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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

to solve anxiety problems. It is therefore an essential first step in treatment that therapists help clients experience the costs of remaining trapped in the idea that effective anxiety control is a prerequisite for leading a better life, and how anxiety control strategies have negatively impacted their life functioning and increased distress when they failed to work as intended (see also Eifert & Heffner, 2003; Levitt et al., 2004).

## Treatment Overview

The ACT for Anxiety program is a unified treatment protocol that guides therapists in the flexible application of ACT principles and techniques for clients presenting with any of the major anxiety disorders (Eifert & Forsyth, 2005). An expanded version of the protocol is also available in the form of a self-help workbook (Forsyth & Eifert, 2008). A formal evaluation and comparison of this ACT protocol with a unified CBT protocol is under way in the context of a clinical trial at UCLA that specifically examines the relation between treatment outcome and processes of change in the two treatment approaches. Here, we will provide an overview of the original unified ACT for Anxiety protocol, followed by outcome data from three clients who have completed the ongoing clinical trial.

The delivery of the treatment protocol itself is organized around three interwoven phases. The goal of Phase 1 (Sessions 1 through 3) is to create an acceptance context for anxiety-related discomfort, and this work sets the stage for the remaining treatment sessions. With the help of metaphors and exercises, clients experience the costs of past efforts to control and manage anxiety. Rather than avoid their anxiety-related experiences, clients begin to learn some basic skills to stay with anxiety-related discomfort and look at it from a mindful observer perspective.

In Phase 2 (Sessions 4 through 7), the focus shifts to identifying clients' most cherished life goals (values) and teaching skills designed to build more flexible patterns of behavior when anxiety and fear arise. During exposure exercises, framed in the context of client values, clients learn to practice mindfulness skills in the presence of anxiety-related discomfort. Mindfulness is an important skill to learn because it counteracts past experiential avoidance strategies aimed at controlling or reducing anxiety-related discomfort that tend to get in the way of value-guided actions. In these sessions, therapists also help clients make commitments to start engaging in actions that are in accord with those values.

In Phase 3 (Sessions 8 through 12) the focus broadens further to help clients engage in value-guided actions in their natural environment and stay committed to moving in those directions in the face of the inevitable anxiety-related barriers. With the help of worksheets adopted from behavioral activation programs (e.g., Addis & Martell, 2004), therapist and client specify concrete and achievable goals that are derived from one or two values identified by clients in Phase 2. As clients engage in such goal-directed activities, they invariably encounter anxiety-related difficulties that used to serve as barriers and often resulted in avoidance behavior. Therapists devote much time to teach clients to move with such barriers by helping them to apply mindful observation and other skills when faced with anxiety-related discomfort. Increasing a client's willingness to stay on the course of committed action, and "taking anxiety along for the ride" if it shows up, is an important focus for the remainder of treatment.

An integral part of ACT is the use of metaphors and related experiential exercises throughout treatment. These exercises allow clients to make experiential contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided because they were too frightening to contact directly. Metaphors are verbal stories that consist of analogies and pictures. As such they cannot be taken literally and allow clients to make experiential contact with an aspect of their experience in a new way and from a different point of view (for a more detailed RFT analysis of metaphors, see Stewart, Barnes-Holmes, Hayes, & Lipkens, 2001). In so doing, they help create distance between themselves and how they are approaching their anxiety, while also opening the door for new solutions to emerge (for detailed descriptions of all metaphors and exercises used in our study, see Eifert & Forsyth, 2005; Forsyth & Eifert, 2008).

## Session-by-Session Treatment Program and Core Process Targets

Although we outline the treatment program in the form of session-by-session guidelines, the actual delivery of ACT is more akin to a fluid dance around several core processes rather than a linear progression. ACT is a functional *approach,* not merely a therapy or collection of treatment technologies. It builds on a model with several interrelated treatment targets that are continually revisited throughout therapy. At a practical level, this means that concepts, metaphors, and exercises introduced early on, may be revisited again at any time they seem relevant. Therapists are encouraged to sequence and apply exercises and metaphors in a flexible and creative fashion. This can be accomplished by individualizing and tweaking techniques based on the specific circumstances and responses of each client. This individualization should be guided by an understanding of the core processes targeted in ACT.

ACT may be applied to all anxiety disorders, in part, because it targets a set of central processes that feed anxiety-related problems, regardless of the specific form or anxiety subtype: the struggle with unwanted emotions

and cognitions and low levels of engagement in meaningful life activities (Hayes et al., 2006). The focus is on changing the function (rather than form or specific content) of unwanted thoughts and emotions so that they no longer get in the way of effective action. In fact, a considerable amount of treatment time is spent on increasing client actions in everyday life that are consistent with what clients value and wish their lives to stand for. Where appropriate and necessary, the protocol addresses anxiety subtype-specific considerations and procedural variations are provided. The protocol also provides therapists with practical guidelines to integrate ACT principles and techniques with the most successful and effective aspects of cognitive behavioral interventions for anxiety disorders—in particular exposure and behavioral activation as well as social skills training to remedy deficits in some persons with social anxiety problems.

**Treatment Orientation—Learning New Skills**

The first session seeks to provide clients with an understanding of the nature and purpose of anxiety and what can make anxiety become problematic or a significant life problem. Here, anxiety and fear are described as adaptive emotions that may, however, turn into life shattering problems when clients respond to their anxious thoughts, feelings, and memories in rigid and inflexible ways with the goal of not experiencing them. Therapists introduce the notion that struggle and control may actually interfere with the client's everyday functioning and life-goal attainment, and then explore that notion briefly in terms of clients' life experiences. Therapy is framed as an opportunity to learn and practice new and more flexible ways of responding when experiencing anxiety. The goal is for clients to learn skills and ways of no longer letting anxiety be an obstacle to doing what they want to do so they can live a rich and meaningful life. Therapists also use the first session to emphasize the active, experiential, and participatory nature of ACT, and focus on developing rapport and dispelling common misconceptions about fear and anxiety (e.g., anxiety is bad and a problem to be solved).

**Examining the Effects of Anxiety Control Efforts—Creative Hopelessness**

The first step in a new direction is to identify and then abandon strategies that have neither helped clients improve their life goal attainment and quality of life nor actually provided any lasting relief from anxiety distress. For this reason, Sessions 2 and 3 focus on creating an acceptance context for treatment as an alternative to anxiety control and avoidance. This is accomplished by gently exploring the usefulness ("workability") and effects and costs of the various strategies clients have used to cope with and manage anxiety and by encouraging clients to make space for new solutions. Specifically, clients examine (a) all the various strategies they have employed to manage and control their anxiety and how well those strategies worked, both in the short and long-term, (b) how experiential avoidance and efforts to control anxiety have constricted or limited the patient's life, and (c) what letting go of the struggle with anxiety might look like. This is accomplished experientially with the help of metaphor-based experiential exercises that are acted out in session by the therapist and client together. The purpose of these exercises is to (a) let clients experience how all their various attempts to down-regulate anxiety-related experiences (e.g., bodily sensations, images, worries) have not worked and constricted their life, and (b) that letting go of their struggle and doing things that go against the grain is not only possible but may be more viable. To illustrate, we provide two examples of metaphors that are typically used at some point in Session 2 or 3.

