

## CHAPTER 1

# Introduction to Acceptance and Commitment Therapy for Psychosis

In this chapter we give a brief overview of psychosis and psychological treatment approaches. We introduce acceptance and commitment therapy (ACT) and its application to psychosis, and then outline the development of our ACT for recovery group intervention.

Given that antipsychotic medication is not well tolerated, is only partially effective, and can have harmful side effects (Furukawa et al., 2015; Lieberman et al., 2005), psychological therapies offer a vital treatment option for clients. International clinical guidelines recommend that people with psychosis are offered individual cognitive behavioral therapy (CBT; Gaebel, Riesbeck, & Wobrock, 2011), but access remains limited in front-line services, mainly due to a lack of trained therapists. To help meet demand, group-based CBT interventions have been evaluated, as these can be offered to more clients at a time and can also be manualized and taught within services to increase the scope of their delivery.

ACT is a contextual cognitive behavioral intervention that lends itself to brief group therapy and to the diverse presentations of psychosis. Rather than targeting particular appraisals, as in traditional CBT, the ACT approach is not symptom specific. It emphasizes the person's relationship with symptoms and encourages values-based living (Hayes, 2004). ACT concepts and skills can be taught and modeled within a group format, plus this approach can appeal to clients who are unable or reluctant to engage with lengthy individual treatments. In addition to these aspects of ACT, the development of our workshops was also informed by our local context and the clients accessing the service, many of whom had histories of marginalization, low educational achievement, and a distrust of authority figures. We wanted to offer a brief group intervention that would be engaging, nonthreatening, and usable by clients in their daily lives.

## Psychosis

*Psychosis* is a broad concept that is something of an umbrella term for lots of different experiences. Clinicians use the term to refer to the positive symptoms of psychotic disorders: unusual beliefs (delusions), anomalous experiences (hallucinations and other perceptual changes), and disturbances of thought and language. Individuals experiencing psychosis may say that people are trying to harm them in some way, or that they are being controlled by an external agent, and they may hear voices insulting them or commanding them to do things against their will. Their thoughts may be jumbled or experienced as inserted into, or stolen from, their mind, and thought disturbances can manifest as tangential or circumstantial speech. Although psychotic experiences are hallmark symptoms of schizophrenia, they also occur with other problems, such as mood and personality disorders, and they are reported by people who don't have a psychiatric diagnosis (Kelleher & DeVylder, 2017; McGrath et al., 2015). People diagnosed with a psychotic disorder, particularly schizophrenia, are also likely to experience negative symptoms, such as lack of motivation and reduced emotional expression, plus cognitive problems of poor memory and concentration. It's worth keeping in mind that all these symptoms can be accompanied—and often preceded—by more common emotional difficulties, such as anxiety and depression (Birchwood, 2003). It is also worth noting that psychotic experiences are not always experienced as unwanted or distressing, and they do not necessarily result in a need for care (Brett, Peters, & McGuire, 2015; Linscott & van Os, 2013).

### *Outcomes Following Psychosis*

Diagnosable psychotic disorders affect 3 percent of the population. So, in a group of 100,000, that works out to be 3,000 people. Psychosis is considered a “severe mental illness,” and it tends to reduce quality of life, social inclusion, and employment opportunities for both service users and family members (Schizophrenia Commission, 2012). It has societal costs as well, including expensive crisis care and clients and caregivers not being able to work to their full potential (Knapp et al., 2014). Psychosis is also associated with an increased risk of physical health problems and early mortality (Hjorthøj, Stürup, McGrath, & Nordentoft, 2017), as well as increased risk of suicide (Nordentoft, Madsen, & Fedyszyn, 2015).

Although individuals who develop psychosis can have a favorable prognosis, recovery rates are variable. Also, even if an individual's psychotic symptoms improve, the person may not achieve a full social and functional recovery.

In the AESOP–10 follow-up study of 557 individuals who experienced a first episode of psychosis in the United Kingdom (Morgan et al., 2014), clinical outcomes were better than social outcomes: almost half of the people in the study didn't have any psychotic symptoms for at least two years, whereas the majority experienced social exclusion (for example, being unemployed or not being in a relationship). In a systematic review of recovery in nonaffective psychoses, Jääskeläinen and colleagues (2013) found that only one in seven individuals met their criteria for both clinical and social recovery. Unfortunately, despite more treatment options in recent decades, such as newer medications and psychological therapies, the proportion of those who recover fully has not improved over time.

Definitions of recovery include “living a satisfying, hopeful and contributing life even with limitations caused by the illness” (Anthony, 1993, p. 527), and factors important in recovery include having a sense of purpose and direction (Deegan, 1988) and developing valued social roles (Slade, 2009). These factors are included in the CHIME framework for personal recovery in mental health (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), which we return to later in the chapter. CHIME is a handy acronym for:

connectedness (connecting with others),

hope (finding and maintaining hope and optimism),

identity (reestablishing a positive identity),

meaning (finding meaning in life), and

empowerment (taking responsibility for one's life, or self-management).

There are lots of reasons why recovery can be a significant challenge for many people with psychosis. Along with unusual experiences, negative symptoms, and cognitive problems, people can struggle with changes in emotional well-being and their sense of identity. In addition, due to the stigma of severe mental illness, people can feel shame and alienation from their communities.

## *Psychological Interventions for Psychosis*

Psychological interventions, for both clients and caregivers, are now an accepted part of routine care and are recommended by international health care guidelines (Dixon et al., 2010; Gaebel et al., 2011; National Institute for Health and Care Excellence, 2014). Cognitive behavioral therapy for psychosis

(CBTp) is an adaptation of CBT for emotional disorders, tailored to the specific difficulties of people with psychosis. Therapy involves working toward personal recovery goals, and its focus includes positive psychotic symptoms, emotional problems, and negative symptoms. Overall, the evidence shows that it is relatively effective, with small to medium treatment effects (Jauhar et al., 2014; National Institute for Health and Care Excellence, 2014; van der Gaag, Valmaggia, & Smit, 2014). Individual family interventions focus on the areas of understanding psychosis, problem solving, emotional warmth, and communication among family members; improving caregiver well-being and interactions with service users; and reducing relapse and readmission rates (National Institute for Health and Care Excellence, 2014).

