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

ACT is listed as an evidence-based treatment by the Clinical Division of the American Psychological Association (http://www.div12.org/PsychologicalTreatments/treatments.html) and by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its National Registry of Evidence-based Programs and Practices (NREPP). The NREPP listing can be found at http://174.140.153.167/ViewIntervention.aspx?id=191

The main website for ACT and for Relational Frame Theory is the one maintained by the Association for Contextual Behavioral Science: www.contextualpsychology.org. Upcoming workshops are always posted there. I highly recommend joining ACBS. It costs what you are willing to pay (dues are “values based” meaning you pay what you think the work is worth and what you can afford; professionals average $50 but many initially pay just a little until they see what they are getting. Anything above $10 will be accepted). The resources there are incredible (you cannot download them unless you are a member). Your membership automatically includes a high quality Elsevier journal called the Journal of Contextual Behavioral Science. If you have any interest in ACT or RFT it would frankly be goofy not to join. There are over 5600 members worldwide.

There is an email list serve for ACT and one for RFT. The website above has links to these and other special purpose ACT list serves. People talk about various issues, ask questions of each other, and so on. It is a world-wide conversation. There are about 1500 participants on the ACT list and 450 on the RFT list.

Workshops: There are ACT trainers all around the world. A list of trainers is posted on the ACT website, along with the values statement ensuring that this whole process is not money focused or hierarchically controlled.

Next two big ACT meetings: The 11th ACBS World Conference in Sydney, Australia, July 2013; the 12th World Con in Minneapolis in 2014. Details are on www.contextualpsychology.com

The Values of the ACT / RFT Community

What we are seeking is the development of a coherent and progressive contextual behavioral science that is more adequate to the challenges of the human condition. We are developing a community of scholars, researchers, educators, and practitioners who will work in a collegial, open, self-critical, non-discriminatory, and mutually supportive way that is effective in producing valued outcomes for others that emphasizes open and low cost methods of connecting with this work so as to keep the focus there.

We are seeking the development of useful basic principles, workable applied theories linked to these principles, effective applied technologies based on these theories, and successful means of training and disseminating these developments, guided by the best available scientific evidence; and we embrace a view of science that values a dynamic, ongoing interaction between its basic and applied elements, and between practical application and empirical knowledge. If that is what you want too, welcome aboard.

How to Learn ACT

Read 3 or 4 key books (a couple of general ones from the list below initially); Join ACBS and especially the list serves; Come to a workshop or a whole ACT convention; Work thru a general ACT self-help book looking at your own processes; Review some ACT DVDs; Form a Peer Consultation Group (www.contextualpsychology.org/act_peer_supervision_groups) if not an actual chapter or local affiliate of ACBS, or seek out local or online supervision from experts; apply ACT following a protocol to a few clients; Apply ACT with supervision but without a formal protocol to a few clients; Do a presentation on ACT. By then you are ready for the tattoo and the chicken ritual (who says ACT is a cult?)
Helpful ACT Books and Tapes (partial list)

**General ACT Books: Professionals**

- **Hayes, S. C., Strosahl, K., & Wilson, K. G.** (2011). *Acceptance and Commitment Therapy: The process and practice of mindful change* (2nd edition). New York: Guilford Press. [This is still the heart of the ACT literature. It is where it started]
- **Chantry, D.** (2007). *Talking ACT: Notes and conversations on Acceptance and Commitment Therapy*. Reno, NV: Context Press. [This is an edited version of the ACT listserv from July 2002 through August 2005 compiled by a therapist, for therapists. Functions as a quick reference on a wide range of ACT topics (acceptance, anxiety, behavior analysis, choice, clinical resources, contextualism, etc)]

**General ACT Books: Clients**

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

**Trauma: Professional book**


**Trauma: Client book**


**Depression: Professional book**


**Depression: Client book**


**Anxiety: Professional book**


**Anxiety: Client book**

**Worry: Client book**

**Chronic pain: Professional books**

**Chronic pain: Client book**

**Aner: Client book**

**Caregivers: Client book**
McCurry, S. M. (2006). *When a family member has dementia: Steps to becoming a resilient caregiver*. Westport, CT: Praeger Publishers. [Although not directly on ACT or mindfulness, this book for caregivers does include a significant emphasis on acceptance, as might make sense given that the author is on of the early ACT therapists from UNR.]

**Eating disorders: Client book**

**Diabetes management: Client book**

**Organizational issues: Professional book**
Hayes, S. C., Bond, F. W., Barnes-Holmes, D., & Austin, J. (2007). Acceptance and Mindfulness at Work: Applying Acceptance and Commitment Therapy and Relational Frame Theory to Organizational Behavioral Management. Binghamton, NY: Haworth Press. [This was a special issue of the Journal of Organizational Behavior Management that was bound into book form. Don't buy it expecting a smooth presentation of the applicability of ACT and RFT to organizational issues -- it is a collection of journal articles gather into a book. But it is still worthwhile if I/O is your area and you are wondering how ACT and RFT might apply.]

**Human performance: Professional book**

**Trichotillomania: Professional book**

**Trichotillomania: Client book**
Behavioral Medicine: Professional book

Assessment: Professional book

Primary care settings: Professional book

Tapes and DVDs
Hayes, S. C. (Ed.). (2007). ACT in Action DVD series. Oakland, CA: New Harbinger. [A set of six DVDs on the following topics: Facing the struggle; Control and acceptance; Cognitive defusion; Mindfulness, self, and contact with the present moment; Values and action; and Psychological flexibility. The tapes include several ACT therapists from around the world in addition to Steve, including Ann Bailey-Ciarrochi, JoAnne Dahl, Rainer Sonntag, Kirk Strosahl, Robyn Walser, Rikard Wicksell, and Kelly Wilson. As the marketing folks say: you've read the books, now see the movies.
A 90 minute ACT tape from the 2000 World Congress is available from AABT (www.aabt.org). It costs $50 for members and $95 for non-members. It shows Steve Hayes working with a client (role-played by a graduate student – Steve did not, however, meet the “client” or know their “problem” before the role playing started so it appears relatively realistic). Recommended, however the mike was not properly attached for the “client” and she is a bit hard to hear.
AABT also markets a taped interview with Steve Hayes about the development of ACT and RFT as part of their “Archives” series. Cost is the same as above.

Applied theory
Hayes, S. C., Follette, V. M., & Linehan, M. (2004). Mindfulness and acceptance: Expanding the cognitive behavioral tradition. New York: Guilford Press. [Shows how ACT is part of a change in the behavioral and cognitive therapies more generally]
Hayes, S. C., Jacobson, N. S., Follette, V. M. & Dougher, M. J. (Eds.). (1994). Acceptance and change: Content and context in psychotherapy. Oakland: New Harbinger.. [Some of the fellow travelers. This was the book length summary of the 3rd wave that was coming. Still relevant]

Basic Theory
Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001) (Eds.), Relational Frame Theory: A Post-Skinnerian account of human language and cognition. New York: Springer-Verlag. [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.]

Philosophical Foundation
There are several additional books on contextualism (see the Context Press list at New Harbinger’s website) and a new book on functional contextualism that is coming within the next year or so.

A Sample of Theoretical and Review Articles Relevant to ACT

A well-balanced scholarly review of ACT, its underlying theory, and scientific status. Makes really good recommendations for development. This is a great review to give to “science skeptics” (especially traditional CBTers) and to use in graduate classes.


A comprehensive review of the evidence in three keys areas that question the idea that trying to change the form of thoughts is helpful. It finds little evidence that specific cognitive interventions significantly increase the effectiveness of CBT or that cognitive change is causal in the symptomatic improvements achieved in CBT. It does not find enough evidence to conclude that there is an early rapid response to CBT (before cognitive methods). Overall, the review supports the view of the basic ACT criticism of traditional CBT.


Good historical review of the acceptance concept.


[A meta-analysis of ACT processes and outcomes. Reviews all AAQ and ACT clinical studies]


Assessment devices
ACT and RFT assessment devices are rapidly increasing. This area is moving too fast to put them in here. You have to see the website. There are measures for scoring tapes, for values, defusion, and for psychological flexibility in specific areas (e.g., smoking, diabetes, epilepsy, etc). There is a nearly 100 page pdf there of all the ACT measures available.

THE QUICK AND DIRTY ACT ANALYSIS OF PSYCHOLOGICAL PROBLEMS

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

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

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

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

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

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

The value of any action is its workability measured against the client's true values (those he/she would have if it were a choice).
Values specify the forms of effectiveness needed and thus the nature of the problem. Clinical work thus demands values clarification.

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

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

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

THE ACT THERAPEUTIC POSTURE

Assume that dramatic, powerful change is possible and possible quickly
Whatever a client is experiencing is not the enemy. It is the fight against experiencing experiences that is harmful and traumatic.

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

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

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

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

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

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

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

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

ACT THERAPEUTIC STEPS

Be passionately interested in what the client truly wants

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

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

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

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

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

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

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 each of the six main ACT processes.

