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ACCEPTANCE AND COMMITMENT THERAPY IN ANXIETY DISORDERS: AN ANALYTICAL REVIEW

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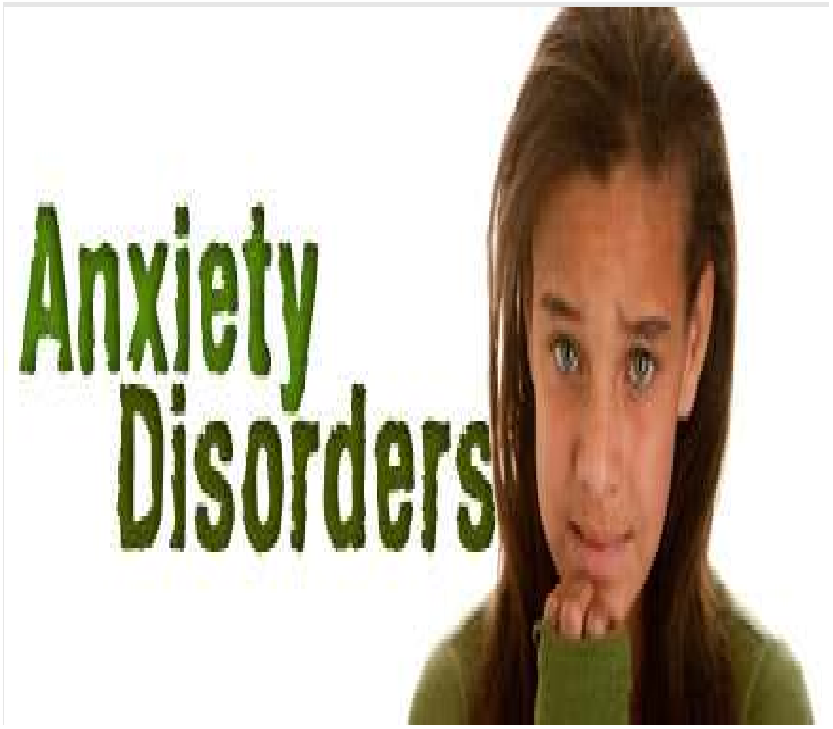

ABSTRACT:
Acceptance and Commitment Therapy (ACT) is the third wave of behaviour therapy, it is an innovative acceptance-based behavior therapy that has been applied broadly and successfully to treat a variety of clinical problems, including the anxiety disorders. Anxiety disorders are the most widespread cause of distress among individuals seeking treatment from mental health services. However, despite the prevalence of research on effective therapeutic interventions and their promising outcomes, significant shortcomings remain. In response to these drawbacks, a novel treatment, acceptance and commitment therapy (ACT), was developed in an attempt to reformulate the conceptualization and treatment of anxiety disorders. Throughout treatment ACT balances acceptance and mindfulness processes with commitment and behavior change processes. This new psychotherapeutic management takes advantage of the power of exposure therapies while simultaneously addressing issues of comorbidity, fear, and avoidance related to them, as well as emphasizing the commitment to client's chosen values. 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). Although the research base is small, a review of the current literature supports the notion that the ACT model of anxiety may be appropriate for conceptualizing and subsequently treating these disorders.

KEYWORDS
acceptance and commitment therapy, anxiety disorders.

INTRODUCTION

Acceptance and commitment therapy is the third wave of behavior therapies. It is neither from the first wave of behavior therapy nor the second, although it builds upon both. ACT is usually described in terms of six interrelated middle-level processes that aim to promote psychological flexibility defined as the ability to be in contract the private experiences that surface in the present moment without needing to avoid and/or escape from them and to adjust one's behavior according to what the situation requires in order to pursue valued ends (Hayes *et al.*, 2006). These middle-level processes are acceptance, diffusion, self as context, contact with the present moment, values, and committed action. However, it is worth noting that these processes are not entirely abstracted from RFT research and need to be more closely defined in terms of RFT formulations (Luciano *et al*., 2011, 2012; Törneke, 2010).

Briefly, therapeutic work in ACT can be summarized in two principles (Luciano et al., 2004): (a) promoting values clarification and actions that are in accordance with such values, and (b) promoting diffusion as a way to engage in the valued end when the feared private events are present. Although reductions of symptoms or cognitive change might occur across treatment with ACT, they are not the primary goal. Instead, ACT aims to alter their functions in order to allow the patients to behave in accordance with their values.

