

Acceptance and Commitment Therapy and the New Generation of Cognitive Behavioral Treatments

Iftah Yovel, PhD

Department of Psychology, The Hebrew University of Jerusalem, Jerusalem, Israel

Abstract: Acceptance and Commitment Therapy (ACT) is one of several recently-developed acceptance-based cognitive behavioral treatments which broaden the scope of CBT. The theory underlying ACT suggests that verbal representations generated by the human mind inevitably increase the psychological presence of pain and often lead to psychological inflexibility or the dominance of language products over other sources of information. Furthermore, the adequacy of problem-solving strategies that are used to achieve desired goals and decrease suffering is substantially decreased when applied to private experience. Therefore, humans have a greatly expanded capacity to experience aversive stimulation, but simultaneously are not well-equipped to deal effectively with such unwanted experiences. Acknowledging the inevitability of psychological pain, ACT aims at replacing experiential avoidance and similar harmful processes with more adaptive strategies, with the general goal of pursuing broad life objectives. This is achieved by encouraging mindful acceptance of unwanted experiences and by fostering committed action which is consistent with one's chosen values.

Over the past fifteen years, the field of behavioral and cognitive therapies has witnessed the development and rapid rise of a new generation of clinical approaches that share several core features. These advancements led to the notion of an emergence of a “third wave” in CBT that may succeed previously-developed behavioral and cognitive treatments, which represent the first and second revolutions in psychotherapy, respectively (1). Examples of this new generation of treatments include acceptance and commitment therapy (ACT)(2), dialectical behavior therapy (DBT) for borderline personality disorder (3), mindfulness-based cognitive therapy (4) and behavioral activation (5) for depression, among several others. There is no consensus on the notion of a “third wave” revolution in CBT. However, even if regarded merely as extensions of existing cognitive and behavioral therapies, these treatments seem to be based on intriguing theoretical ideas and offer a variety of helpful therapeutic techniques (6).

Similarly to earlier forms of CBT, these new therapies focus on behaviors and cognitions, they are grounded in basic science, and are collaborative,

active, practical, goal-directed and evidence-based treatments. Moreover, some (though not all) of the ideas upon which they are founded and the interventions they utilize are essentially similar to “traditional” behavioral formulations and techniques. However, rather than focusing on the change of the form, content or frequency of narrowly-defined disturbing psychological events, these therapies, partly due to the influence of eastern philosophies, focus on changing the *function* of such events and the way individuals relate to them (7). Thus, relative to most other types of CBT, these treatments tend to have broader objectives, as they often seek to create more flexible and effective psychological repertoires that would serve peoples' goals and chosen values.

The present article focuses on ACT, an influential comprehensive clinical approach, which takes a central role among the new generation of cognitive behavioral treatments. ACT is not a treatment manual for a specific condition; neither it is a collection of interventions. It is a broad therapeutic perspective, and the main purpose here is to provide a concise account of its philosophical

Address for Correspondence: Iftah Yovel, PhD, Department of Psychology, The Hebrew University of Jerusalem, Mount Scopus, Jerusalem 91905, Israel. E-mail: yoveli@mscc.huji.ac.il

background, theoretical elements and key aspects. Specific ACT-based treatment guides for a variety of problems and populations, which keep evolving, as well as the growing literature supporting the efficacy of these treatments, are described in detail elsewhere (8).

ACT: Theory of Psychopathology

Medical and behavioral approaches to mental health typically assume that psychological suffering is the result of psychopathological processes associated with abnormal factors, such as biological pathogens or anomalous learning histories. In ACT, on the other hand, it is assumed that psychological pain, which is ubiquitous, is the inevitable result of perfectly normal psychological processes, which may also exacerbate the effects of such abnormal factors. The theoretical roots of this fundamental clinical assumption are briefly discussed below.

