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# Perceptions of two therapeutic approaches for palliative care patients experiencing death anxiety

JOLEEN CAROL SUSSMAN, PHD,[1] AND WILLIAM MING LIU, PHD[2]
[1]Clement J. Zablocki Milwaukee Veteran's Affairs, Milwaukee, Wisconsin
[2]University of Iowa, Iowa city, Iowa

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## ABSTRACT

*Objective:* Evidenced-based psychotherapies are not well researched for palliative care patients experiencing unrelenting anxiety about dying, even less research is focused on young adult palliative care patients with death anxiety. The aim of this study is to provide preliminary data regarding potential clients' perceptions of using evidenced based treatments with dying populations who are experiencing death anxiety.

*Methods:* 104 college students were used as potential clients and randomly assigned to watch either a short video of a cognitive therapy (CT) session or of an acceptance and commitment therapy (ACT) session focused on treating a young adult diagnosed with an acute lymphoid leukemia expressing death anxiety. After watching the video, potential clients rated the session impact of the therapy approach using the Session Evaluation Questionnaire.

*Results:* No differences in ratings of session impact were found between potential clients who viewed the CT session and the ACT session. In regards to potential clients' views of session impact variables, their view of session smoothness was positively related to their post-session positivity, but inversely related to their view of session depth. Additionally, a positive correlation was found between potential clients' views of the therapist and session depth.

*Significance of results:* This preliminary study suggests that palliative care patients expressing death anxiety may benefit from either ACT or CT for death anxiety, however, future research is needed to explore the usefulness of each approach. Findings of this study support the theory that ACT and CT are viewed to have a similar session impact in the palliative care population.

**KEYWORDS:** Palliative care, Acceptance and commitment therapy, Cognitive therapy, Death anxiety

## INTRODUCTION

Advancements in medical technology continue to prolong the lives of persons diagnosed with a terminal illness. However, medical technology mostly aid in the physical needs of dying persons, not their emotional quality-of-life. Therefore, psychologists are needed on palliative care teams to assist palliative care patients achieve a peaceful, meaningful death, without increased death anxiety, consequently increasing clients' emotional well-being and decrease suffering (Wilson et al., 2007; Strada & Sourkes, 2009). Problematically though, more literature has been devoted to understanding the bereaved loved ones grieving process, and less has research has focused on understanding and end-of-life processes, such as the need and benefit of therapy for persons with a terminal illness (Knight & Emanuel, 2007).

Some palliative care patients would benefit from evidence based psychotherapy. Compared to community members, persons diagnosed with a terminal illness are more likely to report thoughts and feelings related to anxiety (Ardelt & Koenig, 2006). One study found the 13.9% of palliative patients met criteria for a DSM-IV-TR anxiety disorder. Further, palliative

Address correspondence reprint requests to: Joleen Sussman, Veteran Affairs, 5000 W. National Ave, Milwaukee WI 53295. E-mail: Joleen.susman@gmail.com

care patients in this study who met criteria for either a depression or anxiety disorder were more likely to be younger, female, and more likely to report suffering and physical symptoms such as pain than patients that did not meet criteria for a disorder (Wilson et al., 2007). Moreover, persons with a terminal illness who report more death anxiety appear to experience fewer characteristics of a good death (e.g., having awareness that one is dying, accepting death peacefully, dying among loved ones, and experiencing physical comfort; Tsai et al., 2005). Thus, psychologists need to focus on treating death anxiety and other mental disorders at the end-of-life in order to improve quality-of-life, especially among younger, women palliative care patients.

Theoretical research on the concept of death anxiety and how it forms has been examined from multiple psychological viewpoints including psychoanalytic, existential, and person-centered (Becker, 1973; Yalom, 1980; Neimeyer & Chapman, 1981). The authors of this study defined death anxiety as significant psychological distress in the form of anxiety about one's death that contributes to functional impairment in one's life.

Interestingly, younger adults report experiencing more death anxiety than older adults (Neimeyer & Moore, 1994; Harrawood, White & Benshoff, 2009), yet the younger adult population is underrepresented in the literature, which is likely due to the lower prevalence of terminal illness compared to older adults. In effort to fill a gap in the literature, the authors of this study sought to provide preliminary evidence on death anxiety treatments by investigating younger adults' perceptions of treatments of death anxiety for palliative care patients.

