Acceptance and Commitment Therapy for Depression

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Abstract

Recent research provides further empirical support for acceptance and commitment therapy (ACT) in alleviating depression and that it does so through processes specific to the model of psychological flexibility on which it is based. These latest investigations have examined ACT's effectiveness in both ameliorating and preventing depression as well as its impact when implemented through alternative delivery systems (e.g., via self-help, bibliotherapy, and telehealth) and when combined with other interventions. ACT appears to be comparable to cognitive therapy in outcomes, but to have greater empirical support for the processes through which it initiates therapeutic improvement. Preliminary findings supportive of ACT in preventing depression when delivered through nontraditional means require validation by comparisons to appropriate control conditions. Component analyses are recommended to substantiate suggestive evidence that ACT may contribute appreciably to the impact of existing treatments for depression and related disorders.

Introduction

Acceptance and commitment therapy (ACT) [1] has become one of the more visible interventions within the latest generation of cognitive-behavioral therapies (CBT) to emerge over the last quarter century [2]. Although ACT was developed as a transdiagnostic approach, the first randomized clinical trials evaluating its efficacy were on depression [3, 4] and has remained a focus of ongoing research. The most recent systematic review and meta-analysis by Ruiz [5**] in 2012 comparing ACT and traditional CBT for depression concluded they were equally efficacious, but evidence that they operated through their purported processes of change was greater for ACT. While the Society of Clinical Psychology [6] has judged the current empirical support of ACT in treatment of depression to be modest, Ost [7] has cited several methodological concerns with the clinical trials in arguing

program for dissemination and implementation of evidenced-based approaches for treatment of depression by the U.S. Veterans Health Administration (VHA) [8]. A 12-16 session ACT protocol showed a large effect size (d = 1.0) in reducing mean Beck Depression Inventory –II scores (BDI-II) [9] from the severe to mild range among over 700 veterans [10**]. The effect size did not vary by age [11] and is similar to those found in controlled trials of ACT [3, 12] as well as to that reported for traditional CBT within the VHA program [13, 14]. The primary objective of ACT for depression, however, is not to

sessions of ACT. Only participants receiving ACT reported significant pre to posttreatment improvement in depression, general health, and quality of life, with these gains maintained over 18 month follow-up. Unfortunately, ACT did not differ from TAU in impacting sick leave and employment status, and in the absence of an appropriate attention-placebo condition and/or another active comparison intervention, the apparent benefits of ACT cannot be unambiguously and specifically attributed to it.

Insufficient control for nonspecific effects was also a limitation in comparing an 8-week ACT group program versus TAU (monitoring support from school counselors) for Australian adolescents experiencing mild to moderate depressive symptoms [19]. While significant improvement was only reported for those receiving ACT, it remains unclear if this reflects a specific effect for ACT, the impact of peer support, a possible attention-placebo effect, or even some combination of all three. In light of their relatively small sample sizes and TAU as the only comparison condition, it seems appropriate to regard both the Folke et al. [18] and Livhiem et al. [19] studies as pilot projects worthy of further evaluation by examining clinically significant, long-term improvements in depression and functional/quality of life measures within randomized trials comparing ACT and alternative interventions.

Alternative Means of Implementing ACT

Efforts over the last several years to explore alternatives to one-on-one psychotherapy in meeting the mental health needs of underserved populations [20] recently also has included innovations in the delivery of ACT to both prevent and alleviate existing depression. For example, an 8-week program of ACT bibliotherapy broadly-focused on mental health issues

waiting-list [21**]. U. S. school teachers and other educational workers reporting normal levels of pretreatment depression who completed an ACT self-help workbook [22] maintained their status over 10 weeks of follow-up, while the 41% displaying at least mild pretreatment depression showed significant improvement over the course of the program, with these gains maintained during follow-up. By contrast, nondepressed waiting-list participants deteriorated significantly from pretreatment to follow-up. Those in the waiting-list who were depressed to begin with remained so at follow-up, but improved significantly after completing the workbook, thereby providing further support for the program's impact.

The results of another recent self-help program suggest that the effectiveness of ACT-based bibliotherapy is not limited to specific cultures or workbooks [23]. Dutch community participants with mild to moderate depressive symptoms were randomized to two self-help conditions that varied in their level of email support or waiting list control. Those assigned to self-help followed a different workbook [24] than that of Jeffcoat and Hayes [21**] and maintained large effect size reductions in depression through follow-up relative to the control group, regardless of the level email support they received.

Further suggestive evidence for the benefits of delivering ACT for depression via self-help has been provided by a recent internet-based study conducted in Sweden [25]. Community participants exhibiting mild to moderately severe major depressive disorder were randomized to either waiting list or access to a 2-month long intervention comprised of an internet-administered self-help group that included elements of both ACT and behavioral activation [26], a related workbook, and minimal weekly access (15 min) to therapist support. Results showed a large between group effect size in depressive symptom reduction favoring the intervention. However, only a modest proportion of treatment participants (25%) showed clinically significant

improvement and there was no difference between conditions in enhanced quality of life. While the overall findings of this study suggest promise in making treatment for depression more accessible via the internet, it's unclear what ingredients of the intervention contributed most powerfully to its impact. In particular, even if specific effects were responsible, further research is needed to determine whether this primarily resulted from the ACT or behavioral activation components.

Somewhat similar ambiguities also surround a recent Finnish program that combined the internet as well as other telehealth-related technologies with 3 professionally

two developmental projects have explored the feasibility of integrating ACT with other approaches in treating depression comorbid with other disorders and clinical features. Gaudiano and his colleagues [28*] in an open trial evaluated a 6-month program that combined elements of ACT and behavioral activation in conjunction with pharmacotherapy in treatment of major depression with psychotic features. Clinically significant improvements in both depressive and psychotic symptoms, as well as psychosocial functioning, maintained through 3 month follow-up suggest that the program is sufficiently promising to merit further evaluation in a randomized trial.

The combination of pharmacotherapy and an ACT-based intervention was also investigated in a recent pilot program by Dalrymple et al. [29*] for psychiatric outpatients experiencing comorbid depression and social anxiety disorder (SAD). The psychotherapy component of the program integrated behavioral activation for depression [30] and exposure therapy for SAD [31, 32] from an ACT-consistent perspective [33]. Results showed significant symptomatic relief in both depression and social anxiety as well as concomitant, but more modest improvement in quality of life and functioning. As with the Gaudiano et al. project [28*], it seems most useful to frame this program as a promising proof of concept that warrants more critical scrutiny in future component, process, and comparative outcome research with larger sample sizes over an extended follow-up.

Process Research

ACT researchers have demonstrated an ongoing to commitment to investigating its purported mechanisms of action [34] dating back to the earliest randomized trials in treatment of depression [35]. Not surprisingly, the majority of the studies reviewed in this paper have also

continuing to examine its purported mechanisms of action. Efforts in these areas so far have been promising and clearly seem worth pursuing further with more rigorous research designs and methodologies. One overarching concern, however, is that such endeavors may overlook the need to further substantiate the extant empirical base for ACT in targeting depression. Despite ongoing controversy and debate surrounding the merits of formally recognizing evidence-based psychotherapies [45, 46, 47, 48], there would appear to both sufficient scientific and financial, as well as likely political advantages [49, 50], to elevating the current empirical support for ACT for depression from “modest” to “strong” [6]. To accomplish this, randomized trials that satisfy methodological concerns [7] and conducted by independent investigative teams with larger sample sizes are recommended. There is certainly something to be said for plowing many fields, but also for insuring that at least some of them are plowed sufficiently deep.

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