

Acceptance and Commitment Therapy in the Treatment of PTSD:  
Theoretical and Applied Issues

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Acceptance and Commitment Therapy (ACT, Hayes, Strosahl, & Wilson, 1999) is a behaviorally based intervention designed to target and reduce experiential avoidance and cognitive entanglement while encouraging clients to make life enhancing behavioral changes that accord with their personal values. While ACT has been applied to a wide variety of problems, it is well suited to the treatment of trauma. Individuals who have been diagnosed with PTSD are often disturbed by traumatic memories, nightmares, unwanted thoughts and painful feelings. They are frequently working to avoid these experiences and the trauma-related situations or cues that occasion them. In addition to the symptoms of PTSD, the painful emotional experience and aftermath of trauma can often lead the traumatized individual to view themselves as “damaged” or “broken” in some important way. These difficult emotions and thoughts are associated with a variety of behavioral problems, from substance abuse to relationship problems.

Although most trauma survivors recover naturally without professional intervention, a small percentage go on to develop problems in living and trauma associated disorders. The job of the professional is to help the latter traumatized individuals “heal” from traumatic experiences. The word “heal” comes from a word meaning “whole.” In an important sense, the client has come to the therapist to be made “whole” once again. Often clients believe that healing somehow involves forgetting or getting away from past traumas – cutting them out of their lives. Clients may work to avoid all emotional, psychological and physical experiences associated with the trauma. From an ACT perspective the task is very nearly the opposite. ACT helps the client make room for their difficult memories, feelings, and thoughts as they are directly experienced to be, and to include these experiences as part of a valued whole life.

### Experiential Avoidance, Cognitive Fusion, and PTSD

The concept of experiential avoidance offers organization to the functional analysis of

trauma-related problems and lends coherence to understanding the sequelae of trauma.

Experiential avoidance occurs when an individual is unwilling to experience certain private events such as negatively evaluated emotional states, thoughts and/or unpleasant physiological arousal and he or she then takes steps to alter the form or frequency of these events even when there is behavior cost to doing so (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). For example, a traumatized individual is engaging in experiential avoidance when they drink alcohol to “drown” feelings of pain. From an ACT perspective, experiential avoidance is natural for human beings because it is built into human language – “figure out how to get rid of bad things and get rid of them” - but nevertheless it is often destructive. The problems with experiential avoidance as a course of action is that (1) if traumatized individuals have feelings that they “cannot have,” then, in one sense, there *is* something wrong; whole parts of their own experience must be denied; (2) humans are very poor in deliberately eliminating automatic emotions and thoughts; and (3) many of the methods that can be used (e.g., avoidance of situations that trigger the thought or feeling) are themselves destructive. On the surface, avoidance maneuvers constitute attempts to be free from painful events. Unfortunately, the very thing survivors are seeking, a sense of wholeness, can be lost in their efforts to avoid private experience (Walser & Hayes, 1998; Follette, 1994).

Experiential avoidance is argued by ACT theorists (e.g., Hayes et al., 1996) to stem in part from human verbal behavior itself (the theory of verbal behavior upon which ACT is based is Relational Frame Theory, see Hayes, Barnes-Holmes, & Roche, 2001). Language, and in particular self-talk, can play a critical role in moderating the damage caused directly by a traumatic event. As aversive experiences are described, categorized, and evaluated, the bi-directional nature of human language makes this process itself aversive (Hayes et al., 1999,

2001). For example, telling the story of a trauma evokes negative emotions and experiences. Furthermore, since verbal behavior can occur under virtually any context, unlike most other forms of behavior, the pain this produces cannot be regulated by avoiding situations per se. Left with seemingly no other alternative, humans begin to attempt to regulate psychological pain not just by avoiding objectively aversive situations, but also by avoiding or suppressing negative private experiences themselves (e.g. trying to forget memories). This network of avoidance can expand almost indefinitely depending on the different contexts that become directly or indirectly related to the painful private experiences (e.g. sexually traumatized individuals may initially have difficulty with romantic relationships following the trauma but this can then spread to avoidance of other social situations).

The verbal nature of trauma has been addressed in the literature. Appraisals of a traumatic event as uncontrollable, unpredictable, and objectively dangerous help determine subsequent reactions to the traumatic event (Foa, Zinbarg, & Rothbaum, 1992). Furthermore, individuals often feel the need to explain unusual, unwanted, or unexpected events and make causal attributions following trauma (Weiner, 1985, 1986). The nature of the individual's explanation will often influence how he or she will respond to the event (Brewin, 1985, 2003; Shaver & Drown, 1986; Tennen & Affleck, 1990; Weiner, 1986).

Some of the key forms of verbal entanglement are captured in the acronym FEAR – fusion, evaluation, avoidance, and reason-giving (Hayes et al., 1999). *Cognitive fusion* refers to a process in which the behavior regulatory power of verbal/cognitive stimuli dominate over other sources of behavioral influence. In this case, individuals view their thinking as literally truth, and they respond to their constructions of the world as if they *are* the world. For example, buying into the idea that “Deep down I am broken as a result of my trauma” can lead to a number of

responses that are unhealthy. “Defusing” from this construction involves seeing the words for what they are – a set of words put together in a particular way, and then choosing to respond in a way that is healthy. *Evaluation* allows us to compare, make decisions, plan and problem solve but it also allows us to judge, evaluate and assess in unhealthy or non-useful ways. For instance, an individual who was traumatized as a child, and is suffering as a result, can imagine what life might be like if they had not been traumatized. The evaluative result may be extensive and painful wishing for a different history or attempts to deny what history has led them to be – an individual with these kinds of memories. When these attempts to forget are unsuccessful, additional negative judgments about oneself are likely to follow such as labeling oneself as a “failure.” Together fusion and evaluation lead readily to *avoidance*, which is harmful for several reasons. It narrows the range of behaviors that can occur, prevents healthy forms of exposure and strengthens responses that are problematic (e.g. avoidance of intimacy). Moreover and paradoxically, efforts to change internal private events can be self-amplifying. For example, as we document later in this chapter, deliberate attempts to try not to think about something tends to bring the event to mind. A cycle of trying not to remember, followed by remembering, followed by trying not to remember may ensue. *Reason-giving*, giving verbal explanations for our behavior (e.g. “I can’t be in a relationship because I have PTSD.”), further amplifies both avoidance and rigidity, and tends to make treatment more difficult since many important “reasons” are unlikely ever to change (for example, if the reason for action is a bad childhood, it seemingly implies that some other childhood would be needed in order to act differently).

ACT targets experiential avoidance and cognitive fusion through acceptance and “defusion” techniques (i.e. mindfulness techniques, viewing thoughts as thoughts, observing personal emotional experience). Acceptance and defusion can create a new context from which

the trauma survivor may view the world and the self. If thoughts are observed and noted rather than believed or disbelieved, and efforts to control private experience are relinquished as a means to mental health, then valued and life enhancing behavioral change is argued to be much more likely.

### Empirical Research: Experiential Avoidance and Cognitive Fusion

A number of empirical studies linked to experiential avoidance and its impact are relevant to PTSD. We will describe several areas of research that underscore the theory of experiential avoidance as a component of pathology. In addition, we will discuss specific research related to the use of acceptance based techniques and ACT in the treatment of stress related symptoms and PTSD.

#### *Avoidance, Fusion and Pathology*

Many of the problematic behaviors seen in PTSD may be the result of unhealthy avoidance strategies, fed by cognitive fusion. Steps taken to avoid experiential states may include directed thinking, rumination and worry. These cognitive strategies are ways to distract oneself from current experience and the cognitive material associated with emotional content (Wells & Matthews, 1994). Worry and self-analysis seems to provide control over events but in fact it has been shown to have minimal constructive benefit (Borkovec, Hazlett-Stevens, & Diaz, 1999) and may only serve to complicate psychological struggle. Numbing oneself to emotional responses or engaging in one type of emotional reaction as a way to avoid another (e.g., using anger to avoid hurt), and removing of oneself from situations and personal interactions that elicit certain negative thoughts or emotions are all examples of additional avoidance maneuvers. A victim of trauma may spend large amounts of energy engaging in a number of these behaviors, specifically, avoiding feelings and thoughts associated with the trauma, or activities that

stimulate memories of the trauma (Shapiro & Dominiak, 1992). In a diagnosis of PTSD, avoidance and numbing are two of the more central aspects (American Psychiatric Association, 1994). Avoidance is not always negative, however. Some forms in some contexts may actually be healthy especially if it is connected also to more active methods of coping that help elaborate healthy repertoires, such as positive distraction. But if this coping process dominates it may result in emotional numbness to cognitive and emotional material and may lead to prolonged problems.

