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VALUES IN ACCEPTANCE AND COMMITMENT THERAPY: A COMPARISON WITH FOUR OTHER APPROACHES

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Abstract: Personal values represent an integral component in Acceptance and Commitment Therapy (ACT), an acceptance-based modern behavioral psychotherapy. Many other psychological approaches have held values to be central to living life. This paper compares and contrasts ACT's approach to values with four other approaches: client-centered therapy, Motivational Interviewing, positive psychology, and radical behaviorism. The ACT model is described as well as the role of values within that model, and brief clinical examples are provided to illustrate how the ACT approach to values may be used in practice.

Key words: Behavior analysis, Motivational Interviewing, Positive psychology, Values.

INTRODUCTION

The primary aim of the present article is to describe the Acceptance and Commitment Therapy model (ACT; Hayes, Strosahl, & Wilson, 1999), an acceptance-based, modern behavioral psychotherapy model, and to explain how it treats personal values, which represent a central component of the ACT model. As a therapy rooted in modern behavior analysis, ACT builds on B. F. Skinner's (1971, 1976) approach to values, but it also shares elements with other approaches to this topic, including the client-centered approach of Carl Rogers (Rogers, 1961/1989), and modern outgrowths of that tradition including Motivational Interviewing and positive psychology.

Before describing the ACT model, we will review the approaches to values of Carl Rogers, Motivational Interviewing, positive psychology, and B. F. Skinner. Having described these, a more detailed account of the general ACT model will

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then be presented, followed by a description of the ACT conceptualization of values. In the course of describing the ACT model and ACT's conceptualization of values, we will draw parallels and distinctions with the other four approaches. Finally, clinical examples of the therapeutic utility of the link between values and pain will be discussed from the ACT perspective.

FOUR APPROACHES TO VALUES

Client-centered therapy

Carl Rogers' client-centered therapy is built on the assumption that each individual has a natural tendency to actualize – "to become his potentialities." In other words, the individual has the «urge to expand, extend, develop, [and] mature» (Rogers, 1961/1989, p. 351). According to Rogers (1961/1989), this actualizing tendency may be buried under thick layers of psychological defenses, such as putting on façades and living to please others and to meet external moral standards. The process Rogers (1961/1989) describes as unfolding in therapy is a movement away from these defenses, and it is made possible by the therapist's stance of unconditional positive regard, congruence (between what the therapist experiences and expresses), and empathy. Through this process, the client moves toward self-direction, openness to experience, complexity, acceptance of others, and trust of self. Rogers (1964) adopts Charles Morris's (1956, pp. 9-12) distinction between "operative values" (preferences shown through behaviors) and "conceived values" (preference for a symbolized object). According to Rogers (1964), the infant's way of valuing is wholly operative, emerging from a thorough contact with one's experience in the present moment, and the value choice is made through an internal organismic process rather than through conscious deliberation. Over time, the infant comes to adopt a more conceived way of valuing, which is more rigid and inefficient, and it does so by introjecting judgments of others, for example those of his/her parents, in order to keep from losing their love.

In therapy, Rogers provides an environment of unconditional positive regard in which the client «senses and realizes that he is a prized person» (Rogers, 1964, p. 163) and can return to trusting his experience to guide his valuing. However, the client does not totally abandon conceived valuing. Rather, conceived values become directly and continually informed by and tested against experience, and the mature valuing that emerges is fluid and flexible. An awareness of experience in the present moment is essential to mature valuing, but this does not preclude consideration (in

that moment) of the past or the future. In short, the mature individual comes to trust all of himself, not just his mind.

Rogers (1964) hypothesizes that the human being's animal capacity for adjusting his behavior based on feedback from his environment is the basis for the valuing process. Further, to the degree that a person is open to his experience, this valuing process will enhance his/her life and the lives of others and contribute to the survival and evolution of the species. The values that emerge from this evolutionarily advantageous valuing process are universal: being real instead of a façade, being self-directed instead of working for the approval of others, being open to his/her experience, being sensitive to others, and pursuing deep relationships. These universal values are different from those previously conceived by social institutions in that they emerge from within the individual rather than being imposed upon him (Rogers, 1964).

Motivational Interviewing

Motivational Interviewing (MI) is «a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence» (Rollnick & Miller, 1995, p. 326). Although it was originally developed to motivate clients to decrease problematic alcohol consumption, MI has been applied to many other areas, including other drugs, smoking, medication compliance, diet, and exercise (Miller & Rollnick, 2002). Consistent with its roots in Rogerian client-centered therapy, MI emphasizes empathy (i.e., acceptance of the client, use of reflective listening, and normalization of the client's ambivalence) as a core therapeutic principle. In addition, the therapist avoids argumentation and the use of judgmental labels (e.g., alcoholic, addict) and rolls with the client's resistance by switching therapeutic strategies. MI departs from a Rogerian approach in that MI therapists do offer their own advice when appropriate and consciously work toward cultivating motivation for change by highlighting a discrepancy between the client's values and behavior (Miller & Rollnick, 2002). Wagner and Sanchez (2002) draw from Morris's and Rogers' conceptions of values and define values from an MI perspective as «either behavioral ideals or preferences for experiences» (p. 285). Behavioral ideals are defined as judgments about the goodness of behavior and corresponding prescriptions about the behaviors in which one should engage. Preferences for experiences involve valuing a behavior for the subjective experience of it (e.g., joy, satisfaction).

A key process in MI is guiding clients to notice the consequences of problematic behavior and the discrepancy between these consequences and their goals and values. Wagner and Sanchez (2002) describe three ways in which behavior may be

discrepant from values. First, the behavior may be self-oriented, benefiting the person engaging in it but harming others. Second, the behavior could be short-sighted, benefiting the individual in the short term but not in the long term, and third, the behavior could be inefficient, consistent with some of the client's values but inconsistent with others. Thus, MI does not view people who engage in problematic behavior as being bereft of values or the victims of a disease. Rather, they are simply choosing behaviors that do not allow them to effectively live consistently with all of their values. Discussing behaviors that might be self-oriented, short-sighted, or inefficient can help both counselor and client to discover and clarify the client's values, which may function as important motivators for change. Focusing on values also provides a non-confrontational way of highlighting the discrepancy between behaviors and values. Viewing problematic behaviors as misguided attempts to pursue valued ends may therefore be important in decreasing resistance to change. The counselor could thus help the client to see opportunities for behavior that is more consistent with all the client's values and to set values-consistent goals, thus increasing hope and confidence.

