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Using Acceptance and Commitment Therapy to Treat Distressed Couples: A Case Study With Two Couples

Brennan D. Peterson
Georg H. Eifert
Tal Feingold
Sarah Davidson
Chapman University

Although the field of couple therapy has made significant strides in recent years, there continues to be a need for theoretically sound and empirically supported treatments. The current case study examines whether Acceptance and Commitment Therapy (ACT), an experiential acceptance-based behavior therapy, can be effective in treating distressed couples. Although ACT has demonstrated effectiveness in treating a variety of disorders in individuals, it has not been systemically applied to the treatment of couple distress, and the current study is the first empirical examination of ACT for the treatment of couples. Two married couples participated in the study. A number of core ACT interventions were modified to treat couples in a conjoint format. Cognitive defusion exercises were used to help couples reduce their fusion with and the believability of negative thoughts and feelings related to the relationship. Mindfulness and acceptance techniques were used to help couples increase awareness of their reactions to negative relationship cycles. Finally, value-directed action was used to help partners act in ways consistent with relationship values even in the presence of unwanted thoughts and feelings. The results of this preliminary case study suggest that ACT may be effective in increasing marital adjustment and satisfaction, and in reducing interpersonal and psychological distress in couples. Future studies with larger samples and more controlled designs are needed to build on the results from this single-case study.

Treatments for distressed couples have gained considerable attention among researchers and clinicians over the past several decades. In their seminal review of the history of couple therapy, Gurman and Fraenkel (2002) noted that most therapists work with couples on a regular basis, and that couples seek therapy to deal with a variety of relationship difficulties, including communication problems, role conflicts, sexual difficulties, extramarital affairs, and poor problem-solving skills. This represents significant progress considering that as little as 40 years ago, approaches to couple therapy lacked empirical support and operated largely without theoretical foundation (Gurman & Fraenkel). Couple therapy is now the treatment of choice to address relationship dissatisfaction, and a number of studies have demonstrated that couple therapy is effective in reducing relationship distress while increasing relationship satisfaction and stability (Christensen & Heavey, 1999; Cordova, Jacobson, & Christensen, 1998; Jacobson et al., 2000; Johnson & Lebow, 2000; Shadish & Baldwin, 2005).

A number of studies have examined the effectiveness of couple therapy. Emotionally focused couple therapy (EFT), which focuses on altering negative relationship interaction cycles by accessing emotions and attachment needs, has been shown to be highly effective in treating couple distress (Johnson & Lebow, 2000). In addition, traditional behavioral couple therapy (TBCT) has demonstrated effectiveness in over 20 randomized clinical trials (Jacobson et al., 2000). Although TBCT has shown effectiveness, concerns regarding its limitations and the long-term maintenance of change led the founders of TBCT to create a new approach called integrative behavioral couple therapy (IBCT). This approach combines the behavior change strategies of TBCT with acceptance strategies aimed at reducing partners' insistence upon change (Jacobson & Christensen, 1996). When tested, these additive ingredients yield improved therapy outcomes (Christensen et al., 2004; Jacobson et al., 2000).

In their study of 21 couples randomly assigned to either IBCT or TBCT, Jacobson and colleagues found that marital satisfaction improved significantly more for husbands and wives receiving IBCT when compared to couples receiving TBCT (Jacobson et al., 2000). A

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randomized clinical trial by Christensen et al. (2004) examined the efficacy of IBCT using 134 chronically distressed married couples and assessed the couples at four time points (intake, 13 weeks, 26 weeks, and posttherapy). The findings indicated that IBCT was as effective as TBCT, and that couples receiving IBCT made steady improvement throughout therapy. In their 2006 follow-up, Christensen and colleagues found that although there were no significant differences in outcome between IBCT and TBCT, couples in both groups experienced different trajectories in improvement; TBCT couples experienced a more rapid improvement, while IBCT couples made more steady improvements over the course of therapy.

In addition to IBCT, there are other acceptance-based approaches aimed at improving relationships and treating emotional dysregulation in couples. Carson and colleagues (2004) tested whether mindfulness-based strategies could improve relationship quality in 44 nondistressed heterosexual couples and found that higher levels of mindfulness were related to improved relationships and decreased relationship stress. Additionally, Kirby and Baucom (2007) integrated components of dialectical behavior therapy and cognitive-behavioral therapy in a couples group format. The results of the study provided support for using this format to treat emotion dysregulation in couples.

Although empirically supported treatments such as IBCT and EFT have demonstrated long-term effectiveness for distressed couples, there are still concerns about the long-term effectiveness of couple therapy in general (Johnson & Lebow, 2000). For instance, couples often wait too long before seeking treatment, and only enter therapy after one or both members of the couple have become severely distressed. This is problematic because a couple's initial distress level is the strongest predictor of treatment outcome (Johnson & Lebow). In addition, outcome studies have consistently found that couples who are severely distressed at the beginning of therapy are least likely to be happily married at the end of treatment (Jacobson & Addis, 1993).

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is an experiential, acceptance-based behavior therapy that targets the function of experiential avoidance and efforts to control aversive experiences (Hayes, Strosahl, & Wilson, 1999). ACT helps clients to respond less literally to their thoughts and emotions by decreasing the believability of thoughts (cognitive defusion), learning to acknowledge and observe private reactions to psychological distress, and committing to and progressing toward valued life directions (Hayes & Wilson, 1994). ACT is based on Relational Frame Theory (RFT), a comprehensive behavior analytic account of how individuals get entangled in language and verbal-symbolic behavior processes that trap them in a struggle with thoughts and emotions they experience as aversive (Hayes, Barnes-Holmes, & Roche, 2001).

Although ACT has shown considerable promise in treating a variety of psychological disorders involving individuals with anxiety, depression, chronic pain, eating disorders, and substance abuse (Eifert & Forsyth, 2005; Hayes et al., 2006; Heffner et al., 2003; Heffner, Sperry, Eifert, & Detweiler, 2002; Orsillo & Batten, 2005; Strosahl & Robinson, 2008; Wicksell, Dahl, Magnusson, & Olsson, 2005), there have not been any systematic studies addressing its application to the treatment of couple distress.

