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# Using Acceptance and Commitment Therapy With People With Psychosis: A Case Study

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## Abstract

There is a small but increasing body of research to suggest that acceptance and commitment therapy (ACT) is useful for people experiencing psychosis. As an intervention, ACT does not specifically target symptom reduction but rather emphasizes more flexible responding in the presence of psychotic symptoms to encourage increases in value-driven behavior. A case study is presented, detailing use of ACT in working with someone experiencing long-standing distressing psychosis, specifically, paranoia, delusions, and associated emotional disturbance. Measures of general distress, severity, and intensity of delusional thoughts and depression were taken at two points prior to therapy starting and again post intervention. All measures showed improvements post therapy, although symptoms did not remit completely. However, the client reported significant increases in value-based activities. The results indicated that, although not a primary treatment target, ACT can help in reduction of symptoms. As expected, the intervention can also assist in increasing value-based behavior, in spite of the presence of ongoing psychotic symptoms.

## Keywords

acceptance, commitment, psychosis, paranoia

## I Theoretical and Research Basis for Treatment

Traditional explanations of psychosis have tended to focus principally on biogenetic models. Psychotic symptoms were seen as unexplainable or by-products of neurological dysfunction, and any underlying meaning of symptoms was disregarded (Freeman & Garety, 2003). However, within the last 20 years, there has been a proliferation of research demonstrating that other factors, in addition to biology, are of importance. Awareness has developed that, rather than being a disease that was either dichotomously present or not, psychotic symptoms can be envisaged on a continuum, with people in the “normal” population also reporting psychotic-like symptoms (Bentall & Slade, 1985; Cox & Cowling, 1989; Romme, Honig, Noorthoorn, & Escher, 1992).

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This observation, along with the limited success of drug treatments and growing survivor movement arising in the early 1990s, has driven the development of integrative, multifactorial models that have sought to combine biological, social, and psychological factors into a comprehensive explanation of the onset and maintenance of psychosis (e.g., Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002; Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Morrison, 2001). Such models have guided development of treatment strategies that emphasize the importance of working more generally to assist people in managing distress and preoccupation associated with symptomatology, by using individualized shared formulations to focus on factors likely to contribute to symptom maintenance. These treatments typically incorporate a range of strategies, including normalization of symptoms, coping strategy enhancement, addressing cognitive biases, or working with underlying negative schemas (P. Chadwick, Birchwood, & Trower, 1996; Fowler, Garety, & Kuipers, 1995; Kingdon & Turkington, 1994).

There is a body of evidence to suggest that cognitive behavior therapy (CBT) for psychosis can be effective in helping those experiencing persisting positive symptoms (Gaudiano, 2006; Wykes, Steel, Everitt, & Tarrrier, 2008), and the National Institute for Clinical Excellence (NICE) published national guidelines pertaining to the treatment of schizophrenia (NICE, 2009), which recommend the use of CBT with people with schizophrenia. However, the effect sizes of such interventions are modest (Wykes et al., 2008). As a result, some researchers have argued that CBT for psychosis should focus on emotional and social functioning, and not be considered a quasi-neuroleptic solely addressing symptom elimination (Birchwood & Trower, 2006).

Mainstream attitudes toward psychosis often center on the unacceptability of unusual/anomalous experiences and the need for these unwanted or engulfing experiences to be eliminated or controlled. Frequently in mental health settings, this common sense view of what psychological health involves (i.e., the absence or minimization of unwanted private experiences) is reflected in the treatment goals. Client progress is often evaluated exclusively on the degree to which psychotic symptoms are reduced by intervention, not taking into account more person-centered outcomes such as personal and social functioning (Mortimer, 2007). The assumption that reducing symptoms (particularly positive symptoms) will improve functioning is held despite unclear evidence on how social recovery and functioning are related to positive symptom reduction. Rather, it appears that functioning is more strongly related to the presence of negative symptoms and cognitive deficits (Fenton & McGlashan, 1992; Harvey, Green, Keefe, & Velligan, 2004; Kay, Opler, & Fiszbein, 1986; Pogue-Geile & Harrow, 1984).

