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The Counseling Psychologist 2013 41: 313 originally published online 22 October 2012

DOI: 10.1177/0011000012461955

The Counseling Psychologist
41(2) 313-335

DOI: 10.1177/0011000012461955
http://tcp.sagepub.com

Quality of Life in Advanced Cancer: An Acceptance and Commitment Therapy View

Julie E. Angiola[1] and Anne M. Bowen[2]

Abstract

Prognosis is poor and quantity of life is compromised for individuals with advanced cancer. Quality of life is impacted, for some, by psychological distress. According to Acceptance and Commitment Therapy (ACT), psychological distress is associated with emotional avoidance and lack of valued living. ACT aims to increase psychological health via acceptance of one's "minding," a focus on present-moment living, and a commitment to value-driven life. In this article, we introduce the advanced cancer patient, the theory behind ACT, and how ACT may be delivered. We present the hypothetical case of J.B., a 56-year-old woman with recurrent Stage III ovarian cancer who reports thoughts of hopelessness and worthlessness, and how ACT might be applied to help J.B. experience a rich and meaningful life irrespective of her time remaining.

Keywords

Acceptance and Commitment Therapy, cancer, psychological flexibility, prevention/well-being

[1]Department of Psychology, University of Wyoming, Laramie, WY, USA
[2]Fay W. Whitney School of Nursing, University of Wyoming, Laramie, WY, USA

Corresponding Author:
Julie E. Angiola, Department of Psychology, University of Wyoming, 1000 E. University Avenue, Laramie, WY 82071, USA
Email: jangiola@uwyo.edu

Advanced Cancer and Quality of Life

Individuals with advanced cancer, such as metastatic breast cancer and late stage ovarian cancer, have poor prognoses, since seldom is their cancer curable (American Cancer Society [ACS], 2012). Treatments are often offered to reduce tumor size, alleviate symptoms, and prolong living, yet quantity and quality of life remains uncertain.

Quality of life is further compromised by fatigue (Stone et al., 1999), pain (Coyle, Adelhardt, Foley, & Portenoy, 1990; Vainio et al., 1996; Walsh, Donnelly, & Rybicki, 2000), and psychological distress (Derogatis et al., 1983; Grabsch et al., 2006; Grassi et al., 1996; Kissane et al., 2004; Kugaya et al., 2000; Vehling et al., 2012; Wilson et al., 2007). It is estimated that as many as 25% of advanced cancer patients meet diagnostic criteria for major depressive disorder and as many as 35% meet the diagnostic criteria for an adjustment disorder (Miovic & Block, 2007). As the literature indicates, not every individual diagnosed with advanced cancer will experience clinically significant psychological distress; so why do some individuals suffer psychologically while others do not?

According to more recent "third wave cognitive behavioral therapies," a major risk factor for experiencing psychological distress is experiential avoidance (Hayes et al., 2004; Kashdan, Barrios, Forsyth, & Steger, 2006; Tull & Roemer, 2007). Experiential avoidance is the "phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them" (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1154). Contexts that trigger uncomfortable and distressing private experiences are avoided, and attempts to control or distract oneself from thoughts may occur. Individuals with cancer who avoid cancer-related cognitions and behaviors are at a greater risk for experiencing psychological distress than those who do not use avoidance-based coping strategies (Costanzo, Lutgendorf, Bradley, Rose, & Anderson, 2005; Costanzo, Lutgendorf, Rothrock, & Anderson, 2006; Donovan-Kicken & Caughlin, 2011; Dunkelschetter, Feinstein, Taylor, & Falke, 1992; Elani & Allison, 2011; O'Brien & Moorey, 2010; Stanton et al., 2000). This phenomenon also appears in studies examining avoidant coping among HIV-infected individuals, alcohol and pornography addicts, those with disordered eating, and victims of childhood sexual abuse (Degenova, Patton, Jurich, & Macdermid, 1994; Hayes et al., 1996; Masuda, Price, & Latzman, 2012; Moser & Annis, 1996; Polusny & Follette, 1995; Wetterneck, Burgess, Short,

Table 1. Summary Explanations of Common Acceptance and Commitment Therapy (ACT) Concepts

