

ACT for people with psychosis

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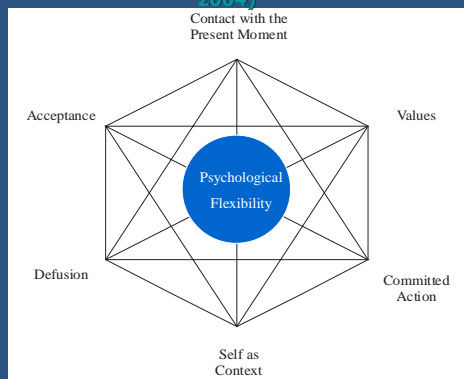
Plan for this afternoon

- Introduce Acceptance & Commitment Therapy
- Why use ACT and mindfulness with psychosis?
- Case Formulation
- Individual and Group Interventions for psychosis
- Experiencing ACT techniques

The ACT stance

- Focusing on ***symptom impact***
- Emphasising acceptance rather than disputation
- Pragmatic truth criterion: focused on moving things forward, rather than finding the cause of psychotic symptoms
- Targets symptoms *indirectly* by altering the context within which they are experienced rather than frequency and believability per se

The Primary ACT Model of Treatment (Hayes et al., 2004)



- In ACT, behaviour is linked to articulated personal values and goals rather than to symptoms.
- Values clarification as providing the rationale for behaviour change (willingness to persist through difficult experiences).
- Towards greater variability, flexibility and increased meaning in life, but with emphasis on process rather than outcome.
- Contrast with mainstream goals of symptom reduction (built in to evaluations of Rx.)

BASIC ASSUMPTIONS

- BASIC SCIENCE UNDERPINNING in RELATIONAL FRAME THEORY (RFT)
- Language is based on arbitrary learned relations that are controlled within relational frames (“rule governed behaviours, bi-directional relations, transformation of functions.”)
- Provides an evolutionary advantage, but also expands the ability to feel, predict, categorize & evaluate; makes behavioural avoidance possible and cognitive dominance likely (“stimulus equivalence and equivalence class.”)

BASIC ASSUMPTIONS cont

- As a result of the abilities conferred by language humans are able to suffer both as a result of direct experience and crucially also of remembered, predicted or imagined experience.

The ACT Model of Human Suffering and Psychopathology

- Human pain (physical and psychological) is ubiquitous, normal and self restorative
- Unwillingness to have pain leads to reliance on avoidance and control based strategies
- Excessive use of control & avoidance leads to a loss of contact with committed actions & vital purposeful living
- It is not physical/mental pain per se that is the “enemy” but our attempts to avoid or control it lead to disorder and suffering
- This cycle of suffering is strongly supported in the culture through language acquisition and socialization

CBT for Psychosis: Acceptance

Therapist behaviour: creating context for change

- Displaying willingness and acceptance
- Reinforcing discussion of experiences (exposure?)
- Allowing defusion through distancing (reformulation, floating alternatives, cognitive model)
- Avoiding trap of being overly literal about beliefs (ie, not colluding but also not demanding belief change)
- Encouraging behaviour change even if psychotic symptoms persist (values/ behavioural regulation)

Part of the rationale: what people do with unusual experiences

How sticky is cognition in psychosis?

