

Age with ACT: A pilot acceptance and commitment therapy group for older adults receiving a community mental health service

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Consistent with global trends, developed countries are projected to have greater numbers of people over the age of 65 (Juni, 2015). While life expectancy has increased, mental health outcomes have not (Brown, 2015). Although older adults face increasing rates of disability and functional loss, acknowledging the cultural and societal context of older people's lives is equally important, particularly given the widespread problems of ageism experienced by older people (Banerjee et al., 2021). Older adults have traditionally not received a holistic approach to their mental health recovery (Sadler & McIlvena, 2015), hence respecting one's dignity and informed decision making are essential current processes to better healthcare (Stubbe, 2021). For instance, the first line of psychiatric intervention is frequently pharmacological, which can present numerous side effects and not adequately address an older person's underlying needs for sustained wellness (Sadler et al., 2018). Therefore, clinicians are being encouraged to provide person-centred care and offer non-pharmacological mental health recovery options to older adults (Petkus & Wetherell, 2013), such as talk-based psychotherapy.

Innovative, evidence-based therapeutic programs for older adults can be offered by various disciplines and professionals to meet the growing mental health needs of the community (Bloch-Atefi et al., 2021). One approach that is gaining momentum as an effective psychotherapy treatment option is acceptance and commitment therapy (ACT). ACT theorises that suffering is a normal part of the human experience and proposes that psychological inflexibility (defined as rigid psychological reactions) and experiential avoidance (of thoughts, feelings, and other psychological experiences) can perpetuate emotional distress (Harris, 2019; Hayes, 2019). Unlike cognitive behavioural therapy (CBT), the primary aim of ACT is not to reduce psychopathology, but rather to welcome life's challenges using acceptance-based and cognitive defusion techniques (the practice of allowing thoughts to come and go, without buying into them). ACT proposes that symptom reduction is often a by-product of living a more mindful and purposeful life consistent with one's values. This is particularly pertinent for older adults with severe or complex mental illnesses who may be living with persistent conditions (Davidson et al., 2017). Given that older adults experience increased grief/loss and physical health adjustment challenges, learning to age with ACT may prove beneficial within a community psychiatric setting.

There has been promising research supporting the use of ACT among older adults. A study looked at 41 older adults living in aged care facilities who were provided with 12 individual sessions of ACT (Davidson et al., 2017). Results found significant reductions in depressive symptoms and improved quality of life. This was consistent with previous research by Wetherell et al. (2011) and Karlin et al. (2013), who found that ACT was significantly effective in reducing both anxiety and depressive symptoms in older adults. A recent systematic review of ACT interventions in the general population found that ACT produced similar effects to CBT in reducing psychiatric symptoms, but reported that acceptance-based interventions increased psychological flexibility more efficiently when compared to CBT (Coto-Lesmes et al., 2020). Furthermore, group-based ACT interventions could improve outcomes by increasing peer-to-peer learning opportunities and social connectedness. Currently, there is no available research into the efficacy of ACT for older adults with complex mental illnesses. Further research is needed to explore whether group-based ACT could benefit a heterogeneous cohort of older psychiatric patients.

Although the application of ACT has recently sparked interest among researchers, no study has explored whether this form of therapy benefits older adults with moderate to severe psychiatric conditions. This is important, as aged community mental health services have traditionally offered psychotropic medications and case management as their main forms of treatment. In 2021, a Victorian Royal Commission into Mental Health recommended that more non-pharmacological recovery options were required. This presents an opportunity to offer a structured acceptance-based psychotherapy program to further aid recovery, as the efficacy of this treatment is still relatively unknown. This cohort is often excluded from research due to its heterogeneous presentations and inter-related comorbid physical health conditions (Sadler et al., 2015, 2018). Therefore, the aim of this project was to explore whether a pilot “Age with ACT” group could be a helpful additional recovery option for older adults receiving a community mental health service. It was predicted that participants’ mental health outcomes would improve on all measures from pre to post group.

