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ACCEPTANCE AND COMMITMENT THERAPY (ACT). BASIS, CHARACTERISTICS AND EVIDENCE

M. Carmen Luciano Soriano y Sonsoles Valdivia
Universidad de Almería

La Terapia de Aceptación y Compromiso (ACT) es la más completa de las incluidas en la Tercera Generación de Terapias de Conducta (Hayes, 2004). Se enmarca en una posición filosófica funcional, se asienta en una nueva Teoría del Lenguaje y la Cognición; ofrece una alternativa a la psicopatología tradicional: la dimensión funcional de la Evitación Experiencial; y promueve la investigación básica y los ensayos controlados. Este artículo se articula en varios apartados. El primero dirigido a los avances en la investigación y el curso de las terapias. El segundo contempla las características de la condición humana y lo que la cultura promueve. El tercero concierne a una breve descripción de la Teoría del Marco Relacional. Finalmente, se describen los métodos y componentes de ACT y la evidencia disponible.
Palabras clave: *Terapia Conducta, Terapia Aceptación y Compromiso, Teoría del Marco Relacional, Evitación Experiencial, Regulación Verbal, Derivación de Funciones.*

This paper describes Acceptance and Commitment Therapy (ACT) as the most complete of those included in the third wave of behavior therapies (Hayes, 2004). ACT has a functional philosophical position and it is based on a new theory of language and cognition (the relational frame theory -RFT). As well, it offers an alternative to mainstream psychopathology: the functional dimension of experiential avoidance; and it promotes basic research and controlled trials in many areas. This paper addresses first, the course of behavior therapy. Second, the characteristics of human condition and what culture is promoting. Third, a brief description of RFT is provided. Finally, the methods and components defining ACT are described, indicating the available empirical evidence in several respects.
Key words: *Behavior Therapy, Acceptance and Commitment Therapy, Relational Frame Theory, Experiential Avoidance, Verbal Regulation, Derived Relations.*

Among the range of therapeutic options for the treatment of psychological disorders, psychology distinguishes the therapies with some scientific value from others that, although popular, do not have these characteristics. Recently, Hayes (2004) differentiated three waves of therapies. The first wave refers to classic behavior therapy, based on direct behavioral change by means of contingency management, mainly using techniques from basic research of contingency management. Despite the enormous advance of the procedures and the successes achieved—still in effect—these procedures were not successful with adults' problems. The need to focus on the cognitive dimension was noted and the clinical approaches known as cognitive-behavioral therapies were formalized. These constitute the second wave of therapies, which in addition to focusing on behavioral change by means of behavioral management, they assign an essential role to cognitive events as the causal and mechanical axis of behavior, and use methods to modify the patient's cognitive events directly. These therapies have been successful but they have important limitations. The main problem is that the explanation and the way they change the problems are functionally equivalent to those established culturally, although they are presented with a special attire. However, to date, they have not provided any experimental basis about the formation, derivation, and change of private events, or of the conditions in which the relation between cognitive events and actions is established and changed, or the experimental basis of most of their clinical methods. Despite these black holes in the basic knowledge about psychological functioning, cognitive-behavioral therapy enjoys good health and is the most successful therapy in the area of psychological treatment of adults. The standard understanding of the functioning of the human being, extensively disseminated by the second-wave therapies—and shared by pharmacological therapies—implies that people's actions are literally controlled by their thoughts and emotions, so that in order to change inefficient functioning, we must somehow control whatever generates discomfort, as well as the discomfort itself.

Correspondence: Carmen Luciano Soriano. *Universidad Almería. Departamento Personalidad, Evaluación y Tratamiento Psicológicos. Cañada de San Urbano. 04120 Almería. España.*
E-mail: mluciano@ual.es

Therefore, the second-wave therapies are aimed at changing cognitive events as a means of changing the actions of the person who presents psychological disorders. Among the limitations of these therapies is the fact that their active principles are unknown, in other words, when significant changes are produced, we do not know what cause them nor why. The effectiveness of these therapies has been more closely related to their behavioral components than to their cognitive ones, which implies a contradiction with their assumption, and, at the same time, a lack of knowledge of the true role of direct intervention in cognitive events. Many questions about the conditions in which these therapies are effective and, in contrast, why they are not effective, remain unanswered.

The emergence of the therapies grouped into the third wave (Hayes, 2004) occurred for several reasons: (a) the lack of knowledge about why cognitive therapy is, or is not, successful; (b) the existence of radical functional conceptions of human behavior; and (c) the increasing amount of basic research on language and cognition from a functional perspective. This offered an opportunity to band together ways of performing therapy, many of them taken from "nonscientific" approaches, and to produce new methods.

The third wave of therapies represents a qualitative leap because the techniques used are aimed, not at avoiding/reducing symptoms, but at enhancing the responsibility for the personal choices and the acceptance of the private events that such choices would imply. Among these therapies are Linehan's (1993) dialectic therapy, Kohlenberg and Tsai's (1991) functional analytic psychotherapy, the integrative couple therapy of Jacobson, Christensen, Prince, Cordova, and Eldridge (2000), Segal, Williams, and Teasdale's (2002) mindfulness-based therapy, and Hayes, Stroshal, and Wilson's (1999) acceptance and commitment therapy (ACT). All these therapies involve—and this is the main difference—a change on a different level from the one proposed by the previous therapies. They do not focus on eliminating cognitive symptoms so as to change the patient's behavior, but instead they aim at changing the function of the symptoms by changing the context in which these cognitive symptoms are problematic.

In all, these therapies are linked to some others considered non-scientific, for example, existential and experiential-type therapies (see Pérez Álvarez, 2001). ACT is the most complete of these new contextual therapies and we will focus on it. It has the following characteristics: (1) it starts out from a global framework of the advantages and disadvantages of human condition; (2) it uses a contextual-functional philosophy; (3) it is coherent with a functional model of cognition and language (the relational frame theory); and (4) it presents a new perspective of psychopathology in which the functional concept of destructive experiential avoidance is central. From this viewpoint, it is understood that the connection between basic research, psychopathology, and clinical methods is crucial to advance in the prevention and modification of psychological disorders. In the following paragraphs, some of these characteristics are commented on.

