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ACT for Life: a Brief Intervention for Maximizing Recovery After Suicidal Crises

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Disclaimer

- This presentation is based on work supported by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

Conflicts of Interest

- None to report

Poll Question #1

What is your primary role related to mental healthcare? **(select all that apply)**

- Consumer
- Student, Trainee, or Fellow
- Clinician
- Researcher
- Administrator, Manager, Policy Maker
- Other

Poll Question #2

Do you work within the Department of Veterans Affairs?

- Yes
- No

Poll Question #3

How familiar are you with Acceptance and Commitment Therapy?

- Never heard of it.
- I've heard of it.
- I've read about it.
- I've been trained in it.
- I use it.

Overview

1. Background on suicide, suicide among Veterans, and challenges of suicide prevention

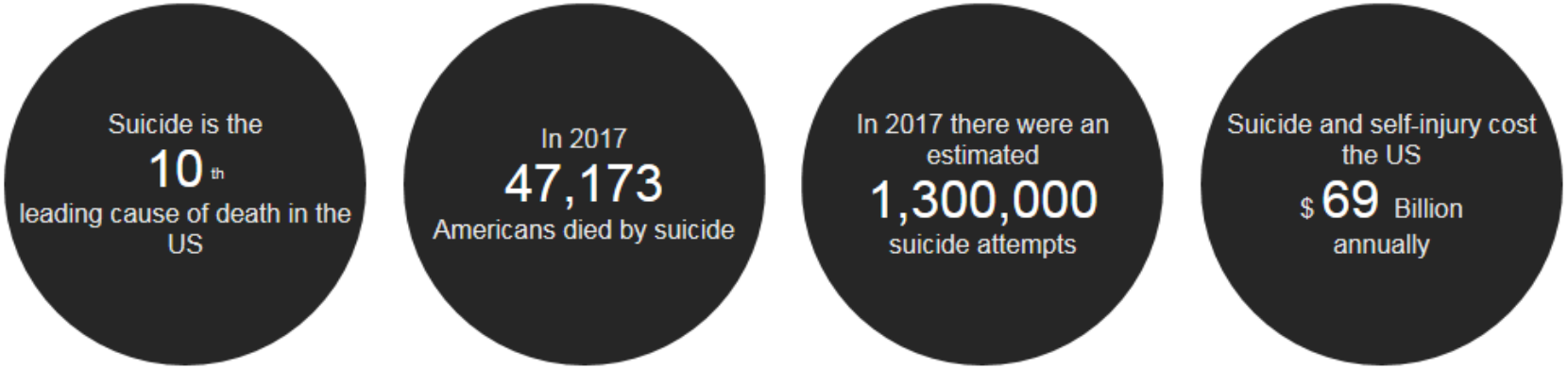
2. Development of ACT for Life Treatment Protocol

3. Randomized controlled acceptability and feasibility study

4. Conclusions and Future Research

Background on suicide, suicide among Veterans, and challenges of suicide prevention

Suicide is a leading cause of death in the United States

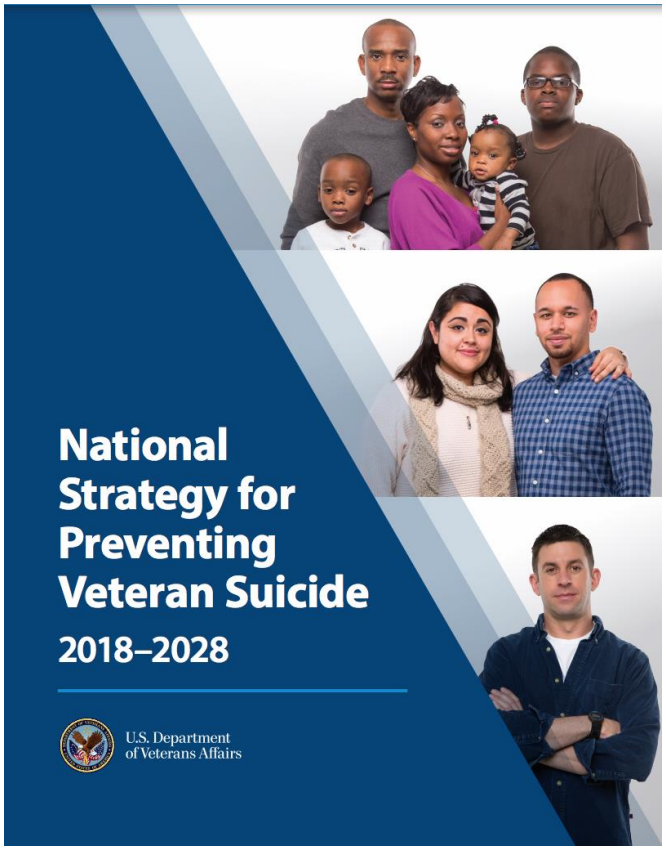


Source: https://afsp.org/about-suicide/suicide-statistics/

Suicide Prevention is VA's Top Priority

Approximately 20 Veterans die by suicide every day.

