

Contextual therapies for the intervention of anxiety and depression in adults

Las terapias contextuales para la intervención de la ansiedad y depresión en adultos

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Abstract:

According to the World Health Organization, there are around 264,000,000 cases of anxiety disorders worldwide. In Latin America, depression is the second most common mental disorder and, in its most severe form, can lead to suicide. Furthermore, adulthood is a stage where significant events occur and autonomy is sought. Although the effectiveness of different psychological treatments has been demonstrated in adults diagnosed with affective disorders, the results are not always maintained over time and cases continue to increase. Consequently, there is currently increasing interest in examining the available evidence on the components and techniques of third-generation therapies in this population. For this reason, a narrative review was carried out focused on interventions based on contextual therapies (acceptance and commitment therapy, mindfulness, behavioral activation, dialectical behavioral therapy, functional analytical therapy) to know their effectiveness in the treatment of anxiety and depression in adults.

Keywords:

Anxiety, depression, contextual therapies, third generation therapies, adults

Resumen:

De acuerdo con la Organización Mundial de la Salud, existen alrededor de 264 000 000 de casos de trastornos de ansiedad en el mundo. En Latinoamérica, la depresión es el segundo trastorno mental más común y, en su forma más grave, puede conducir al suicidio. Además, la adultez es una etapa donde se presentan eventos significativos y se busca la autonomía. Aunque se ha demostrado la eficacia de diferentes tratamientos psicológicos en adultos diagnosticados con trastornos afectivos, los resultados no siempre se mantienen a lo largo del tiempo y los casos siguen aumentando. En consecuencia, hay un creciente interés actual en examinar la evidencia disponible sobre los componentes y técnicas de las terapias de tercera generación en esta población. Por esta razón, se llevó a cabo una revisión narrativa centrada en las intervenciones basadas en las terapias contextuales (terapia de aceptación y compromiso, mindfulness, activación conductual, terapia dialéctica conductual, terapia analítico funcional) con el objetivo de conocer su efectividad en el tratamiento de la ansiedad y la depresión en adultos.

Palabras Clave:

Ansiedad, depresión, terapias contextuales, terapias de tercera generación, adultos

INTRODUCTION

In Mexico, an annual prevalence of mental disorders and addictions is estimated for one-fifth of the total population. 33.9% of cases represent mild disorders, 4.5% moderate disorders, and 25.7% severe disorders. 81.4% of people do not receive appropriate care, anxiety disorder has the highest gap (85.9%), depression 73.9%, and social phobia 83.9%.¹ In 2021, the National Survey of Self-Reported Well-Being showed that 31.3 % of the adult population present symptoms of minimal anxiety, while 19.3 % present symptoms of severe anxiety. The

states of Puebla, Chiapas, and Michoacán show the highest percentages of minimal or severe anxiety symptoms. The states of Nuevo León, Baja California, and Quintana Roo present the lowest percentages.²

On the other hand, in Mexico, depression is found in 5.3% of the population, which represents a total of 3,609,945 expected cases.¹ In 2021, the National Institute of Statistics and Geography² reported that 15.4% of the adult population presents depression symptoms. The states with the highest symptomatology are Guerrero, Tabasco, and Durango, while the

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states with the lowest scores are Quintana Roo, Sonora, and Nuevo León.

Anxiety and depression in early adulthood can hinder developmental milestones such as finishing school, entering college, establishing deeper interpersonal relationships, and entering the workforce.³ Anxiety disorders have shown high associations with mood disorders. It is common for anxious symptoms to present with depressive symptoms.⁴

Among the psychosocial variables associated with depression, the following stand out: a) being a woman, dedicating oneself solely to housework, caring for someone who is sick; b) low socioeconomic level; c) unemployed men; d) social isolation; e) legal problems; f) experiences of violence; g) consume addictive substances; and, h) migration.⁵

Cognitive-behavioral Therapy (CBT) based on the first and second generation has shown ample evidence for the treatment of anxiety and depression.^{6,7} However, there is a third (33.4%) of patients with depression who do not improve with CBT.⁸ Additionally, it is still found that between 40% and 50% of people with anxiety disorders relapse or fail to function over time after CBT, which suggests that some people may resist treatment or that various strategies are needed to maintain improvements over time.⁹ Consequently, there has been growing interest in applying third-generation therapies in the treatment of mental health problems. For this reason, the present narrative review aims to collect information on the effectiveness of contextual therapies in depression and anxiety in adults.

ANXIETY

According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)¹⁰, anxiety is defined as excessive worry about future situations that the person interprets as dangerous or threatening. It is associated with physiological reactions, like sweating, palpitations, headaches, among other cognitive and behavioral symptoms.

