Cognitive Behavioral Therapies for Chronic Depression

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22.1 Introduction

Chronic depression is defined by complex, unremitting, and deeply entrenched psychological impairments, resulting in a high severity of symptoms that are often refractory to treatment [1]. Depressive symptoms are often defined as "chronic" after they have persisted for 2 years or more, although symptoms may remain present well beyond the 2-year mark [2]. Chronic depression is thought to manifest as one of the following subtypes: chronic major depressive disorder, dysthymic disorder, dysthymic disorder with major depressive disorder (MDD) ("double depression"), and MDD with incomplete remission [3]. The prevalence of chronic depression, based on these delineations, has been estimated to comprise approximately 3–6 % of the general population and about 30 % of depressed patients following acute treatment [4, 5].

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Compared with acute forms of depression, chronic depression is associated with more marked impairments in psychosocial functioning and work performance along with increases in healthcare utilization, societal costs, family burden, lost productivity, risk of suicide attempts, and hospitalization [6]. Furthermore, those with an early age of onset (before age 21) are often impaired even more severely and tend to display higher recurrence rates, comorbid personality disorders, psychiatric hospitalizations, and, among women, lower educational achievement and income [2].

Given these elevated risk factors, significant psychosocial impairments, and severe symptom profiles associated with chronic depression, traditional CBT interventions are often inadequate in helping patients achieve remission. While numerous studies and meta-analyses have demonstrated the efficacy of CBT in treating acute major depression [7–14], no substantive evidence has emerged to suggest that traditional CBT alone should be used to treat chronic depression. Instead, the literature points to the utility of a combined approach with CBT and antidepressant medications [15, 16], with combined treatment generally outperforming either treatment alone and medication alone performing significantly better than psychotherapy alone in most cases [2]. Based on these findings, there is a clear need for psychotherapeutic interventions that can effectively address the specific needs of chronically depressed patients. Over the past several

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years, data have emerged for several therapies that may address these needs. Of particular note are the so-called "third-wave therapies" and modified forms of standard CBT.

Preliminary data have suggested that a number of third-wave therapies may be effective in treating patients with chronic and/or treatment-resistant depression. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was specifically developed for this population [17]. Several authors [18, 19] argue that Acceptance and Commitment Therapy (ACT) is particularly effective for patients with severe, chronic, and treatment-resistant conditions. In addition, several modifications to traditional CBT have been suggested to facilitate the treatment of specific subpopulations suffering from depression including those with residual depressive symptoms [20]; patients with Parkinson's disease and comorbid depression [21]; lesbian, gay, bisexual, and transgender individuals with depression [22]; and, of most relevance, patients with chronic depression [1, 23]. While more high-quality randomized controlled trials (RCTs) are needed to determine the efficacy of these therapies for chronically depressed individuals (ACT and CBASP in particular), a small body of literature has surfaced in recent years pointing to their potential utility for this population.

22.1.1 CBASP

The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) is the first empirically supported psychotherapy designed specifically to treat adults with chronic depression [24]. The primary goal of CBASP is to help chronically depressed adults acknowledge and appreciate the consequences of their behaviors and incorporate an algorithmic approach to solving interpersonal issues [24]. While this approach draws upon the orientations of cognitive, behavioral, and interpersonal therapies [25, 27], it is also noticeably distinct from each. CBASP takes a more structured and direct approach than interpersonal therapy [27], and focuses more on the interpersonal realm than cognitive therapy [25], including discussions about patients' relationships with their therapists [24].

22.1.1.1 Conceptualization of Chronic Depression

Chronically depressed patients tend to think about and relate to their circumstances in ways that are especially rigid and maladaptive. These patients feel a complete lack of control over their condition; make global, negative assumptions about their personal worth; and lack the needed motivation to change as a result of gross catastrophizations and false assumptions about their role in the world. To make matters worse, they are often perpetually unaware of these dysfunctional thoughts and actions and, therefore, become increasingly disconnected from their social environments. Thus, the primary goals of CBASP are to reverse these cognitive distortions, promote behavioral change, and facilitate healthy social interactions by instilling "a perceived-functionality expectancy set [17]." This is done by guiding the patient to understand the contingency relationship between their behavior and its consequences. They are made aware of different possibilities for their future and new ways in which they can dynamically interact with, and derive meaning from, their world.

These rigid thought patterns most commonly exist within the context of chronically depressed patients social sphere and the inferences about themselves that are extracted from it. According to McCullough [17], the thought structure and language usage of chronically depressed adults tend to be less adaptive and in line with what one might expect from young children. CBASP draws a parallel between these patients and children in the preoperational stage of cognitive development [28, 29]. As defined by Piaget [30], thought in the preoperational stage is limited only to childrens' immediate perceptual experiences. For chronically depressed adult patients, these immediate perceptual experiences are almost invariably negative, along with any inferences about the future that are extrapolated from them.

Both preoperational children and chronically depressed adults are effectively trapped in their current perceptual experiences [17]. They are unable to extract themselves from the present moment or consider any other explanations for their circumstances other than the negative and destructive ones that are immediately salient.

This view has been found to be quite intractable, particularly in the early stages of treatment when traditional cognitive-behavioral methods are implemented [24]. As a result, these patients develop a worldview that is fixed and intractable, rather than one that is dynamic and reactive to the changing environment [17]. The subsequent worldview that is created by this maladaptive cognitive style does not allow for logical "if-then" reasoning. For these individuals, the future will be just the same as the present and the past, which are both, as a whole, negative.

22.1.1.2 Principles of Treatment

Clearly, there are several unique obstacles the psychotherapist must face in treating a chronically depressed adult. One of the primary goals early on in treatment should be to help the patient better understand the causal relationship between his/her behavior and its consequences [17]. As the patient learns that his/her behaviors do indeed have consequences, his/her can begin to develop the autonomy and motivation required to change these behaviors and the subsequent consequences [24].

