Differential Response to a Dysphoric Mood Induction Procedure
as a Function of Level of Experiential Avoidance

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Abstract

Participants reporting high versus low levels of experiential avoidance as assessed by the Acceptance and Action Questionnaire (Hayes et al., 2004) were compared in their responsivity to a mood induction procedure and in their subjective reactions to resulting changes in dysphoric mood. Both groups showed equivalent changes in levels of dysphoric mood across phases of the induction procedure. As expected, however, high avoidant participants reported higher levels of subjective distress than their low avoidant counterparts in reaction to increased dysphoric mood. The overall findings are related to those of other similar investigations in suggesting that experiential avoidance may be usefully conceptualized as a functional response class that supports diverse forms and levels of human suffering.
Differential Response to a Dysphoric Mood Induction Procedure as a Function of Level of Experiential Avoidance

In recent years, experiential avoidance has been increasingly identified and implicated as a psychological diathesis that may underlie clinical and subsyndromal forms of human suffering (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance refers to the tendency to attempt to alter the type, length, or occurrence of negative private events (thoughts, feelings, memories, somatic sensations, etc.) and the situations in which they may occur (Blackledge & Hayes, 2001). The putative role of experiential avoidance as a core pathogenic process that may contribute to the development, exacerbation, and maintenance of a variety of forms of human suffering and psychopathology has been central to various theoretical approaches within clinical psychology, including the psychoanalytic, client-centered, Gestalt, and existential traditions (Hayes et al., 1996). By contrast, until fairly recently the primary focus within the behavioral and cognitive therapy traditions has been on changing and managing unpleasant private events (Hayes et al., 1996).

One of several emerging cognitive-behavioral treatments that recognizes how experiential avoidance can foster clinical disorders (Linehan, 1993; Segal, Williams, & Teasdale, 2002; Wheeler, Christensen, & Jacobson, 2001) is acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). According to ACT and the functional contextualist approach to human language and cognition upon which it is based (i.e., relational frame theory; Hayes, Barnes-Holmes, & Roche, 2001), “... patients may become excessively entangled with their own thoughts, particularly negative self-referential thoughts and negative evaluations of private experiences” (Hayes et al., 2004,
p. 572). Essentially, it is not unpleasant private events *per se*, but rather clients’ negative evaluations of such events and their ensuing attempts to escape present and avoid future occurrences of such unwanted, aversive experiences that constitute experiential avoidance. The process of struggling to avoid these unwanted experiences is regarded as instrumental in exacerbating otherwise normal, albeit unpleasant, facets of the human condition (for example, grief over the loss of a loved one) into more clinical disorders (major depression, substance or alcohol abuse, etc.).

In highlighting the deleterious effects of experiential avoidance, the ACT literature distinguishes between “clean pain” and “dirty pain” (Hayes et al., 1999; Zettle, 2007). The former term refers to a normal, adaptive response to an unpleasant event or circumstance. Most athletes, for example, will reduce their training regimen following an injury, and may even devise a more efficient training and performance technique to reduce the possibility of further injury. Similarly, a period of dysphoria following a loss or failure, while unpleasant, is considered to be a normal response and even may serve an adaptive function by allowing an organism time to “regroup” (Zettle, 2007, p. 23). By contrast, “dirty pain” refers to psychological suffering and distress that results from failing to control, escape from, or avoid the occurrence of “clean pain.” In seeking to avoid or escape from the experience of pain, we exacerbate and prolong it. Techniques to combat the unwanted experience of “clean pain” may assume many different topographies, in both psychological (e.g., thought suppression and rumination) and behavioral (e.g., substance abuse or overeating) domains. Consequently, experiential avoidance as a response class is defined functionally, and not topographically.
How the process of experiential avoidance may contribute to clinical disorders has been investigated under several analogue conditions. Various laboratory preparations have been used to either simulate or induce clinically-relevant phenomena such as anxiety or panic (Eifert & Heffner, 2003; Feldner, Zvolensky, Eifert, & Spira, 2003; Karekla, Forsyth, & Kelly, 2004), physical pain or discomfort (Gutiérrez, Luciano, Rodriguez, & Fink, 2004; Hayes, Bissett, et al., 1999; Keogh, Bond, Hanmer, & Tilston, 2005; Páez-Blarrina et al., 2008; Zettle et al., 2005), food cravings (Forman et al. 2007), intrusive thoughts (Marcks & Woods, 2005, 2007), and stressful or traumatic life events (Plumb, Orsillo, & Luterek, 2004). To date, anxiety/panic and physical pain and discomfort have been the areas most widely investigated. Some of these studies have been correlational in nature in comparing the reactions of high and low avoidant participants to various challenges. Others have used experimental designs in which various coping instructions and protocols have been manipulated as independent variables.