In the International Classification of Diseases 11 (ICD-11)¹¹, anxiety disorders are defined as conditions characterized by the presence of intense fear or excessive distress, accompanied by physical and cognitive symptoms severe enough to affect the patient's daily functioning. The symptoms are not transitory and are usually present for several months, most days. There is a classification of anxiety disorders in the DSM-5 and ICD-11 (Table 1).^{10,11}

The anxiety disorder that occurs most in the adult population is Generalized Anxiety Disorder (GAD).¹⁰ Therefore, the diagnostic criteria for this condition are listed below.

Diagnostic criteria for generalized anxiety disorder.¹⁰

- A. Excessive anxiety and worry about a series of events or activities (such as work or school performance) present on most days for at least six months.
- B. The person finds it difficult to control worry.
- C. Anxiety and worry are associated with at least three of the following symptoms (some symptoms must be present for more than six months).

- 1. Restlessness or feeling of being nervous.
 - 2. Easy fatigue.
 - 3. Difficulty concentrating or having a blank mind.
 - 4. Irritability.
 - 5. Muscle tension.
 - 6. Sleep disturbance (difficulty falling asleep, remaining asleep, or having unsatisfactory sleep).
- D. Anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas.
- E. The symptoms are not due to the physiological effects of a substance (e.g., drugs, medications) or another medical condition.
- F. The alteration is not better explained by another mental disorder (for example, separation anxiety, obsessions in obsessive-compulsive disorder, weight gain in anorexia nervosa, among others).

Table 1. Anxiety disorders according to DSM-5 and ICD-11.^{10,11}

Classification of anxiety disorders	
Anxiety disorders according to DSM-5	Anxiety and fear-related disorders according to ICD-11
Separation anxiety disorder	Generalized anxiety disorder
Selective mutism	Panic disorder
Specific phobia	Agoraphobia
Social anxiety disorder	Specific phobia
Panic disorder	Social anxiety disorder
Agoraphobia	Separation anxiety disorder
Generalized anxiety disorder	Selective mutism
Substance/medication-induced anxiety disorder	Other specified anxiety or fear-related disorders
Anxiety disorder due to another medical condition	Anxiety or fear-related disorders, unspecified
Other specified anxiety disorder	
Unspecified anxiety disorder	

Depressive and anxious symptoms can vary in intensity and frequency. They can be present in a wide range of psychiatric disorders, as well as in individuals without a diagnosis of a psychiatric disorder.¹²

Social anxiety disorder is often comorbid with other anxiety disorders, major depressive disorder, and substance use disorders; while generalized anxiety disorder is likely to present comorbidity with other unipolar anxiety and depressive disorders.⁹ Genetic vulnerability shows a greater tendency in panic disorder, obsessive-compulsive disorder, and social

phobia. Additionally, childhood abuse and adversity are risk factors for social anxiety disorder.¹⁰

DEPRESSION

The DSM-5¹⁰ defines depression as a mental disorder consisting of various symptoms such as loss of energy and interest, appetite changes, trouble concentrating, feelings of sadness, sleep disturbances, anhedonia, self-blame, weight changes, and agitation, among other symptoms.

According to ICD-11¹¹, mood disorders refer to a higher group of depressive disorders and bipolar disorders. Within the classification, a mood disorder is conceptualized by the presence of symptoms such as sadness, loss of interest in usual activities, loss of energy, decreased self-esteem, excessive guilt, difficulties making decisions, sleep disturbances, and recurrent thoughts of death or suicide. For diagnosing a depressive episode, symptoms must be present for at least two weeks and cause clinically significant distress or impairment in the person's social, academic, occupational, or other important area of functioning.¹¹ There is a classification of depressive disorders in the DSM-5 and ICD-11 (Table 2).

Table 2. Depressive disorders according to DSM-5 and ICD-11.^{10,11}

Classification of depressive disorders	
Depressive disorders in the DSM-5	Depressive disorders in the ICD-11
Disruptive mood dysregulation disorder	Single episode depressive disorder
Major depressive disorder	Recurrent depressive disorder
Persistent depressive disorder (dysthymia)	Dysthymic disorder
Premenstrual dysphoric disorder	Mixed depression and anxiety disorder
Substance/medication-induced depressive disorder	Premenstrual dysphoric disorder
Depressive disorder due to another medical condition	Other specified depressive disorders
Unspecified depressive disorder	Depressive disorders, unspecified
Specifiers for depressive disorders	Other specified mood disorders Mood disorders, unspecified specification

Major depressive disorder shows comorbidities with substance-related disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and borderline personality

disorder.¹⁰ The following are the descriptions of the diagnostic criteria for major depressive disorder.