Positive psychology

Positive psychology (Seligman, 2002) grew out of a reaction to the dominance within psychology of the disease model of mental functioning. Since World War II, psychology has made great strides in the treatment of mental illness but has neglected its previous missions of fostering productivity and fulfillment and identifying and nurturing high talent. Positive psychology's aim is to revive these foci by studying and promoting happiness and well-being—two terms which are used interchangeably—and Seligman (2002) puts forth three positive lifestyles. The first is the pleasant life, which is centered around the pursuit and experience of positive emotions. The second is the good life, which is marked by the pursuit of gratification through the use of one's signature strengths. Seligman (2002) defines gratifications as a class of positive emotions about the present but also notes that «they are not feelings but activities we like doing» (p. 262). We become absorbed in gratifications, and felt emotion and self-consciousness are blocked in the present moment. Finally, the meaningful life involves the application of signature strengths and virtues to a purpose that is larger than the individual's particular needs and desires.

In reviewing the relation between well-being and values, Sagiv, Roccas, and Hazan (2004) draw on Rokeach's (1973) and Schwartz's (1992) ideas to define values as «social-cognitive representations of motivational goals. They are desirable goals that vary in importance and serve as guiding principles in people's lives»

(Sagiv et al., 2004, p. 68). To provide a sample of the work in this area, we will briefly review research from two perspectives discussed by Sagiv et al. (2004): the healthy values perspective and the goal attainment perspective.

Research from the healthy values perspective investigates the idea that holding certain values promotes well-being, while holding other values diminishes it. Following self-determination theory (SDT; Deci & Ryan, 1985, 1991), many researchers from the healthy values perspective distinguish between intrinsic and extrinsic motives. Intrinsic motives are derived from basic internal human self-actualization needs, and goals pursued for these motives have the capacity to be independently satisfying. In intrinsic motivation, behavior is autonomous, meaning that it is «self-endorsed, volitional, and done willingly; that is, it is *self-determined*» (Brown & Ryan, 2004, p. 105). Behavior that is extrinsically motivated, however, is focused on punishments or rewards such as securing others' approval or avoiding their censure; such behavior is externally determined. Research conducted from this perspective has shown that people who rate intrinsic goals (e.g., competence) as more important than extrinsic goals (e.g., financial success) experience more well-being than those with the reverse pattern of importance ratings (e.g., Kasser & Ahuvia, 2002; Kasser & Ryan, 1993, 1996).

The goal attainment perspective hypothesizes that the attainment of goals is important for well-being. Sheldon and Elliot (1999) contend that self-concordant (i.e., intrinsic) goals contribute more to well-being because they reflect inherent psychological needs and therefore are pursued by the individual with more persistence. In contrast with research from the healthy values perspective, Sheldon and Elliot (1999) did not categorize goals as intrinsic or extrinsic a priori. Rather, they asked participants the reasons why they were pursuing each goal, and indeed found that self-concordance predicted persistence at the goal, which in turn predicted attainment of the goal and well-being.

According to Brown and Ryan (2004), the absence of salient punishments or rewards as well as social supports for competence (self-efficacy) and relatedness (secure attachment to the teacher of an activity) tend to cultivate autonomous behavior and the pursuit of intrinsic goals. These external influences on autonomy may be augmented by the internal resource of mindfulness, which Brown and Ryan (2004) define as «an open or receptive awareness of and attention to what is taking place in the present moment» (p. 116). Mindfulness increases autonomy by bringing salient cues and other behavioral controls into awareness, where they may be weighed or ignored in making conscious choices about action. Thus, mindfulness allows the individual to transcend the processes giving rise to automatic, externally controlled behavior and to exercise choice from within.

Psychotherapeutically, the positive psychology approach de-emphasizes the medical model of mental illness, in which suffering is categorized into syndromes, each with a particular prescribed treatment (Joseph & Linley, 2004). Instead, it emphasizes the Rogerian idea of the actualizing potential and follows SDT (and Rogers, 1964) in creating therapeutic contexts in which people move toward intrinsic motivation and autonomy. To this end, Rogers' (1961/1989) techniques of unconditional positive regard, empathy, and congruence may be supplemented with mindfulness techniques and the identification and enhancement of signature strengths, the exercise of which is thought to satisfy fundamental psychological needs.

Radical behaviorism

Although behaviorism is not generally associated with purposeful action for those outside of the tradition, Skinner (1976, p. 61) believed that «operant behavior is the very field of purpose and intention. By its nature it is directed toward the future: a person acts *in order that* something will happen, and the order is temporal». The future that operant behavior is directed towards, however, is actually the past—a history of reinforcement. This history is the cause of the action, and it is an external one. Thus, the cause of a person's loyalty to a loved one, for example, is not internal. It is not a drive to be loved or a belief of being loved. It is rather a history of contact with that loved one. Values (things that are called "good"), for Skinner, are positive reinforcers—they are what purposeful behavior is directed toward (Skinner, 1971). In other words, valuing is behavior under appetitive control. In contrast, behavior shaped by negative reinforcement is under aversive control.

Reinforcers have reinforcing effects because the capacity to be reinforced by them has conferred some evolutionary advantage to the individuals who possess it. They are reinforcing for their survival value. This is similar to Rogers' (1964) view that universal values of self-direction, close relationships, etc. are evolutionarily advantageous. For Skinner, this implies that values are *not* reinforcing because of the feelings they produce. Thus, if one says s/he has a sense of meaninglessness, anhedonia, emptiness, or hopelessness, the important thing that is missing is not a sense of meaning, drive for pleasure, feeling of fullness, or hope. It is contact with things in the world that happen to produce these feelings as by-products: «the important thing is not the feeling, but the thing felt» (Skinner, 1971, p. 102).

Although values are things that exist in the natural world, their value lies not in their physical properties. Consistent with Skinner's functional approach, their value lies in their function for the individual. Other natural sciences, such as physics, focus

on the properties of things more than on their functions, and in that sense values are not the province of those sciences. A functional natural science of human behavior, however, is exactly the approach that may speak to what is valued because it examines the reinforcing effects of consequences.

In addition to behaving for our own good (i.e., reinforcement), it is possible to behave for the good of someone else—that is, for one's behavior to be reinforced by social consequences of approval, affection, praise, etc. "Should" and "ought" statements for Skinner (1971) are statements specifying that such consequences are contingent upon certain behaviors. These statements, for Skinner, do not convey "meaning" between "minds". Rather, such a statement is operant *behavior*—it is uttered not because of its meaning or truth value in a literal sense but because of the similarity of the current situation to past situations in which the utterance had a reinforcing effect (e.g., the correspondence between saying and doing – "telling the truth" – has led to reinforcing consequences).

Behaving according to others' values (behaving for the good of others) by obeying such statements may confer advantages on the individual behaving and thus may be considered behaving for one's own good. For instance, obeying one's teachers reinforces them and allows one to learn useful skills. According to Skinner (1971), there should be a balance between behaving for one's own good and behaving for the good of others because each may be done to excess. For example, excessive behavior for the good of others may result in one's exploitation.

