Housekeeping Items

- Welcome to L.A. Care Provider Continuing Education (PCE) Program's Live Webinar!
- Webinar participants are muted upon entry and exit of webinar.
- ***Webinar attendance will be noted via log in and call in. There are 2 Requirements: Please log in through a computer (instead of cell phone) to Join Webinar / Join Event and also call in via telephone by choosing the Call In Option with the event call in number, event access code and assigned unique attendee ID number. If your name does not appear on the WebEx Final Attendance and Activity Report (only as Caller User #) and no submission of online survey, no CME or CE certificate will be provided.***
- Webinar is being recorded.
- Questions will be managed through the Chat feature and will be answered at the end of the presentation. ***Please keep your questions brief and send to All Panelists.*** One of the Learning and Development Team members / Panelist and webinar co-host, will read the questions submitted via Chat when it's time for Q & A session (last 30 minutes of live webinar).
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- PowerPoint Presentation is allotted 55 minutes and last 30 minutes for Q&A session, total of 90-minute live webinar, 1.50 CME credits for Providers / Physicians, 1.50 CE credits for NPs, RNs, LCSWs, LMFTs, LPCCs, LEPs, and other healthcare professionals. A Certificate of Attendance will be provided to webinar attendees without credentials.

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- Within two (2) weeks after webinar and upon completion of the online survey, you will receive the pdf CME or CE certificate based on your credential and after verification of your name and attendance duration time of at least 75 minutes for this 90-minute webinar.

- **The PDF webinar presentation will be available within 3 weeks after webinar date on lacare.org website located at**

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- Any questions about L.A. Care Health Plan's Provider Continuing Education (PCE) Program and our CME/CE activities, please email Leilanie Mercurio at lmercurio@lacare.org

Presenter Dr. Katherine Bailey's Bio

Katherine Bailey, PhD, is a licensed clinical psychologist at the West Los Angeles VA HealthCare Center and the Deputy Chief of the Substance Use Disorder (SUD) Section for the VA Greater Los Angeles Healthcare System. She is a Health Sciences Clinical Instructor for the UCLA Department of Psychiatry and Biobehavioral Sciences.

Dr. Bailey provides clinical services and supervision in the outpatient SUD and Pain Clinics with a focus on evidence-based therapies. She earned a PhD in clinical psychology from the University of Illinois in Chicago, completed a clinical internship at the West LA VA, and a clinical fellowship in primary care at the San Francisco VA. She is a trainer and consultant for the national VA CBT-Chronic Pain evidence based psychotherapy rollout, and also certified in biofeedback, acceptance and commitment therapy (ACT), and mindfulness.

Dr. Bailey's research interests include chronic pain, Substance Use Disorders and smoking.

Acceptance and Commitment Therapy (ACT) for Depression and Anxiety

September 22, 2022 Live Webinar, 12:00 pm – 1:30 pm PST
Directly Provided CME/CE Activity by L.A. Care Health Plan
1.50 CME/CE Credits

Katherine Bailey, Ph.D.

Clinical Psychologist & Deputy Chief SUD Section; WLA VA Healthcare Center

Health Sciences Clinical Instructor; UCLA Department of Psychiatry & Biobehavioral Sciences

Certified by VA Training Program in ACT-D (Mental Health Services, VA Central Office)

Disclaimer: These slides are not intended to represent The VA

Financial Disclosures

The following CME planners and faculty do not have relevant financial relationships with ineligible companies.

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner
- Katherine Bailey, PhD, Licensed Clinical Psychologist, Deputy Chief of the Substance Use Disorder (SUD) Section at the Greater Los Angeles VA Healthcare System, CME Planner and Faculty

An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME/CE activity.

Learning Objectives

- Describe efficacy of Acceptance and Commitment Therapy (ACT) for Depression and Anxiety.
- State how the ACT construct of “creative hopelessness” (or control as the problem) can offer an alternative way of addressing depression and anxiety.
- Specify at least two (2) core ACT processes that promotes psychological flexibility.
- Summarize how ACT may be useful tool for symptoms of depression and anxiety in the context of COVID-19.

Prevalence and problems associated with depression and anxiety

- About 7% of the US population or 17 million adults had at least one episode of MDD in the last year (NAMI, 2017)
- 19.1% of US population, over 40 million adults, have an anxiety disorder (e.g. generalized anxiety disorder, social anxiety disorder, panic disorder, specific phobia, obsessive compulsive disorder) (NAMI, 2017)
- According to UN Guidelines, depression and anxiety cost global economy more than $1 trillion/year before COVID-19 pandemic (UN News, 2020)
- Depression as second leading cause of disability worldwide and in US (Friedrich, 2017).

