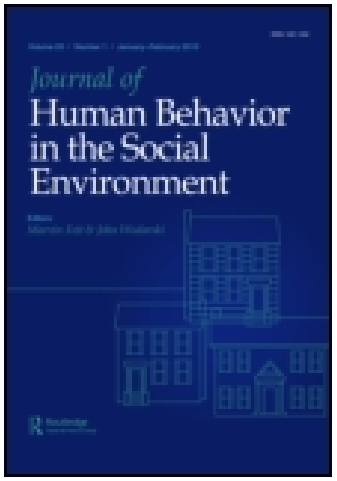

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Acceptance and Commitment Therapy, Functional Contextualism, and Clinical Social Work

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The practice of clinical social work requires interventions that are consistent with social work values, applicable across a range of presenting problems, capable of being applied in multiple contexts, supported by extensive research, and consonant with social work's person-in-environment perspective. This article discusses the fit between social work and acceptance and commitment therapy (ACT), a mindfulness-based cognitive behavioral therapy that meets all of these criteria. ACT is based on a philosophy of science, functional contextualism, that focuses on the behavior of individuals within their historical and situational contexts. ACT draws on a comprehensive theory of language, relational frame theory (RFT), which accounts for the influence of culturally shaped language processes on learning and human behavior. ACT and RFT are supported by a growing body of research that supports ACT's efficacy with a wide variety of problems and suggests that ACT works by its theorized mechanism of change. ACT can be delivered in an array of formats and is easily accessible for those seeking training, and ACT offers a nonstigmatizing, universalizing approach to alleviating suffering that positions social workers and clients as subject to the same, normally occurring processes of human behavior.

Keywords: Acceptance commitment therapy, social work, evidence based practice, functional contextualism, contextual behavioral science, mindfulness, cognitive behavioral therapy

INTRODUCTION

The mission of social work to support those who are most vulnerable requires effective interventions that are broadly applicable, attuned to the complex interaction of people and their

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environments, and consonant with social work values. Acceptance and commitment therapy (ACT, said as a single word; Hayes, Strosahl, & Wilson, 2012b) is a mindfulness-based cognitive behavioral therapy (CBT) that may help social workers meet the rigors of this demand. ACT is different from traditional cognitive behavioral therapies in that it forgoes attempts to change painful thoughts and feelings. Instead, ACT seeks to increase *psychological flexibility*, or the ability to mindfully encounter thoughts and feelings without needless struggle (i.e., acceptance) and act effectively in the service of what matters (i.e., commitment). The efficacy of ACT has been demonstrated in more than 100 randomized control trials with a broad spectrum of problems.

ACT is rooted in a philosophy of science called functional contextualism (Hayes et al., 2012b), which parallels social work's "person-in-environment" perspective in its focus on the complex relationship between people and their historical and situational contexts. Most relevant for the practice of clinical social work, functional contextualism offers a starting point for the scientific development of effective interventions that incorporate a person-in-environment perspective. Thus far, however, ACT and functional contextualism have a limited presence in the social work literature, with few full-length scholarly articles or book chapters devoted to them (e.g., Boone, 2014; Dewane, 2013; Masuda, Boone, Hill, & Pasillas, 2014; Montgomery, Kim, & Hall, 2011). Therefore, this article offers social workers the core principles of functional contextualism, an overview of ACT, and an exploration of their fit with social work theory, practice, and values.[1]

Functional Contextualism: The Pragmatic, Person-in-Environment Philosophy Underlying ACT

ACT begins by articulating the philosophy of science that underlies its theory and interventions. Doing so assists treatment development by answering fundamental questions about where a scientific effort will focus, how it will define truth, and how it will know when it has achieved its goals (Hayes, Barnes-Holmes, & Wilson, 2012a). Functional contextualism, like most social work theory, seeks to understand people within their environments, foregoing reductive explanations of human problems—for example, that a complex problem such as depression can be reduced to a "chemical imbalance." It is a contemporary update of radical behaviorism that assumes that behavior is shaped in an ongoing way by an individual's social and physical environments. In this way, our historical and situational contexts give meaning to everything we do, and studying a behavior outside of its context is meaningless.

