Chapter 19
Psychosocial Rehabilitation: An ART Approach – Clinical Cases

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19.1 Introduction

The leveled Acceptance and Recovery Therapy for psychosis (ART), based on the principles and philosophy of Acceptance and Commitment Therapy (ACT), addresses the limitations of other psychotherapeutic models in the treatment of Psychotic Spectrum Disorders (PSD). It places the affected person at the centre of their rehabilitative process, empowering them and adapting itself not only to their individual needs but also to their expectations of quality of life, demystifying the cultural ideal of happiness and encouraging the recognition and acceptance of their own personal history. It is a form of care focused on the person, on the interaction, on the understanding of experiences in the biographical context, on a recovery of the sense of self and on giving back the horizon of life to the person (Pérez Álvarez et al., 2011).

One of its main goals is to ensure the continuity of care for people with PSD from a biopsychosocial approach and an interdisciplinary perspective, which is not always easily achievable for the intervening team, due, in some cases, to the disparity of intrateam professional criteria and/or the fragmentation of the socio-health system itself, hindering the fluidity of communication. It is proposed as a humanistic model, focused on functionality, with the aim of taking advantage of the synergies of the interventions made by the different professionals participating within the therapy with the common objective of supporting the person so they can achieve the fullest, freest and most satisfactory life possible.

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The three clinical cases presented in this chapter comprise real clinical situations that we have faced in the context of psychosocial rehabilitation. The diversity of both clinical and social influencing factors makes it necessary to formulate each case, in which hypotheses of the origin and maintenance of the problems are considered. This subsequently allows for individualized planning of the intervention. ART provides innovative elements of its own and permits its complementation with interventions based on other models to adapt the processes, techniques and strategies to each particular case.

19.2 First Case: In the Right Direction – Addressing Behavioural Disorganisation in Psychosis

First Hand Experience *"I have not had an easy life. Some of the experiences that I have had, especially during my childhood, have left a mark on me. Hearing voices insulting me or feeling that everyone is against me, without understanding what was happening to me, has been hard. Fortunately, my mother and my sister have always supported me, although sometimes, when I was not well, it was difficult for me to acknowledge it and I have even thought they were against me as well. But deep down, I know that they love me and that they do what is best for me. I would not have been able to get through this without my mother. Professionals' support has also been very important. I know that I have not always made things easy for them and I apologise. Their closeness, understanding and availability have been fundamental for me to get better. They helped me to better understand what is happening to me and to find ways to relieve the suffering. Thanks to this, I have been able to escape from a chaotic life and to focus on things that are important to me in life and that help me live better. I thank all those who have been by my side for their patience and dedication".*

19.2.1 Introduction

Assertive Community Treatment, developed by Leonard Stein and Mary Ann Test in Wisconsin (USA), is a way of structuring care for people with Severe Mental Disorders (SMD) that focuses its field of action on the closest environment of the patient (Stein et al., 1975). The flexibility in care, its adaptation to the particular circumstances of the patient, and the members' availability and accessibility to attend and deal with possible incidents and unforeseen events are other principles of this model.

Assertive Community Treatment focuses on taking care of people with SMD with a high level of clinical severity that significantly affects the patient and/or their environment, who usually present a high level of dysfunctionality and who, in addition, lack of consistent support figures to help them get out of the situation in which they find themselves. Following Martínez-Huidobro and Herrera (2021), in the daily clinical practice of this treatment's teams, we observe that users can be divided in different clinical profiles, according to the following factors:

- Social situation
- Degree of impairment and dysfunctionality
- Level of behavioural disorganisation and alteration
- Subjective perception of the need for support

According to these authors, if we take these factors into account, we can classify the profile of users into four groups:

1. User with predominance of social exclusion
2. Users with predominance of impairment and dysfunctionality
3. Users with predominance of behavioural disorganisation and alteration
4. Users with predominance of anosognosia (Martínez & Herrera, 2021)

Below we present the clinical case of a patient with predominance of disorganisation and behavioural alteration who is being followed-up by an Assertive Community Treatment Team (ACTT), approached from a contextual perspective, and based on the principles of ACT and Functional Analytical Psychotherapy (FAP), as well as some of those proposed by layered ART (Díaz-Garrido et al., 2021).

