Emotion Regulation in Acceptance and Commitment Therapy

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Acceptance and Commitment Therapy (ACT) offers an alternative to traditional psychotherapies designed to regulate affect. ACT is based on the premise that normal cognitive processes distort and enhance the experience of unpleasant emotion, leading clients to engage in problematic behaviors designed to avoid or attenuate those unpleasant emotions. Such avoidant behavior patterns can hinder and prevent client movement toward valued goals and place the client in harmful situations. Rather than working to change cognitions or decrease levels of emotion, the ACT approach involves the client directly experiencing problematic emotions in a context in which the literal functions of language enhancing the negative implications of those emotions are stripped away. The focus throughout the treatment is facilitating the client's movement toward a more valued and personally fulfilling life, in a context in which previously obstructive unpleasant emotions no longer serve as obstructions. A case study is provided to illustrate some of ACT's core techniques. © 2001 John Wiley & Sons, Inc. J Clin Psychol/In Session 57: 243–255, 2001.

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Within our current nosology, failures in emotional regulation are related to several significant forms of psychopathology, from panic to depression to borderline personality disorder. This apparent relationship is confirmed by the research literature as well (e.g., Saarni, 1999). Given this evidence, it may seem odd to write an article in which we maintain that attempts to regulate emotions actually can be a major cause of psychopathology. Yet, that is the view we take here and one we have taken in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). This article explains why and develops a therapeutic alternative based on this analysis.

Before we examine the evidence for this counterintuitive claim, a simple example of our general conceptual approach may be useful. We do not deny the validity of the exist-

ing evidence on emotional regulation, but what has to be remembered is that these findings were obtained in a social/verbal/cultural context that itself both encourages and prescribes emotional regulation—where the "appropriate" response to an unpleasant thought or emotion is to change it or get rid of it. It is that context, we believe, that gives rise to the empirical relations obtained.

As a trivial but fairly precise analogy, imagine a universe in which it is believed that people who are attempting to solve complicated problems also must simultaneously subtract serial sevens. Further, imagine that children are taught this complex dual-tracking skill, and it is a major theme in becoming a productive adult. In such a universe, it might be shown that those who cannot "regulate their sevens" are also poor problem solvers. Treatment programs designed to teach better "seven regulation skills" might be established. Such treatment programs may even be shown to be helpful. Knowledgeable professionals might chafe at the idea that seven regulation is relatively unimportant or even counterproductive, because the overall evidence is so strong.

In our imaginary example, however, all such empirical evidence is culturally bound. One might never know (nor even know to ask) how problem solving would go if no attempt was made to subtract serial sevens simultaneously at all. So it is with emotional regulation. Emotions and emotional language are made to carry a huge cultural weight, being looked to as evidence for maturity, successful living, instability, insanity, health, and so on. Unless this context is appreciated and studied, one might never know (nor even know to ask) how living would go if emotions were treated more as events to be experienced and learned from and less as events to be controlled.

A range of evidence is gathering on this point in studies on thought suppression, emotional suppression, acceptance, mindfulness, meditation, and the like (see Hayes et al., 1999, for a review). We believe that these studies have a consistent theme to their findings: "Negative" thoughts and affect do not produce behavioral harm in and of themselves. Emotions, and failures of emotional regulation, do not cause behavioral outcomes in a mechanical way, although our culture seems to make this assumption. Rather, much of their impact comes from the consequences of failed attempts to avoid them, which include increased frequency and intensity of the emotions, and often harmful attempts (e.g., substance abuse, physically avoiding people, places, or things that elicit the emotion) to avoid or attenuate them. ACT attempts to change the goal from getting rid of unpleasant emotions to fully experiencing these emotions in the service of achieving personally valued goals. Creating such a context requires teaching (generally through experiential exercises and metaphors) the client to experience both the emotions and the words they use to describe the nature and implications of the emotions in a strikingly different manner. Unpleasant emotions are no longer innately harmful and not necessarily the determinate of subsequent behavior.

Before the nature and intent of ACT's exposure and cognitive defusion strategies are discussed, the nature of experiential avoidance should be addressed first. The discussion of ACT is kept necessarily brief here. The reader is referred elsewhere (Hayes et al., 1999) for a full treatment of its theoretical and experimental foundations, and a full description of its nature and techniques.

