ACCEPTANCE AND COMMITMENT THERAPY FOR DEPRESSION WITH COMORBID SOCIAL ANXIETY: RESULTS FROM A PILOT RANDOMIZED TRIAL

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Depression and SAD are Highly Comorbid

- SAD present in 1/3 of patients with depression
- Greater severity of symptoms
- Poorer functioning
- Shared clinical features
  - Interpersonal rejection sensitivity, avoidance behaviors, social disengagement

Effects on Treatment Outcomes

- Pharmacotherapy studies:
  - More severe course of illness (Mulder et al., 2006)
  - Treatment-resistant depression (Souery et al., 2007)
  - Greater number of depressive recurrences (Holma et al., 2008)

- Psychotherapy studies (CBT):
  - Findings somewhat mixed
  - Poorer outcomes (DeRubeis et al., 2005)
  - No difference in rates of improvement (e.g., Erwin et al., 2002)
  - One year follow-up: SAD severity worsened (Marom et al., 2009)

Why ACT?

- Transdiagnostic approach
- Empirically-supported for depression (APA, SAMHSA)
- Preliminary support for SAD (e.g., Dalrymple & Herbert, 2007; Kocovski et al., 2009)
- ACT>CBT for comorbid anxiety and mood disorders at post-treatment and 1 year follow-up (Wolitzky-Taylor et al., 2012)

Open Trial Study (Dalrymple et al., 2014)

- Adults (n=38) recruited from routine outpatient psychiatric practice
- 16 sessions of ACT + medication treatment as usual
- High satisfaction with treatment
- Medium-to-large effect size changes on symptoms, functioning, and processes
- Psychological flexibility and behavioral activation correlated with symptoms and functioning

Current Study Aims

- Further assess feasibility and acceptability of ACT for Depression+SAD
- Test as adjunctive to medication as usual in a typical outpatient psychiatry setting
- Assess preliminary efficacy compared to medication as usual alone

Hypotheses

- ACT would continue to demonstrate feasibility and acceptability

- Initial signal efficacy:
  - Greater effect size change patterns compared to medication as usual alone

Methods

Participants

- Recruited from outpatient psychiatry practice
  - July 2012-January 2016
- Inclusion:
  - Adults 18-65
  - Diagnoses of depressive disorder and SAD
  - Receiving medication management
- Exclusion:
  - Bipolar/psychosis/borderline PD/severe substance
  - Currently in psychotherapy

Measures

- Feasibility:
  - Recruitment targets and therapist training
- Acceptability:
  - Treatment Credibility (RTQ) and patient satisfaction (CSQ-8)
  - Study retention, completed sessions
- Symptoms, functioning, and processes:
  - Diagnoses (SCID & SIDP)
  - Depression severity (QIDS)
  - Social anxiety severity (LSAS)
  - Quality of life (QOLI) & functioning (WHODAS)
  - Behavioral activation (BADS) & psychological flexibility (AAQ-II)

TREATMENTS

- Medication As Usual (MAU)
  - Med management by board-certified psychiatrist
  - Flexible frequency of sessions
  - Typical session length: 15-30 minutes

- MAU+ACT
  - Med management as above
  - Plus 16 individual sessions of ACT
  - Flexibly designed protocol
  - Therapists: doctoral students, residents, postdoctoral fellows

ACT Sessions

- Phases:
  - Sessions 1-3: Identify avoidance, assess workability, introduce willingness
  - Session 4: introduce exposure linked to values
  - Sessions 5-9: defusion
  - Sessions 10-11: self-as-context
  - Sessions 12-13: formal values clarification
  - Sessions 14-15: committed action
  - Sessions 15-16: relapse prevention & post-tx planning

