

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



Website for Relational Frame Theory (also contains ACT info):

www.relationalframetheory.com. Website for ACT:

www.acceptanceandcommitmenttherapy.com.

World Conference on ACT, RFT, and the New Behavioral Psychology, August 13-17, 2003 Linköping, Sweden. Should be an amazing conference.

Registration and submission info and forms at www.swaba.org or

www.psykologpartners.se.

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. 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.

Books (contextual philosophy; relational frame theory, acceptance methods, treatment manuals): Context Press (775) 746-2013 or (888) 4CP-BOOK or www.contextpress.com. To get the ACT or RFT books (they are published by Guilford and Plenum, respectively) go to Amazon and search on "Steven Hayes."

Steve Hayes webpage: WWW.UNR.EDU/PSYCH (then go to faculty web pages).

Workshops: Regularly at AABT, ABA, UNR. 2 ½ day workshops at Tahoe once or twice a year.

The next one is September 5-7. Registration materials are on the websites. We have a small number of trainers all around the world. Inquire with Steve Hayes.

How to reach Steve Hayes: Department of Psychology /296, University of Nevada, Reno, NV 89557-0062; (775) 784-6828 ext. 2005; email: hayes@unr.nevada.edu

A Few Suggested Non-Empirical Readings (Empirical readings at end of this handout)

Hayes, S. C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, L. F. (in press). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? **Behavior Therapy**. [Tutorial review of the evidence on ACT, DBT, and FAP]

Hayes, S. C. (in press). Acceptance and Commitment Therapy, Relational Frame Theory, and the third wave of behavior therapy. **Behavior Therapy**. [Makes the case that ACT is part of a larger shift in the field.]

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 the ACT bible at the moment. A must read is you are interested in ACT.]

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.]

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. You can get it as the Context Press website listed above]

Hayes, S. C., Pankey, J., & Gregg, J. (2002). Anxiety and Acceptance and Commitment Therapy. In E. A. Gosch & R. A. DiTomasso (Eds.), **Comparative treatments of anxiety disorders** (pp. 110-136). New York: Springer. [Decent clinical chapter]

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 the ACT approach to psychopathology]
- Hayes, S. C. & Wilson, K. G. (1993). Some applied implications of a contemporary behavior-analytic account of verbal events. **The Behavior Analyst**, **16**, 283-301. [an entry into RFT and its implications ... but the RFT book is now better]
- Hayes, S. C. & Wilson, K.G. (1994). Acceptance and Commitment Therapy: Altering the verbal support for experiential avoidance. **The Behavior Analyst**, **17**, 289-303. [an entry into ACT and its implications ... but the ACT book is now better]
- Hayes, S. C. & Gregg, J. (2001). Functional contextualism and the self. In C. Muran (Ed.), **Self-relations in the psychotherapy process** (pp. 291-307). Washington, DC: American Psychological Association. [Deal with the self issue]
- Kohlenberg, B., Hayes, S. C., & Tsai, M. (1993). Behavior analytic psychotherapy: Two contemporary examples. **Clinical Psychology Review**, **13**, 579-592. [A quick and dirty description. Useful to give to others if they know nothing]
- 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. Guilford will publish a follow on volume in 2003, edited by myself, Victoria Follette, and Marsha Linehan]

Other materials:

- 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.
- 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.
- Steve will email you a 10 session ACT transcript on request and with proof that you are a therapist and that you understand the confidentiality rules regarding clinical material. Just email him and ask for it.
- On the next page is the AAQ, which is good for population based studies of an aspect of experiential avoidance. The short form does not work very well as a process measure, however. Too short / too trait oriented. One good process measure right now is a modified version of the Automatic Thoughts Questionnaire, adding believability ratings. Likert type rating of willingness in specified domains also works. The best process measures are probably actual measures of in session behavior. We have one validated approach (email Steve for the “Acceptance Process Manual”) but it requires transcribing tapes and training an observation team. We are working on computerized methods of scoring transcripts (a la Pennebaker). The ACT book shows a way of developing client values. Kelly Wilson is turning that into a systematic measure. You can email him for information (kwilson@olemiss.edu).

