Interview with S. Hayes

— What are the factors that led you to choose psychotherapy as your main orientation in the field of mental health?

My original interest was in changing processes related to families and communities, and to promote human growth and well being. I was fascinated by B. F. Skinner and his willingness to extend animal learning work into large scale areas including the utopian vision in “Walden II” (A utopic novel written by Skinner about altering people’s behavior by using science-based methods). I was an environmental activist and even though I was a clinical psychology student, in my doctoral program almost all of my research was on applying psychology to environmental problems. That was the topic of my first book as well: Cone, J. D., & Hayes, S. C. (1980). Environmental problems / Behavioral solutions. Monterey, CA: Brooks/Cole. I became disillusioned, though, with how hard it was to get policy makers to attend to this literature and I realized that psychotherapy had a huge benefit: people want the information and they use it. So I shifted my tactics. I decided to develop new methods of psychotherapy but to do it in a way that would open up new territory for families and communities, and to promote human growth and well being, but focused on the role of human language. My ACT (Acceptance and Commitment) and RFT (Relational Frame Theory) work came out of that strategy.

— Can you explain and contrast the unique features of Acceptance and Commitment Therapy (ACT) in relation to other approaches of psychotherapy? We all know that ACT is different
from CBT whether the targets of interventions are cognition or not. Is this appraisal true? Are there any other manifest differences between CBT and ACT?

I will try to address both of these questions at once. What is different about ACT is the philosophy, basic science, applied theory, targeted processes of change, and many of the techniques of change.

That is a pretty long list and it would take volumes to fully explain them. But in outline form:

1. Philosophy

ACT is rooted in the pragmatic philosophy of functional contextualism, a specific variety of contextualism that has as its goal the prediction and influence of events, with precision, scope, and depth. Contextualism views psychological events as ongoing actions of the whole organism interacting in and with historically and situationally defined contexts. These actions are whole events that can only be broken up for pragmatic purposes, not ontologically. Because goals specify how to apply the pragmatic truth criterion of contextualism, functional contextualism differs from other varieties of contextualism that have other goals, such as hermeneutics, narrative psychology, dramaturgy, social constructionism, feminist psychology, Marxist psychology, and the like which are forms of “descriptive contextualism” because their goal seems to be to appreciate the participants in the whole event. There are contextualistic varieties of CBT (the constructivists, for example) but they look more like descriptive contextualists than functional contextualists.

2. Basic Theory

Nearly a decade and a half passed between the earliest randomized trials on ACT and those in the modern era. In that interval, the basic theory of human language and cognition underlying ACT, Relational Frame Theory was developed into a comprehensive basic experimental research program. RFT is not a basic theory of ACT. It is a basic theory of cognition. But if RFT is workable and if ACT makes sense, you have to be able to do a basic analysis of ACT using RFT – just as you would have to be able to do an analysis of any cognitive procedure using RFT. That is the aspiration – and if you know behavior analysis you will recognize that it is an entirely traditional aspiration for people who do work on behavioral principles – the difference is that now we think we have an angle on human cognition that is empirically and conceptually workable. We are not fully there yet, of course, but we are now seeing the RFT studies of defusion, acceptance, values, and so on and the early data are tremendously exciting.

According to RFT, the core of human language and cognition is the learned ability to arbitrarily relate events, mutually and in combination, and to change the functions of events based on these relations. For example, very young children will know that a nickel is larger than a dime by physical size, but not until later will the child understand that a nickel is smaller than a dime by social attribution. RFT researchers have shown that such relations as knowing that one event is “larger” than another arbitrarily can be trained as an operant and will alter the impact of other behavioral processes. We even have some new data seemingly showing that the symmetry of names and objects are trained as an operant in infants. There are neurobiological data showing that the brain lights up when performing RFT tasks much as it does when doing natural language tasks modeled by the theory.