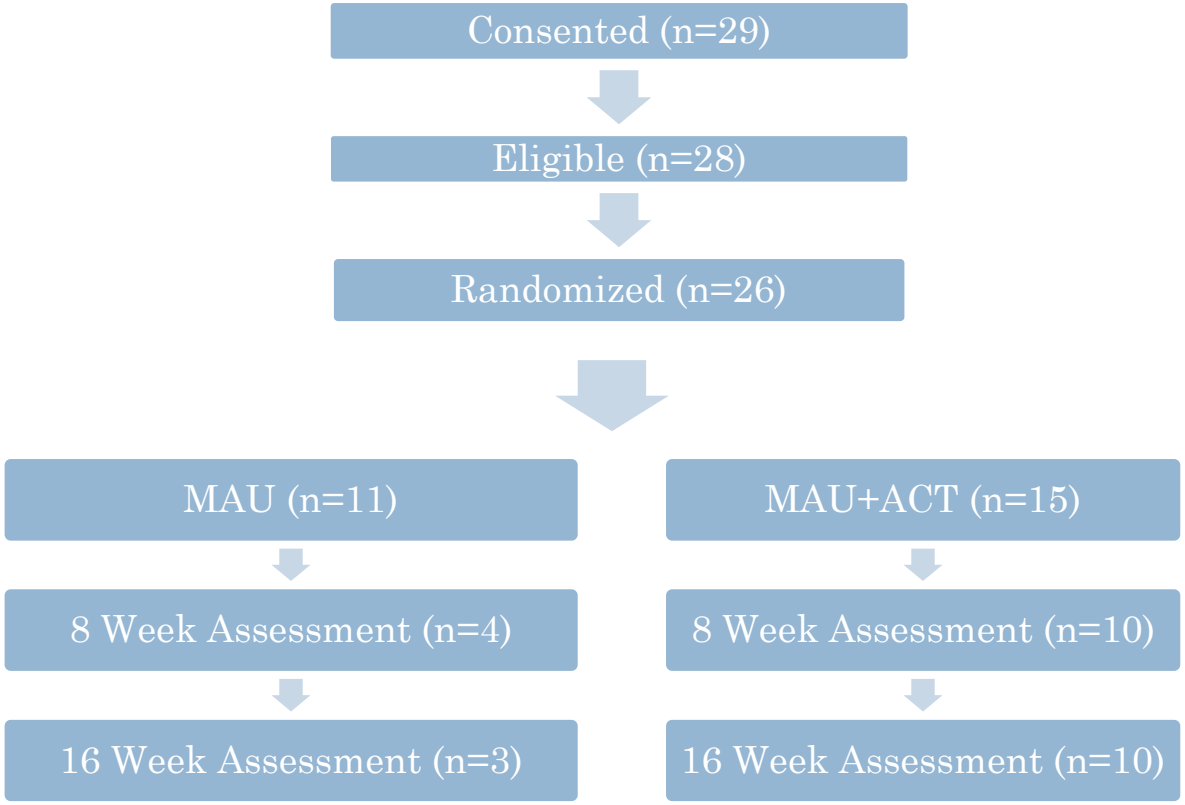
- Metaphors/experiential exercises used throughout

Sample Session Outline

- Session 9: Defusion
  - Review homework (e.g., engagement in valued behaviors, address barriers)
  - Experiential Exercise
    - e.g., Physicalizing, Content on Cards, Tin Can Monster
  - In-session exposure exercise
    - Choose valued behavior to practice
    - Link to personally-identified value
    - Role play, with emphasis on practicing defusion & orienting to value

Results

Participant flow



Baseline Characteristics

- Demographics:
  - Mean age = 38
  - 46% female
  - Majority Caucasian, single, <college degree

- Diagnoses:
  - Avg = 4 total current/partial remission diagnoses
  - Next most common: GAD (52%)
  - Other common: SUD, PTSD, panic, impulse control

Baseline comparisons

- Completers vs. dropouts
  - No differences on demographics or baseline assessments
- MAU vs. MAU+ACT
  - No differences on demographics or baseline assessments

Pharmacotherapy between conditions

Variable	MAU	MAU+ACT
Number of medication visits (*M*)	2.2	3.1
Medication changes made (% of visits)	77.8%	46.2%