An exclusive focus on symptom elimination may be unhelpful because, despite best efforts, a significant proportion of people with psychotic disorders continue to experience either persisting symptoms or repeated relapses (Mason et al., 1995; Robinson et al., 1999). For this significant proportion, the adoption of a broader focus on reducing the *impact* of persisting symptoms and relapses is important, particularly by considering these experiences in the personal context in which they occur (Bentall, 2003).

Recent theoretical developments, using acceptance and mindfulness-based strategies, aim to broaden psychological flexibility and increase engagement in meaningful activity. Acceptance and commitment therapy (ACT) adopts mindfulness and acceptance techniques to offer alternative ways of relating to unwanted internal experiences, placing an emphasis on valued action to engage in a meaningful life (Hayes, Strosahl, & Wilson, 1999). There have been successful applications of the ACT model to a variety of clinical and other problems (see Hayes, Luoma, Bond, Masuda, & Lillis, 2006, for a review), and several research strands point to the utility of an ACT approach for people with psychosis. For example, people who cope poorly with voices use more distraction and thought-suppression strategies (Romme & Escher, 1993), and people with schizophrenia tend to use less acceptance-based coping strategies, even where such strategies

are associated with better psychosocial outcomes (Perry, Henry, & Grisham, 2011). Furthermore, greater use of mindfulness has been found to predict positive changes in delusional distress over time (Oliver, McLachlan, Jose, & Peters, 2011). Research into the clinical adaptation of ACT for psychosis shows early encouraging results in terms of reducing relapse rates (Bach & Hayes, 2002; Gaudiano & Herbert, 2006).

The ACT approach offers an exploration of these unusual, often unwanted, experiences through examining the relationship and internal/external response to them in the context of valued direction (Morris & Oliver, 2009). The ACT model is based on simple value-oriented questions, such as "In a world where you could choose to have your life be about something, what would you choose?" (Wilson & Murrell, 2004, p. 135). This enquiry offers a useful platform from which to develop a motivational, behavioral recovery-based intervention.

Consistent with psychological research that suggests which attempts to suppress psychological content, such as emotions, distressing thoughts, or voices, often worsen such phenomena (Wegner, 2009); the ACT model highlights this as an important maintenance factor. ACT therapists encourage clients to recognize and reduce unhelpful struggle with psychological content and develop a more accepting stance to be able to move in a valued direction.

In ACT, clients are taught mindfulness skills to aid in the development of a more flexible, present-moment focused approach to distressing content, with the aim of creating more psychological distance from such content. This "self as context" can emerge through a training in the skills of mindfulness, nonjudgmental noticing of the process of thinking (separated from the content), and active acceptance, providing a safe place to experience the contents of the mind (Hayes, Strosahl, & Wilson, 1999). Further techniques are used to embed a process of deliteralization of language, aiming to weaken the "grip of literal meaning" and foster a growing awareness of the entanglement of thoughts and feelings. Cognitive defusion refers to this ability to "look *at* your thoughts, rather than *from* them" (Hayes & Smith, 2005, p. 70).

This case study describes a course of ACT with a client who presented with long-standing psychosis and associated mood and anxiety difficulties.

## 2 Case Introduction

"Brian" was a 32-year-old Caucasian British male who was referred to early intervention psychosis (EIP) services following concerns about his increasingly suspicious behavior. Brian lived by himself; however, he spent a considerable amount of time at his partner's home, who lived nearby. At the time of the start of therapy, he was enrolled on a full-time horticultural course that he had been undertaking for the past 12 months.

## 3 Presenting Complaints

During the initial assessment, Brian described a range of psychotic symptoms, including paranoid delusions, delusions of reference, thought broadcasting, and thought insertion. Brian also held distressing beliefs that he was being filmed by the secret service and his accommodation was bugged. Brian was also experiencing secondary mood disturbances, including depressive features, anxiety, and fluctuating suicidal ideation.