Despite the recommendations, the effective implementation of psychological interventions in psychosis services remains limited (Schizophrenia Commission, 2012). These therapies can be complex and lengthy, and their delivery in routine service has been restricted by low numbers of therapists, limited access to adequate training and supervision, and a lack of protected time for staff to deliver the interventions (Ince, Haddock, & Tai, 2015). The high cost of training and supervising psychological therapists in sufficient numbers to meet demand has led researchers and clinicians to evaluate briefer or group-based variants of CBTp, which have the potential to improve both its dissemination and accessibility. However, the evidence base for these treatments remains limited, and they have had a modular focus targeting particular symptoms or problems rather than psychosis more broadly (Freeman et al., 2015; Waller, Freeman, Jolley, Dunn, & Garety, 2011).

Although targeted interventions are effective, when they are applied one after another they can add up to lengthy therapies, restricting their usefulness in busy services with limited numbers of staff trained to deliver these interventions. In addition, people with psychosis often have other problems, such as health concerns, trauma, and emotional difficulties. Another approach to increasing therapy impact and access is to target common processes that contribute to psychological well-being, regardless of diagnosis. A core component of mental well-being is psychological flexibility (Kashdan & Rottenberg, 2010), which involves developing helpful responses to situations and experiences by using acceptance, mindful awareness, choice, and values-based actions. The transdiagnostic approach of ACT aims to increase psychological flexibility, and this approach has been applied successfully to a wide range of mental and physical health problems for which flexibility processes are limited or reduced.

## Acceptance and Commitment Therapy (ACT)

Acceptance and commitment therapy (ACT) belongs to a group of third-wave, or contextual cognitive behavioral therapeutic, approaches that emphasizes altering the way people relate to their thinking and feeling, rather than directly trying to change the form or frequency of these internal experiences (Hayes, 2004). The ACT model is underpinned by a behavioral analytic account of language called relational frame theory (RFT; Blackledge, Ciarrochi, & Deane, 2009), and therapy aims to reduce the impact of thoughts and language in order to increase the amount of choice one has with regard to following a valued life path.

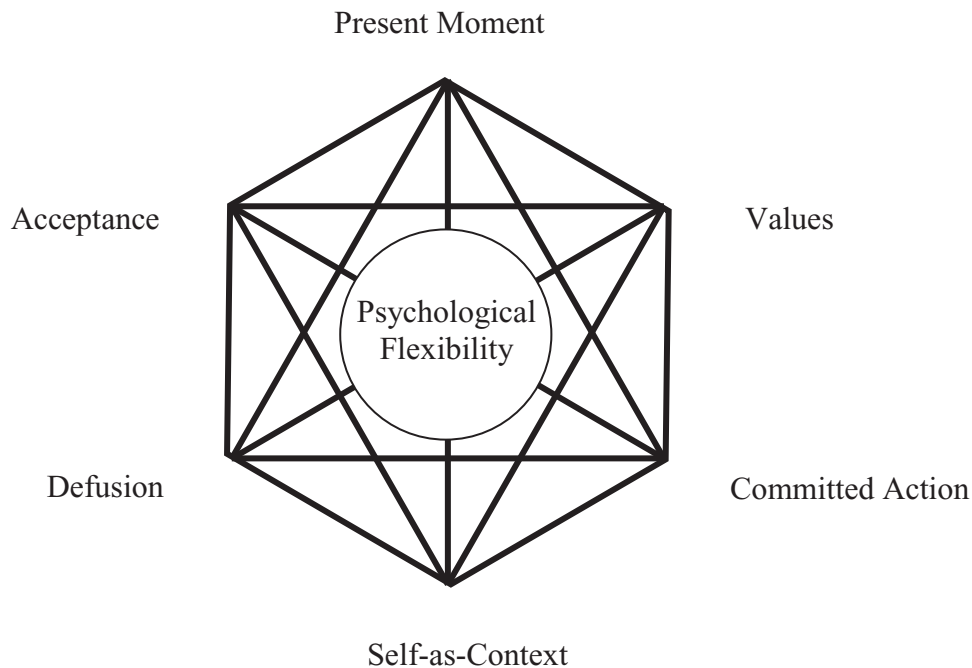
ACT aims to increase psychological flexibility by helping people develop mindfulness and noticing skills, engage in values-based actions, and reduce the processes of experiential avoidance and cognitive fusion that exacerbate negative emotional states and limit functioning (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson 2012). The ACT approach encourages the client to respond to internal experiences (such as thoughts, images, feelings, and memories) as “events in the mind,” rather than literal content, and helps the client develop a perspective of mindful acceptance toward them. This form of intervention can be particularly helpful when clients are struggling with internal events that are not amenable to control, or when persisting with efforts to control them leads to problems in everyday living. An aspect of the approach is to reduce the client’s tendency to try to make literal sense of an experience when it is not useful; ACT helps the client notice when “making sense” of experiences functions as an unhelpful form of control that maintains difficulties. ACT facilitates a shift in emphasis for clients, from focusing on trying to control internal events to focusing more on behavior-change processes that can lead to positive outcomes.

ACT’s treatment efficacy across a range of clinical disorders and problems is gaining empirical support (A-Tjak et al., 2015). Studies show that ACT performs better than either treatment as usual or active control interventions, and they indicate that ACT and established psychological treatments (usually CBT) achieve equivalent outcomes for several disorders. Division 12 of the American Psychological Association, Society of Clinical Psychology, states that there is “modest research support” for ACT as a psychological treatment for a number of mental health problems, including anxiety, depression, and

psychosis (<http://www.div12.org/psychological-treatments/treatments/acceptance-and-commitment-therapy-for-psychosis>). Furthermore, studies suggest that ACT does appear to work through the processes suggested by the psychological flexibility model (Levin, Hildebrandt, Lillis, & Hayes, 2012).

## *The Psychological Flexibility Model*

The six core theoretical processes of ACT are set out in the hexaflex model (figure 1), and they work together to increase *psychological flexibility*, defined as “the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends” (Hayes et al., 2006, p. 7). Although the six processes are represented as distinct in the model, they are highly interdependent, such that starting to use one process is likely to positively impact the others. More recently, these processes have been grouped into three sets of response style: open, aware, and active (Hayes, Villatte, Levin, & Hildebrandt, 2011; see table 1 for a summary of these processes).