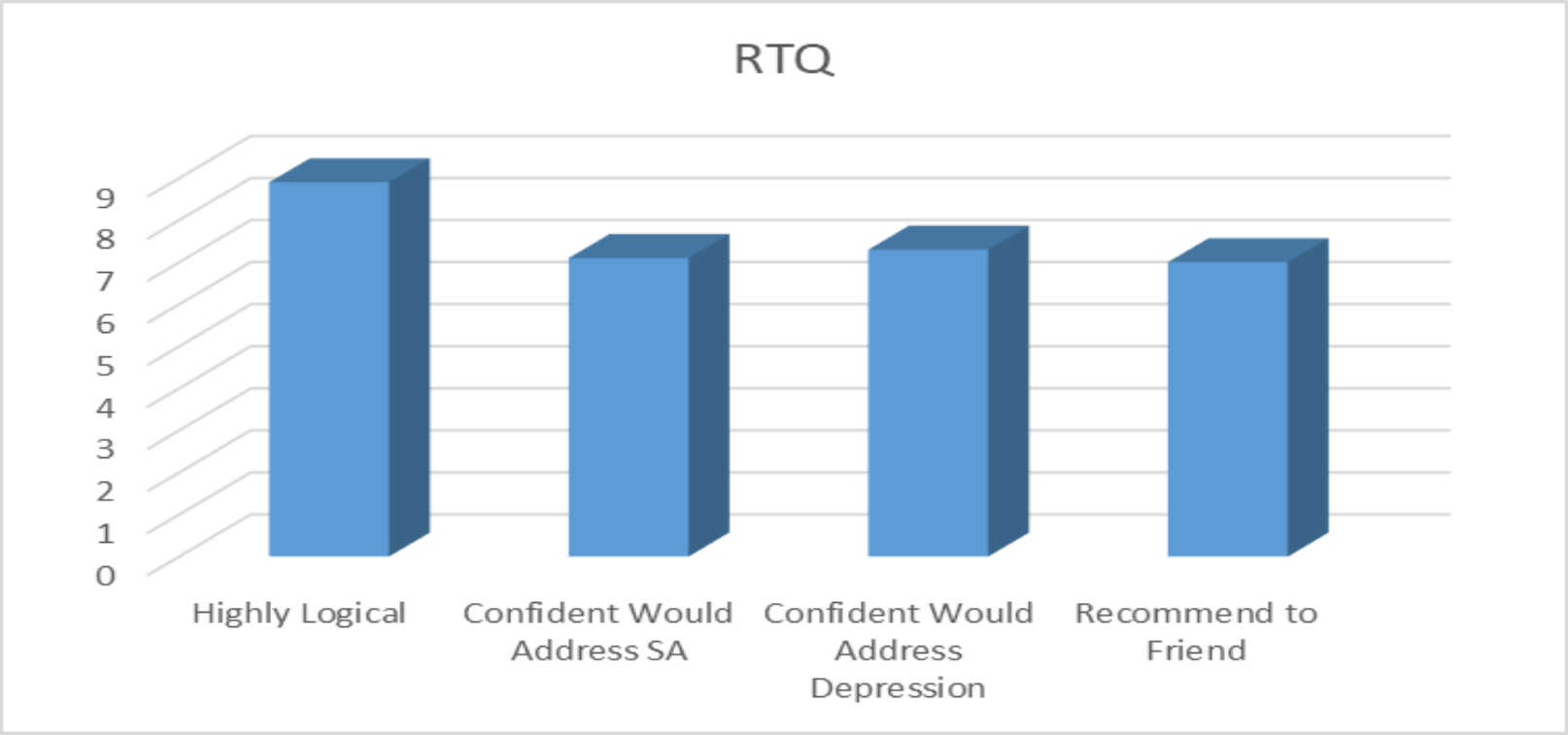
Feasibility

- Able to feasibly recruit
- Trained 7 therapists on protocol
- Drop-out rates:
  - MAU = 64%
  - MAU+ACT = 33%
- Of MAU drop-outs:
  - 3 discontinued treatment completely
- MAU+ACT session completion:
  - 6 patients completed at least 10 sessions over 16 weeks
  - 6 completed all 16 sessions, over avg. of 20 weeks

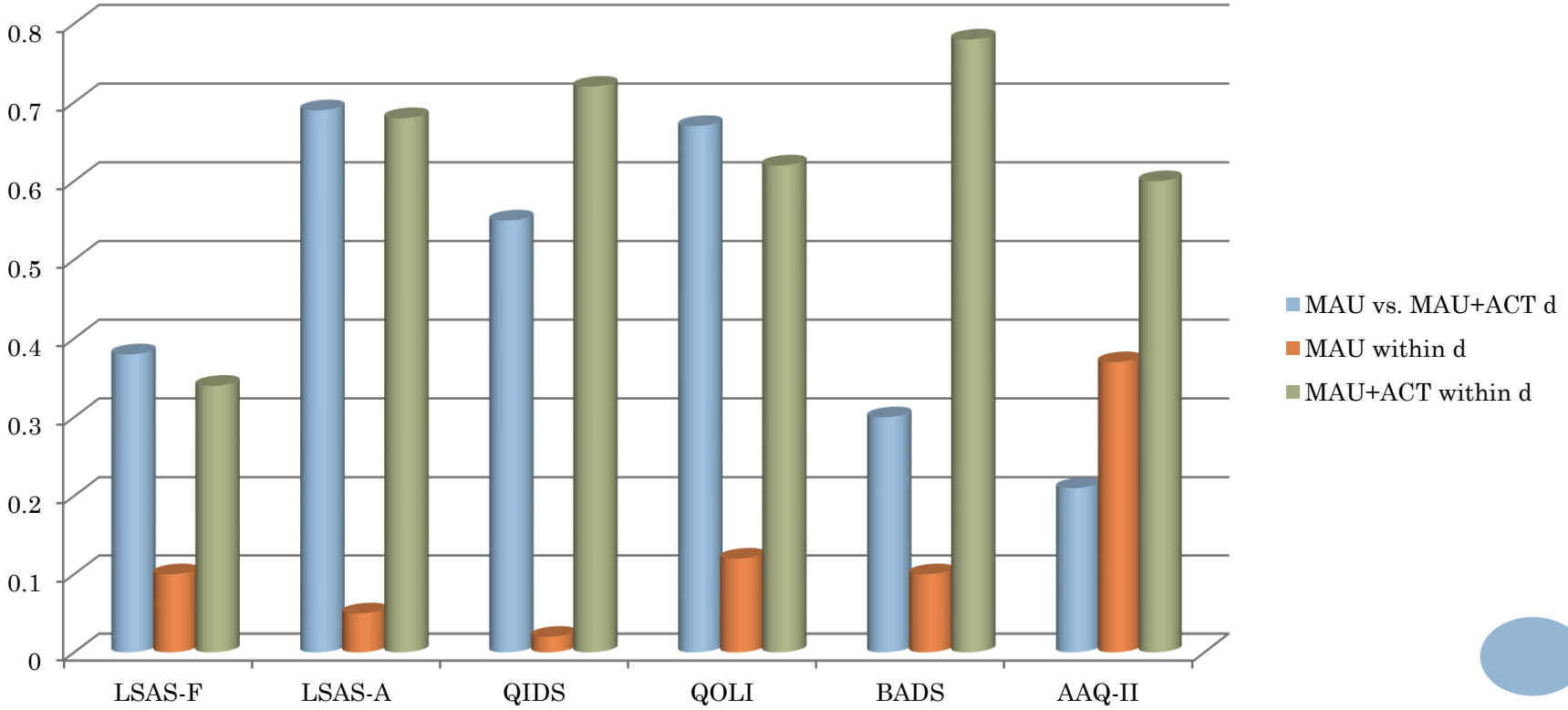
Acceptability (MAU+ACT)

