PROFESSIONAL DOCTORATES

The application of acceptance and commitment therapy to the treatment of adolescents with disruptive behaviours.

Myles, Stephen

Award date:
2002

Awarding institution:
Bangor University

THE APPLICATION OF ACCEPTANCE AND COMMITMENT THERAPY TO THE TREATMENT OF ADOLESCENTS WITH DISRUPTIVE BEHAVIOURS

STEPHEN M. MYLES (MA, PH.D.)

THESIS SUBMITTED FOR THE DEGREE OF D.CLIN.PSY.

2002

THE APPLICATION OF ACCEPTANCE AND COMMITMENT THERAPY TO THE TREATMENT OF ADOLESCENTS WITH DISRUPTIVE BEHAVIOURS

Abstract. Acceptance and Commitment Therapy (ACT) is one of a 'new-wave' of acceptance-focused behaviour therapies. Proponents of ACT argue that it is worthy of the attention of those interested in behaviour change through psychotherapy, for four reasons. The literature review discusses these reasons. First, ACT is based on the philosophy of functional contextualism, which, it is argued, is consistent with the natural analytic agenda of clinicians. Second, ACT offers a broadly applicable theory of psychopathology. The theory holds that much psychopathology results from *experiential avoidance*- efforts by a person to avoid, change, and/or otherwise control difficult private experiences (e.g., emotions, thoughts, memories, bodily sensations). ACT is a treatment for experiential avoidance, in which clients are guided toward willing acceptance of private experiences, in the pursuit of their values. Third, four empirical studies provide evidence for the usefulness of ACT as a treatment approach. This evidence is critically evaluated. Fourth, ACT has been used to treat many different topographically defined psychological problems and may be applicable to others. ACT is a promising treatment approach that requires further empirical investigation.

The research study describes the application of ACT to the treatment of experiential avoidance in two adolescents with disruptive behaviour problems (DBPs). There are a number of reasons to believe that experiential avoidance may be an important functional factor in this population. It was hypothesised that treatment would result in clinically significant decreases in participants' (a) self-reported experiential avoidance, and (b) parent-reported frequencies of DBPs. Single-case experimental methodology was

CONTENTS

ACKNOWLEDGEMENTS

I would like to thank the following people-

'Diane', 'Jack', and their parent(s), for participating in the research study

Judy Hutchings and Ed Blewitt, for providing supervision in designing and carrying out the research study

Robert Jones, for reviewing drafts of the thesis papers

The team members of the North-West Wales NHS Child and Adolescent Mental Health Service, at Talarfon, in Bangor, for accommodating the research study

Steve Hayes, Kathleen Palm, and Julieanne Pankey, for providing advice on practising Acceptance and Commitment Therapy (ACT)

Dermot-Barnes Holmes and Yvonne Barnes-Holmes, for providing advice on practising ACT and guidance in understanding Relational Frame Theory (RFT)

Mike Smith, for providing the opportunity for me to develop my understanding of ACT and RFT through extensive discussion

ETHICS PROPOSAL FOR THE RESEARCH STUDY

Awdurdod Iechyd Gogledd Cymru
North Wales Health Authority
Research Ethics Committee
(West, Central & East sub-committees)

Important guidance notes accompany this form. Applicants MUST refer to the corresponding note before answering each question. Incomplete forms cannot be accepted.

1. Title of project : An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder.

2. Principal investigator :

name : Dr. Stephen M. Myles, MA, Ph.D.

address : Department of Clinical Psychology, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 4UN.

job title: Clinical Psychologist in Training.

telephone number: (Home) 01248-354393

3. Other investigators :

Research Supervisor- Mr. Ed Blewitt, Psychologist
Address- Psychology Department, Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.
Telephone Number- 01248-682682

Supervisor of Clinical Work- Dr. Judy Hutchings*, Consultant Clinical Psychologist
Address- Child & Adolescent Mental Health Service, Talarfon, Holyhead Road, Bangor, LL57 2EE.
Telephone Number- 01248-355825

* Dr. Hutchings is also Director of the Bangor Project for Children with Disruptive Behaviour, School of Psychology, University of Wales, Bangor, Bangor, Gwynedd, LL57 2DG.

[Please see Appendix Seven for Curricula Vitas of all investigators.]

4. Who is initiating this project?

The project represents a Large Scale Research Project, undertaken as a requirement of Dr. Myles' doctoral studies on the North Wales Clinical Psychology Course (NWCPC).

Academic Supervisor: Professor F.C. Mace, Academic Director, NWCPC.

Clinical Supervisor: Dr. Isabel Hargreaves, Clinical Director, NWCPC.

5. Where will the research take place?

The research will take place within the Child and Adolescent Mental Health Service provision area of the North West Wales NHS Trust.

Depending on which arrangement best suits each of the adolescent study participants and his/her parent(s)/guardian(s), the therapeutic intervention (Acceptance and Commitment Therapy) will be provided to him/her either at the Child and Adolescent Mental Health Service centre at Talarfon, in Bangor, the Child and Family Research Unit at Bryn y Neuadd Hospital, in Llanfairfechan, a clinic located as close as possible to the home of the participant, or the private home of the participant.

6. Objectives of the project :

The objective of the project is to determine whether Acceptance and Commitment Therapy is an effective therapy for the treatment of behavioural problems in adolescents with Conduct Disorder.

7. Scientific background to the project :

[Please see attached research proposal for a more detailed description of the scientific background to the project- Appendix One]

<u>Conduct Disorder</u>

"The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules." (APA, 1995, p. 88). Adolescents with Conduct Disorder have typically experienced traumatic events in their life histories (Greenwald, 2000). Concurrent with their Conduct Disorder. By the time that they reach adolescence, they very often experience emotional disorders such as anxiety (Zoccolillo, 1992) and depression (Marmorstein & Iacono, 2001; Simic & Fombonne, 2001).

Conduct Disorders are the most common reason for referral to children's mental health services (Offord, Boyle & Szatmari, 1987). Approximately 10% of children in the United Kingdom have behaviour problems of the Conduct Disorder type (Offord, Boyle & Racine, 1989). Early onset, unresolved Conduct Disorder problems are stable over time (Webster-Stratton, 1991) and predict frequent and severe behaviour problems in adolescence and difficulties in adulthood (Hinshaw, Lahey & Hart, 1993), including school drop-out, alcohol and drug abuse, criminality, and relationship difficulties (Kazdin, 1985).

Behavioural intervention programs involving parent training are an effective treatment strategy for pre-adolescent children with Conduct Disorder problems (e.g., Kazdin, 1987, Webster-Stratton & Herbert, 1994). However, after approximately ten years of age, treatment becomes increasingly difficult (Scott, 1998). Treatment programs for adolescents with Conduct Disorder have typically been unsuccessful (Holland, Moretti, Verlaan & Peterson, 1993).

A behaviour analytic (e.g., Malott, Whaley & Malott, 1997) account of Conduct Disorder suggests that as children enter adolescence, increasingly more of their behaviour is controlled by environmental contingencies that their parents/carers do not have access to and control over (e.g., contingencies outside of the home, the behaviour of their peers, etc.). In addition, increasingly more of their behaviour comes under the control of self-rules (things they say to themselves- e.g., "I'm no good, so it's not worth me trying to be good"). This analysis explains why intervention programs for adolescents with Conduct Disorder based primarily on parent training are unlikely to be effective.

The negative consequences of the problem behaviours of adolescents with Conduct Disorder (e.g., discord within the home environment, academic failure, problems with the authorities) are likely to contribute to the development of emotional disorders. In order to escape from the negative feelings associated with these disorders (e.g., feelings of worthlessness), they are likely to engage in even higher frequencies of problem behaviours (e.g., aggression toward others).

A behaviour analytic consideration suggests that in order to be effective, treatment programs for adolescents with Conduct Disorder should directly involve them in the therapy process, should address their self-rules, and should involve treatment of concurrent emotional disorders.

Further research into the treatment of Conduct Disorder in adolescents is required (Kazdin, 1997).

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) (Hayes, 1987; Hayes & Wilson, 1993; Hayes, Strosahl, & Wilson, 1999) is a cognitive therapy that has developed from empirical research into human verbal behaviour (e.g., Hayes, Zettle & Rosenfarb,1989). ACT is particularly appropriate for use with clients who have emotional problems, problems with self-rules, and problems with making and keeping behavioural commitments.

ACT involves two main therapeutic activities- firstly, helping the client to learn that he/she can experience difficult thoughts and feelings and still function effectively, and, secondly, helping him/her to identify important personal life values and make and keep commitments to behave in ways that are consistent with those values. The client's identified life values are used as "a compass" to guide his/her day-to-day behaviour.

In order to help the client to behave in ways that are consistent with his/her identified life-values, he/she is encouraged to set short-term behavioural goals that follow from those values. In order to achieve these goals, the client may need to learn some new skills, which he/she is helped to do by the therapist.

ACT typically ends when the client has identified his/her life values, has made verbal commitments to behave in ways consistent with those values, has set value consistent goals, and has begun to successfully achieve some of those goals.

ACT has been used in the treatment of clients with, amongst others, problems of anxiety, depression, medical non-compliance, pain management, psychoses, sexual abuse during childhood, stress, and substance abuse (Hayes et al, 1999). It has been used with adults and children (Hayes, 2001- personal communication). In comparative studies, ACT has been demonstrated to be more effective than cognitive-behaviour therapy in the treatment of depression (Zettle & Hayes, 1986). In all controlled treatment comparison studies conducted, ACT has always been demonstrated to be at least as effective as the alternative treatments considered (Hayes et al, 1999).

An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder

The aim of the proposed project is to determine whether Acceptance and Commitment Therapy is an effective therapy for the treatment of behavioural problems in adolescents with Conduct Disorder.

As noted above, ACT is particularly appropriate for use in the treatment of persons who have emotional problems, problems with self-rules, and problems with making and keeping behavioural commitments. These problems are typical of adolescents with Conduct Disorder. No studies have yet been conducted on the effectiveness of ACT in the treatment this population. The proposed study represents an important opportunity to determine whether ACT is an effective treatment for adolescents with Conduct Disorder.

8. Study design (incorporating randomisation and placebo details):

[Please see attached research proposal for a more detailed description of the study design- Appendix One]

Note on the Provision of Therapy

Therapy will be provided through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor. All case-files will be open to Dr. Judy Hutchings, Consultant Clinical Psychologist and Director of the Bangor Project for Children with Disruptive Behaviour. Dr. Hutchings will supervise the provision of therapy by Dr. Myles.

Single-Case Study, Multiple Baseline Design

The study will employ a single case-study, multiple base-line design. It will involve five distinct stages; pre-baseline, baseline, treatment, post-treatment, and follow-up.

The research intervention, as experienced by the adolescent participants, will not differ substantially from usual practice- ACT typically involves clients specifying behavioural goals for themselves, collecting data about their behaviour on a regular basis, and sharing that data with the therapist.

Pre-Baseline

Prior to the commencement of data collection, a number of target behaviours for each adolescent participant will be identified and agreed upon by him/her, his/her parent(s)/guardian(s), and Dr. Myles. These will include both inappropriate behaviours of the types noted in the DSM-IV diagnostic criteria for Conduct Disorder (APA, 1995) (e.g., aggression toward others, destruction of property, serious rule violations) and appropriate behaviours (e.g., attending school, getting up in the morning by a certain time). The target behaviours for each adolescent will likely differ somewhat from those of the others, reflecting the unique nature of his/her Conduct Disorder problem and the importance placed on different appropriate behaviours by him/her and his/her parent(s)/guardian(s). Target behaviours will be operationalised (defined clearly). Target frequencies (desired frequencies) for both appropriate and inappropriate behaviours will be agreed upon, as above.

Baseline

During the base-line period, no treatment will take place. The parent(s)/guardian(s) of each adolescent will record daily frequency data about his/her target behaviours. Each adolescent will also be asked to record frequency data on his/her own target behaviours. Weekly data will be collected from both parties by Dr. Myles either in person, or by telephone. Data for all adolescents will be graphed by Dr. Myles on a multiple base-line graph.

Three base-lines will be used. The third of adolescent participants with the most stable baselines will be assigned to a three week baseline condition. The third with the next most stable baselines will be assigned to a five week base-line condition. The third with the least stable base-lines will be assigned to a seven-week base-line condition.

Treatment

During treatment, each adolescent participant will receive up to 24 bi-weekly ACT sessions, to be provided by Dr. Myles. The exact number of sessions will depend on how rapidly each participant proceeds through the therapeutic process. It is estimated that participants are likely to complete the therapeutic process in 16 sessions or less. Each session will last between 45 minutes and 90 minutes. It is estimated that typical sessions will last for approximately 60 minutes.

Adolescents and their parent(s)/guardian(s) will continue to collect data on target behaviours, as in base-line.

Post-Treatment

For four weeks post-treatment, adolescents and their parent(s)/guardian(s) will continue to collect data, as in base-line.

Follow-up

One-month after the post-treatment period has ended, adolescents and their parent(s)/guardian(s) will collect data for a two week period, as in base-line.

Data Analysis

As is normal practice in single-case study, multiple base-line design research, the results of the study will be analyzed by "eye-balling" graphed data.

It is anticipated that inappropriate behaviours specified as target behaviours will decrease substantially in frequency over the course of the study. It is anticipated that appropriate behaviours specified as target behaviours will increase substantially in frequency.

9. Have you had statistical advice in preparing your protocol? If so, from whom?

The design of this project (single-case study, multiple base-line) does not involve statistical analysis.

10. What are the possible benefits and hazards of this research?

The research is of considerable potential benefit to both adolescent participants and their parent(s)/guardian(s).

The most likely benefit for adolescent participants is that they may experience an improvement in their ability to make and keep commitments to behave in ways that are not problematic for themselves or others, and that are consistent with their achieving meaningful, valuable lives. They may also experience an improvement in psychological well-being through a reduction in psychological trauma associated with pre-existing problems (e.g., anxiety disorders, depression).

Any improvements in the behaviour and/or psychological well-being of adolescent participants is likely to positively affect their relationship(s) with their parent(s)/guardian(s), to their mutual benefit.

The results of the research are likely to be of benefit to other practitioners and researchers in the field of Conduct Disorder in adolescents, in terms of contributing to existing knowledge concerning effective treatment strategies.

No potential hazards have been identified.

11. Participants :

11.1 type of participant

Participants will be adolescents with Conduct Disorder and their parent(s)/guardian(s).

Note on the Exclusion of Potential Adolescent Participants Who Are at Risk of Suicide or Serious Self-Harm

Potential adolescent participants who are currently engaging in suicidal or serious self-harming behaviours or who have suicidal or serious self-harming urges that are

abnormal in frequency or strength or who are apparently at risk of engaging in suicidal or serious self-harming behaviours will be excluded from the study.

Prior to the commencement of research, adolescent participants who have consented to participate in the study will be questioned about suicidal and serious self-harming behaviours and urges, and risk factors for suicidal and serious self-harming behaviours, in interview, by Dr. Myles. Risk factors covered will include: primary risk factors, such as previous attempts; secondary risk factors, such as substance misuse; and, situational risk factors, such as family functioning and perceived support. Each potential participant will also be asked to complete a Beck Scale for Suicide Ideation (Beck & Steer, 1991) (please see Appendix Six).

The results of the screening interviews will be discussed by Dr. Myles with Dr. Judy Hutchings, Consultant Clinical Psychologist, who will supervise all clinical work by Dr. Myles. Any potential participant who Dr. Myles and Dr. Hutchings consider to be at risk of, or who is currently engaging in, suicidal or serious self-harming behaviours will be excluded from the study. Dr. Myles and Dr. Hutchings will immediately take action to ensure the well-being and appropriate treatment of any such excluded potential participants, through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor..

Throughout the course of the study, Dr. Myles will remain alert to risk factors for suicide and serious self-harm by participants, and will immediately report any concerns about the well-being of participants to Dr. Hutchings.

11.2 method of recruitment

Potential participants will be identified through the North West Wales NHS Trust Child and Adolescent Mental Health Service (CAMHS), at Talarfon, in Bangor. Adolescent participants will have been referred to CAMHS for assessment/treatment with regard to behavioural problems of the Conduct Disorder type. They will not currently be receiving treatment.

Each potential adolescent participant and his/her parent(s)/guardian(s) will separately be sent a letter by Dr. Myles and Dr. Hutchings describing the research and asking if they would be interested in participating (see Appendix Two for English and Welsh language versions of the initial approach letters). The letter will clearly note that participation is entirely voluntary and that non-participation will not affect eligibility for treatment in the future or status on the CAMHS treatment waiting list.

Dr. Myles will arrange to meet potential adolescent participant(s) and their parent(s)/guardian(s) who express an interest in participating for the purposes of further explaining the nature of the research and seeking consent for participation. [Please see Appendices Three and Four for English and Welsh language version Consent Forms and Information Sheets to be provided to potential participants.]

Should more than the required number of potential participants express willingness to participate, those who have most priority on the CAMHS treatment waiting list will be selected to participate.

11.3 numbers of participants involved

Up to 9 adolescents and their parent(s)/guardian(s).

11.4 age groups involved

Adolescent participants will be between 14 years 0 months and 17 years 6 months of age at the time of the commencement of research.

11.5 do you intend to recruit 'vulnerable' participants? (if yes, please explain)

The research will involve adolescents with Conduct Disorder, who, by definition, engage in activities that are potentially dangerous to themselves and others (e.g., aggression to others, destruction of property, deceitfulness or theft, rule violations).

11.6 will consent be written or oral, or both?

Both oral and written consent will be obtained from both adolescent participants and their parent(s)/guardian(s) (please see Appendix Three for English and Welsh language versions of Consent Forms). Each participant will receive an information sheet outlining the purpose of the study and describing what participation will entail (please see Appendix Four for English and Welsh language versions of the Information Sheet for potential participants).

11.7 are participants competent to give informed consent?

Yes. Adolescents of fourteen years and above are typically considered to be competent to give informed consent for participation in therapy by the Child and Adolescent Mental Health Service. Their participation in the research will not involve them engaging in any activities that are not commonly involved in, for example, cognitive-behaviour therapy (e.g., they will be asked to talk about their thoughts, feelings and past experiences with the therapist, to complete written and non-written homework exercises, to provide data for the purpose of assessing treatment effectiveness, etc.).

11.8 how much time will be allowed between explaining the research and requesting consent?

Three days.

11.9 who will witness the consent?

Either another family member (e.g., a parent/guardian in the case of adolescent participants) or a member of the Child and Adolescent Mental Health Service.

11.10 will individuals already participating in other research be excluded?

Yes.

11.11 will participants be inconvenienced in any way as a result of taking part in the study?

Adolescent participants will be required to attend regular therapy sessions, either at home or at another location convenient for them. They will also be required to record data on their identified target behaviours, to complete homework exercises (e.g., monitoring their feelings over a week), and to occasionally complete psychometric measures.

Parents/guardians will be required to record data on the identified target behaviours of their adolescent and to occasionally complete psychometric measures.

11.12 will participants receive payment or reward for taking part? If so, please give details.

No.

12. Disclosure of payment or reward to investigators :

12.1 will any payment be made to the investigators or department/unit in respect of this trial?

No.

12.2 if yes, will the payment be a block grant, or will it be based on the number of participants recruited ?

N/A

12.3 if a block grant, please state amount awarded and explain how monies received will be spent.

N/A

12.4 if payment is based on number of participants recruited, please state total sum payable per capita, and number of participants agreed.

N/A

12.5 will participants be informed if the investigator/department is receiving payment, and if so, will they be told the name of the sponsor?

N/A

12.6 do any of the investigators have a personal involvement in the sponsoring company? If so, please give details.

N/A

13. Consent of others clinically involved :

13.1 will the participant's GP be informed of their involvement in the project?

Yes (please see Appendix Five).

13.2 will the consent of others clinically involved be obtained?

No.

14. Resource / service implications :

14.1 will your research have resource/service implications for the NHS?

No.

14.2 if yes, please indicate the applicable areas

N/A

14.3 have you discussed any additional workload and/or financial consequences of your project with the departments and budget holders concerned?

N/A

15. <u>Extra substances to be given to the participants :</u>

15.1 additional drugs

N/A

15.2 dosage form and presentation of these drugs

N/A

15.3 route of administration of these drugs

N/A

15.4 amount

N/A

15.5 frequency

N/A

15.6 desired effect

N/A

15.7 possible side effects

N/A

15.8 precautions

N/A

15.9 does the study medicine to be used have a marketing authorisation (product licence)?

N/A

15.10 if yes, will the medicine be used in accordance with, and for the indications specified in, the licence?

N/A

15.11 if the medicine does not have a product licence, or it will not be used in accordance with a product licence, does it have a clinical trial certificate (CTC) or an exemption under either the CTX or DDX schemes?

N/A

15.12 is the clinical trial randomisation code to be held by pharmacy?

N/A

15.13 what procedures will be followed if the codes are to be broken in an emergency?

N/A

15.14 please give full details of any other extra (non-drug) substances to be given to participants

N/A

16. <u>Extra interventions :</u>

16.1 will the project involve any extra venous samples? If so, please give details.

N/A

16.2 will the project involve any extra arterial samples? If so, please give details.

N/A

16.3 will the research involve extra x-rays, radiation, ultrasonics, scanning, ecg or other tests? If so, please give details.

N/A

16.4 will the research involve extra biopsies? If so, please give details.

N/A

16.5 will the research involve extra local or general anaesthesia? If so, please give details.

N/A

16.6 will the research involve any other extra invasive procedures such as cannulae, probes, catheters, internal examinations,endoscopies or lumbar punctures? If so, please give details.

N/A

16.7 will the research involve extra psychological tests? If so, please give details.

In order to monitor the effects of treatment on their behaviour and psychological functioning, adolescent participants will be asked to complete a number of standard, validated and reliable psychometric measures pre-treatment (once), during treatment (three times), post-treatment (once), and at follow-up (once). These will be: the Beck Depression Inventory (Beck, 1996), the Child Behaviour Checklist- Youth Report Version (Achenbach, 1991), the Harter Self-Esteem Scale (Harter, 1988), and the State-Trait Anxiety Inventory (Spielberger, 1973).

Parents/guardians will be asked to complete the Child Behaviour Checklist-Parent Report Version (Achenbach, 1991) about their adolescent's behaviour pre-treatment (once), during treatment (three times), post-treatment (once) and at follow-up (once). [Please see Appendix Six for copies of psychometric measures.]

16.8 will the research involve extra questionnaires? If so, please give details.

No.

16.9 will the research involve any other extra procedures not mentioned above, such as those using heat or electricity etc.? If so, please give details.

No.

16.10 will the research necessitate any treatments or procedures being withheld which would otherwise be administered? If so, please give details.

No.

17. <u>Ionising radiation :</u>

17.1 will subjects be exposed to ionising radiation as part of this study?

No.

17.2 if so, specify the procedures which will be performed, and state the total effective dose in msv which will be received.

N/A.

18. What problems may hinder successful completion of this study?

An insufficient number of participants may be recruited. This, however, is unlikely, as the single subject, multiple base-line design requires a minimum of only three participants. Participants may "drop-out" or stop collecting data. Providing that at least three remain in the study, and continue to collect data, this would not be problematic.

19. What steps will be taken to safeguard confidentiality of the research records?

Original data collection sheets and completed psychometric measures for each adolescent participant will be retained in his/her case file. Adolescent participants' case-files will be retained in a locked cabinet at the offices of the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, when not in use for the purposes of therapy. All research data will be anonymised and held in the offices of the Bangor Project for Children with Disruptive Behaviour, in the School of Psychology of the University of Wales, Bangor.

20. Please explain any arrangements made for indemnity cover for participants.

N/A.

21. Does the project comply with the requirements of the data protection act?

Yes.

22. Please state the anticipated start and end dates for your study.

The project will run from the beginning of August 2001 till the end of June 2002. Participants will be recruited in August/September. Research will begin in October/November, 2001. Data collection will be completed by March/April 2002. The project will be completed and "written-up" by the end of June, 2002.

23. Investigator's declaration :

The information provided above is to the best of my knowledge accurate. I fully understand my obligations and the rights of the participant, particularly with regard to freely given informed consent.

Signed: [signature] **Print name:** STEPHEN M. MYLES **Date:** 1/5/01

24. Head of Department's endorsement :

I hereby endorse this research proposal with my approval.

Signed: [signature] **Print name:** DR R.S. JONES (RESEARCH CO ORDINATOR) **Date:** 3/5/01

Appendix One: Research Proposal

Title: An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder.

Applicant: Dr. Stephen M. Myles, MA, Ph.D.
Clinical Psychologist in Training
North Wales Clinical Psychology Course
University of Wales, Bangor
College Road, Bangor
Gwynedd, LL57 4UN.

Research Supervisor: Mr. Ed Blewitt, Psychologist
Psychology Department, Bryn y Neuadd Hospital,
Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work: Dr. Judy Hutchings*, Consultant Clinical Psychologist
Child & Adolescent Mental Health Service, Talarfon,
Holyhead Road, Bangor, LL57 2EE.

* Dr. Hutchings is also Director of the Bangor Project for Children with Disruptive Behaviour, School of Psychology, University of Wales, Bangor, Bangor, Gwynedd, LL57 2DG.

[Please see Appendix Seven for Curricula Vitas of all investigators.]

Summary of Project Proposal:

Conduct Disorder is a persistent pattern of behavior in which the rights of others or age-appropriate societal norms or rules are violated. Adolescents with Conduct Disorder typically have histories of trauma, and often also have concurrent emotional disorders.

Conduct Disorder is the most common reason for referrals to children's mental health services. Early onset Conduct Disorder problems predict frequent and severe behaviour problems in adolescence and difficulties in adulthood.

Behavioural intervention programs are an effective treatment strategy for young children with Conduct Disorder. However, treatment programs for adolescents with Conduct Disorder have typically been unsuccessful. Further research into the treatment of Conduct Disorder in adolescents is required.

Acceptance and Commitment Therapy (ACT) is a cognitive therapy that has developed from research into human behaviour. ACT is particularly appropriate for use with clients who have emotional problems, problems with self-rules, and problems with making and keeping behavioural commitments

ACT has been successfully used in the treatment of clients with a wide variety of psychological problems. In all studies conducted, ACT has always been demonstrated to be at least as effective as the alternative treatments considered (Hayes et al, 1999).

No studies have yet been conducted into ACT in the treatment of adolescents with Conduct Disorder. The objective of the proposed project is to determine whether ACT is an effective therapy for the treatment of behavioural problems in adolescents with Conduct Disorder.

The proposed study will involve up to nine adolescent participants with Conduct Disorder, aged 14-17 years, and their parent(s)/guardian(s), living in the service provision area of the North West Wales NHS Trust. It will involve researching the effect of a course of ACT on pre-specified target behaviours (including both inappropriate, problem behaviours and appropriate, non-problem behaviours) exhibited by adolescent participants. A single-case study, multiple baseline design will be employed, using three baselines. Behavioural frequency data will be recorded by both adolescent participants and their parent(s)/guardians. Each adolescent and

his/her parent(s)/guardian(s) will also provide psychometric measure data on his/her behaviour over the course of the study. Adolescent participants will also provide psychometric measure data on their levels of anxiety, depression, and self-esteem over the course of the study.

Introduction

Conduct Disorder

"The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules. Three (or more) characteristic behaviors must have been present during the past 12 months, with at least one behavior present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning" (APA, 1995, p. 88). Adolescents with Conduct Disorder have typically experienced traumatic events in their life histories (Greenwald, 2000), and very often have concurrent emotional disorders such as anxiety (Zoccolillo, 1992) and depression (Marmorstein & Iacono, 2001; Simic & Fombonne, 2001). They are typically more avoidant of responsibility than adolescents without Conduct Disorder (Powell & Rosen, 1999)

Conduct Disorders are the most common reason for referral to children's mental health services (Offord, Boyle & Szatmari, 1987) and are the most frequent problem domain in clinical practice (Kazdin, Siegel & Bass, 1990). Approximately 10% of children in the United Kingdom have behaviour problems of the Conduct Disorder type (Offord, Boyle & Racine, 1989), and the numbers of children with such problems are apparently increasing (Stallard, 1993). Early onset, unresolved Conduct Disorder problems are stable over time (Webster-Stratton, 1991) and predict frequent and severe behaviour problems in adolescence and difficulties in adulthood (Hinshaw, Lahey & Hart, 1993), including school drop-out, alcohol and drug abuse, criminality, and relationship difficulties (Kazdin, 1985). Such problems have serious costs, in terms of both human suffering (Herbert, 1995) and financial impact on the education, social welfare and health services, and the judicial and penal systems. Werry (1997) comments: "Conduct Disorder should be considered one of if not the major public health problems of our time and resources for its study and management should reflect this".

Behavioural intervention programs involving parent training are an effective treatment strategy for young children with Conduct Disorder problems (Kazdin, 1987, Webster-Stratton & Herbert, 1994). However, after approximately ten years of age, treatment becomes increasingly difficult (Scott, 1998). Treatment programs for adolescents with Conduct Disorder have typically been unsuccessful (Holland, Moretti, Verlaan & Peterson, 1993).

A behaviour analytic (Malott, Whaley & Malott, 1997) consideration of Conduct Disorder suggests that as children enter adolescence, increasingly more of their behaviour is controlled by environmental contingencies that their parents/carers do not have access to and control over (e.g., contingencies outside of the home, the behaviour of their peers, etc.). In addition, increasingly more of their behaviour comes under the control of self-rules (things they say to themselves- e.g., "I'm no good, so it's not worth me trying to be good"). This analysis explains why intervention programs for adolescents with Conduct Disorder based solely on parent training are unlikely to be effective.

The negative consequences of the problem behaviours of adolescents with Conduct Disorder (e.g., discord within the home environment, academic failure, problems with the authorities) are likely to contribute to the development of emotional disorders. In order to escape from the negative feelings associated with these disorders (e.g., feelings of worthlessness), they are likely to engage in even higher frequencies of problem behaviours (e.g., aggression toward others).

A behaviour analytic consideration suggests that in order to be effective, treatment programs for adolescents with Conduct Disorder should directly involve them in the therapy process, should address their self-rules, and should involve treatment of concurrent emotional disorders.

Further research into the treatment of Conduct Disorder in adolescents is required.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) (Hayes, 1987; Hayes & Wilson, 1993, 1994; Hayes, Strosahl, & Wilson, 1999; Kohlenberg, Hayes, & Tsai, 1993) is a cognitive therapy that has developed from empirical research into human behaviour (e.g., Hayes, Zettle, & Rosenfarb, 1989). It is a "talking" therapy, which, like cognitive behaviour therapy (Beck, Rush, Shaw, & Emery, 1979), involves the client discussing his/her behaviour, cognitions and emotions with the therapist during therapy sessions, and completing "homework" exercises (e.g., recording data on his/her behaviour) outside of sessions.

ACT is particularly appropriate for use with clients who have emotional problems (e.g., anxiety and depression), problems with self-rules (thoughts about themselves- e.g., "If I try I'll fail"), and problems with making and keeping behavioural commitments (e.g., commitments to behave in ways that they know are good for themselves and others, such as the commitment to find and keep a job or to act in a caring way toward another person).

ACT involves two main therapeutic activities- firstly, helping the client to learn that he/she can experience difficult thoughts and feelings and still function effectively, and, secondly, helping him/her to identify important personal life values (e.g., to be a caring supportive friend to others, to look after one's health, to contribute to society in some way) and make and keep commitments to behave in ways that are consistent with those values. The client's identified life values are used as "a compass" to guide his/her day-to-day behaviour.

These therapeutic activities involve the use by the therapist of metaphors to help the client to gain insight about the relationship between his/her behaviour and cognitions and emotions (e.g., the metaphor of crossing a swamp to help the client to realise that in order to achieve his/her valued goals, he/she will likely have to accept having some difficult experiences, such as aversive thoughts and feelings, e.g., thoughts of failure and feelings of anxiety). They also involve the therapist leading the client through a variety of experiential exercises (such the "Leaves in the Stream" exercise, in which the client is asked to imagine his/her thoughts as leaves floating down a stream in order to demonstrate how when he/she has a particularly emotive thought, it is easy to become "caught-up" in it and lose perspective of it as just being one thought in a "stream" of many).

In order to help the client to behave in ways that are consistent with his/her identified life-values, he/she is encouraged to set short-term behavioural goals that follow from those values (e.g., telephoning a friend each week to ask how he/she is, engaging in some exercise regularly, volunteering at a local animal shelter). In order to achieve these goals, the client may need to learn some new skills (e.g., social skills, planning skills) which he/she is helped to do by the therapist.

ACT typically ends when the client has identified his/her life values, has made verbal commitments to behave in ways consistent with these values, has set value consistent goals, and has begun to successfully achieve some of these goals.

ACT has been used in the treatment of clients with, amongst others, problems of anxiety, depression, medical non-compliance, pain management, psychoses, sexual abuse during childhood, stress, and substance abuse (Hayes et al, 1999). It has been used with non-learning disabled adults and children and learning disabled persons (Hayes, 2001- personal communication). In comparative studies, ACT has been demonstrated to be more effective than cognitive-behaviour therapy in the treatment of depression (Zettle & Hayes, 1986). It has been demonstrated to be more effective than treatment as usual for problems of psychoses (Bach & Hayes, 2001) and substance abuse (Hayes, 2001- personal communication). In all studies conducted, ACT has always been demonstrated to be at least as effective as the alternative treatments considered (Hayes et al, 1999).

An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder

As noted above, ACT is particularly appropriate for use in the treatment of persons who have emotional problems, problems with self-rules, and problems with making and keeping behavioural commitments. These problems are typical of adolescents with Conduct Disorder. No studies have yet been conducted on ACT in the treatment of adolescents with Conduct

Disorder. The proposed study represents an important opportunity to determine whether ACT is an effective treatment for adolescents with Conduct Disorder.

Aims of the Proposed Project

The aim of the project is to determine whether Acceptance and Commitment Therapy is an effective therapy for the treatment of behavioural problems in adolescents with Conduct Disorder.

Note on Dr. Myles' Competence to Practice ACT

Dr. Myles has trained in ACT with its originator, Professor Steven C, Hayes, Professor of Clinical Psychology at the University of Nevada, Reno. Dr. Myles has attended a three day, intensive residential workshop in ACT led by Professor Hayes, and has undertaken additional ACT training for a period of over a week at the University of Nevada. Dr. Myles has practiced components of ACT, under the supervision of Dr. Judy Hutchings, Consultant Clinical Psychologist, with adolescent clients during his successfully completed Child and Adolescent Mental Health training placement, undertaken as an element of his doctoral studies in Clinical Psychology. He has been asked to conduct seminars on the subject of ACT for each of the Clinical Psychology services of the North West Wales NHS Trust, by Dr. Peter Woods, Head of Service.

Plan of Investigation

Note on the Provision of Therapy and Participant Withdrawal from the Study

Therapy will be provided through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor. All case-files will be open to Dr. Judy Hutchings, Consultant Clinical Psychologist. Dr. Hutchings will supervise the provision of therapy by Dr. Myles.

Adolescent participants will be able to withdraw from the study at any point, without explanation. Participants who withdraw from the study will be offered the opportunity to receive alternative therapy from another member of the CAMHS team. Parent/guardian participants may also withdraw from the study at any point.

Participants

Up to nine adolescents (14-17 years of age) who have been referred for treatment to the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, with behavioural problems consistent with a DSM-IV (APA, 1995) diagnosis of Conduct Disorder, and their parent(s)/guardian(s).

Note on the Exclusion of Potential Adolescent Participants Who Are at Risk of Suicide or Serious Self-Harm

Potential adolescent participants who are currently engaging in suicidal or serious self-harming behaviours or who have suicidal or serious self-harming urges that are abnormal in frequency or strength or who are apparently at risk of engaging in suicidal or serious self-harming behaviours will be excluded from the study.

Prior to the commencement of research, adolescent participants who have consented to participate in the study will be questioned about suicidal and serious self-harming behaviours and urges, and risk factors for suicidal and serious self-harming behaviours, in interview, by Dr. Myles. Risk factors covered will include: primary risk factors, such as previous attempts; secondary risk factors, such as substance misuse; and, situational risk factors, such as family functioning and perceived support. Each potential participant will also be asked to complete a Beck Scale for Suicide Ideation (Beck & Steer, 1991) (please see Appendix Six).

The results of the screening interviews will be discussed by Dr. Myles with Dr. Judy Hutchings, Consultant Clinical Psychologist, who will supervise all clinical work by Dr. Myles. Any potential participant who Dr. Myles and Dr. Hutchings consider to be at risk of, or who is

currently engaging in, suicidal or serious self-harming behaviours will be excluded from the study. Dr. Myles and Dr. Hutchings will immediately take action to ensure the well-being and appropriate treatment of any such excluded potential participants, through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor..

Throughout the course of the study, Dr. Myles will remain alert to risk factors for suicide and serious self-harm by participants, and will immediately report any concerns about the well-being of participants to Dr. Hutchings.

Design

The study will employ a single case-study, multiple (three) base-line design. The independent variable will be the provision to each adolescent participant of a course of ACT. The dependent variable will be pre-specified target behaviours for each adolescent. An independent control group is not required with this research design.

Psychometric measures will be used to collect additional data on the effects of treatment on the behaviour of each participant, and his/her self-esteem and levels of anxiety and depression.

[The research intervention, as experienced by the adolescent participants, will not differ substantially from usual practice- ACT typically involves clients specifying behavioural goals for themselves, collecting data about their behaviour on a regular basis, and sharing that data with the therapist.

ACT provided to adolescent participants will follow the protocol described by Hayes et al (1999), with the exception that values identification work will be conducted toward the beginning of the therapeutic process, rather than toward the middle, as described by Hayes et al.]

