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Merging the Waves: An Eclectic Approach to Practicing Acceptance and Commitment Therapy and Cognitive Behavior Therapy

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Abstract

Surveys of major trends in psychotherapy reveal that the large majority of psychotherapists draw therapeutic strategies from a number of different theoretical orientations. Among the most endorsed theoretical orientations by contemporary therapists are cognitive behavior therapy (CBT) and mindfulness-based therapies. Despite the widespread tendency for therapists to eclectically combine theories, few sources exist to guide therapists in cohesively using both CBT and mindfulness theories together in clinical practice. This paper will discuss the clinical and empirical rationale for (and against) using CBT in conjunction with acceptance and commitment therapy (ACT), and explore how both therapies can be systematically used together for the treatment of depression. For this purpose, I will present a set of guidelines that outline for which circumstances an acceptance/mindfulness approach may be more advantageous than a cognitive restructuring approach, and for which circumstances a cognitive restructuring approach may be more advantageous than an acceptance/mindfulness approach. Future directions for research will then be discussed.

Chapter 1:

Introduction

The field of psychotherapy has undergone a tortuous evolution since therapists first began meeting with individual clients in the late 19th century (Marks, 2017). The modern day therapist has the ability to choose between an almost overwhelming number of therapeutic modalities from the past and present. In 1986, Kazdin estimated there to be over 400 independent forms of psychotherapy (Kazdin, 1986). Within the extensive list of therapies there can exist broad and stark diversity in the philosophical, theoretical, and methodological approaches to remedying psychological issues. For example, if one lives in a moderate-sized city it would not be difficult to get in contact with a cognitive behavior therapist, dramatherapist, wilderness-therapist, Jungian analyst, hypnotherapist, or an equine-assisted (horse) therapist.

More importantly, there is a wide range of diversity in what forms of therapy that have been scientifically and societally "mainstream" over the past century. To illustrate this point, if you wanted to receive treatment for depression (or virtually any other disorder) during the first half of the 20th century, the therapist you'd meet would most likely operate from the psychoanalytic tradition (Freedheim, 1992). As such, you would spend a considerable amount of time examining various events in your childhood, your relationship to your therapist, and the etiology of your symptoms in the context of your unconscious mind. In modern times, however, the average therapist you'd encounter would do no such thing – this therapist would likely be trained in cognitive behavior Therapy (CBT) and thus guide you in changing your conscious thinking patterns, attitudes, and beliefs in a more positive direction (J.S. Beck, 2021). In addition, it would also not take much searching nowadays to encounter a mindfulness-based therapist who'd tell you that your thoughts shouldn't be taken that seriously.

Psychotherapeutic practice in the U.S. took a few turns in between the early predominance of the psychoanalytic paradigm in the beginning of the 20th century and the current predominance of cognitive behavior therapies. This century-long paradigmatic evolution can be thought of as occurring in three distinct "waves" (Hayes, 2004). The first wave is characterized by an upsurge of research and theoretical development in the school of behavior therapy. The second wave is characterized by a major shift in focus towards the domain of cognition in treating pathology, and the third-wave represents the creation of therapies which use mindfulness techniques as a primary mechanism of change. Throughout this time many therapists have still practiced forms such psychodynamic therapy and hypnosis, yet these three waves represent the large scale shifts in how psychotherapy has been scientifically studied and put into practice in the U.S.

In terms of the state of U.S. psychotherapy today, CBT is the most widely practiced system of psychotherapy in the United States (Norcross, Karpiak, & Santoro, 2005; Northey, 2002). However, the use of mindfulness-based therapies has been dramatically increasing in recent years (Shapero et al., 2018). A recent survey of 2,200 North American psychotherapists has shown it to be the third most endorsed theoretical orientation by therapists, after family systems therapy and CBT (Cook et al., 2010). Furthermore, many large-scale surveys of practicing psychotherapists have showcased a longstanding and continuous trend, in which the large majority of therapists draw therapeutic strategies from a multitude of different theories, rather than exclusively operating from a singular theoretical orientation (Prochaska & Norcross, 1983; Cook et al., 2010; Smith, 1982). This widespread trend of drawing techniques from multiple independent systems of therapy has been termed "eclecticism" or "technical eclecticism" (Slife & Reber, 2001).

In a relatively recent survey by Cook and his colleagues (2010), out of 2,200 psychotherapists just 59 (2%) reported that they endorse only a single theoretical orientation. The authors of this survey touch upon the disparity between the great extent to which modern therapists lean towards integrating different therapeutic strategies in their practices, and the paucity of resources available to guide therapists in effectively integrating such strategies: "The trend of synthesis or merging of theoretical influences continues… Clearly, any attempts to disseminate evidence-based practices to community psychotherapists should understand and accommodate tendencies to integrate techniques" (Cook at al., 2010 p. 265). The widespread preference of technical eclecticism by modern day therapists, paired with the dearth of resources available to guide therapists in effective and systematic technical eclecticism, has inspired the focus of this project.

In this paper I will explore the ways in which traditional cognitive behavior therapy (CBT) and acceptance and commitment therapy (ACT – said as one word, not individual letters) can be systematically used together in clinical practice. However, exploring how to most effectively use ACT in conjunction with CBT is a large and multifaceted task. To advance this goal within the scope of this paper, I will focus on how cognitive restructuring strategies from CBT, and acceptance/mindfulness strategies from ACT, can be used together in a systematic and maximally effective fashion in the context of treating depression. For this purpose I will present a set of guidelines that outline for which circumstances an acceptance/mindfulness approach may be a more effective response, and for which circumstances a cognitive restructuring approach may be a more effective response. Within these guidelines, the advantage of the technical-eclecticism approach is meant to be self-evident, as both ACT and CBT clearly offer circumstance-specific and non-specific uses and advantages that the other does not.

With a little context we can see how this set of guidelines can be a beneficial contribution to the current field of psychotherapy. At this point, CBT is the most practiced treatment modality, yet third-wave mindfulness-based interventions are right behind and quickly rising in popularity (Shapiro & Carlson, 2009; Cook et al., 2010). Despite the enormous popularity of both cognitive-restructuring and acceptance/mindfulness theories in modern therapeutic practice, along with contemporary therapists majoritively preferring to use strategies from multiple theoretical orientations, there is a surprisingly small number of resources to guide therapists in using cognitive restructuring strategies in conjunction with acceptance/mindfulness strategies in an effective, cohesive, and systematic fashion.

It is clear that psychotherapists could greatly benefit from work that seeks to develop the theoretical and methodological framework of this combination in greater depth. Additionally, it's essential for the details of this combination to be elaborated and clarified to provide more effective theoretical models for future research that can better assess the feasibility and utility of using cognitive restructuring in conjunction with acceptance/mindfulness strategies. The goal of this paper is to provide practitioners or researchers interested in using ACT in conjunction with CBT, or simply using acceptance/mindfulness in conjunction with cognitive restructuring strategies, with more direction in using both approaches in a systematic, cohesive, and effective manner.

The following sections of this introduction will provide a brief overview of the three waves of psychotherapy, which will lead into a section that situates this project within the contemporary context for how the combination of acceptance/mindfulness and cognitive change strategies has already been developing. Lastly, the clinical rationale for eclectically using both ACT and CBT will be discussed.

The Three Waves of Behavior Therapy

To better understand the significance of this project as it relates to the past and present world of psychotherapy, it's useful to understand the historical evolution of the psychotherapeutic paradigms that have led us to our current state of psychotherapy. Hayes (2004) originally posited the notion that the evolution of scientifically developed behavior-based psychotherapy can be thought of as occurring in three distinct "waves", and that the creation of mindfulness-based therapies represented a distinct "third-wave". This framework has since been widely adopted in academic literature and colloquial speech – for example, if you google "third-wave therapy" you will quickly experience the ubiquity of this term in both academic journal articles and everyday web-articles.

In Hayes' model (2004), the three waves of behavior therapy are (1) behaviorism (1920s - 1960s), (2) cognitive behavior therapies (1960s - present), and (3) mindfulness-based therapies (1990s - present).

It's important to note that although the psychodynamic approach was the predominant framework practiced by therapists during the first half of the 20th century (Garfield, 1981), Hayes does not include the psychodynamic paradigm in the model of the three waves. This is because Hayes' model serves to represent the evolution of scientifically developed *behavior therapies*, which is a very broad and inclusive category encompassing a wide range of therapies that derive from the principles of behaviorism (e.g., the original behavior therapies, to present day cognitive behavior therapies and mindfulness-based therapies). However, because traditional psychodynamic therapy does not fall within the category of behavior therapy, Hayes does not include the once ascendant psychodynamic paradigm within his model of the three waves.

Despite this, behaviorism did begin to compete with the psychodynamic approach as the central and dominant clinical orientation in the 1950s and early 1960s (Freedheim, 1992), so with a certain perspective it's possible to view Hayes' model as representing the "mainstream" trends in therapy from the second half of the 20th century onwards. However, when conceiving of these paradigmatic trends it's important not to dismiss the early ascendance of psychodynamic therapy and its influence on the development of psychotherapy as a whole. Without further adieu, I present a brief summary of the three waves of behavior therapy.

The First Wave: Behaviorism

During the first half of the 20th century, the clinical ascendancy of the psychoanalytic approach faced no serious threat (Garfield, 1981). While the research and development of behaviorism began in the 1920s, its influence was only limited to the academic sphere of psychology during the following decades. It was only until the 1950s and 1960s that behaviorism occupied a more central role in the psychotherapy community, and finally came to play a pivotal role in ending the clinical dominance of the psychoanalytic approach (Freedheim, 1992).

The behaviorism paradigm was largely motivated by a movement to develop psychological theories via rigorous scientific methods. This movement was greatly fueled by the reality that prevailing psychoanalytic theories exercised almost no adherence to scientific methods in their origin and propagation (Hayes, 2004). Following the movement towards scientific rigorousness, internal mental events such as thoughts or consciousness were thought of as unobservable and immeasurable constructs by behaviorists, and the study of such was deemed unscientific.

Beginning in the 1920's, behaviorists conducted countless controlled experiments to discover the different ways in which human behavior could be positively and negatively influenced by behaviorist techniques such as classical conditioning, exposure, extinction, reinforcement schedules, and shaping (Lebow, 2008). Over time, key figures such as Pavlov, Watson, Skinner, and Mowrer made advances in developing the learning theory of behaviorism – a theory which mapped how the behavioral patterns of humans result from interactions with specific and modifiable environmental stimuli.

The advancements made in behaviorism learning theory were then applied to the treatment of problematic human behavior, and such was the genesis of behavior therapy. One common example of how behaviorist techniques were applied to the therapeutic context is the elimination of fear and phobias via prolonged exposure therapy. In this form of behavior therapy, patients are exposed to intensely feared stimuli for long periods of time (sometimes 90 minute periods) over many sessions, in order to become habituated to the feared stimuli and eventually eliminate their fearful response. Prolonged exposure differs from systematic desensitization, as the former starts immediately with the intensely feared stimuli, while systematic desensitization will gradually progress a patient through hierarchical stages of their fear stimuli (Lebow, 2008).

Despite the success of many behavior therapy strategies, certain limitations began to be identified in behaviorism learning theory and its scientific approach that ultimately created the context for a shift towards a cognitive therapy paradigm. For one, learning theory could not offer an adequate explanation of language or cognition, and this was a critical flaw during the 1960s when psychology began to be more interested in internal processes such as insight, problem solving, and reasoning (Ciarrochi & Bailey, 2008). Because behaviorism only focused on

externally manifesting constructs, it was not able to provide a framework in which these internally operating constructs could be scientifically analyzed.

Additionally, these limitations were realized when cognitive theories of human functioning were beginning to gain traction (e.g., Bruner et al., 1956; Miller et al., 1960) in the late 1950s and early 1960s. These cognitive theories began to metaphorically conceive of the mind as though it were a "mechanistic computer" with "internal psychological machinery" (Hayes 2004, p. 642). Thus, in the late 1960s, behaviorists were met with the reality that they needed to more directly confront internally operating constructs such as language and cognition, and the early cognitive theories were already providing a framework for which those issues could be studied. Thus was born the cognitive revolution of the 1970s, and the subsequent decline of behaviorism.

The Second Wave: Cognitive Behavior Therapy

The phrase cognitive behavior therapy (CBT) functions as both a name for one particular Beckian form of therapy, as well as an umbrella term for a plethora of therapeutic modalities that all share a similar theoretical foundation and technical approach (J.S. Beck, 2021). While cognitive theories of human functioning began to develop in the 1950s, the first systems of psychotherapy that fall under the umbrella of cognitive behavior therapy (and therefore the ones that originated the category) are rational therapy (later evolving into rational emotive behavior therapy) developed by Albert Ellis in the mid 1950s (Ellis, 1957), and cognitive therapy developed by Aaron Beck in the 1960s (A.T. Beck, 1964).

A.T. Beck's cognitive therapy (CT) had a particularly momentus effect on the field of psychotherapy, and the term cognitive therapy and cognitive behavior therapy are now often used interchangeably (A.T. Beck, 2005). Here is CT in Beck's own words:

> In a broad sense, any technique whose major mode of action is the modification of faulty patterns of thinking can be regarded as cognitive therapy… However, cognitive therapy may be defined more narrowly as a set of operations focused on a patient's cognitions (verbal or pictorial) and on the premises, assumptions, and attitudes underlying these cognitions. (A.T. Beck, 1970, p. 187)

Soon after the genesis of CT, its theory and methodology initially designed for the treatment of depression began to be adapted to a myriad of psychopathologies such as the anxiety disorders, suicidality, phobias, panic disorder, substance abuse, etc. (A.T. Beck, 2005). Additionally, CT and its adaptations became the subject of an unprecedented level of empirical research, which generally supported its effectiveness (A.T. Beck, 2005).

After the cognitive revolution took off in the 1970s (Miller, 2003), anteceding proponents of behaviorism sought to bridge the gap between behavior therapy and the rapidly growing cognitive therapies, and thus the phrase "cognitive 'behavior' therapy" was born in the late 1980s and early 1990s (Roth & Fonagy, 2006). However, behaviorist institutes and research programs ultimately conceded with a major shift in focus from behavior to cognition.

Furthermore, there spawned a few offshoots of the early cognitive therapies that proved to be effective in their own right (e.g., cognitive-behavior modification, behavior activation, problem-solving therapy, cognitive processing therapy), which now all fall under the umbrella

term of cognitive behavior therapy. In addition, Aaron Beck's cognitive therapy is now generically referred to as CBT, and it is considered to be the fundamental form of cognitive behavior therapy from which other cognitively oriented therapies are theoretically adapted (J.S. Beck, 2021).

With the body of empirical research supporting CBTs growing very large, its adaptations accommodating a long list of psychopathologies, and it becoming the predominantly disseminated psychotherapy by graduate training curriculums (Heatherington et al., 2012), CBT quickly became the dominant paradigm of North American psychotherapy.

The Third Wave: Mindfulness-Based Therapies

The third wave of behavior therapies began to emerge in the early 1990s, and includes therapies such as dialectical behavior therapy, acceptance and commitment therapy, cognitive behavior analysis system of psychotherapy, functional analytic psychotherapy, and mindfulness-based stress reduction (Öst, 2008).

The most notable difference between second and third-wave therapies is a comprehensive change in how maladaptive thoughts and feelings are contextualized by the therapist and client. To describe the characteristics of this change: while second wave therapies (CBT) utilize change mechanism that aim to alter the form, content, and frequency of problematic psychological events, third-wave therapies rely on contextual and experiential change mechanisms (primarily mindfulness) that focus on reorienting the way we *relate with* and *respond to* our thoughts and emotions, often without the goal of changing the content or frequency of the thoughts themselves (Hayes, 2004).

I will provide an example to illustrate this major recontextualization of problematic internal events, highlighting the specific change mechanism stated above. If a client were to visit a second wave CBT therapist to receive help with anxious thinking, this therapist would guide them in strategies that function to change the anxious thoughts to non-anxious thoughts (changing the content of thoughts), and to decrease the overall number of anxiety-inducing thoughts (changing the frequency of thoughts). Conversely, if this client were to visit a third-wave therapist, this therapist would guide the client in viewing their anxious thoughts from a different perspective, such as mindfully observing their thoughts as merely passing mental events (changing the context of thinking). Additionally, the third-wave therapist would train the client in techniques that function to improve the client's *direct experience* of anxiety symptoms (experiential change mechanism), such as practicing mindful acceptance and non-attachment to their anxious states.

Mindfulness philosophy is often a central component of third-wave therapies. In an article exploring the operational definition of mindfulness, Bishop and his colleagues (2006) provide a succinct description of mindfulness:

> Broadly conceptualized, mindfulness has been described as a kind of non-elaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is. In a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. (p. 232)

Additionally, mindfulness can be thought of as both a concurrent process of *mindfulness practice*, and an outcome of *mindful awareness* (Shapiro & Carlson, 2009). The process of mindfulness practice is a "systematic practice of intentionally attending in an open, caring, and discerning way, which involves both knowing and shaping the mind". This process leads to the inextricable outcome of mindful awareness, "an abiding presence or awareness, a deep knowing that contributes to freedom of the mind" (Shapiro & Carlson, 2009, p. 10).