Method

Participants

This pilot was available to older adults (>65 years) who were currently being treated by their local community mental health service. An inclusive approach to recruitment was applied to capture the heterogeneous nature of older adults who require involvement from publicly funded psychiatric services. Participants also needed to meet the following eligibility criteria:

- current mental health diagnosis (diagnosed by a consultant psychiatrist and treating multi-disciplinary team) (5th ed.; *DSM-5*; American Psychiatric Association, 2013);
- current community mental health individualised recovery plan and risk management plan;
- residing independently at home or in supported accommodation;
- able to read and write in English;
- provide consent and be willing to attend weekly face-to-face group therapy sessions.

Participants were ineligible for the group if they exhibited:

- current heightened risks (e.g., active suicidal ideation, psychosis, mania, forensic/legal issues);
- cognitive impairment (MMSE score below 25; Folstein, Folstein, & McHugh, 1975), as participants needed cognitive abilities to participate in group psychotherapy activities and complete homework tasks.

Ten participants were eligible for this pilot group (*M* age = 72 years; age range 66–84 years) with 70% identifying as women, 30% identifying as men, and 0% identifying as non-binary. Although no participants identified as being from the LGBTIQ+ community, the authors acknowledge older adults have previously been strongly discriminated against, which can negatively impact their openness to safely disclose this part of their sexuality. All were living independently at home and were cognitively intact (*M* MMSE score = 28/30). All participants were retired and supported by an aged or disability pension. The sample’s relationship status included 40% divorced, 20% married, 30% widowed, and 10% single. Seventy percent of the sample had a previous psychiatric inpatient admission; 40% had a previous suicide attempt; and 30% had previously undergone electroconvulsive therapy.

All participants had a current primary diagnosis for major depressive disorder (chronic/recurrent type; APA, 2013) at baseline, and all participants were on individualised psychotropic medication treatment regimes (managed by their general practitioner and consultant psychiatrist). Five of the 10 participants had a comorbid anxiety disorder and history of trauma (50%), with three participants (30%) having a confirmed personality disorder diagnosis (APA, 2013). Participants were also experiencing a wide variety of chronic medical conditions. Table 1 highlights the participant demographics.

Table 1. Participant Demographics

Participant	Age	Gender	Relationship Status	Psychiatric Diagnoses	Psychiatric Medications	Medical Conditions
1	67	W	Married	Depressive Disorder; Anxiety Disorder; Personality Disorder	Antidepressant x2; Antipsychotic; Hypnotic; Anxiolytic	COPD; HH; Lactose intolerance; Oesophagitis; NIDDM
2*	73	W	Married	Depressive Disorder; Anxiety Disorder	Antidepressant; Antipsychotic; Anxiolytic	AF; HT; TIA; Osteoporosis; GORD; HH
3*	72	M	Divorced	Depressive Disorder	Antidepressant	OA; NIDDM; IHD; TIA; GORD; OSA
4	81	W	Widowed	Depressive Disorder	Antidepressant; Anxiolytic	GORD; HT; Vertigo; IHD; HC; Angioplasty
5	67	W	Divorced	Depressive Disorder	Antidepressant x2 Antipsychotic	OA; HC
6	66	W	Divorced	Depressive Disorder; Anxiety Disorder; Personality Disorder	Mood Stabiliser; Antipsychotic	COPD; OA; AF
7	77	M	Widowed	Depressive Disorder	Antidepressant x2	DVT; Epilepsy; COPD; OA; GORD
8*	71	W	Single	Depressive Disorder	Antidepressant; Anxiolytic	HT; GORD; Grave's Disease
9	84	M	Widowed	Depressive Disorder; Anxiety Disorder	Antidepressant x2; Anxiolytic x2; Antipsychotic	IHD; HT; OA
10	68	W	Divorced	Depressive Disorder; Anxiety Disorder; Personality Disorder	Antidepressant; Antipsychotic	HT; Migraines; Glaucoma; Osteopenia; Breast cancer

N = 10. M = Man (30%). W = Woman (70%). Non-Binary (0%).

