# acceptance and commitment therapy for eating disorders

A Process-Focused Guide to Treating Anorexia and Bulimia

EMILY K. SANDOZ, PH.D.
KELLY G. WILSON, PH.D.
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To Jonathan, my partner and dearest friend. I choose you.

—EKS

Especially for my girls, Sarah, Emma, and Chelsea.
I love you to the moon and back.

—KGW

For Norm, who once skillfully wielded a
shotgun in his capacity as a therapist.

—TD

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# Letter From the Series Editor

Dear Reader:

Welcome to New Harbinger Publications. New Harbinger is dedicated to publishing books based on Acceptance and Commitment Therapy and its application to specific areas of mental health. New Harbinger has a long-standing reputation in the mental health community as a publisher of quality, well-researched books. We offer an effectual forum for you to get this pertinent information to a wider audience.

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As ACT Series Editors, we review all ACT books published by New Harbinger, comment on proposals and offer guidance as needed, and use a gentle hand in making suggestions regarding content, depth, and scope of each book. We strive to ensure that any unsubstantiated claim or claims that are clearly ACT inconsistent are flagged for the authors so they can revise these sections to ensure that the work meets our criteria (see below) and is true to its roots (e.g., not passing off other models and methods as ACT).

Books in the Acceptance and Commitment Therapy Series:

- Have an adequate database. Those meant for the public will have at least one reasonably well-done and successful randomized trial showing that the methods are helpful.

- Be theoretically coherent—they will fit with the ACT model and underlying behavioral principles as they have evolved at the time of writing.
- Refrain from making excessive claims, and orient the reader toward unresolved empirical issues
- Not overlap needlessly with existing volumes
- Avoid jargon and the needless creation of new terms, or unnecessary entanglement with proprietary methods
- Keep the focus always on what is good for the reader
- Support the further development of the field
- Provide information in a way that is of practical use to readers

Sincerely,

—Steven C. Hayes, Ph.D.
Georg H. Eifert, Ph.D
John Forsyth, Ph.D.

# Preface

On a spring day during my graduate training at the University of Mississippi, the gentle, soft-spoken office manager at our campus clinic received an appointment request from an insistent and very direct client who demanded to be seen "as soon as fucking possible." I was fairly new to the clinic, and I wasn't the next therapist in line for a new intake, but my clinic duty time was convenient for a lot of clients, so the assignment came my way.

As the time for our appointment drew near, I started to prepare myself for the intake. What I knew about this client was limited, as it usually is before the first session. I knew without a doubt that she was rather frustrated with our appointment scheduling system. Besides that, I knew that she had cited eating troubles as one of the main reasons for her visit to the clinic. So I did some homework, reviewing a few things I'd found particularly interesting on eating disorders. And I photocopied some appropriate forms, straightened a stack of blank paper that I kept close at hand, and tested two black ballpoint pens. All of these I gathered up with my little brown clipboard marked "Psychological Services Center." Once these obvious chores were done, I took to fretting about the other part of the job, the part that inevitably starts once we get through our administrative tasks and set aside our office supplies—the task of hearing a real person's heart and helping her find her way.

My fretting didn't stop when I greeted this client in the waiting room where she met me, holding her own clipboard, pen, and forms. She was several inches taller than me and very thin, so thin as to seem angular. Jaw, wrists, ribs, hips, and ankles—all of her joints were prominent beneath her skin. But it was the look in her gray eyes, so empty and distant, that provoked tightness in my chest. Whatever she was experiencing, I was blind to it right from the start.

As the session progressed, I found myself unable to hear what it was this woman had come into the clinic to share. I tried repeatedly to encourage her to express what she was experiencing, but she left each offer I made hanging in the air unaccepted. To keep the conversation going, I scampered back from these hard questions to merely gathering information. In an administrative sense, this strategy "worked." I was secretly relieved each time I got something tangible I could write on my clipboard. For her part, my client readily gave me each bit of information I asked for. She was visibly comforted each time she was able to answer my queries with the matter-of-fact details of early weight gain, childhood teasing, failed relationships, and eating or substance use patterns. She had an air of detached defiance as she described the unsuccessful attempts of former teachers, doctors, and therapists to help her.

I set the clipboard aside just as our fifty minutes ended, leaned forward, and confessed that I was having trouble hearing how her struggles fit inside her life, how they touched and impeded the things she really cared about. At this, her eyes narrowed and flashed, no longer empty.

"I sculpt…," she started slowly. But then her words failed her. She fell silent, and her eyes filled. I was still leaning toward her, my hands open in front of me, silently begging her to go on. But it wasn't to be. She blinked and stood suddenly. With a toss of her head, she asked a few questions about how her therapist would be selected. I paused probably too long before I met her in this safer place. I answered her question and escorted her out of the therapy room. When we took leave of each other, we were both smiling politely.

After she was gone, I summarized the information she had given me neatly on the lined forms on my clipboard. I worked carefully, efficiently. But as I did so, I replayed the session over and over in my head, miserable with the thoughts of everything I could have done differently and better. In the end, she was assigned to a more experienced therapist. He tried several times to reach her without success, and after three weeks, the clinic sent the usual form letter to her address, asking her to call us back. To my knowledge, she never did.

The memory of that session lingers with me still. I often wonder if she has described our failed attempt to help her to yet another therapist at yet another clinic. More than that, I wonder about her sculpting, what kinds of figures she loved to form, what it was like for her to have her hands in clay, and what it meant to her to create. Maybe more than that, I wonder how her troubles with eating get in between her and this activity that brings richness and purpose to her life.

In the therapy room, we have two jobs. The first is one that we learn about early in graduate school: gathering information. Onset, duration, family, substance use, education and employment history, and so forth. Just the facts. We're supposed to extract these data from our clients and then summarize, organize, and evaluate them, all within the neat boxes that are printed on the required forms.

The second job is much harder, and they certainly don't tell you about it in the first weeks of graduate school. At the time of the appointment I just mentioned, I hadn't had much practice at it. Kelly Wilson, my mentor then and coauthor now, had persistently (and sometimes painfully) prepared me to do it. Yet as the hour of that appointment approached, I found myself struggling to figure out what exactly *it* was.

In my confusion, I don't think I was alone. Several years later, my coauthors described in their strange and beautiful book *Mindfulness for Two* what this second job of therapy might look like: a way of approaching the therapeutic relationship that involves careful attention to the interactions we have with our clients as they take place, with the goal of uncovering possibilities in all of our conversations.

The first and most apparent job of the intake interview is to gather information about our clients, to see clearly what is and what has been in their lives. The second and most important job of the intake interview is to offer our clients an invitation to see something different.

This book is likewise an invitation to something different. It's an invitation to look at disordered eating in a new way. It's an invitation to carefully consider what it is that shapes and dignifies the hard work we do with clients every day. And it's an invitation to look inward, with kindness, at what we bring with us into the therapy room. The three of us feel very grateful to have been able to put together this volume. We're sincerely honored that you're sharing it with us.

—Emily Sandoz
Lafayette, LA, 2010

# INTRODUCTION

# New Perspectives on the Treatment of Disordered Eating

How common are problems with eating and body image? A great many people, at some point in their lives, experience concern about their eating habits and the impact they might have on physical appearance. Some individuals, though, find their entire lives dominated by these concerns and efforts to manage them. Clinical levels of restriction, bingeing, and purging end relationships, destroy careers, thwart education, and can even extinguish life itself. These problems are almost ubiquitous among our sisters and daughters, and they're becoming more so among our brothers and sons. Rare is the clinician who won't have to consider some client struggling with these problems in the course of his career. Case conceptualization and treatment development for these problems are challenges that just about every therapist must, at one time or another, face.

This book offers one approach to treating the rigidity and narrowness in living that characterize eating disorders from within the framework of acceptance and commitment therapy (ACT). This approach offers you a new way to engage with and support your clients who are seeking a life free from the struggle with disordered eating.

A convergent body of laboratory and clinical research suggests that it may be problematic to focus on changing thoughts and feelings in an attempt to change people's eating behavior. Instead, it may be more useful to focus on changing the relationships between the thoughts and feelings they experience and the way they eat. In other words, the rigidity associated with eating can be addressed by teaching mindful acceptance of these thoughts and feelings and, at the same time, fostering committed action

in valued areas of life. Once people are able to openly embrace both their experiences and their concerns, in the moment and without defense, they're freed up to live richer, more meaningful lives. This is referred to as *psychological flexibility*, and it's the primary goal of ACT.

In the chapters that follow, you'll find a comprehensive orientation to ACT and its process model as it applies to eating disorders. Part 1, Foundations of ACT, presents a broad overview of acceptance and commitment therapy, paying special attention to not only the theoretical and historical contexts from which it emerged but also its philosophical roots. We'll explore in some depth the purpose and goal of ACT, psychological flexibility and valued living. We'll also take a look at eating disorders from the perspective of standard syndromal classification. After examining the impact of that approach, we'll consider an alternative to syndromal classification: a functional classification of the behaviors that characterize eating disorders.

Part 2, Delving into ACT, explores difficulties we typically associate with eating disorders as they present themselves in each of the six ACT process areas (which we will elaborate later). Here, we offer functional guidelines for how you might address breakdowns in each of these areas. In each area, we'll describe deficits you're likely to observe in your clients. And we'll also consider how you might deal with similar deficits as they're likely to show up in you, the therapist. The guidelines we offer in this section address therapy as it progresses, offering case examples of early, intermediate, and advanced work on each of the process components.

In Part 3, Sample Protocol (What This Work Might Look Like), we explicitly address the integration of the each of the process areas—the components of psychological flexibility—in assessment, conceptualization, and intervention with eating disorders. We offer general guidelines on integrated case conceptualization, followed by a sample protocol describing the process of therapy as it might progress in a real series of sessions: from choosing a direction to shaping psychological flexibility in session to bringing flexibility to bear in life. This protocol is organized not only in terms of changes in content of the sessions but also in terms of changes in the behaviors exhibited by the client as psychological flexibility emerges. In this section, we also describe challenges you're likely to face in the course of treatment, and we offer some suggestions for integrating ACT into an existing treatment plan.

ACT is one approach among many emerging therapies for treating eating disorders. We think, though, that ACT is uniquely positioned to treat the life in which the eating disorder is situated. Keep in mind as you read through the book that ACT—at least in our understanding—is a dynamic system that requires as much engagement from the therapist as

from the client, often in very similar ways. Though this book is about treating problems with disordered eating, we invite you to let your mind wander as you go. ACT is designed to address some very ubiquitous problems that each and every one of us might experience with living. Much of what you read here, you may find, will be relevant to other areas of your practice.

# PART 1

# Foundations of ACT

In this part of the book, we'll present a general overview of acceptance and commitment therapy (ACT), including the philosophical and historical context from which it emerged. We'll engage you in a discussion of the nature and purpose of both psychological flexibility and valued living. We'll also take a look at eating disorders from the perspective of syndromal classification. We'll examine the impact of that approach, and then we'll consider an alternative to syndromal classification: a functional classification of the behaviors that characterize eating disorders.

# CHAPTER 1

# What Is ACT?

Different people interact with newspapers differently, according to their temperament. Some read from the first page straight through to the last, skipping ads or not. Others jump right to the business, sports, or op-ed pages. Still others neatly fold the crossword and then dump the rest into the closest trash can. Each takes from the paper what she wants.

And so it is with books, especially books like this one, which are written to share ideas about a dynamic and evolving body of knowledge. We've written this book with practicing psychotherapists in mind. We've also written it for researchers, students, and fellow travelers who are interested in the evolution of ACT as a subject of study, as well as for those people whose lives have been touched by disordered eating in some way and who are interested in a new perspective on this problem.

Your history, reader, will unavoidably condition what you take away from this book and how you'll go about reading it. And as you might do with a newspaper, you might choose to jump to the sections that promise the information in which you are the most interested. If you're a clinician in private practice, you might be inclined to flip ahead to the treatment sections. If you're familiar with ACT, the case-conceptualization material might be calling to you from part 2 of the book.

We hope we can slow you down, though, at least long enough to take in the foundational material that follows. One of the aspects of ACT that draws people into the work is its particular perspective on the whole phenomenon of psychopathology, of human suffering. In relation to other contemporary psychotherapies, this divergence goes beyond technology and even beyond theory. It penetrates to the philosophical root of the work. Brushstrokes conspire to make a painting; God, as they say, is in the details.

Even if you're primarily interested in the bigger picture of conceptual ACT or ACT in practice, we invite you to look more closely for a moment at the subject of our discussion in this chapter, the foundational details of ACT.

## WAYS OF UNDERSTANDING THE WORLD

As with all books that aim to teach a particular approach to a problem or task, we have quite a few terms to define. We need to introduce a number of relevant concepts and the relationships between them before we can propose ways of acting on them. This process is familiar to us all. It's consistent across disciplines both scientific and nonscientific. But what information is actually necessary to define a concept? The answer to that question isn't an obvious one. There are, as we'll see, many different ways to understand the world.

As you move around the world, you're inundated with a constant stream of stimulation. As you read these words, a seemingly endless stream of sounds, tastes, smells, and tactile sensations impinges upon your senses, yet this is not necessarily how you experience the world—as a blur of sensory impression.

For example, take a moment to notice the temperature in your feet. Are they warm? Cold? Do they feel warmer or colder than your hands? You were most likely doing many other things besides thinking of your feet as you read this, yet in an instant, with just a few words, those sensations are suddenly salient.

Instead of experiencing the whole of what the world offers at any given moment, we experience it in categories. We experience a chocolaty espresso, a horn honking, or a floral scent. Cognitive scientists suggest that our very experience of the world is related to how we categorize it in our language. For example, people whose native language gives a feminine gender to the word "bridge" are more likely to describe it as "beautiful" and "elegant" rather than "strong" or "sturdy" (Boroditsky, Schmidt, & Phillips, 2003). In other words, the categories we use and on what those categories are based affect how we understand the world.

One way of categorizing involves describing the structure of a category's members. What are the parts of the concept being defined and how do they work together? From this perspective, a "chair" might be defined as having a wide, flat piece called a "seat," with four long pieces called "legs" extending downward from it, and a wide, flat piece called a "back" extending upward from one side. Likewise, "depression" might be described in terms of what the behaviors (the "parts") associated with depression look like.

Another way of distinguishing a category involves describing the function of its members. In other words, how does the concept being defined work in the world? From this perspective, a "chair" might be defined as "something on which people sit." Likewise, "depression" might be described in terms of what role the behaviors associated with depression play in a person's life.

One thing that distinguishes this second, functional approach is the attention it focuses on context. A chair might be "something on which people sit" in the context of furniture, but it could also be "something under which a mouse hides" in the context of a nursery rhyme or even "a leader" in the context of hierarchy in committee membership. Likewise, the functional properties of depression are not absolute. Rather, they're defined in the context of the life of the person suffering from depression.

## STARTING WITH CONTEXT

In ACT, we're interested in a strategy of categorizing or understanding the world based on how it functions in context. We'll assume that, in order to fully understand something, it's important to understand the context from which it emerges. As an example, imagine you're in a restaurant and you see a person turned away from his table, leaning forward and clutching his stomach. Imagine he's convulsing slightly and gasping for breath, tears streaming from his eyes. What's going on here? The man is choking, possibly, or going into anaphylactic shock. Now imagine that you see this same person, leaning forward, clutching his stomach, convulsing, crying—the whole bit—but down the aisle at a theater during a comedy. Now picture him at a funeral home or in a hospital. Each time, the function of the event is different, even though its formal structure is the same.

So ACT seeks to understand the world in terms of functions in context. That's all fine and well—but why? To understand that, we need to take a look at the philosophical and historical context from which ACT emerges.

## THE PHILOSOPHICAL CONTEXT OF ACT

ACT is based on a particular scientific analysis of human behavior. Scientific analyses are only one kind of analysis. Any single event can be subjected to an almost infinite number of analyses. Take for example a simple interaction between two individuals: a woman approaches an entrance and the elderly man in front of her holds the door open as she passes through. This

interaction could be analyzed in terms of the cultural variables, the schemata, or the learning histories that contribute to this interaction. Each of these analyses would yield different results, but depending on method, all of them could be scientific approaches. Alternately, the interaction could also be analyzed through creation of an abstract painting, a poem, or a hip-hop song. And although each of these might be very effective at conveying some aspect of the experience, none could be classified as a scientific analysis. The difference is critical to our discussion.

Science is generally understood to involve study of the world through systematic observation and experimentation. This understanding is a broad one. It suggests a range of methods and a virtually limitless set of topics, from subatomic particles to political systems to entire galaxies. Scientific methods involve any practical and intellectual activities that contribute to systematic observation of and experimentation with the event being studied.

You'll note that in this broad understanding there's no mention of the *purpose* of science. To what end is scientific study conducted? Basic understandings of science don't generally include answers to this question. In fact, it's rarely considered at all. Science is about seeking truth, isn't it? Why would we study something except to find out what is true about it? This answer is not, however, as simple as it first seems.

## *Pepper's* World Hypotheses

In his book *World Hypotheses* (1942), philosopher Stephen Pepper proposes several dimensions along which worldviews can be distinguished, two of which are the *root metaphor*, which consists of the set of ideas and objects anyone uses to describe and understand the world, and the *truth criterion*, a sort of standard, inseparable from the root metaphor, that gives one the measure by which to assess the validity of any proposition. In more traditional philosophical language, the root metaphor is akin to our ontological assumptions, while the truth criterion is similar to the assumptions we make about epistemology, about what constitutes both knowledge and knowing. Pepper notes that different scientific approaches or worldviews have different criteria for what is knowledge and what is truth.

How does a scientist know when an event is understood? What are the criteria by which she decides what contributes to the understanding of an event? Pepper suggests this depends on the root metaphor being employed. He describes four different root metaphors for the world and its events: the act in context, similarity, the machine, and the growing organism.

- In *contextualism*, the world is like the act in context. Full understanding of an event results from an understanding of the historical and immediate contexts in which the event takes place.
- In *formism*, the world is like a collection of classes of items. Full understanding of an event results from properly classifying it according to its form.
- In *mechanism*, the world is like a machine. Full understanding of an event results from properly identifying the parts, their relationships, and the forces moving through them.
- In *organicism*, the world is like a developing organism. Full understanding results from coherent description of invariably ordered stages through which an event passes.

Once you know the root metaphor you'll use to describe the world, the truth criterion gives you the means of assessing the validity of statements made about it. Pepper proposes three truth criteria: successful working, correspondence, and coherence.

In contextualism, an analysis is true to the extent that it allows the scientist to further his goals. For example, a fashion designer and a podiatrist might analyze a pair of red Prada ankle boots with four-and-a-half inch heels with markedly different conclusions. The analyses might be equally true, despite their differences. Why? Because one is evaluating against style and one is evaluating against foot health. The boots are not good or bad, except with respect to the goals of the analyzer.

In formism and mechanism, an analysis is true to the extent that it allows for classification of all observed events or prediction of new events. For example, a psychologist might propose a new diagnostic category because of examples that are well represented in the population but not adequately classified in the existing system. To consider a mechanist example, simple decay models of forgetting are considered to be less true than interference models of forgetting because of their inability to explain differences in rate of forgetting across different activities.

In organicism, an analysis is true to the extent that it's consistent with existing knowledge in this area. For example, were Fitzgerald's short story "The Curious Case of Benjamin Button" to be presented as fact, existing theories of human development would have to change to account for aging that occurs backward.

The root metaphor and truth criterion, along with other philosophical assumptions, impact nearly every aspect of a scientific approach. The questions the scientist deems worthy of study, the methods he employs to address those questions, the conclusions he draws from the data, and the manner in which he applies and even disseminates those conclusions are all influenced by what he assumes about knowledge and truth. Because of the widespread implications of these assumptions, a valid evaluation of a scientific pursuit only exists from within the same worldview. Open examination of these assumptions can prevent miscommunications and invalid evaluations that are attributable to fundamentally incompatible worldviews.

For example, imagine a developmental psychologist presenting new data on the development of autism that clarifies its developmental course, revealing earlier indications of developmental deficiency than were thought possible. This would be a sound analysis from an organicist perspective. However, the formist might ask about the classification of different developmental patterns that might lead to more precise diagnosis. The mechanist might ask about the events that cause these initial deficiencies and that affect the course of the condition's development. The contexualist might ask about some aspect of the conditions under which these events take place, depending on her analytic goals. Here, she would be uniquely positioned to acknowledge the validity of each analytic approach as consistent with its own corresponding goals.

## *Contextual Behavior Analysis*

ACT is part of a broad discipline of psychology known as *contextual behavior analysis.* Contextual behavior analysis adopts the act in context as its root metaphor, holding that behavior cannot be fully understood until its immediate and historical contexts are understood. Contextual behavior analysis also adopts the pragmatic truth criterion, holding that an explanation is true to the extent that it allows for successful working toward a given goal. Generally speaking, contextual theories can be divided into two categories: descriptive and functional contextualism (Hayes, 1993). Of these, contextual behavior analysis is more closely allied with the latter. *Functional contextualism* takes as its goal the prediction and influence of phenomena with precision (a restricted number of constructs apply to any one event), scope (these constructs apply to a wide number of events), and depth (the constructs at the psychological level cohere with those at other levels). In this way, what is "true" or "correct" is that which allows for prediction and influence of behavior with precision, scope, and depth.

Functional contextualism guides the scientific activities performed within contextual behavior analysis. Keeping with the pragmatic truth criterion of contextualism, the topics and methods that are chosen for study within contextual behavior analysis are so chosen because we think they move us toward an articulated goal. For example, a functional contexualist whose primary goal is suicide prevention may see limited utility in seeking correlational data on electrical neural activity and self-reported suicidal ideation. He will probably be more interested in the data on effects of early intervention workshops with at-risk teens on mood, impulsive behavior, and valued living.

## *The Therapist as Contextual Behavioral Analyst*

The impact of philosophical assumptions doesn't stop in the laboratory. ACT is based on a particular scientific analysis, but most of the individuals who do ACT are not doing science—at least not in the way it's generally understood. Just as in the laboratory, doing ACT involves the application of an analysis, which results in the asking of particular questions, the performance of particular manipulations, and the collection of particular data. A therapist is a kind of analyst, and therapy based on ACT's underlying theory reflects the same assumptions as research based on this theory. Because of the emphasis on context, the analysis itself is applied to assessment, conceptualization, and treatment flexibly and with careful consideration of the functional dimensions of behavior. This will be apparent as the book moves into more specifics about the application of ACT to disordered eating.

Along these lines, consider that we don't target behaviors for change in ACT because they are defined as "abnormal" or "dysfunctional" by some external criterion. Rather, we start with an articulated goal—to help our clients to lead valued lives—and then we target those behaviors for change that are likely to interfere with the client's values. This isn't to say that behaviors distinguished as "abnormal" aren't often interfering with a client's values. They may well be. But our root metaphor is the act in context, not the similarity of items in classes such as "abnormal." We're interested in the specific context of the client's life, and we take this specific context as the focus for treatment.

Furthermore, we don't evaluate interventions or apply them to particular cases based on their formal properties. Their functional properties, once again, capture our interest. Rather than creating, testing, and disseminating a collection of specific techniques, we're looking to identify empirically supported principles for understanding behavior. In other words, we emphasize

teaching the analysis itself rather than the applications of the analysis. This focus on context will play a significant role in our later discussions of case conceptualization, assessment, and treatment structure.

# THE HISTORICAL CONTEXT OF ACT

To belabor even more the idea of context, let's consider the historical context from which ACT emerged. ACT is part of the tradition of behavior therapy, which some have conceptualized as having three "waves" or generations (Hayes, 2004).

## *The First Generation*

The first generation of behavior therapy involved a marked change from mainstream psychotherapy at the time. In the late 1940s, psychoanalysis was the predominant approach both as a theory of psychopathology and as a psychotherapeutic technique. After several decades of practical dominance within the discipline, certain aspects of the approach made it difficult for psychoanalysis to progress. For one thing, the psychoanalysis of the mid-twentieth century placed little to no emphasis on empirical principles. Psychoanalytic theory or techniques didn't adapt to research findings as scientists learned more about human behavior. Add to this the fact that the targeted outcomes of psychoanalysis were vaguely defined and difficult to measure, which made it nearly impossible for therapists working in this tradition to track their progress. Professional training of this period rarely prepared psychoanalysts to be consumers of science, let alone scientists themselves.

Behavior therapy developed with a vastly different agenda. Behavioral principles in the areas of operant and respondent conditioning were well-defined and producing active programs of research that resulted in further refinement of those principles. These findings contributed directly to applied research and treatment-development efforts. Inherent in the behavioral approach to psychotherapy was an emphasis on data collection in treatment to determine empirically the function of different behaviors in context. Training of behavior therapists emphasized both the continuing attention to and integration of current research into everyday psychotherapy and the establishing and tracking of client-specific measurable outcomes. First-generation behavior therapy was based solely on operant and respondent principles of behavior, and it involved early iterations of what are today our

most effective interventions. Exposure- and reinforcement-based technologies make up a majority of empirically supported treatments across a range of psychological difficulties.

Some aspects of human behavior, though, weren't addressed adequately in first-generation behavior therapy. Early behavior analytic approaches assumed that behavior could be predicted and influenced without accounting for how thoughts and feelings—so-called *private events*—related to objectively observable behavior. This assumption, for the most part, yielded positive results in work with young children or the developmentally disabled. Verbally competent individuals, though, demonstrated more variability in their responses to environmental manipulations. In other words, the controlling events for some behaviors just seemed out of reach.

## *The Second Generation*

In the 1960s, psychologists began to ask a new question: what about cognition? Attempts to answer to this question led to the rise of the second generation of behavior therapy. This second wave retained the empirical emphasis and the successful technologies from the first. New to second-generation approaches, however, was a focus on cognitions, on thoughts and general patterns of thinking, or schemas. The second generation of behavior therapy expanded on the successful analyses and technologies of the first generation by focusing on private behavior as a primary target of therapy. For the first time in behavior therapy, private behaviors were considered to be an important part of the cause of public behaviors, and cognitive change was considered to be necessary and, in some cases, sufficient for behavioral change to occur. Cognition was assumed to be subject to the same conditioning principles as other kinds of behavior. Just as a first-generation behavior therapist might praise a client for entering a feared social situation, a second-generation behavior therapist might also praise her for reporting three exceptions to her previously held belief that everyone will hate her. In this example, there are assumptions both that her beliefs regarding others' feelings toward her *can* change and that they *must* change for her to enter the social situation.

While first-generation behavior therapists have enjoyed some success at identifying public behaviors that could be controlled or influenced in a therapeutic way, the same couldn't be easily said for private behaviors, for thoughts and feelings. For example, imagine a client presents with a fingernail-biting habit that is severely interfering with his life. It's not challenging to identify and reinforce a desirable behavior that's impossible to do

while biting one's fingernails. For example, a behavior analyst might give the client a tennis ball and reinforce squeezing and kneading when he's feeling anxious or angry.

Identifying a similar point of intervention isn't so simple with private events. For example, it's not apparent that one can intentionally strengthen the thought *I am competent* without immediately strengthening thoughts like these:

- *Will they see how competent I am?*
- *Will anyone notice my efforts?*
- *Does this make up for the times I messed up?*
- *What if I'm really not competent at all?*

If your theory suggests that thoughts like these—distorted or irrational thoughts that overgeneralize, make faulty comparisons, and so forth—cause problems, and it's possible that trying to change these thoughts actually strengthens them, you have something of a disconnect on your hands.

The possibility that this disconnect is real and significant was strongly suggested in data about incremental validity and mechanisms of change. Second-generation behavior therapy retained the empirical emphasis from its roots, establishing second-generation behavior therapy as having the most support for its efficacy with regard to a number of different psychological difficulties. Researchers repeatedly demonstrated that pairing traditional behavioral techniques with cognitive interventions produced behavior change. It was not clear, however, that those cognitive interventions were necessary for the behavior change or the cognitive change.

For example, when Beck's cognitive behavior therapy for depression was subjected to a component analysis, adding the cognitive components of therapy did not improve the outcomes of treatment, and, for the most depressed clients, the addition of cognitive components actually resulted is slightly less positive outcomes (Jacobson et al., 1996). Perhaps even more disconcerting is the lack of evidence that, when behavior change did occur in these studies, it was because of cognitive change. Instead, mediational analyses failed to demonstrate that the clients whose symptoms improved were the same ones who reported that their thoughts had improved (Longmore & Warrel, 2007). This suggests that although second-generation therapies may be effective, they aren't necessarily effective in the ways that the theory suggests.

### *The Third Generation*

Third-generation behavior therapies expand upon earlier attempts to address the question of cognition. Instead of employing direct strategies to change the content or formal structure of cognition, third-generation behavior therapies tend to emphasize changing the function of cognitive behavior. For example, with an individual whose life is disrupted by her preoccupation with thoughts that she is fat, the emphasis isn't on training more positive evaluations of her body. Rather, work in therapy might be aimed at increasing her flexibility to live life even in the presence of those thoughts (Wilson, Bordieri, Flynn, Lucas, & Slater, 2010). Third-generation behavior therapies also tend to emphasize more generally the broadening of the behavioral repertoire over the elimination of symptoms. Since ACT is among these third-generation behavior therapies, we won't go more deeply into describing their general characteristics. These will become evident as we describe the goal and purpose of ACT.

## THE GOAL AND PURPOSE OF ACT

All interventions do not have the same goals. Some interventions clearly aim to eliminate certain experiences or behaviors. For example, a treatment goal might be to reduce panic attacks to one episode per month. Another goal might be abstinence from use of all substances, initially for a period of time, and eventually for good. Other interventions aim to teach particular skills. A treatment goal might be to exhibit socially appropriate behavior in the classroom or to describe and use successfully four anger management techniques.

From a functional contextual perspective, it's important to clearly describe the general goals of an intervention, because the outcomes of the intervention can only be evaluated with respect to its articulated goals. For example, it wouldn't be valid from this perspective to critique an anger management group for not decreasing panic attacks or increasing intimacy.

The goal of ACT is *psychological flexibility,* meaning that ACT aims to train individuals to actively and openly contact their ongoing experiences in the present moment as fully conscious human beings, without defense and as it serves their chosen values. This is distinct from examples described above that aim for the increase or decrease of particular behaviors. Psychological flexibility is defined functionally, meaning that it will look different depending on the individual who fosters it. As an example,

some individuals might go to great lengths to keep themselves surrounded by and interacting with people. For these individuals, psychological flexibility might be exhibited in a willingness to spend time alone. Other individuals avoid social interaction to the point that it interferes with their academic or occupational success. For these individuals, psychological flexibility might be exhibited in a willingness to pursue positive interactions with others.

In this way, psychological flexibility is context specific with respect not only to people but also to certain events. One could describe an individual's overall psychological flexibility, meaning the flexibility of his repertoire in general. But remember that behavioral repertoires change with context, at least a little. Additionally, clinical research has repeatedly shown that the ability to engage in certain behaviors of interest in particular areas of life is more sensitive at demonstrating the mechanism of change at work in ACT. These domains include not only the external environment but the internal environment as well. For example, an individual might be fairly flexible in most situations but exhibit a high degree of inflexibility when a spider is present. Another individual might be particularly inflexible when she experiences sadness, physical pain, or thoughts of inadequacy.

Psychological flexibility can also be conceptualized as existing on a continuum. Rather than considering flexibility as a skill that someone either has or doesn't have in any given situation, an individual's repertoire can be considered in terms of where it might fall on a continuum from inflexibility to flexibility. This brings us to the purpose of ACT, the reason for the goal of psychological flexibility: *valued living*. We'll get into a more precise and technical definition of values a little later, but the everyday understanding of the word is sufficient for our purposes here. We don't work to foster greater psychological flexibility in our clients and ourselves just for the sake of doing so. Rather, we do this in the service of some chosen values. In the examples above, the behaviors that indicate greater psychological flexibility aren't identified merely because they're out of the ordinary for the individual—an embrace of solitude for the outgoing person, a broadening of interactions for the more solitary sort. From an ACT perspective, neither avoidance of social interaction nor avoidance of being alone is pathological or harmful in and of itself. Instead, just as ACT is evaluated against its articulated goals, an individual's behavioral pattern is evaluated against his chosen values. Social avoidance would be targeted for the individual whose describes his isolation as interfering with his value of parenting, but not necessarily for the individual who expresses his isolation as useful for allowing him time to pursue his valued activity of painting.

# THE SIX COMPONENTS OF PSYCHOLOGICAL FLEXIBILITY

Psychological flexibility is described as having six functionally defined behavioral components. We have also described these as facets in that, like a gem, the whole behavior can be described with respect to the continuum of psychological flexibility in general, or with respect to a continuum of any of the six components (Wilson & DuFrene, 2009). Skill or deficiency in these areas is considered to be interdependent and highly correlated for most people.

The distinction of these six components is purely pragmatic. We don't present these components because they represent fundamentally different aspects of human behavior. We offer them in order to highlight different emphases across presentations and interventions. In other words, these categories function to sensitize the clinician to different emphases in intervention.

These components are present-moment focus, cognitive defusion, experiential acceptance, transcendent self-awareness, valued living, and committed action. We previously defined psychological flexibility as actively and openly contacting one's ongoing experiences in the present moment as a fully conscious human being, without defense and as it serves one's chosen values. Each of these components is thought to allow for discrimination of an aspect of psychological flexibility with which a person might experience particular difficulty and on which an intervention can focus.

In this section, we will review each of these components briefly, and with respect to overall functioning. It will be useful to stop after reading each description and notice ways this may or may not seem to be related to the difficulties associated with disordered eating. In part 2, we will review each of these components at great length and with a particular focus on disordered eating. For now, the examples presented will be those that seem easiest to understand, not those that seem to be most relevant to disordered eating. Remember, our emphasis is on function, so if you understand the way these components work in the difficulties we call depression, or psychosis, or avoidant personality disorder, you can apply them to disordered eating.

## *Present-Moment Focus*

*Present-moment focus* involves employing flexible and focused attention to ongoing events. Present-moment focus refers to perceptions of external events in the environment, and to private events like emotions and cognitions. This

does not mean historical events are avoided. Flexible and focused attention can be brought to bear upon memories, just like any other private event.

By flexible and focused, we mean that attention is able to shift from one event to another with little to no disruption. This can be contrasted with *distractibility*, in which focus is absent and attention jerks from event to event. For example, a student might find it very challenging to remain focused on a lecture when she can hear a bird singing outside, see people passing down the hall, and feel the floor vibrating from the construction next door. In this case, present-moment focus would involve being able to briefly notice the bird singing, people passing, and floor vibrating and turn gently back to the lecture without missing anything important. Present-moment focus can also be contrasted with a *rigid focus*, in which one event dominates attention at the loss of receptiveness to other ongoing events that may be important. For example, a child engrossed in a video game might claim truthfully that he did not notice his mother calling him to dinner. In this case, present-moment focus would involve noticing his mother calling with enough awareness to allow him to decide on a response.

## Cognitive Defusion

*Cognitive defusion* involves experiencing an event fully in its complexity without emotions or cognitions about the event dominating the experience. This does not mean that one perceives the event without thinking or feeling anything about it, but rather that those thoughts and feelings do not prevent the event from being experienced.

Cognitive defusion can be contrasted with *fusion*, in which a person responds more readily to her thoughts or feelings about an event than to the event itself. For example, a new employee whose manager is correcting her for not clocking in properly may experience only her concerns about disapproval and feelings of failure, and miss the manager's instructions on how to clock in properly, his compliments on her performance, and his advice on how to remember the procedures. In this case, cognitive defusion would involve noticing her concerns and disappointment along with other aspects of the experience, such as the manager's words or even the temperature in the room.

## Experiential Acceptance

*Experiential acceptance* involves openly embracing one's experiences, good and bad, without attempting to change them. Acceptance does not

mean enjoying unpleasant experiences. It does not mean that you like to feel bad or to worry. Acceptance does not mean tolerating or enduring. It involves actively choosing the experience, not just allowing its occurrence. Finally, acceptance does not mean resignation or surrendering to to a life directed by whatever experiences come along. It involves letting your experiences be there, while directing your own life.

Experiential acceptance can be contrasted with *experiential avoidance*, in which an individual's actions function to diminish pain or the anticipation of pain. Experiential avoidance sometimes involves private behaviors like distraction, suppression, or logical refutation. For example, the person who fears public speaking might try to stay busy the evening before her presentation in order to avoid worrying about it. She might also try to talk herself into being more confident about her speaking abilities. Experiential avoidance can also involve avoidance of certain external events, because the experience of them is so difficult. For example, a person who fears public speaking may quit a job or drop a class in order to avoid feeling anxious about it. Finally, experiential avoidance can involve contact with aspects of the feared event, but in a way that changes the experience of it. For example, that same person might begin preparing for the presentation months before it is to occur in an effort to make it less scary. In all of these cases, acceptance would involve inviting the fear and anxiety associated with public speaking to well up when it does without affecting her behavior.

## *Transcendent Self-Awareness*

*Transcendent self-awareness* involves flexibility in contacting different ways of experiencing one's self, such that a sense of self that is separate from any particular experience emerges. Transcendent self-awareness is also referred to as *self-as-context*, which emphasizes the perspective from which the different senses of self can be fully experienced. Transcendent self-awareness does not mean never having a role with which one identifies or an idea of the kind of person one wants to be. It is through varied experiences of one's self that transcendent self-awareness emerges. It simply means not letting particular experiences of the self limit other experiences.

Transcendent self-awareness can be contrasted with limited experiences of self, like self-related fusion or a lack of self-awareness altogether. *Self-related fusion* is when one way an individual experiences herself dominates to such an extent as to limit her experiences. For example, around her younger brother, an older sister might be particularly prone to speaking knowingly about what he "should do." This becomes increasingly likely, and

increasingly obnoxious, the more distressed or hopeless he seems. She has become fused with her sense of herself as a big sister and ends up limiting her access to what works better in that situation: shutting up and listening.

Transcendent self-awareness is also contrasted with a *lack of self-awareness*. For example, an individual who grows up in a highly controlled environment, such as an institution, may have very little sense of herself outside of salient contextual variables like the time of day. She may eat not because she is hungry but because it is "lunchtime." She may eat green Jell-O, not because she loves it, but because it's what's being served. This individual has great difficulty articulating what she wants for lunch, let alone contacting who she is or the perspective where she can see all of who she is and could be. This can also be seen in environments in which control is more subversive. For example, an individual might grow up with a caregiver who is emotionally volatile and limits affection on "bad days" to concordance with *his* desires. The child in this environment learns very quickly to read people's expressions, and want what she thinks they want and be what she thinks they need. As an adult, she may find her sense of herself is lost if there is no one around to show her who she needs to be.

## *Valued Living*

*Valued living* involves living in such as way so as to facilitate contact with chosen values. *Values*, from an ACT perspective, are understood as the capacity to engage in an ongoing pattern of valued action (Wilson & DuFrene, 2009). In other words, values are the domains of life for which people choose to work and live. When this choice (that is, "valuing") occurs, people are able to engage in behavior that is difficult and without immediate consequences because it serves that thing they value.

Valued living is contrasted with values fusion and avoidance. With values fusion and avoidance, actions are not freely chosen. They are organized by some feared event or a rule about avoiding some feared event. In *values avoidance*, an individual's actions in a valued domain are more about feeling better than doing better. In *values fusion*, an individual's contact with his value is more like a rule about what should or shouldn't be. For example, a mother might greatly value parenting, but when her son behaves inappropriately, she gets preoccupied with evaluations of her effectiveness and thoughts of how she should be able to handle this. Parenting becomes a burden. The more she tries to get rid of those thoughts and feelings, the less present she is to the experience of parenting, and the less she looks like the parent she wants to be.

## *Committed Action*

*Committed action* involves noticing when actions are not consistent with values and then gently turning back to valued living. From an ACT perspective, commitment does not mean that an individual makes a promise that then organizes her behavior for all time, never turning away from the things she cares about. It means practicing the willingness to notice how her actions may or may not be bringing her toward her values. It means letting go of evaluations of what that means or how that has hurt, and gently returning to actions that serve her value.

Committed action is contrasted with *avoidant inaction* or *persistence*. Sometimes turning away from valued living looks like sitting still when values are calling for action. Sometimes turning away from valued living looks like continuing the same pattern of action when values are calling for a shift. For example, a wife might find herself treating her marriage more like an item on her to-do list than a relationship she chooses. She might find herself doing the things she's always done despite a desire for something more or something different. She might find herself letting go of things she used to do in celebration of that relationship, allowing fears of rejection or disappointment to overwhelm her.

## *Six Processes, One Purpose*

The six components of psychological flexibility—present-moment focus, cognitive defusion, experiential acceptance, transcendent self-awareness, valued living, and committed action—represent the functional targets of ACT. At its core, ACT involves noticing inflexibility as it emerges during session and offering experiences that make flexibility more likely. The therapist presents opportunities for the client to re-create in therapy the rest of his world. The client brings his pain and struggles into session. The therapist allows himself to be moved by that pain and to know that struggle. The client and the therapist come to a shared sense of what hurts and what matters. The therapist gently guides the client in experiencing his pain and his values in new ways and with purpose held a new way. The client experiences a sense of new possibilities and, with it, freedom to build a life he would value. The therapist presents opportunities for the client to stretch out into that freedom. The client chooses direction, commits to action, and returns to that pattern of action whenever he finds himself turned away. The therapist maintains a place to which the client can return to find his valued path laid out before him.

From an ACT perspective, "psychopathology" can often be understood as a lack of psychological inflexibility. Psychological health is characterized by present-moment focus, cognitive defusion, experiential acceptance, transcendent self-awareness, valued living, and committed action. "Symptoms" are problematic not because of their statistical frequency but because they interfere with valued living. In this way, ACT offers the six components of psychological flexibility as functional diagnostic categories. The psychological difficulties typically categorized as "mental disorders" can be categorized, instead, in terms of their functions in people's lives. For some individuals, their struggles are primarily characterized by rigid ideas about who they are and who they should be. Others struggle with being psychologically available to experience their lives in the present moment. Identifying the functions of the things people do that interfere with valued living allows for intervention on those behaviors.

From an ACT perspective, eating disorders are particular forms of psychological inflexibility. Eating disorders and related difficulties are conceptualized in terms of particular deficits in present-moment focus, cognitive defusion, experiential acceptance, transcendent self-awareness, valued living, and committed action. Assessment focuses on the function of disordered eating broadly in the context of the individual's whole life. Treatment focuses on understanding and then working to change that context so as to foster increased flexibility. Disordered eating is targeted not because of its statistical frequency, associated distress, or associated disability but because of its devastating impact on valued living. Likewise, the purpose of treatment for eating disorders is increased contact with the client's chosen values.

## THE PURPOSE OF THIS BOOK

The purpose of this book is twofold: to help you conceptualize disordered eating in a new way, and to help you find some greater measure of psychological flexibility in yourself while working with clients who present disordered eating behaviors.

We have already begun to introduce a way of speaking about client difficulties and intervention that is different from the dominant approach in clinical psychology. The following chapters will apply this different way of speaking to the difficulties often classified as eating disorders. Different ways of speaking about the world allow new aspects of the world to be seen. Considering a particular handshake between two strangers from a psychological, sociological, or physiological standpoint would each yield a distinct analysis using distinct observed variables. The psychologist sees

something different in that event than the sociologist. The physiology of the hand shaking says nothing about its impact on the relationship between the strangers. This book will offer a particular perspective on eating disorders and their treatment, with the hope that this will allow them to be seen in a new way.

We do not offer this perspective on eating disorders because we believe it to be "right" in an absolute sense. From a functional contextual perspective, this perspective is right to the extent that it facilitates you meeting your chosen goals as a therapist working with individuals with eating disorders. Working with individuals with these kinds of difficulties comes with a number of obstacles. If we could express a hope for you, it would be that you might be more able to approach this difficult work actively and openly in the present moment as a fully conscious human being, without defense, and in service of your chosen values. In other words, our intention is to improve the psychological flexibility of you, the therapist, particularly in the context of assessment, conceptualization, and treatment of eating disorders.

Whether or not this book is "right" in that way will depend on your willingness to receive what this book offers. We offer an opportunity to explore your way of experiencing your clients and their struggles and to notice any opportunities to experience them in new ways. We offer an opportunity to explore your way of interacting with your clients and notice any opportunities to go new places with them. Perhaps you are reading this and noticing that you feel totally flexible in your interactions with clients with eating disorders. Perhaps you are still wondering if this book has anything to offer you. Of course, only you can answer that question. We would, however, encourage you to hold off answering the question just yet. The next few chapters will bridge dominating perspectives on eating disorders with the goal and purpose of ACT for eating disorders. It is our hope that, by the end of those chapters, you will experience enough of a sense of what it is we value in treating eating disorders to determine whether or not this approach is something that would serve your own values.

That being said, this book cannot be all things to all people. And so we've had to make some decisions about exactly what we offer here and to what end. This book will not offer an extensive list of techniques to be adopted out of whole cloth into existing protocols. It will not offer a protocol to be lifted and adapted according to the specific population, setting, or format in which you work. Instead, if we successfully achieve our aim, we will provide an example protocol along with tools to create techniques and even whole protocols that are consistent with this approach. We might also give you a different way of understanding the techniques you already use, and how they may or may not be working.

This book is not a persuasive essay. We are not going to struggle to convince you of the way one should do therapy for eating disorders or even the way one should do ACT for eating disorders. We prefer that you approach this book as an invitation. We will describe the ways that we think about these difficulties and the role they play in people's lives. We will explain how this way of thinking affects the things we do to make the choice for change available to our clients. Finally, we will describe what we've noticed about what becomes possible when taking this approach. We hope the presentation of our approach will enable you to imagine what it might look like if something like this emerged in your own work.

# CHAPTER 2

# What Are Eating Disorders?

You may have years of experience working with clients diagnosed with eating disorders, or perhaps you haven't had much exposure to these difficulties and you're looking for a way to approach them. Either way, this chapter will likely include information with which you are at least slightly familiar. We present it here not because we think it's necessary to understanding ACT but because even at the level of describing eating disorders, you will note the influence of the philosophical foundations of our approach.

Answering the question "What are eating disorders?" presents more of a challenge than would be expected. There are published criteria that define the clusters of behaviors, or symptoms, that are classified as eating disorders. These criteria have been empirically established and are continuously refined to reflect the kinds of behaviors that are observed among clients struggling with these difficulties. Even with these published criteria, however, it remains a challenge for us to describe what eating disorders are from a functional contextual perspective.

The very use of the term "eating disorders" is representative of a formist worldview. As described previously, formist approaches emphasize the classification of events with similar features. Systems like that used in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000) categorize psychological difficulties into clusters of behaviors that tend to be observed together, name these clusters as a particular disorder and the behaviors as symptoms, and establish criteria for what fits and doesn't fit into that category. This method of syndromal classification is of limited use to the functional contextualist as it does very little to facilitate progress toward our goals: the prediction and influence of human behavior.

Defining eating disorders in terms of their diagnostic criteria has some advantages with respect to efficient communication about what is typically observed in individuals with these difficulties. More is gained from a functional contextual perspective, however, from reviewing the functions these difficulties serve and the contexts in which they emerge. Eventually, we will do both, and attempt to bridge the two. In this chapter, we will review eating disorders in terms of the diagnostic criteria, and consider the potential impact of this system on assessment and treatment. Then, we will move from how disordered eating is classified to what it actually looks like. This will prepare us for chapter 3, in which we will consider the functions of these behaviors—where they come from and how they work.

# WHAT WE CALL THEM: SYNDROMAL CLASSIFICATION OF EATING DISORDERS

There are two syndromes that are classified as eating disorders in the *DSM–IV–TR* (2000): anorexia nervosa and bulimia nervosa. In addition, individuals can be diagnosed with eating disorder, not otherwise specified (EDNOS). This category includes eating disturbances that are consistent with anorexia or bulimia but aren't quite frequent, severe, or impairing enough to meet criteria. It also includes eating disturbances that aren't consistent with anorexia or bulimia. Among these is binge-eating disorder, which is diagnosed as EDNOS but is described in the *DSM–IV* as a category for possible inclusion in later editions of the *DSM*.

## *Anorexia Nervosa*

*Anorexia nervosa*, according to the *DSM–IV*, is characterized by weight loss, weight phobia, body-image disturbance, and amenorrhea. The weight loss criterion describes a refusal to maintain body weight at or above 85 percent of normal weight expectancy for age and height. Weight phobia involves an intense fear of weight gain or overweight, regardless of actual weight status. Body-image disturbance must involve one or more of these factors: (1) a misperception of body weight or shape, (2) an overemphasis on body weight or shape for self-evaluation, or (3) denial of the seriousness of current low body weight. Finally, amenorrhea is the absence of at least three consecutive menstrual cycles.

The *DSM–IV* also describes specifiers for two different types of anorexia nervosa: the restricting type and the binge-eating/purging type. Binge-eating/purging type is the appropriate specifier if the individual has engaged in regular binge eating or purging during the current episode of anorexia. Otherwise, the disorder is classified as restricting type.

## Bulimia Nervosa

*Bulimia nervosa*, according to the *DSM–IV*, is characterized by binge eating and compensatory behavior that occur at a minimum frequency and duration, body-image disturbance, and an apparent exclusion of anorexia. The binge-eating criterion describes recurrent episodes of eating that (1) involve more food than most individuals would eat in a similar amount of time and under similar circumstances and (2) are accompanied by a sense of lack of control. Compensatory behavior is recurrent inappropriate behavior that functions to prevent weight gain. Both binge eating and compensatory behavior are required to occur, on average, at least twice a week for three months. Finally, this eating disturbance cannot meet criteria for anorexia nervosa. In other words, the individual cannot be underweight and experiencing amenorrhea.

The *DSM–IV* also describes specifiers for two different types of bulimia nervosa: the purging type and the nonpurging type. Purging type is the appropriate specifier if the compensatory behavior includes regular use of self-induced vomiting, laxatives, diuretics, or enemas to prevent weight gain. Otherwise, the disorder is classified as nonpurging type.

## Binge-Eating Disorder

*Binge-eating disorder*, while currently classified under EDNOS, is described in the *DSM–IV* in terms of proposed diagnostic criteria for inclusion of the diagnosis in future editions of the *DSM*. Binge-eating disorder is characterized by binge eating that is particularly atypical, associated with stress or discomfort, occurs with particular frequency and duration, and is distinguished from anorexia nervosa and bulimia nervosa. Binge-eating episodes are described in the binge-eating criteria in the same manner as in bulimia nervosa. The binge-eating criteria describes recurrent episodes of eating that (1) involve more food that most individuals would eat in a similar amount of time and under similar circumstances and (2) are

accompanied by a sense of lack of control. The atypicality criterion further describes binge eating as being much more rapid than normal eating, occurring when the individual is alone or not hungry, and resulting in physical fullness or disgust, guilt, or depression. These episodes must be associated with stress and discomfort, and must occur at least two days a week for six months. Finally, this eating disturbance cannot meet criteria for anorexia nervosa or bulimia nervosa.

## *Eating Disorder, Not Otherwise Specified*

*Eating disorder, not otherwise specified* is characterized either by atypical patterns or disordered eating or patterns that are subthreshold with respect to the frequency or duration criteria. Among those described are anorexia nervosa but with menses or normal weight; bulimia criteria but without frequency or duration; compensatory behavior without binge eating; and binge-eating disorder.

## *Impact of Syndromal Classification of Eating Disorders*

How we approach understanding a phenomenon impacts how we interact with it. Looking at eating difficulties through the lens of syndromal classification of eating disorders has an impact on how we assess and treat these difficulties.

