Acceptance and Commitment Theory of Depression

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This chapter presents a theoretical overview of depression from an acceptance and commitment perspective. While the earliest randomized clinical trials of what is now known as acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) evaluated its relative efficacy in addressing depression (Zettle & Hayes, 1986; Zettle & Rains, 1989), ACT was not explicitly, nor exclusively, created for treatment of mood disorders. From its inception, ACT was developed as a transdiagnostic approach, more focused on targeting pathogenic processes common to diverse forms of human suffering, including depression, rather than on seeking disorder-specific symptomatic relief (Hayes, 1987). Accordingly, although ACT has been adapted and applied to treating depression (Zettle, 2004, 2007; Zettle & Hayes, 2002), there is essentially no corresponding theory that is unique to depression. As a result, what I will present here is an overview of the philosophical-theoretical foundations upon which an acceptance and commitment approach is based, and particularly how an associated conceptual, albeit generic, model of psychological inflexibility and psychopathology can be specifically extended to depression.

ACT is based upon Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001) as a contextualistic-behavioral account of human language and cognition. The original impetus for RFT was two-fold in nature. One was the philosophical recognition that existing approaches to human language and related phenomena primarily were mentalistic, rather than contextualistic, in nature. Secondly, behavior analytic accounts of verbal behavior (Skinner, 1957) by focusing more on speaking than listening also were found to be inadequate, especially when self-talk is involved (Hayes et al.). The roots of ACT and RFT are clearly located within

the behavior analytic wing of the cognitive-behavior therapy movement (Hayes, 2004). However, both acknowledge the challenges posed by human cognition to behavior analysis and the possibility that additional behavioral processes may emerge from language (Zettle, 2005).

An overview of functional contextualism as the philosophical foundation for RFT will be provided before coverage of RFT. This chapter concludes with a conceptual model of depression that, in turn, is derived from how language contributes to psychological rigidity and related human misery according to RFT (Wilson, Hayes, Gregg, & Zettle, 2001).

Overview of Functional Contextualism

Contextualism constitutes one of four philosophical systems or "world hypotheses" identified by Pepper (1942) as applicable to psychology (Hayes, Hayes, & Reese, 1988). Of greatest relevance for our purposes are distinctions that can be drawn between contextualism and the world view of mechanism (Hayes & Brownstein, 1986). An acceptance and commitment approach to depression appears unique in explicitly articulating its philosophical grounding in functional contextualism. By contrast, alternative cognitive-behavioral theories appear to at least implicitly endorse mechanism. Critical distinctions between functional contextualism and mechanism can be clarified by summarizing their respective positions on the following philosophical issues: (a) nature of "truth," and (b) view of behavior and its causes.

Nature of "Truth"

According to Pepper (1942) mechanism adopts a "correspondence-based" truth criterion, whereas contextualism subscribes to "successful working." Mechanists ultimately evaluate the "goodness" or quality of any theory of depression by the degree to which it accurately maps onto what is already known, or even better, is eventually "discovered" about how depression is put

together. In short, the "best" theory of depression is the one that best predicts how its constituent parts are related to each other to create the disorder. Being able to efficaciously treat depression is certainly not unimportant, but it is regarded as secondary to being able to first adequately understand it from a structural perspective. Unfortunately, the variables that are often implicated in understanding depression are ones that cannot be directly impacted. Consequently, the relative emphasis is on prediction alone, rather than upon both prediction and influence (Hayes & Brownstein, 1986).

In contrast to mechanism, functional contextualism is more explicitly pragmatic in adopting the ability to both predict *and* influence behavior (Hayes, 1993) with adequate scope, precision, and depth (Biglan & Hayes, 1996; Hayes, Follette, & Follette, 1995; Hayes & Hayes, 1992) as its truth criterion. "Successful working," however, cannot be specified in the abstract, but only in conjunction with clearly articulated goals, less it become dogmatic in nature (Hayes, 1993). These goals themselves are, in turn, contextually-determined and vary depending, for example, upon whether the focus is primarily scientific or therapeutic in nature.

From the perspective of functional contextualism, an acceptance and commitment account of depression is "true" to the extent that it eventually results in more useful ways of assisting those who struggle with it. Scientifically, the ultimate test of RFT is whether ACT can be shown to be a better way of alleviating human suffering, in general, and of depression, in particular, with adequate scope, precision, and depth. The therapeutic goals against which the truth criterion of "successful working" is evaluated are guided by client valuing. Individually articulated client values become the reference point within ACT against which specific client behaviors and related goals (e.g., "Has trying to figure out why you're depressed moved you

closer to or further away from what you say is most important to you in life?") are evaluated.