Brian's paranoid delusions related predominantly to thoughts that others were talking about him, and plotting and conspiring against him. He would easily misattribute glances between people and the use of particular words as an indication that they were using code language in reference to him and to plot against him. He remained uncertain about the nature of the plotting and the reasons why he was being targeted, but held strong convictions that he was the subject of

a malevolent conspiracy. At initial entry into the service, it transpired that Brian had a significant, 10-year duration of untreated psychosis. He described a probable psychotic episode at the age of 22 when he experienced intense paranoid ideas, believing that he was the victim of a conspiracy. He also recalled having experienced ideas of reference, believing that television advertisements and billboards were relaying unique messages to him. Similarly, song lyrics held significant personal meaning. He became increasingly preoccupied with others' behaviors and words, interpreting them as evidence for his paranoid beliefs. He would spend a considerable amount of time ruminating about these thoughts such that this would impede on performing daily activities. As such, he found it increasingly difficult to engage in social situations, and he described frequent attempts to plan his daily schedule to avoid group situations or crowded places that may trigger paranoid and anxious thoughts. In the intervening years, these symptoms fluctuated in severity, at times abating while at other times occurring with a delusional intensity.

Brian described a long history of depressive moods and anxiety. He recalled thoughts about harming himself in his early years and suicidal intentions in his late teens. Brian described negative thinking patterns and ruminations about his self-worth stemming from paranoid thoughts such as "people are laughing at me" and "people are judging me." Negative beliefs such as "I am a failure" exacerbated his low mood and would intensify avoidance behaviors. Social anxiety was prominent and avoidance arose from fears that strangers might approach him and that he might "freak out." Brian frequently structured his daily schedule so that he would minimize contact with others to avoid these experiences. He found it difficult to engage in daily tasks such as shopping due to the risk of contact with others.

## 4 History

Brian grew up in a densely populated, deprived urban environment with his mother, father, and younger sister. He described his early childhood as characterized by significant turmoil and disruption as a result of his father's frequent aggressive and violent outbursts, directed toward him or his mother and sister. He described having a number of bones broken as a result of his father's violent behavior. Although often unpredictable, these outbursts tended to be precipitated by his father's use of alcohol. To cope with his father's aggression, Brian would try to be very quiet when at home and carefully monitored what he said to avoid upsetting his father. From an early age he would spend a significant amount of time worrying about harm coming to him and his family. Although he described his mother as caring, she was often unable to protect Brian from his father's aggression. As a result of these experiences, he was often anxious, particularly around others. However, he found it relatively easy to make friends, particularly at school, as he was good at sports.

Brian described an extensive history of alcohol and substance misuse, developing from his early teens. He said he found alcohol to be very effective in helping him to reduce anxiety and increase his confidence when interacting with others. Brian began to engage in polysubstance abuse using a number of drugs on a daily basis, including methamphetamine. As with alcohol, Brian found drug use an effective method of coping with his anxiety and low self-confidence. Brian's drug use escalated after he joined the British Armed Forces, as he found drugs freely available. During this period, he started to experience frequent perceptual disturbances, particularly visual hallucinations and paranoid ideation. Brian was eventually discharged from the Armed Forces as his mental health deteriorated, and at this point he began to abuse alcohol. At referral into the EIP service, he was alcohol dependent and after several attempts, underwent a successful detoxification. At his discharge from the EIP service, Brian had been successfully abstinent for 1 year. His use of alcohol and commitment to remain abstinent were regularly explored in the therapeutic context.

## 5 Assessment

When he was assessed for psychological therapy, Brian stated he wished to engage in therapy so that he might develop effective coping strategies for anxiety and paranoia, with the aim to effectively reduce social anxiety and curb the amount of time spent worrying each day, allowing him more freedom in his life.

Brian had previously received two courses of CBT to address his paranoia and anxiety. Following CBT, he reported some improvement in his experiences and reduction in his anxiety. During CBT, he engaged in examining negative thinking patterns and began to attempt to look at these objectively. He made use of strategies to tackle negative thinking and practiced evaluating the accuracy of thoughts, which he found somewhat beneficial. Brian showed a strong commitment to the therapeutic process, remaining motivated to attend despite any increases in anxiety that reflection may have brought on. However, Brian continued to experience a functional impairment due to the intensity of his paranoid beliefs and this affected on his mood and avoidance behaviors.

### Measures

The nature and severity of Brian's difficulties were assessed using the following measures administered at an initial assessment and then just prior to onset of psychological therapy.

*The Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM)*. This is a self-report measure of global distress, including subjective well-being, commonly experienced problems or symptoms, social life and functioning, and risk to self and others. Brian's score on the CORE-OM at the assessment was .88, rising to .97 just prior to therapy commencing. Overall, this indicates a low level of global distress.