There are benefits of syndromal classification of eating disorders. First, as is often argued as support for all diagnostic systems, *DSM–IV* diagnoses allow for ease of communication between treatment providers with regard to the basic behaviors being exhibited and potential medical risks. For example, knowing an individual has been diagnosed with anorexia nervosa allows us to assume that she engages in restriction to the point of being underweight and experiencing some kind of difficulties with the way she relates to her body. Second, we can make assumptions about behaviors that are not included as diagnostic criteria but are known to be associated with the syndrome. For example, an individual diagnosed with anorexia nervosa is likely to exhibit perfectionism and be prone to obsessive-compulsive patterns in other domains such as safety or cleanliness. She also may suffer from some of the cognitive impairment that can result from chronic restriction. Finally, we can prepare to assess for medical conditions that are associated with underweight, such as circulation problems or tachycardia.

Having an initial diagnosis in the context of a basic knowledge of the diagnostic criteria and associated difficulties can improve efficiency with respect to assessment and treatment planning. We can tailor our assessment to include those behaviors associated with the diagnosis. We are able to enter the assessment phase with hypotheses about the treatment plan. Particular treatment packages or components have been empirically established as efficacious with individuals with certain diagnoses, including those components that we may need consultation or referral to provide.

Finally, there are also practical considerations that make syndromal classification desirable, if not necessary. Although it is not ideal, treatment planning is often sensitive to issues of compensation. In a managed-care environment, diagnostic labels are generally required for billing and record-keeping purposes.

Despite the benefits of syndromal classification of eating disorders with regard to communication and compensation, its treatment utility is limited. First, EDNOS accounts for the majority of eating disorders diagnosed. The difficulties in this category vary widely in topography, and no medical, pharmacological, or psychosocial interventions have been developed specifically for EDNOS. The current trend suggests that certain patterns captured under EDNOS could split into separate diagnostic categories (as binge-eating disorder will likely do). This could improve reliability of diagnosis to a point. However, the proliferation of diagnostic categories of eating disorders is not likely to increase the treatment utility of syndromal classification. Or, as the authors of *A Research Agenda for the DSM–V* have put it, "Research exclusively focused on refining the *DSM*-defined syndromes may never be successful in uncovering their underlying etiologies" (Kupfer, First, & Regier, 2002, p. xix). The majority of individuals struggling with these difficulties tend to meet criteria for a number of different diagnoses over time (see, for example, Fairburn & Harrison, 2003).

Even with respect to distinguishing anorexia nervosa from bulimia nervosa, the critical features that impact assessment and treatment are not the diagnosis. Certain medical interventions vary in appropriateness and efficacy across eating disorders. For example, treatment plans should address physical complications associated with prolonged purging or chronic underweight. These are not determined, however, by the diagnosis. They are determined by assessing the frequency of purging and the severity of underweight and their impact on physiological functioning. The diagnosis does not contribute meaningfully once this information is known. In addition, certain pharmacological interventions are more appropriate with particular syndromes. For example, pharmacological interventions that tend to reduce

obsessions may be appropriate for clients diagnosed with anorexia nervosa or bulimia nervosa. This would have to be determined, however, based on the role of obsessive-compulsive patterns in the individual's presentation, regardless of the diagnostic label applied.

With regard to psychosocial interventions, clinicians seem to rely more on the individual presentation for treatment planning than on characteristics that meet or do not meet diagnostic criteria. In a revealing study with clinicians closely involved in the movement to establish empirically based treatments, a majority denied reliance on diagnosis as an important factor in treatment planning (O'Donohue, Buchanan, & Fisher, 2000). The lack of treatment utility of syndromal classification is further reflected in the emergence of cognitive behavioral treatments that take a transdiagnostic approach to conceptualization and treatment of eating disorders with good preliminary results (for example, once again, see Fairburn & Harrison, 2003). These treatment protocols guide the clinician's assessment at the level of the behaviors observed, and facilitate the selection of treatment components based on those observations.

Syndromal classification is not only limited with respect to treatment utility, but can actually hamper treatment. When syndromal classification is overemphasized, it can come to be used as an explanation. For example, an individual's chronic restriction and overemphasis on body image for self-evaluation might be construed as occurring because the individual has an eating disorder. This approach is not useful to providers as it offers no direction for intervention. If the diagnosis is, itself, the problem we're seeking to treat, our treatment options are limited to addressing the diagnosis itself: by providing medication that alters brain chemistry, say, or an intervention that changes thoughts and behavior. This reification of a categorical label takes emphasis away from the many other manipulable variables in the client's environment that might be reasonable targets for intervention.

Overemphasis of the diagnosis in this way can also limit our flexibility during assessment and treatment. We might fail to assess for history or behavioral patterns that are not typical of the diagnosis, but that could be relevant to treatment. We might also fail to consider particular treatment components that have been demonstrated to be efficacious with regard to observed behaviors, simply because the treatment has not been demonstrated to be efficacious with regard to the diagnostic category.

In ACT, the goal is psychological flexibility, on the part of both the client and the clinician. We therefore invite you to hold diagnostic categories lightly, considering where they might serve your values and where they might conflict. We argue that you will be able to do more to promote valued living in your clients by observing the particular behaviors they exhibit than

by fitting them inside a particular diagnostic category, particularly if you consider the function these behaviors serve in their lives.

# WHAT THEY LOOK LIKE: DISORDERED EATING AND RELATED BEHAVIORS

Now we will answer the question "What are eating disorders?" in terms of the behaviors that are often exhibited when these diagnoses are appropriate. This includes not only the outwardly observable behaviors but also more subtle behaviors like feelings, thoughts, and perceptions. The outward behaviors that characterize eating disorders include restriction, binge eating, compensatory behaviors, and body-image avoidance. The less easily observed behaviors that characterize eating disorders include affective, cognitive, and perceptual difficulties.

## *Outwardly Observable Behaviors*

The most typical patterns of eating disorders involve one or both forms of disordered eating: restriction or binge eating. Related overt behaviors are compensatory behavior and body-image avoidance, both of which are defined functionally.

### RESTRICTION

*Restriction* is intentional limiting of caloric intake. This occurs on a continuum. Less extreme forms of restriction involve flexible limitation of certain high-calorie foods. For example, an individual might, at the advice of his doctor, avoid saturated fats or simple carbohydrates. More extreme forms of restriction involve rigid adherence to a repetitive diet that often excludes whole food groups. For example, an individual might consume the same five-hundred-calorie diet every day for as long as she can manage.

Restriction tends to become more extreme over time, as the rate of weight loss slows. Restriction is often a way of managing thoughts, feelings, and perceptions about the body and the self. Restriction is thus maintained by weight loss and the positive experience of the body and the self that results. As weight loss slows, restriction must become more extreme to maintain the positive experience of the self and the body. In addition, binge eating and purging become more likely as restriction becomes more extreme and is unable to be maintained.

### BINGE EATING

Binge eating, as was previously defined, involves the consumption of an amount of food that is greater than would be expected in that context. Often binge eating also involves eating much more quickly than is typical. Binge eating occurs on a continuum with respect to objective patterns such as amount of food consumed, rate of eating, and how often it occurs. Some have suggested that the amount of food consumed should be considered not only in context of the situation but also in context of the individual's typical diet. Others have spoken to the importance of the subjective experience of binge eating above and beyond the objective standards of the amount of food consumed. Many experience binge eating as involuntary. It may be that the experience of being out of control is a more critical feature of a binge. Finally, it may be that the *function* of binge eating is what distinguishes it. Although binge eating tends to follow periods of restriction, it also tends to occur in response to emotional discomfort such as sadness or anxiety and to involve foods with appetitive functions (that is, "comfort foods"). Binge eating seems to be more about coping with extreme emotions than about coping with extreme hunger. Often, however, the relief offered by the binge is quickly replaced by physical and emotional discomfort and related thoughts, making compensatory behaviors increasingly likely.

### COMPENSATORY BEHAVIORS

*Compensatory behaviors* are any behaviors that are engaged in to prevent weight gain. This ranges from acute or relatively harmless behaviors like skipping a meal or running an extra mile on the treadmill to physically detrimental behaviors like chronic purging through self-induced vomiting or laxative abuse. Compensatory behaviors are experienced as behaviors engaged to "make up" for eating. However, educating clients as to the ineffectiveness of purging for weight loss and the danger associated with repeated purging seems to have little effect on the behavior. Instead, the short-term consequences of compensatory behaviors seem to be more important with regard to their maintenance. For example, individuals often describe feeling lighter, tighter, or more energetic after engaging in compensatory behaviors.

### BODY-IMAGE AVOIDANCE

Although not described in the diagnostic criteria, disordered eating is sometimes associated with repetitive checking and managing of appearance, which can both be categorized as body-image avoidance. *Body-image avoidance* is any behavior that functions to change or avoid an individual's

experience of one's own body. Body-image avoidance can involve checking one's appearance to relieve rising concerns about appearing overweight. This can range from checking a mirror a couple of times a day to be assured that there are no bulges in one's silhouette to pinching one's waist every ten to fifteen minutes to be assured that no extra fat has accumulated on the body. This either results in relief or evokes additional avoidant behaviors. Body-image avoidance can also involve hiding the body or certain parts of the body by wearing particular clothing that camouflages or conceals perceived defects. For example, clients might wear restrictive underclothes that make their bodies appear more smooth and tight and/or baggy clothing that hides the shape of the body. Body-image avoidance can also involve preventing perception of one's own appearance by avoiding mirrors and other reflective surfaces. This is likely when checking has not provided relief in the past. Finally, considered more broadly, body-image avoidance includes restriction and compensatory behaviors because both function to change how one experiences one's body.

## *Less Observable Behaviors*

Disordered eating is often associated with a number of difficulties that are not so easy to see in the therapy room. This includes patterns of feelings, beliefs, thoughts, and perceptions that, while they are not unique to disordered eating, are part of the constellation of behaviors we call "eating disorders." Clients often experience difficulties with mood and anxiety. They also tend to use avoidant coping in response. Clients experience a high proportion of thoughts about body image. Also, the quality of their thinking tends to be evaluative, repetitive, and categorical. Finally, clients seem to experience perceptual difficulties with regard to their bodies and food, and sometimes experience dissociative difficulties.

### FEELINGS

Disordered eating is associated with emotional difficulties like sadness and irritability. Across diagnostic categories of eating disorders, clients experience difficulty with depressed or unstable mood. Often it seems mood has become associated with body image and eating in such a way as to promote both increased negative affect and increased eating pathology. In this way, dissatisfaction with the body comes to promote low mood, and low mood comes to heighten body-image dissatisfaction. Furthermore, both restraint and binge eating tend to result in increased negative affect, even if they provide short-term relief.

Disordered eating is also associated with anxiety. This is most commonly fear of weight gain, but many experience anxiety related to food, social situations, or obsessions with safety, purity, or cleanliness. Fear and anxiety can have a significant impact on functioning. A majority of clients diagnosed with eating disorders also meet criteria for an anxiety disorder at some point in their lives, most commonly social phobia and obsessive-compulsive disorder (OCD; Kaye, Bulik, Thornton, Barbarich, & Masters, 2004).

Affective difficulties can be described not only in terms of the feelings that are experienced, but also in terms of the responses that those feelings evoke. Feelings are not, in and of themselves, problematic. It is the manner in which clients cope with them that interferes with their functioning. Sadness itself does not interfere with valued living. Binge eating to provide some relief may. Anxiety about appearance in public does not interfere with valued living. Having to pinch four areas of the body ten times each to ensure satisfactory thinness may. Not being able to attend any social event where there will be food may. Disordered eating itself is often a form of avoidant coping, and is associated with other forms of avoidance. Clients tend to respond to aversive emotional states with efforts to change that experience. These can be overt, as described above, but they can also involve cognitive efforts to force oneself to ignore or change feelings.

## BELIEFS AND THOUGHTS

Disordered eating is associated with rigidly held beliefs about what beauty is and what beauty means. For females, beauty is associated with thinness, sometimes extreme thinness. For males, beauty is associated with muscularity. It is also associated with power, control, acceptance, and love by both genders. Although these beauty ideals are shared by many, individuals who struggle with disordered eating tend to hold them rigidly. Clients at less extreme stages might be able to see logically that other body shapes can be beautiful or that people can be loved or have power without being beautiful. However, their adherence to these beliefs can still be inflexible, in that if asked which body is beautiful, they choose the thinner one. If asked which person they would expect to be more fun, smart, or popular, they choose the thinner one. If asked which body they would prefer to have, they choose the thinner one. This kind of inflexibility is also associated with thinking that is evaluative, nonproductive, and categorical.

Disordered eating is associated with evaluative thinking. Clients' thoughts can come to be dominated by evaluations of their bodies and

their eating, what those evaluations mean, and how to change or maintain them. When the body is evaluated negatively (for example, as "fat"), those evaluations are often extended as meaningful about motivation, willpower, and even self-worth. "Fat" comes to mean weak, lazy, and worthless. Not surprisingly, the very next thought is often what can be done to change this. And thinking is soon dominated by plans for avoidance of particular psychological experiences of the body and the self.

Interestingly, the content of the thinking is not what seems to be so important. A similar pattern is experienced when evaluations are positive. The body is evaluated as "thin" or "beautiful," and those evaluations are extended to the self as worthy and good. This is short-lived, however, as the very next thought is how this condition is likely temporary, and what can be done to maintain the body in this positively evaluated state. In this way, it is the overemphasis on those evaluations as true and meaningful, and the efforts to manage them, that seem most distressing and impairing.

Disordered eating tends to be associated with repetitive, nonproductive thinking focused either on the past (rumination) or on the future (worry). Worry and rumination are often related to eating or the body. For example, an individual might find it difficult to stop ruminating about the caloric content of a particular meal that she consumed, or the image of her body in the mirror earlier that day. Similarly, an individual might find it difficult to stop worrying about what she will wear, what she will eat, or how she will avoid eating at a coming social event to which she is committed.

Although worry and rumination are defined by their nonproductive nature, they are often experienced as productive. Many problems that clients have encountered are such that if they think about them long enough, the problem is solved. Worry and rumination are focused on "problems," which, because they occur in the past or the future, cannot really be solved, regardless of how long an individual thinks about them. The topics of worry and rumination also tend to be about things the individual cannot control, such as what food will be present or how other people will perceive her. Even though they are not successful at producing solutions, worry and rumination promise solutions, providing marginal relief from the concern at hand.

Clients may tend to experience rigid, categorical thinking. Opposing categories like good-bad, and fat-thin aren't approached as on a continuum. Rather, the world is experienced in black and white. This means subtle variations and transitions are either missed or experienced as extreme shifts. This is particularly seen with respect to people, experiences, and ideas as they shift quickly from safe to dangerous, as completely as from white to black.

### PERCEPTIONS

Disordered eating has long been associated with perceptual difficulties. For some time, perceptual problems were thought to be a primary pathology behind eating disorders. Clients would describe their bodies as fat when they were clearly underweight. They would describe a normal-sized meal as a ton of food. Psychologists noticed this and started looking for evidence of perceptual deficiencies that might be responsible. They have not, to date, been successful. In fact, individuals diagnosed with eating disorders do not overestimate body size any more frequently than healthy individuals. Instead, a significant proportion are fairly accurate, and many underestimate body size (Skrzypek, Wehmeier, & Remschmidt, 2001). If there appears to be difficulty in perception of food or the body, it is more likely attributable to the cognitive patterns described above.

Disordered eating is associated with perceptual difficulties in the sense of dissociative experiences. Dissociation is a disruption of how sensations, thoughts, and feelings are perceived. Clients often experience disconnection from their body, their environment, their behavior, and their thoughts, feelings, and memories, as well as from their sense of self. They might describe struggling to recognize themselves in the mirror or to feel like a participant in the world. They might be unable to describe feelings that are apparent from their overt behaviors. They might describe a memory that is arguably distressing and report no feelings about it. When severe, dissociation can be accompanied by persistent misperceptions of time, place, and person.

## CONTEXT AND UNDERSTANDING

We've mentioned over and over that we are taking a contextualist approach to understanding disordered eating and related behaviors. We've proposed that we don't really understand an event until we understand the context from which it emerges. Remember, understanding from this perspective means that we could predict and influence the behavior with precision, scope, and depth. Understanding means that we know when the behaviors we care about are likely, and we know how to change the context to make them less so. In other words, from a functional contextual perspective, we've said very little that would help you to understand disordered eating. We've simply laid the groundwork for you to be able to choose your targets. As an alternative, disordered eating and related behaviors can be considered functionally. In the next chapter, we will round out your understanding of disordered eating by considering the context that evokes and maintains it.

# CHAPTER 3

# Where Do Eating Disorders Come From and How Do They Work?

In the last chapter, we reviewed how disordered eating is classified and what it tends to look like. Now we shift our approach to consider where eating disorders come from and how they work. This question could be answered a number of ways. For example, we could consider genetic or hormonal variables that make disordered eating more likely. This book, however, is about psychotherapy. And unless the field drastically changes, psychotherapists are not doing gene or hormone therapy. Our point of impact is the context. We attempt to create a context in which behavior change is possible. So, to us, the question "Where do eating disorders come from and how do they work?" is about context. From what kind of contexts does disordered eating emerge? What kind of experiences would cause someone to develop and maintain these patterns?

## NOTES ON CONTEXT

Before answering this question, we'd like to start by reviewing what we mean when we refer to "context" in our analysis. Loosely speaking, context includes any event that affects the probability of the behavior. This definition is not quite adequate, however,

Call to mind a behavior—reading this text, for example. Now think of the events that increased the probability of you reading this text in this

moment. They could be fairly proximal events. Maybe you just finished another book. Maybe you had a cancellation this morning. Maybe it's your day off. Maybe you just took on a new client who is struggling with disordered eating. Maybe you've felt dissatisfied with your standard approach to treating clients who are struggling with disordered eating.

They could also be more distal. Maybe you knew someone personally who had or was struggling with eating or body image. Maybe you were touched by a clinical experience in this area early on in your career. Maybe you really love learning new things. Maybe you never feel like you know quite enough to do your best work.

They could be more distal still. Maybe you had an amazing psychology professor your first semester of college. Maybe you saw a cool movie about a psychologist when you were ten. Maybe your dad always had a book in hand. Maybe it rained on your fifteenth birthday and ruined your swimming party. Maybe you were bullied for your appearance or mannerisms.

If we were to propose that you could not fully understand the act of reading this text in this moment until you accounted for every aspect of the immediate and historical context in which that reading is couched, we would quickly feel the burden of the interrelationships of far more events than we could possibly describe. The conclusion would, in the end, be that every event that has ever occurred has, either directly or indirectly, impacted the probability of reading this text in this moment. This may be a very true conclusion in some sense; however, it does not satisfy our goal in getting into this analysis in the first place—prediction and influence.

From a functional contextual perspective, the analysis would not categorize as "context" every event that impacts the probability of the behavior. An adequate account of context should allow for prediction and influence with precision, scope, and depth. If we want to understand you reading this text in this moment, we would need to account for enough context so that we could predict when you read what, and change the context to influence that reading behavior. The same is true of disordered eating. If we want to understand disordered eating and related behaviors, we need to account for enough of the context in which it takes place to predict when disordered eating occurs and to influence its occurrence.

Of course, this contextual behavioral analysis would be somewhat different for each individual. Other readers have come to this text at this moment with learning histories that are different from yours, and thus reading this is serving some slightly different function in their lives. Just as you are reading the same book but probably with different functions, so could two individuals come to exhibit behavior that looks the same, but that serves a different function in their lives. That being said, most of our

learning histories overlap enough so that we can say general things about the contexts that tend to contribute to disordered eating and related behavior. We encourage clinicians, however, to perform this analysis separately for each individual they meet by asking several questions:

- From what kind of context did this particular eating repertoire emerge?
- What kinds of experiences could this person have had that would lead to this behavior?
- What kinds of things might need to change in a client's life for new behavior to emerge?

Questions like these—questions that can help clarify the context in which certain behaviors occur and work for your clients—can be important jumping-off points during the early phases of treatment.

## ANTECEDENT AND CONSEQUENTIAL CONTROL

From a contextual behavioral perspective, disordered eating and related behaviors are learned. Whether we are considering negative evaluations of the body, worry and rumination about appearance, binge eating, anxiety, or wearing baggy clothing, we assume that behavior is learned. These behaviors came to be highly probable because of particular events that were experienced. That context can be classified into different kinds of events, based on when they occur and how they affect behavior. First, the probability of a behavior can be affected both by events that precede it (antecedents) and by events that follow it (consequences).

*Antecedents* are events that precede a behavior, which make the behavior more probable. Some antecedents elicit a particular behavior without any learning. We often refer to unlearned behaviors under strong antecedent control as *reflexes*. These behaviors don't tend to vary much between individuals. For example, most typically developing humans, even small children, will startle to a sudden, loud noise. The noise elicits startling without any learning.

Most antecedents, however, are learned. For example, if a flash of light precedes a sudden, loud noise enough times, the light alone will come to elicit startling. If we observed a flash of light followed by an individual startling, we could hypothesize that the individual had a particular learning

history that contributed to that relationship between the light and the startling. We could then test that hypothesis by flashing the light and observing the person's behavior.

Learned antecedents are shared between individuals to the extent that those individuals have had the same learning history. We probably don't typically startle to flashes of light (a flash of light is not an antecedent for startling for us) because we don't share that learning history. Many of us probably become at least a little anxious if we see a moving blue light, particularly if it is accompanied by a wailing siren. Many of us have had at least some experience with the lights on a police car. Someone who had never had an experience with a police car or heard about a police car would be unlikely to exhibit that same anxiety.

Part of our analysis of disordered eating will include a consideration of antecedent control. Specifically, the analysis will consider questions like these:

- What kinds of events elicit the sadness, irritability, or anxiety observed with eating disorders?
- What kinds of events elicit evaluative, nonproductive, or categorical thinking?
- What kinds of events elicit dissociative experiences?
- What kind of learning history would account for this elicitation?

The examples above were chosen to be particularly simple. For example, startling is under strong antecedent control because it is relatively insensitive to consequences. If we trained you to startle to a flash of light, we could offer you one thousand dollars not to startle, and—no matter how broke you were—it would affect the probability of you startling very little. Often, however, behavior is under both antecedent and consequential control. Many antecedents increase the probability of another kind of behavior by signaling the availability or value of consequences for that behavior. For example, the lights on a police car might elicit anxiety. They might also occasion brake pressing. In this case, brake pressing would increase in the presence of the lights on a police car because of the consequence of brake pressing. For example, it might be true if we had a history of receiving citations for gas pressing and avoiding citations by brake pressing.

*Consequences* are events that follow a behavior, which change the probability of it occurring again. Consequences can increase or decrease the probability of a behavior, referred to as reinforcement and punishment, respectively. Consequences can also involve the introduction of an event

into the context (positive consequence) or the removal of an event from the context (negative consequence). Reinforcement and punishment can both be either positive or negative.

*Positive reinforcement* involves introducing an event following a behavior and thereby increasing the probability of that behavior. For example, a child might be more likely to cry if crying has, in the past, resulted in exclusive attention from his mother. Crying has been reinforced by the introduction of attention. In this example, crying could be under both antecedent and consequential control. For example, the child's crying might be more likely only when his mother is present. The same increased probability of crying would not be observed in the presence of his father if his father did not offer the same attention when the child cried. In this way, the mother's presence occasions crying, and the mother's attention reinforces it.

*Negative reinforcement* involves removing an event immediately following a behavior and thereby increasing the probability of that behavior. For example, the mother might be more likely to pick up her crying child if this has, in the past, resulted in cessation of the crying. Picking up has been reinforced by removal of crying. Picking up the child could be under both antecedent and consequential control. It could be that the mother never picks up the child except when the child cries. In this case, crying occasions picking up, and removal of crying reinforces it.

*Positive punishment* involves introducing an event following a behavior and thereby decreasing the probability of that behavior. For example, a child might be less likely to touch a glass if, in the past, he has been yelled at for reaching toward it. Glass touching has been punished by introduction of the yelling. Glass touching could be under both antecedent and consequential control. It could be that the child's glass touching is only reduced when his mother is present. The absence of his mother might signal that punishment is not available, so glass touching might be at a higher probability.

*Negative punishment* involves removing an event following a behavior and thereby decreasing the probability of that behavior. For example, a child might be less likely to throw his food if, in the past, his mother has removed his plate for throwing food. Food throwing has been punished by removal of the plate of food. Food throwing could be under antecedent and consequential control. It could be that the child's food throwing is only reduced when he has food left on his plate. The absence of additional food might signal that punishment is not available, so food throwing might increase in probability.

Part of our analysis of disordered eating will include a consideration of consequential control. Specifically, this analysis considers these questions:

- What kinds of events occasion restriction, bingeing, compensatory behaviors, and body-image avoidance?
- What kinds of events reinforce these behaviors?
- What kind of learning history would account for this?

Contextual events are not antecedents or consequences in and of themselves. They are defined by their relationships with the behavior in question. For example, the mother's attention, which was a consequence for crying in an example above, could alternatively be an antecedent for joy, or it might occasion babbling. Similarly, the removal of the plate, which was a consequence for food throwing in an example above, could alternatively be an antecedent for sadness, or it might occasion a tantrum.

## *Behavior-Behavior Relations*

In the above examples, the antecedents and the consequences are located outside of the body—a sudden loud noise, a mother's presence, the removal of a plate. Context can also include psychological experiences that are part of the behavioral stream. Certain thoughts or feelings may elicit other thoughts or feelings, or may occasion other behaviors. Certain thoughts or feelings may also reinforce certain overt behaviors. For example, you may have the thought *This is confusing*, which elicits the feeling of frustration, which occasions putting the book down, which is reinforced by relief. In this example, all of the events in the analysis are behaviors.

From a contextual behavioral perspective, however, the analysis above is incomplete because, although it allows for prediction (that is, we can predict when you will think *This is confusing*, when you will feel frustration, and when you will put the book down), it does not allow for influence. If our goal was to keep you reading, we would have to intervene either on the thought *This is confusing*, the feeling of frustration, or the relationships among the thought, the feeling, and the putting down of the book. We cannot intervene on these behaviors or on these relationships among behaviors except by intervening on the context. We would thus be left with one more question to answer: what would be the antecedent that elicited the thought *This is confusing* and the feelings of frustration *and* occasioned putting the book down? From a contextual behavioral perspective, the causes of behaviors are located outside of the behavioral stream.

Intervening on the context in which thinking *This is confusing*, feeling frustration, and putting the book down took place could result in changes

in those behaviors. We could intervene directly on the thinking and feeling. We could cut all this behavior analysis nonsense from the next edition. We could provide you with a companion guide that simplified the more difficult sections. We could suggest skipping any section that seemed difficult. Each of these would be a manipulation of context that might result in less instances of your thinking *This is confusing* and feeling frustration, and subsequently less instances of you putting the book down.

We could also intervene directly on putting the book down by intervening on the consequences. We could pay you one thousand dollars every time you read a chapter. We could restrict your access to your morning coffee until you read for twenty minutes. We could shock you when you tried to put it down. Each of these would be a manipulation of context that might result in less instances of you putting the book down, even when you thought *This is confusing* and felt frustrated. In this case, not only did the overt behavior change because we changed the consequences, but also the relationship of the thoughts and feelings with putting the book down changed. Thinking *This is confusing* elicited frustration, but frustration no longer occasioned putting the book down.

We could intervene directly on the relationships between thinking, feeling, and overt behaviors. For example, we could provide experiences that would make it more likely that you could think *This is confusing*, feel frustrated, and continue with your previous rate of reading, even if it resulted in increases in frustration. In this case, the thoughts and feelings and relationship between them would stay the same, but the relationship of the thoughts and feelings with the overt behavior would change.

## *Appetitive and Aversive Control*

Contextual events can also be distinguished into two general categories: appetitives and aversives. *Appetitives* are events that, when introduced, positively reinforce behavior. The removal of appetitives negatively punishes behavior. In the examples above, the mother's attention and the plate of food were both appetitives. In addition to their role in consequential control, appetitives have eliciting effects. In general, this includes an increase in behavioral sensitivity and flexibility. Humans, like most organisms, are more sensitive and receptive to the environment when appetitives are present. In many cases, behavior under appetitive control is sensitive to a broader range of events (exceptions being behaviors that are under appetitive control in an environment of high deprivation—heroin for a drug user or cookies for a dieter, for example). In these cases, behavior

under appetitive control is more flexible and able to respond to an ever-changing context.

*Aversives* are events that, when introduced, positively punish behavior. The removal of aversives negatively reinforces behavior. In their examples above, the crying and the yelling were both aversives. In addition to their role in consequential control, however, aversives have eliciting effects. In general, this includes a decrease in behavioral variability and flexibility. Humans, like most organisms, narrow behavioral sensitivity when aversives are present. Behavior under aversive control is sensitive only to aversive events and avenues for escape, which means behavior is rigid and unresponsive to many changes in context.

One thing that is unique about humans is that appetitives and aversives don't have to be physically present to be psychologically present. Our capacity for language and cognition allows us to respond to psychological events like thoughts and feelings much as would we respond to other events. When appetitive thoughts, feelings, and memories are present, our behavior is likely to be more sensitive to context (again, except when the appetitives are in a deprivation environment). When aversive thoughts, feelings, and memories are present, our behavior is likely to be more rigid.

The distinction between appetitive and aversive control is easily demonstrated experientially. We encourage you to try it yourself. Call to mind the last experience you had that you would work to experience again. Maybe it was a quiet moment alone, or an intimate interaction, or an exciting physical activity. Just recall some recent moment in your life that you'd choose to have again if you could. Once you have a specific one in mind, close your eyes and see if you can let the world fill in around you as it was in that moment. Let anything you could see, hear, feel, smell, or taste then be present now in this moment. When you feel as if you've got a good sense of that moment as it was, gently breathe that moment in and, on the next exhale, let that moment pass from you.

And now, just let yourself reflect on this exercise without trying to get it right and without thinking too much about what the answers mean for now. How many details were you able to call to mind? Were you able to call to mind the things you saw? The things you heard? The things you felt in or on your body? How about any thoughts you were having? Any emotions? Try it again, if you like. Just bring the experience to mind and see how many details you can call up. If it helps, take a pen and jot down your reactions from this exercise.

Now call to mind the last experience you had that you would work to never experience again. Maybe it was something frightening, or frustrating, or sad. Just recall some recent moment in your life that you would choose

to never have to go through again if you could. Once you have a specific one in mind, close your eyes and see if you can let the world fill in around you as it was in that moment. Let anything you could see, hear, feel, smell, or taste then be present now in this moment. When you feel like you've got a good sense of that moment as it was, gently breathe that in and, on the next exhale, let that moment pass from you.

And now, let yourself reflect on this exercise, without trying to get it right and without thinking too much about what the answers mean for now. How many details were you able to call to mind? Were you able to see the world as it was in that moment? Hear it? Feel it? Were you able to call to mind the thoughts you were having? Emotions? Try it again, if you like. Just bring the experience to mind and see how many details you can call up. If it helps, take a pen and jot down your reactions from this exercise. And, whenever you're ready, read on.

Now we'd like you to compare your experiences between the two exercises. Which exercise was easier to do? Did you find yourself struggling to come up with an example for one? Did you find yourself struggling to let the details fill in? When? Were certain details harder than others? Was it hard not to get distracted? What kinds of things distracted you in the first exercise? And in the second exercise? If you repeated either, what did you notice when you repeated it? Was there anything else you noticed that was different between the first exercise and the second?

Many people will find the first exercise relatively easy, especially if they have any experience with guided imagery or meditation. They are able to call to mind the environmental events relatively easily. They move easily between different details from the visual to the sounds to the feelings. They are often distracted by sounds in the room or other thoughts, but easily return to the exercise without much struggle.

Many people will find the second exercise a bit different. They may call to mind some aspects of the event easily and then begin to struggle on one particular detail. They may find themselves thinking, *Who else was there? I know there was one other person…* or *And what did he say that made me so mad? I said this then he said… Shoot, and I was infuriated! What was it?* They also might find that they feel "done" with the exercise more quickly. Some switch events several times, trying to come up with a "better" example for the exercise. If they are distracted, many find themselves distracted by problems to be solved, like when they are going to get their oil changed, or why this exercise is even in here, or why things like this always happen to them. In short, when faced with aversives, many people find themselves caught in some kind of struggle. If you didn't—great. We'll give plenty of examples of what the struggle looks like in your clients and in your own experience.

## *Aversive Control and Disordered Eating*

From an ACT perspective, psychological inflexibility involves the dominance of aversive control at the expense of appetitive control. Disordered eating and related behaviors are typified by aversive control. An individual learns about herself and her body in such a way that her body comes to function as an aversive. Her experience of herself gradually narrows until it is almost entirely limited to her body. Her sense of self in terms of her qualities, her roles, her relationships, and her dreams drops slowly away as her self-as-body increases in importance. Her experience of her body becomes limited to those perceptions that are related to maintaining a particular physical appearance. The wind on her face is not nearly as important as sensations of hunger or fullness. Appreciation of her body's ability to cool her by sweating is not nearly as critical as disgust with her body's exhaustion. Her ideas of what is good become increasingly focused on beauty, and her ideas of what is beautiful become increasingly focused on weight and shape.

This individual's life narrows as her thoughts, feelings, and attention become increasingly body focused, and her behavior becomes increasingly organized around avoidance of her body image. Changing her appearance, avoiding seeing herself, dieting, exercising, restricting her social interactions, and so on become far more critical activities than her work or education, her relationships, or her hobbies. In some cases, even the work she does do in other domains can come to have an avoidant function, allowing some relief from the struggle with the body or some way of keeping others' focus off of her body.

Similarly, this individual learns about food and eating in such a way that their functions become far more complicated than a biological necessity. For the most part, food, in general, becomes an aversive, and eating, under aversive control. Particular foods become "dangerous" and others "safe." Even the safe foods are not appetitives, in that they are only safe in particular quantities, and can even be dangerous when they seemed safe. Eating and other interactions with food come to be organized almost exclusively around avoidance, either of body image or other aversive experiences that are more salient, intense, or otherwise dominant in the moment. In this way, an individual might be highly likely to binge in one moment as self-doubts, anxiety, and painful memories are present, and far more likely to purge and restrict in the next moment as sensations of fullness, evaluations of her appearance, shame, and guilt become more salient and more intense.

And as we sit with this individual, we are left with this question: what kind of learning history would account for this kind of narrowing from a

full, rich experience of the self and the world to a life dominated by the aversive control exerted by food and the body?

# LEARNING DISORDERED EATING

From a behavioral standpoint, disordered eating emerges not only from the immediate context in which the body and food exert aversive control, but also from a historical context in which those aversive functions came to be. If an individual exhibits disordered eating, we assume that historically these behaviors have worked. Sociocultural, interpersonal, and familial factors have comprised a world in which disordered eating saved him from something insufferable. Again, this is an analysis that we could carry out on each client individually. We describe here factors that are common to clients exhibiting disordered eating. This analysis is not, however, exhaustive, nor can it be universally applied.

## *Learning Beauty and Its Significance*

How do we know what is beautiful? There are certain characteristics, such as symmetry of facial features, that seem universally attractive. However, apart from a few basic characteristics, there's considerable variability in what is beautiful across races, genders, cultures, and generations. From a contextual behavioral perspective, this variability is accounted for by different learning histories. The definition of beauty is learned in a particular societal, cultural, and verbal context.

From dolls and children's books to billboards and movies, thousands upon thousands of images of the human form pour from our media. And some features are simply more common than others. Most of the images we see just don't vary much in the way their bodies are shaped. The women we see in magazines, on billboards, on television, and in movies are, for the most part, thin—significantly thinner than most actual women. And the men we see in magazines, on billboards, on television, and in movies are, for the most part, muscular—significantly more muscular than most actual men. And we humans prefer what is familiar. From these images emerges a standard of what a body does, or should, look like. As we stare at our own bodies in the mirror, we apply this standard to what we see. Any deviation from the shape we've been exposed to over and over throughout our lives is likely to be experienced as unattractive.

It's not just familiarity, however. There are also some messages about what is beautiful that are more explicit. If there is variation in appearance between the characters depicted, the character with the friends and the partner and the job and the money is the one who meets that thin beauty ideal. And the message seems to be received. When appearance is the only information available, people judged as attractive are also more likely to be judged as kind, smart, funny, popular, and so on. Sometimes the message is even more direct: "Tired of those fat, flabby thighs? Try Insta-slim!" And we see an attractive woman testify to how miserable she was when she was overweight as the screen splits to reveal a picture of this lovely woman overweight with her hair disheveled, no makeup, and an outfit from thirty years ago. The message in the popular media is clear—beauty results in happiness and prosperity, and *this* is what is beautiful.

And sometimes the message is not just in the media. From the moment children are born in our culture, they are bombarded with references to not only beauty in general, but their own beauty: "Aren't you cute?" "Such pretty blue eyes…" "She's going to have good hair. You can tell." Or if there is something unattractive in the child's appearance, "You're much smaller than your brother, aren't you?" Sometimes the family environment emphasizes appearance to the exclusion of other characteristics. A child might receive an award for her academic success and be told by her parents, "You looked so beautiful up there. I'm glad we got that new dress" instead of "I'm so proud of how hard you've worked!"

Social groups outside of the home present clear social contingencies based on beauty. Attraction and popularity are closely linked to beauty from a very young age. A child who already pays attention to appearance can learn early on just how important being beautiful is. Attractiveness biases have been demonstrated in children's classrooms and sports teams. The beautiful child is not only assumed to be kind, smart, funny, and popular, but also is treated as if he is—and is, thus, more likely to become so. Sometimes appearance seems relatively insignificant for an individual child until puberty, when his physical maturation (or lack thereof) is likely to be a topic of discussion among peers with serious social implications.

From a contextual behavioral perspective, disordered eating and related behaviors are likely to emerge from a context in which beauty is repeatedly and exclusively associated with extreme body shapes *and* established as a contingency for social acceptance. Anyone who grew up in modern Western culture has been exposed to an extreme beauty ideal. Some get more exposure to this ideal than others, however. For some, this ideal is exemplified in the home among family members and at school among peers. Some are never exposed to a model of beauty that is an exception to this ideal.

In addition, some individuals' bodies are more discrepant from this ideal, making it even more extreme and more distressing. Furthermore, beauty is closely linked in some contexts with social acceptance. Social acceptance is a primary reinforcer for human beings. Without fur, fangs, or claws, it's adaptive for us stick together for warmth and protection. Even now that buildings are heated and predators are few, we need social contact to survive. For some people, satisfaction of this need is established very early on as contingent on beauty and little else.

## *Learning Food and Its Significance*

Just as the meaning of beauty is bound in a social context, so is the meaning of food and eating. Food is a biological imperative. Eating keeps us alive. We also *learn* to eat, however. The functions of eating expand far beyond just keeping us alive. Food becomes more than just sustenance.

Although our feeding repertoire begins as a series of reflexes, feeding becomes operant almost instantly and sensitive to social reinforcement. As we mature, the functions of food and eating expand. Initially, our poor vision does not allow us to see facial expressions except in close proximity, so much of our social behavior is learned in the context of feeding. Early social exchanges like cooing and mutual gazing are often learned during and after feeding. The infant makes a face or noise that the mother finds pleasant and the flow of milk increases, along with stroking, squeezing, or other changes in physical contact that reinforce these behaviors. Soon the mother's reaction alone provides enough reinforcement to maintain what have become social exchanges. When a mother experiences frustration, discomfort, or pain while breastfeeding, she may respond to the infant's early feeding behaviors with stiffness or grimacing, along with decreased milk flow. Unpleasant attempts at feeding may be followed by the mother's avoidance of the infant, as she tends to her own physical and emotional needs. From our very first meal, much of our social reinforcement is contingent on feeding behavior. In addition, the respondent functions associated with this primary social contact—feelings of comfort and the relaxation response, *or* feelings of discomfort and anxiety—become associated with food.

This link between social reinforcement and eating isn't exclusive to children who are breastfeeding. Parents who do not breastfeed are encouraged to hold the infant similarly and allow for similar developmental experiences. They are likely to experience the same frustration and withdraw social reinforcement when the infant does not eat properly. Even after their child's infancy, many parents become greatly distressed when their child doesn't

eat in a way they feel is healthy or appropriate. Eating certain amounts of food or certain kinds of food or at certain speeds is often differentially reinforced. As children mature and become verbally competent, eating can become increasingly meaningful. The child who eats appropriately might be a "good girl." He who eats too little might "eat like a bird." She who eats too much might be "pigging out." Eating is often couched as a direct expression of appreciation for the parent who cooked the meal—"I cooked all this food and you're not even going to eat it?" Children can easily learn that their approval and acceptance in their family depends on how they eat.

This relationship between social acceptance and eating is maintained over the life span and well beyond the family unit. Some foods are traditional to certain cultures, and preparing, serving, and partaking in these foods can identify oneself as a member of this culture. If you are from southern Louisiana, serving chicken and sausage gumbo to your dinner guests might have a different meaning than serving steaks and pasta. The child who brings curry to school in his lunch box is perceived differently than the child who brings a ham sandwich and potato chips. The teenage girl who orders a steak and loaded baked potato on a date makes a certain impression even if she just happens to be hungry. In some ways, we act as if you really are what you eat.

The appetitive respondent functions associated with food can also be further strengthened and elaborated over the life span. Commercials present some foods as exciting, others as pleasurable, others as comforting. Some foods seem to make life more fun or make you more sexually appealing. Even outside of the media, food is associated with emotional events. Birthday, holiday, and wedding celebrations are often built around the preparation and serving of food. Imagine the Thanksgiving without a turkey or the wedding without a cake. In some agricultural areas, communities gather annually to celebrate the rice, or sugarcane, or sweet potatoes that have been harvested that year. The central activities are music and food. From the girl who's just been dumped to the father who's just been widowed, food is offered in consolation when someone suffers with illness, injury, sorrow, or grief. This emphasis on food for feeling good can have different effects for individuals for whom eating has had aversive consequences.

From a contextual behavioral perspective, disordered eating and related behaviors are likely to emerge from a context in which eating is established as a contingency for social acceptance and as a contingency for appetitive emotional experiences. Anyone who grew up in modern Western culture has been exposed to social and emotional contingencies around eating. For some individuals, however, these contingencies are extreme and to the exclusion of other contingencies. Some individuals might not learn many ways other

than eating to please others. They might be exposed to multiple contexts in which preparing food and eating food that's been prepared are the primary acts of love. They might not be exposed to contexts in which other things that they do are socially reinforced. Additionally, some individuals might not be exposed to many ways other than eating to regulate their emotions. For some, eating (and not eating) is the only way to gain relief when life hurts.

## *Learning Feelings and Their Significance*

Finally, just as we learn about beauty and food, we also learn about our own psychological experiences and what they mean. Almost from birth, our thoughts and feelings are labeled: "Oh! He's a mad baby." "She loves her mommy, doesn't she…" Soon we are asked to label them ourselves: "Are you sad?" And it doesn't take long for us to learn that labeling some of our experiences results in efforts to change that experience. If I show my mom that I'm happy, the situation usually stays the same, or may even get better, if she gives me a smile and a squeeze to show that she's happy now, too. If I show my mom that I'm sad, though, the world changes, as she tries to do something to make me feel better. It may be that she stops what she's doing to talk to me, to offer me different things I might need. It may be that she looks exasperated and demands that I "suck it up." As I become more verbally competent, she may offer reasons why I shouldn't feel sad, or things I should have done to prevent it. It soon becomes apparent that some psychological experiences are deviations from the way things should be. Happiness is normal and good, and anything else is not.

This assumption that happiness is normal is often maintained across a number of contexts. When we notice that someone is angry or sad, we ask, "What's wrong?" as if these feelings indicate problems to be solved. The media guarantee our happiness in the form of beauty, food, digital cable, life insurance, and next year's sport utility vehicle. Billions of dollars across hundreds of industries try every day to sell us happiness. And if all that doesn't make us happy, the something that's "wrong" must be us. The most common models of mental health systematize this assumption of happy normality, pathologizing any deviation from happiness that seems to impact functioning as a disorder or illness and targeting the reduction of these feelings in treatment. And so we enter into a conspiracy of silence through which our suffering is a personal defect to be hidden.

From a contextual behavioral perspective, disordered eating and related behaviors are likely to emerge from a context in which the functions of certain psychological experiences are established as aversives and social

acceptance is established as contingent on appetitive psychological experiences. Psychological pain is not just pain. It comes with pain about being in pain. Although this is common to all individuals in Western culture, it touches some individuals differently. Some individuals are in more pain than others. There are more aversives in their world, in their context outside the skin, inside the skin, or both. Some individuals have been exposed mostly to contexts in which social reinforcement was at a premium. They haven't had the opportunity to learn many different ways of seeking the acceptance of another. Some individuals have been threatened with more extreme costs associated with feeling pain. For those with trauma in their histories, particularly repeated trauma, pain is not merely undesired and abnormal, it is deadly. Finally, some are never exposed to contexts in which something valued was borne of pain. For them, if something is painful, all possibility of something good is lost.

## HISTORICAL CONTEXT AND CLINICAL CONVERSATION

From a contextual behavioral perspective, disordered eating and related behaviors are learned. One of the challenges of clinical work from this perspective is considering how this individual learned them. From an ACT perspective, making the historical context a part of the clinical conversation is important for several reasons. The historical context can provide direction for intervention, helping the therapist to fit principles and techniques of the approach to the client's experiences. Disclosing one's history can be an intervention itself, if the therapist provides a context in which the client feels heard and understood. Finally, really hearing the client's story, getting even a glimpse of the context from which his disordered eating emerged, can create a context for the therapist in which she is more likely to see and appreciate a whole person who emerged from a broken context. All that being said, this history often becomes part of the conversation slowly, over the course of therapy. Periodically, perhaps in moments when the client seems really stuck on how broken she is or how hopeless therapy will be, the therapist might ask something like "I want you to pause for a minute and let yourself look back over your life—when was the first time you remember feeling this way?"

# CHAPTER 4

# The Goals and Targets of ACT for Eating Disorders

The last chapter provided an overview of how eating disorders work and where they come from. In this chapter, we will consider the goal and targets of ACT for eating disorders with a particular emphasis on how these functional capacities are observed and measured. ACT offers a particular analysis of psychological difficulties, which creates the foundation for particular interventions. From a contextual behavioral perspective, there is no correct analysis of eating disorders and therefore no correct intervention. The "correct" analysis is that which works, and workability is defined in terms of chosen goals. This chapter will review the goal of ACT for eating disorders and the targets that comprise this goal—in other words, it will provide criteria for workability from an ACT perspective.

## THE GOAL OF ACT FOR EATING DISORDERS: PSYCHOLOGICAL FLEXIBILITY

As described in chapter 1, the goal of ACT is psychological flexibility. ACT defines psychological flexibility as actively and openly contacting ongoing experiences in the present moment as a fully conscious human being, without defense and as it serves one's chosen values.

## *Tracking Psychological Flexibility*

Psychological flexibility can be assessed as a functional dimension of ongoing behavior moment to moment. This would be similar to assessing a runner's form in terms of the ongoing process during a particular run. With proper technology, his form could be observed and assessed from one moment to the next. The assessor could observe how ongoing changes in context, like temperature or focus, affected the runner's form. The assessor could also manipulate context systematically and observe resulting changes in form. The same is true of psychological flexibility. In ACT, one job of the clinician is to observe moment-to-moment changes in psychological flexibility as context changes and is changed.

Psychological flexibility can also be assessed as a functional capacity in an individual's repertoire. This would be similar to assessing a runner's form in terms of his running repertoire. Any single observation would be considered a sample from all possible running forms of which the runner is capable. Multiple observations over time would give the observer an idea of how this capacity is distributed probabilistically. The runner will have some average form. If he is very consistent, the variance of his form will be low. That is, he will deviate from this only slightly. If he is observed enough, however, even the most consistent runner will also exhibit some extremes—times when his form is exceptionally good or exceptionally bad. From a contextual behavioral perspective, his variability in form is attributable to fluctuations in context. The same is true of psychological flexibility. In ACT, we consider our observations samples from a behavioral repertoire and, based on these samples, develop estimates of the individual's baseline capacity for psychological flexibility and systematic variations across different contexts.

The process of estimation described above requires the establishment of some way to measure and quantify psychological flexibility. Multiple methods of assessment exist, each with its own advantages and disadvantages.

Psychological variables are often measured using self-report questionnaires. For example, the Body Image—Acceptance and Action Questionnaire (BI-AAQ; Sandoz, Wilson, & Merwin, 2010) includes items to which clients respond with their perceptions of their own psychological flexibility with body image. You might also observe indications of perceived changes in psychological flexibility based on the content of what clients say in session. For example, a client might describe "shutting down" in situations in which eating is a central activity. Self-report allows for measurement of aspects of psychological flexibility that are difficult to quantify and to which only the

client is privy. For example, it would be challenging to measure how often an individual tries to avoid "feeling fat" without just asking him directly. There are, however, several sources of error. Estimates of psychological flexibility based on self-report are only valid to the extent that the individual (1) discriminated psychological flexibility in his own historical behavior and (2) reported honestly and accurately on his self-assessment.

Another approach is to rely on aspects of psychological flexibility that are publicly observable. The first step of this approach involves considering what psychological inflexibility and psychological flexibility look like for the client. Because psychological flexibility is a functional dimension of behavior rather than a topographical one, it will take different forms for different people. We can identify the overt behaviors that indicate psychological flexibility for a particular client by setting conditions for the client to contact aversives, appetitives, and awareness of her own perspective. For example, we might ask about what troubles bring the client into therapy. This not only allows us to collect information about the client's reasons for seeking therapy, but it may also allow us to observe the client's behavior when she discusses things that are aversive. Any response the client emits, even if it becomes apparent that she is not contacting anything aversive, is data. The client's responses to ongoing changes in context will allow us to estimate her capacities for psychological flexibility and the kinds of contextual events that influence variations in ongoing psychological flexibility.

Direct observation of this type has several advantages. Units of measurement are smaller when estimating psychological flexibility in a single instant rather than attempting to grossly measure the client's capacity for psychological flexibility. This is advantageous because the smaller the units of measurement, the more precise the measurement can be. Imagine the difference between a tape measure that has demarcations only in meters versus one that includes centimeters and millimeters. It also allows for a greater number of measurements. A stream of behavior can be sampled multiple times during a session across a range of contextual conditions. The more data we collect, the more confidence we can have in our estimates. Finally, direct observation avoids problems that are inherent in self-report instruments. Direct observation is subject to its own sources of error, however. Estimates of psychological flexibility based on direct observation are only valid to the extent that we are able to discriminate and estimate (1) our unique influence as an aspect of the client's context and (2) our own biases and how they may influence our observations.

Because different approaches to assessment have different advantages and disadvantages, it is recommended that multiple approaches be used to

measure psychological flexibility. Imagine a fisherman trying to collect fish. He has five nets, each with gaping holes in different parts that would allow fish to escape. Using any one net means that the fisherman would miss out on some fish. However, by layering the nets, one on top of the other, it becomes far less likely that he will miss any fish, as the holes in one net are covered by the strongest parts of another. We suggest that the same is true here. These approaches have holes that could result in our missing important data. By layering different approaches, however, we are increasingly likely to create a more complete body of data.

From an ACT perspective, psychological flexibility involves three broad groups of skills. First, psychological flexibility involves being present to notice the changing context, outside and in. This includes present-moment focus and transcendent self-awareness. Second, psychological flexibility involves being open to experiencing the changing context, outside and in. This includes cognitive defusion and experiential acceptance. Third, psychological flexibility involves making choices that are sensitive to the context and increase contact with values. This includes valued living and committed action. Valued living is also the primary purpose of ACT. In other words, psychological flexibility is not assumed to be virtuous in and of itself. It is assumed to create a context in which valued living is more likely. The remainder of this chapter will consider how these components of psychological flexibility are hampered in disordered eating and related behaviors and how these deficits show up in the room.

