# Chapter 13
# Acceptance and Commitment Therapy for Recovery from Psychosis

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## 13.1 Introduction

Finding purpose, meaning, and personal identity can be a long-term challenge for people who have experienced psychosis. Life can be impacted by unusual, distressing, and preoccupying experiences, along with challenges associated with negative symptoms such as amotivation and emotional flattening. The experience of attention, memory, and executive deficits may further increase difficulties in daily living. People with psychosis, their families and carers, as well as health practitioners, have identified psychological approaches as an important component of care and in supporting personal recovery. For some, it is a preferred alternative to the dominant medical paradigm where medication is the focus. Importantly, such psychologically-informed care and interventions should keep in focus the needs of the person and promote personal recovery (Leamy et al., 2011).

This chapter will outline how Acceptance and Commitment Therapy (ACT: Hayes et al., 1999, 2012) has been developed to support the personal recovery of people with psychosis. ACT is a contextual, third-wave cognitive-behavioural

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therapy that presents a broad model for supporting the wellbeing, functioning, and quality of life for people across a diverse range of situations and experiences of problems. The ACT framework provides ways of understanding psychological distress, highlighting how people can respond to their life situations and inner experiences in ways that result in them becoming trapped and stuck in their suffering. It also suggests which psychological contexts may assist in helping people to find agency and purpose in responding to these circumstances, so that they break free of behavioural patterns that are unworkable. The ACT model suggests there are common processes across problems and disorders that can be attended to, to support people in making changes in their life. We will outline below how this general transdiagnostic model of psychological functioning can be extended to understanding the problems of psychosis and help inform pragmatic and effective ways of helping people pursue personal recovery.

In this chapter, we aim to provide the reader with an understanding of how ACT has been adapted for the needs of people with psychosis, including the key processes and goals of the intervention, modifications made to tailor techniques and language, and the formats that have been subject to empirical research thus far. We will outline the guiding principles of ACT for psychosis and provide several illustrations through case examples of how ACT can be used as a framework to support a person's recovery from psychosis. Finally, we will conclude with considering what are likely to be the next steps in the development of ACT as an intervention for people with psychosis.

## 13.2 Acceptance and Commitment Therapy

Acceptance and commitment therapy is a model of psychological therapy that seeks to change the relationship with unwanted experiences to promote increased valued action as a means of increasing quality of life and purpose. ACT has emerged from contemporary research and theory in behaviour analysis, developed as a cognitive-behavioural therapy informed by an operant learning account of language and cognition known as Relational Frame Therapy (Hayes et al., 2001). ACT emphasises skills in present moment awareness, active acceptance, mindfulness, and connection with chosen life direction (values) to help people to approach and engage with current challenges. ACT is based on the psychological flexibility model, a transdiagnostic framework that hypothesises that many challenges and problems are amplified through rigid and narrow behaviours that may serve purposes of controlling and avoiding unwanted emotions, sensations, and thoughts (experiential avoidance) or be guided unhelpfully by rules, expectations, and narratives (cognitive fusion), at the cost of responding effectively to what situations afford. The maintenance of problems through narrow and rigid behaviours performed repeatedly and seemingly less influenced by the long-term consequences is an important target of ACT, which aims to help people to make greater contact with the present moment, be open to the experiences they would usually seek to control and step back from the thoughts and stories that usually guide them, in order to connect with

longer-term consequences for their behaviours (usually in the form of chosen life directions, or personal values). ACT therefore necessarily involves experiential learning, curiosity about experience, and awareness.

In ACT, the therapist encourages the client to bring a pragmatic perspective to bear in considering how their behaviour works in situations, having greater awareness of the costs of actions, both short-term and long-term, particularly in circumstances where the person's behaviour seems to serve purposes of experiential avoidance or is driven by cognitive fusion. The client is encouraged to consider whether their behaviours are resulting in them being able to act like the kind of person they would like to be, and if not, to consider what may be barriers to acting this way. Through problem-solving and reflection, the client is encouraged to consider whether active acceptance of unwanted experiences may allow for greater focus on doing things that are more aligned with their personal values. In these ways, the client is encouraged to notice their own lived experience of what works and what doesn't, judged by whether these ways of responding to situations let them act more consistently with the kind of person they would like to be.

The philosophy of science that underpins ACT, functional contextualism, provides a pragmatic perspective: what is considered true is what helps to advance a person's goals. Thus, actions, but also perspectives and narratives, can be evaluated within this framework, as to whether they help to serve the person's purposes in achieving their goals. It is not the presence of these experiences that matters. It is what the person does with them which is focused on. Rather than controlling or avoiding unwanted experiences, clients are encouraged to explore whether there is the possibility of acknowledging and reframing these as part of the experience of doing something that matters. Recasting unwanted experiences as something which is part of doing what matters is key – through making a moment be part of something, such as personal direction, there can be the possibility that different behaviours may occur, or that the client approaches the moment with curiosity, openness, and self-compassion.

ACT is an evidence-based psychological therapy. Meta-analytic reviews demonstrate that ACT is as effective as other CBTs (e.g. Ost, 2014; A-Tjak et al., 2015) and there is also a wealth of experimental, descriptive, and processes-based research providing support for the broad psychological flexibility model and the treatment components (Gloster et al., 2020). Moreover, the basic science account of language and cognition – relational frame theory – is showing empirical support and appears to be generative in terms of experimental evidence and applications (Dymond & Roche, 2013; Montoya-Rodriguez et al., 2017).

## 13.3 Acceptance and Commitment Therapy for People with Psychosis

ACT has been adapted to the needs of people with psychosis through both considerations of how the psychological flexibility model may account for the problems of distressing psychosis, as well as the broader influences upon development of

cognitive-behavioural therapies for psychosis in understanding unusual experiences and how people respond and make sense of these. ACT for psychosis (ACTp) has been developed with an appreciation of the normalisation agenda and recovery-focused perspectives that have influenced CBTs over the last 30 years (e.g. Kingdon & Turkington, 1994; Chadwick, 2006; Garety et al., 2001). This includes acknowledging the limited utility of taking a disease/disorder perspective toward psychosis (e.g. Bentall, 1993) for the development of pragmatic psychological perspectives that can positively influence the care and support of people with psychosis.

Similar to other CBTs for psychosis, ACTp considers the person in context, seeking to understand how historical and situational factors have influenced a person's responses to their social environment, and what is important to the person in terms of their identity and goals. Unlike other CBTs which may take an information processing view of understanding a person's appraisals, emotions, and behaviour (e.g. Morrison, 2001; Garety et al., 2001), ACT is based upon a contextual perspective, where considering behaviour in context is key, from an operant learning perspective. This means that the ACTp therapist seeks to work with the client to understand what purposes their behaviours are serving and to help to find more effective ways of meeting their needs and making sense of themselves in light of their experiences.

This functional analytic perspective inherent to ACT means that the therapist is interested in understanding behaviour in context – the antecedents and the consequences, and the ways that the person is relating to their experiences. Importantly, within this framework, the experiences of psychosis themselves, along with other private experiences such as thoughts and emotions, are seen as behaviours. Thus, experiences of psychosis are therefore seen as complex behaviours that occur in contexts and have been shaped by consequences. By seeking to understand how the client makes sense of their experiences, and how this relating may also involve responses to the self that is having these experiences, there is the potential for collaborating to discover more flexible and effective ways of responding. This means that focusing on the person who is having unusual experiences and understanding what they desire, how their mind makes sense of what is happening to them, and their ways of coping with these experiences is the ideal way to be useful as an ACTp therapist.

The adaptations to the ways ACT is usually done are largely around considering the needs of people with psychosis and creating a context in interaction that may be therapeutic (experienced as psychologically safe and affirming). These considerations are related to being aware that many people with psychosis have experienced adversity and trauma and may have been subjected to controlling interventions from health-care providers. Approaching interactions in a trauma-informed way (Fallot & Harris, 2009; Mitchell et al., 2021) is essential – making it evident that the client has choice and influence over what happens in the sessions, that they will be respected, that the therapist is interested in learning about what works best for them. Some adaptations are also to consider the presence of cognitive difficulties and challenges with learning (such as if the client has memory difficulties or executive deficits). Similarly, some adaption is important to consider the impacts of being unable to pay attention in sustained ways, due to mental intrusions and preoccupying experiences, such as hallucinations.

## 13.4 ACT for Psychosis: Therapeutic Style

The style of how ACTp sessions are conducted therefore considers the above adaptations. We also think that there are a set of general principles that are important for the ACT therapist who is engaging people with serious mental health problems. These can be outlined in the following way: Appreciation – Connection – Addition – Construction:

1. *Appreciation*, of the person experiencing psychosis: the ACTp therapist responds to the client as a human being with a rich range of experiences and capacities, who is capable of values-based actions and compassion, and, like every person, is doing the best they can in the situations they find themselves in. The client is an equal partner in the collaboration being built in ACT sessions.
2. *Connection*, around the shared experience of being human: the ACTp therapist seeks to find ways to connect with the client around what it is like to be a human being – feeling, experiencing, caring, and being in the world trying to find meaning and purpose, just like the therapist. Where possible, the ACTp therapist highlights the common experiences of being human and is open about their own experiences and times of struggle (where this is useful to do for therapeutic ends).
3. *Addition*, of coping methods to what the person is already doing: The ACTp therapist seeks to understand how the client is actively coping with their experiences, including with unusual experiences and symptoms. The therapist seeks to understand how these ways of coping have been shaped by the person's history and opportunities, and what the person is trying to achieve when they cope in these ways. Exploration of further coping strategies is done alongside what the client is doing, as additions to the range of ways the client is coping. These coping methods are presented in the spirit of openness and curiosity, and a focus on successful living, based on personal values and goals, is kept as key throughout sessions.
4. *Construction*, of a life worth living today: The ACTp therapist seeks to acknowledge the challenges experienced and sacrifices the client may have made to do their best in coping with psychosis. Helping the client connect with their personal values may arise painful memories and feelings; there may also be challenges with connecting with past events and what the client has lost with their experience of psychosis. The ACTp therapist approaches values work with a sense of construction: conveying the perspective that the client can be supported to build things based on values in the here and now, and that this construction of the life worth living today is valuable in its own right. Values work is approached with a spirit of experimentation and curiosity, compassion, and openness. Whatever has happened before can be acknowledged while also promoting the stance that life can be lived in the here and now, and that there may be mileage in meaning being created each day, as it opens up possibilities and provides purpose.

