Chapter 12
Acceptance and Commitment Therapy (ACT): Contextual Therapy in the Approach to Psychosis

Bárbara Gil-Luciano, Francisco J. Ruiz, and Carmen Luciano

12.1 Acceptance and Commitment Therapy, or Contextual Therapy

Acceptance and Commitment Therapy (ACT; Hayes et al., 1999; Wilson & Luciano, 2002) is the main representative of the so-called contextual therapies due to its philosophical, theoretical, and empirical anchorage. This section will briefly review its philosophical roots and theoretical trunk, considering it as an application of Contextual Behavioral Science (Hayes et al., 2012, 2021).

12.1.1 Philosophical Anchorage of Contextual Behavioral Science: Functional Contextualism

Functional Contextualism (FC; Gifford & Hayes, 1999; Hayes, 1993) is the philosophical anchor on which Contextual Behavioral Science stands. FC is a form of pragmatism that tries to make more explicit the contextual pre-analytical assumptions of Skinner's Radical Behaviorism (Skinner, 1974). For this purpose, FC

B. Gil-Luciano (✉)
Universidad Nebrija, Madrid Institute of Contextual Psychology (MICPSY), Madrid, Spain
e-mail: barbaragil.luciano@micpsy.com

F. J. Ruiz
Fundación Universitaria Konrad-Lorenz, Bogotá, Colombia
e-mail: franciscoj.ruizj@konradlorenz.edu.co

C. Luciano
Universidad de Almería, Madrid Institute of Contextual Psychology (MICPSY), Madrid, Spain
e-mail: mluciano@ual.es

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follows the classification of the world hypotheses of Stephen Pepper (1942). According to this, contextualism is a worldview that employs the root metaphor of action-in-context.

Contextualism considers that each event is inseparable from the historical and situational context in which it takes place and that, therefore, its complete understanding cannot be achieved by tearing apart its elements. This holistic view could lead contextualists to some immobility, as it is impossible to consider all the variables of the context in which psychological events occur. Being aware of this, contextualists allow selecting and analyzing parts of the context in which the psychological event takes place only as a means to achieve their pre-analytical goals, not to discover a preexisting reality. In other words, contextualism adopts a pragmatic truth criterion by which "truth" is defined in terms of its usefulness.

According to the pre-analytical goals pursued, there are multiple forms of contextualism (Hayes et al., 1993). Following the Skinnerian vision, FC proposes the pre-analytical objectives of prediction of and influence in psychological events. Adopting these objectives implies a radical departure from the predominant psychological models in which the explanation of a behavior (e.g., delusional behavior) through another behavior (e.g., experiencing auditory hallucinations) is accepted. Specifically, FC rejects the possibility that a psychological event is directly caused by another psychological event because this type of explanation would not allow progress in the pre-analytical objective of influence. As the psychologist cannot directly modify a psychological event, event-event causal explanations would not be "true" because they would not allow defining strategies to influence such events.

Conversely, FC holds that each psychological event must be explained in terms of contextual variables because these are the only ones that the psychologist can influence. Therefore, it is proposed that the relationships between events depend on contextual variables, even in those cases in which the event-event relationship is apparently causal.

12.1.2 Theoretical Anchorage of Contextual Behavioral Science: Laws of Learning and Relational Frame Theory

The trunk of Contextual Behavioral Science is constituted by the principles detected when performing an analysis that is consistent with the philosophical root represented by FC. Specifically, the trunk is mainly made up of the learning principles that explain the origin of the functions of psychological events, both directly and indirectly. In addition to the well-known learning principles (habituation/sensitization, respondent, and operant conditioning), the theoretical anchorage of Contextual Behavioral Science has been significantly expanded by the findings gathered under the label of the Relational Frame Theory (RFT; Hayes et al., 2001).

RFT is a very important leap in explaining human behavior because it has advanced considerably in providing a contextual-functional explanation of the generativity of language and cognition. For this explanation, RFT has not proposed a new learning principle. Instead, it has specified that derived relational responding is the basis of the generativity of human behavior and that relational responding is a set of purely functional operants, or generalized operants, learned through multiple exemplars with explicit contingencies provided by the verbal community.

During the last decades, a series of relational operants have been identified that involve relating stimuli through arbitrary cues such as coordination ("is," "is the same as," "is equivalent"), distinction ("is different from," "is distinct from"), comparison ("more than," "fewer than," "greater than," "less than"), hierarchy ("is part of," "contains"), perspective or deictic (I-you, here-there, now-then), causality ("if... then..."), etc. Establishing these relationships between stimuli (or framing stimuli) allows the derivation of new relationships and the transformation of their functions.

For example, ever since a child had a traumatic experience with a dog, he begins to experience intense fear and runs away from the situation when he sees a dog (or hears another person say "there is a dog"). If the child is shown a wolf and told that "wolves are *much more dangerous than* dogs," the aversive function associated with the word "dog," and the animal itself, will transform into the word "wolf" and the animal wolf. In this way, the child will react with even more fear and actions aimed at flight when hearing a person pronounce the word "wolf" or seeing a wolf. Note how, in this example, the reaction to the word "wolf" is explained in a functional-contextual way by mentioning how the current context (a person who says "wolf") actualizes functions related to the history of direct (aversive conditioning with a dog) and derived learning (establishment of an arbitrary relationship between "wolf" and "dog" through a comparison cue in a child who has learned to relate stimuli comparatively through multiple exemplars).

Given our interactions with the verbal community, human beings develop great fluency in framing stimuli through multiple types of relations, thus generating a myriad of derived stimulus relations and transformation of functions. This tremendously generative relational ability causes human beings to be in contact much more easily with appetitive and aversive functions than the rest of organisms. Following the above example, it is not necessary to see a dog to actualize explicitly learned aversive functions, but the mere sound of "dog," and even worse, of "wolf," can actualize them. Similarly, the same child can contact appetitive functions when he relates the beginning of December with the proximity of the Christmas holidays, or he can derive aversive functions when the feast of the Magi arrives because it implies going back to school soon.

As we discussed earlier, derived relational responding is the basis of the tremendous generativity displayed by human language and cognition. Thus, relational responding is involved in all complex human behavior such as problem-solving, self-regulation, analogical reasoning, perspective-taking and empathy, the creation of personal values, etc. Of course, understanding relational responding is vitally important to explain the generation of psychological problems, as well as therapeutic work. The following sections will be devoted to the latter issues.