Third-wave therapies often contain a variety of skills that train the client in different aspects of mindfulness practice, such as acceptance, and awareness of the present moment (e.g., Linehan, 2015; Hayes et al., 2012). This leads us to what Hayes (2004) has identified as another distinct feature of third-wave therapies. While cognitive behavior therapies in the second generation are driven by the primary goal of eliminating the client's pathologized problems and negative emotional states, third-wave therapies have a broad goal of providing the client with a repertoire of skills that can be dynamically applied to a wide variety of circumstances, and are primarily meant to be used for the purpose of improving one's experience of living (Hayes, 2004).

Where We Are Now: The Dominance of CBT and the Rise of Third Wave Mindfulness-Based Therapies

Some authors in the psychotherapy literature argue that the phrase "third wave" is misleading when used to refer to mindfulness-based interventions (Hofmann et al., 2010; Hofmann & Asmundson, 2008). A primary argument is that the phrase "third wave" connotes that the previous wave has been superseded and left behind by a more dominant paradigm proving to be more successful, when this is in fact not the case. Although these authors have

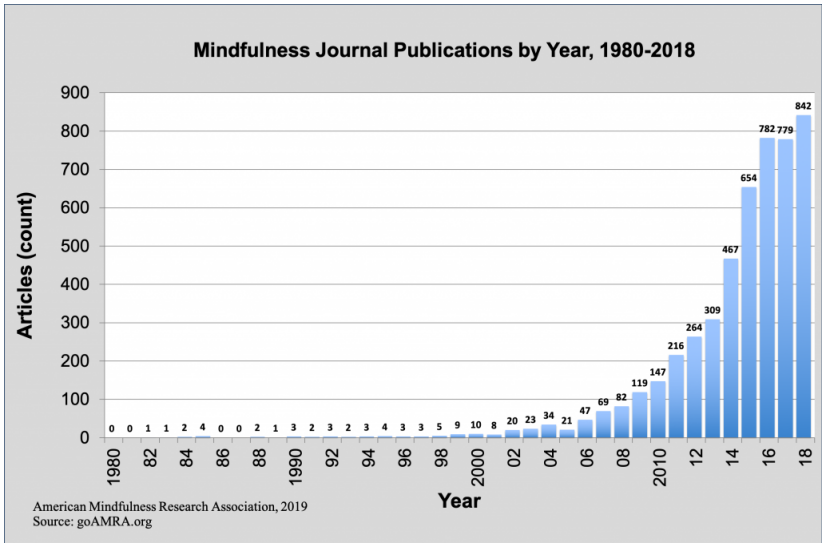
advocated for a revision of the "wave" nomenclature, their efforts have not proven successful, as the phrase "third-wave therapy" has established itself comfortably within the academic literature (Öst, 2008).

However, the aforementioned argument has some merit, as while the phrase "third wave" may point to the fact that mindfulness-based interventions are more recent, the second-wave cognitive behavior therapies are still the most dominant theoretical paradigm in psychotherapy practice (Norcross, Karpiak, & Santoro, 2005; Northey, 2002), in empirical research (Butler et al., 2006), and in graduate level training programs. In fact, some authors even express concern at the CBT monoculture and the concomitant narrowing of theoretical diversity in today's clinical training programs (Heatherington et al., 2012).

While I am not aware of anyone proclaiming that a serious overtaking of the CBT paradigm by mindfulness-based therapies is currently taking place or is on the horizon, it is clear that the scientific interest and psychotherapeutic implementation of mindfulness-based therapies is growing very rapidly. For one, the rate of published empirical research and scientific literature on mindfulness-based therapies has drastically shot up in recent decades (Shapiro & Carlson, 2009). Figure 1 below illustrates the rapidly increasing rate of journal publications broadly related to the topic of mindfulness in psychology.

Figure 1

Mindfulness Journal Publications by Year, 1980-2018



Secondly, there has also been a steep increase in the use of mindfulness theoretical orientations in U.S. therapeutic practice. A recent survey of 2,200 North American psychotherapists revealed mindfulness to be the third most utilized theoretical orientation (now surpassing the psychodynamic orientation), after family systems therapy and CBT (Cook et al., 2010). These results showcase a swift rise in the use of mindfulness-based theories by therapists when compared with previous large-scale surveys assessing theoretical orientations of therapists (e.g., Hollanders & McLeod, 1999; Prochaska & Norcross, 1983; Smith, 1982).

The Present Context: Integrating Mindfulness and Cognitive Change Strategies

I will now begin to broach this paper's focus of using acceptance/mindfulness strategies in conjunction with cognitive restructuring strategies, by discussing how mindfulness strategies as a general category (outside of the specific context of ACT) have been used in combination

with cognitive restructuring strategies. In recent years, a number of researchers have vocalized support for the integration of mindfulness and cognitive change strategies at a theoretical level (Roemer & Orsillo, 2006; Hoffman et al., 2011; Persons, 2008). Although support has been shown, only a small amount of theoretical development has actually occurred on this front.

In one case, Mennin and his colleagues (2013) designed a framework of behavioral adaptation that includes three main dimensions – contextual engagement (mindfulness), attention change, and cognitive change strategies. They support the advancement of a model of CBT that is unified, multimodal, interdisciplinary, and capable of honoring the philosophical differences that underlie the multimodal therapeutic processes (Mennin et al., 2013).

Another case of acceptance/mindfulness being used in conjunction with cognitive change strategies is Dialectical Behavior Therapy (DBT, Linehan et al., 1999). The system of DBT is built around balancing change-oriented approaches with mindfulness (largely from the Zen Buddhist tradition), acceptance, and validation of clients' experiences (Lynch et al., 2006). However, the change-oriented strategies occur largely through skills-training, and there is no direct use of traditional cognitive restructuring strategies in DBT (Linehan, 2015). Although the balancing of change-oriented strategies with acceptance/mindfulness in DBT aligns with the overall theme of this paper, this paper differs as it is particularly interested in how *traditional cognitive restructuring strategies* from CBT can be effectively and cohesively used in conjunction with acceptance/mindfulness strategies.

Moreover, when it comes to using mindfulness in conjunction with cognitive restructuring strategies, what may come to mind for some is mindfulness-based cognitive therapy (MBCT, Segal et al., 2004) – a notable system of therapy adapted from the Mindfulness-Based Stress Reduction (MBSR) program developed by John Kabat-Zinn. Although the originators of

MBCT worked from a foundational background in CBT and the cognitive model, "unlike CBT, there is little emphasis in MBCT on changing the content or specific meaning of automatic thoughts" (from its originators, Segal, Teasdale, & Williams, 2004, p. 54). While the name of MBCT may lead to the conception that this form of therapy uses both mindfulness and cognitive restructuring techniques, MBCT relies almost entirely upon mindfulness techniques as a mechanism of change (Sipe & Eisendrath, 2012).

This leads us to why I chose to draw acceptance/mindfulness strategies from acceptance and commitment therapy rather than a different mindfulness-based therapy such as MBCT or MBSR. Firstly, ACT is considered by some to have the most developed theory and philosophy of the third-wave therapies (Ciarrochi & Bailey, 2008). Additionally, ACT has admirably systematized the ostensibly mysterious and abstract process of mindfulness into a very comprehensible and easily applicable model (the model of psychological flexibility, Hayes et al., 2006). Later in this paper I will describe ACT in greater detail, yet for now it suffices to say that ACT's model of psychological flexibility has impressively modularized the process of mindfulness into individual yet simultaneously interconnected dimensions. Because ACT has such a modular and dimensionally-driven model of mindfulness compared with other mindfulness-based therapies, the use of acceptance/mindfulness strategies alongside strategies from other systems of therapy can be made a much more controlled and organized process.

Moreover, the virtues of ACT go well beyond its "integratable-friendly" mindfulness dimensions. The psychological flexibility model of ACT combines mindfulness dimensions with a set of behavioral activation dimensions and philosophical perspectives that are very useful for developing adaptive functioning and learned resourcefulness. For example, the mindfulness processes in ACT are applied in tandem with a systematic process of taking committed action

towards one's values. Additionally, the mindfulness and behavioral activation processes in ACT are applied under the philosophy of functional contextualism, which suffice to say can greatly enhance the acceptance, mindfulness, and behavioral activation techniques in ACT (Hayes et al., 2006).

For these aforementioned reasons I have chosen ACT to be the source of acceptance/mindfulness strategies to be used alongside cognitive restructuring strategies from CBT. However, while I do discuss ACT-specific techniques in the set of guidelines I propose, many of the points I make would easily apply in the context of any typical acceptance/mindfulness strategies, regardless of their affiliation with any particular system of therapy.

ACT in Conjunction With CBT: Current Theoretical Development

I will now summarize what theoretical development has been made in using acceptance/mindfulness strategies from ACT in conjunction with cognitive restructuring strategies from CBT. Firstly, a number of figures have advocated for the advantages of combining ACT and CBT strategies in clinical practice. An article by Jane Harley (who's received training in both CBT and ACT) discusses the theoretical and methodological similarities and differences between CBT and ACT for the purpose of providing clarity to practitioners who have an interest in practicing both modalities. Harley concludes with a section discussing whether the integration of ACT and CBT could be advantageous, stating that "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" (2015, p. 138).

Additionally, an article by Herbert and Forman (2013) – two noteworthy psychologists in the field of mindfulness and acceptance – discusses the differences and points of overlap in the systems of CBT and ACT. They conclude by stating that "proponents of either perspective should be willing to embrace useful technological innovations from the other without hesitation. Technical eclecticism in this sense makes infinitely more sense than theoretical dogmatism" (p. 222). They argue that ACT practitioners should be open to incorporating cognitive restructuring techniques when those techniques are "theoretically compatible and technically useful", and that CBT and ACT practitioners alike should acknowledge the benefit of using both mindfulness and cognitive change techniques in their practices, as one strategy may be more effective than the other depending on the context. They state that "in fact, we have found anecdotal support within our own clinical work for just such a hybrid strategy" (p. 222).

Furthermore, there are a few noteworthy examples of theoretical development in combining strategies from CBT and ACT. *Emotion Regulation in Psychotherapy: A Practitioner's Guide* is a book written by Leahy, Tirch, and Napolitano (2011), who each come from the different theoretical backgrounds of CBT, ACT, and DBT. The book integrates the techniques of CBT, ACT, DBT, emotion focused therapy, and compassion-focused therapy to provide an integrated manual of emotion regulation strategies. The authors recommend that therapists do not operate exclusively from a singular model, as the efficacy of therapy may be significantly augmented by flexibility in technical approach (Leahy, Tirch & Napolitano, 2011).

Another notable example of theoretical development in using ACT and CBT strategies together, is a book by Ciarrochi and Bailey (2008): *A CBT Practitioner's Guide to ACT: How to Bridge the Gap Between Cognitive Behavior Therapy and Acceptance and Commitment Therapy*. This book offers a pragmatic guide to therapists in using both ACT and CBT strategies together

in their clinical practices. The authors state that "despite the differences between ACT and CBT, we believe that there are many ways to use their techniques together in a philosophically and theoretically coherent fashion" (p. 11). It must be noted, however, that the book's integration work primarily functions to adapt CBT strategies to the ACT model and philosophy. Due to this principal goal, cognitive restructuring techniques are treated with less emphasis and value than acceptance and commitment strategies. Additionally, the information in the book is presented in a very pragmatic style as the chief purpose of the book is to provide therapists with practical and accessible exercises they can use in session with clients. Due to the focus on pragmatism, the authors devote very little of their writing to detailed theoretical development. Nevertheless, Ciarrochi and Bailey offer valuable insight in how to concurrently utilize both cognitive restructuring and acceptance strategies.

Lastly, if we examine the newly released edition of *Cognitive Behavior Therapy: Basics and Beyond* (2021) by Judith Beck (daughter of Aaron Beck), it would not be a stretch to say that the concurrent use of both CBT and ACT techniques is already occurring at a mainstream level. It's important to mention that the content of this book is representative of the most current and mainstream developments in Beckian CBT. This book is the flagship text of the Beck Institute for Cognitive Behavior Therapy, which is the leading international source for CBT training and resources. This seminal text is also widely used in graduate level curriculum across the U.S. as a means of training students in CBT theory and methodology.

If we compare the second edition of this book published in 2011 to the newly published edition in 2021, the incorporation of strategies from ACT and other mindfulness-based therapies is easily observable. For one, the third edition now significantly emphasizes the goal of value-based living as a leading component of CBT (J.S. Beck, 2021), which has been one of the

most essential and impactful contributions to the field of psychotherapy arising from ACT (Hoyer et al., 2020). Furthermore, the recently published edition now includes a new chapter entirely devoted to describing how to integrate mindfulness techniques into CBT. Judith Beck advocates for the utility of using mindfulness strategies in one's practice of CBT, stating that "you should encourage your clients to use either formal or informal mindfulness exercises when they find themself stuck in an unhelpful thought process or caught up in an unhelpful internal experience" (p. 279). The chapter also discusses different internal circumstances wherein mindfulness techniques may be more effective than traditional cognitive restructuring techniques, such as in the case of rumination.

In conclusion, it is clear that many researchers and clinicians are interested in the concurrent use of both CBT and ACT strategies in clinical practice, and there are a few notable instances of theoretical development on this front. However, it is also clear that this field is lacking sources of thorough and in-depth theoretical development that would help guide therapists or researchers in concurrently using cognitive restructuring and acceptance/mindfulness strategies in a systematic and maximally effective fashion.

ACT in conjunction with CBT: Empirical Research

I will now review the few existing studies that have empirically tested a combined program of ACT and CBT. To start, a small number of these studies have tested this combination for treating generalized anxiety disorder and chronic pain (Lunde & Nordhus, 2009; Orsillo et al., 2003; Roemer & Orsillo, 2006). While the results of these previously cited studies all promote the efficacy of this integration, these studies include a very small number of participants, are not randomized, and do not include a control group. Additionally, the previously

cited studies use a therapeutic program that is labeled a combination of ACT and CBT, yet the structure of the programs is characterized by a much greater emphasis on acceptance, mindfulness, and the behavioral components of CBT, while omitting the essential cognitive restructuring techniques of CBT (e.g., Lunde & Nordhus, 2009; Orsillo et al., 2003; Roemer & Orsillo, 2006). While these studies provide valuable direction for the combined use of ACT and CBT, other studies that have adequately instructed clients in both cognitive restructuring and acceptance/mindfulness strategies are of greater pertinence to this paper.

One such study tested a 19-week integrated program of traditional cognitive restructuring techniques, ACT acceptance/mindfulness techniques, and Mennin's emotional regulation techniques (Mennin, 2006) for the treatment of three patients with GAD (Carrier & Côté, 2010). All three participants experienced a clinically significant improvement of anxiety symptoms and no longer met GAD criteria at the three-month follow-up.

However, most noteworthy in the domain of using ACT in conjunction with CBT is a study that tested a manualized group therapy combination of ACT and CT for depression. Hallis and her colleagues (2017) designed a manualized 15-week group therapy program combining the methodology of both CBT and ACT. The manualized program provides clients with traditional cognitive restructuring tools along with the acceptance/mindfulness and behavioral activation strategies of ACT. The program runs for 15 weeks, and is composed of psychoeducation (about depression, and the relationship between thoughts, mood, behavior, etc.), activity scheduling, behavioral experiments, cognitive restructuring lessons (changing maladaptive thinking patterns, attitudes, and core beliefs), workshops covering all processes in the ACT model of psychological flexibility, and relapse prevention training (for a more detailed breakdown of each group session, see Hallis et al., 2016). Along with training in both ACT and CBT techniques, the program

provided a set of guidelines to clients that guided them in understanding which circumstances may be handled more effectively with a cognitive restructuring approach, and which circumstances may be handled more effectively with an acceptance/mindfulness approach.

Hallis and her colleagues assessed the efficacy of this manualized program with a total of four separate therapy groups (Hallis et al., 2017). There were six participants in each group, totaling to a number of 24 clients who received the 15-week treatment program over a span of two years. In the beginning of treatment, the 24 participants were at the severe range of depression (measured with the Beck Depression Inventory), at the end of treatment all participants were at the low/mild end of the scale, and at the three-month follow-up 16 participants (67%) no longer met *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association [APA], 2013) criteria for major depressive disorder (MDD) or dysthymia. These results are comparable with other studies assessing the efficacy of various interventions for depression (Hallis et al., 2017). Additionally, clients experienced significant improvements in quality of life (measured with the WHOQOL questionnaire) during and after the course of treatment.