Diagnostic criteria for major depressive disorder.¹⁰

A. Five (or more) of the following symptoms over two weeks and the results in a change from previous functioning. At least one of the symptoms is (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, almost every day.
2. Decreased interest or pleasure in all or almost all activities most of the day, almost every day.
3. Significant weight loss or gain without dieting or decreased or increased appetite almost every day.
4. Insomnia or hypersomnia almost every day
5. Psychomotor agitation or slowing down almost every day
6. Fatigue or loss of energy almost every day
7. Feelings of worthlessness or excessive or inappropriate guilt almost every day
8. Decreased ability to think or concentrate, or indecisiveness almost every day.
9. Recurrent thoughts of death and recurrent suicidal ideation without a specific plan.

B. Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The episode cannot be attributed to the physiological effects of a substance or another medical condition.

CONTEXTUAL THERAPIES

In the 1950s, clinical psychology relied on the psychoanalysis trend for treating health conditions. However, there was a need for other models that could be more effective, so the first generation of behavioral therapy based on scientific paradigms began to emerge.¹³ Later, the possibility of making population inferences through the application of statistics emerged. Around that time, the technique of systematic desensitization was developed by Joseph Wolpe, aimed at reducing anxiety levels and avoidance behaviors.¹⁴

In the 1970s, second-generation therapies emerged, using multiple techniques based on learning principles, such as classical and operant conditioning, and cognitive and social learning theories.¹⁵ In this wave, beliefs, schemas, and thoughts directly affect the emotional and behavioral responses of the individual. In addition, the first-generation elements remained, but now the variables studied were of a more cognitive nature.¹⁶ One of the main criticisms of the second generation of CBT is that sometimes can be limited by standardizing cases and considering that everything that causes discomfort should be eliminated or reduced.¹⁷

In the 1990s, Third Generation Therapies (TTG) emerged; however, they began to gain importance after the 2000s.¹⁸ At present, the main TTGs are acceptance and commitment therapy, functional analytic psychotherapy, dialectical behavior therapy, behavioral activation therapy, and mindfulness-based therapy.¹⁸

Psychiatry and the first generations of CBT focused mainly on the symptomatology of clinical conditions.¹³ Contextual therapies seek firstly to make individuals aware of their emotions, sensations, behaviors, and beliefs, taking into consideration the context and accepting the experience. The approach focuses on developing in the person more flexible and effective coping strategies that allow psychological acceptance and values that represent the individual.¹⁵

Contextual therapies and cognitive-behavioral therapies differ in fundamental ways. While CBT focuses on modifying dysfunctional thoughts and behaviors, contextual therapies recognize emotional distress and seek to promote a healthier relationship through acceptance of internal experiences (Table 3).¹⁹⁻²²

Table 3. Comparison between cognitive-behavioral therapies and contextual therapies.¹⁹⁻²²

Elements of first, second and third generation cognitive-behavioral therapies		
Element	First and second generation therapy	Third generation therapies
Purpose	It focuses on identifying and modifying irrational thoughts and dysfunctional behaviors.	It focuses on changing the relationship with internal experiences to increase psychological flexibility and valued action.
Main techniques used	Cognitive restructuring, problem-solving techniques, relaxation training, exposure, and task assignment.	Cognitive defusion, commitment to values, experiential exposure, mindfulness, emotional regulation techniques.
Meaning of the symptoms	Seeks to reduce and eliminate symptoms because they are considered problems to be solved.	Symptoms are considered internal experiences that can be accepted and managed.
therapeutic relationship	The therapist emphasizes a collaborative, directive, and structured relationship.	The therapist highlights acceptance, validation and support.

Currently, the Specialized Center for Obsessive Compulsive Disorder (TocMéxico)²³ has professionals trained in the application of CBT treatment programs and contextual therapies for obsessive-compulsive disorder, generalized anxiety disorders, panic disorders, post-traumatic stress, and phobias.

From the perspective of contextual therapies, Acceptance and Commitment Therapy (ACT) postulates that depression and anxiety are the result of failed attempts to avoid or control unpleasant emotional experiences. According to this approach, experiential avoidance contributes to the maintenance of depressive and anxiety symptoms.²⁴

ACT focuses on how symptoms can play an adaptive role in response to difficult or unpleasant experiences. Therefore, contextual therapy aims to help patients identify their values and commit to valuable actions regardless of symptoms.¹⁹

Dialectical behavioral therapy suggests that depression and anxiety arise from the inability to regulate emotions effectively. According to this approach, people with depression and anxiety may experience difficulties in tolerating emotional distress and using maladaptive coping strategies.²⁰

Arch & Craske²⁵ examined certain limitations in the application of contextual therapies, highlighting that people require active engagement and the ability to tolerate anxiety or emotional distress, which can be difficult for some clients. Additionally, people with little motivation or interest in self-reflection may not benefit from contextual therapies.

