Chapter 15
Using Acceptance and Commitment Therapy Within a Functional Analysis Informed Therapy for Hearing Voices

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Auditory verbal hallucinations, commonly referred to as hearing voices, can occur as a persisting experience in a range of populations. Since the twentieth century, voice hearing has been most closely associated with schizophrenia (McCarthy-Jones, 2012), with particular forms of voice hearing being included among Schneider's influential first-rank symptoms proposed to define the syndrome. However, it has become increasingly apparent that persisting voice hearing experiences are encountered in a range of clinical populations, including being relatively common in the diagnostic groups of bipolar, major depression, borderline personality disorder, and PTSD, suggesting relevance as a transdiagnostic phenomenon (Larøi et al., 2012). Indeed, across these groups, the phenomenology of hearing voices is remarkably similar (Waters & Fernyhough, 2017). Experiences of voice hearing are also reported by a number of people with no mental health needs (Beavan et al., 2011; Johns et al., 2014), and may be considered a normative experience in some cultural groups (Larøi et al., 2014). This has given rise to contemporary conceptualisations of hearing voices as part of the spectrum of human experience, rather than as the manifestation of particular disease processes (Johns et al., 2014).

Nonetheless, hearing voices is an experience with which people often struggle. Whilst hallucinatory experiences vary from person to person, hallucination is, by definition, an experience that is as vividly real as a true perception, is experienced as uncontrollable and seems to have a life of its own (Slade & Bentall, 1988). People usually hear voices saying things related to themselves or what they are doing, typically in the form of voices talking to the hearer, or about them (McCarthy-Jones et al., 2014; Nayani & David, 1996). Whilst neutral content such as running commentary is characteristic for some people, negatively valanced content is most

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typical, with voices very often involving hearing criticism, threats to harm the person or others, or commands often to do harmful things (Larøi et al., 2019; Nayani & David, 1996; McCarthy-Jones et al., 2014).

15.1 Psychological Therapies for Hearing Voices

Understandably, hearing voices can be experienced as a highly distressing and distracting experience, and, as such, psychological therapies may have an important role in helping reduce the impact of hearing voices on distress and day-to-day functioning. The most established psychological treatment approach used for hearing voices is the broader intervention model of cognitive behavioural therapy for psychosis (CBTp). CBTp has been extensively studied in randomised controlled trials, typically with persisting positive symptoms including hallucinations, alongside delusions, as a target (van der Gaag et al., 2014). This trial evidence has led to it being widely recommended for people with psychotic disorders and experiences in clinical practice guidelines (e.g. National Institute of Clinical Excellence, 2010; Kreyenbuhl et al., 2010; Royal Australian and New Zealand College of Psychiatrists, 2015). Commonly used CBTp methods applied to hearing voices include enhancing coping strategies (Hayward et al., 2018), and cognitive restructuring of distress-related appraisals about the experience. These can include threat appraisals such as about losing control (Morrison, 1998, 2001), or reflect beliefs held about the person or entity from which the voices are arising (Chadwick & Birchwood, 1994). Chadwick and Birchwood (1994) highlighted that people typically regarded the voices being spoken by real others, holding extraordinary power over the individual, often with malevolent intentions, and proposed such beliefs drive voice-related distress. Hence beliefs about the extent of voice power, and control that the person has over the experience, are a particular target of cognitive restructuring in CBTp applied to voices.

As psychotherapeutic methods have progressed, there has been a range of further psychological interventions applied to help people who hear voices (Thomas et al., 2014). Whilst sometimes presented as alternative models, these are often intended as specialised components of broader therapy, and therefore compatible with a broader CBTp framework (e.g. competitive memory training, van de Gaag et al., 2012; exposure-based methods for associated trauma memories, Paulik et al., 2019; Brand et al., 2021). One notable trend has been a group of therapies that work with the experience that people have of the voices as agents or entities with whom they relate interpersonally (e.g. Craig et al., 2018; Hayward et al., 2014, 2017; Leff et al., 2013; Longden et al., 2021). A further major trend has been the third wave, or "acceptance and mindfulness-based," approaches, which we consider in more detail.

