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Recognizing common clinical mistakes in ACT: A quick analysis and call to awareness

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ABSTRACT

Developing and understanding, both verbally and experientially, the flexible use of Acceptance and Commitment Therapy (ACT) in real-world application may pose challenges for both therapists new to the intervention and seasoned ACT therapists alike. Some of the subtleties of distinguishing the content of behavior from the function of behavior and developing facility with ACT core processes in these areas may, at times, prove difficult. Clinical supervision with proficient ACT therapists can assist in addressing some of these issues. Although there are a number of 'sticking points' that therapists new to ACT may encounter, we explore several of the most common here. Each clinical sticking point can serve as a 'heads up' to therapists new to ACT, followed by possible ACT consistent paths designed to support the therapist in overcoming common barriers. Although targeted to new ACT therapists, the reminders are appropriate for ACT practitioners of all levels of clinical experience, as well as supervisors providing training in ACT.

1. Introduction

> "Isn't it nice to think that tomorrow is a new day with no mistakes in it… yet?" – L.M. Montgomery

The evidence base supporting Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2011; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010) is increasing rapidly, and ACT trainings are available worldwide in many languages. Recognizing the needs of new ACT practitioners, several authors have written texts specifically for those who are early in development as ACT therapists (e.g., Batten, 2011; Ciarrochi & Bailey, 2008; Luoma, Hayes, & Walser, 2007; Harris, 2009). However, beyond learning the initial content, relative newcomers to ACT can experience difficulties in transferring knowledge of ACT gained in training and through written descriptions to real-world clinical settings.

In our clinical supervision and training experience we have encountered a number of common challenges in translating the workshop experience to actual work with clients who have complicated histories and clinical presentations. Using the six core processes of ACT in a flexible way under these circumstances, can initially seem difficult and, at times, discouraging. We have each had new therapists in ACT supervision say something like, "When I hear it, I get it. When I try to do it, I get mixed up. I lose it." Each of us has witnessed disappointed supervisees, both among newer and seasoned therapists.

We have also seen therapists new to ACT, resort to well-established repertoires of ACT-inconsistent behavior when they are unsure of what to do next in a therapy session that is ACT coherent. For example, we have listened to tapes of clinical sessions of therapists in training and heard something like the following:

Client: "I just can't do it. I just can't"

Therapist (attempting an ACT intervention): "Well, let's take a look at that thought. It really has a grip on you. I am wondering if we can do some defusion work with this thought."

Client: "No, I… I just can't do it. You don't understand how hard it is for me. I can't do it"

Therapist (stuck, hesitant and finally relieved when he says this): "Then let's look at it in a different way. I would like to work with you to challenge this thought."

Or

Therapist (stuck, hesitant and finally relieved when he says this): "Well, it sounds like you feel like you really can't do it. That must be hard."

This example, of course, is a bit of a characterization for illustrative purposes. We want to recognize this, but also let the kernel of truth in it stand. When we don't know what to do, we

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turn to what we know. Whilst this can result from many things, it often results from an unwillingness to experience and stand with the client in 'not knowing' together. Here, we point to the importance of being willing to experience challenging private events as a therapist overall, but especially when learning ACT. Willingly experiencing the feelings and thoughts that come along with not knowing what to do next is part of the process. Taking a pause and experiencing the discomfort of not knowing and operating from there – from exactly that place, is part of gaining the capacity to use the ACT processes in a flexible way. This pause and act of willingness can assist the new ACT therapist in moving from the surface-level application of ACT (e.g., "Let's defuse from that thought") to the flexible use of ACT (e.g., "I am stuck here, as I really want to be able to look at this thought for what it is, but I am worried that I am going to get it wrong and if I persist, you might think that I don't understand you, so I am not sure where to go next").