Psychologists working in palliative care settings have few options regarding evidenced based treatment for patients with anxiety about their death. Dating back 50 years, mental health professionals have been encouraged to provide a psychological intervention for palliative care patients whose death anxiety is causing them much psychological turmoil (Feifel, 1959; Kübler-Ross, 1969; Doka, 2009). However, empirical literature related to evidenced based psychotherapies when working with a palliative care patient with bothersome death anxiety is scarce (Furer & Walker, 2008). To date, the most studied psychotherapy for palliative care patients appears to be dignity therapy, yet dignity therapy does not focus on treating death anxiety among palliative care patients (Chochinov et al., 2005).

The lack of empirically supported treatments for palliative care patients with death anxiety may contribute to psychologists reported greater discomfort with topics of death anxiety in therapy than many other significant topics such as intimate partner violence, legal issues, adjustments to a disability, and relational problems (Feifel, 1990; Kirchberg & Neimeyer, 1991; Kirchberg, Neimeyer & James, 1998).

The goal of this study is to provide psychologists working with young adult palliative care patients experiencing death anxiety preliminary information regarding potential clients' perceptions two, data-driven, approaches. One of the comparison treatments is Beck's cognitive therapy (CT). A CT approach seemed warranted for several reasons. First, many psychologists working in a medical setting already use a CT informed approach (Norcross, Karpiak & Santoro, 2005; Andersson & Asmundson, 2008). Second, researchers have started to demonstrate the effectiveness of using CT to decrease distress among palliative care patients (Edelman, Bell & Kidman, 1999; Edelman & Kidman, 2000; Trask et al., 2003; Savard et al., 2006; Maunsell et al., 2008; Moorey, Cort & Kapari, 2009), yet none have focused on using CT to treat death anxiety among palliative care patients. Third, researchers have started to explore the use of CT for clients with death anxiety and have reported mixed results (Hiebert et al., 2005).

Acceptance and commitment therapy (ACT) was chosen as a comparison treatment to CT for several reasons. First, ACT is a time-limited, structured, present-focused treatment like CT. However, contrary to CT, an ACT approach would focus on fully experiencing one's death anxiety rather than trying to unsuccessfully control thoughts and feelings related to death anxiety in service of living a valued life. Second, although ACT is a relatively new treatment approach, empirical support for ACT with various disorders is growing (Hayes et al., 2004; Ruiz, 2010). Third, researchers and psychologists are beginning to advocate for the use of ACT with palliative care patients (Andrew & Dulin, 2007; Ciarrochi, Fisher & Lane, 2010; Karekl & Constantinou, 2010) and further investigation into these recommendations will be useful to providers.

Given the some research supports the use of CT with palliative care patients (Edelman, Bell & Kidman, 1999; Trask et al., 2003), the lack of empirical investigation of ACT with palliative care patients and the abstract nature of ACT, the authors predicted that potential clients would rate the CT session more impactful than the ACT session. Session impact was defined as: (1) more session depth, (2) a smoother session, (3) more feelings of arousal and positivity, and (4) more positive views of the therapist. To our knowledge, this study is the first study to examine perceptions of ACT and CT approaches for processing death anxiety among palliative care patients.

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## COGNITIVE BEHAVIORAL THERAPY FOR DEATH ANXIETY

Following Beck's CT theory, the diagnosis of a life threatening illness can activate cognitive schemas, related to death anxiety, about oneself, others, and one's future. These cognitive schemas are developed through past experiences and fantasies regarding death and dying. Further, these schemas may elicit non-adaptive automatic thoughts about death that would lead to anxiety about personal death (Liese & Larson, 1995). Importantly, according to CT, clients' emotional distress is determined by the way they interpret a situation using their schemas, not the actual situation (Moorey & Greer, 2002). Therefore, two people could receive the same news about their upcoming death and one may feel anxious and one may not, depending on how each person interprets the situation using their personal schemas. Using CT, a psychologist could intervene by identifying beliefs that lead to death anxiety and helping clients challenge death anxiety beliefs. Hopefully, by changing un-adaptive beliefs, clients' death anxiety would decrease, and their psychological well-being would increase (Beck et al., 1979).