In a recent correlational study, Karekla et al. (2004) compared the physiological and emotional responses of participants reporting high and low levels of experiential avoidance as assessed by the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) to inhalations of carbon dioxide-enriched air, used to induce panicogenic symptoms such as chest pain, shortness of breath, tachycardia, and anxiety symptoms. No differences were found between the two groups in physiological measures (skin conductance, heart rate, frontalis muscle tension), or in either group’s self-report of severity of physiological symptoms. However, differences were found between the two groups for emotional and cognitive responses. Specifically, high avoidant group
participants reported greater uncontrollability, fear, and panic responses, as well as a
greater number and greater severity of cognitive panic symptoms, than did the low
avoidant participants.

A similarly-designed investigation into pain tolerance was conducted by Zettle et
al. (2005) using the cold pressor task. There were no differences in pain threshold (the
amount of time elapsed before a participant reported painful sensations) nor in the
intensity of pain experienced by high versus low experientially-avoidant participants.
However, low avoidant participants kept their hands immersed for a longer time
following their initial report of pain sensations and for a longer total time than did high
avoidant participants.

Several experimental studies comparing acceptance- and control-based protocols
with pain (Gutiérrez et al., 2004) and anxiety-inducing procedures (Levitt, Brown,
Orsillo, & Barlow, 2004) have yielded findings that parallel those documented in
correlational research. In an early pain tolerance study, Hayes, Bissett, et al. (1999)
exposed participants to two presentations of a cold pressor task. Between trials,
participants received acceptance, control, or attention-placebo interventions. The
acceptance intervention encouraged participants to notice unpleasant cognitive,
emotional, and physical responses to the induced pain without allowing these responses
to change their overt behavior, while those receiving the control intervention were taught
a variety of techniques, such as positive self-talk, controlled breathing, and positive
imagery, as tools to control or modify the experience of pain. The attention-placebo
intervention emphasized educational facts about pain. Although subjective measures of
pain intensity and unpleasantness did not vary between groups, participants in the
acceptance condition tolerated the pain longer as determined by the length of time they immersed their hands in cold, icy water.

Similar findings have emerged in examining the impact of acceptance and control rationales on anxiety-related experiences. Feldner and colleagues (2003) exposed high and low experientially-avoidant participants to a carbon dioxide inhalation challenge that induced panic-like symptoms. Half of the participants in each group were instructed to either suppress their emotional responses or simply observe their level of arousal. Participants with elevated levels of experiential avoidance reported higher levels of anxiety, displeasure, and emotional dyscontrol relative to their low avoidant counterparts. However, no differences were found regarding autonomic arousal (e.g., heart rate), nor in ratings of physiological arousal, between the two groups. Furthermore, high avoidant participants in the response-suppression condition reported higher levels of anxiety than did low avoidant participants.

In the aggregate, both correlational and experimental research, as exemplified by those studies just cited, have yielded convergent evidence implicating experiential avoidance as a response class that exacerbates the "dirty pain" or secondary distress resulting from efforts to control unwanted psychological and/or physiological distress. Although experiential avoidance has been conceptually linked to the development and maintenance of unipolar depression (i.e., Zettle, 2004, 2007; Zettle & Hayes, 2002), less attention has been focused within this area in laboratory research. The primary purpose of this study, therefore, was to provide an initial investigation into the possible role that differing levels of experiential avoidance might play in participant responses to experimentally-induced dysphoric mood. Given that depression is often referred to as
"the common cold" of psychological disorders (Pilgrim & Bentall, 1999), it seemed useful to complement and extend research on experiential avoidance by determining if the AAQ also can predict how individuals respond to depressing circumstances. Specifically, we anticipated that experientially-avoidant participants would report higher levels of subjective distress than low avoidant participants for comparable increases in dysphoric mood. This prediction is based upon other analogue studies in which high avoidant participants have not differed as much from low avoidant participants regarding levels of "clean pain" as they do regarding reactive distress or "dirty pain" when presented with various challenges (Feldner et al., 2003; Zettle et al., 2005; Zettle, Petersen, Hocker, & Provines, 2007).