THE HUMAN CONDITION AND WHAT CULTURE PROMOTES

ACT does not formulate a new philosophy of life. It gathers the philosophy of life that was pronounced by many studies of the human being long before we knew about the source of self-knowledge and its pros and cons. The experience of the suffering-pleasure dimension has been historically accepted as an intrinsic part of life from various religious traditions and by various anthropologists, doctors, philosophers, and literary authors (Hayes, Stroshal, & Wilson, 1999; Luciano, 2001; Wilson & Luciano, 2002). Experience shows that suffering and pleasure belong to the same dimension, that is, they are the two sides of the same coin. One cannot exist without the other, which means that it is unavoidable to be able to enjoy, for instance, remembering something pleasant, without, sooner or later, remembering situations that bring negative feelings to the present. The suffering-pleasure dimension, which supports positive and negative reinforcement, extends its possibilities when organisms become verbal. The experience we all share—in some way and to some extent—is that we look for pleasure, comfort, and we try to move away from pain and discomfort (in short, punishment and death). We all share the fact that our actions have a reason, a purpose, which can be very basic (pleasure or pain relief per se), or involve the transformation of the immediate consequences by something that symbolically impregnates every act we carry out. For example, actions involving honesty, respect for others, fidelity, knowledge, a feeling of transcendence and so on. This repertory comprises part of the self-knowledge that only a verbal organism can enjoy but which also causes the person more suffering than if s/he did not possess it. It is also important to assume that it is not possible to go back; that once we have learned

to behave verbally, we react with the derived/verbal functions that every moment demands according to the personal history, and we behave literally to such verbal functions, or not, depending on the regulation enhanced in our own history (however, it should be taken into account that this does not mean that we cannot change the way we behave in the presence of such verbal functions).

Taking into account these characteristics that define the human condition, the messages and ideas that are promoted in "advanced" communities as the "right" way of life may be counterproductive. The rules "innocently" offered "to have a good life" generally tell us to avoid or suppress, that is: "say no to anguish, to painful memories, to sadness, to low self-esteem, to pain, etc., because they are all obstacles for living." These formulas warn us to avoid as much as possible all this misery, remove it from our lives as soon as it appears, and look for immediate pleasure and quickly eliminate the slightest sign of discomfort. Following this logic, the media, and often, the professionals provide diverse solutions, such as all kinds of psychological therapies and pharmacological treatments which, in turn, may end up becoming a bad strategy to live in a balanced and satisfactory way. The pervasive logic of "all together against discomfort and pain," and functioning this way are difficult to change as long as certain powerful economic and social sectors, and "what people want immediately" match perfectly, like two pieces of a puzzle. The problem emerges when, over time, this logic do not match what people really value in their lives.

This kind of sayings coincides with the conceptions that are at the bottom of most psychological disorders and the second-wave therapies. In this sense (Luciano, 2001; Pérez-Alvárez, 2001; Szazs, 1960), the logic that underlies the psychological and psychiatric models of "illness and mental health," culturally established in developed societies, is radically against addressing and facing the fact of the human condition in all its extension. In fact, the maxims offered for living go against the human condition and, if the individual learns to behave according to them, then in order to live, he will not really live, but will be trapped in a "logical" functioning according to what is socially constructed ("suffering is bad, so I will act to eliminate my suffering…"), but, over time, far away from what is important for him, and, consequently, with "less life and more suffering."

Our knowledge about this paradoxical functioning is not new. However, it is along the varied paths of research in verbal behavior that the roots of the fact of being verbal are being clarified, and therefore, explanations are provided of what our elders knew very well, and which contemplate fruitful life philosophies. The whys of this functioning that traps the person are found in the characteristics shared by humans with a verbal/relational repertory and the rules of the culture in which such repertories are developed. Research in this area has led to the formulation of a functional theory of language and cognition that we shall comment on briefly.

THE RELATIONAL FRAME THEORY (RFT)

The philosophical framework underlying RFT is Functional Contextualism, which merges with Skinner's radical behaviorism and Kantor's interbehaviorism. Very briefly, (see Dougher & Hayes, 2000; Hayes & Wilson, 1995; Luciano & Hayes, 2001), the organism is conceptualized as a whole always in action, and where the functions that control behavior predominate. This is a monist, non-mentalist, functional, non-reductionist, and ideographic approach. It states that private events (in other words, the cognitive contents and schemas that have been developed) are conformed in the individual history, and that the relations between private events and the organism's actions (verbal regulation of behavior) respond to socially promoted arbitrary relations and not to mechanical relations. From this philosophy, the validity criterion of any theory is its effectiveness not only to predict but also to control or influence, providing the conditions that allow the prevention or modification of behavior.

The Relational Frame Theory is a continuation of the laws established through the functional analysis of behavior research, with a special emphasis on the research on relational learning which is generating a substantial development in cognitive domains. It is a theory aimed at the functional analysis of language and cognition, aspects that had hardly been analyzed previously at an experimental level within the functional-analytical perspective. In this sense, the RFT is not a break, but a continuation that extends and change the available knowledge about the emergence of new behaviors, since it proposes laws that establish the conditions for the formation and modification of functions by indirect procedures, in contrast to the well-known and established direct procedures of contingency management to establish and modify reinforcing, aversive, motivational, and discriminative of approaching or avoidance functions. RFT takes into account the effect of contingencies, but the

focus of analysis is language and cognition, conceived as relational learning. It maintains that relational learning is an operant that consists of learning, from very early ages and through multiple-exemplar training, to relate events conditionally until the abstraction of the contextual relational cue that is then applied to new events that are arbitrary and non-arbitrary related to those that led to the abstraction. This allows the person (1) to respond, on the basis of relational contextual cue, to one event in terms of another event with which it does not share common physical elements; and given the proper contextual cue, (2) to transform the functions of the event. For example, if, after the most basic relational repertory is established— the abstraction of the contextual frame "is" or "is like" or "is the same as"—we are told that MARIA tells stories the same as PEDRO, and we like very much the way PEDRO tells stories, in the absence of PEDRO, we might ask MARIA to tell us a story (in other words, we respond to Maria as we would respond to Pedro in the context of telling stories). If, in addition, we were told that PAULA is "better than" María or Pedro, and we had to choose one of the three to tell stories, we would probably choose Paula, although we had no experience with her. We say that, in the context of telling stories (called Cfun), María is in a relational context (which we call Crel) of coordination with Pedro, and that both of them are in a relational context of comparison (another Crel) with Paula. Consequently, the functions of each of them are different according to the corresponding Crel and to the experience with Pedro as a good story-teller. The relational frames we learn are numerous and allow many transformations of functions. The most basic relational frames are coordination (also named as equivalence) ("X is like Z in certain conditions"), comparison ("In some conditions, X is more than Z or Z is less than X"), opposition ("In certain conditions, X is the opposite of Z"), distinction ("X is different from Z"), spatial ("X is near to Z or far from Z"), temporal ("X is before or after Z or at the same time"), hierarchical ("X belongs to Z"), causal ("if X occurs, then Z occurs"), deictic, and perspective-taking (here-there, you-me, and here-me versus there-you; me-here-now and me-there-before, etc.).