15.2 Acceptance and Mindfulness-Based Approaches

Third-wave approaches applied to hearing voices and/or psychotic experiences and include mindfulness programs (e.g. Böge et al., 2021; Chadwick et al., 2016; Louise et al., 2019; Strauss et al., 2015), acceptance and commitment therapy (ACT; e.g. Bach & Hayes, 2002; Gaudiano & Herbert, 2006; Shawyer et al., 2012, 2013; Thomas et al., 2013) and compassion-focused therapy (e.g. Braehler et al., 2013; Heriot-Maitland et al., 2019). These approaches share a common focus on changing clients' relationship, or patterns of interaction, with thoughts and their broader internal experience. This contrasts with modifying the content of thoughts and beliefs, as in cognitive therapy. Hence, applied to voices, rather than disputing what voices say, or modifying explanatory beliefs about voices, these approaches primarily aim to help the person to be less fused with, preoccupied with, and/or reactive to these experiences (Thomas, 2014, 2015).

ACT is one of the most widely studied of these approaches. A very simplified account of the theoretical basis of ACT is that, due to our evolved internalisation of language as verbal thought, much of our conscious experience occurs in relation to internal representations of events. Thus, imagining a feared catastrophe can elicit anxiety, thinking about a loss can elicit sadness, and dwelling upon past failures can generate shame. It is our interactions with these internal representations where human psychopathologies tend to arise (Hayes et al., 1999). In particular, we often engage in attempts to distract from or suppress these internal representations, which, due to their uncontrollability, can give rise to struggle which intensifies distress. We may also engage in broader forms of experiential avoidance that may narrow our range of experience and dominate our behaviour.

In relation to this, hearing voices is a notable experience in that it reflects a manifestation of internalised verbal representations, yet is experienced as a stimulus arising from, and often located in, external space. Thomas et al. (2013) conceptualised three layers of impact of the experience of voice hearing that may give rise to struggle. First, hearing voices is an intrusive, uncontrollable, inescapable sensory experience. This can intrude into and come to dominate awareness in ways akin to struggles with other sensory experiences such as chronic pain or tinnitus. Additionally, in the context of psychosis, the experience may be further associated with a subjective sense of being particularly salient or important which can make it particularly attention capturing.

Second, hearing voices is a verbal phenomenon, and the preponderance of negative emotional content, such as criticism, threats and harmful commands, involves the activation of broader internal representations that are personally highly salient. Third, hearing voices is typically experienced as interpersonally meaningful, experienced as if sentient others (Benjamin, 1989; Chin et al., 2009; Hayward et al., 2011). This can lead to hearers being drawn into internal dialogue with these experiences (Leudar et al., 1997), which may prolong engagement with them (Thomas, 2015). As voice content may be critical and threatening, patterns of reacting to voices with reciprocal hostility (e.g. internally shouting or swearing at voices) are

particularly common (Hayward et al., 2020; Thomas et al., 2009), which may lead to increased arousal that may reinforce the experience.

Each of these layers of the experience – sensory, verbal and interpersonal – may be associated with struggle, distress and impacts on day-to-day life playing out. In the general ACT model, the antidote to struggle with aversive experience is *acceptance* – or willingness to experience things which are aversive – in combination with shifting from reactive responses to intentional behaviour in line with broader personal *values*. This is further supported by *defusion* exercises and skills, which highlight thoughts as internal representations distinct from environmental threats, and skills in engaging in *self as observer* of experiences, and awareness of the *present moment*, typically using mindfulness exercises. An array of experiential exercises and metaphors are used to support this work, such as those described in Hayes et al. (1999).

The emphasis on acceptance as an adaptive response to voices is notable as it has parallels with a principle of the Hearing Voices Movement (HVM, Corstens et al., 2014), a sociopolitical movement of people identifying as voice hearers and their supporters. The HVM was championed through early research of Romme and Escher (Romme & Escher, 1989; Romme et al., 1992) highlighting that non-clinical voice hearers typically reported accepting attitudes to the experience as being part of their life and were not distressed by the experience. This highlighted that acceptance of voices as part of one's experience may be an adaptive means of living with it, suggesting that this approach may have value to people with distressing voices as an alternative to the traditional paradigm of seeking to eliminate voices as a pathological symptom. Consequently, within the HVM, many people have accounts of learning to live with their voices adaptively by moving from attempts to get rid of voices to turning towards and exploring the experience (Corstens et al., 2014).

A challenge, however, is that the hostile negative voices that are most common in clinical populations are difficult for people to find ways to accept, and this is where the skills in acceptance and mindfulness-based therapies may be facilitative. Following the first applications to psychosis by Bach and Hayes (2002), our group in Melbourne has had an interest in developing and trialling (Shawyer et al., 2012, 2017) these approaches for helping people who hear voices, with an ACT protocol for voices summarised by Thomas et al. (2013).

