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# Applying ACT to Cases of Complex Depression: New Clinical and Research Perspectives

## Part I: Depression with Psychosis and Suicidality

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Grant Support: NIH K23 MH076937

# Outline

- Clinical Features of Psychotic Depression
- ACT for Psychosis Research
- Treatment Development Project
- Clinical Considerations
- Case Example

# Depression with hallucinations and/or delusions



# Psychotic Depression

## ➤ Prevalence rates

- 15-19% of individuals with depression have hallucinations or delusions (Ohayon and Schatzberg, 2002)
- Up to 25% of depressed hospitalized patients (Coryell et al., 1984)

- Psychotic depression can be difficult to diagnose and treat:
  - psychotic features in mood disorders can be more subtle than those found in patients with primary psychotic disorders



➤ Psychotic depression can be difficult to diagnose and treat:

- psychotic features in mood disorders can be more subtle than those found in patients with primary psychotic disorders
- patients often underreport psychotic symptoms due to embarrassment or paranoia



➤ **Psychotic depression can be difficult to diagnose and treat:**

- psychotic features in mood disorders can be more subtle than those found in patients with primary psychotic disorders
- patients often underreport psychotic symptoms due to embarrassment or paranoia
- clinicians frequently fail to fully assess for the presence of psychotic symptoms in patients with mood disorders



How does depression with  
versus without psychotic  
features differ clinically?



# Psychotic vs. Nonpsychotic Depression

- More likely to be non-white
- Less education
- Earlier age of depression onset
- More severe current depression severity
- More current social impairment
- More insomnia, concentration problems, psychomotor disturbance
- More time out of work
- More chronic depression (> 2 years)
- More severe current suicidal ideation
- More past hospitalizations and suicide attempts
- More anxiety disorders and personality dysfunction
- More childhood trauma

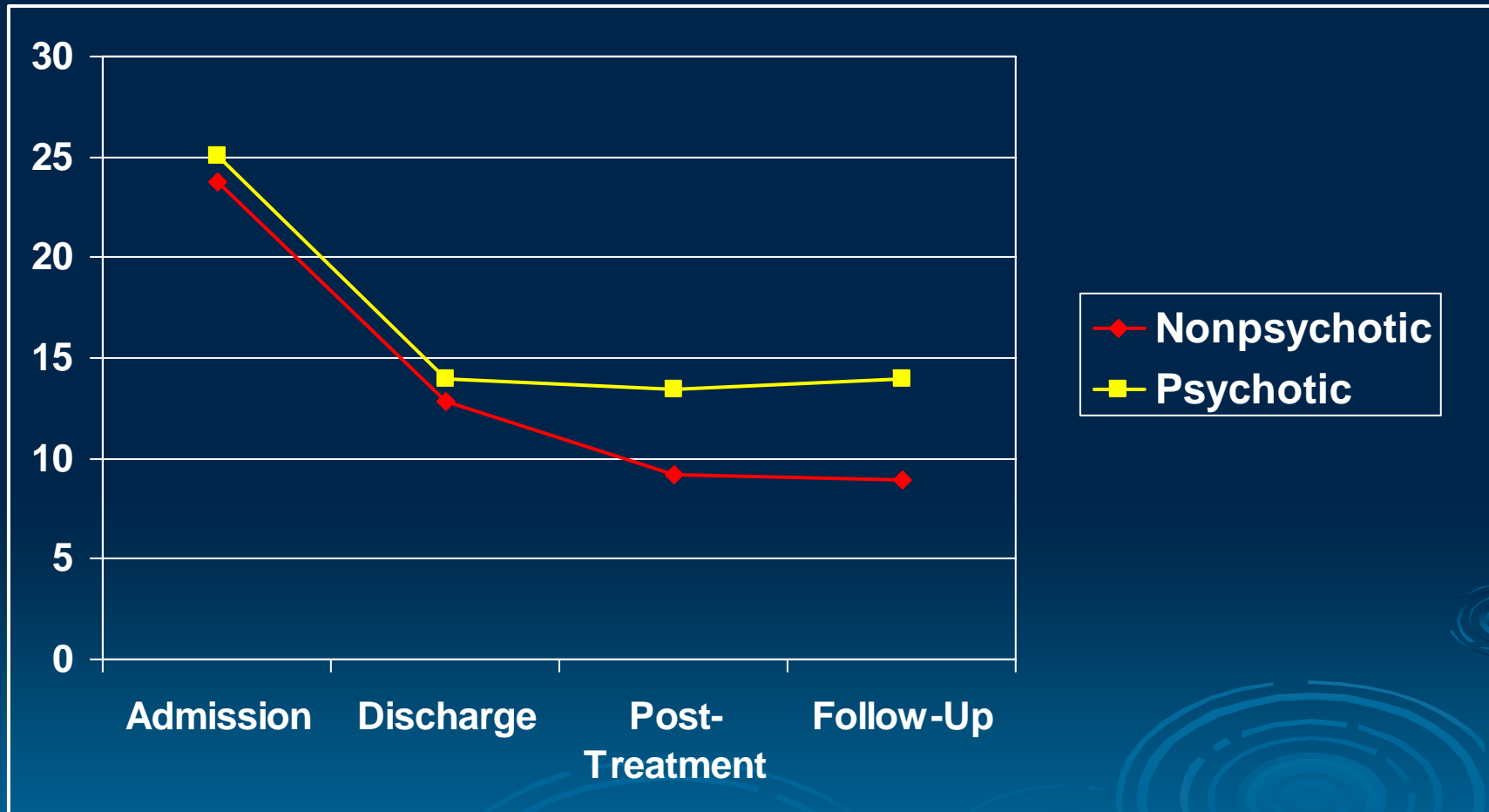
Gaudiano BA, et al. *Depress Anxiety* 2009, 26, 54-64.

Gaudiano BA et al. *Comprehensive Psychiatry* 2008;49:421-429

Patients with psychotic depression show a poorer response to conventional treatment with medications and psychotherapy

