Acceptance and Commitment Therapy: Similarities and Differences with Cognitive Therapy (Part 2)

By Dr Evan Forman & Dr James Herbert

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Comparison of Approaches

Differences in Model

At its most basic a psychotherapy model specifies its theory of etiology (i.e., an explanation of how problem behaviors/psychopathology comes to be), intervention (the therapeutic strategies designed to effect change), mechanisms of action (an account of how intervention produces change) and health (the end goal of the intervention). Each of these model components is considered below. In addition, a simplified depiction of the two models is presented in Figure 1. The figure depicts the CT view of psychopathology (faulty information processing) as guiding intervention (cognitive disputation) which enables changes (in cognition) that result in health (symptom reduction). In contrast, the ACT theory of psychopathology (psychological inflexibility) inspires the interventions (e.g. defusion, acceptance) which purportedly work through specific mechanisms (acceptance of and defusion from internal experiences) to enable health (living a valued life).

Etiology.

Both ACT and CT are members of the larger family of behavior therapies, and thus share several core principles of behavior theory. For instance, both acknowledge the major role played by operant and classical conditioning in learning and strengthening affective and behavioral response tendencies. Both models would view learning as a core explanation for why someone with battlefield trauma develops intense anxiety and avoidance of situations in which loud sounds are present. Furthermore, both models would view brief exposure to a feared stimulus followed by immediate escape as negatively reinforcing. In the case of CT, a large emphasis is placed on the role of cognitions to mediate the impact of specific situations. More generally, CT views psychopathology as a result of systematically biased information processing, characterized by maladaptive beliefs and automatic thoughts. Thus, the battlefield trauma patient would be theorized to have specific anxiety- and avoidance-provoking cognitions such as “I am not safe” that

Dr Evan Forman & Dr James Herbert

Currently Dr. Forman serves as an Assistant Professor in the Department of Psychology as well as the Associate Director of Drexel University's Student Counseling Center (Hahnemann Campus). He teaches both undergraduate and graduate psychology courses including Principles of Psychotherapy, Psychotherapy Theories, and Theories and Practice of Clinical Psychology.

He is conducting a randomized controlled trial comparing traditional cognitive-behavioral therapy with Acceptance and Commitment Therapy (ACT) in the treatment of mood and anxiety

produce fear and avoidance in relevant situations. ACT, in contrast, views psychopathology as resulting from psychological inflexibility stemming from “fusion” (or over-connection) with thoughts (such as “I am not safe”) and other internal experiences; problematic attempts to control, explain, or even dispute such private events rather than merely experiencing them; emotional avoidance (e.g. attempts to avoid the feeling of anxiety); a lack of clarity about one’s core values (e.g., being a good father); and the resulting inability to behave in accordance with those values.

Core Interventions.

Core CT strategies include the identification of basic beliefs and automatic thoughts, and the restructuring of problematic cognitions so that they are more adaptive and accurate. The reader is assumed to be familiar with these techniques. For its part, ACT makes use of a number of therapeutic strategies—many borrowed and elaborated from earlier approaches—to promote *psychological flexibility*, which is defined as the ability to select behavior that, in one’s current context, will enable movement towards chosen life values. First, the therapy aims to increase acceptance of distressing subjective experiences (e.g. negative thoughts and feelings) and to decrease unhelpful experiential avoidance. The patient is helped to carefully examine her past attempts to control unwanted experiences and to use her experience to come to a shared view with the therapist that these control attempts have always been, and are likely to continue to be, ineffective or even counterproductive. Thus, a patient with social anxiety would be asked to reflect on the extent to which strategies to reduce or control internal experiences (e.g., thoughts about and fear of negative evaluation, anxiety, blushing) have been successful. This learning exercise is consistent with ACT’s emphasis on drawing conclusions on the basis of one’s own experiences rather than what other people say or a set of rules. Consistent with ACT’s emphasis on experiential learning, the patient would also be asked to attempt, during the session, to prevent herself from having any thoughts/images/memories of a particular subject (e.g., chocolate cake) for the next 60 seconds. Through this exercise the patient comes to appreciate that we have very limited control over internal experiences, and paradoxically, that this is especially true when we are highly motivated to control these experiences. Furthermore, the lack of control over our experiences is less of a problem than our ineffective, resource-wasting, and suffering-inducing attempts to exert control. Helping
the patient come to the position that control attempts have not and likely never will result in successful living is sometimes referred to as *creative hopelessness.* ACT relies heavily on metaphors to convey its ideas. For example, a quicksand metaphor is used to communicate the idea that struggles to control internal experiences are usually doomed to fail and only make the problem worse. Someone who has fallen in quicksand and struggles to get out will only sink deeper and deeper into the quicksand, whereas laying back and making full contact with the quicksand, although counterintuitive, enables one to gently slide across the surface to its edge. The purpose of these related sets of teachings is to jolt the patient out of her assumptions and help her open up to a new way of addressing her problems

