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Acceptance and Commitment Therapy (ACT): An Analytical Review

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Abstract:
Acceptance and commitment therapy is the third wave of behaviour therapy. In Indian researches there is a paucity of researches on ACT, but the use of Acceptance and commitment therapy in psychotherapeutic management is increasing day by day. This article analyzes the general empirical evidence concerning Acceptance and Commitment Therapy (ACT). In the first place, a brief description of the ACT philosophical and theoretical roots is presented. Subsequently, the most fundamental characteristics of the ACT model for psychological intervention are described. Then, a review of the correlational, experimental psychopathology and outcome studies that are relevant to the ACT model empirical status is exposed. In general, the evidence regarding all these types of studies is very coherent and supports the ACT model. ACT is found to be related with a wide range of psychological disorders and mediates the relation between different type of symptoms and psychological constructs; component studies are showing that acceptance-based protocols are usually more efficacious than other control-based protocols; outcome studies show the efficacy of ACT in a wide range of psychological problems and suggest that it is working through its hypothesized processes of change.

Keywords: *Acceptance and commitment therapy*

1. Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy is a third-wave behaviour therapy rooted in the philosophical tradition of functional contextualism (Hayes, Hayes, Reese, & Sarbin, 1993) and based on Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001). ACT has two major goals: (a) actively accepting unwanted and perhaps uncontrollable thoughts and feelings and (b) commitment and action towards goals that are aligned with one's chosen values. Thus, ACT is about acceptance and change at the same time (Eifert & Forsyth, 2005). ACT is predicated on the notion that psychological suffering is caused by cognitive entanglement (i.e., fusion with maladaptive thoughts), psychological rigidity that prevents individuals from taking action towards their values, and "experiential avoidance" (behaviors that are intended to alter the intensity or frequency of unwanted private experiences such as unpleasant thoughts, feelings, and bodily sensations; Hayes et al., 1999). Six core processes of ACT are used to increase psychological flexibility. These include,

- Cognitive defusion: strategies to reduce the reification of thoughts, sensations, and emotions;
- Acceptance: allowing experiences to be as they are without resistance;
- Contact with the present moment: being open, interested, and receptive to the here and now;
- Self as context: developing a concrete sense of self as observer that is stable and independent of the changing experiences of each moment;
- Values: defining what is most important in a person's life; and
- Committed action: taking actions that are guided by one's values.

2. The Goal of ACT

The goal of ACT is to create a rich and meaningful life, while accepting the pain that inevitably goes with it. 'ACT' is a good abbreviation, because this therapy is about taking effective action guided by our deepest values and in which we are fully present and engaged. It is only through mindful action that we can create a meaningful life. Of course, as we attempt to createsuch a life, we will encounter all sorts of barriers, in the form of unpleasant and unwanted 'private experiences' (thoughts, images, feelings, sensations, urges, and memories). ACT teaches mindfulness skills as an effective way to handle these private experiences. What is mindfulness? It is defined as: 'Consciously bringing awareness to your here-and-now experience with openness, interest and receptiveness.' There are many facets to mindfulness, including living in the present moment; engaging fully in what you are doing rather than 'getting lost' in your thoughts; and allowing your feelings to be as they are, letting them come and go rather than trying to control them. When we observe our private experiences with openness and receptiveness, even the most painful thoughts, feelings, sensations and memories

can seem less threatening or unbearable. In this way mindfulness can help us to transform our relationship with painful thoughts and feelings, in a way that reduces their impact and influence over our life.

3. How Does ACT Differ from Other Mindfulness-Based Approaches?

ACT is one of the so-called 'third wave' of behavioural therapies—along with Dialectical Behaviour Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT) and Mindfulness- Based Stress Reduction (MBSR)—all of which place a major emphasis on the development of mindfulness skills. Created in 1986 by Steve Hayes, ACT was the first of these 'third wave' therapies, and currently has a large body of empirical data to support its effectiveness. The 'first wave' of behavioural therapies, in the fifties and sixties, focused on overt behavioural change and utilized techniques linked to operant and classical conditioning principles. The 'second wave' in the seventies included cognitive interventions as a key strategy. Cognitive-behaviour therapy (CBT) eventually came to dominate this 'second wave'.

ACT differs from DBT, MBCT, and MBSR in many ways. For a start, MBSR and MBCT are essentially manualised treatment protocols, designed for use with groups for treatment of stress and depression. DBT is typically a combination of group skills training and individual therapy, designed primarily for group treatment of Borderline Personality Disorder. In contrast, ACT can be used with individuals, couples and groups, both as brief therapy or long term therapy, in a wide range of clinical populations. Furthermore, rather than following a manualised protocol, ACT allows the therapist to create and individualise their own mindfulness techniques.

