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Acceptance and commitment therapy

Pathways for general practitioners

Background

Acceptance and commitment therapy (ACT) focuses on helping patients to behave more consistently with their own values and apply mindfulness and acceptance skills to their responses to uncontrollable experiences.

Objective

This article presents an overview of ACT, its evidence base and how general practitioners can apply ACT consistent practice in the primary care setting. It describes pathways for general practitioners to develop further expertise in the approach.

Discussion

Acceptance and commitment therapy has been associated with improved outcomes in patients with chronic pain (comparable to cognitive behaviour therapy) and several studies suggest that it may be useful in patients with mild to moderate depression. Preliminary evidence of benefit has also been shown in the setting of obsessive-compulsive disorder, psychosis, smoking, tinnitus, epilepsy and emotionally disordered eating after gastric band surgery. Acceptance and commitment therapy starts with a discussion about what the patient wants and how they have tried to achieve these aims. Strategies previously used to avoid discomfort are discussed. Psychoeducation in ACT involves metaphors, stories and experiential exercises to demonstrate the uncontrollability and acceptability of much psychological experience. In its final phase, ACT resembles traditional behaviour therapy consisting of goal setting and graduated activity scheduling toward goals directed by values.

Keywords

psychotherapy; cognitive therapy/methods; models, psychology



The acceptance and commitment therapy model (ACT) is a psychological therapy that teaches mindfulness ('paying attention in a particular way: on purpose, in the present moment, nonjudgementally')¹ and acceptance (openness, willingness to sustain contact) skills for responding to uncontrollable experiences and thereby increased enactment of personal values.

The therapy is less concerned with eliminating unwanted thoughts, emotions and sensations (often seen as the symptoms of psychiatric disorder) and more concerned with cultivating psychological flexibility: the ability to change behaviour depending on how useful to the patient's life this behaviour is understood to be in the long term. The ACT model predicts people will be most effective when able to:²

- accept automatic thoughts, sensations and urges
- defuse from thinking (ie. observe thoughts without believing them or following their directions)
- experience self as context (ie. a continuous, stable sense of self as an observer of psychological experiences)
- attend to the present moment with self awareness
- clearly articulate values (ie. self chosen, desirable ways of behaving)
- engage in committed action (ie. participating in values-consistent activities, even when psychologically challenging).

Therapy is aimed at strengthening skills in these six overlapping and synergistic processes, collectively referred to as the 'hexaflex'.²

Evidence for efficacy

Acceptance and commitment therapy was designed to be broadly applicable to a range of life difficulties, including those that do not fit into neat diagnostic categories. Over 50 randomised controlled trials have evaluated the benefits of ACT in the setting of various disorders. In patients with chronic pain it has been shown to be more effective than placebo or 'treatment as usual' and comparable to cognitive behaviour therapy.³ Several studies suggest that it may be useful in patients with mild to moderate depression.⁴ Improvements compared to placebo or treatment as usual has been shown in the setting of obsessive-compulsive disorder (OCD),⁵ psychosis,⁶ smoking,⁷ tinnitus,⁸ epilepsy⁹ and emotionally disordered eating after gastric band surgery.¹⁰ Preliminary evidence of benefit has been seen in nonclinical settings (eg. worksite stress,¹¹ mental health stigma¹² and weight



loss¹³). However, there is room for methodological improvement in the studies undertaken, in particular by employing follow up periods of longer than 12 months and controlling for concomitant treatments. Importantly, meta-analyses of its application to a specific disorder, which are required for the National Health and Medical Research Council Level I evidence of efficacy, have yet to be conducted. However, in the opinion of the author, there is sufficient evidence to warrant the use of ACT as a psychological therapy, particularly if the patient has not responded satisfactorily to a first line cognitive behaviour therapy protocol and/or the treating therapist has greater expertise and experience in ACT than other protocols.

Acceptance and commitment therapy

Acceptance and commitment therapy typically starts with an assessment of what the patient wants. Emotional control goals (eg. 'I just want to be happy') are reframed as a means to a more valued life (eg. through asking, 'And if you felt happier and more confident what would you be doing more of?'). Assessment includes identifying all the things the patient has done to try to achieve their aims and how well these have worked in the short and long term. Acceptance and commitment therapy therapists particularly seek to identify patterns of trying to control or avoid uncontrollable internal experiences, particularly those that disrupt valued living. These can range from obvious (eg. overt avoidance of difficult situations, substance use and oversleeping) to subtle (eg. 'putting on a front', 'holding back' or 'not really listening' during conversations). Motivation to change is ideally born from an appreciation that strategies used until now to reduce discomfort have come at the cost of the life one truly wants.