*The Chinese Finger Trap Exercise*

A Chinese finger trap is a tube of woven straw about five inches long and half an inch wide. Therapist and client each take a finger trap and do the exercise together. First, they slide both index fingers into the straw tube, one finger at each end. If one attempts to pull the fingers out, the tube catches and tightens, causing discomfort. The only way to regain some freedom and space to move is to push the fingers in *first* and *then* slide them out. The purpose of this exercise is to let clients discover through experience that attempting to pull away from anxiety, while understandable and seemingly logical (like pulling out of the finger trap), only creates more problems: the harder you pull, the more the trap tightens, resulting in less room to move and even more discomfort. In contrast, doing something counterintuitive, such as pushing the fingers *in* rather than *out* and leaning into the discomfort, effectively ends the struggle and creates literally more space ("wiggle room"). Following the exercise, clients take the finger trap home. We adapted this exercise from the metaphor described by Hayes and colleagues (1999), who present the metaphor to clients only in verbal form. Based on the results of a study we conducted (Eifert & Heffner, 2003), we suggest that both therapist and client act out the metaphor with real finger traps and together explore the experiential effects of various strategies (i.e., pulling out vs. leaning in).

*The Tug-of-War With the Anxiety Monster Exercise*

Similar to the finger trap, this metaphorical exercise sets up a struggle, while pointing to solutions that stand in opposition to what people typically do in a struggle. Interestingly, this metaphor was created by a woman with agoraphobia in the context of her work with an ACT therapist (Hayes, Wilson, Afari, & McCurry, 1990). While therapists explore the clients' efforts to defeat their

anxieties and fears, they gently suggest that this struggle sounds like a tug of war with an anxiety monster. The client is asked if they are willing to see how this might play out in the room. For the exercise, therapists play the role of the anxiety monster. Both therapist and client take one end of a rope (about 3 to 4 feet long) and start pulling. As the tug of war unfolds, clients notice that efforts to pull harder result in the monster pulling harder right back. Acting out this exercise lets clients physically experience how much energy and focus it takes to keep the anxiety monster in check. Also, almost all clients will grab the rope with both of their hands, and this dramatically shows them how their efforts fighting anxiety have left their hands and feet tied up in the fight and no longer free to do other things in life. One key element of this exercise is to let clients experience that they have a choice: continue to fight or drop the rope. Once clients actually drop the rope, they experience the difference this action makes and what they gain from it: less strain and more room to move. Clients also learn that the choice is not whether the anxiety monster is there or not, but whether to pick up the rope again and fight. Here clients experience in a very concrete fashion what they cannot control (what the anxiety monster does) and what they can control—what they do with their hands and feet. To enhance the exercise, therapists may bring important life areas into the room, where the anxiety monster tends to show up and gets in the way of what they want to do. Incidentally, therapists need not worry about ending up in a fight with their clients. We have found that clients fully recognize and stay within the playful boundaries of the exercise.

*Creative Hopelessness*

These metaphors are used during this phase of treatment to induce "creative hopelessness" (Hayes et al., 1999) by letting clients experience that former solutions have not worked (hopelessness) and that therapy presents an opportunity to create new outcomes with a radically different approach (accepting rather than struggling). To get there, clients must let go of old strategies that have not worked. Many clients have difficulty grasping what letting go means in practical terms and what letting-go behavior looks like. A practical aspect of letting go is to learn to observe anxiety-related experiences mindfully rather than struggling with, or attempting to eliminate, such experiences. This theme is introduced with a formal 12-minute eyes-closed mindfulness exercise ("acceptance of thoughts and feelings exercise"), which was adapted from more generic versions (Davis, Eshelmann, & McKay, 2000; Segal et al., 2002) for the purposes of this anxiety treatment program. The goal is for clients to practice paying attention to a single focus, their breathing, and to learn to watch and allow other internal events, such as thoughts, feelings, and sensations, to come and go. If they pay attention to their experience, they will see how it changes from moment to moment, how it comes and goes on its own, without any effort on their part. Clients are asked to practice this exercises at least once a day at home.

**Identifying Values and Goals**

ACT is a constructive approach to behavior change with a focus on enhancing quality of life. This is why perhaps the most important goal of our program is to encourage clients to engage in life-goal directed behavior as an alternative agenda to managing anxiety. To this end, early on (typically in Session 3 at the latest), clients complete several experiential exercises to help them explore their core values in their lives. Clients are encouraged to think about what they *want to do with their lives,* not what they *do not want to have or feel.* This re-orientation is achieved by helping clients define what they want their lives to be about and stand for in key life domains such as family, friends, romantic relationships, leisure, spirituality, health, career, education, and community (see also, Dahl & Lundgren, 2006). At a later point, we use additional experiential exercises and behavioral activation worksheets to define more specific goals that lead them in the direction of those values.

As clients identify values, they often recognize that anxiety management behavior has moved them away from their life values. For example, a woman with a daughter in elementary school told us that her most important life goal was to be a good mother. Yet, she recognized that her agoraphobic avoidance behavior has kept her from attending her daughter's school concerts. In fact, she had not attended a single one. Rather than continue to devote more time and energy to keeping panic away, she made a choice to learn to observe and stay with her discomfort so that she would eventually be able to approach the previously avoided school auditorium and watch her daughter perform.

**Acceptance: Developing Willingness to Stay With Discomfort**

ACT aims to teach clients acceptance as an alternative behavior to experiential avoidance. "Acceptance involves the active and aware embrace of those private events occasioned by one's history without unnecessary attempts to change their frequency or form, especially when doing so would cause psychological harm" (Hayes et al., 2006, p.7). The focus is on teaching clients acceptance and mindfulness skills as ways of learning to observe unwanted anxiety-related responses fully and for what they are (i.e., thoughts as thoughts, physical sensations as physical sensations, images as images, feelings as feelings).

Session 4 and 5 introduce clients to acceptance and mindfulness as a skillful way of approaching our various life experiences. Clients learn to observe anxiety-related

thoughts and feelings without evaluation or judgment, and without holding onto, getting rid of, suppressing, or otherwise changing what they experience. We developed the *acceptance of anxiety* exercise as a mindfulness tool to teach clients how to assume an observer perspective in relation to their anxiety-related feelings and thoughts. This 15-minute closed eyes exercise, to be practiced once or twice a day, builds upon the *acceptance of thoughts and feelings* exercise. Clients again practice paying attention to a single focus, their breathing, and to learn to watch and allow specific anxiety-related thoughts and bodily sensations come and go without trying to change them. Clients are encouraged to make full contact with the experience of anxiety, notice all its facets, stay with it, watch it, and "make room" for it. The goal is to increase willingness to experience discomfort and undermine the tendency to react to anxiety-related thoughts, images, and sensations with strategies aimed at getting rid of such experiences. The exercise also reinforces the notion of choices: Although experiencing anxiety and fear is not a choice, how clients respond to their discomfort is a choice. They can choose to observe and acknowledge their anxiety for what it is, or choose to react to it in a way that has limited their options and their lives.

Additional metaphors and exercises in these sessions are also designed to strengthen the skill of observing rather than responding to anxiety with efforts to control it. These exercises also provide clients with additional practice distinguishing between experiences they have (thoughts, emotions, and physical sensations) and the person having them. Although these are somewhat abstract notions, the development of an accepting observer perspective helps clients experience at a gut level that although their anxiety is part of them, they are more than an anxiety-disordered individual.

Acceptance is closely related to willingness and purposeful action. Linehan (1993) points out that "willingness is accepting what is, together with responding to what is, in an effective and appropriate way. It is doing what works and just what is needed in the current situation or moment" (p. 103). In a similar vein, Orsillo, Roemer, Lerner, and Tull (2004) describe experiential acceptance as a willingness to experience internal events such as thoughts, feelings, memories, and physiological reactions, in order to participate in activities that are deemed important and meaningful. We view acceptance as the willingness to stay with discomfort while also actively and intentionally choosing to engage in life-goal directed behavior (Eifert & Forsyth, 2005). Willingness is a skill to be learned, not a concept or a feeling. It is not about liking, wanting, putting up with, or tolerating, and not about enduring anxiety with brute force of will. It means being open to the whole experience of anxiety (Luoma, Hayes, & Walser, 2007) and making a choice to experience anxiety for what it is––a collection of sensations, feelings, thoughts, and images. In this sense, willingness is the opposite of control and avoidance and a major treatment target in this program.

