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Acceptance and Commitment Therapy With Older Adults: Rationale and Considerations

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Older adults are the fastest growing segment of the population. With these changing demographics, mental health professionals will be seeing more older clients. Additionally, older adults are an underserved population in that most older adults in need of mental health services do not receive treatment. Thus, it is essential that treatments for mental and behavioral health problems are empirically supported with older adults and that mental health professionals are aware of the special needs of older adult populations. Acceptance and Commitment Therapy (ACT) is an emerging approach to the treatment of distress. The purpose of this article is to provide a rationale for using ACT with older adults based on gerontological theory and research. We also review research on ACT-related processes in later life. We present a case example of an older man with depression and anxiety whom we treated with ACT. Finally, we describe treatment recommendations and important adaptations that need to be considered when using ACT with older adults and discuss important areas for future research.

Adults aged 65 and older are the fastest growing segment of the U.S. population. Due to the aging of the "baby boom" generation and advances in health care, estimates suggest that the number of older adults will double by 2030, representing approximately 20% of the population (Administration on Aging, 2009). With the exception of dementia, the rates of mental and behavioral health disorders decrease in older adulthood (Smyer & Qualls, 1999). However, certain subpopulations of older adults who face chronic illness and functional impairment, such as homebound and nursing home–dwelling older adults, are at increased risk for mood or anxiety disorders. Depression and anxiety in older adulthood are associated with a number of adverse outcomes, including higher levels of health care utilization (Porensky et al., 2009; Unutzer et al., 1997), increased risk of nursing home placement (Gibbons et al., 2002), greater functional impairment (Brenes et al., 2005; Lenze et al., 2001), increased mortality (Saz & Dewey, 2001), faster rates of cognitive decline (Dotson, Resnick, & Zonderman, 2008; Sinoff & Werner, 2003), higher rates of suicide (Diefenbach, Woolley, & Goethe, 2009; Turvey et al., 2002), and decreased quality of life (Blazer, 2003; Porensky et al., 2009; Wetherell et al., 2004).

Older adults are an underserved population; the majority of older adults in need of mental health treatment do not receive care (Swartz et al., 1998; Wang et al., 2005). If these individuals do receive treatment, it is typically pharmacological, despite the fact that many prefer counseling (Gum, Iser, & Petkus, 2010). Reasons why older adults do not receive treatment include lack of knowledge about mental health services, lack of perceived need for services (Klap, Unroe, & Unutzer, 2003), and stigma (Livingston & Boyd, 2010). Additionally, provider factors such as the misconception that the patient's problems are part of normal aging, as opposed to a mental health problem, also contribute to underutilization of mental health care by older adults (Smyer & Qualls, 1999).

With changing demographics, psychologists and other mental health professionals will be seeing older adults with greater frequency. Thus, it is essential that treatments for mental and behavioral health problems are empirically supported with older adults and that health care professionals are educated about the special needs of older adult populations. To date, most research examining the effectiveness of psychosocial treatments with older adults have examined cognitive behavioral approaches. Studies have shown that these types of treatments, including problem-solving therapy, are effective in treating depression in older adults in the community and

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primary care (Bell & D'Zurilla, 2009). However, studies have produced mixed findings on their effectiveness with some subpopulations, such as depressed, medically ill homebound older adults (Ayalon, Fialova, Arean, & Onder, 2010; Gellis & Bruce, 2010). CBT approaches may also be suboptimal in the treatment of anxiety in later life (Thorp et al., 2009; Wetherell, Ruberg, & Petkus, 2010). Thus, the need is critical to further develop and test psychosocial treatments to provide better care to older adults.