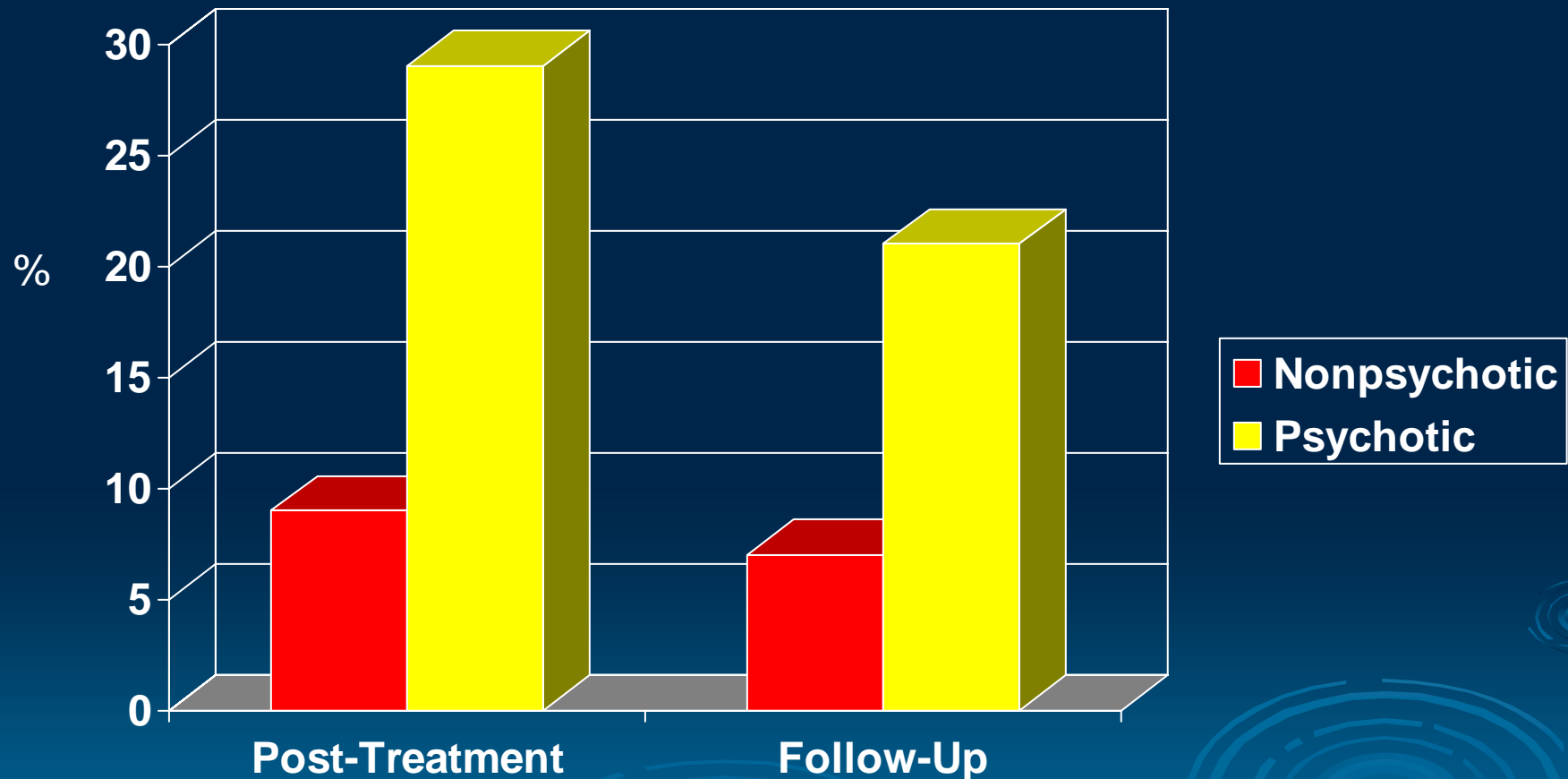


## Combined Pharmacotherapy and Psychotherapy Depression Severity in Psychotic versus Nonpsychotic Depression



Gaudiano, BA et al. J Nervous Mental Disease 2005;193:625-628.

# Post-Treatment High Suicidal Ideation and Depression Severity in Psychotic versus Nonpsychotic Depression



Gaudiano, B.A. et al. J Nervous Mental Disease 2005;193:625-628.

# Current Somatic Treatments for Psychotic Depression

- Medications and electroconvulsive therapy
  - Antidepressant plus antipsychotic may be more effective than either drug alone
  - ECT also effective for short term treatment (maybe more than medications)
- Limitations
  - Treatment adherence
  - Side effects
  - Acceptability issues
  - Treatment preferences
  - Continued residual or chronic symptoms after treatment
  - High relapse rates after treatment discontinuation
  - Don't fully address problems of complex patients
  - Treatment resistance
  - Polypharmacy issues

# ACT for Psychosis



# Why ACT for Psychosis?

- Symptoms of psychosis often are not permanently or completely eliminated with current treatments
- Many patients who remain out of the hospital despite their symptoms report using more acceptance-based coping strategies
- Newer approaches for psychosis place more emphasis on acceptance and improved functioning rather than symptom reduction
- Treatments are needed for patients in acute phases of illness when they are more difficult to engage in psychotherapy

# ACT vs Traditional CBT for Psychosis

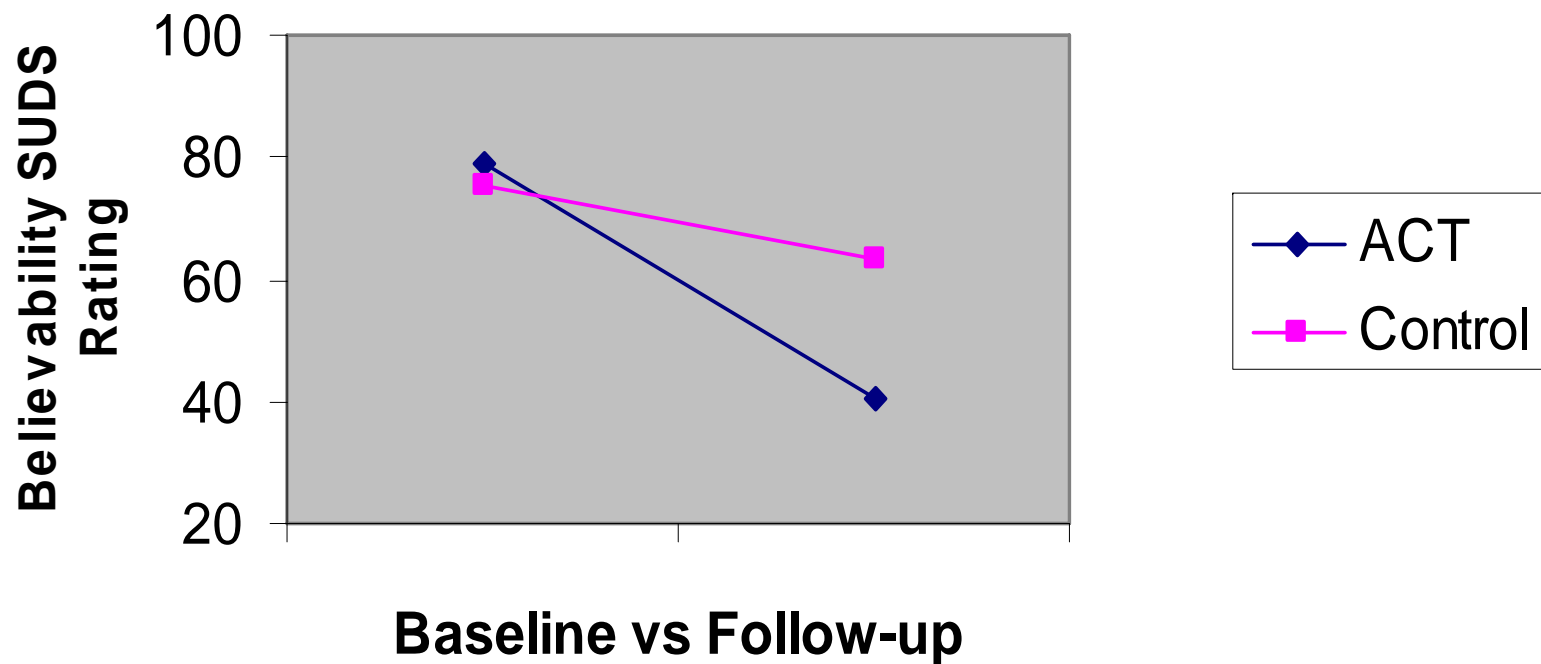
- Traditional cognitive therapy
  - Use rational deliberation, logical reasoning, and Socratic questioning and behavioral experiments to change patient's beliefs about hallucinations and delusions
- ACT
  - Encourage patient to be nonjudgmentally aware of psychotic symptoms in the moment while simultaneously working toward valued goals

# Bach & Hayes (2002)

- 80 inpatients with psychotic disorder randomly assigned to TAU or TAU+ACT (4 sessions)
- Assessments at baseline and 4 months post-hospitalization
  - Self-ratings of psychotic symptoms frequency, believability, and distress
  - Rehospitalization rates

