

TREATMENT OF CROHN'S DISEASE AND COMORBID MENTAL ILLNESS: A  
CLINICIAN MANUAL AND PATIENT WORKBOOK FOR USING ACCEPTANCE  
AND COMMITMENT THERAPY AS PART OF A CONTEXTUAL APPROACH

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY

OF

RUTGERS,

THE STATE UNIVERSITY OF NEW JERSEY

BY

ANGEL CHRISTINA MONTFORT  
IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE  
OF  
DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY

OCTOBER 2014

APPROVED:

\_\_\_\_\_  
Daniel Fishman, Ph.D.

\_\_\_\_\_  
Brenna Bry, Ph.D.

DEAN:

\_\_\_\_\_  
Stanley Messer, Ph.D.

# ACT FOR CROHN'S and MENTAL ILLNESS

Copyright 2014 by Angel C. Montfort

ABSTRACT

The purpose of this dissertation is to develop a clinician manual and patient workbook that will be effective in treating Crohn's disease and comorbid mental illness(s). The model for this treatment program is an existing treatment program that used Acceptance and Commitment Therapy with diabetes patients, producing symptom reduction and better use of coping skills (Gregg et al., 2007). Irritable Bowel Disease and Irritable Bowel Syndrome are defined, and a distinction is made to provide a rationale for the impetus to use acceptance-based strategies. Patients will receive treatment in both group and individual session modalities. Due to the amount of stigma surrounding the disease, an individual psychotherapy component is included to provide a space for more comfortable disclosure as patients begin to develop trust in the group. Patients suffering with Crohn's disease experience depression and anxiety quite often. For this reason, an argument is made that in addition to medical management of the disease, a psychological component is necessary to provide an optimal contextual treatment. The treatment protocol will include regular monitoring of patient physical and mental symptoms as well as step-by-step session modules for group and individual sessions. Strengths and limitations of the manual, in addition to suggestions for future directions of research are discussed.

*Keywords:* Crohn's disease, acceptance, commitment, treatment

## ACKNOWLEDGMENTS

When I chose to create a dissertation geared toward patients with Crohn's disease, I knew that it would be a very personal and very rewarding undertaking. I want to thank my loving family, loyal friends and supportive committee for helping me to achieve this milestone of my graduate school career.

Thank you mom for your countless visits to cook meals, wash clothes and play with the kids. You and dad provided me with a strong foundation and an even stronger faith; which helped me to believe in my own capabilities. Aunt Kathy, thank you for the thoughtful "you did it!" cards that you sent before I was even finished with this paper; your certainty of my success motivated me to do my very best. Aunt Gayle, thank you for your prayers; we know what happens whenever two agree. Uncle Donald, thank you for reading my first draft and for *showing* me how to persevere through adversity to attain a doctoral degree. Uncle James and Aunt Ann, thank you for sending me 'a little something' every month; it meant a lot to us. Uncle Roy, thanks for taking one (huge) thing off of my plate by doing my taxes each year. Thanks so much to all of my aunts, uncles and cousins who have offered support in various ways. Thank you to my line-sisters for your encouraging calls, texts, emails and for the tough love "JUST GET IT DONE!" that I needed when I began to put the pro in procrastination.

I especially want to thank my husband for keeping me grounded in love, and for being my very best friend. Your unwavering support allowed me to work into the night and to take time to relax when I became overwhelmed. To my daughters Diana and Maya, thank you for bringing me life and joy every single day. Your presence was a

## ACT FOR CROHN'S and MENTAL ILLNESS

welcome reminder of my own values and my commitment to living in a way that is consistent with them.

I would like to extend my heartfelt gratitude to Dan Fishman for teaching me since my first year at GSAPP and for taking the time to help me develop this paper from a sparkle in my eye during his Systems class into a dissertation. Your feedback was always thoughtful and pragmatic in a way that brought clarity to areas of uncertainty. Thank you for your patience and understanding. I would also like to thank Brenna Bry for lending such practical assistance with the development of this treatment model and for helping me to scale it back when my ideas started to get global.

I wish to acknowledge and thank my GSAPP family as well. To my advisor, Monica Indart, thank you for being a teacher, mentor and friend. You have taught me immeasurably about the kind of psychologist I aspire to be. To my professors and supervisors, thank you for creating environments in which theory and practice came together seamlessly. The lessons I have learned from you will stay with me always. To Sylvia, thank you for easing my anxiety by replying to my frantic emails right away and for always having an answer to my endless supply of questions.

This dissertation could not have been composed as it is without the help of Steven C. Hayes. Despite his countless number of commitments as a professor, author, clinician and developer of ACT, Dr. Hayes was willing and even enthused, to grant me permission to adapt some of the material from his self-help workbook. I would like to extend thanks for your contribution to my dissertation and to the field of psychology.

Finally I am thankful for the insight gained from my own journey of living with Crohn's disease. It allowed me to connect to the material in a way that fueled a desire to

## ACT FOR CROHN'S and MENTAL ILLNESS

make a meaningful contribution to the resources available to Crohn's patients. There were times that I didn't think I was physically able to finish this dissertation, but the principles I was typing actually worked! I was reminded to stay the course and strive to live a life centered on values such as perseverance, integrity, education, compassion and strength. I have grown professionally and personally as a result of this process, and I am so very grateful for that.

TABLE OF CONTENTS

	PAGE
ABSTRACT.....	ii
ACKNOWLEDGEMENTS .....	iii
CHAPTER	
I.    INTRODUCTION .....	1
Crohn’s Disease Defined .....	1
Comorbidity with Mental Health .....	2
History of IBD/IBS Treatments .....	5
Rationale for Contextual Treatment Model .....	8
II.   METHODOLOGY .....	14
Procedures .....	14
Overview of Modules .....	16
III.  DISCUSSION .....	18
Barriers to Treatment Model.....	18
Advantages of Treatment Model .....	20
Directions for Future Research .....	21
REFERENCES .....	26
APPENDIX A: Clinician Manual .....	36
Overview .....	36
Comorbidity with Mental Health .....	37
Rationale for Treatment Model.....	39

## ACT FOR CROHN’S and MENTAL ILLNESS

Why Group <i>and</i> Individual Therapy? .....	41
Characteristics of Group Leaders.....	42
Considerations Before Beginning .....	43
Treatment Schedule .....	45
Module 1 .....	46
Module 2 .....	81
Module 3 .....	117
Module 4 .....	130
Appendices.....	148
APPENDIX B: Patient Workbook.....	160
Overview .....	160
Module 1 .....	162
Module 2 .....	194
Module 3 .....	230
Module 4 .....	243
Appendices.....	260



## **Chapter 1**

### **Introduction**

#### **Crohn's Disease Defined**

Although there was once a limited amount of information on functional gastrointestinal disorders, much more research and knowledge about Irritable Bowel Disease (IBD) and Irritable Bowel Syndrome (IBS) are becoming available to the medical community and to the consuming public. IBD is a category of gastrointestinal diseases and consists of Crohn's disease and ulcerative colitis while IBS is a more general term describing a host of difficulties with one's bowels (Hanauer, 2006). Crohn's Disease is a gastrointestinal disease that occurs when there is chronic relapsing inflammation of the intestinal mucosa (Hanauer, 2006). Symptoms of Crohn's Disease include intense abdominal pain, bloody stool, persistent or recurrent diarrhea, vomiting, low-grade fever, reduced appetite, malnutrition, and weight loss. It is the frequent combination of these incurable symptoms and co-morbid mental illness (most commonly depression and anxiety) that form the need to create a contextual model for treating the psychological complications inherent in having Crohn's disease. Although it is hypothesized that this model would also be beneficial to patients with ulcerative colitis, this paper specifically focuses on those with Crohn's disease as it has less treatment options available and thus it presents with its own unique challenges for patients. Below a rationale is presented for why a contextual model including individual acceptance-based therapy sessions supplemented with group therapy sessions (including a medical management component) would prove to be beneficial in increasing the quality of life experienced by patients with Crohn's disease.

Complications of Crohn's disease include abscesses, ulcers, intestinal blockages, fistulas and a whole host of unpleasant disturbances. Crohn's disease can manifest in parts of the body from the mouth to the anus; it can affect the joints, eyes, skin, and liver although it frequently primarily affects the end of the small intestine and the beginning of the large intestine. This disease is diagnosable by several ways such as stool tests, blood tests, and colonoscopies (tests done under anesthesia in which the patient's intestine is viewed with a scope). Crohn's disease is marked by an abnormal response of the body's immune system in which the immune system attacks the gastrointestinal tract (Loftus, 2004). Crohn's disease patients also have an increased risk of developing colon cancer and this risk increases with length of active inflammation (Loftus, 2004). There is no cure for Crohn's; it requires a lifetime of care with treatment options that are limited to either managing symptoms through pharmaceuticals and/or surgery, or maintaining remission. Patients are commonly prescribed immunosuppressive agents, biologics or steroids to reduce inflammation; however if these do not prove to be effective, many patients undergo surgery to remove the inflamed portion (Ghosh & Mitchell, 2007). As many as 60-70% of patients with Crohn's Disease will require surgery at some point during their lives, and many of those will go on to require repeat surgeries (Loftus, 2004).

### **Co-morbidity with Mental Health**

Several studies have come to the conclusion that quality of life deficits are associated with IBD and IBS (De Rooy, 2001, Drossman et al. 1991, Dudley-Brown, 2002, Ghosh & Mitchell, 2007). Concerns about factors such as loss of bowel control, producing unpleasant odors, feeling dirty or smelly, and issues with sexual intimacy have been identified through patient surveys (De Rooy et al., 2001). Patients' self-esteem can

be affected, and obsessional traits can develop in relation to fecal incontinence and a preoccupation with having close access to a toilet (Levenstein, 2002). The aforementioned symptoms can have substantial psychological and social implications, causing patients to alter their lifestyles in order to accommodate those symptoms. In a study done by Ghosh and Mitchell (2007), responses were analyzed from surveys of patients who met a definitive diagnosis of either ulcerative colitis or Crohn's disease. These surveys contained information about the demographics of the patients, the history of their disease, their experience of the disease and the impact of their disease on their quality of life, which was measured in terms of ability to enjoy leisure activities, the need for surgery, and worries about performance at work. Seventy-five percent of patients reported that their symptoms affected their ability to enjoy leisure activities. A significant percentage of respondents experienced periods of exacerbated symptoms called "flare-ups" at least every few months (Ghosh & Mitchell, 2007). It has been suggested that the two most significant interventions to dramatically improve quality of life are patient education and appropriate treatment of concurrent depression and anxiety (Husain et al., 2004, as cited in Ghosh & Mitchell, 2007). Patient education referred to the nature of conversations between patients and their physicians. It was suggested that these conversations should include an assessment of the patient's quality of life and an explanation of new treatment options that are available to the patient (Ghosh & Mitchell, 2007).

In a study done by Voth and Sirois (2009), findings indicated that self-blame led to increased avoidant coping which led to poor adjustment while a sense of responsibility was associated with better use of coping skills and better psychological functioning in

IBD patients. Self-blame was defined as the belief that one has in some way intentionally brought about negative outcomes; this is negatively associated with acceptance and a sense of control. Conversely, accepting responsibility for one's health by attributing the source of the blame to their own behavior was associated with patient's ability to use more adaptive coping skills and to be more able to accept the limitations and difficulties inherent in IBD (Voth & Sirois, 2009). Accepting responsibility has been found to be associated with an increased perception of self-control (Wortman, 1975, as cited in Voth & Sirois, 2009). Higher levels of disease severity were linked to the use of avoidant coping strategies such as behavioral and mental disengagement, substance use and abuse, and denial. These behaviors were linked to poor psychological adjustment (Voth & Sirois, 2009).

Patients with IBD have commonly reported distress, anxiety, depression, social isolation, and poor quality of life (Dudley-Brown, 2002). Drossman et al. (1991) found that the impact of IBD was positively associated with greater psychological distress. In this study, patients with IBD were given a disease-specific 25-item survey to measure perceived health status with items geared toward patient concerns regarding the ability to achieve their full potential, being attractive, dying early, loss of sexual drive, being treated as different, being able to have children etc. The impact of the disease was positively associated with poorer psychological functioning and poorer well-being. Several specific domains such as concerns about sexual intimacy related to poorer psychological functioning. Patients suffering with IBD also reported high levels of concern related to developing cancer, feeling of being burdensome to others, body-image issues, and effects of treatments.

**History of IBD/IBS Treatments**

Previous studies of group therapy for IBS have shown that cognitive-behavioral group treatment increases patient use of successful coping strategies and decreases avoidance behavior (Van Dulmen et al., 1996). In this study, patients with IBS were randomly assigned to either a treatment group which participated in eight group sessions over the course of 3 months, each lasting for two hours, or a waiting list control group. These patients were then followed up over a range of 6 months to 4 years upon which gains of decreased abdominal pains, increased successful coping skills, and decreased avoidance behaviors persisted. The treatment group consisted of 25 IBS patients, male and female, with a mean age of 44. Sessions were led by a professional psychologist and a junior psychologist and were based on principles of cognitive behavior therapy. Treatment consisted of: patient education about the relationship of thoughts, feelings, and behaviors as it relates to abdominal concerns; cognitive restructuring; homework (completion of a diary measuring abdominal complaints); group conversation regarding the homework and mutual experiences of problems; training in progressive muscle relaxation; outcome measures to assess abdominal discomfort, psychological distress, avoidant behaviors, and coping strategies (Van Dulmen et al., 1996).

Payne and Blanchard (1995) found that individual cognitive therapy focusing on increasing patients' awareness of the association between stressors and IBS symptoms, modification of cognitive appraisals and behaviors, and changing underlying life scripts yielded significant reductions in gastrointestinal and psychological symptoms. When compared with a self-help group and a symptom-monitoring waiting-list control group, cognitive therapy showed greater reductions in symptoms and improvement on measures

of depression and anxiety (Payne & Blanchard, 1995). In a meta-analysis of psychological treatments for IBS, it was concluded that various psychological treatments such as cognitive behavioral therapy, behavioral psychotherapy, hypnotherapy and biofeedback are effective in reducing symptoms (Lackner et al., 2004).

Previous studies of psychological treatment for IBD have also shown promising gains. A study using individual manualized cognitive-behavioral therapy sessions with adolescent IBD patients found significant reductions in depression symptoms and a perception of improvement of general health even though illness severity remained constant (Szigethy et al., 2004, 2007). Participants were screened in conjunction with patient's medical appointments and sessions were even coordinated around patient's physician visits. Participants completed nine modules of the Primary and Secondary Control Enhancement Therapy-Physical Illness (PASCET-PI) over the course of 9 to 11 sessions. These modules contained interventions to target depression, teach social skills, teach relaxation skills and guided imagery, and to find behavioral moderators to improve medication adherence.

Psychological interventions geared toward Crohn's disease have also been found to decrease patients' need for healthcare utilizations (Deter et al., 2007). In a randomized control trial conducted with Crohn's disease patients between the ages of 18 and 55, patients were assigned to either a treatment group consisting of short-term psychodynamic psychotherapy sessions, relaxation training and glucocorticoid treatment or a control group consisting of glucocorticoid treatment only (Deter et al., 2007). Results indicated significant decreases in the amount of days spent in the hospital and of sick-leave days used in the treatment group as compared to the control group. Interestingly,

this study did not support a significant psychological improvement following the delivery of short-term psychodynamic therapy and relaxation training (Deter et al., 2007).

Another randomized controlled trial compared the effectiveness of a behavioral treatment condition that consisted of IBD education, progressive muscle relaxation, thermal biofeedback, and cognitive coping strategies training to a symptom-monitoring control condition (Schwarz & Blanchard, 1991). Subjects in both conditions met criteria for diagnosis of Crohn's disease (CD) or ulcerative colitis (UC) and had contacted the investigator's center for stress and anxiety disorders for help with disease-specific stress reduction (Schwarz & Blanchard, 1991). All subjects were screened for psychiatric diagnoses and it was determined that they did not meet criteria for current major depressive episode, bipolar disorder or schizophrenia. Although both conditions demonstrated mean reductions of symptoms post-treatment, the symptom monitoring subjects in the control condition showed a significantly greater reduction of symptoms than those in the experimental condition. This finding suggests that symptom monitoring is quite a valuable treatment component. Following the completion of the treatment, participants in the initial control condition completed treatment and showed increases on all symptoms, suggesting a detrimental effect of treatment relative to symptom monitoring that may be specific to patients with ulcerative colitis (Schwarz & Blanchard, 1991). The authors hypothesized that these differences in treatment responses may have been due to inherent differences between CD and UC subjects within the two conditions. The CD subjects demonstrated higher levels of psychological distress and symptom severity than those with UC and tended to respond fairly well to treatment while those with UC reported increases in symptom levels on several symptoms. It is suggested that

in order to resolve this issue, a study should be replicated to include adequate subsamples of UC and CD in each condition (Schwarz & Blanchard, 1991).

### **Rationale for Contextual Treatment Model**

The rationale for providing a contextual treatment consisting of individual and group therapy sessions with a medical management component for Crohn's disease is pragmatic in nature. Participants in previous studies (Lackner et al., 2004; Payne & Blanchard, 1995; Van Dulmen et al., 1996) suffered with Irritable Bowel Syndrome, which has been shown to be quite different than Irritable Bowel Disease in severity, and so a higher intensity of intervention for IBD patients may be necessary. IBS and IBD share similar symptoms of abdominal pain and diarrhea; however, the symptoms of IBS result from signals from the brain to the intestines while the symptoms of IBD result from tissue damage (Lackner, 2007). It has been reported that IBS affects the muscle contractions of the colon and is less severe in nature than IBD (Loftus, 2004). Crohn's disease and ulcerative colitis, the two diseases that comprise the category of IBD, are also distinct in nature. Although Crohn's disease is considered an irritable bowel disease, it is a more severe illness that occurs when inflammation affects the lining of the intestines (Drossman, 1991). Crohn's disease differs from ulcerative colitis in that: it cannot be cured by surgery and invariably recurs after diseased segments are removed; there are less prolonged periods of remission; and it is more chronic in nature with an increased occurrence of complications (Drossman, 1991). It has been found that depression and anxiety were significantly more common following the diagnosis of Crohn's disease as compared to ulcerative colitis diagnosis suggesting that there is a higher level of psychological distress associated with Crohn's disease (Kurina et al., 2001). In the



aforementioned study conducted by Schwarz and Blanchard, it was suggested that patients' responses to treatment may vary depending on whether they are diagnosed with Crohn's disease or ulcerative colitis (1991).

Previous studies have focused on the effectiveness of CBT group therapy for alleviating abdominal complaints but the method proposed in this paper is one to examine the management of psychological distress (Van Dulmen et al., 1996). IBD has been shown to negatively affect psychological functioning (Drossman et al., 1991). Simply treating the depression and anxiety outside of the context of the disease will be insufficient. We know that individual therapy works in the treatment of IBS (Payne & Blanchard, 1995) and IBD (Schwarz & Blanchard, 1991; Szigethy et al., 2004, 2007); we know that group therapy works in the treatment of IBS (van Dulmen et al., 1996) so combining them into one treatment may incur even larger gains. Cognitive behavioral therapy with self-management and medical management has been found to be helpful in treating IBS (Lackner, 2007). Individual cognitive therapy has been shown to be more effective than self-help support groups and wait-list control in treating IBS (Payne & Blanchard, 1995). It has been suggested that psychological factors influence the expression of IBS symptoms and so it makes sense that psychological interventions have generally been found to be effective in reducing symptoms (Lackner et al., 2004). Given the psychological distress associated with a diagnosis of Crohn's disease, it is hypothesized that psychological interventions will be helpful with these patients as well.

Self-help/support groups have been shown to be a positive way to help patients cope with chronic diseases and to provide social support. Many self-help groups for patients with IBD exist; these groups are usually led by health professionals or group

members and are offered through hospitals or organizations such as the Crohn's and Colitis Foundation of American (CCFA) at no cost. Crohn's disease affects approximately 26 to 199 in 100,000 North Americans so it is conceivable that patients may experience feelings of isolation and feel as though they are alone in having this condition (Loftus, 2004). It is estimated that only 0.2% of the US population suffer with this disease so it is also conceivable that patients may have never met someone who has the same disease or who is comfortable sharing his or her diagnosis (Lakatos, 2006). A group component in which patients can engage with others who share similar difficulties inherent in living with Crohn's disease may serve to alleviate some of the feelings of isolation and/or shame.

Since the nature of IBD is biological, a therapy model emphasizing acceptance and value-based goal-reaching *and* medical management is necessary. Patients may feel helpless and embarrassed due to uncontrollable nature of symptoms and unpredictable stages of remission and relapse (Drossman et al., 1991). Acceptance and Commitment Therapy (ACT) is a model that teaches patients to accept those feelings and to be mindful of the process of thinking while linking that acceptance to goal-based action (Hayes et al., 1999). Although cognitive behavioral therapy has proven to be effective in the management of chronic illnesses, it targets patients' thoughts as irrational distortions that need to be challenged with the goal of distress reduction or elimination. However, it has been argued that patients suffering with chronic diseases may not be able to realistically eliminate distress since they are continually reminded of inherently distressing aspects of their medical condition (Gregg et al., 2007). ACT operates on the principle that improved physical and emotional functioning can occur when behavior is less influenced by the

struggle to think the 'right thing' or feel good, and becomes more guided by values related to one's direct experience (Vowles & McCracken, 2008).

ACT has been found to be effective in the treatment of a wide range of psychological and medical problems including anxiety, depression, serious mental illness, posttraumatic stress disorder, substance abuse, epilepsy, chronic pain, stress, diabetes and general health issues (Hayes & Strosahl, 2004). In a pilot study done by Lundgren et al. (2006), the combination of ACT individual and group sessions with anticonvulsant drugs yielded significant improvements in quality of life and seizure index for the treatment of drug refractory seizures in epileptic patients when compared with supportive therapy and anticonvulsant drugs. Acceptance-based coping has been shown to be associated with improved health outcomes for medical patients with various chronic conditions (deRidder & Schreurs, 2001). ACT has also been effective in the treatment of diabetes; with patients experiencing improvements in practicing better diabetes self-care, increased levels of diabetes-related acceptance following an ACT workshop in which they were taught to apply acceptance and mindfulness skills to disease-related thoughts and feelings (Gregg et al., 2007). These gains were found to mediate improvement in blood glucose levels (Gregg et al., 2007). Vowles and McCracken (2008) discovered significant improvements in the areas of pain, depression, pain-related anxiety, disability, medical visits, work status and physical performance in chronic pain patients following the use of ACT within an interdisciplinary treatment program. Improvement in the processes of acceptance of pain and value-based action were associated with improvements in social, emotional and physical functioning (Vowles & McCracken, 2008).

An Acceptance and Commitment Therapy in Health Care Settings (ACT-HC) model has been proposed to focus specifically on the nuances of utilizing ACT in medical settings with a goal of helping medical patients “accept the presence of physical symptoms, as well as thoughts, feelings and memories that accompany them, and shift their attention to positive health behaviors” (Robinson and Hayes, 1997; Robinson et.al, 2004, p 301). The field of mental health is increasingly becoming linked to that of primary care in that psychologists are consulting to/with primary care physicians (PCPs) to provide comprehensive treatment as a part of a biopsychosocial model (Johnson, 2013). It is crucial that patients’ medical illnesses are not treated as isolated conditions. As the role of behavior in disease management has progressively become more obvious, the field of psychology and the field of medicine have made great strides toward the integration of these disciplines (Johnson, 2013). In light of the fact that chronic disease has become the leading causes of death in the US (Hoyert & Xu, 2012, as cited in Johnson, 2013), and that behavior is a substantial component of disease management (Johnson, 2013), a model addressing the psychological impact of symptoms and value-driven behavior presents a practical option for patients and healthcare providers (Johnson, 2013).

As hospitals and medical centers move toward a biopsychosocial model in which patient-centered integrated care is preferred (Johnson, 2013) a treatment model such as this would be of ideal use within an interdisciplinary team. Within such a team, a patient’s psychologist could easily collaborate with his or her gastroenterologist to obtain a richer understanding of the patient’s experience and to share knowledge of their own disciplines with each other to provide an increased quality of care.

Proper patient education and medical compliance have been shown to significantly improve patients' on quality of life (Husain et al., 2004), therefore attention must be given to the physiological aspects of Crohn's Disease. The medical management component would consist of symptom monitoring and receiving education on effective communication with one's physician regarding quality of life and treatment options.

These findings regarding the illness-severity of Crohn's disease, the co-morbidity of Crohn's disease and mental illness, the effectiveness of psychological treatments for IBD, and the effectiveness of acceptance and commitment therapy for chronic diseases combined with the fact that the psychosocial impact of this disease may be buffered by social support (Sewitch et al., 2001) suggest that a treatment model such as the one proposed here will be beneficial to patients. It is the author's hypothesis that combining individual ACT sessions with disease-specific group therapy sessions and proper medical management education will provide a useful component to a well-rounded treatment model that will be effective for management of the disease.

## **Chapter II**

### **Methodology**

This chapter delineates the methods that were used to create a Clinician Manual and Patient Workbook which provide step-by-step guidelines in how to conduct Acceptance and Commitment Therapy sessions (group and individual) with Crohn's patients suffering from comorbid mental illness. The literature review suggested the usefulness of acceptance-based techniques due to the chronic nature of the disease. This treatment resource is intended to function as part of a contextual model in which medical management and mental health management co-occur.

### **Procedures**

A thorough literature review was conducted to determine the need and rationale for a treatment model such as this for the given population. The author has designed an ACT treatment manual and patient workbook adapted from *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*; an existing ACT self-help workbook (Hayes & Smith, 2005). This proposed model consists of four modules to be used in a group and individual setting. Within each module, patients will learn ACT skills, record their gastrointestinal symptoms and participate in discourse with other group members. The clinician manual contains a tutorial of ACT techniques, step-by-step instructions for structuring each group session and guidelines for how to facilitate group cohesion. Since it is uncertain as to whether the group will be gender-specific, guidelines/prompts will address concerns that are primarily geared toward female and male patients. Additional adaptations are necessary to accommodate transgender individuals and individuals experiencing gender dysphoria at time of treatment; however

this level of adaptation would be better suited for future avenues of research. Previous studies have combined disease-specific education with symptom reporting and psychoeducational material to create workbooks that patients can use to facilitate treatment (Evertsz et al., 2012; Gregg et al., 2007; Schwarz & Blanchard, 1991; Szigethy et al., 2007; Van Dulmen et al., 1996). In addition to the psycho-education on incorporating ACT into patients' strategies for managing Crohn's disease and comorbid mental illness, patients will complete self-report measures weekly. Patients will complete a weekly symptom inventory to document GI symptoms (the Harvey-Bradshaw index) and weekly self-report measures (to assess for depression and anxiety (the Beck Depression Inventory-II and the Beck Anxiety Inventory) (Beck & Steer, 1993; Beck et al., 1996; Harvey & Bradshaw, 1980). Before the first session, the Rating Form of IBD Concerns (RFIPC) will be given to assess for the patient's experience of their GI symptoms as a way to inform both the group and individual therapists as to what topics may need to be presented as prompts (De Rooy, 2001, Drossman et al., 1991), the Harvey-Bradshaw Index to assess for symptom severity (Harvey & Bradshaw, 1980), the Beck Depression Inventory-II and the Beck Anxiety Inventory to establish baseline measures of depression and anxiety (Beck, 1996; Beck & Steer, 1993), and the Symptom Checklist-90 to assess for general psychological functioning (Derogatis, 1994). These questionnaires will also be administered at the conclusion of treatment to assess any change that may have occurred. Informed consent will be addressed, and an interview specifically concerning the patient's experience with CD was developed by the author and will be administered following completion of the aforementioned measures. In addition to the group modules in the clinician manual, individual sessions will also be

outlined to ensure uniformity amongst clinicians. Individual sessions will be offered to each patient once weekly; preferably following group session. Each individual session will initially adhere to the theme(s) from the group session for the week, with additional time to process patients' personal reflections and to discuss the application of ACT skills in his/her life.

### **Overview of Modules**

Module 1 will consist of an introduction of group members and group leader(s) as well as an overview of the introductory concepts of ACT. Group leaders will explain the basics of Crohn's Disease and will assess for the necessity of further detail. During this group session, experiential avoidance will be defined, and metaphors will be used to illustrate the ineffective nature of avoidance. Patients will be asked to identify their personal concerns in the form of an "I avoid..." exercise. A coping strategies homework activity will be assigned. In the individual session, patient and therapist will review the homework assignment, discuss patient's reactions to the group session and revisit patient's personal concerns shared in the group. Patient and therapist will complete a "Suffering Inventory" and will use this list to generate treatment goals. Therapist will introduce the concept of cognitive defusion. Patient and therapist will discuss "Diffusion Techniques" listed in the workbook and will apply these techniques to patient's negatively evaluated thoughts about living with Crohn's Disease.

Module 2 begins with an overview of mindfulness, which will be reinforced with an experiential exercise. The concepts of willingness and acceptance will be introduced and patients will be assigned the task of identifying areas of their lives in which avoidance must be replaced with acceptance. In the individual session, patient and



therapist will review the homework assignment, discuss patient's reactions to the group session and generate a list of scenarios in which patient can practice his or her newfound acceptance skills.

In the group session of module 3, the concept of values is explained and patients will be introduced to the "Ten Valued Domains." Patients will be given a "Choosing Your Values" homework assignment, which they will review in the subsequent individual session. Following review of this homework, patient and therapist will work together to complete a "Ranking Your Values" exercise.

In the group session of module 4, patients will share their ranked value lists and will learn about the distinction between values and goals. Patients will discuss the way in which goals are further broken down into actions and sub-actions. Patients will discuss potential barriers they may face on the road to valued-living. The group session will end with a homework assignment in which patients are asked to list their values, goals, actions, potential barriers and ACT strategies that will be helpful along the way. The final individual session will consist of post-treatment questionnaires, a review of the homework assignment and a conclusion discussion. Patient and therapist will process feelings related to termination, and patients will be provided with treatment resources.

## **Chapter III**

### **Discussion**

#### **Barriers To Treatment Model**

Crohn's patients have a medically diagnosable disease that may make it difficult to separate psychological functioning from physical functioning. The disease is characterized by periods of remission and flare-ups (Hanauer, 2006). It has been found that patients tend to drop in and out of treatment during these vacillating periods (Joachim, 1998). This is in keeping with the finding that depression and anxiety are primarily prominent during the periods of acute experiencing of IBD symptoms (Porcelli et al., 1996). Many patients may find the group support to be necessary only during periods of extreme illness (Joachim, 1998). To address this, a brief time limited treatment similar to that of a study by Payne and Blanchard (1995) in which eight sessions of individualized cognitive treatment was found to be more effective in reducing gastrointestinal symptoms and improving psychological symptoms of depression and anxiety than either self-help support groups or wait list control group is suggested. This way, patients can complete the treatment as a preventative measure or as an intervention during extreme periods of illness.

In the beginning stages of a support system intervention such as this, it is important to attend to certain pre-entry issues such as factors that have previously been problematic (Cherniss, 1976). Although support groups have been shown to be helpful for some, they have encountered substantial difficulties in retaining participation such as lack of time to devote to regular group meetings and the fact that participation varied depending on group members' level of symptom severity (Joachim, 1998). Joachim

(1998) noted that some of the patients in an IBD support group commented on the fact that they would have valued a group that was strictly supportive and that did not have an IBD education component due to the fact that they had been diagnosed for several years and felt that they did not need as much information. The presence of such difficulties suggests a need for professionally-led groups with considerations given to participants' age, gender, and length of time since diagnosis.

Not surprisingly, a great deal of stigma is inherent in having Crohn's disease so it may be difficult to find patients who are willing to disclose information about their experience with it. It was also found that hearing about the detail of others' struggles with the disease can "scare away" members (Joachim, 1998). It has been argued that managed care companies want to decrease utilization of mental health care (Levenstein, 2002); this serves as a potential barrier to receiving funding for a program that does not push for the use of pharmaceuticals and that will require several sessions. Since the proposed model will operate within a four-week span, patient dropout may occur due to practical concerns (ie, transportation issues, child care issues) and/or to patients' desire to avoid the emotional arousal that occurs during treatment.

The most prominent limitation is that this model has not yet been implemented with the intended patient population. While the provided rationale and interventions were informed by literature and relevant research, the effectiveness of the model is unknown. It is unclear whether or not the treatment model would demonstrate significant outcomes (improvement in quality of life and depression and anxiety measurement scores) in Crohn's patients suffering with psychological symptoms. Future research in this area is

necessary, and it is the author's hope that the existence of this manual and workbook will aid the process of conducting a pilot study (as described further below).

### **Advantages of Treatment Model**

A potential advantage of using a combination of individual and group sessions is that it may buffer the aforementioned effect of stigma on willingness of patients to participate in groups. If these subjects are aware that there is an individual component, they may feel more comfortable having an opportunity to disclose more personal details in a one-on-one situation. Another advantage is that using professional psychologists as providers of the therapy would allow specialized analysis of group process and psychological symptoms. It is desirable that professionals be involved in the operation of supportive groups (Levine et al., 2005). It has been suggested that those newly diagnosed may be more eager to gain info while those who have been diagnosed for several years may only yearn for the assurance that there are others struggling with the disease (Joachim, 1998). By recruiting participants from a restricted age group (college students), it is conceivable that the group members may be at similar points along this continuum. Prior screening to identify symptoms of depression and anxiety or elevated quality of life deficits would help to create compatible groups in which members feel that they have more in common than just the diagnosis; the lack of common experiences around quality of life, age, gender and onset of disease was found to be a factor in support group dissatisfaction (Joachim, 1998). In addition to the advantages mentioned above, group members will have the added benefit of learning what works and what does not work from listening to each other's stories (Joachim, 1998).

ACT has been found to lend itself well to interactive processes “especially experiential exercises, metaphors and debriefing discussions. Listening to others’ reactions is useful and reactions can converge or diverge, offering an opportunity for group members to receive support and validation, as well as alternative viewpoints from their peers” (Walser & Pistorello, 2004 p. 348). Several studies evaluating the use of ACT in a group format have been conducted and have generally been shown to be effective. In fact, ACT groups have been found to be effective in treating an impressive range of psychological and physiological problems such as anxiety, depression, trauma, coping with medical illness, epilepsy, smoking cessation, and many others (Walser & Pistorello, 2004). ACT groups have been used in treatments lasting several hours in duration (such as workshops or single sessions) to multiple sessions over the course of several weeks (Walser & Pistorello, 2004). Sometimes ACT concepts can be difficult to grasp so it can be helpful for group members to hear other ways of interpreting material/tasks. Seeing others engaged in exercises can encourage and move patients to engage as well. A group setting provides a social context for making public commitments to one’s values (Hayes et al., 1985, as cited in Walser & Pistorello, 2004).

### **Directions for Future Research**

It is the author’s proposal that a pilot study be conducted on the New Brunswick campus of Rutgers University in partnership with the Crohn’s and Colitis Center of New Jersey at Robert Wood Johnson University Hospital. The initial individual and group therapy sessions could be facilitated as part of a practicum externship at the Graduate School of Applied and Professional Psychology where doctoral level graduate students of clinical psychology would be trained to provide the therapy. This would also allow for

the groups to be offered at a discounted rate for participants. Undergraduate university students diagnosed with Crohn's disease would be recruited for participation in the treatment. These students would range in age from approximately 18 years to 22 years. Many previous studies have consisted of subjects of middle age or older. In a quality of life study done by Ghosh and Mitchell (2007), the modal age of Crohn's patients was 30-39; and in a study on group therapy for IBS, the mean age was 44 (van Dulmen et al., 1996). Since the peak age of onset of IBD is 15-30 years old and only about 10% of cases occur in those younger than 18, it provides a rationale for the treatment beginning during college years due to the fact that a large percentage of college-age individuals fall within the age of onset range (Hanauer, 2006). The impact of symptoms often forces patients back into a dependent role during a time that is characterized by a quest for autonomy (Levenstein, 2002). It was found that the increased psychological distress following diagnosis of Crohn's disease was strongest in the year following the initial diagnosis of Crohn's disease (Kurina et al., 2001). During the time shortly after diagnosis, patients often experience lots of uncertainty about symptoms, embarrassment, and uncertainty of existence of others with the diagnosis. In a support group within a hospital, some members cited their reason for dropping out as the fact that they did not need to know as much of the health education because they were diagnosed for 9 years or more (Joachim, 1998). Also adolescence is a time when sexual intimacy concerns are becoming more of an issue because increased freedom and autonomy from parents. During this time there are often concerns about sexual intimacy and body image (Erikson, 1968). Earlier interventions will perhaps decrease the severity of later psychological distress.

When recruiting subjects, it could be helpful for physicians to administer patient surveys that have been found to be helpful in identifying patient concern and impact of symptoms on quality of life (Drossman et al., 1991, Ghosh & Mitchell, 2007). Measures such as the Rating Form of IBD Concerns (RFIPC) have been found to be beneficial (De Rooy, 2001, Drossman et al., 1991) in gathering information on patients' experiences of IBD. The Inflammatory Bowel Disease Questionnaire (IBDQ) is a valid assessment tool to evaluate IBD-specific quality of life and to reflect important changes in patients' health statuses (Irvine, 1994). The Crohn's Disease Activity Index (Best, 1976) is another measure that has been widely used to assess symptoms of Crohn's Disease. A measure to assess for general quality of life such as the SF-36 (Medical Outcomes, 1988, 2002) would be necessary as a secondary outcome measure (Evertsz, 2012). A combination of measures of depression, anxiety and psychological functioning such as the Beck Depression Inventory-II (Beck et al., 1996), Beck Anxiety Inventory (Beck & Steer, 1993), Outcome Questionnaire 45 (Lambert et al., 1994) and Symptom Checklist 90 (Derogatis et al., 1976) would also be necessary to assess improvement in these areas. It would be beneficial to begin recruitment within a university-affiliated medical treatment facility specializing in IBD. This type of setting is ideal because it usually supports cutting edge research on IBD and has a large number of patients within the aforementioned age range, as proposed above. Another benefit to beginning the recruitment process with a gastroenterologist is to make a clear distinction between the diagnosis of Crohn's disease and other gastrointestinal disorders. Given the co-morbidity of mental illness and IBD, it would also be helpful for referrals to come from individual

psychotherapists who would inform their patients of the group as either a supplement to their current individual therapy or as a transfer treatment option.

