ACT early: Acceptance and commitment therapy in early intervention in psychosis

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Mindfulness and acceptance-based therapies may have a role in fostering recovery from early psychosis, through engaging service users' personal values and promoting a psychologically flexible stance. This paper describes using acceptance and commitment therapy in an early intervention setting.

Over the past 15 years there has been increasing interest from researchers and clinicians in the preventative possibilities of intervening early in a first episode of psychosis. This has been driven by the recognition that, if left untreated, a psychotic disorder can have a devastating impact on long-term social and psychological functioning (Bryson & Bell, 2003; Lehman et al., 1982).

Psychological interventions for psychosis, particularly cognitive behaviour therapy (CBT), are now well recognised as an essential treatment. Although there is a body of evidence to suggest that CBT for psychosis has modest effects in helping those experiencing persistent positive symptoms (Gaudiano, 2006; Wykes et al., 2008), the evidence for CBT in early psychosis, although developing, is currently limited (Haddock & Lewis, 2005). This may partly be because the majority of first-episode psychosis (FEP) clients experience a natural recovery in symptoms, irrespective of any intervention offered, and an intervention approach that is centred on positive symptoms is simply less relevant.

What is known is that the majority of FEP clients, despite symptomatic recovery, continue to struggle with emotional disorders and lasting difficulties in social recovery following the episode (Birchwood, 2003). Some researchers have argued that CBT for psychosis should focus on emotional and social functioning and not be considered a quasi-neuroleptic (Birchwood & Trower, 2006).

Acceptance and mindfulness-based approaches

In the last decade there has been increasing empirical interest in acceptance and mindfulness-based therapies (Hayes et al., 2005). One of the more theoretically developed of these approaches is acceptance and commitment therapy (ACT), which uses acceptance and mindfulness strategies in combination with behaviour change processes to produce greater psychological flexibility (Hayes et al., 2005). ACT is derived from a basic science account of language known as relational frame theory, which suggests normal language processes that contribute to human suffering (Barnes-Holmes et al., 2004). When compared to other therapies that may attempt to change the frequency, content or form of distressing thoughts and feelings, ACT focuses instead on altering the relationship that the client has with private experience by teaching mindful awareness and acceptance, and by encouraging action based on personal values rather than avoidance (Hayes et al., 2005). As a consequence, the repertoire of available behavioural responses is broadened, allowing for more effective, flexible engagement in meaningful activity (Hayes et al, 1999). In ACT the client is encouraged to experience in the 'hereand-now' what they think and feel. They let go of the struggle with internal experiences by learning mindful detachment. In this way the client can have increased freedom to make choices about meaningful actions in life areas that they deeply value.

There is now a considerable body of evidence to suggest that the problematic processes targeted by ACT, such as cognitive

fusion and experiential avoidance (when people respond literally to thoughts, attempt to avoid feelings and are unable to act effectively in the presence of difficult private experiences), are functionally related to a broad range of negative psychological outcomes (see Hayes et al., 2006, for a review). Furthermore, ACT interventions have been successfully applied to a wide array of problems and disorders, demonstrating efficacy and process changes consistent with the underlying model (Hayes et al., 2006). There have been initial investigations of the utility of ACT in the treatment of psychosis, which have shown promising results in reducing relapse or rehospitalisation rates (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). Protocols have been developed for ACT with psychosis, in brief (fewer than six sessions in RCTs: Bach & Hayes, 2002; Gaudiano & Herbert, 2006) and longer forms (case studies: Garcia & Perez, 2001; Pankey & Hayes, 2003).

Applying ACT in early intervention

We would argue that mindfulness-based therapy approaches like ACT have potential in assisting recovery and relapse prevention following a first episode of psychosis, by promoting values-based recovery, and emphasising early psychological flexibility through acceptance, mindfulness and behavioural activation strategies. The ACT stance suggests that it is not the presence of symptoms or unusual experiences that may be problematic when recovering from psychosis but rather the impact of these experiences upon functioning and life meaning. Within the ACT model, responses to these unwanted or engulfing internal experiences are viewed in the context of personal values, which provide a measure of functional utility of coping methods.

Personal values play a crucial role in ACT and are defined as 'verbally constructed, global, desired and chosen life directions' (Dahl et al., 2005). The advantages of using values as a yardstick for interventions are that they provide constructive and consistent direction, enhance response flexibility and motivation and encourage persistence when people have unpleasant thoughts and feelings, especially in values-related situations that involve intimacy, vulnerability or ambiguity (Hayes et al., 1999). The ACT approach is to ask clients: 'In a world where you could choose to have your life be about something, what would you choose?' (Wilson & Murrell, 2004). Following a first episode of psychosis, the answer to this question can be part of a process that unifies the purpose of the early intervention: to help the service user to pursue a valued life, rather than simply 'recover'. Developing mindfulness skills in the context of life values can enhance effective coping and provide direction with recovery.