ACT Concept	Our Explanation	Hayes, Strosahl, & Wilson (2012)
"Minding"	Our mind's constant reasoning, comparing, categorizing, arranging, gauging, evaluating, planning, organizing, sorting, etc., that occurs whether or not we attempt to control/alter it.	p. 68
Relational frames	Relational responding	pp. 44-48
Struggle/stuck	When an individual is drawn into his or her private, psychological experience, tries to escape the distress, and thus narrows the scope of his or her life.	p. 64
Cognitive Fusion and Defusion	Fusion—the inability to discriminate thought from experience. Defusion/Deliteralization—the separation of thought from experience. Seeing a thought for what it is and not what it tells you it is.	p. 244
Conceptualized Self (self-as-content)	The story or stories one formulates about who he or she is and which characteristics he or she possesses. Your "identity."	pp. 81-84
Ongoing self-awareness (self-as-process)	Nonjudgmental noticing of continuously changing thoughts, feelings, behaviors, sensations. Mindfully knowing oneself.	pp. 84-85
Observing Self / Perspective Taking (self-as-context)	The aspect of self in which you are looking from An "I, here, now" locus through which all is observed.	pp. 85-88

Smith, & Cervantes, 2012). The result of avoidance-based coping is not only psychological distress, but often one's life is "put on hold" in order to control or escape the distress.

Findings from research with breast cancer patients further indicates that individuals who employ acceptance-based coping of their emotions, as opposed to avoidance-based coping, experience less psychological distress (Carver et al., 1993; Politi, Enright, & Weihs, 2007). Emotional acceptance is the nonjudgmental act of experiencing both positive and negative emotions. In a longitudinal study examining coping strategies and quality of life among

Table 2. Summary Explanations of Acceptance and Commitment Therapy (ACT) Exercises and Metaphors

ACT Exercise/ Metaphor	Our Explanation	Original Source
Gift Watch exercise	Client is asked, "What would you hope to see engraved on a watch received as a gift? What would you like others to say about you and what you stood for? What would you like your life to stand for?"	Hayes, Strosahl, & Wilson (2012, pp. 306-307)
Chinese Handcuffs metaphor	With actual Chinese handcuffs in session: Attempting to pull both index fingers from the tube tightens the grip of the tube. Counterintuitively, pushing in gives your fingers some room to move. Perhaps in order to live life, we make some room in your life. Maybe we push in . . .	Hayes, Strosahl, & Wilson (2003, p. 105)
2-minute mindfulness exercise	Eyes closed, at the beginning of session: we take several deep breaths, notice the noises in the room, the feeling of our bodies in the chairs, mentally scanning our bodies for sensations and minds for thoughts and emotions.	Hayes, Strosahl, & Wilson (2012, p. 207)
Milk, Milk, Milk exercise	What comes to mind when you hear the word *milk*? What else? What shows up? Let's say *milk* out loud, together. (Counselor and client say the word *milk*, quickly, for 1 minute.) What did you notice? What did you hear? (Clients often report the word becomes just a sound, nonsensical, and loses meaning.) The word *milk* became just a word and didn't feel as if it were actually here, being experienced, like it first did.	Hayes, Strosahl, & Wilson (2012, pp. 248-250)
Joe the Bum metaphor	Imagine having a housewarming party and everyone in the neighborhood is invited. You post signs inviting everyone to stop by. Unfortunately, a stinky, dirty neighbor shows up and you're embarrassed and annoyed. You spend a lot of time shooing him out and guarding the door from his reentry (and he tenaciously reenters again and again) and that's a ton of work! All the while you're not enjoying your own party. The party is going on all around you but without you. The question is, *What would you do?*	Hayes, Strosahl, & Wilson (2012. p. 279)

(continued)

Table 2. (continued)

ACT Exercise/ Metaphor	Our Explanation	Original Source
Soldiers in the Parade exercise	Imagine that there are little soldiers marching out from your left ear, down in front of you in a parade. You are watching them come and go from a reviewing stand in the middle. Imagine that each soldier carriers a blank sign. Notice what thoughts or images come up for you and place each one on a passing soldier's sign. The goal is to fill the signs and watch the parade go by. Every time you feel yourself pulled into something else or the parade stops, notice that and go back to watching the parade.	Hayes, Strosahl, & Wilson (2012, pp. 255-258)
Eye Contact exercise	Client and counselor sit closely across from one another, even knee-to-knee, for 3 minutes while maintaining direct eye contact silently. The client is asked to be mindful of what comes up for them (thoughts, feelings, sensations) and to notice how he or she comes and goes from being fully present. This is an exercise in being willing to experience discomfort and distress but still commit to a valued action.	Hayes, Strosahl, & Wilson (2003, pp. 244-245)
Observer exercise	Eyes closed (preferably): beginning with deep breaths and mindfulness. The counselor then directs client to focus attention on the observing self (the person who has been with you your whole life, noticing thoughts, emotions, and sensations, always aware and always present). The client is then guided to memories from a recent time, teenage years, and around 6 or 7 years old. The counselor then guides the client to notice his or her body sensations, roles, emotions, and thoughts and while all of these changes constantly come and go, the client has always been the client. In essence, the client is not just roles, memories, thoughts, feelings, and a body—these are the content, while the client is the context.	Hayes, Strosahl, & Wilson (2012, pp. 233-237

70 Stage I and II breast cancer patients, emotional acceptance at the time of diagnosis predicted decreased distress and increased positive mood 1 year later (Stanton, Danoff-Burg, & Huggins, 2002).

