ACT–D



6. ***Identify New Homework/Behavioral Commitments***
   a. Work together to develop and agree to homework or behavioral commitments. On the one hand, the homework should be doable by the patient, but not so easy that it isn't moderately challenging. On the other hand, help the patient to assess if the homework is too challenging. The goal is to get the patient moving in valued directions, not to incur failure experiences.
   b. The homework should be generally consistent with the core topics being explored or with the values delineated by the patient.
   c. There will typically be three homework assignments per session. These homework assignments include some kind of daily mindfulness practice, written homework, and a selected behavioral activity/goal that is values consistent. This includes a specific action taken that is well defined and moves the patient in the direction of their stated values. Asking the patient to participate in multiple activities outside of the session may seem challenging, however, the work completed outside of the session is one of the more powerful forces for positive change. Let the patient know about the importance of homework and the role it plays in recovery. Patients who participate in outside activities related to therapy progress more than those who don't.
   d. In this protocol, there is also homework for the therapist: revising and updating the Case Conceptualization form as needed and to practice mindfulness routinely.

Clinical Watch: Plan to regularly assign and discuss with the patient the homework they will do between sessions. Assignments can be drawn from a number of places including material taken from this manual or other ACT manuals. Materials downloaded from the Association for Contextual and Behavioral Science (http://www.contextualscience.org) website, or materials developed by you and the patient may also be used. Homework should not be skipped. One of the purposes of homework is to provide small exposure experiences, and to bring the patient into experiential contact with the notion that he or she can move forward even **with** their difficult internal experiences present. Homework will provide valuable experiential information for the patient. It may be helpful to formulate homework assignments as *bold moves* taken in the service of valued living.

Session 1:
Commitment to Therapy and Assessment

Session Structure

1. Therapist preparation (it is possible that this session will take more than one meeting depending on the amount of assessment and information gathered): overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9, WHOQOL-BREF, WAI-SR, AAQ-II and FFMQ, other assessments as appropriate.
3. Provide the rationale for mindfulness (mindfulness is not done in this initial session as it has not yet been introduced).
4. Topic: consent, commitment to therapy, and course of treatment.
5. Conduct formal and informal assessments including a suicide risk assessment.
6. Alliance building (occurs throughout sessions).
7. Assign homework/behavioral commitments:
   a. Materials: Values Worksheet (see Appendix D-2).

Therapist Preparation

The first session is often the most important. This is the time when the therapist and patient begin to form rapport. The therapist approaches the difficulties that the patient presents with seriousness and a sense that something can change. The focus of change is on quality of life and reducing problematic behavior. Willingness to experience is also about change, but the change is recognized in terms of the dynamic process of internal experience and establishing a new relationship with the same. That is, our internal experience is always changing. The goal is to be mindful of this. Acceptance of the patient and their emotional experiences starts here, in the first session. Being present to the patient's struggle and working from an equal, vulnerable, and compassionate position will be essential.

In this first session, begin to think about case conceptualization. As discussed previously, this entails considering the pathological processes that keep patients stuck: non-acceptance, fusion, self-as-identity, being stuck in the future or the past or lack of self-awareness, unclear values or departure from values, or behaving impulsively. This will be helpful in beginning to consider which sessions may need more emphasis or time.

A functional analytic model is the framework that guides ACT-D. Ask, "How does each behavior function?" or "What is the purpose of this behavior?" (including in-session behavior) and what is eliciting and maintaining the behavior. It is also important to understand the purpose of the intervention being conducted. This will guide identifying which core processes are most relevant in helping the patient to move forward.

Open with Mindfulness

Mindfulness is not done in the first session. Rather, inform the patient that mindfulness exercises will occur from this point forward. Provide a rationale for mindfulness and tell the patient that mindfulness will begin at the start of the next session (please see: General Structure of Each Session, Section 1b for example rationale; and Mindfulness and ACT section, page 17).

Session Overview and Content: Commitment to Therapy

- Review standard confidentiality and consent/assent.
- Describe the course of treatment and commitment to that course.

At the beginning of the first session, review the limits of confidentiality and the treatment contract to ensure that there is agreement between patient and therapist regarding the work that will be done together. This includes a discussion about the length of treatment, the expectation for homework completion, and the anticipated ups-and-downs of treatment using the following metaphors to help patients connect with the material experientially:

- Roller coaster metaphor (e.g., therapy has ups and downs; see example below).
- Two mountains metaphor (Hayes et al., 1999; see example below).

The following is an example of brief ACT-specific informed consent/assent:

Therapist: I wanted to introduce you to Acceptance and Commitment Therapy or ACT. It will most likely be different from other therapies you may have tried or from what you may have heard about how therapy works. Largely, what happens in this therapy is contained in its name. We are going to be working on acceptance of emotions and thoughts and commitment to a quality life. In this therapy, we don't work to make you think differently; instead we help you to "see" your thoughts in such a way that they don't continue to have a negative impact on you. We also don't try to change emotions; rather, we focus on acceptance of emotion, but not in a "just give up" fashion. We do it in a way that helps you notice that you have emotion and that you can "carry" emotion with you compassionately and still work to live the kind of life you want to live.

Patient: Are you saying I am just going to have to live with this depression? Because I am here to try and get over this. To make it stop. I don't think I can accept this.

Therapist (compassionately): I hear what you are saying. And I get that you don't want to have the kind of life and problems that you have been having. That's completely understandable. And you may hear me saying in this description "just accept and get over it." But, this therapy is bigger than that. It is really about helping you to get your life back, but perhaps in a way that you may not anticipate. Part of what will happen in here will unfold as we go along, and it isn't easy to explain with just words – just like your feelings aren't easy to explain with just words. Perhaps it will help for you to know that ACT is not based on helping you win the struggle, but rather is about helping you to step out of the struggle. We will be doing a number of things in here, such as finding out about how we relate to our insides and discovering that perhaps it's a myth that we can fully control what our emotions and thoughts do. So I won't be in here helping you to get better control of your emotions, but I will be working with you to get better control of your life. In this process, things may move around a bit. You may feel up and down, sometimes feeling things more strongly and sometimes less…a bit like a rollercoaster ride. You may feel a bit stirred up at times. We will be working with your relationship to your emotions and that can be challenging at times. As we progress, you will know if this is working for you. I will check in with you, but part of what I need is a commitment from you to hang in there a bit and give it a chance. You will know fairly quickly, within four to six sessions. Are you willing to do that?

Patient: Well, I'm not really sure….but I will give it a try.

Therapist: Great. Do you have any questions?

Commitment to a Course

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

Therapist: It is best to carve out space for this treatment. We may end up stirring up some old stuff and at times you may feel like we are not moving forward and at other times things might be painful. It is like exercise; sometimes you feel pain even though you are in the process of getting healthy. I do think that you should hold me accountable. If we are not moving ahead after several sessions, you will know and we will both see it in your life. Let's push ahead for that amount of time, if you agree, and then let's check to see. If at that time things don't seem to be improving then let's talk about the options. If you are moving forward, great, we will press forward. Does this sound like a plan you can live with?

As part of the commitment the patient is told the following:

Therapist: ACT is a very active therapy. I will be asking you to do things and we will be interacting a lot. I will also be talking a bit more than you might think, especially in the beginning of therapy. It is not a therapy where the therapist sits backs and just listens. There is a lot happening and I will be a full participant. We will need to lay a foundation that we can

both work from. As time goes on, you will carry more of the load, but we will still be working together throughout the whole therapy.

An additional point to be sure to include about homework:

Therapist: I will also be asking you to do things outside of therapy. It will be important to begin to implement activities and behaviors that are linked to what you want to see happen. This may be hard, as making and keeping commitments can be challenging. Are there ways in which you might "get in your own way" when it comes to completing commitments outside of this room?

Patient: Well, sometimes I get feeling so down that I hardly do anything. I can see myself forgetting or not feeling like it….

Therapist: I am glad you let me know this. Let's keep our eye on it and see if it shows up. It will be important for us to be honest with each other about this process so we can best problem solve how to get unstuck when it comes to doing homework. Sound reasonable?

Patient: Yes.

After initial confidentiality and course of treatment discussion, begin the assessment process.

Assessment

Both formal and informal assessment strategies are used to formulate the case conceptualization. It is recommended to administer a packet of self-report questionnaires to the patient near the beginning of this session. Consider administering the following: PHQ-9; WHOQOL-BREF; WAI-SR; AAQ-II; and the FFMQ. Optional instruments may also be administered; namely, the Valued Living Questionnaire (VLQ) and the White Bear Suppression Inventory (WBSI). Other assessment instruments may be administered, as appropriate. In informal assessment, asking questions to get a broad picture of the patient's presentation and functioning is helpful.

Informal interviewing is used to identify places where the patient is experientially avoidant, fused with thoughts, living in the past or worrying about the future, attached to the conceptualized self, invested in the elimination of symptoms before "life" can begin and remaining inactive with respect to life values. Questions that tap into these areas are helpful in guiding therapy and in completing the Case Conceptualization form (see Appendix C). The Case Conceptualization form should be completed once the assessment process is completed. This form can then be referred to and refined throughout treatment.

The following is an example of how to open an informal ACT interview with a patient:

Therapist: I want to know more about what brings you into therapy. It will help me to get a sense of your struggle. Tell me what brings you in.

After getting a response, further probes can be used such as: *What would you say are your key challenges? What kinds of things have you been doing to get this fixed? What gets in your way? How long have you been trying to solve this problem?*

Patients may want to know if the therapist has had similar experiences to theirs. The following metaphor can be used (Hayes, et al., 1999):

Two mountains metaphor: It's like you're in the process of climbing up a big mountain that has lots of paths, some very difficult, some easier. My job is to watch out for you and shout out directions if I can see places you might slip or hurt yourself. But I'm not able to do this because I'm standing at the top of your mountain, looking down at you. If I'm able to help you climb your mountain, it's because I'm on my own mountain, just across the valley looking over at you. I don't have to know anything about exactly what it feels like to climb your mountain to see where you are about to step, and to offer what might be a more effective path for you to take.

Lastly, and importantly, it is necessary to assess for suicidality (see the section on Suicide Risk Assessment in Veterans, page 22) with a thorough suicide risk assessment being completed if necessary. Ask about any previous suicide attempts. If yes, the seriousness of the attempts should be assessed as well as what was happening around the time of the attempts. It will also be important to determine current risk and any protective factors. This suicide risk assessment is conducted with consideration of what is needed for the patient and what is appropriate given the clinical setting.

Alliance Building

It is very important to maintain a compassionate stance in this therapy. Connecting to the patient's pain and difficulties with respect and empathy, while also relating to the patient from an ACT perspective is fundamental. When using metaphor and paradox, for instance, the last thing to do is make the patient feel "wrong"; or when using defusion, do not imply that the patient's thinking is "silly" or that they should "just defuse." In the therapeutic alliance it is essential to present the full set of core competencies for the ACT-D therapeutic stance: speaking to the patient from an equal, vulnerable, compassionate, genuine and sharing point of view; modeling acceptance of challenging emotions and thoughts; tailoring exercises to fit the patient's experience, social, ethnic, and cultural context; not arguing, convincing, lecturing, or coercing the patient; and being willing to be in the moment with the patient (Luoma, et. al., 2007). Bring as much of this to light in this initial session as possible and continue to operate from this stance throughout the therapy.

Assign Homework/Behavioral Commitments

In Session 1, provide the patient with the Values Worksheet (Appendix D-2) and explain to the patient how to complete the assessment. It is helpful to take time and work through an example. Ask the patient to bring the completed worksheet to the next session. Explain to the patient that a fair amount of time will be spent on the values assessment in Session 2 and they should not be overly concerned about completing the worksheet "perfectly". The patient will have time to re-evaluate and refine. Walking through an example may be helpful if time in session allows.

End of Material for Session 1

Session 2: Values Assessment

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9.
3. Select and prepare mindfulness exercise (see Appendix B).
4. Review prior session and homework.
5. Topic: values assessment:
   a. Materials: Values Worksheet (Appendix D-2; bring an extra copy, patient should also bring the completed form); Values Card Sort (Appendix D-12).
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Barriers to Valued Living Worksheet (Appendix D-3).

Therapist Preparation

Starting a discussion with the Veteran about values can be very useful in setting up the overall direction of the therapy. Understanding what is important to the patient and how they want to live their lives provides information needed to guide and support them. Conducting a values card sort can assist in clarifying values. Values should be used as a thread weaved throughout all sessions; the work the patient is doing in therapy should routinely be tied back to value-based living. Remember, patients are not asked to experience pain or sadness for the sake of that experience, they are asked if they would be willing to do so if it meant they were able to more fully live a vital life. Conducting a values assessment orients both therapist and patient to what is meant by vital living and it legitimizes confronting painful internal experience.

In completing the values assessment, it is important to keep in mind that values are not goals. That is, values are large overarching directions to head in life. Goals are behavioral actions to take to bring those values to life. A Veteran may say something like, "I would like to have a better relationship with my wife." Although that may appear to be a value, it is actually closer to a goal. Work with what is being presented and attempt to get distinctions in place [e.g., loving relationship (value); take my wife to dinner (goal)].

It is also important to note the distinction between practical barriers and internal experiences that are functioning as barriers. While assessing for barriers, a patient may report their barriers to be about money or the place where they live. Although these may function to cause problems and are worthy of problem solving, they typically do not function to interfere with values such as being loving or kind. Rather, barriers that function to disrupt values are often internal experiences such as sadness or anxiety, or a thought such as, "I can't do it." The patient often articulates the issue as follows: "If I fix my thoughts and feelings then I will be able to do loving things." Therapy centers on undoing that process across time, connecting the patient to the notion that loving things can be done now and that choice to do so is always available.

Lastly, spend time in this session getting a sense of how successful the patient is currently living their values. This can aid in understanding how much the patient has left values behind or set them aside while waiting to feel better. This process can be somewhat challenging as the patient might "bump up" against sadness around unlived values. Be prepared for this. Acknowledging the sadness and letting the patient know you are invested in making things different from this point forward is important, supportive, and helpful.

Assessment

Consider administering the PHQ-9. Optional instruments may also be administered; namely, the Valued Living Questionnaire (VLQ) and the White Bear Suppression Inventory (WBSI). Administer other assessments as appropriate.

Open with Mindfulness

Session 2 begins with a 5-minute mindfulness exercise (see Appendix B). Remind the patient that mindfulness exercises will be conducted at the beginning of each session from this point forward. At this point, take time to summarize the rationale about mindfulness that was provided earlier in this text and/or given in the prior session. The mindfulness practice can start with a basic exercise like paying attention to breathing, body scanning, or mindful listening. The idea is to help the Veteran begin to contact what it means to be mindful of the moment. Mindfulness exercises that are familiar to the patient and are ACT-D consistent may also be used.

Prior Session and Homework

Following the mindfulness exercise, check in with the patient to see if there are any lingering questions that remain from the previous session, and assess any reactions. A question might be, "Did you find yourself thinking about the last session or did you notice any reactions to it?" This is a very brief check-in. This check-in is not intended to get into an extended conversation about the patient's week. There is a fair amount of material to cover in the session, so it is best to stay focused on thoughts or reactions to the prior session. Think of this check-in as a quick "temperature" check on the patient's understanding/reaction to what was previously covered. Redirect the patient to review homework if necessary.

After this brief check-in, the session turns to the Values Worksheet. Bring an extra assessment form in the event that the patient has forgotten to bring their worksheet to the session. If it is helpful, a Values Card Sort (Appendix D-12) can be conducted to further clarify the top values of the patient. Other examples of values card sorts can be found at contextualscience.org.

Session Overview and Content: Values Assessment

Work through the Values Worksheet together in thorough detail. Clarifying and defining values can take a bit of time. It is important to spend time making sure that the values are being "contacted." As mentioned, patients may initially confuse values (lifelong directions) with goals (daily actions taken in the service of values). Sometimes it is helpful to describe or name values and distinguish them from goals. A number of values "words" can be presented (or use values card sort): love, honesty, integrity, kindness, authenticity, genuineness, trust, service, patience, self/other-respect, knowledge, responsible, freedom, humor, faithful, openness, growth, passion, compassion, connection, courage, creativity, appreciation, success, empathy, grace, and the like. As can be seen, these are all broad abstract concepts that can never be fully attained, there is always more to do in each of these areas. An example goal for instantiating the value of love is: take my wife to dinner once a month on the third Friday; or for responsibility: be on time to pick my child up from daycare every day. Helping to make these distinctions can be useful in the values assessment.

Be careful to not judge any values the Veteran may have. These are personally chosen and the patient is free to determine the values he or she would like to live by. It is also helpful if you are clear about your own personal values and keep the two sets of values separate as needed. It may be important however to also be willing to talk about shared values as seems appropriate.

Clinical Definition: Throughout the rest of the treatment sessions, continue to connect the values being assessed here to the metaphors, exercises, and topics addressed in ACT. Use this assessment to guide the treatment; helping the patient to reflect back to values routinely and appropriately. Remember, values should be presented as a choice to make, not as something they "should" do to be a good person. Think "carrot," not "stick."

One of the difficult things that patients can encounter while completing a values assessment is the pain associated with living in ways that are inconsistent with their values. You can see this with Veterans who have stopped attending to values when they return from war and are struggling with wartime issues. Veterans may have lost their sense of values with respect to the government or country or may feel betrayed in ways that steer them away from their values. Veterans may have lost their family due to divorce, or for reasons of long-standing separation, or simply in drifting apart. Loss of job, loss of limb, or brain injury, change in financial circumstances, and other

Veteran Spotlight: Veterans may have stopped attending to values when they return from war. Losing a sense of values and direction post-war may contribute to depression. Pay particular attention to these kinds of issues.

situational issues may lead the Veteran to feel disillusioned and skeptical of committing to a values-based life. It is important to show empathy and understanding for this disillusionment while also thoughtfully redirecting them back to their reason for coming to therapy. The following is an example conversation with a younger Veteran who just returned from Iraq:

Patient: As I worked on this values sheet, I found myself getting angry and thinking "yeah, right." I have done these things in the past only to be ripped off and…. unappreciated.

Therapist: It makes sense to me that you would feel disillusioned. A fair number of not-so-good things have happened to you since your return. Bringing these to mind can remind you of how things have not worked out recently. The pain of lost values or a direction in life is very real. But given that you are here, it tells me that you are searching for something, for restoration perhaps, or for a way back. Would you be okay with not having these values in your life?

Patient: No, but what does it matter? You can live them and get screwed anyway.

Therapist: Yes, that is correct. It can happen that way. But there is also another thing that can happen that seems even more tragic. You don't live your values AND you get screwed anyway. What do these values bring to you? Why do you choose them?

Patient: Because I want my family. I want to be a good father.

Therapist (with concern): So, if that is possible, even with the current problems, would you still choose to be a good father? Or would you relinquish that?

Patient: I don't know.

Therapist: Can you not know and still move in the direction that you value? Imagine that you don't know, but you keep working on the relationship with your kids. Would it be worth it to you?

Patient: Of course, but…

Therapist: I know it seems like there is a "but" in here, But (*with humor*), what if there is no but, there is just this deal: You have been hurt and disillusioned. Where will you go from here?

This conversation is best done from the "heart" – otherwise, it may seem coercive, which is clearly not the intent. This line of conversation is designed to help the patient contact the cost of not living their values, but not because you as the therapist say so, but because it is very real to them. It is the thing that gives life meaning and purpose. For older Veterans these issues may be even more deeply ingrained. For instance, Vietnam Era Veterans who are struggling can feel betrayed by what happened following the war and may have spent many years moving away from values-based living. It will be important to emphasize the power of choice and the possibility of having something different. Bringing those values back to life is a key part of the therapy and it will be important to work with the Veteran from the perspective of engagement, and not letting another day pass without these values being worked on. The cost of not living chosen values can be further explored. Too often the costs are quite extensive by the time an older Veteran comes to see you. The goal is to reverse the costs from this point forward and help the Veteran return to what they choose to do according their values.

Clinical Topic 1: The therapist should keep in mind that values are large life directions and cannot ever be fully completed (e.g., if your value is to be loving, there is always more loving to do, there is always more kindness to engage, etc.). It is more like moving in a direction – east, rather than arriving at a specific destination that is in an easterly direction. Goals are attainable and can be implemented on a daily or regular basis. These are activities to be completed that are connected to chosen values. Examples of goals would include: saying I love you, giving a gift to someone cared about, saying thank you to a partner, attending class, or making an honest statement about feelings. Goals should be ***well-defined, specific, and doable.***

The following example is provided to illustrate how goals and values can be confused. In work with patients, be sure that they have the values (broader principles) and goals (specific behaviors that can be completed) sorted properly.

Correct Example:

Value: Be loving.

Goal: Tell my wife I love her on a weekly basis (every Friday when we have our date).

Barrier: I feel embarrassed. I think she might make fun of me because I haven't said it in a long time. She knows I love her. I just don't say it.

Current Success: 1 (on scale of 0-5; 0 = not successful and 5 = very successful)

Incorrect Example:
Value: Tell my wife I love her.
Goal: Try to do it on a night when we are alone.
Barrier: She is never around.
Current Success: 2

In working with the values assessment, the conversations surrounding values should take the shape of the correct example above. Zettle (2007), Hayes, Strosahl, and Wilson (1999), and Dahl, Plumb, Stewart and Lundgren (2009) provide additional information on assessment of values.

Also, explore the patient's reaction to completing the values assessment. Some patients will feel surprised and perhaps excited about the thought of working on these issues. Some will feel discouraged as they become aware of how much they have not been living consistently with what they value. Be prepared for either, and the strength of emotion that these often bring up.

This in-depth personal assessment will be informative not only in terms of the kind of values the patient wants to work on, but will also provide the opportunity to see what internal barriers seem to be getting in the way. It is these internal barriers that will be the focus of acceptance and defusion. Also, the patient may not have values in every area explored. That is okay. Finally, this assessment usually takes the full hour. Attempt to get as much detail as possible and prioritize the values in order of importance.

Assign Homework/Behavioral Commitments

Homework for this session includes asking the patient to practice mindfulness between sessions by assigning the mindfulness exercise that was done in session. The patient is asked to practice at least one time per day between now and the next session. It is okay to suggest to the patient that they start small (e.g., 3-5 minutes per day). If necessary, the therapist should restate the rationale for mindfulness when assigning this homework. Patient practice with mindfulness will help the overall process and they can track their practice with the Mindfulness Tracking Form (Appendix D-1). Give the patient a copy of the form and ask him or her to fill it out each day and bring it back to the following session for review.

The patient is also asked to take time between sessions to write down all of the different things he has tried to fix his internal negatively evaluated experiences or the barriers listed in the values assessment. The Barriers to Valued Living Worksheet (Appendix D-3) is provided to the patient to record this information. The patient is asked to bring this from back to the next session.

Finally, the therapist should refer to and refine the Case Conceptualization Form (Appendix C) with information obtained as a result of the ongoing assessment that occurred in Session 2. The Case Conceptualization should be considered a working document and be changed based on any new information gained during the session. Understanding the case from an ACT perspective assists with guiding the processes used in session. The therapist is also encouraged to practice mindfulness throughout the week and use the mindfulness tracking form to track the practice.

End of Material for Session 2

Session 3: Creative Hopelessness

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9, AAQ-II.
3. Select and prepare mindfulness exercise (Appendix B).
4. Review prior session and homework (Mindfulness Tracking Form; Barriers to Valued Living Worksheet).
5. Topic: creative hopelessness.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Creative Hopelessness Worksheet (Appendix D-4).

Therapist Preparation

As verbal creatures, humans engage in certain kinds of problem solving activities that are governed by verbal rules (for additional information see Hayes, et. al., 2001 and Hayes & Strosahl, 2004). This includes specifying how problems are to be analyzed and solved. In our culture we apply this not only to solving problematic events in the world outside of the skin, but we also tend to apply the same kinds of problem solving strategies to the world inside of the skin (e.g. painful feelings, difficult thoughts and memories, unpleasant sensations, etc.). Broadly speaking then, when we encounter difficult internal events, we begin to use our minds to problem solve those events (e.g., we try to figure out how to get rid of the difficulty so that the problem will go away). To summarize, psychological and emotional problems are defined as the presence of unwanted thoughts and painful or difficult feelings or sensations. The presence of these experiences is an indication that something is wrong and needs to be fixed. Once these problematic experiences are fixed, then life will return to normal (i.e., good).

ACT-D approaches the patient's situation from a completely different perspective. Rather than viewing the problem as occurring inside the skin (indeed, in ACT emotions and thoughts are not considered problematic) that needs fixing, ACT-D assumes that perhaps the problem is found in language more generally. Specifically, humans use verbal rules excessively and cling to rules such as 'life can only be lived well by having good feelings'. ACT-D works with the patient to help them recognize the difference between verbal rules and experience. ACT-D asks, "What if the problem of painful emotions and difficult thoughts is not actually a problem? What if it is our relationship to our insides? What if all of these emotions and thoughts are *part* of the human experience?" ACT-D suggests that the internal change agenda is flawed, not that the patient hasn't found the right way to fix their "broken" thoughts and feelings. This session is designed to help the patient begin to detect this possibility, connecting to whether problems solving emotions have led to the desired change.

Creative hopelessness functions in therapy to establish the unworkability of excessive and misapplied control to internal experience. Or said another way, verbal rules applied to emotional experience are often ineffective. All of the verbal and/or problem solving strategies the patient has tried to stop feeling sadness or depression are explored and evaluated as working or not working. Typically, as indicated by the patient being in therapy, this kind of verbal control does not work. It is hopeless to try and eliminate certain kinds of internal experience through verbal solutions, but it is also creative to open up to the possibility of doing something different.

Assessment

Formal assessment recommended for Session 3 is the PHQ-9 and the AAQ-II. Other assessments may also be administered as seems appropriate.

Open with Mindfulness

Session 3 opens with a 5-10 minute mindfulness exercise (see Appendix B). Start with basic mindfulness, e.g., paying attention to the breath, conducting a body scan, or mindful listening exercise. The idea is to help the patient begin to contact what it means to be mindful of the moment.

Prior Session and Homework Review

Check in with the patient to assess any reactions to the prior session. A possible question might be, "Did you find yourself thinking about the last session or notice any reactions to it?" This is a very brief check-in. This check-in is not intended to get into an extended conversation about the patient's week. There is a fair amount of material to cover in the session, so it is best to stay focused on thoughts or reactions to the prior session. Think of this check-in as a quick "temperature" check on the patient's understanding/reaction to what was previously covered. Redirect the patient to review homework if necessary.

Review the Mindfulness Tracking Form and ask the patient about their mindfulness practice since the last session. Check for successes and difficulties and explore options to help with these difficulties, if relevant. If the patient had a hard time doing the homework, time should be spent attempting to understand what was getting in the way. If the patient notes that it is "too hard," take care to go over the rationale and support the patient in continuing to practice. It may be necessary to work with the patient to adjust the practice, perhaps suggesting shorter periods of practice initially – less time; or splitting the practice up so that the patient is doing shorter periods several times throughout the day (e.g., 3 minutes, 3 times per day). Also, work with the patient to consider different kinds of mindfulness practice, such as mindful movement, mindful eating, mindful walking, mindful working, etc. Similarly, time should be spent reviewing and then exploring any barriers to completion of the Barriers to Valued Living Worksheet. These barriers will then be further discussed later in the session.

