2011

Experiential avoidance and psychological acceptance in the psychological recovery from enduring mental illness

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Experiential Avoidance and Psychological Acceptance in the Psychological Recovery from Enduring Mental Illness

A thesis submitted in fulfilment of the
requirements for the award of the degree
Master of Science – Research

from

University of Wollongong

by

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March 2011

Certification

I, Vinicius R. Siqueira, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Masters of Science by Research in Psychology, in the Faculty of Health & Behavioural Sciences, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

(Signature)

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March 2011

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Abstract

Objective

The concept of recovery has been generating significant interest in mental health contexts, as has the behavioural change approach of Acceptance and Commitment Therapy (ACT) in psychotherapy contexts. The objective of this study is to observe if psychological acceptance and experiential avoidance, two core concepts of ACT, may be present in the psychological recovery processes of people with enduring mental illness. The reason to study these two psychological constructs is that experiential avoidance has pervasive effects in one's life and is at the core of several significant clinical problems. As such, ACT suggests the use of psychological acceptance to deal with experiential avoidance, which has been proven successful at improving the quality of life.

Method

The research involved two studies which sought to pinpoint the presence of experiential avoidance and psychological acceptance in the psychological recovery process of people with mental illness. The first study was exploratory and qualitative, while the second used a quantitative approach.

In Study One, 45 published narratives and 33 life stories from individuals living with long-term mental illness were content-analysed, seeking to locate textual examples of experiential avoidance and psychological acceptance. The objective of this study was to provide a preliminary examination of the role and frequency of psychological acceptance and experiential avoidance in the process of psychological recovery from enduring mental illness.

Study Two examined the relationship between psychological acceptance and experiential avoidance in psychological recovery from enduring mental illness, using established measures of recovery and psychological well-being. Forty-one participants with a clinical diagnosis of chronic mental illness (at least 12 months) as reflected in the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) Text Revision (DSM-IV-TR) Axis I were recruited from across New South Wales, Australia. The Acceptance and Action Questionnaire (AAQ-19)

was used to examine the presence of psychological acceptance and experiential avoidance; the Recovery Assessment Scale (RAS) and the Stages of Recovery Instrument (STORI) were used to examine the levels of psychological recovery, and the Psychological Well-Being scales (PWB) were used to measure well-being.

Results

In Study One, the high prevalence of psychological acceptance in narratives of people self-reporting success in their recovery journey suggests a potential relationship to positive developments in their journey of recovery. Conversely, the role and frequency of experiential avoidance could be associated with less progress in psychological recovery from mental illness.

In Study Two, a correlational analysis between level of recovery, as assessed by the RAS instrument, and acceptance, as assessed by the AAQ-19, showed no significant relationship between the two variables. The AAQ-19 nonetheless correlated positively with three of the five subscales of the RAS. In addition, positive correlations were found between the overall score for PWB and the high use of psychological acceptance.

Conclusion

While Study One indicated the presence of experiential avoidance and psychological acceptance in narratives of people with enduring mental illness, Study Two demonstrated that there was no clear correlation between the use of psychological acceptance and recovery from mental illness. This study, however, demonstrated that there is a relationship between psychological acceptance and positive levels of psychological well-being among individuals with mental illness, indicating that psychological acceptance may play a positive role in improving the psychological well-being of people with mental illness.

Acknowledgments

I would like to thank Retta Andresen for her comments regarding this thesis.

I would like to thank Kaori Mamiya for her participation on the peer agreement process.

I would like to thank all the participants of this study. Without them this research would not have been possible.

And mainly I would like to thank Lindsay Oades, without his guidance and support this research would not have come this far.

Finally, I would like to thank all my friends and family who helped me in one way or another with this research.

Introduction

It is estimated that 20% (or one in five) of Australians will experience a form of mental illness at some point in their lives (Australian Bureau of Statistics, 2008). Similar statistics are found worldwide and show the importance of dealing with mental illness because of its financial and social costs (Rupp & Keith, 1993), particularly given that these illnesses are typically chronic (Pratt & Mueser, 2002). Although psycho-pharmacological treatments are available, some people are still unresponsive to medications (Silverstein & Harrow, 1978).

Even though these statistics appear to seem discouraging, there is a movement that advocates the idea of recovery from mental illness (Anthony, 1993). Recovery in this context does not imply "cure" or remission of illness but the formation of a new established sense of self based on hope and taking responsibility for one's life. This notion of recovery suggests that one should be more optimistic about the future of a person with mental illness (Deegan, 1996; King, Lloyd, & Meehan, 2007).

Andresen, Oades and Caputi (2003) used the term "psychological recovery" to refer to the formation of a new established sense of self based on hope and personal responsibility, placing no limitations on the consumer's life – the term "consumer" is inserted to distance the passive term "patient", designating those who had or are having treatment for mental illness or psychiatric disorder. The term was coined in an attempt do capacitate people with mental health problems in making their own choices regarding his/her treatment, considering that without them, it could not exist mental health providers (Reaume, 2002).

The same researchers mentioned above identified five stages of recovery from mental illness: (1) Moratorium: A time of withdrawal characterised by a profound sense of loss and hopelessness; (2) Awareness: Realisation that all is not lost, and that a fulfilling life is possible; (3) Preparation: Taking stock of strengths and weaknesses regarding recovery, and starting to work on developing recovery skills; (4) Rebuilding: Actively working towards a positive identity, setting meaningful goals and taking control of one's life; and (5) Growth: Living a full and meaningful life, characterised by

self-management of the illness, resilience and a positive sense of self (Andresen et al., 2003).

In a later study these authors demonstrated the capacity of these constructs to be measured through the development of the Stages of Recovery Instrument (STORI) and the brief Self-Identified Stage of Recovery (Andresen, Caputi, & Oades, 2006), validating the concept of recovery as described by mental health consumers.

The consumer recovery movement is relatively new in the mental health field, even though strong empirical evidence of positive outcomes has been available for many years (Anthony, 1993). Therefore, there are several psychological therapies that have been adapted and developed to assist the objectives set by the recovery movement, such as Cognitive Behavioural Therapy (CBT) (Durrant, Clarke, Tolland, & Wilson, 2007), among others.

To assist the recovery process, new-generation psychological therapies are constantly being discussed in order to develop more efficient and effective psychosocial treatments. One such therapy which has shown promising initial results in assisting people with psychotic symptoms is Acceptance and Commitment Therapy (ACT) (Bach & Hayes, 2002; García & Pérez, 2001). This approach is a multi-factorial and multi-dimensional therapy model that incorporates several components, and is consistent with the principle of psychological recovery from mental illness. This will be discussed in more detail below.

Combining the consumer-defined recovery movement with the ACT perspective may prove fruitful. However, recovery and ACT are comprised of too many constructs and variables to be fully covered in this research, therefore the focus of this thesis will follow experiential avoidance and psychological acceptance, important ACT constructs, in the psychological process of recovery from mental illness.

This research focuses on the two main concepts of ACT: experiential avoidance and psychological acceptance. Experiential avoidance has perversive effects in one's life (Hayes & Wilson, 1994) and is at the core of several significant clinical problems, such as substance abuse and suicide (Baumeister, 1990; Cooper, Frone, Russell, & Mudar, 1995). As such, ACT suggests the use of psychological acceptance to deal with the

negative effects of avoidance, which has proven successful at improving the quality of life (Hayes, Strosahl, & Wilson, 1999).

Given the pervasiveness of experiential avoidance and the benefits of psychological acceptance, this study has sought to observe whether these two psychological constructs are present in the psychological recovery from mental illness and to examine the part which these two psychological constructs may take in the recovery journey.

Study One uses qualitative methods to identify examples of these concepts in the recovery of people with a mental illness, while Study Two uses quantitative methods to examine the relationships between these and recovery-related variables.

The origins of ACT and its most important features are discussed in the following section.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy is seen by some theorists (e.g., Hayes et al., 1999; Hayes, Barnes-Holmes, & Roche, 2001; Hayes, Follette, & Linehan, 2004; among several others) as the third wave of behaviour therapy, considering Behaviour Therapy as the first wave and CBT as the second wave. The basis of this possible interpretation, the historical development of behaviourism, will be covered briefly in this subsection.

. Sketching the development of the behavioural therapy movement, referring to the entire range of behavioural and cognitive therapies, from clinical behaviour analysis to cognitive therapy, is not an easy task. It involves describing a complex interweaving of trends, persons, assumptions, findings and politics. Consequently it is not hard to find major differences among behaviourists about definitions of behaviourism (Hayes, 1987).

This thesis does not intend to cover completely all the possible interpretations of the history of behaviourism (assuming that history is revisionary, alive in the present, existing for the purposes of the present), choosing to follow a line of thought by some theorists (for example, Dougher & Hayes, 2000; Hayes, 1988; Hayes, 2004; Hayes, Follette & Follette, 1995) for the purpose of demonstrating the attempt of ACT to overcome past models of behaviourism.

The first wave of behaviourism dated from the beginning of the nineteenth century where some psychologists were uncomfortable with the method of introspectionism, based on the examination of one's own thoughts and feelings, since this method seemed unreliable and vulnerable to bias. This subjectivity did not match the zeitgeist (the entire cultural and intellectual climate of the world at one time, or the generic features for a given period of time) of other sciences in the world which made use of verifiable and replicable measures in laboratories (Roediger, 2004).

. John B. Watson struggled to achieve an objective psychological science, utilising observable methods without any trace of subjectivity or recurrence of mentalism (Watson, 1924). Watson rejected the study of the "mind" because 1) he claimed that "mind" did not exist, only muscle and glandular movements (Watson even believed that

"private events" came from subvocal speech), and 2) there was no scientifically acceptable method to study it (Hayes et al., 1995).

. In his attempt to build a scientific psychology, Watson (1924) took as his starting point the fact that organisms (animals or humans) adjust to their environment by means of hereditary and habitual mechanisms. One of the influences on this behaviouristic position is the study of animals through Animal Psychology, as well as its extension to humans (parallel among species) through Comparative Psychology. This relation is clear from Watson's statement that behaviourism is a direct consequence of the study of animal behaviour that happened in the first decade of the 20th century.

Watson's concern was to maintain a uniformity of experimental procedures and methods in his work, showing that response mechanisms are similar when subjected to the processes of stimulation (Watson, 1924). Applied behaviour work during this period was not common, and mainly served to demonstrate behavioural principles and not to develop a practical applied technology (Hayes et al., 1995).

Thus, instinct, emotion, learning and thinking had the status of mentalist tautologies on top of conditioned responses. Things that seemed hereditary could have their origins in parenting, so children were not born with the ability to be great musicians or athletes, but were instead influenced by the directions of their parents, through reinforcement and encouragement (Roediger, 2004).

Unfortunately Watson failed to defeat the dualism of the "mind" position; however, his methodological position gained ground. Some theorists who believed in Watson's position that the mind can not be studied directly tried to study it indirectly, even Skinner (1938) for some time before seeing its danger. This first wave succeeded for a time in establishing psychology as the science of behaviour; however, it ended up inspiring more sophisticated sciences of the mind (Hayes, 1988).

From Watson's time (1920s and '30s) to the 1950s, several behavioural principles were developed in psychological laboratories, including the principles of operant conditioning, the use of consequences to modify the occurrence and form of behaviour; classical conditioning, involving an involuntary or automatic response to a stimulus; and associationistic principles, the study of human learning in terms of the formation of direct, lawful connections between stimuli and responses (Custers & Boshuizen, 2001).

By the 1950s and early 1960s, applied behavioural work had accumulated a large basic knowledge ready to be generalised in applied applications. Behaviour therapy then emerged as two different types: Applied Behaviour Analysis and Behaviour Therapy (Dougher & Hayes, 2000).

....Applied behaviour analysis began in the United States and had as its pillar B. F. Skinner, the first editor of the *Journal of Applied Behavior Analysis* founded in 1968. Behaviour therapy emerged in Great Britain and South Africa, having the first journal of behaviour therapy, *Behaviour Research and Therapy*, founded in 1963 in England. The behaviour therapy was associated with the methodological behaviourism of the stimulus-response (S-R) learning theorists, including Joseph Wolpe, Arnold Lazarus, Stanley Rachman, Hans Eysenck, M. B. Shapiro(Dougher & Hayes, 2000).

Applied behaviour analysis was closely related to operant psychology, an inherently interactive and developmental perspective where actions of organisms are situated, both historically and in the current context. The context mentioned includes the structure of the organism itself, but no one part of the situational features of an interaction eliminates the importance of other features (Hayes et al., 1995).

Applied behaviour analysis was also closely related to radical behaviourism, and with professionals who tended to work more with children and institutionalised clients rather than outpatient adults, since a good part of their techniques relied heavily on the direct manipulation of environmental contingences (Hayes et al., 1995). Clinical targets generally involved contextual changes (first-order), done often in a direct and didactic way, including giving instructions and feedback (Hayes, 2004).

.....One of the basic assumptions that differentiates Watsonian behaviourism from Skinnerian behaviourism is that the individual is in a passive condition in the Watsonian perspective, being observed by the experimenter who sometimes introduces the stimulus, whereas in the Skinnerian perspective, the individual is an “active” subject who operates in his or her environment, controlling his or her own learning process (Roediger, 2004).

Applied behaviour analysis had as two of his most important characteristics 1) the rise of operant psychology, the study of reversible behaviour maintained by

reinforcement schedules; and 2) the importance given to behaviour control in establishing the value of psychological theory and analysis (Hayes, 1988).

.....Behaviour therapy, on the other hand, developed almost independently in three countries: South Africa, USA and Great Britain. In South Africa Joseph Wolpe developed the treatment known as systematic desensitisation (a therapeutic intervention that reduces the learned link between anxiety and objects or situations that are typically fear-producing) to deal with phobias and other anxiety disorders. In the USA operant techniques were used with schizophrenic patients by Ogden Lindsley with high rates of success. In England Hans Eysenck developed an alternative to Freud's psychoanalysis, which was based on the idea of hereditary behaviours (Dougher & Hayes, 2000).