The Acceptance and Commitment Therapy 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 behaviours 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). Anxiety disorders are the most common psychological disturbances that lead people to seek mental health services (Narrow, Rae, Robins, & Regier, 2002). However, while effective treatments for these disorders exist, they are not effective for all individuals (Stewart & Chambless, 2009). This problem is amplified in that empirically supported treatments, particularly exposure-based ones, have limited acceptability for patients and mental health practitioners (Becker, Zayfert, & Anderson, 2004). The limited adoption by practitioners of empirically based procedures is also likely influenced by the need to learn various protocols for the treatment of each anxiety disorder—even though these protocols have core features that do not need to be relearned. This has led to interest in the development of unified protocols for all anxiety disorders (Barlow, Allen, & Choate, 2004; Eifert& Forsyth, 2005; McEvoy, Nathan, & Norton, 2009). Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) has been proposed as such an approach (Eifert & Forsyth), but only descriptions of its use as a unified protocol exist (Eifert *et al*., 2009), and its transportability to a private practice is unclear.

The ACT model of anxiety disorders proposes that attempts at regulating anxiety are at the core of anxiety disorders rather than the presence of particular levels of anxiety. This particularapproach to anxiety (and other inner experiences) comes out of behavioural research on language and cognition, mainly relational frame theory (RFT). Research on RFT has shownthat inner experiences occur in functional and relational contexts and that these contexts canbe targeted separately (Steele & Hayes, 1991). Similar to basic behavioural research on extinction, which shows that extinction involves new learning rather than unlearning (Bouton, 2002), it has been shown in RFT research that specific cognitions cannot be unlearned (Wilson& Hayes, 1996). However, the context in which inner experiences occur can be altered, so thatthey have less of a behavior regulatory impact (Levitt, Brown, Orsillo, & Barlow, 2004).Therefore, similar to other third-generation behavior therapies, ACT seeks to alter the functional effects of inner experiences with much less concern for the form, frequency, or likelihood of any particular category of inner experience such as anxiety, worry, or panic sensations. ACT

aims to decrease avoidance of these inner experiences as the dominant response to anxiety. Therepertoire of responses in anxiety is broadened, thus resulting in psychological flexibility (defined as the ability to openly experience anxiety while moving in personally chosen directions). This is accomplished through targeting the six psychological processes thought to be responsible forthe onset and maintenance of anxiety disorders from an ACT perspective: being present, acceptance, diffusion, self as context, values, and committed action (Hayes, Luoma, Bond, Masuda, &Lillis, 2006).

OUTCOME STUDIES

Data supporting the mechanisms of change in ACT are generally stronger than overall ACT outcome data for any one disorder (Hayes et al., 2006). There are more than 40 studies supporting the six processes targeted in ACT, with much of this support being for acceptance (Hofmann, Heering, Sawyer, & Asnaani, 2009; Levitt *et al.*, 2004), diffusion (Marcks& Woods, 2005, 2007; Masuda *et al*., 2010), being present or mindfulness (Arch &Craske, 2006), and values (Páez-Blarrina et al., 2008). There is evidence for the efficacy of ACT for most anxiety disorders, with the most support being for generalized anxiety disorder (GAD) and Obsessive-Compulsive disorder (OCD). One open trial (Roemer & Orsillo, 2007) and one randomized controlled trial (Roemer, Orsillo, & Salters-Pedneault, 2008) evaluated the efficacy of an ACT-based treatment for GAD. In the open trial (Roemer & Orsillo), 16 treatment completers showed significant reductions in GAD severity and depression, and increases in quality of life, with expected process changes. In the randomized clinical trial (Roemer et al., 2008), 31 adults diagnosed with GAD were either assigned to an ACT based treatment or a waitlist control condition; after waitlist, they received treatment. Treatment was more effective than waitlist, and at posttreatment, 78% of treated participants no longer met criteria for GAD. Acceptance of internal experiences and engagement in values-based activities were both positively related to responder status above reductions in worry (Hayes, Orsilo, & Roemer, 2010).

GENERALISED ANXIETY DISORDER (GAD)

GAD is the most common anxiety disorder and perhaps the most difficult to treat because of the diffuse manifestation of anxiety provoking stimuli (Roemer &Orsillo, 2002). Several studies implementing concepts from ACT in the treatment of GAD have demonstrated its potential effectiveness with this population. For example, Huerta, Gómez, Molina, & Luciano (1998) reported a case study of a 26-year-old woman with GAD, who was successfully treated with a therapy that incorporated key elements from ACT. In another study, researchers used an integrated protocol of traditional cognitive-behavioural methods and acceptance-and value-based concepts inherent to ACT to treat four individuals suffering from GAD (Orsillo, Roemer, & Barlow, 2001). After the 10-week treatment period, two of the four clients demonstrated substantial reduction in anxious and depressive symptoms, and the third showed modest improvement.