## 13.5 Understanding the Challenges of Psychosis from a Psychological Flexibility Perspective

Central to understanding how to support people recovering from psychosis using ACT is considering how psychological inflexibility processes may be present when people are highly distressed, preoccupied, and/or impacted by unusual experiences and emotions. From the perspective engendered by the ACT model, it is not the presence of these experiences *per se* that is considered problematic, but rather the impact, which is amplified through psychologically inflexible ways of coping and responding. This perspective is informed by the knowledge that many people in the general community hold unusual ideas, hear voices, experience suspicion and paranoia, or have perceptions that are not shared with others, and do not require mental health treatment (Baumeister et al., 2017; Bebbington et al., 2013; Peters et al., 2016). While there may be qualitative differences between certain types of unusual experience for those who do not require care and those diagnosed with psychosis, it is also that there are differences in the ways people appraise and cope with these experiences that may be associated with distress and substantial impacts on functioning.

In ACTp, there are two ways of responding to these experiences which we are interested in. The first is cognitive fusion, that is taking the experiences and stories about them literally, using them as a guide for action. The other, potentially in an associated way to cognitive fusion, is whether these experiences are responded to with experiential avoidance. That is the person engages in strategies designed to eliminate or avoid experiencing these private events, such as when people may resist hallucinations, or become fearful and avoidant of places and people associated with persecutory beliefs. Experientially avoidant and/or cognitively fused relationships with experiences can be a focus of attention for clients, with associated worry, rumination, preoccupation, and 'tuning in' functioning as various ways to limit attention to the present moment. There can be a disconnection from personal values, if a person is preoccupied, avoiding or changing their behaviours based on unusual experiences; in a related way, there can be experiences of sense of self as different, confusing, or stigmatised that may contribute to the impact of unusual experiences.

An important consideration in the ACT approach to supporting recovery from psychosis is about the Self: how a person relates to themselves having experienced psychosis, how much capacity there is to respond with flexibility and compassion toward oneself, and fears about who one is, whether thoughts and feelings can be trusted, whether there is a sense of shame or humiliation about having been psychotic or experiencing mental health treatment for a serious mental health problem. People may internalise (be fused with) ideas of themselves as mad, unacceptable, untrustworthy, out of control, worthless, etc., due to their experience of psychosis and the treatment they have experienced. Chadwick (2006) described senses of self in the context of psychosis where a person can appraise being entrapped or engulfed by this identity: Thus, it is important in ACT for psychosis to attend to self-related processes that may be impacting the ability of the client to perspective-take about

themselves and others, to find self-acceptance, or to imagine a future for themselves that involves a chosen identity (personal recovery).

A range of associated challenging emotions, moods, fears, and behaviours can make recovery from psychosis complicated. It is important for the ACTp therapist to consider the role that co-occurring depression, anxiety, trauma, substance use, and other mental health problems can play in being targets and consequences of psychological inflexibility. It is common for people with severe and enduring mental health problems to have histories of adversity and trauma that may have lasting impacts, along with associated experiences of social exclusion, discrimination, unemployment and financial problems, housing instability: These problems can be magnified for people who have a minority status(es) related to ethnicity, religion, sexuality, gender expression, and identity.

Finally, it is essential for the ACTp therapist to be sensitive to how the person with psychosis and their community makes sense of unusual experiences and behaviours, what explanations there are for these experiences, the ways people cope, and the cultural and social value of these. Frequently in Western, developed communities, the experiences associated with psychosis are stigmatised, with people who have these experiences subject to ostracism and discrimination. This stigma may mean that people are marginalised and their views subject to ridicule and invalidation. The first experiences of psychosis can occur during adolescence and young adulthood, times of developmental sensitivity, when self-identity, relationships, independence, and social roles are key tasks (Ben-David & Kealy, 2020). Periods of psychosis can disrupt developmental pathways, education and training, and social connections. Important tasks relating to personal agency and identity, valued social roles, and relationships can be disrupted by the experiences of psychosis and challenges in personal recovery.

We argue that the ACT model is consistent with frameworks for personal recovery. This is because ACT emphasises primary goals in supporting people to pursue personal meaning and purpose. The ACT model is consistent with the Connectedness, Hope, Identity, Meaning and Empowerment (CHIME) framework of personal recovery (Leamy et al., 2011), in multiple ways (Morris, 2018):

*Connectedness*: The pro-social approach of ACT orientates us towards connection with others, whether that be through our relationships, roles, striving to make a contribution, and/or recognising that as humans, we all struggle and suffer;

*Hope*: Hope is an active stance we can take towards our world: ACT promotes choices and actions focused on active engagement with life, rather than resignation or entanglement in unhelpful self-stories. The ACT approach is to acknowledge that feelings may come and go; our hopeful actions can be a way to change our world;

*Identity* (re-establishment of a positive identity): ACT encourages contact with self as awareness, noticing the process by which our minds create stories about ourselves. Instead of being entangled in the mind's judgements, we can observe whether these are useful for our chosen life directions. A 'flexible identity' in pursuit of values-based action is promoted, rather than self-consistency;

*Meaning* and purpose (finding meaning in life): Life's pain can be dignified as a part of doing the things important to us. Through acting on personal values, contact with meaning is increased;

*Empowerment* (encouraging self-management): In ACT we help people to be 'response-able', in other words to act on their values rather than their fear, through developing an open, compassionate stance towards their own experiences and themselves. People can be empowered by being encouraged to learn from their experiences.

ACT emphasises that wellbeing and thriving is promoted through engagement in actions that are personally meaningful. This means that these actions are personally defined, fulfilling purposes that the individual seeks in the moment. The ACT model promotes flexibility in ways of coping, in perspectives people take of themselves, in recognising that living involves contact with challenging circumstances, and finding ways to be flexible. At the heart of the ACT model is *psychological flexibility*, the capability that a person has to respond with openness to their experiences, recognise the opportunities of the current moment, and be in connection with their chosen life directions. The ACT model promotes learning from experience and does not have an implicit model of what a 'life lived well' involves, aside from promoting personal agency, connection with the social and physical environment one lives in, and how it may be advantageous to find and connect with personal sources of meaning and purpose. In these ways, the ACT model appears consistent with the notion of personal recovery.

## 13.6 Applying ACT: Open, Aware, and Active Skills

The ACT model can be described as a framework that helps the client and therapist to identify skills that can be strengthened, to enable greater psychological flexibility in daily life. There are various ways to talk about the organisation of these skills, from the six process Hexaflex model (see Hayes et al., 2006), to the ACT Matrix (Polk et al., 2016), to describing ACT as involving two processes – mindfulness and values-based behaviours (e.g. Flaxman et al., 2013). It can be useful to organise the skills that enable psychological flexibility in three groupings: Open, Aware, and Active.

**Open**

Open skills are about active acceptance and detached observation of thoughts and other experiences (cognitive defusion). With these skills the practitioner is seeking to help the client to find ways to observe their experiences from a stance of non-judgement and openness, exploring what it is like to simply be with feelings, sensations, thoughts, and other experiences. In ACTp, it is acknowledged that certain internal experiences are challenging to be open to (such as derogatory voices, paranoid thoughts, memories of trauma if they arise), and that the possibility of responding with active acceptance may be something to experiment with. The client is

encouraged to notice whether a willingness to have experiences – not liking or wanting the experiences, but rather being open to them being there as part of doing things that matter, but not putting further focus or energy into them – opens up possibilities for responding and choosing actions that are more meaningful.

These skills are introduced through metaphors and experiential exercises: the client is encouraged to notice what happens with their ways of responding and coping with unwanted and preoccupying experiences when they engage in active acceptance – does this enable them to better approach doing the things that matter in life? Does this allow for new and different ways of acting and being that may be linked to the directions they want to go in their personal recovery? The Open skills can involve learning from the client how they understand their experiences and working collaboratively to find metaphors and conceptions that allow more personal agency in relation to the experiences (e.g. noticing the limits of what powerful voices can say and do to you; finding similarities between life experiences and how unusual perceptions and beliefs are responded to; trying on different perspectives and ways of acting toward experiences, such as learning to be assertive toward voices, or noticing a tendency toward jumping to conclusions and slowing down). Examples of methods of training Open skills are included in Table 13.1.

