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Psychological Acceptance

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Psychological acceptance has been variously described as allowing, tolerating, embracing, experiencing, or making contact with a source of stimulation, particularly private experiences, that previously evoked escape, avoidance, or aggression (Cordova, 2001). To some degree, the importance of both therapeutic acceptance of the client and of helping the client accept him or herself is recognized by all therapy approaches (Linehan, 1994). Acceptance, viewed broadly, is a critical component through which change strategies are engaged and itself a significant mechanism of change (Greenberg, 1994; Hayes, Jacobson, Follette, & Dougher, 1994; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Wide differences exist, however, in conceptual definitions, the techniques employed by which to elicit acceptance, the mechanism of change thought to be important (client focused or therapist stance), and in a focus on acceptance as a process and acceptance as an outcome.

Acceptance has a long history in behavioral health areas. Freud (1920) delineated psychopathological processes based on unconscious repression and avoidance of unwanted thoughts and emotions. Rogers (1961) focused on acceptance in terms of the

therapist's relationship with the client. Here, acceptance was both a target for the therapist to undertake in providing an unconditional, consistent, genuine, and noncritical psychotherapeutic context; and a client target for acceptance of self. Rogers posited that a genuine, interested, tolerant therapeutic stance known as "unconditional positive regard" was the critical ingredient in the therapeutic process. The therapist sets the context by providing a non-critical place in which the client may recognize and clarify their emotions; and the client may then achieve acceptance of self through "openness to experience" and recognizing their "spontaneous self." (Rogers, 1992).

Acceptance has also been part of the tradition of humanistic/existential psychotherapy (Greenberg, 1994). Fritz Perls (1973) discussed acceptance in terms of allowing oneself an openness and awareness to experience emotion around who one is rather than who one is not.

What is new about acceptance approaches is their manualization, systematic conceptualization, and inclusion in empirically supported therapies. Behavioral and cognitive behavioral researchers and clinicians have been particularly important in this change. For a behavioral point of view, acceptance is a function rather than a form or topography, and it is an action rather than the content of cognition or emotion (Dougher, 1994). Modern research agree that acceptance applies primarily to the domain of private subjective events and experiences (Greenberg, 1994). For example, Cordova and Kohlenberg (1994) define acceptance as the toleration of the emotions evoked by aversive stimuli. Here, experiential avoidance is orthogonal to acceptance. For example, behaviors that function to limit interpersonal closeness are often avoidance maintained,

therefore, tolerance of aversive situations by not engaging behaviors to avoid, escape, or limit interpersonal contact is considered acceptance.

Linehan (1994) posits that acceptance and change highlight the synthesis of polarities in psychotherapy. A key component to Dialectical Behavior Therapy (DBT) (Linehan, 1993a) is the balance of acceptance and change in the treatment of mental disorder. Linehan defines acceptance as an active process of orienting to private experience moment by moment. It is entering reality just as it is at any given moment by noticing and describing without judgment. This sense of engaging acceptance over and over within any given moment is known as *radical acceptance*.

Hayes (1994) has defined psychological acceptance as one of the most important contextual change strategies. Here, acceptance refers to the conscious abandonment of a direct change agenda in the key domains of private events, self, and history, and an openness to experiencing thoughts and emotions as they are, not as they say they are. In this same vein, Dougher (1994) suggests that the key component of acceptance is letting go of one's control agenda and orienting towards valued actions. Defined that way, acceptance is not a goal in and of itself but is a method of empowering the achievement of life goals.

Evidence for the Impact of Acceptance Procedures

Acceptance plays a key role in many empirically supported therapies (Hayes, Jacobson, Follette, & Dougher, 1994). One such therapy is Integrative Behavioral Couple Therapy (IBCT) (Christensen, Jacobson, & Babcock, 1995). IBCT is an acceptance based treatment for couple discord. A recent comparison study between IBCT and traditional

behavioral couple therapy indicated that IBCT resulted in greater increases in marital satisfaction than couples receiving traditional behavioral therapy (Jacobson et al., 2000).

Psychological acceptance is a vital component of Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), a behavior analytically-based psychotherapy approach that attempts to undermine emotional avoidance and increase he capacity of behavior change. Research from a randomized, controlled trial of ACT in the workplace (Bond & Bunce, 2000) found that by increasing acceptance, ACT reduced stress and anxiety and increased behavior change in the workplace. Recent data from a randomized controlled trial using ACT to treat chronic, hospitalized seriously mentally ill patients experiencing hallucinations or delusions (Bach & Hayes, in press) found that acceptance of unwanted hallucinations resulted in higher reporting of positive psychotic symptoms. However, these individuals were nearly four times more likely to remain out of the hospital that were subjected not taught to accept these symptoms. These data suggests that symptom reporting reflected lower levels of denial and higher levels of psychological acceptance (Hayes, Pankey, Gifford, Batten, and Quinones, 2002).