12.1.3 Applications of Contextual Behavioral Science: Contextual Therapy, ACT

Metaphorically, the applications of Contextual Behavioral Science are ramifications supported on the trunk of knowledge of the laws of learning and derived relational responding, which, in turn, are anchored in the philosophical root represented by FC (Luciano, 2016). ACT represents the most recognized application in the clinical and health field due to its vast research volume (see https://contextualscience.org/state_of_the_act_evidence). Proof of this is the nearly 900 randomized clinical trials in multiple problems published as of January 2022. A review of the meta-analyses conducted on the efficacy of ACT can be seen in Gloster et al. (2020). This review concluded that ACT is effective in all the problems analyzed, including anxiety, depression, substance use, pain conditions, etc.

While the long-term aspiration of Contextual Behavioral Science is to define its applied models through principles derived from basic research (Hayes et al., 2021), the ACT model has traditionally been presented through the mid-level. These terms are halfway between technical terms and those coming from the common language. Specifically, mid-level terms are functional abstractions that serve as shortcuts to apply basic principles to complex applied fields (Vilardaga et al., 2009).

Next, we will briefly review the most popular form of presentation of ACT in mid-level terms and leave its explanation in basic terms for the next section. ACT is based on the model of psychopathology and behavioral ineffectiveness called psychological inflexibility – a behavioral pattern in which private experiences dominate action over contingencies related to personal values (Hayes & Strosahl, 2004). As shown in Table 12.1, psychological inflexibility consists of six interrelated processes: dominance of the conceptualized past or future, attachment to self-contents, fusion with the contents, avoidance of the contents, lack of values clarity, and inaction or impulsivity without a horizon of value. Likewise, the ACT model points out that psychological flexibility is a central process involved in mental health and behavioral effectiveness. This is defined as the ability to openly contact ongoing private experiences and respond with an action inserted in the direction of personal value (Hayes et al., 2006; Hayes & Strosahl, 2004). Psychological flexibility comprises six other mid-level processes: being in the present moment, acceptance, defusion, self-as-context, values, and committed action.

12.1.4 ACT in Basic Terms

In this section, we will review a conceptualization of psychological (in)flexibility that has been developing over the last decade in terms of basic processes (e.g., Luciano et al., 2012, 2021a, b; Törneke et al., 2016). For this purpose, we will begin by pointing out how joy and suffering are generated in verbal human beings.

Table 12.1 Mid-level processes involved in flexibility and psychological inflexibility according to the hexaflex model

Psychological flexibility	Psychological inflexibility
Acceptance: Actively and consciously contact the private experiences occasioned by own history without attempting to change their frequency or form, especially when doing so would generate psychological damage.	*Experiential avoidance*: A regulation pattern characterized by conscious attempts to avoid or escape unwanted private experiences.
Cognitive defusion: Deactivating unwanted functions of thoughts and private experiences to change how the person responds to them.	*Cognitive fusion*: Acting according to the immediate functions of private thoughts and experiences.
Contact with the present moment: Nonjudgmental contact with psychological and environmental events as they occur.	*Dominance of the conceptualized past or feared future*: Focusing on events that occurred in the past or may occur in the future.
Self-as-context: Sensation of the self as locus or perspective from which one can be aware of the flow of private experiences without being attached to them.	*Self-as-content*: Attachment to private thoughts and experiences related to the self.
Values: Chosen qualities of purposeful action that cannot be achieved as an object but can be contacted moment by moment.	*Lack of values clarity*: Dominance of pliant rule-following (source of reinforcement is social) or avoidant tracking (actions guided by obtaining relief from discomfort).
Committed action: Actions linked to chosen values.	*Inaction, impulsivity, avoidant persistence*: Actions disconnected from valued directions.

Based on Hayes et al. (2006)

As is known, we are born with a series of positive and negative primary reinforcers, fruit of our phylogenetic history as a species. Quickly, through the interaction between classic and operant conditioning, initially neutral stimuli begin to be conditioned to function as secondary and generalized reinforcers. The development of the relational operants discussed above will cause a much wider range of stimuli to acquire appetitive and aversive functions due to the transformation of functions through the various relational frames (e.g., coordination, opposition, comparison, etc.).

The complexity of the construction of verbal reinforcers increases as fluency develops in the hierarchical relational framework. Numerous reinforcers with an experiential base, both positive and negative, will begin to be inserted into increasingly abstract hierarchical networks (Luciano et al., 2021b). For example, a 6-year-old child for whom relating to other children through play has become reinforcing may begin to relate these activities to more abstract concepts such as "friendship," and this concept will have a series of characteristics such as playing together, telling secrets, trusting or defending each other from dangerous situations. From this moment on, the act of playing with a friend will not only involve the previous reinforcing interactions of play, but the child will also be able to contact hierarchical appetitive functions related to "having good friends," "building a friendship," or "being able to trust someone."

This construction of hierarchical positive reinforcers causes the source of joy and satisfaction to become increasingly symbolic and abstract. These hierarchical reinforcers organize other, more tangible, reinforcers and alter their functions. It also sets up objectives and goals that allow getting in touch with and "advance in the direction" established by the hierarchical reinforcer (e.g., make friends with the boy who plays soccer well, go to summer camp with my best friends, etc.). Similarly, the main sources of suffering become increasingly verbal and abstract until, typically, a hierarchical network of negative reinforcers is established that relates in opposition to the network of hierarchical positive reinforcers (Gil-Luciano et al., 2019; Luciano et al., 2021b). In this way, the child in our example may begin to suffer from events such as the impossibility of going to summer camp because it will imply "not becoming a better friend of his friends" or feeling that a friend prefers to play more with another boy than with him ("he is not such a good friend of mine," "he trusts the other boy more," "he only wants to be with me when the other boy is not there," etc.).

So far, we have reviewed the emergence of hierarchical or higher-order appetitive and aversive functions. However, contact with these functions in the form of private experiences is transitory. Thus, it is worth asking why some people develop a personally meaningful life and others a life tinged with suffering of a symbolic origin. The answer to this question lies in how we respond to our own behavior, including our private experiences. Specifically, Törneke et al. (2016) identified two main ways in which we respond to our own behavior.

The first kind involves responding according to, or in coordination with, the immediate discriminative functions of one's behavior. When it has aversive functions (e.g., thoughts or emotions related to hierarchical aversive functions such as "I can't trust him" or feeling rejected), the immediate discriminative functions are avoidance/escape. By responding in coordination with these discriminative functions, the person would engage in some form of experiential avoidance to diminish or eliminate such aversive functions. This type of response becomes problematic when, through multiple exemplars, a dominant relational functional class (or purely functional operant) is formed through which the person focuses on obtaining negative reinforcement and loses contact with actions and functions linked to hierarchical positive reinforcers. This relational functional class is what we call psychological inflexibility in middle-level terms.

