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The feasibility and acceptability of a brief Acceptance and Commitment Therapy (ACT) group intervention for people with psychosis: The 'ACT for life' study

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ABSTRACT

Background and objectives: Acceptance and Commitment Therapy (ACT) is a contextual cognitive-behavioural approach with a developing evidence base for clinical and cost-effectiveness as an individually-delivered intervention to promote recovery from psychosis. ACT also lends itself to brief group delivery, potentially increasing access to therapy without inflating costs. This study examined, for the first time, the feasibility and acceptability of ACT groups for people with psychosis (G-ACTp).
Methods: Participants were recruited from community psychosis teams. Ratings of user satisfaction, and pre-post change in self-rated functioning (primary outcome), mood (secondary outcome) and ACT processes were all completed with an independent assessor. Of 89 people recruited, 83 completed pre measures, 69 started the four-week G-ACTp intervention, and 65 completed post measures.
Results: Independently assessed acceptability and satisfaction were high. Functioning (Coeff. = -2.4, $z = -2.9$, $p = 0.004$; 95% CI: -4.0 to −0.8; within subject effect size (ES) $d = 0.4$) and mood (Coeff. = -2.3, $z = -3.5$, $p = 0.001$; 95% CI: -3.5 to −1.0; $d = 0.4$) improved from baseline to follow-up. Commensurate changes in targeted ACT processes were consistent with the underlying model.
Limitations: The uncontrolled, pre-post design precluded blinded assessments, and may have inflated effect sizes. Participants may have improved as a result of other factors, and findings require replication in a randomized controlled trial (RCT).
Conclusions: This preliminary study showed that brief group ACT interventions for people with psychosis are feasible and acceptable. Uncontrolled, pre-post assessments suggest small clinical improvements, and changes in psychological processes consistent with an ACT model. Replication in an RCT is required, before implementation can be recommended.

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1. Introduction

Psychotic disorders affect 3% of the population, and are associated with significant consequences and costs to sufferers, carers and service providers (e.g. Knapp et al., 2014; Mangalore & Knapp, 2007). Talking therapies for psychosis can reduce symptom impact

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and improve functioning, and may be of particular value for service users who experience limited benefit from antipsychotic medications (Burns, Erickson, & Brenner, 2014; Morrison et al., 2014).

Cognitive behaviour therapy for psychosis (CBTp) is an adaptation of CBT for emotional disorders, tailored to the specific difficulties of people with psychosis. The evidence base continues to support recommendations for increased access to CBTp in international treatment guidelines (e.g. Gaebel, Riesbeck, & Wobrock, 2011; United Kingdom National Institute for Health and Care Excellence (NICE), 2014), despite recent debate over the size of effects obtained in meta-analytic reviews (van der Gaag, Valmaggia, & Smit, 2014). However, access remains limited in frontline services (Schizophrenia Commission, 2012), and the high cost of training and supervising therapists in sufficient numbers to meet demand has led to evaluations of briefer, group-based, or more readily disseminable variants of CBTp, to improve the potential for cost-effective delivery (e.g. Waller et al., 2013). Evidence to date indicates a need for further development before such interventions can be routinely recommended (NICE, 2014).

Acceptance and Commitment Therapy (ACT) is a contextual cognitive behavioural intervention, with preliminary evidence of clinical and cost-effectiveness when delivered individually to people with psychosis (Bach, Hayes, & Gallop, 2012; Gaudiano & Herbert, 2006; Ost, 2014; White, Gumley et al., 2011a). Rather than targeting particular appraisals, as in traditional CBTp, ACT emphasises the person's relationship with their symptoms, aiming to promote non-judgmental acceptance of difficult mental events and to encourage behaviour that is consistent with the individual's personal values (Hayes, Strosahl, & Wilson, 2011).