The Acceptance and Action Questionnaire – Revised (AAQ-R)

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

- _____ 12. I am in control of my life. [Use in AAQ-16. Score in Action factor]
- _____ 13. If I get bored of a task, I can still complete it. [Use in AAQ-16. Score in Action factor]
- _____ 14. Worries can get in the way of my success. [Reverse score. Use in AAQ-16. Score in Action factor]
- _____ 15. I should act according to my feelings at the time. [Reverse score. Use in 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 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. [Reverse score. 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]
- _____ 19. When I compare myself to other people, it seems that most of them are handling their lives better than I do. [Reverse score. Use in AAQ-9]

Notes: Some previous versions have been scored so that high scores equal high experiential avoidance; other have been scored so that high scores equal high acceptance/willingness. In this version, high scores equal high acceptance/willingness. This overall version can be used to generate the scores either for the single factor, 9-item solution; or the dual factor, 16 item dual factor solution.

There is no need to ask permission to use this instrument as long as you tell us about interesting things you find (hayes@unr.nevada.edu). When using, remove the title of the instrument and use "AAQ" instead.

The validation study for the 9-item 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. (in press). Measuring experiential avoidance: A preliminary test of a working model. **The Psychological Record**. Email Steve Hayes for it (hayes@unr.edu). Mean in clinical populations: about 38-40. The higher above that, the more experientially avoidant. Mean in non-clinical populations: about 30-31. This is not the best process of change measure for ACT (believability is better) – good as a kind of trait measure for large correlational studies of a key aspect of experiential avoidance.

The validation study for the 16-item version is in press at the *Journal of Applied Psychology*. The reference is:

The role of acceptance and job control in mental health, job satisfaction, and work performance. Frank W. Bond and David Bunce, *Goldsmiths College, University of London* .

You can email Frank Bond for more information at f.bond@gold.ac.uk

Alpha is adequate for the short version (about .7) and good for the longer one (approaching .8).
Better with clinical than non-clinical populations. A new AAQ is under development.

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 reasoning; 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.

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

Examples of ACT components

(these are not in a necessary sequence. Often values work comes first, for example)

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

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

These clinical materials were assembled by Elizabeth Gifford, Steve Hayes, and Kirk Stroschal

Empirical studies on ACT, ACT components, or ACT processes
November 2002 version

- 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.
- 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
- 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. (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
- Geiser, D. S. (1992). **A comparison of acceptance-focused and control-focused psychological treatments in a chronic pain treatment center**. Unpublished dissertation. University of Nevada, Reno.
Randomized controlled trial. Shows that an ACT-based pain management protocol (didn't call it by that name though) is as effective as CBT in producing positive outcomes. Evidence that both groups work through acceptance to some degree. Used a modified version of the larger, early AAQ.
- 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 in the seriously mentally ill.
- 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
- Roemer, E. & Orsillo, S. (in press). Expanding our conceptualization of and treatment for generalized anxiety disorder: Integrating mindfulness/acceptance-based approaches with existing cognitive-behavioral models. **Clinical Psychology: Science and Practice**. Originally contained a small series of cases from a small unpublished RCT. Shows that a protocol largely drawn from the ACT protocol is helpful in treating GAD. Published version cut most of the data unfortunately ... but look for the other study.

