

Acceptance and Mindfulness in Behavior Therapy: A Comparison of Dialectical Behavior Therapy and Acceptance and Commitment Therapy

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Abstract

Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT) are both innovative behavioral treatments that incorporate mindfulness practices and acceptance-based interventions into their treatment packages. Although there are many similarities between these treatments, including the fact that they are part of a newer “wave” in behavior therapy involving mindfulness and acceptance interventions, there also are some key differences in the ways in which ACT and DBT conceptualize and use acceptance and mindfulness interventions in treatment. This article discusses these similarities and differences.

Key Words: Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness

Over the past couple of decades, the field of behavior therapy has experienced a shift in focus, with treatment developers showing increased interest in acceptance and mindfulness interventions, as well as in the ways in which clients regulate or manage their emotions (i.e., *emotion regulation*; Gross, 1998). As noted by Hayes (2004), earlier iterations of behavior therapy focused primarily on applying findings from basic behavioral science to the development of interventions for clinical problems. This early research spawned many evidence-based practices, including exposure therapy for anxiety disorders, interventions that change contingencies of reinforcement, behavior modification, and skills training, among other such strategies (Goldfried & Davison, 1976). Subsequently, researchers and treatment developers shifted focus toward the role of cognitive processes and information processing in psychological difficulties. Ultimately, this marriage of cognitive and behavioral techniques resulted in a powerful set of treatments that fall under the rubric of cognitive-behavioral therapy (CBT), which currently dominates lists of evidence-based treatments (Chambless et al., 1996).

Over the past decade or so, newer forms of behavior therapy and CBT (coined the “third generation”; Hayes, 2004) have emphasized phenomena that received comparatively little emphasis in previous iterations of CBT. For instance, these approaches emphasize emotions, emotion regulation, acceptance, experiential avoidance, human language, values, and mindfulness and meditation practices. Two such approaches with notable empirical support and widespread dissemination are Dialectical Behavior Therapy (DBT; Linehan, 1993a), and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). ACT and DBT share many common features, but the most striking similarity is their emphasis on mindfulness and acceptance practices. However, there are substantial differences between ACT and DBT in terms of how they arrived at the focus on mindfulness and acceptance as well as in the ways in which these interventions are conceptualized and implemented in practice. The present paper highlights some key similarities and differences between ACT and DBT in terms of how they conceptualize and use acceptance and mindfulness-based methods.

Infusing Behavior Therapy with Acceptance: The Development of DBT and ACT

The developers of DBT and ACT took different routes to arrive at their focus on acceptance in behavior therapy. Marsha Linehan developed DBT in the process of piecing together an evidence-based

treatment package for suicidal women, for whom the treatment outcome data were rather bleak at the time (early 1980s). Linehan used standard, evidence-based cognitive and behavioral strategies (Goldfried & Davison, 1976) as the building blocks of her new treatment and systematically applied these interventions to suicidal women, many of whom met criteria for borderline personality disorder (BPD). Although these interventions were helpful, clients often reacted negatively to the heavy emphasis on behavioral and cognitive change and frequently dropped out or had difficulty complying with the treatment regimen. Consequently, Linehan incorporated into the treatment her experience and training in mindfulness and Zen practice, as well as acceptance-based approaches from other treatments (e.g., client centered therapies and emotion-focused approaches) in order to convey acceptance of the client, and to help the client accept him or herself and the world in general (Chapman & Linehan, 2005; Robins & Chapman, 2004). Thus, DBT involved bringing together components of existing evidence-based interventions and modifying them based on research and clinical experience.

In contrast, Steve Hayes built ACT from the bottom up. Hayes developed a research program aimed at understanding the ways in which human language and cognition influences and maintains emotional suffering. Based on this research, he developed a general theoretical model of psychopathology that emphasized how language and cognition trap people into behaving in ways that increase or maintain their suffering. One key implication of this research was that *experiential avoidance*, or the avoidance of or escape from unwanted internal experiences (e.g., thoughts and emotions) or those situations related to them (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) drives psychopathology. Hence, interventions aimed at facilitating clients' acceptance of themselves and their experiences constituted the antidote. Therefore, DBT started with evidence-based practice and evolved in response to the clinical needs of specific types of clients; in contrast, ACT began with basic research on mechanisms underlying human suffering and constructed a general model of psychopathology and a related set of interventions.

