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Acceptance and Commitment Therapy for a Heterogeneous Group of Treatment-Resistant Clients: A Treatment Development Study

Sue Clarke, *Bournemouth University*
Jessica Kingston, *Royal Holloway, University of London*
Kelly G. Wilson, *University of Mississippi*
Helen Bolderston and Bob Remington, *University of Southampton*

Acceptance and commitment therapy (ACT) has been shown to have broad applicability to different diagnostic groups, and there are theoretical reasons to consider its use with clients with chronic mental health problems. We report an innovative treatment development evaluation of ACT for a heterogeneous group of "treatment-resistant clients" (N=10) who had attended a mean of 3.5 previous psychological interventions. All clients had Axis I presentations and half met diagnostic criteria for Axis II disorders. Functioning, assessed at pre- and postintervention, and at 6- and 12-month follow-up, showed improvements over time on all primary outcome measures, driven largely by significant changes occurring between baseline and 6-month follow-up. Improvements were associated with ACT processes of change. The data thus suggest that a broad range of clients who had not benefited from standard care may benefit from ACT.

A range of psychotherapeutic methods have been used with marked success to treat acute psychological disorders. Unfortunately, however, evidence from clinical trials shows that a proportion of clients fail to obtain clinically meaningful improvements following such interventions, continue to experience persistent symptoms, and thus remain resistant to treatment. For example, approximately 30 to 60% of clients fail to obtain improvements following cognitive behavior therapy (CBT) for generalized anxiety disorder (Borkovec, Newman, Pincus, & Lytle, 2002), depression (DeRubeis et al., 2005; Dimidjian et al., 2006), bulimia nervosa (Wilson, Fairburn, & Agras, 1997), and mixed symptoms (Westbrook & Kirk, 2005). Similarly inconsistent results have been reported following interpersonal therapy for depression (Elkin et al., 1989) and bulimia nervosa (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000), and following psychodynamic therapy for anorexia nervosa (Dare, Eisler, Russell, Treasure, & Dodge, 2001) and depression (Leichsenring, 2001). From among this sizeable minority of treatment-resistant clients, many will present in clinics with a broad array of symptomatology, often including chronic, comorbid, and personality-disordered symptoms (Fournier et al., 2008).

Thus, there is an urgent need for cost-effective, evidence-based psychological interventions for treatment-resistant clients experiencing a heterogeneous range of clinical disorders. The primary purpose of the present study was to develop a group-based treatment for this transdiagnostic group. In contrast to approaches that focus on specific diagnoses, this intervention was developed to target the psychological processes underlining a range of treatment-resistant presentations. As such, it represented an important initial step toward the development of a pandiagnostic intervention for challenging patients.

In the last 15 years, new therapeutic interventions have been developed that, unlike traditional CBT, are less concerned with modifying the content or frequency of clients' private events (e.g., distressing thoughts and emotions), and instead focus on teaching them to *accept* these events without treating them as literally true. Dialectical behavior therapy (DBT; Linehan, 1993a), acceptance and commitment therapy (ACT; S. C. Hayes, Strosahl, & Wilson, 1999), and mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002)

[1] Video patients/clients are portrayed by actors.

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are examples of acceptance-based interventions that have gained substantial recognition, in part because they may be effective with more hard-to-treat client groups (e.g., Kenny & Williams, 2006; Linehan et al., 2006).

The core difference between ACT and other acceptance-based interventions is the central proposition that diagnostically distinct clinical disorders may be established and maintained through common processes that are rooted in the capacity for language (see Twohig, 2012-this issue; Wilson, Hayes, Gregg, & Zettle, 2001). These common processes include psychologically deleterious *experiential avoidance* (EA; see Twohig, 2012-this issue). EA has been defined as an "unwillingness to experience feelings, physiological sensations, and thoughts, especially those that are negatively evaluated (e.g., fear), as well as attempts to alter the form or frequency of these events and the contexts that occasion them" (S. C. Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). EA has been theorized to underlie a broad range of topographically dissimilar disorders, and has been a central feature of much ACT research, perhaps because the Acceptance and Action Questionnaire (AAQ: S. Hayes, Strosahl, et al., 2004) provides a readily available measure of the process.

