ACT and MI: Lessons from a Combined Group Intervention

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Overview

- Rationale for combining ACT & MI
- Combined Group
  - Setting & Objectives
  - Design
  - Participants
  - Outcomes
- Lessons Learned
- Future Directions

ACT and MI Similarity

- Shared foundation of a collaborative therapy **relationship** marked by empathy and not engaging in a struggle

Bricker & Tollison, 2011; Wagner & Ingersoll, 2012; Miller & Rollnick, 2012

ACT & MI as Complementary

- Acceptance and Compassion
  - MI: therapist stance toward client
  - ACT: therapist stance toward client *and* self, *and* client toward self
- Language
  - MI: focus on language *content* to elicit "change talk" and commitment
  - ACT: focus on language *processes* to facilitate acceptance of difficult thoughts, feelings, and sensations
- Values
  - MI: as a means to an end
  - ACT: as a means *and* the end

Bricker & Tollison, 2011; Miller & Rollnick, 2012

Combining ACT and MI

- Sequential approach
  - The simple, direct, eliciting focus of MI may not be sufficient to produce change; third-wave therapies as complementary and consistent (Wagner & Ingersoll, 2012).
- Greater than the sum
  - Blending the communication approaches may enhance psychological processes targeted by both interventions (e.g., OARS and metaphors) (Bricker & Tollison, 2011).
- For the therapist
  - MI to enhance therapist stance and language; ACT to develop therapist's own psychological flexibility (Gillanders, 2011).

The ACT Program

- Intensive Outpatient Program within the Baltimore VA Medical Center Substance Abuse Treatment Program
- 12-week program, includes 2 phases
- Runs in 5-week cycles that include weekly, experiential ACT-based themes, mindfulness-based relapse prevention, and small interpersonal process groups
- Abstinence-focused

Group Objectives

- Some veterans present to the ACT Program with high readiness to abstain from one substance, but low readiness for total abstinence from drugs and alcohol.
  - A new group that is both ACT-consistent and designed to enhance motivation for abstinence may be helpful for this subset of ACT Program Veterans.
  - The Acceptance and Commitment/Motivational Enhancement (A.C.M.E.) Group emerged.

ACME Group Design

- Four phases that parallel individual MI:
  - Engaging the group
    - Interconnectedness and universality
  - Exploring perspectives
    - Willingness to discuss pros and cons
    - Focus on the present and acknowledge suffering
  - Broadening perspectives
    - Attend to guidance, goals, emotions, meaning, values clarification
    - Stages of Change and Ready-Willing-Able models/heuristics
  - Moving into action

DiClemente & Velasquez, 2002; Wagner & Ingersoll, 2013

Transtheoretical Model and the Stages of Change

Precontemplation
Not thinking about changing

Contemplation
Considering change

Preparation
Making decision/s for change

Action
Commitment and beginning to change

Maintenance
Change has become integrated with life

Relapse

Lapse

Cognitive/experiential processes of change associated with pre-action stages, and Behavioral processes associated with action-oriented stages.

Prochaska, DiClemente, & Norcross, 1992; Carbonari & DiClemente, 2000

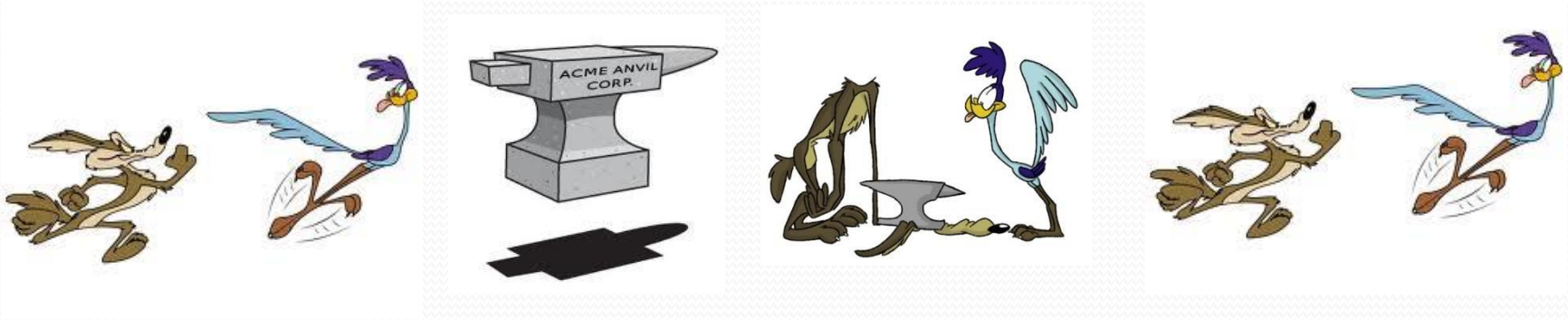
ACT Program Weekly Themes

1. Workability
2. Willingness/Acceptance
3. Defusion
4. Values
5. Committed Action

ACME Session Topics

1. Relationships & Context
2. Pros & Cons / Comfort & Discomfort
3. Stages of Change
4. Values
5. Preparation for Action

A “Running” ACME Metaphor



- Why is it that we all can relate to this cartoon?
  - ACT: humans continually chasing pleasure or avoiding pain
  - MI: more literal “chasing” of a drug or high
- In what ways are you like Wile E. Coyote?
  - How? When? What are your “ACME tools” or control strategies? Will you ever “run out” of tools?

