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# Acceptance and Commitment Therapy for Anxiety Disorders: Three Case Studies Exemplifying a Unified Treatment Protocol

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*Acceptance and Commitment Therapy (ACT) is an innovative acceptance-based behavior therapy that has been applied broadly and successfully to treat a variety of clinical problems, including the anxiety disorders. Throughout treatment ACT balances acceptance and mindfulness processes with commitment and behavior change processes. As applied to anxiety disorders, ACT seeks to undermine excessive struggle with anxiety and experiential avoidance—attempts to down-regulate and control unwanted private events (thoughts, images, bodily sensations). The goal is to foster more flexible and mindful ways of relating to anxiety so individuals can pursue life goals important to them. This article describes in some detail a unified ACT protocol that can be adapted for use with persons presenting with any of the major anxiety disorders. To exemplify this approach, we present pre- and posttreatment data from three individuals with different anxiety disorders who underwent treatment over a 12-week period. The results showed positive pre- to posttreatment changes in ACT-relevant process measures (e.g., reductions in experiential avoidance, increases in acceptance and mindfulness skills), increases in quality of life, as well as significant reductions in traditional anxiety and distress measures. All three clients reported maintaining or improving on their posttreatment level of functioning.*

Over the last 40 years, behavior therapy has led the development of empirically derived and time-limited behavioral and cognitive-behavioral interventions to assist those suffering from anxiety and fear-related problems (Barlow, 2002; Beck, Emery, & Greenberg, 1985). This work continues in earnest, as researchers and practitioners work to improve the potency, durability, and effectiveness of such interventions. Gaining knowledge of mechanisms and processes that mediate positive outcomes continues to receive research attention as well. Over the past decade, part of this effort has focused on exploring mindfulness and acceptance-based approaches. In its most basic form, mindfulness is about focusing our attention on the present moment and making direct contact with our present experiences, with acceptance and without defense, and with as little judgment as possible (Kabat-Zinn, 1994).

This work has led to innovative experimental and applied applications for a wide range of psychopathology (Hayes, Follette, & Linehan, 2004), including anxiety (Hayes, 1987; Orsillo, Roemer, Block-Lerner, LeJeune, & Herbert, 2005) and depression (Segal, Williams, & Teasdale, 2002). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is part of this newer line of exploration, and studies have shown that ACT can be effective for the treatment of generalized anxiety disorder (Roemer, Orsillo, & Salters-Pedneault, 2008), obsessive-compulsive disorder (Twohig, Hayes, & Masuda, 2006), and posttraumatic stress disorder (Orsillo & Batten, 2005). Our purpose here is to describe an integrated application of ACT that can be adapted for use with any of the major anxiety disorders (Eifert & Forsyth, 2005), including outcome data from three clients with different anxiety disorder diagnoses. In doing so, we wish to point out that what follows is just one of several ways (not *the* way) that ACT may be applied to persons suffering from anxiety disorders.

ACT has two major goals: (a) fostering acceptance of problematic unhelpful thoughts and feelings that cannot and perhaps need not be controlled, and (b) commitment and action toward living a life according to one's chosen values. This is why ACT is about acceptance *and* it is about change at the same time. Applied to anxiety disorders, clients learn to end the struggle with their anxiety-related discomfort *and* take charge by engaging in actions that move them closer to their chosen life goals ("values"). Instead of teaching "more, different, better" strategies to change or reduce unwanted thoughts and feelings, ACT teaches clients skills to acknowledge and observe unpleasant thoughts and feelings just as they are.

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This less avoidant and more flexible way of responding to anxiety and other forms of emotional discomfort creates a space for individuals to act in ways that move them in the direction of chosen life goals even when unpleasant thoughts, feelings, and bodily sensations are present.