Rather than suggest that valued actions must only follow after the successful control of internal experiences, the ACT approach helps the client to discriminate those contexts where such control actually increases suffering or comes at great personal cost. The ACT therapist helps the client to directly focus on their personal values by teaching mindfulness and acceptance skills in these contexts, and socialises the client into a behavioural activation approach to pursuing values.

For example, when working with a client who is experiencing derogatory voices, an ACT therapist could encourage the client to outline the various methods used to try to control their voices and the effectiveness of these methods in the short and long term, particularly with reference to the client's life goals and values. The agenda of controlling or eliminating the voices would be explored in terms of costs and benefits, and the alternative of acceptance of this experience through mindfulness and 'defusion' (one of the main core principles) would be suggested as a means to take valued actions (e.g. in relationships, work/education, leisure, spirituality). The focus of therapy therefore becomes about how the client can live the life that they value, even if the voices continue to be part of their experience.

Particularly important for facilitating recovery is tackling negative symptoms. One way to understand these behaviours is to consider them to be the consequence of chronic avoidance of feared consequences relating

to psychotic phenomena. From an ACT perspective, work can focus on helping a person to examine the costs of such behaviour in relation to values. Often, work on clarifying a person's values is first needed, particularly if avoidance has been longstanding.

Similarly, with young people who have experienced recovery from the positive symptoms of psychosis, the stance of acceptance and mindfulness in context of valued actions can be useful in developing flexibility toward self and community stigmatising attitudes about psychosis. This is particularly important considering the prevalence of emotional disorder following the first episode of psychosis, which appears to be related to appraisals of entrapment, shame and loss (Birchwood, 2003). The ACT model helps clients differentiate between internal experiences (thoughts and feelings) and the part of the self that experiences the internal experiences. This can encourage a more flexible and pragmatic stance towards distressing thoughts and feelings and may allow for greater acceptance and distance from self-critical evaluations and social stigma, loosening the control that these experiences have upon choices and actions.

Our service context

We work for the Lambeth Early Onset Service, situated within a densely populated and deprived inner London borough. The service has three main arms: a dedicated 18-bedded inpatient unit; a community assertive outreach team, (incorporating a crisis assessment team) and a prodromal clinic. The psychology team offers services to each of these arms. Within this context, we offer ACT-based interventions, both in an individual and group format.

Group work

On the inpatient ward, we run a weekly, open ACT-focused group that is facilitated by the ward psychologist and ward nurses. It aims to provide people with a taster to ACT ideas, such as values, present moment focus and defusion. We maintain an open-door policy, which means that we need to make the content accessible to everyone. We do this by keeping concepts simple and emphasising fun by using competitions and prizes. We often use case scenarios to encourage people to talk about their own experiences in an easy way.

Alongside the ward groups, we run regular workshops in the community, which provide a more in-depth introduction to concepts. We chose a workshop format to emphasise a more normalising, skills training and learning approach. In terms of structure, we start our workshops with a discussion about what is important to people and then move on to talking about what can get in the way of people living consistently with their values. We use the rest of the workshop to present and try out some of the strategies which we frame as 'What we think might help'. This can include:

- learning how to live in the 'here and 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; and
- being compassionate with yourself.

We use lots of physical props, pictures and cartoons in our discussions to make the content more accessible and fun. For example, we've developed a worksheet we call 'iACT', based on an iPod playlist. We ask participants to think of everyday behaviours as 'tracks on your playlist' and ask them to record what their playlist in the next 24 hours would look like if it was filled with value-based tracks. We also use personally relevant stories and relate metaphors to important clinical issues.

We regularly use mindfulness exercises in the groups, tending to keep the exercises brief and with fewer pauses in the instructions (following the recommendations from Chadwick et al., 2005).

Individual work

We offer ACT individually to clients both on the inpatient ward and in the community. Where possible, we use the ACT groups to consolidate work being carried out in individual treatment sessions. Due to the heterogeneity of the client group we tend not to follow a standard treatment protocol within

individual sessions. As a general rule we start by working on values and discussing what gets in the way of the client moving in a direction consistent with their values.

The ACT sessions tend to involve using multiple components from the model, using a mixture of mindfulness, acceptance, values and behavioural activation techniques, exercises and metaphors. Our sessions tend to follow the structure suggested by Gaudiano and Herbert (2006):

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; and
4. identify a valued goal and formulate specific action plan (however small to be accomplished today).

Conclusion

Based upon the equivocal results of intervention studies for CBT for psychosis, there continues to be a need to develop psychological interventions following the first episode of psychosis that may be effective in enhancing recovery. We suggest that a fruitful direction may be with interventions based upon acceptance and mindfulness methods, which are tied to behavioural principles, and focus on recovery guided by personal values and life meaning. ACT is an example of this type of intervention, and has several novel features that appear to be consistent with empirical understandings of how people cope with unwanted mental experiences, broader trends in behavioural and cognitive therapies, and contemporary developments in recovery-focused interventions in mental health services.

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