Posttrauma consequences are similar across trauma populations (Trimble, 1981) and may be associated with many of these types of experiential avoidance. Combat veterans with PTSD make conscious, effortful attempts to suppress emotional expression (Roemer, Orsillo, Litz, & Wagner 2001), for instance. Emotional numbing is a central feature of PTSD that is consistently associated with the relationships between male veterans and their children (Ruscio, Weathers, King & King, 2002) and is reflected in such negative processes as lack of interest, detachment, emotional unavailability and lessened interest in engagement with others. In addition, many veterans diagnosed with PTSD experience somatization disorders (Omer, 1992), marital problems stemming from loss of emotion and intimacy or physical aggression (Carroll, Rueger, Foy, & Donahoe, 1985), anxiety, nightmares and difficulty in coping (Card, 1987; Fairbank, Hansen, & Fitterling, 1991), increased feelings of alienation (Egendorf, Kadushin, Laufer, Rothbert & Sloan, 1981), and they are more likely to commit suicide (Hendin & Haas, 1991; Sutter, 1986), perhaps the ultimate act of avoidance.

Victims of childhood sexual abuse experience symptoms that include denial and distortion, and emotional difficulty with memories (Shapiro & Dominiak, 1992). Some of the long-term effects of childhood sexual abuse include behaviors that are avoidance oriented, such

as self-harming behaviors as an escape from anxiety (Briere & Runtz, 1993; Browne & Finkelhor, 1986; Polusny & Follette, 1995), dissociation and memory impairment (Anderson, Yassenik, & Ross, 1993; DiTomasso & Routh, 1993), substance abuse (Najavits, 2003; ouimette & Brown, 2003; Rodriguez, Ryan, & Foy, 1992), and eating disorders (Conners & Morse, 1993; Miller, McCluskey-Fawcett, & Irving, 1993). The pervasiveness of these types of avoidance and their role in trauma-related problems support the core conception of an experiential avoidance model.

Victims of disaster demonstrate similar traumatic responses across a variety of event types (Green, 1993). Some of these responses are more transient, but may last for months (Green & Lindy, 1994). Symptoms include depersonalization, derealization, a subjective sense of numbing or detachment, dissociative amnesia and a reduction in awareness, as well as avoidance of reminders, anxiety and arousal, and intrusive reexperiencing of the event (Green & Lindy, 1994). Other symptoms found to be present include time distortion, alterations in cognitions, and somatic sensations (Cardea & Spiegel, 1993). **Site Kessler....**

### *Comorbidity and PTSD*

Studies have found that between 62 and 80% of individuals diagnosed with PTSD also meet criteria for at least one other disorder (Davidson & Fairbank, 1993). Disorders that have been found to co-occur include anxiety (Blank, 1994; Davidson & Foa, 1991; Joseph, Williams, & Yule, 1995); depression (Beitchman, Zucker, Hood, DaCosta, & Granvill, 1992; Joseph, Williams, & Yule, 1995; Polusny & Follette, 1995); dysthymia, obsessive–compulsive disorder, manic–depressive disorder (Blank, 1994; Helzer, Robins, & McEvoy, 1987); somatization disorders (Davidson & Fairbank, 1993); and eating disorders (Beckman & Burns, 1990; Conners & Morse, 1993). Each of these disorders themselves have experiential avoidance and cognitive

fusion components, and diagnostic criteria often reflect some aspect of each disorder that may be considered to be avoidance related, particularly when a functional assessment of the behavior is conducted. For instance, binge–purge eating (Briere & Runtz, 1993), compulsive behaviors (Briere & Runtz, 1993) and self-mutilation (Linehan, 1993) have been viewed as tension-reducing behavioral strategies and are often conceptualized as behavioral forms of emotional avoidance. In addition, there is evidence that fusion and avoidance helps account for some forms of co-morbidity. For example, Williams, Hodgkinson, Joseph, and Yule (1995) developed a measure of negative attitudes toward emotional expression (e.g., “You should always keep your feelings under control”). The more these dysfunctional assumptions were believed, the more survivors of a ferry disaster experienced symptoms of PTSD and generalized anxiety.

Co-occurring substance abuse also fits the model of experiential avoidance. When a client presents with PTSD, co-occurring problems can resemble attempts to medicate or escape certain feared emotions or private experiences. Substance abuse is a common problem for survivors of trauma (McFall, Mackay, & Donovan, 1991; Najavits, 2001; Ouimette & Brown, 2003; Polusny & Follette, 1995; Schetky, 1990) and survivors often report that substance use numbs the traumatic memories (Root, 1989). The notion that alcohol is used as an experiential avoidance strategy is further supported by research that shows that alcohol abusers drink primarily in situations involving negative emotional states (Marlatt & Gordon, 1985). Alcohol also has a tendency to decrease processing of self-relevant information; thus, persons who consume alcohol may be using it as a way to reduce contact with negative self-evaluation information (Stephens & Curtin, 1995). Given these research findings and other explanations for the use of substances, one consistent theme emerges: Substance use is viewed as a means to escape aversive bodily states, emotions, certain cognitions, and other private events.

### *Suppression*

The possible results of avoidance or suppression can be the reoccurrence of intrusive trauma cognitions (Clark, Ball, & Pape, 1991; Wegner, Shortt, Blake, & Page, 1990); and, as noted earlier in the chapter, cause a paradoxical effect to these escape or avoidance tactics. Current research suggests that attempting to avoid or suppress unwanted negative thoughts, emotions, and memories, as a means to create psychological health, may actually contribute to a magnification of the negative emotional responses and thoughts, and to a longer period of experiencing those events (Wegner & Schneider, 2003, Wenzlaff & Wegner, 2000, Wegner, 1994, Cioffi & Holloway, 1993; Wegner & Zanakos, 1994). This means that suppression presents risks of self-amplification: Avoidance of thoughts increases their literal importance (a cognitive fusion process) which then increases their negative impact, and further efforts to avoid them.

The effects of active suppression or avoidance of unwanted private experience (e.g. unwanted thoughts or emotions) has been documented in many studies (Cioffi & Holloway, 1993; Clark et al., 1991; Kelly & Kahn, 1994; Muris, Merckelback, van den Hout, & de Jong, 1992; Salkovskis & Campbell, 1994; Walser, 1998; Wegner, 1994; Wegner, et al., 1990). The effects of long-term suppression have also been explored (Trinder & Salkovskis, 1994). These suppression effects are generally consistent and are briefly explored below.

Thought suppression studies (Macrae, Bodenhausen, Milne, & Jetten, 1994; Wegner, 1994; Wegner, Schneider, Carter, & White, 1987) indicate that subjects have a difficult time suppressing the unwanted thought and mention the thought frequently during suppression conditions. Subjects also report a conscious, effortful search for anything but the thought; however, these efforts to distract fail. This may be due to an unusual sensitivity to the thought

throughout periods of attempted suppression (Wegner, 1994). These findings support the notion that we are more likely to think of the very thing we would like to avoid.

Personally relevant intrusive thoughts, or unwanted thoughts that repeatedly come to mind (Edwards & Dickerson, 1987), such as recurring memories, images, evaluations, judgments, and so on have also been investigated (Rachman & Hodgson, 1980; Salkovskis & Harrison, 1982). For instance, Salkovskis and Campbell (1994) found that suppression causes enhancement of personally relevant, negatively valenced intrusive thoughts. Trinder and Salkovskis (1994) found that subjects who were asked to suppress their negative intrusive thoughts experienced significantly more of those thoughts than subjects who were asked just to monitor their thoughts. In addition, the suppression group recorded significantly more discomfort with the negative intrusions than did subjects in the monitor only group.