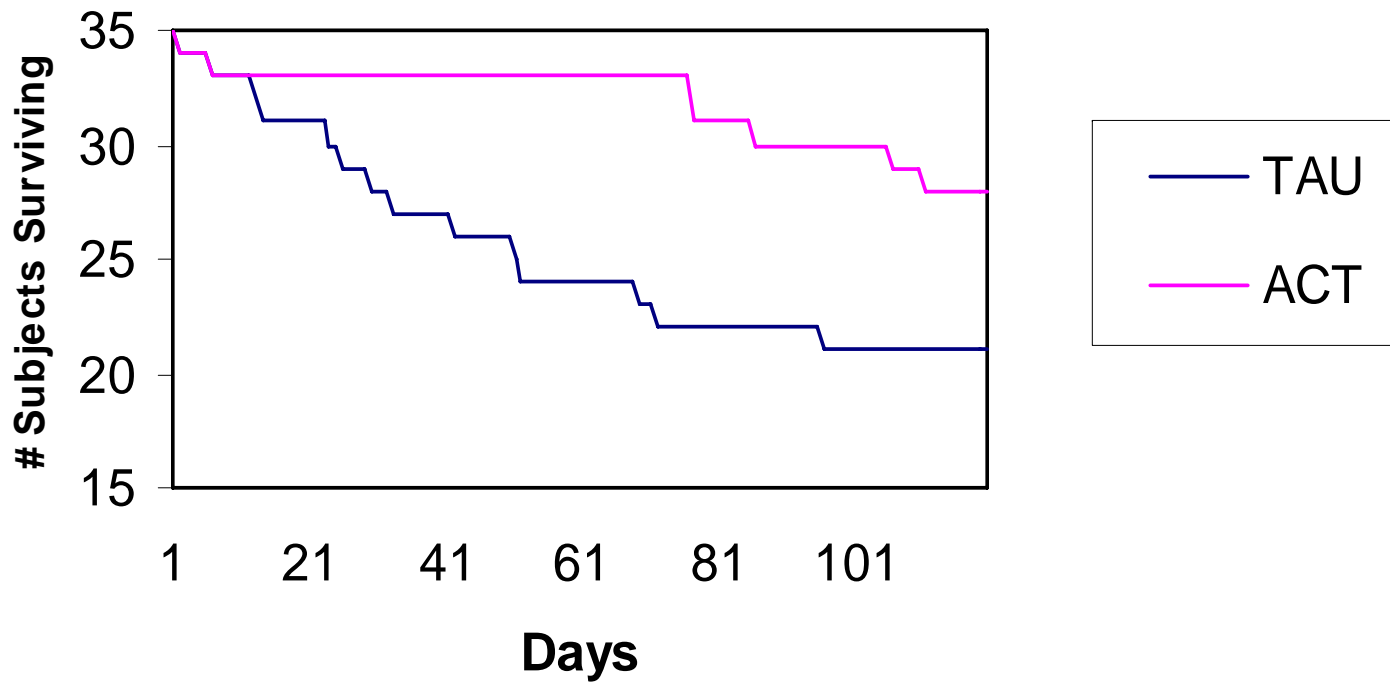
# Psychotic Symptom Believability

## Change in Believability Rating



# Rehospitalization Rates

Survival Curve: Days to Hospitalization



# Gaudiano & Herbert (2006)

- Randomized psychiatric inpatients with psychotic symptoms (schizophrenia, schizoaffective disorder, delusional disorder, psychotic depression, bipolar disorder with psychosis) to treatment as usual with versus without ACT (3 sessions)
- Assessments admission and discharge
  - Brief Psychiatric Rating Scale
  - Sheehan Disability Scale
  - Self-ratings of psychotic symptom: frequency, believability, and associated distress
  - Insurance records of psychiatric rehospitalizations (4 month follow-up)

Gaudiano, B. A., & Herbert, J. D. (2006). Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy: Pilot results. *Behaviour Research and Therapy*, 44, 415-437.

# Sample Description

- N = 40 (TAU = 19 and ACT = 21)
- Mean age = 40
- Mostly male: 64%
- 88% African-American
- 35% not graduating HS
- 86% receiving disability compensation
- 29% homeless
- 12% married
- Drop outs: TAU = 1 and ACT = 1

# Brief ACT for Psychotic Inpatients

## Patients were taught:

1. To accept unavoidable psychological distress
2. To simply notice psychotic symptoms without treating them as either true or false
3. To identify and work toward valued goals despite their symptoms.

Bach, P., Gaudiano, B., Pankey, J., Herbert, J. D., & Hayes, S. C. (2006). Acceptance, mindfulness, values, and psychosis: Applying Acceptance and Commitment Therapy (ACT) to the chronically mentally ill. In R. A. Baer (Ed.), *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications* (pp. 93-116). San Diego: Academic Press.

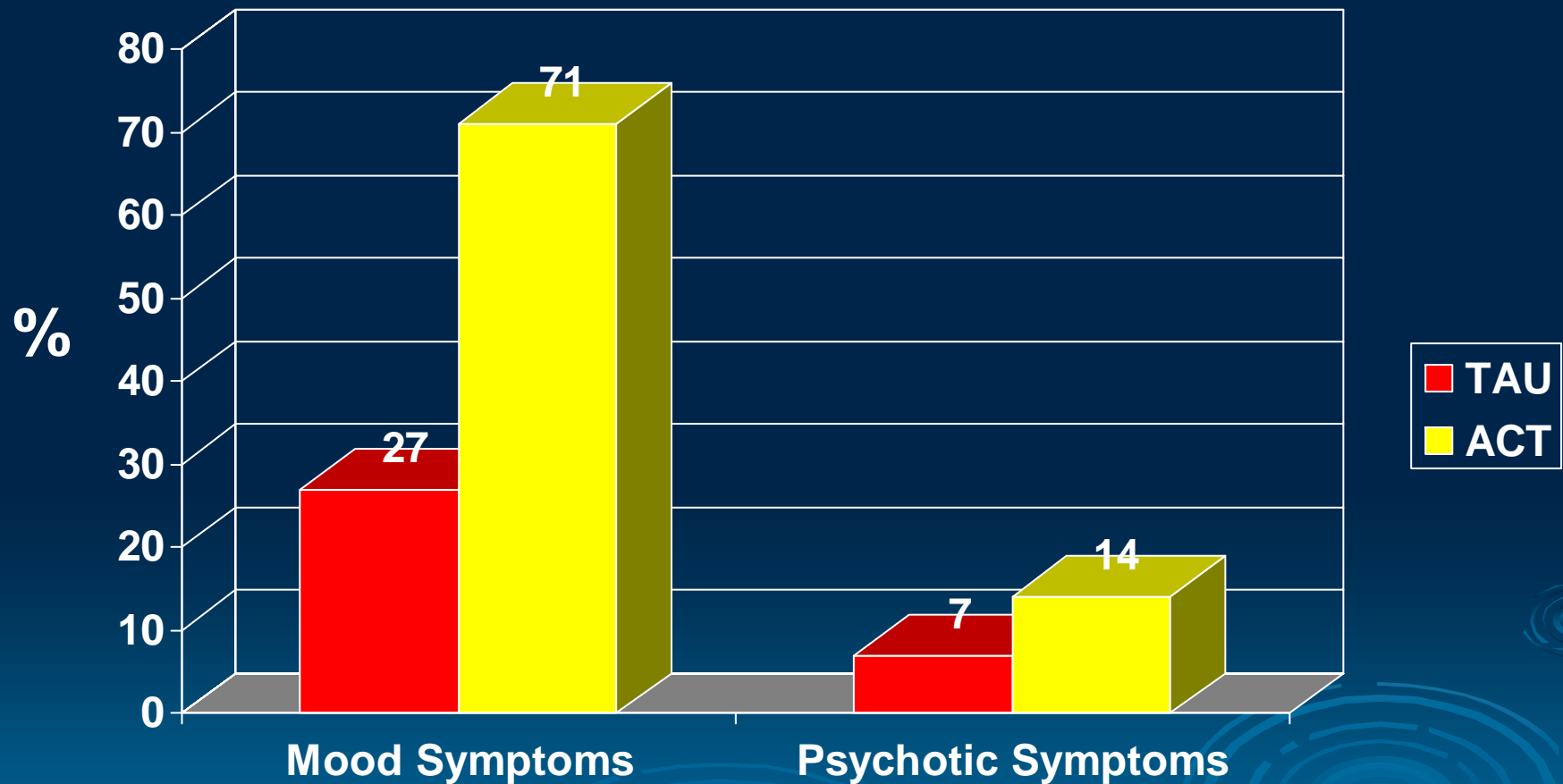
# Change in Distress Related to Hallucinations