Method

Participants

Participants (N = 40) were university students enrolled in psychology classes and part of a larger sample who completed an online administration of the AAQ. The cutting scores used in prior research (e.g., Feldner et al., 2003; Karekla et al., 2004; Zettle et al., 2005) identified participants from this larger sample reporting high (AAQ ≥ 41) or low (AAQ ≤ 26) levels of experiential avoidance. Participants who met this selection criterion were informed via e-mail of their eligibility and invited to participate. Exclusionary criteria for further participation included current psychotherapeutic and/or pharmacological treatment for clinical depression and a preexperimental score of 16 or above on the Beck Depression Inventory-second edition (BDI-II; Beck, Steer, & Brown, 1996). All participants were treated per the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 2002).
The final sample comprised a group high in experiential avoidance \( (N = 20) \) and group low in experiential avoidance \( (N = 20) \). Gender distribution was comparable within each group (14 female, 6 male and 15 female, 5 male, respectively) and the groups did not differ significantly according to age \( (M = 22.16 \text{ vs. } 26.35) \) or preexperimental levels of depression as assessed by the BDI-II \( (M = 5.5 \text{ vs. } 4.3) \).

**Measures**

*Acceptance and Action Questionnaire (AAQ).* The AAQ (Hayes et al., 2004) comprises nine statements relating to experiential avoidance. Example statements include “Anxiety is bad” and “I’m not afraid of my feelings.” Participants rated “the truth . . . as it applies to you” for each of the statements on a Likert scale with responses ranging from 1 “never true” to 7 “always true.” Higher total scores indicate elevated levels of experiential avoidance. The AAQ has adequate internal consistency for use in research as well as convergent and construct validity (Hayes et al., 2004).

*Beck Depression Inventory-Second Edition (BDI-II).* The BDI-II (Beck et al., 1996) contains 21 items addressing areas of depressive symptomatology such as crying, punishment feelings, and loss of pleasure. Responses range from 0 to 3, with higher scores indicating more severe levels of depression. The BDI-II has high reliability and validity (Beck et al.; Carmody, 2005; Dozois, Dobson, & Ahnberg, 1998; Sprinkle et al., 2002; Steer & Clark, 1997; Whisman, Perez, & Ramel, 2000).

*Depression Adjective Check Lists (DACL).* The Depression Adjective Check Lists (Lubin, 1965) contain 32 positively (e.g., “lively” and “alert”) and negatively valenced adjectives (e.g., “downhearted” and “alone”) to assess dysphoric mood. Per standardized instructions, participants were asked to check the words that describe “how
you feel now—today.” Total scores range from 0 to 32, with higher scores indicating increased levels of dysphoric mood. Multiple DACL forms are available and are internally consistent and equivalent (Lubin, 1994). In this study, forms A, B, C, and D were used.

*Subjective Units of Disturbance Scale (SUDS).* Participants’ distress levels following the induction and rumination phases of a mood induction procedure were assessed by a SUDS rating (Wolpe & Lazarus, 1968). Specifically, participants rated the degree to which changes in mood were distressing by providing a number from 1 “not at all distressing” to 100 “completely distressing.”

*Procedure*

After obtaining informed consent, participants were screened for current treatment of clinical depression by means of a semi-structured interview, and the BDI-II was administered to determine preexperimental levels of depression. Participants reportedly undergoing psychotherapy or taking antidepressant medication for clinical depression and those who scored 16 or above on the BDI-II were deemed ineligible, thanked for their time, and dismissed before the mood induction procedure. Remaining participants completed a survey of demographic information as well as DACL Form A to assess their baseline mood.

*Mood induction phase.* Dysphoric mood was induced by the Velten Mood Induction Procedure (VMIP; Velten, 1968). The VMIP includes 60 self-referent statements typical of the thoughts experienced in depression (e.g., “I’ve felt so alone before, that I could have cried” and “All of the unhappiness of my past life is taking
possession of me”). Participants read each statement silently and were asked to feel the mood each statement portrayed.

