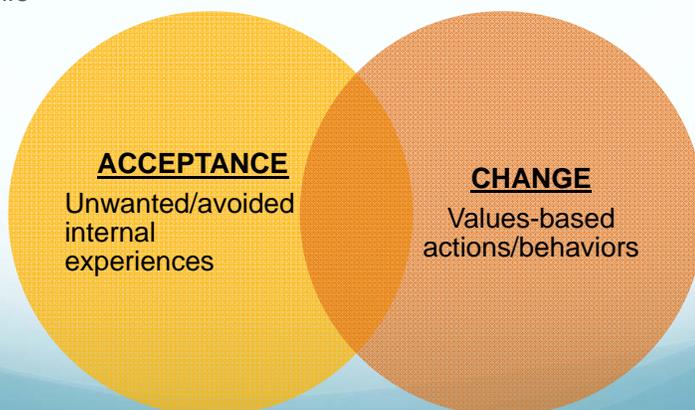


Acceptance and Commitment Therapy for Multiple Sclerosis

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ACT Conceptual Model

- Newer extension of behavior therapy: third wave acceptance-based behavioral therapies
- Two primary goals: 1) Acceptance of unwanted private experiences which are futile to control 2) Committed action towards living a values-based life

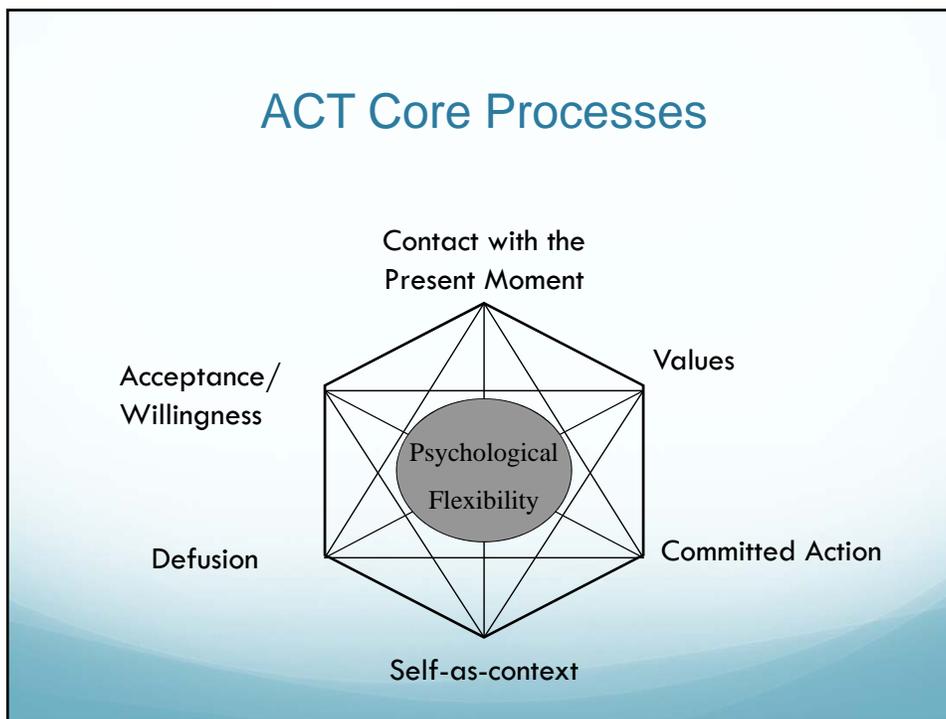


ACT Conceptual Model

- Primary target: experiential avoidance/psychological inflexibility
- Experiential Avoidance = efforts to avoid, suppress, or get rid of unwanted private experiences, even when it's harmful, costly, or ineffective (cause psychological and/or behavioral harm)
- No goal of symptom reduction.
- Experiential exercises, metaphors, and traditional behavioral techniques (e.g., exposure)

ACT Conceptual Model

- Experiential Avoidance is part of human condition
 - We are taught strategies for avoiding negative events and evolved for survival. Generally effective in material/external world
 - We treat unpleasant private experience as same as negative external problem; it becomes a problem to be solved/fixed/avoided/eliminated
- Why is excessive Experiential Avoidance detrimental?
 - Regulation of private events is largely unresponsive to cognitive/verbal control
 - Avoided experience becomes important/prominent
 - Avoidance is possible but control strategy is often costly, unhealthy, or radically changes one's life for the worse



ACT evidence base

- Transdiagnostic
Affective/mood disorders, substance use, psychosis, chronic pain, epilepsy, obesity, diabetes, work-related burnout
- > 100 RCT's conducted
- Meta-analysis of clinically relevant mental and physical health problems: 39 RCTs show ACT equal to or better than either treatment as usual or 'gold standard'
- Strong empirical support for chronic pain, moderate support for depression and mixed anxiety, moderate for OCD, moderate for psychosis
- Targeted processes addressed in ACT (experiential avoidance/acceptance mediate outcomes in most studies)

SAMHSA's National Registry of Evidence-based Programs and Practices, 2010; APA, Society of Clinical Psychology, Research Supported Psychological Treatments, 2015; A-Tjak, Davis, Morina, et al., (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics*, 84(30), 30-36.