Session Overview and Content: Creative Hopelessness

The main goal of this session is to help the patient come into contact with all of the efforts he or she has made to try to eliminate, change, or fix their internal experiences and to guide them in assessing the workability of these efforts. In general, it will be learned that the efforts to eliminate or suppress internal experience do not permanently solve the problem of emotional difficulty or negative thoughts. Work with the patient to assess their experience of workability. Appealing to personal experience will be essential in this section. The patient may say that a strategy has worked. As the therapist it will be your responsibility to point to experiential knowledge, suggesting to the patient that the strategy has not solved the problem; otherwise they would not be seeking therapy. The patient's experience speaks for itself. Do not argue or try to convince. This part of the therapy is not done from a "one-up" position. It is done from an equal, vulnerable, and compassionate place. The in-session topics, metaphors, and exercises are described more fully below and are implemented in session. Do this in a way that is flexible and responsive to the patient's situation. Also, read and consider the Clinical Topics before session.

Creative hopelessness entails exploring difficult emotions and thoughts the patient has been trying to fix and ways in which the patient has attempted to fix these apparently problematic thoughts and emotions. The task is to facilitate the patient becoming psychologically present to what hasn't worked (Note: This can be difficult. After exploring the strategies, the patient is now aware of all the things tried and now it is pointed out that none have worked; be cautious but persistent – the goal is hopelessness around fixing internal experience, but is creative in that new ways are possible. Also it is important to remember with humility that we too engage in control strategies. In this creative hopelessness work, pay attention to and explore any patient reactions that emerge in the process. In session, the person-in-the-hole metaphor is completed (Hayes et al., 1999; Zettle, 2007; See below).

To begin creative hopelessness, ask for a list of the emotions and thoughts that the patient has been struggling with (e.g., sadness, feeling worthless, etc.). These can be written on a sheet of paper or white board. After getting this list, ask the patient to create another list that includes all the things done or tried to fix the emotions and thoughts just listed. The patient generates as many of these "fixes" as possible and notes the length of time spent trying to make pain and negative thoughts go away.

The efforts to change internal experience can range in nature and include both "good" and "bad" efforts. Examples include drinking alcohol, taking medications, lying in bed and waiting, seeing doctors and therapists, eating, sleeping, not sleeping, troubleshooting, understanding, attempting to gain insight, struggling through, talking to friends and family, talking to priests and pastors, exercising, coping, running away, escaping, isolating, etc. Write the strategies down while the patient lists all of the different things he or she has tried. The list should be as extensive and exhaustive as possible. These efforts can be large in number and varied in nature. The key questions are how long has the battle been going on and how successful are/were the strategies in fixing the problem (negative emotions, thoughts, etc.)?

Some patients will report some success with the efforts they have made. This is okay and there is no need to argue about it. It is most important to look at long-term success. If what had worked had been fully successful, the patient would not be in therapy at this time. Control strategies can be effective. They work where they work and sometimes they work on a limited basis.

Everyone engages in them some of the time. The important thing is to ask, "For how long do they work and when do they stop working?" Here is an example:

Patient: But…when I use relaxation exercises they work. I feel more relaxed.
Therapist: That makes sense. I feel more relaxed when I use them, too. The question is for how long and when does it work?
Patient: Well, when I do it, it seems to work most of the time. But I have to remember to do it.
Therapist: Yeah. That's not always easy when you are in the throes of a heated argument or problem. And I also wonder…for how long do you feel relaxed? Does it take care of your bad feelings?
Patient: It fixes them for a little while.
Therapist: And then what happens?
Patient: I don't feel relaxed anymore.
Therapist: Okay. And then what?
Patient: And then I get upset again.
Therapist: So you have to do another relaxation exercise?
Patient (chuckling): I would have to keep doing them.
Therapist: Okay. Makes sense, so the issue here is not that relaxation exercises don't work. They certainly do. It is more important to know when they work and when they don't …and…whether or not they are a long-term solution.
Patient: They must not be a long-term solution. I am here aren't I?
Therapist: Yeah…so I say use them when they work and don't when they don't. And we still have this larger piece to work on… these long-standing struggles.

Once the list of efforts to control is created, have the patient reflect on the list. Ask the patient what he notices about it and how he feels about it. A sense of hopelessness may arise. This is okay. Connecting to the hopelessness of trying to feel good by engaging in efforts of misapplied and excessive control of negative experience is the point of the exercise.

If the patient goes on to complain of needing to try harder or get things added to their list, also ask if the patient has "tried hard" in the past. If the answer is "yes" – add that to the written list of things tried that haven't worked. The goal here is to help the patient assess the utility of the strategies used to try to control emotion and thoughts. Patients may also suggest that they just need to understand their situation or depression better. Again, ask if the patient has been trying to understand and for how long; and how well 'looking to understanding and/or insight' has solved the problem. Understanding and insight can be added to the list of failed efforts. This can have a powerful impact on the patient. Therapy is working to undo years of control and rescuing the patient here is not what is called for (it plays into the same control agenda). Rather, it is important to "hang in there" with the patient with curiosity about this issue and empathize with their sincere efforts to make things better. It should be emphasized that lack of effort is not the reason things haven't worked in the past. The list, even if short, demonstrates efforts to make things different. The key process to stay oriented to is the un-workability of control. The agenda of trying to control emotions is a problematic agenda – a hopeless agenda. Additionally, as noted, take care to appeal to the patient's experience about how well these strategies have worked without convincing or coercing. The patient's experience is information enough. If they take a sincere look, they will "see" the temporary nature of control.

Veteran Spotlight: Veterans may express relief following the Creative Hopelessness session. Some Veterans state that this is the first time that someone has recognized their efforts and how those efforts have failed (e.g., the Veteran is not responsible for being in the hole). See the Man-In-Hole Metaphor; he is now response-able; said as two words. Other Veterans get worried and want to know the answer of how to get out of the hole or they feel confused. Not knowing and confusion at this phase of therapy are okay. Ask the patient to just notice and you can use this metaphor: sometimes we need to burn down the dead forest so that new growth can happen.

Emphasize here that *the patient* is not hopeless; it is the *agenda* that is hopeless. In fact, there is much hope for the patient, but not for the "feel good" agenda. If the patient arrives at a place of confusion or not feeling sure about what to do next, remind them that this is a creative place, not knowing allows openness to new possibilities. This entire process is further explored with a metaphor (digging as control).

Man-in-the-hole metaphor (Hayes et al., 1999): It is as if you were picked up by a helicopter, blind-folded, given a bag of tools and then placed in a large field and told to go live your life. You did but, unbeknownst to you, in this field are some fairly large holes and before you know it you fall in. Being the good problem-solver that you are, you take off the blindfold and open the bag in an effort to find a way out of the hole. You reach into the bag to see what tools you have. Low and behold, in the bag is a shovel. And the rule with shovels is to dig, and so that is what you do. You dig. You dig big shovels full. You dig small shovels full. You dig sideways and vigorously. You try every form of digging (refer back to all of the efforts made to eliminate difficult internal experience). But the problem with digging when you are in a hole is that it makes it bigger, not smaller. What if this system, the system you are stuck in, is like that – the more you try to dig, the more you try to control, the bigger the hole gets.

This metaphor can be used and expanded upon throughout therapy. Patients can be asked if they are "digging" when they slip back into old internal control agendas. The overall point of the metaphor can guide its use: the idea that as patients work to eliminate internal pain, they often create more or sustain the pain. Do not be the expert on this. Again, appeal to each patient's experience and ask how well control has worked in eliminating negative evaluations, thoughts, and emotions. Remember, if the strategy had been successful, the patient would not need therapy.

Ask patients to just notice that they are in a hole and that all that is being asked is to take their hands off of the shovel, to set it down for a bit and just see how "stuck" they have become. Gently help them to see the struggle they can get into when whole parts of experience need to be eliminated. Digging to feel better gets patients into a "first you lose, then you play" game. Natural human emotion then becomes the enemy when it need not be.

The work done in ACT, then, at this point is like laying out in quick sand in order to stay afloat, rather than to push frantically against it and sink.

Clinical Watch: From the ACT perspective, we would argue that the above "change" agenda (trying to fix internal experience) is not very workable in the long run – creative hopelessness is about pointing to the unworkability and cost of this particular change agenda.

Another issue that can be challenging has to do with attempts that are made to "fix" the situation or escape from pain through suicide. It is our experience that many patients will note that they have thought of suicide as an alternative or way to control/escape pain. It can be helpful to talk with the patient about how this solution has not solved the problem. Titrate the work in creative hopelessness to match the patient. Below is an example of one possible way of talking with a patient about suicide.

Patient: Suicide is another thing I have considered as a way to fix my problems. Sometimes suicide seems like the only way out.

Therapist: I can imagine, if you are feeling a lot of pain and want it to stop, then taking your life seems like an option. It's a pretty permanent and costly solution though. And… if the goal of suicide is to escape pain or a situation, what if there is a possibility of something different, an alternative to this kind of escape?

Patient: Sure…I could go for that, but I don't see any alternatives.

Therapist: The deal is, though, this alternative...it doesn't have to do with eliminating pain. But rather, making a better life. In fact, pain itself may not be your enemy and in some places it may even be pretty important.

Patient: What do you mean?

Therapist: Well, if we look on the other side of pain it can often tell us what is important in our lives, what we care about. Imagine if you had no pain at all. You wouldn't care about things. It just wouldn't matter to you. Connection to people, family, and caring for parents and kids… all of that stuff just wouldn't matter. Pain in some ways is helpful to us. It lets us know that we care. The problem is our relationship with pain. What if we could change the relationship and pain was no longer the enemy?

The main point is to get the patient oriented to the problematic notion of using suicide to eliminate pain (if appropriate, also remind the patient that you care about them and do not want them to engage in self-harm). There are other ways to approach this topic:

Clinical Topic 1: Zettle (2007) recommends a modest dose of creative hopelessness, especially for those who have previous suicide attempts or who have been feeling particularly hopeless. It is important to keep in mind that this part of the intervention is really about hopelessness *and* hopefulness. The therapist does well to straddle both of these ideas. It is key to remember that the hopelessness in creative hopelessness is about the unworkable agenda of control (e.g., elimination of negative experience, never thinking of a memory again, not feeling particularly difficult feelings). The hope*ful*ness lies in living a better life even if these experiences continue to occur.

Clinical Topic 2: Creative hopelessness should be done from a compassionate place and from a place of recognition of how hard it has been for the patient. Never take a one-up stance or make patients feel wrong for all of the things they have tried without success. Remaining humble and noting to patients that it makes sense that they have tried all of these things to get rid of negative emotional experience given their verbal culture. They have been taught to do this by family, friends, society, and by numerous messages that support these kinds of activities.

Clinical Topic 3: One of the ways in which patients may have tried to escape emotional experience is through suicidal ideation or attempts. In addition to assessing suicidality in the initial assessment phase, it is very important to continue to assess current suicidal behavior. A safety plan should be put into place if the patient is reporting suicidal ideation and given contact information that provides support.

Be empathic and matter-of-fact and ask directly about attempts and ideation. The most important thing to note is the function of the suicidal behavior (Zettle, 2007). Although we largely tend to view suicide as escape from psychological struggle, there are also cases where suicide is not about that issue. Ask the patient what he or she was or is hoping to accomplish by suicide. If it is linked to escape from pain, then talk more directly about alternative ways to work with emotional pain. If the patient is considering suicide to escape feeling hopeless, then it will be important to explore this more fully, especially in the context of creative hopelessness. Titrate the amount of CH explored in the session (see Zettle, 2007, pg. 59) and remind patients that this is about a certain kind of hopelessness – the hopelessness of the agenda of trying to inappropriately control internal experience. Again, this is not saying that the patient is hopeless; it is the agenda that is hopeless. This point is specifically emphasized a number of times in this manual. This is based partially on our experience working with clinicians. Clinicians, too, get caught up in verbal processes and from time to time will get entangled with the word "hopelessness" – fearing talking about the word itself, giving it excessive power, or fearing the process of creative hopelessness. Zettle notes (2007, pg. 59), "I follow a 'titrating' approach – that is, I adjust the intensity level of interventions used to induce creative hopelessness to what I feel is appropriate for a particular patient…"

It can also be useful to explore with the patient how therapy is designed to be life engaging, in particular to this therapy. The goal is to create a values-based and vital life. So part of what the patient is signing up for here is to stay alive and live well.

It may also be helpful at this point to explore several metaphors that point to the problem trying to be conveyed in creative hopelessness. These include the Chinese handcuffs metaphor, the tug-of-war metaphor (can also be done as an exercise) and the quicksand metaphor:

Chinese handcuffs metaphor (Hayes, et. al, 2012; Zettle, 2007): Perhaps the situation here is something like a 'Chinese handcuff'. Have you ever seen one? It's a small straw or metal tube that you place your two index fingers into and pull. Only when you do that, the tube tightens down on your fingers. The more you pull the tighter it gets. I wonder if your relationship with depression is like this. The more you struggle with not wanting the feelings and thoughts the tighter the grip the feelings and thoughts seem to have on you. You will not want to take my word for it. Check your experience and see if this is what happens – the more you struggle, the worse it is? Now notice when you push in the finger trap loosens. You have more wiggle room when you stop struggling.

Tug-of-war metaphor (Walser & Westrup, 2007): It seems like you are in a bit of a tug-of-war with a monster. We will call this monster the depression monster. The depression monster is big, ugly, and very strong. In between you and the monster is very deep hole, and so far as you can tell it is bottomless. If you lose this tug-of-war, you will fall into the bottomless hole

and be destroyed. So you pull and you pull, but the harder you pull, the harder the depression monster pulls. The battle is fierce, sometimes it seems like you are winning and sometimes it seems like the depression monster is winning. Yet, neither has won. You pull and the monster pulls, back and forth you go. Notice to where your energy and focus go while you are in the tug-of-war – it is right on the monster. From what I understand you have been in this tug-of-war for a very long time. I'm wondering if there is anything else you might be able to do that could change this situation? (Pause and let the patient answer, see if the patient can detect that dropping the rope is it.) What about…dropping the rope?" Notice that the depression monster is still on the other side of the hole. It did not disappear when you let go, but you are no longer in the battle and notice that you are now free to move. You can place your energy and effort in other places (e.g., refer to values if it is appropriate). [The therapist can also act this metaphor out with the patient by bringing rope or similar material to session to support this exercise. The therapist plays the part of the patient's emotional difficulty standing on the other side of the "hole" (e.g., ask the patient to develop an image of his depression and you pretend that you are that image) and have the patient notice the different qualities between tugging and letting go as you each hold on to different ends of the rope. The patient should also notice that the therapist – the emotion – doesn't go away just because the rope is dropped, but that there is much more freedom to move around when the rope is dropped and the ability to make choices that are not linked to the emotion are now available].

Quicksand metaphor (Zettle, 2007): What does your mind tell you to do when you get caught in quicksand? Get out, right? Get out fast! But what happens when you try to get out of quicksand really fast? You sink in even deeper. So the more you struggle, the faster you go down. The way to stay afloat in quicksand is to stop struggling – to lay out in it in a very slow fashion and you will float. So what if this situation is like that. Instead of struggling to fix the emotion we need to "lay out" in it. Get in full contact with it, with what you have been struggling with. This will be hard though because all that you have learned tells you to get out as quickly as possible. However, that kind of getting out, that kind of fixing, may very well be the thing that causes the sinking.

Explore these metaphors and exercises with patients and how they relate to their battle with depression. Take note with patients how fighting with depression seems to add to the problem – depression plus fighting with depression. Near the end of the session, let the patients know that there is nothing to do at this point in therapy but to notice how stuck they have been in the hole or how much they have been sinking in the quicksand. The end point of this session is simply to notice the "stuckness," and begin the process of peeling each patient's fingers off of the shovel, or stopping struggling against the quicksand – essentially hold still and notice. This will set the stage for the next session which begins to tackle the long-standing problem of trying to excessively and in a misapplied way, apply a rule: "What I need is something more, better and different" in order to be okay. However, the agenda of more, better, and different is inherently non-accepting – patients must be something other than what they are. Control seems to be the answer to the problem of difficult emotions. However, here, the case is being built that perhaps emotions are not a problem and that perhaps, control itself is the problem.

Assign Homework/Behavioral Commitments

Session 3 homework: the patients are to continue mindfulness practice, doing some form of mindfulness each day. Patients can track their practice with the Mindfulness Tracking Form (Appendix D-1). Patients are also asked to complete the Creative Hopelessness Worksheet (Appendix D-4). All worksheets should be completed and brought back to the following session.

Your therapist homework includes referring to and refining the Case Conceptualization Form (Appendix C) with information obtained as a result of ongoing assessment that occurred in Session 3. You are also encouraged to select a form of mindfulness and practice personal mindfulness throughout the week, using the Mindfulness Tracking Form to track your own personal practice.

End of Material for Session 3

Session 4:
Control as the Problem

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Creative Hopelessness Worksheet).
5. Topic: control as the problem
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Control-As-Problem Worksheet (Appendix D-5); Action Homework (Appendix D-10).

Therapist Preparation

The main goal of this session is to help the patient contact how human verbal rule systems operate (for additional information see Hayes, et. al., 2001). This objective is borne from relational frame theory, which states that we humans are constantly 'relating', or creating new associations in our minds, between aspects of our experience, existing knowledge, and the environment. In essence, we are walking "sense makers" who are continually creating new relationships between events whenever it helps us to make sense of what's around us. While some learning is shaped by direct experience (e.g., learning to walk), other learning occurs solely in the mind (e.g., derived relationships: if "A" is larger than "B" and "B" is larger than "C" then "A" must be larger than "C"). ACT is specifically concerned with the differences between these two types of learning and subsequent behavioral responses. Direct experience gradually shapes behavior and usually establishes varied and flexible patterns of responding. Derived learning is more categorical – all or nothing – and tends to establish more rigid and rule-based patterns of responding.

Through cultural messages, we derive categorical rules about how we "should" cope with internal events even when they have nothing to do with our own direct life experience (e.g., if we "can't stand it" we should get rid of it or fix it), however, even as we say we "can't stand" we are experientially standing it. This latter kind of learning is experiential knowledge, distinct from the former verbal knowledge. This session targets one particular rule that can be quite ineffective when applied to the realm of emotion – the rule of control – "If you can control, then all will be okay." Control may work well when manipulating external systems, but it can backfire when applied to private experience. The goal in this session is to loosen the derived rule that control "should" work, and have patients look to their experience about what does work and what does not. Note that as the patient makes direct contact with the unworkability of control strategies, the patient becomes more susceptible to direct contingencies (learning directly from experience). Referring back to Chinese Finger Trap and Quicksand metaphors (see Session 3 material) may be helpful.

Assessment

Formal assessment recommended for Session 4: PHQ-9. Other assessments may also be administered as seems appropriate.

Open with Mindfulness

Session 4 opens with a 5-10 minute mindfulness exercise (see Appendix B). Imaginal exercises may be implemented (e.g., leaves on a stream, clouds in the sky) that are about observing thinking (e.g., each thought is placed atop a leaf floating in the stream; the patient is instructed to gently observe as each thought "floats" by).

Prior Session and Homework Review

Following the mindfulness exercise, check-in to see if the patient has any questions related to the previous session. Also, review the Mindfulness Tracking Form and ask the patient about mindfulness practice since the last session. Check for successes

and difficulties and explore options to help with difficulties if relevant. [See Session 3, page 45 for further guidance on the implementation of this section, if needed.] Review with the patient their written homework on Creative Hopelessness, exploring reactions to the homework. Redirect the patient review of homework if necessary.

Clinical Watch: Throughout treatment, patients need help learning to attend to the non-intellectual experience of internal events. Mindfulness is one way to bring attention to these events, and you can guide the patient in identifying ongoing physical sensations in the body that are associated with emotion. You can do this by using metaphor or imagery to describe the patient's moment-to-moment experience. This is what is meant by noting the "experiential quality" of an internal event.

Session Overview and Content: Control as the Problem

During this session, note to patients how control of internal events might actually increase or sustain the experience of those events or lead them away from valued life goals. Although discussed a few times already, it is important to remember that the control being spoken about is excessive and misapplied control to internal events. Sometimes controlling what happens on the inside is useful (e.g., escaping the worries of a hard work-day by watching TV for an hour with family). It is when control becomes excessive and problematic (e.g., escaping the worries of a hard work day by drinking a bottle of wine and checking out while the TV is on and ignoring family) that patients run into trouble. Explain to patients that this is about letting go of internal control, but that they have control over their own life.

In this session, work with patients to help them see how change efforts have really been about controlling private events (e.g., how problem solving and avoidance of emotions and thoughts have been about trying to feel better – trying to be happy). These efforts make sense given that controlling thoughts and emotions are part of our culture and language system. Each of these engrained control strategies is often manifested as attempts to escape or eliminate painful or difficult experiences. The problem with these control strategies is that they often work paradoxically. The more control strategies are applied, the more likely it is that negative experiences will escalate and become the focus of the patient's life. Review the in-session topics, metaphors, and exercises below and implement them in session. Do this in a way that is flexible and responsive to the patient's situation. Read and consider the Clinical Topics before the session.

Clinical Watch: It isn't that in ACT we don't support or wish happiness for patients. Doing this is perfectly fine. Seeking things that support feelings of happiness are also okay (e.g., dinner with a friend, meaningful job, etc.). The question about happiness arises when it is seen as *the* solution. Simply trying to create happy feelings does not then mean that you are happy about your past, that you will always feel happy, that the situation is happy, that the problem has gone away or that more problems, worries and pains will not be experienced in the future. Happiness, like any other emotion, rises and falls, comes and goes. Of course, it is welcome just as much as the other emotions.

In-Session Topics

The focus of Session 4 is on the unworkable agenda of control of private experience and work in the session is to give a name to this agenda. Validate patients' efforts to control painful experiences; many will wonder why they have worked for so long and as hard as they have at control when it doesn't work. Point out how it is that it seems like control *should* work and why they continue to engage in internal control behaviors despite long-term ineffectiveness. There are a number of reasons why control seems plausible. First, control does work outside of the skin; we can control the environment. Second, parents and peers model control strategies and patients are taught that control should work. Similarly, control does appear to work for others – when we compare our internal, private experiences to what we observe outwardly in others we often learn that others appear okay, while we do not. Also, control strategies do work sometimes and it seems like they should continue to work if we just try hard enough. After all, many of us are socialized to believe that hard work pays off. Session 4 then works on the paradox of control by using several exercises and by tying it to the patient's experience.

Exercises:

The following exercises provide examples to the patient of how the system of internal control can be faulty. It is easiest to start with the 95% versus 5% rule and then give examples of this problem by presenting the other exercises. These may be delivered in an interactive way by asking patients questions while presenting the material and by having the patient engage with you about what they are experiencing.

95% versus 5% rule exercise (Hayes & Strosahl, 2004): In the world outside the skin (95%), control works (i.e., you can change your environment). For example, if you don't like the way a room looks you can paint it, make it attractive, etc. For the world inside the skin (5%) no amount of paint can make pain look good.

If you aren't willing to have it you have got it exercise (Hayes, et. al., 2012; Walser & Westrup, 2007): Language allows us to plan, construct, and categorize in ways that are quite helpful. There are many ways that our formulations are brought to bear on our outside world but we also bring them to bear on our inside world. One rule that we have for things outside of the skin works like this – if you don't like something, figure out how to get rid of it and get rid of it. That rule works fine in most areas of our lives. Consider the possibility, however, that the same rule doesn't work when applied to what's going on inside. Check to see how this works, in your experience, not in your thinking mind, look to see whether this rule – if you don't like it, figure out how to get rid of it and get rid of it works more like this: if you aren't willing to have it, you've got it. The more you don't want it, the more effort you make to get rid of it, the more time you spend with it – the more you have it. If you try to eliminate or avoid your own thoughts or feelings you are in an unworkable position. Use the following exercises demonstrate this point:

Perfect anxiety detection machine exercise (Hayes, et al., 1999): State the following to the patient: "Imagine that I could hook you up to the perfect anxiety detection machine and that I would know if you were to get even a little anxious. Then I tell you, your only job here is to *not* get anxious. But I want to make sure you don't get anxious so I am going to motivate you a little – if you get anxious I will whack you with a stick. I am going to turn the switch on now and ask you to not be anxious. What do you think will happen?" (The patient, of course will feel anxiety.) *And,* the patient *is* hooked up to the perfect anxiety detection machine, note this and explain further. "You are hooked up to your own central nervous system and you are motivated to not feel anxious as it means something about you: If you are anxious, something is wrong with you. Anxiety becomes something to be anxious about." Then take time to explore this with the patient, using the example of emotions from the patient's experience.

Don't think about vanilla ice cream exercise (Walser & Westrup, 2007): Ask the patient to not think about certain thoughts as a means to demonstrate the paradox of this strategy. Many Veterans who are depressed are working hard to not think about the past or to suppress thoughts. However, in order to know that you don't want to think about it, you have to think about it. Ask the patient to not think about "vanilla ice cream" and that is exactly what a patient will think about. Point to the problem of trying not to think about thoughts that the patient has found problematic (e.g., "Deep down inside I am flawed."). As the patient tries not to think about it, they necessarily think about it. Control of thoughts is not very useful in this sense. Observing thoughts as what they are – thoughts – is the goal. No need to control, especially when it isn't working.

What are the numbers? exercise (Hayes, et al., 2012): (This is done playfully). Motivate the patient to remember three numbers by offering a million dollars to do so. Then present the numbers "1, 2, 3" and ask the patient to repeat the numbers so that you know that the patient has remembered the numbers. Then state that the only way you will pay the million dollars is if the patient forgets the numbers. Then ask again: "What are the numbers?" The patient will automatically think and/or say "1, 2, 3". Now playfully say "no money for you" and note how small the memory is (e.g., the easy numbers 1, 2 and 3). Time is spent talking about how if the patient spent another hour remembering the numbers, how unlikely it would be that he would forget them when asked, "What are the numbers?" Now point to the impossibility of trying to forget other memories and thoughts that are often much stronger and more deeply remembered. They will be there when they are there, just as "1, 2, 3" will be there when you say, "What are the numbers?" This small exercise points to the futility of trying not to remember the painful things that are remembered. The same paradox as above exists here: "You must think of the memory that you don't want to think about in order to know that you don't want to think about it."

You can also point out that it is just as hard to create positive emotion as it is to eliminate negative:

Fall in love exercise: (again, playfully). Ask the patient to fall in love with the next person the patient sees, again motivating the patient with a "million dollars." Explore with the patient how hard this would be and place it in the context of the problem of forcing emotions to come or go. Even the metaphor "fall" implies that it just happens, not that it is controlled.

Feel happy now exercise: Instruct the patient to feel happy now. The difficulty of this instruction is immediately apparent. We feel happiness when happiness comes along.