Take, for example, a child walking to school. If the child's family values intellectual curiosity and academic rigor, these values will contextualize the act of walking. Walking is not just about getting from one place to another, but also about pursuing these values. In functional contextual terms, we would say pursuing these values is, at least in part, the "function" of walking. But perhaps the child lives in a home that feels narrow-minded and stifling. Walking might have a different function: rebellion and the possibility of escaping someday. Or perhaps the child has received a lifetime of messages from her peers and her teachers, both directly and indirectly, that she is not very smart. Walking to school becomes more like "walking into the lion's den" and serves the function of simply waiting out a culturally expected obligation until the end of high school. Consistent with social work's multidimensional perspective, the context shapes the function of the behavior. And though the behavior looks identical in each of these examples, its function is very different.

[1] Functional contextualism and ACT are nested within a broader program of scientific development called *contextual behavioral science* (CBS; Hayes et al., 2012b), the aim of which is to create "a science more adequate to the human condition" (p. 2) by closely linking philosophy, theory, basic research, and treatment development and dissemination. For in-depth discussions of CBS, see Hayes et al. (2012a, 2012b). For a discussion of the fit between CBS and social work, see Steinwachs and Boone (2014).

Pragmatic Goals and Observable Phenomena

The primary goal of functional contextualism is to develop "an organized system of empirically based verbal concepts and rules that allow behavioral phenomena to be predicted and influenced with precision, scope, and depth" (Biglan & Hayes, 1996, pp. 50–51). In more simple terms, functional contextualism seeks to develop theories and interventions that are useful tools for researchers, health professionals, and clients to produce change. To be empirical, these tools must be based on observable and testable phenomena. Therefore, a functional contextualist would avoid using hypothetical constructs like the *ego* in psychodynamic therapy (Freud, 1910) or a *schema* in cognitive therapy (Young, Klosko, & Weishaar, 2003), which are assumed to operate inside the client but cannot be observed or directly influenced, by either the client or the social worker (Fox, 2006). Instead, functional contextual concepts such as "acceptance" and "psychological flexibility" are descriptions of behaviors or qualities of behavior that can be observed and described. Behavior in functional contextualism includes not just public or overt actions, but also internal events such as thoughts, feelings, memories and physical sensations—behaviors that only the individual experiencing them can observe. For example, a person who is depressed might engage both in overt behaviors such as staying in bed all day and "private" behaviors such as ruminating on hopeless thoughts.

Pragmatic Truth Criterion

In functional contextualism, truth is contextual and pragmatic rather than absolute. As William James, one of the founders of behavioral science, stated, "The truth of an idea is not a stagnant property inherent in it. Truth *happens* to an idea. It *becomes* true, is *made* true by events" (James, 1948, p. 161). Similarly, social work practice's long-held multidimensional perspective maintains that because a person exists in the context of multiple domains, truth is a by-product of contingencies such as language, cultural beliefs, family history, economic status, race, and countless other influences (Lesser & Pope, 2010). Given this, functional contextualism makes a choice about what "truth" to pursue: *What works for a given goal*. This is called the *pragmatic truth criterion*. Therefore, in the clinical realm, a functional contextualist would not ask a client to examine the veracity of his or her negative thought, but rather whether it is useful in the service of some goal, for example, learning a new skill, developing intimacy with a partner, or pursuing a new job. Similarly, in the realm of research, a functional contextualist would not try to determine whether a theory or model of change is a "real" representation of how health and suffering operate in the world, but rather whether the model is useful in the service of whatever outcome is being targeted: increasing quality of life, decreasing worksite stress, or increasing psychological flexibility. Functional contextualism does not deny the existence of an absolute truth or a real world; its interests simply lie elsewhere. A pragmatic truth criterion prevents researchers and practitioners from getting bogged down in questions about whether a theory describes the world "as it really is" and sharpens their focus on the project of effectively helping people.

Relational Frame Theory: Behavior Is Shaped by Language in the Social Environment

In the service of creating practical and testable tools for clinicians, researchers, and clients, functional contextualism starts with basic principles of learning theory such as operant conditioning (e.g., positive and negative reinforcement) and classical conditioning (e.g., Ivan Pavlov's experiments in the early 20th century) and builds from there. Functional contextualism's addition to learning theory, called relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001; Törneke, 2010), seeks to better account for the complexity of human behavior by accounting for the role of language in learning. A thorough review of RFT is beyond the scope of this article,

