



HHS Public Access

Author manuscript

Cogn Behav Pract. Author manuscript; available in PMC 2016 March 17.

Published in final edited form as:

Cogn Behav Pract. 2013 February ; 20(1): 47–56. doi:10.1016/j.cbpra.2011.07.004.

Acceptance and Commitment Therapy with Older Adults: Rationale and Considerations

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Abstract

Older adults are the fastest growing segment of the population. With these changing demographics, mental health professionals will be seeing more older clients. Additionally, older adults are an underserved population in that most older adults in need of mental health services do not receive treatment. Thus, it is essential that treatments for mental and behavioral health problems are empirically supported with older adults and that mental health professionals are aware of the special needs of older adult populations. Acceptance and Commitment Therapy (ACT) is an emerging approach to the treatment of distress. The purpose of this article is to provide a rationale for using ACT with older adults based on gerontological theory and research. We also review research on ACT-related processes in later life. We present a case example of an older man with depression and anxiety whom we treated with ACT. Finally, we describe treatment recommendations and important adaptations that need to be considered when using ACT with older adults and discuss important areas for future research.

Adults aged 65 and older are the fastest growing segment of the U.S. population. Due to the aging of the “baby boom” generation and advances in health care, estimates suggest that the number of older adults will double by 2030, representing approximately 20 percent of the population (*A Profile of Older Americans*, 2009). With the exception of dementia, the rates of mental and behavioral health disorders decrease in older adulthood (Smyer & Qualls, 1999). However, certain subpopulations of older adults who face chronic illness and functional impairment, such as homebound and nursing home-dwelling older adults, are at increased risk for mood or anxiety disorders. Depression and anxiety in older adulthood are associated with a number of adverse outcomes, including higher levels of health care utilization (Porensky et al., 2009; Unutzer et al., 1997), increased risk of nursing home placement (Gibbons et al., 2002), greater functional impairment (Brenes et al., 2005; Lenze et al., 2001), increased mortality (Saz & Dewey, 2001), faster rates of cognitive decline (Dotson, Resnick, & Zonderman, 2008; Sinoff & Werner, 2003), higher rates of suicide (Diefenbach, Woolley, & Goethe, 2009; Turvey et al., 2002), and decreased quality of life (Blazer, 2003; Porensky et al., 2009; Wetherell et al., 2004).

Older adults are an underserved population; the majority of older adults in need of mental health treatment do not receive care (Swartz et al., 1998; Wang et al., 2005). If these individuals do receive treatment, it is typically pharmacological, despite the fact that many prefer counseling (Gum, Iser, & Petkus, 2010). Reasons why older adults do not receive treatment include lack of knowledge about mental health services, lack of perceived need for services (Klap, Unroe, & Unutzer, 2003), and stigma (Livingston & Boyd, 2010). Additionally, provider factors such as the misconception that the patient's problems are part of normal aging, as opposed to a mental health problem, also contribute to underutilization of mental health care by older adults (Smyer & Qualls, 1999).

With changing demographics, psychologists and other mental health professionals will be seeing older adults with greater frequency. Thus, it is essential that treatments for mental and behavioral health problems are empirically supported with older adults and that health care professionals are educated about the special needs of older adult populations. To date, most research examining the effectiveness of psychosocial treatments with older adults have examined cognitive behavioral approaches. Studies have shown that these types of treatments, including problem-solving therapy, are effective in treating depression in older adults in the community and primary care (Bell & D'Zurilla, 2009). However, studies have produced mixed findings on their effectiveness with some subpopulations, such as depressed, medically ill homebound older adults (Ayalon, Fialova, Arean, & Onder, 2010; Gellis & Bruce, 2010). CBT approaches may also be suboptimal in the treatment of anxiety in later life (Wetherell, Ruberg, & Petkus, 2010; Thorp et al., 2009). Thus, the need is critical to further develop and test psychosocial treatments to provide better care to older adults.

