Chapter 8
Acceptance and Commitment Therapy: Interventions with Children

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Traditionally developed as a treatment for adult populations, acceptance and commitment therapy (ACT, read as one word ["ÁKT"/"ÉKT"] and not as an acronym) has been refined to fit children and youth audiences (Hayes & Greco, 2009; Hayes & Ciarrochi, 2015; McCurry & Hayes, 2009; Scarlet, 2017). ACT is inserted within the so-called contextual behavioral therapies, which have as philosophical paradigm the functional contextualism. This is a philosophical view of science similar to and, at the same time, distinct from radical behaviorism. The process of defining functional contextualism sets out to go beyond mere translation of radical behaviorist terms, proposing an important refinement in terms of extension and application.

Radical behaviorism is premised on the goal of predicting and controlling human behavior. According to Hayes (2019a), "'control' can refer to the elimination of variability, and the pragmatic goal of the contextual functional behavioral tradition is not to eliminate variability, but to make a difference" (p. 163). Therefore, a subtle change became necessary: control was replaced by influence, emphasizing the greater complexity of the behavior of human organisms compared to nonhuman organisms. Taking into account such complexity, functional contextualism uses relational framing theory (RFT) to address issues of human language and cognition.

The criterion of truth of contextualism is successful functioning: an analysis is considered true or valid as long as it leads to effective action, according to a certain objective. Thus, topographically mentalistic terms, hitherto rejected by the analytic-behavioral community, are now taken seriously if they enable – mediated by the functional-analytic gaze – an understanding of behavioral phenomena (Hayes,

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1984). Finally, models and theories based on evolutionary science and behavioral principles that facilitate the prediction and influence of behavior with accuracy, scope and depth are admitted – for example, the construction of the psychological flexibility model as an approach to psychopathology and its treatment and the development of Acceptance and Commitment Therapy (ACT) as an approach to the modification of psychological flexibility[1] of the realism controversy (as a philosophical debate) and enables the approach of behavioral issues in an analytical way, going according to the goals of contextual behavioral science.

ACT is presented as a multidimensional approach with a focus on reticulation, a model of scientific and practical development in which theoretical and technological progress occurs at multiple levels (functional contextualist philosophy, basic analytic-behavioral concepts, experimental research, applied research, intervention/public service provision) but in an interconnected way with different patterns of progress for the particular level of work. Thus, when "doing" ACT, one takes into account functional contextualism philosophy, basic behavioral concepts, and empirical research data (Baer et al., 1968; Hayes et al., 2012b; Westrup, 2014).

Because it is presented as a model, ACT is not, then, only an amalgamation of techniques and methods; its proposal is to promote psychological flexibility in different settings and populations. According to Hayes et al. (2012a, b), a unified model is a set of coherent processes that applies with precision, scope, and depth to a wide variety of clinically relevant problems and also applies to issues of human functioning and adaptability. The focus is not on the myriad of topographically defined forms of human suffering (symptoms and syndromes or symptom collective) but on the processes that have as their consequence the aforementioned suffering. This inflexibility is seen as a suffering-generating behavioral repertoire maintained by rigid rule-following (Hayes et al., 1999, 2012a, b).

Rule-Governed Behavior

From the moment we are born, we are exposed to environments where other human beings teach us how to use language. This is done initially by speaking to us, so that we become familiar with the sounds of that language. As development occurs, we are encouraged to produce similar sounds in our own way. Initially, these sounds are related to the world around us (e.g., "mommy," "daddy," "dog"). Quickly, we learn to relate such sounds to the private world: tastes, smells, feelings, sensations, and desires (e.g., "hunger," "thirst," "yummy," "disgusting," "pain," "want," "don't want," "yes," "no").

