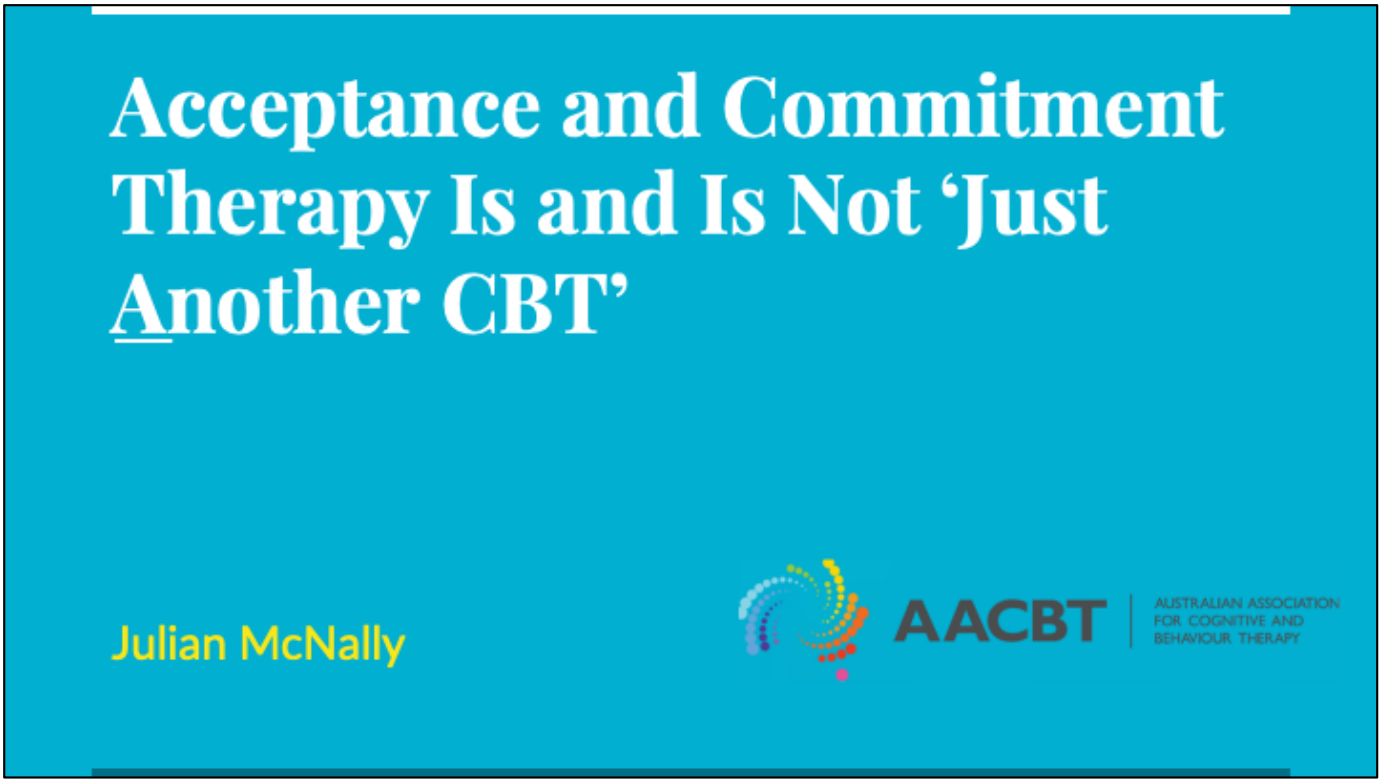
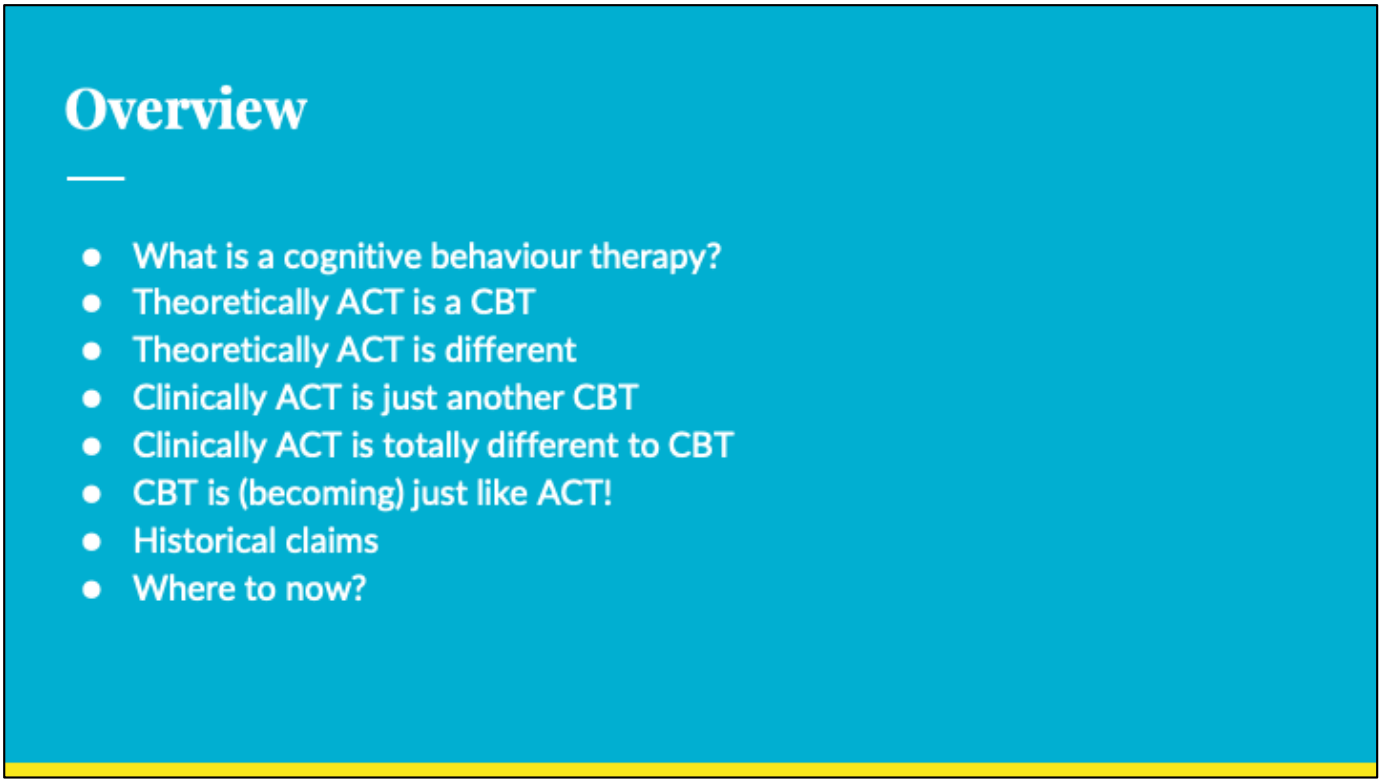


