Edited by
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ACCEPTANCE and COMMITMENT THERAPY and MINDFULNESS for PSYCHOSIS

WILEY Blackwell

Acceptance and Commitment Therapy and Mindfulness for Psychosis

Louise: To Mum and Dad, for your love and endless support, and to my boys – le gioie della mia vita

Joe: To my parents, José and Dennis, for all the love and support you've given me

Eric: To Liz, Matilda & Miles – every day I am grateful for your love and faith in me

Acceptance and Commitment Therapy and Mindfulness for Psychosis

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Eric M. J. Morris is a chartered consultant clinical psychologist and the psychology lead for early intervention for psychosis, at the South London and Maudsley NHS Foundation Trust, UK.

Eric Morris completed training as a clinical psychologist in 1995 at Murdoch University, Western Australia, specialising in psychological interventions for psychosis. On qualifying he worked in a pioneering service for early intervention for psychosis in Perth, Western Australia, before moving to the UK in 1999 to work for the National Health Service in Hampshire and South London. Eric has been a practising Acceptance and Commitment Therapy (ACT) for more than ten years, and is a highly experienced trainer and supervisor of therapists using contextual cognitive behavioural therapies. Eric is completing a PhD at the Institute of Psychiatry, King's College London, researching psychological flexibility and auditory hallucinations, as well as the investigation of ACT as a workplace intervention. He is a founding member and former chair for the Acceptance and Commitment Therapy Special Interest Group of the British Association for Behavioural and Cognitive Psychotherapies.

Eric is a co-director of Contextual Consulting, an independent consultancy specialising in providing training in contextual cognitive behavioural therapies.

Louise C. Johns is a chartered consultant clinical psychologist with the Psychological Interventions Clinic for Oupatients with Psychosis (PICuP), South London and Maudsley NHS Foundation Trust, UK. PICuP provides bespoke training and supervision in cognitive behaviour therapy (CBT) and family intervention for psychosis, as well as a specialist clinical service. Louise is also an honorary lecturer at the Institute of Psychiatry, King's College London, UK, and a tutor and supervisor on the Postgraduate Diploma in CBT for Psychosis, King's College London.

Louise received a BA (Hons) in natural sciences, specialising in psychology, at Cambridge University in 1991, and went on to complete a Doctor of Philosophy

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Since qualifying as a clinical psychologist, Louise has worked continuously in a clinical and research capacity in the field of psychosis. She has extensive experience of delivering therapy and of training and supervising staff across all stages of presentation of psychosis. She has published over 50 articles on psychosis, covering development and psychopathology of symptoms as well as cognitive behavioural treatments. She has led on the first UK funded studies to evaluate ACT for psychosis in group settings.

Joseph E. Oliver is a clinical psychologist working in the Lambeth Early Onset (LEO) Psychosis Service, South London & Maudsley NHS Foundation Trust. He is also co-director of Contextual Consulting, an ACT-based consultancy that offers contextual-CBT training, supervision and psychological therapy.

Joseph graduated from Victoria University, Wellington, New Zealand, receiving a BA (Hons) before going on to complete his postgraduate diploma in clinical psychology and PhD in 2003. His PhD research investigated the psychological processes of stress and wellbeing within the workplace. Alongside his clinical work, specialising in the area of psychosis, Joseph carries out research at the Institute of Psychiatry, King's College London, being involved in a number of trials investigating the use of ACT with people with psychosis and within the workplace. He has published numerous scientific articles and book chapters in the clinical application of ACT and is currently leading on an RCT comparing ACT and mindfulness-based stress reduction interventions for workplace wellbeing.

Joseph is also current chair of the British Association of Behavioural and Cognitive Psychotherapies (BABCP) ACT Special Interest Group, which promotes and develops ACT within the UK, by offering professional development opportunities, grants and training workshops. In addition, he regularly provides ACT and contextual-CBT training, both nationally and internationally.