**Figure 1.** The ACT model of psychological flexibility, or hexaflex

**Table 1. Central ACT processes**

(adapted from Luoma, Hayes, &amp; Walser, 2007)

Process	Definition
<i>Open</i>	
Acceptance	The active and aware embrace of psychological events (thoughts and emotions) without unnecessary attempts to change their frequency or form.
Defusion	The process of untangling from unhelpful thoughts and responding to mental experiences as experiences, rather than guides to action.
<i>Aware</i>	
Self-as-context	A continuous and secure “I” from which events are experienced, but that is also distinct from those events.
Present moment	Ongoing, nonjudgmental contact with internal (thoughts and emotions) and external events as they occur.
<i>Active</i>	
Values	Desired and chosen life directions.
Committed action	The process of linking specific actions to chosen values and building successively larger patterns of effective actions.

## OPEN

The processes of acceptance and defusion work together to assist the broader skill of developing openness toward internal content (thoughts, emotions, memories). *Acceptance* is the process by which clients “embrace” their thoughts and feelings without trying to resist, avoid, or suppress them (experiential avoidance). This acceptance is not merely a passive process of tolerance or resignation but a full willingness to step toward and make space for psychological phenomena, including psychotic symptoms, without engaging in an unworkable struggle against them.

Alongside the process of acceptance, defusion further supports an open stance toward internal experience. Defusion exercises help clients “step back” from internal experiences, such as thoughts, memories, or appraisals of unusual experiences, and see them for what they are (experiences), rather than what they say they are (guides to action and choices), thereby reducing the literal rule-based responses to internal events that are unhelpful. From an ACT perspective, fusion increases the likelihood that an individual’s behavioral repertoire will narrow in response to such experiences, thereby reducing opportunities for values-based actions. Defusion works to expand the repertoire by undermining one’s entanglement with the thoughts and verbal rules that promote restriction or avoidance.

### AWARE

*Self-as-context* refers to the sense of self (I, here, now), from which all internal experiences are observed and contained. An awareness of this particular perspective, cultivated through a mindful contact with the present moment, can loosen attachment to distressing thoughts, images, beliefs, or hallucinations that may arise. Mindfulness (present moment awareness) can help individuals learn to notice but not judge passing thoughts, feelings, or images in order to develop a more decentered stance toward internal experiences and to support engagement with core values.

### ACTIVE

The heart of ACT work is assisting clients to become more engaged with and active in their lives in a chosen way. This happens through a process of identifying and constructing sets of values and then using them to inform the steps one takes toward meaningful goals and specific action plans. Goals are set in ways that increase the likelihood they will be met (for example, setting initially small, measurable tasks, which are increasingly built into larger patterns of committed action).

## *Mindfulness (Noticing) within ACT*

It is worth including a little more detail on mindfulness and its use within ACT, given that the term is used in numerous contexts and, depending on personal experience and practice, is likely to mean different things to different readers. *Mindfulness* is generally described as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn,



1994, pp. 3–4), wherein a person intentionally focuses attention on present-moment experiences in a nonjudgmental and accepting way, and also with compassion and curiosity toward these experiences (Kabat-Zinn, 2003). We can contrast this state of mind with engaging in cognitive processes such as rumination, worry, planning, and fantasizing, or behaving automatically without awareness—that is, being on autopilot (Baer, Smith, & Allen, 2004; K. W. Brown & Ryan, 2003).

Mindfulness has been a component of a number of cognitive behavioral therapy approaches, beginning with dialectical behavior therapy (DBT) for borderline personality disorder (Linehan, 1993). Mindfulness as practiced within mindfulness-based stress reduction (MBSR) was incorporated as a component of mindfulness-based cognitive therapy (MBCT) to help prevent further relapses in people with recurrent major depression (Segal, Williams, & Teasdale, 2002). One of the challenges to the practitioner's understanding of mindfulness is that, although we can learn how to use it as a technique, there are various definitions, including mindfulness as a psychological process, an outcome, or a collection of techniques (Hayes et al., 2012). Within MBCT, for example, the practice of mindfulness is seen as an alternative cognitive mode (Teasdale, 1999) that is incompatible with the kind of cognitive processing that increases risk for relapse in depression.

The rationale for mindfulness within ACT focuses on how it can promote flexible responding and taking action based upon chosen personal values. Mindfulness uses four processes from the psychological flexibility model: present-moment awareness, acceptance, defusion, and self-as-context (Fletcher & Hayes, 2005). This functional definition of mindfulness in ACT means that there is no linkage with particular mindfulness exercises or techniques, so any method that changes these processes is relevant (Hayes & Shenk, 2004).

## *ACT as a Recovery Therapy*

ACT promotes recovery and social inclusion by shifting client focus from that of symptom control to connecting with personal values and participating in life as other people do and as the client may have in the past. The ACT approach maps nicely onto CHIME, the recovery processes mentioned earlier:

- **Connectedness:** The prosocial approach of ACT orients people to connect with others, to learn from their experiences, to understand their perspectives, and to develop compassion for oneself and others. It also helps us to appreciate that we can all step forward in our own journey of personal recovery and purpose.

- **Hope:** Maintaining hope is an active stance we can take on an ongoing basis. Also, while difficult thoughts and feelings may come and go, the hopeful actions that people take are tangible ways to make positive life changes.
- **Identity:** A positive identity can be reestablished by contacting with self-as-awareness and by noticing how our minds create stories about us. Instead of being entangled in the mind's judgments, we observe whether they are useful for our chosen life directions.
- **Meaning:** By finding meaning, we can dignify life's pain and suffering if they are part of the process of doing the things that are important to us. By acting on personal values, we can increase our contact with meaning.
- **Empowerment:** This involves self-management and taking responsibility for one's life. We help people to be "response-able": to act on their values, rather than their fear, through developing an open, compassionate stance toward their experiences and themselves, and by learning from experience.

The clear fit of ACT with recovery principles shows how contextual approaches can inform the way we offer help to people with serious mental illness. ACT assumes that people can develop psychological flexibility regardless of the presenting problem, including persisting psychotic symptoms.