View of Behavior and Its Causes

The fundamental explanatory model of mechanism is that of the machine, while that of contextualism is the "act in context" (Pepper, 1942). To the mechanist, behavior is spoken of as a noun (e.g., "language" vs. "languaging") and commonly regarded as a thing, much like a car engine, that can be adequately explained by specifying the parts that comprise its structure and how they relate to each other (Hayes & Brownstein, 1986). A "good" mechanistic theory of depression is one that can account for how the various signs and symptoms that purportedly distinguish it from other syndromally-classified forms of psychopathology (American Psychiatric Association, 1994) originate and are maintained. Because the correspondence-based truth criterion of mechanism can be approached by prediction alone, it is perfectly legitimate to maintain that one part of the psychological system (e.g., ways of thinking; Beck, 1967) assumes priority or even causal status in accounting for other components (e.g., changes in overt behavior and mood) within it (Hayes & Brownstein, 1986).

Functional contextualism regards behavior not as a thing whose psychological structure is to be predicted by increasingly sophisticated hypothetico-deductive theories, but as the activity of the whole, integrated organism interacting in and with historical and situational contexts (Hayes, 1993). The "acts in context" that typify depression constitute both behavioral deficits (e.g., social withdrawal, discontinuation of previously pleasurable activities, etc.) and behavioral excesses (e.g., hypersomnia, thinking about suicide, etc.). The ability of one behavior, such as ignoring the positive, to serve a controlling function over another is not precluded, although such behavior-behavior relationships are themselves conceptualized as under contextual control

(Hayes & Brownstein, 1986; Zettle, 1990).

To satisfy the truth criterion of successful working, the causes of behavior, more generally, and of depression, in particular, are limited to contextual variables that when manipulated can be shown to not only predict behavior, but to influence it as well. The historical context of which depression is a function, such as previous learning experiences and life events, obviously cannot be directly altered, not because such variables were fundamentally unmanipulable in principle at the time of their occurrence, but because they are not presently accessible. However, the stimulus functions of such events, as will be seen, may be transformed by helping clients retell the stories they have constructed about their histories. Current situational influences upon depression are more directly addressed by alterations in therapist behavior in-session and indirectly by supporting clients in making changes within their physical and social environments.

Summary

While a certain degree of technical eclecticism may be possible, with differing treatment approaches to depression incorporating particular therapeutic techniques developed by others, eclecticism is not possible at the philosophical level because of conflicting "truth criteria." In effect, mechanism and contextualism not only have divergent ways of looking at the world of depression, but also use differing "benchmarks" or standards by which to evaluate their work within this domain.

Overview of Relational Frame Theory

The presentation of RFT here is of necessity abbreviated and the interested reader is encouraged to consult Hayes et al. (2001) for a more expansive account of it. The term

"relational frame" and the more technically-correct gerund ('relational framing") both refer to behavior. Most importantly and consistent with functional contextualism, framing events relationally, speaking, and listening are all viewed as verbal "acts in context" that are acquired, shaped, and maintained through operant conditioning.

Nature of Relational Framing

Most simply and broadly stated, relational framing refers to a kind of relational activity (Hayes & Hayes, 1989), or responding to one event or stimulus on the basis of its relationship to one or more others. Naming, comparing/contrasting, and evaluating are some common forms of relational framing. In depression, for example, clients may negatively appraise their current life circumstances compared to a preferred past as well as dreaded future. No matter how satisfying the here-and-now is, it is always possible to create misery by contrasting it against some imagined place we would rather be.

Properties of Relational Framing

Relational framing displays three properties that distinguish it from the type of limited relational responding exhibited by organisms lacking in language: (a) mutual entailment, (b) combinatorial entailment, and (c) transformation of stimulus functions.

Mutual entailment. The arbitrary relationship established between stimuli that are framed relationally is bidirectional. A child who learns that a dime is more valuable than a nickel also simultaneously learns that a nickel is less valuable than a dime even when this relationship is not directly taught. A common type of bidirectionality that occurs in depression involves frames of coordination between the self and negative evaluations (e.g., "I *am* stupid") that establishes a functional identity or fusion between the two relata (i.e., "I" = "stupid" and "stupid" = "I").

Combinatorial entailment. Once a given stimulus, such as a nickel, has been separately related to other stimuli, such as both a dime and penny, new arbitrary relationships can be derived among the array of relata without being explicitly trained or taught. For example, a child who is separately taught that a nickel is less than a dime and that a nickel is greater than a penny, will derive that a dime is greater than a penny and that a penny is less than a dime. Combinatorial entailment in depression may further the verbal construction of an inferior self-concept through interpersonal comparisons (Zettle, 2007). If 'Jack has his life together better than I do" and "Jill has her life together better than Jack," then "I also don't have my life together as well as Jill does."