**Aware**

Aware skills are ways of developing present moment awareness and capacities to flexibly perspective-take, particularly around content and experiences related to the self. These skills are initially strengthened through 'noticing' exercises: brief and small practices around paying attention to the world around the client (such as with the senses) and anchoring attention by returning a focus back to an object, bodily experience, or the breath (whichever works for the client). The client is encouraged to share what they notice following these exercises, and the therapist encourages an observing and accepting perspective toward experiences. As these practices develop, the client is also encouraged to notice the changeable nature of the experiences they observe, as well as noticing a consistent observing perspective that is available through all these moments of 'noticing'. In ACT terms what may draw attention to is *self as process* and *self as observer*: This latter perspective, of I-HERE-NOW, may be cultivated as a useful anchor across changeable and sometimes intense and

**Table 13.1** Examples of methods of training Open skills

| Technique | Description |
|---|---|
| Leaves on a stream | Participants, through guided imagery, are encouraged to 'watch' their thoughts pass on leaves floating on a stream |
| Passenger on the bus | Participants are taught to see their private experiences as 'passengers' on the 'bus of life' |
| Think the opposite | Participants think a thought 'e.g. don't stand up' and then do the opposite action (e.g. standing up), highlighting that thoughts are just thoughts |
| Lemon, lemon, lemon | Participants repeat the word 'lemon' repeatedly over several minutes, examining how the indirect properties of the word become less prominent (e.g. its relationship to an actual lemon) and the direct properties become more prominent (e.g. the sound of the word) |

confusing experiences – that throughout it all, noticed experientially, is a self that is consistent and unchanging because it can operate as the container of experience. This sense of self is that the observer may be illustrated with metaphors and analogies (such as the Sky and Weather metaphor; Harris, 2009) and is explored for whether this is pragmatic – does it help in terms of pursuing personal recovery, to be connected to a sense of self as an observer? Does this provide room experientially for a range of wanted and unwanted experiences, including aspects of personal history that may usually be struggled with, so that the person can have the flexibility to do the things that matter to them? Examples of methods of training Aware skills are included in Table 13.2.

**Active**

Active skills are about being able to construct and act upon chosen life directions (values) in ways that are flexible and allowing a person to learn from experience (committed action). The capacity to respond in different ways, doing what is most useful with what situations afford, and learning from experience is the hallmark of psychological flexibility. As can be seen in the descriptions of the Open and Aware skills above, the Active skills are woven through ACT for psychosis, with the reflection on progress toward valued directions being the pragmatic goalposts for conversations about ways of coping, skills to strengthen, and perspectives that may be useful. The ACTp therapist acknowledges the efforts the client puts into coping day-to-day and encourages them to consider their actions in the light of what matters to them over the longer-term, including the kind of person they would like to act like, based on what matters to them. This focus on personal recovery can mean that the Active skills may be about exploring different self-conceptions and narratives that help to make sense of life and allow for the opportunity of growth and meaning. Active skills here may be about learning to identify personal goals, to link them to wider valued directions, and to find pragmatic ways to pursue these goals. All of these opportunities may involve support and encouragement, particularly for clients who have not experienced much of a sense of personal agency through years of psychosis and treatment experiences that resulted in feeling entrapped, helpless, and/or lost. A common process in the Active work is about encouraging the client to notice their experiences and responses to them and to decide how they want to act

**Table 13.2** Examples of methods of training Aware skills

| Technique | Description |
|---|---|
| Mindfulness of orange | Take participants through guided mindfulness, focused on examining feel, smell and taste of an orange |
| Noticing the senses | Participants to notice five things they can see, four things they can feel, three things they can hear, two things they can smell, and one thing they can taste |
| Noticing in session | Participants are encouraged to notice their experiences, as they happen, during session |
| Mindfulness of the breath | Participants are taken through a guided mindfulness practice using the breath as an anchor |

in the face of these, judging progress by whether these actions are progressing them in valued directions. Examples of methods of training Active skills are included in Table 13.3.

The Open – Aware – Active grouping allows for the practitioner and client to have a simple model to orient to as they are working together. As the ACT model applies to the practitioner as well, there are lots of opportunities for the therapist to model openness and awareness to the client, through responding in the moment during sessions, as well as sharing aspects of common humanity around suffering and efforts to act on chosen life directions (the use of self-disclosure in ACT for psychosis is discussed in a chapter in this volume by Nicholls, Newman, and Morris). We will now illustrate in the following case vignettes how ACT for psychosis can support recovery for people experiencing common challenges. These vignettes demonstrate how ACT can be applied to different presenting difficulties, as well as demonstrate how ACT can be applied flexibly based on the needs of those seeking support.

## 13.7 Case Example: David

David is a 42-year-old male who lives by himself and works part-time in the construction industry. David has been more distressed and preoccupied by his experience of hearing voices over the last 6 months. He describes hearing voices since he was a young person, and throughout his adult life, he has had periods where the voices have been less intrusive and manageable, and then times when the voices become nasty and controlling, louder, and more frequent.

David grew up youngest in his family; his father was a disciplinarian and held the children to high standards; there was a sense that the children should be doing well at school and getting a trade/profession as their parents had made sacrifices as immigrants. David's siblings performed well at school and enjoyed personal success, while David had a more troubled adolescence. David experienced bullying and exclusion at school due to stuttering and continues to lack confidence socially. He reports that he was given nicknames about the stuttering and found it hard to be

**Table 13.3** Examples of methods of training Active skills

| Technique | Description |
|---|---|
| Values card sort | Participants sort through a series of 'values cards' to identify which are most important to them |
| Committed actions | Through goal-setting, participants look at small steps they can take to act consistent with their values |
| SMART goal setting | Setting of goals that are specific, meaningful, adaptive, realistic, and time-bound |
| Heroes | Participants consider their heroes and the qualities they admire in those people. Discussion can then move to how participants can show these qualities |

trustful of peers. David had a close relationship with his mother, who he felt was more loving and understanding about the troubles he experienced.

David enlisted in the armed forces after leaving school. His aspiration was to be in the navy; he passed through the assessment process on enlistment, however he found basic training too challenging, particularly socially – feeling he did not fit with other recruits, and found the discipline hard (including criticism, the amount of organisation required, the physical and mental demands). He left during training, believing he had let down himself and his family. After returning home David was unsure what he was going to do, and drifted for several months, spending time seeing old friends, smoking cannabis, and playing video games. He did not have a routine, playing games through the night and waking late in the day. David shared that he saw family members sporadically, as they did not share the same waking hours as he did.

David's first episode of psychosis was when he was 20 years old. He was living at home with his parents, unemployed, and spending his days playing video games and smoking cannabis. He started hearing voices and having thoughts that he was under surveillance by the government. He increasingly isolated himself to limit the surveillance; he became concerned that family members were part of what was going on. His mother shared her concerns for David with the family doctor – this led to a hospitalisation where he was diagnosed with schizophrenia and prescribed medication.

David has a few friends and contact with his siblings, a brother and sister. His parents are retired, quite elderly, and are cared for by the other siblings. David lives by himself, working intermittently as a manual labourer. On construction sites he is known as a quiet and good worker, but there can be times when he needs to take a break from being around other people. The foreman of the construction crew he works for is sensitive to this and can chat with David about when he needs to take a break.

David holds persisting persecutory beliefs of being targeted by government agencies for mind control experiments, designed to see what psychological punishment person can take before they lose control (by killing themselves). David believes that agents for the government are using high-tech devices to send signals to his mind (this is the source of the voices he hears) and that he is under regular surveillance. He believes he is an innocent person targeted as the government had records from his brief military service.

David has experienced several hospital admissions at times when more 'tortured' by the voices – believing that the voices are punishing him for shameful past actions. He can present feeling quite guilty, worried about punishment, disclosing that the voices remind him of regretful actions (nothing illegal or harmful to others). At these times, the voices give him commands to harm himself, which he resists by trying to appease them by denying himself pleasurable activities and seeking amends for his perceived misdeeds. Most of the time David is not so preoccupied by the voices. In these times, they occur with limited frequency, do not lead him to worry, and are not a source of persisting distress. He reports this is because the voices are different in quality to the distressing times, whispering rather than

shouting, certain voices are not present (the torturers), and the content of the voices is less accusatory and condemning. David does not drink, but occasionally smokes cannabis recreationally – there is no other substance use.

### *13.7.1 Applying ACT to David*

David participated in ACTp on the recommendation of his case manager. He reported a period of increasing worry and preoccupation, and the return of 'torturing voices', which had discouraged him from going to work and socialising. David reported that he had been taking medication as prescribed and had stopped his occasional use of cannabis. He expressed hope that he was not becoming unwell, but reported being fearful of what may happen next, including the possibility of ultimately ended up doing something he does not want to do (i.e., harm himself).

David had not previously been offered psychological therapy. In the first meeting the therapist met with him and the case manager, to discuss how the sessions would run, and what to expect. The therapist described being interested in understanding what mattered to David and how the voices and other experiences were acting as barriers to him living life the way he wanted to. David reported that he was unsure about what mattered, aside from not feeling so criticised and ashamed by what the voices were saying. He also reported that his focus right now was trying to ignore the voices when he can, and when he can't, trying to cope without getting too depressed.

The beginning sessions of ACTp were about the therapist getting to know how David coped with his voices, his fears and concerns, and the ways these experiences got in the way of him working and socialising. The therapist worked flexibly with David – there were sessions where David had trouble attending, due to how powerful the voices seemed or his suspicions about how others would act toward him as he travelled to the clinic. The therapist responded in an understanding manner and encouraged David to attend even if he found these experiences challenging.