ACCEPTANCE AND COMMITMENT THERAPY: THE GENERAL MODEL

Acceptance and Commitment Therapy (ACT, said as one word, not A-C-T; Hayes et al., 1999) is a behavioral therapeutic approach whose goal is to enable clients to live a more valued life by enhancing psychological flexibility. The barriers to psychological flexibility, which ACT works to undermine, involve verbal processes which have been investigated in the context of Relational Frame Theory (RFT, said as separate letters, not one word; Hayes, Barnes-Holmes, & Roche, 2001), which is a post-Skinnerian behavioral account of human language and cognition.

Philosophy of science

The ACT model is integrated with a radically pragmatic, monistic set of scientific assumptions known as functional contextualism (Biglan & Hayes, 1996; Hayes,

1993; Hayes & Brownstein, 1986; Hayes, Hayes, & Reese, 1988). It is more similar to constructionist approaches such as feminist psychology, hermeneutics, dramaturgy, or social constructionism than to the realistic and mechanistic assumptions of the psychological and Cognitive Behavioral Therapy (CBT) mainstream (Hayes, Hayes, Reese, & Sarbin, 1993) but with a distinct goal. Functional contextualism views truth as the incremental achievement of prediction-and-influence with precision, scope, and depth. As a result, in ACT all concepts need to be linked to context, defined both historically and situationally, since only variables that can be directly manipulated can lead directly to both prediction *and* influence (Hayes & Brownstein, 1986). The ACT rejection of cognitive and emotional causality, the clinical emphasis on values, the de-emphasis of an interest in literal truth, and an emphasis on workability all flow from the radical pragmatism of its underlying philosophy.

Basic foundation

The ACT model is part of modern behavior analysis, or "contextual behavioral science." All of the hard-won and well-established behavioral principles within that tradition are part of the conceptual armamentarium of ACT, but these are expanded by RFT, which has grown to encompass scores of empirical studies on language functions (Hayes et al., 2001). According to RFT, learning to derive relations among events based on arbitrary contextual cues is the key feature of human language and cognition. It begins with the relation between words and objects. If that arbitrary relation is specified in one direction (e.g., this object is named X), even infants (Lipkens, Hayes, & Hayes, 1993) will derive the mutual relation (e.g., X refers to the object). This simple relation will be followed quickly by relations of comparison, time, hierarchical attributes, and so on. There is a growing body of evidence that these relational abilities in fact are operant behavior (Berens & Hayes, 2007; Luciano, Gomez-Becerra, & Rodriguez, 2007).

Relational skills are necessary to human functioning. Verbal problem-solving involves deriving networks of this sort: "because of situation Q, if I do X, Y will follow, which is better than Z." From an RFT perspective such actions involve a small set of relational abilities: names, hierarchical attributes, comparisons, and time or contingency. These relational skills allow many people to be warm, dry, and well-fed – conditions that in other species would constitute the best kind of life possible – but RFT and ACT theorists argue that these same skills also lead to human suffering until humans learn to bring these skills under better contextual control.

The ACT model of pathology

There are a number of challenges presented by these relational abilities. They mean that people can readily remember past pain in the absence of a reason to do so; can compare their condition to an unrealistic ideal; can fear an imagined future; or label, evaluate, and attempt to avoid normal human emotions. In other words, language and cognition can lead naturally to a key process in the ACT model of human suffering: experiential avoidance. Wilson, Hayes, Gregg, and Zettle (2001) have defined experiential avoidance as «the tendency to attempt to modify the form, frequency, or situational sensitivity of private events (thoughts, feelings, memories, behavioral predispositions) even when this effort produces behavioral harm» (p. 215).

Experiential avoidance is argued to be part of why human suffering is so widespread. For example, the annual prevalence of mental disorders in the developed world is approximately 30% (Kessler et al., 1994; Regier et al., 1993). Further, rates of comorbidity among traditional syndromal categories, their low treatment utility, and the lack of biological markers for mental illnesses have led ACT to eschew the medical model of mental illness in favor of an assumption of destructive normality. That is, human suffering is regarded as the result of a *normal* human process, specifically language and cognition, rather than a defect or abnormality.

A good deal of evidence points to the ineffectiveness of experiential avoidance. For example, Wegner (1994) found that the suppression of thoughts leads to a temporary decrease in their frequency followed by a large increase. This temporary decrease may help to explain the finding that when clinical and non-clinical samples are asked what they do when they encounter negative thoughts or feelings, avoidant suppressive strategies (e.g., distraction) are among the most frequently cited (Brewin, Watson, McCarthy, Hyman, & Dayson, 1998; Rippere, 1977). In addition, there is evidence that people who employ emotionally avoidant coping strategies are more likely to later develop psychopathology (Rohde, Lewinsohn, Tilson, & Seeley, 1990).

One reason why experiential avoidance is unsuccessful may be that the avoidance rule evokes the event to be avoided. For example, imagine a person with a fear of heights on a high, shaky footbridge. If the person tries to follow the rule "Don't think about falling because it'll make you anxious", this will involve the person checking to see if s/he is thinking about falling. In doing so, s/he must actually think about falling. In addition, if being anxious is something to be avoided, the mere possibility of anxiety may itself provoke anxiety. This is an example of the application of verbal problem-solving processes to a domain where they are ineffective. That is, treating external problems as things to be avoided or eliminated is often effective,

but treating events of the world within the skin (e.g., anxiety) as such is counter-productive. For instance, if one wanted to keep from falling by strengthening the bridge, one could take verbally-guided steps to avoid this negative outcome, but applying the same strategy to automatic thoughts is doomed to failure.

Although the other approaches discussed above do not incorporate an assumption of destructive normality, they do share in ACT's rejection of the medical model. In Skinner's (1976) approach, the level of analysis is the whole person interacting in and with the environment; internal causes are not sought because they are not directly changeable while the environment is. Since the goal of behavior analysis is to predict and influence behavior and the definition of truth is pragmatic, this leads to the environmentalism of the approach (Hayes & Brownstein, 1986). Problematic behavior, then, is not the outward manifestation of internal chemical or mental abnormalities but is rather the product of contingencies that promote and maintain unhealthy action, including an unhealthy and avoidant posture toward difficult private experiences. Such a conceptualization is important clinically because the clinician may only intervene by establishing contingencies for the client using the clinician's in-session behavior. Even if it were important to change internal causes, the clinician would still only be able to intervene at the level of the environment. From this perspective, the client has all the tools to succeed but simply has not had a history sufficient to produce effective behavior. This is similar to the MI perspective in that it does not regard the client as sick but rather regards the client's choices (behavior) as ineffective.

Skinner's behaviorism appeals to broader principles (e.g., reinforcement) to explain problematic behavior, and this contrasts with the medical model's assumption of distinct etiologies for different syndromal categories. Rogers, positive psychology, and MI also favor broader principles to understand suffering and well-being, but these principles generally involve internal entities with putatively causal status. For Rogers and positive psychology, suffering is a result of the masking of the internal actualizing tendency, and in MI clients are initially not in touch with their motivation for change, which originates from within. ACT embraces somewhat similar concepts but language and cognition processes are viewed as classes of instrumental behavior, and this aligns ACT most closely with Skinner's approach.