In many learning histories, this inflexible relational functional class is dominated by a pattern of thinking that seeks to diminish the aversive functions of private experiences by achieving certainty about what may happen in the future (worry) and coherence or explanation about what happened in the past (rumination). The problem with this reflexive thinking pattern (usually referred to as repetitive negative thinking, RNT) is that it tends to prolong and intensify negative affect, which often actualizes discriminative escape functions that lead to multiple forms of experiential avoidance such as thought suppression, alcohol consumption, self-injurious behaviors, binge eating, or suicide attempts (Brailovskaia et al., 2021; Caselli, et al., 2013; Hughes et al., 2019; Nolen-Hoeksema et al., 2007; Wells, 2002). Additionally, involvement in RNT has tremendously counterproductive effects (Ruiz et al., 2020).

In the first place, it increases the complexity and extension of the relational networks involved in this process, thus facilitating the derivation of new thoughts that will function as discriminative or triggers to restart the process. Secondly, the derivation level of these networks is reduced, thus producing greater speed and automaticity in a future RNT episode. Finally, continued RNT reduces relational flexibility, leading to greater difficulties in disrupting the RNT process.

The second type of response to one's own behavior is to frame it hierarchically with the deictic "I"; in other words, to note one's own behavior as a transient event from a broad perspective of the self that contains any past, present, or future experience. This hierarchical framing allows the person to contact functions related to hierarchical positive reinforcers and behave in accordance with them. As can be seen, this way of responding is considerably more complex, but also more flexible than the previous one and leads to behavior mainly controlled by positive reinforcement. This type of response becomes an adaptive behavioral pattern when, through multiple exemplars, a dominant relational functional class is formed that allows the person to contact and guide their behavior according to functions linked to the hierarchical positive reinforcers built throughout their history (Luciano et al., 2021b). This relational functional class is called psychological flexibility in middle-level terms. According to this conceptualization, the goal of ACT is to shape the relational functional class of framing one's behavior hierarchically with the deictic "I" or psychological flexibility. Törneke et al. (2016) proposed three central strategies for its shaping (see also Luciano et al., 2021a, b) as a guide, without implying any particular order.

Strategy 1. Help the client contact the problematic consequences of the inflexible pattern. The objective of this strategy is for the client to contact experientially with the consequences of their inflexible pattern. For this purpose, through questions, the therapist guides the client to discriminate: (a) the main private experiences to which they respond inflexibly, (b) the types of inflexible responses they put into practice and how they develop over time, (c) their short-term consequences in terms of usefulness in reducing discomfort and advancing in personally valued directions, and (d) the long-term consequences in terms of chronic and extending discomfort and hindering progress toward valued directions.

Strategy 2. Help the client frame limiting private events hierarchically with the deictic "I" as an alternative functional class. This strategy consists of encouraging multiple interactions in which the patient frames the ongoing private events hierarchically with the deictic "I." The main relational processes involved in this strategy are (Luciano et al., 2011, 2021a; Ruiz et al., 2021): (a) framing private experiences (thoughts, sensations, etc.) through deictic cues (I-Here feeling my experience there as something to be observed); (b) framing experiences through hierarchical cues (I contain the experience, experience is a part of me, it is just something transitory that I am experiencing, etc.); (c) deriving rules that indicate valued courses of action (contained in the higher-order functions of positive reinforcement) and providing a regulatory function to the hierarchical framing of one's own behavior; and (d) hierarchically framing the choice made (I am the one who can choose, I have chosen to "be in charge," not my thoughts/emotions).

Strategy 3. Help the client clarify and amplify values as hierarchical positive reinforcers and select actions contained in that motivational context. The work in this strategy consists of helping the client to: (a) establish and/or come into contact with the hierarchy of positive reinforcers that have been established throughout their personal history in connection with actions chosen for their quality; (b) differentiate actions connected with hierarchical positive reinforcers from actions controlled primarily by reinforcement provided by others (e.g., continuously acting to please others even if the behaviors themselves do not have a personally valuable quality) and actions focused on immediate reinforcement, but whose long-term natural consequences do not allow progress toward valuable directions (e.g., pressing the work team to achieve a goal even at the cost of generating an environment that favors the subsequent break-up of the team); (c) identify concrete valued actions that allow progress in objectives symbolically contained in the hierarchy of positive reinforcers; and (d) identify difficulties in carrying out valued actions, promoting their integration from a hierarchical perspective of the self and flexible action when facing them.

These strategies can be seen as angles to shape psychological flexibility and not as rigid phases to be applied in order. In fact, to enhance the effect of the intervention, the three strategies should be addressed together as soon as possible. In this way, the client will learn to: (a) frame the ongoing private event hierarchically with the deictic I, (b) discriminate the inflexible behavioral tendency and its long-term consequences, (c) contact the functions linked to own values, and (d) engage in the action that, at each given moment, allows them to advance in valued directions.

12.1.5 ACT in Psychosis

Psychosis is usually described as the experience of a series of behaviors called positive symptoms (hallucinations and delusions) that are usually accompanied by other behaviors that are considered negative symptoms, such as social anhedonia, flat affect, emotional symptoms, etc. From a traditional perspective, it is usually understood that hallucinations and delusions are symptoms that must be reduced or eliminated to improve the quality of life of the person who experiences them. However, from a functional-contextual perspective, the presence of these behaviors does not necessarily constitute a clinical problem (Bach, 2004). As we discussed in the previous sections, these private experiences, although they may be frequent, are still transitory events to which people can (learn to) respond in different ways.

People with psychotic symptoms show a clinical problem not because they hear voices, but because they act according to the content of the hallucination, ruminate excessively on it, or try to control its emergence, engaging in counterproductive experiential avoidance strategies (suppression, substance use, etc.). Similarly, the person who presents delusional ideas does not have a problem due to *experiencing* these ideas but because of *behaving according to them*. The fact that hallucinations and delusional ideas tend to actualize discriminative functions to behave in a

counterproductive way in the long run in people with psychosis does not mean that this necessarily has to be the case. Proof of this is that most people who experience hallucinations do not have psychological problems; they even tend to evaluate them as positive experiences. Similarly, the presence of ideas that do not correspond to reality is frequent in the general population (Oltmanns & Maher, 1988; Tien, 1991). As for negative symptoms, these are usually consequences of chronic experiential avoidance and the absence of behavior motivated by hierarchical positive reinforcers (values).

