Bridging the Gap between Cognitive Therapy and Acceptance and Commitment Therapy (ACT)

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Abstract

Cognitive Behaviour Therapy (CBT) may be viewed as a family of evolving therapy approaches which have differing behavioural and cognitive orientations. This discussion paper will briefly review the similarities and differences between Beckian Cognitive Therapy and Acceptance and Commitment Therapy (ACT) which has been described as being part of a ‘third wave’ or ‘third-generation’ of cognitive behaviour therapies. Current views about the theoretical and technical similarities and differences between these approaches will be briefly discussed and application to stuttering considered.

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1. Introduction

The terms ‘first’, ‘second’ and ‘third generation or ‘third wave’ are often, although not unanimously, used to describe the development of cognitive-behaviour therapy and the treatment of emotional disorders. ‘First generation’ is used in reference to Behaviour Therapy which was prominent in the 1950s and which was characterized by the use of learning theory and methods, with a focus on behavioural change. ‘Second generation’ refers to the ‘cognitive revolution’ of the 1970s and approaches which combined cognitive and behavioural techniques but focused on the role of cognitions and on making changes within this domain. Beckian Cognitive Therapy became the most widely-
used and empirically-tested of these. It has been referred to as ‘established’, ‘mainstream,’ ‘traditional’ or ‘standard’ CBT to distinguish it from other more recently-emerging cognitive-behavioural approaches. The term ‘standard CBT’ will be used in this discussion.

Hayes (2004) coined the term ‘third wave’ or ‘third generation’ in reference to cognitive-behaviour therapy approaches such as Mindfulness-Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2012) and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2012) that have emerged in recent years. While these approaches have their roots in either the cognitive or behavioural ‘wing’ of CBT they all question the premise that it is necessary to change cognitions or indeed that feeling ‘better’ is the preferred aim in therapy. Instead they promote acceptance or ‘allowing’ of experience and the use of secular mindfulness techniques derived from Buddhist meditation and the work of Kabat-Zinn (1996). There is increasing empirical support for these approaches and widespread discussion of the role of secular mindfulness in western psychological, health and educational sciences.

The problem with calling anything third wave is that it suggests that what went before is being superceded. Proponents of standard CBT, (Hofman & Asmundsen, 2008; Hofmann, Asmundsen, & Beck, 2013) reject the term, referring to the “so-called third generation”, presumably for this reason. They argue that the field of CBT is expanding to include acceptance and mindfulness-based work while remaining unified by a core premise about the role of cognitions, and that newer approaches can therefore be subsumed within CBT, rather than being part of any separate ‘third wave’ (Hofman et al., 2013). They also propose that there is nothing intrinsically new or novel about ACT. Hayes and other proponents of ACT reject this and argue that ACT is a new treatment approach which is philosophically, theoretically and technically distinct and part of a generational shift in cognitive-behaviour therapy. The debate is ongoing and positions taken reflect personal allegiances.

This discussion paper will review some of the theoretical and technical differences, and similarities, between standard CBT and ACT. The two approaches have different theoretical and philosophical roots, different conceptualisation of the role of cognitions and emotions, and may have different clinical goals, however there are also similarities between the two. Ultimately there are issues that will be clarified by future research, however in the interim there is benefit in clinicians who have an interest in both approaches being aware of where they overlap and where critical distinctions need to be drawn. The discussion is necessarily limited in scope and reading of additional sources is recommended for a fuller theoretical, technical and empirical perspective. The author has a post-graduate diploma in Cognitive Therapy from the Oxford Cognitive Therapy Centre, U.K, and 17 years experience using standard CBT with people who stutter following, along with more recent training in ACT.

2. What causes emotional distress?

The way that this question is answered underpins the technical components of any therapy approach. Standard CBT is based on information-processing theory which proposes that cognitions (thoughts, images, perceptions of events, assumptions and beliefs) have a directly causative relationship with emotional and behavioural responses: what you think affects how you feel emotionally and physically, and also what you do (Beck, 1976). Negative emotions are viewed as the result of ‘dysfunctional’, ‘irrational’ or ‘maladaptive’ patterns of thinking and patterns of biased or ‘distorted’ information-processing such as hyper-vigilance to threat cues or excessive attention to negative cues (Deacon, Fawzy, Lickel, & Wolitzky-Taylor, 2011; Hofman & Asmundsen, 2008; Hofmann et al., 2013). Cognitions can thus be understood as the product of a faulty information-processing system rather than as truths in themselves. Problems arise when systematic biases in information processing, which happen at an automatic level, give rise to behavioural responses which in turn reinforce the individual’s perceptions and beliefs, or which in some other way reinforce maladaptive patterns of thinking, creating what is commonly referred to as a vicious cycle.