Transformation of stimulus functions. Through mutual and combinatorial entailment, discriminative, eliciting, establishing, and reinforcing functions that either already exist, or are arbitrarily established for a given stimulus, can be transformed and transferred to other stimuli within the same relational network (Hayes et al., 2006). For example, recently participants were first taught to select the middle-sized member (B) within an array of abstract visual stimuli (Dougher, Hamilton, Fink, & Harrington, 2007) that was then paired with mild shock. Subsequently, participants were presented with the smaller (A) or larger (C) stimuli used in the initial training. According to classical conditioning principles, equivalent, but relative to B, diminished skin conductance changes should have been obtained for both A and C. Instead, and consistent with RFT, participants exhibited a conditioned response to C that exceeded that of B. The transformational property of relational framing may in part explain how hopelessness that clients often express about their future is established. If "today is bad" and tomorrow will be even worse, a future (i.e,"there-then") is verbally constructed via temporal framing that is even

more aversive than whatever circumstances are currently present (i.e., "here-now').

Development of Relational Framing

Developmentally, the first type of relational framing that is acquired is naming. Through what in effect constitutes naturalistic discrete trials training with multiple exemplars, children initially acquire a frame of coordination between objects and their names. Over enough trials and through a process that parallels the acquisition of generalized imitative responding (Gewirtz & Stengle, 1968), a frame of coordination or naming is established as an operant response class that quickly expands. Other functional classes of relational operants, such as opposition and comparison, are thought to be shaped and acquired in a similar manner.

Another repertoire of derived relational responding normally established early on in life that is of particular clinical relevance involves deictic framing (Hayes et al., 2001, pp. 38-39). In deictic framing, relations are consistently specified, and accordingly differentially reinforced, from the perspective of a speaker. Young children asked to tell what they are doing right now, will likely be chided and corrected if they state what another child is doing at the moment and/or what they did yesterday. Consistent with multiple exemplar training, each time children are asked questions of this type, the context of what they, as well as others who are present, may be doing or have just done, will be different. The only constants over such interchanges are the relational properties of "I" versus "you," "here" versus "there," and "now" versus "then." What emerges is perspective taking that provides both a basis for the experience of spirituality (Hayes, 1984) and "theory of mind" (Carruthers & Smith, 1996). As will be seen, a weakened sense of self as context and resulting loss of perspective taking is one of several key processes thought to contribute to various forms of psychopathology, including depression. Particularly during

emotional reasoning, depressed clients who are unable to contact a sense of themselves that stands apart from negative self-referential thoughts and emotions lack a vantage point from which they can mindfully respond to such psychological events.

Summary

RFT does not represent the first nor certainly the only attempt to provide a comprehensive and systematic account of human language, cognition, and problem solving (see Chomsky, 1965; Gibson & Ingold, 1993). However, it is the first to do so from a functional contextualistic perspective in which the ability of humans to derive arbitrary stimulus relations and language are viewed as emerging from the same behavioral processes. From this vantage point, the more critical issue is not whether arbitrarily applicable relational responding serves as the basis for languaging or vice versa, but whether being able to identify and impact the psychological processes common to both enhances our ability to predict and influence both clinical and subclinical forms of human suffering. Unlike other theories of language and cognition, RFT points rather directly to an array of pathogenic processes that are presumably supported by language and relational framing. Perhaps the most widely recognized language-driven process that appears to contribute specifically to depression is rumination (Zettle, 2007). This is especially so when clients rigidly insist that understanding and figuring out their depression is necessary before they can get on with their lives.

An Acceptance and Commitment Model of Depression

From an acceptance and commitment perspective, a primary basis of suffering is psychological inflexibility, or an inability to make the adjustments necessary to sustain value-directed behavior (Hayes et al., 2006, p. 5). As just alluded to, putting valued living on hold

until the mystery of why one is depressed is resolved is but one example of this. Because psychological rigidity is defined functionally, sometimes it takes the form of persisting in the same futile behavior, while in other contexts, it can involve impulsively shifting among an array of ineffective actions. Under both sets of circumstances, a long-term course of valued action is precluded and clients are left with a sense of life as something to be endured rather than as a vital and meaningful process in which to be engaged.