- Patient Satisfaction (CSQ-8):
  - Assessed after final session
  - Highly satisfied with treatment (M = 30; out of 32 pts.)

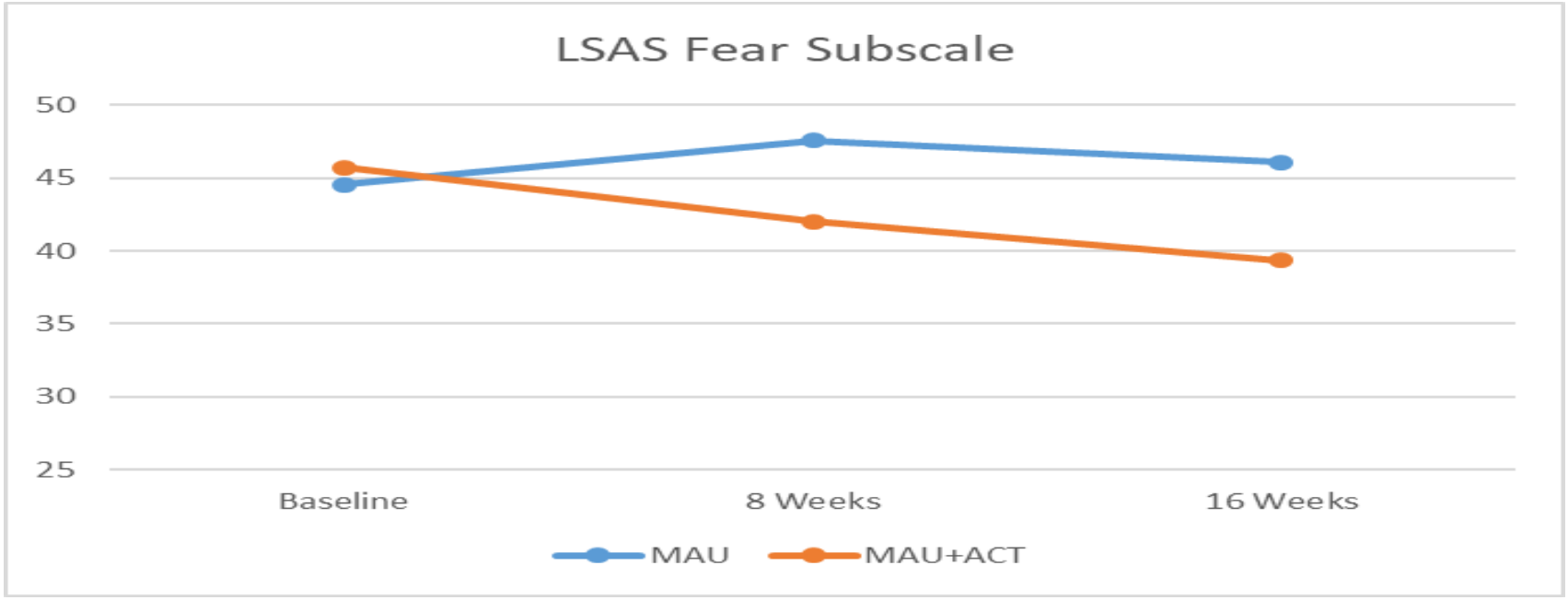
Treatment Credibility



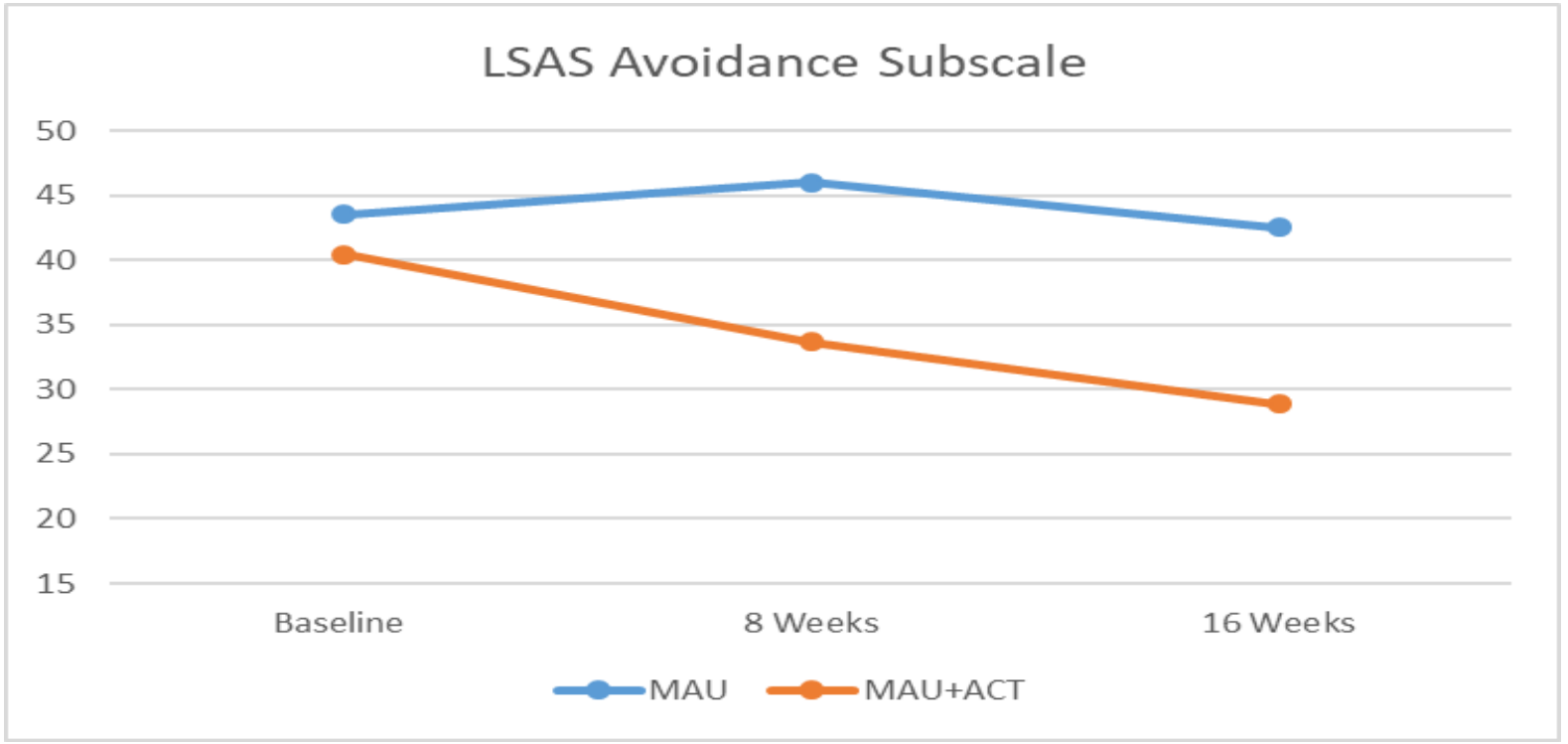
Preliminary Treatment Outcomes