From an ACT perspective, the development and maintenance of distress, conflict, and emotional distance in couples stems from each partner's rigid and unworkable control and experiential avoidance strategies contextualized by the couple's relationship. Common avoidance strategies include avoiding communicating with one's partner when previous communications have led to conflict or emotional distance, avoiding expressions of emotional or physical intimacy due to the fear of rejection, and avoiding joint activities that create meaning and shared memories. These examples of experiential avoidance not only protect the individual from experiencing unwanted thoughts and feelings, but also prevent couples from acting in ways that promote relational health. Additionally, there is entanglement (fusion) with thoughts and feelings about the actions or lack of actions in the relationship. Taking such thoughts literally ("buying into" them) and acting on them maintains couples' negative relationship cycles. ACT seeks to undermine such processes and thereby reduce the unnecessary suffering in couples caused by each partner's experiential avoidance efforts. The ultimate goal of ACT is to help members of a couple become mindful of their cognitive and emotional responses to both their partner and their own behavior within the relationship, clarify the values they hold regarding their relationship, and commit to acting in ways that are consistent with these valued directions, even in the presence of unwanted thoughts and feelings.

When previous learning has taught couples to avoid situations linked with hurt, rejection, or conflict, ACT teaches couples to approach the aversive internal thoughts, feelings, and bodily states linked with these relationship patterns and dynamics. This is easily illustrated when one partner feels emotionally hurt or invalidated, which leads to emotional distancing. While emotional distancing serves to protect the individual and limits the possibility of further emotional distress, ACT teaches couples to approach the thoughts and feelings

that are linked to emotional distancing (e.g., "I can't talk to my spouse about what I am really feeling" or "I just can't argue about this point again") by learning to defuse from these thoughts, practice mindful acceptance of such thoughts, and act in ways that are consistent with the couple's values regarding emotional intimacy and connection. As partners begin to employ these skills and strategies, they become more willing and able to approach a previously avoided situation, giving the couple the opportunity to behave in ways that may improve relationship satisfaction and increase interpersonal intimacy over time. While there is no guarantee that this approach will improve the situation, targeting both individuals' experiential avoidance in the context of the relationship provides couples the opportunity to build stronger connections by helping them approach previously avoided relational thoughts and feelings, and act in ways consistent with both partners' relationship values.

IBCT is an empirically supported treatment for couple distress, and it is worth noting the differences between ACT and IBCT to elucidate ACT's potential to make a unique contribution to the field of couple therapy. ACT for couples shares common therapeutic goals and therapeutic processes with IBCT. Both therapies integrate acceptance into their treatment, and both therapies focus on improving relationship satisfaction through behavior change. In terms of acceptance, IBCT promotes accepting partner differences and deemphasizes the focus on changing one's partner by using interventions such as empathic joining and unified detachment (Jacobson & Christensen, 1996). ACT, on the other hand, encourages each partner to mindfully accept their own private internal reactions to the other's behavior by learning to recognize their (likely negative) evaluations of that behavior as thoughts that need not be acted upon. Specifically, ACT uses cognitive defusion techniques to decrease the believability of thoughts and reduce one's tendency to "become" one's thoughts, which provides greater flexibility and makes space for novel relationship behaviors. ACT also expands on the behavior change strategies of IBCT (e.g., behavior exchange, communication/problem-solving training) by using value-directed action. ACT promotes behavior change by clarifying individual and relationship values, committing clients to act in the service of these values by linking values to short- and long-term goals, and practicing acceptance and willingness to pursue such behaviors even in the presence of unwanted internal negative evaluations. Finally, ACT differs from IBCT in that it uses experientially based interventions to undermine the verbal relational rules governing behavior through utilizing metaphors, mindfulness techniques, and other experiential exercises. ACT teaches couples to respond less literally to their thoughts and emotions and to observe rather than respond to and act upon their thoughts and feelings, particularly in a relational context. Metaphors are stories that allow couples to make contact with unwanted aspects of their relationship experience and help partners recognize the costs of approaching their relationship distress with avoidance and cognitive fusion. The "creative hopelessness" that results when clients acknowledge these costs opens the door for new relationship solutions and interactions.

Single-Case Study Design

The current study uses a single-case study design to examine the effectiveness of using ACT to treat distressed couples. Several researchers have written about the need to conduct more practice-based studies in an effort to bridge the gap between researchers and clinicians, specifically calling for a return to the case study design (Borckardt et al., 2008; Goldfried & Wolfe, 1996; Hilliard, 1993; Lampropoulos et al., 2002). We chose a simple A-B pre-post design with follow-up because it is considered an appropriate research tool for the scientist-practitioner working in applied settings to determine the effectiveness of clinical treatment models (Hayes, Barlow, & Nelson-Gray, 1999). While most studies using single-case designs are still conducted in applied research centers (Hayes, Barlow, et al., 1999), the current study was conducted in a clinical private practice setting, which allowed for the inclusion of the type of couples that therapists are most likely to see in their offices.

The purpose of the present case study was to assess whether ACT could be adapted and successfully incorporated into a treatment plan for distressed couples. The study examines the progress of two couples throughout the therapy process. Core ACT interventions, such as cognitive defusion, mindful acceptance, and the pursuit of valued directions in relationships, were used to help couples commit to behavior that would hopefully lead to increased relationship satisfaction and decreased interpersonal distress.

Method

Participants

Two couples participated in the study. All four participants were white, upper-middle class, and college educated. They were self-referred to the first author through an online search for a therapist and by a recommendation of an acquaintance of one of the couples. Prior to treatment, the study was approved by Chapman University's Institutional Review Board (IRB). Both couples paid the therapist for the services received, which equaled the therapist's standard hourly rate. Neither couple used insurance to pay for therapy services.

The first couple, Landon (33) and Wendy (28) reported low levels of marital satisfaction and high levels

of conflict due to rigidity in joint decision-making. Landon was raised in Europe and moved to the United States as an adult. The couple had been married for 1 year, cohabitated for 6 months prior to marriage, and did not currently have any children. Both members of the couple reported being initially attracted to the other's differences. Landon, who described himself as very serious, was initially attracted to Wendy's engaging personality and lighthearted attitude. Wendy noticed Landon's accent and liked the fact that he was dependable. Both shared similar long-term life goals. Neither reported prior or current substance abuse, nor were there any childhood traumas reported. The couple's main goals for therapy were to increase marital satisfaction, decrease conflict, and increase decision-making flexibility.

