



A systematic review of the use of Acceptance and Commitment Therapy (ACT) in chronic disease and long-term conditions

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HIGHLIGHTS

- A growing body of work (18 studies) has evaluated ACT in long-term conditions.
- Study quality is mostly low. As ACT is used clinically, high-quality RCTs are needed.
- Some promising evidence for parenting of children with LTCs, seizure control, psychological flexibility, self-management.

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ABSTRACT

Many have proposed that Acceptance and Commitment Therapy (ACT) may be particularly effective for improving outcomes in chronic disease/long-term conditions, and ACT techniques are now being used clinically. However, reviews of ACT in this context are lacking, and the state of evidence is unclear. This systematic review aimed to: collate all ACT interventions with chronic disease/long-term conditions, evaluate their quality, and comment on efficacy. Ovid MEDLINE, EMBASE and Psych Info were searched. Studies with solely mental health or chronic pain populations were excluded. Study quality was then rated, with a proportion re-rated by a second researcher. Eighteen studies were included: eight were randomised controlled trials (RCTs), four used pre-post designs, and six were case studies. A broad range of applications was observed (e.g. improving quality of life and symptom control, reducing distress) across many diseases/conditions (e.g. HIV, cancer, epilepsy). However, study quality was generally low, and many interventions were of low intensity. The small number of RCTs per application and lower study quality emphasise that ACT is not yet a well-established intervention for chronic disease/long-term conditions. However, there was some promising data supporting certain applications: parenting of children with long-term conditions, seizure-control in epilepsy, psychological flexibility, and possibly disease self-management.

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1. Introduction

Chronic diseases/long-term conditions such as diabetes, HIV, cancer or brain injury (henceforth long-term conditions) have a detrimental impact on well-being, as indicated by reduced quality of life (QoL) and mood (Barrios et al., 2015; Do et al., 2014; Graham, Rose, Grunfeld, Kyle, & Weinman, 2011; Jopson & Moss-Morris, 2003; Miners et al., 2014; Renn, Feliciano, & Segal, 2011). Nonetheless, a large variation in QoL and mood across people with the same condition or with the same level of disease severity/disability level is often apparent (Graham, Rose, Hankins, Chalder, & Weinman, 2013; Miglioretti, Mazzini, Oggioni, Testa, & Monaco, 2008), and even those with the most severe symptoms may have preserved QoL and mood (Lule, Hacker, Ludolph, Birbaumer, & Kubler, 2008; Robbins, Simmons, Bremer, Walsh, & Fischer, 2001). It therefore follows that factors other than the disease process, or its direct functional limitations, may help explain well-being in these conditions. Indeed, a large body of research shows that psychological factors are particularly important in this context. They explain significant proportions of the variation in QoL and mood, even after controlling for disease severity or disability level. Influential variables include, but are not limited to, illness perceptions, coping strategies, self-efficacy, psychological flexibility, and emotion regulation (de Ridder, Geenen, Kuijer, & van Middendorp, 2008; Dennison, Moss-Morris, & Chalder, 2009; Graham, Weinman, et al., 2014; Moss-Morris, 2013; Pakenham & Fleming, 2011; Petrie & Weinman, 2012).

Cognitive behavioural models, such as the well-known Self-Regulation Model (Leventhal, Nerenz, & Steele, 1984), posit that the explanatory value of psychological variables is derived from their influence on disease self-management behaviour and distress regulation. Any condition is likely to involve a range of adaptive self-management behaviours, such as adhering to medications, attending appointments with health professionals or amending one's activities and diet. A second parallel process of psychological adjustment may also occur, involving evaluation of the functional impact of the condition (for example on social and occupational functioning) and the regulation of any resultant distress (Leventhal et al., 1984).

Empirical support for the importance of psychological processes in long-term conditions has led to the development and application of cognitive behavioural interventions which target these processes to improve a range of outcomes, from QoL and mood to treatment adherence

and disease self-management (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Graham, Simmons, Stuart, & Rose, 2015; Petrie & Weinman, 2012). Consequently, clinical psychologists and healthcare professionals in related disciplines now play a key role in the treatment of people with long-term conditions.

2. Traditional cognitive behavioural therapy in long-term conditions

Mirroring its popularity in mental health conditions (Butler, Chapman, Forman, & Beck, 2006), interventions derived from traditional Cognitive Behavioural Therapy (traditional CBT) have been widely applied to improve distress and self-management in long-term conditions (Beatty & Lambert, 2013; Greer et al., 1992; Hind et al., 2014; Ismail, Winkley, & Rabe-Hesketh, 2004; Petrie, Perry, Broadbent, & Weinman, 2012). These see one's beliefs as the central process in therapy (Beck, 1976; Halford & Brown, 2009), a target supported by the large number of studies showing that aberrant beliefs about illness or medication predict many salient outcomes (e.g. QoL, treatment adherence, mood etc.; Petrie & Weinman, 2012). Consequently, traditional CBT comprises techniques such as verbal modification or behavioural experiments to enable participants to change dysfunctional beliefs about illness, the self, the future, or medication, as a means to reduce distress, instigate better self-management or improve quality of life (Halford & Brown, 2009). Traditional CBT shows promising utility in the context of long-term conditions, with the strongest evidence for distress-reduction in cancer, where a small to medium effect size has been shown (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).

3. Acceptance and Commitment Therapy (ACT) in long-term conditions

ACT is a newer form of cognitive behavioural therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), which has evolved from experimental work regarding the influence of language on behaviour (Zettle, 2005) and is, in part, informed by Relational Frame Theory (De Houwer, Barnes-Holmes, & Barnes-Holmes, 2016). While a full description of this theory is beyond the scope of this review, the main implication for treatment is that language processing is viewed from within the paradigm of behaviourism. Thus, one can understand how 'thinking' affects overt behaviour, in this case ineffective patterns of behaviour

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