19.2.2 Clinical Functional Description

19.2.2.1 Clinical Case

Patricia is a 26-year-old woman diagnosed with paranoid schizophrenia since the age of 18, with numerous admissions to the acute psychiatric hospitalisation unit. She has been legally incapacitated for about 4 years, with her mother being her legal guardian. She has a history of serious self-harm attempts in the context of psychotic decompensation and associated depressive symptoms. She has had multiple partners throughout her life and tends to maintain short, unstable relationships. She was admitted to the medium-stay unit for 6 months. When she was discharged, she was followed up by the ACTT and referred to a day centre for psychosocial rehabilitation activities. Follow-up visits at the user's home are carried out twice a week, while she attends the day centre three times a week. Patricia lives with her mother, but they do not have a good relationship since the patient has difficulties in complying with the rules of cohabitation and tends to present frequent behavioural alterations. In general, Patricia has low tolerance for frustration and a tendency to overwhelm in stressful situations that she does not know how to manage. In this context, she tends to present disorganised behaviours. Within the clinical dimensions recognised in PSD, one of the dimensions that has not received much attention is disorganised behaviour, despite the fact that it generates significant functional impairment. In this dimension we can find, among others, formal thought disorders, disorganised and bizarre conduct, as well as inappropriate affect. In Patricia's case, we observe how in moments of instability, thinking becomes disordered, which is expressed through a maniac, lax and even disintegrated discourse, and which hinders coherent and logical reasoning that allows planning behaviours oriented towards specific goals. In turn, affect also loses internal consistency and its relationship with direct contingencies, so that inappropriate affect is presented, which does not seem to be in accordance with the circumstance. All this leads to Patricia's conducts being chaotic, erratic and without a clear purpose. These behaviours usually occur abruptly, in relation to stressors and generate alarm and overwhelm in her environment, especially in the figure of her mother. The last presents high expressed emotion, which at the same time is a source of stress for Patricia, thus generating a vicious circle. The duration of these periods of disorganisation is variable (from hours to days) and often depends on how soon she can count on some form of support (usually psychotherapeutic or psychopharmacological intervention).

19.2.2.2 Formulation from a Functional Analytical Psychotherapy Approach

The following is a brief formulation of the case from the perspective of FAP, an approach in which the therapeutic relation itself takes on primary importance as the main working tool. Verbal dialogue constitutes the basic interaction, and the therapist acts as social reinforcer (by being natural, emphatic and by allowing intimacy) (Kaholokula et al., 2013). One of the great advantages of working with the FAP approach in an ACTT is that it allows all members of the team involved in the case to have a clear outline of what the patient's main problems are, as well as the goals of the treatment, understanding the relationship between the behaviours that come up in the follow-up interviews and their generalisation to the person's daily life. In a relatively simple way, FAP allows all professionals to work on the same line, to use the same reinforcers and to evaluate from time to time as a team both the objectives and their achievement.

The therapeutic process in FAP is fundamentally based on what the client does and say in the clinical session itself. These behaviours have been named as Clinically Relevant Behaviours (CRB): CRB1 are the client's problems that occur during the sessions, which the therapy must try to diminish; while CRB2 are the client's behaviours that are considered improvements that happen during the session.

We will briefly review the main aspects to be considered from the FAP approach for the formulation of Patricia's case.

(a) *Daily Life Problems*

- Difficulties in communication with her mother and little collaboration in household chores, which leads to frequent conflicts between them.
- Low tolerance to frustration, with escape responses to emotional discomfort. In the face of arguments in the family context, Patricia responds by escaping

from home, frequenting marginal environments and exposing herself to various risky situations (consumption of toxic substances, promiscuity, etc.).
- Difficulty in keeping daily schedules and routines.
- Irregular intake of psychopharmacological medication.

(b) *Problems in the Session (CRB1)*

- Passive attitude towards the recovery process. She is extremely complacent, responding affirmatively to the therapeutic tasks and objectives proposed, but showing superficial commitment, as in general she does not make an effort or carry out concrete actions to comply with what has been agreed.
- Tendency to minimise behavioural alterations, frequently presenting and external locus of control, blaming the environment and the circumstances.
- Difficulty in developing intimate relationships.
- Difficulty in identifying and expressing her internal events.