but in short, RFT describes a process by which humans learn to relate to stimuli in their social environment based on social and cultural conventions rather than simply the physical characteristics of the stimuli. For example, with the right training, some nonhuman animals can choose the bigger of two objects, such as choosing a basketball over a baseball. But as far as we know, only humans can choose a dime over a nickel, a choice based on social conventions that designate the dime as "bigger" than the nickel despite its smaller physical size. Furthermore, it is likely that only a human can treat the word "dime" written on a page, the sound evoked by saying "dime" out loud, and the familiar flat piece of metal as equivalent to one another. According to RFT, these kinds of arbitrary, socially derived ways of relating are learned and rapidly expanded through operant processes and allow humans to communicate and interact with others and with themselves in an ever-expanding number of verbally and socially constructed ways. In the clinical realm, this can explain how human beings can learn to act with fear in response to uncomfortable feelings, difficult memories, or the imagined judgments of others when none of these things is literally dangerous.

At this point, the core tenants of RFT have been supported by more than 50 controlled studies published in peer-reviewed journals (Blackledge, Moran, & Ellis, 2009). But functional contextualism, as a philosophy of science, and RFT, as a theory of language, are not accessible tools for most helping professionals. Therefore, ACT has been constructed on the foundation of functional contextualism and RFT to offer helping professionals more immediate access to understanding and helping the people and alleviating the problems that show up in their work. To draw an analogy from everyday life in the early 21st century, functional contextualism and RFT can be thought of as the computer and operating system, respectively, on which ACT, a practical application for helping people, can be run.[2] It is to ACT, and its relevance to social work assessment and intervention, that we turn next.

ACCEPTANCE AND COMMITMENT THERAPY

ACT undermines the power of socially and verbally constructed ways of relating by helping clients become more present to their moment-to-moment experience. To do so, ACT uses interventions that are less verbal and more experiential than those commonly used in psychotherapy. Though ACT comes from the behavioral tradition in cognitive behavioral therapy (e.g., Barnes & Holmes, 1991; Blackledge 2003), on its surface it can easily resemble existential and humanistic therapies (e.g., Frankl, 2006; Perls, Hefferline, & Goodman, 1951; Rogers, 1951). ACT uses metaphors, mindfulness, and experiential exercises to help clients contact experientially what it is like to simply notice their internal experiences (e.g., thoughts, feelings, memories) rather than trying to change them. For example, to introduce acceptance, a social worker might compare controlling thoughts and feelings to playing tug-of-war with a monster, and then actually enact this tug-of-war with a rope or a scarf in the session so the client can experience the difference between pulling and letting go. Or the worker might encourage the client to observe her anxiety mindfully without trying control it, perhaps even imagining breathing in and out of it. Or the worker might encourage the client to picture himself sitting on a hill watching his thoughts go by like cars on a highway rather than try to change them or question their validity. In each case, the thought or feeling is still there, but the client's relationship to it is different. Thoughts and feelings become more like *what we experience*, rather than representations of *how the world is*.

[2] This analogy is adapted from a similar analogy in Hayes (2008).

Suffering and the Assumption of Destructive Normality

ACT rejects the *assumption of healthy normality*, the widespread, culturally shaped perspective that happiness and feeling "good" are the hallmarks of psychological health. Instead, ACT suggest that all human beings experience a variety of ever-changing internal experiences throughout life—some painful, some pleasant. No thought, feeling, memory, or physical sensation is more "right" than another. ACT theorizes that normal, evolutionarily and culturally shaped psychological processes, when rigidly and indiscriminately applied, turn the normal pain of living into unnecessary suffering. These processes—two of which, experiential avoidance and cognitive fusion, are described below—lead to inflexible and ineffective responses to life circumstances. In ACT this perspective is called the *assumption of destructive normality.*

Psychological Inflexibility

ACT observes that humans, like most (if not all) organisms, are evolutionarily and genetically primed to avoid and escape threats. When faced with danger, most organisms narrow their awareness and focus exclusively on the danger in front of them, as well as the best means of escape. Survival of any species depends, at least in part, on this automatic ability. However, humans, because of their capacity for language and meaning-making, have the ability to create threats where none exist. We can worry about imagined futures and ruminate on painful pasts. We can label internal experiences like thoughts and feelings as "bad" and "dangerous" and try desperately to minimize them.

Thus, just like in the face of real threats, when we encounter these imagined or symbolic "threats," our awareness, and consequently our repertoire of behavioral responses, can become narrow and rigid, focused exclusively on trying to escape pain and discomfort. This is not a problem if it does not have other consequences, but often it narrows our repertoires of behavioral responses in important domains of our lives, such as building relationships, engaging in work, and facilitating our growth. This is *psychological inflexibility*, which is essential in the face of real threats, but destructive when it becomes our predominant pattern of responding. ACT theorizes that psychological inflexibility influences a wide variety of human problems—not just mental health concerns such as depression and anxiety, but also health problems such as chronic pain and other problems such as worksite stress and stigma.