15.3 An Integrative Therapeutic Framework for Hearing Voices

We have run a specialist voices clinic since 2006 offering psychological therapies to people who hear voices (Thomas et al., 2010; Paulik et al., 2020). In providing a specialist service we have a need to consider research evidence in combination with emerging innovations in practice, and, in particular, how to navigate an expanding array of therapeutic approaches. Whilst CBTp is best evidenced and has provided a

useful overall model for practice with psychosis, specific elements for voices are less thoroughly operationalised, particularly if considering voices as a transdiagnostic phenomenon. Indeed, clinical experience in the Voices Clinic was that the best-operationalised cognitive targets for voices, such as perceived voice power, seemed to be the main source of distress for only some clients. In fact, many clients seen in the clinic were very insightful about their experiences, so much of the "psychosis"-focused cognitive work on developing alternative explanatory models has less well-aligned applicability. Many clients would say that they know the voices are being created by their minds, but they still find them intensely distressing. This suggests the potential for approaches with less emphasis on cognitive change. However, meta-analyses of other approaches (e.g. acceptance and mindfulness-based therapies, Louise et al., 2018; trauma-focused therapies, Brand et al., 2018) have not reported average effect sizes superior to those reported for CBTp. Indeed, experience in the clinic is that there is much individual variation in the applicability of most therapeutic approaches.

The development of therapeutic approaches that extend beyond the original CBTp model, but have a much less mature level of supportive evidence, suggests potential value in an integrative therapeutic framework that can flexibly accommodate innovations when working with hearing voices.

To do this, we have adopted a therapeutic model grounded in behaviour therapy – hence being consistent with both CBTp and third-wave therapies – which uses individual behavioural formulation to tailor therapy to the individual. This allows for the incorporation of broader therapeutic methods such as those from ACT. Heavily influenced by an early proto-CBTp approach developed by Tarrier (1992; Tarrier et al., 1990, 1993, 1998), the "Functional Analysis Informed Therapy for Hallucinations" (FAITH) model that we use in the Voices Clinic involves developing an individualised formulation of the patterns of antecedents and responses to episodes of hearing voices. The therapist seeks to understand variability in the experience, such as the onset and persistence of intermittently occurring hallucinations, and periods of increased (or decreased) intensity or distress associated with more continuous hallucinations. This draws on literature finding meaningful patterns of variation in hearing voices in response to identifiable antecedents such as noise levels, environmental stress, arousal, worry, rumination, and engagement in activity (Bell et al., 2022). It also draws on literature examining responses to hearing voices, including observations of meaningful but often inefficient engagement in coping strategies (Farhall et al., 2007), and tendencies to be drawn into hostile dialogue or relating to voices (Leudar et al., 1997; Thomas et al., 2009).

Because patterns of antecedents and response to this experience can vary substantially from person to person, therapy involves a collaborative process of developing individual formulation, or functional analysis, of experiences, used to consider potential ways to break out of unhelpful patterns that maintain distressing voice-hearing episodes. This is done on an ongoing basis as a focus of sessions to formulate recent episodes of hearing voices and identify potential exit points, similar to the chain analysis method used in dialectical behaviour therapy. This may be used both to problem-solve periods of especially challenging voices and to learn from

episodes of voice hearing that had been dealt with well. Through this, the clients' adaptive behaviours are identified and applied more systematically, and new self-management behaviours are introduced as indicated. As well as incorporating preventative and coping strategies, this might include cognitive strategies ("what could you tell yourself?"), mindful responding, defusion, or practice of alternative ways of interacting with voices. In the session, exercises are used as much as possible. Over time the aim is to give the client a strong familiarity with the patterns occurring with their own voices, to know how to avert periods of escalating voice intensity and distress, and build up habitual ways of responding to voices that allow the person to live with hearing voices without it dominating their conscious experience and day-to-day lives.

15.4 Case Study – Chris

To illustrate the integration of ACT methods within a broader functional analysis model, we present a case description of therapy provided by the Voices Clinic to a client we refer to as Chris, who was seen over a course of 18 one-to-one sessions. Chris was a man in his early 20 s who had been experiencing persistent auditory verbal hallucinations for approximately 2 years prior to coming to the Voices Clinic. He primarily heard a single voice, which was male, older, of moderate loudness, and heard continually. The content was almost exclusively derogatory in nature, with occasional directive commanding content. Chris described the voice as "like a grandfather," stern, authoritative, and demanding high standards of achievement. He described the voice making bullying comments such as "you're not good enough…" or "you're not going to be able to do this well." The voice would also encourage suicide or behaviour with negative outcomes such as excessive alcohol consumption. Chris reported experiencing extreme distress associated with these experiences.