While many individuals living with an illness such as advanced cancer may employ acceptance coping strategies and thus invest in a renewed sense of self (Ando, Morita, Lee, & Okamoto, 2008; Helgeson, Reynolds, & Tomich, 2006; Taylor, 2000), others may find emotional acceptance difficult to muster. At diagnosis, in treatment, and during end-of-life care, living with cancer may spark an existential crisis, calling into question one's mortality, purpose or identity, and religiosity/spirituality (Alcorn et al., 2010; Gall & Cornblat, 2002; Hui et al., 2011). A recent multicenter study found that 88% of advanced cancer patients considered religion and spirituality (R/S) to be important facets to coping with their illness (Balboni et al., 2007), including the utility of spirituality in aiding with making meaning of their illness (Carlson & Halifax, 2011). Thus, R/S coping, the use of religion or spiritual-based cognitive and behavioral techniques in the face of distressing events (Tix & Frazier, 1998), is one of the most commonly utilized coping strategies employed by individuals with cancer (Jenkins & Pargament, 1995). R/S coping strategies are associated with increased quality of life (Nelson, Rosenfeld, Breitbart, & Galietta, 2002) and a heightened sense of personal purpose and understanding (Daaleman & VandeCreek, 2000).

Yet attending to a cancer patient's spiritual needs to foster a sense of purpose, in the context of psychotherapy, is an emerging practice. While Dignity Therapy (Chochinov, 2002; Chochinov et al., 2005), Meaning Making Intervention (MMi; Henry et al., 2010; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006), and other interventions (for review, see LeMay & Wilson, 2008) appear promising, there remain limited data on their efficacy. Furthermore, the above-mentioned interventions do not directly address experiential avoidance, a process by which psychological health is also compromised. In summation, advanced cancer patients may be best aided by a psychotherapy that promotes acceptance in the face of distressing internal, private events (i.e., cognitions, memories, and sensations), while also helping patients lead valued, meaningful lives in the unpredictable and possibly short amount of time remaining.

In a recent survey study (Ciarrochi, Fisher, & Lane, 2011) of values and well-being in individuals with cancer, valued living was negatively correlated with emotional avoidance and thus cancer-related distress. Furthermore, valued living was positively correlated with psychological well-being. The results from this study suggest two things: First, values and avoidance are two distinct processes, as previously cited in the literature (Wilson & Murrell, 2004). Second, a value-based psychotherapy that concurrently targets experiential avoidance is appropriate and would be of untold value for advanced cancer patients.

Acceptance and Commitment Therapy (ACT)

ACT (pronounced as a single word) is such an intervention (Hayes, Strosahl, & Wilson, 2012). ACT has been applied to numerous mental and behavioral health concerns, including anxiety and depression, chronic pain, alcohol-related self-stigma, nicotine dependence/smoking cessation, math anxiety, work stress, opiate dependence, weight control, promotion of physical activity, trichotillomania, psychosis, epilepsy, tinnitus sequalae, borderline personality disorder (Butryn, Forman, Hoffman, Shaw, & Juarascio, 2011; Luoma, Kohlenberg, Hayes, & Fletcher, 2012; Powers, Vording, & Emmelkamp, 2009; Westin et al., 2011), and the list is ever growing. There are 62 Randomized Controlled Trials (RCTs) of ACT that have either been published or are currently in press (for a complete list, see Association for Contextual Behavioral Science, 2012). Results from RCTs as well as correlational, component, processes of change, and outcome comparison studies generally support the use of ACT for the above-mentioned clinical phenomena (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Powers et al., 2009; Pull, 2009). Officially, ACT is listed on the National Registry of Evidence-Based Programs and Practices by the United States Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) as well as on the American Psychological Association's (APA) Division 12 Empirically Supported Treatment page, showing moderate support for depression, obsessive compulsive disorder, and mixed anxiety disorders and strong support for chronic pain and psychosis.

The examination of the suitability and efficacy of ACT for individuals with cancer is increasing. In a theoretical-based article (Karekla & Constantinou, 2010), ACT is posited to be a psychotherapeutic intervention particularly adept at addressing R/S by way of mindfulness, acceptance, and valued living. The authors illustrate the application of ACT to a hypothetical breast cancer patient with particular sensitivity to the patient's Greek Orthodox faith. It has been previously noted elsewhere that some of ACT's methods appear to be Buddhist in nature (Hayes, 2002; Shenk, Masuda, Bunting, & Hayes, 2006), making ACT a particularly fitting intervention for patients who consider spirituality part of their self-identity. Although there are few empirical studies of ACT for individuals with cancer, as described below, their preliminary finds are promising.