An acceptance and commitment model of psychopathology has identified six core pathogenic processes that contribute to psychological inflexibility (Hayes et al., 2006): (a) fusion, (b) experiential avoidance, (c) attachment to a conceptualized self, (d) living in the past/future, (e) excessive rule-following, and (f) lack of valued action. The degree to which each process functions independently of the others and which one(s) may be dominant with a given client can only be determined on a case-by-case basis. Consistent with functional contextualism, the six processes are viewed as a way of guiding case conceptualization within ACT, more generally (Bach & Moran, 2008), and in working with depressed clients, in particular (Zettle, 2007). In contrast to a mechanistic perspective, the model is not seen as revealing something essential about the structure of psychopathology. In what follows and for ease of discussion, the specific roles of each of the dysfunctional processes within depression will be considered in turn. How language and relational framing may, in turn, contribute to each process will be further explicated and, when available, supportive research will be discussed and summarized.

Fusion

Fusion refers to how stimulus functions that are transformed and derived through

language can dominate over behavioral regulation that comes from contact with direct contingencies (Strosahl, Hayes, Wilson, & Gifford, 2004). In effect, during fusion, what we say and think about the world influences behavior to a greater degree than does direct, experiential contact with that world. Fusion per se is not always pathogenic such as when we are able to find meaning and value during circumstances that are impoverished and degrading (e.g., Frankl, 1965). Fusion, however, contributes to depression when direct experiences that would otherwise support valued living are relationally framed in certain ways. For example, the attainment of a goal, such as finishing a project at work, may be dismissed as "not being good enough" when framed as disconnected from the value of being a responsible employee. More particularly, fusion appears to contribute to depression through relational framing at multiple levels – evaluating, reason giving, and story telling.

Evaluating. At the simplest level of languaging, fusion occurs when evaluations of referents are responded to as if they were descriptions of them. Negative self-statements that foster attachment to a damaged conceptualized self (e.g., "I *am* worthless") provide perhaps the most common instance of fusion within depression and will be considered in greater detail shortly. Evaluating as a ubiquitous type of relational framing, however, is hardly restricted to how we talk about ourselves and extends to our ongoing stream of other thoughts, feelings, and related psychological experiences.

During language development, most verbal-social communities teach children the appropriate use of certain descriptive terms, such as "bad," "awful," "terrible," and so on, in talking about negative life-events like the loss of a loved one or physical injury. Doing so establishes a frame of coordination or equivalence and bidirectionality between the words used

in talking about the events and the events themselves (e.g., death = "bad," "bad = death). Additionally, through the transfer of stimulus functions, the word "bad" itself now assumes some of the same psychological properties of losing a loved one. Through combinatorial entailment, any new event, such as losing a job, that is now also evaluated as "bad" may exert an emotional impact similar to the death of a family member (i.e., job loss = "bad," "bad" = death, job loss = death). If and when this occurs, the stimulus functions derived from how the event is framed relationally (i.e., "Being fired *is as bad as* someone dying") dominate over those directly related to the event itself and a description of it (e.g., "I received written notice of my termination"). Empirical support for the process of fusion at this level of relational framing is provided by research on dysphoric mood induction procedures, such as the Velten (1968), that attest to the emotional impact of responding literally to simple mood-related statements (Finegan & Seligman, 1995).

Reason giving. Formulating accounts for why depression is present to begin with and/or explanations for how and why it precludes value-directed behavior provide an intermittent level of relational framing that may additionally contribute to psychological inflexibility (Zettle & Hayes, 1986). With both types of reason giving, clients may "buy into" verbal constructions that point to reasons for the initiation and continuation of depression that cannot be altered. Sometimes reason giving may cite previous life events, such as a divorce or job loss, as "causes" for depression that are simply inaccessible and thus currently unmanipulable. The greater problem with this way of thinking about depression lies not so much with fusion with reasons as causes, but additional fusion with how the relationship between the purported causes of depression and its treatment is framed (e.g., "My depression

can't be effectively treated until what caused it in the first place is identified and corrected") (Zettle, 2007).

More commonly cited as reasons for depression than external circumstances are private events such as negative, unwanted thoughts and related feelings of guilt, sadness, regret, and so on (Bloor, 1983; Rippere, 1977). Private events are commonly cited as reasons for a range of undesirable behaviors and are regarded as "good," valid explanations (Hayes, 1987). While thoughts and feelings are certainly potentially more accessible than previous life events, acceptance and commitment theory holds that attempting to alter them is often just as futile and may contribute further to psychological inflexibility and the continuation of depression. Dismantling research within cognitive therapy that has called into question the contribution of cognitive restructuring components lends some related empirical support to this perspective (Jacobson et al., 1995).