Once subjects are recruited, therapy groups should be separated by sex to address the finding that a higher level of IBD concerns was associated with being female (Drossman et al., 1991) and the fact that many of the concerns related to body image and sexual intimacy may be more comfortably discussed in same-sex groups. Previous research suggests that it would be important to distinguish between self-blame and responsibility attributions as well as to give attention to modifying maladaptive coping strategies (Voth & Sirois, 2009). Pre- and post-treatment outcomes would need to be measured using scales such as the Symptom Checklist (SCL-90), a self-report measure of psychological functioning and symptoms, which has been used in previous studies with IBD patients (Derogatis, et al., 1976; Drossman et al., 1991), the Harvey-Bradshaw Index (Harvey & Bradshaw, 1980) and the Rating Form of IBD Concerns (RFIPC) have been found to be beneficial (De Rooy, 2001, Drossman et al., 1991).

From a postmodern constructivist approach, the patient's reality is constructed by a host of psychosocial factors, such as the experience of Crohn's disease. Part of the goal of therapy would be to help the patient to construe meaning from this and to use it in a way that fits into his or her personal narrative with a theme of positive coping. The initial "pilot-study" phase would be more focused on effectiveness and accessibility to patients. A mixed methods approach would be employed in which qualitative and quantitative data are obtained (Dattilio, Edwards, & Fishman, 2010). This could be attained by using patient questionnaires as outcome measures and analyzing content of responses as well as conducting initial and termination interviews with each participant as qualitative data. It



would also be beneficial to use the Reliable Change Index (Jacobson & Truax, 1991) to assess the statistical significance of change within each client. Future studies can then take that information and use it to conduct randomized controlled trials though the immediate issue at hand is how to best help patients with IBD, specifically Crohn's disease, to experience increased psychological functioning.

If the program is determined to be effective, it would be beneficial to train healthcare professionals at student health centers to make use of readily available campus resources. Following implementation of the treatment, significance testing of outcome measures should be done to determine whether this type of combined treatment works well compared with waitlist control before efficacy testing can occur.

### References

- Beck, A.T., & Steer, R.A. (1993). *Beck Anxiety Inventory manual*. San Antonio: Harcourt Brace and Company.
- Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Beck Depression Inventory-Second edition manual*. San Antonio: The Psychological Corporation.
- 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.
- Best, W.R., Bechtel, J.M., Singleton, J.W., & Kern, F.Jr. (1976). Development of a Crohn's disease activity index. National Cooperative Crohn's Disease Study. *Gastroenterology*, 70(3), 439-444.
- Cherniss, C. (1976). Preentry issues in consultation. *American Journal of Community Psychology* 4(1), 13-24.
- Cherniss, C. (1993). Pre-entry issues revisited. In R.T. Golembiewski (Ed.), *Handbook of Organizational Consultation* (pp.113-118). New York: Marcel Dekker.
- Crohn's and Colitis Foundation of America. (2014). *What is Crohn's Disease?* Retrieved from <http://www.ccfa.org/what-are-crohns-and-colitis/what-is-crohns-disease/>
- Dahl, J., Wilson, K.G., Luciano, C., and Hayes, S.C. (2005). *Acceptance and Commitment Therapy and Chronic Pain*. Reno, NV: Context Press.
- Dahl, J., Wilson, K.G., & Nilsson, A. (2004). Acceptance and Commitment Therapy and the treatment of persons at risk for long-term disability resulting from stress and pain symptoms: A preliminary randomized trial. *Behavior Therapy*, 35, 785-802.

- Dattilio, Edwards, & Fishman (2010). Case studies within a mixed methods paradigm: Towards a resolution of the alienation between researcher and practitioner in psychotherapy research, *Psychotherapy, Theory, Research, Practice, Training*, 47, 427-441.
- De Ridder, D. & Schreurs, K. (2001). Developing interventions for chronically ill patients: Is coping a helpful concept? *Clinical Psychology Review*, 21(2), 205-240.
- Derogatis, L.R. (1994). *Symptom Checklist-90-Revised: Administration, scoring and procedures manual, 3<sup>rd</sup> edition*. National Computer Systems, Inc., Minneapolis, MN 55440.
- De Rooy, E.C., Toner B.B., Maunder, R.G., Greenberg, G.R., Baron, D., Steinhart, A.H., McLeod, R., & Cohen, Z. (2001). Concerns of patients with inflammatory bowel disease: results from a clinical population. *American Journal of Gastroenterology*, 96, 1816-1821.
- Deter, H-C., Keller, W., von Wietersheim, J., Jantschek, G., Duchmann, R., Zeitz, M., & the German Study Group on Psychosocial Intervention in Crohn's Disease. (2007). Psychological treatment may reduce the need for healthcare in patients with Crohn's disease. *Inflammatory Bowel Diseases*, 13(6), 745-752.
- Dudley-Brown, S. (2002). Prevention of psychological distress in persons with inflammatory bowel disease. *Issues in Mental Health Nursing*, 23, 402-422.
- Drossman, D.A, Leserman, J., Li, Z., Mitchell, C.M, Zagami, E.A., & Patrick, D.L. (1991). The Rating Form of IBD Patient Concerns: A new measure of health status. *Psychosomatic Medicine*, 53, 701-712.

- Eifert, G. & Forsyth, J. (2005). *Acceptance and commitment therapy for anxiety disorders*. Oakland: New Harbinger Publications, Inc.
- Eifert, G.H., & Heffner, M. (2003). The effects of acceptance versus control contexts on avoidance of panic-related symptoms. *Journal of Behavior Therapy and Experimental Psychiatry*, 34, 293-312.
- Erikson, E.H. (1968). *Identity: Youth and crisis*. New York: Norton.
- Evertsz, F.B., Bockting, C.L.H., Stokkers, P.C.F., Hinnen, C., Sanderman, R., & Sprangers, M.A.G. (2012). The effectiveness of cognitive behavioral therapy on the quality of life of patients with inflammatory bowel disease: multi-center design and study protocol (KL!C-study). *BMC Psychiatry*, 12, 227-236.
- Feldner, M.T., Zvolensky, M.J., Eifert, G.H., & Spira, A.P. (2003). Emotional avoidance: An experimental test of individual differences and response suppression during biological challenge. *Behaviour Research and Therapy*, 41, 403-411.
- Ghosh, S., & Mitchell, R. (2007). Impact of inflammatory bowel disease on quality of life: Results of the European Federation of Crohn's and Ulcerative Colitis Associations (EFCCA) patient survey. *Journal of Crohn's and Colitis*, 1, 10-20.
- Gifford, E.V., Kohlenberg, B.S., Hayes, S.C., Antonuccio, D. O., Piasecki, M.M., Rasmussen-Hall, M.L. et al. (2004). Acceptance theory-based treatment for smoking cessation: An initial trial of Acceptance and Commitment Therapy. *Behavior Therapy*, 35, 689-705.
- Gregg, J.A., Callaghan, G.M., Hayes, S.C., & Glenn-Lawson, J.L. (2007). Improving diabetes self-management through acceptance, mindfulness, and values: A

- randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 75(2), 336-343.
- Hanauer, S.B. (2006). Inflammatory bowel disease: Epidemiology, pathogenesis, and therapeutic opportunities. *Inflammatory Bowel Disease*, 12 (Suppl 1), S3-9.
- Harvey, R.F., & Bradshaw, J.M. (1980). A simple index of Crohn's Disease activity. *Lancet*, 1(8167): 514.
- Hayes, S.C. (2007). *ACT in action*. Oakland, CA: New Harbinger Publications, Inc.
- Hayes, S.C., Barnes-Holmes, D., and Roche, B. (Eds.). (2001). *Relational Frame Theory: A Post-Skinnerian account of human language and cognition*. New York: Plenum.
- Hayes, S.C., Masuda, A., Bissett, R., Luoma, J., and Guerrero, L.F. (2004). DBT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy*, 35, 35-54.
- Hayes, S.C., & Smith, S. (2005). *Get out of your mind and into your life: The new Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications, Inc.
- Hayes, S.C., & Strosahl, K.D. (2004). *A practical guide to acceptance and commitment therapy*. New York: Springer Science+Business Media, Inc.
- Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.
- Hoyert, D.L., & Xu, J. (2012). Deaths: Preliminary data for 2011. *National Vital Statistics Reports*, 61(6). Retrieved from [http://www.cdc.gov/nchs/data/nvsr/nvsr61\\_06.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61_06.pdf).

- Husain, A., & Triadafilopoulos, G. (2004). Communicating with patients with inflammatory bowel disease. *Inflammatory Bowel Disease*, 10, 444-450.
- Irvine, E.J., Feagan, B., Rochon, J., Archambault, A., Fedorak, R.N., Groll, A., Kinnear, D., Saibil, F., & McDonald, J.W.D. (1994). Quality of life: a valid and reliable measure of therapeutic efficacy in the treatment of inflammatory bowel disease. Canadian Crohn's Relapse Prevention Trial. *Gastroenterology*, 106(2), 287-296.
- Joachim, G. (1998). The birth and dissolution of an inflammatory bowel disease support group: Lessons in providing support. *Gastroenterology Nursing*, 21(3), 119-124.
- Johnson, S.B. (2013). Increasing psychology's role in health research and health care. *American Psychologist*, 68(5), 311-321.
- Karekla, M., Forsyth, J.P., & Kelly, M.M. (2004). Emotion avoidance and panicogenic responding to a biological challenge procedure. *Behavior Therapy*, 35, 725-746.
- Krause, J. (1992). Spinal cord injury and its rehabilitation. *Current Opinion in Neurology and Neurosurgery*, 5, 669-672.
- Kurina, L.M, Goldacre, M.J., Yeates, D., & Gill, L.E. (2001). Depression and anxiety in people with inflammatory bowel disease. *Journal of Epidemiology and Community Health*, 55(10), 716-720.
- Lackner, J.M. (2007). *Controlling IBS the drug-free way: A 10-step plan for symptom relief*. New York: Stewart, Tabori, and Chang.
- Lackner, J.M., Morley, S., Dowzer, C., Mesmer, C., & Hamilton, S. (2004). Psychological treatments for irritable bowel syndrome: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*, 72(6), 1100-1113.

- Lambert, M. J., Lunnen, K., Umphress, V., Hansen, N. & Burlingame, G. M. (1994). *Administration and scoring manual for the Outcome Questionnaire (OQ-45.1)*. Salt Lake City: IHC Center for Behavioral Healthcare Efficacy.
- Levenstein, S. (2002). Psychosocial factors in peptic ulcer and inflammatory bowel disease. *Journal of Consulting and Clinical Psychology*, 70(3), 739-750.
- Levine, M., Perkins, D.D., & Perkins, D.V. (2005). *Principles of community psychology (Third edition)*. New York: Oxford University Press.
- Levitt, J.T., Brown, T.A., Orsillo, S.M., & Barlow, D. H. (2004). The effects of acceptance versus suppression of emotion on subjective and psychophysiological response to carbon dioxide challenge in patients with panic disorder. *Behavior Therapy*, 35, 747-766.
- Lipkens, G., Hayes, S.C., & Hayes, L.J. (1993). Longitudinal study of derived stimulus relations in an infant. *Journal of Experimental Child Psychology*, 56, 201-239.
- Loftus, E.V. (2004). Clinical epidemiology of inflammatory bowel disease: Incidence, prevalence, and environmental influences. *Gastroenterology*, 126(6), 1504-1517.
- Lundgren, T., Dahl, J., Melin, L., & Kies, B. (2006). Evaluation of Acceptance and Commitment Therapy for drug refractory epilepsy: A randomized controlled trial in South Africa—A pilot study. *Epilepsia*, 47(12), 2173-2179.
- Luoma, J.B., Hayes, S.C., and Walser, R.D. (2007). *Learning ACT: An Acceptance and Commitment Therapy skills-training manual for therapists*. Oakland, CA: New Harbinger Publications, Inc.
- McCracken, L.M., Vowles, K.E., & Eccleston, C. (2004). Acceptance of chronic pain: Component analysis and a revised assessment method. *Pain*, 107, 159-166.

- Melamed, S., Grosswasser, Z., & Stern, M. (1992). Acceptance of disability, work, involvement and subjective rehabilitation status of traumatic brain-injured (TBI) patients. *Brain Injury*, 6, 233-243.
- Mennin, D.S., Heimberg, R.G., Turk, C.L., & Fresco, D.M. (2002). Applying an emotion regulation framework to integrative approaches to generalized anxiety disorder. *Clinical Psychology: Science and Practice*, 9, 85-90.
- Nation, M., Crusto, C., Wandersman, A., Kumpfer, K.L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist*, 58(6-7), 449-456.
- Payne, A., & Blanchard, E.B. (1995). A controlled comparison of cognitive therapy and self-help support groups in the treatment of irritable bowel syndrome. *Journal of Consulting and Clinical Psychology*, 63, 779-786.
- Porcelli, P., Leoci, C., Guerra, V., Taylor, G.J., & Bagby, R.M. (1996). A longitudinal study of alexithymia and psychological distress in inflammatory bowel disease. *Journal of Psychosomatic Research*, 41(6), 569-573.
- Riegal, B. (1993). Contributors to cardiac invalidism after acute myocardial infarction. *Coronary Artery Diseases*, 4, 215-220.
- Robinson, P., Gregg, J., Dahl, J. & Lundgren, T. (2004). ACT in medical settings. In S.C. Hayes, K.D. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 295-314). New York: Springer Science+Business Media, Inc.
- Robinson, P., & Hayes, S.C. (1997). Acceptance and commitment: A model for integration. In N.A. Cummings, J.L. Cummings, et al. (Eds.), *Behavioral health in*



*primary care: A guide for clinical integration* (pp. 177-203). Madison, CT: Psychosocial Press.

Robinson, P., Wicksell, R.K., & Olsson, G.L. (2004). ACT with chronic pain patients. In S.C. Hayes & K.D. Strosahl (Eds.), *A practical guide to acceptance and commitment therapy* (pp. 315-346). New York: Springer Science+Business Media, Inc.

Roemer, L., Salters, K., Raffa, S., & Orsillo, S.M. (2005). Fear and avoidance of internal experiences in GAD: Preliminary tests of a conceptual model. *Cognitive Therapy and Research*, 29, 71-88.

Schwarz, S.P., & Blanchard, E. B. (1991). Evaluation of a psychological treatment for inflammatory bowel disease. *Behaviour Research and Therapy*, 29(2), 167-177.

Sewitch, M., Dobkin, P., Abrahamowicz, M., Bitton, A., Daly, D., Wild, G., Cohen, A., Katz, S., & Szego, P. (2001). Psychological distress, social support and disease activity in inflammatory bowel disease. *American Journal of Gastroenterology*, 96, 1470-1479.

Szigethy, E.M., Kenney, E., Carpenter, J., Hardy, D., Fairclough, D., Bousvaros, A., Keljo, D., Weisz, J., Beardslee, W.R., Noll, R., & DeMaso, D.R. (2007). Cognitive-behavioral therapy for adolescents with inflammatory bowel disease and subsyndromal depression. *Journal of American Academy of Child and Adolescent Psychiatry*, 46(10), 1290-1298.

Szigethy, E.M., Levy-Warren, A., Whitton, S, DeMaso, D., Weisz, J., & Beardslee, W. (2004). Cognitive-behavioral therapy for depression in adolescents with

- inflammatory bowel disease: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(12), 1469-1477.
- Trickett, E.J. (2002). Context, culture, and collaboration in AIDS interventions: Ecological ideas for enhancing community impact. *Journal of Primary Prevention*, 23(2), 157-174.
- Van Dulmen, A.M., Fennis, J.F.M., & Bleijenberg, G. (1996). Cognitive-behavioral group therapy for irritable bowel syndrome: Effects and long-term follow-up. *Psychosomatic Medicine*, 58, 508-514.
- Voth, J., & Sirois, F.M. (2009). The role of self-blame and responsibility in adjustment to inflammatory bowel disease. *Rehabilitation Psychology*, 54(1), 99-108.
- Vowles, K.E., & McCracken, L.M. (2008). Acceptance and values-based action in chronic pain: A study of treatment effectiveness and process. *Journal of Consulting and Clinical Psychology*, 76(3), 397-407.
- Walser, R.D., & Pistorello, J. (2004). ACT in group format. In S.C. Hayes & K.D. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 347-372). New York: Springer Science+Business Media, Inc.
- Ware, J.E., Kosinski, M., & Keller, S.K. (1994). *SF-36® Physical and mental health summary scales: A user's manual*. Boston, MA: The Health Institute.
- Wituk, S.A., Shepherd, M.A., Warren, M., & Meissen, G. (2002). Factors contributing to the survival of self-help groups. *American Journal of Community Psychology*, 30(3), 349-366.
- Wortman, C.B. (1975). Some determinants of perceived control. *Journal of Personality and Social Psychology*, 31, 282-294.



## **Appendix A**

### **Clinician Manual**

#### **Overview**

This manual is designed for use in a 4-week treatment model consisting of group ACT sessions and individual sessions to process patient concerns related to Crohn's disease and comorbid anxiety and depression. IBD is a category of gastrointestinal diseases and consists of Crohn's disease and ulcerative colitis while IBS is a more general term describing a host of difficulties with one's bowels. Crohn's Disease is a gastrointestinal disease that occurs when there is chronic relapsing inflammation of the intestinal mucosa (Hanauer, 2006). Symptoms of Crohn's Disease include intense pain the abdomen, bloody stool, persistent or recurrent diarrhea, vomiting, low-grade fever, reduced appetite, malnutrition, and weight loss. It is the frequent combination of these symptoms and co-morbid mental illness (most commonly depression and anxiety) that form the rationale for creating a contextual model for treating the psychological complications inherent in having Crohn's disease. Although it is hypothesized that this model would also be beneficial to patients with ulcerative colitis, this paper specifically focuses on those with Crohn's disease as it has less treatment options available and thus it presents with its own unique challenges for patients. It is suggested that a contextual model including individual acceptance-commitment therapy sessions supplemented with group therapy sessions (including a medical management component) will prove to be beneficial in increasing the quality of life experienced by patients with Crohn's disease.

Complications of Crohn's disease include abscesses, ulcers, intestinal blockages, fistulas and a whole host of unpleasant disturbances. Crohn's disease can manifest in

areas from the mouth to the anus; it can affect the joints, eyes, skin, and liver although it frequently primarily affects the end of the small intestine and the beginning of the large intestine. This disease is diagnosable by several ways such as stool tests, blood tests, and colonoscopies (tests done under anesthesia in which the patient's intestine is viewed with a scope). Crohn's disease is marked by an abnormal response of the body's immune system in which the immune system attacks the gastrointestinal tract. Crohn's disease patients also have an increased risk of developing colon cancer and this risk increases with length of active inflammation (Loftus, 2004). There is no cure for Crohn's; it requires a lifetime of care with treatment options that are limited to either managing symptoms through pharmaceuticals and/or surgery, or maintaining remission. Patients are commonly prescribed immunosuppressive agents, biologics or steroids to reduce inflammation; however if these do not prove to be effective, many patients undergo surgery to remove the inflamed portion (Ghosh & Mitchell, 2007). As many as 60-70% of patients with Crohn's Disease will require surgery at some point during their lives, and many of those will go on to require repeat surgeries (Loftus, 2004).

### **Comorbidity with Mental Health**

Several studies have come to the conclusion that there are quality of life deficits associated with IBD and IBS (De Rooy, 2001; Drossman et al. 1991; Dudley-Brown, 2002; Ghosh & Mitchell, 2007). Concerns about areas such as loss of bowel control, producing unpleasant odors, feeling dirty or smelly, and issues with sexual intimacy have been identified through patient surveys (De Rooy et al., 2001). Patients' self-esteem can be affected and obsessional traits can develop in relation to fecal incontinence and a preoccupation with having close access to a toilet (Levenstein, 2002). The

aforementioned symptoms can have substantial psychological and social implications, causing patients to alter their lifestyles in order to accommodate those symptoms. In a study done by Ghosh and Mitchell (2007), responses were analyzed from surveys of patients who met a definitive diagnosis of either ulcerative colitis or Crohn's disease. These surveys contained information about the demographics of the patients, the history of their disease, their experience of the disease and the impact of their disease on their quality of life which was measured in terms of ability to enjoy leisure activities, the need for surgery, and worries about performance at work. Seventy-five percent of patients reported that their symptoms affect ability to enjoy leisure activities. A significant percentage of respondents experienced periods of exacerbated symptoms called "flare-ups" at least every few months. Findings of this study suggest that the two most significant interventions to dramatically improve quality of life are patient education and appropriate treatment of concurrent depression and anxiety (Husain et al., 2004). Patient education referred to the nature of conversations between patients and their physicians. It was suggested that these conversations should include an assessment of the patient's quality of life and an explanation of new treatment options that are available to the patient (Ghosh & Mitchell, 2007).

In a study done by Voth and Sirois (2009), findings indicated that self-blame led to increased avoidant coping which led to poor adjustment while a sense of responsibility was associated with better use of coping skills and better psychological functioning. Self-blame was defined as the belief that one has in some way intentionally brought about negative outcomes; this is negatively associated with acceptance and a sense of control. Conversely, accepting responsibility for one's health by attributing the source of the

blame to their own behavior was associated with patient's ability to use more adaptive coping skills and to be more able to accept the limitations and difficulties inherent in IBD. Accepting responsibility was found to be associated with an increased perception of self-control (Wortman, 1975). Higher levels of disease severity were linked to the use of avoidant coping strategies such as behavioral and mental disengagement, substance use and abuse, and denial. These behaviors were linked to poor psychological adjustment (Voth & Sirois, 2009).

Patients with IBD have commonly reported distress, anxiety, depression, social isolation, and poor quality of life (Dudley-Brown, 2002). Drossman et al. (1991) found that the impact of IBD was positively associated with greater psychological distress. In this study, patients with IBD were given a disease-specific 25-item survey to measure perceived health status with items geared toward patient concerns regarding the ability to achieve their full potential, being attractive, dying early, loss of sexual drive, being treated as different, being able to have children etc. The impact of the disease was positively associated with poorer psychological functioning and poorer well-being. Several specific domains such as concerns about sexual intimacy related to poorer psychological functioning. Patients suffering with IBD also reported high levels of concern related to developing cancer, feeling of being burdensome to others, body-image issues, and effects of treatments.

### **Rationale for Treatment Model**

Since the nature of IBD is biological, a therapy model emphasizing acceptance and value-based goal-reaching *and* medical management is necessary. Patients may feel helpless and embarrassed due to uncontrollable nature of symptoms and unpredictable

stages of remission and relapse (Drossman et al., 1991). Acceptance and Commitment Therapy (ACT) is a model that teaches patients to accept those feelings and to be mindful of the process of thinking while linking that acceptance to goal-based action (Hayes et al., 1999). Although cognitive behavioral therapy has proven to be effective in the management of chronic illnesses, it targets patients' thoughts as irrational distortions that need to be challenged with the goal of distress reduction or elimination. However, it has been argued that patients suffering with chronic diseases may not be able to realistically eliminate distress since they are continually reminded of inherently distressing aspects of their medical condition (Gregg et al., 2007).

ACT has been found to be effective in the treatment of a wide range of psychological problems including anxiety, depression, serious mental illness, posttraumatic stress disorder, substance abuse, epilepsy, chronic pain, stress, diabetes and general health issues (Hayes & Strosahl, 2004). It is hypothesized that combining individual ACT sessions with disease-specific group therapy sessions and proper medical management education will provide a useful component to a well-rounded treatment model that will be effective for management of the disease.

Treatment will be provided in the form of weekly 90-minute individual sessions combined with weekly 90-minute group sessions over the course of 4 weeks. Although this is the recommended manner in which the treatment should be delivered, this model can also be condensed into one or two workshops if working in a setting such as an inpatient or residential unit with high patient turnover rates. Conversely, the 4-week model can also be extended for use in an outpatient setting with more time for patients to process their experience and to practice applying ACT principles within their lives.



Treatment will begin with an initial evaluation session as an effort to socialize the patient to ACT, and to hopefully assuage any fears or apprehensions the patient may harbor about attending a group. Though this manual and workbook are adapted specifically for Crohn's patients, it is important that all core ACT processes are introduced including: acceptance, defusion, contact with the present moment, self as context, values, and building patterns of committed action (Walser & Pistorello, 2004).

Proper patient education and medical compliance have been shown to significantly improve patients' on quality of life (Husain et al., 2004), therefore attention must be given to the physiological aspects of Crohn's disease. Patients will complete a weekly symptom inventory to document GI symptoms (the Harvey-Bradshaw index) and weekly self-report measures (to assess for depression and anxiety (the Beck Depression Inventory-II and the Beck Anxiety Inventory) (Beck et al., 1996; Beck & Steer, 1993; Harvey & Bradshaw, 1980).

### **Why Group *and* Individual Therapy?**

ACT has been found to be effective in individual settings; however, clinical literature has been developed to support the notion that its effectiveness may actually be enhanced when delivered in a group format (Walser & Pistorello, 2004). This is one of the reasons that group and individual therapy have been combined in this treatment model. Another advantage of delivering ACT in a group format is that it lends itself well to interactive processes that are imperative to group therapy such as experiential exercises and exploration of metaphors. Debriefing discussions allow for the very useful experience of listening to the reactions (both convergent and divergent) of other patients following the exercises. This experience provides an opportunity for group members to

support and validate one another while learning to accept and reflect on alternative viewpoints (Walser & Pistorello, 2004). Sometimes ACT concepts can be difficult to grasp so it can be helpful for group members to hear other ways of interpreting material/tasks. If group members come up with spontaneous metaphors or images that are consistent with ACT principles, this can allow the clinician to adopt a language that fits the group; using his or her own flexibility as a model for patients. As Walser and Pistorello (2004) noted, group work provides an opportunity for patients to receive more objective feedback; patients are often better able to recognize when others have fallen into patterns of avoidance. The group component of this treatment model is a powerful one because it provides group members the experience of being impacted by witnessing each other engage in experiential exercises while creating a social context in which patients' commitments to their values are made public (Walser & Pistorello, 2004). Not surprisingly, a great deal of stigma is inherent in having Crohn's disease so it may be difficult to find patients who are willing to disclose information about their experience with it.

### **Characteristics of group leaders**

Though there is no formal certification program for ACT, it is recommended that group leaders attend at least one intensive ACT training workshop and that they have some experience delivering ACT individually (Walser & Pistorello, 2004). Various opportunities are available to make oneself familiar with the theory and practice of ACT such as textbooks, workbooks and online materials (see Appendix A). This allows the clinician to be well versed in the range of core processes in ACT in order to bring these to bear in the moment. Group leaders must be aware of the potential for he or she to be

emotionally affected by the evocative process and content of group. Group leaders as well as group members are asked to tolerate a number of intense, difficult emotions; leaders may find themselves feeling uncomfortable facilitating acceptance of such emotions (Walser & Pistorello, 2004). One person can certainly lead; however a 2-member team might be more effective at tracking relevant group processes. Also, a 2-member team can allow for more seamless recovery when errors are made. Formal certification is not necessary; however it is important that clinicians be familiar with training materials such as (See Appendix A).

### **Considerations Before Beginning**

It may be appropriate to guide some patients into the process of cautious disclosure in a way that fits “their immediate coping resources, when they appear to have few internal resources to cope with the emotional aftermath of significant personal disclosures” (Walser & Pistorello, 2004 p. 353). Therapists and patients will be asked to sit with difficult emotions and will likely find their emotions being evoked in new ways (Walser & Pistorello, 2004). For this reason, it is important to explain the rationale for ACT and to obtain informed consent from each patient (see Appendix B). This model is designed for a closed group, in which members are not permitted to enroll at different points. This provides safety and continuity for group members, and is most beneficial to the patient as the session content builds weekly. Although patients will be reminded to come prepared to group sessions, avoidance may unconsciously manifest itself in subtle ways; it is important for group leaders to bring extra paper and writing utensils in the event that someone forgets to bring these items. The manual contains scripts that group leaders can use to introduce exercises or explain concepts. These scripts are guidelines;

group leaders can choose to read them aloud, paraphrase using language that is comfortable for them (recommended), and/or have group members read sections aloud.

**Treatment Schedule**

	Group	Individual
Intake	NONE	Intake Introduction of Treatment Model Informed Consent Questionnaires Crohn's disease (CD) Interview
Module 1	Introduction of group leaders Group Rules/Expectations Introduction of patients Recap of ACT Quicksand Metaphor Crohn's Review Experiential Avoidance Acceptance and Avoidance cycle Tiger Metaphor Finger Trap Metaphor "I avoid..." Activity HW: Coping Strategies Worksheet and Diary	Complete self-report measures Reactions from group Review Coping Strategies Homework Revisit personal concerns Suffering Inventory Treatment goals Defusion techniques Defusion of negatively evaluated thoughts about living with CD
Module 2	Mindfulness overview Be Where You Are Exercise Willingness HW: Mindful Exercises HW: What Needs to be Accepted	Complete self-report measures Reactions from group Review What Needs to be Accepted HW Process patient's experience with willingness and acceptance HW: Acceptance In Real Time
Module 3	Review Acceptance In Real Time HW Definition/ Explanation of Values Epitaph Exercise HW: Choosing Your Values	Complete self-report measures Reactions from group Review Choosing Your Values HW Ranking Your Values Exercise
Module 4	Creating the Road Map: Setting Goals Goals Worksheet Making Goals Happen Through Action Expected Barriers HW: Values Form	Complete self-report measures Post-treatment questionnaires Reactions to treatment Review Values Form Building Patterns The Choice to Live a Vital Life Termination

## Module 1

### Initial Evaluation

---

Before proceeding into Module 1, each patient will meet with his or her individual clinician to complete a thorough initial intake evaluation to gather relevant information about the patient. This can consist of an agency-specific interview or a structured clinical interview to assess for the presence of anxiety, depression and other forms of psychopathology. During this initial session, clinicians will provide an overview of the treatment model, obtain informed consent from the patient, and administer the *ACT for Crohn's Disease Interview* (see Appendix C). Following this introductory session, patients will attend their first group session. During this initial evaluation session, building a strong therapeutic alliance is key. This is the patients' first encounter with the treatment model so is particularly important that they feel comfortable with you and that they trust you to inform them honestly about the task on which they are about to embark.

### Introduction of Treatment Model

---

Introduce the patient to the ACT model and to the structure of the treatment using the following as a guideline for dialogue<sup>1</sup>: *This treatment model is based on Acceptance and Commitment Therapy, or ACT. This is a new, scientifically based psychotherapeutic modality that is part of what is being called the "third wave" in behavioral and cognitive therapy (Hayes, 2004). ACT is based on Relational Frame Theory (RFT): a basic research program on how the human mind works (Hayes, Barnes-Holmes, & Roche 2001). This research suggests that many of the tools we use to solve problems lead us*

---

<sup>1</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*into the traps that create suffering. To put it bluntly, human beings are playing a rigged game in which the human mind itself, a wonderful tool for mastering the environment, has been turned on its host. Perhaps you've noticed that some of your most difficult problems have paradoxically become more entrenched and unmanageable, even as you've implemented ideas about how to solve them. This is not an illusion. This results from your own logical mind being asked to do what it was never designed to do. Suffering is one result.*

*If you are suffering with a psychological problem, you should know that research suggests that ACT helps with many common psychological difficulties (Hayes, Masuda, et al., 2004). ACT challenges some of the most culturally ingrained forms of conventional thinking about human problems. Research indicates that ACT's methods and ideas are generally sound, which provides reassurance that these concepts and procedures are effective. That doesn't mean they are easy to grasp. Here's a sample of some of the unconventional concepts you will be asked to consider:*

- *Psychological pain is normal, it is important, and everyone has it.*
- *You cannot deliberately get rid of your psychological pain, although you can take steps to avoid increasing it artificially.*
- *Pain and suffering are two different states of being.*
- *You don't have to identify with your suffering.*
- *Accepting your pain is a step toward ridding yourself of your suffering.*
- *You can live a life you value, beginning right now, but to do that you will have to learn how to get out of your mind and into your life.*

*Ultimately, what ACT asks of you is a fundamental change in perspective: a shift in the way you deal with your personal experience. I can't promise that this will quickly change what your depression or anxiety looks like, at least, not anytime soon. I can, however, say that research has demonstrated that the role of these problems as barriers to living can be changed, and sometimes changed quite rapidly. ACT methods provide new ways to approach difficult psychological issues. These new approaches can change the actual substance of your psychological problems and the impact they have on your life.*

*Metaphorically, the distinction between the function of a psychological disorder and the form it takes in one's life can be likened to someone standing in a battlefield fighting a war. The war is not going well. The person fights harder and harder. Losing is a devastating option; but unless the war is won, the person fighting it thinks that living a worthwhile life will be impossible. So the war goes on.*

*Unknown to that person, however, is the fact that, at any time, he or she can quit the battlefield and begin to live life now. The war may still go on, and the battlefield may still be visible. The terrain may look very much as it did while the fighting was happening. But the outcome of the war is no longer very important and the seemingly logical sequence of having to win the war before beginning to really live has been abandoned.*

*This metaphor is intended to illustrate the difference between the appearance of psychological problems and their true substance. In this metaphor, the war looks and sounds much the same whether you are fighting it or simply watching it. Its*



*appearance stays the same. But its impact—it's actual substance—is profoundly different. Fighting for your life is not the same as **living** your life.*

*Ironically, research suggests that when the substance changes, the appearance may change as well. When fighters leave the battlefield and let the war take care of itself, it may even subside. As the old slogan in the 1960s put it: "What if they fought a war and nobody came?"*

*Compare this metaphor with your own emotional life. ACT focuses on the substance, not the appearance, of problems. Learning to approach your distress in a fundamentally different way can quickly change the impact it has on your life. Even if the appearance of distressing feelings or thoughts does not change (and who knows, it might), if you follow the methods described in your workbook, it is far likelier that the substance of your psychological distress, that is, its impact, will change.*

*In that sense, this is not a traditional treatment model. We're not going to help you win the war with your own pain by using new theories. We are going to help you leave the battle that is raging inside your own mind, and to begin to live the kind of life you truly want. Now.*

At this point in the session, explain the rationale for using ACT to treat anxiety and depression for patients with Crohn's Disease (CD) using the following script (see Overview section for references): *This treatment model was created specifically for Crohn's Disease patients because CD presents challenges that are unique to other gastrointestinal diseases. Unlike Irritable Bowel Syndrome, CD (an inflammatory bowel disease) consists of tissue damage, which is more difficult to treat. Unlike Ulcerative Colitis (another inflammatory bowel disease) CD cannot be cured through*

*surgery. CD has been found to be associated with quality of life deficits and issues with self-esteem due to the impact that one's symptoms. It is common to have concerns about loss of bowel control, producing unpleasant odors, feeling dirty or smelly, and having issues with sexual intimacy. The symptoms of CD can have substantial psychological and social implications, causing patients to alter their lifestyles to accommodate those symptoms. Patients may find themselves struggling with depression, anxiety, social isolation and poor quality of life. ACT has been studied and found to be effective in the treatment of a wide range of psychological and health problems such as chronic pain, epilepsy, diabetes, depression and anxiety. It is my hope that through participating in this treatment, you will experience an improvement in your quality of life and will gain tools that will help you to live a valued life.*

Inform patient of the structure of the treatment model, making sure to allow for questions that the patient may have related to group therapy or ACT as a treatment. Use the following dialogue as a guideline: *Later this week, you will attend your first group session where you will learn more about ACT and practice some of the techniques. You will have the opportunity to meet with others who struggle with the impact of CD. This group session will last for approximately 90 minutes. You will have one group per week for 4 weeks. Between each group, you and I will meet for an individual session in which we will review your experience of group and speak about more personal, specific aspects of the reason you're here. We will discuss ways for you to apply the ACT principles to your life. How does this sound to you?*

### **Informed Consent**

---

After introducing the patient to the treatment model, it is important to obtain Informed Consent by reviewing the Guidelines for Informed Consent (see Appendix B) and having the patient sign an informed consent form. Read bolded sections aloud to ensure that patient is aware of the experiential nature of treatment. It is important that you as the clinician explain the highly experiential nature of the group and the discomfort that he or she may experience. Patients should be made aware of the importance of committing to attend all groups and of the challenges inherent in engaging fully in this process.

### **Questionnaires**

---

In order to monitor patient progress, it is recommended to employ the use of self-report measures given pre- and post-treatment. If the patient has consented to treatment and has completed the initial evaluation, invite him or her to complete the SCL-90 (Derogatis, et al., 1976) to measure general psychological symptoms, the SF-36 to assess for general physiological health (Ware, 1992), the RFIPC to assess for IBD-specific quality of life (Drossman et al., 1991), the Harvey-Bradshaw Index to assess for Crohn's Disease symptom severity (Harvey and Bradshaw, 1980), the Beck Depression Inventory second edition (BDI-II) and the Beck Anxiety Inventory (BAI) (Beck & Steer, 1993; Beck et al., 1996). Patients may feel that this is a large undertaking so it is important to validate their feelings and explain that the three shortest measures (Harvey-Bradshaw Index, BDI-II, BAI) are the only measures that will be repeated weekly. Patients will be given the Harvey-Bradshaw Index (1980), BDI-II (Beck et al., 1996), and BAI (Beck & Steer, 1993) to complete immediately

before each individual session. Explain that assessing for depression, anxiety and disease symptomatology weekly permit the assessment of change during treatment and allow for ongoing exchange of feedback between patient and therapist. All other measures will not be given again until the end of treatment.

### **ACT for Crohn's Disease Interview**

---

Following completion of the self-report measures, administer the *ACT for CD Interview* (see Appendix C) to gather relevant information about the patient that is specific to this treatment model. At the end of this session, give patients an opportunity to ask questions, and provide them with the time and date of the next group session.

**Group Session #1**

---

- Introduction of group leaders
- Group Rules/Expectations
- Introduction of patients/check-in
- Recap of ACT model
- Crohn's Disease Education
- Avoidance and Acceptance
- Activity: "I avoid..."
- Homework: Coping Strategies Worksheet and Diary

After introducing yourself and your co-leader (if applicable), begin the group by explaining the rules and expectations for group members and group leaders. Use the following dialogue as a guideline: *This group is designed to be a safe place. It is important that we all agree to keep the information shared in this room confidential. Difficult material will be shared; some of it may bring up feelings of sadness, anxiety or anger; this is natural. It is possible that you may feel worse before feeling better due to the fact that previously avoided material becomes experienced in the moment. Please try to sit with the discomfort and listen to one another. It is important to be an active participant in every aspect of treatment. Try to share as openly as possible; however, if there is anything that you feel unable to share in a group, you may find it easier to talk about it in your individual session. Attendance to group and individual sessions is crucial in order to maximize the benefits you experience from treatment.* Read the list below and allow group members to ask questions if needed.

