Embracing Your Demons: an Overview of Acceptance and Commitment Therapy

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Acceptance and Commitment Therapy is one of the recent mindfulness-based behaviour therapies shown to be effective with a diverse range of clinical conditions. In contrast to the assumption of 'healthy normality' of Western psychology, ACT assumes that the psychological processes of a normal human mind are often destructive and create psychological suffering. Symptom reduction is not a goal of ACT, based on the view that ongoing attempts to get rid of 'symptoms' can create clinical disorders in the first place. RUSSELL HARRIS provides an overview of ACT against a background of the suffering generated by experiential avoidance and emotional control. A case study illustrates the six core principles of developing psychological flexibility; defusion, acceptance, contact with the present moment, the observing self, values, and committed action.

Imagine a therapy that makes no attempt to reduce symptoms, but gets symptom reduction as a by-product. A therapy firmly based in the tradition of empirical science, yet has a major emphasis on values, forgiveness, acceptance, compassion, living in the present moment, and accessing a transcendent sense of self. A therapy so hard to classify that it has been described as an 'existential humanistic cognitive behavioural therapy'.

Acceptance and Commitment Therapy, known as 'ACT' (pronounced as the word 'act') is a mindfulness-based behavioural therapy that challenges the ground rules of most Western psychology. It utilizes an eclectic mix of metaphor, paradox, and mindfulness skills, along with a wide range of experiential exercises and values-guided behavioural interventions. ACT has proven effective with a diverse range of clinical conditions; depression, OCD, workplace stress, chronic pain, the stress of terminal cancer, anxiety, PTSD, anorexia, heroin abuse, marijuana abuse, and even schizophrenia. (Zettle & Raines, 1989; Twohig, Hayes & Masuda, 2006; Bond & Bunce, 2000; Dahl, Wilson & Nilsson, 2004; Branstetter, Wilson, Hildebrandt & Mutch, 2004). A study by Bach & Hayes (2002) showed that with only four hours of ACT, hospital re-admission rates for schizophrenic patients dropped by 50% over the next six months.

The goal of ACT

The goal of ACT is to create a rich and meaningful life, while accepting the pain that inevitably goes with it. 'ACT' is a good abbreviation, because this therapy is about taking effective action guided by our deepest values and in which we are fully present and engaged. It is only through mindful action that we can create a meaningful life. Of course, as we attempt to create such a life, we will encounter all sorts of barriers, in the form of unpleasant and unwanted 'private experiences' (thoughts, images, feelings, sensations, urges, and memories). ACT teaches mindfulness skills as an effective way to handle these private experiences.

What is mindfulness?

When I discuss mindfulness with clients, I define it as: *'Consciously bringing awareness to your here-and-now experience with openness, interest and receptiveness.'* There are many facets to mindfulness, including living in the present moment; engaging fully in what you are doing rather than 'getting lost' in your thoughts; and allowing your feelings to be as they are, letting them come and go rather than trying to control them. When we observe our private experiences with openness and receptiveness, even the most painful thoughts, feelings, sensations and memories can seem less threatening or unbearable. In this way mindfulness can help us to transform

our relationship with painful thoughts and feelings, in a way that reduces their impact and influence over our life.

How does ACT differ from other mindfulness-based approaches?

ACT is one of the so-called 'third wave' of behavioural therapies—along with Dialectical Behaviour Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT) and Mindfulness-Based Stress Reduction (MBSR)—all of which place a major emphasis on the development of mindfulness skills.

In stark contrast to most Western psychotherapy, ACT does not have symptom reduction as a goal. This is based on the view that the ongoing attempt to get rid of 'symptoms' actually creates a clinical disorder in the first place.

Created in 1986 by Steve Hayes, ACT was the first of these 'third wave' therapies, and currently has a large body of empirical data to support its effectiveness.

The 'first wave' of behavioural therapies, in the fifties and sixties, focused on overt behavioural change and utilized techniques linked to operant and classical conditioning principles. The 'second wave' in the seventies included cognitive interventions as a key strategy. Cognitive-behaviour therapy (CBT) eventually came to dominate this 'second wave'.