Several lines of research provide support for this purported relationship between fused reason giving and psychological rigidity within depression. Those who offer more reasons for depression, as assessed by the Reasons for Depression Questionnaire (RFD; Addis, Truax, & Jacobson, 1995; Thwaites, Dagnan, Huey, & Addis, 2004), ruminate more in response to depressed mood (Addis & Carpenter, 1999) and report higher levels of both depression and psychological inflexibility as measured by the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004). A regression analysis indicated that the RFD and AAQ both significantly and independently accounted for variability in depression levels, findings supportive of viewing reason giving as a process that contributes to psychological inflexibility, but which is not synonymous with it (Garst & Zettle, 2006). Of greater practical importance, depressed

clients who score high on the RFD are more treatment resistant and display higher levels of postreatment depression even when controlling for its levels at pretreatment (Addis & Jacobson, 1996).

Story Telling. In story telling clients relate multiple explanations for depression to each other as well as to autobiographical facts to produce a coherent and meaningful narrative account of their lives and experiences with depression. Story telling can be viewed as a network of relational frames that essentially constructs reasons for reasons (Zettle, 2007). As with fusion at the level of individual thoughts and reason giving, that which occurs with the life story is not in and of itself pathogenic as long as psychological flexibility is not compromised.

All too often, however, this rarely appears to be the case, especially with clients who have struggled with chronic, clinical depression. Such clients may assume a "victim role" and somewhat self-righteously insist that struggling with depression is an inevitable outcome given how they were traumatized and mistreated either by life itself or at the hands of others (e.g., "With what I've gone through, I have every right to be depressed"). At this level of fusion, the life story is responded to as a set of immutable and indisputable "facts" rather than as something that can potentially be retold and reconstructed with a different outcome. Within this context, depression itself may be regarded and wielded as a constant reminder, evidence, and validation of the mistreatment the client has suffered. When this occurs, "getting better" is now incompatible with "being right" about the life story. In effect, "being right," "getting even," and not letting transgressors "off the hook" trump "getting better" (Zettle, 2007).

From an acceptance and commitment perspective, depressed clients who respond favorably to therapy would be expected to show reductions in the rigidity with which the

pretreatment life story is held. A literature search revealed no research by proponents of ACT that has addressed this issue, but a recent dissertation from a narrative therapy perspective (White & Epston, 1990) that has. Depressed clients successfully treated with either client-centered (Rogers, 1951) or process-experiential therapy (Greenberg, Rice, & Elliott, 1993) showed greater changes in their life stories than their nonrecovered counterparts (Hardtke, 2008).

Experiential Avoidance

Experiential avoidance is conceptualized as intentional efforts to alter the frequency or form of selective private events; such as negative thoughts, guilt, sadness, regret, and other unwanted emotions; or the contexts in which they occur (Hayes et al., 2006). In large measure, fusion sets the stage for experiential avoidance. It is perhaps easiest to see how these two processes work together to produce psychological rigidity at the level of specific thoughts. All negative thoughts (e.g., "I am responsible for the economy failing") are not targeted for experiential avoidance, but only those with which clients are fused (e.g., "I am responsible for my marriage failing").

According to RFT, we are doomed to be haunted by our own self-awareness. Through the bidirectional transformation of stimulus functions, merely thinking about and recalling an unpleasant life event can have a psychological impact similar to that experienced when the event first occurred. Because experiential avoidance is defined functionally, efforts to avoid or escape from fused, depressing thoughts and memories can take varied forms, ranging from distraction to suicidality (Zettle, 2007). Two of the most common forms of experiential avoidance appear to be thought suppression (Wenzlaff, 1993) and rumination (Nolen-

Hoeksema, 1990), with only the former being discussed here. A consideration of the role that rumination plays in depression will be offered a bit later.

The thought suppression literature consistently shows that efforts to suppress unwanted thoughts backfire in that they rebound with increased strength (Wegner, 1994). In the case of depression, other negative thoughts are often focused upon to divert attention away from a targeted thought. Not surprisingly, such a strategy is less effective than using neutral thoughts as distractors (Wenzlaff, Wegner, & Roper, 1988), reinduces the dysphoric mood present when the initial suppression occurred upon the re-emergence of the targeted thought (Wenzlaff, Wegner, & Klein, 1991), and apparently contributes to rumination and increased depression (Wenzlaff & Luxton, 2003). The futility of experiential avoidance and how it can exacerbate depression is further underscored by findings that a reoccurrence of dysphoric mood can reinstate thought suppression (Wenzlaff et al., 1991), thereby creating a downward, spiraling relationship between these two private events and allowing depression to lead a life of its own.