### Cognitive Defusion

The concept of cognitive fusion may help to explain why thoughts become so threatening to people that they are prepared to engage in behavior that is clearly detrimental to their well-being and quality of life. Cognitive fusion refers to the tendency of human beings to get caught up in the content of what they are thinking with the end result that "literal evaluative strategies dominate in the regulation of human behavior, even when less literal and less judgmental strategies would be more effective" (Hayes, 2004, p. 13). Cognitive fusion is a process that involves fusing with or attaching to the literal content of our private experiences. The event or stimulus (e.g., "I") and one's thinking about it ("I am having a heart attack") become one and the same—they are so fused as to be inseparable, which creates the impression that verbal construal is not present at all (Hayes, 2004). When fusion occurs, a thought is no longer just a thought, and a word is no longer just a sound; rather, we respond to words about some event as if we were responding to the actual event the words describe. Thus, a fast beating heart experienced during a panic attack is no longer just a fast beating heart but a sign of an impending heart attack that we must avoid at all costs by engaging in behavior aimed at down-regulating the physical sensations experienced.

Learning the skill of cognitive defusion is central to ACT. At a basic level, cognitive defusion is the process whereby individuals learn to observe thoughts for what they really are (just thoughts), not for what their minds tells them they are (literal truths that must be acted upon). As thoughts are taken less literally, clients are freed to act on chosen values rather than reacting to anxiety-related, thoughts, worries, and bodily sensations. ACT utilizes a variety of cognitive defusion techniques (e.g., metaphors, mindfulness exercises, paradoxical statements, changing language conventions) to teach clients to respond less literally to anxiety-related thoughts and emotions, and create some distance to their thoughts and feelings. Instead of responding to the literal content of a thought, clients learn to respond to and experience thoughts as just a thought that can simply be observed. Defusion exercises are conducted throughout treatment whenever clients appear to be trapped by and entangled in their evaluative mind and when taking their thoughts literally ("buying their thoughts") interferes with values-consistent behavior. The point of this work is to teach a fine discrimination between thoughts that serve the client well and those that do not. Clients also learn that a thought can simply be observed and need not be

corrected or struggled with, and most importantly, need not be acted on.

For instance, when a client notices the thought "I am having a heart attack" during a panic attack, defusion techniques will help that client recognize and experience the evaluative thought or image for what it is: a thought that can simply be observed and need not be corrected or struggled with, and most importantly, need not be acted upon by dropping everything and driving to the next ER. The goal of cognitive defusion is to help the client forge a new relationship with their private experience (Orsillo & Batten, 2002). Hence, defusion techniques do not target, nor do they seek to correct, the content or validity of the client's evaluation of their physical sensations (whether they are really having a heart attack), only the process of evaluating itself. At the core, defusion techniques help clients to notice the process of thinking. For this reason, the mindful acceptance exercises described earlier are also thought of as defusion strategies within ACT. They help clients make contact with experience as it is, without all the evaluative baggage, including verbal rules and reasons, that are usually present when anxiety occurs. Mindfulness exercises allow clients to notice the process of thinking, evaluating, feeling, remembering, and other forms of relational activity, and not simply the historical products of such activities (Hayes, 2004).

### Applying Acceptance, Willingness, and Defusion to Stay With Anxiety (Exposure)

The goal of Sessions 6 and 7 is learning to stay with anxiety. We describe this part of treatment to clients as "getting ready to face anxiety with mindful acceptance so you can get on with your life" (Forsyth & Eifert, 2008, p. 187). During in-session exposure-like FEEL (i.e., Feeling Experiences Enriches Living) exercises, clients employ mindful observation to let go of the struggle to escape or control anxiety-related thoughts, worries, and bodily sensations by acknowledging their presence and even embracing and leaning into them. The actual procedures used to practice are similar to those used in CBT (e.g., hyperventilation, spinning, or worst-case imagery in the case of chronic worrying). In fact, in the UCLA RCT we use the same exercises in both the ACT and the CBT condition, albeit framed with very different rationales and set within different contexts. In ACT, the stated goal of these exercises is not to reduce or eliminate anxiety but to provide clients with opportunities to practice willingness in the presence of anxiety so they can do what matters to them. The general purpose is to prepare clients for the inevitable times when anxiety and other forms of discomfort show up while engaging in real-life chosen activities that move them in the direction of their values. Thus, exposure exercises within ACT are always done in the context of a client's valued life goals.

Exposure practice is a logical extension of the mindfulness exercises begun earlier. Recall that these exercises were designed to promote an observer perspective, whereby thoughts, feelings, and physical sensations are noticed and experienced as they are with a nonjudgmental and compassionate posture. Using similar instructions as in the *acceptance of anxiety* exercise, clients are encouraged to stay with whatever they are experiencing to help them approach anxiety-related distress from a nonjudgmental, compassionate perspective. They are encouraged to choose to be open to their experience and respond nondefensively. This posture works to foster cognitive defusion so that evaluative verbal-cognitive activity does not get in the way of life goal-directed action. Consequently, the choice of the specific interoceptive and imagery FEEL exercises for a particular client is largely determined by whether the client's reactions brought on by the images or sensations have functioned in the past as a barrier to life goal-directed action.

Exposure practice provides an important opportunity for clients to develop willingness to experience anxiety and to see that willingness is a choice. Nobody chooses anxiety. It happens. The choice is whether one is willing to experience anxiety when it arises and do what matters. So, willingness is about control of choices and actions, not feelings and thoughts, and as this work unfolds in and outside of treatment, clients are encouraged to revisit this central question: "Am I willing to move with my anxiety to do what I really care about or am I going to run away from anxiety and the life I truly want to live?" In this sense, exposure exercises are willingness exercises, where clients are encouraged to make the choice to experience anxiety for what is. In this sense, exposure exercises are willingness exercises, where clients are encouraged to make the choice to experience anxiety for what is. Although exposure exercises within ACT are not conducted for the purpose of fostering extinction processes, such processes are likely to operate regardless of the rationale clients adopt for facing their anxiety rather than avoiding it. So when anxiety reduction occurs as a consequence, we consider it a bonus, not a targeted outcome.

### Value-Guided Action (Naturalistic Exposure)—Moving With Barriers

Sessions 7 to 12 are devoted to helping clients implement meaningful activities that would move them toward reaching selected goals related to their identified values. Using worksheets derived from behavioral activation programs (Addis & Martell, 2004), therapists help clients develop a specific plan of action for each week and identify sequences of actions that need to be taken to achieve goals. This work includes the following: helping clients translate their identified values into goal-directed actions, helping clients set realistic goals and criteria, provide ongoing feedback, and monitoring progress. This

will almost invariably involve clients engaging in previously avoided activities or entering previously avoided situations. Such activities look similar to naturalistic exposure exercises, except that they are not conducted in a context and with the stated purpose of extinguishing anxiety. Clients choose and engage in activities with the stated purpose of reaching important life goals.

