Part II: Acceptance-Based Behavior Therapy for Depression and Social Anxiety

Kristy Dalrymple, Ph.D.
Alpert Medical School of Brown University & Rhode Island Hospital

Third World Conference on ACT, RFT, and Contextual Behavioral Science

Enschede, The Netherlands, July 2009

Sponsored in part by a Young Investigator Award from NARSAD: The Mental Health Research Association

Overview

- Background on depression and social anxiety comorbidity
- ACT for social anxiety
- Applying behavior therapy from an acceptance-based framework with depression and social anxiety

Why pay particular attention to social anxiety with depression?

- The most common comorbid anxiety disorder (15-33%) (Belzer & Schneier, 2004)
- Onset of social anxiety precedes that of depression at least 2/3 of the time (Brown et al., 2001)
- It's typically underrecognized when depression is present (Zimmerman & Chelminski, 2003)
- Yet a majority of clients want treatment for it as well (Dalrymple & Zimmerman, 2008)

Why is it important to treat both concerns?

- Greater severity
  - Earlier onset of depression, more depressive episodes, longer episode duration, more intense suicidal ideation, co-occurring substance use problems (Dalrymple & Zimmerman, 2007; Stein et al., 2001)
- Greater functional impairment
  - Marital status, lower educational attainment, unemployment, greater healthcare utilization and costs (Alpert et al., 1997; Katzelnick et al., 2001)

How are social anxiety and depression clinically similar?

- Low: positive affect, hope, reward sensitivity, curiosity
- High: self-focused attention, avoidance, social disengagment, unassertiveness, reassurance-seeking
- Interpersonal rejection sensitivity

How does social anxiety negatively impact the treatment of depression?

- Clinical: conducting behavioral tasks/activity scheduling
- Research:
  - DeRubeis et al., 2005: Those in CBT condition fared worse when social anxiety was present
  - Holma et al., 2008: Comorbid social anxiety increased risk of recurrence

Why ACT for Social Anxiety?

- 20-25% of clients do not respond to traditional CBT
- Component analyses suggest no clear advantage of cognitive restructuring over exposure
- Quality of life improves only in interpersonal domains
- Acceptance-based approaches may increase receptiveness to exposure (Eifert & Heffner, 2003)
  - Willingness to experience anxiety
  - Linking exposure to personally-identified values