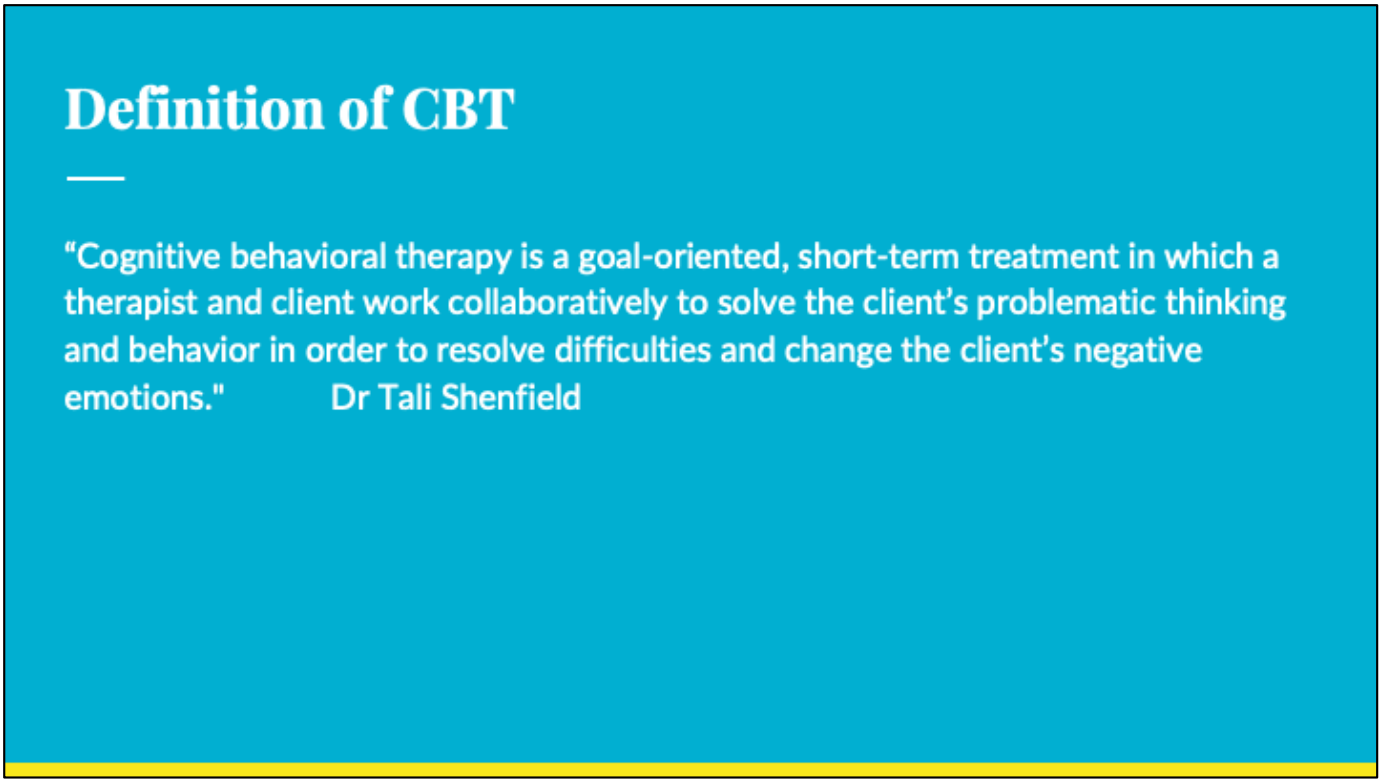
Why is this topic important? Several reasons:

- If you're a predominantly CBT practitioner, because of ACT's popularity, you'll get people asking you for ACT. Should you persuade them that CBT is as good or better? Or should you try to implement ACT-ish CBT?
- on the other hand if you're predominantly an ACT practitioner, should you persuade the client that ACT really is CBT? Or should your try to do CBT-ish ACT?

Who has faced this dilemma? It raises the bigger question of does the patient know what's best for them - they ask for antibiotics to treat viruses - just because they heard from their friend or GP about a particular therapy doesn't mean it's optimal for them. More importantly, are you the optimal person to treat them or to deliver a particular therapy.



- What is a cognitive behaviour therapy?
- Theoretically ACT is a CBT
- Theoretically ACT is different
- Clinically ACT is just another CBT
- Clinically ACT is totally different to CBT
- CBT is (becoming) just like ACT!
- Historical claims
- Where to now?



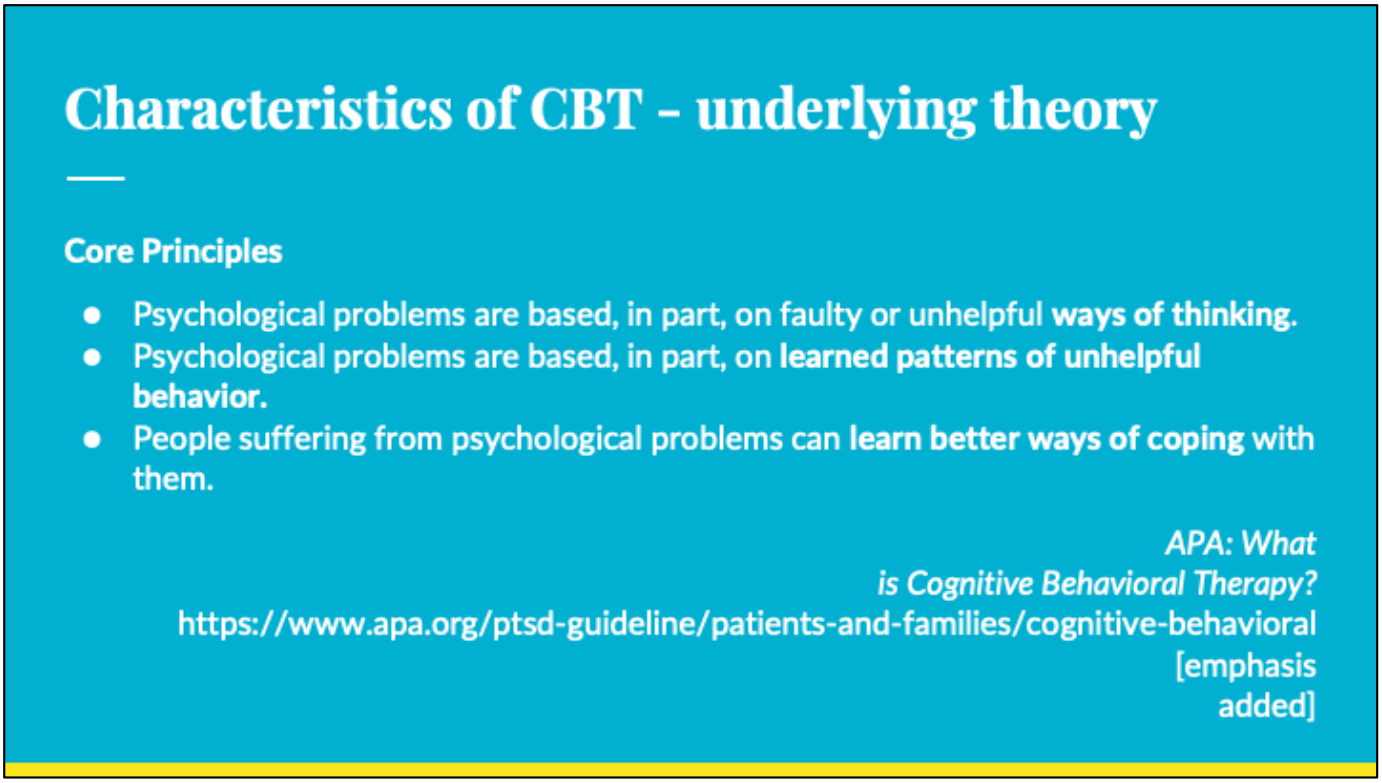
Shenfield definition from https://www.psy-ed.com/wpblog/cognitive-behavioral-therapy/

Anybody disagree?

