Acceptance and Commitment to Chosen Values in Cognitive Behavioral Therapy

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The past two decades have witnessed the development and rapid rise of several different acceptance-based cognitive behavioral clinical approaches. Examples of this generation of “third wave” treatments, which follows the earlier behavioral and cognitive “waves” of developments in this field, include dialectical behavior therapy (DBT) for borderline personality disorder (Linehan, 1993), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) and behavioral activation for depression (Martell, Addis, & Jacobson, 2001), among several others. The present chapter focuses on the most comprehensive and probably most influential “third wave” clinical approach, acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999).

In many ways, ACT is similar to earlier cognitive behavioral forms of therapy. Treatment in ACT focuses for the most part on behaviors and cognitions, and it is collaborative, active, practical, and goal-directed. Moreover, many of the interventions utilized in ACT (but not all) are essentially similar to the ones used in ‘traditional’ CBT. Most importantly, ACT is an evidence-based clinical approach that is grounded in basic science. A rapidly growing body of published studies supports the efficacy of ACT-based treatments for a wide array of problems, ranging from chronic pain (Vowles & McCracken, 2008), management of diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), and smoking cessation (Gifford, Kohlenberg, Hayes, Antonuccio, Piasecki, et al., 2004) to a variety of mental disorders such as generalized anxiety disorder (Roemer, Orsillo, & Salters-Pedneault, 2008), obsessive compulsive disorder (Twohig, Hayes,
Plumb, Pruitt, Collins, et al., 2010), and schizophrenia (Bach & Hayes, 2002). Moreover, new types of treatment packages keep evolving.

Despite the existing similarities, some of the essential foundations of ACT distinguish this broad therapeutic perspective from earlier forms of CBT. These foundations may be usefully conceptualized in terms of two themes in the present volume, choice and meaning. Unlike most clinical approaches, and in contrast to the intuitive and natural coping strategies people typically use, ACT does not directly target changes in the form, content, or frequency of psychological events (e.g., thoughts, emotions, urges, physical sensations), even if these are perceived as aversive, dysfunctional, or in any way ‘distorted’. Instead, ACT focuses on changing the function of these events and the way individuals relate to them (e.g., believing they causally affect behavior). Thus, ACT highlights a basic choice people have: Rather than having to ‘fight’ troubling internal events, ‘solve’ them, or act upon them in ways that are self-damaging, they can accept their occurrence. Importantly, acceptance in ACT is an active process which is based on willful awareness, and it refers mostly to internal events, not to things that are generally amenable to willful control (e.g., behaviors or certain environmental aspects).

The theory behind ACT and the clinical interventions it includes, some of which are influenced by eastern philosophies, are consistent with the focus on choice. In terms of broad treatment objectives, ACT does not target the alleviation of disturbing symptoms. Instead, it aims at creating flexible and effective psychological repertoires that help clients pursue their goals and chosen values. In this regard, ACT, which emphasizes the importance of values and meaning, is more similar to existential approaches than it is to most other types of CBT.

In what follows, we provide a concise account of the theoretical foundations of ACT. We then briefly present the basic therapeutic processes of this clinical approach. The aspects of therapy associated the way in which ACT deals with aversive inner experiences is addressed first.
This section is followed by a short description of the treatment elements in ACT that are focused on values and meaning. In each section, we describe recent studies from our laboratory that provide support for the efficacy of ACT interventions.

**Conceptualization of Psychopathology in ACT**

Most medical and psychological approaches to therapy assume that psychological suffering is the result of psychopathological processes. Different perspectives assume that these processes are associated with different kinds of abnormalities such as morphological or chemical abnormalities in the central nervous system, abnormal learning histories or unresolved internal conflicts. In ACT, on the other hand, it is assumed that psychological pain is ubiquitous because it is the inevitable result of normal psychological processes. These processes may exacerbate the effects of phenomena which are indeed abnormal (e.g., hallucinations). However, more often faulty attempts aimed at eliminating inevitable mental pain inadvertently increase this pain and turn it into more serious suffering, which then may be classified as psychopathological. The theoretical roots of this claim briefly discussed below.