Dalrymple & Herbert, 2007

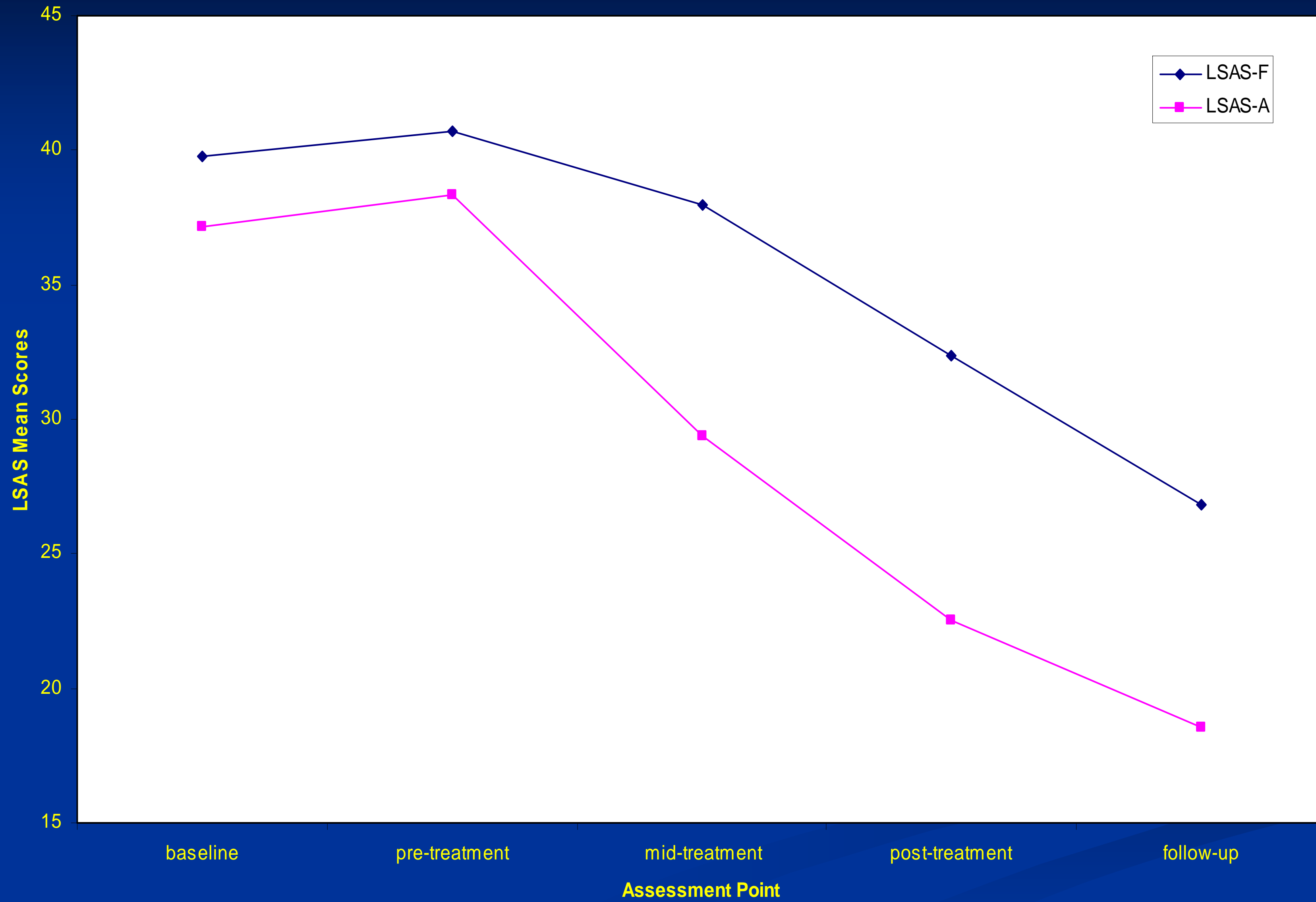
- Open trial of 19 adults, baseline wait period
- Generalized subtype of social anxiety
- 12 sessions of individual treatment integrating ACT and exposure
- Assessments at pre, mid, post-treatment, and follow-up: social anxiety severity, BDI, functional impairment, behavioral assessments, process measures

Dalrymple, K.L., & Herbert, J.D. (2007). Acceptance and Commitment Therapy for Generalized Social Anxiety Disorder: A Pilot Study. *Behavior Modification, 31,* 543-568.

Results

- No changes during baseline period
- Significant decreases in severity, functional impairment, discrepancy in values
- Significant increases in quality of life, social skills, and self-rated performance
- Avoidance decreased earlier than fear

Liebowitz Social Anxiety Scale



Exploratory Process analyses

- Decreased experiential avoidance
- Earlier changes in experiential avoidance predicted later changes in social anxiety severity

Acceptance-based behavior therapy for depression and social anxiety

- Combines behavioral activation and exposure strategies, delivered from acceptance-based framework
- 16 individual sessions
- Addresses problematic processes that underlie both concerns (e.g., behavioral/experiential avoidance, over-attachment to conceptualized self)
- Emphasis on improving functioning

Phases of treatment

- Follow the general phases in the Hayes et al. 1999 ACT book
- Behavioral exercises throughout all phases
- Balance of flexibility and enough structure for research purposes

Phase I: Creative hopelessness & early values identification

- Describe depression & anxiety "loops"
- TRAP exercises to highlight behavioral *and* experiential avoidance
- Metaphors: Tug of War, Polygraph, Chinese Handcuffs
- *Begin* to elicit potential value domains and values

Phase II: Willingness paired with behavioral tasks

- Foster willingness to increase motivation for behavior change
  - Metaphors: Two Scales, Clean vs. Dirty Discomfort
- Pair willingness exercises with behavioral exercises that are linked to initial values
  - "Embrace the cold" exercise

ACT-Based Exposure

- Choose a situation to practice based on values
- Choose a social skill to practice
- Encourage non-judgmental observation of thoughts, feelings, physical sensations
- Review what was observed
- Provide feedback on skills
- Watch out for distraction

Phase III: Defusion and the observer self

- Exercises to foster observing private experiences, rather than buying into them
  - Milk Exercise
  - Soldiers in the Parade
  - Your Mind as a Tantruming Child
- Exercises/metaphors to decrease attachment to the conceptualized self
  - Bad Cup Metaphor

