ACT: a new acronym you need to know about

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Thompson, M. (2007). ACT: a new acronym you need to know about. Clinical Psychology Forum, 172, 19-22.

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This article presents 'acceptance and commitment Therapy' – a theoretically grounded and empirically supported approach that combines aspects of behavioural therapy and mindfulness.

THIS ARTICLE INTRODUCES acceptance and commitment therapy (ACT) to the *Forum* readership (note: ACT is pronounced as one word, 'ACT', not A–C–T). Rather than providing a comprehensive introduction to ACT, this paper presents a broad outline of an approach that is developing both an impressive evidence base and a significant following.

Some of what ACT does may at first appear to be counterintuitive; however, both its theoretical background and therapeutic interventions are strongly grounded in empirical research. The approach focuses on getting individuals back to activities that are important to them, not on symptom control *per se*. Evidence suggests that ACT might be particularly helpful for those with enduring conditions, such as chronic pain, where symptom control is not always the most practical alternative (e.g. McCracken & Eccleston, 2006).

Background

ACT forms part of the third generation of behavioural and cognitive therapies. This movement also includes mindfulness-based cognitive therapy (Segal *et al.*, 2001) and dialectical behaviour therapy (Linehan, 1993). Building on the foundations of traditional behavioural theory, ACT considers the impact of environmental, verbal and cognitive influences on an individual's behaviour. Importantly, rather than trying to alter the *form* cognition takes (the way thoughts look internally), ACT focuses on altering the *function* of cognition (the influence thoughts have externally on how individuals are living their lives).

Two terms are integral to ACT: 'functional contextualism' and 'relational frame theory' (RFT).

Much contemporary psychological research is based around mechanical or mentalistic models that involve hypothetical constructs or cognitive mechanisms (Biglan & Hayes, 1996). Though these may be useful for predicting an individual's action, they can be limited as a basis from which to alter them. Conversely, functional contextualism emphasises the importance of historical variables and our interactions with natural, social, and cultural environments (Hayes, 1993). Accordingly, ACT interventions focus on the interrelations between an individual's experience, thinking and behaviour, not just on the contents of their head.

RFT is a development within behaviour analysis that builds on the foundations of traditional learning theory. RFT is important to ACT because it provides a coherent conceptual framework and growing research base that accounts for the role of human language and cognition. Supporters of ACT would argue that this contrasts with the weaker link that exists between cognitive therapy and basic cognitive science (Hayes, 2002; Hayes *et al.*, 2006). For a fuller account of RFT see Hayes *et al.* (2001).

Avoidance and suffering

Within ACT it is suggested that many of us live under the unhelpful assumption of 'healthy normality'. Accordingly, we expect to be healthy and happy and anything abnormal should immediately be diagnosed, treated and cured. Though advances in medical treatment may partly support this notion, sig-

nificant exceptions remain (e.g. mental health problems or chronic pain, which defy 'cure'). The assumption of healthy normality becomes particularly troublesome when applied to our internal mental lives. Here any examples of suffering, in fact any undesirable private experiences (e.g. thoughts, feelings or bodily sensations), are seen as abnormal and as such are avoided. Avoidance of this kind may have little significant consequence. However, it is also possible that avoidance can significantly restrict an individual's healthy functioning. This idea is well illustrated by Martha Beck, a life coach who works with Oprah Winfrey (yes, ACT has got that far):

> Your true love dumps you, and to stave off grief, you avoid everything you once shared – your favourite song, the beach, mocha lattes. Now you're bereft not only of your ex but also of music, seascapes and a fabulous beverage (Beck, 2006).

ACT argues that suffering is a basic tenet of human existence and that, instead of trying to avoid it, individuals can focus on moving towards things that are important to them.

ACT treatment

So how can the unhelpful avoidance of negative private experience be overcome? Stereotypically, cognitive behavioural therapy might promote the utility of challenging negative thinking. Here ACT would suggest that it might be unhelpful to try and think your way out of a hole that you got into by thinking. Instead, ACT would be more likely to focus on the context of the thought not its content – not what the thought looks like, but the impact the thought is having on other behaviour patterns and the individual's life.

The ACT therapeutic stance adopts six core processes: acceptance, contact with the present moment, values, committed action, self as context and defusion. A detailed description can be found elsewhere (e.g. Hayes *et al.*, 1999), but a thumbnail sketch is provided below.