## FUNCTIONAL TARGETS IN ACT FOR EATING DISORDERS

Psychological flexibility is a functional dimension of behavior that a clinician can assess, either by using self-report data or direct observation. It may be more useful, however, to track psychological flexibility at the level of its components. Beginning at this level of analysis gives us more direction with respect to specific interventions. If a problematic behavior is seen as a deficit in present-moment focus, the intervention on this behavior will target contact with the present moment. It is not to say that these components are independent. To the contrary, because these components are interdependent facets of psychological flexibility, successful interventions on acceptance will also improve contact with the present moment. However, the intervention that targets present-moment focus has a different form and is more effective with respect to present-moment focus.

One challenge for us is to recognize the form present-moment deficits, limited self-awareness, experiential avoidance, cognitive fusion, limited valuing, and inaction take in a particular client's repertoire. Some of these observations will rely on the individual's report, either verbally, during the session, or on self-report instruments. We are also challenged to recognize these shifts in behavior as they occur in session.

We assess components of psychological flexibility by intentionally shifting between aversive and appetitive contexts and observing subsequent changes in the individual's behavior. How does the client's stream of behavior change when hard things are present? Or, in other words, what does aversive control look like in this individual's repertoire? Likewise, how does the client's stream of behavior change when appetitives are present? Or, in other words, what does appetitive control look like in this individual's repertoire? Note that the question is not "What does a bad mood look like?" versus "What does a good mood look like?" (A "good mood" could function as avoidant, to defend against aversives that are present.) The question is "How does the client respond when an aversive event is made present?" These observations are particularly valuable because we can then directly manipulate the context to train the client to (1) recognize these behaviors themselves and to (2) consciously choose to persist or change his behavior. In later sessions, we may simply be able to ask, "Are you having trouble being present right now?" or "Is this avoidant for you?"

# FACILITATING BEHAVIOR CHANGE IN ACT

The goal in ACT for eating disorders is psychological flexibility with the purpose of facilitating valued living. ACT targets broad behavior change, not in the sense of reducing eating disorder symptoms but in the sense of changing the dominant functions of the behavioral repertoire. ACT is about shifting life toward the things an individual cares about. The therapeutic stance in ACT is about making a place for that shift to occur.

## *Sessions as Opportunities*

The therapy session in ACT is approached as an opportunity to create a context for clients to begin interacting with their lives in a different way. Therapists intervene with intention on antecedent control. We create transitions in the session that elicit certain affective, cognitive, and perceptual

experiences. Therapists also intervene with intention on consequential control. We create transitions in the session that occasion flexibility with these experiences and transitions in the session that reinforce that flexibility. Through intervening on antecedents and consequences in the session, therapists in ACT aim to create a context in which aversive control can be decreased. Said another way, ACT therapists make hard things present and help clients find freedom to choose direction inside of those hard things.

## *Shaping Functional Targets*

The path from inflexibility to flexibility is not always obvious. Flexibility is defined in the context of a particular repertoire, and thus looks different for every person. Clients may share a struggle with disordered eating and related disturbances yet exhibit different patterns of flexibility across present-moment focus, transcendent self-awareness, defusion, acceptance, valued living, and committed action. Some individuals are so inflexible that it's hard to see the potential for flexibility. Psychological flexibility and its components are best conceptualized as existing on continua from highly inflexible to highly flexible. One challenge for the therapist is to recognize the form of these functional skills or deficits in the client's repertoire. Where is the client's behavior currently on the continuum from inflexible to flexible? A second challenge is to train flexibility across the components. How can we create the conditions for the client to move along the continuum toward ideal psychological flexibility?

In behavior therapy, shaping is useful any time the target behavior is at or near zero probability in the client's repertoire. For example, a client's end goal may be to travel to New York by plane for his son's wedding, but he does not currently leave his house for weeks at a time. Shaping involves identifying and reinforcing successive approximations of the target behavior. For example, the first step toward the New York trip might be doing a few minutes of gardening in the front yard for a few days. The second might be walking to the mailbox. The third might be walking several hundred yards down the street. The therapist would reinforce the first step in the first phase of treatment, and move on to phase two when the first step was successfully mastered.

ACT therapists shape psychological flexibility from the current repertoire. They assess psychological flexibility across six functional dimensions. They assume a continuum between the behaviors the client currently exhibits and those that would typify psychological flexibility for her. They then establish contingencies that reinforce approximations of that flexibility. In

other words, we notice where the client is and meet her there. We imagine subtle shifts toward flexibility and make a place for those to emerge. If we find we've lost the client, we assume that we've moved too quickly, and we trek back to drop another step in where she couldn't quite make the leap.

Early work in a particular facet is often highly structured, allowing the therapist to manipulate more of the contingencies present. Often this takes the form of metaphor or eyes-closed exercises. Early work emphasizes experiential contact with facets of psychological flexibility, often around content that is less central to the client's primary struggles. More advanced work becomes increasingly flexible. Contingencies similar to conversation are gradually allowed to enter the interaction, making the client's flexibility more likely to generalize to her everyday life. Often advanced work focuses on the struggles that have cost the client the most.

## *With Permission*

ACT therapists help clients to interact more effectively with the things in their lives that hurt the worst and the things that mean the most. This is an extraordinary task for clients, the nature of which necessarily involves them bringing their deepest vulnerabilities into the room. This is not something that is taken lightly in ACT. The ACT clinician makes these vulnerabilities present only with explicit permission. Psychological flexibility is about choosing freedom from aversive control. Offering the client the opportunity to give or refuse permission is the first step to building this freedom. We ask permission early, and we ask it often. Pain chosen is different from mere pain. We ask permission in a way that makes the opportunity to refuse apparent. If we are moving in a direction that's wrong, or in a direction that's too right too soon, then the client has the opportunity to choose something different.

## *Sunsets and Witnesses*

Clients come to therapy because they look at their lives and see problems to be solved. Maybe the problem is that they haven't felt happy in a long time. Maybe it's those last five pounds of flab. Maybe the problem is getting motivated or that they can't think straight. Maybe the problem is that their mothers just won't get off their backs. And if only this problem would be solved, then they could finally start living.

Often, we clinicians buy into the problem-solving agenda our clients present with. We might not focus on the sad problem or the fat problem or the problem with Mom. We see the anorexia problem. We consult on the bingeing problem. We focus on the fusion problem or the avoidance problem. And in doing so, no matter how true or effective our analysis is, no matter how much coherence or compassion it's founded in, we make our clients like a row of math problems. What if in treating someone like a math problem we offer little different than what the world has offered them or what they have offered themselves? The chance for behavior change becomes smaller and smaller as the context we create becomes more and more like the world they know, a world in which they are problems to be solved.

There is an alternative position we find ourselves in from time to time. Sometimes we let go of the problem-solving agenda. We're compelled by something a client says or does and suddenly we take a step back from our conceptualization and plan. We notice the human being in front of us. Without any effort to assess or intervene, we lean in and simply witness. In these moments, the client is less like a math problem than a sunset. Take a moment and imagine what would happen if we tried to experience a sunset by measuring the angle of the light refraction off the water molecules in the air. We gaze out at the horizon with our refractometer and our laptop and let the numbers crunch. We might end up with a correct analysis, but something would be lost. What if it is the same with our clients? What if we have something precious to gain by treating them as sunsets instead of math problems? What if we have something precious to gain by treating ourselves as witnesses instead of problem solvers?

In ACT, we assume that every client has something as lovely to share as a sunset, just waiting to be witnessed. We assume that if we take the posture of a problem solver, the client is likely to show up as a problem. If we take the posture of a witness, however, the client is more likely to show up as a sunset. We also assume that the more our clients are witnessed, the more likely they are to witness others in their lives. It may even be that the more sunsets we witness, the more likely we are to show up as a sunset in our own lives.

Part 2 of the book will consider each facet of psychological flexibility in terms of common difficulties in disordered eating and intervening on those difficulties. As we move into the specifics of case conceptualization and treatment of disordered eating from the ACT perspective, we ask that you keep in mind the importance of being able to set that aside.

# PART 2

# Delving into ACT

In this section of the book, we'll take a look at typical disordered eating behavior through the lens of the six-process ACT model. We explore some functional guidelines for how you, the clinician, could recognize and address process breakdowns that might be part of a disordered eating presentation. We'll describe deficits you're likely to observe in your clients. And we'll also consider how you might deal with similar deficits as they're likely to show up in you, the therapist.

# CHAPTER 5

# Training Present-Moment Focus

Many individuals struggling with disordered eating and related disturbances have difficulty with present-moment focus. Present-moment focus involves employing flexible and focused attention to ongoing events. Often being fully connected to what is present in the moment is more difficult than maintaining a detached focus on past difficulties and/or intentions for the future. Sometimes painful memories show up in a way that is intrusive, resulting in an inflexible focus on those memories. A painful event from the past shows up and the rest of the world disappears as the individual is off ruminating on why this occurred, who is to blame, and how this can be avoided in the future. This can easily result in a rigid focus on unhealthy or idealistic goals for restriction and resulting weight loss. The individual is able to gain some relief imagining how she will skip class to exercise an extra hour, how she will throw away the snack she brought for later, how the world will change just as soon as she loses this weight.

The important dimension of these behaviors is not that the content of her thoughts is in the past or the future. An individual can get present to memories or fears as they are affecting her now. In the examples above, however, the interaction with past and present is detached and rigid, and focused on keeping her safe from the pain that is there.

## TRACKING PRESENT-MOMENT FOCUS

There are many ways that difficulties with present-moment focus show up in session. Individuals struggling with disordered eating might report in session or on questionnaires difficulties maintaining present-moment focus that help to maintain disordered eating. They might report rigid focus on

some aspects of bodily sensations, along with insensitivity to others. For example, when sensations of fullness are present, an individual may have no access to the sensations of muscle exhaustion. Individuals also might describe rigid focus on some areas of the body when perceiving and evaluating physical appearance. When asked to estimate the size of their bodies or to describe their thoughts and feelings about their bodies, they may focus on one body area, such as the thighs, and answer as if they were literally "all thighs." Finally, some individuals who struggle with eating may describe experiencing dissociation, an extreme deficit of present-moment focus. These individuals have periods in which they are not attending to any aspect of the ongoing experience.

Individuals' struggles with present-moment focus may also be apparent in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which present-moment focus is expected to be more or less likely, and observe subsequent shifts in behavior. To what extent is the individual able to retain contact with her ongoing experience over the course of the session? Certain nonverbal behaviors are common indicators that an individual is having difficulty with present-moment focus. An individual might speak in a way that is stereotyped with respect to intonation, pace, volume, and rhythm. She might do things that prevent connection with the clinician. Her posture, facial expression, eye contact, and gestures might make her difficult or undesirable to engage. The content of the client's speech might also indicate difficulty with present-moment focus. Her speech might indicate nonproductive worry or rumination, often about food or the body. She may speak in broad generalizations that lack specific detail. The client might also perseverate on certain topics. She may be insensitive to prompts to change these patterns, or even disconnect further when these are delivered.

## PRESENTING OPPORTUNITIES FOR PRESENT-MOMENT FOCUS

Individuals struggling with disordered eating often benefit from learning to discriminate and maintain a present-moment focus. This is an important target in ACT, not only because it is associated with disordered eating, but also because it is necessary for learning any other skills. The present moment is where contingencies are being presented that can shape effective behavior. This is true not only of contingencies in session, but also out in the individual's life. A lack of present-moment focus is necessary for

individuals to engage in behavior that is self-destructive because they are not present to contact that destruction. In session, present-moment focus will be threatened any time aversives are made present. The clinician is responsible for creating opportunities for the client to practice present-moment focus, making it more likely that she will exhibit it out of session as well.

**Note:** See appendix B for sample process notes for each case example.

# EARLY PRESENT-MOMENT WORK

Early present-moment work involves facilitating flexible focus on primarily sensory experiences. This may include experiences in any of the five sensory domains, but most typically involves auditory and tactile sensations. Clinicians usually provide a high degree of structure in the early stages of present-moment work, gently guiding the client's attention in a flexible and focused way to different aspects of the ongoing sensory experience. If the client demonstrates particular difficulty with one sensory domain, the clinician may focus on flexibility with only that domain. The emphasis at this stage is not on the client being able to describe the sensations or the experience of attending to them, but to contact each of these experientially.

## **CASE EXAMPLE:** Theresa's Early Present-Moment Work

Many of Theresa's activities are disrupted by her hypervigilance. Her gaze shifts constantly among different people and objects in her environment. She freezes her speech or other activities when sudden changes occur in her environment. Theresa describes memory problems and great difficulty concentrating. She reports that her hypervigilance is worse when her weight is high.

### Hearing the Now Exercise

The clinician begins by guiding Theresa's attention to her difficulties with present-moment focus.

*Clinician*: I get the sense that it's difficult sometimes for you to pay attention to a conversation you're having or a task you're trying to complete. Almost like when certain things occur

around you, your attention is yanked away before you even have time to notice it's happening. Is that right?

With Theresa's confirmation, the clinician introduces the Hearing the Now exercise and invites her to participate.

*Clinician*: This can make life feel so chaotic. The littlest things become unbelievably difficult. I wonder if you'd be willing to challenge yourself here today by letting me sort of guide your attention to different sounds in the room.

With Theresa's permission, the clinician begins the exercise by eliminating visual distractions. She dims the lights and asks Theresa to lower or close her eyes.

*Clinician*: I'd like you to start by lowering your eyes. If you feel willing, I'd like you to let your eyes fall closed. If you choose not to close your eyes, I'd ask you to just find a spot on the floor and hold your eyes there, letting them go sort of hazy. And breathe.

Next, the clinician guides Theresa's attention to the sounds in the room without focusing on any one sound.

*Clinician*: And I'd like you to gently shift your attention to the sounds you hear around you. Keep your attention broad for now, not focusing on any one sound. And breathe. And when you feel your attention being pulled to this sound or that, I'd like you to just gently let go of that focus and open your awareness back up to the many sounds in the room. Some of the sounds may be sort of pleasant, others may feel unpleasant or harsh. Some of the sounds may be loud and intrusive, some of them barely audible. And breathe.

The clinician now guides Theresa in narrowing her focus to one sound, starting with the easiest sound to focus on.

*Clinician*: Now I'd like you to see if you can pick out the loudest, most obvious sound. Maybe it's the sound of my voice. Or the clock on the wall. Or your own breath. Whichever sound seems loudest to you. I'd like you to pick out the loudest sound and let your attention come to rest on that sound and that sound only. Notice the volume of that sound. Notice its pitch. Notice the quality of that sound, and the millions

of tinier sounds that make it up. And breathe. Notice the moments of silence around that sound, and the way the sound emerges from that silence. Stay with that sound, turning back to that one loudest sound when your attention is turned away. And when you feel you've got a full sense of that sound, stay with it just a moment or two longer. And breathe.

The clinician again guides Theresa's attention to the sounds in the room without focusing on any one sound.

*Clinician*: And now I'd like you to gently let go of your focus, opening your awareness back up to the other sounds around you. And breathe. And when you feel your attention being pulled to this sound or that, just gently, gently open your awareness back up.

The clinician then guides Theresa in once more narrowing her focus to one sound.

*Clinician*: And when you're no longer being pulled to this sound or that, gently shift your attention gently to the next loudest sound. Again note the volume of the sound, its pitch, its quality. Notice the silence around it and the way it emerges from that silence. Stay with that sound, turning back to that one sound when your attention is pulled away. And breathe. And when you feel you've got a sense of that sound, stay with it just a moment or two longer. And breathe.

The clinician repeats this process, guiding Theresa's attention back and forth between nonfocus and focus on five different sounds in the room, one at a time. Upon conclusion of the exercise, the clinician gives Theresa the opportunity to discuss her experience, getting an additional sense of the extent to which Theresa was able to shift back and forth between focus and more broad awareness. Here are examples of the type of questions that can help elucidate the client's experience:

- What was that like for you?
- When did you find it most challenging to follow my instructions?
- What seemed to get in the way of the exercise?
- Is this something you'd be willing to do again?

# INTERMEDIATE PRESENT-MOMENT WORK

Intermediate present-moment work involves extending flexible present-moment focus across ongoing sensory, cognitive, and affective experiences. Clinicians provide some structure, guiding the client in focusing on different aspects of the ongoing experience across different domains. Clients can also take more of an active role by describing their experience in the moment. If the client's experience tends to be dominated by a particular domain (for example, cognitive), the clinician may focus on building flexibility with that domain and sensitivity across other domains.

## **CASE EXAMPLE:** Maria's Intermediate Present-Moment Work

Maria reports that she worries about her physical appearance regularly, particularly when she is anticipating other difficult experiences. These worries are unproductive, typically involving repetitive consideration of different ways to hide or improve her appearance. Maria has difficulty describing her experiences in detail, often referring more generally to "the way things are."

The clinician begins by guiding Maria's attention to different physical sensations, which seem to often be outside of her awareness.

*Clinician:* To begin, I'd like you to get comfortable in your chair and let your eyes fall closed. And breathe. And gently turn your attention to your breath. And breathe. Notice the temperature of the air as it enters your body.

The clinician offers Maria the opportunity to not only contact but describe her experience in the present moment. The clinician explicitly limits Maria's responses to prevent her delving into explanations about the experience.

*Clinician:* In one word, how would you describe its temperature?

*Maria:* I don't know. Cool?

The clinician provides more details to facilitate Maria's contact with the experience.

*Clinician:* Good. Breathe and notice the coolness of the air as it enters your body, gradually fading as you take it in. Now notice its temperature as it leaves your body. Is it warmer?

*Maria:* Yes.

*Clinician:* Good. Notice the air leaving your body, warmer now, as it mixes with the air all around you. And breathe.

The clinician now guides Maria's attention to other physical sensations.

*Clinician:* Now I'm going to ask you to shift your attention from your breath to other things going on right now. Every once in a while, I'll remind you to breathe, and when I do, see if you can't shift your focus, just briefly, to the sensation of the air entering and leaving your body. Then return to the sound of my voice, and whatever I'm asking you to notice. Do you understand?

*Maria:* Yes.

*Clinician:* I'd like you to start by noticing any tension present in your body. See if you can guide your awareness to one area of your body that is feeling tense right now. And if you notice your mind pulling your attention to concerns you came in with, or that are starting to rise up now, I'd ask you to breathe, and as you let that air flow from your body, see if you can't bring your attention back to settle on that area of tension. In one word, where is one place you feel tension in your body?

*Maria:* Shoulders.

*Clinician:* Shoulders. Good. Let your awareness come to rest on the tension in your shoulders. And breathe, noticing the sensation of drawing breath in, and as the air leaves your body, returning your focus to your shoulders. I'd like you to see if you can't notice the edges around that tension in your shoulders, the transitions between that place where your muscles are tight, and the muscles around them that are loose and relaxed. And breathe.

Now the clinician guides Maria's attention to a second area of tension.

*Clinician:* And when you've traced around the edges of that area of tension, I'd like you to scan your body for another area of tension. And on the next breath in, settle your attention there. When you have focused on another area of tension, tell me in one word where that is.

*Maria:* Neck.

*Clinician:* Neck. Good. Let your awareness come to settle on the tension in your neck. And breathe. And again, I'd like you to trace the edges of that of tension in your neck, noticing the transition between the place where your muscles are tight, and the muscles around them that are loose and relaxed. And breathe.

The clinician now gives Maria the opportunity to repeat this once more without her explicit instructions.

*Clinician:* And I'm going to fall silent here for a moment. And in the next few moments of silence, I'd like you to do the same with one other area of tension that remains.

*Maria:* Feet.

The clinician pauses here for twenty seconds, observing Maria for nonverbal indications of present-moment focus.

*Clinician:* Good, Maria. And breathe.

Next, the clinician guides Maria's focus to emotions she is experiencing.

*Clinician:* And breathe. Now I'd ask you to settle your awareness on any feelings you are experiencing. This may be a feeling you came in with, or a feeling that is rising up right now. See if you can make room for this feeling in your experience. Tell me what feeling is showing up for you in one word.

*Maria:* Hurt.

*Clinician:* Hurt. Good. If there's a part of you that's resisting that hurt, pushing it away, I'd like you to gently let go, allowing that hurt to fill your awareness.

The clinician pauses here, giving Maria the opportunity to settle in to her experience of hurt. Then the clinician guides Maria to another emotion that may be present.

*Clinician:* And breathe. And when you have a full sense of that hurt, I'd like you to gently, gently set that hurt aside, noticing what other feelings might be there. And whenever you're ready, would you name this feeling for me, in one word?

*Maria:* Disappointment.

*Clinician:* Disappointment. Good. And if you feel yourself resisting that disappointment, I'd like you to gently make room for that disappointment to rise up in your awareness.

Once more, the clinician falls silent, giving Maria the opportunity to settle into her experience of disappointment before guiding her attention to another emotion that may be present.

*Clinician:* Good. And breathe. And if you set that disappointment aside, what else is present right now?

*Maria:* Ashamed.

*Clinician:* Ashamed. I'd like you to breathe, and as you take the air in, let that sense of shame fill your awareness.

Next, the clinician guides Maria's attention to noticing any thoughts that she may be experiencing.

*Clinician:* And breathe. And breathe. And now I'd like you to notice the thoughts you are having right now. These may rush by quickly and all in a jumble at first, but I'd like you to see if you can't open your awareness to allow them to pass gently by you. And breathe, noticing the sensations of air entering and leaving your body. And back to your thoughts.

Here the clinician pauses before guiding Maria's attention to settle on one thought.

*Clinician:* As these thoughts pass gently by you, I'd like you to see if you can't allow your awareness to settle on just one. Maybe one that keeps coming back today, or one that feels familiar to you. Maybe a new one that you aren't sure you've had before. Settle on just one of these thoughts, letting it take full shape in your mind. And if you feel any urges to turn away from it, to go on to the next thought, or to try to explain or reason with this thought, I'd like you to let that urge be part of your experience, without engaging it or any other thoughts.

Again, the clinician pauses before asking Maria to describe what she is thinking.

*Clinician:* And breathe. And as you return to that thought, I'd like you to put some words to it, telling me, in just a few words, the thought that you're having.

The clinician then casts anything Maria has as a thought.

*Maria:* No. This is too hard.

*Clinician:* You're thinking that this is too hard. Good. And breathe. And notice the urge to respond to the thought that this is "too hard" coming up again. Maybe you feel the reasons why it's hard rising up inside of you. Maybe the ways it's not all that hard are showing up. And breathe. And return to the thought you are having: *This is too hard.*

The clinician pauses before guiding Maria's attention to another thought that may be present.

*Clinician:* Good. And breathe. And as you exhale, I'd like you to gently let that thought pass from you, opening your awareness to the flood of thoughts you are having right now. And now, gently, I'd like you to settle in to another thought that is showing up.

The clinician pauses to give Maria the opportunity to notice her thought.

*Clinician:* And when this thought takes full shape in your mind, I'd like you to give voice to it, in just a few words.

*Maria:* I'm ugly.

*Clinician:* You're having the thought that you're ugly. And breathe. And notice how difficult it feels to let that thought hang here, in the room. Notice any urges to agree with this thought, or to argue with it. And breathe. And see if you can't just return to the thought you are having: *I'm ugly.*

The clinician pauses before guiding Maria to let go of her focus, and open her awareness to the full experience she is having.

*Clinician:* Good. And breathe. And breathe. And as the air leaves your body, I'm going to fall silent. And as the silence surrounds

you, I'd like you to allow your awareness to open up to the entirety of your experience right now. Notice the sensations in your body, the feelings, the thoughts in your mind.

The clinician pauses before ending the exercise.

*Clinician:* And breathe. And whenever you're ready, open your eyes and join me back in the room.

# ADVANCED PRESENT-MOMENT WORK

Advanced present-moment work involves bringing flexible present-moment focus to bear on not only ongoing experiences, but also on imagined experiences and memories of experiences past. Clinicians may provide less structure at this stage, guiding the quality of the client's awareness more than the content. The client not only contacts, but also describes, her experience as it occurs in the moment.

## **CASE EXAMPLE:** Christina's Advanced Present-Moment Work

Clients who have similar presentations to Christina's are often able to connect relatively easily with individuals around her. Their typical communication style not only conveys their experience with what they are describing but helps their listeners to experience that too. Christina has difficulty maintaining her awareness and connection, however, when discussing her eating. She tends to speak quickly and with a defensive tone. She also tends to repeat conflicting statements in a way that suggests rumination around her eating. This occurs whether Christina makes a healthy or unhealthy eating choice.

### Slowing Down Exercise

The clinician introduces the exercise by suggesting that it may be valuable to slow down to help her to appreciate Christina's experience.

*Clinician:* I hear you starting to tell me how things went last night at the reception, but you're moving just a little quickly for me. This is something important we've been talking about for

a couple of weeks now. You've been worried about the food that might be there, but wanting to support Jay by going. I wonder if you'd be willing to slow way down here, way down, and walk me really slowly through your memories of that night. This is going to make it a little harder on you, but I want to really get what this was like for you. I don't want to miss any part of your experience.

*Christina:* Okay.

The clinician describes to Christina her role in the exercise, and asks her permission to continue.

*Clinician:* Okay, so I'm going to help you slow down here sometimes by asking you different questions about little details you might miss as you speak. Would that be okay with you?

*Christina:* Yeah, sure.

*Clinician:* Great. Now to start, I want you to go back to just before you entered the reception area. Maybe outside the door or in the car?

*Christina:* Okay. Well, I'll start with the car. I made the mistake of looking in the mirror…

*Clinician:* Just before you looked in the mirror, what was showing up for you?

*Christina:* I was excited. A little nervous.

*Clinician:* Okay, and what showed up just before you looked in the mirror?

*Christina:* I remembered I hadn't put on any lip gloss. See, my lips have been really dry and I get these blisters…

*Clinician:* I'm going to stop you here, and ask you just to stay with the experience that night. I want to really see you, and get what it was like for you in that moment. So you remembered that you hadn't put on lip gloss…

*Christina:* I remembered I hadn't put on any lip gloss, but that I'd wanted to. So I opened the mirror.

*Clinician:* Which mirror?

*Christina:* I opened the vanity mirror on the back of my visor.

*Clinician:* The driver's side visor?

*Christina:* Yes. And I don't know why because I could have put the gloss on without it…

*Clinician:* I get that you regret seeing yourself in the mirror. Then what did you see?

*Christina:* My fat.

*Clinician:* You saw your reflection and thought that you looked fat.

*Christina:* Yeah. Well, not right at first. I took my lip gloss out of my purse, leaned in toward the mirror, and put it on. Then I sat back to see more of my reflection and I looked much fatter in my dress than at home.

*Clinician:* What did you see that you evaluated as "fat"?

*Christina:* When I sat back, I saw the way my dress pulled at my boobs. The fabric was tight across my chest.

*Clinician:* Okay. And you thought?

*Christina:* Gross. I thought, *Gross. That is gross.*

*Clinician:* What else?

*Christina:* I considered going home to change, or going home and not coming back at all.

*Clinician:* What else?

*Christina:* I wondered why I hadn't noticed it before.

*Clinician:* And what else?

*Christina:* I tried to convince myself that it was fine, to tell myself it was just the light.

*Clinician:* How did that work?

*Christina:* Not at all.

*Clinician:* Where was your excitement at this point?

*Christina:* Ha. There was no excitement left. The nervousness took over.

*Clinician:* Where did you feel that in your body?

*Christina:* My stomach mostly—which made me feel even more fat.

*Clinician:* Okay. So what happened next?

*Christina:* You know, I thought about my brother. How excited he was when he told me about his award.

*Clinician:* And then you felt?

*Christina:* Guilty for thinking about leaving. Selfish.

*Clinician:* What did you tell yourself then?

*Christina:* That this was not about me. That I needed to suck it up.

*Clinician:* So you had the thought that you should suck it up. Then what?

*Christina:* Then I got out of the car and made my way in. Quickly. No—first I tugged at my dress a little, then I slammed the mirror up, grabbed my purse, and got out of the car. I shut the door and started through the parking lot.

*Clinician:* What was the air like outside?

*Christina:* It was warm. I remember noticing it was warmer than I'd expected. It felt wet, too. I remembered it had rained that day. It was sort of steamy.

*Clinician:* What did you see in the parking lot?

*Christina:* Lots of empty cars. A few couples.

*Clinician:* And you were walking quickly?

*Christina:* Very quickly. I remember because I almost fell when my heel caught the asphalt.

*Clinician:* Good. And what thoughts were you having as you made your way quickly through the parking lot?

*Christina:* Lots of things. I kept going back to my image in the mirror, my boobs busting out of my dress. And why I didn't notice earlier. I thought about the other dresses I'd thought about wearing. I kept trying to focus on why I was there, though.

*Clinician:* And how was that?

*Christina:* It actually helped a little. It got me to the door.

*Clinician:* What feelings came with that thought, the thought that you were there to support your brother?

*Christina:* I don't know. I felt stronger, I guess.

*Clinician:* Okay, good. So you reached the door to the building…

*Christina:* I reached the door to the building, and told the woman at the table my name.

*Clinician:* What was showing up then?

*Christina:* A couple of things. I noticed she was thin. Really thin. And there was a little plate of strawberries next to her.

*Clinician:* Any feelings?

*Christina:* Well, I was annoyed when I noticed she was thin. Then relieved that they had something I could eat.

*Clinician:* Good. What happened next?

*Christina:* She crossed my name off and gestured to the entrance with a big smile telling me, "Have fun!" or something like that.

*Clinician:* And then?

*Christina:* I got more nervous as I got up to the doors. I could hear a blur of voices and they all sounded so happy.

*Clinician:* Go on.

*Christina:* I noticed I didn't feel happy. I felt my dress pull against my chest even tighter now—like it was going to suffocate me.

*Clinician:* Go on.

*Christina:* I started to scan the room for my brother.

*Clinician:* Any thoughts?

*Christina:* I was thinking that if I could just find him, I'd feel better.

*Clinician:* What did you notice in the room?

*Christina:* The band was too loud. I could feel the drums in my ears. It was darker in there than I'd expected. I noticed lots of really skinny women. Lots of great fitting, more expensive dresses than mine. My stomach started to really hurt. I tried to just focus on finding Jay.

*Clinician:* And then?

*Christina:* I spotted him to the right. He was talking to an older guy. Bald, in a black suit.

*Clinician:* Go on.

*Christina:* I remembered I'd met him before. That his name was Sam something. I felt sort of relieved because he's really nice.

*Clinician:* Go on.

*Christina:* So I walked up to them.

*Clinician:* How far?

*Christina:* I don't know—twenty feet?

*Clinician:* And as you walked you were feeling?

*Christina:* Excited really, and relieved. Proud of Jay. I noticed how grown-up he looked.

*Clinician:* Nice.

*Christina:* It was. Really nice.

*Clinician:* And then?

*Christina:* I walked up to them. Gave Jay a hug, and shook Sam's hand. Sam started to talk about how impressive Jay's work was. He seemed to really admire him. Jay looked so embarrassed. I felt really proud.

*Clinician:* How much was your dress on your mind?

*Christina:* Honestly, just then, it wasn't. I was really enjoying the conversation. I felt happy I came.

*Clinician:* What else?

*Christina:* Jay asked me to dance. We danced, talking and laughing.

*Clinician:* What song?

*Christina:* Um…shoot. I don't remember. A rock song my dad used to sing. It's a happy song for us.

*Clinician:* And then?

*Christina:* Ugh. Then Sam suggested we check out the buffet. You know, everything was really going great until that moment. It's like I couldn't have fifteen minutes of fun without starting to freak out again. I…

*Clinician:* So Sam suggested you check out the buffet and…

*Christina:* Just that word. I felt myself cringe. My stomach felt worse then ever. My dress seemed to instantly shrink three sizes.

*Clinician:* What else?

*Christina:* My head started rushing through excuses.

*Clinician:* Did you use one?

*Christina:* They were coming too fast. And Sam and Jay were standing there smiling and the music was so loud and I started to feel hot and I just couldn't react fast enough.

*Clinician:* Slow. You were overwhelmed?

*Christina:* Totally. I just stood there frozen. I probably looked disgusted. Then, suddenly, I caught Jay's eye and blurted out "Sure!" with a big goofy smile on my face.

*Clinician:* Then what?

*Christina:* We walked to the buffet and got some food.

*Clinician:* Slow down here. Could you see the buffet as you walked toward it?

*Christina:* Not at first. Then, it was like the crowd parted.

*Clinician:* What was the first thing you noticed?

*Christina:* The cheese. A giant silver platter overflowing with cheese.

*Clinician:* And then?

*Christina:* Pasta salad, positively swimming in oil.

*Clinician:* What was showing up for you as you noticed the cheese, the pasta?

*Christina:* I felt disgusted, and sort of scared. My mind was going a million miles a minute. Still trying to figure out a way out.

*Clinician:* A way out of?

*Christina:* Having to eat, or pretend to eat.

*Clinician:* Say more.

*Christina:* Well, I kept trying to plan what I would get. I kept going back and forth between picking only foods I'd actually eat, foods that are safe, and what I thought I should get, what would be normal to get. I kept looking at what other people had on their plates, then looking at their bodies.

*Clinician:* What happened next?

*Christina:* I followed Jay to the end where the empty plates were. And just started putting on whatever looked good.

*Clinician:* And this felt?

*Christina:* I felt guilty. Gross. Like a glutton. I remember thinking as my plate got heavier, *You are a glutton*.

*Clinician:* Ouch.

*Christina:* Yeah.

*Clinician:* How does that feel now? To recall that?

*Christina:* Gross.

*Clinician:* Yeah. I get that. And where was your excitement, your feelings of pride for Jay?

*Christina:* They were far away. I stood there, smiling with them, and shoving mini sandwiches and pasta in my mouth and hating myself with every bite.

*Clinician:* Do you recall any tastes?

*Christina:* My first bite was a mini muffuletta. It had so much taste, it surprised me. It was very salty but very good.

*Clinician:* And how was that?

*Christina:* I felt even more disgusting for enjoying it. I ate it really fast.

*Clinician:* And then?

*Christina:* I barely even remember. I ate, said I was sick, and left before Jay even got his award. It wasn't a lie. My stomach felt horrible.

*Clinician:* So you finished eating…

*Christina:* I just checked out. Before I knew it, my plate was empty and I felt like my stomach was going to bust. I was just sitting there thinking about how gross I was and how much I wanted to get away. Then Jay asked me what was wrong. He looked so concerned. And all I saw was my chance to leave. I almost got excited when he asked, but I kept my face really unpleasant, leaned over, and whispered to him that something wasn't going down right. I really played it up. I clutched my stomach, I even moaned a little. And I waited for his permission to leave. I knew he'd tell me to go.

*Clinician:* And what were you feeling during this exchange?

*Christina:* Hating myself, just hating myself. So ashamed. I thought about saying I would stay, but I wanted to leave so badly. I started sobbing and ran to my car as soon as I cleared the door. I wanted to throw up so bad. I made myself just get in the car and drive.

The clinician ends the exercise by acknowledging Christina's hard work.

*Clinician:* That was very powerful. I feel like I really heard your struggle today. I have a sense of how much hurt you've been carrying around since that night. I'm so sorry that things didn't go differently for you.

# CHAPTER 6

# Training Cognitive Defusion

Many individuals struggling with disordered eating and related disturbances have difficulty with cognitive defusion. Cognitive defusion involves experiencing an event fully for its complexity, without certain emotions or cognitions about the event dominating the experience. People with difficulties with cognitive defusion find their experiences of the world categorized into those parts that are "good" or "right" or "safe," and those that are "bad" or "wrong" or "painful." Much in the world is ambiguous, objective, or variable. Issues like what is "right" to eat depend on the person, the situation, what they ate that day, and whether or not they exercised. It can be overwhelming to try to navigate these factors. However, eating "wrong" is so dangerous to the individual that figuring out the rules and playing by them can seem very important. ACT trains individuals to approach their own thoughts differently through cognitive defusion.

## TRACKING COGNITIVE DEFUSION

Individuals struggling with disordered eating might report in session or on questionnaires the dominance of certain cognitions or emotions that help to maintain disordered eating. Clients may report rigid beliefs about what beauty is and what it means. They may describe thoughts about their own body shape or size, and how that impacts or could impact their lives. Clients may also describe categorical evaluations of certain foods or ways of eating. Most traditional questionnaires that survey these cognitive patterns will not appropriately measure fusion, as they focus on content of cognitions rather than the function of them. With respect to fusion, the importance is not the

content of the thought, evaluation, emotion, or belief; it is the dominance of those experiences. Most questionnaires could be easily adapted to measure fusion by including two rating scales for each item—one measuring frequency of the thought and the other measuring how true or believable this thought feels.

Fusion might also be observable in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which defusion is expected to be more or less likely, and observe subsequent shifts in behavior. To what extent is the individual able to experience the session fully without certain emotions or cognitions dominating her experience? Certain in-session responses are common indicators of fusion. A client's moment-to-moment behavior may seem dominated by particular thoughts, beliefs, emotions, and evaluations. Beliefs about the world, especially about beauty, the body, food, and eating, may be repeated. They may also be insensitive to refutation, or even increase when attempts at refutation are made. Clients may use exclusive language such as "must" or "can't," "should" or "shouldn't," "always" or "never," especially when discussing eating or related topics. They may frequently judge, justify, or explain their beliefs or behavior, even when they are not being challenged. Clients may also approach different interventions with rigid expectations and rules for their behavior, and persist even when they aren't working.

## PRESENTING OPPORTUNITIES FOR COGNITIVE DEFUSION

Individuals struggling with disordered eating often benefit from learning to discriminate and maintain contact with the full experience of events as they occur. Defusion is threatened when certain aversive thoughts and feelings, or beliefs about how to avoid those events, are salient. Suddenly, the individual's experience narrows, and the only contingencies to which he is sensitive are beliefs around how to predict, avoid, and escape the aversive. ACT aims to help individuals learn to maintain contact with the full experience of an event even as aversives come and go.

The ACT clinician presents opportunities for defusion by introducing aversives and beliefs about aversives along with contingencies that support continued contact with the full experience. Multiple exemplar training allows for cognitive defusion to emerge as a skill that an individual can apply across contexts, including out in his life. Training defusion begins

by assessing the degree of fusion the client is exhibiting, especially around things that are important to him.

## EARLY COGNITIVE DEFUSION WORK

Early cognitive defusion work provides the first step toward experiencing the full complexity of ongoing events. It is not necessary that the client be introduced to what fusion or defusion is. The clinician simply focuses on guiding the client to notice different aspects of aversive events. Early defusion work usually requires that the clinician specify certain functions to keep the client engaged in the exercise. It is sometimes useful to practice with aversives that are not central to the client's struggle. At this point, the clinician introduces the most aversive conditions under which the client can still successfully exhibit defusion. This way shaping can begin.

### **CASE EXAMPLE:** Susan's Early Defusion Work

Susan exhibits rigid beliefs in most contexts she discusses. Her eating is ritualized and her diet consists of only a few highly specific foods (that is, particular brands). She considers body shape as indicative of worth, with body fat indicating a range of flaws. Susan is also highly critical, particularly of organized religion and conservative politics, and speaks about these in terms of right and wrong. She offers explanations and justifications for her disordered eating. She is comfortable, and almost seems to enjoy, arguing with appeals to logic, and tries to initiate these in session regularly. She has reported that her plan is to comply with treatment just enough to be discharged at her request.

When fusion takes hold to this degree, the indicated defusion intervention would target just a single moment of contact with some of the other functions that are present.

#### The Buffet Exercise

The clinician introduces the Buffet exercise to Susan. Because it has to do with food, something that is an area of significant rigidity for Susan, the clinician gives enough detail about the exercise to allow Susan to give her permission for the difficult work to proceed.

*Clinician:* I know that you and your doctors are trying to agree on a diet plan. I also know that you keep getting stuck. Now I'm not going to try to convince you of anything about this food or that, but I was wondering if you'd be willing to explore some of this with me here today. Basically, we'll just imagine a few different foods were here with us, one at a time. You'll pick what foods, and I'll help you to pay attention to them in a certain way. Would you be willing to try this? To see what shows up?

With Susan's permission, the clinician starts the exercise with a present-moment exercise. When Susan's nonverbal behavior suggests that she is present, the clinician begins the Buffet exercise by describing a counter with a conveyer belt and a series of foods passing by.

*Clinician:* And whenever you're ready, I'd like you to allow a counter to rise up in front of you, extending from the wall at your right to the wall at your left. I'd like you to let the counter be about chest high, with a conveyer belt moving slowly from a window in the wall to your left to a window in the wall to your right. Let your awareness rest on the window to your right, and the belt that's moving slowly toward you. And breathe.

And now I'd like you to become aware of something emerging from the wall on your right. Let this be a food you feel is safe for you, one you eat pretty regularly and without much concern. Would you name the food please?

*Susan:* Oranges.

*Clinician:* Good. So you recognize that on the plate you see coming toward you is an orange. You see its color first. A bright orange that shows up in the dark of the window before you even notice the plates. Then the curve of its shape. And before it even leaves the window, the citrusy smell reaches your nose. You feel your nostrils open up and your mouth begin to water. And as the orange continues to approach, you notice its waxy shine, and the tiny indentations that cover the skin. And when the orange in front finally reaches you, you notice the spot that marks the center of the orange, the soft spot where you would dig your thumb into the orange, were you to peel it.

And as it moves slowly from your right side to your left, I'd like you to notice any urges to action that show up. Any thoughts that begin to form in your mind. Any feelings that rise up inside. And the smell fills your nostrils before the orange starts to continue toward the window to your left. And you notice the detail, and the smell, the thoughts and the feelings, starting to fade before you turn your head back to the window at your right.

And breathe. And as you turn your head to the right, I'd like you to become aware of something else emerging from the window. Let this food be a food that is sometimes safe, one you eat but not regularly.

The clinician continues the exercise like this through four or five foods, each one slightly less "safe" to Susan. Depending on Susan's flexibility and willingness, the clinician might also introduce some "dangerous" foods in the same way.

*Clinician:* And now I'd like to do the same exercise with some foods that are not so safe for you. Would you be willing to continue this exercise with a food that feels really dangerous to you?

Depending on how Susan interacts with this exercise, the clinician may, at the conclusion of the exercise, ask her to relate her experience in this exercise to experiences in her life. It may also be useful to ask Susan to try to notice foods in this same way as she moves about her world during the week.

## INTERMEDIATE COGNITIVE DEFUSION WORK

Intermediate cognitive defusion work typically involves slightly more active participation from the client, with the clinician fading some of her guidance. During this stage, the clinician may use metaphor to introduce the concept of defusion, allowing for the client to discriminate her own experience of defusion. The goal is not that the client could explain fusion or express a desire for more defused thoughts. It is simply to contact, and eventually discriminate, the experience of defusion.

## CASE EXAMPLE:
## Annie's Intermediate Defusion Work

Annie exhibits rigidity in many areas of her life, but also shows the capacity for learning flexibility. For example, she describes learning to interact with her ideas about gender roles differently over the years. Annie describes herself as "just rarely wrong," and has great difficulty interacting with many of the people in her life. She shows a fair amount of inflexibility around food and body weight. However, she is currently more focused on her relationships.

### Searchlight Exercise

The clinician introduces the Searchlight exercise to Annie by beginning to discriminate fusion in Annie's behavior.

*Clinician:* You know, just now, I was sitting here listening to you talk about your interaction with Beth yesterday and I noticed something had changed. It was like as soon as you called the event up in your mind, the world felt tight and small. Like everything else in the world went dark and the only thing there was Beth, being obnoxious and threatening as always. And for a second there, it was like you had no way out, like you had to climb on top of your words to put some distance between you and her, between you and the way she was making you feel. And the more words you set down, one on top of the other, the safer you felt.

The thing that is hard about focusing in like that is that there are bound to be other paths through this that have gone dark. But there you are, on top of this tower you built. Safe, but in the dark, and without much room to move.

I was wondering if we could take a minute to do something a little different. Basically, I'd like you to just get a sense of what else is present, even when Beth shows up. Almost like you were up there, on your tower of words, with darkness all around and Beth down there yapping, and you were sweeping a flashlight around, curious about what else might be there.

So the last thing you said was "She just has no idea what she's talking about." The way this works is that I'd like

you to repeat that, then take a deep breath and give voice to another thought, memory, feeling, or bodily sensation you notice. Like:

"She just has no idea what she's talking about… And my toes are cold."

"She just has no idea what she's talking about… And I need to pick up some cotton balls."

"She just has no idea what she's talking about… And I feel angry."

Would you be willing to give this a try?

The clinician guides Susan through the exercise, initially prompting some of her responses (for example, "And what else is here?" or "How's the temperature of your hands?"), and eventually simply appreciating her experience. If she seems to benefit from the exercise, the clinician might modify it slightly by having her label these experiences as things she's noticing.

*Clinician:* And this time, as you notice another thought, memory, feeling, bodily sensation, I'd ask you to say it like this: "I'm noticing the thought that she just has no idea what she's talking about… And I'm noticing the sensation of coldness in my toes." I wonder if this won't be sort of like climbing down the tower, getting to a place where you can actually move a little. Would you be willing to give this a try?

When Susan becomes familiar with the Searchlight exercise, the clinician may use the metaphors from the exercise as an easy shorthand to discriminate fusion (for example, "Let me stop you for just a second here… Is the world starting to go dark here? Are you about to start building?").

## ADVANCED COGNITIVE DEFUSION WORK

Advanced defusion work involves putting the client in experiential contact with the full range of events, even when the most aversive of experiences is present. Typically the work at this level involves aversives that are more central to the client's struggle and to her values. Advanced defusion work also can include more active participation from the client. If a client is ready for advanced defusion work, she can discriminate fusion in her repertoire (although this might not be what she calls it), and is fairly practiced at settling in to an exercise quickly.

## CASE EXAMPLE:
## Lynn's Advanced Defusion Work

Lynn seems relatively open and flexible with regard to most domains. She becomes extremely rigid, however, when she perceives a situation as evaluative. She describes working from the assumption that she will be unfairly judged because of her being overweight. In new situations, Lynn notices that she is "in her head," and can often barely remember the event later. She refers to herself as "fat" to describe not only her weight, but her activity, motivation, intelligence, and overall self-worth.

### Face the "Fats" Exercise

The clinician introduces Face the "Fats" to Lynn. Again, the clinician provides enough detail that Lynn can give her permission to continue with the exercise.

*Clinician:* As you describe the work that goes into fighting "fat" and all that implies, I find myself wondering what would happen if one day you just didn't? What would happen if you were somehow half sleeping, or sick, or just generally pissed off and off your game, and you just let a little bit of "fat" slip out? Something really bad, right? I was wondering if you might be willing to look a little more closely at that, to dip into that a little and see what shows up.

With Lynn's permission, the clinician guides her in a brief present-moment exercise, and then guides her in contacting a prototypical situation in which this comes up.

*Clinician:* I'd like you to start by just getting settled here in the room. Let your eyes fall closed, and get comfortable here in your chair, letting your hands fall into your lap, your feet on the floor, and breathe, noticing the way it feels as you take the breath in…and out. In…and out. Notice the rhythm your breath takes as you settle in. And if you are willing, I'd like you to slow your breath down just one beat. In (*pauses*)…and out. In (*pauses*)…and out. And whenever you're ready, I'd like you to call to mind yourself as a guest at some kind of gathering. You are surrounded by people you care about, and

are enjoying their company. Notice the faces of two or three people who are there with you, smiling and enjoying you as much as you are enjoying them. Notice the look on your face as you laugh at their stories, or share one of your own. And breathe. In…and out. And let yourself become aware of your body in that moment. What it feels like in your skin as you notice yourself connecting with people you care about. And breathe. And on the next breath you take in, I'd like you to notice suddenly that one of your new classmates has entered the room, and is making her way toward you.

At this point, the clinician asks Lynn to report what this experience is like for her, gently guiding her attention toward specific details.

*Clinician:* And now, without opening your eyes and leaving this scene, I'd like you to describe in just a few words how your experience changes as she makes her way toward you. What do you feel in your body? Does your breath change? Your heartbeat? What's the temperature like in your hands? Your face?

Are there feelings you can pick out? Do you feel disappointed? Frustrated? Hopeful? Nervous?

Are there thoughts that are there? What are you telling yourself as she makes her way over? What are you imagining telling her?

Next, the clinician asks Lynn to become aware of how she expects the scene to play out.

*Clinician:* Do you have any expectations of the way this is going to go? I'd like you to notice them and, in just a few words, tell me your expectations of what is going to happen here.

Again, the clinician guides Lynn's attention toward specific details.

*Clinician:* And how does it feel in your body as that expectation sets in?

Any feelings? Other thoughts that follow?

Then the clinician asks Lynn to imagine that, as her classmate finally reaches her, she tries to be as "fat" as possible, with all of its implications.

*Clinician:* And now, as you realize that your classmate has finally reached you and is reaching her hand out, her mouth just

beginning to open to speak, I'd like you to, as you raise your eyes to meet hers, choose to be as "fat" as possible.

First, physically, imagine you let go of that struggle to hold your body in. I'd like you to feel your muscles go loose. Give your body permission to start to expand, taking up as much room as possible. And breathe. Go slowly here. Start with your face, your hair, your cheeks, the cut of your jaw as you let yourself be as "fat" as you feel. Now your shoulders, your chest, your belly. And breathe. Your hips, your thighs, down to your feet.

Now I'd like you to call to mind all the feelings that come with "fat" for you. Let them rise up in you. Imagine they gushed from you as if someone from across the room could look and see exactly what you were feeling. See your facial expression, any movements you make, or sounds. And breathe.

Notice any urges that are there, tugging at you. If you feel the urge to run or hide, I'd like you to give yourself permission to do this, to carry this out.

And breathe. And let your attention come to rest on your own eyes. See yourself go still and silent as you lock eyes with the you in that moment, recognizing yourself inside of "fat." And breathe. In…and out. In…and out. And whenever you're ready, gently let yourself fill in your own skin, in this room, in this moment, and breathe one last slow breath before you open your eyes and come back into the room.

Often the clinician follows this exercise with some form of debriefing. This should allow the client to relate the experiences in the exercise to her experience out in the world, and to imagine what defusion might feel like when she is faced with the most aversive of experiences.

# CHAPTER 7

# Training Experiential Acceptance

Many individuals struggling with disordered eating and related disturbances exhibit high levels of experiential avoidance. Experiential avoidance includes any efforts to change, avoid, escape, delay, or lessen the intensity or frequency of a private experience. Often these aversive experiences are correlated with external environments. A client might avoid the locker room, or the swimming party, or the reception buffet. However, the stimulus that is being avoided can also be conceptualized as the private experiences that show up in the locker room, the swimming party, or the reception buffet. Individuals struggling with disordered eating often avoid a range of experiences, including their experiences of their body and situations where food and eating are salient, and more general self-evaluations or painful feelings. Often individuals have learned to believe that private experiences reflect how they are doing in life. If they have good feelings, they must be doing things right. But if they have bad feelings, they must have done something wrong and there must be some way to fix it. ACT aims to teach clients to approach experiences of their body and eating with acceptance.

## TRACKING EXPERIENTIAL ACCEPTANCE

Experiential acceptance involves openly embracing one's experiences, good and bad, without attempting to change them. Individuals struggling with disordered eating and related disturbances describe certain perceptions, thoughts, feelings, urges, or memories as intolerable. They may describe acting in a way to avoid or lessen the frequency or intensity of these experiences. Many clients describe body-image avoidance and avoidance of eating-related experiences as particularly common.

Body image involves the thoughts, feelings, perceptions, sensations, and memories that make up the bodily experience. For many individuals who have struggled with disordered eating, their experiences of their bodies have been aversive and often unreliable. The body image has become dangerous, unpredictable, and incredibly meaningful. Body-image avoidance is any effort to control how the body is experienced. Clients might describe avoiding situations in which body images are salient, managing body image through distraction or logic, or attempting to change the body itself.