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

1. General level of experiential avoidance (core unacceptable emotions, thoughts, memories, etc.; what are the consequences of having such experiences that the client is unwilling to risk)

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

B. Consider the possible functions of these targets and their treatment implications.
1. Is this target linked to specific application of the tendencies listed under “A” above
2. If so, what are the specific content domains and dimensions of avoided private events, feared consequences of experiencing avoided private events, fused thoughts, reasons and explanations, and feared consequences of defusing from literally held thoughts or rules
3. If so, in what other behavioral domains are these same functions seen?
4. Are there other, more direct, functions that are also involved (e.g., social support, financial consequences)
5. Given the functions that are identified, what are the relative potential contributions of:
   a. generating creative hopelessness (client still resistant to unworkable nature of change agenda)
   b. understanding that excessive attempts at control are the problem (client does not understand experientially the paradoxical effects of control)
   c. experiential contact with the non-toxic nature of private events through acceptance and exposure (client is unable to separate self from reactions, memories, unpleasant thoughts)
   d. developing willingness (client is afraid to change behavior because of beliefs about the consequences of facing feared events)
   e. engaging in committed action based in values (client has no substantial life plan and needs help to rediscover a value based way of living)

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

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

E. Consider motivation to change and factors that might negatively impact it
1. The “cost” of target behaviors in terms of daily functioning (if this is low or not properly contacted, consider paradox, exposure, evocative exercises before work that assume significant personal motivation)

2. Experience in the unworkability of improperly focused change efforts (if this is low, move directly to diary assessment of the workability of struggle, to experiments designed to test that, or if this does not work, to referral)

3. Clarity and importance of valued ends that are not being achieved due to functional target behavior, and their place in the client’s larger set of values (if this is low, as it often is, consider values clarification. If it is necessary to the process of treatment itself, consider putting values clarification earlier in the treatment).

4. Strength and importance of therapeutic relationship (if not positive, attempt to develop, e.g., through use of self disclosure; if positive, consider integrating ACT change steps with direct support and feedback in session)

F. Consider positive behavior change factors

1. Level of insight and recognition (if insight is facilitative, move through or over early stages to more experiential stages; if it is not facilitative, consider confronting reason giving through defusion strategies; pit being right versus cost to vitality; consider need for self-as-context and mindfulness work to reduce attachment to a conceptualized self)

2. Past experience in solving similar problems (if they are positive and safe from an ACT perspective, consider moving directly to change efforts that are overtly modeled after previous successes)

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

III. Building interventions into life change and transformation strategy

A. Set specific goals in accord with general values
B. Take actions and contact barriers
C. Dissolve barriers through acceptance and defusion
D. Repeat and generalize in various domains
If the hexagon model is being used as a tool for assessing progress of the case it can be helpful to take clinician or client ratings of the six processes regularly. These are rough anchors that clinicians may use for a 0 – 10 scale.

**Present Moment**

0. The client rarely makes good use of events occurring in the present moment (e.g., present instances of his/her own behavior, feelings, or thoughts; present instances of the therapist’s behavior), and the client demonstrates very little skill in maintaining focused attention or in purposely shifting attention. Rigid persistence or distractibility are characteristic. The client’s speech focuses readily and inflexibly on the past, the future, or the abstract.

5. The client knows the difference between present moment awareness and automaticity but may have trouble noticing whether she/he is in the present. Flexible attention to the present is sometimes difficult but occurs readily with encouragement. The client makes good use of events occurring in the present (e.g., present instances of his/her own behavior, feelings, or thoughts; present instances of the therapist’s behavior).

10. The client’s talk of the past, the future, and the abstract is restricted to that which is necessary to connect with the therapist in the present. Speed of speech is generally slow, and speech tends to be high on meaning and low on detail. The client demonstrates remarkable facility in maintaining focused attention and in purposely shifting attention, and the client’s presence is warm, engaging, and interpersonally connected.

**Self Processes**

0. While the client may have religious and spiritual beliefs and practices, the client shows little or no contact with a transcendent sense of self (self-as-perspective) or use of this experience in the creation of psychological flexibility. Client has significant difficulty taking the perspectives of others, and does not track the clinicians likely thoughts or feelings. May show alexithymia, and poor awareness of experience. Defends the conceptualized self and tries to maintain a consistent self-story even when it is not useful to do so.

5. The client’s is aware of an observer perspective and can be brought into awareness of this aspect of self, but requires encouragement. The client may take others’ perspectives but also reverts regularly to viewing others in terms of their evaluated categories. Slips into a self story but can be made aware of it and has some skills in backing away from entanglement with the conceptualized self.

10. The client takes self-labels seriously only to the extent that doing so is useful towards valued ends. Even this defusion from self-as-content is not taken by the client to be evidence of any essential trait. The client maintains regular contact with a sense of perspective or transcendence and uses this to foster intimate, flexible, and productive contact with experiences. The client views others in this way as well and demonstrates empathy and compassion.

**Values**

0. The client seems not to have any sense of what his/her values might be, and no sense of a capacity to choose them or construct them. Client psychological turns values choices over to others, or to the avoidance of guilt or anxiety. Weak relationship between the consequences of action and life meaning (e.g., “life just feels meaningless, without purpose, and I don’t enjoy anything I do).

5. The client is able to choose values but they tend to become unclear, distant, compliant, or fused over time and require repeated reworking to maintain their chosen quality. Clients is not ready or willing to chose values in some keys areas but has made progress in others. Client endorses so many values that few direct behavior, but in some periods or domains show a sense of vitality and connection with values choices.

10. The client demonstrates clarity with respect to values as freely chosen, intrinsically rewarding directions of action. These values are flexible, and the choice to pursue them further is informed by a thorough contact with the moment-to-moment experience of living them. When fusion and avoidance draw the client away from flexible valuing, the client notices this and quickly returns. Pliance is low, and the client has rich sense of the experience and practice of valuing and may be looked to by others for support and wisdom in their struggles around their own values.

**Committed Action**

0. The client's actions are impulsive, or excessively passive. Persistence through difficult tasks is low or is rigid and avoidant. The client feels "stuck" and wants change but either cannot conceive of a way to begin behaving differently and does not follow through on change strategies.

5. The client is able to persist or change in valued action but only in certain limited domains or at certain times. Impulsivity, passivity, or avoidant persistence is at times evident but when noticed the
client is able to make progress in changing these patterns with encouragement and assistance. The client responds to some obstacles and setbacks by needlessly giving up but is also showing progress overall.

10. The client’s behavior is flexible, and active. Obstacles and setbacks are welcomed as challenges. The client’s behavior is organized around large goals across long periods of time. Say-do correspondence, persistence, and accomplishment are high, but there is still a quality of lightness, vitality, and flexibility rather than compulsion. Client is able to change directions to take advantage of affordances.

**Experiential Avoidance/Acceptance**

0. The client’s life is very restricted, as avoidance narrows the person’s repertoire and eclipses valued living. The client may occasionally “white knuckle” a few uncomfortable experiences but with difficulty, struggle and without a sense of repertoire expansion. Avoidance of negative experiences have spilled over into avoidance of positive experiences as well. Avoidant patterns are assumed, impenetrable, or defended.

5. The client has some acceptance skills that can be deployed, but frequently avoids in key domains. Acceptance requires encouragement and focus but back-slides regularly, resulting in a life that is neither overly restricted nor extraordinarily open. The client regularly approaches difficult experiences in the service of valued ends, but also makes a number of values sacrifices in order to avoid private experiences.

10. The client’s repertoire is characterized by the embrace of experience, fully and without defense. The client’s experiences the freedom to pursue what is of value, as very little of the client’s behavior is under aversive control. New behaviors occur with regularity. When difficult issues arise, they are approached as challenges and chances to grow. In session, the client seems open to go wherever the conversation may lead. Serious topics are not skirted, minimized, or intellectualized. Rather, their gravity is fully appreciated and experienced. The client seems open, genuine, present, and connected with his/her experience.

**Fusion/Defusion**

0. Client’s thinking is rigid and impenetrable. Thoughts seemed either true or false in a very real sense, or they dominate over behavior without examination and without awareness of thoughts as ongoing, historically-produced processes distinct from the person him or herself. Client may be entangled with the supposed reasons for behavior or the story of how the client arrived at his present situation. These reasons and stories prevent the client from taking actions contrary to them even if they would be workable. Judgments of self, others, and their behavior reveal the same rigidity. Thus, client may place a premium on being right, in which case dealings with others are largely directed by what they deserve or do not deserve, or on the social approval of others including the therapist. Client’s speech repertoire is characterized by explaining, arguing and/or storytelling and new information quickly is assimilated into dominant themes.

5. The client can sometimes notice when fusion with these verbal products is not useful and can sometimes, in response, hold them more lightly, for example using humor or irreverence. The client’s conversational repertoire sometimes tends towards explaining, arguing, and/or storytelling, but a sense of lightness and presence sometimes emerges from a defused stance. The shift from fusion to defusion and back again tends to be slow and not fully voluntary – often external input is needed to break up a fused pattern.