In the process of engaging in life-goal directed activities, clients inevitably encounter barriers. Most of the time, they are related to anxiety-related concerns that literally seem to hold clients back. An important recurrent task for therapists during Sessions 7 though 12 is to help clients handle barriers to committed action and focus on making and keeping action commitments and on recommitting to action after they have broken a commitment. The focus is on teaching clients how to move with potential barriers rather than try to overcome or push through them. Therapists constantly encourage clients to stay with difficult situations, unpleasant feelings, thoughts, and other anxiety-related barriers to valued living by practicing mindful acceptance and defusion skills. The major goal here is to help clients develop more flexible patterns of behavior when relating with the stimuli, events, and situations that elicit fear or anxiety. Therapists continue to emphasize that the purpose of FEEL exercises and value-related activities is to let clients experience that they can do things that matter to them *and* be anxious at the same time. The crucial point is for clients to learn that anxiety does not have to go down first in order to do what is important to them.

## Method

### Participants

Three individuals who were part of a larger randomized clinical outcome trial comparing ACT and CBT served as participants for this case study. We selected one client from each of the three therapists who were seeing clients (typically each saw two clients at a time) at the time we decided to write up this case report. To illustrate the flexible nature of the treatment program, we selected three participants with heterogeneous anxiety disorders, that is, each had a different principal anxiety disorder diagnosis and also one other secondary diagnosis, which was different in each case.

We selected one client from each of the three therapists who were seeing clients (typically each therapist saw two clients at a time) at the time we decided to write up this case report. There were no particular selection criteria other than that the three clients should be clearly different. So we made sure they were not all of the same gender, were from different age groups, and to illustrate the flexible nature of the treatment program, each should have a different principal anxiety disorder diagnosis with one other secondary diagnosis, which was different in each case. These individuals had presented for treatment at the UCLA Behavioral Anxiety Disorders Research Program in response to ads offering treatment. Clients had not selected ACT as their preferred treatment but had been randomly assigned to the ACT treatment condition as part of the RCT. We changed the clients' names to protect their anonymity.

All clients were assessed with the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Di Nardo, Brown, & Barlow, 1994) and their principal and secondary diagnoses are listed in Table 1. The ADIS-IV is a semistructured interview that assesses for anxiety, mood, and other psychiatric disorders. In addition to assigning diagnoses, the interviewer makes a clinical severity rating (CSR) for each diagnosis to capture the individual's current level of distress and impairment as a function of the particular disorder. CSRs range from 0 (*none*) to 8 (*very severe*). All diagnostic interviewers had extensive training in administering the ADIS-IV and none of them acted as therapists. All diagnoses and CSR ratings were reviewed by a doctoral-level clinical supervisor.

For the 6-month follow-up, therapists contacted their clients by phone. Therapists talked with clients for about 20 minutes, following a standard protocol that included obtaining ratings of the extent of struggle with anxiety, willingness to experience discomfort, practice of mindful acceptance, and progress in life-goal directed action. In case clients had encountered any recurrent barriers to committed action, therapists helped clients troubleshoot solutions.

### Therapists

The therapists were three advanced graduate students enrolled in the doctoral program in clinical psychology at UCLA (EE, JA, DL). All therapists had been trained in ACT theory and methods by the first author and attended a 2-day ACT experiential workshop conducted by Steven Hayes. Treatment consisted of 12 weekly sessions, each lasting 1 hour. All treatments followed the treatment manual by Eifert and Forsyth (2005).

### Anxiety Mood, and Distress Measures

The Anxiety Sensitivity Index (ASI; Peterson & Reiss, 1992) is a 16-item self-report questionnaire that assesses an individual's level of fear of anxiety-related symptoms (e.g., rapid heart beat) based on the belief that such sensations have negative consequences (e.g., embarrassment). Respondents rate the degree to which they agree or disagree with each item on a 5-point scale, anchored from 0 = *very little* to 4 = *very much*. According to Peterson and Reiss 1992), the ASI has a high degree of internal consistency (alpha coefficients from .82 to .91) and stable test-retest reliability over a 3-year period ($r$ = .71).

Table 1
Pre and Post Data for Measures of Anxiety, Mood, and Distress for All Three Cases

| Measure | James | | Daniel | | Janet | |
|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post |
| ADIS Severity | | | | | | |
| –Principal | 4 (panic) | 0 | 5 (social) | 3 | 6 (OCD) | 3 |
| –Secondary | 3 (OCD) | 0 | 4 (dysth) | 0 | 5 (panic) | 0 |
| ACQ | 28 | 49 | 31 | 59 | 50 | 41 |
| ASI | 27 | 7 | 43 | 7 | 34 | 12 |
| PSWQ | 54 | 45 | 53 | 30 | 48 | 34 |
| MASQ | 288 | 185 | 265 | 167 | 181 | 162 |
| FQ –Total | 40 | 17 | 36 | 12 | 39 | 24 |
| –Social | 12 | 3 | 21 | 8 | 11 | 7 |
| Padua | 9 | 7 | 35 | 7 | 106 | 57 |

*Note.* ADIS = Anxiety Disorders Interview Schedule-IV; ACQ = Anxiety Control Questionnaire (higher scores indicate higher perceived control over responses to anxiety symptoms); ASI = Anxiety Sensitivity Index (lower scores indicate lower levels of anxiety sensitivity); PSWQ = Penn State Worry Questionnaire (lower scores indicate lower levels of worry); MASQ =Mood and Anxiety Symptom Questionnaire (lower scores indicate fewer depression and anxiety symptoms); FQ = Fear Questionnaire (lower scores indicate lower levels of fear).

The Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkevec, 1990) is a 16-item measure of trait worry with strong psychometric properties (Meyer et al., 1990; Molina & Borkovec, 1994). Participants rate the extent they agree with each statement on a 5-point Likert scale. Scores can range from 16 to 80. The PSWQ focuses on the generality, intensity/excessiveness, and uncontrollability of clinical relevant worry (Molina & Borkovec), and reliably distinguishes GAD from other anxiety disorders (Brown, Antony, & Barlow, 1992). The PSWQ demonstrates strong psychometric properties (Molina & Borkovec), including good internal consistency ($\alpha$ of .86 to .93 across clinical and college samples) and test-retest reliability ($r$=.74 to .93 across 2- to 10-week periods).

The Mood and Anxiety Symptom Questionnaire (MASQ; Watson & Clark, 1991) is a 90-item self-report questionnaire with five subscales: Anxious Arousal (17 items), Anhedonic Depression (22 items), General Distress (i.e., General Mixed; 15 items), General Anxiety (11 items), and General Depression (12 items). Thirteen items do not belong to a subscale. Participants use a 5-point Likert scale (1 = *not at all* to 5 = *extremely*) to rate the extent to which they experienced each symptom "during the past week, including today." The MASQ anxiety and depression subscales demonstrates good divergent ($r$=.02 to .09), convergent validity ($r$=.67 to .76) with other anxiety and depression scales, and strong incremental validity across student, adult, and patient samples (Watson et al., 1995).

The Anxiety Control Questionnaire (ACQ; Rapee, Craske, Brown, & Barlow, 1996) is a 30-item measure designed to assess perceptions of control over potentially threatening internal and external events and situations associated with anxious responding (alphas from .80 to .89; test-retest, $r$=.88; Rapee et al., 1996). Recent work evaluating the psychometric properties of the original 30-item ACQ in a clinical ($N$=1,550) and nonclinical ($N$=360) sample suggests that the original 30-item ACQ is best represented by a 15-item form equivalent (i.e., patient vs. nonpatient) unifactorial solution, and three lower-order factors reflecting emotion control, threat control, and stress control (Brown, White, Forsyth, & Barlow, 2004). The present study relied on the 15-item version of the ACQ, and the unifactorial solution reflecting perceived control over anxiety-related emotional events.