MINDFULNESS APPLIED TO ANXIETY AND DEPRESSION

Mindfulness is a full attention and awareness, attentive and reflective presence. This concept of mindfulness begins its studies in Buddhist traditions, especially in Zen Buddhism and Vipassana, as well as in the meditations practiced by Tehravadin Buddhists.²⁶ Meditation in clinical practice is of interest to develop the third wave of therapies, focusing attention on the context for explanation and intervention.²⁷

Mindfulness practice is based on several fundamental principles that guide your approach towards greater awareness and well-being. These principles seek to cultivate full attention to the present moment without judgment or expectations and to accept the experience as presented (Figure 1).²⁷

Focusing on the present moment seeks to live the experience in the present moment, leaving aside the need to know how it should happen or how it was lived.

Openness to experience and facts allows the observation to flow with the sensations of the situation. Without letting language and thought constitute an interpretation in a stereotyped way.

Radical acceptance: consists of focusing on the experience, leaving aside evaluations. Discomfort, anger, and sadness are part of nature. It is not necessary to run away from them.

Experiences Choice: people actively choose where they want to get involved, what to pay attention to, and what to spend time on. After selecting the situation, it is essential to experience and live it actively as it is.

Control Relinquishment: the aim is not to control and reduce fear, anger, and sadness but to experience them. The effect produced by these emotions will be indirect.

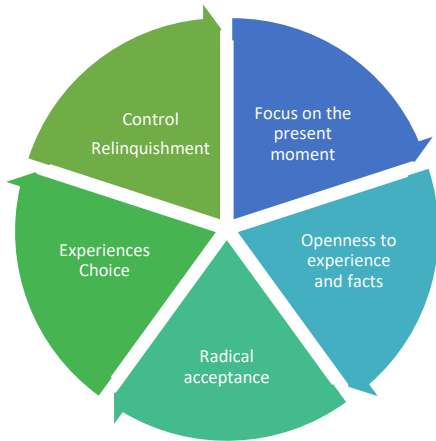


Figure 1. Main components of Mindfulness.²⁷

There are intervention programs based on Mindfulness, including Mindfulness-based Stress Reduction (MBSR) by Kabat-Zinn and Hanh²⁸ and Mindfulness-Based Cognitive Therapy (MBCT) by Segal et al.²⁹, aimed at depression and relapse prevention. Within dialectical behavior therapy²⁰, acceptance and commitment therapy mindfulness strategies are also used.³⁰

MBSR²⁸ consists of 8 weeks of 2- to 2.5-hour group meditation with a trained teacher, daily self-guided practice at home, and a mindfulness retreat in the sixth week. The creation of this program aimed treating medical patients with chronic pain in the treatment of mental health issues.

There is evidence on the application of MBSR in anxiety disorders, for example a randomized controlled trial with 93 people diagnosed with generalized anxiety disorder where they implemented MBSR in one group and maintained a control group. The results showed significant reductions in anxiety scores compared to the control group. The MBSR group had an effect size before and after treatment ($d=1.06$).³¹ These results are consistent with other meta-analyses that provide evidence for MBSR effectiveness in reducing anxiety and stress.^{32,33}

Continuing forward with the evidence, a randomized controlled trial was conducted with 44 college students with a mean age of 19.6 years to examine the effects of an MBSR-based program on depression, anxiety, stress, and mindfulness. The treatment lasted eight weeks, and the experimental group was assigned mindfulness meditations for two hours each week. The results show that, compared to the control group, the MBSR program showed significant reductions in depression, stress, anxiety, and increased mindfulness.³⁴

On the other hand, MBCT consists of eight two-hour sessions applied to a maximum group of 12 people. The intervention begins with the body scan technique, called "mini-meditation", with the objective of experiencing body sensations through breathing. In the cognitive part, the aim is for patients to observe how their thoughts and sensations result from specific situations. In this way, they will understand the value of such cognitions.²⁹

There is evidence about the effectiveness of MBCT in reducing relapse rates among people with high depression, achieving improvements after the intervention.³⁵ These findings coincide with another study where MBCT was applied to people diagnosed with treatment-resistant depression, finding that it reduced depressive symptoms compared to the control group.³⁶

DIALECTICAL BEHAVIOR THERAPY APPLIED TO ANXIETY AND DEPRESSION

Dialectical Behavior Therapy (DBT) was proposed in 1993 by psychiatrist Marsha Linehan²⁰, who initially used it for her patients with a diagnosis of Borderline Personality Disorder (BPD) or complex patients with suicidal tendencies, realizing that they responded effectively to the strategies of acceptance and change. In DBT, emotional dysregulation is built from a biological conception, so the environment is related to the lack of modulation of one's own emotions. Within the person, the lack of emotional dysregulation leads to impulsive and maladaptive behaviors, such as self-directed violence and aggressive behaviors in interpersonal relationships.³⁷

DBT integrates four groups of skills (Figure 2).³⁸

Mindfulness refers to the description and observation of the present moment without judgment.

