

# **ACT: An Overview of Acceptance and Commitment Therapy**

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## **Abstract**

Acceptance and Commitment Therapy (ACT) is an innovative approach to psychotherapy. Currently, the American Psychological Association lists it as an empirically supported treatment for depression. ACT can be adopted to be applicable to various populations and settings. Typically ACT utilizes six core principles: cognitive defusion, acceptance, contact with the present moment, observing the self, values and committed action. A description of ACT and these core principles is provided. A review of the research on ACT is then discussed.

Acceptance and Commitment Therapy (ACT) is a relatively new intervention discussed in the literature. Currently listed as an empirically supported treatment for depression by the American Psychological Association (Hayes, 2010), it has also been suggested by Baer and Huss (2008) that ACT appears to have potential for improving well-being in a range of populations due to it being a flexible approach that can be modified for a wide range of settings and populations. ACT has been noted as the most currently utilized and actively researched of mindfulness approaches. As such, a description of ACT will be provided. Following that, the research related to the efficacy of ACT will be discussed (Forman, Herbert, Moitra, Yeomans, & Geller, 2007).

## **Overview of ACT**

ACT (spoken as a single word) is an outgrowth of clinical behavioral analysis. Behavior-change processes are linked to mindfulness and acceptance processes. "Mindfulness and acceptance skills facilitate behavior changes necessary for the client to pursue a life that feels vital and meaningful" (Baer, 2006, p. 23). It was designed to be applicable to multiple settings and populations. Adaptations exist for depression, anger, anxiety, substance abuse, parenting, work place stress, psychosis, chronic pain,

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children, adolescents and groups interventions (Baer, 2006). Harris and Hayes (2009) describe six core therapeutic processes in ACT. These are contacting the present moment (mindfulness), *defusion* (watching your thinking), acceptance (opening to what is), self-as-context (pure awareness), values (knowing what matters) and committed action (do what it takes). In contacting the present moment, one is consciously aware and not on “automatic pilot.” *Defusion* is the ability to step back from one’s thoughts and see thoughts as separate from oneself. The ACT skill of cognitive *defusion* asks clients to change their relationship to thoughts rather than trying to change the thoughts themselves. A thought is just a thought and a response to a thought is not required. Acceptance allows painful emotions and thoughts to be. Self-as-context refers to the core of which one is despite the roles one may play. Self-as-context is the transcendent self. It is the “you” that is always present, observing and experiencing and yet distinct from your thoughts. Values and committed action clarify what is important in one’s life and encourage one to take steps to implement these values. These six core processes combine to produce psychological flexibility. Psychological flexibility is, “the ability to be present, open up, do what matters” (Harris & Hayes, 2009, p. 12). The acronym for ACT is A-accept your thoughts and feelings and be present, C-choose a valued direction, T-take action (Harris & Hayes, 2009).

Cognitive fusion, experiential avoidance and private experience are key terms in the therapy. Cognitive fusion involves getting caught in a thought. In a state of *defusion* (the opposite of cognitive fusion) one sees thoughts as a bunch of words or pictures inside one’s head. Extreme fusion with a memory would be a flashback and extreme fusion with a thought would be worrying or rumination. “Fusion means entanglement in our thoughts so that they dominate our awareness and have a huge influence over our behavior” (Harris & Hayes, 2009, p. 26). Cognitive fusion is a process in which the mind attaches to a thought, taking it as literally true. It is a process that turns a thought into an assumed truth. Experiential avoidance involves the struggle to avoid unpleasant thoughts and emotions that are a part of one’s private experiences. A private experience is any thought or feelings that others would not know about unless one told them. Attempting to control private experiences is said to create problems.

Fusion and experiential avoidance lead to losing contact with the present. Unworkable action refers to patterns of behavior that pull one away from mindfulness. It is reactive, impulsive and automatic (e.g., using drugs, excessive procrastination). To bring behavior under the influence of values rather than fusion or avoidance is the goal and mindfulness is the vehicle (Harris & Hayes, 2009).

In ACT, the therapist does not help the client to reduce or eliminate “symptoms.” Instead, a new relationship with the “symptoms” is acquired. What was formerly problematic is reframed as “normal human experiences that are a part of a rich and meaningful life” (Harris & Hayes, 2009, p.36). This type of reframing is called “workability.” ACT takes the point of view that suffering is an inevitable part of human life and that attempts to avoid pain only increase it. An individual’s behavior and the context in which the behavior occurs is a focus of treatment (Harris & Hayes, 2009). The goal of ACT is to get the person’s behavior to work successfully, according to that person’s values. ACT measures outcomes in terms of behaviors. For example, going to work while depressed or engaging in a conversation while one is experiencing social phobia. How one relates to a symptom is more important than the reduction of the symptom (Bach & Morgan, 2009).