The unique abilities of the human mind. Relational Frame Theory (RFT), the theoretical basis of ACT, is rooted in functional contextualism, a philosophical perspective that attempts to account for human cognition and language with behavioral analytic principles (9). According to RFT, the unique strength of the human mind lies with its ability to derive countless arbitrary connections among stimuli. Consider, for example, a little child who learns that a certain animal is called “cat,” thus forming the arbitrary connection between the word and the animal (1). Suppose that this child is later scratched while playing with a cat. After that incident, he may feel anxious, cry and run away whenever he hears anyone saying “look, a cat!” Many organisms are able to learn formal connections among stimuli (e.g., between the presence of a cat and the feelings of pain and anxiety). However, the child’s strong reaction occurs despite the fact that physical pain has never been experienced in the presence of the actual sound of the word “cat.” The child’s mind was able to bring these situations together by using the derived relations among them. According to RFT, the human mind is unique in its ability to derive complex arbitrary relations and use them in any given context.

Thus, the human mind can easily consider and manipulate events and contingencies that are

temporally or physically remote or are of very low probability, including ones that have never occurred (9). This extraordinary ability, which is the basis for language and other processes of higher cognition, is an evolutionary essential because it enables humans to evaluate and respond effectively to an extremely wide array of situations. However, according to the ACT perspective on psychopathology, this remarkable ability is also the source of a great deal of pain and suffering (2).

For humans, psychological pain is ubiquitous. Because of the nature of language and the remarkable abilities of the human mind, all types of external and internal events can become “present” at any given time via their verbal representations. Such verbal events may have a strong psychological impact if they are perceived as meaningful to the well-being of the individual. Due to evolutionary reasons, organisms are naturally biased towards attending and responding to anything that is perceived as dangerous or aversive. For humans, because of the nearly limitless ability of their minds to make any type of stimuli verbal and thus psychologically present, the availability of aversive stimuli – via their verbal representations – is exponentially enhanced. Thus, people are able to be afraid of or worry about things that are not happening at the present moment and may or may not happen at some point in the distant future. They can also compare themselves, their partner or current situation to any kind of frightening alternative or desirable ideal. For example, a socially anxious person may think “I will be anxious and miserable if I go to the party and this will be bad, and so I’d better stay home and watch TV.” To take a more extreme, but definitely not a rare example, a depressed individual may say to herself, “I feel sad and hopeless now, and this is bad. If I kill myself I will be dead and not feel anything, and this will be good” (1). Moreover, due the great capacity of the mind to generate any type of arbitrary relations, any person, object or stimuli can be connected to any type of negative emotion, irrespective of the objective or even subjective formal value of that object (e.g., “this party depresses me, because it reminds me of the times before the trauma, when I could really enjoy things”). In sum, in an inevitable course of

action, verbal representations and relations generated by the human mind enhance psychological pain because they greatly increase the reach of aversive stimuli.

Verbal processes may intensify suffering. Due to the great efficiency of language functions, verbal events and literal evaluative rules generated by the mind often tend to dominate other sources of information, including the information provided by direct experience. Hayes and colleagues (2) use the term *cognitive fusion* to describe this phenomenon, and suggest that cognitive fusion often leads to psychological and behavioral inflexibility. *Psychological inflexibility* refers to excessive attention to verbally-generated relations that tend to be rigid, at the expense of being in contact with the actual contingencies of the environment. For example, the typical behavior of phobic individuals is rigidly characterized by fear and avoidance and by refusal to examine the actual attributes of feared external objects (e.g., a cockroach) or internal events (e.g., the pain associated with getting an injection).

Moreover, being over-engaged with internal verbal relations can be detrimental in and of itself. Attempts to evaluate, find reasons, or consider the consequences of negative cognitions often make things worse by increasing the complexity and availability of these problematic verbal relations and networks, a process which is termed in ACT *cognitive entanglement* (2). Indeed, a substantial body of empirical evidence accumulated on the effects of rumination points to the pathological consequences of engaging in repetitive self-focused, negatively-valenced verbal evaluative processes (10).