At the point of presentation, Chris had withdrawn from his apprenticeship and was not working, he had also parted from his long-term girlfriend and was finding it challenging to socialise. When at its worst, he described being very much "drawn into" the experience of the voice and withdrawing from the external environment. Prior to hearing voices for the first time, Chris had been playing sport at a high level which was no longer possible due to a significant injury. His participation in sport had involved daily training as well as competition, and he had described this as a significant part of his social life and identity. The loss of this resulted in a dramatic readjustment of how he spent his time.

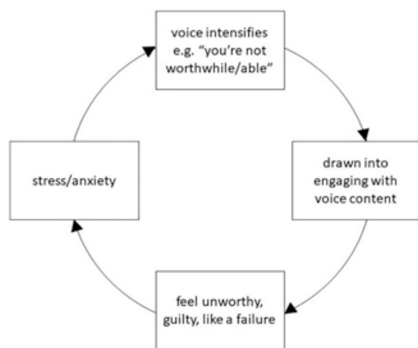
Therapy commenced at the Voices Clinic using the FAITH framework. As Chris experienced hearing voices on a continuous basis, the functional analysis focused on the exploration of when voice content was noticeably more derogatory, loud, or escalated in any way, and/or when he was most distressed. During the first few sessions, multiple situations in which the voice was louder or more derogatory were identified. These included when socialising with friends, when undertaking a task that he wanted to achieve well and when trying to sleep. Further discussion revealed

that these situations usually involved increased anxiety for Chris. This anxiety was fuelled by various factors such as feeling self-conscious or unsure of himself, feelings of guilt and failure associated with high standards of achievement, and rumination when trying to sleep. Anxiety in the social context became an issue for Chris partly due to a loss of social identity that had been enmeshed with his identity as a successful sportsperson. Chris also noted that his tendency to aspire to extremely high standards of achievement was, at least in part, fostered in the sporting environment. He had lost a significant source of validation and direction.

Chris also experienced voice content that would incite paranoid thoughts about being watched or talked about negatively by others. Antecedents for this type of voice content were situations such as walking in public or speaking to someone unfamiliar, for example, asking a question to a shop attendant. Similar to antecedents of escalating derogatory voice content, these circumstances also involved increased anxiety for Chris. These factors were drawn out in two overarching models of his difficulties with voices, illustrated in Fig. 15.1.

In addition to the responses included in these models, Chris would at times argue with or challenge the voice in an attempt to alleviate the distress from the experience. This approach tended to result in an escalation of the voice: Chris noted that the voice would get louder and angrier when challenged and if he tried to ignore the voice it would become very persistent and repetitive. If he asked questions such as "why are you saying this?," the voice would become annoyed that it was being questioned and either assert its authority or ignore Chris's questions.

Throughout the process of developing this shared formulation, Chris's personal conceptualisation of the voice content began to take shape. He noted that "sometimes he says he is helping me," and the voice "stems from my anxiety," observing that it reflected his worries but in a very exaggerated and severe way. Due to the central involvement of anxiety in Chris's voice-hearing experience, strategies for



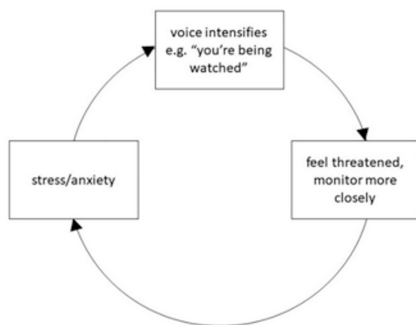


Fig. 15.1 Models of escalation of voice episodes informed by functional analysis. (**a**) Derogatory voice (**b**) Paranoid thoughts incited or encouraged by the voice

managing anxiety were a primary focus throughout sessions. This included psychoeducation about anxiety, identification of strategies for relaxation and reinforcement of regular practice of strategies. In addition to this, once chain analysis was completed for specific incidents of escalated voice hearing, time was spent collaboratively identifying "exits" from the spiral of anxiety and escalation. Some of the "exits" that Chris identified were changing what he was doing, engaging in a breathing exercise, having a shower, and exercising.