- Korn, Zamir (1997). Effects of acceptance/commitment and cognitive behavioral interventions on pain tolerance. Hofstra University. Analog study. Small RCT comparing an ACT rationale with a CBT rationale and a placebo rationale for tolerance of pain. The ACT rationale led to significantly greater tolerance for pain than the CBT rationale, but not the control rationale. The ACT rationale produced significantly lower correlations between reported pain and actual performance than the other two groups.
- Bond, F. W. & Bunce, D. (in press). The role of acceptance and job control in mental health, job satisfaction, and work performance. **Journal of Applied Psychology**. Showed that the AAQ predicted (over a one year period) mental health and an objective measure of job performance, over and above job control, negative affectivity, and locus of control. The beneficial effects of having more job control were enhanced when people had higher levels of acceptance.
- 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.
- 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.
- Metzler, C.W., Biglan, A., Noell, J., Ary, D.V., & 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. RCT to reduce adolescent high-risk sexual behavior. Successful outcomes. Included ACT components in successful treatment.
- 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.
- Heffner, M. & Eifert, G.H. (in progress). *The ACT on Anorexia: Acceptance and Commitment Therapy Client Workbook*. New Harbinger Publication. Due to released in 2004.
- 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 alcoholism and shows resulting data. Case study.

All of these Spanish case studies are also available in:

Luciano, C. (2001) (Ed.), **Terapia de Aceptación y Compromiso (ACT) y el Traastorno de Evitación Experiencial. Un síntesis de casos clínicos.** (Ed.) Valencia: Promolibro

- 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.
- 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.
- 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.

- Gifford, E. (2002) Acceptance and Commitment Therapy versus Nicotine Replacement Therapy as methods of smoking cessation. Doctoral dissertation. University of Nevada, Reno. 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%).
- 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.
- Hayes, S. C., Wilson, K. G., Gifford, E., Bissett, R., Batten, S., Piasecki, M., Byrd, M. & Gregg, J. (May 2002). **The use of Acceptance and Commitment Therapy and 12-Step Facilitation in the treatment of polysubstance abusing heroin addicts on methadone maintenance: A randomized controlled trial**. Paper presented at the meeting of the Association for Behavior Analysis, Toronto. Data are available in a related dissertation that focused on the process results: Bissett, R. T. (2001). **Processes of change: Acceptance versus 12-step in polysubstance-abusing methadone clients**. Doctoral dissertation available from the University of Nevada. Dissertation Abstracts International – B, 63/02, p. 1014, Aug 2002.
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.
- Batten, S. V., & Hayes, S. C. (in press). Acceptance and Commitment Therapy in the treatment of co-morbid substance abuse and posttraumatic stress disorder: A case study. **Clinical Case Studies**.
Case study. Shows improvement with a dually diagnosed patient.

Other case studies on ACT or relevant to ACT

- 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 Modificacion de Conducta*, *24*, 751-766
- 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.

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.

Brian P. Marx, B. P. & Sloan, D. M. (in press) The role of emotion in the psychological functioning of adult survivors of childhood sexual abuse. **Behavior Therapy**. 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.

Sloan, D. M. (in press) Emotion regulation in action: Emotional reactivity in experiential avoidance. **Behaviour Research and Therapy**. 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. (in press). Emotional avoidance and panicogenic responding to a biological challenge procedure. **Behavior Therapy**. 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.

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. About 60% of the 12 month follow ups are now in an the ACT condition is superior at this point – about 38% quit rates version about 15%.

Liz Romer, Sue Orsillo, and Dave Barlow are testing an ACT-related package with GAD. Funded by NIMH

Frank Bond is doing a larger replication and extension of the Bond and Bunce study

[A student of James Herbert \(Hahneman\) is replicating the Bach and Hayes study](#)

[Michael Twohig and Doug Woods \(Univ. of Wisconsin - Milwaukee\) has a multiple baseline with trichotillomania combining ACT and habit reversal \(good outcomes\)](#)

[Heather Nash \(University of Alaska\) has ACT multiple baseline data with eating disorders](#)

A small randomized controlled trial in that same SAMHSA project has found that a one day ACT workshop produces greater decreases in stigmatization of clients by therapists, greater decreases in therapist burnout, and greater increases in client engagement than multicultural training, or a wait list control. Being written up.

A small multiple baseline by Steven Myles at the University of Wales shows that ACT is helpful in reducing conduct disorder problems in adolescents. Soon to be submitted.