The tradition of behaviour therapy was more associated with the neobehaviourism of S-R learning theory, its practitioners tending to work with adults in outpatient settings. The earlier forms of intervention in this tradition focused on associational principles (e.g., thought systematic desensibilisation), giving more attention to problems that were more rapidly resolved through such methods (e.g., anxiety disorders) (Hayes et al., 1995).

. This neobehaviourism followed Watson more in a methodological sense than in a philosophical sense. Methodologically Watson was very rigid when trying to follow his "scientific point of view" while philosophically his approach could be seen as mechanistic, analysing systems in its parts and their relation (Hayes et al., 1995).

. .Both these traditions were committed to the use of clearly defined and replicable techniques, made available by sound design and systematic experimental approaches. However, in the beginning of such traditions, behaviour therapy had more adherents than applied behaviour analysis (Mahoney, Kazdin, & Lesswing, 1974).

Behaviour therapy is considered to be the first "wave" of a scientifically based psychotherapy. The second wave was developed by Aaron Beck in the 1970s and was called cognitive therapy. Unlike behaviourism, the emphasis is not on the environment determinism; instead, cognitive therapy is based on the premise that the inter-relationship between cognition, emotion and thought is implicated in the functioning of the human being (Hayes, 2004).

Cognitive therapy was based on the computer metaphor of the mind, using behaviouristic methods in its attempt to assess the functioning of the mind, trying to look into the gaps between an event and a response to it (Franks & Wilson, 1974).

Early cognitive therapy approached cognition (generally referring to the common sense categories thoughts, ideas, beliefs or assumptions) in a direct and clinically relevant way. Through the use of questionnaires and clinical interviews, clinicians learned to identify cognitive errors in particular populations, and direct means were developed to correct these problems (Hayes, 2004).

The cognitive movement pursued not just the accumulation of a range of verbal psychotherapies to the methodological armamentarium of behaviour therapy, but also the addition of more flexible cognitive meditational constructs (the attempt to bridge temporal and special gaps by modelling internal mechanisms) rather than the rigid meditational concepts of S-R learning theorists. These mediating variables were identified as causal: cognitions – in the form of attitudes, beliefs and schemata – were theorised to be the source of maladaptive behaviour (Meichenbaum, 1993).

This cognitive focus comported so well with the overall approach of the first wave of behaviour therapy that a second generation of behaviour therapy could be simply created by expanding the scope, models and methods of the tradition, such as adding irrational thoughts, pathological cognitive schemes or faulty information-processing styles to the list of direct targets for change, along with new methods appropriate for these targets (Hayes, 2004).

In the mid 1990s, behaviour therapy and cognitive therapy merged into what has been named CBT, reaching unprecedented success. The empirical basis of the field has been enormously strengthened, and in problem area after problem area, empirical clinicians have shown that CBT is helpful, thus establishing CBT as the largest evidence-based therapy today (Roth & Fonagy, 2005).

CBT is one of the most dominant psychotherapy approaches to dealing with a variety of mental disorders, such as anxiety, schizophrenia and personality disorders among others (Butler, Chapman, Forman, & Beck, 2006). Recently, acceptance and mindfulness-based approaches have been generating significant interest in

psychotherapy contexts, thus being called third wave treatments, succeeding behaviour therapy and CBT. One of these approaches is ACT (Hayes et al., 1999).

ACT tries to help clients change the context in which the behaviour happens, and has as some of its essential goals the following: the treatment of emotional avoidance, the treatment of excessive literal response to cognitive content, and the treatment against the inability to make and keep commitments to change behaviours (Kohlenberg, Hayes, & Tsai, 1995).

ACT is not considered by its founders an extension of CBT, but instead a new treatment approach. It is suggested that behaviour therapy can be divided into three waves: traditional behaviour therapy, CBT and contextual approaches, such as ACT (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

There has been a rapid rise of acceptance and mindfulness-based interventions (Hayes et. al, 2006). These "third wave" approaches have been defined as empirically grounded, principle-focused approaches, mostly sensitive to the context and functions of psychological phenomena, not just their form, tending to emphasise contextual and experiential change strategies, but doing so in a more direct and didactic way. These treatments seem to search for a construction of broad, flexible and effective repertoires that are not necessarily narrowly defined by problems, emphasising the relation to the issues they examine for clinicians as well as clients (Hayes, 2004).

Other third wave approaches include dialectical behaviour therapy (DBT) (Linehan, 1993), mindfulness-based cognitive therapy (MBCT) (Segal, Williams, & Teasdale, 2001), and meta-cognitive approaches (Wells, 2000), among several others. Third wave approaches emerged in behavioural and cognitive wings of CBT, thus justifying these changes in terms of a "wave" (Hayes et al., 2006).

ACT is not a mindfulness-based interventions *per se*, but utilises such a method. The practice of mindfulness has become part of behaviour medicine in programs to reduce stress by Kabat-Zinn (1982). The concept, whose origins are in the Eastern practices of meditation (Hanh, 1976), aroused the interest of clinicians outside the field of behavioural medicine in 1990. Stormed contextual behavioural therapists, who had asserted their identity during the previous decade (Zettle & Hayes, 1986) and established mindfulness as a central feature of these (Hayes, 2004).

Kabat-Zinn (1982) defines mindfulness as a specific form of full attention – concentration at the moment, intentionally, and without judgment. Focusing on the present moment means being in contact with the present and not being involved with memories or thoughts about the future. Considering that people function a lot of the time on autopilot, as the author says, the intention to practise mindfulness would be to bring full attention to the action in the current moment. Intentional means that the practitioner of mindfulness makes the choice to be mindful and strives to achieve this goal. This is in contradiction with the general tendency of people to be inattentive and alienated regarding the world around them. Being focused on the current moment, the contents of thoughts and feelings are experienced in the way they present themselves – they are not categorised as positive or negative. Without judgment means that the practitioner accepts all feelings, thoughts and sensations as legitimate. The attitude of judging others is in contrast with the automatic tendency of people to invest in a fight against aversive experiences, failing to live the rest of one's reality. The practitioner does not treat differently certain feelings (e.g., anger or fear), thoughts (immoral ideas) or sensations (e.g., pain), suspending any rationalisations that people tend to make that truncate their perceptions of disturbing events to fit them into their preconceived opinions.

There are several approaches that utilise the same principle, such as Morita therapy, Gestalt therapy, Adaptation Practice, Dialectical behaviour therapy, Hakomi, and Internal Family Systems Therapy, among others; however, there are two main interventions that examine mindfulness as an independent intervention: Mindfulness-based cognitive therapy and Mindfulness-based stress reduction (Brown & Ryan, 2003).

ACT, on the other hand, attempts to create a modern form of behaviour analysis that could overcome the challenge of human cognition by adding the basis needed to deal with cognition from a functional contextual, or behaviour analytic, point of view. The idea is that a contextualistic theory of cognition could possibly bring together practical goals and basic science commitments of the behaviour therapy tradition. This idea is based on the fact that behaviour therapists always resided on actions instead on the context surrounding it, therefore could only have an impact on these actions by manipulating the contextual variables (Hayes, Hayes, Reese, & Sarbin, 1993).

ACT's choice for functional contextualism as a philosophical root is based on the fact that contextualism has as its goals the prediction, influence of events, precision, scope and depth regarding the analysis of behaviours, seeing events as ongoing actions of a whole organism that interacts with its environment in a historically and situationally defined context. ACT therefore shares philosophical similarities with constructivism, narrative psychology, dramaturgy, social constructionism, feminist psychology, Marxist psychology and other contextualistic approaches (Hayes et al., 1993).

ACT uses a contextualistic approach when dealing with the truth criterion, in which ACT emphasises workability, i.e., what works for a given context, highlighting the idea of chosen values as a necessary leading factor in the assessment of workability, since values specify the criteria of workability (Hayes et al., 1993).

With Relational Frame Theory (RFT) as its theoretical antecedent, ACT employs a post-Skinnerian account of the basic processes underlying human language and cognition (Hayes et al., 2001). It is not the objective of this thesis to conduct a complete examination of RFT; however, some basic knowledge of RFT is needed to understand ACT.

RFT sees human beings as having the unique ability to create, derive and combine relations between events, even when they are not directly trained to do so, bringing the stimuli (both the internal and external environment) that bring the relations under arbitrary and verbally derived contextual control. According to RFT, the ability to think, reason and verbalise from the capacity to derive relations between events (Hayes et al., 2001).

The practical applied implications of RFT derive from three basic features. The first is *mutual entailment*, which refers to the fact that if a stimulus, say, A, is related in a certain way to a stimulus, say, B, in a given context, then a human will complementarily infer that B is related to A in the same context (Hayes et al., 2001).

The second feature is *combinatorial entailment*, which refers to the fact that if a human learns that if a stimulus A has some relationship with a stimulus B, and that the same stimulus B has some relationship with a stimulus C, then a human will

complementarily make a connection between stimulus A and stimulus C (or C to A) in a given context (Hayes et al., 2001).

The third and final feature is *transformation of stimulus functions*, which occurs whenever a derived relation between stimuli is made leading to some cognitive relations and cognitive functions are regulated by different contextual features of a situation. That is, when a relation is made between two stimuli, some of the functions, whether directly or verbally acquired, of each stimulus are transformed according to what stimulus they are related to, and how they are related to that stimulus (Hayes et al., 2001).

Some of the usage of RFT in the practical area of psychotherapy and psychopathology extends from these three features, implying that it is often not necessary to focus on the content of cognitive networks in a clinical intervention, but instead on their functions (Hayes et al., 2001).

ACT's central goal is to increase psychological flexibility. Such a goal is sought since Western cultures tend to propagate the idea that private painful experiences are "bad" and therefore should be avoided and/or eliminated from one's life. While such control messages became rules that seemingly had great success in the external and material world, problems arise when individuals apply these rules to the world under the skin, where success is rarely attained, especially in the long term (Hayes et al., 1999).

Attempts to control the world under the skin works poorly for at least two reasons. First, the events that one tries to control are usually involved in a relational framework that can not be stopped or eliminated. Second, the rules used to control internal events usually contain that which is supposed to be controlled (e.g., "Stop thinking about *death*)", which consequently elicit more thoughts about the content one is trying to avoid (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996).

The problem, according to ACT, is that behaviour under the control of verbal-relational contingencies usually is more inflexible than the behaviour that is in direct contact with contingencies. ACT therefore tries to change the locus of behavioural control from verbal-relational contingencies to more direct ones. By letting go of trying to evaluate/judge/compare what is being experienced (verbal-relational contingencies) one can alter the function of the expediencies they have and thus increase psychological flexibility by experimenting the direct contact with the present moment and its context,

promoting acceptance, challenging the workability of behaviours, undermining excessive literality of verbal-relational contingencies, clarifying valued life directions, and engaging in behaviour that goes with those values.

ACT seeks to encourage the acceptance of unwanted thoughts and feelings, and motivate the emergence of behaviours that could contribute to the improvement of one's quality of life (Hayes et al., 1999). ACT therefore suggests a number of techniques to promote psychological flexibility (to be in contact with the present moment fully as a conscious human being, and based on what the situation affords, change or persist in behaviour in the service of chosen values). Hayes et al. (1999) have listed six ACT techniques:

- defusion: a technique designed to reduce the functions of thoughts by altering the context in which they occur, rather than by attempting to alter the form, frequency or situational sensitivity of the thoughts themselves;
- acceptance: willingness to experience psychological events (thoughts, feelings, memories) without having to avoid them or let them unduly influence behaviour;
- contact with the present moment: an ongoing non-judgmental contact with psychological and environmental events as they occur, directly and freely;
- the observing self: a standpoint in which one can be aware of one's own flow of experiences without attachment to them or an investment in which particular experiences occur;
- values: chosen qualities of purposive action that can never be obtained as an object, but can be instantiated moment by moment;
- committed action to improve quality of life: the development of larger and larger patterns of effective action linked to chosen values.

Hayes et al. (2004) developed the Acceptance and Action Questionnaire (AAQ) (see Appendix B) as a way of assessing experiential avoidance and psychological acceptance, two key constructs that are at the core of ACT. Although these two processes are known and considered by several other therapeutic model, e.g., Gestalt Therapy, Existential Psychology and Dialectical Behaviour Therapy, earlier studies had

no reliable and valid measurement instruments. The AAQ has proven to be effective in empirically measuring these two psychological phenomena, i.e., experiential avoidance and psychological acceptance (Hayes et al., 2004). Swedish, Dutch, Spanish and Japanese versions have been validated. It has also been used as the basis of more specific acceptance and defusion measures, such as those developed in the area of smoking and pain.

Although experiential avoidance is not necessarily problematic, as a strategy to deal with events under the skin it does appear to lead to several forms of psychopathology, such as depression and generalised anxiety disorder, among others (Hayes & Gifford, 1997).

Experiential avoidance is defined by Hayes et al. (1996) as the:

> phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioural predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them. (p. 1154)

Although some forms of avoidance such as distraction or relaxation may be beneficial in some contexts, using the same strategy in other contexts may be unproductive and even interfere with a person's progress towards his/hers valued goals. Research has shown that thoughts and feelings associated with an aversive event may become themselves aversive, reducing further opportunities for seeking valued goals (Blackledge & Hayes, 2001). One possible result is that the person attempting to avoid feelings, thoughts, etc. may not move further away from valued goals, but possibly continue to feel hopeless and uneasy (Wenzlaff & Wegner, 2000). For example, a person may have limited participation in intimate relationships in an attempt to avoid feelings of vulnerability and thoughts of possible rejection (Forsyth, Parker, & Finlay, 2003)

Avoidance of unpleasant feelings and thoughts is a widely investigated process in cognitive psychology. This is an extension of the idea from the "material" world: if there is something physical interfering in one's life, one should try to change it, control it or eliminate it. However, attempting to control private experiences under some circumstances can actually cause more harm than good: attempts at suppressing

thoughts and emotions can lead to a later increase of these psychological contents (Clark, Ball, & Pape, 1991; Wegner, Schneider, Carter, & White, 1987).