During the session take some time to begin a discussion about willingness (Session 5) as an alternative to control. Ask the patient to define willingness as a way to start the discussion and explore how willingness *is* acceptance and openness to experience. Talk with the patient about how willingness is a stance taken, rather than something felt. The clinical topics below will help with discussions and topics explored with patients:

Clinical Topic 1: When patients begin to contact this sense of being stuck and that control of internal experience may actually be contributing to the problem, they may begin to feel blamed. That is, they may begin to evaluate themselves negatively for engaging in behaviors that maintain the problem. This can increase the possibly-already-present self-blame. Patients blame themselves for experiencing difficult emotion and then blame themselves for doing things that may be maintaining the difficult emotion. In ACT-D, there is a critical distinction made between responsibility and blame. The person-in-the-hole metaphor can be helpful here. Recall that the person was blindfolded and then fell into the hole. The person has been taught to use control of internal experiences (we all have been taught this – and none are immune to its draw). They are not to blame for doing this – however, they are responsible. But, responsible in this sense: response-able. They are able to respond, they can choose to respond differently and a different outcome is possible as a result. We don't want patients to back up from responsibility. This is the tool that can put them back on track. However, we do want patients to back up from blame. Blame is like standing on the edge of the hole and throwing dirt down on the person inside. Blame does not strengthen it weakens. Sometimes people will blame themselves in order to feel motivated. But blame has the opposite effect: it de-motivates.

Veteran Spotlight: Responsibility can be an enormous issue for the Veteran. He or she may be taking responsibility for something that they need not (e.g., accidents in war; death of a fellow soldier) or they may feel like those in charge were irresponsible.

In ACT-D: response-***able*** is the answer. That is, the Veteran is able to respond from this point forward.

Consider this example where the patient has been feeling depressed for years. The Veteran was ordered to shoot an unarmed man during his wartime service; he regrets the action and blames himself. Notice how the therapist draws on a metaphor used earlier in the therapy:

Patient: What got me in this hole was my decision to do something…something that I am ashamed of. I could have told my commander "no" or I could have shot my commander.

Therapist (in quiet, "connected" voice): Yes, perhaps either of those options could have occurred and they each would have had their own set of consequences. Perhaps you would be in a different hole right now if you had done something different.

Patient: If I had only been able to stand up for this guy or tell him to run. If I would've been able to confront my commander…

Therapist: It seems that if you go back and try to re-trace your steps about how you got in the hole, you might be able to figure out how to get out of the hole. But even if we could define every step, we wouldn't be able to stop this hole. History only goes in one direction. Time moves forward. So even if we know perfectly how it happened and talked about what you could have done differently along the way, you would still be here. It can't be undone.

Patient: Then I really am to blame.

Therapist: What happened when you fell into this hole is tragic. That you had to be in a war, that you had a commander who ordered you to shoot an unarmed man; that you have had to struggle with this memory for so many years – there is a lot of pain here and it is clear to me that you have regretted what happened. However, it seems to me that blaming yourself is just like standing at the top of the hole and kicking dirt down on top of yourself. It doesn't help you get out – in fact, it makes things worse.

Patient: Well, maybe that is the way it is supposed to be.

Therapist: That looks like more blame, another handful of dirt.

Patient: (sighs).

Therapist: The pain of this event is about the loss of life and the way in which it happened. But there is another loss of life happening here, right in front of me and, although issues of responsibility and what happened back then seem to call for us to understand the non-understandable…war…death…, the one thing you can do now is be responsible from this point forward in a way that is about life. I mean this as response-able – or able to respond in ways that are life-affirming, rather than the alternative. This journey is about setting down the shovel, honoring your memories, and connecting to a place where a different life can be lived from this point forward.

Veteran Spotlight: Some Veterans get stuck in thinking they must explore their past in detail in order to figure things out. However, dwelling on what happened may not be very useful. It doesn't mean there isn't a place for talking about the past. That is welcome, but only to the degree that it moves the Veteran forward in therapy and life.

Patient: Will the hole ever go away?

Therapist: If you mean, will this memory ever go away…No, it won't. But there is an opportunity to honor the memory of this man and your life now. What do you say?

Clinical Topic 2: Many patients have come to understand therapy as an exploration of the past. What patients will learn about ACT-D is that it is present-focused and action-focused rather than focused on the past (it does not mean you can't talk about the past, it is more the case that the past is viewed from the place of its interference with the present moment and the future and how it is functionally related to what is happening for the patient at this time). ACT-D therapists move fairly rapidly into the problem of unworkable agendas and finding ways to get the patient's life in line with his or her personal values. Not much time is spent exploring the past. The past is important, but it is specifically important for the purposes that have to do with staying stuck in the hole. The metaphor below can help explain this issue to the patient:

> ***Driving with the rear-view mirror metaphor*** (Hayes, et. al., 1999): What if you tried to drive your car by placing both hands on the rearview mirror, looking into it and then starting to drive? Navigating by where you have been rather than where you are going. You might be okay for a bit, but eventually you would crash. And then, what if you got back in the car and did the same thing, put your hands on the mirror, looked into it and started to drive? It wouldn't be very effective in terms of getting to where you wanted to go. What this therapy is about is getting your hands on the wheel and looking at where you are and where you want to go.

You may need to return to control as the problem at different times throughout the therapy. The man-in-the-hole metaphor can be used from time to time when patients seem to be "digging" by asking patients if they have their hands on the shovel. In fact, there may even be times when you need to return to creative hopelessness, particularly when seeing patients getting stuck in trying to problem solve an emotion. If returning to creative hopelessness, be sure to link it up to control of internal events as the problem. Patients may also want to visit their history with the expectation that understanding something from the past is going to change difficult emotions and thoughts. It can be useful here to ask patients if they have their hands on the rearview mirror. Again, re-visiting these metaphors should be done with thoughtfulness and compassion, revisiting is not designed to shame patients into doing something else.

Finally, while finishing up the paradox of control, begin to link it to the alternative –willingness – and let the patient know that control is good in certain parts of life (i.e., in practical application outside the skin), but that excessive and misapplied control focused on internal events can actually be problematic.

Assign Homework/Behavioral Commitments

Session 4 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to complete the Control as the Problem Worksheet (Appendix D-5). All worksheets should be completed and brought back to the following session for review.

Your homework includes again referring to and refining the Case Conceptualization Form (Appendix C) with information obtained as a result of ongoing assessment that occurred in Session 4. Focus on patient strengths to bring into the next session. You are also encouraged to select a form of mindfulness and practice personal mindfulness throughout the week, using the mindfulness tracking sheet to track your own personal practice.

End of Material for Session 4

Session 5: Willingness: Building Acceptance, Defusing Language – Part I

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9; AAQ-II; optional instruments may also be administered as appropriate.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Control as the Problem Worksheet).
5. Topic: willingness: building acceptance, defusing language – part I.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Willingness Worksheet #1 (Appendix D-6); Action Homework (Appendix D-10).

Therapist Preparation

The goal in this phase of ACT-D is to increase willingness by helping patients build acceptance and begin to learn how to defuse from language (for additional information see Hayes et al., 1999; Hayes & Strosahl, 2004). Willingness is conveyed as openness to experience, and of language as a process (i.e., thinking). Theoretically, ACT-D makes an important distinction between the product of language (i.e., language itself: a set of derived stimulus relations) and the process of language (i.e., "languaging," the mental activity of deriving these relations). Human "languaging" comes so naturally to us that we hardly notice when we're doing it – and we're doing it all the time. Without being conscious of it, our mind is constantly making new associations and creating categories to better understand and organize our world. And once we have created this understanding, we spend much more time looking *from* our thoughts rather than looking at our thoughts or simply observing our mind's process of generating them. By teaching patients to see the process, we can also begin to point out the normal human tendency to fuse with the psychological content of verbal events (i.e., the product).

Keep in mind that fusion with thoughts has to do with the derived function of language: words give us a representation for things in the outside world. While the language itself is simply a sound in the mouth or words in a book, the language *functions* to represent an actual stimulus in the realm of experience. Fusion occurs when we react to these verbal representations as if they are the same as the real thing. The lemon exercise (Session 6; page 62) is a good example of this kind of issue.

When we fail to distinguish between language process and language product, we can get caught in processes that assign undue meaning or value to certain verbal statements. For example, verbal evaluations (e.g., "My life is awful") can be given the same "truth" status as verbal descriptions of primary attributes (e.g., "the blanket is white" or "the table is wood") because of how the sentence is structured ("blank *is* blank"). A verbal evaluation (e.g., "awful") is a quality of the person's affective response to an event, while a verbal description (e.g., "white" or "wood") is a primary attribute of the event. Due to the structure of human language, however, these two types of verbal events seem to carry equal weight; a subjective evaluation takes the same form as a verifiable description and sounds "true." In therapy, watch for these instances of holding thoughts to be literally true and use defusion to help the patient see the process rather than fusing with the product.

Assessment

Formal assessment recommended for Session 5: PHQ-9 and the AAQ-II. Optional instruments may also be administered.

Open with Mindfulness

Session 5 opens with a 5-10 minute mindfulness exercise (see Appendix B). Feel free to expand mindfulness exercises at this point in treatment by incorporating imaginal/guided meditations, body scan, breathing, etc.

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask patients about mindfulness practice since their last session. Check for successes and difficulties and explore options to help with difficulties if relevant. You may suggest different kinds of mindfulness or guided mindfulness and recommend the mindfulness CD's created by John Kabat-Zinn. These are ACT-D consistent and can be used to guide the Veteran through mindfulness work. [See session 3, page 44 for further guidance on the implementation of this section if needed]. Review with the patient the Control is the Problem Worksheet and explore reactions to the homework linking it back to the prior session. Spend time discussing completion/non-completion of values consistent Action Homework and evaluate barriers as well as congratulate successes. Explore a patient's progress in bringing values to life in terms of both emotional and practical outcomes. Redirect the patient to review homework if necessary.

Session Overview and Content: Willingness

Willingness is explored as an alternative to control. Willingness is described as the action of showing up in the moment to emotion and thought content without efforts to make those experiences come or go. Willingness is not about wanting negative thoughts and feelings, conceding to them, or even liking them. It is simply about letting them be there as they are. Willingness is explored as a stance toward self and others – an openness to the ongoing flow of experience.

Several barriers to willingness are also explored. Reasons as causes are undermined as the cause of behavior. Work with patients to "loosen" the idea that a particular story is the cause of their problems. This is not to say that the story isn't important, rather, explore whether the story is helping or hurting the situation. Also, explore the distinction between language and the "the languager". Use exercises and metaphors to help a patient separate thought and thinker. Review the in-session topics, metaphors, and exercises below. Plan to implement them in session in a way that is flexible and responsive to the patient's situation.

In-Session Topics

In Session 5 explore with patients the exercises described below. As a continuation of the prior session, the work in therapy focuses on helping patients to see how avoidance may be increasing negative internal experience in their life. Have patients notice the costs of avoidance, (e.g., how much energy and attention avoidance takes) and note that this energy can be directed elsewhere if willingness is put into place.

Willingness volume exercise (Hayes et al., 2012; Walser & Westrup, 2007, Zettle, 2007): With the patient, further explore willingness as an alternative to control. The two "volume" knobs can be presented by drawing them on the board or by telling it in metaphor: "Imagine that I have two volume knobs, like the volume knobs on a stereo and one volume knob represents anxiety and one represents control. Imagine that something happens and the anxiety/sadness volume knob is set very high. What we tend to do then is set the control knob high as a means to try and control the anxiety/sadness volume – to try to push it down; but what happens is that when we set the control high, it tends to lock the anxiety/sadness knob into place (e.g., anxiety about anxiety or depression about sadness) – as if you are turning a ratchet wrench and it can only go one direction".

What you are asking the patient to do now is to look at an entirely different knob – almost as if it is on another stereo – and this is a willingness knob: "Imagine that the same thing has happened – the volume on the anxiety/sadness knob is set very high and instead of moving the control knob, you choose to set the willingness knob up high. In this case the anxiety/sadness does not get locked into place. It is free to move around. If you are willing, anxiety/sadness will be high at times and low at times. But if anxiety/sadness is high and the control knob is high, then anxiety/sadness will be locked into place."

Barriers to Willingness

Spend time exploring barriers to willingness with patients. The below exercises are often part of what is happening when patients find that they are unwilling. Exploring these exercises and also talking about how these kinds of things might be present in the patient's life are a part of this work. Begin with **reason-giving** by discussing 'reasons are not causes' (Hayes, et al., 1999; pg. 76). Many patients believe that their thoughts, life stories and emotions are the causes of their behavior. For instance, "I didn't do it because I didn't feel like it" or "I can't live my life because I am depressed" may be offered as reasons. The thought – "I didn't feel like it" and the emotion of "depression" have become the causes of dysfunctional behavior. In ACT, the therapist works to undo this causal relationship. The ACT model holds that thoughts and feelings are not causes of behavior – thoughts and feelings are associated with behavior, and are not causal. Talk with patients about why their reasons/thoughts might not be the cause.

There are several points that can be addressed with patients regarding why reasons are not causes. For example, we don't have access to all variables in the patient's life that brought them to where they are today. Ask the patient, "Do you remember your 11th birthday?" They may, but continue by saying, "Do you remember the day after your 11th birthday, or the day after that?" After the patient says "no", gently remind the patient that the stories of their life were being written on those days too and that we do not have access to all of the variables that have shaped who we are and what we do today. Even if we did have access to all the variables, we couldn't formulate it; it would fill pages and pages. Also, even if the reason were true, it is only a small part of the real picture. Now talk about how, although stories of the patient's life are important and should be honored, the stories are not the cause of current behavior. Compassionately ask questions such as *"Does that description of your life help you move forward? Is this helpful to you or is this what your mind does when you get in this place? You are 100% correct, now what? How long have you been telling this story? And, as important as it is, how is it working for you in living your values?"* (Refer to Clinical Topic 2, page 59).

Evaluation is another way in which people get stuck. ACT-D explores how evaluation does not exist *in* the object. Rather it is something that human beings say about objects. We evaluate and should simply notice the evaluation. For instance, the evaluation, "I am worthless" is not contained in the person. It is something that individuals say about themselves. Also it is a thought – one that comes and goes.

Finally, as noted, **fusion** is also problematic. Again, work on drawing the distinction between the process of language versus the product of language. This can be very hard to detect without special effort: humans "fuse" with the content of their minds very easily. Work with the patient on how we tend to look *from* rather than look at the mind. Furthermore, time is spent exploring the arrogance of words. For example, "Tell me how to walk"; see Introduction about how talking about walking is different than doing it. You can ask the patient to tell you how to walk and then follow it out in terms of how the words about walking are not the walking itself.

The above processes are explored to begin to help patients defuse from stories about themselves or their history and literal connection to thoughts so they can begin to experience freedom from them. Choice is more available when stories and thoughts are not "in charge" of behavior.

Exercises to Facilitate Overcoming Barriers:

The following exercises may be used to demonstrate willingness and to work with the patient to think about instituting defusion in their life. This work is practiced in session and assigned to the patient to practice out of session.

Separate thought and thinker, emotion from feeler exercise (Hayes, et. al., 2012): Ask patients to use the following verbal conventions in session as a means to help them be aware of the experience they are currently having and its ongoing flow. Practice these routinely throughout the rest of sessions with the patient and have the patient practice outside of the session too:

- Instead of saying "I am worthless" the patient practices saying "I am having the thought that I am worthless (I can't do this, etc.)."
- "I am having the feeling of… (anxiety, sadness, etc.)."
- "I am having an evaluation of failure."
- Also include – Out with the "buts" (Hayes et al., 1999): have the patient substitute the word "but" with "and" so that they can more readily be aware of the nature of experience. But literally means "be out". It might look like this: "I love my wife but she makes me angry" – or I love my wife, be out love, she makes me angry. In fact, it is both – I love my wife and she makes me angry. This is more accurate when explaining internal experience and speaks more readily to the quality of internal experience – that it is complex.

Take your mind for a walk exercise (Hayes et al., 2012, Walser & Westrup, 2007). Instructions: "In this exercise we are going to take our minds for a walk. At one point you will be the mind and at one point I will be the mind. When you are the mind, I will be the person who is taking you for a walk and vice versa. The person's job, as they walk, is to go wherever they want to go (within the office or on the grounds of the hospital; or in hallway) and the mind's job is to talk non-stop. The mind talks about anything and does what minds do: evaluate, comment, describe, judge, plan, etc. When you are the mind, if you cannot think of what to say, just say, "I can't think of what to say." The goal is to keep talking no matter what. We will each be in these two roles for about 3-4 minutes and then we will take a few minutes to walk alone. While walking alone, observe what happens."

When the exercise is over spend time processing the experience. Take note if the person did whatever the mind said to do when the patient was in the role of the person and also explore how this does not have to be the case. It is important to notice with the patient how busy the mind is and how it continues to be busy even while walking alone. Explore with the patient that no matter what "the mind" is doing the patient can always walk in a chosen direction. Note to the patient that he takes his mind for a walk every day and ask, "Do you walk your mind or does your mind walk you?" (The point is to get the person to walk the mind, rather than simply responding to the mind – the mind is not always correct. The patient may respond to the mind, but the choice to do so versus automatically reacting to the mind is pointed out).

The above exercises are useful in beginning the defusion process in the service of willingness. There are however, some parts of defusion and willingness that are worth further consideration:

Clinical Topic 1: Some patients may hear "being willing" as giving up or giving in to emotional states and thoughts. Willingness does not have this quality. It is not about simply tolerating an experience or giving in to it. It is about being willing to experience all internal events – it is working to create "openness" to experience. Also, we are not asking patients to be willing for no reason. That is, we are not asking patients to feel pain for pain's sake. Rather, we are asking patients if they would be willing to feel pain if it meant they got to move forward in a valued direction.

Patient: You mean I just have to feel this stuff?
Therapist: No, you can continue to try to get rid of it. But recall, when you try to control, manage, get away from this stuff… what happens?
Patient: Okay, okay, I see…
Therapist: I am asking, would you be willing to feel it if it meant you got to have the life you are seeking? I don't want you to just feel pain "because." This is about feeling in the service of getting your values to be alive and well again.

Clinical Topic 2: For Veterans with depression, it will be important to do the exercise of "reasons are not causes" with compassion. Additionally, for many Veterans, the story of their military experience is very important and their fusion with it may even be what led to their current circumstances. To hear that the story is not the cause of their behavior can be very difficult (the possible exception is a Veteran who has TBI and/or severe injuries. Be thoughtful about what parts of the patient's story fit for the circumstances (e.g., being unable to move forward with specific activity goals due to actual physical limitations) and what part of the story is truly preventing forward movement. It will be important to talk about reason-giving in a way that can be "heard" and to remember that you are not arguing about the *truth* of the story, but rather you are trying to get at the *function* of the story. Is it keeping the patient stuck? Spend an appropriate amount of time on reasons are not causes and use language that the patient can connect to. Additionally, it is important to be compassionate and recognize the story as important (recommended reading: Hayes et al., 1999; pg. 163-166).

Consider the example of a Veteran who is feeling depressed and anxious. He states that his life has been ruined by his war experiences and the government (the therapist in this segment is working from a heartfelt place, this conversation is not designed to be punishing to the patient, rather it is designed to help the patient see how workable retelling the story is):

Therapist: Let's check in. How are things going?
Patient: Uh…well, I'm feeling pretty low. Things aren't really happening for me. I can't seem to get things done, especially around here.
Therapist: Yeah, things can move slowly around this place.
Patient: You would think that, with all of this time, the government would finally get it right. But no…it has always been about screwing me and they are still doing it to this day.
Therapist (quizzical): It's frustrating for sure. But let me ask you something. We have been seeing each other for a few weeks and each time you have somehow talked about how the government is screwing you. How long have you been telling this story?
P***atient:*** What do mean, "This story?" It isn't a story, it's true.
Therapist: Yeah, I am not suggesting it isn't. However, I am curious, about how long you have been telling therapists and others that you were screwed by the government?
Patient: Years...because they have been screwing me for years.
Therapist: And how has it worked to tell it? I mean, what do you get by telling it?
Patient: Mostly, not a damn thing.

Therapist (thoughtfully): Puzzling. I wonder why you keep telling it. I mean if you have told it for years and it has got you… well…not much, I am wondering why you keep telling it. What do you think would be different if you told it again?

Patient: Like always…nothing.

Therapist: Do you feel better by telling the story?

Patient: No…often I feel worse and get mad.

Therapist: Curious…and yet you continue to tell it. What if next week you come in here again and tell the same story? Should we just go with it – I mean, I am really starting to wonder about this?

Patient: Well, maybe I am hoping that somebody will finally do something about it.

Therapist: Let's say somebody did. That is, somebody came to you and gave you a great big apology. How would that work? It seems it could work to make you feel better for a little bit. But what if nothing happened after that?

Patient: That would just make things worse.

Therapist: And how long have you been hoping that somebody will finally do something to undo this "screwing?"

Patient: A long time.

Therapist: Is it possible that even if this story is 100% correct – you got screwed, that the story has become part of the problem – a reason to not move forward in your life?

Patient: I guess it's possible.

Therapist: Imagine that you come to see me in two years and you are still telling this story and nothing has changed. I am not saying I don't want things to improve and for you to get the services you need, but what if the story has a hold on you? A hold that is actually keeping you back? Might you be willing to see the story as a part of your history, hold it with compassion – because it's a painful one – and let its grip on you go?

This dialogue shows how the story is acknowledged, but also how it seems to be holding the patient back. This fits with the reasons are not causes piece, as the story that the Veteran was let down by the government is not actually keeping him from taking positive action now. It only seems to be that way. Assisting the patient in seeing this possibility can be powerful, but should not be done from a one-up position and the story should not be treated as if it is not true…it very well may be. The issue, again, is how the story is functioning – how it is working in the patient's life.

Lastly, willingness is the key to values-based living. Additionally, willingness is acceptance. If patients are open to experience, to fully allowing emotions and thoughts, the memories and sensation, then they can come to see these experiences as part of the human condition and as wholly acceptable. Willingness can be both easy and challenging. Continue to build on how to engage willingness in the next session.

Assign Homework/Behavioral Commitments

Session 5 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to complete the Willingness Worksheet 1 (Appendix D-6). The patient should define and then commit to completing one Action Homework (Appendix D-10) that is values-consistent between Sessions 5 and 6. All worksheets should be completed and brought back to the following session for review.

Your homework includes again referring to and refining the Case Conceptualization Form (Appendix C) with information obtained as a result of ongoing assessment that occurred in Session 5. Focus on patient strengths to bring into the next session. Select a form of mindfulness and practice personal mindfulness throughout the week, using the mindfulness tracking sheet to track your own personal practice. In addition, consider doing an Action Homework and to set a goal that is personally values consistent and take action with respect to that goal.

End of Material for Session 5

Session 6: Willingness: Building Acceptance, Defusing Language – Part II

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Willingness Worksheet #1; Action Homework).
5. Topic: willingness: building acceptance, defusing language – part II.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Willingness Worksheet #2 (Appendix D-7); Action Homework (Appendix D-10).

Therapist Preparation

Teaching defusion, or healthy distancing, involves creating situations where the difference between language and "languaging" becomes clearer (also see Hayes et al., 2012). By playing on "loopholes" in language, the ACT-D therapist can teach the patient to see thoughts and feelings as the verbally entangled processes that they are, rather than what they advertise themselves to be (i.e., the world understood; truth; structured and organized reality).

The goal is to help patients contact that thoughts need no longer be experienced solely as statements of truth; a thought is understood, but it is also heard as a sound, seen as a habit, and/or dispassionately observed as something passing through the mind. Defusion exercises can help the patient look to outward experience rather than internal rules as a guide for behavior. This can open up new possibilities for flexible responding to direct experience, rather than rigid responding to derived verbal rules.

Teaching non-judgmental awareness is a key part of developing defusion and implementing willingness. Without ongoing awareness, "languaging" can easily come to dominate behavioral processes. ACT-D exercises help to train patients to notice thoughts and feelings and simply describe them, without adding or subtracting anything. Patients are encouraged to see what they see, as they are seeing it, and describe it directly and uncritically: thoughts, judgments and evaluations are labeled as such, without any comment or criticism about having them. This opens the door for willingness and exposure to thoughts, feelings, and sensations in a new way – as ongoing and flowing aspects of human experience rather than as literal content to be dealt with, fixed, or changed.

Assessment

Formal assessment recommended for Session 6: PHQ-9. Optional instruments may also be administered.

Open with Mindfulness

Session 6 opens with a 5-10 minute mindfulness exercise (see Appendix B). Using exercises that introduce the session topic or seem to be related to the topic may be helpful.

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask patients about mindfulness practice since their last session. Check for successes and difficulties and explore options to help with difficulties if relevant. [See session 3, page 44 for further guidance on the implementation of this section if needed]. Review with patients the Willingness Worksheet 1 and explore reactions to the homework and link it back to the prior session. Spend time discussing completion/non-completion of values consistent Action Homework and evaluate barriers as well as congratulate successes. Explore their progress in bringing values to life in terms of both emotional and practical outcomes. Redirect patients to review homework if necessary.

Session Overview and Content: Willingness

In Session 6, willingness is further explored as an alternative to control. The work in treatment is on continuing to build the "willingness muscle." Work on healthy distancing between person and mind while teaching non-judgmental awareness and undermining fusion. Review the in-session topics, metaphors, and exercises below. Plan to implement them in session in a way that is flexible and responsive to each patient's situation. Read and consider the Clinical Topics before session.

In-Session Goals

The session opens by continuing to explore willingness introduced in the last session and reconnecting with willingness as an alternative to control. Note to the patient that you are planning to continue working with this process with the patient including looking at additional ways to build their willingness "muscle." The exercises below are used to help the patient contact willingness more fully. Take care not to spend too much time describing or explaining. Much of what one is doing here is experiential. Not that words can't participate in the process, but if you feel yourself spending too much time talking or explaining, it is a good time to pause and work to let the exercises speak for themselves. Make sure the exercises and metaphors are linked to the patient's experience. Draw on the information that you have learned from the patient to better connect the in-session work to the patient's personal struggles. There is a list of multiple exercises and metaphors below. Learn these and be prepared to do several, using the ones that seem most appropriate to what is happening for the patient.

Start with the swamp metaphor to begin to tap into why willingness might be important for the patient. The metaphor speaks to the process of experiencing (willingness) in the service of values.

Exercises and Metaphors:

Swamp metaphor (Hayes et al., 2012). Therapist to patient: "Let's say there are things that you might want, but they are on the other side of a swamp. These are important things – things that deeply matter to you. Would you be willing to get muddy to get to the other side of the swamp?" Then explore this metaphor with the patient, noting that values based actions sometimes involve difficult internal experience and may even be the thing that motivates values-based behavior. For example, a father may try to reconnect, as a value, with a long estranged son, only to learn that the son isn't interested in a father-son relationship, but rather an acquaintance-type relationship only. The pain of missing the son and the pain of the outcome are all linked to values. Remaining on the other side of the swamp, however, is simply to live with the pain of missing and not having a connection to the son – not living the value – having never tried a journey through the swamp.

Move forward in session with a focus on building willingness through defusion. Help the patient see that there are ways to allow and open up to experience. One way is to "back out" of the literality of words. Demonstrate with the lemon and saliva exercise. The finding a place to sit exercise is also useful (if you end up choosing to do only one, the lemon exercise tends to be a good way to demonstrate defusion).