When Hallis and her colleagues were designing the manual combining ACT and CBT strategies, they were concerned that the therapy and its more diverse repertoire of techniques may be overly complicated or difficult to follow for some clients. However, post-treatment surveys revealed that clients found the therapy very easy to follow and not overly complicated (Hallis et al., 2017). Furthermore, one of the surveys conducted in the study asked the clients to rank which treatment components they found most useful (of the various acceptance/mindfulness strategies, cognitive restructuring strategies, psychoeducation, etc.). The survey revealed that clients found cognitive restructuring to be the most useful treatment component, and this was

followed by the committed action, acceptance, and mindfulness processes of ACT (Hallis et al., 2017). Additionally, clients reported that it was very helpful to use cognitive restructuring in tandem with acceptance/mindfulness techniques with the guidance provided by the therapists.

While the findings of this study are very encouraging, the authors acknowledge the need for more studies that compare ACT-CBT integrated models of therapy with standalone treatment procedures and control groups, as this is the only way to ascertain whether a combined ACT-CBT program would be more effective than current standalone treatment options. At this point, no study has provided an answer to this question, as there are no randomized-controlled trials testing ACT-CBT combined programs against other treatments.

Although it's crucial to ascertain the empirical efficacy of ACT-CBT combined programs, it's important to acknowledge that regardless of whether integrated theories are empirically supported as being more or less effective than standalone treatments, the large majority of practicing therapists will continue to eclectically use strategies from multiple systems of therapy in their practices (Slife & Reber, 2001; Cook et al., 2010). Therefore, even though the empirical validity of eclectic therapy is currently unclear, it is evident that eclectic therapy is the collective preference of therapists in the U.S., and this reality must be recognized and accounted for.

I anticipate the last few sections of this paper have made it clear that the concurrent use of ACT and CBT is of theoretical, empirical, and practical interest to a considerable number of researchers and psychotherapists. Despite this interest, there is a paucity of thorough and in-depth theoretical development in this field, especially in the domain of how a therapist or client can effectively navigate the use of both cognitive restructuring and acceptance/mindfulness strategies during treatment.

In this paper I will focus on exploring theoretical development in this domain, by providing a set of guidelines outlining for what circumstances an acceptance/mindfulness approach may be more advantageous than a cognitive restructuring approach, and for what circumstances a cognitive restructuring approach may be more advantageous than an acceptance/mindfulness approach. These guidelines can potentially be very useful for practicing therapists who currently lack guidance in how to systematically and effectively use both approaches in their clinical practice, as well as for researchers who plan to conduct future studies on the effectiveness of this combination.

The Rationale for Technical Eclecticism

In the following sections I will discuss the rationale for eclecticism, or in other words why it may be more advantageous to practice both ACT and CBT together rather than practicing either theory independently. I will begin by briefly elucidating the difference between technical eclecticism and theoretical integration. I will then explain why I chose to analyze the combination of ACT and CBT in the context of depression, and introduce how treating the symptomatic profile of depression would be particularly effective with a therapy that includes both acceptance/mindfulness and cognitive restructuring elements. This will be followed by subsections: The Argument Against Eclecticism, The Empirical Rational for Eclecticism, and The Clinical Rationale for Eclecticism

Technical Eclecticism v. Theoretical Integration

During this paper I have been using the phrases “integration” and “using techniques from both therapies” (technical eclecticism) interchangeably. This is because the phrase “integration”

is used somewhat indiscriminately in the psychotherapy integration literature as an umbrella term for generally using two or more therapies together (Fernández-Álvarez et al., 2016). However, it's important to note that "eclecticism" and "integration" technically refer to two different integrative processes: *technical eclecticism* and *theoretical integration* (Lampropoulos, 2001).

The first integrative process is *technical eclecticism*, which involves drawing *techniques* from two or more systems of therapy to maximize treatment adaptability, flexibility, and effectiveness (Lazarus & Beutler, 1993). The second integrative process is *theoretical integration*, which is a much more scrupulous process wherein two or more discrete systems of therapy are blended into one unitary theory. Theoretical integration is not the goal of this paper. Because I am exploring how to cohesively use both acceptance/mindfulness and cognitive restructuring techniques in clinical practice, my focus would likely fall under the label of technical eclecticism. However, I will return to this topic for a more nuanced discussion in the guideline portion of this paper.

The Advantage of Eclectic Therapy in the Context of Depression

To narrow the focus and scope of this paper, I will be exploring how ACT can be used in conjunction with CBT *in the particular context of treating depression*. However, it's important to briefly mention that this combination may also produce an effective therapy in a transdiagnostic context (i.e., applicable to a wide range of *DSM–5* disorders, Sauer-Zavala et al., 2017) rather than for only one particular disorder. This is largely due to the core theoretical models of ACT (the model of psychological flexibility, Hayes et al., 2012) and CBT (the cognitive model, J.S. Beck, 2021) being fundamentally transdiagnostic models which are thereafter precisely adapted to the context of different disorders.

In fact, a transdiagnostic integration is what is argued for in *A CBT Practitioners Guide to ACT*. The authors present a transdiagnostic model unifying ACT and CBT components that is designed to be applied to a wide range of mental health disorders, and they discuss in-session activities irrespective of their applicability to specific disorders over others (Ciarrochi & Bailey, 2008). Additionally, Hayes and his colleagues (1999) argue the many advantages of being guided by a unified philosophy and theory, rather than a set of therapeutic techniques that are closely manualized or tailored to a singular disorder.

Although the transdiagnostic approach has many advantages, I believe that for the scope of this paper, the analysis and discussion I include would be more effective and practically useful if it was written in the context of a particular disorder. I chose to discuss the combination of ACT and CBT in the context of depression, or major depressive disorder (MDD) as it's referred to in the *DSM–5* (APA, 2013), for a few reasons. For one, depression is the most commonly diagnosed disorder, right above the anxiety disorders (Moriarty, 2019). Secondly, Hallis and her colleagues (2017) point out that although CBT is considered the "gold standard" for depression treatments, many studies have found that 30-60% of patients do not show significant improvement after receiving standard CBT treatment for depression (DeRubeis et al., 2005; Dimidjian et al., 2006). Hallis and her colleagues argue that since many clients don't do well with conventional treatments for depression, there is clearly room for improvement, and eclectic approaches that offer a greater variety of circumstance-specific strategies may be a means of increasing treatment efficacy.

Moreover, many previously mentioned and soon-to-be discussed themes in the ACT-CBT eclecticism literature (e.g., that mindfulness or cognitive restructuring techniques can be more effective than the other for different contexts) can be extrapolated to the argument that particular

symptoms and aspects of MDD may be treated more effectively with CBT strategies, and others symptoms of MDD may be treated more effectively with ACT strategies.

This argument will be extensively elucidated in the guideline portion of this paper, yet to briefly illustrate this point, aspects of MDD such as cognitive distortions, negative self-schemas, attitudes and core beliefs, may be more effectively treated with cognitive restructuring strategies. On the other hand, people with MDD also experience poor emotion regulation, ruminative proclivities, avoidance of internal or external experiences, and inaction or amotivation that may be more effectively treated with ACT strategies. Therefore, due to the symptomatic composition of MDD, its treatment may particularly benefit from an approach that utilizes both cognitive restructuring and acceptance/mindfulness strategies.

The Argument Against Eclecticism

Before I begin discussing the empirical and clinical rationale for using acceptance/mindfulness in conjunction with cognitive restructuring, it's important to mention the arguments against eclecticism. One argument, is that the empirical status of eclectic therapies is difficult to ascertain, largely due to the fact that the vast majority of randomized controlled trials test "pure form psychotherapy approaches" (Fernández-Álvarez et al., 2016, p. 825). While many studies have empirically supported particular forms of integrated therapies (Zarbo et al., 2016), there are countless unique formulations of eclectic therapies created and practiced by therapists that have not been empirically vetted.

Another argument states that because so many contemporary therapists eclectically draw from different theories, many run the risk of being "unsystematic eclectics", or therapists that combine discrete techniques in a disorganized, unstructured, or haphazard manner (Slife &

Reber, 2001). Norcross and Tomcho (1993) state that many so-called eclectic therapists are actually practicing *syncretism*, an "arbitrary and unsystematic blending of concepts of two or more of the 400 plus schools of psychotherapy. Their pluralistic intentions are to be commended, but their haphazard hybrids are an outgrowth of pet techniques and inadequate training" (p. 81).

The issue with unsystematic eclecticism is that it can easily result in therapy that isn't cohesive and is therefore ineffective (Benito, 2018). Thus, figures in integrative literature argue that using discrete strategies from multiple systems of therapy must be achieved with careful systematic and scientific approaches, and not simply freehanded (Lazarus & Beutler, 1993). To mitigate the practice and consequences of unsystematic eclecticism, the field of psychotherapy integration has created and advocated for the use of extensive guidelines that systematically structure the eclectic use of different theories and techniques (Slife & Reber, 2001). However, due to the ubiquity of eclecticism in contemporary therapeutic practice, many cases of unsystematic eclecticism are sure to exist.

The Empirical Rationale for Eclecticism

Empirical research has not yet provided definitive evidence that ACT or CBT is more effective than the other in treating depression. Randomized control trials (RCTs) that have compared both ACT and traditional CBT groups within the same study present mixed results. One study assessing 18 clinically depressed women found that patients in the ACT (named "comprehensive distancing" at the time) group experienced a greater reduction in depressive symptoms compared with the CBT group (Zettle & Hayes, 1986). Another early study found that two forms of CBT group therapy were equivalent to ACT group therapy in treating 31 depressed patients (Zettle & Rains, 1989). In a more recent long-term study by Forman and his colleagues

(2012), post-treatment analyses of 90 anxious and depressed outpatients showed an equivalence in efficacy for both ACT and CBT groups for measures of depression, anxiety, overall functioning, and quality of life. However, at the 1.5 year follow-up mark, the CBT group was found to maintain their treatment gains at higher levels than the ACT group, with one-third more patients in the CBT group being in the clinically normative range of depressive symptoms compared with the ACT group (Forman et al., 2012).

Additionally, one meta-analysis examining the few studies comparing both ACT and CBT groups in the same study (the majority of which are mentioned above), found a positive trend in the favor of ACT (Ruiz, 2012). Conversely, a meta-analysis comparing the effect sizes of many different ACT and CBT studies for depression, regardless of whether both therapies were compared within the same study, found ACT and CBT to be equivalent in efficacy for the treatment of depression (A-Tjak et al., 2015).

Furthermore, there have been many "refinements" to the treatment of depression over the past few decades, yet the efficacy of depression treatment has not improved over time, and current interventions for depression are still often unsuccessful (Cuijpers et al., 2020, p. 926). A meta-analysis of 35 RCTs investigating the effects of psychotherapies on major depression found that 66% of patients improved after receiving CBT for depression (Cuijpers et al., 2014), and meta-analyses of ACT find that it is no better or worse at treating depression than CBT (Powers et al., 2009; A-Tjak et al., 2015).

Thus, given that there is plenty of room for improvement in modern treatments for depression (Cuijpers et al., 2020), along with the fact that ACT or CBT is no more effective than the other in treating depression, it is worth investigating whether a combination of ACT and CBT strategies may lead to improved treatment efficacy. I will explore the reasons for this below.

The Clinical Rationale for Eclecticism

You may be wondering at this point: why use both ACT and CBT together in the first place? Why would using acceptance/mindfulness in conjunction with cognitive restructuring be more efficacious than practicing either system independently? A number of arguments make up the clinical rationale for the eclectic use of acceptance/mindfulness and cognitive restructuring strategies, and I will discuss three major arguments below.

Firstly, as Ciarrochi and Bailey argue in their book, *A CBT Practitioners Guide to ACT* (2008), and Hallis and colleagues (2017) argue in the publication of their experiment, if clients have access to both cognitive restructuring and acceptance/mindfulness techniques in their toolbox of techniques, they may experience significantly greater versatility in their ability to respond to internal and external circumstances. In fact, it may be repertoire narrowing to respond to situations with strategies from only one approach. This is because cognitive restructuring or acceptance/mindfulness techniques may be more or less effective in different contexts and for different purposes.

For example, in their book *Behavioral Interventions in Cognitive Behavior Therapy: Practical Guidance for Putting Theory Into Action*, Farmer and Chapman (2008) outline various circumstances where a cognitive change approach may be more effective than an acceptance approach, and vice versa. One such guideline they offer is that when a client's thoughts are justified or accurate (e.g., distressing thoughts related to being overweight, when one is in fact overweight), acceptance strategies may be the more effective response. Additionally, in Judith Beck's (2021) recent instructional book on CBT, she outlines certain features of depression (e.g.,

rumination) where acceptance/mindfulness would be a more effective response than cognitive restructuring.

The notion that either acceptance/mindfulness or cognitive restructuring strategies can be more efficacious than the other in different circumstances was put into practice in the combinatorial study by Hallis and her colleagues (2017). The group therapy program provided a set of guidelines to therapists and clients that outlined what circumstances may be better handled with a cognitive restructuring versus an acceptance/mindfulness response, and the clients reported the guidelines to be very useful in navigating their use of both ACT and CBT strategies (Hallis et al., 2017).

Therefore, given that acceptance/mindfulness and cognitive restructuring may be more effective than the other for different circumstances, a set of guidelines distinguishing between what circumstances may be more effectively responded to with an acceptance/mindfulness versus a cognitive restructuring approach may guide and inform therapists in matching clinically relevant circumstances with the most effective response strategy. While guidelines of this sort may help therapists in making more effective recommendations for clients, the clients themselves may also benefit from using these guidelines in their day-to-day application of ACT and CBT strategies.

A second major argument for eclecticism, is that with an increase in the diversity of available therapeutic strategies and psychological models provided by ACT and CBT, therapists may have a greater capacity to personalize treatment to the unique needs of each client. A number of authors speak on how different therapeutic modalities can be eclectically used to create a more personalizable therapy that can better meet idiosyncratic client needs. For example, in Person's book on case conceptualization in CBT (2008), she writes on the benefit of including

both second-wave and third-wave techniques in one's formulation of how to treat a client (i.e., case formulation). Person promotes an approach of drawing from different empirically supported methods of case formulation, "depending on which appears most acceptable or helpful to the patient who is in his or her office at that time" (p. 8).

Additionally, in writing about an integrated model of emotional regulation, Leahy, Tirch and Napolitano (2011) state that "our clinical experience is that there is no set of interventions that works for every patient, and the clinician can enhance the effectiveness of therapy through flexibility of approach without requiring a strong allegiance to one particular model" (p. 200). Therefore, with an increase in the diversity of available therapeutic strategies and psychological models, therapists can have greater flexibility in precisely tailoring treatment to the idiosyncratic case of each client, and conceptualizing a client's case from different angles or perspectives. A number of studies have shown that personalized treatment approaches can lead to enhanced treatment efficacy (e.g., DeRubeis et al., 2014; Lutz et al., 2015).

Thirdly, while therapists may have more flexibility in personalizing treatment strategies to specific client circumstances, a more comprehensive repertoire of techniques may also afford clients themselves with increased flexibility in selecting the techniques that work most effectively for them. For example, a client can have the ability to choose between acceptance/mindfulness or cognitive restructuring approaches for the wide array of circumstances they may face. Given this choice, clients may have more freedom in selecting strategies that fit their particular internal and external circumstances, limitations/abilities, symptom makeup, personal preferences, personality, or experiential knowledge of what works best for them. Thus, with more freedom to choose from an expanded repertoire of strategies,

clients may be better equipped to adaptively respond to the different circumstances of their disorder.

Closing Statement

I hope that after reading the introduction to this paper, exploring how to most effectively use ACT in conjunction with CBT seems a pertinent and valuable endeavor in the current field of clinical psychology. The following section of this paper will provide a brief overview of both therapies, and discuss how the theoretical and philosophical tensions of both systems can be reconciled while using both concurrently. For the purpose of developing theory for how ACT strategies can be used in conjunction with CBT strategies, I will then present a set of guidelines that discuss for what circumstances an acceptance/mindfulness approach may be more advantageous than a cognitive restructuring approach, and for what circumstance a cognitive restructuring approach may be more advantageous than an acceptance/mindfulness approach.

Chapter 2:

Acceptance and Commitment Therapy and Cognitive Behavior Therapy

Before moving onto the guideline portion of this paper, I will independently summarize the theories of ACT and CBT. Because the guideline portion of this paper speaks of ACT and CBT strategies as removed from the context of their respective theories, it is useful to have an understanding of the underlying theories from which the strategies are derived. Stripping a therapeutic technique of its theoretical context can result in ineffective forms of eclecticism, for both the therapist and client (Lampropoulos, 2001). Thus, to effectively practice eclecticism it's

important to have a comprehensive understanding of a given technique from the point of view of it's originating theory, and understand what role each technique plays in the context of its respective theory (Lazarus & Messer, 1991; Lampropoulos, 2001). I will provide a basic overview of both ACT and CBT theory, and focus on the essential features of these systems that are most relevant to the guidelines presented in this paper.