Acceptance and Commitment Therapy (ACT) is an emerging evidence-based approach to the treatment of emotional distress (Hayes, Strosahl, & Wilson, 1999). In this article, we will provide a rationale for an ACT approach with older adults, drawing upon theories from the literature on adult development and aging, emotion regulation, and knowledge about mental health problems. We will provide a brief description of the ACT model of treatment. We will review the literature on investigations of ACT-related processes in older adults. We will describe treatment recommendations, important adaptations that need to be considered when using ACT with older adults, and provide a case example. Lastly, we will make recommendations for future research.

The ACT Model of Psychopathology and Treatment

ACT assumes that one primary factor, psychological inflexibility, is characteristic of psychopathology (Hayes et al., 1999). The ACT model defines psychological inflexibility as an inability to connect with one's values in the present moment due to experiential avoidance and cognitive fusion (Hayes et al.). The six processes that are associated with psychological inflexibility are experiential avoidance, cognitive fusion, dominance of conceptualized past or future, attachment to conceptualized self, loss of contact with personal values, and inaction, impulsivity, or persistent avoidance. Experiential avoidance is the attempt to control unpleasant thoughts, emotions, memories, and other internal experiences. Cognitive fusion occurs when we conceptualize ourselves by the thoughts, emotions, and other internal experiences we experience. Attachment to the conceptualized self can be thought of as being fused with the cognitions that one is a person who is depressed, worried, or has significant problems. Values give meaning to life and can include family, career, social relationships, and health, among others. Individuals exhibiting psychological inflexibility exert energy and resources on experiential avoidance, while neglecting and losing contact with their core life values.

Research has suggested that the core processes related to psychopathology in the ACT model persist into older adulthood. Experiential avoidance of distressing internal experiences appears to be associated with greater distress in older adulthood. Engaging in thought suppression as a mechanism to cope with unwanted thoughts has been associated with less subjective sense of meaning in life in community-dwelling older adults (Krause, 2007). Thought suppression and avoidance coping have been associated with increased suicidal ideation in depressed older adults with comorbid personality disorders (Cukrowicz, Ekblad, Cheavens, Rosenthal, & Lynch, 2008). Furthermore, engaging in thought suppression has been associated with poorer outcomes in older adults following treatment for depression (Rosenthal, Cheavens, Compton, Thorp, & Lynch, 2005). Engaging in avoidance may mediate the association between past trauma exposure and increased distress later in life (Dulin & Passmore, 2010). In functionally impaired, chronically ill homebound older adults, after controlling for physical illness, functional impairment, and cognitive functioning, engaging in thought suppression was associated with somatic, depressive, and anxiety symptoms (Petkus, Gum, & Wetherell, in press). Additionally, using avoidance as a coping strategy is also associated with increased depression (Andrew & Dulin, 2007) and persistent anxiety (Ayers et al., 2010). Taken together, these studies support the hypothesis that experiential and behavioral avoidance have an adverse effect on functioning in older adults. This suggests that an ACT model of treatment would be potentially effective with this population.

The research examining the effectiveness of ACT with older adults is extremely limited. To date, only one pilot study has been conducted to examine the effectiveness of ACT with older adults (Wetherell et al., 2011). This study examined ACT and CBT in a sample of older adults with generalized anxiety disorder (GAD). Results suggest that ACT is feasible, acceptable, and may be effective at reducing depression and worry. However, this was a small feasibility study (N=21), and larger-scale studies are needed to examine the effectiveness of ACT with this population.

Rationale for ACT With Older Adults

The characteristics of mood and anxiety disorders in older adults support an ACT approach. Comorbidity of anxiety and depression are common and difficult to distinguish among older people (Gum & Cheavens, 2008). Other research suggests that in chronically ill, functionally impaired older adults, anxiety and depressive symptoms commonly co-occur (r=0.71; Petkus et al., 2010). The transdiagnostic nature of ACT may make the assessment and treatment of anxiety and depression more efficient. In disorder-specific approaches to treatment, treatment planning requires distinguishing the primary disorder from which the individual is suffering. In an ACT treatment approach, it is not necessary to distinguish, for example, an anxiety disorder from depression. Under the