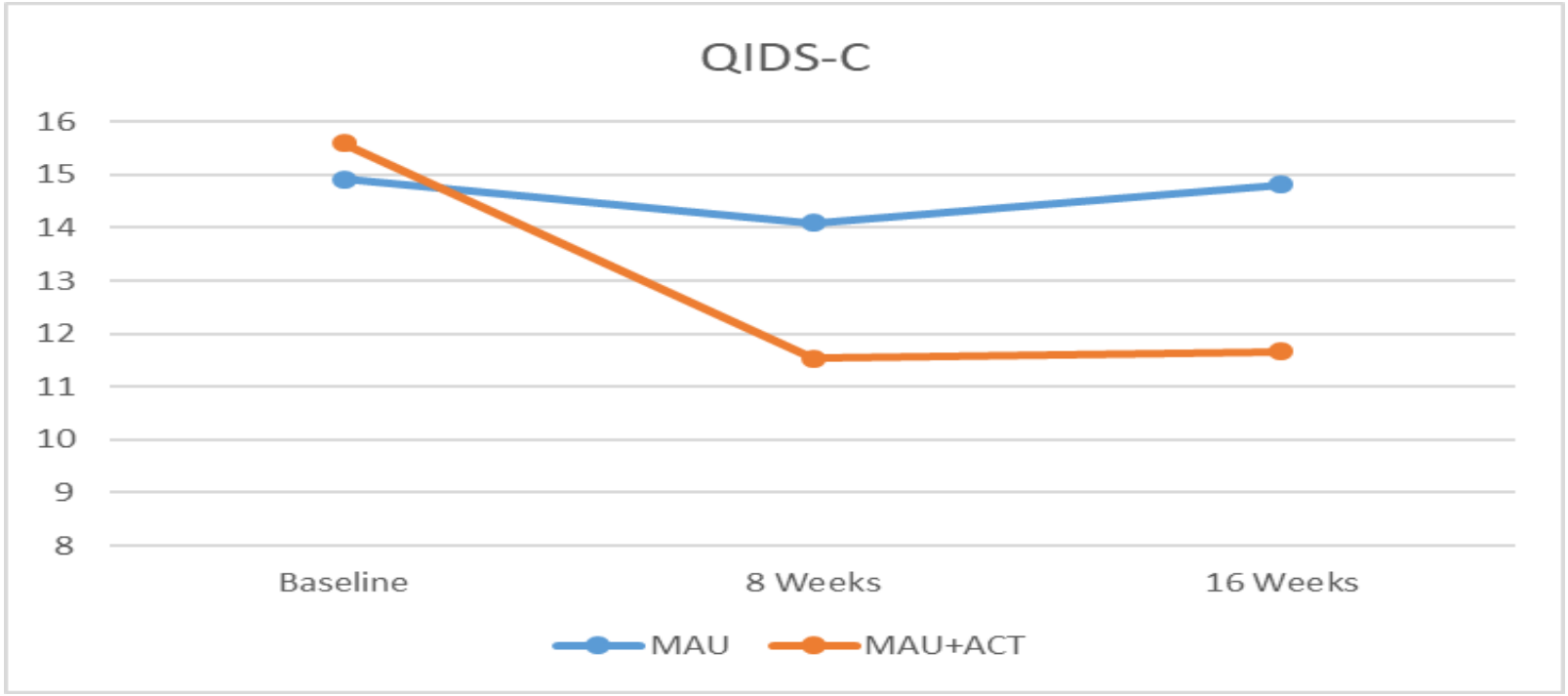
Social Fear


LSAS Fear Subscale
50
45
40
35
30
25
Baseline
8 Weeks
16 Weeks
MAU
MAU+ACT

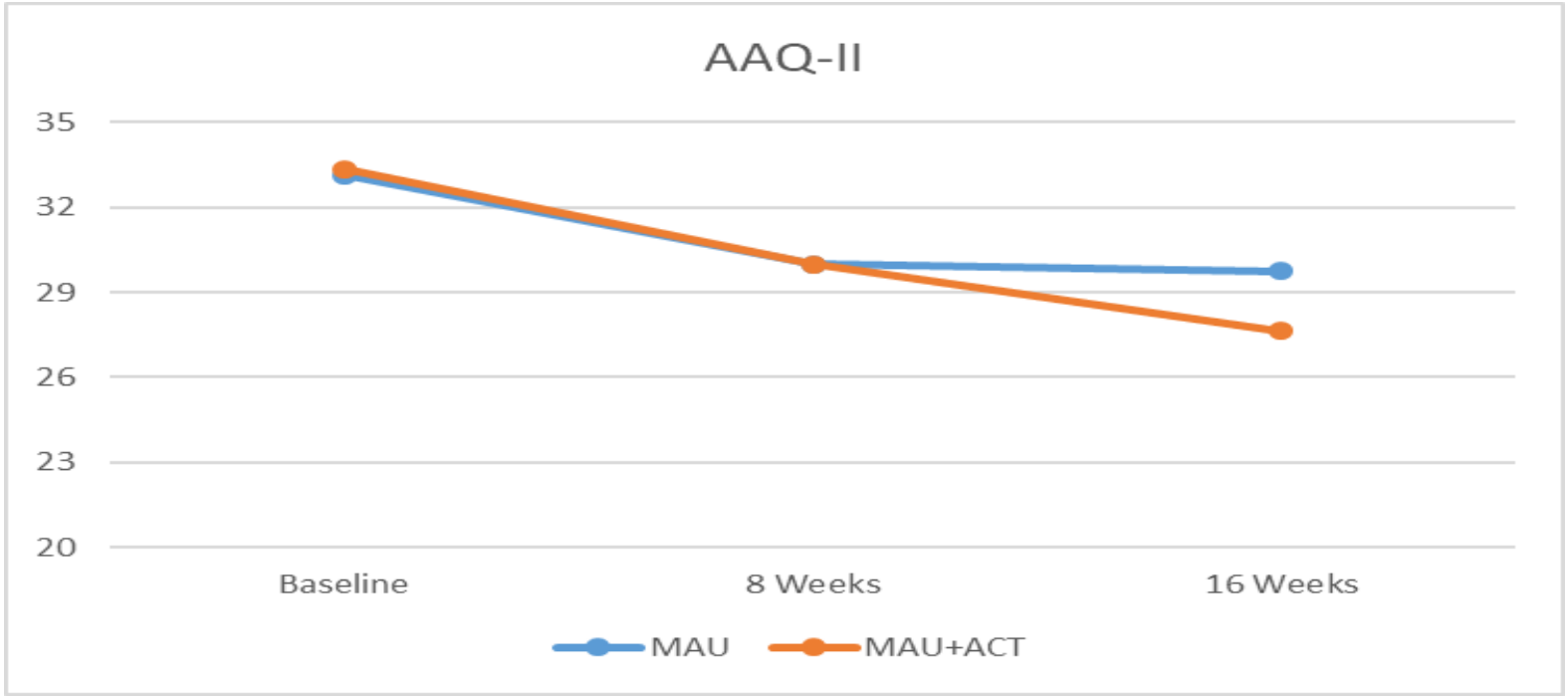