ACT differs from DBT, MBCT, and MBSR in many ways. For a start, MBSR and MBCT are essentially manualised treatment protocols, designed for use with groups for treatment of stress and depression. DBT is typically a combination of group skills training and individual therapy, designed primarily for group treatment of Borderline Personality Disorder. In contrast, ACT can be used with individuals, couples and groups, both as brief therapy or long term therapy, in a wide range of clinical populations. Furthermore, rather than following a manualised protocol, ACT allows the therapist to create and individualise their own mindfulness techniques, or even to co-create them with clients.

Another primary difference is that ACT sees formal mindfulness meditation as only one way of many to teach mindfulness skills. Mindfulness skills are 'divided' into four subsets:

- acceptance;
- cognitive defusion;
- contact with the present moment;
- the observing self.

The range of ACT interventions to develop these skills is vast and continues to grow ranging from traditional meditations on the breath through to cognitive defusion techniques.

What is unique to ACT?

ACT is the only Western psychotherapy developed in conjunction with its own basic research program into human language and cognition—Relational Frame Theory (RFT). It is beyond the scope of this article to go into RFT in detail, however, for more information see *www.contextualpsychology.org/rtf.*

In stark contrast to most Western psychotherapy, ACT does not have symptom reduction as a goal. This is based on the view that the ongoing attempt to get rid of 'symptoms' actually creates a clinical disorder in the first place. As soon as a private experience is labeled a 'symptom', it immediately sets up a struggle with it because a 'symptom' is by definition something 'pathological'; something we should try to get rid of. In ACT, the aim is to transform our relationship with our difficult thoughts and feelings, so that we no longer perceive them as 'symptoms'. Instead, we learn to perceive them as harmless, even if uncomfortable, transient psychological events. Ironically, it is through this process that ACT actually achieves symptom reduction—but as a by-product and not the goal.

Another way in which ACT is unique, is that it doesn't rest on the assumption of 'healthy normality'.

Healthy normality

Western psychology is founded on the assumption of healthy normality: that by their nature, humans are psychologically healthy, and given a healthy environment, lifestyle, and social context (with opportunities for 'self-actualisation'), humans will naturally be happy and content. From this perspective, psychological suffering is seen as abnormal; a disease or syndrome driven by unusual pathological processes.

Why does ACT suspect this assumption to be false? If we examine the statistics we find that in any year almost 30 percent of the adult population will suffer from a recognised psychiatric disorder (Kessler et al, 1994). The World Health Organization estimates that depression is currently the fourth biggest, most costly, and most debilitating disease in the world, and by the year 2020 it will

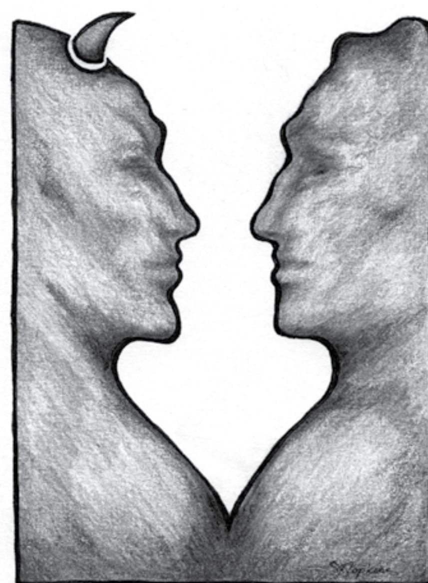


Illustration: Savina Hopkins

be the second biggest. In any week, one-tenth of the adult population is suffering from clinical depression, and one in five people will suffer from it at some point in their lifetime (Davies, 1997). Furthermore, one in four adults, at some stage in their lifetime, will suffer from drug or alcohol addiction. There are now over twenty million alcoholics in the United States alone (Kessler et al, 1994).

More startling and sobering is the finding that almost one in two people will go through a stage in life when they consider suicide seriously, and will struggle with it for a period of two weeks or more. Scarier still, one in ten people at some point attempt to kill themselves (Chiles and Strosahl, 1995).

In addition, consider the many forms of psychological suffering that do not constitute 'clinical disorders'—loneliness, boredom, alienation, meaninglessness, low self-esteem, existential angst, and pain associated with issues such as racism, bullying, sexism, domestic violence, and divorce.

Clearly, even though our standard of living is higher than ever before in recorded history, psychological suffering is all around us.

Destructive normality

ACT assumes that the psychological processes of a normal human mind are often destructive, and create psychological suffering for us all, sooner or later.