Joseph is particularly interested in service user involvement as a method to both promote recovery and improve services. He chairs a group of service user consultants and psychologists who aim to promote and increase effective, recovery based service user involvement. Finally, Joseph has an interest in disseminating ACT ideas and concepts to other professionals and to the general public. In addition to organising ACT events for the wider public, Joseph has also been developing ACT-based animations as teaching tools for training and within therapy. He has produced a number of animations that illustrate key ACT metaphors and has developed a free YouTube channel to promote these.

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We would also like to acknowledge our colleagues, mentors and friends in the area of Cognitive Behaviour Therapy (CBT) for psychosis. We are extremely fortunate to have worked closely with so many experts and pioneers in this field, both in the UK and overseas. In addition to authors in this volume, we have been particularly influenced over the years by Elizabeth Kuipers, Philippa Garety, Til Wykes, Emmanuelle Peters, Suzanne Jolley, Juliana Onwumere, Lucia Valmaggia, Richard Bentall, Gillian Haddock and Tony Morrison. We have learned a great deal from working with these psychologists, which has shaped our understanding of psychosis, our research interests and clinical practice.

It is important for us to acknowledge other colleagues and mentors in the South London and Maudsley NHS Foundation Trust and at the Institute of Psychiatry, King's College London, who have supported us and our work over the years. There are too many to list them all here, but we would particularly like to mention Adrian Webster, Emmanuelle Peters and Suzanne Jolley, who have supervised and managed our work with sound judgement and with compassion when we have erred.

We acknowledge our co-authors for their excellent contributions to this volume and for meeting all the deadlines in a timely fashion, which made our role as editors much easier. We also acknowledge the publisher Wiley-Blackwell for their original interest and for assistance and patience along the way.

Lastly, we would like to acknowledge our respective friends and families for their on-going love and support, which has enabled us to pursue our common value of making a positive difference to the lives of people with psychosis.

Foreword: Acceptance, Mindfulness and Psychotic Disorders
Creating a New Place to Begin

An editorial in the *British Journal of Psychiatry* (Morrison *et al.*, 2012) asks in its title, 'Anti-psychotics: Is it Time to Introduce Patient Choice?' The article is powerful, well-argued and disturbing all at the same time, but it was the title that stopped me cold in my tracks. In any other area of health or service delivery, such a title would completely dumbfound the reader. In any other area of health or service delivery, anyone reading such a thing would force out a mumbled 'Don't we have that now?!' Could we imagine a title in a major journal that read, 'Back Surgeries: Is it Time to Introduce Patient Choice?' or 'Prolonged Exposure: Is it Time to Introduce Patient Choice?'

Those experiencing psychotic disorders are amongst the most stigmatised people on the planet. They are frequently objectified and dehumanised by society. Their unusual experiences and actions are often objects of ridicule or fear. Steps are regularly taken to remove them from society, and their liberties are constantly at risk in ways large and small.

That is a terrible state of affairs, but it is not the worst of it. The cruellest blow is that the treatment delivery system itself often objectifies them as well. This happens in multiple ways. People experiencing psychotic disorders are told cartoon stories about genetics, the brain or neurotransmitters as the certain sources of their difficulties, when the true state of knowledge is far more ambiguous. Horizons and expectations are lowered excessively, and patients are no longer treated as whole human beings. The benefits of medication are overstated and the likelihood of long-term side effects and neurobiological opponent processes from these medications are understated. But the biggest betrayal of all is that patients are offered such a limited range of treatment options.

Fortunately, development of psychosocial interventions has continued. Researchers and clinicians have continued to seek out and find new ways to be helpful. Where there were few options, they have created more choice.

You hold in your hands one of the results. This is the first volume to summarise the literature on modern acceptance and mindfulness based-approaches to psychosis, particularly acceptance and commitment therapy (ACT) and related methods such as person-centred cognitive therapy (PBCT) and emotional processing and metacognitive awareness (EPMA). These new methods are breaking ground, challenging long-held assumptions and offering real choices.