An ACT approach to anxiety disorders is predicated on the notion that anxiety disorders are characterized by experiential and emotional avoidance, defined as a tendency to engage in behaviors to alter the frequency, duration, or form of unwanted private events (i.e., thoughts, feelings, physiological events, and memories) and the situations that occasion them when such avoidance leads to problems in functioning (Hayes et al., 1999). The function of experiential avoidance is to control or minimize the impact of aversive internal experiences. Experiential avoidance can produce immediate, short-term relief from negatively evaluated anxiety-related thoughts and emotions, which negatively reinforces such behavior. It becomes problematic when it interferes with a person's everyday functioning and life-goal attainment. As described in more detail elsewhere (Eifert & Forsyth, 2005; Forsyth, Eifert, & Barrios, 2006), rigid and inflexible down-regulation of emotions and patterns of emotional and experiential avoidance is thought to function as a core psychological diathesis underlying the development and maintenance of several forms of psychopathology (Blackledge & Hayes, 2001; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Kashdan, Barrios, Forsyth, & Steger, 2006), including all anxiety disorders and depression (Barlow, Allen, & Choate, 2004). For instance, Karekla, Forsyth, and Kelly (2004) found that emotional avoidance was more predictive of panic responses than other psychological risk factors for panic such as anxiety sensitivity, even in healthy individuals. This avoidance of discomfort is linked with language processes (e.g., entanglement in one's own judgments and evaluations), rule-governed patterns of action and inaction (e.g., "I might get anxious in that unfamiliar situation, so I'd better not go"), and negative self-evaluations (e.g., "I am worthless" or "I am incompetent"). Such avoidance is problematic because it occurs in the context of competing approach contingencies, that is, actions that clients wish to engage in as part of a good quality of life, and in that context the avoidance behavior tends to dominate over approach behavior. This is why experiential avoidance is one of the most important treatment targets in ACT.

A posture of experiential acceptance, by contrast, "involves experiencing events fully and without defense . . . and involves making contact with the automatic or direct stimulus functions of events, without acting to reduce or manipulate those functions, and without acting on the basis solely of their derived verbal functions" (Hayes, 1994, p. 30). Acceptance, unlike experiential avoidance, reflects an openness to all types of experience (both aversive and pleasant) and a commitment to abandon the change agenda where it does not work well and thereby has a negative impact on functioning and only serves to increase distress, namely, in the realm of private events (Marx & Sloan, 2004). Several independent lines of research (for an extensive review, see Hayes, Luoma, Bond, Masuda, & Lillis, 2006) support the notion that rigid and inflexible (i.e., context insensitive) attempts to suppress and control unwanted private events are largely ineffective, and can result in more (not less) unwanted thoughts and emotions (Koster, Rassin, Crombez, & Näring, 2003; Purdon, 1999), increase distress and restrict effective life functioning (Marx & Sloan, 2004), and reduce engagement in meaningful and valued life activities with a concomitant poorer overall quality of life (Dahl, Wilson, & Nilsson, 2004; Hayes et al., 2006). Other related lines of work have shown that avoidant coping strategies such as denial, mental disengagement, and substance abuse predicted more frequent and intense $CO_2$-induced physical and cognitive panic symptoms than acceptance-based coping strategies (Feldner, Zvolensky, Eifert, & Spira, 2003; Spira, Zvolensky, Eifert, & Feldner, 2004). Similarly, Eifert and Heffner (2003) found that when highly anxious females were exposed to $CO_2$-enriched air, participants in an acceptance context were less avoidant behaviorally, reported less intense fear and fewer catastrophic thoughts, and were less likely to drop out of the study than participants in a control context. These results were replicated in a procedurally similar study with actual clients suffering from panic disorder (Levitt et al., 2004). Lower experiential avoidance and greater acceptance also enhance willingness to engage in exposure exercises (Levitt et al., 2004) and may prevent dropout (Karekla & Forsyth, 2004) in persons with panic disorder. Collectively, this work suggests that experiential avoidance is a potentially toxic process linked with forms of distress and life impairment, and that strategies promoting approach or acceptance of discomfort may be worthwhile as healthier alternatives.

As in the mindfulness-based cognitive therapy program for depression developed by Segal and colleagues (2002), one of the core skills to be learned in ACT programs is how to step out of entanglements with self-perpetuating and self-defeating emotional, cognitive, and behavioral avoidance routines. This is achieved by teaching clients various skills aimed at undermining excessive and rigid thought and emotion regulation (Masuda, Hayes, Sackett, & Twohig, 2004). Based on the bulk of empirical data showing the negative impact of experiential avoidance, ACT does not attempt to help clients to control or manage anxiety and instead teaches them how to let go of their control struggle. Thus, ACT is different from what many clients and therapists typically expect must be done