Deliberate efforts to control unwanted affective states appear to be similarly counterproductive and no more successful than those directed towards thinking. From an acceptance and commitment perspective, dysphoria and sadness are not regarded as pathological, but rather as healthy, adaptive emotions in reacting to loss and blocked goal-attainment (Klinger, 1975; Neese, 2000). To the extent that emotional suffering is linked to valuing, appreciating the sources of our clients' sorrow may even help illuminate what matters most to them as a focal point within ACT (Zettle, 2007). Dysphoria and sadness only become problematic to the extent that failed efforts to experientially control them can escalate into clinical depression. Proponents of an acceptance and commitment approach are in agreement

with others who have argued that depression is most usefully regarded as a "secondary emotion," constituting a reaction to another emotional reaction, such as dysphoria or guilt (Leventhal & Martell, 2006). Support for this formulation is provided by finding that participants reporting high levels of experiential avoidance were significantly more disturbed then their low avoidant counterparts in response to equivalent levels of induced dysphoric mood (Gird & Zettle, in press). What is referred to within ACT as "clean pain" (e.g., dysphoria and sadness) that is an inevitable consequence of leading a full, engaged life, becomes exacerbated into the "dirty pain" of clinical depression through the process of experiential avoidance (Hayes et al, 1999; Zettle, 2007), thereby leaving clients feeling depressed about feeling depressed (cf. Fennell & Campbell, 1984; Fennell & Teasdale, 1987).

Attachment to a Conceptualized Self

One of the hallmarks of depression and part of the "negative cognitive triad " (Beck, 1967) are disparaging thoughts about the self. The potential problem according to an acceptance and commitment model of depression is not negative self-thoughts per se, but *fused* negative thoughts about the self that participate via relational framing in the construction of a negative self concept. Not surprisingly, discomfort in and believability of self-relevant negative thoughts appear to be closely linked and to covary as a function of the level of associated attachment or fusion with them (Masuda, Hayes, Sackett, & Twohig, 2004). Critical self-referential thoughts take the generic form of "I *am* . . . stupid, incompetent, unlovable, no good, etc." and along with demographic details; such as those involving gender, age, marital status, and so on; help form the conceptualized self. In the early stages of depression, clients are likely to engage in suppression, rumination, or other forms of

experiential avoidance to control unwanted thoughts about the self. Doing so is more likely to make the problem of depression bigger rather than smaller, and the time and energy invested in experiential avoidance is diverted away from value-directed behavior.

As depression itself becomes exacerbated through the process of experiential control, fused self-identification with the disorder (i.e, "I *am* depressed" vs. " I am a middle-aged, married male who is experiencing depression") may come to dominate over other ways clients think about themselves. In effect, through the bidirectional transformation of stimulus functions, clients become their depression. If and when this occurs, depression itself is maintained and potentially heightened for at least two reasons. For one, with such a fused self-identity, efforts to remove the depression are psychologically tantamount to assault on a fundamental sense of who the client is, and can accordingly be expected to be resisted. Secondly, depressed clients can become so fused with a verbal construction of themselves as damaged that their ability to nonjudgementally view their own negative self-talk and related depressive experiences from the self-as-perspective established via deictic framing is severely compromised. As suggested by RFT, another behavior commonly engaged in by clients who struggle with depression that further contributes to psychological rigidity and also appears to be incompatible with being mindfully present is rumination.

Living in the Past/Future

Thinking about the causes, implications, and possible solutions to depression has the appearance of problem-solving. However, from an acceptance and commitment perspective, ruminating can be viewed as relational framing that serves an experiential avoidant function. Although rumination, relative to worrying appears, to be more focused on the past than the

future (Papageorgiou & Wells, 2003; Watkins, Moulds, & Mackintosh, 2005), the status of thoughts about the future within the negative cognitive triad of depression (Beck, 1967) and high rates of comorbidity between depression and anxiety disorders, especially generalized anxiety disorder (Mineka, Watson, & Clark, 1998), suggest that depressed clients are also often likely to be preoccupied with the future as well. Either way, clients who struggle with depression as a consequence display fusion with a verbally-constructed past and/or future that limits their ability to respond in a psychologically flexible manner to what appears in the here-and-now (Davis & Nolen-Hoeksema, 2000). Living in the past/future further locks depression in place by being at odds with living a valued life in the moment and in responding mindfully (Kabat-Zinn, 1994) to psychological events they may serve as barriers to it.