**The Unique Abilities of the Human Mind**

In ACT it is assumed that the unique strength of the human mind is its ability to derive limitless arbitrary connections among stimuli. Consider, for example, a young child who learns that a certain animal is called ‘cat’, thus forming the arbitrary connection between the furry animal and the sound ‘CAT’ (Hayes et al., 1999). Suppose that this child is later scratched while playing with a cat. After that incident, he may feel anxious, cry, and run away if he hears his father saying, “Look, Danny, a cat!” Many organisms are able to learn formal connections among stimuli (e.g., between the presence of a cat or any other stimulus such as a certain sound and the feelings of pain and anxiety). However, the child’s strong reaction occurs despite the fact that physical pain has never been experienced in the presence of the actual sound ‘CAT’, because his
mind was able to bring these two stimuli together by using the derived relations between them. That is, the change in status of one component of this simple relational frame (the actual animal, which is now associated with mental pain) has changed, without any additional training or exposure, the status of the other component (the sound ‘CAT’). No other organism is able to do that (Ramnerö & Törneke, 2008).

The human mind is unique in its ability to derive complex arbitrary relations and use them in different contexts. As suggested by other theoretical perspectives (e.g., construal level theory; Liberman & Trope, 2008), humans can easily consider and manipulate events and contingencies that are temporally or physically remote or are of very low probability, including ones that are experienced by others. These abilities enable us to evaluate and respond effectively to an extremely wide range of situations. However, according to the ACT perspective on psychopathology, these extraordinary abilities are also the source of a great deal of pain and suffering (Hayes, Barnes-Holmes, & Roche, 2001).

**Psychological Pain is Ubiquitous and Unavoidable**

Because of the abilities of the human mind, all kinds of external and internal events can become ‘present’ at any given time if their mental representations are activated (Törneke, 2010). Internal events may have a strong psychological impact if they are perceived as relevant to the well-being of the person experiencing them. Most organisms are biased towards attending and responding to stimuli or events they perceive as dangerous or aversive. For humans, who have minds that can easily make any stimuli psychologically present, the availability of aversive stimuli – in the form of mental representations – is greatly enhanced. Thus, humans often feel distressed because of things that are not happening at the moment. People may worry about events that may happen in the future, regardless of how distant this future is or how likely it is to actually come about. They can also compare themselves, their partner, or the current situation to
any kind of frightening alternative or desirable ideal. For example, a socially anxious person may think, “I will be anxious and miserable if I go to the party, so I’d better stay home.” To take a more extreme but unfortunately common example, a depressed individual may say to herself, “I feel sad and hopeless now. If I kill myself I will not feel anything, which is better” (Hayes et al., 1999). Moreover, due to the great capacity of the mind to generate arbitrary relations, any person, object, or stimulus can be connected to any negative emotion, irrespective of the original or formal value of the stimulus (e.g., “This party depresses me, because it reminds me of the times before the trauma when I could really enjoy things”).

In sum, the unique ability of the human mind to generate countless arbitrary connections and to easily ‘travel’ the time, space, probability and social dimensions (cf. Liberman & Trope, 2008) is highly advantageous, but it also brings about a great deal of unavoidable pain. Representations and relations generated by the human mind greatly increase the reach of aversive stimuli, thus making mental pain common and intense.

**Verbal Processes Often Intensify Suffering**

Due to the efficiency of human language, verbal formulations and evaluative rules generated by the mind often dominate other potential sources of information, including the person’s own direct experience. The term *cognitive fusion* is used in ACT to label this phenomenon (Hayes et al., 1999). For example, the typical behavior of phobic individuals is characterized by fear and rigid avoidance resulting from the way objects or events are conceptualized, and by refusal to examine the actual attributes of these avoided external stimuli (e.g., a cockroach) or internal experiences (e.g., the pain associated with getting an injection). Similarly, many people refuse even to taste foods they ‘don’t like’.