The Fear Questionnaire (Marks & Mathews, 1979) is a 15-item scale that assesses fear-related avoidance of a variety of situations. The 9-point scale ranges from "no avoidance" to "total avoidance," and has shown adequate reliability and validity in samples with a variety of anxiety disorders (Cox et al., 1993; Marks & Mathews).

The Padua Inventory—Washing State University Revision (PI-WSUR; Burns, Keortge, Fromea, & Sternberger, 1996) is a self-report questionnaire containing 39 items of the original Padua Inventory (Sanavio, 1988), which had 60 items. Using a 5-point scale, with responses ranging from 1 *(not at all)* to 5 *(very much),* the questionnaire assesses obsessions and compulsions related to harm to self or others, contamination, washing, dressing/grooming, and checking. Burns et al. (1996) found that the internal consistency values of the PI-WSUR subscales ranged from .77 to .88, the test-retest reliability values ranged from .61 to .84, and that the PI-WSUR was a more distinct measure of OCD than the original PI.

### ACT Process Measures

The Acceptance and Action Questionnaire (AAQ; Bond & Bunce, 2003; Hayes et al., 2004) assesses two aspects of psychological flexibility: experiential avoidance and willingness to engage in action despite unwanted

thoughts or bodily sensations. The original AAQ consists of 9 items loading on a single factor. In this study, we used the revised 16-item version by Bond and Bunce (2003) because Hayes et. al. (2004) pointed out that the longer version may be more useful as a therapy process measure, since the larger number of items may allow smaller changes throughout therapy to be detected. The Willingness Scale consists of seven items assessing willingness to accept undesirable thoughts and feelings. The Action Scale consists of nine items assessing whether individuals act in ways that are congruent with values and goals. Participants rate the extent to which they agree with each statement on a 7-point Likert scale. The 16-item version is scored in such a way that higher scores reflect greater acceptance of experience and willingness in the presence of discomfort. A study by Bond and Bunce (2003) using a general population sample of 412 individuals examined the psychometric properties of the 16-item version of the AAQ. Internal consistence was good ($\alpha = .79$) and a confirmatory factor analysis of the construct validity of the measure found that a two-factor (scale) solution was a good fit to the data. Bond and Bunce also report that higher acceptance scores predicted better mental health and job performance over and above negative affectivity.

The 15-item Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003) assesses mindfulness across cognitive, emotional, physical, interpersonal, and general domains. Respondents indicate how frequently they have experienced statements (e.g., provide an item example) using a 6-point Likert scale (anchored from 1 = *almost always* to 6 = *almost never*) with high scores reflecting more mindfulness. Items are scored by summing all individual responses. Brown and Ryan have demonstrated that (a) the MAAS has good psychometric properties, (b) the scale differentiates individuals who are mindful from those who are not, (c) higher scores are associated with enhanced self awareness, and (d) following a clinical intervention, cancer patients showed increases in mindfulness over time that were related to declines in mood disturbance and stress. Within student and adult samples, psychometric properties include good internal consistency ($\alpha = .82$ and .87, respectively), good test-retest reliability (.81, assessed in student sample only), and strong convergent and divergent validity (see Brown & Ryan, 2003). Brown and Ryan reported a mean score of 3.9 ($SD = 0.6$) for a nonclinical sample compared to 4.3 ($SD = 0.6$) for a group of Zen meditation practitioners.

The White Bear Suppression Inventory (WBSI; Wegner & Zanakos, 1994) is a 15-item measure of the tendency to suppress (i.e., not accept) and struggle with unwanted thoughts and feelings. This measure has been used extensively in laboratory and clinical settings to demonstrate the negative effects of experiential avoidance (e.g., Koster et al., 2003). Clinical studies (e.g., Smari & Holmsteinsson, 2001) involving people with various anxiety disorders such as obsessive-compulsive disorder and specific phobias have shown that the WBSI is sensitive to measuring the effects of treatment. Items are scored by summing all individual responses. Lower scores indicate lower thought suppression. In a large, diverse student sample for periods ranging from 3 weeks to 3 months, test-retest reliability was reasonable ($r = .69$), internal reliability was strong ($\alpha = .87$ to .89), and the measure demonstrated good convergent, divergent, and incremental validity (Wegner & Zanakos, 1994). Depending on sample characteristics, Wegner and Zanakos found that average scores for nonclinical samples vary from 43 to 50.

The Believability of Anxious Feelings and Thoughts (BAFT) is a 30-item self-report measure of defusion that includes the content of all 16 ASI items and a set of rationally derived items reflecting excessive thought and emotion regulation getting in the way of effective action (e.g., "When unpleasant thoughts occur, I must push them out of my mind" or "I need to get a handle on my anxiety and fear for me to have the life I want"). Rather than assessing the presence, intensity, or degree of fear of symptoms, the BAFT requires participants to indicate on a scale from 1 (*not at all believable*) to 7 (*completely believable*) how much they believe or "buy into" each statement. Similar believability and defusion measures have been idiographically developed and used successfully as process measures in other ACT outcome studies (e.g., Bach & Hayes, 2002), including mediating outcomes, and have proven to be the most robust indicator of ACT outcome (see Hayes et al., 2006). The BAFT total score is derived by summing responses for all items. Initial psychometric evaluation in a nonclinical university sample ($N = 400$) suggests that the BAFT is unifactorial, with strong internal consistency (coefficient alpha = .95) and convergent validity with other ACT process variables (e.g., experiential avoidance, mindfulness, self-compassion, and quality of life; see Herzberg, Sheppard, Forsyth, & Eifert, 2009).

The Quality of Life Inventory (QOLI; Frisch, 1994) is a 32-item self-report questionnaire developed to measure life satisfaction in the areas of health, self-esteem, goals and values, money, work, play, learning, creativity, helping, love, friends, children, relatives, home, neighborhood, and community. Participants are asked to rate the importance of each area relative to their overall happiness on a 3-point Likert scale (0 = *not important* to 2 = *very important*) and how satisfied they are with each area on a 6-point Likert scale (-3 = *very dissatisfied* to 3 = *very satisfied*). In addition to scores for each life area, the inventory also yields an overall quality of life score. Data from over 1,000 individuals suggest that the QOLI has good stability (at 2-week intervals), internal consistency (alpha coefficients range from .77 to .89), as well as convergent, discriminant, and treatment validity (Frisch et al., 2005).

## Case Descriptions and Results

### The Case of James: A Man Suffering From Panic Disorder

James, a single, 31-year-old Caucasian male, is an aspiring actor and screenwriter. Just a few months before starting treatment, around the time of his 31st birthday, James experienced his first panic attack. Although he reported experiencing very few panic attacks since his first attack, he reported a number of changes in his life and significant distress beginning around the time of the attack. For example, he had given up drinking caffeine to avoid bodily sensations that simulate panic. In addition, he had given up drinking any alcohol because of concern over doing anything that may harm his health. Also beginning around the time of the attack, James began experiencing difficulties sleeping. He reported laying awake in bed late into the night distressed that his not being able to sleep would disrupt the activities he had planned for the next day. His concern over getting enough sleep appeared to contribute to changes in his activities during the day. For example, he began listening to the radio less because of concern that a song may get "caught in his head," making it difficult for him to fall asleep later at night. In addition, everyday decisions, such as deciding what time he should exercise, became difficult for him because they were evaluated in terms of its potential impact on his sleep. Meanwhile, he struggled with his decision not to drink alcohol because it was an essential part of his Hollywood nightclub social life.