As an alternative to a control orientation, patients are presented with the construct of *acceptance*, or the idea that internal experiences can be accepted fully and without defense (Hayes et al., 1999). The idea is to help patients fully embrace all thoughts, no matter how distasteful, all feelings, no matter how painful, and so on. The goal becomes not to feel “better” in the usual sense,

disorders.

James Herbert, PhD is currently Professor in the Department of Psychology and Director of the Anxiety Treatment and Research Program at Drexel.

He has received numerous professional honors and awards, including the University's Outstanding Teacher of the Year Award in 1999.

but rather to experience the full range of one's thoughts and feelings without struggle. As discussed below, acceptance, or *willingness,* as it is also termed, is not viewed as an end in itself, but as the best means to an end, in the sense that one is willing to have difficult internal experiences in the service of living a valued life. Thus, a patient with social anxiety is helped to become more willing to have subjective feelings of anxiety (including thoughts about humiliation, worry, sweaty palms, and flushed face) in the service of forming social relationships, having a fulfilling job, earning a living and becoming more autonomous.

Acceptance also, in part, implies the need for a sharpened sense of awareness of the present moment, including of both external and internal events as they unfold in real time. Together awareness and acceptance are promoted through exercises such as mindful meditation. For instance, patients are trained in an exercise in which they imagine that each of their thoughts, feelings, and sensations are leaves floating down a stream. Patients practice becoming aware of each of these experiences, while also accepting each "leaf" no matter whether it is beautiful or ugly and no matter whether it lingers or rushes by; no efforts are made to speed certain leaves along or slow others down.

A critical component of ACT is the helping patient to *defuse* from subjective experiences, particularly thoughts. *Cognitive defusion* thus refers to the ability to step back from or distance oneself from one's thoughts in a manner that enables patients to see that their thoughts are "just thoughts" that need not be believed nor disbelieved. Cognitive defusion permits one to behave independently of distressing thoughts and feelings. A patient who sees his thought "She won't want to talk to me; she thinks I'm a loser" as merely a collection of words supplied by his anxious brain is less likely to buy into this thought and more likely to be able to approach another person and initiate a conversation, even while simultaneously having the thought. This process is similar to the notion of challenging the believability of the thought in CT. However, unlike in CT, ACT makes no effort to change the thought itself or to replace it with some other thought. The metaphor of colored sunglasses is used to help patients understand the concept of defusion. Wearing yellow sunglasses means that the world is experienced as yellow but without a conscious awareness of this fact. In contrast, holding the sunglasses away from the face reveals the process through which the world is being yellowed. A number of ACT exercises exist to help patients learn to defuse from distressing experiences, such as encouraging description of thoughts and feelings in real time and in language that emphasizes the fact that the patient is a person having thoughts and feelings as opposed to simply being immersed in/fused with the experience (e.g., "Right now I am having the thought 'She is laughing at me").

ACT also works to decrease excessive focus on and attachment to the *conceptualized self.* The conceptualized self is the verbally-based story that we form about ourselves, including what we are, who we are, and how we came to be that way. Such stories are viewed as limiting and self-fulfilling. For instance, a story such as "I was treated very badly by other children when I was little, and so now I can't deal with people" is likely to lead to behavior that is isolating, further strengthening attachment to beliefs of social incompetence.

ACT utilizes *values clarification* to help the patient identify and crystallize key personal values and to translation these values into specific behavioral goals.

Goals are seen as attainable mileposts (e.g., applying for a job), whereas values are directional aspirations (having a fulfilling career). Finally, ACT promotes the concept of “committed action” to increase action towards goals and values in the context of experiential acceptance.