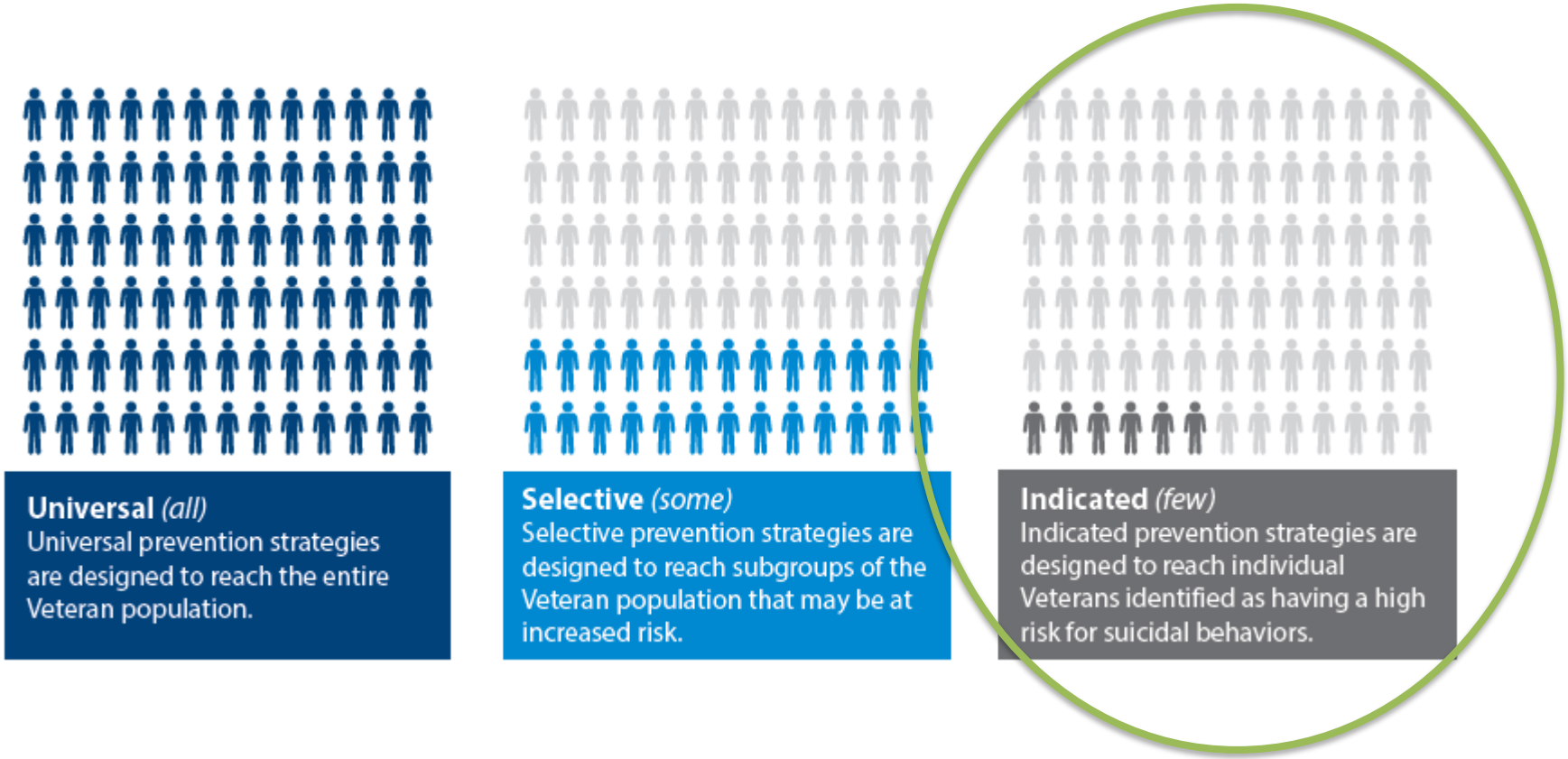
- Only 6 of these Veterans are enrolled in VA healthcare