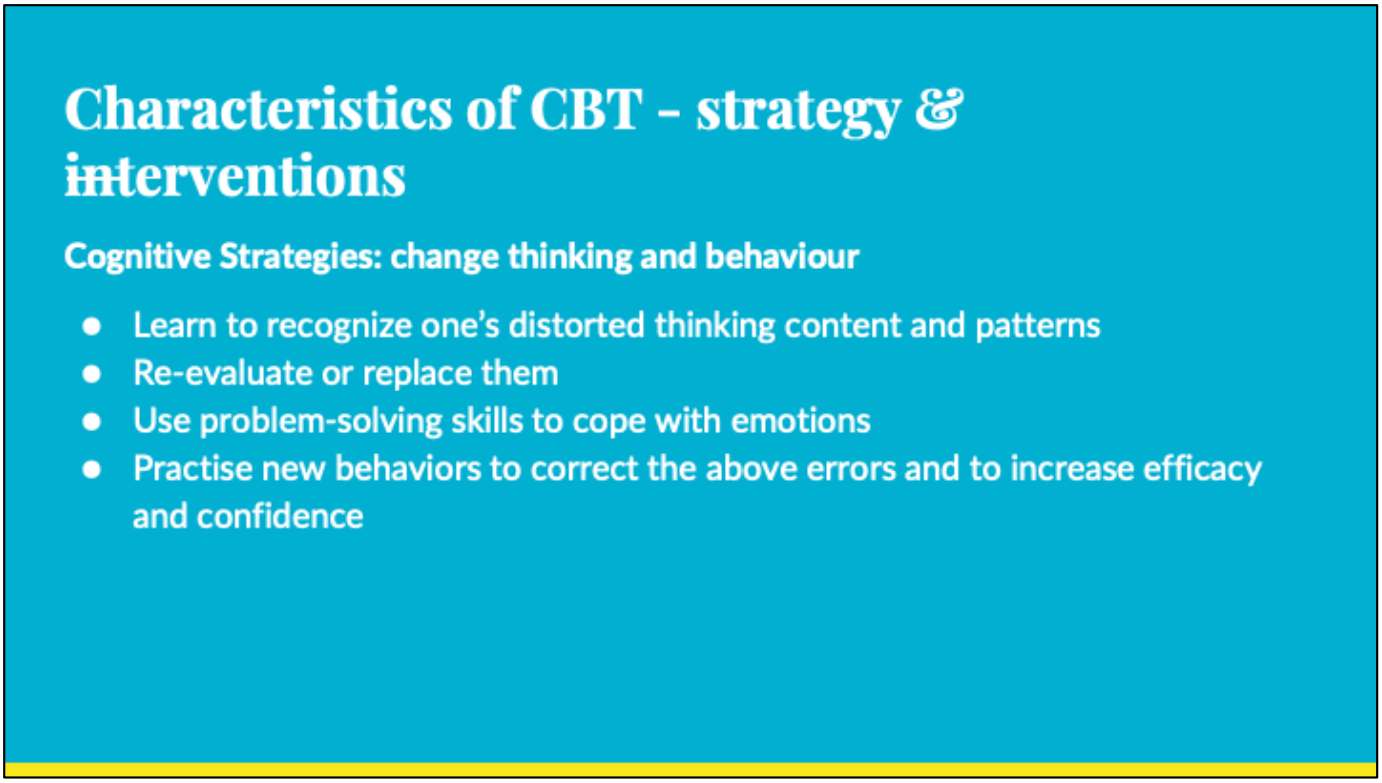
But I found that finding a definition of CBT was difficult. Most articles of the "What is CBT?" type tended to refer to characteristics.

This is helpful for two reasons:

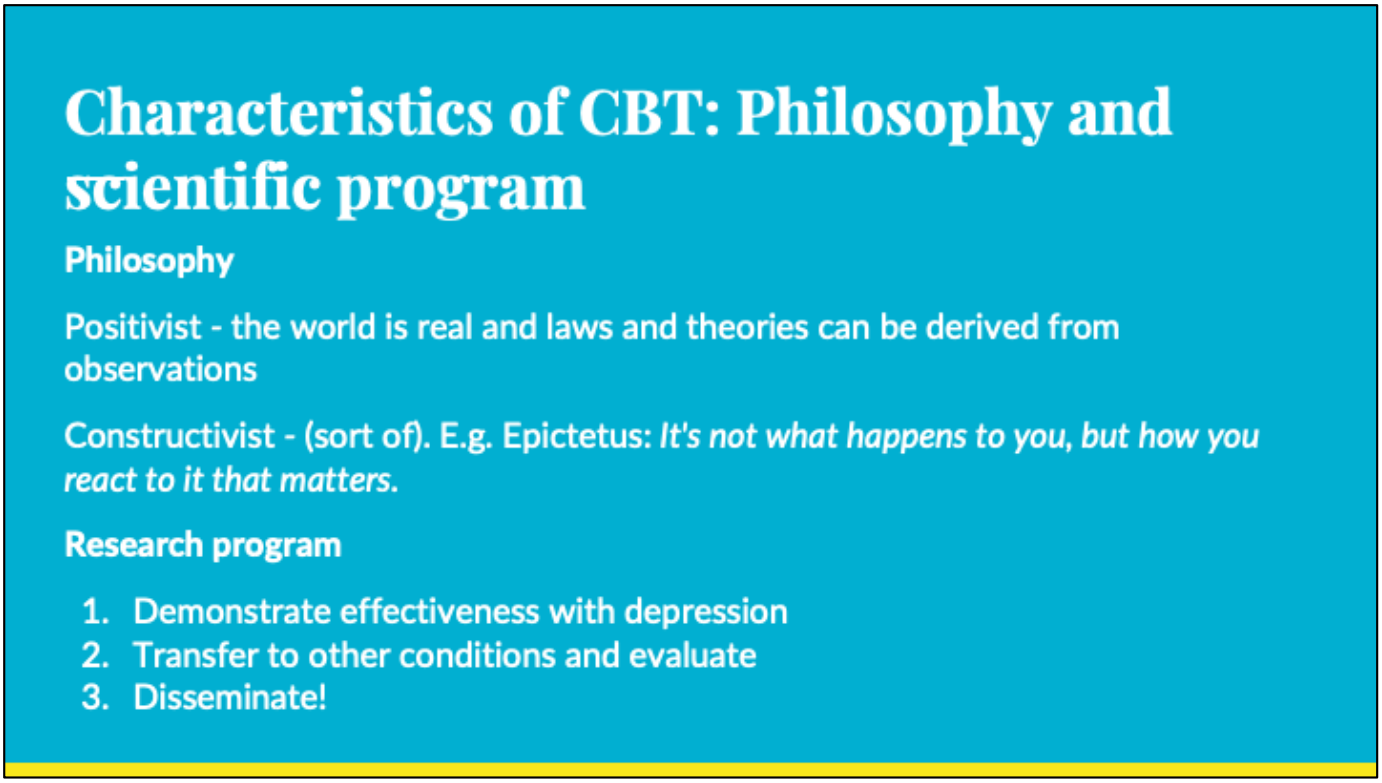
1) You only need a consensus on what characteristics make a protocol or an intervention CBT
2) We can now just evaluate ACT against those characteristics of CBT and see how good a fit it is



APA quote from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral



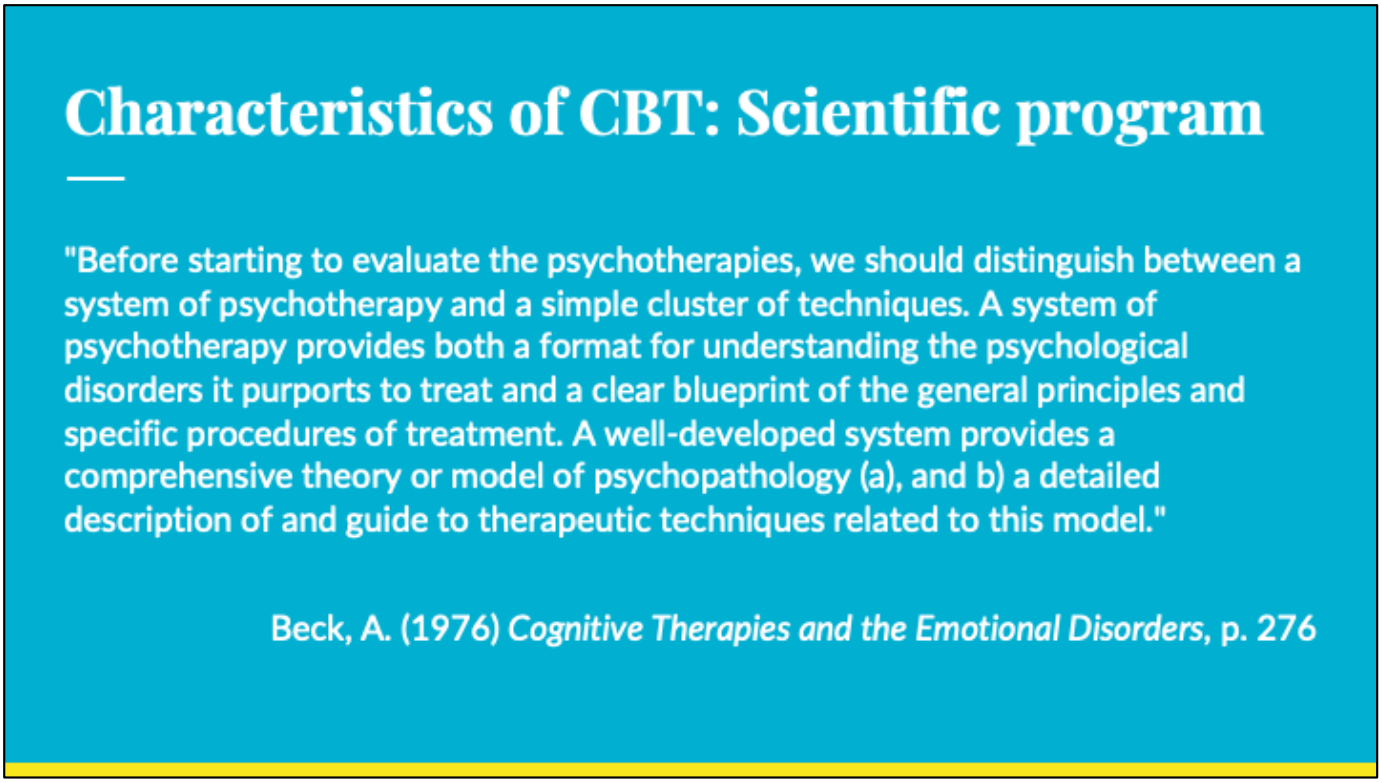
This list is partly from the APA article, partly from my own knowledge of CBT. Anything contentious there? Anything major that's missing?