Being over-engaged with one’s internal verbal relations can be detrimental in itself. Repetitive and unfruitful attempts to evaluate, find reasons, or consider the consequences of
negative thoughts may increase the complexity and availability of these problematic verbal relations and networks, a process which is called in ACT cognitive entanglement. Indeed, a large body of research documents the harmful effects of rumination – repetitive and passive engagement in self-focused, negatively-valenced evaluative thinking (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). ACT also highlights the indirect effects of cognitive entanglement, pointing out that such ruminative processes are particularly detrimental because they often come at the expense of other, more useful activities.

It is also important to acknowledge the futility of efforts directed at breaking or modifying verbal relations. Such attempts often lead to more entanglement because complex and highly interrelated cognitive networks tend to be stable and change-resistant, and they are very efficient at maintaining and preserving themselves. For example, in agreement with Swan’s self-verification theory (e.g., Swann, Wenzlaff, Krull, & Pelham, 1992), it is assumed in ACT that the tendency to verify, validate, and confirm one’s self-views, negative as these may be, often overrides the desire for positive evaluations. Therefore, people’s perceptions of reality tend to be systematically skewed, causing them to dismiss any information the challenges their beliefs, regardless of how negative and self-damaging these beliefs are. Indeed, studies show that individuals with negative self-views seek unfavorable information from others (e.g., Hixon & Swann, 1993; Swann, Hixon, Stein-Seroussi, & Gilbert, 1990), selectively remember feedback only if it is perceived as congruent with their beliefs (Swann & Read, 1981), and become anxious if they receive positive self-discrepant feedback that they cannot easily dismiss (Swann, Stein-Seroussi, & Giesler, 1992). To use ACT terms, regardless of what the price is, the human mind “loves to be right” (Hayes & Strosahl, 2004).

Experiential Avoidance and Psychopathology
The power of verbal rules generated by the human mind may lead to *experiential avoidance* (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), which occurs when a person is unwilling to experience negatively evaluated private experiences such as feelings, thoughts, urges, memories, or bodily sensations, and therefore attempts to modify these experiences or their frequency of occurrence, even when such attempts are clearly inconsistent with well-being. Many mental disorders (e.g., OCD, PTSD) and pathological behaviors (such as suicide or substance abuse) can be usefully conceptualized as effects of particularly problematic methods of experiential avoidance (Hayes et al., 1996).

Why would experiential avoidance be so detrimental? As discussed earlier, humans use their minds, often quite successfully, to achieve desired goals and avoid stimuli or situations they deem aversive or dangerous. However, for a variety of reasons, success rates of such actions drop dramatically when the target stimuli people try to avoid are internal. It is a rather difficult task to ‘calm down’ when feeling anxious, to ‘think positive’ when worrying about something, or to willfully ignore physical sensations. Indeed, numerous studies (e.g., Wegner, Schneider, Carter, & White, 1987) have demonstrated the futility of attempts aimed at suppressing cognitions. Moreover, such attempts paradoxically produce the opposite outcome, as deliberate thought suppression is typically followed by a period of increased frequency of the unwanted cognition (Wegner, 1994). This happens primarily because the regulatory process associated with avoiding an item necessarily includes that actual item (Hayes et al., 1996). Moreover, the inevitable failure of such experiential avoidance attempts may lead to increased stress and feelings of frustration, which creates additional aversive experiences, which, in turn, may intensify the avoidance strategies, thus creating vicious cycle. Indeed, the literature suggests that failed thought suppression is etiologically related to several psychopathological syndromes including OCD, depression, and PTSD (for a review see Purdon, 1999). Thus, the human mind that generates
much of the psychological pain we experience is, unfortunately, rather ineffective in dealing with it.

Experiential avoidance, especially when it is relatively isolated and time-limited, is not always harmful. It is problematic, however, when it is persistent, chronic, and rigidly maintained. Management of inner experiences is particularly detrimental when it adversely affects other aspects of life and stands in the way of achieving one’s goals. As acknowledged by many other forms of CBT, avoidance is strongly reinforced by the short-term relief it often provides. Therefore, it can be particularly difficult to deal with, even when it is associated with much distress and dysfunction.