The goal of ACT in psychosis, as in any other problem, is to promote flexibility in how the person responds to hallucinations and delusions so that they can direct their behavior toward valued directions rather than in an unsuccessful struggle to reduce the aversive functions of these experiences. There are also pragmatic reasons to consider the increase in psychological flexibility as the objective of intervention in psychosis, given the high resistance to change shown by hallucinations and delusions and the tendency to reappear after periods of remission (Bach, 2004).

ACT work on psychosis does not deviate significantly from the typical implementation of this therapy. It is advisable, however, to bear in mind that it is probably necessary to implement strategies to facilitate the development of the intervention according to the intensity of symptoms, cognitive deficits, and communication skills (for more detail in this aspect, we refer the reader to O'Donoghue et al., 2018). We will discuss the path of clinical work in the next sections of this chapter.

12.1.6 Empirical Evidence of ACT in Psychosis

ACT has been evaluated as an intervention in psychosis for the past two decades. Specifically, the recent systematic review conducted by Jansen et al. (2020) found seven randomized controlled trials in which ACT-based interventions were tested in the United States, the United Kingdom, Canada, Sweden, and Australia. Although the results should be considered as preliminary, ACT has shown better results than treatment as usual in terms of rehospitalization (Bach & Hayes, 2002; Gaudiano & Herbert, 2006; Tyrberg et al., 2017), positive symptoms and discomfort related to hallucinations (Shawyer et al., 2017), and negative and emotional symptoms (Gumley et al., 2017; Spidel et al., 2018; White et al., 2011).

12.2 ACT Approach to Psychosis

12.2.1 Clinical Case: Ernest

Ernest, aged 47, comes to the consultation accompanied by his mother. He presents a report from the psychiatry unit with a diagnosis of Major Depressive Disorder of psychotic characteristics and recurrent episodes. But who Ernest is, what his

suffering is, what he longs for, and what personal history surrounds him go far beyond this diagnosis.

Ernest spent his childhood tied to his mother's apron strings. This was his compass for what he did and why he did it. From his early years, he forged an intense dependence on his mother, as well as multiple widespread fears. His parents provided him with a constant context of protection from the world. His adolescence followed the same progression as his childhood, aggravated, among other things, by the characteristic complexity of interpersonal relationships at this stage. Also in this area of his life, his mother continued to direct his actions in his choices, for example, the how and when of his dealings with his peers and friends; as well as with girls. When his mother did not directly intercede in how her son could or should handle the things that happened to him, Ernest himself displayed the pattern of caution and cowardice developed in his childhood. On the other hand, his parents tried not to make excessive demands that he engage in his responsibilities – studies and household chores. They let him do whatever he felt like, trying to reduce any possible discomfort for him. In any case, he was not a bad student and finished his High School studies, without showing interest in any of the subjects or higher studies.

At the age of 18, he began his working life. He began working on his first and only job. His parents got him a post in a car factory located very close to home. In general, interacting with people other than his parents was difficult and uncomfortable for him, so he remained quite apart from any social life. At the age of 20, he had his first and only sexual relationship, which was traumatic for him because he was unsuccessful due to premature ejaculation and the girl's reaction. It happened in the bosom of an old group of classmates and friends, and the girl told them what had happened, mocking Ernest along with the others. From then on, he began to reduce attempts to socialize beyond what was strictly necessary, convincing himself of how complex and aversive human relationships were for him. Later, during most of his adulthood, he used to share very punctual moments with a group of coworkers with whom he shared some hobbies (running or role-playing championships). In his free time, he tended to immerse himself in the world of online video games, a world of fiction and fantasy that, as when he was a child and read, removed him from reality and transported him to a world of brave people.

Although comfortable and fluid in his work (operator on the assembly line), the monotony, solitude, and reduced intellectual demand of this job were gradually creating the conditions that led him to spend much of his time ruminating on his frustrations, worrying more and more about the future. His adult years passed without there being any more advancement or progression in his life except for time. From home, he went to work, and from work, back home. His mother did the household tasks and general chores (shopping, errands, paperwork, medical appointments, etc.) for him. At the age of 37, Ernest went to live alone in an apartment located very close to his parents' house through a real estate offer his father managed to achieve. His mother, however, continued to organize and do things for him. At the age of 42, Ernest began to request a series of sick leaves due to depression and decided to return to live with his parents, encouraged by his mother. In these circumstances, the

company decided to terminate his contract and fire him. At that time, his mother was also diagnosed with a degenerative disease.

At this circumstantial point in his life, he began to have obsessions and ideas about catastrophes of all kinds and he also began to implement increasingly limiting behaviors. Suddenly, in his forties, Ernest came up against a feeling of helplessness, of facing an uncontrollable abyss, and a terrific fear of what might happen. These were feelings that, historically, all his life, he had managed to keep at bay through his way of functioning, but, now, they were triggered after losing his only job (of 27 years duration) and the detection of the degenerative disease of his mother, his only source of guidance, support, and protection so that nothing bad would happen to him. His greatest concern became very vivid: what did the future hold? who would take care of him? how was he going to survive?

Continuous thoughts and rumination surrounding the fear of being helpless began to take over his life, day and night. Thoughts about global and personal catastrophes became increasingly repetitive. He felt an intense fear due to the experience of these thoughts; he felt that some danger lurked at any moment. Through the Internet, he reached pages with examples about the causes of thoughts of this type, and the level of anguish and limitations they could produce, such as, for example, noticing "strange forces" that exerted mental power over people. He began to develop dissociative behaviors, complaints, laments, bodily states of very intense tension and, in the tensest moments, he began to appear on some nights in his parents' room with a kitchen knife (which he never seemed to remember the next morning). After episodes of great alteration, he would spend several days sleeping. He said that he noticed his thoughts aloud ("voices" of "cowards and brave people" who fight) and, after the increase in extreme behaviors and even idealizing suicide, the situation led to consulting a psychiatrist and the prescription of antipsychotics and cognitive-behavioral therapy, which he attended for a year and a half. The systematicity of the most problematic behaviors and the frequency of the "voices" were reduced. Following the psychological intervention, after his mother fell down at home, Ernest returned to the previous frequency of obsessions and severe behaviors. He refused to resume the previous intervention, and the mental health unit decided to refer his case.

The intervention that will be presented herein began at that point. At the time of the consultation, he was receiving an assigned financial benefit for mental disability, he continued living with his parents (who were very worried and worn out), and spent most of the day playing online video games, sleeping, and lying in bed ruminating, and talking aloud with his thoughts.

12.2.1.1 Functional Case Conceptualization

The pattern of psychological inflexibility, gathered from the information from the functional assessment, is described below.