*Psychotic Symptom Rating Scale—Delusions subscale (PSYRATS-DS)*. This is a semistructured interview tool used to measure the presence and severity of different dimensions of delusional ideation, including amount of preoccupation with delusions, duration of preoccupation with delusions, conviction, and amount and intensity of distress and disruption to life caused by beliefs. Brian's PSYRATS-DS score at the initial assessment was 8, which rose to 12 at the assessment prior to therapy starting, indicating that his beliefs were both distressing and causing interruption to his life.

*Center for Epidemiologic Studies—Depression Scale (CES-D)*. The CES-D is a self-report measure of depressive symptoms, including depressed mood, feelings of worthlessness and hopelessness, loss of appetite, poor concentration, and sleep disturbance. Brian scored 30 at both assessment points, which indicates the presence of a significant level of depression.

*Health of the Nation Outcome Scales (HoNOS)*. HoNOS is a clinician-rated routine clinical outcome measure. It has 12 items measuring behavior, impairment, symptoms, and social functioning of people with severe mental illness. This was rated by a clinician independent from the therapy delivery. At the initial assessment point, Brian was rated as having a score of 19. At the pretherapy assessment point this had decreased somewhat to a score of 14, still indicating a significant level of impairment.

## 6 Case Conceptualization

Psychological formulation and therapy were informed by the functional ACT model and adapted for working with psychosis. From the assessment it was evident that a number of interrelated processes were functioning to prevent Brian from moving forward with his life. It was clear that he was very aware of his values and what was important to him. Principally, this included his

relationships with his partner and family. However, he did not appear to be able to take the necessary behavioral steps to move him toward his goal of being more supportive and less reliant on his partner and family. Central to this was a high level of experiential avoidance, particularly associated with perceived negative emotions such as anxiety. As a result, Brian's behavior was overwhelmingly controlled by negative reinforcement contingencies, whereby he was very motivated to engage in behavior that reduced anxiety. The effect of this was that he avoided a number of activities, such as leaving the house or socializing, thereby limiting his opportunities to come into contact with the natural positive reinforcers that occur as a consequence of engaging in value-driven behavior (such as a sense of independence after completing his weekly shop or a feeling of satisfaction after being able to take his partner out for dinner). In addition, absence of these positive reinforcers appeared to be related to concomitant symptoms of depression, including anhedonia, sadness, low motivation, and tiredness.

Brian had a tendency to become "fused" with his thoughts and take them very literally, in particular thoughts related to paranoia. It appeared likely that his early developmental experiences had led him, from an early age, to be sensitive to threat cues and this pattern, although it significantly interfered with his ability to engage in value-based actions, persisted. As a result, Brian tended to spend significant amounts of time ruminating about paranoid thoughts, in an effort to determine if there was a legitimate threat and how to respond. This pattern of rumination led him to be often out of contact with the present moment and had a number of negative implications for him. First, it meant he would spend large amounts of time at home, engaged in ruminative activity. Second, this activity tended to reduce the amount of anxiety he was experiencing as he became less aware of current emotional processes. This negative reinforcement process further increased the likelihood he would engage in future rumination, thereby reducing opportunities for value-based behavior. Third, his rumination reduced the opportunity to experience some of the positive reinforcing emotions that, although not frequent, did occur when he engaged in valued action.

In summary, the combination of a high level of experiential avoidance coupled with a tendency to become easily fused with thoughts meant that Brian often was not in contact with the present moment. Together, these processes resulted in a persistent reduction in behavior that would move him closer to achieving value-based goals.

## **7 Course of Treatment and Assessment of Progress**

Brian was seen for a total of 27 hourly sessions, over a period of 8 months. Each session lasted a maximum of 60 min. The initial stages of therapy were used to help Brian explore his values and what it might mean to live a life consistent with these values. By beginning to identify what was important to him, we could start to look at the processes that stood in the way of living a valued life. Given that avoidance was a prominent part of Brian's life, a value-based agenda provided a useful platform from which to work. As symptom elimination is not the focus of an ACT approach, values provide a functional dimension to understanding the cost of current methods of coping with positive symptoms. For Brian, avoidance and control strategies were aimed at minimizing anxiety and paranoid experiences but carried the cost of limiting his life. The focus of therapy therefore rested on these values and how Brian could live more congruently with them despite the presence of paranoid beliefs and anxiety.