Measures

Psychometric Measures- Beck Depression Inventory (Beck, 1996), Beck Scale for Suicide Ideation (Beck & Steer, 1991), Child Behaviour Checklist, Parent Report and Youth Self-Report Versions (Achenbach, 1991), Harter Self-Esteem Scale (Harter, 1988), State-Trait Anxiety Inventory for Children (Spielberger, 1973). [Please see Appendix Six for copies of psychometric measures.]

Individualised Target Behaviour Data Recording Sheets.

Procedure

Recruitment of Participants

Potential participants will be identified through the North West Wales NHS Trust Child and Adolescent Mental Health Service (CAMHS), at Talarfon, in Bangor. Adolescent participants will have been referred to CAMHS for assessment/treatment with regard to behavioural problems of the Conduct Disorder type. They will not currently be receiving treatment.

Each potential adolescent participant and his/her parent(s)/guardian(s) will separately be sent a letter by Dr. Myles and Dr. Hutchings describing the research and asking if they would be interested in participating (see Appendix Two for English and Welsh language versions of the initial approach letters). The letter will clearly note that participation is entirely voluntary and that non-participation will not affect eligibility for treatment in the future or status on the CAMHS treatment waiting list.

Dr. Myles will arrange to meet potential adolescent participant(s) and their parent(s)/guardian(s) who express an interest in participating for the purposes of further explaining the nature of the research and seeking consent for participation.

Following this meeting, a three day period will be allowed to elapse before consent for participation is sought. Signed, witnessed consent will be sought from each adolescent participant and his/her parent(s)/guardian(s). Consent forms that comply with North West Wales NHS Trust policy will be used. [Please see Appendices Three and Four for English and

Welsh language version Consent Forms and Information Sheets to be provided to potential participants.]

Should more than the required number of potential participants express willingness to participate, those who have most priority on the CAMHS treatment waiting list will be selected to participate.

Procedural Stages- Pre-Baseline

Prior to the commencement of data collection, a number of target behaviours for each adolescent will be identified and agreed upon by him/her, his/her parent(s)/guardian(s), and Dr. Myles. These will include both inappropriate behaviours noted in the DSM-IV diagnostic criteria for Conduct Disorder (APA, 1995) (e.g., aggression towards others, destruction of property, serious rule violations) and appropriate behaviours (e.g., attending school, getting up in the morning by a certain time). The target behaviours for each adolescent will likely differ somewhat from those of the others, reflecting the unique nature of his/her Conduct Disorder problem and the importance placed on different appropriate behaviours by him/her and his/her parent(s)/guardian(s). Target behaviours will be operationalised (defined clearly). Target frequencies (desired frequencies) for both appropriate and inappropriate behaviours will be agreed upon, as above.

Baseline

During the base-line period, no treatment will take place. The parent(s)/guardian(s) of each adolescent will record daily frequency data on his/her target behaviours. Each adolescent will also be asked to record frequency data on his/her own target behaviours. Weekly data will be collected from both parties by Dr. Myles either in person, or by telephone. Data for all adolescents will be graphed by Dr. Myles on a multiple base-line graph.

Three base-lines will be used. The third of adolescent participants with the most stable baselines will be assigned to a three week baseline condition. The third with the next most stable baselines will be assigned to a five week base-line condition. The third with the least stable base-lines will be assigned to a seven-week base-line condition.

Treatment

During treatment, each adolescent participant will receive with up to 24 bi-weekly ACT sessions, to be provided by Dr. Myles. The exact number of sessions will depend on how rapidly each participant proceeds through the therapeutic process. It is estimated that participants are likely to complete the therapeutic process in 16 sessions or less. Each session will last between 45 minutes and 90 minutes. It is estimated that typical sessions will last for approximately 60 minutes.

Adolescents and their parent(s)/guardian(s) will continue to collect data on target behaviours, as in base-line.

Post-Treatment

For four weeks post-treatment, adolescents and their parent(s)/guardian(s) will continue to collect data, as in base-line.

Follow-up

One-month after the post-treatment period has ended, adolescents and their parent(s)/guardian(s) will collect data for a two week period, as in base-line.

Settings and Equipment

Depending on which arrangement best suits each study participant, the research will take place at the Child and Adolescent Mental Health Service centre at Talarfon, in Bangor, the Child and

Family Research Unit at Bryn y Neuadd Hospital, in Llanfairfechan, a clinic located as close as possible to the home of the participant, or the private home of the participant.

No equipment will be used.

Data Analysis

Behaviour frequency data will be graphed on a multiple baseline graph. As is normal practice in single-case study, multiple base-line design research, the results of the study will be analysed by "eye-balling" graphed data.

It is anticipated that inappropriate behaviours specified as target behaviours will decrease substantially in frequency over the course of the study. It is anticipated that appropriate behaviours specified as target behaviours will increase substantially in frequency.

It is anticipated that adolescent participants' scores on the psychometric behaviour measure will also decrease. Their scores on the self-esteem measure should either increase or remain the same. Their scores of the anxiety and depression measures should decrease or stay the same.

Original data collection sheets and completed psychometric measures for each adolescent participant will be retained in his/her case file. Adolescent participants' case-files will be retained in a locked cabinet at the offices of the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, when not in use for the purposes of therapy. All research data will be anonymised and held in the offices of the Bangor Project for Children with Disruptive Behaviour, in the Psychology Department of the University of Wales, Bangor. The Project is directed by Dr. Judy Hutchings, Consultant Clinical Psychologist, who will provide clinical supervision to Dr. Myles.

Risk to Participants

No risks to participants have been identified.

Payment

No payment will be made to participants.

Approval from Professionals

The proposed project has been approved by Dr. Judy Hutchings, Consultant Clinical Psychologist, of the Child and Adolescent Mental health Service, at Talarfon, in Bangor. It has also been approved by Dr. Peter Woods, Head of Psychology Services, North West Wales NHS Trust.

Potential Benefits Arising from the Proposed Project

The research is of considerable potential benefit to both adolescent participants and their parent(s)/guardian(s).

The most likely benefit for adolescent participants is that they may experience an improvement in their ability to make and keep commitments to behave in ways that are not problematic for themselves or others, and that are consistent with achieving meaningful, valuable lives. They may also experience an improvement in psychological well-being through a reduction in psychological trauma associated with pre-existing problems (e.g., anxiety disorders, depression).

Any improvements in the behaviour and/or psychological well-being of adolescent participants is likely to positively affect their relationship(s) with their parent(s)/guardian(s), to their mutual benefit.

The results of the research are likely to be of benefit to other practitioners and researchers in the field of Conduct Disorder in adolescents, in terms of contributing to existing knowledge concerning effective treatment strategies.

Timetable for the Proposed Project

The project will run from the beginning of August 2001 till the end of June 2002. Participants will be recruited in August/September. Research will begin in October/November, 2001. Data collection will be completed by March/April 2002. The project will be completed and "written-up" by the end of June, 2002.

References

Achenbach, T.M. (1991). *Child behavior checklist for ages 4-18*. Burlington, Vermont: University of Vermont.

Achenbach, T.M. (1991). *Youth self-report for ages 11-18*. Burlington, Vermont: University of Vermont.

American Psychiatric Association (1995). *Diagnostic and statistical manual of disorders (4th Ed.)*. Washington, DC: APA.

Bach, P. & Hayes, S.C. (2001). *An Evaluation of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial*. Unpublished study.

Beck, A.T. (1978). *Beck depression inventory*. San Antonio: The Psychological Corporation.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Beck, A.T. & Steer, R.A. (1991). *Beck scale for suicide ideation: Manual*. San Antonio: The Psychological Corporation.

Greenwald, R. (2000). A trauma-focused individual therapy approach for adolescents with conduct disorder. *International Journal of Offender Therapy and Comparative Criminology, 44* (2), 146-163.

Harter, S. (1988). *Harter self-esteem scale*. Denver, Colorado: U. of Denver.

Hayes, S.C. (1987). A contextual approach to therapeutic change. In N. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioral perspectives (pp. 327-387)*. New York: Guilford Press.

Hayes, S.C. & Wilson, K.G. (1993). Some applied implications of a contemporary behavior-analytic account of verbal events. *The Behavior Analyst, 16,* 283-301.

Hayes, S.C. & Wilson, K.G. (1994). Acceptance and commitment therapy: Altering the verbal support for experiential avoidance. *The Behavior Analyst, 17,* 289-303`.

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

Hayes, S.C., Zettle, R.D., & Rosenfarb, I. (1989) Rule following. In S.C. Hayes (Ed.), *Rule-governed behavior: Cognition, contingencies, and instructional control (pp. 191-220)*. New York: Plenum.

Herbert, M. (1995). A collaborative model of training for parents of children with disruptive behaviour disorders. *British Journal of Clinical Psychology, 34,* 325-342.

Hinshaw, S.P., Lahey, B.B., & Hart, E.L. (1993). Issues of taxonomy and comorbidity in the development of conduct disorder. *Development and Psychopathology, 5,* 31-49.

Holland, R. Moretti, M.M., Verlaan, V., & Peterson, S. (1993). Attachment and conduct disorder: The response program. *Canadian Journal of Psychiatry, 38,* 6, 420-431.

Kazdin, A.E. (1985). *Treatment of antisocial behavior in children and adolescents*. Homewood, Illinois: Dorsey.

Kazdin, A.E. (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin, 102,* 187-203.

Kazdin, A.E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology, 26,* 2, 114-129.

Kazdin, A.E., Siegel, T.C., & Bass, D. (1990). Drawing upon clinical practice to inform research on child and adolescent psychotherapy: A survey of practitioners. *Professional Psychology: Research and Practice, 21,* 189-198.

Kohlenberg, R.J., Hayes, S.C., & Tsai, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. *Clinical Psychology Review, 13,* 579-592.

Malott, R.W., Whaley, D.L., & Malott, M.E. (1997). *Elementary principles of behavior (3rd. Ed.)*. Upper Saddle River, New Jersey: Prentice Hall.

Marmorstein, N.R. & Iacono, W.G. (2001). An investigation of female adolescent twins with both major depression and conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 3, 299-306.

Offord, D.R., Boyle, M.H., & Racine, Y. (1989). Ontario child health study: Correlates of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 850-860.

Offord, D.R., Boyle, M.H., & Szatmari, P. (1987). Ontario child health study: II, Six month prevalence of disorder and rates of service utilisation. *Archives of General Psychiatry, 44,* 832-836.

Powell, K.M. & Rosen, L.A. (1999). Avoidance of responsibility in conduct disordered adolescents. *Personality And Individual Differences, 27,* 2, 327-340.

Scott, S. (1996). Delinquent children. *BBC Panorama Programme,* 23/9/96.

Simic, M. & Fombonne, E. (2001). Depressive conduct disorder: Symptom patterns and correlates in referred children and adolescents. *Journal of Affective Disorders, 62,* 3, 175-185.

Spielberger, C.D. (1973). *Manual for the state-trait anxiety inventory for children* . Palo Alto: Consulting Psychologists Press.

Spender, Q. & Scott, S. (1996). Conduct disorder. *Current Opinion in Psychiatry, 9,* 273-277.

Stallard, P. (1993). The behaviour of 3-year-old children: Prevalence and perception of problem behaviour: A research note. Journal *of Child Psychology and Psychiatry, 34,* 413-421.

Webster-Stratton, C. (1991). Annotation: Strategies for helping families with conduct disordered children. *Journal of Child Psychology and Psychiatry, 32,* 7, 1047-1062.

Webster-Stratton, C. & Herbert, M. (1994). *Troubled families-problem children. Working with parents: A collaborative process.* Chichester: Wiley.

Werry, J.S. (1997). *Severe conduct disorder: Some key issues. Canadian Journal of Psychiatry, 42,* 6, 577-583.

Zettle, R.D. & Hayes, S.C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4,* 30-38.

Zoccolillo, M. (1992). Cooccurrence of conduct disorder and its adult outcomes with depressive and anxiety disorders: A review. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 3, 547-556.

Appendix Two (A):

Initial Approach Letter to Parent(s)/Guardian(s) of Potential Adolescent Participants

Re: (Name of Potential Adolescent Participant)

Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder."

Dear (Name of Parent/Guardian)

(Name of adolescent) was referred to the Child and Adolescent Mental Health Service for help with behaviour problems by (name and title of referrer).

I am writing to let you know that in the near future I will be carrying out a research project to find out whether "Acceptance and Commitment Therapy" can help young people with behaviour problems to live less problematic lives.

"Acceptance and Commitment Therapy" can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

Young people who join in this study will each be provided with a course of sessions of "Acceptance and Commitment Therapy", at a place near to where they live. At the moment, "Acceptance and Commitment Therapy" is not otherwise available as a treatment for young people with behaviour problems, in the North West Wales NHS Trust area.

The research project may run for up to six months. It will probably run for four to five months. Therapy sessions will be in English.

Participation in the research *may* help both young people with behaviour problems and their parent(s)/guardian(s).

The most likely benefit for young people is that they will become more able to make and keep plans to behave in ways that are not problematic for them or others, and that may help them to achieve more satisfying lives. They may also find that they have less of a problem dealing with their feelings and thoughts than before.

Any improvement in the behaviour and/or state of mind of a young person who participates is likely to improve his/her relationship(s) with his/her parent(s)/guardian(s).

Participation in this research project is entirely voluntary. Participants can withdraw from participation at any time. Deciding not to participate, or withdrawing from participation will not affect any health care services that are currently being received, or that may be provided in the future. All personal information provided through participation will remain confidential.

If you and the person named above are interested in learning more about this project, please contact Dr. Stephen Myles, Clinical Psychologist in Training, at the telephone number or address noted on this letter. Dr. Myles will arrange to meet you at a time and place that suits you, to provide some more information.

Yours sincerely.

Dr. Stephen M. Myles (MA, Ph.D.).
Clinical Psychologist in Training
C/O North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Dr. Judy Hutchings
Consultant Clinical Psychologist
North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Atodiad Dau (A):

Llythyr Cychwynnol at Riant/Rieni / Gwarcheidwa(i)d Pobl Ifanc a all Gymryd Rhan

Parthed: (Enw'r Sawl a all Gymryd Rhan)

Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Annwyl (Enw Rhiant/Gwarcheidwad)

Cyfeiriwyd (enw'r person ifanc) at y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc gan (enw'r sawl a'i cyfeiriodd) i gael cymorth gyda phroblemau ymddygiad.

Rwy'n ysgrifennu atoch i roi gwybod i chi y byddaf yn gwneud project ymchwil yn y dyfodol agos i weld a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau ymddygiad i fyw bywydau llai problemus.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd pobl ifanc sy'n ymuno â'r astudiaeth hon yn cael cyfres o sesiynau o "Therapi Derbyn ac Ymroddiad" mewn lle sy'n agos i'w cartrefi. Ar hyn o bryd nid yw "Therapi Derbyn ac Ymroddiad" ar gael fel arall fel triniaeth ar gyfer pobl ifanc â phroblemau ymddygiad yn ardal Ymddiriedolaeth GIG Gogledd Orllewin Cymru.

Gall y project ymchwil barhau am hyd at chwe mis. Mae'n debygol y bydd yn para am bedwar neu bum mis. Cynhelir y sesiynau therapi yn Saesneg.

Gall cymryd rhan yn yr ymchwil helpu pobl ifanc gyda phroblemau ymddygiad a hefyd eu rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i bobl ifanc yw y byddant yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddynt hwy eu hunain ac eraill, a chadw atynt. Gall hynny eu helpu i gael bywydau mwy pleserus. Efallai y byddant yn gweld hefyd eu bod yn cael llai o drafferth i ddelio â'u teimladau a'u meddyliau na chynt.

Bydd unrhyw welliant yn ymddygiad ac/neu gyflwr meddwl person ifanc sy'n cymryd rhan yn yr ymchwil yn debygol o wella ei berthynas/pherthynas â'i r(h)ieni/gwarcheidwa(i)d.

Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol. Gall y rhai sy'n cymryd rhan ddynnu'n ôl unrhyw bryd. Ni fydd penderfynu peidio â chymryd rhan, neu dynnu'n ôl ar ôl i'r astudiaeth ddechrau, yn effeithio ar unrhyw wasanaethau gofal iechyd a roddir ar hyn o bryd, neu a all gael eu darparu yn y dyfodol. Cedwir pob gwybodaeth bersonol a roddir wrth gymryd rhan yn gyfrinachol.

Os oes gennych chi a'r sawl a enwir uchod ddiddordeb mewn cael mwy o wybodaeth am y project hwn, cysylltwch os gwelwch yn dda â Dr Stephen Myles, Seicolegydd Clinigol dan Hyfforddiant. Nodir y rhif ffôn a'r cyfeiriad ar ddiwedd y llythyr hwn. Bydd Dr Myles yn trefnu i gwrdd â chi ar adeg ac mewn lle sy'n gyfleus i chi er mwyn rhoi mwy o wybodaeth i chi.

Yn gywir

Dr Stephen M. Myles (M.A., Ph.D.)
Seicolegydd Clinigol dan Hyfforddiant
d/o Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Appendix Two (B):

Initial Approach Letter to Potential Adolescent Participants

Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder."

Dear (Name of Potential Participant)

You were referred to the Child and Adolescent Mental Health Service for help with behaviour problems by (name and title of referrer).

I am writing to let you know that in the near future I will be carrying out a research project to find out whether "Acceptance and Commitment Therapy" can help young people with behaviour problems to live less problematic lives.

"Acceptance and Commitment Therapy" can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

Young people who join in this study will each be provided with a course of sessions of "Acceptance and Commitment Therapy", at a place near to where they live. At the moment, "Acceptance and Commitment Therapy" is not otherwise available as a treatment for young people with behaviour problems, in the North West Wales NHS Trust area.

The research project may run for up to six months. It will probably run for four to five months. Therapy sessions will be in English.

Participation in the research *may* help both young people with behaviour problems and their parent(s)/guardian(s).

The most likely benefit for young people is that they will become more able to make and keep plans to behave in ways that are not problematic for them or others, and that may help them

to achieve more satisfying lives. They may also find that they have less of a problem dealing with their feelings and thoughts than before.

Any improvement in the behaviour and/or state of mind of a young person who participates is likely to improve his/her relationship(s) with his/her parent(s)/guardian(s).

Participation in this research project is entirely voluntary. Participants can withdraw from participation at any time. Deciding not to participate, or withdrawing from participation will not affect any health care services that are currently being received, or that may be provided in the future. All personal information provided through participation will remain confidential.

If you are interested in learning more about this project, please contact Dr. Stephen Myles, Clinical Psychologist in Training, at the telephone number or address noted on this letter. Dr. Myles will arrange to meet you at a time and place that suits you, to provide some more information.

Yours sincerely.

Dr. Stephen M. Myles (MA, Ph.D.).
Clinical Psychologist in Training
C/O North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Dr. Judy Hutchings
Consultant Clinical Psychologist
North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Atodiad Dau (B):

Llythyr Cychwynnol at Bobl Ifanc a all Gymryd Rhan

Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Annwyl (Enw'r Sawl a all Gymryd Rhan)

Fe gawsoch eich cyfeirio at y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc gan (enw'r sawl a'ch cyfeiriodd) i gael cymorth gyda phroblemau ymddygiad.

Rwy'n ysgrifennu atoch i roi gwybod i chi y byddaf yn gwneud project ymchwil yn y dyfodol agos i weld a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau ymddygiad i fyw bywydau llai problemus.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd pobl ifanc sy'n ymuno â'r astudiaeth hon yn cael cyfres o sesiynau o "Therapi Derbyn ac Ymroddiad" mewn lle sy'n agos i'w cartrefi. Ar hyn o bryd nid yw "Therapi Derbyn ac Ymroddiad" ar gael fel arall fel triniaeth ar gyfer pobl ifanc â phroblemau ymddygiad yn ardal Ymddiriedolaeth GIG Gogledd Orllewin Cymru.

Gall y project ymchwil barhau am hyd at chwe mis. Mae'n debygol y bydd yn para am bedwar neu bum mis. Cynhelir y sesiynau therapi yn Saesneg.

Gall cymryd rhan yn yr ymchwil helpu pobl ifanc gyda phroblemau ymddygiad a hefyd eu rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i bobl ifanc yw y byddant yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddynt hwy eu hunain ac eraill, a chadw atynt. Gall hynny eu helpu i gael bywydau mwy pleserus. Efallai y byddant yn gweld hefyd eu bod yn cael llai o drafferth i ddelio â'u teimladau a'u meddyliau na chynt.

Bydd unrhyw welliant yn ymddygiad ac/neu gyflwr meddwl person ifanc sy'n cymryd rhan yn yr ymchwil yn debygol o wella ei berthynas/pherthynas â'i r(h)ieni/gwarcheidwa(i)d.

Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol. Gall y rhai sy'n cymryd rhan dynnu'n ôl unrhyw bryd. Ni fydd penderfynu peidio â chymryd rhan, neu dynnu'n ôl ar ôl i'r astudiaeth ddechrau, yn effeithio ar unrhyw wasanaethau gofal iechyd a roddir ar hyn o bryd, neu a all gael eu darparu yn y dyfodol. Cedwir pob gwybodaeth bersonol a roddir wrth gymryd rhan yn gyfrinachol.

Os oes gennych ddiddordeb mewn cael mwy o wybodaeth am y project hwn, cysylltwch os gwelwch yn dda â Dr Stephen Myles, Seicolegydd Clinigol dan Hyfforddiant. Nodir y rhif ffôn a'r cyfeiriad ar ddiwedd y llythyr hwn. Bydd Dr Myles yn trefnu i gwrdd â chi ar adeg ac mewn lle sy'n gyfleus i chi er mwyn rhoi mwy o wybodaeth i chi.

Yn gywir

Dr Stephen M. Myles (M.A., Ph.D.)
Seicolegydd Clinigol dan Hyfforddiant
d/o Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Appendix Three (A):

Consent Form for Participation by Parent(s)/Guardian(s) in Research

Please see information sheet for a detailed description of this research project.

Title of the Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Names and Positions of Investigators:

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D.
Clinical Psychologist in Training

Contact Address- North Wales Clinical Psychology Course
University of Wales, Bangor
College Road, Bangor
Gwynedd, LL57 2DG.

Telephone Number- 01248-383832

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist
Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings
Consultant Clinical Psychologist
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor, LL57 2EE.

Purpose of the Research Project: The purpose of this project is to find out whether "Acceptance and Commitment Therapy" is an effective therapy for the treatment of behaviour problems in adolescents with Conduct Disorder.

Please Note-

*** Participation in this research project is entirely voluntary.**

*** You can decide not to participate in this project. If you do take part, you can withdraw from it at any time.**

*** Deciding not to participate or withdrawing from participation will not affect any health care services that you are currently receiving or may receive in the future.**

*** All research results provided by you will be anonymised, and will not be used in a way that could identify you as an individual.**

*** All personal information provided by you through your involvement in this project will remain confidential and will not be released or disclosed without your separate consent, except as required by law.**

*** If at any time you have questions about this research project and/or your participation in it, you should contact the principle investigator, Dr. Stephen Myles, who will answer your questions, or, if unable to do so, will direct you to someone who can.**

*** When this research project is completed, Dr. Stephen Myles will offer to describe the research results to you in person.**

*** You will be given a copy of this consent form to retain.**

I agree to participate in this research project. I have been given a copy of this form and have read it.

Name of Participant (please print):_____

Signature:_____ Date:_____

Name of Investigator:_____

Signature:_____ Date:_____

Name of Witness:_____

Signature:_____ Date:_____

Any complaints concerning the way in which this research project has been carried out should be addressed to the following persons:

Professor C.F. Lowe, Head of Department, School of Psychology
University of Wales, Bangor, Gwynedd, LL57 2DG. Tel: 01248-351151

and

Mr. Keith Thomson, Chief Executive, North West Wales NHS Trust
Ysbyty Gwynedd, Bangor, LL57 2PW. Tel: 01248-384211

Atodiad Tri (A):

Ffurflen Gydsynio i Gymryd Rhan mewn Ymchwil gan Riant/Rhieni / Gwarcheidwa(i)d

Gweler y daflen wybodaeth i gael disgrifiad manwl o'r project ymchwil hwn.

Teitl y Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Enwau a Swyddi'r Ymchwilwyr:

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D.
Seicolegydd Clinigol dan Hyfforddiant

Cyfeiriad Cyswllt - Cwrs Seicoleg Glinigol Gogledd Cymru
Prifysgol Cymru, Bangor
Ffordd y Coleg, Bangor
Gwynedd, LL57 2DG.

Rhif Ffôn: 01248 383832

Goruchwyliwr Ymchwil: Mr. Ed Blewitt, Seicolegydd Clinigol
Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor, LL57 2EE.

Diben y Project Ymchwil: Diben y project hwn yw darganfod p'run a ydyw "Therapi Derbyn ac Ymroddiad" yn therapi effeithiol ai peidio ar gyfer trin problemau ymddygiad mewn pobl ifanc gydag Anhwylder Ymddygiad.

Sylwer os gwelwch yn dda -

- **Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol.**
- **Gellwch benderfynu peidio â chymryd rhan yn y project hwn. Os cymerwch ran, gellwch dynnu'n ôl o'r project unrhyw bryd.**

- Ni fydd penderfynu peidio â chymryd rhan neu dynnu'n ôl o'r project yn effeithio ar unrhyw wasanaethau gofal iechyd yr ydych yn eu derbyn ar hyn o bryd neu y gallech eu derbyn yn y dyfodol.

- Bydd yr holl ganlyniadau ymchwil a roddir gennych yn ddi-enw ac ni chânt eu defnyddio mewn ffordd lle gellid eich adnabod.

- Bydd pob gwybodaeth bersonol a roddir gennych wrth gymryd rhan yn y project hwn yn cael ei chadw'n gyfrinachol ac ni chaiff ei rhyddhau neu ei datgelu heb i chi roi caniatâd ar wahân, ac eithrio fel sy'n ofynnol dan y gyfraith.

- Os oes gennych gwestiynau unrhyw bryd yn ymwneud â'r project ymchwil hwn ac/neu eich rhan ynddo, dylech gysylltu â'r prif ymchwilydd, Dr Stephen Myles, a fydd yn ateb eich cwestiynau, neu eich cyfeirio at rywun arall os na all eu hateb ei hun.

- Pan fydd y project ymchwil hwn wedi gorffen, bydd Dr Stephen Myles yn cynnig disgrifio canlyniadau'r ymchwil i chi'n bersonol.

- Byddwch yn cael copi o'r ffurflen ganiatâd hon i'w chadw.

Rwyf yn cytuno i gymryd rhan yn y project ymchwil hwn. Rwyf wedi cael copi o'r ffurflen hon ac wedi ei darllen.

Enw'r Sawl sy'n Cymryd Rhan (printiwch):_____

Llofnod: _____ Dyddiad: _____

Enw'r Ymchwilydd: _____

Llofnod: _____ Dyddiad: _____

Enw Tyst: _____

Llofnod: _____ Dyddiad: _____

Dylid cyfeirio unrhyw gwynion yn ymwneud â'r ffordd y cynhaliwyd y project ymchwil hwn at y canlynol:

Yr Athro C.F. Lowe, Pennaeth yr Ysgol, Ysgol Seicoleg, Prifysgol Cymru, Bangor, Gwynedd, LL57 2DG. Ffôn: 01248-351151

a

Mr. Keith Thomson, Prif Weithredwr, Ymddiriedolaeth GIG Gogledd Orllewin Cymru, Ysbyty Gwynedd, Bangor LL57 2PW. Ffôn: 01248-384211

Appendix Three (B):

Consent Form for Participation by Adolescents in Research

Please see information sheet for a detailed description of this research project.

Title of the Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Names and Positions of Investigators:

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D.
Clinical Psychologist in Training

Contact Address- North Wales Clinical Psychology Course
University of Wales, Bangor
College Road, Bangor
Gwynedd, LL57 2DG.

Telephone Number- 01248-383832

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist
Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings
Consultant Clinical Psychologist
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor, LL57 2EE.

Purpose of the Research Project: The purpose of this project is to find out whether "Acceptance and Commitment Therapy" is an effective therapy for the treatment of behaviour problems in adolescents with Conduct Disorder.

Please Note-

*** Participation in this research project is entirely voluntary.**

*** You can decide not to participate in this project. If you do take part, you can withdraw from it at any time.**

*** Deciding not to participate or withdrawing from participation will not affect any health care services that you are currently receiving or may receive in the future.**

*** All research results provided by you will be anonymised, and will not be used in a way that could identify you as an individual.**

*** All personal information provided by you through your involvement in this project will remain confidential and will not be released or disclosed without your separate consent, except as required by law.**

*** If at any time you have questions about this research project and/or your participation in it, you should contact the principle investigator, Dr. Stephen Myles, who will answer your questions, or, if unable to do so, will direct you to someone who can.**

*** When this research project is completed, Dr. Stephen Myles will offer to describe the research results to you in person.**

*** You will be given a copy of this consent form to retain.**

I agree to participate in this research project. I have been given a copy of this form and have read it.

Name of Participant (please print):_____

Signature:_____ Date:_____

Name of Investigator:_____

Signature:_____ Date:_____

Name of Parent/Guardian:_____

Signature:_____ Date:_____

Any complaints concerning the way in which this research project has been carried out should be addressed to the following persons:

Professor C.F. Lowe, Head of Department, School of Psychology
University of Wales, Bangor, Gwynedd, LL57 2DG. Tel: 01248-351151

and

Mr. Keith Thomson, Chief Executive, North West Wales NHS Trust
Ysbyty Gwynedd, Bangor, LL57 2PW. Tel: 01248-384211

Atodiad Tri (B):

Ffurflen Gydsynio i Bobl Ifanc sy'n Cymryd Rhan mewn Ymchwil

Gweler y daflen wybodaeth i gael disgrifiad manwl o'r project ymchwil hwn.

Teitl y Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Enwau a Swyddi'r Ymchwilwyr:

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D.
Seicolegydd Clinigol dan Hyfforddiant

Cyfeiriad Cyswllt - Cwrs Seicoleg Glinigol Gogledd Cymru
Prifysgol Cymru, Bangor
Ffordd y Coleg, Bangor
Gwynedd, LL57 2DG.

Rhif Ffôn: 01248 383832

Goruchwyliwr Ymchwil: Mr. Ed Blewitt, Seicolegydd Clinigol
Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor, LL57 2EE.

Diben y Project Ymchwil: Diben y project hwn yw darganfod p'run a ydyw "Therapi Derbyn ac Ymroddiad" yn therapi effeithiol ai peidio ar gyfer trin problemau ymddygiad mewn pobl ifanc gydag Anhwylder Ymddygiad.

Sylwer os gwelwch yn dda -

- **Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol.**
- **Gellwch benderfynu peidio â chymryd rhan yn y project hwn. Os cymerwch ran, gellwch dynnu'n ôl o'r project unrhyw bryd.**

- **<u>Ni</u> fydd penderfynu peidio â chymryd rhan neu dynnu'n ôl o'r project yn effeithio ar unrhyw wasanaethau gofal iechyd yr ydych yn eu derbyn ar hyn o bryd neu y gallech eu derbyn yn y dyfodol.**

- **Bydd yr holl ganlyniadau ymchwil a roddir gennych yn ddi-enw ac ni chânt eu defnyddio mewn ffordd lle gellid eich adnabod.**

- **Bydd pob gwybodaeth bersonol a roddir gennych wrth gymryd rhan yn y project hwn yn cael ei chadw'n gyfrinachol ac ni chaiff ei rhyddhau neu ei datgelu heb i chi roi caniatâd ar wahân, ac eithrio fel sy'n ofynnol dan y gyfraith.**

- **Os oes gennych gwestiynau unrhyw bryd yn ymwneud â'r project ymchwil hwn ac/neu eich rhan ynddo, dylech gysylltu â'r prif ymchwilydd, Dr Stephen Myles, a fydd yn ateb eich cwestiynau, neu eich cyfeirio at rywun arall os na all eu hateb ei hun.**

- **Pan fydd y project ymchwil hwn wedi gorffen, bydd Dr Stephen Myles yn cynnig disgrifio canlyniadau'r ymchwil i chi'n bersonol.**

- **Byddwch yn cael copi o'r ffurflen ganiatâd hon i'w chadw.**

Rwyf yn cytuno i gymryd rhan yn y project ymchwil hwn. Rwyf wedi cael copi o'r ffurflen hon ac wedi ei darllen.

Enw'r Sawl sy'n Cymryd Rhan (printiwch): _____

Llofnod: _____ **Dyddiad:** _____

Enw'r Ymchwilydd: _____

Llofnod: _____ **Dyddiad:** _____

Enw Tyst: _____

Llofnod: _____ **Dyddiad:** _____

Dylid cyfeirio unrhyw gwynion yn ymwneud â'r ffordd y cynhaliwyd y project ymchwil hwn at y canlynol:

Yr Athro C.F. Lowe, Pennaeth yr Ysgol, Ysgol Seicoleg, Prifysgol Cymru, Bangor, Gwynedd, LL57 2DG. Ffôn: 01248-351151

a

Mr. Keith Thomson, Prif Weithredwr, Ymddiriedolaeth GIG Gogledd Orllewin Cymru, Ysbyty Gwynedd, Bangor LL57 2PW. Ffôn: 01248-384211

Appendix Four:

Information Sheet for Potential Adolescent and Parent/Guardian Participants

Title of the Research Project

"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Names and Positions of Investigators:

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D., Clinical Psychologist in Training

Contact Address- North Wales Clinical Psychology Course, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 2DG.

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist, Learning Disabilities Service Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings, Consultant Clinical Psychologist Child and Adolescent Mental Health Service, Talarfon, Holyhead Road, Bangor, LL57 2EE.

Purpose of the Research Project

The purpose of this project is to find out whether "Acceptance and Commitment Therapy" can help young people with behaviour problems to lead less problematic lives.

Procedure for the Selection of Participants

Participants will be young people, aged 14 to 17 years, who have been referred to the North West Wales NHS Trust Child and Adolescent Mental Health Service (CAMHS), at Talarfon, in Bangor, for help with behaviour problems of the Conduct Disorder type, and their parent(s)/guardians. All such potential participants will be contacted about this research project. Of those interested in participating, those who have the highest priority on the CAMHS treatment waiting list will be invited to participate.

Procedures of the Research Project

Each young person who participates will be provided with up to 24 twice weekly sessions of "Acceptance and Commitment Therapy" at a place near to him/her, by Dr. Stephen Myles.

"Acceptance and Commitment Therapy" can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

Therapy sessions will last for about one hour each, and will involve the young person talking about his/her thoughts, feelings, and behaviour with Dr. Myles. He/she will also be asked to carry out some "homework" between sessions (for example, keeping a note of how he/she feels).

Before, during, and for a few weeks after the end of therapy, young participants and their parent(s)/guardian(s) will be asked to keep notes on how often the young person's problem behaviours happen. A few times during the course of the study, the young person will be asked to complete questionnaires about his/her thoughts, feelings, and behaviour.

The research project will run for up to six months (probably four to five months). Therapy will be provided in English.

Potential Benefits and Harms of the Research Project

Participation in the research *may* benefit to both young people with behaviour problems and their parent(s)/guardian(s).

The most likely benefit for young people is that they will become more able to make and keep plans to behave in ways that are not problematic for themselves or others, and that may help them to achieve more satisfying lives. They may also find that they have less of a problem dealing with their feelings and thoughts than before.

Any improvements in the behaviour and/or state of mind of these young people is likely to improve their relationship(s) with their parent(s)/guardian(s).

No potential hazards have been identified.

Note on the Provision of Therapy and Participant Withdrawal from the Study

Therapy will be provided through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor. All case-files will be open to Dr. Judy Hutchings, Consultant Clinical Psychologist. Dr. Hutchings will supervise the provision of therapy by Dr. Myles.

Young people who participate will be able to withdraw from the study at any point, without explanation. Participants who withdraw from the study will be offered the opportunity to receive another kind of therapy from another member of the CAMHS team. Parent/guardian participants may also withdraw from the study at any point.

Note on Participant Consent

Participation in this research project is entirely voluntary. Participants can withdraw from it at any time. Deciding not to participate, or withdrawing from participation at any time, will <u>not</u> affect any health care services that are currently being received, or that may be provided in the future. All personal information provided through participation will remain confidential.

If, after reading this information sheet, you decide that you would like to participate in this research project, please read carefully and sign the consent form provided by the investigator, Dr. Stephen Myles.

Please feel free to ask Dr. Myles any questions that you may have about participation in the research project.

Atodiad Pedwar:

Taflen Wybodaeth ar gyfer Pobl Ifanc a all Gymryd Rhan a'u Rhieni/Gwarcheidwaid

Teitl y Project Ymchwil

"Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Enwau a Swyddi'r Ymchwilwyr:

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D., Seicolegydd Clinigol dan Hyfforddiant

Cyfeiriad Cyswllt - Cwrs Seicoleg Glinigol Gogledd Cymru, Prifysgol Cymru, Bangor, Ffordd y Coleg, Bangor, Gwynedd, LL57 2DG.

Goruchwyliwr Ymchwil: Mr. Ed Blewitt, Seicolegydd Clinigol, Gwasanaeth Anableddau Dysgu,Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings, Seicolegydd Clinigol Ymgynghorol Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc, Talarfon Ffordd Caergybi, Bangor, LL57 2EE.

Diben y Project Ymchwil

Diben y project hwn yw darganfod a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau ymddygiad i gael bywydau llai problemus.

Y Dreſn ar gyfer Dewis rhai i Gymryd Rhan

Bydd y rhai fydd yn cymryd rhan yn bobl ifanc, rhwng 14 a 17 oed, sydd wedi cael eu cyfeirio at Wasanaeth Iechyd Meddwl Plant a Phobl Ifanc (CAMHS) y GIG yn Talarfon, Bangor i gael cymorth â phroblemau ymddygiad o fath Anhwylder Ymddygiad, a hefyd eu rhieni/ gwarcheidwaid. Rhoddir gwybod am y project ymchwil hwn i bawb a allai fod â diddordeb mewn cymryd rhan ynddo. Wrth ystyried pobl ifanc i gymryd rhan, gwahoddir rhai sy'n cael y flaenoriaeth uchaf ar restr aros CAMHS am driniaeth.