Takes a comprehensive public health approach to preventing Veteran suicide

https://youtu.be/i-xKK2HbmpI

Need Effective Interventions for Veterans Hospitalized Due to Suicide Risk



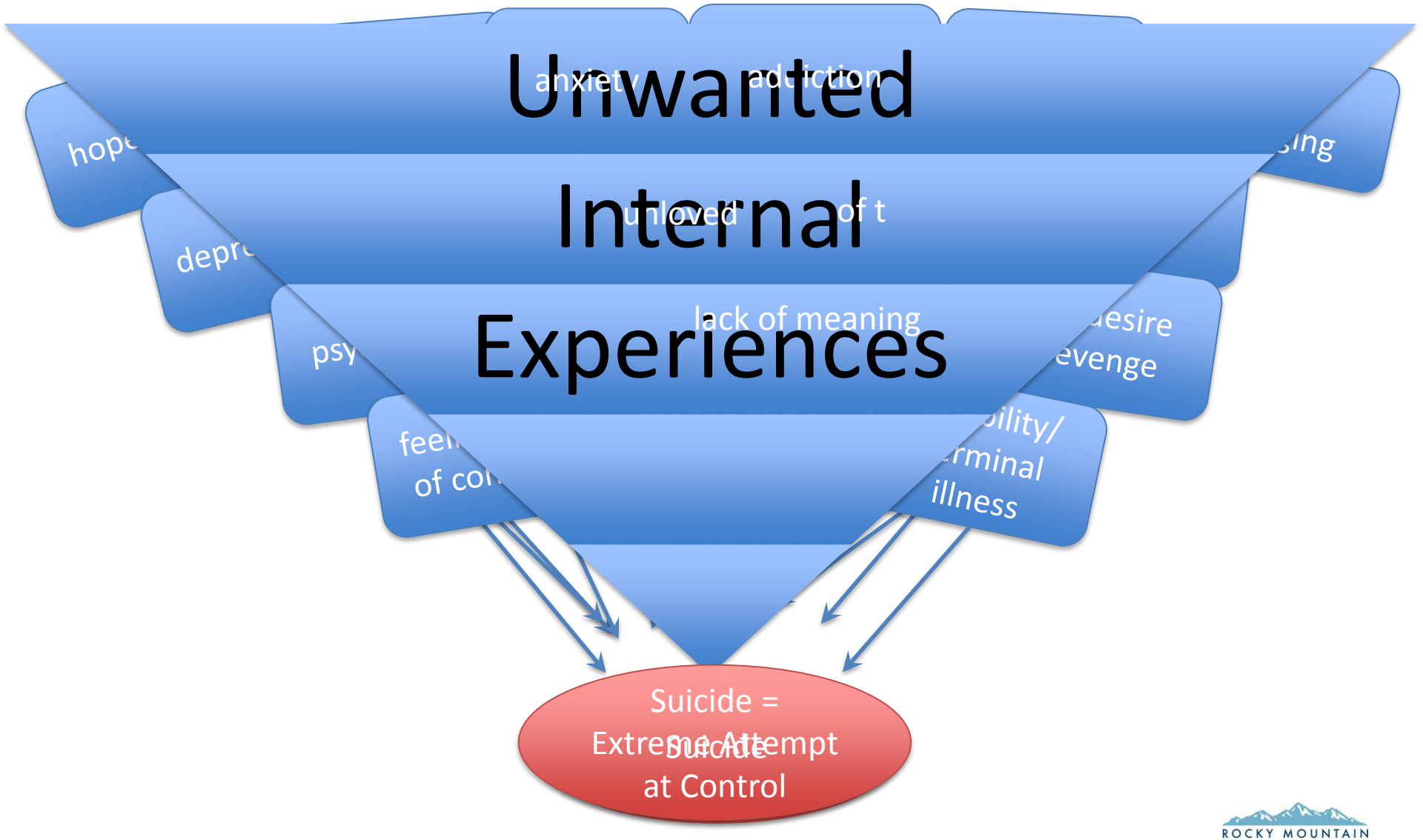
Source: https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

Need for Empirically Supported Behavioral Interventions for Inpatient Care

- Psychiatric hospitalization is a critical opportunity to provide treatment to reduce the risk of suicide and lay the groundwork for functional recovery.
- There is a lack of suicide-specific research-supported psychotherapies that can be feasibly delivered during a typical VHA inpatient stay.
- There are many pathways to suicide. Can we offer an intervention relevant to all of them?

ACT for Life Treatment Protocol Development

There are many paths to suicide. Which should treatment focus on?



Chiles & Strosahl, 2005; Hayes, Strosahl, & Wilson, 2012; Hayes, Pistorello, & Biglan, 2008

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Suicide from a Contextual Behavioral Perspective

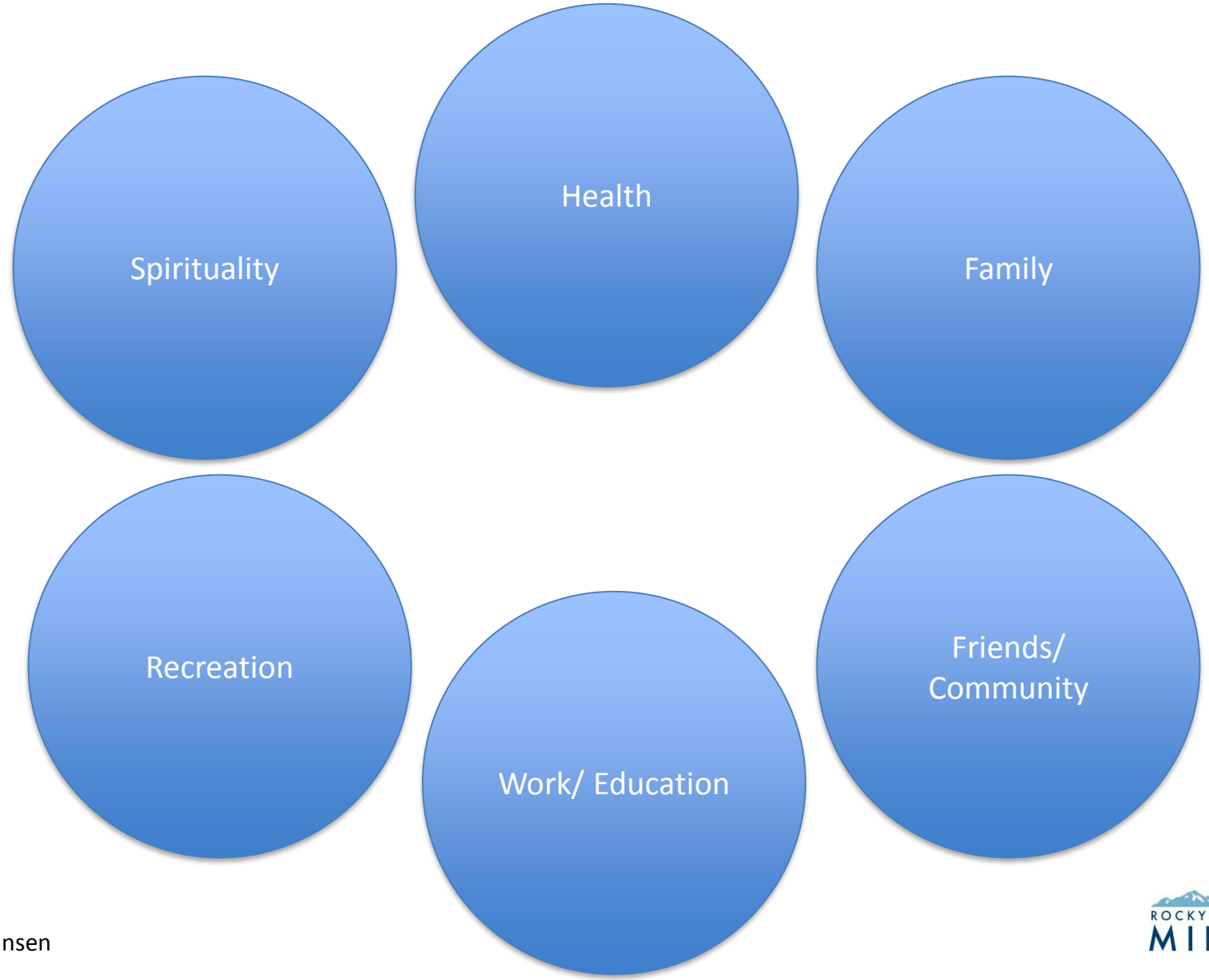
The function of suicide is to **control unwanted** emotions, thoughts, and/or physical sensations (i.e., **internal experience**).