Phase IV: Further values clarification

- More formal values clarification
  - Funeral Exercise
- Pick a valued domain→identify values→long-term goals→short-term goals→subactions related to the ST goals→role played in session and practiced for homework
- Re-emphasize link between willingness and value-guided behavior
  - Bubble in the Road

Phase V: Post-treatment planning

- Create post-treatment plan using same values and goals process as in Phase IV
- Emphasize that this is a process
  - Skiing Metaphor
- How to get back on the trail when you've noticed you've wandered off
  - Path Up the Mountain Metaphor
  - Link to post-treatment plan

Open Trial Methods

- Referred after initial session with psychiatrist
- Inclusion
  - 18 or older
  - Symptoms of depression and social anxiety
  - Other comorbidities allowed
- Exclusion
  - Psychosis, bipolar disorder, substance dependence

Open Trial Methods

- Informed consent/diagnostic interview
- Self-report & clinician measures
  - Depression & social anxiety severity
  - Quality of life and functioning
  - Experiential avoidance
- 16 sessions of individual therapy in addition to pharmacotherapy as usual
- Assessments at pre, mid, & post

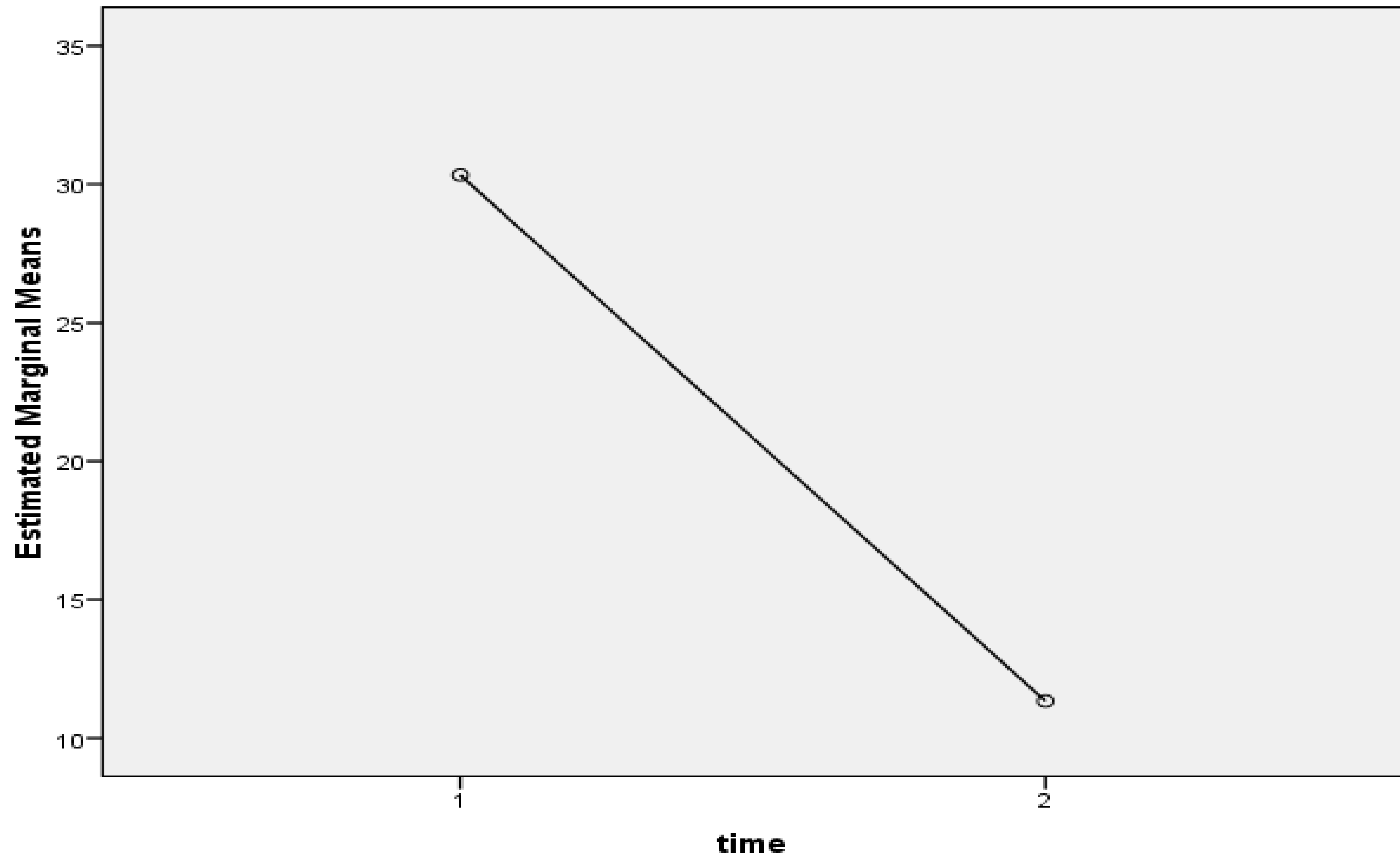
Preliminary Findings

- 10 participants recruited
- 7 completers
- 4 males, 6 females
- Mean age: 45
- 7 employed full time, 1 student, 2 retired
- 3 married, 2 living with partner, 5 single

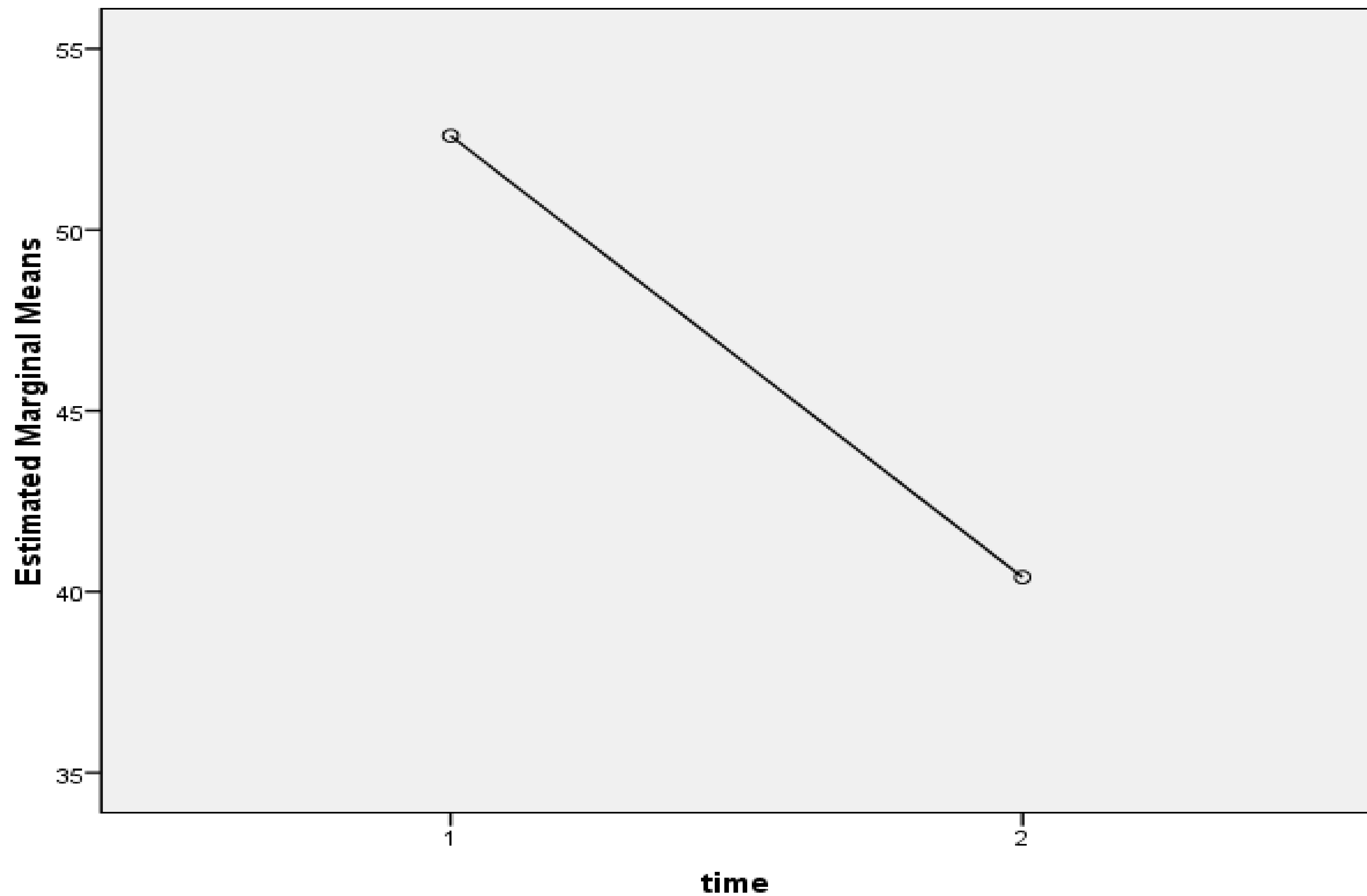
Preliminary Findings

- Depression severity
  - Cohen's $d = 1.5$
- Social anxiety-fear
  - Cohen's $d = .52$
- Social anxiety-Avoidance
  - Cohen's $d = 1.1$
- Experiential avoidance
  - Cohen's $d = .60$