Figure 1. Simplified Models of Cognitive Therapy (CT) and Acceptance and Commitment (ACT)

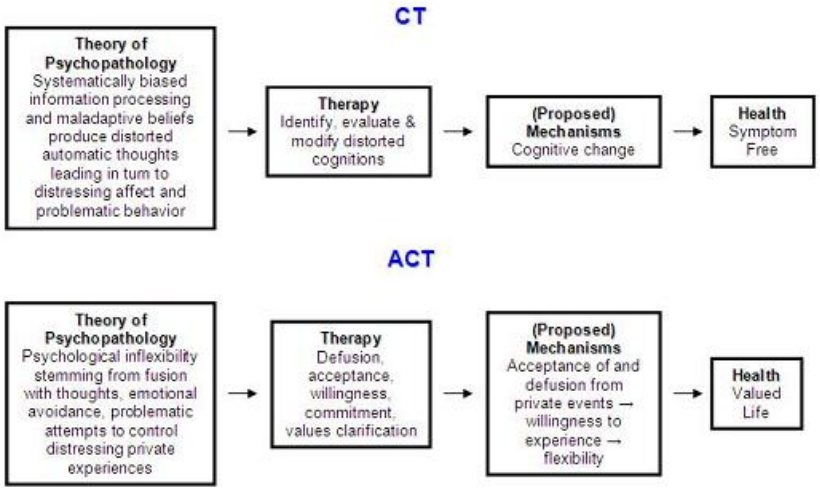

Table 2. Core Interventions.

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Shared	CT	ACT
Relationship-building interventions such as empathy, validation and reflections Didactic instruction of skills Experiential learning Summary statements Behavioral interventions, especially exposure to feared stimuli, behavioral activation, problem solving, role playing, modeling Homework	Presentation of cognitive model (situation → cognitions → affective & behavioral consequences) Identification of automatic thoughts Labeling thought errors Identification of core beliefs, schemas and attributional styles Cognitive conceptualization recognizing that early experiences shape core beliefs which, in turn, determine conditional assumptions, beliefs and rules, automatic thoughts, and compensatory strategies Modification of dysfunctional cognitions; generation of alternative responses	Presentation of model including the idea that attempts to control internal experiences is more of a problem than a solution; induce a necessary state of hopelessness towards doing "more of the same" (i.e., attempts to control). Increase acceptance of internal experiences (thoughts, feelings, images, sensations, urges) Increase awareness of present moment experiences Increase *defusion*, i.e., ability to step back from thoughts and other internal experiences in a way that allows seeing them as "just thoughts" that aren't necessarily true Decrease attachment to *conceptualized self* (i.e., a story told about oneself). Clarification of core life values Increased commitment towards values-consistent behavior, and a willingness to have difficult internal experiences for the sake of moving towards life values

Therapeutic Goals.

Both CT and ACT are goal-oriented therapies that aim to articulate, actively pursue, and measure progress towards specific goals. In the case of CT, goals, while individualized, generally stem directly from presenting problems. Presenting complaints often take the form of the experience of dysphoric affect (anxiety, depression, anger) and stated goals largely focus on the converse (reductions in the frequency and/or intensity of this affect). In contrast, ACT is skeptical of the value of directly targeting symptom reduction per se, and instead places a heavy emphasis on helping individuals discover and clarify their core life values. Goals then become mileposts in the lifelong effort to live consistently with one’s values. In this way, there is often less relationship between a client’s initial presenting complaints and therapeutically established goals than is the case in CT. Thus, ACT and CT are at odds with

respect to the degree to which they explicitly focus on the reduction of unwanted symptoms. An overt goal of CT is the reduction of unwanted thoughts and negative affect, such as depression and anxiety, and treatment success is in large part determined by the degree to which thought and mood changes occur. In contrast, a fundamental ACT principle is that the very desire to do away with distressing feelings or thoughts is often itself problematic, and furthermore that it is possible to engage in desired behaviors even while having highly unpleasant subjective experiences. Therapy therefore aims to replace the goal of symptom reduction with one of "living a valued life," which is defined as making one's behavior maximally consistent with one's chosen values. It is worth noting that although ACT and CT do differ in this regard, the difference is really one of degree of emphasis. For example, many CT therapists help their clients identify important personal values and associated goals, and to accept especially intransient thoughts. In the case of ACT, the concern with experiential control is pragmatic rather than philosophical or absolute. ACT's pragmatic focus allows, even advocates, methods of reducing unwanted internal experiences (e.g. exercising, taking medication, progressive muscle relaxation) that are effective while not imposing undue costs. Nevertheless, the ACT therapist is skeptical of the long-term viability of most direct experiential change efforts, and therefore emphasizes acceptance in the context of behavior change, rather than cognitive change as a necessary precursor to behavioral change.

Comparison of strategies.

In order to further help the reader better understand the similarities and differences between ACT and CT, we discuss below our impressions of several aspects of philosophy and theory of each of the therapies. A summary of this discussion is presented in Table 3.

Table 3.