- Suicidal ideation and behaviors can result in both the cessation of unwanted experiences (e.g., agitation) and/or the start of wanted experiences (e.g., sense of control)
  - *Suicide can be negatively and/or positively reinforcing and is often maintained through multiple pathways.*

Suicide results from persistent and escalating attempts to succeed at an **unworkable agenda of internal control**.

Chiles & Strosahl, 2005; Hayes, Strosahl, & Wilson, 2012; Hayes, Pistorello, & Biglan, 2008

Impact of Unworkable Attempts at Internal Control



Source: Hansen

Impact of Unworkable Attempts at Internal Control

Conclusion

Treatment Target #1 = avoidance of unavoidable pain
Treatment Target #2 = disconnection from valued behavior

Source: Hansen

What is Acceptance and Commitment Therapy (ACT)

- ACT is a recovery-oriented, psychosocial, evidence-based approach for treatment of individuals experiencing unwanted thoughts and feelings.

- The heart of Acceptance and Commitment Therapy is captured in its acronym, "ACT"- to *accept* what is out of your control, *connect* with your values, and *take* actions that are consistent with what you want your life to stand for.

- ACT teaches psychological skills to step out of the struggle with painful thoughts, emotions, and sensations, but unlike other therapies, ACT is not about correcting or getting rid of unwanted thoughts, emotions, and sensations. ACT directly targets functional recovery by assisting patients in identifying and engaging in value-consistent behaviors despite the potential for distress.

See Hayes, Strosahl, & Wilson, 2012

Why ACT is a good fit for inpatient psychotherapy

Barrier	Need	ACT as Solution
Short length-of-stay	Brief interventions	ACT includes experiential exercises and metaphors for rapid learning through lived experiences. Success as 3-hour inpatient intervention for psychosis.[1]
An enormous range of problems can lead to suicide.	Suicide-specific, transdiagnostic interventions	ACT is a transdiagnostic intervention and can address suicide risk regardless of its cause.[2]
Many other interventions focus almost exclusively on distress tolerance/safety and neglect the need to foster recovery and build life.	Recovery-oriented interventions that promote distress tolerance AND build a life worth living.	ACT directly targets functional recovery by helping clients in identifying and engaging in values-consistent behaviors despite associated aversive thoughts, emotions, or sensations.[3]
Inpatients are often severely ill.	Flexible interventions that do not require extensive insight or cognition.	ACT involves experiential exercises that do not require intensive cognitive and verbal processing and can be tailored to the clients level of functioning.[3]
Clients at the highest risk for suicide often do not follow through with treatment recommendations.[4]	Inpatient interventions that increase the likelihood of engaging in outpatient services.	Research on ACT for behavioral health changes (e.g., diet) suggests that as clients become invested in rebuilding a life they value, they are more likely to follow treatment recommendations.[5]

[1]Gaudiano & Herbert, 2006; [2]Hayes, Pistorello, & Biglan, 2008; [3]Hayes, Strosahl, & Wilson, 2012; [4]Knesper, 2010; [5]Gifford et al., 2005

Research and Theoretical Support

- **Research supports the theoretical applicability of ACT to suicide prevention based on associations between ACT processes and suicide-related outcomes**
  - **Experiential Avoidance:** DeBeer et al., 2017; Ellis & Rufino, 2016; Zvolensky et al., 2016
  - **Mindfulness:** Chesin & Jeglic, 2016; Lamis & Dvorak, 2014
  - **Values and Committed Action:** Bahraini et al., 2013; Monteith et al., 2015