A practitioner or clinical researcher drawn to this area of work needs to know that it is young. While there are now several successful randomised trials, these are not turnkey approaches. The purpose of a volume like this is not to provide final answers – it is to open new avenues to explore. A dedicated student or professional reading these pages can be part of creating a path forward. The field is new enough that innovations occur on a regular basis. Treatment development is rapid and ongoing.

Everything a practitioner or a clinical researcher needs to begin to explore this area clinically and empirically is here: rationale, data, assessment tools, protocols and expert guidance. The adjustments needed for specific subpopulations and problem areas (dealing with delusions, auditory hallucinations, the emotional upheaval following psychotic breaks, managing first episodes, acute episodes and so on) are described in detail. Different formats and specific approaches are laid out. The book properly gives voice to end users themselves. The editors have carefully chosen a group of well-prepared chapter authors – this truly is a state-of-the-art volume. There is nothing else like it in the world's scientific and practical literature.

I am writing this foreword with a sense of humbled excitement. It is humbling how much we have to learn and how far we have to go. There are many implications of work in acceptance, mindfulness and values which are yet to be tested, and we don't know how they will work out. The social need for progress is enormous and growing, and we don't know if we can meet this challenge. Even as we develop real treatment alternatives, we are aware that the systems of care are often difficult to change, and at times it may be hard to insert real choice into the current system.

The excitement comes because we have begun in earnest. It now seems undeniable that there is conceptual and clinical progress being made by those interested in ACT, and acceptance and mindfulness methods generally, in understanding and treating these debilitating conditions. We have a long way to go but there is something important in this work. Researchers and clinicians need to tease it out, by studying the processes that give rise to these problems and the processes of change that acceptance and mindfulness methods engage. They need to continue to develop new procedures that foster positive change in these processes, and learn how to integrate them with other methods of known

value. We need a new model of psychotic symptoms and a new approach to intervention. No one is speaking of a panacea, but these pages show the field that there is now another place to begin.

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Get Out of Your Mind and Into Your Life

Reference

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1

Introduction to Mindfulness and Acceptance-based Therapies for Psychosis

Joseph E. Oliver, Candice Joseph, Majella Byrne, Louise C. Johns and Eric M. J. Morris

1.1 Introduction to Psychosis

'Psychosis' is an umbrella term covering a range of associated symptoms, including perceptual, cognitive, emotional and behavioural disturbances. The term tends to refer to 'positive' symptoms of unusual beliefs (delusions), anomalous perceptual experiences (illusions and hallucinations) and disturbances of thought and language (formal thought disorder) (described in Peters *et al.*, 2007). These are invariably accompanied by emotional difficulties such as anxiety and depression (Birchwood, 2003; Freeman & Garety, 2003; Johnstone *et al.*, 1991). In addition, a significant proportion of people diagnosed with a psychotic disorder, particularly schizophrenia, are likely to experience 'negative' symptoms such as avolition and anhedonia (described in Kuipers *et al.*, 2006). The median incidence of psychotic disorders is estimated at 15.2 per 100 000, with estimates ranging between 7.7 and 43.0 per 100 000 (McGrath *et al.*, 2004), indicating a high degree of variability in incidence across geographic regions. The reported lifetime risk remains at approximately 1% (Saha *et al.*, 2005).

One of the diagnostic peculiarities of psychosis is that two individuals can receive the same diagnosis but have completely different sets of symptoms that have no overlap or commonality. This perhaps points to some of the complexities of the disorder, which the current accumulated evidence suggests is likely a manifold interaction between a range of genetic, biological, psychological and social factors, with probable multiple aetiological pathways (Oliver & Fearon, 2008).

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Furthermore, psychotic symptoms are not exclusively reported by those with a diagnosis of psychotic disorder (such as schizophrenia, schizoaffective disorder or delusional disorder), but also occur in varying degrees in other mental-health problems, including bipolar affective disorder, mood disorders and personality disorders (particularly borderline personality disorder (BPD)). Additionally, some authors have vigorously criticised the schizophrenia diagnosis, arguing that the associated breadth and diversity of clinical phenomenology actually represents a lack of construct validity and reliability (Bentall, 2003; Boyle, 2002).