Lemon exercise (Walser & Westrup, 2007): The patient is asked to imagine a lemon. Thoroughly create the image having him "see, smell, and taste" the lemon. Take some time to do this so the patient has a chance to interact and have responses to (e.g., salivation) the thought of a lemon. You can say, "I would like you to picture a lemon in your mind. Notice the intense yellow color and how hard or soft it feels when you hold it in your hand. Squeeze it just a bit and see if it gives a little. Now imagine yourself digging your fingers into the lemon, feel the juice running down your hand and arm. Squeeze into the lemon with both hands until you tear the lemon in half. Notice the inside of the lemon. See the sections, the pulp, the lighter color of yellow. Notice the seeds and juice. Now bring the lemon up to your nose and smell the lemon. Really notice its lemony fresh scent. See if you can catch how it smells. Now take a bit bite out of the lemon and chew and swallow. Okay, now gently leave the image and come back to the room."

After the patient has imagined the lemon, have the patient repeat the word "lemon" over and over again (30 or 50 times, fast; join the patient in this process) until it seems non-sensical – almost not a word at all. To introduce this repetition, you can say, "Okay, now I would like you to do something a little odd with the word lemon. I am going to ask you to repeat the word again and again for a period of time. I will join you and let's see what happens." After repeating the word until it does not make sense, but only seems like a sound, the therapist explores how the image went away after repetition – how it "disappeared." Together, pay attention to how the word lemon just becomes a sound. Have the patient notice how the *interaction* with "lemon" also disappears. Remind the patient that although the patient could imagine (see, smell, taste) the lemon and "interact" with it, that there are no lemons "in the room". That the patient interacted with the lemon fully (interacted with the word fully), "yet there are no lemons

here." It is the same with the word "worthless." You can say to the patient, "There are no lemons in the room and there is no worthless in you. Lemons are not here, and worthless is not there (pointing to patient's chest)." Let the patient know that they may "interact" with the word "worthless," (just as they did with the word lemon) – but it is not there, it is not literally present. After this, and if it makes sense, you can choose a word that the patient seems to be fused with and/or is a negative evaluation of the self. You can also help the patient defuse from other words in the same way by having the patient repeat them again and again until they no longer make formal sense. Remind the patient that you are not making fun of the struggle, rather pointing to the problem of fusion – that lemons seem to be there when they are not and that "worthless" seems to be inside of us when it is not.

Saliva exercise (optional, use this if appropriate or needed in session, Hayes & Smith, 2005): Again, continue to work with the patient to draw the distinction between words and experience. Have the patient imagine spitting into a glass until it is half full with spit. Build the image so that the patient has a good sense of it, and then have the patient imagine drinking this glass of spit. This will generally elicit thoughts of disgust. The patient is reminded, however, that we "drink" our spit every day – about 2 liters of it. Here it is noted that the disgust is not in the spit, it is what our minds say about spit. This is another example of our reactions not being in the thing reacted to. Then relate this back to how the patient is reacting to their self.

Finding a place to sit exercise (Optional, work in if there is time in the session; Hayes et al., 2012): Work with the patient to continue to draw the distinction between words and experience by conducting the "finding a place to sit exercise". Playfully ask the patient to describe a chair well enough that it can be sat in. Verbal description versus experience is immediately contacted – no matter how good the description of a chair the patient will not be able to sit in the description. Sitting is experiential in nature. Here, we are working on pointing the patient back to experience, drawing the distinction between what mind says and what experience says.

The key point of the above exercises is noticing how language gets us entangled, treating words as if they *are* the things referred to. If this distinction can be contacted, then willingness is made more available as the words are no longer what they say they are, they can simply be experienced as words. There is a caution to place here: we are not saying that words do not have meaning or that they are not useful, we are simply seeing them for what they are, to promote dis-entanglement. After exploring the above exercises, it is useful to demonstrate willingness right in the room using the eyes on exercise.

Eyes on exercise (See Clinical Topic 1): Patient and therapist or patient and patient (depending on whether the therapy is done in individual or in group) quietly sit for about 1-2 minutes looking into the other person's eyes. It is very important to remember that *this is a willingness exercise*. The exercise involves observing personal responses, reactions, and feelings, while continuing to look at the other person. It nicely demonstrates willingness and points to how we can feel many feelings (anxiety) and have thoughts ("I don't want to do this") and still stay engaged with the exercise. The point is to bring this kind of willingness into the larger world, being willing to experience while choosing values-based behavior (also see Clinical Topic 1 below). The introduction and rationale are most important to conducting the exercise. To introduce the exercise you can say: "I am going to invite you to do a willingness exercise with me. It involves several things. First, you should know that it is not a "wantingness" exercise or a "liking" exercise, it is all about willingness. The goal here is to watch what happens and stay connected. So in a minute the two of us will sit and silently look into each other eyes. And as we do, I want you to observe your thoughts, emotions, sensations, etc. Watch what your mind gives you and notice any desire to 'run' away, look away, laugh, all of those things that might pull you out of the exercise and see if you can stay with the exercise. If discomfort arises, then notice that, if humor arises, then notice that, if compassion arises, notice that. I will time us and when we are done we will take some time to talk about the exercise. Are you ready? Okay, remember to gently observe and stay connected." After the exercise, ask the patient for his reaction. Whatever is said is grist for the willingness mill. If the patient notices awkwardness then speak to how life can be awkward at times and it can either boss us around, or if we are willing, we can stay engaged in what we are doing, letting the awkwardness come and go – this applies to all emotion and thought experiences that the patient may have had during the exercise. Ask the patient to notice all that occurred and that the patient was able to engage in a behavior – perhaps one that was uncomfortable or awkward (if experienced as such) – and remain engaged. Feelings and thoughts did not dictate the process. This can be drawn out to the larger world. Feelings and thoughts do not need to dictate the larger process of life.

Veteran Spotlight: In the years that we have done this exercise with Veterans, the responses have ranged in nature. Interestingly, they do not respond differently than any others who do the exercise. In a group setting, we have had Veterans report that they felt closer to their "buddy" and that they remembered the camaraderie of being in the service together. They had experienced a sense of friendship that at times had felt lost.

Wind the session down by completing the leaves on the stream exercise. This exercise points to the ongoing flow, the process of thinking. It allows patients to "see" that they experience thinking and that they are not the thinking itself.

Leaves on stream exercise (See Clinical Topic 2; Hayes et al., 2012; Walser & Westrup, 2007): This is a mindfulness exercise where the patient is guided to place thoughts on leaves as they float by on a gentle stream. It is generally done with eyes closed. You might say: "I would like you to gently close your eyes and then imagine that you are sitting next to a stream (allow time for the patient to create the image). Notice that the stream is gently flowing by you, the water is bubbling and passing. Picture this stream and notice the flow of water. Now imagine that a leaf is floating by atop the stream. Watch it as it gently passes (pause). Imagine that another leaf passes and yet another, until one leaf after the next is gently floating by atop the stream. Now imagine that you could place one thought after another atop the leaves. Allow each thought that you think to be placed on a leaf and to gently float by. Notice that thoughts weigh nothing and can gently ride the leaf as it passes. Continue with this process, gently observing thinking by placing each thought on a leaf and watch as it passes. If you notice that the stream has stopped flowing, look to see where your mind took you and place that thought atop the leaf and watch it float by too." Have the patient engage in this exercise for several minutes. Be sure to pace (allow pauses in between instructions) the exercise while using a soft tone. You might remind the patient once or twice that if he gets "caught" by a thought to gently place the thought atop the leaf and let it float by. The key to the exercise is to observe thinking as an ongoing process. Explore the exercise with the patient when finished. If the patient was unable to engage the exercise, explore what happened and ask if the patient might be willing to try it at home.

Clinical Topic 1: For many patients the experience of doing the "Eyes On" exercise will be unusual. It is a fairly intense exercise, but what we have learned across time is that therapists have more worry about doing it than patients do. It is important for you to understand and communicate that this is a willingness exercise, not a wanting or liking exercise. The goal is to have the patient(s) look at the therapist or other patients (into each other's eyes for a short period of time – 1-2 minutes) while noticing/being aware of all that is experienced. Responses to the exercise can range in nature from "Wow, that is the most connected to anyone I have been in a long time" to "I saw deep into the person, I felt like I knew his spirit" to "I just kept trying to stare" to "I didn't like that."

The setup of the exercise and the processing of the exercise will hold the key. How you introduce the exercise and how you respond to the different types of comments listed above will demonstrate what we are considering when working with willingness. First, there is no right or wrong way to do this exercise. Patients may look away and should be gently reminded to look back while continuing to notice what they are thinking and feeling. Second, it is important to remind the patient that it is not a staring contest, rather the patient is being asked to silently "look" and notice, *that's all.* Staring shows up when patients are uncomfortable. That's okay; it is there to be noticed, too. Finally, other comments can be worked with from the perspective of noticing how much "shows up" in such a simple exercise. You can focus on experience, pointing out avoidance or effort to change things to get rid of discomfort (e.g., laughing). Be sure to note that the main issue is willingness – willingness to experience. Again, it is not about wanting or liking. It is about showing up and staying with something even in the face of discomfort (something that is often experienced by patients outside of the therapy session and is a part of life). The goal is to help the patient "see" that even if uncomfortable, action can be taken and persisted in if willingness is present. Additionally, you can work with the sense of connection that can come from participating in this kind of exercise. Again, the focus is willingness while experiencing.

In individual therapy, the therapist can do this with the patient. The only caution comes when the therapist believes that the patient will misinterpret the exercise in an inappropriate way. In this case, the patient can do the exercise with a friend or partner as a homework assignment. If the patient is asked to do this outside of the session, you will still want to give the same instruction – "notice all that arises while staying engaged" by looking into the other person's eyes. You may want to remind the patient to take the exercise with some degree of seriousness. It is intended to demonstrate willingness, not promote avoidance. A final option for altering the exercise includes you and patient sitting quietly together for several minutes with eyes open but cast down. Only do the latter if it seems the most appropriate route. Be careful not to avoid this exercise simply because you feel uncomfortable.

Clinical Topic 2: Many patients report after completing the "leaves on a stream" exercise that they feel relaxed. In fact, they report this after many mindfulness exercises. The issue remains the same: the exercises are not done as a means to help the patient feel relaxed – they are done to help the patient be present and be aware. You can talk with the patient about this issue and

state that relaxation can be a by-product of a mindfulness exercise, but it is not the goal. This should be said gently as the patient should not feel judged for making the comment.

As the session comes to a close, note that willingness is what is being cultivated and that it can be more fully cultivated from a particular perspective. This is where you and patient are headed: self-as-context.

Assign Homework/Behavioral Commitments

Session 6 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to complete the Willingness Worksheet #2 (Appendix D-7). The patient should define and then commit to completing one Action Homework (see Appendix D-10) that is values-consistent between Sessions 6 and 7. All worksheets should be completed and brought back to the following session for review.

Your homework includes again referring to and refining the Case Conceptualization Form (Appendix C) with information obtained as a result of ongoing assessment that occurred in Session 6. Focus on patient strengths to bring into the next session. Select a form of mindfulness and practice personal mindfulness throughout the week, using the mindfulness tracking form to track your own personal practice. In addition, consider doing an Action Homework and to set a goal that is personally values consistent and take action with respect to that goal.

End of Material for Session 6

Session 7:
Self-as-Context – Part I

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9, AAQ-II, WHOQOL-BREF, WAI-SR and FFMQ. Optional instruments may also be administered; namely the VLQ and the WBSI. The therapist may also administer other assessments as it seems appropriate.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Willingness Worksheet #2; Action Homework).
5. Topic: self-as-context – part I.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Self-As-Context Worksheet #1 (Appendix D-8); Action Homework (Appendix D-10).

Therapist Preparation

ACT-D distinguishes between several different senses of "self" (see Hayes, 1995 and for a detailed look at senses of self and perspective taking see McHugh & Stewart, 2012). The main issue for this phase of treatment is distinguishing between conceptualized self Self-As-*Content*) and observing self (Self-As-*Context*). The notion of a conceptualized self comes from our "languaging" processes. As described above, we continually interpret, review, reconstruct, relate, and organize our experience to be more streamlined and understandable. We apply these same processes to generating a self-concept: each of us has told stories, formulated a life history, defined what we believe our personal characteristics to be, and made thousands of self-statements that express these (e.g., "I am a hard worker" or "I am a person who makes time for friends", etc.). By nature, these concepts depend on derived verbal learning – mental 'relating' processes – and are necessarily skewed (please refer to the discussion of reason-giving in Session 5. Also note, we don't have access to all variables that have shaped our lives and we couldn't formulate it simply even if we did; any close-to-accurate explanation of why we are the way we are would fill pages and pages and still not capture a large enough part of the real picture to be accurate).

The observing self is defined as a point-of-view, a place from which observations about experience is made. This sense of you is about the content of the observations, rather it is about the part of oneself that is making the observations. The notion of "I", then, is what's left when all of the content is "taken away"; "I" is the unique perspective from which each of us experiences life. For example, one exercise described in this section is the "continuous you" or "observer" exercise, in which you will lead the patient through different content aspects of self (e.g., specific memories, thoughts, life roles, body shapes/sizes/sensations experienced). The goal of this exercise is not so much to recount content as it is to guide the patient to consider the aspect of self that has been observing and noticing these different experiences over a lifetime (Hayes et. al., 1999; pg. 188). You work with the patient to understand ideas related to the notion of self-as concept. There are three important points. First, the patient is not defined by private experience; rather the patient is a conscious being that "holds" or contacts private experience. Second, the observing self is beyond evaluation, remains stable and has no mechanical qualities. Finally, the observing self is found in experience, not logic.

Clinical Watch: We use the term "I" above to assist in describing self-as-context. However, we also want to note that the term "I" is also a concept. It is a sound that refers to an individual when talking about themselves. Held as fully intended in self-as-context, even "I" would be an experience to be observed by the observer self. This is not necessarily something the therapist needs to share with the patient, but is presented here to indicate that we are deliberately using "I" to describe/refer to this sense of self. To name the perspective from which experiences are observed.

Assessment

Formal assessment recommended for Session 7 and the midpoint of treatment consists of five self-report measures: the PHQ-9, AAQ-II, the WHOQOL, the WAI, and the FFMQ. Optional instruments may also be administered; namely, the Valued Living Questionnaire (VLQ) and the White Bear Suppression Inventory (WBSI). Other assessments may be administered as appropriate. You may choose to provide feedback about progress on the assessments in terms of score improvement. If so, tailor this feedback to point to successes to motivate the patient to continue.

Open with Mindfulness

Session 7 opens with a 5-10 minute mindfulness exercise as in previous sessions (see Appendix B).

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask about mindfulness practice since the last session. Check for successes and difficulties and explore options to help with difficulties if relevant. [See session 3, page 45 for further guidance on the implementation of this section if needed]. Review with patients the Willingness Worksheet 2 exploring reactions to the homework. Spend time discussing completion/non-completion of values consistent Action Homework and evaluate barriers as well as congratulate successes. Explore patient progress in bringing values to life in terms of both emotional and practical outcomes. Redirect patients to review homework if necessary.

Session Overview and Content: Self-as-Context

Willingness to experience as an alternative to control is not always easily done, especially by simple instruction. The patient and therapist need to find a safe place from which willingness is more possible, a place where negative experiences are less threatening. This is one of the objectives of self-as-context. The goal of self-as-context is to help the patient distinguish the self from experiential phenomena. If the patient is able to contact the sense of self as experiencer, then willingness to encounter difficult emotional material is made easier. If not the emotion experienced, but rather the experiencer of the emotion, then emotion is not so dangerous or challenging. Experiential phenomena are viewed as flowing – emotion, thought, sensation, and memories come and go. Experience changes over time. Internal experiences are like leaves passing on a stream, they ride gently atop the stream, and they are not the stream (link to previous session). Some patients will complain that their experience "never" changes, especially with respect to feeling depressed. However, this is only the case when a patient is in a battle to not feel or so out of touch with experience that the patient doesn't notice it changing across time. Mindfulness/awareness can be helpful here, when paying attention, you can begin to notice even subtle changes in experience across time.

Review the in-session topics, metaphors, and exercises below and plan to implement them in session in a way that is flexible and responsive to each patient's situation. Read and consider the Clinical Topics before session.

In-Session Goals

To help the patient contact self-as-context, begin by exploring the concept of "programming" (i.e., thinking itself including verbal rules, evaluations, etc.) An example of programming might be a "message" that the patient got at an earlier time in life (e.g., "People who are depressed are broken" or "Life isn't worth living if you have pain" or "Happiness means you're doing it right"). These messages are without number and you will want to pay attention to the programming that is personally relevant to the patient. You can find this kind of programming by listening for statements/evaluations that patients keep making about themselves. Be sure to spend some time exploring this programming as part of the exercises below. This can be done by having patients give examples of programming they got from parents, friends, partners or being in the military (e.g., "You will never amount to anything," "You are unlovable if you are over-weight," "You are the smartest person alive" etc.) By the way, not all programming is negative, as can be seen by the latter example here. Then ask about how that programming may be controlling or interfering with the patient's life. What is the relationship the patient has with the programming, one of fusion, or one of observation? Ultimately in this session, you are working to distinguish the observer from the observed (i.e., programming). From the place where the patient is self-as-context rather than content, they are free to choose outside of their programming. The two computers metaphor demonstrates this well.

Two computers metaphor (also See Clinical Topic 1; Hayes et. al., 1999): Work with the patient to see how we get "programming." Describe or draw two figures, each sitting in front of their own computers:

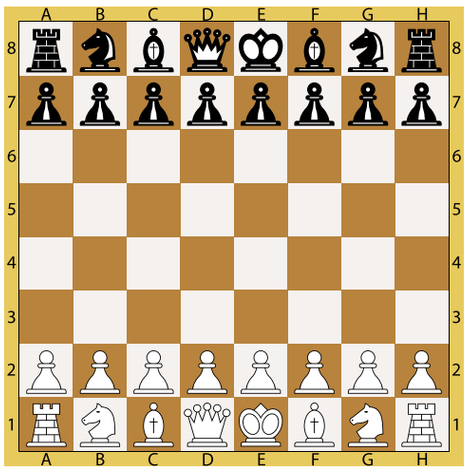
The drawing (see above images) should have one figure sitting back just a bit from the computer screen while the other has his head literally in the computer. Explain that we get programming throughout our life. This programming comes from parents, it comes from teachers and friends, it comes from colleagues and even ourselves. This programming contains all kinds of content including content that is positive and negative and self- and other-evaluative, etc. (content can be positive, negative, or neutral). This programming is non-deletable and it pops up on the screen whenever certain buttons are pushed. During the exercise have the patient imagine that a button is pushed on the keyboard and what pops up on the screen is: "Deep down inside I am broken". For the figure with his head *in* the monitor this is problematic. It seems like he must change the programming if it "*is*" him. In order for him to be okay, he needs to find a way to make this experience different. There is no distinction between him and his programming. For the figure sitting back from the screen, she can have the same thing happen; a button gets pushed and "Deep down inside I am broken" shows up on the screen, but for her the programming is observable for what it is – programming. She has the freedom to curiously observe it and not get stuck in the process of trying to change it. She can choose a life direction outside of her programming.

In this exercise work to see if the patient is "buying" programming versus observing programming. A lot of verbal behavior is automatic: it is programmed. Take note of this for the patient. This can be done by referring back to "What are the numbers" (Session 4; also see Hayes et al., 1999; pg. 128-132). The patient is asked to recall the numbers and note that those numbers are now part of their programming and that when you push a certain button (e.g., by asking, "What are the numbers?"), the numbers 1, 2, 3 pop up on the screen. You can also ask about programmed information that many of us have such as finishing sentences like: "Mary had a little…." (Also see Walser & Westrup, 2007; pg. 92-94). Explore how the patient comes up with the word "lamb" and how difficult it would be to undo, to not think, "lamb" when the words "Mary had a little…" are said (i.e., that button is pushed). Relate this to how difficult it would be to undo other programming that contains evaluation of the self. "I am worthless" might be very difficult to un-program, rather, relating to it as a thought experience might free the patient from the thought. The patient is the place where the thought occurs, not the thought itself.

Let patients know they are going to continue to build this concept of experiencing programming, and other internal experiences like emotions by using the following metaphor:

Chessboard metaphor (Hayes et al., 2012; Zettle, 2007): Here you can choose to bring a chessboard into the therapy room and do the exercise using the pieces to demonstrate the metaphor or use the floor as the board with things from the room as the chess "pieces" on the floor. Describe the game of chess noting how there are two teams. The "good" team (positive thoughts and good feelings) and the "bad" team (negative thoughts and feelings). Have patients tell you their good thoughts and feelings, place some pieces on the board to represent them, and then their bad thoughts and feelings, place pieces on the board to represent them. To this building the two teams typically pitted against each other in chess. Have patients give 5 to 6 of each. Then describe how a war is fought between the pieces and that much effort is made to get certain pieces off of the board (negative thoughts, feelings and memories) by having the good pieces win. That is, we "call out" the good pieces on the board to try and overcome the bad pieces (e.g., high self-esteem should conquer low self-esteem), we make a strategic move to get the bad pieces off of the board. If the good pieces are losing, then one typically needs more strategies to try and control the outcome (i.e., wanting the good pieces to win). However, note to the patients that this board seems to stretch out in all directions and no matter how hard patients try, no matter how many good strategies they apply, they are unable to kick the pieces off of the board – good or bad. The game at

piece level is impossible to win. (Check this out with patients by appealing to their experience by asking, when has this "stuff" – point to the negative pieces – been kicked off of the board – the answer is – they haven't). Finally, ask patients if there is any other place to be in the metaphor. The final answer is the "board." The board holds the pieces, is in contact and is aware of the pieces, yet the board is not the pieces. Then connect patients to the possibility that they *are* "the board" and all of the pieces are their thoughts, feelings, sensations, and memories. The board is the place where these pieces are felt and experienced, but the felt experiences are not the board itself (patients are the place where experiencing occurs). From board-level there is no investment in who wins the game. The pieces can move around as they will and the board can carry/hold them. The board is context for the pieces. This self *is* context for experienced content. The board represents self-as-context – the observer.



Box with stuff in it metaphor (Hayes et al., 1999): This metaphor is the same as above only you, the therapist, place items in a box. The items represent emotions, thoughts, sensations, and memories and the box is the context for these.

After describing the chessboard metaphor you can let patients know that you want to help them get into contact with the "board" level sense of self with the following exercise:

Continuous "You" exercise/Observer exercise (also See Clinical Topic 1; Hayes et al., 1999; McHugh & Stewart, 2012Walser & Westrup, 2007; Zettle, 2007): In this exercise, you lead the patient (The patient's eyes are typically closed; the patient remains silent throughout the exercise or can talk out loud if needed; you can conduct the exercise in segments also as it is a bit of a longer exercise – adapt appropriately) through the different aspects (content) of self while observing the same. Ask the patient to reflect on memories, roles, body shape/size/sensations, emotions, and thoughts as experiences the patient has; and at the same time see that the patient is larger than these experiences. The patient is the place where these experiences occur; not the experiences themselves. Drawing this distinction helps patients to see that they are larger than negative thoughts and feelings. They are the experiencer of them (also the experiencer of positive thoughts and feelings), the context for the content. See example below:

Therapist: (Pace this exercise and give plenty of time in between each instruction for the patient to formulate the image or connect to what is being asked or said).

I would like you to close your eyes and take a few deep breaths…Let yourself settle into the chair. Now I would like you to pick a memory from early this morning and spend time reflecting on that memory (give a moment for the patient to pick a memory). Take a look around the memory and notice its sights and sounds. As you notice this memory, notice the ***noticer***. Notice the observer who is watching this memory.…Now gently let that memory go and turn now to an earlier memory – one from last week or from a month or so ago (allow several moments for the patient to select a memory, as noted, and continue to institute pauses throughout as appropriate). Now observe this memory. Notice the sights and sounds of this memory, what is happening, who are you with, if anyone?...and as you notice this memory, notice the observer. There is a "you" there watching this memory – an observer you. A "you" that is larger than this memory and other memories, this sense of you stretches across your memories, yet is not the memories themselves. So although you experience memories, there is a sense of you that recognizes that you are not

your memories, that you are larger than your memories. In fact, this sense of you stretches way back in time. Select a memory from your childhood. Take a look around that memory, notice the images, sights and sounds. And, as you observe this memory see if you can "catch" the observer. There is a "you" there seeing the memory. A sense of you that is larger than memory. It is the observer. This sense of you also recognizes other parts of your life. Let's look at the roles you play.

Sometimes you are in the role of father, and other times you are in the role of friend. You have been in the role of patient and perhaps the role of parent (make the roles fit the patient). We are both in the role of child. As you notice these roles, also notice that you behave differently in these roles. The role of father is different than the role of patient, how you behave with your mother is different than how you behave with your parent. Notice these subtleties and differences, but also notice the one who notices. There is a "you" there that stretches across these roles and knows that these are the roles that you play in your life, yet you are not these roles. You are larger than any role you might play in your life.

Now gently shift away from roles and to another area of your life, your body. Notice your body as it is today…and also notice how it has changed across time. Your body was once a baby and now you are grown. Across time your body changed and grew. There may have been times that you weighed more or less, were more or less fit. There were times when your body was ill and times when it was quite well. You may now have scars that you didn't once have. You may have had parts of your body removed, but notice that you remain. You washed parts of your body away when you last showered and every cell in your body has changed over time, and as you notice this, notice who is noticing. A *you* that has been there for all of these changes in your body, yet is not just your body. Notice this larger sense of you. Now, let's turn to another area of your life, your emotions. Notice all of the emotions that you might have in a single day. Perhaps they have been higher or lower, perhaps more simple or complex. Sometimes emotions are easy to describe and sometimes you can't seem to find the words to describe how you are feeling. You have felt anxious and fearful, sad, and mad. You have felt joy and happiness, calm, and peace. You have experienced many emotions and as you notice this, also notice who notices. There is a *you* there that knows that you *have* emotion, yet is larger than emotion, you are not simply emotion.

And let's take a look at one last place. This place is the hardest, your thoughts. Your thoughts once came in one and two words and as you learned and grew, your thinking became more complex. Sometimes your thoughts are focused and engaged in solving a problem, sometimes your thoughts are lazy and just wandering around. At other times your thoughts may be racing and hard to slow down and there may be times when you are not aware that you are thinking at all. Sometimes your thoughts are of good things and sometimes of bad. At times, your thoughts are evaluating and categorizing and at other times they are creative. As you notice all of this, also notice the you that knows that you have thoughts. A you that is larger than thoughts. An observer you that knows that you think.

At the end of the exercise, wind down by stating:

Notice that you are not your memories, your roles, your body, your emotions or thoughts. You are larger than these. You are the observer of these experiences, a kind of board level (referring back to chess board metaphor) you that contacts experience, but is not the experience itself, you are the observer – an experiencer."

This is about a 20 minute exercise and one of the key exercises to the process. To review the exercise in its full form, see Hayes, et al., 1999, pg. 192-195. Process the experience of the exercise with the patient taking care to focus on contacting the sense of self that is the experiencer, is larger than emotion and larger than content, and is aware – is consciousness itself. Remember, this is not a logical place, it is a felt sense. Using too many words to describe it may undermine the process.