The chronically depressed adult tends to speak about his/her problems in global terms (e.g., "nobody will ever love me," "I always fail at everything I try, no matter what") and is unable to pinpoint specific problematic situations in his/her life. This presents a large issue in treatment, as the capacity to identify particular problems with a particular individual is the first step in resolving such issues. An even larger barrier is the motivation to change the patient's behaviors and thus change the outcome of his/her problematic situations. The chronically depressed patient often firmly holds the belief that "no matter what he/she does, he/she will always be depressed," which unfortunately is a valid synopsis based on his/her prior history. In order to increase motivation, the therapist must continually show the patient, in-session, that he/she plays an active role in causing and perpetuating his/her own depression [17]. As a by-product of this realization, the patient will learn that he/she is capable of terminating these self-driven feelings of misery by changing his/her behaviors. This can be done during the visit by setting up a series of behavioral contingencies, primarily utilizing negative reinforcement strategies. In particular, it is critical to demonstrate that a patient's sadness and distress is mitigated when he/she engages in more adaptive behaviors [17, 31]. In order to best facilitate this process, the therapists must actively inhibit the natural tendency to talk about his/her patient's thoughts and feelings, as this puts him/her in a more observing role. Instead, the patient should be in a position in which he/she is forced to confront his/her behaviors head-on, rather than think about them abstractly. In this way, the patient may better understand the linear, causal relationship between his/her behaviors and the subsequent consequences.

For example, a patient who was terminated from a job that was "her life" insisted that she would never get another job as rewarding as the one she lost and that she was going to give up even trying to find another job. She stated that she did not have the interest or motivation to even try. In addition, she became preoccupied with the unfairness of life in general. During the therapy session, she only wanted to talk about her anger and hopelessness about not having a life. The therapist addressed the negative impact of her avoidant behavior and set limits on discussing her sense of hopelessness. The therapist queried about the impact of her negativity on her emotions and behaviors. Experiencing and realizing the cost of her negativity helped motivate her to initiate a plan to start exploring job opportunities on the Internet. Refocusing her attention on productive behaviors started to give her renewed hope and that she was responsible for her level of distress.

Another inherent difficulty in treating this population pertains to the patient-therapist relationship. Simply being in the presence of a chronically depressed patient can be a fairly challenging experience, especially early on in treatment. The patient tends to show detachment from his/her therapist and seems unwilling to contribute to the therapeutic process. The therapist must be particularly careful not to respond with frustration or anger in these circumstances and must also not respond in a reciprocal fashion by being overly controlling [17]. This lack of contribution on the patient's behalf often brings about this complimentary response from the therapist and results in the therapist assuming too

much responsibility in the change process. However, it is important (especially for this particular population) for the patient to assume this responsibility himself/herself. The therapist can facilitate this behavioral change by asking the question, "How does blaming others on your situation help you in reaching your goals."

In the interpersonal realm, the chronically depressed adult often carries with him/her an extensive history of failed relationships. The residual cognitive and emotional painful effects from the past are often recreated in the patient's relationship with the therapist. The therapist is viewed as being no different than persons from the past who contributed to the patient's distress. This can present a barrier in creating a working alliance founded upon trust and reciprocity. To counteract this dynamic, the therapist should work to create new corrective interpersonal experiences for the patient. As treatment continues, the patient needs to realize that he/she will not be punished or abandoned by someone close to him/her as previously experienced. The therapist must strive to repeatedly create these experiences and consistently point them out to the patient, remarking on the fact that no negative consequences have taken place [17].

22.1.1.3 Therapeutic Techniques

CBASP incorporates three main therapeutic techniques designed to construct in-session negative reinforcement contingencies (the Interpersonal Discrimination Exercise and Situational Analysis) and rehearse and reinforce skills learned in-session (Behavioral Skill Training/Rehearsal) [17].

22.1.1.4 Interpersonal Discrimination Exercise (IDE)

The chronically depressed patient has a propensity for viewing the therapist as a hurtful significant figure from his/her past. Thus, the patient expects to be hurt, rejected, and punished by the therapist, which is clearly an inhibitory factor in the change process. In an effort to prevent this counterproductive transference early on, the therapist implements the Interpersonal Discrimination Exercise (IDE) in the second session of CBASP. At this time, the therapist administers the Significant Other History procedure [24] and develops several transference hypotheses based on his/her perceptions of the patient's interpersonal issues [17]. During this procedure, the patient provides a brief list of significant individuals from his/her past and is asked to explain how each person influenced his/her life and who he/she became. It comes as no surprise that these influential figures have often had highly destructive effects on the life of the patient. This exercise is particularly useful in catalyzing a cause and effect thought process in the patient, as it requires him/her to draw connections between the actions of the chosen significant other and the way the patient currently behaves. From these realizations, a Causal Theory Conclusion [24] is derived. These conclusions clearly state the relationship each significant other has had on the patient and, subsequently, gives him/her the tools to contrast old and new interpersonal scenarios, thus opening the door for corrective emotional experiences throughout treatment.

22.1.1.5 Situational Analysis (SA)

Situational Analysis [17, 24, 32] is a highly structured social problem-solving exercise, which is introduced in the third session of CBASP. The main goals of Situational Analysis are to eradicate preoperational functioning, expose maladaptive behaviors so they can be modified, and demonstrate the consequences of the patient's behaviors in-session [17]. In SA, the patient is asked to select a specific interpersonal event that occurred recently and was problematic. He/she is then asked to describe the event in a narrative format, including all the details from beginning to end. The patient is strictly urged to stay within the time frame of the given event and not to form generalizations from it, as the patient is likely to do automatically. As the clinician leads the patient through an evaluation of the event, the particular problematic features of the event become clear and are often a microcosm of the more global interpersonal issues that the patient experiences [17]. In this way, the lessons learned from SA are highly translatable to other interpersonal problems in the patient's life.