By exploring current and past coping strategies, we assessed the workability of such efforts. Brian was able to identify previous alcohol and substance misuse as well as behavioral and cognitive avoidance in the management of his paranoia and anxiety. By looking at the costs of these strategies to Brian being able to live a value-consistent life, we were able to introduce an alternative to avoidance through acceptance and willingness. With Brian's assistance, we collaboratively

worked toward formulating a “toolkit” of psychological skills incorporating mindfulness, defusion, willingness, and value clarification.

An introduction to mindfulness raised again the notion of “workability” and the importance of tailoring sessions to the individual’s experiences. For Brian, the traditional “eyes shut” meditative mindfulness approach led to an increase in distracting paranoid ruminations and an alternative practical method using a physical exploration of all five senses proved more workable. Further to this, consistent use of language, referred to the noticing of thoughts and internal experiences, encouraged a mindful relationship to these processes. Intentionally, Brian began to adopt this language himself, often describing his experiences in the form “I noticed my mind becoming paranoid.” Other techniques, such as the use of the “leaves on the stream” mindfulness metaphor (Hayes, Wilson, et al., 1999), were adopted and functioned to create distance from internal experiences, negative evaluations, and distressing anxious thoughts by watching thoughts “float” by.

Cognitive defusion, as an ACT strategy, seeks to foster a nonevaluative, observer perspective to internal experiences such as thoughts and thus creates distance between actual events and verbal evaluations. This process helps to recognize thoughts as simply that. Mindfulness techniques, as described earlier, were used to help facilitate this process for Brian. Further defusion strategies were used through externalizing thoughts via language. For example, asking “what is the paranoia telling you?” With Brian, we would encourage further objectivity by referring to “Paranoia” or “Anxiety” in the third person, as in “What direction would Paranoia have you take now?” or “It seems Anxiety would rather have you avoid this right now.” This served to highlight the disparity between Brian’s valued directions and any movement away from these. Structured defusion techniques, such as singing anxious thoughts in affected accents, were also practiced. This exercise reinforces the idea that, despite the evaluations and emotions attached to them, what we are singing are simply words.

Willingness in ACT is usefully linked to valued direction. It is an enacted choice of being open to experience while committing to action in the service of values. Thus, it stands in direct opposition to avoidance. For Brian, as for others, this was a difficult concept to grasp particularly as willingness is misinterpreted as wanting to experience anxiety. However, through engagement in graded exposure, Brian came to relate willingness as doing what he valued despite experiences of anxiety or paranoia. It is important here to understand the aim of exposure in ACT being about increasing psychological flexibility, as opposed to the habituation to fearful stimuli. As Wilson and Murrell (2004) argue, the purpose exposure is “to not merely to lessen arousal and avoidance, but instead to build a broad and flexible repertoire with respect to the avoided event” (p. 130). The process of graded exposure was, thus, to (a) initially identify activities that Brian would choose to do based on his values; (b) create a hierarchy of these activities according to perceived anxiety levels; (c) formulate strategies to carry out these activities (initially supported and then as homework); and (d) reflect on barriers and progress. In the latter stage, the use of mindfulness and defusion techniques could helpfully address avoidance and internal barriers. The use of a diary helped Brian to effectively manage these scheduled activities, whereas a constant reminder of his values enabled Brian to remain focused on these activities.

## Outcome

During the course of therapy, Brian remained abstinent from alcohol. He frequently referred back to his values in the face of temptation while also working with defusion techniques to distance himself from thoughts of alcohol use. He achieved this by also referring to the addiction in the third person and separating this from his own values. Brian was also supported in his abstinence by a drug and alcohol key worker.

During the course of therapy and with the graded exposure, Brian came to increase his activity levels, which he aligned with his chosen values. By the end of therapy, Brian initiated activities that he had previously avoided and was enjoying the freedom of spontaneity. Although Brian still continued to experience moments of anxiety and episodes of paranoia, these experiences did not prevent him from continuing with his plans. Indeed, as Brian engaged in more activities, he experienced a brief increase in anxiety. This was likely due to simply being more engaged and less avoidant. At the close of therapy, Brian reported feeling less paranoid and also feeling more able to cope with any attacks of paranoia. He recounted being able to examine the paranoia with the tools he had acquired, as described earlier, preventing him from becoming entangled with paranoid thoughts. Brian also reported a reduction in depressive symptoms, particularly low mood, amotivation, and anhedonia. Toward the end of therapy, Brian started working to returning to employment and took on a part-time volunteer position. He described this as initially challenging because it brought him into greater contact with other people and initially increased his paranoia. However, as he found the work rewarding, he stayed in the post and eventually his paranoia subsided.

