Third-Generation Therapies: Achievements and challenges[1]

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ABSTRACT. The term «third-generation therapies» refers to a series of therapies that emerge in the 1990s within the tradition of behavioral therapy. The aim of this article is to review their achievements and challenges. The method involves analyzing recent formulations of these therapies so as to identify their distinctive characteristics and the clinical innovations they represent. As regards their characteristics, it is important to acknowledge the fact that they give back to behavioral therapy its contextual perspective, lost with the advent of cognitive-behavioral therapy, which would now be classed as «second-generation.» This is why they are also called contextual therapies. The two main clinical innovations of these therapies are, on the one hand, psychological inflexibility as a psychopathological model common to various disorders, and on the other, the identification of therapeutic principles, more than specific techniques, in relation to processes of experiential acceptance and behavioral change. Notable among the challenges are those deriving from the very success of these therapies, which have taken on the character of a fashion, without the assumption of the philosophy they entail.

KEYWORDS. ACT. Behavioral activation. Psychological inflexibility. Medical model. Contextual model. Schizophrenia. Theoretical study.

RESUMEN. Las terapias de tercera generación refieren una serie de terapias que surgen en la década de los años noventa en la tradición de la terapia de conducta. El objetivo de este artículo es revisar sus logros y retos. El método consiste en analizar las formulaciones recientes de estas terapias en orden a identificar sus características

distintivas y las innovaciones clínicas que representan. Respecto a sus características distintivas, importa reconocer el hecho de que la terapia conductual recupera la perspectiva contextual perdida con la terapia cognitivo-conductual, que quedaría ahora como «segunda generación». Es por lo que estas terapias también se denominan terapias contextuales. En cuanto a las innovaciones clínicas, importan sobre todo las que se refieran a la conceptualización psicopatológica y los principios terapéuticos. La innovación clínica cuenta con dos grandes aportaciones: la inflexibilidad psicológica como modelo psicopatológico común a diversos trastornos, y la identificación de principios terapéuticos, más que técnicas específicas, en torno a procesos de aceptación experiencial y de cambio conductual. Entre los retos se destacan los derivados del propio éxito de estas terapias, que queden como una moda, sin asumir la filosofía que implican.

PALABRAS CLAVE. ACT. Activación conductual. Inflexibilidad psicológica. Modelo médico. Modelo contextual. Esquizofrenia. Estudio teórico.

The term «third-generation behavior therapies» is a designation, but also a slogan, coined by Steven Hayes, the author of one such therapy, in an article from 2004 (Hayes, 2004). As a designation, it refers to a series of therapies that emerge in the 1990s and establish themselves as a new generation in the first ten years of the new century. This movement is called «clinical behavior analysis» because it represents a move away from cognitivism and back toward radical behaviorism and other forms of behaviorism, in particular functional analysis and behavioral models of verbal behavior (Dougher, 2011). As a slogan it is audacious, in that it highlights the novelty of these therapies with respect to the established ones, but it is also risky, insofar as others will follow it, ushering in the «fourth generation», the «ultimate» therapies or the «new wave.» In Spain, where they were introduced in 1996 in a book (Pérez-Álvarez, 1996), they were well accepted and soon built upon, thanks above all to the work of Luciano (Luciano and Hayes, 2001; Wilson and Luciano, 2002) and of others, including Barraca (2009, 2012), García-Montes and Pérez-Álvarez (2001, 2005, 2010), García Palacios (2006), Kohlenberg et al. (2005), Martín-Murcia, Cangas-Díaz, and Pardo-Gonzalez (2011), Pérez-Álvarez (2006, 2007) and Valero-Aguayo, Kohlenberg, Ferro-García, and Tsai, (2011). These new therapies include: Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, and Wilson, 1999), Functional Analytic Psychotherapy (FAP; Kohlenberg and Tsai, 1991), Dialectical Behavioral Therapy (DBT; Linehan, 1993), Behavioral Activation (BA; Jacobson, Martell, and Dimidjian, 2001), Integrative Behavioral Couples Therapy (IBCT; Jacobson, Christensen, Prince, Cordova, and Eldridge, 2000), and Mindfulness-Based Therapy (MBT; Segal, Williams, and Teasdale, 2002).

Acceptance and Commitment Therapy (ACT), developed by Steven Hayes, is probably the most widely studied of all the third-generation behavior therapy models (Hayes et al., 1999). It is based on Relational Frame Theory (RFT), a psychological theory of human language and cognition, extensively developed by Hayes himself and Dermot Barnes-Holmes (Hayes, Barnes-Holmes, and Roche, 2001). With a philosophical basis in functional contextualism, RFT explores how humans learn language in social interactions. Functional contextualism studies experimentally the learning of psychological events such as feelings, thoughts and behaviors, resituating them in the context of their

interpersonal functions. Functional contextualism is in fact an extension of B. F. Skinner's radical behaviorism, which addresses the question of the emergence of complex linguistic and cognitive abilities and competencies from precursory, more basic learning processes. Both RFT and ACT are supported by growing bodies of empirical evidence (Barnes-Holmes, 2005; Ruiz, 2010), as well as a variety of extensions, including substance abuse (Luciano, Páez-Blarrina, and Valdivia-Salas, 2010) and chess improvement (Ruíz and Luciano, 2009).

Functional Analytic Psychotherapy (FAP) was developed by Robert Kohlenberg and Mavis Tsai based on behavior analysis, and is a functional contextualist approach which also follows in the wake of Skinner's radical behaviorism (Kohlenberg and Tsai, 1991). FAP focuses on client-therapist interactions in session, about which it has developed a functional analysis and classification of clinically relevant behaviors. FAP assumes, creating the conditions for it, that the therapeutic session can become an interpersonal context functionally equivalent to situations of the client's real environmental outside of therapy. The clinical relationship would be the condition and the natural context for therapeutic change, and this often involves the establishment of intense therapeutic relationships. FAP is an example of the translation of theory and research into practice (Weeks, Kanter, Bonow, Landes, and Busch, 2012).

