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Comparing the Acceptability of Treatment Rationales for Two Psychotherapies

by

Marin Gail Olson

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

In

Clinical Psychology

Minnesota State University, Mankato

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Comparing the Acceptability of Treatment Rationales for Two Psychotherapies

Marin G. Olson

This thesis has been examined and approved by the following members of the student's thesis committee.

Advisor
Jeffrey Buchanan, Ph.D.

Committee Member
Kari Much, Psy.D.

Committee Member
Eric Sprankle, Psy.D.

Dedication & Acknowledgements

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Abstract

An effective treatment rationale is important because it can affect whether or not a client decides if they will commit to the therapeutic approach. In recent years, acceptance and commitment therapy (ACT) has developed as an approach that, although related to cognitive-behavioral therapy (CBT), is philosophically distinct. CBT typically places a greater emphasis on changing/eliminating “symptoms” of psychological disorders and the role thoughts play in directly influencing emotional and behavior problems. ACT, on the other hand, places a heavier emphasis on accepting and changing one’s relationship to aversive private experiences. When comparing the assumptions and goals underlying CBT and ACT, individuals from Western cultures are more likely to be familiar with those consistent with CBT. These fundamental differences in how psychological difficulties are conceptualized and treated will be reflected in treatment rationales presented to clients. The aim of the current study was twofold. The first was to determine if there are differences in the acceptability of treatment rationales based on CBT or ACT. The second was to learn why the treatment rationales were deemed acceptable or unacceptable. A mixed-methods between-groups design was utilized where participants were randomly assigned to complete one of two surveys. The surveys included a vignette where a therapist presented a hypothetical client a treatment rationale, one based on CBT and the other on ACT. These treatment rationales were reviewed and approved by subject matter experts in both ACT and CBT. Following the vignette, participants rated the vignette in terms of clarity and acceptability and responded to open-ended questions concerning components of the treatment they liked/disliked as well as what questions they would want to ask the therapist. Results indicated that there is a negative correlation between age and high ratings of clarity for CBT. Though these two approaches are very different in terms of the proposed causes of psychological problems and recommended treatment strategies, results indicate that clients rate them as being equally clear and acceptable. Therefore, concerns about ACT being incompatible with Western views of psychological problems may be unfounded.

Introduction

At the beginning of any treatment, it is expected that the healthcare provider offers an overview of what the proposed treatment is, how it works, and why it is the best course of action for the client. This presentation is called the “treatment rationale” and it is not only a part of ethical practice, but a pivotal point in a client’s healing process where they decide if the proposed treatment, let alone provider, is the best and most worthwhile approach for them and their health (American Psychological Association, 2017). In the context of psychotherapy, effectively presenting a treatment rationale is critical to the client buying into the treatment while also laying the foundation for a cooperative therapeutic alliance (King & Boswell, 2019; Craske & Barlow, 2000). An alternative benefit of clients being exposed to a treatment rationale is that it enhances their willingness to pursue psychological services and gives them a more accurate perception of the requirements of treatment and of psychological difficulties in general (Wollersheim & et al, 1980). Furthermore, a well-executed treatment rationale has the potential to expand upon a client’s meaning and hope in a treatment, and by extension can promote their adherence to the proposed treatment which in turn increases the likelihood of positive treatment outcomes (Trachsel & Holtforth, 2019; Kohlenberg et al., 2002).

Cognitive-behavioral therapy and acceptance and commitment therapy

In the world of psychotherapy, there are several popular treatments which are evidence based, effective, and palatable to clients. Two of these established treatments are the focus of the current study- cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) (Division 12 of the American Psychological Association, 2016). In the existing literature, there are numerous studies that examine whether these treatments create comparable outcomes, but there are none which examine whether ACT or CBT is more acceptable or compelling to clients. Another dearth in the literature and other existing resources is that there are not any peer reviewed treatment rationale vignettes/examples for either CBT or ACT. Although there are countless examples and resources available on how to present the treatment rationale for ACT or CBT, there has not yet been a gold-standard or operationalized method of giving a client the treatment rationale of either treatment approach. With how critical it is to provide a quality treatment rationale, and with the ever increasing abundance of misinformation, it is curious that there has not yet been an attempt to have a recognized ideal of how to offer the treatment rationale in the psychological community.

History of ACT and CBT. As previously acknowledged, ACT and CBT are two popular treatment methods for a variety of psychological ailments and have been for some time. ACT and CBT are extremely similar treatments in the way that they are both evidence based, work with cognitions, behaviors, and feelings, and are

largely effective. Although these treatments share many commonalities, they differ in their history, philosophical underpinnings, and inherently- their approach to treating psychological disorders.

In the wake of the waning popularity of psychoanalytic theory and the beginning of the “cognitive revolution”, Dr. Aaron Beck began pioneering cognitive therapy (Fancher & Rutherford, 2017; O’Donohue, 2009). In the 1960’s, Beck began laying the scientific foundation of cognitive therapy. Cognitive therapy was founded on the basis that many mental disorders (particularly depression) are the product of cognitive distortions and can be treated by restructuring, or changing, these distorted thoughts (Fancher & Rutherford, 2017). By the 1980’s, cognitive therapy integrated with what some call second generation behaviorism to eventually evolve into cognitive behavioral therapy (Fancher & Rutherford, 2017; O’Donohue, 2009). CBT’s approach to mental health treatment is more scientific, data driven, and analytical compared to other treatments. This is mostly due to CBT’s inheritance of the scientific foundation from the first behaviorists (O’Donohue, 2009). The advancement of CBT happened to coincide with the publishing of the DSM-III which promoted a more scientific approach to the assessment, diagnosis, treatment of psychological disorders and thereby added support for the cognitive behavioral approach (Fancher & Rutherford, 2017).

In the 1990’s, the third generation of behaviorism came to pass. This represented the increased prominence of acceptance-based models of CBT which

stressed mindfulness based practices (Forman & Herbert, 2009). With this change, “comprehensive distancing” later known as acceptance and commitment therapy (ACT), rose in popularity as a continuation of Relational Frame Theory and CBT (Forman & Herbert, 2009). According to Luoma et al., Relational Frame Theory explores the way language functions and how this can contribute to a person’s suffering, and ACT uses functional contextualism to build psychological flexibility which in turn undermines the verbal difficulties that are at the root of psychological suffering (2007).

Philosophical differences between CBT and ACT. Although these treatments are inextricably connected historically, they are philosophically distinct from one another. CBT typically places a greater emphasis on changing or eliminating “symptoms” of psychological disorders and the role thoughts play in directly influencing emotional and behavior problems. CBT accomplishes this by weakening or eliminating aversive thoughts via detection, testing, restructuring, reappraisal, and other methods (Hayes et al., 2004). ACT, on the other hand, places a heavier emphasis on accepting and changing one’s relationship to aversive private experiences (Luoma et al., 2007; Hayes et al., 2004).

When comparing the assumptions and goals underlying CBT and ACT, individuals from Western cultures are more likely to be familiar with those consistent with CBT. It in Western societies, mechanism is a more common and intuitive process than functional contextualism (Buchanan, 2021). In Western

cultures, verbal knowledge is prioritized over experiential knowledge, meaning that thoughts are regarded as valid or accurate reflections of reality and result in unpleasant or “negative” emotions that should be diminished and controlled (Buchanan, 2021). This method of thinking directly conflicts with the ACT model which is based on the Eastern concept of mindfulness and acceptance (Buchanan, 2021). These fundamental differences in how psychological difficulties are conceptualized and treated will be reflected in treatment rationales presented to clients.

Effectiveness and CBT and ACT. Aside from these philosophical differences, there is the question of what psychological disorders CBT or ACT can treat effectively. ACT is regarded as an effective and evidence based treatment according to the following organizations: American Psychological Association, Society of Clinical Psychology (Div. 12), California Evidence-Based Clearinghouse for Child Welfare, VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder, Title IV-E U.S. Department of Health and Human Services (HHS) Prevention Services Clearinghouse, The World Health Organization, and the Australian Psychological Society, among others (The Association of Contextual Behavior Science & Hayes, 2020). According to Division 12 of the American Psychological Association, ACT has been proven to be an effective treatment for obsessive-compulsive disorder, chronic pain, depression, mixed anxiety disorders, and psychosis (2016).

Not unlike ACT, CBT is popularly recognized by the psychological community as an effective and evidence based approach to treatment and is also supported by Division 12 of the American Psychological Association (Division 12 of the American Psychological Association, 2016). According to Division 12 of the American Psychological Association, CBT has been proven to be effective in treating the following psychological disorders: generalized anxiety disorder, depression, schizophrenia, adult attention deficit/hyperactivity disorder, anorexia nervosa, binge eating disorder, bulimia nervosa, chronic headaches, insomnia, irritable bowel syndrome, obsessive compulsive disorder, panic disorder, and social anxiety among others (2016). Partly due to CBT's well established presence in the realm of psychology and healthcare at large, and the salient nature of the disorders CBT has been proven to be effective in treating, CBT is also frequently a popular choice for other health care professionals who work in integrative medicine settings (La Buda et al., 2018).

Despite the many differences and commonalities between ACT and CBT, their treatment outcomes are often very comparable. According to a 2012 study by Arch and colleagues, when clients are randomly assigned either ACT or CBT, all clients experienced similar improvement from pre to post treatment. In another study conducted by Craske et al., in 2014 examined whether there would be a difference in treatment outcomes for clients who were randomly assigned ACT, CBT, or a waitlist control. The results indicated that both ACT and CBT outperformed the waitlist

group, and that though there were some subtle differences in the client's psychological flexibility skills, both ACT and CBT produced positive outcomes for the clients (Craske et al., 2014). Another study where ACT and CBT were randomly assigned to anxious children corroborated these findings that ACT and CBT produce similar positive outcomes (Hancock et al., 2018). These studies are further support the assertion that ACT and CBT are appropriate treatments to compare against each other.

Purpose of the Current Study

A small body of research indicates that a clear and understandable treatment rationale is important in terms of improving adherence with treatment. CBT and ACT are both widely practiced and are effective for treating a variety of psychological disorders. Therefore, one question that emerges is which treatment is most acceptable to clients in situations where both are viable treatment options. This logic informed the aims of the current study. The first was to determine if there are differences in the acceptability of treatment rationales based on CBT or ACT. The second was to learn why the treatment rationales were deemed acceptable or unacceptable.