The mere presence of psychotic symptoms, no matter how apparently bizarre they may be, is not sufficient to warrant a diagnosis. Key to a psychotic disorder is recognition that the symptoms must co-occur with significant interruption to the individual's life. Schizophrenia is associated with significant long-term disability (Thornicroft *et al.*, 2004; World Health Organization, 2001) and, in addition to positive and negative psychotic symptoms, depressive symptoms are also strong predictors of poor quality of life in this client group (Saarni *et al.*, 2010). For those who continue to live with distressing psychotic symptoms and emotional disturbance, advances in treatments for psychosis are of paramount importance.

Alongside the devastation that psychosis can cause to the lives of individuals and their families, there are also significant economic costs. Estimates suggest that in 2002 the direct (e.g. service charges) and indirect (e.g. unemployment) costs associated with psychotic disorders were approximately $62.7 billion in the United States (Wu *et al.*, 2005). Similar estimates within the United Kingdom have indicated costs of approximately £4 billion (McCrone *et al.* 2008).

1.2 Interventions

The first line of treatment for psychosis is almost always antipsychotic medication. However, there are limitations to pharmacological treatments, including issues of compliance, intolerable side effects and poor symptomatic response to antipsychotic medication (Curson *et al.*, 1988; Kane, 1996; Lieberman *et al.*, 2005). These findings, in conjunction with the recognition of the importance of social and psychological factors in psychosis (Bebbington & Kuipers, 1994; Garety *et al.*, 2001; van Os, 2004), have contributed to the development of psychological interventions for people with psychosis. Such interventions include family therapy, cognitive behavioural therapy (CBT) and social and cognitive rehabilitation. They are not proposed as alternatives to medication, but are used as adjunctive therapies.

1.2.1 Cognitive Behavioural Therapy

The main assumption underlying CBT is that psychological difficulties are maintained by vicious cycles involving thoughts, feelings and behaviours (Beck *et al.*, 1979). Therapy aims to break these cycles by helping people to learn more adaptive ways

of thinking and coping, which leads to a reduction in distress. In the 1980s and 1990s, research on psychotic symptoms led to treatments that adapted the successful use of CBT for anxiety and depression to the more complex problems of psychosis (Fowler *et al.*, 1995; Kingdon & Turkington, 1991). Cognitive models of psychotic symptoms (e.g. Garety *et al.*, 2001; Morrison, 2001) have informed the development of therapeutic approaches, highlighting that it is not the unusual experiences themselves that are problematic, but the appraisal of them as external and personally significant. CBT for psychosis (CBTp) aims to increase understanding of psychosis and its symptoms, reduce distress and disability arising from psychotic symptoms, promote coping and self-regulation and reduce hopelessness and counter-negative appraisals (of self and illness) (see Johns *et al.*, 2007 for an overview).

Evidence from randomised controlled trials (RCTs) has shown that CBT delivered on a one-to-one basis is efficacious for individuals with psychosis, particularly those with persistent positive symptoms (Smith *et al.*, 2010; Wykes *et al.*, 2008; Zimmerman *et al.*, 2005). A meta-analysis of 33 studies by Wykes *et al.* (2008) revealed a modest overall effect size of 0.40 for target symptoms and effect sizes ranging between 0.35 and 0.44 for positive symptoms, negative symptoms, functioning, mood and social anxiety. A recent study identified CBTp as being most effective when the full range of therapy procedures, including specific cognitive and behavioural techniques, are implemented (Dunn *et al.*, 2011). While CBTp offers symptom improvement in some areas for a number of people, it is not a panacea.

