

### Outline of ACT Assessment/Case Formulation Process

This outline provides additional information on completing the “ACT Initial Case Conceptualization Form.” Much of the process below is taken verbatim from Chapter 3 of the *A Practical Guide to Acceptance and Commitment Therapy* (2004), Edited by S. Hayes and K. Strosahl. Please reference that chapter for more detailed information.

The most important principle in an ACT case conceptualization is that you are not just assessing a particular symptom with a particular topography; you are also attempting to understand the functional impact of the presenting complaint. Attempting to understand the function of client behavior involves a focus on the learning history of the client as well as the current context in which events happen. This context involves both the events of the client’s life and the verbal context in which the client experiences these events. How their current and historical context is functionally organized will alter how the client interacts with situational variables in a way that either promotes or defeats the client’s best interests. Conducting a functional analysis that captures these important variables in order to better guide treatment is the goal of an ACT case conceptualization.

1) **Begin your assessment with an analysis of the presenting problem as formulated by the client.** Take what the client would say is their “problem” and reformulate this in ACT consistent terms (if necessary). For example, frequently clients will nominate a set of negative private events (negative feelings, thoughts, memories, sensations, physical symptoms, and so on) as the “problem.” Instead of “eliminating anxiety so that I can start to live” (the client’s view of the presenting problem) you may eventually reformulate “the problem” in other ways (e.g., “warring with anxiety” or more specifically “not getting on about the business of living while needlessly warring with anxiety”). At a deeper level such reformulations must be consistent with the client’s true goals and values.

Avoid buying into or challenging the initial formulation presented by the client. Take an open, data gathering stance in which you assess the client’s learning history, current situational triggers, the domains of avoided private events and specific behavior avoidance patterns. Pay attention to the function of these behaviors in the client’s life, both “positive” and “negative.”

From an ACT model the two most important initial case conceptualization questions are:

2) **What private experiences is the client attempting to avoid?** Assess these and outline them in the space provided.

3) **What avoidance behaviors are being used and how pervasive are they?** Consider:

- Level of overt behavioral avoidance displayed (e.g., what parts of life has the client dropped out of, what activities/pursuits are not occurring that would occur if the problem was solved? Hint: ask “If a miracle happened and all your problems were solved, what would your life be like then?”)
- Level of internally based emotional control strategies (e.g., negative distraction, negative self instruction, excessive self monitoring, dissociation)
- Level of behaviorally focused emotional control strategies (e.g., drinking, drug taking, smoking, self-mutilation, suicide attempting, overeating)
- In-session avoidance or emotional control behaviors (e.g., topic changes, counterpliance, aggressiveness, dropout risk) – While in-session barriers may not be apparent from the beginning of therapy, it may be possible to predict what could show up later and take proactive steps to address these barriers. For example, you may find out that the client has a tendency to flee relationships when they begin to feel threatened by intimacy. Thus, you might have a conversation at the start of therapy about what the client could do, rather than leave therapy, in the case that they feel they are getting too close to the therapist.

4) **Consider factors related to motivation to change.**

- Is the “cost” of avoidance behaviors contacted in terms of daily functioning (e.g., lack of life direction, no friends, loss of important goals, addicted person has to spend all day getting his “fix”, etc. If this is low or not properly contacted, consider paradox, exposure, evocative exercises before work that assumes significant personal motivation)
- Experience of the unworkability of improperly focused change efforts (if this is low, move directly to diary assessment of the workability of struggle, to experiments designed to test that)
- Clarity and importance of valued ends that are not being achieved due to target behavior and the place of these ends in the client’s larger set of values (if this is low, as it often is, consider values clarification. If it is necessary to the process of treatment itself, consider putting values clarification earlier in the treatment. Consider linking work that requires significant motivation to valued activities and/or relationships.).

- Strength and importance of therapeutic relationship (if not positive, attempt to develop, e.g., through use of self disclosure; if positive, consider integrating ACT change steps with direct support and feedback in session)
- Beliefs about consequences of facing feared events (explore client’s fears and consider teaching defusion skills and willingness, titrate willingness/exposure exercises to a level client can complete successfully)

5) **What environmental factors could be barriers to client’s change?** For example, a client may be motivated to not improve in order to keep their disability payments. A spouse may be unsupportive of change because it is challenging to them. They may have friends which encourage their drug use.

6) **Consider other factors contributing to psychological inflexibility:**

Cognitive entanglement/ fusion	Check for fusion with evaluative thoughts and conceptual categories (e.g., domination of “right and wrong” even when that is harmful; high levels of reason-giving; overuse of “insight” & “understanding,” self-loathing, comparisons with or critical attitudes towards others) Is the client overly attached to beliefs, expectations, right & wrong, good-bad evaluations of experience? Does the client confuse evaluations and experience?
Out of contact with the present moment	Does the client exhibit ongoing, fluid tracking of immediate experience? Does the client find ways to “check out” or get off in their head? Does the client seem pre-occupied with past or future or engage in lifeless story telling?
Fused with self-as-content	Can the client see a distinction between provocative and evocative content and self? Is the client’s identity defined in simplistic, judgmental terms (even if positive), by problematic content or a particular life story?
Out of contact with values	Can the client describe personal values across a range of domains? Does the client see a discrepancy between current behaviors and values? Does the client describe tightly held but unexamined goals (e.g., making money) as if they are values?
Ability to build patterns of committed action	Is the client engaged in actions that promote successful working? Does the client exhibit specific, step by step pattern of action? Can the client change course when actions are not working? Are there chronic self control problems such as impulsivity, self defeating actions (e.g., procrastination, under performing, poor health behaviors, impulsive behavior)?