Study Design

There were two phases to this research study. The objective of the first phase was to validate the quality of the vignettes by obtaining feedback from subject matter experts. The results from phase one of the study were designed to inform

how to proceed with phase two of the study. The aim of the second phase of the study was to see which treatment rationale would be more acceptable and understandable to the average person. For the sake of clarity, the methods and results of phase one will be discussed prior to the methods and results of phase two.

Methods

Phase One - Subject Matter Expert Review

To ensure the validity and quality of the treatment rationales before using them in phase two, the treatment rationales were sent to subject matter experts. These experts were recruited through the researchers' social and professional networks who were known to have educational and clinical experience with either CBT or ACT. Since the participants were part of the researcher's professional and social networks, the researchers provided participants a link to either the CBT or ACT surveys, depending on whichever treatment orientation they subscribe to. The survey required participants to read the vignette, then answer questions that would evaluate the quality of the vignettes, characterize their credentials, their profession (e.g., researcher, clinician, academic professor), along with their level of familiarity with their respective treatment methods they use (CBT or ACT).

There were seven subject matter experts that responded to the CBT survey and eight who responded to the ACT survey. The range of experience with ACT was 3-18 years with an average of 7.5 years of experience. The range of experience with CBT was 3-40 years with an average of 18.71 years of experience. Three of the ACT

subject matter experts characterized their professions as clinicians, and the rest identified as clinicians as well as researchers and/or academic professors. Five of the CBT subject matter experts described their professions as a fusion of being a clinician, researcher, and/or an academic professor, while two others identified as clinicians, and the final person was an academic professor.

Results

Phase One – Subject Matter Expert Review

The quantitative findings for the subject matter expert vignette evaluation were extracted from three 5-point Likert scales. The first question asked how understandable the vignette was. The second asked if the vignette accurately represented the theoretical model upon ACT/CBT is based. The third question asked how similar the vignette was to how a therapist would explain the treatment to a client during an early therapy session. The descriptive statistics for both surveys were analyzed and compared (see Table 1). The subject matter experts were also able to elaborate how the vignettes could be modified to make them more accurate in their presentation through their qualitative responses.

For the CBT vignette evaluation, the subject matter experts were largely in agreement that the vignette was clear and easy to understand and that it was true to the CBT theoretical orientation. Additionally, there was feedback that this vignette was not precisely how a CBT therapist would present their treatment rationale. The subject matter experts were able to elaborate how the vignettes could be modified

to make them more accurate in their presentation through their qualitative responses.

For the ACT survey, the subject matter experts responded that the clarity of the vignette could be improved, was relatively true to the ACT theoretical orientation, but needed improvement for it to be similar to how an ACT therapist would present their treatment rationale. Similar to the CBT subject matter experts, the ACT subject matter experts offered valuable insights in their qualitative responses.

The themes of the comments and suggestions from the subject matter experts for the ACT survey was to simplify the jargon to common language, remove the hexaflex diagram, replace the “quicksand” analogy for the “stranger at a party” metaphor, and to emphasize the concept of carrying one’s emotions. The common themes of recommendations from the CBT survey were to increase the behaviorally focused content, soften the language so that the therapist would sound more sensitive and less like the client was being blamed for their situation. When both vignettes were edited, they were also reduced in size.

Methods

Phase Two – Layperson Feedback

Participants were recruited through social media (i.e., Facebook and email) and from a Qualtrics’ research panel, resulting in an array of individuals with

diverse backgrounds. Participants were randomly assigned to complete one of two online surveys. The surveys required participants to read a vignette where a therapist presented either a CBT or ACT treatment rationale for a client who was suffering from anxiety and depression. After reading the vignette, participants answered two attention check questions that were based on the presented content. The first attention check question asked about whether the treatment focus was to help people learn to accept negative thoughts and feelings, and the other asked if the treatment included homework. In conjunction with these questions, participants answered several demographics questions. These demographics questions included: age, gender, ethnicity, college experience (if any), the number of psychology credits they have taken, and whether they have ever been to counseling or therapy. There were also several Likert scale questions that evaluated 1) the clarity of the vignette, 2) whether they liked the approach, 3) if the subject would continue to see the therapist in the vignette, 4) if the reasons for the homework component were clear, and 5) if there was enough information given to make a decision. In addition to these questions, there were three qualitative questions that asked 1) what components participants liked or agreed with, 2) what parts they did not like or disagreed with, 3) as well as what questions they wish they could have asked the therapist in the vignette.

There was a total of 456 participants who were randomly assigned to take either the CBT (N= 238) or ACT (N=218) surveys. The initial number of participants

was so high due to individuals who opened the survey and did not respond; these responses were removed after the data was cleaned based on previously established inclusion criteria. The inclusion criteria for the current study included: subjects answered the two memory/attention check questions correctly, answered at least four of the five Likert scale questions, and half of the demographics questions were answered. The participants data that was used for analysis for the CBT survey totaled to 67 while the final count for the ACT survey was 68 (see Table 2).

Results

Phase Two- Layperson Feedback

The quantitative findings for this study were derived from the Likert scale questions (see Table 3 and Table 4). Independent samples t-tests were performed between the CBT and ACT groups for each of the questions. There were no statistical differences between the two conditions. Pearson correlations were also run between the each of the demographic variables and the responses to the Likert scale questions. There was one intriguing statistically significant finding, it was a negative correlation between age and the clarity of the CBT vignette ($r^2 = -0.25, p = .05$). This correlation indicates that the younger a person was, the more likely they would understand the description of CBT. This was the only relevant statistically significant correlation found between the two surveys, but it is of note that several correlations were found between the Likert scale question responses (see Table 5 and Table 6). For instance, there were nine statistically significant positive

correlations found between the Likert scale questions for the CBT survey, and nine between the same Likert scale questions from the ACT survey. For both surveys, the only correlation that was not statistically significant correlation (or any correlation at all) was between question 3 (the reasons for the homework were clear) and question 5 (this was enough information to make a decision). These findings indicate that subjects responded similarly to the vignettes.

Though the quantitative findings were modest, there were several themes that were identified in the qualitative responses (see Tables 7, 8, & 9). These themes for each survey were identified through a content analysis where the researcher identified themes for each of the questions, respectively. The researcher then created a coding system for a research assistant to verify the presence of these themes. Afterwards, the researcher refined the themes based on the frequency count of the themes that were coded according to the research assistant.

Unique to the CBT vignette, there were four themes that were identified as what participants liked or agreed with in the treatment rationale: 1) specific elements of CBT and how it works, 2) the approach seemed positive and relatable, 3) the way that the treatment was presented, including how the therapist acted, and 4) the homework. Theme one referred to how the thoughts, feelings, and behaviors work together and the CBT approach to working with thoughts. Theme two was created based on responses regarding how adaptable the treatment seemed and the positive tone that was present in the presentation of the treatment rationale. The

third theme was based on responses which commented on how the therapist conducted themselves when working with the hypothetical client and presenting the rationale for CBT (e.g., "The doctor was caring."). The fourth and final theme was identified regarding the homework. Participants enjoyed that clients were held accountable for their health and were pleased that clients would be participating in their treatment.

As for what the ACT participants liked or agreed with, there were three themes that were found amongst their responses such as: 1) the overall approach, but especially the analogy, 2) ACT's approach to negativity, and 3) how well the therapist understood the client's situation and the level of detail in the explanation when responding to the client's situation. The first theme was developed based on the responses which addressed ACT as a concept and the analogy used to exemplify ACT's approach towards negative thoughts or feelings in the vignette. The second theme was constructed based on the feedback from participants which mentioned how to deal with negative thoughts or feelings or conversely, how to live more positively. The last theme was created from the feedback that participants enjoyed how attentive and warm the therapist was and how well the analogy fit the hypothetical client's situation.

When participants responded to the second qualitative question (list and/or describe 2 things you least liked or disagreed with in the vignette), there were several themes the ACT and CBT participants which were similar. For instance, the

homework was a controversial subject for both groups in that both did not care for the extra work and had several follow-up questions. Interestingly, 7% of CBT qualitative responses were in favor of homework, while 6% of CBT responses and 12% of ACT responses were against the homework. Another commonality was that 12% of CBT responses and 32% of ACT responses expressed they did not like the treatment approaches (these were the more prominent themes as they had the higher frequency counts). As for the themes that differed, there were two themes that were unique to ACT. The first was that treatment description seemed generic or impersonal, and the second was that the description of ACT was confusing, particularly the analogy. There was one theme that was exclusive the CBT vignette, and it was that the CBT approach required too much effort and too much information was given.

The responses to the final qualitative question which asked participants to list any questions they had, yielded almost identical themes such as: 1) the treatment timeline and likelihood of success, 2) how and why the treatment works, and 3) questions concerning the homework (see Table 9). The difference was in the fourth theme where ACT participants asked about pursuing additional or other treatment options, and CBT participants asked cost of treatment, alternative treatment options, the therapist's experience, etc. Please see Tables 7, 8, and 9 for a more complete depiction of these qualitative results.

Discussion

The aim of the current study was twofold. The first was to determine if there are differences in the acceptability of treatment rationales based on CBT or ACT. The second was to learn why the treatment rationales were deemed acceptable or unacceptable. For the first aim, the quantitative results derived from the five Likert scale questions indicated that the treatments were comparably rated. To address the second objective, there were numerous unique themes that were identified which served as explanations as to why CBT or ACT were acceptable or unacceptable treatment approaches.

Aside from these driving lines of inquiry, there was one statistically significant correlation found between participant ages and how the clarity of the CBT vignette was rated. This relationship indicates that the younger a person is, the more likely they are to understand the treatment rationale. In conjunction with this correlation, several correlations were found between the five Likert scale questions (see Tables 5 and 6). These correlations indicate that the responses were consistent across the participants, and from this it can be inferred that the questions were valid.

In terms of how the current study's findings fit the existing literature, the results align with the theme of CBT and ACT to be evenly matched. This is evidenced by the lack of statistically significant differences between the two groups'

Likert scale question responses and the similarity of the themes which emerged from the qualitative responses.

Limitations and Future Directions

Due to the novel nature of this study, naturally there were numerous limitations and opportunities for future growth as a result. For the sake of clarity, the limitations and future directions of the first phase will be discussed prior to the second phase.

