

Acceptance and Commitment Therapy (ACT) Contacts, Resources, and Readings

Website for ACT: www.acceptanceandcommitmenttherapy.com.

Website for Relational Frame Theory (also contains ACT info):
www.relationalframetheory.com

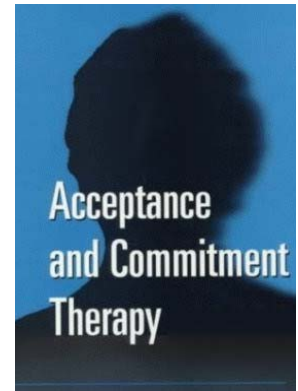
Both are now subsumed under the ACBS site: www.contextualpsychology.com

We have an email list serve for ACT and one for RFT. Go to Yahoo then groups then search on Acceptance and Commitment Therapy or Relational Frame Theory and follow the instructions to join. The websites above also have links. Upcoming workshop are always posted there plus people talk about various issues, ask questions of each other, and so on. It is a world-wide conversation. There are about 900 participants on the ACT list and 400 on the RFT list.

Books (contextual philosophy; relational frame theory, acceptance methods, treatment manuals): See the list maintained at www.contextualpsychology.com. Also check out Context Press (775) 746-2013 or (888) 4CP-BOOK or www.contextpress.com. New Harbinger is coming on very strong lately in the ACT area: www.newharbinger.com

Workshops: Regularly at AABT, ABA, UNR. 2 ½ day workshops at Tahoe once or twice a year. Registration materials are on the websites. We have trainers all around the world. A list of trainers is posted on the ACT website, *along with the values statement ensuring that this whole process is not money focused or centrally controlled.*

Next big ACT meeting: The World Conference on ACT, RFT, and Functional Contextual Psychology, London, England. July 21-28. Details are on www.contextualpsychology.com



The Values of the ACT / RFT Community

What we are seeking is the development of a coherent and progressive contextual behavioral science that is more adequate to the challenges of the human condition. We are developing a community of scholars, researchers, educators, and practitioners who will work in a collegial, open, self-critical, non-discriminatory, and mutually supportive way that is effective in producing valued outcomes for others that emphasizes open and low cost methods of connecting with this work so as to keep the focus there. We are seeking the development of useful basic principles, workable applied theories linked to these principles, effective applied technologies based on these theories, and successful means of training and disseminating these developments, guided by the best available scientific evidence; and we embrace a view of science that values a dynamic, ongoing interaction between its basic and applied elements, and between practical application and empirical knowledge. If that is what you want too, welcome aboard.

Critical ACT Books

If you want to learn ACT, I think there are currently four "must have" books:

Hayes, S. C., Strosahl, K. & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press. [This is still the ACT bible but it should no longer stand alone.]

Hayes, S. C. & Strosahl, K. D. (2005). *A Practical Guide to Acceptance and Commitment Therapy*. New York: Springer-Verlag. [Shows how to do ACT with a variety of populations]

Eifert, G. & Forsyth, J. (2005). *Acceptance and Commitment Therapy for anxiety disorders*. Oakland: New Harbinger. [Great book with a super protocol that shows how to mix ACT processes into a brief therapy for anxiety disorders].

Hayes, S. C. & Smith, S. (2005). *Get out of your mind and into your life*. Oakland, CA: New Harbinger. [A general purpose ACT workbook. Works as an aid to ACT or on its own, but it will also keep new ACT therapists well oriented]

Supportive ACT Books

Applied theory

Hayes, S. C., Follette, V. M., & Linehan, M. (2004). *Mindfulness and acceptance: Expanding the cognitive behavioral tradition*. New York: Guilford Press. [Shows how ACT is part of a change in the behavioral and cognitive therapies more generally]

Hayes, S. C., Jacobson, N. S., Follette, V. M. & Dougher, M. J. (Eds.). (1994). *Acceptance and change: Content and context in psychotherapy*. Reno, NV: Context Press. [Some of the fellow travelers. This was the book length summary of the 3rd wave that was coming. Still relevant]

Applied technology

Dahl, J., Wilson, K. G., Luciano, C., & Hayes, S. C. (2005). *Acceptance and Commitment Therapy for Chronic Pain*. Reno, NV: Context Press. [A solid guide for using ACT with chronic pain. See also Lance McCracken's new book on "Contextual CBT" ... which is mostly ACT]

Heffner, M. & Eifert, G. H. (2004). *The anorexia workbook: How to accept yourself, heal suffering, and reclaim your life.* Oakland, CA: New Harbinger. [An eating disorders patient workbook on ACT.]

Several additional ACT books will be out in the next year. New Harbinger is the most active publisher. They have new ACT books coming out in anger, pain, trauma, GAD, and other areas. Some are workbooks. Some are therapist books. There are original ACT books (not just translations) now available in Spanish, Dutch, Finnish, and one in press in Japanese. Translations are available in Japanese and German. All of these will be on the contextualpsychology.com website

Basic

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001) (Eds.), *Relational Frame Theory: A Post-Skinnerian account of human language and cognition*. New York: Plenum Press. [Not for the faint of heart, but if you want a treatment that is grounded on a solid foundation of basic work, you've got it. This book is the foundation.]

There are several additional RFT relevant books (see contextpress.com) and a "Practical Guide to RFT" that is coming within the next year or so.

Philosophical

Hayes, S. C., Hayes, L. J., Reese, H. W., & Sarbin, T. R. (Eds.). (1993). *Varieties of scientific contextualism*. Reno, NV: Context Press. [If you get interested in the philosophical foundation of ACT, this will help]

There are several additional books on contextualism (see contextpress.com) and a new book on functional contextualism that is coming within the next year or so.

A Sample of Theoretical and Review Articles (New empirical studies are listed later)

Hayes, S. C., Luoma, J., Bond, F., Masuda, A., and Lillis, J. (in press). Acceptance and Commitment Therapy: Model, processes, and outcomes. *Behaviour Research and Therapy*. [A meta-analysis of ACT processes and outcomes.]

- Hayes, S. C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, L. F. (2004). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy*, 35, 35-54. [Tutorial review of the empirical evidence on ACT, DBT, and FAP]
- Hayes, S. C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, 35, 639-665. [Makes the case that ACT is part of a larger shift in the field.]
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Emotional avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64, 1152-1168. [This reviews the data relevant to an ACT approach to psychopathology, as of the mid-90's. Still relevant]
- Salters-Pedneault, K., Tull, M. T., & Roemer, L. (2004). The role of avoidance of emotional material in the anxiety disorders. *Applied and Preventive Psychology*, 11, 95-114. [A more recent review of much of the experiential avoidance literature]
- Fletcher, L. & Hayes, S. C. (in press). Relational Frame Theory, Acceptance and Commitment Therapy, and a functional analytic definition of mindfulness. *Journal of Rational Emotive and Cognitive Behavioral Therapy*. [One of several articles on ACT and mindfulness. If you want them as a set, email Steve]

Tapes

- A 90 minute ACT tape from the 2000 World Congress is available from AABT (www.aabt.org). It costs \$50 for members and \$95 for non-members. It shows Steve Hayes working with a client (role-played by a graduate student – Steve did not, however, meet the “client” or know their “problem” before the role playing started so it appears relatively realistic). Recommended, however the mike was not properly attached for the “client” and she is a bit hard to hear.
- AABT also markets a taped interview with Steve Hayes about the development of ACT and RFT as part of their “Archives” series. Cost is the same as above. Steve thinks this means he is old.
- New Harbinger and Context Press are currently working on a tape series which will be out by summer.

Assessment devices

- ACT and RFT assessment devices are rapidly increasing. This area is moving too fast to put a lot in here. You have to see the websites. There are measures for scoring tapes, for values, defusion, and for psychological flexibility in specific areas (e.g., smoking, diabetes, epilepsy, etc).
- What follows is the AAQ I, which is particularly good for population based studies of an aspect of experiential avoidance but can also be used clinically. The validation study for the 9-item version of the AAQ is Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M. A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth J. P., Karekla, M., & McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record*, 54, 553-578. It is posted on the ACT website. Mean in clinical populations: about 38-40. The higher above that, the more experientially avoidant. Mean in non-clinical populations: about 30-31. This may not be the best process of change measure for ACT (more specific ones generally work better) – good as a kind of trait measure for large correlational studies of a key aspect of experiential avoidance. Its scores are set up so that up is bad. Alpha is sometimes marginal or even unacceptable due to item complexity. The AAI II solves that. There are two 16-item versions of the AAQ I: one is described in the study above on page 561. The other is described in Bond, F. W. & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology*, 88, 1057-1067. It has separate factors for Willingness and Action, so its scores are set up so that higher scores are good. (I know this is confusing. This will all be cleaned up in the new AAQ-II, which is done and being written up.

Frank Bond is taking the lead on it. There are also two scales for children being developed by Laurie Greco. Ruth Baer’s mindfulness scale seems to work also as an ACT process measure.

**The Acceptance and Action Questionnaire –
All Validated Versions of the AAQ I**

Below you will find a list of statements. Please rate the truth of each statement as it applies to you. Use the following scale to make your choice.