The second couple, Michael (32) and Helen (30), came to therapy to address concerns about their marriage. They reported spending a great deal of time working at their respective careers, which was taking a toll on their relationship. During the assessment, the couple reported diminished marital satisfaction, increased emotional distance, and discouragement about their inability to change their situation. Helen was working as a medical resident, a job that consumed the majority of her time. Michael graduated from college with a degree in music and was currently employed in the entertainment industry. The couple had been married for 3 years and did not have any children. The couple previously enjoyed strong social support, but with the limited time available to them as a result of their careers, this support had weakened over time. The couple did not have a history of substance abuse or trauma. The couple's primary goals for therapy included increasing marital satisfaction and strengthening their relationship to prepare for the possibility of integrating a child into the family.

Measures

Marital satisfaction and adjustment were measured using the Dyadic Adjustment Scale (DAS), a 32-item scale developed to measure the quality of adjustment to marriage and similar dyadic relationships (Spanier, 1976; Spanier & Filsinger, 1983). The DAS produces a global adjustment score in addition to scores on four subscales: satisfaction, cohesion, consensus, and affectional expression. Global scores greater than 100 indicate well-adjusted relationships, while scores below 100 indicate significant clinical distress. Although there are no interpretive scores for clinical significance on the subscales, the satisfaction subscale used in this study ranges from 0-50 with higher scores indicating higher levels of satisfaction. The DAS demonstrates concurrent and predictive validity with lower scores relating to increased probability for domestic violence, higher depression, and poor communication (Stuart, 1992). The DAS also shows good reliability with high internal consistency for the total measure and scores as high as .90 and above (Stuart). For the purposes of this study, we used the global adjustment and satisfaction scales.

The Outcome Questionnaire 45.2 (OQ-45.2) was used to measure changes in couple interpersonal and psychological distress over the course of treatment. The OQ-45.2 is designed to be administered at multiple time points during therapy to measure client progress and outcome (Lambert et al., 1996). The OQ-45.2 demonstrates internal consistency (.93), test-retest reliability (.84), and concurrent validity with measures of depression, anxiety, and psychological distress (Lambert et al.). The OQ-45.2 contains 45 total items and includes a global scale and three subscales measuring symptomatic distress, interpersonal distress, and social roles. Scores of 63 or higher on the global scale indicate psychological distress. Clients are considered recovered when scores drop 14 or more points and cross the threshold to a score below 63. Clients are considered improved when scores drop 14 points but do not cross the threshold to a score below 63 or were never above 63. Subscale scores indicate distress in that domain if scores are 15 or higher for interpersonal distress. This study utilized the global psychological distress and the interpersonal relationship distress subscale scores.

The Beck Depression Inventory–II (BDI-II) was used to assess the severity of depression among study participants (Beck, Steer, & Brown, 1996). Higher scores on the BDI indicate the presence of depressive symptoms: 0–13 indicate minimal depression, scores from 14–19 indicate mild depression, scores from 20–28 moderate depression, and scores from 29–63 indicate severe depression. The coefficient alpha estimate of reliability for outpatient samples was .92 and test-retest reliability coefficient over a 1-week period was .93 (Arbisi, 2001). The BDI-II is widely used in research studies to measure depression, and it demonstrates high reliability and good convergent, content, and discriminant validity (Beck et al., 1996).

The 15-item Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003) assesses mindfulness across cognitive, emotional, physical, interpersonal, and general domains. Respondents indicate how frequently they have experienced statements (e.g., "I find it difficult to focus on what's happening in the present") using a 6-point Likert scale (anchored from 1 = *almost always* to 6 = *almost never*) with higher scores reflecting more mindfulness. The MAAS is scored by calculating the average of the 15 individual item responses. Brown and Ryan have demonstrated that (a) the MAAS has good psychometric properties, (b) the scale differentiates individuals who are mindful from those who are not, (c) higher scores are associated with enhanced self-awareness, and (d) following a clinical intervention, increases in mindfulness over

time were related to declines in mood disturbance and stress. Within student and adult samples, psychometric properties include good internal consistency (α=.82 to .87), good test-retest reliability (.81, assessed in a student sample only), and strong convergent and divergent validity (Brown & Ryan). Brown and Ryan reported a mean score of 3.9 (*SD*=0.6) for a nonclinical sample compared to 4.3 (*SD*=0.6) for a group of Zen meditation practitioners.

The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) is a 15-item measure of the tendency to suppress (i.e., not accept) and struggle with unwanted thoughts and feelings. This measure has been used extensively in laboratory and clinical settings to demonstrate the negative effects of experiential avoidance (e.g., Koster, Rassin, Crombez, & Naring, 2003). Clinical studies (e.g., Smari & Holmsteinsson, 2001) have shown that the WBSI is sensitive to and reflects the effects of treatment. The WBSI is scored by summing all individual responses. Lower scores indicate lower thought suppression. In a large, diverse student sample for periods ranging from 3 weeks to 3 months, test-retest reliability was reasonable (*r*=.69), internal reliability was strong (α=.87 to .89), and the measure demonstrated good convergent, divergent, and incremental validity (Wegner & Zanakos, 1994). Depending on sample characteristics, Wegner and Zanakos found that average scores for nonclinical samples vary from 43 to 50.

The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) is a 16-item questionnaire designed to assess psychological flexibility, particularly as it relates to experiential avoidance and willingness to engage in action despite unwanted thoughts or feelings. Participants rate the extent to which they agree with each statement on a 7-point Likert scale. The Willingness Subscale consists of seven items assessing willingness to accept undesirable thoughts and feelings. Scores range between 7 to 49 with higher scores indicating greater levels of willingness. The Action Subscale consists of nine items assessing whether individuals act in ways that are congruent with values and goals. Scores range between 9 to 63 with higher scores reflecting greater action and acceptance of unwanted thoughts and feelings. The AAQ correlates with measures of anxiety, depression, and trauma symptoms and shows reasonable test-retest reliability (*r*=.64) and internal consistency (α=.70) (Hayes et al.).