**Group Rules and Expectations**

- ❖ Attend each session on time
- ❖ Arrive prepared with your workbook and a writing utensil

- ❖ Participate in every session
- ❖ Listen when others are speaking
- ❖ Use non-judgmental language
- ❖ Respect others
- ❖ Be supportive and constructive
- ❖ Try to maintain a focus on the here and now
- ❖ Maintain group confidentiality
- ❖ Complete all activities and homework exercises
- ❖ Continue/Begin appropriate medical management of CD with physician
- ❖ Communicate openly with your therapist throughout this process

Next, have the group members introduce themselves stating:

- ❖ Name
- ❖ Age when diagnosed with CD
- ❖ Reason you are participating in this group

Remind group of the premise of ACT and the rationale for using it to treat depression and anxiety in CD patients. Provide a quick summary of the impact of CD symptoms on quality of life and psychological functioning. Inform patients of the CD Fact Sheet (Appendix D) to review at their leisure. Introduce the quicksand metaphor.

### **SUFFERING: Psychological Quicksand<sup>2</sup>**

An understanding of the definitions of ‘suffering’ and ‘pain’ as used in this treatment model is a useful place to begin facilitating the ACT exercises. Introduce the concept of suffering through a metaphor with the following dialogue as a guide: *This counterintuitive idea of abandoning the battlefield rather than winning the war may*

---

<sup>2</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*sound strange, and implementing it will require a lot of new learning, but it is not crazy. You know about other situations like this. They are unusual, but not unknown.*

*Suppose you came across someone standing in the middle of a pool of quicksand. No ropes or tree branches are available to reach the person. The only way you can help is by communicating with him or her. The person is shouting, "Help, get me out," and is beginning to do what people usually do when they are stuck in something they fear: struggle to get out. When people step into something they want to get out of, be it a briar patch or a mud puddle, 99.9 percent of the time the effective action to take is to walk, run, step, hop or jump out of trouble. This is not so with quicksand. To step out of something it is necessary to lift one foot and move the other foot forward. When dealing with quicksand, that's a very bad idea. Once one foot is lifted, all of the trapped person's weight rests on only half of the surface area it formerly occupied. This means the downward pressure instantly doubles. In addition, the suction of the quicksand around the foot being lifted provides more downward pressure on the other foot. Only one result can take place: the person will sink deeper into the quicksand.*

*As you watch the person stuck in the quicksand, you see this process begin to unfold. Is there anything you can shout out that will help? If you understand how quicksand works, you would yell at the person to stop struggling and to lie flat, spread-eagled, to maximize contact with the surface of the pool. In that position, the person probably wouldn't sink and might be able to logroll to safety.*

*Since the person is trying to get out of the quicksand, it is extremely counterintuitive to maximize body contact with it. Someone struggling to get out of the*

*mud may never realize that the wiser and safer action to take would be to get with the mud.*

*Our own lives can be very much like this, except the quicksand we find ourselves in, often is, in one sense, endless. Exactly when will the quicksand of a traumatic memory vanish? At what moment will the painful quicksand of past criticism from parents or peers disappear? Right now think of a psychological aspect of yourself that you like the least. Take a moment to consider this question. Now ask yourself, “Was this an issue for me last month? Six months ago? A year ago? Five years ago? Exactly how old is this problem?”*

*Most people find that their deepest worries are not about recent events. Their deepest worries have been lurking in the background for years, often many years. That fact suggests that normal problem-solving methods are unlikely to be successful. If they could succeed, why haven't they worked after all these years of trying? Indeed, the very longevity of most psychological struggles suggests that normal problem-solving methods may themselves be part of the problem, just as trying to get free is a huge problem for someone stuck in quicksand.*

*You've chosen to engage in this treatment model for a reason. Most likely, you find yourself in some sort of psychological quicksand and you think you need help freeing yourself. You've tried various “solutions” without success. You've been struggling. You've been sinking. And you've been suffering. Crohn's Disease doesn't go away. One might experience remission, but the effects it can have on your mood and quality of life can feel never-ending. Your pain (both psychological and physical) will be an informative ally on the path that lies ahead. You have an opportunity that someone who*



*hasn't experienced this type of pain doesn't have, because it is only when common sense solutions fail us, that we become open to the counterintuitive solutions to psychological pain that modern psychological science can provide. As you become more aware of how the human mind works (particularly your mind), perhaps you will be ready to take the path less traveled. Haven't you suffered enough?*

*This treatment is not meant to help you free yourself from the quicksand of anxiety, depression and CD. It was created to relieve your suffering and empower you to lead a valued, meaningful, dignified human life. Psychological and physiological issues that you've previously struggled with may technically remain (or they may not), but what will it matter if they remain in a form that no longer interferes with you living your life to the fullest?*

Ask for reactions/thoughts/comments from group members. Introduce the Yellow Jeep exercise using the script below as a guideline.

### **EXERCISE: A Yellow Jeep<sup>3</sup>**

---

*Language creates suffering because the human approach to solving problems is based on the premise that "If you don't like something, figure out how to get rid of it, and then get rid of it." This may be effective for external problems but is not helpful when dealing with internal issues. For example, when a painful thought comes up, you may try to stop thinking it. Thought suppression only makes the situation worse. Harvard psychologist Dan Wegner (1994) has shown that the frequency of the thought that you try not to think may go down for a short while, but it soon appears more often than ever.*

---

<sup>3</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*Let's try an experiment and see whether suppressing a thought can work.*

- 1. Get a clear picture in your mind of a bright yellow Jeep. How many times during the last few days have you thought of a bright yellow Jeep? Write down your answer in the space provided: \_\_\_\_\_*
- 2. Now, spend the next 5 minutes trying as hard as you can not to think even one single thought of a bright yellow Jeep. Really try hard (allow 5 minutes for activity).*
- 3. Write down how many times you had a thought about a bright yellow Jeep, however fleetingly, during the last few minutes while you were trying so hard not to think about it. \_\_\_\_\_*
- 4. Now, spend the next 5 minutes allowing yourself to think whatever thoughts come to your mind (allow 5 minutes for activity).*
- 5. Write down how many times you had a thought about a bright yellow Jeep, however fleetingly, during the last few minutes while you were allowing yourself to think of anything (Ask group members to share their experience of this activity.)*

*If you are like most people, the number of times you thought about a bright yellow Jeep went up over time. You might have been able to keep the thought of a yellow Jeep out of your mind while directly suppressing it, but sometimes even that breaks down, and the number of times such thoughts occur soars. Even if you were able to suppress the thought for a short period of time, at some point, you will no longer be able to do so. When this happens, the occurrence of the thought tends to go up dramatically. That is not simply because you were reminded of a yellow Jeep. In controlled research studies, when*

*participants are told about the Jeep but are not instructed to suppress thinking about it, the number of thoughts does not increase.*

Define experiential avoidance and explain the Acceptance and Avoidance Cycle handout.

### **Experiential Avoidance<sup>4</sup>**

---

*Language creates suffering in part because it leads to experiential avoidance.*

***Experiential Avoidance** is the process of trying to avoid your own experiences (thoughts, feelings, memories, bodily sensations, behavioral predispositions) even when doing so causes long-term behavioral difficulties (like not going to a party because you're a social phobic, or not exercising because you feel too depressed to get out of bed). Of all the psychological processes known to science, experiential avoidance is one of the worst (Hayes, Masuda, et al. 2004).*

*Experiential avoidance tends to artificially amplify the “pain of presence” (issues that are present that you would prefer to go away), and it is the single biggest source of the “pain of absence,” (the activities you would engage in if matters changed) since it is avoidance that most undermines positive actions. Unfortunately, this strategy is built into human language for two reasons: language naturally targets our reactions, not just our situations, and it makes it impossible to control pain by controlling situations, since any situation can be arbitrarily related to pain and thus evoke it. For example, suppose someone very dear to you recently died, and today you see one of the most beautiful sunsets you have ever seen. What will you think? For human beings, avoiding situational cues for psychological pain is unlikely to succeed in eliminating difficult feelings because*

---

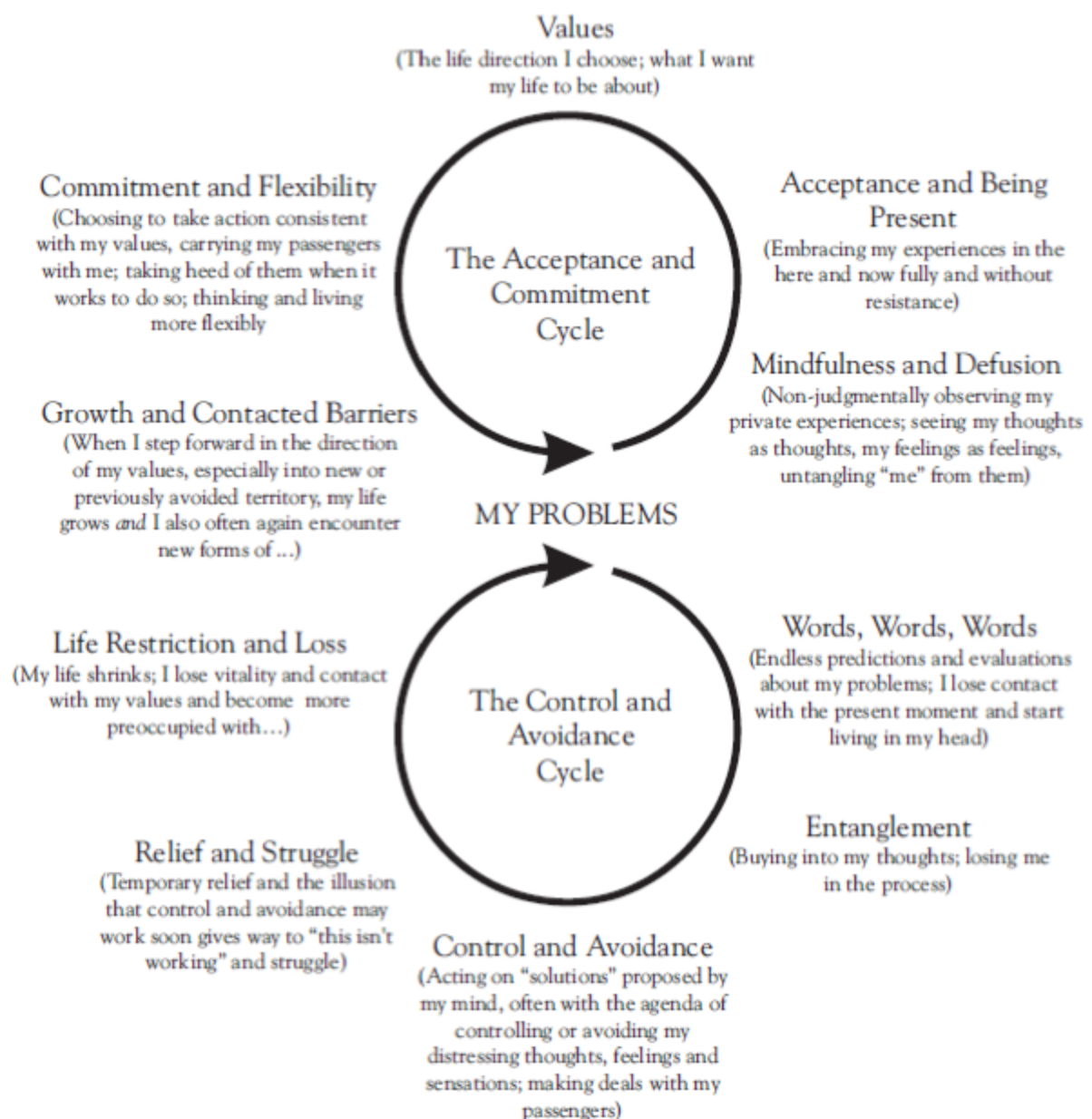
<sup>4</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*all that is needed to bring them to mind is an arbitrary cue that evokes the right verbal relations. This example of a sunset demonstrates the process. A sunset can evoke a verbal history. It is "beautiful" and beautiful things are things you want to share with others. You cannot share this sunset with your dear friend, and there you are, feeling sad at the very moment you see something beautiful.*

*Outside the body, the rule may indeed be, "If you don't like it, figure out how to get rid of it, and then get rid of it." Inside the body, the rule appears to be very different. It's more like, "If you aren't willing to have it, you will." In practical terms, this means for example, that if you aren't willing to feel anxiety as a feeling, you will feel far more anxiety, plus you will begin to live a narrower and more constricted life.*

*Think about the strategies you use to cope with painful thoughts, feelings and situations. If you are like most people, the majority of your coping strategies are focused on your internal processes. Usually, these coping strategies help to regulate your internal processes a little in the short run, but in the long run, they often fail or even make matters worse.*

*Now, consider the possibility that this is so because each of the coping strategies you've developed is a way to avoid your experiences. You develop specific means by which you try to stop feeling the feelings you are feeling or thinking the thoughts you are thinking. You try to avoid the experience of painful thoughts or feelings by burying yourself in distracting activities, combating your thoughts with rationalizations, or trying to quash your feelings through the use of controlled substances. If you are suffering, you may spend a lot of time performing these distracting coping techniques. Meanwhile, your life is not being lived.*

**Figure 1.1 The Acceptance Cycle and the Avoidance Cycle<sup>5</sup>**

<sup>5</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*Two main factors keep people stuck in the system of experiential avoidance. The first factor is that the rule “If you don’t like something, get rid of it” works very well in the outside world. The second factor is that the short-term effects of experiential avoidance, that is, the application of that rule to our experience, often can be positive. Every time you engage in a behavior specifically designed to avoid some negative personal pain, you are likely to feel an immediate sense of relief from not having to deal with the painful thought, feeling, or bodily sensation. The sense of relief you gain reinforces your desire to use the same strategy the next time you are forced with the possibility of having to cope with your pain. Yet, each time you do this, you actually give the painful content, that is, your painful thought, feeling, or bodily sensation, more power.*

### **The Metaphor Of The Hungry Tiger<sup>6</sup>**

---

*Imagine you wake up one morning and just outside your front door you find an adorable tiger kitten meowing. Of course you bring the cuddly little guy inside to keep as a pet. After playing with him for a while, you notice he is still meowing, nonstop, and you realize he must be hungry. You feed him a bit of bloody, red ground beef knowing that’s what tigers like to eat. You do this every day, and every day your pet tiger grows a little bigger. Over the course of two years, your tiger’s daily meals change from hamburger scraps, to prime rib, to entire sides of beef. Soon your little pet no longer meows when hungry. Instead, he growls ferociously at you whenever he thinks it’s mealtime. Your cute*

---

<sup>6</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.

*little pet has turned into an uncontrollable, savage beast that will tear you apart if he doesn't get what he wants.*

*Your struggle with your pain can be compared to this imaginary pet tiger. Every time you empower your pain by feeding it the red meat of experiential avoidance, you help your pain-tiger grow a little bit larger and a little bit stronger. Feeding it in this manner seems like the prudent thing to do. The pain-tiger growls ferociously telling you to feed it whatever it wants or it will eat you. Yet, every time you feed it, you help the pain to become stronger, more intimidating, and more controlling of your life.*

*Consider the possibility, as unlikely as it may seem, that it's not just that these avoidance strategies haven't worked—it's that they can't work. Avoidance only strengthens the importance and the role of whatever you are avoiding—in other words, when you avoid dealing with your problem, it only grows.*

### **The Chinese Finger Trap<sup>7</sup>**

---

*The situation is something like the Chinese finger raps you might have played with as a kid (see figure 1.2). (Pass out finger trap props if available).*

**Figure 1.2: The Chinese finger trap.**



---

<sup>7</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*The trap is a tube of woven straw about as big as your index finger. You push both index fingers in, one at each end, and as you pull them back out, the straw catches and tightens. (Encourage group members to try this). The harder you pull, the smaller the tube becomes, and the stronger it holds your fingers. If the trap is built strongly enough, you'd have to pull your fingers out of their sockets to get them out of the tube by pulling, once they've been caught. Conversely, if you push into it, your finger will still be in the tube, but at least you'll have enough room to move around and live your life.*

*Now, suppose that life itself is like a Chinese finger trap. So, it's not a question of getting free of the tube, it's a question of how much "wiggle room" you want to have in your life. The more you struggle, the more constricted your movements will be. If you let go of the struggle, the more freedom you have to make new choices.*

Ask group members for reactions to this activity. Encourage sharing of examples in which this metaphor can be applied to living with CD.

### **EXERCISE: "I avoid..."<sup>8</sup>**

---

*Pass out index cards to group members and introduce the exercise by saying: I would like you to write down 2 or more things, people, places, situations or experiences that you avoid as a result of living with CD. Please do not write your name on the card, as this is an anonymous exercise. Be as honest as possible, even if some of your concerns may be uncomfortable to admit. It is likely that if you are thinking it or have experienced it; others have as well.*

---

<sup>8</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



When group members are finished, pass around a container and have each person place her card into it. *I will pick cards from this container to read to the group one by one. If this is an area that you suffer with or that applies to you and you feel comfortable sharing, please tell the group about your experience. If you do not feel comfortable, it is ok to stay silent and we will move on to the next response.* Read responses, one by one, pausing after each to allow for group discussion. If group members respond, ask questions about their reasons for avoiding and the thoughts and feelings that accompany the avoidance. It is important for you to familiarize yourself with the symptoms of CD and the difficulties associated with quality of life (see Overview and Appendix D) so that you can normalize some of the patients' concerns and validate the appeal one might find in using avoidance as a coping strategy. Pose questions to the group about possible outcomes when using specific avoidance strategies that have been shared. Ask if there are ever drawbacks? Guide the group in processing the experience of hearing others' struggles with avoidance. Validate the tendency to avoid as a way to problem-solve internal events in the same way that we solve external events. Conclude with an explanation of the alternative—acceptance.

*The “acceptance” in Acceptance and Commitment Therapy is based on the notion that, as a rule, trying to get rid of your pain only amplifies it, entangles you further in it, and transforms it into something traumatic. Meanwhile, living your life is pushed to the side. The alternative is to accept it. Acceptance, in the sense that it is used here, is not nihilistic self-defeat; neither is it tolerating and putting up with your pain. It is very, very different than that. Those heavy, sad, dark forms of “acceptance” are almost the exact opposite of the active, vital embrace of the moment that is meant here.*

Explain to group members that the last part of group will be the homework assignment. Encourage group members review material covered in this session as well as to refer to the homework assignment at least twice over the course of the week to reflect.

### **HOMEWORK: The Coping Strategies Worksheet<sup>9</sup>**

---

Introduce this exercise using the following instructions: *Please glance at the Coping Strategies Worksheet below, and then return here for directions on how to work with it. In the column on the left, write down a painful thought or feeling.*

*Then, in the second column, write down one strategy you've used to cope with this painful thought or feeling. Once you've done this, please rank your coping strategy for two sets of outcomes. The first asks you to rate how effective your coping strategy has been in the short term. That is, how much immediate relief do you get from the behavior? For the second ranking, rate your strategy for how effective it's been in the long term.*

*Think about how much of your total pain is caused by your painful thought or feeling. Has your coping behavior reduced your pain over time? Rate each short- and long-term strategy on a scale from 1 to 5 where 1 is not effective at all and 5 is incredibly effective. For the time being, simply note your rankings. We will look at what they mean in greater detail later in this module.*

*For example, suppose someone writes a thought like this: "I'm not sure life is worth living" in the "Painful thought or feeling" column. The coping technique the*

---

<sup>9</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



### Coping Strategies Diary<sup>10</sup>

For those who may have trouble identifying current coping strategies, introduce this optional addendum to the homework assignment: *If you find that you aren't sure what you've been doing to cope, it may be best to collect this information first in diary form. You can print out multiple copies of the form on the next page and use it to record what happens in your life when you experience something psychologically painful. Note the situation (what happened that evoked a difficult private experience); what your specific internal reactions were (particular thoughts, feelings, memories, or physical sensations); and the specific coping strategy you used then (e.g., distracting yourself, trying to argue your way out of your reactions, leaving the situation). After making entries like these in diary form for a period of one week, you should have a better understanding of what coping strategies you have been using and how effective they are.*

Coping Strategies Diary Entries				
Date	Situation			
Difficult private reactions: (e.g., thoughts, feelings, sensations)				
Distress/disturbance level: (when it first happened)		Not distressing/ disturbing		Extremely distressing/ disturbing
		1	2	3
Coping strategy: (my response to my private reactions)				
Short-term effects:		Not at all effective		Incredibly effective
		1	2	3
Long-term effects:		Not at all effective		Incredibly effective
		1	2	3

<sup>10</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

**Individual Session #1**

---

- Reactions from group
- Review *Coping Strategies* HW
- Revisit personal concerns
- Suffering Inventory
- Treatment goals
- Defusion techniques
- Defusion of negatively evaluated thoughts about being sick

Begin session by asking the patient about his or her experience in the group. Ask for reactions to the format, treatment model and other group members. Ask about the “I avoid...” activity and inquire about his or her willingness to share his or her concerns in this individual session. If patient was not willing to share in group, process this with him or her; asking open-ended questions to understand her reasoning. If patient did share in group, ask questions and explore her responses.

Review Coping Strategies worksheet and Diary (if used). Ask questions related to patient's thoughts and feelings about each painful thought or feeling and about the function of the coping technique used. If patient used the Coping Strategies Diary, review entries and ask about the difficulty identifying coping strategies in a non-judgmental manner. Ask how long the patient has been using each coping strategy, and how he or she came to use each one. Ask how/if the coping techniques the patient uses now are different than those that he or she used when he or she was first diagnosed.

Introduce the concept of suffering and the Suffering Inventory exercise.

**Human Suffering Is Universal<sup>11</sup>**

---

*Often many people we meet in our daily lives seem to have it all. They seem happy. They look satisfied with their lives. You've probably had the experience of walking down the street when you're having a particularly bad day, and you looked around and thought, "Why can't I just be happy like everyone around me? They don't suffer from Crohn's disease (or depression, or anxiety). They don't feel as if a dark cloud is always looming over their head. They don't suffer the way I suffer. Why can't I be like them?"*

*Here's the secret: they do and you are. We all have pain. All human beings, if they live long enough, have felt or will feel the devastation of losing someone they love. Every single person has felt or will feel physical pain everybody has felt sadness, shame, anxiety, fear, and loss. We all have memories that are embarrassing, humiliating, or shameful. We all carry painful hidden secrets. We tend to put on shiny, happy faces, pretending that everything is okay, and that life is "all good." It isn't and it can't be. To be human is to feel pain in ways that are orders of magnitude more pervasive than what the other creatures on planet earth feel. If you kick a dog, it will yelp and run away. If you kick it regularly, any sign of your arrival eventually will produce fear and avoidance behavior in the dog by means of the process called "conditioning." But so long as you are out of the picture and are not likely to arrive, the dog is unlikely to feel or show significant anxiety. People are quite different. As young as 16 months or even earlier, human infants learn that if an object has a name, the name refers to the object (Lipkins,*

---

<sup>11</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*Hayes & Hayes, 1993). Relations that verbal humans learn in one direction, they derive in two directions. Over the past 25 years, researchers have tried to demonstrate the same behavior in other animal species, with very limited and questionable success so far (Hayes, Barnes-Holmes, & Roche, 2001). This makes a huge difference in the lives people live as compared to animals.*

*The capacity for language puts human beings in the special position. Simply saying a word invokes the object that is named. Try it out: "Umbrella. "What did you think of when you read that word? Alright, that one's pretty homeless. But consider what this means if the named object was fearful: anything that reminded the person of his name would invoke fear it would be as if all the dog needs to feel fear is not an actual cake but the thought of being kicked. That is exactly the situation you are in. That is exactly the situation all humans are in with language. Here is an example: Take a moment now to think of the most shameful thing you have ever done. Take a moment to actually do this.*

*What did you just feel? It's very likely that as soon as you read this sentence, you felt some sense of either fear or resistance. You may have tried to dismiss the request and quickly read on. However, if you paused and actually tried to do what we asked, you probably began to feel a sense of shame while you remembered a scene from your past and your actions in it. Yet all that happened here was that you were looking at patterns of ink on paper. Nothing else is in front of you but that. Because relations that verbal humans learn in one direction, they derive in two, they have the capacity to treat anything as a symbol for something else. The etymology of "symbol" means "to throw back as the same," and because you are reacting to the ink on this paper symbolically,*

*the words you just read evoked a reaction from you; perhaps they even reminded you of a shameful event from your past.*

*Where could you go so that this kind of relation could not take place? The dog knows how to avoid pain: avoid you and your foot. But how can a person avoid pain if anytime, anywhere, pain can be brought to mind by anything related to that pain? The situation is actually worse than that. Not only can we not avoid pain by avoiding painful situations (the dog's method), pleasurable situations might also might evoke pain. Suppose someone very dear to you recently died, and today you see one of the most beautiful sunsets you have ever seen. What will you think?*

*For human beings, avoiding situational cues for psychological pain is unlikely to succeed in eliminating difficult feelings because all that is needed to bring them to mind is an arbitrary cue that evokes the right verbal relations. This example of a sunset demonstrates the process. A sunset can evoke a verbal history. It is "beautiful" and beautiful things are things you want to share with others. You cannot share this sunset with your dear friend, and there you are, feeling sad at the very moment you see something beautiful.*

*The problem is that the cues that evoke verbal relations can be almost anything: the ink on paper that made up the "shame," or a sunset that reminded you of your recent loss. In desperation, humans try to take a very logical action: they start trying to avoid pain itself.*

*Unfortunately, as we will discuss in the coming weeks, some methods of avoiding pain are pathological in and of themselves. For example, dissociation or illegal drug use may temporarily reduce pain, but it will come back stronger than ever and further*



*damage will be caused. Denial and learned numbness will reduce pain, but they will soon cause far more pain than they take away.*

*The constant possibility of psychological pain is a challenging burden tht we all need to face. It is the elephant in the living room that no one ever mentions. This doesn't mean that you must resign yourself to trudging through your life suffering. Pain and suffering are very different. I believe that there is a way to change your relationship to pain and to then live a good life, perhaps a great life, even though you are a human being whose memory and verbal skills keep the possibility of pain just an instant away.*

### **EXERCISE: Your Suffering Inventory<sup>12</sup>**

---

Invite the patient to follow along as you read the instructions below. The patient should then fill in the inventory in her workbook. *Please write down a list of all of the issues that are currently psychologically difficult for you. Use the left-hand side of the space provided below. Do not write about purely external or situational events, independent of your reactions to them. We will focus on how you react. Some of your psychological issues will be clearly related to specific situations; others may not be. For example, “my boss” would not be a good example of a difficult issue you experience; but “getting frustrated with my boss” or “feeling put down by my boss” might be. The left-hand column can include any of your thoughts, feelings, memories, urges, bodily sensations, habits, or behavioral predispositions that may distress you, either alone or in combination with external events. Don't overthink it. Just write down what plagues you and causes you pain. Be honest and thorough and create your “suffering inventory” in*

---

<sup>12</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*the space below. After you've completed your list, go back and think about how long these issues have been a problem for you. Write that down as well.*

<b>Painful and difficult issues I experience</b>	<b>How long this has been the case</b>

*Now we would like to ask you to organize this list. First, go back and rank these items in terms of the impact that they have on your life. Then, in the space provided below, write down the same items, but rank them in order. The order should range from those items that cause you the most pain and difficulty in your life to those that cause you the least trouble. You will use this list as a guide throughout the remainder of this book. We'll ask you to refer back to this list as your touchstone for the events and issues that cause you pain.*

---



---



---



---

---

---

---

---

---

---

*Finally, in the area to the right of this list, draw arrows between every item on the list that is related to another item. You will know that two items are related if changes in one might alter another. For example, suppose one of your items is “self-criticism” and another is “depression.” If you think the two are related (that is, the more self-critical you are, the more likely you are to feel depressed, or vice versa), draw a two-headed arrow between self-criticism and depression. You may find that this area becomes cluttered with arrows. That’s fine. There is no right or wrong way to do this. If everything is related, it’s important to know that. If some items relate to only a few others, that is useful information too. The higher on your list the items are and the more other items they connect to, the more important they become. This may suggest a re-ranking of your problems and you may find that you now want to combine some items or to divide them into smaller units. If that is so, you can create your final working list below, ranked from highest to lowest in order of impact on your life.*

---

---

---

---

---



---



---



---



---

*This is your personal suffering list. For you, it is what this workbook is about.*

### **Treatment Goals**

Use the personal suffering list to generate the patient's goals for treatment; this should overlap considerably with the Suffering Inventory list. Validate the patient's feelings about the items on the inventory and simply ask, "What are your goals for treatment?" Other ways to inquire about treatment goals include: "What would you like to change about yourself and/or your life as a result of treatment?" "What would you like to accomplish through this treatment?" "How will you know if the treatment has worked? What will be different for you?"

### **Cognitive Defusion: Separating Your Thoughts From Their Referents<sup>13</sup>**

Introduce the concept of cognitive defusion using the following script as a guideline: *The table below describes a number of different cognitive defusion techniques. These techniques don't necessarily move in a specific predisposed order, in that they don't teach one skill that then leads to another skill in a particular sequence. Rather, they are a set of techniques that intertwine and overlap with one another. Some of the same concepts may be repeated in many different techniques.*

---

<sup>13</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*Defusion techniques are not methods for eliminating or managing pain. They are methods for learning how to be present in the here and now in a broader and more flexible way. Suppose you put your hands over your face and someone asks you, "What do hands look like?" You might answer, "They are all dark." If you held your hands out a few inches away, you might add, "they have fingers and lines in them." In a similar way, getting some distance from your thoughts allows you to see them for what they are.*

*The point is to break through the illusion of language, so that you can notice the process of thinking (i.e., creating relations among events) as it happens rather than only noticing the products of that process—your thoughts. When you think a thought, it structures your world. When you see a thought you can still see how it structures your world (you understand what it means), but you also see that you are doing the structuring. That awareness gives you a little more room for flexibility. It would be as if you always wore yellow sunglasses and forgot you were wearing them. Defusion is like taking off your glasses and holding them out, several inches from your face; then you can see how they make the world appear to be yellow, instead of seeing only the yellow world.*

*After you master defusion, you can make an informed judgment about whether it helps you to be more flexible in living the way you want to live. The best way to do this is practice, practice, practice. You won't be able to make these techniques a part of your behavioral response patterns without practicing them. You can't just read them passively and hope to "get it." Take these skills with you in your life and apply them. Let your experience be your guide. Practice doesn't make perfect, it makes permanent.*

Have the patient read through the list and put a star next to the techniques that are most salient to them. Discuss each of these and facilitate practice applying the technique to the patient's specific issues.

### A Sampling Of Cognitive Defusion Techniques<sup>14</sup>

Describe, don't evaluate	Use descriptions like "I am feeling anxiety and my heart is beating fast" instead of evaluations like "This anxiety is unbearable/terrible/crazy etc"
The Mind	Treat "the mind" as an external event, almost as a separate person. (e.g., "Well, there goes my mind again" or "My mind is worrying again").
Mental appreciation	Thank your mind when you notice it butting in with worries and opinions; show aesthetic appreciation for its products (e.g., "You are doing a great job worrying today! Thanks for the input!") <i>This is not sarcasm...</i> after all, the word machine is doing exactly what it was designed to do all of those thousands of years ago: "problem solve" and avoid danger.
Commitment to openness	If you notice you start to fight with your insides when negative content shows up, ask yourself if such negativity is acceptable, and try to get to yes.
Just noticing	Use the language of observation (e.g., noticing) when talking about private experiences. For example, "So, I'm just noticing that I'm judging myself right now."
"Buying" thoughts	Use active language to distinguish between thoughts that just occur and the thoughts that are believed, e.g., "I guess I'm buying the thought that I'm bad."
Pop-up mind	Imagine that your negative chatter is like Internet pop-up ads.
Cell phone from hell	Imagine that your negative chatter is like a cell phone you can't turn off (e.g., "Hello. This is your mind speaking. Do you realize you need to worry?")
Experiential seeking	Openly seek out more material, especially if it is difficult. If your mind tells you not to do something that is scary but worthwhile, thank your mind for the great hint and do the difficult thing with gusto.
Put it out there	Write down a negative evaluation you are ready to defuse from (e.g., mean, stupid, angry, unlovable, etc.) and put it on a name tag and wear it. Don't explain it to anyone for a while...just feel how it feels to have it out there.
Mind T-shirt	Imagine that your negative evaluations you are ready to defuse

<sup>14</sup> "Material for Patient Workbook/Clinician Manual first appeared in a self-help workbook titled: Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy by Steven C. Hayes, Ph.D. and Spencer Smith, New Harbinger Publishers Inc. and is reprinted here with the authors' permission."

	from are written in bold letters on your T-shirt. If you feel especially bold, actually <i>do</i> that!
Think the opposite	If your mind is stopping action, practice deliberately engaging in a behavior while trying to command its opposite. For example, get up and walk around while saying, "I can't move while I'm reading this sentence!"
Thoughts are not causes	If a thought seems to be a barrier to an action, ask yourself, "Is it possible to think that thought, as a thought, AND do x?" Try it out by deliberately thinking the thought while doing what it has been stopping.
Monsters on the bus	Treat scary private events as monsters on a bus you are driving. See if it is okay just to keep on driving rather than doing what they say or trying to get them to leave.
Who is in charge here?	Treat thoughts as bullies; use colorful language. Who's life is this anyway? Your mind's or yours?
How old is this? Is this just like you?	When you are buying a thought, back up for a moment and ask yourself, "How old is this pattern?" or "Is this like me?"
And what is that in the service of?	When you are buying a thought, back up for a moment and ask yourself, "What is buying this thought in the service of?" If it is not in the service of your interests, stop buying the thought.
Okay, you are right. Now what?	If you are fighting to be "right," even if it doesn't help move you forward, assume the White Queen has decreed that you are "right." Now ask yourself, "So what? What can I actually <i>do</i> to create a more valued life from here?"
Get off your but	Replace virtually all self-referential uses of "but" with "and."
Why, why?	If you find that your "reasons why" are entangling, ask yourself repeatedly why the event exists and why it functions the way it does, until you have a very hard time answering. It may help to show how shallow the story really is and how experiential avoidance creates the pain of absence. For example, "I can't do it." Why? "I feel anxious." And why does that mean you can't do it? "Ahh...don't know."
Create a new story	If you find yourself entangled in a "logical" but sad story about your life, and why things have to be the way they are, write down the normal story, then take all the descriptive facts and write the same exact facts into a different story. Repeat until you feel more open to new possibilities <i>with</i> your history.
Which would you rather be?	If you are fighting to be "right," even if it doesn't help move you forward, ask yourself, "Which would I rather be? Right or alive and vital?"
Try not to think x	Specify a thought not to think and then notice that you do think it.
Find something that can't be evaluated	If you find yourself entangled in negative evaluations, look around the room and notice that every single thing can be evaluated negatively if you choose to. So why should you be any different? This is just what the mind has evolved to do!

And how has that worked for me?	When you are buying a thought, back up for a moment and ask yourself, "How has that worked for me?" and if it hasn't worked ask, "Which should I be guided by, my mind or my experience?"
Carry cards	Write difficult thoughts on 3 x 5 cards and carry them with you. Use this practice as a metaphor for the ability to carry your history without losing your ability to control your life.
Carry your keys	Assign difficult thoughts and experiences to your keys. Then think the thought as a thought each time you handle your keys. Keep on carrying the keys and your thoughts.

At the end of this session, take some time to gather information about the patient's current thoughts and feelings. Explain that he or she will be attending another group session soon that will reinforce some of what has already been talked about but remind patient that he or she can also choose what information is shared in group and what is shared in individual sessions.



## Module 2

### Group Session #2

---

- Mindfulness overview, Tracking thoughts, bodily sensations
- Be Where you are exercise
- Willingness
- HW: Mindful exercises
- HW: What Needs to be Accepted

*Begin this session with a description of mindfulness using the following script as a guide: Mindfulness<sup>15</sup> is a way of observing your experience that has been practiced in the East through various forms of meditation for centuries. Recent research in Western psychology has proven that practicing mindfulness can have notable psychological benefits (Hayes, Follette, & Linehan, 2004). In fact, mindfulness is currently being adopted as a means of enhancing treatment in a number of different psychological traditions in the West (Teasdale et al., 2002).*

*A large part of this approach has to do with mindfulness. What ACT brings to this ancient set of practices is a model of the key components of mindfulness and a set of new methods to change these components. Weeks, months, or years of meditation, helpful as they can be, are not the only practices that can increase mindfulness, and in today's world, new means are needed to augment those that evolved in another, slower millennium.*

*In this manual you will learn to see your thoughts in a new way. Thoughts are like lenses through which we look at our world. We all have a tendency to cling to our*

---

<sup>15</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*particular lens and allow it to dictate how we interpret our experiences, even to the point of dictating who we think we are. If you are now stuck in the lens of your psychological pain, you may say things to yourself like, "I'm depressed." Thoughts of that kind can be dangerous; concrete methods to help you avoid those dangers are provided throughout this manual.*

*As you free yourself from the illusions of language, you will learn to become more aware of the many verbal lenses that emerge every day, and yet not be defined by any one of them. You will learn how to undermine your attachment to a particular cognitive lens in favor of a more holistic model of self-awareness. Using specific techniques, you will learn to look at your pain, rather than seeing the world from the vantage point of your pain. When you do that, you will find there are many other things to do with the present moment besides trying to regulate its psychological content.*

*Mindfulness is difficult, not because it is hard but because it is elusive. We are constantly being hooked by our verbal predictions and evaluations. Furthermore, life is complex. There are many, many things to be mindful of and, as events become more complex, it is easier to lose our way. You could practice focusing on only one aspect of your experience the way you did in the last chapter, but ultimately that would severely limit the breadth and richness of your actual experience.*

*Practicing mindfulness isn't going to do you much good if you just do the exercises written in this book and then forget about them. You need to make an effort to bring your attention more completely to the many moments in your life, fully, without defense, non-judgmentally, defused, and accepting. Formal practice can help you acquire the skills, but it is informal practice, using these skills in your day-to-day life, that is most*

*important. This module will help you develop ways to deepen your existence with mindfulness by asking you to pay attention to many different types of experiences as they enter your awareness. It will also give you some concrete ideas on how you can institute a mindfulness practice into your daily life.*

### **Daily Practice**<sup>16</sup>

*Before moving on to mindfulness techniques it is worthwhile to take some time to speak about when to practice mindfulness. Ultimately, the answer is “all the time.” The problem with this answer is that you probably aren’t accustomed to practicing mindfulness. It’s unlikely that you will randomly remember to apply mindfulness skills to day-to-day moments until they have become well established.*

*To deal with this problem, it’s a good idea to set aside some time to practice mindfulness every day. Once it becomes second nature (if it ever does), you can reconsider whether this is still necessary. Practicing mindfulness every day may sound like a daunting prospect but it becomes worthwhile immediately and, after a while, many people find that they really like doing it. However, regardless of whether you like or dislike it, these preferences are just more content your mind produces, and the whole point is to take back control over your life from your personal word machine. Given that, it is far more effective just to make the decision to practice every day, and then go for it. Here are some ways that you can institute a daily mindfulness practice:*

- 1. Set aside the time.** *In the beginning, it can be useful to set aside a designated amount of time every day or every week to practice mindfulness skills. The section*

---

<sup>16</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.