According to ACT, human behavior is replete with instances in which the dominance of language processes (including private language processes, i.e., thinking) over behavior has needlessly contributed to suffering. For example, a person who values connection with others may avoid social situations because of the behavioral impact of the thought "No one will like you." This impact is not automatic – the thought does not cause the avoidance – rather in certain historical and current con-

texts thought and action are linked in an unhealthy way. In addition, panic attacks in response to being in small, enclosed spaces may generalize to the situation of feeling "trapped" in a relationship, and this occurs not because of any formal similarity between small spaces and relationships but rather because the relationship and small spaces are *verbally* related. When certain contexts influence individuals to take their categorizations and evaluations of other people literally, those individuals respond to other people as the evaluated categories in which they've been placed and fail to get to know them as other individuals.

An ACT model of intervention

In light of the fact that suppressive, avoidant coping strategies are so common in our culture, ACT regards therapy clients as culture's treatment failures and therefore offers them an alternative: acceptance. The English word "acceptance" is derived from the Latin "accipere," which means to receive or take what is offered. Hayes et al. (1999) define acceptance as «an abandonment of dysfunctional change agendas and an active process of feeling feelings as feelings, thinking thoughts as thoughts, remembering memories as memories, and so on» (p. 77). In our culture, however, the word "acceptance" is sometimes used in a different way. It may be synonymous with "tolerance," which is a begrudging, resigned way of experiencing. For example, a depressed client who is merely tolerating sad moods might say: "I don't like feeling sad all the time, but it doesn't look like it's going away, so I guess I should just put up with it." Another way of experiencing that is sometimes confused with acceptance is "white knuckling", that is, participating in a situation superficially while trying to experience as little of it as possible. An agoraphobic client may employ this strategy when taking a trip to the store. Here, the client engages in the feared behavior (going to the store), but the associated private events (anxiety, etc.) are fought strenuously. The stance in "white-knuckling" is: "If I resist this experience hard enough, I'll get through it." Neither tolerance nor white-knuckling exemplify the spirit of approach involved in acceptance. An accepting stance with respect to sadness or anxiety would involve welcoming it, feeling it fully, exploring it, and not engaging in attempts to ignore, change, or ameliorate it. The ACT conceptualization of acceptance echoes a key direction Rogers saw the client taking in therapy: «He approaches the realization that he no longer needs to fear what experience may hold, but can welcome it freely as a part of his changing and developing self» (Rogers, 1961/1989, p. 185). In addition, the Rogerian therapeutic stance of unconditional positive regard, which is also incorporated into MI and positive psychotherapy, is consistent with the ACT view of acceptance in that the therapist has

room for whatever behavior the client may emit and does not engage in direct change strategies. The MI principle of rolling with resistance exemplifies this accepting stance towards client behavior.

A second ACT process is highlighted in the latter part of the definition of acceptance above. That is defusion, which may be defined as a stance of relating to private events (thoughts, feelings, memories, bodily sensations, etc.) as what they are (just "things that the mind does") rather than what they advertise themselves to be (e.g., literal content, causes for behavior). Thus, defusion represents treating the thought: "I'll never amount to anything" as simply a thought and not as an accurate (or inaccurate) prediction. By contrast, fusion leads to the dominance of verbal regulatory functions as a result of taking thoughts literally, or "buying into" them. Metaphorically, fusion with a thought or feeling is characterized by looking at the world *from* or *through* the thought or feeling as a fact about the world rather than *at* it as a private event. Treating thoughts or feelings as causes of one's behavior is a hallmark of a fused stance, and a defused stance toward a sad mood, for example, would be to simply view it as an emotional event, rather than a reason (i.e., a cause) for one to stay in bed all day. Defusion may support acceptance in that a thought as an event may be easier to accept than the content of that thought. Both acceptance and defusion reduce the behavior regulatory functions of private events because they alter the functions of relational networks. This is important in understanding ACT. Relational Frame Theory argues that these relational skills are learned. If verbal networks are learned behavior, they cannot be simply unlearned. Thus, direct cognitive change is very difficult; from an RFT perspective it is far easier to change the function of existing cognitive networks by changing their context. That is what acceptance and defusion arguably do.

Adopting an accepting, defused stance towards private events involves contacting them. Necessarily, this is done in the present. Language allows us to reconstruct the past and to imagine the future, and to the extent that we relate to these constructions and imaginings as if they were real, here, and now, we lose contact with what actually *is* real, here, and now. Thus, ACT advocates contact with the present moment as a way for clients to contact the actual contingencies in their lives rather than the verbally constructed futures which may have little to do with the real world. Importantly, this is not so much about correcting the products of verbal behavior (e.g., attitudes, beliefs, predictions, worries) as it is about contacting reinforcers that may enhance living and shape behavior to be more effective.

The view of the self that emerges from and facilitates the processes of acceptance, defusion, and contact with the present moment is self-as-perspective. This is the self as an observer of events, public and private. It contrasts with self-as-content,

which represents a fused conceptualization of the self as verbal content (e.g., I am attractive; I am inconsiderate). Likewise, self-as-perspective contrasts with self-as-process, which represents the moment to moment observation of cognitive and affective states (e.g., Now I am feeling sad). Self-as-process is useful socially because emotional talk allows us to communicate our behavioral dispositions to others and allows us to predict the behavior of others. Self-as-process is healthy but the moment-to-moment fluidity of self-as-process can easily become ossified into self-as-content as categorical descriptions are inferred from emotional states. For example, after noticing many times that one's mood is sad, one may conclude that s/he is simply a "depressed person," and the repertoire-narrowing effects of this conceptualization could be extensive.

Self-as-perspective is not repertoire-narrowing as is self-as-content. From this stance, one may notice anything, whether or not it is consistent with verbal constructions of mood or trait. Self-as-perspective is a defused stance (a stance that views verbal processes as verbal processes and not as content) that is consistent with acceptance and present moment awareness.

The four processes listed above (acceptance, defusion, contact with the present moment, and self-as-perspective) are regarded as the mindfulness processes of ACT. These processes are key in many mindfulness meditation traditions but may (and should) be applied broadly to situations outside of formal meditation practice. They are, however, not ends in themselves. The goal of ACT, as a behavior therapy, is to change behavior, and mindfulness processes are only useful to the extent that they remove barriers to and provide the context for committed action. Thus, ACT seeks to apply acceptance strategies to domains that cannot readily be directly changed (e.g., thoughts, feelings, memories) and to apply change strategies to situations and overt behavioral domains. In ACT, committed action is defined as behaving in a way that moves towards concrete goals. Although goals and the planning of behavior in the direction of those goals involve a great deal of verbal behavior, there is a significant nonverbal quality of carrying out committed action, i.e., "putting one foot in front of the other." For example, one may plan to go on a job interview and think about what it may be like (verbal behavior), but actually going to the interview and experiencing it in the present (contact with real-world contingencies) is a different process entirely. Mindfulness processes like acceptance and defusion support committed action in that they reduce the behavior regulatory effects of difficult private events that are inevitably encountered in committed action. Thus, a person with panic disorder may go to a shopping mall and may respond to a host of panic-related thoughts, feelings, and bodily sensations in a defused, accepting way, in the present moment, and this may allow her/him to come

in contact with reinforcers involved in going shopping when s/he might otherwise have stayed at home.