Phase One – Subject Matter Expert Review

First, the recruitment process of the subject matter experts was limited. Ideally the sample size would have been larger and consisted of subject matter experts that were not personally or professionally connected to the researchers. An advantage to expanding the sample size is that it would balance the academically based and clinically practicing subject matter experts to ensure that the vignettes reflect what is currently being taught and practiced. In addition to this improvement, it would be ideal if the content analysis (reading the qualitative responses to identify themes) was performed by more than one individual to preserve the validity of the feedback received. This improvement would be necessary if a larger sample were collected. Another possible advancement of this study would be to have the revised vignettes re-validated by subject matter experts to ensure the revisions were applied properly.

Phase Two- Layperson Feedback

The between groups design implemented for this study impacted the conclusions that could be made. It could be debated whether using a between groups design was truly the best design method, as one of the aims of this study was to test if ACT or CBT was more acceptable to potential clients. With the present study design, participants lacked the opportunity to see both treatment rationales and decide if ACT or CBT was more acceptable. On the other hand, it decreased the likelihood of subjects experiencing response exhaustion and increased the probability of receiving quality responses. If limitless time and resources were available for subjects to participate in this study, it would have been preferable to follow a within-subjects design where participants would respond to both the ACT and CBT rationales. This within-subjects design would produce results that would be a more direct comparison.

To combat the length of the vignettes and the length of the survey overall, a possible future improvement could be to alter the delivery of the treatment rationale vignettes to a video format. A video could be more engaging than reading a few paragraphs of text and may yield more complete responses; however, using a text format for the vignette was simpler to control and allowed the participants to respond to the treatment rationales without the potential confounds of subtle wording changes or latent biases of age and gender. In conjunction with these improvements, the vignettes could be altered so that it reflects a more common

presentation of anxiety that would be more relatable to people who are beyond the college student age range which was the original target population for this study. Another possibility would be to increase the monetary incentive for participants to give more complete and thorough responses.

Regarding participant recruitment, the sample of the current study was large enough to achieve adequate statistical power and a relatively balanced representation of English-speaking Americans. Although this is a point of strength, there is more that can be done. Since participants were recruited during the COVID-19 pandemic, the only way that the study could be accessed was through the internet. As it has become more apparent that internet access is not an opportunity available to all (particularly those who are low-income, older adults, part of a racial/ethnic minority, less educated, or live in rural areas), the generalizability of these findings may be limited (Benda et al., 2020). This could be combatted by offering the study in person when social distancing restrictions are lifted, or in a mailed format.

There were also limitations associated with the data analysis strategies used. The methods that were used to analyze the qualitative results could have been formalized so that a measure of inter-observer agreement (e.g., kappa) could have been calculated. An added benefit of a more formal content analysis could have also resulted in chi-squared tests between the two groups. As for the quantitative analyses, a limitation of this study was that not all participants provided responses

to all the questions. If this study were to be replicated, it would be recommended to have a greater sample size to allow for these cases of missing questions to be cleaned from the dataset without the need for inclusion criteria.

An additional limitation concerns the measure of treatment acceptability used for this study. The Likert-scale items were created by the researchers and were not subject to any psychometric evaluations. Therefore, there is the issue of whether the Likert scale questions were a valid measure of whether a treatment was acceptable. Since the sample size was smaller, a principal component analysis was not performed; however, there were several correlations found between the five Likert scale questions which indicate there was an internal consistency and that the questions were adequately measuring the construct of treatment acceptability. A larger sample size would remedy this concern.

Another benefit of obtaining a larger sample size is that it would allow for enhanced statistical analyses and comparisons between the Likert-scale questions and the demographic variables. An alternative would be to recruit participants that identify as a member of a specific group (e.g., ethnicity, gender, etc.) or have a particular history such as with counseling/therapy, college education, or experience with psychology. Pursuing these lines of inquiry would illuminate whether certain variables predict whether a person finds ACT or CBT more acceptable. One other variable that may also have an impact on how individuals view ACT or CBT may be

where they originate from in the world, more specifically if they come from the Western or Eastern hemisphere.

When comparing the assumptions and goals underlying CBT and ACT, individuals from Western cultures are more likely to identify with tenants consistent with CBT. In Western societies, it is common for thoughts to be regarded as valid reflections of reality and result in unpleasant or “negative” emotions that should be diminished and controlled (Buchanan, 2021). This method of thinking directly conflicts with the ACT model which is based on the Eastern concept of mindfulness and acceptance (Buchanan, 2021). It is possible that if the study sample was expanded beyond the United States to include Eastern regions, that participant reactions to either ACT or CBT would have been more polarized. These cultural and philosophical differences may be another avenue of future study.

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Tables

Table 1

Subject Matter Expert Vignette Evaluation Likert Question Results

Question	CBT Vignette Evaluation				ACT Vignette Evaluation			
	<i>n</i>	<i>M</i>	<i>SD</i>	Mode	<i>n</i>	<i>M</i>	<i>SD</i>	Mode
1.) Clarity of vignette?	7	4.71	0.45	5	7	4.29	1.03	5
2.) Accurate representation of the theoretical orientation?	7	4.57	0.49	5	7	4.57	0.49	5
3.) It was similar to how a therapist would deliver a treatment rationale?	7	3.86	1.25	4	7	3.86	0.83	4

Note. 5= Strongly agree while 1 = Strongly Disagree. Though there were 8 subject matter experts who provided feedback in the ACT Survey, 7 of them provided responses to the Likert Scale questions.

Table 2
Participant Demographics

Variable Name		ACT Participants		CBT Participants	
		<i>n</i>	%	<i>n</i>	%
Gender					
	Female	45	66.18%	42	62.69%
	Male	23	33.82%	24	35.82%
	Other	0		1	1.49%
Ethnicity					
	African American	6	8.82%	8	11.94%
	Asian	4	5.88%	5	7.46%
	Caucasian	49	72.06%	43	64.18%
	Hispanic	7	10.29%	9	13.43%
	Native American/First Nations	1	1.47%	1	1.49%
	Other	1	1.47%	1	1.49%
Age					
	18-25	16	23.88%	14	20.90%
	26-35	16	23.88%	18	26.87%
	36-45	12	17.91%	13	19.40%
	46-55	9	39.13%	8	11.94%
	56-65	8	11.94%	5	7.46%
	66-75	5	7.46%	7	10.45%
	76+	1	1.49%	2	2.99%
Number of College Semesters Completed					
	0 to 4	20	34.48%	17	27.87%
	5 to 8	28	48.28%	27	44.26%
	9 to 12	8	13.79%	11	18.03%
	12+	2	3.45%	6	9.84%
Number of Psychology Credits Completed					
	0 to 4	34	53.97%	35	55.56%
	4 to 8	14	22.22%	8	12.70%
	8 to 12	6	9.52%	6	9.52%
	12 to 16	6	9.52%	6	9.52%
	16+	3	4.76%	8	12.70%
History of Counseling or Therapy					
	Yes	40	62.50%	37	59.68%
	No	24	37.50%	25	40.32%

Table 3*ACT & CBT Likert Scale Responses*

Question	ACT Vignette Evaluation						CBT Vignette Evaluation					
	<i>n</i>	<i>M</i>	<i>SD</i>	Mode	Min.	Max.	<i>n</i>	<i>M</i>	<i>SD</i>	Mode	Min.	Max.
1.) Clarity of vignette?	68	4.25	0.66	4	3	5	67	4.24	0.82	5	1	5
2.) Did you like the treatment approach?	67	4.22	0.81	5	2	5	67	4.09	0.87	4	2	5
3.) Were the reasons for the homework clear?	67	4.37	0.78	5	2	5	67	4.42	0.65	5	2	5
4.) Would you continue this therapy?	68	4.16	0.96	5	2	5	67	3.62	1.11	5	2	5
5.) Was this enough information to make a decision?	67	3.87	1.07	5	1	5	67	4.05	1.00	4	1	5

Note. 5= Strongly agree while 1 = Strongly Disagree.

Table 4*Comparison of ACT & CBT Vignette Evaluation Results*

Question	ACT Vignette		CBT Vignette		t(133)	p	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
1.) Clarity of vignette?	4.25	0.66	4.24	0.82	-0.116	0.293	0.743
2.) Did you like the treatment approach?	4.22	0.81	4.09	0.87	-0.942	0.556	0.843
3.) Were the reasons for the homework clear?	4.37	0.78	4.42	0.65	0.074	0.354	0.689
4.) Would you continue this therapy?	4.16	0.96	3.62	1.11	-0.708	0.986	0.976
5.) Was this enough information to make a decision?	3.87	1.07	4.05	1.00	-1.171	0.634	1.092

Note. 5=Strongly agree while 1 = Strongly Disagree.

Table 5*ACT Results and Their Relationships with Participant Demographics*

Variable Name	n	M	SD		Age	Gender	Ethnicity	Counseling History	Number of college semesters completed	1.) Clarity of vignette?	2.) Did you like the treatment approach?	3.) Reasons for the homework clear?	4.) Would you continue this therapy?	5.) Enough information?
Age	67	40.07	16.25		--									
Gender	68	1.33	0.48	Pearson Correlation	0.17	--								
				Sig. (2-tailed)	0.17									
				n	67	68								
Ethnicity	68	2.94	0.84	Pearson Correlation	0.14	0.12	--							
				Sig. (2-tailed)	0.26	0.31								
				n	67	68	68							
Counseling History	64	0.63	0.49	Pearson Correlation	-	-		--						
				Sig. (2-tailed)	0.23	0.03	0.01							
				n	0.07	0.84	0.97							
					63	64	64	64						
Number of college semesters completed	58	6.05	3.56	Pearson Correlation	-	-	-	-	--					
				Sig. (2-tailed)	0.11	0.2	0.06	0.08						
				n	0.41	0.13	0.65	0.56						
					4	58	58	58	58					
1.) Clarity of vignette?	68	4.25	0.66	Pearson Correlation	-	-	-	-	--					
				Sig. (2-tailed)	0.04	0.14	0.06	0.01						
				n	0.44	0.77	0.27	0.63	0.97					
					67	68	68	64	58	68				
2.) Did you like the treatment approach?	67	4.22	0.81	Pearson Correlation	-	-	-	-	.696*		--			
				Sig. (2-tailed)	0.03	0.16	0.08	0.00	*					
				n	0.06	0.79	0.21	0.51	1.00	0				
					66	67	67	63	57	67	67			
3.) Were the reasons for the homework clear?	67	4.37	0.78	Pearson Correlation	-	-	-	-	.494*	.514*	--			
				Sig. (2-tailed)	0.17	0.02	0.11	0.07	0.06	*	*			
				n	0.16	0.85	0.36	0.57	0.67	0	0			
					66	67	67	63	57	67	66	67		
4.) Would you continue this therapy?	68	4.16	0.96	Pearson Correlation	-	-	-	-	.507*	.649*	.526*	--		
				Sig. (2-tailed)	0.21	0.12	0.03	0.04	0.14	*	*	*		
				n	0.09	0.32	0.84	0.74	0.28	0	0	0		
					67	68	68	64	58	68	67	67	68	
5.) Was this enough information to make a decision?	67	3.87	1.07	Pearson Correlation	-	-	-	-	.436*	.593*	.566*	--		
				Sig. (2-tailed)	0.06	0.21	0.05	0.02	*	*	0.15	*		
				n	0.08	0.65	0.09	0.71	0.91	0	0	0.22	0	
					66	67	67	63	58	67	66	66	67	67

