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Acceptance and Commitment Therapy and the Third Wave of Behavior Therapy

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Abstract

Acceptance and Commitment Therapy (ACT) is a mindfulness, acceptance, and values-based psychotherapy, grounded in the behavioral and cognitive behavioral traditions. ACT attempts to alter the normal impact of human cognition in order to increase the capacity for behavior change. The present paper briefly discusses philosophical and theoretical positions of ACT along with empirical supports for ACT theory. An overview of ACT intervention is given, followed by ACT outcome data in a variety of psychological disorders. Finally, an ACT case report is provided.

Key terms: Acceptance; Acceptance and Commitment Therapy; Cognitive Defusion; Mindfulness; Relational Frame Theory; Values;

Acceptance and Commitment Therapy and the Third Wave of Behavior Therapy

Behavior therapy (defined broadly to include traditional behavior therapy, clinical behavior analysis, cognitive-behavior therapy, and cognitive therapy) has had at least two major waves of development (Goldfried & Davidson, 1994). The first wave of behavior therapy development was characterized by techniques linked to operant and classical conditioning principles. Interventions based on S-R learning or classical conditioning principles emerged particularly rapidly in Britain and South Africa while those based on more operant approaches emerged in the United States. In the early and mid 1970's a second wave of development was marked by the rise of a variety of traditional cognitive therapy approaches, tied to cognitive mediational constructs.

Over the last several years a third wave of behavior therapy has emerged from within both the cognitive and behavioral traditions. Examples include Dialectical Behavior Therapy (DBT; Linehan, 1993), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), Integrative Behavioral Couples Therapy (IBCT; Christensen, A., Jacobson, N. S., & Babcock, J. C., 1995; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000), Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), and several others (e.g., Borkovec & Roemer, 1994; McCullough, 2000; Marlatt, 2002; Martell, Addis, & Jacobson, 2001; Roemer & Orsillo, 2002). The factors that unite these new methods are not easy to characterize, but as a group they have ventured into areas traditionally reserved for the less empirical wings of clinical work, emphasizing such issues as acceptance, mindfulness, cognitive defusion, dialectics, values, spirituality, and relationship. Philosophically they seem more contextual than mechanistic. Both "first order" and "second order" change methods are emphasized. Their methods are often more experiential than didactic.

One of the primary examples of this third wave is Acceptance and Commitment Therapy (known as "ACT" – pronounced as one word, not initials). In this paper we will briefly describe this approach and its history, and will reflect on the general implications it hold for understanding the "third wave" interventions. We will then describe the data that currently exist in support of ACT and an ACT model. Finally, we will give a case example of how these ideas are actually applied.

The Theoretical and Philosophical Basis of ACT

In this section, we will describe the philosophical and theoretical underpinnings of ACT. It is a characteristic of ACT that both of these domains are fairly well developed, since the approach has emphasized them as much as technological development.

ACT Philosophy: Functional Contextualism

ACT is based on a variety of pragmatism known as functional contextualism (Hayes, Hayes, & Reese, 1988; Hayes, Hayes, Reese, & Sarbin, 1993). The core analytic unit of functional contextualism is the "ongoing act in context." The core components of functional contextualism are (a) focus on the whole event, (b) sensitivity to the role of context in understanding the nature and function of an event, (c) emphasis on a pragmatic truth criterion, and (d) specific scientific goals. ACT conceptualizes psychological events as a set of ongoing actions of a whole organism interacting with historically and situationally defined contexts. It resists attempts to reduce or expand whole actions into

components parts as an explanatory strategy – whether those elements are material (e.g., component parts of the organism) or contextual (e.g., “stimuli” considered as physical things). The functions and meanings of behavior are to be found within the interaction. Removal of a client's problematic behaviors from the contexts that participate in that event (e.g., merely analyzing manifested behavioral symptoms themselves) is thought to miss the nature of the problem and avenues for its solution.

The truth criterion of all forms of contextualism is successful working (Hayes et al., 1988) but that in turn requires the clear statement of a goal (Hayes, 1993). The goal of functional contextualism in the prediction and influence of ongoing actions of a whole organisms interacting with historically and situationally defined contexts. “Prediction and influence” is seen as a unified goal (analyses should help accomplish both simultaneously), and for that reason functional contextual analyses always include contextual variables. Accomplishing a goal of influencing behavior requires successful manipulation of events, and only contextual variables can be manipulated directly. Stated another way, analyses that deal *only* in psychological dependent variables (e.g., emotion, thought, overt action) can never be adequate as measured against the pragmatic purposes of functional contextualism.

ACT Theory: Relational Frame Theory

The ACT approach to psychopathology and its treatment is based on a 15-year program of basic research on the behavioral processes underlying language and cognition. In this section we will outline that work (for a book length treatment see Hayes, Barnes-Holmes, & Roche, 2001) and additional relevant experimental literature underlying the ACT treatment model.

The basic theory underlying ACT is Relational Frame Theory (RFT; Hayes et al., 2001). RFT argues that arbitrarily applicable derived stimulus relations are the core of human cognition. Non-arbitrary stimulus relations are those defined by formal properties of related events. For example, if one object looks the same as another, or bigger than another, or comes after another, a wide variety of animals would be able to learn that relation and then show it with new objects that are formally related in the same way (e.g., see Reese, 1968 for a book length review of this literature). Human beings seem able to transfer such learning to objects that are *not* related formally, but only on the basis of arbitrary cues that control relational responding. For example, having learned that “X” and “X” are the “same,” humans may then be able to learn that, say, “hot” and “boiling” are the “same,” even though these two sets of letters look very different. Importantly, the “sameness” of hot and boiling need not be taught in all directions. If a human learns that hot is the same as boiling, that person will derive that boiling is the same as hot.

There are three main properties of this kind of relational learning. First, such relations show mutual entailment. That is, if a person learns in a particular context that A relates in a particular way to B, then this must entail some kind of relation between B and A in that context. For example, if Andy is said to be taller than Bill, then we can derive the relation that Bill is shorter than Andy without direct training. We will also call this property “bi-directionality.” Second, such relations show combinatorial entailment: if a person learns in a particular context that A relates in a particular way to B, and B relates in a particular way to C, then this must entail some kind of mutual relation between A and C in that context. For example, if Bill is taller than Charlie then Andy is also larger than Charlie. Finally, such relations enable a transformation of stimulus functions among

related stimuli. If you need a person to clean a ceiling, and Charlie is known to be valuable, Alan is probably even more valuable.