The goal of SA has been achieved when the patient is able to identify the desired outcome of the event and contrast it from the actual outcome, discuss what could have been done differently to achieve the desired outcome, and begin to implement the process of SA independently to other problematic events.

22.1.1.6 Behavioral Skill Training/ Rehearsal (BST/R)

This third CBASP technique involves direct observation of the patient's maladaptive behaviors, the use of skill training to change these behaviors, and, ideally, the creation of more desired outcomes. Once maladaptive behaviors are identified via SA exercises, they are addressed in a variety of ways by the therapist, depending on the specific needs of the patient [33]. Since the patient tends to lack the necessary motivation to change, assertiveness training is often a key aspect of the skill training. Assertiveness training skills help the client achieve the appropriate balance between not being manipulated by others and not overreacting when one's needs are not met. These skills lead to an increase in self-confidence and self-efficacy. Automatic thoughts and emotional outbursts are often targeted as well [17]. It is during BST/R that the bulk of the actual change process takes place.

22.1.1.7 Outcome Studies

A small number of randomized clinical trials (RCTs) have been published on CBASP for chronic depression. Most of the early studies examined the efficacy of CBASP in comparison to antidepressant medications, primarily nefazodone. In a large, 12-site, multicenter clinical trial, Keller et al. [16] randomized 681 chronically depressed patients (illness duration of 2 or more years) to 12 weeks of CBASP or nefazodone or combined CBASP and nefazodone treatment. At the end of the acute-phase 12-week treatment, the overall rate of response (both satisfactory response and remission) was 48 % for both the CBASP and nefazodone groups compared to 73 % for the combination treatment group ($p < 0.001$ for both comparisons). Nonresponders from the nefazodone and CBASP groups were given an opportunity to participate in a crossover study for an additional 12-week trial; 140 agreed to participate (73 from the nefazodone nonresponders and 83 from the CBASP nonresponders). By week 12, the response rate for those crossed over to CBASP was 57 % versus 42 % for those crossed over to nefazodone. The switch to CBASP was associated with significantly less attrition due to adverse events, which was thought to explain the higher intent-to-treat response rate among those crossed over to CBASP. The authors concluded that nonresponders to either CBASP or nefazodone treatments may benefit from switching to the alternative treatment [34].

Only a few studies have compared CBASP with other forms of psychotherapy. Kocsis et al. [35] studied the impact of adjunctive psychotherapy in the treatment of chronically depressed patients who had an incomplete response to an initial antidepressant trial. In Phase 1 of the study, an open-labeled, algorithm-guided, 12-week antidepressant treatment plan was instituted based on a subject's history of antidepressant response; 491 of 808 subjects did not respond or had a partial response to antidepressants. In Phase 2 of the study, 200 subjects received CBASP, 195 received Brief Supportive Psychotherapy (BSP), and 96 received only medications for an additional 12 weeks of treatment. Thirty-seven percent of the subjects experienced remission or partial response in Phase 2, but neither CBASP nor BSP significantly improved outcomes over flexible dosing antidepressant monotherapy.

Schramm et al. [36] randomized 30 subjects, with early-onset chronic depression, to 22 sessions of either CBASP or Interpersonal Psychotherapy (IPT) over 16 weeks. The primary outcome measure was the change in the 24-item Hamilton Rating Scale for Depression posttreatment; a blinded, independent rater made the assessments. The Beck Depression Inventory (BDI) was a secondary outcome measure. Intent-to-treat analyses of covariance showed no significant difference in posttreatment HRSD scores between CBASP and IPT. However, BDI scores showed significantly higher remission rates in CBASP (57 %) versus IPT (20 %). Wiersma et al. [37] carried out a multisite randomized controlled

trial comparing CBASP ($n=67$) with care as usual (CAU) ($n=72$) over a period of 52 weeks. Psychopharmacological interventions were included in both groups since combined treatment is the standard of practice in the Netherlands, where the study was conducted. The primary outcome measure was the Inventory for Depressive Symptomatology (IDS) Self-Report; the IDS was administered at weeks 8, 16, 32, and 52. The CBASP group showed a significantly greater reduction on the IDS compared to CAU treatment only at week 52 ($t=-2.00$, $p=0.05$); there were no significant differences on the IDS between CBASP and CAU at weeks 8, 16, and 32. The authors concluded that CBASP was at least as effective as standard treatment for chronic depression; however, over time, CBASP may have added benefit.

Klein and colleagues [38] examined the efficacy of CBASP alone as a maintenance treatment for chronic depression in a sample of 82 patients who had responded to the acute and continuation phases of CBASP treatment [38]. These patients were assigned to either monthly CBASP sessions or assessment only for 1 year. Recurrence rates for patients in the CBASP condition were significantly lower than those in the assessment only condition, and the two groups differed significantly in terms of decrease in depressive symptoms over time, indicating that CBASP may be particularly effective as a maintenance treatment for chronic depression [38].

Although these results in both the acute and maintenance phases of treatment are promising, larger randomized, controlled studies comparing CBASP with other psychotherapy approaches are needed.

