

Contains Video <sup>1</sup>

## Brief Acceptance and Commitment Therapy and Exposure for Panic Disorder: A Pilot Study

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*Cognitive and biobehavioral coping skills are central to psychosocial therapies and are taught to facilitate and improve exposure therapy. While traditional coping skills are aimed at controlling maladaptive thoughts or dysregulations in physiology, newer approaches that explore acceptance, defusion, and values-based direction have been gaining interest. Acceptance and Commitment Therapy (ACT) involves creating an open, nonjudgmental stance toward whatever thoughts, feelings, and bodily sensations arise in a given moment, experiencing them for what they are, and moving toward them while inner experiences such as anxiety are present. This approach can be seen as consistent with exposure therapies and may be utilized to organize and facilitate engagement in exposure exercises. This study examines the feasibility and efficacy for combining a brief ACT protocol with traditional exposure therapy. Eleven patients with panic disorder with or without agoraphobia received 4 sessions of ACT followed by 6 sessions of exposure therapy, with data collected on a weekly basis. Acquisition of ACT skills and their application during exposure was monitored using a novel “think-aloud” technology. Treatment was associated with clinically significant improvements in panic symptom severity, willingness to allow inner experiences to occur, and reductions in avoidant behavior. Although preliminary, results suggest that our brief training in ACT only (as assessed prior to exposure exercises) and in combination with exposure therapy was acceptable to patients and offered benefits on the order of large effect sizes. Clinical and research implications are discussed.*

COGNITIVE and biobehavioral coping skills are central to psychosocial therapies for anxiety disorders and are taught to facilitate and improve exposure therapy. These control-based coping skills typically aim to change catastrophic appraisals or change somatic symptoms. While traditional coping skills are aimed at *controlling* maladaptive thoughts or dysregulations in physiology, newer approaches that explore acceptance or willingness to experience such states have been gaining interest. One specific cognitive behavioral modality that is receiving increased attention is Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011). ACT is part of the cognitive behavioral tradition, but it focuses

more heavily on acceptance and mindfulness processes as ways of responding to internal experiences (i.e., thoughts, feelings, bodily sensations) than more traditional CBT protocols. To this end, ACT is more similar to other acceptance- and mindfulness-based interventions, such as Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), that focus on the *function* of internal experiences rather than their *form* or content.

With the focus shifting away from the question of whether “CBT works” to “why it works” (i.e., mediators) and “for whom” (i.e., moderators), the examination of novel approaches seems particularly vital (Kazdin, 2007; McNally, 2007; Meuret, Wolitzky-Taylor, Twohig, & Craske, 2012). While the combination of therapeutic components that make up traditional CBT is generally effective for patients suffering from an anxiety disorder (Norton & Price, 2007; Westen & Morrison, 2001), there is considerable room for improvement. This seems particularly true for patients suffering from panic disorder with or without agoraphobia (PD/A). Here, effect sizes for CBT are the smallest among the anxiety disorders (Andrews, Cuijpers, Craske, McEvoy, & Titov,

<sup>1</sup> Video patients/clients are portrayed by actors.

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2010; Hofmann & Smits, 2008; but not Norton & Price, 2007), attrition is high (Haby, Donnelly, Corry, & Vos, 2006), and a large percentage of completers do not reach responder status after treatment (T. Brown & Barlow, 1995).

ACT involves the creation of an open, allowing attitude and nonjudgmental curiosity toward whatever emotions arise in a given moment, including panic-related ones, and the ability to then mindfully turn attention toward values-based actions (Hayes et al., 2011). It aims to help clients notice panic-related inner experiences, see them as simply events occurring within the body, allow them to either occur or not, and continue a valued direction with these experiences as aspects of life. While these procedures are not antithetical to traditional CBT procedures, ACT makes no attempts to eliminate the content of inner experiences. In traditional CBT, clients are encouraged to learn cognitive skills to control negative thoughts or somatic skills to control dysregulated physiology, which are then applied during exposure to feared sensations or situations. In ACT training, clients learn how to function with or without the presence of panic-related inner experiences, rather than trying to regulate or control them before changing behavior. As such, there is little concern for the intensity or frequency of panic-related thought, feelings, or bodily sensations.