Trefn Weithredu y Project Ymchwil

Bydd pob person ifanc sy'n cymryd rhan yn cael hyd at 24 o sesiynau "Therapi Derbyn ac Ymroddiad" ddwywaith yr wythnos gan Dr Stephen Myles mewn lle agos at eu cartrefi.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd y sesiynau therapi yn para oddeutu awr yr un ac ynddynt bydd y bobl ifanc yn siarad am eu meddyliau, eu teimladau a'u hymddygiad â Dr Myles. Hefyd gofynnir iddynt wneud "gwaith cartref" rhwng sesiynau (er enghraifft, nodi ar bapur sut y maent yn teimlo).

Cyn y therapi, yn ystod y project, ac am ychydig wythnosau ar ôl iddo orffen, gofynnir i'r bobl ifanc sy'n cymryd rhan a'u rhieni/gwarcheidwaid gadw nodiadau yn disgrifio pa mor aml y mae problemau ymddygiad y bobl ifanc yn digwydd. Ychydig o weithiau yn ystod yr astudiaeth, gofynnir i'r bobl ifanc lenwi holiaduron yn ymwneud â'u meddyliau, eu teimladau, a'u hymddygiad.

Gall y project ymchwil barhau am hyd at chwe mis (ond pedwar neu bum mis mae'n fwy na thebyg). Cynhelir y sesiynau therapi yn Saesneg.

Manteision a Pheryglon Posibl y Project Ymchwil

Gall cymryd rhan yn yr ymchwil helpu pobl ifanc gyda phroblemau ymddygiad a hefyd eu rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i bobl ifanc yw y byddant yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddynt hwy eu hunain ac eraill, a chadw atynt. Gall hynny eu helpu i gael bywydau mwy pleserus. Efallai y byddant yn gweld hefyd eu bod yn cael llai o drafferth i ddelio â'u teimladau a'u meddyliau na chynt.

Bydd unrhyw welliant yn ymddygiad ac/neu gyflwr meddwl person ifanc sy'n cymryd rhan yn yr ymchwil yn debygol o wella ei berthynas/pherthynas â'i r(h)ieni/gwarcheidwa(i)d.

Ni chredir bod unrhyw beryglon wrth gymryd rhan yn y project.

Darparu Therapi a Hawl y Sawl sy'n Cymryd Rhan i dynnu'n ôl o'r Astudiaeth

Darperir therapi drwy'r Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon, Bangor. Bydd Dr Judy Hutchings, Seicolegydd Clinigol Ymgynghorol yn cael gweld yr holl ffeiliau achos. Bydd Dr Hutchings yn goruchwylio'r ffordd y bydd Dr Myles yn rhoi'r therapi.

Gall pobl ifanc sy'n cymryd rhan dynnu'n ôl o'r astudiaeth unrhyw bryd heb roi esboniad. Bydd rhai sy'n gadael yr astudiaeth yn cael cynnig cyfle i dderbyn math arall o therapi gan aelod arall o'r tîm CAMHS. Gall rheini/gwarcheidwaid sy'n cymryd rhan hefyd dynnu'n ôl o'r astudiaeth unrhyw bryd.

Nodyn ar Gydsyniad Rhai sy'n Cymryd Rhan

Cymerir rhan yn y project ymchwil hwn yn gwbl wirfoddol. Gall y rhai sy'n cymryd rhan ynddo dynnu'n ôl unrhyw bryd. Ni fydd penderfynu peidio â chymryd rhan, neu dynnu'n ôl unrhyw bryd, yn effeithio ar unrhyw wasanaethau gofal iechyd a dderbynnir ar hyn o bryd, neu y gellir eu darparu yn y dyfodol. Bydd pob gwybodaeth bersonol a roddir wrth gymryd rhan yn cael ei chadw'n gyfrinachol.

Os penderfynwch, ar ôl darllen y daflen wybodaeth hon, yr hoffech gymryd rhan yn y project ymchwil hwn, darllenwch y ffurflen ganiatâd a roddir gan yr ymchwilydd, Dr Stephen Myles, yn ofalus os gwelwch yn dda ac yna'i harwyddo.

Mae croeso i chi ofyn unrhyw gwestiynau i Dr Myles am faterion yn ymwneud â chymryd rhan yn y project ymchwil.

Appendix Five:

Letter Informing General Practitioner of Patient's Participation

Dear Dr.

Re:

I am writing to inform you that the person named above, who is a patient of yours, and his/her parent(s)/guardian(s) have recently consented to take part in a research project aiming to evaluate the use of "Acceptance and Commitment Therapy" in the treatment of adolescents with Conduct Disorder.

Acceptance and Commitment Therapy (ACT) is a "talking" therapy, which, like cognitive behaviour therapy (CBT), involves the client discussing his/her behaviour, cognitions and emotions with the therapist during therapy sessions, and completing "homework" exercises (e.g., recording data on his/her behaviour) outside of sessions. ACT is particularly appropriate for use with clients who have emotional problems, problems with self-rules, and problems with making and keeping behavioural commitments. Adolescents with Conduct Disorder typically experience these problems.

Your patient, , will receive with up to 24 bi-weekly ACT sessions, to be provided by Dr. Stephen Myles. The exact number of sessions will depend on how rapidly he/she proceeds through the therapeutic process. Research will be completed within a period of six months from the date of this letter.

It has been made clear to that participation in this study is entirely voluntary and that non-participation will not affect eligibility for treatment in the future or status on the Child and Adolescent Mental Health Service treatment waiting list.

Therapy will be provided through the Child and Adolescent Mental Health Service, at Talarfon, in Bangor. All case-files will be open to Dr. Judy Hutchings, Consultant Clinical Psychologist and Director of the Bangor Project for Children with Disruptive Behaviour. Dr. Hutchings will supervise the provision of therapy by Dr. Myles.

Should require further treatment after the end of the provision of ACT, this will be provided by another therapist, through the Child and Adolescent Mental Health Service.

I will inform you of progress in the treatment of in due course. If you would like more information relating to this person's participation in the study, please do not hesitate to contact me.

Yours sincerely,

Dr. Stephen M. Myles (MA, Ph.D.).
Clinical Psychologist in Training
North Wales Clinical Psychology Course
University of Wales, Bangor
College Road, Bangor
Gwynedd, LL57 4DG.

Dr. Judy Hutchings*
Consultant Clinical Psychologist
North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

* Address for correspondence regarding your patient.

Appendix Six:

Psychometric Measures

Please Note-

The State-Trait Anxiety Inventory for Children (Spielberger, 1973) is not included. I have been unable to locate a copy of this standard measure, at the present time. As soon as possible, I will submit a copy for inclusion with this ethics proposal.

Appendix Seven:

Curricula Vitas of Investigators

Curriculum Vitae

Name: Dr. Stephen M. Myles, MA, Ph.D.

Address: Clinical Psychologist in Training
North Wales Clinical Psychology Course
University of Wales, Bangor
College Road, Bangor
Gwynedd, LL57 4DG.

Telephone Number: (Home) 01248-354393

E-mail Address: s_maxwell_myles@hotmail.com

Date of Birth: 29/7/71

Nationality: British

Occupation: Clinical Psychologist in Training (2nd Year)

Qualifications:

1993- MA (Hons) Psychology (1st Class), University of St. Andrews

1999- Ph.D. Psychology, University of Keele

Currently studying for D. Clin. Psychol. at University of Wales, Bangor

Ph.D. Thesis Title:

"The Achievement of a Life of Value in Community: Lessons from Radical Behaviourism, Walden Two, and Extant Intentional Communities."

Employment:

1998-1999- Employed as a behaviour therapist at Princeton Child Development Institute in Princeton, New Jersey, USA.

Training:

1994-1995- Training in Research Methodology at Manchester University

1998-1999- Traineeship in Applied Behaviour Analysis at Princeton Child Development Institute in Princeton, New Jersey, USA.

1999- 2002- Training in Clinical Psychology at University of Wales, Bangor.

2001 (March)- Three-day intensive work-shop in Acceptance and Commitment Therapy, at University of Nevada, Reno, Nevada, USA, plus one-day further training, with Professor Steven C. Hayes, Professor of Clinical Psychology, University of Nevada, Reno.

2001 (May)- One week further training in Acceptance and Commitment Therapy at University of Nevada, with Professor Steven C. Hayes.

Scholarships Held:

1994-1998- Carnegie Scholarship for the Universities of Scotland.

Dr. Myles is currently studying for a doctorate in Clinical Psychology at the University of Wales, Bangor. He has successfully completed training placements in Adult Mental Health, Older Adult Mental Health, and Child and Adolescent Mental Health.

Dr. Myles has considerable experience of conducting research in both the United Kingdom and abroad (Mexico and the USA), with non-learning disabled adults and learning disabled adults and children. He acquired extensive experience working directly with vulnerable children and their families at the Princeton Child Development Institute in Princeton, New Jersey, USA, which is a world-leading research and service provision facility, in the field of autism.

Dr. Myles has undertaken two trips to the USA for the purpose of training in Acceptance and Commitment Therapy (ACT). He has organised an ACT peer study and supervision group in Bangor. He has practiced components of ACT, under the supervision of Dr. Judy Hutchings, Consultant Clinical Psychologist, with adolescent clients during his successfully completed Child and Adolescent Mental Health training placement, undertaken as an element of his doctoral studies in Clinical Psychology. He has been asked to conduct seminars on the subject of ACT for each of the Clinical Psychology services of the North West Wales NHS Trust, by Dr. Peter Woods, Head of Service.

Brief Curriculum Vitae

Dr. Judy Hutchings,

Director, Bangor Child Behaviour Project, University of Wales, Bangor and
Consultant Clinical Psychologist, North West Wales NHS Trust,

School of Psychology, University of Wales, Bangor, email j.hutchings@bangor.ac.uk
Tel 01248-383758

Qualifications:

1973 M.A. in Occupational Psychology. Birkbeck College, University of London
1996 Doctorate in Clinical Psychology, University of Wales, Bangor
1999 Fellowship of the British Psychological Society

Recent Appointments:

1995- to date. Consultant Clinical Psychologist, North West Wales NHS (formerly Gwynedd Community Health) Trust and Director of the Bangor Project for Children with Disruptive Behaviours, School of Psychology, University of Wales, Bangor.

1992 - 1994. Principal Clinical Psychologist, Gwynedd Community Health Trust and Tutor to the Clinical Psychology Training Course, University of Wales, Bangor.

1988 - 1992. Joint Appointment, Principal Clinical Psychologist - Powys Health Authority / Lecturer - University College of North Wales, Bangor.

Honorary Appointments:

1995 Honorary Lecturer, School of Psychology, University of Wales, Bangor.

Dr. Hutchings has advanced knowledge of behavioural family work with children with severely disruptive behaviours and their families. This is the specialism for which she holds her NHS post and she is also Director of the Bangor Project for Children with Disruptive Behaviours based in the School of Psychology, University of Wales, Bangor and which she established. Her interest in this area of work is long-standing, she was one of the first clinical psychologists in Britain to work with children at risk of physical abuse following the setting up of child abuse "at risk" registers in the late 1970's. She has presented papers in Australia, Israel, Ireland and throughout America on her work as well as throughout Britian. She has international links with people researching child behaviour problems and parent training.

Dr. Hutchings is a British Psychological Society spokesperson on conduct disorder/disruptive behaviour problems. She speaks regularly, in both English and Welsh, which she has learned since coming to live in North Wales 25 years ago, to newspapers and on the radio and television about these problems and the services needed for such children and their families. Her work with children with severe behavioural problems, was the subject of a half-hour BBC Wales Week In Week Out documentary programme.

Since 1995 Dr. Hutchings has obtained almost £250,000 of grant funding, mainly from WORD, for work to research and evaluate interventions with conduct problem children. Four projects have been completed and one is ongoing. Some results have been published in academic journals and others are in preparation.

Selected Publications

Hutchings, J. (1996). Evaluating a behaviourally based parent training group: Outcomes for parents, children and health visitors. Behavioural and Cognitive Psychotherapy, 24, 149-170.

Hutchings, J., Midence, K., & Nash, S. (1997). Assessing social isolation among mothers of conduct problem children: Preliminary findings from the Community Contacts Questionnaire. Clinical Psychology Forum, 108. 24-27.

Hutchings, J., & Pope, S. (1998) Consumer satisfaction and the outcome of behavioural therapy, Clinical Psychology Forum, 116. 2-6.

Hutchings, J. & Nash, S. (1997). The Bangor Project Protocol: A resource from the Bangor Project for Children With Disruptive Behaviours Bangor: University of Wales. ISBN 1 898817 43 X

Hutchings, J., Nash, S., Williams, J. M. G. & Nightingale, D. (1998) Treatment choice for conduct problem children: Has parental autobiographical memory got a part to play? British Journal of Clinical Psychology 37. 303-312.

Hutchings, J., & Nash, S. (1998) Behaviour therapy: what do health visitors know? Community Practitioner 71. 364-367.

Hutchings, J., & Nash, S. (1998) Behavioural treatments of child behaviour problems - An overview of developments over the last 25 years. In J. Fazey and F. Poland (Eds), Realising Academic Potential Collected Papers 1996 (pp. 124-144). Bangor: University of Wales. ISBN 0 904567 87 7.

BIOGRAPHY

EDWARD BLEWITT
LLYS MEDDYG
BRYN-Y-NEUADD
LLANFAIRFECHAN
CONWY

TEL: 01248-682682, Ext: 2556

AREAS COVERED: Meirionnydd (1½ days/wk)
Bryn-y-Neuadd (1½ days/wk)

Apart from working as a clinical psychologist, I have worked in:-

(a) service research

(b) vocational service for people with Learning Disabilities, and

(c) development officer for a voluntary sector consortium.

Within LD my main interests are:

(a) eco-functional analysis

(b) the history of LD, especially the period of "race hygiene"

Outside of the LD area my dilettantism ranges over:

(a) history and philosophy of behaviourism (especially interbehaviourism and radical behaviourism).

(b) Marxism and psychology

APPENDIX EIGHT

AMENDED VERSIONS OF APPROACH LETTERS, INFORMATION SHEETS, AND CONSENT FORMS FOR POTENTIAL PARTICIPANTS AND THEIR PARENTS/GUARDIANS, AS REQUESTED BY THE NORTH WALES HEALTH AUTHORITY RESEARCH ETHICS COMMITTEE (WEST)

Initial Approach Letter to Parent(s)/Guardian(s) of Potential Adolescent Participants

Re: (Name of Potential Adolescent Participant)

Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder."

Dear (Name of Parent/Guardian)

(Name of adolescent) was referred to the Child and Adolescent Mental Health Service for help with behaviour problems by (name and title of referrer).

I am writing to let you know that in the near future I will be carrying out a research project to find out whether "Acceptance and Commitment Therapy" can help young people with behaviour problems to live less problematic lives.

"Acceptance and Commitment Therapy" is a kind of therapy that is designed to help people to realise what they really want their lives to be about, and to start to achieve such lives, despite whatever problems or difficulties they might have.

"Acceptance and Commitment Therapy" can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

Young people who join in this study will each be provided with a course of sessions of "Acceptance and Commitment Therapy", at a place near to where they live. At the moment, "Acceptance and Commitment Therapy" is not otherwise available as a treatment for young people with behaviour problems, in the North West Wales NHS Trust area.

The research project will run for up to six months (probably four to five months). Therapy sessions will be in English.

Participation in the research *may* benefit to both young people with behaviour problems and their parent(s)/guardian(s).

The most likely benefit for young people is that they will become more able to make and keep plans to behave in ways that are not problematic for themselves or others, and that may help them to achieve more satisfying lives. They may also find that they have less of a problem dealing with their feelings and thoughts than before.

Any improvements in the behaviour and/or state of mind of these young people is likely to improve their relationship(s) with their parent(s)/guardian(s).

Participation in this research project is entirely voluntary. Participants can withdraw from it at any time. Deciding not to participate, or withdrawing from participation at any time, will not affect any health care services that are currently being received, or that may be provided in the future. All personal information provided through participation will remain confidential.

If you and the person named above are interested in learning more about this project, please contact Dr. Stephen Myles, Clinical Psychologist in Training, at the telephone number or address noted on this letter. Dr. Myles will arrange to meet you at a time and place that suits you, to provide some more information.

Yours sincerely.

Dr. Stephen M. Myles (MA, Ph.D.).
Clinical Psychologist in Training
C/O North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Dr. Judy Hutchings
Consultant Clinical Psychologist
North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Llythyr Cychwynnol at Riant/Rieni / Gwarcheidwa(i)d Pobl Ifanc a all Gymryd Rhan

Parthed: (Enw'r Sawl a all Gymryd Rhan)

Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Annwyl (Enw Rhiant/Gwarcheidwad)

Cyfeiriwyd (enw'r person ifanc) at y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc gan (enw'r sawl a'i cyfeiriodd) i gael cymorth gyda phroblemau ymddygiad.

Rwy'n ysgrifennu atoch i roi gwybod i chi y byddaf yn gwneud project ymchwil yn y dyfodol agos i weld a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau ymddygiad i fyw bywydau llai problemus.

Mae "Therapi Derbyn ac Ymroddiad" yn fath o therapi a gynlluniwyd i helpu pobl i sylweddoli sut fywydau y mae arnynt eu heisiau mewn gwirionedd, ac i ddechrau cyflawni bywydau o'r fath, bydd bynnag fo'r problemau neu'r anawsterau sydd ganddynt.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd pobl ifanc sy'n ymuno â'r astudiaeth hon yn cael cyfres o sesiynau o "Therapi Derbyn ac Ymroddiad" mewn lle sy'n agos i'w cartrefi. Ar hyn o bryd nid yw "Therapi Derbyn ac Ymroddiad" ar gael fel arall fel triniaeth ar gyfer pobl ifanc â phroblemau ymddygiad yn ardal Ymddiriedolaeth GIG Gogledd Orllewin Cymru.

Gall y project ymchwil barhau am hyd at chwe mis. Mae'n debygol y bydd yn para am bedwar neu bum mis. Cynhelir y sesiynau therapi yn Saesneg.

Gall cymryd rhan yn yr ymchwil helpu pobl ifanc gyda phroblemau ymddygiad a hefyd eu rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i bobl ifanc yw y byddant yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddynt hwy eu hunain ac eraill, a chadw atynt. Gall hynny eu helpu i gael bywydau mwy pleserus. Efallai y byddant yn gweld hefyd eu bod yn cael llai o drafferth i ddelio â'u teimladau a'u meddyliau na chynt.

Bydd unrhyw welliant yn ymddygiad ac/neu gyflwr meddwl person ifanc sy'n cymryd rhan yn yr ymchwil yn debygol o wella ei berthynas/pherthynas â'i r(h)ieni/gwarcheidwa(i)d.

Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol. Gall y rhai sy'n cymryd rhan dynnu'n ôl unrhyw bryd. Ni fydd penderfynu peidio â chymryd rhan, neu dynnu'n ôl ar ôl i'r astudiaeth ddechrau, yn effeithio ar unrhyw wasanaethau gofal iechyd a roddir ar hyn o bryd, neu a all gael eu darparu yn y dyfodol. Cedwir pob gwybodaeth bersonol a roddir wrth gymryd rhan yn gyfrinachol.

Os oes gennych chi a'r sawl a enwir uchod ddiddordeb mewn cael mwy o wybodaeth am y project hwn, cysylltwch os gwelwch yn dda â Dr Stephen Myles, Seicolegydd Clinigol dan Hyfforddiant. Nodir y rhif ffôn a'r cyfeiriad ar ddiwedd y llythyr hwn. Bydd Dr Myles yn trefnu i gwrdd â chi ar adeg ac mewn lle sy'n gyfleus i chi er mwyn rhoi mwy o wybodaeth i chi.

Yn gywir

Dr Stephen M. Myles (M.A., Ph.D.)
Seicolegydd Clinigol dan Hyfforddiant
d/o Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Initial Approach Letter to Potential Adolescent Participants

Re: (Name of Potential Adolescent Participant)

Research Project: "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder."

Dear (Name of Potential Participant)

You were referred to the Child and Adolescent Mental Health Service for help with behaviour problems by (name and title of referrer).

I am writing to let you know that in the near future I will be carrying out a research project to find out whether "Acceptance and Commitment Therapy" can help young people with behaviour problems to live less problematic lives.

"Acceptance and Commitment Therapy" is a kind of therapy that is designed to help people to realise what they really want their lives to be about, and to start to achieve such lives, despite whatever problems or difficulties they might have.

"Acceptance and Commitment Therapy" can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

Young people who join in this study will each be provided with a course of sessions of "Acceptance and Commitment Therapy", at a place near to where they live. At the moment, "Acceptance and Commitment Therapy" is not otherwise available as a treatment for young people with behaviour problems, in the North West Wales NHS Trust area.

The research project will run for up to six months (probably four to five months). Therapy sessions will be in English.

Participation in the research *may* benefit to both young people with behaviour problems and their parent(s)/guardian(s).

The most likely benefit for young people is that they will become more able to make and keep plans to behave in ways that are not problematic for themselves or others, and that may help them to achieve more satisfying lives. They may also find that they have less of a problem dealing with their feelings and thoughts than before.

Any improvements in the behaviour and/or state of mind of these young people is likely to improve their relationship(s) with their parent(s)/guardian(s).

Participation in this research project is entirely voluntary. Participants can withdraw from it at any time. Deciding not to participate, or withdrawing from participation at any time, will not affect any health care services that are currently being received, or that may be provided in the future. All personal information provided through participation will remain confidential.

If you are interested in learning more about this project, please contact Dr. Stephen Myles, Clinical Psychologist in Training, at the telephone number or address noted on this letter. Dr. Myles will arrange to meet you at a time and place that suits you, to provide some more information.

Yours sincerely.

Dr. Stephen M. Myles (MA, Ph.D.).
Clinical Psychologist in Training
C/O North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Dr. Judy Hutchings
Consultant Clinical Psychologist
North Wales NHS Trust
Child and Adolescent Mental Health Service
Talarfon
Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Llythyr Cychwynnol at Bobl Ifanc a all Gymryd Rhan

Parthed: (Enw'r Person Ifanc a all Gymryd Rhan)

Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Annwyl (Enw'r Sawl a all Gymryd Rhan)

Fe gawsoch eich cyfeirio at y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc gan (enw'r sawl a'ch cyfeiriodd) i gael cymorth gyda phroblemau ymddygiad.

Rwy'n ysgrifennu atoch i roi gwybod i chi y byddaf yn gwneud project ymchwil yn y dyfodol agos i weld a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau ymddygiad i fyw bywydau llai problemus.

Mae "Therapi Derbyn ac Ymroddiad" yn fath o therapi a gynlluniwyd i helpu pobl i sylweddoli sut fywydau y mae arnynt eu heisiau mewn gwirionedd, ac i ddechrau cyflawni bywydau o'r fath, bydd bynnag fo'r problemau neu'r anawsterau sydd ganddynt.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd pobl ifanc sy'n ymuno â'r astudiaeth hon yn cael cyfres o sesiynau o "Therapi Derbyn ac Ymroddiad" mewn lle sy'n agos i'w cartrefi. Ar hyn o bryd nid yw "Therapi Derbyn ac Ymroddiad" ar gael fel arall fel triniaeth ar gyfer pobl ifanc â phroblemau ymddygiad yn ardal Ymddiriedolaeth GIG Gogledd Orllewin Cymru.

Gall y project ymchwil barhau am hyd at chwe mis. Mae'n debygol y bydd yn para am bedwar neu bum mis. Cynhelir y sesiynau therapi yn Saesneg.

Gall cymryd rhan yn yr ymchwil helpu pobl ifanc gyda phroblemau ymddygiad a hefyd eu rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i bobl ifanc yw y byddant yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddynt hwy eu hunain ac eraill, a chadw atynt. Gall hynny eu helpu i gael bywydau mwy pleserus. Efallai y byddant yn gweld hefyd eu bod yn cael llai o drafferth i ddelio â'u teimladau a'u meddyliau na chynt.

Bydd unrhyw welliant yn ymddygiad ac/neu gyflwr meddwl person ifanc sy'n cymryd rhan yn yr ymchwil yn debygol o wella ei berthynas/pherthynas â'i r(h)ieni/gwarcheidwa(i)d.

Mae cymryd rhan yn y project ymchwil hwn yn gwbl wirfoddol. Gall y rhai sy'n cymryd rhan dynnu'n ôl unrhyw bryd. Ni fydd penderfynu peidio â chymryd rhan, neu dynnu'n ôl ar ôl i'r astudiaeth ddechrau, yn effeithio ar unrhyw wasanaethau gofal iechyd a roddir arhyn o bryd, neu a all gael eu darparu yn y dyfodol. Cedwir pob gwybodaeth bersonol a roddir wrth gymryd rhan yn gyfrinachol.

Os oes gennych ddiddordeb mewn cael mwy o wybodaeth am y project hwn, cysylltwch os gwelwch yn dda â Dr Stephen Myles, Seicolegydd Clinigol dan Hyfforddiant. Nodir y rhif ffôn a'r cyfeiriad ar ddiwedd y llythyr hwn. Bydd Dr Myles yn trefnu i gwrdd â chi ar adeg ac mewn lle sy'n gyfleus i chi er mwyn rhoi mwy o wybodaeth i chi.

Yn gywir

Dr Stephen M. Myles (M.A., Ph.D.)
Seicolegydd Clinigol dan Hyfforddiant
d/o Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Ymddiriedolaeth GIG Gogledd Cymru
Gwasanaeth Iechyd Meddwl Plant a
Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor
Gwynedd, LL57 2EE

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Consent Form for Potential Parent/Guardian Participants

Consent Form for Participation in the Research Study

Title of the Research Study:

"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Names and Positions of Investigators:

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D., Clinical Psychologist in Training
North Wales Clinical Psychology Course, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 2DG.

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist, Learning Disabilities Service
Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings, Consultant Clinical Psychologist
Child and Adolescent Mental Health Service, Talarfon, Holyhead Road, Bangor, LL57 2EE.

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

Name of Parent/Guardian Participant	Date	Signature

Name of Witness	Date	Signature

Name of Researcher	Date	Signature

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales
NHS Trust

CHILD AND ADOLESCENT MENTAL
HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Ffurflen Gydsynio i Gymryd Rhan ar gyfer Rhiant/Gwarcheidwad

Ffurflen Ganiatâd i Gymryd Rhan yn yr Astudiaeth Ymchwil

Teitl y Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Enwau a Swyddi'r Ymchwilwyr:

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D.
Seicolegydd Clinigol dan Hyfforddiant

Cwrs Seicoleg Glinigol Gogledd Cymru, Prifysgol Cymru, Bangor
Ffordd y Coleg, Bangor, Gwynedd, LL57 2DG

Goruchwyliwr Ymchwil Mr. Ed Blewitt, Seicolegydd Clinigol, Gwasanaeth Anableddau Dysgu,
Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol,
Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc,
Talarfon,
Ffordd Caergybi, Bangor, LL57 2EE.

1. Rwy'n cadarnhau fy mod wedi darllen a deall y daflen wybodaeth a ddyddiwyd ..... (fersiwn .....) ar gyfer yr astudiaeth uchod a'm bod wedi cael cyfle i ofyn cwestiynau.

2. Rwy'n deall fy mod yn cymryd rhan yn gwbl wirfoddol ac y gallaf dynnu'n ôl unrhyw bryd, heb roi unrhyw reswm, heb i hynny effeithio ar fy ngofal meddygol na'm hawliau cyfreithiol.

3. Rwy'n cytuno i gymryd rhan yn yr astudiaeth uchod.

Enw'r Rhiant/Gwarcheidwad sy'n cymryd rhan	**Dyddiad**	**Llofnod**
Enw Tyst	**Dyddiad**	**Llofnod**
Enw'r Ymchwilydd	**Dyddiad**	**Llofnod**

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Consent Form for Potential Adolescent Participants

Consent Form for Participation in the Research Study

Title of the Research Study:

"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Names and Positions of Investigators:

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D., Clinical Psychologist in Training
North Wales Clinical Psychology Course, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 2DG.

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist, Learning Disabilities Service
Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings, Consultant Clinical Psychologist
Child and Adolescent Mental Health Service, Talarfon, Holyhead Road, Bangor, LL57 2EE.

1. I confirm that I have read and understand the information sheet dated .....

(version .....) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

Name of Adolescent Participant	Date	Signature

Name of Parent/Guardian	Date	Signature

Name of Researcher	Date	Signature

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales
NHS Trust

CHILD AND ADOLESCENT MENTAL
HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Ffurflen Gydsynio i Gymryd Rhan ar gyfer Cyfranogwyr Ifanc Posibl

Ffurflen Ganiatâd i Gymryd Rhan yn yr Astudiaeth Ymchwil

Teitl y Project Ymchwil: "Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Enwau a Swyddi'r Ymchwilwyr:

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D.
Seicolegydd Clinigol dan Hyfforddiant

Cwrs Seicoleg Glinigol Gogledd Cymru, Prifysgol Cymru, Bangor
Ffordd y Coleg, Bangor, Gwynedd, LL57 2DG

Goruchwyliwr Ymchwil Mr. Ed Blewitt, Seicolegydd Clinigol, Gwasanaeth Anableddau Dysgu,
Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings
Seicolegydd Clinigol Ymgynghorol
Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc
Talarfon
Ffordd Caergybi, Bangor, LL57 2EE.

1. Rwy'n cadarnhau fy mod wedi darllen a deall y daflen wybodaeth a ddyddiwyd ..... (fersiwn .....) ar gyfer yr astudiaeth uchod a'm bod wedi cael cyfle i ofyn cwestiynau.

2. Rwy'n deall fy mod yn cymryd rhan yn gwbl wirfoddol ac y gallaf dynnu'n ôl unrhyw bryd, heb roi unrhyw reswm, heb i hynny effeithio ar fy ngofal meddygol na'm hawliau cyfreithiol.

3. Rwy'n cytuno i gymryd rhan yn yr astudiaeth uchod.

Enw'r Person Ifanc sy'n cymryd rhan	**Dyddiad**	**Llofnod**
Enw Rhiant/Gwarcheidwad	**Dyddiad**	**Llofnod**
Enw'r Ymchwilydd	**Dyddiad**	**Llofnod**

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Information Sheet for Potential Parent/Guardian Participants

Study title

"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Invitation paragraph

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives, if you wish. If the meaning of any part of the information provided is not clear to you, please ask Dr. Steve Myles to explain. If you have any questions about the study, please ask Dr. Myles to answer them. Please take your time to decide whether or not you would like to take part in the study.

What is the purpose of the study?

The purpose of the study is to find out whether "Acceptance and Commitment Therapy" can help young people with problems to lead less problematic, more satisfying lives.

Acceptance and Commitment Therapy is a kind of therapy that is designed to help people to realise what they really want their lives to be about, and to start to achieve such lives, despite whatever problems or difficulties they might have.

Acceptance and Commitment Therapy can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

The study will involve providing young people with behaviour problems with a course of sessions of Acceptance and Commitment Therapy and assessing whether or not this has helped them to live less problematic, more satisfying lives.

The study will run for up to six months (probably four to five months).

Why have I been chosen to be asked to participate?

You are the parent/guardian of a young person who the Child and Adolescent Mental Health Service has been asked to try to help with the problems that he/she experiences in his/her life. The problems that he/she has are ones that Acceptance and Commitment Therapy might help him/her to deal with. It seems like he/she would be a good person to try this therapy with, to see if it can help young people with problems. We have also asked many other young people and their parent(s)/guardians if they would like join in the study. Up to nine young people and their parent(s)/guardian(s) will be able to join in the study.

Do I have to take part?

You do not have to take part in the study if you do not want to. If you do decide to take part, you will be given this information sheet to keep. You will also be asked to sign a consent form, which will say that you have agreed to take part. You can withdraw from the study at any time, without giving a reason. Withdrawing from the study will not affect the standard of care that either you or the young person involved receives from the Child and Adolescent Mental Health Service.

What will happen to me if I take part?

If both you and your adolescent decide to join in the study, he/she will be provided with up to 24 twice weekly sessions of Acceptance and Commitment Therapy at a place near to where he/she lives, by Dr. Stephen Myles.

Therapy sessions will last for about one hour each, and will involve him/her talking about his/her thoughts, feelings, and behaviour with Dr. Myles. He/she will also be asked to carry out some "homework" between sessions (for example, keeping a note of how he/she feels).

Before, during, and for a few weeks after the end of therapy, you will be asked to keep notes on the behaviour of your adolescent (for example, how often he/she behaves in certain ways). A few times during the course of the study, you will be asked to complete questionnaires about his/her behaviour.

The study will run for up to six months (probably four to five months).

Therapy will be provided in English.

Information that you and your adolescent provide over the course of the study will be compared to that provided by other young people who join in and their

parent(s)/guardian(s) to find out whether or not Acceptance and Commitment Therapy is helpful for different young people with similar problems.

What do I have to do?

During the course of the study, you will not have to do any things that are different from what you do normally, apart from the things noted above (keeping notes on the behaviour of your adolescent, sometimes completing questionnaires).

What are the alternatives for treatment?

It is difficult to help young people who have behaviour problems, and, at the moment, no-one is quite sure of the best way to do this. If you and your adolescent decide not to participate in the study, his/her name will remain on the treatment waiting list at the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, until a therapist is available to work with him/her. When a therapist is available, he/she may meet with your adolescent every week or few weeks to talk about his/her problems and try to help him/her, if that is what he/she would like.

If you and your adolescent decide to join in the study, it is likely that he/she will receive treatment sooner, and more often, than he/she would if you do not participate. As noted before, if you and your adolescent decide not to participate, the standard of treatment that you would normally receive will not be affected.

What are the possible disadvantages and risks of taking part?

No disadvantages or risks of taking part have been identified, beyond those normally associated with psychological therapy (for example, your adolescent may not like the therapy, or it may upset him/her).

What are the possible benefits of taking part?

Taking part in the study *may* be of benefit to both your adolescent and yourself.

The most likely benefit for your adolescent is that he/she will become more able to make and keep plans to behave in ways that are not problematic for him/herself or others, and that may help him/her to achieve a more satisfying life. You may also find that he/she have less of a problem dealing with his/her feelings and thoughts than before.

Any improvements in his/her behaviour and/or state of mind are likely to improve his/her relationship with you.

We hope that Acceptance and Commitment Therapy will help your adolescent. However, this cannot be guaranteed. The results that we find from this study may help us to treat other young people with problems similar to those of your adolescent.

What happens when the research study stops?

When the study stops, if your adolescent still need help with his/her problems this will be provided to him/her by a therapist from the Child and Adolescent Mental Health Service, at Talarfon, in Bangor.

What if something goes wrong?

It is not expected that anything will go wrong during the course of the study, However, if you were to have any complaints about any part of the study, you would be able to contact the following people to complain-

Mr. Keith Thomson, Chief Executive, North West Wales NHS Trust

Ysbyty Gwynedd, Bangor, LL57 2PW. Tel: 01248-384211

and

Professor C.F. Lowe, Head of Department, School of Psychology

University of Wales, Bangor, Gwynedd, LL57 2DG. Tel: 01248-351151

Any complaints will be taken seriously and will be investigated on the authority of the above named people.

Will my taking part in this study be kept confidential?

All information that is collected about your adolescent during the course of the study will be kept strictly confidential. Information about his/her treatment will be kept securely at the Child and Adolescent Mental Health Services, at Talarfon, in Bangor. Any information about him/her that is drawn from his/her treatment records will have his/her name and details removed, so that he/she cannot be identified from it. When the study is finished and a report is written about it, his/her name and details will not be included.

Your adolescent's General Practitioner (GP) will be informed that you and your adolescent are taking part in the study.

What will happen to the results of the research study?

When the study is finished, a report will be written about it. This report will describe how the study was carried out and what the results are. The report may be published in a professional journal (a special type of book for people such as psychologists who work with young people with problems). When this report has been written, you can have a copy, if you would like one. The report will not include your name or details or those of your adolescent.

Who has reviewed the study?

This study has been reviewed and approved by the North Wales Health Authority Research Ethics Committee (West Sub-Committee), Ysbyty Gwynedd, Bangor, LL57 2PW.

Contact for further information

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D., Clinical Psychologist in Training

North Wales Clinical Psychology Course, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 2DG.

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist, Learning Disabilities Service

Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings, Consultant Clinical Psychologist

Child and Adolescent Mental Health Service, Talarfon,

Holyhead Road, Bangor, LL57 2EE.

Thank you for reading this information sheet and considering taking part in the study.

Date: _____ **Version Number: _____**

If you decide to participate, you will be given a copy of this information sheet and a signed consent form to keep.

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL
HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Taflen Wybodaeth ar gyfer Rhieni/Gwarcheidwaid a all Gymryd Rhan

Teitl yr Astudiaeth

"Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Paragraff Gwahoddiad

Fe'ch gwahoddir i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu a ydych eisiau cymryd rhan, mae'n bwysig eich bod yn deall pam mae'r ymchwil yn cael ei gwneud a beth y bydd yn ei olygu. Cymerwch amser i ddarllen y wybodaeth ganlynol yn ofalus, os gwelwch yn dda, a'i thrafod â ffrindiau a pherthnasau os dymunwch. Os nad yw ystyr unrhyw ran o'r wybodaeth yn glir i chi, gofynnwch i Dr. Stephen Myles egluro os gwelwch yn dda. Os oes gennych unrhyw gwestiynau am yr astudiaeth, gofynnwch i Dr. Myles eu hateb. Cymerwch eich amser os gwelwch yn dda i benderfynu p'run a hoffech gymryd rhan yn yr astudiaeth ai peidio.