Acceptance and Commitment Therapy: A Basic Overview

The system of ACT is in large part founded on the premise that psychological inflexibility (also called psychological rigidity) is "a root cause of human suffering and maladaptive functioning" (Hayes et al., 2012, p. 64). Psychological inflexibility is primarily characterized by an inability to focus on the present moment, not living in accordance with one's values, inaction or impulsivity, a maladaptive conceptualization of self, a maladaptive relationship to thoughts, and pervasive avoidance of internal and external experience (Hayes et al., 2012). Because psychological rigidity is primarily responsible for the suffering experienced with psychological disorders and in day-to-day life experience, ACT has designed a transdiagnostic model of psychological flexibility aimed at enhancing adaptive functioning in all of the aforementioned problem categories.

Psychological flexibility is defined as "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" (Hayes et al., 2006). The importance of values in the system of ACT cannot be downplayed. The primary function of all client behavior, and the chief goal of therapy, is to help a client live and act in alignment with their chosen values. Therefore, cultivating psychological flexibility is a process of learning how to apply acceptance/mindfulness strategies in the face of

unhelpful cognitions, emotions, and physical sensations, for the purpose of redirecting one's attention onto the present moment and performing value-congruent behavior (Hayes et al., 2006).

The model of psychological flexibility is composed of six processes (or dimensions, as another way to think of them), and it is the central model that guides the practice ACT. The six processes of psychological flexibility fall into the two major categories of behavioral activation and acceptance/mindfulness. A therapist practicing ACT will spend a considerable amount of time guiding a client in cultivating proficiency in the six processes of psychological flexibility, and a client will work diligently on applying the skills to their daily life. The six processes of psychological flexibility are: acceptance, cognitive defusion, flexible contact with the present moment, self as context, values, and committed action (Hayes et al., 2006). I will briefly summarize each of these processes below.

Acceptance is a process meant to counteract experiential avoidance and suppression. A client is taught to willingly feel and embrace the full extent of their internal experiences, rather than attempting to *change* the form or frequency of these experiences. Acceptance is not taught as an end-goal, but as one step in the process of reorienting towards value-based action.

Cognitive defusion: Put simply, the process of cognitive defusion serves a similar function to mindfulness. Both cognitive defusion and mindfulness serve the function of disentangling one's focus and point-of-view from one's thoughts (hence de-*fusion* from thoughts), and reorienting one's perspective to be more of a detached observer of thoughts. However, to state a more nuanced explanation, cognitive defusion is the process of separating oneself from the symbolic meaning that characterizes verbally-constructed thinking and language processes, with the goal of observing one's verbally-constructed thoughts as meaningless strings

of arbitrary sounds. When cognitive defusion is engaged properly, a disturbing thought will lose its symbolic meaning, and subsequently lose its disturbing effect.

Flexible contact with the present moment is a process of refocusing attention away from past/future-oriented thinking (unless it serves a functional purpose) towards non-judgmental present-moment awareness. Again, this technique is not an end in itself, but is used for the purpose of enhancing psychological flexibility and more effectively engaging in value-congruent behavior.

Self as context is a particular form of self-conception, wherein the self is conceived not as a composite of thoughts, emotions, and sensations, but as the *container* that houses thoughts, emotions, and sensations. Clients are encouraged to leave behind the conceptual and verbally-constructed view of the self (e.g., "I'm a nice guy, I'm depressed"), and view the self as the more transpersonal "'I/here/nowness' of conscious experience" (Hayes et al., 2012, p. 81-82). There are many clinical advantages to this revised self-conception, yet three notable advantages are: a sense of spirituality and transcendence, the adopted viewpoint of consciousness being social, expansive, and interconnected, and the enhancement of compassion, acceptance, and non-judgment felt towards the self and others (Hayes et al., 2012).

Values: The ACT therapist will use a variety of activities to help a client choose certain esteemed qualities and life-directions (i.e., values) related to various domains such as family, career, spirituality, or lifestyle (Hayes et al., 2006). Thereafter, the primary function of all ACT processes (acceptance, diffusion, etc.) and the chief goal of therapy is to help clients live and act in accordance with their chosen values. In ACT, the functionality or "truth-criterion" of all behavior is measured by whether or not the behavior pragmatically brings a client closer to their explicitly chosen goals and values.

Committed Action is a process aimed at developing "larger and larger patterns of effective and flexible values-based behavior" (Hayes et al., 2012, p. 95). Committed action is in some ways a philosophy or ethical principle adopted by the client. The principle of taking committed action towards one's chosen values in the face of disorder-related or non-related adversity aims to directly counteract maladaptive patterns of experiential avoidance, inaction, and impulsivity. Committed action is applied in moment-to-moment behavior, and clients are encouraged to take responsibility for when committed action "slips", and once more put forth effort into a values-based direction (Hayes et al., 2012, p. 95).

This sums up the brief overview of acceptance and commitment therapy and its core model of psychological flexibility. Of course, there are many essential features of ACT that I have left out from this brief overview. Most importantly, I have not discussed the philosophical underpinnings of ACT – functional contextualism and relational-frame theory (Fletcher & Hayes, 2005; Vilardaga et al., 2007) – which are the foundation to its theory and technique. Despite this, I believe the information provided is sufficient to appreciate the forthcoming sections.

Cognitive Behavior Therapy: A Basic Overview

While cognitive behavior therapy was originally developed by Aaron Beck to treat depression (A.T. Beck, 1964), the foundational models of CBT have since been carefully adapted to a wide variety of different disorders (A.T. Beck, 2005; A.T. Beck, 1979). At this point, cognitive behavior therapy exists as an umbrella term for a category of interventions that share the same theoretical and methodological foundations to the CBT introduced and developed by Aaron Beck. However, the term CBT can also refer to the traditional cognitive behavior therapy

(then called cognitive therapy) developed for the treatment of depression (J.S. Beck, 2021). In this brief overview of CBT, I will be discussing the specific theory and models relevant to CBT for depression. This overview does intend to define the overarching characteristics shared by all interventions falling under the broad category of cognitive behavior therapy. However, because the adaptations of CBT share the same core theoretical models and treatment structure, the theory discussed in this overview will doubtless shed some light on the characteristics defining the broad category of cognitive behavior therapies.

The *cognitive model* is the central theoretical model in CBT, and all treatment components are based on the premises set forth by this model. The elements of the cognitive model are primarily used to structure case conceptualization and treatment planning, yet all aspects of treatment are influenced by the model (J.S. Beck, 2021). Haigh and A.T. Beck (2014) distinguish between the *generic* (i.e., transdiagnostic) cognitive model, which "represents a set of common principles that can be applied across the spectrum of psychological disorders" (p. 1), and cognitive models which are tailored to the treatment of specific disorders (e.g., cognitive model of PTSD, Ehlers & Clark, 2000).

The cognitive model of depression posits that clients with depression have highly intensified maladaptive beliefs and attitudes (e.g., about themselves, the world, and the future) which produce systematic negative biases in information processing, such as negative attentional and recall biases, as well as cognitive distortions (A.T. Beck, 2008). Additionally, the intensification of negative beliefs and attitudes (i.e., schemas) in depressed individuals leads to systematic negative biases in cognition.

Most notably, depressed individuals will experience negative biases in automatic thought responses to situations that would otherwise elicit neutral or adaptive cognitive responses (A.T.

Beck, 2008). For example, if a depressed client held a core belief of "I'm incompetent", and they were presented with a difficult task, this core belief may result in the automatic cognitions: "This is just too hard. I'm so dumb. I'll never master this." (J.S. Beck, p. 53). These negative automatic cognitions will then lead to maladaptive emotional responses (e.g., sadness or anxiety), as well as maladaptive behavioral responses (e.g., procrastination, avoidance) that can further reinforce the original maladaptive attitudes and beliefs (J.S. Beck, 2021). Overall, the systematic negative biases in information processing and cognition, along with the maladaptive emotional and behavioral responses ensuing from such, can lead to and perpetuate the symptoms of depression.

The solution to remedying systematic negative biases in information processing and cognition is *cognitive restructuring* (Clark, 2013). The process of cognitive restructuring begins with identifying negative automatic thoughts, or when engaged at a deeper level, identifying underlying maladaptive beliefs, attitudes, rules and assumptions (i.e., negative schemas). As the next step, a client will work with a therapist to evaluate the validity or rationality of maladaptive beliefs or thoughts, for the purpose of gaining a more accurate and adaptive conception of the self and world.

The process of evaluation can be achieved by examining the evidence for and against an identified thought or belief through socratic dialogue with a therapist or the completion of thought records (Clark & Egan, 2015; Waltman et al., 2019). However, testing the validity of a thought or belief can also be achieved through behavioral experiments (Rouf, 2004), in which a therapist and client collaboratively design an experiment that tests a thought or belief in real-world circumstances. These experiments have hypothesized outcomes that either confirm or deny a maladaptive thought or belief, and they can sometimes be the most effective method of gathering evidence against irrational thoughts and beliefs (Bennett-Levy, 2003).

Thus, through the process of socratic dialogue, thought records, and behavioral experiments, a depressed individual's maladaptive thoughts, cognitive distortions, beliefs, and attitudes are substituted for rational and adaptive alternatives. As clients undergo cognitive restructuring, their information processing and response styles will become less negatively biased, they will have improved self- and world-conception, and will respond to situations with more adaptive thought and behavior patterns (J.S. Beck, 2021).

Furthermore, it's important to note that cognitive restructuring is meant to be engaged in tandem with the behavioral components of CBT. For example, CBT is a goal-oriented therapy, meaning that a therapist will work with a client to formulate a set of pragmatic goals, along with a step-by-step plan for how to work towards these goals (Grey et al., 2018). Within the goal-achievement process, behavioral-activation procedures (i.e., action plans) are used to help a client engage in the necessary behaviors to achieve their chosen goals. Moreover, another major behavioral component of CBT is *activity-scheduling*, whereby a therapist will help a client schedule a list of activities to be performed throughout the week that provide clients with a sense of pleasure, connection, mastery, or achievement (Persons et al., 2001). Overall, these two aforementioned behavioral components of CBT effectively counteract the detrimental proclivities of inactivity and amotivation held by depressed individuals, and help improve client mood, thinking, and quality of life (Hopko et al., 2003).

In conclusion, cognitive restructuring performed in conjunction with these aforementioned behavioral-activation components will provide an efficacious therapy for treating depressive symptoms (Butler et al., 2006). In this brief overview I have left out some principal components of CBT, such as the importance of the therapeutic relationship, as well as client case

conceptualization (J.S. Beck, 2021). Despite this, I believe the information provided on CBT is sufficient to appreciate the following sections.

Reconciling the Philosophical and Theoretical Tensions of ACT and CBT

ACT and CBT have quite a few shared characteristics, which may streamline the process of using both therapies concurrently. For example, both therapies have a strong emphasis on goals and values, as well as using behavioral activation strategies to ensure that a client is taking action towards their goals and not succumbing to experiential avoidance. Additionally, both approaches "encourage flexibility of thinking and adaptive perspective-taking, be that through the paradigm of the scientist-observer or that of the mindful observer" (Harley, 2015, p. 136). Furthermore, both therapies encourage clients to distance themselves from cognitions, and not view cognitions as expressions of inherent truth. Beyond these aforementioned points, there are many more points of overlap in ACT and CBT (for a more comprehensive list of shared traits, see Harley, 2015).

Despite these similarities, there are also some notable philosophical and theoretical tensions between both systems of therapy. Herbert and Forman (2013) wrote a comprehensive article delineating the major differences between ACT and CBT. Likely the widest schism between both therapies is the philosophical and empirical stance on change-based strategies. Major proponents of ACT often explicitly state their belief that change-based strategies (rather than acceptance/mindfulness) are a misguided, ineffective, and detrimental approach to treating pathology (Hayes et al., 2012). Additionally, there is tension between ACT and CBT with regards to the perceived importance of cognition in the development and treatment of

psychopathology, as well as the primacy of cognition in directly causing emotions and behavior (Herbert & Forman, 2013).

Despite the philosophical and theoretical tensions of these two interventions, Herbert and Forman state that "proponents of either perspective should be willing to embrace useful technological innovations from the other without hesitation. Technical eclecticism in this sense makes infinitely more sense than theoretical dogmatism" (2013, p. 222). In terms of reconciling the philosophical plurality or tension when using strategies from both therapies, some authors recommend a dialectic approach, in which the theory and philosophy of both systems are independently held true, with each philosophy being perceived as a different approach or perspective to the same problem (Harley, 2015; Hallis et al., 2017). With this approach, a therapist or client will alternate between the perspectives of each independent theory when strategies from that theory are used. This dialectic approach is an alternative to integrating both ACT and CBT into a unified theory and philosophy, which may result in a substandard or contrived outcome due to the philosophical incompatibilities of both systems, and the forfeiture of cohesion resulting from each theory being removed from its whole and independent form.

In the ACT-CBT combinatorial study for depression, Hallis and her colleagues (2017) reconciled the philosophical plurality by including psychoeducation that thoroughly elucidated to each client the philosophical and theoretical underpinnings of ACT and CBT, and presenting each theory as being different possible approaches to the same issues. Additionally, therapists in the study taught clients how to be aware of and dynamically navigate between the psychological and philosophical perspectives that pertained to each acceptance/mindfulness of cognitive restructuring technique they utilized (Hallis et al., 2017). Despite a concern that keeping track of two different theories may confuse clients in the study, post-treatment surveys revealed that

clients found the combinatorial treatment program very easy to follow and not overly complicated. Additionally, clients reported that they frequently used both acceptance/mindfulness and cognitive restructuring strategies, and found both approaches very useful (Hallis et al., 2017).

In conclusion, this study sheds light on how the philosophical tensions of ACT and CBT can be reconciled by alternating between the point of view of each independent theory when strategies from that theory are used. Although valuable insight is gained from this study, more more research is needed to ascertain the efficacy of this approach.

Presenting Guidelines for When to Use Acceptance/Mindfulness or Cognitive Restructuring Strategies

The Underlying Philosophy: Technical Eclecticism and Assimilative Integration

To reiterate the overarching goal of this paper, I am exploring how to most effectively and coherently use both CBT and ACT together in clinical practice. However, a more precise and informative phrasing, is that I am exploring how to most effectively utilize both cognitive restructuring and acceptance/mindfulness strategies for the treatment of depression. This is clearly a very extensive and multidimensional interest, so given the length of this paper, I will only be focusing on creating a set of guidelines for when it may be more advantageous to use either cognitive restructuring or acceptance/mindfulness techniques for a variety of salient circumstances related to depression.

The motivation and perceived utility of creating these guidelines is largely rooted in the philosophy of technical eclecticism (Lazarus & Beutler, 1993) and assimilative psychotherapy

integration (Lampropoulos, 2001). Thus, it would be helpful to briefly summarize the pertinent viewpoints of these approaches. In introducing the approach of technical eclecticism, Lazarus and Beutler (1993) state that "many counselors and clinicians have realized that one true path to understanding and correcting human problems does not exist – no single orientation has all the answers" (p. 381). Thus, a core tenant of the technical eclecticism philosophy is that when a psychotherapist has a greater diversity of techniques and theoretical perspectives in their clinical armamentarium, they can more precisely tailor their clinical methodology to the unique needs and circumstances of each client, and in turn increase the efficacy of treatment.

Furthermore, the assimilative integration approach to psychotherapy (Messer, 2001; not to be confused with theoretical integration) is also driven by a philosophy of having an adaptable therapy that is tailored to the distinct case of each client. However, the assimilative approach places greater focus on maintaining the theoretical integrity associated with each technique being used, and maintaining a strong basis in theory and empiricism while one is importing techniques from other systems of therapy (Lampropoulos, 2001). In this form of integration, "psychotherapy orientations should cultivate integration and work closely together while maintaining their separate identities" (Zarbo et al., 2016, p. 3).

In both assimilative and eclectic integrative approaches, it is thought that maintaining a strict allegiance to a singular theory would in effect reduce the overall scope and comprehensiveness of one's clinical practice, and in turn narrow a therapist's ability to openly respond to the diversity of their clients' problems with greater flexibility and precision (Lampropoulos, 2001). In other words, a psychotherapist taking these integrative approaches would seek to expand their repertoire of clinical methodology beyond an isolated model, so that they can more flexibly, precisely, and effectively match therapeutic theories and techniques to the

idiosyncratic case of each client. For empirical research supporting the efficacy of integrative therapy, see Zarbo et al. (2016).