*below on sitting meditation has some specific examples related to that particular exercise. However, you can use the same basic principles for any of the mindfulness practices you choose to engage in. The first thing you will want to do is figure out how many times a week you want to practice. We recommend that you practice some form of mindfulness every day. If you absolutely can't seem to fit that into your schedule, then figure out how much you can manage. Second, it's a good idea to set a time to limit your practice. Something between fifteen and thirty minutes at a time is a good starting point. You can adjust this as you choose, once you become accustomed to the practice.*

**2. *Relaxation and distraction.*** *People are often tempted to use mindfulness practice as a time to relax. That is a mistake. If you are relaxed, that's fine, but if you are tense, that's okay too. The point, however, isn't to relax. The point is to be aware of whatever is going on for you without avoidance or fusion. It is a matter of acquiring and strengthening skills that can be useful when your verbal repertoire begins to dominate your other forms of experience. Initially, it is a good idea to find a place in which you can practice without having to do other tasks, but that doesn't mean eliminating the distractions your mind presents to you. If you are distracted, that is simply another fact to notice. See it, note it, and then move on with practice.*

**3. *Feeling too bad to practice.*** *There is no such thing as feeling too bad to practice. In some of the exercises below, you will find that when you are actually doing the work, negative content comes up for you. But this is only another set of experiences to be mindful of. It is not a problem; it is an opportunity. Presumably,*

*you started this treatment partly because you are already dealing with negative experiences. Learning what to do when such experiences show up is thus vital to your purpose. Practicing with, say, an irritating itch is in principle not any different than the same skills applied to, say, anxiety or depression. This doesn't mean to persist in the face of impossible circumstances. If you have a pain in your back that must be attended to, then do that. Persistence without self-awareness is just a different kind of trap. Over time, you will see that if you use pain as an excuse to run away from the practice, and if you detect that is how you are using pain, then you can learn how to do something new with pain. Ultimately, mindfulness should be practiced as moment-to-moment awareness in real-time. It is not a special state that you "enter into" like a trance, or self-hypnosis. These guidelines are meant simply to get you to start practicing the techniques. Once you see mindfulness entering into your daily life, you can decide whether to continue with a regimen of this nature.*

### **The Practice**<sup>17</sup>

---

*The practice of mindfulness is about getting in touch with your own experience moment to moment in a defused and accepting way. In earlier techniques we've discussed, you were asked to be mindful of specific areas of our experience (i.e., thoughts in time, bodily sensations, defusing from implicit evaluations). In this module, there will be other things you are asked to notice, but your responses needn't be guided by anything except the experiences that appear.*

---

<sup>17</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*At times, many things may come up for you at once. There are different ways you can handle this. Sometimes, you might alternate back and forth between different sensations. Sometimes, you will be able to hold a number of different things in your awareness at one time. Some of the exercises actually ask you to be mindful of more than one thing at a time.*

*Part of the elusiveness of mindfulness is that it is purposive, and thus evokes evaluations, but the whole purpose of being mindful is to learn how to defuse from your evaluations. The best way to think about it is that there is neither a right nor a wrong way to be mindful. Simply be who you directly experience yourself to be (a conscious observing self) in the moment. If evaluations show up, then observe the evaluations but do not believe or disbelieve them. If you take your verbal judgments about your progress literally, that will be yet another instance of fusion with the verbal story your mind generates. Buying into thoughts that judge you as good or not good at being mindful is just the word machine taking control once again.*

*As you practice, allow yourself to become more mindful of the sensations, thoughts, and feelings that are happening for you. Be gentle and non-judgmental (even with your judgments!). This isn't a test. It's just living. Now, let's dive into the exercises themselves.*

### **EXERCISE: Be Where You Are<sup>16</sup>**

---

*Provide the following introduction to the task to the group: I will now read a mindfulness exercise script aloud to you. Please follow the spoken instructions. Remember not to panic if you become distracted while doing this exercise. Just bring yourself back to the present moment and continue to follow the script.*

Exercise instructions: *Make yourself comfortable in your chair (if trying this at home, you can be seated in a chair or lying down on the floor or your bed). Close your eyes, if you are comfortable doing so, and take a few deep breaths. Relax. Don't let yourself drift off to sleep, but allow your body to rest.*

*Now slowly bring your awareness to the tips of your fingers. Feel your fingers. Rub your fingertips together. How do they feel? Can you feel the small indentations on your fingertips that are fingerprints? Take your time and try to feel them. What are they like? Are your fingertips rough from lots of work or are they smooth and silky? How does it feel to rub them together? Notice the feelings and then move on.*

*Now rest your fingers where they were before. What are they touching? Are they resting on the blanket on your bed, or are they resting on the arm of your chair? What does that feel like? Is it soft or hard? Does it have any other distinguishing features? Is the blanket furry with cotton? Does the armrest have any markings or is it smooth? Take the time to completely absorb the way these objects feel to your fingertips.*

*Now bring your attention to your hands and arms. What do they feel like? Perhaps they are relaxed and heavy. Perhaps they are still tense from a long day's work. Either way is okay. There is no need to judge, simply observe the feelings in your arms and hands. Are there any aches or pains? Take note of these, but do not fixate on them. Simply note the pain and move on. Move your attention down to your toes. Wiggle them around a little. Are they in shoes or socks? Are they free to move about? Swish your toes back and forth feeling whatever is beneath them. How does it feel? Can you tell what it is just by the feeling? Would you be able to tell only by touch? Just notice the sensations as you bring your awareness to your feet.*

*How is your head positioned? If you are sitting, is your head aligned with your spine or is it drooping, resting on your chest. Without trying to change the position of your head, simply note where it is positioned. There is no right way for your head to be. Just let it be where it is. Now think about the sensations in your head. Do you have a headache? Is your head relaxed?*

*What about your face? How does your face feel? There are all kinds of sensations to explore in your face. Think about your brow. Is it smooth and flat or is it crinkled up with stress? Again, don't try to change it, just notice it. Now bring your awareness to your nose. Can you breathe freely or are you plugged up? Take a few breaths in and out through your nose. How does that feel? Can you feel cool air flowing into your lungs or is the air warm? Pay attention to the feeling for a moment. Then think about your mouth. How is your mouth positioned? Is it pursed? Is it open? Is it closed? What about the inside of your mouth? Is it wet or dry? Can you feel the saliva coat the inside of your mouth and throat? Explore all of the sensations throughout your face. Perhaps you can feel oil on your skin. Perhaps your skin is dry. Perhaps there is no feeling at all. Just note it and move on.*

*Now bring your attention to your chest and belly. Place one hand on your chest and one hand on your belly. Can you feel yourself breathing? What is that like? Are you breathing fast or slow? Are your breaths going into your abdomen or into your chest? Breathe in through your nose and out through your mouth. How does that feel? Now invert the pattern. Spend some time with your breath, then place your hands wherever they were before.*



*Now think of your whole body. Where are you sitting or lying? Can you feel the back side of your body touch the chair or bed in various places? Be mindful of the way your body is positioned. There is no need to move, just observe.*

*Now think about the room you are in. Where are you positioned in the room? Do you have a sense of where the door is? What about the ceiling? Can you feel your body in the context of this larger space?*

*When you are ready, open your eyes and take a look around the room. You can move if you wish. Notice the location of the various pieces of furniture. What do they look like? You can spend as much time as you like investigating the different aspects of the furniture. Remember not to judge, just notice.*

Give group members time to observe and describe the room. Ask the group for comments and reactions. Encourage group to look through the mindfulness exercises in the patient workbook and practice one per day until next session. Advise group members that mindfulness exercises can be found on the Internet at no cost.

### **Acceptance And Willingness<sup>18</sup>**

*“Accept” comes from the Latin root “capere,” meaning “take.” Acceptance is the act of receiving or “taking what is offered.” Sometimes, in English, “accept” means “to tolerate or resign yourself” (as in, “Aw, gee, I guess I have to accept that”), and that is precisely **not** what is meant here. By “accept,” we mean something more like “taking completely, in the moment, without defense.”*

---

<sup>18</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*We use the word “willing” as synonym for “accepting” to stay true to that meaning of accept. “Willing” is one of the older words in the English language. It comes from an ancient root meaning “to choose.” Thus “acceptance” and “willingness” can be understood as an answer to this question: “Will you take me in as I am?” Acceptance and willingness are the opposite of effortful control. What follows is a description of what “take me in as I am” really means.*

*In our context, the words willingness and acceptance mean to respond actively to your feelings by feeling them, literally, much as you might reach out and literally feel the texture of the cashmere sweater. They mean to respond actively to your thoughts by thinking them, much as you might read poetry just to get the flow of the words, or an actor might rehearse lines to get a feel for the playwright’s intent.*

*To be willing and accepting means to respond actively to memories by remembering them, much as you might take a friend to see a movie you’ve already seen. They mean to respond actively to bodily sensations by sensing them, much as you might take an all overstretch in the morning just to feel your body all over. Willingness and acceptance mean adopting a gentle, loving posture toward yourself, your history, and your programming so that it becomes more likely for you simply to be aware of your own experience, much as you would hold a fragile object in your hand and contemplate it closely and dispassionately.*

*The goal of willingness is not to feel better. The goal is to open up yourself to the vitality of the moment, and to move more effectively toward what you value. Said another way, the goal of willingness is to feel all of the feelings that come up for you more completely, even—or especially—the bad feelings, so that you can live your life more*

*completely. In essence, instead of trying to feel **better**, willingness involves learning how to **feel** better.*

*To be willing and accepting is to gently push your fingers into the Chinese finger trap in order to make more room for yourself to live in, rather than vainly struggling against your experience by trying to pull your fingers out of the trap (see figure 1.2). To be willing and accepting means to give yourself enough room to breathe.*

*By assuming the stance of willingness and acceptance you can open all the blinds and the windows in your house and allow life to flow through; you let fresh air and light into your into what was previously closed and dark. To be willing and accepting means to be able to walk through the swamps of your difficult history when the swamps are directly on the path that goes in the direction you care about.*

*To be willing and accepting means noticing that you are the sky, not the clouds; the ocean, not the waves. It means noticing that you are large enough to contain all of your experiences, just as the sky can contain any clouds in the ocean any waves.*

*If you find your mind agreeing or resisting, just thank your mind for the thought. Your mind is welcome to come along for the ride but willingness and acceptance are states of being that minds can never learn how to achieve. Even if your mind can't learn how to be willing and accepting, you can learn.*

### **Why Willingness?**<sup>19</sup>

---

*One reason willingness is worth trying is that it is remarkable how consistently the scientific literature reveals its value and the danger of its flipside—experiential*

---

<sup>19</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*avoidance. The ability to practice willingness instead of experiential avoidance is one that is broadly applicable for psychological suffering. It has been studied extensively; the areas that are most relevant to this treatment model are described below:*

***Physical pain.*** *In virtually every area of chronic pain, physical pathology (the objectively assessed physical damage) bears almost no relation to the amount of pain, reduced functioning, and disability (Dahl et al., 2005). The relationship between the amount of pain and degree of functioning is also weak. What predicts functioning is (a) your willingness to experience pain, and (b) your ability to act in a valued direction while experiencing it (McCracken, Vowles, & Eccleston, 2004). These are precisely the processes targeted in this workbook. Training people how to accept their pain and how to watch it or “diffuse from” their thoughts about it greatly increases their tolerance of pain (Hayes et al., 1999) and decreases the amount of disability and sick leave downtime caused by their pain (Dahl, Wilson, & Nilsson, 2004).*

***Physical trauma, disease, and disability.*** *In head injury, spinal injury, heart attack, and other areas of physical illness or injury, the degree of physical pathology is a very poor predictor of rehabilitation success and long-term disability. What is predictive is the patient's acceptance of the condition and the willingness to take responsibility for her or his predicament (Krause, 1992; Melamed, Grosswasser, & Stern, 1992; Riegal, 1993).*

*In chronic diseases like diabetes, your acceptance of the difficult thoughts and feelings the disease gives rise to, and your willingness to act in the presence of these thoughts and feelings predict good self-management of the disease (Gregg, 2004). Other health-care problems, such as smoking, show the same results (Gifford et al., 2004). ACT promotes better health management as a result of changes in your willingness to accept*

*discomfort, unhook from your thoughts, and move toward what is most personally meaningful to you (Gifford et al., 2004; Gregg, 2004).*

**Anxiety.** *Unwillingness to have anxiety predicts having anxiety in many different forms (Hayes, Strosahl et al., 2004). For example, when exposed to the same levels of physiological arousal, experiential avoiders are more likely to feel panic than those who willingly accept their anxiety (Karekla, Forsyth, & Kelly, 2004). This is particularly true if experiential avoiders are actively trying to control their anxiety sensations (Feldner et al., 2003).*

*Among people who habitually pull out their own hair, experiential avoidance predicts more frequent and intense urges to pull, less ability to control urges, and more hair pulling–related distress than among people who are not experientially avoidant (Begotka, Woods, & Wetterneck, 2004).*

*People with generalized anxiety disorder are more likely to have high levels of emotional avoidance (Mennin et al., 2002), and both the amount of worry and degree of impairment they suffer correlates with experiential avoidance (Roemer et al., 2005). Even a very small amount of training in acceptance can be helpful, however. For example, just ten minutes of acceptance training made panic-disordered persons more able to face anxiety; training in distraction and suppression was not helpful (Levitt et al., 2004). Similarly, for anxious people, teaching them simple a simple ACT acceptance metaphor, the Chinese finger trap (see module 1), reduced avoidance, anxiety symptoms, and anxious thoughts more successfully than did breathing retraining (Eifert & Heffner, 2003).*

***Depression.*** *Up to half of the variations in the symptoms of depression can be accounted for by a lack of acceptance and willingness (Hayes, Strosahl et al., 2004).*

*This review could go on for many more pages, and deal with many more areas, but perhaps these examples are enough to make the point. The scientific literature is filled with evidence that the person's willingness to experience whatever emotion is present is of central importance to many areas of human psychological functioning.*

*So, why is willingness so important? Perhaps some first-person accounts of the importance of willingness will be more convincing than a capsule review of the literature. Read the following statements and see if they hold true for you too.*

- ❖ *Why willingness? Because when I am struggling against my painful experiences, the struggle seems to make them all the more painful.*
- ❖ *Why willingness? Because when I move away from the pain that I meet when I'm pursuing what I value most, I also move away from the richness of life that those valued actions bring to me.*
- ❖ *Why willingness? Because when I try to close myself off from the painful parts of my past, I also close myself off from the helpful things I've learned from my past.*
- ❖ *Why willingness? Because I experience a loss of vitality when I am not willing.*
- ❖ *Why willingness? Because my experience tells me that being unwilling just doesn't work.*
- ❖ *Why willingness? Because it is a normal human process to feel pain, and it is inhumane and unloving to try to hold myself to a different standard.*
- ❖ *Why willingness? Because "living in my experience," that is, living in the moment, seems potentially more rewarding than "living in my mind."*

- ❖ *Why willingness? Because I absolutely know how my pain works when I am unwilling, and I'm sick and tired of it. It's time to change my whole agenda, not just the moves I make inside a control and avoidance agenda.*
- ❖ *Why willingness? Because I have suffered enough.*

Ask group members to share their own responses to the question “Why willingness?”

### **What Needs To Be Accepted?**<sup>20</sup>

*In some ways, acceptance of your experience is required, even when the situation calls for deliberately changing your experience. If you accidentally put your hand on a hot stove, you would immediately pull it back. If you did it quickly enough, you might even avoid tissue damage and the pain might pass in a matter of seconds. But to do that you needed to know first that you were hurting.*

*One of the saddest side effects of the chronic unwillingness to feel is that we begin to lose our ability to know what it is that we are avoiding. People who can't identify what they experience emotionally are said to have “alexithymia,” which is a clear example of the unwillingness to feel. If you chronically avoid what you feel, eventually you do not know what you are feeling at all. That's sad for two reasons. First, it's far easier to make mistakes in life as a result. For example, you may begin a bad relationship by missing the signs your own feelings would give you that your new love interest is very similar to past partners who didn't work out for you.*

*Or, by not recognizing the uneasy feelings that might have warned you, you could take a job that would be unhealthy or excessively stressful for you. Like someone who's*

---

<sup>20</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*lost the sense of pain, experiential avoiders can place their psychological hand on top of the hot stove and just leave it there to burn. Second, it is know that experiential avoiders actually tend to respond more intensely to events, both positively and negatively (Sloan, 2004). In the service of keeping their distance from the pain they might otherwise feel more acutely than others, experiential avoiders also stand aloof from the joy they otherwise might feel more acutely than others.*

*The general point is that acceptance doesn't mean that your emotions will change, just as defusion doesn't mean that your thoughts will change. Ironically, if change is possible at all, it is more likely to take place when we adopt an accepting and defused stance. When you avoid getting into an unhealthy relationship, for example, in a very real way you've avoided both pain and damage, just as removing your hand from a stove avoids both pain and damage. But first you had to feel the pain or you wouldn't have removed your hand.*

*There are other kinds of pain that are not like a hot stove. These are forms of pain that either necessarily come along with healthy actions or are historical in their nature, conditioned, and not based on the current situation. If you exercise vigorously, your muscles will be sore. If you study hard, you will be tired. If you remember a past loss, you will be sad. If you open up to relationships, you will feel vulnerable. If you care about the world, you will know that others are hurting. Most psychological pain seems to be of this type.*

*Anxiety is usually not based on real danger; depression is usually not based on the objective current situation. Feelings that are historical in their nature, conditioned, and not directly caused by the current situation are like that. Some of these feelings are*



*not very good guides to action. For example, someone who has suffered abuse may be afraid of intimacy, even if that person's current partner is sensitive and kind.*

*In these kinds of situations, acceptance and willingness are needed for a second reason: without them, healthy action is not possible. Consider someone with panic disorder who has had several panic attacks in shopping malls and no longer dares to go inside a mall. Anxiety is, in part, a conditioned reaction. If shopping, freedom of movement, and the like are important to that person, eventually, it will be time to reenter shopping malls. That doesn't mean that the conditioning will now magically be removed. When such a person enters a mall again, guess what this person will then face? Anxiety. If that is unacceptable, the person now has an insurmountable barrier.*

*Ironically, as was discussed earlier, anxiety is only exacerbated by trying to get rid of it directly. If this person decides to wait until the anxiety disappears until beginning to live again, he or she is likely to wait a very long time.*

*When we say "acceptance" or "willingness" in this workbook we are not referring to accepting situations, events, or behaviors that are readily changeable. If you are being abused by someone else, "acceptance of abuse" is not what is called for. What may be called for is acceptance that you are in pain, acceptance of the difficult memories that have been produced, and acceptance of the emotional pain that will arrive when you stop relying on drugs and alcohol to regulate your emotions. Now, look at the following questions and see what comes up for you. If you have no idea what to write, just skip to the next question.*

**HOMEWORK: What Needs to Be Accepted**<sup>21</sup>

---

The memories and images I most avoid include:

---

---

---

Avoiding these memories and images costs me in the following ways:

---

---

---

The bodily sensations I most avoid include:

---

---

---

Avoiding these bodily sensations costs me in the following ways:

---

---

---

The emotions I most avoid include:

---

---

---

---

---

Avoiding these emotions costs me in the following ways:

---

---

---

---

<sup>21</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

The thoughts I most avoid include:

---

---

---

Avoiding these thoughts costs me in the following ways:

---

---

---

The behavioral predispositions or urges to respond that I most avoid include:

---

---

---

Avoiding these behavioral predispositions and urges to respond costs me in the following ways:

---

---

---

---

We just listed five domains of avoidance (memories and images; bodily sensations; emotions; thoughts; and behavioral predispositions and urges to respond), and we've asked about the costs in each of these domains. If you were able to respond to the questions in two or more domains of those listed above, and if two or more of these have clear costs, then you are ready to embrace willingness.

**HOMEWORK: Mindfulness Exercises<sup>22</sup>**

---

**Silent Walking**

Many cultures have developed different forms of walking meditations. This exercise is a variant of some of these. Take ten minutes (or longer) and walk silently. You might walk around in a circle in your yard, you might walk around the house, or you might take a walk around the neighborhood. Try to remain silent throughout the course of the entire walk so that you can “listen” to the content your mind is producing.

As your attention is drawn to particular in your environment, thoughts in your mind, or feelings in your body, call these out by saying them three times. The purpose of the brief word repetition is to support you in defusing from your thoughts about the event. For example, if you are walking around the neighborhood and you see a car go by, say aloud, “Car, car, car.” If you start to feel stressed out during the walk, you might say “stress” three times. Notice what happens as you do this.

Notice each time your attention is repeatedly drawn to something. For example, if you notice that you keep coming back to certain thoughts or feelings during your walk, you might want to gently file this information away. You might want to focus on these matters with other skills that were presented in this or previous chapters.

**Cubbyholing**

In this next exercise, you will be asked to note the category of your psychological content as it comes up. This exercise can be done on its own, it can be done in conjunction with just about any other exercise in this workbook, or it can be done as you

---

<sup>22</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

carry on with your normal day. As thoughts, feelings, or bodily sensations arise, mindfully note into which category they fall. Do this aloud if you are in a place where you can do that. Do not call out the specific thought or emotion; the point is to focus only on the category to which the content belongs. Here is a list of the different categories from which to choose. Undoubtedly, there are many more categories, but for the purposes of this exercise, stick to the ones listed below.

- ❖ Emotion
- ❖ Thought
- ❖ Bodily sensation (just say “sensation”)
- ❖ Evaluation
- ❖ An urge to do something (just say “urge”)
- ❖ Memory

When you do this exercise, lead-in your labeling of the content with the word “there’s.” For example, if you start to feel your heart beating really fast, say, “There’s sensation.” If you respond to your fast heartbeat with the fear that you are going to have a panic attack, you could say, “There’s emotion.” If your fear is so great, you feel compelled to call a doctor, you could say, “There’s an urge.”

You can do this exercise while sitting, but you can also do it on long drives, while lying in bed at night, on walks, and so forth. Once you start it, try to stay with it for at least several minutes, more if you are able. If you catch yourself in long periods of silence, see if you haven’t been hooked by a thought or feeling that you’ve been following. Then come back to the exercise.

Labeling psychological content by type will help you to learn to deal with content in a defused way. For example, if you have a thought about what you need to do later on, staying with the label, “there’s a thought” supports you in staying present with what is

actually happening. The thought may be about the future, but that is pure content. In fact, the thought is occurring now, and noticing that is a powerful habit of mind. Cultivating this habit can be helpful when even more difficult content appears (e.g., a thought that you may have a panic attack later).

### **Eating Raisins**

Raisins are funny little fruits and when we eat them, we tend to just pop them into our mouths without much thought. You might be amazed to discover how much deeper your experience of a raisin can be if you treat it mindfully.

First, take a raisin and eat it the way you normally do, that is, just pop it into your mouth. Now, get another raisin. Put it down on the table in front of you and examine it. Notice the wrinkles on its skin. Look at the various shapes the wrinkles form. Take out a second raisin and place it next to the first and notice how unlike they are. No two raisins are identical.

Are the two raisins the same size? Think about the raisins in terms of the space they take up in the room, in the world, in the universe. Think about their size in relation to one another.

Now pick up one of the raisins and roll it around between your fingers. Feel the texture on the one side of the fruit. Feel the slightly sticky traces it leaves on your fingers as you move it back and forth.

Place the raisin in your mouth. Roll it around inside your mouth, over and under your tongue. Hide it in the crevices between your jaws and cheeks. Don't chew on it for at least thirty seconds or so. When you are ready, eat the raisin and note the way it tastes.

Note the way it feels on your teeth as you chew. Feel it as it slides down your throat when you swallow it.

Now eat the second raisin, but this time, eat it super slow. Chew the raisin as many times as you can, until it turns into liquid mush in your mouth. Is the flavor different when it is eaten this way than it was last time? How is it different? What does it feel like in your mouth as it falls apart? How does it feel as you swallow it? How does it compare with the last raisin? What's different when you eat the raisin mindfully rather than simply popping it in your mouth and slurping it down? Write down your answers to these questions in the space below:

---

---

---

### **Drinking Tea**

Now we will try a similar exercise with a cup of tea.

1. Boil a pot of water.
2. Get a tea bag or a tea-leaf strainer filled with tea leaves and put it into a cup.
3. Pour the boiled water over the tea bag or the strainer. Fill the cup.
4. Let it steep.

As the tea steeps, watch the water change colors. When you first pour the water over the tea, the water will turn a light brown, green, or red (depending on the kind of tea you are using). Soon it will darken. Let it steep for a few minutes and remove the tea from the water. Look closely at the color of the tea. Is there anything you didn't notice about the color before? If so, you might want to jot down your observation below:

---

---

---

Now place your hands around the outside of the warm cup. Have you ever felt a cup of tea like this before? How does it feel? Is it quite hot, or just warm? Note the temperature.

Bring the cup to your lips. Smell the tea. Take a good long whiff. Ninety percent of your sense of taste is controlled by your nose. If you aren't smelling your tea, you aren't tasting it.

Now take a sip. Does it burn your lips? Is it too hot? Or is it nice and warm? What does it taste like? Try to note your experiences without judging them. Then, describe your experience below:

---

---

---

If you don't like tea, that doesn't really matter. Just try the exercise. Note how much you dislike tea as you taste it. And write down that experience. It's folly to think that you should practice present moments of awareness only in moments of pleasure. That would eliminate half of your life. You know that you will have some unpleasant experiences, so you might as well experience them fully and take them for what they are worth.



**Mindful Eating**<sup>23</sup>

There are as many ways to practice mindful eating as there are schools that practice mindfulness. Some ways require you to eat slowly, some to chew each mouthful of food fifty times, some to eat a limited number of meals, some ask you to test for your hunger responses while you're eating, and so forth.

In many Western cultures, and particularly in the United States, we don't pay a great deal of attention to the food we eat. In a world where everything is supersized and the burger is king, we tend to think of food as not much more than a necessary factor of survival. What's worse, we tend to believe that this factor is as much a given as the air we breathe. We take our food for granted.

In the context of this book, the point of eating mindfully is not the activity of eating itself. It is used as a means to practice mindfulness. Becoming aware of your eating behavior rather than just rushing through it is an excellent way to bring yourself back to the present moment. Observing yourself while you eat is a great way to practice removing yourself from the conceptualized self. It doesn't matter whether you like the activity of eating. The important thing is to practice connecting to the present moment.

To practice eating mindfully, you can use many of the same techniques and much the same attitude as you did while doing the exercises above, only you continue the practice for an entire meal. Set aside some extra time for yourself at your next meal and try it out.

---

<sup>23</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

**Eating Mindfully<sup>24</sup>**

To start, move through the meal slowly. Take your time performing every action and notice what your experience is as you go through it. When you lift a fork or cut your meat, note what that is like for you. As you place a bite of food in your mouth and chew it, think about the flavors and the texture of the food. Is it enjoyable or repulsive? Don't get hung up in judging it. Just notice it.

Do you find that particular thoughts or feelings come up during the course of the meal? If so, simply note those as well. You might want to use some of the techniques used throughout this workbook to help you do that.

Are you eating with a friend or partner? Are you eating alone? It may be interesting to watch your mind as you interact with the people with whom you take your meals. It may also be interesting to note the kinds of thoughts and emotions that come up when you are eating alone.

Because we all have to take the time to eat in order to live, eating mindfully is an excellent way to practice staying in contact with the present moment and making the most of your time.

**Be Mindful of Your Feet While You Read This<sup>19</sup>**

Bring your focus to your feet. Think about how they feel just where they are. Try to remain mindful of your feet while you read the next few lines.

Mary had a little lamb

Whose fleece was white as snow.

---

<sup>24</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

And everywhere that Mary went  
The lamb was sure to go.  
He followed her to school one day  
Which was against the rules.  
It made the children laugh and play  
To see a lamb at school.

Were you able to remain mindful of your feet while reading this nursery rhyme?

Did you notice that your awareness was shifting back and forth between the content of the passage above and your feet? Did you become mindful of your feet only occasionally, when you remembered them? Or were you able to hold onto your feet mindfully while reading the passage above? Take a few minutes to answer some of these questions.

---

---

---

This exercise is particularly interesting on a number of levels. In the first place it asks you to divide your attention in half by asking you to remain mindful of your feet while reading a nursery rhyme. The other interesting thing about this exercise is that it mimics the way we sometimes can get so wrapped up in our own stories that we forget about other things that are going on for us.

When you get scooped up into the story of your depression, your anxiety, or your low self-esteem, often you may forget that there are many other things going on for you. That story may be the only matter you take notice of. You might also pay attention to your feet, your hands, the quality of the air around you, or millions of other factors that

are taking place within you and in your environment, at the same time your psychological distress stories are being generated. Remember, though, the goal is not to think of your feet as a means of forgetting about or ignoring the pain you are in. Rather you can focus on your feet to practice being able to attend in the moment, deliberately and flexibly, as you wish.

You can do this same exercise while reading the newspaper, or indeed this workbook. Pick out something specific to attend to and see whether you can focus in on it while simultaneously being very focused on your reading.

## Individual Session #2

---

- Reactions from group
- Review *What Needs to be Accepted* HW
- Process patient's experience with willingness and acceptance
- HW: Acceptance in Real Time

Begin this session by reviewing patient's reactions from group, as described in module 1. Be sure to ask if patient has been able to practice the mindfulness exercises throughout the week and if they understand the concepts of willingness and acceptance. Clarify and explain if needed.

Review the patient's *What Needs to Be Accepted* homework assignment. Explore patient's responses and inquire about the thoughts and feelings that emerged while completing the assignment. If the patient experienced difficulty coming up with responses, go through each response with her and help her to identify her personal areas of avoidance. In order to identify these areas, it may be helpful to inquire about what (memories, images, bodily sensations etc) make her uncomfortable and then assess for whether avoidance is utilized to cope with the discomfort.

### **HOMEWORK: Acceptance in Real Time<sup>25</sup>**

---

Introduce this homework assignment using the following dialogue as a guide: *In your **What Needs to Be Accepted** homework assignment, you identified memories, images, bodily sensations, emotions, thoughts, and behavioral predispositions that you tend to avoid; that have cost you because of your avoidance (e.g., anxiety, depression,*

---

<sup>25</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*anger, and so on). These are called “targets,” and have been a large part of the exercises you have completed; but what happens when you’re faced with content you struggle with in real-time? What happens when you are out there in the world, going about your real life, and you are faced with situations that cause you pain? If you’re an agoraphobic, for example, and you haven’t been outside of your home for a long time, you are going to be facing some heavy emotions/sensations when you step outside your front door. How should you handle instances like these?*

*The short answer is, the same way you’ve been learning to handle all of your difficult experiences. Open yourself to them by first putting yourself in the observer position, and then with your observer-self look at them with a defused, accepting, mindful posture. However, we would also like to help you deal with difficult experiences in a more concrete way than we’ve just described.*

*What we’d like to do is help you develop a set of experiences that you’re quite sure will bring up the negative content you’ve been avoiding, and then develop a graded-exposure program in which you will actually go out into the world, seek out these scenarios, and experience your experience in real-time.*

*To accomplish this, you’ll begin with the worksheet below. Fill in the space on the left with actual physical scenarios you think will bring up one of the willingness targets you identified earlier. Note that there are ten spaces, so try to come up with ten scenarios. Choose a variety of different situations in which your target will present itself. Think of some that will cause you a lot of distress and some that won’t cause quite so much discomfort. If you think of one scenario that feels really big and daunting, you might want to break it down into its component parts.*




*Once you have done this, take your first scenario, the one you numbered 1, and decide a time and place you would like to expose yourself to it. You can limit the amount of time of your exposure but what you can't safely limit is your willingness to experience what the exposure brings up for you. Avoidance of any kind has to be off the table. If you aren't sure you can make that commitment, generate an even smaller step, or limit this step further with limits on the time and situation. Take some notes in the space provided about when, where, and how long you are willing to do this exposure to the first item:*

---



---



---

*During the actual exposure you will use the skills you've already learned. First we will describe these skills and then we will shrink them down to a bulleted list that you can carry with you to remind you of actions you can take in the situation.*



*You should notice what your body does. Localize where you feel sensations and emotions in your body. Notice the feeling's qualities, and where it begins and ends. Scan your body and notice other places where you are feeling things, and after you've noticed them, psychologically reach out and allow yourself to feel these feelings without defense or manipulations. Make sure your purpose is simply to be present and willing. Nothing else. This is not a secret way to make bad feelings diminish or vanish, and, even if your feelings happen to change, don't buy into any thoughts that tell you otherwise.*

*Look around you when you are exposing yourself and observe what else is happening in the world around you. If there are people there, notice them. If there are objects, or buildings, or plants or trees, notice them. Do not do this to diminish the thing you are struggling with. The point is to add to your experience—in addition to these feelings there is also life going on all around you.*

*Notice what thoughts come up for you. Notice them the way you would notice a cloud drift by. Do nothing to make them come or go. Do not argue with them. Do not disbelieve them or follow them where they go. Just notice them, as you might notice the sound of a radio in the background. Thank your mind for generating all its products for you.*

*Notice the pull to your past and future. But see if you can stay in the present by becoming present with thoughts about the past and future. If you find yourself checking the clock, let go of your attachment to the time.*

*Notice the pull to act. If you feel the pull to leave or avoid or dissociate just feel that pull—willingly and fully.*

*Have some fun. Do something (anything!) new in the situation. Tell a joke. Hum. Eat. Skip. Play little mental games. For example, if there are people around, who can you identify with the worst haircut? What interests you in the situation? Be careful! This is **not** distraction. In **addition** to what you are struggling with, the point is to notice that there is **also** the opportunity to do many, many other things. Broaden the range of things that you can do when you're in contact with your target.*

*If you feel **really** bold, find out what your mind is saying you cannot or must not do and consider doing more of it (but only if you are willing!). If you're anxious and your mind tells you that you might look foolish if you become too anxious, then do something foolish. Put your hat on upside down, or your glasses on backwards. Ask a passerby what month it is. If your mind tells you that you might faint and fall down on the ground, then purposefully lie on the ground and see what it feels like to be there as others react to your prone body.*

*Notice that you are there as an observing-self, through all of this, unchanged. Use that sense to be present with your experiences (do not use it to dissociate or avoid). Above all, watch for every tiny little way your mind has been trying to "protect" you by avoidance. Undermine every form of avoidance, let go of it. And all of this has only one purpose: to practice being willing in the moment. No manipulation. This is not a new, secret way to regulate your internal processes. No more of **that**.*

*Got it? Okay, now go out and do it. Take all of your skills with you, and experience what you experience in real-time, fully and without defense. Set your limits beforehand.*

*Now, below you will see a bulleted list you can use to remind you of things to do. You can augment this list by adding any of the exercises you've done during the course of working with this book to help you either to defuse from or to accept thoughts and feelings, or to contact your observer-self. List any-thing that's worked for you. For example, if you suffer from agoraphobia, and you've decided to walk around the block for your first step, when your anxiety comes up, you might ask yourself: "If this feeling had a size, how big would it be? If this feeling had a shape, what shape would it be?"*

*Take this list with you and glance at it while doing your actual exposure. Notice your body and its sensations. Make room for them.*

- ❖ Notice what is around you. Appreciate your immediate environment.
- ❖ Do not avoid.
- ❖ Notice your thoughts, but just let them come and go. Don't follow them.
- ❖ Notice the pull to your past and future. Then notice that you are here in the present.
- ❖ Don't fight.
- ❖ Notice the pull to act and to avoid. Do nothing about that pull except to notice it.
- ❖ Do something new. Perhaps even be playful.
- ❖ Use your reverse compass (but only if you are willing!).
- ❖ Notice you are noticing all these things.
- ❖ List other things you might do below:

---

---

---

❖ Stick to your commitment: Be present. No avoidance.

*You can continue to repeat your exposure to scenario number one until you feel able to open yourself to the experience and accept what is given to you. This doesn't mean do it until your pain goes away. This isn't about that. Do it until you can make more room for all the thoughts, feelings, urges, bodily sensations, and memories you have. Welcome them into the home of yourself. Inhale them all.*

*When you have accomplished that (it can take multiple exposures), move on to scenario number two and do the same thing. If you hit a level that seems beyond you, put the list aside and come back to it after you've attended more sessions and gained a higher comfort level with ACT techniques.*

*You can continue working with this process indefinitely, using this list and many others. At some point, it may no longer be necessary to list scenarios and then pursue them in this manner. Once you've had some practice with your acceptance skills, you'll be able to integrate them into your daily life, and life itself will give you many chances to apply them. It is amazing how when we begin to say yes, life seems to present us with just the right challenges: always slightly more or slightly earlier than we might have wished and yet doable—if we are willing.*

### Module 3

#### Group Session #3

---

- Review *Acceptance in Real Time* HW
- Definition/ Explanation of Values
- Epitaph Exercise
- HW: Choosing Your Values

Begin group session by asking group members to share their experiences with the *Acceptance in Real Time* homework assignment. Inquire about group members' thoughts, feelings and reactions throughout the exposures, and encourage feedback from other group members.