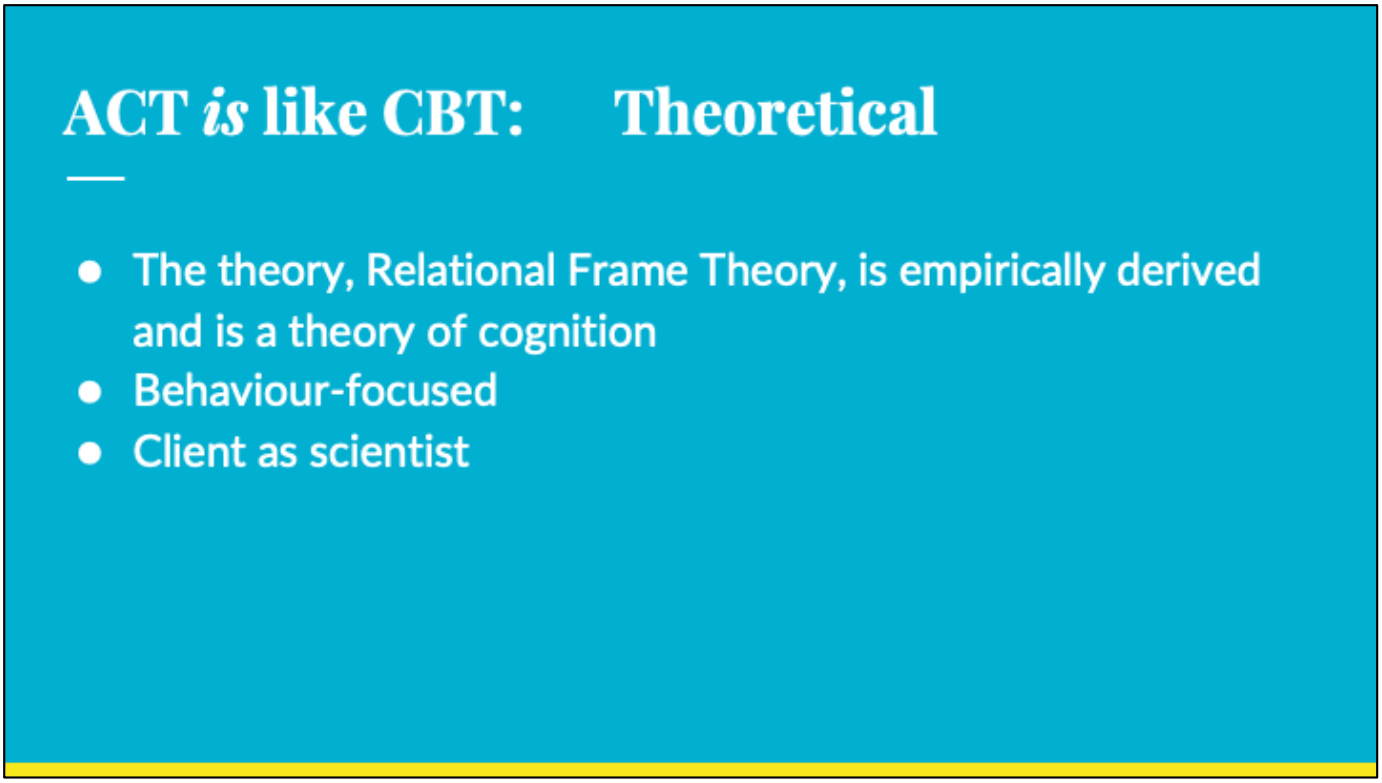
Positivist: also laws and theories about those phenomena can be derived from observation and experimentation. (hypothetico-deductive)
Constructivist (sort of) - not so much that we construct the world from raw perception, but that how we respond to world e.g. with attributions and appraisals, heavily influences our experience of the world and ourselves in it. Therefore Stoicism.

Yes, this is a simplified version of the research program - but again, let me know if I've got that wrong. There's a lot it doesn't include:

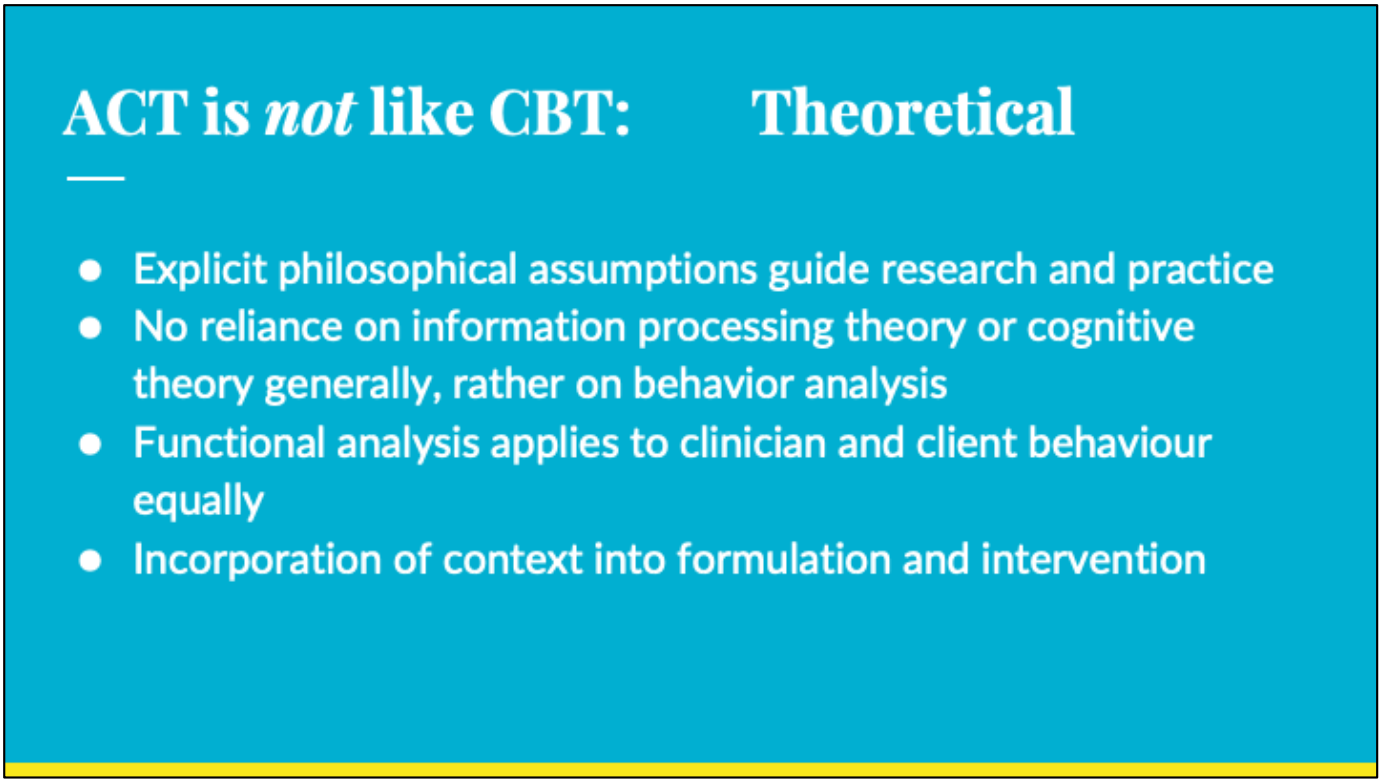
- Condition severity
- Co-treatment e.g. pharmacology
- Client and therapy factors
- Refinement of theory from research findings
- Integrating clinician feedback



