In-session acceptance and cognitive defusion

Clients’ in-session acceptance and cognitive defusion behaviors in acceptance-based treatment of tinnitus distress

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Abstract

Cognitive-behavioral treatment (CBT) is considered to be an effective treatment of distress associated with tinnitus (perception of internal noises without any outer auditory stimulation), but the processes by which the therapy works remain unclear. Mindfulness and acceptance is receiving increased attention in the treatment literature for chronic medical conditions. However, few studies have examined these and related processes with behavioral or observer measures. In the present study 57 videotapes (a total of 1710 min) from 19 clients who participated in a controlled trial of an acceptance-based treatment for tinnitus distress, were coded for frequency and peak level of verbal behaviors expressing either acceptance or cognitive defusion. Frequency of cognitive defusion behaviors and peak level of cognitive defusion as well as peak level of acceptance rated in Session 2, predicted symptom reduction 6 month following treatment. These relationships were not accounted for by the improvement that had occurred prior to the measurement point of the process variables. Moreover, prior symptom changes could not predict process variables rated later in therapy (after most of the improvement in therapy had occurred). Thus, clients’ in-session acceptance and cognitive defusion behaviors appear to play an important role in the reduction of negative impact of tinnitus.

Keywords: Tinnitus, Acceptance, Defusion, Process, Tinnitus distress, In-session behavior
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Introduction

Tinnitus is an auditory perceptual phenomenon, commonly defined as the conscious perception of internal noises without any outer auditory stimulation. The sounds may be very loud and bizarre and are often heard like a high pitched musical tone, or a rushing sound like escaping steam, or air (Andersson, Baguley, McKenna, & McFerran, 2005). Chronic tinnitus is a common condition affecting about one in ten of the adult population (Andersson et al., 2005). For the majority it is not a major health issue, but for between 0.5% and 3% of the adult general population tinnitus can have substantial negative impact on mood, sleep, concentration, and daily functioning (Davis & El Rafie, 2000). The use of cognitive behavior therapy (CBT) for reducing tinnitus distress has been supported by independent meta-analysis and systematic reviews (Andersson & Lyttkens, 1999; Martinez Devesa, Waddell, Perera, & Theodoulou, 2007). Yet, little is known about the particular treatment components that lead to success or about the processes by which the therapy works (Andersson, 2002). This may direct the next generation of research on cognitive and behavioral therapies for tinnitus to focus on the specific processes of treatment.

Recent developments within CBT have focused on methods to increase acceptance of distressing thoughts and other private events to promote successful outcomes (Hayes, 2004). A growing number of studies support that acceptance is associated with less distress across chronic medical conditions (e.g., Greer, 1991; McCracken, 1998), and acceptance-based treatments have demonstrated to be broadly useful for patients with type-2 diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), epilepsy (Lundgren, Dahl, Melin, & Kies, 2006), and chronic pain (McCracken, Vowles, & Eccleston, 2005). Findings from one cross-sectional (Andersson, Kaldo, Strömgren & Ström, 2004) and one longitudinal study (Westin, Hayes, & Andersson, 2005).
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2008), also indicate the positive impact of tinnitus related acceptance on distress associated with the condition. In the present study we investigated potential processes of change in reducing the negative impact of tinnitus during Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999).

ACT is suggested to work through the processes of acceptance and cognitive defusion (Hayes et al., 1999). In other words, the therapy is supposed to teach patients to accept private experiences and to “defuse” or distance themselves from private events by focusing more mindfully to the processes of thinking and feeling. Although studies on ACT are just beginning to emerge, there is growing evidence that the treatment can produce positive outcomes for a variety of different conditions and that these outcomes are partially mediated by the proposed processes of the therapy (see, Hayes, Luoma, Bond, Masuda, & Lillis, 2006, for review).