Although personally relevant intrusive thoughts are quite common and are thought to occur in about 80% of the population (Rachman & de Silva, 1978), they appear to be particularly problematic for survivors of trauma. The suppression of disclosure about disturbing events, such as past trauma, has been linked to both psychological and physiological problems (Pennebaker, Hughes, & O'Heeron, 1987; Pennebaker & O'Heeron, 1984). Riggs, Dancu, Gershuny, Greenberg, and Foa (1992) have found that female crime victims who "hold in" their anger, experience more severe PTSD symptoms. The intrusive experience of emotion seen in PTSD can trigger an opponent process of denial or numbness (Horowitz, 1986) and numbness itself may be used as an avoidance technique to evocative stimuli (Keane, Fairbank, Caddell, Zimering, & Baker, 1985). This numbing, however, may lead to difficulties in emotional processing and maintenance of PTSD symptomatology (Wagner, Roemer, Orsillo & Litz, 2003).

It makes sense that a trauma survivor would engage in behaviors to counteract or avoid

traumatic thoughts and the emotions that may be associated with them given the likely aversiveness of the traumatic event. Furthermore, there is considerable evidence that people attempt to suppress thoughts when they are traumatized (Pennebaker, & O’Heeron, 1984; Silver, Boon, & Stones, 1983), obsessed (Rachman & de Silva, 1978), anxious (Wegner et al., 1990), or depressed (Sutherland, Newman, & Rachman, 1982; Wenzlaff & Wegner, 1990). However, as noted earlier, efforts at control of one’s mood may paradoxically cause the mood to continue and may also lead to the execution of many maladaptive behaviors, such as alcohol use or binge eating (Herman & Polivy, 1993).

Finally, recycling through a process of suppression with recurrence of emotion and thought countered by further attempts at suppression could well produce internal experience that is fairly robust (Wegner et al., 1990). Suppression of thought and emotion may be a part of the development of such disorders as PTSD, depression, anxiety, and panic. What individuals believe to be the antidote may actually be the venom that produces the very problem, further contributing to their distress. Individuals who use suppression and avoidance may actually be generating an assortment of unwanted consequences and problems because of the strategy.

Research that focuses on self-disclosure of traumatic events, a process of talking openly about the trauma without attempts to suppress, has found that disclosing about the event is associated with lower levels of psychological distress and ability to better care for oneself (Lepore, Silver, Wortman, & Wayment, 1996; Pennebaker & Harber, 1993). In addition, self-disclosure can elicit the emotions associated with the negative event thus exposing the individual to the emotions associated with it. This may serve to facilitate a decrease in the negative emotion. In other words, being present to rather than avoiding the emotional content of trauma may be the healthier avenue. For example, Bolten, Glenn, Orsillo, Roemer and Litz (2003) found

that self-disclosure is associated with lower levels of PTSD symptom severity. Verbal and emotional processing of the traumatic event has also been theorized to be an effective treatment for PTSD. This includes a full experiencing of the traumatic memory and associated emotions plus a habituation to the emotions and thoughts experienced (Foa & Rothbaum, 1998).

Emotional engagement rather than emotional avoidance or numbing appears to be a key ingredient (Jaycox, Foa, & Morral, 1998). Acceptance of previously avoided experiences may have a powerful impact in movement toward healthy and valued living.

### *Acceptance, Defusion and Mindfulness*

Mindfulness is traditionally defined as non-judgmental awareness of and contact with the current moment (Kabat-Zinn, 1990). It involves openness to experience and recognition that thoughts and feelings are passing events that do not need to be acted upon. From an ACT point of view, mindfulness involves four key processes (Hayes, 2004): acceptance of experience, defusion from the literal meaning of thought (e.g. observing the thought as a thought, not as what it says it is), continuous contact with the present moment, and a transcendent sense of self.

Mindfulness techniques generally foster all of these processes. These processes provide a context in which the client can experience internal private events in the moment – observing them for something the mind does without necessarily treating these events as reality. Practicing mindfulness allows for exposure to emotion while reducing experiential avoidance and simultaneously demonstrating that emotional events themselves are not harmful. For example, to be aware of feelings of sadness or anxiety without attempts to avoid can help the individual learn more about emotional experience, and come to realize that emotional experience does not have to rule action. That is, clients can learn to be present to emotions, even negatively evaluated ones, and continue to behave in ways that promote health and relationship.

ACT uses mindfulness techniques and also directly targets components of mindfulness. For example, ACT exercises are used to help distinguish between a person as a continuous process or locus of awareness and what one is aware of (Hayes, 1994). That is, the person can locate a sense of “I” that observes, and that can view experience as an ongoing process. “From here now” is argued to be experienced as limitless and therefore not thing like – any or all things can be experienced in this moment. It is a clinically important sense of self because it is not threatened by psychological content: any content, whether “good” or “bad” is experienced from the point of view of “I here now” and given that experience is an ongoing process – it is continuously changing. Finding and experiencing a sense of self as a context for events rather than as those events themselves thus supports acceptance, defusion, and other ACT processes.

### ACT: Clinical Application

#### *Assessment*

Assessment methods focus on the targets of change in ACT - acceptance, defusion, values, and committed action. We review both clinically useful and research capable assessment types in this section. We will not address assessment of PTSD per se since there is a chapter on that topic in this book.

The Acceptance and Action Questionnaire (AAQ; Hayes, Strosahl et al., in press; Bond & Bunce, 2003) is a self-report measure that attempts to assess several of the key features of ACT and its underlying model. Items focus on emotional avoidance, fusion, and interference between these processes and valued inaction. Respondents report the extent to which each statement applies to them using a 7-point Likert scale.

There are three validated versions of the AAQ: a 9-item single-factor scale (Hayes et al., in press), a very similar 16-item single-factor scale (Hayes, Strosahl et al., in press), and a two

factor 16 item solution (Bond & Bunce, 2003). In the latter case, the factors are acceptance and ability to act in the presence of difficult emotions, but this solution indicates that there is also a latent underlying factor as in the single-factor solutions. The single factor solutions are scored so that higher scores indicate greater experiential avoidance. All versions have adequate psychometric properties. What are more impressive are their operational characteristics. In correlational studies, the AAQ correlates in the expected direction with most measures of psychopathology, including depression, anxiety, overall psychiatric severity, and the like (Hayes, Strosahl et al., in press). It also predicts quality of life (Hayes, Strosahl et al., in press), flexibility at work (Bond & Bunce, 2003) and response to treatments and challenges of various kinds. For example, highly emotionally avoidant subjects, as assessed by the AAQ, show more anxiety in response to a CO<sup>2</sup> gas challenge, particularly when instructed to suppress their emotions (Feldner, Zvolensky, Eifert, & Spira, 2003). Similar findings were reported by Karekla, Forsyth, and Kelly (in press).

There are also a number of disorder specific versions of the AAQ. For example, McCracken (1998) validated a pain-related version (called the Chronic Pain Acceptance Questionnaire or CPAQ) originally developed by changing AAQ items to focus on pain. Greater acceptance of pain was associated with reports of lower pain intensity, less pain-related anxiety and avoidance, less depression, less physical and psychosocial disability, more daily uptime, and better work status. Subsequent work has shown that the CPAQ predicts disability and adjustment better than pain ratings themselves in this population (McCracken, & Eccleston, 2003; McCracken, Vowles, & Eccleston, 2004). Gregg (2004) has developed a diabetes related AAQ that has been shown to mediate the impact of ACT in this population; Gifford, Kohlenberg, Hayes, Antonuccio, Piasecki, Rasmussen-Hall, and Palm (in press) have shown similar results in smoking.

The AAQ is known to relate to trauma. Marx and Sloan (in press a) have shown that self-report measures of childhood sexual abuse (CSA), experiential avoidance and emotional expressivity are all significantly related to psychological distress. However, only experiential avoidance mediated the relationship between CSA and current distress. Similarly, Marx and Sloan (in press b) showed the same in a population of 185 trauma survivors who 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 were taken into account, only experiential avoidance was related to PTSD symptoms both 4- and 8-weeks later.