Most clients also describe avoidance of experiences associated with food and eating. They might describe limiting exposure to foods with certain temperatures, textures, or tastes. They might describe ritualizing eating to resolve ambivalence about eating without experiencing a loss of control and subsequent self-evaluations of what they have eaten. They might report that they avoid situations in which they will experience urges to eat or conflicting thoughts about how they should or shouldn't be eating.

Experiential avoidance may also be observable in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which acceptance is expected to be more or less likely, and observe subsequent shifts in behavior. To what extent is the individual able to embrace her experience in session without trying to change it? There are many in-session behaviors that may indicate experiential avoidance. Clients may be completely unwilling to even acknowledge or address aversive experiences. For example, they may refuse to address issues central to their disordered eating or deny its cost to their lives. If they discuss these topics, they may do so in a way that defends against their aversive nature. For example, when they describe struggles with eating or body image, they may do so in a manner that is minimizing or rationalizing, or otherwise disconnected. Clients may also avoid genuine connection with the therapist and the feelings associated with that experience. They may engage in a way that aims instead to gain attention, permission, approval, pity, condemnation, abandonment, or some other social exchange. Overall, clients may rarely embrace the full range of their experiences, and exhibit avoidant resignation or tolerance when prompted to do so.

## PRESENTING OPPORTUNITIES FOR EXPERIENTIAL ACCEPTANCE

Individuals struggling with disordered eating often benefit from learning to embrace their experiences, letting go of efforts to avoid, delay, or

change them. Experiential acceptance is threatened when aversives are present. An aversive enters the individual's experience, and suddenly the only contingency to which she is sensitive is the aversive, that which signals that aversive, and that which allows escape from that aversive. Experiential acceptance work aims to teach clients to approach experiences in their lives with intention. In other words, to say yes to the experience.

The ACT clinician presents opportunities for acceptance by introducing aversives and beliefs about aversives along with contingencies that support approaching the full experience. Multiple exemplar training allows for experiential acceptance to emerge as a skill that an individual can apply across contexts, including out in her life. Training acceptance begins by assessing the degree of acceptance the client exhibits, especially around things that are important to her.

## EARLY EXPERIENTIAL ACCEPTANCE WORK

Early experiential acceptance work focuses on training approach toward some aversive aspect of an experience. The clinician introduces an aversive experience, then presents conditions under which the client might choose to approach that experience. At this stage, this often requires presenting aversives that are peripheral to the client's central struggles. The concept of acceptance is not introduced at this stage. The clinician simply presents conditions under which the client is more or less likely to approach an aversive. The most important thing at this stage is that the client experiences the opportunity to approach an aversive as an option.

### **CASE EXAMPLE:** Karina's Early Acceptance Work

Karina has great difficulty with experiencing anything painful or uncomfortable. She denies distress and appears unable to empathize with others' distress. This has alienated her from many of the people she cares about. Karina avoids any mention of hopes or desires, which seems to protect her from the possibility of not being successful. She exhibits persistent dietary restriction. Her restriction becomes extreme and includes purging when unexpected or seemingly aversive events occur, although Karina denies feeling upset.

## Holding Breath Exercise

The clinician introduces the Holding Breath exercise to Karina.

*Clinician:* One of the things that's important to the work that I do is the variety of ways that people interact with things that are uncomfortable. We can do this pretty simply by timing you holding your breath under different instructions. Would you be willing to do this?

*Karina:* Yes.

*Clinician:* When I say "Begin," I'd like you to inhale, and then hold your breath for as long as you can. I'm going to time you. Ready? Begin.

As Karina holds her breath, the clinician keeps time, shifting her gaze gently to the watch or timer, and back to Karina. The clinician also provides nonverbal support, making eye contact when available and reciprocating facial expressions.

*Clinician:* What was that like? What did you notice?

The clinician guides Karina in responding with as many details as possible, then asks Karina to continue to the next part of the exercise, which involves an explicit instruction that Karina attend to her physical experience of holding her breath.

*Clinician:* Now I'd like to do this again, but this time, I'd ask you to see if you can pay special attention to how holding your breath feels in your body. I'm going to time you again. Hold your breath as long as you can. Ready? Begin.

Again, the clinician times Karina and provides nonverbal support. They debrief, and the clinician requests a rating of Karina's discomfort.

*Clinician:* What did you notice this time? How high did your discomfort get, on a scale from 1 to 10?

Again, the clinician guides Karina in responding with as many details as possible and writes down her discomfort rating. Then the clinician introduces the next part of the exercise, instructing Karina to track her discomfort during the exercise.

*Clinician:* Would you be willing to do this again? This time, I'm going to give you a pen and I want you to rate your discomfort during the exercise, writing down a "1" when your discomfort first shows up, a "2" when it worsens, and so on. So hold your breath as long as you can. Ready? Begin.

Again, the clinician times Karina and provides nonverbal support. She also copies Karina's ratings, along with the time when each was recorded.

*Clinician:* And what was different this time? How high did your discomfort get? What else did you notice?

Again, the clinician guides Karina in responding with as many details as possible and writes down her discomfort rating. Then the clinician introduces the next part of the exercise, instructing Karina to avoid the physical sensations during the exercise.

*Clinician:* If you'd be willing to do this one more time, I'd like you to hold your breath as long as you can. This time, though, I want you to try your best not to feel any discomfort. Imagine you could cut yourself off from it, turning your attention away any time you notice discomfort.

Again, the clinician times Karina and provides nonverbal support. They debrief this final portion and the exercise as a whole.

*Clinician:* Okay. How high did your discomfort get this time? What else did you notice?

Finally, the clinician gives Karina the opportunity to relate this experience to some aspect of her life, which allows the clinician to assess what, if anything, was learned.

*Clinician:* Does this relate to any experiences that come up in your life?

The clinician may or may not relate Karina's experiences in this exercise to broad concepts of avoidance and acceptance, depending on Karina's experience. Regardless of whether or not the clinician helps Karina make sense of this exercise at this point, it may be useful to refer to the different parts of the exercise later in the course of therapy as metaphors for avoidance and acceptance.

# INTERMEDIATE EXPERIENTIAL ACCEPTANCE WORK

Intermediate acceptance work presents the client with the explicit opportunity to choose to approach something aversive. The clinician may use aversives that are more central to the client's struggles, but attempts to present conditions under which the client might actually choose to let go of avoidance. The concept of avoidance as having a cost may be introduced experientially. However, at this stage, the emphasis is not on the client describing experiential avoidance or expressing a desire to be more accepting.

## CASE EXAMPLE: Aja's Intermediate Acceptance Work

Aja is fairly socially withdrawn in a crowd, but seems to enjoy social interactions that are one-on-one. She reports that it is because she is "just fed up with the bullshit." She is unwilling to provide any more detail. Aja regularly claims to be "laid-back" and to "not care," particularly when she is attempting to avoid a potential conflict or manage a perceived conflict.

### The Gift Exercise

The clinician introduces the Gift exercise to Aja by asking her to recall a time when she might have been more accepting.

*Clinician:* You've told me about how laid-back you are compared to the other girls here. I was wondering if you had a sense of when that started. When did you notice that others seemed to be a lot more uptight than you were?

It is not important at this point that the client explain what happened or give additional details. At this point, the clinician simply initiates enough contact with the experience for Aja to be able to give permission for the exercise to continue.

*Clinician:* I was wondering if we could do an exercise reaching back to just before that. I'd like to get a sense of what it was like for you then.

With Aja's permission, the clinician begins with a present-moment exercise. When Aja's nonverbal behavior suggests that she is present, the clinician guides her awareness to the image of herself before she learned to "not care."

*Clinician:* And now I'd ask you to gently let your awareness shift from your experience in this room, right now, and call to mind an image of yourself at about age ten. And breathe. And let an image of that little girl materialize before you. Let yourself notice the way her hair falls about her face, the shape of her cheeks, her jaw, her chin. Notice the way she moves, and the posture she takes when she falls still. And breathe. And I'd like you to let yourself recognize this girl from the inside out. Notice the things that please her, the things that she approaches with excitement. Watch her face change as she contacts these simple joys in her life. And breathe. And on the next breath in, I'd ask you to notice the hurts she carries with her—the things she fears or worries about. Notice her disappointments. And watch her face change as her hurts, and fears, and disappointments begin to show. And breathe. And now, if you're willing, I'd like you to let yourself become aware of the joys and the pain that this little girl has yet to experience. Notice that it won't be long before this little girl begins to let go of her freedom to care. Maybe this happens slowly, over a number of hurts over years. Maybe it happens all at once. And breathe.

Next, the clinician introduces the idea that this avoidance could have a cost, and that there may be other ways of being,

*Clinician:* I'd like you to imagine that you had a gift that you could give this little girl. Something that only you could give her. Imagine that you could give her permission to continue to care—with the freedom she has now—about one thing in her life. The joy that comes with caring and the pain. Maybe it's a person, an experience, a hope. You get to pick. I'm going to fall silent here. And in the moments of silence that follow, I'd like you to let the question rise up around you, without rushing into an answer: would you take the opportunity to offer this little girl this gift?

The clinician pauses here, watching Aja for nonverbal indications of flexibility or inflexibility, then ends the exercise.

*Clinician:* And whenever you're ready, I'd ask you to join me back in this room, right now, letting that question linger.

Upon conclusion of this exercise, the clinician gives Aja the opportunity to share what that experience was like for her. At this point, the clinician's job is simply to appreciate what she conveys.

## ADVANCED EXPERIENTIAL ACCEPTANCE WORK

Advanced experiential acceptance work aims to facilitate the full embrace of all experience, both aversive and appetitive. The aversives introduced in advanced acceptance work are central to the client's struggles, and the client may participate in the exercise more actively. The client who is ready for advanced experiential acceptance work will have some acceptance present in her repertoire. This can be used as a foundation for more explicit acceptance work. Advanced acceptance work introduces the concept of acceptance experientially, and presents conditions under which the client is likely to exhibit acceptance.

### CASE EXAMPLE: Gabriella's Advanced Acceptance Work

Gabriella experiences great distress associated with her body image and usually takes significant measures to make sure her body weight is maintained and her perceived flaws are hidden. She has a rigid exercise routine that she performs at the local gym in early hours to avoid being seen. Gabriella recently removed all the full-length mirrors in her home because she "couldn't stand" to see her body. Despite a sense of style that is evident in her grooming, accessories, and home decor, Gabriella wears clothing that is drab and one or two sizes too big for her. Gabriella is matter-of-fact about the way her body image affects her life. She has admitted that she does not attend events where she would be expected to wear tight or revealing clothing. She is considering borrowing money significantly outside of her means to pay for cosmetic surgery. Gabriella seems to accept most other aversives in her life. She has overcome financial challenges to attend school for social

work and has secured a job training first-line providers in care of foster children. She appears to respond to work-related stress effectively. She has several long-term relationships, which she reports have become more distant as her body-image difficulties increased in the past two years. She presented in therapy wanting to "feel better" about her body.

## The Floating Metaphor

The clinician begins by first guiding Gabriella's attention to her struggle with body image.

*Clinician:* I hear that you've come here with a hard fifteen years of struggling with your body behind you. I hear the way you've made your life smaller to accommodate the struggle. I hear you hoping that there is something we can do together that would make these painful thoughts and feelings about your body go away. I want to tell you truthfully, though, that I have no idea what I would try that you haven't tried already. You've tried diet and exercise to change your body. You've tried affirmations and relaxation to change your thoughts and feelings. You've tried to not care, to distract yourself, to pretend like everything is fine. And even when things have worked for a while, over and over again you've found yourself swept up once more in this struggle with body image. There's a desperation I hear inside of you coming here. I get the sense that, even now, you feel the struggle rising up around you like water, like if you let go of the fight for even a moment, you'd drown. Is this right?

The clinician introduces the Floating metaphor by first describing Gabriella's avoidance and the costs it may have.

*Clinician:* I wonder if it's something like this: Have you ever been to the beach and stood in the spot just before where the waves break? And if you step just a little further out into the water, when the waves recede, the water pools around your chest or your waist, and it can be comfortable, even pleasant. Then the water ahead of you starts to swell, and you see the waves rising just ahead of you. And even if you enjoy being in the ocean, there's an anxiety that starts to build as the wave moves toward you. I feel like you're in that spot right now. You're doing okay at this moment, but you have the sense

that if you turned away for even a minute, you'd be face-down in the water or, worse, swept out to sea. Is that right?

*Gabriella:* Or just drowning, fighting to stay afloat.

*Clinician:* *(Working Gabriella's response into the metaphor.)* Exactly. Kicking and flailing your arms as the water covers your head over and over...

Next, the clinician uses the metaphor to introduce the concept of avoidance experientially and to cast Gabriella's current behavior as avoidant.

*Clinician:* So there are a couple of things you can do when you find yourself in that spot. One is to watch the wave closely, making your body go rigid as you brace yourself for its approach. For you, this is exercising, hiding your body, borrowing money for surgery. So you watch the wave come, and anxiety rises, and the more anxiety rises, the more rigid you become.

The clinician now introduces experientially the idea that avoidance has a cost.

*Clinician:* And this works pretty well, right? The wave breaks hard against you. It might sting a little, get some spray in your face, salt in your eyes, but most of the time it's okay. At least you're not drowning, or swept out to sea.

Except here's the thing…another wave is coming, right? So again you go rigid, watching and bracing yourself for the next hit. It's pretty hard to enjoy a dip in the ocean when you're having to keep one eye on the horizon at all times, bracing yourself for the next wave. And not only that, but eventually there's a wave that's higher than you are tall. And no matter how rigid you go, it's too much—you're going down. So you find yourself coughing and sputtering and wiping the salt from your eyes, but there's barely time to do that before you've got to be ready for the next one.

The clinician then introduces acceptance as an alternative.

*Clinician:* There's something else you can do, though. You can let your body go sort of limp, right? Your arms and legs sort of hanging in the water. And the waves still come, and you get lifted up right along with the water around you. It's

disconcerting, right? Really sort of uncomfortable as your feet leave the sand and you feel yourself carried along. So you make a stroke or two with your arms, kick a little, and eventually your feet find ground again. You might settle down somewhere different from where you started. You might feel sort of uncomfortable and out of control. But here's the thing: you float if you let yourself float. So which is the stronger position?

Finally, the clinician relates the metaphor back to Gabriella's struggles with body image.

*Clinician:* I guess what I'm wondering is this—you've been getting harder and more rigid all this time in your struggle with your body. Your eyes are always on the horizon, waiting for the next time those thoughts and feelings rise up around you. Could it be that it's just like in the ocean? Could it be that you could just float?

The clinician resists giving any direct advice here, except maybe to offer Gabriella the challenge to try acceptance and see what happens.

*Clinician:* It might be worth checking out. What if next time you looked with disgust at your thighs or your stomach, and those familiar feelings started to swell, and you felt yourself start to go rigid, what if you paused and breathed, closed your eyes, and let yourself float? Think it might be worth a try?

# CHAPTER 8

# Training Transcendent Self-Awareness

Many individuals struggling with disordered eating and related disturbances exhibit a sense of self that is limited and thus limiting of their experience. Individuals develop a sense of self from within a social context. Many social contexts emphasize eating and body shape as particularly important and meaningful. Some individuals come to see their bodies and their eating as a proxy for their worth. Managing or ignoring the body and eating can become a way of avoiding contact with feelings of worthlessness. ACT aims to create a context in which multiple senses of self can be experienced, eventually resulting in the discrimination of the aspect of self that is common to all those experiences, the transcendent sense of self.

## TRACKING TRANSCENDENT SELF-AWARENESS

Transcendent self-awareness involves contacting different ways of experiencing one's self flexibly, such that a sense of self that is separate from any particular experience emerges. Individuals struggling with disordered eating and related disturbances often report rigid ideas about who they are and what is possible for them. For example, clients may describe experiencing themselves purely in terms of their body shape or eating behavior. They may report with certainty what their body shape or eating means about what they can and can't do, what they mean about who they are as a person.

Individuals may also report great difficulty adapting to different roles or relationships. For example, they may describe being comfortable only in certain contexts. They may report being hyperaware of feelings of "fatness" or related fears in contexts that are unfamiliar or novel, and subsequently behaving ineffectively.

Limited self-awareness may also be observable in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which self-awareness is expected to be more or less likely, and observe subsequent shifts in behavior. To what extent is the individual able to contact different experiences of self, such that there is a sense of self as being separate from particular experiences? Can the client, for example, recognize herself separate from the experience of food restriction or frequent exercise?

There are many behaviors in session that can indicate difficulties with self-awareness. Clients may equate their sense of self with their current psychological experience. For example, they may experience themselves as "good" when they are feeling happy about successfully restraining or exercising, and have little contact with a self that is separate from their eating. Clients may be unresponsive to prompts to contact different experiences of themselves. For example, they may attach to self-conceptualizations of "an anorexic" or "a fat ass" in a way that prevents self-observation of current or potential traits, roles, or other characteristics. Clients may also allow these limited experiences of self to determine what is worth trying for. For example, they may limit treatment engagement and aim low with respect to treatment goals because of the high likelihood that "a bulimic" will fail. Clients may also have great difficulty speaking from their own perspective, and seem overly reliant on the feedback they receive from the therapist. Others may take on a certain role that is insensitive to therapist feedback.

## PRESENTING OPPORTUNITIES FOR TRANSCENDENT SELF-AWARENESS

Individuals struggling with disordered eating often benefit from learning to contact a sense of self that transcends individual experiences of the self. Transcendent self-awareness can be threatened when an individual's experience of herself has been limited. Transcendent self-awareness is also threatened when a single experience of the self is particularly compelling as an aversive to avoid (for example, "fat"), or a form of avoidance itself (for example, "thin"), and thus comes to dominate. ACT clinicians train

transcendent self-awareness by broadening an individual's experience of herself. The client contacts various experiences of herself using multiple exemplar training across aversive and appetitive contexts. This allows her to discriminate the sense of perspective that is common to all of them.

## EARLY TRANSCENDENT SELF-AWARENESS WORK

Early transcendent self-awareness work involves presenting contingencies that support contact with multiple experiences of the self. Early self-awareness work may not introduce any novel or aversive ways of experiencing the self, but focus instead on moving flexibly among fairly salient experiences of the self. The concept of transcendent self-awareness is not necessarily introduced at this point. Early self work is relatively structured, in order to keep the client from becoming distracted by contingencies of natural conversation.

### **CASE EXAMPLE:** Crystal's Early Transcendent Self-Awareness Work

Crystal seems to work tirelessly to secure and hold the attention of an audience. She is talkative and speaks loudly, using dramatic intonation and gestures to convey her story. She offers her opinion on most things, and has trouble taking others' perspectives. Crystal has great difficulty answering simple questions from her perspective (for example, what she wants). Her relationships are limited, and usually include a dual relationship and an explicit power differential (for example, a sexual relationship with a supervisor). Crystal works hard at her job, particularly when there is a possibility of recognition. She tends to take on more than she can do, and has recently begun staying after work regularly to catch up. Crystal restricts in public and refers often to her "diet." She binges and purges nightly. It appears almost as if Crystal has to work twice as hard as anyone else to be approved of, and without approval, she would cease to exist.

### I Am Exercise

The clinician introduces the I Am exercise to Crystal, describing the process with enough detail to allow her to give her permission.

*Clinician:* In just a moment, I'm going to hand you a few packets of paper and a pencil. On each piece of paper, a series of sentences are started for you. These are sentences you could complete a number of different ways. They are all focused on how you see yourself and how you'd like to be seen. When I tell you to begin, I'd ask you to complete the sentences, one by one, until I tell you to stop. Don't try to think too much about how you are answering. Just write down what shows up for you as you read the sentence. Also, there will be more sentences than you can complete in the time you're given, so when I ask you to stop, gently let go of the exercise and let the blanks be there, unfinished. This is not an easy exercise, but many find it useful. Would you be willing to try it?

With Crystal's permission, the clinician hands her several packets of worksheets (included in appendix F). The clinician asks Crystal to take out the first set of worksheets. They are comprised of a number of lines that read "I am _____."

*Clinician:* I'd like you to take out the first packet, and when I say "Begin," I'd like you to start completing the sentences one at a time, until I tell you to stop. There are no breaks in this exercise, so if you have any questions, please let me know now. Ready? Begin.

The clinician starts the timer and observes Crystal for indicators of flexibility and inflexibility. Crystal attempts to stop the clock to ask questions several times (for example, "What if I already wrote down everything that's true?"). The clinician asks her to please continue with the exercise.

*Clinician:* I know this is not the easiest exercise. And it's going to be most useful to you if you dip back in for now until time is up.

When time is up, the clinician gives Crystal the opportunity to comment or ask questions about the instructions.

*Clinician:* And now I'd like you to go ahead and set your pencil down. As you rejoin me for your next set of instructions, I'd ask you to notice any urges to make sense of your experience and let those go as you focus your awareness on the next part. Do you have anything you'd like to say before we move on? Any questions about the instructions?

*Crystal:* What's the point of this?

*Clinician:* *(Avoids describing the conceptual basis for the exercise.)* We will have time to discuss how the exercise impacted you, which is more important to our work than how it is "supposed to" impact people. For now, though, I'd ask that we continue to the next part of the exercise.

The clinician asks Crystal to take out the second set of worksheets. They are comprised of one hundred lines that read "I am not _____."

*Clinician:* I'd like you to take out the second packet, and when I say "Begin," I'd like you to start completing the sentences one at a time, until I tell you to stop. Again, there are no breaks in this exercise, so if you have any questions, please let me know now. Ready? Begin.

This process continues with the third and fourth packets, which include the prompts "I wish I was _____ and "I fear I may be _____."

Crystal is given ninety seconds with each packet. Upon conclusion of the I Am exercise, Crystal is given the opportunity to look over her responses and discuss her experience.

*Clinician:* What was that like for you?

The clinician's job following this exercise is to appreciate Crystal's experience and to assess her degree of flexibility or inflexibility. If she appears to have struggled with the exercise, the clinician may ask her if she'd be willing to do it again on her own, or in the next session.

## INTERMEDIATE TRANSCENDENT SELF-AWARENESS WORK

Intermediate transcendent self-awareness work involves the introduction of some new ways of experiencing the self. These may be somewhat aversive, but not so aversive that the client is unwilling to contact them. The concept of transcendent self-awareness may be introduced experientially, so that the client can begin to discriminate self-awareness in her own experience. However, the goal is not for the client to be able to describe transcendent self-awareness or its benefits.

## **CASE EXAMPLE:** Jessica's Intermediate Transcendent Self-Awareness Work

Jessica has made a significant number of positive changes in her life over the past year, including leaving an abusive relationship, going back to school, and ceasing her bingeing and purging behavior. Jessica expresses discontent, however, with the narrowness of her life. Part of her approach to changing her life involved changing the contexts she exposed herself to. Jessica let go of many of her relationships because they were not supportive of her decision to leave her husband. She began eating only at home to improve her adherence to her new diet and exercise program. She ceased much of her recreational activity to focus on school. Jessica expresses the belief that if she did not restrict her life in this way, she would not be able to maintain her success.

### The Playground Metaphor

The clinician introduces the Playground metaphor to Jessica by observing the rigidity with which she interacts with herself.

*Clinician:* You know, as I sit here, listening to you talk, I am struck by how you strict you are with yourself. I keep getting this image of you like a kid on the edge of the playground, sort of kicking at the dirt, trying not to meet the eyes of the other kids as they play. It's like someone's told you it's dangerous out there, or you mustn't get dirty, or none of the other children are going to like you. So there you are, on the edge of the playground watching the other kids swing, slide, and play chase.

Next, the clinician introduces the idea that Jessica's rigidity with herself may be chosen, and that there are other options.

*Clinician:* The deal is, though, there's no towering parent, or grumpy babysitter, or horrible bully that's holding you there. It's you. It's like you're sitting there saying, "Nope. That's not for you, Jessica. You know you're not up to the task of going out there alone." And I wonder, what would it be like for you to notice suddenly that that kid on the edge of the playground

> can handle the dirt, and the scuffed knees, and the hurt feelings? What if you could walk up to her slowly, her big eyes lifting to meet yours, and you could crouch down and whisper something in her ear? She'd look back at you eagerly, like "Really?" and you'd nod and gesture her along, like "Go on." What would those first few steps onto the playground be like for her? I bet she'd look back for reassurance a couple of times. And for you? Even as the dirt, and the scuffed knees, and the hurt feelings became more and more likely, you'd gesture her along: "Go ahead. You got it."

The clinician offers Jessica an opportunity to discuss the metaphor without drawing specific conclusions about what she "should" do differently.

*Clinician:* How does this image sit with you? Does it feel like this sometimes?

If Jessica seems to be engaging the metaphor effectively, the clinician might ask her to further relate the metaphor to her life.

*Clinician:* How long do you think you've kept yourself out there on the edge of the playground? What might that little girl need to hear to be able to take that first step? What would you have to be willing to risk to let that little girl go?

Finally, the clinician might introduce the idea that it is up to Jessica herself to continue to build a life that is more satisfying to her.

*Clinician:* What if it's like this? What if you're the only one who can give yourself permission to step out into your life?

## ADVANCED TRANSCENDENT SELF-AWARENESS WORK

Advanced work in transcendent self-awareness introduces the concept of transcendent self-awareness experientially. The clinician presents the client both appetitive and aversive experiences of the client's self and her world. The clinician then draws the client's attention to the aspect of herself that transcends any one thought, feeling, memory, self-evaluation, or other conceptualization.

## **CASE EXAMPLE:** Tonya's Advanced Transcendent Self-Awareness Work

Tonya struggles to reconcile her sense of her self before her eating problems with her ideas of her current self as "sick" or "screwed up." She cherishes her memories of her "perfect childhood" and blames her "carelessness" for the trauma she experienced as a young woman. Tonya sometimes considers this trauma to be indicative that she never quite fit in, "was never quite perfect enough." Tonya alternates between trying to appear perfect to others, which alienates her from her peers, and completely withdrawing from all activities at the first sign of imperfection.

### I-Contact Exercise

The clinician introduces the I-Contact exercise to Tonya by guiding her attention to her struggle with self-conceptualizations.

*Clinician:* I know that it's been a challenge for you to manage your ideas of who you are and who you should be. I'd like to do an exercise with you that involves contacting many different experiences of yourself. Would you be willing to do this with me?

With Tonya's permission, the clinician guides Tonya's focus to the present moment.

*Clinician:* I'd like you to start by just getting comfortable in your chair, and taking a deep breath, noticing the way the air feels passing through your nose or mouth right now. And breathe. And as you exhale, see if you can just let yourself settle here in the room.

When Tonya appears to be present, the clinician introduces the image of a hand mirror and guides Tonya in noticing her face.

*Clinician:* I'd ask you to start by letting a hand mirror be in your hands, a mirror big enough that you can see your whole face in it at once. Raise the mirror so that you are holding it in front of you. I'd like you to start by noticing the way your hair falls about your shoulders, the curls that twist in and out of one another. Let your eyes follow your hair up to

your head, where your hair frames your face. Notice the little baby hairs along your forehead, lighter than the rest. And slowly notice your forehead, the creases your laughter, your surprise, your pain have carved there, around your eyebrows. Now let your eyes trace around to your cheekbones. Notice the color there, the shape they take. Trace your jaw and around to your chin. Notice the shape of your lips. See if you can see where your lips begin, where the color shifts from that of your skin. Now move gently up the cleft above your lips to your nose, circling your nostrils and noticing the slope of your nose, where it shifts into cheek. Notice the way your skin creases in the soft places around your eyes. Notice the way your eyelids rest on your eyes, your lashes fanning outward. And breathe. And finally, let your awareness come to rest on your own eyes. As you gaze into your eyes, notice the swirl of colors there. Try to pick out the browns that are almost black, and the places that gold shines through. Notice the edges between that blur into a soft green. And breathe.

And now, the clinician guides Tonya's awareness to the different experiences she has had of herself, others, and the world.

*Clinician:* And now, I'd ask you to look just beyond the shape and colors and notice in your eyes the things they have seen. As you gaze into your own eyes, I'd like you to recognize your love for your sister, and what it has meant to you to support her during the last three months. And breathe. Notice the thoughtfulness you show to people around you. See in your eyes the joy you get out of making someone feel loved. And breathe. Recognize the struggle you've had with your body, the loathing you've known in the night. And breathe.

Let yourself notice the memories your eyes hold. See the first person you called a friend and meant it. See the first teacher you remember taking an interest in you. See them rise up in your eyes and let their names echo around you. And breathe. Recognize the memory of a time you fell down and cried until someone came. And the memory of a time you fell down and pretended it didn't hurt. And breathe. Gaze into your own eyes and see a time your face went hot with shame… And another… And another… Peer into your eyes and see a time that you were in love… And another…

And another… Let yourself notice the memories that loom like shadows there in your eyes. The ones that catch your breath and turn your stomach. And breathe. Recognize in your eyes yourself as a sister. And breathe. Recognize in your eyes yourself as a student. And breathe. Recognize in your eyes yourself as a dancer. And breathe. Recognize yourself as a patient. And breathe.

Recognize in your eyes yourself as a daughter. And breathe. And breathe. And breathe. And notice the whole of your experiences there, pouring from your own eyes. And breathe. And notice that they are your eyes. Your browns and greens and golds, under your lids with fanning lashes, under your eyebrows, above your cheeks. And whenever you're ready, I'll ask you to rejoin me here and now, seeing the world through the eyes that have known all that.

# CHAPTER 9

# Training Valued Living

Often the struggle with disordered eating has taken the focus off of the aspects of life the client values. Time, energy, and other resources are spent on maintaining disordered eating while life continues with little or no chosen direction. Hopes and dreams are tucked away as intentions for later, "after all this gets sorted out," for "when I've got my weight under control." And life continues, and the individual feels farther and farther from the things she cares about. ACT focuses on building valued living in the present, without the world or the individual having to change.

## TRACKING VALUED LIVING

Valued living involves living in such as way so as to facilitate active engagement with the ways an individual *chooses* to work and live. Individuals struggling with disordered eating and related disturbances often have difficulty reporting what they value. Some may find it difficult to even imagine pursuing anything that really matters to them while in the midst of their struggles with eating and body image. Others may report valuing what they perceive as socially acceptable, and deny any difficulty living consistently with these values. Still others may deny valuing anything other than being able to maintain a particular body weight.

Deficits in valued living may also be apparent in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which contact with values is expected to be more or less likely, and observe subsequent shifts in behavior. Clients may discuss important life decisions based entirely on practical necessity

rather than a sense of free choice. For example, they may identify placating doctors or family members as their purpose for treatment. Clients may seem engaged and motivated only when things are going well, and seem lost when they are confronted with obstacles or setbacks. When clients identify values, they may be held defensively and rigidly. For example, a client may express the value of being a parent as her reason for treatment, but hold this as a burden rather than a choice. She may engage in discussions of these values with hesitation and excessive judging, justifying, explaining, or apologizing.

## PRESENTING OPPORTUNITIES FOR VALUED LIVING

Individuals struggling with disordered eating often benefit from learning to contact chosen values. Valued living is difficult because of the inherent relationship between values and vulnerabilities. In contacting her values, an individual must also contact the distance she is from living them. Values work in ACT involves presenting opportunities for an individual to shift from a life dominated by aversive control to a life guided by chosen values.

## EARLY VALUES WORK

Early values work involves introducing conditions under which an individual's behavior is not dominated by aversive control. Often, at this stage, the only moments not dominated by aversive control are moments of relief. The clinician is challenged to facilitate contact with this experience, but only with the client's permission. Values work at this stage does not involve values clarification or an acknowledgement of values deficits. Rather, the clinician is aiming to create a context in which later values work might occur.

### **CASE EXAMPLE:** Laura's Early Values Work

Laura is attending treatment at her mother's insistence, due to recent health complications associated with her underweight and purging behaviors. She has few relationships, and those that she has are characterized by her attempts to avoid judgment. Laura's grades have recently begun to drop, despite her past academic achievements. She recently quit soccer and ballet,

both of which she formerly enjoyed. The only area of dissatisfaction Laura reports is associated with others' "interference" in her life. She has resisted all discussion of treatment goals.

## A Free Breath Metaphor

The clinician introduces values work by claiming her own vulnerability with regard to their therapeutic relationship.

*Clinician:* I know that coming here to treatment was not your idea. In fact, I get the sense that this feels completely contrary to everything you would want to be doing right now. I'm not interested in being another person in your life who claims to know what you *really* want or what you *should* want. In fact, I think my ideas about your life are going to be completely useless to our work here. For this work to be of any use to you, I'm going to need to get a sense of what matters to *you*, where you find peace. And the only way that I can get a sense of that is for you to share it with me.

The clinician then acknowledges the potential cost inherent in values work and commits to collaborating with Laura to work toward her values.

*Clinician:* This is not an easy thing I'm asking of you, but if you choose to give me a glimpse of what this is all like through your eyes, I commit to working with you to make your work here yours.

Next, the clinician explicitly relinquishes control, giving Laura the opportunity to choose.

*Clinician:* Honestly, you get to pick. The work I'm offering you is not the kind of thing you can be forced into. If I started throwing it at you, without you choosing it, it wouldn't be the same piece of work. So what do you think? Could I ask you a couple of questions? And we can figure things out from there?

With Laura's permission, the clinician introduces the metaphor of a Free Breath.

*Clinician:* So, let's start off by acknowledging that I don't know anything about you. I've read your file. I know how you got

here and what your doctors' concerns are. And that really tells me very little about you. What I do get the sense of is what a fight life has been for you recently, like the world has started to close in. Just knowing that, I wonder, when are the moments when you can feel yourself, alive in your own skin? When are the moments when you can finally draw a free breath?

*Laura:* I don't know. When I'm alone.

*Clinician:* And what shows up for you then, when you're alone? If I could get even a tiny glimpse of one of those moments…

The clinician's job here is to appreciate Laura's experience as she conveys it, to notice the sunset sitting before her.

*Laura:* Well, like yesterday, when they weighed me, I saw my sheet and I'd lost weight instead of gained. I know I'm supposed to be upset or something, but when I got back to my room, I was sort of relieved.

*Clinician:* And in that moment, alone inside of that relief, you could breathe?

*Laura:* I guess. I felt like I'd won.

*Clinician:* Good. Thank you for sharing that with me. I feel like I heard what that meant to you. I appreciate you sharing it.

Finally, the clinician casts their work together as a potential part of Laura's pattern of valued living.

*Clinician:* I wonder if there's something we could do together that could make it to where the time you spent here was about finding more of those moments. And not only here in the office, but out in your life. Would that be something worth coming here and talking to me for? Even on the days it was hard?

## INTERMEDIATE VALUES WORK

Intermediate values work involves facilitating contact with some degree of appetitive control, even when aversive control is dominant. The clinician

helps the client to identify an area of her life in which avoidance limits her contact with values, and helps her to let go of that struggle, if even for a moment. The relationship between acceptance and values is introduced experientially. The focus here is not necessarily clarification of what the client values, but experiential contact with that value.

## CASE EXAMPLE:
## Andrea's Intermediate Values Work

Andrea identifies a number of areas of her life as important, including her relationship with her boyfriend and her work with Family Services. She often struggles, however, with her doubts about whether or not she is competent enough to make a difference in these areas. These self-doubts often show up as body-related concerns, which Andrea says have interfered with intimacy and her ability to train, a major part of her job. Andrea mitigates these doubts these by tightening her control over her body.

### Reaching In Exercise

With Andrea's permission, the clinician begins the exercise by calling her attention to a moment when aversives seem to interfere with her functioning.

*Clinician:* To start, I'd like you to call to mind a situation in your life when your struggle with your body really shows up and grabs hold of you. Got it? Tell me in one word where it is.

Next, the clinician guides Andrea in engaging this event experientially from an external perspective.

*Clinician:* Now what I want you to do is to gently let your eyes fall closed and see yourself up there, in front of the room, like you were a member of your audience, one of your trainees. In one word, what would I see if I was in the audience?

*Andrea:* Confident.

The clinician checks to make sure she understands, providing some additional details to facilitate Andrea's contact with the experience.

*Clinician:* Confident, good. So we in the audience are watching you up there, doing your thing, just exuding confidence and grace. Is that right?

Next, the clinician guides Andrea in shifting to her own perspective.

*Clinician:* Now I'd like you to see if you can't slip your awareness into your own body, up there leading a training. Notice the words gliding from your lips, the rhythm of your breath. Feel your arms as you gesture, making this point, and that. Notice the rhythm of your heart beating in your chest. What is it like in your body, in one word?

*Andrea:* Hot.

The clinician guides Andrea in attending to the physical aspects of that experience.

*Clinician:* Let that heat wash over you from your toes to your ankles, up your legs and around your waist and chest, under your arms and up your neck to your face.

Next, the clinician guides Andrea's attention in shifting to her thoughts.

*Clinician:* And now allow yourself to become aware of any thoughts you are having. Any show up?

*Andrea:* Yes.

*Clinician:* Okay, good. In just a few words, what are you thinking?

*Andrea:* I wish I wasn't here. This is horrible. They're going to know.

The clinician asks Andrea to provide more details here.

*Clinician:* What will they know, Andrea?

*Andrea:* That I'm a fraud, that I don't belong up here.

Again, the clinician clarifies, facilitating Andrea's contact with the experience.

*Clinician:* That you don't belong up there. That you are just fooling everyone. Is that right?

The clinician then ends the eyes-closed portion of the exercise, asking Andrea to retain her sense of the thoughts and feelings that interfere with her performance when she is training.

*Clinician:* I'd like you to take a deep breath and let those images fade from your mind as you rejoin me in the room, but as the image fades I'd like you to keep a hand on that sense that you don't belong there, that you are just about to be found out. Would you be willing to do that?

*Andrea:* Yes.

The clinician asks Andrea's permission to discuss her experience.

*Clinician:* Now I'd like to ask you a few questions about your experience. Would that be okay?

With Andrea's permission, the clinician guides her attention to functions of her engaging this aversive experience.

*Clinician:* I guess the thing I'm struck with the most is how difficult it is for you. What is inside of that experience? I mean, what keeps you up there?

The clinician coaches Andrea not to try to explain it, but simply to express what maintains her engagement in something aversive.

*Clinician:* As you answer, you'll feel yourself wanting to explain and to justify to me why this matters to you. But that's not the part that's important. What's important is that I see, through your eyes, what matters to you inside of this.

The clinician does not avoid or refute responses that indicate avoidance or other inflexibilities (for example, "I do it because I have to"). Andrea's actions are certainly avoidant to some extent, in some moments. Whatever Andrea's response, the clinician leans in, striving to appreciate her experience. The assumption is that if the clinician is able to contact Andrea's experience, then she is in contact with it. When the clinician has a clear sense of that part of her experience, he asks Andrea what other experiences maintain her behavior.

*Clinician:* And if we were to take that sense of responsibility, these trainings as a burden, and gently set them aside, what else would be there?

The clinician continues in this way, appreciating each of Andrea's responses, then setting them aside. The clinician stops when a sense of something that Andrea values emerges.

*Andrea:* I guess I care about the providers knowing how to help. I want them being able to feel what it's like to make a difference.

The clinician builds upon this value, relating acceptance to successful pursuit of Andrea's value.

*Clinician:* And I wonder if the providers you train ever feel lost, like they don't belong, like they really don't know what they're doing.

Finally, the clinician presents Andrea with the options of avoidance and acceptance, casting acceptance as values consistent.

*Clinician:* So now I'm going to ask you to choose: In this hand, you are finally free of your concerns about your appearance, of your pain over your body, and when the people you serve reach out for you, you just don't quite get it. In this other hand, your fears, your concerns, your pain are yours to carry with you throughout your life, and when others share their pain, you rarely feel good enough to really help them, but you are able to hear their struggles. Which would you choose? And how long would you be willing to carry that pain if it meant you could better serve the people you work with?

The clinician may or may not provide an explanation of the concepts of avoidance and acceptance at this point, and how they relate to values. If Andrea seems particularly eager to derive a rule about how she *should* be, it may be more useful for her to let the experience stand for some time. The clinician may thus ask Andrea to simply notice, for now, the places in her life where she engages a difficult experience willingly, and places where she might want to do so.

## ADVANCED VALUES WORK

Advanced values work involves the introduction of values construction, in which the client creates opportunities for valued living in her life. The clinician creates the opportunity for the client to select a domain of living in which she would like to build valued living, and to begin defining what that means to her.

# CASE EXAMPLE:
## Cheryl's Advanced Values Work

Cheryl describes several aspects of her life as valued, including being a parent and pursuing a career in painting. She is defensive of these, however, and tends to justify and explain her values when asked about them. Cheryl has begun to take action in these areas. However, she experiences her values as conflicting and inconsistent with what others would want for her.

### You Get to Pick Exercise

The clinician begins by asking Cheryl's explicit permission to discuss her struggle with values.

*Clinician:* You've worked really hard in the past few months to start taking more action in areas you care about. I hear that lately, though, you feel more weighed down by your values than guided by them. I was wondering if you'd be willing to dig into that a little with me today?

With Cheryl's permission, the clinician guides her attention to a moment in her life when she noticed herself struggling to maintain contact with her values.

*Clinician:* I'd like you to start by telling me a little more about what this is like for you. If you would, call to mind a moment recently when you saw yourself taking action in one of these areas, but felt disconnected from the value behind it. Now you might find yourself wanting to rush through this, because it's a hard thing to sit in, and when you do, I'd encourage you to slow way down, take a deep breath, and walk slowly through this experience. These are precious things in your life, and if we move too quickly, we might miss something. So, slow… Can you call to mind a moment like this that you'd be willing to share?

*Cheryl:* Sure. Um…I was trying to finish that painting in time to submit it for the show downtown and Julie was sick and just miserable and…

The clinician interrupts here to help Cheryl slow down to contact this experience.

*Clinician:* Slow. What were you painting?

*Cheryl:* It's a bird. A…um…a turkey.

*Clinician:* Say more?

*Cheryl:* Okay. It's a piece I've been working on a while. It shows this awkward-looking animal, this turkey, but with its wings spread, and head pulled back, facing upward… I see it in my head, but just haven't been able to get the colors right.

*Clinician:* It's an important piece to you.

*Cheryl:* It is. I thought it was my best chance to get into the show.

*Clinician:* And what else?

*Cheryl:* And it's a piece I've wanted to do for a while, but was scared to try.

*Clinician:* Good. So this night in particular, you were…

*Cheryl:* Working on the shading in the wings.

*Clinician:* Good. Where were you?

*Cheryl:* In my bedroom. Next to my bed.

*Clinician:* And in one word, what was showing up for you as you painted that night?

*Cheryl:* Frustration.

*Clinician:* Any thoughts?

*Cheryl:* Failure. Bad mom.

*Clinician:* Bad mom.

*Cheryl:* Julie was running a fever. She kept waking up. Usually nighttime is my only time to paint, and she needed me that night.

*Clinician:* And what did you do with that?

*Cheryl:* I kept stopping to lie down with her. Then trying to get up as soon as she was settled. Then it would take me a while

to get back to what I was doing. Then as soon as I started working again, she'd cry out for me. I couldn't do either one right.

*Clinician:* So what do you think about that?

*Cheryl:* I don't know. That this is impossible. That I'm trying to pull off something way too hard. That I should just give up.

*Clinician:* Give up.

*Cheryl:* Give up and do something just to pay the bills, to keep a roof over our heads.

*Clinician:* I see. Tell me something, just to shift gears a little here. When you imagine the kind of mother you'd like to be, what shows up for you?

*Cheryl:* I'd like to at least be competent enough to take care of my daughter when she's sick.

*Clinician:* Does that feel like enough to you? Like if you could pick any kind of mom, any kind in the world, you'd want to be the kind of mom that is competent enough to take care of her daughter? Let me ask it another way. What kind of mom would you want for Julie? If you could pick any kind of mom in the world…

*Cheryl:* One that is caring, attentive.

*Clinician:* Good. And what does that look like? Tell me what it's like when you catch a glimpse of it.

*Cheryl:* Well, like last week, I was pushing her on the swing. The sun was beating down on us, but there was a nice breeze. And she said something. I don't remember what. But it was so funny. We just both started laughing—laughing and laughing. And I thought, *Yes—this is it*. But then Sunday came and…

*Clinician:* Slow down there. Do you feel that urge rush through that moment? How quickly you start to scamper away? Take a step back, if you're willing, to that day on the swing. And go gently here. I saw something there, in your eyes, when you spoke of that…

*Cheryl:* Yeah, it was really nice.

*Clinician:* Yeah. And if you could choose to be any kind of mom, you'd choose more of that?

*Cheryl:* For sure.

*Clinician:* Okay. Now how about painting… Is there a moment of sweetness like that inside of painting?

*Cheryl:* Not recently, no.

*Clinician:* So let your mind roll back to a moment of sweetness not recently.

*Cheryl:* Okay. It sounds silly, but I was mixing this red once and I wasn't sure I'd gotten it right—but the instant it hit the canvas, I knew. It was perfect.

*Clinician:* Wonderful.

*Cheryl:* It really was.

*Clinician:* I wonder—if you could bottle that sense, when the red hit the canvas, that you were in the right place, that you were doing what you loved and it was good, if you could bottle it up and give it away, is that an experience you'd want Julie to have?

*Cheryl:* Sure. Of course.

*Clinician:* And is that part of what you'd want to give her as her mother—if you could?

*Cheryl:* Yeah. Sure.

*Clinician:* So let me ask you something hard here, if you're willing.

*Cheryl:* Okay.

*Clinician:* So you've been struggling here with whether or not to quit painting. Which do you think moves you closer to sharing that sweetness with Julie?

*Cheryl:* I don't know.

*Clinician:* Imagine she finds herself struggling like you are one day. Trying to find direction, to make meaning of her life, and

the thing she wants so bad seems too hard and more than she deserves…when she has a night like your Sunday. And giving up makes the most sense of anything…

*Cheryl:* I'd want her to stay in it. To keep trying.

*Clinician:* And what about for you? Cheryl, what if being the mom you want to be and being the painter you want to be are not two different things?

*Cheryl:* I don't know. Don't quit?

*Clinician:* I don't think it's that easy. I think you get to pick. What if you chose to paint in a way that served your value of being a mom? What if you chose to parent in a way that served your value of being a painter? What if in your world you don't need to tease the two apart? What if you could do both in the service of the other?

*Cheryl:* That would be really nice.

*Clinician:* Is it worth a shot?

*Cheryl:* Yes.

*Clinician:* Even if nights like Sunday come along?

*Cheryl:* Yes.

# CHAPTER 10

# Training Committed Action

Individuals struggling with disordered eating often have trouble with committed action. Many persist at using certain strategies to manage weight or feelings about body shape long after they have ceased to work effectively, and have begun to have considerable costs. Some have great difficulty taking action because of fear of what they will have to go through, or that they couldn't ever succeed, or that they don't deserve the chance. ACT aims to teach people to take valued action in a way that is committed, yet sensitive to changing contingencies.

## TRACKING COMMITTED ACTION

Committed action involves noticing when actions are not consistent with values, and gently turning back to valued living. Individuals struggling with disordered eating and related disturbances often have difficulty acknowledging when their actions are not serving their values. For example, they may insist that they can pursue values without having to give up disordered eating behaviors. When they do acknowledge that they are working against their chosen values, clients often have trouble returning to valued living. For example, they may describe persisting in what they are currently doing as their only option even when it's ineffective or harmful. They may also express feeling stuck or paralyzed by the idea of having to face the costs of their actions.

Difficulties with committed action often emerge in session. In order to determine what these struggles look like for a particular client, ACT clinicians intentionally create contexts in which committed action is expected

to be more or less likely, and observe subsequent shifts in behavior. To what extent is the individual able to notice when actions are not consistent with values and commit to something different? There are several difficulties related to committed action that are observable in session. Clients may actively avoid making commitments. If they do make commitments, they may speak about them in terms of what they "have to do" or "should be doing." Clients may exhibit worry and rumination when given the opportunity to make a commitment or faced with the costs of a failure to commit. They may have difficulty choosing treatment goals, or rely excessively on therapists to generate goals for them.

## PRESENTING OPPORTUNITIES FOR COMMITTED ACTION

Individuals struggling with disordered eating often benefit from making and practicing commitments to valued living. Clinicians in ACT present opportunities for clients to discriminate valued living, and change their behavior when necessary. This involves clients learning to choose what valued living looks like for them across different contexts. Clients often must learn to distinguish the ongoing process of valued living from the outcome. Finally, they learn to notice when they are not engaged in valued living as they would choose, and to change that.

## EARLY COMMITMENT WORK

Early commitment work involves introducing conditions under which clients can choose the form their valued living will take. The clinician introduces experientially the concept of valued living as dynamic and shifting between contexts. The emphasis in on clients making experiential contact with choosing valued action, rather than being able to describe valued actions or actually carry them out.

### CASE EXAMPLE:
### Natasha's Early Commitment Work

Natasha describes valuing her education. She has very specific ideas about what her education should look like that seem to have been instilled by her

father. Natasha refuses to entertain alternative ways of pursuing her education, or any other values. She currently uses most of her resources on hiding and maintaining her bingeing and purging behavior.

## Magic Wand Exercise

The clinician begins by facilitating Natasha's contact with her recent struggle with education. He also suggests that valued living is not to be defined by others, and asks Natasha if she would be willing to explore this area.

*Clinician:* You've expressed before that your education is pretty important to you, how disappointed you were to leave school. I know that your mother has encouraged you to start school elsewhere for now, but that you're not interested in that. Now I'm not interested in being another person with an idea of how you should handle this school thing. Pursuing something of value looks different for different people or even for the same person on different days, in different situations. Yet this work we're doing together won't matter a bit if it doesn't make a difference for you in an area you care about. I wonder if you'd be willing to explore more about what being a student would look like for you if you could just choose.

With Natasha's permission, the clinician begins the exercise with a brief present-moment focused exercise. When Natasha appears to be present, the clinician introduces the Magic Wand exercise by asking her to contact experientially what she would be doing tomorrow if she was pursuing the education she cares about.

*Clinician:* And now, with your eyes still closed, I'd like you to imagine that tonight, when you fall asleep, I decide "to heck with this therapy nonsense" and I wave my magic wand and make it so that you are the student you want to be. Now, your mind is going to throw up all the obstacles here, but just remember, my wand is all-powerful and there is no obstacle big enough to stop you from being the student you want to be. So breathe slowly in, and on the next breath out, let what you know about now fade away and see yourself actively being the student you choose. Now I'd like you to focus in on the actions you're choosing as you move through your day as the student you want to be.

The clinician falls silent to allow Natasha to contact this image before introducing another context.

*Clinician:* And breathe. And let this image fade slowly from you. Now I'd like you to allow three years to pass. And when you are ready, see yourself after three years on the path of being the student you want to be. Again, focus on you here. Your life has changed now, and being a student might look a little different. See yourself older, maybe more practiced. I want you to see yourself moving through your day three years from right now, still choosing actions on the path of being a student you started today. And breathe.

Again, the clinician falls silent.

*Clinician:* And breathe. And let this image fade slowly from you. Now I'd like you to allow ten years to pass. And when you are ready, see yourself after ten years on the path of being that student you want to be. Even after ten years, you are still moving along that path actively and persistently. Your life is different now. Watch yourself and the way you've changed. You're older now. You've learned what works for you as a student. What doesn't. Being a student might look different now. Yet there you are, after ten years, still choosing moment-to-moment actions that move you toward being the student you want to be. And breathe.

Again, the clinician falls silent.

*Clinician:* And breathe. And let this image fade slowly from you. Now I'd like you to allow thirty years to pass. And when you are ready, see yourself after thirty years on the path of being that student you want to be. Even after thirty years, you are still moving along the path you chose today. So much is different now. You've learned so much, and done so much. Being a student looks different now. Maybe it's more than you had imagined. Yet there you are, after thirty years, still choosing moment-to-moment actions as the student you want to be. And breathe.