Correlational research using the AAQ and similar instruments has been largely supportive of the role of EA in psychological problems and, in particular, in understanding chronic, comorbid, and personality-disordered symptoms. For example, EA has been shown to mediate the relationship between sexual abuse and psychological distress (Marx & Sloan, 2002), anxiety sensitivity and the use of alcohol as a coping mechanism (Stewart, Zvolensky, & Eifert, 2002), and both negative affect intensity and childhood trauma and a composite measure of risk-taking behaviors (Kingston, Clarke, & Remington, 2010; Kingston, Clarke, Ritchie, & Remington, 2011). Similarly, thought suppression has been shown to mediate the relationship between negative affect and borderline personality disorder (BPD; Cheavens et al., 2005), even after controlling statistically for experience of childhood abuse (Rosenthal, Cheavens, Lejuez, & Lynch, 2005). Forsyth, Parker, and Finlay (2003) reported that, in an inpatient veteran sample with drug abuse problems, clients with comorbid disorders scored significantly higher on the AAQ than their noncomorbid counterparts. Similarly, the chronic use of avoidance is significantly predictive of greater symptom severity across a range of problems (e.g., see Begotka, Woods, & Wetterneck, 2004; Boeschen, Koss, Figueredo, & Coan, 2001; Roemer, Salters, Raffa, & Orsillo, 2005) and of poorer clinical outcomes (e.g., A. M. Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005; Roemer, Litz, Orsillo, & Wagner, 2001). Finally, Westrup (1999, cited in Chawla & Ostafin, 2007) investigated the role of EA in relapse following the treatment of individuals dependent on alcohol, and found that the interaction between high EA and experiencing negative life events significantly predicted relapse above and beyond the effect of negative life events per se. Although correlational in nature, these results suggest that cultivating a willingness to experience—rather than avoid—psychological distress may serve as a protective mechanism for relapse prevention, a finding that complements Teasdale and colleagues' mindfulness research (e.g., Ma & Teasdale, 2004).

The data reviewed previously can be interpreted as suggesting that it may not be the mere occurrence of adverse life events, but the avoidance of private experience associated with them, that gives rise to psychological distress and leads to long-term and complex disorders. It follows that any therapy designed to undermine EA may be effective against such problems. ACT is based on this treatment principle, additionally seeking clients' commitment to making behavior changes that will bring their actions into line with their long-term core values (i.e., desired life qualities that have intrinsically fulfilling properties; Wilson & DuFrene, 2009). These aims are realized through a range of generic exercises, designed to foster acceptance, mindfulness, and a transcendent sense of self (see S. C. Hayes et al., 1999).

Outcome research supporting ACT to date is preliminary. Nevertheless, the available data tentatively indicate that ACT may be effective not only for individuals with acute disorders (see S. C. Hayes, Luoma, Bond, Masuda, & Lillis, 2006) but also for those with complex problems that resist other treatments. For example, S. C. Hayes, Wilson, et al. (2004) used a randomized control trial (RCT) to evaluate the relative effectiveness of ACT, methadone maintenance (MM), and an Intensive 12-Step Facilitation (ITSF) program in the treatment of polysubstance abusing clients (N=109). These clients presented with comorbid disorders (mood disorder: 40%; anxiety disorder: 42%; personality disorder: 52%) and an average of 6.5 previous residential or outpatient substance abuse treatments. Using urine specimens to monitor abstinence, authors reported comparable effects for ACT and ITSF at posttest, with both superior to MM. Moreover, 6-month data suggested that ACT produced longer-term effects than the other interventions, suggesting an "incubation effect."

A second, more preliminary trial (Gratz & Gunderson, 2006) randomized currently self-harming clients with BPD (N=24) to 14 weeks of treatment as usual (TAU) or an ACT-DBT hybrid plus TAU. At posttest, clients in the ACT-DBT hybrid were significantly less likely to self-harm and exhibited fewer BPD symptoms than those receiving TAU. Furthermore, Jacobson and Truax's (1991) criteria for reliable change showed that approximately half the clients in the ACT-DBT group achieved clinically reliable reductions in global psychiatric functioning. Although significant reductions in EA were also reported,