- **Theory-based Publications and Case Studies**
  - Chiles & Strosahl's (2005) *Clinical Manual for Assessment and Treatment of Suicidal Patients*
  - Hayes, Pistorello, & Biglan (2008) article describes how ACT can be applied to suicide prevention
  - Barnes et al. (2017) chapter describes use of ACT to understand and prevent suicide
  - Luoma & Villatte (2012) case study describes use of mindfulness processes in the treatment of suicidal behavior
  - Razzaque et al. (2013) case study of frequent brief inpatient ACT sessions

- **Treatment Research**
  - ACT for Depressed Veterans resulted in increased experiential acceptance scores, which were associated with lower odds of suicidal ideation across time (Walser et al., 2015)
  - ACT for Management of Suicidal Patients pilot showed reductions in suicidal ideation (Ducasse et al., 2014)
  - Small randomized controlled trial of an ACT-based self-help mobile app did not find significant reductions in suicidal ideation (Tighe et al., 2017)

Treatment Protocol Development

- **Formative Evaluation**
  - 18 leading experts on ACT were asked how they would apply the treatment approach with Veterans hospitalized for suicide risk if they only had a total of three contact hours.
  - Provided experts a rough outline of our planned protocol and asked for feedback

ACT Expert Advice	ACT for Life Treatment Manual Revisions
Given the breadth of presenting problems and levels of functioning, the intervention needs to be flexible.	The manual now includes a modular format with flexible session stopping points and alternative exercises.
Incorporate values work in the first session and end with a hopeful message to promote engagement.	Module one now includes values assessment and presents an alternative to the ineffective control strategy.
Engaging in value-consistent action between sessions seems extremely helpful with this population.	This is now incorporated as independent practice between each session.
When brief ACT interventions are delivered without empathy they can seem punishing.	The manual now includes guidance for maintaining an empathic stance and normalizing the Veteran's experience.

ACT for Life:

Learning to Work with Pain and Build a Life Worth Living

Clinician's Guide

Sean Barnes, Geoffrey Smith, & Nazanin Bahraini
in consultation with Robyn Walser

ACT for Life protocol designed to:

- destigmatize suicidal ideation and urges by highlighting them as an extreme part of the control agenda
  - Normalize attempts to control unwanted experiences while also helping the Veteran discover the limited efficacy and high cost of attempts to control unwanted internal experiences
- promote mindfulness of experiences driving suicidal behaviors and increase capacity to respond flexibly in their presence
- directly target ***functional recovery*** by assisting patients in identifying and engaging in value-consistent behaviors despite associated aversive thoughts, emotions, or sensations
- augment safety planning
- Three modules delivered individually over the course of 3 to 6 sessions.

ACT for Life – Module One

Intentions:

(1) Help the Veteran take stock of what is keeping him/her stuck

(2) Uncover the unworkable agenda of control, and identify suicide as an extreme attempt to control experience

(3) Instill hope by identifying values and presenting willingness as the alternative to control

Potential Content:

(1) Introduction to ACT

(2) Creative hopelessness exercises

(3) Initial values identification

(4) Commitment to daily meaningful moves

(5) Introduce/practice mindfulness

Joining with the Client to Undermine the Control Agenda:
Creative hopelessness/assessment

1) *What emotions, thoughts, memories, or physical sensations have you been trying to get rid of?*

Depression, physical pain, boredom, feeling like a failure, shame, "My daughter would be better off without me," "No one loves me," "No one would care if I died,"

2) *What have you tried?*

Rumination, isolation, opiates, drug use, alcohol, exercise, staying busy, focusing on breath, therapy, romantic relationships, thinking about suicide, attempting suicide

3) *How long have you tried it for?*

[many for most of life, others more recent]

4) *How has it worked? Has it gotten rid of it?* (consider both short- & long-term)

[most result in temporary relief, but fail to get rid of unwanted internal experience permanently]

5) *What has it cost you?*

Jobs, relationships, reputation, marriage, money, homes, custody of daughter, time, opportunity

Strosahl, Robinson, & Gustavsson, 2012

"Of course your mind is thinking about killing yourself"

Bad/Broken/ Dirty/Unwanted Things

Unwanted/ "Bad" Internal Experiences

I (and/or the world) am Bad/Broken Dirty/Unwanted

Taught that we Should Get Rid of Them

Told we Should be Able to Get Rid of It

Repeated Failure & Escalation

I Need to Get Rid of This & Nothing Else Will Work

Of Course Your Mind Would Turn to Suicide.....

(but what if you didn't have to get rid of it?)

ACT for Life – Module Two

Intentions:

(1) Explore skills to gain behavioral freedom

(2) Promote willingness and value-driven behavior as an alternative to control

(3) Help Veteran reconnect with values

Potential Content:

(1) Mindfulness practice

(2) Cognitive defusion exercises (e.g., thoughts on cards)

(3) Self as context exercises

(4) Values card sort

(5) Commitment to daily meaningful moves

ACT for Life – Module Three

Intentions:

(1) Help Veteran shift focus from death back to life

(2) Promote more reflection on what the Veteran wants his/her life to be about

(3) Help Veteran plan for a value-driven life and minimize the likelihood of suicidal crises interfering

Potential Content:

(1) Mindfulness practice

(2) Passengers on the Bus/Road Map to Wellness

(3) ACT for Life Safety Plan

(4) Resources for continuing ACT

Randomized Controlled Acceptability and Feasibility Study

ACT for Life Randomized Controlled Acceptability & Feasibility Trial

Aim 1: Determine the acceptability of ACT for Life

- Will Veterans hospitalized for suicide risk find the intervention suitable?
  - Client Satisfaction Questionnaire Mean Score ≥ 24
  - Narrative Evaluation of Intervention Interview

Aim 2: Determine the feasibility of the study design and research procedures.