While other aspects of experience are included in theoretical models, primacy is given to the role of cognitions in explaining emotional difficulties. This unifies treatment protocols for a range of disorders and explains the focus on changing cognitions that is characteristic of standard CBT. Of particular interest in the field of stuttering are theoretical accounts of social anxiety, for which there are two pre-eminent theoretical models. While articulating some differences, both Clark and Wells’ (1995) and Rapee and Heimberg’s (1997) models propose that information-
processing biases such as hyper-vigilance to threat cues, neglect of positive or neutral cues, bias towards interpreting ambiguous information in a negative way, and self-focused attention, together with behavioural responses such as the use of safety behaviours, maintain social anxiety.

ACT is described as a contextual behavioural science in which cognitions are viewed as critically important but only one of many potential contextual causal links which can give rise to negative emotions, with others being the role or purpose of behaviours and social or linguistic contexts (Herbert & Forman, 2013; Hayes, 2008). In essence, proponents of ACT assert that they do not rule out the possibility that cognitions have a critical role, but they also look at other possible links in the ‘causative chain’ rather than affording cognitions a ‘special status.

The theory underpinning ACT is Relational Frame Theory or RFT (Hayes et al., 2012). RFT is a theory of language-learning and cognition which seeks to account for emotional difficulties by exploring the verbal ‘relations’ or rules that are acquired in the process of developing language competency. These linguistic relations or rules are arbitrary (consider the concept of ‘bigger than’ in respect to the relative value of a coin and its’ actual size). They become problematic when applied rigidly and excessively to the individual’s sense of self, affect wellbeing and reduce the scope and flexibility of the individual’s behavioural repertoire or choice. For example, linguistic rules of comparison when applied to the self rather than the physical environment may give rise to a sense of being ‘not as good as’ another. Similarly, the linguistic relation of equivalence may underpin unhelpful personal rules such as ‘I am (am equal to) a failure’.

Language is thus viewed as a double-edged sword which, for all its adaptive advantage, also provides the building blocks for negative self-constructions that individuals may become strongly ‘fused’ with or attached to. In this framework, thoughts, which are conceptualised as language-based behaviours, can be understood as the product of the language-learning mind rather than truths in themselves. Proponents of ACT also argue that human beings have a capacity to problem-solve and are instinctively orientated towards ‘fixing’ problems. This is an advantage in respect to the external world but creates problems when applied to internal experience, as the inclination towards controlling adverse experience results in avoidance and suppression of unwanted thoughts and feelings. This is problematic because it leads to an experiential disconnect and a narrowing of behavioural choices so that the individual behaves in a less personally values-consistent way in order to maintain the sense of control (Hayes et al., 2012).

In summary, both approaches are based on theories of human functioning which, while different, provide a context for viewing cognitions as the product of that respective system rather than an articulation of innate truths. There is also a shared view that automatic, rigid responses to experience become unhelpful to the individual and reinforce problems in one way or another, whether conceptualised as a vicious cycle or as a narrowing of behavioural repertoires and moving away from valued living. A key theoretical difference is the degree of emphasis given to cognitions in directly causing emotional problems (Herbert & Forman, 2013; Hayes, 2008).

3. Application to stuttering

The application of ACT to therapy for people who stutter is gaining a presence in the literature in the form of discussion papers and reports of preliminary clinical outcomes. Beilby, Byrnes and Yaruss (2012) have described group work with adults who stutter integrating ACT and individualized fluency therapy, reporting reduced negative impact of stuttering and increased fluency at 3-month follow-up. In addition, Cheasman and Everard (2013) have reviewed their use of ACT in a 3-day workshop with adults who stutter, reporting significant benefits in terms of increases in mindfulness skills and acceptance of stuttering, and reduced negative thoughts and feelings, avoidance and sense of disadvantage associated with stuttering. One point raised by Beilby et al. (2012) is the apparent paradox of integrating the principles and techniques of ACT with its emphasis on acceptance, with speech restructuring, where control is the intention. However, they propose that the two can be complementary, a view which many clinicians integrating other counselling approaches and speech restructuring skills may agree with.