Procedure

Treatments were conducted by the first author, a Ph.D.-level licensed marriage and family therapist trained in ACT. A 12-session manualized treatment plan was adapted and developed for the conjoint treatment of couples based on Eifert and Forsyth's ACT manual for anxiety disorders (2005). The treatment plan (for details, see Table 1) consisted of couple and individual assessment (Sessions 1 and 2), making room for new relational patterns through mindfulness and acceptance (Sessions 3 and 4), defusing relational thoughts and reactions (Sessions 5 and 6), improving relationship satisfaction through value-directed living (Sessions 7 to 9), and committing to action based on valued directions (Sessions 10 to 12). Both couples received a total of 14 therapy sessions. Couples completed the study measures prior to treatment, at midtreatment, posttreatment, and at 6-months posttreatment. Each couple was mailed a $25 gift card for their participation in the follow-up portion of the study.

Treatment Overview

The interventions used in this study adapted various elements of ACT interventions for individuals for use in conjoint sessions with couples. The goals of the therapy were for each member of the couple to become more mindful of their thoughts and feelings, accept and embrace the discomfort they once avoided, defuse from thoughts and feelings that kept them from moving forward in the relationship, and act in ways consistent with identified valued directions. The key goal of the interventions was to help each member of the couple recognize and accept thoughts, feelings, and emotions that previously maintained negative interactions and contributed to relationship dissatisfaction. Couples were taught to approach situations in which they had previously practiced experiential avoidance. The most common avoidance-producing situations included communication (e.g., too little communication leading to emotional distancing and too much communication leading to conflict), expressions of physical and sexual intimacy, and mutually shared activities. Because of the discouragement of failed past attempts to connect with their partner and their subsequent engagement in experiential avoidance, the couples had become increasingly more inflexible in their attempts to manage and control their aversive internal reactions to thoughts related to these situations, often resorting to avoiding the situations altogether. As couples learned to defuse from these thoughts and practice acceptance (simply observing the thoughts without getting caught up with them by arguing or otherwise responding to them), couples were asked to act in ways consistent with their values, even if it meant doing so in the presence of these unwanted thoughts and feelings at key relational times (e.g., during a conflict, following emotional withdrawal).

Creating a New Way of Relating: Using the Chinese Finger Trap Metaphor and Tug of War Exercise

One of the first interventions was to let clients experience the futility and lack of workability of previously attempted solutions to the couple's marital

Table 1
Protocol for using ACT to treat couple distress.

Session	Strategies	Interventions
Session 1 Intake assessment and treatment orientation	• Detailed couples intake • Introduce ACT	Introduce centering exercises
Session 2 Individual assessments	• Individual interviews • Assess for contraindications: domestic violence, ongoing extramarital affairs untreated psychopathology	Couples planning session integrating individual and couple assessment
Session 3 Evaluating costs of ineffective relational efforts	• Examine costs of couple avoidance and conflict • Develop creative hopelessness	Chinese Finger Trap Metaphor Tug of War With Partner Exercise
Session 4 Mindfulness and acceptance	• Introduce mindfulness and acceptance	Acceptance of Thoughts and Feelings Exercise
Session 5 Cognitive defusion	• Deliteralize negative relationship thoughts for couple	Bus Driver Exercise Thoughts on Cards Exercise[a]
Session 6 Observing thoughts	• Develop observer perspective and compassion to one's own and one's partner's reactions	Thoughts on Leaves Exercise Acceptance of Relationship Reactions Exercise
Session 7 Choosing valued directions	• Help clients clarify and identify life and relationship value directions	What Do I Want in My Life/Relationship to Stand For Exercise[a] Epitaph Exercise[a]
Session 8 Identifying barriers to valued living through acceptance and the observer self	• Review values worksheets • Discuss barriers to valued living and help clients move with them rather than overcome them	Committed Action Worksheet Review of the Bus Driver Exercise
Session 9 Creating flexible patterns of relationship behavior	• Introduce willingness	Committed Action Worksheet
Session 10 Self as context in the relationship	• Nurture choice and response-ability • Have couples experience self as context	Committed Action Worksheet Chessboard Metaphor[a]
Session 11 Acceptance and committed action	• Review emotional willingness in a committed action context	Committed Action Worksheet
Session 12 Working toward termination	• Review relationship values and committed action • Prepare for future committed action and termination	Take Home Committed Action Worksheets Audio CD of mindfulness exercises for home practice

[a] Indicates intervention not discussed in the paper. For a complete description, see Hayes, et al. (1999).

distress. From an ACT perspective, members of a distressed couple get stuck in unwanted interactions as they try to control emotional and cognitive reactions to their partner's behavior and act in ways that predictably trigger familiar emotional and cognitive events in their partner. These control efforts lead to behaviors such as emotional withdrawal, conflict-filled communication, or physically leaving the other's presence in order to rid oneself of the unwanted feelings and thoughts that arise from the relational interactions.

The Chinese finger trap metaphor, a standard ACT technique, was adapted for couples in order to illustrate how each partner's efforts to control uncontrollable events are unhelpful and ultimately counterproductive to relationship satisfaction. The therapist gave the couple a Chinese finger trap and asked each member of the couple to put one finger in each end of the finger trap. The couple was then asked to attempt to pull their fingers out. This attempt tightened the finger trap and the couples got stuck as each partner inevitably reacted to the efforts of the other, thus increasing the overall tension on the trap. When these efforts did not prove effective, the couple had to work together on a new solution by pushing into the trap rather than attempting to pull out. As soon as one partner started to push in, both had more space ("wiggle room") and eventually they were able to move their fingers out. By acting out this metaphor, the couples experienced the counter-intuitive nature of changing their relationship patterns that ACT would encourage. The therapist introduced the idea that, in order for relationship change to occur, the couple needed to learn new ways to relate to each other, moving toward the relationship (and its discomfort) and toward one another in order to make room for new,

more flexible ways of responding to their relationship challenges.