Paez, Luciano, and Gutierrez (2007) conducted a small RCT comparing eight sessions, three individual and five group sessions, of ACT (n = 6) and Cognitive Behavioral Therapy (CBT; n = 6) with breast cancer patients. Follow-up data at 12 months posttreatment showed that participants in the ACT condition had clinically significant lower depression and anxiety and higher quality of life than participants in the CBT condition (d = 1.78).

Research presented at the third annual American Psychosocial Oncology Society conference included a study of fear of relapse among breast cancer patients (Montesinos, Luciano, Paez, & Remedios, 2006). A one-session ACT intervention was applied to eight Stage I and II breast cancer patients. Results showed that ACT was successful in decreasing intensity and severity of relapse-related fears in seven of the eight participants. ACT was also shown to produce clinically significant reductions in emotional distress.

A recent study (Feros, Lane, Ciarrochi, & Blackledge, 2011) aimed to examine ACT for various types of cancer. Participants ($N = 45$) engaged in nine weekly individual sessions of ACT. Results indicated that during the nine sessions, at postintervention, and 3-month follow-up, participants reported significant improvements in quality of life, psychological distress, negative mood, and overall psychological flexibility.

Rost, Wilson, Buchanan, Hildebrandt, & Mutch (2012), in the only study to date using ACT for advanced cancer patients, specifically ovarian cancer, conducted an RCT comparing ACT to Treatment as Usual (TAU). Thirty-one women with Stages III and IV ovarian cancer were randomly assigned to 12 sessions of either an ACT ($n = 25$) or TAU ($n = 22$) condition. Participants in the ACT condition reported statistically significant greater and more rapid decreases in psychological distress and increases in quality of life than the TAU condition. The researchers posit that although during the course of the study the physical health of participants was declining (12 participants passed away during the study), the improvement on quality of life is the result of increased acceptance and valued living. Interestingly, and in alignment with the tenets of ACT, "mental disengagement" (i.e., experiential avoidance) and "active planning" (i.e., value-driven committing) proved to be outcome mediators on both quality of life and psychological distress.

The Application of ACT for Individuals With Advanced Cancer

What Exactly Is ACT?

Simply stated, ACT helps individuals learn ways to detach and let go of distressing thoughts and feelings, be more present-focused and mindful, clarify what they value in life, and commit to living value-laden and enriched lives. Thus, ACT, conceptualized as "contextual cognitive behavioral therapy" (Hayes, Villatte, Levin, & Hildebrandt, 2011), aims to help individuals become psychologically flexible (Hayes et al., 2012; Spiegler & Guevremont, 2010). Psychological flexibility is defined as "the ability to contact the present moment

more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes et al., 2006, p. 8). When thoughts, emotions, sensations, and memories are not changed, escaped, blindly followed, or avoided, their control on overt behavior is considerably reduced. By allowing thoughts, emotions, sensations, and memories to occur without the intent to "cure," individuals are able to do what they value instead of being drawn into their immediate psychological struggle (Kohlenberg, Hayes, & Tsai, 1993). The six core processes, as represented in the ACT Hexaflex model—acceptance, cognitive defusion, being present, a sense of self known as "self as context," values, and committed action—are posited to be the skills needed in order to achieve psychological flexibility (Hayes et al., 2012).

Why Do People Struggle?

In order to understand why some individuals get drawn into their private, psychological struggle or get stuck, we must first briefly look at the role of language in cognitions. ACT developed in conjunction with its own theory on how language influences cognition and thus behavior. Relational Frame Theory (RFT; Hayes & Wilson, 1993) posits that humans learn to respond in relation to various stimuli (i.e., seeing a dog, hearing the word *dog*, and associating the sound "dog" with dogs), eventually combining arbitrary combinations as if they are somehow related (e.g., dog → dog bite → pain → crying → parent's divorce, ergo dog ↔ parent's divorce). Thus, a network of relational frames is inevitably created (Table 1).

For example, if an individual with advanced cancer is afraid of the needles used for his or her chemotherapy treatment, he or she becomes anxious. If that same individual with advanced cancer simply thinks of the chemotherapy needle, he or she will also become anxious. In order to avoid thinking about needles, the individual tries to distract him- or herself with thoughts of being at the ocean. On one level, this distraction may work. RFT posits, however, that in order for the individual to think of the ocean, he or she must also think of needles (i.e., the relational frame is set). The individual has now created an additional relation in which being at the ocean and fear of needles has been networked. It is now likely that the next time the individual thinks of being at the ocean, he or she will activate thoughts of chemotherapy treatment needles and thus may also feel anxious.