As Chris reported back about how he was going with putting into practice the strategies and "exits," an implementation challenge began to emerge. It became evident that strategies which could be viewed as achieved either successfully or not, would increase anxiety and the voice would escalate. For example, when Chris would attempt a breathing exercise with the goal of reducing anxiety, he would feel as though he had failed the exercise if he did not feel any relief from anxiety and the voice's derogatory commentary continued, which would, in turn, increase anxiety further. Imagery exercises were attempted; however, these also had the potential to backfire. When unable to conjure the suggested images, Chris would feel as though he were failing at the task and the voice would begin to interfere with comments about not doing it properly. For example, when attempting a "leaves on a stream" mindfulness exercise, Chris found that the leaves would not float down the stream but would stay still and stuck which would be commented on by the voice and thereby increase anxiety and feelings of failure.

In reviewing these patterns with Chris, we identified that focusing on trying to control the experience of hearing voices was becoming part of the cycles that were maintaining a struggle with hearing voices. We thought with Chris about considering finding an alternative way of responding to voices, paving the way for the integration of ACT methods. This concept was introduced to Chris using a "tug of war with a monster" metaphor (described in Thomas et al., 2013), where the option of "dropping the rope" was regularly reinforced as an alternative approach.

Values-focused work elicited values including maintaining strong positive relationships with friends and family, and hard work. Chris was already actively pursuing these values, however, with a significant level of distress. At this stage, Chris had started working with his father a few days a week, and he described "pushing through" despite often having significant anxiety and intense and derogatory commentary by the voice. This occurred both on the way to work and throughout the day. Chris also continued to spend time with friends on the weekends and work on his hobby of making furniture despite knowing that such activities would likely exacerbate his voice and anxiety. Identifying and discussing values allowed the goal to be redefined as moving towards what he wants in life despite the voice rather than trying to improve or reduce the experience of the voice. Although not explicitly stated this shift in goal was intended to assist with reducing the struggle with anxiety and the voice. It also created space for Chris to be proud of his achievements in areas he valued despite having to do so under distressing circumstances.

Defusion was introduced at this stage with the hope that, with practice, it would help reduce problematic engagement with the voice. Chris had reported a tendency to engage with the voice in his thoughts which had caused difficulty with

concentration and could lead to escalation of the voice and anxiety. The concept of "bad news radio" was introduced as a way to refer to the voices, which fit with Chris's conceptualisation of the voice as an exaggerated and unhelpful reflection of his anxiety. This metaphor was utilised to encourage Chris to allow the voice to play on in the background while he continued with other valued endeavours.

Imagery methods for assisting with the understanding of defusion tended to be problematic due to the voice content interfering and undermining Chris's attempts to focus and grasp the concept. Therefore, helping to develop Chris's understanding of defusion was achieved over time via metaphors, diagrams, and discussion. The idea of observer-self and thinking-self was introduced and initially, Chris tended to liken the observer-self to observing work he was doing and struggled to differentiate between the observer-self and the thinking-self. Without the aid of mindfulness visualisation exercises, defusion proved difficult to grasp, however over time Chris's understanding began to develop. This was achieved by various methods such as visual aids including a cartoon diagram showing thoughts as separate from the self, Titchener's repetition (e.g. "lemon, lemon, lemon…"), and conceptualisation of thoughts as "just words" prior to meaning and emotion being attached to them. These concepts were described often in relation to "thoughts," but it was regularly reinforced that they could extend to voice content, and thoughts and voice content were at times discussed interchangeably.

Metaphors were often integrated with the functional analytic formulation that was developed during earlier sessions. For example, Chris had a hobby of furniture building and had previously enjoyed seeing his work take shape. Unfortunately, his ability to enjoy his work was increasingly sabotaged by the voice which would criticise and make comments about him and his work not being good enough. Chris had developed an understanding that in circumstances involving an element of achievement, internalised high standards would exacerbate the voice's derogatory content. This awareness allowed him to improve on his ability to take a "step back" from these comments and reconceptualise as "bad news radio."

Once it became clear that Chris's understanding of defusion had developed well, the concept of "choice points" and becoming "hooked" by thoughts, feelings or the voice was introduced. This became a common way for the discussion to be framed, particularly when discussing events that occurred between sessions and were often helped with the visual aid of a choice point diagram. Chris developed skills in identifying his choice points and both utilising strategies identified during functional analysis and recruiting his observer-self to help get himself "unhooked." It was noted that becoming hooked by anxiety or the voice would usually involve becoming stuck in a spiralling situation as described by the functional analysis models in Fig. 15.1. At this point, Chris had reported that he wished to reconcile with his ex-girlfriend but was very anxious about how this might go. Increased anxiety in association with new experiences and changing circumstances was regularly normalised during sessions. Work then focussed on "making room" for anxiety and practicing becoming "unhooked" from anxiety. Again, without the aid of visualisation such as the ACT "expansion" exercise, this was achieved by other methods. The concept of "leaning into" the anxiety and allowing it to be there while he continues with what