Existing measures of coping styles can be used in ACT consistent fashion. There is a significant relationship between methods of coping and certain forms of symptomatology (Abramsom, Seligman, & Teasdale, 1978; Fondacaro & Moos, 1987), many of which are included in the diagnosis of PTSD. The Ways of Coping Questionnaire (WOC; Folkman & Lazarus, 1988), a widely used research instrument for assessing coping strategies, and the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1990) are each useful instruments that tap into emotion-focused or avoidant strategies. They assess a wide range of thoughts and behaviors that individuals use to deal with stressful life experiences. Three dominant means of coping with stressful situations have been identified. These are task-oriented, emotion-oriented, (Folkman & Lazarus, 1988) and avoidance-oriented (Endler and Parker, 1994). Task-oriented coping refers to the attainment of problem resolution through conscious efforts to solve or modify the situation, and emotion-oriented coping is defined by a set of reactions, such as tension and anger, of a self-oriented nature that occur in response to a problematic event. Avoidance-oriented coping involves responses that have the effect of

distracting or diverting the individual's attention away from the stressful situation (Turner, King, & Tremblay, 1992).

Use of the WOC in studies of sequelae of childhood sexual abuse (Leitenberg, Greenwald, & Cado, 1992) and substance abuse (McMahon, Kelly, & Kouzekanani, 1993), have been found to be predictive of outcome and supportive of the emotional avoidance perspective. Although these findings are encouraging, the data are only correlational and not causal, and they do not directly assess client's reactions to their own emotion and thought.

The Emotional Approach Coping Scale (EAC) is an 8-item measure developed to assess 2 aspects of emotional coping: emotional processing (4 items) and emotional expression (4 items) (Stanton, Kirk, Cameron, & Danoff-Burg, 2000). Items are rated on a 4-point scale (from 1 "I usually don't do this at all" to 4 "I usually do this a lot") for how often various emotional approach strategies are used to cope with a stressful situation. Psychometric properties of the EAC are strong (Stanton et al., 2000). The questions on the scale include items like "I acknowledge my emotions" and "I take time to figure out what I am really feeling." This instrument is short, easy to give and can give a quick snapshot of the individuals emotional processing and expression.

Other instruments that more directly assess avoidance and cognition include the White Bear Inventory (WBSI; Wegner & Zanakos, 1994) and the Automatic Thoughts Questionnaire (ATQ; Kendall & Hollon, 1980). The WBSI is a self-report questionnaire designed to assess thought suppression or an individuals reported level of desire or ability to successfully avoid a thought (Wegner & Zanakos, 1994). Respondents report the extent to which each of 15 statements applies to them using a 5-point Likert scale with higher scores indicating increased desire to suppress. However, recent studies suggest that the WBSI does not exclusively measure

thought suppression, but also addresses the experience of intrusive thoughts. Hence, the WBSI does not seem to measure suppression per se, but rather failing suppression (Rassin, 2003). In a recent study, one factor of the WBSI was interpreted as "Unwanted Intrusive Thoughts", the other as "Thought Suppression". The full scale's correlation with measures of depression, anxiety, and obsessive-compulsive behaviour was largely due to the Unwanted Intrusive Thoughts factor rather than the Thought Suppression factor. The Unwanted Intrusive Thoughts factor correlated negatively with avoidant coping. Neither factor correlated with self-disclosure. The theoretical meaning of separating thought intrusions from thought suppression may play an important role in assessment and research.

Recently, measures of thought control have also emerged as a useful assessment tool. One of these measures, the Thought Control Questionnaire (TCQ, Wells & Davies, 1994), was designed to assess strategies that are used to control unpleasant or unwanted thoughts. Wells and Davies (1994) studied the relationship between the use of different strategies of control and measures of stress vulnerability and psychopathology. In factor analyses of the TCQ the authors found 5 replicable factors: Distraction, Social Control, Worry, Punishment, and Reappraisal. Associations were also found between assessment of emotional vulnerability and perceptions of weakened control over cognitions and the punishment and worry subscales of the TCQ.

McKay and Greisberg (2002) examined the properties of the TCQ and the WBSI by exploring the relationship between obsessive-compulsive symptoms and worry and the items on the measures. The findings indicated that the Punishment and Worry subscales of the TCQ were related to obsessive-compulsive symptoms and worry. Scores on the WBSI showed an association between Worry and Slowness. The authors concluded that the TCQ better predicts performance in rebound experiments and has greater clinical usefulness. In addition, item

analyses indicated that the TCQ and WBSI formed 2 factors: Dysfunctional and Functional Thought Control Strategies.

The Automatic Thoughts Questionnaire (Hollon & Kendall, 1980) is a questionnaire that assesses a person's frequency of thoughts that have occurred over the past month. The ATQ taps into four aspects of automatic thoughts: personal maladjustment and desire for change, negative self-concepts and negative expectations, low self-esteem, and helplessness. Respondents report the extent to which each thought occurs using a range of 1 = "never" to 7 = "always." ACT researchers have attempted to measure defusion from thoughts, and not merely the presence of thoughts, by adding a "believability" scale to the ATQ (asking "if this thought occurred to you now, how believable would it be?"). The first to do so was Zettle and Hayes (1986) who showed in a small randomized controlled trial comparing ACT to Cognitive Therapy that ACT produced a greater reduction in believability but not frequency of depressogenic thoughts than did CT, and that this was associated with greater gains in the ACT condition. The ATQ-B has since been used in ongoing research (e.g., Walser, Westrup, Rogers, Gregg, & Loew 2003; Walser, Loew, Westrup, Gregg & Rogers, 2002) with individuals diagnosed with PTSD and to date has shown an effect for defusion. ACT researchers have used similar believability ratings in other studies, such as ratings of the believability of positive psychotic symptoms (Bach & Hayes, 2002), or of the believability of stigmatizing thoughts by clinicians toward difficult clients (Hayes, Bissett, Roget, Padilla, Kohlenberg, Fisher, et al., in press). These measures have been shown to be particularly sensitive to ACT treatment, and to mediate outcomes.

There are two mindfulness measures that may prove useful in assessing level of awareness to current experience and ACT consistent behavior. The Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith & Cochran, In Press) is a 39-item self-report measure

that is designed to assess general tendency to be mindful in daily life and includes four areas of mindfulness skills: observing, describing, acting with awareness and accepting without judgment. The *Observe* items include noticing or paying attention to a number of internal and external events, feelings, thoughts, and sensations. The *Describe* items focus on ability to put thoughts, feelings, sensations, etc. into words. The *Act with awareness* items refer to engaging in activity with undivided attention and the *Accept without judgment* items refer to the act of making judgments or evaluations about one's own experiences. Much of ACT is directed at cultivating these four areas as a means to free oneself from excessive fusion. All of the sub-scales of the KIMS except the "observe" sub-scale correlate significantly with the AAQ. The KIMS has been found to have high internal consistency and adequate to good test-retest reliability (Baer, et al, in press).

A second mindfulness measure is the Mindfulness Attention Awareness Scale (MAAS; Brown and Ryan, 2003). This is a recently developed 15-item measure that uses a Likert-style self report mechanism to assess a single factor of mindfulness. The MAAS items generally focus on the presence or absence of attention to the present moment and includes questions like "I find it difficult to stay focused on what is happening in the present," "I rush through activities without really being attentive to them" and "I do jobs or tasks automatically without being aware of what I am doing." Most of the questions appear to be assessing level of attention to specific tasks. The MAAS has been shown to be a reliable and valid instrument for use in student and adult populations.

Finally, several of these assessment instruments may be used throughout therapy to track the client's progress. The WBSI and AAQ are relatively short instruments that can be given on a regular basis. The client can also use a daily diary that tracks both emotional willingness and

action as it relates to valued living. These can be tracked with simple Likert-type scales that assess each area.

One of the most important aspects of assessment from the ACT approach is related to commitment and action. Individuals who have been diagnosed with PTSD are often not living the lives they would like to be living and are inactive around a number of important values. Assessing how the clients are doing with respect to their values in a number of areas lends support to a specific target of intervention when using ACT and lends support to the effectiveness of the treatment. The Valued Living Questionnaire (VLQ; Wilson & Groom, 2002; Wilson & Murrell, 2004) is a 20-item assessment instrument that evaluates both the importance of a particular value plus the degree to which the value is being practiced in an individual's life. Ten different domains are assessed: Family (other than marriage or parenting), Marriage/couples/intimate relations, Parenting, Friends/social life, Work, Education/training, Recreation/fun, Spirituality, Citizenship/Community Life, Physical self care (diet, exercise, sleep). The psychometric properties of the VLQ are currently under investigation, however, it is a useful clinical tool and helps guide both clinician and client with respect to target values. A second clinical assessment of values is also possible. The Values and Goals Worksheet (see Figure 1) includes the client's personal definition of their values, goals related to achieving

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Insert Figure 1 about here.