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

Table 6

CBT Results and Their Relationships with Participant Demographics

Variable Name	n	M	SD		Age	Gender	Ethnicity	Number of College Semesters Completed	History of Counseling or Therapy	1.) Clarity of vignette?	2.) Did you like the treatment approach?	3.) Reasons for the homework clear?	4.) Continue this therapy?	5.) Enough information?
Age	67	40.54	16.39	Pearson Correlation	--									
				n	67									
Gender	67	1.39	0.52	Pearson Correlation	0.14	--								
				Sig. (2-tailed)	0.25									
				n	67	67								
Ethnicity	67	2.90	0.94	Pearson Correlation	-0.11	-.256*	--							
				Sig. (2-tailed)	0.39	0.04								
				n	67	67	67							
Number of College Semesters Completed	61	7.5	5.59	Pearson Correlation	0.09	-0.14	-0.03	--						
				Sig. (2-tailed)	0.50	0.30	0.84							
				n	61	61	61	61						
History of Counseling or Therapy	62	0.6	0.49	Pearson Correlation	-0.11	0.01	.289*	--						
				Sig. (2-tailed)	0.39	0.97	0.02							
				n	62	62	62	60	62					
1.) Clarity of vignette?	67	4.24	0.82	Pearson Correlation	0.053	0.064	0.033	56	0.059	--				
				Sig. (2-tailed)	0.668	0.609	0.791	66	0.646					
				N	67	67	67	61	62	67				
2.) Did you like the treatment approach?	67	4.09	0.87	Pearson Correlation	0.123	0.056	0.012	0.1	0.112	**	--			
				Sig. (2-tailed)	0.322	0.652	0.925	39	0.384	0				
				N	67	67	67	61	62	67	67	67		
3.) Were the reasons for the homework clear?	67	4.42	0.65	Pearson Correlation	0.085	0.095	0.171	0.0	0.099	.461	.574	--		
				Sig. (2-tailed)	0.495	0.445	0.168	58	0.442	0	0			
				N	67	67	67	61	62	67	67	67	67	
4.) Would you continue this therapy?	67	4.06	1	Pearson Correlation	0.11	0.016	0.106	0.0	0.053	.316	.713	.355	--	
				Sig. (2-tailed)	0.377	0.897	0.392	57	0.682	0.00	**	**	**	
				N	67	67	67	64	62	67	67	67	67	67
5.) Was this enough information to make a decision?	67	3.63	1.11	Pearson Correlation	0.038	0.034	0.212	0.0	0.055	.449	.586	0.21	.539	--
				Sig. (2-tailed)	0.759	0.785	0.085	47	0.672	**	**	7	**	**
				N	67	67	67	19	0.7	0	0	7	0	6
				N	67	67	67	61	62	67	67	67	67	7

* Correlation is significant at the 0.05 level (2-tailed).

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

Table 7*Comparison of Qualitative Responses- Question 1*

Question	ACT		CBT	
	Themes	Quotes	Themes	Quotes
List and/or describe 2 things you most liked or agreed with in the vignette.	1) The overall approach, but especially the analogy.	"I loved the party scenario. It was very realistic, and I could feel myself in the situation, I thought it was good to have ultimately have the party crasher stay, so I could be present for the party."	1) Specific elements of CBT and how it works.	"I like the idea that emotions, behavior, and thoughts are all connected"
	2) ACT's approach to negativity.	"The idea of accepting [accepting] negative moods made sense."	2) The approach seemed positive and relatable.	"I liked how it felt like it knew mw [me]."
	3) How well the therapist understood the client's situation and the level of detail in the explanation when responding to the client's situation.	"That the doctor repeated things the client had talked about"	3) The way that the treatment was presented, including how the therapist acted.	"The doctor was caring."
			4) The homework.	"I like the journal/log they keep. It makes it seem more accountable."

Table 8*Comparison of Qualitative Responses- Question 2*

Question	ACT		CBT	
	Themes	Quotes	Themes	Quotes
List and/or describe 2 things you least liked or disagreed with in the vignette.	1) The overall treatment approach.	"I don't think just accepting the feelings is going to solve the problem. Some of the issues are real problems that they may need help with"	1) The overall treatment approach.	"I dislike when therapists claim that the issue is your thinking about the situation because it discounts the actual harm that situations can have"
	2) The treatment description seemed generic or impersonal.	"It felt hyper impersonal"	2) This required too much effort and too much information was given.	"That's a lot for the first meeting" & "[a] lot of work"
	3) The description was confusing, particularly the analogy.	"It would require some additional reading or questions to gain full clarity" & "Allowing the interloper into my party which means I must allow it/him to be nearby and possibly ruin my fun."	3) The homework.	"Homework example felt miraculous, patient solved their own issues by writing them down."
	4) The homework.	"Homework, although simple enough, would make me too aware of what I want to avoid."		

Table 9*Comparison of Qualitative Responses – Question 3*

Question	ACT		CBT	
	Themes	Quotes	Themes	Quotes
List any questions you would want to ask Dr. Happy ¹ before deciding to start treatment that was described to you.	1) The treatment timeline and likelihood of success.	"How soon would he [I] expect results to be apparent and how long we would need to keep up with treatment sessions[?]"	1) The treatment timeline and likelihood of success.	"How long before I feel better[?]"
	2) How and why the treatment works.	"How exactly would I be learning to deal with those emotions[?]"	2) How and why the treatment works.	"How will you help me work through my issues?"
	3) Many questions concerning the homework.	"...Why does homework help me? How can it be useful to do homework as a reflection?"	3) Many questions concerning the homework.	"Maybe not use the word homework?"
	4) Questions concerning other treatment options, specifically the possibility of incorporating medication.	"...do you think medication would help too[?]"	4) Practical questions such as: cost of treatment, alternative treatment options, the therapist's experience, etc.	"What is your fee? What are your credentials? (serious questions) How long in total do you think I will need to see you? ..."

Note: ¹Dr. Happy was the therapist in the vignette.

Appendix A

Informed Consent for Phase One – Subject Matter Expert Review

Informed Consent for Participation in the Research

Title: The title of this research study is, “Comparing the acceptability of treatment rationales for two psychotherapies.”

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato’s Psychology Department.

Purpose

The purpose of this research study is to understand how valid and realistic a treatment rationale is for either cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT).

Participants

I have been asked to participate because I am a subject matter expert in either CBT or ACT.

Procedure

A treatment rationale will be provided to me that will eventually be given to college students in a university setting. The vignette depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked to read the vignette and rate the vignette according to: 1) how clear or understandable the treatment rationale is, 2) how accurately the vignette represents the theory related to CBT or ACT, and 3) if the vignette is similar to how a therapist would actually explain the treatment rationale to a real client. You will also be asked to provide any constructive feedback about the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered.

Risks

The risks associated with this study are no more than experienced in normal daily life. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. All information will be kept on the student investigator's password protected computer and destroyed after three years. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato Information and Technology Services Help Desk (507-389-6654) and ask to speak to Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may refuse to participate or you may end your participation at any time without repercussions by contacting the principal investigator at the phone number below. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at 1(507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

MSU IRBNet LOG # 1525015

Do you consent to participate in this study?

Appendix B

Informed Consent for Phase Two – Layperson Review

Informed Consent for Participation in the Research

Title: The title of this research study is, “Comparing the Acceptability of Treatment Rationales for Two Psychotherapies.”

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato’s Psychology Department.

Purpose

The purpose of this research study is to see if college students prefer cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT) when provided treatment rationale.

Participants

I have been asked to participate because I am 18 years or older.

Procedure

A vignette will be provided via an online Qualtrics survey that depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked some demographics questions, read the vignette, and answer some questions about your response to the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered and you may close your browser.

Risks

The risks associated with this study are no more than experienced in normal daily life. The experimenters encourage you to use a secure internet connection, and to participate in the study where you would have privacy where only you can view your computer screen. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. If you would like more information about the specific

privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may choose not to answer any of the survey questions or you may end your participation at any time by closing the web browser. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at 1(507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

Minnesota State University, Mankato IRBNet LOG # 1598327

Do you consent to participate in this study?

Appendix C

Survey from Phase One- ACT Subject Matter Expert Review

Default Question Block

Informed Consent for Participation in the Research

Title: The title of this research study is, "Comparing the acceptability of treatment rationales for two psychotherapies."

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato's Psychology Department.

Purpose

The purpose of this research study is to understand how valid and realistic a treatment rationale is for either cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT).

Participants

I have been asked to participate because I am a subject matter expert in either CBT or ACT.

Procedure

A treatment rationale will be provided that will eventually be given to college students in a university setting. The vignette depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked to read the vignette and rate the vignette according to: 1) how clear or understandable the treatment rationale is, 2) how accurately the vignette represents the theory related to CBT or ACT, and 3) if the vignette is similar to how a therapist would actually explain the treatment rationale to a real client. You will also be asked to provide any constructive feedback about the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered.

Risks

The risks associated with this study are no more than experienced in normal daily life. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. All information will be kept on the student investigator's password protected computer and destroyed after three years. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato Information and Technology Services Help Desk (507-389-6654) and ask to speak to Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may refuse to participate or you may end your participation at any time without repercussions by contacting the principal investigator at the phone number below. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at (507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

MSU IRBNet LOG # 1525015

Do you consent to participate in this study?

Yes

No

Block 5

Please read the following clinical vignette that depicts a therapist explaining the rationale for treatment to a client who presented with symptoms of depression and social anxiety. After reading the vignette, please respond to the questions regarding your opinions about the vignette to the best of your ability. When finished, your responses will be automatically recorded and you may close your browser.