Clinical Topic 1: Our histories are unchangeable. Just as emotions and thoughts reflect the immediate content of our verbal behavior, so, too, our histories function as repositories of verbal behavior. We carry our histories around, and they can be incredibly useful, but they can also be painful or sometimes seem to push us ar und (e.g., "I can't live a good life because I had a terrible childhood" or "I have been divorced, I can never love again"). Most importantly, they are not controllable. Time goes in one direction and we can't go back and rewrite the past. Therefore the domain of memory and historical events are domains that call for acceptance, not control.

Veteran Spotlight: Some Veterans are attached to their histories/ identities in ways that are problematic. For instance, some Veterans may be so strongly attached to their identity as a soldier or a Vietnam Era Veteran that they have lost connection with the sense of self that is bigger than these particular identities. These Veterans may need help re-connecting to their larger sense of self. Noting all of the identities they might have or have had, e.g., father, brother, worker, etc.

Additionally, human beings tend to identify with their programming (histories) in particular ways. By the time patients come into therapy, they have extensive histories and rules that they are carrying around (e.g., the way the world works, their fundamental worth as a human, the way they work in the world). Although certain histories and rules are valuable, others, when the patient is overly attached, can be problematic. When patients *over-identify* with a rule, identity (a conceptualized self), or a piece of history or programming, then the responses they engage in the world may be limited by the identity (e.g., once a soldier, always a soldier).

With self-as-context, patients are taught to identify with their sense of consciousness and continuity. This can decrease the attachment to history and ineffective rules. They can learn to step in and out of identities as called for (e.g., civilian identity and soldier identity). The self-as-context perspective is more expansive and, from this place, all experience is acceptable – the patient is whole (with their history) rather than the patient needing to become whole (paradoxically by eliminating experience). If the patient is whole now, no part of internal experience needs to be avoided, then choices about how to behave can emerge from a place of what matters and is valued rather than from a place of avoidance and control.

Here we can give an example: many Veterans who are struggling may come to identify themselves, or get overly or exclusively attached to, a particular identity (e.g., "I am a Vietnam Vet."). Not only do they have a particular persona that embodies this identity, their life also seems to be defined by it. From the perspective of self-as-context you can work with patients to see themselves as having a history that contains many details of wartime and memories of that experience. But they also have a history that contains many other identities. They are fathers and mothers, sons and daughters, brothers and sisters, husbands and wives. They have memories from before war and from after. Self-as-context can help loosen the grip that a particular history has on a patient, thus freeing them to make choices outside of the identity rather than from the identity.

From the place of self-as-context freedom is possible. Freedom to choose values and life directions is wholly available, if you are not your thoughts and feelings, they are less threatening, less pushy – you can change your relationship with them and see them as something you experience rather than something that you are. They do not need to be changed before something different can happen. Share this with the patient and note that choice is always available from this place.

Assign Homework/Behavioral Commitments

Session 7 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to complete the Self-As-Context Worksheet 1 (Appendix D-8). The patient should define and then commit to completing one Action Homework (Appendix D-10) that is values-consistent between Sessions 7 and 8. All worksheets should be completed and brought back to the following session for review.

Your homework includes referring to the Case Conceptualization Form (Appendix C) and checking for progress while also identifying remaining barriers that are to be addressed in the time that is left. Practice personal mindfulness throughout the week.

End of Material for Session 7

Session 8: Self-as-Context – Part II

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Self-As-Context Worksheet #1; Action Homework).
5. Topic: self-as-context – part II.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Self-As-Context Worksheet #2 (Appendix D-9); Action Homework (Appendix D-10).

Therapist Preparation

ACT-D is concerned with the differences between self-as-content and self-as-context because each seems to be differentially threatened by the prospect of change (see also Hayes et al., 2012; McHugh & Stewart, 2012). As mentioned, patients are often familiar with, and quite attached to, their conceptualized selves (e.g., they can offer verbal descriptions such as "I am depressed", "I'm a good worker", "I'm someone who can be counted on"). The conceptualized self is based on a lifetime of "languaging" about the self, constructing self-concepts, and then acting in ways that are consistent with them. Hayes et al. (1999) point out that the conceptualized self can come to dominate behavior in ways that are problematic: "We begin to behave in a way so as to maintain our own process of self-reflective categorization and evaluation…we try to live up to our own and others' views of ourselves" (p. 182). In so doing, we can also cling to these views to the extent that we might misremember or reinterpret events just to be consistent with them. We defend our sense of self simply for the sake of maintaining consistency and "being right". By again confusing the derived functions of language with the direct functions of experience, we can become drawn into protecting our conceptualized selves almost as if it were the same as our physical being, and essential to our very existence.

The concept of the observing self is, by contrast, quite different. When people are asked questions about their history or experience, the content of their answers will always be diverse and variable; even repeated reporting of the same event can be quite different across time. The only thing that will be consistent over time is the context, or perspective, from which the answer occurs (the "I" referred to in session 7). ACT-D takes the stance that the "I" being referred to in this case is not just a physical organism but a sense of perspective that is not physically defined: a perspective that is the experience of knowing and seeing from one's unique and individual vantage point across time. While experiential content changes (e.g., memories, thoughts, and emotions) the perspective of "I" is necessarily stable; In other words, you can't interact with and perceive the world from any other perspective than your own.

In this way, an important distinction is made between the content of a verbal event (i.e., the literal answer to any question about the self) and the context of a verbal event (i.e., the locus from which observations are made: the observing self). The observing self is critical to acceptance work because it means that there is at least one stable, unchangeable, immutable fact about oneself that can be experienced (through exercises like "continuous you" or the "chess board" metaphor). That kind of stability and constancy makes it less threatening for a patient to enter into the pain of life, knowing that this "I" will not be at risk.

Assessment

Formal assessment recommended for Session 8: PHQ-9. Other assessments may also be administered as seems appropriate.

Open with Mindfulness

Session 8 opens with a 5-10 minute mindfulness exercise as in previous sessions (Appendix B).

Prior Session and Homework Review

Following the mindfulness exercise, check-in with the patient to see if he has any questions related to the previous session. Review the Mindfulness Tracking Form and ask the patient about mindfulness practice since the last session. Check for successes and difficulties and explore options to help with difficulties if relevant. [See session 3, page 44 for further guidance on the implementation of this section if needed]. Review with the patient the Self-As-Context Worksheet 1 and explore reactions to the homework and link it back to the prior session. Spend time discussing completion/non-completion of values consistent Action Homework and evaluate barriers as well as congratulate successes. Explores the patient's progress in bringing values to life in terms of both emotional and practical outcomes. Redirect the patient to review homework if necessary. Remember, this check-in is not designed to start a long conversation about the patient's week.

Session Overview and Content: Self-as-Context

It is useful to do multiple exercises and metaphors covering self-as-context. It is a key component of the therapy, and working to get self-as-context established is an important aspect to acceptance. Additionally, some patients will connect with certain metaphors, and not with others. Expanding on the exercises and metaphors provides the opportunity for patients to contact experientially to what you are working on by using multiple examples. The different metaphors also highlight different aspects of the "observer" phenomenon. Finally, experiential exercises are particularly useful for demonstrating the concept of self-as-context. Patients can begin to see themselves as larger than their content and they can learn how content does not define them or their self-worth.

In Session 8, continue to broaden the concepts and processes that instantiate self-as-context, including: helping patients to see themselves as conscious beings that contacts experience but is not the content of the experience; helping patients to explore the observing self as beyond evaluation; helping patients to observe that self-as-context has no mechanical qualities; and helping patients to observe that self-as-context is found in experience not logic.

Things to know: You should review the in-session topics, metaphors, and exercises below and plan to implement them in session in a way that is flexible and responsive to the patient's situation. You should also read and consider the Clinical Topics prior to the session.

In-Session Goals:

The following exercises can be used to help the patient continue to contact self as context. Again, draw on the patient's experience and bring it fully into the session. You may choose to start with the physicalizing exercise, which is useful in assisting the patient to observe the ongoing experience of emotion. It points to both the experiencer and to how emotions change across time. All emotion is welcomed and able to be observed.

Exercises and metaphors

Physicalizing exercise (Hayes et al., 2012, Walser & Westrup, 2007; Zettle, 2007): This exercise can be done silently, with you asking questions and the patient responding internally or the patient can state things out loud – either is okay, use clinical judgment to decide which will work best. This is an eyes closed exercise where the patient is asked to connect to a particularly difficult struggle and the emotion that comes along with it (e.g., sadness, anxiety). The patient is then asked to notice where this is experienced most in their body. Have the patient "connect" to the sensation and experience it as best they can and then have them imagine that the emotion could be "pulled" from the body, set before them, and given an image (e.g., the patient silently creates an image that seems to match their emotion: red ball of flame, giant monster, etc.). The patient should be allowed time to develop and "see" the image "out in front" of them. The patient is then guided to notice the image and their response to it. The response to the image is elicited in a relatively quick fashion. You will want to know the patient's immediate reaction to the image (e.g., if the patient states: "It is a large green lizard with sharp teeth", the immediate reaction to that might be fear). This *reaction* (emotional response to the first image) is then "found" in the body (e.g., where does it seem to physically live in the body) and pulled out and given an image too, just as was done with the first emotional experience (in the response to the lizard example, fear might be the image of someone shrinking away with their hands up in defense). This process is repeated for three images. After the patient has observed each image ask the patient to let each image "come back" – as an open invitation – to where it came from in the body, one image at a time. Then you might say: "Now focus on the third image. Bring it gently back to the body, placing it back at the place that it was originally experienced. Let it gently rest there. Now do the same with the second image. Allow this one back too.

And finally, bring back the first image. Notice if there is any withholds or resistance and see if you can gently allow this one back too. These are all experiences that belong to you. No need to fight, force or make them come or go. Just let them gently rest in the place where they resided." As noted, ask the patient to gently bring the image back and let it "rest" in the place from where it seemed to be located originally, without any effort to make it different. Guide the patient to see the changing nature of experience and that the patient can "hold" this experience without any need to escape it.

In exploring the exercise after it is completed it should be noted that the images may become more compassionate as the patient moves from image one to image three. Point this out to the patient and explores the process. If the second or third image is one that represents something more compassionate, note that and explore with the patient. Build on compassion whenever possible. Occasionally, the images stay the same or get worse. When this happens, simply explore the exercise and process how we experience emotion. Invite the patient to continue the exercise, asking the patient to respond to the unchanging nature of the images and explore their reaction to the unchanging nature of the experiences. Then have the patient notice that they can experience this too, as part of what can be observed and experienced without any need to make it come, go or be different. Have the Veteran notice it is possible to have compassion for this sensed experience and invite the patient to do that. One potential way to work the latter is to ask how the patient might respond to someone who was having similar experiences (e.g., a friend or family member). Ask how the Veteran would respond to that person carrying this kind of pain. Hopefully, the patient will respond with some kind of caring or compassion. Ask further if the patient could choose to do the same for him or herself.

This exercise assists the patient in experiencing the ongoing flow of emotion. The Label Parade and the Holding the Conceptualized Self exercises are optional, but are provided here to give additional exercises to assist the patient in contacting self-as-context. Use these when more work is needed to establish this sense of self or if time permits. The *label parade* exercise can help the patient more fully contact the ongoing flow of thought and how it does not need to be the "commander" of behavior and choice and the *holding the conceptualized self exercise* helps the patient to hold stories about the self more lightly, creating freedom from the idea that their sense of self should be based on the concept.

Label parade exercise (Walser & Westrup, 2007): This exercise mimics the chessboard metaphor. Here ask about the patient's thoughts and emotions. Each are written on a card and then placed in the patient's hands or taped to their shirt. The Veteran is then asked to walk around the room carrying these thoughts and emotions in any direction that the patient wants to go. Again, the goal is to help the patient connect to the process of experiencing and choosing rather than letting experiences choose for the patient. This exercise is particularly good in groups.

Holding the conceptualized self exercise (Walser & Westrup, 2007): This is a guided imagery exercise where the patient is asked to describe (looks, feelings, thoughts) three different aspects of himself or herself (e.g., best self, hurt self, soldier self, etc.) forming an image, one after another, of each. The patient is then walked through an eyes closed exercise and asked to imagine each image one at a time. With each image, the patient is asked to notice their response to the image and then is invited to hold the image lightly, perhaps as if holding a butterfly in the palm of the hand, as the patient is larger than that self-concept. You say, "Now that we have these images described, I am going to ask you to close your eyes and get centered. Now, place the 'best' image of you, the one you created, right before you. Imagine this image standing in front of you just as you have described it, right here in the room. Notice your reaction to this sense of you, this image. Imagine that for some reason you could no longer hold on to this sense of you. That you had to let this sense of you go. What might you cling to? What might you easily let go of? No matter, this is not you anyway, you are larger than this sense of you. Hold this sense of you lightly, like a butterfly in the palm of hand your hand." Take the patient through each of the three images using the language above and asking the patient to hold each lightly in an effort to continue to build self-as-context – a sense of self that is larger than any conceptualized self. The patient has many senses of self (content) and is the experiencer of them all (context). For further details on this exercise see Walser and Westrup (2007; pp. 197-181).

Finally, the next exercise can be used as a titrated exposure exercise. Again, the goal is to help the patient contact internal experience without the need to avoid. Observing sensations of the body without escaping them can be useful when working to re-engage life.

Tin can monster exercise (Hayes et al., 1999): This metaphor helps with interoceptive exposure to physical sensations. Talk about the threat of a *giant* tin can monster (a monster made of individual tin cans e.g., a coffee can for a head, soup cans strung together for the arms and legs, etc.). If viewed as the entire monster it can seem quite threatening and noisy. However, if the cans are looked at separately they are not as threatening and can be experienced as individual tin cans (i.e., individual sensations).

For instance, with anxiety a patient might be feeling a rapid heart rate, be sweating and have shaking hands (individual tin cans). Taken all together this can feel threatening, like a monster is taking over your body. Taken individually (as each can; as each sensation) none of the sensations pack the punch they seem to as a whole. You can walk the patient through this exercise after describing the metaphor: "I would like you to close your eyes and recall a particularly difficult situation. Notice what you felt during that situation. Pick an emotion that seems to rise to the top and seems stronger or more present than the others. Where do you experience this emotion (allow the patient time to respond)? Now I would like you to focus on this emotion as if you were interested in a single tin can (the patient may focus on a single sensation, e.g., a tight band around their forehead), rather than the whole tin can monster. Simply focus on this experience itself and notice its qualities and intensity. See if you can let it be as it is. Simply experience it as you focus on a single tin can (a single sensation)." The therapist continues with this type of intervention for two or three more sensations and follows the same pattern of speech. When finished, gently bring the patient back and explore the exercise. Then note to the patient that individual experiences of anxiety or other difficulties, single cans, is different than being overwhelmed by the whole tin can monster. Invite the patient to practice using the Tin Can Monster exercise outside of session in different situations.

During this session, it may be a good time for to consider other barriers to willingness and letting go of the conceptualized self. There can be a number of barriers that manifest in different ways. We explore a few here to give you a sense of the kinds of things we are talking about.

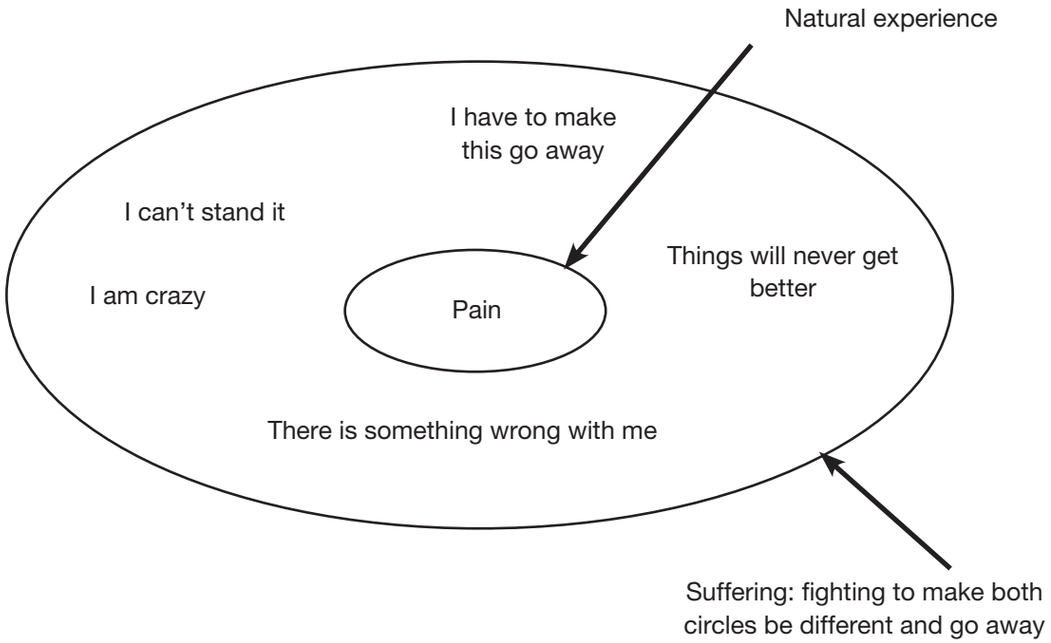
You may explore the ACT-D perspective on confidence: "con" means with and "fi" means fidelity. Confidence is not a feeling it is an action. Being confident means doing things with fidelity or with trueness to oneself. Sometimes depressed patients are overly invested in "feeling" confident as a means to recovering. Here we want them to see confidence as something that is immediately available as an action, not a feeling.

Issues of right and wrong may also be explored. Some patients get stuck in "being right" at the cost of living and their conceptualized self can be one of someone who was been wronged. From this place, the patient may find it difficult to move forward – waiting to be "un-wronged". The goal here would be to assist the patient in letting go of being right if it is too costly. The larger question is "Do you want to be right or do you want to live?" Discuss with the patient the cost of being right. Being invested in being right often means sacrificing values. See Clinical Topic 2 below for further information.

Issues of forgiveness can stand in the way of living values and may be explored as a potential barrier. Forgiveness can be misinterpreted as a feeling. There are feelings that come along with being forgiving, but forgiveness literally means "to give what went before." It is an action and a process. The patient is asked to engage in a process of forgiveness if appropriate and relevant, however the patient defines what the action of forgiveness looks like. This is done as a means to move forward in life, especially if the patient is stuck in anger as a result of non-forgiveness. Anger tends to impact the patient much more than the entity or the one whom the patient is angry with. Work with the patient to discover what action can be taken that is about forgiveness, especially if forgiveness is needed to move forward in their life (see Clinical Topic 1 below). Discuss forgiveness as it relates to the distinction between pain and suffering. Non-forgiveness can be part of suffering that is about something other than the original pain (e.g., making the other person or self "pay").

Veteran Spotlight: Veterans can struggle with issues of forgiveness. Helping the Veteran to see forgiveness as an action and a process rather than a feeling may be very useful.

Finally, explore and emphasize that willingness cannot have control as an underlying agenda. Note to the patient how eliminating emotions and thoughts is actually a part of suffering. Also note that you are quite interested in helping the patient to decrease suffering, but not by avoiding natural experience or changing the response to it, but rather by opening up to all that is experienced through willingness (see graph below). Draw this graph for patients and note how they are working to decrease suffering. What you are asking patients to do here is to slow down and "show up" to their experience, all of it – that which is contained (see graph) in the inner circle and the outer circle (rather than having these plus a battle to not have them).



Clinical Topic 1: Working with forgiveness in the Veteran population can sometimes be a "sticky" venture. Veterans can have deep issues of pain and struggle around the meanings they have made about some of the events in their lives. They may feel unable to forgive others for what has happened to them, or they may be unable to forgive themselves. Forgiveness can be centered on many different kinds of issues, ranging in nature from not being present when a child was born to not being able to protect a buddy from harm to witnessing or participating in the occurrence of war atrocities. Many of these issues are also related to values "violations." That is, they are inconsistent with what the patient would normally choose to do. Veterans struggling with these kinds of issues will report that they have been unable to forgive themselves, or God, or the government, etc. They will often state that they do not feel forgiving and will blame themselves and others for perceived or actual misdeeds.

From an ACT-D perspective, waiting to *feel* forgiving is part of the problem. If a patient is waiting to feel better as a sign that they have forgiven or have been forgiven, then they could be waiting for a very long time. Forgiveness here is conceptualized as an activity, not a feeling. Forgiveness literally means to give what went before. It is a *giving*, not a receiving of some feeling. The feelings that are associated with forgiveness can come and go. However, the activities of forgiveness can always be engaged in. Ask the patient, "If you were to treat someone in a forgiving fashion what would that look like?" The response will provide the details of the actions that can be taken. The patient can then be forgiving as an activity and choice, and the feelings associated with it will be whatever they are.

Finally, with war atrocities, the fusion seems to be even stickier. You may want to work with the patient to act in a forgiving way toward self, but also perform symbolic reparations if that seems to make sense. You can explore with the patient what this would mean (e.g., volunteering, donating, etc.). You can also explore with the patient values and how the values might unfold in this arena. Working with Veterans to see their own humanness can be helpful. Working to have the patient engage in values related behavior toward the "self" too is also important. Lastly, forgiveness does not mean concession or agreement with a past harm. This should be elaborated, especially with those who cannot forgive a perpetrator (e.g., rape victim). Remember to work with the patient from a perspective of helping the patient to move forward, noticing the personal cost of non-forgiveness (e.g., anger, remaining in the victim stance, etc.). Forgiveness is about the patient moving forward, not the perpetrator.

Clinical Topic 2: Issues of right and wrong can also be a struggle for patients. When a patient is depressed, he or she may feel wronged about something or by someone. We all experience this from time to time and it may not be problematic for very long. However, for some people, when they

Veteran Spotlight: Getting stuck in being right about something can interfere with valued living. Some Veterans can get so focused on this place (e.g., being right about how they have been wronged by the war, by a wife or husband, by the government) that they lose sight of values. The goal is to bring those values back into focus.

feel they are wronged they have a very difficult time letting go of the experience. You can recognize this in strong feelings of bitterness or unwillingness to move forward until the person who did the wrong apologizes or somehow undoes the pain. Being right about something can truly be a barrier to willingness and the feelings that might come along with letting go.

If a patient presents with being right as part of the struggle (this can look like anger or punishment of the self in addition to other experiences), there are a number of things that can be done to work with this issue. You might engage the patient in the "right/wrong" game (for details of this game see Walser & Westrup, 2007, p.174-178). Or you could have an open discussion about the costs of being right. Indeed, some patients are so focused on being right about a particular issue that they may even consider suicide as an option. Often we give away pieces of vitality or full vitality in order to be right about things. You may compassionately ask the question of the patient, "Do you want to be right or do you want to live?" You might also ask the patient to pretend as if the patient has won, is right and victorious. Have the patient take a "victory lap" in their imagination, hands held high, and then explore what happens after this imaginal experience. Time can be spent exploring the meanings in choosing to be right versus choosing to live. You might find that the patient is *taking the poison and waiting for the other guy to die.* Loosening the patient's grip on being right is the target. See if the patient can take action with respect to letting go and working on vitality rather than being right.

Wrap up the session with the patient by briefly returning to self-as-context and asking about the patient's experience of this sense of self and the openness that is possible there (even to such things as forgiveness and right and wrong issues). Note how contacting this sense of self can be powerful in terms of life choices. Internal events are no longer the dictators of life activities from this perspective – they can play a role, but they don't "have" to play a role. Rather, values can guide behavior.

Assign Homework/Behavioral Commitments

Session 8 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to complete the Self-As-Context Worksheet 2 (Appendix D-9). The patient should define and then commit to completing one Action Homework (Appendix D-10) that is values-consistent between Sessions 8 and 9. All worksheets should be completed and brought back to the following session for review.

Your homework includes referring to the Case Conceptualization Form (Appendix C) and checking for progress. Additionally, assess change in the patient's behavior. Look at where the patient has made progress and where the Veteran may still be avoiding and engaging in non-acceptance. The case conceptualization and treatment plan should be updated accordingly. You are encouraged to practice personal mindfulness throughout the week.

End of Material for Session 8

Session 9: Values – Part I

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9, AAQ-II.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Self-As-Context Worksheet #2; Action Homework).
5. Topic: values – part I (Values Assessment will be needed).
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Values Worksheet (Appendix D-2); Action Homework (Appendix D-10).

Therapist Preparation

Behavior is generally shaped by its consequences, both the direct experience of consequences that have happened in the past and from the verbally derived (i. e., "if…then") relations we create as humans (see Ramnero & Torneke, 2008). That is, the behaviors that people engage to work toward a specific future can include events with which they have had no direct experience. One example is working for many years to get a college degree, having never had the experience of holding a college degree, and being guided by the verbally derived consequence, "If I get my degree, then I'll be able to earn more money." Although ACT-D focuses on undermining self-defeating derived verbal rules, it also tries to build verbal control where such control works: valuing is one of those areas.

Values are *verbally constructed, global, desired life consequences.* Without verbal involvement, consequences are only effective in shaping behavior within a very short time frame after the behavior occurs (e.g., if the treat is awarded too long after the dog obeys a command, it will cease to meaningfully reinforce the desired behavior). The usefulness of verbally constructed consequences, then, is that they allow actions to be coordinated and directed over long time frames.

Another important feature of values is that they cannot be fully satisfied or permanently achieved. For example, the value of "having loving relationships" is not a static achievement; it must be continually sought on a day-to-day basis through specific instances of loving behavior (e.g., calling one's spouse to say "I love you" or listening to your spouse talk about their day). A person can never "reach" being a loving person the way they can reach a destination like San Francisco. This abstract and global quality of values means that they are less subject to satisfaction and change, and therefore tend to be relevant over many varied situations and time frames. Now that willingness has been explored and hopefully established through mindfulness/acceptance, defusion and self-as-context processes (assuming the patient is connecting to the material), help the patient to engage these while actively living out personal values. These processes help to create openness to experience, setting the stage for action. The patient can now "hold" experience while also moving toward values.

Assessment

Formal assessment recommended for Session 9: PHQ-9 and AAQ-II. The therapist may also administer other assessments as appropriate.

Open with Mindfulness

Session 9 opens with a 5-10 minute mindfulness exercise as in previous sessions (see Appendix B).

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask the patient about mindfulness practice since the last session. Check for successes and difficulties and explore options to help with difficulties if relevant. [See session 3, page 45 for further guidance on the implementation of this section if needed]. Review with patients the Self-As-Context 2, exploring reactions to the homework. Spend time discussing completion/non-completion of values consistent Action Homework and evaluate barriers as well as congratulate successes. Explore the patient's progress in bringing values to life in terms of both emotional and practical outcomes. Redirect the patient to review homework if necessary.