(c) *Cognitive Concepts that Interfere with Therapy*

Since Patricia's discourse tends to be induced, sparse and rather superficial, it is not easy to determine, at first, which cognitive concepts interfere with therapy. Even so, the belief that she is a "victim of the disease" and that she does not have an active role in the evolution and development of her own life and future stands out particularly.

(d) *Daily Life Goals*

- Improve communication with her mother and reduce conflicts.
- Collaborate in household chores.
- Reduce avoidance/escape behaviour and increase tolerance in stressful situations.
- Comply with the schedules established with her mother for arriving home, and in case of going out, give an account of where and with whom she is, so as not to generate an alarm in the intra-family environment.
- Create routines and schedules to be able to get up early and attend the day centre for activities focused on psychosocial rehabilitation.
- Reduce the consumption of toxic substances.
- Avoid risky sexual behaviour. Use contraceptive and barrier methods to avoid unwanted pregnancies and the spread of sexually transmitted diseases.
- Improve adherence to psychopharmacological treatment.

(e) *Objectives in the Session (CRB2)*

- Increase the frequency of the verbalisation of mental and emotional processes.
- Increase the number and frequency of assertive statements, making direct requests about one need's and wishes; recognise when she does not agree with any of the proposals made in therapy and be able to introduce her own criteria and negotiate with the therapists regarding the objectives to be achieved during the approach.
- Clarify values and promote concrete value-oriented actions.
- Improve the ability to foresee the potential consequences of her actions.
- Increase involvement and active commitment in her therapeutical and recovery process.

19.2.2.3 Functional Analysis

In the profile of patients in whom behavioural alterations and disorganisation predominate, such as with Patricia, functional analysis of conduct is particularly useful, as it allows professionals and the patient to understand problematic behaviours in terms of the interaction between the environmental variables and those of the person themselves, in order to be able to influence these variables to modify these behaviours (Martínez-Huidobro & Herrera, 2021).

When carrying out the functional analysis in PSD, it is essential to take into consideration the existence of possible difficulties at a cognitive level. Patricia presents attentional and working memory deficits, which is why it is necessary to simplify the functional analysis. Some adaptations to keep in mind when preparing this analysis together with patients with cognitive impairment are (a) not to use technical terms, (b) use a chain analysis instead of organizing the elements under the three-term contingency and (c) the number of elements included should be relative to the working memory capacity.

As it can be observed in the conducted formulation based on the FAP perspective, Patricia has multiple problems both in her daily life and in the session itself. This means that various functional analyses of the case can be carried out if we want to break down and try to understand each of the patient's behaviours in different contexts. However, a maintenance hypothesis is proposed based on the negative reinforcement paradigm of the escaping/avoidance response type, which attempts to relate some of the daily problems to the difficulties that exhibited during the session. Description of prototypical situation: Patricia was at home with her mother during a therapeutic leave and her mother criticises her for spending the whole morning in bed without doing any housework. Patricia feels anger, distress and impotence, she thinks everyone is against her, that no one loves her and that she can no longer bear the situation, so she leaves the house amidst unintelligible shouting and slamming the door.

What is the problematic behaviour? The one to be analysed was that of escaping/running away from home and from the psychotherapeutic session itself, as a response to unpleasant internal events.

What precedes this conduct? It can be understood that the antecedent of the problematic behaviour in the described situation is the argument with her mother (interpersonal stressor) and the unpleasant internal events (thoughts, emotions and sensations), which from Patricia's reinforcement history have acquired a discriminative stimulus function. Patricia's escape responses tend to occur in interpersonal contexts that involve participation and bonding in intimate relationships. It is crucial to consider that context and conduct have a bidirectional relationship.