Experiential avoidance and psychopathology. A predictable and harmful consequence of the dominance of literal verbal rules generated by the human mind is experiential avoidance (11). Experiential avoidance is the phenomenon that occurs when the individual is unwilling to experience negatively evaluated private experiences such as feelings, thoughts, urges, memories or bodily sensations. Indeed, many types of mental disorders (e.g., OCD, PTSD) and pathological behaviors (such as suicide or substance abuse) can be usefully conceptualized

as particularly problematic methods of experiential avoidance (11). This view is shared by other recent contextual approaches (5), and it is consistent with earlier cognitive and behavioral theories of psychopathology that emphasize the role of avoidance in the etiology of psychopathology (12).

But why would experiential avoidance be so detrimental? As discussed earlier, humans use their minds, often very successfully, to achieve desired goals and avoid stimuli or situations they deem aversive or dangerous. However, for a variety of reasons, success rates drop dramatically when the target stimuli we try to avoid (or enhance) are internal. It is a rather difficult task to “calm down” when feeling anxious, “think positive” when worrying about something or ignore physical pain. Indeed, empirical evidence supports this notion. For example, Wegner and colleagues demonstrated the futility of attempts aimed at suppressing cognitions by demonstrating how difficult it is to “not think of a white bear” (13). The literature accumulated since Wegner’s seminal study suggests that such attempts paradoxically produce the opposite outcome, as deliberate thought suppression is typically followed by a period of increased frequency of the unwanted cognition. Moreover, experiential avoidance attempts, and particularly their inevitable failure, often lead to increased stress and feelings of frustration. Then, more aversive internal experiences are likely to surface, including physical arousal, verbal evaluative processes and their emotional counterparts (e.g., feelings of failure). These, in turn, are likely to intensify the attempts to employ self-focused avoidance strategies, thus creating a pathological vicious cycle. Indeed, many studies suggest that this “white bear phenomenon” of failed thought suppression characterizes and is even etiologically related to several psychopathological syndromes including OCD, depression and PTSD (14). Thus, the human mind, which is the source of much of the pain we psychologically encounter, is quite ineffective in dealing with the aversive stimuli it creates.

Experiential avoidance, especially when it is relatively isolated and time-limited, is not always harmful. It becomes problematic when people *persistently* attempt to modify the form or frequency of unwanted experiences or the contexts in which

they occur. Management of inner experiences is particularly detrimental when it adversely affects other aspects of life and stands in the way of achieving one's goals (e.g., when a socially-anxious individual refuses promotion at work because the new job involves public speaking). Indeed, as acknowledged by many forms of CBT, avoidance can be particularly tricky when it provides short-term relief, but for the heavy price of long-term suffering.

In essence, any thought, memory, feeling, urge or sensation, regardless of its formal value, can potentially become the target of avoidance. Thus, depressed individuals typically avoid engaging in potentially pleasant activities, any trauma-related object or cognition may be avoided in PTSD, and it is not uncommon to encounter individuals who refrain from being sexually aroused because they associate such feelings with panic symptoms. Indeed, the scope of the targets of experiential avoidance is closely related to the extraordinary ability of the human mind to make an infinite number of connections and associations. Therefore, enormous amounts of time and effort are often devoted to the management of one's aversive inner experiences, to the extent that life itself is "put on hold" (15). People may then comfort themselves that once they "get over" their problems, they will be able go on with their lives. One of the main goals in ACT is to make clients realize that the former is not a necessary condition of the latter.

Basic Features of ACT

Key assumptions. The therapeutic process in ACT is directly based on the perspective that the experience of psychological pain is unavoidable and that the use of experiential avoidance and similar coping mechanisms to deal with this pain, though understandable, often increases suffering. Usually, the main goal of the first phase of treatment is to help clients recognize the extent to which this is relevant to their idiosyncratic problems by carefully examining the nature of these difficulties and the effectiveness of their previous coping attempts.