Although his principal diagnosis was panic disorder (clinician ADIS rating=4) with subclinical symptoms of OCD (clinician ADIS rating=3), it became clear during the initial treatment sessions that it was his dissatisfaction with the current state of his life that was most distressing for James. He was frustrated with the lack of progress in his career and was struggling with thoughts of not having accomplished enough to this point in his life and fears of being a "failure." What was most upsetting for him about his panic symptoms and his difficulty sleeping was that they served as further obstacles to progress in his career. He felt as if his life was closing in on him and was left feeling increasingly out of control of his life.

Several metaphors, such as the Chinese Finger Trap, presented early on in treatment, helped James connect with his sense of being stuck within his current situation and to his own experience of how his attempts to gain control over undesirable internal experiences were actually contributing to further distress and a narrowing of his life space. While he related the metaphors to his struggle with panic symptoms and his difficulty sleeping, being able to relate the metaphors to his struggle with feelings of failure and lack of accomplishment proved more significant for James. His verbal attributions for the lack of progress in his career, including "problems with the industry" and "the incompetence of his manager and agent," while functioning to help him feel less like a "failure" in the short-term, also served as barriers to taking action and creating his own opportunities for career progress. Following the second session, without any prompting from the therapist, James resumed working on a script that he had been putting off for several months.

Defusion, especially around the word "failure," was a major focus of James' later sessions. James described a long history of self-deprecating thoughts around being a failure. Through a series of direct experiential exercises in session, James gradually became less emotionally reactive to the word "failure." For example, when presented with the word "failure" written on a flash card, James reported wanting to rip up the card and throw it in the trash. The therapist then asked James whether he was willing to put the card in his lap, simply read it, let it be, and have the card touch him as a thought. James agreed and was surprised to notice that he could do this without getting tangled up in what the card says. He was also willing to take the card with him over the next week everywhere he went. In addition, James and his therapist did an exercise in which they rapidly repeated the word "failure" for approximately 30 seconds (Masuda et al., 2004) while observing what happens to the quality of the word when doing so. James reported that after saying the word repeatedly "failure" was reduced to merely a string of almost unrecognizable sounds and he could see that it was ultimately just a word. Exercises such as this helped James to become a better observer of his own thinking and he learned that he does not have to take his thoughts, even historically difficult thoughts, so seriously and do what they say. Decreases in the degree to which James believed his anxiety-related thoughts are demonstrated by the drop in his BAFT score from 122 at pretreatment to 51 at posttreatment.

More importantly, James learned to use defusion skills to help him persist in value-consistent behavior in the presence of difficult thoughts. This change was also reflected in the increase of his AAQ-Action score. For example, during the course of treatment James completed his screenplay and put together a team of actors to present his screenplay to an audience for the very first time, despite experiencing occasional thoughts of failing throughout the process. In addition, by the end of treatment, James enrolled as a volunteer at a local children's hospital, something he had wanted to do for years and has been putting off due to thoughts of "not having enough time." His increased participation in valued activities was reflected in changes in his in QOLI scores, which increased from a score in the 1$^{st}$ percentile at pretreatment to a score in the 55$^{th}$ percentile at posttreatment.

Meanwhile, his original concerns over panic symptoms and difficulty sleeping faded increasingly into the background over the course of treatment. Toward the end of treatment, James did note occasional trouble falling asleep but that his episodes of sleeplessness were less distressing than they used to be. During instances of difficulty sleeping, James reported that he would watch his mind "do the thing it does" until, sooner or later, he would fall asleep. In addition, James reported less interference in his daily activities as a result of panic and sleep-related concerns. For example, without any prompting from the therapist, James reintegrated caffeine and alcohol into his daily life. Additionally, James no longer reported distress over engaging in daily activities that might influence his sleep. The lack of interference and distress over panic and problems with sleep are evidenced by increases in his AAQ-Acceptance score (from 12 pretreatment to 36 posttreatment) and by clinician severity ratings of 0 for both panic disorder and OCD at the end of treatment. Increases in his ACQ score and decreases in his ASI score also indicate that he experienced more control over and was less concerned about anxiety-related sensations.

At 6-month follow-up, James continued to report little to no distress or impairment over panic or OCD-related symptoms. Although he experienced a significant setback with respect to his career since completing the treatment—he experienced an injury that put him out of work for several months—James reported using the skills he learned in therapy to help him accept the limitations of his situation without becoming overly frustrated or discouraged.

### The Case of Daniel: A Man Suffering From Social Phobia

Daniel, a 51-year-old Caucasian male, presented with generalized social phobia and also received a secondary diagnosis of dysthymia. The social situations he feared most were public speaking, being assertive, speaking with unfamiliar people, and attending social gatherings. Daniel could not remember a time when his social phobia had not been significantly distressing and impairing. In recent years, his relationship with his anxiety symptoms had also begun to disrupt his sleep and adversely affect his physical well-being. He had maintained a mid-level job at a government agency for over 15 years without a promotion, although he believed he would qualify for one if he applied. He reported that his coworkers frequently took advantage of him because he would not stand up for himself or express his opinions. He was unable to approach his long-term girlfriend to discuss his relationship concerns because he feared tension and rejection. Understandably, he felt quite hopeless and helpless. He approached his first session of ACT motivated to change while simultaneously being highly skeptical that change would be possible.

Initially, Daniel's social anxiety manifested as reluctance to express emotions that he feared would upset his therapist. The creative hopelessness metaphors helped Daniel recognize that his previous methods of dealing with painful emotions (e.g., avoiding, struggling) left him feeling hopeless and "trapped," despite his best, life-long attempts to avoid and fight these emotions. The mindful acceptance exercises provided Daniel with the opportunity to approach painful emotions in a different way. For the first time in his life, he took a step back and looked at his emotions and physical sensations with a more compassionate stance, appreciating emotions and physical sensations as momentary, ephemeral experiences. He found the *acceptance of thoughts and feelings* and *acceptance of anxiety* exercises so helpful that he practiced them more than once a day (as requested by the protocol) and took careful notes about his experiences.

Daniel reported that he experienced these exercises as relaxing at times and anxiety-inducing at other times. It is important for therapists to respond to any such client comments, particularly if clients state they like the mindfulness exercises because they find them relaxing. The danger here is that clients link acceptance to positive feeling outcomes and may be attempting to use mindfulness to achieve the goal of relaxation or anxiety relief, which has little to do with mindful acceptance (Segal et al., 2002). At that point, therapists should emphasize that the goal of these exercises is not to bring about any particular effect, such as relaxation, and that any effect is fine as long as clients focus on watching thoughts and feelings come and go. As Segal et al. indicate, the goal is not to relax the mind or body but to learn to relax with oneself. Daniel practiced challenging tasks, such as declining inappropriate work requests from coworkers, noticing the anxiety yet focusing on the task at hand. His increased willingness to experience his emotions also extended into other parts of his life once the treatment started to focus on life goal-directed action. Instead of delaying action until he eliminated his anxiety symptoms, Daniel began to move towards his goals of improving communication with his girlfriend and getting a promotion at work *with* his anxiety symptoms present.