Couples also completed an in-session tug-of-war experiential exercise where the therapist asked the couple to grab hold of separate ends of a rope. One member of the couple was then asked to pull on the rope. When pulled in one direction, the partner naturally and automatically began pulling back. The therapist would then ask one partner to pull harder, which necessitated the other partner to pull equally hard. When the therapist asked how they could get out of this struggle, neither seemed to know. Eventually, the therapist suggested to one partner to loosen the tension by moving towards the partner, perhaps even dropping the rope altogether, to see what would happen. The couples noted the relief of dropping the rope as well as the regained possibility of being able to move around more freely. This exercise was used to illustrate that the couple's relationship struggles may be maintained by each partner's entanglement with their personal and relationship reactions and that they will both remain stuck as long as they try to win the struggle by pulling harder. The therapist posed the question: "What would it be like if the next time you struggle with these reactions, you drop the rope and did something different—even opposite—from what you were used to doing?"

Acceptance and Mindfulness

The therapist introduced the concept of mindfulness at the conclusion of the first session and conducted a centering exercise with the permission of both members of the couple. The therapist informed the couple that each future session would begin with a centering exercise to help the couple be present with their in-session thoughts, feelings, and bodily sensations. The therapist informed the couple that by observing and becoming aware of their thoughts, feelings, and sensations about the relationship, each partner could observe and begin to change the relational patterns. Thus, as two mindful partners engaged in relationship interactions, each partner could choose not to respond to negative relational evaluations and thoughts that they might normally let dictate relational behavior. The centering exercise was the first step to introduce mindfulness, and throughout the therapy, more advanced exercises were adapted for couples and conducted in-session, including an "acceptance of thoughts and feelings exercise" and an "accepting relationship reactions exercise" (Eifert & Forsyth, 2005). Couples were also given a CD with mindfulness exercises recorded by the therapist and were encouraged to practice these exercises at home.

Relational Value Directions and Committed Action

One of the key goals of ACT is to help clients behave in ways consistent with their personal values. This component of the therapy was adapted for couples by helping them first clarify their life and relationship values. Each member of the couple independently completed a "Valued Directions" worksheet that lists 10 value domains: family, intimate relationships, parenting, friends, work, education, recreation, spirituality, citizenship, and health (Eifert & Forsyth, 2005). In addition, each member of the couple was asked to complete a "Valued Directions in Couple Relationships" worksheet that was developed for the purpose of this study. This worksheet specifically targeted 10 value domains related to interpersonal relationships: communication, emotional intimacy, physical affection, sexuality, finances, joint recreational activities, household responsibilities, childcare/parenting, extended family relationships, and joint decision-making. Couples rated the value domains in terms of importance, satisfaction, the number of times per week they took action toward the value, and the barriers that prevented value-directed actions.

Once values were clarified and discussed, the concept of committed action was introduced. Committed action involves taking steps toward realizing valued life goals. It involves making a commitment to action and adjusting what can be changed in the direction of chosen values. In this stage of ACT, clients learn that who they are as individuals, the thoughts and feeling they have about themselves, and what they do with their lives are three distinct and different constructs. Couples in the study committed to behavioral goals based on their identified values using weekly and monthly "Committed Action Worksheets" that linked goals to values and identified possible barriers to action. The therapist discussed the barriers that had previously kept them from achieving their relational goals. The most common barriers were the fear of partner rejection, feelings of discouragement from previous failed relationship attempts, and relational insecurities. The therapist taught the couples techniques to move *with* these barriers rather than attempting to push through them or to get rid of them (Eifert & Forsyth, 2005). Although ACT focuses on the process of valuing, goal-setting is a critical part of treatment. While values underlie goals, goal-setting shows a client how to move in a valued direction.

Learning Defusion: Driving the Life Bus Metaphor

Cognitive defusion is central to ACT therapy. Cognitive defusion is the process whereby individuals learn to observe thoughts for what they really are (thoughts that come and go), not for what their minds tell them thoughts are (truths and rules that must be followed). As thoughts are taken less literally, both members of the couple are more free to act on chosen values rather than react to the multitude of negative relationship thoughts produced mentally. For couples locked in negative cycles of behavior, cognitive defusion techniques can play a major role in

improving each partner's ability to create a value-directed relationship. In a couple experiencing relationship distress, the degree to which a partner is fused with evaluative thoughts about the other partner and the relationship (i.e., how much he or she believes the thoughts or "buys into" them) can affect the intensity of arguments and maintain couple distress. Defusion begins when one partner recognizes a thought as just a thought, and not as something that must be believed or acted upon. Experiential exercises such as the "watching thoughts on leaves exercise" (where clients learn to observe their thoughts as if watching them float gently down a stream) helped individuals learn this skill (Eifert & Forsyth, 2005).

The Life Bus metaphor is a key ACT technique used to develop defusion skills and keep people on track when moving in valued directions (see Hayes, Strosahl, et al., 1999; Eifert & Forsyth, 2005 for a complete description of the intervention). In the current study, this exercise was adapted for the treatment of couple relationships and conducted with each member of the couple while their partner was present in session. The therapist asked one member of the couple to stand up and walk to the edge of the room. They were told that in this exercise they were the driver of a bus that represents their life. Along their life journey, they had picked up several passengers, some wanted and some unwanted. These passengers had taken the form of various thoughts, feelings, memories, and bodily sensations. The participant was pointed in the direction of their partner and was told that this represents driving the bus in the valued directions of the relationship. Occasionally some of the unwanted passengers (e.g., negative relationship thoughts and feeling/emotional states) would give the driver messages (e.g., "if you do this or say this to your partner, you'll get rejected," or "if you say this, you'll end up in a fight") that ultimately caused the driver to literally turn the bus in a different direction because the driver started to engage with this thought (e.g., by arguing with it or listening to it). When this occurred, the bus was no longer going where the driver wanted, but in a direction chosen by this unwanted passenger. As the therapist turned the client increasingly away from the partner, eventually facing the opposite direction of where their partner was sitting, the therapist asked the driver what it was like to be moving in the opposite direction of where they really wanted to go. The driver often reported that although the passenger on the bus was quiet now, they were personally unhappy about the direction they were headed. The client was then encouraged to turn back toward the direction of their partner and was asked what they would need to do to keep the bus going in the chosen direction.