The phenomenon of relational framing also occurs with emotions and memories. For example, if an individual with advanced cancer recounts how his or her doctor delivered the prognosis, he or she may become anxious and depressed. Most likely the advanced cancer patient was able to re-experience the scenario, using his or her senses to see the treatment room, hear the sounds

of the office, and feel his or her stomach drop when hearing the prognosis. What has happened is that the recounting of this moment now functions in much the same way as the original, real moment. Thus, the individual with advanced cancer may react in the same way as when he or she was first given the prognosis, as a result of the fusing of these events (Hayes, Strosahl, & Wilson, 1999). Yet this alone does not lead one to become stuck since relational framing is a distinct facet of being human (Hayes et al., 2006; Hayes et al., 2004). Furthermore, research indicates that individuals with cancer, who undoubtedly have vast relational frames regarding their illness, are often able to lead meaningful lives (Thompson & Pitts, 1993).

ACT theory suggests that where getting stuck occurs is in one's relationship to internal, private events (Table 1). Thoughts, feelings, and memories—internal private events—are not in themselves "bad," maladaptive, or pathological. At some point, however, the stuck individual has fused these internal events with his or her identity (e.g., "I am depressed" instead of "I am feeling depressed"). In an attempt to alter these internal, private events, humans engage in "minding," (Table 1). "Minding" entails our constant reasoning, comparing, categorizing, evaluating, planning, organizing, sorting, and so forth and occurs whether or not we wish it to or attempt to alter or control it (Hayes et al., 2012). "Minding" for the external versus internal world may look much like this: "My medical bill is due today but I can't afford it until later. I will pay the bill next week." Compare that to "I'm hopeless and sad and I can't handle it so I won't think about my sadness right now." This "minding" is not likely to work; humans cannot simply shut off or avoid certain internal events, such as unpleasant thoughts. Proof of the ineffectiveness of controlling "minding" has been presented in research that shows how efforts to suppress thoughts are ineffective and conversely increase the quantity and valence of said suppressed thoughts following supposed extinction (see "White Bear" suppression exercise; Wegner, Schneider, Carter, & White, 1987; Wegner & Zanakos, 1994). Additionally, experiential avoidance tactics, while in the short term may produce a positive affect (i.e., relief from distress), will result in the avoided event resurfacing more powerfully (Wegner & Zanakos, 1994).

How Does ACT Work?

Whereas CBT places emphasis on changing the *content* of "minding" via cognitive restructuring (Beck, 2011), ACT places emphasis on changing the *context* of "minding." The aim of ACT is to change the relationship individuals have with their internal events while helping them to clarify their values and commit to vale-congruent actions in order to expand and enrich

their effective behaviors. ACT helps one to distinguish thoughts from his or her person (e.g., "I am ill" versus "I have an illness"), since the inability to distinguish the thought from the person is believed to have deleterious consequences (Hayes et al., 2012). Moreover, the discovery of self as context emerges—one becomes aware of one's own stream of experiences (including thoughts, feelings, and memories) over time without being drawn into particular incidents or attached to specific future incidents (e.g., "I must only fill my life with good memories"). Thus, the transcendence of self occurs where one views the self as context, or perspective, and not as content. The self becomes a consistent perspective (e.g., the ACT Bicycle metaphor: "You are always falling over and yet you move forward") with which to view and accept all experiences.

According to ACT, accepting thoughts as thoughts, emotions as emotions, and memories as memories—nothing more and nothing less—results in the dismantling of cognitive fusion in a process called cognitive defusion (Table 1). Accepting, and not struggling with, one's internal events allows his or her behavioral repertoire to expand; when one is not engaged in "fighting" with his or her distress, other ways in which time can be spent become available. When this occurs, individuals can commit to leading valued, meaningful lives. Psychological flexibility has been thus increased.

In the last section of this article, we present a prototypic case example illustrating how ACT might be applied to an individual with advanced cancer.

The Case of J.B.

J.B. is a 56-year-old European American female. J.B. resides with her husband, a home contractor; they have been married for 34 years. J.B. and her husband have two daughters, ages 28 and 30, who live in neighboring towns. In the past, J.B. would see both of her daughters at least once a week. J.B. is currently on medical leave from her job as an administrative assistant for the local school district.

