

ACT Early

Acceptance and Commitment Therapy to assist recovery from a first episode of psychosis

Eric Morris & Joe Oliver

Lambeth Early Onset Services

South London & Maudsley NHS Foundation Trust



Aims of this session

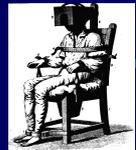
- To explore the potential of ACT in helping young people recover from psychosis
- To provide some examples of using ACT within an early intervention service
- To demonstrate how the ACT approach can be sensitive to the needs of young people living in a diverse, socially-deprived inner city setting

Psychosis

- Peak age of first onset 16-35
- Symptoms:
 - Positive: delusions, hallucinations
 - Negative: affective flattening, amotivation
 - Disorganisation: thought disorder
- Various diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder, depression with psychosis etc.
- Characterised by heterogeneity in symptoms and outcome
- Bio-psycho-social vulnerability influenced by stress

Traditional Interventions in Psychosis

- Significant proportion never receive MH services
- Long delays and numerous health agencies contacted before patients finally engaged in treatment
- 80 - 85% FEP patients hospitalised
 - involuntary and police admissions
 - lengthy stays in hospital
 - conventional antipsychotics in high doses
- High drop-out with community follow-up
 - focus on treating positive psychotic symptoms
 - neglect of psychological and functional recovery
 - co-morbidity (e.g. depression, drug use) overlooked
 - limited attention to needs of carers



Recovery from first episode psychosis

- up to 20% show persisting positive symptoms
- 50-65% will relapse within 2 years despite medication adherence; there is a growing risk of treatment-resistant symptoms with each subsequent relapse
- over 50% of FEP clients report significant depression and/ or anxiety secondary to psychosis
- Up to 70% of recovering FEP clients will continue to be unemployed/ out of education 12 months after starting treatment
- most of the disability associated with schizophrenia occurs within the first five years following FEP

Sources: Edwards et al., 2002; Birchwood, 2003; Whitehorn, 2002; Robinson, 1999

Early Intervention in Psychosis

- In the last 10 years increasing international interest in efforts to improve recovery and reduce long-term disability following FEP
- Development of early intervention services as an alternative to standard mental health care, focusing on early detection and assertive outreach

Psychological Therapies in Early Intervention

- An important component of the EI approach is the use of psychological therapies
- Cognitive behavioural approaches are used, however the evidence is not conclusive (Penn et al., 2005)
- Family intervention appears to be helpful in improving communication and preventing relapse. However there have been mixed results within early intervention (Haddock & Lewis, 2005).

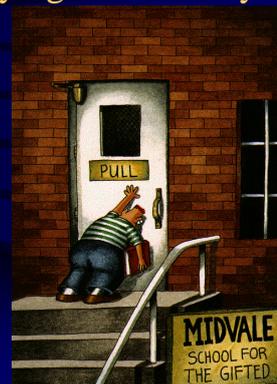
The ACT stance with psychosis

- ACT presents a pragmatic alternative to symptom elimination, through behavioural activation and promotion of psychological flexibility to anomalous experiences, emotions and thoughts in general
- Emphasising acceptance rather than disputation; 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

ACT & Early Intervention

- 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).
- Recovery may usefully be linked with values – moving from unhelpful pliance and tracking methods (“just take your meds & you’ll stay well”)
- Acceptance-based methods in carer/family work: focusing on “what works” rather than “who is right”, values in communication, being present
- Prodromal/ high risk groups – prevention of psychosis?

Identifying unnecessary struggle?



Service Context

Lambeth Early Onset Service (LEO)

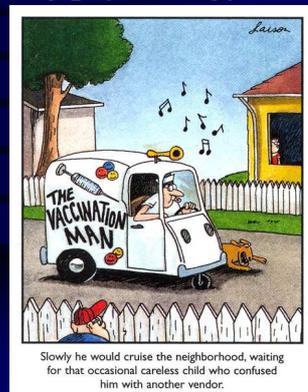
- A service for young people aged 16-35, residing in Lambeth (south London), experiencing symptoms of psychosis for the first time
- service focuses on engagement, multi-modal treatment, and relapse prevention
- works within a recovery model



Socioeconomic context of Lambeth

- High levels of crime (Home Office, 2006)
- High levels of deprivation (ODPM, 2004)
- Higher rates of smoking, drinking, drug use (Lambeth PCT, 2006)
- Poorer health outcomes
- Highly transient population
- Greater proportion of BME communities
- Higher levels of psychosis (Garety & Rigg, 2006; Kirkbride, et al., 2006)

Offering psychology to EI folk...



ACT across the system

- Individual therapy
- Group therapy in a community team
- Group therapy on an inpatient unit
- Staff training in mindfulness, compassionate approaches
- Group therapy with clients at risk of developing psychosis
- Research with early psychosis

Using ACT in EI: General Principles

- 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
- Emphasise values, willingness and choice

Individual Therapy

- ACT is an option for every client in our service, offered flexibly across the various “phases” of recovery from psychosis (acute, post-episode recovery, persisting symptoms)
- Informed by British CBT for psychosis approach (normalising, functional)
- Amount of sessions can vary
- Supported and reinforced by group program

A Case Example

- “Andrew” 24 y.o male
- Unemployed, living in the inner city with his family
- 3rd episode of psychosis, 2 admissions
- “Partial” adherence with meds + PSI program
- Occasional cannabis use
- Referred due to distress and disability associated with longstanding delusional beliefs

Assessment

- Andrew reported a belief that he was chosen by God to fight the Devil in the Last Days.
- Needed to be prepared for this battle as it could happen “at any moment” and he was unsure of how the agents of the Devil would try to attack him until then.
- Changed appearance to hide, tended to avoid going out of the house, carried a knife; changed course at college as part of his “mission”.
- Depressed and anxious, “never relaxed”; reported that he was ashamed that he was regarded as mentally ill