Unfortunately, acceptance and cognitive defusion have typically been measured either at midpoint or at the end of treatment and by then significant improvement in therapy have often already occurred (e.g., Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Gaudiano & Herbert, 2006; McCracken et al., 2005). This limitation prevents a detailed examination of the temporal relation of process variables and symptom change measures (Feeley, DeRubeis, & Gelfand, 1999). Secondly, the findings that support acceptance and cognitive defusion as important casual agents in ACT rely almost exclusively on self-report measures (e.g., Gregg et al., 2007; Lundgren, Dahl, & Hayes, 2008; McCracken et al., 2005). Given the limitations associated with client self-report in psychotherapy process research (Doss, 2004), behavioral or observer measurers may provide a more demanding assessment of the purported processes by which the therapy works. Previous research has shown that clients’ verbal behaviors in-session are related to treatment outcomes (e.g., Amrhein, William, Tahne, Palmer, & Fulcher, 2003; Tang,
Baberman, DeRubeis, & Pham, 2005), and may hence be an important source of information about the therapeutic process. Therefore, we designed a measure to investigate clients’ in-session verbal behavior to explore the processes of acceptance and cognitive defusion in ACT for severe tinnitus distress. We hypothesized that clients’ behavior rated before the majority of the improvement (averaged for the clients used in the analysis) had occurred in therapy would predict final outcome, even after controlling for earlier improvement that had occurred prior to the measurement point of process variables.

Method

Participants

Clients. Clients and data were collected from the two first inclusions in an ongoing controlled study of ACT for tinnitus distress. There were 24 clients randomly assigned to ACT in the inclusions. To be included in the trial participants needed (a) to have tinnitus as their primary problem (b) to be of ≥18 years old, (c) to receive a score of ≥30 on the Tinnitus Handicap Inventory (THI; Newman, Jacobson & Spitzer, 1996), (d) a duration of tinnitus of ≥ 6 months, (e) not to suffer from a severe psychiatric disorder, and (f) not to have previously received a psychological treatment for tinnitus. For inclusion in the present study clients’ Session 2, Session 4 and Session 6 videotapes also needed to be available, viewable and audible. We did not have access to 5 of the 24 clients required videotapes, leaving 19 clients available for analysis. The 19 clients were between 34 and 72 years old (M = 52.7, SD = 11.2 years). The majority was female (67%) and all were Swedish citizens. Mean duration of tinnitus was 7.4 years (SD = 6.5 years; two could not report how long they had experienced tinnitus). Average hearing loss (pure-tone average calculated for the “better ear” over the frequencies 0.5, 1, 2, and 4 kHz), was 12.8 dB HL (SD = 5.6 dB HL). Regarding occupational status, 41% were
working full-time, 12% part-time, 12% had retired, 23% were on sick leave, 6% unemployed, and 6% were students (two did not report occupational status).

Therapists. Five female and three male therapists participated in the study. Therapists were between 25 and 32 years old ($M = 28.1$, $SD = 2.8$ years). Six therapists were master program students in clinical psychology and two were clinical psychologists. Therapists were monitored through videotapes for adherence to treatment and received ongoing and weekly supervision by two licensed psychologists and psychotherapists who had experience in ACT and supervision.

The medical ethics committee in Linköping, Sweden, approved the protocol as part of the controlled study.

Treatment

The ACT treatment was delivered in individual format using a treatment manual developed according to the ACT treatment principles outlined by Hayes et al. (1999). All participants received a maximum of 10 sessions of ACT and the weekly delivered sessions ranged from 45 to 75 minutes. The average number of treatment sessions was 8.7 ($SD = 1.2$). Treatment consisted of mindfulness and acceptance training to promote goal-directed behaviors in valued life-domains. The mindfulness exercises involved approaching the tinnitus sound and related reactions (i.e., exposure). Other treatment components included evaluating and changing tinnitus related behavioral patterns, working with values and life goals, and psychoeducation regarding tinnitus. In addition, in the later phase treatment addressed other problems related to tinnitus handicap (e.g., insomnia or hearing difficulties).

Measures

Outcome measure. Tinnitus Handicap Inventory (THI) was used as the primary measure of tinnitus problems. THI is a 25-item inventory that is widely used to assess
distress and handicap related to tinnitus (Newman et al., 1996). It has high internal consistency (Baguley & Andersson, 2003), high convergent validity with other measures of tinnitus distress (Baguley, Stoddart, & Hodgson, 2000), and good test-retest reliability (Newman et al., 1996; Newman, Sandridge, & Jacobson, 1998). Patients were given the THI at the intake interview, prior to each therapy session, one week post treatment, and at 6 month post treatment. To be able to investigate the possible effect of early symptom changes on process variables, prior change scores were calculated. The prior change score for a rated session is the difference between the pretreatment THI and the session rated THI. As a measure of final outcome the difference between pretreatment and 6-month follow up THI score was used. Higher residualized scores always reflected better outcome (greater symptom relief).