The literature has more to offer with respect to standard CBT and stuttering as the last fifteen years have seen a growing body of work addressing pertinent theoretical, empirical and clinical issues, and exploring the relevance of cognitive models of social anxiety and their proposed mechanisms to stuttering (Menzies, Onslow & Packman, 1999; Craig & Tran, 2006; Iverach, Menzies, O’Brien, Packman, & Onslow, 2011; Lowe et al., 2012). A recent summary of the current status is provided by Iverach and Rapee (2014). Clinically, standard CBT has been shown to
reduce social anxiety in adults who stutter (Menzies et al., 2008), and single-subject studies have explored the effectiveness of an intensive treatment programme for adolescents which integrates standard CBT, speech restructuring and communication skills training (Fry, Botterill & Pring, 2009; Fry, Botterill & Millard, 2014). Fry (2013) has provided clinical reflections on the process of standard CBT with one adult who stutters in tandem with the client’s own reflections. More recent developments are the use of standard CBT with children (Kelman & Wheeler, 2014), the development of an on-line CBT resource for people who stutter (Helgadottir, Menzies, Onslow, Packman, & O’Brien, 2014), and interest in the role of cognitive bias modification interventions with people who stutter (Lowe et al., 2012).

4. The aim of therapy

The aim of standard CBT is to reduce, regulate or eliminate emotional distress, and the cognitive, emotional, physiological and behavioural symptoms of that distress, in order to improve wellbeing and help individuals function better in their lives (Hofmann & Asmundsen, 2008; Hofmann, Asmundsen & Beck, 2013; Arch & Craske, 2008). While both cognitive and behavioural techniques are used, the underlying explanatory theory means that there is a focus on changing or ‘correcting’ the ‘dysfunctional’, ‘irrational’ or ‘maladaptive’ cognitions, thinking patterns and information-processing biases that are conceptualized as underpinning and maintaining emotional problems.

Conversely, ACT explicitly does not target symptom-reduction as a primary goal or set out to try to regulate or ‘control’ emotional or cognitive content (Hayes, 2008). Although proponents of ACT acknowledge that symptom-reduction does occur this is regarded as a secondary by-product rather than the primary intended outcome (Hayes, 2008; Hayes et al., 2013). In fact, the helpfulness of control is explicitly questioned, both theoretically and with clients, and the process of therapy is predicated on a relinquishing of control as the desired end. Instead, ACT promotes psychological flexibility and aims to help individuals have a different and more allowing relationship with unwanted internal events rather than struggling with them.

Psychological flexibility is defined as the individual’s ability to directly connect with and experience all aspects of their internal world, including those that are aversive; the ability to be more open to and accepting of experience rather than avoidant; of being less attached to or ‘fused’ with language-based concepts or narratives about the self, and the ability to make more values-consistent behavioural choices in order to increase life meaning or value (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes et al., 2012). These are represented in the psychological flexibility model or ‘hexaflex’ (Hayes et al., 2012).

5. Core therapeutic processes

Menin, Ellard, Fresco and Gross (2013) suggest that ACT and standard CBT both target change in attention, thinking and behaviour, albeit in different ways. The aims and processes of both approaches will be briefly discussed in respect to these domains.

5.1 Attention

Standard CBT works in the domain of attention in two ways. Firstly, individuals are helped to develop awareness of their internal experience, be that cognitions, patterns of thinking, physiological responses, or feeling states. Many core techniques of standard CBT, such as drawing out ‘conceptualisations’ or diagrams of how problems are triggered and maintained, identifying negative automatic thoughts and emotional responses, or learning about and noticing patterns of thinking, are supported by and in themselves support this increased awareness of or attention to experience. The aim is to encourage an objective, curious and to some extent analytical awareness of internal events. Secondly, biases in attention are targeted for change. These may include biases towards self-focused attention, attentional neglect of positive environmental cues, excessive focus on negative cues or hyper-vigilence towards threat cues (Iverach & Rapee, 2014). Attention training in the form of ‘tuning-in’ to these processes is the precursor to addressing attentional bias through techniques such as practicing switching from internal to external focus of
attention, keeping a diary of positive information, or intentionally searching for positive cues. Cognitive bias modification is of increasing interest in the field of social anxiety (McAllister, Kelman, & Millard, 2014) and may potentially be applied as an attention training intervention with people who stutter.

