# Acceptance and Commitment Therapy (ACT): A Third Wave Behaviour Therapy

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**Abstract.** This paper introduces Acceptance and commitment Therapy (ACT) as one of the newer contextualist behaviour therapies. A brief history of the development of ACT is outlined. The concepts of equivalence and laterality and the important relationship between Relational Frame Theory and ACT are then described. The "hexagram" summary of the six core linked processes in ACT is presented and, finally, the research evidence to support the effectiveness of ACT applied to a range of clinical conditions and client groups is summarized.

*Keywords:* ACT, behaviour therapy, third wave therapies, contextual therapies.

## Introduction

Acceptance and Commitment Therapy (ACT) has been hailed as one of the "third wave of behaviour therapies" (Hayes, 2004) and is proving to be very popular amongst clinicians, judging by the numbers attending workshops and conferences. Its origins lie not in traditional cognitive behavioural therapies, but in Skinner's radical behaviourism (Cullen, 1991). In this paper I provide a brief overview of the history and current thinking about ACT, although it has to be understood that the therapy – or perhaps it is best thought of as a framework – is rapidly evolving. Its originator, Steven Hayes, refers to it as a "work in progress". It is important to consider the historical roots, since the philosophy underlying ACT is crucial. Detailed discussion of what is involved in the therapy is to be found on the ACT website (www.contextualpsychology.org) and in various publications (cf. Hayes, Strosahl and Wilson, 1999). The hugely successful self-help book by Hayes and Smith (2005), and therapist manuals such as Luoma, Hayes and Walser (2007) are particularly useful.

## Early days

Zettle (2005) presents a scholarly analysis of the evolution of ACT. In 1976 Zettle became the first doctoral student of Steven Hayes, the 'founder' and most prominent exponent of ACT. Together they started to explore the role of language in clinical conditions, particularly the role played by verbal and rule-governed behaviour. This was an important topic in radical behaviourism and had been discussed extensively by Skinner (cf. Catania and Harnad, 1988).

The work carried out by Hayes and Zettle was a direct challenge to the cognitive behaviour therapy (CBT) of Mahoney (1974) and also to Ellis' Rational Emotive Therapy, Beck's Cognitive Therapy, and Bandura's Social Learning Theory, all of which had been grouped into the fold of CBT. Zettle and Hayes (1982) argued that radical behaviourism and behaviour analysis provided an appropriate philosophical and scientific basis for cognitive behavioural therapies; in particular, the part played by rule-following in clinical problems was emphasized. Their position was that CBT, while apparently effective, lacked a sound, scientific explanatory basis.

At the same time Hayes was developing a new treatment protocol that became known as "comprehensive distancing", this name being influenced by Beck's emphasis on the importance of clients being able to "distance" themselves from their thoughts, emotions and beliefs (Zettle and Hayes, 1982, p. 107). The essence of comprehensive distancing, which is retained in ACT, is that attempts to control thoughts and feelings are often counter-productive, and make the problem worse. Many clients' problems exist or are exacerbated because they are trying to control thoughts and feelings by avoiding or escaping from them. Experiential avoidance, it was argued, underlies much of human suffering (Hayes and Melancon, 1989). Hayes (1987) describes the syllogism underlying the five stage "trap" of traditional cognitive approaches:

1.  Behaviour is caused by something
2.  Reasons are causes
3.  Thoughts and feelings are reasons
4.  Therefore thoughts and feelings are causes
5.  To control behaviour we must control thoughts and feelings

This is a "false" syllogism. Being able to give a reason for psychological distress does not mean that its causes have been identified, as we have been taught by Freud and others since. Typically, people identify thoughts, feelings and beliefs when asked to "explain" their behaviour.

What comprehensive distancing did was to "undermine" this system (Hayes, 1987, p. 342) by telling clients that control is the problem, and that so long as they try to control thoughts and feelings – as in CBT – they are likely to continue to experience emotional suffering.

### Equivalence and literality

Comprehensive distancing also relied heavily on the behaviour analysis research area of equivalence (cf. Sidman, 1994). A substantial amount of behavioural research had been carried out into how arbitrary stimuli can become equivalent to each other. A child is taught that a picture of a dog is equivalent to the spoken word "dog", and that the spoken word "dog" is equivalent to the written letters D-O-G. Once these two relations have been learnt, then, *without further training*, the child knows that the written word D-O-G is equivalent to the picture of a dog. So far as we know, this appears to be a fundamentally unique type of stimulus control that is acquired readily by verbal humans, and hardly ever – if at all – by non-humans.