Furthermore, ACT postulates that the root of this suffering is human language itself. Human language is a highly complex system of symbols, which includes words, images, sounds, facial expressions and physical gestures. We use this language in two domains: public and private. The public use of language includes speaking, talking, miming, gesturing, writing, painting, singing, dancing and so on. The private use of language includes thinking, imagining, daydreaming, planning, visualising and so on. A more technical term for the private use of language is 'cognition'.

Now clearly the mind is not a 'thing' or an 'object'. Rather, it is a complex set of cognitive processes—such as analysing, comparing, evaluating, planning, remembering, visualising—and all of these processes rely on human language. Thus in ACT, the word 'mind' is used as a metaphor for human language itself.

Unfortunately, human language is a double-edged sword. On the positive it helps us make maps and models of the world; predict and plan for the future; share knowledge; learn from the past; imagine things that have never existed, and go on to create them; develop rules that guide our behaviour effectively, and help us to thrive as a community; communicate with people who are far away; and learn from people who are no longer alive.

The dark side of language is that we use it to lie, manipulate and deceive; to spread libel, slander and ignorance; to incite hatred, prejudice and violence; to make weapons of mass destruction, and industries of mass pollution; to dwell on and 'relive' painful events from the past; to scare ourselves by imagining unpleasant futures; to compare, judge, criticise and condemn both ourselves and others; and to create rules for ourselves that can often be life-constricting or destructive.

Experiential avoidance

ACT rests on the assumption that human language naturally creates psychological suffering for us all. One way it does this is through setting us up for a struggle with our own thoughts and feelings, through a process called *experiential avoidance*.

Probably the single biggest evolutionary advantage of human language was the ability to anticipate and solve problems. This has enabled us not only to change the face of the planet, but to travel outside it. The essence of problem-solving is this:

Problem = something we don't want.

Solution = figure out how to get rid of it, or avoid it.

This approach obviously works well in the material world. A wolf outside your door? Get rid of it. Throw rocks at it, or spears, or shoot it. Snow, rain, hail? Well, you can't get rid of those things, but you can avoid them, by hiding in a cave, or building a shelter. Dry, arid ground? You can get rid of it, by irrigation and fertilisation, or you can avoid it, by moving to a better location. Problem solving strategies are therefore highly adaptive for us as humans (and indeed, teaching such skills has proven to be effective in the treatment of depression). Given this problem solving approach works well in the outside world, it's only natural that we would tend to apply it to our interior world; the psychological world of thoughts, feelings, memories, sensations, and urges. Unfortunately, all too often when we try to avoid or get rid of unwanted private experiences, we simply create extra suffering for ourselves. For example, virtually every addiction known to mankind begins as an attempt to avoid or get rid of unwanted thoughts and feelings, such as boredom, loneliness, anxiety, depression and so on. The addictive behaviour then becomes self-sustaining, because it provides a quick and easy way to get rid of cravings or withdrawal symptoms.

The more time and energy we spend trying to avoid or get rid of unwanted private experiences the more we are likely to suffer psychologically in the long term. Anxiety disorders provide a good example. It is not the presence of anxiety that comprises the essence of an anxiety disorder. After all, anxiety is a normal human emotion that we all experience. At the core of any anxiety disorder lies a major preoccupation with trying to avoid or get rid of anxiety. OCD provides a florid example; I never cease to be amazed by the elaborate rituals that OCD sufferers devise, in vain attempts to get rid of anxiety-provoking thoughts and images. Sadly, the more importance we place on avoiding anxiety, the more we develop anxiety about our anxiety—thereby exacerbating it. It's a vicious cycle, found at the centre of any anxiety disorder. (What is a panic attack, if not anxiety about anxiety?)

A large body of research shows that higher experiential avoidance is associated with anxiety disorders, depression, poorer work performance, higher levels of substance abuse, lower quality of life, high risk sexual behaviour, borderline personality disorder, greater severity of PTSD, long term disability and alexithymia.

Of course, not all forms of experiential avoidance are unhealthy. For example, drinking a glass of wine

to unwind at night is experiential avoidance, but it's not likely to be harmful. However, drinking an entire bottle of wine a night is likely to be extremely harmful, in the long term. ACT targets experiential avoidance strategies only when clients use them to such a degree that they become costly, life-distorting, or harmful. ACT calls these 'emotional control strategies', because they are attempts to directly control how we feel. Many of the emotional control strategies that clients use to try to feel good (or to feel 'less bad') may work in the short term, but frequently they are costly and self-destructive in the long term. For example, depressed clients often withdraw from socialising in order to avoid uncomfortable thoughts—*'I'm a burden'*, *'I have nothing to say'*, *'I won't enjoy myself'*—and unpleasant feelings such as anxiety, fatigue, fear of rejection. In the short term, canceling a social engagement may give rise to a short-lived sense of relief, but in the long term, the increasing social isolation makes them more depressed.