A “Running” ACME Metaphor

- What might the coyote experience, and be free to do, if he were to drop the struggle?
- Values
  - Slowing down and experiencing vitality.
- Committed Action and Confidence
  - MI : “I can DO this.”
  - ACT: “I can FEEL whatever comes up *as* I do this.”

Referrals & Engagement

- Group participants were Veterans from both phases of the ACT program referred by individual case manager.
- ACME group as an “add-on”/adjunct to current IOP schedule.
- November 2012 – May 2013:
  - 23 Veterans referred to ACME
    - 5 Veterans did not attend group
    - 6 Veterans attended 1 session
    - 7 Veterans attended 2-4 sessions
    - 5 Veterans completed all 5 sessions

Group Participants

- 18 Veterans participated in pilot phase of ACME group:
  - 17 (94%) Male
  - 16 (89%) Black/African American
  - Mean age 50.47 (SD 9.87), range 29 – 64
  - 11 (61%) in IOP Phase 1
- Substances (7 dual/poly):
  - 18 alcohol
  - 6 cocaine
  - 4 cannabis
  - 2 heroin
  - 1 methamphetamine
  - 1 benzodiazepine

Evaluation Measures

Measure	Items	Reliability Cronbach's α
Acceptance and Action Questionnaire II (AAQ-II)	7	.84 (.78–.88)
University of Rhode Island Readiness to Change Assessment (URICA) – Alcohol Use	24	Precontemplation = .75 Contemplation = .81 Action = .83 Maintenance = .86
Processes of Change (POC) – Alcohol Use Experiential/Cognitive Processes subscale Behavioral Processes subscale	20	Exp = .83 Beh = .78
University of Rhode Island Readiness to Change Assessment (URICA) – Illicit Drug Use	24	Precontemplation = .71 Contemplation = .71 Action = .69 Maintenance = .52
Processes of Change (POC) – Illicit Drug Use Experiential/Cognitive and Behavioral subscales	20	Total 40-item scale = .87

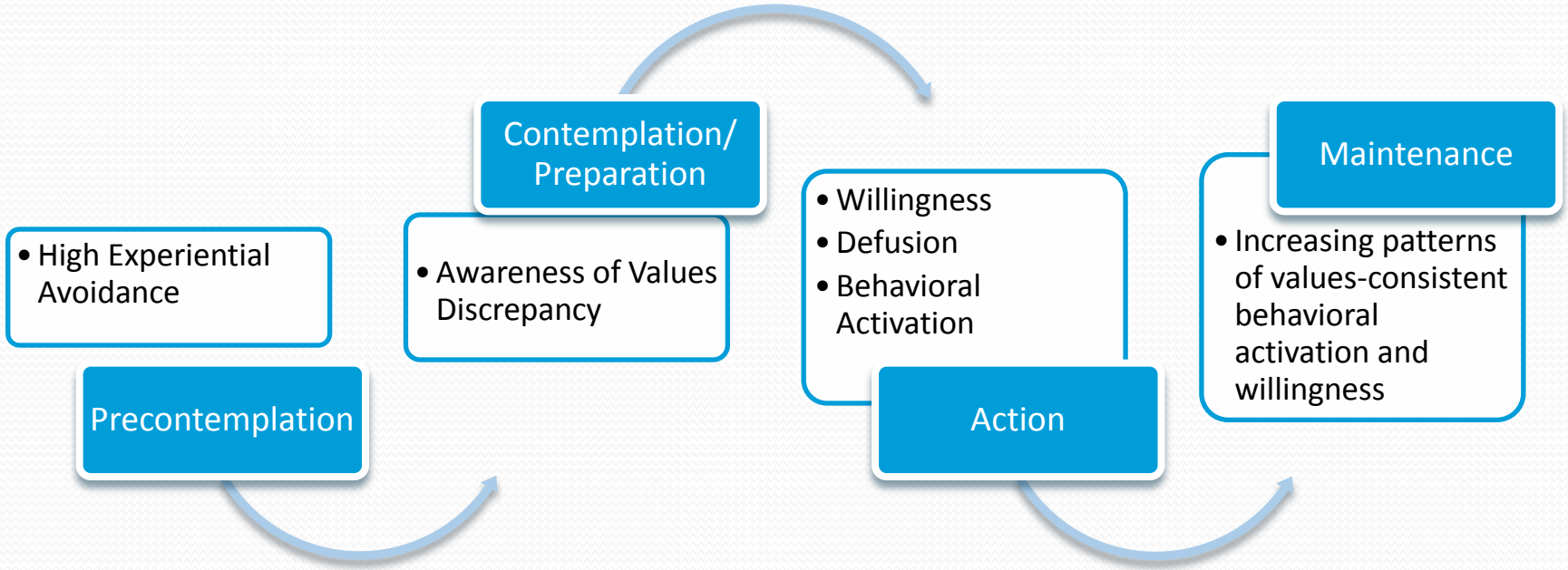
Belding et al., 1996; Bond et al., 2011; Carbonari et al., 1994; Tejero et al., 1997; VonSternberg, 2005

