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Happiness in Valued Living:

Acceptance and Commitment Therapy as a Model for Change

Louise Hayes

School of Behavioural and Social Sciences and Humanities, University of Ballarat,  
Australia

Correspondence

Correspondence: Dr Louise Hayes, Department of Behavioural, Social Sciences and Humanities, University of Ballarat, PO Box 663, Mount Helen, Victoria Australia 3353, email: [l.hayes@ballarat.edu.au](mailto:l.hayes@ballarat.edu.au)

## Happiness in Valued Living:

### Acceptance and Commitment Therapy as a Model for Change

*The amount of happiness that you have  
depends on the amount of freedom you have in your heart.*

*Thich Nhat Hanh*

Acceptance and Commitment Therapy has an ultimate goal of helping individuals to develop behaviours that service their deepest values, thereby bringing joy and meaning into life (Hayes, Strosahl, & Wilson, 1999). Happiness pales in comparison - a transient emotion that is sensitive to the fluctuations of daily living. From an ACT perspective the question, “am I happy?” is incidental to valuing questions such as, “what do I want my life to stand for?”

The purpose of this chapter is to review how Acceptance and Commitment Therapy (ACT, spoken as the word act not the letters A-C-T) can contribute to improving the human condition. Happiness and suffering go hand in hand with this. The chapter is written in six sections, taking the reader from philosophical assumptions through to outcome studies. In section one the reader is given an overview of the social context in which ACT was developed, providing an understanding of the important assumptions that are the foundation of the ACT model. Section two provides the reader with an overview of the theory of verbal behaviour on which ACT is based. Section three then reviews the philosophical

platform on which the model of ACT therapy rests. An understanding of this philosophical worldview helps therapists and researchers adapt the ACT model to their context. Section four provides an overview of the ACT model while section five reviews the research outcomes for adults. Finally section six considers the future by discussing ACT work with young people, in the hope that there are opportunities to help future generations live with value and meaning.

#### *A Discontented Culture as the Context for ACT*

In Westernised cultures today we face a constant pull to seek happiness. Our media calls individuals to find happiness, to compare their own to happiness to that of others, and to find remedies if they fall short on their expected happiness quotient. The greatest exposure comes through reports on celebrities who appear to ‘have it all’ but all too often we follow their demise when former shining stars ‘lose it all’. It seems there is little doubt that our obsession with happiness is growing at rapid speed. In 2008, approximately 4000 books were published on happiness compared to a mere 50 in the year 2000 (Flora, 2009).

Paradoxically this search for happiness has not made us happier as a society. Epidemiological evidence points to remarkably high rates of distress. Twelve-month prevalence estimates from the US show a staggering 1 in 4 people met criteria for a DSM-IV Axis I disorder (Kessler, Berglund, Demler, Jin, Merikangas, Walters, 2005). Almost half these people were reported to have more than one disorder, and over half were rated as moderate to severe. However, this data is based on DSM-IV disorders only. If we consider for a moment non-diagnostic problems then the breadth of suffering becomes plain. In developed countries the leading causes of disease burden comes from lifestyle factors, including alcohol, tobacco and obesity related

illnesses, whereas non-developed countries suffer most through poor nutrition, water and sanitation (Ezzati, et al., 2002). And we can add to this picture other forms of distress. Divorce for example, was virtually non-existent 100 years ago and is now estimated to occur in 32% of marriages (Hewitt, Baxter, & Western, 2005).

Workplace stress in the US has become so normative that if you are not stressed there is a perception that you are not working hard enough (Peterson & Wilson, 2004). One can only conclude from these data that suffering is ubiquitous in Western society.

In the West we have responded to these high population rates of distress by attempting to inoculate our children and young people from suffering. Our assumption - if we can teach children early in their life cycle we will see lower rates of distress as adults. We are yet to see aims come to fruition. Epidemiological data suggests rates of depression are at 18% ( $N=9,863$ ) of school based young people (Saluja, et al., 2004). Suicidal thoughts occur in more than 50% of young people, with 15% reporting they have seriously considered attempting suicide, and 5% making a suicide attempt (Drum, Brownson, Denmark, & Smith, 2009). School prevention programs aimed at preventing distress are not reliably achieving long-term reductions in psychological distress (Merry et al., 2004) .

This evidence for adults and young people shows unhappiness isn't something that happens to 'other people'. We suffer. And so, the happiness we envy in others may be an illusion – they are just as likely to be unhappy but we cannot see it.