By the end of treatment, Daniel was more willing to accept undesirable thoughts, as measured by the AAQ and the WBSI, and to act in accordance with his values as suggested by increases in his AAQ Action subscale score (see Table 2). Daniel's success at cognitive defusion was clearly evident in a three-fold decrease from pre- to posttreatment in the believability of thoughts and feelings as measured by the BAFT. As he began to move forward in his life, he also reported significant decreases in distress related to anxiety and dysthymia. For instance, Daniel

Table 2
Pre and Post Data for Process Measures of Acceptance, Mindfulness, and Defusion as Well as Participants' Quality of Life

| Measure | James | | Daniel | | Janet | |
|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post |
| AAQ | | | | | | |
| –Acceptance | 12 | 36 | 20 | 32 | 33 | 35 |
| –Action | 34 | 40 | 31 | 40 | 44 | 44 |
| BAFT | 122 | 51 | 174 | 53 | 92 | 87 |
| MAAS | 3.8 | 4.7 | 3.1 | 4.5 | 5.1 | 4.7 |
| WBSI | 66 | 53 | 45 | 36 | 65 | 38 |
| QOLI | | | | | | |
| –Overall Score | –1.2 | 2.8 | 0.7 | 2.9 | 2.6 | 3.3 |
| –Percentile (%) | 1 | 55 | 9 | 59 | 71 | 49 |
| –Classification | Very low | Average | Very low | Average | Average | Average |

*Note.* AAQ = Acceptance and Action Questionnaire (higher scores indicate higher levels of acceptance and valued action); BAFT = Believability of Anxious Feelings and Thoughts (lower scores indicate lower believability of thoughts and feelings); MASS = Mindfulness Attention Awareness Scale (higher scores indicate higher levels of daily mindfulness); WBSI = White Bear Suppression Inventory (lower scores indicate lower levels of suppression and struggle with unwanted thoughts and feelings); QOLI = Quality of Life Inventory (larger QOLI scores indicate greater reported quality of life).

reported reductions in his anxiety sensitivity (ASI), worry (PSWQ), mood-related distress (MASQ), and a dramatic decrease in worry and obsessional thinking as measured by the Padua. In addition, ratings of impairment (i.e., ADIS Severity) declined from 5 to 3 for social phobia and from 4 to 0 for dysthymia. The magnitude of improvements was impressive, yet changes occurred gradually throughout treatment and seemed to occur subsequent to Daniel's increasing abilities with acceptance and defusion.

Daniel occasionally speculated whether he had perhaps succeeded in eliminating his anxiety once and for all. Whenever he brought this issue up, the therapist reminded him that the objective was to move in a valued direction regardless of his anxiety. If Daniel were to focus on his decreased anxiety-related distress, the next time he experienced anxiety he would be drawn back into the metaphorical tug-of-war to "defeat" his anxiety again. At the 6-month follow-up, Daniel reported that he was consistently using the skills he developed in therapy. He said he had not experienced much anxiety-related discomfort and that experiencing such occasional discomfort did not "get in the way of [his] life."

### The Case of Janet: A Woman Suffering From OCD and Panic Disorder

Janet, a single, 52-year-old Caucasian female and corporate accountant, presented with a lifelong history and principal diagnosis of OCD and a secondary diagnosis of panic disorder. Her obsessions involved severe fear of contamination and having to urinate. Her compulsions involved excessive washing behaviors and avoiding places without an easy escape or readily accessible bathroom. For several hours each day, Janet obsessed about her contamination and urination fears, and engaged in compulsive behaviors. She felt embarrassed and shameful about these behaviors, which led her to limit meaningful social contact and relationships. She also experienced spontaneous panic attacks approximately once per week. Following her first panic attack 5 years earlier, she had felt worried and distressed about panic symptoms on a daily basis.

Janet had for many years avoided intimate relationships with men and close supportive friendships with women, and had not completed her undergraduate degree despite showing much academic promise. She placed a high premium on her current job but had remained with a "disrespectful boss" for several years. She also felt unable to stand up for her needs or respond effectively to her negative emotions at work, which seemed to be linked with her decreased job satisfaction. She feared being "an OCD" her entire life. Having recently completed 20 years in therapy with little effect on her anxiety symptoms, she was not confident ACT could help her.

When Janet initially began to increase her experiential willingness, she felt a strong increase in anxiety, sadness, and anger as she allowed herself to feel fully what was happening inside of her for the first time in her life. In Session 3, she vigorously questioned the therapist whether this treatment would ever help her or just be a waste of her time. This is an important moment in any treatment whenever this issue arises. The therapist responded that we could not promise her anxiety reduction but that she could learn new skills that would most likely help her develop a new relation to her anxiety if she persisted with practicing the acceptance, mindfulness, and other exercises. It is important for therapists to address this common concern in a way that gets the message across that ACT is about gaining new skills that can be learned over time with sufficient practice. Indeed,

once she honed her mindful observing skills through the *acceptance of thoughts and feelings* exercise, she learned through her experience that it was possible to simply experience intrusive thoughts and uncomfortable emotions, without having to do what they seem to be telling her to do.

Janet showed substantial increases in self-acceptance and increases in life-goal directed behavior during therapy. For the first time, she discovered that she could live according to her own needs and values rather than spending time trying to reduce her anxiety and please others. This discovery coincided with dramatic increases in her willingness and acceptance of her OCD symptoms. On a measure of thought suppression (the White Bear Suppression Inventory), her score dropped from 65 at pretreatment to 38 at posttreatment, indicating significantly decreased suppression and increased willingness to experience her obsessive thoughts. Whenever they appeared, she literally began saying to herself, "Hello, OCD thoughts and feelings! Hello, friends! How are you today? You're not my enemy. I can live *with* you." She began working with panic and anger-related experiences in the same manner. Janet learned to recognize when she avoided situations due to anxiety, and chose to respond to anxiety differently. She attended more singles events, resumed dating, socialized more with her women friends, and communicated more honestly and compassionately with her family, friends, and colleagues. Instead of continuing to put herself down, she deliberately started to engage in behaviors that were designed to be "compassionate and kind to myself," including taking time to read, take baths, and watch movies. For the same reason, she also began looking for a new job more to her liking. With these changes, Janet also reported feeling happier than she had felt in many years.

Janet's pre- to posttreatment PSWQ, FQ, and ACQ scores show lower levels of distress and more perceived control over anxiety. Her OCD severity dropped from moderately severe at pretreatment (clinician ADIS rating=6) to subclinical levels at posttreatment (clinician ADIS rating=3). Whereas her ADIS panic severity pretreatment rating had been 6, her fear of anxiety-related symptoms dropped so dramatically by posttreatment (e.g., her ASI scores dropped from 34 to 12 pre to post) that she no longer endorsed any panic disorder distress in the posttreatment assessment (clinician ADIS rating=0). Interestingly, she chose not to eliminate some mild hand-washing compulsions via exposure, because they no longer caused her distress or interfered with valued activities. Although Janet reported more acceptance of urges informally, she did not report much change on the formal measures of acceptance and defusion except for a dramatic decrease of thought suppression (her WBSI decreased from 65 to 38).

At 6-month follow-up, Janet's OCD problems remained at subclinical levels (clinician ADIS rating=3). She also reported a significant change in her life. After remaining in a job in which she endured poor treatment by her boss for 4 years, she took a brief leave from work to clear her mind, then quit her job and secured another. Although several OCD problems remain, including mild hand washing and urination compulsions, finding a new job realized one of Janet's major goals and reflected moving toward her personal value of self-respect.

## General Discussion

The three case studies illustrate several important points about our ACT program for the treatment of anxiety disorders. First, the ACT for Anxiety treatment manual (Eifert & Forsyth, 2005) flexibly accommodated different clinical presentations of anxiety disorders. In an age of increasingly detailed distinctions among disorders and equally detailed treatments, we take comfort in our initial finding that a single treatment manual can be flexibly applied to treat different forms of anxiety-related suffering and presenting concerns.