There is support for this conceptualization of PD/A (e.g., Levitt et al., 2004; Levitt & Karekla, 2005; Orsillo, Roemer, Block-Lerner, & Tull, 2004) and growing evidence supporting the utility of ACT for anxiety disorders (as reviewed in Codd, Twohig, Crosby, & Enno, 2011). Correlational studies have shown that psychological inflexibility (the target process in ACT) predicts anxiety and anxiety sensitivity across a range of patients (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Randomized controlled trials of ACT for anxiety disorders are emerging, including ACT for test anxiety (L. Brown et al., 2011; Zettle, 2003), social anxiety disorder (Kocovski, Fleming, & Rector, 2009), generalized anxiety disorder (Roemer, Orsillo, & Salters-Pedneault, 2008), and obsessive-compulsive disorder (Twohig et al., 2010). ACT protocols can be applied across a variety of anxiety disorders. This has been demonstrated in case studies (Codd et al., 2011), effectiveness studies with samples of participants diagnosed with anxiety disorders (Lappalainen et al., 2007), or studies with clinically severe levels of anxiety and depression, albeit undiagnosed (Forman, Herbert, Moitra, Yeomans, & Geller, 2007).

While some of these studies purposefully exclude exposure exercises for experimental reasons (Codd et al., 2011; Twohig, Hayes, & Masuda, 2006; Twohig et al., 2010), ACT is complementary to traditional exposure exercises. From an ACT perspective, "The purpose of exposure is not

to reduce emotional arousal but to practice acceptance of private experiences and the ability to function in a more free, flexible, and values-based way in their presence" (Hayes et al., 2011, p. 400; see also Hayes, 1987, p. 365). This view is consistent with a current view of exposure put forth by Craske and colleagues (2008) that exposure may work by optimizing learning based on increasing tolerance for fear and anxiety, rather than the traditional focus on fear reduction. With empirical support for fear reduction serving as a predictor of treatment outcome largely lacking (Baker, Mystkowski, Culver, Yi, Mortazavi, & Craske, 2010; Craske et al., 2008; Culver, Stoyanova & Craske, 2012; Kircanski et al., 2012; Meuret, Seidel, Rosenfield, Hofmann, & Rosenfield, in press), the quest for identifying outcome predictors is more pertinent than ever.

Hence, ACT may offer a potent alternative approach that enhances the acceptability of and engagement in exposure therapy/behavioral change by creation of response flexibility and new learning that occurs while exposing oneself to the feared stimuli. Preliminary evidence for this thesis has been shown in recent experimental studies in which brief training in emotional acceptance lowered distress and increased tolerance for experimentally induced anxiety symptoms in individuals with PD/A (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Eifert & Heffner, 2003; including carbon-dioxide inhalation challenges, Levitt et al., 2004). Similar results have been shown for pain tolerance (e.g., Hayes, Bissett, et al., 1999) and exposure to distressing International Affective Picture System slides (Arch & Craske, 2006).

The current investigation aimed to assess the feasibility and efficacy of a behaviorally based ACT treatment that was systematically divided into a skill training phase and a skills application phase. Patients in this pilot trial suffered from a principal *DSM-IV* (American Psychiatric Association, 1994) diagnosis of PD/A. They received 4 sessions of ACT focusing on acceptance, defusion, and values-based action, followed by 6 sessions of ACT combined with exposure therapy. Panic symptom severity and willingness to accept panic-related inner experiences were examined after ACT only and after the combination of ACT with exposure.

## Methods

### Patients and Procedure

Eleven patients (ages 20 to 55, average age=34.3) participated in the open series of behaviorally based ACT treatment. The study was conducted at two sites: the Stress, Anxiety, and Chronic Disease Research Program at Southern Methodist University, Dallas (SMU;  $N=5$ ), and the Anxiety Disorders Research Center at the University of California, Los Angeles (UCLA;  $N=6$ ). Patients were recruited by regional postings, newspaper advertisements, and by self-referrals to the anxiety clinics, and selected

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