A Comparison of ACT and Traditional CT Strategies

Issue	Shared	ACT	CT
Role of disputation	Both are averse to attempts to directly "control" thoughts	Skeptical of disputation strategies, and generally avoid	Disputation is the core strategy of CT
Role of defusion	Both view cognitions as observable by the self	Defusion is a core strategy to enhance willingness & promote action	Defusion is a byproduct of cognitive restructuring
Emphasis on affective expression	Both seek to facilitate emotional expression as a means to an end	Therapy encourages the expression of difficult affect as part of the goal of reduction of experiential avoidance leading to greater psychological flexibility	The depth and permanence of cognitive restructuring is theorized to be enhanced when performed in the context of heightened affect
Behavioral strategies (exposure, behavioral activation)	Both utilize behavioral strategies	Behavioral strategies utilized to promote psychological flexibility in the context of increased willingness to experience distressing private experiences	Behavioral strategies utilized in the service of reducing negative affect (e.g., anxiety reduction through exposure)
Therapeutic relationship	Both emphasize a collaborative relationship	Greater emphasis on principles applying to therapist & client alike	Therapist as a benevolent coach, gently leading toward cognitive change

Role of disputation.

As Beck (1993) has noted, CT "is best-viewed as the application of the cognitive model of a particular disorder with the use of a variety of techniques designed to modify dysfunctional beliefs and faulty information processing characteristic of each disorder" (p. 194). Thus, classical CT is fundamentally

about disputing, testing and modifying cognitions. In contrast, ACT takes the position that cognitive disputation is often an inert or even harmful intervention. Reasons for this position include the following interrelated assertions (a) disputation, rather than eliminating unhelpful cognitions, tends in fact to elaborate them; (b) patients will only become further “entangled” in the verbal quagmire of their belief systems; and (c) restructuring can act as an attempt at thought control which, like other forms of experiential control, is likely to fail, especially when the “stakes” are highest (Ciarrochi & Robb, 2005; Hayes, 2005; Hayes et al., 1999). Yet the distinction between ACT and CT lessens when one considers that “(CT) avoids direct attempts to ‘control’ thoughts, since such attempts often result in effects opposite to the ones intended” (Alford & Beck, 1997; p. 30). Moreover, ACT formally embraces an explicit “pragmatism” that would call for direct manipulations of thought when there is evidence (presumably rare) that this produces desirable outcomes without undue cost.

Role of defusion.

Inherent in each of the two treatments is the notion that cognitions are observable by and distinguishable from the self, a concept that has been variously termed metacognitive awareness, distancing, and cognitive defusion. In fact, the enhancement of cognitive defusion is a core strategy within ACT with a number of exercises and metaphors are employed to help clients grasp and develop this skill. Generally speaking, defusion is more of a byproduct of cognitive restructuring (and in particular cognitive self-monitoring) rather than an explicit focus in CT, although as discussed below some evidence suggests that the positive effects of CT may be largely attributable to defusion (Teasdale et al., 2002). While defusion is not as central a concept in traditional CT nor are as many strategies employed to enhance defusion, a direct challenge as to the believability of specific thoughts is a common CT intervention. In fact, CT patients are often asked “how much do you believe that thought” (both orally and in “thought records”), and an oft-repeated reminder from the therapist is “Just because you have a thought doesn’t make it true” (J. S. Beck, 1995). Still, whereas CT has little to say about thoughts that are “true” and functional, ACT takes the position that it is important to recognize that even these thoughts are just a “bunch of words" (Ciarrochi, Robb, & Godsell, 2005).

Role of acceptance.

It has been argued that mindfulness consists of two core components: awareness and acceptance (Herbert & Cardaciotto, 2005; Kabat-Zinn, 2005). Acceptance refers to the psychological readiness to willingly receive (“fully and without defense”) any thoughts, feelings, urges, images, etc. that happen to arise. Whereas awareness is an explicit focus of both treatments, acceptance is a much more central concern of ACT than of CT. Thus, in ACT, there is an explicit and heavy emphasis on the problems inherent in lack of acceptance (i.e. avoidance) of internal experiences, on the advantages of acquiring an accepting stance, and on strategies to enhance acceptance.

Emphasis on affective expression.