Session Overview and Content: Values

ACT-D is a values-oriented intervention. We don't ask patients to experience emotion for its own sake and we don't ask patients to accept in order to feel better, or to reduce the intensity of an emotion. Rather, the intervention dignifies feeling emotion in the service of valued living *as defined by the patient.* Personal values are emphasized. They do not need to be defended, only lived. Patients can freely choose which values they want to matter about and then they are encouraged to do the activities that would bring those values to life (just as they have been doing in the Action Homework assignments). Values clarification is a worthy endeavor as a part of this process. As the values assessment has already been completed, reflect back with the patient on these values to see if they need to be refined and to see what values are coming to life. The patient does not have to feel like it or feel better in order to take action with respect to values. Review the in-session topics, metaphors, and exercises below. Plan to implement them in session in a way that is flexible and responsive to the patient's situation. Read and consider the Clinical Topics prior to the session.

In-Session Goals

One way to start this session is by reviewing the values assessment that was created earlier and then engaging in a discussion about values. Bring the assessment "back into the room" and explore how the patient has been doing. Move forward with the session by delving even deeper into values. The following exercises should be implemented. Both are designed to clarify values. It is most effective to start with the tombstone exercise and then move on to the funeral/retirement party/80th birthday exercise.

What would it say on your tombstone? exercise (Hayes et al., 2012; Walser & Westrup, 2007; Zettle, 2007): This exercise is done with compassion and good judgment. Ask patients what they would like their life to stand for. Draw two tombstones on a whiteboard or piece of paper with each initially reading: "Darren (insert patient's name) was about…." And then state: "What would this read right now on the first tombstone and what would you like it to read on the second?" Generally, the issue for the first tombstone is about what the patient has been doing that is more oriented toward feeling better (e.g., Darren was about worrying about the future and trying to figure out ways to get rid of his depression) versus the second which is designed to get the patient oriented toward values (e.g., Darren was about bringing vitality through being loving, connecting with family, etc.). Explore with the patient what it would be like to have each of these tombstones. Note to patients that they do not have to feel better before they can begin to engage the values on tombstone number two. Values are immediately available to be lived.

Funeral/Retirement party/80th birthday exercise (Hayes et al., 1999): Walk patients through their own funeral, retirement party or 80th birthday in a guided imagery exercise (be patient and expansive in these exercises regardless of which is picked, and have the patient fully create the images being requested in their imagination). The main goal is to have people who would attend these events speak about the patient, but not in words that the patient thinks the people would say based on the past, rather, the patient is guided to have the people in attendance to the funeral/party speak about the patient in the ways that the patient would like and would choose. Ask the patient to think big, be bold and really let the people say those things that the patient wants. The goal is to have the patient connect to values – ways of being that the patient would like to be remembered for. You might open the exercise by stating (take pauses as appropriate, give the patient time to follow the instructions in their imagination): "Please close

Veteran Spotlight: A fair number of Veterans have experienced death in ways that are beyond the typical experience. They may find memories about death quite painful and will work to avoid them – thinking that this is the best way to handle these experiences. This may not be costly. However, it may also cause problems if this kind of avoidance keeps the Veteran from contacting the limited time that we all have in life. Check with the Veteran to see if the avoidance is problematic. Look to see if it disconnects him from an important value. This exploration is not morbid in nature, rather it is existential – the therapist should work with these issues to define meaning (also see Clinical Issue 2).

your eyes and get comfortable. Take a few deep breathes…now, I am going to ask you to visit a particularly important day; it is some time in the future and it is the day of your funeral. Imagine that you could observe your own funeral. Create what this funeral would look like. Picture it in your head. See all of the people who are there to pay their respects. Now imagine that it has come that time during the funeral where people are standing to talk about you and how you lived your life. Now the important thing to do here is to give them the words that *you would like them to say about you,* not the words that you think they will say. Give the words you would like to be remembered for. Have them say those words. Bring a family member to speak about you." Allow time for the "family member" to speak – this is done silently – the patient does this in his imagination. Then continue the exercise. Have the patient continue by having one at a time – a friend, and a parent or child – also speak at the funeral (have about three people speak at the funeral). Then bring the exercise to a close by saying, "Now imagine that it is that time at the funeral when they have closed the comments. Take one last look around to see who is there. Notice what is happening and then gently begin to leave this funeral, returning back to this day, to this time, when your life lies before you. Take a deep breath and when you are ready, rejoin the room."

Time is then spent processing the exercise. Be sure to work with the patient on the purpose and stay oriented on values. If the patient has a negative reaction to the exercise, that is there to process also. You will most likely find values in whatever reaction patients are having (e.g., not wanting to attend the funeral because people are too sad; this speaks to the importance of relationships and the desire to be connected. This kind of content is used to explore values). Also see Clinical Topic 1 below.

Questions to consider with the patient during this session include: *What do you value? What are specific goals related to those values? What are the barriers (thoughts, feelings, other experiences) to living out those goals? What stands between you and living life in the direction of what you value?*

Clinical Topic 1: From time to time, a Veteran will have a response to the funeral exercise that is difficult. For instance, Veterans may report that they "just can't go there." This sometimes has to do with fear of death and sometimes has to do with recently attending a funeral. Other times Veterans get caught up in what they think people will actually say at their funeral rather than what they would like them to say. The former can "grab the mind" and "push" the patient away from the exercise. You can handle these responses in a number of ways, but first, it is important to communicate the point of the exercise – to discover values. The exercise is designed to help Veterans better define personal values; it is about personal legacy, not death per se. You may choose to do the retirement or birthday exercise instead, however, be careful not to avoid the funeral exercise as a result of your own fears.

Clinical Topic 2: Veterans will, like others, report that life is meaningless – especially as it relates to some issues of war (loss of civilian life, atrocities, etc.). Rather than try to convince the patient that life has meaning, reflect on life as it is. That is, life is happening and the patient is here living it. Here is an example:

Patient: There is no purpose…it's all meaningless.
Therapist (with sincerity): That may be the case, it may not. But we do know that you are here. That you were born and…at some point you will pass. It is the way this thing works. The question becomes then, what will you do with your time here… given that you *are* here anyway.
Patient: What does it matter?
Therapist: That is a very good question. One that deserves an answer, but you are the only one who can answer it. Mattering is an activity. It is something that you do. The question might be better asked this way: what will you spend <u>*your*</u> time mattering about?
Patient: Good question.
Therapist: This is a great place to start….let's spend some time discovering that.

Exploring values is one of the key components to this therapy. Have patients keep their values squarely in front of them as a guiding light, providing direction and meaning and reminding them that if a valued path is exited, it can always be re-entered.

Assign Homework

Session 9 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to review and revise the Values Worksheet (Appendix D-2). The patient should define and then commit to completing one

Action Homework (Appendix D-10) that is values-consistent between Sessions 9 and 10. All worksheets should be completed and brought back to the following session for review.

Your homework includes referring to the Case Conceptualization Form (Appendix C) and checking for progress. Practice your own personal mindfulness throughout the week.

End of Material for Session 9

Session 10: Values – Part II

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Values Worksheet; Action Homework).
5. Topic: values – part II.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Values Worksheet (Appendix D-2); Action Homework (Appendix D-10).

Therapist Preparation

Values are useful because they help people select among alternatives (Hayes, et al., 1999). For humans, selecting between alternatives almost always occurs with verbal reasons (e.g., "I will do this because…", "I think this is the right course of action because…"). When an alternative is selected based on a verbally represented reason, ACT-D specifies this as a *judgment*: a selection that is explained, linked to, and guided by verbal evaluation.

It is critical in ACT-D that *values* not be confused with *judgments* – that valuing does not become entangled with reason-giving. Instead, values are to be based on choices: selections that can be made *with* reasons but not *for* reasons. Choices are not explained, they are made. For example, the act of selecting one brand of cola over another (e.g., Coke vs. 7-Up) can be verbally linked to reasons ("I picked it because it tastes better," "I drank the 7-Up because it has fewer calories") but the actual physical process of choosing can still be performed independently (i.e., you can have 1000 reasons to choose 7-Up, and still reach your hand out to pick up the Coke).

With respect to valuing, the verbal formulations that a person constructs about "why" they are choosing certain values are not seen as actual causes for their choices [Refer to back to the discussion of reasons-as-causes in Session 5]. In this important way, patients can freely value without also needing to engage in justification and explanation, which could run the risk of drawing them back into the same social conventions that may have produced their problems in the first place. Therapists work with patients to explore these issues.

Assessment

Formal assessment recommended for Session 10: PHQ-9. Other assessments may also be administered as appropriate.

Open with Mindfulness

Open with a 5-10 minute mindfulness exercise (see Appendix B).

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask the patient about mindfulness practice since the last session. Check for successes and difficulties and explore options to help with difficulties if relevant. [See session 3, page 44 for further guidance on the implementation of this section if needed]. Review with the patient the Values Worksheet exploring reactions to the homework. Spend time discussing completion/non-completion of values, consistent Action Homework, and evaluate barriers as well as congratulate successes. Explore the patient's progress in bringing values to life in terms of both emotional and practical outcomes. Redirect the patient to review homework if necessary.

Session Overview and Content: Values

As noted more fully in the last session and as explored throughout the manual, ACT-D is a values-oriented intervention. The goal is to guide and support patients in creating behavioral change that is consistent with their personal values. Focusing on defining values and working with patients to take actions that instantiate those values is an important part of the therapy. We ask patients to "hold" their emotional and thought experience with compassion and gentle awareness, while continuing to make life enhancing choices. Remember to emphasize choice when working with values living. If we look at the acronym "ACT" – we get the broad perspective of the intervention: Accept, Choose, and Take Action. Again, as the values assessment has already been completed, the therapist and patient continue to focus on this as a work in progress. Review the in-session topics, metaphors, and exercises below and plan to implement them in session in a way that is flexible and responsive to the patient's situation. Read and consider the Clinical Topics prior to the session.

In-Session Goals

As the therapy work continues to focus on and explore values, begin to more fully introduce choice. It is often the case that when patients feel stuck, they also feel as if they have no choice. It should be emphasized that choice is always available, even if the mind says it isn't. The objective is to get choice lined up with values using the following exercises:

Choice and moment by moment choosing exercise (Hayes et al., 2012): Explore with the patient the process of awareness and moment-by-moment choosing. If the patient practices awareness and notices thoughts and emotions without reacting to these unconsciously, then the patient is more likely to choose actions that are consistent with values. This exploration can be tied to the following exercises:

Coke versus 7-Up exercise (Hayes, et al., 1999; Walser & Westrup, 2007): Ask of the patient, "Which would you pick, Coke or 7-Up?" Then follow up with questions about why the patient chose Coke over 7-Up or vice versa. Regardless of the number or the strength of the reasons (e.g., I love coke, 7-Up makes me sick, etc.), the patient can always pick the other drink. This exercise points to choice and how reasons are not causes. The key piece of information to communicate is that – even though we have powerful stories and reasons for why we do what we do – the stories and reasons do not need to dictate our behavior. We can choose outside of these (refer back to reasons are not causes if needed) and in ways that are consistent with values. It may also be important to recognize that choosing Coke or 7-Up has a different quality than choosing a values-based action. The patient may protest by saying that this kind of choice is easy to make even if reasons say otherwise. Take special care under these circumstances. This exercise is not used to imply that the process is easy, rather it is used to contact how choice is available, even with very compelling reasons. For instance, a patient had the desire to return to school. The patient's values around education and success were important. However, the Veteran had many reasons for avoiding the choice, e.g., "I might fail, it will be too hard, I will be the oldest student in the room, I feel too anxious, I didn't do well last time I went, etc." All of these might seem like good reasons to avoid returning to school. The patient was letting these reasons make their choice, rather than choosing based on a value the patient holds. The therapist worked with the patient to help the Veteran see that the reasons were not causal, but that it also made sense that the choice seemed difficult, it meant a significant life change and the risk of failure. All choices have consequences. The choice to not go to school also contains feelings and thoughts of failure. This process can be both "easy" and "hard." You will want to acknowledge this and explore values lived versus values unlived with patients. It may also be helpful to do the two-sided coin exercise.

Two-sided Coin exercise (also see Clinical Topic 1). Produce a coin and talk about the head and tail sides. Point out that it would be impossible to have a coin with only one side. Have the Veteran imagine that one side of this coin was really beautiful, while the other was terribly ugly. Point out that a person might be happy to carry a beautiful coin, but reluctant to carry an ugly one. However, in order to buy anything, they must be willing to carry each side of the coin. Then have the Veteran imagine the sides of the coin represent love and hate, or happiness and sadness, or courage and fear, failure or success, pointing out, again, that the presence of one necessitates the presence of the other. In any case, a person can choose to carry both sides, or choose to carry neither of them, but cannot choose to carry only one or the other. Again this can be helpful when exploring values and consequences to making choices.

Veteran Spotlight: Past hurts can get in the way of living future values. Depression and anxiety can drive family members away. Values can reorient the Veteran back to the family and how he or she would like to be as a family member (e.g., accessible, thoughtful, loving).

Finally, valuing as an activity should also be explored. Remind the patient that values are instantiated by action not by feelings.

Process versus outcome exercise: Valuing is a process not an outcome (see Clinical Topic 1 below). Explore this notion with the patient and talk about how valuing is like walking in a direction – East let's say – and that there is always more East to go. Values are never arrived at; they are only instantiated in the behaviors that we choose to engage on a daily basis. This can be further explored with the patient by delivering the skiing metaphor.

Skiing metaphor (Hayes et al., 1999): Talk with the patient about the process of skiing. The vitality is in the movement downhill, not in the waiting at the bottom. The process of skiing is what makes it so lively, not the outcome – getting to the bottom of the hill. Relate this back to values-based living and talk about it in terms of two major issues. **Brings vitality:** involves exploring how values bring vitality to life; and **Provides meaning:** involves exploring how values give meaning to life.

Clinical Topic 1: Values can never be attained as an outcome. Values lived are lived as a process. If you choose to be loving as a value, there is always more loving to do. Sometimes patients will miss this point and grasp onto the notion that if they live their values that they will then feel happy. However, this is not how living values unfolds. Happiness can be a part of living values, but pain can also be a part of living values (see patient example below). Help the patient contact that valued living is happening in an ongoing fashion, process *is* the outcome.

Patient: One of the values I have wanted to live is about my relationship with my son. I have wanted to be closer to him.
Therapist: What has been standing in your way?
Patient: I am worried he won't talk to me. I am worried he doesn't want to see me.
Therapist (*with compassion*): It sounds like your worries, your fears, are dictating what you will do here? Is there a way that you can line your feet up with this value and carry these worries and fears with you? And, go connect with your son?
Patient: I guess…but what if he rejects me? That would be worse.
Therapist: In the process of not taking any action about the relationship with your son, what have you been feeling?
Patient: Sad.
Therapist: It seems like you are already in a state of rejection. Does that make sense?
Patient: Yeah.
Therapist: So it is one of those things where if you don't want it you've got it.
Patient: Yeah (chuckles).
Therapist: So what is here to be done?
Patient: I guess I just need to make contact and see what happens.
Therapist: Makes sense to me. It could be, too, that your son doesn't respond to you the way you would like. That would be painful, I know. But you can move forward never living this value and feeling rejected or you could move forward living this value and see what happens. Rejection might be a part of that, but something else might be a part of that too… like connection.

This kind of conversation can be helpful to the patient. Reminding patients that valued living doesn't always contain happiness is important. For example, a Veteran once made a connection with a family member who responded in a surprised way and wasn't really ready to have contact. The Veteran felt quite sad and spent a good deal of time with tears over what happened. Yet, the Veteran was grateful to have had the chance to reach out and even though the family member wasn't ready to open a relationship, the person did say that they would be. The family member welcomed an occasional email from the Veteran. Even small attempts can yield fruit.

Take time in this session to note to the patient that the end of therapy is nearing and that there are only a few sessions left.

Assign Homework

Session 10 homework for the patient is to continue mindfulness practice with daily tracking. The patient is asked to use different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). The patient is also asked to continue to review and revise the Values Worksheet (Appendix D-2). The homework also involves having the patient define and then commit to completing the Action Homework (Appendix D-10) that is values-consistent between now and next

session. You should be working with the patient at this time to target values that have not been engaged or to challenge the patient in areas that are still difficult. All worksheets should be completed and brought back to the following session for review.

Your homework includes referring to the Case Conceptualization Form (Appendix C) and checking for progress, any final revisions should be made at this point. You are also encouraged to practice personal mindfulness throughout the week.

End of Material for Session 10

Session 11: Committed Action

Session Structure

1. Therapist preparation: overview of concepts and functional processes.
2. Administer self-report measures as planned:
   a. Suggested measures: PHQ-9, AAQ-II.
3. Select and prepare mindfulness exercise.
4. Review prior session and homework (Mindfulness Tracking Form; Values Worksheet; Action Homework).
5. Topic: committed action.
6. Assign homework/behavioral commitments:
   a. Materials: Mindfulness Tracking Form (Appendix D-1); Committed Action Assignment (Appendix D-11); Action Homework (Appendix D-10).

Therapist Preparation

While acceptance may seem to have a quality that is more passive (although it is not), committed action involves active and purposeful engagement in the service of moving towards values (see Hayes et al., 2012 and Hayes & Strosahl, 2004). While formulating values is essential, the concrete behaviors by which patients move towards living their values will bring these to life. It is only through committed action that people can move from knowing what they want from life, to finding what actually works to get there.

More technically, committed action is the mechanism through which patients can begin to challenge the verbally derived, language-based "rules" that inflexibly guide their behavior. When new behaviors are experienced as successful or unsuccessful in meeting valued ends, the old rules will be abandoned and/or reformulated to include what works for a particular patient. In this way, committed action can be the single most powerful behavioral change tool in the ACT-D repertoire, and should be promoted whenever possible. Earlier discussions aimed at reason-giving can be particularly helpful in this phase of therapy as verbal escape is discouraged for any explanation of behavior. As always, the patient's values are the guide for choosing new behavior and workability is key.

Furthermore, willingness is a primary condition of committed action. Work with patients to help them "see" that there is no such thing as partly willing (this is not about tolerating; or white knuckling). In addition, acknowledge that committed action inevitably invites unwanted experience. Any barriers to committed action can be identified with the F.E.A.R. concept addressed in the Introduction. Additional concepts focus on how commitment is funded by the ongoing process of valuing and the goal of building larger and larger patterns of behavior that are values-consistent.

Assessment

Formal assessment recommended for Session 11: PHQ-9 and AAQ-II. Other assessments may also be administered as appropriate.

Open with Mindfulness

Open with a 5-10 minute mindfulness exercise (see Appendix B).

Prior Session and Homework Review

Following the mindfulness exercise, check-in with patients to see if they have any questions related to the previous session. Review the Mindfulness Tracking Form and ask patients about mindfulness practice since the last session. Check for successes and difficulties and explore options to help with difficulties if relevant. Patients should be praised for the mindfulness work and asked to recommit to continuing the mindfulness practice. At this point explore the value of mindfulness and how it has worked across time for patients. Encourage patients to continue beyond the end of therapy and to practice daily and whenever it may prove useful. Review the Committed Action Worksheet with patients. Spend time discussing completion/non-completion of values, consistent Action Homework, and evaluate barriers, as well as congratulate successes. Explore each patient's progress in bringing values to life in terms of both emotional and practical outcomes. Discuss continuing this process beyond therapy with patients.

Session Overview and Content: Committed Action

These final sessions are focused on holding internal experience and moving in values directions. Accepting response-ability for change is an important topic (i.e., a person is able to respond). Talk with compassion and non-judgment to the Veteran about taking action. Action can range in nature from very small to grand activities. One of the things we say in ACT-D is that, "you can jump off of a piece of paper or you can jump out of an airplane, but *JUMP!*" This is what committed action is about. The jumps should be specifically linked to values. Review the in-session topics, metaphors, and exercises below. Plan to implement them in session in a way that is flexible and responsive to the patient's situation. Read and consider the Clinical Topics before session.

In-Session Goals

In this session, spend time emphasizing how DOING what takes Veterans in the direction of their values is what brings them to life. Care must be taken to be compassionate in this exploration. It is not helpful to try to coerce or shame patients into living their values. Present the following metaphors to help patients get connected to the process of willingness and action:

Passengers on the bus metaphor (Hayes et al., 2012; Walser & Westrup, 2007; Zettle, 2007): This metaphor nicely captures what is happening in ACT-D work. The patient is the driver of a bus and he is picking up passengers along the way. These passengers come in many shapes and sizes and some are tidy and kind (the thoughts and emotions we like) and some are big and scary (the thoughts and emotions we don't like). Once they get on the bus they don't get off. Explore with the patient the kinds of passengers that are on their bus. The passengers can be noisy at times and can even come to the front of the bus and make a ruckus. It may seem that the driver needs to get the noisy, unpleasant ones off, but in fact, they don't go and won't go. The patient might try to wrestle the unpleasant passengers off of the bus but the patient has to first stop the bus in order to do this. The patient ends up in a wrestling match (much like the tug-of-war metaphor) instead of heading where the bus driver wants to go. This stopping represents how patients get stuck in their life – working to eliminate negative experience before they can drive again. However, the most important piece of information about these passengers is that they don't have the ability to do anything to the driver other than make the driver aware of them and raise a fuss – be noisy. They don't actually have the power to harm the driver even if they say they do (they can't cross the yellow line). You can link this to verbal knowledge versus experiential knowledge. That is, verbal knowledge says that these experiences are destructive in some way, however, experiential knowledge says that it is uncomfortable, but that it doesn't actually destroy. Emotions and thoughts do not have that power. The key point is for the driver to keep their hands on the wheel and drive in the direction they choose – towards values, letting the passengers do what they will do.

ACT: Accept, Choose, Take action (Hayes et al., 1999): To help orient patients they should be taught the F.E.A.R. and ACT acronyms. The F.E.A.R. acronym is a self-monitoring procedure designed to help patients pinpoint each type(s) of barrier to willingness that have surfaced. F.E.A.R. requires patients to look at the following areas: Fusion with thoughts, Evaluation of experiences, Avoidance of experiences, and Reason-giving for behavior. This list can be printed on a wallet-sized card or laminated if you are inclined and have the means. Patients can carry it or post it in a conspicuous place. When patients are feeling stuck the algorithm may give some needed guidance. On the other side of the card, the ACT acronym can be presented: Accept your reactions and be present, Choose a valued direction, and Take action. You can also explore with patients the following:

A life selected exercise: Here explore with Veterans the possibility of taking actions that are chosen in the service of selecting a life rather than life "selecting" the them (i.e., the patient chooses to live according to values, rather than being defined and guided by symptoms). This is an active and lively process. It is about choosing life and engaging when and wherever possible.

Willingness Question exercise (Hayes, et al., 2012): Spend some time exploring the following question with patients: "Out of the place from which there is a distinction between you and the things you have been struggling with and trying to change or control, are you willing to experience those things, fully and without defense, as they are and not as what they say they are, AND do what works for you in this situation according to what you value?"

Embedded in this question are the six core ACT-D concepts: Out of the place from which there is a distinction between you and the things you have been struggling with and trying to change ***(Self-as-context)***, are you willing to experience those things, fully and without defense ***(Acceptance/willingness)***, as they are and not as what they say they ***(Defusion)*** are, AND do what works for you ***(Committed Action)*** in this situation ***(Present Moment)*** according to what you value ***(Values)***?

Then introduce an exercise that is pertinent to the first part of the question, (are you willing to experience things fully and without defense?) addressing acceptance. The child exercise below is used to help patients contact willingness – to be open to the self and treat the self with compassion.

Child exercise (Hayes, et al., 1999; Walser & Westrup, 2007): This exercise can be used to emphasize self-compassion and speaks to the first half of the Willingness Question. It is a *guided imagery exercise,* eyes closed, that typically takes 10 minutes or so. Begin by having patients close their eyes and then guide them to imagine themselves as they were as children – say age 6 or 7. Patients are asked to pick a time when they were quite young and when they can connect to the vulnerability of being a child. Allow time to let patients fully contact and create the image. Ask patients to imagine themselves as that child. Then guide patients through their home at that age, have them start by entering their home and then moving through it; seeing the furniture and photos, etc. Then have patients find and "see" each of their parents, one at a time, (expand as necessary in order to best create the image for the patient) stating, "Now go to the place in the house where you might find your mom. Notice where you found her? What is she doing?" If needed, have patients bring their parents back (e.g., parents are passed on or refer to a mother or father figure) during the guided imagery. When patients finds each parent in the home, first one and then the other, have patients, (still imagining themself as that little child) get their parents' attention so that the parent looks at them and then have the "child" ask for what they need from the parent. This is not intended to be a physical object like a bike; rather it is intended to be a value, like love, protection, or support. Ask patients to see if what was asked for is given and to just gently observe what happens. Allow a short period of time with each parent and then ask patients to leave the home and to encounter themselves as the adult they are today (e.g., the child self, meets the adult self that he is today) on the street outside of the home. Here ask patients to get the adult's attention and also ask for what is needed. Typically the same kinds of things are needed from the older adult self as were needed from their parents. Patients are invited to give what was needed in the exercise in whatever form it takes. The goal is both self-acceptance and compassion for self (also see Clinical Topic 1 below). You should briefly process the exercise when done and be sure patients connect to giving what was needed and to note to patients that it can be given now.

Clinical Topic 1: The child exercise can be particularly moving for many patients. It is a final acceptance exercise wherein patients are guided to extend compassion toward self. Largely this exercise is done without too many problems. However, some patients will get caught up in the content and lose the meaning of the exercise. It will be important to process how the exercise went once you are done.

Patients can get caught in the exercise when they get too lost in revisiting their home as a child. That is, it is as if the home and parents have captured them in a way that they are no longer able to follow the exercise and they lose the point. Here you can be more active and guide the imagery exercise a bit more (it is important to be very familiar with the exercise so its function is understood, not just the content) or you can adjust it so that patients do not visit the childhood home. Do the latter only if it is deemed that it will not work for a patient. Take care to not change it just to manage or avoid your own feelings or worries about doing the exercise with patients.

Again, the main point of the exercise is acceptance and compassion. Compassion is often lost to individuals who have been caught up in depression and anxiety. But not just for reasons that have to do with others, also as a result of turning away from the self. This exercise reminds patients to come back to relating to themselves in a compassionate way.

The following is a patient example of part of the Child Exercise.

Patient: I saw the child before me, but I couldn't give her what she wanted.
Therapist: What was standing in the way?
Patient: I just wanted her to be different. I wanted her to not have to deal with what she had to deal with. I wanted her to be liked and better.
Therapist: Let's imagine that she stands before you and she can hear you saying these things. What might she be experiencing?
Patient: Wow…she would feel rejected and…and just like I have felt all of my life.
Therapist: What does she need as she feels this way?
Patient: She needs someone…(tearing up). She needs someone to accept her just as she is.
Therapist: I wonder if you could be that someone. Not because you want to, but because you choose to.
Patient (crying): Yes…I could accept. But where do I start?
Therapist: Start with letting her know, turn toward her and extend yourself in whatever way seems like it will help her feel accepted.

Patient: I could give her a hug.
Therapist: Go ahead, close your eyes and imagine that is just what you are doing.
Patient: (closes eyes and sits quietly)
Therapist (after pause): Now from this position, what would it be like to move forward in your life?

