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Acceptance and Commitment Therapy: Similarities and Differences with Cognitive Therapy (Part 1)

By Dr Evan Forman & Dr James Herbert

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Part 1 - An Introduction to Acceptance and Commitment Therapy

Over the past four decades cognitive behavior therapy (CBT) has been gradually replacing psychoanalysis/psychodynamic psychotherapy as the prevailing model of psychotherapy in clinical practice (A. T. Beck, 2005; Norcross, Hedges, & Castle, 2002; Norcross, Hedges, & Prochaska, 2002). CBT now dominates the psychotherapy landscape in terms of demonstrated efficacy, acceleration of usage, and prominence in academic and medical centers. While CBT can be conceptualized as a broad umbrella of related models of psychotherapy, the most well known and widely practiced model of CBT is Beck's cognitive therapy (CT). The central feature of CT is that problems are conceptualized within a framework of dysfunctional belief systems, and intervention entails modification of these beliefs.

A new breed of CBT, sometimes referred to as "acceptance-based" or alternatively as "third-generation" behavior therapies, has gained increasing notoriety in recent years. Among the most popular of these new therapies is an approach known as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). ACT is of particular interest to clinicians for a number of reasons. First, ACT is the fastest growing and most empirically supported of the new acceptance-oriented behavior therapies (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004). Second, acceptance-based constructs are being increasingly invoked and integrated into existing interventions by leading CBT theorists such as Wells (2005a; , 2005b), Barlow (Barlow, 2002; Levitt, Brown, Orsillo, & Barlow, 2004; Orsillo, Roemer, & Barlow, 2003) and Borkovec (Borkovec, Alcaine, & Behar, 2004; Borkovec, Ray, & Stober, 1998). Third, recent evidence from component analysis studies, mediational analyses, and comparative outcome trials is calling into question the efficacy of cognitive disputation, which is the central theorized change component of CT



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(Longmore & Worrell, 2007). Fourth, clinicians anecdotally report that a subset of their patients do not respond well to traditional cognitive interventions; ACT provides a series of innovative techniques for facilitating behavior change that do not rely on standard cognitive challenges.

A useful way to introduce ACT is by comparing and contrasting it with traditional CT. CT serves as an obvious starting point because it is assumed that most readers will be at least moderately familiar with its theory and practices, and many will have utilized it in their clinical work. In addition, CT is generally consistent with Western folk psychology (such as around the ability to control and/or avoid thoughts and feelings, and the benefits of doing so in order to promote behavior change), whereas ACT is less so. Also, ACT evolved in part directly from CT (Zettle, 2005). Nevertheless, ACT and CT differ sharply on key theoretical and technological grounds, and these differences are likely to be of great interest to practicing clinicians.

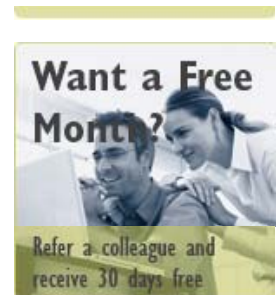
This introductory overview is based on a sample of representative and descriptive books, chapters, and journal articles describing CT (e.g. A. T. Beck, 1976; A. T. Beck, Emery, & Greenberg, 1985; A. T. Beck, Freeman, & Davis, 2004; A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995, 2005; Dobson, 2001; Dobson & Shaw, 1995; Hollon, Haman, & Brown, 2002; Leahy, 2003a, 2003b; Ledley, Marx, & Heimberg, 2005) and ACT (e.g. Dahl, Wilson, Luciano Soriano, & Hayes, 2005; Dahl, Wilson, & Nilsson, 2004; Eifert & Forsyth, 2005; Gifford et al., 2004; Hayes, 2004a, 2004b; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 1999; Hayes & Strosahl, 2005; Herbert & Cardaciotto, 2005; McCracken, Vowles, & Eccleston, in press; Wilson & Murrell, 2004). The descriptions of the two approaches are based on an integration of these various sources. Thus, specific citations are not provided for each and every point of comparison between the two approaches. Additionally, given space limitations, our treatment of each approach will necessarily be incomplete and in some ways superficial.