The transformation of stimulus function is especially relevant to clinical problems. What makes relational framing clinically relevant is that functions given to one member of related events tend to transfer to other members. Let us consider a simple example. Suppose a child has never before seen or played with a cat. After learning the word \rightarrow object, and word \rightarrow oral name relations, the child can derive four additional relations: object \rightarrow word, oral name \rightarrow word, oral name \rightarrow object, and object \rightarrow oral name. Now suppose that the child is scratched while playing with a cat. The child may cry and run away. Later the child hears mother saying, "oh, look! A cat." Now the child again cries and runs away even though the child was never scratched in the presence of the words "oh, look! A cat."

These kinds of processes are not based on the simple and familiar processes of stimulus generalization based on the shared formal properties among these stimuli. These new forms of behavior are established through very indirect means. Such effects may help explain why, for example, agoraphobics can have an initial panic attack while "trapped" in a shopping mall, and soon find that they are worrying about being "trapped" in an open field, in a marital relationship, on a bridge, or in a job. What brings these situations together is not their formal properties in a simple sense, but the verbal activities that relate these events.

An important empirical finding that becomes relevant as this theory is applied is that the derived stimulus relations are extraordinarily difficult to break up, even with direct, contradictory training (Wilson & Hayes, 1996). In other words, once verbal relations are derived, they never seem to go away. You can add to them, but you cannot readily eliminate them altogether. This may explain the rigidity of self-rules, and consequently the insensitivity of behavior occasions by these rules, despite the fact that what the rules say is not consistent with how the world works. Furthermore, derived relational responding will be maintained indefinitely by "sense making." Basic research shows that once we learn how to derive relations among events, we do so constantly as long as we are able to make order out of our world by doing so (e.g., Leonhard & Hayes, 1991).

According to RFT, human language and cognition are both dependent on relational frames. When we think, reason, speak with meaning, or listen with understanding, we do so by deriving relations among events – among words and events, words and words, events and events. Because of the mutual entailment quality of relational frames, when a human interacts verbally with his or her own behavior, the psychological meaning of both the verbal symbol and the behavior itself can change (i.e., transformation of stimulus functions). RFT argues that it is this bidirectional property that makes human self-awareness useful. For example, if an incorrect choice is made, evaluation of that choice will alter the function of the original environment when it is next encountered. This same property of human cognition, however, makes self-awareness painful.

Human language and cognition is a two-edged sword (Hayes, et al., 1999). The bi-directional nature of human cognition, for example, can easily bring psychological and emotional reactions to previous painful events to the present. If a person verbally relates the word "relationship" and his experience of breaking up with his ex-girlfriend, the word

relationship may trigger emotional and psychological reaction, which he experienced during that incidence. This process presents an extreme challenge to human beings. A nonhuman trying to avoid pain can avoid the situations in which it occurs. A human cannot because language allows pain to occur in almost any situation through derived relations. In self-defense, humans begin to try to avoid the painful thoughts and feelings themselves – what we term “experiential avoidance,” even though this is often tremendously destructive in the long run, as we will show in a later section. Even though this process is harmful, it is not obvious what alternatives there are. Relational learning (e.g., verbal rules) gradually dominates over other sources of behavioral regulation in humans (what we term “cognitive fusion”; Hayes, 1989), making an individual become less mindful about here-and-now experience (Hayes, et al., 1986) and more dominated by verbal rules (Hayes, Brownstein, Haas, and Greenway, 1986; also see Hayes, 1989 for a book length treatment of the effects of verbal rules). From an RFT perspective, even such a simple rule as “I can’t stand this feeling” can lead human beings into years of needless struggle. Problems with rules regarding experiential avoidance are confirmed by the experimental literature on the effects of suppression.

There is a growing body of literature that indicates that, in general, attempts to suppress unwanted private experiences can be detrimental. For example, emotion focused and avoidant strategies have been found to negatively predict outcome in a variety of clinical domains, including depression (DeGenova, Patton, Jurich, & MacDermid, 1994), substance abuse (Ireland, McMahon, Malow, & Kouzekanani, 1994), and sequelae of child sexual abuse (Leitenberg, Greenwald, Cado, 1992). The thought suppression literature provides insight into some of the processes underlying the deleterious effects of avoidance. Research has found that deliberate attempts to suppress target thoughts actually increased the occurrence of these thoughts (Wegner, Schneider, Carter, & White, 1987; Clark, Ball, & Pape, 1991). Such findings provide a description of the ways in which rules regarding avoidance or suppression of experiential stimuli can become counter productive. If individuals react to the presence of certain thoughts and feelings with efforts to suppress, such efforts are likely to lead to amplification.

The literatures on derived stimulus relations and suppression provide us with a view into the cognitive and verbal processes that define the human condition. Verbal cognitive processes permit humans to imagine worlds unseen but they can also run amok. For example, fusing with the thought “I simply can’t have this feeling,” i.e., responding to the stimulus functions of this thought as literal truth rather than observing the thought *as a thought* emerging from one’s history, can carry with it a host of problems. The literature on suppression supports the futility of efforts to avoid aspects of internal experience, and some of the problematic outcomes attendant on these efforts. Unfortunately, the culture teaches many instances of these rules, and almost everyone’s history contains examples of them.

The means by which ACT intervenes on these processes is discussed below, but the core insight is this: verbal / cognitive processes are contextually controlled. Direct attempts at cognitive change can be unhelpful, but contextual approaches can make changes in these private events unnecessary.

ACT Interventions

From ACT perspective, a main problem that clients have is the narrowness and inflexibility of his or her behavior repertoires. The wasted time and energy clients spend

avoiding or escaping from their aversive private experiences, such as feelings, thoughts, memories, and physiological reactions, keeps them from engaging in vital actions (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). The general clinical goals of ACT, therefore, are to undermine the literal grip of the verbal content of cognition that occasions avoidance behavior and to construct an alternative context where behavior in alignment with one's value are more likely to occur.