**Experiential Avoidance**

David described coping with voices and worries by trying to block them by listening to music on his phone, although he found he could only listen to music without lyrics, as the torturing voices would include critical messages in the songs. David also coped when the voices were particularly critical by writing in a notebook, where he would write about pleasant memories and situations where he had felt that he had done things he was proud of. He stated that as he became more depressed, it was harder to feel positive about past events, or feel he was an acceptable person. David also reported that working helped him to cope by engaging in physical labour he had things to concentrate on and felt tired at the end of a day. This would help him to go to sleep earlier, and therefore having less time with hearing negative voices.

When David was having a 'bad day' he coped by staying in bed, trying to sleep through the day, with not much energy or enthusiasm to do things. When he did get

up in the afternoon, David tended to then spend time listening to music, do some reading, or writing in his notebook.

**Cognitive Fusion**

David admitted living his life 'on hold', hoping that over the years the experiments and surveillance would stop, but this had never occurred. He did report periods of time when he had been less worried about this, times when he had been working more, having more of social life, but then something always happened to remind him that the experiment was still happening. This could be a random remark from a workmate or an acquaintance, or an occasion where David had felt that his tools or apartment had been disturbed, or just a sense that something was not right. David reflected that when his happened, he responded by withdrawing from others and worrying about what could happen next. He stated that he would also sleep less, spending more time checking around his apartment, and when he travelled outside, he would do things to ensure he was not being followed or having his belongings disturbed. David reported finding it hard to be present with doing things that matter, because part of his mind focused on scanning for threats. He shared how tiring it was with vigilance about harm from others.

**Workability**

The therapist engaged David in a review of how he was spending his time and sought to understand the various ways that he coped with the voices, the things he did to keep busy and feel better, and the times when he felt that he did not have the energy to do things for himself. The therapist asked David to reflect on the times when he really felt alive, when things were meaningful and important, when he felt that he was doing what matters. David appeared to struggle with this, stating that he did not have very much to be proud of, and that he was regretful about how the life's opportunities had passed him by. It was like he was living in limbo, hoping for the day when the surveillance and experiments would stop, so that he could live more freely to do what matters. There was a strong sense that living this way was unworkable, with David reflecting on the costs of vigilance to surveillance.

**Function**

The ACTp therapist formulated that, along with the patterns of *experiential avoidance* that David displays, there is a strong level of *coherence* to the beliefs of being the target of experimentation and surveillance, and with being a victim to powerful sources (such as the government agencies sending signals to his mind causing voices). The persecutory beliefs David holds and acts upon appear consistent with his experiences of unwanted attention and powerlessness he first experienced as a child (with bullying and family expectations) that have influenced how he tends to perceive himself in relation to others as an adult (as being weaker, a target of humiliation and shame: Iqbal et al., 2000; similarly finding voices to be omnipotent: Morris et al., 2014). David has *limited contact with personal sources of meaning and purpose*, due to the patterns of focusing his attention on avoiding and controlling threats, lack of closeness to others, and feeling that he needs to stay vigilant about losing control of his behaviour (an inaccurate rule he feels he needs to live by:

e.g. Torneke et al., 2008). It was planned to share this formulation with David and develop it further, to make sense of his experiences and guide how ACTp may help.

### *13.7.2 Intervention*

**Aware**

The therapist carefully introduced David to present moment awareness skills, through first practicing this toward objects around him, then bodily sensations, and then finally to internal experiences including thoughts, memories, emotions, and the voices. Throughout these practices, David was encouraged to notice his experiences and the things that his mind was doing with these, and to do this as an observer of his experiences. This was challenging at times, and David would sometimes feel overwhelmed by the number and intensity of the experiences he was noticing. At these times, the therapist encouraged him to centre his attention on how he was sitting or standing, feeling the ground beneath his feet or the arms of the chair, so that David had a consistent 'place' to watch his experiences from. It was also important to offer these practices from a position of choice, the therapist emphasising to David that he could choose to disengage from a practice when he wanted to, and that the focus was just about 'noticing', rather than achieving any particular goal. David did stop practices several times in the early sessions: he was encouraged to share the experiences he was having, and the ways that he was responding to these. David was also encouraged to use these skills of noticing at other times, outside of the therapy sessions, to practice this way of relating to inner experiences. After practice over sessions David did report some occasions of 'more noticing' in day-to-day life: when going for a walk and noticing changes in a local park with the plants; when eating his favourite meal; when he was anticipating that the voices would comment on memories he was having (and noticing that what was said by the voices was not too upsetting).

The therapist worked with David to develop a shared formulation: it was important to validate David's feelings about what he believed was happening with the experimentation. The therapist indicated that these urges to be vigilant was understandable if you were concerned about the harm that could occur if you did not stay on guard. The therapist asked about what it was like in the short-term – seeking examples of times when David had needed to be vigilant – looking for any clues to confirm that active surveillance was occurring, such as hidden cameras and microphones in his flat. It was important for the therapist to understand the feelings, thoughts, and urges David experienced during these times. David also seemed concerned about whether the therapist believed him about these instances; there were occasions where the therapist and David 'agreed to disagree'. At these times, David reported disappointment that the therapist could not see things the way he did, although did say it was hard for people to understand if they had not been targets of surveillance too.

The therapist also invited David to reflect on what it has been like long-term to live with these suspicions. David stated that it was exhausting, that he felt angry about his life being disrupted, that it was unfair that he needed to stay alert to the experimentation. When asked, David indicated that he could not be sure whether surveillance was happening, especially when the voices were less punishing. He conceded there may have been occasions when he was mistaken, perhaps he had been too suspicious – however, acting as though things are OK felt too risky for David: he did not want to be fooled.

**Active**

The therapist also supported David to explore his chosen life directions (his values). This work focused on how David would like to act in different parts of his life: when he is spending time in his flat by himself, when he is working, when he is socialising with family members and friends, when he is out in his local community. In suggesting these areas of David's life, the therapist presented the idea that values are ways of finding meaning and purpose, even (or especially) when life has been challenging. This was contrasted with the meaning that life appeared to offer David otherwise – to just survive, to live as small as possible, to be vigilant but also limit commitment to others or the things that matter. The therapist asked David to consider whether this would be what he would choose life to be about, if he had a free choice: David said this definitely would not be the life he would choose and he did not feel he had much choice. He stated the pain of caring about things for them to be messed with or taken away seemed too much to bear.

The therapist engaged David in an exercise about remembering a moment in his life filled with meaning – the Sweet Spot exercise (Wilson, 2009) – providing several examples of these types of memories (doing something kind for another person; memories of being loved and cared for; a memory of appreciating something, a place, or a person, and being connected to your body). David shared a memory from his youth: spending time with his grandfather, collecting fruit in the orchard, and preparing a fruit salad for his family; what it had been like to just share time with his grandfather, listening to his stories. David described a particular memory – being on the veranda helping his grandfather to prepare the salad – what it was like to be preparing the food and the sunlight on the veranda. The therapist asked David to stay within this image and to connect with what was happening in his body, to connect again with what it was like to be there then. When asked what this moment meant David stated feeling close to his grandfather, that they had made something together for the family, that he enjoyed doing something useful. The therapist asked him what about the situation could be a purpose to guide his actions today. David said that while he was not close to others like he was with his grandfather, he did find something important in doing work that others relied upon. He stated that this is what made working important for him: many days he could see his labour made a difference, as he worked in a team of people constructing things. He reported that when he could not work due to mental health problems, this was something he missed. The therapist suggested that they note these reflections about what mattered

and suggested to David there may be ways of heading in these directions, possibly even on days when it was hard to go to work.

**Open**

The painful work of connecting David more with what he cared about was done carefully through present moment awareness exercises and checking with him about experiences of doing this. Through engaging in exercises over sessions, and the therapist encouraging him to practice openness and curiosity to his emotions and mental experiences (through exercises like the Leaves on a Stream and metaphors like the Tug of War with the Monster), David appeared to be more actively accepting of a variety of feelings, including those arising when he felt suspicious or worried about the voices.

The therapist shared a perspective to develop the shared formulation – that due to David's unfortunate experiences as a young person with peers, he had learnt how being the focus of attention was hurtful, leading a person to feel rejected and ashamed. Could these powerful experiences when he was younger have become lessons learned about how life works, that he still lives by? David reflected on this, sharing with the therapist about the best ways to survive surveillance, voices and unknown others messing with you, through vigilance and avoidance. The therapist invited David to consider what the younger version of him would have wanted during these periods of being teased and rejected by peers – David stated that he would have wanted someone to be looking out for him, to protect him from the bullies, to have friends. Instead, he had to just cope by himself. The therapist validated that David had done the best that he could do in the situation.

Within the formulation, the therapist described the idea that thoughts and feelings can become familiar and frequent, so that new experiences are seen from this lens too. From this perspective, it is easier to continue to see the world as dangerous, to live with the rule 'it is better to be safe than sorry' through being vigilance, and that taking a chance to trust others becomes too risky to do. This idea of being a 'very familiar' story and one that keeps David 'playing it safe' was discussed over several sessions, with the therapist encouraging David to also notice it as a set of experiences that arise in his body and mind through his present moment skills.

A metaphor was offered – that David's concerns of surveillance and experimentation and the ways he had learned to live with these fears were like being caught in a spider's web, being entangled so that he felt he did not have much opportunity to move, and also that whatever he did would set off vibrations through the web, drawing attention to himself. It was like life needed to be lived with as little vibration as possible, for fear of something worse happening to him. Life's purpose had become to live as quietly as possible, to not stir up trouble, rather than it being about what he would *like* for his life to be about. It was sticky and strong, when he was caught up in a web of suspicion and worry. David stated that life was like being trapped, afraid of drawing more attention to himself, for fear of what would come… Interestingly, David said he had never seen who created the web (the spider?), with all these years of being worried of being stuck and worse things happening. The

therapist reflected with David about whether this was the power of the web: making him fearful of things worse than being stuck (even if these things had not happened).