There are many ways in which learning ACT can be challenging. For some, working to understand the theory and principles underlying ACT is a fundamental shift in the way they have been taught and/or think about human behavior. This is no small affair. Moving from a mechanistic view of human behavior, for instance, to a functional contextual view can be a stretch; however, this process is part of the ACT learning experience. Understanding the function of behavior in context and the behavioral principles (see and digest Hayes; Romnero & Torneke; Torneke[1]) that guide intervention will bring the new therapist more than half way to skilfully applying ACT. We take the stance that this shift can be done and is done all the time. Nevertheless, this shift, in and of itself, is not enough. Simply gaining a verbal understanding of ACT theory and application keeps the process 'in the head'. We contend that contacting an experiential understanding of ACT is also part of the learning process, even when this includes the experience of *not knowing*, feeling the discomfort of mistakes and jumping into the work from there.

We posit that many of the common mistakes that new ACT therapists make involve attempts to quickly solve an issue in therapy rather than pausing, getting present to not knowing, and working from that point forward. We focus on 11 of these, recognizing that there are certainly others. We invite readers to digest these mistakes in three ways. First, we will ask you to reflect on your own clinical practice, looking to see if you find yourself making these very mistakes or variations of them. Second, we invite you to notice the thoughts and feelings that you encounter in these places. Notice if evaluation about yourself and your work isn't a part of the experience. Notice if defense of self is not also there. Of course, other kinds of experiences may be present. Here we are expressing some of the ones we readily encounter in the training context. Wanting to get it right, especially when you report to supervisor, can hold the heavy hand of evaluation. Shame is often experienced by trainee therapists both in session and in supervision (Yourman, 2003) and can be part of the experience for those new to ACT. Consider even the evaluation that emerges in using the term "mistake." Third, we invite the reader to turn toward these experiences or any others that might arise in considering your own learning process and the inevitable mistakes that will be made.

2. 11 Common mistakes

The first 5 mistakes have similar characteristics, but are ultimately distinguishable. All of the first 5 are also highly verbal in nature and give some indication that the experiential work done in ACT may still be absent or little felt in the therapeutic process. We explore these and provide examples where relevant. The last 6 stand independently and will be explored in turn. One of the key points to remember when considering these mistakes is the distinction between contingency-shaped versus rule-governed behavior. Our hope is that clinicians will let the experiences in therapy shape some of their performance (e.g., allowing open and flexible responses from the client to shape the work you are doing) versus simply following verbal-rules (e.g., apply ACT this way only). Not that verbal rules are not useful, but we recommend that you pay attention to the function of your own in-session behavior in addition to paying attention to the function of your client's behavior.

2.1. Talking about doing ACT rather than doing ACT

This mistake, at times, can be hard to detect, but at most times it can be caught right away. Therapists will notice it when they are giving the client a didactic course on the tenets of ACT. The easily detectable forms of this mistake can often be rooted out when you hear therapists start sentences like this, "In ACT…" or "In this therapy…" and these are followed by a monologue about what ACT therapy is. This might happen in a first session when the therapist is completing an informed consent and describing the therapy to a client. But if you begin to hear these kinds of "starts" on a routine basis, then it is more likely than not that the therapist has shifted from doing ACT to talking about doing ACT. We assume that everyone knows that it is one thing to *do* something and a different thing to *describe* it. Talking about tennis playing is not the same as tennis playing, even if the description is really good.

There are also times when talking versus doing is more difficult to detect. This second more subtle talking versus doing form can be represented by two sorts of behavior. The first is more of a "felt sense" or quality than the former. The therapist in this case may appear to be more engaged with the client as they might be asking questions and trying to detect an understanding on the client's part, but the delivery of ACT exercises and metaphors feels more like reading from a protocol (we explore this further in mistake number 2) than digging in from an experiential place. Responses to the client have more of a 'canned' feeling rather than a functional, connected feeling. This type of mistake is often linked to doing the therapy 'right.' In the latter case, the therapist seems to be more concerned about the proper wording of the metaphors and exercises rather than functional responses to the client.

Consider the following example representing 'talking about' versus doing. The therapist is interacting with the client seated across from her.

Talking about: 'Defusion,' in part, is being able to make a distinction between your thoughts and what you are thinking about. So, for example, you are sitting in a chair. Thoughts you have about sitting in a chair might be 'true' and are not the same thing as you sitting in a chair.