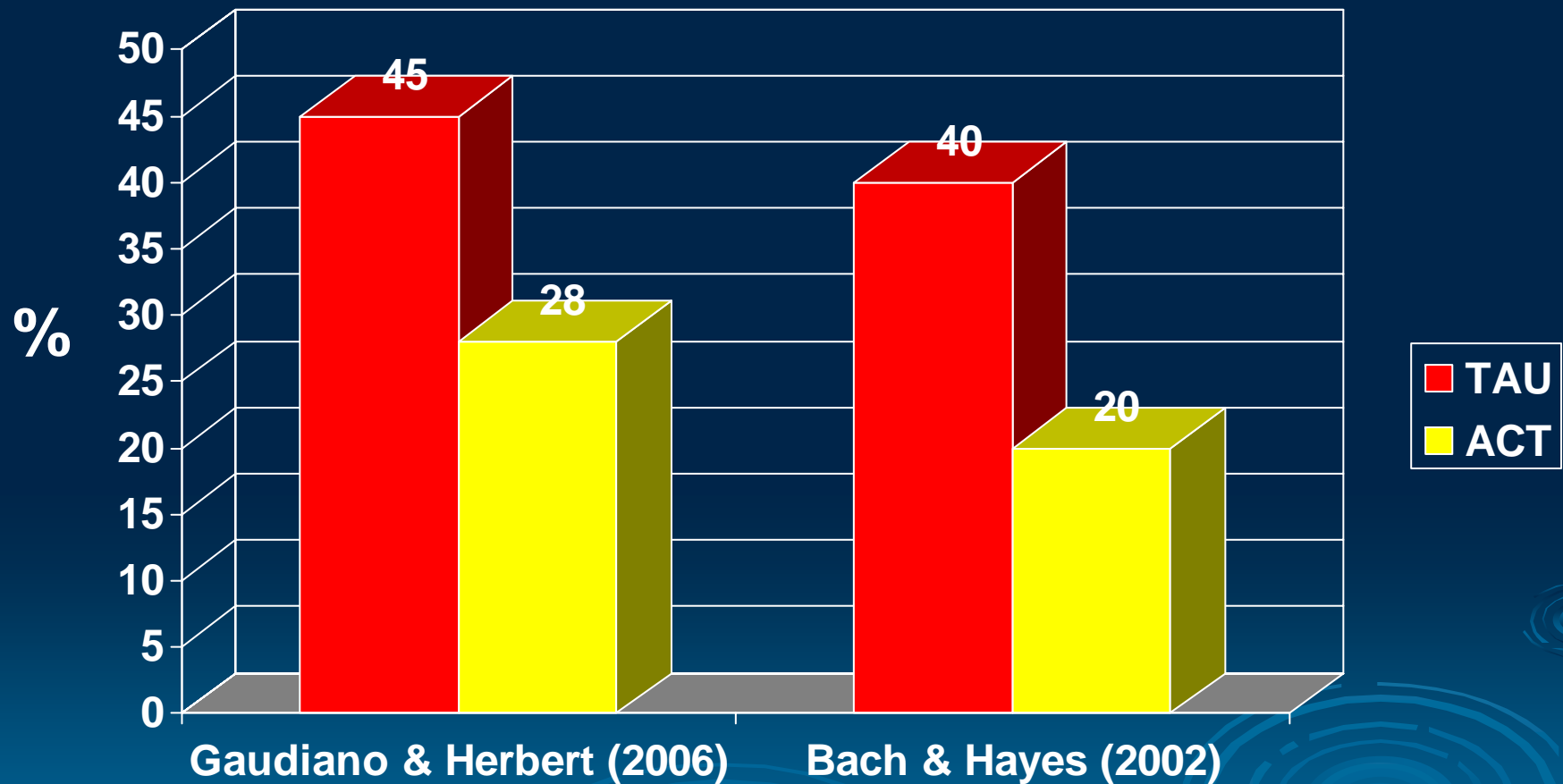
# Change in Perceived Disability Related to Illness



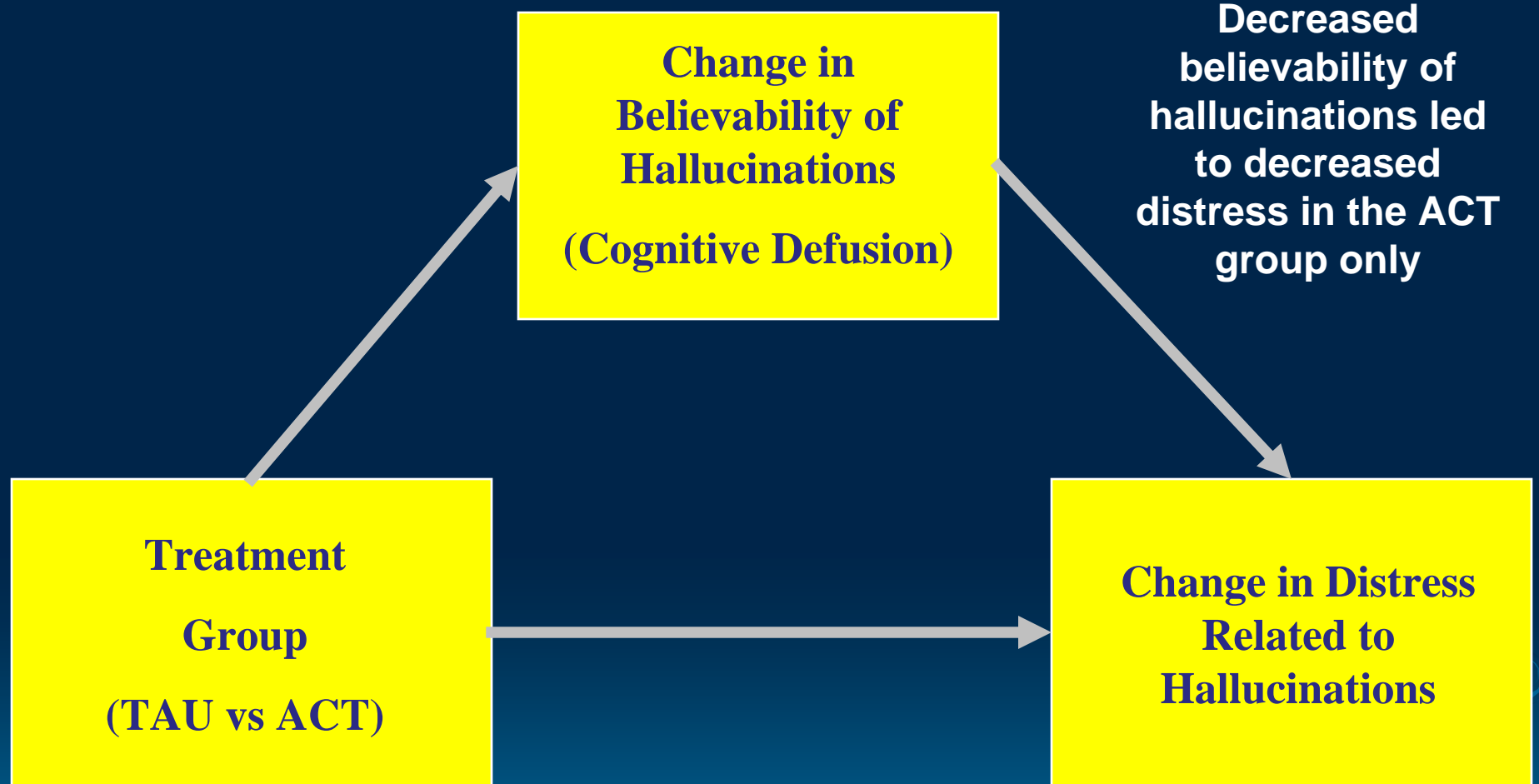
# Clinically Significant Change in Symptoms Pre-Post (> 2 SD)