Psychoeducation in ACT consists of metaphors, stories and experiential exercises to illustrate the uncontrollability and acceptability of much psychological experience and reveal thoughts to be less powerful and limiting than usually regarded. For example, a patient might be taught to interact with a painful self belief (eg. 'I'm a loser') by saying the words out aloud, varying the speed, pitch or tone: treating the stimulus as a sound rather than responding to it literally. To illustrate the difference between struggling to suppress such a thought and accepting it, the thought might be written on a card that the therapist first pushes toward the patient while the patient pushes it back, then second, places on the patient's lap, where the patient practises allowing contact with the thought. Self awareness can be developed by having the patient watch their thoughts and move their finger to indicate when thinking drifts into the past or present, instead of the 'here and now'. Reasons a patient gives for being unable to change (eg. 'I was abused') might be framed as chapters in a book of which there are many, none more important than any other. As reasons for not changing come to mind throughout the day, the patient can label each as another chapter (eg. the 'I never finished school' story). Acceptance and commitment therapy encourages patients and therapists to continually develop new and varied strategies to treat thoughts as harmless and unimportant.

In its final phase, ACT resembles traditional behavioural therapy consisting of goal setting and graduated activity scheduling toward goals directed by values. Values are made clear and vivid, often assisted with imagery exercises (eg. 'Imagine witnessing your 80th birthday party and hearing the tributes of those who knew you. What would you like them to say?'). As individuals pursue goals, further unwanted emotions and thoughts emerge as apparent barriers, to which the acceptance and defusion skills previously introduced are then applied.

While mindfulness meditation (repetitive practice of prolonged attention to present moment sensation) is not incompatible with ACT, neither is it seen as essential. Instead, ACT coaches patients to adopt mindfulness as a quality or attitude with which any planned action is taken.

Applications and contraindications

Acceptance and commitment therapy may be practised either in a step-by-step, formalised way, or, more typically, in a flexible, principle driven way. Acceptance and commitment therapy may be offered as self help, individually or in group, as a brief intervention for high functioning patients or intensively over months for patients with chronic, highly comorbid presentations. Like any psychotherapy, ACT is not suitable for people whose cognitive functioning is impaired such that they have difficulty comprehending and generating answers to routine assessment questions or virtually no substantive memory of previous conversations. It is not appropriate for individuals who are floridly psychotic, intoxicated, require emergency medical treatment or have organic brain injury.

In many trials ACT has been used in conjunction with pharmacotherapy to good effect.⁵⁻⁷ Individuals should have stable type and dose of any antidepressant, mood stabiliser or antipsychotic medication before commencing ACT. The use of quick-acting benzodiazepines (eg. alprazolam or oxazepam) is incompatible with the ACT aim to reduce experiential avoidance. If individuals are using the equivalent of more than 15 mg diazepam, a controlled benzodiazepine reduction regimen is recommended and progress is unlikely to be satisfactory unless individuals are willing to work toward this. Acceptance and commitment therapy may assist with individuals coping with the discomfort of this reduction, although this has not been empirically evaluated.

ACT resources for the primary care clinician

See *Resources* for useful books, websites and a DVD. Simple strategies the clinician can employ include:

- assess the individual's life context, including relationships, work, recreation and health
- assess 'workability'. For example, ask: 'What have you tried to cope with this problem? How have these strategies worked over time? Have there been any unintended side effects of these strategies?'
- assess strengths and weaknesses in the six core ACT processes (as you would in a mental state examination) (*Table 1*).



