Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for the Anxiety Disorders: Two Approaches With Much to Offer

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Arch and Craske (2008) examine the similarities and differences between cognitive behavioral therapy and acceptance and commitment therapy for the anxiety disorders and suggest that the two treatment approaches have as many similarities as differences. We agree and believe that there is merit in this conclusion—it brings us together in common purpose and helps move us toward improved approaches to reducing client suffering. Our discussion focuses on the similarities that we think about most positively and the differences of which we should be mindful.

Key words: acceptance and commitment therapy, anxiety disorders, cognitive behavioral therapy, meditation, treatment mechanisms. [Clin Psychol Sci Pract 15: 296–298, 2008]

Unlike much of the rhetoric that has attempted to describe acceptance and commitment therapy (ACT) as the next wave of behavior therapy, holding the promise to correct the multitudes of inadequacies of cognitive behavioral therapy (CBT), Arch and Craske (2008) give credit to both CBT and ACT for their substantial contributions and for their potential importance to the future understanding and treatment of anxiety and its disorders. We believe that the philosophical, and ultimately empirical, approach espoused by Arch and Craske will lead us more efficiently to answer a most important question: How do we best go about the business of assisting clients with anxiety disorders to lead less distressing, happier, and more fulfilling lives?

Examinations of the similarities and differences between CBT and ACT have appeared here and elsewhere (e.g., Hofmann & Asmundson, 2008). Part of our pleasure at seeing these articles is that they help us to come to a place of mindful distance, observation, and engagement. As Arch and Craske (2008) point out, attempts to distinguish novel treatment approaches from more traditional ones may serve to amplify differences rather than similarities, providing us with less than a totally accurate snapshot of the current state of affairs and sometimes interfering with attempts to seek out meaningful differences. In this commentary, we consider what we see as the most important similarities and differences between CBT and ACT for the anxiety disorders.

The discussion of the theoretical and pragmatic distinctions between cognitive restructuring in CBT and cognitive defusion in ACT is quite interesting. One of the criticisms leveled at CBT by advocates of ACT is that cognitive restructuring may be counterproductive. In discussing this criticism, both Arch and Craske (2008) and Hofmann and Asmundson (2008) refer to the work of Gross (2002) on emotion regulation. Hofmann and Asmundson draw the useful distinction from Gross's work that CBT relies more heavily on antecedent-focused strategies for emotion regulation, whereas ACT relies more heavily on response-focused strategies for the same goal. Gross (1998, p. 275) defines emotion regulation as “the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions.” These are important goals for individuals with anxiety disorders when applied in adaptive fashion: When maladaptively applied, they become a mechanism for avoidance of emotional experience (Mennin, Heimberg, Turk, & Fresco, 2002, 2005). Emotional avoidance is not an acceptable outcome for either CBT or ACT, although ACT proponents have made experiential avoidance (somewhat broader than emotional avoidance) a key target of treatment.

Hayes, Strosahl, and Wilson (1999) suggest that cognitive restructuring (a) focuses too much on cognitive content and (b) communicates to the client that anxious thinking needs to be suppressed. Of course, the literature on thought suppression (e.g., Wenzlaff & Wegner, 2000) would suggest that this is a bad idea. However, cognitive reframing or reappraisal is a key aspect of cognitive restructuring work, and it is not dependent on suppression. Arch and Craske note that reframing generally

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decreases the intensity and expression of negative emotion without the counterproductive effects of suppression and, in fact, go so far as to describe cognitive restructuring as an approach-oriented technique for responding to anxiety. We add that (without the ACT framework or the label of cognitive defusion) many clinicians who identify themselves with CBT to one degree or another have engaged in cognitive defusion techniques for many years. In working with panic disorder patients, for instance, it is typical to teach clients to identify thoughts as panic thoughts and simply instruct them to observe these thoughts and let them flow “in one ear and out the other.” We acknowledge that this is not ACT terminology, nor do we take credit for any of this. If one looks at current work on the treatment of generalized anxiety disorder (e.g., Borkovec & Sharpless, 2004; Craske & Barlow, 2008; Dugas & Robichaud, 2006; Mennin, 2005), there is an emphasis on the distinction between worries that one can objectively do something about, typically treated with a problem-solving approach, and worries that represent the creation of a fictional future or about which the person can actually do nothing, which are treated with various techniques that are consistent with an acceptance point of view. Similarly, cognitive restructuring involves looking at one’s thoughts from a different stance than has been most habitual—a method of creating distance but staying in the present moment, a variant of cognitive defusion. Cognitive restructuring challenges the frequent belief that thoughts are facts by redefining them as hypotheses to be tested against experiential evidence. It also interrupts the process of one negative thought leading to another by the mindful substitution of one cognitive activity for another.