10. The client does not give any thought or idea a great deal of credence beyond its utility in a given situation. The client notices her/himself occasionally giving reasons, judging, explaining, telling stories, wanting to be right, etc., and quickly backs away from these processes when they are unhelpful. Thoughts are viewed with interest, and their historical meaning is given due weight, but with a sense of distinction between thoughts as ongoing processes, the truths they claim to reveal, and the person thinking them. When fusion occurs that is unhelpful, the client is quick to notice and move to a defused stance. The client regularly, appropriately, and non-avoidantly uses nonchalance, humor, and irreverence in response to difficult verbal content. In session, the client pays attention to the function of words exchanged with the therapist instead of primarily to their literal content. As a result, the client seems engaged and present.
Best for visually tracking client progress
For treatment planning and case formulation

- Acceptance
- Defusion
- Now
- Values
- Action
- Self
Contact with the Present Moment

Acceptance

Values

Defusion

Guilt, Shame

Self-criticism

Self-judgment

Critical parent; use of child to meet parents' needs

Self as Context

Committed Action
ACT ADVISOR Psychological Flexibility Measure

In this diagram there are six double-headed arrows, each with contrasting statements at either end. The arrows represent sliding scales, numbered 1-10, between each set of statements. For each scale, choose whereabouts you would place yourself (i.e., at which number), depending on how closely you feel the statements apply to you. If you feel that the statements apply equally, or that neither statement applies to you, score 5.
Core ACT Competencies
You can use this as a self assessment device

Core Competencies Involved in the Basic ACT Therapeutic Stance
Collectively, the following attributes define that basic therapeutic stance of ACT.

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

Core Competencies for ACT Core Processes and Therapeutic Interventions

Developing Acceptance and Willingness/Undermining Experiential Control

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

Undermining Cognitive Fusion

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

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

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

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

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

- Therapist helps client develop larger and larger patterns of effective action
- Therapist non-judgmentally helps client integrate slips or relapses as an integral part of keeping commitments and building effective responses

**A Few Examples of ACT Components**

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

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

**Purpose:** To notice that there is a change agenda in place and notice the basic unworkability of that system; to name the system as appropriately 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:*

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

**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

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

Why, why, why?
Show the shallowness of causal explanations by repeatedly asking “why”

Create a new story
Write down the normal story, then repeatedly integrate those facts into other stories

Find a free thought
Ask client to find a free thought, unconnected to anything

Do not think “x”
Specify a thought not to think and notice that you do

Find something that can’t be evaluated
Look around the room and notice that every single thing can be evaluated negatively

Flip cards
Write difficult thoughts on 3 x 5 cards; flip them on the client’s lap vs. keep them off

Carry cards
Write difficult thoughts on 3 x 5 cards and carry them with you

Carry your keys
Assign difficult thoughts and experiences to the clients keys. Ask the client to think the thought as a thought each time the keys are handled, and then carry them from there

Wearing your badges
Put feared negative self-evaluations in bold letters on your chest

Bad news radio
Practice saying sticky negative thoughts as if they came from a radio station in your head you cannot not turn off. It’s bad new radio! All bad news! All the time!

Pop up ads from hell
Imagine that you mind sends thoughts like internet pop-up ads

Mr. Hands
Imagine your thoughts are spoken by South Parks “Mr. Hands”

Mr. Bush
Imagine your thoughts are spoken by President Bush (alter to fit politician you are skeptical of)

Acceptance

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

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

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

Examples of techniques designed to increase acceptance:

| Unhooking | Thoughts/feelings don’t always lead to action |
| Identifying the problem | When we battle with our inner experience, it distracts and derails us. Use examples. |
| Explore effects of avoidance | Has it worked in your life |
| Defining the problem | What they struggle against = barriers toward heading in the direction of their goals. |
| Experiential awareness | Learn to pay attention to internal experiences, and to how we respond to them |
| Leaning down the hill | Changing the response to material – toward 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 that 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

<table>
<thead>
<tr>
<th>Observer exercise</th>
<th>Notice who is noticing in various domains of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic relationship</td>
<td>Model unconditional acceptance of client’s experience.</td>
</tr>
<tr>
<td>Metaphors for context</td>
<td>Box with stuff; house with furniture; chessboard</td>
</tr>
<tr>
<td>“confidence”</td>
<td>con = with; fidence = fidelity or faith – self fidelity</td>
</tr>
<tr>
<td>Riding a bicycle</td>
<td>You are always falling off balance, yet you move forward</td>
</tr>
<tr>
<td>Experiential centering</td>
<td>Make contact with self-perspective</td>
</tr>
<tr>
<td>Practicing unconditional acceptance</td>
<td>Permission to be – accept self as is</td>
</tr>
<tr>
<td>Identifying content as content</td>
<td>Separating out what changes and what does not</td>
</tr>
<tr>
<td>Identify programming</td>
<td>Two computers exercise</td>
</tr>
<tr>
<td>Programming process</td>
<td>Content is always being generated – generate some in session together</td>
</tr>
<tr>
<td>Process vs outcome</td>
<td>Practice pulling back into the present from thoughts of the future/past</td>
</tr>
<tr>
<td>ACT generated content</td>
<td>Thoughts/feelings about self (even “good” ones) don’t substitute for experience</td>
</tr>
<tr>
<td>Self as object</td>
<td>Describe the conceptualized self, both “good” and “bad”</td>
</tr>
<tr>
<td>Others as objects</td>
<td>Relationship vs being right</td>
</tr>
<tr>
<td>Connecting at “board level”</td>
<td>Practice being a human with humans</td>
</tr>
<tr>
<td>Getting back on the horse</td>
<td>Connecting to the fact that they will always move in and out of perspective of self-as-context, in session and out.</td>
</tr>
<tr>
<td>Identifying when you need it</td>
<td>Occasions where “getting present” is indicated (learning to apply first aid)</td>
</tr>
<tr>
<td>Contrast observer self with conceptualized self</td>
<td>Pick an identity exercise</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>Identify painful experiences as content; separate from context</td>
</tr>
</tbody>
</table>
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

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

<table>
<thead>
<tr>
<th>Love</th>
<th>Intimacy</th>
<th>Truth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kindness</td>
<td>Freedom</td>
<td></td>
</tr>
<tr>
<td>Fun</td>
<td>Change</td>
<td></td>
</tr>
<tr>
<td>Honesty</td>
<td>Joyfulness</td>
<td></td>
</tr>
<tr>
<td>Interdependence</td>
<td>Equality</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>Empathy</td>
<td></td>
</tr>
<tr>
<td>Sincerity</td>
<td>Nurturance</td>
<td></td>
</tr>
<tr>
<td>Transcendence</td>
<td>Public Service</td>
<td></td>
</tr>
<tr>
<td>Connection</td>
<td>Knowledge</td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>Curiosity</td>
<td></td>
</tr>
<tr>
<td>Thoughtfulness</td>
<td>Inspiration</td>
<td></td>
</tr>
<tr>
<td>Patience</td>
<td>Discovery</td>
<td></td>
</tr>
<tr>
<td>Persistence</td>
<td>Passion</td>
<td></td>
</tr>
<tr>
<td>Stability</td>
<td>Tranquility</td>
<td></td>
</tr>
<tr>
<td>Tolerance</td>
<td>Accountability</td>
<td></td>
</tr>
<tr>
<td>Humor</td>
<td>Tenderness</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Justice</td>
<td></td>
</tr>
<tr>
<td>Flexibility</td>
<td>Leadership</td>
<td></td>
</tr>
<tr>
<td>Adventure</td>
<td>Integrity</td>
<td></td>
</tr>
<tr>
<td>Affection</td>
<td>Harmony</td>
<td></td>
</tr>
<tr>
<td>Creativity</td>
<td>Empowerment</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Sharing</td>
<td></td>
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<tr>
<td>Ethical</td>
<td>Reflection</td>
<td></td>
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<tr>
<td>Peace</td>
<td>Discretion</td>
<td></td>
</tr>
<tr>
<td>Diversity</td>
<td>Influence</td>
<td></td>
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<tr>
<td>Cooperation</td>
<td>Uniqueness</td>
<td></td>
</tr>
<tr>
<td>Competition</td>
<td>Wisdom</td>
<td></td>
</tr>
<tr>
<td>Comfort</td>
<td>Collaboration</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td>Self-reliance</td>
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</tr>
<tr>
<td>Mentorship</td>
<td>Artistry</td>
<td></td>
</tr>
<tr>
<td>Gentleness</td>
<td>Efficiency</td>
<td></td>
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<tr>
<td>Efficiency</td>
<td>Confidence</td>
<td></td>
</tr>
<tr>
<td>Friendship</td>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td>Sophistication</td>
<td></td>
</tr>
<tr>
<td>Privacy</td>
<td>Serenity</td>
<td></td>
</tr>
<tr>
<td>Tolerance</td>
<td>Merit</td>
<td></td>
</tr>
<tr>
<td>Variety</td>
<td>Compassion</td>
<td></td>
</tr>
<tr>
<td>Consistency</td>
<td>Genuineness</td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>Acceptance</td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td>Innovation</td>
<td></td>
</tr>
<tr>
<td>Spontaneity</td>
<td>Courage</td>
<td></td>
</tr>
<tr>
<td>Respect</td>
<td>Devotion</td>
<td></td>
</tr>
<tr>
<td>Beauty</td>
<td>Whimsical</td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td>Cleverness</td>
<td></td>
</tr>
<tr>
<td>Skepticism</td>
<td>Resourcefulness</td>
<td></td>
</tr>
<tr>
<td>Simplicity</td>
<td>Luxury</td>
<td></td>
</tr>
<tr>
<td>Conservation</td>
<td>Lightheartedness</td>
<td></td>
</tr>
<tr>
<td>Loyalty</td>
<td>Encouragement</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>Faithfulness</td>
<td></td>
</tr>
<tr>
<td>Tenacity</td>
<td>Nature</td>
<td></td>
</tr>
</tbody>
</table>
Partial List of Empirical Studies on ACT, ACT Components, or ACT Processes

**ACT Effectiveness Studies**

**General outpatient populations (mostly anxiety and depression)**

Lappalainen, R., Lehtonen, T., Skarp, E., Taubert, E., Ojanen, M., & Hayes, S. C. (2007). The impact of CBT and ACT models using psychology trainee therapists: A preliminary controlled effectiveness trial. *Behavior Modification, 31*, 488-511. Randomized controlled study in which 14 student therapists treat one client each from an ACT model or a traditional CBT model for 6-8 sessions following a 2 session functional analysis. Participants with any normal outpatient problem were included, mostly anxiety and depression. At post and at the 6 month follow up ACT clients are more improved on the SCL-90 and several other measures. Greater acceptance for ACT patients; great self-confidence for CBT patients. Both correlated with outcomes, but when partial correlations are calculated, only acceptance still relates to outcome.