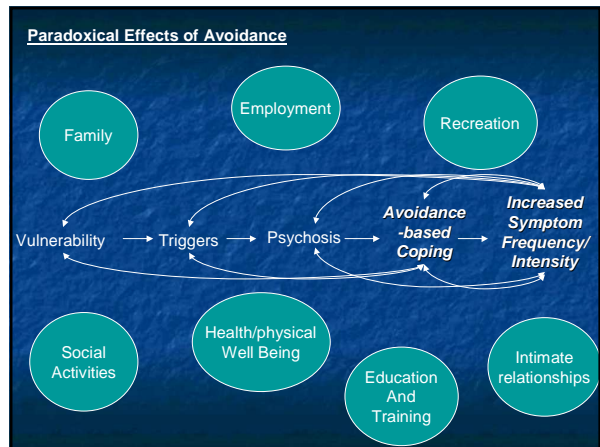
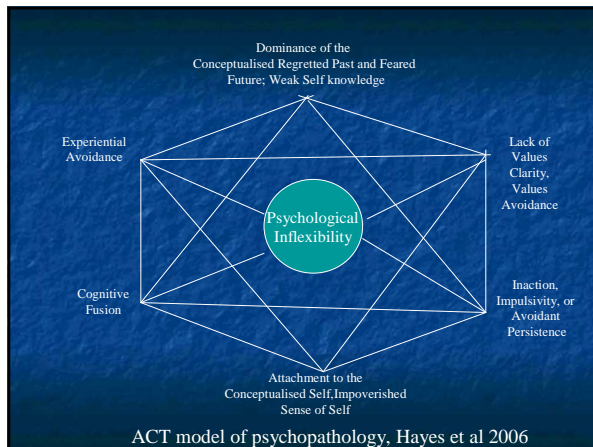
- people with schizophrenia tend to talk more about issues related to disordered thinking, and make more frequent references to their own cognition, as compared to normal controls (Rosenburg & Tucker, 1979)
- Thought suppression and deliberate ignoring are common coping methods (Shergill, Murray & McGuire, 1998).
- Metacognitive beliefs present in those with ARMS and established psychotic disorders (Morrison, French & Wells, 2007)

An ACT view of psychotic symptoms

- Exploring the effects of cognitive fusion and experiential avoidance with delusions and hallucinations
- The experience, or the feared outcomes of it, as targets for avoidance = increasing impact
- Negative symptoms – a possible outcome of chronic avoidance? (limited social reinforcement)
- The context of literality

ACT is helpful for therapists

- The level playing field
- Therapist **behaviour**: creating context for change
- Noticing your own private events
- Noticing the context of literality and avoidance when discussing “odd” content
- Not treating people as broken or incomplete
- Mindfulness, choice and commitment



Model Holds That Ordinary Psychological Processes (Psychology of Self) may Amplify The Core Difficulty and/or Exacerbate Unusual Conditions (such as Psychosis)

Exercise: Taking Your Mind for a Walk

ACT Model & Case Conceptualisation

General Approach

- A functional approach to the problems/ symptoms
- Consider CONTEXT =
learning history + current events + verbal context
How do these interact?
- Pragmatic truth criterion: successful working
- What private experiences is the client attempting to avoid?
- What avoidance behaviours are being used and how pervasive are they?

ACT Made Even Easier

1. Explore unworkable coping strategies (struggle, avoidance)
2. Suggest acceptance (and other underused coping strategies) as an alternative stance
3. Place acceptance in the context of a valued life domain
4. Identify a valued goal and formulate specific action plan (however small to be accomplished today)

Gaudio, 2005

Mindfulness and Psychosis

- Teaching mindfulness as a functional technique rather than formal meditation
- Use brief mindfulness, anchored to the breath or physical sensations, limiting periods of silence (Chadwick, Newman Taylor & Abba, 2005)
- Encourage practice but don't make it a deal-breaker

Metaphor use with folks who have cognitive impairment

- Use simple, brief metaphors
- Concrete examples
- Use physical props/ pictures/ cartoons
- Personally relevant stories & relate metaphors to important clinical issues
- Repetition
- Be prepared for people not to "get it", limit your explanations/ move on to something else

Values: Meaningful Activity Scheduling?

- Values are what we want our lives to stand for
- Values are not feelings but CHOICES
- Everyone possesses the ability to define a life direction
- Separate what you value from what you believe you can accomplish (separate values from perceived obstacles)

Lifetime Achievement Award

Imagine one day when you are older that your friends, relatives, co-workers etc. decide to give you a lifetime achievement award. What would you want to be recognised for?

What would you want people to say about you?

How do you want to be remembered?