Dialectical Behavioral Therapy (DBT) was developed by Marsha Linehan specifically for multiple personality disorder (Linehan, 1993), but is also applied to other disorders. This therapy sets out to combine acceptance and change in dialectic fashion. Acceptance in DBT places particular emphasis on the validation by the therapist of the client's experiences and behaviors, characterized in borderline personality disorder by a marked emotional dysregulation. Therapy is offered as a context of acceptance and validation in which to develop skills for changing emotional regulation. While on the one hand feelings are valid and we must accept them, it is also true that being dependent upon them can be harmful to oneself and others, especially considering the possibility that they can be changed. The application of DBT includes individual and group modalities, as well as crisis hotlines and the possibility of crisis intervention. This kind of therapy is well established in the treatment of borderline personality disorder (Soler *et al.,* 2012).

Behavioral Activation (BA) emerged from the analysis of ingredients of cognitive depression therapy, after it was shown that the behavioral activation component alone was as effective as the complete therapy (Jacobson *et al.,* 1996). This component by itself, reworked in accordance with behavioral principles, gave rise to behavioral activation therapy, which has shown in major depression to be more effective than cognitive therapy and more advantageous than medication (Dimidjian *et al.,* 2006; Pérez-Álvarez, 2007). There are two application protocols, scarcely distinguishable in their names: «behavioral activation», which emphasizes functional analysis, and «behavioral activation therapy,» which stresses the «matching law», regarding the relative value of reinforcers depending on the reinforcers of the alternative behavior (Barraca, 2009). Scales for the assessment of depression have been developed in line with this conception (Barraca, Pérez-Álvarez, Bleda, and Lozano Bleda, 2011).

Integrative Behavioral Couples Therapy (IBCT) was also developed, like behavioral activation, by Neil Jacobson, borne out of his dissatisfaction with traditional behavioral

couples therapy. Its roots are in the Skinnerian distinction between contingency-shaped and rule-governed behavior. The latest version of its original formulation follows the lines of acceptance and change that characterize third-generation therapies (Christensen and Jacobson, 1998; Jacobson *et al.,* 2000).

Mindfulness-Based Therapy (MBT) is a therapeutic approach, derived from Buddhism, that involves focusing one's attention on the experience of the moment, including feelings, thoughts, bodily states and other private events, as well as on the environment, without judging or analyzing them, but instead adopting an attitude of openness, curiosity and acceptance (Bishop *et al.,* 2004). The philosophy and techniques based on mindfulness have shown their efficacy in depression and anxiety (Hofmann, Sawyer, Witt, and Oh, 2010) as well as demonstrating a range of healthy psychological effects (Keng, Smoski, and Robins, 2011). Mindfulness has been integrated into ACT, FAP, and DBT.

This aim of this theoretical study is to review their achievements and challenges. Notable among the achievements of these therapies are the distinctive characteristics for which they are also called contextual therapies. Likewise, it is important to highlight the clinical innovations they represent, particularly with regard to the psychopathological conception and therapeutic procedure. As far as the challenges are concerned, it is important to acknowledge those deriving from the very success of these therapies, and especially from their drift in the direction of mindfulness, whose connotations of snobbery may work to the detriment of their establishing affinities with the Western philosophical tradition. Another challenge to consider concerns the role of these therapies in schizophrenia, the touchstone of any psychological therapy worthy of the name. The challenge here is for them to avoid remaining as mere adjuncts to medication, representing as they do a contextual model alternative to the medical model. The method to be followed involves analyzing recent formulations of the most representative therapies (so as to identify their characteristics and innovations) and contrasting them with typical current models. This work being of an interpretive nature (Fernández-Ríos and Buela-Casal, 2009), its results, discussion and conclusions are presented following the argumentation, and using formats which make for easier reading, including summary boxes (Hartley, 2012). The exposition is confined to dealing with the objectives set.

Achievements: Contextual perspective and clinical innovation

Contextual perspective: Meanings of context

The words «context» and «contextual» are among the most amenable in Psychology. It is hard to find any theory or procedure that does not consider itself as contextual. However, self-definitions apart, it is possible to distinguish clinical approaches that are actually contextual from others which are not, or only barely so. Moreover, the meaning of context in therapy is not univocal. As regards third-generation therapies, their contextual character has three senses or dimensions: environment, therapeutic relationship and person.

The context of environment refers to the medium in which people's lives unfold. It denotes a social and cultural setting that includes the various areas of everyday life

(family, social relations, education, work, leisure, etc.), with its norms and values. In this line, the context is roughly equivalent to the «lebenswelt» of phenomenology or the «circumstances» of Ortega and Gasset's philosophy (Pérez-Álvarez and Sass, 2008). Of the therapies described above, IBCT and BA are those which most «exploit» this dimension: the first as a therapy for a problem that is actually interpersonal, and the second as a therapy consisting in activating the person so as to modify the environmental conditions that can change their depressive state.

The context of the therapeutic relationship refers to the context provided by the psychotherapy itself, as a place and time in which to have experiences that could be corrective, and thus learn new ways of understanding and changing the problems that occur. The approach and conceptual framework of the therapy, in which the problem is explained, interpreted and reappraised, form an important part of the therapeutic relationship context. Of the mentioned therapies, FAP and DBT are those that most «exploit» this dimension. Both bring the therapeutic relationship into play as a relationship that is itself therapeutic. The consideration of therapy as an experiential and learning context is in line with psychoanalytically inspired psychotherapies that stress the curative role of the corrective emotional experience.