Introduce the topic of values using the following script as a guide: *This is some of the most difficult work in this book. Values are intentional qualities that join together a string of moments into a meaningful path. They are what moments are **about**, but they are never possessed as objects, because they are qualities of unfolding actions, not of particular things. Said another way, values are verbs and adverbs, not nouns or adjectives; they are something you **do** or a quality of something you do, not something you **have**. If they are something you do (or a quality of something you do), they never end. You are never finished.*

*For example, say one of your values is to be a loving person. This doesn't mean that as soon as you love someone for a few months you are done, as you can be done with building a house or done with earning a college degree. There is more loving to do—always. **Love is a direction, not an object.***

*To complete the definition of "values" we must also define "choice." Choices are selections between alternatives that may be made in the presence of reasons (if your mind*

*gives you any, which it usually does, since minds chatter about everything), but this selection is not **for** those reasons in the sense that it is not explained by, justified by, or linked to them. A choice is not linked to an evaluative verbal yardstick. Said another way, choice is a defused selection among alternatives. It is different than judgment, which is a verbally guided selection among alternatives.*

*The word “values” comes from a Latin root that means “worthy and strong.” It carries an implication of action, which is why that same root leads to the word “wield.” It connotes actually using what is important and strong. Values define not only what you want to pursue from day to day but what you want your life to be about. In some sense, what’s at stake here is a matter of life and death, or at least the difference between a vital life and a deadened life.*

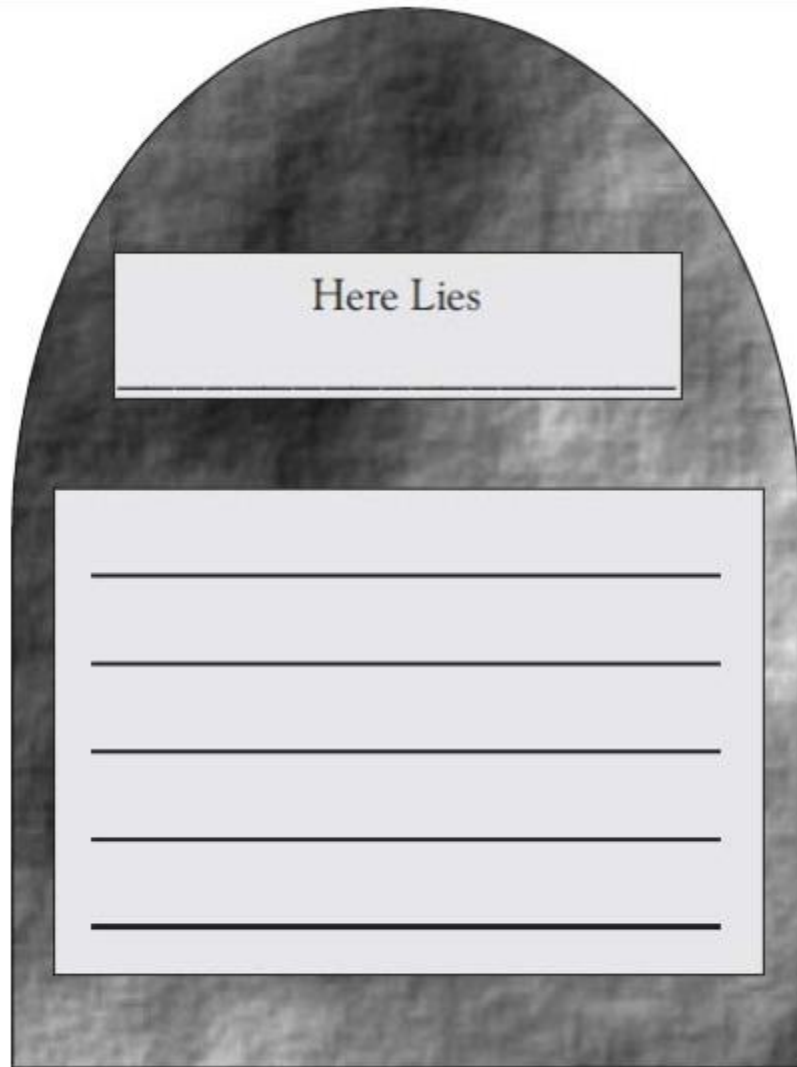
### **EXERCISE: Your Epitaph**<sup>26</sup>

---

*When people are buried, an epitaph is often written. They say things like “Here lies Sue. She loved her family with all her heart.” If the headstone below was yours, what inscription would you like to see on it? How would you most like your life to be characterized? Again, this is neither a description nor a prediction; it is a hope; an aspiration; a wish. It is between you and the person in the mirror. What would you like your life to stand for? Think about it for a moment and see if you can distill your innermost values into a short epitaph and write it out on the illustration of the tombstone below. Allow 10-15 minutes for group members to complete the exercise.*

---

<sup>26</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.



**Figure 3.1: Your epitaph<sup>27</sup>**

*This short exercise provides a broad beginning. Hopefully, it stirred up something in you that will allow you to become bolder and clearer about what it is you really want to*

---

<sup>27</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*be about. You are alive, not dead. How do you want to **live**? To give this question some structure, consider the following ten domains that might be of some importance to you:*

- 1. Marriage/couple/intimate relationship*
- 2. Parenting*
- 3. Family relations (other than intimate relations and parenting)*
- 4. Friendship/social relations*
- 5. Career/employment*
- 6. Education/training/personal growth and development*
- 7. Recreation/leisure*
- 8. Spirituality*
- 9. Citizenship*
- 10. Health/physical well-being*

### **HOMEWORK: Choosing Your Values<sup>28</sup>**

---

Introduce the homework assignment using the instructions below and explain to the group that this exercise will be reviewed in their individual session.

*What follows is a brief description of each of the above-mentioned domains as well as space for you to describe your own values in that domain. Keep in mind, as you go through this, that values are not specific goals, but general life directions. We'll get to concrete goals later. If you find yourself writing down material things that can be obtained such as an object, stop and rethink what it is we are asking for; that is,*

---

<sup>28</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



*directions that can always be made to manifest but that can never be fully obtained or finished.*

*Take what you've learned about values up to this point in this workbook and apply that to the following exercise. Remember the epitaph you just wrote, and see whether elements from that applies to one or more of these domains.*

*As you work through this exercise, you may discover that certain domains are very important to you and others are not. Some domains may be areas in which you are currently doing little. That's to be expected. It's not as though you need to value each of these different areas of life to the same degree. Different people have different values. A little later, we'll help you rate these values for yourself. For the moment, try to find a value that you hold in each domain. If there is an area for which you really can't think of anything, it's okay to skip it.*

*It may also be difficult to distinguish sharp boundary lines in certain areas. For example, some people have a hard time distinguishing between intimate relationships and family relations. Others may find it difficult to mark the difference between leisure and social relations. Read the description of each domain and try to keep the boundaries as clear as you can. If certain entries overlap, or you repeat a value in more than one domain, that's okay, but we encourage you not to overdo it.*

*This isn't a test. You need not show this to anyone if you don't want to. So be honest and open and give yourself the opportunity to explore what **you** value. Don't base this exercise on what you think your friends', family's, or society's expectations are. Write about what **you** value. There are no right or wrong answers.*

***Marriage/Couple/Intimate Relationship***

*For most people, intimate relationships are very important. This is the relationship you have with your “significant other”: your spouse, lover, or partner. If you are not in such a relationship right now, you can still answer these questions in terms of what you aspire to find in such a relationship.*

*What kind of person would you most like to be in the context of an intimate relationship? It might help to think about specific actions you would like to take, and then use those to dig down to the underlying motives for such actions. What are those underlying motives? How do they reflect what you value in your relationship? Do not put down goals (like “getting married”); there will be an opportunity for those later.*

---

---

---

---

***Parenting***

*Think about what it means to you to be a mother or father. What would you like to be about in this role? If you don't have children, you can still answer this question. What do you want to be about in supporting this role in others?*

---

---

---

---

***Family Relations (Other Than Intimate Relations and Parenting)***

*This domain is about family, not about your husband or wife or children, but about other areas of family life. Think about what it means to be a son, daughter, aunt, uncle, cousin, grandparent, or in-law. What would you like to be about in your family relationships? You may think about this broadly or only in terms of your nuclear family. What values would you like to see manifest in your life in this area?*

---

---

---

---

***Friendship/Social Relations***

*Friendships are another area of personal relations that most people value. What kind of friend would you like to be? Think about your closest friends and see if you can connect with what you would like to have manifest in your life regarding your friends.*

---

---

---

---

***Career/Employment***

*Work and careers are important for most people because that area is where a great deal of your life is spent. Whether your work is humble or grand, the question of values in work pertains. What kind of an employee do you most want to be? What do you*

*want to stand for in your work? What kind of a difference do you want to make through your job?*

---

---

---

---

***Education/Training/Personal Growth and Development***

*This area can cover all kinds of learning and personal development. School-based education is one. But this area includes all the things you do to learn, as well. Working through this workbook could be an example. What type of learner do you want to be? How would you like to engage with that area of your life?*

---

---

---

---

***Recreation/Leisure***

*Recreation, leisure, and relaxation are important to most of us. It is in those areas that we recharge our batteries; the activities in this area are often where we connect with family and friends. Think about what is meaningful to you about your hobbies, sports, avocations, play, vacations, and other forms of recreation. In these areas, what would you like to have manifest in your life?*

---

---

---

---

### ***Spirituality***

*By spirituality, we don't necessarily mean organized religion, although that could certainly be included in this section. Spirituality includes everything that helps you feel connected to something larger than yourself, to a sense of wonder and transcendence in life. It includes your faith, spiritual and religious practices, and your connection with others in this domain. What do you most want to be about in this area of your life?*

---

---

---

---

### ***Citizenship***

*How would you like to contribute to society and be a member of the community?  
What do you really want to be about in social/political/charitable and community areas?*

---

---

---

---

---

***Health/Physical Well-Being***

*We are physical beings, and taking care of our bodies and our health through diet, exercise, and sound health practices is another important domain. What do you want to have revealed in your life in these areas?*

---

---

---

---

*Sometimes we get confused about what values are. People often make the mistake of stating that they value something when, in fact, that chosen value has been dictated by the desire of others. To test your values, look over the exercise above and ask yourself the following question in regard to each of the values you wrote down: "If no one knew that I was working on this, would I still do it?" If you find that you've written down statements that don't "ring true," or are more a matter of "being a good boy or girl" than stating what is truly in your heart, go back and edit what you wrote. This list is not for anyone else. It is for you.*

---

---

---

---

### Individual Session #3

---

- Reactions from group
- Review *Choosing Your Values* HW
- Exercise: Ranking Your Values

Begin this session by reviewing patient's reactions from previous group, as described in module 1. Review *Choosing Your Values* homework assignment, taking time to go through each of the ten valued domains. It is important to explore patients' experience in completing this exercise as well as to help them to identify values if they had trouble doing so. Ask patients to provide examples of ways in which they feel they exemplify (or would like to exemplify) these values in their daily life. When list of values has been solidified, move on to introducing the *Ranking Your Values* exercise.

#### **EXERCISE: Ranking Your Values**<sup>29</sup>

---

*In some ways, it's not very important that certain values are more meaningful to you than others. All of the things you wrote about in the exercises above are areas of your life that you would like to pursue in order to live more completely. However, it can be useful to put a rank marker on your values in order to see in which areas of your life you might begin to take action.*

*Look back over the **Choosing Your Values** assignment. Now, distill each area down to one key value (if you have several, you can pick the most important one), and write a phrase to remind you of that key value in the space below. Now rate each area in two ways. First, ask yourself how important this particular area is to you right now on a*

---

<sup>29</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*scale of 1 to 10, with 1 meaning not at all important and 10 meaning extremely important. We aren't asking if this area is important in your actual behavior; we are asking what you would want if you could have your life be as you would want it to be.*

*Then, rate each area according to your actual current behavior. How well have you been currently living this value on a scale of 1 to 10? With 1 meaning it is not at all manifested in my behavior to 10 meaning it is extremely well manifested in my behavior.*

*Finally, subtract the score you got for your actual current behavior from the importance score above that to arrive at the total of your "life deviation" score.*

Table 12.1: Ranking Your Values				
Domain	Value	Importance	Manifestation	Life Deviation
Marriage/Couple/ Intimate Relationships				
Parenting				
Other Family Relations				
Friendship/ Social Relations				
Career/Employment				
Education/Training/ Personal Growth				
Recreation/Leisure				
Spirituality				
Citizenship				
Health/ Physical Well-Being				



**Table 3.1 Ranking Your Values**<sup>30</sup>

Complete this form with the patient; exploring his or her process of ranking each value and evaluating its importance and manifestation in his or her life. Discuss the patient's rationale for the *rankings and his or her reactions to the numbers in the Life Deviation column*.

*The number on the far right is probably the most important. The higher that number, the more your life needs to change in this area to bring it in line with what you really care about. High numbers under the Life Deviation column are a sign and source of suffering. You may want to highlight or circle those numbers that show the largest gap between the importance of your values and their actual presence in your life.*

---

<sup>30</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

## Module 4

### Group Session #4

---

- Creating the Road Map: Setting Goals
- Goals Worksheet
- Making Goals Happen Through Action
- Expected Barriers
- HW: Values Form

Introduce the concept of goal setting using the following script as a guide: In the last module, you explored and developed some ideas about what you value. *Each of those values is a compass point by which you can chart the course of your life. The next thing to do is start walking in that direction. This is basically a four-part process that repeats itself endlessly: Contacting your values, developing goals that will move you in a valued direction, taking specific actions that will allow you to achieve those goals, and contacting and working with internal barriers to action.*

*Go back to the **Ranking Your Values** exercise you did in module 3. In it, you listed some values and assigned importance, manifestation, and life-deviation scores. It's now time to decide which of those values you want to work toward enacting in your life right now. Ultimately, you'll work on all of them, but for now let's start with one. This will give you a model to follow for the other valued directions you want to take.*

*The values you choose to work on first can have a high life-deviation score, or if you sense that there are barriers there you are not yet ready to confront, you can choose something lower on your list. They are all important; they simply hold different levels of relative importance and you may pick any one to start with. Write down your stated value on the line below:*

---

*If your value is the compass point by which you want to guide your life's journey, your goals are the road map that can lead you there. Goals are different from values in that they are practical, obtainable events that move your life in the direction of your values. Goals are the guideposts by which you can mark your life's journey, and they are important for a number of reasons. Goals give you a practical means to make your values manifest. They also offer you a metric against which you can measure your progress on your valued path. The true goal of goals is to orient you toward your values so you can live a valued life, moment by moment. You may know what you want to be about, but without goals, it's unlikely you'll be able to live these values in the real world.*

*To start developing your goals you'll need to consider both short-term and long-term objectives. **Short-term goals** are the points on the map that are attainable in the near future; **long-term goals** are further down the road. Having both short-term and long-term goals makes for a paced journey that leads from one guidepost to the next. This is a very efficient way to travel. Theoretically, you could just wander around until you found your destination. But, as you know, that's not very effective. Goal-oriented travel is much more practical.*

*Look back at the value you wrote down above. Now think of one thing you could do that would allow you to make that value manifest in a practical way. In this workbook, there have been various discussions on values and goals. There also have been a number of examples that may offer you some guidance. Remember to think about this in terms of a practical outcome. Don't come up with something that is obviously outlandish.*

*If you're a fifty-year-old salesclerk who values public service, and you decide your goal is to become the president of the United States, that isn't likely to happen.*

*Choose a goal that is a workable step in the direction of your values. If you are that fifty-year-old salesclerk who values public service, there are hundreds of ways you might approach making a public service contribution that is both practical and obtainable. For example, you could do volunteer work in your community; perhaps serve food at a soup kitchen. Or, you might want to campaign for someone running for local office. This isn't said to discourage you from taking bold steps. Be bold. But be real. Don't be too easy on yourself, but be realistic and decide on something you can achieve.*

*Once you have your goal firmly in mind, write it down in the space below:*

---

---

---

Now check your goal for the following items:

- ❖ Is it practical?
- ❖ Is it obtainable?
- ❖ Does it work with your current situation?
- ❖ Does this goal lead you in the direction of your stated value?

*If you answered yes to these questions, then you have successfully created a goal for yourself. If you couldn't answer yes to whatever you wrote down in the space above, please raise your hand so that we can try to get clearer on what a goal is. (Allow time for further explanation, if necessary). The next step is to figure out whether this is a long-term goal or a short-term goal and whether or not you will need to complete additional goals to get there.*

---

*Next, on the following time line, plot a point where this goal would fall for you. The far left of the time line is your life, starting today. The end of the time line is your death, some reasonable amount of time in the future. Where on this line does your goal fall?*

---

**Life today****End of life**

*The relative distance between where you are today and when you think you could reasonably achieve this goal will tell you whether it is a long-term or short-term goal. If you've established that your goal looks like a long-term one, you'll need to develop some additional short-term goals to get there. If it's a short-term goal, you might ask where this goal is leading you and where you'd like to go after it's completed. Either way, you can return to the process described above until you are satisfied that you've produced a good set of long-term and short-term goals for the value you chose to work on. The following exercise will help you keep track of all this information. The following exercise will help you to keep track of all this information.*

**EXERCISE: Goals Worksheet<sup>31</sup>**

---

Guide patients in completing this worksheet; allowing approximately 3-5 minutes per section. Ask patients who are *willing* to share their goals.

Value:

---

This value will be manifested in the following long-term goal:

1. 

---

---

---

Which, in turn, will be manifested in these short-term goals:

1. 

---

---

---
2. 

---

---

---
3. 

---

---

---

---

<sup>31</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

This value will be manifested in the following long-term goal:

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which, in turn, will be manifested in these short-term goals:

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Repeat this process until you have a good working set. (It need not be comprehensive; you can always add and subtract from these at any time.)*

*There are no hard and fast rules about how many goals you need to have. This is about your life. Think about what you would like to accomplish, and set your goals in terms of how they will fit practically into your life. The numeration in the worksheet above is arbitrary. Perhaps starting with one long-term goal makes sense for you. Or if not, a single short-term goal may be a good place to start. You need not have a particular number of goals to be “doing the right thing.” If you’re getting caught in thoughts of this*

*nature, remember your mind is talking to you again. Use the strategies you've learned throughout this workbook and set your compass in the direction you want to live.*

*Setting goals is all about workability. If you don't make your goals workable within the context of your life, it's unlikely you'll get very far down the path of your values. Choose achievable, obtainable outcomes that can realistically fit with your life. Doing this makes it much more likely you'll actually be able to live your values every day. The true goal of this process is to become better able to focus on life as a valued process. Every goal is a step leading you further down the path of your life. The path itself doesn't end (at least not until your life ends). Being vital means there will always be some new way to pursue your values. Achieving your goals isn't an end, but a new beginning; a point of closure at which you can refresh your journey by starting anew. Guideposts are important, but don't be trapped by them. Celebrate goals achieved and keep on keeping on.*

### **Making Goals Happen Through Action<sup>32</sup>**

Introduce the concepts of actions and sub-actions and explain the importance of expecting barriers. Use the following script as a guide: *You can talk the talk all you want, but if you don't walk the walk, your life won't come alive for you. What we've been exploring in this workbook is important, but what are you going to **do** about it? If you know where you want to go and don't go there, then the knowledge makes little*

---

<sup>32</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



*difference. ACT is all about action. To make a difference in your life, you need to act.*

*What actions are you going to take to achieve your goals? To move in the direction set by your value compass toward your first goal, what do you need to do? Because life is a process, things happen one step at a time. Once you know what you value and what your goals are, you can choose which steps to take first.*

*Think about one of your short-term goals from the **Goals Worksheet**. It is important to define specific actions you need to take to achieve your goals. Make sure that you choose actions that you can actually do. Don't be vague (e.g., "Do better"), and don't write down things you cannot directly control by action (e.g., "Feel better"). Choose a specific situated action: this is an act that has a beginning and an end, a specified form, and a specified context. For example, "build friendships" is not a specific action. "Call friends" is better, but it is still too vague. "Call Sally" is fine. It has a beginning and end, a specified form, and a specified context. Try to include at least one thing you can do **today**.*

*For example, let's say, as part of a longer-term goal of letting friends know you care about them, you've decided to contact old friends. One specific action might be to call a specific old friend ("Sally") with whom you've lost contact. But this action may require others. The first thing you have to do is find out how to get in touch with her. To do this, you might call some other friends who know her, look her up on the Internet, find her number in the white pages, or contact members of her family to see where she is. Each of these options would be a specific action that would take you one step further toward your goal of getting in contact with your old friend. Try to come up with enough actions and sub-actions so that if you did them all, achieving your goal would become*

*highly likely, or even certain.*

### **Barriers**<sup>33</sup>

*Unfortunately, it's often not so simple. Unfortunately, barriers will come up. Some will come in the form of practical problems you'll face moving down your valued path. But more importantly for the work we are doing here, barriers are going to show up in the form of the experiences you've been trying to avoid, or in the form of the thoughts you've been fused with. In order to identify barriers, focus on the actions that you have identified and think about what psychological resistance you may have toward them. If you were to engage in the actions and sub-actions that you identified earlier, what would you expect to encounter psychologically that would slow you down? Look for difficult thoughts, feelings, bodily sensations, memories, or urges. If you aren't sure, close your eyes and picture engaging in the behavior and watch for indications of the barriers.*

*Once you are able to identify potential barriers, consider the strategies you have learned in this workbook up to this point. If you've developed "favorite" cognitive defusion, mindfulness, and acceptance strategies, you might consider using these. Flipping back through the book could help you remember what these are. In an ACT approach you do not "get over" barriers or "get around" barriers. You do not even "get through" barriers. You get **with** barriers. One successful ACT patient described it this way: "I used to run away from pain. Now I inhale it."*

---

<sup>33</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*So far, we've been exploring how you might walk down the path that a single value generates for you. But in module 3 we explored ten different valued domains. In each domain you may have written down more than one value. In addition, you may come up with values that don't necessarily fit the categories we've been exploring. If you valued a single thing, life would, perhaps, be simpler. But it wouldn't be as full and dynamic as it is when you value so many different things. If your list of values is full, that means you have an exciting journey ahead of you.*

### **HOMEWORK: Values Form**<sup>34</sup>

---

*Different journeys require different maps. Since we aren't moving toward a destination on a physical plane, we can take many different journeys at the same time. You can and should pursue different values in different domains at the same time. Life would be stripped of its richness if we weren't given this variability. The work you've done in this module could be summarized on the following form:*

---

<sup>34</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

Values Form			
Value: _____			
Goals	Actions	Barriers	Strategies

*If you wish, you can summarize the information we've discussed about your values and goals earlier in this session on this form. What's more, you can use this form as a way to generate road maps for each of your valued paths. You may want to photocopy it several times and go back to the values you worked out in module 3. Start with one of those values, write it down in the space at the top of the form, and do the*

*whole process again. In this way, you'll formulate a concrete game plan for the next steps on your life path that will span the many different areas you care about.*

After answering any questions group members may have about the assignment, allow time to process the ending of the group. Ask for group members' reactions to ending and remind them that they will have one final individual session as well. Offer your own reflections and observations about the progress that the group has made and the journey that you have all traveled together. Remind group members of the patient resource page in the event that they need more information about CD, or that they want to continue with an ACT therapist.

**Individual Session #4**

---

- Post-treatment questionnaires
- Reactions to treatment
- Review *Values Form* HW
- Building Patterns
- Termination

Ask patient to arrive early to complete post-treatment questionnaires. These include: SCL-90 (Derogatis, et al., 1976) to measure general psychological symptoms, the SF-36 (Medical Outcomes, 2002), the RFIPC to assess for IBD-specific quality of life (Drossman et al., 1991), the Harvey-Bradshaw Index to assess for Crohn's Disease symptom severity (Harvey & Bradshaw, 1980), the Beck Depression Inventory (BDI-II) and the Beck Anxiety Inventory (BAI) (Beck & Steer, 1993; Beck et al., 1996). Begin session by reviewing patient's responses and discussing her progress over the course of treatment.

Next, review *Values Form* homework assignment, taking time to go through each goals area with patient. Process patient's experience with the exercise and gather additional details about the responses she has provided on the form.

Introduce the concept of "pattern smashing" using the following script as a guide: *The biggest problem with avoidance and fusion is that they get so rigid because they become such large patterns. For new things to happen, we must break down the old things. ACT patients sometimes call this the "reverse compass." They learn that if a habit points north, it may be time to head south. When large, old, inflexible patterns break down, you have an opportunity to establish new patterns where they are needed. Some of these patterns can be consistent if it works for them to be so (for example, you may find that it*

*works to keep your commitments); others can be deliberately established as more flexible patterns if being more flexible works.*

*Let's discuss some pattern-smashing games that you might play. Suppose you notice the pull to "look good" and "be right" when you are with other people.*

*Superficially, your efforts cost you nothing, but you suspect they are part of a larger pattern of trying not to feel small, which, in turn, is part of a larger pattern of trying not to be seen, for fear of seeming small, and that is part of a larger pattern of accepting the idea that you are, indeed, small. If you noticed that pull, you might try doing something that would create social discomfort intentionally, for no other reason than to feel what it is like to be uncomfortable socially.*

*For example, wear white socks with dark clothing, but don't talk about it. Skip putting on your make-up or apply it in a silly way. Tell a lame joke deliberately, but don't explain it. Deliberately misstate a fact you know, but don't admit you are doing it deliberately. Tell an embarrassing story about yourself to friends. Pay for something using only small change. Purchase something odd (like deodorant) and then return it.*

*Do you see the point? The goal is not to be silly or to be a fool. Once you've broken up the pattern, new behaviors will become possible. The goal is to confront your larger patterns when you detect they have built a box for you to live in that spreads into areas you care about.*

*For example, if you can return deodorant, you also might be slightly more likely to knock on a stranger's door and ask for a contribution to feed hungry children (if an action like that appeared on one of the "action" lists linked to your goals and values. Or*

*you could call someone you barely know and ask for a date (if that showed up on one of the “action” lists linked to your goals and values).*

*One great way to break up unhelpful larger patterns is to do truly new things regularly. Paint a painting if you’ve never done so; learn to dance; sing a song in a karaoke bar; join a social group; take a cooking class; fix or build something yourself; write a poem; start a journal. This can be especially useful if these “things I just don’t do” are part of a larger pattern of avoiding failure.*

*Superficially, it seems as though it wouldn’t matter if you can’t give a toast because, “I’ll be embarrassed if it’s bad.” After all, how often would you have to give a toast anyway? But what larger pattern is being fed? If it is a larger pattern of playing small, you may be building yourself a straightjacket with these tiny choices. You may be feeding a conceptualized self (“I’m just not good at doing social things” or “I’m just too anxious”) that is systematically narrowing your own ability to live. If so, it’s time to kill off that conceptualized self by breaking the pattern.*

*We’ve identified some of the key larger patterns that language encourages: experiential avoidance, cognitive fusion, attachment to the conceptualized self, and so on. If you do anything different in the presence of events that normally lead to these patterns, you are helping to create more psychological flexibility. In the grandest scheme of things, that is the ultimate goal of ACT—the ability to fit your behavior creatively into the larger patterns you wish to create. Said another way, the ultimate goal of this workbook is psychological liberation. How much has your life been about what your mind suggests, rather than what you want it to be about?*

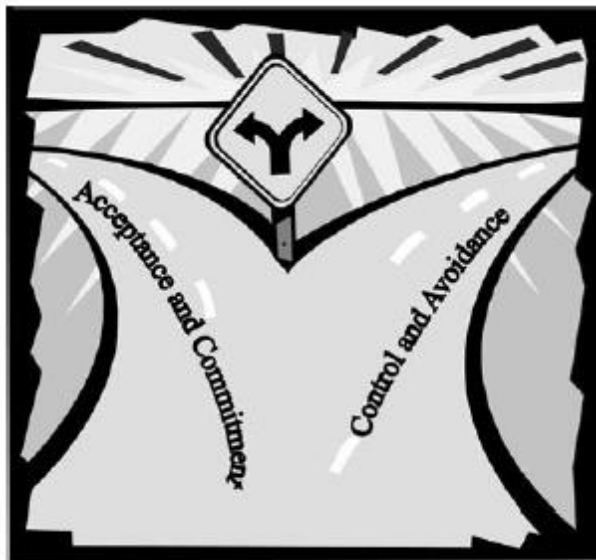


**CONCLUSION: The Choice to Live a Vital Life<sup>35</sup>**

---

*Present the information below to patient using the following script as a guideline:*

*When you confront a core problem within yourself, you are at a choice point much like the figure below illustrates. Off to the right lies your old path of avoidance and control. This is the path that the negative parts of yourself want you to take. It is the logical, reasonable, sensible, verbal path. Your mind will chatter on about dangers, risk, and vulnerabilities and will present avoidance as a method of solution. You've been down this path, over and over and over again. It's not your fault; you've done what any reasonable person would do. It just turns out not to be effective, vital, or empowering.*



**Figure 4.1: The crucial fork in the road.**

---

<sup>35</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

*It's not your fault, but now that you know, it is your responsibility. Life can and will make you hurt. Some of that you don't get to choose: it comes regardless. An accident may confront you with physical pain; an illness may confront you with disability; a death may confront you with feelings of loss. But even then you have the ability to respond (the response-ability).*

*The consequences that come into your life derive from the actions you engage in, and most especially the actions we've been discussing throughout this book. No one but you can engage in acceptance or avoidance; fusion or defusion; or living in your head or living in the present. Most of all, no one but you can choose your values.*

*There is a crucial fork in the road. You must choose which path to take. The less traveled path to the left is the path of acceptance, mindfulness, defusion, and valuing what you really care about. Down that road is vulnerability and risk, but it is about something.*

*These two roads lead to very different places. It's not that one leads to problems and one doesn't. It is not that one leads to pain and one doesn't. They both lead to problems. And they both lead to pain. To the right the problems are old and familiar; to the left they are new and even more challenging. To the right the pain is deadening and suffocating; to the left the pain is bittersweet and intensely human. You've often taken the right-hand path. By now its results are extremely predictable. Predictability makes this choice curiously "safe" but doesn't remove its deadening qualities. Acceptance and commitment offers a path with unknown ends. Its newness makes it a more frightening path but it also makes it a more vital one. Life is a choice.*

*Life is a choice. The choice here is not about whether or not to have pain. It is whether or not to live a valued, meaningful life.*

## **Termination**

---

Use this time to offer feedback to your patient about her progress over the course of treatment and to discuss ways in which he or she will live an intentional lifestyle. Offer your reactions about ending; and provide a space for your patient to do the same. Be sure to encourage patient to refer back to this workbook frequently, and to repeat exercises if he or she begins to feel stuck. Advise patient to incorporate mindfulness exercises into his or her daily or weekly routine and to continue regular medical management with his or her gastroenterologist. Remind patient of the “Patient Resources” page (see Appendix E), in the event that he or she wants more information about CD or is interested in continuing treatment with an ACT therapist. Terminating with a patient is a delicate process so allow yourself and your patient the space to express the myriad of emotions that can be associated with ending treatment.

## Appendix A

### Helpful ACT Resources

Hayes, S.C., Strosahl, K.D., and Wilson, K.G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press. [Seminal ACT book, recommended reading for all ACT clinicians.]

Hayes, S.C. and Strosahl, K.D. (2004). *A practical guide to acceptance and commitment therapy*. New York: Springer Science+Business Media, Inc.

Hayes, S.C. and Smith, S. (2005). *Get out of your mind and into your life: The New Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications, Inc.

Hayes, S.C. (2007). *ACT in action*. Oakland, CA: New Harbinger Publications, Inc.  
[DVD series]

Luoma, J.B., Hayes, S.C., and Walser, R.D. (2007). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists*. Oakland, CA: New Harbinger Publications, Inc.

Learning Acceptance and Commitment Therapy: [www.learningact.com](http://www.learningact.com)

Association for Contextual Behavioral Science: <http://contextualscience.org>

## Appendix B

### Guidelines for Informed Consent<sup>36</sup>

Clinicians are encouraged to have patients review and sign (if in agreement) an informed consent form. Due to the experiential and unconventional nature of ACT, it is important that patients be aware of what treatment will entail. The following are guidelines for material that can be added to existing informed consent forms of private practitioners, medical health-care settings, community mental health centers etc.

**Address alternative therapies.** It is beholden on the clinician to mention alternative treatment approaches that have demonstrated efficacy (including pharmacotherapy) and also to mention that alternative treatments where the direct evidence base is not substantial, but appears to be sensible given the more general evidence available in the literature. If there is a gold standard, like Barlow's Panic Control Treatment for panic—tell them about it. Explain that this treatment is designed to *supplement* medical treatment of Crohn's Disease and is NOT recommended as a substitution for medical management.

**Address risks and benefits.** This does not look much different than risks and benefits for any treatment—i.e. not everyone benefits from any treatment, even the most successful varieties. Inform the patient that the treatment we will do is directly connected to a tradition that has been useful for a lot of difficulties and that the evidence for this particular looks very promising in the breadth of difficulties for which it seems useful. Tell clients that treatment is difficult work and that they may experience significant distress during treatment. Commit to gathering feedback from the patient along the way

---

<sup>36</sup> Adapted from: *Informed Consent for ACT*. Retrieved from the Association for Contextual Behavioral Science webpage, Wilson, K.G. Full posting found at: [http://contextualscience.org/informed\\_consent\\_for\\_act](http://contextualscience.org/informed_consent_for_act)

to measure treatment progression.

**Propose specific time frame.** Inform patient that treatment will consist of approximately four 90 minute sessions of individual therapy combined with approximately four 90 minute sessions of group therapy.

**Set clear expectations.** Make sure that the patient understands the importance of attending all group and individual sessions. In the event of an illness or emergency, ensure that patient has the appropriate contact information and encourage patient to provide as much notice as is possible.

**Orient person to therapist, patient roles.** Inform patients that you will be working from a perspective that sees the people we call patients and the people we call clinicians as being in the same boat. Explain that if the clinician is to be most useful to them, it will help if the clinician can see the world through their eyes, feel it with their hands. Although the clinician cannot literally do so, explain that you will ask them to do their best to give you a sense of what it is like to live in their skin. Explain the experiential nature of ACT and explain that sometimes the clinician will be more active and sometimes the patient will be.

**Give general descriptions of operating principles.** Explain that ACT is based on many of the same principles as the best supported treatments available, and will use many of the same methods, but that it tends to look at difficulties in the broader context of whole lives and an individual's valued directions. Therefore the treatment will end up looking at valued domains of living and the ways that these difficulties fit into that whole life.

Explain that the work is acceptance focused and whole life focused, rather than being focused on very specific problems. Problems are not ignored, at all; however, they are looked at in this broader way. Explain that it will be very, very hard work and that we will not do a bit of work except in the service of the direction they would like to take their lives.

**Appendix C****ACT for Crohn's Disease Interview**

Note: The following interview is structured on the assumption that a thorough intake has already been conducted, that self-report measures have been completed, that this evaluation confirmed that patient is suffering with anxiety and/or depression, and that the treating clinician has reviewed this information.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

When were you diagnosed with Crohn's Disease? \_\_\_\_\_

Are you currently being treated by a physician for CD?    Y    N

How is your CD currently managed? \_\_\_\_\_

Please list current medications and dosages: \_\_\_\_\_

\_\_\_\_\_

Have you had any CD-related surgeries?    Y    N

If so, please list date(s) and procedure(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any other health problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Psychiatric Diagnoses or conditions (obtain before session from initial evaluation; review as needed) \_\_\_\_\_

Have you ever been in individual therapy before?    Y    N

Please describe type of treatment and overall outcome:

\_\_\_\_\_

Have you ever been in group therapy before?    Y    N

Please describe type of treatment and overall outcome:

\_\_\_\_\_

Have you ever deliberately hurt yourself in any way?    Y    N

If yes, describe:

\_\_\_\_\_

Have you ever thought that life is not worth living, or thought about killing yourself (or others)?    Y    N

If yes, when and how often?

\_\_\_\_\_

Have you gone so far as to make a careful plan as to how you would kill yourself (or others)?    Y    N

If yes, describe:

\_\_\_\_\_

Do you intend to act on this plan or intend to hurt yourself (or others)?    Y    N

\*If yes, discontinue interview and conduct a formal suicide risk assessment. If patient is currently at high risk for acting on these impulses, the suicidal or homicidal behavior

requires clinical attention beyond the scope of this treatment model. Treatment should be deferred until the patient has been psychiatrically stabilized.

What brings you to seek treatment at time?

---



---



---

What are your goals for treatment?

---



---

What do you view as your strengths?

---



---



---

Is there anything else about your life now or about how CD is affecting you that you think I should know?

---



---



---

## Appendix D

### Crohn's Disease Fact Sheet<sup>37</sup>

Named after Dr. Burrill B. Crohn, who first described the disease in 1932 along with colleagues Dr. Leon Ginzburg and Dr. Gordon D. Oppenheimer, Crohn's disease belongs to a group of conditions known as Inflammatory Bowel Diseases (IBD). Crohn's disease is a chronic inflammatory condition of the gastrointestinal tract.

When reading about inflammatory bowel diseases, it is important to know that Crohn's disease is not the same thing as ulcerative colitis, another type of IBD. The symptoms of these two illnesses are quite similar, but the areas affected in the gastrointestinal tract (GI tract) are different.

Crohn's most commonly affects the end of the small bowel (the ileum) and the beginning of the colon, but it may affect any part of the gastrointestinal (GI) tract, from the mouth to the anus. Ulcerative colitis is limited to the colon, also called the large intestine.

Crohn's disease can also affect the entire thickness of the bowel wall, while ulcerative colitis only involves the innermost lining of the colon. Finally, in Crohn's disease, the inflammation of the intestine can "skip"—leaving normal areas in between patches of diseased intestine. In ulcerative colitis this does not occur.

### Recognizing the Signs and Symptoms

Crohn's disease can affect any part of the GI tract. While symptoms vary from patient to patient and some may be more common than others, the tell-tale symptoms of Crohn's disease include:

Symptoms related to inflammation of the GI tract:

- Persistent Diarrhea

---

<sup>37</sup> Adapted from: *What is Crohn's Disease*. Retrieved from the Crohn's and Colitis Foundation of America webpage: <http://www.ccfa.org/what-are-crohns-and-colitis/what-is-crohns-disease/>

- Rectal bleeding
- Urgent need to move bowels
- Abdominal cramps and pain
- Sensation of incomplete evacuation
- Constipation (can lead to bowel obstruction)

General symptoms that may also be associated with IBD:

- Fever
- Loss of appetite
- Weight Loss
- Fatigue
- Night sweats
- Loss of normal menstrual cycle

Even if you think you are showing signs of Crohn's Disease symptoms, only proper testing performed by your doctor can render a diagnosis.

People suffering from Crohn's often experience loss of appetite and may lose weight as a result. A feeling of low energy and fatigue is also common. Among younger children, Crohn's may delay growth and development.

Crohn's is a chronic disease, so this means patients will likely experience periods when the disease flares up and causes symptoms, followed by periods of remission when patients may not notice symptoms at all.

In more severe cases, Crohn's can lead to tears (fissures) in the lining of the anus, which may cause pain and bleeding, especially during bowel movements. Inflammation may also cause a fistula to develop. A fistula is a tunnel that leads from one loop of intestine to another, or that connects the intestine to the bladder, vagina, or skin. This is a serious condition that requires immediate medical attention.

The symptoms you experience may depend on which part of the GI tract is affected.

**What are the Causes of Crohn's Disease? Who is Affected?**

Crohn's disease may affect as many as 700,000 Americans. Men and Women are equally likely to be affected, and while the disease can occur at any age, Crohn's is more prevalent among adolescents and young adults between the ages of 15 and 35.

The causes of Crohn's Disease are not well understood. Diet and stress may aggravate Crohn's Disease, but they do not cause the disease on their own. Recent research suggests hereditary, genetics, and/or environmental factors contribute to the development of Crohn's Disease.