Given the possibility of paradoxical effects of deliberate attempts to control private experiences, ACT uses a less confrontational manner and less directive forms of verbal interaction, such as metaphor, paradoxes, and experiential exercises, to loosen the entanglement of thoughts and the self. Again, the whole idea is that undermining the literal impact of verbal events help to alter client's contexts so that value-oriented actions are likely to occur, while avoidance actions is unlikely to occur.

There are several more specific domains of ACT intervention, and each has its own specific methodology, exercises, homework, and metaphors. The following is a brief synopsis of these areas:

- Creative hopelessness
- Control is the problem, not the solution
- Acceptance as an alternative agenda
- A transcendent sense of self
- Defusing language and cognition
- Values
- Willingness and commitment
- The ACT therapeutic relationship

Confronting the System: "Creative Hopelessness"

The goal of the first stage of ACT is to identify the strategies that the client has employed until this point and to help him or her notice whether or not these agenda are working. As exploring previously used tactics, ACT therapists ask the client to consider the possibility that maybe the problem is not that the client has not tried hard enough or has not been motivated enough. Instead, perhaps it is the case that the methods that the client is using is part of the problem and will actually never bring the client closer to his or her values.

We should be clear here about what we mean by the term "creative hopelessness." ACT does not attempt to make the client *feel* hopelessness (indeed, most clients begin to feel more hopeful in this phase of ACT). Instead, ACT help the client see that the ways client deals with his or her pain are not working and are unlikely to begin to do so now. This type of hopelessness is creative because it allows the client to let go of the struggle and try something new. In addition, creative hopelessness has validation components, normalizing the client's pain.

It is important to allow the client to come into experiential contact with the effectiveness of their change agendas without didactic or rhetorical argument with the ACT therapist. The arbiter during this exploration is never the therapist's opinion—it is the client's experience (Hayes, et al., 1999).

This dialogue in this phase of ACT might look something like this:

Therapist: So you are telling me you've tried quite of number of things to attempt to control your depression. You've tried ignoring it; you've tried toughing

it out; you've tried to have others help. What is your sense of how these things have worked for you?"

Client: Well, I've tried and tried and I can't seem to find something that works. I just want to make it stop.

Therapist: You've certainly tried different things. It looks like that to me. You've done all the usual things people do. I think you have tried your best. And bottom line it's not working. So I want you to consider this. You know it *hasn't* worked. What if it *can't* work?

Client: What do you mean? I feel stuck then. Ok, so now I'm really confused.

Therapist: Good. Maybe we are in a place where we can do some work. Because you've already tried all the obvious stuff. You've already done what makes sense to you and yet you are here. So, perhaps these things you've tried simply *cannot* work. Maybe these so called solutions are actually part of the problem.

An important cornerstone of ACT therapy is the use of metaphor and metaphorical language in order to undermine language-induced struggle. Metaphors can have an impact without invoking the client's normal verbal defenses (Hayes et al., 1999). One of the core ACT metaphors introduced within the context of creative hopelessness is the *Man in the Hole Metaphor*. This is a flexible metaphor that can be used to help a client understand on a more experiential level the unworkability of their struggle. With this metaphor, the clients are asked to imagine that they are a person who has been placed in an open field blindfolded with a tool bag to carry and who is told that living a life means running around that field. Unfortunately the field is filled with a variety of large holes. Inevitably, they fall into one of the holes, and are stuck at the bottom, much like they are stuck in the current predicament. After a while they feel inside the tool bag to see if there is something that that would help. It contains nothing but a shovel. So they dig, with big scoop or little, fast scoop or slow. But the hole is not getting smaller, it's getting bigger. And here they are, seeing a therapist, in the secret hope that therapy is a really *huge* shovel. But shovels aren't for getting out of holes – shovels make holes.

Control is the Problem

From ACT perspective, the deliberate attempts to control private experience are problematic, although these are prevalent ways of dealing with our private experiences. As human beings, it is our common-sense notion that, if we do not want something, we must figure out how to get rid of it and get rid of it (Hayes & Wilson, 1994). Controlling strategies (e.g., removing, suppressing, and distracting) are taught repeatedly and have become common sense agenda to manage our problems. Deliberate attempts to control things work quite well in most domains in our lives but they do not work so well with private experiences. Indeed, verbal regulatory rules often occasion the very events they purport to control. Deliberately not thinking of something usually fails because the rule ("don't think of x") contains the avoided item.

The *Polygraph Metaphor* is a core intervention at this stage of ACT therapy to help clients experience the un-workability of control strategy in one's private experiences.

Therapist: "Now suppose I have you hooked up to the world's most sensitive polygraph machine. I want you to imagine that this machine is incredibly effective in measuring anxiety. The task is simple. All you have to do is stay relaxed. However, I know you want to do well, to try hard, so I am

going to add an extra incentive here. I will have a loaded .44 Magnum trained at your skull. You must stay calm or I'm going to shoot you. I'll kill you if you get anxious, which I'll know you are based on this polygraph. What do you think might happen here? The tiniest bit of anxiety would terrify you, wouldn't it?

Client: Oh man, that is scary to think about.

Therapist: It is because you know how difficult it would be to try and keep calm. This is the paradox with controlling emotion. If you aren't willing to have it, you will.

Acceptance as an Alternative Agenda

If the therapist has been able experientially to establish the client's control agenda as destructive, it becomes useful to point to the alternative: acceptance and willingness. At this point, willingness is merely opened up briefly. Metaphors such as the Two Scales Metaphor are used to introduce the concept of control and its relationship to psychological distress.