The context relative to the person refers to persons themselves as social-verbal individuals, incorporating an entire past and characterized by a coping style. Needless to say, the person is in a dialectical relationship with the world, in the sense of Ortega's «I am myself and my circumstances» (Pérez-Álvarez and Sass, 2008). The context of the person consists of the explanations, appraisals and ways of understanding psychological problems that prevail in the society of reference and that one has learned and considers as natural. Of the above therapies, ACT and MBT are those that most «exploit» this dimension. In its own way, each tries to change the person's relationship with their own symptoms (experiences, feelings, thoughts, obsessions, voices, etc.).

It need hardly be pointed out that the three contexts (environment, therapeutic relationship, person) are not only mutually exclusive, but also mutually reinforcing. The fact that some therapies «exploit» one context more than another does not mean they are not assuming and considering the others. Thus, the therapeutic relationship is fundamental to any therapy worth its salt, including those that emphasize the environmental dimension, such as, BA. Without a good therapeutic relationship it would be difficult to «activate» someone who is very depressed. Meanwhile, environmental change is expected to derive from the new experiences, actions and reactions learned in a therapeutic relationship such as that provided by FAP or DBT. Likewise, possible change in one's relationship with one's own private events depends on a good therapeutic relationship – like the one required for the client to do something that probably goes against common sense, such as «accepting» the symptoms he or she wishes to «eliminate». Changing the relationship with one's own experiences also depends on the environment (*e.g.,* family and other clinical professionals) accepting the symptoms without the usual interference and stigmatization. In turn, therapies that emphasize the therapeutic relationship and environmental change also assume that the way the client experiences the symptoms will change. Table 1 presents the therapies according to their affinity with aspects of the context indicated.

TABLE 1. Affinity between the aspects of context and the different therapies.

Aspect of context	More affinity therapies
The environment as interpersonal social context	Integrative Behavioral Couples Therapy Behavioral Activation
The therapeutic relationship as experiential learning context	Functional Analytic Psychotherapy Dialectical Behavioral Therapy
The person as social verbal context	Acceptance and Commitment Therapy Mindfulness-Based Therapy

The contextual perspective: Medical model vs contextual model

The contextual perspective of third-generation therapies offers an alternative to the internalist perspective adopted by second-generation therapies, namely cognitive or cognitive-behavioral therapy, which had undermined the contextual (environmental) nature of first-generation behavioral therapy.

An internalist perspective corresponds to a medical model of illness, even when its terms are psychological. Its emphasis on deficits or dysfunctions of supposed internal mechanisms (neural, cognitive or neurocognitive) ends up de-contextualizing the problem in question. Likewise, an internalist approach tends to consider psychological techniques as specific to the presumed dysfunction they are trying to remedy (in the same way as drugs), even if it is difficult to find evidence that psychotherapeutic techniques function beyond the context of the therapy, including its conceptual framework and the interpersonal relationship it involves. Indeed, the great debate in psychotherapy is between the medical model of psychotherapy and the contextual model of psychotherapy (Wampold, 2001). The most significant representative of the medical model today is probably cognitive therapy or cognitive-behavioural therapy (both second-generation therapies).

The medical model of psychological therapy can be characterized, analagously with the medical-psychiatric, psychopharmacological model, according to four dimensions, referring to explanation, causal mechanism, treatment and efficacy criteria.

The medical model of psychological therapy proposes an internal psychological explanation of mental disorders. Where the medical-psychiatric model offers a neurobiological explanation, the medical-psychological model (*e.g.,* cognitive therapy) offers a psychological explanation, usually in terms of information processing. In spite of the different terms, on the one hand neurobiological and on the other psychological, the two models maintain the same internalist perspective.

The medical model of psychological therapy assumes a dysfunction or deficit in psychological functioning, typically a cognitive schema (*e.g.,* a depressogenic schema), as causal mechanism. Where the medical-psychiatric model assumes a neurobiological malfunction, typically a neurochemical imbalance or a defective circuit, the medical-psychological model (particularly cognitive therapy) assumes a dysfunction, deficit or defect in cognitive processing. Both models adopt a mechanistic view of disorders.

The medical model of psychological therapy applies specific techniques for each disorder, supposedly aimed at repairing or restructuring the underlying dysfunction. Where the medical-psychiatric model offers medication indicated for each disorder, the

medical-psychological model (cognitive therapy) offers a specific technique, typically involving cognitive restructuring for the underlying schemas, beliefs or cognitions (depression schema, panic schema, etc.). The point is that there are no actual specific treatments, either psychopharmacological or psychological. Thus, for example, the psychoactive drugs that are good for one disorder also work well for other conditions, other than that for which they were designed and marketed. Expressions such as «antidepressant» or «antipsychotic» reflect commercial motives, not supposed etiologically specific psychopharmacological actions. For their part, psychological treatments are not specific in this etiological sense either. Proof of this is that relatively different treatments have quite similar efficacy (without going so far as to say that any procedure works for any problem). Moreover, there is no psychological technique, however specific for a given problem, that can function outside the context of the therapeutic relationship. The efficacy of psychological techniques is dependent on the context of the therapy: therapeutic relationship, explanation of the problem, etc. (Wampold, 2001).