7) **Consider specific treatment implications/foci based on particular patterns of client behavior, e.g.:**

- *Client has a strong tendency toward rule following and being right*
  - Consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to the conceptualized self.
- *High level of conviction or behavioral entanglement with unworkable strategies*
  - This is usually seen as an insistence on doing the same thing even though the client admits it doesn’t seem to work. If this is an issue, consider the need to undermine the improperly targeted change agenda, using creative hopelessness interventions.
- *Belief that change is not possible combined with a strong attachment to a story that promotes this conclusion.*
  - This is often seen in chronically distressed clients or clients with history of repeated trauma. If this is an issue, consider using defusion strategies, especially attacking the attachment to the story; revisit the cost of not trying in terms of valued life goals; arrange behavioral experiments to test whether even small changes can occur.
- *Fear of the consequences of change.*
  - This is often seen in clients that are hiding in unsatisfying relationships or jobs for fear of the unknown. If this is an issue, consider working on values clarification and teaching qualities of committed action, choice and decision; work on acceptance of feared experiences under conditions of change.
- *Domination of a rigid, content-focused self-identity in which changing would pose a threat to a dearly held set of self beliefs.*
  - This is often seen in “therapy wise” clients or clients with a history of treatment failure. If this is an issue, consider undermining the story using various defusion strategies such as the autobiography rewrite; consider values work to get the client to make contact with the “cost” of holding to the story.
- *Domination of the conceptualized past or future.*
  - This is often seen in clients complaining of excessive worry, regret, or anticipatory fear that functions to block effective behavior. If this is an issue, consider self-as-process and self-as-context work, including “just

noticing” interventions, and experiential exercises to help make contact with the moment. Link this to defusion work so that temporal thoughts can be caught and observed without belief or disagreement.

- *Short term effect of ultimately unworkable change strategies is evaluated as positive.*
  - This is often seen in addictive behaviors, chronic suicidality, or chronic pain. If this is an issue, consider values clarification and creative hopelessness work tied to what have you tried, how has it worked, what has it cost you?
- *Social support for avoidance and fusion.*
  - This is often seen in trauma victims, “disabled” clients of all kinds and may involve relationships, family, financial or institutional reinforcement. If this is an issue, early values clarification work can be used to highlight the cost of not changing.

8) **Consider factors contributing to psychological flexibility** (i.e., client strengths). If a client has had past experience engaging life problems in ways that are ACT consistent, these experiences can sometimes be harnessed to allow one to move more quickly through the protocol. Current therapy efforts can usefully be linked to these past experiences, allowing these experiences to serve as models for current actions.

- Prior positive experience with mindfulness, spiritual practice or human potential concepts (if they are positive and safe from an ACT perspective, consider linking these experiences to change efforts; if they are weak or unsafe - such as confusing spirituality with dogma - consider building self-as-context and mindfulness skills)
- Episodes in life where “letting go” of urges, self defeating thoughts, uncontrollable feelings led to greater personal efficacy (i.e., Alcoholics Anonymous, smoking cessation, getting through a death)
- Moments in life when the client felt intensely present and in contact with life, even if the experience involved negative affect
- Prior experiences where laughing at oneself, seeing the irony or humor in a situation seemed to decrease the gravity associated with it
- Times in the past when the client took a course of action that was painful but was consistent with their values
- Prior experiences with setting personal goals, taking step by step concrete steps to achieve them
- Prior experiences with starting in one life direction and ending up going in another more positive direction

9) In this section, **describe specific treatment procedures for this particular client.** Consider following a specific, relevant treatment manual that has evidence for its effectiveness. Consider relevant ACT process and outcome measures. Consider modifications to the general, step-wise process of treatment that outlined in the ACT (1999) book. Consider client strengths in this conceptualization and how these might be harnessed to potentially move through the process more quickly. Consider social, financial, and vocational resources available to mobilize in treatment. Consider use of other compatible techniques and theories that may be relevant but not directly theorized about in ACT (e.g., contingency management, skills building). Address life skills deficits (if this is an issue, consider those that may need to be addressed through first order change efforts such as relaxation, social skills, time management, personal problem solving)

Given the functions that have been identified in this assessment consider the relevant contributions of:

1. Generating creative hopelessness (client has not faced the unworkable nature of the current agenda)
2. Understanding that emotional control is the problem (client does not understand experientially the paradoxical effects of control)
3. Developing willingness (client is afraid to change behavior because of beliefs about the consequences of facing feared events)
4. Experiential exposure to the non-toxic nature of private events through acceptance and defusion (client is afraid to change behavior because of beliefs about the consequences of facing feared events)
5. Generate experiences of self-as-context to facilitate experiencing of feared events in the present moment (client is unable to separate self from reactions, memories, unpleasant thoughts; client needs safe place from which to engage in exposure)
6. Make contact with the present moment/mindfulness (client lives in conceptualized future, e.g., worry; client is not contacting reinforcements already present in the environment)
7. Values exploration (client does not have a substantial set of stated values or is out of contact with their values)
8. Engage in committed action based on chosen values (client needs help to rediscover a value based way of living; client’s behavior is not generally productive or well-directed and client could use help in maintaining consistency of life direction; client has little motivation to engage in exposure)