Evaluation Outcomes

	Sample (N=15)	Group Completers (n=5)		
	Baseline	Baseline	Post	Change
Measure	Mean (SD)	Mean (SD)	Mean (SD)	
AAQ-II	33.87 (8.45)	36.20 (9.04)	32.60 (12.84)	-3.60
URICA - Alcohol	9.82 (1.92)	9.83 (2.92)	10.53 (1.86)	0.70
Behavioral POC - Alcohol	3.26 (0.96)	3.64 (0.87)	5.52 (4.19)	1.88
Experiential POC - Alcohol	3.19 (0.96)	3.68 (0.99)	3.22 (0.49)	-0.46
URICA - Drugs	9.53 (2.71)	10.46 (3.15)	11.58 (1.78)	1.13
Behavioral POC - Drugs	2.61 (1.02)	2.88 (1.41)	3.88 (1.09)	1.00
Experiential POC - Drugs	2.43 (1.06)	3.00 (1.38)	3.68 (1.00)	0.68

SD, standard deviation

Convergence of Processes



Lessons Learned

- Commonalities or key differences?
  - Acceptance and Compassion
  - Values
  - Language
- Too soon to tell if ACT and MI combined serve to activate multiple processes of change with “value- added”
  - Motivation and readiness
  - Willingness to experience difficult thoughts, emotions, and internal experiences
  - Behavior change

Future Directions

- Both treatments emphasize that the facilitator not become “overly attached” to a group curriculum or plans:
  - Currently revising group content and process
  - Stronger emphasis on substance use behaviors and practical, individual applications and worksheets

- Research and evaluation
  - RCTs comparing ACT, MI, and combinations
  - Continue to design and evaluate applied groups

Wagner & Ingersoll, 2013

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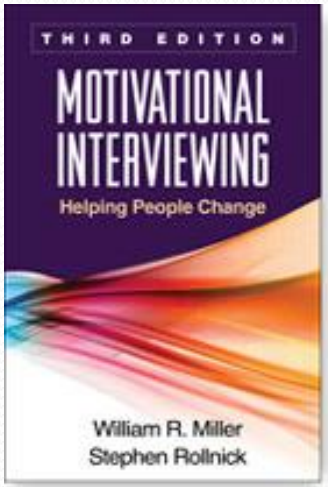
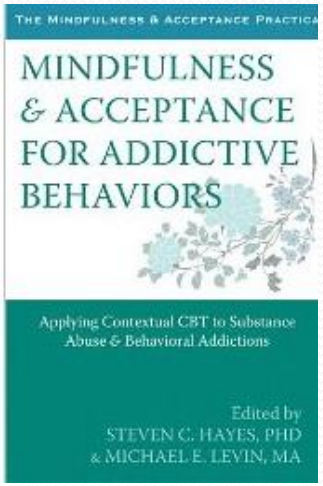
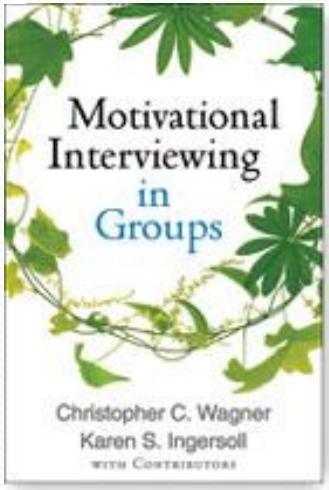
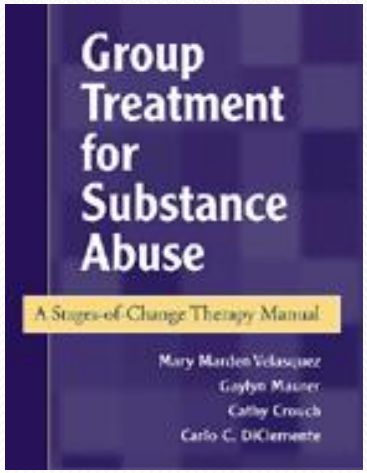
Recommended Books









Key Differences

MI

Philosophical basis:
Humanism

Relevant theories:
Self-Perception Theory
Speech Act Theory
Transtheoretical Model

The problem:
Ambivalence

The goal:
Reduce problem behaviors, symptom reduction

ACT

Philosophical basis:
Functional contextualism

Relevant theories:
Relational Frame Theory

The problem:
Avoidance

The goal:
Values-consistent action

Bricker & Tollison, 2011; Wagner, Ingersoll, & Rollnick, 2012; Gillanders, 2011