Cognitive fusion, which results from the ability of the mind to make connections and associations, can turn any thought, memory, feeling, urge, or sensation into a target of avoidance. Any object or cognition associated with a trauma may be avoided in PTSD, and many individuals with panic disorder refrain from being sexually aroused because they associate these feelings with somatic anxiety. Thus, in many cases cognitive fusion leads to narrow and rigid behavioral repertoires. These do not serve the person’s interests because they are excessively governed by verbally generated relations, at the expense of being in contact with the actual contingencies of the internal and external environment. This general state is referred to in ACT as *psychological inflexibility*. People may devote enormous amounts of time and effort to managing their aversive inner experiences, to the extent that most other goals are ‘put on hold’ (Hayes & Strosahl, 2004). They may then tell themselves that once they ‘get over’ their problems, they will be able to go on with their lives. One of the main goals in ACT is to make clients realize that the former is not a necessary condition for the latter.

**Basic Features of ACT**
Treatment in ACT is directly and explicitly based on the theory outlined above. Early in the therapeutic process, clients learn that the experience of psychological pain is unavoidable, and that the use of strategies such as experiential avoidance to deal with this pain is natural and understandable, but often leads to more suffering. This learning is accomplished by examining their typically long histories of ineffective struggle with their problems, and by using a variety of metaphors and experiential exercises. It is important for clients to realize and acknowledge that the problem does not lie primarily with what they consider to be their difficulties (e.g., anxiety, obsessions, low self-esteem), but rather with the futile and endless fight against them. They also learn that there is another option they may choose, which is to stop fighting problems or attempting to solve them. In essence, they learn that they can simply ‘quit the war’ (Hayes et al., 1999).

Many forms of pharmacotherapy and psychotherapy attempt to replace aversive inner experiences with more desirable or adaptive ones. For example, most treatments are aimed at changing certain emotions (e.g., anxiety) because they are perceived as aversive, and because they are associated with problematic action tendencies (such as escape and avoidance; e.g., Roseman, Wiest, & Swartz, 1994). In contrast, ACT does not aim at modifying the form, content, or frequency of unwanted feelings, cognitions, urges, or physical sensations. Instead, it is assumed that whether or not these unwanted events are problematic depends, not on their own qualities, but on the context in which they occur. That is, psychological events become harmful only when they need to be explained, believed, or disbelieved (thus leading to cognitive entanglement), controlled (thus leading to experiential avoidance), or acted upon (thus causing adverse outcomes). For example, rather than targeting the content of certain cognitions or emotions, treatment aims at changing the way they are perceived (e.g., the importance attached to them) or the regulatory power they have on behavior.
The general goal in ACT is to increase psychological flexibility, defined as the ability to consciously and mindfully attend to the variety of internal and external experiences existing at the present moment, and behave in ways that serve one’s valued goals (for a recent review of this construct see Kashdan & Rottenberg, 2010). This is achieved via several overlapping and interrelated core processes described briefly below.

**Choice in ACT: Dealing with Aversive Internal Events**

As a fundamental alternative to experiential avoidance, ACT encourages acceptance, or the conscious and active experience of unwanted private events, without attempting to alter their form, content, or frequency, particularly when these attempts cause adverse consequences. Such active acceptance is conditioned on the individual’s willingness to be mindful to the present moment. Thus, therapy also emphasizes the state of being present, or the non-judgmental, mindful experience of both internal and external events. This is done by a variety of mindfulness exercises in which language is used as a tool to describe rather than evaluate events, with the goal of increasing the previously limited repertoire of responses to such events (e.g., fear and avoidance).