Cognitive Therapy

As noted above, in terms of its widespread applicability, acceleration of use and training, empirical support, and acceptance by the scientist-practitioner community, CT has emerged as the predominant model of psychotherapy in North America (Prochaska & Norcross, 1994). Hundreds of controlled clinical trials of the larger family of CBT have been undertaken in recent years (Dobson, 2001; Hollon & Beck, 1994), and a recent review of meta-analyses found multi-study support for the effectiveness of CT to treat a plethora of psychological conditions, including unipolar and bipolar depression, panic disorder, obsessive-compulsive disorder, social anxiety disorder, generalized anxiety disorder, schizophrenia-linked psychotic symptoms, and bulimia nervosa (Butler, Chapman, Forman, & Beck, 2006). Furthermore, most treatments on lists of empirically supported therapies for specific disorders (Chambless & Hollon, 1998) are CBT in nature. Additionally, CBT is fast becoming the majority orientation among clinical psychologists, in particular scientist-practitioner program faculty (Norcross, Karpiak, & Santoro, 2005; Norcross, Sayette, Mayne, Karg, & Turkson, 1998). Moreover, all residency training programs in psychiatry now offer specific

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training in CBT (Accreditation Council for Graduate Medical Education, 2004).

CT can be described as an active, collaborative, current problem-oriented and relatively short-term treatment that takes its name from the use of both cognitive and behavioral strategies to alleviate distress and reduce clinical symptomatology. It is based on the notion that affect and behavior (and thus psychopathology) are largely determined by in-the-moment cognitive phenomena (e.g. thoughts, images, interpretations, attributions), which, in turn, are influenced by historically developed core beliefs or cognitive schemas (Dobson & Shaw, 1995). Although CT incorporates some traditional behavioral principles and technologies, what distinguishes it from the larger family of behavioral therapies is the emphasis on cognitive factors as presumed mediators of change, as well as the focus on direct attempts to modify cognitive processes (A. T. Beck, 1993).

The History of Behavior Therapy

Whereas CT has traditionally focused on reducing or eliminating unwanted symptoms, ACT focuses less on symptom reduction per se and more on promoting behavior change consistent with personally relevant goals. Instead of attempting to alter the content or frequency of cognitions, ACT seeks to alter the individual's *psychological relationship* with his or her thoughts, feelings and sensations in order to promote psychological flexibility (Hayes, Jacobson, Follette, & Dougher, 1994).

An understanding of ACT and of its relationship to CT is best appreciated in the context of the history of behavior therapy over the past half century. Hayes (2004b) divides the behavior therapy movement into three semi-distinct eras. The first wave of behavior therapy, which crested in the late 1950s and into the 1960s, sought to take an empirical, objective, scientific approach to the understanding and treatment of psychological problems, and developed in reaction to the perceived shortcomings of psychoanalytic theory and therapy. The focus was on modifying problematic behavior, broadly defined to include not only overt motor behavior but cognitive and even affective responses, through classical (Wolpe, 1958) and operant (Skinner, 1953) learning principles. The late 1960s through the 1990s represented a second wave of behavior therapy, in which cognitive factors assumed greater importance in both theory and practice. Cognitions were viewed as playing a critical role in individuals' interpretation of, and thus emotional and behavioral responses to, environmental stimuli (Bandura, 1969). Several related psychotherapies combining cognitive and behavioral change strategies were developed, including Rational Emotive Behavior Therapy (Ellis, 1962) and CT (A. T. Beck et al., 1979). These approaches hold that maladaptive thoughts, schemas or information processing styles are responsible for undesirable affect and behavior, and, through psychotherapy, can be modified or eliminated.

The third generation of behavior therapies, also sometimes referred to as "acceptance-based behavioral therapies," encompasses a number of treatment approaches that have risen to prominence during and since the 1990s, including Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (Linehan, 1993), and ACT (Hayes et al., 1999). These approaches share a number of features

that distinguish them from earlier behavioral therapies. Perhaps the most noteworthy is a shift from the assumption that distressing symptoms, including unwanted thoughts and feelings, must be changed in content or frequency in order to increase overall psychological wellbeing. Instead, acceptance-based therapies attempt to foster a perspective of nonjudgmental acceptance of distressing private experiences in the context of promoting behavior change. For example, traditional first-generation behavior therapy would tend to ignore cognitions related to an individual's anxious avoidance and focus strictly on the avoidance behavior. Second-generation CBT would emphasize examining the validity of thoughts putatively responsible for the avoidance with an eye toward fostering more adaptive/accurate cognitions. Acceptance-based models of CBT might suggest becoming increasingly aware of, while simultaneously stepping back from, these anxiety-related thoughts as a way of increasing willingness to act in accordance with one's goals even while experiencing anxiety.