Block 1

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

Although your mind tells you to control your anxiety and depression, these emotions just keep getting bigger and more distressing, possibly, because you are trying to control and avoid emotions and thoughts that cannot be controlled or avoided. When you are feeling depressed you want to avoid this feeling by not accepting invitations to social gatherings because you are worrying that other people will not like you. Although avoiding the party does prevent you from feeling anxious, you also may feel like a failure because you've missed an opportunity to connect with others and have fun. The avoidance of interacting with other people leaves you feeling depressed and like a failure.

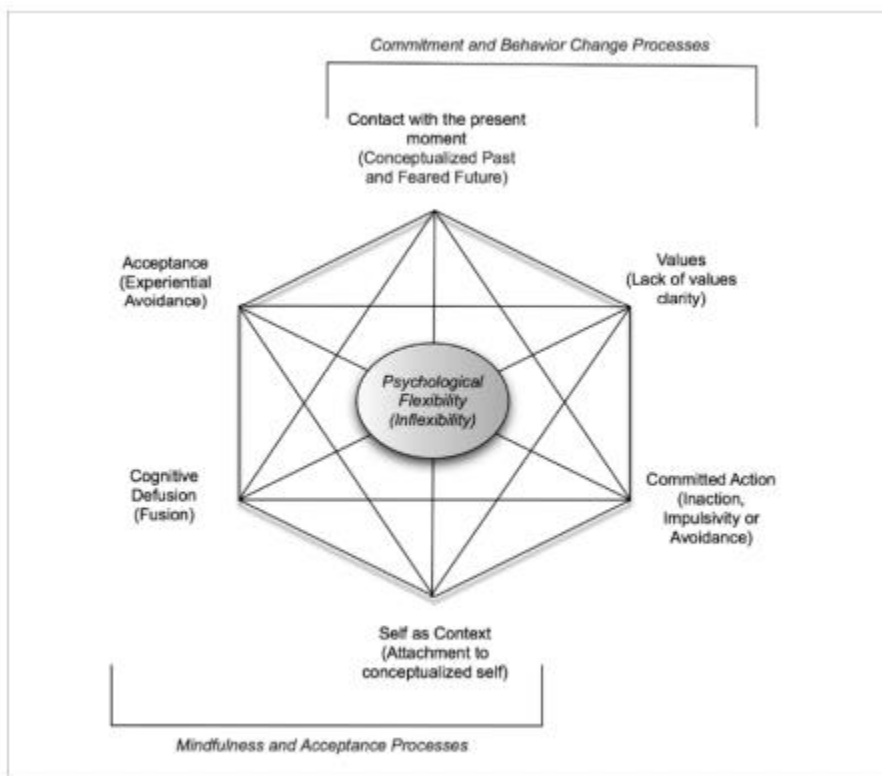
Let's consider an example: I would like you to imagine you are lying in quicksand. It is natural in this situation to struggle and try to push yourself out. The problem is that this strategy will only make you sink deeper into the quicksand. What you need to do instead, is to lie on your back and have as much of your body as possible make contact with the quicksand. By doing this, you remain on the surface of the quicksand and do not sink. In other words, to survive quicksand, you need to stop struggling and fighting and, instead, make contact with it even though it is the "enemy." As this applies to you, perhaps we need to learn how stop struggling and fighting negative emotions and thoughts (similar to the quicksand), and instead, learn ways to contact the distress and uncomfortable feelings, while still living the life you wish to live. In other words, perhaps deliberate attempts to control negative emotions and thoughts is part of the problem and actually not the solution.

Now let's examine an example that you told me about earlier in our session. You described to me was that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious

that he might be upset with you although you have no evidence he is actually upset with you. You are having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because you fear the interaction will go badly. I wonder if we can find ways to have those emotions and still do things that move you closer to achieving goals such as improving relationships.

I understand that you might be tired of feeling anxious and depressed and that it is too difficult to have these emotions. Wanting to control or get rid of negative emotions is very natural. The fact that you are fed up with your anxiety and sadness is actually our biggest ally right now. It is important to acknowledge that your mind is not ready to let go of the agenda of controlling or getting rid of these negative emotions - it is wired to think this way. The dilemma is that we need to let go of an agenda that your mind has no idea how to let go of.

Let me explain a little more (see diagram below). There are six processes that are targeted in this therapy and I'll give a brief explanation of each of these concepts. Acceptance involves embracing thoughts, feelings, and bodily sensations without trying to get rid of them. Diffusion, involves learning to view thoughts as thoughts and not as true reflections of reality. Self as context includes things like being aware of yourself, how you think about yourself, and the ways you describe yourself. Contact with the present moment is to experience thoughts feelings and bodily sensations as they occur in any given moment. Values work will involve identifying what is really important to you and will help guide what specific behavior changes you choose to make.



Speaking of values, one of most important parts of this treatment is getting a better understanding of who you are and what you stand for as a person – in other words, what are your values. Your values will dictate and guide everything we do in therapy. We will never do something here that does not align with your core values. To get this process started, I would like you to complete some homework that will ask you to specify your values and goals in different areas of your life (see the form below). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy.

<p>LOVE (deepest, most meaningful relationships – including children, partner, parents, close friends and relatives)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>WORK (paid work, studying/ education/ apprenticeships, and unpaid work such as volunteering, or domestic duties)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>
<p>PLAY (rest and relaxation, hobbies, creativity, sport, and all forms of leisure, recreation and entertainment)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>HEALTH (physical, psychological, emotional, or spiritual health and wellbeing.)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>

Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

This vignette was understandable (i.e., it reads clearly and coherently)?

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

This vignette accurately represents the theoretical model upon which Acceptance and Commitment Therapy is based.

- Strongly Agree
- Agree
- Disagree

- Strongly Disagree

This vignette is similar to how a therapist would explain the treatment rationale to a client during an early therapy session.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Were there specific parts of the vignette you believe were inaccurate or unclear? If so, please provide recommendations for improving the content so it is clearer and/or more accurately represents the goals and purposes of Acceptance and Commitment Therapy.

How many years have you researched or practiced Acceptance and Commitment Therapy?

How would you characterize your credentials?

- Ph.D.
 Psy.D.
 M.A. in Psychology
 Other

How would you describe your credentials with Acceptance and Commitment Therapy?

- Expert
 Knowledgeable
 Familiar
 Unfamiliar

How would you characterize your professional occupation in the psychological field? (Please select all that apply.)

- Researcher
 Academic Professor
 Clinician
 Other

Block 3

Thank you for participating in this survey. Your response has been recorded and you may now close your browser. Please contact Marin Olson if you have any questions or concerns at marin.olson@mnsu.edu or 1(507)-389-2724.

Appendix D

Survey from Phase One- CBT Subject Matter Expert Review

Informed Consent for Participation in the Research

Title: The title of this research study is, "Comparing the acceptability of treatment rationales for two psychotherapies."

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato's Psychology Department.

Purpose

The purpose of this research study is to understand how valid and realistic a treatment rationale is for either cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT).

Participants

I have been asked to participate because I am a subject matter expert in either CBT or ACT.

Procedure

A treatment rationale will be provided to me that will eventually be given to college students in a university setting. The vignette depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked to read the vignette and rate the vignette according to: 1) how clear or understandable the treatment rationale is, 2) how accurately the vignette represents the theory related to CBT or ACT, and 3) if the vignette is similar to how a therapist would actually explain the treatment rationale to a real client. You will also be asked to provide any constructive feedback about the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered.

Risks

The risks associated with this study are no more than experienced in normal daily life. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. All information will be kept on the student investigator's password protected computer and destroyed after three years. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato Information and Technology Services Help Desk (507-389-6654) and ask to speak to Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may refuse to participate or you may end your participation at any time without repercussions by contacting the principal investigator at the phone number below. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at (507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

MSU IRBNet LOG # 1525015

Do you consent to participate in this study?

- Yes
 No

Please read the following clinical vignette that depicts a therapist explaining the rationale for treatment to a client who presented with symptoms of depression and social anxiety. After reading the vignette, please respond to the questions regarding your opinions about the vignette to the best of your ability. When finished, your responses will be automatically recorded and you may close your browser.

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

In therapy, it is important to understand your emotions, behaviors, and thoughts, as well as how environmental situations trigger these reactions. Also, situations, emotions, behaviors, and thought all can affect each other (see the figure below).



Of all these factors on the diagram, I have found that therapy is most helpful when we try to change people's thinking. I tend to believe it is not what happens to us that makes us upset, but it is how we think about and

interpret these situations that makes us depressed or anxious. There is a quote by a Greek philosopher that perhaps explains it better, "People are not disturbed by the events that happen to them, but by their view of these events."

The situations you have described to me are certainly stressful and upsetting, but the way that you interpret these situations is very important in determining why you feel the way you do.

You have told me about some of the thoughts that frequently run through your head, but it would be helpful for us to start learning more about the kinds of thoughts you commonly have about yourself, the things that happen to you, and your future. My guess is that many of these thoughts are negative, exaggerated, inaccurate, and generally unhelpful. I also suspect that all of these thoughts may be the reason you feel depressed and anxious and that they hold you back from doing important things such as completing schoolwork or being with the people you care about. Therefore, I think it is very important to understand what it is going on in your head when you become anxious or depressed. In order to help us identify what you are thinking, it is very helpful if you complete some homework between sessions. This homework will involve you writing down your negative thoughts, what was happening around you when you felt this way (i.e., the events), your emotional responses to the situation, and what you did in the situation (i.e., your behavior). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy. The figure below shows an example of the kind of homework I'll be asking you to complete.

Thought Log

Event	Thought	Consequence / Behavior	Rational Counterstatement
Example: Supervisor at work is angry.	"I must have made a mistake—now I've done it. They'll fire me sure."	<ul style="list-style-type: none"> • Feeling of sadness and anxiety • Spend time obsessing over mistakes 	"My supervisor could've been angry about anything. They are usually happy with my work, so even if I've made a mistake it isn't a big deal."

Provided by **Therapist Aid** © 2012

Once we have an idea of what negative thoughts you experience, I will begin to challenge some of your unhelpful thinking patterns. We will then work to help you replace the negative thoughts with ones that are more accurate, adaptive, and useful. This process of identifying, challenging, and replacing thoughts should lead you to feeling less depressed and anxious. I hope that over time, you will be able to use the skills of challenging and replacing your negative thinking patterns on your own - this is when we know we will be done.