Acceptance and Commitment Therapy (ACT) integrates mindfulness into the intervention in a less manualized and less central manner, compared to other popular mindfulness approaches such as Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy. ACT does not require that providers have extensive mindfulness training and mindfulness is one of many treatment components (Greco & Hayes, 2008). In ACT, mindfulness is taught through different experiential exercises, such as observing and objectifying thoughts and emotions, metaphor and paradox. These exercises are modified based on the therapist’s discretion and the context of the client. Mindfulness skills are developed so that an individual can re-contextualize values and commit to behavior change (Bach & Morgan, 2009).

### **Review of ACT**

Hayes (2008) stated that the research on the effectiveness and efficacy of ACT is positive but preliminary. ACT is currently listed as an empirically supported treatment

for depression by the American Psychological Association, and is being considered for the list of helpful treatments for substance abuse problems by the Substance Abuse and Mental Health Services Administration (Hayes, 2010). The American Psychological Society, Division 12, lists ACT for depression as having modest support. Modest support is a label utilized for what is termed, probably efficacious treatments. This standard is met through one well-designed study, plus two or more adequately designed studies where the treatments efficacy is demonstrated. This standard can also be met through a series of well-controlled single case studies (APA Presidential Task Force on Evidence-Based Practice, 2006). The empirical investigation of ACT is recent, thus the most well-designed studies will be discussed in this review.

Powers, Vörding and Emmelkamp (2009) meta analytic review examined ACT in comparison to waiting lists, placebos, treatment as usual and established treatments such as Cognitive Behavioral Therapy, Cognitive Therapy, systematic desensitization and twelve step facilitation. There were 18 randomized controlled trials included in the study. ACT was superior to control conditions, waiting lists, placebos and treatment as usual. ACT was not shown to be more effective than established treatments. These results state that ACT is more effective than control conditions for several problem areas, but that there is no evidence that ACT is more effective than established treatments.

Ruiz (2010) points out that there has been controversy over the data concerning ACT. The randomized controlled studies which compare ACT to other therapies and that compare the methodology of ACT with those used in CBT studies have been specifically targeted. Ruiz (2010) did a comprehensive review of the studies done on ACT. He found that the outcome studies show that ACT is efficacious for many problems where experiential avoidance and cognitive fusion play a role. Such problems include chronic pain, anxiety, stress and depression. He states that more controlled studies with larger samples are needed to determine if ACT is superior to CBT. His review of correlational studies showed support for the ACT model.

Johnston, Foster, Shennan, Starkey, Johnson, Starkey and Johnson (2010) looked at the effectiveness of ACT as an intervention for persons suffering from chronic

pain. The 24 participants were individuals who were either identified from a pain clinic psychologist's waiting list or who had been assessed by the pain clinic, not referred to the psychologist, but were judged by the referral as having a level of distress which might be helped by the intervention. Acceptance was measured by the Chronic Pain Acceptance Questionnaire (CPAQ). The CPAQ measures acceptance of pain through assessing an individual's level of activity despite pain and the degree to which that individual attempts to control the pain. Quality of life was measured with The Quality of Life Inventory (QOLI). The Satisfaction with Life Scale (SWLS) was used to measure participants' subjective well-being. The Chronic Pain Values Inventory (CPVI), a self-report questionnaire, was used. The CPVI was developed for use with chronic pain patients and it measures the extent to which one who is in chronic pain can live in accordance with one's values. The value domains are family, intimate relations, friends, work, health, and growth or learning. One rates the importance of the values in each domain and then reflects how successful they are at living in accordance to these values. The Short-Form McGill Pain Questionnaire (SF-MPQ) was used to measure levels of pain and The Chicago Multi-scale Depression Inventory (CMDI) and The Beck Anxiety Inventory (BAI) were used for measuring affect. Because of the cost of individualized therapeutic ACT, the study looked at the use of ACT through a self-help workbook that participants completed with minimal input from a therapist. The participants in the study completed the workbook with weekly telephone support from a trained ACT therapist over a six week period. The researchers found that all participants who utilized the self-help workbook showed statistically significant improvements for acceptance, quality of life and the value of a chronic pain illness compared to the control group that did not utilize the workbook. There were medium effect sizes for reduction of pain. The study suggests that utilization of an ACT based workbook may be a useful tool for those suffering from chronic pain.