The VMIP was accompanied by music shown to induce and enhance dysphoric mood (Bates, Thompson, & Flanagan, 1999; Knight, Maines, & Robinson, 2002; Trask & Sigmon, 1999). The VMIP instructions and statements were displayed on a notebook computer screen using a slide presentation, with the audio tracks synchronized to the video image. Participants were told that music would be played over headphones to reduce distractions and enhance concentration on the task. The VMIP instructions were only slightly modified from the original instructional set to reflect differences in presenting statements (e.g., “slides” substituted for “cards”). The original instruction to say each statement aloud was also eliminated. Each of the 15 instructional slides was presented for 30 s.

The 60 Velten statements were identical to the original set, except for statement 13, in which the phrase “war in Viet Nam” was replaced with “threat of terrorism,” and statements 18 and 41, in which the words “loved ones” and “family” replaced “parents.” The statements were each displayed for 12 s, accompanied by Barber’s “Adagio for Strings” and Sibelius’ “The Swan of Tuonela.” The experimenter sat a comfortable distance behind participants, out of their line of sight. The mood induction procedure took approximately 12 min. Immediately afterwards, participants completed DACL Form B and the first SUDS rating.

**Rumination phase.** For 5 min, participants next underwent a rumination phase. This phase was included to evaluate the degree to which the two groups responded differentially to efforts to prolong levels of dysphoric mood. Based upon findings of
Trask and Sigmon (1999), it was anticipated that rumination would maintain elevated dysphoric mood at least for the high avoidant participants, thereby providing a second opportunity to assess their subjective reactions to it. Instructions for the rumination phase were consistent with those used by Watkins and Teasdale (2004) and asked participants to “use your imagination and concentration to think about the causes, meanings, and consequences of each item.” Each of the three instructional slides was displayed for 20 s. A series of five ruminative statements, modeled after the research of Nolen-Hoeksema and colleagues (e.g., Lyubomirsky & Nolen-Hoeksema, 1993; Nolen-Hoeksema & Morrow, 1993), were presented to participants. Ruminative statements included “Think about the physical sensations in your body” and “Think about the possible consequences of the way you feel.” The rumination statements were displayed for 60 s each, and were accompanied by Prokofiev’s “Russia Under the Mongolian Yoke,” recorded at half-speed, again delivered over headphones. Participants then completed DACL Form C and the second SUDS rating.

**Distraction phase.** The final phase consisted of a distraction task of about 5 min designed to return participants’ dysphoric mood to baseline levels. Three instructional slides, presented for 20 s each, directed participants to “focus your attention on the thoughts and ideas presented.” Distraction tasks included “Describe to yourself what a white bear looks like” and “Walk the length of a shopping mall. Describe each of the stores you will pass.” Each distraction statement was presented for 60 s accompanied by the “Largo” movement of Dvorak’s “New World Symphony.” Following the completion of the distraction phase, participants completed the DACL Form D before receiving a debriefing statement to read.
To summarize, all participants completed DACLs both immediately before and after a mood induction procedure, as well as following rumination and distraction phases, to track changes in dysphoric mood. SUDS were also obtained following the mood induction and rumination phases to assess the psychological reactions of participants to any changes in their levels of dysphoric mood.

Results

Dysphoric Mood

To determine changes in levels of dysphoric mood, a 2 (participant group: high avoidant vs. low avoidant) × 4 (experimental phase: baseline vs. postinduction vs. postrumination vs. postdistraction) repeated-measures ANOVA was performed. A significant main effect for experimental phase alone was found, $F(1, 38) = 42.3, p < .001, \eta_p^2 = .565$. As can be seen in Figure 1, DACL scores across the four phases displayed a quadratic trend with scores at each phase differing significantly from each other. The Group × Phase interaction was nonsignificant and a series of $t$ tests across the four phases found no differences in levels of dysphoric mood between the two participant groups.

Subjective Distress

A 2 (participant group) × 2 (experimental phase: postinduction vs. postrumination) repeated-measures ANOVA was conducted on the SUDS ratings. As apparent from Figure 2, significant main effects were found for both experimental phase, $F(1, 38) = 12.53, p = .001, \eta_p^2 = .248$, and for participant group, $F(1, 38) = 9.98, p = .003, \eta_p^2 = .208$. Specifically, high avoidant participants reported significantly higher levels of distress than their low avoidant counterparts at both postinduction ($M = 47, SD$
Discussion