Therapists working with ACT also help individuals to attend to internal experience and develop meta-awareness skills but through different practices and with a different aim in mind. Secular mindfulness techniques are used to develop the individual’s ability to focus attention on the present moment in a non-judgemental or accepting way (Kabat-Zinn, 1996). Secular mindfulness techniques encourage individuals to directly connect with the present-moment, to watch thoughts and other internal events as they arise and go, and to stay with all aspects of their experience, including uncomfortable thoughts and emotions, instead of avoiding them by disengaging (Menin et al., 2013).

Both approaches use techniques which actively use attentional processes, increase observation and awareness of internal experience, increase curiosity about internal experience and develop attentional flexibility, and both also encourage objectivity and curiosity. However, the mindfulness practice used in ACT offers a more structured and explicit process of attention training than is found in standard CBT. The intention is also different. In standard CBT the aim is to help the individual to observe their experience analytically and with the aim of making changes, whereas in ACT the aim is to help the individual observe, with friendly, compassionate curiosity (Menin et al., 2013), and to develop the ability to tolerate rather than avoid negative aspects of experience which arise.

5.1. Thinking

This is the area which appears to attract the most interest in comparative discussions. The aim in standard CBT is to change the content of thinking and develop greater flexibility of thinking, in order to regulate symptoms. Individuals are helped to become aware of their cognitions by identifying their negative automatic thoughts, dysfunctional assumptions, negative core beliefs and their habitual patterns of thinking, using thought diaries to record their thoughts and notice emerging themes and patterns (Beck, 1995). They are encouraged to view thoughts as the product of a biased or inaccurate information-processing system and as hypotheses rather than innate truths, and to adopt a scientific, hypothesis-testing orientation towards them.

Individuals are then helped to challenge or question the accuracy of their negative automatic thoughts, to consider alternative perspectives, to re-evaluate assumed meanings, and to generate more ‘balanced’ or ‘accurate’ thoughts through cognitive restructuring tasks and the use of Socratic questioning on the part of the therapist (Hofmann et al., 2013; Hofman & Asmundsen, 2008). Socratic questioning may also explore the degree to which cognitions are helpful or unhelpful (Beck, 1995) however questioning the veracity or accuracy of thoughts remains a central concern, particularly in the field of anxiety where heightened appraisal of threat is a theoretical cornerstone.

In ACT individuals are similarly helped to become aware of their thoughts and thought processes by mindfully observing thoughts as they arise. They are encouraged to view the process of thinking as the product of the ‘language’ mind, and thoughts as just thoughts rather than as facts in themselves. The focus of interest in ACT is the usefulness or ‘workability’ of thoughts, namely do they move the individual towards or away from living in a way that is consistent with personal values; do they expand or restrict the individual’s behavioural responses? (Hayes et al., 2012). Rather than change the content or frequency of troublesome thoughts the aim in ACT is to create distance between the self and thinking, to help individuals ‘decouple’ or ‘defuse’ from the literal meaning of their thoughts and gain a sense of being able to observe their thoughts from a distance. This process of stepping back from believing literal meaning renders thoughts less powerful and less able to influence behavioural choices.

Together with encouraging a mindful awareness of thinking as it occurs, a variety of metaphors and experiential exercises are used with the intention of breaking the link between language and literal meaning, and encouraging defusion. For example, words and phrases may be repeated over and over until their literal meaning is deconstructed as in the “milk” exercise (Masuda, Hayes, Sackett & Twohig, 2004), individuals may be encouraged to identify the process of thinking (“I am having the thought that….“), or visualise leaves floating down a stream while they place thoughts on them as they float past, and metaphors such as viewing thoughts as disruptive passengers on a bus which can be ‘made room for’ rather than argued with, without distracting the driver from his or her destination may
be introduced (Hayes et al., 2012). A sense of the ‘Self as Context’, or a sense of self which is not defined by the content of thoughts and feelings but which is, instead, expansive enough to contain experience is also encouraged through exercises and metaphors which foster a sense of the separate or ‘Observing Self’ (Harris, 2009).

There are similarities between how standard CBT and ACT approach cognitions but also a key difference. Both propose that developing the individual’s insight and meta-cognitive ability has psychological benefit, and that not getting “tied up in thinking” is helpful in some way (Arch & Craske, 2008). Both encourage flexibility of thinking and adaptive perspective-taking, be that through the paradigm of the scientist-observer or that of the mindful observer or more expansive sense of self. In addition, both approaches are interested in the impact of thoughts on behaviour, and both refer to the helpfulness or otherwise of cognitions, although this is one possible line of enquiry in standard CBT where emphasis is also given to testing the accuracy of thoughts, while helpfulness or workability is the central concern of ACT and the concept of ‘veracity’ is not a concern. Finally, although mindfulness practice explicitly promotes self-compassion, standard CBT may also encourage individuals to be a ‘fairer critic’ when patterns of self-criticism are activated, although this may be less explicit within the process of therapy or more dependent on individual therapist style.