Again, the clinician falls silent before ending the exercise.

*Clinician:* And now, gently, let this image fade slowly from you. And breathe… And breathe. And whenever you're ready, open your eyes, and join me back in the room.

# INTERMEDIATE COMMITMENT WORK

Intermediate commitment work involves introducing conditions under which the client distinguishes the process of valued living from the outcome. The clinician introduces experientially the concept of valued living as a functional quality of action, rather than associated with outcome. The emphasis is on clients making experiential contact with the range of outcomes that might encourage or discourage valued living.

## CASE EXAMPLE: Katerina's Intermediate Commitment Work

Katerina describes several domains of her life as important to her, including her marriage, her physical health, and her spirituality. She has been questioning her commitment to her marriage since her husband admitted that he had an affair the last time she was in inpatient treatment for eating problems. Katerina has expressed guilt about this, saying that "a good wife wouldn't even consider leaving."

### It's Not in the Cards Exercise

The clinician introduces the It's Not in the Cards exercise to Katerina by facilitating Katerina's contact with her recent struggle with her commitment to her marriage.

*Clinician:* I can hear that this has been just an agonizing struggle in your head to figure out what the "right" choice is. I know that part of bringing it up is probably your wanting to move toward making a decision about this. I want to be honest with you that I don't think anyone else can make the decision here except you. What I can help you with, though, is letting go of that struggle. We could start that today, if you're willing to walk through some of the things that have

been pulling you around. Is that something you'd be willing to do?

With Katerina's permission, the clinician starts the exercise by handing her a pile of index cards, and asking her to identify beliefs with which she gets fused, some of which she would respond to by leaving her marriage and some of which she would respond to by staying in her marriage.

*Clinician:* On these cards, I'd like you to write up to three things you know to be true about your current situation that seem to push you to want to hold on to your marriage. These can be feelings or facts about the situation, one on each card. What are the things you know to be true that feel like reasons to hold on to your marriage?

Katerina writes:

- "Jim is a good dad."
- "Jim has supported me every time I got sick."
- "I still love Jim."

*Clinician:* Good. Now, on these cards, I'd like you to write up to three things you know to be true about your current situation that seem to push you to want to let go of your marriage. Again, these can be feelings or facts about the situation. What are the things you know to be true that feel like reasons to let go of your marriage?

Katerina writes:

- "Jim slept with his boss."
- "I feel hurt."
- "I am afraid."

The clinician also asks Katerina to identify worries with which she gets fused.

*Clinician:* Now I'd like you to write three things that you worry might be true about your current situation. These should be thoughts you've had, what-ifs that if you knew they were true, they'd feel like reasons to let go of your marriage.

Katerina writes:

- "Jim doesn't love me anymore."
- "I never stop feeling hurt."
- "Jim has another affair."

The clinician asks Katerina to identify hopes with which she gets fused.

*Clinician:* This time I'd like you to write three things that you hope might be true about your current situation. These should be thoughts you've had, what-ifs that if you knew they were true, they'd feel like reasons to save your marriage.

Katerina writes:

- "Things get much better after counseling."
- "Jim's affair is a one-time thing."
- "I don't get sick again."

The clinician asks Katerina to identify any other beliefs with which she gets fused.

*Clinician:* If you've got any other thoughts, feelings, or facts that are showing up for you that feel like reasons to stay or to go, take a minute and write them down now.

Katerina writes:

- "I'm a bad wife."
- "Ten years is too long to just walk away."

The clinician asks Katerina to identify the behaviors she thinks of as part of staying in her marriage, and the ones she thinks of as part of leaving her marriage.

*Clinician:* Good. Now I'd like you to write down, in the present tense, what saving the marriage might look like for you. Write down at least two things you could do that could be "saving the marriage." Include only the thing you do, not how it turns out.

Katerina writes:

- "I agree to attend counseling with Jim"

- "I recommit to our marriage."
- "I follow my discharge plan."

*Clinician:* Good. Now I'd like you to write down, in the present tense, what "letting go of the marriage" might look like for you. Write down at least two things you could do that could be "letting go of the marriage." Include only the thing you do, not how it turns out.

Katerina writes:

- "I take the kids to my mom's home and file for divorce."
- "I call Jim a 'cheating bastard' in front of all of our friends."
- "I tell Jim I've met someone else just to hurt him.

The clinician asks Katerina to identify outcomes with which she gets fused.

*Clinician:* Okay. Now I'd like you to write down, in the present tense, what could be the different outcomes that could be going on in three to six years. Try to write six things that are possibilities for how this all could turn out.

Katerina writes:

- "Jim and I have no relationship."
- "Jim and I are still struggling with our marriage."
- "Jim and I are married and happy."
- "Jim and I are friends."
- "I'm dating someone new."
- "I'm alone and lonely."

*Clinician:* Now I'd like you to write two final cards. One should say something like "and that's okay." The other should say something like "and it's not okay." These can be in your own words if you want.

Katerina writes:

- "And that's okay."

- "And that's not okay."

Next, the clinician presents the opportunity for defusion by asking Katerina to contact the variety of decisions that could be made and outcomes that could result.

*Clinician:* Good. Now we have five piles here. This one includes the things you know are true. I'd like you to shuffle them up so they're not in any order. This one includes thoughts you've had that might be true. Shuffle those up, please. This one includes the choices you could make. Shuffle those. And this one includes the ways this could turn out. Shuffle those. And this one includes the outcomes being okay or not okay. Now what I'd like you to do is pick one card from each pile and lay them out without looking at them.

Katerina picks five cards, one from each pile, and lays them out in a line.

*Clinician:* And now I'd like you to turn them over, one at a time, telling the story the cards lay out.

Katerina lays out the following cards:

- "Jim has supported me every time I got sick."
- "Jim doesn't love me anymore."
- "I agree to attend counseling with Jim."
- "Jim and I have no relationship."
- "And that's okay."

*Clinician:* Now I'm going to ask you to sit with this for just a minute here, imagining that you are to that time when everything is okay. Then, whenever you're ready, I'd like you to read it again in the past tense as if I didn't know anything about it and you were just telling me about something that had happened to you.

*Katerina:* *(Pauses, then speaks.)* Jim supported me every time I got sick, and over time he stopped loving me. I agreed to attend counseling, but inside, I'd rejected my commitment to what our marriage meant to me. Now we have no relationship. But honestly, that's okay.

*Clinician:* Good. Now what I'd like you to do is put each card back in its pile, shuffle, take a deep breath, then do this again.

The clinician guides Katerina in laying out two additional series before moving on to the last phase of the exercise, in which she relates this exercise to life as it actually is.

*Clinician:* What if it's really like this? What if commitment could mean any of these decisions or outcomes, depending on what it is you want? What if there is no promise that anything you think or feel or do in this moment guarantees a certain outcome? What if there's no guarantee that an outcome will feel like you want it to? That's not what we assume, though, right? We assume that we have to figure out the perfect decision. The one that leads to being okay. What if "okay" could happen either way? What if this decision is about something more than that?

For this last part of the exercise, I want you to shuffle every card together and pick six to lay out here from the whole pile, reading them aloud as you do.

Katerina lays out the following cards:

- "Jim's affair is a one-time thing."
- "I still love Jim."
- "And that's okay."
- "I call Jim a 'cheating bastard' in front of all of our friends."
- "I agree to attend counseling with Jim."
- "I'm a bad wife."

*Clinician:* What if the choice to continue to commit to your marriage is a active choice for right now? In this moment? And tomorrow? In that moment? And in ten years? In that moment? What if that choice is independent of any of these things we put on cards that feel so important? What if the true meaning of commitment to a value is right there, inside of the moment that you make it?

# ADVANCED COMMITMENT WORK

Advanced commitment work involves introducing conditions under which the client notices that she is turned away from her values and turns back. The clinician introduces experientially the concept of commitment as turning back. The emphasis is on clients making experiential contact with the opportunity to recommit to a value.

## CASE EXAMPLE:
## Misty's Advanced Commitment Work

Misty describes her work and her family as the thing she values most. She regularly establishes flexible goals at work for short-term and long-term projects. She has close, positive relationships with her siblings and visits her only living grandparent at least twice monthly. Since her mother died six years ago, however, Misty has only seen her father once. She describes ambivalence about contacting him.

### Changing Direction Metaphor

Misty brings up the topic of her father every few months. This time, the clinician asks Misty to contact whether or not this might be part of her values.

*Clinician:* I've noticed that the topic of your dad comes up every so often. It's clearly something that is upsetting to you, but I get the sense that it's not merely upsetting. I get the sense that there's something that matters to you inside of this. Do you have a sense of what that might be?

*Misty:* I don't know. He's my dad, you know?

*Clinician:* See, I know what it means to me, but I really don't have a clear sense of what it means to you. I know that your family is really important to you, but how your relationship with your father fits in, I'm just not sure.

*Misty:* Yeah, I guess it's messed up that he's the only one I don't talk to.

*Clinician:* You know, I'm a parent. And I don't know that I would want my kid to call me because it's messed up not to.

*Misty:* It's not just that.

*Clinician:* There's more?

*Misty:* There's more.

*Clinician:* Help me to understand what your relationship with your dad means to you. Try to let go of the judgments you have about what you've done and haven't done, or what he's done and hasn't done.

*Misty:* I started losing weight pretty bad when my mom got sick. I was sixteen. I'd had problems before, but they just ignored it. This time, they couldn't. The worse she got, the worse I got. They had just gone home with hospice the night Evan, a neighbor, found me passed out. I'd collapsed from diet pills and exercise and probably dehydration or something. My dad came to the hospital. I heard him talking to my sister outside the door: "She needs to just stop. This is sick, and worse than that, it's selfish. When your mother dies, thank your sister for her antics, because it will be the worry over Misty that finally does her in." A few days later he came by again and I pretended to be sleeping. The next time I saw him was at her funeral. I hid in the back. I don't even think he knew I was there.

*Clinician:* You must have been so hurt.

*Misty:* It's no excuse, though.

*Clinician:* For?

*Misty:* For not answering his calls, sending his letters back, telling my siblings to tell him I'd died.

*Clinician:* You feel sorry.

*Misty:* I do.

The clinician helps Misty to contact her full experience of her father.

*Clinician:* What shows up when you think of him?

*Misty:* Guilt mostly. Some anger. I was just a kid, you know?

*Clinician:* What else?

*Misty:* Yesterday my sister and I were remembering this voice he used to do to make us laugh when he woke us up in the morning.

*Clinician:* You sound amused.

*Misty:* Yeah. He was a funny guy before Mom got sick.

*Clinician:* What else is there?

*Misty:* Honestly, I miss him. I feel curious about him, how he's doing. I want to tell him about my job. I think he'll be proud. I want him to know I'm getting better. Getting my life together.

*Clinician:* You want to contact him.

*Misty:* I almost did a couple of times. But it was just too much.

*Clinician:* Too much?

*Misty:* It's been too long. And I've been too…

*Clinician:* Too what, Misty?

*Misty:* Too selfish. I mean, what if he's right?

*Clinician:* So the longer you go without being a daughter…

*Misty:* The more certain I am that I can't.

The clinician introduces the concept that Misty's value of being a daughter is something she can always turn back to using the metaphor of changing direction.

*Clinician:* What if it's like this, Misty—what if being a daughter isn't the kind of thing that you can get too far from to pick up on again? What if it's like going north? You might turn away sometimes, and head east or west. You might even wake up one day and find you've been going south for miles, but are you ever too far south to turn around?

*Misty:* I guess not.

The clinician relates Misty's act of contacting this in session to her pattern of committed action.

*Clinician:* We've been working together for a while now. We've even talked about your dad a little. And I saw something today in your eyes I've never seen. I think what I saw was you looking over your shoulder at how far south you've come, and wondering what it would be like to take a step north.

*Misty:* It feels like that.

*Clinician:* Yeah, and the deal is that you get to choose your direction. And heading north is heading north whether you're coming from New Orleans or Portland. Where you start from might change. Where you end up might change too, but the journey—the journey is still north. And even taking the biggest step doesn't mean you have less north left to go.

The clinician then relates considerations around being a daughter to her chosen value of family.

*Clinician:* Would it be alright if I asked you a couple of questions? I want you to not answer me, though. If you could pick a tiny thing you could do this week that would be like heading north, would you like to commit to that? And a harder question: What would heading north look like for you right now? Don't answer now. It's the kind of thing I would ask you to hold on to in the coming week, to spend some time with. Would you be willing to do this? Willing to choose what being a daughter means to you? What being a daughter might look like for you? What shape would it take? We've agreed to work on things that honor your family relationships. What if asking yourself that question this week, and sitting in all the hurt it pulls up for you, is a way of honoring that commitment, even if you decide that you're just not willing? Does that seem like something worth doing?

# CHAPTER 11

# Measuring and Making Change

One way of approaching case conceptualization is to move through assessment, conceptualization, and intervention serially, one after the other. The clinician spends a chunk of time collecting data at the initiation of therapy. Then he takes another chunk of time to get it all organized into a coherent conceptualization. Finally, he begins intervening. Assessment prepares the way for conceptualization which prepares the way for intervention. This is not necessarily how it goes in ACT.

In ACT, every moment of a session, whether it is the first or the fourth or the hundredth session, is approached as an opportunity to promote behavior change. Assessment is no less important. Conceptualization still takes a central role in organizing intervention. However, these are not approached serially like tasks to be checked off the to-do list. Assessment, conceptualization, and intervention are considered to be ongoing processes.

## ASSESSMENT, CONCEPTUALIZATION, AND INTERVENTION

In ACT, we assume that the context we provide during a session has an effect on the individual's behavior. Just because it's the assessment phase does not mean the client stops learning so we can get a good picture of what's going on. Instead, while we are administering questionnaires, observing overt behavior, and conducting clinical interviews, the client is learning about us and about therapy. Whether or not we acknowledge it, we are intervening on behavior just by asking individuals questions about their struggles. In ACT, we attempt to approach assessment with intention, using

the same goals and methods as we do to guide intervention. We provide opportunities for psychological flexibility and observe the response.

We also assume that the conceptualization we develop has an effect on our behavior. The way that we perceive and make sense of the things that we observe impacts the likelihood of us doing this or saying that. I might observe a new client being verbally aggressive with a staff member in the waiting room, and subsequently be a little more directive and dominant during the intake interview. This happens constantly, whether or not we acknowledge it. As the conditions under which we observe the client change, we build and rebuild conceptualizations of what they do and what function that serves. This constantly impacts our assessment and intervention. We set the conditions for certain kinds of observations because of our ideas of what we might find. We choose what to focus on teaching next because of our ideas of how it might help. In ACT, we attempt to approach conceptualization with intention, using the same goals and methods as we do to guide intervention. We hold our conceptualizations lightly, as a story that is not yet written and that is being edited right in front of us.

In ACT, assessment, conceptualization, and intervention are ongoing processes that run parallel to one another. In other words, they are different functions of a clinician's behavior. A single action that we emit might serve as an intervention, making flexibility increasingly likely, but not necessarily move us forward in assessment or conceptualization. Other actions we emit might serve as interventions, and also allow for assessment and improved conceptualization, as we observe the client in a new context. Assessment, conceptualization, and intervention are intimately integrated throughout the therapeutic process. In session, we weave back and forth between assessment and intervention and our conceptualization is constantly being elaborated.

## PLANNING AND MEASURING INDIVIDUAL PROGRESS

In keeping with the broader behavior therapy tradition, ACT is based in scientific values. ACT's implementation is supported by data, not only in terms of its effectiveness having been demonstrated among groups of individuals, but also in terms of its effectiveness being monitored in individual cases. Keeping data over the course of therapy allows the clinician to examine the impact of therapy on targeted outcomes and processes. In this way, the clinician not only can prove that his interventions are working, but also can determine how the intervention is working and modify it based on this

feedback. For example, if progress toward defined goals is always accompanied by improvements in acceptance, the clinician may come to target acceptance in a more direct and focused way. If regression on targeted outcomes is accompanied by increases in acceptance, the clinician may choose to focus on values temporarily to improve motivation for change.

Examining change at the individual level is not easy, simply because people's behavior is variable. Combining measurements of many people evens out some of the variability, making it easier to see relationships. However, we don't treat samples, and we don't move means. We treat individuals, and so our interventions, to be deemed effective, should effect change at the individual level. Seeing this change in an individual requires that we choose measures that are sensitive to the change we hope to demonstrate and that we establish a useful baseline.

The first step of single-subject data collection is to choose how progress will be assessed. Because of the intimacy between assessment and intervention, these assessments should be chosen quickly so that baseline functioning can be established before intervention effects are observed. Assessment methods should be as valid and reliable as possible without threatening the practicality of repeated measurement. This is often a direct trade-off, as many of the measures with the most well-established psychometric support are also the most impractical because of length, burden, or accessibility. These assessments should take place regularly and under relatively similar conditions so that variability can be attributed to time and therapy. Finally, data should represent both outcomes and processes. For outcomes, ACT clinicians might include assessments of problematic "symptoms" and measures of valued living. For process, ACT clinicians might include assessments of psychological flexibility or some of the six components that seem particularly relevant. The final array of assessment methods should include both self-report and direct observation to provide estimates of both how the individual perceives her own struggles and how she is perceived by others.

Self-report data may be collected through interviews or questionnaires. This gives us a measure of how the client sees her own struggles. Outcome measures might include diagnostic interviews or eating inventories. Process measures might include measures of psychological flexibility that seem most relevant to this individual's struggles.

## *Outcome Measures*

Below are some commonly used measures for tracking individual client progress. Italicized suggestions of how they might be used are based on

weekly outpatient treatment and should be adapted to planned course of treatment, treatment setting, and client variables.

**Eating Disorder Diagnostic Scale** (Stice, Fisher, & Martinez, 2004). A twenty-two-item questionnaire that assesses *DSM–IV* diagnostic criteria for all three eating disorders. *This instrument is relatively brief and easy to complete. It would be most useful if administered upon initiation of treatment, again once progress is observed through other assessments, and upon termination. It can also be useful when motivation for treatment lags or when the dyad considers termination or a change in focus.*

**Body Image Quality of Life Inventory** (Cash & Fleming, 2002). A nineteen-item assesses the influence of body-image experiences on psychosocial functioning and general well-being. *This instrument is relatively brief and easy to complete. It would be most useful if administered weekly or biweekly.*

**Valued Living Questionnaire–2** (Wilson & DuFrene, 2009). A twenty-item rating scale across six dimensions that assesses valued living in terms of how important twelve commonly valued domains of living are, and how consistently an individual has been living with those values. *This instrument may require some education with the client about how to complete. It may be most practically administered on a biweekly or monthly basis, depending on the predicted course of treatment.*

## *Process Measures*

Below are some commonly used measures for tracking individual client progress. Again, italicized suggestions of how they might be used are based on weekly outpatient treatment and should be adapted to planned course of treatment, treatment setting, and client variables.

**Body Image—Assessment and Action Questionnaire** (Sandoz, Wilson, & Merwin, 2010). A twelve-item questionnaire that assesses body-image flexibility, or the extent to which an individual embraces the perceptions, sensations, feelings, thoughts, and beliefs about the body fully and intentionally while pursuing effective action in other life domains. This questionnaire is included as appendix A. *This instrument is brief and relatively simple to complete. It could be administered weekly or daily as part of a self-monitoring packet.*

**Body Image States Scale** (Melnyk, Cash, & Janda, 2003). A six-item measure of current body-image experiences at a specific point in time. *This measure is brief and could be most useful as part of a self-monitoring packet.*

*It has been modified to also include ratings of willingness toward the current body-image experience.*

**Hexaflex Functional Diagnostic Experiential Interview** (Wilson & DuFrene, 2009). A ninety-minute semistructured interview that assesses valued living as the client describes it, and psychological flexibility as directly observed during the interview. *This interview requires significant time and energy on the part of both the therapist and the client. It most useful if administered upon initiation of treatment, again once progress is observed through other assessments, and upon termination. It can also be useful when motivation for treatment lags or when the dyad considers termination or a change in focus.*

## Self-Report Measures

Self-report data can also involve self-monitoring in which the individual monitors and records instances of relevant behavior. This may include a daily record of her food intake, compensatory behavior, body checking, thoughts and feelings before and after these behaviors, flexibility with those thoughts and feelings, and other behaviors relevant to her current repertoire. A template for a customizable self-monitoring diary is found in appendix D.

Conclusions from self-report data are strongest if they converge with data from direct observation. Direct observation can occur inside or outside of the therapy session. Inside the session, the ACT clinician monitors psychological flexibility as described in chapter 4. Clinician worksheets that describe topographical markers of psychological flexibility across the six facets are included in appendix F.

Observation outside of session may be more likely in inpatient settings, where the client can be observed interacting with other clients and treatment providers regularly. However, even an outpatient client can be observed in the waiting room or with the receptionist. Any behavior emitted by the client is data.

Many behaviors of others, including our own overt and covert reactions to a client, can also be considered data. How is it to sit with this person? What kind of things does her presence bring up? How must people respond to this person out in her life? How might their responses keep her stuck? Is there a way to offer something different? Systematic measurement of these kinds of data can be challenging. However, using consistent methods, and combining these data with those from other methods, can allow others' impressions of the client to be useful.

## Establishing a Baseline

Once the assessment methods are chosen, the next step of single-subject data collection is to establish a baseline that allows for the estimation of treatment effects. Whether the data are totals on an inventory of thoughts and feelings, completed self-monitoring diaries, or ratings of observed acceptance, there should be enough data points to allow for estimations of the behavior's typical level, how much it varies, and how it may systematically vary over time. Treatment effects can be observed in all three of these dimensions.

Take, for example, self-monitoring of frequency of daily binge eating. It may be that after one week (seven data points), the clinician sees that the client binge eats about twice a day. This will be represented in the level of the data. It may also be apparent that this varies from one day to the next. The client might not binge eat at all one day, but binge eat five times another day. This would be represented in the stability of the data. Finally, it may be apparent that binge eating increases in frequency over the course of the week with it being most probable over the weekend and least probable at the start of the week. This would be represented in the trend of the data. During the course of therapy, different treatment effects might be apparent. We may see an initial dip in frequency, from twice a day to no more than once a day. The data might also become more stable, with binge eating never occurring more than once a day. We may see that the trend of the data remains, with the individual being the most at risk for binge eating on the weekends. As therapy continues, binge eating may become less and less frequent, allowing the unit of analysis to change from days to weeks, maybe even months. Meanwhile, the clinician is looking for complementary changes to level, stability, and trend of the other data being collected. We have made available a template to facilitate electronic storage of these data on the book's website at www.newharbingeronline.com/act-for-eating-disorders.html.

## Data Collection: Client-Clinician Cooperation

In keeping with the therapeutic posture in ACT, the process of data collection is not conducted as something the clinician does *to* the client. Instead, much of the process, from selection of assessments to examining treatment effects in processes and outcomes, can be done in cooperation with the client. In ACT, this is couched firmly within the model of psychological flexibility. The challenge to the clinician is to create a context in

which this process of planning and conducting of data collection facilitates flexibility in clients. We often cast data collection as potentially part of the pattern of valued living.

*Clinician:* We have a hard piece of work ahead of us. It's the kind of work that's not worth doing if it's about what your mom wants, what your doctor thinks would be better, or even what I would hope for you after hearing your struggle. See, if it's about anything other than building the life you want, it's not the piece of work we are signing up for. So we are going to watch how the work that we do in here maps onto changes out in your life. If we find it's not making a difference for you in the things that matter, we'll change up what we're doing.

The individual's chosen values are particularly important in guiding the selection of assessments. We often emphasize other facets of psychological flexibility as well. We may emphasize acceptance and present-moment focus, for example, in predicting how difficult self-monitoring is going to be.

*Clinician:* I know I'm asking something big of you. It seems like one thing that's gotten you through this struggle has been being able to sort of turn away and move on to the next thing. This work is going to ask you to step into the struggle and look around. We're going to take some time here to know the struggle, to get our bearings, and to see what other possibilities might arise.

By the end of treatment, our aim is to have come to a shared conceptualization of how the individual struggles and how that struggle costs him in valued living. Further, we aim to have taught the skills whereby the client can use self-assessment in a way that fosters valued living.

# PART 3

# Sample Protocol (What This Work Might Look Like)

There is another book we could have written. We could have started with a brief justification for why ACT for eating disorders might be important to learn, and then moved straight into a step-by-step treatment manual that you could pick up and apply right away in your practice. We could have saved you the effort of reading about the philosophical and historical context of ACT—and we could have saved ourselves from writing it. The final product would have been one of countless ways that ACT principles could be applied to struggles with disordered eating—and it would have served a very different purpose.

We didn't write that book. We wrote this book—and not by accident. We wrote this book because we value the process through which a clinician "tries on" ACT—not as a technology for treating eating disorders, but as a way of seeing the struggles involved in disordered eating. We wrote this book because we trust that the outcomes of that process, the work you end up doing if you try on ACT and choose to use it, will be better than the work you would do following a protocol we wrote. People in the lab do better earning points under changing contingencies if you don't give them a rule on how the game works (Shimoff, Catania, & Matthews, 1981). The same is true here.

We say this sort of thing to clinicians we train, as we toil with philosophical assumptions and functional definitions. And all over the world they ask, "But what does it *look like*?" And though it certainly runs the risk

of limiting the possibilities of the work, we give in and describe ways ACT therapy *might* look.

The next three chapters make up a sample protocol—a description of what therapy might look like with someone struggling with disordered eating if you used ACT principles to guide your work. We don't mean to suggest that this protocol is comprehensive, including all the possibilities, nor do we intend to imply that it should or even could be applied universally. We offer it as an example and as an invitation to create your own examples in the work you do.

Often the course of therapy in ACT is described as moving serially through the facets of psychological flexibility. The therapist emphasizes present-moment work, then defusion, then acceptance, and so on. The course of therapy in ACT can also be conceptualized as involving three phases, distinguished by function. The function of the first phase of therapy is to establish a baseline, informed consent, and the therapeutic contract. The function of the second phase of therapy is to shape psychological flexibility in session. The function of the third phase of therapy is to support the emergence of psychological flexibility outside of session. Within each of these phases arise challenges due to psychological inflexibility. Therapy involves meeting these challenges in a way that creates the conditions for psychological flexibility, over and over, as it serves chosen values.

The sample protocol that follows is as much a survival guide as a map. It sets a course for therapy, allowing you to move from one stop to the next with purpose. It also anticipates obstacles that might arise along the way, and helps you to prepare the client to meet those obstacles without getting too far off course. The obstacles described are not exhaustive, but we hope they provide enough examples to prepare you to respond creatively when faced with similar events.

# CHAPTER 12

# Phase 1: Choosing Direction

Imagine what it is like presenting for therapy. Maybe you've been thinking about it for a while, considered asking for a referral, and suddenly things just seem too bad to wait any longer. Maybe you've been to therapy before, and you return when you feel that familiar struggle coming on. Maybe people in your life notice your struggle and encourage you to "get help" or "talk to somebody." Maybe your doctor or your friends or your mother or your spouse has decided you no longer get to choose to struggle without help. Regardless of the process that leads up to presenting for psychotherapy, the initiation of the therapeutic relationship is never easy. It involves asking for help. And asking for help is not something that most people are very good at.

To initiate any journey, the travelers must first figure out where they are, agree on where they are going, and plan on how they are going to get there. The same is true of therapy. The clinician must engage the client in the process of establishing a baseline, informed consent, and a therapeutic contract.

# SESSION 1: INITIAL INFORMED CONSENT AND BEGINNING BASELINE

## *Part 1: Introductions, Expectations, and Practical Concerns*

During the first session, the clinician has two tasks: to establish initial informed consent and to begin collecting baseline data. You begin by introducing yourself and your position. Depending on how the client was referred, you might also ask the client if she knows why she is there. If she was self-referred, you might ask how she selected you as a provider. This gives you an opportunity to assess the client's perspective on her struggle and her motivation for change. After coming to a shared understanding of how the client ended up here, it's important to let her know what to expect as far as content and process. Before having to make herself vulnerable, the client should have an understanding of what is going to happen and for what purpose. The first session can be incredibly difficult for clients and therapists, and any aversive is easier to bear if you know its shape and purpose.

You might also distinguish how this first session is different from typical sessions. This will vary, but we usually mention that we'll be asking a range of questions about current and historical functioning, some of which may seem to have little to do with why the client is here. We also acknowledge that we'll be taking detailed notes, which we don't typically do in other sessions. Finally, we mention that we will be asking her to fill out some questionnaires at the end of the session and that, although we do some assessment throughout, she will only be filling out this many on rare occasions.

You will review privacy, confidentiality, and related issues. We mention what documentation includes, who has access to records, the possibility of observation and/or recording, the role of supervision and/or consultation, and the possibility of research participation. This is not only about education. It begins laying the foundation for informed consent. It is an opportunity to demonstrate sensitivity to potential client concerns and to establish transparency in your responses to those concerns. Giving the client the opportunity to ask questions, and asking the client's permission to continue with the session now that she has this information establishes the initiation of this work as the client's choice, regardless of how she got here.

## CHALLENGES IN INTRODUCTIONS, EXPECTATIONS, AND PRACTICAL CONCERNS

During this part of session 1, several challenges might arise, each of which gives you the opportunity to begin a foundation for the work you will be offering. Again, this is part of informed consent. The client should be getting an idea of what it will be like to work with you.

**Lack of present-moment focus.** You might notice a lack of present-moment focus. It may be difficult to keep the client engaged as you talk. You might find yourself wanting to rush through if the client appears uninterested or indicates that she knows about all of this already. Often, it's important to slow down in these moments. You might emphasize to the client why this process is important. We often cast it as a personal concern.

*Clinician:* I know this is a lot of information, and it may not seem particularly important or relevant at this point. And, if we are going to be working together, it's important to me that you have a clear idea of how all this works.

**Experiential avoidance.** You might also notice experiential avoidance. The client may prolong this process to avoid having to talk about her struggles. She may challenge certain protocols or ask questions that are unrelated, challenging, or premature. If you have the impression that she is successfully delaying, it may be useful to orient the client to the additional tasks that you had planned for this session and the time that is left. We might set aside the clipboard or keyboard and say something like this:

*Clinician:* I'd like to pause for just a moment here. I'm noticing that we are spending more time on this particular part of the session than I'd planned, so I wanted to make sure we are on the same page. One of the things that I wanted to do today was to get a broad idea of who you are, what your struggle has been like, and what you hope to get out of treatment. This can take a while and we have about thirty minutes left. Would you like to set that job aside for next week, giving us the rest of today's session to take our time with these concerns? Or would you like to go ahead and finish this up so we can move into the next part of our session?

At this point, the client has not consented to treatment and we have not built the foundation for acceptance interventions per se. If the client is avoiding, one approach is to acknowledge her freedom to choose to do so. Giving her the choice to avoid also makes explicit the opportunity to choose something different. If she chooses to delay the intake interview, you facilitate rapport by supporting her right to do so. If she chooses to continue with the intake interview, she demonstrates flexibility.

When the client has agreed to move into the intake interview, it may be useful to cast it as the first step in your really getting her perspective, seeing her world through her eyes. You might warn her that you may need to interrupt her to clarify certain points or move on to another topic. You might also let her know that you have certain questions you ask of every client you see, and remind her that some of your questions may seem unrelated to her struggle. Finally, you might acknowledge that most people find it difficult to talk to someone they've just met about their lives and struggles. We often acknowledge the client's freedom to decide what she shares, and ask her to just let us know if she is unwilling to share something now, or if she has any questions about privacy or confidentiality along the way.

## *Part 2: Intake Interview*

Most clinicians have a format for the intake interview that is specific to their institution, setting, population, and preferences. These usually include the severity, frequency, and duration of current complaints, psychiatric history, substance use, medical history, educational and occupational history, psychosocial history, current physical complaints, and current psychosocial functioning. Many clinicians who work with disordered eating regularly use semistructured interviews to assess the patterns around disordered eating and related disturbances and to allow for diagnosis. With clients struggling with disordered eating, it is also particularly important to assess medical complaints, physical self-care, and access to regular medical care. It may be useful to ask specifically about menstruation, weakness and fatigue, headaches, sore throat, chills, frequent illness, insomnia and restlessness, gastrointestinal symptoms, and cardiac symptoms (for example, heart "fluttering" or "pounding"). This can help you to assess for malnutrition and other physical complications of disordered eating, so that you can make appropriate referrals. If a client is on medications, it can be useful to check side effects for changes in appetite, in which case the medication may be contraindicated. It may also be particularly important in some settings to get releases to communicate with treating physicians, if it should become necessary.

From an ACT perspective, it is important for the intake interview to review not only struggles but also potential valued domains. It's important that from the very beginning, the context of therapy is one in which values are salient. This not only provides a foundation for later values work. It also helps the client to experience herself as more than just her symptoms. We ask about her struggles. And we also ask about the people she loves, the places she feels most alive, the activities she'd love to find more time to do. Often this can be built into more standard interviews simply by expanding some of the sections. When asking about self-care, for example, we might ask if there is something she does to care for herself when she's feeling sick or down. When reviewing psychosocial history, we might ask her to tell us about something she enjoyed doing with someone she's identified as important to her at that time.

## CHALLENGES IN THE INTAKE INTERVIEW

During this part of session 1, several challenges might arise due to client inflexibility. The data collected in this interview is not only the content in the client's responses, it is also her process as she answers, or doesn't answer. You will usually observe far more inflexibility than you are able to intervene on. The inflexibility that you are interested in intervening on at this point is that which interferes with the goal of completing the interview. Even at this level, the emphasis is on workability toward chosen goals.

**Experiential avoidance.** You might notice experiential avoidance. The client might be reluctant to share certain things or might deny distress and impairment. She might seem to be explaining, justifying, or rationalizing her history or her current struggles. The client may be obviously managing her affect, or trying to manage yours. Sometimes it may be useful simply to ask directly about feelings in the past (for example, "Were you disappointed?"), or at that moment (for example, "Is this hard to share right now?"). If avoidance persists, you may also find it useful to acknowledge how difficult it is to tell someone else of your struggles and remind the client that you are there to listen.

*Clinician:* I know that it's hard to sit here with me right now as I ask about things that most people in your life don't know. I just want to let you know that the only thing I am here to do today is to receive what you have to say. To bear witness to your joy and your pain. I find myself touched by some of what you share. Know that it's not your job to protect me from anything I might feel. I will certainly have thoughts

about the things that you're saying. You may see my face change as these thoughts come up. Let me just say that any judgments I might have about what you have done or should do isn't part of our work here. This is your time, and I am here to make sure you have the space you need to use it.

**Limited sense of self.** Difficulties related to a limited sense of self might also be apparent during this initial intake. The client might attribute the struggles she describes to personal faults. She might speak as though the aversive events in her life indicate something meaningful about her. If this comes up, it may be useful to simply remark in a way that casts her as the survivor rather than the villain (for example, "I'm struck by how much you've been through to be right here in this moment."). The client might also speak as though she is the perpetual victim of the people in her life and the world in general. She may emphasize her freedom from blame in a way that shields her from fully experiencing her memories. In this case, it may be useful to inquire about other people's perspectives in such a way that to answer the question, she must attempt to take another's perspective (for example, "That must have affected every member of your family a little differently. What do you suppose it was like for your mother during that time?").

The client might also speak as though she is her diagnosis. She might speak articulately about the details of her disordered eating, but struggle to say anything about her relationships, her education, or her hobbies. Asking about the experience of these other events in her life in a present-moment-focused way may be useful (for example, "What is it like for you when you're writing? Where do you feel that in your body? Are there other feelings there? Thoughts?"). Most difficulties related to a limited sense of self can be addressed simply by asking about the aspects of the experience that are not salient to the client. Other times it may be useful to guide the client more explicitly.

*Clinician:* There are moments, when you talk, when I see you showing up behind your eyes. Not your roles or your family members or your struggles, but you—the you who knows the inside of your roles and your relationships and your struggles but is somehow more. The you that doesn't need explaining or defending is the you that will serve our work here. And I just want to say welcome. Your presence is noticed and appreciated.

**Cognitive fusion.** You might notice inflexibilities in the client's presentation that are related to cognitive fusion. Apart from stories about who she is, the client may also have rigid ideas about how the world is and should be that seem to get in the way of the intake. For example, she may express opinions about the setting, therapy in general, or even you that challenge the idea that she could benefit from this work. It may be useful when you observe something like this to introduce the idea that she does not have to believe anything in particular in order to benefit from therapy.

*Clinician:* You know, I hear that there are a million reasons that this shouldn't or couldn't work for you. And I'm not interested in trying to convince you of anything. The fact is, it doesn't matter what you believe. It doesn't matter what I believe. If we do a piece of work together, sometimes we will believe in it, and sometimes we won't. Our job is not to believe anything. It's to show up. Even when that means showing up to the possibility that this could all be in vain.

**Impoverished values.** You might notice impoverished values that make it difficult to assess anything besides suffering. It may be useful in this case to orient the client to the idea of working for valued living instead of symptom reduction.

*Clinician:* I feel like it's important to confess that I am not here to make you feel better about your body or start eating a certain way. I've sat here with you and heard you talk about your life, and frankly I feel like you deserve more than just "no disordered eating." And I'm not willing to work for less than you deserve. I am here to help you build a place where a full, rich, meaningful life can grow. Not full or rich or meaningful according to me, but the life you would grow if you could choose it. Maybe part of that is letting go of the struggle with eating and body image. Maybe it isn't. Regardless, I know it's not merely that. I assume that you have everything you need right now at this moment, without you or the world having to change, in order for you to begin moving in the direction of the life you would choose.

**Values fusion.** The client might be able to speak to things that she cares about, but interact with those values rigidly. In other words, she might

exhibit fused valuing. For example, she might be able to articulate that she would like to do something to help kids, but have very rigid ideas about what that would have to look like and how she would have to be to accomplish that. She might express that she could never be helpful to a child without getting control of her weight first. She might see being a teacher as the only form that helping children could take. She might describe having to want to be with kids all the time in order to serve this value. When fused valuing is apparent, it may be useful to invite the client to let go of figuring out how it is going to happen.

*Clinician:* I hear, as you talk about this, that helping children is something that you really care about. I also hear that, because you care about it, you have ideas about how it could happen and what it would look like. I want to encourage you to let go of figuring this out for a while. It can only take you so far, and often it doesn't say anything about what you can do right now, in this moment, from this place. This is too important for you to wait until the world aligns. What if there were little things that we could do this week that would move out in that direction without anything having to change? Would that be something that seems worth doing?

## *Part 3: Planning Treatment and Assessment*

After the intake interview has been completed, it is often useful to give the client an overview of what it is you heard from her. This should be done only with permission, as it can be a very powerful experience.

*Clinician:* Thank you for sharing all this with me. Now, I was wondering if it would be okay if I told back to you some of the things that I heard. The important part, what you're listening for, is not that I get every fact right or don't miss anything. What you're listening for is the sense that I get how this struggle works in your life. And if you don't hear me getting it, we'll talk a while and I'll try again.

With the client's permission, you will tell her story to her as you hear it, as you see it, and as you feel it. This process may facilitate defusion by including the major events of her story but without the client's understanding of how or why this came to be. For example, you might say, "And

things got harder for you after your mom died" rather than "Your mom dying made everything harder for you." The client's understanding might be completely accurate. Life in the context of grief is more difficult. The language of causation leaves little room for possibility, however. If the causes of a person's struggle are in the past, there is little hope of relief. Inflexibility, even with accuracy, has costs. Leaving out mention of "this causing that, which caused that" at this point can serve as the first step in building flexibility with the client's own story.

This process can also facilitate acceptance if the client is able to see that you have allowed yourself to be touched by her struggles and, perhaps even more importantly, that you are willing to be touched by her struggles. If we are unwilling to be touched by the client's struggles, how can we ask it of her? If we choose to sit with her struggles, however, give voice to them, and invite her back, it opens the possibility that she could too. In fact, we have found that the content of what we say matters very little. It is looking into our eyes and seeing that we get it and are still choosing to stick around that seems to be important. We tend to scale this to a level that is representative of the work that we would be willing to do regularly.

*Clinician:* It sounds like for a while there, things were going pretty well. You were enjoying your friends, doing pretty well in school, playing volleyball. I hear that you see yourself as almost carefree during that time. I also hear that your mom's death was very difficult for you. It sounds like suddenly the smallest things, things that had seemed like no big deal before, felt overwhelming. And the things you cared about—your friends, school, volleyball—it sounds like they suddenly felt trivial. And then you started losing weight, and one day you realized that you felt good for the first time in a long time. The numbers on the scale gave you something to look forward to. You got better and better at losing weight without anyone noticing that you were dieting. For a while. I also hear that at some point, the enjoyment and feelings of accomplishment that came with weight loss started to fade. That even relief became harder and harder to find. And now, it sounds like you are finding yourself alone and crouched against a wall. I see you crouched there, so still, barely breathing, as if, with any sudden movement, the world would come crashing down.

Often clinicians fear that something like this might be pushing the client too hard too early. Again, it is important to ask permission to move into this process and to respond to any indications that the client is retracting permission. It is not just what the client says that indicates permission or lack of permission. It is often useful to ask permission again if you notice increases in inflexibility.

Following this process, it may be useful to begin some loose treatment planning based on this shared conceptualization. Often this simply involves a commitment from the therapist to work to make things different.

*Clinician:* I get what it's like to feel your life shrink down until it's almost suffocating. And I care about helping people to stretch their lives out in ways they care about, to find freedom and room to breathe. I would be honored to do this piece of work with you. Does this sound like something you'd be interested in?

If the client expresses interest in working together, this can be a good time to introduce assessment and tracking of treatment progress. By this time, you will have an idea of what kind of outcome and process measures might be most applicable. It can be useful to take a collaborative stance here, as the client often feels vulnerable at this point. We typically introduce each questionnaire we have selected and ask if the client would like to commit to filling it out with whatever frequency we think is appropriate. For example, we might say something like "I'd like to use this questionnaire to ask you about your reactions to your body image. Take a look at the items and let me know if you'd be willing to fill this one out each week before our session." Then the client will fill out the first set of measures. In most cases, these should take no more than ten to fifteen minutes. Lengthier measures, such as the Valued Living Questionnaire, should be completed at home over the next week.

Following the selection and completion of the assessment measures, it may be useful for the clinician to make a small commitment to the work. We often schedule the client's next session and then make a specific commitment to be present for her for that hour. Once the client has left, it may be useful to record observations on psychological flexibility while you still remember them. We use the worksheet included in appendix E to keep our process notes.

# SESSION 2: EXPERIENTIAL ASSESSMENT OF FUNCTIONAL TARGETS AND ADJUSTMENT OF BASELINE

## *Part 1: Checking In*

The second session extends the informed consent process and collection of baseline data. (The third session, which we address below, does the same.) The client arrives and completes whatever assessments have been planned for weekly completion. Sessions 2 through 4 begin with the clinician checking in with the client regarding if and how she regarded the previous session over the week. This is particularly important in the highly structured sessions of the first phase, as it gives the client a limited but predictable time to request or provide feedback or process current events in her life. A secondary goal of the check-in is to shape the client's ability to relate her experiences and behavior in therapy to her experiences and behavior out in her life. Finally, this is often an opportunity to assess the client's psychological flexibility that day and to help her settle in for that day's session.

In session 2, the clinician asks about how the client's experience from session 1 may have shown up for her over the week. The clinician may ask questions like these:

- Did you think about some of the things you had shared? How so?
- Did you consider not coming back? What showed up as you considered not returning? What showed up that you made it back here?
- What was your biggest concern about today?
- What else has been going on in your life?

As the client shares, the clinician's primary job is to appreciate what she offers. After the specified amount of time, the clinician introduces the next part of the session.

### CHALLENGES WITH CHECK-IN

**Experiential avoidance.** During check-in, clients may again exhibit experiential avoidance in the form of efforts to avoid moving on to the planned

activity. You can respond as described in session 1, allowing the client to avoid, but both of you acknowledging what is going on. Some clients may need a slower, more gradual entry. However, practical constraints on time and resources may limit your ability to be flexible with admission procedures. You may also find yourself unwilling to offer the opportunity for the client to avoid moving on in this and later sessions. Acknowledging your unwillingness at this point models for the client that permission is real in your relationship, that she too can say no when asked for permission. Finally, it may be important with some clients to move forward in order to give them enough information about what therapy with you will actually be like so that they can give or retract their informed consent.

If you decide to intervene on the avoidance at this point, it may be useful to cast continuing as part of the work you both agreed to. At this point, your treatment contract and informed consent process have been initiated, so there is a shared, although limited, understanding of what you and the client are there for.

*Clinician:* I truly wouldn't mind sitting here talking about the Saints or this ridiculous cold for the rest of our time. Except here's the thing—I committed to a certain piece of work with you. And regardless of how much I'd enjoy it, I feel like if chatting was going to help you find your way, it would have worked already. There's this other bit of work I've prepared for today. It's hard. But it's not merely hard. It's our next step in me really getting what the world looks like from your eyes. So how about it? Do I have your permission to move on to this next piece of work?

Note that even if we are unwilling to not move on, we still ask for the client's permission. We do this because we cannot do the next piece of work without the client, and if she gives her permission, she is more likely to be present.

**Cognitive fusion.** The client may also exhibit fusion with the idea that some problem she has brought up needs to be solved before you can move on. It may be useful to find out how long this problem has been going on and what she has been doing about it so far. If the issue does not involve an immediate threat of harm to the client or someone else, it may be useful to help the client let the struggle with the problem go before she has come up with a solution.

*Clinician:* I hear the struggle around this, and it just sounds brutal. It's like you start laying out a path this way, brick by brick, when all of a sudden something yanks your attention over here, and your path turns, and you head that way, brick by brick, then you notice where you've landed and start to head back, but you're not sure you want to, and it's like the bricks you are carrying to build that path get heavier and heavier as you scurry this way and that. I think sometimes the thing to do is to set the bricks down and rest a while, noticing what's around you, and imagining what could be just beyond that. Still, we are not going to solve this problem today or if we talked about it this session and the next session too. But more than that, sometimes the best way to solve a problem is to let go of problem solving altogether. What if it's the case that if this is something you really care about, our work together can serve that even when we aren't talking about it? I'm not asking you to believe this, but I am asking you if you'd be willing to check it out over the next couple of weeks and see what you think. How about it? Can we move on to the next piece of work in service of you finding peace in this pain?

But what if she says no? If the client says that she doesn't give her permission, it may be useful simply to thank her for trusting you with that, and ask her to tell you more about what she is saying no to. There may be clarifications or corrections you can offer that can help to move past this point; however, this is often not an issue of misinformation. People are ambivalent about treatment. When a client does not give her permission, this is an opportunity to demonstrate that it really is her choice. It is also a bit of data to be interpreted in the context of everything else you know about this person. What function does saying no serve for this person at this moment? Many individuals struggling with disordered eating may not have had the opportunity to say no out loud before. This may be what psychological flexibility looks like at this point. For others, this is them doing what they do everywhere to turn away from those that might be able to help. Regardless, it is important that the no is heard and respected. Often we will simply ask, "How would you hope our time together could go today?" If the client describes something that you are willing to do, it may be useful to build a contract around that. If the client describes something that you

are not willing to do, it may be useful to discuss the appropriateness of treatment with you at that time. (For example, "That's just not the kind of work I do. If it is the only thing you are willing to try right now, I would be happy to find you someone who might be able to help you with that.")

## *Part 2: Hexaflex Functional Diagnostic Experiential Interview*

After check-in, the remainder of session 2 involves introduction and initiation of the Hexaflex Functional Diagnostic Experiential Interview (HFDEI; appendix F). The introduction casts the importance of values as guiding the hard work of therapy. The introduction also includes enough about what to expect to allow the client to give informed consent to the interview.

*Clinician:* We have spent some time now discussing your life broadly and your struggles in detail. I feel like I am starting to get a sense of the path that brought you here, and of what it feels like in that spot against the wall. What I've barely begun to know, though, is how all this touches the things that matter to you. I got glimpses of it last time we met—of moments when you got a little room, when you were able to draw a full, free breath, if only for a moment. And I want more for you. We committed to doing a piece of work that's about getting you free. This is not going to be easy work, and you will do most of it. The thing is, I am completely useless to you unless I can get a sense of what we are heading toward, of what would make up the life you would choose, of the things you care about that make this hard work worth something.

This is not something you could just tell me about like you'd tell me your address or telephone number. The important part is not that I could repeat the words back to you, but that as I did, you could hear your own longing, your own hope, your own passion, in my voice. We will start by taking a look at areas of life that many people value. We'll look for areas in which you'd like to build and grow. Inside these, we'll find pieces of the struggle we've talked about, and we will consider that struggle slowly and carefully in light of the life you want. Some of the conversation

> will involve talking like we are now, and other parts will involve me asking you to close or lower your eyes, fall silent, and visualize different areas of your life, slowly and singly. Our goal here is to fill the room with our appreciation of what you've suffered and how that's affected your life. And, funnily enough, it's when you find yourself surrounded by that appreciation that you have the most room to breathe. Does that sound like something you'd be willing to move into right now?

With the client's permission (yes, *again*), the next step is to introduce the Valued Living Questionnaire–2 (VLQ-2). The VLQ-2 (appendix F) assesses valued living across twelve life domains. These domains were generated from clinical experience and include (1) family (other than couples or parenting), (2) marriage/couples/intimate relations, (3) parenting, (4) friends/social life, (5) work, (6) education/training, (7) recreation/fun, (8) spirituality, (9) community life, (10) physical self-care, (11) the environment, and (12) aesthetics. Clients are asked to assign a numerical rating from 1 through 10 in response to the following questions:

- How possible is it that something very meaningful could happen in this area of your life?
- How important is this area at this time in your life?
- How important is this area in your life as a whole?
- How much have you acted in the service of this area during the past week?
- How satisfied are you with your level of action in this area during the past week?
- How concerned are you that this area will not progress as you want?

The VLQ and VLQ-2 can be and have been used as self-report questionnaires. However, early versions were developed to guide conversations in clinical practice about valuing, and both versions have also been used as part of a structured interview. With individuals struggling with disordered eating, we have used it most effectively by introducing it as part of a clinical interview at least once, and having the client complete it biweekly or monthly as a self-report questionnaire once she has an understanding of how to fill it out. Of course, understanding is not the only variable affecting

the validity of the data. We usually experience a small shift in these data when we switch from the interview to self-report when clients have not yet developed the skills to recognize or intervene on their own fused or avoidant responding. Rather than trying to predict and prevent this, we usually simply document when the switch occurred, and get a rating from the client on how open she felt to completing this questionnaire today.

To introduce the VLQ-2, it may be useful to cast it as the first step in the therapeutic process and to predict how it might be difficult for this particular client.

*Clinician:* We start this process by surveying areas of life that are valued by some people and how you might be relating to these areas in your life right now. We're going to start by getting a sense of what each of these areas means to you. The goal is not for you to think about what I mean by "family" or what society means by "recreation," but rather what it means to you—what it looks like, or doesn't look like, in your life right now. Most people don't value all of these areas or value all areas the same. When you find yourself wondering what I expect or think of you, or what others would expect or think of you, see if you can gently shift back to you and your own perspective. You may find yourself rating areas of your life in ways others would be surprised about. It's okay. We are here to make a place where things can change. The first step is to notice where and what you might be holding back.

The next step is to instruct the client to read through the twelve life domains represented on the VLQ-2. It may be useful to have the client name the life domain, pause to visualize an image that represents that domain to her, then name the domain again before moving on. We find that having the client name the domain before *and after* visualization can slow her down just a little, keeping her from avoiding just as soon as she contacts the image. We try to not only instruct this, but also warn clients that we may interrupt to guide them.