Cognitive entanglement / Fusion	Strong attachment to belief that things will end badly (conceptualised future). Domination of thoughts about “right” and “wrong”.
Out of Contact with Present Moment	Preoccupied with future events, spends a lot of time ruminating about possible attacks and weight of responsibility.
Fused with Self as Content	Attached to idea of self as champion of God, target of the Devil. Also attached to self as “others see me” – a loser, “schizo”
Out of Contact with Values	Recognises what he has given up due to his mission – feels regret and sadness about this. Does see a discrepancy between his personal values and current behaviours. However, unclear in describing personal values. Contacting loss and fearing consequences of change.
Ability to build patterns of committed action	Procrastination, engaging in behaviours to “play it safe”, sacrificing action on personal values

ACT approach

- Seen for 15 sessions in the community
- Clarifying personal values: lifetime achievement award
- Explored ways of coping, short and long term costs, ironic outcomes: Man in the Hole metaphor
- Present-moment focus, mindfulness, exploring where “choice” and willingness could be
- Defusion: Two Computers metaphor
- Defusing from the conceptualised self: Chess Board
- Behavioural activation



ACT in Groups

Inpatient ACT group

- Weekly ACT-focused group run on the LEO inpatient ward
- Facilitated by psychologist and ward nurses
- Open door policy
- Emphasise fun - competitions and prizes
- Average of 6 people a week
- Aim to provide a “taster” to ACT ideas such as values, present moment focus, defusion
- Try to be as accessible to everyone – concepts very simple, people are guided thru with examples.
- Often use case scenarios and then use this as a way in for people to talk about their own experiences

Who is the worst famous person you can think of?

- To win a million pounds you have to pretend to be their biggest fan - what would you do?



Gina hears voices. She doesn't fight with them but she doesn't necessarily believe what they say to her.

Is this like:

A: Trying to pull out of the trap?

or

B: Moving into the trap?

Which of these famous people has admitted to self harming?

- Amy Winehouse (singer)
- Johnny Depp (actor)
- Angelina Jolie (actress)
- Princess Diana (princess)

Lost your Mojo?

Learn Psychological Skills to get back into life
Find out how to get your Mojo back!

Come to the half-day LEO workshop
Learn something, have fun!
Thursday 13th March 2-5pm

Food provided
Talk to Eric or Joe @ LEO



Mojo Group - ACT in a community setting

- Accessible – one size fits all, guide people through (Beginner group)
- Use lots of scenarios and not rely on people to volunteer
- Use food to attract people in
- Workshop style – to normalise and easier for less organised folk
- Lots of fun activities, visual aids and prompts to maintain attention. Give handouts + a mindfulness CD.
- Advanced workshops for those interested (more ACT!)

Sometimes, moving from struggling daily with the situation to living your life with more freedom is not easy. The workshop is about helping you to plan a way ahead and hopefully to take a few steps along the road to a more fulfilling life.

You can speak to Joe, Eric or Sally at the LEO community team if you want to know anything more.

When is it on?
Thursday 22nd of May
1pm to 3pm
@LEO Community Team -
Beale House



Mojo Workshop
Get back into life!



A 2 hour workshop designed to help you move forward in your life and relate to your problems.

What we think might help

- Learning how to live NOW
- Finding choices in each moment
- Sticking with doing what YOU care about
- Noticing when your mind helps you AND when it doesn't
- Accepting what you can't change
- Being compassionate with yourself

PAIN AND SUFFERING CIRCLES



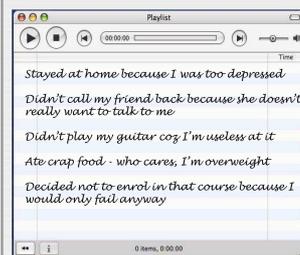
Source: Gordon Mitchell, Amy Hodgson, 2007



Houdini's final undoing

iACT

What is on your playlist today?



Staff Training

- We use ACT principles to foster the flexibility of staff interactions with clients
- This is important in our setting as the EI model involves ongoing questioning of assumptions regarding prognosis, formulations of client problems (stigma)
- We do this through training, supervision, consultation

Your last day at LEO

- What would you *hope* that service users and your colleagues say about your actions?
 - What would you *fear* would be said?
- Our collective actions are for a purpose:
- What is that purpose in LEO? If that purpose was a direction (e.g., North), how would we know we are heading north?
 - **How do you embody that purpose?**



Using ACT with people experiencing “at risk mental states”

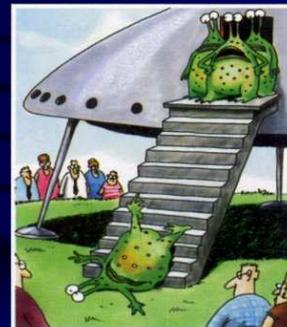
(Louise Johns, Majella Byrne, Ellen Craig & Eric Morris: OASIS Service)

- Meta-cognition in ARMS, FEP and with persisting symptoms
- Pilot work for an ACT/mindfulness group for ARMS
 - Teaching early flexibility toward anomalous experiences
 - 6 session group using normalisation, mindfulness, values, committed action
 - Can doing this prevent/delay/ameliorate transition to psychosis?

Planned research studies

- Validation of the Acceptance & Action Questionnaire-2 with distressed voice-hearers
- Comparisons of predictive power of baseline illness appraisal vs experiential avoidance on post-psychotic depression in FEP clients
- Multiple-baseline single-case design study investigating processes of change in acceptance-based intervention with persisting voices

What is it like to do ACT in this setting?



Contact:

Eric.Morris@slam.nhs.uk
Joseph.Oliver@slam.nhs.uk