And what are the consequences of such conduct? The short-term consequence of the problematic behaviour, the escaping, is the relief of discomfort. However, this brings some other problems, since during this escaping, Patricia tends to frequent marginal environments, consume toxic substances, engage in risky sexual behaviour, abandon her medication and expose herself to other risky situations. In turn, this generates discomfort and emotional overwhelm in her mother, resulting in higher levels of expressed emotion and the subsequent conflict between them. The hypothesis formulated following the functional analysis of the escaping/running away response type states that this behaviour is maintained through the reduction of emotional distress, with negative reinforcement as a function.

And how does the functional analysis of this problematic behaviour relate to the problems that appear during the session? (Figure 19.1). The escaping behaviour that usually occurred in the family context in response to emotional distress had also occurred in therapy context, since Patricia abruptly stood up and left the shouting in two occasions. During the sessions, a poor ability to perceive her own psychological events is continuously observed. It is likely that this difficulty in observing and describing what is happening to her on a cognitive and emotional level, which occurs during the session, also happens in her daily life, for example, during arguments with her mother. Since she is not able to tolerate such discomfort, she tends to escape from aversive situations.

19.2.2.4 Evaluation

Following ART's proposal, in order to plan and tailor the intervention to the person's needs, it is necessary to take into consideration whether there is cognitive or functional impairment, and if so, to what degree. The patient was referred to the neuropsychology unit for a cognitive functioning assessment. The results are shown below:

Used Tests and Psychometric Results
Qualitative Results

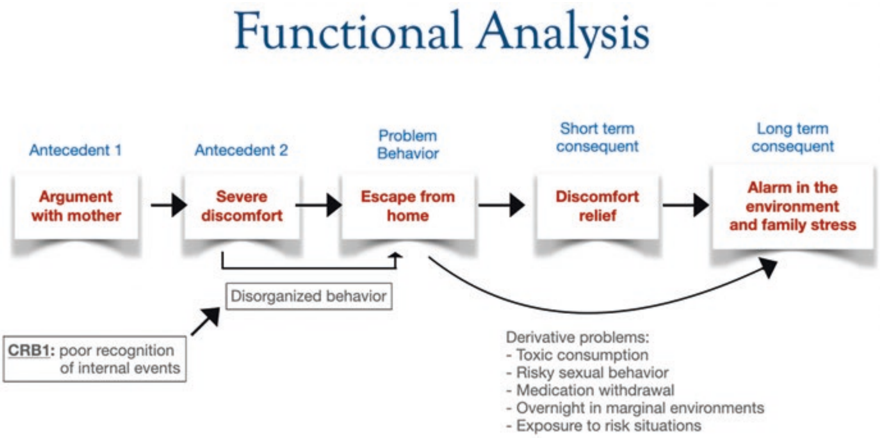

Fig 19.1 Functional analysis

The results obtained show:

- At the attentional level, the patient obtains pathological results.
- The same occurs in visuoconstruction, with results that are considered pathological. In visuorientation and perception (gnosia), the results are established as average.
- Working memory shows low but not pathological results. There is difficulty in learning, with impaired capacity for information storage (pathological).
- Executive functions measured through the capacity for response inhibition show pathological results. Alternating attention shows low but no pathological results.
- Language is affected at the level of phonological fluency, not semantic fluency (the lower limit).
- Functionality has not been ascertained.

19.2.2.5 Psychotherapeutic Intervention

From FAP's point of view, what the client does both inside and outside the consultation room is directly related, so that, by working on the objectives in the session, they would be generalised and would also be applicable to the "daily life goals."

In this case, the escape behaviour that usually occurs in the family context in response to the emotional distress had also occurred within the therapeutic context, where, on two previous occasions, Patricia had got up abruptly and left the room screaming.

In this case, the limited ability to observe and describe her own internal events results in the disruptive appearance of disorganised behavioural disturbances in everyday life. Therefore, we tried to help Patricia increase her capacity to observe and discriminate her own internal events, as well as to understand their relationship with her conduct in different contexts, reducing her disorganised behaviour and its negative consequences. The main tool used in therapy to move from CRB1 to CRB2, as proposed by FAP, is the therapeutic relationship itself, with the therapist using their own reaction as a possible natural contingent reinforcer to Patricia's conduct.

