Advanced ACT: Process-Based Work

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced ACT: Process-Based Work

RFT under the bonnet, process-based therapy, and ACT with complexity, chronic pain and long shadows.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Advanced ACT: Process-Based Work course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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How to use this manual

Beneath ACT's accessible surface sits a rigorous behavioural science, and beyond its protocol sits a movement reshaping how psychological treatment is organised. This course works at both depths, for experienced ACT practitioners who want the model's foundations and its hardest applications.

The first module opens the bonnet. You will study Relational Frame Theory in working clinical form, why human language both builds and traps the mind, and what derived relational responding means for how interventions generalise, then follow the field's process-based turn: the move from named protocols for named disorders towards processes of change identified case by case. The second module takes ACT onto hard ground: chronic pain, where the evidence is strongest and the willingness work most demanding, and long-entrenched presentations where values have been abandoned for decades. Throughout, the evidence is read honestly, including where it is thin, mixed or oversold.

Extended written lessons with key points and advanced practice tasks, with a study tutor available for the theoretical and clinical questions this material raises. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Practise process-based ACT flexibly, moving with what the moment offers rather than following a module order
- Work with self-as-context at depth, including perspective-taking exercises grounded in relational frame theory
- Apply ACT to entrenched, multi-problem and high-shame presentations
- Integrate compassion-focused and exposure-based work within an ACT frame coherently
- Use your own psychological flexibility, in the room, as the primary instrument of the work
- Evaluate the process-based therapy movement critically, including its measurement problems

PART 1

Foundations of Relational Frame Theory

This module explores Relational Frame Theory and its integration into process-based clinical formulation and intervention.

CHAPTER 1

Relational Frame Theory for the working clinician

Relational Frame Theory (RFT) is the theoretical engine that underpins Acceptance and Commitment Therapy (ACT) and provides the clinician with a precise map of how language shapes human experience. At its core, RFT posits that language is not a simple conduit for describing pre-existing objects, but rather a generative system of derived relational framing. In other words, the human mind learns to relate any stimulus to any other stimulus along dimensions of sameness, opposition, comparison, hierarchy, temporal ordering, causality and perspective, and it can derive these relations without direct training. This combinatorial capacity of language explains both the extraordinary flexibility of human cognition and the clinical challenges that arise when relational networks become maladaptive.

The claim that “language equals derived relational framing” is supported by a substantial body of experimental work. Research has demonstrated that participants can acquire arbitrary stimulus relations (e.g., A > B, B > C) and then spontaneously generate untrained relations (e.g., A > C) that obey the same relational properties. Such combinatorial expansion is the hallmark of derived relational responding and underlies the way that a single word can evoke a cascade of associated meanings, emotions and behavioural tendencies. The clinical implication is that any verbal stimulus carries with it a network of relational frames that can alter the function of other stimuli, even when those other stimuli have never been directly paired with the original word.

One of the most consequential properties of relational networks is the transfer of function along derived relations. When a stimulus acquires a particular function – for example, fear – that function can migrate to other stimuli that are related to it through a derived frame. This principle explains why a client may experience a physiological response to a neutral cue that has been placed in a relational network with a previously feared stimulus. In a classic experiment, Dougher and colleagues (1994) taught participants two equivalence classes of arbitrary stimuli and then paired one member of one

class with electric shock; most participants then showed a skin-conductance response to the other members of that class, which had never been paired with shock. The function of fear transferred along the derived relation, illustrating how relational framing can amplify and generalise emotional reactivity.

The transfer of function also clarifies why attempts at thought suppression often backfire, a phenomenon known as the rebound effect. When a client is instructed to “do not think about failure”, the verbal instruction itself contains the target content – the word “failure” – within a relational frame of negation. Because the frame includes the very stimulus it seeks to exclude, the network activates the suppressed content, and the client experiences an involuntary intrusion of the unwanted thought. This process was demonstrated by Wegner, Schneider, Carter and White (1987), who found that participants who first tried not to think about a white bear later thought about it more often than participants who had been free to think about it from the start. In RFT terms, the instruction “do not think about X” creates a relational frame of opposition (X versus not-X) that nonetheless embeds X, allowing the function of the thought to persist and even intensify.

Perspective-taking frames are another pivotal element of relational language that underlie both empathy and the ACT concept of self-as-context. When a person adopts the relational stance “I-here-now” versus “you-there-then”, they are shifting the point of view from a concrete, content-filled perspective to a more abstract, contextual perspective. This shift is not merely a cognitive exercise; it is a relational transformation that changes the functional properties of internal experiences. Empathy, for instance, can be understood as the capacity to adopt the other’s perspective frame – “I-there-then” – and to relate one’s own internal states to the other’s expressed behaviour through derived relations of similarity and opposition.