## ACCEPTANCE AND COMMITMENT THERAPY FOR DEATH ANXIETY

In this study, ACT was defined as an approach in which therapists aide clients in decreasing the need for control over their emotions and thoughts related to death anxiety, which is congruent with Hayes et al. (1999) view of therapeutic change. According to ACT theory, non-acceptance of uncontrollable private experiences such unpleasant emotions, thoughts, bodily sensations, and memories leads to suffering (Hayes et al., 1999). According to Hayes et al. (1999), clients engage in avoidant behaviors (e.g., not spending time with family, not attending doctors' appointments) in an effort to control unwanted or negative private experiences such as death anxiety. In the act of avoiding such events, clients deprive themselves of living toward their chosen values, which creates further psychological turmoil. In an effort to decrease psychopathology, clients are encouraged to be aware of and be willing to experience a wide array of unpleasant emotions and thoughts (Hayes, 2004).

An ACT therapist focuses on encouraging a client to engage in behaviors of willingness to experience a full range of private events (e.g., death anxiety) without trying to control or act on the private events in order to live a more meaningful life with less suffering (Hayes, 2004). Therefore, using ACT, a therapist would focus on encouraging palliative care patients to experience their death anxiety rather than avoiding meaningful situations such as time with their family or conversations with their doctors.

## METHODS

### Participants

Participants, who were enrolled in an undergraduate psychological course, were recruited from a large Midwestern, public university. Two hundred and fifty-five students were enrolled in the undergraduate psychological course during the Fall 2010 term. Seven course sections were offered, which were taught by six instructors. Forty-two percent of the total participants volunteered without receiving course credit; 22% of the total participants were required to participate in research studies to pass the course; and 36% of the total participants received extra credit in the course if they participated in research studies.

Before starting the larger study, a pilot study, using the same recruitment and online survey methods as well as randomization of conditions (i.e., watch an online ACT session or CBT session), was completed to ensure the study ran smoothly. Five participants completed the CBT pilot condition and four participants completed the ACT pilot condition. The pilot participants' demographics were similar to those in the larger study. In the ACT pilot group, the majority of the participants were women (75%), Caucasian (75%), and between 19–22 years of age (100%). Similarly, in the CBT pilot group, most participants were women (80%), Caucasian (80%), and between 19–22 years of age (80%). No changes were made to the data collection process after the pilot study, so the researchers incorporated the pilot study participants' data into the larger study for data analysis.

A total of 107 participants completed the study (42% response rate). Each interested participant was randomly assigned by the authors to either the CBT condition or the ACT condition. Three manipulation check items were integrated into the study to ensure participants were watching the video and answering questions according to their opinion rather than randomly answering items. Three participant's data were deleted because they failed to pass the manipulation check items. Therefore, 104 participants' data were considered valid and used for the analyses. In the CBT condition, 51 participants completed the online study and passed the manipulation checks. Comparably, in the ACT condition, 53 participants completed the online study and passed the manipulation checks.

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Similar demographic characteristics were identified among the ACT and CBT participants. As expected, of the total sample (CBT $N = 53$; ACT $N = 51$), the majority of the participants ranged in age from 18 to 23 (CBT = 92%; ACT = 96%), were women (CBT = 70%; ACT = 78%). Ninety-four percent of CBT and 90% of ACT participants identified as Caucasian; 0% of CBT and 3% of ACT identified as Asian American; 4% of CBT and 2% of ACT participants identified as Hispanic/Latino/Latina; 0% of CBT and 4% of ACT participants identified as African-American; 0% of both groups identified as multiracial; and 2% of CBT and 0% ACT participants reported "other."

## Measures

### *Session Impact*

Session impact was assessed with the Session Evaluation Questionnaire (SEQ) - form 5. The SEQ assesses participants' perceptions of the session, the therapist and participants' post-session mood. The SEQ measures two dimensions of participants' evaluation of the session, depth and smoothness, and two dimensions of their post-session mood, positivity and arousal. The depth scale measures the session's power, value, fullness and specialty. The smoothness scale measures the session's comfort and relaxation (Stiles et al., 2002). The positivity scale assesses feelings of confidence and happiness, and arousal scale assesses feelings of excitement (Stiles & Snow, 1984).