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D. & Geller, P. A. (2007). A randomized controlled effectiveness trial of Acceptance and Commitment Therapy and Cognitive Therapy for anxiety and depression. *Behavior Modification, 31*(6), 772-799. 101 heterogeneous outpatients reporting moderate to severe levels of anxiety or depression were randomly assigned either to traditional CT or to ACT. 23 junior therapists were used. Participants receiving CT and ACT evidenced large and equivalent improvements in depression, anxiety, functioning difficulties, quality of life, life satisfaction and clinician-rated functioning. “Observing” and “describing” one’s experiences mediated outcomes for those in the CT group relative to those in the ACT group, whereas “experiential avoidance,” “acting with awareness” and “acceptance” mediated outcomes for those in the ACT group. And extension of this study [Forman, E. M., Chapman, J. E., Herbert, J. D., Goetter, E. M., Yuen, E. K., & Moitra, E. (2012). Using Session-by-Session Measurement to Compare Mechanisms of Action for Acceptance and Commitment Therapy and Cognitive Therapy. *Behavior Therapy, 43*, 341-354] found using session by session measurement that increased utilization of cognitive and affective change strategies relative to utilization of psychological acceptance strategies mediated outcome for CT, whereas for ACT the mediation effect was in the opposite direction.

**Group and Controlled Time-Series ACT Efficacy Studies (by topic and chronologically within topic)**

**Depression**
Small controlled trial. Shows that ACT is more effective that cognitive therapy for depression when presented in an individual format, and that it works by a different process. Has several methodological holes.

Zettle, R. D., & Rains, 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 two variants of cognitive therapy for depression (a full package of CT vs. one without distancing) when presented in a group format, and that it works by a different process. A full intent to treat reanalysis and mediation analysis using modern statistical methods was published in Zettle, R. D., Rains, J. C., & Hayes, S. C. (2011). Do Acceptance and Commitment Therapy and Cognitive Therapy for depression work via the same process: A reanalysis of Zettle and Rains, 1989. *Behavior Modification, 35*, 265-283. The reanalysis, without the odd partial cognitive therapy group that was included for theoretical reasons of importance in the early days of ACT, shows that ACT did better than CT on the BDI at follow up and that the results were mediated by post scores on cognitive fusion but not level of depressogenic thoughts or general dysfunctional attitudes.


Fledderus, M., Bohlmeijer, E.T., Pieterse, M. E., & Schreurs, K. M. (2011) Acceptance and commitment therapy as guided self-help for psychological distress and positive mental health: a randomized controlled trial. *Psychological Medicine, 11*, 1-11. Large RCT of an early intervention study for mild to moderate depression using ACT self-help with or without heavy email support. Reductions in depression, anxiety, fatigue, experiential avoidance and improvements in positive mental health and mindfulness; sustained at follow up.

Folke, F., Parling, T., & Melin, L. (2012). Acceptance and Commitment Therapy for depression: A preliminary randomized clinical trial for unemployed on long-term sick leave. *Cognitive and Behavioral Practice, 19*, 583–594. Small (N = 34) RFT of ACT (1 individual session; 5 group sessions) versus TAU for unemployed individuals on sick leave suffering from depression. Lower level of depression and higher level of quality of life and general health in ACT.

There are also several published studies with good depression outcomes as part of other problems – some who were in the clinical range -- e.g., see McCracken et al., 2005; Vowles & McCracken, 2008 in the pain section; Woods et al., 2006 in the OCD section; Páez, et al., 2007 in the chronic disease section; Muto et al in the stress section below. There are also very positive data coming from UNR on the impact of an ACT self help book on depression (Jeffcoat et al., in press 2012). The VA rollout of ACT has very impressive outcomes and that manuscript (Walser et al) is about to be reviewed. Also a moderation analysis of Arch et al (see anxiety section below) shows better outcomes for anxiety patients who also have depression.

**Stress/distress: Work, military, educational, prevention**


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. Those in the ACT condition then actively modified the work environment even though that was not targeted directly in the intervention. Process analyses fit the model.


RCT comparing ACT, stress inoculation training, and waitlist on worksite stress (N = 107). ACT and SIT equally effective; ACT mediated by psychological flexibility, SIT not successfully mediated by cognitive change.


RCT on the impact of *Get Out of Your Mind and Into Your Life* on the mental health of international students (N = 70). Better general mental health at post and follow up. Moderately and above depressed or stressed, and severely anxious students showed improvement compared to those not receiving the book. Outcomes mediated and moderated by psychological flexibility.


Larger RCT of ACT vs. wait list. ACT worksite intervention found to be particularly effective for workers with above average levels of psychological distress. Following ACT, 69% of initially distressed workers improved to a clinically significant degree.

decreased stress and burnout, and increased general mental health compared to a waiting list control among the 2/3 who were stressed at baseline. Among participants with high stress, a substantial proportion (42%) reached criteria for clinically significant change.


Lloyd, J., Bond, F. W., & Flaxman, P. E. (in press). Identifying psychological mechanisms underpinning a cognitive behavioural therapy intervention for emotional burnout. *Work & Stress*. ISSN 0267-8373. Government workers assigned in an RCT (N = 100), to ACT (N = 43) or waitlist. 3 half-day sessions 2 ½ months. Good outcomes on various aspects of burnout mostly mediated by earlier changes in psychological flexibility.

### Coping with psychosis


Bach, P., Gaudiano, B. A., Hayes, S. C. & Herbert, J. D. (in press). Acceptance and Commitment Therapy for psychosis: Intent to treat hospitalization outcome and mediation by believability. *Psychosis*. The combined data set from the two trials above (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) were examined to assess the impact of ACT on intent to treat analyses of hospitalization outcomes and the mediating role of symptom believability on hospitalization outcomes. Results showed reduction of rehospitalization at the 4 month follow-up, mediated by symptom believability but not symptom related distress. One of the studies collected mediators at post and one at follow up but the mediation effects were the same, indicating that violation of temporariness was not the source of the mediation results seen.


**Anxiety**

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.


Arch, J. J., Eifert, G. H., Davies, C., Vilardaga, J., Rose, R. D. & Craske, M. G. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptan and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology, 80*, 750-765. doi:10.1037/a0028310 RCT (N = 128; 52% female; 33% minority) of 12 sessions of ACT v. tradition CBT for heterogeneous anxiety disorders; both including behavioral exposure. Broadly similar outcomes at post but in blind clinical interviews ACT participants improve more in clinical severity from post to follow up than CBT (large effect: d = 1.33). Among completers their end-state clinical severity ratings were much better (d = 1.03). Better improvement for ACT in psychological flexibility (medium effect for completers: d = .59) for ACT;

**Addiction**

Hayes, S.C., Wilson, K.G., Gifford, E.V., Bissett, R., Piasecki, M., Batten, S.V., Byrd, M., & Gregg, J. (2004). A randomized controlled trial of twelve-step facilitation and acceptance and commitment therapy with polysubstance abusing methadone maintained opiate addicts. *Behavior Therapy*, 35, 667-688. A large randomized controlled trial was conducted with polysubstance abusing opiate addicted individuals maintained on methadone. Participants (n=114) were randomly assigned to stay on methadone maintenance (n=38), or to add ACT (n=42), or Intensive Twelve Step Facilitation (ITSF; n=44) components. There were no differences immediately post-treatment. At the six-month follow-up participants in the ACT condition demonstrated a greater decrease in objectively measured (through monitored urinalysis) opiate use than those in the methadone maintenance condition (ITSF did not have this effect). Both the ACT and ITSF groups had lower levels of objectively measured total drug use than did methadone maintenance alone.

Gifford, E.V., Kohlenberg, B.S., Hayes, S.C., Antonuccio, D.O., Piasecki, M.M., Rasmussen-Hall, M.L., & Palm, K.M. (2004). Acceptance theory-based treatment for smoking cessation: An initial trial of Acceptance and Commitment Therapy. *Behavior Therapy*, 35, 689-705. Medium sized randomized controlled trial comparing ACT to nicotine replacement therapy (NRT) as a method of smoking cessation. Quit rates were similar at post but at a one-year follow-up the two groups differed significantly. The ACT group had maintained their gains (35% quit rates) while the NRT quit rates had fallen (<10%). Mediational analyses shows that ACT works through acceptance and response flexibility.