Hernández-López, Luciano, Bricker, Roales-Nieto and Montesinos (2009) completed a study that compared ACT to CBT for smoking cessation. Participants were 52 women and 29 men with a mean age of 42 who had smoked for at least the past last five years, were currently smoking at least ten cigarettes a day and who were not using

any other smoking cessation treatment. The Acceptance and Action Questionnaire (AAQ), a nine-item measure used to assess experiential avoidance was utilized. Abstinence was measured with a Bedfont Micro Smokerlyzer CO monitor developed by Bedfont Technical Instruments Ltd, in Sittingbourne, Kent, United Kingdom. It is the most often used biochemical measure that provides easy, non-invasive, and immediate support of self-reported abstinence. A quasi-experimental design was used to compare the two treatments. CBT is currently considered the most commonly used intervention for smoking cessation. It was hypothesized that while CBT assists individuals in avoiding or reducing cravings, ACT would assist individuals with stopping the avoidance of unpleasant cravings. In ACT, through the experiencing of cravings, individuals are taught to respond with acceptance to unpleasant emotions and thoughts and to be guided by their core values in decision making. Both the CBT and ACT interventions were delivered in seven weekly 90-minute group sessions consisting of eight to ten smokers. The session structure was similar in each group. Overall, this study suggested that ACT for smoking cessation is feasible and demonstrates promising effectiveness in comparison with CBT. This study is important because it was the first to suggest that ACT is effective for smoking cessation, it compared ACT for smoking cessation with the current standard, it delivered ACT in a group format which is more cost-effective, and used a biochemically supported measure of abstinence. The study was however, a preliminary one (Hernández-López, et al., 2009).

### **Conclusion**

As additional studies are being done on ACT, the research base for ACT continues to grow. ACT appears to have potential for improving well-being in a range of populations. It is a flexible approach that can be adapted for a wide range of settings and populations (Baer & Huss, 2008).

ACT turns the idea that people have to think and feel better in order to live better, upside down. To live well with what you think and feel is the new challenge, while embracing the inevitability of human suffering in the quest for a valued and meaningful

life. ACT is an exciting intervention that is paving the way for a new conceptualization of psychopathology (Richard & Huprich, 2009).

We are all in the business of understanding, preventing, and alleviating human suffering while promoting human dignity and vitality. The clinical prize here is a life, one that does not have to disavow normal pain and hardship but creates space to move forward with that pain in the service of valued ends (Richard & Huprich, 2009, p.276).

### References

- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.
- Bach, P. & Morgan, D. (2008). *ACT in practice: Case conceptualization in acceptance and commitment therapy*. Oakland, California: New Harbinger.
- Baer, R. (2006). *Mindfulness based treatment approaches: A clinicians guide to evidence-based practice*. San Diego, California: Elsevier.
- Baer, R. & Huss, D. (2008). Mindfulness and acceptance based therapy. In Lebow, J. (Ed.), *Twenty-first century psychotherapies* (pp. 123-165). Hoboken, New Jersey: John Wiley & Sons.
- Forman, E. Herbert J., Moitra, E., Yeomans, P., & Geller, P. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification*, 31, 772-799.
- Greco, L., & Hayes, S. (2008). *Acceptance & mindfulness treatments for children & adolescents: A practitioners guide*. Oakland, CA: New Harbinger.
- Harris, R., & Hayes, S. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. Oakland, CA: New Harbinger.
- Hayes, S. (2008). State of the ACT evidence. Retrieved September 9, 2010 from [http://contextualpsychology.org/state of the act evidence](http://contextualpsychology.org/state_of_the_act_evidence).
- Hayes, S. (2010). A note on the research supporting ACT. Retrieved September 14, 2010 from <http://contextualpsychology.org/node/5076>.

- Hernández-López, M., Luciano, C., Bricker, J., Roales-Nieto, J., & Montesinos, F. (2009). Acceptance and commitment therapy for smoking cessation: A preliminary study of its effectiveness in comparison with cognitive behavioral therapy. *Psychology of Addictive Behaviors, 23*(4), 723-730
- Johnston, M., Foster, M., Shennan, J., Starkey, N., & Johnson, A. (2010). The effectiveness of an acceptance and commitment therapy self-help intervention for chronic pain. *The Clinical Journal of Pain, 26*(5), 393-402.
- Powers, M., Vörding, M. & Emmelkamp, P. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics, 8*, 73-80.
- Richard, D., & Huprich, S. (2009). *Clinical psychology: Assessment, treatment and research*. San Diego, CA: Elsevier Inc.
- Ruiz, F. (2010). A review of acceptance and commitment therapy: (ACT) empirical evidence: correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology and Psychological Therapy, 10*, 125-162.