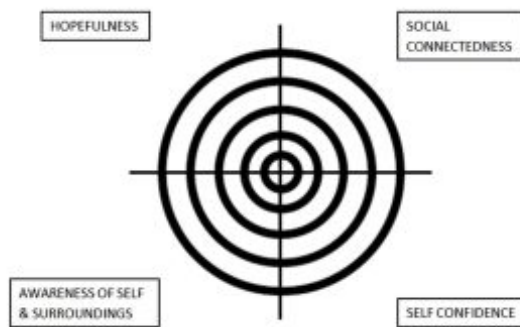
* = Non-completers/discontinued group attendance. COPD = Chronic obstructive pulmonary disease. AF = Atrial fibrillation. HH = Hiatus hernia. HT = Hypertension. TIA = Transient ischaemic attack. GORD = Gastro oesophageal reflux disease. OA = Osteo arthritis. OSA = Obstructive sleep apnoea. NIDDM = Non-insulin dependent diabetes. IHD = Ischaemic heart disease. HC = Hyper cholesterolemia. DVT = Deep vein thrombosis.

Materials

Several outcome measures were completed on two separate occasions, at baseline (week 0) and post treatment (week 6). The Health of the Nation Outcome Scale 65+ (HoNOS 65+; Burns et al., 1999) was used to assess global psychiatric symptom severity. It is a clinician-rated tool that contains 12 items (including suicidality, psychosis, problems with relationships) on a Likert scale ranging from 0 = no problem to 4 = severe problem. Scores range from 0 to 48, with higher scores representing a higher level of psychiatric symptom severity. The Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) was used to assess mood symptom severity. It is a self-rated tool on a 4-point Likert scale (0 = never to 3 = almost always) and possesses 21 statements related to symptoms of depression (“I felt that life was meaningless”), anxiety (“I experienced trembling”), or stress (“I found it hard to wind down”) experienced during the week prior to administration. Higher scores on the DASS-21 represent greater mood disturbance, with total scores ranging from 0 to 63. Participants’ subjective physical health status was measured using the EuroQol Health Scale (EQ; The EuroQol Group, 1990). Authors used the single-item visual analogue EQ subscale, which asked participants to rate their current level of physical health on a visual scale from 0 to 100. Higher scores on the EQ represent a better current subjective health status. The Life Skills Profile was used to assess participants’ abilities with respect to basic life skills (Rosen et al., 1989). It consists of 16 clinician-rated items on a Likert scale (0 = no difficulty to 3 = extreme difficulty). Its focus is on the participant’s general functioning and disability rather than their clinical symptoms. Scores range from 0 to 64, with higher scores indicating poorer life skills/functional impairment. It is important to note that the aforementioned collection of outcome measures has been commonly used with older adult populations and shows reasonable reliability and validity (Sadler et al., 2015, 2018).

To align with this pilot study’s examination of the efficacy of ACT, the authors were interested in collecting data that aligned with strengths-based recovery principles (e.g., living by their values), and did not only rely on measuring psychiatric symptom reduction. Therefore, participants’ perceptions of their values were measured using the Valuing Questionnaire – Progress subscale (VQ-P; Smout et al., 2014). This self-rated measure includes five statements rated from 0 (not true) to 6 (completely true). Higher scores demonstrated increased awareness of what was personally important and valuable to the person, with total scores ranging from 0 to 30. An additional experiential metric was applied in this pilot project to measure participants’ sense of the other goals of an ACT intervention: hopefulness, social connectedness, awareness of self/surroundings, and self-confidence. Authors based this circular visual metric on Russ Harris’s book, *ACT Made Simple* (2019), and the “ACT Values Bullseye”. Although the ACT Bullseye is not a validated outcome measure, the authors felt it provided a meaningful single-item tool for older adults to efficiently complete. Clinicians asked participants to rate their current level of hopefulness, social connectedness, self-awareness, and self-confidence on the ACT Bullseye visual dartboard scale, with higher scores being closer to the middle of the target. Each circle represented 20 points, with total scores for the four items ranging from 0 to 100. Figure 1 depicts the ACT Bullseye experiential measure.