Acceptance and Commitment Therapy

Like other third-generation behavior therapies, ACT evolved in part from traditional CBT. In fact, its earliest incarnation was called "comprehensive distancing" because it elaborated and expanded on Beck's notion that clients should be taught to "distance" themselves from their beliefs (Zettle, 2005; Zettle & Rains, 1989). Over time, a central unifying goal of ACT was developed and termed "psychological flexibility," referring to one's ability to choose one's actions from a range of options in order to behave more consistently with personally held values and aspirations rather than having one's behavior constrained by the avoidance of unpleasant "private events" (i.e., thoughts, feelings, sensations, memories, urges, etc.).

Among the new generation of behavior therapies, ACT in particular has shown signs of rapid growth in the fields of psychotherapy theory and practice. For instance, as of mid-2007, nearly 200 articles were listed in *PsychLit* with "acceptance and commitment therapy" as a keyword. Additionally, there have been several dozen paper presentations, posters, workshops and panel discussions related to ACT presented at each of the most recent Association of Behavioral and Cognitive Therapies (ABCT) meetings, more than any other specific therapy.

In terms of empirical support, ACT lags far behind CT; evidence for the effectiveness of ACT comes from a relatively small set of studies. The most comprehensive review of ACT outcome studies was conducted by Hayes, Luoma, Bond, Masuda and Lillis (2006). The authors identified 11 studies comparing ACT to "active, well-specified" treatments for depression, anxiety (social anxiety, work stress, agoraphobia and math anxiety), distress from cancer, job burnout, substance use (polysubstance abuse, smoking), and diabetes management. Overall, ACT outperformed the comparison treatment by approximately one-half a standard deviation. The authors also presented 11 additional studies supporting ACT's effectiveness when compared with waitlist, placebo or treatment as usual for the treatment of social anxiety, agoraphobia, work stress, trichotillomania, psychosis, borderline personality disorder, chronic pain and even epilepsy. However, it must be stressed that the number of comparative trials and participants remains too small to draw definitive conclusions, that only a handful of studies compared ACT to a "gold standard" treatment, and that the studies were conducted by investigators

with an expressed interest in ACT, thus raising the possibility of unintentional experimenter bias. On the other hand, two very recent randomized controlled trials by investigators (and with therapists) without clear allegiance reported finding that ACT was at least as effective as CT in mixed outpatient settings (Forman, Hebert, Moitra, Yeomans, & Geller, in press; Lappalainen et al., 2007).

There are signs that ACT is becoming increasingly popular among both clinicians and consumers. Stories about ACT have begun appearing in the popular media such as *Time Magazine*, *The New York Times*, *The Philadelphia Inquirer*, *The Sunday Telegraph*, *Psychology Today*, *O [Oprah] Magazine*, and *Salon.com*. Additionally, interest in ACT is spreading to an increasing number of practitioners over a wide geographic spread, at least as reflected by the main ACT listserv for practitioners and researchers (<http://tech.groups.yahoo.com/group/acceptanceandcommitmenttherapy/>), which, as of mid-2007 counts nearly 1300 members from North, Central and South Americas; the United Kingdom and continental Europe; South Africa; the Middle East; and New Zealand and Australia. A website devoted to ACT (www.contextualpsychology.org) receives high traffic. A surprising number of practitioner-oriented and self-help ACT books have also been published or are forthcoming (Table 1). One of these, *Get Out of Your Mind and Into Your Life* (Hayes & Smith, 2005), spent time on the New York Times and Amazon.com bestseller lists.

Table 1. Books on ACT.