Doing: "I'll ask you to think this thought, 'I am sitting in a chair.' (Pause)

If for a moment we considered thoughts from the perspective of true and false, would you say the thought you are thinking is true? (Practitioner waits for affirmative answer.) Now, I would like to invite you to notice the sensations you experience in your back (pause), hips (pause) and legs (pause) as you sit in the chair. Notice the experience of sitting in the chair – the felt sense of it (Pause). Now let's go back to the thought. Can you notice that, even when a thought is 'true,' the thought is not the same as the actual experience? Noticing that difference between your thoughts and what your thoughts are about is part of what we are working on in here.

[1] There are many excellent readings on behavioral principles, functional contextualism and ACT. Please visit www.contextualscience.org for more information,

Or this example of Talking About (e.g., canned responses).

Client: "I'm inadequate. I have proof. I am getting bad marks on the job, girls won't go out with me, my friends criticize me. It's proof. I'm inadequate."

Therapist: "Thank your mind for that."

Doing (the therapist is more responsive and empathic to the client, the functional aspect is pointed to):

Client: "I'm inadequate. I have proof. I am getting bad marks on the job, girls won't go out with me, my friends criticize me. It's proof. I'm inadequate."

Therapist: "I would like to explore this thought, 'I'm inadequate.' It seems like your mind tells you that fairly often. And when it does, things slow down, you get stuck. It is like your mind is evaluating you again and again and it nearly always says the same thing – 'I'm inadequate.' It's as if, when something goes wrong, you could almost thank your mind in advance…because you know what it is going to say."

We can summarize this mistake, talking about versus doing, and its solution, with a metaphor. Consider the difference between looking at a map of London to plan what route you might wish to take and actually walking around the streets of London. There might be value in looking at the general structure of a street map, and indeed, with certain online mapping software you can even see pictures of the route that you might take, but looking at a map and physically treading the path with all the sights, sounds and smells are different activities. When learning ACT, we strongly recommend the former, but want to insist to the degree that we can, on the latter in application. Looking at the 'map' is indicated, but showing up to the process of actually walking is the most ACT-consistent move as you apply the therapy. This means understanding the functions of particular exercises and applying them adaptively depending on the context, not just 'parroting' a phrase or giving a didactic course on ACT.

2.2. Reading the metaphors or exercises from paper in session

We are not suggesting this behavior is always a mistake. There may be times when a therapist would read something to a client in session. If asked when to do this, we would respond, "It depends." Sometimes poems are shared or sections of a book. However, we do want to suggest that the skills involved with reading aloud or listening to a metaphor or exercise are different than the skills that are needed to effectively deploy the same in a psychotherapy session. Reading the therapy to the client is a form of delivery, but it is also a form that is rife with problems.

First, you can lose contact with the client for a long period of time. Reading directly from a written script can interfere with the therapeutic relationship and does not convey concepts in as genuine or relatable of a way. Additionally, the therapist reading exercises and metaphors will miss the client's non-verbal reactions to these interventions. Second, it can take on an overly school-like quality. Third, it probably indicates a lack of preparation. It can be daunting to try to remember some of the longer experiential exercises, and it is important to remember that it is unlikely that they will go exactly as planned the first time attempted by a new ACT therapist. More importantly, it is the function of the metaphor or exercise, rather than specific words which the therapist most needs to understand. Knowing the words of the exercise is secondary to function.

We recommend understanding the metaphors and exercises for their purpose, first. This will hasten the journey from adherence to competence. This should probably be followed by some form of rehearsal. We recommend, however, that this method, reading and rehearsal, only be used during practice in between sessions and during supervision. (By the way, we have supported therapists new to ACT carrying in a "cheat sheet" with a short list of bullets or helpful information to guide the therapist). Finally, the therapist is invited to find the way of utilizing the metaphor or exercise that fits their own voice and presence in therapy. This will help with a sense of ownership and workable delivery.