*Clinician:* I'd like you to read each of these areas of life aloud, slowly and gently pausing after each one. In that pause, I'd like you to call to mind an image that represents what that area means to you. It can be a scene from an event that actually occurred in your life. It can be something you wish had happened or could happen. It can even be symbolic or

fantastical. Just a single image to remind you, as we move through this work, what this area meant to you today, on this day, and to notice what it means to you in this moment. When you feel that you have the image in your mind, I'd ask you to say the area of life again. So now, one by one, slowly, begin at the top and work through each of the areas of life we'll be talking about today, naming the area, pausing and calling to mind an image that represents it to you, then naming the area again. I will ask you to slow down when I hear you starting to rush through, and remind you of our job here if you start to stray, but for the most part I won't be speaking—I'll just witnessing.

During this part of the interview, the clinician minimizes intervention in the client's process. You might be most comfortable staring at the paper (as the client often does). We would ask that you try watching the client as she engages this process, and see if you don't notice a sunset right there behind her eyes as she calls to mind, or struggles with calling to mind, that which is most important to her. You might also find yourself thinking of the history you took in the intake and trying to imagine what these domains might mean to her. There will be time for this. At this time, it may be useful, if you are willing, to call to mind your own images that represent what these domains mean to you. This is not to assume any similarity in the *content* of your values and the client's. However, the *process* of valuing is the same, regardless of content. Contacting your own values as you watch the client is the closest thing you have to being privy to her process at this point. Even if you are not willing, it may be useful to notice your unwillingness, just to acknowledge how hard the thing is that you are asking her to do.

## CHALLENGES WITH THE HEXAFLEX FUNCTIONAL DIAGNOSTIC EXPERIENTIAL INTERVIEW

You might observe experiential avoidance in the form of rushing through the task. We will sometimes intervene on this avoidance, directly asking the client to notice her own avoidance and make some moves toward acceptance.

*Clinician:* And I'd ask you to pause here, just briefly, and notice how difficult it is to slow down around these things that are important to you. I'd like you to notice how often we might rush by these things out in our lives, saying we just don't

have time. I wonder if you could offer yourself that precious time right now, right here. I'd ask you to take a slow, deep breath, then gently resume reading starting where you left off and this time intentionally giving yourself time to relish the images you come to. And when you find a kernel of pain inside of the image that comes to you, see if you can't trust yourself to slow down just a little more, letting that pain fill you up before you move on to the next thing.

The client will most likely speed up at least once more. After intervening with the above, you can often slow her down again by saying something simple, like "And pause. And breathe… Now slowly back."

You might notice cognitive fusion that interferes with this part of the activity. The client might seem to get stuck on one area. She may hesitate or appear to be struggling to come up with an image. She may appear to become increasingly frantic as time elapses. Sometimes simply describing what the client might be experiencing and giving her permission to let go can facilitate defusion. If we catch the client start to struggle, we might say something like this:

*Clinician:* And if you notice yourself getting stuck on an area, I'd ask you to pause and let go of making sense of any images or thoughts or feelings that might be showing up right now. And see if you can't give yourself three slow, free breaths in which you have no other job but those three breaths and being a vessel through which these experiences, like your breath, can move. (*Pause for three breaths.*) Now gently turn your attention back to the exercise, starting with the last area of life you named.

The client might appear to be following instructions, but with disruption of present-moment processes. The client may pick up a rapid and regular rhythm, allowing herself to make more contact with the sound of the words than with the words' other functions. Clients will sometimes even nod or move their body slightly to the beat. The intention of this exercise is for the client to make experiential contact with other functions of the named life domains. For this reason, it may be useful to intervene and to simply call the client's attention back to events in the present moment.

*Clinician:* And I'd like you to gently pause here and call your attention to your breath. In…and out… In…and out… See if you can notice the rhythm your breathing falls into as you let your

> words fall away. In…and out… And when you have a good sense of that rhythm, I'd ask you to see if you can slow it down by holding it for barely one beat. In…and hold…and out… In…and hold…and out…(*pause*). And now I'd like you to gently shift your attention to your hands. First, notice the weight they have that holds them in place there on your lap, that keeps them from floating away. Let your awareness sort of wrap around them almost like a wide bandage, starting at your thumbs from tip, to knuckle, down to wrist, then wrapping around the backs of the hands, up around your palms, and then around each finger—first…second…third… and fourth. And breathe, slowing that breath back down. In…and hold…and out… And now notice the temperature of your hands...

We usually continue with this exercise until we see indications that the client is settling in through subtle changes in her breathing, her posture, and her facial expression. It may be useful to follow your own instructions as you give them. If we instruct clients to call their attention to their hands, we call our attention to our own hands. This helps us to pace the exercise by not moving on until we have had a chance to follow the instruction. In addition, it facilitates our present-moment focus and, thus, our sensitivity to those subtle shifts in the client's behavior that indicate fluctuations in flexibility.

After the client has named and visualized each of the twelve life domains listed on the VLQ-2, it may be useful to stop briefly and ask for permission to continue with the exercise. At this point, the client is familiar with your requests for permission, and you can begin making these requests more briefly. We will sometimes say, "Is it alright if we continue to digging a little deeper into these?" or simply, "Is this okay? Can we go on?"

When the client has given her permission to move forward, the next step is to talk through each life domain in terms of possibility, current importance, overall importance, action, and satisfaction with action. Rather than the clinician rating the client's responses as in most structured interviews, it may be useful to have the client answer the questions in conversation, then rate her answers herself according to the scale. We also typically have the client choose the order we go in as we move through the domains. These small instructions can add to the client's sense that this is her work and that she chooses what it means and what it is for. This is an opportunity for the client to challenge her sense of self and exhibit committed action. When the client has named a life domain, the clinician asks her about

possibility as it is cast on the VLQ-2 (for example, "How possible does it feel that something really meaningful could happen in your life in this area?"). After the client has given her answer in conversation, the clinician tells her to rate that on the sheet from 1 to 10, with 1 indicating little to no possibility and 10 indicating infinite possibility. This continues through each of the rating scales. Then, the clinician asks the client to name another life domain, and the process repeats.

## CHALLENGES WITH PROCESS TRAINING

**Present-moment focus.** You might notice difficulties with present-moment focus that interfere with this exercise. For example, the client will often use the questionnaire to avoid eye contact, keeping her focus down at the paper. If you notice this occurring, it may be useful to request present-moment focus explicitly.

*Clinician:* I know this would be a lot easier if I would just let you complete the questionnaire on your own. It's not "easy" I'm going after here, though. If I am going to be useful to you, I need a sense of the shape your life has taken and how that is working for you. It's easy to get lost in your thoughts about these things, but I can't meet you there. The only way I can begin to gain your perspective is by meeting you here and now. I'm going to ask you about possibility in the area of education again. And this time, hesitate, letting your answer begin to rise inside you. I'll hold my hand palm-up like this, and I want you to let the words fall away and let your sense of possibility in the area of education fill you. Imagine you could communicate it to me without words, that it could fill you until it poured from your eyes. Then I'll lower my hand palm-up, and ask that you let the words come, still staying with my eyes.

We don't always use the hand to signal, and we fade it quickly. Frequently, however, it is a useful part of helping the client to learn to discriminate her own present-moment focus. This may be particularly important for clients who avoid their own bodily sensations. If you discriminate the client's shift into present-moment focus using a salient external signal, and then you fade that signal, she will soon come to discriminate present-moment focus in terms of her private experiences. This process also negatively reinforces the operant aspects of present-moment focus, as discomfort tends to build with silence and relief comes suddenly when the client is allowed to respond.

**Cognitive fusion.** You might also observe the client exhibiting cognitive fusion in the form of trying to explain or justify her responses. She might seem to be struggling to find the perfect words. You might see her self-correcting, hesitating, or saying things that seem to conflict. If you notice this, it may be useful to say it out loud and offer another possibility.

*Clinician:* I'm going to stop you here for just a moment. These are big questions we're facing now, and it's hard not to try to answer them perfectly. I see you sort of grappling with them, trying to find the perfect words. What if it's not important whether or not we understand logically why you would answer this way or that? What if it's not the words that matter at all, but the experience behind them? Like you could be speaking a different language, and I could still get it. Let's dip back into that last question, and this time, when you feel yourself start to struggle with the words, I'd ask you to simply let go of that struggle—to give yourself permission to say it all wrong, focusing instead on feeling the experience behind the words, and letting me hear that.

Sometimes the client will start to struggle with what you mean by this, asking for clarification or explanation. We typically choose to ask her to try it instead of trying to understand it logically.

*Clinician:* You know, this may be the sort of thing that's harder to explain than to do. Like riding a bike. Most people can't describe all the tiny muscle movements that go into keeping balanced, or the coordination of leg and foot movements that keep the wheels turning. But that doesn't mean they can't ride. Would you be willing to give this a shot?

**Limited conceptualization of self.** You might observe the client struggling with limited conceptualizations of self in the form of trusting her own sense of what she wants and what is important to her. She might seem to struggle with which area to choose, or how to rate her responses. She might say she "doesn't care," seem to be waiting for you to advise her, or explicitly ask for help or for you to do it for her. If this comes up, it may be useful to cast making these choices in this exercise as part of the pattern of positive change.

*Clinician:* I might have some sense of how this works for me, of what I would do in my own life. I might even have opinions about

importance or possibility for you in this area. But none of that matters here. What I would pick for me, or even for you, just doesn't matter—because this work isn't about me or what I want. It's about you. And making these little choices in here starts us on the path of you making bigger choices out in your life.

**Experiential avoidance.** You might notice the client exhibiting experiential avoidance that interferes with the exercise. She might deny importance or concern in areas she hasn't been successful in. She might exaggerate her sense of possibility, her action, or her satisfaction with action in areas that are particularly important to her. You might notice that her report seems inconsistent with what you learned in her intake interview, or that she seems less than genuine as she describes these valued domains. This is difficult to intervene on, as it could be easily interpreted as an accusation of lying. You will rarely have the relationship with the client at this point to support questioning her sincerity.

In the absence of this relationship, we will often not intervene directly on avoidance, but focus instead on present-moment focus. It is our experience that avoidance cannot survive the present moment because it involves turning away from an aspect of the ongoing experience.

*Clinician:* As I listened to you speaking about how important your brothers and sisters are to you, it was like I could understand logically what you were saying, but I had a hard time connecting with the experience of it. I found myself sort of looking for you even though you're sitting right here talking to me. I was wondering if we could try this again. And this time, I'm going to really try to make room for you to show up to whatever is going on for you when you call this area of life to mind, even the stuff that is hard to sit with. Would you be willing to dip back into the importance of your family to you and give this a try?

If you decide to intervene in this way, it is most useful in our experience to do so early on, when you first notice the avoidance, and to only do so with permission. You may also be able to anticipate where avoidance might show up from what you already know about the client, and might speak to that even before moving into that particular domain or rating.

*Clinician:* I get the sense from what you've already shared that this is a precious area in your life. I want to make sure that we

handle it carefully. Sometimes the things that are most dear to us are the hardest to look into. Yet, when we do so, we can find truly amazing things there. As we move into this next piece, I'm going to really try to make room for you to show up to whatever is going on for you when you call this area of life to mind, even the stuff that's hard to sit with.

# SESSION 3: EXPERIENTIAL ASSESSMENT OF FUNCTIONAL TARGETS AND ADJUSTMENT OF BASELINE (CONTINUED)

## *Part 1: Checking In*

## *Part 2: Hexaflex Functional Diagnostic Experiential Interview (Continued)*

The HFDEI is continued in session 3. After completing the VLQ-2 interview, the next step of the HFDEI involves direct observation and rating of psychological flexibility during an exercise we have called Sitting Inside of Significant Questions. This is a values-focused mindfulness exercise that involves guiding the client in making contact with each of the domains from the VLQ-2 and noticing the experiences that show up. The clinician rates the client's psychological flexibility across all six facets in the context of each life domain. Worksheets are included in appendix F to facilitate the clinician ratings.

After check-in, we begin this part of the HFDEI by introducing the exercise.

*Clinician:* I've asked a lot of questions of you so far, and the thing about questions is that we barely finish hearing the question before our minds start scrambling to generate the answers. In this next exercise, we're going to do something a little different. We've both come to this moment with a flurry of activity from the days, hours, and minutes since we met pushing us from behind. We'll start by taking a minute to settle in, and then we'll call to mind the different areas of life we discussed last week. When I start to ask you questions, I'm

> going to ask you to let go of finding answers. They will come anyway, but when they do, you don't need to check them out and evaluate whether or not they fit. Instead, just linger inside the questions. When we get there, I'll pause with you, and together we will just see how each group of questions moves us.

The Sitting Inside of Significant Questions exercise is included in its entirety in appendix F, including the clinician script and worksheets for clinician ratings. This part of the HFDEI is distinct from all other sessions in that the clinician does very little to intervene on client process apart from that which is built into leading the exercise (for example, speaking slowly and deliberately). When psychological inflexibility is observed, it is documented as data and marked for follow-up during the interview that follows.

## SESSION 4: BROAD CONCEPTUALIZATION, INFORMED CONSENT, AND THERAPEUTIC CONTRACT

At this point in the therapeutic process, we find ourselves in a position to make a therapeutic contract that is sensitive to the client's current struggles, psychological flexibility, and chosen values. In our ratings of the client's present-moment focus, sense of self, experiential acceptance, cognitive defusion, valued living, and committed action, we have everything we need to create a case conceptualization from the ACT perspective.

We often find it useful at this point to write a narrative that summarizes these aspects of client functioning. An example of what this might look like is included in appendix G. This case conceptualization is most useful, however, if held lightly as one way of speaking about the client's life. More often than we'd care to admit, we find ourselves latching on to our ideas about how the client's inflexibilities might be costing her and how flexibility could serve her values. In this latching on, our own inflexibilities can come to bear on the therapeutic process. We can all too easily find ourselves seeing every instance of avoidance, every turn away from the present, every fused idea, as a threat to progress that must be fixed. And suddenly we notice that despite our efforts, the client has become a problem (albeit an "ACT-consistent" problem) that it is our job to solve. And the

more distressed, or ill, or unpredictable the client seems to us, the tighter our grip becomes.

When we notice this fusion with case conceptualization in ourselves, we strive to do what we ask our clients to do with their inflexibilities. We breathe them in, letting our fears about potential failures and what that means about us as clinicians, wash over us. We lean in, reaching for the value that's inside all of that struggle. We became clinicians for all sorts of reasons. We wanted to help people. Somebody said we'd be good at it. Our adviser or parents made us pick something. We thought maybe we'd be rich. We thought maybe we could make a difference. We come to work to be clinicians every day for all sorts of reasons. Some days it's about just doing what people do: they wake up and go to work, and come home, and feed the dog, and fix supper, and take out the trash, and go to bed, and wake up and go to work, and so on, and so forth. And inside of all that is something precious.

Maybe we notice it in the moment when we say good-bye to a client we've done a lovely piece of work with. Maybe we notice it when a client we were really struggling with suddenly opens up and looks at her life a new way. Maybe we notice it when a new client reaches out and we find ourselves moved by her vulnerability. And often we just don't notice it. We notice the struggle. We notice our worries. We notice our doubts. We notice everything we did wrong as the session closes, and everything we could have done differently. And inside the pain that pushes that struggle along is our value—our sense of the kind of clinician we want to be. As we sit down to write our case conceptualization, we strive to open ourselves up to appreciating the sunset—the sunset in the client and the sunset in ourselves.

You'll notice that the case conceptualization in appendix G describes client functioning in terms of the six facets of psychological flexibility but includes no technical language. We choose to do it this way for several reasons. First, we do it because it contextualizes our observations in terms not only that any clinician could understand, but also that the client herself could understand. We don't make therapeutic contracts around reducing fusion or experiential avoidance. The client doesn't consent to doing ACT in order to facilitate her transcendent sense of self. We make therapeutic contracts around improving the client's life in a way she cares about. She consents to doing ACT in order to move her closer to the being the person she wants to be. One challenge the ACT clinician faces here is mastering a technical analysis of disordered eating while maintaining contact with the experience the client faces every day. Transitioning back and forth between technical language and nontechnical language is one way of meeting this challenge.

### *Part 1: Checking In*

### *Part 2: Acknowledgment and Looking Forward*

Following check-in at session 4, it may be useful to acknowledge the work the client has done in the last three meetings.

*Clinician:* I'd like to take a moment here to acknowledge the work that you have done so far. This work asks people to reach into things that hurt and to put out there the things that they care about the most. This is not something the world asks of us very often, and you have risen to this challenge with great courage. The fact that you are here today—knowing this is not going to be anywhere near the easiest, most enjoyable thing you do this week—speaks to that. And yet, here you are. Thank you for sharing this work with me so far.

The job of session 4 is to propose to the client your case conceptualization and the work that you are offering to do with her from here. It is important that the client understand that ACT is not the only approach to therapy, and that she has the freedom at any point to make a different choice. It is also important that she understand that this work is not about what you want or think is best, but about what she wants. It may be useful to start by orienting her to where you are in the therapeutic process, and what she can expect from that day's session.

*Clinician:* We discussed when we first met that our first job was going to involve me getting a sense of your struggles, how they have affected your life, and how our work here could move you toward the things you care about. Today we'll discuss this last piece of the work we could do, the shape it might take, and what we would focus on moving toward. Then we'll make a specific plan including how often we'll meet and how we'll track our progress. Finally, you will choose whether or not this feels like a piece of work you would like to do.

Next, the clinician asks for the client's permission to move forward and share the case conceptualization; for example, "With your permission, I'd like to share a little about how I have come to understand the things you've told me." With the client's permission, the clinician shares her case conceptualization, moving slowly through the different aspects of

psychological flexibility as they show up in the client's life. This not only facilitates rapport, but also begins to broaden the client's sense of self.

This exercise can be incredibly challenging for both the client and the clinician, as they assume positions of vulnerability. We sometimes have the urge to approach this from the standpoint of our expertise, or experience, or facility with the ACT model. This can protect clinicians against our own vulnerability around spending all this time with the client and getting it wrong. But the only way to get it wrong is to work to get it right, because in doing that, we let go of the client who we're there to care for. As we said before, we've found that the actual content of what you say matters little here. What does matter is that the client recognizes her struggle in your eyes, that she has been witnessed. The following is an example of what this exercise might sound like:

*Clinician:* We talked before about finding yourself stuck, crouched against the wall, with the things you care about seemingly out of your reach, maybe even out of sight. As we sit with this a little more, I hear that life these days feels almost like you're not even in it. It sounds like most of your days feel like a blur, punctuated by studying and checking your weight. I hear that you're able to really dig in and focus when in comes to schoolwork, but that it comes with a sort of desperation, like failure is hot on your tail and at any second you could really screw it up. It sounds like what people see on the outside is a confident young woman, a hard worker, the girl who has it all together and under control. And I hear that inside you feel lost and weak and out of control.

I hear that you miss your mom, and that you push that away. I hear you feeling guilty for not being stronger enough to move on. I hear that you really care about your relationships with your family. When you speak about your sister, Beth, I see in your eyes what it means to you to be a sister. I also hear that you've turned away from that part of you, you as a sister—that you've come to see yourself as dangerous to her. I hear that the only relief you get these days is inside of striving for "thin." It sounds, though, like even this is short-lived and costly. I find myself wondering if you could ever lose enough weight to get the sense that you're okay, that you can stop now, that you can rest. I hear you doubting that that day will ever come. And far more quietly than that, I

hear a faint whisper of hope that maybe, just maybe, things could be different.

There is often a tangible sense of urgency in the room following this exercise. As with most occasions in therapy, we recommend that if you feel rushed to move on, it's a good time to slow down. It may be useful to let the silence fill in around both of you until the sense of urgency passes. You might also have the urge to hear reassurance from the client that you've done a good job, that you got it all right. We encourage you to peel that back, putting your hand on what lies just beneath it—your value of helping the client. Making contact with this will serve to guide you as you move into the next step: offering the client the piece of work you would like to do with her.

*Clinician:* I know that there's no way that you could see this, but I have this sense that things could be different for you. We could do a piece of work together that aimed to free you to get back into the moment-to-moment experience of your life. I see this as a piece of work that would position you to receive what your life has to offer, the joyous and the painful, and to choose to move toward being the sister you want to be, the student you want to be, or whatever else you choose—not because it feels right or necessary, but simply because you choose it.

This work would look a lot like what we've done so far. We'd meet weekly here and practice different skills, and then we'd discuss them and where they might be applicable in your life. Some weeks would be a little harder, some weeks a little easier, but each week would involve moving through hard things you've been pushing away to get just a bit closer to the life you would choose.

It's important that you understand that not all therapy works just like this, and that this work is not for everyone. If you had walked into the office of another therapist, this work might look quite different. For example, many approaches would focus on improving your eating habits and the way you feel about your body. We would be focusing instead on how they have impacted your life.

It's also important that you understand that this work has to be chosen, or it's not the same work. And if you choose this piece of work today, we'll come to a number

of points where I ask again for your permission to move forward. And starting with this piece of work, you get to decide if you could choose whatever I'd be offering in a way that served what you care about, that got you closer to the life you would choose.

I would like to start by committing to eight weekly sessions. And in those sessions, I commit to practice sitting with you in the hardest places in your thoughts, feelings, memories, and experiences, and with the urges to turn away. I commit to sitting with *you*, not what you look like on the outside, or what you fear you are, but with *you*. And on the days that you choose not to do this work, I commit to being here, ready to receive you when you return. I will ask hard things of you, and I commit that everything I ask of you will be in service of that life you are choosing to build, that sister you want to be, the education you'd like to pursue, and anything new that you choose on the way. I commit to showing up every week for eight weeks, not just in body, but in awareness. And when I find myself turned away from that, I commit to returning. I would be honored, truly, to do this piece of work with you. Does this sound like a piece of work you might be interested in?

## CHALLENGES WITH OVERVIEW AND LOOKING FORWARD

You might observe experiential avoidance at this point in the form of the client rejecting what you have offered. If the client indicates that she is not interested, it is important that your response indicate that you trust her to be able to make that choice for herself. What, exactly, happens from there will depend largely on your setting and other logistical details. If the client is limited to services with you, it may be useful to find out what she is saying no to. Sometimes, the client is saying no to the number of sessions, or to having to close her eyes, or to filling out the food diary. Some of these might be pieces you'd be willing to change. Sometimes, she is saying no to opening up to that which hurts and matters when she doubts change is possible. Negotiating the therapeutic contract from here involves figuring out if there is a piece of work both the clinician and client are willing to do that could serve the client's values. And sometimes we just don't get there. And in those moments, the challenge for the clinician is to sit inside that

experience and hold the door open for the client to turn back. We often inform the client in specific terms that the opportunity remains and how she could request to resume this work if she found herself interested at a later date.

You might observe difficulties with informed consent and the therapeutic contract related to a limiting conceptualization of self. A client might seem enthusiastic and hopeful, but hesitant about committing to the work. If this becomes apparent, it may be useful to acknowledge self-doubt and note that it does not have to be resolved for the work to begin.

*Clinician:* I know that there might be a part of you that doesn't buy that you're good enough, or strong enough, or deserving enough to do this piece of work. A part of you that thinks it knows what you are and what you are capable of, and has decided that this piece of work is out of reach. But what if you don't have to feel good enough, or strong enough, or deserving enough to be able to step into this kind of work? What if there may even be times that feeling bad, and weak, and undeserving puts you in a position to see an opportunity for life change you wouldn't have noticed otherwise? I'm offering this piece of work to you, exactly as you are in your strongest moments, in your weakest moments, and in this moment.

You might notice difficulties with informed consent and therapeutic contract that could be related to fused and avoidant valuing. The client's consent might seem to be more about compliance than about choice. When you ask her about the work you would propose, you might notice her watching your responses to her closely and modulating her behavior based on them. She might mimic your affect, intonation, and posture, or begin quickly to speak like you do about her life. You might be able to feel her pulling for your approval instead of reflecting on what she wants. And you might find yourself making a contract that is sound in words, but that feels insincere. In these circumstances, we often try to take our approval out of the decision altogether.

*Clinician:* I was wondering if right now we could skip back just slightly to the moment just before I asked for your commitment. Would that be okay? Remember when I said this was a piece of work that had to be chosen? As you spoke, I saw instants of that—moments when you seemed to be reaching in and setting your hand on that whisper of hope. I also saw

something of a scramble—other moments when, instead of reaching in, you seemed to be reaching out, grasping the air for something solid to lay your hand on. In just a minute, I'll ask you to give yourself a few deep, slow breaths, and then go back through what you were telling me about doing this piece of work. The words do not have to change at all, but this time I want to see you show up to make this choice. This is your life. It's just too important to do it any other way.

The client may also need additional reminders to slow down and breathe as she goes through her commitment again.

## *Part 3: Anticipating Change*

Once the client has committed to the work, the next step is to review the assessment plan, to examine the data that have been collected so far, and to discuss goals for how those data might look if treatment were to be successful. This helps to maintain motivation for assessment, and to expand the client's interactions with her own struggles from something to be avoided to something to be examined.

You may find it useful to consider each assessment instrument individually in terms of how it seems to fit with the work to which you have both committed. We usually start by asking the client's experience with the questionnaire or self-monitoring task (for example, "How's this one to complete?"). Then we ask the client's impression of how this assessment seems to fit with our plan for treatment (for example, "How do you think this fits with the work we've committed to?"). Finally, we ask if the client is willing to commit to continuing to complete the assessment regularly (for example, "Is this something you'd be willing to continue to do as part of our work together?").

If the client indicates her willingness to continue with that particular assessment, the clinician presents the data that has been collected on that dimension so far. We typically present this in the form of graphs. It is important, when examining these graphs, to relate the points representing the baseline data to the behaviors or experiences of the client.

*Clinician:* So this questionnaire asks about negative thoughts and feelings people have about their bodies. Right now you are here (indicating baseline points). So these points right here stand for those moments you feel disgust at catching a glimpse of

your body in the mirror or you think, "I wish I could get rid of this bulge beneath my belly button."

Then the clinician orients the client to how the data being collected in each assessment relates to the treatment plan.

*Clinician:* We've said a number of times that a lot of our work is going to involve sitting with difficult experiences. These [indicating baseline points] represent some of those experiences that we are going to be learning to sit with.

Finally, the clinician and the client discuss how the graphs would change if work continued over the next eight weeks. It may be useful to start by asking the client's impression (for example, "If we do the work we've committed to, do you think we will see a change in this graph?"). Sometimes the client will respond differently from how we would. She might indicate that she thinks that her weight will stay the same, or that all her distress will go away. As long as the client understands what is and is not the focus of therapy, she does not have to articulate or believe in the clinician's specific model to commit to the work. We might simply indicate what we would want or anticipate.

*Clinician:* I don't know what might change, if anything, on this graph. Some people find that it's only after learning to sit with these hard things that they start to change. Others find that these difficulties come and go for most of their lives. The line on that graph would rise and fall with other difficulties in your life. It's hard to know what to expect, but I think if I could hope for something for you with this graph, it would be that whether the line rose or fell, on the days your body really bothered you and on the days you felt pretty good, you could continue the same movement toward the life you choose.

After reviewing each assessment method and making necessary changes, it may be useful to let the client know that you will review the data after four weeks and again after eight weeks. You might also warn her that, from time to time, you will ask about responses on questionnaires or self-monitoring records. Finally, you might offer to answer any questions she might have about assessment methods or purpose along the way.

## *Part 4: Checking In*

Session 4 is concluded by giving the client a chance to ask any questions or make any comments she might have about the therapeutic process so far.

*Clinician:* Today has been something of a whirlwind, and I've been doing a lot of talking. I wanted to save a few minutes to check in with you and find out if you have anything you'd like to ask or share about your experience so far.

As the client responds, the clinician's focus is on appreciation.

# CHAPTER 13

# Phase 2: Building Flexibility in the Therapy Session

The first phase of this work serves to find out where the client is, where she wishes to go, and what challenges she might meet on her way. The second phase of this work serves as practice meeting those challenges. The focus is on shaping psychological flexibility in the therapy session, where the clinician can manipulate many of the contingencies that come to bear on the client's flexibility and inflexibility. In this way, the client learns to discriminate flexibility from inflexibility, and to choose flexibility when it is important.

The content of phase 1 was fairly structured. The assessment, consent, and treatment planning goals during phase 1 require the clinician to be far more directive in the first four sessions with respect to content. Depending on the clinician's preferences and the needs of the client, the content of phase 2 can be far more flexible. The goal of sessions 5 through 8 is to begin to shape psychological flexibility in the therapy session. Although the clinician remains directive with respect to function, the content of the session is often not as specified beforehand. We do not, for example, typically specify certain exercises through which functional goals will be accomplished. Instead, we aim to ask questions that direct the client to present content with which she is likely to be inflexible. We then intervene on that inflexibility according to the goals of that session.

The functions of sessions 5 through 8 aim to shape flexibility in the client's repertoire. In the fifth session, the clinician focuses on building flexibility around being present in the therapeutic context. In the sixth session, the clinician focuses on evoking and helping the client to notice psychological inflexibility. In the seventh session, the clinician focuses on evoking inflexibility and shaping flexibility. In the eighth session, the clinician focuses on shaping the discrimination of inflexibility and flexibility.

# SESSION 5: BEING IN THE ROOM

## *Part 1: Checking In*

Session 5 begins with checking in. This provides an opportunity for you to address practical or logistical concerns that the client may have. This is also a good time to check for compliance with the assessment protocol and to make any necessary adjustments. Finally, it may be useful with some clients to inquire how things are going more generally (for example, "How were exams last week?"). You also may find it useful to vary the questions you ask of the client, some being relatively neutral and others somewhat aversive. This provides an opportunity for you to assess the client's psychological flexibility under variable but relatively unstructured conditions. You can then continue shaping psychological flexibility in the way you respond to the client (for example, "I noticed your voice change just then. Is it hard to tell me this now?" or "I'd like you to slow down here, and pause for just a moment. This feels important…"). This will provide a broad behavioral sample upon which the rest of the session can be based.

## *Part 2: Committing to the Present*

Following check-in, you introduce the concept of present-moment focus by noticing out loud times that the client was present and other times that the client was not present.

*Clinician:* You know, just now, as you described talking to your sister and not hearing from your friend, I noticed that sometimes I could look at you and see what it was you were describing, right there behind your eyes. You were totally present, like I could have gone deaf in that moment and I still would have

gotten what it was you were expressing. Did you notice any moments like that?

You might then cast present-moment focus as useful to your work together.

*Clinician:* I've told you before how important it is for me to get what your struggle has been through your eyes. And you've sat with some really difficult things over the past month to help me get how you came to be here, in this place, right now. I wonder if these little moments of when you show up and are present, even if it's around something small, might be just as important to our work. What do you think?

Finally, you might then ask the client if she'd be willing to commit to being present, noticing when she's not present, and returning to the present.

*Clinician:* I was wondering if you think it might be useful to you, part of being the sister you want to be, the student you want to be, to work on being present on purpose. To work on the ability to choose to open up to the things you're experiencing, to see what opportunities might be there. Does this sound like something you'd be interested in?

## *Part 3: Shaping Present-Moment Focus*

If the client agrees, the clinician can then return to the some of the content presented in check-in to leverage intervention on present-moment focus. You might consider your case conceptualization and ratings of the client's present-moment focus during baseline to guide where you begin intervention. You might also consider how you've intervened on present-moment focus during the first phase and the impact those interventions had.

If the client appears to be fairly limited with respect to present-moment focus, you may create an exercise that simply emphasizes being present to a single domain of sensory experience.

*Clinician:* I'd like you to call to mind what you were just telling me about your difficulty with coming in this morning. Let those doubts you were describing rise up and begin to take shape right now, in this moment. And breathe in, nice and slow,

letting that air fill your lungs just a little at a time. And out, letting the air leave your body just as slowly as you can. And I'd like you to now gently shift your attention to the way your shoes feel on your feet…

You might find it useful to move among different aspects of the sensory experience until you observe the client's focus shifting to the present. When she appears present, you might then punctuate the focus on tactile sensations (or whatever domain you've chosen to focus on) with a shift to the experience you've drawn from what she shared in check-in.

*Clinician:* And again, gently open up to those doubts that you carried with you today. Notice their presence here in the room, even as you shift your attention to this or to that. And see if, on the next breath, you can't gently breathe them in, making room for them to be here, as we move on with our work.

On the other hand, if the client has demonstrated some significant capacities for present-moment focus, you may return to some of the content she presented during check-in, guiding present-moment focus on different aspects of that memory.

*Clinician:* I'd like you to gently call to mind the last moment you felt those doubts really rising up, taking hold of your attention. When was it?

*Client:* This morning.

*Clinician:* Just this morning. Good. What were you doing?

*Client:* Brushing my teeth.

*Clinician:* Good. See yourself brushing your teeth this morning. Were you in your bathroom? In front of your sink?

*Client:* Yes.

*Clinician:* I'd like you to slow way down inside of that memory. Imagine you could pour your awareness into that moment. Look through your eyes and see what you saw this morning. Feel those doubts, not as a memory but as an experience rising up inside of you right now…

Following intervention, you might find it useful to debrief with the client, still emphasizing focus on the present moment.

*Clinician:* And whenever you're ready, I'd like you to join me back in the room, still keeping your sense of presence in the now. I might ask you to slow down, to breathe as we talk, and when I do, I'd like you to take that moment to open yourself up to whatever is going on for you right then, letting go of explaining yourself or justifying your reactions, and simply showing up to them, letting them pour forth as you express…

At this point, you can begin to debrief by asking questions such as:

- How was that exercise for you?
- What makes it difficult to show up right here right now?
- Did you notice times when you felt very present? Times when you felt whisked away with your thoughts?

Finally, you might share with the client how difficult present-moment focus is, how rarely we do it, and how it might be useful to the work of therapy.

*Clinician:* You know, we move about our world in a completely different state than what we've worked on today. We move so quickly from this thing to the next to the next, often without slowing down long enough to see what's going on around and inside of us. And often, this is fine. We can brush our teeth, pay our bills, go to work, run our errands, all sort of half present. And sometimes, this has a cost. We miss so much. Missing the feeling of our feet in our shoes is unlikely to cost us much, but what if what we miss is an opportunity to take a step toward something we care about? If anything we do here is going to be useful, I want us to be present to see it.

## SESSION 6: EVOKING AND NOTICING INFLEXIBILITY

The shape of sessions 6 through 8 can vary widely among clients, depending on their presentation and the areas of inflexibility that seem to be most

impacting their lives. The emphasis is not on the clinician's assessment of the degree of inflexibility. From an ACT perspective, inflexibility is not considered to be bad in and of itself. However, inflexibility is considered to have real costs, some of which are costs in domains that really matter to the client. You may observe what seem to be fairly large deficits that don't impact a client's life very much. For example, a client might exhibit significant fusion around the evils of corporate America, but this might have little to do with her struggle to relate to the people she loves. You may also observe what seem to be slight deficits that significantly interfere with valued living. For example, a client may have some difficulty accepting physical discomfort associated with anxiety, but might find herself most anxious when she is pursuing the education she desires.

Between sessions 5 and 6, the clinician should spend some time considering the case conceptualization and asking the following questions:

- What does valued living look like to the client?
- What facets of inflexibility seem to have the biggest costs with respect to this client's valued living?
- What content is likely to evoke this inflexibility?
- What form is this inflexibility likely to take in session?

The answers to these questions will serve you in selecting interventions for sessions 6 through 8. You may find it useful to look back at chapters 5 through 10 to help you generate ideas for interventions.

## *Part 1: Checking In*

## *Part 2: Contacting Aversive Content*

In this part of session 6, the clinician establishes conditions for the client to exhibit inflexibilities in her repertoire that are impacting her pursuit of values, or lack thereof. Because this involves introducing aversive content that you know to be central to the client's struggles and her values, it is important to ask the client's permission to do so. You may find it useful to build on the experience of showing up that was introduced in session 5 and extended during check-in.

*Clinician:* We said last time that being present is important because it helps us to see opportunities to move in directions you care about. I've been thinking about some of the things in your life that might be hardest for you to be present to, but that might have some value tucked right inside of them. I was wondering if we could look more closely at some of these today.

With the client's permission, you might start with a brief present-moment-focused exercise, then transition into creating conditions for her to contact aversive content. If the client appears to be present, this can take the form of a conversation growing out of a question about this content.

*Clinician:* What shows up for you right now if you imagine calling your sister?

The client's first answer will rarely have the qualities that you're looking for. The issue is not whether the answer is right. The goal here is not information gathering. More times than not, you will know the answers to the questions you are asking. What's important here is that the client makes contact, however brief, with those answers because these are the experiences that the client makes contact with when making contact with her values.

*Clinician:* And if you'd be willing, pause here and breathe for a moment, gently letting that sense of yourself as "toxic" fill you up…

What you are looking for is an instance of the client contacting the aversive experiences associated with her values so that you can both observe the inflexibilities that result.

## *Part 3: Noticing Inflexibility*

This part of session 6 involves helping the client to notice her inflexibility and its cost to valued living. The emphasis is not necessarily on the client being able to describe experiential avoidance or cognitive defusion. We are not interested in the client being able to articulate the relationship between her inflexibility and her pursuit of her chosen value. Rather, it is simply that the client brings present-moment focus to bear on her inflexibilities and costs they may have in therapy.

Throughout this session, you will want to be mindful of the client slipping into compliance. It often becomes important to ask for permission again, particularly if you notice the client repeatedly losing contact with the present moment.

*Clinician:* I want to ask you to slow way down again here. Back up just a little and start again. Is this okay? I don't want to be trampling you down here, particularly around things this important to you.

With the client's permission, guide her attention to the moment just before she made contact with the aversive, asking her to notice the transition into inflexibility.

*Clinician:* I noticed something changed just then. I heard it in your voice, saw it in your eyes… It was like for just an instant you were there, present with the pain rising up in you and all around you, then suddenly you were somewhere else… Did you notice that?

It may be necessary to introduce the aversive repeatedly before the client is able to notice her inflexibility.

*Clinician:* I know that this is difficult. And I was wondering if you'd be willing to let yourself slip into that moment just before you turned away into silence. You were describing the moment when you dial the last digit in your sister's phone number. I'd ask you to let that moment and all it brings with it fill you up right now, noticing the urges to turn away…

When you feel that the client has some awareness of her inflexibilities, ask the client's permission to continue.

*Clinician:* May I ask you a hard question here?

With the client's permission, you guide attention to the cost this has.

*Clinician:* When you turn away, what does this cost you? What else might you be turning away from?

If the client does not describe turning away from her values, asking her to consider this may be necessary.

*Clinician:* I wonder, when you do turn away, do you feel closer to or farther from the sister you want to be?

# SESSION 7: NOTICING INFLEXIBILITY AND SHAPING FLEXIBILITY

## *Part 1: Checking In*

## *Part 2: Noticing Inflexibility*

The second part of session 7 revisits the piece of work introduced in session 6, this time giving the client more responsibility to identify instances of inflexibility in her own repertoire. You may find it useful to start by referring back to the idea of inflexibility introduced in session 6 and asking the client to notice instances of inflexibility in session.

*Clinician:* Last time we spent some time noticing the way you tend to turn away from interactions with your sister because of the way they make you think and feel about yourself. You talked about how turning away buys you short-term relief but results, in the long term, in you moving further and further from the sister you want to be.

I find myself wondering about other times and ways in which you defend yourself against things that are uncomfortable like that. Most people do this constantly, just like during our eyes-closed exercises…sort of coming in and out as they move about their worlds. As an example, I'd like you to think gently back to the conversation we just had. Take a deep breath and notice the moments when you showed up completely, and the moments when you were barely here at all. Can you call to mind the times you turned away or hid from showing up because of what you felt when you got there?

If the client does not provide an example, you may find it useful to ask her permission to ask again about aversives that were presented during check-in.

*Clinician:* It's hard to see, isn't it? Would it be okay if I asked you about some of the things that seemed uncomfortable for you during that conversation?

With the client's permission, you begin by asking questions about topics that appeared aversive to her during check-in.

*Clinician:* Would you be willing to tell me more about your thoughts on the way here this morning? About wanting to cancel?

As she answers the questions, look for opportunities to draw her attention to her own inflexibility when it occurs.

*Clinician:* Did you feel that? Right there. Just before you started talking about not being sure you understood everything from the last session. It's like I sort of lost you there. What was showing up for you just now?

## *Part 3: Shaping Flexibility*

In the third part of the session, the clinician begins shaping flexibility with whatever content was introduced in part 2. The facet of flexibility you focus on will depend again on the inflexibilities that seem to have the most cost with respect to valued living.

You may find it useful to begin by asking the client's permission to intervene on inflexibility.

*Clinician:* We do this so automatically. Most of the time, we don't even realize it. Sometimes, though, noticing it would mean that we could do something different. Would you be willing to practice not only noticing when you're turning away, but taking those moments as opportunities to do something different?

With the client's permission, guide her attention back to the content that evoked her inflexibility and begin to shape flexibility. Consider the client's case conceptualization here, and her most current ratings of flexibility. The exercise that you choose should build on the client's current skills and should emphasize the facet or facets of flexibility that have the largest impact on the client's valued living.

*Clinician:* I heard that as you made your way here, one of the things that kept coming up was how lost you were afraid you would be. That I'd start talking about the work we did last time and you'd have no idea what to say or what to do. It's like you suddenly realize you're in the woods, almost completely surrounded by thick forest except for this one path. And you've been on that one path, and all it does is go round and round before spitting you back into this clearing. You might

be able to get away from feeling lost while you're making your way down the path or sitting down for a moment to rest, but you know what's there and it's nothing you want. There's another option, though. You could step out into the woods. Stepping over brush and pushing through branches, you'd almost certainly feel lost, and everything else that comes with it. And who knows what you might find. It's like today—when you walked through that door and told me how confused you were feeling, you stepped into those woods. You chose to step into being lost. What if that's what it's going to take? Would you be willing to step into those woods long enough to find out if there's anything in here that you value? Would you be willing to commit to coming here, week after week, even if you knew that part of what you'd find here is that sense of being lost, if it had the chance to get you closer to the things you care about?

## SESSION 8: NOTICING FLEXIBILITY AND INFLEXIBILITY

### *Part 1: Checking In*

### *Part 2: Noticing Flexibility*

You might begin the second part of session 8 by acknowledging the work of the previous session and asking the client's permission to build on that work.

*Clinician:* I wanted to begin by acknowledging the work you did last session. I know that it was difficult for you, and I saw you reaching over and over to stay present and open. I'd like to step right in to another exercise today, this time doing something a little different. Would that be something you'd be willing to do?

With the client's permission, part 2 of session 8 moves directly into an exercise building on the work of session 7. It may be useful, however, to select an exercise that differs slightly in form and function from that of session 7. The content of the exercise is not particularly important. If you

noticed an instance of inflexibility during check-in that seems to impact the client's values broadly, it might be useful to build an exercise around that content. Otherwise, using the same content from session 7 can also be useful.

*Clinician:* I'd like you let your eyes fall closed. Take a moment to get comfortable in your chair. And breathe. And as you breathe, I'd like you to take a moment to notice the rhythm of your breath. In…and out. In…and out. And now I'd like you to imagine you could see yourself sitting here, breathing, in this room right now. And breathe. And on your next breath, I'd like you to let your awareness expand out of this room, in this moment, to the evening last week when you stood in front of the mirror and wept. Let your awareness settle on this moment. See a woman a lot like you peering at the mirror, her eyes begging for something, anything other than what she is feeling. Let your awareness settle on her eyes. And breathe.

And gently let your awareness shift to take in her appearance, piece by piece. Glance once more into her eyes, and then gently trace her cheekbones down to her jaw, her neck. Notice the slope of her shoulders, the way her arms hang, her thin wrists, her hands. Let your awareness wrap around her breasts, her back, and back around to her belly. Notice her hips and her bottom, the curve of her thighs to her knees, trace her calves down to her ankles and the tips of her toes.

And breathe, letting your awareness settle again on her eyes. And on your next breath in, I'd ask you to let yourself be filled with the feelings that pour from her eyes. Imagine you could breathe in those feelings in such a way as to give the woman a moment of peace. And breathe.

And gently let your awareness expand from that woman in the mirror last week. And breathe. And on your next breath out, let that woman with her eyes and her image and her pleas fade. Let yourself become aware now of a girl, much younger, much smaller, in another house in another time. Let your awareness settle on this girl as she turns to face her own mirror. Let yourself notice her eyebrows begin

to pull together, and her eyes begin to squint and fill with intensity as she regards herself in the mirror. And breathe. And gently let your awareness shift to take in her appearance as she turns to the side, her eyes riveted to her image in the mirror. Let your awareness stay with this girl as she pulls her stomach in, her ribs protruding, making sharp curves in her shirt. And breathe. And on your next breath in, I'd ask you to let yourself be filled with the feelings that pour from her eyes. Imagine you could breathe in those feelings in such a way as to give the girl a promise of peace. And breathe.

And gently let your awareness expand from that girl in the mirror so long ago. And breathe. And on your next breath out, let that girl, with her eyes and her image, and her stomach held tight, fade. And gently let your awareness settle back upon you, sitting, and breathing, in this room right now. And breathe. And whenever you're ready, come back into the room.

Following an exercise like this, the client is given time to process her experience. It may be useful to start with a broad question (for example, "What did you notice?") and probe for details related to noticing flexibility and inflexibility as necessary (for example, "That sounds difficult. How long were you able to sit with that?" or "Were you able to come back to the exercise?"). Your goal during the processing of this exercise is to appreciate the client's experience.

## *Part 3: Noticing Flexibility and Inflexibility*

The third part of session 8 involves discriminating flexibility and inflexibility in the present moment.

*Clinician:* I'd like return to the work we just did. This time, however, I'd like you to guide me, telling me not only what you see, but what you experience as you move through the exercise. I'd like you to let go of any efforts to remember the details of what I said or how I said it. I'd also like you to let go of any efforts to get it right or to do a good job. Take a moment to let yourself settle in, finding your breath, and whenever you're ready, give voice to your experience.

# CHALLENGES IN PHASE 2

The client is likely to demonstrate some inflexibilities during this phase that make intervention difficult. When you notice these inflexibilities, you may decide to intervene on them, depending on the context. Ask yourself how much they interfere with the client's ability to contact the work and how central they are to the individual's difficulties. If these inflexibilities are interfering with behavior change and tend to interfere with the client's functioning more broadly, it may be useful to intervene.

## CHALLENGES IN NOTICING INFLEXIBILITY

**Lack of present-moment focus.** The client may exhibit inflexibilities related to a lack of present-moment focus. Her speech, gestures, and other nonverbal behaviors may limit rather than facilitate connection with her own experience. If the client struggles to remain present during unstructured conversation, you might opt to use the structure of an eyes-closed exercise to help make the aversives present.

*Clinician:* I'd like you to imagine that you walk out of this office, sit down on the bench outside, and take out your phone to call your sister. Let yourself see each tiny movement that makes up the action in slow motion, noticing what shows up along the way. You reach into your bag. Feel your hand rummaging around, closing first around your wallet, passing along the bristles of your brush, then finally closing around your phone. Notice any thoughts that show up as you start to lift the phone from your bag…

It may be necessary to return to brief eyes-closed exercises several times in order to help the client to be present enough to contact the intervention.

**Experiential avoidance.** The client may exhibit some inflexibility related to avoidance that interferes with intervention. She might avoid aversive experience. She might also deny being aware of her experience, the consequences of her behavior, or that her experience and its consequences are distressing during the exercise and debriefing. She might tell jokes or make other efforts to maintain her comfort. She may give permission for the intervention, then struggle to reject her own experience, saying yes but doing no. If you observe this, it might be useful to ask her directly to open her awareness to the parts of this that might not be comfortable.

*Clinician:* You know, we humans are pretty good at managing discomfort or pain in the short term. We have all kinds of ways of buying ourselves a little distance from the things that are hard for us. The problem is, of course, that our discomfort doesn't stay gone for long, and often our pain is right inside of the things we care about the most. It's important that we let those hard things show up here so we can practice continuing on our path with them instead of letting them dictate where we can and can't go. I'd like you to close your eyes just briefly and notice the parts of you that are saying no to this experience. Notice if you've got any places you're not letting yourself go, any thoughts or feelings you're turning away from. And breathe, and as you exhale, I'd like you to see if you can't loosen your grip on that no that could be holding you back from something precious.

If avoidance seems to persist, it may be useful to ask the client to generate her own example of whatever it is you are attempting to convey.

*Clinician:* I don't want to tell you what your experience is, and I appreciate you not letting me do so. I'm afraid I might have not picked a good example. I apologize. Would you be willing to help me out a little here? Would you be willing to tell me about an experience in your life that you turn away from, but that you think might be important for you to turn back toward if you could find a way?

**Cognitive fusion.** The client may exhibit some inflexibility related to fusion that interferes with intervention. She might request extended explanations of how these processes work or how these will be useful. She might intellectualize her experience, explaining how or why she struggles with this or finds it easy. If you observe this, it may be useful to cast this as an example of how difficult this work is.

*Clinician:* I'd like to stop you here for just a moment so we can notice how difficult this work can be. It's so hard for our minds to let go of trying to analyze the world, trying to figure out what's safe for us and why. When they aren't stuck in some other problem like the doubts you walked in with, they are stuck in trying to make sense of our experiences. I wonder if you'd be willing to sit with this over the next week. I'd

like you to notice when you are present and when you are not, letting your thoughts about how this might or might not work for you sort of roll around. We could spend some time talking about this here, but I wonder if your experience won't do a better job of speaking to some of the things you're bringing up.

**Limited sense of self.** The client might exhibit some inflexibility related to limited conceptualizations with self. Her beliefs about her own limitations might make it difficult for her to contact the exercise. She might appear to be managing your impressions by striving to come up with the "right" answers or to respond like a "good" client. Alternatively, she might describe an inability to do the exercise or explicitly deny its worth to her. She might also present a compelling dramatic response that reflects her understanding of herself as too broken or sick to do this work successfully. If you observe this, it may be useful to ask her to trust herself to be able to pursue this in a way that serves her values.

*Clinician:* You know, because this work is so different from the way we've learned to be over the years, it can be hard to imagine how it fits with our experience of ourselves. You might find yourself wondering if you will be able to do this "right," or if there's a risk that you'd put forth this effort and nothing would change. I'm going to ask you to be gentle with yourself here, and to trust yourself to be big enough, and strong enough, and stable enough to take this on. I'm not asking you to believe anything different about yourself or the exercise. I am going to ask you, though, to trust yourself to find your way through to your sense of the sister you want to be, the student you want to be, and to let that lead you. I'm here to meet you in this moment, wherever you find yourself. Even when it's pretty far from where you'd choose.

**Fused values.** The client might exhibit inflexibilities related to fusion with values. She might interpret the exercises as a rule for how she *should* be moving about her world. She might also have trouble reconciling her work with what she thinks valued living *should* look like. If this is observed, you might emphasize that anything that you ask her to engage will be in service of the things that she's said she cares about. You might also mention that

only she can notice when and where this kind of focus might foster valued living.

*Clinician:* If you find yourself struggling a bit with trying to pull a rule from the exercise about how you should be, or how this may or may not fit with your experience of the things you care about, I'm going to ask you to let go of that urge to make this another burden on you, another something that has to be done just so. The things that I ask you to do in here will be in service of the commitment we've made to your values. Values are sort of like this, though: Only you can tell when this may or may not serve them. Only you can tell when slowing down and showing up might be the next step on the path. We practice this here, not so that you will go out and remain present all the time, but so that you might be more likely to see the opportunity, even in here, where bringing present-moment focus to bear might put you in a position to receive something your experience offers you.

**Lack of action.** The client might exhibit inflexibilities related to avoidant persistence or inaction. She might experience clinician instruction and feedback as aversive, and respond to intervention with decreases in awareness and increases in inflexibility. If you observe this, it may be useful to facilitate client values around which this work is based.