22.1.2 ACT

Acceptance and Commitment Therapy (ACT) is one of the most recent developments among the cognitive-behavioral therapies. Behavioral therapy (BT) was the first wave of cognitive-behavioral therapies and was derived from classical and operant conditioning. Treatment with BT focuses on exposure to help patients learn to tolerate and ultimately reduce disturbing emotions and maladaptive behaviors, as well as identifying positive and negative reinforcers of maladaptive behaviors. Cognitive therapy (CT) was the second wave of cognitive-behavioral therapies and developed from an information-processing perspective. Clinicians and researchers soon recognized that cognitions also impact emotions and behavior. Treatment with CT focuses on identifying irrational and dysfunctional beliefs and replacing them with more realistic and more adaptive interpretations of internal and external experiences. ACT developed coincidentally with mindfulness-based cognitive therapy and dialectic behavioral therapy; together, they make up the third wave of cognitive and behavioral therapies [39]. Historically, ACT developed from relational frame theory (RFT) which argues that context and experience determine our responses to language and cognition. In ACT, treatment focuses on learning to respond to internal experiences (thoughts, feelings, sensations, images, and memories) based on context rather than content; it essentially addresses the functionality of our internal experiences. Thus the goal of treatment is not to change the content of our negative thoughts, but to change our relationships to our negative thoughts. According to ACT, language is a significant contributor to psychopathology [40]. Summarized the impact of language on our experiences. Language processes can dominate over experience, thus allowing individuals to become insensitive to environmental contingencies and to persist in unproductive behaviors (e.g., carry grudges). Language has the power to change experiences. With our words, we can generate distressing experiences without actually having the experiences (i.e., the word disaster can generate a fear response without experiencing the disaster). Language provides targets of avoidance, including thoughts, feelings, sensations, images, and memories; language allows us to conclude that we cannot tolerate rejection, before actually experiencing rejection. And finally, language processes are controlled by context; external sources of reinforcement can lead to relational or functional interventions. In a

given situation, having the thought, "I am a loser," can be responded to by identifying multiple examples of being a loser (relational response), or the thought, "I am a loser," can be responded to based on how the thought assists in engaging in activities that have meaning and purpose (functional response).

ACT differs from traditional BT in that it uses exposure in the service of realizing an individual's values rather than reducing one's painful emotions or maladaptive behaviors. ACT acknowledges that with engagement in value-based activities, exposure to pain and distressing internal experiences is inevitable; pain and distress are very much a part of value-based activities. CBT uses relational interventions to undermine negative thoughts by challenging their validity (cognitive restructuring). ACT uses functional interventions to undermine the power of negative thoughts by responding to them based on their functional utility. ACT is not about insight, figuring out what went wrong, challenging beliefs, or stopping pain. The aim of ACT is to encourage the pursuit of actions that contribute to a life with meaning, purpose, and vitality, while accepting associated painful internal experiences.

The individuals that benefit from ACT are those whose behaviors are controlled by their internal experiences. Typical beliefs include: "I'll never accomplish anything"; "I can't get rid of my anger"; "I'm a victim of my past"; "I can't take this anymore"; "I can't tolerate rejection"; and "I can never be close to a woman." Giving these beliefs attention gives them power and leads to being "stuck" and, thus, living stops.

ACT recognizes two states of mind: the "thinking mind" or "conceptualized self," and the "observing mind" or "self as context." The thinking mind is always active and is a "thought generator" based on past experiences [41, 42]. The thinking mind is important in communicating with others, solving problems, making judgments, creating, planning for the future, and making decisions. These are very important attributes of the thinking mind. However, the thinking mind, through the use of language, can also create negative constructs about self, others, environment, past, and/or future. The thinking mind contributes to harsh judgments, self-criticism, painful comparisons, self-hatred, ruminations about painful past events, and worries about the future. In addition, the thinking mind constructs painful "stories" about self, others, and future. The degree of distress experienced is determined by how tight the attachment or "fusion" with the stories is. When we give these negative constructs too much attention, they add to our distress and we become creators of our suffering:

> "As a human species, we encounter many of the same painful events as do other species; humans and nonhuman animals alike are faced with loss, unexpected upsets, and physically painful experiences. Yet we do something with these encounters that they do not; we 'mind' about them, and through this process we amplify our suffering and we bring it with us" [43].

What separates us from nonhumans is our ability to observe our thinking; here resides our true self that transcends time and place. The thinking mind continues to generate positive and negative constructs, and we cannot prevent this from occurring. However, our true self enables us to observe and choose whether attending to the constructs of the thinking mind interferes or assists with the engagement in behaviors that give us a life with purpose and meaning.

According to ACT, psychopathology is determined by "psychological inflexibility" [42]. The resulting distress from fusion with painful thoughts or stories leads to avoidance, escape, or attempts to get rid of the associated negative thoughts, feelings, sensations, and/or memories; this process of avoidance is referred to as "experiential avoidance" [42]. The combination of fusion and experiential avoidance leads to a life that is narrow and constricted, thus resulting in psychological inflexibility, and a response repertoire that is limited. Other processes that contribute to psychological inflexibility include: inflexible attention or ruminations about the past and/or worries about the future (not being present in the moment), attachment to the conceptualized self (product of the thinking mind), lack of clarity about or contact with one's values (what matters, what one wants his or her life to be about), and inaction or acting inconsistently with one's

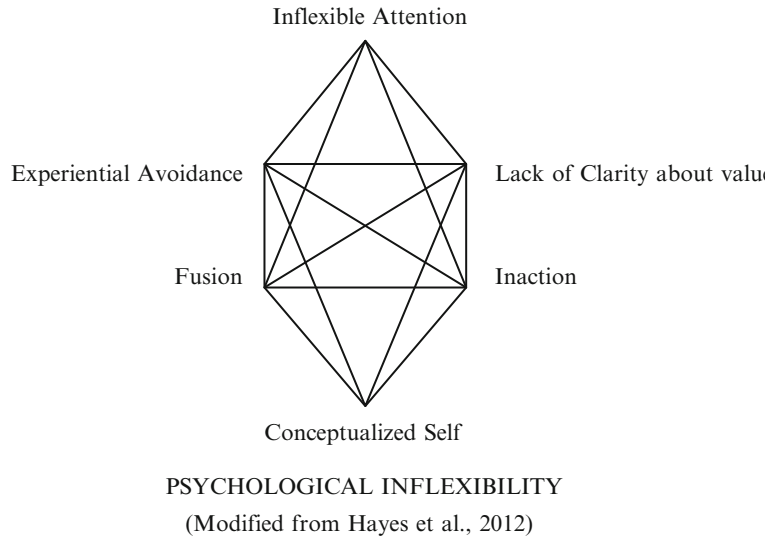

Fig. 22.1 Six processes that contribute to psychological inflexibility (modified from [42])

values. With psychological inflexibility, living a life with purpose and meaning "stops." Figure 22.1 depicts the six processes that contribute to psychological inflexibility. These six processes are interactive and depend on the other.