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greater degrees of success in living those values, barriers or reasons the values are not being lived and current level of success in living particular values. Of note, barriers are often experiential-avoidance related and should be addressed in therapy.

All of these dimensions of the ACT model are possible to assess directly, not merely through self-report. Unfortunately, the current methods for doing so are relatively cumbersome. For example, it is possible to reliably code therapy tapes for these behavioral processes (Khorikiwala, 1991) but it requires full sets of transcripts in addition to therapy tapes.

### Evaluation of Treatment

Evaluation of treatment should generally be based on three specific areas: (1) changes in ACT processes; (2) changes in the client's value oriented action and (3) client acceptability of the treatment. The first domain was covered in the last section. The second can be assessed by well-established outcome measures supplemented by changes in more specific behavioral targets in a given case such as a decrease in number of drinking days, reduction in self-harm, relationship improvement, steady employment, volunteer services, or a steady exercise program. It is important in ACT to examine both domains (process and outcome) since research has shown that positive long term outcomes are fostered by learning how to act while fully in contact with moment-by-moment private experience.

The third area of assessment can be examined with instruments such as the Credibility/Expectations Scale (Borkovec & Nau, 1972) that assesses the extent to which clients view a particular therapy package as credible and able to provide sufficient expectancy for change. Clients also report the percent improvement they think and feel will occur by the end of the treatment sessions. Recent research (Deville & Borkovec, 2000) demonstrates that the assessment instrument has high internal consistency within the subscales and good test-retest reliability.

### *Guidelines for client selection*

ACT can be used with a variety of clinical presentations and clients with no specific limitations to its use, however, it is most useful when applied with clients who are assessed to be emotionally avoidant and/or cognitively fused, have chronic conditions, or who have multiple treatment failures. ACT has been demonstrated to be effective when used in the treatment of PTSD (Follette, Pistorello, Bechtle, Naugle, Polusny, Serafin & Walser, 1993; Walser, et al, 2002, 2003; Batten & Hayes, in press), anxiety and stress (Bond & Bunce, 2000; Twohig & Woods, in press; Zettle, 2003), substance abuse/dependence (Gifford et al., in press; Hayes, Wilson, Gifford, Bissett, Batten, Piasecki, et al., in press), coping with positive psychotic symptoms (Bach & Hayes, 2002), chronic pain (Dahl, Nilsson, & Wilson, in press; McCracken, Vowles, and Eccleston, in press), stigma and burnout (Hayes, Bissett, Roget et al., in press), depression (Folke & Parling, 2004; Zettle & Hayes, 1986; Zettle & Raines, 1989), and a variety of other conditions (see Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004 for a recent review). There are also effectiveness data for ACT. Strosahl, Hayes, Bergan, and Romano (1998) found that training clinicians in ACT produced better overall clinical outcomes in a general clinical practice in a managed care setting.

When selecting clients who have trauma or who have already been diagnosed with PTSD, there are a number of things to keep in mind. First, the client must be ready (able to commit to a number of sessions) or willing to undergo an intensive therapy in which the therapist is quite active in session. Second, if the client has problems that the literature suggests would better be treated by a different approach, these approaches need to be implemented first or integrated into the course of ACT. For example, if the client has Borderline Personality Disorder, Dialectical Behavior Therapy should be tried, with ACT brought in during later stages. Finally, a functional

analysis of the case should fit the ACT model (e.g., the presenting issue is one of emotional or experiential avoidance, cognitive fusion, lack of clarity about values, and so on).

*Overview of treatment approach: Acceptance Theory And Intervention*

The following section provides detailed information about how to use ACT in a clinical setting. There are several main goals that are generally presented in order when using ACT. This is not to say, however, that the ACT goals cannot be presented in a different order, or the ACT therapist cannot choose to emphasize one goal of ACT over another depending on the client's specific issues. ACT is diverse and flexible and allows for a range of concepts to be presented depending on client needs. In addition, we will not present a comprehensive listing and set of ACT interventions, but rather focus on the main goals with examples as applied in the clinical setting and issues related directly to PTSD and trauma. For a comprehensive presentation of ACT see Hayes et al., 1999 and Hayes and Strosahl, in press.

The acronym "ACT": Accept, Choose and Take Action, distills ACT into its basics. The premise involves the conscious abandonment of the mental and emotional change agenda when change efforts do not work, replacing it with emotional and social willingness -- openness to one's own emotions and the experience of others (Hayes, 1994). Such acceptance applies to the domain of private subjective events and experiences, not to overt behavior or changeable situations (Greenberg, 1994). For instance, when speaking directly of trauma, the therapist using ACT would not encourage a client to stay engaged and "just accept" an abusive situation, rather, the client in this situation would be encouraged to experience emotional process while engaging in practical, safe and valued behavior that may include getting out of the situation. Thus, as the very name suggests, ACT involves a focus on both acceptance and change.

Choosing or choice relates specifically to the client's ability to see and exercise action

with respect to a valued direction. Although in tremendous pain, most often clients have a sense of what is important or what matters in their lives. Frequently, however, these valued goals have been lost or given up due to thoughts, feelings, or states of experience that tell the client that they cannot have those valued things in their lives until the certain thoughts, feelings, memories and so on change or go away. For instance, the sexual abuse survivor may have the thought that she was “damaged” by the abuse and therefore unable to engage in romantic relationships until the “damagedness” goes away. Sometimes the client will be in such pain, that the idea of meaningful intimate relationship will rarely be contacted. Inside the pain there is a strand back to values and choice, however, since the pain of “damage” implies a desire for intimacy.

In a more theoretical sense there are six essential components of ACT (Hayes, 2004) which are shown graphically in Figure 2: (1) acceptance, (2) defusion, (3) self-as-context, (4)

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Insert Figure 2 about here.

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contact with the present moment, (5) values, and (6) committed action The figure helps note the relationship between these six processes. Defusion and acceptance both involve undermining excessive literality, or “letting go;” self as context and contact with the present moment both involve verbal and non-verbal aspects of contacting the “here and now” as a conscious human being; values and committed action both involve positive uses of language to choose and complete courses of action or “getting moving in life.” The hexagram in Figure 2 can be sliced into two larger sections that define ACT more broadly. The first section (see Figure 3) describes

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Insert Figure 3 about here.

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the acceptance and mindfulness processes included in ACT and the second section (see Figure 4)

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Insert Figure 4 about here.

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describes the commitment and behavior change processes in ACT. The overall main goal of ACT is to create psychological flexibility: contacting the present moment fully as a conscious human being with a history, and based on what the situation affords, changing or persisting in behavior in the service of chosen values. This goal is embodied in the following question and is graphed in Figure 5 on top of the hexagram: Given a distinction between you and the things you

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Insert Figure 5 about here.

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are struggling with and trying to change are you willing to have those things, fully and without defense, as it is, and not as what it says it is, AND do what takes you in the direction of your chosen values at this time, in this situation? We briefly review the goals of ACT below and show how acceptance might be integrated into a treatment approach for trauma.

The first goal of ACT is *Creative Hopelessness* (Hayes, et al., 1999). This occurs when the workability of efforts the client has been using to rid themselves of negative emotional content is viewed honestly and the client begins to open up to the possibility of truly new ways of living. Typically clients feel that if they had a different history (one without sexual abuse, disaster trauma, or war trauma), then their problems would be solved and they would no longer be in emotional turmoil; they would feel better. However, as they try these solutions over and

over again, the behavioral relevance of their painful history is only magnified and much search for still more “solutions.” With ACT, the solutions the client has been trying are viewed as part of the problem. Metaphors are often used to demonstrate the client’s situation:

**THERAPIST:** Here is a metaphor that will help you understand what I am saying.

“Imagine you are blindfolded and given a bag of tools and told to run through a large field. So there you are, living your life and running through the field. However, unknown to you, there are large holes in this field and sooner or later you fall in. Now remember you were blindfolded so you didn’t fall in on purpose; it is not your fault that you fell in. You are not responsible for being in the hole. You want to get out, so you open your bag of tools and find that the only tool is a shovel. So you begin to dig. And you dig. But digging is the thing that makes holes. So you try other things, like figuring out exactly how you fell in the hole, but that doesn’t help you get out. Even if you knew every step that you took to get into the hole, it would not help you to get out. So you dig differently. You, dig fast, you dig slow. You take big scoops, and you take little scoops. And, you’re still not out. Finally, you think you need to get a “really great shovel,” and that is why you are here to see me. Maybe I have a gold-plated shovel. But I don’t, and even if I did, I wouldn’t give it to you. Shovels don’t get people out of holes—they make them.”