Acceptance and Commitment Therapy (ACT) is an emerging evidenced-based approach to the treatment of emotional distress (Hayes, Strosahl, & Wilson, 1999). In this article, we will provide a rationale for an ACT approach with older adults, drawing upon theories from the literature on adult development and aging, emotion regulation, and knowledge about mental health problems. We will provide a brief description of the ACT model of treatment. We will review the literature on investigations of ACT-related processes in older adults. We will describe treatment recommendations, important adaptations that need to be considered when using ACT with older adults, and provide a case example. Lastly, we will make recommendations for future research.

The ACT model of psychopathology and treatment

ACT assumes that one primary factor, psychological inflexibility, is characteristic of psychopathology (Hayes et al., 1999). The ACT model defines psychological inflexibility as an inability to connect with one's values in the present moment due to experiential avoidance and cognitive fusion (Hayes et al., 1999). The six processes that are associated with psychological inflexibility are experiential avoidance, cognitive fusion, dominance of conceptualized past or future, attachment to conceptualized self, loss of contact with personal values, and inaction, impulsivity, or persistent avoidance. Experiential avoidance is the attempt to control unpleasant thoughts, emotions, memories, and other internal experiences. Cognitive fusion occurs when we conceptualize ourselves by the thoughts,

emotions, and other internal experiences we experience. Attachment to the conceptualized self can be thought of as being fused with the cognitions that one is a person who is depressed, worried, or has significant problems. Values give meaning to life and can include family, career, social relationships, and health, among others. Individuals exhibiting psychological inflexibility exert energy and resources on experiential avoidance, while neglecting and losing contact with their core life values.

Research has suggested that the core processes related to psychopathology in the ACT model persist into older adulthood. Experiential avoidance of distressing internal experiences appears to be associated with greater distress in older adulthood. Engaging in thought suppression as a mechanism to cope with unwanted thoughts has been associated with less subjective sense of meaning in life in community-dwelling older adults (Krause, 2007). Thought suppression and avoidance coping have been associated with increased suicidal ideation in depressed older adults with co-morbid personality disorders (Cukrowicz, Ekblad, Cheavens, Rosenthal, & Lynch, 2008). Furthermore, engaging in thought suppression has been associated with poorer outcomes in older adults following treatment for depression (Rosenthal, Cheavens, Compton, Thorp, & Lynch, 2005). Engaging in avoidance may mediate the association between past trauma exposure and increased distress later in life (Dulin & Passmore, 2010). In functionally impaired, chronically ill homebound older adults, after controlling for physical illness, functional impairment, and cognitive functioning, engaging in thought suppression was associated with somatic, depressive, and anxiety symptoms (Petkus, Gum, & Wetherell, manuscript under review). Additionally, using avoidance as a coping strategy is also associated with increased depression (Andrew & Dulin, 2007) and persistent anxiety (Ayers et al., 2010). Taken together, these studies support the hypothesis that experiential and behavioral avoidance have an adverse effect on functioning in older adults. This suggests that an ACT model of treatment would be potentially effective with this population.

The research examining the effectiveness of ACT with older adults is extremely limited. To date, only one pilot study has been conducted to examine the effectiveness of ACT with older adults (Wetherell et al., 2011). This study examined ACT and CBT in a sample of older adults with Generalized Anxiety Disorder (GAD). Results suggest that ACT is feasible, acceptable, and may be effective at reducing depression and worry. However, this was a small feasibility study ($N = 21$), and larger scale studies are needed to examine the effectiveness of ACT with this population.

Rationale for ACT with older adults

The characteristics of mood and anxiety disorders in older adults support an ACT approach. Comorbidity of anxiety and depression are common and difficult to distinguish among older people (Gum & Cheavens, 2008). Other research suggests that in chronically ill, functionally impaired older adults, anxiety and depressive symptoms commonly co-occur ($r = 0.71$; Petkus et al., 2010). The transdiagnostic nature of ACT may make the assessment and treatment of anxiety and depression more efficient. In disorder-specific approaches to treatment, treatment planning requires distinguishing the primary disorder from which the individual is suffering. In an ACT treatment approach, it is not necessary to distinguish, for

example, an anxiety disorder from depression. Under the ACT model, assessment includes determining how the core processes such as experiential avoidance strategies, cognitive fusion, life values, and current behaviors are contributing to the client's current problem.