Imagine there are two scales, like the volume knobs on a stereo. One is right out here in front of us and it is called "Anxiety" (Use labels that fit the client's situations such as "Anger, guilt, urges, worry," etc. It may also help to move one's hand as if it is moving up and down a numerical scale). It can go from 0 to 10. In the posture you're in, what brought you in here was this: "This anxiety is too high." In other words you have been trying to pull the pointer down on this scale (the therapist can use the other hand to pull down unsuccessfully on the anxiety hand). But now there's also another scale. It's been hidden. It is hard to see. This other scale can also go from 0 to 10 (move the other hand up and down behind your head so you can't see it). What we have been doing is gradually preparing the way so that we can see this other scale. We've been bringing it around to look at it (move the other hand around in front). It is really the more important of the two, because it is this one that makes the difference and it is the only one that you can control. This second scale is called "Willingness." It refers to how open you are to experiencing your own experience when you experience it--without trying to manipulate it, avoid it, escape it, change it, and so on. When Anxiety (or whatever fit to the client) is up here at 10, and you're trying hard to control this anxiety, make it go down, make it go away, then you're unwilling to feel this anxiety. In other words, the Willingness scale is down at 0. But that is a terrible combination. It's like a ratchet or something. When anxiety is high and willingness is low, the ratchet is on and anxiety can't go down. That's because if you are really, really unwilling to have anxiety then anxiety is something to be anxious about. It's as if when anxiety is high, and willingness drops down, the anxiety kind of locks into place. So, what we need to do in this therapy is shift our focus from the anxiety scale to the willingness scale. You've been trying to control anxiety for a long time, and it just doesn't work. It's not that you weren't clever enough; it simply doesn't work. Instead of working on the anxiety scale, we will turn our focus to the willingness scale. Unlike the anxiety scale, which you can't move around at will, the willingness scale is something you can set anywhere. It is not a reaction--not a feeling or a thought--it is a choice. You've had it set low. You came in here with it set low--in fact coming in here at all may

initially have been a reflection of its low setting. What we need to do is get it set high. If you do this, I can guarantee that if you stop trying to control anxiety, your anxiety will be low ...[pause] *or* ... it will be high. I promise you! And when it is low, it will be low, until it's not low and then it will be high. And when it is high it will be high until it isn't high anymore. Then it will be low again. ... I'm not teasing you. There just aren't good words for what it is like to have the willingness scale set high.

Self as Context: A Transcendent Sense of Self

It is not realistic to ask clients to become willing to expose themselves to their most feared emotions and thoughts, until the client can see directly that his or her survival will not be threatened by such exposure. There is one aspect of human experience that usually provides a fairly firm foundation: their continuity of consciousness. Seeing that there is a part of themselves that is constant provides great comfort to clients being asked to do that which they have avoided, often for their entire life. The *Chessboard metaphor* is a central ACT metaphor for the distinction between self and avoided psychological content.

It's as if there is a chess board that goes out infinitely in all directions. It's covered with different colored pieces, black pieces and white pieces. They work together in teams, like in chess--the white pieces fight against the black pieces. You can think of your thoughts and feelings and beliefs as these pieces; they sort of hang out together in teams too. For example, "bad" feelings (like anxiety, depression, resentment) hang out with "bad" thoughts and "bad" memories; same thing with the "good" ones. So it seems that the way the game is played is that we select which side we want to win. We put the "good" pieces (like thoughts that are self-confident, feelings of being in control, etc.) on one side, and the "bad" pieces on the other. Then we get up on the back of the white queen and ride to battle, fighting to win the war against anxiety, depression, thoughts about using drugs, whatever. It's a war game. But there's a logical problem here, and that is that from this posture, huge portions of yourself are your own enemy. In other words, if you need to be in this war, there is something wrong with you. And even though these pieces are in you (they are different facets of your experience), from the level of the pieces they can be as big or even bigger than you. Plus, even though it is not logical, the more you fight the bigger they get. If it is true that "if you are not willing to have it, you've got it" then as you fight them they get more central to your life, more habitual, more dominating, and more linked to every area of living. The logical idea is that you will knock enough of them off the board and you eventually dominate them, except your experience tells you that the exact opposite happens. Apparently, the black pieces can't be deliberately knocked off the board. So the battle goes on. You feel hopeless, you have a sense that you can't win, and yet you can't stop fighting. If you're on the back of that white horse, fighting is the only choice you have because the black pieces seem life threatening. Yet living in a war zone is no way to live.

As the client connects to this metaphor, it can be turned to the issue of the self.

Therapist: Now, let me ask you to think about this carefully. In this metaphor, suppose you aren't the chess pieces. Who are you?

Client: Am I the player?

Therapist: That may be what you have been trying to be. Notice, though, that a player has a big investment in how this war turns out. Besides, who are you playing against? Some other player? So suppose you're not that either.

Client: Am I the board?

Therapist: It's useful to look at it that way. Without a board, these pieces have no place to be. The board holds them. If you're the pieces, the game is very important; you've got to win, your life depends on it. But if you're the board, it doesn't matter if the war stops or not.

Cognitive Defusion and Mindfulness

The ACT therapist seeks to undermine the impact of language so that the ongoing cognitive processes are evident in the moment. From RFT perspective, cognition does not have its current functions inherently. Rather, they are contextually learned. As we become more verbal, our cognition becomes the reality (e.g., who you are is what a thought says you are, such as "you are worthless"). In other words, we are trapped because we fuse with the content of our cognition. Cognitive defusion techniques erode the tight verbal relations that establish stimulus functions through relational learning (Hayes et al., 1999; Hayes & Wilson, 1994).

A number of verbal conventions are adopted with ACT clients, designed to increase the psychological distance between the client and the client's private events. An example of a language convention has to do with our use of the words 'but' and 'and.' "But" literally means that what follows the word, "but", contradicts what went before the word; "*but* that" means that there are two things that are inconsistent, that are literally at war with each other. In the ancient etymology of the word in English, one has to 'be out' given the other. The ACT convention is to say '*and*' instead of '*but*' whenever possible, which reduces the psychological sense that something is wrong and must be changed whenever literally contradictory reactions are noticed.

Another example of a defusion technique is the *Milk, Milk, Milk* exercise, first used by Titchener (1916, p. 425). It consists of an exploration of all of the properties of "milk" (white, creamy, etc.) followed by two or three minutes of the client and therapist saying the word "milk" out loud until it loses all meaning. The point is that all words are like that: in addition to their "meanings" they are also just sounds.

Mindfulness exercises are the positive side of cognitive defusion – by contacting events in the here and now, without buying into evaluative and judgmental language, more flexible forms of responding are encouraged. A variety of mindfulness exercises are used in ACT, such as imagining watching one's thoughts as they float by like leaves on a stream.