1-----2-----3-----4-----5-----6-----7
 never very seldom seldom sometimes frequently almost always always
 true true true true true true true

- _____ 1. I am able to take action on a problem even if I am uncertain what is the right thing to do. [Use in AAQ-9, reverse score. Use in single-factor AAQ-16, reverse score. Score in Action factor in two factor AAQ-16 and do not reverse score]
- _____ 2. When I feel depressed or anxious, I am unable to take care of my responsibilities. [Use in AAQ-9. Use in single-factor AAQ-16. Score in Action factor in two factor AAQ-16 and reverse score]
- _____ 3. I try to suppress thoughts and feelings that I don’t like by just not thinking about them. [Use in single factor AAQ-16. Score in Willingness factor in two factor AAQ-16 and reverse score]
- _____ 4. It’s OK to feel depressed or anxious. [Use in single factor AAQ-16 and reverse score. Score in Willingness factor on two factor AAQ-16 and do not reverse score]
- _____ 5. I rarely worry about getting my anxieties, worries, and feelings under control. [Use in AAQ-9, reverse score. Use in single-factor AAQ-16, reverse score. Score in Willingness factor in two factor AAQ-16 and do not reverse score]
- _____ 6. In order for me to do something important, I have to have all my doubts worked out. [Use in single-factor AAQ-16. Score in Action factor in two factor AAQ-16 and reverse score]
- _____ 7. I’m not afraid of my feelings. [Use in AAQ-9, reverse score. Use in single-factor AAQ-16, reverse score. Score in Willingness factor in two factor AAQ-16]
- _____ 8. I try hard to avoid feeling depressed or anxious. [Use in single-factor AAQ-16 and do not reverse score. Score in Willingness factor in two factor AAQ-16 and reverse score]
- _____ 9. Anxiety is bad. [Use in AAQ-9. Use in single-factor AAQ-16. Score in Willingness factor in the two factor AAQ-16 and reverse score]
- _____ 10. Despite doubts, I feel as though I can set a course in my life and then stick to it. [Use in single-factor AAQ-16, reverse score. Score in Action factor in two-factor AAQ-16 and do not reverse score]
- _____ 11. If I could magically remove all the painful experiences I’ve had in my life, I would do so. [Use in AAQ-9. Use in single-factor AAQ-16. Score in Willingness factor in the two factor AAQ-16 and reverse score]
- _____ 12. I am in control of my life. [Use in single-factor AAQ-16, reverse score. Score in Action factor in two-factor AAQ-16 and do not reverse score]
- _____ 13. If I get bored of a task, I can still complete it. [Use in two-factor AAQ-16. Score in Action factor]

- _____ 14. Worries can get in the way of my success. [Reverse score. Use in two-factor AAQ-16. Score in Action factor]
- _____ 15. I should act according to my feelings at the time. [Reverse score. Use in two-factor AAQ-16. Score in Action factor]
- _____ 16. If I promised to do something, I'll do it, even if I later don't feel like it. [Use in two-factor AAQ-16. Score in Action factor]
- _____ 17. I often catch myself daydreaming about things I've done and what I would do differently next time. [Use in AAQ-9]
- _____ 18. When I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact. [Use in AAQ-9 – reverse score]
- _____ 19. When I compare myself to other people, it seems that most of them are handling their lives better than I do. [Use in AAQ-9 and in the single factor AAQ-16]
- _____ 20. It is unnecessary for me to learn to control my feelings in order to handle my life well [Use in the single factor AAQ-16, reverse score]
- _____ 21. A person who is really “together” should not struggle with things the way I do [Use in the single factor AAQ-16. Do not reverse score ... actually this is one folks who do not understand ACT are surprised by. Thinking you should never struggle is itself a kind of struggle. Neat that it loads that way]
- _____ 22. There are not many activities that I stop doing when I am feeling depressed or anxious [Use in the single factor AAQ-16, reverse score]

Notes: This 22 item version can be used to score all four validated versions of the AAQ in existence. The multiple versions are confusing in several areas.

Direction: People have used the AAQ in various contexts and it has sometimes been scored so that high scores equal high experiential avoidance or so that high scores equal high acceptance/willingness. In a non-clinical context (e.g., Bond's two factor solution was used in an I/O context) the high scores equal high acceptance/willingness works. In a clinical context the high scores equal high experiential avoidance works. That's why items are reversed or not depending on the version.

Versions: This overall version can be used to generate the scores all for validation versions: the single factor, 9-item solution; the single factor, 16 item solution (described on page 561 in the Hayes et al validation study); Bond and Bunce's 16-item dual factor solution; or Bond and Bunce's 16 item single factor solution. Whew.

They are all very, very highly correlated, but they do have some slightly different operating characteristics.

The validation study for the 9-item and the 16-tem single factor version is:

Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M., A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth J. P., Karekla, M., & McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record*, 54, 553-578.

The validation study for the 16-item dual factor version with 3 rewritten items (and a single factor version based on those same items) is in the *Journal of Applied Psychology*. The reference is:

Bond, F. W. & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology*, 88, 1057-1067.

If you want to use it for the Hayes et al single factor, 16 item solution go to the *Psychological Record* validation article and that will tell you which 16 to use ... in order not to be too confusing the “16 item” references above are referring only to the Bond and Bunce versions.

If you want to use it for Bond and Bunce’s single factor solution, you can just sum the two subscales (he actually did that in one part of the Bond and Bunce study). Frank found that the two factors had a latent factor and he encourages using the single factor scale for that reason (he’s published a few things using it that way). When you use the Bond and Bunce versions score those so that up is bad.

Confused? That’s why we are creating an AAQ-II. Frank Bond is heading up that effort internationally (f.bond@gold.ac.uk) and we have a version BUT it is not published yet so it is a bit risky to use it.

Which version to use: large population studies work with any of these. For process of change studies, probably either of the 16 item versions would work better than the 9 item just because it gives you more room to move. If you use this 22 item version, though, you can reconstruct all four methods of scoring, so just using this and deciding later seems fine.

There is no need to ask permission to use this instrument. Do ask permission if you want to translate it because we would not want multiple versions in any given language, and to avoid that we need to keep track. We will approve any careful and needed translation efforts.

Here is the AAQ II. It’s alpha is generally much better than any of the AAQ I version because the items are simpler

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

1. Its OK if I remember something unpleasant.	1	2	3	4	5	6	7
2. My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
3. I’m afraid of my feelings.	1	2	3	4	5	6	7
4. I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
5. My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6. I am in control of my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Emotions cause problems in my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. It seems like most people are handling their lives better than I am. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Worries get in the way of my success. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. My thoughts and feelings do not get in the way of how I want to live my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Here is the scoring (set so that up is good)

AAQ-II SCORING

**HIGHER SCORES INDICATE GREATER PSYCHOLOGICAL FLEXIBILITY.
ITEMS WITH AN 'R' NEXT TO THEM ARE REVERSED FOR SCORING PURPOSES.**

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Its OK if I remember something unpleasant. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. My painful experiences and memories make it difficult for me to live a life that I would value. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I'm afraid of my feelings. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. I worry about not being able to control my worries and feelings. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. My painful memories prevent me from having a fulfilling life. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. I am in control of my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Emotions cause problems in my life. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. It seems like most people are handling their lives better than I am. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Worries get in the way of my success. R | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

10. My thoughts and feelings do not get in the way of how I want to live my life. 1 2 3 4 5 6 7

Here are the preliminary data on the AAQ II

Construct validity

6 data sets: N ranged from 206-854

Reliability: .81 - .87

Variance accounted for by the one factor: 40 - 46

Scree plot also indicates one factor

With the exception of 1 item across 2 studies, all loaded on the factor at $> .40$.

The one exception loaded at .38 in one study and .26 in another

Criterion-related validity

Total DASS score: $-.601^{**}$

Depression Anxiety Stress Scales:

Depression: $-.593^{**}$

Anxiety: $-.484^{**}$

Stress: $-.561^{**}$

SCL-10R: $-.673^{***}$

BDI II: $-.75^{**}$

BAI: $-.59^{**}$

General Health Questionnaire: $-.31^{**}$

Correlates at least to a 'medium' extent with the SCL-90 subscales.

Other

Social desirability

Marlowe-Crown: $r = .17$ ($p = .14$)

White Bear Suppression Inventory:

$-.582^{***}$

BUT we have not yet used the scale in mediational studies (etc) so there is a certain amount of hoping and praying if you use it that way.

Which version to use: large population studies work with any of these. For process of change studies, use a more specific version if available and if not use the 22 item AAQ I version, and try the different methods of scoring or use the AAQ II.

There is no need to ask permission to use this instrument as long as you tell us about interesting things you find (hayes@unr.edu). When using, remove the title of the instrument and use "AAQ" instead. Do ask permission if you want to translate it because we would not want multiple versions in any given language, and to avoid that we need to keep track. We will approve any careful translation efforts.

An ACT Case Formulation Framework

I. Context for case formulation

The goal of ACT is to help clients consistently choose to act effectively (concrete behaviors in alignment with their values) in the presence of difficult or interfering private events.

II. Assessment and Treatment Decision Tree

Beginning with the target problem, as specified by the client or significant others, refine these complaints and concerns into functional response classes that are sensitive to an ACT formulation and to the client's contextual circumstances, and link treatment components to that analysis

A. Consider general behavioral themes and patterns, client history, current life context, and in session behavior that might bear on the functional interpretation of specific targets in ACT terms. These may include:

1. General level of experiential avoidance (core unacceptable emotions, thoughts, memories, etc.; what are the consequences of having such experiences that the client is unwilling to risk)
2. Level of overt behavioral avoidance displayed (what parts of life has the client dropped out of)
3. Level of internally based emotional control strategies (i.e., negative distraction, negative self instruction, excessive self monitoring, dissociation, etc)
4. Level of external emotional control strategies (drinking, drug taking, smoking, self-mutilation, etc.)
5. Loss of life direction (general lack of values; areas of life the patient "checked out" of such as marriage, family, self care, spiritual)
6. Fusion with evaluating thoughts and conceptual categories (domination of "right and wrong" even when that is harmful; high levels of reason-giving; unusual importance of "understanding," etc.)

