Edited by
Eric M. J. Morris
Louise C. Johns
Joseph E. Oliver

# ACCEPTANCE and COMMITMENT THERAPY and MINDFULNESS for PSYCHOSIS

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*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, Louise C. Johns
and Joseph E. Oliver

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*Editorial Offices*
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The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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# About the Editors

**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 (DPhil) at the University of Oxford. Her Doctorate in Clinical Psychology (DClinPsy) was completed in 1998 at the Institute of Psychiatry, London. She has a Postgraduate Certificate in Academic Practice from King's College London, and is an accredited cognitive behavioural therapist with the British Association of Behavioural and Cognitive Psychotherapies (BABCP).

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.

# List of Contributors

**Patty Bach**, PhD
Psychology Clinic Director, Clinical Assistant Professor, Department of Psychology, University of Central Florida, Orlando, FL, USA

**Andrew M. Busch**, PhD
Assistant Professor, Department of Psychiatry & Human Behavior, Warren Alpert Medical School of Brown University and Centers for Behavioral and Preventive Medicine, The Miriam Hospital, Providence, RI, USA

**Majella Byrne**, BA (Hons), MA, MSc, PhD, DClinPsy
Clinical Psychologist, Department of Psychosis Studies, King's College London and Outreach and Support in South London (OASIS), South London and Maudsley NHS Foundation Trust, Lonon, UK

**Isabel Clarke**, MA Cantab, BA (OU), CClinPsychol
Consultant Clinical Psychologist, Intensive Support Programme Lead, Southern Health NHS Foundation Trust, Hampshire, UK

**Lyn Ellett**, PhD, DClinPsy
Lecturer in Clinical Psychology, Royal Holloway, University of London, London, UK

**John Farhall**, BA(Hons), MA(Clin Psychol), PhD
Senior Lecturer, School of Psychological Science, La Trobe University, and Consultant Clinical Psychologist, North Western Mental Health, Melbourne Health, Melbourne, Australia

**Daniel Freeman**, PhD, DClinPsy, FBPsS
Professor of Clinical Psychology and UK Medical Research Council (MRC) Senior Clinical Fellow, Department of Psychiatry, Oxford University, and Oxford Health NHS Foundation Trust; Fellow of University College, Oxford, UK

**José Manuel García Montes**, PhD
Professor of Theories and Processes of Personality, Departamento de Psicología, University of Almería, Almería, Spain

**Brandon A. Gaudiano**, PhD
Assistant Professor, Department of Psychiatry & Human Behavior, Warren Alpert Medical School of Brown University, and Psychosocial Research Program, Butler Hospital, Providence, RI, USA

**Mark Hayward**, BA (Hons), DClinPsy, PhD
Director of Research, Sussex Partnership NHS Foundation Trust, and Visiting Senior Lecturer, Department of Psychology, University of Sussex, Brighton, UK

**Claire Hepworth**, PhD, DClinPsy
Clinical Psychologist, South London and Maudsley NHS Foundation Trust, London, UK

**Louise C. Johns**, MA, DPhil, DClinPsy
Consultant Clinical Psychologist, Psychological Interventions Clinic for Outpatients with Psychosis (PICuP), South London and Maudsley NHS Foundation Trust, London, UK; Honorary Lecturer, Department of Psychology, Institute of Psychiatry, King’s College London, London, UK

**Candice Joseph**, BSc, MSc
Trainee Clinical Psychologist, School of Psychology, University of East London, UK

**Amy McArthur**, BA (Hons), DClinPsychol
Clinical Psychologist, NHS Fife, Department of Psychology, Lynebank Hospital, Fife, UK

**Helena B. McGuinness**, BA, MA
Design Lecturer and Service User, UK

**Gordon Mitchell**, BSc, MSc
Consultant Clinical Psychologist, Psychological Interventions for Psychosis Service (PIPs) NHS Fife, Department of Clinical Psychology, Stratheden Hospital, Cupar, Fife, UK

**Eric M. J. Morris**, BAppSc, GradDipAppSc, MAppPsych (Clinical), CPsychol, AFBPsS
Psychology Lead for Early Intervention, Psychosis Clinical Academic Group, South London and Maudsley NHS Foundation Trust, London, UK

**Joseph E. Oliver**, BA (Hons), PGDipClinPsyc, PhD
Clinical Psychologist, Early Intervention Service, South London and Maudsley NHS Foundation Trust, London, and Clinical Tutor, Department of Psychology, Institute of Psychiatry, King's College London, London, UK

**Marino Pérez Álvarez**, PhD
Professor of Clinical Psychology, Facultad de Psicología, University of Oviedo, Oviedo, Spain

**Salvador Perona Garcelán**, Psychologist Specialist in Clinical Psychology
Clinical Psychologist, Virgen del Rocío University Hospital in Seville, and Associate Professor, Department of Personality, Evaluation and Psychological Treatment, University of Seville School of Psychology, Seville, Spain

**Fran Shawyer**, BSc (Hons), PhD
Research Fellow, School of Psychology and Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Australia

**Helen Startup**, DPhil, DClinPsy
Principal Clinical Psychologist, South London and Maudsley NHS Foundation Trust, London, and Department of Psychiatry, Oxford University, Oxford, UK

**Clara Strauss** BA (Hons), DPhil, DClinPsych, PGDip (Cognitive Therapy)
Clinical Psychologist & Research Lead, Sussex Mindfulness Centre, Sussex Partnership NHS Foundation Trust and Acting Research Director, Clinical Psychology Training Programme, University of Surrey, Surrey, UK

**Neil Thomas**, BSc (Hons), DClinPsy, CPsychol, MAPS, AFBPsS
Senior Clinician, Monash Alfred Psychiatry Research Centre, The Alfred, and Brain and Psychological Sciences Research Centre, Swinburne University, Melbourne, Australia

**Ross White**, BSc, DClinPsy, PhD
University Teacher, Institute of Health and Well-being, University of Glasgow, and Honorary Principal Clinical Psychologist, NHS Greater Glasgow and Clyde, UK

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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.

Steven C. Hayes
University of Nevada
Co-developer of ACT and author of
*Get Out of Your Mind and Into Your Life*

## Reference

Morrison, A., Hutton, P., Shiers, D. & Turkington, D. (2012). Antipsychotics: is it time to introduce patient choice? *British Journal of Psychiatry*, 201, 83–84.

# 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). 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