The focus of ACT treatment is on opening experience in the moment by: defusion from self-constructs that interfere with valued living, allowing room in our conscious awareness for painful experiences as an opportunity to observe and therefore learn, focusing on the present moment with flexible attention to enhance defusion, acceptance of self and external experiences to clarify one's values, and engaging in value-based actions in the present moment. These six processes contribute to psychological flexibility:

> "Psychological flexibility is contacting the present moment more fully as a conscious human being, as it is, not as what our mind says it is, and based on what the situation affords, changing or persisting in behavior in the service of chosen values." [43]

In other words, psychological flexibility is being aware and willing to experience, in the moment, distressing thoughts, feelings, sensations, images, and/or memories, while engaging in actions that matter.

Harris [44] describes psychological flexibility as: being more psychologically present in the moment; more in touch with one's values; more able to make room for inevitable pain; more able to defuse from unhelpful thoughts, feelings, sensations, and memories; more able to take effective action in the face of emotional discomfort; more able to engage fully in what one is doing; and more able to appreciate each moment of one's life, no matter how he or she is feeling. Figure 22.2 depicts the interaction of the six processes that contribute to the development of psychological flexibility. These processes interact and depend on the other.

22.1.2.1 Case of Jack

The case of Jack is a composite of cases in our clinic and is used to demonstrate the ACT model in clinical practice. Historical content and clinical content have been changed in order to protect confidentiality. Jack came to therapy at the age of 45 and reported feeling chronically depressed over the past 20 years. He attributed his depression to being alone. For years he desperately wanted to have a relationship with a woman and eventually get married, but he was extremely fearful of rejection. He believed that he would "fall apart" and be unable to tolerate the pain if he was rejected by a woman. Jack grew up in a conservative religious home with both parents and two siblings. His father made it clear that he did not want any children, and as a result, Jack never felt accepted by him. His mother was unavailable for Jack and his siblings due to her preoccupation

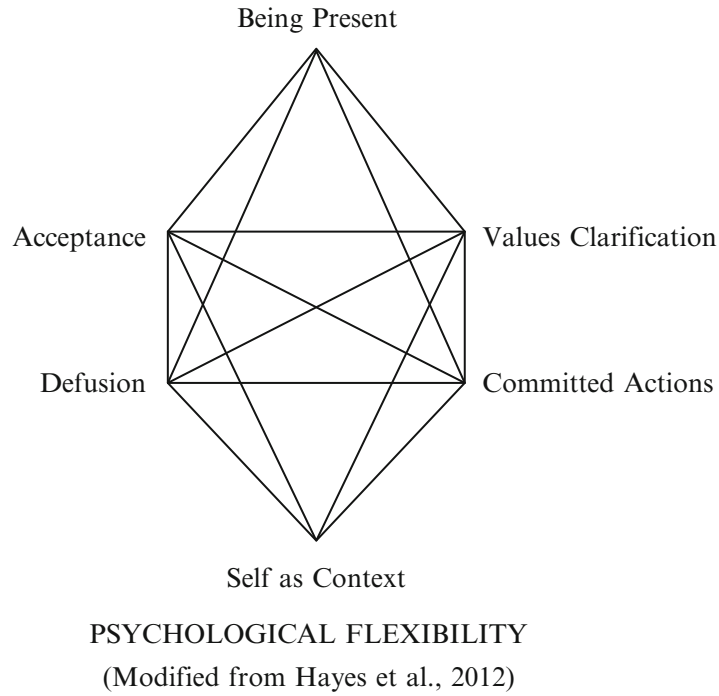

Fig. 22.2 The interaction of the six processes that contribute to the development of psychological flexibility (modified from [42])

with becoming a minister and spending most of her time taking classes at a nearby seminary. Jack learned from an early age that self-sacrifice was a virtue and having bad thoughts was equivalent to acting on them. He recalled the many times that he would run home from school, petrified that he would burn in hell for having bad thoughts. His fears of eternal damnation went unchallenged because there was no one available to give him comfort or help him get perspective. His father was very disrespectful towards women, and so Jack never felt he learned how to relate to them. Jack was not allowed to date girls throughout his teens which added to his insecurity in being with women. Throughout his adulthood, Jack felt inadequate with women, and when he made attempts at dating, he feared disappointing them and worried that his desires for closeness and intimacy would be perceived as being selfish and self-centered. At these times, he would experience intense guilt and punish himself with harsh self-deprecating statements; his only solution was to distance himself from women to avoid hurting them and to avoid feelings of guilt. Over the recent past, Jack's "thinking mind" constructed the following stories about his current situation: " I have no life because I have no one with whom to share it"; " If I have any pleasure with a woman, I feel that I am taking advantage of her"; "My past history renders me defective and inadequate to be able to have a meaningful relationship with a woman"; "The pain will be too great if a woman rejects me"; "I have not been successful in changing who I am through years of psychotherapy and medications; thus, I am damaged beyond repair"; "I'm 45 years old without a close relationship and I have no future." Jack often turned to recreational drugs to numb the pain of his suffering. The abuse of drugs complicated his life further by interfering with work as a software consultant, participating in his love of playing classical guitar, and taking adult education classes to address his intellectual curiosities in astronomy.