The GI tract normally contains harmless bacteria, many of which aid in digestion. The immune system usually attacks and kills foreign invaders, such as bacteria, viruses, fungi, and other microorganisms. Under normal circumstances, the harmless bacteria in the intestines are protected from such an attack. In people with IBD, these bacteria are mistaken for harmful invaders and the immune system mounts a response. Cells travel out of the blood to the intestines and produce inflammation (a normal immune system response). However, the inflammation does not subside, leading to chronic inflammation, ulceration, thickening of the intestinal wall, and eventually causing patient symptoms.

Crohn's tends to run in families, so if you or a close relative have the disease, your family members have a significantly increased chance of developing Crohn's. Studies have shown that 5% to 20% of affected individuals have a first – degree relative (parents, child, or sibling) with one of the diseases. The risk is greater with Crohn's disease than ulcerative colitis. The risk is also substantially higher when both parents have IBD. The disease is most common among people of eastern European backgrounds, including Jews of European descent. In recent years, an increasing number of cases have been reported among African American populations.

The environment in which you live also appears to play a role. Crohn's is more common in developed countries rather than undeveloped countries, in urban rather than rural areas, and in northern rather than southern climates.

## **APPENDIX E**

### **Patient Resources**

#### **Acceptance and Commitment Therapy Resources**

Hayes, S.C. and Smith, S. (2005). *Get out of your mind and into your life: The new Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications, Inc. [This self-help workbook delves further into the principles of ACT and includes several experiential exercises.]

To find an ACT therapist:

<http://contextualscience.org/civicism/profile?gid=17andreset=1andforce=1>

#### **Crohn's Disease Resources**

Crohn's and Colitis Foundation of America: [www.ccfa.org](http://www.ccfa.org)

"A Patient's Guide to Crohn's and Colitis"—Jill Sklar

"Crohn's Disease and Ulcerative Colitis"—Fred Saibil, MD

## **Appendix B**

### **Patient Workbook**

Welcome! This treatment model is designed to use Acceptance and Commitment Therapy (ACT; said “act,” not spelled out) to reduce the symptoms of depression and anxiety that can accompany a diagnosis of Crohn’s disease (CD). Whether you are newly diagnosed, or have been diagnosed for years, the impact of CD is a significant one. Crohn’s disease is a gastrointestinal disease that occurs when there is chronic relapsing inflammation of the intestinal mucosa (Hanauer, 2006). Symptoms of CD include intense pain the abdomen, bloody stool, persistent or recurrent diarrhea, vomiting, low-grade fever, reduced appetite, malnutrition, and weight loss. It is the frequent combination of these symptoms and co-morbid depression and anxiety that form the rationale for creating this treatment program.

Treatment will be provided in the form of weekly 90-minute individual sessions combined with weekly 90-minute group sessions over the course of 4 weeks. Before beginning therapy sessions, you will meet with your individual therapist to complete an initial intake evaluation to gather relevant information about you. During this initial session, your therapist will provide an overview of the treatment model and ask you some questions about your experiences with CD. Please use this session to ask any questions you may have so that you can feel as comfortable as possible with the treatment program. Following this introductory session, you will attend your first group session.

This workbook contains psychoeducational information, experiential exercises and homework assignments to be completed between sessions. Be sure to bring this



workbook, a writing utensil and an open mind to each group and individual session. Let's get started!

**Module 1<sup>38</sup>****Initial Evaluation Session**

---

- Intake
- Introduction of Treatment Model
- Informed Consent
- Questionnaires
- Crohn's disease (CD) Interview

At the beginning of this session, your therapist will ask you some questions to get to know you better and to gather information about your history.

**Introduction of Treatment Model**

Acceptance and Commitment Therapy (ACT) is a new, scientifically based psychotherapeutic modality that is part of what is being called the “third wave” in behavioral and cognitive therapy (Hayes, 2004). ACT is based on Relational Frame Theory (RFT): a basic research program on how the human mind works (Hayes, Barnes-Holmes, & Roche 2001). This research suggests that many of the tools we use to solve problems lead us into the traps that create suffering. To put it bluntly, human beings are playing a rigged game in which the human mind itself, a wonderful tool for mastering the environment, has been turned on its host. Perhaps you've noticed that some of your most difficult problems have paradoxically become more entrenched and unmanageable, even as you've implemented ideas about how to solve them. This is not an illusion. This results from your own logical mind being asked to do what it was never designed to do. Suffering is one result.

---

<sup>38</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

If you are suffering with a psychological problem, you should know that research suggests that ACT helps with many common psychological difficulties (Hayes, Masuda, et al., 2004). ACT challenges some of the most culturally ingrained forms of conventional thinking about human problems. Research indicates that ACT's methods and ideas are generally sound, which provides reassurance that these concepts and procedures are effective. That doesn't mean they are easy to grasp. Here's a sample of some of the unconventional concepts you will be asked to consider:

- Psychological pain is normal, it is important, and everyone has it.
- You cannot deliberately get rid of your psychological pain, although you can take steps to avoid increasing it artificially.
- Pain and suffering are two different states of being.
- You don't have to identify with your suffering.
- Accepting your pain is a step toward ridding yourself of your suffering.
- You can live a life you value, beginning right now, but to do that you will have to learn how to get out of your mind and into your life.

Ultimately, what ACT asks of you is a fundamental change in perspective: a shift in the way you deal with your personal experience. I can't promise that this will quickly change what your depression or anxiety looks like, at least, not anytime soon. I can, however, say that research has demonstrated that the role of these problems as barriers to living can be changed, and sometimes changed quite rapidly. ACT methods provide new ways to approach difficult psychological issues. These new approaches can change the actual substance of your psychological problems and the impact they have on your life.

Metaphorically, the distinction between the function of a psychological disorder and the form it takes in one's life can be likened to someone standing in a battlefield fighting a war. The war is not going well. The person fights harder and harder. Losing is a devastating option; but unless the war is won, the person fighting it thinks that living a worthwhile life will be impossible. So the war goes on.

Unknown to that person, however, is the fact that, at any time, he or she can quit the battlefield and begin to live life now. The war may still go on, and the battlefield may still be visible. The terrain may look very much as it did while the fighting was happening. But the outcome of the war is no longer very important and the seemingly logical sequence of having to win the war before beginning to really live has been abandoned.

This metaphor is intended to illustrate the difference between the appearance of psychological problems and their true substance. In this metaphor, the war looks and sounds much the same whether you are fighting it or simply watching it. Its appearance stays the same. But its impact—it's actual substance—is profoundly different. Fighting for your life is not the same as **living** your life.

Ironically, research suggests that when the substance changes, the appearance may change as well. When fighters leave the battlefield and let the war take care of itself, it may even subside. As the old slogan in the 1960s put it: "What if they fought a war and nobody came?"

Compare this metaphor with your own emotional life. ACT focuses on the substance, not the appearance, of problems. Learning to approach your distress in a fundamentally different way can quickly change the impact it has on your life. Even if the appearance of

distressing feelings or thoughts does not change (and who knows, it might), if you follow the methods described in your workbook, it is far likelier that the substance of your psychological distress, that is, its impact, will change.

In that sense, this is not a traditional treatment model. We're not going to help you win the war with your own pain by using new theories. We are going to help you leave the battle that is raging inside your own mind, and to begin to live the kind of life you truly want. Now.

This treatment model was created specifically for Crohn's Disease patients because CD presents challenges that are unique to other gastrointestinal diseases. Unlike Irritable Bowel Syndrome, CD (an inflammatory bowel disease) consists of tissue damage, which is more difficult to treat. Unlike Ulcerative Colitis (another inflammatory bowel disease) CD cannot be cured through surgery. CD has been found to be associated with quality of life deficits and issues with self-esteem due to the impact that one's symptoms. It is common to have concerns about loss of bowel control, producing unpleasant odors, feeling dirty or smelly, and having issues with sexual intimacy. The symptoms of CD can have substantial psychological and social implications, causing patients to alter their lifestyles to accommodate those symptoms. Patients may find themselves struggling with depression, anxiety, social isolation and poor quality of life. ACT has been studied and found to be effective in the treatment of a wide range of psychological and health problems such as chronic pain, epilepsy, diabetes, depression and anxiety. It is my hope that through participating in this treatment, you will experience an improvement in your quality of life and will gain tools that will help you to live a valued life.

**Informed Consent**

Your therapist will explain the nature of treatment and other factors such as safety, attendance and confidentiality with you. If you are in agreement with what is presented to you; you will then be asked to sign a form consenting to treatment.

**Questionnaires**

In order to monitor your progress, you will be asked to complete several questionnaires before the first session of treatment and after the last session of treatment. It is understandable that you may feel that this is a large undertaking; however, the only questionnaires that will be repeated weekly are the three shortest ones. Checking in with you regularly about the way that you feel mentally and physically allows for an ongoing exchange of feedback between you and your therapist.

**ACT for Crohn's disease Interview**

Following completion of the self-report measures, your therapist will ask you questions related to your experience of living with Crohn's Disease and your goals for treatment.

**Group Session #1**

---

- Introductions
- Group Rules/Expectations
- Recap of ACT model
- Crohn's Disease Education
- Avoidance and Acceptance
- Activity: "I avoid..."
- Homework: Coping Strategies Worksheet and Diary

This group is designed to be a safe place. It is important that we all agree to keep the information shared in this room confidential. Difficult material will be shared; some of it may bring up feelings of sadness, anxiety or anger; this is natural. It is possible that you may feel worse before feeling better due to the fact that previously avoided material becomes experienced in the moment. Please try to sit with the discomfort and listen to one another. It is important to be an active participant in every aspect of treatment. Try to share as openly as possible; however, if there is anything that you feel unable to share in a group, you may find it easier to talk about it in your individual session. Attendance to group and individual sessions is crucial in order to maximize the benefits you experience from treatment.

**Group Rules and Expectations**

- ❖ Attend each session on time
- ❖ Arrive prepared with your workbook and a writing utensil
- ❖ Participate in every session
- ❖ Listen when others are speaking
- ❖ Use non-judgmental language
- ❖ Respect others
- ❖ Be supportive and constructive

- ❖ Try to maintain a focus on the here and now
- ❖ Maintain group confidentiality
- ❖ Complete all activities and homework exercises
- ❖ Continue/Begin appropriate medical management of CD with physician
- ❖ Communicate openly with your therapist throughout this process

Now, please introduce yourself:

- ❖ Name
- ❖ Age when diagnosed with CD
- ❖ Reason you are participating in this group

---

### **SUFFERING: Psychological Quicksand<sup>39</sup>**

---

This counterintuitive idea of abandoning the battlefield rather than winning the war may sound strange, and implementing it will require a lot of new learning, but it is not crazy. You know about other situations like this. They are unusual, but not unknown.

Suppose you came across someone standing in the middle of a pool of quicksand. No ropes or tree branches are available to reach the person. The only way you can help is by communicating with him or her. The person is shouting, "Help, get me out," and is beginning to do what people usually do when they are stuck in something they fear: struggle to get out. When people step into something they want to get out of, be it a briar patch or a mud puddle, 99.9 percent of the time the effective action to take is to walk, run, step, hop or jump out of trouble. This is not so with quicksand. To step out of something it is necessary to lift one foot and move the other foot forward. When dealing with quicksand, that's a very bad idea. Once one foot is lifted, all of the trapped person's

---

<sup>39</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



weight rests on only half of the surface area it formerly occupied. This means the downward pressure instantly doubles. In addition, the suction of the quicksand around the foot being lifted provides more downward pressure on the other foot. Only one result can take place: the person will sink deeper into the quicksand.

As you watch the person stuck in the quicksand, you see this process begin to unfold. Is there anything you can shout out that will help? If you understand how quicksand works, you would yell at the person to stop struggling and to lie flat, spread-eagled, to maximize contact with the surface of the pool. In that position, the person probably wouldn't sink and might be able to logroll to safety.

Since the person is trying to get out of the quicksand, it is extremely counterintuitive to maximize body contact with it. Someone struggling to get out of the mud may never realize that the wiser and safer action to take would be to get with the mud.

Our own lives can be very much like this, except the quicksand we find ourselves in, often is, in one sense, endless. Exactly when will the quicksand of a traumatic memory vanish? At what moment will the painful quicksand of past criticism from parents or peers disappear? Right now think of a psychological aspect of yourself that you like the least. Take a moment to consider this question. Now ask yourself, "Was this an issue for me last month? Six months ago? A year ago? Five years ago? Exactly how old is this problem?"

Most people find that their deepest worries are not about recent events. Their deepest worries have been lurking in the background for years, often many years. That fact suggests that normal problem-solving methods are unlikely to be successful. If the

could succeed, why haven't they worked after all these years of trying? Indeed, the very longevity of most psychological struggles suggests that normal problem-solving methods may themselves be part of the problem, just as trying to get free is a huge problem for someone stuck in quicksand.

You've chosen to engage in this treatment model for a reason. Most likely, you find yourself in some sort of psychological quicksand and you think you need help freeing yourself. You've tried various "solutions" without success. You've been struggling. You've been sinking. And you've been suffering. Crohn's Disease doesn't go away. One might experience remission, but the effects it can have on your mood and quality of life can feel never-ending. Your pain (both psychological and physical) will be an informative ally on the path that lies ahead. You have an opportunity that someone who hasn't experienced this type of pain doesn't have, because it is only when common sense solutions fail us, that we become open to the counterintuitive solutions to psychological pain that modern psychological science can provide. As you become more aware of how the human mind works (particularly your mind), perhaps you will be ready to take the path less traveled. Haven't you suffered enough?

This treatment is not meant to help you free yourself from the quicksand of anxiety, depression and CD. It was created to relieve your suffering and empower you to lead a valued, meaningful, dignified human life. Psychological and physiological issues that you've previously struggled with may technically remain (or they may not), but what will it matter if they remain in a form that no longer interferes with you living your life to the fullest?

**EXERCISE: A Yellow Jeep**<sup>40</sup>

---

Language creates suffering because the human approach to solving problems is based on the premise that “If you don’t like something, figure out how to get rid of it, and then get rid of it.” This may be effective for external problems but is not helpful when dealing with internal issues. For example, when a painful thought comes up, you may try to stop thinking it. Thought suppression only makes the situation worse. Harvard psychologist Dan Wegner (1994) has shown that the frequency of the thought that you try not to think may go down for a short while, but it soon appears more often than ever. Let’s try an experiment and see whether suppressing a thought can work.

6. Get a clear picture in your mind of a bright yellow Jeep. How many times during the last few days have you thought of a bright yellow Jeep? Write down your answer in the space provided: \_\_\_\_\_
7. Now, spend the next 5 minutes trying as hard as you can not to think even one single thought of a bright yellow Jeep. Really try hard (allow 5 minutes for activity).
8. Write down how many times you had a thought about a bright yellow Jeep, however fleetingly, during the last few minutes while you were trying so hard not to think about it. \_\_\_\_\_
9. Now, spend the next 5 minutes allowing yourself to think whatever thoughts come to your mind (allow 5 minutes for activity).

---

<sup>40</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.

10. Write down how many times you had a thought about a bright yellow Jeep, however fleetingly, during the last few minutes while you were allowing yourself to think of anything (Ask group members to share their experience of this activity.)

If you are like most people, the number of times you thought about a bright yellow Jeep went up over time. You might have been able to keep the thought of a yellow Jeep out of your mind while directly suppressing it, but sometimes even that breaks down, and the number of times such thoughts occur soars. Even if you were able to suppress the thought for a short period of time, at some point, you will no longer be able to do so. When this happens, the occurrence of the thought tends to go up dramatically. That is not simply because you were reminded of a yellow Jeep. In controlled research studies, when participants are told about the Jeep but are not instructed to suppress thinking about it, the number of thoughts does not increase.

### **Experiential Avoidance**<sup>41</sup>

---

Language creates suffering in part because it leads to experiential avoidance.

**Experiential Avoidance** is the process of trying to avoid your own experiences (thoughts, feelings, memories, bodily sensations, behavioral predispositions) even when doing so causes long-term behavioral difficulties (like not going to a party because you're a social phobic, or not exercising because you feel too depressed to get out of bed). Of all the psychological processes known to science, experiential avoidance is one of the worst (Hayes, Masuda et al. 2004).

---

<sup>41</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

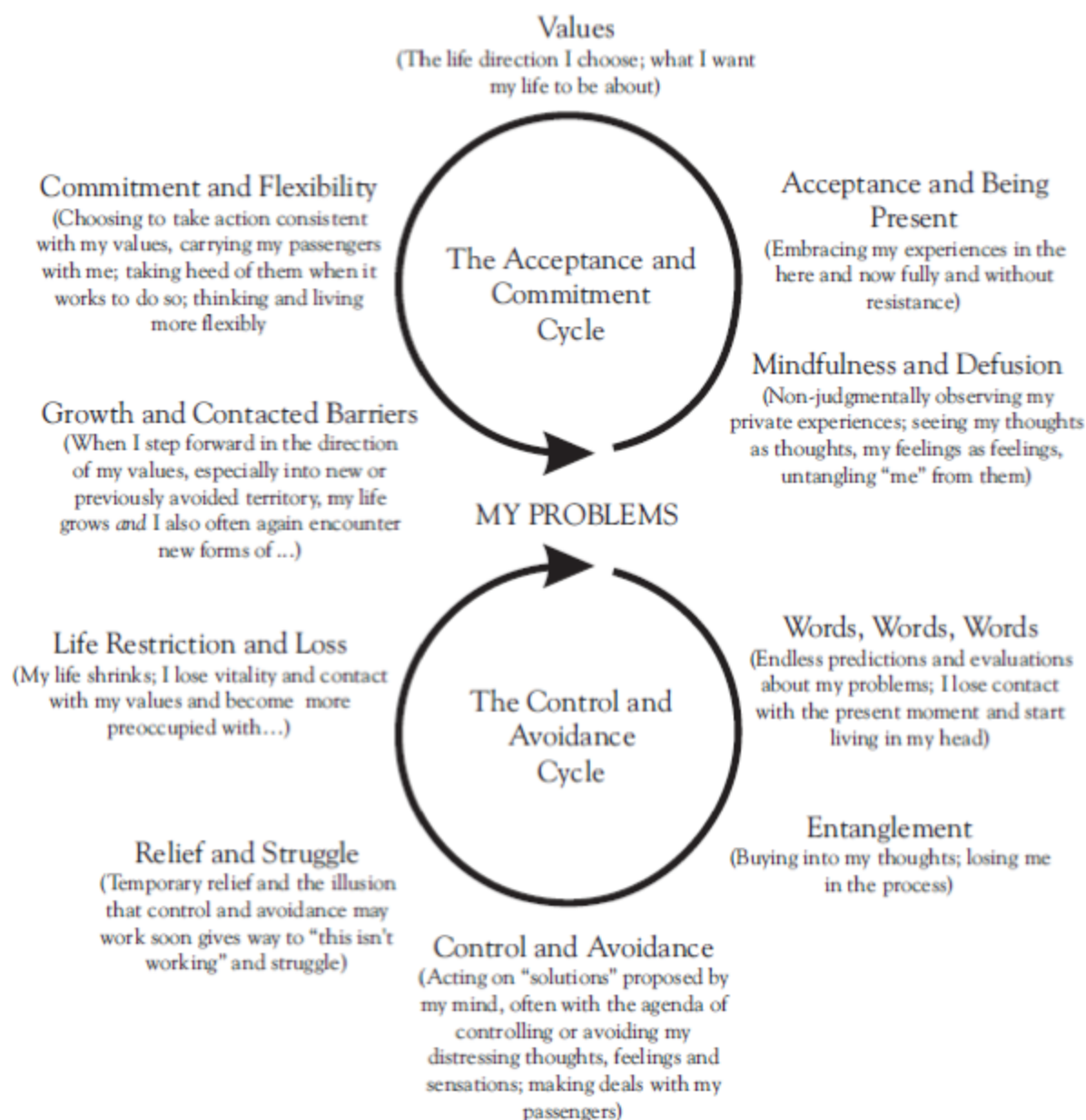
Experiential avoidance tends to artificially amplify the “pain of presence” (issues that are present that you would prefer to go away), and it is the single biggest source of the “pain of absence,” (the activities you would engage in if matters changed) since it is avoidance that most undermines positive actions. Unfortunately, this strategy is built into human language for two reasons: language naturally targets our reactions, not just our situations, and it makes it impossible to control pain by controlling situations, since any situation can be arbitrarily related to pain and thus evoke it. For example, suppose someone very dear to you recently died, and today you see one of the most beautiful sunsets you have ever seen. What will you think? For human beings, avoiding situational cues for psychological pain is unlikely to succeed in eliminating difficult feelings because all that is needed to bring them to mind is an arbitrary cue that evokes the right verbal relations. This example of a sunset demonstrates the process. A sunset can evoke a verbal history. It is “beautiful” and beautiful things are things you want to share with others. You cannot share this sunset with your dear friend, and there you are, feeling sad at the very moment you see something beautiful.

Outside the body, the rule may indeed be, “If you don’t like it, figure out how to get rid of it, and then get rid of it.” Inside the body, the rule appears to be very different. It’s more like, “If you aren’t willing to have it, you will.” In practical terms, this means for example, that if you aren’t willing to feel anxiety as a feeling, you will feel far more anxiety, plus you will begin to live a narrower and more constricted life.

Think about the strategies you use to cope with painful thoughts, feelings and situations. If you are like most people, the majority of your coping strategies are focused on your internal processes. Usually, these coping strategies help to regulate your internal

processes a little in the short run, but in the long run, they often fail or even make matters worse.

Now, consider the possibility that this is so because each of the coping strategies you've developed is a way to avoid your experiences. You develop specific means by which you try to stop feeling the feelings you are feeling or thinking the thoughts you are thinking. You try to avoid the experience of painful thoughts or feelings by burying yourself in distracting activities, combating your thoughts with rationalizations, or trying to quash your feelings through the use of controlled substances. If you are suffering, you may spend a lot of time performing these distracting coping techniques. Meanwhile, your life is not being lived.

**Figure 1.1 The Acceptance Cycle and the Avoidance Cycle<sup>42</sup>**

<sup>42</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

Two main factors keep people stuck in the system of experiential avoidance. The first factor is that the rule “If you don’t like something, get rid of it” works very well in the outside world. The second factor is that the short-term effects of experiential avoidance, that is, the application of that rule to our experience, often can be positive. Every time you engage in a behavior specifically designed to avoid some negative personal pain, you are likely to feel an immediate sense of relief from not having to deal with the painful thought, feeling, or bodily sensation. The sense of relief you gain reinforces your desire to use the same strategy the next time you are forced with the possibility of having to cope with your pain. Yet, each time you do this, you actually give the painful content, that is, your painful thought, feeling, or bodily sensation, more power.

### **The Metaphor Of The Hungry Tiger<sup>43</sup>**

---

Imagine you wake up one morning and just outside your front door you find an adorable tiger kitten meowing. Of course you bring the cuddly little guy inside to keep as a pet. After playing with him for a while, you notice he is still meowing, nonstop, and you realize he must be hungry. You feed him a bit of bloody, red ground beef knowing that’s what tigers like to eat. You do this every day, and every day your pet tiger grows a little bigger. Over the course of two years, your tiger’s daily meals change from hamburger scraps, to prime rib, to entire sides of beef. Soon your little pet no longer meows when hungry. Instead, he growls ferociously at you whenever he thinks its mealtime. Your cute

---

<sup>43</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.



little pet has turned into an uncontrollable, savage beast that will tear you apart if he doesn't get what he wants.

Your struggle with your pain can be compared to this imaginary pet tiger. Every time you empower your pain by feeding it the red meat of experiential avoidance, you help your pain-tiger grow a little bit larger and a little bit stronger. Feeding it in this manner seems like the prudent thing to do. The pain-tiger growls ferociously telling you to feed it whatever it wants or it will eat you. Yet, every time you feed it, you help the pain to become stronger, more intimidating, and more controlling of your life.

Consider the possibility, as unlikely as it may seem, that it's not just that these avoidance strategies haven't worked—it's that they can't work. Avoidance only strengthens the importance and the role of whatever you are avoiding—in other words, when you avoid dealing with your problem, it only grows.

### **The Chinese Finger Trap<sup>44</sup>**

---

The situation is something like the Chinese finger raps you might have played with as a kid (see figure 1.2).

**Figure 1.2: The Chinese finger trap.**



---

<sup>44</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

The trap is a tube of woven straw about as big as your index finger. You push both index fingers in, one at each end, and as you pull them back out, the straw catches and tightens. (Encourage group members to try this). The harder you pull, the smaller the tube becomes, and the stronger it holds your fingers. If the trap is built strongly enough, you'd have to pull your fingers out of their sockets to get them out of the tube by pulling, once they've been caught. Conversely, if you push into it, your finger will still be in the tube, but at least you'll have enough room to move around and live your life.

Now, suppose that life itself is like a Chinese finger trap. So, it's not a question of getting free of the tube, it's a question of how much "wiggle room" you want to have in your life. The more you struggle, the more constricted your movements will be. If you let go of the struggle, the more freedom you have to make new choices.

**EXERCISE: "I avoid..."<sup>45</sup>**

---

On an index card, write down 2 or more things, people, places, situations or experiences that you avoid as a result of living with CD. Please do not write your name on the card, as this is an anonymous exercise. Be as honest as possible, even if some of your concerns may be uncomfortable to admit. It is likely that if you are thinking it or have experienced it; others have as well.

Group leaders will come around with a container for your index card. The group leader will then pick cards from this container to read to the group one by one. If this is an area that you suffer with or that applies to you and you feel comfortable sharing,

---

<sup>45</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

please tell the group about your experience. If you do not feel comfortable, it is ok to stay silent and we will move on to the next response.

The “acceptance” in Acceptance and Commitment Therapy is based on the notion that, as a rule, trying to get rid of your pain only amplifies it, entangles you further in it, and transforms it into something traumatic. Meanwhile, living your life is pushed to the side. The alternative is to accept it. Acceptance, in the sense that it is used here, is not nihilistic self-defeat; neither is it tolerating and putting up with your pain. It is very, very different than that. Those heavy, sad, dark forms of “acceptance” are almost the exact opposite of the active, vital embrace of the moment that is meant here.

### **HOMEWORK: The Coping Strategies Worksheet<sup>46</sup>**

---

Please glance at the Coping Strategies Worksheet below, and then return here for directions on how to work with it. In the column on the left, write down a painful thought or feeling.

Then, in the second column, write down one strategy you’ve used to cope with this painful thought or feeling. Once you’ve done this, please rank your coping strategy for two sets of outcomes. The first asks you to rate how effective your coping strategy has been in the short term. That is, how much immediate relief do you get from the behavior? For the second ranking, rate your strategy for how effective it’s been in the long term.

Think about how much of your total pain is caused by your painful thought or

---

<sup>46</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.

feeling. Has your coping behavior reduced your pain over time? Rate each short- and long-term strategy on a scale from 1 to 5 where 1 is not effective at all and 5 is incredibly effective. For the time being, simply note your rankings. We will look at what they mean in greater detail later in this module.

For example, suppose someone writes a thought like this: "I'm not sure life is worth living" in the "Painful thought or feeling" column. The coping technique the person uses may be to have a beer, watch sports, and try not to think about it. While watching TV, the short-term effectiveness of the strategy may be ranked a 4; but later, the thoughts may be stronger than ever and the long-term effectiveness may be ranked a 1.

[illegible]

### Coping Strategies Diary<sup>47</sup>

If you find that you aren't sure what you've been doing to cope, it may be best to collect this information first in diary form. You can print out multiple copies of the form on the next page and use it to record what happens in your life when you experience something psychologically painful. Note the situation (what happened that evoked a difficult private experience); what your specific internal reactions were (particular thoughts, feelings, memories, or physical sensations); and the specific coping strategy you used then (e.g., distracting yourself, trying to argue your way out of your reactions, leaving the situation). After making entries like these in diary form for a period of one week, you should have a better understanding of what coping strategies you have been using and how effective they are.

Coping Strategies Diary Entries				
Date	Situation			
Difficult private reactions: (e.g., thoughts, feelings, sensations)				
Distress/disturbance level: (when it first happened)			Not distressing/ disturbing 1            2            3	Extremely distressing/ disturbing 4            5
Coping strategy: (my response to my private reactions)				
Short-term effects:			Not at all effective 1            2            3	Incredibly effective 4            5
Long-term effects:			Not at all effective 1            2            3	Incredibly effective 4            5

<sup>47</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

**Individual Session #1**

---

- Reactions from group
- Review of *Coping Strategies* HW
- Revisit personal concerns
- Suffering Inventory
- Treatment goals
- Defusion techniques
- Defusion of negatively evaluated thoughts about being sick

**Human Suffering Is Universal<sup>48</sup>**

---

Often many people we meet in our daily lives seem to have it all. They seem happy. They look satisfied with their lives. You've probably had the experience of walking down the street when you're having a particularly bad day, and you looked around and thought, "Why can't I just be happy like everyone around me? They don't suffer from Crohn's disease (or depression, or anxiety). They don't feel as if a dark cloud is always looming over their head. They don't suffer the way I suffer. Why can't I be like them?"

Here's the secret: they do and you are. We all have pain. All human beings, if they live long enough, have felt or will feel the devastation of losing someone they love. Every single person has felt or will feel physical pain everybody has felt sadness, shame, anxiety, fear, and loss. We all have memories that are embarrassing, humiliating, or shameful. We all carry painful hidden secrets. We tend to put on shiny, happy faces, pretending that everything is okay, and that life is "all good." It isn't and it can't be. To

---

<sup>48</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

be human is to feel pain in ways that are orders of magnitude more pervasive than what the other creatures on planet earth feel. If you kick a dog, it will yelp and run away. If you kick it regularly, any sign of your arrival eventually will produce fear and avoidance behavior in the dog by means of the process called “conditioning.” But so long as you are out of the picture and are not likely to arrive, the dog is unlikely to feel or show significant anxiety. People are quite different. As young as 16 months or even earlier, human infants learn that if an object has a name, the name refers to the object (Lipkins, Hayes & Hayes, 1993). Relations that verbal humans learn in one direction, they derive in two directions. Over the past 25 years, researchers have tried to demonstrate the same behavior in other animal species, with very limited and questionable success so far (Hayes, Barnes-Holmes, & Roche, 2001). This makes a huge difference in the lives people live as compared to animals.

The capacity for language puts human beings in the special position. Simply saying a word invokes the object that is named. Try it out: “Umbrella. “What did you think of when you read that word? Alright, that one’s pretty homeless. But consider what this means if the named object was fearful: anything that reminded the person of his name would invoke fear it would be as if all the dog needs to feel fear is not an actual cake but the thought of being kicked. That is exactly the situation you are in. That is exactly the situation all humans are in with language. Here is an example: Take a moment now to think of the most shameful thing you have ever done. Take a moment to actually do this.

What did you just feel? It’s very likely that as soon as you read this sentence, you felt some sense of either fear or resistance. You may have tried to dismiss the request and



quickly read on. However, if you paused and actually tried to do what we asked, you probably began to feel a sense of shame while you remembered a scene from your past and your actions in it. Yet all that happened here was that you were looking at patterns of ink on paper. Nothing else is in front of you but that. Because relations that verbal humans learn in one direction, they derive in two, they have the capacity to treat anything as a symbol for something else. The etymology of “symbol” means “to throw back as the same,” and because you are reacting to the ink on this paper symbolically, the words you just read evoked a reaction from you; perhaps they even reminded you of a shameful event from your past.

Where could you go so that this kind of relation could not take place? The dog knows how to avoid pain: avoid you and your foot. But how can a person avoid pain if anytime, anywhere, pain can be brought to mind by anything related to that pain? The situation is actually worse than that. Not only can we not avoid pain by avoiding painful situations (the dog's method), pleasurable situations might also evoke pain. Suppose someone very dear to you recently died, and today you see one of the most beautiful sunsets you have ever seen. What will you think?

For human beings, avoiding situational cues for psychological pain is unlikely to succeed in eliminating difficult feelings because all that is needed to bring them to mind is an arbitrary cue that evokes the right verbal relations. This example of a sunset demonstrates the process. A sunset can evoke a verbal history. It is “beautiful” and beautiful things are things you want to share with others. You cannot share this sunset with your dear friend, and there you are, feeling sad at the very moment you see something beautiful.

The problem is that the cues that evoke verbal relations can be almost anything: the ink on paper that made up the “shame,” or a sunset that reminded you of your recent loss. In desperation, humans try to take a very logical action: they start trying to avoid pain itself.

Unfortunately, as we will discuss in the coming weeks, some methods of avoiding pain are pathological in and of themselves. For example, dissociation or illegal drug use may temporarily reduce pain, but it will come back stronger than ever and further damage will be caused. Denial and learned numbness will reduce pain, but they will soon cause far more pain than they take away.

The constant possibility of psychological pain is a challenging burden that we all need to face. It is the elephant in the living room that no one ever mentions. This doesn't mean that you must resign yourself to trudging through your life suffering. Pain and suffering are very different. I believe that there is a way to change your relationship to pain and to then live a good life, perhaps a great life, even though you are a human being whose memory and verbal skills keep the possibility of pain just an instant away.

### **EXERCISE: Your Suffering Inventory**<sup>49</sup>

---

Please write down a list of all of the issues that are currently psychologically difficult for you. Use the left-hand side of the space provided below. Do not write about purely external or situational events, independent of your reactions to them. We will focus on how you react. Some of your psychological issues will be clearly related to specific situations; others may not be. For example, “my boss” would not be a good

---

<sup>49</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

example of a difficult issue you experience; but “getting frustrated with my boss” or “feeling put down by my boss” might be. The left-hand column can include any of your thoughts, feelings, memories, urges, bodily sensations, habits, or behavioral predispositions that may distress you, either alone or in combination with external events. Don’t overthink it. Just write down what plagues you and causes you pain. Be honest and thorough and create your “suffering inventory” in the space below. After you’ve completed your list, go back and think about how long these issues have been a problem for you. Write that down as well.

Painful and difficult issues I experience	How long this has been the case

Now I would like to ask you to organize this list. First, go back and rank these items in terms of the impact that they have on your life. Then, in the space provided below, write down the same items, but rank them in order. The order should range from those items that cause you the most pain and difficulty in your life to those that cause you the least trouble. You will use this list as a guide throughout the remainder of this book.

You will be asked to refer back to this list as your touchstone for the events and issues that cause you pain.

---

---

---

---

---

---

---

---

---

---

Finally, in the area to the right of this list, draw arrows between every item on the list that is related to another item. You will know that two items are related if changes in one might alter another. For example, suppose one of your items is “self-criticism” and another is “depression.” If you think the two are related (that is, the more self-critical you are, the more likely you are to feel depressed, or vice versa), draw a two-headed arrow between self-criticism and depression. You may find that this area becomes cluttered with arrows. That’s fine. There is no right or wrong way to do this. If everything is related, it’s important to know that. If some items relate to only a few others, that is useful information too. The higher on your list the items are and the more other items they connect to, the more important they become. This may suggest a re-ranking of your problems and you may find that you now want to combine some items or to divide them

into smaller units. If that is so, you can create your final working list below, ranked from highest to lowest in order of impact on your life.

---

---

---

---

---

---

---

---

---

---

This is your personal suffering list. For you, it is what this workbook is about.

### **Treatment Goals**

Using this personal suffering list, work with your therapist to generate a list of treatment goals; this should overlap considerably with the Suffering Inventory list. Ask yourself questions such as, “*What are my goals for treatment? What would I like to change about myself and/or my life as a result of treatment? What would I like to accomplish through this treatment? How will I know if the treatment has worked; what will be different for me?*”

**Cognitive Defusion: Separating Your Thoughts From Their Referents<sup>50</sup>**

---

The table below describes a number of different cognitive defusion techniques. These techniques don't necessarily move in a specific predisposed order, in that they don't teach one skill that then leads to another skill in a particular sequence. Rather, they are a set of techniques that intertwine and overlap with one another. Some of the same concepts may be repeated in many different techniques.

Defusion techniques are not methods for eliminating or managing pain. They are methods for learning how to be present in the here and now in a broader and more flexible way. Suppose you put your hands over your face and someone asks you, "What do hands look like?" You might answer, "They are all dark." If you held your hands out a few inches away, you might add, "they have fingers and lines in them." In a similar way, getting some distance from your thoughts allows you to see them for what they are.

The point is to break through the illusion of language, so that you can notice the process of thinking (i.e., creating relations among events) as it happens rather than only noticing the products of that process—your thoughts. When you think a thought, it structures your world. When you see a thought you can still see how it structures your world (you understand what it means), but you also see that you are doing the structuring. That awareness gives you a little more room for flexibility. It would be as if you always wore yellow sunglasses and forgot you were wearing them. Defusion is like taking off your glasses and holding them out, several inches from your face; then you can see how they make the world appear to be yellow, instead of seeing only the yellow world.

---

<sup>50</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

After you master defusion, you can make an informed judgment about whether it helps you to be more flexible in living the way you want to live. The best way to do this is practice, practice, practice. You won't be able to make these techniques a part of your behavioral response patterns without practicing them. You can't just read them passively and hope to "get it." Take these skills with you in your life and apply them. Let your experience be your guide. Practice doesn't make perfect, it makes permanent.

Read through the list and put a star next to the techniques that are most salient to you.