## *Rationale for ACT for Psychosis (ACT<sub>p</sub>)*

There are a number of reasons why an ACT approach can be useful for people experiencing and recovering from psychosis. Ultimately, improvements in functioning and quality of life result from changes in behavior rather than reductions in positive symptoms (Bach, 2004), and psychological flexibility can mediate these changes. In addition to increasing well-being, reducing avoidance, and enhancing values-based living, promoting psychological flexibility with ACT offers benefits for the particular problems and symptoms of psychosis. Some of the qualities (intrusive, uncontrollable, negative, frightening) of distressing voices and delusional beliefs increase the likelihood that people respond to them with suppression or avoidance (Morris, Garety, & Peters, 2014; Oliver, O'Connor, Jose, McLachlan, & Peters, 2012). Conversely, some psychotic experiences can be very engaging, in that they can be magical, interesting, and have high personal meaning, especially in the context of a life

devoid of meaningful activity and social connection. As such, clients may engage with these experiences to escape a mundane life, although doing so has the potential for high personal cost in the long term. The qualities of positive psychotic symptoms and people's responses to them are discussed further below. In addition, people with psychosis can display particular reasoning biases that limit psychological flexibility, including a tendency to blame other people for negative events (Martin & Penn, 2002), a tendency to jump to conclusions on the basis of relatively little evidence (Dudley, Taylor, Wickham, & Hutton, 2015), and a poor ability to generate alternative explanations for experiences (Freeman et al., 2004).

## RESPONDING TO VOICES

Auditory hallucinations tend to be compelling verbal experiences for people with psychosis, and they are often negative, personally salient, and highly distressing (Nayani & David, 1996). To try to cope, people who hear voices develop responses based on their beliefs about the voices and interpersonal beliefs about their social standing within relationships. People might resist or engage with voices, depending on whether they perceive the voices as malevolent or benevolent, respectively (Chadwick & Birchwood, 1995).

*Resistance* is an attempt to suppress or control voices, with the aim of eliminating or reducing them. Resistance to hostile voices can be divided into the fundamental *fight* (attempts to confront) or *flight* (attempts to escape or avoid) responses (P. Gilbert et al., 2001), coping methods that tend to be ineffective in the long run. Research has shown that fight strategies, such as shouting back at or arguing with voices, are associated with poorer emotion control (Farhall & Gehrke, 1997), and flight responses, such as trying to block out the voices, are associated with depression (Escher, Delepaul, Romme, Buiks, & van Os, 2003) and reduced self-esteem (Haddock, Slade, Bentall, Reid, & Faragher, 1998). Resistance strategies may also have the effect of maintaining voices and beliefs about their power and identity in the longer term (Morrison & Haddock, 1997). In terms of the fight response, actively hostile attitudes and behaviors toward voices can increase physiological arousal, which contributes to increased voice frequency (P. Gilbert et al., 2001; Romme & Escher, 1989). The flight response of engaging in safety-seeking behaviors, such as appeasing or complying with the commands of malevolent voices (done to prevent a feared outcome), prevents the disconfirmation of the person's fearful beliefs about the voices (Hacker, Birchwood, Tudway, Meaden, & Amplett, 2008).

*Engagement*, on the other hand, is defined as "elective listening, willing compliance, and doing things to bring on the voices" (Chadwick & Birchwood,

1994, p. 192). It involves listening to some or all of the voices and directly accepting what they say (Farhall & Gehrke, 1997; Frederick & Cotanch, 1995). However, actively engaging with voices has the potential to become overly intimate and may have hidden costs in terms of flexibility, confidence, and engagement with other activities and relationships (Birchwood & Chadwick, 1997). Passive engagement may incorporate submissive responses to voices, such as complying with commands from benevolent voices (Braham, Trower, & Birchwood, 2004; Shawyer et al., 2008).

These forms of response—engagement and resistance—may inadvertently reinforce the experience of hearing voices and compound the client’s distress and disability. Both forms of response perpetuate the relationship with voices by keeping clients involved with them, and this continued preoccupation can impede the pursuing of important life goals (for a more detailed discussion see Thomas, Morris, Shawyer, & Farhall, 2013).

## DELUSIONAL THINKING

Experiences associated with delusional thinking, such as anxiety, shame, or humiliation, can directly lead people to avoid these experiences and triggering situations. This familiar form of experiential avoidance has been termed *passive* avoidance (García-Montes, Luciano Soriano, Hernández-López, & Zaldívar, 2004), whereby the person seeks to avoid private experiences and behaves in ways to reduce those experiences and the conditions that generate them. Some delusions, however, can be understood as *active* forms of experiential avoidance (García-Montes et al., 2004; García-Montes, Pérez-Álvarez, & Perona-Garcelán, 2013). With these, the experiential avoidance is more elaborate, and the delusional symptom itself becomes a means of avoiding some other matter (for example, low self-esteem, guilt, or depression). The “active” aspect of experiential avoidance overlaps with cognitive fusion, whereby the person verbally constructs an alternative reality or world, which they become fused with and immersed in via the processes of worry and rumination. Although, a person’s delusions may not always start this way, these processes become maintaining factors. This overinvolvement with the content of delusions, while initially positively reinforcing, can have a negative impact on the person’s valued life directions.

## ACCEPTANCE APPROACHES

Given the negative impact that suppression and avoidance strategies have in the long term, acceptance is a potentially more adaptive response to psychotic experiences. Cohen and Berk (1985) identified acceptance as a “do

nothing” coping response used by some patients with schizophrenia, suggesting they had learned to live with their symptoms. They distinguished this response from a less healthy “do nothing” strategy involving helplessness and giving up.

One way that therapists have attempted to promote acceptance in therapy has been to cultivate insight. This form of acceptance has been a part of some forms of cognitive behavioral therapy for psychosis (CBTp; Kingdon & Turkington, 1994). Interventions include nonconfrontational and personalized discussions of alternative models of experiences, including the evaluation of beliefs about the power and identity of voices or other perpetrators and, ultimately, the reattribution of unusual experiences to the self (Garety, Fowler, & Kuipers, 2000). By accepting symptoms as part of an illness rather than as coming from real people, therapists hope that people will be less fearful and will be able to disengage from the content of voices and beliefs (Chadwick & Birchwood, 1994; van der Gaag, 2006). However, such discussions within CBTp have the potential to be unhelpful if the therapist does not consider the function of the symptoms, particularly if they are forms of active avoidance as described above. It is also possible that, by excessively focusing on cognition and the search for meaning, and by communicating the need to “fix thinking” before effective action can be taken, some therapeutic efforts to modify thoughts may actually maintain or accentuate processes that impede recovery (Bach, 2004).