2.3. Treating metaphors and exercises as techniques to be applied to the client

The largest cost of this mistake is "loss" of the client. The metaphors and exercises thought of as simply techniques means losing their function with respect to *this client in this context*. Metaphors can be tremendously helpful as a way of interacting with sometimes complex and confusing private thoughts and experiences and many of the published ACT protocols detail specific metaphors that can be utilized in various phases of ACT treatment. However, none of these interventions are intended to stand alone and none are designed to simply be a tool applied to a problem in a rote manner. Indeed, one of the core competencies of ACT is flexible responding to the client (e.g., avoids use of 'canned' ACT interventions; tailoring interventions to fit the client's language and life experience; applying ACT interventions in response to client need). The client is not a set of problems that will be solved with the right application of an 'ACT tool', especially when this issue is approached from a rule-governed way. Flexible and responsive use of metaphors and exercises, depending on the client's context and the function of their behavior, requires thoughtful attention to what process is engaged and explored in addressing the presenting issue. Process and function of behavior rise above application of a particular ACT technique.

It is also important to keep in mind that a commonly made misstep in ACT therapy, as with all ACT consistent techniques, is to assume that matching metaphors to certain client presentations is how they are best applied. Matching can be done and can also be very effective, but should not be mechanical, but rather functional in nature.

2.4. One metaphor or exercise after another

In response to a given metaphor not leading to the desired outcome, therapists new to ACT will sometimes resort to offering another metaphor or exercise and perhaps another one after that. The therapy looks like a parade or succession of metaphors and exercises, with little feedback or experiential responsiveness. This often leads to a lack of vitality in a therapy session and takes the therapist away from being fully present and connected to her clients. Additionally and rather like rummaging through a tool chest to find the exact wrench or lubricant to loosen a stubborn nut on a car, therapists can find themselves staring at the tools rather than paying sufficient attention to the experience. It has this quality: "This one didn't work, let me try another and…that one didn't work, let me try this one." There is also an increased likelihood that therapy will become 'heady' in this situation as the drive to gain or impart understanding takes control. It may be important to explore what is happening between therapist and client or to address emotion or being stuck, rather than trying yet another metaphor to make the client understand.

2.5. Talking too much

Given that ACT encourages the use of metaphors and exercises and given that many protocols request much of the therapist, a kind of over-talking on the therapist's part can emerge during session. Additionally, the ACT therapist is expected to be relatively active in session. This therapy is not about sitting back and simply listening. Therapist and client are working, talking, and listening alike. What can happen under these circumstances is a 'tip of the balance', whereby the voice of the therapist begins to dominate

the therapy. This verbal domination on the part of the therapist can involve the mistakes listed above, but can also take on a life of its own that is not necessarily about stating one metaphor after another, or treating metaphors as techniques to be applied. Over-talking may take many forms – use of metaphor, describing, evaluating, telling the client how they feel and what they think, interpreting, rapid questioning, etc. Apart from the obvious impact on the collaborative nature of therapy, the balance between therapist, client and the intervention is lost.

Over-talking may be a way that a therapist deals with personal discomfort. For example, being fused or caught up with 'being a good therapist' can lead to an unwitting 'over-performance.' Additionally, the therapist may be caught up in trying to make the client understand, as if understanding were the key to the current problem. The therapist may simply be unaware of their verbal presence in the room. Perhaps listening to tapes of therapy sessions can assist, but certainly being aware of your and the clients presence, activity and experiential states in the room can help to guide whether it is a time for talking, listening or silence.

2.6. Reading and watching ACT experts rather than practicing

Watching other people doing ACT well can certainly help individuals to increase their skills, and we recommend watching experts to improve skill. Similarly, reading can be helpful in increasing one's knowledge base and, as mentioned, is a necessity. Yet, from time to time, we have encountered trainees who substitute watching others or reading for actually practicing ACT. Another book recommendation or turning a role play over to the supervisor rather than struggling through it oneself are possible signs of this mistake. Almost everyone finds that initially when developing a new skill, they do not perform that well. Even those who have some prior experience are not nearly as skilled as they, eventually, would like to be. To become skilled, one must be starting from a place of not being skilled. This is a *great* place to start. We recommend that the therapist new to ACT bring his fears of clumsiness and not getting it, right into their practice. It probably goes without saying, but if a therapist is unwilling to feel what they feel when they are unskilled, development will be hampered.