1.2.2 Developments in CBT: Contextual Approaches

Additional developments in the field of behavioural and cognitive therapy approaches have led to the evolution of a cluster of therapies termed 'contextual CBTs' (Hayes *et al.*, 2011). This evolution has been in response to several anomalies present within the CBT model, including debate about whether cognitive change/restructuring is actually the necessary component of therapy (Hayes, 2004; Longmore & Worrell, 2007). While not ignoring the importance of cognition, contextual approaches emphasise the historical and situational context an organism is situated within as a means for focusing upon central processes to be targeted to effect behavioural change. Critically, contextual approaches deemphasise the importance of changing the content and frequency of cognition, moving instead towards the use of acceptance and mindfulness procedures to alter the context in which these experiences occur, thereby increasing behavioural flexibility.

A number of approaches fall under the umbrella of contextual CBT, including dialectical behaviour therapy (DBT) (Linehan, 1987), functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1991), mindfulness-based cognitive therapy (MBCT) (Teasdale *et al.*, 1995), integrative behavioural couples therapy (IBCT) (Jacobson & Christensen, 1996), Acceptance and Commitment Therapy (ACT) (Hayes *et al.*, 1999), metacognitive therapy (MCT) (Wells, 2000) and person-based cognitive therapy

(PBCT) for psychosis (Chadwick, 2006). These therapies include components such as mindfulness, experience with the present moment, acceptance, values and greater emphasis on the therapeutic relationship. While they may incorporate more traditional behavioural and cognitive techniques, they tend to be more experiential in nature and involve second-order strategies of change as well as first-order ones. Within these therapies, ACT, PBCT and mindfulness groups have mostly been implemented in the psychological treatment of psychosis.

1.2.3 Acceptance and Commitment Therapy

ACT is a modern behavioural approach that incorporates acceptance and mindfulness to help people disentangle from difficult thoughts and feelings in order to facilitate engagement in behavioural patterns that are guided by personal values. It has firm roots in behavioural traditions and is underpinned by a behavioural analytic account of language: relational frame theory (RFT) (Blackledge *et al.*, 2009). Broadly, the ACT stance focuses on changing one's relationship to internal experiences (thoughts, feelings) rather than altering the form or frequency of these experiences (Hayes *et al.*, 1999). The approach is transdiagnostic and uses the same theoretical model to formulate and target common processes underlying a wide range of symptomatically diverse problems (such as depression, BPD and diabetes).

ACT's six core theoretical processes are set out visually in a hexagonal shape (known colloquially as the 'hexaflex'; see Figure 1.1) and move in synchrony towards increasing psychological flexibility or 'the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends' (Hayes *et al.*, 2006, p. 7). These processes are highly interrelated and, although represented as distinct entities in the model, share considerable overlap. More recently, the processes have been clustered into

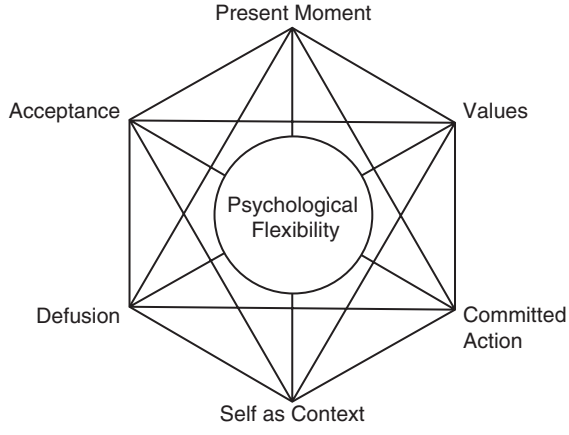

Figure 1.1 The ACT model of psychological flexibility

Table 1.1 Central ACT processes (adapted from Luoma *et al.*, 2007)

Process	*Definition*
Open	
Acceptance	The active and aware embrace of private events that are occasioned by our history, without unnecessary attempts to change their frequency or form, especially when doing so would cause psychological harm.
Defusion	The process of creating nonliteral contexts in which language can be seen as an active, ongoing relational process that is historical in nature and present in the current context.
Aware	
Self as Context	A continuous and secure 'I' from which events are experienced, but which is also distinct from those events.
Present Moment	Ongoing, nonjudgmental contact with psychological and environmental events as they occur.
Active	
Values	Verbally constructed, global, desired and chosen life directions.
Committed Action	Step-by-step process of acting to create a whole life, a life of integrity, true to one's deepest wishes and longings.

three broader sets of response styles: open, aware and active (Hayes *et al.*, 2011) (see Table 1.1).