4. What is Unique to ACT?

ACT is the only Western psychotherapy developed in conjunction with its own basic research program into human language and cognition—Relational Frame Theory (RFT). ACT does not have symptom reduction as a goal. This is based on the view that the ongoing attempt to get rid of 'symptoms' actually creates a clinical disorder in the first place. As soon as a private experience is labeled a 'symptom', it immediately sets up a struggle with it because a 'symptom' is by definition something 'pathological'; something we should try to get rid of. In ACT, the aim is to transform our relationship with our difficult thoughts and feelings, so that we no longer perceive them as 'symptoms'. Instead, we learn to perceive them as harmless, even if uncomfortable, transient psychological events.

5. ACT Empirical Reviews

This review contained the correlational evidence concerning experiential avoidance, the experimental psychopathology and ACT component studies, the randomized controlled trials (RCT) and processes of change studies. The first exhaustive review of ACT empirical evidence was published (Hayes et al., 2006). Subsequently, Öst (2008) carried out a qualitative and quantitative review of the ACT empirical evidence from RCTs. The reported effect sizes were very similar to ones presented by Hayes et al. (2006). Specifically, over the 15 RCTs considered, the effect sizes were: d= .96 versus no treatment control condition, d= .79 versus TAU, and d= .53 versus active treatments. In order to establish a path for comparing ACT versus Cognitive Behavioral Therapy (CBT), this author selected a "twin" CBT study published in the same journal within a difference no greater than one year. The conclusion was that ACT studies showed lower scores in a methodological scale compared with CBT studies. Finally, Öst (2008) concluded that ACT does not fulfill the criteria for being considered as an empirical validated treatment (Chambless & Ollendick, 2001).

However, Gaudiano (2009) has conducted a re-analysis of this review. According to it, 38% of the ACT studies could not be "matched" with a CBT study because the studies were conducted over different disorders. In fact, most of the ACT studies described treatments implemented to more difficult problems shown by more resistant populations than the CBT studies did (specifically, ACT: 2 studies in depression, 3 in anxiety disorders, 2 in chronic medical conditions, 2 with psychotic symptoms, 2 in addictions, 1 in chronic pain and 1 in borderline personality disorder; while CBT: 2 studies in depression and 11 in anxiety disorders). Another relevant issue was that CBT studies were 4.5 more times funding than ACT studies were. Furthermore, the difference in the methodological rigor between CBT and ACT studies could be due to these two factors (the more difficult problems treated in ACT studies and the difference in funding that ACT and CBT studies received). More recently, Powers, Zum Vörde Sive Vörding, & Emmelkamp (2009) have conducted another meta-analytic review of ACT empirical evidence in RCT studies. The conclusions of this review were that ACT is better than wait-lists and placebo attention conditions (g= .68), better than TAU (g= .42), but not significantly better than established treatments (g= .18; p= .13). However, Levin & Hayes (2009) have re-analyzed the database reported by Powers et al. (2009) concluding that ACT was better than established treatments (g= .27; p= .03). In sum, during the last few years several controversies have appeared with respect to the empirical status of ACT. These controversies have been focused on a specific type of studies (the RCTs), comparing the differential effect of ACT versus other conditions and comparing the methodology of ACT studies with those employed in CBT studies.

Accordingly to these studies: (1) ACT is better than control and TAU conditions (Hayes et al., 2006; Öst, 2008; Power et al., 2009); (2) more evidence is needed in order to determine if ACT is better than established treatments (Levin & Hayes, 2009; Powers et al., 2009); (3) the RCTs conducted in ACT literature can be methodologically improved (Öst, 2008), although such limitations are characteristic of the earlier RCTs of any emerging psychotherapeutic approach (Gaudiano, 2009).

However, in my opinion, the debate has been narrowed into very specific issues and a global vision of the ACT model characteristics and empirical evidence has been lost. About many years have passed since the Hayes et al. (2006) global review of ACT model, and a good number of studies have been conducted during this time. The aim of this article is to summarize the current evidence of the ACT model to take a global vision of the singular characteristics of it.

6. Outcome Studies

Outcome studies are reviewed below for studies in clinical psychology are presented. Subsequently, studies in health psychology are reviewed and, finally, studies in other areas such sport performance, work stress or in prejudice are exposed. At the end of each area, tables that summarize the studies are presented. Such tables contain relevant data: comparison treatment, number of participants and sessions, effect sizes and processes of change. Effect sizes that have been not reported in the original works have been calculated using Cohen's d when data were available. Since the aim is not to conduct a meta-analytic review, all types of outcome studies are taken into account.

Clinical Psychology. Presently, two studies have investigated the effect of ACT in depressed patients. In a small RCT, Zettle & Hayes (1986) compared an initial version of ACT called Comprehensive Distancing, applied in 12 sessions, with two versions of Beck's Cognitive Therapy (CT). ACT was better than the two CT versions in the reduction of depressive symptoms at post-treatment and at the 2 month follow-up. Recently, Hayes et al. (2006) have conducted a mediational analysis of the data of this study. The conclusion is that the scores in the ATQ-B (Automatic Thoughts Believability Questionnaire; Hollon & Kendall, 1980) that was taken as measure of cognitive fusion, mediated the results of the Beck Depression Inventory (BDI) and the Hamilton's Depression Scale (HRS-D) according to the four steps of the mediational model proposed by MacKinnon (2003). Specifically, the higher the changes in the believability of the depressive thoughts were at mid-treatment, the higher the effect in the scores of BDI and HRS-D were at post-treatment and follow-up.