Social Avoidance



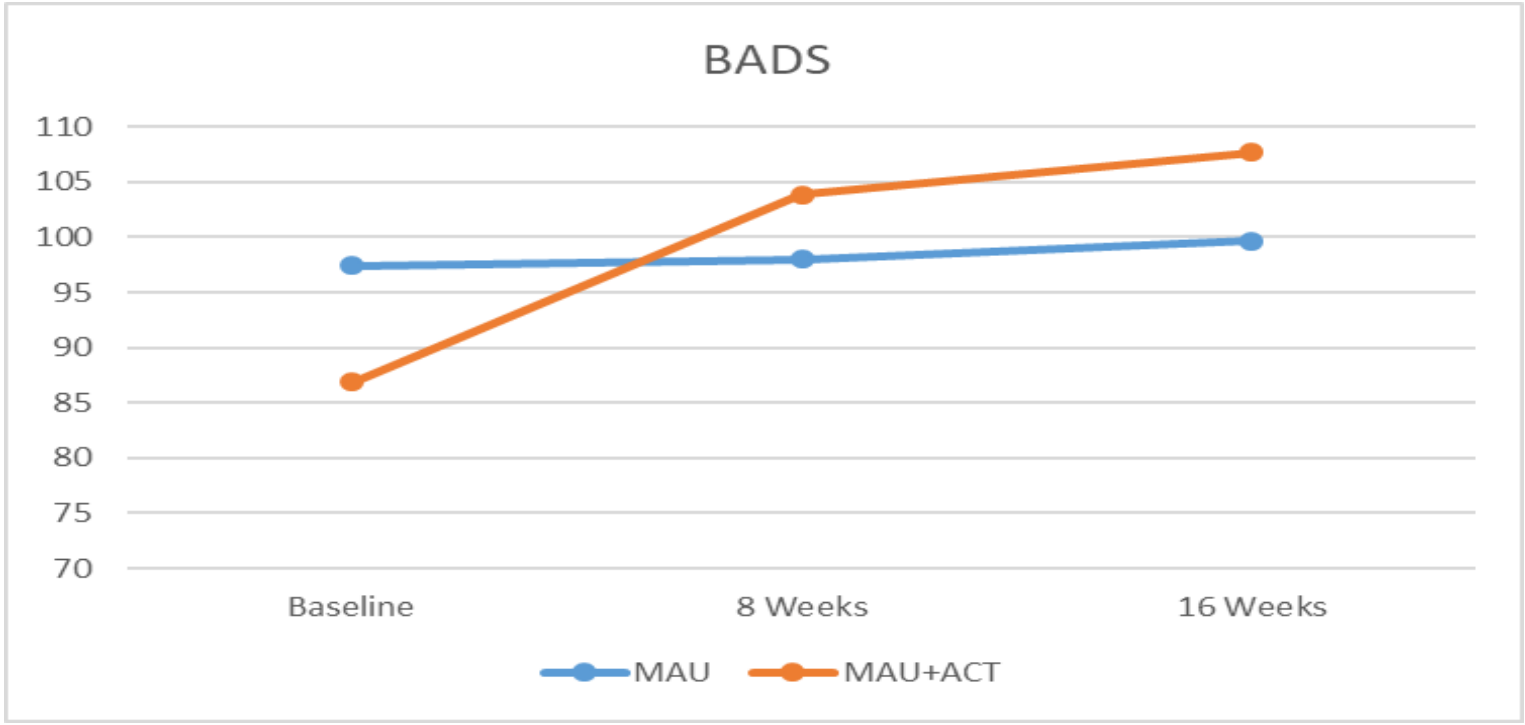
Depression Severity



Psychological Flexibility (lower=better)