Depression & Anxiety Prevalence During COVID-19

- Meta-analysis of 62 studies (n=162,639 from 17 countries):
  - pooled prevalence depression 28% (95% CI, 23-32%)
  - pooled prevalence anxiety 33% (95% CI, 28-38%)
- Highest among those with a pre-existing hx and COVID-19 infection
- Similar between healthcare workers and general public (though China, Italy, Turkey, Spain, Iran higher among healthcare workers)
- Common risk factors are female gender, nurse occupation, lower SES, high risk of contracting COVID-19, and social isolation

Luo et al., 2020

Depression & Anxiety among COVID-19 Survivors

Meta-analysis of 31 studies of COVID-19 survivors (n=5153; mostly Chinese) found:

- Prevalence of depression 45%
- Prevalence of anxiety 47%
- Prevalence of sleep disturbance 34%
- No gender differences

Deng et al., 2021

Depression & Anxiety among COVID-19 Survivors

Study of 402 survivors (265 male; mean age 58; Italian), 1-month post hospitalization:

- 28% PTSD
- 31% Depression
- 42% Anxiety
- 20% OC symptoms
- 40% insomnia

- Females suffered more for anxiety and depression
- Both previous psych history and higher baseline systemic immune-inflammation index associated with higher scores of depression and anxiety

Mazza et al., 2020

Percent of adults with depression & anxiety during early COVID-19

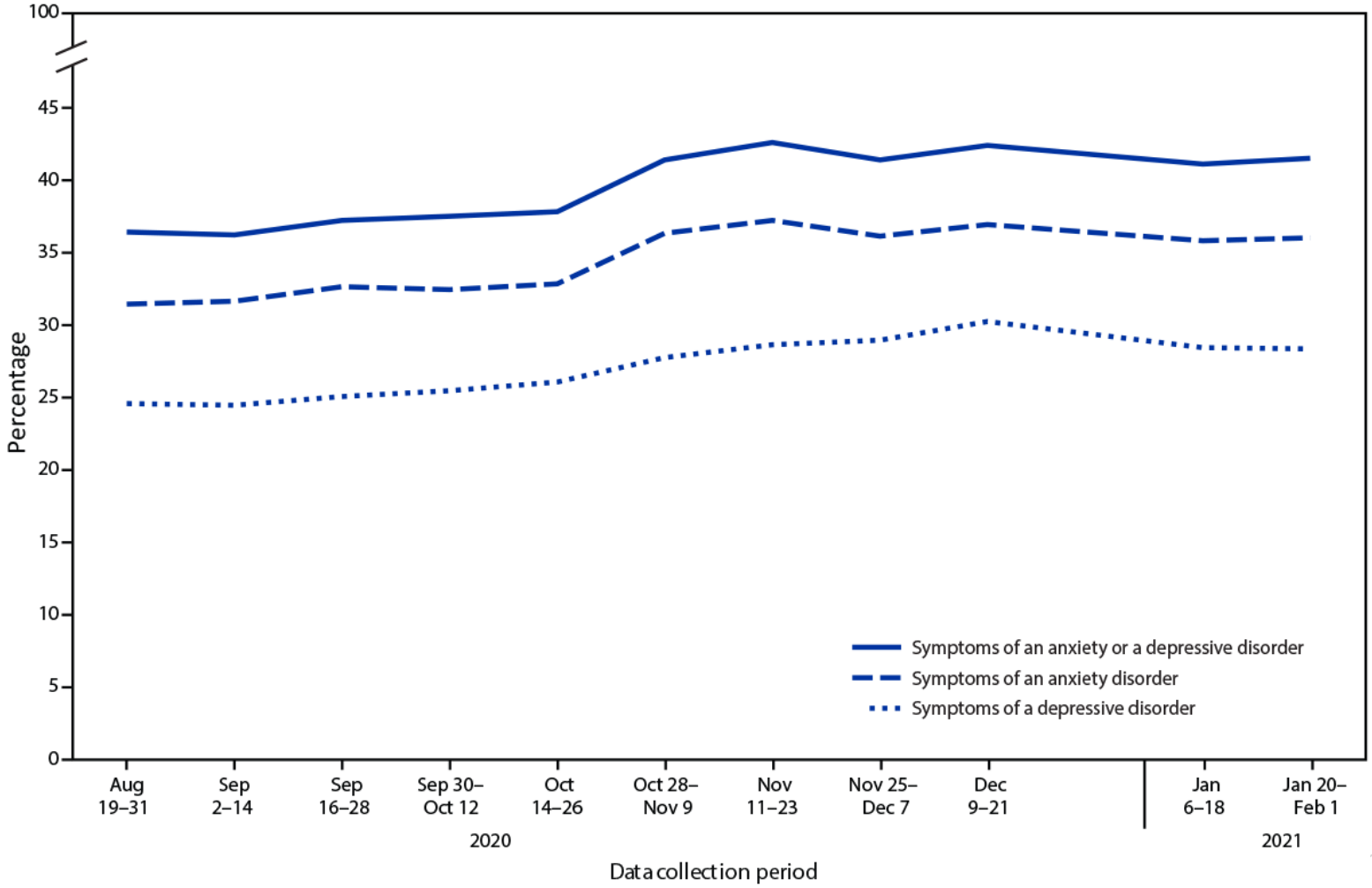
- Initial prevalence of depression symptoms in the US during April 2020 was more than 3-fold higher during COVID-19 compared with before the pandemic (Ettman et al., 2020)
  - N=1441 during pandemic (50.2% male, 64.7% non-Hispanic white) v. N=5065 pre-pandemic (51.4% female; 62.9% non-Hispanic white
  - Risk factors = lower income and exposure to more stressors
- During June 2020 (Czeisler et al., 2020)
  - 30.9% reported symptoms of anxiety or depression
  - 10.7% considered suicide in the last 30 days but higher among
    - Age 18-24 (25.5%)
    - Latinx (18.6%)
    - Black, non-Hispanic (15.1%)
    - Unpaid caregivers (30.7%)
    - Essential workers (21.7%)

Percent of adults with depression & anxiety during later COVID-19 pandemic

- From August 2020– February 2021:
  - Adults with symptoms of an anxiety or a depressive disorder increased significantly (from 36.4% to 41.5%),
  - Percent reporting that they needed but did not receive mental health counseling or therapy during the past 4 weeks increased from 9.2% to 11.7%
  - Increases were largest among adults aged 18–29 years and among those with less than a high school education.
  - Significant increases were observed for all demographic subgroups presented, except adults aged ≥80 years and non-Hispanic adults reporting races other than White, Black, or Asian.