A case example in early psychosis

(Morris, 2007)

Case Study: "Diane"

- 20 y.o. female, Black British
- Born & raised in south London; Lives with mother & sister
- Unemployed (previously worked as administrator)
- Seen by early intervention team when acutely psychotic: describing paranoid beliefs re people trying to harm her, also grandiose delusion about being a famous singer. Thought disordered. Had been unwell for 6 months.
- Family reported that she isolated herself, was aggressive, disorganised, with poor self care.
- Prescribed antipsychotic medication. Given option of psychological therapy.

Presentation at assessment

- Adherent with medication (ambivalent)
- Thoughts about being a famous singer reduced in frequency and believability, but continuing to distress her; depressed and anxious
- Functioning: spending most of her time at home, listening to music & watching TV, not socialising with friends or seeking work
- Diane's stated therapy goals: [1] To be "normal", [2] Be able to get back into employment, [3] Improve self-esteem

Hypothesised Vulnerability to Psychosis

- Family history of psychosis (brother)
- Low SES, inner city, minority status
- History: emotional & physical abuse from father, persistently bullied at school
- Long period of unemployment (12 months)
- Duration of untreated psychosis approx. 18 months
- Recent life events:
 - Return of estranged brother to family home
 - Family friend killed on the estate

Acceptance	Ongoing efforts to suppress thoughts appraised as "psychotic", scanning for signs Avoiding "shameful" situations CRB?: (Finds it hard to describe specifics, talks in generalities) Highly experientially avoidant
Defusion	Attached to evaluations of private experiences as good/bad, normal/abnormal Reason-giving around lack of action
Contact with Present Moment	Frequent rumination about past events Engages regularly in fantasies of being successful/ popular etc.
Self as Context	Attached to self-as-content: victim, freak, past events & now psychosis defining her
Contact with Values	Unclear about what is important to her aside from "being normal". Sees self as capable of "more" but feels trapped.
Patterns of Committed Action	Has "dropped out" of several life areas: work, friendships, intimate relationships Procrastination ++

ACT approach

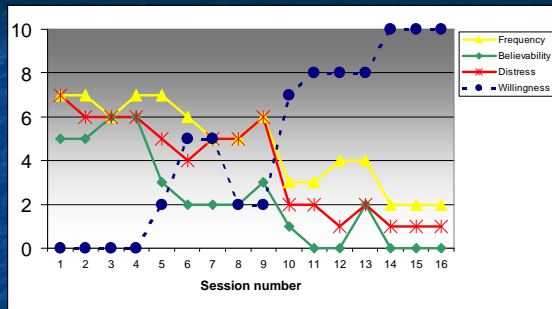
- 16 sessions over 9 months at a community clinic
- Initial focus on values clarification & goal setting
- Exploring efforts at controlling thoughts/feelings: short vs long-term
- When it works to be guided by experience rather than "how it should be"
- Normalisation, "with an ACT twist" (noticing what minds do)
- Mindfulness/ Willingness / Letting go
- Perhaps with psychosis it is: "get out of your mind & into your life" – noticing opportunities that have come with losing your mind

ACT approach 2

- modification of ACT metaphors to be personally relevant
 - Mindfulness: "Trains at Waterloo Station"
 - Valuing as action: "The Cliff Richard Fan"



Session Ratings – Intrusive Thoughts



- Frequency ratings 0–7 days
- Believability/Willingness/ Distress ratings 0–10

Outcomes

Living more consistently to values – approaching feared tasks such as looking for work, actively engaged in friendships, acting in more caring way toward family

Intrusive thoughts – greater acceptance of "psychotic" thoughts, less believability about thoughts in general, more freedom to act even if feeling ashamed & anxious

AAQ ratings moved in a general acceptance/ willingness direction post therapy, particularly:

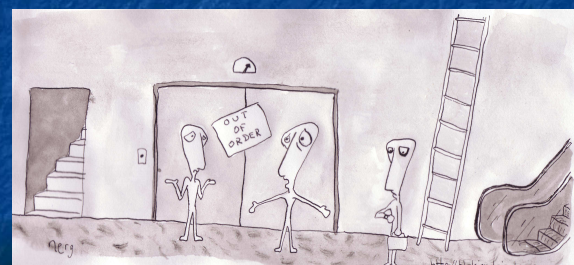
- If I could magically remove all the painful experiences I've had in my life, I would do so.
- It's OK to feel depressed or anxious.