Thus, commitment involves willingness to experience difficult as well as pleasurable private events, and such willingness is an all-or-none endeavor. One cannot be partially willing to remain in contact with private events. An ACT therapist may liken willingness to jumping: it cannot be broken up into steps because if it is, it is no longer one jump—it is two. Similarly, there is no way to "figure out how" to be willing or accepting; one simply exercises willingness and acceptance or does not. That is, willingness does not depend on understanding a series of steps or having the right feeling. The abandonment of the idea that behaviors depend on these internal mental events is another echo of behavioral theory in the ACT therapeutic approach. From a more modern behavioral perspective, "figuring out how" represents another application of verbal problem-solving to domains where it does not belong. In this case the domain is a certain kind of choice.

The size and degree of safety of the jump may only be limited by the situation. One may choose small jumps (e.g., being willing to experience what comes up when watching a relatively superficial romantic comedy) or large jumps (e.g., opening oneself up to feeling what comes up at one's mother's funeral). One may not choose to be willing to experience some private events and not others. For example, being willing to experience sadness only if it doesn't make one cry is not really willingness because it is conditional. It lacks the quality of jumping in which one moves oneself off of a ledge (be it high or low) and lets gravity do the rest.

Values in ACT

The discussion of committed action begs the question: Committed to what? Within the ACT model, this question is answered by specifying values, which are defined as verbally-construed, global desired life consequences that are reflected moment to moment in ongoing patterns of action (Hayes et al., 1999). The ACT model draws an explicit distinction between values and goals. Goals in ACT are consequences in more traditional terms: concrete future events towards which one can work, and which can be obtained. Earning a degree, finding a job, or having children are examples of goals. They have event status and they occur at the end of chains of actions. Values, by contrast, are qualities of ongoing patterns of action. They have a temporal extension, but contact with them is continuously available and need never cease. Metaphorically they are more like directions on a compass (e.g., going east or west) than destinations. The moment that a person embraces a value, it is like turning in a direction.

Actions can be engaged in that maintain contact with that value, but no matter how far they are pursued there is more to be done, just as a person heading west could keep heading that way indefinitely. For example, suppose one values loving relationships. At the moment this value is fully embraced, the behavior that is emitted (whatever it happens to be) is a loving action and involves a kind of caring about and attention toward others. Since love is a quality of on-going actions in a relationship, it is not achieved in the same way that one can get a degree and hang it on the wall. The quality of loving is not the same thing as the status of the relationship (happy, stable, etc.). In a way it is not an outcome at all: it is a choice to treat a process as an outcome. The processes of respect, caring, acceptance, and concern that constitute qualities of loving actions are more like adjectives and adverbs than nouns or even verbs cut off from the key adverbs that define the qualities of action. "Values" from an ACT perspective, then, may be more properly regarded as a process: *valuing*.

In essence, ACT builds on Skinner's (1971) definition of values as reinforcers, but it adds several key features: these consequences are verbally constructed, they occur as part of the moment to moment quality of continuous patterns of action, and they are actively chosen. We will explore these dimensions further as we explore the distinctions between an ACT approach and the four comparison approaches we have selected.

Values are a special type of reinforcer. The ACT approach departs from Skinner's definition – and is similar to the MI conceptualization of values – in that values are not merely synonymous with reinforcers. For Skinner one's values are the reinforcers that in reality direct one's behavior, whether or not they are verbally construed and chosen. One cannot behave in a way that is contrary to one's values in such an approach. Skinner's (1971) conceptualization of values is, therefore, similar to Rogers' (1964) idea of operative values. It makes good sense so far as it goes, but from an ACT perspective it does not go far enough in focusing on the features of values that hold possibilities for life transformation. Defining values as verbally (i.e., relationally) construed allows them to be abstract qualities of action, in turn allowing people to gain reinforcement from their own behavior by virtue of its being relationally framed with these abstract qualities. Thus, values are a particular kind of reinforcer, not just any reinforcer.

Sagiv et al.'s (2004) definition of values from a positive psychology perspective as «social-cognitive representations of "motivational goals" that are "desirable" and serve as guiding principles in people's lives» (p. 68) broadly comports with ACT's definition, but there are several differences which we will explore. The first, however, is similar to the distinction between reinforcers in general and values. The

ACT model draws an explicit distinction between values and goals that Sagiv et al. (2004) do not. The ACT perspective departs from the goal attainment perspective in positive psychology in that ACT contends that the value of the behavior is not in its outcome but is rather in the process of engaging in it.

The role of acceptance and mindfulness. Mindfulness processes support the clarification of values in ACT because they make possible a thorough history of contact with real external contingencies in the present moment, and this history in turn makes possible the kind of deep, broad knowing involved in values clarification. Consistent with this, Rogers states: «This valuing process in the human being is effective in achieving self-enhancement to the degree that the individual is open to the experiencing which is going on within himself» (Rogers, 1964, p. 165). Openness to experience, for Rogers, allows the individual to contact a more organismic level of wisdom – a more operative valuing. In MI, the open exploration of ambivalence about change, a state which may be uncomfortable for the client, is key to getting the client in touch with his/her values. In ACT terms, mindfulness allows values clarification to come under the control of direct contingencies of reinforcement rather than purely verbally constructed ones.

This conceptualization of the role of mindfulness contrasts with the positive psychology perspective of Brown and Ryan (2004), which contends that mindfulness allows for freedom from conditioning processes and fosters the exercise of conscious control originating from within. From an ACT perspective this is confusing clinical language and scientific language. ACT therapists would agree that there is a feeling of freedom in values, and that the language of free choice is clinically useful, but from the perspective of naturalistic assumptions would want to specify the history and context that allows these events to occur. Rogers' (1964) view might be regarded as midway between ACT's view and Brown and Ryan's (2004) in that openness to experience allows for a less rigidly conceived (verbal), more organismic valuing process, but Rogers (1964) does conceptualize the valuing to come from within rather than being the result of contact with external contingencies.