ACT offers clients an alternative to experiential avoidance through a variety of therapeutic interventions.

ACT assumes that the psychological processes of a normal human mind are often destructive, and create psychological suffering for us all, sooner or later.

Therapeutic interventions

In general, clients come to therapy with an agenda of emotional control. They want to get rid of their depression, anxiety, urges to drink, traumatic memories, low self-esteem, fear of rejection, anger, grief and so on. In ACT, there is no attempt to try to reduce, change, avoid, suppress, or control these private experiences. Instead, clients learn to reduce the impact and influence of unwanted thoughts and feelings, through the effective use of mindfulness. Clients learn to stop fighting with their private experiences—to open up to them, make room for them, and allow them to come and go without a struggle. The time, energy, and money that they wasted previously on trying to control how they feel is then invested in taking effective action (guided by their values) to change their life for the better.

Thus ACT interventions focus around two main processes:

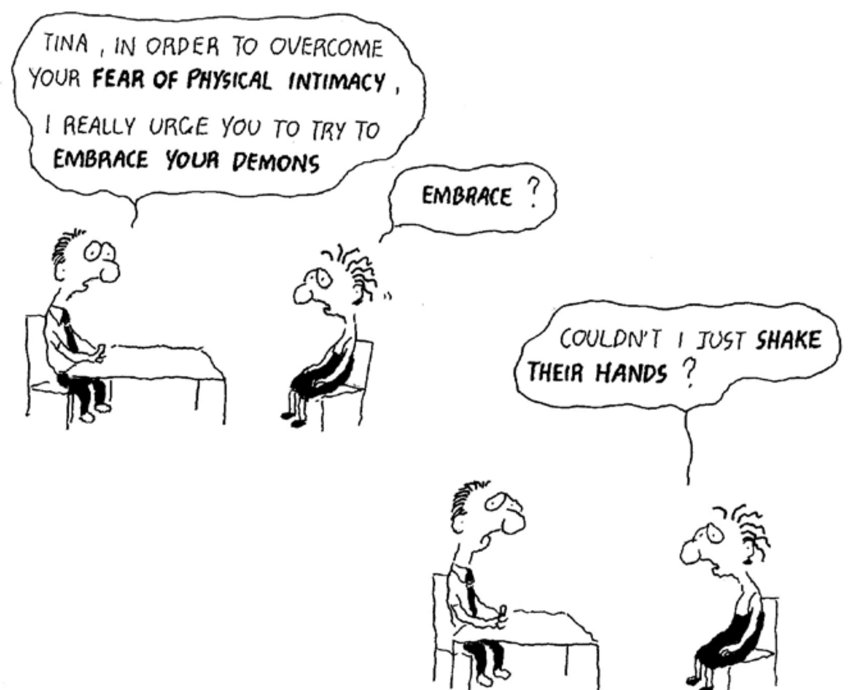
1) developing acceptance of unwanted private experiences which are out of personal control,
2) commitment and action towards living a valued life.

What follows is a brief summary of some core ACT interventions, illustrated with vignettes of clinical work with a client called 'Michael'.

Confronting the agenda

In this step, the client's agenda of emotional control is gently and respectfully undermined, through a process similar to motivational interviewing. Clients identify the ways they have tried to get rid of or avoid unwanted private experiences. They are then asked to assess for each method: *'Did this reduce your symptoms in the long term? What did this strategy cost you, in terms of time, energy, health, vitality, relationships? Did it bring you closer to the life you want?'*

'Michael' was a 35 year old accountant who suffered from significant social anxiety, and had seen a number of therapists to no avail. On the first session we ran through the many strategies he had used to avoid or get rid of his social anxiety. They included: drinking alcohol, taking Valium, being a 'good listener' (asking lots of questions, but sharing little of himself), arriving late, leaving early, avoiding social events altogether, deep breathing, relaxation techniques, using positive affirmations, disputing negative thoughts, analysing his childhood, blaming his parents (who were both socially avoidant), telling himself to 'get over it', self-hypnosis and so on. Michael realised that none of these strategies had reduced his anxiety in the long term. Although strategies such as taking Valium, drinking alcohol, and avoiding social events had reduced his anxiety in the short term, they had created significant costs to his



quality of life. His 'homework' was to notice and write down other emotional control strategies, and to assess their long-term effectiveness and costs to his quality of life.