Arch and Craske aptly note that exposure, which is a common intervention in both CBT and ACT for anxiety disorders (e.g., Eifert & Forsyth, 2005), may involve some form of cognitive restructuring as thoughts may be changed without the use of specific change techniques. Furthermore, cognitive restructuring may be a form of exposure to one’s own internal events, a process important to ACT for the anxiety disorders. Although not often mentioned, one must learn to be aware of a thought before deciding to either distance oneself from it or to change it. Engagement with the content of the thought is essential, and unavoidable, before selecting the appropriate strategy. One of us (RGH) has asked whether clients (or anyone else for that matter) are capable of adopting a truly mindful distance from their thoughts if those thoughts include irrationally excessive assessment of threat. Although this may be an empirically difficult question, evolutionary theory would suggest that we would be unlikely to do so or be able to do so, because the perception of threat should be tied to survival of the species (when that mechanism is functioning correctly).

We were struck by Arch and Craske’s statement that both CBT and ACT require thinking to avoid getting tied up in thinking. This point has been clearly made about CBT by advocates of ACT, but it is clearly true for both approaches. Mindful recognition of one’s thoughts and deciding to allow them or to react to them in particularly helpful ways requires a great deal of quite sophisticated self-instructional thinking. Not a thing wrong with that either.

Arch and Craske call for empirical research looking into components of the therapies that actually make a difference. We add that an examination of how much of each therapy actually exists in the other is quite important to undertake. There is a lot of acceptance-oriented material in the way many do CBT.

An aside that is relevant to the treatment of anxiety disorders, the question of whether cognitive restructuring adds to the efficacy of exposure, is a bit of a straw person. A careful examination of research studies reveals that they are typically underpowered to find differences between active treatments. They also tend to use a design where a control group (sometimes) is tested versus exposure alone versus exposure plus cognitive techniques—a design that compares 0 treatment versus 1 treatment versus 2 treatments. One can argue that the component added last will be least likely to demonstrate an effect. The literature is almost totally devoid of full factorial designs. Along another line of reasoning, treatments involving exposure plus cognitive techniques actually use less exposure to achieve roughly the same outcomes. Given that exposure can be emotionally painful and difficult to arrange, a tie in terms of outcomes may actually favor the full CBT package. This view is important in interpreting some of Arch and Craske’s points, and it suggests that the position attributed to Hayes et al. (i.e., that cognitive techniques are not needed) can be viewed from a broader perspective.

It is important that we do not place mindfulness under the sole purview of ACT. It is a potentially potent
therapeutic tool and ACT uses it well. However, it has been used by others for a long time. This includes Kabat-Zinn (1990), Borkovec (2002; Borkovec & Sharpless, 2004), and Roemer and Orsillo (2002, 2007).

The debate on the relative emphasis on symptom reduction versus valued living is important, and ACT advocates have brought this into focus. However, we have long wondered about the size of the gulf between the two therapies. ACT’s position is perhaps more clearly articulated, but there are few CBT therapists who want to help their clients achieve anxiety reduction so that they can sit more comfortably at home doing nothing. Coming from the perspective of either ACT or CBT, we work with clients to achieve their important (valued) life goals (e.g., relationships, independence). CBT endorses the idea that it is easier to do this in the context of less anxiety, but it is also fine with the idea that clients need to take action, even when anxious, if such action moves them closer to the goal. In fact, this is often a focus of cognitive intervention in CBT for social anxiety (Heimberg & Becker, 2002). Perhaps the “values” piece of ACT, though with the least empirical support at present, may emerge as more important.

REFERENCES


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