Relational learning allows deriving new behavior and forming/altering functions. For example, if one learns that the product PU is like CO, and that RA is like CO, and that DI is like PU (three explicitly learned basic relations), then one derives that CO and PU are equivalent (CO-PU), as are CO-RA, and PU-DI (they are called mutual entailment relations), emerging combinatorial entailments: for example, PU-RA and DI-RA and DI-CO. If, in addition, an aversive effect occurs with the product PU (instead of curing an illness, it makes it worse), then none of the products coordinated to PU will seem useful to treat that illness. The aversive, and discriminative of avoidance, functions of those products, for that kind of circumstances, would have been generated by verbal or relational means insofar as they proceed from: the aversive function (Cfun) directly acquired by PU and the relational context that entails all the elements (in this case, a coordination type Crel). Responding to one stimulus in terms of another and the parallel transformation of functions is essential to understand the striking suffering of verbal beings. For example, once the comparison, temporal, and deictic frames have been learned, it is no longer possible to escape from the transformation of functions that occurs when comparing the events—and oneself—in the here, the now, and the symbolic future. Fear of the future, for example, is a product derived from one's personal relational history, and whose emergence in particular contexts is not under the individual's control. Albeit, it should be noted that what it is possible to do is to choose the personal reaction to a particular derived fear to the future.

These characteristics of relational learning have advantages and disadvantages. For example, they allow the derivation of positive memories but also of negative ones; they allow us to understand, reason, and derive formulas, make us successful to follow them in controlling the environment, but also to derive formulas that might regulate actions with dangerous and maladaptive effects. They also explain how moods —and motivations—are derived and how they change "for no apparent reason," they explain how we can think positively about someone or something, or change our appraisal of someone or something, without having had any experience that would justify it. Relational learning is the basis of publicity, politics, clinical methods, and many other human activities aimed at actualizing and changing psychological functions by verbal means. And it is essentially relevant because of its economy, because with few contingencies, new relations are produced and functions are formed and changed. And mainly because, without relational learning, verbal regulation of behavior (that is, formulating, understanding, and following rules) is not feasible.

RFT differentiates three functional types of behavior regulation: pliance, tracking, and augmenting. Pliance regula-

tion is rule-following behavior controlled by a reinforcement history in which the relevant consequences are mediated by others. A generalized repertory of pliance regulation is limiting as it generates extreme dependence on others and produces insensitivity to the direct consequences of actions. Tracking regulation is rule-following behavior controlled by a reinforcement history in which the consequences attached directly to the form of the actions predominate (i.e., brushing one's teeth under the control of the toothtaste or the effect produced by the toothbrush on the teeth). A tracking repertory that is generalized or applied in areas in which it cannot work is problematic (for example, doing something to achieve what the rules say: "I don't want to be sad" or "Don't think about being sad"). Augmenting behavior is rule-following under the control of transformed stimulus functions. For example, if the behavior of studying increases after placing studying in a temporal and causal frame with valued aspects ("a degree is—means—to be independent or to exercise a profession that is good for X" and "getting the degree implies studying today every subject"), this verbal regulation would be an augmenting behavior that occurs because studying has acquired reinforcing functions by verbal means. Augmenting regulation has many possibilities. Some that allow the person to adapt to life by acting on a moral valued and/or transcendence trayectory (behaving in a certain way despite of the pain, or because of moral principles that go beyond the contingencies that significant others can provide, etc.) Others can also be problematic, for example, if sadness is placed in a frame of temporal opposition to life ("sadness and negative thoughts are bad and I can't live with them"), and under some circumstances, discomfort and negative thoughts emerge, then the sadness and discomfort of the person's thoughts would become more intense. This intensification would be caused by situating discomfort/negative thoughts in a temporal opposition with valued actions (positive symbolic function), because the transformation of functions in a frame of opposition turns the positive into the negative and—as an additive effect—increases the negative value that sadness might already have. Consequently, in the absence of a deictic frame to contextualize all these elements, the person would undertake actions to avoid/escape from this mood. This is the regulation that defines the experiential avoidance pattern whose persistence can become destructive if it produces a limitation in one's personal life, even to the extreme of becoming total avoidance: suicide.

Summing up, the RFT research affects most human actions and necessarily concerns psychopathology and psychological therapies (see, especially, Hayes et al., 2001, and also Barnes-Holmes, Barnes-Holmes, McHugh, & Hayes, 2004; Hayes et al., 1999; Luciano, Rodríguez, & Gutiérrez, 2004; Wilson, Hayes, Gregg, & Zetle, 2001; Wilson & Luciano, 2002). We emphasize: (1) the establishment of many contextual frames or contextual relations among stimuli as generalized operants, and (2) their derived characteristics: mutual and combinatorial entailment, and transformation of functions—that is, formation and change by verbal means of aversive, reinforcing, and discriminative functions; (3) the functioning by addition of the relational network when it is confronted directly; (4) the rebound effects when direct changes are attempted to change the content of the network; (5) the conditions for the establishment of pliance, tracking, and augmenting regulations as well as the conditions for rule-following which potentiate (in)sensitivity to natural contingencies; (7) the analysis of multiple and combined contextualized relations among stimuli, and the corresponding derivation or transformation of functions. All this leads to a broad range of applications for the analysis of many complex phenomena. For example, understanding, analogical reasoning, problem-solving, self-efficacy, locus of control, abstract thought, social categorizing, self-concept, attitudes, stereotypes and stigma, establishing of emotive functions, mood, and thought, among others. To sum up, basic and applied research on the relational frame theory is very extensive and goes beyond its implications in the clinical field.