Control is the problem, not the solution

In this phase, we increase clients' awareness that emotional control strategies are largely responsible for their problems; that as long as they're fixated on trying to control how they feel, they're trapped in a vicious cycle of increasing suffering. Useful metaphors here include *'quicksand'*, *'the struggle switch'*, and the concepts of *'clean discomfort'* and *'dirty discomfort'*. We might deliver these metaphors like this:

Remember those old movies where the bad guy falls into a pool of quicksand, and the more he struggles, the faster it sucks him under? In quicksand, struggling is the worst thing you can possibly do. The way to survive is to lie back, spread out your arms, and float on the surface. It's tricky, because every instinct tells you to struggle; but if you do so, you'll drown.

The same principle applies to difficult feelings: the more we try to fight them, the more they overwhelm us. Imagine that at the back of our mind is a 'struggle switch'. When it's switched on, it means we're going to struggle against any physical or emotional pain that comes our way; whatever discomfort experienced, we'll try our best to get rid of it or avoid it.

Suppose the emotion that shows up is anxiety. If our struggle switch is ON, then that feeling is completely unacceptable. This means we could end up with anger about our anxiety: *'How dare they make me feel like this?'* Or sadness about our anxiety: *'Not again. Why do I always feel like this?'* Or anxiety about our anxiety: *'What's wrong with me? What's this doing to my body?'* Or a mixture of all these feelings. These secondary emotions are useless, unpleasant, and unhelpful, and a drain upon our vitality. In response we get angry, anxious or guilty. Spot the vicious cycle?

But what if our struggle switch is OFF? Whatever emotion shows up, no matter how unpleasant, we don't struggle with it. So if anxiety shows up, it's not a problem. Sure, it's unpleasant. We don't like it, or want it, but at the same time, it's nothing terrible. With the struggle switch OFF, our anxiety levels are free to rise and fall as the situation dictates. Sometimes they'll be high, sometimes low and sometimes there will be no anxiety at all. Far more importantly, we're not wasting our time and energy struggling with it.

Without struggle, we get a natural level of physical and emotional discomfort, depending on who we are and the situation we're in. In ACT, we call this *'clean discomfort'*. There's no avoiding 'clean discomfort'. Life serves it up to all of us in one way or another. However, once we start struggling with it, our discomfort levels increase rapidly. This additional suffering, we call *'dirty discomfort'*. Our struggle switch is like an emotional amplifier—switch it on, and we can have anger about our anxiety, anxiety about our anger, depression about our depression, or guilt about our guilt.

Obviously, these metaphors are tailored to the particular feelings the client struggles with. With the struggle switch ON, not only do we get emotionally distressed by our own feelings, we also do whatever we can to avoid or get rid of them, regardless of the long term costs. We draw clients' attention to the many ways they've tried to do this—through more obvious strategies such as drugs, alcohol, food, TV, gambling, smoking, sex, surfing the net—to less obvious emotional control strategies, such as ruminating, chastising themselves, blaming others and so on. (As mentioned earlier, many control strategies are not an issue, as long as they are used in moderation.)

Michael was able to connect with these metaphors readily, especially the idea of the struggle switch. We were able to refer back to this in subsequent sessions whenever he experienced anxiety. *'Okay, right now, you're feeling anxious. Is the struggle switch on or off?'*

Once the emotional control agenda is undermined, we then introduce the six core principles of ACT.

Six core principles of ACT

ACT uses six core principles to help clients develop psychological flexibility:

- defusion;
- acceptance;
- contact with the present moment;
- the Observing Self;
- values, and;
- committed action.

Each principle has its own specific methodology, exercises, homework and metaphors. Take defusion, for example. In a state of *cognitive fusion* we are caught up in language. Our thoughts seem to be the literal truth, or rules that must be obeyed, or important events that require our full attention, or threatening events that we must get rid of. In other words, when we fuse with our thoughts, they have enormous influence over our behaviour.