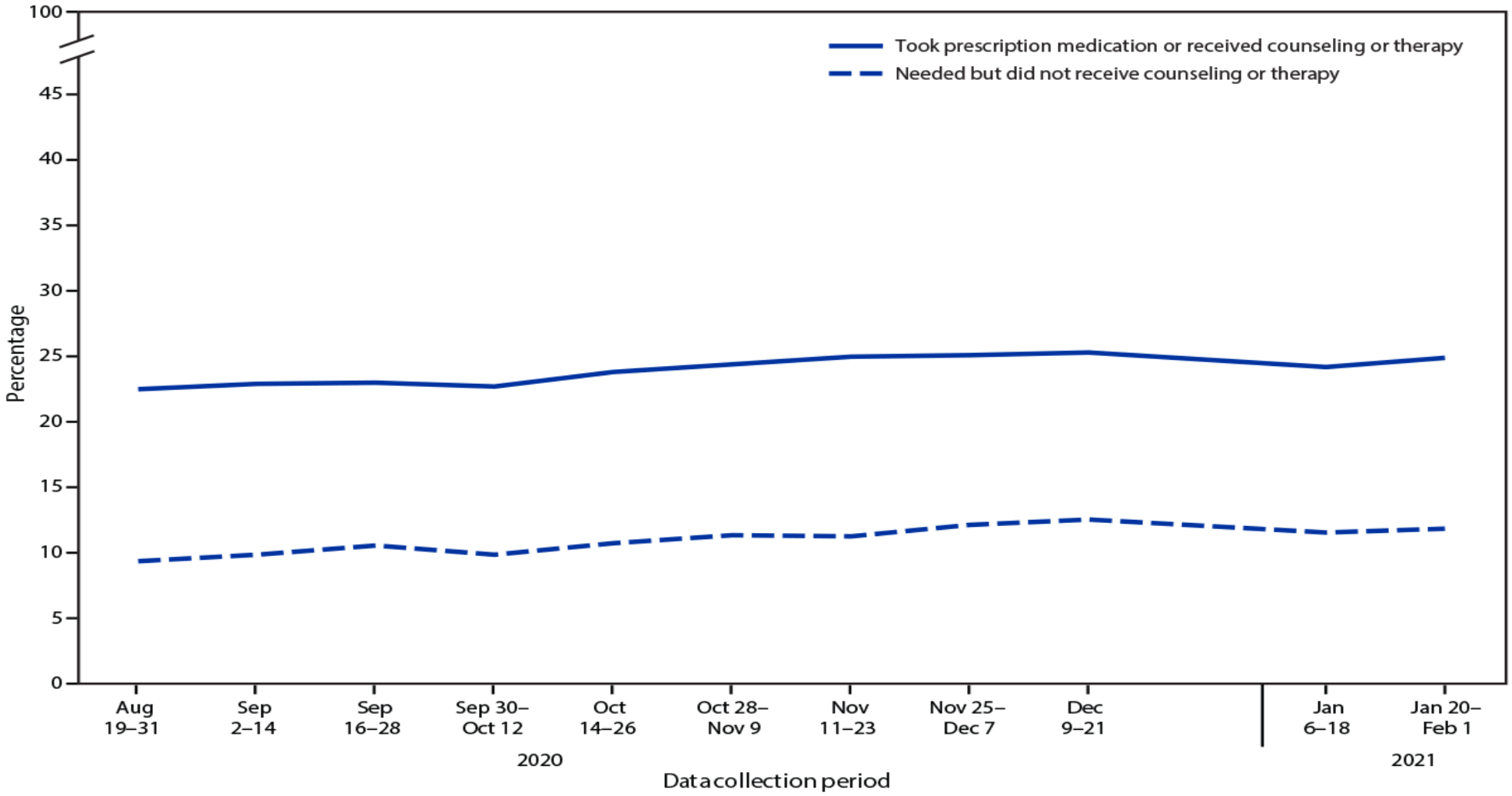
Vahratian et al., 2021

Percentage adults with anxiety and/or depression in the last 7 days



Vahratian et al., 2021

Percent adults with MH Tx Needs During COVID-19

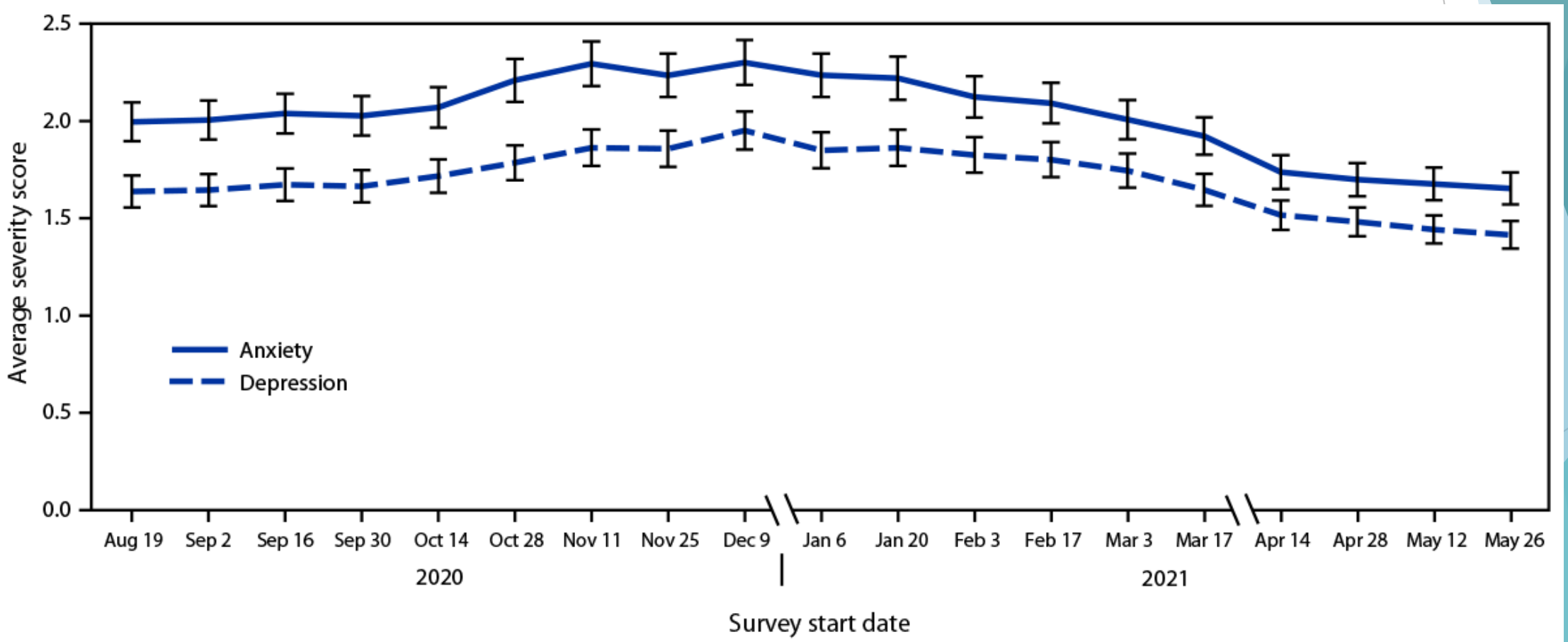


Vahratian et al., 2021

Severity of Depression & Anxiety during COVID-19 in US

- Representative sample of US adults based on age, sex, race/ethnicity and educational attainment showed increases in severity of anxiety and depression between August 2020 to February 2021 (Jia et al., 2021)
  - Largest increases among ages 18-29 and less than HS education
  - Nationally anxiety scores increased 13% from August 2020 to December 2021 then decreased 26.8% from December to June 2021
  - Average depression scores increased 14.8% from August to December 2020 then decreased 24.8% from December to June 2021
  - State trends were similar; anxiety and depression scores peaked between December to mid-January 2021
  - Scores correlated with with the average number of daily COVID-19 cases
  - Rates remained elevated compared to 2019 survey estimates