Beth yw diben yr astudiaeth?

Diben yr astudiaeth hon yw darganfod a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau i gael bywydau llai problemus a mwy boddhaol.

Mae "Therapi Derbyn ac Ymroddiad" yn fath o therapi a gynlluniwyd i helpu pobl i sylweddoli sut fywydau y mae arnynt eu heisiau mewn gwirionedd, ac i ddechrau cyflawni bywydau o'r fath, bydd bynnag fo'r problemau neu'r anawsterau sydd ganddynt.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd yr astudiaeth yn golygu rhoi cyfres o sesiynau Therapi Derbyn ac Ymroddiad i bobl ifanc â phroblemau ymddygiad ac asesu p'run a ydyw hynny wedi eu helpu ai peidio i fyw bywydau llai problemus a mwy boddhaol.

Bydd yr astudiaeth yn para am hyd at chwe mis (pedwar i bum mis mae'n debyg).

Pam y penderfynwyd gofyn i mi a hoffwn gymryd rhan?

Rydych yn riant/gwarcheidwad person ifanc y gofynnwyd i'r Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc geisio ei helpu â'r problemau sydd ganddo yn ei fywyd/bywyd. Mae'r problemau sydd ganddo/ganddi yn rhai y gallai Therapi Derbyn ac Ymroddiad ei helpu i ddelio â hwy. Mae'n ymddangos y byddai ef/hi yn rhywun da i roi prawf ar y therapi hon i weld a all helpu pobl ifanc â phroblemau. Rydym wedi gofyn i lawer o bobl ifanc eraill hefyd, ynghyd â'u rhieni/gwarcheidwaid, a fyddent yn hoffi cymryd rhan yn yr astudiaeth. Bydd hyd at naw o bobl ifanc a'u rhieni/gwarcheidwaid yn gallu ymuno â'r astudiaeth.

Oes rhaid i mi gymryd rhan?

Nid oes rhaid i chi gymryd rhan yn yr astudiaeth os nad ydych eisiau gwneud hynny. Os penderfynwch gymryd rhan byddwch yn cael y daflen wybodaeth hon i'w chadw. Hefyd gofynnir i chi arwyddo ffurflen ganiatâd a fydd yn dweud eich bod wedi cytuno i gymryd rhan. Gellwch dynnu'n ôl o'r astudiaeth unrhyw bryd heb roi rheswm. Ni fydd tynnu'n ôl o'r astudiaeth yn effeithio ar safon y gofal yr ydych chi neu'r person ifanc dan sylw yn ei dderbyn gan y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc.

Beth fydd yn digwydd i mi os cymeraf ran?

Os penderfynwch chi a'r person ifanc ymuno â'r astudiaeth bydd ef/hi yn cael hyd at 24 o sesiynau "Therapi Derbyn ac Ymroddiad" ddwywaith yr wythnos gan Dr Stephen Myles mewn lle agos at ei gartref/chartref.

Bydd y sesiynau therapi yn para oddeutu awr yr un ac ynddynt bydd ef/hi yn siarad am ei m(f)eddyliau, ei t(d)eimladau a'i (h)ymddygiad â Dr Myles. Hefyd gofynnir iddo/iddi wneud "gwaith cartref" rhwng sesiynau (er enghraifft, nodi ar bapur sut mae ef/hi yn teimlo).

Cyn y therapi, yn ystod yr astudiaeth, ac am ychydig wythnosau ar ôl iddi orffen, gofynnir i chi gadw nodiadau ar ymddygiad y person ifanc (er enghraifft, pa mor aml y mae ef/hi yn ymddwyn mewn ffyrdd arbennig). Ychydig o weithiau yn ystod yr astudiaeth, gofynnir i chi lenwi holiaduron yn ymwneud â'i (h)ymddygiad.

Gall yr astudiaeth barhau am hyd at chwe mis (ond pedwar neu bum mis mae'n fwy na thebyg). Cynhelir y sesiynau therapi yn Saesneg.

Bydd gwybodaeth a roddir gennych chi a'r person ifanc yn ystod yr astudiaeth yn cael ei chymharu â'r hyn a roddir gan bobl ifanc eraill a fydd yn cymryd rhan a'u rhieni/gwarcheidwaid i weld p'run a ydyw Therapi Derbyn ac Ymroddiad o gymorth ai peidio i wahanol bobl ifanc gyda phroblemau tebyg.

Beth fydd yn rhaid i mi ei wneud?

Yn ystod yr astudiaeth ni fydd yn rhaid i chi wneud unrhyw beth sy'n wahanol i'r hyn rydych yn ei wneud fel rheol, ar wahân i'r pethau a nodwyd uchod (cadw nodiadau ar ymddygiad y person ifanc, llenwi holiaduron weithiau).

Beth ellir ei gynnig yn lle triniaeth?

Mae'n anodd helpu pobl ifanc sydd â phroblemau ymddygiad ac ar hyn o bryd nid oes neb yn sicr iawn beth yw'r ffordd orau i wneud hynny. Os penderfynwch chi a'r person ifanc beidio â chymryd rhan yn yr astudiaeth, bydd ei (h)enw'n dal ar y rhestr aros am driniaeth yn y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor nes bo therapydd ar gael i weithio gydag ef/gyda hi

Pan fydd therapydd ar gael, efallai y bydd ef/hi yn cwrdd â'r person ifanc bob wythnos neu am ychydig wythnosau i siarad ag ef/â hi am ei b(ph)roblemau a cheisio ei helpu os bydd yn hoffi hynny.

Os penderfynwch chi a'r person ifanc ymuno â'r astudiaeth mae'n debygol y bydd ef/hi yn cael triniaeth yn gynt, ac yn amlach, nag y byddai pe baech yn peidio â chymryd rhan. Fel y nodwyd uchod, os penderfynwch chi a'r person ifanc beidio â chymryd rhan, nid effeithir ar safon y driniaeth y byddech yn ei derbyn fel rheol.

Beth yw'r anfanteision neu'r peryglon posibl wrth gymryd rhan?

Ni welwyd bod unrhyw anfanteision na pheryglon o gymryd rhan, ac eithrio'r rhai a gysylltir yn arferol â therapi seicolegol (er enghraifft, efallai na fydd y person ifanc yn hoffi'r therapi neu efallai y gall ei g(ch)ynhyrfu).

Beth yw manteision posibl cymryd rhan?

Gall cymryd rhan yn yr astudiaeth eich helpu chi a'r person ifanc.

Y fantais fwyaf tebygol i'r person ifanc yw y bydd yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau iddo ef/iddi hi ei hunan ac eraill, a chadw atynt. Gall hynny ei helpu i gael bywyd mwy pleserus. Efallai y byddwch yn gweld hefyd ei f(b)od yn cael llai o drafferth i ddelio â'i d(th)eimladau a'i f(m)eddyliau na chynt.

Bydd unrhyw welliant yn ei (h)ymddygiad ac/neu gyflwr ei f(m)eddwl yn debygol o wella ei b(ph)erthynas â chi.

Rydym yn gobeithio y bydd Therapi Derbyn ac Ymroddiad o help i'r person ifanc. Fodd bynnag, ni ellir sicrhau hynny. Gall y canlyniadau a gawn o'r astudiaeth hon ein helpu i drin pobl ifanc eraill gyda phroblemau tebyg.

Beth fydd yn digwydd pan fydd yr ymchwil yn dod i ben?

Pan ddaw'r astudiaeth i ben, os bydd y person ifanc yn dal i fod angen help gyda'i b(ph)roblemau fe gaiff hynny gan therapydd o'r Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor cyn gynted ag y bydd un ar gael.

Beth os bydd rhywbeth yn mynd o'i le?

Ni ddisgwylir y bydd unrhyw beth yn mynd o'i le yn ystod yr astudiaeth hon. Fodd bynnag, os ydych eisiau cwyno am unrhyw ran o'r astudiaeth, gellwch gysylltu â'r bobl ganlynol:

Mr. Keith Thomson, Prif Weithredwr, Ymddiriedolaeth GIG Gogledd Orllewin Cymru, Ysbyty Gwynedd, Bangor LL57 2PW. Ffôn: 01248 384211

ac

Yr Athro C.F. Lowe, Pennaeth Adran, Ysgol Seicoleg, Prifysgol Cymru, Bangor, Gwynedd LL57 2DG. Ffôn: 01248 351151

Caiff unrhyw gwynion eu cymryd o ddifrif ac ymchwilir iddynt ar awdurdod y bobl a enwir uchod.

Fydd y ffaith fy mod yn cymryd rhan yn yr astudiaeth hon yn cael ei chadw'n gyfrinachol?

Bydd pob gwybodaeth a gesglir am y person ifanc yn ystod yr astudiaeth yn cael ei chadw'n hollol gyfrinachol. Bydd gwybodaeth am ei d(th)riniaeth yn cael ei chadw'n ddiogel yn swyddfeydd y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor. Tynnir ei (h)enw a manylion amdano/amdani o unrhyw wybodaeth a godir o'i g(ch)ofnodion triniaeth fel na ellir ei (h)adnabod. Pan fydd yr astudiaeth hon wedi ei gorffen ac adroddiad yn cael ei ysgrifennu arni, nid fydd ei (h)enw a manylion amdano/amdani yn cael eu cynnwys.

Rhoddir gwybod i Feddyg Teulu'r person ifanc eich bod chi ac ef/a hi yn cymryd rhan yn yr astudiaeth.

Beth fydd yn digwydd i ganlyniadau'r astudiaeth ymchwil?

Ar ôl i'r astudiaeth gael ei gorffen, ysgrifennir adroddiad arni. Bydd yr adroddiad hwn yn disgrifio sut y gwnaed yr astudiaeth a beth oedd y canlyniadau. Efallai y caiff yr adroddiad ei gyhoeddi mewn cyfnodolyn proffesiynol (math arbennig o lyfr ar gyfer pobl fel seicolegwyr sy'n gweithio â phobl ifanc â phroblemau). Pan fydd yr adroddiad hwn wedi cael ei ysgrifennu, gellwch gael copi os hoffech un. Ni fydd yr adroddiad yn cynnwys eich enw na manylion amdanoch chi na'r person ifanc.

Pwy sydd wedï adolygu'r astudiaeth?

Mae'r astudiaeth hon wedi cael ei hadolygu a'i chymeradwyo gan Bwyllgor Moeseg Ymchwil Awdurdod Iechyd Gogledd Cymru (Is-bwyllgor y Gorllewin), Ysbyty Gwynedd, Bangor LL57 2PW.

Cysylltiadau ar gyfer gwybodaeth bellach

<u>Prif Ymchwilydd</u> - Dr. Stephen M. Myles, MA, Ph.D., Seicolegydd Clinigol dan Hyfforddiant

Cyfeiriad Cyswllt - Cwrs Seicoleg Glinigol Gogledd Cymru, Prifysgol Cymru, Bangor, Ffordd y Coleg, Bangor, Gwynedd, LL57 2DG.

<u>Goruchwyliwr Ymchwil:</u> Mr. Ed Blewitt, Seicolegydd Clinigol, Gwasanaeth Anableddau Dysgu,Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

<u>Goruchwyliwr Gwaith Clinigol:</u> Dr Judy Hutchings, Seicolegydd Clinigol Ymgynghorol Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc, Talarfon Ffordd Caergybi, Bangor, LL57 2EE.

Diolch i chi am ddarllen y daflen wybodaeth hon ac am ystyried cymryd rhan yn yr astudiaeth.

Dyddiad: _____ Rhif Fersiwn: _____

Os penderfynwch gymryd rhan, byddwch yn cael copi o'r daflen wybodaeth hon a ffurflen ganiatâd wedi ei llofnodi i'w cadw.

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Ffordd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL
HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Information Sheet for Potential Adolescent Participants

Study title

"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Conduct Disorder in Adolescents."

Invitation paragraph

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives, if you wish. If the meaning of any part of the information provided is not clear to you, please ask Dr. Stephen Myles to explain. If you have any questions about the study, please ask Dr. Myles to answer them. Please take your time to decide whether or not you would like to take part in the study.

What is the purpose of the study?

The purpose of the study is to find out whether "Acceptance and Commitment Therapy" can help young people with problems to lead less problematic, more satisfying lives.

Acceptance and Commitment Therapy is a kind of therapy that is designed to help people to realise what they really want their lives to be about, and to start to achieve such lives, despite whatever problems or difficulties they might have.

Acceptance and Commitment Therapy can be used to help people who have problems with their emotions (for example, anxious or depressive feelings), problems with thoughts about themselves (such as, "I can't do this- if I try I'll fail"), and problems with their behaviour (for instance, not being able to keep to a plan to behave in ways that they know are good for themselves and other people).

The study will involve providing young people with behaviour problems with a course of sessions of Acceptance and Commitment Therapy and assessing whether or not this has helped them to live less problematic, more satisfying lives.

The study will run for up to six months (probably four to five months).

Why have I been chosen to be asked to participate?

The Child and Adolescent Mental Health Service has been asked to try to help you with the problems that you have in your life. The problems that you have are ones that Acceptance and Commitment Therapy might help you to deal with. It seems like you would be a good person to try this therapy with, to see if it can help young people with problems. We have also asked many other young people if they would like join in the study. Up to nine young people will be able to join in the study.

Do I have to take part?

You do not have to take part in the study if you do not want to. If you do decide to take part, you will be given this information sheet to keep. You will also be asked to sign a consent form, which will say that you have agreed to take part. You can withdraw from

the study at any time, without giving a reason. Withdrawing from the study will not affect the standard of care that you receive from the Child and Adolescent Mental Health Service, or any other part of the National Health Service.

What will happen to me if I take part?

If you decide to join in the study, you will be provided with up to 24 twice weekly sessions of Acceptance and Commitment Therapy at a place near to where you live, by Dr. Stephen Myles.

Therapy sessions will last for about one hour each, and will involve you talking about your thoughts, feelings, and behaviour with Dr. Myles. You will also be asked to carry out some "homework" between sessions (for example, keeping a note of how you feel).

Before, during, and for a few weeks after the end of therapy, you will be asked to keep notes on your behaviour (for example, how often you do things that you know you should and things that you know you shouldn't). A few times during the course of the study, you will be asked to complete questionnaires about your thoughts, feelings, and behaviour.

The study will run for up to six months (probably four to five months). Therapy will be provided in English.

Information that you and your parent(s)/guardian(s) provide over the course of the study will be compared to that provided by other young people who join in and their parent(s)/guardian(s) to find out whether or not Acceptance and Commitment Therapy is helpful for different young people with similar problems.

What do I have to do?

During the course of the study, you will not have to do any things that are different from what you do normally, apart from the things noted above (attending therapy sessions, keeping notes, sometimes completing questionnaires).

What are the alternatives for treatment?

It is difficult to help young people who have behaviour problems, and, at the moment, no-one is quite sure of the best way to do this. If you decide not to participate in the study, your name will remain on the treatment waiting list at the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, until a therapist is available to work with you. When a therapist is available, he/she may meet with you every week or few weeks to talk about your problems and try to help you, if that is what you would like.

If you decide to join in the study, it is likely that you will receive therapy sooner, and more often, than you would if you do not participate. As noted before, if you decide not to participate, the standard of treatment that you would normally receive will not be affected.

What are the possible disadvantages and risks of taking part?

No disadvantages or risks of taking part have been identified, beyond those normally associated with psychological therapy (for example, you may not like the therapy or it may upset you).

What are the possible benefits of taking part?

Taking part in the study *may* be of benefit to both you and your parent(s)/guardian(s).

The most likely benefit for you is that you will become more able to make and keep plans to behave in ways that are not problematic for yourself or others, and that may help you to achieve a more satisfying life. You may also find that you have less of a problem dealing with your feelings and thoughts than before.

Any improvements in your behaviour and/or state of mind are likely to improve your relationship(s) with your parent(s)/guardian(s).

We hope that Acceptance and Commitment Therapy will help you. However, this cannot be guaranteed. The results that we find from this study may help us to treat other young people with problems similar to your own.

What happens when the research study stops?

When the study stops, if you still need help with your problems this will be provided to you by a therapist from the Child and Adolescent Mental Health Service, at Talarfon, in Bangor, as soon as one is available.

What if something goes wrong?

It is not expected that anything will go wrong during the course of the study. However, if you were to have any complaints about any part of the study, you would be able to contact the following people to complain-

Mr. Keith Thomson, Chief Executive, North West Wales NHS Trust

Ysbyty Gwynedd, Bangor, LL57 2PW. Tel: 01248-384211

and

Professor C.F. Lowe, Head of Department, School of Psychology

University of Wales, Bangor, Gwynedd, LL57 2DG. Tel: 01248-351151

Any complaints will be taken seriously and will be investigated on the authority of the above named people.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the study will be kept strictly confidential. Information about your therapy will be kept securely at the offices of the Child and Adolescent Mental Health Service, at Talarfon, in Bangor. Any information about you that is drawn from your therapy records will have your name and details removed, so that you cannot be identified from it. When the study is finished and a report is written about it, your name and details will not be included.

Your General Practitioner (GP) will be informed that you are taking part in the study.

What will happen to the results of the research study?

When the study is finished, a report will be written about it. This report will describe how the study was carried out and what the results are. The report may be published in a professional journal (a special type of book for people such as psychologists who work with young people with problems). When this report has been written, you can have a copy, if you would like one. The report will not include your name or details.

Who has reviewed the study?

This study has been reviewed and approved by the North Wales Health Authority Research Ethics Committee (West Sub-Committee), Ysbyty Gwynedd, Bangor, LL57 2PW.

Contact for further information

Principle Researcher- Dr. Stephen M. Myles, MA, Ph.D., Clinical Psychologist in Training

North Wales Clinical Psychology Course, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 2DG.

Research Supervisor- Mr. Ed Blewitt, Clinical Psychologist, Learning Disabilities Service

Bryn y Neuadd Hospital, Llanfairfechan, LL33 0HH.

Supervisor of Clinical Work- Dr. Judy Hutchings, Consultant Clinical Psychologist

Child and Adolescent Mental Health Service, Talarfon, Holyhead Road, Bangor, LL57 2EE.

Thank you for reading this information sheet and considering taking part in the study.

Date: _____ Version Number: _____

If you decide to participate, you will be given a copy of this information sheet and a signed consent form to keep.

GWASANAETH IECHYD MEDDWL
PLANT A PHOBL IFANC
(Cynorthwyo Plant)

Talarfon, Fforddd Caergybi
BANGOR, Gwynedd, LL57 2EE

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales NHS Trust

CHILD AND ADOLESCENT MENTAL
HEALTH SERVICE
(Child Guidance)

Talarfon, Holyhead Road
BANGOR, Gwynedd, LL57 2EE

Ffon/Telephone: 01248 355825
Ffacs/Fax: 01248 371109

Cyf./Ref.:JH/SM/GLT

Taflen Wybodaeth ar gyfer Pobl Ifanc a all Gymryd Rhan

Teitl yr Astudiaeth

"Gwerthusiad o Therapi Derbyn ac Ymroddiad wrth Drin Pobl Ifanc gydag Anhwylder Ymddygiad."

Paragraff Gwahoddiad

Fe'ch gwahoddir i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu a ydych eisiau cymryd rhan, mae'n bwysig eich bod yn deall pam mae'r ymchwil yn cael ei gwneud a beth y bydd yn ei olygu. Cymerwch amser i ddarllen y wybodaeth ganlynol yn ofalus, os gwelwch yn dda, a'i thrafod â ffrindiau a pherthnasau os dymunwch. Os nad yw ystyr unrhyw ran o'r wybodaeth yn glir i chi, gofynnwch i Dr. Stephen Myles egluro os gwelwch yn dda. Os oes gennych unrhyw gwestiynau am yr astudiaeth, gofynnwch i Dr. Myles eu hateb. Cymerwch eich amser os gwelwch yn dda i benderfynu p'run a hoffech gymryd rhan yn yr astudiaeth ai peidio.

Beth yw diben yr astudiaeth?

Diben yr astudiaeth hon yw darganfod a all "Therapi Derbyn ac Ymroddiad" helpu pobl ifanc gyda phroblemau i gael bywydau llai problemus a mwy boddhaol.

Mae "Therapi Derbyn ac Ymroddiad" yn fath o therapi a gynlluniwyd i helpu pobl i sylweddoli sut fywydau y mae arnynt eu heisiau mewn gwirionedd, ac i ddechrau cyflawni bywydau o'r fath, bydd bynnag fo'r problemau neu'r anawsterau sydd ganddynt.

Gellir defnyddio "Therapi Derbyn ac Ymroddiad" i helpu pobl sydd â phroblemau gyda'u hemosiynau (er enghraifft, teimladau o bryder neu iselder ysbryd), problemau â'u meddyliau amdanynt eu hunain (megis, "Fedra i ddim gwneud hyn - os gwna i geisio rwy'n sicr o fethu"), a phroblemau â'u hymddygiad (er enghraifft, methu â chadw at gynllun i ymddwyn mewn ffyrdd y maent yn gwybod sy'n dda iddynt eu hunain a phobl eraill).

Bydd yr astudiaeth yn golygu rhoi cyfres o sesiynau Therapi Derbyn ac Ymroddiad i bobl ifanc â phroblemau ymddygiad ac asesu p'run a ydyw hynny wedi eu helpu ai peidio i fyw bywydau llai problemus a mwy boddhaol.

Bydd yr astudiaeth yn para am hyd at chwe mis (pedwar i bum mis mae'n debyg).

Pam y penderfynwyd gofyn i mi a hoffwn gymryd rhan?

Gofynnwyd i'r Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc geisio eich helpu â'r problemau sydd gennych yn eich bywyd. Mae'r problemau sydd gennych yn rhai y gallai Therapi Derbyn ac Ymroddiad eich helpu i ddelio â hwy. Mae'n ymddangos y byddech chi'n rhywun da i roi prawf ar y therapi hon i weld a all helpu pobl ifanc â phroblemau. Rydym wedi gofyn i lawer o bobl ifanc eraill hefyd a fyddent yn hoffi cymryd rhan yn yr astudiaeth. Bydd hyd at naw o bobl ifanc yn gallu ymuno â'r astudiaeth.

Oes rhaid i mi gymryd rhan?

Nid oes rhaid i chi gymryd rhan yn yr astudiaeth os nad ydych eisiau gwneud hynny. Os penderfynwch gymryd rhan byddwch yn cael y daflen wybodaeth hon i'w chadw. Hefyd gofynnir i chi arwyddo ffurflen ganiatâd a fydd yn dweud eich bod wedi cytuno i gymryd rhan. Gellwch dynnu'n ôl o'r astudiaeth unrhyw bryd heb roi rheswm. Ni fydd tynnu'n ôl o'r astudiaeth yn effeithio ar safon y gofal yr ydych yn ei dderbyn gan y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc, nac unrhyw ran arall o'r Gwasanaeth Iechyd Gwladol.

Beth fydd yn digwydd i mi os cymeraf ran?

Os penderfynwch ymuno â'r astudiaeth byddwch yn cael hyd at 24 o sesiynau "Therapi Derbyn ac Ymroddiad" ddwywaith yr wythnos gan Dr Stephen Myles mewn lle agos at eich cartref.

Bydd y sesiynau therapi yn para oddeutu awr yr un ac ynddynt byddwch yn siarad am eich meddyliau, eich teimladau a'ch hymddygiad â Dr Myles. Hefyd gofynnir i chi wneud "gwaith cartref" rhwng sesiynau (er enghraifft, nodi ar bapur sut rydych yn teimlo).

Cyn y therapi, yn ystod yr astudiaeth, ac am ychydig wythnosau ar ôl iddi orffen, gofynnir i chi gadw nodiadau ar eich ymddygiad (er enghraifft, pa mor aml yr ydych yn gwneud pethau yr ydych yn gwybod y dylech eu gwneud a phethau y gwyddoch na ddylech eu gwneud). Ychydig o weithiau yn ystod yr astudiaeth, gofynnir i chi lenwi holiaduron yn ymwneud â'ch meddyliau, eich teimladau, a'ch ymddygiad.

Gall yr astudiaeth barhau am hyd at chwe mis (ond pedwar neu bum mis mae'n fwy na thebyg). Cynhelir y sesiynau therapi yn Saesneg.

Bydd gwybodaeth a roddir gennych chi a'ch rhiant/rhieni/gwarcheidwa(i)d yn ystod yr astudiaeth yn cael ei chymharu â'r hyn a roddir gan bobl ifanc eraill a fydd yn cymryd rhan a'u rhieni/gwarcheidwaid i weld p'run a ydyw Therapi Derbyn ac Ymroddiad o gymorth ai peidio i wahanol bobl ifanc gyda phroblemau tebyg.

Beth fydd yn rhaid i mi ei wneud?

Yn ystod yr astudiaeth ni fydd yn rhaid i chi wneud unrhyw beth sy'n wahanol i'r hyn rydych yn ei wneud fel rheol, ar wahân i'r pethau a nodwyd uchod (mynd i sesiynau therapi, cadw nodiadau, llenwi holiaduron weithiau).

Beth ellir ei gynnig yn lle triniaeth?

Mae'n anodd helpu pobl ifanc sydd â phroblemau ymddygiad ac ar hyn o bryd nid oes neb yn sicr iawn beth yw'r ffordd orau i wneud hynny. Os penderfynwch beidio â chymryd rhan yn yr astudiaeth, bydd eich enw'n dal ar y rhestr aros am driniaeth yn y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor nes bo therapydd ar gael i weithio gyda chi.

Pan fydd therapydd ar gael, efallai y bydd ef/hi yn cwrdd â chi bob wythnos neu am ychydig wythnosau i siarad â chi am eich problemau a cheisio eich helpu os byddech yn hoffi hynny.

Os penderfynwch ymuno â'r astudiaeth mae'n debygol y byddwch yn cael therapi yn gynt, ac yn amlach, nag y byddech pe baech yn peidio â chymryd rhan. Fel y nodwyd uchod, os penderfynwch beidio â chymryd rhan, nid effeithir ar safon y driniaeth y byddech yn ei derbyn fel rheol.

Beth yw'r anfanteision neu'r peryglon posibl wrth gymryd rhan?

Ni welwyd bod unrhyw anfanteision na pheryglon o gymryd rhan, ac eithrio'r rhai a gysylltir yn arferol â therapi seicolegol (er enghraifft, efallai na fyddwch yn hoffi'r therapi neu efallai y gall eich cynhyrfu).

Beth yw manteision posibl cymryd rhan?

Gall cymryd rhan yn yr astudiaeth eich helpu chi a'ch rhiant/rhieni / gwarcheidwa(i)d.

Y fantais fwyaf tebygol i chi yw y byddwch yn dod yn fwy abl i wneud cynlluniau i ymddwyn mewn ffyrdd nad ydynt yn achosi problemau i chi eu hunan ac eraill, a chadw atynt. Gall hynny eich helpu i gael bywyd mwy plesenus. Efallai y byddwch yn gweld hefyd eich bod yn cael llai o drafferth i ddelio â'ch teimladau a'ch meddyliau na chynt.

Bydd unrhyw welliant yn eich ymddygiad ac/neu gyflwr eich meddwl yn debygol o wella eich perthynas â'ch rhiant/rhieni/gwarcheidwa(i)d.

Rydym yn gobeithio y bydd Therapi Derbyn ac Ymroddiad o help i chi. Fodd bynnag, ni ellir sicrhau hynny. Gall y canlyniadau a gawn o'r astudiaeth hon ein helpu i drin pobl ifanc eraill gyda phroblemau tebyg i'ch rhai chi.

Beth fydd yn digwydd pan fydd yr ymchwil yn dod i ben?

Pan ddaw'r astudiaeth i ben, os byddwch yn dal i fod angen help gyda'ch problemau fe gewch hynny gan therapydd o'r Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor cyn gynted ag y bydd un ar gael.

Beth os bydd rhywbeth yn mynd o'i le?

Ni ddisgwylir y bydd unrhyw beth yn mynd o'i le yn ystod yr astudiaeth hon. Fodd bynnag, os ydych eisiau cwyno am unrhyw ran o'r astudiaeth, gellwch gysylltu â'r bobl ganlynol:

Mr. Keith Thomson, Prif Weithredwr, Ymddiriedolaeth GIG Gogledd Orllewin Cymru, Ysbyty Gwynedd, Bangor LL57 2PW. Ffôn: 01248 384211ac

Yr Athro C.F. Lowe, Pennaeth Adran, Ysgol Seicoleg, Prifysgol Cymru, Bangor, Gwynedd LL57 2DG. Ffôn: 01248 351151

Caiff unrhyw gwynion eu cymryd o ddifrif ac ymchwilir iddynt ar awdurdod y bobl a enwir uchod.

Fydd y ffaith fy mod yn cymryd rhan yn yr astudiaeth hon yn cael ei chadw'n gyfrinachol?

Bydd pob gwybodaeth a gesglir amdanoch yn ystod yr astudiaeth yn cael ei chadw'n hollol gyfrinachol. Bydd gwybodaeth am eich therapi'n cael ei chadw'n ddiogel yn swyddfeydd y Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc yn Talarfon ym Mangor. Tynnir eich enw a manylion amdanoch o unrhyw wybodaeth a godir o'ch cofnodion therapi fel na ellir eich adnabod. Pan fydd yr astudiaeth hon wedi ei gorffen ac adroddiad yn cael ei ysgrifennu arni, nid fydd eich enw a manylion amdanoch yn cael eu cynnwys.

Rhoddir gwybod i'ch Meddyg Teulu eich bod yn cymryd rhan yn yr astudiaeth.

Beth fydd yn digwydd i ganlyniadau'r astudiaeth ymchwil?

Ar ôl i'r astudiaeth gael ei gorffen, ysgrifennir adroddiad arni. Bydd yr adroddiad hwn yn disgrifio sut y gwnaed yr astudiaeth a beth oedd y canlyniadau. Efallai y caiff yr adroddiad ei gyhoeddi mewn cyfnodolyn proffesiynol (math arbennig o lyfr ar gyfer pobl fel seicolegwyr sy'n gweithio â phobl ifanc â phroblemau). Pan fydd yr adroddiad hwn wedi cael ei ysgrifennu, gellwch gael copi os hoffech un. Ni fydd yr adroddiad yn cynnwys eich enw na manylion amdanoch.

Pwy sydd wedi adolygu'r astudiaeth?

Mae'r astudiaeth hon wedi cael ei hadolygu a'i chymeradwyo gan Bwyllgor Moeseg Ymchwil Awdurdod Iechyd Gogledd Cymru (Is-bwyllgor y Gorllewin), Ysbyty Gwynedd, Bangor LL57 2PW.

Cysylltiadau ar gyfer gwybodaeth bellach

Prif Ymchwilydd - Dr. Stephen M. Myles, MA, Ph.D., Seicolegydd Clinigol dan Hyfforddiant

Cyfeiriad Cyswllt - Cwrs Seicoleg Glinigol Gogledd Cymru, Prifysgol Cymru, Bangor, Ffordd y Coleg, Bangor, Gwynedd, LL57 2DG.

Goruchwyliwr Ymchwil: Mr. Ed Blewitt, Seicolegydd Clinigol, Gwasanaeth Anableddau Dysgu,Ysbyty Bryn y Neuadd, Llanfairfechan, LL33 0HH

Goruchwyliwr Gwaith Clinigol: Dr Judy Hutchings, Seicolegydd Clinigol Ymgynghorol Gwasanaeth Iechyd Meddwl Plant a Phobl Ifanc, Talarfon Ffordd Caergybi, Bangor, LL57 2EE.

Diolch i chi am ddarllen y daflen wybodaeth hon ac am ystyried cymryd rhan yn yr astudiaeth.

Dyddiad: _____ Rhif Fersiwn: _____

Os penderfynwch gymryd rhan, byddwch yn cael copi o'r daflen wybodaeth hon a ffurflen ganiatâd wedi ei llofnodi i'w cadw.

APPENDIX NINE

CONFIRMATION OF FULL ETHICS APPROVAL BY THE NORTH WALES HEALTH AUTHORITY RESEARCH ETHICS COMMITTEE (WEST)

Pwyllgor Moeseg Ymchwil
Awdurdod Iechyd Gogledd Cymru
(Is-bwyllgorau'r Gorllewin, y Canol a'r Dwyrain)

North Wales Health Authority
Research Ethics Committee
(West, Central & East sub-committees)

WEST SUB-COMMITTEE

Ffôn/Tel : (01248) 384 877 (direct line)
Ffacs/Fax : (01248) 370 629
Llyth-el/E-mail : liz.james@nww-tr.wales.nhs.uk

Room 1/164
Ysbyty Gwynedd
Bangor
Gwynedd LL57 2PW

Dr S Myles
Clinical Psychologist in Training
North Wales Clinical Psychology Course
University of Wales, Bangor
College Road
Bangor LL57 2DG

31st July 2001.

Dear Dr Myles

CONFIRMATION OF FULL ETHICS APPROVAL

Re : An evaluation of acceptance and commitment therapy in the treatment of adolescents with conduct disorder.

I confirm that the North Wales Health Authority Research Ethics Committee (West) is pleased to grant full ethics approval to the above, on condition that:

- the protocol is followed as agreed
- the project commences within 3 years of the date of this letter
- the committee is notified of all protocol amendments and serious adverse events as soon as possible
- the committee receives annual progress reports and/or a final report within 3 months of completion of the project.

Approval from host institutions must be sought separately.

The Committee reserves the right to audit local research records relating to the above study. Ethics approval is granted on this basis.

The Committee aims to be fully ICH/GCP compliant. Please find attached a copy of our working constitution and a list of members, indicating those present at the meeting of 21.6.01 when this proposal was reviewed.

Yours sincerely

for Mr B Napier
Chairman, Ethics Committee (West)

APPENDIX TEN

REQUEST FOR AMENDMENTS TO THE RESEARCH PROTOCOL AND NOTIFICATION OF APPROVAL BY THE NORTH WALES HEALTH AUTHORITY RESEARCH ETHICS COMMITTEE (WEST)

Ymddiriedolaeth GIG
Gogledd Orllewin Cymru
North West Wales
NHS Trust

Dr. Stephen M. Myles
Clinical Psychologist in Training
Child and Adolescent Mental Health Service
Talarfon, Holyhead Road, Bangor
Gwynedd, LL57 2EE.

Liz James
North Wales Health Authority
Research Ethics Committee
West Sub-Committee
Ysbyty Gwynedd
Bangor
LL57 2PW.

7th December 2001

Dear Liz,

Re: Research Project Entitled: **"An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder."**

I would like to inform the North Wales Health Authority Research Ethics Committee (West) of two minor amendments to the research protocol of my project entitled "An Evaluation of Acceptance and Commitment Therapy in the Treatment of Adolescents with Conduct Disorder", which was approved by the committee earlier this year. Mr. Bruce Napier has informed me that the appropriate course of action in regard to amendments of this type is to bring them to your attention, for consideration by the committee.

1) In the protocol, I noted that the project would commence in August 2001, that data collection would be completed by the end of April 2002, and that the project would be "written-up" by the end of June 2002. In fact, due to personal circumstances, I was unable to commence the project until early October 2001. Therefore, it will be necessary for me to continue data collection until mid-June 2002. The project will still be "written-up" by the end of June 2002. [The design of my project (multiple base-line) allows much of the analysis of data and "write-up" to be completed as the data is gathered.]

2) I would like to add the "Acceptance and Action Questionnaire" (AAQ) (Hayes, 2000) to the measures that I will be reporting in the project "write-up." The AAQ is an easy to complete, nine item, instrument designed for use in Acceptance and Commitment Therapy. The AAQ measures the extent to which people avoid difficult thoughts and feelings. All the items included in the AAQ are questions that are typically asked of clients at various stages in the course of Acceptance and Commitment Therapy, for the purposes of both assessment and the monitoring of the effects of intervention. The AAQ allows answers to these questions to be scored and compared to pre-existing norms.

The AAQ has very recently been demonstrated to be a consistent and valid measure. Participants will be asked to complete the AAQ at assessment, during intervention, immediately post-intervention, and at follow-up. I have included a copy of the AAQ with this letter.

Please let me know if you require any additional information in regard to these amendments.

Yours sincerely,

Dr. Stephen M. Myles
Clinical Psychologist in Training
Principal Investigator.

Dr. Judy Hutchings
Consultant Clinical Psychologist
Supervisor of Clinical Work.

Acceptance and Action Questionnaire

Below you will find a list of statements. Please rate the truth of each statement as it applies to you. Use the following scale to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

_____ 1. I am able to take action on a problem even if I am uncertain what is the right thing to do.

_____ 2. I often catch myself daydreaming about things I've done and what I would do differently next time.

_____ 3. When I feel depressed or anxious, I am unable to take care of my responsibilities.

_____ 4. I rarely worry about getting my anxieties, worries, and feelings under control.

_____ 5. I'm not afraid of my feelings.

_____ 6. When I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact.

_____ 7. When I compare myself to other people, it seems that most of them are handling their lives better than I do.

_____ 8. Anxiety is bad.

_____ 9. If I could magically remove all the painful experiences I've had in my life, I would do so.

Pwyllgor Moeseg Ymchwil
Awdurdod Iechyd Gogledd Cymru
(Is-bwyllgorau'r Gorllewin, y Canol a'r Dwyrain)

North Wales Health Authority
Research Ethics Committee
(West, Central & East sub-committees)

IS-BWYLLGOR Y GORLLEWIN
WEST SUB-COMMITTEE

Ffôn/Tel : (01248) 384 877 (llinell uniongyrchol/direct line)
Ffacs/Fax : (01248) 370 629
Llyth-el/E-mail : liz.james@nww-tr.wales.nhs.uk

Uned Cefnogi Rheolaeth Glinigol /
Clinical Governance Support Unit
Ysbyty Gwynedd
Bangor
Gwynedd LL57 2PW

21.12.01

Dr SM Myles
Clinical Psychologist in Training
CAMHS
Talarfon
Holyhead Road
Bangor
LL57 2EE

Dear Dr Myles

Re: An evaluation of acceptance and commitment therapy in the treatment of adolescents with conduct disorders

Thank you for your correspondence dated 1.12.01.