The fifth form of the SEQ consists of 24 items organized in a seven-point affective Likert scale. Higher scores indicate greater depth, smoothness, positivity, arousal, and therapist liking (Stiles et al., 2002). Some authors have added a third scale, good therapist, to assess clients' evaluation of the therapist (Stiles et al., 1994). This scale was used in the current study. The same therapist was used in both sessions, so the scale was used to lend insight into evaluations of therapist based on her approach.

Past studies reported Cronbach's alphas for the five outcome variables as follows: depth ($\alpha = 0.74–0.96$), smoothness ($\alpha = 0.71–0.93$), positivity ($\alpha = 0.74–0.93$), arousal ($\alpha = 0.60–0.80$), and therapist goodness ($\alpha = 0.77$, Stiles et al., 1994; Myers & Hayes, 2006; Reynolds, Stiles & Grohol, 2006; Shechtman & Nir-Shfrir, 2008). An internal consistency analysis for the current study revealed similar Cronbach's alpha values (depth $\alpha = 0.88$; smoothness $\alpha = 0.77$; positivity $\alpha = 0.82$; arousal $\alpha = 0.68$; therapist goodness $\alpha = 0.79$).

### *Attitudes toward Seeking Psychological Help*

Attitudes toward seeking psychological help were assessed by the Attitudes Toward Seeking Professional Psychological Help — abbreviated measures (Modified, ATSPPH-A, Fischer & Farina, 1995). A measure of help seeking behavior was included in the study to increase the validity of the study given that college students evaluated the sessions and were potential rather than actual clients; therefore the measure was used to control for participants' attitudes who about seeking professional psychological help. Thus, the measure accounted for the variance in perceptions that were more due to attitudes about psychotherapy seeking than perception of a particular approach to treating death anxiety. The ATSPPH-A has demonstrated adequate reliability and validity. Test-retest correlation within a month between tests was 0.80. The reported Cronbach's alpha of the 10 items was 0.84 (Fischer & Farina, 1995). In this study, the ATSPH-A yielded a Chronbach alpha of 0.79.

### *Death Anxiety*

Given that the level of death anxiety of the participants was not germane to this study or a major variable of interest, the researchers preferred to use a brief measure, with a few subscales, and strong psychometric proprieties. However, such a measure was not found. Therefore, the researchers decided to assess death anxiety by asking participants to rate their fear of death on a Likert type scale (1 = not afraid of death at all to 10 = very afraid).

Considerable debate exists related to a superior measure of death anxiety. For example, the most widely used measure, the Death Anxiety Scale (DAS, Templer, 1970), a uni-dimensional measure, has been criticized for unstable factors range restriction problems, potential for social desirability answering, and weak internal consistency ranging from 0.65 to 0.83 (Templer, 1970; Lonetto, Fleming & Mercer, 1979; Martin, 1983; Lonetto & Templer, 1986; Gilliland & Templer, 1986; Kastenbaum, 1988; Neimeyer et al., 2003). These short-comings have led some to recommend abandoning the DAS completely (Durlak, 1982). In response, other measures have been developed to assess the multi-dimensional nature of death anxiety. Collett and Lester (1969) developed the Collett-Lester Fear of Death Scale (CLFDS). However, the CLFDS has also been criticized for unstable factor structure, weak validity, and high social desirability (Lester, 1994). Therefore, similar to the DAS, caution is advised when interpreting these scales (Neimeyer et al., 2003). The Multi-dimensional Fear of Death Scale (Hoelter, 1979), demonstrates stronger psychometric properties, measures several dimensions of death anxiety, and appears to be the most widely used multi-dimensional death anxiety measure. However, consisting of eight scales and 42 items scored on a

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five-point Likert type scale, it lacks brevity and seemed inappropriate to use in the current study.

## PROCEDURES

Each class instructor agreed to distributed the solicitation announcements to his/her students. The solicitation announcement detailed an opportunity to participate in a research study about death anxiety in psychotherapy sessions. The solicitation sheet indicated that the participant must be over the age of 18 to participate in the study and the activities expected of the participant (e.g., watch an online video and complete several online questionnaires).