Experiential Avoidance

Experiential avoidance occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them, even though doing so incurs a behavioral cost. Experi-

ential avoidance is often harmful. Classic examples of harmful avoidance strategies include excessive drinking, drug use, or high-risk sexual behavior. Other forms of avoidance could include staying away from or sabotaging one's involvement in intimate relationships (due to the anxiety or fear such relationships might engender) or otherwise avoiding risks that would facilitate the achievement of valued goals due to the aversive thoughts and/or feelings that might arise in the process of risk taking.

Experiential avoidance has been recognized, implicitly or explicitly, among most systems of therapy. Behavior therapists recognize that "the general phenomenon of emotional avoidance is a common occurrence; unpleasant events are ignored, distorted, or forgotten" (Foa, Steketee, & Young, 1984, p. 34). Client-Centered Therapy worked with a client to become "more openly aware of his own feelings and attitudes as they exist" (Rogers, 1961, p. 115). Current experiential therapists suggest that "for healthy functioning, [emotional] avoidances need to be overcome and new ways of coping implemented" (Greenberg & Paivio, 1997, p. 56). Existential psychologists focus on avoidance of a fear of death: "To cope with these fears, we erect defenses . . . that, if maladaptive, result in clinical syndromes" (Yalom, 1980, p. 47). Recognizing and dealing with experiential avoidance has been a central theme of modern therapies such as Dialectical Behavior Therapy (Linehan, 1993).

Ironically, attempts at experiential avoidance often serve to actually increase the frequency or intensity of the avoided thoughts and feelings. When subjects are asked to suppress a thought, they later show an increase in this suppressed thought when compared to those not given suppression instructions (e.g., Clark, Ball, & Pape, 1991). Wegner and his colleagues (e.g., see Wegner & Zanakos, 1994) empirically demonstrated some other effects of suppression. First, the rebound is greatest specifically in contexts in which the suppression took place or when the person is in the same mood he/she was in when suppressing the thought. Indeed, the suppression strategy maintains and even intensifies that thought. As might be expected from this point of view, those who show thought suppression as a general trait have higher levels of depressive and obsessive symptoms. The paradoxical effects of suppression also occur for somatic sensations. Additionally, subjects instructed to suppress painful stimuli later rated the pain as more unpleasant than those who were asked to focus on the pain. Furthermore, disappearance of pain following withdrawal of the painful stimulus was slower (Cioffi & Holloway, 1993).

We are not arguing that avoidance strategies are always harmful. Simple distraction and other forms of avoidance can be helpful at times. In general, however, experiential avoidance is counterproductive.

Language and Experiential Avoidance

If experiential avoidance can create negative effects, why does it persist? We argued elsewhere that the basic problem is built into human language. Loosely, we react to the words we use to describe and interpret experiences as if those words were those experiences. There is a growing body of evidence that even human infants learn that symbols and the events they "refer to" are equivalent in many ways (Hayes & Gifford, 1997). This means that there is a degree of mutual transfer of functions between words and their referents. One consequence of this is that unpleasant events will transfer some of their negativity to the words used to describe these events, and vice versa. For example, someone listening to a man describe a frightening fight he saw at the supermarket might react negatively to the description even though she had not witnessed the fight. Negative verbal descriptions will make even largely neutral events somewhat aversive.

These processes alone can lead to experiential avoidance. Private experiences can be described and evaluated, and those that are negatively evaluated can be avoided. We are taught the nature and meaning of specific "emotions," for example. A loose collection of bodily states, thoughts, behavioral predispositions, and contextual factors are gathered together under a verbal label, and we learn to call them "depression" or "anxiety." Our emotions become distinct and verbally accessible. These then are evaluated, making them positive or negative and desirable or undesirable largely according to cultural convention. This process can lead to finer and finer discriminations about the content of private experiences. Without language, it would be impossible to construct an experience called "existential angst," and there would be no way to recognize such an event should it occur. This ability to notice and label our emotions and thoughts is important in the present context because it allows humans to evaluate and then struggle with the internal events that are constructed as a result. Now that we know what existential angst is, we can run from it.

These verbal abilities can allow the avoidance of negative emotion to spread to circumstances associated with them. For example, if a panic-disordered client imagines a terrible end produced by anxiety in a novel, high-visibility situation (e.g., losing control while on stage giving a talk to hundreds of people), the imagined bad end will seem immediately present. Unfortunately, anxiety is a natural response to immediately present and highly likely aversive events. As a result of the loose equivalence between words and experiences, imagining such an end may itself give rise to panic symptoms, which unfortunately will make the imagined bad end seem all the more imminent.