Virtually every component of ACT is connected conceptually to RFT, and several of these connections have been studied empirically. Among other applied implications of RFT, its primary implications in the area of psychopathology and psychotherapy can be summarized as follows 1. normal cognitive processes necessary for verbal problem solving and reasoning underlie psychopathology, thus these processes cannot be eliminated; 2. the content and impact of cognitive networks are controlled by distinct contextual features; 3. cognitive networks are historical and thus are elaborated over time. Much as extinction inhibits but does not eliminate learned responding, the logical idea that cognitive networks can be logically restricted or even eliminated is generally not psychologically sound; and, 4. direct change attempts focused on key nodes in cognitive networks, tend to elaborate the network in that area and increase its functional importance. ACT is based on these ideas. Most of traditional CBT is not.

3. Applied Theory

From an ACT/RFT point of view, while psychological problems can emerge from the general absence of relational abilities (e.g., in the case of mental retardation), the primary source of psychopathology
in most adults and language able children is the way that language and cognition interacts with direct contingencies to produce an inability to persist or change in the service of long term valued ends. This kind of psychological inflexibility is argued in ACT and RFT to emerge from weak or unhelpful contextual control over language processes themselves. The now vast literature on experiential avoidance is but one example of how this manifests itself. Other processes are cognitive fusion; the domination of temporal and evaluative relations over contact with the now; the effect of all of this on weak self-knowledge; attachment to a conceptualized self; unclear values or values based in looking good in the eyes of others or avoiding pain rather than self-congruent choices; and impulsivity or avoidant persistence.

The contextual theory behind ACT situates all of these processes in context – it does not leave them “in the head.” These contexts can be directly changed and that is exactly what ACT tries to do. The functional contexts that tend to have such deleterious effects include excessive or poorly regulated contexts of literalism, reason-giving, and emotional control among others. In essence, the contexts that support verbal / cognitive functions are too widespread and are over applied. Acceptance and mindfulness are a prophylactic for that excess.

4. Clinical Methods

ACT targets each of these core problems with the general goal of increasing psychological flexibility – the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends. The six targeted processes are acceptance, defusion, being present, a transcendent sense of self, values, and committed action.

These core ACT processes are both overlapping and interrelated. Taken as a whole, each seems to support the other and all target psychological flexibility. They can be chunked into two groupings. Mindfulness and acceptance processes involve acceptance, defusion, contact with the present moment, and self as context. Indeed, these four processes provide a workable behavioral definition of mindfulness. Commitment and behavior change processes involve contact with the present moment, self as context, values, and committed action. Contact with the present moment and self as context occur in both groupings because all psychological activity of conscious human beings involves being in the now as known.

You can draw lots of parallels to new developments in CBT, and even some in traditional CBT, but it is pretty obvious that these packages are not the same thing. I have trained several thousand therapists in ACT workshops of one day or more. I have literally never had a single CBT person do extensive training and come out saying “this is the same as traditional CBT.”

If you want to pick one of the most salient differences, pick defusion (also known as deliteralization). In ACT, a troublesome thought might be watched dispassionately, repeated out loud until only its sound remains, or treated as an external observation by giving it a shape, size, color, speed, or form. A person could thank their mind for such an interesting thought, say it very slowly, or label the process of thinking (“I am having the thought that I am no good”). They might note how the back and forth of a mental argument is like a volleyball game and then literally play that out while watching from the sidelines. There are perhaps 100 defusion techniques that have been written about somewhere in the ACT literature. Not one of them involves evaluating or disputing these thoughts.

ACT is an approach to psychological intervention defined in terms of its philosophy, basic principles, and targeted theoretical processes. You can easily create and test protocols to test ACT with various disorders but it is not a specific technology anymore than, say, using candy contingently is “reinforcement.” In theoretical and process terms we can define ACT as a psychological intervention based on modern behavioral psychology, including Relational Frame Theory, which applies mindfulness and acceptance processes, and commitment and behavior change processes, to the creation of psychological flexibility.

—What are the distinctive features of therapist’s stance in ACT?