ACT aims to increase an individual's behavioural flexibility – to allow them to do more things they consider personally important. Accordingly, it encourages individuals to be in contact with the present moment, no matter what private experiences are happening, and still to engage in behaviour that serves their values. Put simply, values are principles that an individual wants their life to stand for (e.g. ways of living in terms of family, friends, self-development, health, community and spirituality). Allowing an individual to reconnect with their values is an integral part of any ACT intervention as they have often been lost sight of as the individual wrestles with experiences that do not feel good.

Within ACT it is recognised that change can occur either by altering content or by altering function. However, as already mentioned, for ACT it is considered more pragmatic to address the impact private experiences have on behaviour rather than to attempt to alter their form or frequency. Accordingly, ACT treatment involves a move from cognitive fusion to defusion. The former involves thinking and acting directly as one's thoughts dictate. Though this is a normal process, behaviour can become excessively or improperly regulated by such influences. If this happens thoughts are blindly followed and behaviour becomes increasingly guided by an individual's verbal networks, not their values. Rather than struggling to change these thoughts or stop them occurring ACT encourages full, engaged contact with negative private events. So, for example, the thought 'I am no good' stays as just that, a thought whose content is 'I am no good'. This is one example of how ACT encourages acceptance or willingness. Importantly, this is not about giving up, nor is it an end in itself; instead, it provides a space that encourages the flexibility to move in more than one direction, including the direction of values.

As ACT promotes the importance of ongoing, non-judgmental contact with the present moment it is perhaps unsurprising that it encourages the practice of mindfulness (Fletcher & Hayes, in press; Kabat-Zinn, 1990). Mindfulness encourages individuals to increase their ability to pay attention to what is taking place in the present, including their thoughts, feelings, bodily sensations and behavioural urges. Without such awareness,

behaviour often automatically follows the urges that result from an individual's fusion with negative private experience. Being aware of what is going on in the present moment allows individuals the opportunity to move in the direction of their values.

Where is the data?

There is an evidence base that is growing at an accelerating rate which suggests that the ACT model works. Currently this literature encompasses over 30 correlational studies from different populations, about 15 papers which test different components of the ACT model, over 20 randomised controlled trials and at least a dozen mediational analyses. There are also about a dozen group and controlled time-series efficacy studies, two effectiveness studies and scores of case studies (S. Hayes, personal communication, 19 June 2006). For detailed outcome reviews see Hayes *et al.* (2006) or Hayes *et al.* (2004).

Hayes *et al.* (2006) cite evidence that ACT is useful for individuals suffering from anxiety, addiction, depression, panic, post-traumatic stress disorder, psychosis, work-based stress and even diabetes and epilepsy. They report that ACT appears 'to be working across an unusually broad range of problems, and across a range of severity' (Hayes *et al.*, 2006, p.21).

The author of this article works as part of an interdisciplinary team that carries out ACT-based interventions in the area of chronic pain. We are based at the Royal National Hospital for Rheumatic Diseases in Bath and information about our research outcomes can be found at www.bath.ac.uk/pain-management or in print (e.g. McCracken, 2005; McCracken & Eccleston, 2006)

Further information

Though this article can only provide an outline of ACT, there is space to supply further information for those wishing to find out more:

- a recent academic article providing a detailed overview of ACT, its processes and the current outcome data is available (Hayes *et al.*, 2006).
- 'Acceptance and Commitment Therapy: An experiential approach to behaviour change' (Hayes *et al.*, 1999) provides an excellent resource for those wishing to use ACT therapeutically.
- If you have clients, or know of others, who might be interested in ACT then a self-help manual *Get Out of Your Mind and into Your Life* is also available (Hayes & Smith, 2005).

Aside from printed material, the website www.contextualpsychology.org provides a gateway to many ACT resources and a global meeting place for those interested in this approach. It also provides up-to-date information on training events and contains details of the Second World Conference on ACT, RFT and Contextual Behavioural Science, which took place at the Institute of Education, University of London from July 24–28 2006.

Acknowledgements

With grateful thanks for the comments of Jeremy Gauntlett-Gilbert, Lance McCracken and Kevin Vowles; and to Steven Hayes who provided up-to-date information about the ACT evidence base.

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