B. Consider the possible functions of these targets and their treatment implications.

1. Is this target linked to specific application of the tendencies listed under "A" above
2. If so, what are the specific content domains and dimensions of avoided private events, feared consequences of experiencing avoided private events, fused thoughts, reasons and explanations, and feared consequences of defusing from literally held thoughts or rules
3. If so, in what other behavioral domains are these same functions seen?
4. Are there other, more direct, functions that are also involved (e.g., social support, financial consequences)
5. Given the functions that are identified, what are the relative potential contributions of:
 - a. generating creative hopelessness (client still resistant to unworkable nature of change agenda)
 - b. understanding that excessive attempts at control are the problem (client does not understand experientially the paradoxical effects of control)
 - c. experiential contact with the non-toxic nature of private events through acceptance and exposure (client is unable to separate self from reactions, memories, unpleasant thoughts)
 - d. developing willingness (client is afraid to change behavior because of beliefs about the consequences of facing feared events)

- e. engaging in committed action based in values (client has no substantial life plan and needs help to rediscover a value based way of living)

C. Consider the factors that may be perpetuating the use of unworkable change strategies and their treatment implications

1. Client's history of rule following and being right
(if this is an issue, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to a conceptualized self)
2. Level of conviction in the ultimate workability of such strategies
(if this is an issue, consider the need to undermine the improperly targeted change agenda, i.e., creative hopelessness)
3. Belief that change is not possible
(if this is an issue, consider defusion strategies; revisit cost of not trying; arrange behavioral experiments)
4. Fear of the consequence of change
(if this is an issue, consider acceptance, exposure, defusion)
5. Short term effect of ultimately unworkable change strategies is positive
(if this is an issue, consider values work)

D. Consider general client strengths and weaknesses, and current client context

1. Social, financial, and vocational resources available to mobilize in treatment
2. Life skills (if this is an issue, consider those that may need to be addressed through first order change efforts such as relaxation, social skills, time management, personal problem solving)

E. Consider motivation to change and factors that might negatively impact it

1. The "cost" of target behaviors in terms of daily functioning (if this is low or not properly contacted, consider paradox, exposure, evocative exercises before work that assume significant personal motivation)
2. Experience in the unworkability of improperly focused change efforts (if this is low, move directly to diary assessment of the workability of struggle, to experiments designed to test that, or if this does not work, to referral)
3. Clarity and importance of valued ends that are not being achieved due to functional target behavior, and their place in the client's larger set of values (if this is low, as it often is, consider values clarification. If it is necessary to the process of treatment itself, consider putting values clarification earlier in the treatment).
4. Strength and importance of therapeutic relationship (if not positive, attempt to develop, e.g., through use of self disclosure; if positive, consider integrating ACT change steps with direct support and feedback in session)

F. Consider positive behavior change factors

1. Level of insight and recognition (if insight is facilitative, move through or over early stages to more experiential stages; if it is not facilitative, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to a conceptualized self)
2. Past experience in solving similar problems (if they are positive and safe from an ACT perspective, consider moving directly to change efforts that are overtly modeled after previous successes)

3. Previous exposure to mindfulness/spirituality concepts (if they are positive and safe from an ACT perspective, consider linking these experiences to change efforts; if they are weak or unsafe – such as confusing spirituality with dogma – consider building self-as-context and mindfulness skills)

III. Building interventions into life change and transformation strategy

- A. Set specific goals in accord with general values
- B. Take actions and contact barriers
- C. Dissolve barriers through acceptance and defusion
- D. Repeat and generalize in various domains

THE QUICK AND DIRTY ACT ANALYSIS OF PSYCHOLOGICAL PROBLEMS

Psychological problems are due to a lack of behavioral flexibility and effectiveness

Narrowing of repertoires comes from history and habit, but particularly from cognitive fusion and its various effects, combined with resultant aversive control processes.

Prime among these effects is the avoidance and manipulation of private events.

“Conscious control” is a matter of verbally regulated behavior. It belongs primarily in the area of overt, purposive behavior, not automatic and elicited functions.

All verbal persons have the "self" needed as an ally for defusion and acceptance, but some have run from that too.

Clients are not broken, and in the areas of acceptance and defusion they have the basic psychological resources they need if to acquire the needed skills.

The value of any action is its workability measured against the client's true values (those he/she would have if it were a choice).

Values specify the forms of effectiveness needed and thus the nature of the problem. Clinical work thus demands values clarification.

To take a new direction, we must let go of an old one. If a problem is chronic, the client's solutions are probably part of them.

When you see strange loops, inappropriate verbal rules are involved.

The bottom line issue is living well, and FEELING well, not feeling WELL.

THE ACT THERAPEUTIC POSTURE

Assume that dramatic, powerful change is possible and possible quickly

Whatever a client is experiencing is not the enemy. It is the fight against experiencing experiences that is harmful and traumatic.

You can't rescue clients from the difficulty and challenge of growth.

Compassionately accept no reasons -- the issue is workability not reasonableness.

If the client is trapped, frustrated, confused, afraid, angry or anxious be glad -- this is exactly what needs to be worked on and it is here now. Turn the barrier into the opportunity.

If you yourself feel trapped, frustrated, confused, afraid, angry or anxious be glad: you are now in the same boat as the client and your work will be humanized by that.

In the area of acceptance, defusion, self, and values it is more important as a therapist to do as you say than to say what to do

Don't argue. Don't persuade. The issue is the client's life and the client's experience, not your opinions and beliefs. Belief is not your friend. Your mind is not your friend. It is not your enemy either.

Same goes for your clients.

You are in the same boat. Never protect yourself by moving one up on a client.

The issue is always function, not form or frequency. When in doubt ask yourself or the client "what is this in the service of."

ACT THERAPEUTIC STEPS

Be passionately interested in what the client truly wants

Compassionately confront unworkable agendas, always respecting the client's experience as the ultimate arbiter

Support the client in feeling and thinking what they directly feel and think already -- as it is not as what it says it is -- and to find a place from which that is possible.

Help the client move in a valued direction, *with* all of their history and automatic reactions.

Help the client detect traps, fusions, and strange loops, and to accept, defuse, and move in a valued direction that builds larger and larger patterns of effective behavior

Repeat, expand the scope of the work, and repeat again, until the clients generalizes

Don't believe a word you are saying ... or me either

Core ACT Competencies

You can use this as a self assessment device

Core Competencies Involved in the Basic ACT Therapeutic Stance

Collectively, the following attributes define that basic therapeutic stance of ACT.

- The therapist speaks to the client from an equal, vulnerable, genuine, and sharing point of view and respects the client's inherent ability to move from unworkable to effective responses
- The therapist actively models both acceptance of challenging content (e.g., what emerges during treatment) and a willingness to hold contradictory or difficult ideas, feelings or memories
- The therapist helps the client get into contact with direct experience and does not attempt to rescue the client from painful psychological content
- The therapist does not argue with, lecture, coerce or attempt to convince the client of anything.
- The therapist introduces experiential exercises, paradoxes and/or metaphors as appropriate and de-emphasizes literal "sense making" when debriefing them
- The therapist is willing to self disclose about personal issues when it makes a therapeutic point
- The therapist avoids the use of "canned" ACT interventions, instead fitting interventions to the particular needs of particular clients. The therapist is ready to change course to fit those needs at any moment.
- The therapist tailors interventions and develops new metaphors, experiential exercises and behavioral tasks to fit the client's experience, language practices, and the social, ethnic, and cultural context
- The therapist can use the physical space of the therapy environment to model the ACT posture (e.g., sitting side by side, using objects in the room to physically embody an ACT concept)
- ACT relevant processes are recognized in the moment and where appropriate are directly supported in the context of the therapeutic relationship

Core Competencies for ACT Core Processes and Therapeutic Interventions

Developing Acceptance and Willingness/Undermining Experiential Control

- Therapist communicates that client is not broken, but is using unworkable strategies
- Therapist helps client notice and explore direct experience and identify emotion control strategies
- Therapist helps client make direct contact with the paradoxical effect of emotional control strategies

- Therapist actively uses concept of “workability” in clinical interactions
- Therapist actively encourages client to experiment with stopping the struggle for emotional control and suggests willingness as an alternative.
- Therapist highlights the contrast in the workability of control and willingness strategies (e.g., differences in vitality, purpose, or meaning).
- Therapist helps client investigate the relationship between levels of willingness and suffering (willingness suffering diary; clean and dirty suffering)
- Therapist helps client make experiential contact with the cost of being unwilling relative to valued life ends (Are you doing your values; listing out value, emotional control demand, cost, short term/long term costs and benefits)
- Therapist helps client experience the qualities of willingness (a choice, a behavior, not wanting, same act regardless of how big the stakes)
- Therapist can use exercises and metaphors to demonstrate willingness the action in the presence of difficult material (e.g., jumping, cards in lap, box full of stuff, Joe the bum)
- Therapist can use a graded and structured approach to willingness assignments
- Therapist models willingness in the therapeutic relationship and helps client generalize this skill to events outside the therapy context (e.g., bringing the therapist’s unpleasant reactions to in session content into the room, disclosing events in the therapist’s own life that required a willingness stance)

Undermining Cognitive Fusion

- Therapist can help client make contact with attachments to emotional, cognitive, behavioral or physical barriers and the impact attachment has on willingness
- Therapist actively contrasts what the client’s “mind” says will work versus what the client’s experience says is working
- Therapist uses language conventions, metaphors and experiential exercises to create a separation between the client’s direct experience and his/her conceptualization of that experience (e.g., get of our butts, bubble on the head, tin can monster)
- Therapist uses various interventions to both reveal that unwanted private experiences are not toxic and can accepted without judgment
- Therapist uses various exercises, metaphors and behavioral tasks to reveal the conditioned and literal properties of language and thought (e.g., milk, milk, milk; what are the numbers?)
- Therapist helps client elucidate the client’s “story” while highlighting the potentially unworkable results of literal attachment to the story (e.g., evaluation vs. description, autobiography rewrite, good cup/bad cup)
- Therapist detects “mindiness” (fusion) in session and teaches the client to detect it as well

Getting in Contact with the Present Moment

- Therapist can defuse from client content and direct attention to the moment
- Therapist models making contact with and expressing feelings, thoughts, memories or sensations in the moment within the therapeutic relationship
- Therapist uses exercises to expand the clients awareness of experience as an ongoing process
- Therapists tracks session content at multiple levels (e.g., verbal behavior, physical posture, affective shifts) and emphasizes being present when it is useful
- Therapist models getting out of the “mind” and coming back to the present moment
- Therapist can detect when the client is drifting into the past or future and teaches the client how to come back to now

Distinguishing the Conceptualized Self from Self-as-context

- Therapist helps the client differentiate self-evaluations from the self that evaluates (thank your mind for that thought, calling a thought a thought, naming the event, pick an identity)
- Therapist employs mindfulness exercises (the you the you call you; chessboard, soldiers in parade/leaves on the stream) to help client make contact with self-as-context
- Therapist uses metaphors to highlight distinction between products and contents of consciousness versus consciousness itself (furniture in house, are you big enough to have you)
- The therapist employs behavioral tasks (take your mind for a walk) to help client practice distinguishing private events from the context of self awareness
- Therapist helps the client make direct contact with the three aspects of self experience (e.g., conceptualizations of self, ongoing process of knowing, transcendent sense of self)

Defining Valued Directions

- Therapist can help clients clarify valued life directions (values questionnaire, value clarification exercise, what do you want your life to stand for, funeral exercise)
- Therapist helps client “go on record” as standing for valued life ends
- Therapist is willing to state his/her own values if it is relevant in therapy, and is careful not to substitute them for the clients value’s
- Therapist teaches clients to distinguish between values and goals
- Therapist distinguishes between goals (outcomes) and the process of striving toward goals (growth that occurs as a result of striving)
- Therapist accepts the client’s values and, if unwilling to work with them, refers the client on to another provider or community resource