Process measure. To investigate clients’ acceptance and defusion in-session behavior we designed the Acceptance and Defusion Process Measure (ADPM). The measure was inspired by the Functional Acceptance and Commitment Therapy Scale (FACTS), which has been used to measure therapist adherence to ACT treatment (Forman et al., 2007). Videotapes from a sample of sessions (not included in the further analyses) were analyzed in the development of the measure. The developers were blind to the outcome of the current study at the time when the measure was created.

Raters used videotapes to identify verbal behavior as a defusion or an acceptance statement. Codable verbal behavior was considered to be a complete thought or intent expressed by the client either in an unsolicited manner or in response to therapist behavior (e.g., inquiries, comments, interventions). A defusion behavior was defined as a verbal statement that included the client noticing, labeling and separating self from a private experience (e.g., a thought, feeling), whereas an acceptance statement was defined as a statement where a client expressed emotional willingness, an active
approach of making room for difficult feelings, memories, and physical sensations in order to be able to pursue valued goals. Raters were instructed never to infer an acceptance or a defusion behavior, but instead only to rate the statement explicitly reported by the client. Once a statement was identified and classified, the verbal behavior was given an “extensiveness rating”. The behavior’s extensiveness was rated on a 5-point scale for both acceptance and defusion (1 = a highly diminished statement, 2 = a moderate, somewhat qualified statement, 3 = a straightforward statement, 4 = a statement with some in-depth amplification, 5 = an absolute in-depth statement). A sample of coded clients’ in-session acceptance and defusion behaviors on different extensiveness levels is presented in Table 1. The frequencies of both acceptance and defusion behavior are summed. The highest extensiveness score given to a behavior during a session is used as a peak level for the current session. The frequency and peak level for both defusion and acceptance are used in the analyses.

---Insert Table 1 about here---

Procedures

All study sessions in the ACT condition were videotaped with digital video recorders. The camera was positioned in the room so as to capture both the therapist and the client. Four raters rated all the sessions in the study. Two primary raters were licensed psychologists who had experience of conducting ACT therapy, and two secondary raters were undergraduate master program students in clinical psychology, who had theoretical knowledge about ACT. All the raters received training (approximately 16 hr) with the manual before making the study ratings. Additional meetings after the completion of the training were held to minimize rater drift. A segment of each taped session was burned to a DVD, which was labeled without client or session identity. The middle 30 minutes of each of the sessions were coded. This part
was selected since it typically represented the “working part” of the session. Raters were blind with respect to identity of patient, time of the assessment, and to outcome. Three sessions of ACT were rated for each patient: Session 2 in the beginning, Session 4 in the middle, and Session 6 in the late part of treatment. A total of 57 sessions (1710 min) were coded in the study. The sessions were randomly assigned to raters and each of the raters rated an average of 17 sessions, including the independent sessions used to establish agreement between raters (not included in the further analyses).

Thirteen randomly selected sessions (23%) of all the rated sessions \((n = 57)\) were used to establish interrater reliability in the study. Reliability of the ADPM was calculated after completed rater training. The four raters formed two pairs. The pairs were composed of a primary and a secondary rater. Raters were compared by protocol (time and comment) for the identified verbal behavior rated. Two forms of interrater agreement were then computed: one for intercategory assignments and one for intracategory extensiveness ratings. Interrater reliability for intercategory assignments of defusion and acceptance behavior was calculated using, Cohens’s kappa \((\kappa)\). The combined interrater agreement for the two pairs of raters was \(\kappa = .77, p < .001\) (Pair 1 = .69; Pair 2 = .88). The two-way random model of intraclass correlation (ICC) was computed to assess interrater reliability for intracategory extensiveness ratings (ranging from 1 to 5). The combined ICC single measure coefficient for the two pairs of raters was .78 for acceptance (Pair 1 = .70; Pair 2 = .84), and .81 for defusion (Pair 1 = .62; Pair 2 = .90).