Another reason that normal language processes lead to internal struggles is that we learn to explain and justify our own behavior in emotional and cognitive terms. A person saying "I was too depressed to leave the house" certainly will be thought to have said something reasonable and understandable. He or she may even garner sympathy or reassurance for this formulation. "I have no idea why I didn't go" probably will receive a much less positive response.

Unfortunately, as people learn to tell stories based on emotional "causes" they also begin to believe their own stories, and they thus begin to respond as if those stories were true. This means that if, for example, depression "explains" social withdrawal within a social community, then ironically this loose set of experiences called "depression" will indeed begin to produce social withdrawal. This is because the individual views the detection of depression as a cue to withdraw, firm in the knowledge that the community will understand. This contextual view of emotion and emotional regulation holds that such cultural beliefs and practices become self-confirming because they discourage actions that are discordant with these beliefs and practices, and encourage concordant action. The disadvantages of failures to emotionally regulate thus become a self-fulfilling prophecy. Eventually, it is actually "true" that "not doing your sevens" can make it hard to solve problems, and not "regulating your emotions" can make it hard to behave in a way that works.

Emotional Acceptance and Cognitive Defusion as an Alternative to Experiential Avoidance

Stated simply, the ACT model of psychopathology holds that a great deal of our difficulties comes from fusion with cognitions (i.e., believing that a thought that interprets experience is actually true) and resultant experiential avoidance that disrupts or impedes movement toward valued goals. The form of the particular pathology is determined in part by the particular cognitive fusion and experiential avoidance patterns. For example, some forms of substance abuse and, say, panic disorder, may work very differently and yet serve a common function: They may be two manifestations of anxiety avoidance.

The alternative to avoidance is acceptance. Etymologically, acceptance comes from the word "to take," meaning to receive or take what is offered. Psychologically, it connotes an active taking in of an event or situation. Psychological acceptance at its simplest level is implicit in any psychotherapy because at the minimum, the client and therapist must "take in" the fact that there is a problem to be worked on. At a higher level, acceptance involves an abandonment of dysfunctional change agendas and an active process of feeling feelings as feelings (e.g., experiencing emotions simply as constellations of physiological sensations, urges, and so on that have no intrinsic power to harm us or hold us back), thinking thoughts as thoughts (and not as prescriptive realities), remembering memories as memories (and not as descriptions of the present), and so on, and still behaving effectively.

In the ACT approach, a goal of healthy living is not so much to feel *good*, but rather to *feel* good and to *live* good. In general, it is psychological healthy to feel "bad" feelings as well as "good" feelings when the situation results in bad feelings. When our interpretations about the nature and consequences of our feelings dominate, we seemingly cannot afford to stop defending ourselves against feelings. Conversely, when feelings are just feelings, they can mean what they do mean: Namely, that a bit of our history is being brought into the present by the current context. That is always interesting and often important whether the feeling is "good" or "bad." It does not dictate what happens next— what we actually do depends on the context and the goals in the moment.

The alternative to cognitive fusion is to appreciate in the moment that a thought is a thought, a process that then immediately opens up a wide variety of response options. We begin to notice the process of thinking, not just the literal content of that activity. We begin to notice the act of structuring the world, and not just the apparently "real" world that is silently structured by language. Stated in terms of a metaphor often used in ACT, we begin to notice that we are wearing colored glasses rather that simply looking at the environment as colored by the glasses we wear. Paradox, confusion, and meditative exercises are examples of defusion techniques, and are used because they point out how words cannot accurately describe experience.

The Goals of Acceptance and Defusion

Acceptance and cognitive defusion is not an end in itself. It is not an outcome goal, it is a process goal. Asking a client to regularly accept and fully experience aversive thoughts and emotions simply for the sake of accepting and experiencing them might be a rather sadistic endeavor. Instead, ACT clients are taught to accept aversive emotions and cognitions that necessarily arise while they are pursuing valued outcomes.

Thus, a significant component of ACT is the clarification of values, and commitment to behaviors that are in accord with these values. If, in the process of pursuing valued outcomes thoughts and feelings emerge that would normally serve as a barrier to behavioral movement, then new, nonavoidance coping strategies are needed.

