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Rational Emotive Behavior Therapy

Albert Ellis founded Rational Emotive Behavior Therapy (REBT) in the mid-1950's and it became the first form of cognitive-behavioral therapy. REBT's approach is based in the processes of cognition, with a focus on beliefs as the source of our emotions. As humans, normally we prefer effective ways of thinking or rational beliefs, but we also have the capacity for self-defeating thoughts or irrational beliefs. These ineffective, inflexible, and absolutistic thoughts create psychological difficulties and other specific symptoms. REBT is considered an integrative approach, with thoughts, emotions, and actions viewed as interconnected. Patients entertain and maintain irrational beliefs about events and life situations, which influence the way they feel about those interpretations. Therapists play an active role as educators, helping patients identify, address, remove, and replace the absolutistic demands that debilitate their feelings and behaviors. Thus, by correcting their cognitive distortions, patients change the way they react toward events, leading to modified emotional expressions. Through disputation and logical reasoning, work and practice, REBT helps people feel better, get better, and stay better (Ellis, 2001; Corey, 2015).

Acceptance and Commitment Therapy

Steven C. Hayes founded Acceptance and Commitment Therapy (ACT) in 1980's. ACT is a behavioral analytic therapy inspired by the philosophical approach of functional contextualism, or pragmatism. Contextualism emphasizes the wholistic aspect of an event, its historical and situational context, and the pragmatic nature of truth (Hayes, Strosahl, & Wilson, 2011). Hayes developed ACT to integrate cognitive and behavioral therapies based on the principles of Relational Frame Theory (RFT). RFT is a theory of human language which stresses the importance of contextual elements that determine the emergence and functions of relationships among events. Based on RFT's principles, ACT focuses on changing the functional context of events, ignoring the relational aspect. ACT theorists assert that the patient's main problem is psychological inflexibility, manifested as cognitive fusion and experiential avoidance. In cognitive fusion, patients take their thoughts excessively in their literal sense, dominating and debilitating their behavior. That leads the person to avoid any experience involving the formal or situational aspect of these events. Thus, ACT promotes psychological flexibility, achieved through cognitive de-fusion, and using a variety of cognitive and behavioral techniques. Psychological flexibility enables a person to accept the present experience with maximum consciousness and to adapt behavior in the pursue of self-determined values. Ultimately, ACT combines acceptance and mindfulness methods in a behavioral analytic framework aiming for change through psychological flexibility (Hayes et al, 2011; Kazantzis, Reinecke, & Freeman, 2010; VandenBos, Meidenbauer, & Frank-McNeil, 2014).

REBT and ACT – similarities and differences

There is strong and ample empirical evidence supporting both REBT and ACT models. REBT can be applied successfully to diverse populations and settings, including children, couples, families, groups, addressing various conditions like anxiety, depression, eating disorders, psychotic disorders, parenting, adult attention deficit disorder, etc. (Corey, 2013; White & Freeman, 2005; Haaga & Davison, 1993). Likewise, ACT is an effective strategy applied to a variety of disorders like depression, anxiety, phobias, and other affective disorders, PTSD, substance abuse and dependence, schizophrenia and other psychotic disorders, with children, adolescents and their parents, chronic pain patients, in medical or group format settings (Bach & Hayes, 2002; Dahl, Wilson, & Nilsson, 2004; Hayes & Strosahl, 2004; Eifert & Forsyth, 2005). Some authors who compared the two therapies decided that ACT does not bring anything new than REBT and that they work on similar theoretical premises (Hofmann & Asmundson, 2008). Other critics defend the unique contributions of ACT compared to REBT and highlight the differences between them (Robb & Ciarrochi, 2005; Hayes, 2005; Gaudiano, 2011). There are attempts to compromise some of their aspects to create and integrative approach that would reconcile the two therapies (Ellis, 2005). After reviewing some of these articles, it seems that despite their commonalities, ACT distinguishes from REBT. The distinction between the two therapies fades only in the eyes of those who don’t understand them in depth.

Although REBT works from a mechanistic perspective, changing the thoughts and feelings to achieve behavior amelioration, while ACT relies on functionalist contextualism, avoiding thought correction, both therapies are

focused on improving the symptoms (Robb, 2005). The paths taken to reduce emotional distress are different, but the outcome is the same (Gaudiano, 2011). Some REBT theorists claim a constructivist agenda, meaning that patients develop and construct their own ideas, positive or negative. ACT can also be considered constructivist in the sense that patients learn how to feel, as opposed to feel right. Both theories are based on the processes of cognition; however, in REBT dysfunctional thoughts are identified, challenged, and disputed, whereas in ACT there is no challenge of the logic of beliefs. There are REBT proponents advancing the idea that REBT doesn't challenge the inference but invite the patient to examine the consequences of their negative beliefs, thus coming close to the way in ACT there is no attempt to challenge the thoughts. However, in ACT there is secondary change and no cognitive restructuring, meaning patients change relationships with their experiences (Hayes, 2005).

REBT discriminates between positive or rational beliefs, and negative or irrational beliefs; in ACT there is no appraisal of the quality of thoughts, thoughts are reviewed and accepted, or " what is true is what it works." The role of context in ACT is that it promotes successful working as opposed to the successful thinking of REBT (Hayes, Strosahl, & Wilson, 2011, p. 20). Both therapies rely heavily on techniques, REBT stressing the importance of homework, practice, and maintenance, has a strong psychoeducational component, teaches assertiveness, problem-solving skills, communication and social skills. Similarly, ACT includes homework and techniques borrowed from behavioral therapies (Corey, 2013). However, while REBT can be self-

taught using tapes, books, exercises, one cannot teach oneself ACT (Ellis, 2005; Hayes, 2005).

Hayes (2005) admitted that REBT may be the closest to the third wave of cognitive behavioral therapies, including ACT. Thus, he recognizes that REBT incorporated unconditional acceptance (self, others, and life), acceptance of frustration, and questioned the validity of self-evaluation. However, the problem of disputing irrational beliefs in REBT draws a clear line of separation from ACT. RFT is key in showing the difference: ACT focuses on thought functionality, whereas REBT on thought content (Hayes, 2005). Acceptance is a key concept in ACT. Ellis (2006) suggests that acceptance is a common component of REBT and ACT. Testing how acceptance works in both models, one study demonstrated that REBT acceptance and ACT acceptance can predict emotional distress successfully, but in different ways (Wild, Podea, Macavei, 2017). Ellis (2005) dismissed meditation as a form of interference, but in ACT it is an essential defusing strategy, breaking the domination of intrusive thoughts (Robb & Ciarrochi, 2005). Ellis (2005) also highlighted that both REBT and ACT have in common commitment to action or to values and a life-enhancing philosophy. Finally, despite their similarities, REBT and ACT have importance differences, evidenced by their respective underlying theoretical principles.

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