For the medical model of psychological therapy, the criterion of efficacy is the reduction of the symptoms that define a clinical condition. And if the medical-psychiatric model uses a list of symptoms (treatable with medication), the medical-psychological model (cognitive therapy) in fact uses practically the same questionnaire. Even though this has permitted cognitive therapy to measure and show its effectiveness with respect to medication (a great achievement that should be acknowledged), the fact is that this success has been at the cost of mimicking the medical model. More is expected of psychological therapies than merely matching and competing with medication. A clinical approach that measures its efficacy through the reduction of symptoms will find it hard to entertain the possibility that a patient has improved or even overcome the problem if he or she is «symptomatic.» However, it may be the case that a person continues to have symptoms that appear on a list but they are no longer a problem that disrupts his or her life.

In relation to these dimensions, a contextual model of psychological therapy would be characterized as follows. The contextual model of psychological therapy explains the disorder in interactive, functional and contextual terms, and not as something that is defective inside the individual – in the brain or in the mind – or necessarily outside – in the society or the culture – but rather in the co-evolutionary history of the person and their circumstances. The disorder or problem would not be within the person; rather, so to speak, the person would be within a certain set of circumstances or problematic situation. For example, depression would not be something one has within oneself, but a situation in which one is (Martell, Addis, and Jacobson, 2001; Pérez-Álvarez, 2007).

The contextual model of psychological therapy assumes that the problem has to do with the individual in their dealings with others and with themselves – with their own experiences, feelings, thoughts and other «private events». It does not assume that there must be some defect, deficit or dysfunction in some hypothetical psychological mechanism from which to understand the problem, as the underlying cause. On the contrary, it is understood that psychological disorders are possibilities of life, due more to the human condition than to the natural condition. They are said to be human «possibilities» not because of the truism that if they exist it is because they are possible, but rather because of the consideration (anthropological and philosophical) of humans as having an open nature, insofar as they are capable of «being» in various

ways, including those that may become problematic. Nor are these possibilities necessarily abnormal – in the sense of failure to comply with a norm – since, even though they may be problematic or pathological, they deploy new norms and ways of being (Canguilhem, 1966/1971). Indeed, mental disorders cannot be defined on the basis of a supposed normal natural design (cerebral or mental), with respect to which they would be a defect or malfunction, given the essentially interactive and historical-cultural nature of psychological problems (Pérez-Álvarez, 2008, 2012b).

The contextual model of psychological therapy, rather than specific techniques, provides general therapeutic principles, an aspect we shall discuss later on. The contextual model superannuates the role of the patient as passive, mechanistic, a processor of information, and ushers in the role of the active client, a responsible person, with a capacity for response (ability) and to take responsibility for his or her actions. Very often the solution to a psychological problem requires the client to make decisions about what to do with his or her life.

The contextual model of psychological therapy measures its efficacy more by personal achievements in the direction of the values in the different domains selected than by the reduction of symptoms from a list. A possible improvement might consist in doing something worthwhile, in spite of the symptoms that may persist, such as sadness or voices. Even so, it is not a case of always having to do something while bearing the burden of suffering, but rather of managing to change the context in which the suffering occurs, both the social-interpersonal context by improving the environmental conditions, and one's social-verbal context with respect to oneself through self-distancing. Table 2 compares the medical model – psychiatric and psychological – with the contextual model in accordance with the terms used.

TABLE 2. Comparison between medical model, -psychiatric and psychological- and contextual model.

	Medical Model		Contextual Model
	Psychiatric (Psychopharmacological)	Psychological (cognitive therapy)	Psychological (third generation behavior therapy)
Explanation	Neurobiological explanation (brain structures, neurochemical mechanisms)	Intrapsychic psychological explanation (cognitive structures and processes)	Interactive psychological explanation (functional and contextual)
Causal mechanism	"Internal failure" Neurochemical imbalances, faulty circuits	"Internal failure" Cognitive dysfunction (*e.g.,* depressogenic schema)	No mechanism Possible human condition
Treatment	Medication (antidepressant, antipsychotic)	Specific techniques (cognitive therapy for depression, panic, etc.)	General principles: Acceptance and activation
Efficacy criterion	Reduction of symptoms	Reduction of symptoms	Positive achievements (personal horizons expanded)

Clinical innovation: Psychological inflexibility as a model of psychopathology

Third-generation therapies represent a clinical innovation, with regard to both psychopathological conceptualization and the therapeutic procedure. Such innovations

should be considered as not only of interest within their own tradition, but as important and relevant for all clinical conceptions, be they psychological or psychiatric. As regards the psychopathological concept, third-generation therapies offer a functional-contextual, transdiagnostic alternative to the established classification systems. The alternative offered by these therapies is radically different from the much-maligned but persistent system of diagnostic categories (the DSM-IV containing more categories than the DSM-III, and presumably fewer than the forthcoming version V). Their radical nature consists in identifying the common processes that are at the root of the different disorders and proposing a unified concept of the psychopathological condition.

This concept is offered by ACT, as the third-generation therapy that has most extensively developed its proposals theoretically and empirically. This psychological process and the concept to which it gave rise was initially introduced in 1996 as experiential avoidance (Hayes, Wilson, Gifford, Follette, and Strosahl, 1996; Luciano and Hayes, 2001). In subsequent reworkings, experiential avoidance became just one processes, which together with others made up the broader concept of psychological inflexibility (Hayes, Levin, Plumb-Vilardaga, Villatte, and Pistorello, 2011; Hayes, Luoma, Bond, Masuda, and Lillis, 2006). Psychological inflexibility, as a functional dimension common to the etiology and maintenance of various disorders, is in line with other proposals for transdiagnostic approaches with an emphasis on self-focused attention (Harvey, Watkins, Mansell, and Shafran, 2008; Ingram, 1990) and on hyperreflexivity, as an even more inclusive concept (Pérez-Álvarez, 2008, 2012b).