Anxiety & Depression Scores during COVID-19

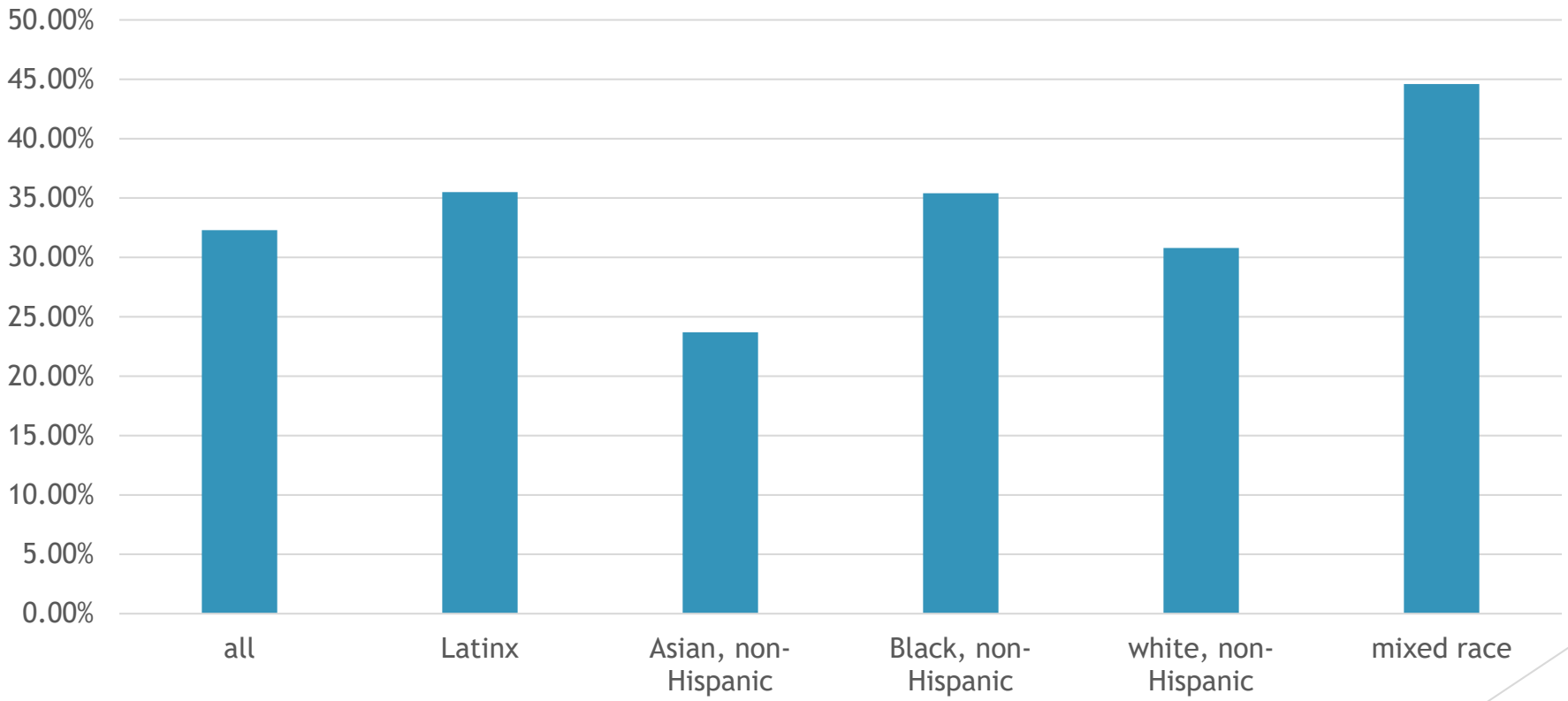


Jia et al., 2021

Cultural Considerations for Depression & Anxiety

- Racism is a public health issue (AAP, AMA, ACP)
- According to US Department of Health and Human Services OMH:
  - Higher percentage of African-Americans and Latinos report feelings of sadness, hopelessness, and “everything is an effort” (CDC, 2019 c.f. USDHHS OMH)
  - Higher percentage of Native Americans report serious psychological distress in the past 30 days
  - Lower percentage of Asian-Americans report recent serious psychological distress or feelings of sadness, hopelessness; however, suicide is the leading cause of death among age 15-24
  - Native Hawaiians/Pacific Islanders report similar rates of mental illness to white populations but are less likely to receive care

Percent adults reporting symptoms during COVID-19 by race & ethnicity



US Census Bureau Household Pulse Survey 2022

Cultural Considerations for COVID-19

- Disproportionate burden of illness and death from COVID-19 on ethnic minorities (CDC, 2020)
  - Overrepresentation of African-Americans among hospitalized patients
  - Death rates double among African-American, American Indian/Alaska Natives, Latino populations compared to white or Asian-American populations (Shiels et al., 2021)
  - Overrepresentation of ethnic and minority children lost a primary caregiver to COVID-19 (Hillis et al., 2021)

What is Acceptance and Commitment Therapy?

- Acceptance and Commitment Therapy or ACT (Hayes, Strosahl, & Wilson, 1999) is a "3rd Wave" behavioral therapy
- ACT takes the view that trying to change how we think and feel can be counterproductive
- Emphasizes acceptance of distress (i.e. feelings, thoughts, memories, sensations) and committing to actions that are consistent with core values
- Hold and move

Efficacy of ACT for Depression

- Recent meta-analysis of 18 studies suggest ACT is superior to control through 3 month follow up among adults with mild depression (Zhenggang et al., 2019)
- 5 RCTs comparing ACT to Cognitive Therapy demonstrating similarly successful outcomes (Zettle & Rains, 1989; Zettle & Hayes, 1986; Forman et al., 2007; Lappalainen et al., 2007; Forman et al., 2012).