J.B. was diagnosed with Stage IIIC[1] epithelial ovarian cancer[2] at age 53, underwent surgery and five cycles of chemotherapy, and was in complete remission. Twelve months later, J.B.'s CA-125[3] levels had increased and a recurrence of the ovarian carcinoma was detected by CT/PET scan. J.B. underwent a second successful surgery and three more rounds of chemotherapy. She has been in remission for 6 months.

On a recent visit to her gynecologic oncologist, results of J.B.'s blood test, once again, revealed increased CA-125 levels. Results from a PET/CT scan[4] confirmed recurrence of cancer, and J.B.'s gynecologic oncologist suggested

additional chemotherapy. J.B. stated that she felt "too hopeless to make these decisions right now" and told her doctor that she would "think on it." After not hearing from J.B. for 3 weeks, the gynecologic oncologist called J.B. to discuss treatment planning. J.B. stated that she was finding it difficult to get out of bed and didn't have the energy to speak with her physician. J.B. was referred by her gynecologic oncologist for mental health services and saw the ACT counselor 2 months after she was told the cancer had come back.

The Functional Analysis: Listening and Seeing as an ACT Clinician

During intake, the ACT counselor aims to answer two questions. First, what type of life does J.B. want to live in the *possibly* short amount of time remaining? Second, what psychological and environmental barriers are prohibiting her from living that life? The ACT counselor began to answer these questions by first listening for verbal accounts of struggle and looking for nonverbal behaviors that signal struggle.

J.B. often looked out the window and down at the floor during the intake session. Her posture suggested fatigue as she was slumped down in her chair with her head resting on the chair back. When asked a question, J.B. would first pause and then begin answering slowly, with her voice often fading out midsentence. Each word and sentence appeared to take a great deal of energy. J.B. repeated several times that she was "hopeless" and "worthless" and that she "didn't know." She stated that she was spending almost all day, every day in bed alternating between crying, "feeling numb and staring at the ceiling," and "nonstop worrying." J.B. worried about many things, including whether or not she should even undergo chemotherapy, how much time she had remaining, if God was punishing her for something and why her begging for forgiveness wasn't working, and losing her husband, daughters, and friends. J.B. had stopped returning calls from friends and work colleagues and had not seen her two daughters in weeks. She reported that she was "ashamed" of how she was "acting" and that she should just "suck it up and move on" like "good Christians do." J.B. said that she also felt guilt over not seeing her gynecologic oncologist, as recommended. J.B. stated that although she wanted to spend time with her husband, she "didn't want to be a burden"; therefore, she stayed in the guest bedroom of their house. Lastly, J.B. had also given up her hobbies of photography and book club, telling the counselor "what's the point?" Although J.B. felt that she was missing out on life, she stated, "I don't understand how I can live while I die."

In addition to the intake interview, J.B. was given the Acceptance and Action Questionnaire (AAQ; see Hayes et al., 2004) to assess her level of

experiential avoidance and the Valued Living Questionnaire (VLQ; see Wilson, Sandoz, Kitchens, & Roberts, 2010) to assess domains of valued living and the extent to which she behaved in accordance with those values every day. J.B.'s score on the AAQ indicated that lack of defusion, acceptance, and living in the now were the biggest problems, while her values were a relative strength. Furthermore, scores from her VLQ indicated that family relations, marriage relations, social relations, spirituality, physical well-being, and recreation were her most important values. However, scores on how consistent her actions were in these domains were low, indicating that while these are all important values, she was not actively living in accordance with these values. J.B.'s scores on the AAQ and VLQ provide corroborating evidence regarding her high experiential avoidance and lack of valued living.

In the case of J.B., the ACT counselor believed that J.B. had "bought into" the idea and self-identified as hopeless, punishable, and a bad mother, wife, friend, and Christian, as a result of cognitive fusion. She displayed verbal and nonverbal evidence of her lack of contact in the present moment, including her poor eye contact in session, continuous referral to the past, ruminative thinking of what she had done wrong or how she had angered God, and recounting tales of things she had done with family and friends when she was "able" in the past. When asked during intake what she was experiencing "now" in the room with the counselor, J.B. looked at the floor, shrugged, and responded, "I don't know." J.B. experientially avoided her internal events (e.g., "numbed out") and had displayed overt external avoidance (e.g., staying in bed all day, not attending medical appointments, and disengaging from loved ones) all in the hopes of feeling better. She stated that she "didn't want to be sick and have these terrible thoughts." The focus of ACT with J.B. was on accepting her thoughts, emotions, and memories and making room for them to "just be" while at the same time helping her to recommit to a valued, meaningful life.

Session Progression

Given the uncertainty of J.B.'s future, sessions commenced with values and commitment work. It should be noted that although ACT does include six core processes, there is no prescribed order for administering ACT. Nor should clinicians feel that they must address each of the six processes with every client. Quantity and order of targeted processes is determined by the functional analysis and is thus made on a case-by-case basis (Hayes et al., 2012).