Let's examine an example that you told me about earlier in our session. You described to me that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious that he might be upset with you although you have no evidence he is actually upset with you. You are having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because you fear the interaction will go badly. If we can look at ways to change your thoughts and perception of this event, it may lead to you feeling and acting differently in future situations.

Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

Block 4

This vignette is understandable (i.e., it reads clearly and coherently)?

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

This vignette accurately represents the theoretical model upon which Cognitive-Behavioral Therapy is based.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

This vignette is similar to how a therapist would explain the treatment rationale to a client during an early therapy session.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Were there specific parts of the vignette you believe were inaccurate or unclear? If so, please provide recommendations for improving the content so it is clearer and/or more accurately represents the goals and purposes of Cognitive-Behavioral Therapy.

How many years have you researched or practiced Cognitive Behavioral Therapy?

How would you characterize your credentials?

- Ph.D.
 Psy.D
 M.A. in Psychology
 Other

How would you describe your credentials with Cognitive Behavioral Therapy?

- Expert
 Knowledgeable
 Familiar
 Unfamiliar

How would you characterize your professional occupation in the psychological field? (Please select all that apply.)

- Researcher
 Academic Professor
 Clinician
 Other

Thank you for participating in this survey. Your response has been recorded and you may now close your browser. Please contact Marin Olson if you have any questions or concerns at marin.olson@mnsu.edu or 1(507)-389-2724.

Appendix E

Phase Two – Layperson Review – ACT

Informed Consent for Participation in the Research

Title: The title of this research study is, “Comparing the Acceptability of Treatment Rationales for Two Psychotherapies.”

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato’s Psychology Department.

Purpose

The purpose of this research study is to see if college students prefer cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT) when provided treatment rationale.

Participants

I have been asked to participate because I am 18 years or older.

Procedure

A vignette will be provided via an online Qualtrics survey that depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked some demographics questions, read the vignette, and answer some questions about your response to the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered and you may close your browser.

Risks

The risks associated with this study are no more than experienced in normal daily life. The experimenters encourage you to use a secure internet connection, and to participate in the study where you would have privacy where only you can view your computer screen. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may choose not to answer any of the survey questions or you may end your participation at any time by closing the web browser. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at (507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

Minnesota State University, Mankato IRBNet LOG # 1598327

Do you consent to participate in this study?

Yes

No

What gender do you identify as?

- Male
- Female
- Other
- I prefer not to respond

What ethnicity do you identify as?

- Caucasian
- African American
- Native American/First Nations
- Hispanic
- Asian
- Other
- I prefer not to respond

What is your age in years?

We would now like you to imagine that you are seeking counseling/psychotherapy because you are depressed and anxious. More specifically, you have been experiencing the following symptoms: feeling sad/down, having trouble sleeping, poor appetite, difficulty concentrating on your schoolwork, having no energy, feeling anxious about bad things that might happen in the future, low self-confidence, and have little interest doing things you normally love to do, including hanging out with friends. In fact, you no longer contact your friends because they were expressing concern for your well-being. You have been feeling this way for about 6 months and you finally decided to see a therapist/counselor in hopes of finding better ways to cope with your depression.

We would like you to imagine that you and the therapist are near the end of your first session. During this first session, the therapist interviewed you about the depression you are experiencing, your current life circumstances (e.g., school, job, relationships), and your background (e.g., quality of your upbringing, your relationship with your parents growing up, experiences you had in school).

On the next page, you will be asked to read a short passage that occurs at the end of your first session. In this passage, the therapist will explain to you the type of treatment she is recommending, why this treatment will be used, and why this treatment should be effective for you. After you read this passage, you will be asked a series of questions about what you just read.

When finished, your responses will be automatically recorded and you may close your browser.

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

Although your mind tells you to control your anxiety and depression, these emotions just keep getting bigger and more distressing, possibly, because you are trying to control and avoid emotions and thoughts that cannot be controlled or avoided. When you are feeling depressed you want to avoid this feeling by not accepting invitations to social gatherings because you are worrying that other people will not like you. Although avoiding the party does prevent you from feeling anxious, you also may feel like a failure because you've missed an opportunity to connect with others and have fun. The avoidance of interacting with other people leaves you feeling depressed and like a failure.

Let's consider an example: I would like you to imagine you are at a party that you are hosting and all of your guests have arrived. The doorbell rings and it is someone you did not invite who you dislike. This person comes in and starts helping themselves to your party. You ask the person to leave and escort them out the door. As your friends and guests are having fun in the other room at the party, you are staying by the door to make sure that party crasher does not come back. While you are guarding the door, you hear everyone having fun at your party and begin wishing you could be there too. After thinking about whether it would be worse to have that party crasher come in or to miss your party entirely, you decide that going to the party is more important. A few minutes later, the party crasher comes back and you are talking with your friends. Instead of having the party crasher leave and interrupting the good time you are having with your friends, you choose to let them be. In this scenario, the unwanted guest is your anxiety and depression and the point of this example is to show you how you can work harder to avoid these difficult feelings or you could learn how to work with them.

Now let's examine an example that you told me about earlier in our session. You described to me that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious that

he might be upset with you although you have no evidence he is actually upset with you. You are having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because you fear the interaction will go badly. I wonder if we can find ways to have those emotions and still do things that move you closer to achieving value based living such as improving relationships.

I understand that you might be tired of feeling anxious and depressed and that it is too difficult to carry these emotions. Wanting to control or get rid of negative emotions is very natural. The fact that you are fed up with your anxiety and sadness is our biggest ally right now. It is important to acknowledge that your mind is not ready to let go of the agenda of controlling or getting rid of these negative emotions - it is wired to think this way. The dilemma is that we need to let go of an agenda that your mind has no idea how to let go of and teach it a new way of functioning.

One of the most important parts of this treatment is getting a better understanding of who you are and what you stand for as a person – in other words, what are your values. Your values will dictate and guide everything we do in therapy. We will never do something here that does not align with your core values. To get this process started, I would like you to complete some homework that will ask you to specify your values and goals in different areas of your life (see the form below). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy.

<p>LOVE (deepest, most meaningful relationships – including children, partner, parents, close friends and relatives)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>WORK (paid work, studying/ education/ apprenticeships, and unpaid work such as volunteering, or domestic duties)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>
<p>PLAY (rest and relaxation, hobbies, creativity, sport, and all forms of leisure, recreation and entertainment)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>HEALTH (physical, psychological, emotional, or spiritual health and wellbeing.)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>

Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

The focus of this therapy is to help people learn to accept negative thoughts and feelings in order to live a more satisfying life.

- True
 False

This therapy does not require a client to complete homework.

- True
 False

The description of why this therapy should work was clear and understandable.

- Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
-

I liked the description of why this therapy should work.

- Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
-

The reasons for doing the homework were clear to me.

- Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
-

Given the description of this treatment that I just read, if I was the person from the vignette I would want to continue seeing Dr. Happy to receive this therapy.

- Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree
-

This is enough information to decide about treatment.

Strongly agree

Somewhat agree

Neither agree nor
disagree

Somewhat disagree

Strongly disagree

List and or describe 2 things you most liked or agreed with in the vignette.

#1

#2

List and or describe 2 things you least liked or disagreed with in the vignette.

#1

#2

List any questions you would want to ask Dr. Happy before deciding to start treatment that was described to you.

What is your major?

How many semesters of college have you completed (you may include this semester)?

How many psychology credits have you completed (you may include the current semester)?

0 to 4

4 to 8

8 to 12

12 to 16

16+

Have you ever been to counseling or therapy?

- Yes
 No

Block 3

Thank you for participating in this survey. Your response has been recorded and you may now close your browser. Please contact Marin Olson if you have any questions or concerns at marin.olson@mnsu.edu or 1(507)-389-2724.

Appendix F

Survey Phase Two – Layperson Review – CBT

Informed Consent for Participation in the Research

Title: The title of this research study is, “Comparing the Acceptability of Treatment Rationales for Two Psychotherapies.”

Investigators

This study is conducted by Marin Olson under the guidance of Dr. Jeffrey Buchanan of Minnesota State University, Mankato’s Psychology Department.

Purpose

The purpose of this research study is to see if college students prefer cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT) when provided treatment rationale.

Participants

I have been asked to participate because I am 18 years or older.

Procedure

A vignette will be provided via an online Qualtrics survey that depicts a therapist explaining the treatment rationale for either CBT or ACT to a client. You will be asked some demographics questions, read the vignette, and answer

some questions about your response to the vignette. It is estimated that your participation will take about 15 minutes. The study will end when all the questions are answered and you may close your browser.

Risks

The risks associated with this study are no more than experienced in normal daily life. The experimenters encourage you to use a secure internet connection, and to participate in the study where you would have privacy where only you can view your computer screen. You may choose not to answer any of the survey questions or end your participation at any time by exiting the survey.

Benefits

Results of the study will provide information about how understandable and acceptable treatment rationales are for two forms of psychotherapy.

Confidentiality

The findings of this study will be completely confidential. Confidentiality will be protected in that your name will not be included on any records. All information collected during this study will be used for research purposes only and will only be accessible to the principal investigator, Dr. Jeffrey Buchanan, the student investigator Marin Olson. If you would like more information about the specific privacy and anonymity risks posed by online surveys, please contact the Minnesota State University, Mankato IT Solutions Center (507-389-6654) and ask to speak to the Information Security Manager.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may choose not to answer any of the survey questions or you may end your participation at any time by closing the web browser. The decision whether or not to participate will not affect your relationship with Minnesota State University, Mankato and refusal to participate will involve no penalty or loss of benefits.

Questions

If you have any questions, you are free to ask them. If you have any additional questions, you may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Marin Olson at (507) 389-2724 and marin.olson@mnsu.edu. If you have questions about participants' rights and for research-related injuries, please contact the Administrator of the Institutional Review Board at (507) 389-1242.

Closing Statement

Submitting the completed survey will indicate your informed consent to participate and indicate your assurance that you are at least 18 years of age.

Please print a copy of this consent form for your records.

Minnesota State University, Mankato IRBNet LOG # 1598327

Do you consent to participate in this study?

Yes

No

What gender do you identify as?

Male

Female

Other

I prefer not to respond

What ethnicity do you identify as?

Caucasian

African American

Native American/First Nations

Hispanic

Asian

Other

I prefer not to respond

What is your age in years?