Psychological inflexibility can be understood as an intensified entanglement in one's own experiences, emotions and thoughts, impeding contact with reality and one's involvement in matters of value for one's life. More specifically, psychological inflexibility refers to a series of processes (actions, reactions and experiences) that involve a narrowing of the behavioral repertoire. These processes are the following six (Hayes *et al.,* 2006, 2011): cognitive fusion, experiential avoidance, loss of flexible contact with the present, attachment to a conceptualized self, values problems, and inaction, impulsivity, or avoidant persistence.

Cognitive fusion is characterized by taking thoughts literally, as though they were already facts to which to respond. Cognitive-verbal processes dominate behavioral regulation to the virtual exclusion of other sources of control, such as the contingencies actually present. There is excessive trust in the rules and, on the other hand, insensitivity to contingencies. One is «fused» with what one thinks and says to oneself, to the detriment of considering how things really are. Rather than questioning the rationality of the thoughts, as cognitive therapy would do, ACT sets out to make contact with the processes under way, neither analyzing nor judging them, as though saying that thoughts are nothing more than «thoughts».

Experiential avoidance is the tendency to avoid or escape from aversive private events such as thoughts, emotions, memories and bodily sensations, even if this prejudices one's behavior (leading to more of the same). The relational nature of human cognition and language makes it possible to categorize, evaluate and try to avoid the emotional responses themselves, whose avoidance negatively reinforces their intensity and persistence, thus severely restricting behavioral flexibility and effectiveness. The alternative to avoidance is acceptance, understood as an open, responsive and flexible

attitude with respect to the experience of the moment. Acceptance is not resignation or passive resistance, but rather positive action that changes the function of experiences of events to be avoided, in favor of a focus of interest and curiosity as a part of living a worthwhile life, beyond the unquieting experience of the moment.

Loss of flexible contact with the present is a consequence of the fusion and avoidance consisting in becoming entangled in analysis of the past and the future. This entanglement leads to one's losing touch with the contingencies of the present moment. If «rumination» over the past is associated with depression, worry about the future would be associated with anxiety. In order to extricate onself from this entanglement, ACT encourages the use of language more as a tool for becoming aware of and describing private events than for predicting and judging them. In this regard, it is common to use exercises of contemplation and mindfulness for putting into practice different «modes of mind» that are less analytical, judgmental and controlling, and conversely, more exploratory, open and flexible.

The concept of attachment to the conceptualized self refers to evaluative stories have learned from the social-verbal context about who we are, in this case, a sort of fusion with the self, without any kind of perspective or distance. Such attachment to the self impedes the person from being in touch with a more transcendent sense of self. In contrast to self-attachment, ACT promotes a certain self-distancing or perspective with regard to the self, on distinguishing self-as-context – the observer self or transcendent self – from self-as-content, comprising the different events one is continually experiencing. Self-as-context is promoted in ACT through mindfulness exercises, metaphors, and experiential processes. Thus, clients can be asked to imagine they are older or they look like they did when they were younger, or to write a letter of advice to the person (themself) who is now having the problems. In Spanish, the dual nature of the verb «to be» (*ser* and *estar*) is of great utility for appreciating these dual aspects of self.

Problems with values concern their lack of clarification, being as they are in ACT directions and horizons that give meaning to life. In ACT, «values are freely chosen, verbally constructed consequences of ongoing, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioral pattern in itself» (Wilson, Sandoz, Kitchens, and Roberts, 2010, p. 253).

Inaction, impulsivity or persistent avoidance are the consequence of the mentioned processes and the quintessence of psychological inflexibility. In contrast to this is the commitment to act in the direction of values, reflected in the name and the essence of Acceptance and Commitment Therapy, to say «act.»

Psychological inflexibility, consisting in the mentioned processes, supplants and impedes a worthwhile life, insofar as one is occupied with oneself, trying in vain to get out of the situation due to the entrenched and inflexible patterns currently dominating one's life. In contrast, the clarification of values would give meaning – direction and significance – to life, permitting and motivating one to move forward in spite of the current experiences and suffering. Eventually, values would enable the person to ignore the «symptoms,» going on to reduce and eliminate them. Hence, ACT does not directly seek the removal of the symptoms (as in the medical model); rather, this is something that may derive from greater psychological flexibility and a reorientation of life toward one's values, which is actually what is proposed in this therapy and in third-generation

therapies in general. Values are more directions that guide one's way (horizons) than destinations that are reached (goals and targets). In practice, the clarification of values is expressed in life domains that are important and consistent for the person, such as family, marital and kinship relations, friendship and social relationships, work, education and training, entertainment, spirituality, community or civic life, or physical well-being. Table 3 summarizes the six psychopathological processes and the corresponding healthy and therapeutic ones.