It assumes that dramatic, powerful change is possible and possible quickly. ACT therapists believe that whatever a client is experiencing is not the enemy. It is the fight against experiencing experiences that is harmful and traumatic and thus you can’t rescue clients from the difficulty and challenge of growth. In therapy, ACT practitioners compassionately accept no reasons -- the issue is workability not reasonableness.
If the client is trapped, frustrated, confused, afraid, angry or anxious be glad – it is assumed that this is exactly what needs to be worked on and it is here now. The goal is to turn the barrier into the opportunity. If you yourself feel trapped, frustrated, confused, afraid, angry or anxious be glad: you are now in the same boat as the client and your work will be humanized by that. In the area of acceptance, defusion, self, and values it is more important as a therapist to do as you say than to say what to do. The therapist should not argue or even persuade. The issue is the client’s life and the client’s experience, not your opinions and beliefs. Belief is not the clients’ friend. Your mind is not your friend. It is not your enemy either. Same goes for your clients. You and the client are in the same boat. Never protect yourself by moving one up on a client. The issue is always function, not form or frequency. When in doubt ask yourself or the client “what is this in the service of.”

— And ‘metaphor’ is one of the main concepts of ACT. What is the function of metaphor in the course of an ACT session? 

Like experiential exercises, metaphor allows us to use language in a way that is less prescriptive and more experiential. It is inherently efficient for reasons RFT helps explain.

— ACT is only one aspect of Contextual Behavior Science (CBS). There are other issues existing in this approach like Relational Frame Theory and Implicit Relational Assessment Procedure etc. And there is a rapidly growing interest around the world. How will CBS influence the mainstream psychiatry and psychology practice? Do you have any prediction about this?

It remains to be seen, but the goal is to create a psychology more worthy of the challenge of the human condition. ACT has opened doors; RFT can in behind that; but the real impact I predict will be from CBS itself. CBS is nothing more than a revitalization of behavior analysis. Contextual Behavioral Science (CBS) is a principle-focused, communitarian strategy of reticulated scientific and practical development. Grounded in contextualistic philosophical assumptions, and nested within multi-dimensional, multi-level evolution science as a contextual view of life, it seeks the development of basic and applied scientific concepts and methods that are useful in predicting-and-influencing the contextually embedded actions of whole organisms, individually and in groups, with precision, scope, and depth; and extends that approach into knowledge development itself so as to create a behavioral science more adequate to the challenges of the human condition.

— What do you believe are applications of ACT in the fields of education and public mental health that could help preventing psychiatric problems?

I’m not sure we yet know. There are exciting studies but it is still too early to say for sure.

— From your point of view, what type of developments do you expect to see with the theory and practice of cognitive and behavioral spectrum therapies?

I expect to see more focus on process and as that happens I expect evidence based psychotherapy to focus more on psychological flexibility as the core issue.

— You are especially pointing out evidence-based processes rather than evidence-based treatment packages. What do you think about the advantages of focusing on evidence-based processes in scientific and clinical practice?

When CBT broke away from traditional behavior therapy, functional analysis became far less central and attention turned toward packages linked to syndromes. By adding contextual cognitive principles to the mix, CBS affords a new way back to the vision of evidence-based processes linked to evidence-based procedures. The big advantages are the liberation of clinicians, the ability to fit methods to people, and progress.

If you just think in terms of packages of methods it is hard to progress quickly.

If some methods are contained in these packages that are inert or even harmful, it could take decades to ferret them out – and even when they are it may be too late to change practices easily. In routine applied work it is more natural to use procedures linked to processes. That is what ACT does with the psychological flexibility model.

Fitting methods to individual needs based on good principles and theory seems destined to constitute the heart of applied work in CBS. The wider range of applied problems CBS is dealing with seems to demand it.
— What types of projects related to ACT, either theoretical or practical, do you have in mind for the near future?

My main new project is to link CBS to evolution science. It is time to heal that needless historical breach.

— What is your opinion about the future direction of ACT? Will ACT walk this road alone or with a more eclectic perspective?

CBS is inherently eclectic at the level of technique. It used behavioral ideas as a foundation, not as a fence. So I expect more involvement from humanistic, analytic, and other perspectives in CBS at the same time that I expect CBS to continue to build as a contextualistic system linked to evolution science.