The ACT model is compatible with conceptualisations of recovery from severe mental illness (defined as “living a satisfying, hopeful and contributing life even with limitations caused by the illness”, Anthony, 1993; and “having a sense of purpose and direction”, Deegan, 1988), and therefore well-suited for people with psychosis. The focus on specific cognitive behavioural processes of mindfulness, acceptance, distancing, and values-based action makes ACT interventions typically brief (Bach and Hayes (2002) suggest four sessions); and mediation studies suggest that the positive clinical effects of ACT are achieved by changing these targeted psychological processes (Bach, Gaudiano, Hayes, & Herbert, 2013; Bacon, Farhall, & Fossey, 2014; Gaudiano, Herbert, & Hayes, 2010; White, Gumley et al., 2011a; Zettle, Rains, & Hayes, 2011). Furthermore, the explicit sharing of common human experience and the underlying transdiagnostic model lends ACT to group delivery (Hayes et al., 2011; Morris, Johns, & Oliver, 2013), offering a potential route to improve group CBTp interventions. Group interventions are notionally a more efficient use of therapist time than individual work, and may confer additional benefits of social support from peers, normalising, and access to other perspectives (Ruddle, Mason, & Wykes, 2011; Walser & Pistorello, 2004).

The potential for cost savings, should a brief ACT group intervention be effective in promoting recovery from psychosis, is therefore considerable. No study to date has formally evaluated ACT groups for people with psychosis, although preliminary reports are encouraging (McArthur, Mitchell, & Johns, 2013).

This study represents the first formal, albeit preliminary, investigation of ACT groups for individuals with psychosis. Following published guidance for the evaluation of complex interventions (Craig et al., 2008; Moore et al., 2014), our initial aim was to determine the feasibility and acceptability of delivering the intervention, in a group format, according to a standardised, manualised protocol, in routine community psychosis services in the United Kingdom. The second aim was to conduct a preliminary evaluation of potential clinical effects, to inform future development and randomized controlled evaluation. Finally, we wished to investigate change in ACT-relevant processes, and their influence upon clinical outcomes. We anticipated that participants would find the intervention acceptable, both in terms of general group factors and specific ACT processes. We hypothesised that, following the group, participants would report durable improvements in their daily functioning and their mood. We also hypothesized associated changes in the targeted psychological processes over the course of the group: reduced experiential avoidance (more acceptance), reduced cognitive ‘fusion’ (greater distancing from thoughts), and increased mindfulness.

2. Method

2.1. Participants

Recruitment took place through liaison with community mental health teams serving people with early and established psychosis, in the South London and Maudsley National Health Service Foundation Trust. Inclusion criteria were adult age range (18–65 years), a sufficient command of English to participate in groups without an interpreter, and persisting distress and/or difficulty reaching a life goal. Access to other services and routine care was unrestricted.

2.2. Measures

Demographic characteristics (age, service (early or established psychosis), gender and ethnicity (dichotomised into Black or Minority Ethnic (BME)/non-BME) were self-reported, supplemented by the clinical record. Feasibility and acceptability were assessed by attendance, completion rates, service user feedback and satisfaction ratings. Standardised measures were used to assess change in functioning, mood, and psychological flexibility.

2.2.1. Primary clinical outcome: functioning

This was assessed by the Sheehan Disability Scales (Sheehan, 1983), comprising self-reported functional impairment ratings from 0 (low impairment) to 10 (high impairment) in three domains: work/study, social life/leisure activities, and family life/home responsibilities. Total score was the outcome, ranging from 0 to 30. The scale has good construct validity, internal reliability and sensitivity to change (Leon, Olfson, Portera, Farber, & Sheehan, 1997; Sheehan & Sheehan, 2008); internal reliability in the current study was acceptable (Cronbach alpha = 0.7).

2.2.2. Secondary clinical outcome: mood

This was assessed by the Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith, 1983), comprising 14 questions, seven for anxiety and seven for depression, each self-rated from 0 (not at all) to 3 (most of the time), forming a total score ranging from 0 to 42, with higher scores indicating greater severity of emotional problems. The scale is well-established and psychometric properties, as reported by the authors, are good. In the current study, internal reliability was good (Cronbach alpha = 0.8).

2.2.3. Potential mechanisms of change

Participants' relationship with their symptoms was assessed using three measures of ACT-relevant processes. The Acceptance and Action Questionnaire (AAQ-II, Bond et al., 2011) is a 7-item questionnaire designed to measure psychological flexibility. Respondents rate the degree to which each statement applies to them, from 1 (never true) to 7 (always true). Lower scores suggest greater acceptance of mental experiences and persistence with life goals in the face of these experiences (Range 7 to 49). The Cognitive Fusion Questionnaire (CFQ, Gillanders et al., 2014) is a 7-item scale designed to assess the extent to which a person's behaviour is

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