Initially, valued behaviors themselves may be presented in emotional terms, and in this case the false need for emotional regulation should be distinguished from the real need for behavioral regulation. For example, a loving husband who is nevertheless abusing a spouse may say he needs to "control his anger." The behavioral problem is real, but not the emotional formulation. He needs to build a rich, intimate, and nonviolent relationship, not "control his anger." Paradoxically, learning to *feel* anger (and the hurt, anxiety, or vulnerability that usually preceded it) and to share these feelings appropriately with his spouse will make it more possible to build such a relationship.

Case Illustration

The following case consisted of a 1-hour intake and five 50-minute sessions, conducted with a client displaying a relatively circumscribed problem. It was chosen because it illustrates the cornerstone strategies of ACT, and ACT's ability to be used as a brief treatment approach when warranted. Clients with much more extensive or complicated psychological concerns require more extensive exposure to the exercises and metaphors used here as well as to a number of other strategically similar exercises and metaphors. For such clients, the experiential exposure, cognitive defusion, and values clarification components of ACT generally require much more protracted use, and the course of treatment would be correspondingly longer.

Presenting Problem/Client Description

The client, whom we shall call "Mark," was a single, White male in his early twenties. Mark was a college student who recently had moved to the area. He came to therapy primarily because of his consistent lack of involvement in intimate relationships. In addition, the client expressed a lack of satisfaction with his life for reasons that were unknown to him.

Mark had a history that (as would be discovered in therapy) led him to be distrustful of and anxious about close relationships. His mother divorced his father due to the years of physical abuse he inflicted upon her when Mark was a young child. Mark also suspected that he may have been physically abused during this time as well.

Mark described how he had deeply trusted his stepfather, whom his mother married several years later. He greatly admired him, as well as his mother, and believed that their relationship was secure. It came as an extreme shock to him when they divorced after he left for college. His parents had concealed both their marital discord and the fact that his father had a severe drinking problem for the past several years. This was a primary cause of the divorce. Mark described feeling extremely displaced during this time. He had just left home for college (the first time he had been on his own), and his parents' separation and subsequent sale of their home left him feeling very alone. He described feeling very upset and betrayed by both his mother and stepfather.

Mark's experiences with the opposite sex, in both the distant and recent past, had not gone well either. One of his most distinct memories of interactions with females who interested him occurred in middle school. In this case, he was disciplined by the school principal for consistently expressing his interest to a girl who did not reciprocate his interest. He reported feeling very ashamed and humiliated about this instance for some time after.

Mark had not dated anyone for more than a few weeks. He said he felt "too anxious" to initiate a relationship with young women who interested him, explaining that he "feared rejection." Instead, he occasionally dated young women whom he found only mildly interesting because interactions with them elicited less anxiety. These relationships did not progress far, however, due to his disinterest, his guilt about "settling" for them, and to his still-present anxiety. Mark had not yet had a sexual relationship. This fact was the source of negative self-evaluations and convinced him that that there was something wrong with him.

Mark's family history had not provided good models about how or what to do with negative emotions. He described his father as "not knowing how to deal with emotions" and "not knowing how to be there." His mother's concealment of her feelings toward his stepfather also was indicative of a larger pattern of emotional privacy in his family. And

his lack of intimate relationships with friends and romantic interests meant there were few opportunities to practice disclosing personal thoughts and feelings.

Mark's anxiety about intimacy was painfully apparent in the first sessions of therapy. While often very composed and articulate during the intake and the first two sessions, he routinely became strikingly anxious when the therapist made comments about the relationship between them. His voice became shaky, his face turned red, a look of anxiety and embarrassment appeared in his eyes, and he had great difficulty expressing himself.

Case Formulation

For several reasons, Mark was avoiding the experiences involved in fostering an emotionally and physically intimate relationship. These included intense anxiety and persistent negative self-evaluations. Some of the anxiety likely was due directly to his punishing history with respect to close relationships, namely with his father, stepfather, mother, and grade-school crush. Another source of anxiety likely was his lack of experience with relationships and with expressing private feelings and thoughts. Whereas the historical source of Mark's anxiety seemed clear enough, his patterns of experiential avoidance and beliefs in his own inadequacy kept him from becoming close with others.