To summarize, there is significant overlap and nuance between the technical eclecticism and assimilative integration approach (e.g., Lazarus & Messer, 1991), yet the forthcoming guidelines are generally rooted in the aforementioned philosophies of both approaches. On one end, I think it's useful to draw techniques from both ACT and CBT depending on the clinical context (technical eclecticism), yet I also believe that effective practice of these techniques is contingent upon a strong understanding of and adherence to the respective theoretical framework from which each technique derived (assimilative integration).

The Importance of Practicing Systematic Eclecticism

In attempts to reduce the propagation of irresponsible and ineffective practices of therapy, leaders in the field of technical eclecticism often emphasize a very important distinction between two forms of technical eclecticism. The first form is termed *unsystematic eclecticism* or *syncretism*, and is is described with spirited candor by Lazarus and Beutler as a "haphazard mishmash of divergent bits and pieces" wherein a therapist "selects concepts and procedures according to an unstated and largely unreplicable process", and blends them "often in an arbitrary, subjective, if not capricious manner" (1993, p. 381). This approach of unsystematically selecting therapeutic techniques from multifarious systems based on whim or arbitrary intuition has been frequently admonished in the integration literature (Benito, 2018).

The second form of eclecticism is termed *systematic eclecticism*, and is a process of carefully selecting therapeutic techniques to match client circumstances based upon systematic guidelines that elucidate for what contexts a given technique would be useful, or when it may be

more effective to utilize a different technique (Mahalik, 1990). These guidelines have the purpose of aiding therapists in informed decision-making (often via detailed criteria) and understanding how to navigate the use of different techniques in a cohesive and deliberate manner (Lazarus & Beutler, 1993). The backlash against *unsystematic eclecticism* and the concomitant movement towards *systematic eclecticism* by the integrationist field, can be seen as a response to the potential risks of misconducted eclecticism, and the recognized need for well-thought-out guidelines that effectively organize the use of diverse therapeutic techniques in clinical practice.

In terms of this project's focus of systematizing the joint usage of acceptance and change strategies in therapy, Farmer and Chapman state that "an important therapist consideration is the relative balance between acceptance- and change-oriented interventions with a particular client. Some clients do well in treatments that almost solely involve changing behavior and problem solving… but others require a more even balance between acceptance and change" (Farmer & Chapman, 2008, p. 262). Thus, I believe it's very important to develop systematic guidelines that explore how to best use cognitive change and acceptance/mindfulness techniques concurrently, to ensure that psychotherapists practicing both strategies are able to do so in the most cohesive, balanced, and effective manner.

Introduction to The Set of Guidelines

To summarize previous sections, therapists and clients may benefit from an expanded repertoire of strategies which includes both cognitive restructuring and acceptance/mindfulness techniques. With a greater diversity of empirically supported therapeutic strategies and models, and a set of guidelines for systematically navigating their use, therapists can more precisely

match treatment strategies to particular client circumstances, and clients themselves may have more flexibility in responding to the varying internal and external circumstances related to their disorder (Zarbo et al., 2016).

Furthermore, the use of both acceptance/mindfulness and cognitive restructuring techniques may be a particularly powerful combination for the treatment of depression. Within the complex symptomatic profile of clinical depression, it may be more advantageous to use either cognitive restructuring or acceptance/mindfulness techniques for different circumstances. This argument will be extensively elucidated in the forthcoming guideline portion of this section.

The set of guidelines is divided into two sections. The first section will discuss the relevant circumstances of depression for which the acceptance and mindfulness strategies of ACT may be a more effective response. The guidelines in this section will also incorporate the more behavior-oriented ACT processes such as *committed action* and *values*, as there are certain features of depression for which these ACT processes can be very useful. The second section of guidelines will discuss the relevant circumstances of depression for which the cognitive restructuring techniques of CBT may be a more effective response. For certain subsections of these guidelines, I will incorporate illustrations of a theoretical clinical vignette centered around a fictional character with MDD named *Jimmy*.

The forthcoming guidelines are not making a recommendation of using either acceptance or restructuring strategies for every possible experience of depression. There are surely numerous circumstances where the superiority of using one approach over the other may be ambiguous, such as with normal day-to-day maladaptive thinking. In these ambiguous circumstances, the choice of either acceptance/mindfulness or cognitive restructuring may be a

matter of client personal preference, a judgment based on previous experience, or therapist recommendation, rather than theoretical rationale.

That said, the chief purpose of these guidelines is to highlight particular circumstances where an acceptance/mindfulness approach may be more efficacious than a cognitive restructuring approach, and where a cognitive restructuring approach may be more efficacious than an acceptance/mindfulness approach (and also provide rationale for why this is the case). Additionally, the guidelines will highlight a few advantageous possibilities that ACT and CBT each uniquely bring to the table, to emphasize the benefit of taking an eclectic approach with these two theories.

Lastly, the content of the upcoming guidelines is derived from a few different methods and sources. For one, I have synthesized and distilled ideas from other authors who have also compared the efficacy of acceptance and cognitive restructuring strategies across different circumstances. Additionally, this set of guidelines is drawing from writing that independently discusses mindfulness, acceptance, and cognitive change strategies, in terms of the circumstances and purposes these techniques are individually designated for (i.e., irrespective of comparison). Furthermore, I am also incorporating my own original thoughts that have developed over my time with this literature. Although many of the concepts in this set of guidelines aren't novel, the synthesis and organization of these concepts in this way has resulted in, to my knowledge, the first thorough set of guidelines for systematically using both acceptance/mindfulness and cognitive restructuring techniques in clinical practice.

When it May be More Advantageous to use Acceptance and Commitment Strategies

When Thoughts or Beliefs are Justified

In their book on behavioral interventions in CBT, Farmer and Chapman (2008) suggest that when a client's cognitive or emotional response to a given circumstance is justified, or in other words, "is warranted by the current situation" (p. 258), then acceptance and mindfulness strategies may be a more effective response than cognitive change strategies. In addition, Judith Beck recommends in her recent instructional book on CBT that when unhelpful thoughts and beliefs are *accurate*, using acceptance strategies, shifting one's focus back onto their values, and applying problem-solving strategies to the situation is the go-to response (J.S. Beck, 2021). To better understand the rationale for these suggestions, I will explain how cognitive restructuring is an ineffective response to cognitions that are accurate to the situation.

Cognitive restructuring generally begins with a process of evidence assessment for the purpose of exposing the inherent invalidity (i.e., inaccuracy) of a thought or belief (Clark, 2013). After a thought is exposed as invalid, it can be substituted with an alternative thought or belief that more accurately reflects the situation and is helpful to the client. However, the process of evidence assessment and substitution is contingent on the maladaptive thought or belief being identified as one that is inaccurate and invalid. Therefore, when a thought or belief is valid to begin with (is accurate to the situation), the traditional multi-step approach of CR is not viable, and a different approach must be employed to effectively respond to the maladaptive thought or belief.

Thus, in this circumstance, Farmer and Chapman (2008) suggest that acceptance and problem-solving strategies are a more effective response than cognitive change strategies. However, these authors do not provide much detail beyond this suggestion. I am going to extend

their suggestions via illustration of a more specific and nuanced clinical vignette, and supplement additional ACT processes into the suggested response.

This clinical vignette is centered around a major feature of depression, in which the client will experience a high frequency of thoughts or beliefs that are maladaptive in nature and predominantly focus on the negative aspects of one's life (A.T. Beck, 2002). These cognitions subsequently cause or reinforce adverse emotional or behavioral responses, which in turn reinforce depressive symptoms. In CBT, cognitive restructuring strategies are used when these maladaptive thoughts and beliefs are characterized by cognitive distortions, invalidity, irrationality (J.S. Beck, 2021). Again, I will illustrate the use of acceptance and commitment strategies in this circumstance wherein maladaptive thoughts or beliefs are in fact *justified*. I will describe a theoretical situation in the life of *Jimmy*, a fictional character with MDD, through the lens of the cognitive model of CBT.

> Before Jimmy had begun working with his therapist, he had been in and out of jobs. Jimmy was overly picky about his work environment, and he generally felt a lack of motivation that often made it difficult to complete his work responsibilities. Jimmy and his therapist collaboratively uncovered a persistent automatic thought which eventually evolved into a belief: "I am unable to hold a job". This persistent thought often communicated meanings of self-judgement, disappointment, and incompetence. Additionally, these thoughts often lead to sadness and amotivation, which in turn lead to maladaptive behavioral responses.

After Jimmy and his therapist performed an evidence assessment of the persistent thought, Jimmy's therapist realized that although Jimmy's persistent thought and belief was causing him distress, it was fairly accurate to his recent experiences. Due to this fact, cognitive restructuring was not a viable course of action. Jimmy's therapist discerned that acceptance and commitment strategies along with problem-solving strategies would be an effective response. The therapist guided Jimmy in the *acceptance* techniques of ACT, so that Jimmy would feel less distress when thinking of his incapability of holding a job. Jimmy was taught *defusion* and *self-as-context* techniques, which allowed him to realize that his thoughts don't need to be taken so seriously, and that he could perceive himself as separate from his thinking and feeling states. This newfound conception of himself and his thinking greatly improved Jimmy's relationship with his distressing thoughts and emotions.

Jimmy was also guided in *values* and *present moment awareness* strategies. These processes allowed him to realize that his disruptive thoughts related to his recent occupational experiences did not serve a functional purpose towards achieving his goals in the present moment, and that he could redirect his focus and effort back into values-based action. Lastly, Jimmy began practicing *committed action* techniques, which encouraged him to apply his problem-solving and skills-training strategies with increased motivation and commitment. Although the learning and practicing of these ACT strategies was a considerable time commitment that spanned over many sessions of therapy, these were efficacious strategies that could be readily applied to a wide variety of circumstances.

ACT Strategies May be Useful When Maladaptive Thoughts or Beliefs are Reinforced by Life Experiences

To further extend the points of Farmer and Chapman (2008), the acceptance and commitment approach would also come in handy when maladaptive thoughts or beliefs are confirmed or reinforced by life experiences, therefore making certain thoughts or beliefs appear *more justified or accurate*. One narrow but important case is when the behavioral experiments of CBT do not result in the desired outcome. In this case, the outcome of a behavioral experiment may end up further reinforcing the maladaptive belief or thought which the behavioral experiment initially sought to disprove. However, a more broadly applicable case is when a client finds themselves in a circumstance where they are building awareness of specific maladaptive beliefs and thoughts, yet may have those beliefs and thoughts inauspiciously confirmed or supported by certain life experiences. I will briefly illustrate this latter case.

> Jimmy is aware that he has socially awkward behavioral proclivities that sometimes create awkward or uncomfortable social situations. Although Jimmy is improving via social-skills training, and working on strengthening new adaptive beliefs about his social skills, he still finds himself in situations where he's committed a faux pas, which reinforce his residual negative beliefs and distressing thoughts about his still-present socially awkward behavior.

In this circumstance, cognitive restructuring techniques would be of use in evaluating any maladaptive extrapolations or conclusions that arose from the events of social awkwardness (J.S. Beck, 2021). However, in terms of Jimmy responding to the actual event of his still-present social awkwardness and its reinforcement of any persisting negative beliefs or thoughts, the aforementioned ACT strategies may be the best response. Applying the ACT strategies in this

circumstance would help Jimmy accept that he still has socially awkward tendencies, and take committed action towards the improvement of his social skills in the present moment.

To Aid in Emotion Regulation

ACT acceptance/mindfulness techniques can be taught to clients to provide an effective strategy for emotion regulation. Dysregulated affect is a primary feature of major depressive disorder. Individuals suffering from depression often experience an excess of dysregulated unpleasant emotions – namely sadness, anger, guilt, shame, and anxiety (Berenbaum et al., 2003). Additionally, research has shown that people with depression tend to more frequently utilize maladaptive emotion regulation techniques such as suppression and rumination, and have a reduced ability to use adaptive emotion regulation techniques such as distraction or appraisal (Joormann & Stanton, 2016). As follows, a core component of many therapeutic interventions is to reduce emotional dysregulation and increase adaptive emotion regulation for the purpose of improving client functioning and well-being (Papa et al., 2012).

In its earlier forms, CBT had been chiefly focused on restructuring maladaptive cognitions, yet it has since broadened its scope to more systematically include emotion regulation techniques such as reappraisal, and also to prevent emotional avoidance in clients (Joormann & Stanton, 2016). Additionally, acceptance techniques are commonly endorsed or suggested by proponents of CBT as an effective emotion regulation strategy. For example, the notable instructional book on CBT, *Cognitive Behavior Therapy: Core Principles for Practice*, strongly advocates for acceptance techniques as an effective emotion regulation strategy to be used in the practice of CBT (O'Donohue & Fisher, 2008). Additionally, Judith Beck (2021)

suggests the use of acceptance and mindfulness techniques as effective emotion regulation strategies in her recent instructional book on CBT.

In terms of how acceptance/mindfulness techniques may be uniquely advantageous compared with other emotion regulation strategies, Hallis and colleagues (2016) suggest that acceptance/mindfulness may be particularly effective when the emotions are especially intense or difficult to cope with. Judith Beck (2021) makes a similar suggestion, stating that acceptance and mindfulness is useful when clients are dealing with emotions or other internal experiences that are intense or disturbing.

The place of acceptance techniques within depression interventions is rightly justified, as depression is often characterized by avoidant behavior and non-accepting attitudes towards emotions (Ottenbreit & Dobson, 2004). For example, a meta-analysis of studies examining the connection between people's attitudes towards their emotions and their depression severity, found that attitudes of non-acceptance of emotion, fear of emotion, and distress intolerance were all significantly associated with depression severity (Yoon et al., 2018). Additionally, a meta-analysis examining the efficacy of acceptance techniques for a range of different goals found that acceptance techniques were an effective strategy for regulating emotion (Kohl et al., 2012).

I will now discuss how ACT techniques can be an efficacious strategy for emotion regulation. A paper by Blackledge and Hayes (2001) is entirely devoted to discussing the use of acceptance and commitment techniques for emotional regulation, and I will discuss the key theoretical aspects of the paper.

Firstly, much of the motivation for using acceptance techniques in therapeutic interventions stems from the countless studies showcasing the detriments of experiential

avoidance and suppression of disturbing internal experiences. A wide variety of harmful effects caused by emotional avoidance and suppression have been recorded (e.g., Chawla & Ostafin, 2007), yet for the sake of brevity I will just cover a handful of notable consequences. Gross and John (2003) performed a number of studies on emotional suppression, revealing that emotional suppression is associated with an increase in the same negative affect that's attempting to be suppressed, an increase in the tendency to ruminate, a decrease in the experience of positive affect, a decrease in one's ability to repair mood, and a decrease in various factors related to well-being and interpersonal function. To broadly summarize the literature, emotional avoidance and suppression is shown to be a pernicious emotion regulation strategy associated with a wide variety of harmful consequences (Salters-Pedneault et al., 2010).

Acceptance techniques effectively seek to do the opposite of avoidance and suppression. Many clients innately operate within a mental context characterized by an avoidant or suppressive orientation towards unpleasant emotions. This orientation treats unpleasant emotions as sensations that must be quickly eliminated or changed in a prompt and often reflexive manner, which can frequently lead to suppression and its consequences. The *acceptance* process of ACT instructs clients (generally through metaphors and experiential exercises) to create a context wherein unpleasant emotions are no longer seen as sensations to run away from, but to wholeheartedly feel and experience in their entirety (Blackledge & Hayes, 2001).

Additionally, the *defusion* processes of ACT are intended to improve client's experience of willingly feeling unpleasant emotions, as clients are meant to "feel feelings as feelings" and experience emotions "simply as constellations of physiological sensations, urges, and so on that have no intrinsic power to harm us or hold us back" (Blackledge & Hayes, 2001, p. 247). Furthermore, the *self-as-context* process of ACT leads to a particular conception of the *self* as

being separate from or not composed of our emotional sensations, which enables the experience of emotions from the point-of-view of a detached or transcendent observer (Hayes et al., 2012). Experiencing emotions from the *self-as-context* point-of-view can enhance a client's ability to accept and defuse from emotions. Lastly, it's important to note that acceptance for emotion regulation in ACT is a process performed for the ultimate goal of living in accordance with one's values in the present moment. Thus, acceptance of emotion is always performed with this goal in mind.

Altogether, these aforementioned ACT processes lead to an orientation of acceptance and a willingness to feel emotion. Research has shown acceptance to be a much more effective and less detrimental emotion strategy approach than avoidance or suppression (Lindsay & Creswell, 2019). Additionally, while acceptance is considered to be a versatile response to all forms of unpleasant emotion, acceptance is thought to be an especially useful emotion regulation strategy in the face of more intense, disturbing, or difficult emotion (Hallis et al., 2016; J.S. Beck, 2021). Therefore, acceptance/mindfulness techniques from ACT may certainly be an advantageous option for clients who struggle with intense emotions, suppression, or avoidance.