2 years on, following first episode: no relapse despite several BLIPS, employed



"Now, what are we going to do? "

When we are not in the moment, we miss opportunities to discover what works





ACT & Early Intervention: Possibilities

- Recovery may usefully be linked with values – moving from unhelpful pliance and tracking methods (“just take your meds & you’ll stay well”)
- a pragmatic alternative to symptom elimination, through behavioural activation and promotion of psychological flexibility to anomalous experiences, emotions and thoughts in general
- May help clients to develop early flexibility toward the dominant “messages” about psychosis (symptom elimination or limited life meaning, stigma of mental illness, minds can be controlled etc).
- Helping the psychological flexibility of clinicians

(Morris & Oliver, 2008)

Two Tracks of Life

Inner Life (Your Mind)
Feelings Thoughts Urges Memories

- less control over these - can happen without you wanting them
- it takes a lot of effort to change these, can lead to doing things that are harmful in the long run
- a private experience – only you observe what happens in your mind, other people only know if you tell them

Outer Life (what You do)
Actions Behaviour Choices

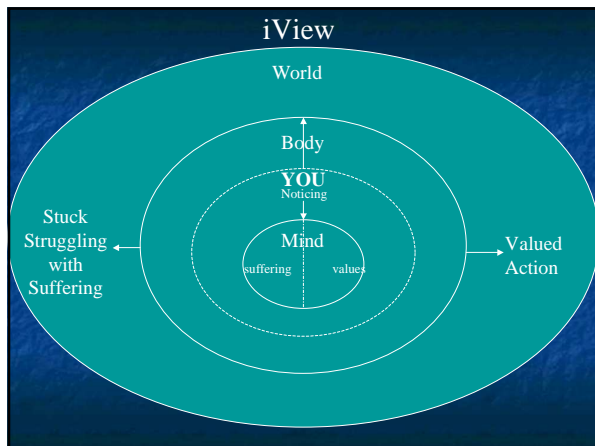
- more control over this, greater choice about what you do
- able to do things even if your mind (thoughts/feelings) says that you can't
- choices and actions are things that other people can observe, you can act in a way that is different from how you feel



ACT in Groups

WHY A GROUP APPROACH?

- Group processes facilitates “experiential driven” behaviour change.
- Mental health colleagues receive direct clinical experience and supervision, also helping create and maintain an “act consistent culture.”
- The Group process, combined with a “course” outline, encourages active personal learning rather than the passive stance of receiving therapy.
- Participants able to “top-up” and repeat Course in future, facilitating personal learning and the group process



Life Manual for _____

1. Family (other than marriage or parenting) _____
2. Marriage/Couples/intimate Relationships _____
3. Parenting _____
4. Friends/Social Life _____
5. Work _____
6. Education/Training _____
7. Recreation/Fun _____
8. Spirituality _____
9. Citizenship/Community Life _____
10. Physical Self Care _____

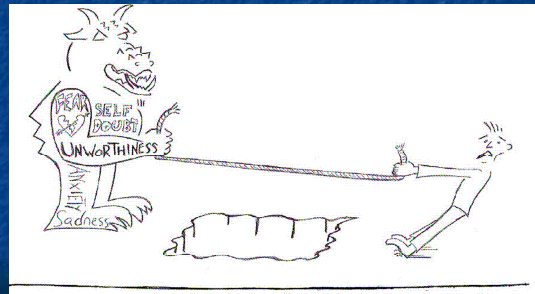
Suffering List

(thoughts, feelings, and sensations that you do not want)

Solutions list

(what you have done to reduce, eliminate, avoid, or escape your suffering)