Cognitive behavioral treatments have limited effectiveness in older adults suffering from GAD (Thorp et al., 2009). Given the characteristics of GAD in late life, an ACT approach may theoretically be better than a CBT approach. First, GAD is often a chronic condition that arises early in life and persists into older age (Chou, 2009; Le Roux, Gatz, & Wetherell, 2005). Given that most older GAD patients have had the disorder the majority of their lives, an acceptance and mindfulness approach may be more beneficial than a control-oriented strategy. Additionally, the worry content of older adults generally tends to center around changes in health or possible developmental losses (Diefenbach, Tolin, Gilliam, & Meunier, 2008). A CBT approach that challenges the validity of these thoughts may not be beneficial with older adults because these worries, while excessive and maladaptive, may not be unrealistic. An acceptance approach in which individuals learn to focus on their remaining resources may be more beneficial than an approach in which they are encouraged to modify their thinking about loss or disablement.

Theories of adult development and successful aging suggest that an ACT approach to treatment could be useful for older adults. Dynamic interplay occurs throughout the lifespan, such that individuals experience gains and losses in functioning at all stages (Baltes, 1997). Although gains still occur in older adulthood, the gain/loss dynamic shifts, such that this period is characterized by an increased proportion of losses, some of which are unchangeable. The selective optimization with compensation (SOC) model of successful aging (Baltes, 1997; Freund, 2008) explains one way in which individuals adapt to gains and losses as they age. The SOC model posits that throughout life, individuals select goals toward which to devote resources and seek the optimal means to achieve the selected goal. If declines in functioning result in the inability to achieve a goal, compensatory alternative strategies such as expending additional resources or changing the original goals are implemented in order to maintain functioning. Thus, this model of successful aging suggests that accepting declines that are unchangeable followed by identifying goals that are still attainable is adaptive and beneficial.

Research supports this idea; older adults who actively engage in efforts to eliminate problems that cannot be solved are at increased risk for depression (Isaacowitz & Seligman, 2002). Additionally, disengaging from inappropriate commitments or goals and replacing them with more feasible goals is associated with better emotional well-being (Wrosch, Dunne, Scheier, & Schulz, 2006; Wrosch, Scheier, Miller, Schulz, & Carver, 2003). Studies suggest that religiosity, which is more common among the current cohort of older people and can facilitate a strong connection to core values, may be associated with better health (Krause, 2004).

Research on emotion regulation in older adulthood also provides theoretical support for the use of ACT with older adults. Paradoxically, although declines in some cognitive domains occur, the ability to regulate emotions appears to improve with age (Schiebe & Carstensen, 2010). For example, older adults, on average, exhibit lower and less variable levels of

negative affect than do younger people (Labouvie-Vief, 2003). In one study, poor performance on challenging cognitive tasks led to more distress among younger adults than among older individuals, despite the fact that cognitive decline is a concern with particular relevance to older adults (Chow et al., 2007). Zautra and colleagues (2000) posit that aging is accompanied by resilience due to the ability to dissociate past feelings from current feelings, which could suggest lower levels of cognitive fusion. Given this research, an ACT intervention may be especially beneficial as it may draw upon the strengths of older individuals.

Furthermore, evidence suggests that older adults are often less knowledgeable about behavioral and mental health problems than are younger people (Fisher & Goldney, 2003). Additionally, older adults may have difficulty recognizing mental health problems in themselves. One study with homebound older adults found that only 50 percent of participants with a depressive, substance use, or anxiety disorder, and 35 percent with a current adjustment disorder, were aware that they were experiencing a problem (Gum et al., 2009). Older adults in another study were less accurate than younger people in classifying a list of symptoms as depression, anxiety, both, or neither (Wetherell et al., 2009).

An ACT intervention may be more credible with older adults because of their lower levels of awareness of mental health issues. The goals of cognitive behavioral approaches to treatment are to decrease depressive, anxiety, or other distressing symptoms. Because older adults are less familiar with depression and anxiety, they may be less likely to understand the purpose of or engage in a treatment whose goal is to decrease anxiety and depression. The goal of an ACT intervention is to live life in accordance to deeply held values. This goal of treatment may resonate more with older adults. This in turn may potentially make it more likely they will actively engage in treatment. A recently completed pilot study by our group suggests that attrition rates may be lower among older adults treated with ACT when compared to those who received CBT (Wetherell et al., 2011).