Table 1. Proforma for assessing strengths and weaknesses in the six core acceptance and commitment therapy processes

Acceptance of experiences						
-3	-2	-1	0	1	2	3
Extremely unwilling, attempts to avoid all discomfort	Frequently tries to change or eliminate difficult experiences	Slightly unwilling, avoidant	Conditional acceptance: willing to have discomfort only under limited conditions	Slightly willing, open	Frequently willing to have difficult experiences for sake of values	Extremely willing, open to full range of experience
Defusion from thought						
-3	-2	-1	0	1	2	3
Extremely fused: thoughts seen as facts	Frequently fused: follows subjective rules as imperatives	Slightly fused	Defuses with assistance but not independently and especially not if emotionally aroused	Slightly defused	Frequently able to defuse; only has difficulty under extreme arousal	Extremely defused: thoughts are epiphenomena and need not be acted on
Values clarity						
-3	-2	-1	0	1	2	3
No concept of what's important to them	Frequently sees no ability to choose, choosing is aversive	Slightly unclear	Can articulate values with assistance but not independently, especially when conflicts with 'rules'	Slightly clear	Frequently clear how he/she wants to behave; uncertainty only under extreme emotional arousal	Extremely clear vision of how he/she wants to live
Mindfulness						
-3	-2	-1	0	1	2	3
Constantly preoccupied with worries about the future or regret about the past	Frequently worries, ruminates, intellectualises or otherwise disattends to present moment experiences	Slightly preoccupied with past or present, or overintellectual explanation	Conditional mindfulness: able to attend to present moment with instruction and not aroused	Slightly able to attend to present moment on own	Frequently able to attend to present moment experience on own unless highly aroused	Able to give full attention to internal and external environment, in the 'here and now'
Committed action						
-3	-2	-1	0	1	2	3
Behaviour impulsive, self-defeating; no action toward long term values	Frequently behaviour dictated by instant gratification or relief; only enacts values when 'feels like it'	Slightly uncommitted	Conditional committed action: willing to pursue values only under limited conditions	Slightly committed	Frequently behaves consistent with values and only inconsistent under high emotional arousal	Always behaves consistent with values in a broad, diverse range of ways



Table 1. Proforma for assessing strengths and weaknesses in the six core acceptance and commitment therapy processes (continued)

Self as context						
-3	-2	-1	0	1	2	3
Extremely fused with self concept: causal explanations about the self, no self evaluations are seen as facts; there is no distinction between 'self' and roles, attributes or experiences	Frequently sees explanations, stories about the self, and self evaluations as facts Behaviour is constrained by self knowledge	Slightly fused with self concept and unable to adopt observer perspective	Conditional ability to experience self as context: can do so only with instruction and when not aroused	Slightly able to adopt observer perspective on own	Frequently able to adopt observer perspective on own and only unable under high arousal	Readily adopts observer perspective on experience and has stable sense of self greater than and not reducible to specific sensations, traits

Take care not to reinforce societal messages that particular emotions or thoughts need to be eliminated before life enhancing actions can be taken.

Model acceptance of uncomfortable life experiences, including appropriate self disclosure.

Model defusing from 'bossy'/'nagging'/'persuasive' rules (directions from the mind): again, including appropriate self disclosure (eg. 'My mind is always telling me to fit more patients in a day; if I let that thought dictate my behaviour I would work myself to death, because there are always more patients to see. Instead, I might thank my mind for the suggestion and proceed to work with my planned schedule').

Use defused language when reflecting the patient's psychological experience (eg. if the patient says, 'I'm weak', reflect, 'You're having the thought 'I'm weak'').

Ask patients, 'What's the next step you could take to live more like the way you want to in the area of (relationships, work, recreation, health)' and check their progress in that area the next time you see them.

Final word

Acceptance and commitment therapy was designed as a simple, yet powerful, set of transdiagnostic processes that have broad applicability to a range of life difficulties including those that do not fit into neat diagnostic categories. Its emphasis on the normality of human suffering, highlighting to clinicians the commonality of experience shared with patients, has created a training and research community characterised by compassion, supportiveness and creativity that rarely fails to touch and inspire those who become connected with the work.

Resources

Training

Interested practitioners can attend introductory workshops, now regularly available in Australia. Acceptance and commitment therapy workshops emphasise experiential learning through practising mindfulness and acceptance of personally uncomfortable thoughts and emotions. Being trained in ACT has been shown to enhance psychotherapeutic outcomes even when the practitioner employs

other therapeutic approaches,¹⁴ so experiencing the principles in action may help to facilitate ACT consistent interactions with patients, even without additional technique training. The Australian New Zealand chapter of the Association for Contextual Behavioural Science (see below) provides opportunities to further develop skills