Around 14 to 16 months of age, language in human beings begins to differ from the language of other mammals (Hayes & Smith, 2005), and, around 23 months, they learn the behavior of deriving relations (Lipkens et al., 1993). The behavior of

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[1] For an in-depth discussion, see Zettle et al. (2016) and Hayes (2019a, b).

deriving relations, unlike learning by direct contingencies, enables the learning of new relations between events without the obligation of exposure to situations (for example, imagine that Ana is hit by a toy tricycle, possibly resulting in a pain response. Later, Ana is told: "A car is **bigger than** the tricycle, **so be** careful." This enables Ana to learn to avoid contact with moving cars, because the probability of getting an aversive consequence is even greater).

ACT underpins its practice by *relational frame theory* (*RFT*), which explains the learning of the operant of deriving relations, mentioned above (relational arbitrarily applicable response (RRAA)). It is not up to this chapter, however, to address the emergence of RFT and its basic principles in depth[2], so only the most relevant aspects of this theory to be taken into account when addressing rule-governed behavior and psychopathology will be highlighted.

RFT states that during the period of language skill development, humans learn to relate arbitrary stimuli, which quickly becomes a generalized operant response through multiple exemplar training (exposure to multiple situations in which such an operant is emitted) (Healy et al., 2000). Through such multiple exemplar training, relational contextual cues (Crel[3], e.g., "same as," "opposite to," "greater than," "better than," and "part of") are abstracted and then applied arbitrarily to new stimuli.[4] The child will quickly be able to relate stimuli that don't share formal properties with each other. Thus, stimuli that have never been related in their learning history acquire functional properties; the functions to be established, however, depend on the social context that selects them (Luciano et al., 2009).

In an attempt to understand complex human behavior, Skinner (1966) proposed the concept of rules as antecedent stimuli that specify contingencies. Following rules, according to Skinner, enables the learning of new responses without the need for exposure to direct contingencies. From a view of RFT, it is said that rules alter the behavior of an individual through the transformation of functions resulting from contact with the elements included in them.

Rules are present in all contexts and periods of human development. Children delight in showing that they know the rules. At primary school age, they learn to behave according to the moment, for example, at playtime, or to sit in a chair and be quiet. By the end of primary school age, they know many rules that promote connection and cooperation. There are rules of behavior for different social contexts, for example, they learn to respond appropriately to the question, "How are you?"

There are three categories of rule-governed behaviors: *pliance*, *tracking*, and *augmenting*. *Pliance* is a category of verbally governed behavior[5] that happens under the influence of consequences that are mediated by a speaker. A child, about to go out to play, may hear his mother's rule: "Take a coat because it will be cold."

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[2] See Barnes-Holmes et al. (2000), and Barnes-Holmes and O'Hora (2004).

[3] *Crel*: context in which a history of a particular type of relational responding is brought to bear on the current situation.

[4] "Arbitrary," here, refers to a type of stimulus that depends on social conventions.

[5] There is, as yet, no consensus on the official translation of the terms, so they are used in English.

In this example, the rule will be followed not because of the immediate conse-quence, since it is not cold at the moment, but because the mother, in the role of a talker, mediates the consequences of taking a coat (e.g., punishing if it is not done, gifting when it is done, etc.) (Hayes et al., 1989; Zettle & Hayes, 1982).

Tracking is behavior established by the verbal community once a certain level of behavior governed by *pliance* is present. It is a category of verbally governed behav-ior under the influence of the apparent correspondence of the rule and the way the environment is organized. For example, a child, after playing in the dirt and having dirty hands, may hear from an adult, "Let's wash your hands, because they are dirty." As the hands are washed, the child may be told that the hands are getting cleaner, without the addition of arbitrary social consequences for doing so. In this case, the consequence of washing hands is having clean hands (Hayes et al., 1989; Zettle & Hayes, 1982).