In ways that are too many to mention here, our culture fosters the management of inner experiences (2). For example, we are taught that negative feelings and thoughts are bad and ought to be

removed or at least minimized, and that positive ones should always be aspired to. Similarly, many forms of pharmacotherapy and psychotherapy target the replacement of certain aversive inner experiences (e.g., anxiety, irrational thoughts) with more positive or adaptive ones. In contrast, in ACT it is not assumed that, for example, the problem in "anxiety disorders" is anxiety per se, and treatment does not aim at modifying the form, content or frequency of unwanted feelings, cognitions, urges or physical sensations. Instead, it aims at changing the context in which these events occur. Contexts are assumed problematic when such internal unwanted events need to be explained, believed or disbelieved (thus leading to cognitive entanglement), controlled (thus leading to experiential avoidance), or acted upon (thus causing adverse behavioral outcomes).

For example, in contrast to some other forms of treatment (including earlier forms of cognitive therapy), ACT does not attempt to directly modify "problematic" cognitions. Rather, it is assumed in ACT that relational networks are numerous, elaborated structures that, once established, tend to maintain and preserve themselves. Consequently, it is very difficult to restrict, change or eliminate cognitions via verbal analysis (2). Instead of focusing on the validity of the content of thoughts, therapy aims at changing their function and reducing their impact. Consider, for example, the conceptualized self (e.g., "I am a failure"). In ACT, the content of such cognitions is not directly challenged. Instead, therapy focuses on modifying the ways such cognitions are perceived and the regulatory power they have on the person's life.

Basic processes. The general goal in ACT is to increase psychological flexibility, defined as the ability to consciously and mindfully experience the present moment and behave in ways that serve one's valued goals (2). This is achieved via several overlapping and interrelated core processes or domains of interventions described briefly below.

As an alternative to experiential avoidance, *acceptance* is taught as the conscious and active experience of unwanted private events, without attempting to alter their form, content or frequency, particularly when these attempts cause adverse

consequences. To ensure motivation, clients are first encouraged to consider the price of their control attempts and examine their long-term effectiveness. Rather than challenging the content of thoughts, the purpose of *cognitive defusion* techniques is to modify the undesirable function of unwanted cognitions by changing the way people relate to them. Clients are typically asked to distance themselves from the literal quality of negative thoughts in various ways, including, for example, by treating them as external and observable events, by repeating them out loud many times or by labeling the actual process of thinking (e.g., “I am having a thought that...”). Eventually, these and other interventions help in decreasing the tendency to relate to cognitions as what they refer to (e.g., “she hates me”) instead of what they really are (the thought “she hates me”). Acceptance and cognitive defusion are closely related to the state of *being present*, or the non-judgemental mindful experience of both internal and external events. This is done by treating the *self as a context* of verbal experiences, and by a variety of mindfulness exercises in which language is used as a tool to describe rather than to evaluate events, with the goal of increasing the previously-limited repertoire of responses to such events (e.g., not only with fear and avoidance).

The skills taught in ACT are not conceptualized as ways of avoiding psychopathology, but as positive psychological skills aimed at promoting valued living. Thus, clients are encouraged to identify *values* or consistent life directions in various domains (e.g., family, career), which are not influenced by processes such as experiential avoidance or social compliance. ACT also fosters the development of *committed action*, or meaningful patterns of behaviors aimed at achieving specific and concrete goals which are consistent with one's chosen values. This is done using well-known behavioral techniques such as goal setting, problem solving, skill acquisition and exposure.

To summarize, ACT is a broad behavioral clinical approach. It encourages change and values-committed action where change is possible, and fosters acceptance and mindfulness in areas where pain is inevitable. Many “traditional” CBT interventions and techniques (e.g., behavioral analysis, exposure) are compatible with ACT. However, such

interventions may be beneficially conceptualized and perhaps further clarified using ACT perspective (e.g., by highlighting the importance of being mindful to the nature of feared objects and of accepting associated aversive inner experiences when doing exposure). Others seem to be both theoretically and practically different (e.g., cognitive restructuring vs. acceptance or cognitive defusion) (6). Finally, compared to earlier forms of CBT, ACT-based treatments typically expand the focus of change and therefore they may suit a broader range of human difficulties.

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