Stigma and prejudice

A medium sized randomized controlled trial that found that a one day ACT workshop produces greater decreases in stigmatization of clients by therapists and greater decreases in therapist burnout than an educational control and (or some comparisons) than multicultural training. Mediational analyses fit the model.

Lillis, J. & Hayes, S. C. (2007). Applying acceptance, mindfulness, and values to the reduction of prejudice: A pilot study. *Behavior Modification, 31*, 389-411. Undergraduates enrolled in two separate classes on racial differences were exposed Acceptance and Commitment Therapy and an educational lecture drawn from a textbook on the psychology of racial differences in a counterbalanced order. Results indicate that only the ACT intervention was effective in increasing positive behavioral intentions at post and a 1-week follow-up. These changes were associated with other self-reported changes that fit the ACT model.


Pain
A small randomized controlled trial shows that a four hour ACT intervention reduced sick day usage by 91% over the next six months compared to treatment as usual in a group of chronic pain patients at risk for going on to permanent disability.


108 chronic pain patients with a long history of treatment are followed through an ACT-based 3-4 week residential treatment program. Measures improved from initial assessment to pre-treatment on average only 3% (average of 3.9 month wait), but improved on average 34% following treatment. 81% of these gains were retained through a 3 month follow up. Changes in acceptance predicted positive changes in depression, pain related anxiety, physical disability, psychosocial disability, and the ability to stand. Positive outcomes were also seen in a timed walk, decreased medical visits, daily rest due to pain, pain intensity, and decreased pain medication use.


Vowles, K. E. & McCracken, L. M. (2008). Acceptance and values-based action in chronic pain: A study of effectiveness and treatment process. *Journal of Clinical and Consulting Psychology, 76,* 397-407. Effectiveness study. 171 completers of an ACT interdisciplinary treatment program, examine a pre, post, follow up. Significant improvements for pain, depression, pain-related anxiety, disability, medical visits, work status, and physical performance. Effect size statistics were uniformly medium or larger. Both acceptance of pain and values-based action improved, and increases in these processes were associated with improvements in the primary outcome domains.


Wicksell, R. K., Melin, L., Lekander, M., & Olsson, G. L. (2009). Evaluating the effectiveness of exposure and acceptance strategies to improve functioning and quality of life in longstanding pediatric pain - A randomized controlled trial. *Pain, 141,* 248-257. Small RCT (n = 32) comparing a brief ACT intervention (10 individual sessions) to multidisciplinary treatment plus amitriptyline (MDT) for chronic pediatric pain. Treatment continued in the MDT condition during the 3.5 and 6.5 month follow-up, which complicated comparisons at follow-up assessments due to more sessions for MDT, but results showed substantial and sustained improvements for the ACT group. When follow-up assessments were included, ACT performed significantly better than MDT on perceived functional ability in relation to pain, pain intensity and pain...
related discomfort (intent-to-treat analyses). At post-treatment, before the dose differences happened, significant differences in favor of the ACT condition were also seen in fear of re/injury or kinesiophobia, pain interference and in quality of life. Mediation analysis is published in Wicksell, R. K., Olsson, G. L., & Hayes, S. C. (2011). Mediators of change in Acceptance and Commitment Therapy for pediatric chronic pain. Pain, 152, 2792-2801. Pain interference and depression were used as outcome variables. Six different variables relevant to theories underlying ACT and CBT were included in the analyses as possible mediators of change: pain impairment beliefs, pain reactivity, self-efficacy, kinesiophobia, catastrophizing, and pain intensity. Results illustrated that pain impairment beliefs and pain reactivity were the only variables that significantly mediated the differential effects of treatment on outcomes at follow-up.

Vowles, K. E., & McCracken, L. M. (2010). Comparing the influence of psychological flexibility and traditional pain management coping strategies on chronic pain treatment outcomes. Behaviour Research & Therapy, 48, 141-146. Effectiveness trial showing that ACT targets account for progress more so than traditional pain targets.


Vowles, K. E., McCracken, L. M., O’Brien, J. Z. (2011). Acceptance and values-based action in chronic pain: A three-year follow-up analysis of treatment effectiveness and process. Behaviour Research and Therapy, 49, 748-755. Follow up study of 108 participants with chronic pain examining outcomes three years after treatment completion. Significant improvements (generally medium to large) in emotional and physical functioning relative to the start of treatment, as well as good maintenance of treatment gains relative to an earlier follow-up assessment. 65% of patients were reliably improved in at least one key domain. Improvements in acceptance of pain and values-based action were associated with improvements in outcome measures.


Jensen, K. B., Kosek, E., Wicksell, R., Kemani, M., Olsson, G., Merle, J., Kadetoff, D., & Ingvar, M. (in press). Treatment with Cognitive Behavioral Therapy increases pain-evoked activation of the prefrontal cortex in patients suffering from chronic pain. Pain. The first RCT (N = 43; all female; w/ Fibromyalgia) with chronic pain to examine post-Rx effects on brain activity. Some the neurobiological data are presented in the above publication, while most psychosocial data are presented in Wicksell, R. K., Kemani, M., Jensen, K. B., Kosek, E., Kadetoff, D., Sorjonen, K., Ingvar, M. & Olsson, G. L. (in press). Acceptance and Commitment Therapy for fibromyalgia: A randomized controlled trial. European Journal of Pain. These studies compared ACT vs. wait list. 12 weekly group sessions and 3 mo f-up. Better outcomes in favor of ACT were seen in pain related functioning, fibromyalgia impact, mental health related quality of life, self-efficacy, depression, anxiety, psychological inflexibility. fMRI in response to pain taken at pre and post. ACT led to increased activations in the ventrolateral prefrontal / lateral orbitofrontal cortex; increased vlPFC-thalamic connectivity after treatment. Suggests a change in the cognitive functions of pain. Follow up outcomes mediated by pre to post changes in psychological inflexibility.

condition exhibited significantly greater improvements in depressive symptoms, general functioning, and migraine-related disability than patients in the WL/TAU group.


**OCD and OCD spectrum**


A series of controlled single case designs show that ACT, and ACT combined with habit reversal helps with hair pulling


**BPD**


**Chronic disease: Diabetes, epilepsy, cancer, MS, tinnitus, cardiac care**


Lundgren, T., Dahl, J., Yardi, N., & Melin, L. (2008). Acceptance and Commitment Therapy and yoga for drug-refractory epilepsy: A randomized controlled trial. Epilepsy & Behavior, 13, 102–108. 18 participants from India with EEG-verified epilepsy diagnosis with drug-refractory seizures were randomized to ACT or yoga (12 hours of Rx both individual and group) and followed for 1 year. ACT reduced seizures more than yoga but both improved quality of life (ACT more on the WHOQOL-BREF; yoga more on the SWLS).


Rost, A. D., Wilson, K. G., Buchanan, E., Hildebrandt, M.J., & Mutch, D. (2012). Improving psychological adjustment among late-stage ovarian cancer patients: Examining the role of avoidance in treatment. Cognitive and Behavioral Practice, 19, 508-517. Very cool RCT (N = 31; 47 originally but the rest died or entered hospice care) comparing ACT and traditional CBT approaches to coping with end-stage cancer. Super outcomes in favor of ACT.

**Weight loss, stigma, maintenance, eating disorders**


Tapper, K., Shaw, C., Isley, J., Hill, A. J., Bond, F. W., & Moore, L. (2009). Exploratory randomised controlled trial of a mindfulness-based weight loss intervention for women. Appetite, 52, 396–404. Small RCT. 62 dieting obese women randomly assigned to 4 2-hr ACT sessions or to wait list; at 6 mo. better exercise (p < .05), and for those applying the workshop, better weight loss as reflected by BMI differences (0.96 relative to controls, equivalent to 2.32 kg, p < 0.5).

larger RCT of ACT versus CT, ACT produced greater reductions in eating pathology, and greater increases in global functioning.


**Performance enhancement**


**Use in training**


**Studies on ACT itself or on ACT clinicians**


Brown, L. A., Gaudiano, B. A., & Miller, I. W. (2011). Investigating the similarities and differences between practitioners of second- and third-wave cognitive-behavioral therapies. *Behavior Modification, 35*, 187-200. Preferences and biases of second (N = 55) and third wave (N = 33) CBT practitioners were assessed via an internet survey. 3rd wavers used more mindfulness/acceptance techniques and exposure; 2nd used moiré cognitive restructuring and relaxation. 3rd wavers more eclectic; no diffs in attitudes toward science and practice, only techniques employed.

Tests of ACT Components (Chronological; partial list; too many to keep up with but write for a meta-analysis we've done)

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 (Turk's protocol)
Small randomized trial that replicated Hayes, Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999. An acceptance rationale plus two ACT defusion exercises (“Leaves on the Stream” and “Physicalizing”) did significantly better than a matched control-focused intervention on pain tolerance, or a lecture on pain.
Randomized study comparing control versus acceptance during a CO2 challenge with anxious subjects. Acceptance oriented exercise (the finger trap) reduced avoidance, anxiety symptoms, and anxious cognitions as compared to breathing training.
This case study describes a heavily values focused ACT treatment of a case of alcohol dependence within an Acceptance and Commitment Therapy model. Identifying valued directions seemed to help the client achieve sobriety and put a plan into action to "start living."
Randomized study with analogue pain task showing greater tolerance for pain in the defusion and acceptance-based condition drawn from ACT as compared to a closely parallel cognitive-control based condition.