Figure 1. The ACT Bullseye Measure



Procedure

The pilot was completed prior to the COVID-19 pandemic as part of a local improvement and innovation project within the Aged Persons Mental Health Service (APMHS) at Eastern Health, Victoria, Australia. Approval to conduct the pilot was granted by the Eastern Health Quality and Safety Committee in 2019 (EH/IIPv2/ACT). Mental health clinicians within the service invited eligible participants over a 4-week recruitment period. Interested participants provided consent to participate in the ACT group and completed the pre-outcome measures at week 0. A total of 12 participants provided consent and were eligible to participate, however two withdrew prior to the first session, leaving 10 participants who commenced the group in week 1. Participants also received their treatment as usual over the course of the 6-week pilot (e.g., medications, contact with their mental health clinician). Participants who completed the group therapy program were given a brief opportunity to provide open feedback at the conclusion of the final session.

Intervention

The aim of the Age with ACT group was to assist participants' mental health recovery and adjustment to ageing processes. This program included 6 weekly face-to-face group sessions. The 60-minute sessions were co-facilitated by two mental health clinicians (psychologist and social worker) at the APMHS outpatient centre. The authors developed ACT session agendas and program workbooks and the ACT-based skills were taught and applied with participants during each group session. Visual and audio materials were also utilised in each session to further demonstrate therapeutic skills (e.g., values, defusion, mindfulness). The therapists were familiar with ACT prior to delivering the pilot group. They received preliminary training in the session delivery protocol by practicing session agendas and therapy worksheets with the first author, an experienced clinical geropsychologist. They also received weekly clinical supervision with the first author during the course of treatment. Table 2 demonstrates a summary of the pilot Age with ACT group program.

Results

This pilot study collected pre and post data on several outcome measures to explore whether the ACT group benefitted the participants' mental health. Seven participants were considered to have completed treatment (defined as attending at least four sessions), with four participants completing all six sessions and three completing five sessions. Three of the 10 participants completed less than four sessions, identified as cases 2, 3, and 8 in Table 1. Reasons for non-completion of the group for these participants were acute bereavement, transport challenges, and finding the group therapy format too confronting.

Table 2. Summary of the Age with ACT Pilot Group Program

Session	ACT Content
1	Welcome and Socialisation Introduction to ACT Hexaflex and Mindfulness

2	Values and Committed Action Mindfulness of the senses (sight)
3	Acceptance of Emotions Mindfulness of the senses (sound)
4	Self-Compassion Mindfulness of the senses (smell)
5	Defusion Mindfulness of the senses (touch)
6	Summary and Relapse Prevention Mindfulness of the senses (taste)

Table 3 highlighted the mean outcome measure raw scores. Each measure showed promising preliminary improvements from pre to post completion of the ACT group ($n = 7$). More specifically, six out of the seven (6/7) participants' (86%) mood improved (reflected by reductions in the DASS-21 total scores from pre to post); 7/7 participants' (100%) level of psychiatric symptoms improved (reductions in HoNOS 65+ total scores); 6/7 participants' (86%) life skills improved (reductions in the Life Skills Profile total scores); 5/7 participants' (72%) sense of progressing their personal values improved (increases in the VQ-P total scores); 5/7 participants' (72%) subjective physical health status improved (increases in the EQ total scores); 6/7 participants' (86%) sense of confidence improved (increases in the visual confidence measure); 4/7 participants' (57%) sense of self-awareness improved (increases in the visual awareness measure); 5/7 participants' (72%) sense of hopefulness improved (increases in the visual hopefulness measure); and 5/7 participants' (72%) sense of connectedness improved (increases in the visual connectedness measure).