Ernest had a very strong pattern of psychological inflexibility that was very limiting. Since his childhood, he had received a context of continuous caution about the

dangers involved in the interaction with the world and with others, and constant support and help in the face of the slightest challenge, constantly deciding and doing things for him. He looked at the world and interacted with it through his maternal figure, directly or indirectly. He did it based on rules he had learned about the world, others, and himself. Of all of them, the one that seemed the most limiting was that "he was *incapable,"* thus, he needed *others* (until then, his mother) to show the way and set the favorable conditions to function and to avoid discomfort in the face of loneliness and uncertainty about what might happen. From this rule, other rules emerged, "The world is a dangerous and unsafe place, do not trust people's intentions," "The most important thing is to be calm and without upsets," "If something is difficult and involves a lot of effort, it might be bad for you, do not do it", "I am a person with a disabling disease, I have limitations," and so on. Frustration and fear of being helpless had been slowly and progressively emanating from the costs of the way he lived his life. The most problematic outburst occurred when his greatest fear became very present. The possible loss of his only source of support, security, and guidance (his mother), and losing the only support he had ever had, brought to the present the most aversive private events for him.

In the presence of such an intensity of suffering, Ernest resorted to his pattern of escape and avoidance, connecting his fears with thoughts of possible catastrophes. In this context, he began to consider his thoughts as *unbearable* "voices," external to him, in the face of which he resorted to increasingly limiting and greater escape and avoidance behaviors. His emotional lows in the face of these contents and his struggle to avoid discomfort produced a context of incapacity and anomaly directly associated with his history of overprotection and dependence, sustained by formal diagnoses of psychotic symptomatology and depression. This context chronified the coupling of his rules about the world and himself, multiplying them while increasing his discomfort, and he adjusted his responses to try to reduce it. Psychotropic drugs and psychological treatment to modify these thought networks reduced the "voices" and catastrophic thoughts and also the most dangerous responses of his limiting pattern. However, these changes took place apart from vital advances and progress that would have allowed him to build a pattern of interaction with himself that was effective in the long term, both in his facet of work and in the field of interpersonal relationships (friendships, possible partners, family, community …) and of personal care.

Ernest's pattern had come at a very high cost in interfering with his deep desires and interests, as will be seen later in the investigation of the pattern of inflexibility in the intervention process.

In the face of these rules, his pattern had been to keep clear from vital advances and progress, both in the area of his occupation (studies, work, various responsibilities) and in interpersonal relationships (friendships, possible partners, the possibility of starting a family, the social community in general). Overall, the pattern of psychological inflexibility in the functional X-ray shown in Table 12.1 of the following section can be seen in greater detail.

12.2.2 Approach to Contextual Therapy

The objective of ACT is always the same, no matter the profile of psychopathology, as, in all cases, the therapist's behavior will be adjusted to the patient's behavior with the same purpose: to build a repertoire of psychological flexibility. This is defined by interacting and responding to the thoughts and emotions that occur in each circumstance under the motivational function of value or personal meaning. As explained in the introductory section of the chapter, ACT has been presented in various ways over the last twenty years and, also, basic-applied research has shown part of the relational processes that are involved in the work carried out by the therapist and the patient (see the texts recently published in Luciano et al., 2021a, b). In this chapter, we will follow the trail of the processes or principal elements detected in the process of change. We will not delve into these processes here but instead, we will present the summary of the intervention following the three strategies that, as a whole, are oriented to build – or enhance – the pattern of psychological flexibility. (1) On the one hand, interactions aimed at helping the patient experience their pattern and limiting consequences will be presented, while opening a horizon of personal meaning. (2) On the other hand, interactions aimed at helping the patient to generate a space or observation point that allows them to experience their own behavior without becoming fused to their private events. (3) Furthermore, those strategies aimed at amplifying the central motivational function of personal life.

It is important to emphasize that the three clinical strategies of contextual therapy are not subject to any particular order, but instead, therapists can make use of them through multiple tools, adapting them elastically to their purpose. This is none other than to promote examples of flexibility so that a flexible pattern of responses is built, crowned with motivational functions of personal meaning. The clinician may choose to use multiple tools through physical exercises or imagination, metaphors, and variability in their interactions with the patient. The elasticity of the therapist's repertoire is aimed at producing flexibility in their patients. That is why a single or closed protocol will not be valid but instead, the action protocol of ACT is defined by its variability to adapt to the variability of behaviors that each patient will deploy in response to the therapist's behaviors.

Patients with a history of chronicity and inflexibility that impacts considerably their functionality usually require initial work on very basic skills to begin to "detach" from their own behavior. For example, in many of these cases, the degree of psychological inflexibility present in the session is so high that the therapist has to intervene to facilitate a minimum level of patients' detection of their own behavior. Thus, having produced some level of flexibility in session, the conditions would be established for other more complex clinical movements that allow the patient to detect their rules, their way of functioning, take charge of the effects of their pattern, and open and amplify horizons of personal meaning. In any case, both initially and later on, the intervention will revolve around generating flexibility in the face of private events (rules, emotions, etc.) that were triggering rigid and fused reactions. In the following sections, we will show the general lines of the process followed with Ernest.

12.2.2.1 First Steps to Produce Psychological Flexibility

Ernest's profile met the characteristics that we have indicated at the end of the previous section. For example, his behavior in session varied between examples of problematic behavior formally identified as manic episodes, dissociation when conversing with his symptoms, self-aggressions, emotional instability, etc., to which were added very reduced communication skills, and difficulty in maintaining attention. Whether due to the interference of the high degree of psychological inflexibility, or the effects of medication, these repertoires become the central point of the initial work. Inevitably, it becomes necessary to adapt each tool to build flexibility in the patient's behavior in such a way that, as in this case, very active short phrases and physical keys, and brief movements are used to catch the patient's attention. That is, interactions that, in other cases, could be redundant.

As mentioned at the beginning, the flexibility to be built in the face of thoughts-voices, delusions, hallucinations, and any private events of a very intense nature will alter the patient's relationship with them, how he responds, and what he pursues with it. From the beginning of the intervention, Ernest resorted in session to dissociating, ruminating at full speed "on a loudspeaker," crying uncontrollably, or self-harming (scratching wounds that he had made previously) when something evoked uncomfortable sensations and thoughts. At such times, it is very easy for the therapist to go into an orbit in which he can easily be influenced by the strong impact of some of the patient's behaviors, but he should take advantage of them to alter their function *in situ.* From the beginning, the therapist asked permission to work in a way that was most useful to the patient, warning him that he could interrupt at any time. In addition, the patient was ensured that the therapist would be with him, by his side, so that he could feel whatever he felt and think whatever he thought. In this context, the relationship between patient and therapist was marked by the integration and validation of all the thoughts and sensations that emerged, as a context of value that sustained the intervention.