121. doi:10.1017/S1754470X11000043. One day training workshops with practitioners (N = 73) led to increased ACT knowledge, and self-reports of impact on practice one year later. The workshop process itself was positively rated.
exposure to an aversive film and less negative affect during the post-film recovery period that did control strategies in individuals with anxiety and mood disorders.


A large and well-controlled randomized study that replicated Hayes, Bissett, Korn, Zettle, Rosenfarb, Cooper, & Grundt, 1999. Acceptance methods drawn from the 1999 ACT book and from the Hayes et al. 1999 pain study (the methods used included an acceptance rationale, practicing awareness of experience, the “Passengers on the Bus” exercise, and the ‘Two Scales Metaphor’) increased pain tolerance and decreased pain ratings in a cold pressor task as compared both to suppression methods (based on thought stopping) and to participants preferred method of coping (which tended to include distraction, relaxation, and keeping the hand still). The latter two conditions did not differ from each other in the main analysis.

Williams, L. (2007). Acceptance and Commitment Therapy: An example of third-wave therapy as a treatment for Australian Vietnam War veterans with post-traumatic stress disorder. Salute, 19, 13-15. Perhaps this should not be listed as published yet but we will mention it. This is a small RCT for PTSD that found better outcomes for a full ACT package than for one that did not include self-as-context work, but both were helpful. This is a short, discursive summary article for a Veteran’s magazine – the data are described in her thesis which is not yet published: Williams, L.M. (2006). Acceptance and commitment therapy: An example of third-wave therapy as a treatment for Australian Vietnam War veterans with posttraumatic stress disorder: Unpublished dissertation, Charles Sturt University, Bathurst, New South Wales.


98 participants with chocolate cravings were exposed to a well known CBT protocol (Kelly Brownell’s LEARN program) and an ACT-based protocol or no instructions and required to carry chocolate with them for two days. Those more impacted by food related cues ate less and had fewer cravings in the ACT condition.

Páez-Blarrina, M., Luciano, C., Gutiérrez-Martínez, O., Valdivia, S., Ortega, J., & Rodríguez-Valverde, M. (2008). The role of values with personal examples in altering the functions of pain: Comparison between acceptance-based and cognitive-control-based protocols. Behaviour Research and Therapy, 46, 84-97. A two-wave randomized study showed that a values-focused ACT protocol, with or without defusion, was superior to a protocol that viewed pain as incompatible with valued action.

McMullen, J., Barnes-Holmes, D., Barnes-Holmes, Y., Stewart, I., Luciano, C., & Cochrane, A. (2008). Acceptance versus distraction: Brief instructions, metaphors and exercises in increasing tolerance for self-delivered electric shocks. Behaviour Research and Therapy, 46(1), 122-129. Pain tolerance. 80 participants randomly assigned to 5 groups: Acceptance or distraction rationales, with or without exercises, or no instructions. Participants in both of the acceptance conditions more likely to continue with the task even when reporting more pain. Full acceptance condition best pain tolerance.

Low, C. A., Stanton, A. L., & Bower, J. E. (2008). Effects of acceptance-oriented versus evaluative emotional processing on heart rate recovery and habituation. Emotion, 8, 419-424. Participants (N = 81) were randomly assigned to write about a stressful experience while evaluating the appropriateness of their emotional response, attending to their emotions in an accepting way, or describing the objective details of the experience. Writing in an accepting way led to less efficient heart rate habituation and recovery.


Assessment devices


**ACT components as parts of larger packages**


**ACT Case Studies**


Describes the use of ACT in the treatment of complicated bereavement and shows resulting data. Case study.


Describes the use of ACT in the treatment of agoraphobia and shows resulting data. Case study.


Describes the use of ACT in the treatment of psychotic disorders and shows resulting data. Case study.


Describes the use of ACT in the treatment of chronic pain and shows resulting data. Case study.


Describes the use of ACT in the treatment of cancer pain and shows resulting data. Case study.

A number of the 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


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.


Process studies not mentioned earlier

There are now over 150 papers on experiential avoidance so this section is a partial listing and will soon have to be abandoned. You cannot keep up with it anymore. When ACT gets like that this whole handout will have to be abandoned or changed.


Marx, B. P. & Sloan, D. M. (2002). The role of emotion in the psychological functioning of adult survivors of childhood sexual abuse. *Behavior Therapy, 33*, 563-577. Correlational study showing that childhood sexual abuse (CSA), experiential avoidance and emotional expressivity were significantly related to psychological distress. However, only experiential avoidance mediated the relationship between CSA and current distress.

Bond, F. W. & Bunce, D. (2003). The role of acceptance and job control in mental health, job satisfaction, and work performance. *Journal of Applied Psychology, 88*, 1057-1067. Shows that AAQ predicts positive work outcomes (mental health, satisfaction, performance) even one year later, especially in combination with job control. Re-factors the AAQ and shows that a two factor solution can work on a slightly different 16 item version.


Donaldson, E. & Bond, F.W. (2004). Psychological acceptance and emotional intelligence in relation to workplace well-being. *British Journal of Guidance and Counselling, 34*, 187-203. Study compared experiential avoidance (as measures by the AAQ) and emotional intelligence in terms of their ability to predict general
mental health, physical well-being, and job satisfaction in workers (controlling for the effects of job control since this work organisation variable is consistently associated with occupational health and performance). Results from 290 United Kingdom workers showed that emotional intelligence did not significantly predict any of the well-being outcomes, after accounting for acceptance and job control. Acceptance predicted general mental health and physical well-being but not job satisfaction. Job control was associated with job satisfaction, only. Not controlling one’s thoughts and feelings (as advocated by acceptance) may have greater benefits for mental well-being than attempting consciously to regulate them (as emotional intelligence suggests).

Kashdan, T.B., & Breen, W.E. (2007). Materialism and diminished well-being: Experiential avoidance as a mediating mechanism. *Journal of Social and Clinical Psychology, 26*, 521-539. This correlational study examined the hypothesis that experiential avoidance mediates associations between excessively materialistic values and diminished emotional well-being, meaning in life, self-determination, and gratitude. Results indicated that people with high materialistic values reported more negative emotions and less relatedness, autonomy, competence, gratitude, positive emotions, and sense of meaning – all of these relations were mediated by experiential avoidance mediated all of these relations. Emotional disturbances such as social anxiety and depressive symptoms failed to account for these findings after accounting for shared variance with experiential avoidance.


Butler, J. and Ciarrochi, J (2007). Psychological acceptance and quality of life in the elderly. *Quality of Life Research, 16*, 607-615. In a sample of 187 elderly those higher in psychological acceptance had higher quality of life in the areas of health, safety, community participation and emotional well-being; and had less adverse psychological reactions to decreasing productivity.


Sloan, D. M. (2004) Emotion regulation in action: Emotional reactivity in experiential avoidance. *Behaviour Research and Therapy, 42*, 1257-1270. Examined the relationship between emotional reactivity (self-report and physiological reactivity) to pleasant, unpleasant, and neutral emotion-eliciting stimuli and experiential avoidance as measured by the AAQ. Sixty-two participants were separated into high and low experiential avoiders. Results indicated that high EA participants reported greater emotional experience to both unpleasant and pleasant stimuli compared to low EA participants. In contrast to their heightened reports of emotion, high EA participants displayed attenuated heart rate reactivity to the unpleasant stimuli relative to the low EA participants. Findings were interpreted as reflecting an emotion regulation attempt by high EA participants when confronted with unpleasant emotion-evocative stimuli.


Begotka, A. M., Woods, D. W., & Wetterneck, C. T. (2004). The relationship between experiential avoidance and the severity of trichotillomania in a nonreferred sample. *Journal of Behavior Therapy and Experimental Psychiatry, 35*, 17-24. In a large sample of adults suffering from trichotillomania, experiential avoidance as measured by the 9 item AAQ correlated with more frequent and intense urges to pull, less ability to control urges, and more pulling-related distress than persons who were not experientially avoidant. Actual pulling did not differ.

severity. Thought suppression (but not experiential avoidance) was associated with severity of posttraumatic stress symptoms when controlling for their shared relationship with general psychiatric symptom severity.


Marx, B.P. & Sloan, D.M. (2005). Experiential avoidance, peritraumatic dissociation, and post-traumatic stress disorder. *Behaviour Research and Therapy, 43*, 569-583. 185 trauma survivors were assessed for peritraumatic dissociation, experiential avoidance (using the AAQ), and PTSD symptom severity. Both peritraumatic dissociation and experiential avoidance were significantly related to PTSD symptoms at baseline. After the initial levels of PTSD was taken into account, only experiential avoidance was related to PTSD symptoms both 4- and 8-weeks later.