Avoidance of Internal or External Experiences

Much of what's been said about teaching clients acceptance strategies as a substitute for avoiding unpleasant emotions can also be said about teaching clients acceptance strategies as a substitute for avoiding various other unpleasant internal or external experiences. Avoidance of disturbing internal experiences is termed *experiential avoidance*, and it refers to when "a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or

frequency of these events and the contexts that occasion them" (Blackledge & Hayes, 2001, p. 244). Teaching a client acceptance and commitment strategies can be very helpful if a client engages in experiential avoidance. In addition, many clients would generally benefit from a reduction in avoidant attitudes and the acquisition of open and accepting attitudes in dealing with the experiences of their disorder.

Experiential avoidance is effectively the antithesis of acceptance (Herbert & Forman, 2009). Avoidance has been significantly linked to the severity of anxiety and depression symptoms in a number of studies (Berking et al., 2009; Chawla & Ostafin, 2007; Kashdan et al., 2006) and is a principal construct targeted by many systems of therapy. A common form of experiential avoidance is thought suppression, which like emotional suppression, has been linked to a number of counterintuitive and deleterious consequences. For example, Wegner and Zanakos (1994) conducted a number of studies on thought suppression and observed that suppression attempts often lead to clients' suppressed thoughts being subsequently maintained and amplified in intensity. They found that this "rebound of [suppressed] thought" (p. 618) often occurred in stream-of-consciousness thinking when clients were thinking of the same topic or found themself in the same mood as when the suppression occurred. Given these counterintuitive effects of suppression, it is no surprise that levels of thought suppression (as measured by the White Bear Suppression Inventory) predicted levels of depressive/anxious affect and obsessive thinking in their patients (Wegner & Zanakos, 1994).

Due to the prevalent and harmful nature of avoidant behavior in many common disorders, experiential avoidance is a primary target within the transdiagnostic system of ACT. As an alternative to experiential avoidance clients will learn to embody *psychological acceptance*, which is "an intentionally open, receptive, flexible, and non-judgmental posture with respect to

moment-to-moment experience" (Hayes et al., 2012, p. 77). The ACT form of acceptance is an active process of willingly accepting and embracing the unpleasant experiences of one's disorder.

However, a client must cohesively engage all of the ACT processes in tandem with psychological acceptance to most effectively respond to experiential avoidance. The combined emphasis on present-moment awareness, committed action, and achieving values-based living will greatly enhance and direct the process of psychological acceptance (Hayes et al., 2012).

Apart from circumventing the psychological consequences of avoidance and suppression, a number of studies suggest that when disturbing internal experiences are responded to with psychological acceptance, those internal experiences become significantly less disturbing. Firstly, myriad studies show that responding with psychological acceptance significantly lessens the intensity of psychological distress directly related to having cancer, and also mitigates the general distress experienced by cancer patients (Secinti et al., 2019). Secondly, the perturbing sensations of addiction cravings are felt remarkably less intensely when using psychological acceptance techniques (Larimer et al., 1999). Thirdly, physiological sensations of pain are felt significantly less intensely while using acceptance techniques compared with suppression and spontaneous coping conditions (Masedo & Rosa Esteve, 2007).

In conclusion, when clients respond with psychological acceptance to their disturbing internal experiences (e.g., thoughts, emotions, memories, physiological sensations, etc.), they are less likely to experience the harmful consequences of avoidant behavior, and may also decrease the intensity of distress accompanying their internal experiences. As I mentioned in the previous section, psychological acceptance of disturbing experiences is not an end goal in itself, but one step in the process of achieving values-based living. From a strong foundation of psychological acceptance, clients are more empowered to act in alignment with their goals and values in the

present moment. This extension of acceptance/mindfulness is one example of what makes ACT unique among other mindfulness-based therapies, and some clients may particularly value or benefit from the merging of acceptance, mindfulness, committed action, and values processes into an unified procedure.

Responding to Maladaptive Obsessive Thought Processes (e.g., Rumination, Worry, Self-criticism)

Acceptance/mindfulness strategies can be a very effective response to maladaptive obsessive thought processes such as rumination, worry, or self-criticism. From this list, ruminative thinking is particularly prevalent in depressed individuals (Nolen-Hoeksema, 1991). According to response-styles theory, rumination is a form of responding to distress that causes one to engage in a passive, cyclical, and repetitive thinking often narrowly focused on distressing symptoms or experiences, and on the causes or consequences of such symptoms and experiences (Nolen-Hoeksema et al., 2008). There is ample research showing that ruminative thinking exacerbates and prolongs depressive symptoms, augments negative thinking, and interferes with adaptive functioning and social support (Nolen-Hoeksema et al., 2008).

In Judith Beck's recent instructional book on CBT (2021) she emphasizes the effectiveness of using mindfulness to respond to obsessive thought processes such as rumination, worry, or self-criticism. In a case example outlining how to effectively respond to ruminative thinking, Beck states that cognitive change approaches can be an ineffective response to rumination, and recommends the use of mindfulness strategies instead:

> Responding to his thoughts was important, but it just wasn't effective enough. After learning mindfulness, Abe was able to recognize when he was ruminating, accept the experience and his negative emotion, and then choose not to engage with his thoughts. Initially, he learned to do this by focusing on his breath and then later was able to focus on his external experience. (J.S. Beck, 2021, p. 275)

Depressed individuals often get caught in long cycles of ruminative thinking because disengaging one's attention from the negative material is especially difficult (Koster et al., 2011). Mindfulness is an effective response to rumination (and other obsessive thought processes) because it directly counteracts the innate difficulty of cognitively disengaging from rumination, by creating contextual changes that take the entrancing or attention-stealing power away from self-relevant ruminative thoughts (Masuda et al., 2004).

For example, when a client engages the ACT mindfulness processes *defusion*, *self-as-context*, and *present moment awareness*, thoughts are viewed under a new metacognitive context. This context is characterized by the perception of thoughts as passing mind-information with no intrinsic or literal meaning, that is contained by, and not characteristic of, the *self* (Masuda et al., 2004; Hayes et al., 2012). When reorienting within this new context, ruminative thoughts can lose their hypnotic or entrancing quality, and clients are in a better position to discern whether their thinking is functionally useful to achieve their goals and values in the present moment. Thus, when operating in this new context created by ACT mindfulness processes, a client is much more empowered to disengage their attention from ruminative thinking and redirect it towards values-based action in the present moment.

A number of empirical studies support the efficacy of using mindfulness strategies to disengage from ruminative thinking. Jain and her colleagues (2007) conducted a randomized control trial (RCT) comparing the efficacy of mindfulness meditation versus relaxation training in reducing ruminative and distracting thoughts, distress, and increasing positive states of mind. The researchers found that the group receiving training in mindfulness meditation experienced a significant post-test reduction in ruminative and distracting thoughts and behavior, compared with the relaxation training and no-training control group (Jain et al., 2007). The study's mediation models also suggested that the positive effects on distress brought about by the mindfulness meditation training were mediated by decreases in ruminative thinking levels. For more RCTs supporting the efficacy of using mindfulness to improve levels of ruminative thinking, see Heeren & Philippot (2011), Labelle and colleagues (2010), or Campbell and colleagues (2012).

When it May be More Advantageous to use Cognitive Restructuring Strategies

When Thoughts or Beliefs are Unjustified, or When Clients Value Accurate Thinking

In their book *Behavior Interventions in Cognitive Behavior Therapy*, Farmer and Chapman (2008) discuss different client circumstances for which an acceptance or cognitive change response may be more effective. They suggest that when a client's response to a circumstance is unjustified (i.e., does not accurately reflect the reality of the circumstance, or is not a warranted response), the most effective approach is to either help the client change their response to one that is more congruent with the reality of the circumstance (i.e., using cognitive

restructuring), or help the client apply acceptance techniques but avoid acting in a manner that perpetuates the unjustified cognitions.

Furthermore, Ciarrochi and Bailey (2008) state that clients can sometimes value or prioritize accurate thinking and the awareness of cognitive errors. Similarly, Hallis and colleagues (2016) suggest that cognitive restructuring is useful "when you want to find out whether or not your thoughts are accurate" (p. 201). Thus, for the type of client who values accurate mental schemas or seeks to evaluate the accuracy of their cognitions, the process of cognitive restructuring would be an indispensable tool in deciphering whether or not their thoughts or beliefs are accurate to the situation.

Using Cognitive Restructuring to Respond to Cognitive Distortions

I will flesh out the advantages of using cognitive restructuring strategies when cognitions are unjustified/inaccurate, or when clients value accurate thinking, in the context of using cognitive restructuring to identify and respond to cognitive distortions. Cognitive distortions (otherwise known as cognitive errors) are an important treatment component of CBT for depression (Yurica & DiTomasso, 2005). Cognitive distortions are certain errors in cognition that affect a client's thinking patterns on a systematic level. The thinking of mentally healthy individuals is characterized by many adaptive cognitive errors that distort reality in a positive direction (Kendall, 1992). However, the thinking patterns of depressed individuals are characterized by cognitive errors that distort reality in very negative directions, and frequently lead to disturbing, stressful, or fearful states (Bowins, 2004).

There are many distinct forms of cognitive distortions commonly found in the mind of the depressive client. Aaron Beck initially defined six forms of cognitive distortions in the late

1960's, yet the list has since been extended by subsequent researchers (Yurica & DiTomasso, 2005). For example, the depressed client can have the proclivity to magnify the negative aspects and minimize the positive aspects when evaluating themselves, an event, etc. (*magnification/minimization*, Burns, 1981). Additionally, depressed clients can experience *dichotomous/black-and-white thinking*: the tendency to perceive a situation as fitting into two polar opposite categories (e.g., entirely good or bad), rather than viewing the situation as a continuum with nuanced components or conclusions (Burns, 1981).

I will illustrate a scenario in which Jimmy experiences cognitive distortions while he's at work, and use the example to elucidate why it may be more effective to respond to cognitive distortions with a cognitive restructuring approach rather than an acceptance/mindfulness approach.

> Jimmy eventually secures a job he is fond of, working as an assistant software engineer at a very large software development company. After a few weeks at work, Jimmy is generally content with his position and work environment, and he feels much more confident in his ability to complete his work responsibilities. One afternoon, Jimmy has a spontaneous meeting with one of the two project managers overseeing Jimmy's work. The project manager speaks to Jimmy about some mistakes Jimmy had made in following instructions when working on a very important project. Since it is Jimmy's first time making a mistake, the project manager tells Jimmy not to worry too much, but just to be more conscious in the future when following directions. As Jimmy gets back to work, he begins to experience some maladaptive automatic thoughts such as, "what if he was considering firing me – he's probably still thinking about firing me." During the next

day at work, Jimmy has interactions with both of his project managers and they appear to sound much more cold and irritated with him than usual. For the rest of the workday and when Jimmy returns home, Jimmy is overloaded with many thoughts pointing to the conclusion that his project managers are planning on firing him for his recent mistakes. These thoughts lead to anxiety, frustration, and rumination. As time passes, it becomes clear to Jimmy that his corrective meeting with one of his project managers, quickly followed by the cold tone of both his project managers, is definitive evidence that his project managers are planning to fire him. Jimmy returns to work thinking that it's only a matter of time before he will receive the unfortunate news.

Two cognitive distortions known as *Jumping to Conclusions* and *Catastrophizing* (Yurica & DiTomasso, 2005) were responsible for Jimmy interpreting the occurrence of a corrective meeting as definitive evidence for his imminent termination. Additionally, the cognitive distortion known as *Mind Reading* (Yurica & DiTomasso, 2005) led Jimmy to derive arbitrary and overblown conclusions from the cold demeanors of his project managers. Overall, the interplay of these events and cognitive distortions led to the misperception that Jimmy's project managers were intent on firing him, and these distorted thoughts led to disturbing states such as anxiety and rumination.

In the circumstance where a client misperceives an event or situation at the hands of cognitive distortions, it may be more advantageous to use cognitive restructuring strategies over acceptance/mindfulness strategies (Hallis et al., 2017). This is also an argument that can be made for certain unjustified or inaccurate thoughts, as they are also distortions, yet to a far lesser

degree. I will discuss the following viewpoints to provide a rationale for why cognitive restructuring may be the most effective response to cognitive distortions.

Firstly, it is common for people with MDD to have a large number of cognitive distortions that are often being perpetuated without their knowledge. Blake and colleagues (2016) classified half of the depressive participants in their study as "high distorters", meaning that a median of 5 distinct cognitive errors (and as high as 10) became manifest during *a single* 50-minute session of talk therapy. Because cognitive distortions are so prevalent in people with MDD, and they frequently lead to disturbing and self-debasing states (Bowins, 2004), it may be more effective to take a very direct and targeted approach to identifying and restructuring cognitive distortions.

Proponents of ACT often express the stance that ACT does not directly seek to change symptoms or cognitions, but cognitions will often change as a natural byproduct of cultivating psychological flexibility as one progresses with treatment (Hayes et al., 2012). Additionally, ACT theory does not directly address the construct of cognitive distortions (to the best of my knowledge). Therefore, when taking the ACT approach to cognitions, one is likely to think that because cognitive distortions may gradually go away on their own without the need for direct identification and restructuring, cognitive change strategies are unnecessary.

However, if given the choice between using acceptance strategies and cognitive restructuring strategies in treating clients with cognitive distortions, cognitive restructuring is likely the superior response when prioritizing *efficiency* and *thoroughness* in matching therapeutic strategies with client issues. Put simply, a client may be able to much more *efficiently* and *thoroughly* remedy their cognitive distortions if the client utilizes an approach (i.e., cognitive restructuring) that actively seeks to precisely identify and restructure cognitive distortions, rather

treating the elimination of cognitive distortions as an incidental byproduct of other therapeutic processes.

Secondly, because cognitive distortions are "a systematic negative bias in the cognitive processing of clients" (J.S. Beck, p. 252), and as such have pervasive effects, it is worth taking steps to directly and thoroughly restructure cognitive errors. Since cognitive errors are a systematic issue, clients can often experience the same cognitive distortions negatively influencing their responses to a variety of different circumstances. For example, while Jimmy exhibited the cognitive distortions of *catastrophizing* and *mind reading* in response to specific circumstances in his work environment, it is likely that these same cognitive distortions will systematically affect his thinking in other contexts as well. It is likely that Jimmy's cognitive error of *jumping to conclusions* would compel him to draw irrationally negative conclusions in other circumstances as well.

Therefore, because cognitive distortions are a systematic issue that often have pervasive effects, taking steps to thoroughly restructure a cognitive error may in turn lead to systematic improvements in one's thinking patterns that can permeate across a variety of different circumstances (Burns, 1981). This point is especially important when a cognitive distortion consistently results in disturbing states such as anxiety, frustration, and rumination in the case of Jimmy. It's possible to use acceptance in the face of all of these experiences, yet it may be more efficient to eliminate the systematic *cause* of all of these maladaptive responses (i.e., the distortion itself), rather than continuously using acceptance/mindfulness in response to the secondary effects of the distortion. Therefore, due to the systematic positive changes that can ensue from taking a restructuring approach to cognitive errors, cognitive restructuring may be the worthwhile approach.

Thirdly, a helpful consideration for therapists aiding clients with cognitive distortions is the potential detriment of responding to cognitive distortions with acceptance techniques. If a client responds to a cognitive distortion with acceptance, and without evaluation or challenge, the cognitive distortion will be treated just like any other thought. Without an approach of evaluation, the client is not in a position to discover that the cognitive error is in fact an error. Therefore, the acceptance approach may lead to the perpetuation (or perhaps a slower rate of elimination) of the cognitive error and its resulting misperceptions beyond the awareness of the client. This circumstance can have a handful of consequences, but it can be especially damaging when the client begins to make decisions or perform actions from the basis of accepted distorted thoughts and misperceptions.

For example, when Jimmy returns to work the next day thinking that his dismissal at the hands of his project managers is imminent, Jimmy may in turn behave and make decisions during work on the basis of these distorted cognitions. For example, Jimmy may engage his duties with less care and effort, because he thinks there's a high chance he will get fired anyways. Jimmy may also behave more nervously in his workspace or when speaking to his project managers, which could lead to negative perceptions being cast upon him. There are likely other potential examples of poor behavior at work that could arise if Jimmy were to not evaluate or challenge his erroneous thinking. Broadly speaking, similar circumstances like this could occur if a client does not evaluate or challenge distorted schemas and their resulting misperceptions, and begins to make judgments and behave from the basis of unchallenged distorted schemas.

In conclusion, when a cognitive distortion leads to disturbance or impediment for the client, the process of precisely identifying and thoroughly restructuring the distortion may

provide a greater benefit than the more passive acceptance/mindfulness approaches. Additionally, thoroughly restructuring cognitive distortions may lead to helpful systematic changes in cognition that can yield positive effects across a variety of different situations. This point exemplifies well the potential utility of the eclectic approach, as the varying issues of a disorder or client (in this case cognitive errors) may be more effectively addressed when drawing from a diversity of theory and methodology, rather than an allegiance to a singular framework.