Acceptance and Change in ACT and DBT

Notwithstanding these differences, DBT and ACT share elements of *dialectical philosophy*. Hayes (2004) has mentioned dialectics and the tension between acceptance and change in his descriptions of ACT, although this has been a more recent development. As Linehan discovered that an exclusive focus on change in therapy was intolerable to some of her clients, she weaved acceptance and mindfulness into the treatment, both as stances taken by the therapist and as behavioral skills for the client.

Ultimately, DBT came to rest upon a *dialectical philosophy*, characterized primarily by balancing and synthesizing acceptance and change-based approaches. According to the dialectical world view, often linked with Marxism and the thinking of Hegel, reality consists of opposing, or polar forces (e.g., thesis and antithesis) that are incomplete on their own and repeatedly are synthesized into wholes that are more complete. For instance, in DBT, acceptance and change are opposing forces, with the tension between them often palpable during sessions. When the therapist pushes for behavior change, the client often feels invalidated and desires acceptance. When the therapist exclusively offers acceptance, the client may believe that the therapist is not taking his or her problems seriously enough to push for change. In DBT, the therapist is constantly balancing and synthesizing the opposing forces of acceptance and change. The goal in any given moment is to find the best synthesis, given the client's goals, characteristics and the current context.

In contrast, in ACT, the synthesis between acceptance and change rests largely on the notion that emotions and cognitions are not readily changeable (Hayes, 2004). Change-based interventions focus on overt action and valued directions in life, whereas acceptance targets private experiences, such as thoughts and feelings. Acceptance of these private experiences facilitates change, and change in behavior

may facilitate acceptance of private experiences. Ultimately, in both DBT and ACT, the distinction between acceptance and change is somewhat arbitrary, as acceptance often involves a marked change from the client's previous way of relating to his or her life or experiences.

Another interesting difference in acceptance interventions between ACT and DBT falls within the arena of skill-building. Enhancing the client's capabilities (behavioral skills) is an essential function of DBT, based on the notion that clients with BPD lack key behavioral skills, particularly in the area of regulating emotions. Consequently, DBT involves a regular skills-training group that teaches skills in the areas of mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation. Acceptance-based skills occur in many of these different skill modules, but are most prominent in the mindfulness skills (discussed below) and in the distress tolerance skills. For instance, radical acceptance is one of the DBT skills designed to help clients tolerate distress and survive crises, and involves simply accepting what is happening in the present moment. Radical acceptance also can be applied to distressing events and experiences in the client's history (e.g., trauma, behavior of which the client feels ashamed, etc.).

In ACT, acceptance generally is not taught explicitly as a behavioral skill, although recent writings on ACT have suggested that both acceptance and mindfulness may be considered skills (Hayes, 2004). Whereas in DBT, there is a structured format for delivering defined acceptance-oriented skills, in ACT, the therapist uses acceptance interventions in a more idiographic manner. Essentially, ACT sessions often involve a variety of exercises that provide the client with an experience of the many factors that promote experiential avoidance and get in the way of acceptance. Some of these factors involve taking language literally, repeated attempts to control rather than accept unwanted experiences, and the experience of being "stuck" to thoughts and feelings as if they are a part of the person him or herself.

Mindfulness in ACT and DBT

One of the major points of similarity between ACT and DBT is the use of mindfulness in treatment. Mindfulness essentially involves "keeping one's consciousness alive to the present reality" (Hanh, 1976). In most applications of mindfulness, there is an emphasis on paying attention, being aware and awake to the experience of the present moment, and in some cases, stepping back and observing the experience of the here and now. Mindfulness has become a key component of both well-established and newer treatment approaches over the past two decades, and research on these treatments has indicated that the use of mindfulness in behavior therapy has merit (e.g., Hayes et al., Luoma, Bond, Masuda, & Lillis, 2005; Teasdale et al., 2000; Robins & Chapman, 2004). Mindfulness plays an important role in both ACT and DBT, but there are noteworthy differences between these two approaches in terms of how they conceptualize and use mindfulness in treatment.

In DBT, mindfulness plays an explicit and prominent role, both as a set of skills for the client and as a stance for the therapist. Linehan took components of Zen practice, contemplative prayer, and other mindfulness practices and distilled them into behavioral skills for the client and the therapist. Influenced by the focus in Zen on awakesness and openness to the present moment, several therapeutic strategies in DBT seek to help the client see and respond to reality as it is in the present (Chapman & Linehan, 2005). DBT therapists encourage one another to stay awake, focused, and present, both during therapist team meetings and in interactions with clients. Therapists often engage in regular mindfulness practice, both alone and with other therapists on the team.