Early in ACT treatment, the therapist develops a case conceptualization by asking the following questions: What is the client's understanding of the problem(s)? What thoughts, feelings, sensations, images, and/or memories is the client avoiding? What approaches have been used to address negative internal experiences? How have these approaches worked? What has been the

cost of continuing with these failed approaches? And what would life be about if the problem(s) did not exist? By asking the question, "What internal experiences need fixing or need to be changed," the therapist gains insight into the degree that the client fuses with his or her negative thoughts, feelings, and memories. Acknowledging the cost of continued engagement in failed approaches helps motivate the client to consider an alternative psychotherapy approach that does not focus on insight, challenging beliefs, or avoiding pain. Asking the question, "What would life be about if the problem did not exist," is used by the therapist to open the door to values clarification. When one is fused with negative internal experiences and the conceptualized self, unwilling to accept his or her present situation, and not present in the moment due to ruminating about the past and worrying about the future, awareness of one's values is often absent. In developing Jack's case conceptualization, the therapist elicited the following responses from Jack to these questions:

1. Jack's understanding of the problem: "My past has rendered me defective in being able to have a relationship with a woman"; "I was never given the skills necessary to have a meaningful relationship."
2. Jack's thoughts, feelings, sensations, images, or memories that he avoided: "I'll fail at having a relationship"; "I will end up hurting a woman because of my own selfish desires"; "I'm depressed, anxious, and fearful all the time"; "I have a history of being unloved"; "My history is one of failure in being able to have a meaningful relationship with a woman."
3. Jack's approaches to address negative internal experiences: "psychotherapy to review how my past caused my problem," "medications to help me feel less depressed," "use of recreational drugs to numb my pain," and "periods of not trying treatment because of demoralization and hopelessness."
4. The cost to Jack for his engagement in these approaches: "I have felt like a failure since nothing has worked"; "I am still extremely lonely"; "My avoidance and fear of rejection have resulted in me not experiencing love"; "My heavy use of drugs to numb my pain has complicated my life in multiple ways."
5. What would Jack's life be about if the problem did not exist: "I would feel valued and a part of someone's life"; "I would be sharing my interests and pleasures"; "I would be there for someone"; "I would be experiencing love."

The therapist also assessed Jack's current behavior along the six processes (acceptance, defusion, present moment, self as context, values, and committed action) for psychological flexibility. Using the Flexibility Rating Sheet [42], each process was scored along a 10-point scale from 0 to 10; a rating of 0 means none or very rarely, 5 means at times or with encouragement, and 10 means fluent and flexible. On "acceptance," Jack scored a 2 because he believed that since he was not accepted by his father, he would be unacceptable to anyone; he was extremely fearful and avoidant of situations where there was any risk of being rejected. Jack scored a 1 on "defusion"; he was totally fused with his story that he was a victim of his past and therefore "damaged goods." On "being present," Jack scored a 1; throughout the assessment period, he ruminated about his past and his anger over not being loved. He reported that while alone in his apartment, he would have the image of yelling at his father for not being there for him and ruining his life. Jack reported that he could never get over his rage at his father. He also was preoccupied with being convinced that he has no future and he will live a life of loneliness and despair. Jack's score on "self as context" was a 1 since he was totally fused with the self-construct of being damaged beyond repair. He focused on being a victim of his past, and he could not see how the damage could be corrected; he also strongly believed that the damage had to be corrected in order to have a life. With regard to "values," the therapist gave Jack a score of 5. Jack was clear about the importance of having a relationship that was reciprocal and giving. But there were times that he would allow avoidance to intervene, and he would retreat into believing that having the value of an intimate relationship was meaningless since it was unattainable. On "committed action," the therapist gave Jack a

score of 3. Jack's willingness to engage in working on having a relationship was minimal. In the recent past, he made a few attempts to date, but he would not pursue relationships beyond a few encounters. His fear of rejection and his construct that he would "fall apart" if he was rejected prevented him from any willingness to expose himself to pursuing a relationship with a woman.

Throughout Jack's previous treatments, he struggled with trying to figure out and understand his history and why he ended up in his present situation. In his past treatments, Jack believed that insight would eventually resolve his problem. However, reliving the past kept him in the past and perpetuated his emotional distress. He also focused on trying to control his distress with avoidance out of fear of failure and trying to control his pain with drugs. He was consumed with experiential avoidance. His history was one of never feeling accepted by important people in is life; thus, he concluded that acceptance by anyone was unattainable. Therefore, his attachment to his negative internal experiences controlled his behaviors rather than his values or what he wanted his life to be about. When Jack was asked to identify his values, he stated that he was embarrassed to say that he had never thought about what mattered to him, because much of his attention was focused on being damaged and defective due to his past. He also said that his experiences were limited to avoidance of pain. Thus, Jack's behavior was not determined by values and experience but by avoidance of negative internal experiences.

ACT offered Jack an alternative approach to his struggles. Rather than reliving the past in order to gain insight as a means to resolve his problem, the approach using ACT was to be willing to have one's history and hold on to it lightly, while engaging in behaviors that were based on his values. It was the engagement in value-based behaviors that would give Jack a sense that he was living a life with meaning and purpose.

The elements of Jack's treatment included the following:

1. The therapist provided psychoeducation about the "thinking mind" and the "observing mind" in order to help Jack understand that "being a victim of his past" was a construct of the thinking mind and that his attachment to "being a victim" kept him stuck in the past and prolonged his suffering. With this awareness, it became clear to Jack that he had a choice with regard to his focus of attention. Learning mindfulness meditation skills and getting access to the observing mind enabled Jack to defuse from "being a victim of his past."
2. Acceptance of self and his history was also introduced early in order to free Jack from ruminations about his past and worries about the future. Acceptance allowed him to be present and engage in value-based activities that were available to him in the moment.
3. Learning to be present with his negative internal experiences enabled Jack to see that his distressing thoughts, feelings, and memories disappear or go to the background of conscious awareness when not trying to control them. His experience taught him that the more he tried to control his negative internal experiences, the more he had them.
4. Mindfulness practice not only enabled Jack to defuse from ruminations about the past and worries about the future, but he became cognizant that his only reality was in the present moment. And by being present, his awareness was broadened to what was available in that moment, which provided him more opportunities to engage in value-based activities.
5. Work on values clarification included not only Jack's values in the context of having a loving relationship but values in the domains of other relationships (e.g., friends, family, coworkers), intellectual pursuits (e.g., adult education classes), healthy lifestyle (e.g., nutrition, abstinence from drugs, exercise), recreation (e.g., music), and work (e.g., improve work skills). Values clarification helped him develop a repertoire of values in which to engage with committed actions, when needed in the present moment. These value-based actions also helped keep Jack present and defused from ruminations about the past and worries about the future. Values provided Jack with directions to take in life, whereas his value-based goals became targets for achievement.