The relevance of equivalence relations to understanding human behaviour lies in the idea that thoughts and feelings are often in equivalence sets, so that the thought becomes as salient as the subject of that thought. For example, being hurt, physically or emotionally, is a real world

phenomenon that the majority of people would prefer to avoid or escape from. Thinking about being hurt may come to be as powerful as the hurt itself, and acquires the same properties, so that we try to avoid or escape from the thought *as if it were* the event itself. This is referred to as "literality". For example:

> The word anxiety takes on a literal meaning, and the very reading or thinking of the word can bring into the client's immediate experience the entire spectrum of negatively perceived events with which it is related. (Hayes and Melancon, 1989, p. 190)

### Relational frames as a post-Skinnerian analysis

Comprehensive distancing thus began its transition to become a cognitive behaviour therapy (Zettle, 2005). Put bluntly, since the majority of clinicians had been alienated by usually inaccurate and unsympathetic presentations of radical behaviourism, and had shown that they were unlikely to embrace a therapeutic approach based on radical behaviourism, the best tactic would be to engage with the therapeutic milieu that was prominent at the time – CBT.

This made considerable sense. Radical behaviourists had long acknowledged the importance of private events such as thoughts and feelings and had attempted to provide a natural science account of them (cf. Skinner, 1945, 1963). Skinner was interested in the application of radical behaviourism, although he was not himself a clinician. For example, in the 1930s he had worked with Henry Murray, the psychoanalyst originator of the Thematic Apperception Test, one of the most widely used projective personality tests, in devising the verbal summator (Skinner, 1936). He also published papers on psychosis, anxiety, psychoanalysis, and intellectual impairment (Skinner, 1972).

Hayes and his network of colleagues began to develop a "post-Skinnerian" approach to language and cognition as it became clear that Skinner's theoretical analysis of verbal behaviour was not – in their eyes – able to account for the language and cognition that are important in many clinical situations. Equivalence relations, for example, came to be seen as one of the types of relations that can exist among verbal events, and as an example of the broader area of relational frame theory (RFT), which underpins ACT (cf. Blackledge, 2003). Zettle (2005) identifies the development of RFT as the transition period between comprehensive distancing and ACT.

Emphasizing the relation between RFT and ACT encourages debate on whether one can be a truly competent practitioner without understanding the theoretical basis of the practice. This debate has been around in behaviour analysis for many years (cf. Michael, 1980; Baer, 1981). At numerous conventions at which Hayes has presented ACT, he often makes reference to the theory underlying it (RFT), but says that it is too difficult and time consuming to go into. In the popular self-help book on ACT (Hayes and Smith, 2005), RFT is described as "technical, extensive, and . . . hard to explain" (p. 199). However, in recent years the emphasis has shifted, and a glance at the ACT website – an extensive and comprehensive repository for ACT resources – shows how RFT and ACT are inter-related, and how RFT informs our understanding of verbal behaviour and its role in clinical problems.

Hayes and Smith (2005) describe a number of frames of relation between things and events. These include frames of co-ordination (e.g. "same as"); temporal and causal frames (e.g. "if/then"; "cause of"); comparative and evaluative frames (e.g. "better than"; "more successful than"); and spatial frames (e.g. "near/far"). They argue that the ability to form and use such

relational frames lies at the very heart of humankind's ability to cope so successfully. However, the flip side of the coin is that relational frames can also be at the core of psychological distress. They put it neatly thus:

> [E]ven beautiful sunsets may not be safe for human beings in pain. . . If "happy" is the opposite of "sad", then happiness can remind human beings of being sad. The two are related.
>
> (Hayes and Smith, 2005, p. 21)

RFT explains how (and why) we are able to carry our hurt around with us, and how even the most innocuous sights, sounds, smells or events can trigger painful thoughts and emotions. Many of us expend considerable psychological energy in trying to avoid, escape from, or otherwise control these phenomena.

## Core ACT processes

ACT is described as a set of six core processes, linked to each other in various ways. Hayes presents this diagrammatically as a hexagram, with each element at a corner, to show that the processes in combination form a variety of functional units. Each of these is a "positive psychological skill" rather than – as with comprehensive distancing (cf. Zettle, 2005) – a way of eliminating pathology. There is no necessary "order" in these, as in a traditional treatment manual. The aim is to increase psychological flexibility, described in various publications and on www.contextualpsychology.org as: "contacting the present moment fully as a conscious, historical human being, and based on what the situation affords changing or persisting in behaviour in the service of chosen values."

The six core processes come together to enhance psychology flexibility. The first process is acceptance, not an end in itself but an alternative to avoidance. For example, rather than trying to control the extent or frequency of feelings of anxiety (as in traditional CBT?), the client is encouraged to "feel" anxiety as it is, a bodily state. Clients are helped to accept the feeling of anxiety without trying to escape from it; to embrace the feeling actively and with awareness.

Cognitive defusion is a related process and together with acceptance undermines the literality of private events. A particularly painful thought will be examined, reported, spoken out loud until it "becomes" what it actually is rather than the event or thing thought about. There are clear parallels here with exposure procedures. The more one can be "with" a painful thought or feeling, the more likely it is that the suffering associated with that thought will diminish.