Books

- Robinson PJ, Gould DA, Strosahl KD. Real behaviour change in primary care. Oakland, California: New Harbinger, 2011. This book has been written for the primary care practitioner and includes ultra brief (2–5 minute) ACT consistent assessment and intervention guides
- Good titles for patients include those by Hayes and Smith,¹⁵ Forsyth and Eifert¹⁶ and Dahl and colleagues.¹⁷ These have demonstrated efficacy in clinical trials

Websites

- The Association for Contextual Behavioural Science (ACBS): www.contextualpsychology.org. Values based dues (pay what you think it's worth) allow you to access demonstration videos, research articles, treatment protocols, client handouts and a list of ACT practitioners
- The Australian branch of ACBS: www.anzact.com and contains information about Australian and New Zealand conferences
- Russ Harris' Australian website (www.actmindfully.com) contains clinician handouts, details of upcoming workshops in Australia and a list of ACT practitioners in Australia
- An international email list for clinicians and researchers to discuss new research and clinical practice is available at <http://tech.groups.yahoo.com/group/acceptanceandcommitmenttherapy>

DVD

- ACT in action DVD set: provides clinical demonstrations of therapeutic strategies targeting each of the six ACT processes. Available at www.newharbinger.com.

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Harbinger, 2006.

References

1. Kabat-Zinn J. *Wherever you go, there you are: mindfulness meditation in everyday life*. New York: Hyperion, 1994.
2. Hayes SC, Strosahl KD, Wilson KG. *Acceptance and commitment therapy: the process and practice of mindful change*. New York: Guilford, 2011.
3. Website on research-supported psychological treatments. Acceptance and commitment therapy for chronic pain. Available at www.div12.org/PsychologicalTreatments/treatments/chronicpain_act.html.
4. Website on research-supported psychological treatments. Acceptance and commitment therapy for depression. Available at www.div12.org/PsychologicalTreatments/treatments/depression_acceptance.html.
5. Twohig MP, Hayes SC, Plumb JC, et al. A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder. *J Consult Clin Psych* 2010;78:705–16.
6. Shawyer F, Farhall J, Mackinnon A, et al. A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behav Res Ther* 2012;50:110–21.
7. Gifford EV, Kohlenberg BS, Hayes SC, et al. Does acceptance and relationship focused behaviour therapy contribute to bupropion outcomes? A randomized controlled trial of functional analytic psychotherapy and acceptance and commitment therapy for smoking cessation. *Behav Ther* 2011;42:700–15.
8. Westin VZ, Schulin M, Hesser H, et al. Acceptance and commitment therapy v tinnitus retraining therapy in the treatment of tinnitus: a randomised controlled trial. *Behav Res Ther* 2011;49:737–47.
9. Lundgren T, Dahl J, Melin L, Kies B. Evaluation of acceptance and commitment therapy for drug refractory epilepsy: a randomized controlled trial in South Africa – a pilot study. *Epilepsia* 2006;47:2173–9.
10. Weineland S, Arvidsson D, Kakoulidis T, Dahl J. Acceptance and commitment therapy for bariatric surgery patients, a pilot RCT. *Obes Res Clin Pract* 2012;6:e21–30.
11. Flaxman PE, Bond FW. A randomised worksite comparison of acceptance and commitment therapy and stress inoculation training. *Behav Res Ther* 2010;48:816–20.
12. Masuda A, Hayes SC, Fletcher LB, et al. Impact of acceptance and commitment therapy versus education on stigma toward people with psychological disorders. *Behav Res Ther* 2007;45:2764–72.
13. Lillis J, Hayes SC, Bunting K, Masuda A. Teaching acceptance and mindfulness to improve the lives of the obese: a preliminary test of a theoretical model. *Ann Behav Med* 2009;37:58–69.
14. Strosahl KD, Hayes SC, Bergan J, Romano P. Assessing the field effectiveness of acceptance and commitment therapy: an example of the manipulated training research method. *Behav Ther* 1998;29:35–64.
15. Hayes SC, Smith S. *Get out of your mind and into your life: the new acceptance and commitment therapy*. Oakland, California: New Harbinger, 2005.
16. Forsyth JP, Eifert GH. *The mindfulness and acceptance workbook for anxiety: a guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, California: New Harbinger, 2008.
17. Dahl J, Lundgren T, Hayes SC. *Living beyond your pain: using acceptance and commitment therapy to ease chronic pain*. Oakland, California: New

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