Clinical Topic 2: Sometimes it can be difficult to get moving when it comes to doing. Focusing on the character of commitment can be helpful. One way to talk about this is to liken it to a game. This should be done lightly or seriously depending on the patient sitting in front of you. Games are designed to be played in a number of ways. But generally, you need to get to the end of the game by following a set of rules based on the notion that where you are is not where you want to be. If you are playing Trivial Pursuit, you roll the dice, you answer questions and move your piece until you get to the center. The game continues until you arrive at the middle. But games are always there to be played. Life is like that. The direction you move in comes from making a choice that where you are is not where you want to be. You might then ask patients what game they want to play. If they are undecided, then the undecided game has its own set of rules and consequences. If they decide that they don't want to play because they might lose, like sitting out of a game of tag because you don't want to get tagged, then they are playing the game of not playing. That has its own set of rules and consequences. The message is to pick a game and play – with its rules and consequences. The best part is patients get to pick the game.

Reminding about termination: Work with Veterans in determining the ending of therapy. Progress, set-backs, change on assessment, etc. should be reviewed. If a patient has not progressed, then you may want to revisit and consider the barriers that the Veteran is having to shifting their relationship to internal events while also considering values-based behaviors. You might consider the follow questions: (a) Are there places where the patient is still stuck or fused; (b) Is the patient still buying stories that are interfering with progress; (c) Have mindfulness and present moment awareness work been lacking; (d) Have actions not been taken, or homework not engaged; (e) Is the patient still not willing to experience certain internal events; (f) Has there been no change on any of the measures, if yes, then why not? These kinds of questions can guide the conceptualization of what additional work needs to be done, or if necessary, what referrals may need to be made. You should consider what else needs to be explored and other areas that are left to work on. You may consider extending the sessions based on this review and then targeting the processes that still need to be addressed or further explored in additional sessions.

If the patient has progressed, you should spend time during this session exploring the ending of therapy. Remind the patient that there is only one session left. Check to see if there are any reactions or issues to address regarding the coming of termination. It is also important at this stage of therapy to reflect on some of the changes noticed in how the Veteran has shifted their relationship to thoughts and feelings as compared to earlier sessions. You might consider revisiting exercises (e.g., child exercise or passengers on the bus) to exemplify these changes. You should briefly explore any concerns the patient may have about termination, self-efficacy, or what comes next. You can use this to inform the processing of the experience of therapy with the patient during the last session. This may also be a time to begin to process some of the relational elements of therapy and give or receive personal feedback, which should also be done in the last session.

Assign Homework

Session 11 homework for the patient is to continue mindfulness practice with daily tracking. Ask the patient to explore using different kinds of mindfulness and to track their practice with the Mindfulness Tracking Form (Appendix D-1). Also ask the patient to complete the Committed Action Assignment (Appendix D-11). Have the patient also define and then commit to completing the Action Homework (Appendix D-10) that is values-consistent between now and next session. All worksheets should be completed and brought back to the following session for review.

Your homework includes referring to the Case Conceptualization Form (Appendix C), checking for progress and noting patient change in preparation for the final session. You are also encouraged to practice personal mindfulness throughout the week.

End of Material for Session 11

Session 12: Termination

Session Structure

1. Therapist preparation: review concepts and session materials.
2. Select and prepare mindfulness exercise.
3. Review prior session and homework (Mindfulness Tracking Form; Committed Action Assignment; Action Homework).
4. Topic: termination.
5. Wrap up: Joe the Problem metaphor or revisit willingness question (session 11; Hayes et al., 1999; pg 239-240; Walser & Westrup, 2007; pg. 186).
6. Stand and commit.
7. Suggested post-treatment assessments: PHQ-9, AAQ-II, WHOQOL, WAI, FFMQ. Optional instruments may also be administered – VLQ & WBSI. The therapist may also administer other assessments as it seems appropriate.

Therapist Preparation

In this last session, the focus is on recognizing the work you and your patient have done together. Taking time to note the patient's accomplishments is useful. You will want to explore what else the patient can work on to develop acceptance while continuing to work on a values-based life. It is also helpful to note that this session is really the beginning of a process that the patient will be involved in for the rest of their life. Patients are encouraged to continue to implement ACT-D processes, noting how they are committing to values-based living. Also take time to let patients talk about their sense of progress and experience of the therapy, which should also be acknowledged and reinforced by you.

The goal of this session is to tie together all of the work that that has been done in therapy. Walking the patient through a short summary of the ACT-D model can be very useful. It may also be useful to help the patient recognize the acceptance and mindfulness, and commitment and behavior change processes that have worked and that have been a part of the patient's progress or success. If the patient is still having difficulty, it will be worthwhile to explore how these processes have the potential to be helpful in those areas where the patient still struggles. Depending on the patient's progress, you may want to consider booster sessions. These sessions can occur at intervals of different lengths and can be used to review and instantiate ACT-D processes. Discuss this possibility with the patient. You may also want to consider referring the patient to an ongoing ACT group if available.

Open with Mindfulness

As in prior sessions, Session 12 opens with a 5-10 minute mindfulness exercise as in previous sessions (see Appendix B).

Prior Session and Homework Review

Check-in with the patient to see if there are any lingering questions that remain from the previous session. Keep this quick "temperature" check very brief. Stay focused on reactions to the prior session. The check-in is not intended to generate an extended conversation about the patient's week. Redirect the patient to review of homework if necessary.

As in previous sessions, ask the patient about mindfulness practice since the last session and reflect on the mindfulness process and how things have been going. The patient should be praised for the mindfulness work and asked to recommit to continuing the mindfulness practice on an on-going basis.

Review with the patient the Committed Action Assignment and explore reactions to the homework and link it back to the prior session. Spend time discussing values-consistent actions from the values homework, evaluate barriers, and congratulate successes. Explore progress in bringing the patient's values to life, in terms of both emotional and practical outcomes.

Telling the story

In this last session you may want to briefly tell the story (i.e., we started here and ended here) of ACT therapy. You might say something like this, but with a bit more expansion if preferred: "We looked at what didn't work and called it creative hopelessness and then we talked about what it was that wasn't working: excessive and misapplied control. We then explored an alternative to

control: willingness. We talked about willingness as openness to your own internal experience and it involves acceptance and being aware that you have a mind, rather than being your mind. We also worked on building the willingness muscle by developing a sense of self that is larger than your thoughts, emotions and sensations, a sense of you that is a context, an experiencer. From that place, where you are not your thoughts and feelings, you are free to make choices. So with the freedom to make choices, we explored values and talked about getting your feet moving in a direction that was consistent with those values, as a choice."

Together process the experience of therapy and talk about what work is left to do outside of therapy. You might spend time talking about what it was like to work with the patient, noting the patient's progress and encouraging the patient to continue to work on their values and accept their internal experience: to hold and move. Give patients time to give personal feedback about their experience in therapy.

Wrap-up

Certainly you should make sure to do what makes sense in terms of wrapping up therapy. Sometimes it is helpful to give patients a small story that they can remember that brings everything together. You may choose to use the one below or one that you feel will resonate with the patient.

Joe the Problem metaphor (Hayes et al., 1999): Imagine that you have just purchased a new home. You are so excited that you decide to hold a housewarming party. You get your place all fixed and post signs around the neighborhood inviting all to come. The day arrives and people begin to show up. You have a nice spread with good food and drinks. All is going well. Then you hear a knock at the door and when you answer you discover that it is Joe the Problem. Joe the Problem doesn't have manners. He is loud and obnoxious, difficult to be around. You don't want him at your party. You quickly try to close the door so he can't enter, but he places is foot between the door and the door jam. You kindly say, Joe, this party isn't for you. Joe argues back, "But I thought it was for everyone, you even posted signs saying all could come." You hesitate but recognize Joe's argument is valid. Besides he has gone on to say he is not going away. You decide to invite him in, but quickly usher him to the kitchen and ask him to stay put, away from the party. You close the kitchen door and walk away. But as you begin to walk away you discover that Joe is opening the door and coming out right behind you. You escort Joe back and once again remind him to stay in the kitchen and you turn to go back to your party. Yet again, Joe is right behind you. He is not staying behind the door to the kitchen. So you once again put Joe in the kitchen, but this time you place your foot up against the kitchen door so Joe can't get out. You find that you have to stay right there in order to keep Joe away from the party. What you discover about this is that you aren't at your party either. So the question is: would you be willing to let Joe wander around your party if it meant you got to be at your party too?

Lastly, you should review the **Willingness Question** one final time: *Out of the place from where there is a distinction between you and the things you have been struggling with and trying to change, are you willing to experience those things, fully and without defense, as they are and not as what they say they are, AND do what works for you in this situation according to what you value?* In reviewing the work together with the patient, ask about the progress the patient felt was made during the time together. You should be sure to notice and report on the positive life steps – values chosen and lived – that you have noticed throughout the therapy and reflect back to the patient where you have seen gains. Also, the patient should be allowed to share the same with you. You can ask where else the patient could work as the Veteran moves forward in life.

Stand and Commit

As the last activity before concluding, ask patients to complete a commitment exercise (see Hayes, et al., 1999). This entails having patients declare their values and intentions about moving forward with their life. Patients make clear statements regarding what they wants to make their life about. In wrapping up therapy, also explore with patients the need for referral to additional services and also address any "what next" questions.

Final Assessment

Have the patient complete the final assessment measures indicated (same assessment instruments that were administered in Session 1; see Appendix C).

End of Material for Session 12

CONCLUSION

This integrated manual presents therapists with the fundamental work done in Acceptance and Commitment Therapy for depression as it is applied more generally and with considerations for a unique Veteran focus. It presents a time-limited approach to decreasing the suffering caused by depression and related mental health problems. ACT-D is considered a "third generation" behavioral therapy that is among a number of exciting mental health treatment developments that have occurred in recent years. It has followed a distinct path in its development wherein behavioral understandings of language and cognition have been linked to applied theories of psychopathology and psychological change. Furthermore, specific efforts have been made to connect theory and application when training therapists in the ACT-D intervention.

The description of ACT-D presented in this manual guide therapists to use mindfulness and acceptance processes combined with commitment and behavioral change techniques to help patients live a life more in line with their personal values. The overall premise of ACT-D defines change as actions taken not in order to *feel* better, but rather to *live* better. The process of living better involves a willingness to be present to internal experience both pleasant and unpleasant along with a direct effort to let go of the need to feel differently in order to live differently. This "letting go" is about decreasing suffering and creating a more workable life that includes a wide range of human experience as a part of vital living. The information and resources in this manual provide great tools to help therapists understand these tenets and guide them through the "how to" of ACT-D implementation.

The manual provides brief conceptual underpinnings of ACT-D and concise explanations of the six core clinical processes and their pathological targets. The conceptual work is done in the service of clarifying the theoretical foundation of this intervention and will assist in preventing inconsistencies in therapy that are related to acceptance versus control messages. Readers are encouraged to further their understanding of the theoretical approach by investigating the resources reviewed in this manual.

The manual also emphasizes the use of case conceptualization with ongoing revision of the same as it can be essential for gleaning which functional aspects of behavior, as opposed to the form, are relevant to treating the patient. Understanding why someone is engaging in particular behaviors from a functional perspective is far more useful in the ACT-D than simply knowing what the behaviors look like. This behavior analytic approach easily lends itself to tailoring, based on the unique aspects of each individual patient's problems. Furthermore, it is hoped that the introduction to theory, description of the steps involved in conducting the approximately 12 individual sessions, clinical examples, and the experiential exercises and metaphors presented throughout the manual have brought these processes to life and guide therapists through the "nuts and bolts" of ACT-D.

Even as the fabric of ACT-D has been emphasized in the manual, we also want to return to the thread that we believe weaves the therapy together – use of compassion while integrating the core concepts into the session in the service of a strong and empathic therapeutic relationship. ACT-D holds the therapeutic relationship as key to the overall success of the intervention.

We included Veteran Spotlights, Clinical Definitions and Clinical Topics as a means to support therapists in understanding particular sensitivities with this population when using ACT-D and to guide therapists in understanding important definitions and core concepts related to the processes of acceptance, defusion, present moment, self-as-context, values, and committed action. Homework that asks patients to practice awareness through mindfulness, to engage the material being covered, and to take specific action with respect to values is also provided. This was done with recognition of the importance of bringing the work done in therapy into the world of the patient outside of the therapy room.

Finally, as therapists learn to integrate the material presented here into their own practice, a more flexible use of the model may appropriately develop, though it is important that therapists maintain fidelity to the model. This will create a therapeutic experience that is responsive to the moment and will allow appropriate implementation of technique and theory as it applies to a specific individual with a specific problem at a specific moment. Learning to become and be an ACT-D therapist includes engaging and applying the model personally, in the therapist's own life. It is the intention of this manual to help therapists gain a firm grounding in ACT principles and, from an open and engaged place, learn to apply them in session in an equal and collaborative way with patients. This is all done in the service of a vital life guided by values for both patients and therapists.

APPENDICES

Appendix A-1

Additional Supportive Readings Supplemental to Sessions

Session 1: Consent and Assessment

Informed Consent and Commitment to Therapy

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 9, pg. 157-161.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapters 1 & 2.
- Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies:* Chapter 3, pg. 36-37.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152-1168.

Formal and Informal Assessment

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 4, Chapter 5, and Appendix A.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 8, pg. 222-229.
- Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 6, pg. 82-92.
- Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies:* Chapter 11.

Session 2: Values Assessment

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Appendix E, F, H, I, Chapter 9, pg. 193-218 (please note that Values work in this protocol comes at the end of the protocol and not at the beginning as in this manual)
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 8, pg. 222-223, 225-229
- Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 6, 89-92
- Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies:* Chapter 8, pg. 139.

Session 3: Creative Hopelessness

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 4: pg. 58-62; Chapter 9, pg.161-166.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 4.
- Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* pgs. 100-102, 135-36, 144-151.
- Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the Treatment of Post-Traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies:* Chapter 4.

Session 4: Control as the Problem

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 9, pg. 167-172.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 5.
- Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 4.

Session 5: Willingness – Part I

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 7, 109-113; Chapter 9, 171-172.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapters 4, 5 & 6.
- Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapters 5, 8, & 9.

Session 6: Willingness – Part II

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 7, 109-113; Chapter 9, 171-172.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapters 4, 5 & 6.
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapters 5, 8, & 9.

Session 7: Self-as-Context – Part I

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 8, 147-155; Chapter 9, 180-82.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapters 5 & 6.
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* pgs. 105-106, 180-86.
- Hayes, S. C. (1984). *Making sense of spirituality. Behaviorism, 12*, 99 110.

Session 8: Self-as-Context – Part II

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 8.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 7.
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* 105-106, 180-86.
- Hayes, S. C. (1984). *Making sense of spirituality. Behaviorism, 12*, 99 110.

Session 9: Values – Part I

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 7
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 8
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 9 & 11.

Session 10: Values – Part II

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 7.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 8.
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 9 & 11.

Session 11: Committed Action

- Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression:* Chapter 7.
- Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change:* Chapter 9.
- Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders:* Chapter 11

Appendix A-2: General Reading List

Therapist Guides

Bach, P. A., & Moran, D. J. (2008). *ACT in practice: Case conceptualization in acceptance and commitment therapy.* Oakland, CA: New Harbinger.

Luoma, J., Hayes, S. C., & Walser, R. (2007). *Learning ACT.* Oakland, CA: New Harbinger.

Hayes, S. C., & Strosahl, K. D. (2004). *A Practical Guide to Acceptance and Commitment Therapy.* New York: Springer-Verlag.

Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy.* Oakland, CA: New Harbinger.

Wilson, K.G., & Dufrene, T. (2008). *Mindfulness for two: An acceptance and commitment therapy approach to mindfulness in psychotherapy*. Oakland, CA: New Harbinger.

Published ACT Protocols

General ACT

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

Depression

Zettle, R. (2007). *ACT for Depression: A Clinician's Guide to Using Acceptance & Commitment Therapy in Treating Depression.* Oakland, CA: New Harbinger.

Anxiety

Eifert, G., & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders.* Oakland: New Harbinger.

Trauma

Walser, R., & Westrup, D. (2007). *Acceptance & Commitment Therapy for the treatment of post-traumatic stress disorder & trauma-related problems: A practitioner's guide to using mindfulness & acceptance strategies.* Oakland, CA: New Harbinger.

Self-Help Support Books for Patients

General

Hayes, S. C., & Smith, S. (2005). *Get out of your mind and into your life.* Oakland, CA: New Harbinger.

Depression

Strosahl, K. D., & Robinson, P. (2008). *The mindfulness and acceptance workbook for depression.* Oakland, CA: New Harbinger.

Anxiety

Forsyth, J. P., & Eifert, G. (2007). *The mindfulness and acceptance workbook for anxiety.* Oakland, CA: New Harbinger.

Trauma

Follette, V., & Pistorello, J. (2007). *Finding life beyond trauma: Using Acceptance and Commitment Therapy to heal from post-traumatic stress and trauma-related problems.* Oakland, CA: New Harbinger

Chronic pain

Dahl, J. C., & Lundgren, T. L. (2006). *Living beyond your pain: Using Acceptance and Commitment Therapy to ease chronic pain.* Oakland, CA: New Harbinger.

Anger

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

Eating Disorders

Heffner, M., & Eifert, G. (2004). *The anorexia workbook: How to accept yourself, heal suffering, and reclaim your life.* Oakland, CA: New Harbinger.

Diabetes Management

Gregg, J., Callaghan, G., & Hayes, S. C. (2007). *The diabetes lifestyle book: Facing your fears and making changes for a long and healthy life.* Oakland, CA: New Harbinger.

Worry

Lejeune, C. (2007). *The worry trap: How to free yourself from worry & anxiety using Acceptance and Commitment Therapy.* Oakland, CA: New Harbinger.

DVDs:

- VA ACT DVD: A DVD created to for VA staff. It includes Veteran testimonials regarding their experience of doing ACT. It also includes examples of the six core components of ACT (visit https://vaww.portal.va.gov/sites/act_community/ACT%20Rollout/default.aspx for more information)
- Hayes, S. C. (Ed.). (2007). *ACT in Action DVD series*. Oakland, CA: New Harbinger. [A set of six DVDs on the following topics: Facing the struggle; Control and acceptance; Cognitive defusion; Mindfulness, self, and contact with the present moment; Values and action; and Psychological flexibility. The tapes include several ACT therapists from around the world in addition to Steve, including Ann Bailey-Ciarrochi, JoAnne Dahl, Rainer Sonntag, Kirk Strosahl, Robyn Walser, Rikard Wicksell, and Kelly Wilson.

Additional Resources on the Theory and Application of ACT

The following publications are excellent resources for additional information about the underlying theory and application of ACT.

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

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition.* New York: Plenum Press.

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

Ramnero, J. & Torneke, N. (2008). *The ABC's of human behavior: Behavioral principles for the practicing clinician.* Oakland, CA: New Harbinger Publications.

Torneke, N. (2010). *Learning RFT: An introduction to relational frame theory and its clinical application.* Oakland, CA: New Harbinger Publications.

Luoma, J. B., Hayes, S. C. & Walser, R. D. (2007) *Learning ACT: An acceptance and commitment therapy skills training manual for therapists.* Oakland, CA: New Harbinger Publications.

Zettle, R. D. (2007). *ACT for depression: A clinician's guide to using Acceptance & Commitment Therapy in treating depression.* Oakland, CA: New Harbinger Publications.

Appendix B: Mindfulness Exercises

A number of mindfulness exercises are provided below. They are in no particular order and may be used for opening each session with mindfulness and patient mindfulness homework. You should adapt these exercises to fit the patient, making them shorter or longer, changing the wording or focus as needed or appropriate. In addition, for VA staff only, other standalone mindfulness exercises can be found at http://vaww.portal.va.gov/sites/act_community/default.aspx.)

Zettle (2007), Eifert and Forsyth (2005), and Walser and Westrup (2007) have published protocols that provide more detail on mindfulness exercises. Information can also be found at: www.contexualpsychology.org. John Kabat-Zinn has developed a set of CD's (http://www.mindfulnesstapes.com/) that are excellent examples of mindfulness exercises; and other products are commercially available as well.

If using mindfulness exercises from other locations, you will find that there is value in being familiar with the exercises to make sure that they are consistent with ACT-D. Many different kinds of exercises can be used and may be quite helpful to patients.

Mindful Breathing

Use a soft tone and well-timed pacing. You will want to deliver the mindfulness exercise in a fashion that allows for the instruction to be engaged by the patient and also you will want to include pauses in order for the patient to practice in the moment (allow silences):

Therapist: First, I will ask you to get into a comfortable position in your chair and put away anything you have out (e.g., papers). I will invite you to do sitting mindfulness and I will instruct you as we go. We will do this for about five minutes. Some people feel comfortable closing their eyes, and others feel more comfortable leaving their eyes open or half open. Choose whatever works for you. If you decide to leave your eyes open, it might be helpful to pick a spot on the floor to look at, so that your focus is more on your breath, what we'll be focusing on today, rather than on what you see….This sitting mindfulness consists of focusing on your breath and observing the experience of your breath. It will involve simply being aware of breathing in and breathing out, wherever you may feel your breath, in your belly, or in your chest rising and falling, or in your nostrils, wherever you feel your breath. Just tune into the feeling of the breath as it enters and leaves your body, over and over again. Your mind may wander, as minds have a tendency to wander to various thoughts such as "Am I doing this right?", or thoughts about the future or the past. If you notice your mind wandering, just note that your mind has wandered and gently bring your focus back to your breath, again and again. Continue in this way, gently escorting your attention back to your breath, over and over.

Continue the mindfulness exercise for five to ten minutes. Allow silent pauses between instructions and from time to time bring the patient back to the breath by stating: "If your mind has wandered, notice where it went, and then gently refocus your attention on the breath."

You might also help the patient to stay focused by including the following instruction: "If it helps, you can say to yourself, 'breathing in' on the in breath and 'breathing out' on the out breath."

Therapist: Now I am going to ask you to open your eyes if they are closed and re-focus your attention back to the room.

Mindful Eating

Ask the patient to practice either observing or describing with eating candy (or a raisin or other small item of food) for about 5 minutes.

Therapist: Today we are going to do some mindful eating. So rather than focusing on the breath, I will ask you to focus your attention on what it is like to be tasting, chewing, etc., by either observing or describing your experience in the moment, what it is like to have the candy in your mouth.

Walk the patient through a mindful eating exercise. Gently prompt them to be aware of such things as taste, texture, movement of the tongue or jaw. Have them eat slowly. Work slowly and in the moment to get the full experience of eating.

Therapist: As with sitting mindfulness, if you find your mind wandering, as minds often do, just acknowledge that your mind has wandered and bring your attention back to the experiences that you are having with the candy – its shape, texture, flavor, and your own responses.

Mindful Walking (adapted from Kabat-Zinn, 1994)

Patients who are more anxious or aroused often like more active forms of mindfulness such as walking mindfulness:

Therapist: In addition to our typical sitting mindfulness practice, I would like to introduce the practice of walking mindfulness. There are many ways to do mindfulness, and some people really enjoy walking mindfulness and other active forms of mindfulness, so I thought we would introduce that practice today. The idea of walking mindfully is that rather than focusing on your breath, as we do with sitting mindfulness, focus on the bottom of your feet as you take each step while you walk. I would encourage you to walk slower than you typically do, focusing your attention to feeling your feet making contact with the floor.

Let patients know where they will be walking. Use the sitting mindfulness instructions above – everything is the same, just where you are focusing your attention is different.

Feel free to experiment with having patients do a brief sitting mindfulness first and then begin their walking mindfulness. You can also ask patients to practice all kinds of activities while being mindful as part of their mindfulness homework (e.g., working mindfully, washing the dishes mindfully, speaking mindfully, etc.).

Cubbyholing Exercise (adapted from Hayes & Spencer, 2005)

You can also use this exercise in session to do mini exposures to emotional experience and sensation with the patient.

Therapist: I am going to ask you to practice an exercise for a five minute period called cubbyholing. It is a type of mindfulness exercise in which you label your experience by categorizing what shows up, like a sensation or a thought. This is done to help in the effort of learning to not cling to any experience…to learn how to not get "sucked" in. It is helpful in that it you can begin to observe how experience changes across time and while experiencing you can begin to see it for what it is…heart beating, thought arising, itch, etc. You will be asked to focus on your breath, as you typically do during your meditation practice. However, you will also be asked to practice noticing your thoughts, feelings, memories, or sensations, as they are, as thoughts, feelings, memories, sensations. To assist with this, we will ask you to label whatever arises into your attention, into your consciousness next. When a thought, feeling, memory, or bodily sensation arises, simply label it in your mind: thought, feeling, sensation (e.g., itch). Simply acknowledge it. So, if you have the sensation of experiencing pain in your back, say to yourself, "sensation," and then re-focus your attention back to your breath. And then, let's say your mind wanders to the thought "Am I doing this right?" say to yourself, "thought," and then refocus your attention back to your breath.

Do this exercise for five to ten minutes. It is called cubbyholing as you are capturing individual experiences in a "cubby-hole."

Yes and No Exercise

Therapist: In this exercise, I am going to ask you to avoid experiencing whatever seems to arise. So for instance, if you have a thought about this exercise say "no" to that thought. If you have a sensation such as an itch, say "no" to that itch. If you experience pain or tension, in your mind, say a loud "no" to that pain or tension. Do the same with emotions. Resist all that you think, feel and sense. For the next minute, whenever you notice something arise, I want you to say "no" to it, whatever it may be.

Wait a minute or two and then refocus the patient's attention on the room. Ask the patient what it was like.

Therapist: Ok, now I'd like to do the same exercise except rather than avoiding or resisting the thoughts, feelings and sensations, I would like you to do the same thing and this time say "yes". If you have a thought about this exercise say "yes" to that thought. If you have a sensation such as an itch, say "yes" to that itch. If you experience pain or tension, in your mind, say a soft "yes" to that pain or tension. Do the same with emotions. Allow all that you think, feel and sense. For the next minute or so, whenever you notice something arise, I want you to say "yes" to it, whatever it may be.

Wait one minute or so and then have the patient refocus attention on the room. Ask the patient what it was like. Process their different experiences with "yes" and "no" as it may relate to willingness and control strategies.

Compassion Exercise

This is designed to help patients experientially get in touch with compassionate feelings for others, and then practice turning it towards themselves.

Therapist: As a way to get in better touch with feelings of compassion, I would like to do an exercise in which you focus on the compassionate feelings you have experienced. I will ask you to just gently close your eyes or focus them on a spot in front of you. Allow yourself just a few moments to get present to your current experience. What it is that you feel while sitting in the chair, notice your own breathing. I will now ask you to think back to an experience that you have had when you have felt compassion for someone or witnessed compassion by others. It might have been a time when you were younger or middle aged or more recently (allow time for the patient to find this image). When you have found that time, notice what is happening. How is the compassion being expressed? Let yourself just be present to that experience for the next few moments (give time for this to happen). Now, I will ask you to think of a time when you were in pain (allow time). See if you can extend the same kind of compassion that you were witnessing yourself doing to someone or seeing someone else doing to another. See if you can give this to yourself. Notice that the heart has a natural tendency to reach out to those in pain and see if you can allow that same experience to be there for you in your time of pain. Let yourself gently rest in compassion (allow time for the patient to engage this process). Now gently let go of this image and bring your attention back to the experience of sitting here in this chair in this room. Mindfully follow a few breaths. Gently return to the room.