Experiential avoidance has been linked with a variety of clinical problems, from substance abuse to suicide. For example, the use of substances that alter one's mind is frequently linked with an attempt to avoid psychological stressors (Cooper et al., 1995). It is estimated that half of actual or attempted suicides are related to an effort to escape from aversive events and negative emotions such as guilt and anxiety (Baumeister, 1990).

Using experiential avoidance as a strategy to deal with unwanted private contents can lead to an inability to take necessary action in the face of such experiences (Hayes, & Strosahl, 2004). ACT focuses on the pervasiveness of experiential avoidance when dealing with cognitive content, seeking to promote greater psychological flexibility to assist one to be in a more direct relation with the environment and not be dominated by verbally mediated processes, such as judgments, avoidance and cognitive control (Hayes et al., 1999).

ACT suggests the use of psychological acceptance to deal with the possible harm of using experiential avoidance. The idea of psychological acceptance has been a part of many religious practices and beliefs, such as Catholicism. In such a context, the use of acceptance in the face of physical or emotional suffering (which one can do little about other than wait for the pain to subside) is a required strategy, which intuitively may well have some value, with empirical evidence tending to support this perspective. In reality, however, a small but growing body of evidence has indicated that in certain contexts the lack of psychological acceptance in favour of experiential avoidance may correlate with a number of psychological problems (Barnes-Holmes, Cochrane, Barnes-Holmes, Stewart, & McHugh, 2004).

Acceptance can be defined as "actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively" (Hayes et al., 1996, p. 1163).

Acceptance should not be regarded as passive tolerance or fatalistic resignation, but as the ability to embrace internal experiences (thoughts, emotions, etc.) as they occur. Such a stance brings benefits to the person since he or she can then become more in

touch with the workability of their behaviours, in other words, he or she can see more clearly what behaviours works better in their pursued of their individual valued goals (Hayes et al., 1994; Hayes et al., 1999; Hayes & Strosahl, 2004).

Psychological acceptance is one of the key elements of ACT in achieving psychological flexibility since it can be understood as a way of getting in contact with private events (e.g., thoughts and feelings) that are frequently unchangeable, or when attempts to modify them can lead to further negative consequences (Hayes et al., 2001; Hayes & Wilson, 1994; Hayes et al., 1996).

The acceptance of unavoidable private events instead of the use of avoidance has proven to be beneficial in the context of mental illness. Bach and Hayes (2002) found that the use of this technique, combined with others provided by ACT, significantly reduced rehospitalisation and improved social functioning.

While ACT has become popular in psychotherapy, the concept of recovery has been generating great interest in mental health circles.

Recovery: From the Medical to the Psychological

..... Recovery from mental illness is an idea that arose in recent decades, but is still struggling to fight the "old" belief that such a thing is not possible. The perception of how people see mental illness reflects the way the person with mental illness is treated, e.g., the "old" idea that a person can not recover from mental illness resulted in institutionalisation and exclusion from normal life in the community. This, added to negative perceptions coming from the media, lead to an enduring stigma and discrimination for people diagnosed with a mental illness (Allott, Loganathan, & Fulford, 2002).

. New studies have shown that people diagnosed with a mental illness can recover, and the method used to helm them do so is through treatment and care in community-based environments, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while seeking his or her full potential (Carpenter, 2002). The evidence is so clear that many countries are now following the recovery orientation of how to care for and treat people living with mental illness (see Commonwealth of Australia, 2009; Mental Health Commission of Canada, 2009; Mental Health Commission of New Zealand, 1998).

The recovery movement worldwide is heavily influenced by the recovery literature from the USA, where some suggest that the movement had its creation in the 1970s and 1980s when people living with a mental illness started to share their experience of recovery (Meehan, King, Beavis, & Robinson, 2008). People with a lived experience of mental illness joined a group, influenced by black, gay and women's liberation movements of the time, and formed the psychiatric survivor movement, from which they excluded practitioners and the general public who did not share their radical views of mental illness (Deegan, 2003; Schiff, 2004).

At first the recovery model exported from America to other countries was based on work developed by professionals and academics rather than people living with a mental illness. This resulted in a dominance of psychiatric rehabilitation and biomedical models (O'Hagan, 2004).

.....New Zealand, along with other countries, began to question the values and philosophy behind psychiatry, especially regarding the American conceptualisation of recovery, since it was based on work by professionals rather than consumers. The points of disagreement were related to the lack of acknowledgment of important issues such as discrimination, human rights, cultural diversity or the potential for communities to support recovery. New Zealand sought to deal with such matters and is now considered having the most coherent and progressive national recovery policies (O'Hagan, 2004).

In Australia, the notion of recovery was embedded into policy; however, there has been criticism that the rhetoric of recovery was not put into practice. It has been noted that there are several pervasive barriers to people living with mental illness, at the individual, collective consumer, clinical and systemic levels; however, the most notorious and present barrier at all levels is stigma and discrimination (Rickwood, 2004).

When trying to define recovery, there are two major models of recovery related to mental health which are considered by some to be in tension with each other. The first is the medical model which drives the clinical view of recovery as a return to a former state of health, observed as reduced symptomatology, hospitalisation and medication use. The second is a personal view of recovery driven by people's lived, subjective experiences of recovery from mental illness, challenging the idea that it is something permanent. This model of recovery includes empowerment, hope, choice, self-defined goals, healing, well-being and control of symptoms (Slade, Amering, & Oades, 2008).

The medical model emerged from scientific and clinical literature that assumes that mental illness is a physical disease due to a long-lasting chemical brain imbalance, which is present at birth; following such a model, recovery signifies "cure" or absence of symptoms (Ahern & Fisher, 2001). This medical model implies that individuals with such a disease can not make rational choices and therefore act rationally. Another assumption is that the patient's perspectives should be rejected as a subjective alteration of an objective reality (Lauder, 1999). Recovery from this perspective is related to outcomes associated with sustained remission and invariance across individuals, which may include reduced symptomatology, hospitalisation and medication use (Andresen et al., 2003).

Those opposing the medical model argue that some consumers could never recognise themselves as recovered under such definition (Ahern & Fisher, 2001; Andresen et al., 2003), since this perspective assumes chronicity of psychiatric disabilities (Carpenter, 2002). Those in favour of the medical model argue that outcomes such as reduced symptomatology, among others, are important aspects that should define recovery (Resnick, Rosenheck, & Lehman, 2004).

The rehabilitation perspective follows the medical model of recovery which posits mental illness as a permanent disability, and that individuals need to learn to live with the limitations of their illness (Andresen et al., 2003).

Recovery is considered by some as something that the consumers from mental services experience, not something provided by a formal service system (Tooth, Kalyanasundaram, & Glover, 1997). In fact, many of those who recovered from mental illness have done so without any help from others (Ralph & Corrigan, 2005). This ability has manifested itself in the development of a "consumer-oriented" model (Corrigan & Ralph, 2005).

Personal recovery is understood as a deeply personal and ongoing process lived by those with mental illness, in which they deal with the influence of their disability on all aspects of life (Deegan, 1996; King et al., 2007). It is a perspective that was based on accounts of people with the lived experience of mental illness (Deegan, 1988). This model differs from the medical model of recovery since it was based on a system of health promotion, in which individuals have the choice to define their needs and collaborate with other professionals in the healing process (Schiff, 2004).

Based on the principles that emerged from the experiences of consumers in recovery, an empowerment model of recovery was created challenging the notion of permanent mental illness (Schiff, 2004). This model tries to instil hope, personhood, self-defined goals, choices, the opportunity for people to speak for themselves, peer support, ending discrimination, self-control of symptoms, well-being, liberty and freedom, and healing from within (Fisher, 1994).

The empowerment perspective argues that people are born with a relatively balanced state of being. During our lives, however, all of us are faced with a variety of stressful situations, and for some people this may lead to the occurrence of a mental

illness. To recover from mental illness one must restore one's emotional balance by developing an attitude of optimism, understanding, trust and empowerment. This would allow the person to maintain social roles and to be seen as a person *with* a mental illness, rather than a mentally ill person (Ahern & Fisher, 2001). This perspective advocates that recovery is possible for everyone, with the assistance of self-managed care and social supports (Schiff, 2004). Some even say that the strong version of the empowerment perspective denies the need for medical treatment (Andresen et al., 2003).

Andresen et al. (2003) propose a psychological definition of recovery that refers to the formation of a new established sense of self based on hope and responsibility, placing no limitations on the person's life. These authors suggest that their definition is positioned between the rehabilitative view and empowerment view of recovery.

Andresen et al. (2006) proposed a sequential five-stage model based on findings from five published qualitative studies.

The five stages according to these authors are: moratorium (a time of withdrawal characterised by a profound sense of loss and hopelessness); awareness (realisation that all is not lost, and that a fulfilling life is possible); preparation (taking stock of strengths and weaknesses regarding recovery, and starting to work on developing recovery skills); rebuilding (actively working towards a positive identity, setting meaningful goals and taking control of one's life); and growth (living a full and meaningful life, characterised by self-management of the illness, resilience and a positive sense of self).

Within the recovery process, four key processes that are related to the five phases of recovery are: finding hope, redefining identity, finding meaning in life, and taking responsibility for recovery, all linked with the concept of finding and pursuing personal goals (Andresen et al., 2003).

They also developed a method to measure psychological recovery as the concept is described by mental health consumers in the Stages of Recovery Instrument (STORI) (Andresen et al., 2006). The results provided preliminary empirical testing, and supported its validity as a measure of the consumer definition of recovery; it also supported the model of psychological recovery consisting of four component processes and five stages.

One of the most frequently used definitions of recovery is from Anthony (1993), in which the author states that recovery is a deeply personal, unique process of changing attitudes, values, feelings, goals, skills and roles. Anthony argues that people can recover from mental illness even if the illness is not "cured", continuing the process of recovery even in the presence of symptoms and disability. Still, according to Anthony, recovery should be a way of living a satisfying and hopeful life, developing a new meaning and purpose that surpass the effects of mental illness.

This brief review of the concept of recovery shows that a concise definition is hard to arrive at. Seeing that recovery means different things to different people, recovery can vary between different persons' belief systems and perceptions; furthermore, the term is not well understood by either consumers or professionals and policy makers who are supposed to assist them. The term can be confusing and even contradictory since it can be considered as both a process and an outcome (Slade et al., 2008).

Shepherd, Boardman and Slade (2008) suggest that there are some dangers in a concise definition of recovery since it can reduce all of its potential and personal nature. However, these authors also believe that it is important to describe the concepts underlying recovery because it could result in a better operationalisation of practice.

There are several concepts that interact and facilitate the recovery journey for people diagnosed with a mental illness, such as: taking control of one's own life, understanding one's illness, developing a healthy lifestyle, social supports, nurturing the whole person and social inclusion.

To take control of his or her own life, a person is encouraged to take responsibility regarding managing medicines, choices, setting goals and taking risks to grow. That leads to empowerment over the individual's life and the formation of a new sense of self that is not bound by the stigma of having been diagnosed as having a mental illness. Consequently the concept of empowerment may lead to the person trying to voice and influence social structures in which he or she lives through advocacy (Andreson et al., 2003). But firstly, to do so, a person should accept the illness as only one part of a multidimensional existence and multifaceted sense of personal identity (Davidson, O'Connell, Tondora, et al., 2006). A theme underlying all the concepts mentioned is

hope, which is cultivating positivity in the face of challenges that may arise (Resnick et al., 2004).

Another key concept on the road to recovery is understanding one's illness through information about mental illness, medication and symptoms so that people can understand the cause of their illness and the services available so the ill person can make an informed decision regarding his or her own treatment (Resnick et al., 2004).

Maintaining and/or developing a healthy lifestyle, such as giving up smoking, reducing alcohol and other drug use, and maintaining dental care, physical exercise and proper nutrition, among others, has shown to assist recovery (Mead & Copeland, 2000).

Social support, especially from people with the lived experience of mental illness, has been shown to be beneficial to recovery since it may serve as an opportunity to those who are in later stages of recovery to feel valued as a role model, and at the same time giving hope to those who are in earlier stages of recovery. With the support of others a person can cultivate empathy, compassion and rapport with a person that is non-judgmental, non-critical, thus providing a space of security in which the person with mental illness can better deal with the obstacles of mental illness (Schiff, 2004).

Nurturing the whole person, considering a person as more than a label given by a diagnosis of mental illness, is considered of great importance to the journey of recovery. To be achieved, several aspects of a person's life must be dealt with, such as spiritual beliefs, the possibility of alternative therapies, management techniques that encourage stress reduction and relaxation, hobbies, etc. (Andreson et al., 2003).

Social inclusion is also considered to be a central component of recovery, in which a person becomes an active citizen through participation – economically, socially, civically – in his or her own treatment, in service evaluation and advocacy activities, in creative and fun activities, among several others (Mead & Copeland, 2000).

Some argue that it is legitimate to refute the medical model of recovery since many consumers feel that their diagnosis is a pessimistic life sentence from which they can not escape or change (Andresen et al., 2006). Others consider that the personal view of recovery and the medical model can actually complement each other, since reduced symptomatology, among others, are important aspects that should define recovery

(Resnick et al., 2004). The consumer conception of recovery was adopted in this study because it was observed that the form in which the experience of recovery is conceptualised affects directly the way of approaching mental illness (Glover, 2005).

The recovery movement shares some similarities with the ACT approach and this will be explored in the next subsection.