As anticipated, there was a comparable response to the induction procedure for each participant group, with both reporting increased dysphoric mood relative to baseline levels. Also as expected, participants scoring higher on the AAQ differed from their low avoidant counterparts in reporting significantly greater levels of subjective distress in reaction to the experimentally-induced mood. In short, the two participant groups did not differ from each other in their levels of induced “clean pain” as assessed by the DACL. However, as revealed by the SUDS ratings, they did differ from each other in their levels of reactive distress, or “dirty pain,” in response to mood changes. These results parallel similar laboratory preparations (Feldner et al., 2003; Karekla et al., 2004; Zettle et al., 2005) that have found comparable differing psychological reactions between high and low avoidant participants to unwanted private events that are experimentally-induced. Our study, however, is the first to document the ability of the AAQ to predict differential levels of distress in reaction to dysphoric mood induction. Its overall findings, especially when combined with those from related studies, provide further support for an acceptance and commitment model of psychopathology (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) in which experiential avoidance is associated with greater levels of reactive distress.

There was one finding that was not anticipated. A rumination phase was included as part of the mood induction procedure in order to prolong levels of dysphoria induced by the VMIP. Instead, as seen in Figure 1, participants in the aggregate unexpectedly
reported lower levels of dysphoric mood at the end of the rumination phase. Separate $t$ tests indicated that the decrease in dysphoria during the rumination phase was significant for the low avoidant, $t (19) = 2.19, p = .04$, but not for the high avoidant participants, $t (19) = 1.96, p = .06$. However, these results are still contrary to what was generally expected in light of other findings that rumination maintains induced dysphoric mood (Trask & Sigmon, 1999).

Our findings of decreased dysphoria during rumination may initially seem to present a challenge to an acceptance and commitment model of psychopathology. As a form of experiential avoidance, rumination would be expected to prolong, and possibly even further increase, dysphoric mood. A possible explanation why this anticipated effect was not found, and one that remains consistent with overall model, has been suggested by Trask and Sigmon (1999). Rumination in their two related studies prolonged dysphoric mood less when it was induced by the VMIP than through reading and imagining a story about the painful death of one’s mother. To the extent, as suggested by Trask and Sigmon, that “the VMIP is actually a ruminative task” (p. 237), our findings may represent an habituation effect. That is, our rumination phase may have been the functional equivalent of asking participants to continue a process that they had already been engaged in for the last 12 min. Mulling over negative thoughts for an additional 5 min may have been enough time to appreciably lessen their impact. Although the inclusion of the rumination phase thus did not have the intended impact of prolonging dysphoric mood, it nonetheless was useful in providing a second opportunity to assess reactive distress with the SUDS ratings to dysphoria that remained elevated relative to baseline levels.
There are several possible limitations to this study. As with any analogue preparation, there are concerns about external validity as results from a dysphoric mood induction procedure with college students may not generalize to a population experiencing clinical levels of depression. Additionally, the design of this study does not allow for drawing conclusions as to causality. However, results comparable to those obtained in this and other correlational studies (Karekla et al., 2004; Zettle et al., 2005) have also been noted in experimental investigations in which experientially-avoidant versus accepting instructional conditions have been manipulated as independent variables. For example, Feldner and colleagues (2003) found similar differential levels of subjective distress after providing differing instructional sets (i.e., suppression/avoidant vs. observation/acceptance) to participants undergoing a carbon-dioxide challenge. Levitt et al. (2004) obtained comparable results while manipulating acceptance versus suppression instructional sets in a participant group comprised of individuals clinically diagnosed with panic disorder. Taken in the aggregate, findings from both prior correlational studies, as well as those that do not share this limitation, have yielded converging results and lend credibility to the outcome of this investigation.

Systematically extending an examination of the impact of differing coping instructions from anxiety disorders to depression would constitute an apparent relevant research agenda. Another area for future research would be to further experimentally compare the impact of avoidant versus accepting instructions upon participants who report midrange (i.e., neither high nor low) levels of experiential avoidance as assessed by the AAQ when presented with a variety of psychological challenges that include, but are not limited to, dysphoric mood induction.
A conceptual limitation of this study follows from how experiential avoidance was measured. This study as well as several of those to which it has been compared (e.g., Feldner et al., 2003; Karekla et al., 2004; Zettle et al., 2005, 2007) have used a paper-and-pencil measure (the AAQ) to identify participants who vary in their levels of experiential avoidance. The advantage of the AAQ is that it provides a convenient as well as efficient and economical way of evaluating experiential avoidance. The disadvantage, however, of using this shortcut is that doing so may lead to thinking and speaking of experiential avoidance as a hypothetical construct rather than as a functional response class.