- ACT has been established as an evidence based treatment for chronic pain with positive outcomes for depression (Vowles & McCracken, 2008)
- Study of brief ACT compared to TAU for unemployed with depression demonstrated significantly lower depression, higher Q of L, general health and perceived level of functioning (Folke & Parling, 2004)
- Experiential avoidance and acceptance appear to be mechanisms of change

Implementation of ACT among Veterans

- Implementation of ACT in the VA demonstrated decreased severity of depression and decreased odds of suicidal ideation (Walser et al., 2015)
- N=981 Veterans, 76% male, mean age= 50.5 years
  - 73% white
  - 13% Black
  - 11% Asian
  - 6% Latinx
- 647 or 66% completed treatment
- For Vets with SI, mean BDI decreased from 33.5 to 22.9 (severe – moderate)
- For Vets without SI, mean BDI decreased from 26.3 to 15.9 (moderate – mild)
- Increases in experiential acceptance and mindfulness scores were associated with a reduction in depression severity
- Increases in acceptance were associated with lower odds of SI

ACT results at one-year follow-up

- Recent RCT (n=82) comparing CBT to ACT for depression (A-Tjak, Morina, Topper & Emmelkamp, 2021)
- Participants age 18-65 with MDD on stable dose of medication
- 9-20 sessions over 30 week period (mean # ACT sessions=15.02, sd 5.75 v. mean # CBT sessions = 14.89, sd=5.60)
- At 12 month follow-up:
  - Remission rates for depression were 75% for ACT and 80% for CBT
  - Both conditions associated with significant and large reductions in depressive symptoms (d= -1.26 to -1.60)
  - Improved quality of life (d= .91 to -1.28)
- Experiential avoidance mediated treatment effects in ACT but not CBT

Efficacy of ACT for Anxiety

- Review of 36 RCTs of ACT for depression and anxiety suggests ACT superior to waitlist control, and treatment as usual; equivalent effects to traditional CBT (Twohig & Levin, 2017)
- RCT (n=128) of CBT v. ACT for mixed anxiety disorders found similar outcomes even at 12 month follow up suggesting ACT as viable treatment for anxiety disorders (Arch et al., 2012)
- Comparison of 12 sessions of CBT or ACT for 87 people with anxiety disorders (Wolitzky-Taylor et al., 2012)
  - CBT superior for those with higher baseline anxiety sensitivity
  - ACT superior for those with co-morbid mood disorders