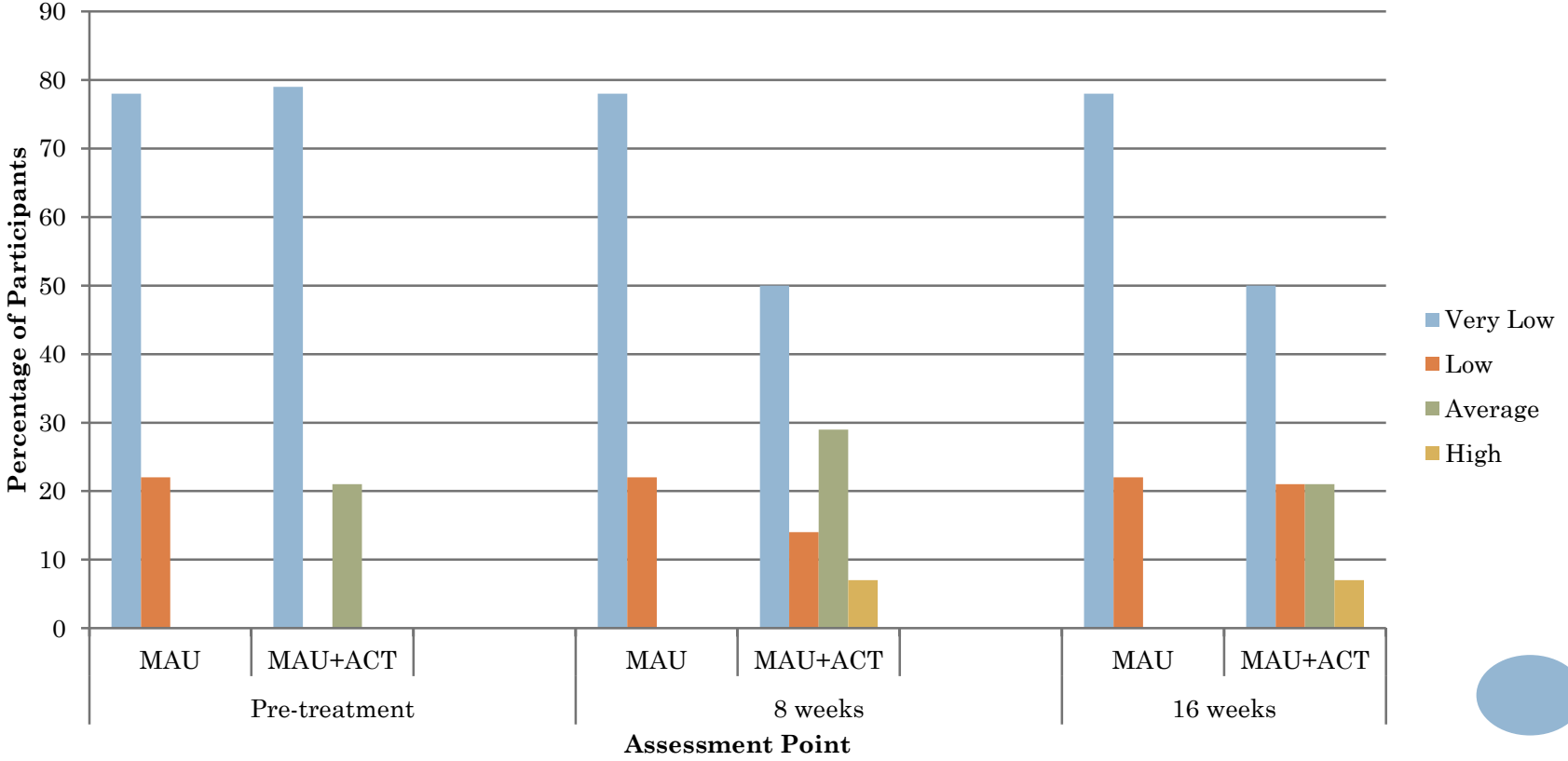
Behavioral Activation (higher=better)



Reliable Change

Measure	Completer		ITT	
	MAU	MAU+ACT	MAU	MAU+ACT
QIDS-C (Depression)	0%	77.8%	9.1%	46.7%
LSAS-F (Social Anxiety Fear)	0%	22.2%	0%	13.3%
LSAS-A (Social Anxiety Avoidance)	33.3%	55.6%	9.1%	33.3%

Quality of Life



DISCUSSION

Summary of Results

- Good feasibility and acceptability
- Preliminary signal of efficacy
  - Within MAU+ACT Cohen's *d*:
    - Depression (0.72), SA avoidance (0.68)
    - Psych flex (0.60), BA (0.78)
- But high attrition in MAU (~66%)
  - Nearly ½ of MAU dropouts ended treatment completely at the practice

Premature Termination in MAU

- Potential reasons:
  - Receiving non-preferred treatment
    - Depression: patients prefer psychotherapy over medication (McHugh et al., 2013)

- Consistent with recent meta-analysis (Swift et al., 2017)
  - Rates as high as 69% in comparative treatment trials
  - SAD: 1.29 OR, with higher rate in meds alone

Preliminary Efficacy

- Results comparable to open trial
- Encouraging results with quality of life
- Consistent with effectiveness studies
  - Effect sizes - 1.06-1.13 for depression (Hans & Hiller, 2013)
  - Reliable change – 50%, 15-30% (McEvoy & Nathan, 2007; Westbrook & Kirk, 2005)

Limitations

- Small sample size
- Large confidence intervals
- High MAU attrition rate
- Intention-to-Treat: LOCF method
- Unstructured MAU

Future Implications

- Comparison with other active psychotherapies
- Improve study retention, especially in MAU
- Further examination of target mechanisms

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- Questions?
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