The founders of Acceptance and Commitment Therapy (Hayes, et al., 1999) argue that our Westernised assumptions that happiness is normal and distress is abnormal are indefensible. Hayes et al. contend that we have generalised the medical model of disease, where the absence of disease represents good physical health, into a

psychological science where the absence of distress represents good psychological well-being. They argue, that epidemiological data shows this is a flawed assumption and that has negatively impacted on the contribution of psychology to wellbeing.

An alternative to the disease model is found in ACT. This is that language is the key to understanding our Western pursuit of happiness and also that language is the source of our universal suffering (Hayes, et al., 1999). The central tenet is that only humans have language and only humans can suffer when there are no physical stimuli present to cause distress. For example, an animal will not be distressed if its need for food, warmth, and shelter are met; yet humans can have an abundance of material wealth and be completely miserable. We use our language skills to predict the future, to worry about the past, and with regard to happiness, to compare ours to the happiness of others. These authors argue that we can understand language through a basic science of verbal behaviour and that in doing so we can learn to use language without being trapped in it (Hayes, et al., 1999).

Acceptance and Commitment Therapy (Hayes, et al., 1999) is one of the family of behaviour therapies, along with Dialectical Behaviour Therapy (Linehan, 1993) and Functional-Analytic Psychotherapy (Kohlenberg, et al., 2005). As a therapeutic approach, ACT has mutual connections in the scientific laboratories of behaviour analysts and is developing from both clinic and laboratory based work. This pattern of mutual lab and clinical development is not common amongst psychotherapies. ACT is grounded in a theory of verbal behaviour called Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001) and rests on clearly articulated philosophical assumptions of functional contextualism (FC). To understand ACT it is necessary to consider the theoretical and philosophical assumptions as well as the clinical model.

*Relational Frame Theory - A Theory of Verbal Behaviour as the Foundation for ACT*

Relational Frame Theory is the theory of human language and cognition upon which ACT was developed (Hayes, Barnes-Holmes, & Roche, 2001; Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004). A detailed account of RFT is beyond the scope of this paper (for a detailed theoretical discussion of RFT the reader should refer to Blackledge, 2003; Hayes, et al., 2001; Ramnerö & Törneke, 2008); however, an explanation of the basic concept of ‘relating’ provides the grounding needed to link the philosophy, theory and therapy.

RFT has its roots in Skinnerian operant conditioning, and so the core principles of reinforcement, punishment and extinction are applicable. However, RFT builds on this by adding a newly argued principle of verbal behaviour - *arbitrarily applicable derived relational responding* (Hayes, et al., 2001). To clarify the definition of *arbitrarily applicable derived relational responding* and its relevance to ACT, the definition is described in the table below along with a clinical example to explain the meaning, practically and with clinical relevance. The example used is of Sarah, an adolescent with lowered mood, a history of being bullied and now attending a new school.

<i>Term</i>	<i>Definition*</i>	<i>Example:</i>
		Sarah reports to her therapist that when she walked past some kids at school today they stopped talking and she “knows” they think she is a “loser” and they do not like her.
Arbitrarily applicable	Incoming stimuli is related to other stimuli through our histories rather than any	Sarah’s conclusions are <i>arbitrary</i> because there are no formal properties relating the ceased conversation to her conclusion.

	formal properties of the stimuli	The notion is arbitrarily based on her verbal/social history.
Derived	Humans use inference rather than direct experience	Sarah has then <i>derived</i> from their stopped conversation that the new kids do not like her.
Relational responding	Humans relate stimuli in order to group the stream of incoming information from the environment into previously established relational networks	She has <i>related</i> their ceased conversation as equivalent to her previous experiences of bullying.

\* (Bach & Moran, 2008)

The above example describes in a more practical way that relational framing shapes our experiences within the context of our history through multiple exemplar training. In this example with Sarah, she has made sense of her experience relationally, based on its contextual qualities, and transferred the stimulus function from her previous experiences of bullying to this new situation (in this example the stimulus functions as a punisher because her social interaction behaviours are reduced). However, two important caveats must be considered along with this example. Firstly, in any behavioural account a functional assessment would be required, where the behaviour is assessed contingently by considering antecedent, behaviour and consequence. And second, her behaviour would be considered arbitrary only if she has never experienced a conversation stopping as she walked past (if she has, then her behaviour is contingently controlled).