The therapist also helped the driver defuse or personify the unwanted passengers with the greatest power to move the driver in a different way by giving them a name. The most commonly identified passengers were fear of rejection, hopelessness, and fear of being hurt by one's partner. The therapist then asked the driver if he/she could welcome these passengers onto the bus by acknowledging them and accepting them without qualification. Clients were asked to say, "fear of rejection, you can come on the bus." Although difficult to do, this exercise allowed clients to make contact with the thoughts, feelings, and emotions they had previously avoided, and which ultimately had them moving in the wrong direction in their relationship. As the client became more willing to experience the thoughts and feelings that previously kept them from moving toward their partner––and at the same time recognizing them as merely thoughts––they were better able to move toward relationship improvements, even in the presence of the unwanted passengers.

Maintenance

To enhance maintenance of treatment gains, the therapist recorded a personalized audio file for each couple consisting of a summary of the therapy as well as the three in-session mindfulness exercises. A copy of the CD was given to each member of the couple. They were asked to listen to the exercises between sessions and following therapy. In addition, couples were asked to continue completing weekly and monthly committed action worksheets.

Treatment Results

Because the couple was the unit of treatment, the data are presented for each dyad. Figures 1 through 4 present the scores for marital adjustment, marital satisfaction, interpersonal distress, and psychological distress for both couples. Table 2 presents each couple's scores on the ACT process measures for mindfulness, thought suppression, and willing action.

Marital Adjustment and Satisfaction

Figure 1 shows the average scores for the couples' global marital adjustment. Both couples began therapy in the clinically distressed range (scores <100), with Couple 1 reporting more severe distress (88) than Couple 2 (97). Each couple reported steady gains in marital adjustment throughout therapy, with both couples demonstrating gains at midtreatment and posttherapy. At the 6-month follow-up, both couples were in the well-adjusted range (≥100), with Couple 2 showing continued improvement (116 posttherapy vs. 124 6-month follow-up), whereas Couple 1 was essentially unchanged, with a slight dip in scores from posttherapy to follow-up (111 vs. 107, respectively).

Figure 2 shows each couple's changes in marital satisfaction over the course of therapy, as measured by the DAS satisfaction subscale. Both couples reported

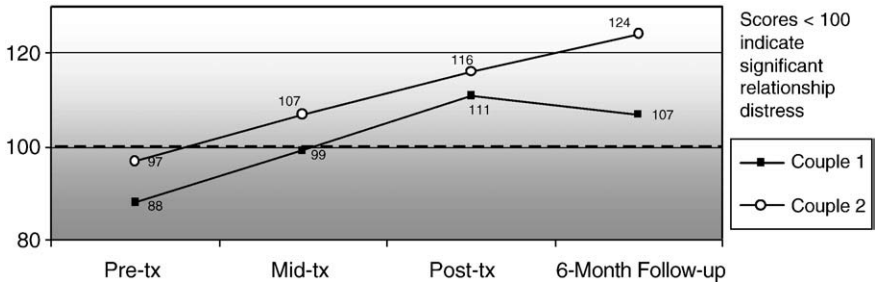

Figure 1. Global marital adjustment scores for couple 1 and couple 2.

similar gains and trajectories of increased marital satisfaction. As with global adjustment, Couple 1 began therapy slightly less satisfied than Couple 2 and gains in satisfaction were maintained for both couples at the 6-month follow-up (see Figure 2).

Interpersonal Relationship Functioning and Psychological Distress (OQ-45.2)

Figure 3 illustrates the couples' improvements in interpersonal functioning as measured by the OQ-45.2. Both couples began therapy in the distressed interpersonal range (scores ≥ 15). At midtreatment, both couples were in the non-distressed range and continued to improve post therapy. At the 6-month follow-up, both couples continued to report scores in the nondistressed range.

Figure 4 shows the reductions in overall psychological distress over the course of treatment for both couples. Couple 2 began treatment in the distressed range (scores ≥ 63) and Couple 1 approached clinical distress with a score of 62. Both couples showed a consistent decrease in overall psychological distress (OQ 45.2) over the course of therapy and were in the nondistressed range at 6-month follow-up (38 vs. 29, respectively).

Depression

Neither Couple 1 nor Couple 2 was in the depressed range as measured by the BDI-II (≥ 14) at pretherapy (12 vs. 10, respectively), depression scores fell to single digits for both couples at midtherapy, posttherapy, and at 6-month follow-up.

ACT Processes Measures

Table 2 presents the scores for both couples on the MAAS, WBSI, AAQ-A, and AAQ-W. Both couples reported increased levels of mindfulness, as measured by the MAAS, from pretherapy to 6-month follow-up (Couple 1: 4.3 to 4.8; Couple 2: 4.6 to 5.1). According to Brown and Ryan (2003), these changes represent an increase of just less than one standard deviation in the desired direction for both couples from a pretreatment level that was equal to or exceeded that of experienced practitioners of Zen meditation.

Reports of thought suppression as measured by the WBSI dropped for both couples. Couple 1 reported significant decreases from pretherapy to 6-month follow-up (42 vs. 27), which represents a reduction of about two standard deviations in the desired direction. Couple 2 also reported a decrease from pretherapy to 6-month follow-up (27 to 20). This change represents a reduction of about one standard deviation in the desired direction from a pretreatment level that was already more than one standard deviation lower than the average score for nonclinical individuals reported by Wegner and Zanakos (1994).

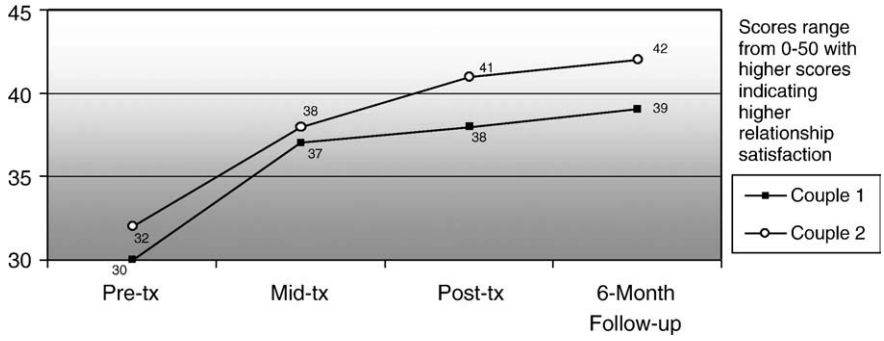

Figure 2. Marital satisfaction scores for couple 1 and couple 2.