Relationship between Psychological Acceptance, Experiential Avoidance and Psychological Recovery

To further the understanding of individuals with mental illness and possibly develop new ideas and practices, it is informative to compare and contrast the recovery and ACT models. Table 1 illustrates similarities between key processes in psychological recovery as defined by Andresen et al. (2003) and the ACT model as defined by Hayes et al., (1999).

Table 1

Similarities between components of psychological recovery in mental health and psychological acceptance/experiential avoidance process from Acceptance and Commitment Therapy

Key processes of psychological recovery (Andresen et al., 2003)	Key processes in ACT (Hayes et al., 1999)
Loss of self-identity is a recurrent theme in mental illness, in which there is a process of redefining one's identity by seeing the illness as a small part of the whole self.	A new formation of sense of self could be interpreted through the lens of ACT as a way to escape the excessive fusion with the conceptualised self of being a mentally ill person.
Finding meaning in life is integral to recovery; however, the source of that meaning can vary greatly between individuals, and possibly over time.	Finding valued goals, i.e., discovering what is important/meaningful in one's life, is one of the most important and motivational foci of therapy for ACT.
Taking responsibility for recovery includes self-management of wellness and medication, autonomy in one's life, accountability for one's actions, and willingness to take informed risks in order to grow, in other words, making one's own choices.	ACT states that "pliance", i.e., blindly following rules by practitioners, family or friends, may not represent the best course of action for some contexts; in the case of recovery the act of choosing by oneself may led to empowerment, self-determination and commitment to recover.

Clarifying some of the statements of Table 1, it is considered that stigmatisation is still a big problem for people with a mental illness (SANE Australia, 2008). The subtle change from "being" a mentally ill person to "having" a mental illness is significant, since the individual ceases to see himself through a static and detrimental perspective, and starts to deal with his situation, in the moment, in a more conscious way.

The definition of "pliance", mentioned in Table 1, is the process of following a rule because, in the person's social history, following rules in itself resulted in reinforcements (Hayes et al., 1999). Thus, in the case of recovery from mental illness where active new ways of dealing with his environment are necessary, pliance can lead to a passive static existence.

Hope is identified by Andresen et al. (2003) as a key process in psychological recovery. ACT, however, is a behaviourally committed approach that does not necessarily need to instil feelings or cognitive contents to achieve value goals (Harris, 2008). This apparent difference can nevertheless be resolved by examining the definition of hope according to Andresen et al. (2003). These authors adopt Snyder's hope theory (Snyder, Michael, & Cheavens, 1999), where hope is comprised of three distinct elements: a goal, envisaging pathways to the goal, and belief in one's ability to pursue the goal. It is also described as anticipation of a continued good state, an

improved state or a release from perceived entrapment. From this perspective, ACT is also a therapy with a philosophical foundation of instilling hope as a catalyst for a person's work (Hayes et al., 1999).

As Table 1 illustrates, key processes of recovery defined by Andresen et al. (2003) are comparable with ACT. The similarity between the two approaches opens a window for positive dialogue between them. This signifies that the integration of work with recovery from mental illness is possible and that the utilisation of ACT constructs could facilitate personal recovery and its conceptualisation.

It is possible to theorise the role of experiential avoidance and psychological acceptance in the recovery process by observing the apparent presence of these two constructs in the description of the five stages of recovery identified by Andresen et al. (2003). In the first stage, moratorium, the presence of experiential avoidance in "denial" and "withdrawal", characteristics of this stage, seem evident. In the second stage, awareness, the idea that a person can overtly accept the mental illness as a part of the self, but not being the whole self, indicates the role of psychological acceptance in this stage. In the third, fourth and fifth stages, psychological acceptance seems to be involved in accepting one's values, strengths and weaknesses as well as accepting the possibility that suffering and setbacks are a normal part of the recovery process.

Experiential avoidance likely plays a negative role and psychological acceptance a positive role differentially across the stages of psychological recovery; it can be seen how the likely use of these psychological constructs may influence (favourably or adversely) the progress of one's recovery journey.

...Considering that psychological recovery is also a subjective phenomenon, a new formation of a sense of self could be interpreted through the lens of ACT. Psychological acceptance may be a way to escape the excessive fusion involved in conceptualising the self as being a mentally ill person, by transforming to a new perspective where the person sees him- or herself as having mental illness. This subtle change is significant once the individual ceases to see him- or herself through a static and detrimental perspective, and starts to deal with his or her context, in the moment, in a more conscious way (Davidson & Strauss, 1992; Hayes & Wilson, 1994).

A cornerstone of the fight for progress for patients with mental illness is the patient's need to accept accountability/responsibility for his or her life (Linhorst, 2006). This fight initially occurs because of misleading messages that are sent to consumers that they lack the capacity to control their own lives. This has pervasive effects for recovery since this process depends on the active involvement of the consumer (Deegan, 1996; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). ACT attributes this pervasiveness to a consequence of pliance. Pliance becomes problematic once it leads the individual to blindly follow rules that may not represent the best course of action in a given context (Hayes et al., 1999). As noted above, pliance can become an obstacle to recovery since in its process one must find active new ways of treating his environment, and pliance can lead to a passive static existence.

Glover (2005) noted that many people undergoing recovery have a sense of hopelessness, stigma and discrimination in social discourse, leading to a lack of willingness to ask questions and participate in their treatment. In such cases, the use of psychological acceptance, defined as "*actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively*" (Hayes et al., 1996, p. 1163 [emphasis added]), could prove to be a way of effectively influencing service delivery.

Enduring mental illness is also regarded as a chronic medical problem that has significant financial and social costs, including stigma and discrimination. The psychological dimension of living with such chronic disease is often overlooked; however, it is an issue of great importance not covered by many authors. Evidence shows that the perception and representation or meaning of the illness impacts on individual recovery (White, 2001).

The definition of chronic mental illness is somewhat unclear, since the functional definition at one time may not be applicable at another. Definition according to particular diagnoses has not been useful, because a wide range of functional impairment might be associated with all of the diagnoses. The extent of the functional disability of significant duration in persons with a diagnosable mental illness is the most relevant aspect for defining chronic mental illness. However, it must be noted that there is potential for rehabilitation or improvement in a person's quality of life for almost all

people affected, and there are great variations in the extent of their disability (Stone, 1996).

Recovery is an ongoing process in the chronic forms of mental illness. As such, a person with mental illness has to learn how to live with this disease in the same way that a person with diabetes has to learn how to live with such a disease. There is evidence that ACT can assist in the treatment of both physical and mental disorders (Dahl, Wilson, & Nilsson, 2004; McCracken, MacKichan, & Eccleston, 2007; McCracken, Vowles, & Eccleston, 2005; Wicksell, Melin, & Olsson, 2007; among others). The utilisation of mindfulness modifies the way in which meanings are processed and, as a consequence of such training, people with psychosis showed improvements in the quality of their lives (Chadwick, Taylor, & Abba, 2005).

Other authors (for example, Gaudiano & Herbert, 2006) have also indicated the benefits of using ACT in the long-term treatment of individuals with psychotic symptoms using a normal ACT treatment-program, which consists of defusion with a story, acceptance of discomfort, setting of realistic goals and embracing values, not necessarily in this order (Harris, 2008).

There are not many literatures regarding the use of ACT for people living with a mental illness (Bach & Hayes, 2002). It is therefore necessary to explore in more detail which ACT constructs can assist these individuals in their journey of recovery to achieve psychological health, so that appropriately focussed therapeutic strategies can be developed to help them.

This brief comparison between ACT and recovery revealed several parallels and possible points of conjunction that could prove beneficial to those on their journey of recovery, and at the same time expand the use of ACT as a treatment model to deal with mental illness. However, it must be stressed that further in-depth practical work should be pursued to better observe the detailed relation between these two movements. It must be also noted that there are several other movements in psychology that have been used with the recovery movement and have proven to be effective, such as cognitive-behavioural psychology (Kurtz, 1997) and positive psychology (Resnick & Rosenheck, 2006), among others.

The concept of psychological well-being is related to psychological recovery, and this will be discussed below.

Psychological Well-Being and Mental Health

Positive psychology is a relatively new branch of psychology that promises to improve quality of life and prevent pathologies from arising when life seems pointless and unproductive. It differs from mainstream psychologies that focus on pathology and disregard positive features in human life such as hope, wisdom, creativity, among others (Seligman & Csikszentmihalyi, 2000).

Psychological research has indicated that good or positive mental health is comprised not only of the absence of mental illness – as previous paradigms were – but also involves factors such as subjective well-being (e.g., happiness and life satisfaction), personal growth (e.g., self-actualisation and a sense of meaningfulness) and spirituality (e.g., "other-centeredness" and self-renunciation) (Compton, 2001).

Subjective well-being is a new field of study that seeks to understand the evaluations that people make of their own lives (Diener, Suh, & Oishi, 1997). This field had an accelerated growth in the last decade, having as its major research topics happiness and satisfaction (Diener, Scollon & Lucas, 2003). Such evaluations must be cognitive (global satisfaction with life and other specific domains such as marriage and work) and should also include personal analyses of the frequency with which one experiences positive and negative emotions. To be able to report an adequate level of subjective well-being, it is necessary that a person maintains an elevated level of satisfaction with life, a high frequency of positive emotional experiences and low frequency of negative emotional experiences. Still, according to Diener et al. (1997), in this field of knowledge one does not seek to study negative or pathologic psychological states, such as depression, anxiety and stress, but rather to differentiate between the different levels of subjective well-being that an individual can reach in his or life. These conceptions reaffirm that subjective well-being comprehend a theme adherent to the principles defended by the current researchers in positive psychology (Seligman & Csikszentmihalyi, 2000).

Currently, subjective well-being is conceived of by Diener and Lucas (2000) as requiring self-evaluation, that is, it can only be observed and reported by the individual him- or herself and not by external indicators chosen and defined by others, even if such

indicators have strong statistical strength. To access subjective well-being it is necessary to consider that each person evaluates his or her own life according to subjective conceptions, which according to Diener and Lucas (2000) are organized by thoughts and feelings about each individual's existence.

This new paradigm considers mental health and mental illness to be on different planes, rather than at opposite ends of a continuum (Keyes & Lopez, 2002). In this conception, mental health is composed of symptoms that are objectively observable over a period of time, and is made up of good or positive mental and social functioning (i.e., subjective well-being) (Keyes & Haidt, 2006).

Keyes and Haidt (2006) assert that one quarter of the people in the world between the ages of 25 to 74 are "flourishing", which they characterise as a "state in which an individual feels positive emotion toward life and is functioning well psychologically and socially" (p. 294).

The opposite position of florishing according to Keyes and Haidt (2006) is called "languishing", which is defined as a "state in which an individual is devoid of positive emotion toward life, is not functioning well psychologically or socially but has not been depressed during the past year" (p. 294). It must be noted, however, that languishers do not necessarily have a mental illness or are mentally "unhealthy".

Others are described as "floundering" in life because they not only have a mental illness (in this important aspect differing from "languishing"), but also have very low levels of emotional, psychological and social well-being. However, some adults who have a mental illness may also experience moderate or high levels of emotional, psychological and social well-being, a state described as "struggling" with life (Keyes & Lopez, 2002).

Most of the authors from a "positive psychology" perspective see "floundering" and "languishing" as the most important psychological constructs since they aim to deconstruct the ideology of "illness" according to the DSM-IV-TR, seeing all humans as simply having strengths and/or weakness (Snyder & Lopez, 2002).

Researchers such as Ryff and Keyes (1995) and Keyes and Ryff (2003) assert that people can function well or poorly in spite of a mental illness status, which is consistent with the idea of recovery.

According to Resnick and Rosenheck (2006) Positive Psychology, and the recovery movement, have had parallel tracks, both focusing on a person's strengths and capacities rather than his or her weaknesses and disabilities. The recovery movement advocates the need for people with mental illness to achieve well-being, empowering them to take an active role (Andresen et al., 2006), correlating therefore its work with the contemporary view of psychological well-being.

The propositions regarding psychological well-being appear as critics towards the fragile formulations that held subjective well-being and the psychological studies that emphasise unhappiness and suffering, neglecting the causes and consequences of positive functioning.

The work of Ryff (1989), and later Ryff and Keyes (1995), are two marks in the literature regarding the theme of psychological and subjective well-being. According to these authors, the theoretical formulations supporting the notion of subjective well-being are fragile for several reasons. First, they pointed to the fact that while the classic study by Bradburn (1969) suggested that the existence of two dimensions in the structure of affect (positive and negative) are the result of the effect of serendipity – since Bradburn sought to identify how certain macro-level social changes (changes in educational levels, employment patterns, urbanisation and political tensions) affected the living standards of citizens – this was therefore Bradburn's sense of well-being, giving minimal attention to actually understanding well-being. Similarly, satisfaction with life, postulated as a cognitive component of subjective well-being, appeared as such when dislocations of the concept emerged in the field of sociology, without having the same consistent theoretical background in psychology.

As a second argument to support the propositions of psychological well-being, Ryff and Keyes (1995) argue that in the field of psychological theorising, there are several theories that allow one to build solid ideas about psychic functioning, emphasising the positive aspects. This theoretical framework, primarily developed in the 1950s and

1960s, could extract support for the conceptual designed process applied to solving challenges that arise throughout life (Keyes, Shmotkin, & Ryff, 2002).

While psychological well-being traditionally records ratings of satisfaction with life and a balance between positive and negative affects that show happiness, the theoretical concepts of psychological well-being are strongly built on psychological formulations about human development and scaled in capacity to meet the challenges of life.

According to a summary presented by Ryff (1989), after analysis and review of the literature, the structure of an approach to positive psychological functioning was found to be based on several existing classical theories in psychology, which are in turn based on a clinical approach. Positive psychology used similar theoretical perspectives found on a number of traditional theories in psychology regarding human development, including the formulations on the development of stages, as well as descriptions of changes in personality and stages of old age. In addition to the propositions mentioned above, positive psychology was also used relating to mental health (Jahoda, 1958), in which it was applied to justify the concept of well-being as the absence of disease and to strengthen the meaning of psychological health.