When Ernest issued any of the behaviors indicated in the previous paragraph, movements were made aimed at making him respond flexibly. For example, (a) they sought to alter his inflexible behavior by directing the stimulating control towards the therapist, reminding him that (the therapist) was there with him, while he felt whatever he felt, and directly asking him to focus his gaze on the therapist, to focus on his voice, to feel his arm resting on the armchair, his feet on the ground, etc.; (b) maintaining his attention on the therapist, he was asked to say what he was feeling or thinking, the location of parts of his body right there, what he saw in the room, what those thoughts or emotions suggested; (c) through the patient's responses, he was trained to discriminate the context of who experienced those thoughts, who noticed them, along with the variability of private events, noticing that there were many sensations at that moment that he could feel, and that he was there to decide what he paid attention to and how he wanted to do it. If appropriate, (d) a flexible action was trained at that moment. Finally, the contingencies of having done so were noted.

These movements constitute one of the basic strategies of contextual therapy called, in mid-terms, defusion. As indicated in the introduction, they allow generating a space between oneself and one's private events to be able to turn one's attention towards actions that have a more relevant meaning. The literature of ACT and other contextual therapies offers numerous keys that can have the same function and which is none other than to generate, through different trials of this type (multiple trials), the foundations to build psychological flexibility in the face of painful or threatening content for the patient. Following the principles of discrimination, work can be initiated through neutral examples, that is, promoting neutral private events in deictic and hierarchical discrimination and, little by little, incorporating or provoking others that could provoke aversive or appetitive functions due to the patient's history.

Ernest was learning this repertoire. Multiple examples were made, either flexible or inflexible examples, as a way to build flexibility around private events. The frequency of flexibility began to increase, and this context cleared the way to work on other points, such as beginning to face the ways of coping he had used– and continued to use– on many occasions, and the interference that they had produced till now. This context opened the horizon to delve into how he could reorient his life, and on which personal meaning to base it.

12.2.2.2 Ernest, Caught in the Story About Himself

Gradually, the therapist began to help Ernest to contact his inflexible repertoire more broadly: what other ways did he have of dealing with his uncomfortable emotions and thoughts, what was their outcome, and what had been their outcome in his life, and whether they had interfered with something that was, or could be, relevant for him. This strategy is encompassed in the functional analysis and aims to help the patient become aware of the effects of their inflexible repertoire. Examining what his life was like now and what it had been like prior to these last years, Ernest stated that he missed his job and daily routine, and even his own space, like when he lived alone. Delving into what things he missed the most, he went on to point out that feeling useful and capable had been the things that he valued more than any other feeling. When asking him to compare in detail examples of situations in which he had come to feel something like this, Ernest broke down in a session, sobbing, and said that his biggest problems had always revolved around feeling weak and unable to live his life like everyone else seemed to. He spoke of his inability to identify and carry out valuable life goals, stating that "If at least I had something to hold on to now, maybe I would feel stronger about what is happening to my mother…" It was painful for him not to have been able to reach an intimate relationship with anyone except for his parents (including the possibility of having a partner), to have traveled, and to have developed in a more interesting job. They began to identify the private events that were old acquaintances when it came to setting up a barrier to opening up, like he said, "living outside the box." His history made him control those contexts and situations that would guarantee the comfort and security of not

feeling threatened at all times. Underneath that was a central rule, about himself, as someone who was *unable to survive in conditions (feelings) of weakness and vulnerability*, therefore, *he had to escape and avoid contexts that generated them*. His family history would have been decisive to generate the armor of avoidance with which he walked through life. The conceptualization of the case presented in previous sections incorporates the information collected during this process.

Contextual therapy does not try to break the patient's coherence concerning the history they learned about what they *are* by discussing it and trying to modify it. Instead, it addresses the futile result of always behaving according to that history and the patient's own experience. Thus, the patient's most limiting ways to remain safe and sheltered from his feelings of incapacity and vulnerability were incorporated into the therapy. Figure 12.1 shows the functional schema of this pattern. Functional analysis movements are most effective if they are performed experientially, that is, taking advantage of clinical behavior *in situ* (when an example of the inflexible pattern is occurring in session) and leading the patient to contact the presence of their inflexible rules (private events), way of responding, and consequences. These movements will have to be repeated throughout the intervention because discriminating the pattern requires multiple, infinite examples in which it manifests to unify them as a problematic functional class. The objective is for the patient to manage to abstract the discrimination from his general tendency to behave under the mandate of the rigid rule prevailing according to his history. This, with care, allowed establishing the conditions to begin to move, with little big steps, in another direction.

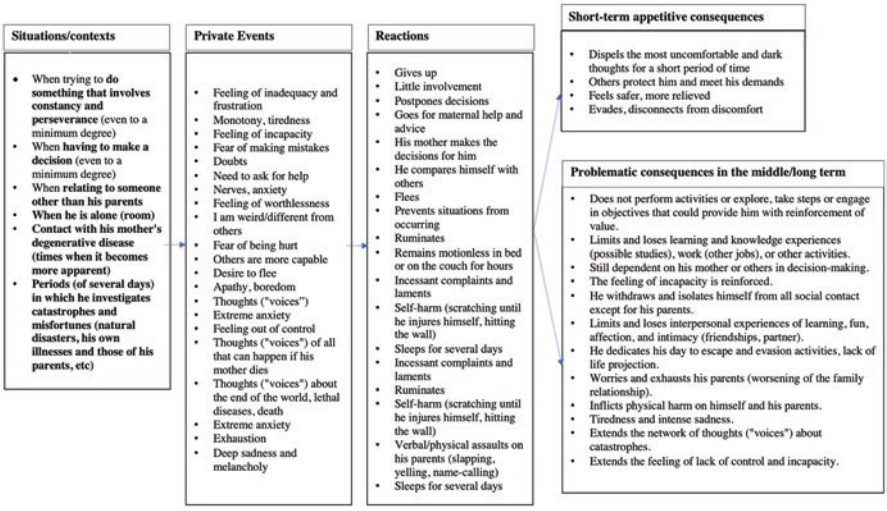

Fig. 12.1 Functional analysis of Ernest's pattern of psychological inflexibility

12.2.2.3 Investigating and Situating a Context of Meaning and Personal Value

Ernest had great difficulty not only making decisions, as he insisted, but also taking the initiative and exploring new paths. He did not find within himself what he wanted to do with his life but, instead, his answers were diluted by what his mother had insisted on throughout his life: avoid the evils that occur in many places and try to guarantee safety. Any possibility of exploring was stopped in its tracks by difficulty, effort, and fear that something would happen that would hurt him. This way of functioning had prevented contact with the natural contingencies of any interpersonal, academic, and labor process, or any other learning process. His need for his mother's support and guidance, or other sources of help, had been an inescapable link in his life. The process of contacting this mode of functioning began to make a dent in Ernest, to the point of beginning to consider "breaking the chains" with the avoidance armor he wore everywhere. He wanted to "live," but the private events in the face of what that could include were overwhelmingly present in session. It was necessary to delve into the motivation so that he could take charge of such fears.