Treatment recommendations with older adults

In the rest of this paper, we present adaptations that should be considered when using ACT with older adults. It is important to note, however, that ACT is not a “by the book” intervention, but rather an approach to treatment based on theory (Hayes et al., 1999). Thus, the information that follows should be taken as general guidance for professionals that may be refined according to individual client needs. In this following section we will describe important characteristics of older adults that need to be considered during the assessment process. We will also describe adaptations in value clarification and emotional acceptance work that should be considered when working with older clients.

Assessment must address the unique biopsychosocial context of older adults. It is essential that the therapist collaborate with the client's primary care physician to better understand any medical comorbidities or functional impairments that may influence treatment. A number of important clinical characteristics need to be considered when conducting the assessment of the ACT-related core processes with older adults. It is particularly important to assess for suicidality when working with older people. Suicide can be considered the most

extreme form of experiential avoidance (Hayes et al., 1999). Older adults, particularly older white males, have the highest suicide rate of any segment of the population (Smyer & Qualls, 1999). Additionally, it is important to assess for substance abuse as an internal control strategy as these problems are commonly misdiagnosed or undetected in older adults (Loukissa, 2007).

Cognitive fusion is another important area of assessment with older adults. It is important to assess to what extent the individual is fused with a damaged conceptualized self. Attitudes about aging are important, and having negative opinions about growing older can develop into a negative self-stereotype (Levy, 2003). Furthermore, older adults who have negative beliefs about aging tend to have worse functional and mental health outcomes in older adulthood (Nuevo et al., 2006). Cognitive fusion with this damaged conceptualized aged self may create a barrier to behavioral change. It is also important to assess cognitive fusion among disabled and chronically ill older adults. Chronic illness and functional impairment are commonly co-morbid in depressed and anxious older adults. It is important to assess to what extent the client is fusing with a damaged sense of self that may be arising from chronic illness and functional impairment (i.e., defining the self as helpless or infirm). Typically, this problem can be evaluated by asking people how medical challenges influence their behaviors. Patients who limit their activities beyond what is imposed by physical disability, while attributing these limitations solely to health, are likely fusing with this damaged conceptualized self. Similar to attitudes about aging, fusing with a damaged conceptualized self arising from chronic illness needs to be addressed in treatment and may pose a barrier to behavioral change.

Treatment should be time-limited and depending on the client may consist of 12-16 fifty-minute sessions. Cognitive changes such as decreased processing speed, working memory, and attention occur as part of the normal aging process (Schaie, 2005). The therapeutic process generally is slower with cognitively or functionally impaired patients, so more sessions may be needed to cover the important components. Because many older adults have difficulty noticing and identifying internal experiences, we engage in a mindfulness exercise, such as mindful breathing, at the beginning of each session in order to develop and practice this skill (Zettle, 2007). Following the mindfulness exercise, we typically review the homework and concepts that were covered in the previous session. The new material for the session is then covered, and homework is assigned. Typically homework handouts are given in different colored paper to designate that they are homework and patients are asked to repeat the assignment in their own words to ensure that they understand what it is they are supposed to do between sessions. Additionally, handouts for homework or other tools used in therapy may need to be modified for clients who are experiencing sensory impairments such as poor vision (e.g., large fonts, bold print).

Table 1 displays the basic themes addressed in a 12-session ACT intervention with older adults with depression or anxiety. In addition to providing a framework for the intervention and increasing likelihood of engagement in therapy, discussing life values at the onset of therapy is particularly useful with older depressed clients. Research has demonstrated that depressed older adults are more likely to present with “depression without sadness” that is characterized by severe anhedonia (Gallo & Rabins, 1999). Commonly, older adults will not

describe being sad; rather, their presenting complaint is that they just do not get any enjoyment out of the things they have enjoyed in the past. An ACT framework may conceptualize this problem as the pursuit of value-incongruent goals or failing to pursue value-congruent goals as a reaction to changes and losses that are characteristic of the aging process. Thus, working towards reconnecting the client with his or her values at the onset of treatment may be most beneficial when doing ACT with older adults.