TABLE 3. Processes of psychological inflexibility and alternative healthy and therapeutic processes.
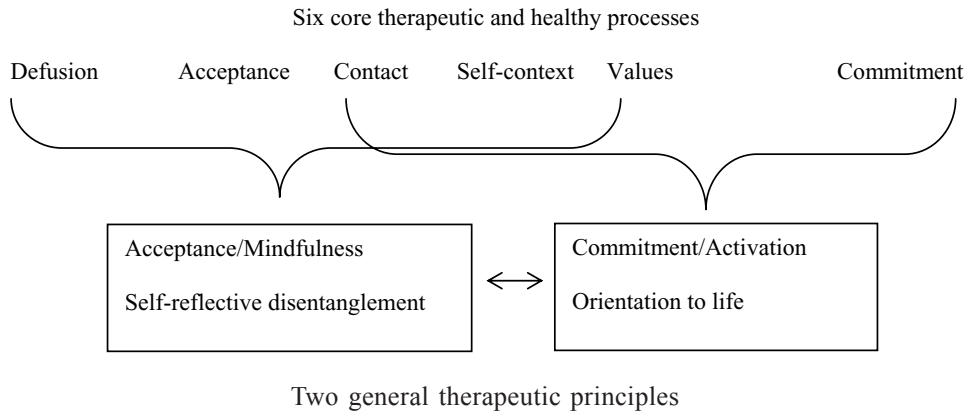
Processes of psychological inflexibility	Alternative healthy and therapeutic processes (psychological flexibility)
Cognitive fusion	Defusion
Experiential avoidance	Acceptance
Dominance of the conceptualized past and feared future; weak self-knowledge	Contact with the present moment
Attachment to the conceptualized self	Self as context
Lack of values clarity	Values clarification
Inaction, impulsivity, or avoidance persistence	Committed action

Clinical innovation: Cognitive disentanglement and behavioral activation as therapeutic principles

The third-generation therapies represented by ACT and as outlined above are characterized not by a collection of techniques, but by offering general therapeutic principles. The key is in being clear about the goal of the psychotherapy, which in this case is the promotion of psychological flexibility, not, for example, the reduction of symptoms, which would be secondary, not due to lack of interest, but because it follows from other changes. In terms of the contextual dimensions highlighted in the characterization of these therapies, their objective is to change the context and function of the «symptoms», not their content and form (topography and frequency). Thus, ACT seeks to change the context of the self or relational framework within the person experiencing the problematic events, so that even without changing such events there is a radical change in their function, from fusion to self-distancing or from inflexibility to flexibility. BA sets out to change the environment through operant behaviors in the client that can open up new possibilities and contingencies, which may in turn, feed back positively onto depressogenic thoughts and feelings. FAP creates an interpersonal therapeutic context in which the client can have corrective experiences.

The six healthy and therapeutic processes corresponding to the different psychopathological processes identified by ACT converge in two main principles referred to in this therapy as mindfulness and acceptance processes, covering defusion, acceptance, contact with the present moment and self as context, and commitment and behavior change processes, which embrace commitment to action, values, self as context and contact with the present moment, the last two being common to the two principles (Hayes *et al.,* 2006, 2011). In the words of Francisco Ruíz, «therapeutic work in ACT can be summarized in two principles: 1) promoting values clarification and actions that are

in accordance with such values; and 2) promoting defusion as a way to be involved in the valued ends when the feared private events are present» (Ruiz, 2010, p. 128). In more general terms, they could be called cognitive or self-reflexive disentanglement and behavioral activation or re-orientation to life. Figure 1 shows the convergence.

Six core therapeutic and healthy processes

| Defusion | Acceptance | Contact | Self-context | Values | Commitment |

| Acceptance/Mindfulness Self-reflective disentanglement | ←→ | Commitment/Activation Orientation to life |

Two general therapeutic principles

FIGURE 1. Convergence of different healthy processes in two general principles.

The notion of self-reflexive disentanglement implies that some kind of intensified – and not just unproductive, but counterproductive – reflexivity is a pathogenic condition common to the different diagnoses (Pérez-Álvarez, 2008). The fact that this disentanglement implies acceptance suggests that life already, of itself, involves suffering and problems that people must face, even though they may live in the «welfare society» and have received the promise of technological solutions for everything, including those provided by psychopharmacology and psychotherapy. The truth is that people must recover the normal acceptance of the possiblity of suffering and distress. The paradox is that people today need therapies that give them back the expropriated acceptance or, so to speak, return them to reality (Freud's «ordinary unhappiness»). And thank goodness that there are therapies with the lucidity and means to do so, such as ACT and the other third-generation therapies, not forgetting others, such as logotherapy or existential therapy (Pérez-Álvarez, 2001).

For its part, the notion of reorientation to life assumes that the meaning of life, whatever it be, is beyond the person, not within us; it is on a horizon, as obiously out there as it is ever-elusive and beyond us (a question of values). Reorientation to life, in therapy, is as important or more so than disentanglement (acceptance). It is not a question simply of involvement in pleasurable activities, but rather one of activation with meaning, oriented toward something meaningful (valued). If self-reflexive disentanglement permits a reorientation of life toward valued or worthwhile things, one's own involvement in the world, beyond oneself, avoids self-entanglement, or at least pushes it into the background. The more we are immersed in the world, the less we are self-entangled, and the greater the self-entanglement, the less life there is.

According to Hayes *et al.* (2011), with regard to ACT in relation to cognitive therapy, the important question is not to compare the empirical efficacy of packages of techniques or brands of therapies, but rather to establish, and where appropriate to compare, assumptions, theories and processes. Not microscopic processes, the typical «mechanisms» (the word already suggests mechanicism) – which, moreover, could entangle whole lifetimes of diligent researchers – but rather philosophically theoretically, scientifically and clinically grounded principles, such as those already mentioned. As far as we are concerned here, the most relevant philosophy for psychopathology and psychological therapy probably lies somewhere between phenomenology and existentialism (Pérez-Álvarez, 2012b).