A rapidly expanding program of research to test RFT is underway and has shown that relational responding develops with language and is evident even in early infancy (Lipkens, Hayes, & Hayes, 1993). Children with delayed language abilities, as seen in autism, also have delayed relational responding. Early intervention programs for children with developmental delay are showing that these basic

language skills can be trained (Cairns, 2009). Research is also showing that the cognitive components of some psychological disorders can respond to RFT training (Bach & Hayes, 2002).

In summary, relating is used to make sense of stimuli, and this sense making is based on our history of responding.

### *Functional Contextualism: The Philosophical Foundation of ACT*

Functional contextualism (Hayes, 1993) is a philosophical worldview that is important to describe here because it is the psychological space in which ACT treatment occurs. It is perhaps easiest to understand functional contextualism (FC) by contrasting it with a mechanistic view, simply because the mechanistic view dominates our explanations of human functioning, particularly biological functioning. This does not imply that one worldview is superior to another.

From a mechanistic viewpoint, healthy functioning is seen when an individual reports happiness and satisfaction with life. At a clinical level one would look for an absence of pathological thinking and perhaps an affirmative answer to the question, “Are you happy?” In this worldview, cognitions are equated with the metaphor of a computer or machine and when a person is suffering there is a ‘part’ to be fixed in order to correct the problem. This mechanistic view is clearly evident in depression theories and treatments. For example, Beck postulated schema were “cognitive structures within the mind” (Beck, 1995, p. 166) and argued that in the case of depression there are negative schemas of the self, world and future (Weersing & Brent, 2006). Thus cognitions such as “I must win” can be labelled as false beliefs,

automatic thoughts, or defective schema (Persons, 2001) and a goal would be to replace the faulty or irrational cognitions with new more rational ones such as “I would like to win” (Bach & Moran, 2008, p. 33). Thoughts can be viewed as causes of feelings or behaviours, with irrational thoughts leading to negatively evaluated feelings and dysfunctional behaviour. When thoughts are ‘corrected’ it is presumed that feelings and behaviour will also improve.

By way of contrast, in a functional contextualist worldview, suffering or unhappiness can be seen as either normal or problematic, depending on the context in which they occur. The act-in-context is the subject matter and therefore thoughts are not viewed as faulty, nor are they viewed as causes of behaviours or emotions (Ciarrochi, Robb, & Godsell, 2005). The target of change from this worldview is the *function* of thoughts - the thoughts themselves may or may not change. The underlying premise is one of pragmatism - there is no ‘right’ solution, only solutions that will work for an individual (Hayes, Luoma, Bond, Masudam, & Lillis, 2004). Successful working is the goal and this is achieved when the individual attains valued living and achieves desired goals, which may or may not include feeling unhappy or having unhappy thoughts (Bach & Moran, 2008).

To summarise, from a theoretical and philosophical view, the assumption behind ACT is that wellness cannot be defined by an absence of suffering or unhappiness. Taking RFT as a theory of language, we wish to use operant principles with a newly argued principle of verbal behaviour, that of ‘relating’, to effect more flexible verbal behaviour. And, taking the goals of functional contextualism, we wish to describe, predict, and influence behaviour in the historical and situational context in which the individual interacts. With this understanding we will now turn to an explanation of ACT as a psychological approach to change.

### *The ACT Model for Creating Change in Human Behaviour*

Acceptance and Commitment Therapy is a model for behaviour change with six key processes. The aim of ACT is to increase psychological flexibility, which is: “the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends” (Hayes et al. 2006, p7). Notably, ACT does not aim to eliminate suffering or to eliminate negative cognitions.

The ACT model is most commonly depicted using two hexagons (see figures 1 and 2). Figure 1 depicts the model of psychological distress and its six core processes that contribute to psychological inflexibility. The model of psychological wellness is shown in Figure 2 and depicts the six opposite processes that contribute to psychological flexibility.

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Insert Figure 1 about here

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Although each process will be described separately below it should be noted that the six processes are overlapping rather than discrete. In practice, clinicians use experiential techniques to expand an individual’s behavioural repertoire, ranging from metaphor, behavioural experiments, or physicalising exercises. The strength of ACT is that the theory and model is clearly articulated and so therapists can create exercises to suit a client, often this occurs spontaneously to match a client’s behaviour change needs. However, there are many exercises and experiences that have been published in manuals for use with a variety of client groups and more are being

developed and tested across the world (Bach & Moran, 2008; Harris, 2007; Hayes & Smith, 2005; Strosahl & Robinson, 2008). The ACT model begins with a functional assessment of the presenting problems.