- Will treatment providers refer their patients? Will the patients be eligible and want to participate?
  - Feasibility is defined as ≥ 50% eligible and (of these) ≥ 30% willing to participate
- Will participants be able to complete the intervention before discharge from the hospital?
  - A minimum of 70% completing the entire intervention will be considered feasible.
- Will participants complete the follow-up assessments? (post-treatment, one-month, three months)
  - ≤ 30% lost to follow up in each group considered feasible

Aim 3: Identify outcome and treatment process measures sensitive to change for use in a future efficacy trial.

ACT for Life Randomized Controlled Acceptability & Feasibility Trial

- Trained 4 clinicians
- 5 Veterans completed the intervention
- Feedback from the participants and clinicians was used to revise the manual
  - 3-6 sessions rather than only 3 sessions
- 70 Veterans were block randomized to ACT for Life or Treatment as Usual
- Post-treatment data were available for 30 of 35 participants randomized to ACT for Life

Client Satisfaction Questionnaire – 8 Results Support Acceptability

Question	Mean (SD)	Median (range)	95% CI
How would you rate the quality of service you received?	3.8 (0.5)	4 (2, 4)	3.7-4.0
Did you get the kind of service you wanted?	3.6 (0.7)	4 (1, 4)	3.4-3.9
To what extent has our program met your needs?	3.3 (0.8)	3 (1, 4)	3.1-3.6
If a friend were in need of similar help, would you recommend our program to him/her?	3.8 (0.7)	4 (1, 4)	3.5-4.0
How satisfied are you with the amount of help you received?	3.5 (0.9)	4 (1, 4)	3.2-3.9
Have the services you received helped you to deal more effectively with your problems?	3.6 (0.6)	4 (2, 4)	3.4-3.8
In an overall, general sense, how satisfied are you with the service you received?	3.7 (0.6)	4 (2, 4)	3.5-4.0
If you were to seek help again, would you come back to our program?	3.7 (0.6)	4 (2, 4)	3.5-4.0
Total score	29.1 (4.2)	30 (12, 32)	27.6-30.7

Note. N = 30 or 35 randomized, per protocol n = 28, response options range from 1 to 4, with 1 = poor etc. and 4 = excellent etc.

Qualitative Analysis of Post-treatment Interview Data

- Thematic analysis (Braun & Clark, 2006)

Table 1 Phases of thematic analysis

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

- Transcribed and cleaned audio files
- Four raters. Each transcript independently coded by at least two raters
- Consensus meeting between each pair of independent raters who coded the same transcripts to identify initial themes.
- Consensus meeting among all raters to decide on final themes

Qualitative Results Support Acceptability

- **28 of 30 participants reported that they benefitted from ACT for Life**
  - The two participants who indicated that they didn't benefit discontinued participation.

"Family questions. That was something that I'm struggling with and I'm not ready to talk about."

"Well I just didn't feel like I was really a good candidate for taking the ACT for Life so I figured I wouldn't go ahead and go forward with it."

Intervention met participants needs; they could explain *how* their needs were met

"I can live with my suicidal thoughts differently… I don't have to follow through with it, they can just be there. I don't' have to fight with them."

"I felt like it caught everything that I was going through."

"There was definitely change during this…The exercises and the techniques that I was shown to deal with my anxiety and stress and emotions and feelings were probably- not probably- they are the best coping mechanisms that anybody's ever given me. I use them every day."

"I've been coming to mental health here for a little bit and I got more out of these two sessions than all of the other ones combined, so it was impactful."

Participants descriptions of change aligned with the theoretical approach and goals of Acceptance and Commitment Therapy

"I'd say the biggest change that's happened is the realization that you don't have to constantly struggle with your negative thoughts or emotions in order to overcome them. You can find ways to move on with the rest of your life and kinda put those on the back burner so they're not in your face all the time."

"It let me know that I have values and goals and a purpose."

"When shame comes on board… the shame is there… I'm gonna feel it… but it can't harm me…. It doesn't stop me from living my life."

"He taught me meditation, how to look at your emotions, how to accept them…. I thought it was quite helpful."

Individual format and intensity/depth of the intervention was appreciated and preferred to past treatment experiences.

"It was more hands-on which I really appreciated…other interventions I've attended in the past were a little bit more of verbiage and words and trying to explain different solutions rather than showing you different solutions."

"It's much more frequent…so I think that was helpful for me rather than the once a week stuff."

"It was just two people talking back and forth, which made me more comfortable in sharing things. And, then, believe it or not, I really enjoyed like the homework aspect of it. That kept me more engaged because then I knew I had that one-on-one session which was very intense."

"All the times I've gone to the VA for help, I got more out in one intervention with this study program than I did in going to the VA for a month at a time."