Augmenting is a type of rule that, instead of specifying consequences or contin-gencies (as is the case with *pliance* and *tracking*), modifies (increases) the reinforc-ing value of the consequences specified in the rule, having a similar function to motivational operations (Michael, 1993). In this case, for example, a child faced with a food he or she does not like (and therefore acting as an aversive antecedent stimulus) may hear from an adult, for example: "If you eat this, you will get big and strong!" If the rule is followed under the influence of adult-mediated consequences (e.g., approval), it may be considered *pliance*. If it is followed under the influence of the more delayed consequences of following (getting big and strong), it will be *augmenting*, because of the transformation from aversive to discriminative function. *Augmentals* may also specify consequences that are abstract and do not have to be directly contacted to exert control over behavior (e.g., development of morality and sense of justice) (Hayes et al., 1998; Carvalho, 2016).

Rules are not always helpful in promoting a prosperous life; verbal evaluations and rules tend to generate insensitivity to prevailing contingencies (Hayes, 1989). Imagine the hypothetical case of John, whose father abuses authority by belittling and assaulting him. It would be natural, therefore, for John to learn the rule: "adults cannot be trusted." In following it, it is possible that John – in coming into contact with other contexts, away from his father – misses important opportunities to develop trusting relationships with other adults, for example, with a kind teacher who wants to help him. The same complex human behavior (of following rules) that allows us to thrive as a species can also promote psychological inflexibility (Luciano & Hayes, 2001).

Psychological Flexibility and Inflexibility

The psychological flexibility model is by nature inductive and linked to basic human processes largely derived from basic science. It is a model of psychopathology, psychological well-being, and psychological intervention (Hayes et al., 2012a). Serving as a metaphor rather than the model itself, the six processes that contribute
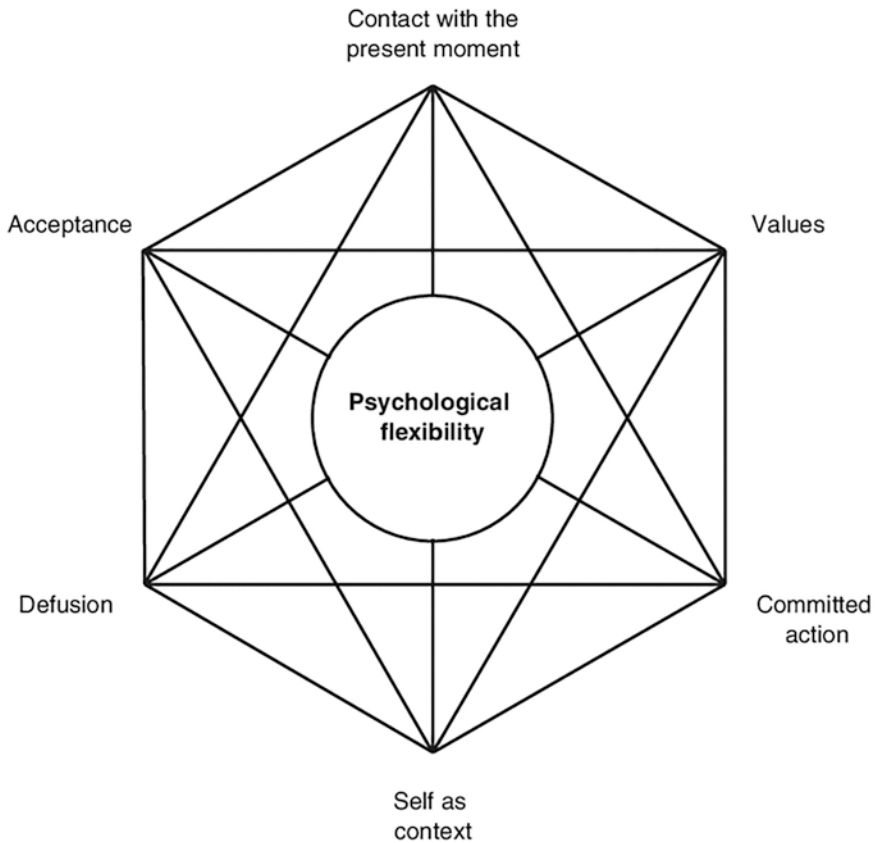
Fig. 8.1 Psychological inflexibility as a model of psychopathology

to psychological inflexibility are commonly represented in the figure of a hexagon[6] (Fig. 8.1), these being inflexible attention, disruption or lack of value clarity, inaction or impulsivity, attachment to concepts about the self, cognitive fusion, and experiential avoidance. In Fig. 8.2, the six core processes that correspond to psychological flexibility are presented: flexible attention to the present moment, chosen values, committed actions, self-with-context, defusion, and acceptance.