CULTURE, LANGUAGE, AND DESTRUCTIVE EXPERIENTIAL AVOIDANCE

As mentioned, as a product of the scientific research and technology, the economic-political powers offer a kind of life in which there is no room for discomfort and pain. The meaning of wellbeing is to enjoy right now, the more the better, without any difficulties or problems, and at the same time without generating —and this is the big problem—the conditions for behaving with responsibility for long-term goals with a sense of transcendency. Consequently, the most primitive domain predominates, and pain is demonized as being ABNORMAL—contrary, it is natural to life and part of the human condition as verbal organisms. We have mentioned that human beings cannot escape their verbal condition, and that means that, just as we can remember past reinforcing situations —or imagine future ones- in the same way we remember or

imagine situations that bring discomfort. Being verbal means establishing comparisons, seeing ourselves and other things as far or near, placing events in the before, the now, or the afterwards, offering explanations and regulating our life according to them. It means that we can see ourselves as a psychological entity but at the same time, we can take perspective of our cognitive events and, consequently, not to behave according to their literal content. It means being able to build valued directions in our life, etc. In short, self-knowledge is learning to be aware of all this, and of the resulting regulation that, according to the personal interactions, may not necessarily match the reinforcing consequences that might be appropriate for a person to have a satisfactory life. For example, we can learn to be trapped by the literality of verbal functions, and to get lost in them, and thus, not to be present and aware of such verbal functions nor of what the situation demands in the here and now, which is precisely what it would be needed for behaving in valued direction. Being frequently trapped by the verbal functions of events means acting in disperse, non-valued, directions, and this way of behaving is likely to generate psychological disorders.

Consequently, the true nature of the human condition is verbal, doubtless, within the framework of the culture in which the person develops and is educated. Thus, when "ALWAYS FEELING GOOD" is the primary goal (as the key element to be able to live), following such a rule will become problematic to the extent that the verbal traps are inevitably present due to derivation (that is, given the proper relational and functional contexts, according to the person's history, thoughts, memories, and feelings with aversive or positive functions will be derived). The persistent search for positive private events, and control of the negative ones, as a primary goal in life, is a fundamental trap because of the unavoidable derivation of thoughts; however, behaving to control what cannot be controlled *is* avoidable. Apparently, when the long-term consequences of this strategy are an increase and extension of discomfort, and a reduction of the capacity to fully live, then the person is in a paradoxical spiral. This plan of functioning is known as destructive experiential avoidance.

The Experiential Avoidance Disorder (EAD; Hayes, Wilson, Gifford, Follete, & Strosahl, 1996; Luciano & Hayes, 2001) is an inflexible pattern that consists of persistently acting to control and/or avoid the presence of certain thoughts, memories, feelings and other private events in order to be able to live. This inflexible pattern is made up of numerous responses with the same function: to control discomfort and the private events, as well as the circumstances that generate them. The permanent need to avoid discomfort and to attain immediate pleasure in order to live forces the person to behave following a plan that, paradoxically, places the person away from what he really values. The problem is that such behavior provides immediate relative relief at times, but it has a boomerang effect (that is, the discomfort returns, sometimes more intensely and more extensively, and relief is short-lived). This "makes" the person carry on ceaselessly in the attempt to make discomfort go away, which, in turn, makes it more and more present because of the boomerang effect. In the end, the days become nothing more than doing things to make discomfort disappear, and the result is that the person abandons all actions in valued directions.

Inflexible experiential avoidance is a central component in many disorders that are differentiated in current classification systems. EAD has been detected in affective disorders, anxiety, addictions, anorexia and bulimia, in disorders of control of impulses, in psychotic symptoms, in posttraumatic stress, and when dealing with illnesses, and in processes in which pain plays an essential role (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004; Hayes et al., 1996, Luciano & Hayes, 2001). Experiential avoidance is conceived as a functional dimension that is the base of many disorders. It is a radically different way of presenting and understanding psychological or mental disorders; of understanding psychopathology from a genuinely psychological perspective, very remote from reductionist approaches, in particular, the biological ones.

From RFT, there are several verbal contexts that define EAD: the contexts of Literality, Evaluation, Reasons Giving or Explaining, and Control (Hayes et al., 1996; Luciano, Rodríguez, & Gutiérrez, 2004). The context of literality is an unavoidable product of verbal behavior and involves responding to one event in terms of another because of the properties of the relational repertory (mutual and combinatorial entailments and the transformation of functions). The verbal context of evaluation is the tendency to judge almost everything, and because of literality, not to distinguish the intrinsic properties of an event ("I'm sad") from its socially established and arbitrary evaluation ("being sad is bad"). This involves the difficulty of differentiating the dimensions of the self, socially constructed during the person's development, so that, without differentiating the self as a context for all thoughts in any particular moment, one only behaves fused to the verbal properties of the

thoughts. The context of reason-giving is promoted by the cultural viewpoint that behavior is explained by emotions and thoughts (for example, "these thoughts are terrible and I cannot live with them: I cannot work, I cannot be with my children….I must get rid of them, etc."). Finally, the context of control of causes is the key context that gives meaning to the other ones as it means behaving according to these paradoxical reasons. For example, fusing to troublesome thoughts, given as causes for behaving: "if I could get rid of them, I'd be alright; I'd be another person and could do many things." Thus, only if these "causes" disappear will the person be in a position to "give himself permission" to act in the direction of values-based living. This last context is the one that closes the contingency circle by providing the powerful reinforcement of being right (by following the rules to be able to live) which is accompanied by immediate, but short-lived, relief. And all this happens despite the long-term cost of such strategies (more discomfort and fewer actions to achieve positive reinforcement). Generalized experiential avoidance is an inflexible and limiting strategy for living that adopts many forms. For example, null or low basic regulation to control impulsiveness and/or frustration tolerance, is behavior regulated just for the verbal properties of discomfort, which prevents sensitivity to the effective contingencies of the behavior. One example is when the predominant behavior, in a particular domain, is only regulated by the transformation of functions provided for comparison, temporal, causal frames (i.e., "if it were me, they would criticize me", "I will do it poorly", "I am a different person, I make mistakes", "if I do this, it will get worse, it won't come out right", "if I wouldn't have done it, this would not have happened", etc.). This means that the person is literally guided by such derived functions and, hence, his behavior is regulated without having applied the deictic frames (which would lead to the discrimination of the private verbal events and the person who is noticing them. Consequently, becoming aware of these private events as not intrinsically barriers). Regulation of behavior in which the transformed functions of private events predominate without application of deictic frames, will prevent sensitivity to what is really important, because it does not allow the person to discriminate his private events from himself with valued directions (Luciano & Törneke, 2006).