Mark particularly believed thoughts about the meaning and implications of consistent inability to become close to others. He perceived his lack of experience as extremely abnormal and unacceptable. To him, his lack of success with women was proof that there was something fundamentally wrong with him. The shame engendered by this perpetuated the avoidance of intimate experiences. In his eyes, if anyone were to know about his inexperience (particularly sexually), they would surely reject him. This made him more likely to conceal personal information about himself, making emotional intimacy less and less likely.

The establishment of intimate relationships was one of Mark's primary values. Yet, any step in this direction produced a storm of difficult emotions and thoughts. The goal of treatment from an ACT perspective seemed clear: Mark needed to learn to recognize his negative self-evaluations simply as words rather than truths, and to stop avoiding the anxiety and fear he experienced in response to intimacy. Because the intimacy of the client–therapist relationship elicited these reactions, it could be used to facilitate exposure to previously avoided private experiences.

Course of Treatment

One of the first steps taken with ACT clients involves assessing how they have tried to fix the problems that brought them into therapy, and how well or poorly these attempts have worked. This phase of treatment, called "creative hopelessness," is designed to help the client see whether their rational and logical attempts to fix the problem(s) have worked. Most of the time, the "solutions" the client has been pursuing actually consist of experiential avoidance strategies that have not been effective. If so, the "solutions" are actually part of the problem.

The creative hopelessness phase begins by recasting the problem not as the presence of aversive experiences, but as ineffective and harmful attempts to avoid the experiences. The aim of this phase of ACT is to create an openness to more radical or counterintuitive change strategies (e.g., acceptance and defusion) based on the experienced futility of more conventional change strategies that already have been attempted.

Given the relatively circumscribed nature of Mark's problem and his readiness to change, the creative hopelessness component conducted with Mark was very brief. The component covered the end of the intake session:

THERAPIST: What have you tried to get around this anxiety you feel when you start getting close to someone?

CLIENT: I've tried scripting out what I'm going to say in advance, in my head, so I won't get so nervous when I put myself on the line. Or sometimes I just try to tell myself that it's not really a big deal, that I'm just making too much of it.

THERAPIST: How have those things worked for you?

CLIENT: It doesn't. It never goes like I plan it, and I actually start getting more nervous when it starts to fall apart. It makes things worse! And I'm never really able to convince myself that it doesn't matter. It does.

THERAPIST: What else have you tried?

CLIENT: Well—I generally don't even put myself on the line anymore. I don't ask out any girls that I'm really interested in, and I don't talk about anything personal to anyone. I sometimes date girls I don't really like because it's easier, but I don't seem to get anything out of the relationship except guilt.

THERAPIST: How have those things worked for you?

CLIENT: I don't get anxious. But I stay very lonely.

THERAPIST: So, it sounds like you've tried several things—everything you could think of—to try to get over that anxiety, that fear, so you can be close to someone, less lonely. In fact, it sounds to me like you've done everything reasonable, everything rational, that I could think of. But nothing has worked.

CLIENT: Nothing.

THERAPIST: Can you think of anything else you could try to get over it?

CLIENT: (*pause*) No. I've done everything I could think of. That's why I came here.

THERAPIST: Believe it or not, this is a good place to start. Nothing you've tried has worked. That's why you're here—so you can learn some way to get rid of that anxiety that keeps you from getting close to people who you really want to get close to . . . (*compassionately*). But I can't teach you how to do that. I don't know how to get rid of that anxiety, that fear. If it's been there that consistently in the past, my guess is its going to continue to be there. But I want you to consider this before our next session. What if—and I'm definitely not minimizing the seriousness of what you feel when you try to get close . . . but, what if it isn't really a problem that you feel anxious when you start to 'put yourself on the line,' when you start to get close to someone?

At the beginning of the next session, Mark disclosed that he was baffled by the notion that feeling anxious wasn't a problem. The therapist responded by asking him what being anxious and afraid of being close to someone meant to him. After a while, he replied (*very anxiously*) that it meant there was something wrong with him because it was something that came easy to others and that he couldn't do it no matter how hard he tried.

To allow an exposure opportunity and set the stage for some strategies designed to illustrate how his interpretations of his experience differed from his actual experience, a rather standard experiential exercise was conducted. The client was asked to close his eyes and focus, one at a time, on specific somatic elements of the anxiety he felt while describing his problem to the therapist. In a meditation-like fashion, when other experiences emerged while he was focusing on a specific physical sensation (e.g., thoughts, urges, and so on), he was guided to simply notice the distraction, allow it to be there, and focus back on the sensation. Mark's anxiety, at that moment, included queasiness in his stomach, tension in his shoulders, tightness in his jaw, and the sensation of his heart falling down into his stomach. Each physical component was focused on for several minutes.