The four processes on the left (self-with-context, flexible attention to the present moment, acceptance, and defusion) refer to *mindfulness* and acceptance processes; the four processes on the right (self-with-context, flexible attention to the present moment, committed action, and values) are commitment and behavioral activation/behavioral change processes. The processes of self-within-context and flexible attention to the present moment are present in both.

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[6] Just as a way of representing the processes of psychological flexibility, this hexagon is nicknamed "hexaflex" – that is, a hexagon representing psychological flexibility.
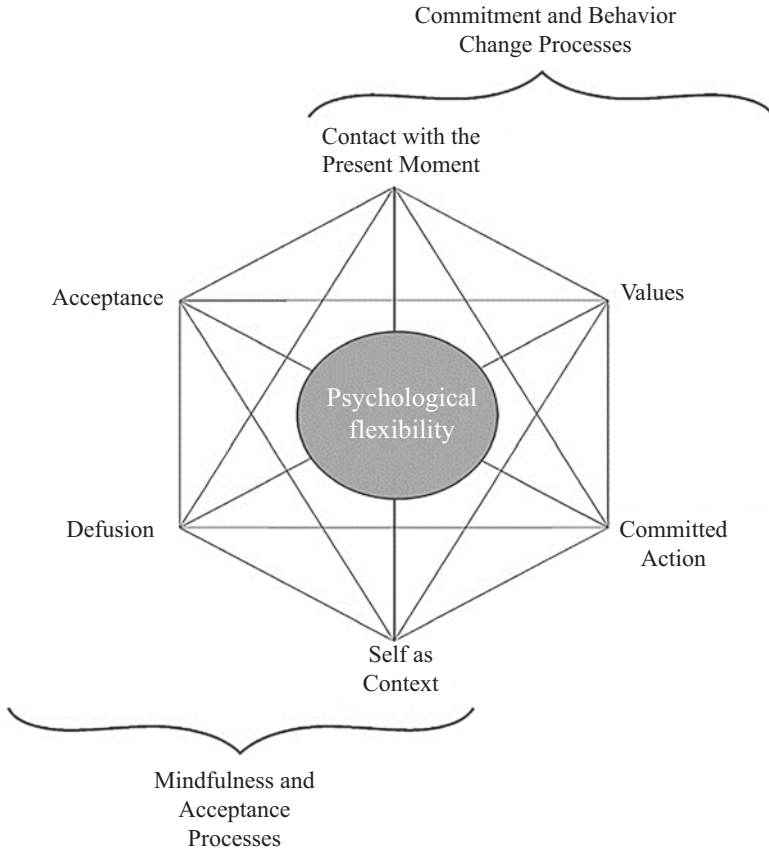
Fig. 8.2 Psychological flexibility as a human model of functioning and behavioral change

Psychological flexibility, thus defined, would be the behavioral repertoire that makes the individual able to contact the present moment as a conscious human being, in an integral manner, divesting himself of unnecessary defenses. In this situation, he is capable of interpreting the situation as it presents itself and not as it appears. Based on what the situation allows, it is the gesture of persisting or changing behavior, in the service of chosen values (Hayes et al., 2012a, b). It is a model that assumes that the core of psychopathology and human suffering is psychological inflexibility, consisting of attempts to control psychological reactions to discomfort when they compromise the possibility of engaging in value-based actions.