A randomized controlled trial by Joanne Dahl, Kelly Wilson, and colleagues shows a stunningly large effect of ACT (especially at follow-up) compared to treatment as usual in preventing permanent disability in workers beginning to miss many days due to pain. The effect increases through the follow-up period. The data are being written up.

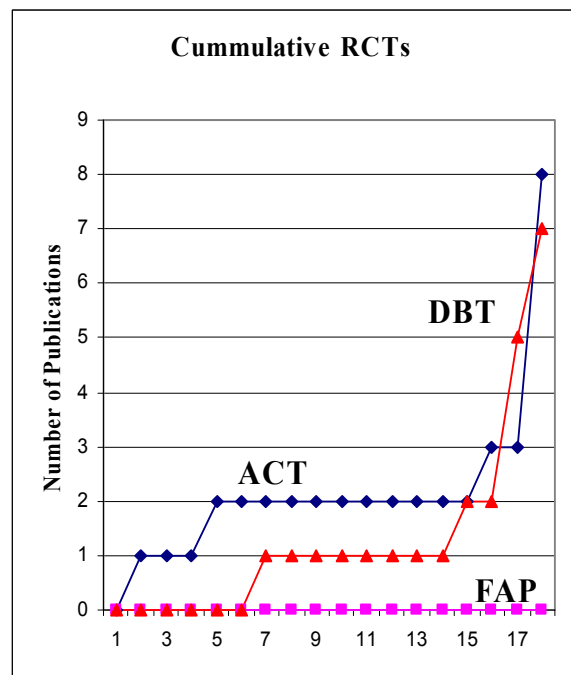
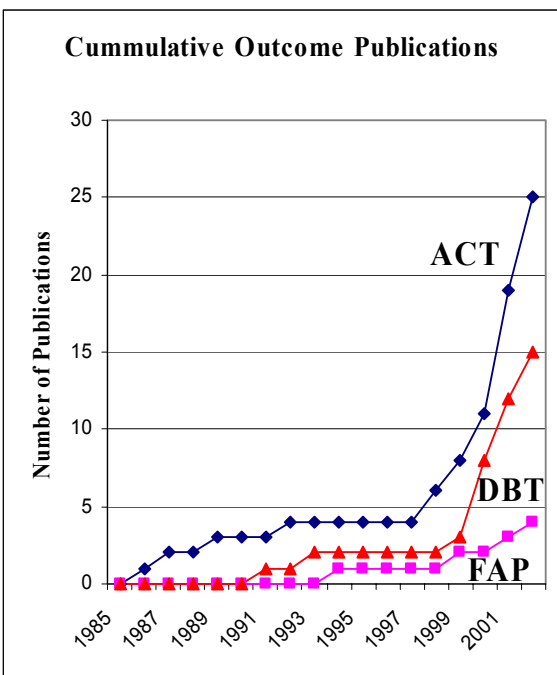
A small uncontrolled trial conducted by Laura Ely & Kelly Wilson shows that a brief, intensive ACT intervention showed good results with college students at risk for academic failure.