Moreover, older adults may be more likely to understand and relate to values than to the idea of emotional struggle. By starting treatment with the values module the likelihood that the older adult patient will engage in treatment is increased. Losing contact with one's life values may occur following important significant life events such as retirement or new functional impairments that arise from a chronic illness. For example, clients who were extremely engaged in their career their entire adult life may strongly fuse with the value of making a contribution to society, which was manifested through work. Thus, if the client is unable to transition to new behavioral goals consistent with these values following retirement, he or she may experience disconnection with core values. Additionally, new functional impairments that stem from chronic illnesses may render current goals physically unattainable. If these unattainable goals are not replaced with attainable goals that are in accordance with values, the individual may lose contact with a deeply held life value.

The values clarification module has the following objectives, which we have drawn in part from an ACT intervention used with distressed caregivers (Marquez-Gonzalez, Romero-Moreno, & Losada, In press). Specifically, the module has the objective of helping the client reconnect with the values that give meaning and purpose to life. A second objective is to increase awareness of valued life directions and ways in which current behavior has not been in accordance with these deeply held values. After identifying these values, the therapist works with the client to identify alternate strategies to work towards these values by obtaining assistance from others or to identify alternative goals which are still attainable. Committed actions in service of these values are discussed throughout treatment. Common barriers are fatigue, experiencing uncomfortable emotions, and fusing with self evaluative internal experiences. Strategies to overcome these barriers are addressed in the acceptance piece of the intervention.

Increasing acceptance and awareness of internal experiences is the second module of treatment. This module contains two main components, increasing awareness of uncomfortable internal events and decreasing avoidance of these events. The first component, increasing emotional awareness, entails connecting the individual with his or her internal experiences and increasing the ability to label and discriminate between emotions. Furthermore, the client should be educated on the way in which thoughts, emotions, and physiology are interconnected.

Increasing awareness of thoughts and emotions may be particularly difficult with older adult clients. As described previously, research suggests that older adults are often not good at identifying symptoms of anxiety and depression (Gum et al., 2009; Wetherell, Petkus et al., 2009). Depressed older adults commonly present with complaints about loss of interest and deny depressed mood (Gallo & Rabins, 1999). Additionally, older adults suffering from

anxiety disorders may have difficulty describing their symptoms. Instead of identifying what they are experiencing as “worry” or “anxiety,” it is not uncommon for older GAD patients to describe the process in idiosyncratic terms (Wetherell, Ruberg, & Petkus, 2010). It is also common for both depressed and anxious older adults to present with somatic complaints such as fatigue or loss of appetite and find it challenging initially to describe internal experiences.

We found helpful an exercise drawn from an ACT intervention with caregivers in which the client is asked to visualize a recent situation that was particularly uncomfortable or distressing. Upon allowing clients some time to reflect on the situation, they are asked to reflect on what emotions they experienced, what physiological symptoms they had in that situation, what they were thinking in the moment, and what happened that could be related to the emotions. After working with the individual to identify these emotions and cognitions, it is important to ask how the client reacted to these internal experiences. Did the client try to suppress or change these unpleasant emotional experiences? Clients are then instructed to practice at home by rating the severity of the upsetting internal experience they are struggling with as well to rate how much they have attempted to fight or suppress this thought/emotion. The specific exercise is useful, especially with an older client who is having particular difficulty identifying internal experiences.

After awareness of internal experiences is increased, the therapist works with the client to increase acceptance of these aversive internal events. The goals of this module are to help the client understand that avoidance does not work, and in fact may be the primary problem. After helping the client recognize that avoidance does not work, the therapist works with the client to increase willingness, or being open to experience unpleasant emotions or thoughts without trying to modify or avoid them. The last goal of this module is to undermine the client's cognitive fusion.