The notion of self-as-context in ACT is precisely a relational frame that positions the observing self as a container for experience rather than a content-filled entity. The frame “I-here-now” functions as a relational hub that is linked to all temporal and emotional episodes, allowing the client to observe thoughts, feelings and bodily sensations without being fused with them. This relational perspective can be strengthened through specific ACT exercises such as the “Observer Self” metaphor, which invites the client to imagine themselves as the sky that contains weather. The sky metaphor is

not a metaphor in the ordinary sense; it is a relational transformation that re-codes the function of internal events from commanding agents to transient phenomena within a broader contextual frame.

To illustrate how these theoretical principles translate into clinical practice, consider a concrete worked example involving a client named Maya who presents with severe social anxiety, as measured by a GAD-7 score of 16 and a PHQ-9 score of 14. Maya reports that whenever she is invited to a work gathering, she experiences a sudden urge to “run away” and a vivid mental image of a past humiliation in a school cafeteria. She also tells the therapist that she has been trying to “stop thinking about the embarrassment” for the past six months, but the thoughts keep resurfacing, often at night. A traditional cognitive-behavioural approach might focus on disputing the accuracy of the memory or on exposure to the feared social situation. An RFT-informed ACT approach, however, first identifies the relational frames that are maintaining Maya’s distress.

The therapist recognises that Maya’s instruction “do not think about the embarrassment” has created a suppression frame that contains the very content she wishes to avoid. The function of the embarrassment (shame, threat) has transferred to the cue “work gathering” through a derived frame of temporal association (the gathering occurs now, the embarrassment occurred then) and through a hierarchical frame that places the past self-category “embarrassed student” above the present self. Moreover, Maya’s self-as-content frame “I am a socially incompetent person” has been reinforced by a hierarchy that positions the label “socially incompetent” above her broader identity, thereby granting the label the function of controlling behaviour. The therapist therefore selects interventions that target these specific frames.

First, the therapist introduces a defusion exercise that explicitly re-frames Maya’s thought as an object: “I am having the thought that I will be judged”. By adding the relational operator “having” and the higher-order frame “thought as object”, the function of the thought shifts from a command to a mere event within Maya’s relational network. This transformation reduces the immediacy of the urge to flee. Second, the therapist works on perspective-taking by guiding Maya through a series of self-as-context visualisations, encouraging her to adopt the “I-here-now” frame and to notice the thought as a passing cloud in the sky of her awareness. This practice

weakens the hierarchical frame that had placed the past self-category above her present self, thereby diminishing the automatic transfer of shame to the current social cue. Third, the therapist conducts a values-guided exposure, inviting Maya to attend a small, low-stakes social event while maintaining the observer self stance. The exposure is not aimed at disproving the embarrassment, but at creating new relational frames of safety and competence that can coexist with the older frames, thereby enriching the relational network rather than attempting to delete the old connections.

The outcome of this RFT-guided intervention is that Maya reports a reduction in the intensity of the urge to flee (from a 9/10 to a 4/10 on a visual analogue scale) and a modest decrease in her GAD-7 score after six sessions. Importantly, the change is not explained by the eradication of the original memory, but by the alteration of the functional properties of the relational frames that linked the memory to present-day behaviour. This example demonstrates how the clinician can move from a generic technique to a precise, process-based intervention by first mapping the relational frames at play and then selecting the technique that transforms the targeted function.

The clinical utility of RFT for the working clinician lies in its capacity to provide a selection algorithm that is grounded in relational analysis rather than in a checklist of techniques. When a client appears “fused” with a self-category, the clinician recognises a hierarchical frame that needs to be re-coded into a container frame (self-as-context) before any content work can be effective. When a client exhibits a rapid, cue-driven surge of emotional intensity, the clinician identifies a function-transfer frame and applies defusion or acceptance strategies to alter the function of the cue. When a client struggles with empathy or perspective-taking, the clinician targets the underlying perspective-taking frames through exercises that cultivate the “I-there-then” stance. In each case, the therapist asks the RFT question: “Which relational frame is conferring the problematic function, and which ACT process will transform that function?” This question moves the practitioner from a technique-driven mindset to a process-driven mindset, aligning with the broader aim of the Advanced ACT module to situate therapy within a process-based framework.