Efficacy of ACT for anxiety via web

- Systematic review of ACT delivered via internet (with and without therapist guidance) for GAD, SAD, general anxiety reported significant reductions in anxiety symptoms (Kelson et al., 2019)
  - N=20 studies, 11 RCTs and 9 uncontrolled studies
  - 7/10 studies in US, 7/10 Sweden, remaining 6 from Australia, Netherlands, Finland and Denmark
  - Age from 18-59 years, 72.62% clinical
  - 18 studies reported significant anxiety reduction after iACT treatment, both with (n=13) and without therapist guidance (n=5 studies)
  - Attrition rate was 19.19%
  - Above average to high treatment satisfaction
  - 4 studies found sustained anxiety reductions at 3 and/or 6 month follow-up
- Need more, higher quality studies
- Web based interventions may have increased utility during pandemic conditions

Cultural Considerations for ACT

- More work on ACT with diverse populations is needed
- Meta-analysis of ACT among other acceptance based treatments has been studied among ethnic minority populations with good results (Fuchs et al., 2013)
- ACT has been found effective in decreasing effects of self-stigma, internalized oppression, and other effects of discrimination (Brewster et al., 2013; Luoma et al., 2007; Lucksted & Drapalski, 2015)
- Pilot study of ACT based approach to decreasing impact of internalized racial oppression of Black women found a significant decrease in symptoms of depression and anxiety, internalized oppression and shame (Hudson Banks et al., 2021)
- Racism should not be addressed via psychotherapy for marginalized and oppressed groups. Racism should be eliminated at a systemic, institutional and individual level

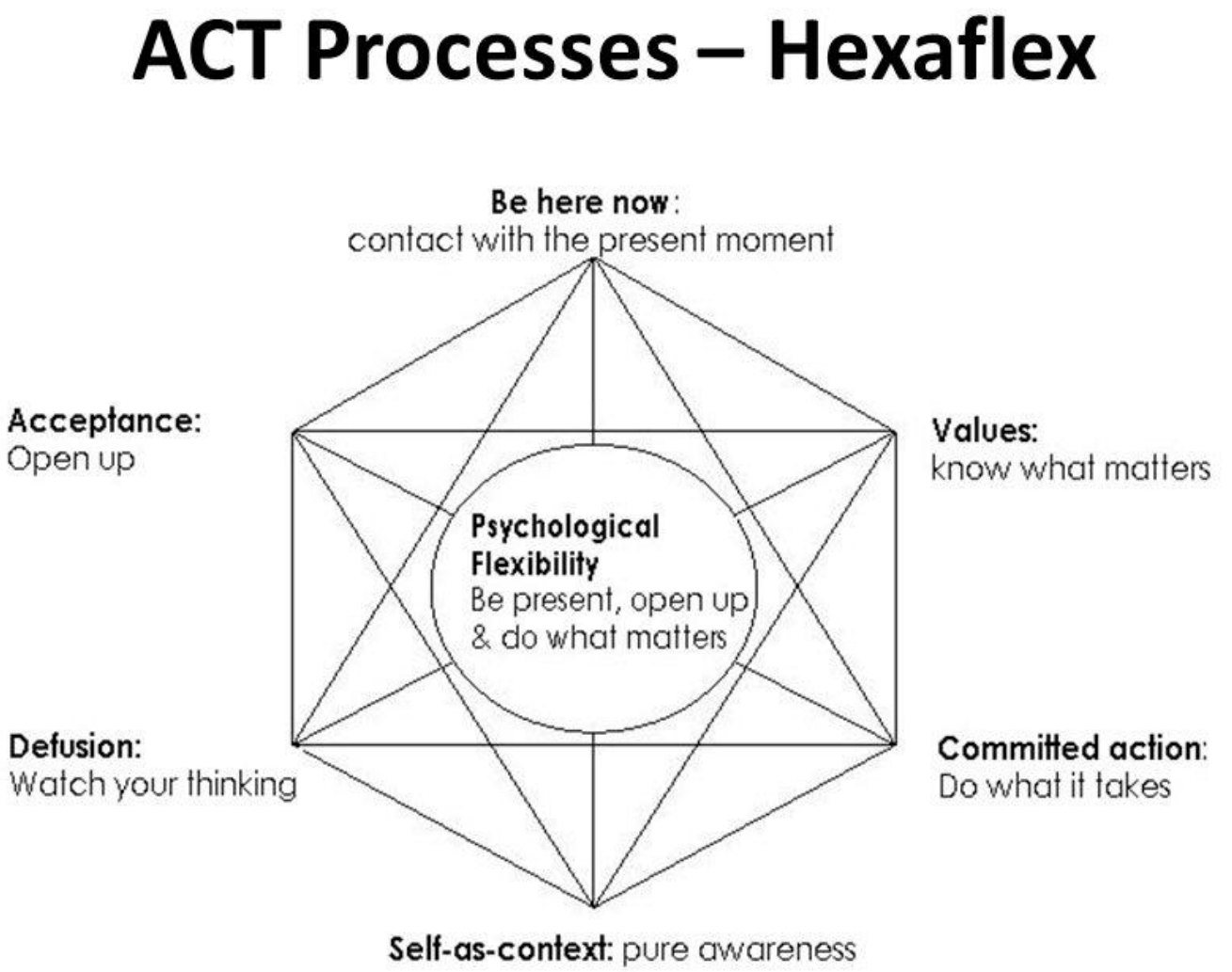
ACT efficacious for depression & anxiety