Hence, one of the ways of increasing the recognition and expression of emotions involves the modelling and reinforcement that take place during the session. Thus, the therapist has the role of evoking Patricia's emotional response to encourage and reinforce discrimination (tacting), as well as sharing her own emotional reactions in the therapy setting, in a way that models intimate behaviours. Continuous feedback and clarification of the therapist's own emotional response is of enormous importance in the treatment of schizophrenia, as the tendency to interpret facial expressions representing neutral emotions as negative has been described.

The generalisation of CRB2 can be facilitated if it is systematically reinforced by the members of the *extended therapeutic team*, "who will constitute an extension of the therapist for observation, evocation and reinforcement of CRBs". As an example, we will discuss its application within the present case: Patricia, when she is distressed, starts to wander around the hospital ward and makes continuous demands to the staff to provide her with certain tools (tobacco, toiletries and especially medication). These repeated demands generate stress in the staff, who end up using punitive responses that increase Patricia's distress and discomfort, with greater behavioural and emotional instability.

A broader outlook at the function of the conduct allows us to understand that Patricia's demands were attention-seeking and constituted a form of dysfunctional communication. Through the joint understanding of the patient's conduct by the extended therapeutic team and the application of consequences contingent on the "real" function of the behaviour by all members, it is easier to get an increased emotional expression and the establishment of bonds of intimacy, as well as their generalisation. This way, the "disguised authorities" were extinguished, while facilitating the implementation of the alternative conduct, emotional expression and direct request of needs, which was reinforced in the form of active listening by team members.

Regarding the discrimination of internal events (sensations, thoughts and emotions), mindfulness was also implemented, intending to facilitate the distancing from the literal content (cognitive defusion) and increase the window of tolerance to discomfort. Cognitive defusion interventions are especially useful in patients with a predominance of impulsivity, given the difficulty in distinguishing between external events and their own thoughts, which conditions an imminent reaction to the subjective experience felt at that moment (Martínez-Huidobro & Herrera, 2021). We therefore work in gradually weakening the control that internal events exert over behaviour. For example, Patricia was able to understand that her feelings and thoughts of "imminent harm and catastrophe" associated with the intense discomfort she felt when arguing with her mother were more a response to her own inner world than to external events.

The mindfulness activity lasted for five minutes during individual sessions, with verbal guidance (that faded progressively) redirecting Patricia to *environmental sounds* as anchors every sixty seconds initially. Mindfulness was also included in other group activities, in which the duration was increased to ten minutes. This reduction and adjustment of the duration of mindfulness-based exercises responds to Chadwick's proposals (2009) in relation to psychosis, but above all to the need to adapt the intervention to the patient's attentional difficulties. In psychosis, it is important that the anchors are chosen by the patients, especially when there is sensory-perceptual phenomenology, since if the symptomatology is not adequately explored, the therapist's guidance towards generic anchors can lead the person to have psychotic experiences directly. In Patricia's case, no hallucinatory or delusional symptoms were present during the intervention.

Continuous work in the functional analysis of problematic behaviours makes it easier for the person to become aware of the sequence that leads and maintains dysfunctional behaviour. It facilitates the observation and discrimination of internal events and conduct, promotes the ability to anticipate consequences, and the understanding of the relationship between the different variables, thus easing the implementation of alternative conducts that are more context-adaptive (reinforcing).

Furthermore, the joint performance of the functional analysis favours an active involvement in the recovery process and strengthens the therapeutic alliance.

The behavioural alterations of this patient profile often lead to a high degree of alarm in their immediate environment, therefore, working with the people around them, training them in the recognition and management of their own emotions and facilitating the understanding of how their behaviour/response can influence the patient can be of great help (Martínez & Herrera, 2021). Two types of approaches were carried out in the family setting:

(a) Contextual dialogic intervention. During one of the patient's escapes, after being found by the police and returned to her home, part of the therapeutic team (psychiatrist, nurse and social worker) went to her home and carried out an intervention in situ, with the presence of her social support network (her mother and a very close friend), where the point of view of the different parties about Patricia's current situation was presented and decisions were taken jointly regarding a therapeutic plan.