Emotion regulation integrates strategies for changing emotions and responding functionally to them.

Interpersonal effectiveness includes the activities of behaving and communicating assertively as well as practicing self-respect.

Discomfort tolerance strategies for accepting difficult life situations and controlling impulsive actions.

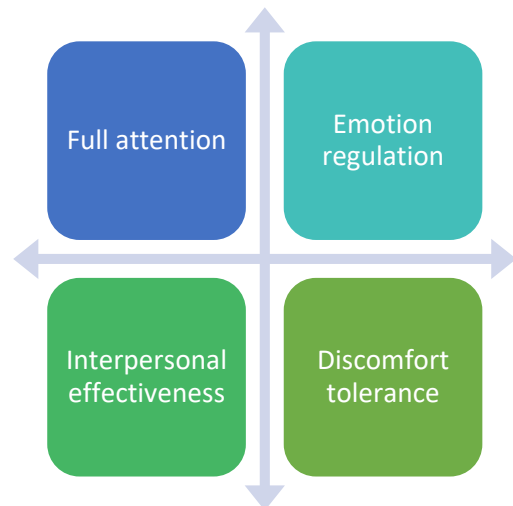


Figure 2. Dialectical Behavior Therapy Skills.³⁸

Initially, DBT emerged for BPD treatment, but it has also been used for treating anxiety and depression. Based on Linehan³⁸, the following briefly describes a DBT intervention approach. It is worth noting that one may consult the complete structure and explanation in depth in the same reference manual.³⁸

A. Assessment: the therapist conducts an in-depth assessment to identify and understand the patient's maintenance factors, functional difficulty areas, and anxiety and depression symptoms.

B. Objectives and treatment design: in conjunction with the information collected and the patient, general and specific objectives are established for the treatment that addresses anxiety and depression symptoms together with training in DBT skills.

C. Skills training: Composed of four modules, each module requires eight training sessions.

1. Mindfulness skills help patients develop acceptance experiences and decrease emotional reactivity and may be applied in three sessions. However, they are reviewed and reinforced before each new module.

2. Interpersonal efficiency skills seek to enable patients to relate and request support within their relationships. Through role-playing techniques, hypothetical cases, and daily life practice activities.

3. Emotion regulation skills are taught to identify emotions, tolerate emotional distress, and regulate emotional intensity through conscious breathing and distraction.

4. Discomfort tolerance skills are based on mindfulness and Buddhist philosophies related to acceptance. They include techniques such as radical acceptance, self-awareness exercises, half-smile, and self-observation.

Skills training performed in a group setting lasting two and a half hours by one or two therapists and individual psychotherapy by a different therapist. The treatment is enhanced by telephone consultation and supervision meetings between the different therapists handling a case.³⁸

Regarding the effectiveness of DBT-based interventions applied to anxiety and depression treatment, Afshari et al.³⁹ conducted a study that aimed to compare CBT and DBT effectiveness in 72 people with generalized anxiety and depressive symptoms. The CBT intervention program consisted of 16 individual sessions lasting one hour. On the other hand, the DBT-based intervention was also applied individually in 16 one-hour sessions. Most sessions focused on mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness skills. The results showed a reduction in anxious and depressive symptoms evaluation in both groups. However, it is relevant to remember that the CBT group showed higher changes than DBT in executive functions, while DBT is a more effective treatment.³⁹

Another study examined DBT versus CBT's effects on emotion regulation and mindfulness in patients with generalized anxiety disorder; Participants were randomly assigned to one of two groups. The results showed that the CBT group had higher reductions in anxiety and depression symptoms than the DBT group. However, the DBT group showed higher improvements in emotion regulation and mindfulness.⁴⁰

On the other hand, there is evidence on the application of DBT in a group modality. For example a study, was conducted to

verify the effectiveness of an intervention that integrated DBT's emotional regulation and mindfulness skills to prevent depression relapse. Seventy-five people with major depressive disorder participated in the study. The program lasted ten weeks, with a follow-up of one year in a group format of 8 to 12 participants each. The results showed that the DBT-based group was not more effective in preventing relapses. However, they presented a significant reduction in depressive symptoms.⁴¹

In the study carried out by Neacsiu et al.,⁴² they applied a 16-week group treatment for Dialectical Behavioral Therapy Skills Training (DBT-ST) and a 30-minute individual session with their therapist. Forty-four people who presented anxious and depressive symptoms without a diagnosis of BPD and with high emotional dysregulation participated. Results over time show that the DBT-ST group showed improvements in emotional regulation.