From an RFT perspective, mindfulness can be viewed as nominally framing private events in the here-and-now (e.g., "There's a thought"). As such, it functionally undermines both temporal (e.g., "How much longer am I going to feel this way?") and evaluative (e.g., "Why do I feel this way?') relational framing (Fletcher & Hayes, 2005). Research documenting an incompatibility between ruminating and mindfulness (Ramel, 2007; Ramel, Goldin, Carmona, & McQuaid, 2004) and the role of the former in the initiation, maintenance, and reoccurrence of depression is by now fairly extensive and will only be briefly summarized here. Whether construed as a coping style (Nolen-Hoeksema, 1990) or as an analytical and evaluative response set (Watkins & Teasdale, 2001), rumination has been implicated in depression in both correlational/prospective (e.g., Nolen-Hoeksema, Parker, & Larson, 1994) as well as experimental research (e.g., Lyubomirsky, Tucker, Caldwell, & Berg. 1999) with nondepressed (e.g., Nolen-Hoeksema & Morrow, 1991), dysphoric (e.g, Lyubomirsky &

Nolen-Hoeksema, 1993), and depressed (Rimes & Watkins, 2005) participants. Also, consistent with an acceptance and commitment model of depression, ruminative "problem solving" appears to contribute to psychological inflexibility by producing both a more restricted range of possible solutions as well as an unwillingness to commit to them (Lyuobmirsky & Nolen-Hoeksema, 1993; Ward, Lyubomirsky, Sousa, & Nolen-Hoeksema, 2003).

Excessive Rule-Following

According to RFT, rules are viewed as frames of coordination between two relational networks that control behavior (Barnes-Holmes, O'Hora, Roche, Hayes, Bissett, & Lyddy, 2001). Instructions, advice, commands, and requests - whether issued by others or formulated by oneself - are common types of rules that may come to exert functional control over behavior (Zettle, 1990). As with languaging and relational framing more broadly, the degree to which rule-following may contribute to depression is contingent upon the extent to which it limits valued living. At least two functional units of rule-governed behavior, tracking and pliance (Zettle & Hayes, 1982), are thought to more broadly contribute to psychological inflexibility.

Tracking is rule-following under the control of an apparent correspondence between the rule (e.g., "The quickest way to get to Kansas City from Wichita is by the turnpike") and external contingencies independently of the delivery of the rule (Barnes-Holmes et al., 2001; Zettle & Hayes, 1982). The critical external contingencies that participate in tracking can either be appetitive or aversive in nature. Although tracking under appetitive control is typically repertoire-expanding, tracking which is controlled by aversive contingencies is often rigid and inflexible (Wilson & Murrell, 2004). The type of valued-directed actions that ACT

seeks to support is one example of appetitive tracking (e.g., ways of being a loving parent), while pursuing a fearful and overly cautious approach to life exemplifies avoidant tracking. The operative rule, or track (Zettle & Hayes, 1982), in the former may be something like "There are an infinite number of things I can do in being a 'good parent' to my children," while that which controls avoidant tracking may be "If I don't take risks, I won't make mistakes."

Pliance is rule-governed behavior under the control of apparent socially mediated consequences for a correspondence between the rule itself and the relevant behavior. Following the advice and suggestions has been learned as operant behavior because of the consequences for doing or not doing so. Because punishment for noncompliance tends to be more widely used than positive reinforcement in consequating rule-following, pliance is also typically under aversive control. Loosely speaking, depressed clients may adopt a risk-averse approach to living not so much to avoid mistakes per se, but to spare themselves from the criticism and scorn of others who have offered advice on what to do to avoid such errors. Similarly, clients may pursue certain course of actions not because they are congruent with personal values, but because doing so is what they are "supposed to" or "expected" to do. What may appear on the surface to be valued action is functionally avoidant behavior.

Support especially for the impact of pliance in generally limiting psychological flexibility and creating an insensitivity to external contingencies of reinforcement has come from laboratory investigations of rule-governance and human operant responding (see for example, Hayes, Zettle, & Rosenfarb, 1989). However, later research examining the behavior of dysphoric/depressed participants using similar preparations has produced inconsistent findings (Baruch, Kanter, Busch, Richardson, & Barnes-Holmes, 2007; McAuliffe, 2004;

Rosenfarb, Burker, Morris, & Cush, 1993), suggesting the need for a more extensive experimental analyses of rule-following in better understanding the roles that avoidant tracking and pliance may play in depression.