The contrast that gains the most attention in the literature is that while standard CBT promotes evaluation of thoughts and change in their content or frequency through cognitive restructuring, ACT promotes a different relationship with thoughts, nurturing an ability to hold thoughts in awareness rather than try to change or diminish them, through a focus on present-moment awareness, indeed viewing a change agenda as being fundamentally at odds with an acceptance-based philosophy (Deacon et al., 2011).

Proponents of ACT argue that challenging the content of thoughts is risky. Firstly, because paradoxically it can make those thoughts more central, noticed or important (Hayes et al., 2013), and also because it encourages thought suppression as people will tend to suppress thoughts which are perceived to be ‘faulty’ (Hayes et al., 2013; Arch & Craske, 2008). Leahy (2008) defends standard CBT on this point, arguing that the practice of identifying negative automatic thoughts actively encourages expression of thoughts rather than suppression.

5.2. Behaviour

Proponents of both standard CBT and ACT use behavioural techniques, not surprisingly given their shared behavioural roots, and ultimately target behavioural change (Menin et al., 2013) and a reduction in behavioural avoidance (Arch, Wolitzky-Taylor, Eifert & Craske, 2012). Those with an allegiance to standard CBT articulate this in terms of helping individuals to achieve greater life satisfaction (Hofmann & Asmundsen, 2008) by engaging in behaviours which have previously been avoided due to their association with fear and anxiety (Arch et al., 2012). Those with an allegiance to ACT refer to helping individuals engage in valued behaviours that have been avoided due to attempts to control aversive experience (Hayes et al., 2012).

Behavioural tasks include goal setting, activity scheduling and exposure, the latter of which will be the focus of this section. While both standard CBT and ACT therapists may introduce exposure tasks these have a different purpose that reflects the nature of each approach. In standard CBT for anxiety, exposure tasks are undertaken with the aim of reducing or extinguishing anxiety and fear, and in order to ‘disconfirm expectancies’, in service of the overall goal of changing the individual’s view of themselves and the world (Hofman & Asmundsen, 2008). ‘Behavioural experiments’ are used to test the validity of specific cognitions, thus contributing to cognitive change and a reduction of negative emotions. This is a critical component of therapy for social anxiety where individuals test out the degree to which they experience the negative listener reactions and judgments that they expect (Clark & Wells, 1995).

In ACT, exposure is used to increase the individual’s willingness and ability to experience aversive feeling states such as anxiety without struggling with them (“feel the fear”) and to develop, or discover, the capacity to tolerate these states without letting them influence behavioural choices (“do it anyway”) (Hayes, et al, 2013). Contrasting these two approaches to exposure, the theme of connecting with and accepting internal experience rather than seeking to change it continues.
Proponents of ACT propose that clarifying personal values supports the change process by keeping each individual’s sense of ‘what really matters’ in sight and providing the necessary impetus for committed action, particularly when rewards are not immediate (Menin et al., 2013) or when tasks are challenging. They argue that values represent a more over-arching guiding principle than goals which are more typically identified in standard CBT. Some proponents of standard CBT argue that it targets an increase in life-satisfaction as a by-product of symptom reduction, i.e. working the other way around, and that this equates to working at a level of life values (Arch & Craske, 2008; Hofmann & Asmundsen, 2008). These authors cite early sources identifying the goal of increased life satisfaction for clients (Beck, Rush, Shaw and Emery, 1979), and argue that experienced therapists have always worked in this domain as well as that of regulating symptoms. That being said, direct and explicit work on clarifying and pursuing life values and linking these to behavioural choices does not feature as a component of standard CBT treatment protocols and it seems reasonable to view it as a more distinctive feature of ACT.

6. Discussion

Questions which may be relevant to clinicians are:

- How distinct are standard CBT and ACT?
- Can elements of both approaches be integrated?
- Does the advent of more recent cognitive-behavioural therapies mean that approaches are converging?