6. While engaged in the experience of value-based behaviors (e.g., dating), Jack realized the cost of fusion with his negative constructs of the "thinking mind" and the resulting experiential avoidance.
7. During the course of his treatment, Jack discovered that engagement in value-based behaviors included painful experiences as well (e.g., fear of rejection while still engaged in dating). However, he became more willing to accept painful experiences because he was on his path of living a life with meaning and purpose.

In teaching the six processes that lead to psychological flexibility, the therapist used metaphors and Jack's past experiences as contexts for learning. For example, the therapist introduced the metaphor of having a tug-of-war with a monster to address his conceptualized self of "being damaged beyond repair." The more one pulls on the rope, the more the monster pulls and, therefore, the more one is engaged with the monster. Jack learned that the solution was to stop pulling and drop the rope. Ultimately, his degree of suffering and the cost of his experiential avoidance were the motivating factors that lead Jack to "drop the rope" and to start committing to value-based actions (e.g., working on relationships). Before committing to behaviors towards having a relationship with a woman, Jack pursued less challenging value-based actions. These included abstinence from drugs, committing to a more healthy lifestyle (e.g., going to the gym and improving nutrition), and getting back to playing the guitar. Eventually, he was open and willing to experience the possibility of rejections as a part of the process of engaging in his value-based pursuit of having a loving relationship with a woman. He learned from his experience that when a relationship did not work out, although it was painful, it was because there was not a good fit, rather than a confirmation of his thinking mind construct, that his past had rendered him defective in being capable of having an intimate relationship. The more engaged in committed actions towards his valued-based goal to eventually marry, the more open he became to learn from his experience, which enhanced his social skills and confidence in relating to women.

22.1.2.2 Outcome Studies

There are very few studies comparing ACT with CT in patients with depression in general and even fewer in patients with chronic depression. The following outcome studies represent the available studies for both the acute and long-term effectiveness of ACT versus CT. Theoretically, the ACT approach of disengagement from one's prolonged history of distress, while engaging in value-based actions, might have added benefit over cognitive restructuring for patients with chronic depression; however, there are no studies that definitively address this query.

In a randomized controlled effectiveness trial of ACT versus CT for outpatients ($n = 101$ randomized; 57 completers; 80.2 % women) presenting with a mixture of depression and anxiety, Forman et al. [45] found large and equivalent improvements in depression (Beck Depression Inventory) and anxiety (Beck Anxiety Inventory), functioning (Outcome Questionnaire), quality of life (Quality of Life Index), life satisfaction (Satisfaction with life Scale), and clinician-rated functioning (Global Assessment of Functioning Scale) in both treatment groups. The authors also examined hypothesized differences in mechanism of action of the two treatment groups by conducting exploratory analyses of mediation. Formal mediational analyses could not be performed because there was no control group and because mediator variables were assessed simultaneously with outcome variables. The clinical practice of CT focuses on changing the content of dysfunctional thoughts using cognitive restructuring, whereas ACT focuses on changing one's relationship to his or her negative thoughts by defusion and engaging in value-based activities. The authors found that "observing" and "describing" one's experience were closely associated with outcomes in the CT group, while measures of experiential avoidance, acting with awareness, and acceptance were more closely associated with outcomes with the ACT group. These results suggest functionally distinct mechanisms for CT and ACT outcomes.

Forman et al. [46] also reported on one of the first long-term follow-up randomized controlled trials comparing ACT with CT. One hundred

thirty-two anxious or depressed patients were randomized to either ACT or CT. Assessments were performed posttreatment ($n=90$) and at 18 months posttreatment ($n=91$). There were no differences between the two groups immediately posttreatment on the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Outcome Questionnaire (OQ), and Quality of Life Index (QOLI). However, assessments at 18 months showed that one-third more CT patients were in the normative range for depression and more than twice as many CT patients were in the normative range for level of functioning compared to ACT patients. CT showed more durability on these two measures. The authors offered three explanations for the differences in outcome: CT is more intuitive and easier to apply once treatment has terminated, whereas ACT runs counter to social norms and customs; the ACT therapists were less experienced since they were trainees; and most patients in the study were high functioning with modest symptoms, and according to some authors, ACT is more effective for patients with severe, chronic, treatment-resistant conditions [19, 19].

Carlbring et al. [47] reported on a randomized, 8-week, controlled trial using an Internet-based behavioral activation and acceptance-based treatment for depression. Behavioral activation was combined with elements from ACT; the components added from ACT included defusion, acceptance and mindfulness skills, and values clarification to determine the content of behavioral activation. Eighty subjects were randomized to treatment versus a wait list. The primary outcome measure posttreatment was the BDI-II; the between group effect size on the BDI-II was $d=0.98$ (95 %CI=0.51–1.44). The treatment gains persisted over the following 3-month period without further significant improvement. The remission rate was 25 %, which was low compared to 44.3 % in a tailored CBT treatment versus 26.5 % in a standard CBT Internet treatment [48]. The authors concluded that their Internet-based behavioral activation and acceptance-based treatment can be effective in reducing symptoms of depression.