We would now like you to imagine that you are seeking counseling/psychotherapy because you are depressed and anxious. More specifically, you have been experiencing the following symptoms: feeling sad/down, having trouble sleeping, poor appetite, difficulty concentrating on your schoolwork, having no energy, feeling anxious about bad things that might happen in the future, low self-confidence, and have little interest doing things you normally love to do, including hanging out with friends. In fact, you no longer contact your friends because they were expressing concern for your well-being. You have been feeling this way for about 6 months and you finally decided to see a therapist/counselor in hopes of finding better ways to cope with your depression.

We would like you to imagine that you and the therapist are near the end of your first session. During this first session, the therapist interviewed you about the depression you are experiencing, your current life circumstances (e.g., school, job, relationships), and your background (e.g., quality of your upbringing, your relationship with your parents growing up, experiences you had in school).

On the next page, you will be asked to read a short passage that occurs at the end of your first session. In this passage, the therapist will explain to you the type of treatment she is recommending, why this treatment will be used, and why this treatment should be effective for you. After you read this passage, you will be asked a series of questions about what you just read.

When finished, your responses will be automatically recorded and you may close your browser.

Block 1

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

In therapy, it is important to understand your emotions, behaviors, and thoughts, as well as how environmental situations trigger these reactions. Also, situations, emotions, behaviors, and thought all can affect each other (see the figure below).



Of all these factors on the diagram, I have found that therapy is most helpful when we try to change people's thinking. I tend to believe it is not what happens to us that makes us upset, but it is how we think about and interpret these situations that makes us depressed or anxious. There is a quote by a Greek philosopher that perhaps explains it better, "People are not disturbed by the events that happen to them, but by their view of these events."

The situations you have described to me are certainly stressful and upsetting, but the way that you interpret these situations is very important in determining why you feel the way you do.

You have told me about some of the thoughts that frequently run through your head, but it would be helpful for us to start learning more about the kinds of thoughts you commonly have about yourself, the things that happen to you, and your future. These thoughts or worries can be quite natural responses to what you have experienced, but they can also be negative, exaggerated, inaccurate, and generally unhelpful. I think that these thoughts may be the reason you feel depressed and anxious and that they hold you back from doing important things such as completing schoolwork or being with the people you care about. Therefore, I think it is very important to understand what it is going on in your head when you feel [MO3] anxious or depressed. In order to help us identify what you are thinking, it is very helpful if you complete some homework between sessions. This homework will involve you writing down your negative thoughts, what was happening around you when you felt this way (i.e., the events), your emotional responses to the situation, and what you did in the situation (i.e., your behavior). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy. The figure below shows an example of the kind of homework I'll be asking you to complete.

Thought Log

Event	Thought	Consequence / Behavior	Rational Counterstatement
Example: Supervisor at work is angry.	"I must have made a mistake—now I've done it. They'll fire for me sure."	<ul style="list-style-type: none"> • Feeling of sadness and anxiety • Spend time obsessing over mistakes 	"My supervisor could've been angry about anything. They are usually happy with my work, so even if I've made a mistake it isn't a big deal."

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Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

<p>The focus of this therapy is to help people learn to accept negative thoughts and feelings in order to live a more satisfying life.</p> <p><input type="radio"/> True</p> <p><input type="radio"/> False</p>
<p>This therapy does not require a client to complete homework.</p> <p><input type="radio"/> True</p> <p><input type="radio"/> False</p>
<p>The description of why this therapy should work was clear and understandable.</p> <p>Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>
<p>I liked the description of why this therapy should work.</p> <p>Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>
<p>The reasons for doing the homework were clear to me.</p> <p>Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>
<p>Given the description of this treatment that I just read, if I was the person from the vignette I would want to continue seeing Dr. Happy to receive this therapy.</p> <p>Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>
<p>This is enough information to decide about treatment.</p> <p>Strongly agree Somewhat agree Neither agree nor disagree Somewhat disagree Strongly disagree</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>

List and/or describe 2 things you most liked or agreed with in the vignette.

#1

#2

List and/or describe 2 things you least liked or disagreed with in the vignette.

#1

#2

List any questions you would want to ask Dr. Happy before deciding to start treatment that was described to you.

Block 5

What is your major?

How many semesters of college have you completed (you may include this semester)?

How many psychology credits have you completed (you may include the current semester)?

- 0 to 4
- 4 to 8
- 8 to 12
- 12 to 16
- 16+

Have you ever been to counseling or therapy?

- Yes
- No

Thank you for participating in this survey. Your response has been recorded and you may now close your browser.
Please contact Marin Olson if you have any questions or concerns at marin.olson@mnsu.edu or 1(507)-389-2724.

Appendix G

Original ACT Vignette

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

Although your mind tells you to control your anxiety and depression, these emotions just keep getting bigger and more distressing, possibly, because you are trying to control and avoid emotions and thoughts that cannot be controlled or avoided. When you are feeling depressed you want to avoid this feeling by not accepting invitations to social gatherings because you are worrying that other people will not like you. Although avoiding the party does prevent you from feeling anxious, you also may feel like a failure because you've missed an opportunity to connect with others and have fun. The avoidance of interacting with other people leaves you feeling depressed and like a failure.

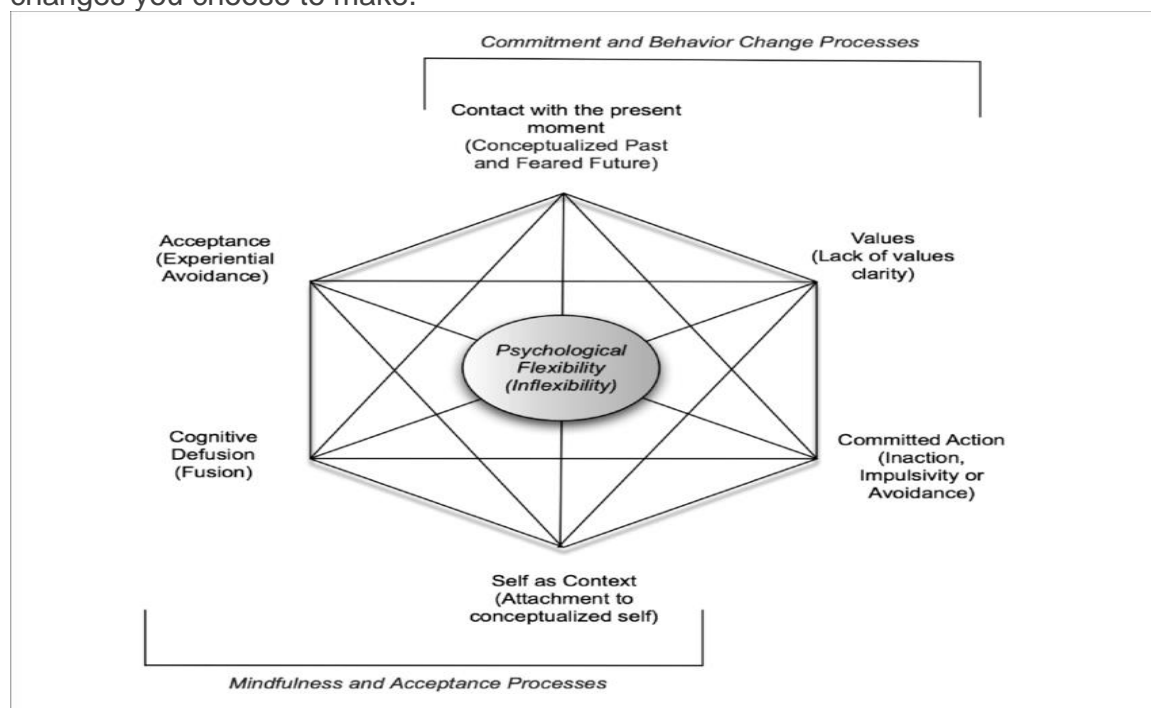
Let's consider an example: I would like you to imagine you are lying in quicksand. It is natural in this situation to struggle and try to push yourself out. The problem is that this strategy will only make you sink deeper into the quicksand. What you need to do instead, is to lie on your back and have as much of your body as possible make contact with the quicksand. By doing this, you remain on the surface of the quicksand and do not sink. In other words, to survive quicksand, you need to stop struggling and fighting and, instead, make contact with it even though it is the "enemy." As this applies to you, perhaps we need to learn how stop struggling and fighting negative emotions and thoughts (similar to the quicksand), and instead, learn ways to contact the distress and uncomfortable feelings, while still living the life you wish to live. In other words, perhaps deliberate attempts to control negative emotions and thoughts is part of the problem and actually not the solution.

Now let's examine an example that you told me about earlier in our session. You described to me was that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious that he might be upset with you although you have no evidence he is actually upset with you. You are having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because you fear the interaction will go badly. I wonder if we can find ways to have those emotions and still do things that move you closer to achieving goals such as improving relationships.

I understand that you might be tired of feeling anxious and depressed and that it is too difficult to have these emotions. Wanting to control or get rid of negative

emotions is very natural. The fact that you are fed up with your anxiety and sadness is actually our biggest ally right now. It is important to acknowledge that your mind is not ready to let go of the agenda of controlling or getting rid of these negative emotions - it is wired to think this way. The dilemma is that we need to let go of an agenda that your mind has no idea how to let go of.

Let me explain a little more (see diagram below). There are six processes that are targeted in this therapy and I'll give a brief explanation of each of these concepts. Acceptance involves embracing thoughts, feelings, and bodily sensations without trying to get rid of them. Diffusion, involves learning to view thoughts as thoughts and not as true reflections of reality. Self as a context includes things like being aware of yourself, how you think about yourself, and the ways you describe yourself. Contact with the present moment is to experience thoughts feelings and bodily sensations as they occur in any given moment. Values work will involve identifying what is really important to you and will help guide what specific behavior changes you choose to make.



Speaking of values, one of the most important parts of this treatment is getting a better understanding of who you are and what you stand for as a person – in other words, what are your values. Your values will dictate and guide everything we do in therapy. We will never do something here that does not align with your core values. To get this process started, I would like you to complete some homework that will ask you to specify your values and goals in different areas of your life (see the form below). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy.