- VA/DoD Clinical Practice Guidelines recommend ACT:
  - as a first line psychotherapy for mild to moderate MDD with strong evidence
  - or in combination with medication for severe, chronic or recurrent MDD
- APA Div. 12 and United States Substance Abuse and Mental Health Services Administration (SAMHSA) list ACT as an evidence based treatment for depression, mixed anxiety, OCD, and chronic pain
- NAMI recommends practicing mindfulness and acceptance techniques during COVID-19 pandemic

Goal of ACT

- Typical goal of therapy: To feel better. Or even to feel good!
- Often a “story” for why they are not feeling a certain way
- ACT presents an alternative way:
  - accept emotions and thoughts as they are and commit to values-driven actions even if unwanted emotions, thoughts and memories continue to occur
  - change the function of thoughts and feelings – they no longer have to drive behavior
- Increase experiential knowledge rather relying on verbal knowledge
- Get out of Your Mind and Into Your Life by Steven Hayes PhD
- Goal of ACT is to live a rich, meaningful life in spite of pain

ACT Core Processes

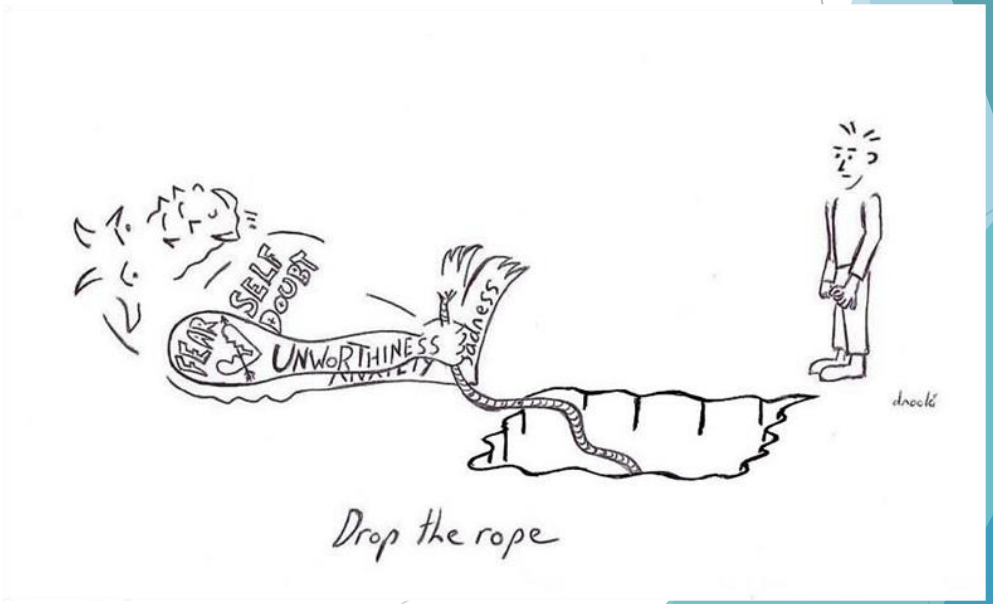


Mindfulness in ACT

- Mindfulness is secular practice of “paying attention, on purpose, in the present moment and non-judgmentally” -Jon Kabat-Zinn
- Used to treat depression, anxiety, chronic pain among other health problems
- Mindfulness is a practice that models core processes of ACT including acceptance, defusion, contact with the present moment and a transcendent sense of self (or self-as-context)
- Openness to experience and practice of observing and the practice of observing thoughts, feelings, sensations, as an ongoing flow of events that don’t necessarily need to be acted on
- Start most sessions with mindfulness, and encourage frequent practice between sessions
- Emphasize that mindfulness is not relaxation or way to avoid and escape reality; relaxation may be a by-product but it is not the goal

ACT Core Process: Acceptance

- The opposite of avoidance – running away or escaping from difficult or painful emotions and thoughts
- Willingness -- being willing to have internal experiences without trying to change or escape them in any way
- Willingness is not wanting
- Creative Hopelessness as a path to acceptance



Creative Hopelessness

- Letting go of fruitless attempts to change their experience – hopelessness about the possibility of eliminating pain
- Creatively making room for a new way forward
- There is often a strong belief that if you can get rid of negative experiences (i.e. depression, anxiety, grief, trauma) then you can heal and be able to move on and live well
- Trying to control feelings, thoughts, sensations and memories can be counterproductive – people report fear of fear, sadness about depression
- Must connect with failed efforts to make internal lives different

Letting go of the “feel good agenda”

Things you’ve struggled with (stuff you tried to make go away) : Sadness, anxiety, feeling unloved, loneliness, panic symptoms	
Positive efforts: -exercise -socializing -reading -therapy -changed diet -getting a job -mindfulness -acupuncture -leaving unhealthy relationship	Negative efforts: -isolation -drinking, cannabis use, misusing prescription drugs -being angry/lashing out -overeating or undereating -excessive tv -pushing people away -avoiding people, places, and things -staying quiet or keeping secrets
Look how hard you’ve tried to get rid of depression or anxiety – how well has this worked? What is the cost of these strategies?	