Despite being a fairly new approach within psychology, at the time of writing, there are 296 randomized clinical trials on the subject, and this number is still expanding (Hayes, 2019b). Although there are considerably fewer empirical studies with children, significant growth in interest in the utility of ACT in this population is observed. A review study (Swain et al., 2015) concluded that emerging research is encouraging in this regard. In recent years, ACT has increasingly established

itself as a transdiagnostic model[7]. Alternatively, unified or transdiagnostic treatment protocols have been put forward to address different diagnostic categories, focusing on core features of disorders. Many disorders defined in the Diagnostic and Statistical Manual of Mental Disorders[8] share common dimensions such as impulse control difficulties, attentional control problems, rumination or preoccupation, cognitive inflexibility, and self-awareness difficulties, among others.

The goal of the most modern behavioral and cognitive therapies is not to eliminate, modify, or suppress private events (feelings, thoughts, sensations, and memories) but to promote more positive life trajectories. To do so, it is necessary to know the processes that foster growth and development so that more effective interventions can be developed (Hayes & Hoffman, 2018). Therefore, from a process-based therapy perspective, thinking about children's ACT involves thinking about processes shared by this population and how to adapt interventions so that they are accessible to different levels of development.

ACT for Children

Given that ACT focuses on language-derived processes, working with children is of particular importance. Studies show that the issues of concern to children of varying ages have a recognizable pattern: the older the child, the greater the complexity and variety of their concerns (e.g., Chorpita et al., 1997). This statement may seem simple at first glance, but it touches on the issue that has a central place in discussions in ACT and RFT: language development. The more developed a child's language processes, the greater and more complex their concerns (e.g., Vasey & Daleiden, 1994).

When we work with the common focus of ACT, typically developing adults, we are dealing with individuals whose language processes are refined and complex and whose behavior, therefore, is under a great deal of verbal control. ACT processes are then intended to minimize this control and to give the subject tools to live the life they would like to live. An important reflection, therefore, and one that has been increasingly discussed is: what is the impact of these tools for an audience whose language control is still in its early stages of development?

In early childhood, children respond to stimuli that are present in the immediate environment, and their behavior is governed by the direct consequences of their behavior (Greco et al., 2005). Thus, for example, for a child, the behavior of touching a dog may decrease in frequency after a bite, and the probability of vocalizing the word "mommy" may increase if it is followed by gestures of attention and affection.

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[7] That applies to more than one condition.
[8] 5th edition; DSM-5 (American Psychiatric Association, 2013).

However, as children grow older, their behavior becomes under control not only of direct contingencies but also of verbal contingencies (Greco et al., 2005). Thus, we can imagine the following situation: Pedro was bitten by a dog when he was little and, since then, has fearful reactions and moves away when he sees any dog (dogs in general acquire an aversive function through the generalization process). At school, he hears a friend telling him that he hates cats, because a cat scratched him, and that they are much worse than dogs. In this situation, Peter's avoidance and evasion behaviors toward cats may increase in frequency. Although he has never suffered any negative consequences from direct contact with a cat, the history of verbal learning related to the contextual cue "worse than" influences the stimulus "cat" to stop being neutral and start acquiring aversive functions enhanced by its relation with the stimulus "dog."

From situations like Peter's, verbal individuals also begin to behave under control of consequences that exist only in language. As they grow up, children respond more and more to verbal stimuli, and rules about past, present, and future increasingly influence their behavior. Studies linking childhood anxiety and overprotective parents (e.g., Greco & Morris, 2002; Rapee, 1997; Rapee & Melville, 1997), for example, suggest that a child who has grown up in a context where he or she constantly heard rules about care and protection may follow rules derived from these, in which the world takes on an aversive function, as a dangerous place. Thus, even stimuli usually considered neutral can be seen as aversive, as well as feelings and thoughts related to these experiences.