28 of 30 participants said they would continue participating in the intervention and 29 of 30 said they would recommend it to others.

"I would [recommend it to other Veterans] because it is so much more active than just sitting and talking through therapy. Having the materials, having the guide plans and things like that… it helps to get your ideas out of your head so that you can actually look at them and see whether or not they make any sense at all"

"I would recommend it. It's a program that would open your eyes up about a lot of things. I'm sure that people don't really recognize or understand what's going on. I know that I didn't."

"…I found it to be helpful and I honestly didn't think that it was going to make a difference for me. I thought I was just beyond it."

"…practicing is really paying off, noticing in just this short period of time how I view everything and how I react to things, life changing for lack of better words… it sounds extreme but it really is…. I think it can definitely help other Veterans in the future.."

Simplicity of the intervention was helpful

"Their expertise, they didn't push it on me, they shared it with me. I think that was what made the difference. They shared their knowledge with me to where I could understand it. Even though it was informative, it was simple."

"The visualization of the paperwork…more the pictures because I have problems reading and remembering--hearing things is hard to remember--but when she showed me the paperwork with pictures that described things, it helped out a lot"

"[The intervention] really in my mind makes me think that this is a very simple activity, which it truly is not. It's very complex. And it's very deep."

"She broke it down so I could finally understand something…. We did practical exercises. There's a lot of not just her sitting there talking, but it was actual like hands-on doing shit."

When Asked What About the Intervention Was Least Helpful

- Several participants noted that parts of the intervention were unpleasant, but seemed necessary.
  - *"Well I would say looking back was undesirable. I mean, uh, it was painful…, but… necessary."*
- One participant noted that at times the intervention felt too scripted.
- A participant reported that one of the worksheets seemed too "cartoonish" for the serious subject matter.

Aim 2: Determine the feasibility of the study design and research procedures.

- Will treatment providers refer their patients? Will the patients be eligible and want to participate?
  - Many potential participants were not eligible because they were discharging out of the area and would not be able to participate in the follow-up assessments.
    - Began allowing participation in follow-up assessments by telephone.
  - 99 patients were referred. 91 were eligible. Above cutoff ≥ 50% eligible
    - Reasons for Ineligibility: 1 legal status, 3 already receiving suicide-focused individual therapy, 3 symptoms too severe, 1 not hospitalized due to suicide risk
  - 11 patients discharged prior to invitation, 80 patients invited to participate, 70 were willing to participate. Above cutoff ≥ 30% willing to participate
- Will participants be able to complete the intervention before discharge from the hospital?
  - 80% (28 out of 35) of participants completed the intervention per protocol based on clinician rating at time of discharge. Above minimum of 70%
- Will participants complete the follow-up assessments? (post-treatment, one-, three-months)
  - Loss of data to follow up was a significant issue prior to making changes to participant retention strategies.

Participant Retention

- Goal was 70% participation at follow-up assessment
- Original Retention Plan
  - Standard scheduling, reminder calls, alternative contacts
  - Compensated $20 for each follow-up assessment and additional reimbursement for travel expenses.
  - Allowed participation by phone

Participation at Follow Up	30 Day Assessment		90 Day Assessment	
Original Retention Plan (n=47)	**Count**	**Percent**	**Count**	**Percent**
Did not Participate	20	43%	24	51%
Fully Complete	26	55%	23	49%
Partially Complete	1	2%	0	0%

Participant Retention

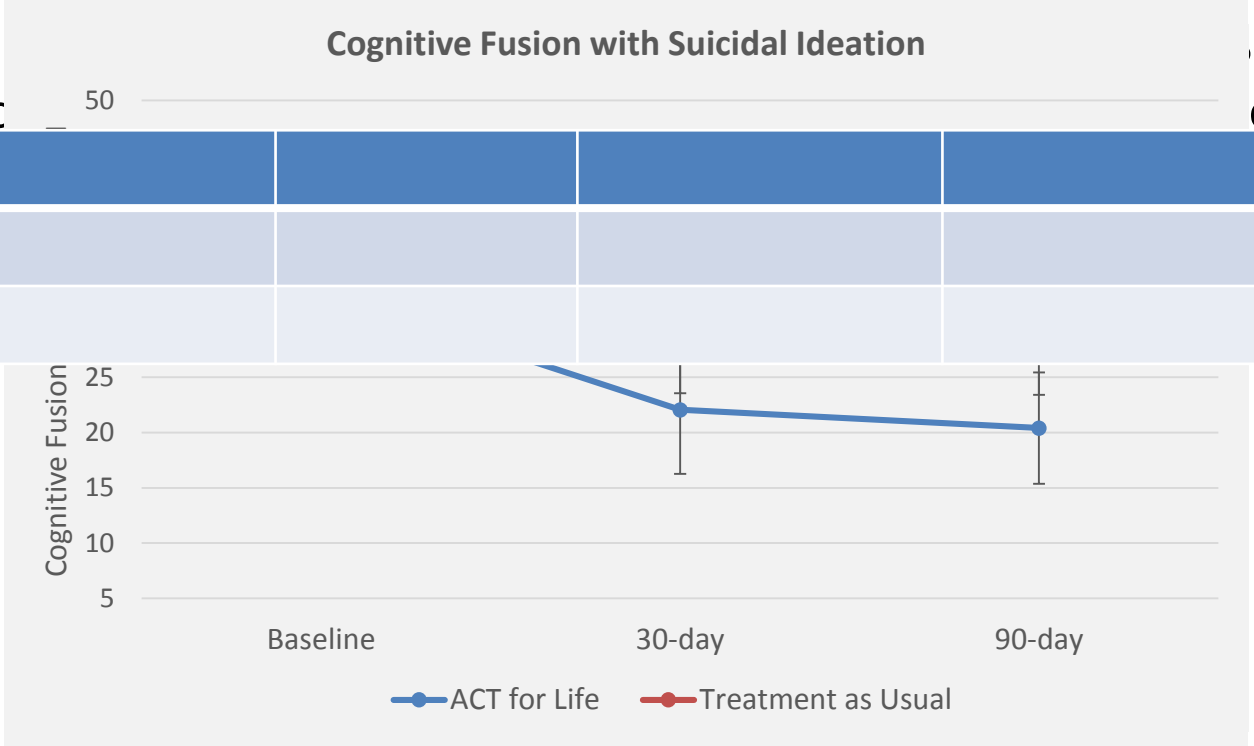
- Revised Retention Plan
  - Revised language in consent form, reminder letters, reminder cards, and phone scripts to emphasize the importance of participating in the follow-up assessments, stress the value of helping other Veterans via participation, and remind participants that they would be compensated.
  - Optional consent for text message appointment reminders, contact before or after other VA appointments, coordinating scheduling through residential programs when applicable
  - Increased compensation from $20 per visit to $50 per assessment and additional reimbursement for travel expenses.
  - Allowed participation by phone, mail, or a combination of phone and mail