Greco, L. A., Heffner, M., Poe, S., Ritchie, S., Polak, M. & Lynch, S. K. (2005). Maternal adjustment following pre-term birth: Contributions of experiential avoidance. *Behavior Therapy, 36*, 177-184. Experiential avoidance as measured by the AAQ correlated positively with post-discharge parental stress and traumatic stress symptoms surrounding preterm birth. Moreover, it partially mediated the association between stress during delivery and later traumatic stress symptoms. This process was not moderated by parent reports of child temperament or perceived social support, suggesting that experiential avoidance plays a mediating role irrespective of child characteristics or perceived support from family members and close friends.

Kashdan, T. B. & Steger. M. F. (2006) Expanding the topography of social anxiety: An experience sampling assessment of positive emotions and events, and emotion suppression. *Psychological Science, 17*, 120-128. In a 21-day experience sampling study, dispositional social anxiety, emotional suppression, and cognitive reappraisal was compared daily measures of social anxiety. Socially anxious individuals reported the lowest rate of positive events on days when they were more socially anxious and tended to suppress emotions, and the highest rate of positive events on days when they were less socially anxious and more accepting of emotional experiences. Irrespective of dispositional social anxiety, participants reported the most intense positive emotions on days when they were less socially anxious and more accepting of emotional experiences.

Kashdan, T.B., Barrios, V., Forsyth, J.P., & Steger, M.F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy, 44*, 1301-1320. [two studies, one correlational and one longitudinal, show that experiential avoidance as measured by the AAQ fully or partially mediated the relationships between coping and emotion regulation strategies on anxiety-related pathology, (Study 1) and psychological distress and hedonic functioning over the course of a 21-day monitoring period (Study 2). The variables examined included maladaptive coping, emotional responses styles, and uncontrollability on anxiety-related distress (e.g., anxiety sensitivity, trait anxiety, suffocation fears, and body sensation fears), and suppression and cognitive reappraisal on daily negative and positive experiences. The data showed that cognitive reappraisal, a primary process of traditional cognitive-behavior therapy, was much less predictive of the quality of psychological experiences and events in everyday life compared with EA.

Zettle, R. D., Petersen, C. L., & Hocker, T. R. (2007). Responding to a challenging perceptual-motor task as a function of level of experiential avoidance. *Psychological Record, 57*(1), 49-62. High vs. low avoidant subjects as assessed by the AAQ do a perceptual-motor task while wearing “drunk goggles” to induce blurred vision, dizziness, disorientation, etc. Low avoidant subjects perform the task significantly better.

Cochrane, A., Barnes-Holmes, D., Barnes-Holmes, Y., Stewart, I., & Luciano, C. (2007). Experiential avoidance and aversive visual images: Response delays and event related potentials on a simple matching task. *Behaviour Research and Therapy, 45*, 1379-1388. [Two experiments. In Experiment 1, participants high (n = 15) or low in avoidance (n = 14), as measured by the Acceptance and Action Questionnaire, completed a
simple matching task that required them to choose whether or not to look at an aversive visual image. Only the high-avoidance participants took longer to emit a correct response that produced an aversive rather than a neutral picture. Additionally, the high-avoiders reported greater levels of anxiety following the experiment even though they rated the aversive images as less unpleasant and less emotionally arousing than their low-avoidant counterparts. In Experiment 2, three groups, representing high- mid- and low-avoidance (n = 6 in each) repeated the matching task with the additional recording of event related potentials (ERPs). The findings replicated Experiment 1 but also showed that high-EA subjects had significantly greater negativity for electrodes over the left hemisphere relative to the midline suggesting that the high-EA group engaged in verbal strategies to regulate their emotional responses.


Wicksell, R. K., Melin, L., & Olsson, G. L. (2009). The Chronic Pain Acceptance Questionnaire (CPAQ): Further validation including a confirmatory factor analysis and a comparison with the Tampa Scale of Kinesiophobia. *European Journal of Pain, 13*, 760-768. In a sample of 611 participants reporting chronic pain and symptoms of whiplash associated disorders, a Swedish translation of CPAQ was evaluated with explained more variance than the Tampa Scale of Kinesiophobia in pain intensity, disability, life satisfaction, and depression.

For a diabetes related AAQ see Gregg et al (mentioned above)

Greco, L. A., Lambert, W., & Baer, R. A. (2008). Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment, 20*(2), 93-102. The authors describe the development and validation of the Avoidance and Fusion Questionnaire for Youth (AFQ-Y), a child-report measure of psychological inflexibility engendered by high levels of cognitive fusion and experiential avoidance. Consistent with the theory underlying acceptance and commitment therapy (ACT), items converged into a 17-item scale (AFQ-Y) and an 8-item short form (AFQ-Y8). A multimethod psychometric approach provides preliminary support for the reliability and validity of the AFQ-Y and AFQ-Y8. In 5 substudies, 3 samples (total N = 1369) were used to establish (a) item comprehension (n = 181), (b) initial item selection (n = 513), (c) final item reduction and development of a short form for research (n = 346), (d) comprehensive psychometric evaluation of the AFQ-Y and AFQ-Y8 (n = 329), and (e) convergent and construct validity for both versions of the AFQ-Y. Overall, results suggest that the AFQ-Y and AFQ-Y8 may be useful child-report measures of core ACT processes.

Vowles, K. E., McCracken, L. M., McLeod, C., & Eccleston, C. (2008). The Chronic Pain Acceptance Questionnaire: Confirmatory factor analysis and identification of patient subgroups. *Pain, 140*, 284-291. Good study showing the factor stability of the CPAQ (the pain specific version of the AAQ). After two such studies a series of cluster analyses were performed using a combined sample (N = 641) showing three clusters: one with high scores on both subscales (n = 146), one with low scores on both subscales (n = 239), and one with discrepant scores that were high on the Activity Engagement subscale and low on the Pain Willingness subscale (n = 286). At follow up those with low CPAQ scores reported more difficulties in comparison to the group with high scores, while the group with discrepant CPAQ scores generally reported difficulties that fell in between. These results provide further support for the CPAQ.

Bond, F. W., Flaxman, P. E., & Bunce, D. (2008). The influence of psychological flexibility on work redesign: Mediated moderation of a work reorganization intervention. *Journal of Applied Psychology, 93*, 645-654. In a quasi-experimental study an intervention designed to increase job control improved mental health and work absence rates, particularly for individuals with higher levels of psychological flexibility (the moderator) if intervention enhanced perceptions of job control (the mediator).

Tull, M. T., & Gratz, K. L. (2008). Further examination of the relationship between anxiety sensitivity and depression: The mediating role of experiential avoidance and difficulties engaging in goal-directed behavior when distressed. *Journal of Anxiety Disorders, 22*, 199-210. Correlational study with 391 undergraduate students found that experiential avoidance and difficulties engaging in goal-directed behavior mediated the relationship between fear of cognitive dyscontrol and fear of publicly observable anxiety reactions and depressive symptom severity. The model distinguished between clinically significant depressed and non-depressed participants but in this analysis only experiential avoidance was a significant mediator.


Korte, K. B., Veiel, L., Batten, S. V., & Wegener, S. T. (2009). Measuring avoidance in medical rehabilitation. *Rehabilitation Psychology, 54*(1), 91–98. 139 spinal cord dysfunction, stroke, amputation, or orthopedic surgery patients given multiple measures. Data suggest that experiential avoidance plays an important role in rehabilitation outcomes. AAQ, correlated with depression, negative affect and negative with hope, positive affect, and spiritual well-being. Predicted life satisfaction and level of handicap at 3-month follow-up.

Hesser, H., Pereswetoﬀ-Morath, C. E., & Andersson, G. (2009). Consequences of controlling background sounds: The effect of experiential avoidance on tinnitus interference. *Rehabilitation Psychology, 54*, 381–389. Small experimental RCT with 35 patients with tinnitus showing that asking patients to control background sound lead to less initial interference by tinnitus over cognitive tasks but greater long term interference as compared to a situation in which control of background sound was not possible.

Wicksell, R. K., Lekander, M., Sorjonen, K., & Olsson, G. L. (2010). The Psychological Inflexibility in Pain Scale (PIPS) – statistical properties and model fit of an instrument to assess change processes in pain related disability. *European Journal of Pain, 14*, 771.e1-14. Validation study of the PIPS with 611 participants with whiplash associated disorders. Good factor structure; correlates sensibly with the Chronic Pain Acceptance Questionnaire (CPAQ) and the Tampa Scale of Kinesiophobia (TSK) but hierarchical regression showed that the PIPS explained more variance than TSK in pain, disability, life satisfaction and depression, and mediated the relationship between pain and disability.


increases in each of the processes of psychological flexibility. Processes measures generally were significantly related to changes in the measures of depression, anxiety, and disability.


Low, J., Davis, S., Drake, R., King, M., Tookman, A., Turner, K., Serfaty, M., Leurent, B., & Jones, L. (2012). The role of acceptance in rehabilitation in life-threatening illness. Journal of Pain and Symptom Management, 43, 20-28. Cross-sectional study (N = 101); patients attending palliative care day therapy unit for rehabilitation completed AAQ-II, and measures of physical and psychological function. Psychological flexibility was negatively correlated with psychological morbidity (r=-0.59) and positively correlated with sit to stand (r=0.27) and distance walked (r=0.21).