Many of the standard ACT metaphors and exercises (e.g., tug-of-war with a monster, p. 109; finger traps, pp. 104-105; chocolate cake, pp. 124-125; passengers on the bus, pp. 157-158; page numbers are from Hayes et al., 1999) are helpful in engendering creative hopelessness and mindfulness and demonstrating the futility of control. We have also developed some new exercises and metaphors; for example, having the client pour water into a cup with a hole in it to demonstrate the futility of control, and in particular, control by overengaging in activities, which is a common form of experiential avoidance among older adults with anxiety disorders (Wetherell et al., 2009). With one client, a retired singer, we used the lyrics from the *Casablanca* theme (“a sigh is just a sigh, the fundamental things apply as time goes by”) to illustrate the concept of cognitive fusion and the way in which it interferes with living according to one's values.

As described above, we address values earlier and to a greater extent than is usually done with younger people. We explicitly incorporate religion into discussions about values because this is a very important domain for many older people. We also talk about end-of-life issues in the context of values-driven behavior. We often start this discussion by inviting clients to imagine that they have just been told that an illness will end their life in two years; we ask how they would like to spend that time, and why. In our work as part of a home-

based primary care team, we collaborate with other medical providers in discussions about palliative approaches to medical care for those with life-limiting illness; these approaches are very compatible with an ACT model. A case example is provided below as a practical example of the core treatment components and modifications applied to the treatment of a depressed and anxious older adult.

Case example

Joe was a 69 year old divorced white male presenting to the clinic with problems with depression and anxiety. Over the past 10 years, Joe had difficulty coping with many stressful life events. Joe's wife divorced him, his mother for whom he provided care passed away, he developed skin cancer (in remission), his business went bankrupt, he lost his house and had to relocate to a studio apartment, and he had to ask his son for money to help support him. Joe's symptoms included depressed mood, anhedonia, problems falling asleep, extreme fatigue throughout the day, feelings of worthlessness, and inability to concentrate. Additionally, Joe reported significant symptoms of GAD such as excessive and hard to control worry about his health, finances, family, and future. A problem-solving conceptualization and approach to treatment for his depression was initially tried, with no significant improvements in symptoms.

Following the ineffectiveness of the problem-solving approach, Joe's problems were conceptualized using an ACT approach. In the ACT conceptualization, Joe was stuck in a conceptualized past and future self manifested by rumination about when he was successful, had his own house, went to work, and felt closer to his family. Additionally, he was overly attached to his conceptualized future self in that he feared that his health was going to deteriorate and that his son (to whom he was close) was going to reject him because he was asking for money. He had difficulty labeling thoughts or feelings at the onset of treatment and would just describe himself as being "very tired." Joe was engaging in experiential avoidance by sleeping or distracting himself most of the day. He stopped actively looking for employment because he was turned down for jobs many times and did not like the way it made him feel. As a result of his experiential avoidance, Joe was not actively engaging in value-consistent behaviors such as looking for employment, spending time with his family, or taking care of his health.

Joe's treatment plan consisted of 12 sessions with the following goals: 1) reconnect Joe to his values and identify how his current behaviors were not in service of the things he values most, 2) increase Joe's awareness of his thoughts and feelings, 3) increase Joe's willingness to experience distressing internal experiences, and 4) increase value-consistent behaviors.

Sessions 1-3: Values clarification

Before the first session, Joe filled out the Valued Living Questionnaire (Wilson, Sandoz, Kitchens, & Roberts, 2010), a brief self-report assessment that measures value-consistent behaviors. The first three sessions started with a brief mindfulness exercise (focusing on the breath) but primarily consisted of educating Joe about the nature of values, about how values are things that can never be achieved and always have to be worked towards. The "attending your own eulogy" exercise was done in which Joe was asked what he what he would like to

be remembered for (Hayes et al., 1999, p. 216). Joe identified his family, especially his two children, contributing and helping others, and his career as his main values. Joe was educated about the difference between values and goals and the importance of setting reasonable goals was discussed.