Experiential Avoidance

Inflexible patterns of responding are characterized in part by *experiential avoidance*. Experiential avoidance means attempting to avoid, control, or suppress internal experiences such as thoughts and feelings, as well as the circumstances that give rise to them. For example, when a veteran with posttraumatic stress disorder avoids crowds and intimate relationships because of the feeling of irritability and vulnerability she encounters, that is experiential avoidance. When a father skips a supervised visit with his son to prevent experiencing the shame he feels at having his parental rights removed, that is also experiential avoidance. And when a social worker thoughtlessly redirects a client who mentions a past trauma, not because doing so is clinically useful but because hearing about the trauma brings up overwhelming feelings inside of *him*—that is also experiential avoidance.

Cognitive Fusion

Cognitive fusion, or simply *fusion*, means overidentifying with the mind, allowing our capacity for thinking and meaning making, which is essential in most contexts, to have undue influence over

our behavior. The term "fusion" is based on a metaphor of being "stuck" (i.e., "fused") to a thought. A good example of the problematic effects of fusion can be seen in the relationship between a person with social anxiety and her self-evaluations. After a conversation, she ruminates on the thought "I said something wrong" or even "I *am* wrong" and becomes preoccupied with imagined failures. This preoccupation crowds out other sources of information, like the small intimacy of engaging with another person or the smile on the other person's face. She subsequently becomes even less likely to engage with others in the future.

In ACT, fusion is neither inherently bad nor good, but rather workable or unworkable in the service of building a meaningful life. (Note the congruence here with functional contextualism's pragmatic truth criterion.) The workability of fusion depends on its context, and there are times when fusion is essential to thriving in the world. For example, fusing to the thought "I need to finish this project by Friday" can be very useful in the service of building a successful work life. Similarly, the workability of experiential avoidance also depends on function and context. Surfing the internet for an hour to get rid stress after a long day is certainly avoidance, but it is unlikely to be harmful. However, spending many hours on the internet every night may negatively impact work performance and relationships.

ACT INTERVENTIONS

To undermine unworkable fusion, avoidance, and other inflexible responses, ACT teaches clients to become more psychologically flexible—to respond with willingness to whatever they encounter, whether thoughts and feelings or external circumstances, when doing so serves building a rich and meaningful life. For heuristic and practical purposes, psychological flexibility is broken down into six interrelated component processes: values, committed action, defusion, self-as-context, acceptance, and contact with the present moment. The ACT clinician teaches the client to bring these processes to the fore, both in therapy and in life. This section briefly describes these processes, as well as experiential exercises, metaphors, and other strategies social workers can use to help facilitate them in practice. More extensive descriptions of exercises can be found throughout the ACT literature (e.g., Harris, 2009; Hayes & Smith, 2005; Hayes et al., 2012b).

Values and Committed Action

In ACT, clients are encouraged to work toward building a rich and meaningful instead of avoiding discomfort or rigidly following the rules generated by their habitual thinking. To do so, ACT encourages clients to begin by articulating their *values*. ACT defines values as desired global qualities of ongoing action (Hayes et al., 2012b). Note that values are not goals—they are not things one can obtain or achieve. Instead, values are self-generated guidelines for engaging the world. ACT-consistent values might include statements such as "to be authentic, genuine, and real" (Harris, 2013, p. 86), "to be curious, open-minded, and interested" (p. 87), or "to be responsible and accountable for my actions" (p. 88). A range of interventions can help clients identify these values, including visualizing friends' and family members' speeches at one's funeral to illustrate one's "best self," writing about what one cares most about in life, or completing one of many values inventories (e.g., the Valued Living Questionnaire; Wilson & DuFrene, 2008).

Since values are not actions in themselves, ACT encourages clients to identify and engage in *committed actions* in the service of values. A committed action can be anything large or small that moves the client in the direction of his or her values, from simply getting up in the morning to the constellation of actions required to look for a new job. Committed action can also involve traditional behavior therapy strategies, such as exposure and response prevention for obsessive-compulsive disorder or habit reversal training for chronic hair pulling. Values help guide, motivate,

and dignify committed actions. For example, a client who values "building loving relationships" but avoids confronting a partner about hurtful actions may experience renewed commitment to speaking up in light of values clarification.

