

# Reducing Experiential Avoidance in Treatment for Generalized Anxiety Disorder

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## Introduction

As a field, we have a wealth of information about the efficacy of various treatments; however, we lack information on specific mechanisms of change that occur during treatment (Kazdin, 2007). Identifying mechanisms of change might enable us to learn which components of treatment actually produce change. This knowledge has the potential to increase treatment response rates, streamline evidence-based treatments, and facilitate dissemination efforts.

Acceptance-Based Behavior Therapy (ABBT) and Applied Relaxation (AR) both have demonstrated efficacy in treating Generalized Anxiety Disorder (GAD) (Roemer & Orsillo, 2007; Roemer et al 2008; Borkovec & Costello, 1993). Research is needed to determine whether this efficacy is associated with common or distinct mechanisms.

One potential mechanism is experiential avoidance (EA), which refers to an unwillingness to stay with internal experiences, and a desire to control or eliminate them (Hayes et al., 1996). Experiential avoidance has been targeted as a possible mechanism in ABBT, but it may also change in AR (Hayes-Skelton et al., 2012).

## Methods

A randomized control trial comparing the efficacy of ABBT and AR for GAD revealed comparable effects (Hayes-Skelton et al., in press). The current study examined the impact of these treatments on reports of experiential avoidance.

All participants received a principal diagnosis of GAD on the Anxiety Disorders Interview Schedule (ADIS-4, DiNardo, Brown, & Barlow, 1994). Participants received 16 individual sessions of ABBT or AR. We only included participants who completed questionnaires at all 5 time points in our analyses (pre, week 4, week 8, week 12, and post).

**Table 1. Demographic Information (n=61)**

Self Identified Race		Sexual Orientation	
White	50 (82%)	Gay, Lesbian, or Bisexual	3 (5%)
Latino/a	4 (7%)	Heterosexual	57 (95%)
Asian	3 (5%)	Gender Identity	
Black	3 (5%)	Female	40 (66%)
Asian and White	1 (2%)	Male	21 (34%)
Note: sexual orientation data missing for one participant		Age	Mean = 34.95 SD = 12.18

## Measures

**Acceptance and Action Questionnaire** The AAQ is a self report measure designed to capture experiential avoidance. Higher scores on the AAQ indicate higher levels of EA. For this study we used the 16 item single factor version (AAQ, Hayes et al., 2004).

**Clinician Severity Rating (CSR)**, a measure of GAD symptom severity and interference rated by an assessor blind to treatment condition (scores range from 0 (not at all severe) to 8 (extremely severe/distressing)).

**Quality of Life Inventory (QOLI)**; Frisch, Cornwell, Villanueva, & Retzlaff, 1992), a measure of life satisfaction across a number of important domains.

## Results

A repeated measures ANOVA examining change at pre, week 4, week 8, week 12, and post revealed a significant main effect of Time ( $F(4, 56) = 30.69, p < .001, \eta_p^2 = .69$ ), and a significant Time X Treatment effect ( $F(4, 56) = 2.68, p < .05, \eta_p^2 = .16$ ), with ABBT associated with a greater decrease over time than AR. Examination of the means (Table 2) indicates that this difference is particularly evident during the first half of treatment.

To examine course of change while accounting for any non-significant pretreatment differences, we conducted a repeated measures ANCOVA of AAQ scores across the course of treatment, controlling for pre-treatment levels. The Time X Treatment effect was no longer significant, but a medium to large effect size emerged ( $F(3, 56) = 2.14, p = .11, \eta_p^2 = .10$ ).

**Table 2. Mean AAQ scores across treatment time points**

	Pre	Week 4	Week 8	Week 12	Post
ABBT	75.91	69.91	64.37	59.10	55.71
AR	70.85	67.09	65.61	62.81	57.19

Note: AAQ=Acceptance and Action Questionnaire 16 item single factor version (Hayes et al., 2004)

To examine whether or not change in AAQ scores was correlated with change in GAD symptoms and reported quality of life we calculated residualized gain scores for change on the AAQ as well the Quality of Life Inventory (QOLI) and Clinician Severity Rating (CSR) from the ADIS-4 Anxiety Disorders Interview.

**Table 3. Correlations between unstandardized residuals for AAQ scores and outcome measures within each treatment condition**

AAQ	CSR	QOLI
ABBT	.35	-.45*
AR	.61**	-.58**

Note: CSR= Clinician Severity Rating; QOLI= Quality of Life Inventory; \*\*=significant at the p < .01 level, \*= significant at the p < .05 level

Residualized gain scores on the AAQ in the ABBT group were significantly correlated with quality of life [ $r(30) = -.45, p < .001$ ] and were marginally significantly related to clinician severity rating [ $r(30) = .35, p = .06$ ]. Residualized gain scores on the AAQ in the AR group were significantly correlated with quality of life [ $r(30) = -.58, p < .001$ ] and clinician severity rating [ $r(30) = .61, p < .001$ ]. (see Table 3). All correlations were in the hypothesized directions.

## Discussion

Results suggest that, although significant change on the AAQ occurs in both treatments (suggesting a potential common mechanism), the degree of change may vary. It appears that some of the treatment difference is related to starting in a different place, but there is still some difference in change over time. Results suggest that targeting experiential avoidance is important during these treatments. Examining scores on the AAQ over time may be helpful for clinicians working with individuals with a diagnosis of GAD who are working to decrease experiential avoidance.

Change in AAQ scores was correlated with change in GAD severity and quality of life within both treatment conditions, suggesting AAQ may be a common mechanism of change. In fact, the correlations within AR were higher than those within the ABBT condition.

Larger samples are needed to replicate these findings. One of the limitations of this study is that these analyses do not establish temporal precedence, which is needed to conclude that a mechanism of change has been identified.

We used the 16 item single factor version of the AAQ which is multifaceted. The AAQ has been used historically as a measure of EA, which was the construct of interest in this study. However, it also contains items that reflect avoidance of action when distressed, rather than solely focusing on clearly EA items. As a result, some have begun to refer to it as a measure of psychological flexibility, which is an extremely broad construct. Future research will be needed to determine whether EA specifically accounts for the observed findings.