Romme and colleagues pioneered an important acceptance approach; they suggest that clients can learn to accept voices by exploring their personal meaning, acknowledging their positive aspects, and learning to incorporate them into life rather than attempting to eliminate them (Romme & Escher, 1989; Romme & Escher, 1993; Romme, Honig, Noorthoorn, & Escher, 1992). This work has been influential with groups for people who hear voices, such as *Intervoice: The International Hearing Voices Network*, and via self-help publications, peer-support groups, conferences, and online resources. More recently, this approach has been incorporated into a case-formulation intervention for voices, to help clients understand the meaning of voice content within the context of broader life experiences and interpersonal relationships (Longden, Corstens, Escher, & Romme, 2012), and to help them relate to voices in more accepting ways through voice dialogue (Corstens, Longden, & May, 2012).

Though quite different in approach, all these therapeutic forms of acceptance depend on the person “accepting” some particular explanation for psychotic experiences. Thus, interventions incorporating this approach rely on the person adhering to a verbally based narrative about the experience. It is

assumed that these revised understandings will result in less distress and life disruption. While these client-formed explanations may inform the use of certain coping strategies, they do not specifically encompass skills to accept the presence of psychotic experiences as they occur. This is important, because the experiences of voices and other anomalous experiences in the moment often remain real and engulfing despite clients having the ability to reflect on them afterward. As a result, these alternative explanations and frameworks to promote acceptance may have limited effectiveness in those moments when clients need help the most.

## *An ACT Approach to Psychosis*

ACT highlights a form of acceptance that fosters skills that people can apply as psychotic experiences occur. This mindful acceptance is neither a specific coping strategy nor a process of providing meaning, rather it's a particular style of relating to uncontrollable psychological events. It involves the skills of *nonjudgmental awareness*, deliberately observing mental events as they occur without judging them as good or bad and without reacting to them, and *disengagement* (detachment), detaching from the literal meaning of the content of voices and delusions—that is, distinguishing the actual experience (sounds and words) from what it represents (literal reality). (See the definition of “defusion” in table 1.)

The broader mindfulness and psychosis literature informs the mindful acceptance of psychotic experiences within ACT (Chadwick, Newman-Taylor, & Abba, 2005; Dannahy et al., 2011). For example, Chadwick's (2006) person-based cognitive therapy (PBCT) emphasizes the development of metacognitive awareness through mindfulness practice to reduce experiential avoidance and entanglement with psychotic experiences. Studies indicate that mindfulness-based interventions (MBIs) are acceptable and can be useful for people with distressing symptoms of psychosis (Chadwick et al., 2016; Khoury et al., 2013; Strauss, Thomas, & Hayward, 2015).

The therapeutic focus of ACT—changing the person's relationship with symptoms, rather than the symptoms themselves—can reduce the impact of the symptoms and help the person focus more on valued actions (Pérez-Álvarez, García-Montes, Perona-Garcelán, & Vallina-Fernández, 2008). ACT emphasizes the *workability* of the individual's behavior, with greater flexibility and more response options (Pankey & Hayes, 2003). For example, through acceptance work, a person who typically responds to hearing voices with social isolation and arguing with them may develop a broader range of behavioral

responses to hearing voices. These might include activities, such as going out of the house, having a conversation with another person, deliberately noticing the acoustic properties of the voices, or engaging in a valued activity, as well as their usual responses to control the voices. The clinical focus of ACT is to add new positive functions and associations to the experience of hearing voices.

## *Evidence Base for ACTp*

Five randomized controlled trials (RCTs) have evaluated the efficacy of ACT approaches for people with psychosis (Bach & Hayes, 2002; Gaudio & Herbert, 2006; Shawyer et al., 2012; Shawyer et al., 2017; White et al., 2011), and there have been systematic reviews of these approaches for psychosis as well (Cramer, Lauche, Haller, Langhorst, & Dobos, 2016; Khoury et al., 2013; Ost, 2014). Although the trials had modest sample sizes, the findings were promising, indicating that such interventions may help reduce the impact of psychotic symptoms, particularly in terms of believability and emotional impact and disruption to functioning; they also had positive follow-up outcomes (Bach, Hayes, & Gallop, 2012). Importantly, all the studies showed that the interventions are feasible and acceptable with this group of people, and that it is possible for participants to respond in a psychologically flexible way to their unusual experiences. Clients do not get overwhelmed, provided that the mindfulness and other experiential exercises are adapted to take into account their difficulties.

The initial RCTs focused on rehospitalization rates. Bach and Hayes (2002) randomly allocated eighty inpatients with positive psychotic symptoms to treatment as usual (TAU) or to four individual sessions of ACT plus TAU. The ACT involved teaching patients to defuse from difficult thoughts, feelings, and psychotic experiences (just noticing them rather than treating them as true or false) and to identify and focus on actions directed toward valued goals. The ACT participants had lower rehospitalization rates than the TAU participants at the four-month follow-up, and this difference was maintained one-year postdischarge (Bach, Hayes, et al., 2012). There was an outcome difference worth noting; the intervention had little impact on the rehospitalization rate of participants with delusions but a large treatment effect for those experiencing auditory hallucinations.

In a smaller study comparing TAU and ACT plus TAU for psychotic inpatients, Gaudio and Herbert (2006) found that, at discharge, patients in the ACT treatment arm showed greater improvements in mood, social impairment, and distress associated with hallucinations. Although the four-month

rehospitalization rates were similar to those of the 2002 study, the group difference was not statistically significant.

RCTs involving outpatient psychosis samples have focused on either depression following psychosis or responses to ongoing positive symptoms. White and colleagues (2011) conducted an RCT of ACT for emotional dysfunction following psychosis, in which the participants were recovering from a recent episode of psychosis and experiencing depression or anxiety, or both. They compared a ten-session ACT intervention plus TAU (community psychiatric care) with TAU alone. Those receiving ACT showed a significant reduction in depression and negative symptoms, plus they had significantly fewer crisis contacts over the course of the study. White and colleagues recently completed the ADAPT study, a pilot RCT of ACT for depression after psychosis (ACTdp), comparing ACT plus standard care (SC) with SC alone, in order to inform a definitive, pragmatic multicenter trial of the effectiveness of ACTdp (Gumley et al., 2016).