Dialectial Behavior Therapy (DBT) (Linehan, 1984), is an acceptance and change based cognitive behavioral treatment for chronically parasuicidal borderline patients. Data from a randomized controlled trial of DBT demonstrated that subjects who received DBT for one year had fewer incidences of parasuicide and less medically severe parasuicides, were more likely to stay in individual therapy, and had fewer inpatient psychiatric days (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). A follow-up randomized trial of DBT as compared with treatment as usual in the community at one year posttreatment found that during the initial 6 months of the follow-up, DBT subjects

had significantly less parasuicidal behavior, less anger, and better self-reported social adjustment. During the final 6 months, DBT subjects had significantly fewer psychiatric inpatient days and better interviewer-rated social adjustment.

Process evidence. The thought suppression literature provides insight into some of the processes underlying the deleterious effects of avoidance and the positive effects of acceptance (Hayes et al., 2002). Wegner, Schneider, Carter, & White (1987) found that active attempts to suppress targeted thoughts increased the occurrence of these thoughts, suggesting that active attempts to avoid private experience may have an ironic, paradoxical effect in that the attempts themselves increase the likelihood of the thought. Further research (Wenzlaff, Wegner, & Klein, 1991) demonstrated that individuals who try to suppress thoughts experience a reinstatement of the mood state that existed during the initial period of suppression.

A meta-analysis of coping strategies (Suls & Fletcher, 1985) found that avoidance strategies (denial, distraction, repression and suppression) were more adaptive in the short-run; but that nonavoidant strategies (attention, noticing, and focusing) had more positive long-term outcomes. Avoidance is omnipresent by nature in all its overt and covert iterations. Contrasted with the beneficial health outcomes related to reductions in emotional avoidance (McCurry, 1991), it seems clear that acceptance in some form may be widely beneficial across the continuum of more benign forms of psychological unrest to more overt psychopathology (see Hayes, Wilson, Gifford, Follette, & Strosahl,1996, for a review).

Who Benefits/Contraindications

Acceptance is particularly helpful with considered a the problems clients face are not amenable to the instrumental change strategies (Cordova, 2001), such as acceptance of a difficult childhood history, or acceptance of automatic thoughts or conditioned emotions. In some areas (e.g., acceptance of the continuity of consciousness or of "self") acceptance is the only healthy alternative available.

Acceptance procedures are contraindicated, however, when they are applied to external situations or behaviors that can and should be controlled. For example, a pedophile might be encouraged to accept the presences of urges to molest children, but should not be encouraged to accept molesting behaviors; an abused spouse might be encouraged to accept angry reactions or feelings of shame, but should not be encouraged to accept abusive behavior or an abusive environment; a trichotillomanic might be encouraged to accept thoughts about pulling hair or the urge to do so, but should not be encouraged to accept hair pulling; a person with self-loathing thoughts would be encouraged to accept these thoughts as an ongoing process (e.g., "now I am having the thought that I am bad") but would not be encouraged to accept their literal content (e.g., "and in fact I am bad"). The evidence is not yet clear on this distinction in some areas, however. For example, it is not known if it is better to accept thoughts as thoughts (see Chapter on cognitive defusion), or to dispute their content.

Acceptance Technology

Acceptance is not a specific technique per se, in relation to other techniques or treatment technologies; but rather a stance or posture from which to conduct therapy, and from which a client can conduct life. It is a context.

The techniques that foster this context (see Table 1) are:

a) detecting and challenging experiential avoidance

b) encouraging aware, flexible, open exposure to previously avoided events,

c) encouraging the development of new response functions in the presence of previously avoid events, and

d) using defusion techniques when exposure to private verbal events leads to verbal entanglement.

Insert Table 1 About Here

Detecting and challenging experiential avoidance. It is not possible to foster acceptance unless the logical alternative is challenged and reduced. Clients arrive in therapy convinced that they need to reduce or eliminate various private events (e.g., fear, sadness, self-doubt, and so on) in order to live a powerful and vital life. This stance is usually simply assumed – it is more a metacognition than a cognition. If this control-focused stance is not challenged, acceptance will be viewed by the client as a new, more sophisticated way to manipulate or control negative private experience (e.g., "if I stop trying to control my fear, it will go away"). There is little evidence that this is useful, and in functional terms it represents nothing new.

A wide variety of techniques can be helpful in challenging an ingrained control and avoidance focused agenda. Previous internally focused change efforts can be explored in depth and the client can be asked if each was an ultimate, final, and fully satisfactory solution. The answer is always "no" or else the client would not still be

seeking services. When a full set of control-focused efforts are developed, the therapist can point out that obvious: the client's own experience suggests that internally focused change efforts have provided no ultimate, final, and fully satisfactory solution. A client might be asked "which are you going to believe: you mind or your experience."