Defusion

As clients begin to focus on values and committed action, fusion (defined above) can quickly become an obstacle. Clients often encounter seemingly disabling thoughts such as "I shouldn't be feeling this way" or "If I feel depressed, I can't go to work." *Defusion* helps to counteract the influence of such thoughts. Defusion means becoming mindful of the process of thinking and allowing thoughts to have influence only when they are useful. Unlike traditional cognitive behavioral therapy interventions, defusion does not involve examining the veracity of thoughts. Common defusion interventions include labeling thoughts as thoughts (nothing more), exploring the usefulness of thoughts in the service of values instead of focusing on their truthfulness, and using mindfulness to expand the awareness of present moment experience that such thoughts often narrow. ACT clinicians also introduce metaphors, such as imagining thoughts as passengers on a bus the client is driving or framing the mind as a storyteller (Hayes, et al, 2012b). Defusion can also be supported by writing thoughts on cards to objectify them, practicing mindfulness exercises in which one simply notices thoughts, and introducing the "observing self," a perspective from which one notices thoughts and feelings but does not automatically identify with them.

Self-as-Context

The observing self is a stance toward experience that helps clients become aware of thoughts, feelings, and behaviors as they occur. It is the perspective from which one observes the act of reading this article (e.g., the movement of one's eyes, the sound of the words in one's mind), emotional reactions to reading (e.g., excitement, boredom), and the thoughts that emerge while reading (e.g., "That makes sense," "I don't get it"). This perspective is inherent in defusion: As one notices thoughts occurring, one makes a distinction between the thoughts and the self that experiences the thoughts. An individual fusing with "I don't get it" may very well stop reading this article. However, an individual who defuses from the thought by taking an observer's stance may be able to mindfully keep reading and thus act in a way that is consistent with the value of becoming a more knowledgeable and effective social worker.

The observing self is one facet of a process called *self-as-context* in ACT. Self-as-context means flexibly taking multiple perspectives on the self and experience. For example, flexible perspective taking may include noticing the narratives one tells about oneself (e.g., "I am a bad person," "I am a good social worker"), observing the process of one's ongoing experience (e.g., the flicker of thoughts in the mind, the ebbing and flowing of physical sensations), or tuning in to the imagined experiences of others (i.e., what psychological researchers call "theory of mind"). Self-as-context can facilitated in multiple ways, from asking clients to "notice who's noticing" during a mindfulness exercise to introducing a metaphor in which the self is an old sturdy house that remains steadfast through the years as the inhabitants, activity, and decor inside it (i.e., thoughts and feelings) constantly change (Hayes & Smith, 2005). The unusual term "self-as-context" is best understood if one substitutes the word "container" for the word "context": The self is the container of all it experiences and is big enough to hold whatever arises.

Acceptance

Defusion and self-as-context naturally lead to *acceptance*. Acceptance means "taking an intentionally open, receptive, nonjudgmental posture" (Wilson & DuFrene, 2008, p. 46) toward internal experiences, as well as cultivating a willingness to engage in actions that may give rise to difficult thoughts and feelings when doing so serves what's important to the individual (Hayes et al., 2012b). Acceptance is distinct from approval, resignation, or wanting. It simply means allowing what is there to be there without struggling with it. Letting go of struggling is facilitated with metaphors such as the "Quicksand" metaphor (Hayes, Strosahl, & Wilson, 1999), in which controlling thoughts and feelings is likened to trying to fight one's way out of quicksand, and experiential exercises such as "physicalizing" (Hayes & Smith, 2005), in which one imagines an emotion as an object and describes its color, texture, and other qualities. Acceptance goes hand-in-hand with defusion and values. For example, a person with agoraphobia who experiences powerful anxiety accompanied by the thought "I can't stand this" could step back from the thought by naming it, mindfully observing her urge to escape without trying to change, and identifying the values (e.g., being a loving parent, building a meaningful career) that would be served by engaging in behavior that might make it more present (e.g., going to work, attending a child's dance recital).