Building Patterns of Committed Action

- Therapist helps client value based goals and build a concrete action plan
- Therapist helps client distinguish between deciding and choosing to engage in committed action
- Therapist encourages client to make and keep commitments in the presence of perceived barriers (e.g., fear of failure, traumatic memories, sadness)
- Therapist helps client identify the impact being “right” might have on the ability to carry through with commitments (e.g., fish hook metaphor, forgiveness, who would be made right, how is your story every going to handle you being healthy)
- Therapist helps client to expect and to be willing to have any perceived barriers that present themselves as a consequence of engaging in committed actions
- Regardless of the size of the action, therapist helps client appreciate the special qualities of committed action (e.g., increases in sense of vitality, sense of moving forward rather than backward, growing rather than shrinking)
- Therapist helps client develop larger and larger patterns of effective action
- Therapist non-judgmentally helps client integrate slips or relapses as an integral part of keeping commitments and building effective responses

A Few Examples of ACT Components

(these are not in a necessary sequence. Often values work comes first, for example. They are also not comprehensive. *These clinical materials were assembled by Elizabeth Gifford, Steve Hayes, and Kirk Strosahl*)

Facing the Current Situation (“creative hopelessness”) / Control is a Problem

Purpose: To notice that there is a change agenda in place and notice the basic unworkability of that system; to name the system as inappropriately applied control strategies; to examine why this does not work

Method: Draw out what things the client has tried to make things better, examine whether or not they have truly worked in the client’s experience, and create space for something new to happen.

When to use: As a precursor to the rest of the work in order for new responses to emerge, especially when the client is really struggling. You can skip this step in some cases, however.

Things to avoid: Never try to convince the client: their experience is the absolute arbiter. The goal is not a feeling state, it is what the Zen tradition calls “being cornered.”

Examples of techniques designed to increase creative hopelessness:

Creative hopelessness	Are they willing to consider that there might be another way, but it requires not knowing?
What brought you into treatment?	Bring into sessions sense of being stuck, life being off track, etc.
Person in the Hole exercise	Illustrate that they are doing something and it is not working
Chinese handcuffs Metaphor	No matter how hard they pull to get out of them, pushing in is what it takes
Noticing the struggle	Tug of war with a monster; the goal is to drop the rope, not win the war
Driving with the Rearview Mirror	Even though control strategies are taught, doesn’t mean they work
Clear out old to make room for new	Field full of dead trees that need to be burned down for new trees to grow
Break down reliance on old agenda	“Isn’t that like you? Isn’t that familiar? Does something about that one feel old?”
Paradox	Telling client their confusion is a good outcome
Feedback screech metaphor	Its not the noise that is the problem, it’s the amplification
Control is a problem	How they struggle against it = control strategies (ways they try to control or avoid inner experience).
The paradox of control	“If you aren’t willing to have it, you’ve got it.”
Illusion of control metaphors	Fall in love, jelly doughnut, what are the numbers exercise
Consequences of control	Polygraph metaphor
Willingness vs. control	Two scales metaphor
Costs of low willingness	Box full of stuff metaphor, clean vs. dirty discomfort

Cognitive Defusion (Deliteralization)

Purpose: See thoughts as what they are, not as what they say they are.

Method: Expand attention to thinking and experiencing as an ongoing behavioral process, not a causal, ontological result

When to use: When private events are functioning as barriers due to FEAR (fusion, evaluation, avoidance, reasons)

Examples of defusion techniques

‘The Mind’	Treat “the mind” as an external event; almost as a separate person
Mental appreciation	Thank your mind; show aesthetic appreciation for its products
Cubbyholing	Label private events as to kind or function in a back channel

	communication
“I’m having the thought that ...”	Include category labels in descriptions of private events
Commitment to openness	Ask if the content is acceptable when negative content shows up
Just noticing	Use the language of observation (e.g., noticing) when talking about thoughts
“Buying” thoughts	Use active language to distinguish thoughts and beliefs
Titchener’s repetition	Repeat the difficult thought until you can hear it
Physicalizing	Label the physical dimensions of thoughts
Put them out there	Sit next to the client and put each thought and experience out in front of you both as an object
Open mindfulness	Watching thoughts as external objects without use or involvement
Focused mindfulness	Direct attention to nonliteral dimensions of experience
Sound it out	Say difficult thoughts very, very slowly
Sing it out	Sing your thoughts
Silly voices	Say your thoughts in other voices -- a Donald Duck voice for example
Experiential seeking	Openly seek out more material, especially if it is difficult
Polarities	Strengthen the evaluative component of a thought and watch it pull its opposite
Arrogance of word	Try to instruct nonverbal behavior
Think the opposite	Engage in behavior while trying to command the opposite
Your mind is not your friend	Suppose your mind is mindless; who do you trust, your experience or your mind
Who would be made wrong by that?	If a miracle happened and this cleared up without any change in (list reasons), who would be made wrong by that?
Strange loops	Point out a literal paradox inherent in normal thinking
Thoughts are not causes	“Is it possible to think that thought, as a thought, AND do x?”
Choose being right or choose being alive	If you have to pay with one to play for the other, which do you choose?
There are four people in here	Open strategize how to connect when minds are listening
Monsters on the bus	Treating scary private events as monsters on a bus you are driving
Feed the tiger	Like feeding a tiger, you strengthen the impact of thoughts but dealing with them
Who is in charge here?	Treat thoughts as bullies; use colorful language
Carrying around a dead person	Treat conceptualized history as rotting meat
Take your mind for a walk	Walk behind the client chattering mind talk while they choose where to walk
How old is this? Is this just like you?	Step out of content and ask these questions
And what is that in the service of?	Step out of content and ask this question
OK, you are right. Now what?	Take “right” as a given and focus on action
Mary had a little	Say a common phrase and leave out the last word; link to automaticity of thoughts the client is struggling with
Get off your butts	Replace virtually all self-referential uses of “but” with “and”

What are the numbers?	Teach a simple sequence of numbers and then harass the client regarding the arbitrariness and yet permanence of this mental event
Why, why, why?	Show the shallowness of causal explanations by repeatedly asking “why”
Create a new story	Write down the normal story, then repeatedly integrate those facts into other stories
Find a free thought	Ask client to find a free thought, unconnected to anything
Do not think “x”	Specify a thought not to think and notice that you do
Find something that can’t be evaluated	Look around the room and notice that every single thing can be evaluated negatively
Flip cards	Write difficult thoughts on 3 x 5 cards; flip them on the client’s lap vs. keep them off
Carry cards	Write difficult thoughts on 3 x 5 cards and carry them with you
Carry your keys	Assign difficult thoughts and experiences to the clients keys. Ask the client to think the thought as a thought each time the keys are handled, and then carry them from there
Wearing your badges	Put feared negative self-evaluations in bold letters on your chest
Bad news radio	Practice saying sticky negative thoughts as if they came from a radio station in your head you cannot not turn off. It’s bad new radio! All bad news! All the time!
Pop up ads from hell	Imagine that you mind sends thoughts like internet pop-up ads
Mr. Hands	Imagine your thoughts are spoken by South Parks “Mr. Hands”
Mr. Bush	Imagine your thoughts are spoken by President Bush (alter to fit politician you are skeptical of)

Acceptance

Purpose: Allow yourself to have whatever inner experiences are present when doing so foster effective action.

Method: Reinforce approach responses to previously aversive inner experiences, reducing motivation to behave avoidantly (altering negatively reinforced avoidant patterns).

When to use: When escape and avoidance of private events prevents positive action

Examples of techniques designed to increase acceptance:

Unhooking	Thoughts/feelings don’t always lead to action
Identifying the problem	When we battle with our inner experience, it distracts and derails us. Use examples.
Explore effects of avoidance	Has it worked in your life
Defining the problem	What they struggle against = barriers toward heading in the direction of their goals.
Experiential awareness	Learn to pay attention to internal experiences, and to how we respond to them
Leaning down the hill	Changing the response to material – <u>toward</u> the fear not away
Amplifying responses	Bring experience into awareness, into the room
Empathy	Participate with client in emotional responding

In vivo Exposure	Structure and encourage intensive experiencing in session
The Serenity Prayer	Change what we can, accept what we can't.
Practice doing the unfamiliar	Pay attention to what happens when you don't do the automatic response
Acceptance homework	Go out and find it
Discrimination training	What do they feel/think/experience?
Mindreading	Help them to identify how they feel
Journaling	Write about painful events
Tin Can Monster Exercise	Systematically explore response dimensions of a difficult overall event
Distinguishing between clean and dirty emotions	Trauma = pain + unwillingness to have pain
Distinguishing willingness from wanting	Bum at the door metaphor – you can welcome a guest without being happy he's there
How to recognize trauma	Are you less willing to experience the event or more?
Distinguishing willingness the activity from willingness the feeling	Opening up is more important than feeling like it
Choosing Willingness: The Willingness Question	Given the distinction between you and the stuff you struggle with, are you willing to have that stuff, as it is and not as what it says it is, and do what works in this situation?
Focus on what can be changed	Two scales metaphor
Caution against qualitatively limiting willingness	The tantruming kid metaphor – if a kid knew your limits he'd tantrum exactly that long; Jumping exercise – you can practice jumping from a book or a building, but you can step down only from the book – don't limit willingness qualitatively
Distinguish willing from wallowing	Moving through a swamp metaphor: the only reason to go in is because it stands between you and getting to where you intend to go
Challenging personal space:	Sitting eye to eye

Self as Context

Purpose: Make contact with a sense of self that is a safe and consistent perspective from which to observe and accept all changing inner experiences.