# Rehospitalization Rates at 4 Month Follow-up



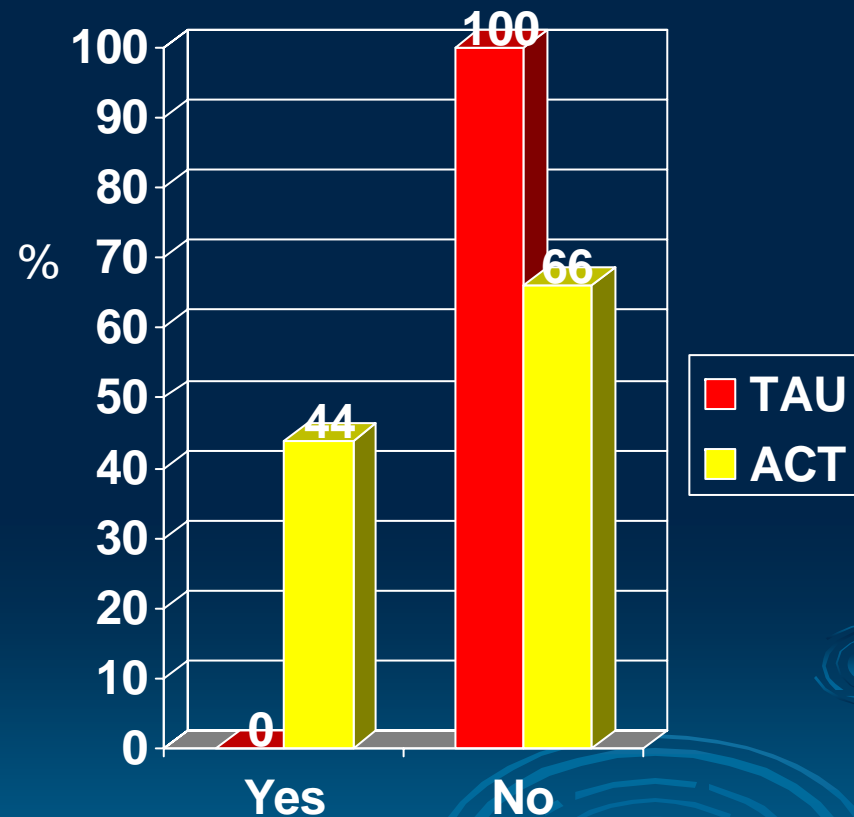
# ACT-Consistent Mediation of Treatment Effects



ACT produced greater reductions in hallucination-related distress compared with TAU alone

# Clinically Significant Improvement in Subgroup with Psychotic Depression

- ACT group showed greater clinically significant improvement on BPRS compared with TAU



Gaudiano, B. A., Miller, I. W., & Herbert, J. D. (2007). The treatment of psychotic major depression: Is there a role for adjunctive psychotherapy? *Psychotherapy and Psychosomatics*, 76, 271-277.

# Current Treatment Development: Adjunctive Psychotherapy for Psychotic Depression

- U.S. National Institute of Mental Health grant funded study
- Phase I
  - Conduct an open trial of medication (antidepressant + antipsychotic) plus outpatient therapy with ACT (n = 15)
- Phase II
  - Conduct a pilot randomized-controlled trial of medication alone versus medication plus ACT (n = 30)
- Phase III
  - Prepare to conduct a full-scale randomized-controlled trial in a subsequent grant application

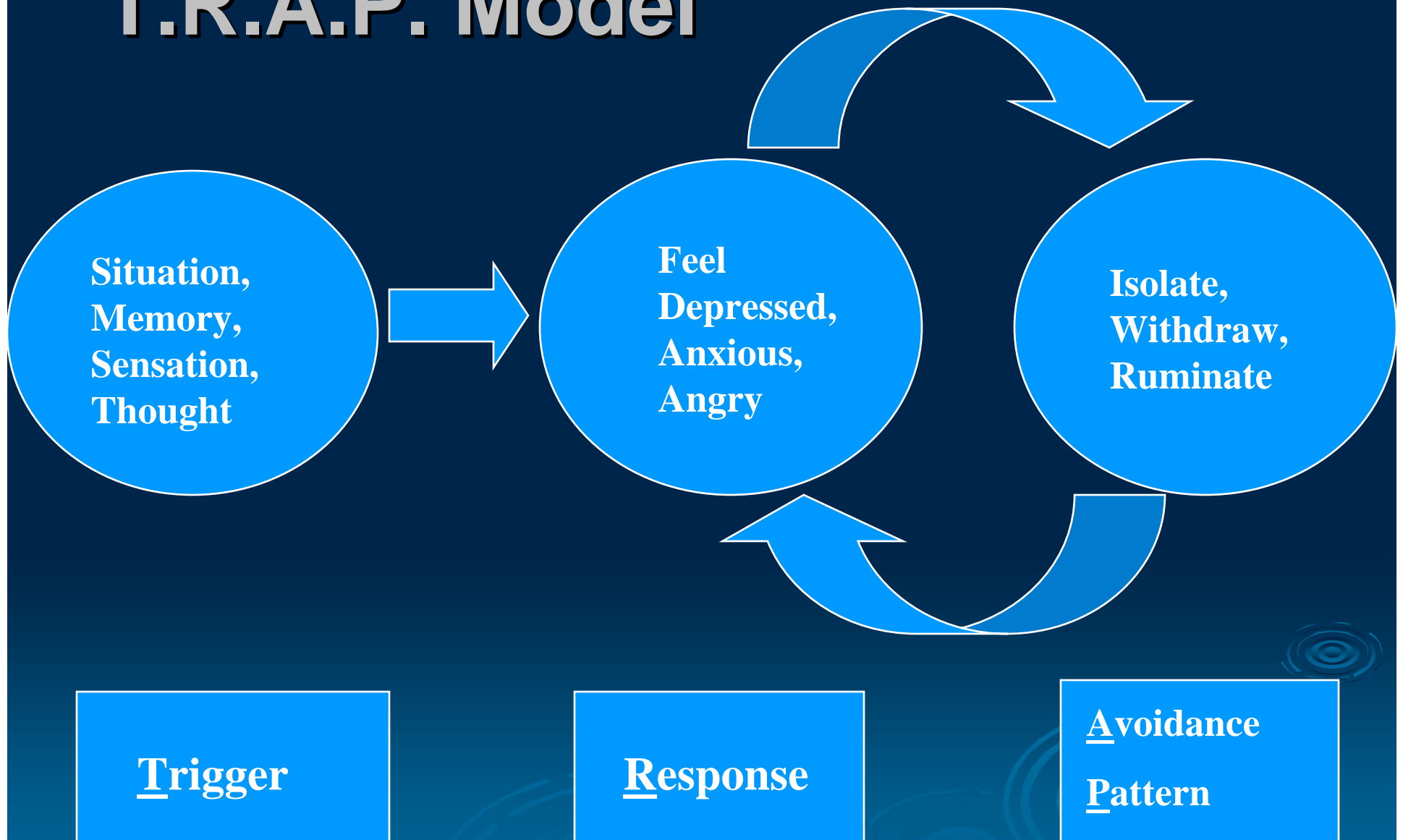
# ADAPT

- Acceptance-Based Depression and Psychosis Therapy (ADAPT)
  - Acceptance and Commitment Therapy
    - 2 clinical trials showing efficacy for psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) and 2 early clinical trials showing efficacy for depression (Rob Zettle)
  - Behavioral Activation
    - Identify avoidance behaviors that lead to isolation and withdrawal; introduce graded activities scheduling to resume normal functioning
    - Clinical trials showing as efficacious as cognitive therapy or antidepressant medications for severe depression (Jacobson et al., 1996; Dimidjian et al., 2006)

# Therapy Outline

- Acute Treatment Phase (Sessions 1-4)
  - Rapport building and goal setting
  - Acceptance as an alternative to avoidance
  - Values clarification for increasing motivation
- Skills Building Phase (Sessions 5-17)
  - Identifying avoidance behaviors
  - Activities scheduling
  - Mindfulness for rumination
  - Values clarification for suicidality
  - Acceptance-based strategies for psychotic symptoms
- Termination Phase (Session 18-20)
  - Planning for longer-term goals and values (e.g., employment)
  - Relapse prevention skills

# T.R.A.P. Model



Depression in Context: Strategies for Guided Action. Martell, C.R., Addis, M. E., & Jacobson, N.S. (2001). New York: W. W. Norton & Company, Inc.