Values

It is only within the context of values that action, acceptance, and defusion come together into a sensible whole. Indeed, ACT therapists often do values clarification work before other ACT components for that reason.

A value is a direction that can be instantiated in behavior but not possessed like an object. ACT therapists ask their clients "What do you want your life to stand for?" In this phase of treatment a client is asked to list values in different life domains such as family, intimate relationships, health, spirituality, and so on.

Various evocative exercises are used to develop more clarity about fundamental values. For example, the ACT therapist may ask the client to write out what he or she

would most like to see on his or her tombstone, or the eulogy he or she would want to hear at his or her own funeral. When values are clarified, achievable goals that embody those values, concrete actions that would produce those goals, and specific barriers to performing these actions are identified. In essence it is values that dignifies the need for exposure to painful thoughts and feelings.

Willingness and Commitment to Valued Actions

The concrete actions and specific psychological barriers identified in the previous step become the final focus of ACT. In essence, the last stage of ACT is simply learning a generalized strategy of behaviorally moving forward valued ends, dissolving barriers through defusion and acceptance. At this point exposure work is very common, as is skills work and commitment exercises. ACT merges into more typical behavior therapy strategies, but done from an ACT perspective.

In this stage of ACT clients begin to see that life itself is asking them this question: given that there is a difference between you as a person and your own private experiences, are you willing to contact those experiences, fully and without defense, as they are and not as they say they are, and do what moves you in the direction of chosen values in this situation? If the answer is “no,” the person gets smaller. If the answer is “yes,” the person gets bigger and concrete behavior change work become the focus.

The Therapeutic Relationship

The techniques within the ACT protocol are multifaceted and complex, and often paradoxical and confusing to the clients because of the metaphorical and experiential nature of the therapy. It is important for the therapist to maintain a compassionate yet challenging approach, which creates a context for some difficult emotional work on the part of the client but not judgmental or evaluative.

A description of the ACT relationship is exemplified by the *Two Mountains Metaphor*:

Therapist: It’s like this. You and I are both kind of climbing our own mountains of life. Imagine that these mountains are across each other in a valley. Perhaps, as I climb my mountain I can look across the valley, and from my perspective, see you climbing your mountain. What I can offer to you as a therapist is that I can comment from my perspective, to give you my viewpoint from outside of your experience. It is not that you are broken; it is not that I am always skillful with my own barriers. We are both human beings climbing our mountains. There is no person who is “up,” while the other is “down.” The fact that I am on a different mountain means I have some perspective on the road you are traveling. My job is to provide that perspective in a way that helps you get where you really want to go.

There are two risks that a competent ACT therapist must bear in mind. One risk is that it is often tempting to discourage clients from expressing emotional or cognitive content that is painful to hear. For example, therapists may want to “rescue” clients from their bad feelings, instead of modeling how these feelings can be embraced compassionately in the service of effective action. In the therapeutic relationship in ACT, acceptance of experiential material is practiced regardless of the content of this material.

The second and related risk when practicing ACT is that it is easy to get pulled into “buying” the client’s formulations about reality; or, conversely, into rejecting their

version of reality and attempting to argue them out of it. The strength of literal formulations is potent, and as verbal creatures therapists are susceptible to fusing with their own and their client's formulations. For example, it may be tempting to buy into thoughts about the hopelessness of the client's situation, or to attempt to argue the client out of such beliefs. In particular, the therapist must be aware of the risk of fusing with any of the implicit or explicit rules regarding reasons for ineffective behavior. The goal is to help the client become aware of, and defuse from, these formulations, not to do battle with them at a content level. If the therapist remains unaware of such thoughts and their struggle and/or fusion with them, it will reduce the therapist's ability to help the client identify and defuse problematic cognitions, and thus reduce the client's opportunity to create a life more in accordance with their values.

ACT Empirical Findings

ACT has been used for a wide range of psychological problems. These include depression (e.g., Zettle & Hayes, 1986; Zettle & Raines, 1989), a variety of anxiety disorders (e.g., Block, 2002; Hayes, 1987; Zettle, in press), psychosis (e.g., Bach & Hayes, 2002), substance use disorders (e.g., Gifford, 2002; Hayes, Wilson, Gifford, Bissett, Batten, Piasecki, Byrd, & Gregg, 2002), chronic illness (e.g., Geiser, 1992), eating disorder (Heffner, Sperry, Eifert, & Detweiler, 2002), work-related problems (Bond & Bunce, 2000), among others (e.g., Paul, Marx, and Orsillo, 1999; Luciano Soriano & Gutierrez Martinez, 2001). Effectiveness research has shown that training in ACT produces clinicians who are better able to produce positive outcomes in general outpatient practice and to do so more rapidly (Strosahl, Hayes, Bergan, & Romano, 1998). In this section, we will overview ACT empirical finding for a variety of behavioral problems.

Depression

In the area of depression two small, randomized controlled trials (Zettle & Hayes, 1986; Zettle & Raines, 1989) and one case study (Luciano Soriano & Cabello Luque, 2001) on ACT have been reported. Both randomized controlled trials compared ACT with Beck's Cognitive Therapy (CT; Beck, Rush, Shaw, & Emery, 1979). Results demonstrated that, when given with an individual format, both treatments significantly reduced depression at post-treatment, compared to pre-treatment. However, ACT reduced depression significantly greater than CT at follow-up (two-month follow-up). When given with a group format, ACT and CT significantly reduced depression at post and two-month follow-up, compare to baseline. Results also showed that the process of change in the two conditions: ACT reduces the believability of depressogenic thoughts quickly, but their frequency comes down more slowly; in CT the reverse is characteristic (Zettle & Hayes, 1986).