ACCEPTANCE AND COMMITMENT THERAPY (ACT) APPLIED TO DEPRESSION AND ANXIETY

Acceptance and Commitment Therapy is based on the relational frameworks and functional contextualism theory, which refers to understanding and influencing the human context of human behavior.⁴³

Within ACT, "psychological flexibility" is of utmost importance. It refers to the ability to connect with internal experiences, use them, observe cognitions as simple thoughts, conceive a meaning in life, and pay attention to significant events.⁴³

Psychological flexibility is made up of six intertwined change processes.⁴³

Acceptance implies allowing the experience of unpleasant thoughts, sensations and emotions without seeking to modify them.

Flexible attention to the present moment refers to consciously directing attention to the current experience without judging or trying to change it.

Values clarification implies committing to one's values and what is most significant to oneself.

Committed actions refer to measures aligned with personal values, even when experiencing difficult moments.

Self context implies recognizing the influence of circumstances and the environment in our actions.

Defusion refers to the thoughts and beliefs distancing to observe them with a broader and clearer vision.

The goal of ACT for anxiety disorders is to function better with the symptoms the person is experiencing, as well as to intervene in the way the person learns to function with the internal experiences that cause distress.⁴⁴

It is worth considering that Hayes et al.¹⁹ present an analysis of acceptance and commitment therapy where they also mention possible adverse effects, such as patients experiencing temporary difficulties during treatment, as an initial increase in anxiety when facing difficult experiences. However, these

adverse effects generally decrease over time and are considered part of the therapeutic process.

This therapy's available evidence describes, an ACT intervention for a case of mixed anxiety and depression disorder.⁴⁵

1. Assessment: an interview was conducted to collect data and identify the patient's problem behaviors. A behavioral evaluation was also carried out, and psychometric tests were applied.

2. Intervention: it was made up of 14 sessions taught weekly.

This program was divided into four blocks:

A) Creative hopelessness refers to recognizing neglected vital areas through verbalizations.

B) Clarification of values list of values with actions aimed at vital objectives.

C) Control is the problem: it aims to reduce control behaviors and experiential avoidance.

D) Deliteralization of verbal functions: the patient sought to increase value-oriented actions.

3. Post-test evaluation: psychometric tests were applied at the end of treatment to examine the intervention effects.

The results of this study show a positive change, a discomfort decrease, and a reduction in anxious and depressive symptoms.⁴⁵

A meta-analysis also found the effects of group therapy based on ACT on anxious and depressive symptoms in adults over 18 years of age, including clinical and non-clinical populations. 77% of the studies consisted of interventions of 6 and 12 sessions. The results showed a medium to high effect on anxiety symptoms ($g = 0.52$). Similarly, 40 studies were effective for depressive symptoms, with a small to medium effect ($g = 0.47$).⁴⁶ An investigation examined possible moderating factors that may influence the effectiveness of ACT treatment. It found that group ACT was significantly effective compared to non-active controls in reducing anxiety symptoms, but when comparing it to active controls, there were no statistically significant effects. In contrast, it was effective in reducing depressive symptoms compared to active and non-active controls. The ACT group dropout rate was 18%, compared to the individual dropout rate of 16%; these percentages are similar.⁴⁷

At an individual level, there is also evidence of ACT application. For example, a case study was conducted on a 42-year-old adult with social anxiety and depressive symptoms, and an ACT-based 14-session intervention was applied, together with behavioral activation.⁴⁸

In evaluating said study, psychological flexibility was measured with the Acceptance and Action Questionnaire (AQQ) by Wilson & Luciano Soriano.⁴⁹ In pretreatment, it reached 40, reduced to 20, and then to 12. Regarding depressive symptoms, they used the Beck Depression Inventory (BDI-II) by Beck et al.,⁵⁰ where he initially obtained a 32 score, later 15 and 5 in the follow-up. In the levels of anxious symptomatology, he got a 33 score on the State-Trait Anxiety Questionnaire (STAI) by

Guillen and Buela.⁵¹ After the intervention it reduced to 23 and in the follow-up to 10. In the assertiveness measures, they found a change from 120 to 40 in the Gambril and Richey Assertiveness Questionnaire.⁵² Finally, in the response probability scale of Carrasco et al.,⁵³ there was a score reduction from 158 to 65 and the follow-up to 40.⁴⁸

Finally, Scott et al.⁵⁴ conducted a study focused on the effects of acceptance and commitment therapy in treating chronic pain. They found that some patients experienced an initial anxiety or depression increase when confronting their painful experiences. However, such effects diminished over time, and participants reported a significant improvement in their quality of life.