Ernest felt that he was a person with a very low-profile life, a life that did not satisfy him and that produced a high level of frustration. Much of his frustration emanated from somewhere, and that place is usually made up of not cultivating something, of not living the life one would want—even if one had never tasted it. In one way or another, these are motivations of personal meaning; sometimes remote and sometimes derived, even from the omission with which one has lived. Motivations with true personal meaning are the directions of value and the drivers of behavior. Without exploring, amplifying, and continuously making this driver present, clinical change is unlikely and is not maintained over time. Patients with a history in which the context has been rigid in promoting rules and contingencies that match their adherence, accompanied by the corresponding derivations, are patients who learn inflexible behavior that becomes chronic over time. That is, it is not chronic patients, but chronic contexts that select one or another type of functioning. These are patients who have difficulty knowing what interests them, what they would like to do, what they would like to address, what trail they would like to follow to its end. Ernest's life story had not followed trajectories that were valuable to him, but were instead guided by the avoidance of fear; even less so since his entry into the "circuit of the diagnosis of psychotic mental illness." His fears, weakness, and incapacity, together with the suffering multiplied by the psychotic diagnosis, had acquired considerable strength and taken over the foreground to direct his life. Far, far back, diffuse, forgotten, or perhaps nonexistent, there was the possibility of doing something useful, of realizing some dream, and of functioning with some freedom.

A central premise derived from the basic-applied knowledge of RFT is also the premise in ACT that "something of immense value is at the epicenter of all suffering." The work on values in contextual therapy is not only based on exploring objectives or goals but fundamentally on the motivational context that gives meaning to the steps or actions. Therefore, the reinforcement of action lies in its meaning of

value, especially when private events of considerable discomfort concur, such as those habitual ones in the case of Ernest. The process carried out to bring him into contact with such positive reinforcers of personal meaning also made Ernest come into contact with his inflexible pattern and its consequences: he said he felt trapped in his self-humiliation because of his dependence on his parents and his aggression toward them in moments of intense suffering when he felt useless, with nothing to do and no plan for anything, including establishing personal relationships. In contrast, the therapist's questions allowed Ernest to contact something deeper in himself and to indicate that, if he could, he would really want to be *useful, independent, loving, and brave.*

Multiple examples were practiced in session in which Ernest faced making small choices and carrying them out as if they were acts of courage and independence. It did not matter if they were significant actions but, instead, their significance lay in the fact that they were chosen, that he had to choose between two or three options, and he chose one without guaranteeing the result, he performed it, and exposed himself to the consequences. Soon it included exploring moments in his life to carry out actions guided by choice, courage, and independence, especially some actions that he performed under the custody and mediation of his mother. On the one hand, these steps were decisive, as he himself indicated later, in the learning process to build a new repertoire selected for contingencies of personal value. On the other hand, other steps began to be taken when teasing out the importance or meaning of Ernest's hobbies, past and present, no matter how insignificant they may seem to him. For example, concerning his preferences and their rationale, whether it was his favorite foods, video games, type of books, type of people, conversations, or what he was like that pleased him; the high school subjects that had captured his attention and why, and so on.

The exploration was not aimed at knowing formal details but, instead, trying to get Ernest to identify and experience what was of value at that time, even to imagine doing something in that direction and to feel whatever he felt. In other words, the exploration is carried out by investigating the quality of those interests that Ernest formulated and the actions that they implied. The quality highlighted the value reinforcers, while also allowing to know what dominance they might have in the face of problematic feelings and thoughts. The ACT literature is replete with questions and interactions that lead to these goals. For example: *"What do you like about what you are saying? Can you bring any of that here, what it made you feel? When you say that you have fun or that you enjoy reading that book, what is it that makes you enjoy it, what is in that story that grabs you so much? You say that you are caught by that character because he investigates and takes risks …, what moves you when you are reading that he takes risks…?* Many of these questions are aimed at teasing out the feelings attached to the peaks of the reinforcers with personal meaning, to try to get the patient to contact, right there, the functions that come from actions performed, or possible future actions.

Gradually, a possible map was drawn with Ernest. The guide, or compass, were broad-spectrum motivations to which uncertainty and fears were inevitably linked.

Ernest wanted to be independent, helpful, loving, and brave. Later, he discovered other qualities, such as his interest in learning, or being diligent.

One move that proved useful was to create a metaphor with Ernest that could encompass all those qualities that he was discovering. To the question*, what might you look like if you saw yourself being brave, independent, diligent..?* he replied that it would be like being *"an eagle,"* mainly because of its freedom of movement and bravery. From there on, to aim every day to promote an "*Ernest-eagle"* was placed as the global horizon of work; a free, independent, useful, courageous Ernest, and so on. The metaphor started especially from his love of literature. He professed a true passion for adventure books. As a child, he had been passionate about reading and had continued this passion, also through video games. As a child, he recognized himself taking refuge for hours in books and adventure comics, which took him to parallel realities in which he enjoyed himself and admired how the characters challenged themselves until they managed to save themselves, or save others. In session, he was asked to tell some of these stories to explore possible reinforcers of value in reading, and evaluate possible extrapolations that could be found in some work or personal relationship. Through several movements like this and multiple exercises, a repertoire of discrimination of what possesses personal meaning was gradually sharpened, which Ernest recognized at the base of *his* identity.

This work involved the constant integration of the multiple thoughts and feelings that acted as barriers. Feelings of worthlessness, incapacity, shame, and failure *appeared* when exploring and amplifying actions with quality or value. However, the therapist did not engage in conversation with the patient's private events. Instead, he made him notice them, validating them, and placed Ernest in the perspective of his thoughts or emotions and actions. After this, the patient was asked for permission to *(up)hold* those feelings and continue to explore the value that could be located at the core of his pain or his fear.