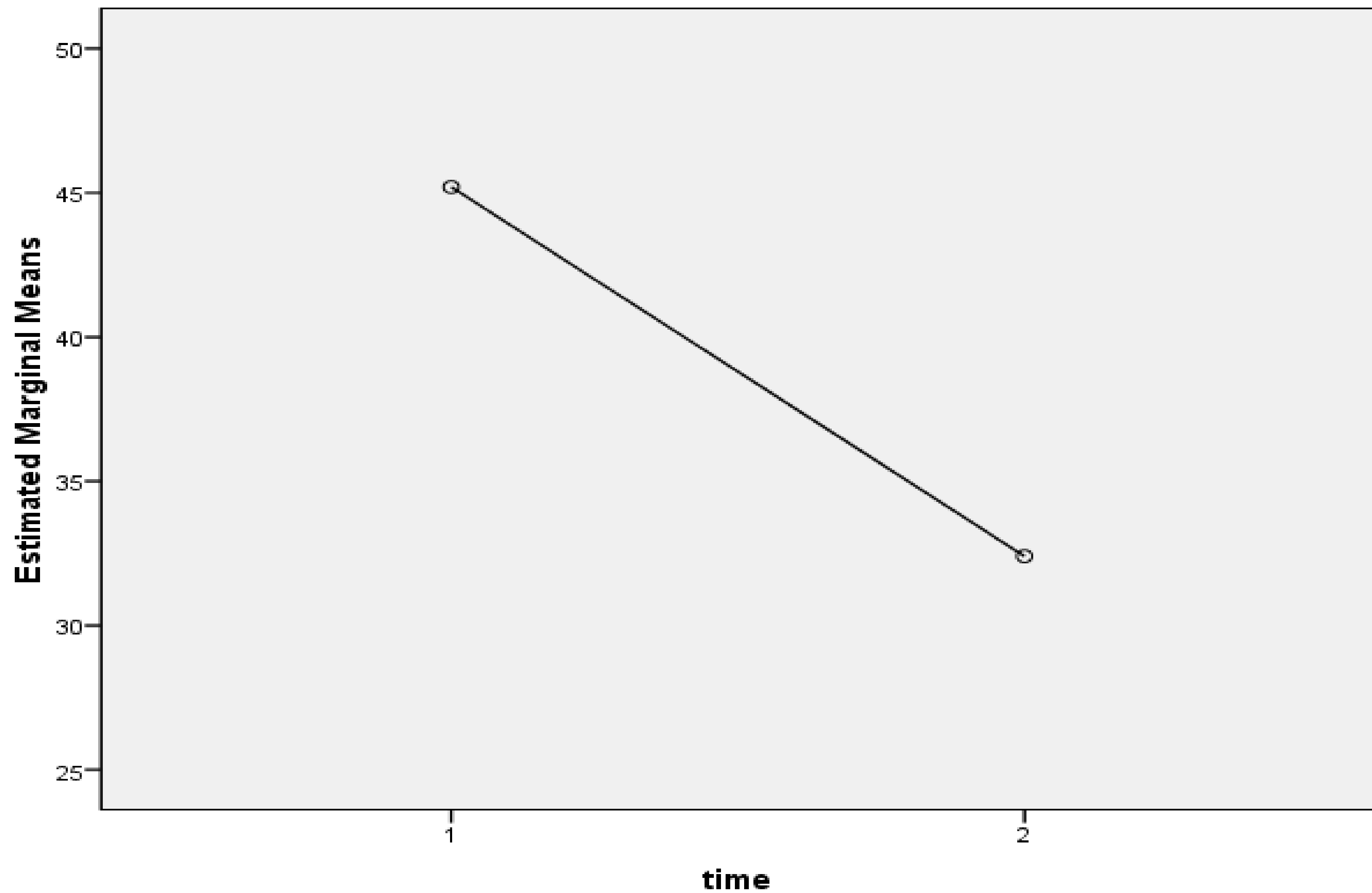
Inventory of Depressive Symptomatology



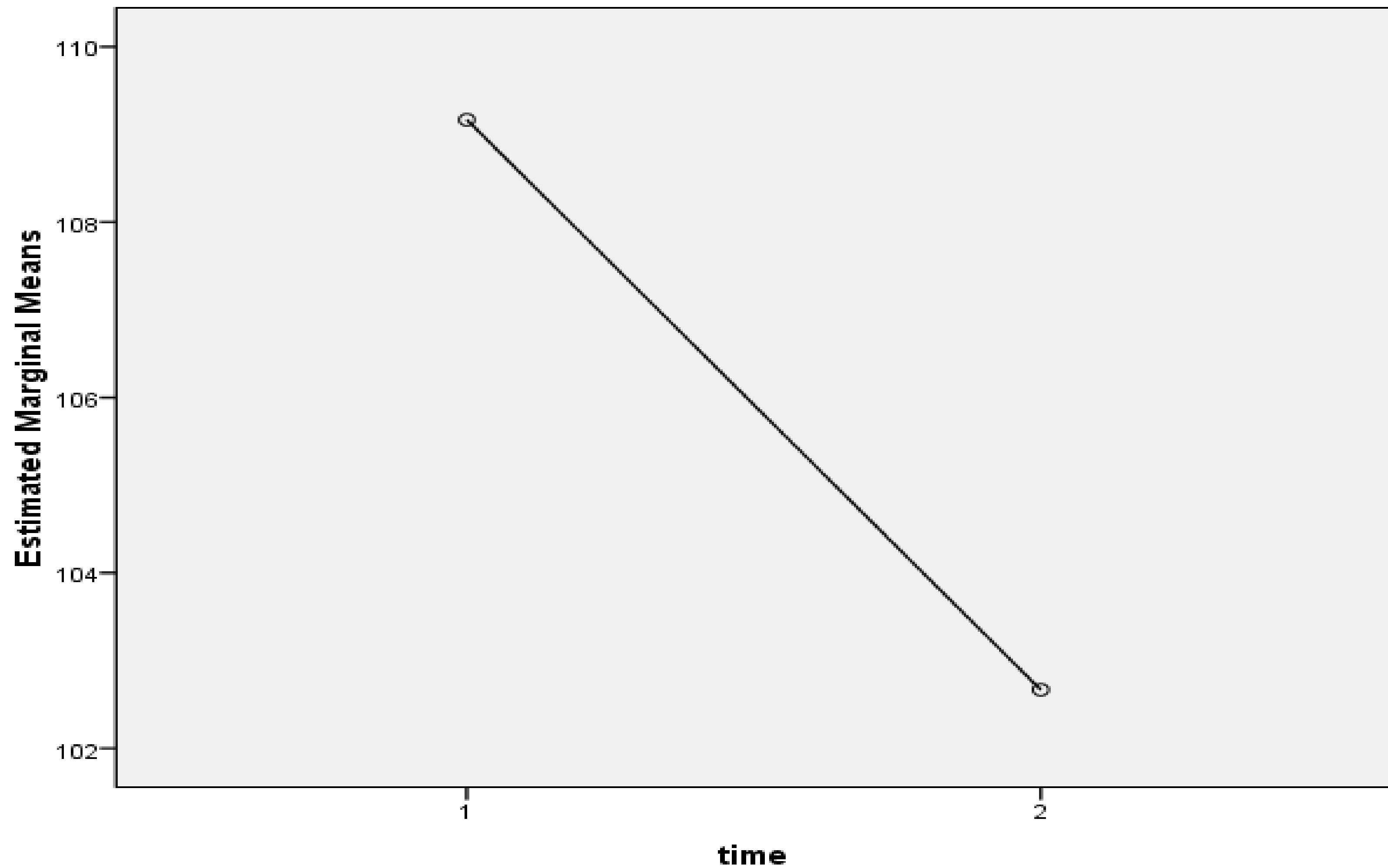
Liebowitz Social Anxiety Scale-Fear



Liebowitz Social Anxiety Scale-Avoidance



Experiential Avoidance



Future Directions

- Randomized trial underway
  - Meds+ Enhanced Assessment vs. Meds+Therapy
- Continue to examine outcomes, as well as processes
- Long-term future: component analyses

Many Thanks To:

- Mark Zimmerman, M.D.
- Van Miller, Ph.D.
- Janine Galione, B.S.