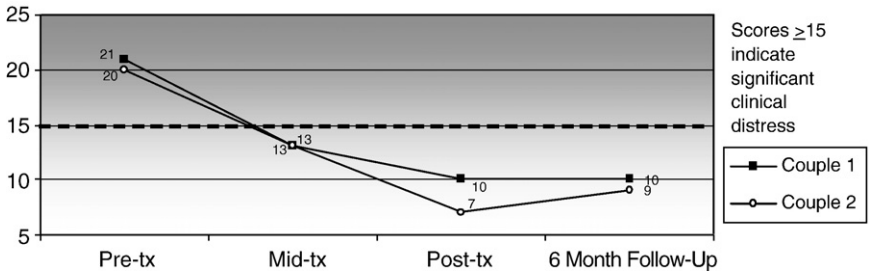

Figure 3. Interpersonal relationship distress for couple 1 and couple 2.

Levels of willingness to engage in action despite unwanted thoughts or feelings as measured by the AAQ Action Scale remained stable for Couple 1 (45 pretherapy vs. 47 6-month follow-up) and increased slightly in Couple 2 (45 pretherapy vs. 50 6-month follow-up). Levels of willingness to be present with unwanted or distressing thoughts and feelings as measured by the AAQ Willingness Scale remained essentially unchanged for Couple 1 (36 pretherapy versus 38 6-month follow-up) and showed a moderate increase in Couple 2 (38 pretherapy vs. 45 6-month follow-up). Although these changes are rather modest, it should be noted that baseline AAQ levels were average (i.e., in the normal range) to begin with.

Discussion

The data from this preliminary single-case study suggest that ACT may have the potential to increase overall marital adjustment and satisfaction, and decrease interpersonal and psychological distress in couples. Both couples reported gains in global marital adjustment and in marital satisfaction throughout the therapy and at six-month follow-up. Furthermore, at posttherapy, both couples reported clinically significant reductions in interpersonal distress and overall psychological distress.

Although it has been consistently demonstrated that psychotherapy for couples is effective, outcome research has also found that different approaches achieve their effectiveness through different change mechanisms (Lambert & Ogles, 2004). From an ACT perspective, there are a number of possible explanations as to why couples in this study reported positive outcomes. ACT posits that change occurs as couples begin to relate to their internal private events with increased defusion. This defusion ultimately decreases each partner's entanglement with negative thoughts and reactions and increases mindful acceptance, which ultimately decreases the pervasive nature of negative relationship patterns and behaviors. Increasing cognitive defusion and mindful awareness of their thoughts and reactions likely helped the couples to become observers of their internal negative relationship reactions and thus make choices not to engage in old patterns of avoidance and conflict behavior. Although the reported changes in mindfulness, thought suppression, and acceptance for both couples were more moderate and not as large as we expected, repeated in-session reports from the couples indicated that their use of cognitive defusion contributed to their increased willingness to approach relationship situations they had previously avoided. Future efforts to develop a scale to measure cognitive defusion seem increasingly important given the powerful nature and central focus of this construct. A comparison of baseline levels of mindfulness, thought suppression, and acceptance of our couples with levels reported by the authors of these questionnaires for nonclinical samples suggests that our couples entered therapy with pretreatment scores that were in the normal range––and in some cases even better than average––and quite different from means reported for samples of

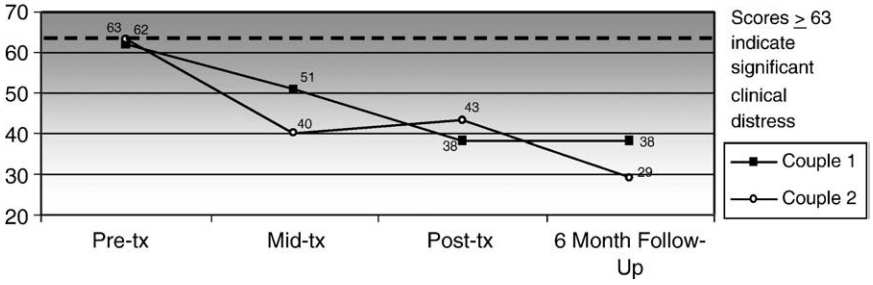

Figure 4. Overall psychological distress for couple 1 and couple 2.

Table 2
Acceptance and Commitment Theraphy (ACT) Process Measures by Couple at Four Time Points

	Couple 1	Couple 2
MAAS [a]		
Pre-Treatment	4.3	4.6
Mid-Treatment	4.1	4.6
Post-Treatment	3.8	4.4
6 Month Follow-Up	4.8	5.1
WBSI [b]		
Pre-Treatment	42	27
Mid-Treatment	24	24
Post-Treatment	39	30
6 Month Follow-Up	27	20
AAQ-A [c]		
Pre-Treatment	45	45
Mid-Treatment	45	50
Post-Treatment	47	50
6 Month Follow-Up	47	50
AAA-W [d]		
Pre-Treatment	36	38
Mid-Treatment	35	43
Post-Treatment	40	45
6 Month Follow-Up	38	45

[a] A prior study found a mean of 3.9 for a non-clinical sample and a mean of 4.3 for Zen Practitioners. Higher scores reflect higher levels of mindfulness.

[b] Average scores for nonclinical samples vary from 43–50 with lower scores indicating lower thought supression.

[c] Scores range between 9–63 with higher scores indicate higher levels of action in the presence of undesirable thoughts and feelings.

[d] Scores range between 7–49 with higher scores indicating higher levels of willingness to accept undesirable thoughts and feelings.

clients with clinical DSM diagnoses (Forsyth, Parker, & Finlay, 2003). As a result, there was less room for dramatic improvements.