Method: Mindfulness and noticing the continuity of consciousness

When to use: When the person needs a solid foundation in order to be able to experience experiences; when identifying with a conceptualized self

Examples of techniques designed to increase self as context

Observer exercise	Notice who is noticing in various domains of experience
Therapeutic relationship	Model unconditional acceptance of client's experience.
Metaphors for context	Box with stuff; house with furniture; chessboard
"confidence"	con = with; fidence = fidelity or faith – self fidelity
Riding a bicycle	You are always falling off balance, yet you move forward
Experiential centering	Make contact with self-perspective
Practicing unconditional acceptance	Permission to be – accept self as is
Identifying content as content	Separating out what changes and what does not

Identify programming	Two computers exercise
Programming process	Content is always being generated – generate some in session together
Process vs outcome	Practice pulling back into the present from thoughts of the future/past
ACT generated content	Thoughts/feelings about self (even “good” ones) don’t substitute for experience
Self as object	Describe the conceptualized self, both “good” and “bad”
Others as objects	Relationship vs being right
Connecting at “board level”	Practice being a human with humans
Getting back on the horse	Connecting to the fact that they will always move in and out of perspective of self-as-context, in session and out.
Identifying when you need it	Occasions where “getting present” is indicated (learning to apply first aid)
Contrast observer self with conceptualized self	Pick an identity exercise
Forgiveness	Identify painful experiences as content; separate from context

Valuing as a Choice

Purpose: To clarify what the client values for its own sake: what gives your life meaning?

General Method: To distinguish choices from reasoned actions; to understand the distinction between a value and a goal; to help clients choose and declare their values and to set behavioral tasks linked to these values

When to use: Whenever motivation is at issue; again after defusion and acceptance removed avoidance as a compass

Examples of values techniques

Coke and 7-Up	Define choice and have the client make a simple one. Then ask why? If there is any content based answer, repeat
Your values are perfect	Point out that values cannot be evaluated, thus your values are not the problem
Tombstone	Have the client write what he/she stands for on his/her tombstone
Eulogy	Have the client hear the eulogies he or she would most like to hear
Values clarification	List values in all major life domains
Goal clarification	List concrete goals that would instantiate these values
Action specification	List concrete actions that would lead toward these goals
Barrier clarification	List barriers to taking these actions
Taking a stand	Stand up and declare a value without avoidance
Pen through the board	Physical metaphor of a path – the twists and turns are not the direction
Traumatic deflection	What pain would you have to contact to do what you value
Pick a game to play	Define a game as “pretending that where you are not yet is more important than where you are” -- define values as choosing the game
Process / outcome and values	“Outcome is the process through which process becomes the outcome”
Skiing down the mountain metaphor	Down must be more important than up, or you cannot ski; if a helicopter flew you down it would not be skiing
Point on the horizon	Picking a point on the horizon is like a value; heading toward the tree is like a goal
Choosing not to choose	You cannot avoid choice because no choice is a choice
Responsibility	You are able to respond
What if no one could know?	Imagine no one could know of your achievements: then what would you value?
Sticking a pen through your hand	Suppose getting well required this – would you do it
Confronting the little kid	Bring back the client at an earlier age to ask the adult for something
First you win; then you play	Choose to be acceptable

Empirical Studies on ACT, ACT Components, or ACT Processes

ACT Effectiveness Studies

- Strosahl, K. D., Hayes, S. C., Bergan, J., & Romano, P. (1998). Does field based training in behavior therapy improve clinical effectiveness? Evidence from the Acceptance and Commitment Therapy training project. *Behavior Therapy, 29*, 35-64.
Controlled study, but not randomized. Shows that training in ACT produces generally more effective clinicians, as measured by client outcomes

Group and Controlled Time-Series ACT Efficacy Studies

- Bond, F. W. & Bunce, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *Journal of Occupational Health Psychology, 5*, 156-163.
Randomized controlled trial. Shows that ACT is more effective than a previously empirically supported behavioral approach to reducing worksite stress and anxiety, and that both are better than a wait list control. Process analyses fit the model.
- Bach, P. & Hayes, Steven C. (2002). The use of Acceptance and Commitment Therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 70* (5), 1129-1139. Shows that a three-hour ACT intervention reduces rehospitalization by 50% over a 4 month follow-up as compared to treatment as usual with seriously mentally ill inpatients. Process of change fit the model but would be very much unexpected outside the model.
- Gaudiano, B.A., & Herbert, J.D. (in press). Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy. *Behaviour Research and Therapy*. This study replicates the Bach and Hayes study with better measures and a better control condition. Good results esp. on measures of overt psychotic behavior (the BPRS). Mediation analyses fit the ACT model and are described in more detail in Gaudiano, B. A., & Herbert, J. D. (in press). Believability of hallucinations as a potential mediator of their frequency and associated distress in psychotic inpatients. *Behavioural and Cognitive Psychotherapy*.
- Zettle, R. D. & Hayes, S. C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4*, 30-38.
Small controlled trial. Shows that ACT is more effective than cognitive therapy for depression when presented in an individual format, and that it works by a different process.
- Zettle, R. D., & Raines, J. C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45*, 438-445.
Small controlled trial. Shows that ACT is as effective as cognitive therapy for depression when presented in a group format, and that it works by a different process
- Hayes, S. C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B. S., Fisher, G., Masuda, A., Pistorello, J., Rye, A. K., Berry, K. & Niccolls, R. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*, 821-835.
A medium sized randomized controlled trial that found that a one day ACT workshop produces greater decreases in stigmatization of clients by therapists and greater decreases in therapist burnout than an educational control and (or some comparisons) than multicultural training. Mediation analyses fit the model.
- Dahl, J., Wilson, K. G., & Nilsson, A. (2004). Acceptance and Commitment Therapy and the treatment of persons at risk for long-term disability resulting from stress and pain symptoms: A preliminary randomized trial. *Behavior Therapy, 35*, 785-802.
A small randomized controlled trial shows that a four hour ACT intervention reduced sick day usage by 91% over the next six months compared to treatment as usual in a group of chronic pain patients at risk for going on to permanent disability.
- Twohig, M. & Woods, D. (2004). A preliminary investigation of acceptance and commitment therapy and habit reversal as a treatment for trichotillomania. *Behavior Therapy, 35*, 803-820.
A series of controlled single case designs show that ACT, and ACT combined with habit reversal helps with hair pulling

- Twohig, M. P., Hayes, S. C., Masuda, A. (in press). Increasing willingness to experience obsessions: Acceptance and Commitment Therapy as a treatment for obsessive compulsive disorder. *Behavior Therapy*.
Multiple baseline showing very large reductions in OCD with an 8 session ACT protocol without in session exposure
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Bissett, R., Piasecki, M., Batten, S. V., Byrd, M., & Gregg, J. (2004). A randomized controlled trial of twelve-step facilitation and acceptance and commitment therapy with polysubstance abusing methadone maintained opiate addicts. *Behavior Therapy*, 35, 667-688.
A large randomized controlled trial was conducted with polysubstance abusing opiate addicted individuals maintained on methadone. Participants (n=114) were randomly assigned to stay on methadone maintenance (n=38), or to add ACT (n=42), or Intensive Twelve Step Facilitation (ITSF; n=44) components. There were no differences immediately post-treatment. At the six-month follow-up participants in the ACT condition demonstrated a greater decrease in objectively measured (through monitored urinalysis) opiate use than those in the methadone maintenance condition (ITSF did not have this effect). Both the ACT and ITSF groups had lower levels of objectively measured total drug use than did methadone maintenance alone.
- Gifford, E. V., Kohlenberg, B. S., Hayes, S. C., Antonuccio, D. O., Piasecki, M. M., Rasmussen-Hall, M. L., & Palm, K. M. (2004). Acceptance theory-based treatment for smoking cessation: An initial trial of Acceptance and Commitment Therapy. *Behavior Therapy*, 35, 689-705.
Medium sized randomized controlled trial comparing ACT to nicotine replacement therapy (NRT) as a method of smoking cessation. Quit rates were similar at post but at a one-year follow-up the two groups differed significantly. The ACT group had maintained their gains (35% quit rates) while the NRT quit rates had fallen (<10%). Mediation analyses shows that ACT works through acceptance and response flexibility.
- Zettle, R. D. (2003). Acceptance and commitment therapy (ACT) versus systematic desensitization in treatment of mathematics anxiety. *The Psychological Record*, 53, 197-215.
Small randomized controlled trial shows that ACT is as good as systematic desensitization in reducing math anxiety, but works according to a different process. Systematic desensitization reduced trait anxiety more than did ACT.
- McCracken, L. M., Vowles, K. E., & Eccleston, C. (in press). Acceptance-based treatment for persons with complex, long-standing chronic pain: A preliminary analysis of treatment outcome in comparison to a waiting phase. *Behaviour Research and Therapy*.
108 chronic pain patients with a long history of treatment are followed through an ACT-based 3-4 week residential treatment program. Measures improved from initial assessment to pre-treatment on average only 3% (average of 3.9 month wait), but improved on average 34% following treatment. 81% of these gains were retained through a 3 month follow up. Changes in acceptance predicted positive changes in depression, pain related anxiety, physical disability, psychosocial disability, and the ability to stand. Positive outcomes were also seen in a timed walk, decreased medical visits, daily rest due to pain, pain intensity, and decreased pain medication use.
- Gratz, K. L. & Gunderson, J. G. (in press). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with Borderline Personality Disorder. *Behavior Therapy*. Randomized trial comparing and ACT / DBT combo to TAU. Very strong outcomes on self-harm and other measures. Follow-up is not in this MS. It will appear in another publication. The buzz is that outcomes continue to improve; along with acceptance scores.
- Woods, D. W., Wetterneck, C. T., & Flessner, C. A. (in press) A controlled evaluation of Acceptance and Commitment Therapy plus habit reversal for trichotillomania. *Behaviour Research and Therapy*. A small randomized trial (25 completers) comparing ACT plus habit reversal to a wait list. Wait list subjects then receive ACT/HR. Solid hair pulling, anxiety, and depression outcomes, maintained at a 3 month follow up. Wait list participants also improve once they get ACT. AAQ moves and correlates well with outcomes.
- Twohig, M. P., Hayes, S. C., & Masuda, A. (in press). A preliminary investigation of Acceptance and Commitment Therapy as a treatment for chronic skin picking. *Behaviour Research and Therapy*. [Multiple baseline. Good effects at post but less so at follow up]
- Blackledge, J. T. & Hayes, S. C. (in press). Using Acceptance and Commitment Training in the support of parents of children diagnosed with autism. *Child & Family Behavior Therapy*. [Within design looking at the effects of an ACT workshop of parental distress. Reduced depression.]