Sessions 4-5: Creative hopelessness and acceptance/willingness

The goals of the next two sessions were to foster creative hopelessness and acceptance/willingness. After a brief mindfulness exercise (either focus on the breath or body scan), the therapist had Joe identify all of the things he had tried to overcome his current problems, and these were listed on a worksheet along with the short-term and long-term outcomes. Joe listed at least three pages of things he had tried and was able to see that although in the short term they helped, in the long term he still experienced anxiety and depression. In the tug-of-war with a monster exercise (Hayes et al., 1999, p. 109), Joe was given a rope and told that his current situation seems like a game of tug of war with his depression and anxiety. The therapist then pretended to be his anxiety/depression monster and pulled on the rope. The therapist made Joe see that when he tried to fight with the monster, the therapist/monster pulled the rope harder, resulting in Joe having to engage more energy to keep up the fight. As a result of this fight, Joe lost focus on everything going around him in the room, as all his energy was focused on this fight with his emotional pain. The cost of his real-world control efforts were discussed. He described that he was not attending gatherings with his extended family due to feeling ashamed of his divorce and losing his job. The therapist then proposed the option of “letting go of the rope” by accepting that he has these distressing thoughts and feelings, yet can still work towards things that he values. The therapist brought up how staying at home allowed him to avoid those feelings of embarrassment, yet he was unable to see his family whom he cared about. Furthermore, he knew that his children wanted to spend more time with him. Additionally the “do not think of chocolate cake” exercise (Hayes et al., 1999, pp. 124-125) was performed to demonstrate the futility of attempting to control internal experiences.

The “passengers on the bus” exercise (Hayes et al., 1999, pp. 157-158) was particularly useful in conveying the idea of willingness. In this exercise, a bus was drawn on a whiteboard and all of the thoughts and feelings that have been standing in Joe's way were written down as the passengers trying to prevent Joe from driving his bus towards his values. To make the exercise more meaningful to Joe, the exercise was modified to highlight how Joe had been successful in the past in moving towards his values. Joe was asked to describe times in the past when he wasn't feeling well, was tired or anxious, yet still “drove his bus” by going to work or being there for his children.

Sessions 6-7: Defusion

The goals of the next two sessions with Joe were to increase his awareness of his thoughts and feelings. Once again, sessions began with a mindfulness exercise, this time asking Joe to attend to his thoughts, feelings, and physical sensations. Initially Joe characterized everything that he was experiencing as “feeling tired” and that he had “racing thoughts going through his head”. He exhibited difficulty in connecting these thoughts to his behaviors and emotions. Initial exercises consisted of having Joe describe in a step by step

matter what thoughts he had going through his head and feelings that he experienced in the morning (the time of day which he had the least motivation). Worksheets with sample thoughts and feelings were used to aid in him describing things that were going through his head.

Sessions 8-9: Mindfulness

Although mindfulness exercises were conducted at the beginning of every session, they were emphasized during the next two sessions. The “leaves on a stream” exercise in which Joe was encouraged to notice the thoughts and feelings that he was experiencing, put these internal sensations on a leaf, and let it flow down the stream, was particularly useful (Hayes et al., 1999, p. 159). He described how his stream quickly filled up with leaves. He deemed the exercise helpful and said that he rarely ever slowed down and actually noticed all of the things going through his head.

Session 10-12: Committed action

The last three sessions focused on increasing value-consistent behaviors. Reassessing short-term goals that were consistent with his values was particularly important for Joe. He initially identified obtaining a comparable job to that which he had before as the only goal consistent with his value of career, and getting back together with his ex-wife as the only goal consistent with his value of family. The idea of flexibility and importance of setting achievable short-term goals was discussed. The therapist and Joe worked together during the initial sessions to identify simple actions such as calling his son and working for 30 minutes on his resume between sessions as value-consistent goals in which he could engage. By later sessions Joe was applying for at least one job a week, was actively contacting old friends in his field to inquire about job openings, and was spending time with his son once a week.

Treatment outcome and challenges

The change in approach from problem-solving to ACT was beneficial in treating Joe's depression and anxiety. At the end of treatment he was actively engaging in valued behaviors such as applying for jobs and contacting his son with greater frequency. Joe obtained employment following session 12. He reported that during the interview process, the mindfulness exercises were particularly helpful in getting him to notice what he was thinking and feeling, yet perform well in the interview. His Beck Depression Inventory score decreased from 31 at the beginning of treatment to 18 at post-treatment, a 42% improvement.