# T.R.A.C. Model



These  
processes are  
interconnected

Contact with the  
Present Moment

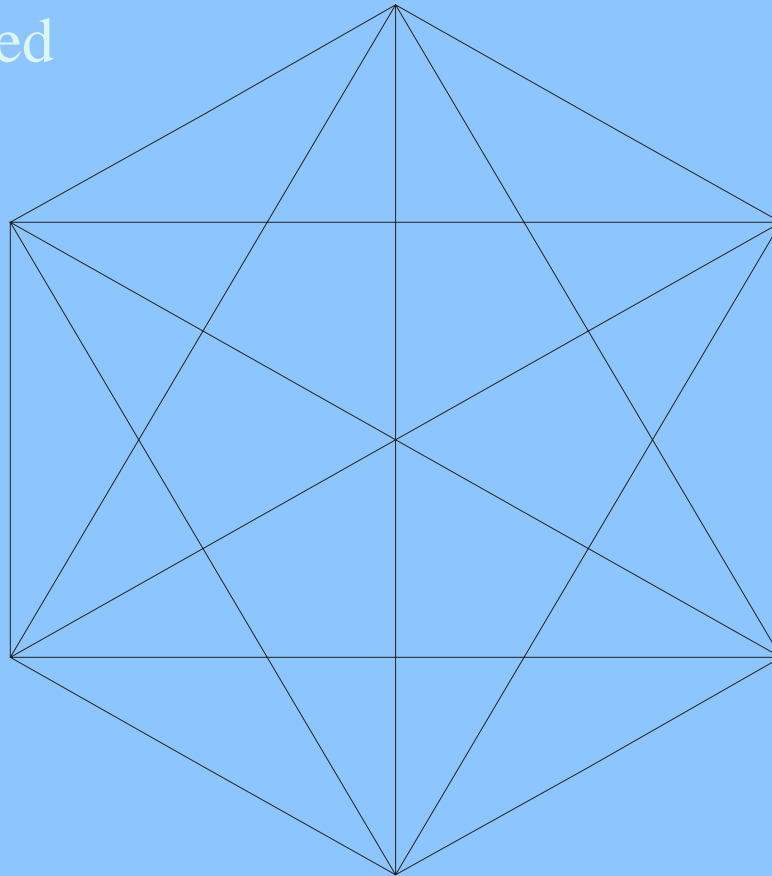
Acceptance

Values

Defusion

Committed  
Action

Self as  
Context



# ACT-Based Behavioral Activation

- Values Clarification
  - Focus on process versus outcome
- Acceptance/Defusion
  - Dealing with interfering rumination
- Present-Moment Awareness
  - Mindfulness when engaging in activities
- Committed action
  - Emphasize choices
- Dealing with interfering psychotic symptoms

# ACT for Psychotic Experiences

- Make room for psychotic experiences without treating them as true or false and committing to valued action
- Hallucinations
  - Acceptance, Self-as-Context, Mindfulness
- Delusions
  - Values, Committed action, Defusion



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# Helpful Metaphors/Exercises

- Tug of War with a Monster Metaphor (acceptance)
- Chessboard Metaphor (self-as-context)
- Skiing Metaphor (values)
- Switchback Hiking Metaphor (committed action)
- Physicalizing Exercise (defusion)
- Carry Your Keys Exercise (acceptance)
- Leaves in the Stream (present moment)
- Take your Mind for a Walk (defusion)
- “I can’t hold this pen” Exercise (defusion)

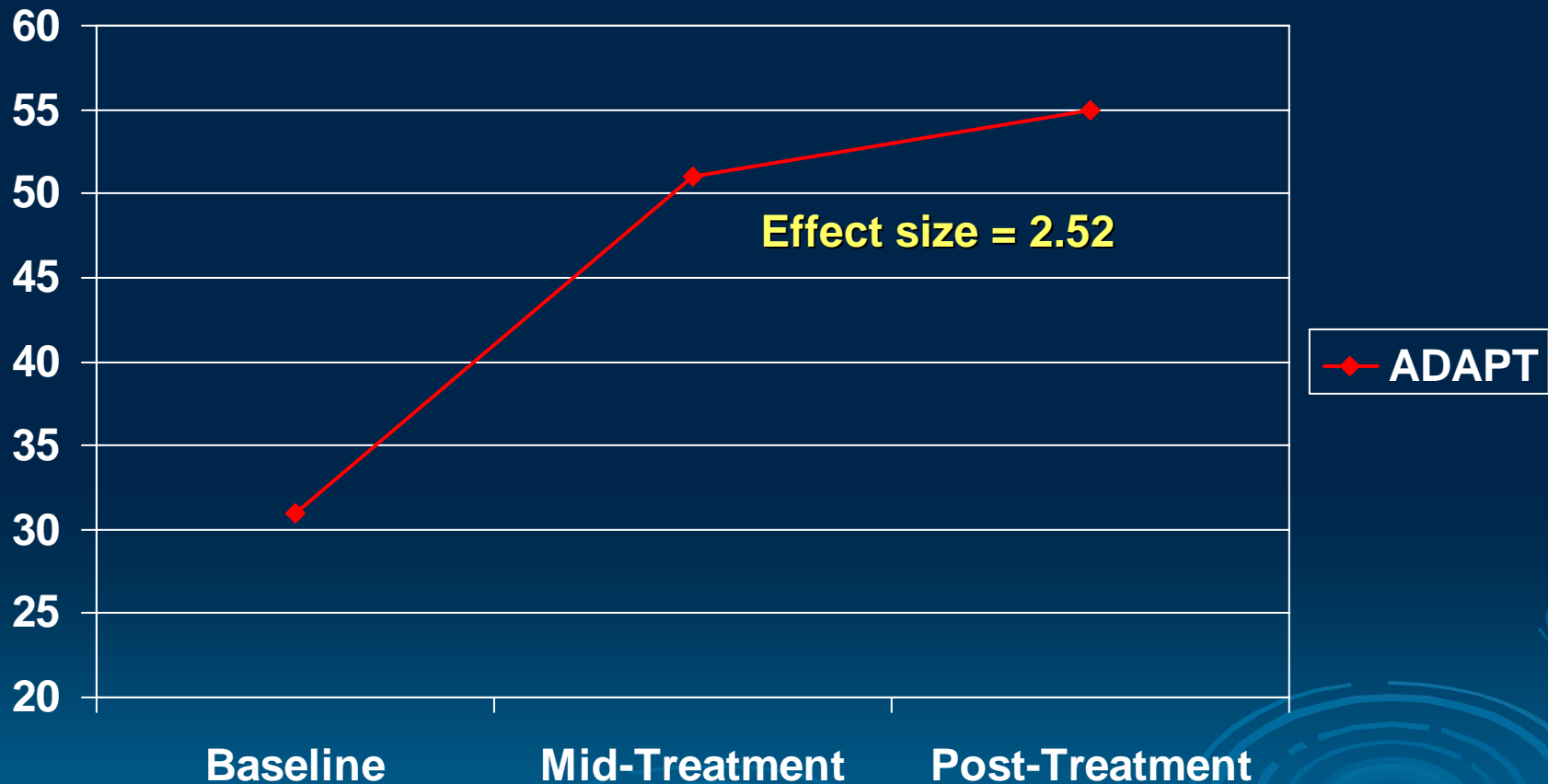
# ACT for Suicidality

- What is the function of suicidality?
  - Often experiential avoidance
- Values/goals clarification
  - “Titration” of values work
- Acceptance/Defusion
  - In session, small amounts at first
- Focus on behavioral activation
  - Making changes in behavior regardless of mood