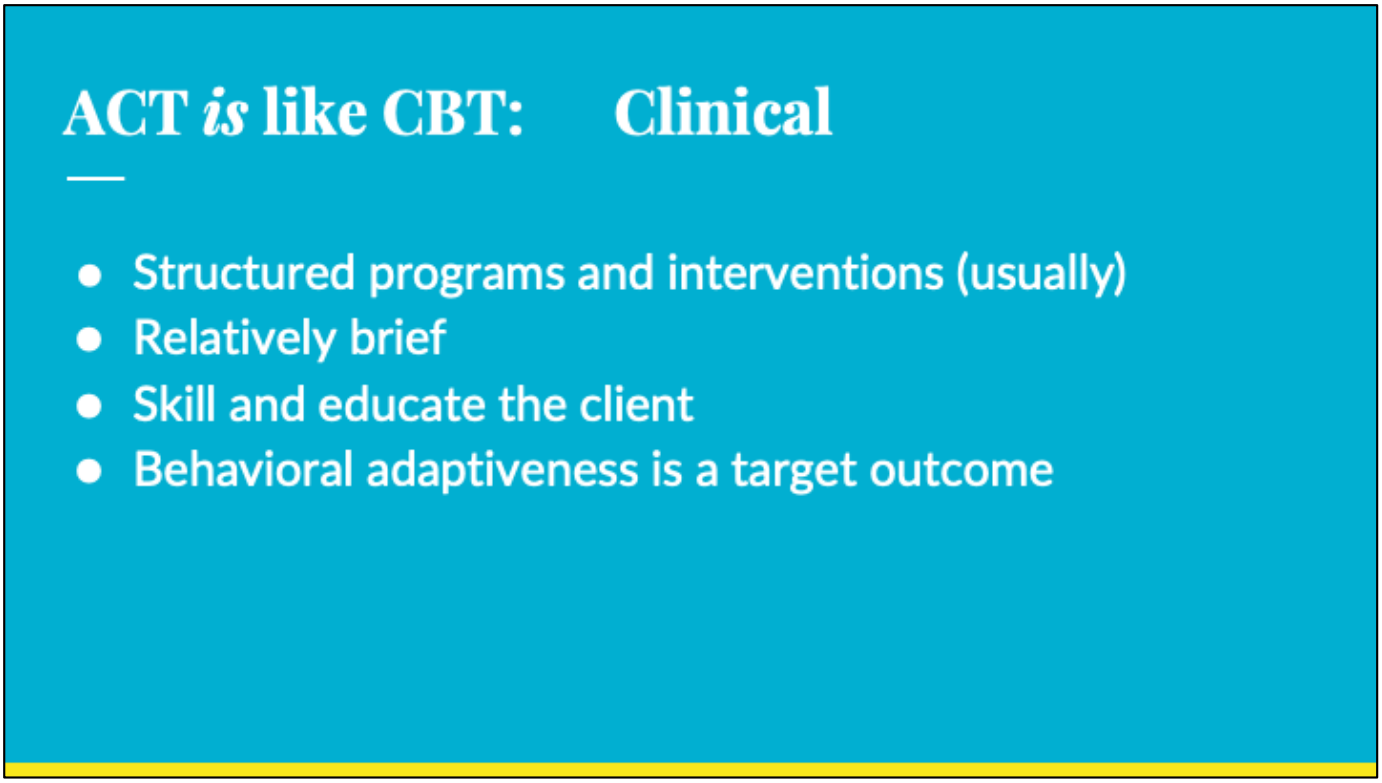
I think what Beck says here applies equally to the ACT approach. Although we in ACT world joke a bit about stealing techniques recklessly and sharing shamelessly, there is still a system at play. Like CBT we provide a way of understanding psychological disorders and a set of principles guiding their treatment.



- RFT empirically derived - goes back to observations by Sidman of stimulus equivalence (reflexivity “if a then a", symmetry “if a=b, then b=a" and transitivity “If a=c and c=b, then b=a [derived relation]")
  RFT was formally described 40 years ago, and since then has generated its own research program with advances in explaining the self and in training theory of mind, increasing IQ and countering prejudice and bias - as well as in basic science and clinical applications.
- Behaviour focused means that the act (behaviour) in context is the unit of study for both the researcher and the clinician. No need for purported entities such as minds, personalities, schemas, etc.
- The job of the client is to discover not so much who they are or how they got where they are, but what actions will make a difference in the direction they want to go