The committee is pleased to approve the two amendments outlined in your letter.

Yours sincerely

for Dr P Barry
Chairman

24/12/01

SM

LITERATURE REVIEW PAPER

ACCEPTANCE AND COMMITMENT THERAPY: PHILOSOPHY, THEORY, EVIDENCE, AND FURTHER APPLICABILITY

Stephen M. Myles[1]

Department of Clinical Psychology, University of Wales, Bangor,

Gwynedd, LL57 2DG, UK

Judy Hutchings

Bangor Project for Children with Disruptive Behaviour, University of Wales, Bangor,

Gwynedd, LL57 2DG, UK

Ed Blewitt

Learning Disabilities Service, North-West Wales NHS Trust, Llanfairfechan,

Gwynedd, LL33 OHH

[1] Reprint requests or other enquiries should be sent to- Stephen M. Myles, Department of Clinical Psychology, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 4UN, UK

Abstract. Acceptance and Commitment Therapy (ACT) is one of a 'new-wave' of acceptance-focussed behaviour therapies. Proponents of ACT argue that it is worthy of the attention of those interested in behaviour change through psychotherapy, for four reasons. Each is discussed. First, ACT is based on functional contextualism, the philosophical assumptions of which, it is argued, are consistent with the natural analytic agenda of clinicians- the interpretation, prediction, and influence of important psychological events. Second, ACT offers a broadly applicable theory of psychopathology. The theory holds that much psychopathology results from *experiential avoidance*- efforts by a person to avoid, change, and/or otherwise control difficult private experiences (e.g., emotions, thoughts, memories, bodily sensations). ACT is a treatment for experiential avoidance, in which clients are guided toward willing acceptance of private experiences, in the pursuit of their values. Third, four empirical studies provide evidence for the usefulness of ACT as a treatment approach. This evidence is critically evaluated. Fourth, ACT has been used to treat many different topographically defined psychological problems and may be applicable to others. It is concluded that ACT is a promising treatment approach that requires further empirical investigation.

Keywords: Acceptance and commitment therapy (ACT), functional contextualism, experiential avoidance, functional diagnostic dimensions.

Introduction

Acceptance-focused approaches to behaviour change have been utilised by practitioners of mystical, spiritual, and religious traditions for many centuries (Hayes, 1984; 2002). Within psychology, they are present in some of the oldest forms of psychotherapy (e.g., existential therapy, gestalt therapy) (Hayes, Jacobson, Follette, & Dougher, 1994).

Recent decades have seen the rise of a 'new-wave' of psychotherapies that utilise acceptance-focused approaches, including: Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999; Hayes & Wilson, 1994; Kohlenberg, Hayes, & Tsai, 1993), Dialectical-Behaviour Therapy (Linehan, 1994; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) and Integrative Behavioral Couple Therapy (Jacobson, 1992; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Their rise has been accompanied by the application, for the first time, of the "theoretical and methodological skills of modern empirical psychology" to the analysis of acceptance-focused approaches (Hayes et al., 1994, p. 10).

Proponents of Acceptance and Commitment Therapy (ACT- said as the word 'act') argue that it is worthy of the attention of those interested in behaviour change through psychotherapy for four main reasons (e.g., Hayes at al., 1999). First, ACT is based on a philosophy that is consistent with the achievement of the natural goals of clinicians. Second, ACT offers a broadly applicable theory of psychopathology. Third, four empirical studies provide evidence for the usefulness of ACT as a treatment approach. Fourth, ACT has been used to treat many different topographically defined psychological problems and may be applicable to others.

The purpose of this paper is to inform the reader about ACT, through discussion of each of these four points. Evidence for the usefulness of ACT as a treatment approach is critically evaluated.

The philosophical base of ACT

In order to have theory, it is necessary to have philosophy (Hayes et al., 1999). A philosophy is a collection of pre-analytic assumptions and values (e.g., rules of evidence, truth criteria). These assumptions and values enable the analysis of the truthfulness of theory (Hayes & Wilson, 1995). All theories of psychopathology are based on assumptions and values. Few, however, explicate them, which makes analyses of the truthfulness of those that do not impossible.

ACT is based on the philosophy of functional contextualism (Biglan & Hayes, 1993; Hayes, 1993; Hayes & Wilson, 1995). It is important to explicate this philosophy, because it is "a subtle position, with assumptions that differ radically from normal ways of thinking about the world" (Hayes, S.C. & Hayes, L.J., 1992a, p. 245). The key assumptions of functional contextualism are as follows:

1. Psychological analysis takes place at the level of whole events. Whole events are the functionally defined behaviours of whole organisms (e.g., throwing a ball, writing a book). The purpose with which an analysis is undertaken determines the size of the event to be analysed (Hayes & Toarmino, 1999).

2. The functions of events are contextually determined. Separated from their contexts, events cannot be understood (Hayes, 1987).

3. The truthfulness of a particular analysis depends on the extent to which it is useful in achieving its goals (Hayes & Follette, 1992; Hayes & Melancon, 1989). This is the *pragmatic truth criterion.* It is not assumed that the world exists in preorganised, discoverable parts, rather "what is true is what works" (Hayes et al., 1999, p. 20).

The pragmatic truth criterion necessitates the statement of goals of analysis (Hayes, S.C. & Hayes, L.J., 1992a). The integrated, pre-analytic, goals of functional contextualism are the prediction and influence of events (Biglan, 1993). These goals have an important practical impact; because behaviour cannot be directly manipulated, analyses must point to contextual

features that are manipulable (Hayes & Wilson, 1995). Analyses that describe behaviour-behaviour relations (e.g., "he did x because he thought y") enable prediction but not influence and are therefore rejected (Gifford & Hayes, 1999; Hayes & Brownstein, 1986).

Hayes et al. (1999) argue that functional contextualism should be of interest to clinicians because it is consistent with their natural analytic agenda- the interpretation, prediction, and influence of important psychological events. According to the pragmatic truth criterion, the truthfulness of this analysis depends upon the extent to which therapies based on functional contextualism "work" as approaches to understanding and treating psychopathology. Evidence for thė usefulness of ACT as a treatment approach is evaluated later in this paper.

The ACT theory of psychopathology

The ACT theory of psychopathology holds that clients' presenting problems are often dysfunctional consequences of their efforts to avoid, change, and/or otherwise control difficult private experiences (e.g., emotions, thoughts, memories, bodily sensations). The term *experiential avoidance* describes such efforts (Hayes et al., 1999; Wilson, Follette, Hayes, & Batten, 1996).

According to the theory, difficult private experiences are not inherently problematic. Their functions are determined by the psychological contexts within which clients interact with them. Within the context of non-acceptance, they occasion experiential avoidance.

Clients' efforts to avoid/change/control difficult private experiences are inevitably unsuccessful. Such efforts typically result in increases in the frequencies and intensities of avoided experiences. This often leads to feelings of loss of control, which occasion further avoidance efforts. Over time, these efforts produce the signs and symptoms of psychological disorders. Experiential avoidance may "initiate a self-amplifying behavioral loop that can produce extreme behavioral outcomes" (Hayes & Gifford, 1997, p. 170).

For example, the collection of signs and symptoms in a person that are called 'panic disorder' (e.g., concern about having panic attacks, avoidance of situations in which attacks have occurred) can often be understood to have resulted from a series of failed efforts by that person to avoid sensations of physical arousal (e.g., accelerated heart-rate, trembling). Over time, such avoidance efforts have produced increases in the frequencies and intensities of these sensations and have led to feelings of loss of control, thoughts of concern, and overt avoidance behaviours.

Sensations of physical arousal do not necessarily occasion avoidance. They do so only within the context of non-acceptance. Within the context of acceptance, their function is different; typically, they occasion observation. A person with panic disorder may welcome normally avoided sensations when they occur in particular situations (e.g., when riding a roller-coaster or going on a date).

According to the ACT theory of psychopathology, experiential avoidance is a natural consequence of self-awareness, which is inherently painful (Friman, Hayes, & Wilson, 1998; Hayes & Bissett, 2000; Hayes et al., 1999; Hayes & Wilson, 1993). The ACT theory of psychopathology is based on a theory of language and cognition- *relational frame theory (RFT)* -that explains experiential avoidance by appealing to basic verbal processes (e.g., Hayes, 1994a, 2002; Hayes & Gifford, 1997; Hayes, S.C. & Hayes, L.J., 1992b; Wilson, Hayes, & Gregg, 2001). A large and growing body of experimental evidence supports RFT. An explication of RFT is beyond the scope of the present paper. For a book-length treatment, the reader is directed to Hayes, Barnes-Holmes, & Roche (2001).

The ACT theory holds that experiential avoidance is supported by the promotion in most human verbal cultures of the contexts of *literality* and *reason giving* (Hayes, Kohlenberg, & Melancon, 1989; Hayes et al., 1999).

Literality refers to the *fusion* of a person with her/his private experiences (e.g., "I'm bad" rather than "I'm experiencing thoughts that I'm bad"). Within the context of literality, a person fails to discriminate her/himself as the 'place' where her/his private

experiences occur, and responds to those experiences as if they are her/him. If those experiences are negatively evaluated, the person has no choice but to avoid them, to prevent anticipated psychological damage (Hayes & Wilson, 1995).

Reason giving refers to the practice of identifying reasons as the causes of problems. Within the context of reason giving, a problem occasions efforts to identify its causes. Reasons are accepted as causes. Private experiences are considered good reasons and are accepted as causes. In order to solve the problem, avoidance/change/control efforts are directed toward private experiences (Hayes, 1987; Hayes & Melancon, 1989).

Hayes et al. (1999) argue that the ACT theory of psychopathology is broadly applicable and precise. From a functional contextualist viewpoint, the truthfulness of this analysis is dependent upon the extent to which ACT "works"; theory is useful to clinicians only if it "helps get their job done" (Hayes, 1998, p. 87).

ACT is a treatment specifically for experiential avoidance. In order to make meaningful to the reader an evaluation of the available evidence for the usefulness of ACT as a treatment approach, evidence for experiential avoidance as a pathogenic process is first briefly reviewed, below. Following this, ACT as a therapy is briefly described.

Evidence for experiential avoidance as a pathogenic process

Three distinct bodies of research are cited by proponents of ACT as evidence for experiential avoidance as a pathogenic process (e.g., Hayes et al., 1999; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). These are: (a) research into the effects of the suppression of private experiences, (b) research into the effects of different styles of coping with difficult private experiences, and (c) research into the relationship between process and outcome variables in psychotherapy. Each is briefly described below, with the purpose of familiarising the reader with the evidential base that has informed the development of the

ACT theory of psychopathology. For a more detailed discussion of the evidence, the reader is directed to Hayes et al. (1996).

Efforts to suppress particular thoughts have been experimentally demonstrated to produce increases in the frequencies of those thoughts (e.g., Wegner, Schneider, Carter, & White, 1987; Wegner, Schneider, Knutson, & McMahon, 1991). Increases in the frequencies of target thoughts are most likely to occur in the contexts in which suppression efforts took place (Wegner et al., 1991). Such contexts include the emotional state of the subject at the time of suppression (Wenzlaff, Wegner, & Klein, 1991). Suppressed thoughts can subsequently function to produce the emotional state in which suppression took place.

Subjects who were instructed to suppress thoughts about the painful sensations induced by a cold-pressor procedure later rated those sensations as being more unpleasant, and recovered more slowly from their discomfort, than did subjects instructed to focus on them (Cioffi & Holloway, 1993). Subjects instructed to suppress also subsequently rated an innocuous vibration as being more unpleasant than did subjects instructed to focus. In another study, subjects encouraged to use control-focussed techniques to try to modify and regulate cold-pressor induced painful sensations demonstrated lower tolerance for those sensations than did subjects encouraged to use acceptance-focussed techniques (Hayes, Bissett, Korn, Rosenfarb, Cooper, & Grundt, 1999).

Research into coping styles has reported that the use of strategies involving efforts to suppress, change, and/or otherwise control undesirable thoughts (e.g., by supplanting them with desirable ones) negatively predicts outcomes for people experiencing a variety of psychological problems, including depression and child sexual abuse sequelae (DeGenova, Patton, Jurich, & MacDermid, 1994; Leitenberg, Greenwald, & Cado, 1992). People who suppress thoughts as a general coping strategy are more likely to experience depression and obsessional symptomology than are those who do not (Wegner & Zanakos, 1994). Further,

emotionally avoidant people are more likely to experience depression than those who are not, particularly when they are also thought suppressers.

In a review of more than 1000 studies concerning the relationship between process and outcome variables in psychotherapy, "self-relatedness" (being 'in touch' with one's feelings) was the variable most positively correlated with beneficial therapeutic outcomes (Orlinsky & Howard, 1986).

Acceptance and Commitment Therapy: A contextual approach to behaviour change

ACT is radically different in both form and function to classical cognitive-behaviour therapy (CBT) (e.g., Beck, Rush, Shaw, & Emery, 1979). The most fundamental functional difference concerns how the two therapies address private experiences. In CBT, therapeutic efforts are directed toward changing the form, frequency, and/or intensity of the psychological *content* (private experiences) considered to comprise the client's problem (Wilson, Hayes, & Gifford, 1997). In ACT, therapy focuses on changing the psychological *contexts* within which private experiences occasion dysfunctional avoidance/change/control efforts (Hayes, Follette, & Follette, 1995; Hayes & Wilson, 1995).

ACT is utilised with the purpose of helping clients to achieve successful living (Hayes et al., 1999). Successful living is defined as living in accordance with one's values. To achieve successful living, it is unnecessary for a person to have psychological content of a particular type. It is, however, necessary for the person to interact with her/his content in a manner that enables behaviour consistent with the pursuit of her/his values.

Experiential avoidance is not necessarily considered to be problematic. It is only considered problematic if it has consequences that interfere with successful living. For example, staying at home to avoid the difficult private experiences that may occur when one goes outside is only problematic if successful living necessitates leaving home (e.g., to

attend college classes- a behaviour consistent with pursuing the value of furthering one's education).

The alternative to experiential avoidance is the willing acceptance of private experiences (Hayes et al., 1999; Walser & Hayes, 1998). Behaviourally, acceptance is observing private experiences without trying to avoid/change/control them ("the act of being open to one's inner experience"- Gifford, 1994, p. 220). The ACT therapist strives to help her/his clients replace problematic experiential avoidance with willing acceptance.

The basic verbal processes that give rise to experiential avoidance cannot be prevented. However, the culturally promoted verbal contexts that support avoidance- literality and reason giving -can be weakened. Also, change efforts can be re-directed from where they are not appropriate (the realm of private experiences) to where they are appropriate (the realm of purposeful action in the pursuit of values) (Hayes & Gifford, 1997).

Experiential exercises and metaphors are much used in ACT (Hayes et al., 1999; Hayes & Wilson, 1994). There is an important reason for this. Experientially avoidant clients are 'trapped' in rigid patterns of avoidance/change/control behaviours. During therapy, they will very likely try to form and apply new rules about acceptance with the purpose of avoiding/changing/controlling their private experiences (e.g., "If I accept my difficult feelings they will go away."). This is experiential avoidance, not acceptance. Experiential exercises and metaphors are particularly useful tools for shaping acceptance because it is difficult for clients to extract rules from them. When rules are extracted, they are typically sufficiently 'loose' with regard to the contingencies specified that they do not result in rigid responding.

The theoretical focus of each of the six typical stages of ACT is briefly described, below. For descriptions of experiential exercises and metaphors typically used in each stage, the reader is directed to Hayes et al. (1999).

Creative hopelessness: Challenging the normal change agenda

The therapist's aim is to begin weakening the context of reason giving, in which problems in a client's life occasion efforts to avoid/change/control difficult private experiences. The client is guided to discern the rule that has governed previous efforts to solve her/his problems (i.e., "to solve problems, private experiences must be avoided/changed/ controlled") and to experientially contact its inevitable consequences- her/his presenting problems. This is achieved by asking the client to describe multiple examples of previous efforts to solve her/his problems and their outcomes.

Contacting the consequences of this unworkable rule functions to weaken rule-following. This begins to weaken the context of reason giving. The client typically has a sense of *creative hopelessness*; she/he has abandoned avoidance/change/control efforts and does not know what to do. This is a creative state, because abandoning these efforts 'frees' the client to learn a fundamentally different way of interacting with her/his private experiences.

Control is the problem, not the solution

Unworkable rule-following and the context of reason giving are further weakened. Consequently, the client's sensitivity to the direct consequences ('workability') of her/his behaviour increases.

The client is guided to experience and verbally understand that efforts to avoid/change/control private experiences are inevitably unsuccessful and often have dysfunctional consequences ("control is the problem, not the solution"). To help guide her/him away from unworkable rule-following, a new rule of private experiences is introduced: "Inside your head, if you aren't willing to have it, you've got it".

Building acceptance by defusing language

The therapist begins to work to weaken the context of literality. The client is guided through exercises designed to help her/him to experience that words can have multiple functions, not all of which necessitate avoidance/change/control efforts (e.g., they can be experienced as sounds and muscle movements). She/he learns that thoughts and emotions do not have to be responded to as if they are literally true.

Discovering self, defusing self

Guiding the client to contact a sense of self-as-context for private experiences further weakens literality.

Different senses-of-self emerge as natural consequences of language use (Hayes, 1995; Hayes & Gregg, 2001). These include: self-as-context (the locus from which a person experiences her/his experiences), self-as-ongoing-self-awareness (awareness of experiences), and self-as conceptualised-content (the thoughts that one has about oneself) (Hayes, 1994b; Walser & Hayes, 1998).

Typically, self-as-conceptualised-content dominates. Contact with self-as-context (the "observing self"- Hayes, 1984) weakens literality by helping the client to experience and verbally understand that she/he is not her/his private experiences. Rather, she/he is the 'place' where those experiences occur and from which they may be willingly accepted (Gifford, 1994; Hayes, 1995).

Valuing

The client is guided to identify her/his life values (e.g., to have close friendships with others) and to form workable rules to direct her/his behaviour appropriately, over the long-term.

These rules provide a framework for the achievement of successful living through purposeful action. The client is also guided to identify short-term goals consistent with her/his values, the achievement of which will keep her/his behaviour 'on track'.

Willingness and commitment.

The client is guided to pursue her/his values through committed action directed toward achieving goals. In taking such action, previously avoided private experiences are likely to be contacted. The therapist guides the client to contact these experiences and to desensitise to their functions, within a context of willing acceptance. Acceptance is done in the service of pursuing values, not for its own sake (Wilson et al., 1996).

As the client contacts the direct consequences of her/his valued behaviours, those behaviours are strengthened. Experiential avoidance, and the contexts that support it, is further weakened.

Evidence for the usefulness of ACT as a treatment approach

The application of ACT to the treatment of clients with problems of chronic depression, relationship difficulties, exhibitionism, and panic disorder has been described in single-case-studies (Blackledge & Hayes, 2001; Hayes et al., 1995; Hayes & Melancon, 1989; Paul, Marx, & Orsillo, 1999). All of these studies report clinically significant positive treatment outcomes. However, none are experimental in design, meaning that scientifically valid inferences about the relationships between treatment and outcome variables cannot be drawn from them (Kazdin, 1981).

Three randomised-controlled-trial (RCT) studies provide experimental evidence for the efficacy of ACT as a treatment approach. Zettle & Hayes (1986) compared ACT to classical CBT (Beck et al., 1979) in the treatment of depression. 18 depressed female outpatients

were assigned to either an ACT or a CBT condition. Subjects received 12-weeks of therapy, on an individual basis. Over treatment, both groups showed significant reductions in scores on the Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1960). ACT produced significantly greater reductions in scores at post-treatment and at two-month follow-up than did CBT.

The Automatic Thoughts Questionnaire (Hollon & Kendall, 1980) was used to measure the frequency and believability of subjects' negative thoughts over the course of the study. While the groups reported equivalent reductions in the frequency of negative thoughts, the ACT group reported significantly greater reductions in the believability of them at post-treatment. Zettle & Hayes argue that this finding indicates that the processes of change in the groups differed. They suggest that ACT "works as expected" by changing the context within which clients interact with their private experiences (p. 36).

In a follow-up study, 31 depressed female outpatients received 12-weeks of either ACT or CBT, on a group basis (Zettle & Raines, 1989). The two groups showed equivalent significant reductions in scores on the HRSD and the Beck Depression Inventory (Beck & Steer, 1987) at post-treatment and at two-month follow-up. The CBT group, but not the ACT group, reported significant reductions in scores on the Dysfunctional Attitude Scale (DAS) (Weissman, 1979) over the course of the study. Zettle & Raines argue that this is additional evidence that ACT and CBT are effective through different processes. They interpret the reductions in the CBT group's DAS scores as being changes in content.

Bach & Hayes (in press) examined the impact of a brief form of ACT on the rehospitalisation of psychotic clients. 80 inpatients with psychotic symptoms (hallucinations and delusions) at an acute care facility were assigned to either a treatment as usual (TAU) condition or a TAU plus ACT (TAU-ACT) condition. While hospitalised, the TAU group received medication, psycho-education, and individual psychotherapy. Post-discharge, they received community-based healthcare services, including case-management services and

medication. The TAU-ACT group received TAU (as above) plus four 45-minute sessions of ACT, while hospitalised.

At four-month follow-up, the rehospitalisation rate in the TAU-ACT group was approximately 50% less than in the TAU group, a statistically significant difference. During the four-month follow-up period, TAU-ACT group subjects remained out of hospital for an average of 22 days longer than TAU group subjects. The results were not due to differences between the groups in either medication compliance or reductions in distress or symptom frequency over the course of the study.

At follow-up, the TAU-ACT group reported a significantly greater reduction in the believability of the content of their hallucinations and delusions than did the TAU group. As in Zettle & Hayes (1986), Bach and Hayes suggest that ACT is effective by changing the context within which clients interact with their private experiences.

Further evidence for the usefulness of ACT as a treatment approach is provided by Strosahl, Hayes, Bergan, and Romano (1998). Strosahl et al. make a distinction between *clinical efficacy research* (undertaken to determine whether a treatment approach *can* work-typically in highly controlled settings) and *field effectiveness research* (undertaken to determine whether a treatment approach *does* work in normal clinical practice). In order to investigate the field effectiveness of ACT, Strosahl et al. compared the treatment outcomes of clients of two groups of qualified, practicing therapists, one trained in ACT and one not.

Eight therapists were assigned to the ACT-training group, 10 to the non-training group. Subjects self-selected their group. On average, subjects had been qualified for 5.2 years. They all worked for a private health-management–organisation, in one geographical region. ACT group subjects received one year of training, consisting of five days of workshop training, the provision of a detailed therapy manual, and monthly three-hour group-supervision meetings. The other group received no training.

Pre-training, all the new clients for one-month of therapists in each group were recruited and assessed, on a number of dimensions. They were assessed again five-months later (still

pre-training). Post-training, this process was repeated (with new clients). Clients had a wide range of problems, including disorders of adjustment, affect, anxiety, and personality, and parent-child and partner relationship problems.

Post-training, clients of ACT-trained therapists reported significantly better coping outcomes than did clients of untrained therapists, at five-month assessment. Also, significantly more clients of ACT-trained therapists had completed therapy at five-months post-initiation than had clients of untrained therapists. Further, there was much greater agreement between ACT-trained therapists and their clients that treatment was completed (respectively, 90% and 86%) than there was between untrained therapists and their clients (respectively, 78% and 49%). The results were not due to differences in clinical effectiveness between the therapist groups at pre-training or differences in problem severity between their client groups at pre-training or at post-training. Strosahl et al. argue that the results indicate that ACT training results in therapists becoming generally more effective in normal clinical practice.

Each of the studies described above has a number of commendable features. With regard to the three RCTs, particularly noteworthy are the inclusion of treatment comparison groups and the measurement of both process and outcome variables. These features are unusual in treatment outcome studies. The field effectiveness study utilises an innovative design to address a difficult research question. To date, it is the only study to demonstrate that training in a particular treatment approach produces improved clinical outcomes across the full range of clients serviced by clinicians in normal practice.

However, the studies also have a number of shortcomings and weaknesses that limit the extent to which scientifically valid inferences can be drawn from them regarding the usefulness of ACT at a treatment approach. First, there is evidence for the efficacy of ACT as a treatment approach only for depression and psychosis. With regard to the field-effectiveness study, while therapists in the ACT-trained group were clearly practicing

differently post-training as compared to pre-training, the extent to which they were using ACT in practice is unclear.

Second, two of the RCTs and the field-effectiveness study involved relatively small numbers of participants. It is possible that the results of one or more of the studies were subject to sample-bias error.

Third, all of the studies involved relatively short follow-up periods. It is unclear whether the effects reported were maintained over the long-term.

Fourth, the originator of ACT and/or his students carried out all the studies. The possibility of experimenter bias must be acknowledged.

Fifth, the researchers involved in each study and the therapist-subjects in the field-effectiveness study received training in ACT from its originator. The extent to which this is a factor in the results reported is uncertain.

Taking into account these shortcomings and weaknesses, it is reasonable to conclude only that ACT (a) holds promise both as an efficacious treatment approach for depression and psychosis and as an effective training approach for therapists in normal clinical practice, and (b) seems to involve a process of change that is consistent with the theory on which it is based. To conclude further on the basis of the available evidence would be to risk "getting ahead of the data"- a significant danger for ACT and a number of other prominent behaviour therapies (Corrigan, 2001).

In order to enable stronger and more comprehensive conclusions about both the usefulness of ACT and the process of change that it involves to be drawn further research is required. Ideally, this should address the inadequacies noted above.

Some such research is currently underway. ACT is being compared to established treatments for smokers who want to quit and polysubstance-abusing heroin addicts in large-scale RCTs involving extensive follow-up periods (Wilson & Hayes, 2000; Wilson, Hayes, & Byrd, 2000). Results so far suggest that ACT is more efficacious than the comparison treatments (Hayes, 2001, personal communication).

Experiential avoidance as a functional diagnostic dimension: Implications for the further application of ACT

Syndromal approaches to the classification of psychological problems (e.g., DSM-IV-APA, 1995) focus on the topography of clients' behaviours in the making of diagnoses. In contrast, functional approaches focus on the functional processes that are considered important in the etiology and maintenance of behaviours of concern (Hayes et al., 1996).

Experiential avoidance is a *functional diagnostic dimension* in which avoidance functions are understood to produce a great variety of dysfunctional behaviours (e.g., bingeing, overdrinking alcohol, overworking, sexual promiscuity- Bissett & Hayes, 1999). Experiential avoidance 'cuts across' many syndromal classifications (e.g., anorexia nervosa, substance dependence, obsessive-compulsive disorder).

Theoretically, as a therapy for experiential avoidance, ACT should be applicable to the treatment of clients with any psychological problem involving (a) the avoidance by them of private experiences, and (b) the utilisation by them of ineffective or dysfunctional avoidance strategies, regardless of the topography of that problem. In fact, ACT has been applied to the treatment of a great variety of topographically defined problems. In addition to those noted above, ACT has been used to treat clients with problems including: agoraphobia (Zaldivar & Hernandez, 2001); alcohol abuse (Luciano, Gomez, Hernandez, & Cabello, 2001; Velasco & Quiroga, 2001), anxiety (Luciano & Gutierrez, 2001), bereavement trauma (Luciano & Cabello, 2001), childhood sexual abuse sequelae (Wilson et al., 1996), chronic pain (Luciano, Visdomine, Gutierrez, & Montesinos, 2001), distress in families with severely physically disabled children (Biglan, 1990), PTSD (Walser & Hayes, 1998), and work-related stress (Bond & Bunce, 2000). ACT has also been developed into a model for guiding the integration of behavioural and primary health care services (Robinson & Hayes, 1997).

A consideration of the diagnostic criteria for, among others, the following syndromally classified problems suggests that ACT should be applicable to the treatment of at least some of the many clients diagnosed with them: anorexia and bulimia nervosa, conduct disorder, oppositional defiant disorder, pathological gambling, social phobia, and some forms of sexual dysfunction (APA, 1995). As yet, ACT remains untested with these problems. Interested clinicians may potentially contribute valuably to the advancement of the field by investigating the applicability of ACT to the treatment of small numbers of clients with these problems, using single-case experimental methodology (SCEM) (e.g., Hayes, Barlow, & Nelson-Grey, 1999).

A helpful tool for clinicians to use in assessing whether or not experiential avoidance is an important factor in their clients' presenting problems is the Acceptance and Action Questionnaire (AAQ) (Hayes, 2000). The AAQ is a 9-item, client-completed, questionnaire that measures the extent to which the client is experientially avoidant and unable to take valued action. It has been demonstrated to be both internally consistent and valid, and is a useful general measure of psychopathology and distress (Hayes et al., 2000).

Conclusions

Proponents of ACT argue that it offers a broadly applicable and precise theory of psychopathology. According to the assumptions of functional contextualism, the philosophy on which ACT is based, the ACT theory of psychopathology is true to the extent that it enables the understanding, prediction, and influence of important psychological events. The available evidence concerning ACT as a treatment approach *suggests* that this theory is true. A number of shortcomings and weaknesses of the evidence prevent a stronger conclusion about the truthfulness of the ACT theory of psychopathology from being drawn.

ACT is a promising treatment approach. Further empirical investigation is required before it can definitely be concluded either that ACT is efficacious in the treatment of specific psychological problems or that it has field effectiveness. Both RCT and SCEM research are potentially of value in the further investigation of ACT.

References

APA (1995). *Diagnostic and statistical manual of mental disorders: DSM-IV (4th ed.).* Washington: APA.

BACH, P.A., & HAYES, S.C. (in press). The use of Acceptance and Commitment Therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology.*

BECK, A.T., & STEER, R.A. (1987). *Beck depression inventory manual.* San Antonio, TX: Psychological Corporation.

BECK, A.T., RUSH, A.J., SHAW, B.F., & EMERY, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

BIGLAN, A. (1990). A contextual approach to treating family distress. In G. Singer & L. Irvin (Eds.), *Supporting the family: Enabling a positive adjustment in children with disabilities.* Baltimore: Paul H. Brookes.

BIGLAN, A. (1993). A functional contextualist framework for community intervention. In S.C. Hayes, L.J. Hayes, H.W. Reese, & T.R. Sarbib (Eds.), *Varieties of scientific contextualism.* Reno: Context.

BIGLAN, A., & HAYES, S.C. (1993). Should the behavioral sciences become more pragmatic? The case for functional contextualism in research on human behavior. *Applied and Preventive Psychology: Current Scientific Perspectives, 5,* 47-47.

BISSETT, R.T., & HAYES, S.C. (1999). The likely success of functional analysis tied to the DSM. *Behavior Research and Therapy, 37,* 379-383.

BLACKLEDGE, J.T., & HAYES, S.C. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology, 57,* 243-255.

BOND, F.W., & BUNCE, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *Journal of Occupational Health Psychology, 5,* 156-163.

CIOFFI, D., & HOLLOWAY, J. (1993). Delayed costs of suppressed pain. Journal of *Personality and Social Psychology, 64,* 274-282.

CORRIGAN, P.W. (2001). Getting ahead of the data: A threat to some behavior therapies. *The Behavior Therapist, 24,* 189-193.

DEGENOVA, M.K., PATTON, D.M., JURICH, J.A., & MACDERMID, S.M. (1994). Ways of coping among HIV-infected individuals. *Journal of Social Psychology, 134,* 655-663.

FRIMAN, P.C., HAYES, S.C., WILSON, K.G. (1998). Why behavior analysts should study emotion: The example of anxiety. *Journal of Applied Behavior Analysis, 31,* 137-156.

GIFFORD, E.V. (1994). Setting a course for behavior change: The verbal context of acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, & M.J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy.* Reno: Context.

GIFFORD, E.V., & HAYES, S.C. (1999). Functional contextualism: A pragmatic philosophy for behavioral science. In W. O'Donohue & R. Kitchener (Eds.), *Handbook of behaviorism.* San Diego: Academic.

HAMILTON, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23,* 56-61.

HAYES, S.C. (1984). Making sense of spirituality. *Behaviorism, 12,* 99-110.

HAYES, S.C. (1987). A contextual approach to therapeutic change. In N.S. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioral perspectives.* New York: Guilford.

HAYES, S.C. (1993). Analytic goals and the varieties of scientific contextualism. In S.C. Hayes, L.J. Hayes, H.W. Reese, & T.R. Sarbib (Eds.), *Varieties of scientific contextualism.* Reno: Context.

HAYES, S.C. (1994a). Relational frame theory: A functional approach to verbal events. In S.C. Hayes, L.J. Hayes, M. Sato, & K. Ono (Eds.), *Behavior analysis of language and*

cognition: The fourth international institute on verbal relations. Reno: Context.

HAYES, S.C. (1994b). Content, context, and the types of psychological acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, & M.J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy*. Reno: Context.

HAYES, S.C. (1995). Knowing selves. The Behavior Therapist, 18, 94-96.

HAYES, S.C. (1998). Understanding and treating the theoretical emaciation of behavior therapy. *The Behavior Therapist, 21,* 67-68 & 87.

HAYES, S.C. (2000). *Acceptance and action questionnaire*. Unpublished test. (Available from Steven C. Hayes, University of Nevada, Reno, NV 89557-0062)

HAYES, S.C. (2002). Acceptance, mindfulness, and science. *Clinical Psychology: Science and Practice, 9,* 101-106.

HAYES, S.C., BARNES-HOLMES, D., & ROCHE, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. USA: Plenum.

HAYES, S.C., BARLOW, D.H., & NELSON-GREY, R.O. (1999). *The scientist practitioner: Research and accountability in the age of managed care*. Boston: Allyn & Bacon.

HAYES, S.C., & BISSETT, R.T. (2000). Behavioral psychotherapy and the rise of clinical behavior analysis. In J. Austin & J.E. Carr (Eds.), *Handbook of applied behavior analysis*. Reno: Context.

HAYES, S.C., BISSETT, R.T., KORN, R.D., ROSENFARB, I.S., COOPER, L.D., & GRUNDT, A.M. (1999). The impact of acceptance versus control rationales on pain tolerance. *The Psychological Record, 49,* 33-47.

HAYES, S.C., BISSETT, R.T., STROSAHL, K., WILSON, K., PISTORELLO, J., TOARMINO, D., POLUSNY, M.A., BATTEN, S.V., DYKSTRA, T.A., STEWART, S.H., ZVOLENSKY, M.J., EIFERT, G.H., BERGAN, J., & FOLLETTE, W.C. (2000). *Psychometric properties of the acceptance and action questionnaire (AAQ).* Unpublished Paper.

HAYES, S.C., & BROWNSTEIN, A.J. (1986). Mentalism, behavior-behavior relations, and a behavior-analytic view of the purposes of science. *The Behavior Analyst, 9,* 175-190.

HAYES, S.C., & FOLLETTE, W.C. (1992). Can functional analysis provide a substitute for syndromal classification? *Behavioral Assessment, 1,* 345-365.

HAYES, S.C., FOLLETTE, W.C., & FOLLETTE, V.M. (1995). Behavior therapy: A contextual approach. In A.S. Gurman & S.B. Messer (Eds.), *Essential psychotherapies: Theory and practice*. New York: Guilford.

HAYES, S.C., & GIFFORD, E.V. (1997). The trouble with language: Experiential avoidance, rules, and the nature of verbal events. *Psychological Science, 8,* 170-173.

HAYES, S.C., & GREGG, J. (2001). Functional contextualism and the self. In J.C. Muran (Ed.), *Self-relations in the psychotherapy process*. Washington: APA.

HAYES, S.C., & HAYES, L.J. (1992a). Some clinical implications of contextualistic behaviorism: The example of cognition. *Behavior Therapy, 23,* 225-249.

HAYES, S.C., & HAYES, L.J. (1992b). Verbal relations and the evolution of behavior analysis. *American Psychologist, 47,* 1383-1395.

HAYES, S.C., JACOBSON, N.S., FOLLETTE, V.M., & DOUGHER, M.J. (1994). *Acceptance and change: Content and context in psychotherapy*. Reno: Context Press.

HAYES, S.C., KOHLENBERG, B.S., & MELANCON, S.M. (1989). Avoiding and altering rule-control as a strategy of clinical intervention. In S.C. Hayes (Ed.), *Rule-governed behavior: Cognition, contingencies, and instructional control*. New York: Plenum.

HAYES, S.C., & MELANCON, S.M. (1989). Comprehensive distancing, paradox, and the treatment of emotional avoidance. In L.M. Ascher (Ed.), *Therapeutic paradox*. New York: Guilford.

HAYES, S.C., STROSAHL, K., & WILSON, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.

HAYES, S.C., & TOARMINO, D. (1999). The rise of clinical behaviour analysis. *The Psychologist, 12,* 505-509.

HAYES, S.C., & WILSON, K.G. (1993). Some applied implications of a contemporary behavior-analytic account on verbal events. *The Behavior Analyst, 16,* 283-301.

HAYES, S.C., & WILSON, K.G. (1994). Acceptance and commitment therapy: Altering the verbal support for experiential avoidance. *The Behavior Analyst, 17,* 289-303.

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 behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152-1168.

HOLLON, S.D., & KENDALL, P.C. (1979). Cognitive self-statements in depression: Development of an automatic thoughts questionnaire. *Cognitive Therapy and Research, 4,* 383-395.

JACOBSON, N.S. (1992). Behavioral couple therapy: A new beginning. *Behavior Therapy, 23,* 493-506.

JACOBSON, N.S., CHRISTENSEN, A., PRINCE, S.E., CORDOVA, J., & ELDRIDGE, K. (2000). Integrative behavioral couple therapy: An acceptance-based, promising new treatment for couple discord. *Journal of Consulting and Clinical Psychology, 68,* 351-355.