Interested students randomly received an e-mail recruitment message with one of the two links to an online survey study (i.e., CT or ACT). If interested participants had not completed the online web-based study within a week of the initial e-mail, a second reminder e-mail was sent with a link. The link directed interested participants to a consent screen. If participants agreed to participate, they were presented with demographic questions. Following, participants were prompted to complete the ATSPPH-A. Next, depending on the link they were randomly assigned, participants either viewed the 10-minute CT session or 10-minute ACT session and were asked to vicariously be the client through watching a video. After the video, participants answered two manipulation check questions about the beginning and end of the video to ensure they watched the video. Last, they were prompted to complete the Session Evaluation Questionnaire.

The therapy videos were created from scripts that depicted the distinct aspects of CT and ACT. Both videos contained the same client actress and therapist actress. In both sessions, the client was a young woman who reported being referred to therapy by her primary medical provider because she was dying with acute lymphoid leukemia. She indicated that recent medical treatments were not effective, and her doctor informed her that she had about 3 to 6 months left to live. She expressed much anxiety about dying.

Each script was developed by the author using the basic tenets of each theory. Next, each script was evaluated and revised by four practicing psychologists in the community with expert knowledge of the particular approach. After the revisions each expert validated the scripts by completing a questionnaire regarding the integrity of the session. During the CT session, the therapist explained death anxiety using a CT model, assessed for automatic thoughts that lead to death anxiety and challenged a distressing thought, using socratic questioning, to decrease death anxiety. During the ACT session, the therapist explained the ACT rationale, assessed for experiential avoidance, encouraged the client to be willing to experience death anxiety rather than avoid difficult feelings in service of living a more valued life, and helped the client practice experiencing the emotion of death anxiety. For full scripts and expert evaluations, please contact the lead author.

## RESULTS

The hypothesis was tested by a multivariate analysis of covariance (MANCOVA). The independent variable was the therapeutic approach. The covariate was attitudes toward seeking psychological help. The dependent variable was session impact, which included session depth, session smoothness, potential client post-session positivity, potential client post-session arousal, and therapist goodness. The demographic variables were gender, age, ethnicity/race, and death anxiety.

Inter-correlations, means, standard deviations, reliability coefficients were calculated for the variables and are presented in Table 1. The current study's unadjusted SEQ means were comparable to Reynolds and Stiles (2007) compilation of means and standard deviations from prior studies using the SEQ with college student clients, for all session impact variables except for arousal ratings. Arousal scores were on average lower for the current study. This discrepancy may be due to participants in past studies being part of the therapy session; therefore, direct influences on physiological responses were more likely in past studies than the current study. In the current study, participants were asked to vicariously be the client through watching a video. Overall, the current sample broadly resembles other college students' perceptions of therapy.

### Correlations

Consistent with other literature (Depaola et al., 2003; Abdel-Khalek, 2005; Pierce Jr. et al., 2007), women in this study reported more death anxiety than men ($r = 0.20$; $p < 0.05$). In regard to the dependent variables of the study, which assessed session impact, somewhat surprisingly a correlation indicated an inverse relationship between session depth and session smoothness ($r = -0.30$; $p < 0.01$) as measured by the SEQ. In past literature, the correlation between depth and smoothness is often not reported, but when reported, the relationship is either positive (Stiles et al., 1994) to a non-significant relationship (Kahn et al., 2008). Two significant positive correlations were found among the session impact variables. Session smoothness and post-session positivity were positively related ($r = 0.57$; $p < 0.01$), which is consistent with past studies (Stiles

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**Table 1.** *Correlations, coefficients, and psychometric data for all study variables*