Bond, F. W., Lloy, J. & Guenole, N. (2012). The work-related acceptance and action questionnaire (WAAQ): Initial psychometric findings and their implications for measuring psychological flexibility in specific contexts. Journal of Occupational and Organizational Psychology, pp. 1-25. ISSN 0963-1798 The work-related AAQ (WAAQ) was developed with 745 participants across three studies. Solid psychometrics. The WAAQ, in comparison to the AAQ-II, correlates significantly more strongly with work-specific variables. In contrast, the AAQ-II tends to correlate more strongly with outcomes that are likely to be more stable across different contexts (e.g., mental health and personality variables).


As yet unpublished dissertations


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.

Jonas Sand & Dan Rosenqvist (2006) Mindfulness based smoking cessation for groups - an explorative study. Thesis at the Lund University, Sweden. 6 acceptance and mindfulness group sessions during 35 days including individual homework assignments. 8 of 10 participants completed the program. At 1 mo follow up 50 percent (of 8 completers) were non-smokers, and the rest showed a decrease in smoking at a rate between 45 and 75 percent. Increase of the acceptance aspect of mindfulness was correlated with non-smoking.

Projects underway or recently completed that we know about

Fredrick Livheim (livheim@hotmail.com) has conducted a randomized prevention trial with ACT in a school setting. Good outcomes post and at one year and two year follow up.

Funded randomized trial underway on ACT for command hallucinations in Australia. Under the direction of John Farhall Fran Shawyer at the Mental Health Research Institute of Victoria. email: fshawyer@mhri.edu.au
Julieann Pankey has found a new RCT showing that ACT helps with developmentally delayed + Axis I dually diagnosed.

An RCT in Nigeria done by Prof. Oluwole at the University of Ibadan shows better outcomes for ACT than DBT in dealing with aftermath of abuse due to religious beliefs.

Julieann Pankey has found that the AAQ predict complicated grieving

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

Greco, D., & Blomquist have a small uncontrolled pilot-feasibility study currently underway examining the impact of ACT for adolescents with chronic abdominal pain, anxiety, and depression.

Greco has examined willingness and experiential avoidance among children who experience chronic abdominal pain and persistent headaches. Unpublished as of yet. After controlling for gender, age, and pain frequency, duration, and severity, higher levels of acceptance predicted life quality (Beta = .38), and experiential avoidance/fusion predicted greater use of school medical services and school restrooms during class time (Betas = .24 and .23, respectively), lower quality of life (Beta = -.49), higher anxiety (Beta = .64), and lower teacher-rated academic competence (Beta = -.29).

Greco & Russell (2004) evaluated the short-term effects of participating in a summer camp for diabetic youth and investigated the extent to which psychological acceptance moderated children’s response to camp. Psychological acceptance (using the WAM) moderated the relation between pre- and post-camp diabetes self-care behavior, with self-care ratings increasing most when psychological acceptance was high (Beta = .24, p < .05).

Heather Murray, James Herbert, and Evan Forman have a group ACT vs group CBT RCT for Smoking Cessation underway.

Replication of the 2004 Hayes et al. study on stigma and burnout was done by Sue Clarke in the UK and it did not work well; Steve Hayes also found only weak effects in a replication study. Both were more intensive interventions that the original study though – could have just been too strong. Studies are still being analyzed – not yet clear what happened.

Evan Forman has an NIH grant (R21) for an ACT RCT on weight control. Data are in (haven’t seen the results but they must be OK because he is chasing an R01 now)

Jonathan Bricker at UW has a large ($3M) grant for ACT for smoking

Jonathan also has a new grant for do telephone ACT in smoking cessation w

Evan Forman is writing up an ACT RCT on exercise

Laura Ely and Kelly Wilson have a small (n = 10) open trial with college students at risk for drop out. Showed improvements on grades and on many of the subscales of the LASSI (study skills inventory) such as time management and using study aids which were never directly addressed

Debra Moore and Kelly Wilson have a small (n = 20) RCT on teens at risk for high-school drop out. Data being entered

Irish ACT studies (all at NUI Maynooth and all involving the Barnes-Holmes team):

Claire Keogh is working on an extension of the Masuda study on defusion. So far the data are consistent with the original.

Claire Keogh, & Hilary-Anne Healy have completed a study on the utility of a defusion statement ("I am having the thought that") when presented in the context of positively and negatively evaluated self-referential statements in an automated procedure. Good data

Anne Keogh is comparing acceptance and control as interventions with experimentally induced radiant heat pain. Data is looking good for acceptance. May be a gender diff

Andy Cochrane, is looking at acceptance and a behavioral approach task relevant to spider phobia. All interventions fully automated. No data yet.

Geraldine Scanlon is working with a sample of ADHD kids on self-esteem, trying to replicate the recent study of me-good and me-bad relations published in the Record by Rhonda and Kelly.

Claire Campbell is investigating the PASAT and mirror tracing procedures for stress tolerance and applying ACT interventions to them.

Fodhla Coogan and Loretto Cunningham are looking at experimental analogues of experiential avoidance in the context of equivalence relations and aversive versus positive pictures.

Kevin Vowles and John Sorrell have been piloting a group treatment for chronic pain patients integrating the traditional educational stuff that is often part of psychological treatments for pain (e.g., meds, exercise,
nutrition, sleep, communication) with ACT. The treatment consists of eight 90-minute sessions. Data so far look good

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

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

JoAnne Dahl and students have RCTs underway in smoking and OCD
JoAnne Dahl has an RCT underway with headache and one with social phobia
Judith also has a trial on ACT for geriatric GAD

Chris Watson and Christine Purdon at the University of Waterloo, Canada, compared cognitive defusion (using word repetition) to imaginal exposure and no intervention in reducing the believability, distress, and meaningfulness associated with contamination-related thoughts in individuals with high levels of obsessive-compulsive disorder (OCD). Significant reductions in belief, distress, and meaningfulness were observed following defusion but not the other two conditions. At follow up both defusion and exposure produced gains. The loss of verbal meaning in defusion was associated with reductions in appraisal ratings at follow-up.

There is an RCT for lupus being done by Tomás Quirosa and Olga Gutiérrez in Almeria
Annie Umbricht at Johns Hopkins has submitted a grant on ACT and Contingency Management for substance abuse
Jan Blalock has an NIH grant for an RCT on ACT for smoking (as of 2009)
Angie Stotts is nearing completion of her RCT of ACT to help with drug detoxification

Rhonda Merwin is close on a grant for ACT for anorexia
Jean Fournier fournier@u-paris10.fr has several studies coming on ACT for high level athletes in France

Jane Morton, Sharon Snowden, and Michelle Gopold in Melbourne have an RCT on ACT for BPD … under review right now

Niloofar Afair at UC San Diego / VA has a VA grant for an RCT of ACT for binge eating
Niloo is also doing a pilot study of ACT for distress and treatment decision-making in early stage prostate cancer patients.

Julie Wetherell at UC San Diego has a VA grant to do a non-inferiority trial comparing ACT in person to ACT in telehealth for chronic pain.

Frank Bond has a paper coming on a work-related AAQ that shows that creative workers high in psychological flexibility are more creative.

Frank Bon has an RCT showing that ’traders in an investment bank who underwent a traditional transformational leadership programme, enhanced with ACT, led/managed teams that made more money over the next six months than those traders who underwent the traditional TL programme.

Paul Flaxman has a study under review showing that cultivating mindfulness skills (particularly experiential acceptance) through ACT facilitated (i.e., mediated) improvements in employees' goal-directed behaviour.

This paper is being written up on adolescent depression: Livheim, F., Hayes, L., Tengström, A., Högfeldt, A., Magnusdottir, T. & Ghaderi (in preparation). Acceptance and Commitment Therapy for the Treatment of Adolescent Depressive Symptomatology and Stress: Two Randomized, Controlled Trials in Two Countries.

The International OCD Foundation award a grant to Michael Twohig, at Utah State, to combined ACT with exposure to see if it enhances treatment engagement

Andrew Gloster (a German ACT and CBT researcher) has a funded RCT underway on ACT for treatment failures for those with Panic Disorder and/or Agoraphobia who are "treatment failures" with CBT or meds.
Rena Wing and Jason Lillis at Brown U have R01 testing Standard Behavioral Treatment (SBT) vs SBT + ACT for people who score high on internal disinhibition (eating in response to thoughts, emotions, stress). Planned n=160
Meghan Butryn got an NIH R01 for testing ACT + an intervention in the home environment for weight loss.
Niloo Afari at UCSD has a new grant to test ACT for binge eating and obesity
Jennifer Potter in University of Texas Health Science Center at San Antonio is working on a pain/opiate grant
Jonathan Bricker and Bryan Comstock, at the University of Washington, have just completed a double-blind RCT of computerized ACT for smoking cessation (N = 222) comparing an ACT website to a national website utilizing current best practices (the National Cancer Institute's smokefree.gov). Three month later ACT participants had significantly lower levels of nicotine dependence (18% vs. 44%; p = .036) and higher levels of acceptance of physical (p =.001), emotional (p = .022), and cognitive (p = .083) cues to smoke.
A team in Sweden (Monica Buhrman; Astrid Skoglund; Josefin Husell; Kristina Bergström; Torsten Gordh; Timo Hursti; Nina Bendelin; Tomas Furmark; and Gerhard Andersson) has completed a successful RCT of internet ACT for chronic pain. It is under review.