Using J.B.'s self-reporting that she highly valued family, marriage, social relations, spirituality, physical well-being, and recreation, the counselor

asked J.B. how these areas might be improved if she could stop fighting her internal events. Since ACT posits that our "minding" results in unsatisfactory action guidance especially in the context of control, literality, and reason giving (e.g., "if only I could stop being so sad, I could spend some quality time with my husband"), the counselor was hoping to illustrate just how much J.B. had given up in her control of her sadness, hopelessness, and fear. These sessions focused on J.B. evaluating what she wanted her life to stand for, and this was done with the aid of the Gift Watch Exercise (Table 2; e.g., "What would you want inscribed on the back of your gift watch? What would you want others to say about who you are and what your life stands for?"). The counselor then helped J.B. to understand the difference between a value (i.e., a continuous commitment to a specific domain) and a valued action (i.e., behavioral steps). J.B. and the counselor next generated actions (i.e., mini-goals linked to larger goals) that were consistent with J.B.'s values. For example, J.B. stated that she highly valued spirituality and she had made one of her values "being a good Christian." She and the counselor were able to identify that one of her goals was to help "those who are suffering more than me," achieved, in part, by visiting homebound individuals. J.B. and the counselor further broke "visiting homebound individuals" into smaller goals, including calling her church to be placed on the roster and scheduling her first home visit. Breaking down larger goals into smaller actions, in the service of larger goals, was done for each of her self-reported values.

Values clarification work led into a discussion of the ramifications of fighting a psychological battle. The counselor asked J.B. about the methods she used to control or escape her distress, and J.B. provided an exhaustive list, including "numbing out," crying, distracting, trying to only think positive thoughts, and chastising and threatening herself when she had a distressing internal event (e.g., "Don't you dare think that!"). J.B. was commended for having worked so hard and tried so many different methods. Letting go of the struggle for cognitive control was presented to J.B. via the Chinese Handcuffs metaphor (Table 2). Letting go was done by examining the workability of previous attempts of controlling her internal events (i.e., J.B. tried to pull her finger from the woven tube and it tightened further, being a metaphor for her attempts to avoid certain feelings) and introducing the idea that by pushing into the tube and into her distress, J.B. may find she has room to move her finger, room to live.

In order to truly live, one must first be present. The counselor and J.B. then progressed into working on bringing J.B.'s attention into the present moment. For example, the counselor helped J.B. attend to the "now" by asking J.B. to describe what was present for her during responses of "I don't know." The counselor asked J.B. to scan her body, noting sensations in response to "I don't know" and listening to her breath and her voice, all in an effort to help

J.B. make contact with the "now." Subsequent sessions were begun with a 2-minute mindfulness exercise (Table 2).

Mastering being mindful led into helping J.B. view herself in three forms: the conceptualized self, ongoing self-awareness, and the observing self (Table 1). J.B.'s conceptualized self, how she thought of herself, was stated as, "I am a woman dying of ovarian cancer." J.B.'s ongoing self-awareness, her ability to be aware of and use continual behavioral states in order adjust to the daily, changing circumstances of life, was now more developed thanks to her previous present-moment work. Lastly, J.B.'s observing self, the "person behind your eyes" (Hayes, Strosahl, & Wilson, 1999, p. 186), was someone who had always been with her, experienced everything, and could contact those moments freely.

The counselor helped teach J.B. that she is not defined by her private experiences, or "minding;" rather she is an individual who contains private experiences, and these experiences do not need to be evaluated or changed, and should be experienced by the peaceful, nonjudgmental, nonevaluative observing self. J.B. was able to successfully complete the eyes-closed Observer Exercise (Table 2) in which she was asked to notice how her emotions are constantly changing while she remains the constant, observing perspective. J.B. was able to defuse her sense of self from her experience of emotions (e.g., "I *have* the emotion of sadness, but I *am* not sadness").

Further defusion exercises included the Milk, Milk, Milk exercise (Table 2), in which what milk represents and brings to mind is dissociated from the word. J.B. then did this repetition exercise with personally high-valence words such as *worthless, useless*, and *sick*. Deliteralization strategies were also used to disrupt J.B.'s problematic language routines, as in the case of sadness (reason giving) preventing her from acting—"I wanted to attend the book club meeting last week, *but* I was feeling too blue" versus "I wanted to attend the book club meeting last week, *and* I was feeling too blue"—thus enabling an expanded behavioral repertoire. Changing *but* to *and* implies an acceptance of the experience regardless of the literal contradiction and now weakens the association between feeling blue and eliminating social engagements. This exercise paved the way for the last focus of treatment—acceptance.