BEHAVIORAL ACTIVATION APPLIED TO ANXIETY AND DEPRESSION

The interest in applying Behavioral Activation (BA) arises from the study of Jacobson et al.,⁵⁵ later, in collaboration with other authors published a guide proposal called "Depression in Context: Strategies for Guided Action" to substantiate the techniques of BA from a contextual perspective.⁵⁶ There is currently a more recent guide published in 2010 titled "Behavioral Activation for Depression: A Clinician's Guide."⁵⁷ From a behavioral activation perspective, people with depressive symptoms have little access to events that bring them pleasure, which leads to a higher depressed mood. Furthermore, symptoms play a role in the environment and are regarded as behaviors in terms of behavioral avoidance. In this way, life events are related to the decrease in positive reinforcement or rewarding activities.⁵⁸

Behavioral activation uses strategies for monitoring activities and mood through self-records. These observations allow functional analysis of behavior and the development of social skills and time management.⁵⁹ The effectiveness of this therapy is evidenced in treating depression,⁶⁰ anxiety disorder, and other comorbid disorders in adults.^{60, 61}

The following describes an intervention program based on behavioral activation developed by Martell et al.⁵⁷ structured according to the main principles:

A. Evaluation: the therapist identifies and understands the individual's behavioral patterns and the relationship to the problem.

B. Establishing objectives: based on the information collected and the patient's collaboration, the therapist establishes rewarding activities missed due to symptoms.

C. Activity planning: design a plan with rewarding activities according to the patient's interests and values so that they can practice and integrate them into their daily life.

D. Monitoring mood and activities: patients should record their mood and activities daily to identify patterns and evaluate the impact of these activities on their emotional state.

E. Generalization of skills: the patient is motivated to integrate the skills learned into their daily life and to carry them out generally in different events and contexts.

F. Evaluation and monitoring: After the treatment, the therapist evaluates the patient to review the effect on depression and anxiety. Likewise, progress is regularly monitored to keep track of the patient's changes.

Based on the evidence of BA in anxiety disorders, a randomized clinical trial was conducted in 2023 with 102 adults diagnosed with GAD. To compare the effectiveness of an intervention program based on BA and another focused on Based Therapy. In Exhibition (EXP), the duration of both programs was 10 weekly sessions of 90 minutes. Exposure-based therapy focuses on gradually exposing the person to anxiety-provoking stimuli or situations to reduce the fear and avoidance response.⁶²

Participants received an intervention complementary folder that included each session's outlines, basic descriptions of concepts, and worksheets to do at home. Behavioral techniques were used within sessions, while cognitive techniques were not. Results showed that decreases were similar after the intervention in both modalities and persisted for six months. Additionally, they found BA has more rapid anxiety and depression reduction scores during treatment and better ratings by participants following therapy. Finally, Bayesian analyses showed that the probability of higher change with Behavioral Activation ranged from 74% to 99% after the intervention.⁶²

Regarding applying BA in a group format, Coto-Lesmes et al.⁶³ conducted a systematic review. They reviewed seventeen studies with anxiety and depression patients. Said studies compared BA with a control group without intervention. In general, samples were too heterogeneous and modest, ranging from 18 to 80 participants. All interventions were brief, ranging between five and 20 sessions. Generally, the frequency was weekly, and the duration was 1 to 2 hours. In general, they found a higher effectiveness of behavioral activation in the experimental groups compared to the control group, that is, a reduction in anxiety and/or depression.

Additionally, in 2021, a meta-analysis examined whether cognitive restructuring (CR), CBT, and BA compare effects in adults. The results showed that of the 45 studies (3,382 participants), there were no differences in effectiveness between the treatments. Highlighting CR, CBT and BA were superior to usual care and the waiting list.⁶⁴

In the use of Information and Communications Technologies, there is a systematic review and meta-analysis to measure the effectiveness of programs based on behavioral activation administered through the Internet. The article included nine randomized controlled trials with a total of 2,157 participants whose diagnoses were depression, depression with comorbid diabetes, and postpartum depression, among others. Internet-based behavioral activation refers to the use of online resources to assess, formulate goals and strategies, and monitor progress over time. The results show that BA was not inferior to behavioral therapy. However, it was superior to physical activity, psychoeducation, treatment as usual, and the waiting

list. Comparing psychoeducation and usual treatment, they found moderate evidence.⁶⁵

FUNCTIONAL ANALYTIC THERAPY APPLIED TO ANXIETY AND DEPRESSION

Functional Analytical Psychotherapy (FAP) has its origins in 1991 by Kohlenberg and Tsai.⁶⁶ Which is based radical behaviorism philosophy, which works on behavior modification, considering the therapeutic context. Two fundamental assumptions of the FAP are:⁶⁶

A. The consultant's daily life interpersonal problems (PVD) are reflected in the relationship with the therapist during the sessions.