Mark did unusually well in experiencing the somatic components of his anxiety without significant avoidance. The meditationlike posture of "just noticing" distracting thoughts that intruded formed the beginning of recognizing his thoughts as words and not described realities. After the exercise, these thoughts were addressed more directly. The following dialogue captures the essence of the exchange that followed.

THERAPIST: I want you to think of those specific, physical feelings as the raw data in this experience called 'anxiety,' and your thoughts about what that anxiety means and says about you as a kind of amateur theory. People kind of run around all the time like amateur psychologists, amateur theorists, trying to make sense of the raw data of our experiences. Your mind takes the raw data in this experience we call 'anxiety' (*making quotation marks in the air with hands*)—your queasy stomach, tight shoulders, tight jaw, and heart falling into your stomach—and comes to some quick conclusions about what that data means. "I'm not good enough." "There's something wrong with me." These thoughts seem very real, like they're Truth with a capital 'T.' But there are so many variables here—so many things that have happened to you over your life that determine how you feel, how you think, what you do—and we are so bad at determining what leads to what, and even remembering anything more than a fraction of what's happened to us. And yet we delude ourselves into believing that our anxiety means this or that. Now I'm not trying to talk you out of these thoughts, because they will probably continue popping up along with your anxiety. I'm just asking you to consider—from the gut—that maybe that anxiety isn't whatever you think it is. When we did that experiential exercise, what were those physical feelings like—what was that anxiety like?

CLIENT: It was different than I thought it would be. The feelings weren't as bad as I thought they would be—I was actually really scared when you asked me to feel more of them, but I was able to do it. It really wasn't that bad.

THERAPIST: What if that's all there is? The queasiness in your stomach? The tight shoulders? What if what your mind gives you about what all that means is not Truth with a capital 'T,' but rather just more mind stuff?

CLIENT: (*long pause*) Wow. Maybe!

THERAPIST: Now remember—I don't want you to believe anything I'm saying here. I'm just asking you to check in with your experience during that exercise. Was that experience of anxiety something different than you thought it would be?

CLIENT: Yeah. Very different.

THERAPIST: So maybe your mind is just talking.

This is a relatively intellectual version of this phase of ACT, but it allows us to present the core issue succinctly. The focus of this component is cognitive, and it can look much like traditional cognitive therapy. The difference is that the goal is not to correct thoughts so much as it is simply to notice them in the service of recognizing that thinking need not influence action. The distancing component of cognitive therapy, which is normally used to set up cognitive disputation and correction, instead is amplified in ACT in the service of preventing thoughts from leading to automatic action. No attempt is made to get rid of "bad" thoughts—rather the goal is to see thoughts as thoughts, not as truths.

Given that goal, it is critical that the content of any defusion technique is itself not canonized as true. Defusion techniques are meant to question literal meaning, not enshrine it. Thus, for example, the therapist in the previously mentioned session says "I don't want you to believe anything I'm saying here." The process of questioning is logically coherent in a narrow view, but the larger point is that rational thinking process (even the

therapist's) cannot be entirely trusted when dealing with the meaning and implications of human experience. If the client is continually redirected to recognize thoughts as simply words, and contact the experience that thoughts elaborate and distort, literal belief may be suspended long enough for the client to learn some positive and lasting lessons.

Other defusion strategies rely more on experiential methods. In the second session, Mark reported feeling rejected by a young woman he had dated during the past week. In discussing the incident, he first admitted that he had not yet had a sexual relationship. The therapist focused on the anxiety, shame, and embarrassment he felt in response to the rejection and to his admission of a lack of sexual experience, using a format very similar to the experiential exercise described earlier. When negative self-evaluations emerged, the therapist was careful not to try to talk the client out of any of these thoughts. Rather, he would respond to Mark's self-evaluative statements with comments like, "Thank your mind for that thought," or "Those are interesting words." This immediately focused the client back on the specifics of the feelings. Some of this exposure work was done informally, for example, by asking Mark what it felt like to remember certain details, what it felt like to tell the therapist this, and so on. Some of the exposure was done using formally structured exercises. The client was asked during an eyes-closed exercise, for example, to picture and focus, one at a time, on imaginary objects (which he chose) that perfectly captured the essence of each individual feeling (shame, anxiety, and embarrassment), methodically noticing the specific character, color, shape, movement, and texture of each object before willingly "pulling" each object back into himself.