KOHLENBERG, R.J., HAYES, S.C., & TSAI, M. (1993). Radical behavioral psychotherapy: 2 contemporary examples. *Clinical Psychology Review, 13,* 579-592.

LEITENBERG, H., GREENWALD, E., & CADO, S. (1992). A retrospective study of the long-term methods of coping with having been sexually abused during childhood.

Child Abuse and Neglect, 16, 399-407.

LINEHAN, M. M. (1994). Acceptance and change: The central dialectic in psychotherapy. In S.C. Hayes, N.S. Jacobson, V.M. Follette, & M.J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy*. Reno: Context.

LINEHAN, M.M., ARMSTRONG, H.E., SUAREZ, A., ALLMON, D., & HEARD, H.L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060-1064.

LUCIANO, M.C., & CABELLO, F. (2001). Bereavement and acceptance and commitment therapy. *Analisis y Modificacion de Conducta, 27,* 399-424.

LUCIANO, M.C., GOMEZ, S., HERNANDEZ, M., & CABELLO, F. (2001). Alcoholism, experiential avoidance, and acceptance and commitment therapy (ACT). *Analisis y Modificacion de Conducta, 27,* 333-371.

LUCIANO, M.C., & GUTIERREZ, O. (2001). Anxiety and acceptance and commitment therapy. *Analisis y Modificacion de Conducta, 27,* 373-398.

LUCIANO, M.C., VISDOMINE, J.C, GUTIERREZ, O., & MONTESINOS, F. (2001). ACT (acceptance and commitment therapy) and chronic pain. *Analisis y Modificacion de Conducta, 27,* 473-501.

ORLINSKY, D.E., & HOWARD, K.I. (1986). Process and outcome in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change.* New York: Wiley.

PAUL, R.H., MARX, B.P., & ORSILLO, S.M. (1999). Acceptance-based psychotherapy in the treatment of an adjudicated exhibitionist: A case example. *Behavior Therapy, 30,* 149-162.

ROBINSON, P., & HAYES, S.C. (1997). Acceptance and commitment therapy: A model for integration. In N.A. Cummings, J.L. Cummings, & J.N. Johnson (Eds.), *Behavioral health in primary care: A guide for clinical integration.* Madison: Psychosocial Press.

STROSAHL, K.D., HAYES, S.C., BERGAN, J., & ROMANO, P. (1998). Assessing the field effectiveness of acceptance and commitment therapy: An example of the manipulated training research method. *Behavior Therapy, 29,* 35-64.

VELASCO, J.A., & QUIROGA, E. (2001). Study of a clinical case of alcohol abuse treated by acceptance and commitment therapy. *Psicothema, 13,* 50-56.

WALSER, R.D., & HAYES, S.C. (1998). Acceptance and trauma survivors. In V.M. Follette, J.I. Ruzek, & F.R. Auberg (Eds.), *Cognitive-behavioral therapies for trauma.* New York: Guilford.

WEISSMAN, A.N. (1979). *The dysfunctional attitude scale: A validation study.* Unpublished doctoral dissertation. University of Pennsylvania.

WEGNER, D.M., SCHNEIDER, D.J., CARTER, S.R., & WHITE, T.L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53,* 5-13.

WEGNER, D.M., SCHNEIDER, D.J., KNUTSON, B., & MCMAHON, S.R. (1991). Polluting the stream of consciousness: The effect of thought suppression of the mind's environment. *Cognitive Therapy and Research, 15,* 141-151.

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

WENZLAFF, R.M., WEGNER, D.M., & KLEIN, S.B. (1991). The role of thought suppression in the bonding of thought and mood. *Journal of Personality and Social Psychology, 60,* 500-508.

WILSON, K.G., FOLLETTE, V.M., HAYES. S.C., & BATTEN, S.V. (1996). Acceptance theory and the treatment of abuse survivors: Implications of acceptance theory for the treatment of survivors of childhood sexual abuse. *National Center for PTSD Clinical Quarterly, 6.*

WILSON, K.G., & HAYES. S.C. (2000). Why it is crucial to understand thinking and feeling: An analysis and application to drug abuse. *The Behavior Analyst, 23,* 25-43.

WILSON, K.G., HAYES. S.C., & BYRD, M.R. (2000). Exploring the compatibilities between acceptance and commitment therapy and 12-step treatment for substance abuse. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 18,* 209-234.

WILSON, K.G., HAYES, S.C., & GIFFORD, E.V. (1997). Cognition in behavior therapy: Agreements and differences. *Journal of Behavior Therapy and Experimental Psychiatry, 28,* 53-63.

WILSON, K.G., HAYES. S.C., & GREGG, J. (2001). Psychopathology and psychotherapy. In S.C. Hayes, D. Barnes-Holmes, & B. Roche (Eds.), *Relational frame theory: A post-Skinnerian account of human language and cognition.* New York: Kluwer Academic/Plenum.

ZALDIVAR, F., & HERNANDEZ, M. (2001) Acceptance and commitment therapy: Application to an experiential avoidance with agoraphobic form. *Analisis y Modificacion de Conducta, 27,* 425-454.

ZETTLE, R.D., & HAYES, S.C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4,* 30-38.

ZETTLE, R.D., & RAINES, J.C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45,* 438-445.

APPENDIX

BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY-

INSTRUCTIONS TO AUTHORS

Third Party Material excluded from digitised copy.
Please refer to original text to see this material.

RESEARCH STUDY PAPER

THE APPLICATION OF ACCEPTANCE AND COMMITMENT THERAPY TO THE TREATMENT OF ADOLESCENTS WITH DISRUPTIVE BEHAVIOURS

Stephen M. Myles[1]

Department of Clinical Psychology, University of Wales, Bangor,

Gwynedd, LL57 2DG, UK

Judy Hutchings

Bangor Project for Children with Disruptive Behaviour, University of Wales, Bangor,

Gwynedd, LL57 2DG, UK

Ed Blewitt

Learning Disabilities Service, North-West Wales NHS Trust, Llanfairfechan,

Gwynedd, LL33 OHH

---

[1] Reprint requests or other enquiries should be sent to- Stephen M. Myles, Department of Clinical Psychology, University of Wales, Bangor, College Road, Bangor, Gwynedd, LL57 4UN, UK

Abstract. Disruptive behaviour problems (DBPs) are the most common reasons for referrals to child and adolescent mental health services. DBPs are typically stable and persistent, and often have serious negative effects for children, their families, and society. For pre-adolescents with DBPs, parent-management-training is the empirically-proven treatment of choice. It is uncertain how DBPs in adolescents may be most effectively treated. *Experiential avoidance* may be an important functional factor in DBPs in many adolescents. Experiential avoidance describes efforts by a person to avoid, change, and/or otherwise control difficult private experiences (e.g., emotions, thoughts, memories, bodily sensations). Avoidance efforts typically result in increases in the frequencies and intensities of avoided experiences. The study describes the application of Acceptance and Commitment Therapy (ACT) to the treatment of experiential avoidance in two 15-year-old adolescents with DBPs. It was hypothesised that treatment would result in clinically significant decreases in participants' (a) self-reported experiential avoidance, and (b) parent-reported frequencies of DBPs. Single-case experimental methodology, involving a multiple-baseline design, was employed. The results support the hypotheses. ACT may be an effective treatment approach for adolescents with experiential avoidance and DBPs. Further empirical investigation is required.

Keywords: Acceptance and Commitment Therapy (ACT), experiential avoidance, functional factors, disruptive behaviour problems, adolescents.

Introduction

Disruptive behaviour problems (DBPs) are the most common reasons for referrals to child and adolescent mental health services (Kazdin, 1994a; Kazdin & Wassell, 2000). Two major types are recognised- oppositional defiant disorder (ODD) and conduct disorder (CD). ODD is "a pattern of negativistic, hostile, and defiant behaviour" (APA, 1995, p. 96). CD is "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (p. 92). ODD is more common in pre-adolescents; CD is more common in adolescents. Approximately 50% of children with ODD develop CD (Lahey & Loeber, 1994).

DBPs are typically stable and persistent, and often have serious negative effects for children (in terms of impairments to their education, psychological well-being, and social functioning), their families, their teachers, and society in general (Frick & Loney, 1999; Horne & Glaser, 1993; Kazdin, 1993; Kolko, 1993; Spender & Scott, 1996). Without effective treatment, the long-term prognosis for children with DBPs is poor (Kazdin, 1994b).

For pre-adolescents with DBPs, parent-management-training (PMT) is the empirically-proven treatment approach of choice (Kazdin, 1994b; Ollendick & King, 2000; Rey & Walter, 1999; Schoenwald & Henggeler, 1999; Webster-Stratton & Hancock, 1998).

It is uncertain how DBPs in adolescents may be most effectively treated (Horne & Glaser, 1993; Kazdin, 1997). PMT is much less effective with adolescents (Altepeter & Korger, 1999; Kazdin, 2000). Two promising treatment approaches are problem-solving skills-training (PSST) (Finch, Nelson, & Ott, 1993; Shure, 1992) and multisystemic therapy (MST) (Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

PSST assumes that adolescents with DBPs lack the cognitive skills necessary to solve their problems in functional ways. PSST provides training in these skills. MST assumes

that any of the different 'systems' in which an adolescent functions (e.g., family, peers, neighbourhood, school) may be important in maintaining her/his DBPs. Where a system is identified as maintaining DBPs, MST applies an appropriate intervention (e.g., PMT, marital therapy, PSST). Both approaches have been demonstrated to result in statistically significant decreases in DBPs in adolescents, suggesting that their analyses of the factors maintaining such problems are, at least partly, true (Kazdin, 1997, 2000). However, it is uncertain whether they produce clinically significant changes (Kazdin, 1997).

An additional factor that may be important in DBPs in many adolescents is *experiential avoidance*. Experiential avoidance describes efforts by a person to avoid, change, and/or otherwise control difficult private experiences (e.g., emotions, thoughts, memories, bodily sensations) (Hayes & Gifford, 1997; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). A growing body of evidence indicates that experiential avoidance has pathogenic effects. Typically, it results in increases in the frequencies and intensities of avoided experiences and slower recovery from psychological problems. [Cf. Hayes et al, 1996, for a review of the evidence for experiential avoidance as a pathogenic process.]

Experiential avoidance is a *functional diagnostic dimension* in which avoidance functions are understood to produce a great variety of dysfunctional behaviours (e.g., bingeing, overdrinking alcohol, overworking, sexual promiscuity) (Bissett & Hayes, 1999). It is likely to be an important function in any psychological problem that involves a person engaging in (a) avoidance of difficult private experiences, and (b) the use of ineffective or dysfunctional avoidance strategies.

There are three reasons to believe that experiential avoidance may be an important functional factor in a significant proportion of adolescents with DBPs. First, difficult private experiences are very common in this population. The dysfunctional expression of anger is typically regarded as the defining characteristic of DBPs. In addition, adolescents with DBPs have high co-morbid rates of anxiety, depression, and post-traumatic stress disorder (Greenwald, 2000; Ledingham, 1999; Munir & Boulifard, 1995; Rapp & Wodarski, 1997;

Reinecke, 1995; Steiner & Wilson, 1999). Prevalence rates of 25% for anxiety and depression and 48% for emotional disorders in general have been reported (Loeber & Keenan, 1994; Rutter, Tizard, & Whitemore, 1970). The association between DBPs and emotional problems is so strong that it has been suggested that they are symptoms of a single underlying disorder (e.g., Lambert, Wahler, Andrade, & Bickman, 2001; Zoccolillo, 1992).

Second, behaviour patterns that may serve avoidance functions are very common in this population. These include behaviours noted in diagnostic criteria sets for DBPs (e.g., arguing, temper-tantrums, fighting, theft) and substance abuse (Bukstein, 2000; Stahl & Clarizio, 1999; Steiner & Dunne, 1997). A prevalence rate of 52% for substance use disorder has been reported in adolescents with CD (Reebye, Moretti, & Lessard, 1995). DBPs are strongly associated with the ultimate avoidance strategy- suicide (Pfeffer, 1991). Antisocial adolescent males are over four times more likely to commit suicide than non-antisocial males (Shaffer, 1988).

Third, adolescents with DBPs are significantly more likely to use avoidance-based, emotion-focused, cognitive coping strategies in dealing with life stresses than are those without (Ebata & Moos, 1991; Hastings, Anderson, & Kelley, 1996; Reinhard & Bowi, 1988).

A treatment approach that might benefit adolescents with experiential avoidance and DBPs is Acceptance and Commitment Therapy (ACT) (Hayes, 1987; Hayes, Strosahl, & Wilson, 1999; Kohlenberg, Hayes, & Tsai, 1993). In ACT, clients are guided to willingly accept difficult private experiences in the pursuit of their values. Therapy focuses on weakening the dominance of psychological contexts within which such experiences occasion dysfunctional avoidance/change/control efforts (Hayes, Follette, & Follette, 1995; Hayes & Wilson, 1995).

ACT has been applied to the treatment of clients with a wide range of topographically defined problems, including: alcohol abuse (Velasco & Quiroga, 2001), childhood sexual

abuse sequelae (Wilson, Follette, Hayes, & Batten, 1996), heroin addiction (Wilson & Hayes, 2000), PTSD (Walser & Hayes, 1998), and relationship difficulties (Blackledge & Hayes, 2001). Empirical evidence suggests that it is an efficacious treatment for depression and psychosis (Bach & Hayes, in press; Zettle & Hayes, 1986; Zettle & Raines, 1989).

The present paper describes the application of ACT to the treatment of two adolescents with DBPs. In both cases, experiential avoidance was identified as a likely functional factor in the etiology and maintenance of their DBPs. It was hypothesised that treatment would result in clinically significant decreases in participants' (a) self-reported experiential avoidance, and (b) parent-reported frequencies of DBPs.

Methods

Participants

[Note. Participants' names and minor details of their cases have been changed to protect confidentiality.]

Participants were recruited through a NHS Child and Adolescent Mental Health Service. All adolescents aged 14-to-15 years referred with DBPs within the previous six-months, and their parent(s), were offered the opportunity to participate. The participants were the first two adolescents to accept.

Participant one. 'Diane', 15, was referred by her family physician. She lived with her parents. Her father was employed. Her mother was a home-maker.

Diane and her parents reported that she had a two-year history of increasingly frequent arguing, non-compliance, and angry behaviours (e.g., screaming, shouting, swearing, slamming doors) at home. On numerous occasions, Diane had been verbally aggressive toward and physically assaulted (hit, kicked, and/or pushed) either one or both parents. She

had also often assaulted peers. In one incident, she "beat up" an older girl who had called her a "slut". Diane was physically aggressive toward someone else approximately every six-weeks. Early in pre-treatment, she assaulted her mother. Toward the end of pre-treatment, Diane's Head Teacher reported to her parents that she had recently been verbally aggressive toward her teachers on a number of occasions.

Participant two. 'Jack', 15. Jack's mother requested a service for him, with regard to DBPs and depression. Jack lived with her and his younger brother (10). She was a home-maker.

Jack's mother reported that he had a two-year history of increasingly frequent arguing, non-compliance, and angry behaviours (e.g., shouting, swearing, slamming doors) at home. He had often been verbally and physically aggressive toward his brother. He was occasionally verbally aggressive toward his mother. At the start of treatment, Jack pushed her aggressively during an argument. Mid-way through pre-treatment, Jack was temporarily suspended from school for truancy and non-completion of work.

Jack's mother said that he often reported symptoms and displayed signs of depression: low mood, negative thoughts about himself and the future, irritability, and lethargy.

Jack confirmed his mother's reports of his difficulties.

The participants' non-aggressive DBPs met the diagnostic criteria for ODD. Their aggressive behaviours were more characteristic of CD.

Measures

Parent-completed daily DBPs frequency record. The parent(s) of each participant was/were asked to record daily the number of times that she/he (a) argued with her/them, (b) was non-compliant with her/their requests, and (c) engaged in angry behaviours (as defined

by her/them- in both cases these included: screaming, shouting, swearing at her/them, slamming doors, striking furniture/walls).

They were instructed that an episode of one of the above behaviour classes (e.g., angry behaviours) that involved either multiple different behaviours (e.g., screaming and shouting) or the same behaviour multiple times (e.g., shouting twice) should be recorded as a single incident. An episode involving, for example, two behaviour classes (e.g., arguing and non-compliance) should be recorded twice (once as arguing and once as non-compliance).

Data recording sheets were provided (see Appendix A). The parent(s) returned completed sheets each week.

Parent-completed behaviour questionnaires. The Eyberg Child Behaviour Inventory (ECBI) (Eyeberg & Ross, 1978) (see Appendix B). The ECBI is a valid and reliable measure of disruptive behaviours (Eyberg & Robinson, 1983). It asks parents of children aged 2-to-17 years to rate 36 potentially problematic behaviours on a 1-to-7 point frequency-of-occurrence scale ranging from 'never' (1) to 'always' (7). The ratings are summed to generate an intensity score. It also asks parents if the behaviours are currently problematic for them. The responses are summed to generate a problem score.

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997, 1999) (see Appendix B). The SDQ is a valid measure of psychological problems (Goodman & Scott, 1999). It asks parents of children aged 4-to-16 to note whether 25 negative or positive attributes are 'not true', 'somewhat true', or 'certainly true' for their child. Responses are divided between 5 five-item scales, generating scores for Conduct Problems, Emotional Symptoms. Hyperactivity, Peer Problems, and Prosocial Behaviours. The first four scales are summed to generate a Total Difficulties score. An Impact supplement asks parents whether they consider their child to have a problem and, if so, to what extent it impacts on her/his functioning in different life areas. The scores in different areas are summed to generate an overall Impact score.

Each participant's mother was asked to complete both the ECBI and the SDQ early in pre-treatment and at end-of-treatment.

Adolescent-completed questionnaires. The Acceptance and Action Questionnaire (AAQ) (Hayes, 2000) (see Appendix B). The AAQ is a valid measure of both experiential avoidance and general psychopathology and distress (Hayes et al., 2000). It asks clients to rate the truthfulness of nine statements about their interactions with private experiences on a 1-to-7 point scale ranging from 'never true' (1) to 'always true' (7). The ratings are summed to generate an avoidance score.

Each participant was asked to complete the AAQ at pre-treatment, at end-of-treatment, and at two-weeks post-treatment.

The Beck Depression Inventory-Second Edition (BDI-II) (Beck, Steer, & Brown, 1996). The BDI-II is a valid and reliable measure of depressive symptamology. It asks clients to select the one of either four or seven statements on a 0-to-3 point scale that best describes their functioning over the previous two-week period, on 21 different dimensions. The ratings are summed to generate a depression score.

Jack was asked to complete the BDI-II at pre-treatment, at end-of treatment, and at two-weeks post-treatment.

Design

A multiple-baseline-across-participants, A/B, design was employed (Hayes, Barlow, & Nelson-Grey, 1999). See 'Procedures' section for details of phase shifts.

The theoretical focus of each of the six typical stages of ACT is described below. [Cf. Hayes et al (1999) for greater detail.]

Creative hopelessness: Challenging the normal change agenda. The therapist's aim is to guide the client to discern the rule that has governed her/his previous efforts to solve her/his problems (i.e., "to solve problems, private experiences must be avoided/changed/ controlled") and to experientially contact its inevitable consequences- her/his presenting problems. This is achieved by asking the client to describe multiple examples of previous efforts to solve her/his problems and their outcomes.

Contacting the consequences of this unworkable rule functions to weaken rule-following. The client typically has a sense of *creative hopelessness*, because abandoning avoidance/change/control efforts 'frees' her/him to learn a fundamentally different way of interacting with her/his private experiences.

Control is the problem, not the solution. Unworkable rule-following is further weakened. Consequently, the client's sensitivity to the direct consequences ('workability') of her/his behaviour increases.

The client is guided to experience and verbally understand that efforts to avoid/change/control private experiences are inevitably unsuccessful and often have dysfunctional consequences ("control is the problem, not the solution"). To help guide her/him away from unworkable rule-following, a new rule of private experiences is introduced: "Inside your head, if you aren't willing to have it, you've got it".

Building acceptance by defusing language. The client is guided through exercises designed to help her/him to experience that words can have multiple functions, not all of which necessitate avoidance/change/control efforts (e.g., they can be experienced as sounds and muscle movements). She/he learns that thoughts and emotions do not have to be responded to as if they are literally true.

Discovering self, defusing self. Literality is further weakened by guiding the client to contact a sense of self-as-context for private experiences. Contact with self-as-context (the "observing self"- Hayes, 1984) weakens literality by helping the client to experience and verbally understand that she/he is not her/his private experiences. Rather, she/he is the 'place' where those experiences occur and from which they may be willingly accepted (Gifford, 1994; Hayes, 1995).

Valuing. The client is guided to identify her/his life values (e.g., to have close friendships with others) and to form workable rules to direct her/his behaviour appropriately, over the long-term. These rules provide a framework for the achievement of successful living through purposeful action. The client is also guided to identify short-term goals consistent with her/his values, the achievement of which will keep her/his behaviour 'on track'.

Willingness and commitment. The client is guided to pursue her/his values through committed action directed toward achieving goals. In taking such action, previously avoided private experiences are likely to be contacted. The therapist guides the client to contact these experiences and to desensitise to their functions, within a context of willing acceptance. Acceptance is done in the service of pursuing values, not for its own sake (Wilson et al., 1996).

As the client contacts the direct consequences of her/his valued behaviours, those behaviours are strengthened. Experiential avoidance, and the contexts that support it, is further weakened.

Experiential exercises and metaphors are much used in ACT (Hayes & Wilson, 1994). For an explanation of why they are used and descriptions of those typically used, the reader is directed to Hayes et al. (1999). [See Appendix C for descriptions of those used in the present study.]

Procedure

Assessment and treatment sessions were provided to each participant individually in a therapy room at a NHS outpatients' mental health clinic. Sessions typically lasted between 40 and 50 minutes.

Pre-treatment. Assessment sessions took place, on average, once a week. Each participant was asked about her/his relevant personal and family histories, current functioning, and general style of coping with difficulties. Two assessment sessions were conducted with each participant's parent(s), at home, for the purpose of gathering additional information.

Diane and Jack entered baseline at the same point in real time. Diane remained in baseline for four-weeks, receiving three assessment sessions. Jack remained for 10-weeks, receiving six sessions. The timings of the phase changes from baseline to treatment were determined by the completion of each participant's assessment.

Diane- case history

Prior to approximately two-years pre-assessment, Diane did not engage in disruptive behaviours to a problematic extent. She enjoyed positive social relations with her parents. When distressed, she would obtain comfort and support from her mother.

Approximately two-years pre-assessment, Diane's mother had a car accident that caused her serious health concerns, for a few months. Diane's mother and father attempted to conceal these difficulties from her, in order to avoid causing her distress.

Also around this time, Diane was being bullied by peers at school. On one occasion, she was badly "beaten-up". Diane's parents were unaware of the bullying, at least partly because they were preoccupied with her mother's serious health concerns.

Diane became aware that her parents were concealing something important from her. In addition to the distress resulting from being bullied, she began to experience feelings and thoughts of concern, distrust, resentment, and anger toward her parents, both because she knew that they were concealing something and because they were not helping her. Diane's style of coping with difficult private experiences changed from one of expressing them to others to one of concealing and suppressing them. She began to "bottle things up inside till I explode".

At this time, Diane's behaviour started to become problematic at home. She also started to behave aggressively toward peers who she perceived to be 'attacking' her verbally. Her DBPs gradually increased in frequency and intensity over the following two-year period, and generalised to school.

From an ACT perspective, experiential avoidance is apparently an important functional factor in Diane's DBPs. Diane's adverse circumstances at home and school caused her to have intensely difficult private experiences. Unable to express these to her mother, she suppressed them, which resulted in increases in their frequencies and intensities.

It is hypothesised that Diane's non-aggressive DBPs followed from her thoughts and feelings of distrust, resentment, and anger toward her parents, and served the function of avoiding them. Her occasional aggressive behaviours functioned, in the short-term, to avoid intolerable levels of difficult private experiences resulting from confrontational situations (e.g., arguments with her parents, verbal 'attacks' by peers). In the long-term, they functioned to increase these experiences.

Jack- case history

Jack's parents divorced during his infancy. He lived with his mother until eight years of age. At this age, he went to live with his father, partly because his mother had an alcohol-

abuse problem. Two-years later, he returned to live with his mother. At this time, Jack's behaviour started to become problematic at home. He also started to display signs and report symptoms of depression. After a few months, his difficulties stabilised at levels that were tolerable for both him and his mother.

Approximately two-years pre-assessment, Jack's difficulties became problematic again. His DBPs gradually increased in frequency and intensity over the following two-years. They were typically most severe during periods of very low mood.

Since the age of five, Jack had lived in numerous locations and attended many different schools. With each move, his social relationships were disrupted. He had friends, but did not think that they knew him well or that he could rely on them.

Jack did not enjoy school; he had difficulty concentrating and was doing poorly academically. He sometimes truanted.

Jack said that he did not often experience emotions other than anger, sadness, and boredom. He had difficulty describing situations in which he had felt happy. He could not remember much about the period of time during which he went to live with his father, but knew that he had felt confused and distressed about being separated from his mother.

Jack's style of coping with difficult private experiences was to try not to think or feel them. He often smoked cannabis when he felt low, because "it makes me feel better".

Experiential avoidance is apparently an important functional factor in Jack's difficulties. It seems likely that the disruptions in Jack's history caused him to have intensely difficult private experiences. His efforts to suppress and/or avoid these experiences resulted in increases in their frequencies and intensities.

It is hypothesised that Jack's non-aggressive DBPs followed from his feelings of anger, sadness, and boredom, and served the function of avoiding them. His occasional aggressive behaviours functioned, in the short-term, to avoid intolerable levels of difficult private experiences resulting from confrontational situations (e.g., arguments with his mother or

brother). In the long-term, they functioned to increase these experiences. His tolerance for such experiences was lowest during periods of low mood. His cannabis use functioned to avoid feelings of low mood.

Treatment. Treatment sessions took place once or twice a week. Diane remained in treatment for eight-weeks, receiving eight sessions. Jack remained for 11-weeks, receiving thirteen sessions. The timings of the phase changes from treatment to post-treatment were determined by each participant's clinical progress.

Therapy progressed through the six typical stages of ACT.

Post-treatment. The parent(s) of each participant was/were asked to continue collecting data for four-weeks post-treatment.

Results

Frequencies of DBPs

Diane's parents jointly provided data for 15 of the 16 weeks of her participation in the study. Jack's mother provided data for 10 of 23 weeks. Jack typically stayed with his father and/or friends for 3-to-4 days each week. His data describe the first three days of each week on which he stayed with his mother.

Each participant's weekly frequencies of DBPs over baseline, treatment, and post-treatment are presented in Figure 1.

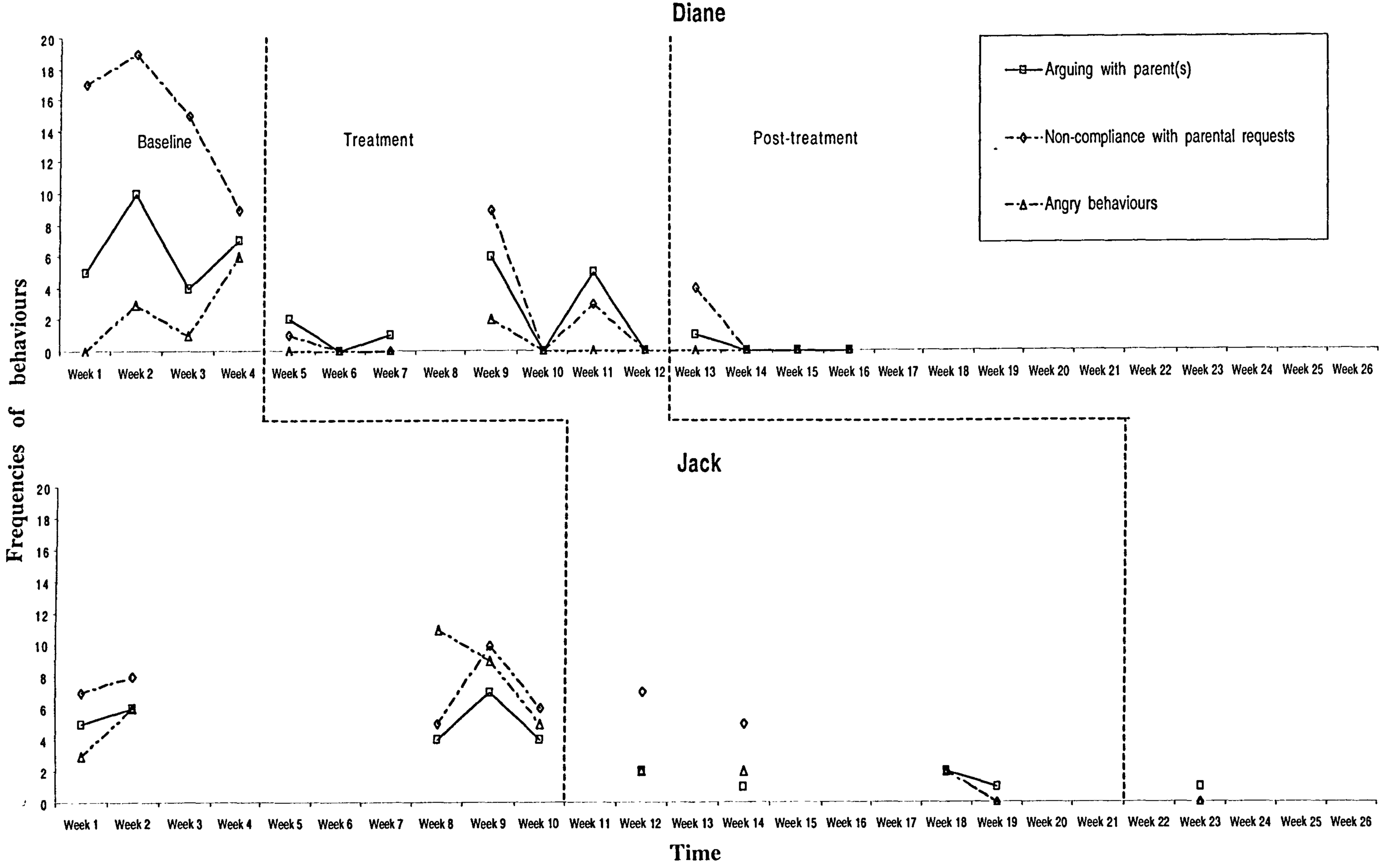


Figure 1. Diane's and Jack's weekly frequencies of disruptive behaviours over baseline, treatment, and post-treatment

Diane. Over baseline, the level of Diane's arguing was relatively stable. There was a relatively large decreasing trend in the level of her non-compliance and a gradually increasing trend in her angry behaviours.

Immediately after treatment commenced, the levels of each of her DBPs decreased. They remained, without trend, at their decreased levels during the first half of treatment. In the second half, the levels of arguing and non-compliance varied considerably and increased slightly from their first half levels, without identifiable trend. Their levels were lower than during baseline. Apart from a small increase in the first week of the second half of treatment, angry behaviours remained at their first half level.

The levels of arguing and non-compliance increased slightly during the first week of post-treatment, before decreasing to, and remaining at, 0. Angry behaviours remained at 0 throughout post-treatment.

During baseline, Diane argued with her parents an average of 6.5 times per week. The average frequency per week of arguing decreased during the first half of treatment to 1. It increased to 2.75 during the second half. It decreased again to 0.25 during post-treatment.

Diane's non-compliance decreased from an average frequency of 15 times per week during baseline to 0.333 times per week during the first half of treatment. The average frequency per week of non-compliance increased to 3 during the second half, decreasing again to 1 during post-treatment.

Diane's angry behaviours decreased from an average frequency of 2.5 times per week during baseline to 0 times per week during the first half of treatment. The average frequency of 0.5 times per week during the second half decreased again to 0 during post-treatment.

During post-treatment, Diane's parents reported that she had not been verbally or physically aggressive toward them since the start of pre-treatment. Her teachers had reported to them that she had behaved appropriately in school in recent weeks.

Jack. Over baseline, the levels of each of Jack's DBPs were relatively stable, despite considerable variability, particularly in angry behaviours. Over treatment, there were gradually decreasing trends in the levels of each. Their levels at the end-of-treatment were maintained during week-two of post-treatment.

During baseline, Jack argued with his mother an average of 5.2 times per week. Arguing decreased during the first half of treatment to an average of 1.5 times per week, at which level it remained during the second half. During week-two of post-treatment, Jack argued once with her.

Jack's non-compliance decreased from an average of 7.2 times per week during baseline to 6 times per week during the first half of treatment. It further decreased to an average of 1 time per week during the second half and to 0 during week-two of post-treatment.

Jack's angry behaviours decreased from an average of 6.8 times per week during baseline to 2 times per week during the first half of treatment and 1 time per week during the second. During week-two of post-treatment, Jack did not engage in angry behaviours.

During post-treatment, Jack's mother reported that he had not been verbally or physically aggressive toward her since the first week of treatment. Jack and his mother decided that he should withdraw from school and apply to college, which he did.

ECBI scores

Diane's pre-treatment Intensity score was 168 (clinical significance 'cut-off' level, a score above which indicates that the child's overall frequency of disruptive behaviours is clinically significant: 127). Her Problem score was 26 (clinical significance 'cut-off' level, a score above which indicates that the child's behaviour is problematic to a clinically significant extent to the person completing the questionnaire: 11). Her end-of-treatment Intensity score was 93. Her Problem score was 8. Diane's end-of-treatment Intensity and Problem scores

were approximately at the norms for her age (respectively, 94.4 and 7.4- Eyberg & Robinson, 1993).

Jack's pre-treatment Intensity score was 120. His Problem score was 14. His end-of-treatment Intensity score was 66, well below the norm for his age (as above). His Problem score was 7, approximately at the norm.

SDQ scores

Pre-treatment, Diane scored within the 'Abnormal' ranges on the Conduct Problems and Hyperactivity sub-scales (see Table 1). Her Total Difficulties score was 17 ('Abnormal' range: 17-40). Her Impact score was 3 ('Abnormal' range: 2-10). At end-of-treatment, her score on the Conduct Problems sub-scale was within the 'Normal' range. Her score on the Hyperactivity sub-scale remained within the 'Abnormal' range. Her Total Difficulties score was within the 'Normal' range. Her Impact score was within the 'Borderline' range.

Pre-treatment, Jack scored within the 'Abnormal' ranges on the Conduct Problems, Emotional Symptoms, and Peer Problems sub-scales (see Table 1). He scored within the 'Borderline' range on the Prosocial Behaviours sub-scale. His Total Difficulties score was 20. His Impact score was 7. At end-of-treatment, his scores on all sub-scales and his Total Difficulties score were within the 'Normal' ranges. His Impact score was at the bottom of the 'Abnormal' range.

Table 1. Diane's and Jack's scores on the Strengths and Difficulties Questionnaire at pre-treatment and end-of-treatment

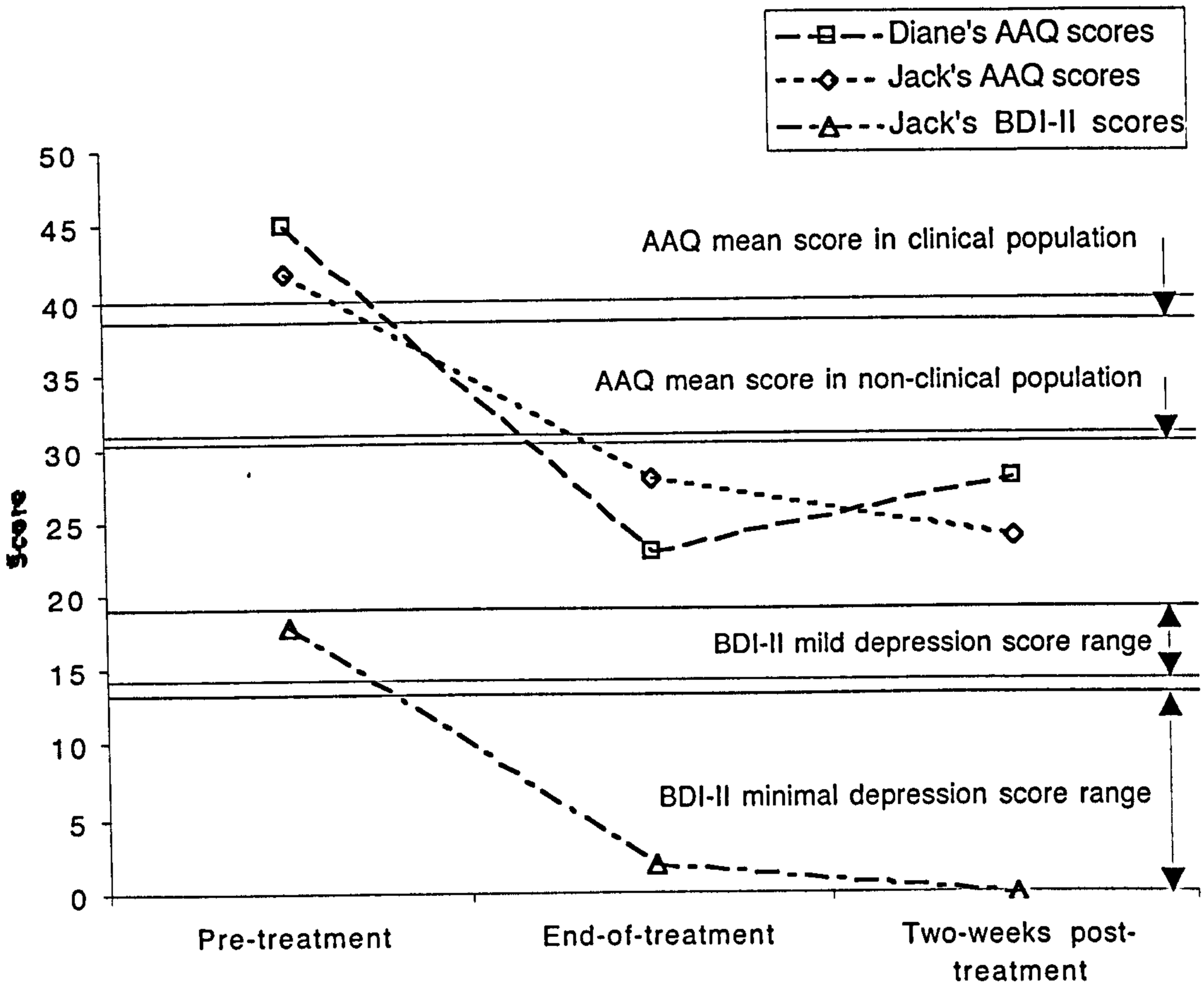
Scale	Time			
	Pre-treatment		End-of-treatment	
	Diane	Jack	Diane	Jack
Conduct Problems	4 (A)	4 (A)	0 (N)	2 (N)
Emotional Symptoms	3 (N)	7 (A)	4 (B)	1 (N)
Hyperactivity	10 (A)	5 (N)	8 (A)	3 (N)
Peer Problems	0 (N)	4 (A)	1 (N)	0 (N)
Prosocial Behaviour	6 (N)	5 (B)	6 (N)	7 (N)
Total Difficulties	17 (A)	20 (A)	13 (N)	6 (N)
Impact	3 (A)	7 (A)	1 (B)	2 (A)

Note. (A) = abnormal score range, (B) = borderline score range, (N) = normal score range

AAQ scores

Pre-treatment, Diane's AAQ score was 45 (mean in clinical populations: 38-40) (see Figure 2). At end-of-treatment, it was 23 (mean in non-clinical populations: 30-31). Two-weeks post-treatment it was 28.