In a pilot study treated seven older primary care patients with 12 sessions of ACT and another nine patients with CBT (cognitive-behavioural therapy; Wetherell *et al.*, 2011). Whereas all participants in the ACT condition completed all 12 sessions, only five out of the nine participants in the CBT condition completed treatment. However, completer data for both groups revealed significant improvement in symptoms of anxiety and depression. The researchers noted that although the effects of ACT in their study were smaller than those demonstrated in younger adult samples with GAD (Roemer & Orsillo, 2007; Roemer *et al*., 2008), ACT may be beneficial for the older adult population and merits additional empirical evaluation.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

The therapeutic effect of acceptance and commitment therapy has also been seen in the patients with obsessive compulsive disorder. Number of studies has been done like Twohig, Hayes, and Masuda (2006) evaluated the efficacy of an eight-session ACT intervention in four patients with OCD. They hypothesized that acceptance and diffusion would be especially useful with this population because individuals with OCD are overly focused on their obsessive thoughts and engage in a variety of escape and avoidance behaviors (American Psychiatric Association, 2000). The authors found that there was a significant reduction in the number of compulsions by the end of treatment for all participants based on a self-report measure of the frequency of compulsions, and these results were maintained at the 3-month follow-up. All participants also evidenced significant reductions in levels of anxiety and depression, even though this was not the goal of therapy.

Another case study done by Eifert et al. (2009) involving a 52 year-old woman with a principal diagnosis of OCD and a secondary diagnosis of panic disorder who was successfully treated with the ACT protocol. The woman received a total of 12 weekly 1-hour sessions, and by the end of treatment, her OCD severity dropped from moderately severe at pretreatment to subclinical levels at posttreatment. She also endorsed significantly lower levels of overall distress, and notably, no distress related to her panic. At 6-month follow-up, her OCD problems remained at subclinical levels, and she reported making positive life changes in regards to career aspirations.

To see the comparison with progressive relaxation training and ACT on OCD patients, one randomized clinical trial has been done of an 8-session ACT protocol to progressive relaxation training (PMT) in the treatment of 79 individuals with OCD without in-session exposure (Twohig *et al.*, 2010). The authors found that although treatment refusal and drop-out were low in both conditions, those treated with ACT demonstrated greater changes at posttreatment and follow-up on OCD severity than those treated with PMT.

Post-Traumatic Stress Disorder (PTSD)

Orsillo and Batten (2005) provided a case example of a 51 year-old Vietnam combat veteran successfully treated with ACT for a long history of PTSD symptoms including intrusive memories, nightmares, panic attacks, and significant guilt associated with the acts he had carried out in Vietnam. The authors demonstrated how effective application of several ACT-consistent interventions improved this patient's functioning and how these interventions might be generalized to successfully treat other client's PTSD diagnoses. They argue that ACT is a suitable treatment for clients presenting for treatment due to life problems related to the experience of a traumatic event. Twohig (2009) also presented a case study of a 43 year-old woman with PTSD and major depressive disorder successfully treated with 21 sessions of ACT after being unresponsive to 20 sessions of CBT.

Panic Disorder

As an outcome studies the treatment of panic disorder are also evident in the ACT literature. Carrascoso (2000) conducted a case study with a 28 year-old male with a diagnosis of panic disorder with agoraphobia. After 12 treatment sessions, the man no longer met diagnosistic criteria for panic disorder, and in the three years following had not sought additional treatment. Morón (2005) successfully treated a young boy with panic attacks and agoraphobia with 9 sessions of ACT. At the end of treatment, the number of panic attacks and his agoraphobic symptoms had significantly decreased.

Eifert *et al.* (2009) provided a case illustration of the successful treatment of a 31 year-old man with a primary diagnosis of panic disorder and a secondary diagnosis of obsessive-compulsive disorder (OCD) who was successfully treated using the ACT protocol. By the end of the 12-week treatment program, clinician severity ratings for his panic were "0," and test scores indicated that he experienced more control over his panic and OCD-related symptoms.

CONCLUSION

Through the review of the researches, it can say that ACT has a relatively clear and supported model of anxiety disorders and their treatment. The underlying ACT model was developed out of intensive work with the problems inherent to anxiety disorders. Thereis preliminary data on its efficacy for anxiety disorders, and the limited data is supportive of its process of change. Still, there is very limited testing of ACT as a unified protocol foranxiety disorders. Although the research base is small, preliminary data support the notion that the ACT model of anxiety may be appropriate for conceptualizing and subsequently treating these disorders. However, the successfulness of ACT rests on the outcomes of future research studies.

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