Although ACT treatment was largely successful with Joe, some challenges existed during treatment. Specifically, the cognitive defusion and starting committed action were challenging. For example, Joe became defensive and had difficulty understanding the purpose of the quickly repeat the word “ice cream” and “worthless” cognitive defusion exercise (Hayes & Smith, 2005, p. 71-72). To overcome this challenge, different cognitive defusion activities such as the passenger's on the bus activity was done which Joe was better able to understand. Additionally, Joe initially had difficulty carrying out his committed action. He initially would come up with goals for action that were largely out of his control such as getting employment and ambitious. To overcome this challenge we spent a lot of

time breaking down this goal into smaller steps that were observable and had a high probability of success. A barrier to these actions was that he would eat breakfast, feel lousy and then take a nap for the rest of the morning. As a result, we initially set basic goals that were in service of his value of career such as cleaning up after his breakfast, shaving, showering, and getting out of his pajamas every day. He then built off these simple committed actions and was more active in finding employment.

Future directions and conclusion

Rapid increases in the older adult population during the next 40 years will increase the importance of evidence-based psychosocial treatments for this population. To date, most research has focused on cognitive behavioral treatments for mental or behavioral health problems. Theories of adult development and aging provide a strong rationale for the potential utility of an ACT-based intervention with older adults. The present paper reviewed research on adult development and aging, the presentation of emotional distress in older adults, and mental health knowledge of older people to bolster the rationale for this approach with aging individuals. Further, we also presented important aspects of older adulthood that need to be considered when conducting assessment and treatment planning with ACT.

It should be acknowledged that the appropriateness of ACT for older adults is based in gerontological theory and research largely conducted with individuals who do not have depressive or anxiety disorders. More research is needed to examine the association between ACT-related processes and psychopathology in older adulthood. In addition to examining this treatment with community-dwelling older adults, it is strongly recommended that ACT be examined among those who are ill and frail, including special populations such as homebound and nursing home dwelling older adults.

A transdiagnostic intervention for depression and anxiety may have important implications for implementation into a home health care setting. Due to barriers experienced by this population such as functional impairment and disability, many do not receive adequate mental health services (Gum et al., 2010). One potential strategy to increase access of empirically supported treatments is to implement these treatments into existing home care services. Research should examine whether ACT can be delivered competently and safely by a home health care provider such as a nurse under the supervision of a mental health professional. If ACT is effective and can be competently administered by a professional already working in the home, the transdiagnostic nature of the treatment would make it potentially easier to implement. Under disorder-specific treatment protocols, the professional would potentially have to learn numerous treatment manuals for the various disorders. A transdiagnostic approach would enable the professional to use one approach for unipolar mood and anxiety disorders as well as stress inherent in aging, making it potentially more efficiently implemented into existing services.

In conclusion, older adults are an understudied yet increasingly important segment of the population. Gerontological research provides a strong rationale for the use of ACT with this population. We provide a number of proposed adaptations and important characteristics of older adults to consider when conducting ACT with this population. Future research needs

to develop transdiagnostic treatments for older adults, particularly older adults who are at high risk for depressive or anxiety disorders, such as homebound elders.

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Table 1

Themes for an ACT intervention with older adults.

Values	Sessions 1-3 <ol style="list-style-type: none"> 1 Regaining contact with values: What matters? 2 The role of religion 3 Making the most of the remaining time
Acceptance/Willingness	Sessions 4-5 <ol style="list-style-type: none"> 1 What's worked? What hasn't? What are the costs? 2 Control is the problem 3 Experiencing vs. avoiding 4 How does this fit with values?
Defusion	Sessions 6-7 <ol style="list-style-type: none"> 1 Awareness of internal experiences 2 A thought is just a thought 3 Having a thought vs. content of a thought 4 Defusion from damaged conceptualized self
Mindfulness and Self as Context	Sessions 8-9 (Mindfulness exercise conducted at the beginning of every session) <ol style="list-style-type: none"> 1 Being in the present moment 2 Not judging thoughts or feelings 3 Thoughts and selves
Committed Action	Begins during the Values sessions and continues throughout the intervention, but is emphasized during Sessions 10-12 <ol style="list-style-type: none"> 1 What goals are consistent with values? 2 What actions work toward these goals? 3 Breaking it down into steps 4 Problem-solving potential barriers 5 Enlisting support

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