Correct values. Some examples of valued directions that may be identified in ACT include interpersonal connection, self-care, world peace, and communion with nature, but ACT takes the stance that there are no "correct" or "superior" values. As an empirical matter, it might be possible to identify the impact of certain values – but the importance of that impact would still need to be evaluated. This means that values are fundamental to the assessment of workability – ultimately they cannot themselves be assessed without entering into an infinite regress. ACT has to take this position in part because it is based on a form of pragmatic philosophy, functional contextualism, that holds that truth is assessed by successful working

relative to a stated purpose. This contrasts, in a sense, with the Rogerian approach in which clients naturally move in a direction of values that are universal, e.g. acceptance of others and deep interpersonal relationships (Rogers, 1964). Even if that were empirically correct it does not mean that acceptance of others and deep interpersonal relationships should be valued. In the same way, the ACT perspective contrasts with the healthy values perspective in positive psychology. Both Rogers and the healthy values researchers have technically just *described* the values of those experiencing well-being, but they can have a prescriptive quality that ACT therapists would eschew.

Choice. From an ACT perspective, valued directions are chosen in that they involve the action of selecting among alternatives. They can be distinguished from decisions not because choices are literally free but because the selection is not tied to or justified by verbal reasons. Since humans are verbal creatures, reasons will likely be generated, of course, but the choice is made *along with* reasons if they are there but not *for* reasons.

The act of valuing from an ACT perspective is more similar to postulating or stating assumptions than it is to evaluating or judging. This distinction does not seem to be made in the MI definition of values as behavioral ideals, which are judgments about the goodness of behavior and easily could be heavily defended on verbal grounds. From an ACT perspective, ideals could be values but judgments at best are based on values. They are not values themselves. Actions may be taken and commitments may be made for the reason that they are consistent with a valued direction, but these directions remain undefended. This property of valued directions is logically necessary because if something is to be evaluated, it must ultimately be evaluated against an unevaluated standard. Values are that standard.

This conception of choice is superficially similar to that of the lay culture and non-behavioral approaches (including the three discussed here) in that it appears to regard people as the free originators of action. If this were literally the case it would conflict with a Skinnerian conceptualization, which regards internal, autonomous causes to be inappropriate to a deterministic scientific analysis of behavior, as they can be neither predicted nor influenced directly. As a matter of science, ACT endorses the behavioral perspective that *free* choice is an illusion because the fundamental philosophical unit for ACT is the action in context. Said in another way, behavior is always situated in history and its current situation. This is the same as radical behaviorism. The difference between an ACT conception and radical behaviorism comes because of how ACT treats human language.

From an ACT perspective what is true is what works, and thus the goal of speaking needs to be kept in mind when the truth of speaking is evaluated. Within

functional contextualism the purpose of scientific speech is prediction and influence with precision, scope, and depth. The purpose of clinical speech is different: it is the accomplishment of the client's purposes in seeking help.

Clinically, viewing values as choices reduces the artificial dominance of verbal stories and justification in the regulation of behavior. Every action can be thought of as a choice in a naturalistic sense: There are alternatives and time is being allocated to one thing or another. Behavior analysts have developed a science of choice in a non-verbal sense, and at the verbal level there could be a similar science of values that examined the historical and situational contingencies that lead one value to be chosen over another. That is not what the ACT work represents. Choice is not being used to *explain* which alternative is selected: it is being used to create a situation in with the attachment to explanations about why particular alternatives must be selected is reduced. The question for applied science is not why people choose the values they choose but how to enhance life and reduce suffering through the use of values.

Said in another way, values are choices within a clinical language system. Therapists practicing ACT speak of *free* choice because it helps people to defuse from the literal content of language and its behavior regulatory effects. Indeed, ACT therapists themselves may "believe in" free choice at an experiential level while rejecting it at a scientific level. The coexistence of ACT's scientific and therapeutic stances toward the issue of free choice comports with the use of language as a tool, which is itself a defused stance focused on workability. Such a stance is consistent with Skinner's (1971) conceptualization of language as operant behavior rather than symbols that transmit mental material.

Once the grip of literal language on a person's life has been loosened and the agenda to change private events has been weakened, values answer the question "What now?" Thus, ACT's therapeutic goals comport with those of positive psychology to reach beyond symptom reduction to the cultivation of a meaningful, vital life. In ACT, symptom reduction is only important if symptoms are barriers to living such a life.

The verbal nature of values. The first feature in the ACT definition of values is "verbally-construed." This represents a bit of an irony, at least superficially, because a major process of change in ACT is the weakening, through processes of acceptance and defusion, of the behavior regulatory functions of language (e.g., suppression and avoidance). There is no contradiction, however. In keeping with a flexible, defused way of relating to one's own language processes, in ACT clients are encouraged to continue to engage in the clarification of values by contacting, in the present moment, the real-world consequences of particular ways of valuing. The workability of such ways of valuing may then be contacted directly, and valued directions

may be adjusted. For example, a person who enjoys hiking may choose communion with nature as a valued direction but later find that what is really valuable about hiking is the connection this person experiences with the friends. Although a major benefit of valuing is the persistence it engenders, slavish fusion to the *idea* of "communion with nature" as a valued direction might prevent contact with these other features of hiking and in turn prevent this person from living a more meaningful, vital life. The flexibility described here is very similar to the flexibility Rogers (1964) sees developing as rigid conceived values are abandoned for conceived values that are more sensitive to changing experiences.

The appetitive nature of values. Defined as a direction *towards* which one moves, valuing is not, then, moving *away* from aversive consequences. In Skinnerian terms, valued behavior is under appetitive control rather than aversive control (Skinner, 1971). In valuing caring, one does not act in a caring way in order to avoid feeling bad about oneself—one acts in a caring way because the act of caring itself is of worth. "Valuing" under aversive control tends to be repertoire-narrowing and depleting, onerous, or resentful, while appetitive valuing tends to foster broader behavioral repertoires and flexibility. It often has the character of feeling satisfying, meaningful, peaceful, vital, empowering, etc.

Behavior under aversive control often has a fused, avoidant character. For example, acting in a compassionate way towards others to avoid feeling bad about one self is directed towards not being evaluated negatively. It involves fusion with such evaluations (e.g., worthless, bad) and avoidance of emotions (e.g., sadness). MI's focus on values to cultivate motivation for change may be regarded as shifting the control of change behavior from aversive to appetitive, and the distinction between appetitive and aversive control is very similar to that made in positive psychology between intrinsic and extrinsic motives. The difference, however, is that appetitive and aversive control are both considered control by external contingencies, while intrinsic motives are theorized in positive psychology to originate from within and to satisfy inherent internal psychological needs.

Behavior under aversive control that is confused with valuing is often controlled by the desire to avoid social disapproval, while true valuing is experienced as a free choice that is deeply true to oneself. Rogers and positive psychology both regard living life for someone else to be unhealthy. For example, Rogers (1964) describes a movement in the course of therapy away from introjected "shoulds" and "oughts" towards self-direction, and in the realm of positive psychology, a great deal of research is focused on cultivating autonomous behavior. In the process of values clarification in ACT, the therapist may repeatedly ask the client, "And what is that in the service of?" as the client describes the purposes of his/her actions. In the

course of this questioning the client may discover that s/he has been working to become a doctor, for example, not because s/he wants to become a doctor but because s/he wants to please others (e.g., parents).