**CLIENT:** “So what is the solution? Why should I even come here?”

**THERAPIST:** I don’t know, but it is not to help you dig your way out. Perhaps we should start with what your experience tells you. That what you have been doing hasn’t been working. And what I am going to ask you to consider is that it can’t work. Until you open up to that, you will never let go of the shovel because as far as you know, it’s the only thing you’ve got. But until you let go of it, you have no room for anything else.

As a therapist working with trauma survivors, it is very important when working on this goal to take extra care that the client does not feel blamed. When clients are told that they are responsible for their “digging,” it can easily be misunderstood as blame. It will be important to acknowledge that it is not the client’s fault that she fell into the hole and that given this circumstance she is responding in the only way she knows how. Responsibility is couched as the “ability-to-respond,” thus opening up opportunities to do things differently. In addition, the therapist should always operate from a place of compassion for clients’ situations and the struggles they have been engaging in their lives. At this early point in therapy, it also helps to note to the trauma survivor that it is the agenda that is not working, the client herself and her life is open to all possibilities based on what is actually done from here. This may take some special emphasis in the case of client’s who have been diagnosed with chronic PTSD. They will often evaluate themselves as hopeless in the lay sense of that term and do not yet have the tools to turn this experience into a support for positive action. Understanding this perspective comes later in the therapy. At times, when it seems relevant to the situation, we will say that we do have hope for the possibility of a better life – thus paradoxically the actual emotion most commonly felt in this phase of therapy is relief and hope.

*Control of private events as the problem* (Hayes et al., 1999) is the second goal of ACT therapy. Emotional and cognitive control are explored as barriers to successful solutions to clients’ problems in living; that is, conscious, purposeful efforts to get rid of, escape, or avoid negative thoughts and feelings actually may be preventing clients from behaving in ways that are consistent with what they value, and may be exacerbating the very events they are trying to control. If a trauma survivor is trying to escape something, a specific memory, perhaps, then (1) that is what the client is doing rather than some other, more productive form of action; and they

have the added problem that (2) the memories are likely to increase in frequency and negative impact.

In this stage of therapy the focus is on how efforts to control may not only prove ineffective, but that these very efforts may lead to increased difficulty. One of the metaphors that points to this issue is as follows:

Therapist: Are you familiar with the Chinese Finger Trap? This toy is a tube generally made of straw. You place your two index fingers in the tube and then try to pull them out. What happens is that the more you pull the tighter the straw tube clamps down on your fingers. Making it virtually impossible to escape the trap, and the more effort you put into escaping the more uncomfortable you feel – the more trapped you become. Trying to escape negative emotional experience can work like a Chinese Finger Trap. The harder you try not to have the emotions, the more the emotions “clamp” down on you. Examples of this kind of problem include excessive drinking to escape anxiety. Now you not only have the problem of anxiety, but you also have the problem of excessive drinking and all that that brings with it.

One important note here is that many trauma survivors are triggered by issues related to control and much of what they are trying to do is get back in control of their disrupted or chaotic lives. Many traumas occur under circumstances of loss of a personal sense of control. Therapists will hear clients report that they “just want to get their lives back.” An important message to be delivered that is consistent with ACT theory is that you are not asking the client’s to give up control as it is viewed culturally, but rather, you are asking them to give up control of internal experience so that they can get in control of their lives.

*Distinguishing “I” as content from “I” as context* is the third goal (Hayes et al., 1999). In

this phase of therapy, the goal is to create a place in which clients can come to see themselves as context rather than content and to defuse from the literal content of self-talk. It is from the position of “I” that clients, and all of us, struggle; that is, it is as if the words that a person says and the actual person become fused. For example, when thinking “I am bad,” from the position of self-as-content, then that statement seems to become what one literally is, rather than just a thought about what one is. From this position, the client has to fight to not be “bad.” Now, suppose that “I am bad” could be viewed as just a thought and the client did not have to adhere to the construction, but rather could deliteralize or become “de-fused” from the thought. In the ACT approach, this defusion is only likely from an experiential perspective in which “I” equates with an ongoing awareness. Much like a walking meditation, ACT attempts to establish a place from which abandonment of control is not threatening, because the private events are mere content, not “who you are.”

There are three aspects of the self that are important to this issue and that can be addressed in ACT sessions. First, the conceptualized self, which is created by our ability to interact verbally with ourselves and others. We can categorize, evaluate, explain, rationalize, and so on. This is what might be called, “self-as-content”; a conceptualized self that we create verbally to make sense of ourselves, our history, and our behavior. A problematic issue occurs in this area when one holds the content of this conceptualized self to be literally true. If a person makes the comment, “I am messed up because I was abused as a child,” the problem to be solved becomes unworkable because no other childhood will occur. Therefore, acceptance of the conceptualized self held literally is not desirable.

The second self is the self as a process of knowing. We know about ourselves and can respond to others about our feelings and reactions. This knowing is valuable in terms of

socialization and civilization. Through a process of training, we can report when we are hungry or when we are in pain, and so on. We can categorize our own and others' behavior based on this process. When a person's training history needed to gain this kind of knowledge is deviant, then that person may not know how to behave with respect to the social environment. For instance, suppose a young boy is sexually abused and his reactions to the abuse are ignored, denied, or reinterpreted. This type of developmental history could set the stage for a person to be unable to know or report to others accurately what he or she is feeling. One can imagine other histories where the process of accurately being able to describe your feelings or to express them appropriately is inhibited. Given this, ACT seeks to reorient the client to a process of knowing that includes both historical and current experience. One can observe oneself or see oneself as a process of ongoing behavior. Helping the client to identify current emotion and thought states is helpful in the goal of mindfulness and acceptance.

The third sense of self is self-as-context. This is the self in which "I" is the place from which one responds verbally. It is the sense of one's own perspective or point of view. This self is consistent and is present at all times. If we ask you questions about yourself, you *always* answer from your perspective. The content of your answers will change; however, the context from which you answer does not.

It is not too difficult to help clients experience this sense of connection to self-as-context. Localizing past memories and events, and current situations easily puts the client in contact with this sense of "I." The only reasonable thing to do is to engage self-as-context, since much verbal behavior is based upon it and we cannot function effectively as nonverbal organisms. It is also this form of self that allows other forms of acceptance. If self-as-context is always present, other kinds of content may come and go, and a stable sense of "I" will remain. Therefore, one may

experience pain or horrible memories, but that does not make one literally those things. They too shall pass and new content will be present, but the sense of “I” will remain unchanged.

In the ACT approach, many techniques are then used to deliteralize language and establish self-as-context. These include (1) imagery exercises in which thoughts are allowed to flow as leaves on streams, without being bought, believed, adopted or rejected; (2) repeating thoughts rapidly for dozens or hundreds of times; the word loses its meaning and allows the client to see it for what it is— a sound or thought; (3) use of imagery exercises that turn emotions and thoughts into objects to be viewed and inspected; private experiences are given shapes, sizes, colors, and so on; (4) metaphor is also used extensively. An example of a useful metaphor is the Chessboard (adapted from Hayes, et al.):

Imagine a chessboard that goes out infinitely in all directions. It’s covered with black pieces and white pieces. They work together in teams, as in chess—the white pieces fight against the black pieces. You can think of your thoughts and feelings and beliefs as these pieces; they sort of hang out together in teams too. For example, “bad” feelings (like anxiety, depression and resentment) hang out with “bad” thoughts and “bad” memories. Same thing with “good” ones. Now in the game of chess the goal is to win the war. So it seems that the thing to do is to defeat the team that you don’t like or want. So you get upon the pieces that are “good” -- and the battle begins. You work hard to kick the “bad” pieces off the board. But, there is a big problem here – huge pieces of yourself are your own enemy. And what you find as you engage the battle is that the pieces never leave the board, remember it stretches out infinitely in all directions. So you fight harder. And if you fight hard and long enough, that is what life becomes, a battle to not have what this game has to offer. You have the sense that you can’t win and you can’t stop fighting. If

you are at the piece level, this seems the only thing to do. However, there is another place to be in this game. Do you know what it is? Board level -- the board can hold the pieces and it doesn't have to be invested in the battle at all and notice that the board is not the pieces. You are not your content (1999, pp. 190-191).