Similarly, in contrast to many other forms of treatment, including earlier forms of cognitive therapy, ACT practitioners do not attempt to modify ‘problematic’ cognitions directly, mainly because it is assumed that relational networks are numerous and elaborated structures that tend to maintain and preserve themselves. Instead of focusing on the content (e.g., the validity) of troubling cognitions, treatment is aimed at changing the way people interact with their thoughts. Specifically, the goal is to modify the problematic function (rather than content) of unwanted thoughts by decreasing the tendency to relate to them as what they refer to (e.g., “she hates me”) instead of what they really are (the thought “she hates me”). This is done using a variety of cognitive ‘defusion’ techniques, in which clients are asked to distance themselves from the literal
quality of negative thoughts in various ways, including, for example, by treating them as external and observable events, by repeating them out loud many times, or by labeling the actual process of thinking (e.g., “I am having a thought that…”).

**Empirical Evidence**

Several recent studies provide support for components and processes associated with ACT (e.g., Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Hofmann, Heering, Sawyer, & Asnaani, 2009; Masuda, Hayes, Sackett, & Twohig, 2004; Najmi, Riemann, & Wegner, 2009; Singer & Dobson, 2007). In a yet unpublished study recently conducted in our laboratory, we attempted to examine, in well-controlled experimental settings, the processes associated with *cognitive restructuring* and *cognitive defusion*, the core cognitive components of traditional cognitive therapy (CT) and ACT, respectively (Yovel, Mor, & Shakarov, in preparation). To do so, we used a 3-phase procedure specifically designed for the study of therapeutic interventions that target troubling cognitions.

The aim of the tasks administered in Phase 1 of this procedure was to elicit an emotionally “hot” cognition (cf. Metcalfe & Mischel, 1999). Participants (136 college students) completed a paper and pencil task in which they were instructed to describe in writing an unpleasant event they had experienced that at times still disturbs and saddens them. Several general examples of such events were provided (e.g., “Has it ever happened that you failed at something that was important to you, and at times it still troubles you?”). In addition, they were asked to write a saddening thought about themselves that was triggered by the event and continues to be triggered by its recollection (e.g. “When Adam failed a test, he thought: ‘I don’t understand any of the material; there’s no way I’ll ever finish my degree.’”).

Subsequently, a “focused rumination” task was administered, in which participants were requested to contemplate the thought they had selected by following the instructions displayed on
a computer screen (12 items, each of which remained on the screen for 25 seconds). This task was based on Nolen-Hoeksema and Morrow’s (1993) general rumination induction, but items were worded to refer to a particular cognition (e.g., “Consider the content of your thought; what does it reveal about you?”; ” Think what ramifications this event may have for your future”). The focused-rumination task was designed to enable participants to conceptually and emotionally re-experience the saddening event and the negative thought and immerse themselves in it (cf. Kross & Ayduk, 2008), thus facilitating the creation of an emotionally ‘hot’ cognition that would be the target of the brief intervention.

Treatment-based interventions that targeted participants’ idiosyncratic cognitions were administered in Phase 2. Participants were randomly assigned to one of four experimental conditions: ACT-based intervention (cognitive defusion), CT-based intervention (cognitive restructuring), and two control conditions. Each intervention commenced with a brief clinical rationale that explained the logic underlying the techniques to be used. The overall aim of the ACT-related task was to facilitate cognitive distancing from the literal meaning of the emotion-laden cognition (Hayes et al., 1999). It included a variety of cognitive defusion techniques, in which participants were asked to write their thoughts in various ways (e.g., by using the non-dominant hand, in upper-case letters), label the process of thinking in writing (“the thought crossed my mind that…”), watch a cartoon character portrayed as thinking the thought, or visualize it from different vantage points (e.g., written on a bus moving away from them).

The CT intervention was designed to resemble cognitive restructuring or reappraisal procedures in which clients are asked to critically examine the validity of their aversive cognitions. It was based on CT techniques (adopted from Beck, 1995) which were modified to suit the experimental framework. Participants were asked to designate the degree to which they believed the thought was correct, examine whether it was influenced by several common
cognitive distortions (e.g., black or white thinking), and provide evidence supporting and disputing the validity of the thought. They then generated an alternative, more balanced thought, and designated the degree to which they believed this new thought was accurate. Finally, they rated the accuracy of their original thought for a second time, based on the tasks they had just completed.