**Results**

The difference in means between pretreatment \((M = 44.2, SD = 14.5)\) and 6-month follow-up \((M = 28.1, SD = 20.9)\) for the primary outcome measure THI was found to be statistically significant, \(t(17) = 4.39, p < .001\), with a within group effect size of
Cohen’s $d = .91$. One case did not complete the 6-month follow-up. The average change of the THI between pretreatment and follow-up at 6 month was 16.2 points ($SD = 15.6$, range = -15–56). The reductions of tinnitus distress appeared to occur rapidly. By Session 4 more than half of the total mean change in THI score had occurred (9.9/16.2) and by Session 6 the mean THI score had dropped 12.0 points (74%) of the 16.2 total decrease. The mean decrease from pretreatment to Session 2 was not statistically significant, but there was a statistically significant difference in means between pretreatment ($M = 45.4$, $SD = 15.0$) and Session 3 ($M = 37.5$, $SD = 20.4$), $t(18) = 2.6$, $p = .02$.

**Acceptance, defusion and long term Outcome**

Means and standard deviations are provided for each process variable across therapy stage in Table 2. Given the rapid response in the present therapy (statistically significant symptom reduction by session 3), and the a priori concern that the early improvement could contaminate the potential relationships between later rated process variables and outcome, early processes rated in Session 2 were analyzed as predictors of final outcome (decreases in symptom distress between pretreatment and 6-month post treatment). In all cases, correlations are positive when higher ratings on a process measure are associated with greater symptom reduction.

Both frequency and peak level of defusion rated in Session 2 had a positive significant relationship with long term outcome ($r = .62$, $p = .006$, and $r = .50$, $p = .03$, respectively). In addition, a significant positive relationship between peak level of acceptance in Session 2 and outcome was found ($r = .51$, $p = .03$). The relationship between frequency of acceptance behavior and outcome was not statistically significant ($r = .19$, $p = .46$).

--Insert Table 2 about here--
Effect of process on outcome controlling for earlier outcomes

Although no significant improvement in outcomes were seen by Session 2, an additional analytic step was taken to ensure that clients’ prior improvement in treatment could not be responsible for the relationships seen between in-session acceptance and defusion and later outcomes. A series of hierarchical regression analyses were conducted in which the Session 2 THI score was entered in step 1 as a predictor of pre to follow-up outcome changes. In the second step, the process variable rated in Session 2 was added to the model. Thus, the effect of the process predictor was examined only after controlling for outcomes as measured by the Session 2 THI score. This analysis was repeated separately for all process variables.

In the second and final step, frequency of defusion behavior remained a significant predictor of long term outcome, $\beta = .63$, $t(15) = 3.9$, $p = .001$, independently contributing with 40%, over and above the contribution by Session 2 THI score, $-\beta = .47$, $t(15) = 2.9$, $p = .01$, with a significant final model, $F(2, 15) = 11.5$, $R^2 = .60$, $p = .001$. Peak level of cognitive defusion also remained a significant predictor, $\beta = .48$, $t(15) = 2.5$, $p = .03$, contributing independently with 23% of the variance above the contribution by Session 2 THI score, $-\beta = .43$, $t(15) = 2.2$, $p = .04$, with a significant final model, $F(2, 15) = 5.8$, $R^2 = .44$, $p = .01$. Similarly, peak level of acceptance remained a significant predictor of long term outcome, $\beta = .45$, $t(15) = 2.2$, $p = .04$, contributing with 20% of unique variance over and above Session 2 THI score, $-\beta = .38$, $t(15) = 2.2$, $p = .08$, with a significant final model, $F(2, 15) = 5.0$, $R^2 = .40$, $p = .02$. Consistent with the previous correlation analyses, frequency of acceptance behavior did not yield a significant positive effect, $\beta = .17$, $t(15) = .76$, $p = .46$, controlling for the contribution by Session 2 THI score, $-\beta = .44$, $t(15) = 1.9$, $p = .07$, in the final model, $F(2, 15) = 2.3$, $R^2 = .23$, $p = .14$. 
To control for the possible confound that early rated process variables were functions of clients’ initial levels of symptom severity, we also computed zero-order correlations between process variables rated in Session 2 and clients’ pretreatment scores on THI. None of the correlations were significant (all $p’s > .08$; mean $r = .17$; range $r = -.01$ to $.40$).