Early in pre-treatment, Jack's AAQ score was 41. At end of pre-treatment it was 42 (see Figure 2). At end-of-treatment, it was 28. Two-weeks post-treatment it was 24.



Note. Jack completed both the AAQ and BDI-II twice during pre-treatment. The second score for each, from end-of-pre-treatment, is reported.

Figure 2. Diane's AAQ scores and Jack's AAQ and BDI-II scores at pre-treatment, end-of–treatment, and two-weeks post-treatment

BDI-II scores (Jack only)

Early in pre-treatment, Jack's BDI-II score was 13 (minimal depression range: 0-13). At end of pre-treatment, it was 18 (mild depression range: 14-19) (see Figure 2). At end-of-treatment, it was 2. Two-weeks post-treatment, it was 0. Jack's reports in session of changes in his depressive symptoms were consistent with the changes in his BDI-II scores.

Discussion

The present study describes the application of ACT to the treatment of experiential avoidance in two adolescents with DBPs. Such application of ACT has not previously been reported.

Pre-treatment, both participants frequently engaged in non-aggressive disruptive behaviours and were occasionally aggressive toward others. Over treatment, each participant's DBPs decreased dramatically in frequency. By the end-of-treatment, each engaged only occasionally in non-aggressive disruptive behaviours. Diane had not been aggressive since the beginning of pre-treatment. Jack had not been aggressive since the beginning of treatment. Parental ratings of each participant's behaviours on two valid measures of DBPs (the ECBI and SDQ) were within the score ranges normal for their age. At the end-of-treatment, each participant and her/his parent(s) agreed that her/his behaviour was no longer problematic, indicating that the changes were clinically significant (Kazdin, 1977).

The decreases in the frequencies of Diane's and Jack's DBPs were maintained for, respectively, one-month and two-weeks post-treatment. It is not known whether they were maintained beyond these points. An aim of further research should be to determine whether treatment effects endure over the long-term.

Pre-treatment, both participants reported frequently having difficult private experiences. Both also reported having avoidant styles of coping with such experiences. Their scores on the AAQ were within the clinically significant range. By end-of-treatment, their AAQ scores were within the non-clinical range, indicating clinically significant decreases in experiential avoidance. Their scores remained in the non-clinical range at two-weeks post-treatment.

Pre-treatment, Jack was mildly depressed. Over treatment, his depressive symptoms, as measured using the BDI-II, gradually decreased in frequency and intensity. By end-of-treatment, he was not depressed.

The believability of treatment as the cause of the results depends on the extent to which alternative causes can be discounted. Kazdin (1981) identifies five major threats to internal validity: history, maturation, testing, instrumentation, and statistical regression. These were controlled for through the employment of a multiple-baseline design.

Following baseline phases of different lengths, the initial decreases in each participant's frequencies of DBPs occurred at different points in real-time. The principle of the improbability of successive coincidences suggests that it is unlikely that they resulted from either history or maturation (Hayes et al., 1999). Further, history and maturation are unlikely to be causes of change during treatment in stable problems (Hayes et al., 1999; Kazdin, 1981).

Testing, instrumentation, and statistical regression toward the mean are most likely to threaten validity when dependent variables are measured on only a few occasions (e.g., at pre and post-treatment) (Hayes et al., 1999; Kazdin, 1981). They are controlled for by the measurement of participants' frequencies of DBPs on relatively large numbers of occasions.

The timing and magnitude of the decreases in each participant's frequencies of DBPs adds to the believability of treatment as their cause. They occurred relatively suddenly after the phase change from baseline to treatment. In Diane's case, they occurred almost immediately. In Jack's case, within a few weeks. Relative to baseline levels of DBPs, the decreases were large. Effects that are sudden and large, and for which alternative explanations can be discounted, are considered believable (Hayes et al., 1999; Kazdin, 1992; Linscheid, 2000; Morley, 1989).

The other dependent variables were not included in the multiple-baseline design. It is possible that the changes in them resulted from threats to internal validity. However, the fact that the clinically significant decreases over treatment in each participant's scores on the ECBI, SDQ, and AAQ (and in Jack's case BDI-II) were consistent with the decreases in their frequencies of DBPs strongly suggests that they resulted from treatment.

The results support the experimental hypotheses.

The present study is a first step in the investigation of the treatment of experiential avoidance in adolescents with DBPs. From the results, it can be concluded only that ACT resulted in clinically significant decreases in experiential avoidance and frequencies of DBPs in two particular adolescents. In order to enable further conclusions to be drawn, replication is necessary. Replications carried out by other researchers, in different locations, involving a variety of baseline lengths, would be of the most value, because they would provide the greatest degree of control of threats to internal validity. The believability of the treatment effects would increase with each successful replication (Hayes et al., 1999; Turpin, 2001). External validity depends upon replication (Hayes, 1981).

On the basis of the results, research into both the prevalence rate of experiential avoidance in adolescents with DBPs and its function in the etiology and maintenance of such problems seems potentially valuable.

Existing theoretical accounts of DBPs in adolescents do not identify experiential avoidance as an important functional factor. Treatment approaches based on these accounts (e.g., PMT, PSST, MST) do not address it. The identification of experiential avoidance as an important functional factor in a significant proportion of adolescents with DBPs would necessitate changes to both existing theories and treatment approaches.

References

ALTEPETER, T.S., & KORGER, J.N. (1999). Disruptive behavior: Oppositional defiant disorder and conduct disorder. In. S.D. Netherton, D. Holmes, & C.E. Walker (Eds.), *Child and adolescent psychological disorders: A comprehensive textbook.* New York; Oxford University Press.

APA (1995). *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC: American Psychiatric Association.

BACH, P.A., & HAYES, S.C. (in press). The use of Acceptance and Commitment Therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology.*

BECK, A.T., STEER, R.A., & BROWN, G.K. (1996). *Beck Depression Inventory-Second Edition: Manual.* San Antonio: The Psychological Corporation.

BISSETT, R.T., & HAYES, S.C. (1999). The likely success of functional analysis tied to the DSM. *Behavior Research and Therapy, 37,* 379-383.

BLACKLEDGE, J.T., & HAYES, S.C. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology, 57,* 243-255.

BUKSTEIN, O.G. (2000). Disruptive behavior disorders and substance use disorders in adolescents. *Journal of Psychoactive Drugs, 32,* 67-79.

EBATA, A.T., & MOOS, R.H. (1991). Coping and adjustment in distressed and healthy adolescents. *Journal of Applied Developmental Psychology, 12,* 33-54.

EYBERG, S., & ROBINSON, A.E. (1983). Conduct problem behavior: Standardization of a behavioral rating scale with adolescents. *Journal of Clinical Child Psychology, 11,* 130-137.

EYBERG, S.M., & ROSS, A.W. (1978). Assessment of child behavior problems: The validation of a new inventory. *Journal of Clinical Child Psychology, 7,* 113-116.

FINCH, A.J., NELSON, W.M., & OTT, E.S. (1993). *Cognitive-behavioral procedures*

with children and adolescents: A practical guide. Needham Heights, MA: Allyn & Bacon.

FRICK, P.J., & LONEY, B.R. (1999). Outcomes of children and adolescents with oppositional defiant disorder and conduct disorder. In H. C. Quay & A. E. Hogan (Eds.), *Handbook of disruptive behavior disorders*. New York: Kluwer Academic.

GIFFORD, E.V. (1994). Setting a course for behavior change: The verbal context of acceptance. In S.C. Hayes, N.S. Jacobson, V.M. Follette, & M.J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy*. Reno: Context.

GOODMAN, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38,* 581-586.

GOODMAN, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry, 40,* 791-799.

GOODMAN, R., & SCOTT, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? *Journal of Abnormal Child Psychology, 27,* 17-24.

GREENWALD, R. (2000). A trauma-focussed individual therapy approach for adolescents with conduct disorder. *International Journal of Offender Therapy and Comparative Criminology, 44,* 146-163.

HASTINGS, T.L., ANDERSON, S.J., & KELLEY, M.L. (1996). Gender differences in coping and daily stress in conduct-disordered and non-conduct-disordered adolescents. *Journal of Psychopathology and Behavioral Assessment, 18,* 213-226.

HAYES, S.C. (1981). Single case experimental design and empirical clinical practice. *Journal of Consulting and Clinical Psychology, 49,* 193-211.

HAYES, S.C. (1984). Making sense of spirituality. *Behaviorism, 12,* 99-110.

HAYES, S.C. (1987). A contextual approach to therapeutic change. In N.S. Jacobson (Ed.), *Psychotherapists in clinical practice: Cognitive and behavioral perspectives*. New

York: Guilford.

HAYES, S.C. (1995). Knowing selves. The Behavior Therapist, 18, 94-96.

HAYES, S.C. (2000). *Acceptance and action questionnaire*. Unpublished test. (Available from Steven C. Hayes, University of Nevada, Reno, NV 89557-0062)

HAYES, S.C., BARLOW, D.H., & NELSON-GREY, R.O. (1999). *The scientist practitioner: Research and accountability in the age of managed care*. Boston: Allyn & Bacon.

HAYES, S.C., BISSETT, R.T., STROSAHL, K., WILSON, K., PISTORELLO, J., TOARMINO, D., POLUSNY, M.A., BATTEN, S.V., DYKSTRA, T.A., STEWART, S.H., ZVOLENSKY, M.J., EIFERT, G.H., BERGAN, J., & FOLLETTE, W.C. (2000). *Psychometric properties of the acceptance and action questionnaire (AAQ)*. Unpublished Paper.

HAYES, S.C., FOLLETTE, W.C., & FOLLETTE, V.M. (1995). Behavior therapy: A contextual approach. In A.S. Gurman & S.B. Messer (Eds.), *Essential psychotherapies: Theory and practice*. New York: Guilford.

HAYES, S.C., & GIFFORD, E.V. (1997). The trouble with language: Experiential avoidance, rules, and the nature of verbal events. *Psychological Science, 8,* 170-173.

HAYES, S.C., STROSAHL, K., & WILSON, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.

HAYES, S.C., & WILSON, K.G. (1994). Acceptance and commitment therapy: Altering the verbal support for experiential avoidance. *The Behavior Analyst, 17,* 289-303.

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 behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,*

1152-1168.

HENGGELER, S.W., & BORDUIN, C.M. (1990). *Family therapy and beyond: A multi systemic approach to treating the behavior problems of children and adolescents.* Pacific Grove, CA: Brookes/Cole.

HENGGELER, S.W., SCHOENWALD, S.K., BORDUIN, C.M., ROWLAND, M.D., & CUNNINGHAM, P.B. (1998). *Multisystemic treatment for antisocial behavior in children and adolescents*. New York: Guilford.

HORNE, A.M., & GLASER, B.A. (1993). Conduct disorders. In R.T. Ammerman, C.G. Last, & M. Hersen (Eds.), *Handbook of prescriptive treatments for children and adolescents*. Boston: Allyn & Bacon.

KAZDIN, A.E. (1977). Assessing the clinical or applied importance of behavior change through social validation. *Behavior Modification, 1,* 427-451.

KAZDIN, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49,* 183-192.

KAZDIN, A.E. (1992). *Research design in clinical psychology (2nd Ed.)*. Boston: Allyn & Bacon.

KAZDIN, A.E. (1993). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology, 5,* 277-310.

KAZDIN, A.E. (1994a). Psychotherapy for children and adolescents. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change (4th Ed.)*. New York: John Wiley & Sons.

KAZDIN, A.E. (1994b). Antisocial behavior and conduct disorder. In L.W. Craighead, W.E. Craighead, A.E. Kazdin, & M.J. Mahoney (Eds.), *Cognitive and behavioral interventions: An empirical approach to mental health problems*. Boston: Allyn & Bacon.

KAZDIN, A.E. (1997). Practitioner review: Psychosocial treatments for conduct disorder in children. *Journal of Child Psychology and Psychiatry, 38,* 161-178.

KAZDIN, A.E. (2000). Treatments for aggressive and antisocial children. *Child and Adolescent Psychiatric Clinics of North America, 9,* 841-858.

KAZDIN, A.E., & WASSELL, G. (2000). Therapeutic changes in children, parents, and families resulting from treatment of children with conduct problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 414-420.

KOHLENBERG, R.J., HAYES, S.C., & TSAI, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. *Clinical Psychology Review, 13,* 579-592.

KOLKO, D.J. (1993). Conduct disorder. In M. Hersen, R.T. Ammerman, & L.A. Sisson (Eds.), *Handbook of aggressive and destructive behavior in psychiatric patients.* New York: Plenum.

LAHEY, B.B., & LOEBER, R. (1994). Framework for a developmental model of oppositional defiant disorder and conduct disorder. In D.K. Routh (Ed.), *Disruptive behavior disorders in childhood.* New York: Plenum.

LAMBERT, E.W., WAHLER, R.G., ANDRADE, A.R., & BICKMAN, L. (2001). Looking for the disorder in conduct disorder. *Journal of Abnormal Psychology, 110,* 110-123.

LEDINGHAM, J.E. (1999). Children and adolescents with oppositional defiant disorder and conduct disorder in the community. In H. C. Quay & A. E. Hogan (Eds.), *Handbook of disruptive behavior disorders.* New York: Kluwer Academic.

LINSCHEID, T.R. (2000). Case studies and case series. In D. Drotar (Ed.), *Handbook of research in pediatric and clinical child psychology: Practical strategies and methods.* New York: Kluwer.

LOEBER, R., & KEENAN, K. (1994). Interaction between conduct disorder and its comorbid conditions: Effects of age and gender. *Clinical Psychology Review, 14,* 497-523.

MORLEY, S. (1989). Single case research. In G. Parry & F.N. Watts (Eds.), *Behavioural*

and mental health research: A handbook of skills and methods. Hove: Lawrence Erlbaum.

MUNIR, K., & BOULIFARD, D. (1995). Comorbidity. In G.P. Sholevar (Ed.), *Conduct disorders in children and adolescents*. Washington, DC: American Psychiatric Press.

OLLENDICK, T.H., & KING, N.J. (2000). Empirically supported treatments for children and adolescents. In P.C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures*. New York: Guilford.

PFEFFER, C.R. (1991). Suicide and suicidality. In J.M. Wiener (Ed.), *Textbook of child and adolescent psychiatry*. Washington, DC: American Psychiatric Press.

RAPP, L.A., & WODARSKI, J.S. (1997). The comorbidity of conduct disorder and depression in adolescents: A comprehensive interpersonal treatment technology. *Family Therapy, 24,* 81-100.

REEBYE, P., MORETTI, M.M., & LESSARD, J.C. (1995). Conduct disorder and substance use disorder: Comorbidity in a clinical sample of preadolescents and adolescents. *Canadian Journal of Psychiatry, 40,* 313-319.

REINECKE, M.A. (1995). Comorbidity of conduct disorder and depression among adolescents: Implications for assessment and treatment. *Cognitive and Behavioral Practice, 2,* 299-326.

REINHARD, H.G., & BOWI, U. (1988). Coping style and conduct disorder. *Acta Paedopsychiatrica, 51,* 38-43.

REY, J.M., & WALTER, G. (1999). Oppositional defiant disorder. In R.L. Hendren (Ed.), *Disruptive behavior disorders in children and adolescents*. Washington, DC: American Psychiatric Press.

RUTTER, M., TIZARD, J., & WHITMORE, K. (1970). *Education, health, and behavior*. London: Longmans.

SCHOENWALD, S.K., & HENGGELER, S.W. (1999). Treatment of oppositional defiant disorder and conduct disorder in home and community settings. In H. C. Quay &

A. E. Hogan (Eds.), *Handbook of disruptive behavior disorders*. New York: Kluwer Academic.

SHAFFER, D. (1988). The epidemiology of teen suicide: An examination of risk factors. *Journal of Clinical Psychiatry, 49,* 36-41.

SHURE, M.B. (1992). *I can problem solve (ICPS): An interpersonal cognitive problem solving program*. Champaign, IL: Research Press.

SPENDER, Q., & SCOTT, S. (1996). Conduct disorder. *Current Opinion in Psychiatry, 9,* 273-277.

STAHL, N.D., & CLARIZIO, H.F. (1999). Conduct disorder and comorbidity. *Psychology in the Schools, 36,* 41-50.

STEINER, H., & DUNNE, J.E. (1997). Summary of the practice parameters for the assessment and treatment of children and adolescents with conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 1482-1485.

STEINER, H., & WILSON, J. (1999). Conduct disorder. In R.L. Hendren (Ed.), *Disruptive behavior disorders in children and adolescents*. Washington, DC: American Psychiatric Press.

TURPIN, G. (2001). Single case methodology and psychotherapy evaluation: From research to practice. In C. Mace, S. Moorey, & B. Roberts (Eds.), *Evidence in the psychological therapies: A critical guide for practitioners*. Philadelphia: Taylor & Francis.

VELASCO, J.A., & QUIROGA, E. (2001). Study of a clinical case of alcohol abuse treated by acceptance and commitment therapy. *Psicothema, 13,* 50-56.

WALSER, R.D., & HAYES, S.C. (1998). Acceptance and trauma survivors. In V.M. Follette, J.I. Ruzek, & F.R. Auberg (Eds.), *Cognitive-behavioral therapies for trauma.* New York: Guilford.

WEBSTER-STRATTON, C., & HANCOCK, L. (1998). Training for parents of young children with conduct problems: Content, methods, and therapeutic processes. In C.E.

Schaefer & J.M. Briesmeister (Eds.), *Handbook of parent training*. New York: John Wiley & Sons.

WILSON, K.G., FOLLETTE, V.M., HAYES. S.C., & BATTEN, S.V. (1996). Acceptance theory and the treatment of abuse survivors: Implications of acceptance theory for the treatment of survivors of childhood sexual abuse. *National Center for PTSD Clinical Quarterly, 6.*

WILSON, K.G., & HAYES. S.C. (2000). Why it is crucial to understand thinking and feeling: An analysis and application to drug abuse. *The Behavior Analyst, 23,* 25-43.

ZETTLE, R.D., & HAYES, S.C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4,* 30-38.

ZETTLE, R.D., & RAINES, J.C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45,* 438-445.

ZOCCOLILLO, M. (1992). Co-occurrence of conduct disorder and its adult outcomes with depressive and anxiety disorders: A review. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 547-556.

APPENDIX A

PARENT-COMPLETED DAILY DBPS FREQUENCY RECORDS

How Many Times Today Did ..... ?

Date on Monday _____

You should answer each of these questions every day.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1.	How many times today did _____ argue with you?	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum
2.	How many times today did _____ not do something that you asked _____ to do?	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum
3.	How many times today did _____ get angry?	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum	Dad Mum

Note. Diane's father and mother jointly completed the record. In Jack's case, only his mother completed it.

APPENDIX B

ACCEPTANCE AND ACTION QUESTIONNAIRE

EYBERG CHILD BEHAVIOUR INVENTORY

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE

APPENDIX C

ACCEPTANCE AND COMMITMENT THERAPY-

EXERCISES AND METAPHORS USED IN THE RESEARCH STUDY

ACCEPTANCE AND COMMITMENT THERAPY-

EXERCISES AND METAPHORS USED IN THE RESEARCH STUDY

Creative hopelessness

The 'Person in the Hole' metaphor

The situation you are in seems a bit like this. Imagine that you're placed in a field wearing a blindfold, and you're given a little tool bag to carry. You're told that your job is to run around this field, blindfolded. That is how you are supposed to live life. And so you do what you are told. Now, unbeknownst to you, in this field there are a number of widely spaced, fairly deep holes. You don't know that at first- you're naive. So you start running around and sooner or later you fall into a large hole. You feel around, and sure enough, you can't climb out and there are no escape routes you can find. Probably what you would do in such a predicament is take the tool bag you were given and see what is in there; maybe there is something you can use to get out of the hole. Now suppose the only tool in the bag is a shovel. So you dutifully start digging, but pretty soon you notice that you're not out of the hole. So you try digging faster and faster. But you're still in the hole. So you try big shovelfuls, or little ones, or throwing the dirt far away or not. But still you are in the hole. All this effort and all this work, and oddly enough the hole has just gotten bigger and bigger and bigger. Isn't that your experience? So you come to see me thinking "Maybe he has a really huge shovel- a gold-plated steam shovel." Well, I don't. And even if I did I wouldn't use it, because digging is not a way out of the hole- digging is what makes holes. So maybe the whole agenda is hopeless- you can't dig your way out, that just digs you in. (Hayes, Strosahl, & Wilson, 1999, p. 102)

The 'Tug-of-War with a Monster' metaphor

It's like being in a tug-of-war with a monster. Between you and the monster is a great pit. If you get pulled into the pit, you will be destroyed. You have to win the tug-of-war. But the monster is strong. Very strong. The fight seems almost hopeless, but what else can you do? What option do you have? So you struggle and pull. You fight the good fight. But it's the hardest thing to see that what you need to do in that situation is not to win the war. You can't do that. What you need to do is to drop the rope. (Hayes, McCurry, Afari, & Wilson, 1991, p. 16)

The 'Steering with the Rear-View Mirror' metaphor

It's as if you got into your car and took off down the highway. Unfortunately, whoever taught you how to drive told you that the way to steer the car is by holding onto and turning the rear-view mirror. Now, you might be able to go a long way once you start down the road driving without anything happening, depending upon whether the road you're on is straight, or whether there is much oncoming traffic, etc. Eventually, however, the car is going to crash. Then you dust yourself off, put both hands on the rear-view mirror and off you go again. The problem isn't with the car, or with the driver; the problem is that you can't steer a car with the rear-view mirror. This kind of therapy is not about how to turn the rear-view mirror, even though you may be convinced that that is what you need to learn. This therapy is not about changing your past; about changing your programming. It's about how to put your hands on the steering wheel. It's about how to move forward from where you are rather than from where you wish you were, or feel you need to be. (Hayes et al., 1991, p. 11)

The 'Coach' metaphor

This kind of therapy is like the difference between a reporter and a coach. A reporter goes to a football game, reports the facts of what he sees: "So-and-so made this pass, or that touchdown," etc. It's all logical and accurate. The coach, on the other hand, is saying things to the players like "pretend you're a freight train," or "let the ball have wings," or "float like a butterfly down the field." Of course, the ball never does really have wings; the reporter would never say that. But the reporter talk is for a different purpose. Our talk in here will be like coach-talk. This kind of therapy won't be literal, logical stuff. You don't have to believe what I say. Just work with me and let our work do what it will. (Hayes et al., 1991, p. 12)

Control is the problem, not the solution

The rule of private events

Discuss control of private events (thoughts and feelings). Emphasize how in the outer world the rule is "If you don't like something, figure out how to get rid of it." We will call this conscious, deliberate, or purposeful control. Explore this and show how it works in so many areas. If you don't like dirt of the floor, vacuum it up; if you don't like ignorance, go to school; if you don't like poverty, get a job. The outer world is 95% of what is important. It encompasses the great majority of everything other living creatures on the planet are dealing with: hunger, shelter, warmth, stimulation. But we have these things, and yet we are not happy. There is this last little bit- the last 5%, that is composed of the world inside the skin. Ask the client to consider the possibility that in this last 5%, the world works differently. A different rule may apply. Just consider the possibility that in the inner world this approach is not only ineffective, but in some instances, it is even harmful. Review briefly some of what the client has done in the area of emotional control. Ask the client. 'In your experience,

not in your logical mind, check it out and see if it isn't so: in the world inside the skin, the rule actually is, "If you aren't willing to have it, you've got it..."' (Hayes et al., 1991, pp. 114-15)

The 'Polygraph Machine' metaphor

Suppose I had you hooked up to the best polygraph machine that's ever been built, and I tell you, all you have to do here is stay relaxed. This is a perfect machine, the most sensitive ever made, so there's no way that you can not be relaxed that I won't know it. But I want to give you a little motivation. I happen to have a handgun which I'll hold to your head. So I tell you, if you just stay relaxed I won't blow your brains out, but if you get nervous (and I'll know it because you're wired up to this perfect machine), I'm going to have to kill you. So, just relax! What do you think would happen?...It's pretty clear, but notice this. If I told you, vacuum up the floor or I'll shoot you, you'd vacuum the floor. If I said paint the house, or else, you'd be painting. But if I simply say "Relax", not only will it not work, but it's the other way around. The very fact that I would ask you to do this under such circumstances would produce anxiety. But this isn't just a funny story. You have the perfect polygraph machine already hooked up to you: it's your own nervous system. And you've got something pointed at you that is more powerful and more threatening than any gun- your own self-esteem and success in life. It's like the gun. So here you are saying "Relax! Don't be anxious! Or else" And it's not working. If it's really, really important for you not to have a panic attack, guess what you get? (Hayes et al., 1991, p. 15)

The 'Fall in Love for $10 Million' metaphor

But it's not just negative emotions. Here's a test. I come to you and say, "See that person? If you fall love with that person in 2 days, I'll give you $10 million dollars." Could you do it? What if you came back to me in 2 days and said, "I did it", and then I say, "Sorry, it was just a trick; I don't have $10 million dollars." What are you going to do next? In other words, it's not just getting rid of negative emotions that is difficult, but it is equally difficult to create them, even ones you like, in any kind of predictable, systematic, controllable way. (Hayes et al., 1991, p. 15)

The 'Don't Think of a Warm Jelly Donut' metaphor

It's not just emotions either. Let's look at thoughts. Suppose I tell you right now, "I don't want you to think about..." See I can't even tell you because you know what would happen. Well, OK, let's see. Don't think about...Warm jelly donuts! Don't think of them! Don't think about how they smell when they first come out of the oven...Don't think of that! The taste of the jelly when you bite into the donut as the jelly squishes out the opposite side into your lap through the wax paper...Don't think of that! And the white flaky frosting on the top on the round soft, rounded shape? DON'T THINK ABOUT ANY OF THIS! (Hayes et al., 1991, p. 15)

The 'Feeding a Small Tiger' metaphor

It's like living with a small tiger who looks very hungry. It looks like he is going to eat you- you think. It's a small tiger, but scary. So you throw him some meat so he doesn't eat you and, sure enough, it shuts him up while he's eating the meat. For a while he leaves you alone. For a while. But he also grows a little bigger. So the next time he's hungry, he's a

little bigger and more dangerous (it appears to you). And you throw him more meat. That little tiger is getting bigger and bigger and bigger. And pretty soon it's a big tiger. A really big tiger. You've got (name an emotion that the client is struggling with) tigers out there that could seemingly swallow you whole, and you keep hoping that if you just keep feeding them, keep trading in your life flexibility just a little bit more, eventually they'll leave you alone. (Hayes et al., 1991, p. 16)

The 'Two Scales' metaphor

Imagine there are two scales, like the volume and balance controls on a stereo. One is called (name an emotion that the client is struggling with). It can go from 0 to 10. The other is called "Willingness," and it can go from 0 to 10. Check this and see if it isn't the case that the posture you're in, what brought you in here, is this: "This (emotion) is too high. It's way up here and I want it down here and I want you (the therapist) to help me do that, please." But now there's also this other scale; it's been hidden but in the past couple of weeks we've been bringing it out to look at. This other scale, the Willingness scale, is really the more important of the two, because this is the one that makes the difference. When (emotion) is up here at 10, and the Willingness scale is down at 0, that is, when you're trying hard to control this (emotion), make it go down, and you're unwilling to feel this (emotion), then by definition this means that (emotion) is something to be (emotion) about. It's as if when (emotion) is high, as willingness drops down, the (emotion) kind of locks into place. It's like a ratchet or something, like trying to use a wrench when the ratchet is turned the wrong way. You turn the ratchet the wrong way and no matter what you do with that tool, it drives it in tighter. So, what we need to do in this therapy is shift our focus from the (emotion) to the willingness scale. You've been trying to control (emotion) for a long time, and it just doesn't work. Instead of doing that, if we turn our focus to the willingness scale, and let it go up, we stop trying to control the (emotion). When you do that I guarantee

you (and you can hold me to it) that your (emotion) will be low...or it will be high. I promise you! It will be either low or it will be high. When it's low, it will be low...until it's high again. And it will be high, until it's not high, and then it will, be low. (Hayes et al., 1991, p. 18).

The 'Box Full of Stuff' metaphor

Suppose we had this trash here. (Grab a box or a trash can.) This (put various small items in the box, some nice and some repulsive) is the content of your life. All your programming. There's some useful stuff in here. But there are also some old cigarette buts and trash. Now let's say there are some things in here that are really yucky. Like (name a problematic event in the clients' life). That would be like this. (Blow your nose into a tissue and put it in the box.) What would come up? (Pause to allow the client to answer.) OK, so that's this. (Take an item and put it in the box.) What else would come up? (Pause to allow the client to answer.) OK, so that's this. (Take an item and put it in the box.) What else? (Pause to allow the client to answer.) OK, so that's this. (Take an item and put it in the box.) Do you see what's happening? The box is getting pretty full, and notice that a lot of these items have to do with the first yucky one. Notice that the first piece isn't becoming less important- it's becoming more and more important. Because your programming doesn't work by subtraction, the more you try to subtract an item, the more you add new items about the old. Now it's true, some of this stuff you can shove back in the corners and you can hardly see it anymore, but it's all in there. Stuffing things back in the corners is seemingly a logical thing to do. We all do it. Problem is, because the box is you, at some level the box knows, is in contact with, literally up next to, all the bad stuff you've stuffed in the corners. Now, if the stuff that's in the corners is really bad, it's really important that it not be seen. But that means that anything that is related to it can't be seen, so it too has to go into the corner. So you have to avoid the situations that will cause light to be cast into the corners. Gradually

your life is getting more and more squeezed. And note that this doesn't really change your programming- it just adds to it. You're just stuffing another thing back into the corner. There are more and more things that you can't do. Can you see the cost? It must distort your life. Now the point is not that you need to deliberately pull all the stuff out of the corner- the point is that healthy living will naturally pull some things out of the corner, and you have the choice either to pull back to avoid it or let going forward with life open it up.

(Hayes et al., 1999, pp. 136-137)

Building acceptance by defusing language

The 'Two Computers' metaphor

Imagine two computers, identical machines. Each has an operator sitting in front of the little video-monitor. This machine is your programming, and you're sitting here working at it. At one point, Mom comes over and works on the keyboard for a while; a little later Dad comes over. At various times, (name some people important in the client's life)- they all spend a little time at the computer. Now if you're given a certain amount of input, particular software, and this particular hardware when you push a key, a particular readout will show up. It shows up because of the programming. Say you push a key and it comes up on the screen, "Deep down there's something wrong with me." So there it is on the screen. Now, two different situations. In situation 1, the operator is totally lost in the operation of the computer. It's like being lost in a movie; you're not watching, it is actually happening to you. Now the person at this computer is like that- he's forgotten that there's any distinction between the screen and himself. So he reads it, "Deep down there's something wrong with me." Now, from that place, what must he do? Who wouldn't try to reprogram it? Who's going to accept that type of "fact"? Who's going to accept that deep down inside there's something wrong with them? That's like saying it would be okay to be eaten by the tiger. Situation 2: Same computer, same programming, everything is the same. The same readout

comes up, "Deep down there's something wrong with me." But this person is sitting back a little. He can see it clearly, and he understands the read-out, and it is clear that it is from his machine but there's a distinction between himself and the machine. He's the operator of the machine, he's working on the machine, but it's not him in any simple, point-to-point, one-to-one fashion. What does he do? See, he could call someone over and say "Hey, look at this, Joe! My screen says 'Deep down there's something wrong with me.' How interesting." The readout doesn't have to change. Note that the operator might even believe it. For example, it says on the screen, "Boy, I am really anxious!" He may evaluate it as true. The issue isn't whether it's false, or whether you believe it exactly, rather, it's whether there is a distinction between yourself and the stuff that is your life. (Hayes et al., 1991, pp. 20-21)

The 'Passengers on the Bus' metaphor

Suppose there is a bus and you're the driver. On this bus we've got a bunch of passengers. The passengers are thoughts, feelings, bodily states, memories, and other aspects of experience. Some of them are scary, and they're dressed up in black leather jackets and they have switchblade knives. What happens is that you're driving along and the passengers start threatening you, telling you what you have to do, where you have to go. "You've got to turn left," "You've got to go right," and so on. The threat they have over you is that if you don't do what they say, they're going to come up from the back of the bus.

It's as if you've made deals with these passengers, and the deal is, "You sit in the back of the bus and scrunch down so that I can't see you very often, and I'll do what you say pretty much." Now what if one day you get tired of that and say, "I don't like this! I'm going to throw those people off the bus!" You stop the bus, and you go back to deal with the mean-looking passengers. But you notice that the very first thing you had to do was stop. Notice now, you're not driving anywhere, you're just dealing with these passengers.

And they're very strong. They don't intend to leave, and you wrestle with them, but it just doesn't turn out very successfully.

Eventually, you go back to placating the passengers, trying to get them to sit way in the back again where you can't see them. The problem with this deal is that you do what they ask in exchange for getting them out of your life. Pretty soon they don't even have to tell you, "Turn left"- you know as soon as you get near a left turn that the passengers are going to crawl all over you. In time you may get good enough that you can almost pretend that they're not on the bus at all. You just tell yourself that left is the only direction you want to turn. However, when they eventually do show up, it's with the added power of the deals that you've made with them in the past.

Now the trick about the whole thing is that the power the passengers have over you is 100% based on this: "If you don't do what we say, we're coming up and we're making you look at us." That's it. It's true that when they come up they look as if they could do a whole lot more. They have knives, chains, and so forth. It looks as if you could be destroyed. The deal you make is to do what they say so they won't come up and stand next to you and make you look at them. The driver (you) has control of the bus, but you trade off the control in these secret deals with the passengers. In other words, by trying to get control, you've actually given up control! Now notice that even though your passengers claim they can destroy you if you don't turn left, it has never actually happened. These passengers can't make you do something against your will. (Hayes et al, 1999, pp. 157-158)

Defusing self, discovering self

The 'Chessboard' metaphor

Imagine a chessboard that goes out infinitely in all directions. It's covered with black pieces and white pieces. They work together in teams, as in chess- the white pieces fight against the black pieces. You can think of your thoughts and feelings and beliefs as these pieces; they sort of hang out together in teams too. For example, "bad" feelings (like anxiety, depression, resentment) hang out with "bad" thoughts and "bad" memories. Same thing with the "good" ones. So it seems that the way the game is played is that we select the side that we want to win. We put the "good" pieces (like thoughts that are self-confident, feelings of being in control, etc.) on one side, and the "bad" pieces on the other. Then we get up on the back of the black horse and ride to battle, fighting to win the war against anxiety, depression, thoughts about using drugs, whatever. It's a war game. But there's a logical problem here, and that is that from this posture huge portions of yourself are your own enemy. In other words, if you need to be in this war, there is something wrong with you. And because it appears that you're on the same level as these pieces, they can be as big or even bigger than you are- even though these pieces are in you. So somehow, even though it is not logical, the more you fight the bigger they get. If it is true that "if you are not willing to have it, you've got it," then as you fight these pieces they become more central to your life, more habitual, more dominating, and more linked to every area of living. The logical idea is that you will knock enough of them off the board that you eventually dominate them- except that your experience tells you that the exact opposite happens. Apparently, the white pieces can't be deliberately knocked off the board. So the battle goes on. You feel hopeless, you have a sense that you can't win, and yet you can't stop fighting. If you're on the back of that black horse, fighting is the only choice you have, because the white pieces seem life threatening. Yet living in a war zone is no way to live.