*Self-as-context* can prove difficult for some clients . On the one hand, therapists may encounter clients who report that they have no sense of self. For instance, women who were sexually abused as children (often being revictimized) can have a difficult time locating the sense of self that experiences emotions and thoughts. That is, their sense of self has been so shattered by historical events that they glean who they are from others or have difficulty viewing themselves as separate entities. The therapist can work with these clients to re-establish that sense of self that is continuous and that can observe personal behavior including thoughts and feelings. The therapist can ask at relevant times “Who is saying this right now?” “Who is this person in the room talking with me? And can that person see that you are talking to me?” The therapist, then, begins to help the client reconnect to that observer self through gentle questioning. It is not too difficult to help clients experience this sense of connection to self-as-context. Localizing past memories and events, and current situations easily puts the client in contact with this sense of “I.” It is also this form of self that allows other forms of acceptance. The client may experience difficult memories or pain, but that does not make the client literally those things. They too shall pass and new content will be present, but, as noted, the sense of “I” will remain.

On the other hand, there are clients who are over-identified with their sense of self. For instance, many Vietnam veterans who have chronic PTSD strongly identify themselves as “Vietnam Veterans” along with all of the cultural characteristics that accompany that identity.

This identity is tightly held and seems to define the individual at nearly all levels of personal existence. Here the ACT therapist can work with the client on the conceptualized self or the “self-as-content.” Both self-as-context and deliteralization techniques are useful when addressing this issue.

*Letting go of the struggle* is the fourth goal of ACT (Hayes et al., 1999). The goal in this stage of therapy is to encourage the client to let go of the agenda of control. This is a willingness move; that is, the client is asked to be willing to have whatever thoughts, feelings, memories, or bodily sensations that might show up without having to gain control over them, but simply experience them for what they are. Private events are brought into the therapy room and dissembled into component pieces (thoughts, memories, feelings, etc.). The goal is not to gain control, but to experience without attempts to escape or modify. Many “willingness exercises” are used at this point and generally include use of imagery and experiential exercises. When working with a trauma survivor in this phase, a great deal of emotional exposure is done.

The fifth goal of ACT is *making a commitment to valued action* and behavior change (Hayes et al., 1999). It is at this point in therapy that clients commit to actions that are specific to their chosen values and goals. Through the previous work, ACT establishes the ability to discriminate between unworkable solutions to a problem (i.e., control and avoidance of emotions, etc.) and workable solutions (e.g., commitments to behavior change). The client can begin to lead a valued life and choose directions that support that life. In this phase of therapy with a trauma survivor, the issues turn from making room for one’s own history to creating a valued life. For example, concrete steps to develop more productive relationships might be taken, while simultaneously watching to prevent needless struggles with private experiences that might arise.

### *Common Treatment Obstacles and Possible Solutions*

There are three areas in which therapists generally make mistakes when using acceptance-based approaches. First, and specifically with ACT therapy, it is very easy to get caught up in the content of what the client has to say, and therapy can be derailed when this happens. It is critical to maintain a focus on context. This can be done by asking the client to “notice” the content and the process on a frequent basis. The therapist should also take notice at those times, in the sense of being mindful of the ongoing process. This process helps create a sense of perspective on the content at issue.

A second issue that is particularly crucial in the treatment of trauma survivors pertains to nonacceptance–acceptance of history. We are not asking clients to accept what has happened to them in an overt behavioral sense. Rather, clients are being asked to embrace those aspects of themselves that they have been trying to cut off. It is not a move in which clients are asked to “like” their history, but a move to hold it for what it is—a memory or thought. That is, clients’ histories can inform them rather than “drive” them. Finally, as stated before, acceptance of private events does not mean acceptance of behavior. Behavior that is harmful or unhealthy is not the kind of acceptance we mean. This distinction should be made clear to the client.

Third, the role of responsibility in therapy with trauma survivors needs careful focus. As mentioned, it is important to couch responsibility as “ability-to-respond,” ability to take action. The therapist must be careful not to make the client feel blamed for the trauma when talking about responsibility. Furthermore, if the therapist is not operating from a place of compassion for the client’s dilemma, the client can be easily made to feel “wrong” about trying to control his or her private experience. From an ACT standpoint, “right” and “wrong” are also seen as content and not necessarily useful for progress. Essentially, there is only one way for the therapist to

participate honestly, and that is for the therapist to be experientially willing also.

### *Summary*

We cannot remove our private experiences or histories (Hayes, 1994). The difficult part about this reality is that some people have traumatic events that have occurred in their history, and these events may play a role in current situations. In addition, as a result of our ability to construct events verbally, we can compare ourselves to an ideal self and imagine that if our history had only been different, we might be able to become that ideal (Hayes, 1994). Under these conditions, trauma survivors will often imagine that if their history were different, or if they could change their attitude about their history, they would not currently be experiencing PTSD or trauma-related problems. However, history is additive, and we can only build it from where we are at the moment, and simply having positive psychological reactions to negative experiences does not mean that a difficult psychological history will be removed (Hayes, 1994). The solution is building a positive history from this moment forward, *with* all of our past experiences in tow. It is a willingness to have all aspects of the self, including the “good” and the “bad.” It is an acceptance of private events in conjunction with directed action. Under these conditions, the trauma survivor can begin to live a valued life with the history rather than living a life driven by the history.

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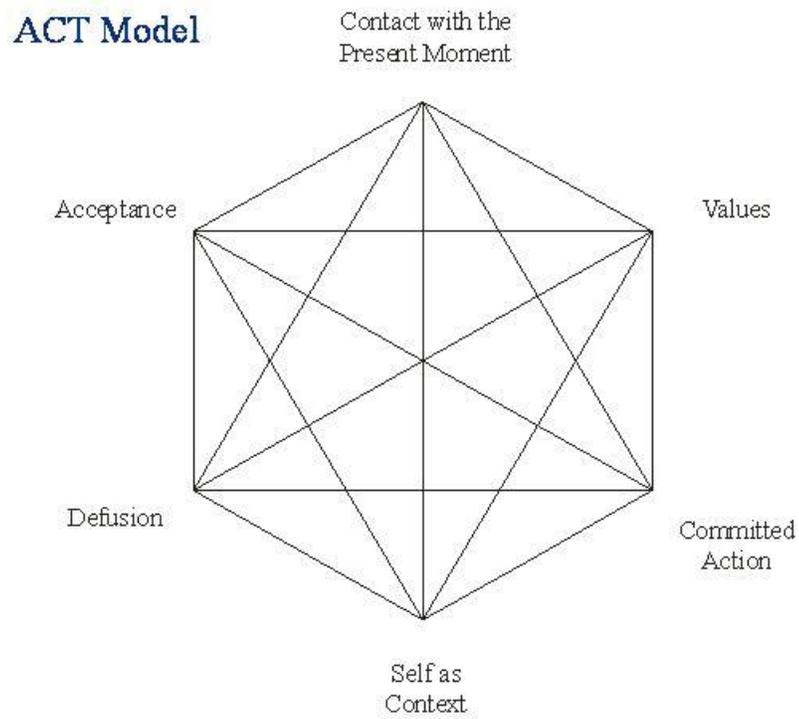
VALUES AND GOALS WORKSHEET

Instructions: Below is a list of life areas that most people have important goals and values in. That is, there is usually something important in these areas that most people are trying to achieve in their lives. Values are very subjective, and what may be important to you is not necessarily important to someone else. In each area, please write down the values that you have. Try to describe your values as if no one would ever read this worksheet. This is not a test to see if you have the "correct" values. Try to think in terms of both concrete goals and values that are important to you. We are not asking what you think you could realistically get, or what you or others think you deserve. We want to know what YOU care about, what you would want to work toward in your life.