Anxiety Disorders

In the areas of anxiety and anxiety-related problems, two ACT randomized controlled trials were reported, both of which compared ACT to an empirically supported treatment. One was for mathematics anxiety (Zettle, in press) where ACT was compared to systematic desensitization, and the other for social phobia where ACT was compared to a cognitive-behavioral therapy (Block, 2002). The two studies demonstrated that ACT is at least as effective as the ESTs for the given anxiety problems, but on some specific measures ACT was superior (e.g., behavioral avoidance, Block, 2002). Empirical evidences in other types of anxiety disorders primarily consist of a number of supportive

single or multiple ACT case-reports (e.g., Carrascoso López, 2000; Hayes, 1987; Huerta Romero, Gomez Martin, Molina Moreno, & Luciano Soriano, 1998; Zaldivar Basurto & Hernandez Lopez, 2001).

Psychosis

One randomized controlled trial (Bach & Hayes, 2002) and a case report (Garcia Montes & Perez Alvarez, 2001) have been reported in the area of psychotic symptoms (e.g., delusion and hallucination). The randomized controlled trial was conducted with inpatient participants with positive psychotic symptoms (Bach & Hayes, 2002). The study demonstrated that adding a very brief ACT intervention with treatment as usual (TAU) reduced the rehospitalization rate by about 50% over the next four months. Process analysis suggested that acceptance and defusion accounted for the impact of ACT. None of the ACT subjects who both admitted to symptoms and showed reduced symptom believability were readmitted to the hospital during follow-up.

Substance Use Disorders

In the area of substance use problems, two treatment-comparison randomized controlled trials have been reported. A first one is a large randomized controlled trial was conducted with polysubstance abusing opiate addicted individuals maintained on methadone (Hayes, Wilson, Gifford, Bissett, Batten, Piasecki, Byrd, & Gregg, 2002; data are available in Bissett, 2001). In an additive model, the effects of ACT with methadone maintenance were compared to the Intensive Twelve Step Facilitation (ITSF) with methadone maintenance and the methadone maintenance only. There were no differences immediately at 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. Both the ACT and ITSF groups also had lower levels of objectively measured total drug use than did methadone maintenance alone. Another RCT compared ACT to nicotine replacement therapy (NRT) as a method of smoking cessation (Gifford, 2002). The quit rates, as assessed by objective monitoring of CO levels, were equivalent at the end of treatment, but at a one-year follow-up the two groups differed significantly. The ACT group had maintained their gains while the NRT quit rates had fallen. In addition, several case reports have demonstrated successful ACT treatment for substance abusers (e.g., Batten & Hayes, in press; Luciano Soriano, Gomez Martin, Hernandez Lopez, & Cabello Luque, 2001).

Chronic Conditions

A quasi-experiment (Geiser, 1992) and several case reports (Luciano Soriano, Visdómine Lozano, Gutiérrez Martínez, & Montesinos Marin, 2001; Montesinos Martin, Hernandez Montoya, & Luciano Soriano, 2001) demonstrated the effects of ACT for psychological suffering due to chronic conditions. The quasi-experiment (Geiser, 1992) compared an ACT-based treatment with CBT for treatment of individuals with chronic pain. Both conditions resulted in comparable clinically significant improvement at the end of treatment and the effects were maintained at a three-month follow-up.

Work-Related Stress

ACT was also utilized in a workplace stress management intervention. A large randomized controlled trial (Bond & Bunce, 2000) compared an ACT stress protocol, to a behaviorally-oriented Innovation Promotion Program that encouraged participants to identify and change stressful events in their workplace, or to a waitlist control. ACT

demonstrated significantly greater improvements than the IPP and control groups in a general measure of stress and psychological health at post-treatment and at follow-up. As compared to the control group, both interventions were equally effective in relieving depression and increasing the propensity to take concrete actions to reduce worksite stressors. The latter finding is important because this outcome was specifically targeted by IPP but not by the ACT intervention. Increased acceptance was shown to mediate the impact of ACT.

Other Behavioral Problems

Finally, successful case reports have been presented in a variety of other areas such as exhibitionism (Paul, Marx, & Orsillo, 1999), marital distresses (Luciano Soriano & Gutierrez Martinez, 2001), and anorexia nervosa (Heffner, Sperry, Eifert, & Detweiler, 2002).

Case Example

In order to describe how ACT can be used we will describe a case of an adult depressed male. The client was a 54-year-old Caucasian male with college degree education. He lived with his second wife in a townhouse. The client previously worked in law-enforcement. When he came to the session, he was employed as a security manager.

The client became extremely distressed four months prior to therapy due to loss of employment, financial difficulties, and divorce entanglements (e.g., a court case regarding child support was ongoing during the ACT intervention). Furthermore, the client was struggling with problems in a second marriage. The client reported that he had lost the direction in his life and had overwhelming sense of depression, anger, guilt, victimization, and difficulty with making decisions.

Measurements

Measurement tools were given before the beginning of each session. Because the client's initial concern was depression and difficulty in making decision, the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) was provided with the client to assess his depression symptoms. The BDI was given in each session, from session 1 through session 17. In addition to the BDI, the Acceptance and Action Questionnaire (AAQ; Hayes, Bergan, Strosahl, Wilson, Polusny, & Naugle, under review) was administered to measure the changing process in the client's private experience. The AAQ is a 9-item, 7-point Likert-Scale, which is designed to measure the degree of experiential avoidance behavior. Mean AAQ total score in clinical populations is between 38 and 40, and mean in non-clinical population is between 30 to 31. The AAQ data were available from session 2 through session 17.

ACT Intervention

The ACT intervention was conducted in a psychology clinic at a university. The intervention consisted of 17 sessions over 27 weeks. The session 1 through 4 primarily consisted of assessment. Session 5 through 17 included ACT interventions. Each session lasted approximately 50 minutes, ranged from 40 minutes to 70 minutes.

Session 1 through 4 (week 1, 2, 3, and 4) The purpose of the first four sessions was to establish a case conceptualization. They consisted of assessment of the client's background information, identification of target behavior and his previous attempts to manage his problems, and treatment contract. It is important to note that although the first four sessions were primarily designed for assessment, they were conducted with ACT

manner. The client's main problems, previous attempts to manage these problems and their workability in different life domains, and his values were assessed.