The two additional interventions were used as control conditions. The tasks that were used in the “Active Distraction” condition were essentially a combination of the tasks used in the two treatment-based interventions, but rather than participants’ own distressing thoughts, the target was a non-distressing sentence provided by us. In contrast, in the “Written Rumination” condition participants needed to focus on their distressing thought by answering in writing questions that were essentially similar to the items of the focused rumination task (e.g., explore the causes of the thought). The non-distractive “Written Rumination” condition was designed to control for immediate effects of the intervention-based conditions (measured in Phase 2), and the “Active Distraction” condition was used to control for the protective effects against a reactivation of the distressing thought, assessed later in Phase 3.

The main goal of Phase 3 was to examine the protective or buffering effects of the two treatment-based interventions against a relevant emotional challenge, compared to the Active Distraction control condition. To do that, a second “focused rumination” task was administered. This 5-minute task was similar to the task administered in Phase 1, but to avoid repetition, different items were used.

A computerized mood assessment was used to assess state negative affect throughout the experiment. This instrument included eight depression-related PANAS items (e.g. sadness, disappointment; Watson, Clark, & Tellegen, 1988), each measured by a visual analogue scale (VAS). Findings showed that the Phase 1 tasks reliably produced “hot” cognitions: Reported levels
of negative affect at the end of this phase were considerably higher across all conditions compared to baseline \((d' > 1.0)\). More importantly, a repeated measures ANCOVA, in which we controlled for baseline mood and for the subjective significance of the selected personal material (measured by several post-experiment items), indicated that both ACT- and CT-based intervention conditions resulted in greater reduction of negative mood, compared to the relevant non-distractive control condition.

The clinical significance of these interventions, which did not differ from each other, was further supported by the large effect sizes of the negative mood reduction in both conditions \((d' > 0.80)\). Clinical significance was also indicated by the larger proportion of ‘greatly improved’ participants in these conditions relative to the non-distractive control condition, identified by Jacobson’s reliable change index (RCI) analysis (Jacobson, Roberts, Berns, & McGlinchey, 1999). Interestingly, mood improvement in both treatment-based conditions (but not in the control conditions) correlated with theoretically-relevant measures of metacognitive beliefs. In the CT condition, mood reduction correlated with a scale that included items such as “I think I need to correct my thought,” whereas in the ACT condition, improvement was associated with statements such as “I believe that the very existence of this thought prevents me from living my life the way I want to” [reversed].

In terms of protective effects, both cognitive restructuring and cognitive defusion moderated the negative mood increase caused by the second focused-rumination task (administered in Phase 3) better than the Active Distraction control task. The two treatment-based conditions did not differ from each other in terms of average performance. However, based on Jacobson’s RCI analysis, only the ACT-based condition produced better outcomes than the control condition (in terms of the proportion of individual participants who “survived the emotional challenge” and did not experience a significant mood increase).
In sum, these findings suggest that cognitive defusion, which encourages the acceptance of distressing cognitions without directly addressing their verbal content, is at least as efficacious as cognitive reappraisal, and that improvement due to both kinds of interventions is specifically associated with theoretically relevant metacognitive beliefs. At the end of the experiment participants rated the extent to which they believed the intervention was helpful, and interestingly this face validity measure was associated with mood improvement only in the CT-based condition, not in the ACT condition. This finding, which replicates similar findings in both field studies (Lappalainen, Lehtonen, Skarp, Taubert, Ojanen, et al., 2007) and laboratory settings (Hofmann et al., 2009), indicates that, compared to the strategies commonly used in CBT (e.g., reappraisal), those used in ACT (e.g., acceptance) are less straightforward and clear, despite their efficacy.