Table 3. Mean Outcome Measure Raw Scores

Measures	Pre (<i>M</i>)	Post (<i>M</i>)	Improvement
Mood (DASS 0–63)	27.57	17.14	-10.43
Psychiatric Symptoms (HoNOS 0–48)	13.57	8.01	-5.57
Life Skills (LSP 0–64)	9.00	6.00	-3.00
Values Progress (VQ-P 0–30)	17.14	20.86	+3.72
Physical Health Status (EQ 0–100)	64.29	75.43	+11.14
Confidence (0–100)	41.43	67.85	+26.42
Awareness (0–100)	64.29	78.57	+14.28
Hopefulness (0–100)	58.57	77.85	+19.28
Social Connectedness (0–100)	57.14	67.85	+10.71

N = 7. *M* age = 72 years. Women = 5. Men = 2. DASS = Depression Anxiety Stress Scale 21 item version. HoNOS = Health of the Nation Outcome Scale 65+. LSP = Life Skill Profile Scale. VQ-P = Values Questionnaire Progress Subscale. EQ = EuroQol Health Visual-Item Scale.

At the end of the final session, participants were invited to briefly provide feedback to a neutral clinician (who was not part of designing or facilitating the group). This clinician was a provisional psychologist on placement with a different mental health program within Eastern Health. Six of the seven participants who completed the program provided brief reflections to the question, “What was your overall experience of participating in the group?” The participants’ direct quotes were documented by the neutral clinician and are displayed below:

Participant 1 (67-year-old woman)

“It helps to know other people who are suffering the same things as I am. It ended up being a core group of us. It was good to have males in the group for a different perspective.”

Participant 4 (81-year-old woman)

“It’s been extremely beneficial. I felt accepted by the group.”

Participant 5 (67-year-old woman)

“I just wanted Tuesdays to come around because I’ve enjoyed it. I’ve had fun here . . . and there’s nothing wrong with that. It was well worthwhile.”

Participant 6 (66-year-old woman)

“I found it intriguing. I can relate to everyone’s depression – it’s good to probably get it out. It’s given life a different perspective. The facilitators were good. We came from deep depression, they handled us well.”

Participant 7 (77-year-old man)

“Initially I was a bit resistant to the whole thing . . . it’s all been put out in a simple way. I initially thought it was too simple, but it’s given me more things to think about now. It hasn’t cured it, but it’s given me helpful things to cope. It’s given life a different perspective. I think we’ve all gained from this program.”

Participant 9 (84-year-old man)

“On the whole I’ve learnt a few new tricks. It worked well.”

Retrospective clinical file audits were completed by the first author at 3 months post treatment (week 18). Two out of the seven participants (29%) had reached remission (diagnosed by the treating team; APA, 2013) and had been discharged from the mental health service; four out of the seven (57%) were clinically stable and working with their mental health clinician towards discharge; and one (14%) had relapsed, requiring acute psychiatric inpatient treatment.

Discussion

The authors acknowledge ACT-based interventions can be offered by various disciplines and mental health clinicians who undergo regular clinical training and targeted supervision (Bloch-Atefi et al., 2021). The purpose of this study was to explore whether a pilot ACT group could benefit older adults who were receiving a community mental health service. The study supported its hypothesis, which predicted participants would demonstrate improvements in their mental health from pre (week 0) to post (week 6) treatment. Improvements in mood and psychiatric symptom severity were found, with reductions in pre to post outcome measure scores. Participants also recorded benefits in their subjective health status, life skills, confidence, hopefulness, social

connectedness, awareness, and positive progress with their perceived values. These preliminary results add richness to the field of aged mental health by highlighting group-based ACT as an additional recovery option for older adults living with persistent mental illness.

Traditionally, older adults with complex mental health concerns have been excluded from research for a multitude of societal and cultural reasons (Banerjee et al., 2021; Sadler et al., 2018; Stubbe, 2021). The current study attempted to be inclusive and respect the heterogeneity and choices of its participants by offering an opportunity to take part in the Age with ACT non-pharmacological group program. The results from this study supported previous research that has shown benefits for older adults who participate in a form of ACT (e.g., Davidson et al., 2017; Jacobs, Luci, & Hagemann, 2018; Petkus & Wetherell, 2013). It is suggested that ACT was a beneficial treatment for older individuals living with a major mental illness, as ACT theory aligns well with ageing and recovery principles. This is because ACT requires participants to re-focus on matters that are intrinsically important and bring meaning (value) to their lives (examples include family, nature, music, etc.). If participants have disengaged from a previous value or activity due to inability (such as declining health or physical function), they are asked to find new, creative ways to re-engage. ACT also supports participants to practice acceptance and self-compassion in relation to their challenges, thus softening the negative impacts of the ageing process.