The session 1 and 2 consisted of the assessment of the client's clinical problems and background information. Questions related to his clinical problems included (a) the nature of his problems (depression and difficulty with making decision), (b) reason of seeking psychotherapy, and (c) previous attempts to deal with the problems. For the background information, the client's histories were assessed in the areas of intimate/family relationship, educational/vocational activities, past history of psychological treatment, and physical condition. Session 3 primarily focused on the further functional assessment around his coping skills (e.g., avoidance) in the areas of interpersonal relationships (e.g., first marriage, second marriage, an affair, and his children). Session 4 consisted of the assessments of his feelings and thoughts in these contexts.

The assessment results showed his life-long avoidance patterns especially in the areas of his private experiences and relationship struggles. For example, he had tendency to suppress his feelings and thoughts and hardly disclosed them to significant others. For example, during his first marriage, the client distracted himself from his psychological issues by spending most of the times working outside, and he eventually left the family without telling them why. The client also reported similar behavior patterns in his current relationship. In addition, the client had maladaptive rules, such as "showing own feelings and thoughts (e.g., being vulnerable) to others is a sign of weakness", "I have to prioritize others' needs over my own," "I do things for everybody, but nobody does things for me". In sum, these cognitive and behavioral patterns seemed to induce his psychological distresses, and triggered avoidance repertoires, while, at the same time, preventing him from contacting with his private experience. In session 4, the client finally agreed to work on his own personal struggles (i.e., private experience).

Session 5 (week 5) Session 5 consisted of the brief value assessments in the various domains of his life (e.g., intimate/family relationships, friendship, vocational activities). Although the value assessment is typically introduced at a later phase of ACT, it was administered to identify the costs of cognitive rigidity (e.g., reason giving, evaluation, and cognitive fusion) and avoidance. The client reported difficulties with identifying and articulating his values.

Session 6 (week 6) Session 6 did not include an ACT intervention per se and dealt with a financial and legal crisis related to his divorce.

Session 7 (week 8) Session 7 consisted of (a) ACT creative hopelessness and (b) brief introduction of control as the problem. After the treatment contract was briefly overviewed (because therapy was not conducted in the previous session), ACT creative hopelessness was introduced. "The man in the hole metaphor" (Hayes, et al., 1999, p. 101-104), along with his previous and current interpersonal struggles was used to help him become oriented to paradoxical nature of his previous attempts to deal with his problems. The workability and rigidity of his attempts to suppress his difficult feelings and thoughts and his avoidance pattern in the context of interpersonal relations were also included in the exercise. Following the metaphor, the ACT control as problem was briefly introduced to identify the paradoxical effects of his previous coping styles.

Session 8 and 9 (week 9 and 10) Session 8 and 9 focused on "control as the problem." These sessions had two main goals. One was to help the client notice the futility of previous

controlling attempts (e.g., emotional avoidance). A second goal was to generate therapeutic contexts where willing to experience his struggles without the attempts of suppressing, distracting, or getting rid of them. The paradoxical effect of controlling strategies were again discussed along with “the man in the hole metaphor”, and the willingness to contact with his private events as an alternative was briefly introduced.

In addition, session 8 and 9 were also designed to help him discriminate contexts where controlling strategies work and where they do not work. Session 9 especially focused on the discriminating training. During the session, the clients was asked to see if he could notice that controlling strategies might not work in the area of his private experiences, especially from a long-term perspective, while he had controls over his own overt actions (e.g., looking for a better paid job, and working on the child-protection case).

Session 10 and 11 (week 11 and 12) Session 10 and 11 included "Acceptance as an alternative agenda". Session 10 consisted of “willingness exercises” and “self-as-context”. The session consisted of (a) ACT willingness exercises, and (b) a brief ACT experiential exercises. In the willingness exercises, Two Scales Metaphor (Hayes, et al., 1999, p. 133-134) was used to direct his attention from his psychological struggles to willingness to experience the struggles. Subsequently, in order to enhance his willingness and to change the function (meanings) of his private experiences (thoughts, feelings, and memories) a brief ACT Observer Exercise (Hayes et al., 1999, p. 192-196) was provided with the client. Similar to session 10, session 11 continued along with ACT willingness exercise. The session included the overview of willingness and normalization of human struggles. The "Box Full of Stuff Metaphor" (Hayes et al., 1999, p. 136-138) was introduced to enhance his willingness as an alternative to concealing and suppressing private experiences and to show that there is a cost to being unwilling. In addition the distinction between willingness and tolerance was discussed.

Session 12 (week 14). This session dealt with his feelings about an affair. Which included a brief period of moving away from home, and with his subsequent choice to rebuild his relationship with his wife. Issues related to willingness and commitment were discussed.

Session 13 (week 15). Session 13 consisted of (a) willingness and responsibility and (b) self-as-a-context. The client reported that he was working to rebuild his relationship with his wife, and that he spent more time with his wife than ever before. While discussing his goal of increasing communication skills with his wife, anticipated struggles were identified and discussed in rebuilding the relationship (e.g., arguments during communication and his frustration for ineffective communication skills). To encourage his communication with his wife, willingness was revisited. No particular intervention for enhancing his communication skills was implemented.

Following the discussion of willingness, self-as-a-context was introduced, including the Chessboard Metaphor (Hayes et al, 1999, p. 190-192) and the observer exercise (Hayes et al., 1999, p. 192-196). In the chessboard metaphor exercise, the client reported that his self-criticizing thoughts still evoked aversive feelings and he notice the pull to use confrontation or distraction strategies (e.g., telling himself “no that’s not true!”) to suppress these thoughts and feelings. Because he had difficulty defusing from difficult private experiences, the observer exercise was used to experience the distance between himself and the content of his thoughts and feelings. The client reported a clear experience of cognitive defusion during the observer exercise.

Session 14 through 17 (week 20, 22, 24, and 27). The session 14 through 17 primarily were designed to work once again on the identification of the client values and the commitment to value-oriented actions. Session 14 consisted of assessment of his between-session activities in the areas of his relation with his wife, since the duration of between session 13 and 14 was five weeks due to difficulties scheduling (e.g., Christmas break). Because the client mentioned that he had been fully experiencing his life events, and his mood and activities seemed to become stable over the two-month periods, the client and therapist decided to reduce the frequency of therapy to every two weeks.