Thus, more than from technical «tricks», change can come from the horizon of meaning. The presence of a horizon of values can transform distressing experiences as an inherent part of one's life course which, otherwise, could easily give rise to an experiential avoidance disorder, as demonstrated experimentally by Carmen Luciano's team (Luciano *et al.,* 2010; Páez Blarrina *et al.,* 2008). Thus, when distressing experiences in experimental tasks (irritating noises) are framed in an ACT context or protocol they become less annoying, unlike when they are framed in a protocol of avoidance, as tends to occur in everyday life, governed by age-old wisdom according to which one must «feel all right» before doing something, and indeed feel happy in order to move forward. The acceptance-based protocol, compared to that based on avoidance, is very similar to the practice of ACT, as well as to everyday situations, as indeed the ACT protocol seeks to be, asking the client for similar examples from his or her life (Luciano, Molina *et al.,* 2010). The identification of such similarities makes this study relevant in relation to FAP, a therapy which focuses particularly on establishing functional equivalence between real life and the clinical situation. Likewise, the ACT protocol's concern with stressing to the client that «it is you who is hearing the sensation or feeling […] and you choose to do nothing with that feeling» (Luciano, Molina *et al.,* 2010, p. 102) is also relevant for FAP, given its interest in developing private control of the self (Kohlenberg and Tsai, 1991). Furthermore, the ACT protocol implies a philosophy for cultural change, beginning by integrating distress as a part of valued behavior.

Challenges: Less mindfulness and more philosophy

As would be expected, the third-generation therapies face numerous challenges, starting with those derived from their own success. Thus, they are at risk of becoming a fashion to which many subscribe without the necessary preparation or training, given that their logic and procedure are quite different from those already established in academic, clinical and popular contexts. Much of the risk related to fashion is due to the alliance between these therapies – particularly ACT – and mindfulness, which, without wishing to belittle its relevance, lends itself to snobbery. While mindfulness can offer valuable techniques and attitudes, beyond that it may not really contribute anything relevant, and might even mislead, insofar as one's strength is invested in this aspect to the detriment of commitment to the world and to values. We have already stressed the transformational power of a horizon of values in relation to one's own experiences. The roads of the Himalayas were not built with mindfulness. We should not overlook

the fact that those who practice mindfulness in the temples of Tibet appear to have little interest in the starving children they meet on the way in (Begley, 2008, p. 22).

Another risk of success may reside in the «fetishism» of the techniques, depending on the tastes of those who train in them, when what is actually relevant are the philosophical, theoretical and practical principles, in that order, and in any event, principles rather than techniques.

Apart from the challenges they face for distinguishing themselves from cognitive therapy (Herbert and Forman, 2011; Hofmann, Asmundson, and Beck, 2011), and with respect to particular concepts (Kämpfe *et al.,* 2012), the greatest and most interesting challenge for the third-generation therapies is to strengthen each other, given their generational affinities, and to establish affinities with other therapeutic approaches. Regarding the links between them, up to now there would seem to be more influence of ACT on the rest, insofar as they have adopted the concept of acceptance, but there has not been so much adoption in the other direction, despite the fact that ACT lacks concepts which the others have especially developed, such as the self in the case of FAP. Researchers on each therapy should check their own «psychological inflexibility» and «fusion» with their theories. As regards the relationship with other traditions, some have been identified, including the affinity between FAP and psychoanalytic psychotherapy and between existential therapy and ACT (Pérez-Álvarez, 2001). The fact of these similarities is evidence of the sound progress of third-generation therapies, which should not remain unaffected by what is already known in the therapeutic tradition. Sometimes, originality consists in having read little, as Freud acknowledged.

Other challenges concern philosophical bases of more solidity and with greater scope. The third-generation therapies should be praised for the declaration of their philosophical assumptions, and in particular because they are those of functional contextualism, a type of psychological pragmatism with its origins in Skinner's radical behaviorism. With this in mind, and also for pragmatic reasons of asserting themselves in the wide world of psychology and psychiatry, the philosophy of the third-generation therapies, led by ACT, should be more ambitious and radical. Its simple psychological pragmatism entails weaknesses of philosophical dimensions. Thus, ontological abstinence (Hayes *et al.,* 2011, p. 3) becomes a kind of philosophical vegetarianism which is perceived, for example, in relation to the conception of values (Wilson *et al.,* 2010), which displays vulgar subjectivism and is dependent on choice as though it were a case of selecting products in a supermarket (closely in step, incidentally, with economic liberalism). If values have the importance they do it is because they are objective, socially institutionalized, out-there in the world and even imposed, insofar as individuals form part of a society that is already up and running. As though gangsters or anorexics, for example, had no values and values give the same ones that other. Ontological abstinence is also perceived in the failure to ask what psychological disorders are, about their nature, beyond the «processes» involved («psychological inflexibility,» etc.). This meta-empirical question is important if only for the «pragmatic» reason of having to confront contrary positions, not least those of psychiatry.

As a philosophical remedy, the third-generation therapies could highlight their affinities with the Western philosophical tradition. The slogan could be along the lines of «less Buddhist mindfulness and more Western philosophy.» By way of an indication, we might consider a couple of philosophical affinities with radical behaviorism, which

is, after all, at the root of functional contextualism and of RFT. We are referring to Aristotle and phenomenology. Although such references were not intended to remedy the philosophical «diet» of the third-generation therapies, they could be of relevance for them. In any case, the question is to situate psychological pragmatism in a broader context. For example, the doctrine of Aristotle's four causes applied to behavior permits us to conceive a notion of organism and even of person which, on the one hand, prevents us from falling into intrapersonal mechanicism, and on the other, roots all behavior in the historical-cultural context (Pérez-Álvarez, 2009; Pérez-Álvarez and García-Montes, 2006). Likewise, the application of the four causes to psychopathology allows a radically contextual ontological approach to mental disorders (Pérez-Álvarez, 2004; Pérez-Álvarez, Sass, and García-Montes, 2008).