Lack of Valued Action

Reductions in both pleasurable and task-oriented activities often occur in depression (Beck et al., 1979, pp. 197-203). From an acceptance and commitment perspective, what is most critical is not any change in activity levels itself, but the extent to which such alterations constitute reductions in valued living. Within ACT, values are defined as "verbally construed global life consequences" (Hayes et al, 1999, p. 206) and value-congruent behavior is viewed as naturally reinforcing. Values, such as "being a good parent," themselves are not verbally constructed, but they can be accessed and contacted via language. Doing so may be useful therapeutically because it serves an augmenting function.

Augmenting is a third unit of rule-governed behavior due to relational networks that serve an establishing function (Michael, 2000) by altering the capacity of certain events to function as reinforcers and punishers (Barnes-Holmes et al, 2001; Zettle & Hayes, 1982). For example, certain parenting behaviors such as changing diapers and toilet training can be seen as "burdens," or, alternatively, be reframed as actions that are consistent with the value of "being a good parent." The naturally reinforcing consequences of such actions may be increased when they are now placed within a frame of coordination with valuing. Moreover, the mere reaffirmation and clarification of values, apart from engaging in overt actions consistent with them, may help attenuate physiological and psychological stress reactions (Creswell, Welch, Taylor, Sherman, Gruenewald, & Mann, 2005).

The potential contribution of a lack of valued action to psychological inflexibility and depression is underscored by findings that those who are less successful at living their most important values report higher levels of experiential avoidance, depression, and fusion with negative thoughts (Plumb, Hayes, Hildebrandt, & Martin, 2007). Additionally, consistent with the purported roles discussed in the previous section that avoidant tracking and pliance may play in depression, individuals who according to a values questionnaire (Blackledge & Ciarrochi, 2005) based their selection of "values" upon feeling "ashamed guilty or anxious if I didn't" (avoidant tracking) or "because somebody else wants me to" (pliance), also reported higher levels of depression, experiential avoidance, and fusion with negative thoughts.

Summary

From an RFT perspective, the conceptual model just presented which highlights how relational framing may contribute to core processes that, in turn, support depression can be regarded as essentially yet another verbal construction. While I believe that the model of depression offered is consistent with a broader acceptance and commitment conceptualization of psychological inflexibility and human suffering, it should be acknowledged that it is not the only one that could be presented. What has been presented is not *the* ACT model of depression and others familiar with ACT might offer somewhat different versions. Fusion with the current model is also discouraged for another reason. Holding it lightly may increase the likelihood that "new and improved" models subsequently will be developed. The present model is undoubtedly "wrong" in some respects, but right now, exactly how it is wrong remains unknown and unclear. For example, consistent with functional contextualism, it may prove more useful in the future to speak of fewer or more than the six core processes incorporated

within the current model.

Conclusion

The theory of depression presented in this chapter, as mentioned, is not specific to this form of human suffering, but rather represents an extension of a broader acceptance and commitment model of psychological inflexibility based upon a functional contextualistic account of human language and cognition. According to this more generic model, six distinguishable, albeit related, processes contribute to clinical depression: (a) fusion, (b) experiential avoidance, (c) attachment to a conceptualized self, (d) living in the past/future, (e) excessive rule-following, and (f) lack of valued action. Although increasing research supports the overall model (Hayes et al., 2006), as well as the roles that each of the six core processes individually and collectively play in transforming dysphoria and sadness into clinical depression, the relative contributions of each process may vary considerably from client to client.

This chapter began with a discussion of some of the fundamental differences between the philosophical systems of functional contextualism and mechanism. It also seems to be an appropriate place at which to end it. Without an appreciation of the philosophical distinctions between mechanism and functional contextualism (see Hofmann & Asmundson, 2008), disagreements across differing cognitive-behavioral theories and conceptualizations of depression may appear to be of a capricious, trivial, or arbitrary nature. Moreover, an understanding of differing philosophical positions is especially pertinent in clarifying why proponents of ACT regard the critical differences between it and approaches representative of the second-wave within cognitive-behavior therapy, such as cognitive therapy (Beck, Rush,

Shaw, & Emery, 1979) as fundamentally paradigmatic in nature, inextricably linked to discrepant values, and, therefore, likely ultimately unresolvable (Zettle, 1990). This is not to suggest that functional contextualism is "better than" mechanism in any meaningful sense of the term. Indeed, a comparative evaluation of them could only be made against some truth criterion which itself cannot be justified on grounds that transcend a philosophical level of analysis (Hayes, 1993). For the functional contextualist, the bottom line clinically is being able to better assist clients who suffer from and struggle with depression. The most valued therapeutic approach, whether that is ACT or some alternative, is the one which best attains this goal.

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