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Insert Figure 2 about here

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*Avoidance versus Acceptance.* There is a wealth of empirical evidence showing that avoidance is a key factor in psychological problems (Foa, McNally, Steketee, & McCarthy, 1991; Zinbarg, Barlow, Brown, & Hertz, 1992). Avoidance is evident when an individual is unwilling to remain in contact with difficult private experiences or when they take steps to avoid the contexts in which they occur (Hayes, et al., 1999). The ACT model proposes that acceptance is the alternative to avoidance. Component studies have shown that increased acceptance is associated with reductions in avoidance and improvements in quality of life (Eifert & Heffner, 2003, Levitt et al., 2004, Vowles et al., 2007). Clinically, acceptance is developed through willingness experiences. This involves exposure to difficult thoughts and feelings - contrasting the paradoxical effects of pushing thoughts away, with the experience of willingly accepting these difficult experiences whilst also engaging in meaningful value driven behaviour. Individuals are encouraged to take steps toward valued behaviour even though distress may be present.

*Cognitive Fusion versus Cognitive Defusion.* Fusion occurs when thoughts become related to distressing stimuli. In ACT, thoughts and feelings are understood as cumulative and contextually controlled, they are therefore difficult to dismantle. Suppression of difficult thoughts has been shown to be ineffective, with greater

suppression related to higher dysfunction (Marcks & Woods, 2005; Marcks & Woods, 2007). Thus, defusion techniques in ACT do not aim to stop difficult cognitions or over-ride them with positive thinking. Rather an individual is encouraged to experience thoughts for what they are, symbols of one's history. Returning to our example in Table 1 with Sarah, she has the thought "I am a loser" and this thought cannot be erased; she cannot have the experience of never having had that thought. Therefore in certain contexts the thought "I am a loser" will arise. However, it is her behavioural response to her thought that causes the distress, not the thought as such. Defusion techniques aim to help clients notice that thoughts are symbols of history rather than descriptions of reality.

*Dominance of the Conceptualised Past or Feared Future versus Contact with the Present Moment.* ACT contrasts the suffering that arises when an individual spends more time thinking about the past or fearing the future – living in their heads – rather than living in the present moment. This is most evident with worrying and rumination. ACT helps individuals experience the present so they can contrast this as a different experience to worry and rumination over the past or future. A range of mindfulness techniques would be used, many adapted from other mindfulness work (for examples see, Hayes, 2004; Kabat-Zinn, 2005; Segal, Teasdale, & Williams, 2004). The direct experience of mindfulness becomes reinforcing and may elicit other behaviours that facilitate moving in valued directions.

*Self-as-Content versus Self-as-Context.* The processes entitled self-as-content versus self-as-context, can be confusing for people learning the ACT model. Self-as-content describes the conceptualised self, which is evident in the descriptors, labels, and images that an individual constructs. For example, "I am right", or, "I am worthless". In the ACT model, when one is too attached to these conceptualisations

they take on a regulatory role, reducing flexibility and inhibiting behaviour (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). ACT approaches this by using experiences that help an individual to gain perspective on this process and to experience their ‘self’ as the context in which all thoughts and behaviours arise. In other words, their thoughts come and go, but they are not their thoughts. Mindfulness exercises are central here in creating an experience of this transcendent nature of the self. A common metaphor is the chessboard, where thoughts and other content are black and white chess pieces, but the individual is the chess board – unchanging and able to hold all their experiences, thoughts and feelings (metaphor adapted from Hayes, et al., 1999).

*Lack of Values Clarity versus Valued Living.* Values work is the heart of ACT. Values work is where clients find meaning and purpose – within the ACT model this takes precedence over the transient emotion of happiness. Eliciting deep-seated values can provide the motivation needed for behaviour change and build the willingness to experience unwanted thoughts and feelings that might accompany valued action. The model purports that lack of valued living, unclear values, and rigid verbal behaviour (“I should do X...”) are all evidence of psychological inflexibility (Hayes, et al., 2006). These behaviours share a commonality in that they all pull the client away from behaviour that is self-fulfilling. For example, an individual that shows excessive pliance would behave in socially expected ways in order to please the peer group, rather than behave in ways that are personally meaningful.