Steadily, David and the therapist worked on ways for him to find connection with his chosen life directions, even when he would experience upsetting voices and paranoid thoughts. David found that by being able to become more present he felt less panicky and anxious to seek safety, and more able to check things out, holding his suspicions a little more lightly. He also discovered that he was able to do more than 'play it safe' – by connecting more with his workmates and family members – particularly by doing things that linked to his values of contributing, making things, and acts of kindness. By practicing being present with these valued actions, David also reported that even if the experiment was happening, he was able to work to make the world a better place, which mattered most to him.

## 13.8 Case Example: Tom

Tom is a 23-year-old male. He was born into a high-achieving family, the eldest of three boys. His mother is a lawyer, and his father is a doctor. From an early age, there were high expectations that Tom would be as high achieving as his parents. When Tom met these high expectations, he was the centre of attention in his family and rewarded with praise, increased attention, and gifts. In contrast, when Tom did not meet these expectations, he was berated by his parents and compared unfavourably to his brothers. Tom's father did not show emotion or obvious signs of affection in front of the children, with most interactions focused on Tom's academic and sporting achievements. When Tom's father was angry, or intoxicated, he would often use violence against the children as a form of punishment. In contrast, Tom's mother's parenting style was varied, alternating between not engaging in any emotional expression and engaging in large amounts of emotional expression and praise.

Tom was generally a successful and popular child throughout his schooling, achieving high grades across most subjects. Tom was also successful in sports, becoming a skilled cricket player. However, despite these successes, Tom's parents continued to push him to achieve more. During high school, Tom began to experience high levels of anxiety, particularly around examinations, tests and sporting matches, with ongoing fears that he would perform poorly. Towards the end of his schooling, Tom commenced attending parties, increasingly consuming large amounts of alcohol at these events. Despite this, he achieved grades which were sufficiently high to enter a pre-medicine course at a prestigious university.

Tom's transition to university was characterized by a 'work hard, play hard' approach. This would involve significant periods of intense study (including 'all nighters'), broken up by period of intense 'partying', including recreational drug use, particularly marijuana, and binge drinking of alcohol. Following successful completion of the pre-medicine course, Tom then commenced studying medicine in a postgraduate course at age 22.

During his first year of studying medicine, Tom found the academic stress increasingly difficult to manage. This resulted in increased periods of intense, last-minute, studying, combined with increased alcohol and drug use during 'down times'. Increasingly, Tom's substance use would occur when alone, rather than with others. During this period, Tom started to develop a series of beliefs about being on a special mission to revolutionise the practice of medicine. At the same time, Tom began hearing a single male voice. This voice was initially very 'positive', encouraging Tom in his special mission. At this time, Tom managed these experiences by ignoring them when possible and by hiding them from those in his life.

As the first year of medicine progressed, Tom became increasingly stressed, relying more on periods of extreme studying, combined with alcohol and other drugs, to manage this. This resulted in him failing his second semester. Following this, Tom became increasingly pre-occupied with his mission to change the practice of medicine in the world and he begun devoting much of his time to this. He began speaking to his family about his special purpose and ceased his studies to focus exclusively on his mission. When his family expressed concern, he was largely dismissive of their worries. Initially, his family attempted to manage this without support, before eventually contacting the mental health crisis team who involuntarily admitted Tom to the local public mental health unit.

During this admission, Tom was prescribed Olanzapine. This helped in reducing the intensity of his pre-occupation with his voice and his beliefs; however, both remained. He also developed increasing depressive symptoms, including low mood and amotivation. The voice became increasingly 'negative', consistently pointing out how much of a failure Tom was. Once discharged from hospital, Tom became increasingly isolated, often ruminating about his behaviour while 'unwell' as well as his perceived failures. He managed this by attempting to ignore these experiences, by using drugs and alcohol and becoming increasing immersed in obscure theories of medicine. The voice started to initially make statements such as 'you're not worth having around' before graduating to commands to suicide. Several weeks after his discharge from hospital, Tom acted on these commands through taking a large number of paracetamol tablets with intent to suicide.

### *13.8.1 Applying ACT to Tom*

Following his suicide attempt, Tom was referred to an ACTp therapist to provide increased support and for 'improved coping skills'. Initially, Tom was hesitant to engage in psychological intervention, making clear that 'there is nothing wrong with me', however agreed to 'give it a go'. With a focus on building collaboration, the ACTp therapist spent the initial part of the intervention working with Tom to gain a shared understanding of his current circumstances. From an ACT perspective, the therapist was particularly interested in exploring the role of two key contexts: experiential avoidance and cognitive fusion. There was also a focus on working with Tom to gain an understanding of the function of his behaviours and

his experiences, and examining whether what he was doing was contributing him towards living a 'life worth living', as seen from Tom's own perspective. Given the role of suicidal behaviour in Tom's presentation, and the potential risk to life, the ACTp therapist was particularly attentive to understanding drivers of this behaviour in the early stages of treatment.

**Experiential Avoidance**

Tom's behaviours are indicative of the potential presence of multiple instances where experiential avoidance is contributing directly to his difficulties. During the initial phases of the ACTp intervention, Tom worked with the therapist to identify the range of experiences which he actively worked to avoid. This included his experiences of anxiety, thoughts of being a failure, his experiences of low mood, and the negative content of his voice.

Tom was also able to identify that he employs a range of strategies with the purpose of reducing the amount of contact he has with these unwanted private events. This includes the use of drugs and alcohol, which he noted had the effect of 'numbing out' his unwanted internal experiences. Tom also identified his attempts to 'ignore' his unwanted private events, particularly thoughts and voices, by focussing on other activities, such as intense studying, as having the goal of avoiding unwanted private events. Tom also noted using his encouraging voice as a tool to avoid unwanted experiences, ignoring the latter by focusing as much as possible on the former. Finally, as the intervention progressed further, Tom formulated his suicidal behaviour (discussed in more detail below) as also serving the function of helping him to escape his unwanted experiences.

The ACTp therapist was also be interested in the broader context for the development of Tom's experiential avoidance and helped Tom to explore this in the early stages of engagement. This included the history of this approach being reinforced during his early years, with Tom encouraged by his parents to present outwardly as successful and happy, regardless of his internal experience, with rewards (e.g. praise) associated with this. Tom also observed this behaviour growing up, both in terms of his father and, on occasions, his mother.

**Cognitive Fusion**

There is also a key role of cognitive fusion in Tom's presenting difficulties. Tom presented to the ACTp therapist with fusion with a series of cognitions and beliefs, including around beliefs of being a failure and beliefs around having a special purpose to change the practice of medicine. In the early stages of engagement, the ACTp therapist focused on supporting Tom to simply identify this process: Acknowledging that, at times, he sees these as the literal truth and acknowledges the associated behaviours, and this leads him to engage in (e.g. becoming pre-occupied with obscure theories of medicine and spending most of his time researching this).

**Workability**

When looking at the contexts of cognitive fusion and experiential avoidance, the ACTp therapist and Tom focused on the workability of these behaviours. This included an examination of whether these contexts are contributing to him moving

towards the life he wants to live. For Tom, there is evidence that both experiential avoidance and cognitive fusion are contributing to significant relief from his unwanted private experience in the short-term, but are leading to significant difficulties in the long-term. Through these early discussions, the ACTp therapist was able to identify that there is evidence that these contexts are directly contributing to suffering and preventing Tom from living a rich and meaningful life, and thus were important to consider for formulation and intervention purposes.

**Function**

This vignette highlights the important role of understanding function when building an understanding of behaviours, including Tom's presenting 'symptoms'. Tom presents with some private experiences which he may experience as desirable and some which he may experience as aversive. Thus, they are likely maintained by different consequences. In both cases, it was important for the ACTp therapist to build an understanding of these behaviours through the lens of function and support Tom to also develop this understanding to assist him in making more overt choices about how he responds to different situations.

In terms of private events which he may experience as desirable, Tom presents with a preoccupation with beliefs associated with changing the world (these could sometimes be termed 'grandiose delusions') and a voice which sometimes delivers content consistent with these beliefs. The ACTp therapist, in their initial sessions, worked with Tom to build an understanding of these in terms of the function they served for Tom. With exploration, and examining his history of learning that failure is considered unacceptable, the therapist and Tom formulated these behaviours as being an escape mechanism from feelings of failure associated with the difficulties he was experiencing in his medical studies. That is to say, these experiences were maintained by helping Tom to avoid feeling like a 'failure', as well as by the associated positive feelings associated with having a 'special purpose'.

Tom also experiences private events associated with psychosis that he likely experiences as aversive (i.e., as unwanted). Notably, he at times experiences a voice which provides him with negative feedback and encourages him to withdraw from his friends and family. The ACTp therapist worked with Tom to explore this, understanding it within the context of the approach used by his parents to encourage him (i.e., berating him with a view to encouraging him to do better). Tom initially identified the voice as serving to motivate him. However, with exploration he was also able to identify a protective function of the voice, noting that it stopped him from taking risks which may lead him to engage in further failure. Tom was able to also see similar thoughts as serving similar functions as this voice.