### A Sampling Of Cognitive Defusion Techniques<sup>51</sup>

Describe, don't evaluate	Use descriptions like "I am feeling anxiety and my heart is beating fast" instead of evaluations like "This anxiety is unbearable/terrible/crazy etc"
The Mind	Treat "the mind" as an external event, almost as a separate person. (e.g., "Well, there goes my mind again" or "My mind is worrying again").
Mental appreciation	Thank your mind when you notice it butting in with worries and opinions; show aesthetic appreciation for its products (e.g., "You are doing a great job worrying today! Thanks for the input!") <i>This is not sarcasm...</i> after all, the word machine is doing exactly what it was designed to do all of those thousands of years ago: "problem solve" and avoid danger.
Commitment to openness	If you notice you start to fight with your insides when negative content shows up, ask yourself if such negativity is acceptable, and try to get to yes.
Just noticing	Use the language of observation (e.g., noticing) when talking about private experiences. For example, "So, I'm just noticing that I'm judging myself right now."
"Buying" thoughts	Use active language to distinguish between thoughts that just occur and the thoughts that are believed, e.g., "I guess I'm buying the thought that I'm bad."
Pop-up mind	Imagine that your negative chatter is like Internet pop-up ads.
Cell phone from hell	Imagine that your negative chatter is like a cell phone you can't

<sup>51</sup> "Material for Patient Workbook/Clinician Manual first appeared in a self-help workbook titled: Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy by Steven C. Hayes, Ph.D. and Spencer Smith, New Harbinger Publishers Inc. and is reprinted here with the authors' permission."

	turn off (e.g., “Hello. This is your mind speaking. Do you realize you need to worry?”)
Experiential seeking	Openly seek out more material, especially if it is difficult. If your mind tells you not to do something that is scary but worthwhile, thank your mind for the great hint and do the difficult thing with gusto.
Put it out there	Write down a negative evaluation you are ready to defuse from (e.g., mean, stupid, angry, unlovable, etc.) and put it on a name tag and wear it. Don't explain it to anyone for a while...just feel how it feels to have it out there.
Mind T-shirt	Imagine that your negative evaluations you are ready to defuse from are written in bold letters on your T-shirt. If you feel especially bold, actually <i>do</i> that!
Think the opposite	If your mind is stopping action, practice deliberately engaging in a behavior while trying to command its opposite. For example, get up and walk around while saying, “I can't move while I'm reading this sentence!”
Thoughts are not causes	If a thought seems to be a barrier to an action, ask yourself, “Is it possible to think that thought, as a thought, AND do x?” Try it out by deliberately thinking the thought while doing what it has been stopping.
Monsters on the bus	Treat scary private events as monsters on a bus you are driving. See if it is okay just to keep on driving rather than doing what they say or trying to get them to leave.
Who is in charge here?	Treat thoughts as bullies; use colorful language. Who's life is this anyway? Your mind's or yours?
How old is this? Is this just like you?	When you are buying a thought, back up for a moment and ask yourself, “How old is this pattern?” or “Is this like me?”
And what is that in the service of?	When you are buying a thought, back up for a moment and ask yourself, “What is buying this thought in the service of?” If it is not in the service of your interests, stop buying the thought.
Okay, you are right. Now what?	If you are fighting to be “right,” even if it doesn't help move you forward, assume the White Queen has decreed that you are “right.” Now ask yourself, “So what? What can I actually <i>do</i> to create a more valued life from here?”
Get off your but	Replace virtually all self-referential uses of “but” with “and.”
Why, why?	If you find that your “reasons why” are entangling, ask yourself repeatedly why the event exists and why it functions the way it does, until you have a very hard time answering. It may help to show how shallow the story really is and how experiential avoidance creates the pain of absence. For example, “I can't do it.” Why? “I feel anxious.” And why does that mean you can't do it? “Ahh...don't know.”
Create a new story	If you find yourself entangled in a “logical” but sad story about your life, and why things have to be the way they are, write down the normal story, then take all the descriptive facts and



	write the same exact facts into a different story. Repeat until you feel more open to new possibilities <i>with</i> your history.
Which would you rather be?	If you are fighting to be “right,” even if it doesn’t help move you forward, ask yourself, “Which would I rather be? Right or alive and vital?”
Try not to think x	Specify a thought not to think and then notice that you do think it.
Find something that can’t be evaluated	If you find yourself entangled in negative evaluations, look around the room and notice that every single thing can be evaluated negatively if you choose to. So why should you be any different? This is just what the mind has evolved to do!
And how has that worked for me?	When you are buying a thought, back up for a moment and ask yourself, “How has that worked for me?” and if it hasn’t worked ask, “Which should I be guided by, my mind or my experience?”
Carry cards	Write difficult thoughts on 3 x 5 cards and carry them with you. Use this practice as a metaphor for the ability to carry your history without losing your ability to control your life.
Carry your keys	Assign difficult thoughts and experiences to your keys. Then think the thought as a thought each time you handle your keys. Keep on carrying the keys and your thoughts.

## Module 2

### Group Session #2

---

- Mindfulness overview, Tracking thoughts, bodily sensations
- Be Where you are exercise
- Willingness
- HW: Mindful Exercises
- HW: What Needs to be Accepted

Mindfulness<sup>52</sup> is a way of observing your experience that has been practiced in the East through various forms of meditation for centuries. Recent research in Western psychology has proven that practicing mindfulness can have notable psychological benefits (Hayes, Follette, & Linehan, 2004). In fact, mindfulness is currently being adopted as a means of enhancing treatment in a number of different psychological traditions in the West (Teasdale et al., 2002).

A large part of this approach has to do with mindfulness. What ACT brings to this ancient set of practices is a model of the key components of mindfulness and a set of new methods to change these components. Weeks, months, or years of meditation, helpful as they can be, are not the only practices that can increase mindfulness, and in today's world, new means are needed to augment those that evolved in another, slower millennium.

In this manual you will learn to see your thoughts in a new way. Thoughts are like lenses through which we look at our world. We all have a tendency to cling to our particular lens and allow it to dictate how we interpret our experiences, even to the point

---

<sup>52</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

of dictating who we think we are. If you are now stuck in the lens of your psychological pain, you may say things to yourself like, “I’m depressed.” Thoughts of that kind can be dangerous; concrete methods to help you avoid those dangers are provided throughout this manual.

As you free yourself from the illusions of language, you will learn to become more aware of the many verbal lenses that emerge every day, and yet not be defined by any one of them. You will learn how to undermine your attachment to a particular cognitive lens in favor of a more holistic model of self-awareness. Using specific techniques, you will learn to look at your pain, rather than seeing the world from the vantage point of your pain. When you do that, you will find there are many other things to do with the present moment besides trying to regulate its psychological content.

Mindfulness is difficult, not because it is hard but because it is elusive. We are constantly being hooked by our verbal predictions and evaluations. Furthermore, life is complex. There are many, many things to be mindful of and, as events become more complex, it is easier to lose our way. You could practice focusing on only one aspect of your experience the way you did in the last chapter, but ultimately that would severely limit the breadth and richness of your actual experience.

Practicing mindfulness isn’t going to do you much good if you just do the exercises written in this book and then forget about them. You need to make an effort to bring your attention more completely to the many moments in your life, fully, without defense, non-judgmentally, defused, and accepting. Formal practice can help you acquire the skills, but it is informal practice, using these skills in your day-to-day life, that is most important. This module will help you develop ways to deepen your existence with

mindfulness by asking you to pay attention to many different types of experiences as they enter your awareness. It will also give you some concrete ideas on how you can institute a mindfulness practice into your daily life.

### **Daily Practice**<sup>53</sup>

Before moving on to mindfulness techniques it is worthwhile to take some time to speak about when to practice mindfulness. Ultimately, the answer is “all the time.” The problem with this answer is that you probably aren’t accustomed to practicing mindfulness. It’s unlikely that you will randomly remember to apply mindfulness skills to day-to-day moments until they have become well established.

To deal with this problem, it’s a good idea to set aside some time to practice mindfulness every day. Once it becomes second nature (if it ever does), you can reconsider whether this is still necessary. Practicing mindfulness every day may sound like a daunting prospect but it becomes worthwhile immediately and, after a while, many people find that they really like doing it. However, regardless of whether you like or dislike it, these preferences are just more content your mind produces, and the whole point is to take back control over your life from your personal word machine. Given that, it is far more effective just to make the decision to practice every day, and then go for it. Here are some ways that you can institute a daily mindfulness practice:

- 4. Set aside the time.** In the beginning, it can be useful to set aside a designated amount of time every day or every week to practice mindfulness skills. The section below on sitting meditation has some specific examples related to that

---

<sup>53</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.

particular exercise. However, you can use the same basic principles for any of the mindfulness practices you choose to engage in. The first thing you will want to do is figure out how many times a week you want to practice. We recommend that you practice some form of mindfulness every day. If you absolutely can't seem to fit that into your schedule, then figure out how much you can manage. Second, it's a good idea to set a time to limit your practice. Something between fifteen and thirty minutes at a time is a good starting point. You can adjust this as you choose, once you become accustomed to the practice.

- 5. Relaxation and distraction.** People are often tempted to use mindfulness practice as a time to relax. That is a mistake. If you are relaxed, that's fine, but if you are tense, that's okay too. The point, however, isn't to relax. The point is to be aware of whatever is going on for you without avoidance or fusion. It is a matter of acquiring and strengthening skills that can be useful when your verbal repertoire begins to dominate your other forms of experience. Initially, it is a good idea to find a place in which you can practice without having to do other tasks, but that doesn't mean eliminating the distractions your mind presents to you. If you are distracted, that is simply another fact to notice. See it, note it, and then move on with practice.
- 6. Feeling too bad to practice.** There is no such thing as feeling too bad to practice. In some of the exercises below, you will find that when you are actually doing the work, negative content comes up for you. But this is only another set of experiences to be mindful of. It is not a problem; it is an opportunity. Presumably, you started this treatment partly because you are already dealing with negative

experiences. Learning what to do when such experiences show up is thus vital to your purpose. Practicing with, say, an irritating itch is in principle not any different than the same skills applied to, say, anxiety or depression. This doesn't mean to persist in the face of impossible circumstances. If you have a pain in your back that must be attended to, then do that. Persistence without self-awareness is just a different kind of trap. Over time, you will see that if you use pain as an excuse to run away from the practice, and if you detect that is how you are using pain, then you can learn how to do something new with pain. Ultimately, mindfulness should be practiced as moment-to-moment awareness in real-time. It is not a special state that you "enter into" like a trance, or self-hypnosis. These guidelines are meant simply to get you to start practicing the techniques. Once you see mindfulness entering into your daily life, you can decide whether to continue with a regimen of this nature.

### **The Practice**<sup>54</sup>

---

The practice of mindfulness is about getting in touch with your own experience moment to moment in a defused and accepting way. In earlier techniques we've discussed, you were asked to be mindful of specific areas of our experience (i.e., thoughts in time, bodily sensations, defusing from implicit evaluations). In this module, there will be other things you are asked to notice, but your responses needn't be guided by anything except the experiences that appear.

---

<sup>54</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

At times, many things may come up for you at once. There are different ways you can handle this. Sometimes, you might alternate back and forth between different sensations. Sometimes, you will be able to hold a number of different things in your awareness at one time. Some of the exercises actually ask you to be mindful of more than one thing at a time.

Part of the elusiveness of mindfulness is that it is purposive, and thus evokes evaluations, but the whole purpose of being mindful is to learn how to defuse from your evaluations. The best way to think about it is that there is neither a right nor a wrong way to be mindful. Simply be who you directly experience yourself to be (a conscious observing self) in the moment. If evaluations show up, then observe the evaluations but do not believe or disbelieve them. If you take your verbal judgments about your progress literally, that will be yet another instance of fusion with the verbal story your mind generates. Buying into thoughts that judge you as good or not good at being mindful is just the word machine taking control once again.

As you practice, allow yourself to become more mindful of the sensations, thoughts, and feelings that are happening for you. Be gentle and non-judgmental (even with your judgments!). This isn't a test. It's just living. Now, let's dive into the exercises themselves.

---

**EXERCISE: Be Where You Are<sup>16</sup>**

Exercise instructions: Make yourself comfortable in your chair (if trying this at home, you can be seated in a chair or lying down on the floor or your bed). Close your eyes, if you are comfortable doing so, and take a few deep breaths. Relax. Don't let yourself drift off to sleep, but allow your body to rest.

Now slowly bring your awareness to the tips of your fingers. Feel your fingers. Rub your fingertips together. How do they feel? Can you feel the small indentations on your fingertips that are fingerprints? Take your time and try to feel them. What are they like? Are your fingertips rough from lots of work or are they smooth and silky? How does it feel to rub them together? Notice the feelings and then move on.

Now rest your fingers where they were before. What are they touching? Are they resting on the blanket on your bed, or are they resting on the arm of your chair? What does that feel like? Is it soft or hard? Does it have any other distinguishing features? Is the blanket furry with cotton? Does the armrest have any markings or is it smooth? Take the time to completely absorb the way these objects feel to your fingertips.

Now bring your attention to your hands and arms. What do they feel like? Perhaps they are relaxed and heavy. Perhaps they are still tense from a long day's work. Either way is okay. There is no need to judge, simply observe the feelings in your arms and hands. Are there any aches or pains? Take note of these, but do not fixate on them. Simply note the pain and move on. Move your attention down to your toes. Wiggle them around a little. Are they in shoes or socks? Are they free to move about? Swish your toes back and forth feeling whatever is beneath them. How does it feel? Can you tell what it is just by the feeling? Would you be able to tell only by touch? Just notice the sensations as you bring your awareness to your feet.

How is your head positioned? If you are sitting, is your head aligned with your spine or is it drooping, resting on your chest. Without trying to change the position of your head, simply note where it is positioned. There is no right way for your head to be.



Just let it be where it is. Now think about the sensations in your head. Do you have a headache? Is your head relaxed?

What about your face? How does your face feel? There are all kinds of sensations to explore in your face. Think about your brow. Is it smooth and flat or is it crinkled up with stress? Again, don't try to change it, just notice it. Now bring your awareness to your nose. Can you breathe freely or are you plugged up? Take a few breaths in and out through your nose. How does that feel? Can you feel cool air flowing into your lungs or is the air warm? Pay attention to the feeling for a moment. Then think about your mouth. How is your mouth positioned? Is it pursed? Is it open? Is it closed? What about the inside of your mouth? Is it wet or dry? Can you feel the saliva coat the inside of your mouth and throat? Explore all of the sensations throughout your face. Perhaps you can feel oil on your skin. Perhaps your skin is dry. Perhaps there is no feeling at all. Just note it and move on.

Now bring your attention to your chest and belly. Place one hand on your chest and one hand on your belly. Can you feel yourself breathing? What is that like? Are you breathing fast or slow? Are your breaths going into your abdomen or into your chest? Breathe in through your nose and out through your mouth. How does that feel? Now invert the pattern. Spend some time with your breath, then place your hands wherever they were before.

Now think of your whole body. Where are you sitting or lying? Can you feel the back side of your body touch the chair or bed in various places? Be mindful of the way your body is positioned. There is no need to move, just observe.

Now think about the room you are in. Where are you positioned in the room? Do you have a sense of where the door is? What about the ceiling? Can you feel your body in the context of this larger space?

When you are ready, open your eyes and take a look around the room. You can move if you wish. Notice the location of the various pieces of furniture. What do they look like? You can spend as much time as you like investigating the different aspects of the furniture. Remember not to judge, just notice.

When you have completed the Be Where You Are exercise, take a few minutes to comment on it below. If you wish, you can continue this practice of writing your responses in a journal after each time you try the exercise, but this is not necessary.

---

---

---

### Acceptance And Willingness<sup>55</sup>

---

“Accept” comes from the Latin root “**capere**,” meaning “take.” Acceptance is the act of receiving or “taking what is offered.” Sometimes, in English, “accept” means “to tolerate or resign yourself” (as in, “Aw, gee, I guess I have to accept that”), and that is precisely **not** what is meant here. By “accept,” we mean something more like “taking completely, in the moment, without defense.”

We use the word “willing” as synonym for “accepting” to stay true to that meaning of accept. “Willing” is one of the older words in the English language. It comes

---

<sup>55</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

from an ancient root meaning “to choose.” Thus “acceptance” and “willingness” can be understood as an answer to this question: “Will you take me in as I am?” Acceptance and willingness are the opposite of effortful control. What follows is a description of what “take me in as I am” really means.

In our context, the words willingness and acceptance mean to respond actively to your feelings by feeling them, literally, much as you might reach out and literally feel the texture of the cashmere sweater. They mean to respond actively to your thoughts by thinking them, much as you might read poetry just to get the flow of the words, or an actor might rehearse lines to get a feel for the playwright’s intent.

To be willing and accepting means to respond actively to memories by remembering them, much as you might take a friend to see a movie you’ve already seen. They mean to respond actively to bodily sensations by sensing them, much as you might take an all overstretch in the morning just to feel your body all over. Willingness and acceptance mean adopting a gentle, loving posture toward yourself, your history, and your programming so that it becomes more likely for you simply to be aware of your own experience, much as you would hold a fragile object in your hand and contemplate it closely and dispassionately.

The goal of willingness is not to feel better. The goal is to open up yourself to the vitality of the moment, and to move more effectively toward what you value. Said another way, the goal of willingness is to feel all of the feelings that come up for you more completely, even—or especially—the bad feelings, so that you can live your life more completely. In essence, instead of trying to feel **better**, willingness involves learning how to **feel** better.

To be willing and excepting is to gently push your fingers into the Chinese finger trap in order to make more room for yourself to live in, rather than vainly struggling against your experience by trying to pull your fingers out of the trap (see figure 1.2). To be willing and accepting means to give yourself enough room to breathe.

By assuming the stance of willingness and acceptance you can open all the blinds and the windows in your house and allow life to flow through; you let fresh air and light into your into what was previously closed and dark. To be willing and accepting means to be able to walk through the swamps of your difficult history when the swamps are directly on the path that goes in the direction you care about.

To be willing and accepting means noticing that you are the sky, not the clouds; the ocean, not the waves. It means noticing that you are large enough to contain all of your experiences, just as the sky can contain any clouds in the ocean any waves.

If you find your mind agreeing or resisting, just thank your mind for the thought. Your mind is welcome to come along for the ride but willingness and acceptance are states of being that minds can never learn how to achieve. Even if your mind can't learn how to be willing and accepting, you can learn.

### **Why Willingness?<sup>56</sup>**

---

One reason willingness is worth trying is that it is remarkable how consistently the scientific literature reveals its value and the danger of its flipside—experiential avoidance. The ability to practice willingness instead of experiential avoidance is one that

---

<sup>56</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

is broadly applicable for psychological suffering. It has been studied extensively; the areas that are most relevant to this treatment model are described below:

**Physical pain.** In virtually every area of chronic pain, physical pathology (the objectively assessed physical damage) bears almost no relation to the amount of pain, reduced functioning, and disability (Dahl et al., 2005). The relationship between the amount of pain and degree of functioning is also weak. What predicts functioning is (a) your willingness to experience pain, and (b) your ability to act in a valued direction while experiencing it (McCracken, Vowles, & Eccleston, 2004). These are precisely the processes targeted in this workbook. Training people how to accept their pain and how to watch it or “diffuse from” their thoughts about it greatly increases their tolerance of pain (Hayes et al., 1999) and decreases the amount of disability and sick leave downtime caused by their pain (Dahl, Wilson, & Nilsson, 2004).

**Physical trauma, disease, and disability.** In head injury, spinal injury, heart attack, and other areas of physical illness or injury, the degree of physical pathology is a very poor predictor of rehabilitation success and long-term disability. What is predictive is the patient's acceptance of the condition and the willingness to take responsibility for her or his predicament (Krause, 1992; Melamed, Grosswasser, & Stern, 1992; Riegal, 1993).

In chronic diseases like diabetes, your acceptance of the difficult thoughts and feelings the disease gives rise to, and your willingness to act in the presence of these thoughts and feelings predict good self-management of the disease (Gregg, 2004). Other health-care problems, such as smoking, show the same results (Gifford et al., 2004). ACT promotes better health management as a result of changes in your willingness to accept

discomfort, unhook from your thoughts, and move toward what is most personally meaningful to you (Gifford et al., 2004; Gregg, 2004).

**Anxiety.** Unwillingness to have anxiety predicts having anxiety in many different forms (Hayes, Strosahl et al., 2004). For example, when exposed to the same levels of physiological arousal, experiential avoiders are more likely to feel panic than those who willingly accept their anxiety (Karekla, Forsyth, & Kelly, 2004). This is particularly true if experiential avoiders are actively trying to control their anxiety sensations (Feldner et al., 2003).

Among people who habitually pull out their own hair, experiential avoidance predicts more frequent and intense urges to pull, less ability to control urges, and more hair pulling–related distress than among people who are not experientially avoidant (Begotka, Woods, & Wetterneck, 2004).

People with generalized anxiety disorder are more likely to have high levels of emotional avoidance (Mennin et al., 2002), and both the amount of worry and degree of impairment they suffer correlates with experiential avoidance (Roemer et al., 2005). Even a very small amount of training in acceptance can be helpful, however. For example, just ten minutes of acceptance training made panic-disordered persons more able to face anxiety; training in distraction and suppression was not helpful (Levitt et al., 2004). Similarly, for anxious people, teaching them simple a simple ACT acceptance metaphor, the Chinese finger trap (see module 1), reduced avoidance, anxiety symptoms, and anxious thoughts more successfully than did breathing retraining (Eifert & Heffner, 2003).

**Depression.** Up to half of the variations in the symptoms of depression can be accounted for by a lack of acceptance and willingness (Hayes, Strosahl et al., 2004).

This review could go on for many more pages, and deal with many more areas, but perhaps these examples are enough to make the point. The scientific literature is filled with evidence that the person's willingness to experience whatever emotion is present is of central importance to many areas of human psychological functioning.

So, why is willingness so important? Perhaps some first-person accounts of the importance of willingness will be more convincing than a capsule review of the literature. Read the following statements and see if they hold true for you too.

- ❖ Why willingness? Because when I am struggling against my painful experiences, the struggle seems to make them all the more painful.
- ❖ Why willingness? Because when I move away from the pain that I meet when I'm pursuing what I value most, I also move away from the richness of life that those valued actions bring to me.
- ❖ Why willingness? Because when I try to close myself off from the painful parts of my past, I also close myself off from the helpful things I've learned from my past.
- ❖ Why willingness? Because I experience a loss of vitality when I am not willing.
- ❖ Why willingness? Because my experience tells me that being unwilling just doesn't work.
- ❖ Why willingness? Because it is a normal human process to feel pain, and it is inhumane and unloving to try to hold myself to a different standard.
- ❖ Why willingness? Because "living in my experience," that is, living in the moment, seems potentially more rewarding than "living in my mind."

- ❖ Why willingness? Because I absolutely know how my pain works when I am unwilling, and I'm sick and tired of it. It's time to change my whole agenda, not just the moves I make inside a control and avoidance agenda.
- ❖ Why willingness? Because I have suffered enough.

### **What Needs To Be Accepted?**<sup>57</sup>

In some ways, acceptance of your experience is required, even when the situation calls for deliberately changing your experience. If you accidentally put your hand on a hot stove, you would immediately pull it back. If you did it quickly enough, you might even avoid tissue damage and the pain might pass in a matter of seconds. But to do that you needed to know first that you were hurting.

One of the saddest side effects of the chronic unwillingness to feel is that we begin to lose our ability to know what it is that we are avoiding. People who can't identify what they experience emotionally are said to have "alexithymia," which is a clear example of the unwillingness to feel. If you chronically avoid what you feel, eventually you do not know what you are feeling at all. That's sad for two reasons. First, it's far easier to make mistakes in life as a result. For example, you may begin a bad relationship by missing the signs your own feelings would give you that your new love interest is very similar to past partners who didn't work out for you.

Or, by not recognizing the uneasy feelings that might have warned you, you could take a job that would be unhealthy or excessively stressful for you. Like someone who's lost the sense of pain, experiential avoiders can place their psychological hand on top of

---

<sup>57</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



the hot stove and just leave it there to burn. Second, it is known that experiential avoiders actually tend to respond more intensely to events, both positively and negatively (Sloan, 2004). In the service of keeping their distance from the pain they might otherwise feel more acutely than others, experiential avoiders also stand aloof from the joy they otherwise might feel more acutely than others.

The general point is that acceptance doesn't mean that your emotions will change, just as defusion doesn't mean that your thoughts will change. Ironically, if change is possible at all, it is more likely to take place when we adopt an accepting and defused stance. When you avoid getting into an unhealthy relationship, for example, in a very real way you've avoided both pain and damage, just as removing your hand from a stove avoids both pain and damage. But first you had to feel the pain or you wouldn't have removed your hand.

There are other kinds of pain that are not like a hot stove. These are forms of pain that either necessarily come along with healthy actions or are historical in their nature, conditioned, and not based on the current situation. If you exercise vigorously, your muscles will be sore. If you study hard, you will be tired. If you remember a past loss, you will be sad. If you open up to relationships, you will feel vulnerable. If you care about the world, you will know that others are hurting. Most psychological pain seems to be of this type.

Anxiety is usually not based on real danger; depression is usually not based on the objective current situation. Feelings that are historical in their nature, conditioned, and not directly caused by the current situation are like that. Some of these feelings are not

very good guides to action. For example, someone who has suffered abuse may be afraid of intimacy, even if that person's current partner is sensitive and kind.

In these kinds of situations, acceptance and willingness are needed for a second reason: without them, healthy action is not possible. Consider someone with panic disorder who has had several panic attacks in shopping malls and no longer dares to go inside a mall. Anxiety is, in part, a conditioned reaction. If shopping, freedom of movement, and the like are important to that person, eventually, it will be time to reenter shopping malls. That doesn't mean that the conditioning will now magically be removed. When such a person enters a mall again, guess what this person will then face? Anxiety. If that is unacceptable, the person now has an insurmountable barrier.

Ironically, as was discussed earlier, anxiety is only exacerbated by trying to get rid of it directly. If this person decides to wait until the anxiety disappears until beginning to live again, he or she is likely to wait a very long time.

When we say "acceptance" or "willingness" in this workbook we are not referring to accepting situations, events, or behaviors that are readily changeable. If you are being abused by someone else, "acceptance of abuse" is not what is called for. What may be called for is acceptance that you are in pain, acceptance of the difficult memories that have been produced, and acceptance of the emotional pain that will arrive when you stop relying on drugs and alcohol to regulate your emotions. Now, look at the following questions and see what comes up for you. If you have no idea what to write, just skip to the next question.

**HOMEWORK: What Needs to Be Accepted**<sup>58</sup>

---

The memories and images I most avoid include:

---

---

---

Avoiding these memories and images costs me in the following ways:

---

---

---

The bodily sensations I most avoid include:

---

---

---

Avoiding these bodily sensations costs me in the following ways:

---

---

---

The emotions I most avoid include:

---

---

---

Avoiding these emotions costs me in the following ways:

---

---

---

The thoughts I most avoid include:

---

---

---

---

<sup>58</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

---

Avoiding these thoughts costs me in the following ways:

---

---

---

The behavioral predispositions or urges to respond that I most avoid include:

---

---

---

Avoiding these behavioral predispositions and urges to respond costs me in the following ways:

---

---

---

---

We just listed five domains of avoidance (memories and images; bodily sensations; emotions; thoughts; and behavioral predispositions and urges to respond), and we've asked about the costs in each of these domains. If you were able to respond to the questions in two or more domains of those listed above, and if two or more of these have clear costs, then you are ready to embrace willingness.

**HOMEWORK: Mindfulness Exercises<sup>59</sup>**

---

**Silent Walking**

Many cultures have developed different forms of walking meditations. This exercise is a variant of some of these. Take ten minutes (or longer) and walk silently. You might walk around in a circle in your yard, you might walk around the house, or you might take a walk around the neighborhood. Try to remain silent throughout the course of the entire walk so that you can “listen” to the content your mind is producing.

As your attention is drawn to particular in your environment, thoughts in your mind, or feelings in your body, call these out by saying them three times. The purpose of the brief word repetition is to support you in defusing from your thoughts about the event. For example, if you are walking around the neighborhood and you see a car go by, say aloud, “Car, car, car.” If you start to feel stressed out during the walk, you might say “stress” three times. Notice what happens as you do this.

Notice each time your attention is repeatedly drawn to something. For example, if you notice that you keep coming back to certain thoughts or feelings during your walk, you might want to gently file this information away. You might want to focus on these matters with other skills that were presented in this or previous chapters.

**Cubbyholing**

In this next exercise, you will be asked to note the category of your psychological content as it comes up. This exercise can be done on its own, it can be done in conjunction with just about any other exercise in this workbook, or it can be done as you

---

<sup>59</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

carry on with your normal day. As thoughts, feelings, or bodily sensations arise, mindfully note into which category they fall. Do this aloud if you are in a place where you can do that. Do not call out the specific thought or emotion; the point is to focus only on the category to which the content belongs. Here is a list of the different categories from which to choose. Undoubtedly, there are many more categories, but for the purposes of this exercise, stick to the ones listed below.

- ❖ Emotion
- ❖ Thought
- ❖ Bodily sensation (just say “sensation”)
- ❖ Evaluation
- ❖ An urge to do something (just say “urge”)
- ❖ Memory

When you do this exercise, lead-in your labeling of the content with the word “there’s.” For example, if you start to feel your heart beating really fast, say, “There’s sensation.” If you respond to your fast heartbeat with the fear that you are going to have a panic attack, you could say, “There’s emotion.” If your fear is so great, you feel compelled to call a doctor, you could say, “There’s an urge.”

You can do this exercise while sitting, but you can also do it on long drives, while lying in bed at night, on walks, and so forth. Once you start it, try to stay with it for at least several minutes, more if you are able. If you catch yourself in long periods of silence, see if you haven’t been hooked by a thought or feeling that you’ve been following. Then come back to the exercise.

Labeling psychological content by type will help you to learn to deal with content in a defused way. For example, if you have a thought about what you need to do later on, staying with the label, “there’s a thought” supports you in staying present with what is

actually happening. The thought may be about the future, but that is pure content. In fact, the thought is occurring now, and noticing that is a powerful habit of mind. Cultivating this habit can be helpful when even more difficult content appears (e.g., a thought that you may have a panic attack later).

### **Eating Raisins**

Raisins are funny little fruits and when we eat them, we tend to just pop them into our mouths without much thought. You might be amazed to discover how much deeper your experience of a raisin can be if you treat it mindfully.

First, take a raisin and eat it the way you normally do, that is, just pop it into your mouth. Now, get another raisin. Put it down on the table in front of you and examine it. Notice the wrinkles on its skin. Look at the various shapes the wrinkles form. Take out a second raisin and place it next to the first and notice how unlike they are. No two raisins are identical.

Are the two raisins the same size? Think about the raisins in terms of the space they take up in the room, in the world, in the universe. Think about their size in relation to one another.

Now pick up one of the raisins and roll it around between your fingers. Feel the texture on the one side of the fruit. Feel the slightly sticky traces it leaves on your fingers as you move it back and forth.

Place the raisin in your mouth. Roll it around inside your mouth, over and under your tongue. Hide it in the crevices between your jaws and cheeks. Don't chew on it for at least thirty seconds or so. When you are ready, eat the raisin and note the way it tastes.

Note the way it feels on your teeth as you chew. Feel it as it slides down your throat when you swallow it.

Now eat the second raisin, but this time, eat it super slow. Chew the raisin as many times as you can, until it turns into liquid mush in your mouth. Is the flavor different when it is eaten this way than it was last time? How is it different? What does it feel like in your mouth as it falls apart? How does it feel as you swallow it? How does it compare with the last raisin? What's different when you eat the raisin mindfully rather than simply popping it in your mouth and slurping it down? Write down your answers to these questions in the space below:

---

---

---

### **Drinking Tea**

Now we will try a similar exercise with a cup of tea.

5. Boil a pot of water.
6. Get a tea bag or a tea-leaf strainer filled with tea leaves and put it into a cup.
7. Pour the boiled water over the tea bag or the strainer. Fill the cup.
8. Let it steep.

As the tea steeps, watch the water change colors. When you first pour the water over the tea, the water will turn a light brown, green, or red (depending on the kind of tea you are using). Soon it will darken. Let it steep for a few minutes and remove the tea from the water. Look closely at the color of the tea. Is there anything you didn't notice about the color before? If so, you might want to jot down your observation below:



---

---

---

Now place your hands around the outside of the warm cup. Have you ever felt a cup of tea like this before? How does it feel? Is it quite hot, or just warm? Note the temperature.

Bring the cup to your lips. Smell the tea. Take a good long whiff. Ninety percent of your sense of taste is controlled by your nose. If you aren't smelling your tea, you aren't tasting it.

Now take a sip. Does it burn your lips? Is it too hot? Or is it nice and warm? What does it taste like? Try to note your experiences without judging them. Then, describe your experience below:

---

---

---

If you don't like tea, that doesn't really matter. Just try the exercise. Note how much you dislike tea as you taste it. And write down that experience. It's folly to think that you should practice present moments of awareness only in moments of pleasure. That would eliminate half of your life. You know that you will have some unpleasant experiences, so you might as well experience them fully and take them for what they are worth.

**Mindful Eating**<sup>60</sup>

There are as many ways to practice mindful eating as there are schools that practice mindfulness. Some ways require you to eat slowly, some to chew each mouthful of food fifty times, some to eat a limited number of meals, some ask you to test for your hunger responses while you're eating, and so forth.

In many Western cultures, and particularly in the United States, we don't pay a great deal of attention to the food we eat. In a world where everything is supersized and the burger is king, we tend to think of food as not much more than a necessary factor of survival. What's worse, we tend to believe that this factor is as much a given as the air we breathe. We take our food for granted.

In the context of this book, the point of eating mindfully is not the activity of eating itself. It is used as a means to practice mindfulness. Becoming aware of your eating behavior rather than just rushing through it is an excellent way to bring yourself back to the present moment. Observing yourself while you eat is a great way to practice removing yourself from the conceptualized self. It doesn't matter whether you like the activity of eating. The important thing is to practice connecting to the present moment.

To practice eating mindfully, you can use many of the same techniques and much the same attitude as you did while doing the exercises above, only you continue the practice for an entire meal. Set aside some extra time for yourself at your next meal and try it out.

---

<sup>60</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

**Eating Mindfully<sup>61</sup>**

To start, move through the meal slowly. Take your time performing every action and notice what your experience is as you go through it. When you lift a fork or cut your meat, note what that is like for you. As you place a bite of food in your mouth and chew it, think about the flavors and the texture of the food. Is it enjoyable or repulsive? Don't get hung up in judging it. Just notice it.

Do you find that particular thoughts or feelings come up during the course of the meal? If so, simply note those as well. You might want to use some of the techniques used throughout this workbook to help you do that.

Are you eating with a friend or partner? Are you eating alone? It may be interesting to watch your mind as you interact with the people with whom you take your meals. It may also be interesting to note the kinds of thoughts and emotions that come up when you are eating alone.

Because we all have to take the time to eat in order to live, eating mindfully is an excellent way to practice staying in contact with the present moment and making the most of your time.

**Be Mindful of Your Feet While You Read This<sup>19</sup>**

Bring your focus to your feet. Think about how they feel just where they are. Try to remain mindful of your feet while you read the next few lines.

Mary had a little lamb

Whose fleece was white as snow.

---

<sup>61</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

And everywhere that Mary went  
The lamb was sure to go.  
He followed her to school one day  
Which was against the rules.  
It made the children laugh and play  
To see a lamb at school.

Were you able to remain mindful of your feet while reading this nursery rhyme?

Did you notice that your awareness was shifting back and forth between the content of the passage above and your feet? Did you become mindful of your feet only occasionally, when you remembered them? Or were you able to hold onto your feet mindfully while reading the passage above? Take a few minutes to answer some of these questions.

---

---

---

This exercise is particularly interesting on a number of levels. In the first place it asks you to divide your attention in half by asking you to remain mindful of your feet while reading a nursery rhyme. The other interesting thing about this exercise is that it mimics the way we sometimes can get so wrapped up in our own stories that we forget about other things that are going on for us.

When you get scooped up into the story of your depression, your anxiety, or your low self-esteem, often you may forget that there are many other things going on for you. That story may be the only matter you take notice of. You might also pay attention to your feet, your hands, the quality of the air around you, or millions of other factors that

are taking place within you and in your environment, at the same time your psychological distress stories are being generated. Remember, though, the goal is not to think of your feet as a means of forgetting about or ignoring the pain you are in. Rather you can focus on your feet to practice being able to attend in the moment, deliberately and flexibly, as you wish.

You can do this same exercise while reading the newspaper, or indeed this workbook. Pick out something specific to attend to and see whether you can focus in on it while simultaneously being very focused on your reading.

## Individual Session #2

---

- Reactions from group
- Review *What Needs to be Accepted* HW
- Process patient's experience with willingness and acceptance
- HW: Acceptance in Real Time

Begin this session by reviewing patient's reactions from group, as described in module 1. Be sure to ask if patient has been able to practice the mindfulness exercises throughout the week and if they understand the concepts of willingness and acceptance. Clarify and explain if needed.

Review the patient's *What Needs to Be Accepted* homework assignment. Explore patient's responses and inquire about the thoughts and feelings that emerged while completing the assignment. If the patient experienced difficulty coming up with responses, go through each response with her and help her to identify her personal areas of avoidance. In order to identify these areas, it may be helpful to inquire about what (memories, images, bodily sensations etc) make her uncomfortable and then assess for whether avoidance is utilized to cope with the discomfort.

### **HOMEWORK: Acceptance in Real Time<sup>62</sup>**

---

In your *What Needs to Be Accepted* homework assignment, you identified memories, images, bodily sensations, emotions, thoughts, and behavioral predispositions that you tend to avoid; that have cost you because of your avoidance (e.g., anxiety, depression, anger, and so on). These are called “targets,” and have been a large part of the

---

<sup>62</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

exercises you have completed; but what happens when you're faced with content you struggle with in real-time? What happens when you are out there in the world, going about your real life, and you are faced with situations that cause you pain? If you're an agoraphobic, for example, and you haven't been outside of your home for a long time, you are going to be facing some heavy emotions/sensations when you step outside your front door. How should you handle instances like these?

The short answer is, the same way you've been learning to handle all of your difficult experiences. Open yourself to them by first putting yourself in the observer position, and then with your observer-self look at them with a defused, accepting, mindful posture. However, we would also like to help you deal with difficult experiences in a more concrete way than we've just described.

What we'd like to do is help you develop a set of experiences that you're quite sure will bring up the negative content you've been avoiding, and then develop a graded-exposure program in which you will actually go out into the world, seek out these scenarios, and experience your experience in real-time.

To accomplish this, you'll begin with the worksheet below. Fill in the space on the left with actual physical scenarios you think will bring up one of the willingness targets you identified earlier. Note that there are ten spaces, so try to come up with ten scenarios. Choose a variety of different situations in which your target will present itself. Think of some that will cause you a lot of distress and some that won't cause quite so much discomfort. If you think of one scenario that feels really big and daunting, you might want to break it down into its component parts.

For example, if you are suffering from OCD, and dirt or germs set off your compulsion to clean, it may be too much for you to go out and roll around in the mud. Break it down. In this case, one scenario that might cause your target to show itself could be to put a small amount of dirt on a white cloth and carry the cloth with you for a day. Then, you might want to wear a soiled shirt. And so on and so on.

Once you have done this, order your scenarios from 1 to 10, where 1 is the scenario you think will cause you the least amount of contact with your target, and 10 is the scenario you think will cause you the greatest amount of contact with your target. Numbering them from 1 to 10 will give you a graded way to expose yourself to this material.

Scenario	Rank




Once you have done this, take your first scenario, the one you numbered 1, and decide a time and place you would like to expose yourself to it. You can limit the amount of time of your exposure but what you can't safely limit is your willingness to experience what the exposure brings up for you. Avoidance of any kind has to be off the table. If you aren't sure you can make that commitment, generate an even smaller step, or limit this step further with limits on the time and situation. Take some notes in the space provided about when, where, and how long you are willing to do this exposure to the first item:

---



---



---

During the actual exposure you will use the skills you've already learned. First we will describe these skills and then we will shrink them down to a bulleted list that you can carry with you to remind you of actions you can take in the situation.