is important to him, was frequently promoted. Chris was also encouraged to take inventory of the physical sensations of anxiety like a "curious scientist". The goal of this activity was to reduce fear of the feeling of anxiety and assist with creating distance or "unhooking" from it. There was also frequent discussion about how the feeling could exist at the same time as Chris could continue to do something he valued. There were some hiccups with the practice of "leaning into" anxiety, and it was identified that during this practice, Chris was hoping the anxiety would reduce. It was important to regularly reinforce that the goal was simply to be curious and approach with an exploratory attitude.

Chris was a very driven individual and working from a values-oriented perspective seemed to suit him well. He had strongly held values in relation to positive relationships with friends and family and achievement in work and leisure. During the early stages of his treatment at the Voices Clinic, Chris had already started to re-engage with some of these areas of life including spending time with friends and starting work, which he persisted with, despite often tolerating high to extreme levels of anxiety and distress associated with voice hearing. Chris was fortunate to live with his family whom he described as very supportive and encouraging which assisted him to stay engaged with his values and associated goals. The therapeutic goal of sessions with the Voices Clinic was primarily distress reduction and gently assisting him to shift focus from fixing the problem (making the voice stop) to pursuing a meaningful and fulfilling life despite the voice. Sessions included regular discussion of the previous week's events and associated challenges, which were informed by the functional analytic formulation, with the focus driven by his values.

Towards the end of sessions with the Voices Clinic, Chris described having arrived at a point of knowing the voice would be there but having decided to "move on" and "take action" anyway. His ability to disengage from the previous problematic spirals of anxiety and escalating voice causing increasing anxiety was becoming easier and more habitual. Whilst the voice remained present, he referred to it as not being "too bad". At this point, he had begun a full-time apprenticeship with his father's business, he had reconciled with his ex-girlfriend, was exercising regularly, and frequently spending time with friends. Reengaging with these valued areas of life, presumably increased Chris's sense of achievement and self-esteem, which likely also assisted with reducing anxiety. By the final session with the Voices Clinic, Chris reported that he felt equipped and enthusiastic about continuing his recovery on his own and getting on with life.

15.5 Discussion

This case study illustrates the potential for ACT methods to be integrated within an individualised formulation-based therapy for hearing voices. ACT methods were particularly indicated in this case because of the behavioural repertoire of attempting to control the experience of hearing voices operated as part of the maintaining cycle, which made a simple self-management or coping enhancement approach

difficult to effect change. Whilst behaviours that Chris could engage in that would help to reduce voice-related distress were identified, the intention behind their application required a different framing in order to be effective, which was supported by the experiential exercises on acceptance, defusion and values. This enabled him to use the strategies that had been discussed earlier in therapy and do so without being drawn into a cycle of unsuccessfully trying to forcibly suppress either the voices or related anxiety, which appeared to exacerbate the overall problem. In this way, ACT methods were supportive of the overall therapeutic approach, and enabled progress that appeared otherwise difficult to achieve.

A question arising is whether a pure ACT approach from the outset would have been equally successful. Whilst we do not know how therapy would have progressed in this case, the work on shared formulation provided the opportunity for socialisation into a shared understanding of how patterns of voices were being maintained, providing a rationale for exploring alternative ways of responding to them. This may be supportive of establishing a stronger therapeutic alliance, and stronger buy-in to the application of methods that are a significant shift from existing ways of coping. Qualitative data from a randomised controlled trial of a focused one-to-one ACT intervention for persisting positive symptoms (Shawyer et al., 2017) was that clients sometimes felt a disconnect between ACT exercises and their own experiences (Bacon et al., 2012). Anecdotal therapist experience from that trial was also that ACT could be confronting for many participants by threatening an established equilibrium of just getting by. We speculate that additional time on building a shared formulation may be important groundwork that enables a rationale for adopting a different approach to be developed, allowing ACT methods to be used more effectively.

Finally, the use of ACT within a functional analytic framework enables integration with a broader behavioural therapeutic model. This offers a coherent approach to clients for presentation of different therapeutic methods that allow for individualisation of therapeutic approach, beyond less voice-specific CBTp models, whilst also grounding the overall intervention in an empirically-supported framework that offers a balance between evidence-based practice and individualisation of therapy.

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

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