# Preliminary Results of Open Trial: ADAPT + Pharmacotherapy

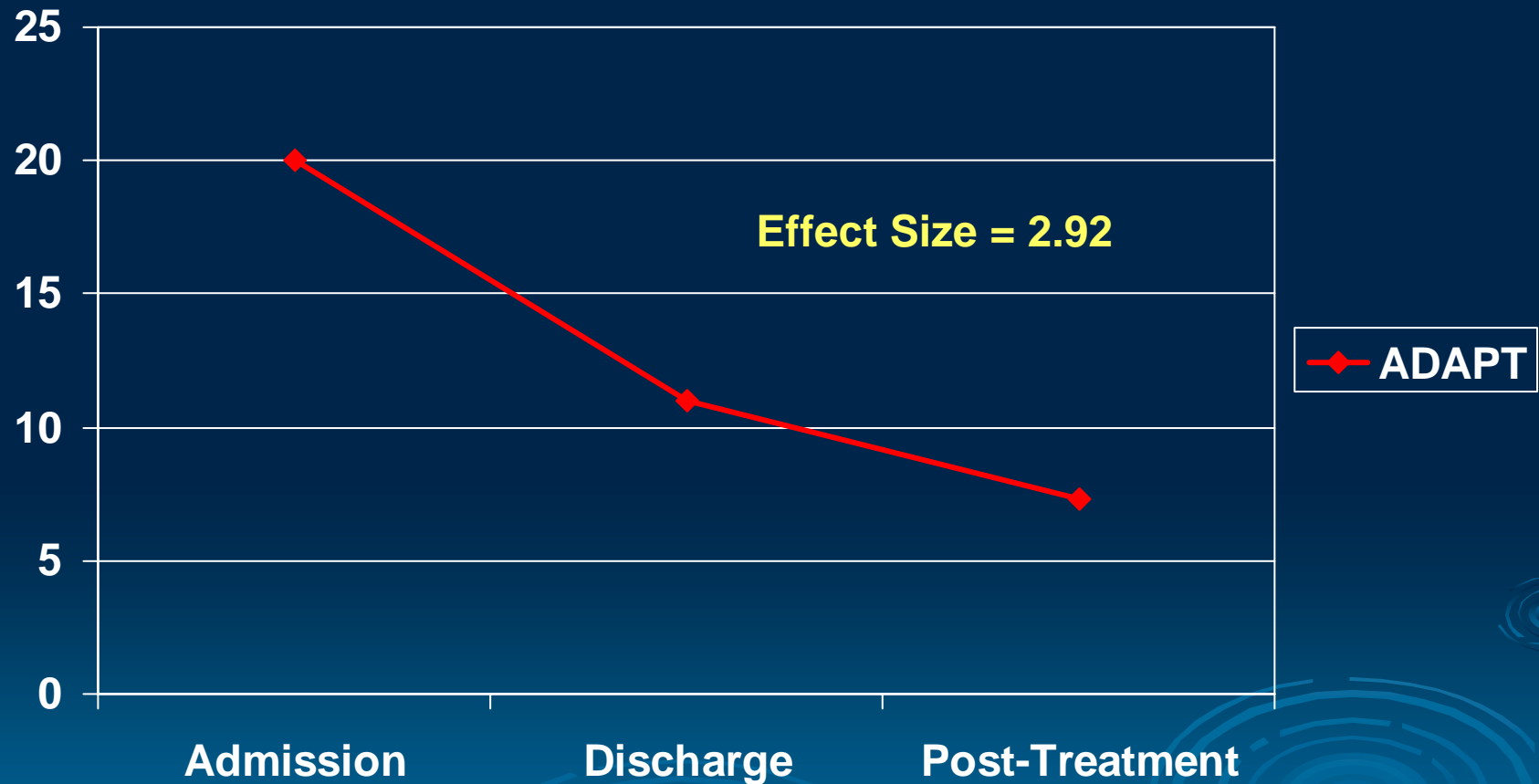
Open Trial n = 8 completed  
Diagnosed with Major Depressive  
Disorder, severe with psychotic  
features

# Psychological Flexibility (Acceptance and Action Questionnaire-II)



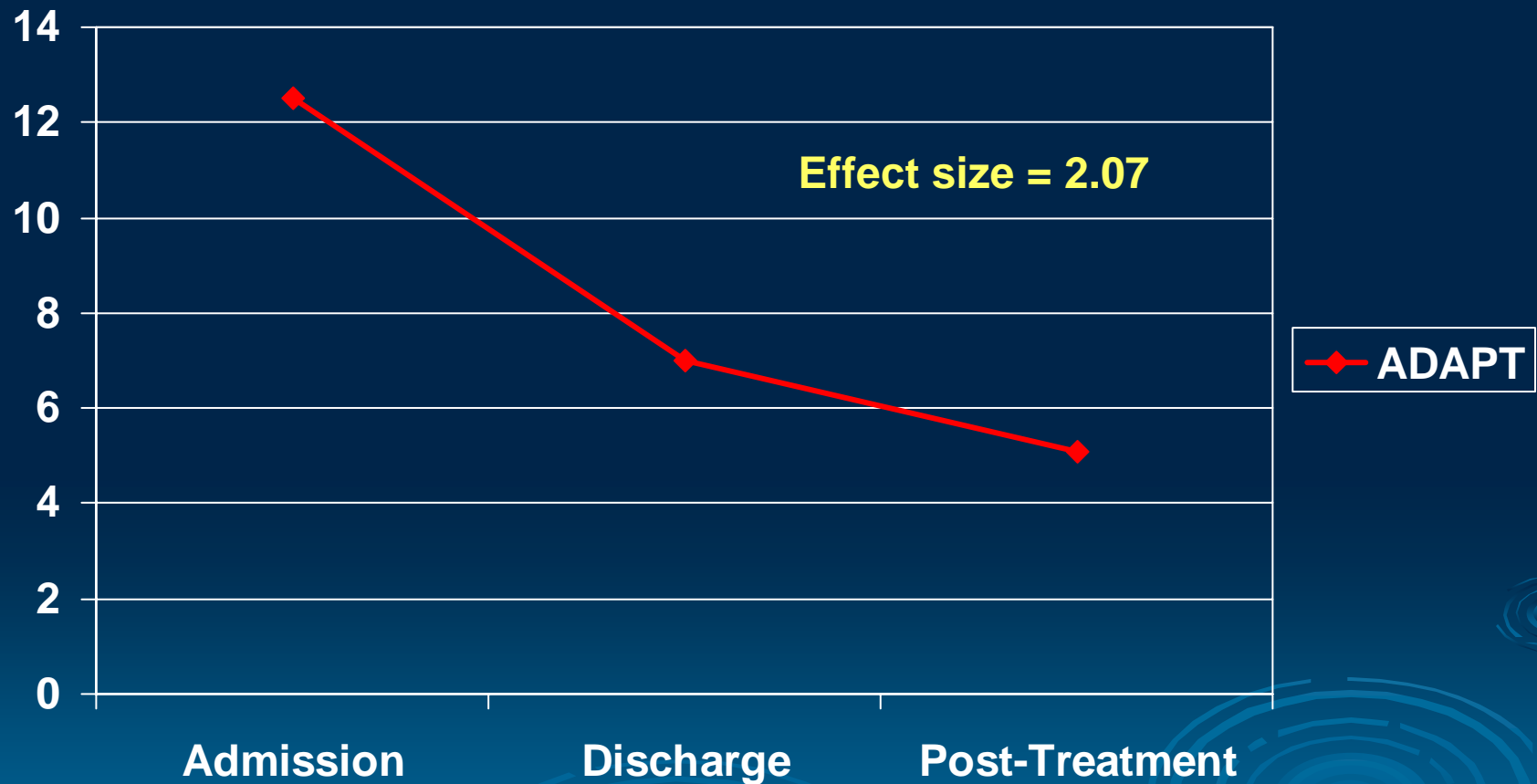
# Depression Severity

(Quick Inventory of Depressive Symptomatology)