<p>LOVE (deepest, most meaningful relationships – including children, partner, parents, close friends and relatives)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>WORK (paid work, studying/ education/ apprenticeships, and unpaid work such as volunteering, or domestic duties)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>
<p>PLAY (rest and relaxation, hobbies, creativity, sport, and all forms of leisure, recreation and entertainment)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>HEALTH (physical, psychological, emotional, or spiritual health and wellbeing.)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>

Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

Appendix H

Revised ACT Vignette

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

Although your mind tells you to control your anxiety and depression, these emotions just keep getting bigger and more distressing, possibly, because you are trying to control and avoid emotions and thoughts that cannot be controlled or avoided. When you are feeling depressed you want to avoid this feeling by not accepting invitations to social gatherings because you are worrying that other people will not like you. Although avoiding the party does prevent you from feeling anxious, you also may feel like a failure because you've missed an opportunity to connect with others and have fun. The avoidance of interacting with other people leaves you feeling depressed and like a failure.

Let's consider an example: I would like you to imagine you are at a party that you are hosting and all of your guests have arrived. The doorbell rings and it is someone you did not invite who you dislike. This person comes in and starts helping themselves to your party. You ask the person to leave and escort them out the door. As your friends and guests are having fun in the other room at the party, you are staying by the door to make sure that party crasher does not come back. While you are guarding the door, you hear everyone having fun at your party and begin wishing you could be there too. After thinking about whether it would be worse to have that party crasher come in or to miss your party entirely, you decide that going to the party is more important. A few minutes later, the party crasher comes back and you are talking with your friends. Instead of having the party crasher leave and interrupting the good time you are having with your friends, you choose to let them be. In this scenario, the unwanted guest is your anxiety and depression and the point of this example is to show you how you can work harder to avoid these difficult feelings or you could learn how to work with them.

Now let's examine an example that you told me about earlier in our session. You described to me was that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious that he might be upset with you although you have no evidence he is actually upset with you. You are having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because

you fear the interaction will go badly. I wonder if we can find ways to have those emotions and still do things that move you closer to achieving value based living such as improving relationships.

I understand that you might be tired of feeling anxious and depressed and that it is too difficult to carry these emotions. Wanting to control or get rid of negative emotions is very natural. The fact that you are fed up with your anxiety and sadness is our biggest ally right now. It is important to acknowledge that your mind is not ready to let go of the agenda of controlling or getting rid of these negative emotions - it is wired to think this way. The dilemma is that we need to let go of an agenda that your mind has no idea how to let go of and teach it a new way of functioning.

One of the most important parts of this treatment is getting a better understanding of who you are and what you stand for as a person – in other words, what are your values. Your values will dictate and guide everything we do in therapy. We will never do something here that does not align with your core values. To get this process started, I would like you to complete some homework that will ask you to specify your values and goals in different areas of your life (see the form below). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy.

<p>LOVE (deepest, most meaningful relationships – including children, partner, parents, close friends and relatives)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>WORK (paid work, studying/ education/ apprenticeships, and unpaid work such as volunteering, or domestic duties)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>
<p>PLAY (rest and relaxation, hobbies, creativity, sport, and all forms of leisure, recreation and entertainment)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>	<p>HEALTH (physical, psychological, emotional, or spiritual health and wellbeing.)</p> <p>My Values:</p> <p>Short Term Goals:</p> <p>Medium Term Goals:</p> <p>Long Term Goals :</p>

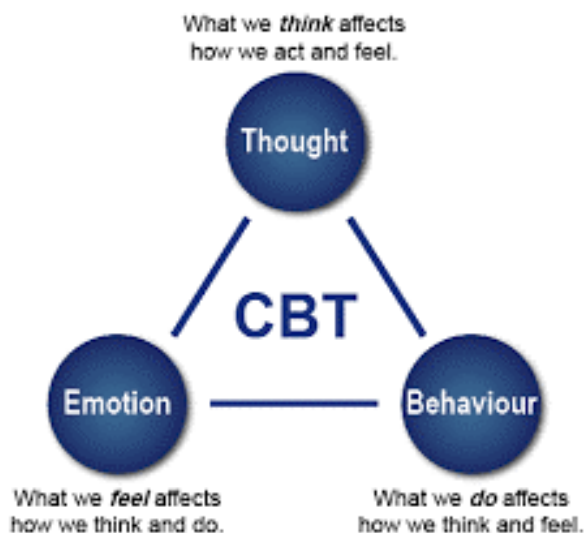
Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

Appendix I

Original CBT Vignette

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

In therapy, it is important to understand your emotions, behaviors, and thoughts, as well as how environmental situations trigger these reactions. Also, situations, emotions, behaviors, and thought all can affect each other (see the figure below).



Of all these factors on the diagram, I have found that therapy is most helpful when we try to change people's thinking. I tend to believe it is not what happens to us that makes us upset, but it is how we think about and interpret these situations that makes us depressed or anxious. There is a quote by a Greek philosopher that perhaps explains it better, "People are not disturbed by the events that happen to them, but by their view of these events." The situations you have described to me are certainly stressful and upsetting, but the way that you interpret these situations is very important in determining why you feel the way you do.

You have told me about some of the thoughts that frequently run through your head, but it would be helpful for us to start learning more about the kinds of thoughts you commonly have about yourself, the things that happen to you, and your future. My guess is that many of these thoughts are negative, exaggerated, inaccurate, and

generally unhelpful. I also suspect that all of these thoughts may be the reason you feel depressed and anxious and that they hold you back from doing important things such as completing schoolwork or being with the people you care about. Therefore, I think it is very important to understand what it is going on in your head when you become anxious or depressed. In order to help us identify what you are thinking, it is very helpful if you complete some homework between sessions. This homework will involve you writing down your negative thoughts, what was happening around you when you felt this way (i.e., the events), your emotional responses to the situation, and what you did in the situation (i.e., your behavior). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy. The figure below shows an example of the kind of homework I'll be asking you to complete.

Thought Log

Event	Thought	Consequence / Behavior	Rational Counterstatement
Example: Supervisor at work is angry.	"I must have made a mistake—now I've done it. They'll fire for me sure."	<ul style="list-style-type: none"> • Feeling of sadness and anxiety • Spend time obsessing over mistakes 	"My supervisor could've been angry about anything. They are usually happy with my work, so even if I've made a mistake it isn't a big deal."

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Once we have an idea of what negative thoughts you experience, I will begin to challenge some of your unhelpful thinking patterns. We will then work to help you replace the negative thoughts with ones that are more accurate, adaptive, and useful. This process of identifying, challenging, and replacing thoughts should lead you to feeling less depressed and anxious. I hope that over time, you will be able to use the skills of challenging and replacing your negative thinking patterns on your own - this is when we know we will be done.

Let's examine an example that you told me about earlier in our session. You described to me that your brother went on a trip without you and you felt depressed because he did not include you, so you felt anxious that he might be upset with you although you have no evidence he is actually upset with you. You are

having thoughts of being lonely, abandoned or rejected, and these thoughts lead you to feeling depressed and anxious. You then avoid talking to your brother because you fear the interaction will go badly. If we can look at ways to change your thoughts and perception of this event, it may lead to you feeling and acting differently in future situations.

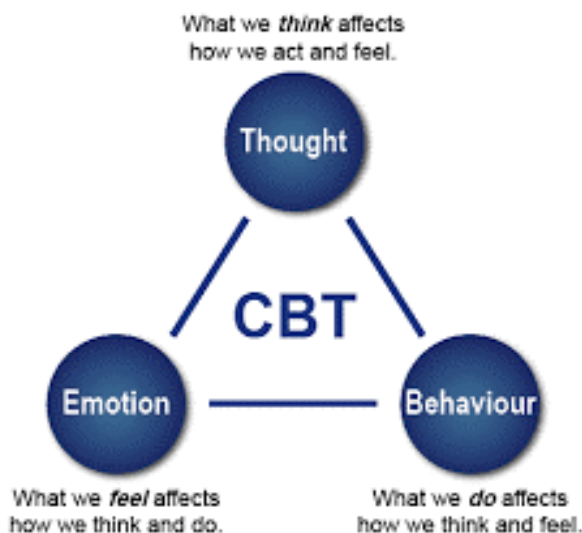
Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.

Appendix J

Revised CBT Vignette

Dr. Happy: You've given me a lot of information over the past 45 minutes and I appreciate you being so willing to answer all of my questions. It seems like your main concerns are feeling depressed, having little interest in doing almost anything, and feeling like a failure. You also talked about having a lot of anxiety about whether other people like you, if you can complete college, if you will get a job you enjoy, or if you will ever have a meaningful relationship. This is certainly a lot to deal with. Now I would like to spend some time talking about the kind of treatment I do with clients who have problems similar to yours. I also want to explain why I think this kind of treatment is appropriate for you.

In therapy, it is important to understand your emotions, behaviors, and thoughts, as well as how environmental situations trigger these reactions. Also, situations, emotions, behaviors, and thought all can affect each other (see the figure below).



Of all these factors on the diagram, I have found that therapy is most helpful when we try to change people's thinking. I tend to believe it is not what happens to us that makes us upset, but it is how we think about and interpret these situations that makes us depressed or anxious. There is a quote by a Greek philosopher that perhaps explains it better, "People are not disturbed by the events that happen to them, but by their view of these events." The situations you have described to me are certainly stressful and upsetting, but the way that you interpret these situations is very important in determining why you feel the way you do.

You have told me about some of the thoughts that frequently run through your head, but it would be helpful for us to start learning more about the kinds of thoughts you commonly have about yourself, the things that happen to you, and your future. These thoughts or worries can be quite natural responses to what you have

experienced, but they can also be negative, exaggerated, inaccurate, and generally unhelpful. I think that these thoughts may be the reason you feel depressed and anxious and that they hold you back from doing important things such as completing schoolwork or being with the people you care about. Therefore, I think it is very important to understand what it is going on in your head when you feel[MO3] anxious or depressed. In order to help us identify what you are thinking, it is very helpful if you complete some homework between sessions. This homework will involve you writing down your negative thoughts, what was happening around you when you felt this way (i.e., the events), your emotional responses to the situation, and what you did in the situation (i.e., your behavior). This homework is an essential ingredient in therapy and people who consistently complete homework tend to benefit more from therapy. The figure below shows an example of the kind of homework I'll be asking you to complete.

Thought Log

Event	Thought	Consequence / Behavior	Rational Counterstatement
Example: Supervisor at work is angry.	"I must have made a mistake—now I've done it. They'll fire for me sure."	<ul style="list-style-type: none"> • Feeling of sadness and anxiety • Spend time obsessing over mistakes 	"My supervisor could've been angry about anything. They are usually happy with my work, so even if I've made a mistake it isn't a big deal."

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Hopefully, this explanation makes sense and gives you an idea of what treatment will look like and what we hope to accomplish in therapy. I want to now ask you some questions about what I have just explained to you.