2.7. Assuming control and avoidance are bad

Because a significant part of ACT work is undermining the negative effects of excessive and misapplied control, and because a key target of ACT is to reduce experiential avoidance, many therapists new to ACT may assume that all control and avoidance behavior has to be addressed. Here, we just want to reiterate that it is excessive and misapplied control or avoidance that is problematic, not control and avoidance themselves. Indeed, there may be times when control of emotional experience is exactly the functional thing to do. We recommend assessing whether control and avoidance are workable or unworkable given the client's life values and goals. Remember, it is the function of avoidance that is of most value from an ACT perspective.

Many therapists trained from a behavior analytic perspective would easily recognize this process, and our hope is that others with different training backgrounds would also come to find functional analysis a useful way to approach therapy. Regardless, we also want to acknowledge that functional analysis is not always a simple task. Similar forms of behavior can have different functions, and different forms of behavior can have the same function. With respect to avoidance, the therapist needs to work to identify the role that avoidance plays in the day-to-day life of the client rather than labeling specific control behaviors as problematic or bad. Evaluating and labeling of behaviors can occur subtly, if therapists seem to target specific avoidance behaviors without making clarification of their function explicit, clients may take an implicit meaning that these are 'wrong behaviors.'

As a quick example, many individuals may choose to have a glass of wine after a stressful day at work; this drink may in fact serve an avoidant function. However, the ACT therapist would not assume automatically that drinking the glass of wine was problematic, even if it was a type of avoidance. The therapist would explore whether the use of wine for this purpose was mindfully chosen and what the impact of drinking to 'wind down' is on the various parts of the client's life over time. From an ACT perspective, therapists are interested in flexible behavioral repertoires rather than the categorization of good and bad behaviors in and of themselves.

2.8. Focusing more on behavior going down than behavior going up

Broadly speaking, much of clinical work and training about how to treat has been focused on elimination of symptoms. We also think that there is often a pull from clients to eliminate their suffering by decreasing their pain. These in combination may orient the clinician to a particular focus in therapy. In ACT, however, the focus is broadened to include support of values-based living (or increasing behaviors that are consistent with values). Overall, we hope to increase the frequency and duration of functional behavior. We do think that clinicians want this for their clients, but can get lost in symptom reduction when new to ACT therapy.

A quick example will demonstrate what we mean. When it comes to something like addictive behavior, focusing on increasing the frequency and duration of valued behavior will, as a side effect, most likely decrease addictive behavior, because the addictive behavior would not fit with the individual's values. On the other hand, if one is successful only in reducing addictive behavior, valued behavior may still remain low. Thus, focusing on increasing behavior that is consistent with values often works more effectively than simply trying to reduce behavior deemed 'problematic.' Similarly, if fearfulness is high and values-based living goes up, one still gets to live a values-based life even if fearfulness remains high. More value-based living is not achieved simply by reducing fearfulness.

2.9. 'Sticking' to values

Choosing behaviors that are guided by what is important and matters deeply to clients is a recognizable feature of ACT. It can be a transformative moment in therapy when clients identify that much of their behavioral repertoires have been under aversive control, and some clients will make great strides when the door marked 'Values' has been opened. Many clients, particularly those who have experienced highly aversive or even toxic learning histories, can have great difficulty in finding that door or state there is nothing inside when it is opened. Such is the 'sticky' nature of aversive control that, metaphorically speaking, clients have been living their lives looking behind trying to keep ahead of feared and unwanted experience, and it is hard to begin to look ahead if one's eyes are not pointed in that direction.