The treatment of resistant command hallucinations (TORCH) trial compared befriending with fifteen sessions of an acceptance-enhanced CBT (A-CBT) intervention (Shawyer et al., 2012). There were no significant differences in the blind-rated outcome measures between the A-CBT and befriending groups (both interventions showed improvements), although the A-CBT participants reported subjectively greater improvement with command hallucinations. While the quality of the trial was high, it had difficulty recruiting the full number of participants with command hallucinations to have adequate power. The Lifengage trial (Thomas et al., 2014) compared eight sessions of ACT with befriending therapy for ninety-six outpatients with persisting and distressing psychotic symptoms. Participants in both therapy groups improved, and there was no group difference in overall mental state. However, participants in the ACT group were more satisfied with therapy and reported greater subjective benefit. They also showed greater improvement in positive symptoms at follow-up, consistent with the treatment focus in the study (Shawyer et al., 2017).

Mediation analyses within these treatment trials suggest that changing the targeted processes of psychological flexibility is what achieved the positive clinical effects of ACT for psychosis (ACTp). Changes in mindfulness mediated emotional adjustment to psychosis (White et al., 2011), and the reduced believability of hallucinations mediated the effect of ACT on hallucination-related distress (Gaudiano, Herbert, & Hayes, 2010). Using the combined data from the Bach and Hayes (2002) and Gaudiano and Herbert (2006) studies, Bach, Gaudiano, Hayes, and Herbert (2012) found that the decreased



believability in the literal content of psychotic symptoms postintervention significantly mediated the effect of ACT on rehospitalization rates. Clinicians consider believability a proxy for cognitive defusion, and it has mediated ACT outcomes in other populations too (Zettle, Rains, & Hayes, 2011). In addition to mediation studies, qualitative data from client interviews have revealed similar themes with regard to the active therapeutic processes of ACTp: mindfulness, defusion, acceptance, and values work (Bacon, Farhall, & Fossey, 2014).

## *Adaptations to the Practice of ACT with People with Psychosis*

In using ACT with people experiencing psychosis, it has been necessary to adapt interventions to suit the client group and service contexts. This section outlines some of these practical adaptations, drawn from our own experiences and those of others in the wider literature.

### THERAPEUTIC RELATIONSHIP

The therapeutic relationship is a key part of any form of psychological intervention for psychosis. It has been highlighted as being central to cognitive behavioral therapy for psychosis (CBTp; for example, Johns, Jolley, Keen, & Peters, 2014), and research has found the therapeutic alliance to be causal in determining whether or not clients benefited from CBTp (Goldsmith, Lewis, Dunn, & Bentall, 2015). Within ACTp, the therapeutic relationship is validating, normalizing, and collaborative. It creates a context that teaches the limits of literal language for problem solving and encourages the experiential learning of different ways of relating to private experiences while expanding values-based behaviors.

The social context of the relationship involves *radical acceptance*, an appreciation of the whole person. In addition to the therapist accepting the client, radical acceptance includes clients accepting themselves, including unwanted experiences, and other people. The therapist views clients as complete human beings, not broken or different, for whom psychosis is one part. The therapist-client connection, with the common experience of being human, is nicely illustrated by the “two mountains” metaphor (Hayes, Strosahl, & Wilson, 1999), which therapists can share with clients when introducing ACT to them:

It's like you're climbing your mountain over there and I am climbing my mountain over here. From where I am on my mountain I can see

things on your mountain that you can't see—I might be able to see an easier pathway, or that you're using your pickaxe incorrectly, or that there's an avalanche about to happen. But I wouldn't want you to think I'm sitting on the top of my mountain, no problems, no issues, just sitting back and enjoying life. I'm climbing my own mountain, over here. And we're all climbing our mountain till the day we die. But what we can learn to do is to climb more effectively, climb more efficiently, and learn how to enjoy the climbing. We can learn how to take a break and have a good rest and take in the view and appreciate how far we've come. We're both in the same boat, we're dealing with the human condition.

This metaphor highlights how we are in the same situation as those recovering from serious mental illness; we all face the challenge of living according to our values despite unwanted and entangling experiences. However, it is also important to acknowledge that people with psychosis often have a greater number of experiences (of greater intensity, too) to handle in their lives. We can end the metaphor with something like this: “I don't have to know anything about what it feels like to climb your mountain to see where you are about to step or to see what might be a better path for you to take.” Facilitator self-disclosure—the ways they struggle and the between-session commitments they will undertake—is an important component of our ACTp groups. Not only does this modeling engage group participants, it encourages the sense of universality and perspective-taking described above.

## OPEN PROCESSES

Acceptance and defusion work together to assist the broader skill of developing openness toward internal experiences. Clients are encouraged to embrace their thoughts and feelings without trying to resist, avoid, or suppress them. This form of acceptance is not a passive process of tolerance or resignation but a full willingness to have experiences (which can persist with psychosis despite treatment). The ACT emphasis on learning by addition (rather than replacement) is key for this client group, who often remain attached to coping strategies that are effective in modulating extremely distressing experiences in the short term. In the ACTp groups, it is useful to understand which strategies participants use in order to get things done in their lives, and to respectfully introduce the idea of willingness as an additional skill in the toolkit. Therapists encourage experiential learning, that clients “try willingness out” to see if the approach can result in more valued actions.

## AWARE PROCESSES

When using mindfulness with people with psychosis, some adaptations are necessary to take into account experiences related to unpleasant voices, images, or paranoid thoughts (Chadwick et al., 2005). As in MBSR protocols, we start with breath and body awareness, using the breath as a central focal point. However, the breath focus is difficult for some clients with high anxiety or dissociative experiences, so it can be helpful to use the soles of the feet as the focal point, which helps to ground the person in the room. In our mindfulness practices, we invite participants to cultivate an ongoing awareness of psychotic experiences and the associated thoughts and feelings. The practices carefully limit states of deep concentration, which have been linked to the onset of auditory hallucinations (Chadwick, 2006), and we use briefer and more “talky” mindfulness exercises than those used in MBSR and MBCT. None of the mindfulness exercises is longer than ten minutes, so as not to be overwhelming to participants experiencing distressing symptoms. We give frequent instructions, with pauses of no longer than ten seconds in the initial exercises, in case participants find silence difficult and become lost in responses to psychotic experiences. Pauses are extended slightly during exercises in the latter sessions. The mindfulness exercises are termed “noticing” exercises and include a range of practices, including mindful eating, stretching, and walking. We encourage home practice, supported by audio recordings of the exercises used in the workshops, but take an accepting stance to noncompletion.