The destructive regulation, functionally defined as problematic experiential avoidance, is treated in second-wave therapies—including pharmacological ones—following the same logic already involved in such a behavior regulation: trying to directly reduce the discomfort and any other private events (for example, substituting the irrational thoughts for rational ones, reducing/avoiding fears, sadness, discouragement, memories and feelings of discomfort, unfriendly voices, increasing self-esteem, etc.). The solutions disseminated for these ends coincide in assigning the value of "mechanical" cause to the cognitive content and schemas; so that the predominant focus of action is aimed at directly changing such cognitive content. The therapeutic approach of EAD, focused on the analysis of the verbal contexts that support destructive experiential avoidance, is radically different.

ACT, AN ALTERNATIVE TO CHANGE EAD. BASIS AND EVIDENCE

ACT (Hayes et al., 1999; Wilson & Luciano, 2002; Hayes & Stroshal, 2004) is a radical change of direction in the focus of therapy: on the one hand, it does not attempt to change or reduce troublesome thoughts/feelings/memories but instead to change their function and generate flexibility in the regulation of behavior. On the other hand, the clinical methods appeal to contextual changes in order to change the function of private events without changing the specific content of such private events. ACT attempts to generate the conditions for the patient to become aware of the paradox of his behavior (for which it is necessary to contextualize his strategy to control private events in the areas that are valued as important by the patient), and attempts to promote clinical interactions that allow the patient to become fully and openly aware of the flow of private events –all of them emerging when behaving in valued directions- so that he can use them, or not use them, to act in valued directions. The clinical methods—although some were taken from other therapies—are understood in terms of relational learning. The paradoxes, metaphors, and exercises of full/conscious exposure to private events in the here/now of oneself, are essential in ACT. The KEY is the direction of all these clinical interactions which is to accept the private events when this acceptance is at the service of a chosen action impregnated with personal values.

BASIC EVIDENCE OF ACT

ACT (Hayes et al., 1999) is not a mere therapy but instead a therapy with a specific theory (the Relational Frame Theory) that merges in the philosophy and the knowledge provided by the experimental and applied analysis of behavior. It is supported as well by the data

provided by other areas of psychology about coping strategies with paradoxical effects (for a summary, see Hayes et al., 1996). In addition to the comments about RFT in the introduction, we add here the summary of the basic contributions that support ACT: (1) there is evidence about the emergence of thoughts, emotions, memories through derived means; (2) there is evidence that relational behavior correlates with intelligence; (3) there is evidence of the types of verbal regulation which become life-limiting (4) there is evidence of the correlation between fused activity—or literal performance of experiential avoidance—and many problems; (5) there is evidence on the working by addition of the verbal relations, so that attempts to change or suppress its contents have boomerang effects; (6) contrary, there is evidence of the impact of the transformation of functions of cognitive contents with methods of contextual change, so that, although the relational networks remain intact, they no longer have the previous functions, nor, at long-term, are they experienced as before; (7) there is evidence of the benefits of multiple practice in accepting private experience versus controlling it, especially when discomfort is high but is contextualized in valued directions; (8) evidence of the types of transformation of functions in the clinical methods is beginning, for example, (a) in the practice of exposure to private events from the self as context; (b) in the use of metaphors; and, (c) in the methods to clarify values (Barnes-Holmes, Barnes-Holmes et al., 2004; Barnes-Holmes, Cochrane, et al., 2004; Dahl, Wilson, Luciano, & Hayes, 2005; Gutiérrez, Luciano, Rodríguez, & Fink, 2004; Hayes & Stroshal, 2004; Luciano, Rodríguez, & Gutiérrez, 2004; O'Hora & Barnes-Holmes, 2004; Wegner & Zanakos, 1994).

BRIEF DESCRIPTION OF THE ACCEPTANCE AND COMMITMENT THERAPY

ACT attempts to generate an extensive and flexible repertory of actions aimed at advancing towards goals or objectives in personally valued directions, and not by the presence or absence of certain cognitive and emotional states judged to be negative (pain, anxiety, sadness, fear, etc.). Thus, for example, it maintains that "fear of death," "fear of relapse," or "guilt" are not in themselves incapacitating symptoms, but instead, what ends up limiting life is the action fused to the literality of such thoughts. In these cases, the person is not aware of the thoughts and feelings as an ongoing evaluative and reasoning process; that is, he does not realize that they are only thoughts and feelings, and that behind them all is a person, or that part of the psychological dimension of the self that contains them; that this context of oneself provides the perspective to notice any cognitive content, as an ongoing process, to be aware of what is ultimately important to him. In other words, "behind" any discomfort and thoughts is the context that provides the perspective to be aware of the part of us that is ultimately "like the boss" of all those cognitive products that so easily trap us because of the literality of verbal functions." To be fused with cognitive contents is equivalent to act without the perspective that allows the person to be aware of all of them. It prevent the person from being able to choose whether or not he will behave according to such contents, depending on the direction this takes him (valued or not). Without that perspective—provided by the deictic frames—the person cannot distinguish himself from the content and process of thinking and feeling, and in fact, he is fused with his thoughts by responding to them as what they said literally they are and not what they really are: verbal functions.

Summing up, ACT: (a) is a treatment oriented to the person's valued actions; (b) it considers discomfort/suffering as a natural process in the human condition as verbal organisms; (c) it states that one learns to resist natural suffering and that this resistance is what generates the pathological suffering; (d) it promotes the functional analysis of the patient's behavior and, consequently, it is based on the patient's experience to control his private events as the key to treatment. The message is "what does your experience tell you when you do that? What do you get that is truly important? What would you be doing every day if you could devote yourself to doing something else other than removing suffering?"; (e) its goal is to generate flexibility in the reaction to discomfort given that the patient's experience tells him that resisting his private events as a rigid pattern is limiting his life, that focusing on them is to be lost in his way. The main goal of ACT is to disrupt the rigidity of the pattern of destructive avoidance, that is, the excessive or maladaptive regulation of verbal processes that culture amplifies by spreading rules of feeling good immediately and avoiding pain as the essential goals in life; (f) it involves clarifying values to act in chosen valued direction, accepting with full awareness the private events that emerge when acting in such a direction, and promoting this practice as soon and as often as possible; and (g) it means learning to "fall down and get up again, " that is, to choose over and over again to act in valued directions

in the presence of whatever private events that emerge because of the fall.