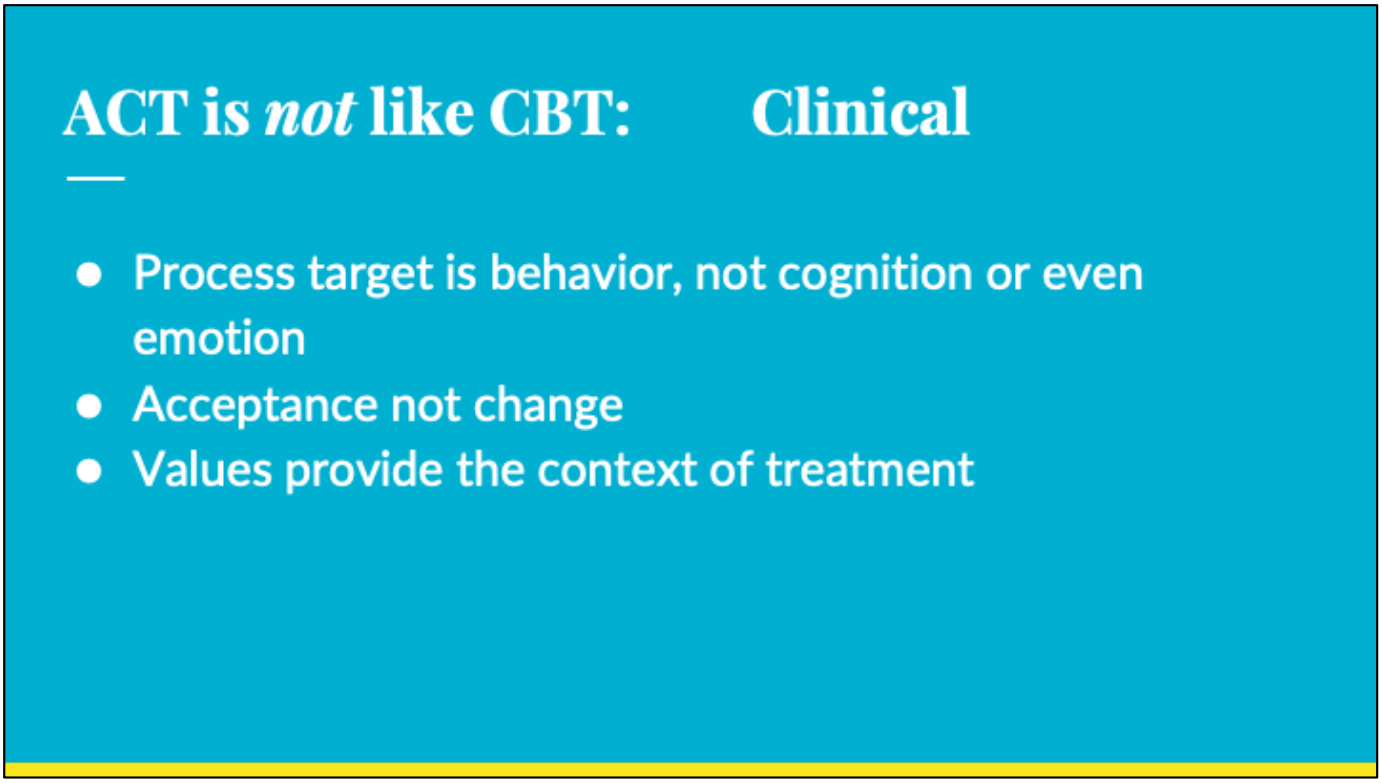


- Explicit philosophical assumptions guide research **and** practice. Functional contextualism: What is the function of this behaviour in this context?
- No reliance on information processing theory or cognitive theory generally, rather on behavior analysis (RFT is a behavior analytic account of cognition). So our case conceptualisation is a behaviour analytic one. Antecedent-Behaviour-Consequence
- Functional analysis applies to clinician **and** client behaviour equally. You can analyse either's behaviour in context, and as the clinician you should - e.g. tracking (attend to the consequences) the impact of your own behaviour on the client. Not saying this doesn't happen in CBT, but we're explicit and open about it in ACT and even disclose it to the client as a therapeutic intervention.
- Incorporation of context into formulation and intervention. CBT includes context too, but in ACT it's global and primary. Hence the answer, "it depends". Leads to idiographic research being valued as highly as RCTs - e.g. for the individual client (But ACT publications and researchers favour RCTs because that is the game they're in as evidenced by over 1300 RCTs since 1987.)

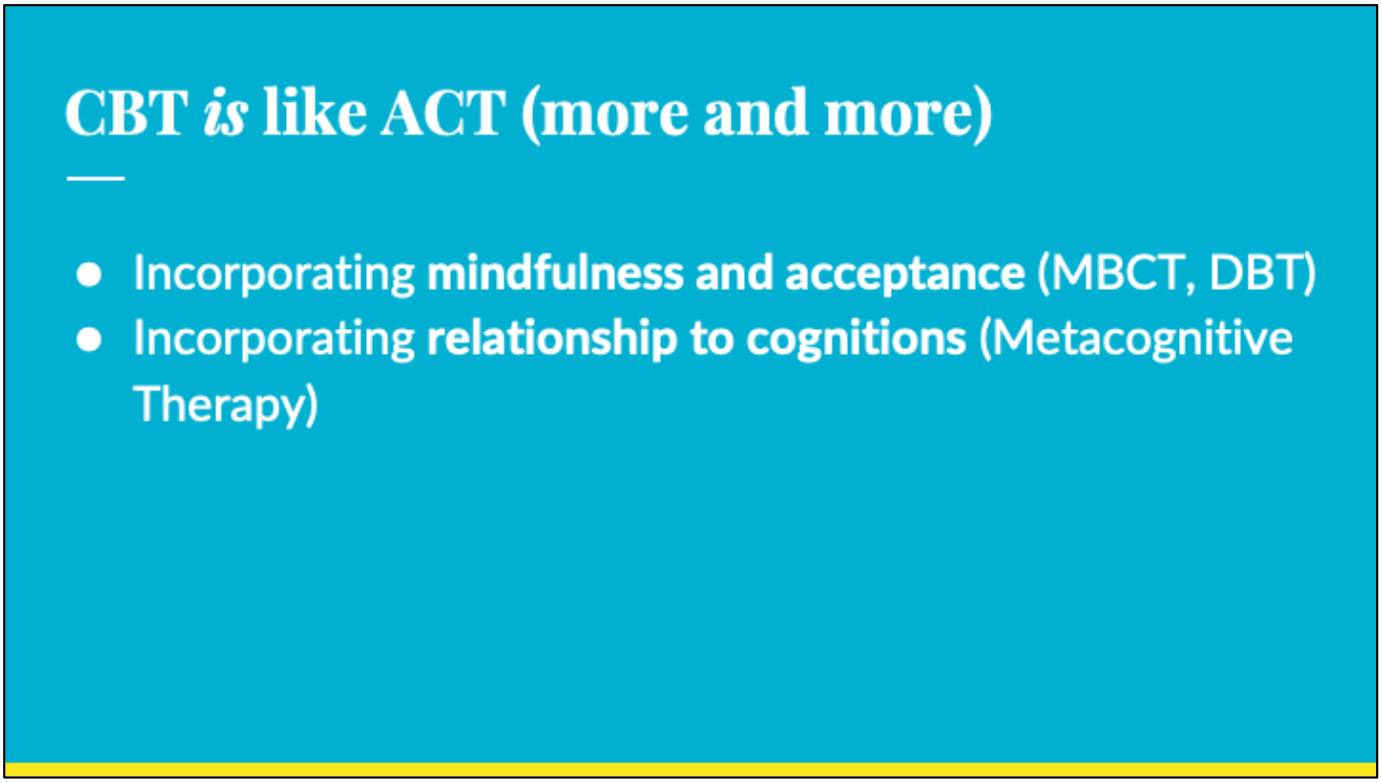


This should be self-explanatory - any quibbles?

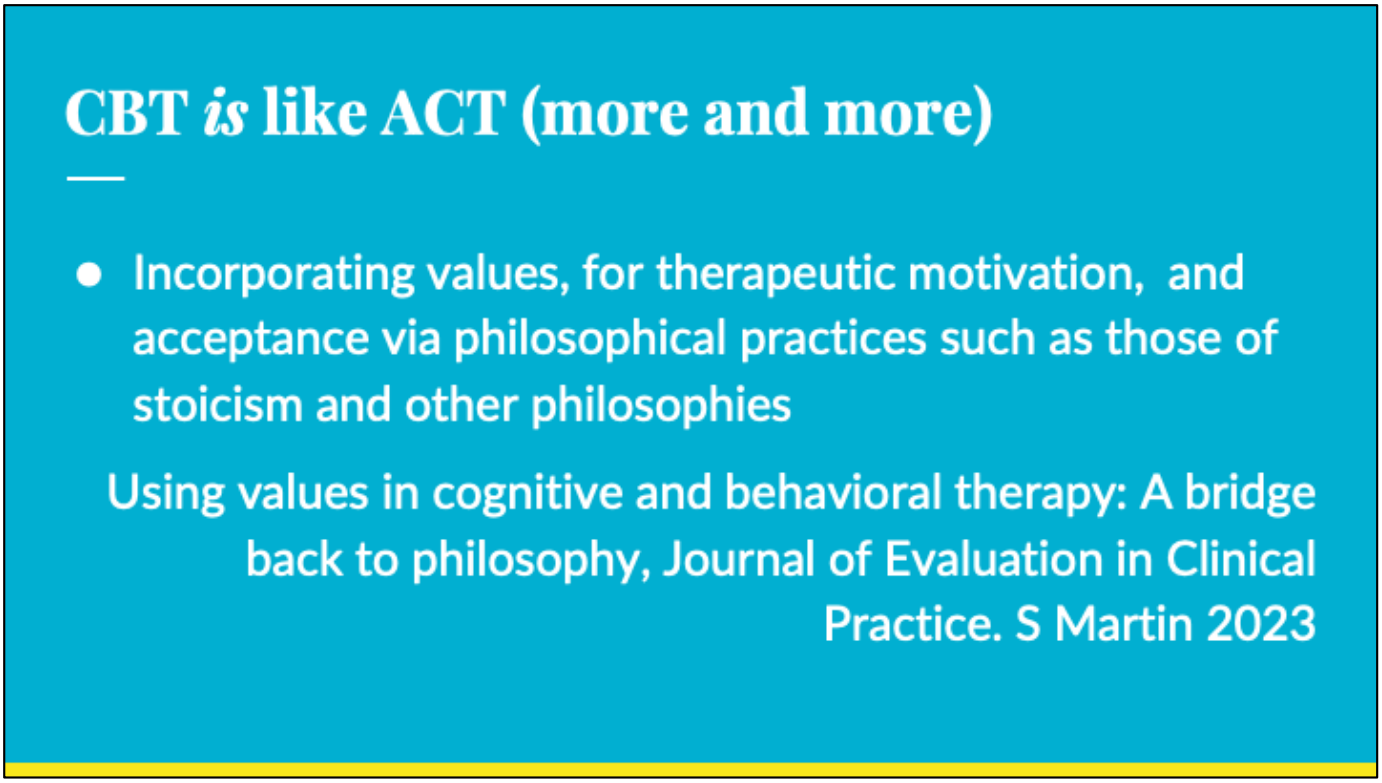
- Structured - we can explain to the client and others what we're doing - it's transparent and comprehensible
- Brief - faster relief is better - life is waiting for you outside the therapy room door - my job is to put myself out of a job
- Know what and know how
- Adaptiveness - CBT and ACT both have an embedded set of values - that life can be better, that pain is part of life, but suffering can be reduced or diminished