Tug of war with the monster

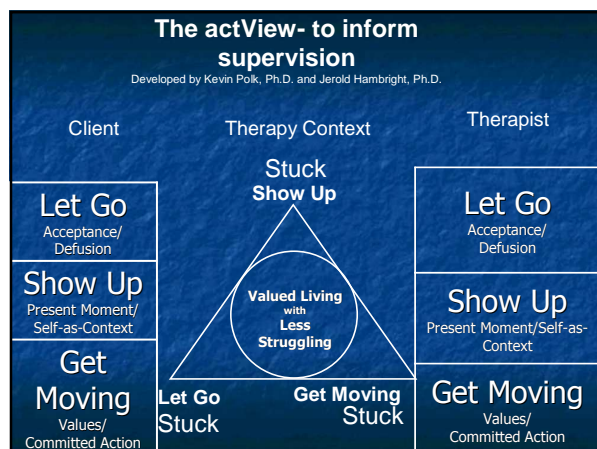
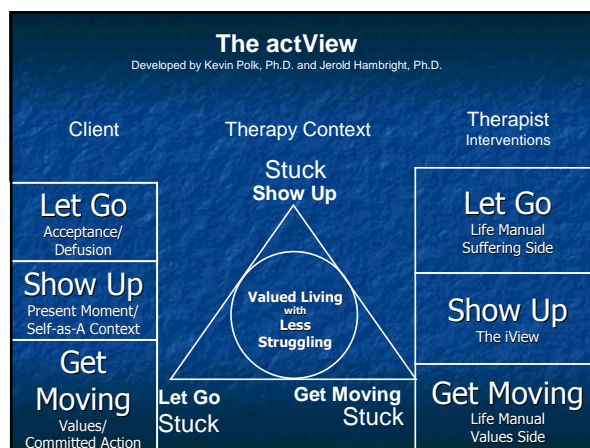
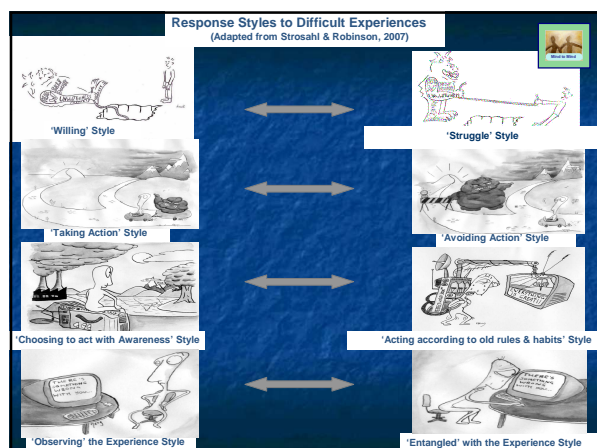


What does it really mean to “drop the rope”



Which passenger is telling you what to do now?





Clinical example of pitfalls

- Reviewing an agreed committed action from previous session with client

DEMOGRAPHICS

- Range of SEMI diagnoses and ages (20-58 years)
- 17 female and 3 male clients started, 3 repeats; 2 drop-outs, 1 discharge
- 4 in-patient groups completed so far
- Length of contact with services from 3-27 years
- Previous admissions from 1-33
- Attendance rate for those who finished >90%

ANECDOTAL OUTCOMES (PARTICIPANTS)

- Poor histories of engagement but all functioned relatively well in course
- Definite **group process** developed
- Staff "positively surprised" by examples of goal-setting & committed action
- AAQ scores
 - Pre-group high scores decreased (but remained high)
 - Pre-group low scores increased! (? < denial of avoidance)

FUTURE DEVELOPMENTS

- Commitment to staff keen to develop skills and knowledge base.
- Development of Integrated Care Pathway (ICP)
- Interim pilot study (joint collaboration with Department of Nursing, Dundee University – “qualitative” approach + evaluation of ICP process)
- Outcome measurements
 - patient (e.g. responses to experiences, relapse/re-admission rates, improved help seeking, flexibility)
 - service changes (e.g. use of PRN meds & attitudes to patients’ expressed distress [learn from pain!])