The Ernest "*eagle*" dreamed of being able to have some job or occupation in which he taught children stories, either by reading them or teaching them some skill related to writing and imagination. On a personal level, he dreamed of being able to have a child and, beyond that, share that experience with a partner. He wanted to go back to living alone and contributing to his parents' support and security, rather than being a source of concern for them. He wanted to be more physically fit, to resume *running* (which also generated "eagle sensations": freedom, utility for the reward of effort…). This activity also used to be shared with colleagues from his previous work, and resuming the relationship with them was also something of great importance for Ernest, as it had been his only social source beyond the family.

Parallel to the systematic work of the experiential discrimination of the destructive function of his avoidant pattern, allowing contact with the consequences generated in the short and long term, several phases were organized in the intervention. We worked with Ernest on the "eagle" project at various times; always through personal choice, encouraging:

1. Contact with *value, independence, and affection* by reducing aid from his parents in basic domestic tasks: lunches, dinners, cleaning, and personal hygiene.

2. Contact with *courage, value, and independence* by helping and teaching children, collaborating with a children's volunteer association for children in need.
3. Contact with *affection, courage, and independence* when resuming the relationship with former coworkers, running, and other activities (with others or alone).

In the course of the process, Ernest drew future steps under the umbrella of that new Ernest: learn to drive, give support classes to disadvantaged children in reading and writing, become independent again in his own home, create a profile on dating websites, etc.

12.2.2.4 Clinging to a New Anchor in the Face of Emotional Relapse

During the process, emotional swings were an inevitable constant in the face of the strength of the sole and inflexible pattern of functioning. The therapist responded to the emergence of any of these emotions and thoughts with validation and invited the patient to relate to them inclusively, while making present whatever made personal sense. In the face of chronic patterns, it has been previously described that the whole process will be a constant dance between noticing inflexible examples and promoting flexible examples. What we present in this last section is the approach to an episode of relapse after several weeks, in which Ernest had begun to be present with his threatening thoughts, willing to feel his anguish *("in the form of a black fist, oppressor, in his chest,"* he verbalized), and breathe deeply while opening his eyes to focus on the small (but large) actions he had committed to doing.

The strong episode of relapse occurred in the wake of an interaction with his parents, in which his mother complained about Ernest's refusal to let her do things for him, as she had always done. For his part, his father reproached him for making his mother suffer despite her difficulties and warned him that he would always be a sick person who had to be cared for, that he would never be responsible because he had never shown courage. Ernest's worst thoughts were present.

Within seconds, Ernest entered a state of extreme anxiety to which he reacted by giving voice to his threatening thoughts, and to his old voices that *"he would do something bad if he didn't control his anxiety."* Ernest escaped to his room, shouting at his voices, and took an overdose of antidepressants. The episode ended with a mental health notice and transfer to the hospital. After a week, Ernest came to the session desolate, very depressed, and assuming that he could never lead another life, that he was condemned, and that he had thought about taking his own life again.

The possibility of a relapse is normal with long inflexible trajectories of patients like Ernest. On the one hand, in a contextual/functional view, relapses are *part of* building a new pattern. In fact, learning to live is not learning not to fall, but learning to *fall and get up*; that is our condition. On the other hand, contextual vision in therapy does not assume that building a pattern eliminates the previous one. Building a flexible pattern reduces the likelihood of inflexibly reacting to emotions and thoughts, but that requires a lot of training. Even in high doses, there may always be a time when the meaning of personal value could be clouded and, then, the patient

may respond guided by the emotional obstacles present at that time. The need for practice in the flexible pattern, of multiple examples to build it, is something known at the level of basic research. Any pattern is an operant that is only constructed from multiple examples (see Luciano et al., 2021a, b). However, patients like Ernest, who carry a backpack of life defined by an inflexible pattern (that is, a functional operant that is not useful to them in the long run, even if it is useful to some degree because of its coherence), will need to take charge of the effects of relapse more than other patients and recover the rhythm of the flexible pattern at those moments.

Relapses like Ernest's produce stirrings of discomfort and thoughts of uselessness in the therapist. However, it is appropriate to apply the same medicine that the professional has to apply to his patient and react by showing his regret when noticing the patient's regret for what happened. In this case, what Ernest felt was validated, and an attempt was made to normalize his thoughts by remembering, once more, that living entailed this possibility: to feel even worse than at the beginning.

At first, Ernest said, *"I had no hope, I thought there was no solution... then I saw that there was a spark of light in the darkness... but, suddenly, everything has become much darker than before."* He argued that both the patient and the therapist were "wrong," and that ending his life would be the true act of bravery. The therapist sustained his own emotions upon hearing that and shared them with the patient. At the same time, he shared with the patient his joy at seeing him there, whole, showing his emotions and everything he thought. He invited Ernest to stop, to let the air flow between so many emotions, telling him to breathe deeply to feel whatever they had to feel right there, both of them. After a few minutes, he asked Ernest to look at him, Ernest burst into tears, and the therapist invited him to hold all that inside him, like weights that are put on us and are floating in us. And they remained that way for a few more minutes. In the end, both of them stated that they felt at a common point to *continue* working on building more flexibility.

The context of value of the interaction has been summarized by emphasizing that both therapist and patient are verbal human beings, who think and feel. The contextual therapist's way of being in session is to include their own private events, wrapping them in the value of what is important in their work – building the repertoire of flexibility in their patient. This session was one of the most important for Ernest in the direction of starting to be *another* Ernest.

12.3 Conclusions

Contextual therapy, or ACT, tries to break the patient's relationship with the problematic impact of their personal history, that is, with the thoughts or emotions that act as a barrier to a vital journey with meaning and personal value. In the chronic patient, as is often the case with a psychotic profile, the private experience of some private events called "psychotic" invites them to behave in very limiting ways. Progressively, the vital journey of these patients is directed by contents of the Self that revolve around disability, dependence, and weakness, forming a pattern of

inflexibility that perpetuates and amplifies these private events. Contextual therapy affects the rupture of the pattern in the same way as in the face of any problem; adjusting the intervention process to the initial repertoire of psychological inflexibility of the patient in session. The refinement of contextual therapy based on the basic-applied research of the last decade allows focusing on three movements or strategies in the work towards the patient's psychological flexibility. Presented throughout this chapter, they involve an enormous elasticity that the therapist can use to adapt them according to the requirements of the context of each patient's repertoire. The purpose and the ultimate definition of building psychological flexibility is nothing more than to generate an alternative, flexible, and adaptive way of traveling down vital pathways that make sense and have personal meaning. Through the (necessary) emotional ups and downs of the intervention process, flexibility means that patient and therapist work in the same direction through multiple examples that make up a new repertoire. A new way of working, a course towards the lighthouse, explored and amplified, of personal meaning.

Disclaimer Clinical cases presented in this chapter do not include real names or personal information of real persons.

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