As with any mindfulness exercise, the debrief inquiry about what participants notice is often the most challenging stage. This is particularly the case with this group of clients, who are very focused on developing methods to further control their experiences and can be quick to notice the immediate benefits of the exercises, such as relaxation. We aim to balance the need to reinforce the range of experiences that participants notice, both positive and negative, with any response that highlights ACT-consistent processes. We gently emphasize these processes to the rest of the group and also model them in our feedback.

## ACTIVE PROCESSES

Identifying and clarifying values in this client group, particularly for those individuals with established psychosis, can bring up themes of loss and missed opportunities. Some participants might be unclear of what they value, especially if they have personal histories of invalidation or trauma, or participants may have lost touch with their values through channeling their efforts to manage the psychosis. Although people’s experiences of the past impact the

group work, as well as the ways people can act more effectively in the present, ACTp focuses less on the past and more on the idea of constructing a meaningful life, starting from today. Connecting with values is seen as a work in progress and as a voyage of discovery, a trying out of new things. We sometimes describe it like fashion and trying on new clothes—unfamiliar and uncomfortable to begin with but getting more comfortable with time. In line with other authors, we also highlight compassion to self and others as a valued life direction (White, 2015).

Committed action is an integral part of the therapy. In ACTp workshops, we encourage clients to set values-based goals by identifying a small action in line with their values that they can complete between sessions. We emphasize that completion is not the only aim of the committed action; the ability to notice thoughts, emotions, and sensations that may show up along the way and, crucially, automatic and unhelpful responses to these, are also important processes. The process of “setting” homework was influenced by previous research on engaging people in behavioral activation: dividing into smaller groups, providing plenty of reinforcement for small steps, and understanding the balance between control and willingness that is needed to manage having intense experiences.

## THERAPEUTIC STYLE

As with CBTp, ACTp is matched to the client’s pace, and it has a gentle, conversational style. The use of scaffolding is important in our workshops; facilitators model and use examples, thus enabling clients to build up to applying the exercises themselves. Showing videos and case vignettes can also make it easier for participants to share their experiences, ways of coping, and values. Experiential and physicalizing exercises are used as much as possible to bring the therapy alive and to make the learning points more memorable. We act out our central metaphor, the “passengers on the bus,” so that participants can experiment in session with how to relate differently to distressing thought content.

## *ACT Groups for People with Psychosis (G-ACTp)*

There are a number of motives for developing ACT as a group-based intervention for people who experience psychosis (G-ACTp; for further discussion, see McArthur, Mitchell, & Johns, 2013). The explicit sharing of common

human experience and the underlying transdiagnostic model of ACT both suit group delivery (Hayes et al., 2011; Walser & Pistorello, 2004). In addition, particular aspects of the intervention lend themselves to a group format: many ACT metaphors are interactive and benefit from more people, observing others being present and willing can promote these processes in oneself, and making commitments in a social context is likely to strengthen action. For people with psychosis, group interventions can be particularly valuable, affording opportunities for normalizing psychotic experiences, gaining peer support, and facilitating perspective-taking skills, all of which augment specific therapeutic strategies (Abba, Chadwick, & Stevenson, 2008; Dannahy et al., 2011; Jacobsen, Morris, Johns, & Hodkinson, 2011; Ruddle, Mason, & Wykes, 2011). Our workshops aim to connect participants and facilitators around our shared humanity, help reduce stigma, and increase self-compassion. We also validate the courage participants show in expanding their lives despite the difficulties associated with psychosis, including fearing recurrence, wanting to appease voices, being concerned about the motives of other people, and coping with social stressors.

In terms of the therapist-client ratio and/or number of group sessions offered, group interventions can be a more efficient use of therapist time than individual work. Mental health staff from different professional groups can be trained via workshops to facilitate group-based interventions (Oliver, Venter, & Lloyd, 2014; Wykes et al., 2005). In addition, groups offer staff excellent opportunities for development through cofacilitation. Hence, brief group ACT (G-ACT) formats, which can be readily disseminated through staff training, offer the potential for cost-effective, wide-scale delivery.

## *Development of the ACT for Recovery Group Intervention and Manual*

Our G-ACTp intervention evolved from efforts to develop therapeutic groups that would engage clients with psychosis living in inner-city boroughs of South London. Considering the difficulties in accessing individual CBTp and the benefits of group approaches, G-ACTp offered promise by expanding the choice and availability of psychological therapies. The intervention seemed applicable and helpful for a diverse set of mental health service users from different cultural and socioeconomic backgrounds.

We developed our treatment manual for community and inpatient settings over several years, drawing on brief ACT interventions to reduce psychotic relapse and on mindfulness groups for people with psychosis. We piloted it in

early intervention and community psychosis teams and further adapted it for inpatient wards (described in chapter 3). Influenced by our local context, it seemed important to make the groups welcoming, fun, and lighthearted. However, there were many heartfelt moments when group members shared their courage in committing to values-based actions or connected with how challenging it can be to experience and recover from psychosis.

## ACT FOR LIFE STUDY

We formally evaluated our G-ACTp intervention in the ACT for Life study (reported by Johns et al., 2015). The first aim of this study was to determine the feasibility and acceptability of delivering the intervention, according to a standardized, manualized protocol, in routine community psychosis services in the United Kingdom. The second aim was to conduct a preliminary evaluation of clinical outcomes that could inform the future development of the intervention and randomized controlled evaluation. The ACT for Life study found that our four-week G-ACTp intervention was feasible for and acceptable to people with psychosis. Uncontrolled pre- and postassessments suggested that participants experienced small improvements in mood and functioning, as well as changes in their psychological flexibility processes consistent with the ACT model.

We were successful in our manualization of the intervention, and it was possible to deliver G-ACTp using a standardized protocol in a routine service setting. (You can download the *ACT for Life* manual at <http://drericmorris.com/wp-content/uploads/2014/10/ACT-for-Life-Groups-Manual-2012.pdf>, and further details of the study and the ACT for recovery group protocol are also described by Butler and colleagues, 2016.) We chose a brief group format (four two-hour sessions, held weekly), partly based on the research literature but also on our experience; we understood the challenges of running longer therapy groups and maintaining consistent attendance over a number of weeks. The group was closed, comprising four to eight participants, and facilitated by a lead therapist competent in ACT who was accompanied by one or two cofacilitators, mental health practitioners with experience working with people with psychosis. They had also attended a two-day ACT training designed for the study. The two-hour workshop sessions were structured to make the experience predictable each week, and every session had a similar format: a warm-up exercise, two noticing (mindfulness) exercises, a review of the committed action, a group discussion and activity (including role-playing and experiential exercises), time to plan a committed action for the coming week, and feedback.