Tests of ACT Components

- Masuda, A., Hayes, S. C., Sackett, C. F., & Twohig, M. P. (2004). Cognitive defusion and self-relevant negative thoughts: Examining the impact of a ninety year old technique. *Behaviour Research and Therapy*, *42*, 477-485.
Shows in a series of time-series designs and a group study, that the “milk, milk, milk” defusion technique reduces distress and believability of negative self-referential thoughts
- Gutiérrez, O., Luciano, C., Rodríguez, M., & Fink, B. C. (2004). Comparison between an acceptance-based and a cognitive-control-based protocol for coping with pain. *Behavior Therapy*, *35*, 767-784.
Randomized study with analogue pain task showing greater tolerance for pain in the defusion and acceptance-based condition drawn from ACT as compared to a closely parallel cognitive-control based condition.
- Hayes, S.C., Bissett, R., Korn, Z., Zettle, R. D., Rosenfarb, I., Cooper, L., & Grundt, A. (1999). The impact of acceptance versus control rationales on pain tolerance. *The Psychological Record*, *49*, 33-47.
Analog study. Shows that an acceptance rationale drawn from the ACT protocol produces more pain tolerance than a pain control rationale drawn from a CBT pain management package
- Levitt, J. T., Brown, T. A., Orsillo, S. M., & Barlow, D. H. (2004). The effects of acceptance versus suppression of emotion on subjective and psychophysiological response to carbon dioxide challenge in patients with panic disorder. *Behavior Therapy*, *35*, 747-766.
Acceptance methods (drawn directly from the ACT book) did a better job than control strategies in promoting successful exposure in panic disordered patients
- Eifert, G. H. & Heffner, M. (2003). The effects of acceptance versus control contexts on avoidance of panic-related symptoms. *Journal of Behavior Therapy and Experimental Psychiatry*, *34*, 293-312.
Randomized study comparing control versus acceptance during a CO2 challenge with anxious subjects. Acceptance oriented exercise (the finger trap) reduced avoidance, anxiety symptoms, and anxious cognitions as compared to breathing training.
- Heffner, M., Eifert, G. H., Parker, B. T., Hernandez, D. H. and Sperry, J. A. (2003). Valued directions: Acceptance and Commitment Therapy in the treatment of alcohol dependence. *Cognitive and Behavioral Practice*, *10*, 378-383
This case study describes a heavily values focused ACT treatment of a case of alcohol dependence within an Acceptance and Commitment Therapy model. Identifying valued directions seemed to help the client achieve sobriety and put a plan into action to "start living."
- Feldner, M. T., Zvolensky, M. J., Eifert, G. H., & Spira, A. P. (2003). Emotional avoidance: An experimental tests of individual differences and response suppression during biological challenge. *Behaviour Research and Therapy*, *41*, 403-411. High emotional avoidance subjects showed more anxiety in response to CO2, particularly when instructed to suppress their emotions.
- Takahashi, M., Muto, T., Tada, M., & Sugiyama, M. (2002). Acceptance rationale and increasing pain tolerance: Acceptance-based and FEAR-based practice. *Japanese Journal of Behavior Therapy*, *28*, 35-46.
Small randomized trial that replicated Hayes, Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999. An acceptance rationale plus two ACT defusion exercises (leaves on the stream and physicalizing) did significantly better than a match control focused intervention on pain tolerance, or a lecture on pain.
- Marcks, B. A. & Woods, D. W. (2005). A comparison of thought suppression to an acceptance-based technique in the management of personal intrusive thoughts: A controlled evaluation. *Behaviour Research and Therapy*, *43*, 433-445. Two studies. Correlational study shows suppressing personally relevant intrusive thoughts is associated with more thoughts, more distress, greater urge to do something. Those who accept are less obsessional, depressed and anxious. Experimental study shows that instructions to suppress does not work and leads to increased level of distress; instructions of accept (using a couple of short metaphors drawn from the ACT book) decreases discomfort but not thought frequency.
- Keogh, E., Bond, F. W., Hanmer, R. & Tilston, J. (in press). Comparing acceptance and control-based coping instructions on the cold-pressor pain experiences of healthy men and women. *European Journal of Pain*.
Simple acceptance-based coping instructions improved affective pain more than distraction but only for women.

ACT components as parts of larger packages

- Metzler, C. W., Biglan, A., Noell, J., Ary, D., & Ochs, L. (2000). A randomized controlled trial of a behavioral intervention to reduce high-risk sexual behavior among adolescents in STD clinics. *Behavior Therapy, 31*, 27-54.
Components from ACT were included as component of a successful program to reduce high risk sexual behavior in adolescents.

ACT Case Studies

- Orsillo SM, Batten SV. (2005). Acceptance and commitment therapy in the treatment of posttraumatic stress disorder. *Behavior Modification, 29*, 95-129. Discussion article and case study showing how to apply ACT to the treatment of PTSD.
- Wicksell, R. K., Dahl, J., Magnusson, B. & Olsson, G. L. (in press). Using Acceptance and Commitment Therapy in the rehabilitation of an adolescent female with chronic pain: A case example. *Cognitive and Behavioral Practice*.
Case study. Shows dramatic improvement with a 14 year old chronic pain patient using a values focused ACT protocol.
- García-Montes, J. M., & Pérez-Álvarez, M. (in press). Exposition in existential terms of a case of “Negative Schizophrenia” approached by means of Acceptance and Commitment Therapy. *International Journal of Existential Psychology & Psychotherapy*.
Descriptive case study in a schizophrenic with mostly negative symptoms.
- Pankey, J. & Hayes, S. C. (2003). Acceptance and Commitment Therapy for psychosis. *International Journal of Psychology and Psychological Therapy, 3*, 311-328. Case study with a retarded psychotic person experiencing command hallucinations and multiple delusions. Believability drops dramatically over treatment but not frequency. Good functional improvement.
- Batten, S. V. & Hayes, S. C. (2005). Acceptance and Commitment Therapy in the treatment of comorbid substance abuse and posttraumatic stress disorder: A case study. *Clinical Case Studies, 4*(3), 246-262. Case study. Shows improvement with a dually diagnosed patient.
- Montesinos, F. (2003) ACT, sexual desire orientation and erectile dysfunction. A case study. *Analisis y Modificación de Conducta, 29*, 291-320. A successful application of ACT to a 30-year-old male with difficulties in accepting his bisexual orientation and with an erectile dysfunction is presented.
- Carrascoso Lopez, Francisco Javier (1999). Acceptance and commitment therapy (ACT) in panic disorder with agoraphobia: A case study. *Psicothema, 11*, 1-12
- Paul, R. H., Marx, B. P. & Orsillo, S. M. (1999). Acceptance-based psychotherapy in the treatment of an adjudicated exhibitionist: A case example. *Behavior Therapy, 30*, 149-162.
- Huerta Romero, Francisca; Gomez Martin, Serafin; Molina Moreno, Antonio M; Luciano Soriano, M Carmen (1998). Generalized anxiety: A case study. *Analisis y Modificación de Conducta, 24*, 751-766
- Hayes, S. C. (1987). A contextual approach to therapeutic change. In N. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioral perspectives* (pp. 327-387). New York: Guilford Press. Shows a series of uncontrolled case evaluations on ACT with anxiety problems
- Biglan, A. (1989). A contextual approach to the clinical treatment of parental distress. In G. H. S. Singer & L. K. Irvin (Eds.), *Support for caregiving families: Enabling positive adaptation to disability* (pp. 299-311). Baltimore, MD: Brookes. Uncontrolled. Presents case data on the use of ACT components with families.
- Gardner, F. L. & Moore, Z.E. (2004). A mindfulness-acceptance-commitment based approach to athletic performance enhancement: Theoretical considerations. *Behavior Therapy, 35*, 707-724. Case study. An ACT protocol with an emphasis on mindfulness helps with sports outcomes.
- Dougher, M. J. & Hackbert, L. (1994). A behavior-analytic account of depression and a case report using acceptance-based procedures. *The Behavior Analyst, 17*, 321-334
- Garcia R. F. (2000). Application of acceptance and commitment therapy in an example of experiential avoidance. *Psicothema, 12*, 445-450.
- Heffner, M., Sperry, J., Eifert, G. H. & Detweiler, M. (2002). Acceptance and Commitment Therapy in the treatment of an adolescent female with anorexia nervosa: A case example. *Cognitive and Behavioral Practice, 9*, 232-236. Describes the use of ACT in anorexia and shows resulting data. Case study. The case study is followed by discussion articles:
Wilson, K. G. & Roberts, M. (2002). Core principles in Acceptance and Commitment Therapy: An application to anorexia. *Cognitive and Behavioral Practice, 9*, 237-243.

- Hayes, S. C. & Pankey, J. (2002) Experiential avoidance, cognitive fusion, and an ACT approach to anorexia nervosa. *Cognitive and Behavioral Practice*, 9, 243-247.
- Orsillo, S. M. & Batten, S. J. (2002). ACT as treatment of a disorder of excessive control: Anorexia. *Cognitive and Behavioral Practice*, 9, 253-259.
- There is also a cognitive paper that is nominally a response to the case, but it mentions ACT only in passing, focusing instead on the traditional CBT model.
- Luciano, C. (2001). On the Experiential Avoidance Disorder and Acceptance and Commitment Therapy (ACT). *Análisis y Modificación de Conducta*, 27, 113, 317-332. A case study on ACT.
- Luciano, C., Gómez, S., Hernández, M., & Cabello, F. (2001). Alcoholism, Experiential Avoidance, and Acceptance and Commitment Therapy (ACT). *Análisis y Modificación de Conducta*, 27, 113, 333-372.
- Describes the use of ACT in the treatment of alcoholism and shows resulting data. Case study.
- Luciano, C., & Gutierrez, O. (2001). Anxiety and Acceptance and Commitment Therapy (ACT). *Análisis y Modificación de Conducta*, 27, 113, 373-398.
- Describes the use of ACT in the treatment of anxiety problems and shows resulting data. Case study.
- Luciano, C. & Cabello, F. (2001). Bereavement and Acceptance and Commitment Therapy (ACT). **Análisis y Modificación de Conducta**, 27, 113, 399-424.
- Describes the use of ACT in the treatment of complicated bereavement and shows resulting data. Case study.
- Zaldívar, F. & Hernández, M. (2001). Acceptance and Commitment Therapy (ACT): Application to an experiential avoidance with agoraphobic form. **Análisis y Modificación de Conducta**, 27, 113, 425-454.
- Describes the use of ACT in the treatment of agoraphobia and shows resulting data. Case study.
- García, J.M. & Pérez, M. (2001). ACT as a treatment for psychotic symptoms. The case of auditory hallucinations. **Análisis y Modificación de Conducta**, 27, 113, 455-472.
- Describes the use of ACT in the treatment of psychotic disorders and shows resulting data. Case study.
- Luciano, C., Visdómine, J.C., Gutiérrez, O., & Montesinos, F. (2001). ACT (Acceptance and Commitment Therapy) and chronic pain. **Análisis y Modificación de Conducta**, 27, 113, 473-502.
- Describes the use of ACT in the treatment of chronic pain and shows resulting data. Case study.
- Montesinos, F., Hernández, B., & Luciano, C. (2001). Application of Acceptance and Commitment Therapy (ACT) in cancer patients. **Análisis y Modificación de Conducta**, 27, 113, 503-524.
- Describes the use of ACT in the treatment of cancer pain and shows resulting data. Case study.
- López, S. & Arco, J.L. (2002). ACT como alternativa terapéutica a pacientes que no responden a tratamientos tradicionales: un estudio de caso [ACT as an alternative for patients that do not respond to traditional treatments: A case study]. **Análisis y Modificación de Conducta**, 120, 585-616. Presents data on ACT with a patient who failed a course of cognitive therapy.
- A number of the Spanish case studies are also available in:
 Luciano, C. (2001) (Ed.), **Terapia de Aceptación y Compromiso (ACT) y el Trastorno de Evitación Experiential. Un síntesis de casos clínicos.**
 (Ed.) Valencia: Promolibro