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| 1. Gender | — | | | | | | | | |
| 2. Age | −0.22* | — | | | | | | | |
| 3. Death Anxiety | 0.20* | −0.04 | — | | | | | | |
| 4. ATSPPH-A | 0.15 | 0.07 | 0.14 | — | | | | | |
| 5. SEQ – Depth | −0.06 | −0.07 | 0.20 | 0.27** | — | | | | |
| 6. SEQ – Smooth | −0.05 | 0.16 | 0.10 | 0.10 | −0.30** | — | | | |
| 7. SEQ – Positivity | −0.05 | 0.15 | −0.18 | −0.04 | −0.19 | 0.57** | — | | |
| 8. SEQ – Arousal | −0.11 | −0.05 | −0.07 | −0.19 | −0.06 | −0.16 | 0.15 | — | |
| 9. SEQ – Therapist Gd | −0.03 | 0.08 | −0.05 | 0.20* | 0.64** | 0.15 | 0.12 | −0.17 | — |
| CBT | | | | | | | | | |
| *M* | — | 21 | 5.36 | 17.08 | 5.32 | 3.93 | 4.00 | 3.01 | 5.66 |
| *SD* | — | 5.36 | 2.41 | 5.88 | 1.23 | 1.16 | 1.05 | 0.92 | 1.06 |
| Range | — | 18–34 | 1–10 | 3–27 | 2.2–7 | 1–6.6 | 2–6.6 | 1–5.6 | 3–7 |
| ACT | | | | | | | | | |
| *M* | — | 20 | 5.12 | 17.16 | 5.07 | 3.80 | 4.06 | 2.92 | 5.40 |
| *SD* | — | 5.12 | 2.21 | 5.74 | 1.08 | 0.99 | 1.04 | 0.88 | 1.06 |
| Range | — | 19–31 | 1–10 | 0–28 | 1.4–7 | 1.8–6.4 | 2–6.4 | 1.6–5 | 2.3–7 |
| $\alpha$ | — | — | — | 0.79 | 0.88 | 0.77 | 0.82 | 0.68 | 0.79 |

Note: RCI-10 = Religious Commitment Inventory; ATSPPH-A = Attitudes Toward Seeking Professional Psychological Help Abbreviated; SEQ = Session Evaluation Questionnaire; SEQ Depth = Session Depth; SEQ Smooth = Session Smoothness; SEQ Positivity = Feelings of Positivity; SEQ Arousal = Feelings of arousal; SEQ Therapist Gd = Therapist Goodness. *$p < 0.05$; **$p < 0.01$.

et al., 1994; Snir & Wiseman, 2010). Session depth was positively correlated with therapist goodness ($r = 0.64$; $p < 0.01$), which is congruent with the only past study found that reported correlations for therapist goodness (Stiles et al., 1994). Last, session depth was positively correlated with attitudes toward psychotherapy ($r = 0.27$; $p < 0.01$).

In summary, there was an association for potential clients who perceived sessions as valuable and powerful (i.e., deep) to also view the session as tense and distressing (i.e., not smooth). Further, potential clients who tended to perceive the sessions as smooth often identified more feelings of positivity after watching the therapy video. Last, there was a tendency for participants who evaluated the therapist positively to also perceive the sessions as powerful and valuable.

## CT VS. ACT

The researchers' hypothesis was tested by performing a MANCOVA, with view of seeking therapy as the covariate. Before conducting the analysis, the assumptions of homogeneity of variance and equal slopes were tested to be satisfied. The covariate, view of seeking professional help, was found to be significantly related to perceptions of session impact ($p = 0.007$). The results of the MANCOVA indicated that once view of seeking therapy was controlled, session impact did not significantly differ between the ACT and CT session (Wilks $\lambda = 0.959$; $F(5,97) = 0.82$; $p = 0.537$).

Therefore, contrary to the initial hypothesis, the average ratings for session impact from potential clients who viewed the CT session were not statistically higher ratings than potential clients who viewed the ACT session. Nonetheless, in line with the hypothesis, participants watching the CT video did have higher average, significant ratings on four of the five measures of session impact; however, the magnitude of the differences was not large enough to provide conclusive evidence of an effect (See Table 2). In sum, participants who viewed the ACT session and participants who viewed the CT session did not differ enough on their perceptions of session impact as measured by session depth and smoothness, therapist goodness, and levels of positivity and arousal after viewing the therapy session to reach statistical significance.