Second, clients observed shifts in targeted processes of change, including reductions in experiential avoidance and defusion of anxiety-related thoughts and beliefs. James, for example, realized that his fear of failure and external attributions of his career difficulties (e.g., "problems with the industry," "the incompetence of his manager and agent") contributed to inaction in the pursuit of his writing and acting aspirations. Defusion of his failure-related cognitions and his verbal explanations for his lack of career success facilitated the completion of value-oriented goals, including having his screenplay performed before an audience for the first time. Daniel, after a lifetime of struggling with his anxiety, no longer defined himself by his symptoms; he saw his anxiety as a part of his overall experience of life.

Third, although ACT does not target anxiety reduction per se, all three clients experienced less distress at the end of treatment, as evidenced by changes in virtually all anxiety and mood distress-related measures. For example, Table 2 shows significant reductions from pre- to posttreatment in anxiety sensitivity (ASI), worry (PSWQ), negative mood and anxiety (MASQ) as well as general fearfulness and fear in social situations (Fear Questionnaire). Moreover, the post-ADIS severity ratings were much lower at the end of treatment than before treatment. As in previous experimental studies (Eifert & Heffner, 2003; Levitt et al., 2004), we observed a paradoxical effect in regard to perceived control over anxiety. As clients developed skills to let go of their previous efforts to control unwanted cognitions and emotions, two clients (James and Daniel) were surprised to find that they actually felt more in control, as reflected

in increased score on the Anxiety Control Questionnaire. Janet, on the other hand, reported becoming more aware of her inability to control the occurrence of obsessions (reflected in increased score on the ACQ) but indicated she accepted this inability and that she was not going to fight it anymore.

Fourth, a focal point of ACT is living a life-goal-directed life and addressing the barriers that are standing in the way of such a life. Although we observed only modest increases on the ACT Action scale for James and Daniel, and none for Janet, all clients felt empowered by the treatment's focus on valued living and engaged in behaviors in accord with their chosen life goals. The resulting increases in the participant's quality of life were clearly reflected in the changes on the Quality of Life Inventory. For instance, James completed and began producing a screenplay and realized his dream of volunteering at a local hospital, Janet began socializing more broadly and found a new job, and Daniel strengthened his romantic partnership and successfully requested a promotion. In terms of barriers, there continues to be a debate (e.g., Hayes, 2008; Hofmann & Asmundson, 2008) whether cognitions are causal factors for behaviors and feelings. Even if therapists are uncertain as to where they stand in regard to this issue, they can adopt the ACT strategy to change the function of thoughts: clients can learn that cognitions (and emotions for that matter) need not determine what they do even if cognitions and emotions are intense and seem compelling. This was one of the most important lessons for all our clients to learn because all three clients felt that anxiety-related thoughts and feelings were the main barriers in their lives. As a result, therapists had to address those barriers repeatedly throughout treatment. Following the introduction of the mindful acceptance and other defusion exercises, clients began to struggle less with their thoughts and emotions. Janet's increased kindness and compassion in self-care illustrated this shift. Interestingly, her shift occurred after she expressed skepticism about the treatment's ability to help her, which for her (as would be the case for most clients) initially meant having fewer obsessions and feelings of panic. Likewise, having untangled his self-identity from his anxiety symptoms, Daniel was able to make space for exploring who he wanted to be and pursuing his values. His progress in observing and accepting his thoughts and emotions freed him to start moving, and his values guided his actions. James learned that failure-related cognitions did not have to be eliminated before he could engage in life goal-directed behavior.

Apart from some new techniques and exercises, the *ACT for Anxiety* program incorporates many established behavior therapy interventions. They include behavioral activation and exposure exercises—although they are conducted in a different way and with a different rationale than is typical. Behavioral skills training may also be employed for individuals with social skills deficits. As Hayes et al. (1999) indicated, "during the later portions . . . ACT takes on the character of traditional behavior therapy, and virtually any behavior change technique is acceptable" (p. 258). On the other hand, there is a crucial difference between ACT and traditional CBT in how therapists approach difficult cognitive and emotional content (e.g., "irrational thoughts"). Segal et al. (2004) expressed this difference clearly in regard to mindfulness-based cognitive therapy, and it applies equally well to ACT: "Unlike CBT, there is little emphasis in MBCT on changing the *content* of thoughts; rather, the emphasis is on changing *awareness of* and *relationship to* thoughts, feelings, and bodily sensations" (p. 54).

Arguing from an emotion regulation perspective, Hofmann and Asmundson (2008) point out that CBT is more focused on changing the evaluation of the situational or internal emotion cues (antecedent-focused emotion regulation), whereas ACT encourages primarily emotion-focused problem-solving strategies—changing a person's response to emotions by encouraging their acceptance rather than trying to change them. ACT also recognizes, however, that there are situations when it is not desirable to accept unpleasant thoughts and feelings and focus on changing the antecedent conditions. Examples might include women who feel anxiety and terror because they are trapped in an abuse relationship. In such cases, treatment may very well focus on changing the antecedent condition, that is, helping the women to leave the relationship and the physical context of abuse. Acceptance does not imply resigning oneself to a bad situation, particularly if the situation is harmful and the person can leave or change the situation. In such instances, acting on what the person's mind and emotion are telling her ("get out") is useful and serves to enhance the person's quality of life. Acceptance is only the better option when acting on one's thoughts and feelings does not serve to enhance one's quality of life. Utility (or workability) is the ultimate criterion, and this would seem apt with any strategy.

The unified transdiagnostic "one-shoe-fits-all" approach presented herein has clear advantages in terms of greater simplicity as well as more efficient training and dissemination. These advantages, however, are predicated on the assumption that the same processes (e.g., experiential avoidance, fusion) operate across all anxiety conditions. Although there is considerable support for this assumption (Hayes et al., 2006; Hayes, 2008), future studies will need to examine what specific adjustments might need to be made to the program when clients present with particularly intense and overwhelming emotions as in PTSD.

Walser and Westrup (2007) have presented some useful suggestions in this regard.

The purpose of this case study was to illustrate the ACT for Anxiety treatment program, its implementation in some detail, and point out some differences to traditional CBT protocols. As with any case report such as this, it is important to be appropriately cautious and not make sweeping generalizations—the large clinical trial from which we selected completed cases is still ongoing. We must await the outcomes of that work before making claims about the efficacy of this program compared to an established CBT protocol. In the context of the large RCT, we will particularly examine the relation of treatment outcome to changes in process variables. We will be able to address issues such as client resistance and the impact of clients not willing to let go of the struggle agenda, therapist training and maintaining a consistent ACT or CBT posture throughout treatment, and what variables may trigger early termination and dropout.

We also noticed from supervision tapes that there may be a relation between outcome and therapist competence in terms of how successfully therapists modeled the skills they wish to foster in their clients (e.g., being mindful, open, genuine, and compassionate). These are questions that cannot be addressed in a case report and will need to be examined with sufficiently large groups of clients. There is research evidence that ACT outcomes are mediated by relevant clinical processes such as acceptance, defusion, and engagement in life-goal-directed behavior (for summaries, see Hayes et al., 2006, 2008). In an updated presentation on this topic, Hayes, Levin, Yadavaia, and Vilardaga (2007) were able to show that pre-to-post changes in ACT processes accounted for nearly 50% of the pretreatment to follow-up changes in outcome produced by ACT. The comparison conditions in the set included CBT, pharmacotherapy, psychoeducation, supportive treatment, and wait-list controls. Almost all of the studies showed significant reductions in the direct outcome path when adjusted for the mediator at least at the $p<.1$ level (and the great majority at the $p<.05$ level). This work is now being subjected to further careful scrutiny and criticism (Arch & Craske, 2008; Hofmann & Asmundson, 2008), and we remain optimistic that ACT and related acceptance-based behavior therapies will continue to be guided by data and help move the field forward in reaching our goal of alleviating a wide range of human suffering.

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