<u>Books for Clinicians</u>
<i>Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change</i> (Hayes et al., 1999)
<i>A Practical Guide to Acceptance and Commitment Therapy</i> (Hayes & Strosahl, 2005)
<i>Acceptance & Commitment Therapy for Anxiety Disorders: A Practitioner's Treatment Guide to Using Mindfulness, Acceptance, And Values-Based Behavior Change Strategies</i> (Eifert & Forsyth, 2005)
<i>Acceptance And Commitment Therapy For Chronic Pain</i> (Dahl et al., 2005)
<i>Acceptance And Mindfulness at Work: Applying Acceptance And Commitment Therapy And Relational Frame Theory to Organizational Behavior Management</i> (Hayes, 2006)
<i>Talking ACT: Notes and Conversations on Acceptance and Commitment Therapy</i> (Chantry, in press)
<i>Learning Act: An Acceptance and Commitment Therapy Skills Training Manual for Therapists</i> (Luoma, Hayes, & Walser, 2007)
<i>Acceptance & Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder: A Practitioner's Guide to Using Mindfulness & Acceptance Strategies</i> (Walser & Westrup, 2007)
<i>Act in Practice: Case Conceptualization in Acceptance And Commitment Therapy</i> (Bach & Moran, in press)
<i>Act for Depression: A Clinician's Guide to Using Acceptance and Commitment Therapy in Treating Depression</i> (Zettle, 2007)

<u>Self-help Books</u>
<i>Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy</i> (Hayes & Smith, 2005)
<i>The Anorexia Workbook: How to Accept Yourself, Heal Your Suffering, and Reclaim Your Life</i> (Heffner, Eifert, & Hayes, 2004)
<i>Act on Life Not on Anger: The New Acceptance & Commitment Therapy Guide to Problem Anger</i> (Eifert, McKay, & Forsyth, 2006)
<i>Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems</i> (Follette & Pistrone, 2007)
<i>Living Beyond Your Pain: Using Acceptance & Commitment Therapy to Ease Chronic Pain</i> (Dahl & Lundgren, 2006)
<i>The Act on Anxiety Workbook: Acceptance and Commitment Therapy for Anxiety, Phobias, and Worry</i> (Forsyth & Eifert, 2007)
<i>The Worry Trap: How to Free Yourself from Worry & Anxiety using Acceptance and Commitment Therapy</i> (LeJeune, 2007)

The popularity of the approach does not, of course, necessarily imply that it is effective. In fact, there are several examples of psychotherapies that are well known but of dubious efficacy. Corrigan (2001), in fact, has criticized ACT as “getting ahead” of the (then-current) database of support. While the empirical support for ACT has grown rapidly in the years since Corrigan offered his critique, the explosion of interest in ACT outpaces the accumulation of data, thereby necessitating caution. Certainly, as ACT gains in popularity, it becomes increasingly important to understand its similarities and differences to other CBT approaches, and, of course, the degree to which any differences might translate into improved or reduced effectiveness.

Quick Glance Summary

- **CBT now dominates the psychotherapy landscape in terms of demonstrated efficacy, acceleration of usage, and prominence in academic and medical centers.**
- **A new breed of CBT, sometimes referred to as “acceptance-based” or alternatively as “third-generation” behavior therapies, has gained increasing notoriety in recent years.**
- **Among the most popular of these new therapies is an approach known as Acceptance and Commitment Therapy**

(ACT).

- **ACT provides a series of innovative techniques for facilitating behavior change that do not rely on standard cognitive challenges.**
- **A useful way to introduce ACT is by comparing and contrasting it with traditional CT.**
- **Whereas CBT has traditionally focused on reducing or eliminating unwanted symptoms, ACT focuses less on symptom reduction per se and more on promoting behavior change consistent with personally relevant goals.**
- **Instead of attempting to alter the content or frequency of cognitions, ACT seeks to alter the individual's psychological relationship with his or her thoughts, feelings and sensations in order to promote psychological flexibility.**
- **The third generation of behavior therapies, including Mindfulness-Based Cognitive Therapy, Dialectical Behavior Therapy, and ACT is a shift from the assumption that distressing symptoms must be changed in content or frequency in order to increase overall psychological wellbeing.**

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