It is essential to acknowledge that relational networks are not erased by new learning; they are elaborated. This principle, consistent with the resurgence

of earlier derived relations when newer ones stop being reinforced (Wilson and Hayes, 1996), explains why “getting over it” is not a realistic therapeutic goal. Instead, the clinician facilitates the addition of new, more flexible relational frames that can coexist with the older, more rigid frames, thereby expanding the repertoire of functional responses. The therapist’s role is therefore not to delete the painful network but to re-configure its functional architecture, a process that is precisely what ACT’s core processes—acceptance, defusion, self-as-context, values, and committed action—are designed to achieve.

In summary, Relational Frame Theory provides the clinician with a sophisticated lens through which language, cognition and behaviour can be understood as a dynamic network of derived relations. By appreciating that language is derived relational framing, that functions transfer along those relations, that suppression rebounds because the frame contains the negated content, and that perspective-taking frames underlie both empathy and the observing self, the advanced practitioner can select interventions with surgical precision. The result is a therapy that is not merely a collection of techniques, but a coherent, evidence-based process that reshapes the relational architecture of the client’s mind, fostering psychological flexibility and lasting change.

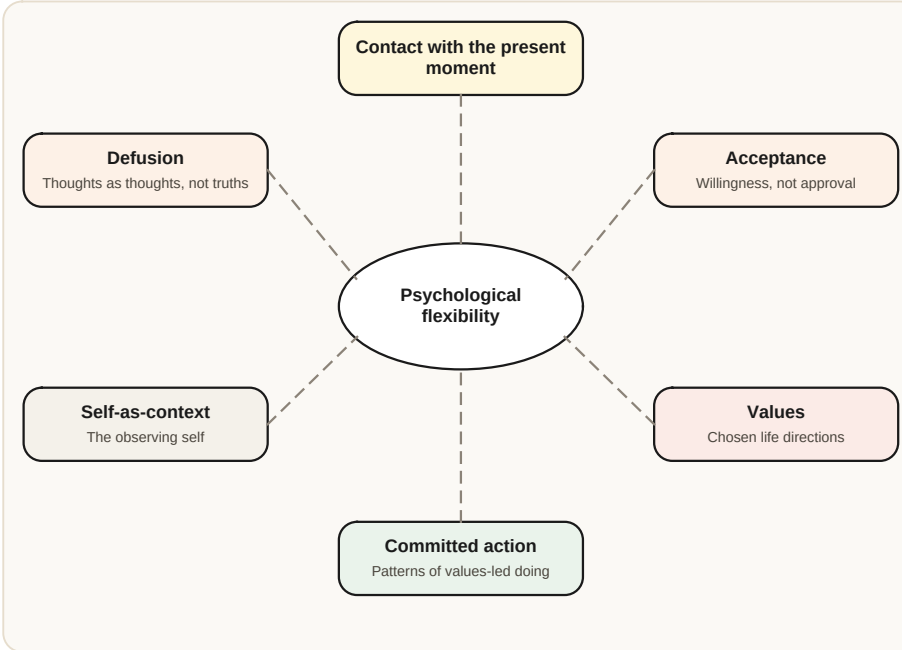


FIGURE 1.1 The ACT hexaflex

Six interlocking processes make up psychological flexibility, the capacity to stay in contact with the present moment and act by one's values even in the presence of difficult private experience. Each process is trainable, and each has a pathological opposite that maintains suffering.

Points worth keeping

- Language = derived relational framing; functions transfer along relations
- Suppression rebounds because the frame contains what it negates
- Perspective-taking frames underlie empathy and self-as-context

PRACTICE TASK

Explain in three sentences, using transfer of function, why telling a phobic client "it is perfectly safe" can strengthen the fear.

CHAPTER 2

The process-based turn

Process-based therapy represents the most coherent response to a long-standing paradox in clinical psychology: the undeniable efficacy of therapeutic interventions, the proliferation of brand-name protocols, and the persistent failure of diagnostic categories to capture the underlying mechanisms that sustain distress. The seminal proposal by Hayes and Hofmann (2018) inverts the traditional research architecture. Rather than asking which manualised protocol treats which DSM-5 disorder, the inquiry shifts to which biopsychosocial processes are maintaining the client's problem and which evidence-based kernels, extracted from the full spectrum of therapeutic traditions, can be deployed to alter those processes. In this view, diagnosis recedes from the role of primary unit of analysis, supplanted by a process formulation that directly informs intervention. The ACT brand, and indeed any brand-name package, becomes a historically useful container whose boundaries are expected to soften as the therapist tailors kernels to the client's idiographic network.