Taking as reference all the above theoretical concepts, especially those that allow one to abstract different views of positive psychological functioning, Ryff (1989) proposed an integrative model of six components of psychological well-being, subsequently reorganised and reshaped by Ryff and Keyes (1995): autonomy, environmental mastery, positive relationships with others, purpose in life, personal growth and self acceptance. Therefore, for a person to be mentally healthy he or she must be at peace with all facets of him - or herself, have trustworthy relationships with others and have direction in life so that they can evolve into a better person and have some self-determination (Ryff, 1989).

Similar to Positive Psychology, ACT seeks to improve quality of life (subjective well-being), focusing on a person's values and commitment to "grow". In this case acceptance, rather than avoidance, plays a significant role in achieving these objectives (García & Pérez, 2001). Supporting this claim, studies of related treatment models, such as mindfulness-based approaches, have shown positive effects in improving the

psychological well-being of individuals (Brown & Ryan, 2003; Kingston, Dooley, Bates, Lawlor, & Malone, 2007).

Rationale for the Study

Given that there is currently little empirical research investigating the psychological recovery process in mental health, further exploration using established psychological constructs such as psychological acceptance and experiential avoidance may be fruitful.

Examining recovery through the lens of ACT can also complement the previous conceptualisations made by consumers and other psychological theories. Based on the literature review above, it appears that no previous research has investigated the role and frequency of experiential avoidance and psychological acceptance in the psychological recovery process.

Study One:

Psychological Acceptance and Experiential Avoidance in Narratives of Psychological Recovery

....Study One was divided into two progressive stages in which it was necessary to successfully complete the first phase to proceed to the next one. The first part of Study One had the preliminary purpose of discovering whether psychological acceptance and experiential avoidance appear in published narratives of recovery from mental illness through content analysis.

The following phase of this study was an attempt to utilise the same methodology as in Phase 1 in a different sample (data/stories that were not published), seeking to discover whether similar results can be achieved (as the ones in Phase 1), and, furthermore, co-validate the results of the methodology of Phase 1 with a standardised measure of recovery, the Self-Identified Stage of Recovery (SISR).

Both phases sought to answer the same questions, and gather more and differentiated data to support the conclusions of Study One.

Research Questions

1. Are psychological acceptance and experiential avoidance psychological constructs used by those narrating their recovery from enduring mental illness?
2. What is the extrapolative role and frequency of psychological acceptance and experiential avoidance in narratives of psychological recovery?

Phase 1

Method

Participants

A convenience sample of 45 published personal accounts were selected from Medline, PsycInfo and Cinahl databases, along with supplementary material at hand and relevant works cited in the gathered literature (see Appendix G). The criteria for

selecting these sources were that they should be a consumer account of recovery, or a article based on consumer accounts.

Procedure

A content analysis method was developed, identifying textual examples of the two psychological constructs experiential avoidance and psychological acceptance in these narratives. Categories that represented instances of psychological acceptance and experiential avoidance were defined as follows.

Psychological acceptance was defined as "actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively" (Hayes et al., 1996, p. 1163).

Experiential avoidance was defined as a

> phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them. (Hayes et al., 1996, p. 1163)

The content analysis involved quantifying the presence of the two chosen constructs by selecting terms that are both explicitly as well as implicitly implicated in the idea of either construct (see Appendix A).

All the words and phrases identified in the published narratives that could represent a presence of psychological acceptance or experiential avoidance were analysed in the context in which they appeared. The approval or rejection of such possible textual examples were based upon the theoretical definition of the constructs.

Thus in the sentence "*I tried to drown those concerns with loud music*" it can be seen how a person might pursue ways of trying to alter the form or frequency of undesirable private contents. In the sentence "*I wouldn't battle against myself anymore*", although appearing to be related to experiential avoidance because of the word "battle", the negatives "wouldn't" and "anymore" change the meaning of the phrase to acceptance.

In the sentence "*I embrace those feelings that upset me*" the word "embrace" signals psychological acceptance. The sentence "*struggling with thoughts that are not welcome*" also seemed to resemblance psychological acceptance because it deals with unwanted psychological contents. However, the theoretical definition of psychological acceptance suggests that the wording does not represent the construct.

The researcher identified the textual examples of experiential avoidance and psychological acceptance in the published narratives. This procedure was based on the protocol of the content analysis described above. The number of identified instances of experiential avoidance and psychological acceptance in each story was then counted. The researcher totalled the number of appearances identified as experiential avoidance or psychological acceptance in all narratives. It was assumed that the frequency of their appearance in the stories would represent their relevance to the success or otherwise of the recovery process as described by each individual.

Following the initial analysis of the data, a peer agreement approach was used to validate the methodology. Ten of the narratives that presented instances of experiential avoidance and/or psychological acceptance were randomly selected to represent all the narratives. These were then analysed by a peer following the same methodology.

The peer, who had completed four years in psychology, had no specific training or familiarity with ACT approaches, having been chosen to counterbalance a possible bias by the initial rater, who has significant knowledge of ACT. The peer rater had an introductory level of understanding of the concepts of experiential avoidance and psychological acceptance, gained from the material presented in this thesis. The peer was blind to the initial ratings, so as not to influence their results.

Of the overall 63 textual examples of the two constructs in the sample, there was disagreement regarding only two, one related to psychological acceptance and the other to experiential avoidance. This represents a 97% rater agreement of the methodology, providing preliminary evidence of its utility as a method to identify textual examples of experiential avoidance and psychological acceptance in published narratives of recovery from mental illness.

Limitations of the Method

It must be noted that qualitative research does not see "role" as the term is used in quantitative research, that is, findings that may be generalised to all people in similar situations. The focus in qualitative research is whether it is possible to identify patterns and themes that develop the idea, in this case, regarding the recovery process.

The qualitative method was chosen since it is considered the most suitable approach when dealing with perceiving personal, interpersonal and social processes that are not completely understood, such as those dealt by this research (Ridgway, 2001). Although it does not employ experimental procedures seeking quantifiable variations, the strength of the qualitative method lies in its capacity to provide a profound understanding of a given phenomenon, including a social context, providing the identification of factors that are intangible. Besides, qualitative data, although having low generalisability to the general population, may in some instances be extended to people sharing similar characteristics to the population under study (Mack, 2005).

This study sought to improve the understanding of patterns common in the lived experience of recovery, such as the use (or not) of psychological acceptance and experiential avoidance in published first person accounts of recovery from psychiatric disability. The strategy used was content analysis, since through this method it is possible to quantify the use of common themes and patterns and therefore extrapolate the possible function of the two psychological constructs in the recovery process.

Results and Discussion

In the 28 stories in which examples of psychological acceptance or experiential avoidance were observed, the total number of instances of psychological acceptance was 92, and of experiential avoidance 25, yielding a total of 117 textual indications of these psychological constructs, as set out in Table 2.

Table 2
Frequency of occurrence of psychological acceptance and experiential avoidance in published recovery narratives

Narratives	*No.*	*%*
Narratives with psychological acceptance and/or experiential avoidance	28	62
Narratives with only psychological acceptance	10	22
Narratives with only experiential avoidance	2	4
Narratives with psychological acceptance and experiential avoidance	16	35
Total Narratives	45	100

These numbers are relatively low in light of the length of these narratives of an average of 2,000 words. It might be suggested that these psychological constructs do not appear more frequently throughout the short narratives of recovery simply because these processes were not important or significant enough to the participants to be expressed at greater length throughout the narratives. However, it should be taken into account that the focus of the stories was not on displaying these constructs. Therefore their spontaneous appearance in 62% of the stories can possibly point to their relevance in the recovery process.

The narratives were relatively brief, understandably so since they were to be contained in a journal or part of a collection of stories for a book. The brevity of the narratives meant that the authors needed to choose their words carefully in order to produce a text that contained what they considered to be important. Consequently this raises the issue of the importance of the manifestations of psychological acceptance and experiential avoidance in these narratives.

In the majority of cases, experiential avoidance was mentioned in the past tense, referring to bad experiences and mistakes made: "*I felt hurt and humiliated and I just wanted it all to go away*" (Schmook, 1994). Others were related to first steps in recovery or wrong decisions made in approaching their illness: "If I didn't try, then I wouldn't have to undergo another failure" (Deegan, 1996).

Psychological acceptance was almost always used in the present tense regarding positive attitudes, good results, improvement and later stages of recovery: "I cope by

recognizing and confronting my paranoid fears immediately and then moving on with my life, freeing my mind for other things" (Leete, 1989).

Whenever indications of psychological acceptance and experiential avoidance appeared they were in the same sentence or in sentences close to each other, usually displaying contrast and/or internal conflict: "Sometimes it's hard to accept that I generated these seemingly external observations. I avoid the use of 'voice' to describe what occurs in my thinking. Instead, I prefer to conceptualize these occurrences by saying it is *as if* I hear 'voices'" (Greenblat, 2000).

In some cases individuals reported examples of psychological acceptance and experiential avoidance by other people in which psychological acceptance was seemingly related to role models and experiential avoidance to the damaging figures in their lives. Deegan (1988), based on a similar principle, recommends the employment of people with some sort of disability in rehabilitation programs to serve as models, since "It becomes very difficult to continue to convince oneself that there is no hope when one is surrounded by other equally disabled persons who are making strides in their recovery!"

Evidence in published narratives shows that the use of psychological acceptance is more prominent in self-reported cases of successful recovery, possibly indicating that the role of psychological acceptance in recovery is related to positive developments in one's journey of recovery. Conversely, the presence of experiential avoidance is seemingly associated with negative consequences when dealing with aspects of mental illness, possibly indicating a negative role of experiential avoidance in the recovery process.

It could be expected that experiential avoidance processes might be more prominent in those who are unsuccessful in recovery. The stories of those people are less likely to be published, since published reports are likely to be biased towards success stories. It can be speculated consequently that experiential avoidance might be more prominent in reports of those struggling or in early stages of recovery and is not represented in the published literature of first person accounts of recovery in mental illness. Another issue regarding avoidance is that this psychological construct was difficult to detect in this study, since it is assumed that it depends on a great deal of insight into his or her

condition to recognise experiential avoidance in their behaviour and thus they may not express this in their stories.

In Phase 2 of this study, the frequency of psychological acceptance and experiential avoidance was compared with success rates of recovery given by the SISR, seeking to draw a comparison between the use (or non-use) of these psychological constructs as a means of co-validating the results gathered in Phase 1.

Phase 2

Method

Participants

Phase 2 of the study utilised a compilation of 33 life stories of people with a mental illness. They were recruited from a larger study (Australian Integrated Mental Health Initiative; Oades et al., 2005). All participants in that study had met the criteria of a psychotic disorder (schizophrenia, schizoaffective disorder or bipolar disorder, all low prevalence disorders) of over 6 months' duration, aged between 18 and 65 years, and who described themselves as "making good progress" with recovery from mental illness. These consumers were from the Illawarra, Shoalhaven and Sydney regions of NSW, Australia. The collection of data of these participants had ethics approval granted by the University of Wollongong Human Research Ethics Committee.

Procedures

Advertisements were run in the NSW Consumer Advisory Group newsletter, local radio and print media, as well as local consumer advocate groups in the Illawarra, Shoalhaven and Sydney regions of NSW, Australia. Each participant was screened for suitability in a 10-minute telephone interview and baseline measures (such as demographic info like age, education, location, diagnose, etc.) were collected before commencing the collection of their life stories. These life stories were audio-recorded and transcribed verbatim for later analysis by the researcher.

The initial procedures of Phase 2 followed the same steps as those taken in Phase 1. However, there was no peer-rater agreement method utilised in this phase since the content analysis methodology was the same as that employed in Phase 1 and had already shown its utility as a method for identifying examples of psychological acceptance and experiential avoidance.

In addition the researcher's identification of psychological acceptance and experiential avoidance were compared with stages of recovery, as identified by the participants on the SISR (Andresen, Caputi & Oades, 2010). With this comparison it was sought to observe if there would be a co-validation between the use of psychological acceptance with high stages of recovery, and the use of experiential avoidance with low stages of recovery.

Measurement

. The SISR (see Appendix F) was used to classify the participant's current stage of psychological recovery. This instrument is a brief stage measure based on the stage model of recovery (Andresen et al., 2003). It consists of five statements, each representing a stage of recovery. Respondents select the one statement that best describes their current experience of recovery. The SISR has been shown to correlate with the client-rated RAS ($r = 0.45$, $p < 0.05$) and Kessler-10 ($r = -0.32$, $p < 0.05$), and with the clinician-rated Health of a Nation Outcome Scales ($r = 0.39$, $p < 0.05$) (Andresen et al., 2010).

Results and Discussion

Of the 33 narratives of recovery collected in Phase 2, 23 included textual examples of either psychological acceptance or experiential avoidance, therefore demonstrating a considerably frequency (69%) of those psychological constructs in these stories. Of the 23 narratives with instances of these psychological constructs, 13 had only examples of psychological acceptance, 1 had an example of experiential avoidance without also having at least one example of psychological acceptance, and the remaining 9 had examples of both constructs.

In the 23 stories with examples of these two psychological constructs, instances of psychological acceptance were found 56 times, and of experiential avoidance 26 times, yielding a total of 82 instances of the psychological constructs.

After observing that the presence of psychological acceptance and experiential avoidance seems to interfere with the recovery progress, as seen in Phase 1 of this study, it was considered informative to illustrate this with textual examples of both psychological constructs in the recovery journey.