Cognitive defusion means we are able to 'step back' and observe language, without being caught up in it. We can recognise that our thoughts are nothing more or less than transient private events—an ever-changing stream of words, sounds and pictures. As we defuse our thoughts, they have much less impact and influence.

If you look through the wide variety of writings on ACT, you will find over a hundred different cognitive defusion techniques. For example, to deal with an unpleasant thought, we might simply observe it with detachment; or repeat it over and over, out aloud, until it just becomes a meaningless sound; or imagine it in the voice of a cartoon character; or sing it to the tune of 'Happy Birthday'; or silently say *'Thanks, mind'* in gratitude for such an interesting thought. There is endless room for creativity. In contrast to CBT, not one of these cognitive defusion techniques involves evaluating or disputing unwanted thoughts.

Here's a simple exercise in cognitive defusion for yourself:

Step 1: Bring to mind an upsetting and recurring negative self-judgment that takes the form *'I am X'* such as *'I am incompetent'*, or *'I'm stupid.'* Hold that thought in your mind for several seconds and believe it as much as you can. Now notice how it affects you?

Step 2: Now take the thought *'I am X'* and insert this phrase in front of it: *'I'm having the thought that . . .'* Now run that thought again, this time with the new phrase. Notice what happens.

In Step 2, most people notice a 'distance' from the thought, such

that it has much less impact. Notice there has been no effort to get rid of the thought, nor to change it. Instead the relationship with the thought has changed—it can be seen as just words.

There now follows a brief description of the six core principles, with reference to the case of Michael.

1. *Cognitive Defusion*: learning to perceive thoughts, images, memories and other cognitions as what they are—nothing more than bits of language, words and pictures—as opposed to what they can appear to be—threatening events, rules that must be obeyed, objective truths and facts.

In session two, Michael, said he experienced frequent distress from thoughts such as *'I'm boring'*, *'I have nothing to say'*, *'No one likes me'*, and *'I'm a loser'*. As the session continued, I had Michael interact with these thoughts in a number of different ways, until they began to lose their impact. For example, I had him bring to mind the thought *'I'm a loser'*, then close his eyes and notice where it seemed to be located in space. He sensed it was in front of him. I asked him to observe the thought as if he was a curious scientist, and to notice the form of it: whether it was more like something he could see, or something he could hear. He said it was like words that he could see, and he noticed that as he 'looked' at it, it became less distressing. I asked him to imagine the thought as words on a Karaoke screen; then change the font; then change the colour; then imagine a bouncing ball jumping from word to word. By this stage, Michael was chuckling at the very same thought that only a few minutes earlier had brought him to tears. 'Homework' included practising several different defusion techniques with distressing thoughts—not to get rid of them, but simply to learn how to step back and see them for what they are—just 'bits of language' passing through.

2. *Acceptance*: making room for unpleasant feelings, sensations, urges, and other private experiences; allowing them to come and go without struggling with them, running from them, or giving them undue attention.

In session three, I asked Michael to make himself anxious by imagining himself at a forthcoming office party. When I asked him to scan his body and notice where he felt the anxiety most intensely he reported a 'huge knot' in his stomach. I asked him to observe this sensation as if he was a curious scientist who had never seen anything like it before; to notice the edges of it, the shape of it, the vibration, weight, temperature, pulsation, and the myriad of other sensations within the sensation. I had him breathe into the sensation, and 'make room for it'; to allow it to be there, even though he did not like it or want it. Michael soon reported a sense of calmness; a sense of being at ease with his anxiety, even though he didn't like it. 'Homework' included practising this technique with his recurrent feelings of anxiety—not to get rid of them, but simply to learn how to let them come and go without a struggle.

3. *Contact with the present moment*: bringing full awareness to your here-and-now experience, with openness, interest, and receptiveness; focusing on, and engaging fully in whatever you are doing.

In session four, I took Michael through a simple mindfulness exercise, focused on the experience of eating. I gave him a sultana, and asked him to eat it 'in slow motion', with a total focus on the taste and texture of the fruit, and the sounds, sensations and movements inside his mouth. I told him, *'While you're doing this, all sorts of distracting thoughts and feelings may arise. The aim is simply to let your thoughts come and go, and allow your feelings to be there, and keep your attention focused on eating the sultana.'* Afterwards, Michael said he was amazed that there was so much flavour in one single sultana. I was then able to use this experience to draw an analogy with social situations, where Michael would be so caught up in his thoughts and feelings that he wasn't able to engage fully in conversation, and missed out on the 'richness'. 'Homework' included practising full engagement with all the five senses in a number of daily routines (having a shower, brushing his teeth, and washing the dishes) as well as continuing to practise his defusion and acceptance techniques. He agreed also to practice mindful engagement in conversations; i.e. keeping his attention on the other person, rather than on his own thoughts and feelings.