With the aim of weakening the control of rules that restrict the subject's behavior and strengthening a value-directed repertoire (i.e., psychological flexibility), ACT proposes interventions in six fields: acceptance, cognitive defusion, *self-with-context*, present moment contact, values, and committed action (Hayes et al., 2012a, b). Interventions in each of the fields involve, in addition to analytic interventions (i.e., molar and molecular functional analysis), strategies such as experiential exercises and metaphors, which are useful tools in providing context for less rigid language use. Through strategies like this, therefore, ACT aims at a change of context, which will alter the individual's relationship with the relational response itself (Hayes et al., 2012a, b). Thus, the child inserted in the overprotective context, for example, can, in therapy, learn to respond to his own feelings and thoughts about possible threats, looking at them from a flexible perspective, with the possibility of relating to them in different ways.

Such strategies, if considered in the context of child therapy, may facilitate the communication and engagement of children and adolescents, since they escape a purely discursive therapeutic context. Based on the assumptions of functional contextualism, the child therapist can formulate the case conceptualization and understand the function of his/her client's repertoire, having the flexibility to use strategies already presented in the ACT literature, as well as to formulate play interventions that are useful for each case. To illustrate this process, we will discuss the field of cognitive defusion, a component of hexaflex. Cognitive defusion consists of responding to private stimuli (feelings, sensations, thoughts) as what they are (i.e., feelings, sensations, and thoughts), rather than responding to them as fact or reality (Hayes et al., 2012a, b). Consider, then, that 10-year-old Isabela, after her parents'

separation, is faced with constant thoughts that she needs to take care of her mother or something horrible will happen to her. When Isabela cries and fights with her mother so she won't leave or won't accept being alone at her father's house, we can say that she is responding to the content of her thoughts. If the mother responds to the child's behavior, by not going out, for example, we can say that the probability of occurrence of that behavior increases from the process of negative reinforcement.

A therapist who understands this dynamic could work with Isabella on ways to change the context in which that thought arises and transform its functions. One strategy for cognitive defusion might be to write or draw the thoughts on a whiteboard in different ways. Meanwhile, therapist and client are talking about the thoughts as clouds in the sky that come and go. Here the therapist tries to model with the child the behavior of looking at the thought and responding to it for what it really is: just a thought, without having to act to avoid or modify it (connecting to the field of acceptance). Another aspect to be considered in psychotherapeutic work with children is the inclusion of the family in the process. Considering that parents or caregivers are usually the most significant part of the child's context, their inclusion is necessary in most of the sessions. Interventions in this sense include aspects commonly covered by traditional behavior analytic therapy, such as psychoeducation, guidance, and functional analysis of family dynamics. When considering the problematic worked by ACT, it is necessary to reflect on the importance of analyzing how the six aspects of psychological inflexibility worked by hexaflex also present themselves in the family (Coyne et al., 2011; Swain et al., 2015).

The adults who play a central role in the child's life mostly come from an advanced process of language development and rule-following. The central phenomenon of ACT, experiential avoidance, is commonly evident in the caregiver who brings the child to therapy. Considering the cultural context in which the normal is to feel good and suffering should be avoided, the adult may engage in avoidance and evasion behaviors of their own aversive private events arising from contact with the child's different forms of suffering. Through modelling and shaping processes, the child often comes to the clinic presenting a rigid behavioral pattern of experiential avoidance which is also a reflection of the caregiver's way of dealing with his/her private events (Greco et al., 2005).

From the ACT perspective, a possible path would be to work the fields of psychological flexibility also through interventions with caregivers and child together. In this way, the cognitive defusion exercise mentioned earlier could be done with the adult present, also talking about his own private events and building, together with the child, new ways to respond to them.

ACT is a model that, even in its work with adults, uses experiential, playful, and not very literal interventions with the aim of weakening the control exercised by language. For children, developing individuals, this kind of intervention can be even richer and bring a new range of possibilities. Here the therapist finds a unique opportunity: working less to remedy problems generated by language and more to prevent them, contributing to the formation of subjects capable of dealing with their own suffering more effectively and thus able to walk toward what makes life worth living.

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