Participation at Follow Up	30 Day Assessment		90 Day Assessment	
Revised Retention Plan (n=23)	**Count**	**Percent**	**Count**	**Percent**
Did not Participate	6	26%	4	17%
Fully Complete	16	70%	16	70%
Partially Complete	1	4%	3	13%

  - Self-directed violence during the follow-up period was assessed via a combination of self-report and medical record review resulting in 96% complete data.

Aim 3: Identify outcome and treatment process measures for use in a future efficacy trial.

- Candidate Outcome Measures
  - Inventory of Psychosocial Functioning, Outcome Questionnaire – 45.2, PROMIS Global Short From and Satisfaction with Social Roles and Activities, Satisfaction with Life Scale, Brief Adherence Rating Scale, Columbia-Suicide Severity Rating Scale, Treatment Engagement.
- Candidate Treatment Process Measures
  - Acceptance and Action Questionnaire – 2, Cognitive Fusion Questionnaire – Suicidal Ideation, White Bear Suppression Inventory – Suicide, Leiden Index of Depression Sensitivity, Interpersonal Needs Questionnaire
- With few [redacted] UT the confidenc [redacted] ecessary to e[redacted]



Note. Baseline N=34 per condition; ACT for Life 30-day and 90-day n=20; Treatment as Usual 30-day n=23, 90-day n=19

Note. ACT for Life baseline n=35, 30-day and 90-day n=20; Treatment as Usual baseline n=34, 30-day n=23, 90-day n=19

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Aim 3: Identify outcome and treatment process measures for use in a future efficacy trial.

- What did we learn by collecting all these data?
  - Participants' functioning was too impaired for the Inventory of Psychosocial Functioning due to most participants not engaging in many domains of functioning.
  - Pattern of change on treatment process measures support possibility that improvements are related to Acceptance and Commitment Therapy.
  - VA providers did an excellent job getting Veterans to attend at least one outpatient appointment following discharge. Treatment engagement analyses will need to focus on sustained engagement.
  - We will use measures of participant-rated clinical significance to support selection of measures for efficacy trial.
  - Variability on candidate measures will be used for power analyses.

Conclusions and Future Research

Conclusions & Future Research

- ACT for Life was found to be acceptable.
- It was feasible to use ACT for Life on our psychiatric inpatient unit.
- We refined the ACT for Life clinical research manual.
- Our research design required some revisions, but is now feasible and can be used to evaluate the efficacy of ACT for Life.
- Does ACT for Life "Work"?
  - Unknown until we conduct a larger randomized controlled efficacy trial.
- **Findings suggest that Acceptance and Commitment Therapy may be useful for helping those at risk of suicide build lives they will choose to live, but more research is needed.**

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Resources and Trainings on Suicide Risk Management & Safety Planning

https://www.mirecc.va.gov/visn19/education/products.asp

Concise description of VA Suicide Prevention Efforts:

https://www.mentalhealth.va.gov/suicide_prevention/docs/VA_Suicide_Prevention_Program_Fact_Sheet_508.pdf

National Strategy for Preventing Veteran Suicide:

https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

For More Information on Acceptance and Commitment Therapy:

https://contextualscience.org/

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SUICIDE RISK MANAGEMENT Consultation Program

FOR PROVIDERS WHO SERVE VETERANS

Why worry alone?

The Suicide Risk Management Consultation Program provides free consultation for any provider, community or VA, who serves Veterans at risk for suicide.

Common consultation topics include:

- Risk Assessment
- Conceptualization of Suicide Risk
- Lethal Means Safety Counseling
- Strategies for How to Engage Veterans at High Risk
- Best Practices for Documentation
- Provider Support after a Suicide Loss (Postvention)

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