As yet unpublished dissertations

- Block, J. A. (2002). *Acceptance or change of private experiences: A comparative analysis in college students with public speaking anxiety*. Doctoral dissertation, University at Albany, State University of New York.
- Small RCT on the treatment of social anxiety. Compared ACT to Cognitive Behavioral Group Therapy and to a no treatment control. Results indicated that ACT participants evidenced a significant increase in reported willingness to experience anxiety, a significant decrease in *behavioral* avoidance during public speaking, and a marginally decrease in anxiety during the exposure exercises as compared with the control group. Similar results were found for CBGT, but ACT found greater changes in behavioral avoidance.
- Blackledge, J. T. (2004). *Using Acceptance and Commitment Therapy in the treatment of parents of autistic children*. Unpublished doctoral dissertation, University of Nevada, Reno.
- Per – post study shows that ACT workshop helps parents cope with the stress of raising autistic children. Under review at Child & Family Behavior Therapy
- Folke F., & Parling, T. (2004). Acceptance and Commitment Therapy in group format for individuals who are unemployed and on sick leave suffering from depression: A randomized controlled trial. Unpublished thesis, University of Uppsala, Uppsala, Sweden.
- RCT showing that ACT significantly reduces depression among workers on sick leave.

- Gregg, J. (2004). *Development of an acceptance-based treatment for the self-management of diabetes*. Unpublished doctoral dissertation, University of Nevada, Reno.
RCT showing that six hour ACT workshop with patient education works better than patient education alone in producing changes in diabetes self-management and blood glucose (at 3 month follow-up). Mediation analyses show that ACT works through increased acceptance and defusion of diabetes related feelings and thoughts.
- Lundgren, A. T. (2004). *Development and evaluation of an integrative health model in the treatment of epilepsy: Two randomized controlled trials investigating the effects of a short term ACT intervention, yoga, and attention control therapy in India and South Africa*.
Two small RCTs (N = 18; and N = 28) comparing a three session ACT protocol (two individual; one group) to two other conditions. As compared to yoga, significantly reduced seizures in the ACT condition; as compared to attention control, significantly reduced seizures and experiential avoidance, and significantly increased quality of life in the ACT condition at a one year follow up.

Experiential avoidance studies not mentioned earlier (AAQ and related measures)

- Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M., A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth J. P., Karekla, M., & McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record*, 54, 553-578. The AAQ validation study. All 2000 subjects of it. Validates both a 9 and 16 item version, both single factor.
- Bond, F. W. & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology*, 88, 1057-1067.
Shows that AAQ predicts positive work outcomes (mental health, satisfaction, performance) even one year later, especially in combination with job control. Re-factors the AAQ and shows that a two factor solution can work on a slightly different 16 item version.
- McCracken, L. M. (1998). Learning to live with the pain: acceptance of pain predicts adjustment in persons with chronic pain. *Pain*, 74, 21-27.
This study is based on a pain related early version of the AAQ. Greater acceptance of pain was associated with reports of lower pain intensity, less pain-related anxiety and avoidance, less depression, less physical and psychosocial disability, more daily uptime, and better work status. A relatively low correlation between acceptance and pain intensity showed that acceptance is not simply a function of having a low level of pain. Regression analyses showed that acceptance of pain predicted better adjustment on all other measures of patient function, independent of perceived pain intensity. This work is replicated, refined and extended in McCracken, L. M. & Eccleston, C. (2003). Coping or acceptance: What to do about chronic pain. *Pain*, 105, 197-204. and McCracken, L. M., Vowles, K. E., & Eccleston, C. (2004). Acceptance of chronic pain: Component analysis and a revised assessment method. *Pain*, 107, 159-166.
- For a diabetes related AAQ see Gregg 2004 (mentioned above)
- Marx, B. P. & Sloan, D. M. (2002). The role of emotion in the psychological functioning of adult survivors of childhood sexual abuse. *Behavior Therapy*, 33, 563-577. Correlational study showing that childhood sexual abuse (CSA), experiential avoidance and emotional expressivity were significantly related to psychological distress. However, only experiential avoidance mediated the relationship between CSA and current distress.
- Marx, B.P. & Sloan, D.M. (2005). Experiential avoidance, peritraumatic dissociation, and post-traumatic stress disorder. *Behaviour Research and Therapy*, 43, 569-583. 185 trauma survivors were assessed for peritraumatic dissociation, experiential avoidance (using the AAQ), and PTSD symptom severity. Both peritraumatic dissociation and experiential avoidance were significantly related to PTSD symptoms at baseline. After the initial levels of PTSD was taken into account, only experiential avoidance was related to PTSD symptoms both 4- and 8-weeks later.
- Donaldson, E. & Bond, F.W. (2004). Psychological acceptance and emotional intelligence in relation to workplace well-being. *British Journal of Guidance and Counselling*, 34, 187-203. Study compared experiential avoidance (as measured by the AAQ) and emotional intelligence in terms of their ability to predict general mental health, physical well-being, and job satisfaction in workers (controlling for the effects of job control since this work organisation variable is consistently associated with occupational health and performance). Results from 290 United Kingdom workers showed that emotional intelligence did not significantly predict any of the well-being outcomes, after accounting for acceptance and job control. Acceptance predicted

general mental health and physical well-being but not job satisfaction, Job control was associated with job satisfaction, only. Not controlling one's thoughts and feelings (as advocated by acceptance) may have greater benefits for mental well-being than attempting consciously to regulate them (as emotional intelligence suggests).

- Sloan, D. M. (2004) Emotion regulation in action: Emotional reactivity in experiential avoidance. *Behaviour Research and Therapy*, 42, 1257-1270. Examined the relationship between emotional reactivity (self-report and physiological reactivity) to pleasant, unpleasant, and neutral emotion-eliciting stimuli and experiential avoidance as measured by the AAQ. Sixty-two participants were separated into high and low experiential avoiders. Results indicated that high EA participants reported greater emotional experience to both unpleasant and pleasant stimuli compared to low EA participants. In contrast to their heightened reports of emotion, high EA participants displayed attenuated heart rate reactivity to the unpleasant stimuli relative to the low EA participants. Findings were interpreted as reflecting an emotion regulation attempt by high EA participants when confronted with unpleasant emotion-evocative stimuli.
- Karekla, M., Forsyth, J. P., & Kelly, M. M. (2004). Emotional avoidance and panicogenic responding to a biological challenge procedure. *Behavior Therapy*, 35, 725-746. Normal participants high or low on the AAQ were exposed to a CO2 challenge. High emotional avoiders reported more panic symptoms than low avoiders. No difference physiologically.
- Roemer, L., Salters, K., Raffa, S. D., & Orsillo, S. M. (2005). Fear and avoidance of internal experiences in GAD: Preliminary tests of a conceptual model. *Cognitive Therapy and Research*, 29, 71-88. Correlational study. Shows that the AAQ is associated with GAD symptoms in both clinical and non-clinical populations.
- Begotka, A. M., Woods, D. W., & Wetterneck, C. T. (2004). The relationship between experiential avoidance and the severity of trichotillomania in a nonreferred sample. *Journal of Behavior Therapy and Experimental Psychiatry*, 35, 17-24.
- In a large sample of adults suffering from trichotillomania, experiential avoidance as measured by the 9 item AAQ correlated with more frequent and intense urges to pull, less ability to control urges, and more pulling-related distress than persons who were not experientially avoidant. Actual pulling did not differ.
- Greco, L. A., Heffner, M., Poe, S., Ritchie, S., Polak, M. & Lynch, S. K. (2005). Maternal adjustment following preterm birth: Contributions of experiential avoidance. *Behavior Therapy*, 36, 177-184. Experiential avoidance as measured by the AAQ correlated positively with post-discharge parental stress and traumatic stress symptoms surrounding preterm birth. Moreover, it partially mediated the association between stress during delivery and later traumatic stress symptoms. This process was not moderated by parent reports of child temperament or perceived social support, suggesting that experiential avoidance plays a mediating role irrespective of child characteristics or perceived support from family members and close friends.
- Tull, M. T., Gratz, K. L., Salters, K., & Roemer, L. (2004). The role of experiential avoidance in posttraumatic stress symptoms and symptoms of depression, anxiety, and somatization. *Journal of Nervous & Mental Disease*, 192(11), 754-761. Correlational study. Among a sample of individuals exposed to multiple potentially traumatic events, general experiential avoidance (but not thought suppression in particular), predicted symptoms of depression, anxiety, and somatization when controlling for posttraumatic stress symptom severity. Thought suppression (but not experiential avoidance) was associated with severity of posttraumatic stress symptoms when controlling for their shared relationship with general psychiatric symptom severity.
- Zettle, R. D., Hocker, T. R., Mick, K. A., Scofield, B. E., Petersen, C. L. Song, H., & Sudarjanto, R. P. (in press). Differential strategies in coping with pain as a function of level of experiential avoidance. *The Psychological Record*. Correlational. High versus low EA participants show differences in pain tolerance and in pain coping.
- Plumb, J. C., Orsillo, S. M., & Luterek, J. A. (2004). A preliminary test of the role of experiential avoidance in post-event functioning. *Journal of Behavior Therapy and Experimental Psychiatry*, 35, 245-257. Correlational study. Showed that experiential avoidance was correlated with post-traumatic symptomatology over and above other measures of psychological functioning.
- Kashdan, T. B. & Steger, M. F. (in press) Expanding the topography of social anxiety: An experience sampling assessment of positive emotions and events, and emotion suppression. *Psychological Science*. In a 21-day experience sampling study, dispositional social anxiety, emotional suppression, and cognitive reappraisal was compared daily measures of social anxiety. Socially anxious individuals reported the lowest rate of positive events on days when they were more socially anxious and tended to suppress emotions, and the highest rate of positive events on days when they were less socially anxious and more accepting of

emotional experiences. Irrespective of dispositional social anxiety, participants reported the most intense positive emotions on days when they were less socially anxious *and* more accepting of emotional experiences.