We used experiential exercises as much as possible to highlight the processes by which participants can become caught up in struggling with their

symptoms and adopt ineffective ways of coping. Exercises were brief and learning points were carefully paced and structured to accommodate any cognitive difficulties. Drawing on participant feedback from our previous pilot work, we chose the “passengers on the bus” metaphor (Hayes et al., 1999) as the central, overarching theme for the workshop sessions. The sessions were all supplemented by PowerPoint slides, worksheets, audio recordings of the mindfulness exercises, and handouts summarizing group content. We paid particular attention to supporting practice between sessions. At the close of each session, participants described the committed actions they were going to undertake during the week, which we reviewed in the following session. We offered an optional midweek telephone reminder for this action. This “check in” phone call reinforced any noticing of internal experiences participants had while they tried to engage in committed actions, and it also served as a reminder of the psychological flexibility skills covered in session. Participants also received a follow-up phone call two weeks after the final session. To further generalize the use of the skills in daily life, we encouraged participants to link up with their clinical team for continued support, and we gave them information about local activities and organizations.

The decision to use the passengers on the bus as the central metaphor proved to be successful. This metaphor describes driving your “bus of life,” in which you, the bus driver, make choices about the direction your bus travels, moving toward or away from chosen values. On the bus are various passengers you have picked up on your journey of life, and they represent internal experiences (thoughts, feelings, memories, and sensations). The metaphor highlights the ways you interact with your passengers (for example, trying to get rid of them, agreeing with them, appeasing them, just noticing them) and how these interactions can limit or increase your movement in valued directions. All six ACT processes are represented within the metaphor, making it particularly beneficial, and it is applicable to all group members and facilitators.

In our G-ACTp protocol, we revisited the metaphor during each session and used it as a memory aid, which was helpful for participants who might otherwise struggle to recall the key elements. Initially we presented it as a story, and facilitators and participants later acted it out. We used a scripted video of a character describing challenges in his life, played by an actor, to illustrate the relevance and applicability of the metaphor. For participants experiencing auditory hallucinations, a potential issue that can arise is whether the hallucinated voice should act as a passenger. Given that most participants identified the voice as an external experience coming from an outside source, over which they had little control, we tended to encourage participants to label

their thoughts and beliefs about the voice as the passengers. However, for clients who understand that their voices are self-generated, it is also possible to label the voice-hearing experience as a passenger.

## ACT FOR RECOVERY STUDY

Based on the observations and outcomes of the ACT for Life study, the ACT for Recovery study developed the G-ACTp intervention further. For the evaluation study, we recruited clients with established psychosis, mainly due to service-development priorities and our clinical commitments. We also added G-ACT for caregivers as part of the intervention, which the generic exercise-based nature of our protocol allows us to do. We ran separate workshops for caregivers based on the same protocol (see chapter 2 for details). We feel it is important to consider the needs of caregivers, given that many service users maintain close contact with informal caregivers, and the caregiving role can have a negative and long-term impact on the mental and physical well-being of caregivers (Onwumere et al., 2015; Poon, Harvey, Mackinnon, & Joubert, 2016). It is well recognized that caring relationships are important for client recovery, and this fact has informed treatment recommendations for supporting caregivers themselves (for example, National Institute for Health and Care Excellence, 2014).

In ACT for recovery, we label the group sessions as “workshops” in the manual, both to emphasize the recovery-focus and skills-building aspects and to make the sessions relevant for caregivers, many of whom do not need to attend “therapy” groups. We also added an introductory “taster” session in which we introduce ACT principles and exercises; this allows people to opt in to the four-week course. This session helps reduce the chances of drop out after the first workshop session, which we observed in the ACT for Life study. Additionally, we run two weekly “booster” sessions, held eight weeks after the workshop program ends. These sessions do not introduce any new material; rather their aim is to provide a refresher of skills practiced in the sessions, and the opportunity for participants to reflect on any progress or difficulties encountered after the workshops have ended.

The sessions themselves retain the same structure and content, with minor adaptations to some of the exercises to improve participant understanding of the principles. We recorded videos specific for the workshops, one of an actor role-playing a client with psychosis (Paul), and one of an actor role-playing the client’s caregiver (his father, George). We created an animation of the “passengers on the bus” metaphor, which provides a visual representation. As before, the workshops are facilitated by a lead therapist competent in ACT,



accompanied by one or two cofacilitators who are either mental health practitioners or, novel to this intervention, service-user peer supporters. In updating the protocol, we thought that having experts by experience, those who have experienced mental health difficulties firsthand, would help to engage participants and add a dimension of validity in our efforts to link ACT processes to the journey of personal recovery within and beyond mental health services. In chapter 4 we describe this involvement of workshop cofacilitators with lived experience of mental health problems.

A pilot study, in which service users and caregivers either received G-ACTp immediately or after a twelve-week waiting period, evaluated the effectiveness of this intervention in improving well-being (Jolley et al., in press). Preliminary findings suggest that G-ACTp improves self-reported overall well-being, with no difference in outcomes immediately after the intervention, at twelve weeks, or between service users and caregivers.

## Summary

Psychosis is a severe mental illness associated with reduced quality of life for both sufferers and family members. Cognitive behavioral therapy is recommended for people with psychosis, but access remains limited in front-line services. Group-based cognitive behavioral interventions, including ACT, have the potential to improve both the access and dissemination of therapy. ACT is a contextual cognitive behavioral intervention that lends itself to brief group therapy and to the diverse presentations of psychosis. This therapeutic approach emphasizes clients' relationship with their symptoms, helping them develop a perspective of mindful acceptance toward them, and encourages values-based living. The evidence base for ACT is growing across a range of physical and mental health problems, including psychosis. The key ACT processes work together to improve a person's psychological flexibility, and this approach can be particularly useful for people experiencing psychosis due to the qualities of psychotic symptoms and associated cognitive biases. ACT fosters mindful acceptance skills that can be applied as the psychotic experiences occur, and it helps the client focus less on symptoms and more on engaging in valued actions.

Our team has developed and adapted our approach to G-ACTp to suit the client group, and we have evaluated the groups in a range of community and inpatient settings. We wish to share our experience and learning in this area, so that you can run engaging and effective groups in your service context.