- “"Not cognition or even emotion" Yes, we do cognitive interventions, but not to change the content of the cognition, rather to alter the client’s response to the cognition. The thing in common with ACT and conventional CBT here is altering the client’s behaviour. Emotion: Not trying to help the client feel more good feelings and fewer bad feelings, but to bring those bad feelings into a context that permits a more satisfying life.
- “Acceptance not change" rather change **through** acceptance - we are going for change, but indirectly because directly is unworkable (Just feel happy, just stop procrastinating) - except when it’s not.
- “Values provide the context" What you would do if you didn't have the problem tells me what you value. What if you could act on those values while having the problem?

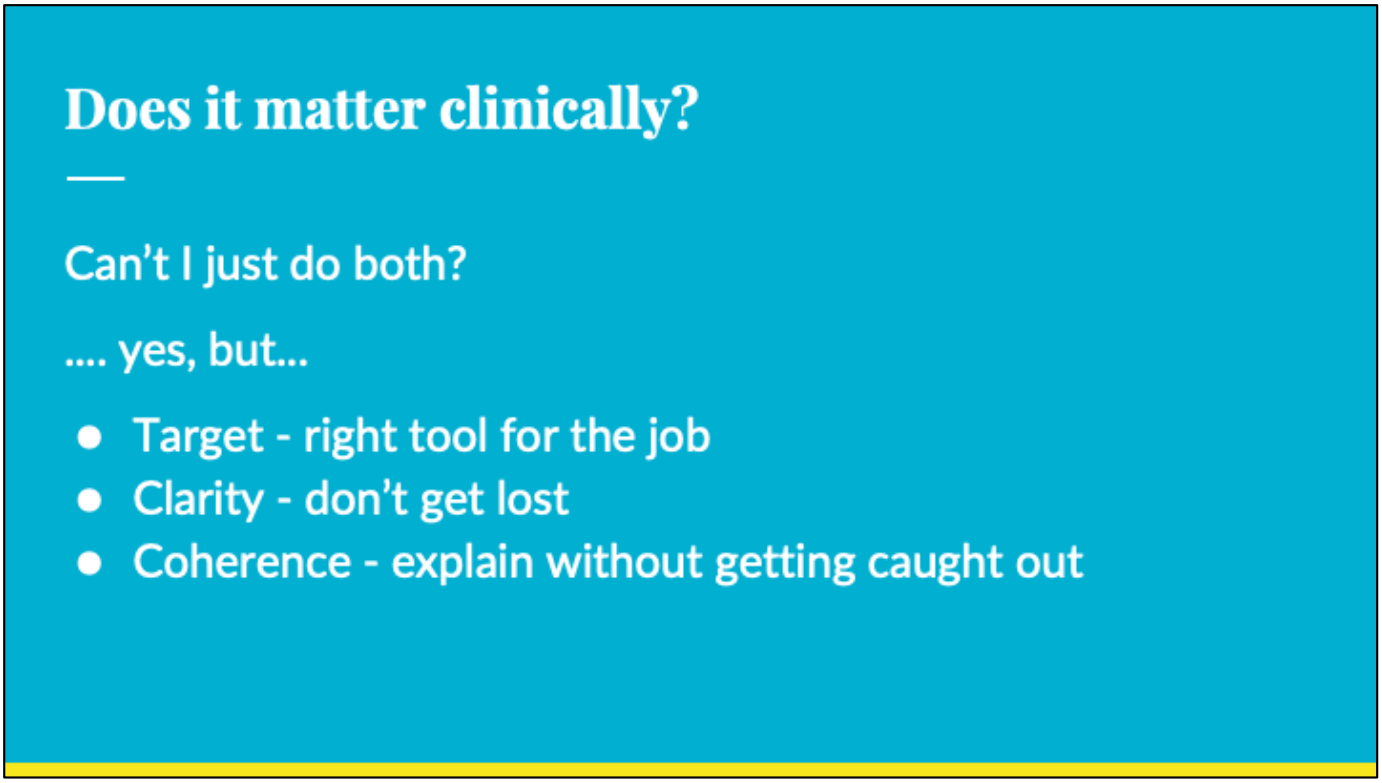


- Any other mindfulness-friendly CBTs?
- But Metacognitive therapy still targets beliefs (about beliefs or thoughts) as content, rather than changing the person's response to the original belief [example quote?] For example, beliefs about how worrying will help, how one's evaluative thoughts are accurate and reliable and at times how thoughts themselves are threatening.

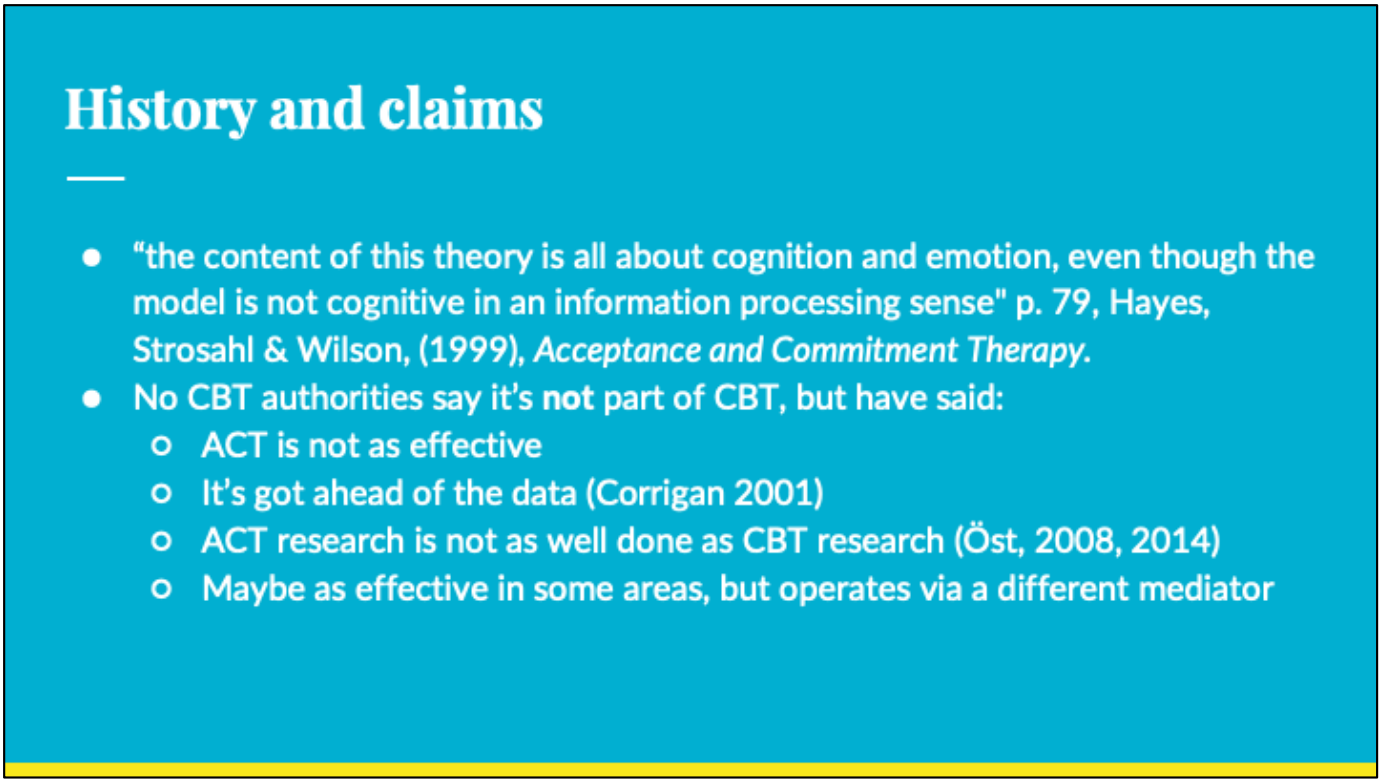


- Values in CBT: (https://pubmed.ncbi.nlm.nih.gov/37226577/ Using values in cognitive and behavioral therapy: A bridge back to philosophy, S Martin 2023.