How successful are you in living your values? Use the scale below and write down the number in the column provided.  
 Not at all successful= 1      Somewhat Successful = 2      Moderately Successful = 3      Successful = 4      Very Successful = 5

Values	Describe Your Personal Values Below	List Several Concrete Goals	Reasons that values are not being lived	Success
Relationships (intimate, marriage, couples, families)				
Friendships/Social Relations				
Employment/Education/ Training				
Recreation/Citizenship				
Spirituality				
Physical Well-being				

*Figure 1. Values and Goals Worksheet.*



*Figure 2.* The ACT Model: Hexaflex.

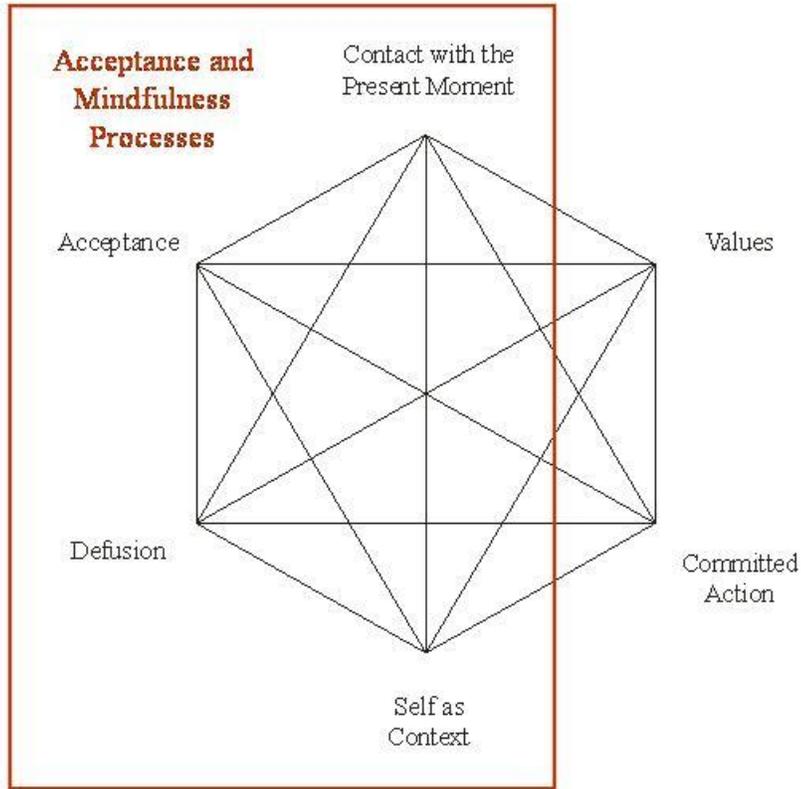


Figure 3. Acceptance and mindfulness processes of the ACT model.

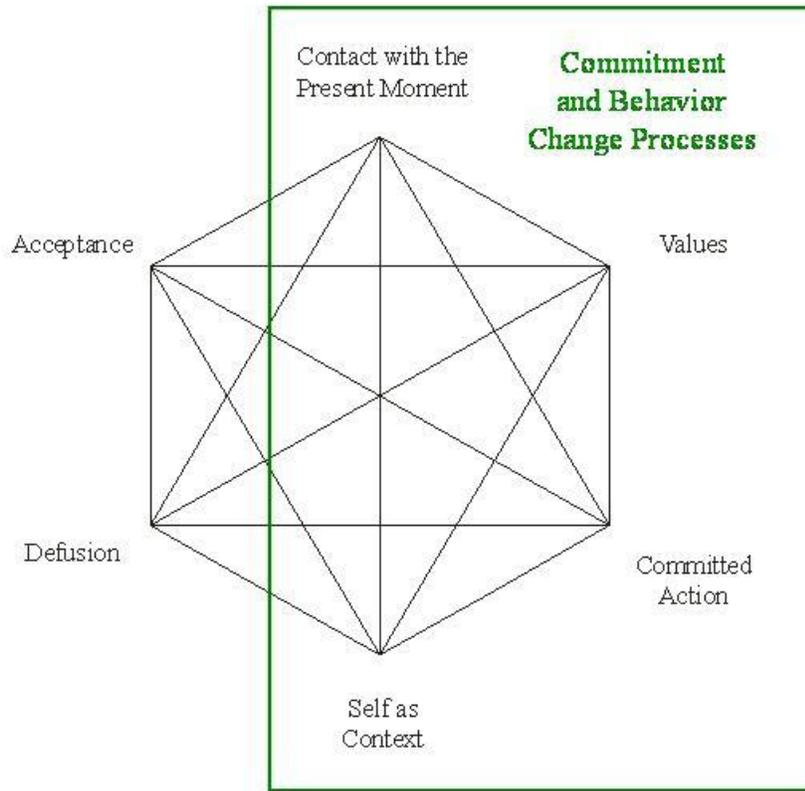


Figure 4. Commitment and behavior change processes of the ACT model.

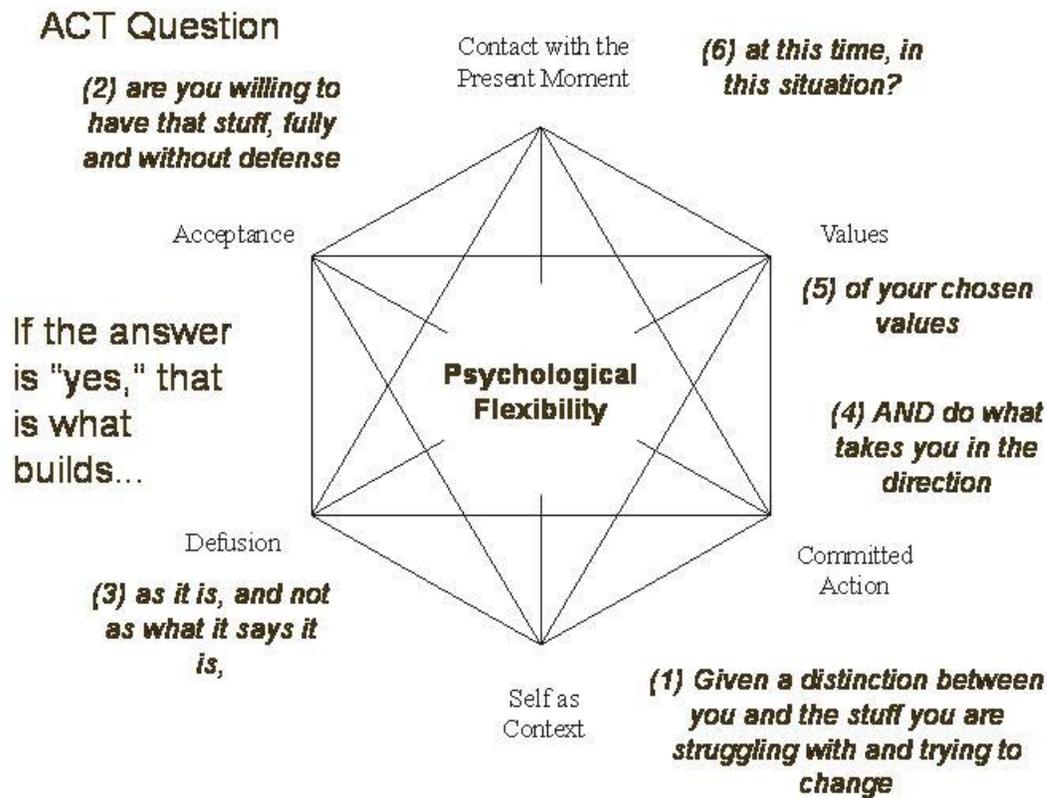


Figure 5. The “ACT Question” as it relates to the ACT model: (1) Given the distinction between you and the stuff you are struggling with and trying to change (2) are you willing to have that stuff, fully and without defense (3) as it is, and not as what it says it is, (4) AND do what takes you in the direction (5) of your chosen values (6) at this time, in this situation?