Now let me ask you to think about this carefully. In this metaphor, suppose you aren't the chess pieces. Who are you? (Client- "Am I the player?") That may be what you have been trying to be. Notice, though, that a player has a big investment in how this war turns out. Besides, whom are you playing against? Some other player? Suppose you're not that either. (Client- "Am I the board?") It's useful to look at it that way. Without the board, these pieces have no place to be. The board holds them. For instance, what would happen to your thoughts if you weren't there to be aware that you thought them? The pieces need you. They cannot exist without you- but you contain them, they don't contain you. Notice that if you're the pieces, the game is very important; you've got to win, your life depends on it. But if you're the board, it doesn't matter whether the war stops or not. The game may go on, but it doesn't make any difference to the board. As the board, you can see all the pieces, you can hold them, you are in intimate contact with them; you can watch the war being played out in your consciousness, but it doesn't matter. It takes no effort. (Hayes et al., 1999, pp. 190-191)

The 'House Filled with Furniture' metaphor

It's as if you were a house, filled with furniture. The furniture is not, and can never be, the house. Furniture is the content of the house, or what's inside it. The house merely holds or contains the furniture and is the context in which the furniture can be furniture. Whether the furniture is thought to be good or bad says nothing about the value of the house. Consider the possibility that you are the house, but are not the furniture. Your thoughts and feelings are the furniture. Just as the furniture is not the house, your thoughts and feelings are not you. They are experiences you have, like pieces of furniture. (Hayes et al., 1991, pp. 23-24)

The 'Observer' exercise

We are going to do an exercise now that is a way to try to begin to experience that place where you are not your programming. There is no way that anyone can fail at the exercise; we're just going to be looking at whatever you are feeling or thinking, so whatever comes up is just right. Close your eyes, get settled into your chair, and follow my voice. If you find yourself wandering, just gently come back to the sound of my voice. For a moment now, turn your attention to yourself in this room. Picture the room. Picture yourself in this room and exactly where you are. Now begin to go inside your skin and get in touch with your body. Notice how you are sitting in the chair. Notice any bodily sensations that are there. As you see each one, just sort of acknowledge that feeling and allow your consciousness to move on (pause). Now notice any emotions that you are having, and if you have any, just acknowledge them (pause). Now get in touch with your thoughts and just quietly watch them for a few moments (pause). Now I want you to notice that as you noticed these things, a part of you noticed them. You noticed those sensations...those emotions...those thoughts. And that part of you we will call the "observer you." There is a person in there, behind those eyes, who is aware of what I am saying right now. And it is the same person you've been your whole life. In some deep sense, this observer you is the you that you call you.

I want you to remember something that happened last summer. Raise your finger when you have an image in mind. Good. Now just look around. Remember the sights...the sounds...your feelings...and as you do that, see whether you can notice that you were there then, noticing what you were noticing. See whether you can catch the person behind your eyes who saw, and heard, and felt. You were there then, and you are here now. I'm not asking you to believe this. I'm not making a logical point. I am just asking you to note the experience of being aware and check and see whether it isn't so that in some deep sense the you that is here now was there then. See whether you can notice the essential continuity- in some deep sense, at the level of experience, not of belief, you have been you your whole life.

I want you to remember something that happened when you were a teenager. Raise your finger when you have an image in mind. Good. Now just look around. Remember all the things that were happening then. Remember the sights...the sounds...your feelings...take your time. And when you are clear about what was there, see whether you can, just for a second, catch that there was a person behind your eyes then who saw, and heard, and felt all of this. You were there then too, and see whether it isn't true- as an experienced fact, not as a belief- that there is an essential continuity between the person aware of what you are aware of now and the person who was aware of what you were aware of as a teenager in that specific situation. You have been you your whole life.

Finally, remember something that happened when you were a fairly young child, say, around age 6 or 7. Raise your finger when you have an image in mind. Good. Now just look around again. See what was happening. See the sights...hear the sounds...feel your feelings...and then catch the fact that you were there, seeing, hearing, and feeling. Notice that you were there behind your eyes. You were there then, and you are here now. Check and see whether in some deep sense the you that is here now was there then. The person aware of what you are aware of here now was there then.

You have been you your whole life. Everywhere you've been, you've been there noticing. This is what I mean by the "observer you." And from that perspective or point of view, I want you to look at some areas of living. Let's start with your body. Notice how your body is constantly changing. Sometimes it is sick, and sometimes it is well. It may be rested or tired. You may have even had parts of your body removed, as in an operation. Your cells have died, and not all the cells in your body now were there when you were a teenager, or even last summer. Your bodily sensations come and go. Even as we have spoken, they have changed. So if all this is changing and yet the you that you call you has been there your whole life, that must mean that although you have a body, as a matter of experience and not just of belief, you do not experience yourself to be just your body. So just notice your body

now for a few moments, and as you do this, every so often notice that you are the one noticing (give the client time to do this).

Now let's go to another area: your roles. Notice how may roles you have or have had. Sometimes you are in the role of (fit these to the client). In the world of form you are in some role all the time. If you were to try not to, then you would be playing the role of not playing a role. Even now part of you is playing a role...the client role. Yet all the while, notice that you are also present. The part of you you call you is watching and aware of what you are aware of. And in some deep sense, that you does not change. So if your roles are constantly changing, and yet the you that you call you has been there your whole life, it must be that although you have roles, you do not experience yourself to be your roles. Do not believe this. This is not a matter of belief. Just look and notice the distinction between what you are looking at and the you who is looking.

Now let's go to another area: emotions. Notice how your emotions are constantly changing. Sometimes you feel love and sometimes hatred, sometimes calm and the tense, joyful-sorrowful, happy-sad. Even now you may be experiencing emotions- interest, boredom, relaxation. Think of things you have liked and don't like any longer; of fears that you once had that now are resolved. The only thing that you can count on with emotions is that they will change. Although a wave of emotion comes, it will pass in time. Yet while these emotions come and go, notice that in some deep sense that "you" does not change. It must be that although you have emotions, you do not experience yourself to be just your emotions. Allow yourself to realize this as an experienced event, not as a belief. In some very important and deep way you experience yourself as a constant. You are you through it all. So just notice your emotions for a moment and as you do, notice also that you are noticing them (allow a brief period of silence).

Now let's turn to a most difficult area. Your own thoughts. Thoughts are difficult because they tend to hook us and pull us out of our role as observer. If that happens, just come back to the sound of my voice. Notice how your thoughts are constantly changing.

You used to be ignorant- then you went to school and learned new thoughts. You have gained new ideas and new knowledge. Sometimes you think about things one way and sometimes another. Sometimes your thoughts may make little sense. Sometimes they seemingly come up automatically, from out of nowhere. They are constantly changing. Look at your thoughts even since you came in today, and notice how many different thoughts you have had. And yet in some deep way the you that knows what you think is not changing. So that must mean that although you have thoughts, you do not experience yourself to be just you thoughts. Do not believe this. Just notice it. And notice, even as you realize this, that your stream of thoughts will continue. And you may get caught up in them. And yet, in the instant that you realize that, you also realize that a part of you is standing back, watching it all. So now watch your thoughts for a few moments- and as you do, notice also that you are noticing them (allow a brief period of silence).

So as a matter of experience and not belief, you are not just your body...your roles...your emotions...your thoughts. These things are the content of your life, whereas you are the arena...the context...the space in which they unfold. As you see that, notice that the things you've been struggling with and trying to change are not you anyway. No matter how this war goes, you will be there, unchanged. See whether you can take advantage of this connection to let go just a little bit, secure in the knowledge that you have been you through it all and that you need not have such an investment in all this psychological content as a measure of your life. Just notice the experiences in all the domains that show up, and as you do, notice that you are still here, being aware of what you are aware of (allow a brief period of silence). Now again picture yourself in this room. And now picture the room. Picture (describe the room). And when you are ready to come back into the room, open your eyes.

(Hayes et al., 1999, pp. 193-195)

Valuing

The 'What do you Want Your Life to Stand For?' exercise

I want you to imagine that through some twist of fate you have died but you are able to attend your funeral in spirit. You are watching and listening to the eulogies offered by (people important to the subject, such as their friends, parents, brother/sister, etc.) Imagine just being in that situation, and get yourself into the room emotionally. OK, now I want you to vizualize what you would like these people who were part of your life to remember you for. What would you like (a person important to the subject) to say about you (as a friend, son/daughter, brother/sister, etc.)? Have (her/him) say that. Really be bold here. Let (her/him) say exactly what you would most like (her/him) to say if you had a totally free choice about what that would be. Now what would you like (another important person) to remember you for, (as a friend, son/daughter, brother/sister, etc.) Again, don't hold back. If you could have them say anything, what would it be? Even if you have not actually lived up to what you would want, let them say it as you would most want it to be. (adapted from Hayes et al., 1999, p. 216)

The 'Argyle Socks' exercise

Let's do a silly little exercise called the *Argyle Socks Exercise*. Do you care how many people wear argyle socks? (Client- "No, why should I?") OK. Well, what I want you to do is really, really develop a strong belief that college boys have to wear argyle socks. Really feel it in your gut. Really get behind it! (Client- "I can't.") Well, really try. Feel overwhelmingly strongly about this. Is it working? (Client- "No.") OK. Now I want you to imagine that even though you can't make yourself feel strongly about this, you are going to act in ways that make argyle socks important to college students. Let's think of some ways. For instance, you could picket the dormitories that have low percentages of argyle socks

wearers. What else? (Client- "I could beat up college students not wearing them.") Great! What else? (Client- "I could give away free argyle socks to college students."). Super. And notice something. Although these things may be silly actions, you could easily do them. (Client- "And would be forever remembered as that stupid guy who wasted his time worrying about argyle socks!") Yes, and possibly because of your commitment to it, as the person responsible for bringing argyle socks back into fashion. But also notice this: If you behaved in these ways, no one would ever know that you had no strong feelings about argyle socks at all. All they would see is your footprints...your actions. (Client- "OK.") Now here is a question. If you did this, would you be following a value that says that argyle socks are important? Would you in fact be "importanting" about argyle socks? (Client- "Sure.") OK. So what stands between you and acting on the basis of things that you really do hold as important? It can't be feelings if they are not critical even when we are dealing with something so trivial. (Hayes et al., Strosahl, & Wilson, 1999, p. 211)

The distinction between a choice and a decision

The difference between choice and decision is important because this is the area in which willingness and commitment become possible. If you do something because of a decision, then commitment becomes impossible, because if the reasons you made your decision for later change, then the decision itself (logically) must be altered. You can't be willing to make a commitment, because you know you may not be able to keep it. On the other hand, if reasons change, a choice doesn't have to be changed. Reasons may be part of the context of a choice, but reasons don't dictate choice; you can keep a commitment you choose to make regardless of whether the initial reasons for making the commitment remain the same. More importantly, in the context of process and choice, you can be willing to make a commitment, to take a direction with your life even knowing that you won't always be able to keep it, but knowing that outcome is not really the issue. (Hayes et al., 1991, p. 41)

The 'Choice' exercise

Ask the client to imagine being given a choice between two kinds of soft drinks: Coke and 7-Up. Ask the client to choose. Whatever the client says, ask why. If a reason is given, attack the reason, point out that the choice could have been different even with that reason, and ask the client once again to choose. "And besides, the issue is which do you choose, not which do your reasons choose?" Continue until it is clear that any reason the client gives can be argued, but that reasons, per se, aren't necessary. Tell the client the issue isn't even doing things because you want to do them or not. Rather, the issue is choosing simply because you choose. That's coach talk, not reporter talk. Say, "You have the capacity to take a course of action for no other reason than you choose to take it. It's not necessary to defend or explain." (Hayes et al., 1991, p. 39)

The 'Skiing' metaphor

Suppose you go skiing. You take a lift to the top of a hill, and you are just about to ski down the hill when a man comes along and asks you where you are going. "I'm going to the lodge at the bottom, " you reply. He says, "I can help you with that," and promptly grabs you, throws you into a helicopter, flies you to the lodge, and then disappears. So you look around kind of dazed, take a lift to the top of the hill, and you are just about to ski down it when that same man grabs you, throws you into a helicopter, and flies you to the lodge. You'd be upset, no? Skiing is not just the goal of getting to the lodge. Skiing is how we are going to get there. Yet notice that getting to the lodge is important because it allows us to do the process of skiing in a direction. If I tried to ski uphill instead of down, it wouldn't work. Valuing down over up is necessary in downhill skiing. There is a way to say this: Outcome is the process through which process can become the outcome. We need

goals, but we need to hold them lightly so that the real point of living and having goals can emerge. (Hayes et al., 1999, pp. 220-221)

The 'Standing at the Edge of the Ocean' metaphor

It's like you are standing at the edge of the ocean. The tide sometimes moves in and the water almost is over your head. At other times, the tide is low, and your feet barely get wet. You don't have any control over how high or low the water is at any point in time. What you can do, however, is mark a point on the horizon and head that way. It may be that in places the water will get very deep, and at those times, it would be easy to lose your way if you were only paying attention to your immediate surroundings. But as long as you keep your eyes on that spot on the horizon, you can keep moving in the chosen direction, no matter how deep the water gets. (Hayes et al., 1991, p. 36)

The 'Path up the Mountain' metaphor

Suppose you are taking a hike in the mountains. You know how mountain trails are constructed, especially if the slopes are steep. They wind back and forth; often they have "switchbacks," which make you literally walk back and forth, and sometimes a trail will even drop back to below a level you had reached earlier. If I asked you at a number of points on such a trail to evaluate how well you are accomplishing your goal of reaching the mountain top, I would hear a different story every time. If you were in switchback mode, you would probably tell me that things weren't going well, that you were never going to reach the top. If you were in a stretch of open territory where you could see the mountaintop and the path leading up to it, you would probably tell me things were going very well. Now imagine that we are across the valley with binoculars, looking at people hiking on this trail. If we were asked how they were doing, we would have a positive progress report every time.

We would be able to see that the overall direction of the trail, not what it looks like at a given moment, is the key to progress. We would see that following this crazy, winding trail is exactly what leads to the top. (Hayes et al., 1999, pp. 221-222)

Willingness and commitment

The 'Parachute Jump' metaphor

Willingness is like a parachute jump. Before the first jump, you don't know what will happen if you just let go and jump. And there is no way anyone can really prepare you for the experience. You have to jump and to experience it. That's what we are doing in here. We are working on jumping. (Hayes et al., 1991, p. 24)

The 'Jumping' metaphor

Jumping out of an aeroplane seems impossible. But watch this: (therapist should then stand on a magazine or file folder, and exaggeratedly jump). See what I did? The action of jumping is the same if I jump off this folder as it is when I jump off this chair (then jump off chair). And it is the same action that is used to jump off the plane. I'm not asking you to jump out of a plane right now; I'm asking you to be willing to practice your jumping action for a while. Then you will be ready to choose to jump where or whenever jumping is the thing that would work to do. (Hayes et al., 1991, p. 45)

The 'Pick up a Pen' exercise

OK, what I'd like you to do is to try to pick up this pen. Try as hard as you can. No- you're picking up the pen- I want you to try to do it... (Hayes et al., 1991, p. 40)

The 'Swamp' metaphor

Suppose you are beginning a journey to a beautiful mountain you can clearly see in the distance. No sooner do you start the hike than you walk right into a swamp that extends as far as you can see in all directions. You say to yourself, "Gee, I didn't realize that I was going to have to go through a swamp. It's all smelly, and the mud is all mushy in my shoes. It's hard to lift my feet out of the muck and put them forward. I'm wet and tired. Why didn't anybody tell me about this swamp?" When that happens, you have a choice: abandon the journey or enter the swamp. Therapy is like that. Life is like that. We go into the swamp, not because we want to get muddy, but because it stands between us and where we are going. (Hayes et al., 1999, p. 248)

The 'Riding a Horse' metaphor

If the client is worried that s/he will lose what s/he has learned, say something like "You will lose it. That is not a problem, as long as you get it back quickly enough. It is like the old cowboy movies where the guy jumps on the horse but holds on to the saddle horn. When his feet hit the ground he jumps back over the horse and his feet hit the ground on the other side. He is constantly falling off the horse, but he is moving forward as fast as if he had stayed in the saddle." (Hayes et al., 1991, p. 61)

References

HAYES, S.C., MCCURRY, S.M., AFARI, N., & WILSON, K. (1991). *Acceptance and commitment therapy: A therapy manual for the treatment of emotional avoidance*. Reno: Context.

HAYES, S.C., STROSAHL, K.D., & WILSON, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.

APPENDIX D

BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY-

INSTRUCTIONS TO AUTHORS

CRITICAL REVIEW PAPER

THE APPLICATION OF ACCEPTANCE AND COMMITMENT THERAPY TO THE TREATMENT OF ADOLESCENTS WITH DISRUPTIVE BEHAVIOURS: A CRITICAL REVIEW

A re-cap of the hypotheses of the research study

The research study describes the application of Acceptance and Commitment Therapy (ACT) to the treatment of experiential avoidance in two adolescents with disruptive behaviour problems (DBPs). Such application of ACT has not previously been reported.

It was hypothesised that treatment would result in clinically significant decreases in participants' (a) self-reported experiential avoidance, and (b) parent-reported frequencies of DBPs. The aim of the study was to test these hypotheses.

The hypotheses followed from two bodies of empirical evidence. First, a large body of evidence, from many different sources, that suggests that experiential avoidance is an important functional factor in a significant proportion of adolescents with DBPs. Second, a small body of evidence, from a few sources, that suggests that ACT is an efficacious treatment approach for other topographically defined problems in which experiential avoidance is thought to be an important functional factor.

Ten important questions about the research study

1. Why was single-case experimental methodology employed?

Single-case experimental methodology (SCEM) is particularly suitable for application in the investigation of the usefulness of new treatment approaches (Barlow, 1973; Bergin & Strupp, 1972; Hayes, 1981; Kazdin, 2001; Salkovskis, 2002; Turpin, 2001). SCEM enables experimental research (i.e., research in which threats to validity are controlled to a

satisfactory extent) to be conducted with small numbers of participants in the course of normal clinical practice (Hayes, Barlow, & Nelson-Grey, 1999; Hayes & Haas, 1990). Single-case research, typically of non-experimental design (e.g., uncontrolled case-studies or case-series), has been an important first step in the investigation of the usefulness of a number of what are now the most empirically-supported treatment approaches (e.g., cognitive-behaviour therapy, systematic desensitization) (Barlow, 1981; Hayes, 1997; Salkovskis, 1995; Turpin, 2001).

Randomised-controlled-trial (RCT) methodology, the main experimental alternative to SCEM, was rejected for use in the research study, for both practical and philosophical reasons. Practically, it would not have been possible for the author to have recruited and treated sufficient numbers of participants to meet the requirements of an RCT, with the resources available to him. Philosophically, it made little sense to him to attempt to investigate the usefulness of ACT in the treatment of experiential avoidance in a relatively large number of adolescents with DBPs until it had been demonstrated to be useful in the treatment of a few. In fact, he considered that it would have been unethical to do so. Further, he was keen to ensure that the results of the study would have as much external validity as possible. SCEM research can be conducted in a manner that approximates normal clinical practice (Barlow, 1980; Hayes et al., 1999; Kazdin, 2001). The results of RCTs, in which experimental rather than clinical factors dictate practice (e.g., length of treatment), typically reflect the reality of clinical practice to a much lesser degree than do those of clinical SCEM studies.

The two cases reported form an experimental clinical replication series (Hayes et al., 1999; Hayes & Haas, 1990). The multiple-baseline design employed enables each case to function both as its own control and as a control for the other. Threats to internal validity are controlled to a much greater extent that they would be in non-experimental designs (e.g., uncontrolled case-studies or case-series, or case-series involving unitary length baselines). The study falls significantly further along "the continuum that reflects the degree to which

scientifically adequate inferences can be drawn" than would a non-experimental study (Kazdin, 1981, p. 185).

2. Are the results clinically significant within the time frame of the research study?

Clinicians are interested in helping their clients to make meaningful positive changes in their lives. Such changes are described as being *clinically significant* (Barlow & Hersen, 1984; Hayes et al., 1999; Kazdin, 1977). Researchers who are interested in identifying treatment approaches that result in such changes need to discriminate between statistical and clinical significance when evaluating outcomes (Barlow & Hersen, 1984; Bergin & Strupp, 1972; Garfield, 1980, 1981). A statistically significant change (e.g., a significant decrease in scores on a depression inventory in a group of moderately depressed participants) is not necessarily clinically significant (the participants may all still be moderately depressed). Treatment approaches that result in statistically but not clinically significant changes are of little use to clinicians (Barlow, 1980).

One approach to determining whether or not outcomes are clinically significant is to ask participants and/or those who are most affected by their behaviours of concern if they think that treatment has resulted in meaningful positive changes. This is known as *social validation* (Baer, Wolf, & Risley, 1968; Kazdin, 1978; Wolf, 1978).

In the research study, pre-treatment, both participants frequently engaged in non-aggressive disruptive behaviours at home and were occasionally aggressive toward others. Each participant and her/his parent(s) considered her/his behaviours to be problematic to the extent that they required intervention. At end-of-treatment, each participant and her/his parent(s) agreed that she/he was no longer engaging in these behaviours to an extent that was problematic. The changes in the participants' DBPs may therefore be considered to be clinically significant, within the time frame of the study.

Pre-treatment, both participants reported frequently having difficult private experiences. Both also reported having avoidant styles of coping with such experiences. Their scores on the AAQ were within the clinically significant range. Jack was mildly depressed. At end-of-treatment, both reported having difficult private experiences much less frequently and using acceptance-focussed coping styles. Their scores on the AAQ were within the non-clinically significant range. Jack was no longer depressed. The changes in their experiential avoidance may also be considered to be clinically significant, within the time frame of the study.

3. Are the results clinically significant over the long-term?

The decreases in the frequencies of Diane's and Jack's DBPs were maintained for, respectively, one-month and two-weeks post-treatment. Jack's mother ceased data collection at this point, citing other commitments as the reason for doing so. The decreases in Diane's AAQ score and Jack's AAQ and BDI-II scores were maintained for two-weeks post-treatment. The time constraints of the study prevented a longer follow-up period. It is not known whether treatment resulted in clinically significant changes over the long-term.

ACT will have little value as a treatment for experiential avoidance in adolescents with DBPs if its effects do not last for clinically significant periods of time. An aim of further research should be to determine whether or not treatment outcomes endure over the long-term.

4. Is treatment believable as the cause of the results?

The believability of treatment as the cause of the results depends on the extent to which potential alternative causes can be discounted. Kazdin (1981, 1992) identifies five major threats to internal validity: history, maturation, testing, instrumentation, and statistical

regression (similarly, Hayes et al., 1999; Turpin, 2001). Each of these is considered with regard to the decreases in the participants' frequencies of DBPs.

"History" refers to events occurring in time (e.g., illness in a participant's family, changes in the weather). "Maturation" refers to processes of change occurring within a participant (e.g., puberty). In non-experimental designs, history and maturation cannot be discounted as possible causes of changes in dependent variables. They are controlled for in the research study through the employment of a multiple-baseline design.

Following baseline phases of different lengths, the initial decreases in each participant's frequencies of DBPs occurred at different points in real-time. The principle of the improbability of successive coincidences suggests that it is unlikely that they resulted from either history or maturation (Hayes et al., 1999). Further, DBPs in adolescents are known to be typically stable over relatively long periods of time (e.g., Kazdin, 1993). History and maturation are unlikely to be causes of change during treatment in problems that are typically stable (Hayes et al., 1999; Kazdin, 1981, 1992).

Testing, instrumentation, and statistical regression toward the mean are threats to validity that are most likely to occur when dependent variables are measured on only a small number of occasions (e.g., at pre and post-treatment) (Hayes et al., 1999; Kazdin, 1981, 1992). They are unlikely to influence dependent variables over many occasions. In the research study, they are controlled for by the measurement of the frequencies of DBPs on a relatively large number of occasions.

The timing and magnitude of the decreases in each participant's frequencies of DBPs adds to the believability of treatment as their cause. The decreases occurred relatively suddenly after the phase change from baseline to treatment. In Diane's case, they occurred almost immediately. In Jack's case, they occurred within a few weeks. Relative to his two-year history of DBPs, this is a sudden effect. Relative to baseline levels of DBPs, the decreases were large. In SCEM research, effects that are sudden and large, and for which

alternative explanations can be discounted, are considered believable (Hayes et al., 1999; Kazdin, 1992; Linscheid, 2000; Morley, 1989).

Treatment is believable as the cause of the decreases in each participant's frequencies of DBPs because the multiple-baseline design employed enables threats to internal validity to be discounted. The other dependent variables were not included in this design. It is possible that the changes in these variables resulted from threats to internal validity. However, the fact that the clinically significant decreases in each participant's scores on the ECBI, SDQ, and AAQ (and in Jack's case BDI-II) between pre-treatment and end-of-treatment were consistent with the decreases in her/his frequencies of DBPs strongly suggests that they resulted from treatment.

Two additional threats to internal validity potentially apply to all the results. First, it is possible that one or both of the participants and/or their parent(s) may have provided biased data because they wanted to try to please the author by demonstrating that treatment was effective. Second, it is possible that the results were caused by factors present during treatment that were non-specific to ACT (e.g., the author may have provided a significant level of non-contingent positive reinforcement to the participants during treatment but not baseline). The study design does not control for these potential threats. Replications of the study by other researchers may enable them to be discounted. Until such replications take place, the inability to control for these threats must be acknowledged as a weakness of the study.

On balance, the author considers that the results support the experimental hypotheses.

5. Was ACT delivered to the participants?

In the evaluation of treatment efficacy, it is important to consider the issue of treatment integrity (Hayes & Nelson, 1986; Salend, 1984; Yeaton & Sechrest, 1981). Treatment

integrity is "the degree to which treatments are implemented as intended" (Gresham, 1996, p. 93).

A common approach to assessing treatment integrity is for the researcher to have a competent independent evaluator observe delivery and provide integrity ratings (Gresham, 1996; Hayes et al., 1999; Waltz, Addis, Koerner, & Jacobson, 1993). This is a topographical approach; the evaluator provides ratings based on the appearance of treatment delivery.

A less common alternative is a functional approach, in which the researcher measures the extent to which treatment works as intended (Hayes et al., 1996; Morley, 1989). For example, in assessing the treatment integrity of cognitive-behaviour therapy (CBT) for depression, the researcher could monitor changes in cognitions (Hayes et al., 1999; Hayes & Nelson, 1986). According to the theory that underlies CBT, if treatment is delivered as intended the client's cognitions should change.

In assessing treatment integrity in the research study, a functional approach was adopted, for two reasons. First, a competent independent evaluator was not available to assess integrity live in session. The author was of the opinion that recording treatment sessions could potentially interfere with therapeutic progress, by making the participants less willing to discuss their histories and current difficulties (cf. Margison, 2001, for a discussion of the potential negative effects of tape-recording sessions). Second, a functional approach is consistent with ACT theory. ACT is defined functionally rather than topographically (Hayes, Strosahl, & Wilson, 1999). ACT is being delivered if treatment results in clinically significant decreases in experiential avoidance, regardless of the form of treatment.

The AAQ is a useful measure of ACT treatment integrity, because it specifically measures experiential avoidance. The large, clinically significant, decreases in each participant's experiential avoidance over treatment strongly suggest that ACT was delivered.

6. What were the processes of change involved?

The processes involved in the changes in each participant's experiential avoidance and frequencies of DBPs are uncertain. A causal link between experiential avoidance and DBPs cannot be discriminated from the available data. However, consistent with the data, it may be hypothesised that (a) experiential avoidance was an important functional factor in the maintenance of each participant's DBPs, and (b) the reductions in her/his experiential avoidance resulting from treatment led to the decreases in her/his frequencies of DBPs.

7. Can any conclusions be drawn from the results?

The research study is a first step in the investigation of the treatment of experiential avoidance in adolescents with DBPs. It would be unwise to draw any conclusions about the usefulness of ACT as a treatment for this population from only two cases. On the basis of the results of the study, it can be concluded only that ACT resulted in clinically significant decreases in experiential avoidance and frequencies of DBPs in two particular adolescents.

It was originally planned that the study would involve nine participants, across three baselines. Results from nine participants (if generally consistent) would have enabled preliminary conclusions about the usefulness of ACT as a treatment for this population to have been drawn. Difficulties in recruiting participants prevented this design from being enacted. A total of only five potential participants were recruited. Of these, one was excluded and provided with alternative treatment because he reported a history of suicidal ideation (a reviewer of the study's ethics proposal stipulated the exclusion of such individuals as a condition for approval). Another was excluded because he exhibited no DBPs during baseline (his referral to the Child and Adolescent Mental Health Service had reported DBPs in school, but these ceased prior to baseline when peers stopped bullying him). A third had completed baseline but not treatment by the time that it was necessary to 'write-up' the

study. At this time, he had received six treatment sessions. The frequencies of his DBPs were apparently decreasing. However, it would not be appropriate to consider his incomplete data series in evaluating the usefulness of ACT as a treatment approach for this population.

In retrospect, it is unsurprising that a lone researcher conducting the study within a relatively short period of time was unable to obtain complete data series from more than two participants. With reference to clinical SCED research, Barlow, Hayes, and Nelson (1984) note that typically less than half of the cases that clinicians initially become involved with result in evaluations "worth sharing" (p. 286). Adolescents with DBPs are a particularly difficult client group to engage in treatment and research (e.g., Greenwald, 2000; Horne & Glaser, 1993; Sommers-Flanagan, J. & Sommers-Flanagan, R., 1998).

8. What further research is necessary to enable conclusions about the usefulness of ACT as a treatment approach for experiential avoidance in adolescents with DBPs to be drawn?

In order to enable conclusions about the usefulness of ACT as a treatment approach for experiential avoidance in adolescents with DBPs to be drawn, replications of the treatments reported in the research study are necessary. For SCEM research to have external validity, replication is essential (Hayes, 1981; Kiesler, 1981).

The cases reported and subsequent replications could be included together in a natural multiple-baseline design (Hayes et al., 1999; Hayes & Nelson, 1986). Replications carried out by other researchers, in different locations, involving a variety of baseline lengths, would be of the most value, because they would provide the greatest degree of control of threats to internal validity. The believability of the treatment effects would increase with each successful replication (Hayes et al., 1999; Turpin, 2001). Even a small number of replications would increase believability greatly. Replications by several different researchers would enable an evaluation of therapist effects (Hayes et al., 1999).

The study provides three pieces of information necessary for other researchers to carry out replications: (a) descriptions of the participants, (b) a description of the independent variable, and (c) descriptions of the dependent variables (Hayes et al., 1999). The adequacy of the descriptions will be determined by the ability of other researchers to carry out replications, based on those descriptions (Hayes & Nelson, 1986).

9. What other further research seems potentially valuable?

As noted above, there are good reasons to believe that experiential avoidance is an important functional factor in DBPs in many adolescents. Research into experiential avoidance is in its infancy. The prevalence rate of clinically significant experiential avoidance in adolescents with DBPs is currently unknown (as it is in all other clinical populations). On the basis of the results of the study, research into both the prevalence rate of experiential avoidance in adolescents with DBPs and its function in the etiology and maintenance of such problems seems potentially valuable.

10. What important developments in the theoretical understanding and treatment of DBPs in adolescents may the research study potentially lead to?

The research study may potentially lead to important developments in both theory and practice through further research.

Existing theoretical accounts of DBPs in adolescents do not identify experiential avoidance as an important functional factor, and treatment approaches based on these accounts (e.g., parent-management-training, problem-solving skills-training, multi-systemic therapy) do not address it. The identification of experiential avoidance as an important functional factor in a significant proportion of adolescents with DBPs would necessitate changes to both existing theories and treatment approaches.

If ACT were determined to be a useful treatment approach for experiential avoidance in adolescents with DBPs, it could potentially be incorporated into existing treatment approaches that address other factors important in the maintenance of DBPs (e.g., lack of behaviour-management skills in parents, lack of cognitive problem-solving skills in adolescents).

It is important to note that even if ACT is determined to be a useful treatment approach for this population, it will only ever be applicable to those adolescents who want to be helped.

References

BARLOW, D.H. (1973). Single-case experimental designs. *Archives of General Psychiatry, 29,* 319-325.

BARLOW, D.H. (1980). Behavior therapy: The next decade. *Behavior Therapy, 11,* 315-328.

BARLOW, D.H. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. *Journal of Consulting and Clinical Psychology, 49,* 147-155.

BARLOW, D.H., HAYES, S.C., & NELSON, R.O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings*. New York: Permagon.

BARLOW, D.H., & HERSEN, M. (1984). *Single case experimental designs: Strategies for studying behavior change (2nd Ed.)*. Boston: Allyn & Bacon.

BAER, D.M., WOLF, M.M., & RISLEY, T.R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis, 1,* 91-97.

BERGIN, A.E., & STRUPP, H.H. (1972). *Changing frontiers in the science of psychotherapy*. Chicago: Aldine-Atherton.

GARFIELD, S.L. (1980). *Psychotherapy: An eclectic approach*. New York: John Wiley & Sons.

GARFIELD, S.L. (1981). Evaluating the psychotherapies. *Behavior Therapy, 12,* 295-307.

GREENWALD, R. (2000). A trauma-focused individual therapy approach for adolescents with conduct disorder. *International Journal of Offender Therapy and Comparative Criminology, 44,* 146-163.

GRESHAM, F.M. (1996). Treatment integrity in single-subject research. In R.D. Franklin, D.B. Allison, & B.S. Gorman (Eds.), *Design and analysis of single-case research*. Mahwah: Lawrence Erlbaum.

HAYES, S.C. (1981). Single case experimental design and empirical clinical practice.

Journal of Consulting and Clinical Psychology, 49, 193-211.

HAYES, S.C. (1997). Technology, theory, and the alleviation of human suffering: We still have such a long way to go. *Behavior Therapy, 28,* 517-525.

HAYES, S.C., BARLOW, D.H., & NELSON-GREY, R.O. (1999). *The scientist practitioner: Research and accountability in the age of managed care.* Boston: Allyn & Bacon.

HAYES, S.C., & HAAS, J.R. (1990). Research in outpatient clinical practice. In M.E. Thase, B.A. Edelstein, & M. Hersen (Eds.), *Handbook of outpatient treatment of adults: Nonpsychotic mental disorders.* New York: Plenum.

HAYES, S.C., & NELSON, R.O. (1986). Assessing the effects of therapeutic interventions. In R.O. Nelson & S.C. Hayes (Eds.), *Conceptual foundations of behavioral assessment.* New York: Guilford.

HAYES, S.C., STROSAHL, K.D., & WILSON, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* New York: Guilford.

HORNE, A.M., & GLASER, B.A. (1993). Conduct disorders. In R.T. Ammerman, C.G. Last, & M. Hersen. (Eds.), *Handbook of prescriptive treatments for children and adolescents.* Boston: Allyn & Bacon.

KAZDIN, A.E. (1977). Assessing the clinical or applied importance of behavior change through social validation. *Behavior Modification, 1,* 427-451.

KAZDIN, A.E. (1978). Evaluating the generality of findings in analogue therapy research. *Journal of Consulting and Clinical Psychology, 46,* 673-686.

KAZDIN, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49,* 183-192.

KAZDIN, A.E. (1992). *Research design in clinical psychology (2nd Ed.).* Boston: Allyn & Bacon.

KAZDIN, A.E. (1993). Treatment of conduct disorder: Progress and directions in

psychotherapy research. *Development and Psychopathology, 5,* 277-310.

KAZDIN, A.E. (2001). Progression of therapy research and clinical application of treatment require better understanding of the change process. *Clinical Psychology: Science and Practice, 8,* 143-151.

KIESLER, D.J. (1981). Empirical clinical psychology: Myth or reality? *Journal of Consulting and Clinical Psychology, 49,* 212-215.

LINSCHEID, T.R. (2000). Case studies and case series. In D. Drotar (Ed.), *Handbook of research in pediatric and clinical child psychology: Practical strategies and methods.* New York: Kluwer.

MARGISON, F. (2001). Practice-based evidence in psychotherapy. In C. Mace, S. Moorey, & B. Roberts (Eds.), *Evidence in the psychological therapies: A critical guide for practitioners.* Philadelphia: Taylor & Francis.

MORLEY, S. (1989). Single case research. In G. Parry & F.N. Watts (Eds.), *Behavioural and mental health research: A handbook of skills and methods.* Hove: Lawrence Erlbaum.

SALEND, S.J. (1984). Therapy outcome research: Threats to treatment integrity. *Behavior Modification, 8,* 211-222.

SALKOVSKIS, P.M. (1995). Demonstrating specific effects in cognitive and behavioural therapy. In M. Aveline & D.A. Shaprio (Eds.), *Research foundations for psychotherapy practice.* Chichester: John Wiley &Sons.

SALKOVSKIS, P.M. (2002). Empirically grounded clinical interventions: Cognitive-behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural and Cognitive Psychotherapy, 30,* 3-9.

SOMMERS-FLANAGAN, J., & SOMMERS-FLANAGAN, R. (1998). Assessment and diagnosis of conduct disorder. *Journal of Counseling and Development, 76,* 189-197.

TURPIN, G. (2001). Single case methodology and psychotherapy evaluation: From research to practice. In C. Mace, S. Moorey, & B. Roberts (Eds.), *Evidence in the*

psychological therapies: A critical guide for practitioners. Philadelphia: Taylor & Francis.

WALTZ, J., ADDIS, M.E., KOERNER, K., & JACOBSON, N.S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 61,* 620-630.

WOLF, M.M. (1978). Social validity: The case for subjective measurement or How applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11,* 203-214.

YEATON, W.H., & SECHREST, L. (1981). Critical dimensions in the choice and maintenance of successful treatments: Strength, integrity, and effectiveness. *Journal of Consulting and Clinical Psychology, 49,* 156-167.

APPENDIX

STATEMENT OF WORD COUNT

STATEMENT OF WORD COUNT

Component of the thesis	Word count
Thesis abstract, ethics proposal, and papers	
Thesis abstract-	300
Research study ethics proposal-	3138
Literature review paper (including abstract)-	5199
Research study paper (including abstract)-	5391
Critical review paper-	3000
Total for the above noted components-	17028
Tables, figures, reference lists, and appendices	
Tables-	115
Figures-	54
Reference lists-	5321
Appendices-	11958
Total for the above noted components-	17448
Total for all thesis components-	34476