B. Clinically relevant behaviors (CCR) improvement given by direct contingencies during the session will be generalized, seeking to help the patient with daily life problems.

One of the fundamental tools that the therapist uses is the contingent response to the client's behaviors, which can be through shaping, differential reinforcement, and positive reinforcement to increase behaviors, as well as stimulus control and generalization. Another task of the therapist is understanding the language's function during sessions. Therefore, it prioritizes behavior change mechanisms within the therapeutic relationship over topography. Within this therapy, target behaviors (VD) and the responses given by the therapist (VI) are reconsidered.⁶⁷

Within the FAP concept, there are daily life problems (DLP) identified in the therapist's relationship with the patient, the behaviors linked to the DLP outside the session (O) and the behaviors carried out within the session. (CCR). The therapist will seek to reduce CCR1 behaviors (type 1 behaviors) and increase CCR2 behaviors (type 2 behaviors). Finally, CCR3 is the functional explanation of the patient respecting his behavior, focusing on their increase.⁶⁶

Below are five rules for the therapist to develop effective behaviors in the patient.⁶⁶

A. Observe the behaviors carried out within the session.

B. Evoke the behaviors carried out within the session aiming to identify the reinforcements that maintain them. This way, the therapist can reinforce the CCR2.

C. The therapist will make contingent responses to the behaviors carried out within the session.

D. Consider whether the strategies are working on the patient's desired behavior.

E. Prepare a functional analysis of behavior and designate tasks for the week to generalize the behaviors to your daily life.

Regarding the evidence of FAP application, a case study of a 35-year-old woman with panic without agoraphobia and anxiety attacks is reported. In the first stage, the case formulation was carried out according to the functional analysis of the patient's problems, considering clinically significant behaviors. In the intermediate stage, type 1 behaviors occurred frequently. The intervention lasted five months with 14 90-minute sessions. A

telephone follow-up was carried out at 6 and 18 months. The results showed that the patient reported a decrease in the practice of problematic behaviors she maintained over time. This study lacks methodological limitations due to the lack of measurements during treatment. However, it shows the description of how to carry out a treatment based on the FAP in a case of Panic Disorder.⁶⁸

On the other hand, in Mexico, an intervention based on functional, analytical psychotherapy combined with ACT was carried out to reduce depressive and anxious symptoms in a 28-year-old woman with a history of romantic breakups. The intervention consisted of 9 sessions of 50 minutes, taught once a week. During the program, ACT components were used, including values clarification, experiential avoidance pattern analysis, metaphors, and defusion. Within the FAP elements, type one and type two clinically relevant behaviors (CCR) analysis was carried out. This study showed a decrease in anxiety and depression scores and an increase in the patient's behaviors in valuable situations.⁶⁹

In an individual modality, López-Bermúdez et al.⁷⁰ examined the FAP effectiveness for anxiety, depression, emotional control, sexual obsession, and personality problems. The results showed statistically significant changes in post-treatment measurements with a large effect maintained at one-year follow-up. This study highlighted that the FAP approach requires evaluating and intervening individuals separately to carry out the functional analysis of each diagnosis. In the same way, this approach seeks for the person to relate to others in a social and close way.

However, there is also evidence on the application of functional analytical therapy in group mode to reduce depressive symptoms. This study's sample was made up of 21 adult women assigned to three groups. The intervention lasted 16 weekly sessions of two hours each. The results showed that 12 participants had clinically significant improvements after treatment, while 15 maintained improvements after two years of follow-up.⁷¹

CONCLUSIONS

The present narrative review highlights effective third-generation therapies for anxiety and depression individually and in groups. Contextual therapies emphasize attention to your experiences, emotions, and beliefs and consider the role of the context in the problems, not focusing solely on the reduction of symptoms. On the one hand, we have that ACT promotes clarity in personal values and meaningful actions. However, more research is needed on psychological flexibility compared to CBT. Due to the fact that mindfulness allows a person to focus on the present moment without judgment and improves adaptability, it can also reduce symptoms of anxiety and depression. AC seeks to modify avoidant behaviors that maintain depressive and anxious symptoms, promoting the incorporation of meaningful activities in daily life. DBT also offers an effective approach to these problems, especially for those who also experience emotional dysregulation. However,

it is suggested to conduct more studies on the effectiveness of DBT skills in cases of anxiety and depression disorders without BPD. Finally, FAP focuses on helping the person understand the factors that contribute to their emotional difficulties, demonstrating its effectiveness at the individual level and with control groups.

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