Therapist: What did you notice while doing the exercise? Were you able to get in touch with the experience of compassion? What did it feel like? Was it difficult? How did the experience change over time?

Body Scan

This exercise is designed to assist Veterans in becoming more aware of bodily experience and sensation and to remain present to sensations, even if they are uncomfortable (i.e. "mini" exposure).

Therapist: I would like you to sit comfortably in your chair, close your eyes or place them on a spot on the floor in front of you assuming a gentle gaze and then I will invite you to do a mindful body scan. First, we will start by simply becoming aware of the breath. Notice your breathing as you inhale and exhale (allow time for the client to get present to the breath and sit with breathing for a period of time). Now, I would like you to gently release your attention from the breath and turn your attention to your feet and notice the sensation you experience as you become aware of them touching the floor (pause, after each of the following instructions, pause and allow time for the client to do as you are inviting them to do). Notice if you can experience the sensations of wearing shoes…the pressure or tightness? Now I will ask you to gently shift your attention to your calves, notice any sensations or experiences that you are aware of at your calves.

Continue this process with well-timed pauses from feet to head. Depending on time, you may want to cover more or less parts of the body. One suggested sequence is: feet, calves, knees, thighs, low back, stomach, upper back, chest, neck, face, and head. You may also want to do the exercise in larger "chunks": feet, knees, back, stomach, and head. It is suggested that you practice body scans yourself as well as consider the time you have to complete a body scan in session. You may consider asking clients to do longer body scans outside of session. John Kabat-Zinn has excellent body scan exercises found in *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness* (Kabat-Zinn, 2005).

End the exercise as follows:

Therapist: Now I would like you to gently release your attention from the top of your head (or according to where you finished) and return your attention to your breathing, simply following the breath in and out for just a few moments. (pause). Now I will ask you to rejoin the room by opening your eyes.

Word/Phrase Exercise

Ask the patient to consider a word or phrase that captures the sense of compassion for self that they would like to cultivate. This might include words like peace, love, gentle, kindness or phrases like: "I wish myself loving kindness" or "May I feel peace". Discuss the word/phrase with the client before starting the exercise to make sure it is appropriate.

Therapist: I would like you to begin by turning your attention to your breath. Notice each breath as it moves in and out of your body. (Pause). Now, with each outbreath, repeat the word/phrase to yourself. Notice your breath coming in and as it goes out gently state the word or phrase you have chosen. I would like you to continue to do this for the next few minutes. Stating the word/phrase to yourself with each outbreath. If you find your mind wandering, as minds often do, just note that it has wandered and focus your attention back on the breath and the word or phrase. At times, it might feel odd, just allow those feelings or whatever other feelings that may come up to be, as they are, and gently return your attention to this word/phrase. You can use your breath as an anchor to the present moment as you focus your attention on your chosen word/phrase.

Additional Resources: Mindfulness Exercises/Reading:

Hayes, S. C. & Smith, S. (2005). *Get out of your mind and into your life: The new Acceptance and Commitment Therapy.* New Harbinger Publications: Oakland, CA.

Kabat-Zinn (1994). *Wherever you go, there you are: Mindfulness Meditation in everyday life.* Hyperion, New York, NY. Especially consider the Mountain and Lake meditations, they are consistent with ACT and represent the self-as-context.

Living Well Site: http://www.livingwell.org.au/mindfulness-exercises-3/

The Guided Meditation Site: http://www.the-guided-meditation-site.com/mindfulness-exercises.html

Pocket Mindfulness Site: http://www.pocketmindfulness.com/6-mindfulness-exercises-you-can-try-today/

Mindfulness Exercises, DBT Self Help: http://www.dbtselfhelp.com/html/mindfulness_exercises.html

Psychology Today: Six Mindfulness Exercises that Take Less Than One Minute:
https://www.psychologytoday.com/blog/in-practice/201302/6-mindfulness-exercises-each-take-less-1-minute

Appendix C: Case Conceptualization Form

1. Presenting Problem: How does the patient describe their problem at the present time? Patient initial goals (What does he/ she want from therapy and from life?): ACT reformulation of presenting problem:
2. Experiential Avoidance: What core thoughts, emotions, memories, sensations, scenarios is the patient is unwilling to experience? Thoughts Emotions Memories Other
3. What are the "reasons"/expected consequences of having such experiences that the patient is unwilling to risk? [Assessing this serves to draw out the verbal system that may have them stuck in the problem.]

4. What does the patient do to avoid these experiences?

- Overt behavioral avoidance (Activities/situations/people the patient actively or passively avoids):

- Internal and external emotional control strategies (e.g., distraction, self-instruction, dissociation, drugs, self-harm):

- In-session avoidance or emotional control efforts (e.g., topic changes, argumentativeness, dropout risk):

5. Relevant motivational factors (e.g., perceived cost of this behavior in terms of patient's daily life, experience of "unworkability" around change efforts, patient's contact with/clarity of values, strength of the therapeutic relationship):

6. Environmental barriers to change (e.g., negative contingencies (disability), unsupportive home/social environment, unchangeable circumstances, financial circumstances, costs of changing (social losses, etc.):

7. Factors contributing to psychological inflexibility (e.g., excessive rule governance, being right, reason-giver, self issues (lacking a sense of self/unable to describe feelings or wants), extremely low tolerance of emotional experiences, lack of present moment awareness, intellectual-logical (figures things out), excessive attachment to conceptualized self):
8. Given the above, what components of ACT may need to be emphasized in treatment?
9. Patient Strengths (e.g., level of insight – if facilitative rather than fused, patient experience/success with mindfulness or intense presence to the moment, previous values-consistent yet painful actions):
10. Initial ACT treatment plan (specific goals in accord with values, bold moves to contact barriers, dissolve barriers through acceptance and defusion, repeat and generalize in various domains):

ACT Initial Case Conceptualization Form adapted from its original version,
with permission from authors Jason Lillis & Jason Luoma.

Appendix D: Homework Assignments

D1: Mindfulness Tracking Form

Week beginning on: _____/_____/_____

Day of Week	Type of Meditation/ Mindfulness	Number of Meditation/ Mindfulness Sessions	Total Minutes Spent Meditating/Mindful
Monday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Tuesday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Wednesday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Thursday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Friday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Saturday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		
Sunday	Guided meditation / breathing		
	Body scan		
	Informal practice (other)		

D2: Values Worksheet

Instructions: Below is a list of life broad areas. Values such as being loving are often applied in these different areas. Values are subjective and personally chosen. Please be sure this is about what is important to you, not what you think others want. In each area, please write down two specific goals related to the value and a potential barrier (barriers are thought, feelings, sensations that seem to interfere with the chance to obtain the goal/live the value. Example: Relationship Value: being a loving partner; Goal: tell my partner "I love you."; Barrier: I am afraid I will be embarrassed or rejected.

Values	List a personal value in the box below	List two goals related to the value and potential barriers
Relationships (intimate, marriage, couples, families)		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):
Friendships/ Social Relations		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):
Employment/ Education/ Training		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):
Recreation/ Citizenship		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):
Spirituality		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):
Physical Well-being		1. Barrier (thought, feeling, sensation): 2. Barrier (thought, feeling, sensation):

Work with your therapist to help you complete this form. Use this form and revisit and refine it across time/therapy. Ask for additional forms if needed or wanted.

D3: Barriers to Valued Living

Instructions: In the table below, please write down your personal values in the column to the left. Next, write down all of the barriers you have to living your personal values in the second column. In the final column, list all of the different things you have tried to fix the barriers you listed.

Personal Value	Barriers to living personal values	What have you done to try to fix or overcome these barriers?
Example: Being kind to others	*Worried about being rejected or seen as weak.*	*Look strong, reject others before they reject me.*

D4: Homework Assignment: Creative Hopelessness

Instructions: Over the next week, use the following assignment to begin to notice how you get stuck. In particular pay attention to and notice how long you have been struggling and what actions you take when a particular struggle (emotion or thought that is challenging and that you want to get rid of) shows up. During the week, please answer the following questions at least once each day keeping in mind what the cost of this struggle has been in your life. Don't change anything about what you are doing right now. Just begin to notice your experience. If nothing happens on a particular day, that's okay.

Day/Time	Situation	Thought, emotion, body sensations, memory	How long have you been struggling with these kinds of experiences?	What did you do to try to make it better, different, or to make it go away?	How well did that work for you? (0= Not at all 10= Very well)
Example: Mon/3pm	*Friend asked me to the movies*	*Depression, "I don't have the energy"; "I'll just bring everyone else down."*	*5 years*	*Stayed home and watched TV*	*0* *It felt worse*

D5: Control as the Problem

Instructions: Over the next week notice something you do each day to avoid or control difficult feelings/emotions, bodily sensations, thoughts, or memories. These can be subtle things like telling a joke or eating when you feel uncomfortable or less subtle things like "forgetting" to do something important or having a drink. Notice how well (or not well) the control strategy worked. Finally, write down the cost, if there was one, to engaging in the control strategy. Use the table below to help you track this over the next week. If you don't control on a particular day, leave the box blank.

Day	Control move	What was being avoided or controlled (thought, feeling, sensation, memory)	Did it work?	What was the cost?
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

D6: Willingness Worksheet #1

Instructions: Over the next week, start to notice the stories (reasons) that you have about your life – why it is the way it is. Notice when these stories come into your mind and what telling the story is in the service of. Write down each story you notice. Use the table below to help you keep track of these throughout the week.

Punch line of the "story"	When did you tell it?	Who did you tell it to?	What was the result?
EX: I am a failure, I can't do what is asked of me.	*Whenever I thought about doing something to lift my spirits.*	*To myself, my therapist and family.*	*I didn't do anything that I really wanted to do. I hung out around the house.*

Finally, look to see how the story(ies) are functioning. Are they keeping you from doing what you really want to do? Write about what you have discovered here (use the back side of the sheet if necessary):

D7: Willingness Worksheet #2

Instructions: Take two times this coming week to be willing, as an action. Choose something that you would typically avoid because you want to avoid feeling further pain or other difficult internal experiences. An example of this could be saying "yes" when you might typically say "no" (e.g., saying no to a friend who asks you to go to a movie because you will feel too anxious in a crowded place). Ask yourself, given this example: Will I choose to be willing, to have the discomfort that I feel AND go to the movie with my friend? In the first column include the action or event that you want to do and, in the second column write about the internal experience (thoughts, emotions, sensations) you would have to feel in order complete the activity. Challenge yourself to complete the activity. In the final column, describe your experience of willingness, e.g., do the action and report on it.

Action/ Event	What would you have to be willing to have (e.g., feel or think) in order to do this activity?	Describe what it was like to be willing and take action:
1.		
2.		

D8: Self-as-Context Worksheet #1

Instructions: Take one time each day to notice your thoughts, emotions and, bodily sensations and write them down in the table below. Try to choose different times each day and times when you are engaged in different activities. Notice these internal experiences (thoughts, emotions, sensations) as an on-going process that is continually shifting throughout the day and from day to day. Write them here without judging them or trying to change them. Share this sheet with your therapist.

Day	Time	What Activity?	What Thoughts?	What Emotions?	What Body Sensations?
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

D9: Self-as-Context Worksheet #2

Instructions: This is an exercise to help you contact your "observer self" – the part of you that is aware and conscious – the part of you that can observe your experiences. Choose 1 or 2 days this week and practice "contacting" or noticing this observer part of you and record the experiences. Use the table below to help you track your experience.

Each day take a short period of time to check in with yourself. Notice where you are, what you are doing, who you are with, what sounds or smells are around you and what thoughts, emotions, sensations you are experiencing. Stop and contact the present moment and yourself in it. Reflect on how there is a part of you that is the same across all of those different periods of time. Be aware of how you are there to experience all that is happening to you. Notice how experiences change and notice how you are able to observe those changes.

Time	Where are you?	What are you doing?	Who are you with?	What are your senses telling you? (sounds, smells)	What are your thoughts, emotions, sensations?

D10: Action Homework

If just for today you could do exactly what you wanted to do, according to what you value, what would that be? Choose something to work on between sessions that you would feel "bold" about doing. This Action should be something that would show you that your values are being lived. The Action should be very specific; for example, instead of "I will be nice to my wife," the Action would be "I will take my wife out to dinner to her favorite restaurant on Thursday night this week." The Action should not be too easy or something you would already do. It should not be so difficult as to set you up for not being able to complete the task. It should challenge you, but be thoughtful in choosing an achievable task. Make sure the Action is linked to a value.

Name: _____Date: _____

Action Homework for this next week		
I will do (action):	**Consistent with this value:**	**Potential barriers to completing the action:**

Answer the following questions:
Did you complete the action homework above? If you did, what was that experience like for you?

If you didn't, what was that experience like for you?

Reminders:
Your next session is scheduled for: _____ Date _____ Time

Where will you put this sheet to remember it? Wallet ____ Refrigerator door ____ Notebook ____

(tear here)

Therapist Reminder Copy
Patient Initials: Today's Date:

Action Homework for next session		
Patient will do (action):	**Consistent with this value:**	**Potential barriers:**

D11: Committed Action Assignment

Committed actions are the things that we do that show us on a daily basis how we are living our values.

Below, identify at least three committed actions that you can complete in the next week and that are related to one of your chosen values. Also note whether or not you completed your action and what the experience of doing it or not doing it was like for you.

Value	Committed Action	Did you complete it?	What was your experience of this like?

Value	Committed Action	Did you complete it?	What was your experience of this like?

Value	Committed Action	Did you complete it?	What was your experience of this like?

D12: VALUES CARD SORT

Clarifying your values can be helpful in making choices about *how* you want to move forward in your work and personal life. Sometimes when we are stressed we lose sight of what is important to us. Reconnecting to what brings meaning and purpose to your life can help you to get re-oriented and provide a "compass direction" for how you want to engage and behave toward yourself and others. Take the values card sort below to help clarify your values.

Instructions for Values Card Sort:

Cut out the "cards" below.

Step 1: Sort through the full set of cards, separating them into two piles: **"Important to me"** and **"Not important to me."** Try to select rapidly at first – going with your "first instinct." When you are done, set aside the *not important to me* pile.

Step 2: Take the "Important to me" group and sort the cards again cards into three categories: **"Very important to me", "Important to me,"** and **"Of little importance to me."** Set those cards in the *of little importance to me* aside.

Steps 3 and beyond: Repeat this process until you have identified your top five values.

Look closely at the top five cards – these are your top values. If these are out of balance in terms of priorities, then you will be out of balance as well. Notice if you've left them behind, or if you've set them aside in the service of something else; notice if you've been neglecting some of your values.
Ask: What can I do today to bring these values to life?
Do: What is possible as you engage in the process of ongoing values-based living?

Kindness	**Justice**
Loyalty	**Honor**
Empathy	**Independence**
Courage	**Growth**
Safety	**Openness**
Respect	**Faithfulness**
Humor	**Intellect**
Vitality	**Service**
Freedom	**Trust**
Honesty	**Learning**
Integrity	**Gratitude**
Truth	**Reliability**
Creativity	**Patience**
Compassion	**Pleasure**
Success	**Love**

Appendix E

E-1: Acceptance and Action Questionnaire (AAQ-II)

E-2: Recommended Assessment Schedule

E1: Acceptance and Action Questionnaire (AAQ–II)

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	**very seldom true**	**seldom true**	**sometimes true**	**frequently true**	**almost always true**	**always true**

1. It's OK if I remember something unpleasant.	1 2 3 4 5 6 7
2. My painful experiences and memories make it difficult for me to live a life that I would value.	1 2 3 4 5 6 7
3. I'm afraid of my feelings.	1 2 3 4 5 6 7
4. I worry about not being able to control my worries and feelings.	1 2 3 4 5 6 7
5. My painful memories prevent me from having a fulfilling life.	1 2 3 4 5 6 7
6. I am in control of my life.	1 2 3 4 5 6 7
7. Emotions cause problems in my life.	1 2 3 4 5 6 7
8. It seems like most people are handling their lives better than I am.	1 2 3 4 5 6 7
9. Worries get in the way of my success.	1 2 3 4 5 6 7
10. My thoughts and feelings do not get in the way of how I want to live my life.	1 2 3 4 5 6 7

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Bond, F. W., Hayes, S. C., Baer, R., Carpenter, K. M., Guenole, N., Orcutt, H. K.,…Zettle, R. D. (2011). Preliminary Psychometric Properties of the Acceptance and Action Questionnaire-II: A Revised Measure of Psychological Inflexibility and Experiential Avoidance. Behavior Therapy, 42, 676-688. doi:10.1016/j.beth.2011.03.007

Scoring

Before summing all items, 2, 3, 4, 5, 7, 8, & 9 are reversed scored. Higher scores indicate higher levels of psychological flexibility.

E2: Recommended Assessment Schedule

1. PHQ-9 – Patient Health Questionnaire
2. AAQ-II – Acceptance and Action Questionnaire-II
3. WHOQOL-BREF – Quality of Life Questionnaire (optional)
4. WAI-SR (Working Alliance Inventory-Short Revised) (optional)
5. 5-Facet Mindfulness Scale

PHQ-9 Weekly	AAQ-II	PHQ-9 (3x)	WHOQOL (3x)	5FMS (3x)	Demographics	WAI-SR (4x)
____ week 1	____ week 1	____ week 1	____ week 1	____ week 1	____ week 1	_____ week 1
____ week 2						
____ week 3	____ week 3					
____ week 4						
____ week 5	____ week 5					
____ week 6						
____ week 7	____ week 7	____ week 7	____ week 7	_____week 7	_____week7	
____ week 8						
____ week 9	____ week 9					
____ week 10						
____ week 11	____ week 11					
____ week 12						
____ week 13	____ week 13					
____ week 14						
____ week 15	____ week 15	___ final sess	___ final sess	___ final sess		
____ week extra						

Appendix F

VA SAFETY PLAN QUICK GUIDE FOR CLINICIANS

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support Veterans can use who have been deemed to be at high risk for suicide. Veterans can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **Veteran's own words,** and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any Veteran who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the Veteran on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the Veteran in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are **Six Steps** involved in the development of a Safety Plan. See the attached brief instructions on the next page.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

- **Assess** the likelihood that the **overall safety plan** will be used and problem solve with the Veteran to identify any barriers or obstacles to using the plan.
- **Discuss** where the Veteran will keep the safety plan and how it will be located during a crisis
- **Evaluate** if the format is appropriate for the Veterans' capacity and circumstances
- **Review** the plan periodically when Veteran's circumstances or needs change

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE VETERAN AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN.

Clinicians are strongly advised to read the manual, *VA Safety Plan Treatment Manual to Reduce Suicide Risk* (Stanley & Brown, 2008), and review associated video training materials at the following link: http://vaww.mentalhealth.va.gov/files/suicideprevention/VA_Safety_planning_manual_8-19-08revisions.doc

VA Safety Plan: Brief Instructions

Step 1: Warning Signs

- Ask ***"How will you know when the safety plan should be used?"***
- Ask ***"What do you experience when you start to think about suicide or feel extremely distressed?"***
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the Veteran's own words.

Step 2: Internal Coping Strategies

- Ask ***"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"***
- Assess likelihood of use: Ask ***"How likely do you think you would be able to do this step during a time of crisis?"***
- If doubt about use is expressed, ask ***"What might stand in the way of you thinking of these activities or doing them if you think of them?"***
- Use a collaborative, problem solving approach to address potential roadblocks and identify alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- Instruct Veterans to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask ***"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"***
- Ask for safe places they can go to do be around people (e.g., coffee shop).
- Ask Veteran to list several people and social settings, in case the first option is unavailable.
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that Veteran will engage in this step; identify potential obstacles, and problem solve.

Step 4: Family Members or Friends Who May Offer Help

- Instruct Veterans to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- Ask ***"Among your family or friends, who do you think you could contact for help during a crisis?"*** or ***"Who is supportive of you and who do you feel that you can talk with when you're under stress?"***
- Ask Veterans to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- Assess likelihood Veteran will engage in this step; identify potential obstacles, and problem solve.
- Role-play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- Instruct Veterans to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask ***"Who are the mental health professionals that we should identify to be on your safety plan?"*** and ***"Are there other health care providers?"***
- List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255)).
- Assess likelihood Veteran will engage in this step; identify potential obstacles, and problem solve.

Step 6: Making the Environment Safe

- Ask Veterans which means they would consider using during a suicidal crisis.
- Ask ***"Do you own a firearm, such as a gun or rifle?"*** and ***"What other means do you have access to and may use to attempt to kill yourself?"***
- Collaboratively identify ways to secure or limit access to lethal means: Ask ***"How can we go about developing a plan to limit your access to these means?"***
- For methods with low lethality, clinicians may ask Veterans to remove or restrict their access to these methods themselves.
- Restricting a Veterans' access to a highly lethal method, such as a firearm, should be done by a designated responsible person – usually a family member or close friend, or the police.

SAFETY PLAN example

Step 1: Warning signs:

1. *Needing to be alone.*
2. *Having a few too many drinks.*
3. *Feeling kinda numb.*

Step 2: Internal coping strategies – Things I can do to take my mind off my problems:

1. *Go lift at the gym.*
2. *Watch sports ("Cubbies").*
3. *Play drums.*
4. *Go for a walk.*

Step 3: People and social settings that provide distraction:

1. *Go to the coffee shop.*
2. *Call my uncle 714-555-3868.*
3. *Go to the grocery store.*

Step 4: People whom I can ask for help:

1. *Call my mom 555-4321.*
2. *Call my uncle 714-555-3868.*

Step 5: Professionals or agencies I can contact during a crisis:

1. *Call Dr. Bills 555-3434.*
2. *Go to Local VA Urgent Care.*
3. *Call Suicide Prevention Hotline: 1-800-273-TALK (8255), push 1.*

Step 6: Making the environment safe:

1. *Ask wife to give the gun to her brother until her father can get it.*

Glossary

Acceptance: defined in ACT as "actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively." (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 163)

Acceptance and Action Questionnaire (AAQ-2): A 10-item self-report instrument developed to measure psychological flexibility and to establish an internally consistent measure of ACT's model of mental health and behavioral effectiveness.

The Beck Depression Inventory-II (BDI-II): A 21-item self-report instrument developed to measure severity of depression in adults in the previous one or two weeks. Each item consists of four statements reflecting increasing levels of severity of a particular symptom of depression. The score for each individual item ranges from 0 to 3. The total score ranges from 0 to 63 and is achieved by adding the 21 ratings. Interpretation guidelines (Beck et al., 1996) on the severity of depression based on the BDI-II total score are: 0–13 (minimal depression), 14–19 (mild depression), 20–28 (moderate depression), and 29–63 (severe depression).

Behavioral activation: An approach to treating depression based on Lewinsohn's behavioral model of depression, whereby the therapist encourages patients to identify and implement one or two actions that can make a difference in quality of life.

Behavior Therapy: behavior modification; an approach to psychotherapy based on learning theory which aims to treat psychopathology through techniques designed to reinforce desired and eliminate undesired behaviors.

Case conceptualization: Individualized formulation of the patient's presenting problems in order to guide treatment planning and intervention.

Cognitive fusion: the human tendency to get caught up in thought content so that it dominates over other, potentially more useful, sources of behavioral regulation. We tend to merge thought content with an automatic attribution of meaning, thus losing awareness of the ongoing (and imperfect) process of thinking itself.

Committed Action: A series of actions that move an individual in the direction of chosen values, regardless of internal barriers such as negatively evaluated thoughts and emotions.

Conceptualized Self: The descriptive and evaluative thoughts and stories we tell about ourselves.

Core Processes: The six processes used in acceptance and commitment therapy that are considered the key interventions to creating change (i.e., mechanisms of change).

Defusion: The process of creating non-literal contexts in which language can be seen as an active, ongoing, relational process that is historical in nature and present in the current moment.

Deliteralization: The original ACT terms for cognitive defusion, which was replaced because it is so difficult to pronounce.

Experiential Avoidance/control: The attempt to control or alter the form, frequency, or situational sensitivity to internal experiences, even when doing so could cause harm.

Experiential Knowledge: Ways of knowing that are based on direct experience or practice and distinct from knowledge gained through verbal processes.

Five-Facet Mindfulness Questionnaire (FFMQ): A 39-item measure consisting of five subscales (observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience) that speaks to an individual's level of mindfulness.

Function of Behavior: The purpose of behavior analyzed in the context of its history and current setting, as understood through principles of behaviorism.

Functional Analysis: The process of developing an understanding of the patient's difficulties in terms of behavioral principles in order to identify important relationships between variables that are targets of intervention and that could be changed or influenced.

Fusion: The tendency of human beings to get caught up in the content of what they are thinking so that it dominates over other useful sources of behavioral regulation.

Hexaflex: The six (i.e. hex) cornered image representing the inter-relationship between the core processes. These core processes are designed to be used flexibly (i.e., flex) to create psychological and behavioral flexibility – at the core of the hexaflex.

Literality: Contexts in which symbols (thoughts) and their referents (what the thoughts seem to refer to) are fused together, thus lessening the distinction between thinking and the world as it is directly experienced.

Mind: In ACT, the mind is not considered to literally exist as an entity, rather it is seen as a collection of verbal abilities we call thinking.

Mindfulness: Turning attention to make direct contact with the present moment, and without judgment, while maintaining a sense of being a conscious observer of the experience.

Patient Health Questionnaire (PHQ-9): A 21-item self-report instrument developed to measure severity of depression in adults and older adults in the preceding two weeks and is used to gauge progress and assist in treatment planning.

Private Events: Thoughts, feelings, emotions, memories, sensations, and images are all forms of private behavior. In ACT, public and private events are all considered to be behavior.

Psychological Flexibility: The process of contacting the moment fully as a conscious human being, and persisting or changing behavior in the service of chosen values.

Psychological Inflexibility: The inability to persist or change behavior in the service of chosen values, usually due to the domination of verbal processes.

Reason-giving: Verbal explanations for behavior.

Safety plan: A prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises.

Self-as-Content: The literal view of oneself that takes thoughts, emotions, memories, and sensations – the conceptualized self – to be the self.

Self-as-Context: Experiencing events from I/here/now, the view of oneself in the now, from which thoughts, emotions, memories and sensations are observed; the observer self.

Suicide risk assessment: An evaluation of the risk and protective factors for suicide that involves the determination of whether or not a patient is imminently or likely to be dangerous to himself.

Values: Chosen qualities of actions that are personally important ways of living and that can never be obtained as an outcome or object. Additionally, values are not divorced from human action and are better stated as a verb in ACT: valuing.

Willingness: An active stance of acceptance (as opposed to passive) instantiated by action.

WHO Quality of Life-BREF (WHOQOL-BREF): A brief measure of international cross-culturally comparable quality of life. It has a focus on individual perceptions based on the context of their culture and values system focusing on personal goals, standards and concerns. The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment.

Working Alliance Inventory (WAI): A brief measure for inquiring about the therapeutic alliance derived from Bordin's (1979) theory of change-inducing relationships, which has as key components of the working alliance (a) agreement on the treatment goals, (b) agreement on how to achieve the goals (task agreement), and (c) development of a personal bond between patient and the therapist.

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