DBT also involves a specific set of skills that comprise the essential components of mindfulness practice. For instance, *observing* involves simply noticing the sensations of the present moment, whether these sensations involve cognitive activity (thoughts or images), physical experiences, or emotions. The skill of *describing* involves describing exactly what is observed, or the "facts" of the situation.

Participating is another skill, and it involves having the client throw him or herself completely, with abandon, and without self-consciousness, into the activities of the present moment (Linehan, 1993b). In DBT, clients are encouraged to practice mindfulness in a non-judgmental manner (“non-judging”), while focusing on one thing at a time (“one-mindfully”), and with an emphasis on effective behavior (“effectiveness”). In addition, several of the skills used in DBT to help the client tolerate current distress (“distress tolerance skills”) involve mindfulness, such as radical acceptance and observing the experience of breathing.

Mindful practice also occurs in ACT, but it has different roots and plays a somewhat different role than it does in DBT. For instance, there has been no mention of Zen, contemplative prayer, or other spiritual traditions in the genesis of mindfulness in ACT (Hayes et al., 1999). In ACT, specific mindfulness strategies ultimately aim to increase clients’ psychological flexibility. The theory is that the dominance of language and verbal rules reduces clients’ contact with direct contingencies in the environment and creates narrow, inflexible behavioral repertoires (Hayes, 2004; Hayes et al., 1999). Certain mindfulness-based strategies in ACT directly tackle this phenomenon and seek to open the client up to the experience of direct contingencies in the environment. One such intervention (mentioned earlier) involves repeating a word (e.g., “milk”) over and over again until its derived stimulus functions (e.g., “white”, “creamy”, “smooth”) disappear and the direct experience of the sound of the word becomes salient.

Other strategies involve reducing the extent to which clients experience their thoughts and feelings as being equivalent to themselves as a whole. Such strategies involve helping clients establish and get in contact with an “observing self”. For instance, in ACT, the therapist uses the “chessboard metaphor” (Hayes et al., 1999) to demonstrate that the client is not his or her thoughts and feelings (i.e., the “pieces” on the chessboard), but rather, the context (i.e., the chessboard itself) in which these experiences occur. Another strategy involves having the client objectify and observe his or her thoughts (e.g., to see them as written on placards moving along in an imaginary “thought parade”).

Like ACT, DBT also includes exercises that involve observing thoughts, emotions, and physical sensations. In addition, DBT mindfulness skills encourage the client to experience a thought as a thought, and a feeling as a feeling; however, compared with ACT, there is less of an emphasis in DBT on having the client step back and *separate* him or herself from the current experience. On the contrary, one of the key goals of mindfulness in DBT is to help clients enter into, participate, and become “one” with their experiences (Chapman & Linehan, 2005). Nevertheless, in both ACT and DBT, mindfulness involves accepting and experiencing “what is” in the present moment.

Summary and Discussion

In summary, although both ACT and DBT fit firmly within a relatively new wave of behavior therapy that emphasizes mindfulness and acceptance, there are several important differences between these treatments. Marsha Linehan developed DBT specifically to treat suicidal women, and the treatment subsequently evolved and focused on borderline personality disorder (BPD). Limitations inherent in attempts to apply existing change-oriented treatments to multi-problem, suicidal clients spawned the infusion of acceptance-oriented interventions into DBT. In contrast, Steve Hayes built ACT out of behavioral theory and research on human language and cognition, and the treatment as a new paradigm for a variety of clinical problems. ACT is less specifically focused on severe, multi-problem clients than is DBT.

Although both DBT and ACT utilize mindfulness and acceptance strategies, these strategies developed differently and, at times, have different purposes and roles in therapy. In DBT, acceptance and mindfulness are taught as behavioral skills, and as stances and behaviors used by the therapist and the

client. In contrast, acceptance and mindfulness in ACT are not normally taught as behavioral skills and are generally employed to undermine the verbal factors that promote and maintain experiential avoidance. Both DBT and ACT are innovative treatments with empirical support (see Robins & Chapman, 2004 for a recent review of studies on DBT; see Hayes, 2005 for a recent review of research on ACT) and the potential to enhance our continued attempts to reduce the suffering of our clients.

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