J.B. was taught numerous metaphors and exercises, including the Joe the Bum metaphor and the Soldiers in the Parade mindfulness exercise (Table 2). In the last one, J.B. was asked to notice internal events and then "place" any thought (e.g., "I am going to leave my husband a widower"), feeling (e.g., guilt over not spending time with husband), belief (e.g., "A good mother would choose to undergo more chemotherapy"), or body sensation (e.g., emptiness or pain) onto imagined placards carried by soldiers marching in a parade. This mindfulness exercise allowed J.B. to contact these experiences in the present

moment without judgment and with the intention of "making space" for them—in other words, with acceptance. Acceptance of distress was also taught via the Eye Contact exercise (Table 2), in which J.B. and the counselor sat across from one another, knee-to-knee, for 3 minutes while maintaining direct eye contact silently. This exercise asked J.B. to stay present and engaged in the "now," despite the urge to look away, nervously giggle, or be consumed by thoughts (e.g., "I wonder if I look as tired as I feel right now"). The goal of this exercise was to show J.B. how she could accept distress when acting on a value. Treatment came full circle and ended with a discussion of how, even with her "minding," J.B. had the acceptance skills to reinvest in a life that she deemed worth living.

Conclusion

The above-mentioned case of J.B. illustrated how ACT can be used with advanced cancer patients. ACT helped J.B. accept her thoughts, feelings, and memories and successfully change her sense of self, from one fused with content to one free to experience in a more objective and accepting way. J.B. was better able to "tap into" and live in the present moment while also doing what mattered to her. In essence, J.B. was able to accept and commit.

Similar to the hypothetical case of J.B., ACT provides a psychotherapeutically comprehensive way to help advanced cancer patients live rich, meaningful lives regardless of quantity of time remaining. Preliminary data suggest that ACT is helpful for a variety of cancer-related concerns and may be an especially suitable intervention for those with advanced cancer. The intention of this article was to briefly and as simply as possible describe the theory of ACT and how it could be applied to an advanced cancer patient. This article is not an exhaustive guide on how to "do" ACT. Furthermore, it should be noted that ACT is not a set protocol or manual. As there is no singular prescribed way of "doing" ACT, counselors who conceptualize from an ACT perspective are encouraged to use the exercises provided in the ACT seminal book (Hayes et al., 2012) as well as create exercises that are personally relevant and useful. The Association for Contextual Behavioral Science (ACBS), which is considered ACT's clinical and research home, has an ever-growing list of exercises and metaphors, developed by and shared freely among those in the ACT community. As a result, ACT in practice aims to create in its clinicians what it does in its clients—flexibility.

Of course, no one form of therapy should be considered a panacea. Nonetheless, the research support for ACT is growing. Counselors looking for a treatment approach that addresses cognitions and behaviors with a concurrent eye to spiritual and transcendent issues would be well advised to learn more about ACT.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Notes

1. The cancer cells have metastasized to tissues outside the pelvis or regional lymph nodes. This is the final stage before Stage IV, incurable epithelial ovarian cancer (www.cancer.gov).
2. This is cancer of the cells on the surface of the ovary (www.cancer.gov).
3. This is a substance that may be found in high levels of the blood in patients with ovarian cancer. CA-125 levels are often used to assess treatment efficacy and cancer recurrence (www.cancer.gov).
4. This combines PET and CT into one set of images. The PET scan utilizes radioactive glucose solution and functional imaging of tissue function/cell activity. The CT scan utilizes contrast agents and cross-sectional structural images, or slices (www.radiologyinfo.org).

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Bios

Julie E. Angiola, MS is a clinical psychology doctoral student at the University of Wyoming and is currently a predoctoral intern at Geisinger Medical Center. Her primary research focuses on various health problems, including cancer and obesity, and the application of Acceptance and Commitment Therapy to the psychological sequelae of these issues. Additional research and clinical foci include behavioral medicine, primary care, and rural health.

Anne M. Bowen, PhD, is a professor in the Fay W. Whitney School of Nursing and Director of the Nightingale Center for Nursing Scholarship at the University of Wyoming. Dr. Bowen is a licensed clinical psychologist with interests in health promotion and interventions for people with chronic illnesses. Her research focuses on reducing risks for acquiring and transmitting the HIV virus. Dr. Bowen is especially interested in developing interventions for rural people. She recently completed an Internet intervention for rural MSM with exciting results and is currently developing an Internet intervention to reduce depression among rural men who have sex with men. The intervention will be innovative in that the approach utilizes the techniques of Acceptance and Commitment Therapy (ACT) and mindfulness to help men live the life they want to live.