Control as the problem

Control as the problem

- What if feelings of depression and anxiety are not the problem? And trying to control internal events might actually increase or sustain them?
- When misapplied control to internal events becomes excessive, that is the problem
- Controlling our thoughts and emotions is part of our culture and language system (”I can’t stand….”)
- Validate the idea that it seems like control *should* work (control works outside the skin, it seems to work for others by outside appearances)
- Exercises:
  - Perfect Anxiety Detection Machine
  - What are the numbers?
- Willingness as an alternative to control

ACT core process: Defusion

- Fusion is believing thoughts to be literally true – unable to recognize them as just thoughts
- Fusion as a barrier to change (e.g. social anxiety, substance use)
- Noticing thoughts rather than being caught up in them and acting on them
- Trying to treat the mind as an entity
  - What thought is your mind handing you?
  - Who's talking here, you or your mind?
  - I'm loser v. I'm having the thought that I'm a loser OR I'm noticing I'm having the thought that I'm a loser
- Mindfulness

ACT Core Process: Values

- Guiding principle
- Freely chosen, deeply personal and do not need to be justified
- Aspirational directions that we can always strive for, not goals that can be completed
- Compass metaphor
- Speech in your honor/funeral/80th birthday/retirement

ACT Core Process: Contact with the present moment

- To address living in the past or worrying about the future
- Allows you to catch cognitive fusion as it's happening
- Provides information about whether to persist in a behavior or change
- Facilitates connection with values
- Mindfulness
- 5-5-5: notice 5 things you can see, hear, feel right now

ACT Core Process: Self-as-Context

- Self-as-Context is a way of thinking about identity
- How we usually think of ourselves is “self-as-content”
  - I am…….a woman; a licensed psychologist; a parent; my race and/or ethnicity; my religion or spiritual stance; an addict; depressed; lonely; afraid; victimized
- Self-as-context is the “observer self” that can accept ever-changing internal experiences
- Promote the idea of a larger, more constant stable self; this self has remained intact despite depression, loss, anxiety, trauma
- Acknowledge the part of you that notices thoughts, feelings, sensations

ACT Core Process: Committed Action

- With acceptance, willingness, self-as-context, values in place, we can now move in our chosen direction
- Identify actions that can be done today, tomorrow, this week
- Use problem-solving when needed, noticing barriers like fusion, experiential avoidance
- Passengers on the bus

How ACT can be a useful tool during COVID-19 Pandemic

- Studied in diverse groups including unemployed, subclinical populations, and those with depression and anxiety
- Can be tailored to personal values
- Promotes acceptance of experiences that may not be changed, while still identifying actionable ways to connect with values
- Because it is individually tailored to personal values can be applied to diverse populations
- Helps promote resilience by guiding people to demonstrate values-consistent behaviors even in the face of challenging experiences

ACT during COVID-19 Pandemic

mindfulACT

ACT related resources for COVID-19

- Doing What Matters in Times of Stress – WHO Illustrated Guide
- COVID Coach App –mindfulness, finding meaning/core values
- APAHC resources -- https://ahcpsychologists.org/covid19/

Doing What Matters in Times of Stress:
An Illustrated Guide

World Health Organization

Manuals and other resources

- Many manuals and workbooks available:
  - ACT-D from VA Evidence Based Psychotherapy Roll Out (Walser, Sears, Chartier, & Karlin, 2012)
  - Get Out of Your Mind and Into Your Life (Hayes & Smith, 2005)
  - ACT made Simple by Russ Harris
  - ACT for the Treatment of PTSD and Trauma—Related Problems (Walser & Westrup, 2007)
- https://contextualscience.org/
- http://www.tlconsultationservices.com/ – Robyn Walser PhD
- https://www.actmindfully.com.au/
- ACT coach for apple and android

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Contact

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FAQs

- What is the goal of ACT?
  - To live a rich, vital life in spite of pain
- How does ACT differ from traditional CBT therapies?
  - Traditional CBT postulates that thoughts shape feelings and behaviors and therefore targets thoughts, in addition to behaviors to effect change
  - ACT does not directly target thoughts. ACT says you don't need to change your thoughts in order to change your behavior.
- What is mindfulness and how is it utilized in ACT?
  - Mindfulness is a meditation practice that promotes paying attention to the present moment. It is a big part of promoting psychological flexibility in ACT and models a number of core processes in ACT. I use it in every session.

FAQs

- How many sessions of ACT are necessary?
  - ACT has been studied in a variety of delivery methods and numbers of sessions from one session workshops to 16-20 sessions with success. You can tailor to the client.
- Can ACT be delivered in a group format?
  - Yes! There are many group manuals available and it has also been studied with good results in group treatment.

Q & A

L.A. Care PCE Program Friendly Reminders

- **Friendly Reminder,** a survey will pop up on your web browser after the webinar ends (please do not close your web browser and wait a few seconds) and please complete the survey.

Please note: ***the online survey may appear in another window or tab after the webinar ends.***

- Upon completion of the online survey, you will receive the pdf CME or CE certificate based on your credential, verification of name and attendance duration time, within two (2) weeks after webinar.

- ***Webinar participants will only have up to two weeks after webinar date to email Leilanie Mercurio at lmercurio@lacare.org to request the evaluation form if the online survey is not completed yet. No name, no survey or completed evaluation and less than 75 minutes attendance duration time via log in means No CME or CE credit, No CME or CE certificate.***

Thank you!