In session 15 (week 22), his values in various domains of his life (e.g., intimate, family, and social relations, vocational and recreational activities) were briefly outlined. In session 16 (week 24), his values and value-oriented actions were discussed. In session 17 (week 27), the barriers or obstacles to take value-oriented actions and the commitment to these actions were discussed. During session 17, the client reported that his value-oriented actions took place in different life domains. These value-oriented domains included intimate relationship with his wife and family relationship. In the domain of intimate relationship, the client and his wife had been sharing time together more often than before (e.g., having a breakfast, go shopping, going out for dinner), while acknowledging occasional arguments. He also addressed that these arguments were not severe, which indicated in the improvement in his interpersonal skills. In the domain of family relation, the client started making contact with his son from his first marriage, to whom he hardly talked previously. Because of these stable progresses, both the client and therapist agreed to terminate the therapy.

Treatment Outcomes

The primary goal of the treatment was to help the client find valued-direction in his life by encouraging him to live with fully experiencing his own experiences. As mentioned above, to show the therapeutic progresses, the client's depression and the degree of cognitive rigidity and entanglement were assessed throughout the course of therapy. Figure 1 show the level of his depression throughout the course of treatment. During the assessment phase, the client's BDI score was 29 at the beginning of treatment, which fell in the clinical range, and his DBI score gradually fell in the normal range. At the second intervention session (i.e., session 6), the client's BDI score returned to the clinical range once, however, his BDI score was gradually reduced to lower levels and eventually to zero as therapy went by. As shown in Figure 2, The AAQ scores indicated that the client's struggles with his private experiences and subsequent avoidance behaviors were reduced over the course of ACT intervention. Similar to the BDI score, his AAQ score increased in session 6, however, the score gradually decrease throughout the ACT intervention sessions. During session 13 and 14, the score fell under the non-clinical range and continued to decrease.

Case Discussion

The client initially was overwhelmed by the enormous amount of psychological distresses due to his financial and relationship struggles. During the early phases of ACT intervention, he did not engage in any changes discussed within sessions, especially the area of intimate relationship with his second wife, because he thought it impossible. Therapy was conducted with non-confrontation manner, gradually pointing out the paradoxical effects of his personal rules and worldviews in general and his avoidance activities in the area of private experiences and interpersonal relationships. Once he was willing to contact his avoided private experiences (e.g., feeling of being weak and

vulnerable) without the attempts to suppress or remove them, he established a more healthy distance between himself and his negative private experiences, and abandoned previous avoidance behaviors.

The client voluntarily became willing to repair the relationship with his second wife, ended the affair, and deliberately engaged in various activities with his wife (e.g., going out for a dinner, taking for a walk, and watching TV, discussing each other's concern for their lives). These changes generalized to greater involvement with his son. His depression lifted.

Summary and Discussion

ACT is not so much a specific set of techniques as it is a model of behavior therapy itself. In the context of a powerful therapeutic relationship, it focuses on a small number of key issues: defusion, mindfulness, acceptance, values, and committed action. Each of these is linked to a basic account.

The third wave of cognitive-behavior therapy is exemplified by ACT. Most of these third wave treatments address – in one way or the other – issues of mindfulness and defusion, relationship, acceptance, and values. The change is not so much revolutionary as evolutionary, in that the best of the tradition of behavior therapy is retained. Whether these new treatments represent a step forward in the outcomes that behavior therapists can produce remains to be seen, but the fact that these new therapies have remained committed to the empirical values of the behavior therapy tradition means that in the near future that question will be answered.

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Footnotes

1. ACT was originally called Comprehensive Distancing, and early ACT studies are referenced under that name. In this paper, we have used the more current term.

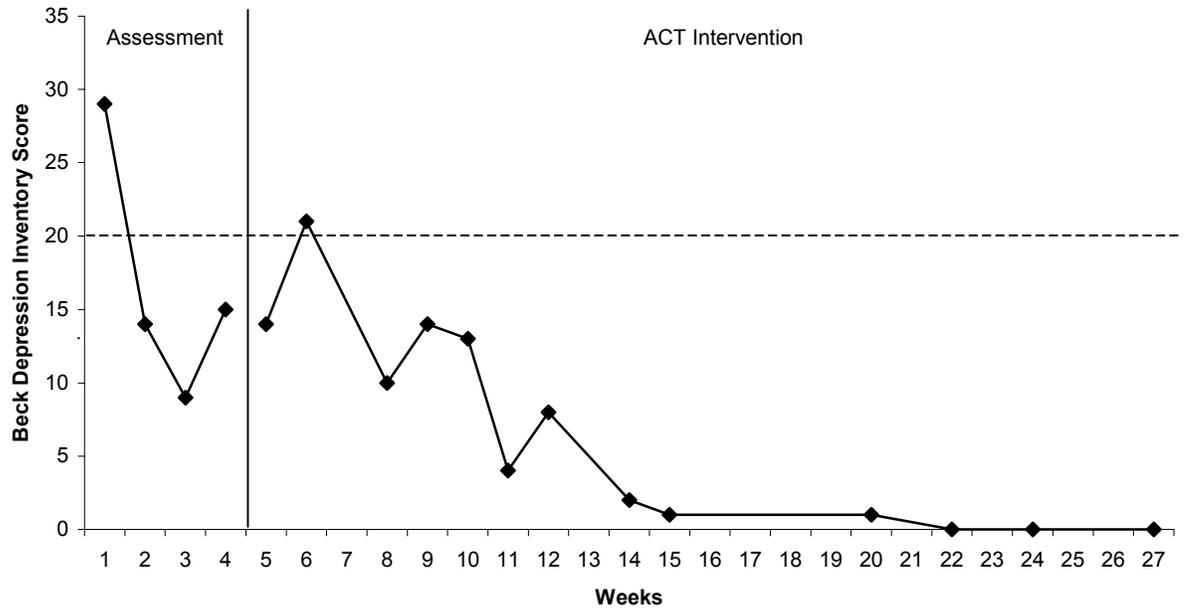
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Figure Caption

Figure 1. The client's BDI scores over the course of ACT intervention.

Figure 2. The client's AAQ scores over the course of ACT intervention.

Beck Depression Inventory



Acceptance and Action Questionnaire (AAQ)