During the third session, exercises designed to highlight the distinction between the client and his thoughts were conducted. This was done because the client stated he was having difficulty recognizing his thoughts simply as thoughts. If thoughts are to be experienced in nonliteral fashion, they must be experienced as distinct from oneself.

The exercise began by asking the client to picture himself in front of a stream. As each new thought arose, he was asked to notice it, place it on a leaf, and watch it float past. Mark was directed to do this with each thought (even ones that occurred repeatedly), patiently noticing and accepting lapses in the process. Then, he was asked to focus on his breathing. When a thought occurred to him, he was to "place it on a leaf" and focus back on his breathing. Finally, he was asked to focus on the specifics of the anxiety he had encountered last week during his session, similarly placing his thoughts on leaves.

Another defusion exercise conducted during this session appeared to be very beneficial. The client was asked to repeat the word "milk" with the therapist over and over, out loud, for over a minute. Although one can almost taste, see, and feel actual milk during the first repetitions of the word, it loses nearly all of its functions after it is repeated many times. The only function remaining by the end of the exercise consists of a strange, unidentifiable audio stimulus. After the client's reaction to the exercise was briefly processed, the therapist described how this serves as a perfect example of the true nature of words. Although they seem perfectly descriptive and actually evoke the "realities" they describe, they consist simply of arbitrary sounds that hold no power in themselves.

After processing the client's experience from the last session, the client distilled his experience down to two potent words: "I'm worthless." The phrase was repeated by therapist and client over and over several dozen times, just as with the milk exercise. Mark stated that although the feelings that arose while initially saying the phrase were still there, they seemed much less concrete, and the phrase "I'm worthless" had temporarily lost its literal meaning.

By the fourth session, the client's demeanor and reports of behavior out of therapy had changed dramatically. He reported having approached a young woman he was moderately interested in (one who had previously embarrassed him by pointing out his shy-

ness and anxiety around her) with the intent of completely and willingly experiencing the anxiety he expected to occur. Mark maintained this attitude throughout the interaction and was successful in arranging a date with her. He stated that he felt more like himself on the date than ever. He explained that this meant he was willing to experience more of the emotions and cognitions that occurred during the date. He was able to focus more on the interchange between himself and the young woman (rather than being absorbed in his own discomfort and his effort to regulate it) than he had ever recalled doing before. Mark also appeared much more at ease when the relationship between he and the therapist was addressed. Another exposure exercise was conducted to help practice acceptance and defusion skills.

During the fifth and final session, the client reported successfully approaching and dating another woman that he had been very interested in for some time. Further, he stated that he disclosed details about his past that he had never discussed with anyone (except for the therapist) before. The disclosures were met favorably, and the client stated he was feeling closer to her as a result. Again, the client seemed markedly more at ease in session than previously.

Outcome and Prognosis

This is not a terribly complicated case, but for our present purposes that is an advantage. Mark came by his anxiety honestly, but he was enhancing it by trying to avoid it, in part because his continued disconnection from others made him feel more alienated and thus more anxious. Mark's early experiences with intimacy outside of therapy involved uncomfortable situations: Given his history, there simply was no other sequence that was likely to occur. He first described an instance where he had been able to more fully experience his anxiety while asking out and later dating a young woman that he previously had been unable to approach. He later reported that he approached another young woman (previously a friend) in whom he was extremely interested and asked her for a date. Although he was expecting anxiety and was willing to experience it, he was very surprised to find that very little arose. He also reported that, although he had some negatively evaluative thoughts throughout the interaction, he chose to view those thoughts as words and not truths. Mark had applied what he had learned in therapy. He was focused on pursuing a value (intimacy) rather than avoiding anxiety, and had perceived his self-evaluative thoughts not as descriptions of reality, but rather as mere verbal habit.

The measure and the source of progress here are not a decrease in anxiety, but an increase in the willingness to experience anxiety. Commonly, however, as willingness increases, anxiety goes down because, paradoxically, what has kept anxiety high is the attempt to keep it low.