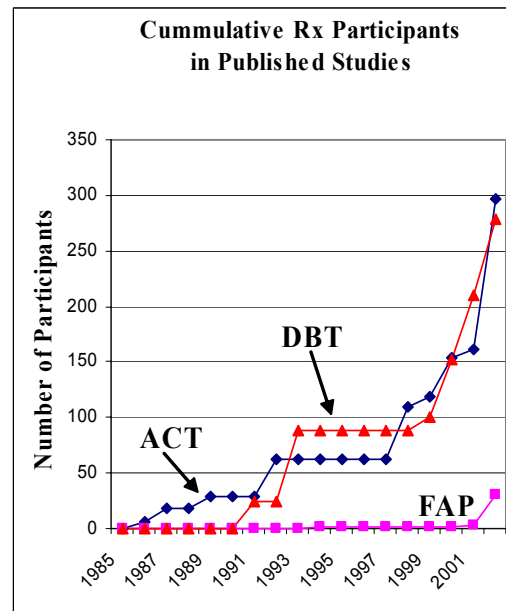
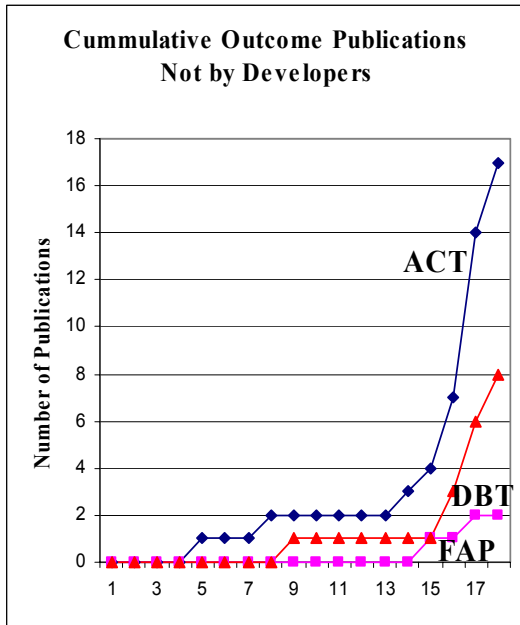
As a follow up to this study, Debra Moore and Kelly Wilson are conducting an RCT examining ACT versus a package of standard psycho-educational interventions for high school students at-risk for drop out and/or academic failure. Study funded by U. S. Department of Justice pass through money from the State of Mississippi Office of the Attorney General.

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.

If you know of others: let us know!

State of the ACT evidence. Recently ACT, FAP, and DBT were publicly criticized for “getting ahead of their data.” We do not think that is correct. DBT is the best established of the three; FAP is the least well established; but ACT is doing pretty well in producing empirical tests, both of the technology and the processes of change. ACT is also based on a very robust basic program of research. Considering only outcome studies, here is the current state of the literature in terms of the pure amount of data:





Given all of this, when should you use ACT?

The data on ACT are positive, but preliminary. It is not yet an empirically supported treatment by accepted standards, though it is approaching that status in some areas. We recommend ACT on an experimental basis with any problem that fits the underlying model (e.g., the problem appears to involve cognitive fusion, or experiential avoidance, or a lack of clarity of values, and resulting inactivity, inflexibility, and ineffectiveness) provided it is used with systematic evaluation and there is a good reason not to use existing ESTs first (e.g., if they have already failed; client rejects their use). We think that approach is particularly appropriate for the following problems, since at least some efficacy data are available (this listed only published data, divided into randomized controlled trials and other types of studies – e.g., pre-post designs or single case designs):

Depression:	2 RCTs; 1 other. Some indication that it is superior to CBT in some settings. Evidence of a distinct process.
Anxiety / Stress:	2 RCTs; 5 other. Some indication that it is superior to CBT in some settings. Evidence of a distinct process.
Psychosis	1 RCT; 1 other. Not yet compared to other psychosocial methods but effects seem large. Usually done in addition to antipsychotic medication.
Substances	3 RCTs; 1 other. Some indication that it does better than existing pharmacotherapy methods, or supplements their effects.
Pain	2 RCT; 3 other. Seems about as good as CBT so far. No data yet that it is better.
Prejudice and burn out	1 RCT. Beats multicultural counseling. Helps in both stigma and burnout.
Marital problems	1 other. Very limited data.
Eating disorder	1 other. Very limited data.
Sexual deviation	1 other. Very limited data.
Dually diagnosed.	1 RCT (sub-analysis). 1 other. Promising but limited data.

There are some data on effectiveness. Limited though these data are, they are higher quality data than are common. Thus, we feel that we can recommend ACT to systems of care provided they

use it under the limitation suggested above and will work with us to train it properly, and to evaluate its impact.