## DISCUSSION

This study aimed to explore perceptions of possible treatment approaches for palliative care patients experiencing death anxiety. It was the first study to specifically look at the use of CT, in comparison to ACT, in regards to providing psychological care for palliative care patients with death anxiety. Results did not support the original hypothesis that potential clients would perceive CT as more helpful than ACT. These findings preliminarily suggest that the therapeutic approach (i.e., ACT or CT) used to work with someone facing their death with anxiety does not

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**Table 2.** *Descriptive data for ACT and CT*

| Variable | Mean (*A Mean) | SD | Range | Alpha |
|---|---|---|---|---|
| Death Anxiety | | | | |
| Fear of death item | | | | N/A |
| CT | 5.36 | 2.41 | 1–10 | |
| ACT | 5.12 | 2.21 | 1–10 | |
| View of Therapy | | | | |
| ATSPPH-A | | | | 0.789 |
| CT | 17.08 | 5.88 | 3–27 | |
| ACT | 17.16 | 5.74 | 0–28 | |
| Session Evaluation | | | | |
| SEQ Depth | | | | 0.881 |
| CT | 5.32 (5.32) | 1.23 | 2.2–7 | |
| ACT | 5.07 (5.07) | 1.08 | 1.4–7 | |
| SEQ Smoothness | | | | 0.765 |
| CT | 3.92 (3.93) | 1.16 | 1–6.6 | |
| ACT | 3.80 (3.80) | .99 | 1.8–6.4 | |
| SEQ Positivity | | | | 0.820 |
| CT | 3.95 (4.00) | 1.05 | 2–6.6 | |
| ACT | 4.05 (4.06) | 1.04 | 2–6.4 | |
| SEQ Arousal | | | | 0.679 |
| CT | 3.01 (3.01) | .92 | 1–5.6 | |
| ACT | 2.92 (2.92) | .88 | 1.6–5 | |
| SEQ Therapist Good | | | | 0.788 |
| CT | 5.6 (5.66) | 1.06 | 3–7 | |
| ACT | 5.4 (5.40) | 1.06 | 2.3–7 | |

Note: Total $N$=104; CT $N$ = 53; ACT $N$ = 51. Fear of death was a single item that asked participants to rate their fear of death on scale of 1 (not at all) to 10 (very afraid); RCI-10 = Religious Commitment Inventory–10; ATSPPH-A = Attitudes Toward Seeking Professional Psychological Help Abbreviated; SEQ = Session Evaluation Questionnaire form 5; SEQ Depth = session depth; SEQ Smooth = session smoothness; SEQ Positivity = feelings of positivity; SEQ Arousal = feelings of arousal; SEQ Therapist Gd = therapist goodness.
*These are the adjusted mean for each group after accounting for the covariate, view of seeking psychotherapy (ATSPPH-A).

influence potential clients' perceptions of the session impact.

## Common Factors

Several explanations can be postulated for the lack of client preference for either a CT or ACT approach. One plausible explanation may be related to the psychologist rather than the approach. Both groups of potential clients viewed a therapy session with the same woman psychologist conducting the session. Therefore, potential clients' view of the psychologist may have been more influential on their perceptions of the session impact than specific techniques. This explanation is congruent with the idea that characteristics of the individual psychologist are better predictors of treatment outcomes than specific techniques such as ACT or CT techniques (Wampold, 2001; Wampold & Brown, 2005).

Moreover, in both sessions, the psychologist discussed death and the client's fear of death rather than avoiding the topic and pretending the client was not dying. Therefore, talking about death anxiety may be a common factor between the two approaches that lead them both to be viewed equally. This explanation is consistent with years of death and dying research that promotes the notion that palliative care patients need to be listened to about their fears of dying (Feifel, 1959; Kübler-Ross, 1969; Doka, 2009). The current study evidences that the theoretical framework behind the way health care professionals listen to dying patients may not be as important as long as we are talking about fears of death. This argument is congruent with literature that suggests the general approach of the therapist is more important than specific interventions and models when working with palliative care patients (Crunkilton & Rubins, 2009).

## ACT VS. CT

Another explanation for the lack of potential client preference between the approaches may be related to similarities and general liking of the two therapy styles. Both of the therapy approaches were viewed positively as the means of session depth, feelings of positivity, and therapist evaluation fell in the upper range of possible scores. The approaches may have

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been viewed similarly given that the psychologist, in each session, was working toward the same goal of discussing the death anxiety through a different theoretical process.