Meaning: Commitment to Chosen Values in ACT

ACT aims at increasing psychological flexibility, not at reducing psychological pain, and treatment goals are not defined in terms of symptom reduction per se. Thus, for example, acceptance-based techniques taught in therapy are not conceptualized as new ways of avoiding psychopathology, but as positive psychological skills aimed at promoting valued living. Clients are encouraged in therapy to identify values or consistent life directions that are meaningful to them in various domains (e.g., family, career). It is important that these values are not influenced by problematic processes such as experiential avoidance or social compliance. ACT also fosters the development of continuous committed action, or meaningful patterns of behavior aimed at achieving specific and concrete goals consistent with one’s chosen values. This is typically done by using well-known behavioral techniques such as goal setting, problem solving, and exposure to feared objects and situations.

Arch and Craske (2008) identified the focus on values as a central component that distinguishes ACT from other forms of CBT. While most types of psychotherapy view the facilitation of a
fulfilling life as an important result of therapy, they differ in how directly and clearly valued living, as an alternative to symptom reduction, is addressed in treatment. ACT explicitly focuses on the former, whereas other forms of CBT typically focus on the latter. Promoting valued living and avoiding the experience of negative symptoms can both be conceptualized as broad and general motivators in psychotherapy. Indeed, theorists have long identified approaching desirable outcomes and avoiding undesirable states or events as two primary and distinct bases of human motivation (e.g., Elliot, 1999). For example, Higgins (1997) identified approach and prevention as two types of regulatory focus that lead to different desired end states: Promotion focus is associated with accomplishments and desired gains; prevention focus is associated with safety and security.

**Focusing on Values in Therapy: Empirical Evidence**

Although a great deal of research supports most core processes in ACT (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010), empirical support for interventions associated with the values component, which may function as a positive reinforcement in treatment (Wilson & Murrell, 2004), is relatively small. Basic research on regulatory focus has shown that promotion focus leads to greater action initiation and persistence, whereas prevention focus leads to earlier withdrawal (e.g., Crowe & Higgins, 1997; Roney, Higgins, & Shah, 1995). More specific support comes from several recent studies that examined the efficacy of values-based interventions in dealing with the experience of physical pain (e.g., in a cold pressor task; see Ruiz, 2010). Findings from these studies suggest that focusing on one’s values improves the ability to cope with pain and discomfort (Branstetter-Rost, Cushing, & Douleh, 2009), and it may also strengthen the efficacy of acceptance-based techniques in this regard (Paez-Blarrina, Luciano, Gutierrez-Martinez, Valdivia, Ortega, et al., 2008).

In a study we recently conducted (Catane & Yovel, in preparation) we attempted to examine in laboratory settings whether focusing on chosen personal values leads to greater motivation to
undergo difficult tasks in therapy. The first part of the experiment, which was designed to create simulated therapeutic conditions, was identical to Phase 1 of the 3-phase procedure described earlier. Participants (112 college students) recalled and wrote about an unpleasant event they had experienced, extracted a relevant negative thought, and performed a “focused rumination” task, with the aim of creating a distressing, emotion-laden idiosyncratic cognition. They were then randomly assigned to four experimental conditions.

Participants in the “Values” condition were asked to identify personal values and goals by following procedures typically used in ACT (Hayes & Strosahl, 2004). For example, they rated the subjective importance of certain general value domains (e.g., intimacy, career, family), and identified personal goals they have not been able to achieve because of issues associated with the negative thought they had identified in the preceding task. They were then asked to write several sentences such as “If the thought […] weren’t such a problem for me, I would have [personal goal].”

Participants in the “Symptom Reduction” experimental group performed similar tasks, but rather than emphasizing personal values, symptom reduction was emphasized. For example, participants needed to rate the subjective importance of certain negative emotions and complete sentences such as “If the thought […] was not such a problem for me, I would feel less [negative emotion].” A control group performed distraction tasks that did not focus on distressing cognitions (e.g., they rated the extent to which they like certain colors), thus controlling for time and for the potential distraction effect from the negative thought caused by the manipulation. Because distraction has been shown to decrease negative affect (e.g., Fennell & Teasdale, 1984), a second control group did not perform any manipulation task, thus maintaining negative affect and controlling for mood.