One way of assessing experiential avoidance in a manner more consistent with a behavior analytic approach would be to instead develop behavioral ways of sampling it. Research by Brown and his colleagues (Brown, Lejuez, Kahler, Strong, & Zvolensky, 2005) suggests that a task as simple as breath-holding may serve this function. The length of time individuals were able to hold their breath both postdicted and predicted lapse following smoking cessation. Although the duration of breath-holding was explicitly depicted by Brown et al. as a measure of “distress tolerance,” it can also be usefully conceptualized as an index of experiential avoidance (Hayes & Smith, 2005). In further research, individuals scoring across the entire range of the AAQ could be compared in their responses to various challenging tasks, such as breath-holding and the cold pressor. Determining the relationship among these ostensibly different ways of assessing experiential avoidance may be a next useful step in identifying and ultimately developing an efficient behavioral alternative to the AAQ in evaluating the strength of experiential avoidance as a functional response class.
A methodological limitation of this study is that no manipulation checks were included. It is therefore possible that participants may have disregarded the instructions presented prior to each experimental phase. For example, participants may have closed their eyes frequently, and in doing so, missed one or more of the statements during the limited time each was displayed. Participants may also have ignored the instructions to “believe” the mood induction statement, “think about” the rumination statements, or “visualize” the scenes presented in the distraction phase, possibly in favor of engaging in other cognitive tasks (e.g., thinking about an impending class assignment, distracting, etc.) during the various phases of the experiment, either deliberately or automatically. Future research utilizing a similar design could include checks to determine if participants faithfully follow instructions as they are presented, and what, if any, coping styles they may use during the course of the experiment (cf. Zettle et al., 2005).

Because it was made fairly clear to participants that a dysphoric mood was expected to result from the induction procedure, our findings could also perhaps be attributed to demand characteristics. This limitation is minimized, however, by the findings of several researchers (Berkowitz & Troccoli, 1986; Clark, 1983; Finegan & Seligman, 1995; Larsen & Sinnett, 1991; Martin, 1990; Westerman, Spies, Stahl, & Hesse, 1996) that the Velten technique has been shown to induce changes in mood over and above what could be attributed to a desire to please an investigator. At best, demand characteristics would only appear to be capable of accounting for the main effect for phase noted on the DACL.

For our purposes, the more conceptually relevant findings were the significant differences noted between the two groups in their SUDS ratings following the induction
and rumination phases. It seems improbable that participants in both groups reported higher levels of dysphoric mood in response to experimenter cues, but that only high avoidant participants were unduly influenced to report correspondingly higher levels of subjective distress. If this were indeed the case, it could plausibly be seen as indirectly lending further support to the concept of experiential avoidance. That is, presumably only high avoidant participants may have sought to avoid displeasing the researcher when reporting both depression and distress levels.

This study was largely designed to examine the types of reactions to increases in dysphoric mood that might be analogous to those that occur in cases of unipolar depression. Similar changes might be speculated to also occur in instances of bipolar depression, but where the shift in mood may be relative to and away from a period of euphoria, as opposed to a baseline level of “normal mood.” It is unclear how the process of experiential avoidance as examined in this study may contribute to increases in either dysphoric or euphoric mood states in individuals suffering with bipolar disorder. Future analogue research might examine the degree to which similar or differing processes function in a bipolar presentation by tracking subjective reactions to both euphoric and dysphoric mood states that are experimentally-induced.

Despite some limitations of this study, our findings support the importance of experiential avoidance to understanding unipolar depression (Zettle, 2004, 2007; Zettle, & Hayes, 2002). More broadly, our findings, when added to the growing body of literature and research that has implicated experiential avoidance in the initiation and maintenance, as well as the alleviation of human suffering (Hayes et al., 2006), further
suggests the breadth and scope of experiential avoidance as an apparent core pathogenic process.
References


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Figure Captions

Figure 1. Mean DACL ratings for participant groups across mood induction phases.

Figure 2. Mean SUDS ratings for participant groups across mood induction phases.
Figure 1.
Figure 2.

Mean SUDS Ratings

Post Induction  Post Rumination

Experimental Phase

- High Avoidant
- Low Avoidant