The process of looking forward toward meaningful activities is not necessarily intuitive and requires some skill – and more importantly compassion. Therapists focusing too much on values-based actions or whether a client's stated value really is a value or not often springs from good intentions, but can lead to sticky places in therapy. It is helpful if the therapist is willing to sit with painful non-movement and, for the time being, resist the urge to point them toward a more meaningful and valued life, even if it is very strong. Unhooking from the 'Velcro' of aversive control can itself be experienced as painful if it is done without choice or without sufficient context for change. To begin with, it can be more beneficial for therapists to be more compassionately present

with clients, seeing from where they look, rather than compel clients to turn their heads in the direction that therapists think they should go. It is not a case of whether a value is a better rule to govern behavior, from an ACT perspective, it is the promotion of flexibly choosing what to do.

2.10. Moving too quickly when strong affect shows up

Most therapists have gone into the mental health field because they wish to help people, make the world a better place, and alleviate human suffering. In addition, many cultures train individuals from an early age not to show strong negative affect and to find ways to calm or distract others who are expressing strong emotions. Thus, it is only natural to reassure, provide a tissue, or help a client to "look on the bright side" when he or she is showing sadness, pain, or other intense affect. It is what most compassionate people have been trained to do since childhood.

However, it will be important for the therapist new to ACT to engage mindfully, being aware of those automatic reactions and their functions. If the function is to eliminate or close off emotional experience, it may be best to slow down and show up to the client. The ACT therapist assists the client in learning that strong affect does not necessarily need to be avoided. If the therapist moves too quickly to help the client 'feel better' in session, it may rob the individual of the chance to learn that strong emotions are not the enemy – instead, it is the unwillingness to experience those emotions that leads to problems in functioning.

2.11. Operating as if everything is about making strong affect show up

At the same time, there is nothing inherently beneficial in the experience or display of strong emotion. Therapists new to ACT may run the risk of confusing form with function as it relates to the expression of affect. For example, they may readily notice a pattern in which a lack of emotion is associated with problematic experiential avoidance. Although frequently true, this does not mean that the antidote to avoidance is the evocation of affect in session.

The presence of emotion in the therapeutic interaction can provide a powerful in vivo opportunity to practice skills of mindful observation, present moment focus, and experiential willingness. However, to be consistent with an ACT model of treatment, this exposure to affect must be in the service of moving the client forward with respect to his or her values, not to experience emotion just for its own sake. This kind of problem can arise when therapists new to ACT have themselves had a productively intense emotional experience in a training workshop; they may initially believe that strong affect is the goal of the treatment. Living effectively in the presence of strong emotion is a key ACT skill, but it is helpful if the ACT therapist holds the function of evoking affect in session in mind, rather than being guided primarily by form.

3. Conclusion

ACT is principally concerned with assessing the client's unique version of psychological inflexibility and promoting a flexible approach to daily life by expanding behavioral repertoires, aided by the 6 core processes of ACT (defusion, values clarification, committed action, self-as-context, acceptance, present moment awareness). It is understandable that therapists new to ACT might struggle at the level of technique, before considering function. However, a solid and skilled foundation in ACT therapy may be improved for new therapists by watching for the common mistakes described above. Compassionately considering your own willingness and flexibility in therapy sessions, noticing what makes it difficult to stay present, and noticing how you might get caught up in your own discomfort and 'sticky' places as you sit with a client's suffering requires as much focus as learning specific new tools and metaphors. Bringing these issues to clinical supervision is an ideal way to consolidate learning and further develop an ACT-consistent approach.

We want to note that, although our focus has been on therapists new to ACT, we also want to reach out to seasoned therapists. It is worth pausing and reflecting to ensure that your ACT work continues to be consistent and not creeping toward the mistakes we suggest here. Even the best of us have found ourselves over-explaining, sticking to familiar metaphors and exercises or using them in a perfunctory manner. Ongoing awareness, in our opinion, is the best antidote.

Finally, we would invite supervisors to consider these issues and think about how you might create a supervision context where therapists new to ACT can explore these mistakes, noting their own fears of evaluation and making room for all to be aware of the shame that can be present when appearing to fail at learning a new therapy. You might consider, if you haven't already, what things you can do to set the context (see Follette & Batten, 2000; Walser & Westrup, 2007) for an open and engaging supervision process that fully welcomes 'mistakes' in the therapy room.

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