*Clinician:* We spent a lot of time at the beginning of this work together choosing direction. Every once in a while, it's useful for us to sort of reach out and put our hands on the sweetness we are working toward, just to make sure we both know what we're doing here. I'd like you to take a moment and call to mind a moment of sweetness. It can be a recent moment or a moment that's hovered in your memory a while. It should be a moment during which that struggle to make sure you're okay just fell away. It doesn't have to be a moment that is important or that anyone else even knows about. The important thing is simply that it is a moment in which you drew a full free breath and were comfortable in your own skin. I'd like you to let your eyes fall closed and just call to mind this moment of sweetness. Imagine you could pour your

awareness into yourself in that moment so that the experience rising up in you in that sweet, sweet moment could rise up inside of you right now. Breathe that moment in, and out. And whenever you're ready, I'd like you to come back into the room.

I was wondering if you'd be willing to share with me some of what you experienced during the exercise. Don't spend too much time worrying about finding the right words. The words, I find, are more limiting than helpful. Instead I'd like you to express just a word or two about your experience, then let your experience pour forth from your presence.

# CHAPTER 14

# Phase 3: Bringing Flexibility to Bear in Daily Life

The second phase focused on shaping psychological flexibility in the therapy session, where the clinician has access to many of the controlling contingencies. At the end of this phase of work, the client should not only be exhibiting higher levels of psychological flexibility, but should also be able to discriminate her own flexibility and inflexibility during session. The third phase of this work aims to increase psychological flexibility outside of the session.

Sessions 9 through 12 aim to shape psychological flexibility outside of session and to establish the skills necessary for continued building of flexibility following the termination of treatment. The ninth session involves midpoint assessment of progress and recommitment. In the tenth session, the clinician focuses on helping the client to see opportunities for flexibility outside of session. In the eleventh session, the clinician focuses on helping the client to choose flexibility out of session. Finally, in the twelfth and final session, the clinician and the client to let go of the therapeutic relationship as a context that is no longer necessary for flexibility to be exhibited.

# SESSION 9: ASSESSMENT OF PROGRESS AND RECOMMITMENT

## *Part 1: Acknowledgement of Progress and Orientation to Session 9*

Session 9 begins by acknowledging the client's progress and orienting her to the shape of the session.

*Clinician:* I'd like to start today by acknowledging the work that you've done so far. You've brought your most precious values and personal struggles here, week after week. I'm honored to have been a part of this journey and look forward to whatever this last leg of our journey together brings.

Today's session is going to be a little different. When we first started meeting, we did a piece of work in which we considered different areas of life and what they mean to you in order to choose a direction for our work. Today we'll revisit this in order to get a sense of how our work together may be impacting the areas of life that are most important to you. Then, we'll take a look at what our progress looks like on paper. Finally, we'll save some time to discuss what all this means for the time we have left together. Does this sound okay?

## *Part 2: VLQ-2 Interview*

With the client's permission, you conduct the VLQ-2 interview from the HFDEI. The interview begins with the client calling to mind each area of life included on the questionnaire. The client names the area, calls to mind an image that represents the meaning of that area to her, and then names the area again. Then you discuss each area one by one in terms of possibility, current importance, overall importance, action, and satisfaction with action, with the client recording her ratings. Refer to session 2 for wording of instructions to the client. Although the client has completed the interview before, using similar instructions helps with confidence in interpreting differences as attributable to treatment. Following the interview, it may be useful to ask the client for her experience of completing the VLQ-2 interview for the second time.

*Clinician:* How was that? Did you notice any differences between this time and when we did this exercise before?

## *Part 3: Examination of Progress*

Following the VLQ-2 interview, the examination of progress begins with a consideration of the differences in VLQ-2 ratings between present and baseline.

*Clinician:* Good, now let's compare your ratings today to your ratings from that first time.

It may be useful to allow the client to lead the discussion at first.

*Clinician:* What stands out to you here? What does that mean to you?

Then, you might guide the client's attention to differences that you believe to be significant, asking the same sorts of questions. It might then be useful to discuss what she might want to work toward at the end of treatment.

*Clinician:* What would you like to see these look like if we really do our job well over the next month?

We sometimes find it useful to tell the client of the dynamic and ongoing nature of valued living.

*Clinician:* I want to make sure, also, that you understand what a rough measure this is. If we had the perfect measure of valued living, one that took constant recordings like a thermometer, we'd see these things fluctuating constantly. Valued living is about your moment-by-moment orientation to the things you care about. For example, in a single class period, you might have some moments where you are really on the job, being the student you want to be, and in the next moment you might be all about scrambling to just be good enough. Maybe no one could tell on the outside, but your valued living could change over and over in the course of the class period. Does that make sense?

We then take some time examining graphs of other assessment results. Depending on the assessment plan, you may have time to examine them all, or you may have selected some that seem particularly important. Either

way, giving the client a chance to share what these mean to her and what she would like to see change over the remainder of your work can help to orient you both to the task at hand.

### *Part 4: Recommitment*

The last part of session 9 involves recommitment to the therapeutic contract. You might begin by summarizing the discussions from part 3 in terms of her understanding of her progress and what she would like to emphasize from here.

*Clinician:* So, from what I've gathered you are pleased with the way your eating has changed, but would like to work more on finding your way back to your relationship with your sister, and your connection with others in general. Is that right?

Once the client has confirmed or clarified, end the session by recommitting to the work.

*Clinician:* I started today by acknowledging the hard work you've done so far. Now, before you go, I'd like to recommit myself to the remainder of our time together. I commit to being present here for you over the next month and to turning back when I find I've turned away. I commit to opening myself up to receive your experience without judging or attempting to change. I commit to bringing questions and conversations to you in service of you expanding and building your connection to those around you. I commit to seeing you, not some story about who you are and what is or isn't possible in your life.

## CHALLENGES IN ASSESSMENT OF PROGRESS AND RECOMMITMENT

**Cognitive fusion.** The client may exhibit difficulties with the assessment of progress and recommitment that seem attributable to cognitive fusion. She might struggle with ideas of what her ratings should look like that make it difficult for her to actually contact her experience enough to make a rating. You might hear her puzzling or arguing with herself as she talks through the ratings on the VLQ-2. If you observe this, it may be useful to guide

the client's attention to her own experience rather than her assessment of that experience.

*Clinician:* I hear your mind sort of buzzing around this task before us, trying to make sure it's done just right. I know it's all activated because this is important and it feels like doing it wrong could cost you. What if it's the case, though, that there's no way your mind is up to the task? That your mind can't speak to your experience, only about what it thinks about your experience, and that's not the question. I'd like you to slow way down here, take a deep breath, and shift your focus back to your experience in the present. And let's return to our task: How much of a sense of possibility do you have with respect to your education?

**Limited sense of self**. The client may exhibit difficulties with this session that seem attributable to a limited sense of self. She might frame each question in terms of what fits with her self-conceptualization. For example, she might have trouble experiencing and rating importance because of her experience of impossibility. When examining her progress, she might focus on the areas where her progress has lagged, and take these to be confirmation of her ineptitude. If you observe behaviors like this, it may be useful to guide her attention to her sense of self that has known her doubts along with her other experiences.

*Clinician:* I'd like you to take a moment to get present in your own skin, as a whole, complex human being with your history stretching out behind you and the infinite number of possibilities for your future scattered out in front of you. I'd like you to notice that you are a person who has known doubt, who has looked out at the world and noticed that sinking feeling that there's just no way out this time, that bad things are coming. And breathe. I'd like you to notice that you are also a person who has known hope, who has looked out at the world and noticed that rising sense that extraordinary things are starting, just out of your line of vision. I'd like you to notice that you are a person who has known fear. You are a person who has known excitement. You are a person who has grieved. You are a person who has loved. I'd like you to notice the part of you, as a whole person, that has known each of these experiences, and that carries them

with you. And breathe. And let's return to our work without letting go of that perspective.

# SESSION 10: SEEING POSSIBILITIES FOR FLEXIBILITY

## *Part 1: Checking In*

## *Part 2: Contacting Valued Domains*

The second part of session 10 involves experiential contact with the client's chosen values. You may find it useful to start by asking permission to ask some questions about this area of the client's life.

*Clinician:* Last time, we talked about shifting our purpose here just slightly to be more focused on your connection with your sister in particular, and with other people in your life. Today I'd like to take some time to get a sense of what this connection would be like for you, what it means to you. Would it be alright if I asked you some questions about this area of your life?

With the client's permission, ask her to describe the value in her own words. It may be useful to use a metaphor that removes all obstacles that would make this impossible or too hard.

*Clinician:* I want you to close your eyes and call to mind the faces of some of the people in your life that you care about. And breathe. One by one, call to mind their faces slowly, letting yourself fill with whatever rises up as you focus on each person's image before moving on to the next face.

And now, even if you haven't finished, I'd like you to imagine that it's fifty years from now. And the work that you and I did here had positioned you to be the sister, lover, friend, daughter, granddaughter, wife, or mother you dream of today. And breathe. And imagine that the people in your life have come together in some sort of celebration in your honor. It's your birthday or retirement or something, and you are surrounded by these people with whom you've spent fifty years building close, connected relationships. Suddenly

someone begins a toast, and one by one, these people who have come together in your honor begin to speak to the kind of person you've been for them. I want you to take a deep breath and let yourself hear their words. And breathe. And now, a question. If you were to step out of this door today with the commitment to being the person you want to be for the people you love, and you came back to that over and over for the next fifty years, what might be said about you? In a few moments, I'm going to ask you to tell me about this. And it's going to be difficult. When you feel urges to figure out what's possible or reasonable, or what response feels exactly right, gently let go of that, and return to expression. If I feel you going away, I may call you back to where I am here, ready to receive what you are experiencing. And whenever you're ready, open your eyes.

You wait for the client to open her eyes and begin talking, with your body and face oriented toward the client in an open posture. As the client begins to speak, your job is to appreciate what she is saying. You may find it useful to provide periodic prompts to help her to maintain present-moment focus.

*Clinician:* I'd like you to slow down just a bit here, so I can really get what it is you're experiencing, who you would be in those relationships.

## *Part 3: Seeing Possibilities*

The last part of session 10 involves having the client identify specific situations in her life in which she might have the opportunity to engage in valued living. The emphasis is not on her analyzing these situations to determine the likelihood of being successful in her pursuits, but to contact the experience of what success in this situation might be like.

*Clinician:* Now I'd like to take some time to consider where you might like to see this value play out in your life. I want you to take a deep breath and once more call to mind the people that are in your life right now that you'd choose to have this kind of relationship with. I want you to again call to mind the faces of the people you care about, one by one. When you have a sense of one person and what they mean to you, I'd like you

to imagine that you were that person to them that you long to be—dependable, accepting, comforting, helpful, strong, safe. Then, without explaining who they are or what your relationship is today, I'd like you to simply say that person's name to me, letting your hope for that relationship pour forth as you make them present here today.

As the client speaks the names, you may wish to write them down and to keep a copy to allow for later use.

# SESSION 11: CHOOSING FLEXIBILITY OUTSIDE OF SESSION

## *Part 1: Checking In*

## *Part 2: Choosing Action*

The second part of session 11 involves choosing specific courses of action that are part of the client's pattern of valued living. It may be useful to start this process by casting it as a free choice.

*Clinician:* Today we're going to start to consider the specific actions that you could take, large and small, that when strung together would be part of your path to the connection with the people you love. Now, it's really tempting here to focus on what would or wouldn't work with this person, what is or isn't a good way to go about this, who may or may not be willing to make changes to your relationship. That's not the job today. Doing that job can keep you stuck, and where you find yourself right now has not been satisfying to you. Instead, I'd ask you to, when your mind starts to try to analyze the situation, simply take a deep breath and come back to the question at hand. Does that sound okay?

With the client's permission, you introduce an exercise that allows her to generate examples of actions she would choose to take that would be consistent with the person she wants to be in her relationships.

*Clinician:* Here are three piles of paper squares. In just a minute, we'll take some time to get settled in the present, and then I'm

going to ask you to write something in each of these squares that you would choose to be part of your valued path. It's like you're here with three piles of bricks or stones that you are going to fit together to make your valued path. It's not your job to figure out what the world would choose that path to look like. Starting today, it is yours to build. You'll notice that the three piles are different sizes. On the smallest ones here, I'd like you to write a tiny thing you could do. Something you could do today, when you got home, that would be part of your valued path. Maybe something no one else would even notice. On the largest ones here, I'd like you to write something that feels really big for you. And on the middle ones here, I'd like you to write down actions that are in the middle—not tiny, but not giant. You will not have enough time to finish—because there isn't enough time. Relationships are not the kind of things that you work on for a certain amount of time, then clap your hands together and say, "Great! Job done!" The value of the relationship is in building and rebuilding and building again; it's in relating to the other person in a way that matters to you. So today will be a tiny start of a work in progress. Does this sound like something you'd be willing to do?

With the client's permission, you may want to start this kind of exercise with a brief present-moment-focused exercise. Then, guide the client's attention to the relationships she cares about by speaking the names she generated the session before, one by one, and asking her to visualize herself connecting with each person in a way that she would value.

*Clinician:* Beth… What would it mean to you to be there for Beth? Look into her eyes and see her trusting you and appreciating your love.

Ralph…

After reading all the names, ask the client to begin writing down valued actions.

*Clinician:* And now, without losing your sense of these people in your life and who you would like to be to them, I'd ask you to open your eyes and begin writing down the valued actions you could choose to build into your life.

### *Part 3: Coming Back*

In the last part of this session, you orient the client to the concept of commitment, and offer her the opportunity to choose one of the actions she wrote down to commit to.

*Clinician:* In just a minute, I'd like to offer you the opportunity to make a commitment. First, though, I want to tell you what I mean by commitment. A lot of times, when people say "commitment," they mean a promise they make that, from then on, governs their behavior—until it doesn't, then the promise they made is broken, and useless to everyone. That's not what I'm talking about here. What I'm talking about here involves committing to a particular valued path and building that path action by action. It also involves noticing when you're turned away, coming off the sides of the path you wanted, or turned around second-guessing this action or that, and then coming back to the valued path you're building. This kind of commitment is never broken. Once you've laid down this valued action or that, it's there for you to stand on. The deal is that sometimes you're building on it, and sometimes you're not, and you can always return to keep building. Does that make sense?

Would you like to leave here with a commitment to one of these actions you wrote down?

Let the client choose whether or not to make a commitment. If she does, you might find it useful to guide her in saying out loud, "I commit to _____."

You might also find it useful to remind the client that the next session will be her last, and ask her to think about anything she'd like to ask or discuss during check-in the next week.

## CHALLENGES WITH SEEING POSSIBILITIES AND CHOOSING POSSIBILITY

**Present-moment focus.** The client may exhibit difficulty seeing possibilities for and choosing flexibility that seems attributable to present-moment focus. She may speak in vague categories, struggling with providing details about the kind of relationships she would like to have, specific relationships she might want to work on, or specific ways she would like to work on

them. She might avoid eye contact, and her speech, gestures, and posture might serve to prevent connection with you instead of facilitate it. If you observe this kind of difficulty, it may be useful to build in more structured eyes-closed exercises with instructions for present-moment focus that do not include values-related content.

**Experiential avoidance.** The client may exhibit difficulty seeing possibilities for and choosing flexibility that seems attributable to experiential avoidance. She may resist contacting possibilities because of her regret for not having taken advantage of them before. She may resist choosing action because of her fear that it might not work out. She may minimize the importance of improving her relationships. She may avoid the eyes-closed exercises altogether. She may also "play small," choosing moderately positive descriptors for the kind of person she'd want to be, choosing action that does not challenge her, or focusing only on relationships that are fairly good already. If you observe avoidance like this, it may be useful to acknowledge the hard things that are inside of values work, and to ask her explicitly to accept these things.

*Clinician:* I want to take a moment to acknowledge that the things I'm asking you to do are not easy. Values are closely associated with vulnerabilities. By asking you to reach out and lay a hand on your values, I am also asking you to expose your vulnerabilities. By coming into contact with what you want, you are in contact with your own sense of loss, regret, or fear. I want you to imagine that being able to sit with those experiences—the loss, regret, and fear—means you get a chance to grow into the person you want to be. Would it be worth sitting with these experiences if it put you closer to being the sister you want to be?

**Cognitive fusion.** The client may exhibit difficulty seeing possibilities for and choosing flexibility that seems attributable to cognitive fusion. She might focus on the ways that events in the world over which she has no control might impact the outcome of her efforts, and conclude that considering possibility or taking action is futile. If you observe this, it may be worth guiding the client's attention to her ability to make a choice that is valued independent of outcome.

*Clinician:* I see you sort of stuck in a struggle of trying on the one hand to convince yourself that making changes would be worth it, but on the other hand to save yourself from the

disappointment and frustration if things don't work out like you would hope. I'd like you to ask yourself a question that's a little different. Could it be that looking for opportunities for your relationships to grow, and making efforts to grow those relationships, in and of itself, is part of being the person you want to be?

**Fused values.** The client may exhibit difficulty seeing possibilities for and choosing flexibility that seems attributable to fused values. She may imagine the valued relationship in rigid, stereotyped terms that seem externally determined instead of chosen. She may appear to experience the opportunity to consider or make changes a burden that she "should" carry. Her interaction with these exercises may seem to be more motivated by guilt than by willingness. If you observe this, it may be useful to have her interact with the same valued domain, but with the threat of evaluation or judgment eliminated.

*Clinician:* I want you to imagine that you could choose one relationship to work on, but for the next year, the changes you made in service of the person you want to be in this relationship couldn't be things that anyone else could know about. What would be one action you would choose to take?

# SESSION 12: LETTING GO OF THE THERAPEUTIC RELATIONSHIP

## *Part 1: Checking In*

## *Part 2: Looking Back*

The second part of session 12 begins by examining the assessment data from baseline to present. As in session 9, you might allow the client to lead the discussion, saying what the data means to her, and how she would like these aspects of her life to continue to change.

Next, the client is given the opportunity to reflect on the work she has done. It may be useful to guide her attention to different aspects of her experience.

*Clinician:* Remember how stuck you felt when you first came in?

When did you feel the world start to open up around you?

Were there times you doubted your work here would make a difference?

What pieces of this work do you expect to carry with you?

You might also take a moment to acknowledge for a final time the work that the client has done over the past month.

### *Part 3: Looking Ahead*

Part 3 of session 12 involves casting termination as a transition to doing this work independently.

*Clinician:* Now we have reached a point where the next step for you is to carry the path you started here out into your world.

The client leaves that day with all of the paper squares she created the session before, including those that are blank.

*Clinician:* I'm going to send these with you. Those that you wrote on and those that you didn't, because some of the opportunities ahead you see today and some you couldn't even imagine.

## CHALLENGES WITH LETTING GO OF THE THERAPEUTIC RELATIONSHIP

The client may exhibit difficulties with letting go of the therapeutic relationship that seem attributable to a range of inflexibilities. At this point, however, it may be useful to begin to mostly let go of intervention as your work with the client comes to a close.

# CONCLUSION

# What Now? Integration and Reconceptualization

In the previous chapters, we have outlined a philosophy, a theory, and a number of techniques that together make up an approach to treatment of disordered eating and related difficulties based on acceptance and commitment therapy. It is our hope that this might provide you, the clinician, with a perspective that serves your values with respect to treatment of these kinds of difficulties.

## BUILDING ON COMMON GROUND

Change is hard, and it can be overwhelming as you get a sense of the differences between our take on ACT and whatever approach you've been using. As you read, you may have had the experience of thinking, *Well shoot, that's not what I would have said at all! I guess I'm not getting this as well as I thought I was.* On the other hand, there may have been many things we described about which you may have thought, *Well, of course you do that. That's just good therapy*. Regardless of your experience, there are a number of areas of potential overlap between ACT and other treatments of disordered eating in terms of therapeutic factors, goals, and techniques.

### *Common Therapeutic Factors*

Both the therapeutic relationship and client engagement have been identified as factors predictive of positive treatment response across treatment

approaches. Our hope is not that ACT-specific factors would be more powerful predictors of treatment response, but that ACT-specific factors would facilitate the therapeutic relationship and client engagement. It may be that the ACT model creates a context for the emergence of client and clinician behaviors that make these nonspecific therapeutic factors more probable.

ACT shares with many other approaches to psychotherapy an appreciation of the importance of the therapeutic relationship. In ACT, the therapeutic relationship is conceptualized as the context in which new behaviors can be emitted, the repertoire can broaden, and psychological flexibility can emerge. From an ACT perspective, the therapeutic relationship is a relationship characterized by psychological flexibility. In this way, the same processes that are purported mechanisms of change in ACT are identified as mechanisms of the therapeutic relationship. The therapeutic relationship is, from an ACT perspective, the pursuit of shared values with present-moment focus, experiential acceptance, cognitive defusion, and transcendent sense of self (Wilson & Sandoz, 2008). When both the clinician and the client bring these processes, the facets of psychological flexibility, to bear upon pursuit of their shared values, a context of possibility is created. Because the clinician's primary method of intervention is his own behavior, the therapeutic relationship in ACT begins with the clinician's psychological flexibility.

ACT also shares with many other approaches an emphasis on client engagement. Client engagement is explicit in ACT in several ways. First, the ultimate purpose of ACT is the client's valued living, as she chooses. The client and the clinician commit early on to working for life changes that serve the things that matter to the client. Any therapeutic goals are chosen because they seem to be part of the path to the life the client wants to live. ACT is not something that the clinician does *to* the client. The clinician presents the opportunity, over and over, for the client to choose to engage particular pieces of work the clinician offers in service of values. The clinician is not positioned as the expert or even the teacher, but as a part of the context in which valued living can occur. The clinician does not necessarily emphasize the client's conceptual understanding of the theory from which she is working. Rather, the focus is on experiential contact with the processes as they apply to her life. The client is encouraged to open up to receive not the clinician's perspective or experience but her own perspective and experience throughout the course of therapy.

## Common Treatment Goals

Most treatments for disordered eating and associated difficulties share common goals for treatment. Across approaches, goals are established that relate to symptom reduction and quality of life. Treatment typically aims to reduce body-image dissatisfaction and disordered eating. Reduction of mood and anxiety problems and improved coping with these experiences are often targeted. Treatment may also aim to improve physical self-care and social functioning. For the most part, treatment goals tend to directly reflect diagnostic criteria. The idea is that as goals are met, the client moves closer and closer to an a priori concept of "normal" functioning.

In ACT, treatment goals are approached a little differently. The goals for treatment are established because they are part of the client's chosen pattern of valued living. The idea is that as goals are met, the client moves further along on her chosen path of valued living. Additionally, consistent with traditional behavior therapy, goals are established that broaden the behavioral repertoire. This has been described in terms of the "dead man test," which says that a goal for treatment should never be one with which a dead man would be more successful (Lindsley, 1991).

Despite these differences, treatment goals in ACT for disordered eating often overlap with those common to other treatments. Healthy eating behavior is often established as a goal for treatment. Disordered eating tends to directly interfere with valued living, both because of the time, attention, and energy it takes to maintain and because of its negative impact on physical health. Treatment goals also often include improved self-care or social functioning. Some clients identify these as valued domains, and for those who do not, improvements in these areas often allow for more effective pursuit of other values. Finally, treatment goals often include more effective interaction with aversive private experiences like body dissatisfaction, depression, and anxiety. Consistent with the ACT model, however, these goals specify psychological flexibility in the presence of these aversive experiences rather than reduction of the experiences themselves. The primary difference is that these goals are not selected because they tend to move the client toward "normal" living, but because the client has identified them as part of valued living.

## Common Therapeutic Techniques

Although ACT is based on a distinct model of psychological functioning, many techniques developed in other approaches can be adapted for use

in ACT. Whether or not a technique is consistent with the ACT model is determined based on its function, not on its origins or form. Any technique that facilitates flexibility in terms of present-moment focus, cognitive defusion, experiential acceptance, transcendent sense of self, valued living, or committed action is ACT consistent.

As an example, ACT departs significantly from the traditional cognitive model. However, traditional cognitive therapy for disordered eating often includes techniques that can be adapted for use in an ACT approach:

- Self-assessment and identification of negative consequences of disordered eating can be cast in terms of costs to valued living.
- Examination of thoughts, feelings, sensations, and actions, the situations in which they occur, and the consequences of actions can serve to identify potential targets for all facets of psychological flexibility.
- Rating subjective units of distress, noticing automatic thoughts, and using many relaxation techniques all necessarily involve present-moment focus.
- Identification of rigid beliefs or schemas can serve to identify potential targets for defusion exercises.
- Exposure to aversive environmental stimuli often involves exposure to aversive private events, which can result in defusion.
- Behavioral experimentation and behavioral activation can be cast in terms of valued living and committed action.

The ACT clinician can also add simple instructions to any of these techniques that facilitate contact with processes not explicitly targeted.

## WHEN YOU'RE PART OF A TEAM

Multidisciplinary treatment is particularly useful for disordered eating because of its impact on physical health. Working as part of a team of providers, however, can present a number of obstacles to adopting a new approach, as it must be integrated into the team's general approach to treatment. ACT deviates from many popular treatment approaches on issues like the utility of symptom-based classification and treatment planning. In certain settings among certain groups of providers, it can seem that ACT just doesn't fit.

Based in functional contextualism, ACT is a pragmatic approach that evaluates what is true or right on the basis of workability. If a diagnosis is required to facilitate treatment, a diagnosis is given. If symptom-based treatment objectives are necessary to maintain funding, symptom-based treatment objectives are established. ACT does not reject symptom-based classification and treatment planning when they work, it just calls them into question in the many situations in which they do not.

Sometimes a clinician can find himself not only trying to learn ACT but also struggling to manage communications with and impressions of coproviders. If you are part of a team that staffs cases together, sharing your conceptualization and treatment plan in language that is not specific to ACT not only will help you to communicate openly with coproviders, but also will require you to become increasingly facile with the model. Being open to feedback from coproviders regarding your actual work with clients (as opposed to their criticisms of ACT in general) can help to make any evaluations of your switch to ACT a more valuable conversation for everyone involved.

## ACT IN GROUPS

Limits on resources have made group therapy for disordered eating and related disturbances increasingly more popular. Some have noted the emphasis on client presentation and values and suggested that ACT may not be appropriate for group administration. This is not our experience. In fact, some of the most powerful work that we've done in this area has been in group-based sessions. And it's not just us. The majority of studies exhibiting positive outcomes with ACT included a group component (Hayes, Bond, Masuda, & Lillis, 2006). Any exercise described in this book could be adapted for group work. Depending on the group dynamic, format, structure, and purpose, we've adapted individual exercises for group work on a continuum from focusing primarily on independent exercises and self-reflection to taking advantage of the interpersonal context to build psychological flexibility.

## AN INVITATION TO A JOURNEY

ACT is most definitely a work in progress, the collective journey of a community of researchers, scholars, clinicians, and fellow travelers who are committed to developing a science of human liberation. The work doesn't

exist in a vacuum or for the sake of its own existence. Rather, it is vital and important only to the extent that it can help you, the working clinician, be of service to the men and women who share their struggles with you each day. If what you've found here helped you in any way to make a difference in the life of even one of your clients, we'll consider our work here well rewarded.

In whatever way might be right for you, we hope you'll continue to be a part of this work, to draw on this treatment community for new ideas and further resources. Only through your efforts is ACT dignified and made relevant to the needs of people everywhere; only through your kind participation and engagement will ACT continue to grow. Wherever your encounter with this work and this book might take you, we wish you every bit of success.

# APPENDIX A

# Body Image—Acceptance and Action Questionnaire (BI-AAQ)

*Directions: Below you will find a list of statements. Please rate the truth of each statement as it applies to you. Use the following rating scale to make your choices. For instance, if you believe a statement is "Always True," you would write a 7 next to that statement.*

| Never True | Very Seldom True | Seldom True | Sometimes True | Frequently True | Almost Always True | Always True |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

_____ 1. Worrying about my weight makes it difficult for me to live a life that I value.

_____ 2. I care too much about my weight and body shape.

_____ 3. I shut down when I feel bad about my body shape or weight.

_____ 4. My thoughts and feelings about my body weight and shape must change before I can take important steps in my life.

_____ 5. Worrying about my body takes up too much of my time.

_____ 6. If I start to feel fat, I try to think about something else.

_____ 7. Before I can make any serious plans, I have to feel better about my body.

_____ 8. I will have better control over my life if I can control my negative thoughts about my body.

_____ 9. To control my life, I need to control my weight.

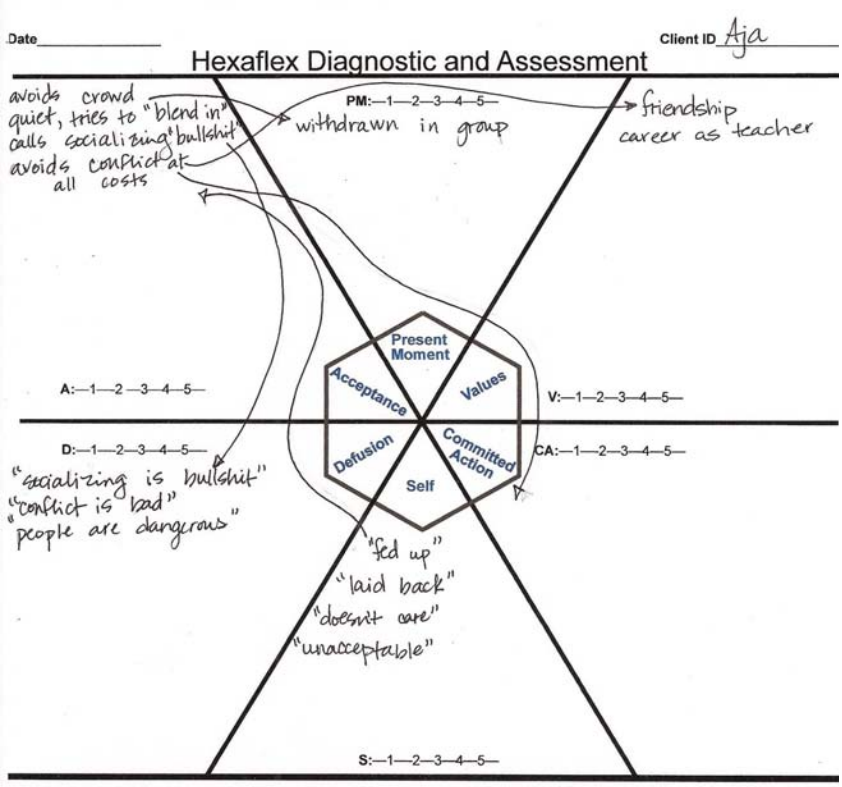
_____ 10. Feeling fat causes problems in my life.

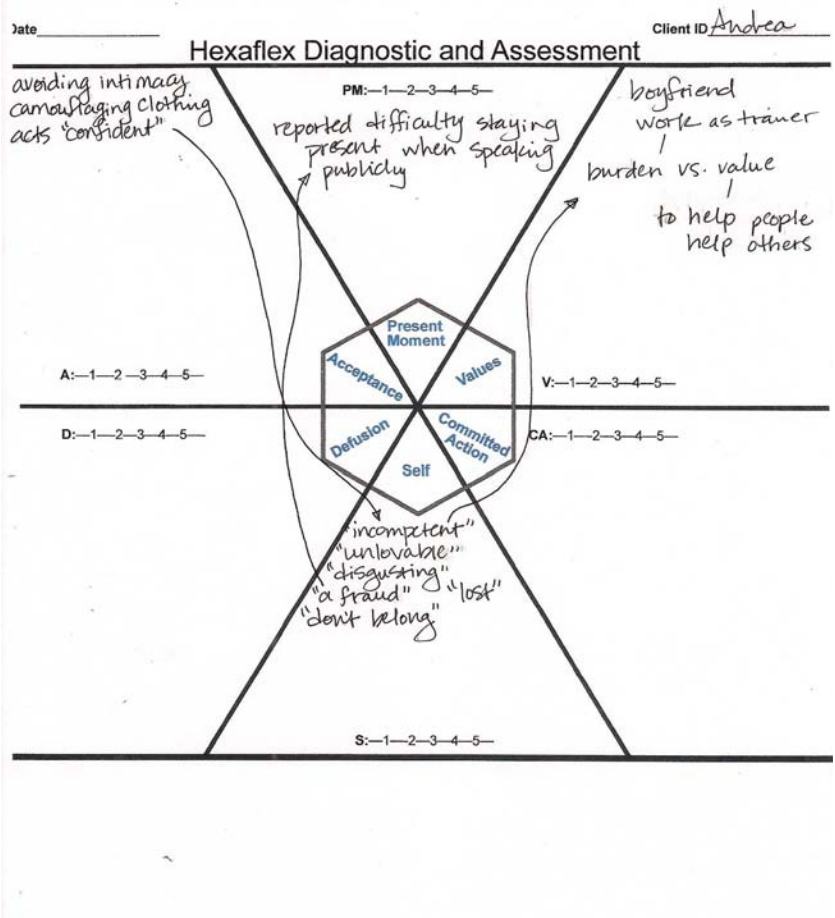
_____ 11. When I start thinking about the size and shape of my body, it's hard to do anything else.

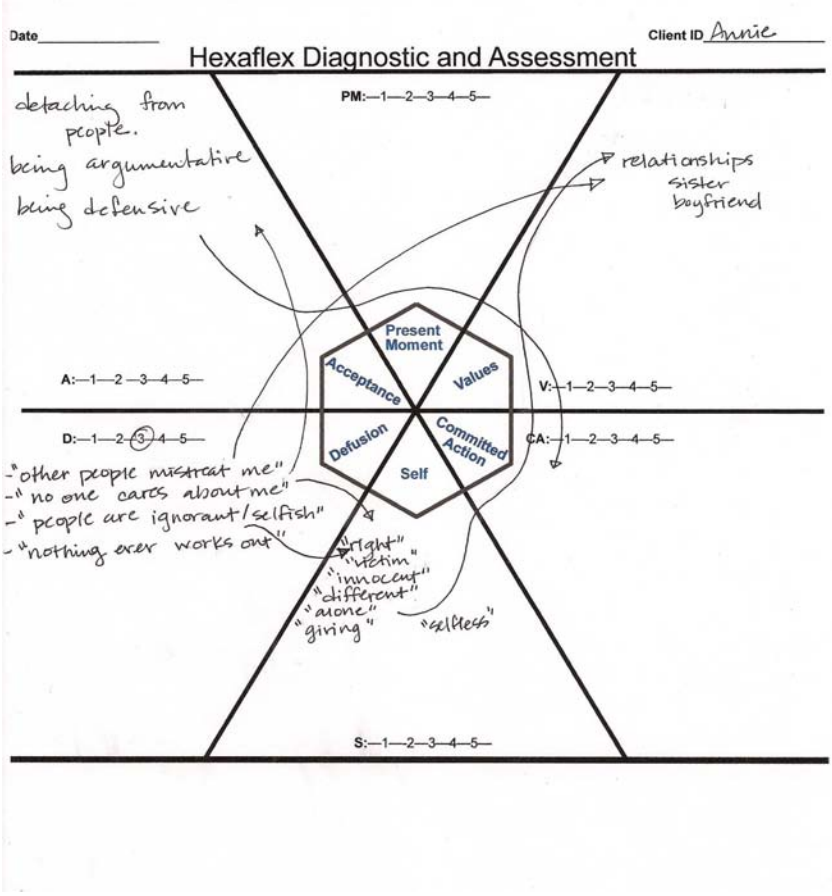
_____ 12. My relationships would be better if my body weight and/or shape did not bother me.

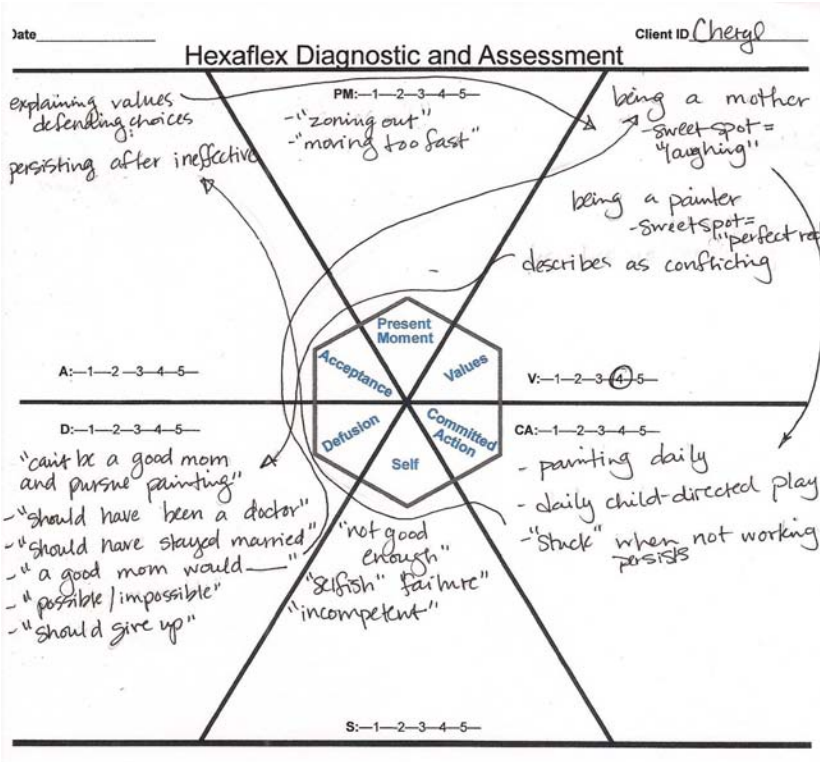
# APPENDIX B

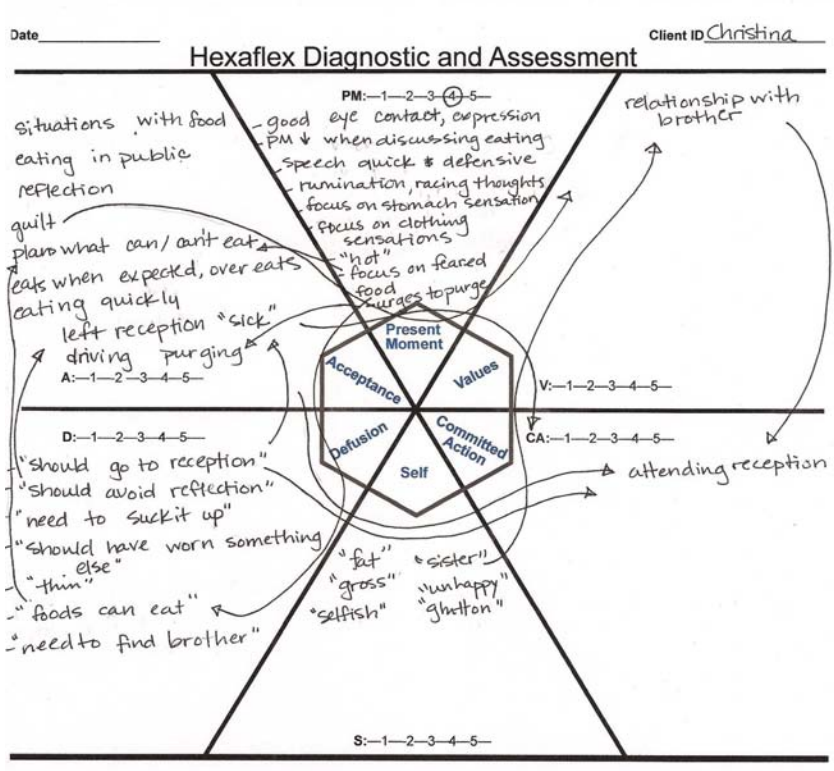
# Process Notes

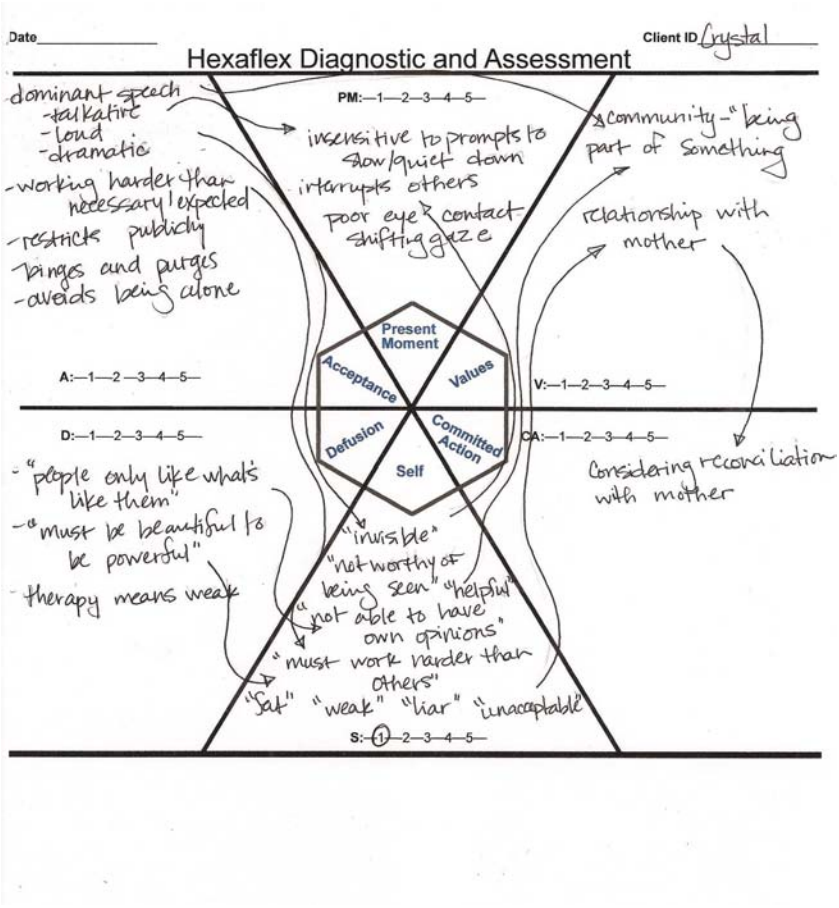

Date
Client ID Aja
Hexaflex Diagnostic and Assessment
avoids crowd
quiet, tries to "blend in"
calls socializing 'bullshit'
avoids conflict at all costs
PM:—1—2—3—4—5—
withdrawn in group
friendship
career as teacher
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"socializing is bullshit"
"conflict is bad"
"people are dangerous"
"fed up"
"laid back"
"doesn't care"
"unacceptable"
S:—1—2—3—4—5—

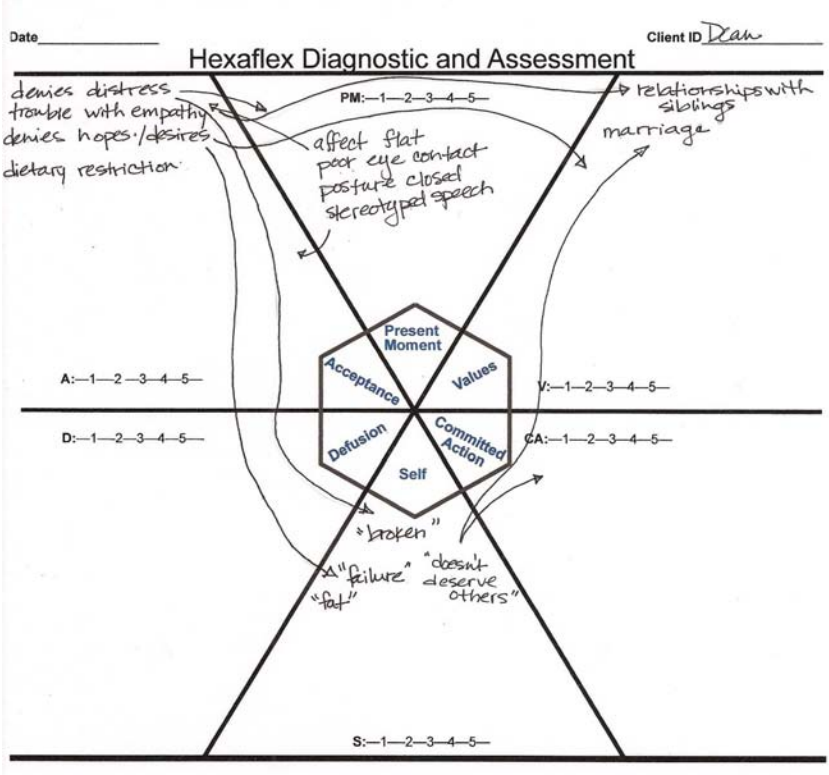

Date
Client ID Andrea
Hexaflex Diagnostic and Assessment
avoiding intimacy
camouflaging clothing
acts "confident"
PM:—1—2—3—4—5—
reported difficulty staying present when speaking publicly
boyfriend
works as trainer
burden vs. value
to help people
help others
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"incompetent"
"unlovable"
"disgusting"
"a fraud"
"lost"
"don't belong"
S:—1—2—3—4—5—

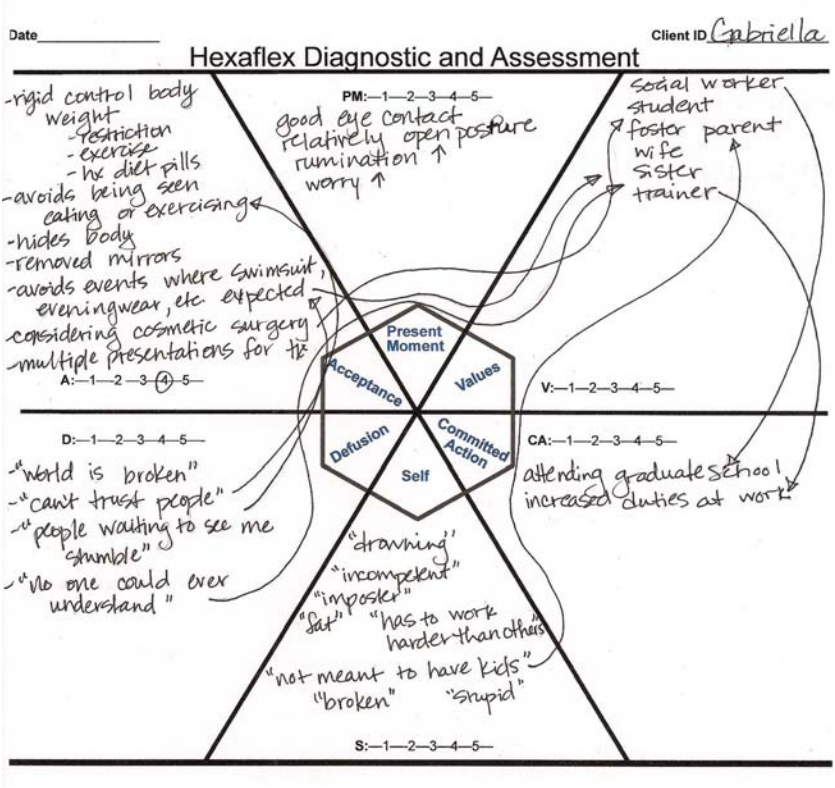

Date
Client ID Annie
Hexaflex Diagnostic and Assessment
PM:—1—2—3—4—5—
detaching from people.
being argumentative
being defensive
relationships
sister
boyfriend
Present Moment
Acceptance
Values
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
Defusion
Committed Action
Self
CA:—1—2—3—4—5—
-"other people mistreat me"
-"no one cares about me"
-"people are ignorant/selfish"
-"nothing ever works out"
"right"
"victim"
"innocent"
"different"
"alone"
"giving"
"selfless"
S:—1—2—3—4—5—

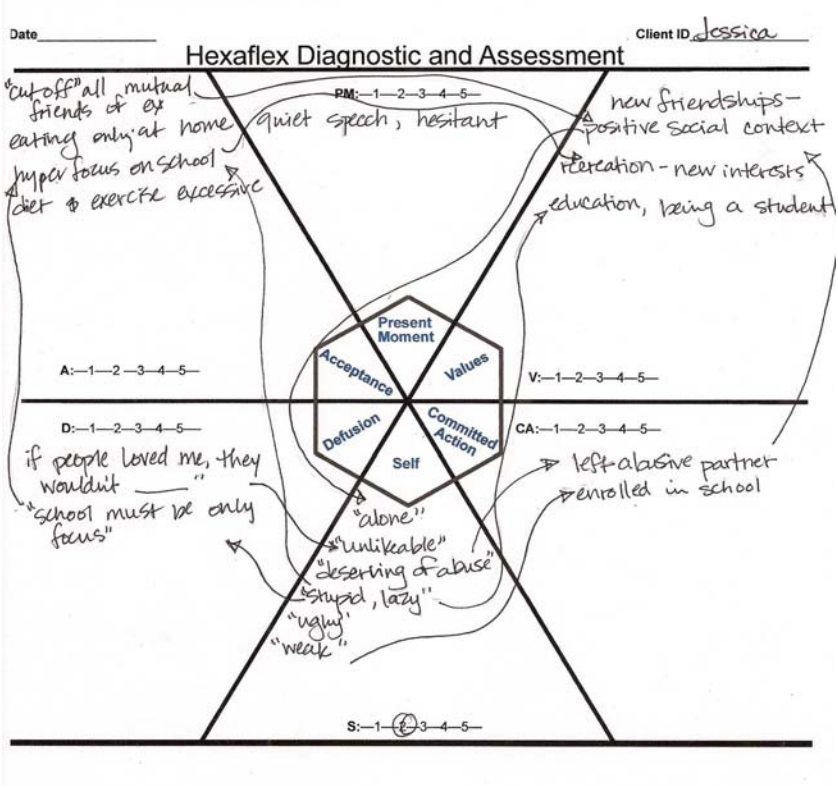

Date
Client ID: Cheryl
Hexaflex Diagnostic and Assessment
explaining values
defending choices
persisting after ineffective
PM:—1—2—3—4—5—
-"zoning out"
-"moving too fast"
being a mother
-sweet spot = "laughing"
being a painter
-sweetspot= "perfect red"
describes as conflicting
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"can't be a good mom and pursue painting"
-"should have been a doctor"
-"should have stayed married"
-"a good mom would—"
-"possible/impossible"
-"should give up"
"not good enough"
"selfish" "failure"
"incompetent"
- painting daily
- daily child-directed play
-"stuck" when not working- persists
S:—1—2—3—4—5—

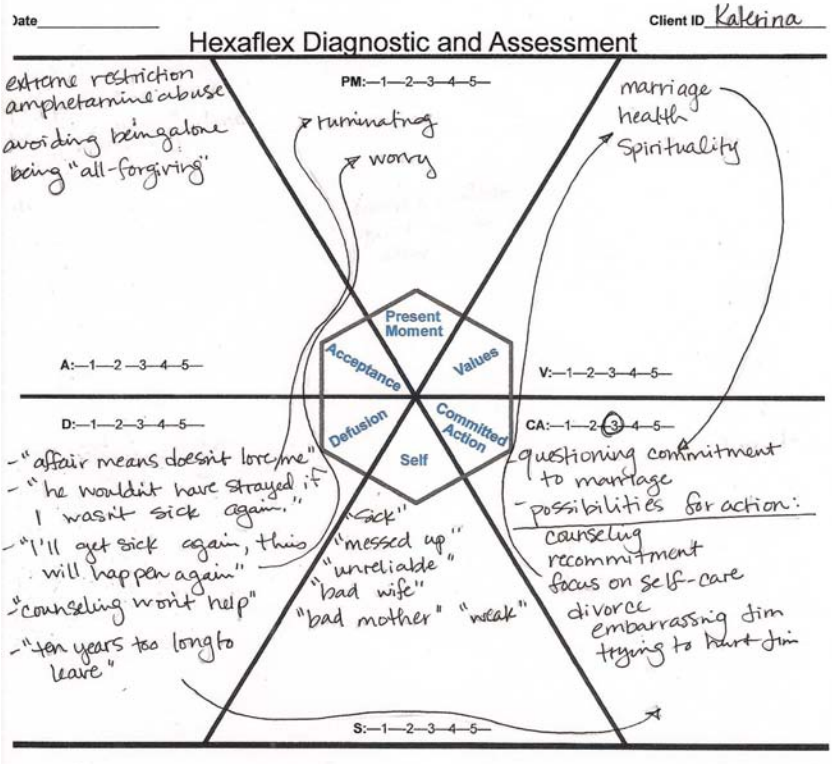

Date
Client ID Christina
Hexaflex Diagnostic and Assessment
PM:—1—2—3—4—5—
good eye contact, expression
PM ↓ when discussing eating
speech quick & defensive
rumination, racing thoughts
focus on stomach sensation
focus on clothing sensations
"hot"
focus on feared food
urges to purge
relationship with brother
situations with food
eating in public
reflection
guilt
plans what can/can't eat
eats when expected, over eats
eating quickly
left reception "sick"
driving purging
A:—1—2—3—4—5—
Present Moment
Acceptance
Values
V:—1—2—3—4—5—
D:—1—2—3—4—5—
Defusion
Committed Action
Self
CA:—1—2—3—4—5—
attending reception
"should go to reception"
"should avoid reflection"
"need to suck it up"
"should have worn something else"
"thin"
"foods can eat"
"need to find brother"
"fat"
"sister"
"gross"
"unhappy"
"selfish"
"glutton"
S:—1—2—3—4—5—