Two illustrative profiles or case studies are presented to examine the role that psychological acceptance and experiential avoidance: (1) seem to appear; (2) be more relevant; and (3) influence the recovery progress; comparing the research ratings with the results attained by the SISR (Andresen et al., 2003).

Case 1

David (pseudonym), a 28 year old male, told his story in April 2007. He was first diagnosed with depression at the age of 16. David had not been hospitalised for eight

years at the date of the interview. Using SISR, David reported himself to be in the fourth stage of psychological recovery, Rebuilding, in which a person actively works towards a positive identity, setting meaningful goals and taking control of his or her life.

In this particular case there was a significant use of psychological acceptance in five instances. David had had exposure to Buddhism, an oriental philosophy that influenced the development of ACT and shares similar aspects and procedures, such as the use of psychological acceptance.

David reported achieving great success using such processes in his recovery journey, incorporating psychological acceptance and applying it to his life. This can be observed in this quotation where he talks about processes that he considered to be important in his recovery:

> *diligence, sticking to things… patient with being – sometimes you just sort of not want everything to happen all at once and become well and it's all over you know. You've got to be patient and just stick with it. Go on the right path… I think over time just sticking with everything and stuff… because sometimes I get impatient and I think everyone does, and I think about them all the time. I try to – yeah sort of keep them in mind.*

As can be seen in David's story, he tried to get in contact with psychological experiences without avoidance and achieved considerable success with this approach since his last hospitalisation was a long time ago.

David's use of psychological acceptance is consistent with later stages of recovery as defined by Andresen et al. (2006) since, through the use of this psychological construct, it is possible to let go of unnecessary struggles and direct one's efforts towards actively working to achieving a positive identity, setting meaningful goals and taking control of one's life.

It could equally be argued that David is simply patient and persistent and not necessarily "accepting". It should be also noted that there is no clear evidence that he is "without avoidance" since no research instrument was used to objectively search for psychological acceptance and/or experiential avoidance.

Case 2

Marty (pseudonym), a 39 year old male, told his story in May 2007. He was diagnosed with posttraumatic stress disorder in the 1990s, although reported having signs of the illness prior to the diagnosis being made. Marty had had several recent hospitalisations prior to the interview. On the SISR, Marty placed himself in the third stage of psychological recovery, Preparation, in which a person takes stock of strengths and weaknesses regarding recovery, and starts to work on developing recovery skills.

Marty displayed evidence of experiential avoidance on six occasions. The majority of cases were related to his past experience with enduring mental illness, but some were also referring to present experience. He described himself as being "socially absent", "withdrawn", "not responding", "not reacting" and "ignoring people". These are all signs of experiential avoidance, since he was avoiding situations that may give rise to private "negative" experiences.

Marty also mentioned signs of psychological acceptance on two occasions, relating ways in which he could, in the future, succeed in his recovery from mental illness: "respond and not just ignore them, but respond and be ready… facing that and being prepared to face that".

Observing the use of psychological acceptance and experiential avoidance in Marty's account, it can be noticed that even though he seems to acknowledge that psychological acceptance could improve his situation, he does not effectively use it. There are more occurrences of experiential avoidance in his narrative, possibly leading to his situation of placing himself in the intermediary stages of recovery as defined by Andresen et al. (2003).

Conclusion

Study One sought to qualitatively observe the role and frequency of psychological acceptance and experiential avoidance. The most important contribution of this study is the preliminary development of a methodology for identifying textual examples of acceptance and avoidance. The results of Phases 1 and 2 of this study cautiously suggest that the high prevalence of psychological acceptance in narratives of recovery of people who self-report success in their recovery journey is consistent with positive developments in recovery. Conversely, experiential avoidance, as seen through its

frequency and role in the published narratives and in the case studies, is possibly associated with setbacks and difficulties when dealing with aspects of mental illness and earlier stages of psychological recovery.

…..These conclusions are corroborated by the results of the content analysis of the published narratives in which experiential avoidance was mostly couched in the past tense, referring to setbacks in the recovery process. Psychological acceptance on the other hand was almost always couched in the present tense, regarding positive outcomes in the recovery journey.

..However, it must be noted that the results of Study One are only preliminary and that further research on psychological acceptance and experiential avoidance are necessary. A follow-up study seeking to support and validate the initial findings of the current study, using an objective quantifiable measure, was considered necessary, and this will be described in the next section.

Study Two:
Acceptance and Avoidance Processes at Different Levels of Psychological Recovery from Enduring Mental Illness

Aim

The aim of Study Two was to discover if psychological acceptance and experiential avoidance are employed by people with enduring mental illness in their psychological recovery process, using quantitative methods.

Hypotheses

1. There is a significant relationship between acceptance (as assessed by the AAQ-19) and the stage of recovery (as assessed by the RAS).
2. There is a significant relationship between acceptance (as assessed by the AAQ-19) and the stage of psychological recovery (as assessed by the STORI instrument).
3. There is a significant relationship between the RAS and the PWB scales.
4. There is a significant relationship between acceptance (as assessed by the AAQ-19) and psychological well-being (as assessed by PWB) for people with enduring mental illness.

Method

Participants

Participants were 41 adults (26 females and 15 males), ranging in age between 21 and 66 years, with a mean age of 42.29 years (*SD* = 12.83). They had been recruited from the metropolitan and rural areas in New South Wales, Australia, and selected on the basis of suitability, as defined by the researcher, based on their demographic characteristics, as well as availability. Participants were included if they had chronic mental illness (at least 12 months) as listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (Diagnostic and Statistical Manual of Mental Disorders – 4th edition, American Psychiatric Association, 1994), Axis I diagnostic criteria (e.g., schizophrenia, major depressive disorder, schizo-affective disorder, bi-polar disorder), provided there was an absence of serious brain injury, intellectual disability

or cognitive disability and had greater than five total needs on the Camberwell Assessment of Need (CAN; Phelan, Slade, Thornicroft, Dunn, & Holloway, 1995). The range of existing clinical primary diagnoses reported for the study sample was, with number of participants in parentheses: schizophrenia (5), Bipolar Disorder (10), Major Depression (20), Posttraumatic Stress Disorder (3), Obsessive Compulsive Disorder (1), Schizoaffective Disorder (1) and Generalized Anxiety Disorder (1). The mean length time since the primary diagnosis was given was 10.52 years. Thirty-seven participants reported taking medication.

Procedures

Advertisements were run in the NSW Consumer Advisory Group newsletter, local radio and print media, as well as local consumer advocate groups in the Illawarra and Sydney regions, NSW, Australia. Each participant was screened for suitability in a 10-minute telephone interview, and baseline measures were collected before commencement of intervention.

The processes carried out in this study had ethics approval from the University of Wollongong Human Research Ethics Committee.

Measures

Acceptance and action questionnaire

Hayes et al. (2000) developed the AAQ (see Appendix B) as a way of assessing psychological acceptance and experiential avoidance, two key constructs that are at the core of ACT (it must be noted that psychological acceptance and experiential avoidance are not subscales of the AAQ, but two points on a continuum with each psychological construct as its counterpart). This instrument has been shown to be effective in capturing these two psychological phenomena (Hayes et al., 2000). Versions in Swedish, Dutch, Spanish and Japanese have been validated. It has also been used as a basis for more specific acceptance and defusion measures, such as those developed in the area of smoking and pain. The internal consistency for the AAQ is (α = .81) (Hayes et al., 2004).

AAQ-19 is associated with variables to which it is theoretically tied, and it is not associated with variables to which it is theoretically unconnected. For example, higher levels of psychological flexibility, as measured by the AAQ-19, are related to lower

levels of depression, anxiety, stress and overall psychological distress. Beyond mere association, however, results indicate that lower levels of psychological flexibility may serve as a risk factor for mental ill-health (Hayes et al., 2004).

Recovery Assessment Scale (RAS)

The Recovery Assessment Scale (RAS) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) (see Appendix C) is a measure of the construct of recovery. This was developed based on two studies combining participatory action research and narrative analysis to generate the first version of the RAS. This was then reformulated based on the analysis of four accounts of recovery, and subsequently reviewed by a different group of researchers. This resulted in the final 41-item RAS that showed to have adequate test-retest reliability and internal consistency (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

In this research, however, a shorter version of this scale was used. The short version has 24-items (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004) consisting of 5 factors: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms. This version demonstrated test-retest reliability (r = .88), with a Cronbach's alpha internal consistency *(α = 0.93).* (McNaught, Caputi, Oades, & Deane, 2007).

Stages of recovery instrument

The Stages of Recovery Instrument (STORI) was created by Andresen et al. (2006). It is based on a personal experience model of psychological recovery consisting of four component processes and five stages (see Appendix D). Pearson correlations between STORI stage and other measures ranged from $r = 0.52$ ($p < 0.01$) with the RAS to $r = 0.62$ ($p < 0.01$) with the total PWB scale, indicating that overall scores on the STORI are a valid measure of the recovery construct.

Scales of Psychological Well-Being (PWB)

The 18-item form of the PWB (Keyes, 2002) includes six subscales: autonomy, environmental mastery, positive relationships with others, purpose in life, personal growth, and self-acceptance (see Appendix E). These scales are theoretically grounded in the idea that individuals possess psychological well-being when they are happy with all parts of themselves, have warm trusting relationships, have direction in life, are

developing into better people and have a degree of self determination (Ryff, 1989). This particular instrument has been validated in numerous studies (Ryff & Keyes, 1995) and has demonstrated internal consistency (α = .81) for the 18-item form (Keyes, 2002).

Results

The first hypothesis of Study Two was not supported since no significant relationship was found between levels of recovery, as assessed by the RAS, and psychological acceptance, as assessed by the AAQ-19, as seen in Table 3. However, the AAQ-19 had a small positive correlation with three of the five subscales of the RAS. These were "not dominated by symptoms", "willingness to ask for help" and "personal confidence and hope". There were no significant correlations with the other two subscales ("goal and success orientation" and "reliance on others").

Table 3
Correlations between the AAQ-19 and the RAS and its subscales

AAQ-19	RAS (overall score)	Goal and success orientated (RAS subscale)	Not dominated by symptoms (RAS subscale)	Willingness to ask for help (RAS subscale)	Rely on others (RAS subscale)	Personal confidence and hope (RAS subscale)
1.000	.209 (p<0.089)	.143 (p<0.248)	.300(*) (p<0.014)	.251(*) (p<0.041)	.067 (p<0.588)	.263(*) (p<0.032)

*Correlation is significant at the 0.05 level.

The second hypothesis, that there would be a significant relationship between acceptance and the stage of psychological recovery, could not be tested since the STORI data had insufficient variance for analysis. The vast majority of individuals were classified as being in the fourth stage of recovery, i.e., Rebuilding.

A positive correlation was found between the scores for the RAS and the scores for PWB, as shown in Table 4, thus confirming the third hypothesis.

Table 4
Correlations between Recovery Assessment Scale (RAS) and Psychological Well-Being (PWB) scales

		RAS	PWB
RAS	Pearson Correlation	1	-.595(*)
	Sig. (2-tailed)		.000
	N	41	41
PWB	Pearson Correlation	-.595(*)	1
	Sig. (2-tailed)	.000	
	N	41	41

*Correlation is significant at the 0.01 level (2-tailed).

Regarding the overall score for the PWB scales, the findings showed that there was a positive correlation between these and the scores for the AAQ-19, confirming the fourth hypothesis that the use of psychological acceptance is related to improving one's psychological well-being. However, for the PWB subscales, correlations were found only between the AAQ-19 and Purpose in Life (see Table 5).

Table 5

Correlations between the AAQ-19 and the Psychological Well-Being (PWB) scales and subscales

AAQ-19	Psychological Well-Being (PWB overall score)	Acceptance (PWB subscale)	Purpose (PWB subscale)	Mastery (PWB subscale)	Relations (PWB subscale)	Growth (PWB subscale)	Autonomy (PWB subscale)
1.000	-.313(*) (p<0.011)	-.192 (p<0.122)	-.264(*) (p<0.032)	-.076 (p<0.544)	-.132 (p<0.289)	-.089 (p<0.479)	-.158 (p<0.206)

*Correlation is significant at the 0.05 level.

Discussion

Hypothesis 1 states that there would be a significant relationship between psychological acceptance (measured by the AAQ-19) and recovery (measured by the RAS), based on work by García and Pérez (2001) and Bach and Hayes (2002) that suggests that the potential use of ACT constructs with persons in recovery from mental illness could assist in improving their psychological health. However, no correlation was found between the use of psychological acceptance and high recovery.

Table 3 shows, however, that some subscales of the RAS demonstrated a correlation with psychological acceptance. For example, "willingness to ask for help" showed a strong correlation with the use of psychological acceptance. Such a correlation could be explained by the similarity between concepts of psychological acceptance, defined as "*actively contacting psychological experiences – directly, fully, and without needless defense – while behaving effectively*" (Hayes et al., 1996, p. 1163) and willingness, defined as "*the quality or state of being willing; free choice or consent of the will; freedom from reluctance; readiness of the mind to do or forbear*" (Webster's Revised Unabridged Dictionary, 2008 [emphasis added]). Since the two concepts share some similarities, and are drawn from tests that are proven to reliably identify these concepts, it was expected that a strong relationship between the two would be found.

The report of psychological acceptance had a positive correlation with the factor "not dominated by symptoms" assessed by the subscale of the RAS. Although there are some differences in how consumers see the presence of symptoms in their lives (Lynch, 2000; Mead & Copeland, 2000). Tooth et al. (1997) revealed that only 14% of consumers understood recovery as an absence of symptoms, with the remaining 86% accepting the presence of ongoing management of illness in their lives. For this reason it was expected that a level of psychological acceptance was to be involved in the factor "not dominated by symptoms" in high levels of recovery.

Hope is undoubtedly a common theme in the literature of recovery (Roberts & Hollings, 2007). That psychological acceptance, as measured by the AAQ-19, is

correlated with the subscale "personal confidence and hope" of the RAS indicates the potentially positive influence of psychological acceptance in this important component of recovery.