Experiential exercises are often used to make explicit how valued actions are the outcome of interest. The *Skiing Metaphor* is reproduced below as an example of how valued living can become overt:

*Suppose you go skiing. You take a lift to the top of a hill, and you are just about to ski down the hill when a man comes along and asks where you are going. "I'm going to the lodge at the bottom," you reply. He says, "I can help you with that," and promptly grabs you, throws you into a helicopter, flies you to the lodge, and disappears. So you look around kind of dazed, take a lift to the top of the hill, and you are just about to ski down it when that same man grabs you, throws you into the helicopter, and flies you to the lodge. You'd be upset, no? Skiing is not just the goal of getting to the lodge, because any number of activities can accomplish that for us. Skiing is how we are going to get there. You notice that getting to the lodge is important because it allows us to do the process of skiing in a direction. If I tried to ski uphill instead of down, it wouldn't work. Valuing down over up is necessary in downhill skiing. There is a way to say this: outcome is the process through which process can become the outcome. We need goals, but we need to hold them lightly so that the real point of living and having goals can emerge. (Hayes, et al., 1999, p. 220)*

*Inaction, Impulsivity, or Avoidant Persistence versus Committed action.* ACT purports that individuals who are psychologically inflexible behave impulsively, have difficulty taking goal directed action, and fail to keep commitments or avoid setting goals at all. In contrast, psychologically flexible individuals are able to take committed action that takes them in a valued direction. Committed action includes the standard behavioural techniques such as behavioural activation, skills training, and goal setting. The ACT therapist engages an individual in values work as the driving force to commit to action. From there basic behavioural interventions would be used, including small action changes, setting goals, and weekly homework.

### *Research Investigating the ACT Model*

Research testing the ACT model includes (a) correlational studies that examine the processes in the model, (b) clinical treatment studies, and (c) outcome studies conducted in non-clinical settings, including organisational settings, health

settings (smoking prevention), counsellor burnout, and child development (autism). For a comprehensive review, see Hayes et al, 2006. A short summary follows.

*ACT with adults.* In adult studies, the underlying principles of ACT have been demonstrated in a meta-analysis across 32 studies with 6628 participants (Hayes, et al., 2006). In this analysis psychological flexibility was associated with improved quality of life and life outcomes, while inflexibility has also been correlated with poorer mental ill-health (Bond & Bunce, 2000, 2003; Donaldson-Feilder & Bond, 2004).

ACT outcome research with adults has shown this treatment is trans-diagnostic and can achieve positive long-term outcomes for depression, anxiety, psychosis, chronic pain, work stress, stigma and burn-out (Hayes, et al., 2006; Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004). In a 2006 review across 21 studies (Hayes, et al., 2006) the weighted mean effect size was 0.66 at posttreatment ( $N=704$ ) and this was maintained at follow-up ( $ES=0.66$ ,  $N=519$ ). The effect sizes remain large at posttreatment ( $ES=0.48$ ,  $N=456$ ) when ACT is compared with control groups that have active well-specified treatments, and this large effect continues improved through to follow-up ( $ES=0.63$ ,  $N=404$ ) (Hayes, et al., 2006).

With regard to outcome studies in non-clinical settings, ACT has been shown to improve well-being and general health in organisational settings, where it is generally relabelled as Acceptance and Commitment Training, rather than therapy. The aim is to improve wellbeing, as evidenced by increased psychological flexibility. To test this effect in the workplace, Bond & Bunce (2000) used an experimental design and compared ACT with an alternative workplace intervention and a control group. They found that changes in workplace outcomes were mediated by increases in

psychological flexibility, as seen by acceptance of undesirable thoughts and feelings (Bond & Bunce, 2000). Other studies have shown that counsellors trained in ACT have reported lower burn-out rates (Hayes, Bissett, et al., 2004).

In health settings, ACT has also been shown to be an effective treatment. There is strong evidence for chronic pain treatment showing improvement in life satisfaction and less pain disability in adult and paediatric populations (Vowles & McCracken, 2010; Wicksell, Ahlqvist, Bring, Melin, & Olsson, 2008; Wicksell, Melin, Lekander, & Olsson, 2009; Wicksell, Melin, & Olsson, 2007). Positive findings have been shown for management of chronic illness, including diabetes management (Gregg, M., Hayes, & Glenn-Lawson, 2007), epilepsy (Lundgren, Dahl, Yardi, & Melin, 2008), obesity and weight management (Forman, Butryn, Hoffman, & Herbert, 2009; Hayes, et al., 1999), and cigarette smoking (Bricker, Mann, Marek, Liu, & Peterson, 2010).