Kashdan, T.B., Barrios, V., Forsyth, J.P., & Steger, M.F. (in press). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy*. [two studies, one correlational and one longitudinal, show that experiential avoidance fully or partially mediates the effects of maladaptive coping, emotional responses styles, cognitive reappraisal, and uncontrollability on anxiety-related distress and is associated with diminished daily positive affective experiences and healthy life appraisals, and less frequent positive events, and greater negative affective experiences and more frequent negative events.

Batten, S. V., Follette, V.M., & Aban, I (2001). Experiential Avoidance and high risk sexual behavior in survivors of child sexual abuse. *Journal of Child Sexual Abuse, 10(2)*, 101-120. Correlational study showing that generalized experiential avoidance accounted for 67% of the variance in distress in a sexually abused population.

Projects underway or recently completed that we know about

A large RCT on smoking using Zyban or Zyban plus ACT is just finishing the follow up phase. Funded by NIDA. 12 month follow ups are superior in the ACT condition – about 38% quit rates versus about 15%. Liz Gifford and Steve Hayes are the investigators.

Liz Roemer, Sue Orsillo, and Dave Barlow are testing an ACT-related package with GAD. Funded by NIMH Frank Bond has completed and is writing up two replications and extensions of the Bond and Bunce 2000 study Fredrick Livheim (livheim@hotmail.com) has conducted a randomized prevention trial with ACT in a school setting. Good outcomes post and at one year follow up. Two year follow up now being collected.

Heather Nash who was at University of Alaska, has relocated to Las Vegas. She has a study of ACT with eating disorders using a multiple baseline

Kristy Dalrymple, James Herbert, and Brandon Guadiano at Drexel are doing a study on ACT for social phobia.

John Forsyth and Maria Karekla (University of Albany) have a small RCT underway comparing an Acceptance Framed version of Panic Control Therapy vs. a "treatment as usual" version of Panic Control Therapy for persons suffering from panic disorder.

A large study on ACT + exposure versus traditional exposure is underway by Michelle Crask, Georg Eifert, & John Forsyth

Similar ACT-based anxiety protocols are being tested by Jill Levitt.

Branstetter, A., Wilson, K. G., & Mutch, D. G. (August 2003). ACT and the treatment of psychological distress among cancer patients. Paper given at the World Conference on ACT, RFT, and the New Behavioral Psychology, Linköping, Sweden. Large randomized trial showing that ACT is more helpful than traditional CBT in dealing with end stage cancer and works through a different process. Amazing data. (Write it up Ann!)

There is a large trial of ACT for methamphetamine abuse underway under the direction of Matthew Stout in Australia

Mike Twohig, Deacon Schoenberger and Steve Hayes have multiple baseline data on treatment of marijuana addictions. Good data through post; follow up not as successful. Under review.

Randomized trial underway on ACT for command hallucinations in Australia. Under the direction of Fran Shawyer at the Mental Health Research Institute of Victoria. email: fshawyer@mhri.edu.au

Aki Masuda has replicated and extended his "milk, milk, milk" study showing that a rationale, or rationale plus one second, is not as good as 3 or 10 seconds of repetition, and that is not as good as 20 or 30 seconds. Distress reductions are quicker than believability reductions.

Julieann Pankey has found that the AAQ is highly correlated with complicated grieving.

Dosheen Cook has found that the AAQ-health relationship is the same in Asian as in Caucasian populations

Meyer, B., & Chow, L. (2003, June). Preference for experiential/mindfulness versus rational/cognitive Therapy: The role of information processing styles and sociopolitical attitudes. Poster presented at the annual convention of the Society for Psychotherapy Research, Weimar, Germany. Found that ACT was preferred by liberals ... conservative preferred CBT. You can get this manuscript from b.meyer@roehampton.ac.uk

- Rob Zettle and students have done a study on the performance of high vs. low avoidant subjects as assessed by the AAQ on a perceptual-motor task while wearing "drunk goggles" to induce blurred vision, dizziness, disorientation, etc. Low avoidant subjects perform the task significantly better. Not accepted for publication yet.
- Greco, Dew, & Blomquist have a small uncontrolled pilot-feasibility study currently underway examining the impact of ACT for adolescents with chronic abdominal pain, anxiety, and depression.
- Greco has examined willingness and experiential avoidance among children who experience chronic abdominal pain and persistent headaches. Unpublished as of yet. After controlling for gender, age, and pain frequency, duration, and severity, higher levels of acceptance predicted life quality (Beta = .38), and experiential avoidance/fusion predicted greater use of school medical services and school restrooms during class time (Betas = .24 and .23, respectively), lower quality of life (Beta = -.49), higher anxiety (Beta = .64), and lower teacher-rated academic competence (Beta = -.29).
- Greco, Dew, & Baer have a manuscript underway that presents psychometric properties of the Willingness and Action Measure (WAM), Avoidance and Fusion Questionnaire (AFQ), and Child Acceptance and Mindfulness Measure (CAMM). Findings suggest that the WAM and CAMM correlate positively with positive functioning, whereas scores on the AFQ correlate positively with physical and emotional symptoms and school disability.
- Greco & Russell (2004) evaluated the short-term effects of participating in a summer camp for diabetic youth and investigated the extent to which psychological acceptance moderated children's response to camp. Psychological acceptance (using the WAM) moderated the relation between pre- and post-camp diabetes self-care behavior, with self-care ratings increasing most when psychological acceptance was high (Beta = .24, $p < .05$).
- Laurie Greco is testing out ACT with eating disorders
- Heather Murray, James Herbert, and Evan Forman have a group ACT vs group CBT RCT for Smoking Cessation underway
- Evan Forman and James Herbert have a very cool ACT vs CBT RCT for treatment of mood & anxiety in naturalistic setting
- Laura Ely and Kelly Wilson have a small ($n = 10$) open trial with college students at risk for drop out. Showed improvements on grades and on many of the subscales of the LASSI (study skills inventory) such as time management and using study aids which were never directly addressed
- Debra Moore and Kelly Wilson have a small ($n = 20$) RCT on teens at risk for highschool drop out. Data being entered
- Irish ACT studies (all at NUI Maynooth and all involving the Barnes-Holmes team):
- Claire Keogh is working on an extension of the Masuda study on defusion. So far the data are consistent with the original.
- Claire Keogh, & Hilary-Anne Healy have completed a study on the utility of a defusion statement ("I am having the thought that" when presented in the context of positively and negatively evaluated self-referential statements in an automated procedure. Good data
- Anne Keogh is comparing acceptance and control as interventions with experimentally induced radiant heat pain. Data is looking good for acceptance. May be a gender diff
- Andy Cochrane, is looking at acceptance and a behavioral approach task relevant to spider phobia. All interventions fully automated. No data yet.
- Geraldine Scanlon is working with a sample of ADHD kids on self-esteem, trying to replicate the recent study of me-good and me-bad relations published in the Record by Rhonda and Kelly.
- Claire Campbell is investigating the PASAT and mirror tracing procedures for stress tolerance and applying ACT interventions to them.
- Fodhla Coogan and Loretto Cunningham are looking at experimental analogues of experiential avoidance in the context of equivalence relations and aversive versus positive pictures.
- A recent completed study presented in abstract form [Vowles, K. E., McNeil, D. W., Gross, R. T., McDaniel, M., Mouse, A., Bates, M., Gallimore, P. & McCall, C. (2005, April). Pain-related acceptance and physical impairment in individuals with chronic low back pain. *Journal of Pain*, 6 (Suppl. 1), S4.] and now under submission. An acceptance-based instructional set significantly reduced physical impairment in 74 individuals with chronic low back pain as compared to a control-based intervention.
- Kevin Vowles and John Sorrell have been piloting a group treatment for chronic pain patients integrating the traditional educational stuff that is often part of psychological treatments for pain (e.g., meds, exercise,

nutrition, sleep, communication) with ACT. The treatment consists of eight 90-minute sessions. Data so far look good

Frank Gardner at La Salle has a study being written up that shows that

1. Individuals who score high on measures of anger (STAXI) also score high on experiential avoidance and low on emotion regulation.
2. Individuals who score high on anger AND demonstrate behavioral dysregulation are likely to have a significant aversive early life history (across multiple domains) unlike those patients with behavior dysregulation with minimal anger. These same patients score much lower on QOLI and a values assessment that we have been using as well.-
3. The AAQ predicts early termination from treatment (explaining 51% of the variance)... when directly targeted with a 10 minute "psychoeducation" about experiential avoidance premature termination (69% of which occurs between intake and session 1) is reduced by 50%.

Sofia Engdahl, Marina Järvinen, and Ata Ghaderi (University of Uppsala) have bulimia pilot underway. 16 group sessions over twelve weeks. 11 participants with chronic histories. Pre-post-follow up design. Significant decreases in level of diet restriction, overall symptoms, importance of body weight and shape; depression and an increase in life satisfaction. Follow up still underway.

JoAnne Dahl and students have RCTs underway in smoking, OCD, and obesity.

Jason Lillis (Nevada) has an RCT underway in obesity.

Rob Zettle and Steve Hayes have a multisite crossover study underway on ACT versus CT for depression

JoAnne Dahl has an RCT underway with headache and one with social phobia

Mónica Hernández-López Jesús Gil Roales-Nieto & Carmen Luciano Soriano have a completed smoking RCT comparing ACT to CBT with good outcomes