In the early stages of engagement, the ACTp therapist also worked with Tom to build an understanding of his suicidal behaviour through the lens of function, building on the understanding as discussed under 'experiential avoidance'. The ACTp therapist and Tom were able to identify that he had been feeling unable to cope with the feelings associated with failure (named as 'shame' and 'embarrassment'). Thus, the suicidal behaviour had been driven by a last-ditch effort to escape these painful experiences. He was able to identify that this behaviour was also reinforced by an

admission to the local mental health inpatient unit where he was able to 'take a break' from the challenges he was experiencing. Given the dangers associated with this behaviour, the ACTp therapist worked to build a more comprehensive understanding of the multiple drivers of this behaviour early on in the intervention to ensure Tom was empowered to identify and manage scenarios where he is at increased risk, while the therapist was also able to spot these and intervene as needed. Drivers of this behaviour included increases in 'negative' psychotic experiences (which were subject to their own functional analysis) as well a reduction in the positive experiences (e.g. the 'grandiose delusions'), associated with the use of medication. In Tom's case, there was also an important role of increased 'insight' in contributing to his recent suicidal behaviour (i.e., the medication led him to a reduction in 'protective' psychotic experiences, increasing his suicidality).

### *13.8.2 Intervention*

Based on the above considerations of experiential avoidance, cognitive fusion, workability, and function, the ACTp therapist worked with Tom to build a comprehensive understanding of his behaviours in terms of the key ACT processes of open, aware, and active. This understanding was then used to jointly develop a plan for intervention. Initially, following gaining an understanding of Tom's behaviours, he was introduced to the Passengers on the Bus metaphor which was used to introduce key concepts and help with the development of a shared language between the Tom and therapist (e.g. private experiences came to be called 'passengers' during session). In short, this metaphor describes our private experiences as 'passengers' on our bus our life, which we are trying to drive towards where we want to go ('valued direction'). Different response styles to the passengers are shown to be unhelpful (e.g. arguing with them, listening to them) or helpful (e.g. acceptance). This also provided an introduction to Tom of each of open, aware, and active.

**Active**

Tom's history indicates a significant focus on pleasing others and achieving, because this is seen as something which 'must' be done. Upon exploration, there was little evidence that Tom was gaining internal satisfaction from his studies nor attending parties, but rather was doing these things because he felt they were 'what you have to do' to live a good life.

Given this, in combination with Tom's hesitancy to engage in intervention, the early work focused on building Tom's own sense of what his values were. In the initial stages of this intervention, Tom struggled to speak about his own values, linking them directly to his sense of failure and the associated pain. Thus, this work commenced by adding a layer of separation between Tom and values. This was done through exploration of Tom's heroes and what he admired about them. He identified a doctor, a family friend, who worked with Médecins Sans Frontières ('Doctors without Borders'), whom he had looked up to since adolescence. The ACTp

therapist worked with Tom to identify exactly what he admired about this doctor through looking at specific behaviours he engaged in, with Tom identifying his compassion, persistence, and skill as being the key attributes he admired.

This then helped inform a discussion of how Tom could embody these behaviours in his own actions. While Tom initially identified larger goals (e.g. himself becoming a doctor and travelling to Africa to work), with support from the ACTp therapist, he was able to break this down into much smaller 'committed actions' which he could engage in to live these values. Tom's initial focus was on wanting to set goals which others saw and admired, rather than linking them to his values. Thus, the intervention also had a particular focus on building Tom's own sense of achievement and satisfaction from completing these goals. This included engaging in committed actions which were not witnessed by others in his life and then exploring these in detail during session (framed as an 'experiment' initially). Examples of early goals included making a small donation to a charity, reading an article on a new technology in medicine, and emailing his course co-ordinator to look at options for recommencing his studies with a reduced load.

Over time, and while working on the other ACT processes (open and aware, below), Tom was able to build on these initial committed actions, taking on more and more challenging goals, using his values as the compass to choose these. Unsurprisingly, while completing this work, Tom experienced a range of unwanted private experiences (including voices, emotions, and thoughts) which were addressed through focusing directly on the 'open' process of ACT.

**Open**

Tom presented with a range of strategies specifically focused on avoiding his unwanted private experiences (as discussed under 'experiential avoidance' and 'function', above). The initial parts of the intervention around 'open' with Tom involved exploring the benefits and costs of his efforts to avoid his unwanted private experiences (sometimes referred to as 'creative hopelessness' in ACT). This involved the ACTp therapist and Tom exploring three key questions: First, there was an examination he had already done to manage the unwanted private experiences (i.e. clearly identifying all the avoidance strategies being employed). Second, Tom and the ACTp therapist explored whether these strategies had actually worked, given how much effort was being committed to them. Tom identified that these strategies were highly effective in the short-term in that they provided temporary relief from his unwanted private experiences. However, he was also able to identify, from his own experience, that these strategies had been highly ineffective in the long-term, identifying that these behaviours ultimately served to make his difficulties worse. Finally, Tom was asked to consider the 'cost' of engaging in these strategies. Tom identified that these strategies had cost him 'almost everything'. Through the Passengers on the Bus metaphor, Tom was introduced to an alternative to his attempts to control, openness (termed 'willingness' in this intervention).

Open interventions targeted a range of Tom's experiences. Early on in the intervention, there was a focus on the voices and Tom's thoughts. Tom initially focused on identification of his unwanted private experiences, through simply

naming them as ‘passengers’. During sessions, the ACTp therapist would help Tom to identify his ‘passengers in’ the moment (e.g. ‘I just noticed a shift in your facial expression. Has a passenger just shown up?’). Additionally, when reviewing each week during a session, Tom was asked to consider in given scenarios: who was driving the bus? That is, Tom explored times when he let his ‘passengers’ guide his behaviour and times he made a true choice, despite the presence of an unwanted ‘passengers’. Over time, as patterns were identified in the ‘passengers’, Tom was able to name certain ‘passengers’ to more easily spot them. This included the ‘suicide passenger’ (i.e. auditory hallucination and thoughts telling Tom to die) and the ‘fantasy passenger’ (i.e. auditory hallucinations and thoughts which told Tom how amazing he was, about his special mission, etc.). Over time, Tom was able to more and more readily identify these passengers as a part of his whole experience, rather than as the absolute truth. This substantially lessened the impact of the experiences on Tom and allowed him to make more deliberate choices in the face of these experiences. Rather than choosing avoidance strategies, he was able to increasingly engage in active values-based actions, moving towards where he wished to go rather than away from things he was trying to escape. As Tom became more familiar with his frequent ‘passengers’, he was also able to also better understand them in terms of their function and see them within a context of his ‘mind’ working to attempt to help him. This increased his ability to respond openly to the experiences.

Tom also did similar work around his unwanted emotional experiences. This included considering them within the passengers on the bus metaphor, learning to name them in the moment (e.g. ‘the shame passenger’), and learning to understand them in terms of function and purpose.

Finally, during this part of the intervention, the ACTp therapist worked with Tom to explore his strongly held beliefs (e.g. around having a ‘special purpose’ in the field of medicine). As with other cognitive-behavioural therapies, the ACTp intervention did not focus on the ‘truth’ of these beliefs, but rather on their workability. The ACTp therapist and Tom explored the benefits and costs of focusing on these beliefs. As the intervention progressed, Tom was also encouraged to see these beliefs within the broader range of his experience and in terms of their function (i.e. in this case, Tom identified that focusing on these beliefs helped avoid the emotion pain associated with not achieving as highly as he wished to). As the intervention progressed, and Tom began to build up values-based actions in other areas, his focus on these beliefs reduced significantly as they became a less central part of his experience and thus were given less and less attention.

**Aware**

Finally, the ACTp therapist worked with Tom to build his aware skills. As with all ACT interventions, there was overlap with the other processes in this section, and these skills were focused on in a non-linear fashion. That is to say, sessions jumped between focus on all three processes. One rationale for focusing on aware skills which was particularly important for Tom was improving his ability to track his own behaviour. That is, being more aware of the triggers for his behaviours (including

his private experiences) and understanding their function, to allow him to make more active choices in any given moment.

For Tom, who remained passionate about engaging in physical activity, awareness was initially taught through focusing on paying attention to physical movement. During sessions, the ACTp therapist and Tom would engage in physical activities (stretching, jogging on the spot), but with specific instructions to pay attention to specific parts of the activity (e.g. focusing on the change in breath while jogging, focusing on the feet, noticing the feelings associated with a stretch). As Tom became more comfortable with these interventions, he decided to commence more formal 'meditation' practice using an 'app' on his phone between sessions, initially every other day before commencing daily practice.

Sessions also often involved 'check-ins' in any given moment, in which Tom would be encouraged to pay attention and notice what was happening in specific moments (including both private experiences and in the room). As the intervention progressed, Tom was able to increasingly engage in these 'check-ins' effectively, regardless of his emotional/mental state. This increased his ability to identify and allow private experiences (i.e. his open skills) and make choices to act on his values (i.e. his active skills).

Some aspects of Tom's presentation required some special consideration as they did not relate directly to psychosis specifically, but remained important part of the intervention.

**Anxiety, Depression, and Substance Use**

In addition to experiences directly linked to his psychosis, Tom presented with other difficulties including those associated with anxiety, depression, and alcohol and other drug use. These were important considerations when discussing an intervention plan with Tom and their relative importance determined by the impact they were having on Tom's ability to live a valued life. In this case, the substance use was seen as particularly important for Tom and thus a particular focus. However, as has been noted, while these behaviours were important to consider, they were considered within the same model (i.e., that of psychological flexibility and ACT) and were treated using the same 3 processes. Thus, while the intervention considered these important 'co-morbidities', the treatment itself did not need to be modified, except to incorporate these within the range of behaviours being examined.