**Prediction of process variables from prior symptom change**

Given that more than half of the mean change in THI score had occurred by Session 4, we explored whether prior symptom change could predict process variables rated later in therapy. All correlations between prior symptom change and process variables rated in Session 4 and Session 6 were small or negative (mean $r = -.11$; range $r = -.34$ to $.05$), and none were statistically significant (all $p’s > .1$), except that between frequency of acceptance behavior rated in Session 6 and symptom change that had occurred prior to the rated session. This correlation was negative however ($r = -.48$, $p = .04$), indicating that clients who reported greater gains before the rated session, expressed less frequently acceptance behaviors in Session 6. This suggests the possibility that some early outcomes changes might have occurred through suppressive processes, or that early improvement might have lead to re-emergence of a lack of acceptance. However, it does not suggest that the predictive relationships between in-session processes and long term outcomes were due to the impact of outcome on these processes.

**Discussion**

The objective of this investigation was to examine how acceptance and cognitive defusion expressed by clients’ in-session relate to improvement during ACT for tinnitus distress. Both in-session acceptance and defusion rated early in therapy emerged as predictors of sustained positive treatment effects of ACT, even when the symptom
improvement that had occurred prior to the measurement point of the process variables were taken into account statistically. Furthermore, prior symptom change could not predict process variables rated later in therapy (after most of the improvement had occurred). As this is probably the first study to measure the processes of acceptance and cognitive defusion with in-session verbal behaviors, these results are informative in a number of ways. First, the fact that acceptance and defusion behaviors exist with some frequency and depth in ACT and can be measured in a reliable way is an important finding in itself. Secondly, and more importantly, our findings provide preliminary evidence suggesting that clients’ in-session behaviors are causally related antecedents of outcome, rather than mere results of symptom relief. These results call for continued investigation of therapy process variables using observable behavior from video ratings.

Recently, acceptance and mindfulness have received increasing attention in psychotherapy, including in the treatment of chronic medical conditions. Acceptance- and mindfulness-based treatment approaches have showed preliminary positive outcomes for a variety of conditions, such as chronic pain (McCracken et al., 2005), epilepsy (Lundgren et al., 2006), and cancer (Speca, Carlson, Gooden, & Angen, 2000). An acceptance- and mindfulness-based approach to human suffering include being aware and notice thoughts and feelings and embrace their presence rather than changing or controlling them. Indeed, in the present study when the client expressed a high degree of willingness to experience difficult thoughts, emotions and physical sensations or used a high amount of verbal behaviors that expressed the ability to observe and disengage oneself from private experiences in-session, a better outcome following ACT was achieved. As such, the primary findings are in line with the growing number of studies demonstrating that both mindfulness and acceptance are negatively associated with physical symptom complaints (Brown & Ryan, 2003; Chawla & Ostafin, 2007).
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Still, our study leaves a crucial question unanswered: If clients’ in-session rated defusion and acceptance is related to outcome in therapy, what leads to acceptance and cognitive defusion behavior? Given the limitations associated with correlational data, it is of course possible that third, unidentified variables account for the relationships that emerged between the process variables and the outcome. When the effects of process variables are found as early as in Session 2, one may wonder whether defusion and acceptance behavior reflect pretreatment patient characteristics, rather than specific skills learned in therapy. Obviously, this limitation precludes firm conclusions regarding the role of therapist behaviors and the specific treatment content. However, acceptance and defusion may still be important factors explaining a significant amount of variance in the outcome. The usefulness of acceptance and cognitive defusion strategies to reduce distress and negative impact on adaptive behavior has been shown in experimental analog studies (e.g., Keogh, Bond, Hanmer, & Tilston, 2005; Masuda, Hayes, Sackett, & Twohig, 2004). Furthermore, the observation that ACT has been found to be useful even when presented in very brief form may be part of the story (e.g., Gaudiano & Herbert, 2006; Gregg, et al., 2007). For example, Gregg et al. (2007), showed that approximately 4 hours of ACT could be beneficial for patients suffering from type-2 diabetes and that the outcome was partly mediated by the proposed change mechanism. Yet, to address this vital issue, future research will need to look to ways to measure acceptance and defusion behaviors pretreatment and examine how therapist behaviors and treatment content relate to client behaviors. The effects of ACT overall are also far from established (Öst, 2008), but process research forms a vital part of the further development of ACT as a form of psychological treatment. In particular this research is needed to distinguish special features of ACT in relation to CBT in general (Hofmann & Asmundson, 2008).
Contrary to predictions, frequency of acceptance behavior was not significantly related to the outcome. Thus, our findings suggest that the depth of specific acceptance statements may more successfully predict outcomes and accordingly more accurately mark clients’ in-session level of willingness to experience distressing internal events than the mere frequency of such behaviors. This correspond with previous studies exploring clients’ language talk in other psychological treatments, showing that strength or depth of specific language episodes during treatment is more strongly related to psychotherapeutic change than the frequency of these events (e.g., Amrhein et al., 2003; Pos, Greenberg, Goldman, & Korman, 2003). Behaviors that topographically look like acceptance statements may not functionally represent acceptance as has been described in the literature (e.g., Hayes et al., 1999). Our findings may guide future research to explore different forms of acceptance in relation to psychotherapy outcomes. In addition, investigating how in-session behavioral measures are associated with self-report measures of acceptance and related phenomena would be a valuable contribution to empirical literature examining ACT related processes.