Contact With the Present Moment

Contact with the present moment means "[bringing] attention to bear in a focused, deliberate, yet flexible fashion" (Wilson & DuFrene, 2008, p. 61) to experience as it occurs from moment to moment. It is the antithesis of worrying about the future or ruminating on the past. Contact with the present moment is introduced through mindfulness exercises, including structured meditations that focus on allowing room for pain (e.g., "Acceptance of Anxiety"; Eifert & Forsyth, 2005) and expanding awareness alongside painful inner experiences (e.g., "Expansion"; Harris, 2008), as well as brief, less formal exercises in which the social worker asks the client to stop and simply notice what is arising as he or she is talking.

THE PRACTICAL FIT BETWEEN ACT AND CLINICAL SOCIAL WORK

In addition to the theoretical and philosophical fit between ACT, functional contextualism, and clinical social work, ACT and functional contextualism are a good fit for the *practice* of clinical social work for a variety of reasons. These include its broad applicability, its growing body of research support, its congruence with social work values, and the accessibility of ACT training, among others.

Broad Applicability

Over 100 randomized controlled trials have been published on ACT or are in press, and all have shown promising results in comparison to an established treatment such as CBT, treatment as usual, psychological placebo, or a waitlist control (A-Tjak et al., 2015, Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Öst, 2008, 2014; Powers, Zum Vording Sive Vording, & Emmelkamp, 2009; Ruiz, 2012). Of note to social workers working in mental health settings, ACT has shown at least preliminary efficacy (e.g., in pilot studies) with many mental health problems, including depression, anxiety, mixed anxiety disorders, borderline personality disorder, obsessive-compulsive disorder, generalized anxiety disorder, trichotillomania, various manifestations of addiction, psychotic symptoms, emotional distress following psychosis, worries, test anxiety, social anxiety/public speaking, subclinical eating pathology, and body image dissatisfaction. ACT has also been

shown to help with a wide variety of health concerns, such as chronic pain, epilepsy, cancer, weight loss, smoking, diabetes, increasing physical activity, tinnitus distress, chronic headache, and bariatric surgery. See Montgomery et al. (2011), Öst (2014), Ruiz (2010), and Smout, Hayes, Atkins, Klausen, and Duguid (2012) for recent reviews, as well as the Association for Contextual Behavioral Science (ACBS, the ACT professional organization) website, which has a periodically updated list of RCTs (http://contextualpsychology.org/ACT_Randomized_Controlled_Trials).

Beyond mental health and medical problems, ACT has also performed favorably with "non-clinical" problems. This is welcome news given that suffering does not always fit nicely into DSM and ICD categories of illness. ACT has been shown in RCTs to be effective with worksite stress, stress among social workers, stigma and burnout among substance abuse counselors, stigma toward people with psychological disorders, the willingness of clinicians to refer for evidence-based pharmacotherapy in substance abuse treatment, the mental health of K-12 teachers and staff, and experiential avoidance and sense of efficacy (among other things) in early childhood special educators.

Finally, ACT has been adapted for a variety of formats that are different from the typical individual 50-minute hour, including workshops (e.g., Masuda et. al., 2007), groups (e.g., Chadwick, Taylor, & Abba, 2005), coaching (e.g., Blonna, 2011), family work (e.g., Blackledge & Hayes, 2006), self-help books (e.g., Hayes & Smith, 2005), online applications (e.g., Walser, 2013; Walser &Westrup, 2013), and brief interventions (Strosahl, Robinson, & Gustavsson, 2012). ACT as a brief intervention is especially promising for social work given the many roles that social workers inhabit in which they may have only limited interaction with clients. For example, a case manager or medical social worker may have only a few hours with a client spread out over a few days. In this context, the worker can rely on a simple, integrated rubric for organizing the work, such as "Show up and do what matters." For example, a conversation about negotiating complicated family dynamics could be grounded in identifying what cannot be controlled, such as a difficult family member's personality and the feelings that show up for the client, and what can be controlled, such as how the client interacts with the family member during moments of tension. Or a conversation about finding housing could be framed in terms of what is important to the client (e.g., a safe and stable home) and accepting the feelings that might show up while pursuing what is important (e.g., fear of change, concerns about the judgments of potential landlords).