**Risk**

Tom presented to the ACTp sessions following a recent suicide attempt. Given the risk to life of such behaviour, this was also an important part of the intervention, again considered within the framework of psychological flexibility and ACT. In the early stages of therapy with Tom, the ACTp therapist worked with Tom to build his ability to understand what had occurred and what had led to the attempt (i.e. using his aware skills) and built his ability to have the associated internal experiences without resorting to escape strategies such as suicide (i.e. using his open skills). This was then paired with a plan of what to do in the event of another crisis, built around his values, including seeking support and engaging in other activities he identified as helpful, such as exercise (i.e. using his active skills).

**Medication**

This vignette also highlighted the importance of the ACTp therapist understanding the function of behaviours, within the broader context of antipsychotic medication. Tom's suicide attempt occurred following the prescription of medication which had helped to ameliorate experiences that Tom had found desirable, and subsequently left him unable to cope with the resulting negative emotions. That is to say, the psychotic experiences had been serving a protective function for Tom in that they were helping him to avoid unwanted experiences that he was unable to otherwise cope with. Thus, the ACTp therapist worked closely with the medication prescriber to ensure that any changes/increases to medication were considered within this context.

## 13.9 Case Example: Maya

Maya is a 17-year-old non-binary young person (they/them pronouns), who lives with their mother Stacey and her new partner Chris, Maya's older brother Jaxon, and younger sister Zara. Maya recently dropped out of school, and they are currently single. Maya recently experienced a first-episode of psychosis.

Maya had experienced a gradual deterioration in mental state and functioning over the previous 18 months. Maya recently dropped out of year 11 at school, after having increasing difficulty with attendance and workload, and started to fail subjects. Prior to this, they enjoyed school, with particular strengths in creative arts and literature. Maya had worked hard to get good grades and took part in extra-curricular activities including drawing and writing classes.

Maya was a quiet, shy person, and had been bullied and excluded in primary school. As Maya entered high school, they discovered their interest in art and creativity, and through this connected with a small, though reliable, group of friends. Over the past 18 months Maya started to withdraw from these friends, in part as attendance at school and extra-curricular activities reduced. Maya also developed some worries that these friends didn't like them and believed they were excluding them from things and talking about them behind their back.

Maya had previously been in a 1-year relationship with Jorden, who Maya had met at art class, and were in the same friendship group. Maya reluctantly ended this relationship 6 months ago, after being sexually assaulted by Jorden. Maya was conflicted about the assault, and in part felt they 'asked for it'. Maya also felt the other people in the friendship group did not believe them, and lost these friends when the relationship ended.

Maya's parents separated when they were in primary school, due to physical and emotional abuse perpetrated by Maya's father, towards their mother Stacey. Maya's father was sexually abusive towards Maya and their younger sister Zara. Maya's mother found out about the sexual abuse towards Zara, and it was at this point that the separation occurred. Soon after separating, Stacey repartnered with Chris. Over the years, he has been staying more often at Maya's house, and Chris recently

moved into the family home. Maya has become increasingly suspicious of Chris and worries he is trying to hurt them and Zara.

Maya was recently admitted to hospital after experiencing a first-episode of psychosis, and anorexia nervosa. As part of their experience of psychosis, Maya hears intense and distressing voices. There are three distinct voices – one providing neutral commentary and two with negative and demeaning content. The negative voices included themes of Maya being worthless and deserving punishment. They would also tell Maya that other people, particularly family and friends, disliked them and were trying to hurt them. Maya was experiencing episodes of dissociation, described as periods of feeling detached and disconnected from their body, at times in conjunction with flashbacks from past trauma. Maya's mother noted times when she would check on Maya, and Maya would not respond for several minutes. Often Maya would try and cope with distress and dissociation by withdrawing and self-harming, and this was increasing in the lead up to the hospital admission.

Several factors contributed to Maya's experience of dissociation: hearing distressing voices, gender dysphoria, and body image concerns. When Maya experienced loud and intense voices, commonly at times of heightened stress, dissociation would serve the function of 'switching off' the voices, blocking them out, as well as everything else in the external world. Maya experienced gender dysphoria, identifying as non-binary, and being distressed by primary and secondary sexual characteristics of their birth-assigned gender. Often Maya would become highly distressed when looking in the mirror as they did not identify with their reflection, and their body did not feel like their own. Additionally, as part of their experience of anorexia nervosa, Maya had body image concerns, believed they were overweight, and were preoccupied with losing weight. They also believed they did not deserve to eat and needed to be punished. Maya engaged in restricting food intake and purging behaviour to lose weight. Maya had lost a significant amount of weight due to their anorexia, and at the time of admission was medically compromised due to their low body mass index (BMI).

After a 3-week inpatient stay, Maya has been referred for ongoing outreach community support.

### *13.9.1 Applying ACT with Maya*

Maya was reluctant to continue on medication commenced in hospital, due to suspiciousness about the medication, as well as significant distress associated with weight gain. Maya raised this with treating team, and together they developed a plan for Maya to stop medication, and for treatment to focus on engagement in ACT.

Maya and the therapist met to discuss what therapy may look like, and what Maya's goals for therapy were. Maya identified their main struggles were with ongoing voices, episodes of dissociation, and self-harming. They reported experiencing low mood, amotivation, poor sleep, and low self-esteem. Maya spent their days mostly in their bedroom watching movies and television, and sleeping. Maya

also has two people they would connect with online, one who was also seeking professional mental health support, as well as a childhood friend. Maya was also continuing to restrict food intake and purge, and had ongoing body images concerns, which had been exacerbated by weight gain from antipsychotic medication. Maya was ambivalent about addressing disordered eating, though was open to discussing this further as they were aware they would need to return to hospital if their weight dropped and they became physically compromised and wanted to avoid this. Maya didn't feel their gender identity was accepted by their family, who continues to misgender them, and wanted to raise this with their family.

Maya and the ACTp therapist worked together to develop a shared understanding of Maya's struggles, using an ACT lens.

**Experiential Avoidance**

Maya described avoidance as one means of coping with distressing experiences. When Maya experienced negative voices or flashbacks from past trauma, they would work to shut them out; at its most extreme, this resulted in dissociation. Maya would be completely disconnected from their internal and external world, and Maya was unresponsive if others tried to communicate with them.

There were also forms of avoidance related to Maya's body image concerns and gender dysphoria, as well as disordered eating. Maya actively avoided looking at themself in the mirror or looking at photos of themself to avoid distress from gender dysphoria, and distress from their distorted perception of themself as 'fat' and 'ugly'. Maya aimed to control their weight by restricting their food intake – refusing food in efforts to avoid weight gain and fear of 'fatness'.

Maya also coped by withdrawing from life broadly – spending most days in their room watching movies and television, and sleeping. They had minimal interaction with their family and only an occasional conversation with friends online. They no longer engaged in creative endeavours.

**Cognitive Fusion**

Cognitive fusion was a common way that Maya engaged with their internal experiences. Maya was often fused with the voices, taking what they said as 'truth'. Maya would get 'sucked in' to what the voices were saying, believing them when they said Maya was 'worthless' and 'disgusting'. Similarly, Maya would get 'hooked' when eating disorder cognitions arose, such as 'you're fat' and 'you don't deserve to eat'. Maya also held conviction in their own beliefs about themself being worthless, and others being dangerous, and subsequently Maya 'hated' themself and was mistrustful and distanced from others.

**Workability**

When the ACTp therapist was exploring Maya's ways of coping with their experiences, the central questions that were considered were 'how is that approach going for you?' and 'is that helping you to live he life you want to be living?'. Maya reflected that on most occasions, cognitive fusion and experiential avoidance were not serving them well. When Maya got 'sucked in' to their voices and beliefs about themselves, it left them feeling flat and defeated, withdrawing from those things that

Maya identified as important – friendship and creative exploration. When Maya spent their energy avoiding and shutting out distressing experiences, they inevitably shut out the rest of the world too, for example via dissociation, or because all their energy was going into avoiding rather than doing things that mattered to Maya.

**Function**

A functional analysis of the voices was done collaboratively, and the voices started to be understood as symbolic of Maya's self-hate, internalised following past harm from others. The voices created a dynamic where Maya experienced others and the world around them as unsafe, consistent with their past life experiences. The voices were also acknowledged as somewhat 'protective', as they served to keep Maya withdrawn and distanced from others, which was helpful in protecting them from further hurt. However, this came at the cost of feeling disconnected from others.

There was exploration of the function of the eating disorder. Maya described it as a means for them to have some sense of control over their life, particularly when the voices and dissociation left them feeling out of control. Maya also identified when they felt thin, they felt less at risk of others hurting them, feeling 'almost invisible'. When they were at extremely low BMI, there were also physical and physiological changes which minimised sexual characteristics, thus reduced Maya's gender dysphoria.

Maya identified that their withdrawal to their room served the function of keeping themselves distanced from other people, which to Maya meant keeping themself 'safe'. This social separation also served to reduce Maya's struggle with self and identity – it minimised opportunity for misgendering and avoided social comparison around body image, as well as reducing exposure to stigma and alienation in the context of experiencing psychosis and anorexia nervosa – experiences Maya was ashamed of.