Given that ACT conceives of experiential avoidance as a critical component of psychopathology and psychological inflexibility, a great deal of emphasis is placed on helping clients experience their affective reactions, especially those that they may habitually avoid such as anxiety, sadness and anger. This is accomplished through a variety of means, including facilitative, empathic

exchanges with a therapist who has worked to create a deep connection with his or her client, and experiential exercises that evoke strong affect (e.g. vividly role playing a feared confrontation with a spouse). While some have stereotyped CT as an emotionless exercise in logical reasoning, this is not accurate. In fact, CT writers have long maintained the importance emotions in the therapeutic work (A. T. Beck et al., 1979), and particularly of facilitating "hot cognitions", i.e., "important automatic thoughts and images that arise in the therapy session itself and are associated with a change or increase in emotion" (J. S. Beck, 1995, p. 80). According to A.T. Beck, "emotional arousal is a key part of what [cognitive therapists] do" (A. T. Beck, 2002, p. 2). In part, this is because cognitive modification is predicted to take place more fundamentally to the extent that it occurs within an affective context. Thus, one recommended experiential exercise for facilitating modification of recalcitrant maladaptive core beliefs is to have clients vividly recall, affectively respond to, and then cognitively reprocess memories of early life in which the core belief was invoked with great intensity (J. S. Beck, 1995). Importantly, neither ACT nor CT advocate "cathartic" expression of emotion for its own sake, but rather it is sometimes encouraged as a means to an end. In the case of ACT, the end is psychological flexibility, while in the case of CT the end is cognitive modification and symptom reduction.

Behavioral strategies.

ACT and CT are both behavioral therapies, and both utilize behavioral strategies such as exposure to feared stimuli, skills training, and behavioral activation. An interesting difference exists, however, in the context within which the behavioral strategies are employed. Within ACT, behavioral strategies are utilized to promote psychological flexibility in the context of increased willingness to experience distressing private experiences while engaging in value-directed behavior. Within CT, behavioral strategies are utilized primarily in the service of changing dysfunctional beliefs and reducing negative affect (e.g., anxiety reduction through exposure).

Therapeutic relationship.

Both treatment models emphasize a collaborative therapist-client relationship. ACT, more than CT, emphasizes that principles taught and explored within the therapy apply equally to both client and therapist, i.e. "we're all in the same soup." For its part, the CT therapist is conceived of as a kind of benevolent coach, gently leading the client toward cognitive change.

Conclusions

CT has established itself as the preeminent model of modern psychotherapy. However, a new generation of acceptance-based behavior therapies, best represented by ACT, is emerging as a viable alternative to traditional CT. As a behavior therapy with some historical overlap with CT, ACT shares a large number of features with CT. On the other hand, the two therapies also differ in important ways on both philosophical and technological grounds. In terms of overall empirical support, CT maintains a distinct advantage, though evidence supporting the effectiveness of ACT is growing rapidly. Already there are signs that acceptance-based theory, outcome, and mediational data are beginning to influence the practice of traditional CT. Thus, aspects of acceptance-based theory appear destined to play an increasing role in cognitive behavioral treatments.

Quick Glance Summary

• Both CBT and ACT acknowledge the major role played by operant and classical conditioning in learning and strengthening affective and behavioral response tendencies.

• CBT views psychopathology as a result of systematically biased information processing, characterized by maladaptive beliefs and automatic thoughts.

• ACT, in contrast, views psychopathology as resulting from psychological inflexibility stemming from “fusion” (or over-connection) with thoughts and other internal experiences; problematic attempts to control, explain, or even dispute such private events rather than merely experiencing them; emotional avoidance; a lack of clarity about one’s core values; and the resulting inability to behave in accordance with those values.

• Psychological flexibility is defined as the ability to select behavior that, in one’s current context, will enable movement towards chosen life values

• ACT’s emphasis is on drawing conclusions on the basis of one’s own experiences rather than what other people say or a set of rules.

• Lack of control over our experiences is less of a problem than our ineffective, resource-wasting, and suffering-inducing attempts to exert control.

• As an alternative to a control orientation, patients are presented with the construct of acceptance, or the idea that internal experiences can be accepted fully and without defense.

• Acceptance also, in part, implies the need for a sharpened sense of awareness of the present moment, including of both external and internal events as they unfold in real time. Together awareness and acceptance are promoted through exercises such as mindful meditation

• Cognitive defusion thus refers to the ability to step back from or distance oneself from one’s thoughts in a manner that enables patients to see that their thoughts are “just thoughts” that need not be believed nor disbelieved.

• ACT also works to decrease excessive focus on and attachment to the conceptualized self.

• ACT utilizes values clarification to help the patient identify and crystallize key personal values and to translation these values into specific behavioral goals

• ACT promotes the concept of "committed action" to increase action towards goals and values in the context of experiential acceptance.

• A fundamental ACT principle is that the very desire to do away with distressing feelings or thoughts is often itself problematic, and furthermore that it is possible to engage in desired behaviors even while having highly unpleasant subjective experiences.

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