Mark's in-session demonstrations of progress were substantial as well. During the intake and the first two sessions, Mark had great difficulty focusing on comments about the client–therapist relationship as well as difficulty revealing thoughts about his own inadequacy. Focusing on these issues during the last two sessions appeared to be much easier for him, as evidenced both by therapist observations and client disclosures. Although he still had difficulties identifying his specific feelings during the course of the final sessions (which would be expected for someone with little experience in identifying such feelings), he consistently demonstrated both a willingness to focus on them and to accept the uncomfortable ambiguity of sometimes not knowing exactly what they were.

Notably absent from Mark's case was an extensive need to clarify the client's values. This process normally can take several sessions and is an intensely personal and integral

part of ACT therapy. Mark's specific concern, however, allowed a hasty assessment of values relevant to the course of treatment. Mark was clear that he valued intimacy and closeness even though he did not know how to produce it.

The client terminated after this session due to his success and mounting responsibilities in other areas of his life. A phone contact with him approximately a month later indicated that his relationship with his new partner had continued to progress and that he was able to disclose and share more with her.

The possibility exists that these changes will not be maintained. ACT clients who notice that acceptance of unpleasant emotions leads to a reduction in their intensity or frequency may begin to use acceptance as a strategy designed to reduce or eliminate the emotions. This is functionally no different from control strategies such as suppression and would be expected from an ACT perspective to be similarly ineffective over time. Part of the last session was spent "inoculating" the client from this possibility. This was done partly by simply reminding the client that the goal is not the absence of anxiety, but effective movement toward what he values. It also was accomplished by asking the client to continually check back with his direct experience to determine both if the anxiety is not as bad as it "says" it is and if trying to eliminate the anxiety was in fact counterproductive.

The possibility also exists that another bad experience (such as a betrayal of his trust) in a close relationship might throw Mark "off the wagon." Hopefully, his practice with defusing from the descriptions/implications of experiences gained in therapy will either prevent this or allow him to climb back on the wagon if necessary. As was done with Mark, follow-up sessions are either scheduled or encouraged in case of such an occurrence.

Clinical Issues and Summary

Mark's presenting problem fit with the underlying view of psychopathology from an ACT perspective. The client's initial formulation was that his problems stemmed from his fear of rejection by women and from the deep conviction that there was something wrong with him. He expected that therapy would somehow alleviate this fear and insecurity so that he then would be able to build and sustain intimate relationships. The therapist viewed it slightly differently: The client's problems came from trying to *avoid* his fear of women, rejection, and the deep conviction that there was something wrong with him. He needed to abandon the attempts to manipulate his emotions and thoughts, and instead bring them along as he set about cultivating intimate relationships. His job was to feel feelings as feeling, and to think thoughts as thoughts, fully and without defense, *and* get on with the business of living.

Mark's willingness and even his eagerness to engage this alternative agenda is not extraordinarily unusual. It is quite common for clients to be a bit shocked by the possibility that emotional regulation is not necessarily the means to the end of successful living. Many clients have never considered the possibility that it is not necessary to line up emotions and cognitions properly before real living can begin. Sometimes seeing that there is an alternative can be a relief.

Conclusion

When emotional regulation is no longer the focus (being replaced by effective living), ironically emotions usually become much more moderate over time. Humans, due to their language abilities, can sustain emotional distress for many years without the physical

presence of an aversive event because language can present these events indirectly and experiential avoidance can amplify this distress. For example, if anxiety is something to be anxious about, anxiety will be maintained and will build. Emotional acceptance and cognitive defusion essentially disconnect the process that sustains and builds on previous pain. For example, if anxiety is something to be willingly felt when it emerges as part of effective living, anxiety is just an interesting echo of the past. As new experiences occur, that past is integrated into a more effective present, and the echoes of the past become less distinct and less disruptive. In the same way, as emotional regulation is no longer the issue, emotions tend to assume more moderate levels.

And so we return to our imaginary person trying so hard to think through a complex problem while subtracting serial sevens. Guilt-ridden and full of failure, she seeks out a therapist to help her regulate her sevens. Even if this person's entire culture is convinced that better sevens are needed before problems can be solved, we might hope that some therapist somewhere would have the good sense to say ". . . who said THAT was the problem?!" In our current "feel good" culture, guilt-ridden patients, full of failure, seek out therapists for guidance in controlling or moderating thoughts, sensations, feelings, memories, urges, and the like so that effective living might soon be more possible, but perhaps therapists should step back and say . . . who said THAT was the problem?

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