Brian was successfully discharged from psychological therapy and mental health services, returning to the care of his general practitioner. Subjectively, Brian described a marked improvement in his quality of life, reporting that he was enjoying his life more and felt satisfied with the impact of these interventions (and the associated hard work required). His partner agreed that Brian had improved greatly during the course of therapy.

### *Posttreatment Measures*

Results of each of the measures are presented below, with the accompanied clinical interpretation of these scores. For each of the measures, the reliable change (RC) index was calculated to estimate if any change observed in the scores was because of measurement error (Christensen & Mendoza, 1986). The RC index provides the amount of change in pre- and postscores needed to be 95% confident that the difference was not due to measurement error.

- *PSYRATS-DS*:  
Initial assessment: 8  
Pretherapy: 12  
Posttherapy: 7

Pre- and postmeasures are indicative of a reduction in the delusional intensity of paranoia. However, the RC index for the *PSYRATS-DS* was 5.41, which is slightly above the observed change, indicating that some of this difference may be accounted for by measurement error. Reduction was accounted for largely by reductions in the amount of distress associated with Brian's paranoid thoughts. However, he reported the thoughts still occurred but he was much less preoccupied by them and held them with less conviction.

- *CES-D*:  
Initial assessment: 30  
Pretherapy: 30  
Posttherapy: 22

Again, the *CES-D* scores represent a marked reduction in depressive symptoms. The RC index for the *CES-D* was 7.90, indicating this was a reliable change.



- CORE-OM:  
Initial assessment: .88  
Pretherapy: .97  
Posttherapy: .68

An initial pretherapy score of .97 is indicative of low level of subjective distress. The post-therapy result of .68 falls below clinical cutoff and indicates an improvement in subjective well-being. The RC index for the CORE-OM was .17, suggesting the change observed was reliable and not because of measurement error alone.

- Health of the nation outcome scales (*HoNOS*):  
Initial assessment: 19  
Pretherapy: 14  
Posttherapy: 2

Brian's HoNOS scores, as rated by an independent clinician, indicated that there was a significant reduction in problematic behavior, symptoms, and problems with social and occupational functioning. The RC index for the HoNOS was 7.38, indicating that this change in scores was reliable.

## 8 Complicating Factors

Working with an individual with paranoid delusions demanded a certain degree of modification of the technologies of ACT; this served to reinforce workability as a key component. Doing so shifted the emphasis away from symptom elimination, to recognizing the impact that this exclusive focus had had of Brian's ability to move forward with his life. However, Brian found these symptoms highly distressing and, together with views present in mental health system and broader society about the need to eliminate psychotic symptoms, meant that he had strong beliefs about the need to be symptom free before being able to take steps toward his values. It was therefore important that discussions about workability were undertaken with sensitivity. It was crucial to validate the distress Brian was experiencing, in addition to the effort he had exerted in trying to move his life forward. It is important to emphasize that the ACT model does not suggest that all experiential avoidance behaviors are inherently negative but that, used exclusively as a response to unwanted internal experience, will likely lead to psychological inflexibility (Luoma, Hayes, & Walser, 2007). As such, any discussions about the workability of Brian's coping responses required a functional assessment to understand whether they were useful (in terms of moving him toward his values), and this discussion needed to be both validating and had with compassion.

Specific techniques that did not relate to Brian's circumstances were altered to ensure that they were appropriate, so that the approach remained person centered and sensitive to context. In particular, the use of metaphor and in vivo experiential exercises were performed with caution. Mindfulness practices were modified to accommodate the preferences in learning style for this client and with the intention to avoid intensification of psychotic symptoms. For Brian, eyes-shut exercises were not tolerable, therefore adaptations that incorporated more physical exercises alongside increased instruction. Although Chadwick and colleagues (P. Chadwick, Hughes, Russell, Russell, & Dagnan, 2009; P. D. J. Chadwick, Newman-Taylor, & Abba, 2005) have reported that mindfulness exercises are generally acceptable to voice hearers, the experiences of Brian suggest that individuals with high levels of rumination and paranoia may benefit from adaptations and less reliance on traditional mindfulness exercises.