1.2.3.1 Open

The processes of acceptance and defusion work synergistically to build the broader skill of developing openness towards internal content that occurs 'under the skin' (thoughts, emotions, memories, perceptions). Psychotic symptoms, by their nature, have a number of qualities that tend to increase the likelihood that people will respond to them with suppression or avoidance. Symptoms, such as voices, are often highly distressing, critical and personally salient (Close & Garety, 1998; Nayani & David, 1994). Experiences associated with delusional ideation have been shown to be highly linked with appraisals of shame, humiliation and entrapment (Birchwood *et al.*, 2000) and therefore much more likely to lead to experiential avoidance. Research bears this out, demonstrating that people with distressing psychosis tend to utilise more suppression and avoidance and less acceptance strategies (Morrison *et al.*, 1995; Perry *et al.*, 2011). Conversely, psychotic experiences can be extremely 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, these experiences may be used as a method to escape a dreary, mundane existence, but this may come at high personal cost in the long term.

Acceptance is the process by which clients are encouraged to embrace their thoughts and feelings without trying to resist, avoid or suppress them via

'experiential avoidance'. This is not merely a process of tolerance or resignation, but a full willingness to step towards and make space for psychological phenomena, including psychotic symptoms, without engaging in unworkable struggle against them.

Alongside the process of acceptance, building of defusion further supports an open stance towards internal experience. Defusion aims to help clients step back from internal experiences such as thoughts, memories or appraisals of external experiences (voices or other anomalous experiences) and see them for what they are, rather than what they say they are, thereby reducing unhelpful literal, rule-based responding to internal events. From an ACT perspective, fusion increases the likelihood of a narrowing of an individual's behavioural repertoire in the face of such experiences, thereby limiting opportunities for values-based actions. Defusion works to expand and add to that repertoire by undermining adherence to thoughts and verbal rules that promote restriction, narrowing or avoidance. For example, an ACT therapist might usefully work on defusion related to a thought such as 'I can't tolerate this paranoia' that occurs in the context of high anxiety and avoidance of valued activities such as connecting with friends. An intervention might focus on assisting the client to first notice this as a thought and then develop a more defused stance towards it, so that subsequent actions are guided more by values (actively connecting with friends) rather than fusion ('I must avoid situations that lead to paranoia'). This is contrasted with more traditional cognitive approaches, in which interventions target the veracity of thoughts or appraisals and, where distorted, adjust or correct them.

1.2.3.2 Aware

The self as context is the perspective from which all internal experiences are observed and in which they are held. By promoting an awareness of this particular perspective, detachment to distressing thoughts, images, beliefs or hallucinations that may arise is cultivated through a mindful contact with the present moment. The idea that language gives humans a sense of 'self' and perspective explains the inclusion of spirituality in human existence, because the 'mind' has no boundaries (Hayes, 1984). Mindfulness can help individuals learn to notice, but not judge, passing thoughts, feelings or images, in order to develop a more centred stance towards internal experiences, so as to support engagement with core values.

1.2.3.3 Active

The heart of ACT work is in assisting clients to become more engaged with and active in their lives, through a process of identifying and constructing sets of values and using them to inform the development of goals and specific action plans. Goals are set in ways that increase the likelihood they will be met, for example by setting initial small, measureable, meaningful tasks, which are increasingly built into larger and larger patterns of committed action. To use a sailing metaphor, the verbal construction and articulation of values is comparable to the setting of sails,