ACT clinical methods partially come from other therapies (see Hayes et al., 2004; Paéz, Gutiérrez, Valdivia, & Luciano, 2006; Pérez Alvárez, 2001) and, partially, from research, but always focused in the adjustment to the patient's needs with a clear goal in mind. This means that the key does not lie in the techniques/methods in themselves, but instead in this clearly specified goal: to generate flexibility of reactions where there previously was problematic rigidity. That is, to allow thoughts, emotions, etc., to show up, choosing their acceptance—instead of their control—within the frame of the patient's personal chosen commitment with his values. ACT clinical methods use verbal modalities that are inherently not literal: the metaphors should be analogies of the problem—whatever are appropriate as long as they get in touch functionally with the avoidance pattern; the paradoxes reveal the verbal traps, and the experiential exercises consist of practicing exposure to private events—the more specific the better—that generate discomfort in situ, just as they show up at any moment, from the perspective of the self as their context and, necessarily, in the here and now. For example, the metaphor of "a man in a hole with a shovel" not only shows that by digging, he can't get out of the hole, but also that by digging, holes become bigger. This is equivalent to the patient's regulation pattern when, for example, he tries to get rid of the feelings of guilt in order to live, and he searches for responses that suppress such thoughts, which may seem right until the person finally has the experience that such feelings have extended (the hole has gotten bigger), and there has been a decrease in the actions that could have procured some positive reinforcement, due that all he has done is digging. This kind of discourse style might prevent language traps and, instead, favor a verbal context that questions the value of rationality in some areas, validating instead the "truth" of the client's experience and explicitly eliminating any attempt to place the truth in the therapist's logic or values. Therefore, the therapist will not make any demands about what to do, nor will she discuss what may be better or worse, nor what is rational or irrational about the thoughts and feelings showing up. Instead, the patient's experience (the benefits obtained following the avoidance strategy) is the basis for the questions, the metaphors, and the exercises. Such exercises are utilized to clarify values and to generate many opportunities for the patient to notice, from the I-as-context, any thoughts, memories, discomfort showing up in the present moment while being present of what the situation demands according to his values.

The components of ACT have been presented with some variations in successive versions (Hayes et al., 1999; Wilson & Luciano, 2002), with the most recent one of Hayes and Strosahl (2004) as the practical guide to apply it to various problems; and the specific to chronic pain (Dahl et al., 2005). In the latest contributions, the functional analysis of the patient's problem and the goals in ACT mention six central aspects that define psychological inflexibility and its alteration (or the interruption of the behavioral rigidity in the experiential avoidance disorder). These six aspects are described like six vertices of a hexagon, all interconnected. On one side, the levels both of acceptance of private events and of cognitive defusion. On the other side, the level of clarification of personal values and the level of valued actions; in the upper vertex, the level of contact in the present moment ("being present here and now") while doing what is important, and in the lower vertex, the dimension of the self as the context for all cognitive contents. Functional analysis will reveal the characteristics of the inflexible pattern of experiential avoidance, and the clinical actions will be aimed at strengthening the weaker aspects to facilitate flexibility with private events while one steers one's life towards what is truly important. Concretely, the actions in the clinical setting will be directed at (1) clarifying values and commitment with action on the chosen path, which means acceptance or commitment to notice without resistance the private events that show up along that path and, necessarily, (2) practicing defusion, or discriminating or becoming aware of the thoughts, feelings, and memories showing up in the here and now, from the self as a context when acting responsibly in the chosen direction. Needless to say that the ACT therapist must adapt the various components of the therapy to the kinds of inefficient regulation that are observed in the functional analysis and, obviously, she must adapt the metaphors and the content to be noticed in the exposure exercises to each patient.

Taking into account the direction towards which all ACT actions lead, the modus operandi does not follow a strict order or formal protocol for each session. The clinical style is flexible and any activity is valid as long as it promotes flexibility in the patient's reaction to private events (partially merging functional analytical psychotherapy and ACT along the lines indicated in Luciano [1999] and

in Wilson and Luciano [2002]). ACT is developed in different phases with actions aimed at establishing and maintaining a context for the therapeutic relation. In this sense, the ACT therapist will tell the patient in words and actions that, he, the patient, and his experience when he tries to resolve his life are what matters in the session. The therapist will try to minimize the function of someone who tells the patient what kind of life to live, or what he should feel or think; she will create the conditions so that the patient will experience the result of his strategy, disabling—because of the results it produces—-the rationale that systematically "justifies" inefficient strategies. She will empower the patient's capacity to choose the valued direction and to be in touch with discomfort; she will show the patient when psychological discomfort is a sign linked to his values. The ACT therapist will introduce—and ask the client—metaphors or examples, she will reveal paradoxes and will promote as many exercises as necessary to normalize the discomfort that shows up in session, accepting difficult or contradictory thoughts, feelings, and memories, etc., without making any move to free the patient to contact such private experiences when they were in the valued direction for the client. That is, whenever possible, encouraging opportunities in session to promote the discrimination of the self-context when cognitive contents show up in order to create the necessary psychological space to let the patient chooses the valued action even in the presence of the emotions, thoughts, or memories that previously controlled his action in a literal way.

The purpose of the first part is having the patient connect with the functions of the problem, that is, to generate the conditions for the client to experience the creative hopelessness (an experience that will be repeated throughout the therapy). With the clinical actions included in this part, the patient will experience what he wants, what he does to achieve it, and the short- and long-term results. This is a somehow bitter experience because it makes the patient comes into contact with the paradox of trying to control his life by suppressing, changing or avoiding his private events, while he verifies that such a strategy does not really work (it produces some immediate benefit but ultimately, it produces dissatisfaction because of the personal cost in what it is important for the client). More over, it will be clear that this strategy cannot work unless the patient is willing to pay a high cost in personal areas. From this point, the clinical actions are directed to having the patient realizes that his strategy of controlling private events, as a goal to life, is itself the problem and not the solution, and that the private events by themselves are not the problem, thus the acceptance of such events might be an alternative. The patient learns by metaphors, paradoxes, and experiential exercises that "if you don't want certain thoughts or feelings, you get them and, in addition, they spread into more personal areas." The patient will be then in a position to learn the ability of being completely willing to have an unwanted or difficult private content.