The current study's results also supported the suggestion of Coto-Lesmes et al. (2020) that group-based ACT interventions could improve mental health by increasing peer-to-peer learning opportunities and social connectedness. However, the 60-minute length of sessions in the current pilot group was a potential limitation to this. Extending the session length would allow more time for social interaction and peer discussion (e.g., 45 minutes; 10-minute break; then another 45 minutes). Furthermore, the number of weekly sessions could be extended from six to at least nine. Reflections obtained from the co-facilitators during weekly supervision suggest this would allow more time for content delivery and implementation. This is supported by previous research, which highlighted that other ACT interventions were 10-12 sessions in length (Coto-Lesmes et al., 2020).

The pilot group demonstrated a high completion rate (70%), suggesting participants were receptive to this form of treatment. A positive therapeutic alliance with their peers and co-therapists was likely developed to facilitate confidence and adherence to homework activities. Studies suggest that, for older adults, it is important to provide written information and resources that are specifically tailored for them (Jacobs et al., 2018; Petkus & Wetherell, 2013). It was proposed that developing ACT-based resources using multi-dimensional learning strategies (e.g., workbooks, mindfulness activities, video/audio clips) was also helpful, as was using larger font and older adult case scenarios. The information worksheets provided during each session were simple and relevant to the session topic.

One of the main challenges with effectively running the face-to-face program for this cohort was the extensive organisation that was needed to obtain the right therapeutic environment. Careful decisions were made on several logistical issues, including needing an appropriate venue with car parking and disability access, refreshments, a large activity group room, close toilet facilities, and digital access for audio/visual resources. Fortunately, these important environmental factors were successfully achieved in this pilot, however, other modes of ACT treatment would be worth exploring. One option for future consideration, particularly in light of the COVID-19 pandemic, would be to trial delivering this group via telehealth (video link). Such a modality would reduce the need to organise a physical space within a community mental health service, enable more older adults to participate (e.g. those who are unable due to physical disability or distance), and adhere to current social distancing guidelines.

Noteworthy pathways for future research which have been generated by this exploratory pilot group can be discovered by acknowledging the study's main limitations. This study had a small sample size ($N=10$) with seven participants completing the group therapy. This meant the study was clearly under powered and could only provide a general evaluation of raw scores rather than generating statistically meaningful results. In addition, although the DASS-21 measure is locally validated and widely administered among the adult population, it focuses on symptoms rather than asking thorough questions about underlying causal and contributing factors that may be contributing to those symptoms (e.g., chronic pain, disability, grief). This study also excluded participants who could not read and write English, which restricted its impact for culturally and

linguistically diverse older people. The absence of control measures and comparison groups was a further limitation. Future research is required on a larger scale with comparison groups and control measures to determine the effectiveness of ACT for older adults in community psychiatric settings. The current study also acknowledges that greater consideration is required for the intersectional needs of older people across diverse demographic variables, such as culture, sexuality, disability, gender, and family configurations. For instance, older men were significantly underrepresented in this study, something that is common to many investigations with older adults. ACT could be a particularly relevant intervention for older men, especially given the increased suicide rate among them (Shah et al., 2016). Should the authors be successful in running a larger ACT trial, it is suggested that proactive efforts be made to recruit older men and provide a gendered analysis of the results. Important issues including communal support, societal stigma, systemic forms of oppression, ageism, and loneliness each need to be fully considered by future research when conceptualising the delivery of psychotherapy among older adults. Despite these important areas of development, this pilot study provided promising evidence that ACT groups could be a viable adjunct recovery option for older adults receiving community mental health services.

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Declarations

No funding was received for conducting this study. No conflict of interest was declared. Participants provided informed consent to complete this pilot group and were free to withdraw at any time. Since raw scores were provided in this study no additional data set was included. Each author significantly contributed to the completion of this manuscript.

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