Similarly to the experiment described earlier, negative mood was assessed several times using a computerized VAS instrument. Subsequently, participants in all groups were asked to follow the instructions displayed on the computer screen and perform several tasks they were told would help
them cope with their distressing thoughts. These tasks were all based on cognitive defusion techniques adopted from Hayes and Smith (2005).

Two different dependent measures indicated that participants in the Values group showed particularly high levels of motivation when performing the therapeutic tasks. First, in one of the tasks they performed they were asked to imagine a certain scenario. An ANCOVA, in which negative mood and reading speed (measured by the time spent on reading instructions prior to the manipulation) were used as controls, showed that participants in this condition spent significantly more time (measured by the computer) on this task, compared to all other groups (which did not differ significantly from each other). In addition, after performing several tasks, participants were presented with the option of completing additional therapeutic tasks or of doing a task unrelated to their distressing thought (rating a nature video clip), which was ostensibly needed for a different experiment. Of the participants who indicated in a post-experimental questionnaire that the therapeutic interventions were relevant to what they wrote about in the manipulation tasks (achieving valued and goals or symptom reduction), a significantly larger proportion of the participants in the Values group (80%) chose to continue doing therapeutic tasks, compared to only 38% in the Symptom Reduction group. Thus, in contrast to those who focused on their values, most participants who focused on the alleviation of their negative symptoms preferred to “quit therapy” and rate the video clip. Importantly, the groups did not differ in terms of negative mood levels, which remained high following the manipulations, except for the expected significant reduction observed in the Active Distraction control group. Thus, the findings cannot be attributed to any direct effect that focusing on personal values versus symptom reduction had on participants’ mood. Taken together, these results suggest that focusing on one’s chosen values rather than on the alleviation of disturbing symptoms may increase motivation in therapy, thus providing a rare support for the values component of ACT.
Concluding Remarks

ACT is a broad behavioral clinical approach based on a comprehensive theory of human language (Hayes et al., 1999). Unlike many kinds of psychological and psychiatric therapy, ACT does not focus directly on symptom reduction. Similarly to other recently developed cognitive behavioral therapies, ACT is influenced by eastern philosophies, as it fosters acceptance and mindfulness where pain is inevitable. In terms of broad treatment objectives, ACT is similar to existential perspectives in encouraging the identification of personal values in therapy, and strongly encouraging value-committed action where change is possible.

In ACT, clients are introduced to the fundamental choice they can make, and may never have considered, to accept the unavoidable presence of unwanted experiences without attempting to prevent their occurrence, change their form, or act on them. They are further encouraged to behave in ways that are consistent with their chosen values. Many ‘traditional’ CBT interventions (e.g., exposure, behavioral analysis) are frequently used in ACT treatments. But ACT promotes the acceptance of unwanted private events, and therefore behavioral interventions (e.g., relaxation) or cognitive interventions (e.g., cognitive restructuring) that specifically target the change of such experiences are not compatible with this approach. Because ACT does not focus on the alleviation of narrowly defined symptoms, this approach expands the focus of change compared to earlier forms of CBT, and it may consequently suit a broader range of human difficulties.

Theories and research on issues such as psychological distance (Liberman & Trope, 2008), thought suppression (Wegner, 1994), rumination (Nolen-Hoeksema et al., 2008), self-verification (Swann, Stein-Seroussi et al., 1992), and regulatory focus (Higgins, 1997) are consistent with central aspects of ACT theory and practice, and a rapidly growing body of literature provides support for the efficacy of treatments derived from ACT for a wide variety of difficulties and
mental disorders (Ruiz, 2010). Here we described two recently conducted laboratory examinations of core treatment processes in ACT. The findings demonstrate the efficacy of the unique methods used in ACT for dealing with aversive cognitions, as well as the superiority of considering one’s chosen values versus symptom reduction while engaging in therapeutic tasks. Thus, the values-based treatment objectives of n ACT, which greatly expand the focus of change in cognitive behavioral treatments, may be useful motivators in therapy.

References