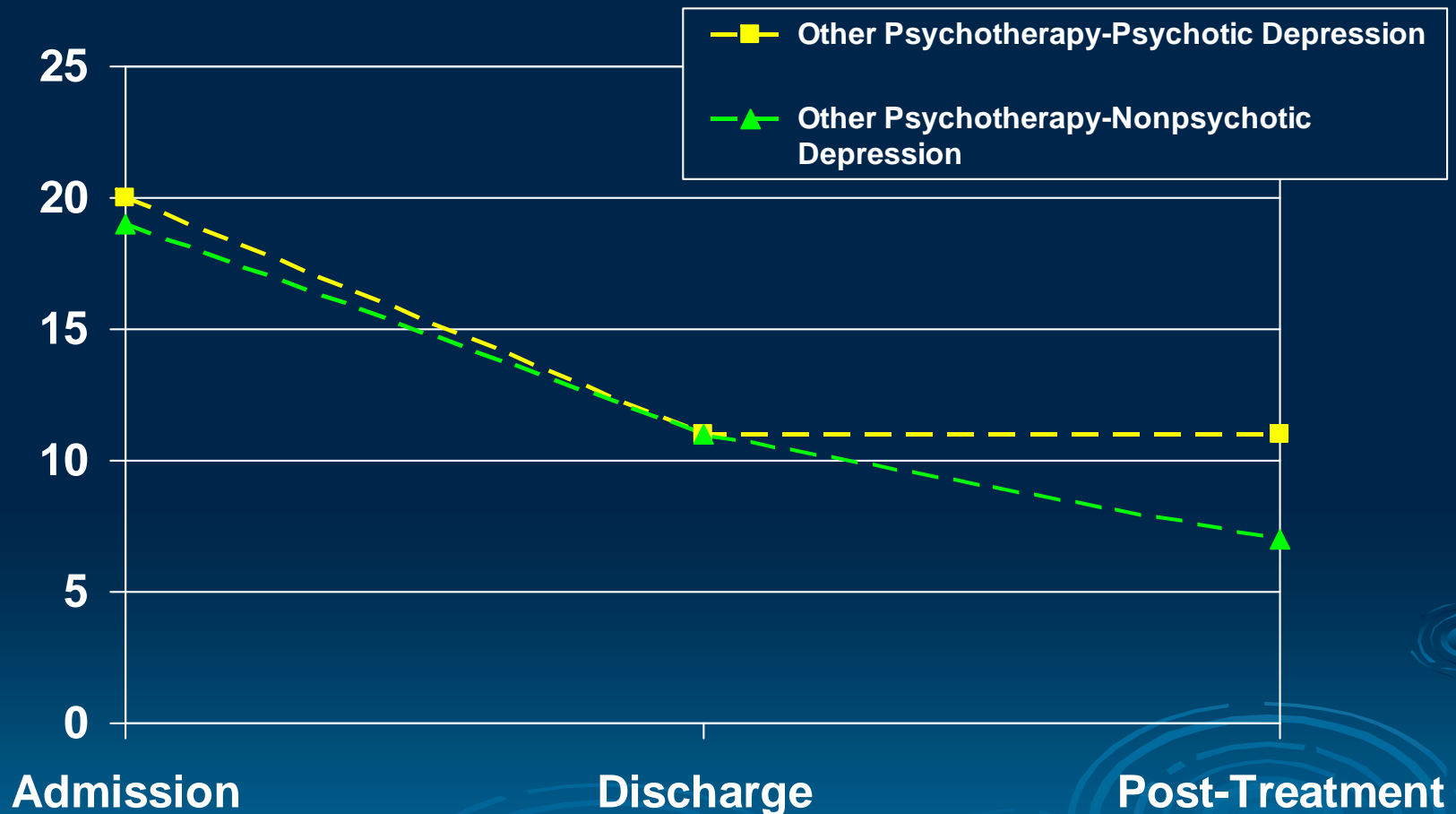


# Psychosis Severity

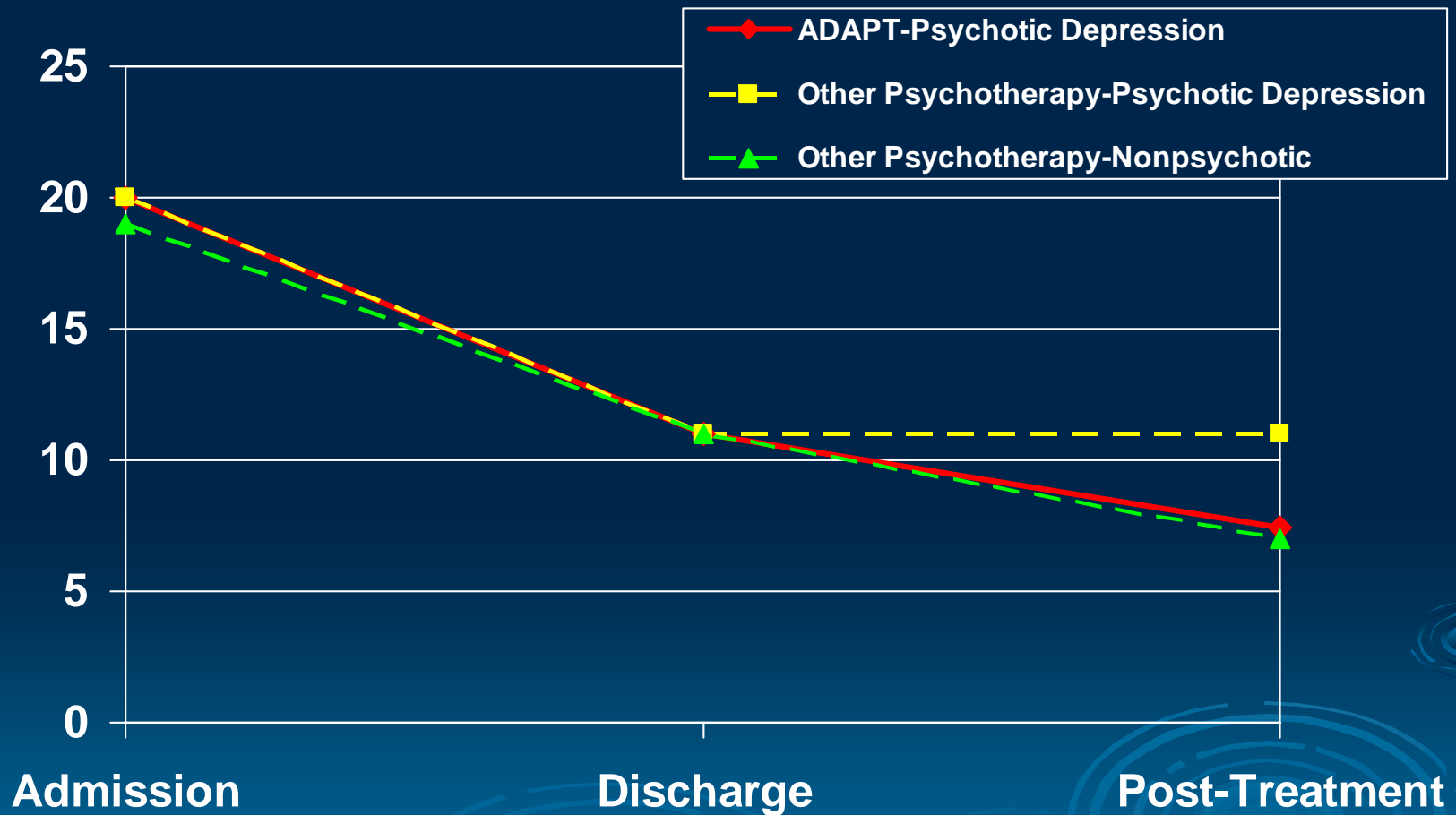
(Brief Psychiatric Rating Scale)



## Combined Treatment Response in Psychotic versus Nonpsychotic Depression using Traditional Psychotherapy



## ADAPT Open Trial and Previous Clinical Trial Outcomes for Psychotic versus Nonpsychotic Depression



# Treatment Considerations



# How Should Therapy Be Adapted?

- Focus more on rapport building early
- Proceed cautiously with defusion exercises
- Acceptance helpful even in early stages
- Visual/written aids for cognitive deficits
- Tailor interventions for multi-problem patient
- Include family member/significant other in some sessions

# Are There Any Contraindications?

- Titrating intensity of treatment based on acuity of illness (e.g., values, acceptance)
- Refrain from intensive meditation/relaxation techniques while actively psychotic



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