Questioning the Value of Using Cognitive Restructuring for Cognitive Distortions and Other Invalid Cognitions: The Cognitive Mediation Debate

It is difficult to find empirical research that supports the value and effectiveness of using cognitive restructuring to treat cognitive distortions. This is partly because it would be very difficult to study cognitive restructuring and cognitive distortions together, as isolated constructs stripped from other related components of CBT. Additionally, effectively measuring the construct of cognitive distortions in an experimental setting is a difficult feat (Blake et al., 2016). Likely the closest we can get to empirically supporting the value of using cognitive restructuring to treat cognitive distortions are studies which assess cognitive restructuring as an isolated component of CBT – in terms of whether cognitive restructuring on its own can successfully change maladaptive cognitions (e.g., attitudes, automatic thoughts, beliefs) and produce positive treatment results.

Interestingly, there is an ongoing debate as to whether the cognitive change components of CBT actually contribute to the successful outcomes often seen in empirical research, or whether the non-cognitive components (i.e., the behavioral components) are primarily responsible for the successful outcomes of CBT (Longmore & Worrell, 2007). Most notably,

Hayes and his colleagues (2011) outline a number of empirical findings that challenge the efficacy of cognitive change strategies, leading to the conclusions that (a) component analyses of have failed to support the effectiveness of cognitive change components of CBT, (b) that rapid improvements in symptoms are often seen before cognitive change interventions are introduced to clients, and (c) there is no empirical consensus on the validity of the cognitive mediational model (i.e., whether cognitive change mediates symptom improvement, Quilty et al., 2008). However, these critiques of CBT by Hayes and his colleagues have been rebutted extensively by Hofmann & Asmundson (2008).

In terms of whether the cognitive mediational model achieves its goal of cognitive change to begin with, there is sufficient evidence that cognitive restructuring strategies do in fact lead to a decrease in maladaptive cognitions such as dysfunctional attitudes, automatic thoughts, beliefs, etc. (Garratt et al., 2007; Lorenzo-Luaces et al., 2015). However, when it comes to the question of whether those changes in maladaptive cognition actually mediate symptom improvement in depressed patients, the results are still mixed and the answer to the question may be more complicated than we think. One of the complexities pointed out by Hofmann (2008) in his analysis of the common misconceptions in cognitive mediational research, is that "component analysis cannot answer the question of mediation because cognitions can change and mediate treatment through a number of ways, not only through direct cognitive challenges" (p. 67).

However, in an impressive review of cognitive mediational research, Lorenzo-Luaces and colleagues (2015) conclude that "cognitive procedures are effective in alleviating symptoms of depression and that cognitive change, regardless of how it is achieved, contributes to symptom change, a pattern of findings that lends support to the cognitive theory of depression" (p. 3).

They also discuss the methodological and inferential limitations of much of the cognitive mediational research, and propose a framework that allows for causal links to be made between cognitive change strategies, cognitive change, and symptom improvement (Lorenzo-Luaces et al., 2015).

In conclusion, there is ample evidence that cognitive change strategies do in fact change maladaptive cognitions such as dysfunctional attitudes, automatic thoughts, and beliefs, yet the debate is still ongoing as to whether these changes in cognition mediate symptom improvement in depressed individuals, or whether symptom improvement is primarily occurring through a different mechanism other than cognitive change. However, regardless of this ambiguity in clinical research, when a cognitive distortion appears to be causing some disturbance in a client, and the therapist discerns that this disturbance may be improved via the restructuring of the distortion, engaging in cognitive restructuring may be a worthwhile endeavor.

Restructuring Beliefs

A primary focus of CBT is identifying and restructuring maladaptive beliefs related to client's conception of the world, self, and future (Dozois & A.T. Beck, 2005). Judith Beck makes a distinction between *core beliefs*, which are clients' most fundamental beliefs about themselves and the world, and *intermediate beliefs*, which are the often unarticulated attitudes, rules, and assumptions held by the client (J.S. Beck, 2021).

When clients' core beliefs are inaccurate, judgmental, or unhelpful, this can pose a remarkable detriment to their sense of self-worth, self-efficacy, and vulnerability to mood disturbances (Wenzel, 2012). Additionally, the identification and restructuring of maladaptive beliefs can lead to many positive outcomes for the depressed client. For example, restructuring

maladaptive core and intermediate beliefs is an essential component of eliminating maladaptive automatic thought patterns, which according to the cognitive model are primarily responsible for catalyzing negative mood states and maladaptive behavior (J.S. Beck, 2021).

Furthermore, many empirical studies conducted in this field have shown that pre-existing maladaptive beliefs and attitudes are the primary cognitive risk factors that increase cognitive vulnerability to depression, and predict depressive symptoms when activated by stressful life events (for a comprehensive review of empirical research on the diathesis-stress model, see Dozois & Beck, 2008). For example, Halvorsen and her colleagues found that measures of core beliefs (i.e., early maladaptive schemas, measured by Young Schema Questionnaire) predicted episodes of major depression and levels of depression severity in 115 clinically depressed, previously depressed, and never depressed individuals across a nine-year follow-up period.

Within the system of CBT, the benefit and importance of restructuring maladaptive beliefs and schemas cannot be downplayed. However, over the past few decades these benefits have been explicated in great length by proponents of CBT. For this set of guidelines I will focus on a less commonly discussed yet nevertheless important usage of cognitive restructuring as it relates to belief change: using cognitive restructuring to intentionally strengthen or formulate adaptive beliefs and attitudes (i.e., core and intermediate beliefs).

Cognitive Restructuring is Useful for Intentionally Forming Adaptive Beliefs

Using the process of cognitive restructuring, a client can work with a therapist to intentionally replace maladaptive beliefs with new and individualized adaptive beliefs related to self- and world-conception. Some examples of adaptive beliefs are: “I’m responsible, considerate, competent, self-reliant” and “I can cope (if bad things happen)” (J.S. Beck, 2021, p.

45). The elimination of negative (maladaptive) beliefs has traditionally been the dominant focus of CBT, yet an increased focus on the formation of positive (adaptive) beliefs has recently been developing. For example, The Beck Institute of CBT has been advancing a new formulation of CBT named recovery-oriented cognitive therapy (CT-R, A.T. Beck et al., 2020). In speaking of the major differences between traditional CBT and CT-R, Judith Beck (2021) writes that CT-R is founded on the same theoretical principles of CBT (cognitive model, treatment delivery, etc.), "but it adds an additional emphasis on the cognitive formulation of clients *adaptive* beliefs" (p. 7), rather than primarily focusing on clients symptoms and psychopathology. Recovery-oriented cognitive therapy was originally developed for serious mental-health conditions such as schizophrenia, yet it is currently in the process of being adapted to a wide range of conditions by The Beck Institute.

There are currently no sources that describe the specific processes involved in formulating adaptive beliefs, yet it is reasonable to assume that the same methods used to change maladaptive beliefs would also be used to formulate or strengthen adaptive beliefs. For example, thought records (McManus et al., 2012) could be used to recognize the supportive evidence for a new or developing adaptive belief, and behavioral experiments (Bennett-Levy, 2003) can be executed to generate or strengthen supportive evidence for a developing adaptive belief. Both of these strategies could serve the function of providing enough supportive evidence for a previously held adaptive belief to be strengthened or for a new adaptive belief to be adopted.

The possibility of using cognitive restructuring to intentionally formulate adaptive beliefs can lead to great benefits. For example, Lai and his colleagues (2014) assessed the effects of negative and positive personal beliefs (the cognitive triad: beliefs about self, the world, and the future) on various measurements of clients' adaptive functioning (their ability to perform

functional daily activities and adequately manage the conditions of their depression). They also tested whether personal beliefs mediated the correlation between learned resourcefulness (the ability to apply adaptive cognitive or behavioral skills to successfully manage one's symptoms and perform daily activities) and adaptive functioning.

The researchers found that the presence of positive personal beliefs, rather than merely the absence of negative beliefs, significantly predicted measures of adaptive functioning (Lai et al., 2014). Additionally, while learned resourcefulness significantly improved personal beliefs and adaptive functioning, the presence of positive personal beliefs was found to significantly mediate the relationship between learned resourcefulness and adaptive functioning. These findings indicate that changes in adaptive functioning may be occurring through changes in one's personal beliefs, which provides evidence for A.T. Beck's theory on the effect of personal beliefs on one's overall functioning and performance of daily activities (Lai et al., 2014).

Although this study sheds light on the importance of forming positive beliefs, there is generally a paucity of empirical research on the practical benefits of intentionally forming positive beliefs for the treatment of depression. The existing research is primarily concentrated in the recovery-oriented field, which has traditionally focused on more severe disorders such as schizophrenia and psychosis (A. T. Beck et al., 2020; Hodgekins & Fowler, 2010). I will discuss three potential benefits of using cognitive restructuring to intentionally formulate positive beliefs, attitudes, and assumptions when working with the depressed client.

Firstly, a client can directly work with a therapist to improve their self- and world-conception with positive belief and attitude formation. This can be very beneficial for the depressed client, as depressed individuals notably have disproportionately negative conceptions

of the self and world, which are the source of countless detrimental cognitive and behavioral consequences (Dozois & A.T. Beck, 2008).

One of the benefits of having a positive self-conception was examined in an experiment by Sedikides (1992). He found that participants with positively valenced self-conceptions reported feeling significantly happier when writing a story about themselves, when compared with participants with negatively valenced self-concepts. In a different condition, participants were asked to write about an acquaintance rather than themselves, and there was no difference in reported mood. Sedikides' study exemplifies how having either a positive or negative self-conception can influence mood when thinking or focusing on oneself. Thus, this study is one example of how intentionally building a positive self- and world-conception via the strengthening or formation of positive beliefs and attitudes, may be an advantageous use of cognitive restructuring (to read more about the benefits of having a positive self-concept, see Bracken and Lamprecht 2003).

Secondly, a potential benefit of using cognitive restructuring for adaptive belief formation is the capacity for intentionality and precision in replacing a maladaptive belief or attitude with one that is adaptive. To illustrate this point, if one were to exclusively practice ACT, new adaptive beliefs or self-conceptions may naturally form as a result of the behavioral, cognitive, and overall life improvements that would ensue from ACT (assuming the outcomes of ACT are occurring through the mechanisms of the cognitive model). Therefore, the formation or strengthening of adaptive core and intermediate beliefs would likely not be an intentional or targeted effort, but a secondary effect of other ACT processes.

However, with cognitive restructuring there is a much greater capacity for precision and intentionality in the formulation of adaptive beliefs, or the strengthening of those that already

exist. This is particularly evident when examining the use of thought records and behavioral experiments (two major components of the cognitive restructuring process), which are in large part directly designed for belief change (McManus et al., 2012). For example, if Jimmy and his therapist identified the maladaptive attitude, “If I avoid challenges, I’ll be okay, but if I try to do hard things, I’ll fail” (J.S. Beck, 2021, p. 48), they could directly target the replacement of this maladaptive attitude with one that is adaptive. Additionally, the adaptive substitute can be intentionally formulated by the client and therapist with some level of verbal specificity: “It’s important to work hard and be productive” or “It’s important to be responsible, competent, reliable, and helpful” (J.S. Beck, 2021, p. 48).

This capacity for the client to target the formation or strengthening of adaptive beliefs and attitudes can potentially be a very useful tool. Firstly, shifting self- and world-conception in a positive and non-depressogenic direction may be a more streamlined and thorough process, and secondly, clients can have far more control over how their self- or world- conception develops during the course of therapy.

A third potential benefit of intentional belief change, is that the formulation or enhancement of adaptive core and intermediate beliefs may lead to an increase in positive cognitions, such as adaptive thought patterns. This argument is predicated on the causal relationship between core/intermediate beliefs and automatic thought patterns outlined by the Beckian cognitive model. In the cognitive model, core/intermediate beliefs are thought to be directly responsible for the quality and form (e.g., adaptive or maladaptive) of the automatic cognitions that arise when interfacing with any given circumstance (J.S. Beck, 2021).

There is a growing amount of research investigating the advantages of having positive cognitions for a variety of clinical contexts. In one study, Zauszniewski and her colleagues

(2002) researched the role of positive cognitions in the development of learned resourcefulness (the ability to apply adaptive cognitive or behavioral skills to successfully manage one's symptoms and perform daily activities) and the improvement of depressive symptoms in 82 women with diabetes. Positive cognitions were defined as "specific positive thinking patterns that are thought to enhance one's ability to effectively manage daily activities and promote mental health" (p. 733).

The study found that positive cognitions strongly mediated the effects of depressive symptoms on learned resourcefulness. In other words, the degree to which a patient experienced positive thinking patterns significantly mediated the relationship between that patient's depressive symptoms and their ability to adaptively respond to the challenges of their depression and perform daily activities. Given these important mediational effects of positive cognitions, Zauszniewski and her colleagues stress the need for more interventions that strongly emphasize the formulation of positive cognitions in depressed clients, particularly when it comes to developing resourcefulness (2002).

Finally, holding true the causal relationship between intermediate/core beliefs and cognition outlined by the cognitive model (J.S. Beck, 2021; Dozois & A.T. Beck, 2008), formulating or strengthening adaptive core and intermediate beliefs may be an effective method of enhancing positive cognitions. However, more research must be conducted to empirically ascertain whether this prospective causal relationship also extends to the specific case of positive core/intermediate beliefs and positive cognitions.

In conclusion, using cognitive restructuring for the intentional formulation of positive core and intermediate beliefs may have a number of advantageous effects, and may be especially useful in the case of the depressed client. There is evidence to suggest that the formation of

positive beliefs may improve levels of learned resourcefulness in depressed individuals (Lai et al., 2014). Additionally, the formulation of adaptive beliefs, attitudes, and assumptions can directly lead to an improved self- and world-conception, which may be achieved with greater precision and intentionality when compared with ACT. Lastly, the formation of positive beliefs may lead to an increase in positive cognitions such as automatic thought patterns, yet more research must be completed to support this proposed causal connection. Given these potential advantages of intentionally formulating adaptive beliefs and attitudes, therapists and clients may benefit from practicing this use of cognitive restructuring.

When a Client Has Metacognitive Beliefs About Their Thinking Processes

Cognitive restructuring can be useful when a depressed client has metacognitive beliefs about their own thinking processes. In illustrating an example of this circumstance, Hallis and her colleagues write that, "you may believe that worrying or ruminating serves a useful purpose by protecting you, keeping you on guard or allowing you to solve problems. In this case, it may be helpful to challenge the reasonability of these beliefs and thoughts" (Hallis et al., 2016).

To illustrate the advantage of metacognitive belief change with regards to a metacognitive belief about one's own thinking processes, I will discuss maladaptive beliefs about ruminative thinking. Metacognitive belief change may be an especially useful strategy in the context of rumination, as depressed individuals with ruminative proclivities frequently possess a variety of maladaptive metacognitive beliefs about their own ruminative tendencies (Papageorgiou & Wells, 2001). For example, some depressed individuals believe that rumination is an effective strategy for coping with or analyzing their experiences of depression, and that engaging in rumination can be necessary. Other depressed individuals hold a belief that

rumination is uncontrollable, and that they are incapable of stopping themselves (and the list goes on, e.g., Papageorgiou & Wells, 2001).

Additionally, in a longitudinal study spanning one year, Weber and Exner (2013) found a significant effect of positive-valence beliefs about rumination (e.g., rumination is beneficial or useful) on the frequency of rumination, indicating a causal link between beliefs about rumination and the frequency of rumination. In a previous section on using ACT strategies to respond to obsessive thinking states such as rumination, I discussed how mindfulness strategies may be useful when one finds themselves engaging in (or about to engage in) obsessive cycles of thought. While this skill is important, restructuring metacognitive beliefs about obsessive thinking states such rumination may affect a client's underlying *propensity or desire to initiate* these states to begin with, as opposed to just responding to these states after they have already begun.

Therefore, using cognitive restructuring to change metacognitive beliefs about rumination may be a very effective strategy in improving a client's relationship with rumination. Furthermore, it's important to emphasize that this strategy may also be advantageous when it comes to clients' metacognitive beliefs about other types of thinking, such as clients beliefs about anxiety, states of incessant thinking, acceptance, worry, etc.

When a Client Has Metacognitive Beliefs About Their Emotions

Cognitive restructuring may also be useful when clients possess maladaptive metacognitive beliefs about their own emotions. For example, clients can believe that negative emotions are unsafe to experience or that they will lose control, and these beliefs can lead to harmful avoidance or suppression of certain emotional states or the situations that catalyze them

(J.S. Beck, 2021). In these circumstances it may be productive to guide clients in restructuring their beliefs about experiencing negative emotions. I will illustrate this point using Jimmy's clinical vignette:

> Jimmy has been struggling with anger for a good portion of his life. Jimmy's therapist recently uncovered a belief possessed by Jimmy: "anger is unsafe, because I will lose control." Largely due to this belief, Jimmy consistently suppressed any anger he was feeling. This belief even caused Jimmy to be fearful of experimenting with the acceptance-based emotion regulation skills he was learning with his therapist, and he continued to resort to using suppression with his anger. Additionally, Jimmy often avoided circumstances he thought would prompt his anger, such as important conversations with his family members. This avoidance and suppression was hindering Jimmy's ability to achieve his treatment goals and live a values-based life.