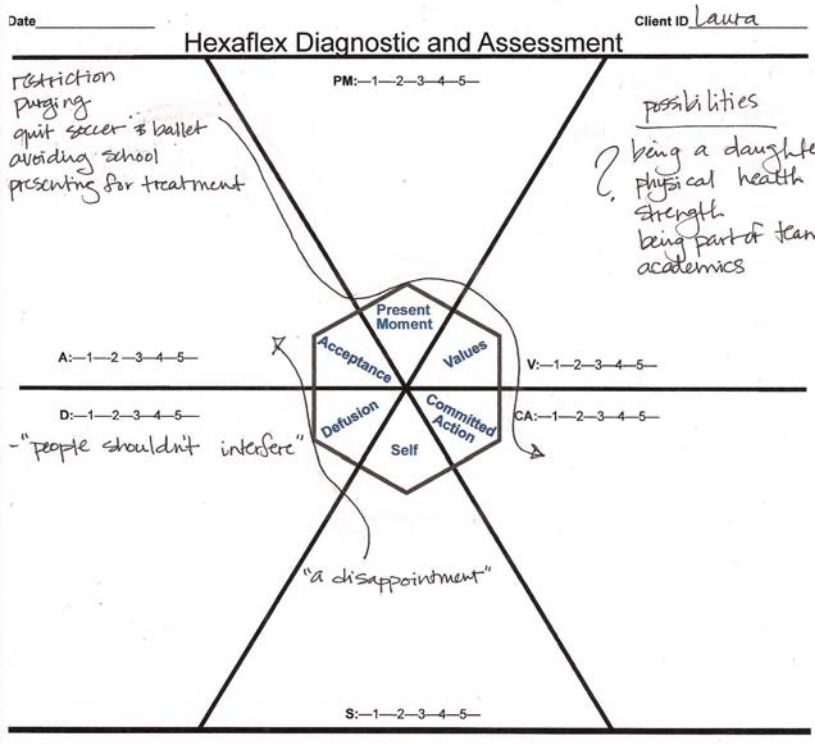

Date
Client ID Crystal
Hexaflex Diagnostic and Assessment
dominant speech
-talkative
-loud
-dramatic
-working harder than necessary/expected
-restricts publicly
-binges and purges
-avoids being alone
PM:—1—2—3—4—5—
insensitive to prompts to slow/quiet down
interrupts others
poor eye contact-shifting gaze
community-"being part of something
relationship with mother
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
Considering reconciliation with mother
- "people only like what's like them"
- "must be beautiful to be powerful"
- therapy means weak
"invisible"
"not worthy of being seen" "helpful"
"not able to have own opinions"
"must work harder than others"
"fat" "weak" "liar" "unacceptable"
S:—1—2—3—4—5—

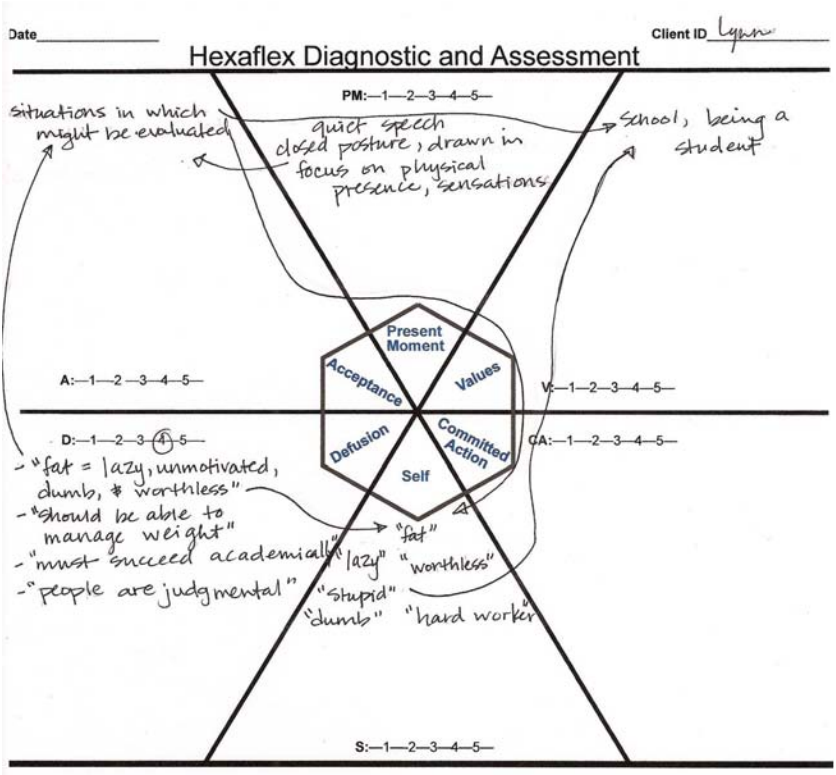

Date
Client ID Dan
Hexaflex Diagnostic and Assessment
denies distress
trouble with empathy
denies hopes/desires
dietary restriction
PM:—1—2—3—4—5—
affect flat
poor eye contact
posture closed
stereotyped speech
relationships with siblings
marriage
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"broken"
"failure"
"doesn't deserve others"
"fat"
S:—1—2—3—4—5—

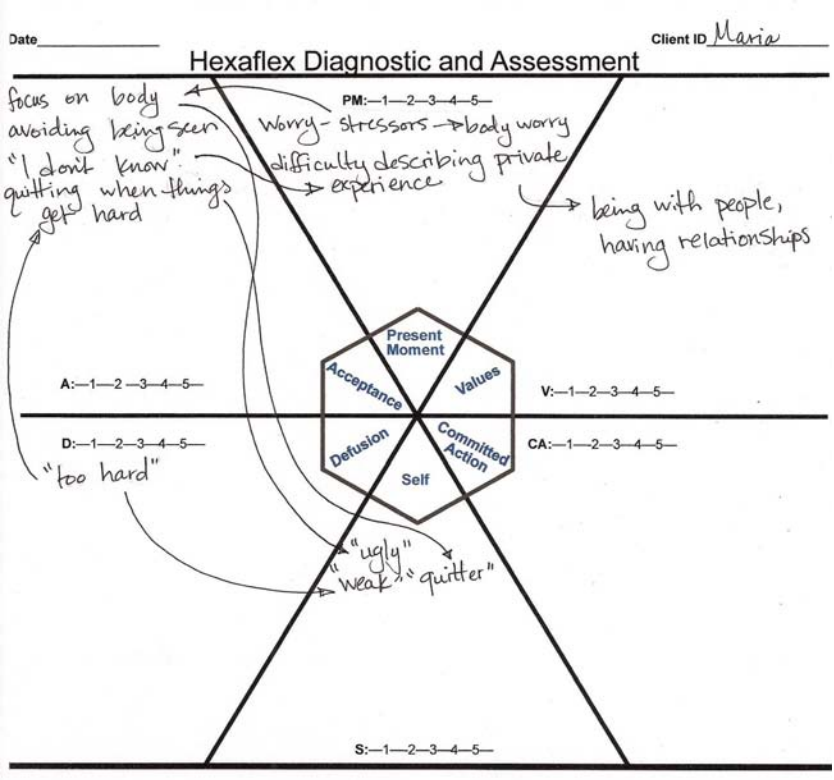

Date
Client ID Gabriella
Hexaflex Diagnostic and Assessment
-rigid control body weight
-restriction
-exercise
-hx diet pills
-avoids being seen eating or exercising
-hides body
-removed mirrors
-avoids events where swimsuit, eveningwear, etc. expected
-considering cosmetic surgery
-multiple presentations for the
A:—1—2—3—4—5—
PM:—1—2—3—4—5—
good eye contact
relatively open posture
rumination ↑
worry ↑
social worker
student
foster parent
wife
sister
trainer
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
V:—1—2—3—4—5—
D:—1—2—3—4—5—
-"world is broken"
-"can't trust people"
-"people waiting to see me stumble"
-"no one could ever understand"
CA:—1—2—3—4—5—
attending graduate school
increased duties at work
"drowning"
"incompetent"
"imposter"
"fat"
"has to work harder than others"
"not meant to have kids"
"broken"
"stupid"
S:—1—2—3—4—5—

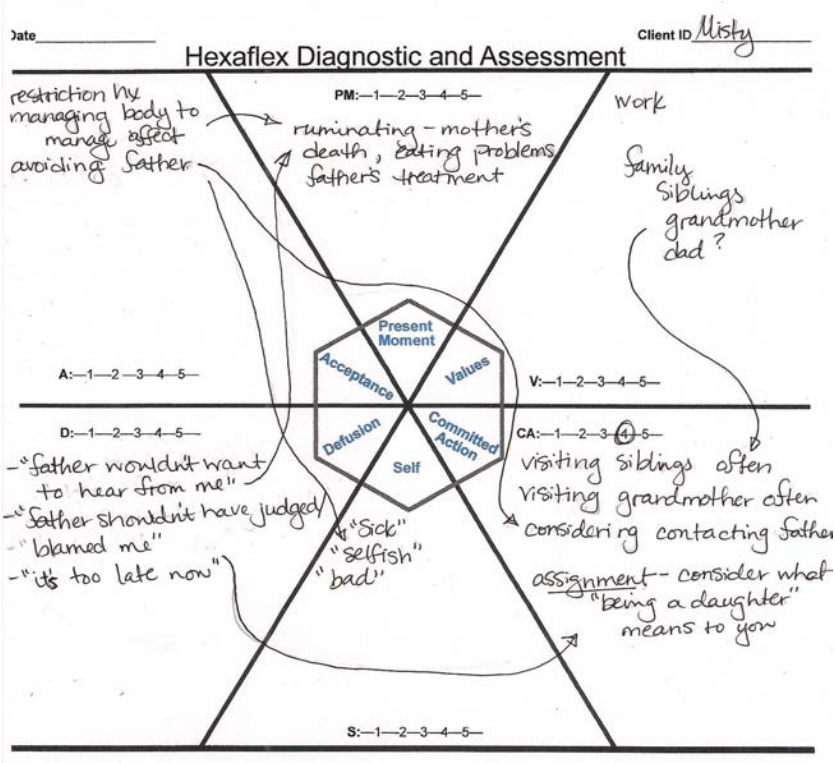

Date
Client ID Jessica
Hexaflex Diagnostic and Assessment
"cut off" all mutual friends of ex
eating only at home
hyper focus on school
diet & exercise excessive
PM:—1—2—3—4—5—
quiet speech, hesitant
new friendships—positive social context
recreation - new interests
education, being a student
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
if people loved me, they wouldn't ___"
"school must be only focus"
"alone"
"unlikeable"
"deserting of abuse"
"stupid, lazy"
"ugly"
"weak"
left abusive partner
enrolled in school
S:—1—2—3—4—5—

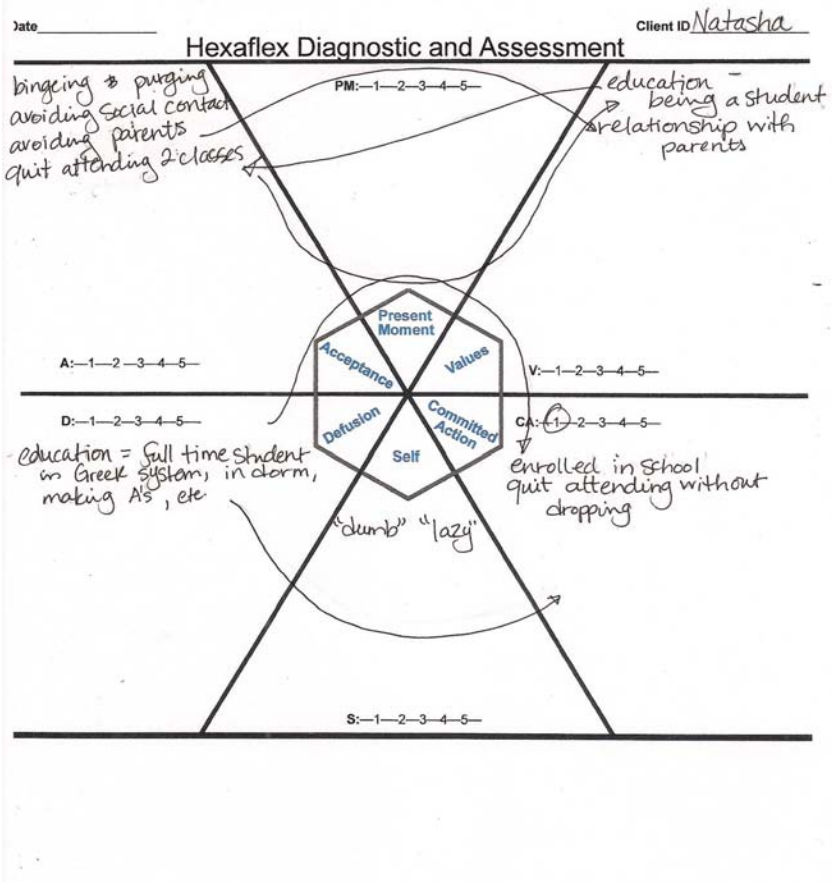

Date
Client ID Katerina
Hexaflex Diagnostic and Assessment
extreme restriction
amphetamine abuse
avoiding being alone
being "all-forgiving"
PM:—1—2—3—4—5—
ruminating
worry
marriage
health
Spirituality
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
-"affair means doesn't love me"
-"he wouldn't have strayed if I wasn't sick again."
-"I'll get sick again, this will happen again"
-"counseling won't help"
-"ten years too long to leave"
"sick"
"messed up"
"unreliable"
"bad wife"
"bad mother" "weak"
questioning commitment to marriage
- possibilities for action:
counseling
recommitment
focus on self-care
divorce
embarrassing Jim
trying to hurt Jim
S:—1—2—3—4—5—

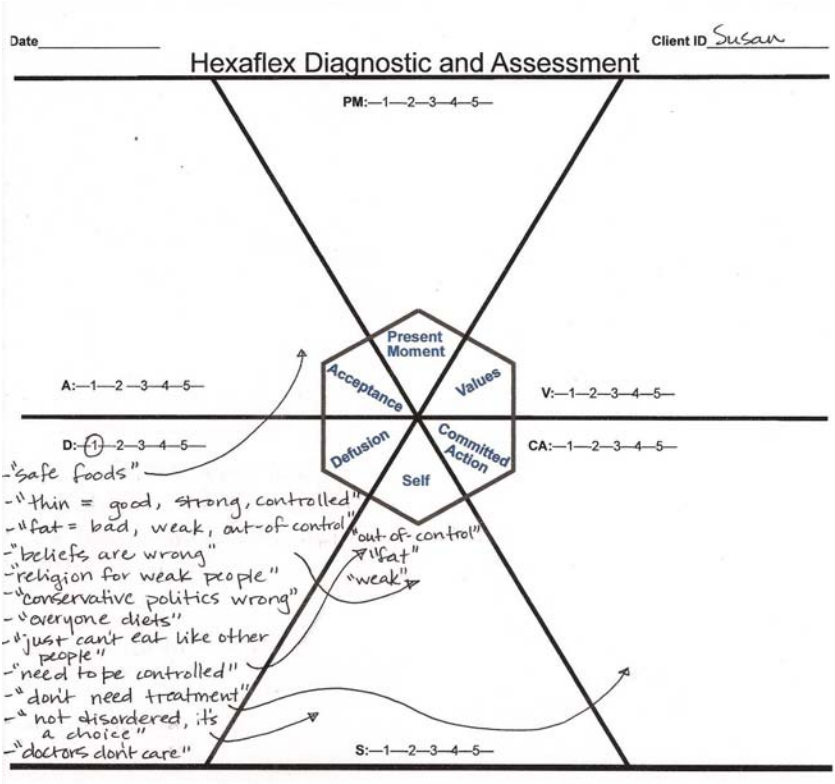

Date
Client ID Laura
Hexaflex Diagnostic and Assessment
restriction
purging
quit soccer & ballet
avoiding school
presenting for treatment
PM:—1—2—3—4—5—
possibilities
being a daughter
physical health
strength
being part of team
academics
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
-"people shouldn't interfere"
"a disappointment"
S:—1—2—3—4—5—

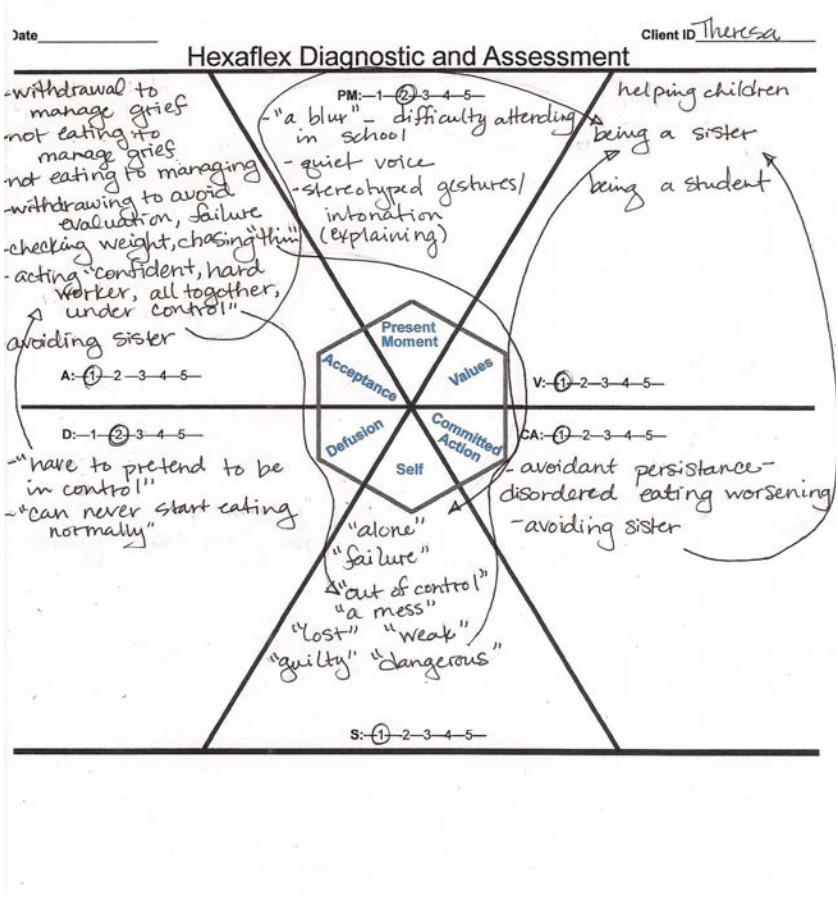

Date
Client ID Lynn
Hexaflex Diagnostic and Assessment
PM:—1—2—3—4—5—
situations in which might be evaluated
quiet speech
closed posture, drawn in
focus on physical presence, sensations
school, being a student
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
- "fat = lazy, unmotivated, dumb, & worthless"
- "should be able to manage weight"
- "must succeed academically"
- "people are judgmental"
"fat"
"lazy"
"worthless"
"stupid"
"dumb"
"hard worker"
S:—1—2—3—4—5—

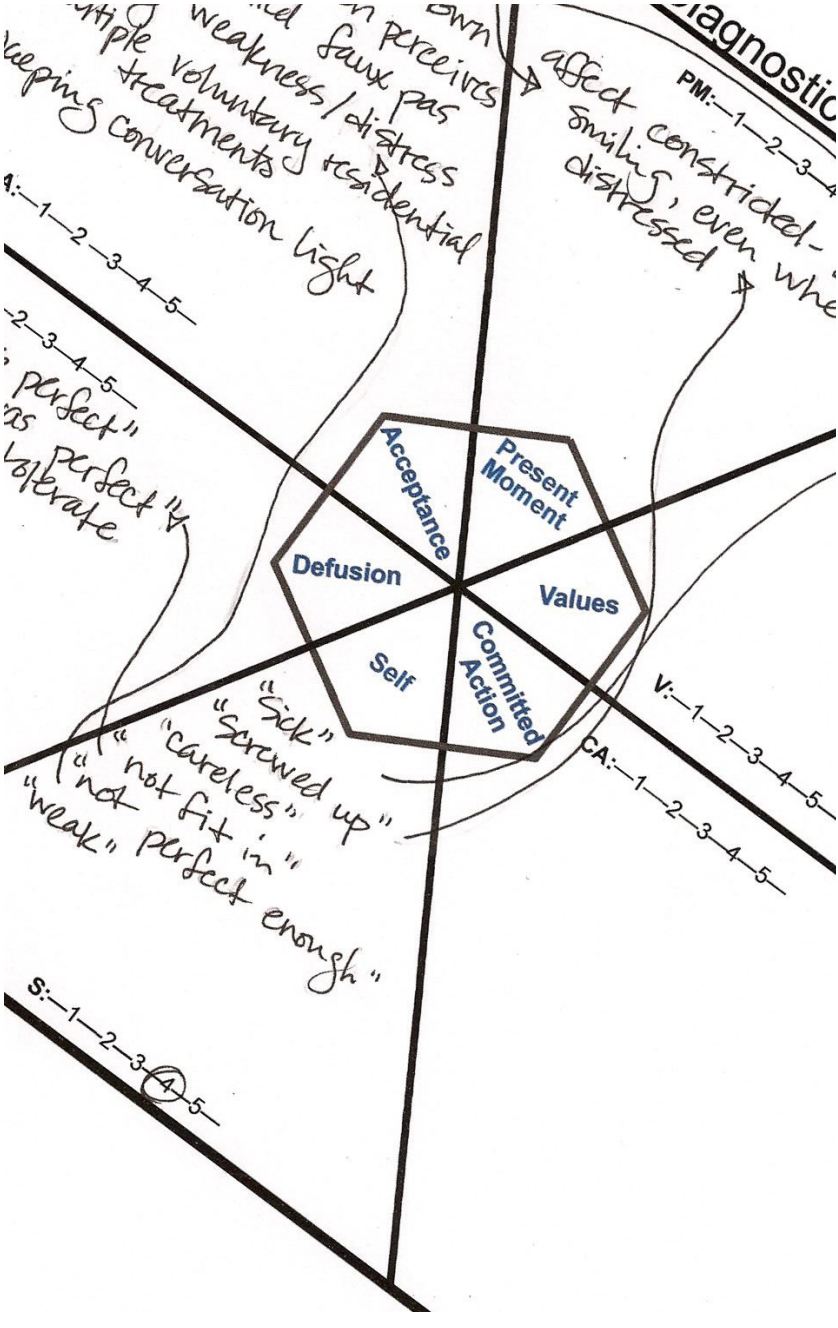

Date
Client ID Maria
Hexaflex Diagnostic and Assessment
focus on body
avoiding being seen
"I don't know"
quitting when things get hard
PM:—1—2—3—4—5—
worry- stressors → body worry
difficulty describing private experience
being with people, having relationships
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"too hard"
"ugly"
"weak" "quitter"
S:—1—2—3—4—5—


Date
Client ID Misty
Hexaflex Diagnostic and Assessment
restriction by managing body to manage affect
avoiding father
PM:—1—2—3—4—5—
ruminating – mother's death, eating problems, father's treatment
work
family
siblings
grandmother
dad ?
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
"father wouldn't want to hear from me"
"father shouldn't have judged/ blamed me"
"it's too late now"
"sick"
"selfish"
"bad"
visiting siblings often
visiting grandmother often
considering contacting father
assignment – consider what "being a daughter" means to you
S:—1—2—3—4—5—


Date
Client ID Natasha
Hexaflex Diagnostic and Assessment
binging & purging
avoiding social contact
avoiding parents
quit attending 2 classes
PM:—1—2—3—4—5—
education - being a student
relationship with parents
Present Moment
Acceptance
Values
A:—1—2—3—4—5—
V:—1—2—3—4—5—
Defusion
Committed Action
Self
D:—1—2—3—4—5—
CA:—1—2—3—4—5—
education = full time student in Greek system, in dorm, making A's, etc.
enrolled in school quit attending without dropping
"dumb" "lazy"
S:—1—2—3—4—5—

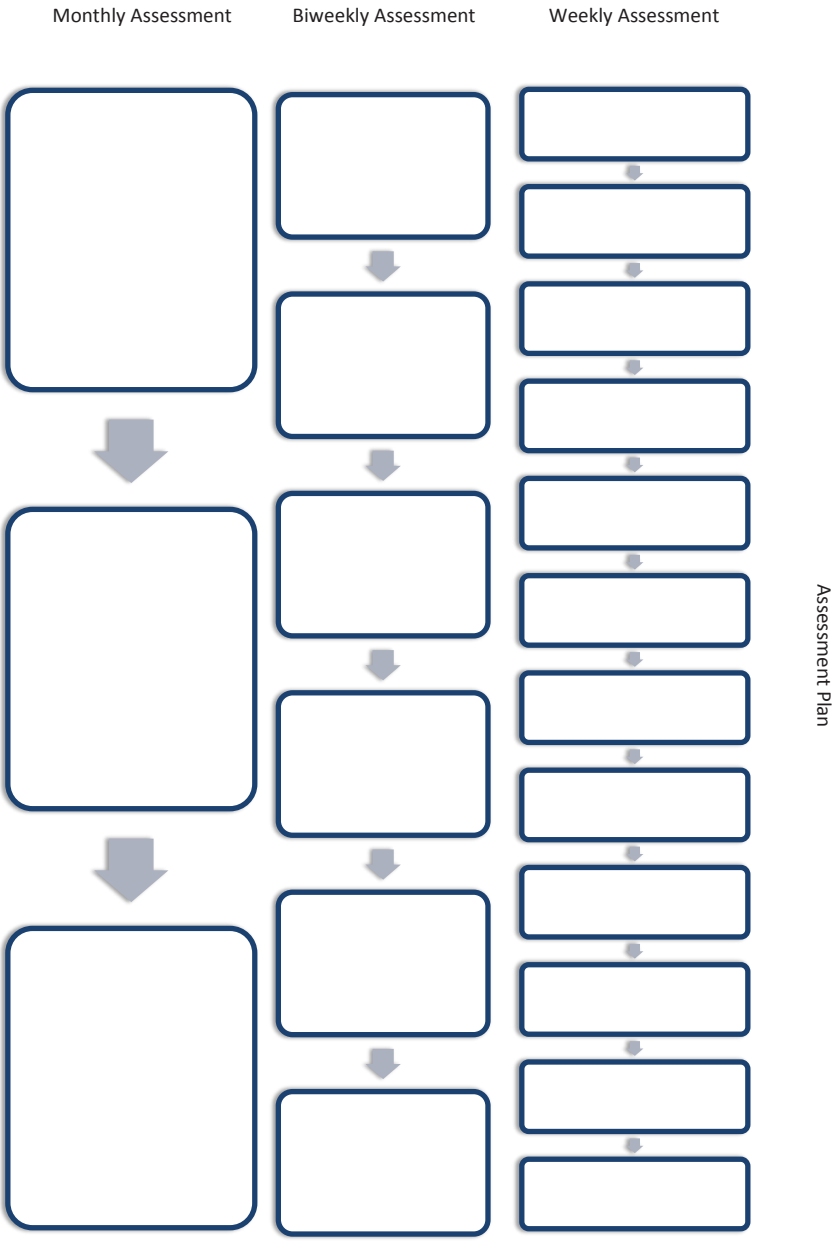

Date
Client ID Susan
Hexaflex Diagnostic and Assessment
PM:—1—2—3—4—5—
Present Moment
Acceptance
Values
A:—1—2—3—4—5—
V:—1—2—3—4—5—
D:—1—2—3—4—5—
Defusion
Committed Action
CA:—1—2—3—4—5—
Self
-"safe foods"
-"thin = good, strong, controlled"
-"fat = bad, weak, out-of-control"
-"beliefs are wrong"
-"religion for weak people"
-"conservative politics wrong"
-"everyone diets"
-"just can't eat like other people"
-"need to be controlled"
-"don't need treatment"
-"not disordered, it's a choice"
-"doctors don't care"
"out-of-control"
"fat"
"weak"
S:—1—2—3—4—5—


Date
Client ID Theresa
Hexaflex Diagnostic and Assessment
-withdrawal to manage grief
-not eating to manage gries
-not eating to managing
-withdrawing to avoid evaluation, failure
-checking weight, chasing "thin"
- acting "confident, hard worker, all togother, under control"
avoiding sister
A:-1-2-3-4-5-
D:-1-2-3-4-5-
-"have to pretend to be in control"
-"can never start eating normally"
PM:-1-2-3-4-5-
-"a blur" - difficulty attending in school
- quiet voice
-stereotyped gestures/ intonation (explaining)
helping children
being a sister
being a student
Present Moment
Acceptance
Values
Defusion
Committed Action
Self
V:-1-2-3-4-5-
CA:-1-2-3-4-5-
- avoidant persistance- disordered eating worsening
-avoiding sister
"alone"
"failure"
"out of control"
"a mess"
"lost" "weak"
"guilty" "dangerous"
S:-1-2-3-4-5-


Acceptance
Present Moment
Defusion
Values
Self
Committed Action
PM:—1—2—3—4—5—
V:—1—2—3—4—5—
CA:—1—2—3—4—5—
S:—1—2—3—4—5—
"Sick"
"Screwed up"
"careless"
"not fit in"
"weak" perfect enough"
affect constricted-
smiling, even whe
distressed
weaknesses / distress
treatments residential
keeping conversation light
perfect"
perfect"
tolerate

# APPENDIX C

# Template for Assessment Plan


Monthly Assessment
Biweekly Assessment
Weekly Assessment
Assessment Plan

# APPENDIX D

# Template for Self-Monitoring Food Diary

| **Date:** _____ | | | | |
|---|---|---|---|---|
| | **Before** | | | **Action** |
| **Time** | **Inside** *thoughts, feelings, memories, etc.* | **Outside** *who, what, where, etc.* | **Hiding Out** *how, how long, etc.* | **Eating** *what, how much, how, etc.* |
| | | | | |
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| | | | |
|---|---|---|---|
| **Action** | **After** | | |
| **Compensating** *what, how, how long, etc.* | **Inside** *thoughts, feelings, memories, etc.* | **Outside** *who, what, where, etc.* | **Other Comments?** |
| | | | |
| | | | |
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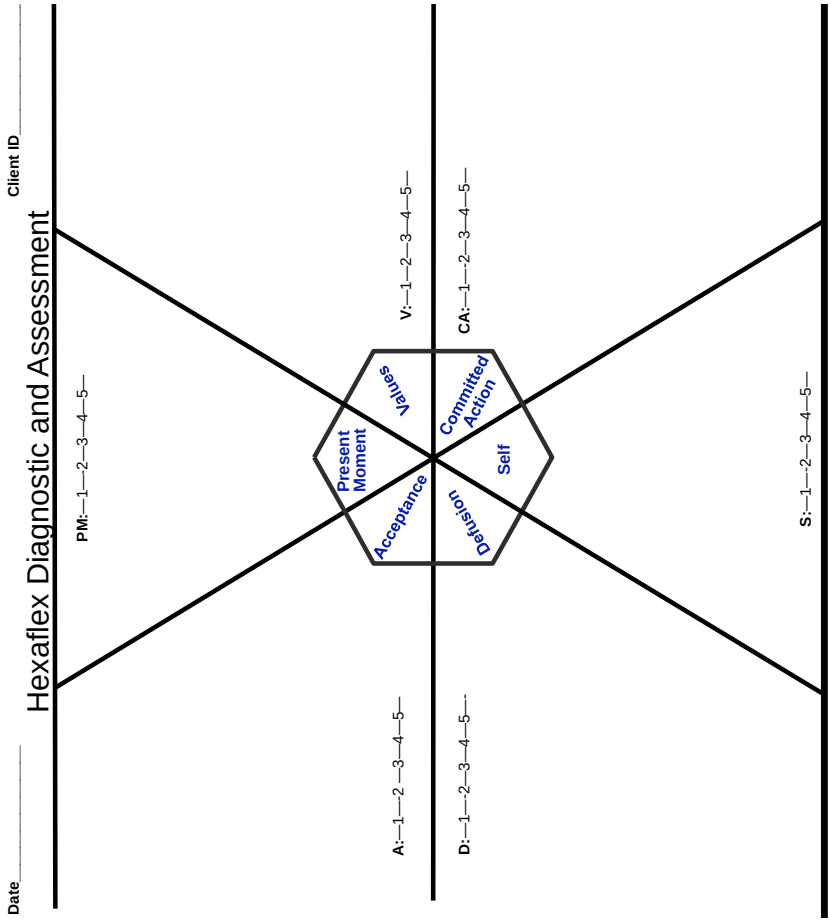
| | | | |
| | | | |
| | | | |

# APPENDIX E

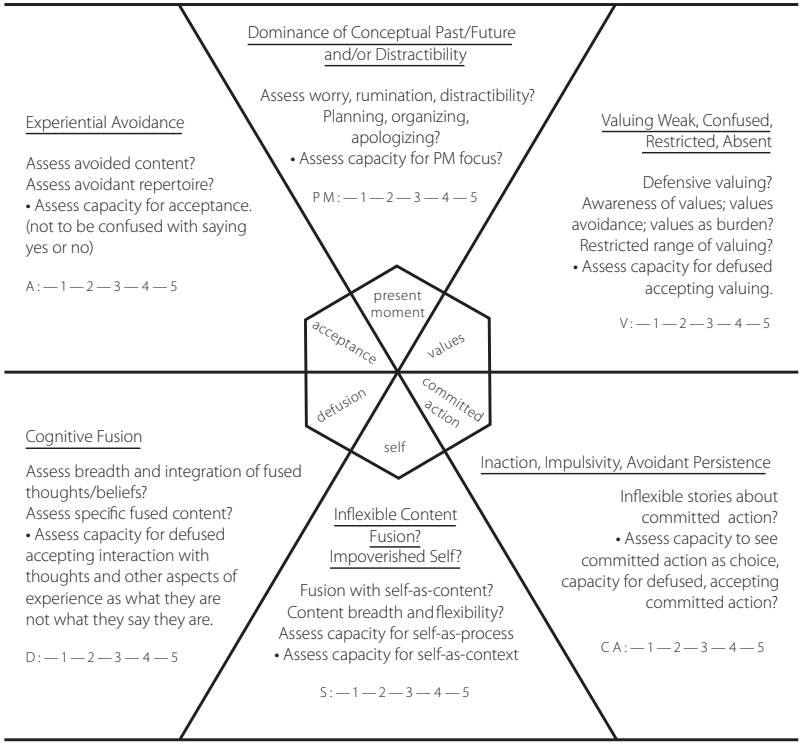
# Blank Hexaflex


Hexaflex Diagnostic and Assessment
Date
Client ID
PM:—1—2—3—4—5—
V:—1—2—3—4—5—
CA:—1—2—3—4—5—
A:—1—2—3—4—5—
D:—1—2—3—4—5—
S:—1—2—3—4—5—
Present Moment
Values
Committed Action
Self
Defusion
Acceptance

# APPENDIX F

# Hexaflex Functional Diagnostic Experiential Interview (HFDEI)

## Hexaflex Diagnostic and Assessment




**Hexaflex Diagnostic and Assessment Worksheets**

The hexaflex diagnostic is a functional dimensional approach to case conceptualization, assessment. and "diagnosis." It is intended to link assessment of functioning on clinically relevant dimensions to interventions. The approach is explicitly tied to a ACT and behavior theory more generally. The diagram above provides some domain specific orientation to common clinical difficulties within the dimension. The rating scale for each domain is intended as a general estimate of functioning within the domain with 1 as low functioning and 5 as high functioning. The worksheets should not be approached as a mere gathering of information. Deliber ate, present moment focused questioning will give the best estimate of both capacities and for areas for therapeutic focus.

Hexaflex diagnostic note pages can be used to conceptualize therapist and client functioning in a given session. High scores con note optimal functioning. Low scores connote poor functioning. Note sheets can also be used as case notes to describe focus of intervention in a session and functioning with each noteworthy domain

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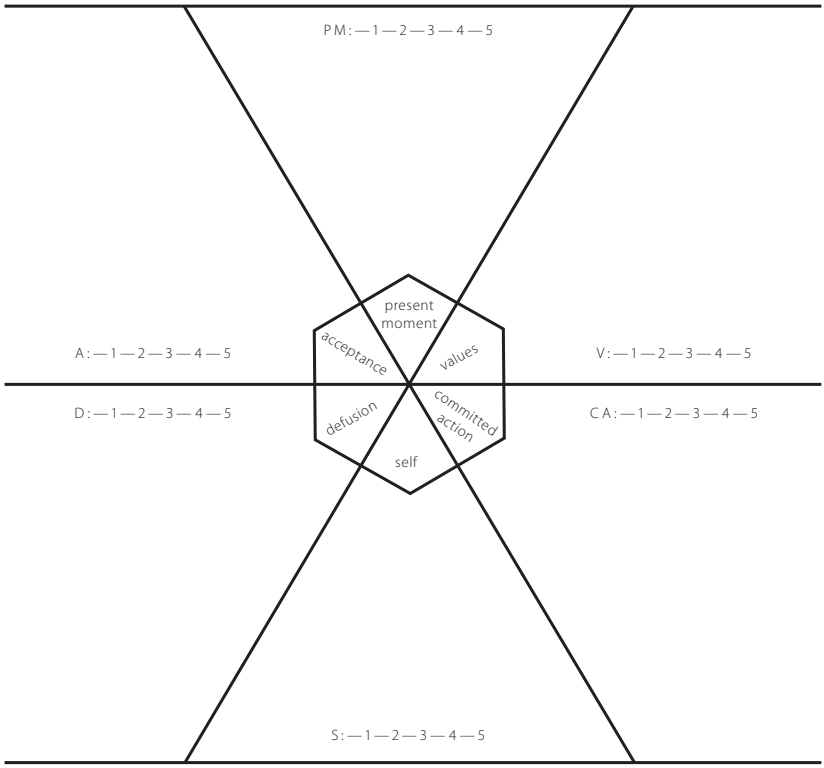
## Hexaflex Diagnostic and Assessment




date: _____ client ID: _____

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## Present Moment Worksheet

**Capacity for Present Moment Focus:** Assess client's ability to be in the present moment. Assess using relatively benign content, such as a simple breathing meditation. Also assess with respect to more challenging material. Watch for changes in pace during therapy. Assess clients capacity to slow, focus, and retain that pace during ongoing interactions in therapy

date:_____ client ID: _____

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## Acceptance/Experiential Avoidance Worksheet

**Avoided Content:** Assess content that is unacceptable. Remember, even things that seem pleasant may take on aversive qualities. Intimacy may be highly valued and terrifying. Content may take any form. Aversives are simply things an individual would work to postpone, eliminate, avoid, or to reduce in intensity and duration. Although experiential avoidance refers to aspects of one's experience that are avoided, you should also list external events that the client avoids in this section. Often external events are experienced as aversive in their own rite. For example, situations involving interpersonal conflict may be avoided. Individuals doing so may find that these situations generate anxiety, fear, and memories of conflict that are also avoided. Remember that experiential avoidance may take many forms. What is the client rationalizing, tolerating, ignoring, or experiencing with resignation (which sometimes looks a bit like acceptance, but without the vitality). Where you see these you will find avoided content. Many of the items listed here will also be important as potential areas for defusion work. List external events, bodily states, emotions, thoughts, memories, urges, cravings, memories that are avoided. Finally, list the personal qualities clients see themselves as lacking (e.g., courage, intelligence?).

date:_____ client ID: _____

Specific aspects of experience the client avoids or struggles to tolerate: thoughts, urges, bodily sensations, memories, emotions....

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Situations the client avoids or struggles to tolerate: conflict, intimacy, social settings...

Things the client wishes were more so: courage, honesty, intelligence...

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## Acceptance/Experiential Avoidance Worksheet

**Avoidant Repertoires:** Means of avoidance need not appear to be avoidant. Avoidance is defined by the extent to which a response allows the client to avoid, escape, or attenuate the aversive content listed previously. Asking a client how they cope (e.g., get busy, distract, think positive thoughts). What clients do when such content emerges will provide a starting place for our list of avoidant repertoires. Remember, the form of avoidance does not have to look pleasant. Depending on a client's history, getting angry might help him or her to avoid feeling sad. Conversely, getting sad may help him or her to avoid feeling angry. Avoidance does not even always have to look like avoidance, so things like "putting up with," resignation, tolerating, fighting, and rationalizing might all be means of avoiding.

date:_____ client ID: _____

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# Fusion/Defusion Worksheet

date: _____ client ID: _____

**Fusion:** Assess fused thoughts, beliefs, emotions, evaluations. stories about "how the world is," "what happened (past fusion)," "what the future will be like (future fusion)," why clients believe they have the problems they have (past fusion), beliefs about what would have to happen in order for them to move ahead in life and whether that is viewed as possible. Include stories about people in the client's life, especially when "how they are" is a strong theme. Stories about past, future, and current situation that have the feel of inflexibility. Work to get a felt sense of the interiority of these stories (bring present moment focus to them). Stay out of conversations about the veracity of possibility/impossibility, truth/falsity, or justice/injustice of the stories, except to get a felt sense of the clients experience of possibility/impossibility, truth/falsity, or justice/injustice—stay mindful, these will hook you!

Past-Fusion

Future-Fusion

World-Fusion

Others-Fusion

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# Self Worksheet

date:_____ client ID: _____

**Self-as-Content:** Assess breadth and flexibility of content. Use the Valued Living Questionnaire as a guide in this conversation.

**Self-Fusion/Avoidance:** List content of self-as-content fusion—fusion with "my story" possibly including a story about "I don't know why I am how I am." Assess capacity to experience self as distinct from content. Self-as-process exercises can sometimes be the simplest way to both assess and shape this capacity.

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## Values Worksheet

date:_____ client ID: _____

**Valued Patterns:** Describe domains of valued living as dynamic, ongoing patterns. Generate short narratives in relevant valued domains. Linger inside the questions about valued domains before allowing any answers. Stay in the questions. Again, this is not mere information gathering. Mindful appreciation is key.

**Values Fusion/Avoidance:** Values areas/content where a sense of constraint, "impossible," "have to," or "values as burden" emerges. Capacity to be present to values and to **action or non-action** as a choice. It is in this place that freedom lives, where choice is real and not under aversive control.

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# Commitment Worksheet

date:_____ client ID: _____

**Domain and Specifics of Commitment:** Assess domains of committed action and meaning of commitment. In a world where the client could make and keep commitments, what commitments would they make and keep? What is a major commitment they would like to make and keep? What small, but meaningful commitment would they like to make and keep? Very present moment focused assessment will be helpful here.

**Commitment Fusion/Avoidance:** Assess client stories about commitment—especially failures, inevitabilities, or any story that contains a strong sense of limitation or constraint. You will find these if you mindfully examine commitments in valued domains using the questions above.

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### Valued Living Questionnaire-2

Below are areas of life that are valued by some people. We are concerned with your quality of life in each of these areas. There are several aspects that we ask you to rate. Ask yourself the following questions when you make ratings in each area. Not everyone will value all of these areas, or value all areas the same. Rate each area according to your own personal view of each area.

**Possibility:** How possible is it that something very meaningful could happen in this area of your life? Rate how possible you think it is on a scale of 1-10. 1 means that it is not at all possible at all and 10 means that it is very possible.

**Current Importance:** How important is this area at this time in your life? Rate the importance on a scale of 1-10. 1 means the area is not at all important and 10 means that the area is very important.

**Overall Importance:** How important is this area in your life as a whole? Rate the importance on a scale of 1-10. 1 means that the area is not at all important and 10 means that the area is very important.

**Action:** How much have you acted in the service of this area during the past week? Rate your level of action on a scale of 1-10. 1 means you have not been active at all with this value and 10 means you have been very active with this value.

**Satisfied with Level of Action:** How satisfied are you with your level of action in this area during the past week? Rate your satisfaction with your level of action on a scale of 1-10. 1 means you are not at all satisfied and 10 means you are completely satisfied with your level of action in this area.

**Concern:** How concerned are you that this area will not progress as you want? Rate your level of concern on a scale of 1-10. 1 means that you are not at all concerned and 10 means that you are very concerned.

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| | Possibility | Current Importance | Overall Importance | Action | Satisfied with Action | Concern |
|---|---|---|---|---|---|---|
| 1. Family (other than couples or parenting) | | | | | | |
| 2. Marriage/Couples/ Intimate Relation | | | | | | |
| 3. Parenting | | | | | | |
| 4. Friends/Social Life | | | | | | |
| 5. Work | | | | | | |
| 6. Education/Training | | | | | | |
| 7. Recreation/Fun | | | | | | |
| 8. Spirituality | | | | | | |
| 9. Community Life | | | | | | |
| 10. Physical Self-Care (diet/ exercise/sleep) | | | | | | |
| 11. The Environment (caring for the planet) | | | | | | |
| 12. Aesthetics (art, music, literature, beauty) | | | | | | |

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**If you could chose five of these twelve areas to work one, which would they be?**

_____

_____

_____

_____

_____

**If you could choose just three of the twelve, which would they be?**

_____

_____

_____

**If you could choose just one of the twelve areas to work on, which would it be?**

_____

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# Client Worksheet

I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
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I am … _____
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I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____
I am … _____

# Sitting Inside Significant Questions

Consider the things you'd like to do in your own life. Especially consider things with fairly high stakes: should I get married or divorced, have children, change careers, or start a new business?

Ponder one of these or another that feels significant to you. Try doing this while intentionally not deciding one way or the other, and without evaluating or drawing any conclusion. Rather than decide or conclude, let yourself wonder what you will do.

If you notice yourself deciding or weighing the pluses and minuses, gently let go of that process and come back to the question. Repeat the question gently to yourself, listening with care to each word. If you find yourself concluding, "Well, I'm not really going to do that" or "Sure, that's a good idea," let yourself notice that you are drawing conclusions about an unknown future. Your conclusion may indeed be the most likely outcome, but sometimes very, very unlikely things happen. As many times as you find yourself concluding or deciding, gently come back to the question and linger. Let yourself wonder for a few minutes. Notice also how quickly you are ready to move on to the next thing on your to-do list.

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# APPENDIX G

# Example Narrative Conceptualization

Theresa's difficulties seem to have started after her mother died. It seems that initially she coped with her grief by withdrawing from social and recreational activities. She stopped eating and sleeping, and began to lose weight. Theresa soon identified her weight as a domain of life she could control, which resulted in some relief from her grief. She began restricting her diet on purpose and withdrawing further to avoid detection. Her weight loss has recently begun to disrupt her life significantly. Theresa wants to be a successful, engaged student; however, she is having increasing difficulty attending and concentrating in school. Her grades have begun to drop rapidly. Theresa cares deeply about being a supportive and inspiring sister. When Theresa's sister began to diet, she began avoiding her because of her fears that she is "dangerous" to her sister. The more her sister reaches out, the more Theresa withdraws. In session, Theresa speaks quietly and often seems to be explaining herself.

# Resources

As hard as we've worked on this book, we've found ACT is best learned through multiple exposures in different formats, with different emphases, and from different perspectives. If something we've presented resonates for you, we'd recommend digging in a little deeper. Trust us, there is always more to learn. There are many resources available to provide clinician support in learning, practicing, and researching ACT.

## ASSOCIATION FOR CONTEXTUAL BEHAVIORAL SCIENCE (ACBS)

ACBS is a professional organization dedicated to the advancement of ACT, relational frame theory (RFT), and contextual behavioral science. ACBS hosts an Online Learning and Research Community, which is available at contextualpsychology.org. Available through the website with paid membership are email Listservs for clinicians and researchers interested in ACT and RFT; clinical tools like assessment instruments, handouts, and protocols; and an extraordinary number of full-text, peer-reviewed empirical publications. Also available on the website is information about both live and online training opportunities, including the annual conference of ACBS.

## NEW HARBINGER PUBLICATIONS

New Harbinger has published several books designed to help clinicians master the ACT approach. For example, our text *Mindfulness for Two* (2009) offers a unique consideration of the process model we discuss in this

book. *Learning ACT* (2007) is an in-depth clinician skills training manual that includes a number of role-played examples in audio and video. Also available through New Harbinger are workbooks clinicians can use to build in-session exercises, to generate homework, or as part of preparation for termination. Among these are *The Anorexia Workbook* (2004), which is specific to anorexia and related difficulties, and *Get Out of Your Mind and Into Your Life* (2005), which is appropriate for a range of difficulties.

## YOU

That's right, you. Every process we've discussed in this book is available to you for intensive individualized experiential training. No fee. All you have to do is show up. You might not suffer about your body or use your eating to manage your suffering, but we're going to go ahead and guess that you have known what it is to suffer. And we're going to assume that you have known what it is to watch yourself turning away from something you care about just to buy a moment of peace. And if you never read or hear or speak another thing about ACT, openness to that experience might be the thing most worth carrying with you through your world and into the therapy room.

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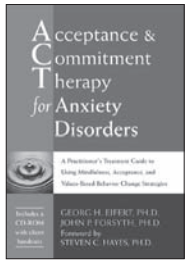


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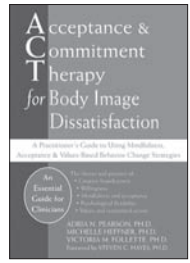


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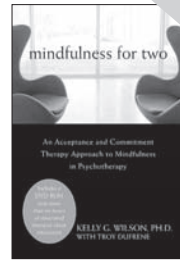


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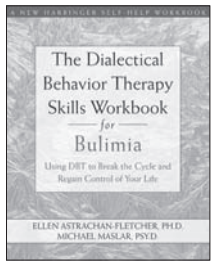


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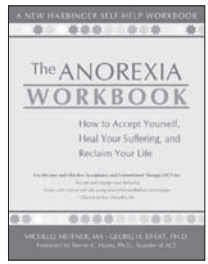


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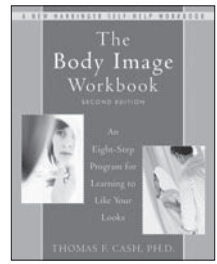


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# A Process-Focused Guide to Treating Eating Disorders with ACT

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This professional guide offers a review of acceptance and commitment therapy (ACT) as a theoretical orientation and presents case conceptualizations that illuminate the ACT process. Then, it provides session-by-session guidance for training and tracking present-moment focus, cognitive defusion, experiential acceptance, transcendent self-awareness, chosen values, and committed action—the six behavioral components that underlie ACT and allow clients to radically change their relationship to food and to their bodies. Both clinicians who already use ACT in their practices and those who have no prior familiarity with this revolutionary approach will find this resource essential to the effective assessment and treatment of all types of eating disorders.

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