Both ACT and CT approaches use goal setting, emphasize common factors such as active listening and empathy, and provide focus, structure, and feedback (Forman et al., 2007). Each therapeutic approach allows clients to discuss their fears and concerns about dying through emotion regulation techniques. In the current study, during the ACT session, the psychologist used an approach that countered maladaptive response-focused emotion regulation (i.e., acceptance), while the CT therapist used an antecedent-focused emotion regulation strategy (i.e., cognitive restructuring) to help the client deal with death anxiety (Hofmann & Asmundson, 2008). This explanation is supported by the growing body of literature suggesting that CT and ACT are more similar than distinct (Arch & Craske, 2008; Hofmann et al., 2010). Furthermore, the results are consistent with other research comparing ACT and CT for various disorders which has demonstrated no statistical outcome differences between the two treatments (Forman et al., 2007; Powers et al., 2009).

## LIMITATIONS

No study is without limitations. For instance, in order to increase internal validity, each participant was asked to vicariously be the client while watching either a video of a CT session or an ACT session. Yet, this process limited the ecological validity of study as the participants were likely not palliative care patients with death anxiety. Additionally, the videos demonstrating the ACT and CT session were both 10 minutes long in an effort to maintain participants' attention, but most CT or ACT treatments are on-going, 50-minute sessions for at least a couple weeks. Therefore, CT and ACT techniques were condensed into a short amount of time, which may have influenced potential clients' perceptions of the sessions. Last, the sample of participants was limited in regards to age, education, spirituality beliefs, geographic location, gender identity, and ethnicity/race. Future studies should broaden the population sample of participants in an effort to increase the generalizability of the results by including: community members, persons from a range of social classes, person with diverse spiritual beliefs, and older adults.

### Clinical Implications

Several practical implications can be drawn from this study. The results of the current study provides preliminary evidence that potential clients do not have a preference regarding therapeutic approach (i.e., ACT and CT) when working with palliative care patients expressing anxiety about dying. Therefore, psychologists working with dying persons expressing anxiety should assess the fit of the treatment, ACT or CT, with the particular client as well as their own competence in delivering the treatment. When choosing a treatment, psychologists should review research relevant to death anxiety and terminal illness as well as consider characteristics of their clients such as: age, gender identity, family structure, ethnicity, social class, spirituality beliefs, values, and preferences related to treatment in addition to many other considerations (American Psychological Association, 2006).

The results of this study afford the opportunity for psychologists to use both approaches, ACT and CT, with dying clients. If such an approach is appealing, psychologists would be greatly aided in treatment conceptualization and implementation by using a practitioner's guide that bridges ACT and CT as a whole treatment (Ciarrochi & Bailey, 2008). Specific to death anxiety treatment, Furer and Walker (2008) provide excellent guidelines for using a CT approach with an emphasis on some ACT components such as living toward one's values and practicing mindfulness.

As discussed above, when choosing a particular treatment, psychologists should consider client characteristics and personal competence. However, additional variables should be considered when providing therapy to a palliative care patient. For example, the realistic timeline for treatment is an important consideration. Some approaches such as dignity therapy have been developed that are only one session and can be completed at a bedside or at a home (Chochinov et al., 2005; McClement et al., 2007), but this approach does not focus on death anxiety. Further, psychologists should consider clients' psychological, cognitive, and physical energy throughout treatment as one approach may work better depending on the stage of illness, current treatments and medications, and locations of therapy.

## CONCLUSION

The current study fills a gap in the literature by establishing a foundation for empirical research grounded in evidenced-based approaches for psychotherapy treatment with palliative care patients and death anxiety. Little psychotherapy research is focused on working with patients at the end of their life expressing death anxiety. At the minimum, the current study alerts clinicians and researchers for the need to further investigate and serve persons

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who are dying. Further, this study should challenge some healthcare professionals beliefs that dying persons are not as important as others and that dying patients do not have enough time to benefit from psychological treatment (Crunkilton & Rubins, 2009). Just as psychologists strive to help healthy adults achieve a peaceful life, they need skills to assist dying adults achieve a positive death.

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