The actions aimed at clarifying valued directions are the base of ACT (for a review, see Páez et al., 2006) and they are, some way or another, present from the start of therapy because without a valued context, there would be no suffering, nor any problem to solve, nor would the experience of creative hopelessness be possible. The formal clarification of the valued directions involves the introduction of various metaphors and exercises (i.e., the garden, the exercises of the funeral, the epitaph) that let the patient discern what he wants his life stand for and the whys of his choices in terms of values as guides to his life; differentiating the valued directions from goals, and the actions taken to pursue such goals in such directions, as well as the private events that are interposed. This clarification revolves around the detection of the areas that are important for the client (i.e., family, work, social area, and others). It is relevant to mention that formal areas are not values. Values are defined as socially and verbally constructed reinforcers in one's personal life, which lead one in certain direction and thus conform and perpetuate the already mentioned types of verbal regulation. The process of values clarification is central and continuous while doing ACT, however, it will be more exhaustive in some cases than in others. The ultimate goal is having the patient take responsibility of his actions, teaching him to discriminate his actions as chosen acts in a particular direction at each moment in life, while being willing to have the private events that the choices involve.

Finally, acceptance and, consequently, actions in the valued direction—giving himself permission to have private events—is not possible without some level (necessarily practical) of perspective-taking of the private events, which means practicing their observation in situ as they show up. The patient will learn exercises to de-literalize private contents and will learn to take perspective of them, differentiating the act of having a thought from the thought, and the person (himself) who is aware of this process. On the one hand, the aim of de-literalizing is to minimize the role of

words by breaking the link between words and function, and noticing them for what they are. Thus, their functional power becomes reduced. This process involves altering the contexts of literality, evaluation, and the great power of reasons that justify actions, so that the client will learn to realize whether he just is behaving fused, trapped by a thought, by a memory; other way saying, whether "he is buying these cognitions" when he behaves according to their literality. The components aimed at differentiating the dimensions of self involve taking perspective of one's private events from the only safe, unique, untransferible and permanent context (the part of oneself that is experience as I, as the context for all the private contents and for the process of having them). This experience of psychological distancing is only feasible from one's full awareness, as a verbal being, of what emerges at each moment, in the here-and-now. In addition to using metaphors to realize this process, the patient needs to practice many times with different exercises, all of them focused in helping the client to become aware of the process, for example, of having the thought of being guilty and its negative evaluation, or having the thought "I will do it wrong" and being very much afraid, or noticing palpitations, or noticing anger when thinking about X. It is the experience of becoming aware of the process of having thoughts and realizing that one is much more than such thoughts, one is big enough to have all the cognitive contents. The metaphors and exercises for de-literalizing and for taking perspective involve the transformation the functions of private events via different relational contexts, essentially, the deictic ones. Placing private events in the context of deictic frames allows one to observe any private content from the self-context, allows to be present with any content, allows to detect oneself "being trapped by thoughts or sensations," allows the practice of noticing whatever private events, and allows being back to the demands of valued directions at each moment, and doing that as many times as one may detect "to have bought again the thoughts". To sum up, the patient will learn to be able to have private events while noticing what he wants and, consequently, being able to choose to respond to such private events, not by their literal function, but by having them fully aware while acting in the valued direction.

To conclude, we would like to point out that working with ACT requires using all the components more or less extensively. Although in some cases, only a minimum of values clarification and a very small dose of practice in acceptance with defusion exercises (de-literalizing and mainly taking perspective of uncomfortable private events) appears enough to produce relevant changes that are usually maintained; usually, the clinical action requires the systematic practice on all fronts. Clarifying values without some de-fusion abilities, or defusion practice without having clarified somehow the valued directions (in the context of which giving oneself permission for such defusion practice makes sense), are probably errors. We want to emphasize the importance of learning repeatedly, over and over, the ability of acceptance, that is, of being open to having private events by noticing them from the perspective of the self-context, while acting in the valued direction (Hayes et al., 2004, Luciano, 2001; Wilson & Luciano, 2002).

Clinical Evidence. ACT has been proved to be effective in numerous case studies as well as in outcome randomized clinical trials (comparing ACT with empirically validated cognitive treatments, with placebo conditions and waiting lists; see reviews in Hayes, 2004, and Hayes et al., 2004, Hayes & Strosahl, 2004)[1]. ACT has been shown to be superior (especially in chronic cases) and equally effective at the end of treatment, but follow-up data with ACT are substantially better (for example in depression, stress in the work-site, psychotic symptomatology, obsessive-compulsive patterns, anxiety and social phobia, drug and tobacco consumption, multiple esclerosis, psycho-oncology, tricotilomania, fears and worries, diabetes control, epileptic episodes, chronic pain, self-injury actions, parenting of children with generalized developmental disorders). Brief individual and group ACT protocols, implemented by different persons and in different countries, have been proved to be useful to prevent chronicity by changing the early course of varied sequelae and symptoms. The research on the measure of experiential avoidance (the AAQ of Hayes et al.,1999), cognitive fusion (Baer, 2005), and values (Blackledge & Ciarrochi, 2006; Wilson & Groom, 2002) requires more studies, being a good signal the rapid development of the IRAP (Implicit Relational Assessment Procedure)—a procedure based on RFT that adds new possibilities to measure implicit relations (Barnes-Holmes, Barnes-Holmes, Power, Hayden, Milne, & Stewart, 2006).

The analysis of the components and, mainly, of the verbal processes of change involved in the various clinical

[1] A list of specific references is omitted but can be requested from the first author.

methods began years ago but still is not sufficient (Barnes-Holmes et al., 2004; Luciano, Rodríguez, & Gutiérrez, 2004). Despite these limitations, an effect is replicated systematically, both in basic research (Hayes et al., 1999; Gutiérrez, Luciano, Rodríguez, & Fink, 2004) and in randomized controlled studies (for a review, see Hayes et al., 2004): it is the consistency in disconnecting private events and valued actions, which involves a functional change of the former without reducing necessarily their frequency or their emotional impact, at least in the short-term.

To finish, the balance is optimistic but should be considered with the caution and parsimony of any scientific project that proposes a therapy linked to a theory of language and cognition; a connection that can be considered the missing link between the laboratory studies of experimental analysis of behavior, from the 60s to the 80s, and the functional analysis of cognition, with its clinical, social, and educational implications. This project represents a radical behavioral view of private events highly enriched by research in relational learning. This is an ambitious basic-applied research project that will improve therapy and will allow us to achieve a more precise knowledge of the human condition rending in better prevention and treatment protocols.