This study provides preliminary evidence suggesting that clients’ acceptance and defusion behavior in-session are two dimensions worth attending to in psychotherapy process research or at least in the specific case of ACT. However, several limitations need to be recognized. The sample consisted of distressed tinnitus patients and was relatively small and homogenous, most noteworthy with regard to ethnicity and race. This may restrict the generalizability of our results and further empirical investigations would be useful, especially by extending the research to other populations than tinnitus patients (e.g., patients with other chronic conditions, such as chronic pain or diabetes). The middle 30 minutes of each session was selected for ratings because the middle portion was assumed to represent the working part of the session. However, a longer
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segment of the session may have provided a better representation of clients’ performance of acceptance and defusion in each session. Although this study provided some evidence that in-session rated acceptance and defusion behaviors are related to outcome in ACT, the design of the study did not allow to test if the effects obtained are unique to this form of therapy. Further research may address the extent to which these processes generalize to other psychotherapies. Future ACT process research may also benefit from collecting longitudinal data with frequent repeated assessments of outcomes and processes over the course of treatment and follow-up, and analyzing it in a way that will allow a detailed examination of the relations of process variables and symptom change. Several advanced statistical methods are now available for assessing trajectories over multiple time points of assessment that may facilitate the study of change processes in psychotherapy (Laurenceau, Hayes, & Feldman, 2007). Finally, we encourage researches to continue to explore acceptance and cognitive defusion with behavioral or observer measures. Within a growing literature on acceptance- and mindfulness-based treatment approaches, such research efforts have the promise of clarifying the active ingredients in psychotherapy and in a direct and potent way assist in the development of therapeutic procedures for chronic medical conditions.

Acknowledgement

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References


outcome in comparison to a waiting phase. *Behaviour Research and Therapy, 43*, 1335–1346.


Table 1  

*Sample coded acceptance and defusion behavior on different extensiveness levels*  

<table>
<thead>
<tr>
<th>Extensiveness</th>
<th>Category</th>
<th>value</th>
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</table>

**Defusion**

- "I can hear my tinnitus right now"a
- "They (thoughts) trick me sometimes”  
- "I can see them (thoughts)"
- "I had that thought again”
- "It’s *only* a thought”
- "The thoughts passed by me, I didn’t get hooked ”

**Acceptance**

- "I can’t do anything to change it"a
- "I need to learn how to live with it”
- "I believe I can accept it”
- "I can let it be there (tinnitus)”
- "I’m *willing* to experience that”
- "I was in charge, they (thoughts) were just passengers”

*Note. a = this statement was used as an anchor for the coders and was not rated*
Table 2

*Means and standard deviations of process variables across therapy stage*

<table>
<thead>
<tr>
<th>Process variable</th>
<th>Session 2</th>
<th>Session 4</th>
<th>Session 6</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Defusion Frequency</td>
<td>2.11</td>
<td>1.79</td>
<td>3.32</td>
</tr>
<tr>
<td>Peak level (1-5)</td>
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<td>1.51</td>
<td>1.58</td>
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<td>Acceptance Frequency</td>
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<td>.75</td>
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<tr>
<td>Peak level (1-5)</td>
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<td>1.55</td>
<td>2.47</td>
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*Note. N = 19.*