Martin proposes that CBT can extend to include exploration of values and says that this is consistent with the proposals of philosophers such as Wittgenstein who saw a philosophical problem as an illness and doing philosophical work as work on oneself and Kant who proposed that one should: '(1) think for oneself; (2) think into the place of the other; (3) always think consistently with oneself'. These instructions can be seen to encompass fundamental Values of CBT: Autonomy, empathy and rationalism. CBT already trains people in philosophical skills from Socrates and Epictetus - the tools of evidence seeking, and logic and reality testing. Why not extend it to include these other tools and perhaps also the notion of philosophical health - having the world and one's place in it make sense. See Luis de Miranda's work in this area.

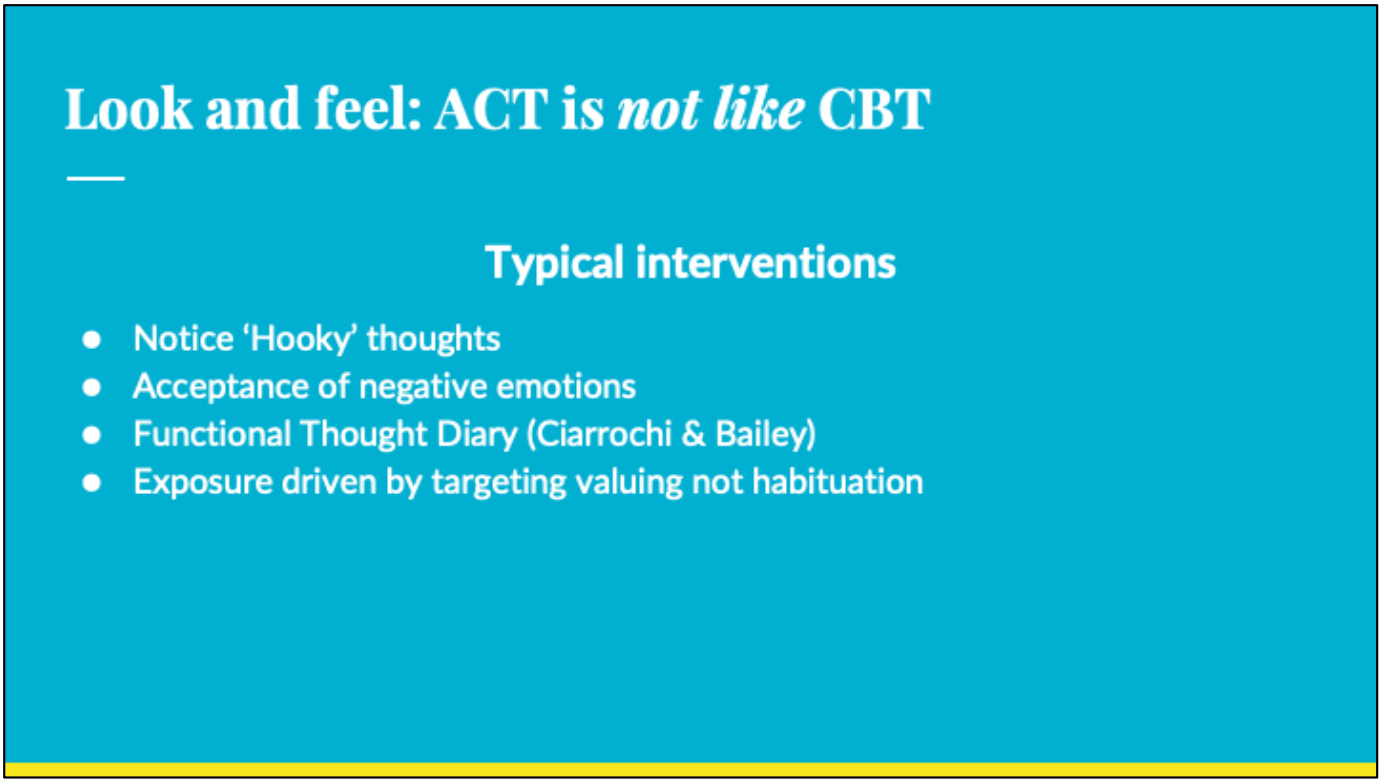


- Target: if you use an ACT intervention for CBT purposes e.g. if you train someone to defuse from a negative self-evaluation, it may well work, but why not just use the original CBT intervention - e.g. evidence and disputation.
- Clarity: it's easier to practise if you're clear about where you're going. If you're doing ACT and you start trying to reduce unpleasant emotions, it's very hard to then coherently promote acceptance.
- Coherence: Both approaches are internally and logically coherent. It is easier to explain what you're doing if you stick to one story.



- What CBT authorities have said is:
    - ACT is not as effective as CBT - Pro: CBT has been shown to successfully treat a broad range of disorders - many more than ACT, Con: hasn't had the depth and breadth of empirical research CBT has
    - May be as effective as CBT in some areas, but operates via a different mediator - acceptance and behaviour change, rather than control of thoughts. However, Arch & Craske 2008 - p.266 "cognitive restructuring is an approach-oriented technique for responding to anxiety" (But I think, so is acceptance, curiosity, willingness!) i.e. both are forms of exposure.
      Ost: research not done as well. The studies Ost matched were across both fields were not truly matched (Gaudiano, 2009) and the 2014 meta-analysis by Ost was riddled with errors of rating, interpretation and sheer fact that it can't be considered valid.
    - Similarity re function of defusion: "The process of monitoring, stating, and challenging threat-related cognitions may function as a form of exposure. Thought challenging that takes the form of behavioral experimentation also serves as exposure" p.266
- CBT aims to modify preconscious belief systems and attentional processing through cognitive restructuring

- Goal-setting - used in lots of ACT and CBT protocols. Goals in ACT are aligned with stated values
- Psychoeducation: Allows us to show off what we know and be superior to clients!! Sets the stage for treatment planning, normalises experiences
- D vs E: Helps the client to recognise when they're taking a position in relation to the world rather than experiencing the world as it is.
- Not Activating event-Beliefs, etc. - In ACT we don't care what the beliefs are. We're going to target changing the behaviour. Either way explaining the ABC or ABCDE model to the client fits under psychoeducation.



- Just notice, don't intervene. Keep Calm and Carry On. Re-focus on valued actions
- Similar to Urge Surfing - this too shall pass, it is what is - uncomfortable, but temporary.
- Functional Thought Diary - not interested in whether or how upset you were by the thoughts, but rather what were you pursuing when they showed up and how you responded to them

- I'm not going to tell you what to conclude - I haven't! - that is up to you. So interested in your responses and questions.
- More importantly - where to next? My take is to focus at the research level on factors that improve outcomes for clients
    - Therapist factors
    - Idiographic research - there's often more variance within diagnostic or treatment groups than there is between them. Nobody is average
    - Processes that move clients forward - focused on a more fulfilling life and overall health
    - Social (and economic and cultural) determinants of health - some of us are prone to poor mental health and respond less well to psych treatments because of the burden of disadvantages