For its part, the affinity of radical behaviorism with phenomenology and existentialism permits an understanding of psychological disorders in the context of life problems, which is how they should be understood (García-Montes and Pérez-Álvarez, 2010). Thus, for example, in the broader context of phenomenology, functional contextualism may confront problems such as schizophrenia. ACT handles itself well in the area of «neurotic» disorders, as do, in general, the rest of the psychological therapies, but it goes nowhere in relation to schizophrenia, where the concept of «psychological inflexibility» itself is overwhelmed. Staying on the subject of schizophrenia, the «psychological flexibility» in that disorder may be an aspect that is more psychopathological, characteristic of the condition, than healthy. If the third-generation therapies are clinical innovations that go beyond fashion, we can also expect «groundbreaking» conceptions in disorders such as schizophrenia, as long as we seek to consider it as a disorder of the self rather than of the brain (Pérez-Álvarez, 2012a).

Notes for an extension of ACT to schizophrenia

Various case studies (García-Montes, Luciano, Hernández, and Zaldívar, 2004; García-Montes and Pérez-Álvarez, 2001, 2010; Veiga-Martínez, Pérez-Álvarez, and García-Montes, 2008) and clinical trials (Bach and Hayes, 2002; Gaudiano and Herbert, 2006; Shawyer *et al.,* 2012; White *et al.,* 2011) have shown the feasibility and usefulness of ACT for the relief of psychotic symptoms, including the reduction of hospital readmissions within one year of follow-up (Bach, Hayes, and Gallop, 2012). While acknowledging the merit of this, it must be said that the results are somewhat modest. Althoug the lower rehospitalization rate in those receiving ACT might make for a striking headline along the lines of «brief psychotherapy technique keeps psychotic patients out of hospital», the patient's status does not change (Bach *et al.,* 2011).

The modesty of these results may be due in large part to the role ACT seems to have accepted in schizophrenia, like the other psychological therapies, as adjuncts to medication, within the dominant biomedical model. The point is that ACT, in the context of the third-generation therapies, has more to offer in schizophrenia, beginning by criticizing and challenging the biomedical model, given that its own model is a contextual one. Its potential contributions come up against the accepted conceptions and practices, and are limited by them. Thus, its shifting of the focus from the reduction of symptoms to changing the way patients respond to them, and to leaving behind the «illness» label, collides with established clinical conventions, including the indoctrination of people in the medical model. It is true that today it is difficult to find any patients not on

medication to whom to apply psychological therapy, but it is also true that patients could eschew medication: this is more an instititional question than a scientific one (Pérez-Álvarez and García-Montes, 2012).

In any case, given the circumstances, ACT should undoubtedly overcome its own «doctrinal inflexibility» to be in a position to deal with schizophrenia. Let us consider some potentially worthwhile ways forward.

ACT should recognize that other therapies also use the concept of acceptance, and with notable success, prestige and coverage. These would include the «accepting» and «making sense of» voices approach developed by Marius Romme and Sandra Escher (Romme and Escher, 1993, 2000). Two aspects of this approach could be of interest to ACT. One is related to «making sense» of the voices in the biographical context, which might be more acceptable and pragmatic for some patients than not going into the content of the voices, as advocated by ACT. Another concerns that fact that given its naturalistic conception of what people do with the voices, Romme and Escher's approach emphasizes strategies which in some cases might be more viable than quasi-psychotic ACT procedures such as «taking the mind for a walk,» seeing thoughts as «thoughts,» materialized without meaning, or deliteralizing words – practices in which many schizophrenic patients are already «experts.»

Acceptance of the symptoms must also apply to other clinicians with whom the patient is dealing, and to their families. Non-acceptance of the symptoms by others in the clinical team, especially psychiatrists, is at the root of backsliding in patients who were being treated with ACT (García-Montes and Pérez-Álvarez, 2001). In contrast, it has been shown that closer collaboration between clinicians helped the patient's course, including the reduction of medication (Veiga-Martínez et al., 2008). On the other hand, there are plenty of reports of patients successfully treated with ACT without being on medication (García-Montes and Pérez-Álvarez, 2010). Acceptance by family members is also crucial in the ACT perspective. Clinicians and family should be trained in the ACT philosophy, rather than in the theory of vulnerability-stress. The better prognosis of schizophrenia in less developed countries, compared to more developed ones, has to do with the greater acceptance of «psychotic crises» (Pérez-Álvarez, 2012a). As we have mentioned, ACT has implications for cultural change (Luciano, Molina et al., 2010).

Given that the therapeutic relationship is a fundamental aspect of psychotherapy for schizophrenia, in the sense that the interpersonal chemistry is more important than the interneuronal chemistry (Pérez-Álvarez and Garcia-Montes, 2012a; Pérez-Álvarez, García-Montes, Vallina-Fernández, Perona-Garcelán, and Cuevas Yust, 2011), the therapeutic relationship in ACT can be improved on the basis of FAP (Baruch, Kanter, Busch, and Juskiewicz, 2009). Thus, the interpersonal context can provide opportunities for the recovery of sense of self as proposed by FAP (Kohlenberg and Tsai, 1991). The recovery of sense of self in the therapeutic context may include the development of a narrative that frames experiences and values (Pérez-Álvarez et al., 2011). Just as an ACT protocol transforms pain experiences (Luciano, Molina et al., 2010), there is no reason why it should not do the same in relation to psychotic experiences. ACT can also benefit from the BA strategies developed for treating depression, in this case for negative psychotic symptoms, with a view to facilitating access to reinforcement contingencies (Mairs, Lowell, Campbell, and Keeley, 2011).

Taking into account all of these suggestions, the contextual, de-medicalizing

philosophy of ACT can confront schizophrenia, going beyond the ancillary role and the modest results which have been its fate up to now. As in the case of schizophrenia, recovery does not take place without transformations.

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