After uncovering Jimmy's metacognitive beliefs about anger, Jimmy and his therapist collaboratively designed a behavioral experiment that consisted of inducing states of anger during therapy, with Jimmy's therapist subsequently guiding him through mindfulness strategies for emotion regulation (idea taken from J.S. Beck, 2021, p. 237). The application of mindfulness techniques within the behavioral experiment allowed Jimmy to experience his capability of feeling his anger while simultaneously remaining in control.

This behavioral experiment provided evidence against his maladaptive belief that "anger is unsafe, because I will lose control." Additionally, the experiment provided ample evidence to support an *adaptive belief*, "I can feel my anger and still be in control", that was intentionally

spelled out by Jimmy and his therapist to be a logical conclusion of the experiment's success. As Jimmy integrated these experiments into circumstances outside of therapy, he collected enough experiential evidence to change his maladaptive belief, "anger is unsafe, because I will lose control", to his newly formulated adaptive belief. As Jimmy's old maladaptive belief weakened and his new adaptive belief became dominant, Jimmy became far more willing to use acceptance/mindfulness as an emotion regulation strategy, which greatly ameliorated his suppressive proclivities. Additionally, since Jimmy now had a strong belief in his ability to control his anger, he no longer avoided situations he anticipated to induce anger.

To summarize, using cognitive restructuring to change metacognitive maladaptive beliefs related to thoughts or emotions may be advantageous when treating the depressed client. Regarding metacognitive beliefs about emotions, I illustrated the utility of changing maladaptive beliefs about anger. However, the same approach may also be fruitful in examining clients' metacognitive beliefs related to other emotional states, such as clients' beliefs about sadness, guilt, shame, confidence, etc. Furthermore, I also discussed the utility of using cognitive restructuring to change clients' maladaptive beliefs about their own thoughts, using rumination as an example. Similarly, it may also be advantageous to examine or restructure clients' metacognitive beliefs about other types of thinking, such as clients beliefs about anxiety, incessant thinking, acceptance, worry, etc.

Closing Statement on The Guidelines

This set of guidelines intends to distinguish between circumstances for which an acceptance/mindfulness approach may be more advantageous than a cognitive restructuring approach, and circumstances for which a cognitive restructuring approach may be more

advantageous than an acceptance/mindfulness approach. Furthermore, these guidelines also intend to showcase the advantageous possibilities that ACT and CBT each uniquely bring to the table, that could not be gained if a therapist were only practicing one orientation. In this way, the utility of the technical-eclecticism approach is meant to be self-evident in these guidelines, as each of the two approaches clearly offer circumstance-specific and non-specific uses that the other does not.

This set of guidelines is not stating that one technique should ultimately be used over the other in any given circumstance, or making any claims of supremacy – it is highlighting the efficacy that can be gained from using both ACT and CBT together within a technical eclecticism approach. By drawing from the principles of systematic eclecticism (Mahalik, 1990), these guidelines offer direction for how to concurrently use strategies from both theories in a systematic, cohesive, and effective fashion.

As was mentioned, there are surely multifarious circumstances where the advantage of using one approach over the other may be ambiguous, or cases where both systems of therapy offer empirically-supported techniques for the same circumstances. For example, these guidelines never discussed the most effective response to normal day-to-day maladaptive thinking. Both ACT and CBT offer a variety of their own system-specific techniques to respond to day-to-day maladaptive thinking, and the choice of which to use may come down to client personal preference, what has been experientially more effective for the client, therapist recommendation, etc.

That said, I hope that by shedding light on which circumstances may be better suited for either an acceptance and commitment or cognitive restructuring approach, practitioners using

both acceptance/mindfulness and cognitive change theories will have more guidance in using both approaches in a more systematic, cohesive, and effective manner.

Chapter 3:

Discussion

In the concluding section of this paper, I will discuss some potential limitations of using acceptance/mindfulness in conjunction with cognitive restructuring, the need for more empirical research evaluating eclectic therapy formulations, and also make suggestions of specific research approaches that can be taken to assess the efficacy of this combination. I will end with a few paragraphs summarizing and concluding this paper.

Limitations of Using Acceptance/Mindfulness with Cognitive Restructuring

Although the ACT-CBT combinatorial study by Hallis and her colleagues (2017) found that clients did not have a difficult time navigating between acceptance/mindfulness and cognitive restructuring strategies during in the 15-week program, it would still be worth conducting further investigation as to whether clients can easily comprehend and effectively apply both strategies concurrently. The theory and philosophy underlying both ACT and CBT strategies is complex and multi-faceted, and having a comprehensive understanding of both systems such that strategies from both therapies can be effectively applied and seamlessly alternated between in various life circumstances, may be a lot to ask from some clients.

For one, if a therapist provides psychoeducation on ACT and CBT theory, and techniques from both are taught to clients, it would be worth investigating whether clients properly

understand the theory and philosophy underlying the techniques, or whether they're merely emulating the procedures of the techniques. Additionally, it would be worth investigating whether a lack of proper understanding of the underlying theory and philosophy would limit a client's ability to practically utilize and benefit from these strategies. If proper understanding of both theories would significantly moderate the extent to which clients could effectively apply and benefit from both ACT and CBT techniques, then this may pose serious limitations for clients who have a harder time with the comprehension of complex theory and philosophy. Despite this, it's possible that therapists can elucidate to clients distilled versions of ACT/CBT theory and philosophy without suffering a large drop-off in technique effectiveness.

Furthermore, the greater the number and diversity of response strategies that clients can choose from in different situations – the more room for error – compared with clients just using one type of response (e.g., acceptance/mindfulness) for all circumstances. Although having two types of response strategies (i.e., acceptance/mindfulness and cognitive restructuring) instead of one is not that sharp an increase, the previous statement still holds true. To account for the extra room for error, it would be prudent for therapists practicing both acceptance/mindfulness and cognitive restructuring to be attentive to whether clients have a cohesive understanding of what response type is most effective for what circumstance.

However, some clients may nevertheless be confused about, or sometimes find it difficult to discern whether acceptance/mindfulness or cognitive restructuring is the best response strategy for a given circumstance. In these situations, a client may mistakenly end up choosing the less effective approach. Despite this possibility, if therapists are very clear and thorough in psychoeducation with clients, and also disseminate guidelines that match client comprehension

capabilities, the possibility of client error in choosing the optimal response strategy will likely not pose a significant threat to treatment efficacy.

Lastly, it's generally difficult to pinpoint the limitations of using acceptance/mindfulness in conjunction with cognitive restructuring because there is a dearth of empirical research testing this combination. For example, the only study putting the ACT-CBT combination to the test (Hallis et al., 2017) did not assess its effectivenss across different cultures or for non-white U.S. populations. Therefore, there is currently no way of knowing whether acceptance/mindfulness used in conjunction with cognitive restructuring would be an effective treatment across different cultural demographics. Furthermore, a significant limitation of ACT-CBT is the lack of empirical research comparing the effectiveness of this combination with independently practiced ACT, CBT, and other forms therapy. While the theoretical arguments for this combination are strong, at this point, theoretical arguments are all that can be made.

Future Directions: The Need For More Empirical Research Assessessing Eclectic Therapy Formulations

There is a notable point of dichotomy between the field of clinical research and contemporary applied psychotherapy, in which the vast majority of clinical research assesses "pure-form" (i.e., by itself) systems of psychotherapy, yet it is extremely rare for a system of psychotherapy to be practiced in its pure form by a contemporary therapist in the U.S. (Cook et al., 2010). Another angle of this issue is that although the vast majority of practicing therapists use a multitude of different theories and techniques in their practices, the effectiveness of eclectic therapy formulations is very rarely assessed in clinical research. While this dichotomy does have practical consequences, its reasons are very understandable. For one, many eclectic therapy

formulations are unsystematic and non-manualized, so formally researching them would likely be a complicated and undesirable process.

The chief problem resulting from the aforementioned dichotomy, is that due to the paucity of empirical research on eclectic therapy, it's difficult to ascertain the empirical validity of eclectic therapy formulations practiced by therapists, including the ACT-CBT combination. For one, it would be valuable to study how practicing therapists independently synthesize eclectic therapy formulations and apply them in real-world contexts, as there is very little information known on this subject given the ubiquity of this phenomenon.

Secondly, there must be more empirical research conducted on systematic or manualized formulations of eclectic therapy to truly ascertain whether certain formulations of eclectic therapy present a more efficacious alternative to their pure-form counterparts. As of now, the only study that tested the ACT-CBT combination did not include pure-form ACT, pure-form CBT, or wait-list control groups (Hallis et al., 2017), so it's unclear as to whether combining acceptance/mindfulness and cognitive restructuring is empirically more effective than using either ACT or CBT in its pure form. Thus, although the advantages of using acceptance/mindfulness in conjunction with CR are very evident in theory and on paper, there is an absence, and therefore a strong need, of randomized control trials (RCTs) assessing the efficacy of this eclectic formulation.

Different Approaches to Empirical Research

A number of different approaches to research could be taken to shed light on the potential advantages of using acceptance/mindfulness in conjunction with cognitive restructuring. The most obvious would be to compare the efficacy of acceptance/mindfulness and cognitive

restructuring combined programs against pure-form CBT and pure-form ACT for the treatment of depression. After the ACT-CBT feasibility study by Hallis and colleagues (2017) returned promising results, the experimenters stated their plan to conduct a following RCT testing their manualized ACT-CBT group-therapy combination against pure-form CBT, pure-form ACT, and wait-list control groups. While this RCT is an exciting study to look forward to and a necessary route to ascertaining the efficacy of using cognitive restructuring in conjunction with acceptance/mindfulness, there are other routes to doing so as well.

At this point, the only head-to-head studies directly comparing the efficacy of ACT and CBT measure treatment efficacy using a number of fairly broad constructs. Most measure the extent to which patients show general improvements in depression symptoms, whether patients still meet diagnosis criteria of MDD, or whether they maintain treatment gains at follow-up (e.g., Forman et al., 2012; Zettle & Hayes, 1986; Zettle & Rains, 1989). While this type of research has its unique advantages, this broad-strokes approach will not reveal how either a cognitive restructuring or acceptance/mindfulness strategy may be more effective than the other for various specific circumstances, or the ways in which specific ACT or CBT techniques offer unique advantages to treatment.

To investigate these possibilities, a different approach to research must be taken. Rather than evaluating which therapy is overall more effective, this different approach would need to create head-to-head comparisons of specific therapeutic strategies and mechanisms from ACT and CBT, to evaluate which techniques are more effective across a variety of different circumstances. I will broadly outline two research paradigms to illustrate this alternate approach to empirically evaluating the advantages of using acceptance/mindfulness in conjunction with cognitive restructuring.

The Dismantling Approach in an RCT Format. One possible research methodology is the use of a dismantling study comparing individual components or strategies from ACT and CBT against each other in the context of the same goal or circumstance.

For example, one could recruit participants that have a history with experiential avoidance, rumination, or cognitive distortions, and randomly assign them to either the cognitive restructuring group, acceptance/mindfulness group, or combined A/M and CR response-style group. Baseline measures would be taken in the symptom categories of experiential avoidance, rumination, and cognitive distortions, and after a full course of treatment (e.g., 8–12 sessions), follow-up measures in these symptom categories would be taken to demonstrate improvement and compare it across groups. Such a comparison would reveal whether a specific response-style (e.g., cognitive restructuring) is responsible for greater improvement in each symptom category, or whether different response-styles benefited patients differently across categories.

A Smaller Study With an Idiographic Approach. It's possible that a smaller study with a more idiographic approach may be an effective alternative to conducting large-scale dismantling studies with head-to-head comparisons of therapeutic mechanisms. For example, participants in a small study could each be taught both acceptance/mindfulness and cognitive restructuring strategies, and told to experiment with both strategies when responding to circumstances of rumination, experiential avoidance, accurate/inaccurate thinking, emotional distress, etc.

After enough time has passed for participants to have adequate experience with both types of strategies, participants could report which type of strategy they found to be most

effective for each type of circumstance being targeted. If examining a large enough number of participant reports, certain trends could be identified as to whether patients reported either acceptance/mindfulness or cognitive restructuring strategies to be a more effective response for certain circumstances. Additionally, by tracking patients' individual experiences and variations, researchers would be able to test whether certain patient characteristics were more benefited by certain treatment strategies.

These examples of possible research paradigms intend to illustrate the multifarious approaches to conducting empirical research evaluating the advantages of using acceptance/mindfulness in conjunction with cognitive restructuring. At this point, more RCTs must be conducted on systematic formulations of the ACT-CBT combination to truly ascertain whether this combination presents a more efficacious alternative to its pure-form constituents. Additionally, it would be worthwhile to conduct studies that analyze how cognitive restructuring or acceptance/mindfulness strategies can be more effective than the other for different circumstances. I look forward to seeing what research emerges as this field gains more traction.

Conclusion

The set of guidelines presented in this paper offer a systematic approach to using ACT acceptance/mindfulness strategies in conjunction with CBT cognitive restructuring strategies, and they are an important addition to clinical literature for a number of reasons. For one, we live in a clinical zeitgeist in which second-wave (cognitive-change) approaches coexist with third-wave (acceptance/mindfulness) approaches as dominant treatment paradigms in contemporary psychotherapy. An online survey of 2,200 U.S. therapists by Cook and his

colleagues (2010) found that CBT is the most practiced theoretical orientation by contemporary U.S. psychotherapists, and that mindfulness-based theories are the third most practiced, right after family-systems theories.

Additionally, contemporary U.S. psychotherapy is characterized by a longstanding trend in which the vast majority of psychotherapists use an eclectic approach to therapy, wherein treatment strategies are from two or more systems of psychotherapy are used in combination (Northey, 2002; Prochaska & Norcross, 1983; Slife & Reber, 2001; Smith, 1982). In the most recent large-scale survey of U.S. psychotherapists (Cook et al., 2010), only 2% of psychotherapists reported that they use a singular system of psychotherapy exclusively in their practice.

Therefore, despite the enormous popularity of both cognitive-restructuring and acceptance/mindfulness theories in modern therapeutic practice, along with contemporary therapists majoritively preferring to use strategies from multiple theoretical orientations, there is a surprisingly small number of resources to guide therapists in using cognitive restructuring strategies in conjunction with acceptance/mindfulness strategies in a maximally effective, cohesive, and systematic fashion. It's crucial to provide therapists with systematic guidelines for the practice of eclectic-therapy models, to mitigate the reliance on intuitive thinking or other potentially less-effective methods of combining strategies (i.e., practicing unsystematic eclecticism, Lazarus & Beutler, 1993; Mahalik, 1990).

On one level, this paper aims to fill this gap, by providing a systematic set of guidelines that delineates for what circumstances an ACT acceptance/mindfulness approach may be the most effective response, and for what circumstances a CBT cognitive restructuring approach may be the most effective response. However, on another level, the guidelines aim to exemplify the

advantage of the eclectic approach, by illustrating how the treatment of depression (and likely other disorders) may be enhanced by an approach that includes both acceptance/mindfulness and cognitive restructuring strategies. As evidenced by the guidelines, different features of depression symptomatology may be more effectively addressed with a cognitive restructuring approach versus an acceptance/mindfulness approach.

Furthermore, in exploring the benefits of using ACT in conjunction with CBT, I only focused on the concurrent use of acceptance/mindfulness with cognitive restructuring strategies. However, using both ACT and CBT can offer advantages that go far beyond the use of these particular strategies in different circumstances. For one, having a comprehensive understanding of both a cognitive-change and acceptance/mindfulness system of psychotherapy may remarkably broaden the scope and comprehensiveness of one's therapeutic practice, given that these orientations take an entirely different approach to the treatment of pathology. For example, having a thorough understanding of psychological models, philosophical orientations, and empirically-supported methodology from both mindfulness-based and cognitive-change orientations may open up entirely new pathways for case-conceptualization, treatment structure, the therapeutic relationship, etc.

Thus, being well-versed in both a cognitive-change and an acceptance/mindfulness-based system of psychotherapy in one's clinical practice may remarkably broaden the scope of treatment adaptability and flexibility, and therefore improve one's ability to precisely match treatment strategies with idiosyncratic client circumstances.

All in all, I hope that this paper provides a valuable contribution to the field of clinical psychology. I look forward to witnessing how the eclectic use of both acceptance/mindfulness

and cognitive restructuring develops with the passage of time, and how the paradigms of clinical psychology evolve as I position myself within this field.

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