

Acceptance and Commitment Therapy in the Treatment of Alcohol Use Disorder and Comorbid Affective Disorder: A Pilot Matched Control Trial

Thekiso B. Thekiso¹
Philip Murphy¹
Jennie Milnes
Kathryn Lambe
Aisling Curtin
Conor K. Farren*

Trinity College Dublin, St. Patrick's University Hospital

This study examined whether acceptance and commitment therapy (ACT) enhances treatment as usual (TAU) in improving treatment outcomes in patients with alcohol use disorder (AUD) and comorbid affective disorder.

Fifty-two participants were included in the study, of whom 26 were patients with AUD and either depression or bipolar disorder treated with ACT group therapy in parallel with TAU (inpatient integrated treatment) and 26 were matched controls who had received TAU alone. Drinking and craving outcomes were total alcohol abstinence, cumulative abstinence duration (CAD) and Obsessive Compulsive Drinking Scale (OCDS) scores at 3 and 6 months postintervention. Affective and anxiety outcomes were Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Young Mania Rating Scale (YMRS) scores at these follow-ups.

Baseline demographic and clinical characteristics were similar in both groups. Retention rates were high: 100% of the ACT group were followed up at 3 and 6 months; 92.3% and 84.6% of the TAU alone group were followed up at 3 and 6 months, respectively. Patients in the ACT group reported significantly

higher CAD at 3 and 6 months, significantly lower BDI and BAI scores at 3 and 6 months, and significantly lower OCDS scores at 3 months, than those who received only TAU. No other significant differences in treatment outcomes were found between the groups.

ACT provides added benefit to TAU in improving drinking, craving, depression and anxiety outcomes in patients with AUD and comorbid affective disorder. Most treatment improvements were sustained over a 6-month follow-up period.

Keywords: alcohol use disorder; affective disorder; depression; bipolar disorder; acceptance and commitment therapy

ALCOHOL USE DISORDER (AUD) is often accompanied by comorbid affective disorder, either depression or bipolar disorder. Indeed, there is evidence that the combination of AUD and affective disorder represents 50% of the AUDs and 30% of the affective disorders presenting for treatment (Hasin et al., 2007). Moreover, this co-occurrence is mutually detrimental, as patients with this type of dual diagnosis generally have increased severity of symptoms (McKowen et al., 2005), are more difficult to treat, have a worse prognosis (Burns, Teesson, & O'Neill, 2005; Hasin et al., 2002), have a higher suicide rate (Dalton et al., 2003; Potash et al., 2000), and are more costly to the health services (Hoff & Rosenheck, 1999) than patients with either disorder alone.

Despite the considerable public health significance of AUD and comorbid affective disorder,

*Address correspondence to Conor K. Farren, M.D., Ph.D., St. Patrick's University Hospital, James's Street, Dublin 8, Ireland; e-mail: cfarren@stpatsmail.com.

¹These authors contributed equally to this work and have joint first authorship.

The authors thank the Board of St. Patrick's University Hospital for their financial support of this study.

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there is a paucity of research on treatment for these co-occurring disorders. Pharmacotherapy trials in depressed alcoholics have produced mixed results, with some finding pharmacotherapy helpful in improving both alcohol and depression outcomes (Cornelius et al., 1997; Mason et al., 1996; Pettinati et al., 2010) and some others finding no added benefit from the pharmacotherapy (Kranzler et al., 2006; Pettinati et al., 2001). A meta-analysis suggested that pharmacotherapy interventions for treating depressive symptoms alone in alcohol dependent individuals are only modestly effective, with a significant heterogeneity in effect sizes across different studies (Nunes & Levin, 2004). For bipolar alcoholics, there has been some evidence for pharmacotherapy treatment efficacy in relation to both drinking and affective outcomes (Brown, Garza, & Carmody, 2008; Salloum et al., 2005) but there are few well-controlled studies.

One approach that seems to be bearing fruit for patients with a dual diagnosis of AUD and comorbid affective disorder is integrated treatment, in which both disorders are treated simultaneously (Tiet & Mausbach, 2007). In a longitudinal cohort study, Farren and McElroy (2008) demonstrated evidence for the efficacy of a comprehensive inpatient integrated treatment program, which involved psychoeducation, psychotherapy, and pharmacotherapy, as both depressed and bipolar alcoholics had significant reductions in all measurements of mood, craving and alcohol/drug consumption at 6 months post-discharge. These treatment gains were even maintained at 5-year follow-up (Farren, Murphy, & McElroy, 2014). Moreover, in a randomized controlled study, Weiss et al. (2007) showed that patients with bipolar disorder and comorbid substance dependence who received integrated group therapy, which was primarily based on cognitive-behavioral therapy principles and designed as an adjunct to pharmacotherapy, had significantly better substance use outcomes, including fewer days of alcohol use and fewer days of alcohol use to intoxication during treatment and follow-up, than did those who received group drug counseling, an active control treatment. However, despite the significant benefits demonstrated for patients having been treated with integrated treatment, these interventions have not received widespread clinical adoption.

In an effort to enhance integrated care, one approach is to develop therapies that target experiential avoidance. Experiential avoidance has been proposed as one functional classification dimension that may cut across traditional diagnostic criteria (Hayes et al., 1996). It is described as a process in which a person is unwilling to experience a negative private event (e.g., thought, feeling, memory, urge,

bodily sensation) and thus takes action to reduce, numb, or get rid of that private event despite significant behavioral harm (Hayes et al., 1996). There is a body of evidence that suggests that substance misuse including AUD is frequently a form of experiential avoidance (Luciano et al., 2001; Shoal & Giancola, 2001; Stewart, Zvolensky, & Eifert, 2002). Similarly, experiential avoidance has been identified as a core psychopathology process in individuals presenting with affective disorder and anxiety (Feldner et al., 2003; Roemer & Orsillo, 2002).

One treatment that has been specifically developed to reduce experiential avoidance is acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). Two large reviews have demonstrated growing evidence for the efficacy of ACT with a number of clinical populations (Hayes et al., 2006; Ruiz, 2010). There are some studies showing positive mental health outcomes for patients with substance misuse including AUD (Hayes et al., 2004; Heffner et al., 2003) and those with affective disorder and anxiety (Forman et al., 2007; Zettle & Raines, 1989) using ACT. Only one study to date has evaluated ACT for patients with a dual diagnosis of AUD and comorbid affective disorder (Petersen & Zettle, 2009). This study demonstrated some benefits of ACT over treatment as usual (TAU), including participants receiving ACT requiring a shorter treatment phase and smaller dose of individual therapy to meet criteria for discharge compared to their TAU counterparts. However, there were no significant differences between the two groups in affective outcomes. This may have been due to the particularly small study numbers of 12 participants in each group, which limited the statistical power to detect differences between the groups, or to other factors such as participants in both treatment conditions continuing in therapy until they met the same discharge criteria. Moreover, the study did not explore any differences in alcohol outcomes. The purpose of the present study, therefore, was to add to this research by conducting a pilot trial to test the hypothesis that a manualized course of ACT group therapy enhances an inpatient integrated treatment program (TAU) in improving AUD and affective disorder treatment outcomes in patients with these co-occurring disorders.

Methods

STUDY DESIGN AND SETTING

This was a matched cohort study where AUD patients with comorbid affective disorder treated with ACT group therapy in parallel with TAU (inpatient integrated treatment) were individually matched with historical controls who had received TAU

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