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REFERENCES

Baer, R.A. (2005). *Kentucky Inventory of Mindfulness Skills* (*KIMS*).[2]

Barnes-Holmes, Y., Barnes-Holmes, D., McHugh, L., & Hayes, S.C. (2004). Relational frame theory: Some implications for understanding and treating human psychopathology. *International Journal of Psychology and Psychological Therapy, 4*, 355-375.

Barnes-Holmes, D., Barnes-Holmes, Y., Power, P., Hayden, E., Milne, R. & Stewart, I. (2006). Do you really know what you believe? Developing the implicit relational assessment procedure (IRAP) as a direct measure of implicit belief. *Irish Psychologist, 32*, 169-177.

Barnes-Holmes, D., Cochrane, A., Barnes-Holmes, Y., Stewart, I., & McHugh, L. (2004). Psychological acceptance: Experimental analysis and theoretical interpretations. *International Journal of Psychology and Psychological Therapy, 4*, 517-531

Blacklegde, J.T., & Ciarrochi, J. (2006). Personal values questionnaire[3].

Dahl, J.A., Wilson, K.G., Luciano, M.C., & Hayes S.C. (2005). *Acceptance and commitment therapy for chronic pain.* Reno, NV: Context Press.

Dougher, M.J. & Hayes, S.C. (2000). Clinical behavior analysis. In M.J. Dougher (Ed.), *Clinical behavior analysis* (pp. 11-26). Reno, NV. Context Press.

Gutiérrez, O., Luciano, M.C., Rodríguez, M., & Fink, B. (2004). Comparison between an acceptance-based and a cognitive-control-based protocol for coping with pain. *Behavior Therapy, 35*, 767-783.

Hayes, S.C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35,* 639-665.

Hayes, S.C., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition.* New York: Kluwer Academic/Plenum.

Hayes, S.C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, L.F. (2004). BDT, FAP, and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy, 35,* 35-54.

Hayes, S.C., & Strosahl, K.D. (2004). *A practical guide to acceptance and commitment therapy*. New York: Springer-Verlag.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and commitment therapy*. New York: Guilford Press.

Hayes, S.C., & Wilson, K.G. (1995). The role of cognition in complex human behavior: A contextualistic perspective. *Journal of Behavior Therapy and Experimental Psychiatry, 26,* 241-248.

Hayes, S.C., Wilson, K.G., Gifford, E.V., Follette, V.M., & Strosahl, K. (1996). Experiential avoidance and behavior disorder: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152-1168.

Jacobson, N.S., Christensen, A., Prince, S.E., Cordova, I., & Eldridge, K. (2000). Integrative behavioural cou-

[2] Available in the Department of Psychology (R. A. Baer), University of Kentucky, U.S.A.

[3] Available in the Department of Psychology (J. T. Blackledge), University of Wollongong, New South Wales, Australia.

ple therapy: An acceptance-based, promising new treatment for couple discord. *Journal of Consulting and Clinical Psychology, 68*, 351-355.

Kohlenberg, R.J., & Tsai, M. (1991). *Functional analytic psychotherapy*. New York: Plenum Press.

Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Luciano, M.C. (1999). La psicoterapia analítico funcional (FAP) y la terapia de aceptación y compromiso (ACT) [Analytic functional psychotherapy (AFP) and acceptance and commitment therapy (ACT)]. *Análisis y Modificación de Conducta, 25*, 497-584.

Luciano, M. C. (2001). Sobre el trastorno de evitación experiencial (TEE) y la terapia de aceptación y compromiso (ACT) [About the experiential avoidance disorder (EED) and the acceptance and commitment therapy (ACT)]. In C. Luciano (Ed.), *Terapia de aceptación y compromiso (ACT) Libro de casos* (pp. 3-18) [Acceptance and commitment therapy (ACT). Case book].Valencia: Promolibro.

Luciano, M.C., & Hayes, S. C. (2001). Trastorno de evitación experiencial [Experiential avoidance disorder]. *Revista Internacional de Psicología Clínica y de la Salud, 1,* 109-157.

Luciano, M.C., Rodríguez, M., & Gutiérrez, O. (2004). A proposal for synthesizing verbal contexts in experiential avoidance disorder and acceptance and commitment therapy. *International Journal of Psychology and Psychological Therapy, 4*, 377-394.

Luciano, M.C., & Törneke, N. (2006). Experimental basis of ACT clinical methods from an RFT perspective. *Workshop II International Institute of RFT-ACT*. London.

O'Hora, D., & Barnes-Holmes, D. (2004). Instructional control: Developing a relational frame analysis. *International Journal of Psychology and Psychological Therapy, 4*, 2, 263-284.

Páez, M., Gutiérrez, O., Valdivia, S., & Luciano, M. C. (2006). La importancia de los valores en el contexto de la terapia psicológica [The importance of values in the context of psychological therapy]. *International Journal of Psychology and Psychological Therapy, 6*, 1-20.

Pérez-Alvárez, M. (2001). Afinidades de las nuevas terapias [Affinities of the new therapies]. *International Journal of Health and Clinical Psychology, 1,* 15-23.

Szazs, T. (1960). The myth of mental illness. *American Psychologist, 15*, 113-118.

Seagal, Z. V., Williams, J. M., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression. A new approach to preventing relapse.* New York: Guilford Press.

Wegner, D.M., & Zanakos, S.I. (1994). Chronic thought suppression. *Journal of Personality, 62,* 615-640.

Wilson, K.G., & Groom, J. (2002)[4]. *The valued living questionnaire*.

Wilson, K. G., Hayes, S. C., Gregg, J., & Zettle, R. (2001). Psychopathology and psychotherapy. In S.C. Hayes, D., Barnes-Holmes, & B. Roche (Eds.), *Relational frame theory* (pp. 211-238). New York: Kluwer Academia.

Wilson, K.G., & Luciano, M. C. (2002). *Terapia de aceptación y compromiso. Un tratamiento conductual orientado a los valores* [Acceptance and commitment therapy. A behavioral treatment oriented towards values]. Madrid: Pirámide.

[4] Available in the Department of Psychology (K. G. Wilson), University of Mississippi, Mississippi, U.S.A.