Social approval and values. "Valuing" for others is unworkable because a positive evaluation is not an experience. That is, the content of the verbal product, "You're a good girl/boy," is not real in the sense that the person is infused with some real thing called "goodness" upon being evaluated as "good." "Goodness" is not a property of people or things. Rather, it is part of our evaluation of them and is only to be found in that evaluation. A person or thing does not change simply as a result of being evaluated differently. "Goodness" is merely a construction. However, working in a career that involves a valued direction of behavior is real. The grit and grain of it may be engaged in, lived, and experienced first-hand every day.

Emotions and values. Valuing is also sometimes confused with feeling. To return to the example of a loving relationship, valuing this type of relationship is not the same as *feeling* love—it is behaving lovingly. Thus, of Seligman's (2002) three lifestyles, the meaningful life most closely approaches ACT's conceptualization of values—behavior in the service of desired abstract concepts. The pursuits of Seligman's pleasant life and of MI's values as preferences for experiences are impractical according to ACT because they both entail an agenda about emotional content, which is counterproductive. If gratifications are defined simply as behaviors in which one becomes absorbed as part of pursuing Seligman's good life, such pursuit may be regarded as more ACT-consistent than pursuing the pleasant life in that the focus in the good life is on valued action rather than private experience.

The dependence of valued behavior on feelings or thoughts is not valuing from an ACT perspective. Thus, ideas within positive psychology of the importance for autonomous behavior of thoughts and feelings about competence and relatedness are inconsistent with the ACT model, as is the Rogerian emphasis on the client realizing «that he is a prized person» (Rogers, 1964, p. 163). In addition, ideas within MI that hope, confidence, and even motivation are important for change may be viewed as inconsistent with an ACT approach. From a Skinnerian perspective, such thoughts and feelings may accompany valuing, but they are the result of it, not its cause (Skinner, 1971). According to ACT, beliefs that one must have such thoughts and feelings before one can act in a valued direction are indeed inaccurate. Further, fusion with these beliefs allows them to function as obstacles to valued action.

Such fusion is an obstacle because it means that one cannot organize behavior over long periods of time (e.g., pursue an advanced degree or make the lifetime commitment of marriage). In order to highlight the benefit of staying one's course with respect to valued directions, ACT clinicians sometimes liken life to planting a

garden and values to a plot of land. Some plants take more time to grow than others, and if one pulls up roots every time there is another plot that looks more level or when there seem to be too many rocks in the soil of the current plot, then only plants that grow quickly will survive. The client may then be posed with the question: "Do you want to live on lettuce, or do you want something more substantial, like potatoes?"

While feeling is not valuing, feelings may provide clues to what is valued. For example, the therapist may ask the client what s/he is doing when s/he feels the most alive, excited, satisfied, peaceful, etc. Or, the therapist may ask how the client feels when s/he thinks about committing to pursue a particular direction. These feelings do not provide reasons for choosing to value a given direction of action. (Indeed, recall that valuing is an undefended choice – a choice that is not made for reasons.) However, getting in touch with the experience of which the feeling is part likely has a profound (but unconscious) effect on this choice. Rogers (1964) referred to this as valuing at the organismic level. From a deterministic Skinnerian perspective, the valued choice is a result of the contingencies the person has contacted in his lifetime, including those in which feelings of vitality, etc. played a part (Skinner, 1971). From this perspective, these feelings should not be regarded as reinforcers (consequences that influence future behavior) but rather as epiphenomena. It makes sense, then, for a heroin addict to get clean and choose to value family over the drug, despite the fact that heroin has produced feelings of ecstasy far greater than any felt in a family gathering. It makes sense because family has likely brought the person into contact with a far broader and more consistent history of reinforcers than heroin. Skinner (1971) would not have regarded the reinforcers delivered by family as the *feelings* of security, safety, love, being cared for, etc., but rather a consistent pattern of behaviors actually delivering a safe, secure, loving, caring environment, that is, one complete with food, shelter, protection etc. Skinner (1971) eschewed feelings as causes not only because of their implausibility but also because they were not directly manipulable and thus were not useful to his goals of prediction and control of behavior. Similarly, ACT clients are guided to eschew feelings as causes for choices because they cannot be directly controlled and because relating to them as causes interferes with living a valued life.

Pain and values. Painful experiences may be among the most useful in values clarification. Referring again to the example of addiction, one may be put in touch with values of family and self-care only when the losses around these become so great that the addict can no longer escape them using drugs. This is often referred to as "hitting rock bottom." The intense sense of loss (e.g., the sense of an utterly empty life) highlights what is missing (what is truly valuable to the client) and can

be a transforming experience. Thus, acceptance of difficult experiences is not only workable – even necessary – in that it enables people to pursue valued directions; it is also key to clarifying what those valued directions are. Values and pain may be regarded as two sides of the same coin. One cannot value something without feeling pain upon a loss in that domain, and pain about a situation most often occurs because a value is being violated.

Thus, ACT therapists encourage their clients to "lean into" their pain, not only because attempts at avoiding or eliminating are counterproductive and make valuing more difficult, but because wisdom may be found in the pain. At an experiential level, the pain is part of a contingency which, only upon being contacted, has the potential to enhance living through direct learning. And at a verbal, intellectual level, the intensity of pain can highlight the preciousness of a value through the logical connection of the pain and the value (i.e., one is dependent upon the other), thus motivating valued action. In keeping with its behavioral roots, ACT regards verbal, logical processes as behaviors, and the therapeutic strategy of leaning into pain and connecting it to values is consistent with a behavioral approach in that the therapist does not attempt to erase learning (as part of an agenda to change negative appraisals of events) but is rather building on already established patterns of verbal responding (negative evaluation of a situation) by connecting it to something new. In addition to aiding values clarification, the values-pain connection may also be useful in motivating acceptance and values-consistent action. MI takes advantage of this connection in drawing a discrepancy between behavior and values: The discrepancy is worth changing because the violation of values is so painful.

ACT outcomes

What is striking about the current body of work on ACT is the breadth of the work. Research on ACT has only begun in earnest since 1999. Studies range from psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) to smoking (Gifford, Kohlenberg, & Hayes, 2004); from diabetes management (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007) to professional burn-out (Hayes, Bissett, Roget, Padilla, Kohlenberg, Fisher, et al., 2004); from chronic pain (McCracken, MacKichan, & Eccleston, 2007) to prejudice (Lillis & Hayes, 2007). There are several dozen correlational and treatment studies supporting the ACT model of psychopathology, as well as showing that changes in ACT processes mediate ACT outcomes (see Hayes, Luoma, Bond, Masuda, & Lillis, 2006 for a review). Within this body of work there is evidence that values interventions are a key component of ACT (Paez-Blarrina, Luciano, Gutierrez-Martinez, Valdivia, Ortega, & Rodriguez-

Valverde, 2008) and that values mediate ACT outcomes (Lundgren, Dahl, & Hayes, 2008).