Growing Research Support

ACT is supported not just by RCTs that demonstrate its efficacy, but also by research that adds nuance to our understanding of what makes it efficacious. As of 2011, approximately two thirds of ACT studies had included mediation analyses (Hayes, Villatte, Levin, & Hildebrandt, 2011), statistical tests that determine whether changes in measured outcomes (e.g., degree of depression, quality of life) are driven, at least in part, by the processes theorized by the treatment model. This kind of analysis is important because when a treatment works, it is often difficult to determine the primary mediating factors. According to Hayes et al. (2011), "Across all studies, about 50% of the between-group differences in follow-up outcomes can be accounted for by the mediating role of differential post levels in psychological flexibility and its components" (p. 26). Furthermore, as noted above, more than 50 studies support the basic tenants of RFT (Hayes et al., 2012b). Moreover, a growing body of research has demonstrated that a variety of specific, brief ACT or ACT-like interventions (i.e., accepting thoughts and feelings, being mindful, focusing on your values) make a difference when compared to trying to control thoughts and feelings or, alternatively, doing nothing. For example, Eifert and Heffner (2003) showed that encouraging people with high anxiety sensitivity to accept their feelings while experiencing experimentally induced panic symptoms resulted in less distress than teaching them to try to control their experiences by using diaphragmatic breathing. See Levin, Hildebrandt, Lillis, and Hayes (2011) for a recent meta-

analysis of ACT and ACT-consistent intervention such as this. Finally, ACT theory and research draw from other areas of research in the social sciences. For example, Daniel Wegner, a Harvard psychologist, has demonstrated in multiple studies that trying to suppress thoughts and feelings may work in the short term but often leads to a rebound over the middle and long-term (e.g., Wegner, 1994). This body of work is consonant with ACT's emphasis on letting go of directly controlling thoughts and feelings.

This depth of research support has contributed to ACT's credibility as an evidence-based intervention. In 2011 the Substance Abuse and Mental Health Services Administration (SAMHSA), the behavioral health wing of the U.S. Department of Health and Human Services, included ACT in its online compendium of evidence-based treatments (SAMHSA, 2013). The U.S. Veterans Health Administration (VHA) now requires that ACT be available for veterans suffering from depression and anxiety (Veteran's Health Administration, 2008) and funds training in ACT for VHA clinicians. Division 16 of the American Psychological Association, which maintains a website that rates the research strength of various therapies, considers ACT to have "strong support" for the treatment of chronic pain (Society of Clinical Psychology, n.d.) and "modest support" for the treatment of depression, mixed anxiety, psychosis, and OCD (Society of Clinical Psychology, n.d.).

Despite the credibility afforded by recognition from SAMHSA, VHA, and APA, the question of whether ACT is better than established treatments is still very much open. Thus far, six meta-analyses of ACT outcomes have been published. (Meta-Analyses combine data from multiple studies.) Five meta-analyses (A-Tjak et al., 2015; Hayes et al., 2006; Öst, 2008, 2014; Powers et al., 2009) found ACT superior to control conditions such as waitlist, psychological placebo, and treatment as usual. Two early meta-analyses (Hayes et al., 2006; Öst, 2008) found ACT superior to active comparison interventions such as traditional cognitive behavior therapy and nicotine replacement therapy, but three later meta-analyses (A-Tjak et al., 2015; Öst, 2014; Powers et al., 2009), which incorporated more studies, did not. Ruiz (2012) compared ACT to traditional cognitive behavioral therapy only and found ACT superior overall, but found no statistically significant differences between ACT and CBT on depression or anxiety outcomes. A more recent meta-analysis (Öst, 2012) found no difference in outcomes between ACT and traditional CBT. All studies noted research design limitations, with Öst (2014) providing the most strenuous critique and A-Tjak et al. (2015) drawing more favorable conclusions about the sturdiness of ACT research at roughly the same point in time. Readers are encouraged to read these studies and their critiques of ACT research, as well as the responses, reanalyses, and updates that have followed (Guadiano, 2009; Levin & Hayes, 2009; Öst, 2009; Smout et al., 2012).

Consistent With Social Work Values

ACT is consistent with social work values. Though an extensive exploration is beyond the scope of this article, three areas of overlap between social work and ACT are worthy of mention here: the centrality of understanding people within their social and physical environments, the commonality between helpers and those being helped, and a commitment to going beyond DSM diagnoses to understand human suffering. (For an exploration of the fit between ACT and the core social work values listed in the NASW Code of Ethics [2008], see Boone [2014].)