Empirical Support: Study 1

- Open trial: half-day ACT workshop (5 hours) (N = 15)
- Intent-to-treat analysis; 3 month follow up
 - Depression scores decreased (large effect size)
 - Effect of pain on mood and behavior decreased but not impact of fatigue on behavior (large effect size)
 - Mental Health component of SF-36 showed trend towards improvement but not Physical Health component.
- ACT process measures
 - Significant reductions in thought suppression (large ES)
 - Mindfulness did not improve; Average time practicing per week 2.8 hours (small ES)
 - Significant improvement in QoL (large ES)
- Conclusions
 - Even if actual experience of pain remains unchanged, effect of pain on behavior can be mitigated
 - Depression not explicitly targeted or discussed and scores decreased from moderate-to-severe to mild-to-moderate range
 - QoL improved; a primary aim of ACT when applied to chronic medical conditions

Sheppard, S. C., Forsyth, J. P., Hickling, E. J., & Bianchi, J. (2010). A novel application of acceptance and commitment therapy for psychosocial problems associated with multiple sclerosis: Results from a half-day workshop intervention. *International Journal of MS Care*, 12(4), 200-206.

Empirical Support: Study 2

- ACT v. Relaxation (N = 21)
 - Five sessions- group format
- Both conditions resulted in significant decrease in depressive symptoms from pre- to post-treatment but significant differences between conditions not maintained 3 month follow up
- Relaxation group significant reductions in anxiety (HADS-A)
- Relaxation group reported higher frequency of daily practice
- Experiential avoidance significantly decreased and maintained at 3 month follow up among ACT group but not relaxation group
- Need to use behavioral measures rather than symptom measures given different foci of each intervention approach
- Incubation period of outcomes observed in ACT; improvements may not be realized until > 6 months post-treatment

Nordin, L., & Rorsman, I. (2012). Cognitive behavioural therapy in multiple sclerosis: a randomized controlled pilot study of acceptance and commitment therapy. *Journal of rehabilitation medicine*, 44(1), 87-90.

Empirical Support: Study 3

- Pakenham et al 2014 (N = 35)
- ACT group intervention: 7 two hour sessions
- Significant decrease in distress and depressive symptoms from pre-to post
- Significant improvement in values-based living, willingness, and cognitive defusion

ACT Case Conceptualization

Good medication adherence, healthy diet, exercise, vitamin supplement

Gloria believes that her lifestyle choices, with medication were working to keep her in remission

Most recent relapse resulted in more fatigue

Wondering what she 'did wrong'; believed she was doing everything 'right'. Wonders if she was working too much, under too much stress.

She is also angry at her health care providers, thinking that it was their job to prevent attacks and they failed her. And, she is experiencing low mood, reduced interest in activities, and she does not at the moment feel that she is enjoying anything at all.

[self-esteem based on the belief that she only has value if she "does the right things" in life, which is related to self-blaming. Underlying beliefs re: fairness: If she does the right things in life, she will receive back in kind.]

She has always been something of a control freak and perfectionist....she needed to control others and her environment in order to feel "OK" internally, or to "soothe herself" in the face of loss.

Low tolerance of uncertainty coupled with high striving for control/perfectionism

ACT Case Conceptualization

1. Presenting Problem: How does patient describe their problem at the present time?

2. Experiential Avoidance: What core thoughts, emotions, memories, sensations, scenarios is the patient unwilling to experience?

Thoughts: **I may not be able to predict/control relapse**

Emotions: **Anxiety (low tolerance of uncertainty)**

Memories: **initial symptom onset, receiving diagnosis**

Physical sensations: **Fatigue, MS relapse symptoms (tingling, numbness)**

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ACT Case Conceptualization

3. What does the patient do to avoid these experiences?

- Overt behavioral avoidance (Activities/situations/people the patient actively or passively avoids):
- Internal and external emotional control strategies (e.g., distraction, self-instruction, dissociation, substance use...):
If I do everything right...perfectionism, rule-governance, reason-giving (working too much, under too much stress)
- In session avoidance or emotional control efforts (e.g., topic changes, argumentativeness, dropout risk): **anger at providers**

4. Factors contributing to psychological inflexibility (e.g., excessive rule governance, extremely low tolerance of emotional experiences, lack of present moment awareness, self issues (lacking sense of self/unable to describe feelings/wants), over-analytic/intellectual, etc.)

Good medication adherence, healthy diet, exercise, vitamin supplement: Is this values based behavior or rule-governed?

5. Patient strengths (level of insight – if facilitative rather than fused, ability to be present in the moment, previous history with values-consistent yet painful actions)

6. Environmental barriers to change (e.g., financial circumstances, etc.)

ACT Clinical Demonstration

References and Resources

- A-Tjak, J. G., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A., & Emmelkamp P. M., (2015) A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics*, 84(30), 30-36.
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- Nordin, L., & Rorsman, I. (2012). Cognitive behavioural therapy in multiple sclerosis: a randomized controlled pilot study of acceptance and commitment therapy. *Journal of rehabilitation medicine*, 44(1), 87-90.
- Pakenham, K., Ryan, A., Mawdsley, M., & Brown, F. (2014). Evaluation of an ACT Resilience Training Program (READY) for People with Diabetes or Multiple Sclerosis. Paper presented at ACBS Annual World Conference XIII, Minneapolis, MN.