In a subsequent study, Zettle & Rains (1989) compared the differential effect of ACT in group format versus the previous two CT versions applied also in groups. There were not statistically significant differences at post-treatment or at the 2 month followup. However, a recent analysis (Hayes et al., 2006) have found a medium differential effect size between ACT and the complete version of CT (d= .53 at post-treatment and d= .75 at follow-up). Zettle, Rains, & Hayes (in press) have conducted a meditational analysis concluding that the level of cognitive fusion at post-treatment mediated the effect at follow-up. With respect to anxiety disorders, there are two studies in OCD, one in which a multiple baseline design across participants was used (N= 4) showing positive results with all participants (Twohig, Hayes, & Masuda, 2006) and a RCT that compares ACT with Progressive Relaxation Training (Twohig, 2007). Preliminary data in the later study showed that at post-treatment and at the 3 month follow-up, the ACT group showed less compulsion than the relaxation group. The results of the mediational analysis revealed that changes in experiential avoidance and cognitive fusion were produced previously and mediated the changes in the measures of the level of severity of OCD. Four studies have been conducted in Social Phobia (SP). In the first study, Block (2002) compared 6 group sessions of ACT versus 6 group sessions of Cognitive Behavioral Therapy (CBT) in participants with subclinical social anxiety (N= 26). At post-treatment, the ACT group was better than CBT in a behavioral measure of public speaking. Three open trials have been conducted showing that ACT is a promising treatment for SP (Dalrymple & Herbert, 2007; Kocovski, Fleming, & Rector, 2009; Ossman, Wilson, Storaasli, & McNeill, 2006).

On Generalized Anxiety Disorder (GAD), Roemer & Orsillo (2007) have conducted an open trial in which they founded that a largely based ACT protocol obtained large effect sizes in reducing GAD symptoms. In a subsequent RCT study, Roemer, Orsillo, & Salters-Pedneault (2008) compared their protocol versus a wait-list control condition. Once again, the effects of the protocol were large

Zettle (2003) conducted a small RCT comparing 6 sessions of ACT versus the same number of session of Systematic Desensitization in the treatment of math anxiety. There were no statistically significant differences at the two month follow-up in participants' experienced anxiety. Montesinos, Luciano, & Ruiz (2006) conducted a RCT comparing a very brief protocol of only 1 session with a control condition in the treatment of subclinical worries. Participants in the ACT condition decreased their scores in the intensity and interference of worries at the 6 week follow-up.

In a related problem with anxiety as Trichotillomania, two studies have been conducted in which ACT has been combined with Habit Reversal (HR): one with a multiple baseline design (Twohig & Woods, 2004) and the other study compared ACT with a wait-list condition (Woods, Wetterneck, & Flessner, 2006). Both studies reported positive results in decreasing the number of hairs pulled. With respect to the treatment of skin picking, Lappalainen, Lehtonen, Skarp, Taubert, Ojanen, & Hayes (2007) showed that ACT obtained more improvements in the SCL-90 GSI (Global Severity Index of SCL-90; Derogatis & Cleary, 1977) at post-treatment and at the 6 month follow-up. Improvements in the ACT condition correlated with the decrease of experiential avoidance and the improvements in the CBT condition correlated with the increase of self-confidence. In Forman, Herbert, Moitra, Yeomans, & Geller (2007) study, no significant differences were found in any measure at post-treatment. Once again, there are some indications of the different process of change. Changes in patients treated with ACT were correlated with the decrease in AAQ and the increase in acceptance without judgment and acting with awareness of the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004). Changes in the CT condition were correlated with increases in the observation and description scales of KIMS. This study has not reported follow-up data.

Two studies have been conducted in addictive behaviors. Hayes, Wilson et al.(2004) presented a RCT in which they examined the treatment of polysubstance abusing individuals being maintained on methadone. Participants were assigned to either ACT, Intensive Twelve-Step Facilitation, or the methadone maintenance only. Participants in the ACT condition showed a greater decrease in objectively measured total drug use than participants in the methadone maintenance alone at the 6 month follow-up. Also, ACT participants showed greater decreases in self-reported total drug use than participants of the other two conditions.

On the other hand, Twohig, Schoenberger, & Hayes (2007) presented three case studies with marijuana dependence treated with 8 session ACT interventions. The effects of the intervention were assessed using a nonconcurrent multiple baseline across participants design. At the 3 month follow-up, 1 participant was still abstinent and the other

were using but at a lower average level of consumption compared to baseline.

In summary, it can say that ACT fundamental tenets seem to have a strong support in view of the correlational, the experimental psychopathology, and the outcome evidence. It is worth noting that ACT is a therapy with very singular characteristics. It is explicitly rooted in specific philosophical assumptions (Hayes, 1993; Hayes et al., 1988) and in a contextual approach to human language and cognition (Hayes et al. 2001).

7. References

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