The intellectual machinery that underpins this shift is the extended evolutionary meta-model (EEMM), a framework that organises processes across six functional dimensions: cognition, affect, attention, self, motivation, and behaviour, each examined at biological, psychological and social levels. The EEMM asks, for each dimension, whether there is unhelpful variation, selection, or retention that contributes to the maintenance of the problem. This evolutionary lens reframes maladaptive patterns as processes that have been reinforced, rather than as static symptom clusters. The model provides a common language that allows clinicians to map processes identified in cognitive-behavioural therapy, acceptance-and-commitment therapy, dialectical-behaviour therapy and other traditions onto a single meta-theoretical scaffold.

Idiographic network modelling is the methodological sharp edge of process-based work. In contrast to nomothetic approaches that aggregate data across many clients, idiographic networks capture the unique causal architecture of an individual's experience. The therapist asks, for a particular client, what feeds what: which variables act as antecedents, which act as

consequences, and which form feedback loops that sustain distress. A simple example might be rendered as follows: sleep loss feeds rumination; rumination feeds self-attack; self-attack feeds social withdrawal; withdrawal feeds further sleep loss. This cyclic pattern illustrates how a single node—rumination—can have multiple outgoing arrows, indicating its centrality in the maintenance system. Two clients who share a diagnosis of major depressive disorder may nevertheless present with diametrically opposed networks: one's low mood may be driven primarily by experiential avoidance, while the other's may be sustained by over-commitment to unrealistic standards. The network, not the diagnostic label, identifies the most promising treatment target: the node with the greatest number of outgoing connections, or the node that, when altered, is predicted to produce the greatest downstream change.

The hexaflex, a core visual metaphor in ACT that depicts the six processes of psychological flexibility—acceptance, cognitive defusion, present-moment awareness, self-as-context, values, and committed action—occupies a modest but honourable place within the broader process-based formulation. In the EEMM perspective, the hexaflex represents one map of an important territory, but a complete formulation may require additional maps that capture processes such as rumination, intolerance of uncertainty, or interpersonal over-involvement. The practitioner's task is to integrate these maps into a coherent network that reflects the client's lived reality.

The shift to process-based work is not a theoretical curiosity awaiting consensus; it is a set of practices that can be implemented now across three interlocking domains: formulation, measurement, and flexible intervention selection. Formulation begins with the explicit construction of the client's maintenance network, using the client's own language to label nodes (e.g., "feeling worthless when I cannot help others") and arrows (e.g., "leads to" or "triggers"). This formulation supersedes the diagnostic label and the therapist's preferred model as the primary guide to target selection. Measurement follows, requiring the therapist to track the processes identified in the formulation on a session-by-session basis. If the formulation posits that experiential avoidance is a load-bearing process, the therapist may employ the Acceptance and Action Questionnaire-II (AAQ-II), acknowledging its known psychometric limitations, alongside outcome measures such as the PHQ-9 for depressive symptoms or the GAD-7 for anxiety. The inclusion of process measures renders the formulation

falsifiable: if the targeted process does not change, the therapist must revisit the network and consider alternative nodes or kernels.

Intervention selection is guided by the principle that the therapeutic package should be as fluid as the network it seeks to modify. If the network indicates that rumination is the pivotal process, the therapist may draw on evidence-based kernels such as Watkins's rumination-focused interventions, which in a randomised trial improved residual depressive symptoms through changes in rumination (Watkins et al., 2011). If intolerance of uncertainty emerges as the load-bearing node, a Dugas-derived module that teaches probabilistic thinking and exposure to uncertainty may be appropriate. When avoidance dominates, the ACT willingness machinery—mindful exposure, defusion from avoidance rules, and values-guided action—offers a robust set of tools. The therapist's allegiance, therefore, is to the client's network rather than to any particular brand.

A concrete worked example illustrates the process-based turn in action. Maya, a 34-year-old woman, presents with a diagnosis of treatment-resistant major depressive disorder after two adequate courses of protocol-driven cognitive-behavioural therapy and a course of standard ACT. She reports chronic fatigue, pervasive guilt, and a sense that she must constantly say "yes" to every request at work and in her personal life. A detailed idiographic network is constructed in collaboration with Maya. The client describes the following chain: "Saying yes to everything" leads to "over-commitment and exhaustion"; exhaustion fuels "self-criticism" (the belief that she is a failure when she cannot meet expectations); self-criticism intensifies "guilt"; guilt reinforces the rule "I must say yes to be valued," which in turn drives further "yes-saying". The central node with the most outgoing arrows is the rule-driven behaviour of saying yes, which is sustained by a fused verbal rule: "My worth equals my usefulness."