## 9 Follow-Up

Brian was seen for a follow up appointment 6 months after therapy sessions had finished. At this session, he reported that he remained abstinent of drugs and alcohol. He reported that he continued to work, although still found the experience challenging as a result of some ongoing anxiety and paranoia. However, he reported that he felt much more able to “notice these experiences and let them go.” He reported that he felt more connected with his partner and family as he was able to be more supportive of them.

## 10 Treatment Implications of the Case

Overall, Brian’s response to treatment was positive and there was a decrease in general distress, depression, and psychotic symptomatology. Independent ratings on the HoNOS were consistent with this, indicating significant reductions over a broad range of problematic behaviors, although, as seen in the outcome measures, Brian did not achieve full symptomatic remission. However, consistent with the focus in ACT, he reported to be continuing to engage in valued activities in the presence of ongoing distress, with a subjective improvement in quality of life. Interestingly, when Brian was expanding his behavioral repertoire and engaging in more approach behavior, he reported increases in distress and paranoia. An approach that was focused exclusively on symptom elimination may have, implicitly or explicitly, discouraged activity that increased the probability of a return in symptoms, thereby limiting the opportunity for new learning and value-consistent behavior. Instead the ACT approach is to encourage an active embracing of unwanted experiences combined with practicing mindfulness toward the appraisals of these, particularly when the client notices increases in the frequency and intensity of symptoms when engaging in value-consistent actions. These occasions provide opportunity to strengthen an approach-based repertoire, through flexible contact with current context, as an alternative to the rigid, narrow experiential avoidant responses that have contributed to and may be maintaining the client’s difficulties. Taking an experiential learning approach to the client’s situation means that workability is central to discussions about the merits of alternative responding: does mindfulness and clarifying values help the client to do more that is vital and meaningful for their lives? Therapy is therefore a process of discovery, placing the client’s lived experience and chosen values as central arbiters of outcome.

By emphasizing workability, there was limited need to challenge the veracity of symptoms. Direct challenges of symptoms of psychosis by well-meaning family or mental health professionals can often be a highly aversive experience for people with psychosis. It can also inadvertently exacerbate difficulties by promoting enmeshment with symptoms, thereby increasing the likelihood of a rebound effect (Pankey & Hayes, 2003). Rather, from an ACT perspective, the focus is on the behavioral response to symptoms and whether this helps the client to move in a valued direction. This then leads to alternative approaches such as mindfulness, acceptance, and defusion, that help the client develop a different relationship with their symptoms.

## 11 Recommendations to Clinicians and Students

Using ACT with people with psychosis, particularly paranoia and delusions, will require good familiarity with the model. Although studies have shown that ACT can be applied with effectiveness by therapists relatively new to the model (Brinkborg, Michanek, Hesser, & Berglund, in press; Lappalainen et al., 2007), this has not been demonstrated in work with people with psychosis. However, there are now a number of training manuals that outline the core ACT principles and techniques, including “Learning ACT” (Luoma et al., 2007) and “ACT Made Simple”

(Harris, 2009). In addition, Bach (2004) has written further about using the ACT model specifically with people with psychosis.

Several other recommendations for applying ACT with people with psychosis came out of this case study. First, it is important to keep the workability of responses to symptoms central. However, this needs to be done in a way that validates the distress experienced and previous selection of coping strategies. Second, avoid any direct challenges of symptoms by emphasizing workability. Not engaging in direct challenges reduces the possibility of further enmeshment with symptoms and is likely to enhance the therapeutic relationship, as the context of therapy allows for an open and flexible exploration of symptoms and promotes a collaborative relationship between client and therapist. Finally, the use of strategies such as mindfulness needs to be flexibly employed. Prolonged eyes-shut exercises may be experienced as aversive and therefore alternative approaches are required. The ACT model does not specify that mindfulness needs to take a particular form, rather it is the function, in terms of bringing a person into greater contact with their experiences in the present moment, that is important. More generally, by emphasizing the function of symptoms of psychosis, rather than just their form, ACT can help an individual build a more helpful, flexible relationship with these experiences, to come closer to chosen values.

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## Bios

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