6.1. How distinct are standard CBT and ACT?

Herbert and Forman (2013) describe CBT as a broad umbrella term for a group of approaches which share certain features but which also have distinct and unique features. Other authors with an allegiance to ACT also emphasise its distinct nature (Hayes et al., 2013). The degree to which standard CBT and ACT are distinct ultimately rests on whether or not they operate through similar or different mechanisms of change. Both are backed by treatment effectiveness research, although standard CBT claims a more established track record in this respect, and this has led some to call for research which investigates the mechanisms of change as a priority over the ‘horse race’ of comparing treatment outcomes. The question of interest is whether these two approaches work for the same reason or whether there are fundamentally different mechanisms operating (Deacon et al., 2011; Arch et al., 2012). There is also interest in research which demonstrates that treatment mediators tie in with respective theories. In other words, does change happen in a way that is predicted and explained by the relevant theory, or ‘does it do what it says on the theoretical tin’? (Herbert et al., 2013). If theory and process align then it can be expected that a reduction in the occurrence and believability of cognitions will predict outcome in standard CBT whereas increase in cognitive defusion, psychological acceptance and value-guided action will predict outcome in ACT.

This is an ongoing debate. Some authors support the view that there is an overlap of process, referring to findings that cognitive defusion mediates change in standard CBT as well as in ACT even though not directly targeted in the former (Arch et al., 2012). It is also suggested that some standard CBT tasks, such as writing thoughts down, effectively function in the same way as defusion tasks by creating emotional distance between the individual and their thoughts and the opportunity to literally observe the process of thinking (Menin et al., 2013). Others support the view that ACT is a distinct approach which operates through distinct and unique mechanisms (Hayes et al., 2013).

6.2. Can elements of the two be integrated?

This is a pertinent question for therapists with a background in standard CBT and an interest in ACT. While Hayes et al. (2013) argue against adding “a dash of mindfulness here and a dollop of values there” (p195), others take the view that, despite a tension between an agenda of change and an agenda of acceptance, there may be some contexts in which a ‘hybrid’ approach might be helpful. For example, Herbert and Forman (2013) writing with an allegiance to ACT suggest that cognitive restructuring is more effective than acceptance strategies when specific
information is needed. Behavioural experiments which help people who stutter investigate listener reactions, or find out to what extent fluent peers report some anxiety about public speaking may be examples of such contexts. Similarly Burton et al. (2012) have suggested that mindfulness practices may help individuals to engage with cognitive restructuring techniques because of the impact that mindfulness practice has on emotion regulation, thus being a first step in an integrated programme. Arch et al. (2012) have also suggested that the there may be benefits in matching the approach with the type of emotional problem, reporting that standard CBT resulted in better outcomes for treatment of anxiety while ACT resulted in better outcomes for depression.

Finally, from a clinical perspective, some individuals may find that a combination of cognitive defusion and cognitive restructuring skills is beneficial in a given situation, despite the philosophical tensions between the two, or may simply be a combination that fits with their personal preference or thinking style. What seems critical is that therapists are clear about the philosophy and theory behind the interventions that they use and seek to ensure that conflicts do not arise that will confuse rather than help the individual client. Considering which treatment is likely to be most effective for each individual, on an individual basis, may be a sensible way forward.

6.3. Is there convergence?

Rector (2013) has suggested that while standard CBT and ACT arise from different theoretical traditions, and belong to one family of CBTs, they are converging in the use of mindfulness, which is a core component of Mindfulness Based Cognitive Therapy (Segal et al., 2012) as well as ACT. MBCT also uses ‘decentering’ from thoughts in order to gain objectivity, a concept which was originally highlighted by Beck et al. (1979), which may be similar to defusion. Finally, Arch and Craske (2008) have discussed changes in the way that exposure is conceptualised in standard CBT, identifying that its’ focus is shifting from fear extinction towards increasing the individual’s ability to tolerate fear and anxiety, essentially using the language of acceptance.

There is consensus that the field of CBT is evolving and that new approaches are enriching an understanding of how to relieve the problem of human suffering. Mindfulness Based Cognitive Therapy is also being explored in relation to stuttering (Cheasman, 2013; Boyle, 2011) and together with ACT these approaches open up new possibilities in therapy. Proponents of both standard CBT and ACT reinforce the importance of ongoing research at a clinical and theoretical level and of continued respect for the contributions made by all. In whichever way therapists define their own therapeutic approach, the vital and exciting role of mindfulness and acceptance based strategies and the relevance of this for people who stutter stands out. Watch, or mindfully observe, this space.

References