The formulation identifies the fused rule as the primary target. The therapist selects ACT kernels that directly address rule fusion: cognitive defusion techniques (e.g., the "leaves on a stream" metaphor) are used to create distance from the rule, while values clarification helps Maya differentiate between her authentic contribution and the compulsive need to prove herself. In addition, a behavioural experiment archive is constructed, wherein Maya systematically practices refusing requests in low-stakes situations, records the emotional and behavioural outcomes, and reflects on the

evidence that her self-worth remains intact despite saying no. Process measurement includes weekly administration of the AAQ-II (to monitor changes in experiential avoidance), the Rumination Response Scale (to capture any shifts in rumination), and the PHQ-9 (to track depressive symptom change). Over eight sessions, Maya's AAQ-II scores decline from 38 to 24, indicating reduced avoidance, while her PHQ-9 scores fall from 18 to 10, reflecting a clinically meaningful reduction in depressive severity. Importantly, the reduction in AAQ-II scores precedes the drop in PHQ-9 scores, a sequence consistent with the hypothesised causal chain: loosening the fused rule reduces avoidance, which in turn alleviates depressive symptoms.

Maya's case demonstrates the practical utility of the process-based turn. Three distinct brand-name protocols—standard CBT, standard ACT, and a third-generation mindfulness-based approach—had previously targeted the label of depression with limited success. By re-conceptualising the problem as a network of interlocking processes, the therapist was able to pinpoint a load-bearing node, apply a targeted kernel, and observe measurable change in both process and outcome variables. The network formulation, rather than the diagnostic category, guided the therapeutic agenda, and the flexible use of kernels across traditions exemplified the softened boundaries of the brand-name package.

The implications for advanced practice are profound. First, the therapist must cultivate competence in constructing idiographic networks, a skill that draws on interview techniques, collaborative mapping, and an understanding of the functional relations described by the EEMM. Second, the practitioner must adopt a measurement mindset that privileges process variables alongside symptom outcomes, ensuring that each session contributes data that can confirm or disconfirm the hypothesised causal pathways. Third, the therapist must maintain a repertoire of evidence-based kernels that can be drawn from any tradition, recognising that the most effective intervention may combine elements of ACT, CBT, interpersonal therapy, and other modalities, provided they are matched to the client's unique network.

The process-based turn also aligns with broader movements in psychology towards precision medicine and personalised care. Just as oncology has shifted from organ-based classification to molecular profiling, clinical psychology is moving from disorder-based classification to process

profiling. The idiographic network serves as a personalised map of the client's functional architecture, and the EEMM offers a common language that can be shared across research and practice. This convergence facilitates the accumulation of data across cases, allowing meta-analytic synthesis of process-level effects that can inform future kernel development and refinement.

In summary, the process-based turn in advanced ACT work reorients the clinician from asking "what treats this label?" to asking "what, in this one life, feeds what?" It requires the practitioner to formulate the client's maintenance network in idiographic terms, to measure the targeted processes with rigour, and to select evidence-based kernels that directly modify the identified load-bearing nodes. The hexaflex remains a valuable map of psychological flexibility, but it is now one of several maps that together constitute a comprehensive formulation. Maya's vignette illustrates how this approach can rescue a client from treatment resistance by moving beyond brand-name protocols to a precise, process-focused intervention. The shift is not a distant theoretical ideal; it is a concrete, usable set of practices that can be integrated into everyday advanced clinical work, offering a pathway towards more effective, personalised, and scientifically grounded therapy.

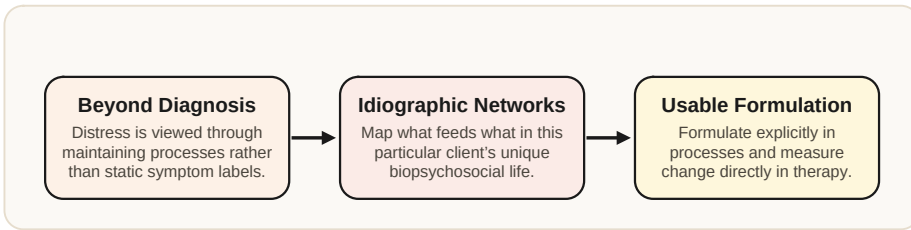


FIGURE 2.1 The Process-Based Therapy Shift
Moving from diagnostic categories to individualised process formulations. This approach targets the specific mechanisms maintaining distress in a client's life.

Points worth keeping

- Process-based therapy targets maintaining processes, not diagnoses
- Idiographic networks: what feeds what in this particular life
- Usable now: formulate in processes and measure them

PRACTICE TASK

Sketch a five-node network (nodes and arrows) for a client whose worry, checking, insomnia and irritability feed each other.