A recent Dutch study suggests that early intervention using ACT for adults with some depressive symptomatology may reduce the risk of the development of a full clinical episode of depression [49]. The authors randomized 93 subjects with symptoms of depression to either 8 weekly two-hour group sessions of ACT ($n=49$) versus a wait list ($n=44$). The primary outcome measure was the Center for Epidemiologic Studies Depression Scale (CES-D), which is a 20-item questionnaire that measures depressive symptoms in the general population. Subjects rate on a 4-point scale ranging from hardly ever (less than 1 day; score of zero) to predominantly (5–7 days; score of three) with regard to depressive symptoms in the previous week. The ACT group compared to the wait-list showed a significant reduction in symptoms of depression on the CES-D. The CES-D effect sizes for ACT posttreatment and at 3-month follow-up were Cohen's $d=0.60$ and 0.63, respectively. The authors also performed mediational analyses. In the mediational analyses, they used the Acceptance and Action Questionnaire-II as a measure of experiential avoidance. Controlling for CES-D and AAQ-II at baseline, treatment with ACT significantly reduced symptoms of depression at follow-up. Improvement in AAQ-II scores from baseline with ACT significantly predicted changes in CES-D scores at follow-up. The mediating effect of AAQ-II was significant at $p<0.05$ with bootstrapping values between −4.10 and −0.67.

To further address the uniqueness of the processes of change between ACT and CT, Zettle et al. [50] performed a mediation reanalysis on an earlier study by his group [51]. Their mediational reanalysis study is a response to recent critics that ACT is no different than CBT [52, 53]. Mediational analysis assists in addressing the question of what is the mechanism for change with a given treatment. Zettle et al. [50] point out that Hayes et al. [54] performed a reanalysis of their early small study [55] and showed that the differences between ACT and CT were mediated by reductions in believability (measure of cognitive fusion) of depressive thoughts rather than their occurrence. Zettle and Rains' [51] original early study compared ACT and CT in depression. Patients were randomized to ACT ($n=12$), CT ($n=13$), and CT ($n=12$) without cognitive dis-

tancing elements. The authors hypothesized that if ACT was nothing more than an extreme form of cognitive distancing applied in CT, then ACT should have the best outcome followed by CT and CT without cognitive distancing. However, ACT had the best outcome followed by CT without cognitive distancing and CT; however, the differences were minimally statistically different. Zettle and Rains concluded that ACT was not just distancing as conducted in CT. In their recent mediational analysis comparing ACT with CT, the ACT group showed greater reductions in the Beck Depression Inventory (BDI) using an intent-to-treat analysis. Posttreatment measures of defusion, using the Automatic Thought Questionnaire-B (ATQ-B), mediated this reduction in the BDI. Interestingly, the occurrence of automatic thoughts and the degree of dysfunctional attitudes, as measured by the Automatic Thoughts Questionnaire and Dysfunctional Attitudes Scale, respectively, were not mediators of outcome. Thus, this study supports earlier studies demonstrating that the mechanism of change in ACT is distinct from CT.

22.1.2.3 Assessment

In the chronically depressed patient, symptoms as well as functioning can be assessed utilizing the same validated instruments presented in Chapter 6 of this handbook. The aforementioned scales associated with ACT are utilized within delivery of that treatment.

22.1.2.4 Summary

CBASP is the first psychotherapy that specifically targets clients who are chronically depressed. According to CBASP, chronically depressed patients feel they have no control over their condition; make global, negative assumptions about their personal worth; and lack motivation to change as a result of false assumptions about their role in the world. In addition, they lack awareness of these dysfunctional thoughts and actions and, as a result, become increasingly disconnected from their social environments. Thus, the aim of CBASP is to reverse these cognitive distortions, promote behavioral change, and facilitate healthy social interactions. This is accomplished by helping clients understand the relationships between their behaviors and their consequences. As the clients learn that their behaviors do indeed have consequences, they can begin to develop the autonomy and motivation required to change these behaviors and the subsequent consequences. CBASP incorporates three main therapeutic techniques to assist clients in achieving more adaptive behavioral changes including: Interpersonal Discrimination Exercise, Situational Analysis, and Behavioral Skill Training/Rehearsal. There are a limited number of studies showing the efficacy of CBASP in chronically depressed patients.

However, CBASP has been shown to be:

- As effective as the antidepressant, nefazodone
- Combined treatment with CBASP plus nefazodone is most effective
- Treatment with CBASP through the continuation and maintenance phases results in low relapse rates
- Clients who fail to respond to an antidepressant may benefit from CBASP
- CBASP is as effective as other psychotherapy approaches and may have added benefit in the long term

However, large, randomized, control studies are needed to confirm these findings.

ACT stresses the importance of living a life that has meaning and purpose, while being aware and allowing negative internal experiences that are creators of our suffering. ACT also teaches that experience and values should be the determinants of behavior rather than unwanted thoughts, feelings, and memories. Fusing with negative internal experiences leads to experiential avoidance and a life that is narrow, limited, and absent of vitality. Although clients are unable to control the "showing up" in conscious awareness of negative internal experiences, they do have a choice, whether to engage or pay attention to those internal experiences based on their value-based functionality. ACT has been shown to be an effective treatment for depression acutely and in the long term. However, there is no clear evidence that ACT is superior to CT; the results are mixed and there is a need for adequately powered, randomized, controlled trials of ACT versus

CT in not only acute, but chronic, depression as well. Mediational analysis suggests that ACT has a distinct mechanism of action compared to CT.

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Additional Resources: On-line Resources

69. BluePages: provides psychoeducation on depression and its treatment.
70. MoodGYM: an online CBT package.
71. University of Michigan. Self-management of depression resources. http://depressiontoolkit.org/.
72. The American Psychiatric Association has guidelines for evidence-based treatments (http://psychiatryonline.org/guidelines.aspx).
73. The UK based National Institute for Health and Care Excellence has information on evidence-based treatments for psychiatric disorders. http://www.nice.org.uk.
74. TED talk on depression. www.ted.com/talks/andrew_solomon_depression_the_secret_we_share.html.

Additional Resources: Phone Applications

75. Life charge. J Your Ups Downs. https://itunes.apple.com/us/app/life-charge-journal-your-ups/id648567759?mt=8.
76. The Cognitive Behavioral Institute of Albuquerque's CBT app: https://itunes.apple.com/us/app/ipromptu/id717391862?mt=8.
77. MoodKit. www.moodkitapp.com.