CASE EXAMPLES

The case of Pat

A case example may help to illuminate the clinical utility of the link between values and pain in ACT:

> Pat is a 55-year old female client whose mother's cognitive functioning is slowly declining in the course of Alzheimer's disease. Pat's mother lives with her, and Pat finds herself having to look after her mother more and more, making sure she is dressed properly and eats enough throughout the day. Pat reports that she feels as though she should be a good daughter and care for her mother but that watching her mother's "slow, pathetic deterioration" is too painful for her to handle. In therapy, Pat has often said, "I just wish I could run away."

Pat's report that she feels she should be a good daughter probably indicates that she is more in touch with negative evaluations around *not* caring for her mother than she is with the positive consequences of being there for her in a loving way. Thus, her behavior is probably largely under aversive control. It is likely, however, that there is some value for Pat in caring for her mother in the years they have lived together but that Pat's avoidance of her sadness about losing her mother is getting in the way of her living this value. The therapist may ask Pat:

> "What value would you have to give up not to feel this pain? If getting rid of this pain meant that you couldn't care about your mom, would you give it up? And if letting this pain in meant that you could be there for her in a much bigger way, would you be willing to do that?"

Further, Pat's negative judgments of herself about not caring for her mother are likely a defense against facing the pain of knowing she's not acting in a valued direction by approaching this situation as an obligation. The wisdom in the client's self-judgments may be revealed using acceptance and defusion. Thus, the therapist may say:

> I want you to close your eyes and think about your mom for a moment.

> Think about what your relationship with her was like before her dementia. Think about how she was there for you and how you were there for her. And now picture her face. Look into her eyes. If you start to hear the "shoulds" about what kind of daughter you're supposed to be, just let those "shoulds" go by and return to what you feel in this very moment looking into your mom's eyes. And now take a moment to consider what you *want* to be to her in these last years of her life – not what you think other people would think is right or even what you think is right at the level of belief. This is about you choosing to be about what you value in your heart of hearts, and the question is: "Do you want to be about being there for her or do you want to be about escaping from your pain?"

The case of Martin

In addition to self-judgments, clients' judgments of others may be used to bring clients in contact with their values. Consider another clinical example:

> Martin is a 23-year old male college student presenting with depression and a general sense of meaninglessness. Martin has only a few acquaintances and no romantic partner or very good friends. He often laments that he's been "screwed over" so many times by friends or romantic interests that he now believes that close relationships are not worth the trouble and cannot bring him anything positive. In therapy, Martin often makes comments such as "I think the problem is that everyone at this school is just selfish and stupid. All they care about is themselves, and they're not even that interesting to talk to." When the topic of forming close relationships comes up, Martin generally says that he doesn't need anyone else and that he doesn't know what they could possibly offer him except hurt, annoyance, and frustration.

Taken at face value, Martin's negative talk about close relationships might indicate that connection with others is not a value for him. However, it is likely that Martin's arrogance serves to defend him against the pain of not feeling connection with people at his college. Likewise, his bitterness and resignation would only be as pronounced as they are if there was a strong value of connection around which he had experienced loss and pain in the past. The therapist, thus, may help Martin to find some meaning in his experience of meaninglessness and to see a valued direction in which to act. The therapist may say:

> If there were some meaning in your life, where would it come from? If there were a person out there who wasn't selfish and stupid, would a close relationship with them have meaning for you? And what would it be like to have room for the possibility of getting hurt and to have room for people to be stupid *and* for you to still see what opening up to others again could be like? My guess is that there's something important in there for you and that what you're doing right now isn't much fun.

In keeping with ACT's conceptualization of client issues as products of normal human language processes, therapists may (in fact, almost certainly do) engage in the same processes of judgment and disconnection from values as their clients. Indeed, they may engage in these processes with respect to their clients, and the values-pain link may be useful for them to reclarify their values as therapists and to act with respect to their clients in a way that is more consistent with those values. In the case of Martin, it is possible that the therapist might have some negative judgments around the way he talks about other people (e.g., that he is arrogant and bitter in an off-putting way). The therapist might step back from these judgments and view them as simply thoughts (i.e., defuse from them), give up any avoidance or suppression agenda around them (i.e., accept them), and get in touch with why this client's behavior is so troubling. It may be, for example, that the therapist is in contact with what Martin's arrogance and bitterness are costing him. Perhaps Martin's attitudes and behavior remind the therapist of him/herself earlier in life. Perhaps therapy is moving along without much progress, and the therapist's judgments allow him/her not to contact the pain around the client's suffering or the thought that s/he is failing as a therapist. Indeed, the therapist may then have judgments about him/herself as a therapist. Behind these judgments, however, is likely a genuine caring for Martin—an earnest desire to help him to have a meaningful life. When the therapist is fused with judgments about Martin or him/herself, it is difficult to contact the experience of valuing. Notice also that judging another person or oneself constitutes relating to those judged as objects, that is, as self-as-content. However, contemplating why a person might be behaving in a certain way or noticing the experience of having a self-judgment involves self-as-perspective. Thus, acceptance, defusion, and self-as-perspective allow the therapist to step out of the mire of judging to broaden her/his perspective and contact a valued way of being with the client.

SUMMARY - CONCLUSION

The approaches to values of Rogers, MI, positive psychology, Skinner, and ACT share key features and differ in important ways. All approaches share a de-emphasis on the medical model and hold that people have what is necessary to form and follow their values. Rogers, positive psychology, and ACT agree that mindfulness and openness to experience can enhance valuing, but these approaches differ as to their explanations of how they may do so. Specifically, ACT posits that mindfulness amounts to contact with direct external contingencies which inform valuing at the level of experience, while Rogers and positive psychology contend that mindfulness and openness to experience lessen the control of contingencies of reinforcement and punishment, enhancing internal autonomous control of behavior. Although Rogers' description of valuing at the organismic level (i.e., with the whole organism and not just the mind) is very close to the ACT conceptualization in its emphasis on knowing at the level of experience, the idea of an internal actualizing tendency is contrary to a behavioral approach, as are ideas of thoughts and feelings as causal entities, which are either implicit or explicit in positive psychology and MI. The ACT model's behavioral roots are apparent in its core contention that people need not cede control of their behavior to thoughts or feelings, and the post-Skinnerian behavioral approach to language and cognition on which ACT is based (RFT) predicts the harmful effects of verbal processes, such as the avoidance of private events. The ACT view of language also predicts links, such as that between pain and values, which may have great clinical utility.

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