The Interaction of People and Their Social and Physical Environment

The fit between ACT, functional contextualism, and core social work values begins with a mutual understanding that behavior is learned over time in a reciprocal back-and-forth between an individual and his or her social and physical environments. This is a nonblaming, skills-based approach. If problems do not reside "inside" people, but rather are learned, then new, more

functional behaviors can also be learned. In functional contextualism, behavior is shaped by helping clients create new contexts in which new behaviors can be learned. Social workers may be especially equipped to do this because they often work with people in the very environments in which they are having difficulty, for example, at home or at school. Whether the social worker intervenes by helping a client access housing and health care, assisting classroom teachers to be more responsive to a client's needs, or using the therapeutic relationship to undermine the influence of a "feel good" culture that encourages clients to strive for happy feelings (i.e., experiential avoidance) and positive thinking (i.e., fusion), the social worker is influencing the client's context. Though ACT usually targets the culturally shaped context of thinking and feeling in the client's life, there is nothing in ACT that precludes helping to shape broader contextual factors such as access to resources, the political environment for underserved populations, or the home and classroom environments in which clients live day-to-day. All of these types of interventions are ACT-consistent.

The Universality of Suffering and the Commonality Between Workers and Client

Another basic assumption underlying functional contextualism, ACT, and social work is that we are all "in the same soup"— in other words, that workers and clients are only different in that they inhabit different roles in the helping relationship. In ACT terms, this means that social workers are likely to encounter the same struggles with experiential avoidance and fusion as their clients; suffering is the norm, not the exception. Thus, ACT also encourages practitioners to become present, open up to experience, and act in the service of values—not just to support others, but also to support themselves. For example, ACT has been applied in training contexts to reduce burnout in mental health providers (Hayes et al., 2004) and reduce stress among social workers (Brinkborg et al., 2011), and increase resiliency in caregivers of people who have dementia (McCurry, 2006). This universalizing upends the inevitable hierarchy in the therapeutic relationship and provides a level ground on which helpers and those being helped can connect in the service of mutual growth.

Going Beyond DSM *to Better Understand Human Suffering*

One possible downside to receiving clinical support is being labeled "mentally ill" or "mentally disordered." There is almost certainly a benefit to these labels for some people; finding a name for a problem can diminish self-blame and motivate help-seeking. Yet, when we fuse with labels—that is, when we allow labels to calcify into fixed identities that drive behavior—there are almost certainly consequences, such as rigidly fulfilling our expected roles as people who are "depressed," "borderline," or "bipolar." The necessity of labeling (i.e., diagnosing) is more and more a part of the funding landscape for clinical social work and does not appear to be diminishing despite recent consternation about the publication of *DSM 5* (e.g., Greenberg, 2013). ACT and functional contextualism provide a workable complement to this diagnostic system, one that theoretically fits with nearly every category within it. ACT offers a coherent explanatory system for how constellations of behaviors labeled as "major depressive disorder" or "borderline personality disorder" function in a client's life (e.g., as experiential avoidance, fusion, and other inflexible processes) as well as a yardstick for determining whether to target them (i.e., workability in the service of building a life worth living). At the same time, ACT encourages clients to hold labels such as "major depression" and "borderline personality" lightly, following them only as far as they are useful, while providing a system for understanding them which is flexible, nonblaming, and universalizing.

Accessibility of Training

The Association for Contextual Behavioral Science (ACBS), the professional organization of ACT, has no certification process for trainers. Instead, there is a low-cost peer review process, and peer-reviewed trainers are simply listed on the ACBS website (contextualpsychology.org). This keeps the quality of trainings consistent while avoiding the "trademarking" that increases the cost of training for many therapies. Thus, ACT is likely to be affordable and accessible to social workers from a variety of income levels. For those who cannot afford the time or money for training workshops, the ACBS website offers a wealth of resources for people interested in self-study, including podcasts, PowerPoint presentations, research protocols, and articles. These resources are available to anyone who is a member of the organization, and membership requires values-based dues that can be as low as $10. Finally, aspiring ACT practitioners are allowed to call themselves "ACT therapists" when they feel they are competent, which further avoids potential barriers created by trademarking and expensive certification processes.

CONCLUSION

The theories underlying acceptance and commitment therapy, as well as a range of other benefits, including the scope of its applicability, the relative accessibility of training in ACT, and the link to social work values, all make it is a good fit for clinical social work. The main tenets of functional contextualism—pragmatic truth criteria, the interrelation of behavior, function, and context, and an emphasis on pragmatism and observable phenomena—mesh well with social work's mission and emphasis on person-in-environment. ACT concepts such as psychological inflexibility, fusion, and experiential avoidance give social workers nonstigmatizing tools for understanding human behavior. Finally, ACT offers social workers useful tools for supporting growth and change in their clients.

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