4. *The Observing Self*: accessing a transcendent sense of self; a continuity of consciousness that is unchanging, ever-present, and impervious to harm. From this perspective, it is possible to experience directly that you are not your thoughts, feelings, memories, urges, sensations, images, roles, or physical body. These phenomena change constantly and are peripheral aspects of you, but they are not the essence of who you are.

In session five, I took Michael through a mindfulness exercise designed to have him access this transcendent self. First, I asked him to close his eyes and observe his thoughts: the form they took, their apparent location in space, the speed with which they were moving. Then I asked him: *'Be aware of what you are noticing. There are your thoughts, and there is you noticing them. So there are two processes going on—a process of thinking, and a process of observing that thinking.'* Again and again, I drew his attention to the distinction between the thoughts that arise, and the self who observes those thoughts. From the perspective of this *Observing Self,* no thought is dangerous, threatening, or controlling.

5. *Values*: clarifying what is most important, deep in your heart; what sort of person you want to be; what is significant and meaningful to you; and what you want to stand for in this life.

In session six, Michael identified important values around connecting with others, building meaningful friendships, developing intimacy, and being authentic and genuine. We discussed the concept of *willingness*. The willingness to feel anxiety doesn't mean you like or want it. Instead it means you allow it to be there in order to do something you value. I asked Michael, *'If taking your life in the direction of these values means you need to make room for feelings of anxiety, are you willing to do that?'* His reply was *'Yes.'*

6. *Committed Action*: setting goals, guided by your values, and taking effective action to achieve them.

Continuing session six, we moved to setting goals in line with Michael's values. Initially, he set the goal of

going for lunch with a work colleague every day, and sharing some personal information on each occasion. In subsequent sessions, he set increasingly challenging social goals, and continued to practice mindfulness skills to handle the anxious thoughts and feelings that inevitably arose. At the end of ten sessions, Michael reported that he was socialising a lot more, and more importantly, he was enjoying it. Thoughts of being 'a loser' or 'boring' or 'unlikeable' still occurred, but usually he did not take them seriously or pay them any attention. Likewise, feelings of anxiety still occurred in many social situations, but no longer bothered him or distracted him. Overall, his anxiety levels had diminished considerably. This reduction in anxiety was not the goal of therapy, but was a pleasant by-product. This illustrates how ACT can result in good symptom reduction without ever aiming for it. First, a lot of exposure took place, as Michael engaged in increasingly challenging social situations. It is well known that exposure frequently can lead to reduced anxiety. Second, the more accepting Michael became of his unwanted thoughts and feelings, the less anxiety he had about those thoughts and feelings. Indeed, practising mindfulness of unwanted thoughts and feelings is a form of exposure in itself.

The ACT therapeutic relationship

ACT training helps therapists to develop the essential qualities of compassion, acceptance, empathy, respect, and the ability to stay psychologically present even in the midst of strong emotions. Furthermore, ACT teaches therapists that, thanks to human language, they are in the same boat as their clients—so they don't need to be enlightened beings or to 'have it all together'. In fact, they might say to their clients something like: *'I don't want you to think I've got my life completely in order. It's more as if you're climbing your mountain over there and I'm climbing my mountain over here. It's not as if I've reached the top and I'm having a rest. It's just that from where I am on my mountain, I can see obstacles on your mountain that you can't see. So I can point those out to you, and maybe show you some alternative routes around them.'*

Conclusion

The experience of doing therapy becomes vastly different with ACT. It is no longer about getting rid of bad feelings or getting over old trauma. Instead it is about creating a rich, full and meaningful life. This is confirmed by the findings of Strosahl, Hayes, Bergan and Romano (1998) who showed that ACT increases therapist effectiveness and Hayes et al (2004) who showed that it reduces burnout. If I had to summarise ACT on a t-shirt, it would read: *'Embrace your demons, and follow your heart.'*

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AUTHOR NOTES

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