Conversely, contrary to prediction the use of psychological acceptance does not seem to be associated with high levels of recovery from mental illness, at least as measured by the RAS. However, there was a significant correlation between three out of the five subscales of the RAS and the use of psychological acceptance, demonstrating therefore its possible significance for important components of the recovery process. Two possible interpretations are considered. It is possible that psychological acceptance simply is not a psychological construct involved in recovery – which, given the chronic nature of mental illness in this sample, seems unlikely – as acceptance can be a useful coping mechanism to deal with chronicity. However, the AAQ-19 has been revealed as having some problems achieving alpha levels in certain instances due to scale brevity and item wording, item selection procedures and others (Bond et al.; Manuscript submitted for publication). Therefore it is possible that future research could improve upon such measurement issues. Further research utilising an updated and more psychometrically sound measure, such as the AAQ-II (Bond et al., Manuscript submitted for publication), is recommended to clarify the relationship between the use of psychological acceptance and the recovery process.

Due to insufficient variance in the data gathered from the STORI instrument the hypothesis 2 could not be tested, since the vast majority of these individuals were classified as being in the fourth stage of recovery, i.e., Rebuilding. A comparison of individual cases, on the other hand, showed that individuals who achieved high scores of psychological acceptance on the AAQ-19 also reached a classification on the final stages of recovery (Growth) using the STORI instrument. Conversely, the same individuals who demonstrated a high incidence of experiential avoidance with the AAQ-19 were found to be in initial stages of recovery (Preparation) according to STORI. However, these were only four cases out of the forty-one cases gathered.

It is worth noting that "psychological acceptance" as measured by the AAQ-19 did not correlate with the subscale "acceptance" on the PWB scales. This could be explained by the different definitions of acceptance used by the two instruments. While the AAQ-19 sees psychological acceptance as "*actively contacting psychological*

experiences – directly, fully, and without needless defense – while behaving effectively" (Hayes et al., 1996, p. 1163), the PWB uses the idea of "self-acceptance" as holding positive attitudes toward oneself, accepting the self and one's past life (Ryff, 1989).

The overall results of the RAS demonstrated a slight difference from the STORI instrument. While STORI classified most of the individuals as being in the fourth stage of recovery (Rebuilding), the RAS placed these individuals on a medium to superior level on a continuum of recovery. Such a difference may be attributed to the fact that these instruments measure slightly different constructs. STORI is focused on classifying the stages of recovery whereas the RAS is more related to measures of psychosocial functioning and relationship to one's symptoms.

These results are a starting point to understand how psychological acceptance and ACT can be utilised to improve the psychological well-being of individuals going through recovery from enduring mental illness.

Hypothesis 3 stated that there would be a correlation between the scores of the level of recovery and psychological well-being. This hypothesis was generated based on studies such as Resnick and Rosenheck (2006) which show the link between psychological well-being and recovery. As expected, there was a positive correlation between the RAS scores and the scores of the PWB scales, as shown in Table 4.

Hypothesis 4 stated that there would be a correlation between psychological acceptance and psychological well-being. This hypothesis was generated based on research that suggested that the use of ACT constructs and methodology, or of related treatment models such as mindfulness-based approaches, may help increase psychological well-being (e.g., Brown & Ryan, 2003; Kingston et al., 2007).

Hypothesis 4 was confirmed, as can be seen in Table 5 which shows a correlation of the overall score of PWB and the use of psychological acceptance (as measured by the AAQ-19). However, there were no other significant correlations between the AAQ-19 and the PWB subscales besides the subscale "purpose". This result can be explained by the fact that each subscale of the PWB scales focuses on detecting specific psychological constructs.

Conclusion

This study contributes to emerging findings of a correlation between the use of psychological acceptance and positive levels of psychological well-being by individuals with enduring mental illness. Any such relationship with recovery, however, appears to be more complex. These results were somewhat limited by the lack of sufficient variance in the sample with regards to stages of psychological recovery.

Overall Research Conclusions

The results from Study One showed a possible relationship between the use of psychological acceptance in narratives of successful recovery from mental illness that were not substantiated by the data collected in Study Two. An analysis of objectively quantifiable measures found no clear correlation between the use of psychological acceptance and recovery in mental illness as measured by the RAS. The data, however, showed a relationship between psychological acceptance and some components of recovery, thereby demonstrating its possible value in the recovery process.

The major contribution of this research was the emerging correlation that was observed between psychological acceptance and positive levels of psychological well-being among individuals with mental illness. This indicates that psychological acceptance may play a positive role in improving the psychological well-being of people with mental illness. This may be explained by the fact that psychological acceptance is a fundamental psychological construct used in several mindfulness-based approaches to improve the quality of life of individuals with a chronic illness, such as a mental illness (Chadwick, Taylor, & Abba, 2005).

This research demonstrates, consistent with previous work, that recovery is a multi-factorial and multi-dimensional process that incorporates several component processes. One of these processes, hope, may be facilitated by the use of psychological acceptance. Psychological well-being is another dimension in recovery and the use of psychological acceptance may contribute to improving psychological well-being in those who have a diagnosis of mental illness.

Limitations and Future Research

When analysing the participant sample used in Study One it needs to be taken into account that (1) the narratives used were not designed to display the constructs studied in this research; (2) that the content of these stories was brief; and (3) that these accounts were mostly representative of positive or "recovery" experiences of people living with mental illness.

Also, while the case studies used in Study One have the potential to offer insight into the subject of recovery in mental illness, they still represent only one individual and therefore may not be representative of the general group or population.

Thus, as Study One employed qualitative research, it has the problems and limitations associated with qualitative methodology. It was necessary to conduct a quantitative study to substantiate the results achieved in Study One. This was addressed through the development of Study Two.

Study Two was limited by the instruments and measures utilised. Such instruments were initially chosen based on their validity, proven in other studies and considered to be the most representative of the psychological constructs studied in this research. However, more up-to-date instruments have since been developed and therefore it is suggested that a follow-up study using a particular "new" instrument (called Acceptance and Action Questionnaire II or AAQ II) to verify whether the use of a more sophisticated instrument could arrive at a different or clearer relationship between psychological acceptance and recovery in mental illness.

While the 41 individuals comprising the volunteer sample used in Study Two, all of whom have been diagnosed with mental illness, correspond only to a small percentage of the Australian population that have endured mental illness in their lives and can thus not be generalised to a broader population, the findings can nevertheless be utilised to hypothesise about such a generalisation to the broader population.

Regarding Study Two, it should be noted that researchers investigating this population in Australia generally experience difficulties with recruiting participants,

including finding participants who are available and willing to participate. Nevertheless, a larger sample should be pursued for a follow-up study or one that replicate this study.

A characteristic of the sample used in Study Two is its diversity of mental health disorders, as defined by the DSM-IV-TR. This research focused on the recovery process of a person dealing with enduring mental illness, in which the type of disorder (e.g., schizophrenia, major depressive disorder, schizo-affective disorder, bi-polar disorder, etc.) was not considered of relevance due to the similar process that dealing with a mental illness entails, as described in several works, for example, King, Lloyd, and Meehan, (2007). However, one could argue that the use of psychological acceptance and experiential avoidance could vary according to the type of mental disorder, and as such influence the recovery process. Therefore it is recommended that another study investigates this possibility.

The mean length time since the primary diagnosis of the participants on Study Two was 10.52 years. Although this characteristic was not taken into consideration given that the participants had volunteered and came from a diverse range of contexts, a study observing the use of psychological acceptance and experiential avoidance in earlier and/or later years since diagnosis from mental illness and its relation with successful recovery from mental illness could prove fruitful.

A final issue regarding the sample from Study Two is the use of medication by 37 participants. This characteristic was not taken into consideration in this research given that the participants had volunteered but this variable could play an important role in their answers. However, it must be taken into consideration that even though the development of medication for mental disorders has improved greatly over the years, diminishing the pervasive secondary effects of the drugs, the use of medication can come to interfere with the use of relative complex psychological constructs such as psychological acceptance and experiential avoidance. For this reason, it is recommended that a further study be conducted investigating how this variable could come to affect the use of psychological acceptance and experiential avoidance and its relation with successful recovery from mental illness.

In addition, it should be noted that ACT is not restricted to psychological acceptance and experiential avoidance. There are several other important psychological constructs

in ACT, such as defusion, that should be studied in relation to recovery. Such studies are needed since they may reveal valuable data that could help individuals in their recovery process from mental illness. To date there are few publications that link ACT and the recovery model.

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Appendices

Appendix A: Psychological Acceptance and Experiential Avoidance Terms

Psychological acceptance was constituted by words and phrases such as:

- acceptance/accepting/accept/accepted * think/thinking/thought/feel/feeling/be/being/pass through/worry
- agreement/agreeing/agree/agreed * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- harmony * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- ok * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- union * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- contact * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- take/taking as it is presented/as it is
- get/getting in touch with think/thinking/ thought/feel/feeling/be/being/pass through/worry
- make contact with think/thinking/ thought/feel/feeling/be/being/pass through/worry
- receive/receiving fully/without fight-fighting/worry
- respect/respecting/respected * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- identification/identify/identified * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- feeling fully/without fight-fighting/worry
- recognition/recognizing/recognized * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- approve/approval/approving/approved * think/thinking/thought/feel/feeling/be/being/pass through/worry
- consent/consenting/consented * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- acknowledge/acknowledgment/acknowledging/acknowledged * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- admit/admitting/admitted * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- allow/allowing/allowed * think think/thinking/ thought/feel/feeling/be/being/pass through/worry
- grant * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- let/letting * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- permit * think/thinking/ thought/feel/feeling/be/being/pass through/worry

- tolerance/tolerate/tolerating/tolerated * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- favourable reception * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- being able/capable * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- mindful/mindfulness
- open * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- patient/patience * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- relax/relaxing/relaxed * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- seek/searching/sought * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- stick/sticking * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- carry on * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- face * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- deal/dealing * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- soldiering * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- respond/responding * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- run/running/ran with * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- willing * think/thinking/ thought/feel/feeling/be/being/pass through/worry

  (* refer to any linking words)

Experiential avoidance will be constituted by words and phrases such as:

- avoid/avoidance/avoiding/avoided * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- reject/rejection/rejected * think/thinking/thought/feel/feeling/be/being/pass through/worry
- escape/escaping * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- run/ran/running away/off * think/thinking/thought/feel/feeling/be/being/pass through/worry
- fight * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- distract/distraction/distracted * think/thinking/ thought/feel/feeling/be/being/pass through/worry

- get away * think/thinking/thought/feel/feeling/be/being/pass through/worry
- evade/evading/evaded * think/thinking/thought/feel/feeling/be/being/pass through/worry
- dodge/dodging/dodged * think/thinking/thought/feel/feeling/be/being/pass through/worry
- prevent/preventing/prevented * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- refuse/refusal/refusing/refused/refutation * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- denied/denial/denying/denied * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- dismiss/dismissal/dismissing/dismissed * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- eliminate/elimination/eliminated * think/thinking/ thought/feel/feeling/be/being/pass through/worry
- ignore/ignoring/ignored * think/thinking/thought/feel/feeling/be/being/pass through/worry
- not enter in contact with think/thinking/feel/feeling/be/being/pass through/worry
- try/trying/tried not * think/thinking/thought/feel/feeling/be/being/pass through/worry
- effort/put an effort not * think/thinking/thought/feel/feeling/be/being/pass through/worry
- seek/searching/sought not * think/thinking/thought/feel/feeling/be/being/pass through/worry
- repress/repressing * think/thinking/thought/feel/feeling/be/being/pass through/worry
- hide/hiding * think/thinking/thought/feel/feeling/be/being/pass through/worry

  (* refer to any linking words)

All these words and phrases must be taking into context once there are ambivalent words and phases, such as:

- stop think/thinking/thought/feel/feeling/be/being/pass through/worry

That can represent both a form of acceptance or avoidance, thus it should be observed the context in which is presented in the narrative, trying to link with the idea of one of the two psychological constructs to categorize the words or phrases.

Appendix B**: Acceptance and Action Questionnaire (AAQ-R)**

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

_____ 3. I try to suppress thoughts and feelings that I don't like by just not thinking about them.

_____ 4. It's OK to feel depressed or anxious.

_____ 5. I rarely worry about getting my anxieties, worries, and feelings under control.

_____ 6. In order for me to do something important, I have to have all my doubts worked out.

_____ 7. I'm not afraid of my feelings.

_____ 8. I try hard to avoid feeling depressed or anxious.

_____ 9. Anxiety is bad.

_____ 10. Despite doubts, I feel as though I can set a course in my life and then stick to it.

_____ 11. If I could magically remove all the painful experiences I've had in my life, I would do so.

_____ 12. I am in control of my life.

_____ 13. If I get bored of a task, I can still complete it.

_____ 14. Worries can get in the way of my success.

_____ 15. I should act according to my feelings at the time.

_____ 16. If I promised to do something, I'll do it, even if I later don't feel like it.

_____ 17. I often catch myself daydreaming about things I've done and what I would do differently next time.

_____ 18. When I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact.

_____ 19. When I compare myself to other people, it seems that most of them are handling their lives better than I do.

Appendix C: [RAS-short] Recovery Assessment Scale (RAS)

Instructions: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number that best describes the extent to which you agree or disagree with the statement. Circle only one number for each statement and no not skip any items.

		Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1.	I have a desire to succeed	0	1	2	3	4
2.	I have my own plan for how to stay or become well.	0	1	2	3	4
3.	I have goals in life that I want to reach.	0	1	2	3	4
4.	I believe I can meet my current personal goals.	0	1	2	3	4
5.	I have a purpose in life.	0	1	2	3	4
6.	Even when I don't care about myself, other people do.	0	1	2	3	4
7.	Fear doesn't stop me from living the way I want to.	0	1	2	3	4
8.	I can handle what happens in my life.	0	1	2	3	4
9.	I like myself.	0	1	2	3	4
10.	I have an idea of who I want to become.	0	1	2	3	4
11.	Something good will eventually happen.	0	1	2	3	4
12.	I'm hopeful about my future.	0	1	2	3	4
13.	I continue to have new interests.	0	1	2	3	4
14.	Coping with my mental illness is no longer the main focus of my life.	0	1	2	3	4
15.	My symptoms interfere less and less with my life.	0	1	2	3	4
16.	My symptoms seem to be a problem for shorter periods of time each time they occur.	0	1	2	3	4
17.	I know when to ask for help.	0	1	2	3	4
18.	I am willing to ask for help.	0	1	2	3	4
19.	I ask for help, when I need it.	0	1	2	3	4
20.	Being able to work is important to me.	0	1	2	3	4
21.	I can handle stress.	0	1	2	3	4
22.	I have people I can count on.	0	1	2	3	4
23.	Even when I don't believe in myself, other people do.	0	1	2	3	4
24.	It is important to have a variety of friends.	0	1	2	3	4

Appendix D: Stages of Recovery Instrument (STORI)

"STORI"

The following questionnaire asks about how you feel about your life and yourself since the illness. Some of the questions are about times when you don't feel so good. Others ask about times when you feel pretty good about life.

If you find some of the questions upsetting, and you need to talk to someone – please take a break and talk to a friend – or ring one of the support phone numbers listed at the front of the booklet.

The questions are in groups of five.
Read all five questions in a group, and then answer those five questions.
Circle the number from 0 to 5 to show how much each statement is true of you now.
Then move on to the next group.

When you choose your answer, think about **how you feel now**, not how you have felt some time in the past. For example:

Q.38 says "I am beginning to learn about mental illness and how I can help myself."
Q.39 says "I now feel fairly confident about managing the illness."

If you are now fairly confident about managing the illness, you would give a higher score to Q.39 than you would to Q.38, which says you are just *beginning* to learn.

The questions are about how you feel about your life on the whole these days.
Try not to let things that might be affecting your mood just at the moment affect your answers.

Read all five questions in Group 1, then answer those five questions.
Circle the number from 0 to 5 that shows how much each statement is true of you *now*.
Then move on to Group 2, and so on.

When you choose your answer, think about how you feel now, not how you have felt in the past.

	Group 1	*Not at all true now*					*Completely true now*
1	I don't think people with a mental illness can get better.	0	1	2	3	4	5
2	I've ***only recently*** found out that people with a mental illness *can* get better.	0	1	2	3	4	5
3	I am ***starting*** to learn how I can help myself get better.	0	1	2	3	4	5
4	I am working hard at staying well, and it will be worth it in the long run.	0	1	2	3	4	5
5	I have a sense of "inner peace" about life with the illness now.	0	1	2	3	4	5

	Group 2	*Not at all true now*					*Completely true now*
6	I feel my life has been ruined by this illness.	0	1	2	3	4	5
7	I'm ***just starting*** to realise my life doesn't have to be awful forever.	0	1	2	3	4	5
8	I have ***recently*** started to learn from people who are living well in spite of serious illness.	0	1	2	3	4	5
9	I'm starting to feel ***fairly*** confident about getting my life back on track.	0	1	2	3	4	5
10	My life is really good now, and the future looks bright.	0	1	2	3	4	5

	Group 3	*Not at all true now*					*Completely true now*
11	I feel like I'm nothing but a sick person now.	0	1	2	3	4	5
12	Because others believe in me, I've ***just started*** to think maybe I can get better.	0	1	2	3	4	5
13	I am ***just beginning*** to realise that illness doesn't change who I am as a person.	0	1	2	3	4	5
14	I am ***now beginning*** to accept the illness as part of the *whole person* that is me.	0	1	2	3	4	5
15	I am happy with who I am as a person.	0	1	2	3	4	5

	Group 4	*Not at all true now*					*Completely true now*
16	I feel as though I don't know who I am any more.	0	1	2	3	4	5
17	I have ***recently begun*** to recognise a part of me that is not affected by the illness.	0	1	2	3	4	5
18	I am ***just starting*** to realise that I *can* still be a valuable person.	0	1	2	3	4	5
19	I am learning new things about myself as I work towards recovery.	0	1	2	3	4	5
20	I think that working to overcome the illness has made me a better person.	0	1	2	3	4	5

	Group 5	*Not at all true now*					*Completely true now*
21	I'll never be the person I thought I would be.	0	1	2	3	4	5
22	I've ***just begun*** to accept the illness as part of my life I'll have to learn to live with.	0	1	2	3	4	5
23	I am ***starting*** to figure out what I am good at and what my weaknesses are.	0	1	2	3	4	5
24	I'm ***starting*** to feel that I am making a valuable contribution to life.	0	1	2	3	4	5
25	I am accomplishing worthwhile and satisfying things in my life.	0	1	2	3	4	5

	Group 6	*Not at all true now*					*Completely true now*
26	I am angry that this had to happen to *me*.	0	1	2	3	4	5
27	I'm just ***starting*** to wonder if some good could come out of this.	0	1	2	3	4	5
28	I am ***starting*** to think about what my special qualities are.	0	1	2	3	4	5
29	In having to deal with illness, I am learning a lot about life.	0	1	2	3	4	5
30	In overcoming the illness I have gained new values in life.	0	1	2	3	4	5

	Group 7	*Not at all true now*					*Completely true now*
31	My life seems completely pointless now.	0	1	2	3	4	5
32	I am ***just starting*** to think maybe I *can* do something with my life.	0	1	2	3	4	5
33	I am ***trying*** to think of ways I might be able to contribute in life.	0	1	2	3	4	5
34	These days I am working on some things in life that are personally important to me.	0	1	2	3	4	5
35	I am working on important projects that give me a sense of purpose in life.	0	1	2	3	4	5

	Group 8	*Not at all true now*					*Completely true now*
36	I can't do anything about my situation.	0	1	2	3	4	5
37	I'm ***starting*** to think I could do something to help myself.	0	1	2	3	4	5
38	I am ***starting*** *to* feel more confident about learning to live with the illness.	0	1	2	3	4	5
39	Sometimes there are setbacks, but I come back and keep trying.	0	1	2	3	4	5
40	I look forward to facing new challenges in life.	0	1	2	3	4	5

	Group 9	*Not at all true now*					*Completely true now*
41	Others know better than I do what's good for me.	0	1	2	3	4	5
42	I want to ***start*** learning how to look after myself properly.	0	1	2	3	4	5
43	I am ***beginning*** to learn about mental illness and how I can help myself.	0	1	2	3	4	5
44	I now feel ***reasonably*** confident about managing the illness.	0	1	2	3	4	5
45	I can manage the illness well now.	0	1	2	3	4	5

	Group 10	*Not at all true now*					*Completely true now*
46	I don't seem to have any control over my life now.	0	1	2	3	4	5
47	I want to ***start*** learning how to cope with the illness.	0	1	2	3	4	5
48	I am ***just starting*** to work towards getting my life back on track	0	1	2	3	4	5
49	I am ***beginning*** to feel responsible for my own life.	0	1	2	3	4	5
50	I am in control of my own life.	0	1	2	3	4	5

Appendix E: Psychological Well-Being (PWB) Scales

Please indicate how strongly you agree or disagree with each of the following statements.

	Agree				Disagree		
	Strongly	Some–what	A little	Don't know	A little	Some–what	Strongly
1. I like most parts of my personality	1	2	3	4	5	6	7
2. When I look at the story of my life, I am pleased with how things have turned out so far.	1	2	3	4	5	6	7
3. Some people wander aimlessly through life, but I am not one of them	1	2	3	4	5	6	7
4. The demands of everyday life often get me down	1	2	3	4	5	6	7
5. In many ways I feel disappointed about my achievements in life	1	2	3	4	5	6	7
6. Maintaining close relationships bas been difficult and frustrating for me	1	2	3	4	5	6	7
7. I live life one day at a time and don't really think about the future	1	2	3	4	5	6	7

8. In general, I feel I am in charge of the situation in which I life	1	2	3	4	5	6	7
9. I am good at managing the responsibilities of daily life	1	2	3	4	5	6	7
10. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6	7
11. For me, life has been a continuous process of learning, changing, and growth	1	2	3	4	5	6	7
12. I think it is important to have new experiences that challenge how I think about myself and the world	1	2	3	4	5	6	7
13. People would describe me as a giving person, willing to share my time with others.	1	2	3	4	5	6	7
14. I gave up trying to make big improvements or changes in my life a long time ago	1	2	3	4	5	6	7
15. I tend to be influenced by people with strong opinions	1	2	3	4	5	6	7
16. I have not experienced many warm and trusting relationships with others	1	2	3	4	5	6	7

17. I have confidence in my own opinions, even if they are different from the way most other people think	1	2	3	4	5	6	7
18. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6	7

Appendix F: Self-Identified Stage of Recovery (SISR)

Part 1

People who are told they have a serious illness can feel differently about life with the illness at different times. Below are five statements describing how people may feel at times when living with a mental illness.

Please read **all five** statements (A-E) before answering the question that follows.

A) "I don't think people can recover from mental illness. I feel that my life is out of my control, and there is nothing I can do to help myself."	☐
B) "I have just recently realised that people can recover from serious mental illness. I am just starting to think it may be possible for me to help myself."	☐
C) "I am starting to learn how I can overcome the illness. I've decided I'm going to start getting on with my life."	☐
D) "I can manage the illness reasonably well now. I am doing OK, and feel fairly positive about the future."	☐
E) "I feel I am in control of my health and my life now. I am doing very well and the future looks bright."	☐

Of the five statements above, which one would you say ***most closely*** describes how you have been feeling over the **past month** about life with the illness? Tick the box next to that statement.

Part 2

Below are four statements about how people can feel about aspects of their lives.
For the **past month**, how much would you agree with each statement?
Please circle the appropriate number.

1) I am confident that I will find ways to attain my goals in life.

Disagree Strongly	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Agree Strongly
1	2	3	4	5	6

2) I know who I am as a person, and what things in life are important to me.

Disagree Strongly	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Agree Strongly
1	2	3	4	5	6

3) The things I do in my life are meaningful and valuable.

Disagree Strongly	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Agree Strongly
1	2	3	4	5	6

4) I am completely responsible for my own life and well-being.

Disagree Strongly	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Agree Strongly
1	2	3	4	5	6

Appendix G: Summary of consumer-based literature used to identify experiential avoidance and psychological acceptance

First-Person Accounts of Recovery

Anonymous. (1989). First person account: A delicate balance. *Schizophrenia Bulletin*, *15* (2), 345-346.

Anonymous. (1994). Coping & recovery. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

Anonymous. (1994). The challenge of recovery. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

Alexander, D. (1994). A death-rebirth experience. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 36–39). Boston: Center for Psychiatric Rehabilitation.

Armstrong, M. (1994). What happened and how "What Happened" got better. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 52–53). Boston: Center for Psychiatric Rehabilitation.

Berman, R. (1994). Lithium's other face. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 40–45). Boston: Center for Psychiatric Rehabilitation.

Campbell, T. (2000). First person account: falling on the pavement. *Schizophrenia Bulletin*, *26* (2), 507–509.

Chovil, I. (2000). First person account: I and I, dancing fool, challenge you the world to a duel. *Schizophrenia Bulletin*, *26* (3), 745–747.

Chovil, I. (2005). Reflections on schizophrenia, learned helplessness/dependence, and recovery. *Psychiatric Rehabilitation Journal*, *29* (1), 69–71.

Clark, M. (1994). *Altered Lives: Personal experiences of schizophrenia*. North Fitzroy, Victoria, Australia: Schizophrenia Fellowship of Victoria.

Cloutier, G. R. (1994). Overcoming the black garden. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 29–34). Boston: Center for Psychiatric Rehabilitation.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11* (4), 11–19.

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Dickerson, G. (1994). Keeping time in chaos. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 26–28). Boston: Center for Psychiatric Rehabilitation.

Fekete, D. J. (2004). How I quit being a "mental patient" and became a whole person with a neuro-chemical imbalance: conceptual and functional recovery from a psychotic episode. *Psychiatric Rehabilitation Journal*, *28* (2), 189–194.

Greenblat, L. (2000). First Person Account: Understanding health as a continuum. *Schizophrenia Bulletin*, *26* (1), 243–245.

Henderson, H. From depths of despair to heights of recovery. *Psychiatric Rehabilitation Journal*, *28* (1), 83–87.

Koehler, M. (1994). My road to recovery. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, *15* (2), 197–200.

Leibrich, J. (1997). The doors of perception. *Australian and New Zealand Journal of Psychiatry*, *31*, 36–45.

Lynch, K. (2000). The long road back. *Journal of Clinical Psychology*, *56*, 1427–1432.

Lynn, D. (1994). My struggle for freedom. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 50–51). Boston: Center for Psychiatric Rehabilitation.

McDermott, B. F. (1994). Transforming depression into creative self-expression. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

McQuillin, B. (1994). My life with schizophrenia. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 7–10). Boston: Center for Psychiatric Rehabilitation.

Schmook, A. (1994). They said I would never get better. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery* (pp. 1–3). Boston: Center for Psychiatric Rehabilitation.

Unzicker, R. (1994). On my own: A personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal*, *13* (1), 71–77.

Watson, B. E. (1994). My self story. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

Weingarten, R. (1994). The risks and rewards of advocacy. In L. Spaniol & M. Koehler (Eds.), *The Experience of Recovery*. Boston: Center for Psychiatric Rehabilitation.

Weingarten, R. (2005). Calculated risk-taking and other recovery process for my psychiatric disability. *Psychiatric Rehabilitation Journal*, *29* (1), 77–80.

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