A second explanation for the treatment gains is the role and function of valued action, particularly in the context of the relationship. Couples in the study practiced value clarification through in-session experiential exercises and through the completion of worksheets outside of session. Couples reported that the very act of clarifying values had an impact on increasing relationship satisfaction because couples began to see more clearly the importance of the relationship in their lives. They also were reminded of what their partner valued in life and in their relationship. While recognizing the importance of the relationship may explain some of the rise in satisfaction, value-directed action is most likely responsible for the long-term changes observed to date, particularly in Couple 2. Unfortunately, there are still no standardized measures available to assess this important component of ACT. Couples committed to acting in new ways by completing committed action worksheets during and outside of session. Here, couples not only understand the value of the relationship in some abstract fashion, but they behave in concrete ways that are consistently aimed at strengthening the relationship in each value domain. In fact, it is possible that the positive gains in therapy could be linked directly to the commitment of both members of the couple to behave in new ways based on individual and shared relationship values. We did observe changes in valued actions by inspecting the weekly worksheets, but unfortunately there are no formal assessments available to measure such changes in a standardized manner. This lack of formal measures will need to be addressed by ACT researchers as a group. Further studies are also needed to assess the relative contribution of behavior change and mindfulness processes in changing couples' reports of marital satisfaction.

The data from these preliminary case studies can benefit clinicians working with couples desiring to address a wide range of clinical goals, including improved communication, increased emotional connection, and enhanced sexual intimacy. The ACT processes of cognitive defusion and mindful acceptance can help couples begin to relate to their own internal reactions and relationship choices in new ways. By combining these with committed action in the service of values, couples can increase relational flexibility by making novel behavioral choices in regard to their relationship. For example, one couple in the study had concerns with the sexual health of their relationship. The couple was stuck in a pattern of approach by the husband and lack of desire by the wife. Soon, the husband began to stop approaching because he felt rejected, and his wife was unhappy due to the resulting emotional distance. Following the life bus metaphor, the husband realized that his fear of rejection was keeping him from acting in ways that increased their physical and emotional closeness––a core value he identified as critical to his relationship. His willingness to accept and disentangle from what his mind told him about rejection enabled him to choose to approach his wife in more flexible ways. In turn, his wife experienced that she could also respond in a different way than she had before and could communicate more clearly with him regarding the issue. The couple shared a core value of sexual intimacy and was committed to working toward the goal of increasing the sexual health of their relationship. Witnessing how one's partner experiences his/her barriers (passengers) on their life bus helped develop mutual compassion and understanding that paved the way for more flexible responding to one's own passengers as well as those of one's partner. Not surprisingly, both partners reported an increase in the quality of the sexual relationship following this intervention.

The benefits of this study include the use of a single-case design, which allowed for the close examination of couples like those frequently seen in the offices of

practitioners. The study also had the couples complete the study measures at multiple points in time, allowing for the examination of gains in treatment at various time points and ensuring that improvements reported at posttreatment were maintained 6 months later. It was encouraging to see that all treatment gains were at least maintained, and that, for some measures, further improvements were reported at 6-month follow-up. Being able to observe the effects of treatment over a longer period of time was particularly helpful when examining the gains in marital adjustment and satisfaction. It was interesting to note that both couples reported similar trajectories of increased adjustment at midtherapy and at posttherapy (see Figure 1) with Couple 2 showing further improvement at follow-up and Couple 1 remaining unchanged with a slight dip to the downside. These findings should also be viewed in the context of differences in the two couples' initial distress level. Although Couple 2 was in the distressed range at pretherapy, it should be noted that they were approaching the clinically adjusted cutoff (97 vs. 100), whereas Couple 1 was much more distressed (88). It is possible that these differences in initial distress scores are related to the different pattern of 6-month follow-up scores as a couple's initial distress level has been identified as the largest predictor of treatment success in behavioral marital therapy, accounting for as much as 46% of the variance in outcomes, with less distressed couples doing better at the end of therapy (Johnson & Lebow, 2000). Further, it lends support to the idea that it is important for couples to begin therapy before their distress level is too severe.

Although it was not an intended target of treatment, and neither couple was in the depressed range as measured by the BDI, psychological distress as measured by the OQ-45.2 (which includes depressive symptoms) showed clinically significant reductions for both couples. The lack of clinically significant depression symptoms on both couples' BDI scores may indicate that the psychological distress was highly related to their relationship dissatisfaction, as opposed to depression caused by other factors. The decreases in the couples' overall psychological distress may be the result of treating relationship distress, which is commonly linked with depression and can be treated in a couple therapy context (Gollan, Freidman, & Miller, 2003).

Conducting in-session experiential exercises with both members of the couple was a crucial part of the treatment. By conducting these exercises in the presence of both partners, each person got immediate feedback and insight into his or her partner's experience. This provided an opportunity for both members of the couple to see the relational context of their partner's reactions to their own behavior. Throughout the therapy, couples anecdotally reported to the therapist that the in-session exercises provided them with important experiences that helped them view and approach their relationship in a new way.

It is important to note the limitations of this single-case study. Because of the small sample size (n=2 couples) and lack of control group, there are a number of threats to internal and external validity. We cannot unequivocally attribute the change in each couple to the treatment interventions because we could not control for factors like coincidental events that occurred during the treatment, the process of maturation which may mimic change, and repeated completion of the assessment measures (Hayes, Barlow, et al., 1999). Also, because of the single-case design and the demographical similarity of the two couples (White, upper-middle class, educated), we cannot generalize these findings to all types of couples.

This study is also limited by other factors. Therapy sessions were not videotaped to ensure treatment fidelity, some of the process measures lack cutoff scores that would be helpful in evaluating the clinical meaningfulness of observed changes, and the AAQ has weak test-retest reliability. Finally, the study relied only on self-report measures at pretreatment, midtreatment, posttreatment, and a 6-month follow up. Because of these limitations, it is clear that more rigorous research designs are needed before any firm conclusions can be made about the effectiveness of ACT in treating distressed couples.

In summary, this single-case study suggests that adapting ACT to treat distressed couples may show promise. Based on an ACT treatment perspective, increasing cognitive defusion and mindful acceptance helps couples experience negative relational thoughts and reactions in new ways, thus decreasing a couple's entanglement with them. Couples learn to defuse and accept previously avoided thoughts and situations that once acted as barriers to relationship growth and development. The clarification of relationship values and commitment to act in ways consistent with these values provides couples with an opportunity to choose to behave in ways that can lead to relationship satisfaction and can reduce interpersonal and psychological distress. We hope that future studies will build on the results of this single-case study by examining the application of ACT to distressed couples using larger, more diverse samples and more controlled research designs.

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Address correspondence to Brennan D. Peterson, Ph.D., Chapman University, Department of Psychology, One University Drive, Orange, CA 928661; e-mail: bpeterson@chapman.edu.

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