**Open**

One aspect of the therapeutic work was inviting Maya to explore whether responding to distressing experiences with a curious detached stance was helpful. Specifically, there was an experiential examination of whether Maya was better able to do things that mattered to them when they were able to defuse from distressing voices.

There was exploration of various ways Maya could respond to their voices. Commonly Maya would listen to the negative voices and believe what they were saying, which would leave Maya feeling alone, worthless, and mistrustful of others. It would contribute to Maya withdrawing to their room, and disconnecting from family, friends, and creative activities. When the voices were particularly loud and harsh, Maya's response was one of avoidance: Maya would dissociate, blocking out the voices, and the rest of the world along with them. The therapist engaged Maya in a creative hopelessness exercise (described in the 'Tom' vignette) and presented the idea that although Maya could not control the voices, Maya could choose their response to the voices. Alternative ways of responding were explored and practiced, including talking back to the voices, as well as Maya acknowledging the voices with a curious stance. Given the perceived omnipotence and of the voices, it was

challenging to create some defusion. To assist this process, Maya and the therapist began to think of the voices like they were mean young children, after Maya shared that they reminded them of when their younger sister would have fights with their friends in primary school. Maya recalled the young children exchanging harsh words such as 'I don't want to be your friend anymore' and 'Eww, you're disgusting', or laughing at someone if they got an answer wrong in class. However, given the context of these words coming from young children, the words lost some of their sting, and Maya knew that young children did not yet know any better. This reframe of the voices made it possible for Maya to defuse and notice them with detached curiosity.

An experiment was done so Maya could experience which way(s) of responding to the voices felt most workable. This included trying listening to the voices and becoming fused with them, dissociating, talking back, or defusing. Through the experiment, Maya noted their distress associated with their voices was heightened by their fusion with the voices. The voices would hook Maya into their narrative of Maya being 'good for nothing' and others 'coming for you', and Maya's world would close in around them. Maya found the most workable response was to acknowledge them and notice what they were saying, while imagining them being a mean young child. The voices remained and content was unchanged; however, the voices lost some of their perceived power and control, and Maya was at times able to continue to engage in the world around them despite the voices.

**Aware**

At the commencement of the intervention with the ACTp therapist, Maya frequently was experiencing dissociation, feeling detached from themselves and the world around them. Dissociation is an almost complete temporary shutting off from the external world, including things that are meaningful, and people that matter. Thus, aware skills were identified as important skills to strengthen with Maya. The therapist and Maya normalised dissociation as a response that can develop following traumatic experiences. The therapist discussed with Maya the challenges that can arise when responses that may have been helpful THERE-THEN during past trauma may no longer be as helpful HERE-NOW, when the traumatic incident is no longer present, and instead the focus is on meaningful things such as creativity or connecting with others.

The therapist introduced grounding skills to help Maya manage during times of distress and dissociation. This included strategies using the five senses – such as splashing icy water on face, or chewing sour candy. Another skill was introduced to Maya to support them in developing present moment awareness, 'dropping anchor'. This involved in session practice when Maya started to become distressed and appearing to be 'zoning out'. The therapist would invite Maya to notice and acknowledge the thoughts and feelings coming up for them, re-connect with their body by stretching their arms and moving, noticing their body in the chair, and finally reconnecting with the room and people/activity around them. There was also teaching of simple prompts for Maya to continue practice out of session.

During therapy, the main focus was supporting Maya to be able to 'put on the brakes' and develop skills in being able to notice and flexibly respond to their internal experiences and the external world based on their values. There was not any deliberate focus on working directly with trauma content or flashbacks as this was contraindicated given Maya's mental state (i.e. this was expected to worsen the current situation).

**Active**

Since discharge from hospital, Maya had limited engagement with activities that meant something to them. The therapist invited Maya to engage in values exploration, and used this information to encourage behavioural activation, given the lack of structure to Maya's days, and lack of sense of ownership over their own life. This was done via both top-down and bottom-up approaches.

Using a top-down approach, perspective-taking was employed to invite Maya to think about what mattered to them prior to becoming unwell. Maya spoke about the importance of learning and creative expression and enjoyed activities such as art, writing, and reading. They also identified value in connecting with other people, including helping friends in need and being a role model for their younger sister. They had hoped to become a children's art teacher in future. From this, the therapist invited Maya to drill down to specific creative activities that would be possible to engage with now. This process was generative, and if desired, a large list of possible activities could be identified. As an example, Maya identified exploring their local parklands and finding a scene to paint as something they would find meaningful.

Using a bottom-up approach, the therapist asked Maya what they would do if they won a million dollars. Maya spoke about buying themself an art studio in an artist community, buying their sister a new bicycle that their sister has wanted for some time, and starting to save money for a possible overseas trip that they used to dream about with their childhood friend. From these specific tasks, the therapist invited Maya to describe what it was that mattered to them for each. From this exploration, key themes emerged of Maya valuing connection with others, creativity, and learning and discovery.

From this process, the therapist and Maya developed goals for Maya to start engaging in some values-based activities. Maya began to reflect that they noticed starting to have more energy and slightly lifted mood after engaging in activity. They also noted some sadness, as starting to re-engage in meaningful activity also served as a reminder of the lost time and experiences because of being unwell, as well as highlighting their reduced attention span compared to the past. This can be a common process when working with values in those whose life trajectory has been significantly impacted by an experience of psychosis. This may be especially so when this occurs during adolescence, a formative developmental stage.

**Co-morbid Eating Disorder**

The ACTp therapist introduced a central metaphor to frame the work – food as energy for the body necessary to engage in valued activity, just as a car needs fuel to make its journey. Psychoeducation was provided on the interplay between undernourishment, cognitive impact, and impact on experiences of psychosis. There was

also discussion about the medical need for Maya to maintain stable weight to avoid further hospitalisation and medication.

Family sessions took place, to discuss how family could work together to support Maya at meal times. This included things such as encouraging family to sit and eat meals together, and Maya's mother seeking individual support to address her own body image and disordered eating issues. Maya had noticed their younger sister had started to express some body image concerns and engage in some disordered eating behaviour. This was explored in family sessions. In individual sessions, perspective taking was used to encourage Maya to consider their younger sister's experience of Maya's eating disorder and utilise Maya's care for their sister as motivation to address their eating disorder and work towards a healthier relationship with food and with their body.

**Self and Identity**

Given the various challenges Maya experienced with who they are, some targeted work occurred on the self. Firstly, the ACTp therapist introduced a self-compassion piece. This involved Maya writing a letter to themself; writing to themself from the perspective of a good friend, utilising Maya's strength as compassionate and caring for their friend who also experienced mental health struggles and inviting Maya to show that same care for themself.

The ACTp therapist also attempted to strengthen the process of 'self as context' – this is the concept that the self is an observer of experiences –serving as a container for internal experiences such as thoughts and feelings, but not being these internal experiences. For example, the ACTp therapist utilised perspective taking to support defusion from self-stories such as 'I am worthless' that Maya was fusing with. The ACTp therapist invited Maya to imagine themself as a small child, noticing that it was the same self looking out of through same eyes as Maya here and now in session. The therapist also invited Maya to notice that it is the same Maya during periods of wellness as unwellness, that they are a *container* for their psychotic and non-psychotic experiences, and they are not their experiences of psychosis. This helped to encourage flexible responding in response to Maya's feelings of shame, embarrassment, and internalised stigma about their mental health struggles.

Part of treatment also offered to Maya was connection to lived experience supports to help destigmatise experience of psychosis (e.g. hearing voices network, peer support worker), and Maya chose to engage with these supports.

**Working with Young People**

In the context of working with a young person, there is an emphasis on working with families and including families in treatment, given the developmental context. Family sessions occurred, to explore and work through the challenges Maya experienced relating to their gender identity. Maya used this space to discuss their distress when family misgendered them and create opportunity for family to learn more about gender and what being non-binary means (utilising a genderbread person as tool for discussion: Killermann, 2016), for the family to better understand Maya's experience. Family sessions also served to create space to explore family reactions to Maya's gender identity and encourage perspective taking among family

members, as well as respectful open communication; also worked individually with Maya to consider where Maya could connect with others in a safe supportive space – explore youth services in LGBTQI+ community and referrals supported.

A separate family worker was involved to facilitate family sessions, to protect Maya's alliance with their individual therapist. In addition to above-described goals, family sessions were also a more general space for the broader family system to work through any questions, concerns, and challenges and support them in their understanding of Maya's struggles and facilitate a dialogue between Maya and their family on how family could best support Maya in their recovery.

## 13.10 Conclusion

ACTp can be a useful approach in supporting the personal recovery of people with psychosis. The underpinnings of ACT – inviting people to make space for experiences both positive and negative, in service of living the life they would like – align with the personal recovery framework. The therapeutic stance is collaborative, emphasising common humanity and the universal experience of suffering, which can be a useful approach for individuals with psychosis who have often had past experiences of being ostracised or pathologised and controlled by the medicalised health system and society broadly. The central processes of open, aware, and active lend themselves to addressing key challenges in psychosis – unusual and often distressing experiences, which tend to invite psychologically inflexible responses (e.g. avoidance, fusion) and commonly result in people withdrawing from meaningful engagement with the world and losing their personal identity in the process. ACT is transdiagnostic and inherently flexible, thus can be useful across a range of contexts and presentations of psychosis, as demonstrated by the case vignettes. With empirical evidence available, there is utility in psychological approaches such as ACTp to be routinely offered as a treatment option to individuals seeking support for psychosis.

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

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