You should notice what your body does. Localize where you feel sensations and emotions in your body. Notice the feeling's qualities, and where it begins and ends. Scan your body and notice other places where you are feeling things, and after you've noticed them, psychologically reach out and allow yourself to feel these feelings without defense or manipulations. Make sure your purpose is simply to be present and willing. Nothing else. This is not a secret way to make bad feelings diminish or vanish, and, even if your feelings happen to change, don't buy into any thoughts that tell you otherwise.

Look around you when you are exposing yourself and observe what else is happening in the world around you. If there are people there, notice them. If there are objects, or buildings, or plants or trees, notice them. Do not do this to diminish the thing you are struggling with. The point is to add to your experience—in addition to these feelings there is also life going on all around you.

Notice what thoughts come up for you. Notice them the way you would notice a cloud drift by. Do nothing to make them come or go. Do not argue with them. Do not disbelieve them or follow them where they go. Just notice them, as you might notice the sound of a radio in the background. Thank your mind for generating all its products for you.

Notice the pull to your past and future. But see if you can stay in the present by becoming present with thoughts about the past and future. If you find yourself checking the clock, let go of your attachment to the time.

Notice the pull to act. If you feel the pull to leave or avoid or dissociate just feel that pull—willingly and fully.

Have some fun. Do something (anything!) new in the situation. Tell a joke. Hum. Eat. Skip. Play little mental games. For example, if there are people around, who can you identify with the worst haircut? What interests you in the situation? Be careful! This is *not* distraction. In *addition* to what you are struggling with, the point is to notice that there is *also* the opportunity to do many, many other things. Broaden the range of things that you can do when you're in contact with your target.

If you feel *really* bold, find out what your mind is saying you cannot or must not do and consider doing more of it (but only if you are willing!). If you're anxious and your mind tells you that you might look foolish if you become too anxious, then do something foolish. Put your hat on upside down, or your glasses on backwards. Ask a passerby what month it is. If your mind tells you that you might faint and fall down on the ground, then purposefully lie on the ground and see what it feels like to be there as others react to your prone body.

Notice that you are there as an observing-self, through all of this, unchanged. Use that sense to be present with your experiences (do not use it to dissociate or avoid). Above all, watch for every tiny little way your mind has been trying to "protect" you by avoidance. Undermine every form of avoidance, let go of it. And all of this has only one purpose: to practice being willing in the moment. No manipulation. This is not a new, secret way to regulate your internal processes. No more of *that*.

Got it? Okay, now go out and do it. Take all of your skills with you, and experience what you experience in real-time, fully and without defense. Set your limits beforehand.

Now, below you will see a bulleted list you can use to remind you of things to do. You can augment this list by adding any of the exercises you've done during the course of working with this book to help you either to defuse from or to accept thoughts and feelings, or to contact your observer-self. List any-thing that's worked for you. For example, if you suffer from agoraphobia, and you've decided to walk around the block for your first step, when your anxiety comes up, you might ask yourself: "If this feeling had a size, how big would it be? If this feeling had a shape, what shape would it be?"

Take this list with you and glance at it while doing your actual exposure. Notice your body and its sensations. Make room for them.

- ❖ Notice what is around you. Appreciate your immediate environment.
- ❖ Do not avoid.
- ❖ Notice your thoughts, but just let them come and go. Don't follow them.
- ❖ Notice the pull to your past and future. Then notice that you are here in the present.
- ❖ Don't fight.
- ❖ Notice the pull to act and to avoid. Do nothing about that pull except to notice it.
- ❖ Do something new. Perhaps even be playful.
- ❖ Use your reverse compass (but only if you are willing!).
- ❖ Notice you are noticing all these things.
- ❖ List other things you might do below:

---

---

---

❖ Stick to your commitment: Be present. No avoidance.

You can continue to repeat your exposure to scenario number one until you feel able to open yourself to the experience and accept what is given to you. This doesn't mean do it until your pain goes away. This isn't about that. Do it until you can make more room for all the thoughts, feelings, urges, bodily sensations, and memories you have. Welcome them into the home of yourself. Inhale them all.

When you have accomplished that (it can take multiple exposures), move on to scenario number two and do the same thing. If you hit a level that seems beyond you, put the list aside and come back to it after you've attended more sessions and gained a higher comfort level with ACT techniques.

You can continue working with this process indefinitely, using this list and many others. At some point, it may no longer be necessary to list scenarios and then pursue them in this manner. Once you've had some practice with your acceptance skills, you'll be able to integrate them into your daily life, and life itself will give you many chances to apply them. It is amazing how when we begin to say yes, life seems to present us with just the right challenges: always slightly more or slightly earlier than we might have wished and yet doable—if we are willing.

### Module 3

#### Group Session #3

---

- Review *Acceptance in Real Time* HW
- Definition/ Explanation of Values
- Epitaph Exercise
- HW: Choosing Your Values

This is some of the most difficult work in this book. Values are intentional qualities that join together a string of moments into a meaningful path. They are what moments are *about*, but they are never possessed as objects, because they are qualities of unfolding actions, not of particular things. Said another way, values are verbs and adverbs, not nouns or adjectives; they are something you *do* or a quality of something you do, not something you *have*. If they are something you do (or a quality of something you do), they never end. You are never finished.

For example, say one of your values is to be a loving person. This doesn't mean that as soon as you love someone for a few months you are done, as you can be done with building a house or done with earning a college degree. There is more loving to do—always. *Love is a direction, not an object.*

To complete the definition of “values” we must also define “choice.” Choices are selections between alternatives that may be made in the presence of reasons (if your mind gives you any, which it usually does, since minds chatter about everything), but this selection is not *for* those reasons in the sense that it is not explained by, justified by, or linked to them. A choice is not linked to an evaluative verbal yardstick. Said another way, choice is a defused selection among alternatives. It is different than judgment, which is a verbally guided selection among alternatives.

The word “values” comes from a Latin root that means “worthy and strong.” It carries an implication of action, which is why that same root leads to the word “wield.” It connotes actually using what is important and strong. Values define not only what you want to pursue from day to day but what you want your life to be about. In some sense, what’s at stake here is a matter of life and death, or at least the difference between a vital life and a deadened life.

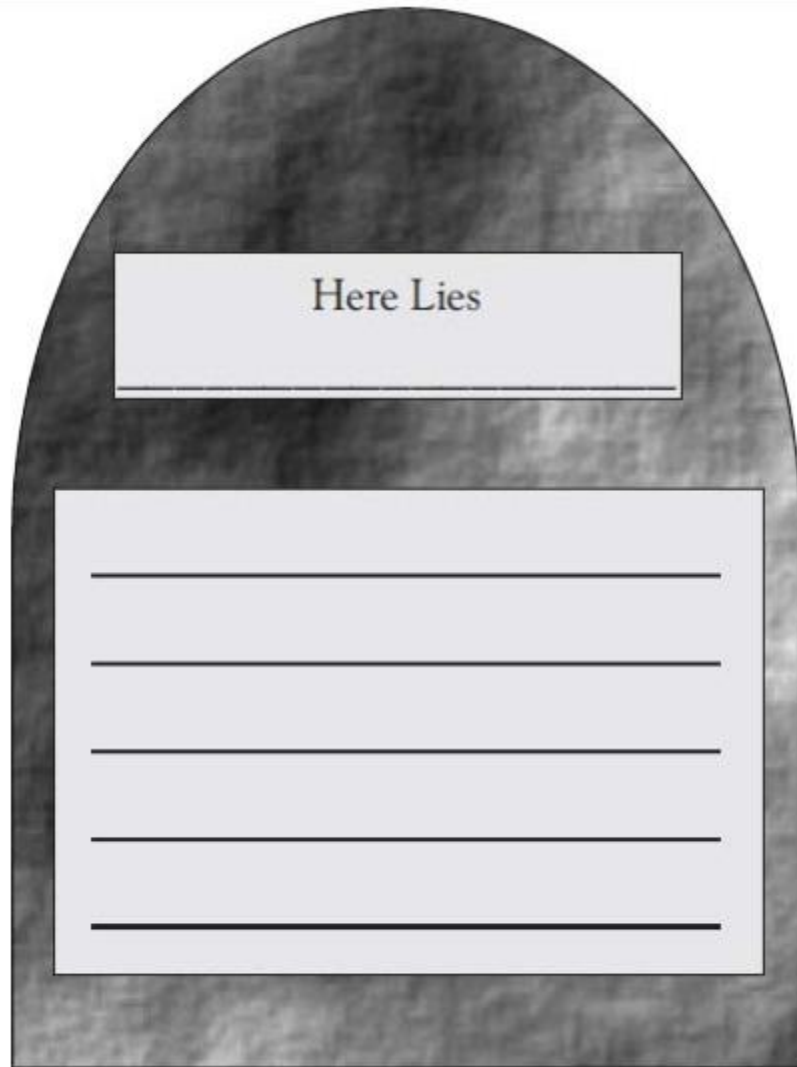
**EXERCISE: Your Epitaph**<sup>63</sup>

---

When people are buried, an epitaph is often written. They say things like “Here lies Sue. She loved her family with all her heart.” If the headstone below was yours, what inscription would you like to see on it? How would you most like your life to be characterized? Again, this is neither a description nor a prediction; it is a hope; an aspiration; a wish. It is between you and the person in the mirror. What would you like your life to stand for? Think about it for a moment and see if you can distill your innermost values into a short epitaph and write it out on the illustration of the tombstone below.

---

<sup>63</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.



**Figure 3.1: Your epitaph<sup>64</sup>**

---

<sup>64</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



This short exercise provides a broad beginning. Hopefully, it stirred up something in you that will allow you to become bolder and clearer about what it is you really want to be about. You are alive, not dead. How do you want to **live**? To give this question some structure, consider the following ten domains that might be of some importance to you:

1. Marriage/couple/intimate relationship
2. Parenting
3. Family relations (other than intimate relations and parenting)
4. Friendship/social relations
5. Career/employment
6. Education/training/personal growth and development
7. Recreation/leisure
8. Spirituality
9. Citizenship
10. Health/physical well-being

### **HOMEWORK: Choosing Your Values<sup>65</sup>**

---

What follows is a brief description of each of the above-mentioned domains as well as space for you to describe your own values in that domain. Keep in mind, as you go through this, that values are not specific goals, but general life directions. We'll get to concrete goals later. If you find yourself writing down material things that can be obtained such as an object, stop and rethink what it is we are asking for; that is, directions that can always be made to manifest but that can never be fully obtained or finished.

---

<sup>65</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

Take what you've learned about values up to this point in this workbook and apply that to the following exercise. Remember the epitaph you just wrote, and see whether elements from that applies to one or more of these domains.

As you work through this exercise, you may discover that certain domains are very important to you and others are not. Some domains may be areas in which you are currently doing little. That's to be expected. It's not as though you need to value each of these different areas of life to the same degree. Different people have different values. A little later, we'll help you rate these values for yourself. For the moment, try to find a value that you hold in each domain. If there is an area for which you really can't think of anything, it's okay to skip it.

It may also be difficult to distinguish sharp boundary lines in certain areas. For example, some people have a hard time distinguishing between intimate relationships and family relations. Others may find it difficult to mark the difference between leisure and social relations. Read the description of each domain and try to keep the boundaries as clear as you can. If certain entries overlap, or you repeat a value in more than one domain, that's okay, but we encourage you not to overdo it.

This isn't a test. You need not show this to anyone if you don't want to. So be honest and open and give yourself the opportunity to explore what *you* value. Don't base this exercise on what you think your friends', family's, or society's expectations are. Write about what *you* value. There are no right or wrong answers.

### **Marriage/Couple/Intimate Relationship**

For most people, intimate relationships are very important. This is the relationship you have with your "significant other": your spouse, lover, or partner. If you are not in

such a relationship right now, you can still answer these questions in terms of what you aspire to find in such a relationship.

What kind of person would you most like to be in the context of an intimate relationship? It might help to think about specific actions you would like to take, and then use those to dig down to the underlying motives for such actions. What are those underlying motives? How do they reflect what you value in your relationship? Do not put down goals (like “getting married”); there will be an opportunity for those later.

---

---

---

---

### **Parenting**

Think about what it means to you to be a mother or father. What would you like to be about in this role? If you don't have children, you can still answer this question. What do you want to be about in supporting this role in others?

---

---

---

---

### **Family Relations (Other Than Intimate Relations and Parenting)**

This domain is about family, not about your husband or wife or children, but about other areas of family life. Think about what it means to be a son, daughter, aunt,

uncle, cousin, grandparent, or in-law. What would you like to be about in your family relationships? You may think about this broadly or only in terms of your nuclear family.

What values would you like to see manifest in your life in this area?

---

---

---

---

### **Friendship/Social Relations**

Friendships are another area of personal relations that most people value. What kind of friend would you like to be? Think about your closest friends and see if you can connect with what you would like to have manifest in your life regarding your friends.

---

---

---

---

### **Career/Employment**

Work and careers are important for most people because that area is where a great deal of your life is spent. Whether your work is humble or grand, the question of values in work pertains. What kind of an employee do you most want to be? What do you want to stand for in your work? What kind of a difference do you want to make through your job?

---

---

---

---

**Education/Training/Personal Growth and Development**

This area can cover all kinds of learning and personal development. School-based education is one. But this area includes all the things you do to learn, as well. Working through this workbook could be an example. What type of learner do you want to be? How would you like to engage with that area of your life?

---

---

---

---

**Recreation/Leisure**

Recreation, leisure, and relaxation are important to most of us. It is in those areas that we recharge our batteries; the activities in this area are often where we connect with family and friends. Think about what is meaningful to you about your hobbies, sports, avocations, play, vacations, and other forms of recreation. In these areas, what would you like to have manifest in your life?

---

---

---

---

**Spirituality**

By spirituality, we don't necessarily mean organized religion, although that could certainly be included in this section. Spirituality includes everything that helps you feel connected to something larger than yourself, to a sense of wonder and transcendence in life. It includes your faith, spiritual and religious practices, and your connection with others in this domain. What do you most want to be about in this area of your life?

---

---

---

---

**Citizenship**

How would you like to contribute to society and be a member of the community?  
What do you really want to be about in social/political/charitable and community areas?

---

---

---

---

**Health/Physical Well-Being**

We are physical beings, and taking care of our bodies and our health through diet, exercise, and sound health practices is another important domain. What do you want to have revealed in your life in these areas?

---

---

---

---

Sometimes we get confused about what values are. People often make the mistake of stating that they value something when, in fact, that chosen value has been dictated by the desire of others. To test your values, look over the exercise above and ask yourself the following question in regard to each of the values you wrote down: “If no one knew that I was working on this, would I still do it?” If you find that you’ve written down statements that don’t “ring true,” or are more a matter of “being a good boy or girl” than stating what is truly in your heart, go back and edit what you wrote. This list is not for anyone else. It is for you.

---

---

---

---

**Individual Session #3**

---

- Reactions from group
- Review *Choosing Your Values* HW
- Exercise: Ranking Your Values

**EXERCISE: Ranking Your Values<sup>66</sup>**

---

In some ways, it's not very important that certain values are more meaningful to you than others. All of the things you wrote about in the exercises above are areas of your life that you would like to pursue in order to live more completely. However, it can be useful to put a rank marker on your values in order to see in which areas of your life you might begin to take action.

Look back over the *Choosing Your Values* assignment. Now, distill each area down to one key value (if you have several, you can pick the most important one), and write a phrase to remind you of that key value in the space below. Now rate each area in two ways. First, ask yourself how important this particular area is to you right now on a scale of 1 to 10, with 1 meaning not at all important and 10 meaning extremely important. We aren't asking if this area is important in your actual behavior; we are asking what you would want if you could have your life be as you would want it to be.

Then, rate each area according to your actual current behavior. How well have you been currently living this value on a scale of 1 to 10? With 1 meaning it is not at all manifested in my behavior to 10 meaning it is extremely well manifested in my behavior.

---

<sup>66</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.



Finally, subtract the score you got for your actual current behavior from the importance score above that to arrive at the total of your “life deviation” score.

<b>Table 12.1: Ranking Your Values</b>				
Domain	Value	Importance	Manifestation	Life Deviation
Marriage/Couple/ Intimate Relationships				
Parenting				
Other Family Relations				
Friendship/ Social Relations				
Career/Employment				
Education/Training/ Personal Growth				
Recreation/Leisure				
Spirituality				
Citizenship				
Health/ Physical Well-Being				

**Table 3.1 Ranking Your Values<sup>67</sup>**

The number on the far right is probably the most important. The higher that number, the more your life needs to change in this area to bring it in line with what you really care about. High numbers under the Life Deviation column are a sign and source of

<sup>67</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

suffering. You may want to highlight or circle those numbers that show the largest gap between the importance of your values and their actual presence in your life.

## Module 4

### Group Session #4

---

- Creating the Road Map: Setting Goals
- Goals Worksheet
- Making Goals Happen Through Action
- Expected Barriers
- HW: Values Form

In the last module, you explored and developed some ideas about what you value. Each of those values is a compass point by which you can chart the course of your life. The next thing to do is start walking in that direction. This is basically a four-part process that repeats itself endlessly: Contacting your values, developing goals that will move you in a valued direction, taking specific actions that will allow you to achieve those goals, and contacting and working with internal barriers to action.

Go back to the *Ranking Your Values* exercise you did in module 3. In it, you listed some values and assigned importance, manifestation, and life-deviation scores. It's now time to decide which of those values you want to work toward enacting in your life right now. Ultimately, you'll work on all of them, but for now let's start with one. This will give you a model to follow for the other valued directions you want to take.

The values you choose to work on first can have a high life-deviation score, or if you sense that there are barriers there you are not yet ready to confront, you can choose something lower on your list. They are all important; they simply hold different levels of relative importance and you may pick any one to start with. Write down your stated value on the line below:

---

If your value is the compass point by which you want to guide your life's journey, your goals are the road map that can lead you there. Goals are different from values in that they are practical, obtainable events that move your life in the direction of your values. Goals are the guideposts by which you can mark your life's journey, and they are important for a number of reasons. Goals give you a practical means to make your values manifest. They also offer you a metric against which you can measure your progress on your valued path. The true goal of goals is to orient you toward your values so you can live a valued life, moment by moment. You may know what you want to be about, but without goals, it's unlikely you'll be able to live these values in the real world.

To start developing your goals you'll need to consider both short-term and long-term objectives. *Short-term goals* are the points on the map that are attainable in the near future; *long-term goals* are further down the road. Having both short-term and long-term goals makes for a paced journey that leads from one guidepost to the next. This is a very efficient way to travel. Theoretically, you could just wander around until you found your destination. But, as you know, that's not very effective. Goal-oriented travel is much more practical.

Look back at the value you wrote down above. Now think of one thing you could do that would allow you to make that value manifest in a practical way. In this workbook, there have been various discussions on values and goals. There also have been a number of examples that may offer you some guidance. Remember to think about this in terms of a practical outcome. Don't come up with something that is obviously outlandish.

If you're a fifty-year-old salesclerk who values public service, and you decide your goal is to become the president of the United States, that isn't likely to happen.

Choose a goal that is a workable step in the direction of your values. If you are that fifty-year-old salesclerk who values public service, there are hundreds of ways you might approach making a public service contribution that is both practical and obtainable. For example, you could do volunteer work in your community; perhaps serve food at a soup kitchen. Or, you might want to campaign for someone running for local office. This isn't said to discourage you from taking bold steps. Be bold. But be real. Don't be too easy on yourself, but be realistic and decide on something you can achieve.

Once you have your goal firmly in mind, write it down in the space below:

---

---

---

Now check your goal for the following items:

- ❖ Is it practical?
- ❖ Is it obtainable?
- ❖ Does it work with your current situation?
- ❖ Does this goal lead you in the direction of your stated value?

If you answered yes to these questions, then you have successfully created a goal for yourself. If you couldn't answer yes to whatever you wrote down in the space above, please raise your hand so that we can try to get clearer on what a goal is. The next step is to figure out whether this is a long-term goal or a short-term goal and whether or not you will need to complete additional goals to get there.

---

Next, on the following time line, plot a point where this goal would fall for you. The far left of the time line is your life, starting today. The end of the time line is your death, some reasonable amount of time in the future. Where on this line does your goal fall?

---

**Life today**

**End of life**

The relative distance between where you are today and when you think you could reasonably achieve this goal will tell you whether it is a long-term or short-term goal. If you've established that your goal looks like a long-term one, you'll need to develop some additional short-term goals to get there. If it's a short-term goal, you might ask where this goal is leading you and where you'd like to go after it's completed. Either way, you can return to the process described above until you are satisfied that you've produced a good set of long-term and short-term goals for the value you chose to work on. The following exercise will help you keep track of all this information. The following exercise will help you to keep track of all this information.

**EXERCISE: Goals Worksheet<sup>68</sup>**

---

Value:

---

This value will be manifested in the following long-term goal:

1. 

---

---

---

Which, in turn, will be manifested in these short-term goals:

1. 

---

---

---
2. 

---

---

---
3. 

---

---

---

---

<sup>68</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

This value will be manifested in the following long-term goal:

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which, in turn, will be manifested in these short-term goals:

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Repeat this process until you have a good working set. (It need not be comprehensive; you can always add and subtract from these at any time.)

There are no hard and fast rules about how many goals you need to have. This is about your life. Think about what you would like to accomplish, and set your goals in terms of how they will fit practically into your life. The numeration in the worksheet above is arbitrary. Perhaps starting with one long-term goal makes sense for you. Or if not, a single short-term goal may be a good place to start. You need not have a particular number of goals to be “doing the right thing.” If you’re getting caught in thoughts of this



nature, remember your mind is talking to you again. Use the strategies you've learned throughout this workbook and set your compass in the direction you want to live.

Setting goals is all about workability. If you don't make your goals workable within the context of your life, it's unlikely you'll get very far down the path of your values. Choose achievable, obtainable outcomes that can realistically fit with your life. Doing this makes it much more likely you'll actually be able to live your values every day. The true goal of this process is to become better able to focus on life as a valued process. Every goal is a step leading you further down the path of your life. The path itself doesn't end (at least not until your life ends). Being vital means there will always be some new way to pursue your values. Achieving your goals isn't an end, but a new beginning; a point of closure at which you can refresh your journey by starting anew. Guideposts are important, but don't be trapped by them. Celebrate goals achieved and keep on keeping on.

### **Making Goals Happen Through Action<sup>69</sup>**

You can talk the talk all you want, but if you don't walk the walk, your life won't come alive for you. What we've been exploring in this workbook is important, but what are you going to *do* about it? If you know where you want to go and don't go there, then the knowledge makes little difference. ACT is all about action. To make a difference in your life, you need to act. What actions are you going to take to achieve your goals? To

---

<sup>69</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

move in the direction set by your value compass toward your first goal, what do you need to do? Because life is a process, things happen one step at a time. Once you know what you value and what your goals are, you can choose which steps to take first.

Think about one of your short-term goals from the *Goals Worksheet*. It is important to define specific actions you need to take to achieve your goals. Make sure that you choose actions that you can actually do. Don't be vague (e.g., "Do better"), and don't write down things you cannot directly control by action (e.g., "Feel better"). Choose a specific situated action: this is an act that has a beginning and an end, a specified form, and a specified context. For example, "build friendships" is not a specific action. "Call friends" is better, but it is still too vague. "Call Sally" is fine. It has a beginning and end, a specified form, and a specified context. Try to include at least one thing you can do *today*.

For example, let's say, as part of a longer-term goal of letting friends know you care about them, you've decided to contact old friends. One specific action might be to call a specific old friend ("Sally") with whom you've lost contact. But this action may require others. The first thing you have to do is find out how to get in touch with her. To do this, you might call some other friends who know her, look her up on the Internet, find her number in the white pages, or contact members of her family to see where she is. Each of these options would be a specific action that would take you one step further toward your goal of getting in contact with your old friend. Try to come up with enough actions and sub-actions so that if you did them all, achieving your goal would become highly likely, or even certain.

**Barriers**<sup>70</sup>

Unfortunately, it's often not so simple. Unfortunately, barriers will come up. Some will come in the form of practical problems you'll face moving down your valued path. But more importantly for the work we are doing here, barriers are going to show up in the form of the experiences you've been trying to avoid, or in the form of the thoughts you've been fused with. In order to identify barriers, focus on the actions that you have identified and think about what psychological resistance you may have toward them. If you were to engage in the actions and sub-actions that you identified earlier, what would you expect to encounter psychologically that would slow you down? Look for difficult thoughts, feelings, bodily sensations, memories, or urges. If you aren't sure, close your eyes and picture engaging in the behavior and watch for indications of the barriers.

Once you are able to identify potential barriers, consider the strategies you have learned in this workbook up to this point. If you've developed "favorite" cognitive defusion, mindfulness, and acceptance strategies, you might consider using these. Flipping back through the book could help you remember what these are. In an ACT approach you do not "get over" barriers or "get around" barriers. You do not even "get through" barriers. You get **with** barriers. One successful ACT patient described it this way: "I used to run away from pain. Now I inhale it."

So far, we've been exploring how you might walk down the path that a single

---

<sup>70</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

value generates for you. But in module 3 we explored ten different valued domains. In each domain you may have written down more than one value. In addition, you may come up with values that don't necessarily fit the categories we've been exploring. If you valued a single thing, life would, perhaps, be simpler. But it wouldn't be as full and dynamic as it is when you value so many different things. If your list of values is full, that means you have an exciting journey ahead of you.

### **HOMEWORK: Values Form**<sup>71</sup>

---

Different journeys require different maps. Since we aren't moving toward a destination on a physical plane, we can take many different journeys at the same time. You can and should pursue different values in different domains at the same time. Life would be stripped of its richness if we weren't given this variability. The work you've done in this module could be summarized on the following form:

---

<sup>71</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors' permission.

Values Form			
Value: _____			
Goals	Actions	Barriers	Strategies

If you wish, you can summarize the information we've discussed about your values and goals earlier in this session on this form. What's more, you can use this form as a way to generate road maps for each of your valued paths. You may want to photocopy it several times and go back to the values you worked out in module 3. Start with one of those values, write it down in the space at the top of the form, and do the

whole process again. In this way, you'll formulate a concrete game plan for the next steps on your life path that will span the many different areas you care about.

**Individual Session #4**

---

- Post-treatment questionnaires
- Reactions to treatment
- Review *Values Form* HW
- Building Patterns
- Termination

Please arrive early to this session to complete the post-treatment questionnaires. You and your therapist will review your responses and discuss your progress over the course of treatment.

**Building Patterns**

---

The biggest problem with avoidance and fusion is that they get so rigid because they become such large patterns. For new things to happen, we must break down the old things. ACT patients sometimes call this the “reverse compass.” They learn that if a habit points north, it may be time to head south. When large, old, inflexible patterns break down, you have an opportunity to establish new patterns where they are needed. Some of these patterns can be consistent if it works for them to be so (for example, you may find that it works to keep your commitments); others can be deliberately established as more flexible patterns if being more flexible works.

Let's discuss some pattern-smashing games that you might play. Suppose you notice the pull to “look good” and “be right” when you are with other people. Superficially, your efforts cost you nothing, but you suspect they are part of a larger pattern of trying not to feel small, which, in turn, is part of a larger pattern of trying not to be seen, for fear of seeming small, and that is part of a larger pattern of accepting the idea that you are, indeed, small. If you noticed that pull, you might try doing something that

would create social discomfort intentionally, for no other reason than to feel what it is like to be uncomfortable socially.

For example, wear white socks with dark clothing, but don't talk about it. Skip putting on your make-up or apply it in a silly way. Tell a lame joke deliberately, but don't explain it. Deliberately misstate a fact you know, but don't admit you are doing it deliberately. Tell an embarrassing story about yourself to friends. Pay for something using only small change. Purchase something odd (like deodorant) and then return it.

Do you see the point? The goal is not to be silly or to be a fool. Once you've broken up the pattern, new behaviors will become possible. The goal is to confront your larger patterns when you detect they have built a box for you to live in that spreads into areas you care about.

For example, if you can return deodorant, you also might be slightly more likely to knock on a stranger's door and ask for a contribution to feed hungry children (if an action like that appeared on one of the "action" lists linked to your goals and values. Or you could call someone you barely know and ask for a date (if that showed up on one of the "action" lists linked to your goals and values).

One great way to break up unhelpful larger patterns is to do truly new things regularly. Paint a painting if you've never done so; learn to dance; sing a song in a karaoke bar; join a social group; take a cooking class; fix or build something yourself; write a poem; start a journal. This can be especially useful if these "things I just don't do" are part of a larger pattern of avoiding failure.

Superficially, it seems as though it wouldn't matter if you can't give a toast because, "I'll be embarrassed if it's bad." After all, how often would you have to give a



toast anyway? But what larger pattern is being fed? If it is a larger pattern of playing small, you may be building yourself a straightjacket with these tiny choices. You may be feeding a conceptualized self (“I’m just not good at doing social things” or “I’m just too anxious”) that is systematically narrowing your own ability to live. If so, it’s time to kill off that conceptualized self by breaking the pattern.

We’ve identified some of the key larger patterns that language encourages: experiential avoidance, cognitive fusion, attachment to the conceptualized self, and so on. If you do anything different in the presence of events that normally lead to these patterns, you are helping to create more psychological flexibility. In the grandest scheme of things, that is the ultimate goal of ACT—the ability to fit your behavior creatively into the larger patterns you wish to create. Said another way, the ultimate goal of this workbook is psychological liberation. How much has your life been about what your mind suggests, rather than what you want it to be about?

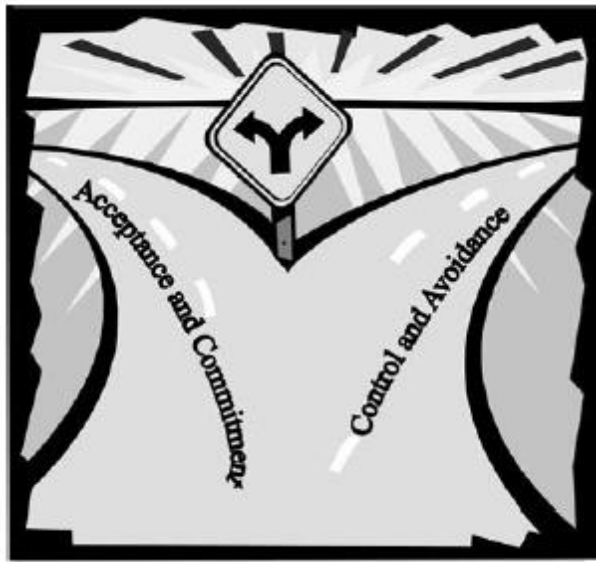
### **CONCLUSION: The Choice to Live a Vital Life<sup>72</sup>**

---

When you confront a core problem within yourself, you are at a choice point much like the figure below illustrates. Off to the right lies your old path of avoidance and control. This is the path that the negative parts of yourself want you to take. It is the logical, reasonable, sensible, verbal path. Your mind will chatter on about dangers, risk, and vulnerabilities and will present avoidance as a method of solution. You’ve been down this path, over and over and over again. It’s not your fault; you’ve done what any reasonable person would do. It just turns out not to be effective, vital, or empowering.

---

<sup>72</sup> Material for Patient Workbook/Clinician Manual is adapted from a self-help workbook titled *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy*, by Steven C. Hayes, Ph.D. and Spencer Smith, 2005, Oakland, CA: New Harbinger Publishers Inc. Copyright © 2005 by Steven C. Hayes and Spencer Smith. Reprinted with the authors’ permission.



**Figure 4.1: The crucial fork in the road.**

It's not your fault, but now that you know, it is your responsibility. Life can and will make you hurt. Some of that you don't get to choose: it comes regardless. An accident may confront you with physical pain; an illness may confront you with disability; a death may confront you with feelings of loss. But even then you have the ability to respond (the response-ability).

The consequences that come into your life derive from the actions you engage in, and most especially the actions we've been discussing throughout this book. No one but you can engage in acceptance or avoidance; fusion or defusion; or living in your head or living in the present. Most of all, no one but you can choose your values.

There is a crucial fork in the road. You must choose which path to take. The less traveled path to the left is the path of acceptance, mindfulness, defusion, and valuing what you really care about. Down that road is vulnerability and risk, but it is about something.

These two roads lead to very different places. It's not that one leads to problems and one doesn't. It is not that one leads to pain and one doesn't. They both lead to problems. And they both lead to pain. To the right the problems are old and familiar; to the left they are new and even more challenging. To the right the pain is deadening and suffocating; to the left the pain is bittersweet and intensely human. You've often taken the right-hand path. By now its results are extremely predictable. Predictability makes this choice curiously "safe" but doesn't remove its deadening qualities. Acceptance and commitment offers a path with unknown ends. Its newness makes it a more frightening path but it also makes it a more vital one. Life is a choice.

Life is a choice. The choice here is not about whether or not to have pain. It is whether or not to live a valued, meaningful life.

### **Termination**

---

This is a time for you and your therapist to discuss your time in treatment and to discuss ways in which you will live an intentional lifestyle after treatment. Be sure to refer back to this workbook frequently, and to repeat exercises if you begin to feel stuck. It is important that you incorporate mindfulness exercises into your daily or weekly routine and that you continue regular medical management with your gastroenterologist. Remember to also utilize the "Crohn's Disease Fact Sheet" (see Appendix A) and the "Patient Resources" page (see Appendix B), in the event that you want more information about CD or that you are interested in continuing treatment with an ACT therapist.

## Appendix A

### Crohn's Disease Fact Sheet<sup>73</sup>

Named after Dr. Burrill B. Crohn, who first described the disease in 1932 along with colleagues Dr. Leon Ginzburg and Dr. Gordon D. Oppenheimer, Crohn's disease belongs to a group of conditions known as Inflammatory Bowel Diseases (IBD). Crohn's disease is a chronic inflammatory condition of the gastrointestinal tract.

When reading about inflammatory bowel diseases, it is important to know that Crohn's disease is not the same thing as ulcerative colitis, another type of IBD. The symptoms of these two illnesses are quite similar, but the areas affected in the gastrointestinal tract (GI tract) are different.

Crohn's most commonly affects the end of the small bowel (the ileum) and the beginning of the colon, but it may affect any part of the gastrointestinal (GI) tract, from the mouth to the anus. Ulcerative colitis is limited to the colon, also called the large intestine.

Crohn's disease can also affect the entire thickness of the bowel wall, while ulcerative colitis only involves the innermost lining of the colon. Finally, in Crohn's disease, the inflammation of the intestine can "skip"—leaving normal areas in between patches of diseased intestine. In ulcerative colitis this does not occur.

### Recognizing the Signs and Symptoms

Crohn's disease can affect any part of the GI tract. While symptoms vary from patient to patient and some may be more common than others, the tell-tale symptoms of Crohn's disease include:

Symptoms related to inflammation of the GI tract:

- Persistent Diarrhea

---

<sup>73</sup> Adapted from: *What is Crohn's Disease*. Retrieved from the Crohn's and Colitis Foundation of America webpage: <http://www.ccfa.org/what-are-crohns-and-colitis/what-is-crohns-disease/>

- Rectal bleeding
- Urgent need to move bowels
- Abdominal cramps and pain
- Sensation of incomplete evacuation
- Constipation (can lead to bowel obstruction)

General symptoms that may also be associated with IBD:

- Fever
- Loss of appetite
- Weight Loss
- Fatigue
- Night sweats
- Loss of normal menstrual cycle

Even if you think you are showing signs of Crohn's Disease symptoms, only proper testing performed by your doctor can render a diagnosis.

People suffering from Crohn's often experience loss of appetite and may lose weight as a result. A feeling of low energy and fatigue is also common. Among younger children, Crohn's may delay growth and development.

Crohn's is a chronic disease, so this means patients will likely experience periods when the disease flares up and causes symptoms, followed by periods of remission when patients may not notice symptoms at all.

In more severe cases, Crohn's can lead to tears (fissures) in the lining of the anus, which may cause pain and bleeding, especially during bowel movements. Inflammation may also cause a fistula to develop. A fistula is a tunnel that leads from one loop of intestine to another, or that connects the intestine to the bladder, vagina, or skin. This is a serious condition that requires immediate medical attention.

The symptoms you experience may depend on which part of the GI tract is affected.

**What are the Causes of Crohn's Disease? Who is Affected?**

Crohn's disease may affect as many as 700,000 Americans. Men and Women are equally likely to be affected, and while the disease can occur at any age, Crohn's is more prevalent among adolescents and young adults between the ages of 15 and 35.

The causes of Crohn's Disease are not well understood. Diet and stress may aggravate Crohn's Disease, but they do not cause the disease on their own. Recent research suggests hereditary, genetics, and/or environmental factors contribute to the development of Crohn's Disease.

The GI tract normally contains harmless bacteria, many of which aid in digestion. The immune system usually attacks and kills foreign invaders, such as bacteria, viruses, fungi, and other microorganisms. Under normal circumstances, the harmless bacteria in the intestines are protected from such an attack. In people with IBD, these bacteria are mistaken for harmful invaders and the immune system mounts a response. Cells travel out of the blood to the intestines and produce inflammation (a normal immune system response). However, the inflammation does not subside, leading to chronic inflammation, ulceration, thickening of the intestinal wall, and eventually causing patient symptoms.

Crohn's tends to run in families, so if you or a close relative have the disease, your family members have a significantly increased chance of developing Crohn's. Studies have shown that 5% to 20% of affected individuals have a first – degree relative (parents, child, or sibling) with one of the diseases. The risk is greater with Crohn's disease than ulcerative colitis. The risk is also substantially higher when both parents have IBD. The disease is most common among people of eastern European backgrounds, including Jews of European descent. In recent years, an increasing number of cases have been reported among African American populations.

The environment in which you live also appears to play a role. Crohn's is more common in developed countries rather than undeveloped countries, in urban rather than rural areas, and in northern rather than southern climates.

## **Appendix B**

### **Patient Resources**

#### **Acceptance and Commitment Therapy Resources**

Hayes, S.C. and Smith, S. (2005). *Get out of your mind and into your life: The new Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications, Inc. [This self-help workbook delves further into the principles of ACT and includes several experiential exercises.]

To find an ACT therapist:

<http://contextualscience.org/civicism/profile?gid=17andreset=1andforce=1>

#### **Crohn's Disease Resources**

Crohn's and Colitis Foundation of America: [www.ccfa.org](http://www.ccfa.org)

"A Patient's Guide to Crohn's and Colitis"—Jill Sklar

"Crohn's Disease and Ulcerative Colitis"—Fred Saibil, MD