Mediational analyses to test the process of change in ACT treatment work shows that ACT processes mediate the changes seen in therapy (Ciarrochi, Bilich, & Godsel, 2010). Many studies have shown that post-test improvements in outcomes are mediated by psychological flexibility also measured at posttest. However, the strongest evidence of mediation is shown in studies where the changes in flexibility preceded changes in outcome. For example, using the Zettle and Hayes (1986) data on depression to test for mediation, Hayes et al. (2006) found that the believability of depressive thoughts taken mid-treatment were predictive of significantly different treatment outcomes for ACT when compared with CT.

*Changing our Culture: Can ACT Help Future Generations?*

Although it is a tall order, a task of psychology is to reduce suffering in future generations. It seems appropriate therefore to consider whether ACT might contribute to change through future generations.

Adolescent studies are encouraging although more are needed. Empirical work on psychological inflexibility in adolescents (two samples,  $N=513$  and  $N=675$ ) has shown that inflexibility is positively correlated with clinical measures of anxiety, somatisation, and behaviour problems, and negatively correlated with quality of life, social skills and academic competence (Greco, Lambert, & Baer, 2008). With regard to treatment studies, Wicksell and colleagues trialled ACT on adolescents with chronic pain across two studies, a randomised controlled trial (Wicksell, et al., 2009) and an earlier pilot study (Wicksell, et al., 2007) and found that ACT treatment resulted in significant improvements in functional ability, pain intensity, and pain related discomfort. Finally, Hayes, Boyd and Sewell (under review) also found positive results for ACT with adolescents in a randomised trial comparing ACT to treatment as usual for depression in a psychiatric setting. With regard to intervention in schools, one RCT has been completed, comparing ACT to passive control with adolescents and showed significantly improved outcomes up to two years later on measures of stress and psychological flexibility (Livheim, 2004), and a group study has shown ACT can be effective for group work with adolescents in schools (Hayes, Rowse, Turner, 2009). Although these results with young people are preliminary the future is likely to see tests of ACT at prevention and early intervention levels for children and adolescents.

### *Conclusion*

Epidemiological data shows that psychological distress is a significant problem in developed countries and that reducing the prevalence of distress at a population level is daunting. Acceptance and Commitment Therapy may be a valuable approach for working with human suffering and unhappiness. ACT has philosophical foundations that emphasise the function of behaviours, and is based on a theory of verbal behaviour that continues to be vigorously tested in laboratory studies. ACT as a therapeutic and training model, aims to develop psychological flexibility, encouraging individuals to move in valued directions in life rather than wait until their unhappiness is resolved. Recent ACT outcome and mediational studies suggest that psychological flexibility can be a target of treatment and it can show positive outcomes that are maintained at follow-up.

Perhaps the greatest strength of the ACT model comes from its comprehensive approach, where researchers and clinicians are working together across science and clinical applications. Although work on the model began more than 20 years ago, the past 10 years have seen an explosion in ACT and RFT work across the world with over 40 books published in nine languages and a wealth of empirical studies. This work is underpinned by a philosophical approach where human suffering is seen as part of the human condition. Developing greater psychological flexibility can help individuals live with their difficult experiences as well as increasing value directed living. In this way, perhaps directing our efforts towards helping others increase meaning and value in their lives can make changes more broadly in our society. This demands that happiness is relegated to its rightful place, as an emotion that is pleasant but transient.

*Recommendations for practitioners:*

- The breadth of research and treatment material for ACT is extensive. An online learning and research community can be found at the Association of Contextual Psychology website ([www.contextualpsychology.org.au](http://www.contextualpsychology.org.au)). This is a good place to look around ACT and find literature and practice materials to try on the model.
- ACT is a comprehensive model of treatment that can be flexibly used where human suffering is evident. The model is trans-diagnostic and useful in clinical and non-clinical settings.
- Many new practitioners find that ACT comes to life when they experience the model in ACT workshops. Written language falls short in this regard.
- ACT practitioners are encouraged to see how the model works in their own lives. The underlying assumption of the model is that we all suffer, practitioners and clients alike and we can find greater meaning in life when we tune into our experience.

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## Figure Captions

Figure 1. ACT Model of Psychopathology (Hayes, Luoma, Bond, Masuda, & Lillis, 2006)

Figure 2. ACT Hexaflex Model of Therapeutic Processes (Hayes, et al., 2006)