Two other processes – being in the present and understanding self as context – deal with how a person makes contact with the present moment and has a sense of "being". As in mindfulness-based therapies (cf. Williams, Teasdale, Segal and Kabat-Zinn, 2007), these processes work together to help the client to experience the here-and-now, rather than living in their "mind", going over past or hypothetical future events. These processes are fostered in ACT by mindfulness exercises, experiential processes and the use of metaphor. Strosahl, Hayes, Wilson and Gifford (2004) suggest many interesting clinical interventions for each of the processes.

Clarifying and understanding values, and committing to action, are the "activation" processes, helping the client to move forward in their chosen life directions. One of the specific outcome measures used by ACT practitioners involves getting clients to evaluate the extent to which their behaviour is in accord with their values.

Hayes, on www.contextualpsychology.org, defines ACT thus:

> ACT is a functional contextual therapy approach based on Relational Frame Theory which views human psychological problems dominantly as problems of psychological inflexibility fostered by cognitive fusion and experiential avoidance. In the context of a therapeutic relationship, ACT brings direct contingencies and indirect verbal processes to bear on the experiential establishment of greater psychological flexibility primarily through acceptance, defusion, establishment of a transcendent sense of self, contact with the present moment, values, and building larger and larger patterns of committed action linked to those values.
>
> Said more simply, ACT uses acceptance and mindfulness processes, and commitment and behaviour change processes, to produce greater psychological flexibility.

## Effectiveness of ACT

ACT has been used with a wide variety of populations and problems, including adults and children with common psychological problems such as anxiety and depression, psychosis, chronic pain, phobias, worry, social anxiety, intellectual impairment, and autism. The most useful resource for those wanting to examine outcome and other literature is the website www.contextualpsychology.org. There are many training workshops throughout the UK and elsewhere, but no formal accreditation system, unlike the situation with most other modalities.

There is a disparity between the amount of time ACT has been around (over 20 years) and the number of high quality randomized controlled trials that have been published. Hayes, Luoma, Bond, Masuda and Lillis (2006) and Hayes, Masuda, Bissett, Louma and Guerrero (2004) have comprehensively reviewed all existing literature up to Spring 2005 that relates to ACT or its components:

> Reviewing the entire body of evidence suggests that the ACT model seems so far to be working across an unusually broad range of problems, and across a range of severity from psychosis to interventions for ordinary people (e.g. worksite stress interventions). Effect sizes generally seem somewhat larger with more severe problems, and larger at follow-up than immediately post intervention, although the literature is too young to say for sure. The studies conducted so far cover different ethnic groups, classes and geographic regions, from poor institutionalized native South Africans to behavioural health professionals in the United States, with no indication that outcomes or processes covary in accord with such factors. It appears that the processes targeted by ACT are at least in part responsible for the outcomes ACT produces and that these processes seem not targeted, or are not targeted as efficiently, by the other treatments examined so far, including empirically supported interventions such as traditional cognitive and cognitive-behavioral therapy. It also appears that the processes being targeted seem to work in broadly similar ways across the tested range of settings and populations. (Hayes et al., 2006, p. 21)

The authors go on to point out that many studies of ACT are relatively limited in scope and short in duration. However, it is only in recent years that there has been a body of clinicians/researchers in the ACT "community" available to carry out the research.

At national and international conventions, ACT sessions are very well attended, with keynote addresses often standing room only. ACT workshops in the UK are generally oversubscribed. Is this because clinicians are deserting traditional CBT in their hundreds, or is it that they are looking for "new tools" to add to their eclectic clinical toolbox? In my experience, there

are many clinicians only too willing to engage with the clinical tools – such as the use of ACT metaphors – while not seeing the necessity of engaging with the tenets of RFT or even behaviour analysis. However, perhaps it has always been so, and as Baer (1981) argues, may not necessarily be a bad thing.

Perhaps what is happening is that earlier forms of CBT have been found wanting and clinicians are gradually moving to approaches that offer more sophistication. Hayes (2004) uses the term "third wave" for newer therapies that adopt a more contextualist approach, placing value on the functions of behavioural and private events rather than their form. Among the first approaches to specifically challenge CBT from within were dialectical behaviour therapy (Linehan, 1993) and mindfulness-based cognitive therapy (Williams et al., 2007), but there are a number of other contextualist models such as functional analytic psychotherapy (Kohlenberg and Tsai, 1991). Hoffman and Asmundson (2008) use the term "enriched CBT" to describe CBT that includes acceptance-based strategies. Many of these approaches adopt experiential procedures that help clients to be in the present moment, and to give up the struggle for control of difficult thoughts and emotions, as a prelude to behavioural change. They work on the assumption that understanding context is important. The importance of ACT might be in getting clinicians to appreciate that understanding context lies at the heart of understanding human behaviour.

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