Specific common sense metaphors can be used to show that sometimes deliberate change efforts are doomed to failure. ACT (Hayes et al., 1999) uses the following metaphor as one of several designed to make this point:

> The situation here is something like those "Chinese handcuffs" we played with as kids. Have you ever seen them? It is a tube of woven straw about as big as your index finger. You push both index fingers in, one into each end, and as you pull them back out the straw catches and tightens. The harder you pull, the smaller the tube gets and the stronger it holds your finger. You'd have to pull your fingers out of their sockets to get them out by pulling them out once they've been caught. Maybe this situation is something like that. Maybe these tubes are like life itself. Maybe there is no healthy way to deliberately get out of certain aspects of your life, like your history, your memories, or your automatic feelings and any attempt to do so just restricts the room you have to move. With this little tube, the only way to get some room is to push your fingers in, which makes the tube bigger. Maybe this situation is like that. Pushing in may be hard at first to do because everything your mind tells you to do casts the issue in terms of "in and out" not "tight and loose." But your experience is telling you that if what you are struggling with is cast in terms of "in and out," then life will be tight. And your life has gotten tighter and tighter, has it not? Isn't that really part of why you

came to see me? Well, maybe we need to come at this situation from a whole different angle than what your mind tells you to do with your painful experiences.

A variety of similar metaphors can be used to make the same point (e.g., struggling with anxiety is like struggling in quicksand; trying to push away experiences is like trying to push away fly paper; etc).

Encouraging aware, flexible, open exposure to previously avoided events. Acceptance is not merely passive – it involves directly contacting the previously avoided functions of events. For example, acceptance of anxiety involves detecting its presence, and deliberately exploring how it feels to be anxious. The methods of interoceptive exposure can be thought of in this way, as can many methods drawn from Gestalt and more experiential traditions.

An example of an acceptance technique of this kind is the "tin can monster" exercise used in ACT. The idea is that many experiences are difficult to experience because they are multifaceted. Like a huge monster made up of many less threatening pieces (e.g., bubble gum, bailing wire, and tin cans) it might be easier to deal with the pieces rather than the entire monster all at once. The client is asked to close their eyes and get into contact with a private experience they are trying to avoid or escape (e.g., anxiety). The client is then directed to notice, one at a time, specific bodily sensations that are occasioned by this overall experience. As each sensation is identified, the client is encouraged to see where the sensation begins and ends, what it feels like, and whether it is possible to feel that one sensation without avoidance. After several sensations are examined, the same approach is used with other response dimensions, such as emotions,

urges to act, memories, and thoughts. Within each domain individual experiences are identified, examined, deliberately produced, and ultimately no longer avoided.

Marlatt and Gordon (1985) have presented a metaphor for this stage of acceptance from their work on addiction: "urge surfing." Cravings ebb and flow, throughout our lives. At the peak of the wave (crest), individuals are most vulnerable to "giving in" to urges because they fear that it will "only get worse". The urge surfing metaphor is employed to help clients understand that individuals can become skilled at experiencing the rising and passing of urges without allowing them to be thrown off balance.

Encouraging the development of new response functions in the presence of previously avoid events. Acceptance allows the response functions of previously avoided events to more varied. Etymologically, “acceptance” means “to take in.” Taking in what a situation affords is not merely a matter of feeling, sensing, of thinking what one has always felt, sensed, or thought. It also means developing *new* functions. Acceptance procedures can thus include any technique that multiplies and variegates the functions of previously avoided events. For example, suppose a panic disordered person is taken to a mall. In addition to feeling anxious, deliberately and with awareness, the therapist and client might spend time guessing the careers of the people walking by; or find the ugliest store front in the mall; or see how long it takes to walk from one end to the other; or see how long they can balance on one foot; or together agree to do something silly (e.g., if the person is worried that panic will lead to social humiliation, the client and therapist might go into a women’s clothing store and order a hamburger). What new functions are established is not as important as the process of expanding a constricted repertoire.

Using defusion techniques when exposure to private verbal events leads to verbal entanglement. Acceptance of thoughts is a difficult process, because what is being accepted in not their content, but the process of thinking that content. Defusion techniques (see the Chapter in this volume) are very helpful in allowing acceptance of verbal / cognitive events.

Mindfulness techniques, such as those used in DBT (Linehan, 1993a; 1993b) involves all four of these steps. Mindfulness has to do with the quality of awareness that one brings to activities and requires for its practice acceptance of the moment (Linehan, 1994). These skills are taught to individuals in an effort to help them focus on one task or activity at a time, engaging in it with alertness, awareness, and wakefulness. DBT also offers skills training in *distress tolerance*, which are aimed at tolerating distress rather than acting from a place to ameliorate the pain. These skills include distraction, self-soothing, improving the moment, and pros and cons which focuses on pros of tolerating versus the cons of not tolerating. These skills are the mechanism by which one can *radically accept*, or enter reality as it is in the moment, accepting of "total allowance now."

Conclusion

It is a paradox that acceptance is one of the more powerful forms of clinical change, because it involves a change in the purpose of change efforts themselves. There is a growing evidence base that acceptance skills are central to psychological well-being and can increase the impact of psychotherapy with a broad variety of clients.

Suggestions for further reading:

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Table 1. Steps in the Use of Acceptance Methods

1. Detect and challenge experiential avoidance
2. Encourage aware, flexible, open exposure to previously avoided events
3. Encourage the development of new response functions in the presence of previously avoid events
4. Use defusion techniques when exposure to private verbal events leads to verbal entanglement.