(b) Psychoeducational intervention, where in addition to emotional recognition and management, aspects such as high expressed emotion and functional analysis were addressed. This helped Patricia's mother to understand her role in the events and how she could also influence them with some behavioural modifications. For example, by decreasing criticism and expressing emotion during conversations with her daughter. In addition, work was done on the use of explicit and direct wish requests and expression of needs, as this also difficulted family communication.

Values orientation was another fundamental pillar in the intervention, due to the fact that for long periods of time, they had been living a chaotic, precarious life without a clear orientation because of their life circumstances. The process consisted basically in a clarification of values at first (family, friends, academic training, work and sport) through the Values Questionnaire of Wilson and Luciano (2019), and then to start taking concrete steps that were translated into actions oriented towards these values. Emphasis was placed on the difference between "wanting" to do something and "having the will" to do it. It was necessary to use experiential exercises to make the interventions more concrete, given that the patient has some difficulty in abstract thinking, like many psychotic patients with neurocognitive impairment (Reininghaus et al., 2019). The introduction of metaphors and experiential exercises is important as it involves biographical elements in the memory, thus facilitating recall. It is also important to take into consideration that episodic memory is generally preserved in psychosis, and that deficits are found in semantic memory. Thus, for example, we applied the experiential exercise of the glass of water with Patricia, in which, at first, she was asked to walk from one side of the room to another with a glass full of water in her hand, without spilling a drop. Patricia tried to do it with great difficulty and could not practically take a step without spilling water, so she was unable to move forward. Secondly, she was told to try to focus on getting to the other side of the room, without paying much attention to whether or not water spills out of the glass. This way, Patricia was able to make the functional equivalence between the stalemate of focusing on avoiding spilling water and her personal situation of actively trying to avoid discomfort, yet still being able to move forward.

According to the neuropsychological assessment carried out, Patricia presented neurocognitive impairment in some neuropsychological areas, for which a series of adaptations were made in the interventions following ART (Díaz-Garrido et al., 2021). In general, attention difficulties require a reduction in consultation time, continuous repetition of the elements throughout the sessions, with a slower pace of presentation, using verbal and written summaries. The sessions focused on psychotherapeutic aspects and had a duration of 35 minutes, due to the difficulties in maintaining attention, and with a frequency of twice a week, so that Patricia would have enough space and time to assimilate the content. Individual sessions were structured as follows:

- Five minutes for mindfulness exercises to work on the observation and description of body sensations and emotions.
- Five minutes to remember the content of the previous session. An outline of the previous session is provided, and the amnesic evocation is addressed, giving clues in case of difficulty, to facilitate recognition. The elements remembered or recognised are written down by Patricia on the diagram provided.
- Ten minutes for the elaboration and comprehension of the functional analysis adapted to the cognitive capacities of the patient.
- Ten minutes on value orientation and agreement on the implementation of specific valued-oriented actions. Likewise, sessions were focused on a specific topic, avoiding addressing several topics at the same time, due to the difficulties detected in response inhibition. In addition, if at any time Patricia's discourse was more maniac or disperse, she was redirected as many times as necessary to focus her attention. A single experiential exercise (the one with the glass of water) was used as a guide for the whole process, so that by performing it repeatedly, Patricia could internalise its functional equivalence in her daily life. Similarly, instead of resorting to multiple metaphors, which could have been overwhelming and even confusing for Patricia, a single guiding metaphor was used, in this case, the "Storm Metaphor" proposed by Díaz-Garrido et al. (2021).
- The last five minutes are devoted to reviewing and elaborating an outline of the content covered to facilitate recall of the session.

Throughout the process, the therapeutical bond was the fundamental pillar of each intervention, and the adaptative behaviours were successively reinforced and moulded. It should be noted that given that ACT provides a holistic approach, in addition to these spaces dedicated to psychotherapy, other spaces were also dedicated to social-community aspects and rehabilitative activities (accompaniment to shopping, financial management, supervision of personal hygiene, etc.).

After a period of intensive work based on the assertive community approach and the contextual principals and some of the adaptation proposed by ART, the patient has made significant progress in her recovery process, which mainly translates into an improvement in her psychosocial functioning and quality of life. She has been able to understand the dynamics underpinning her behaviours through the

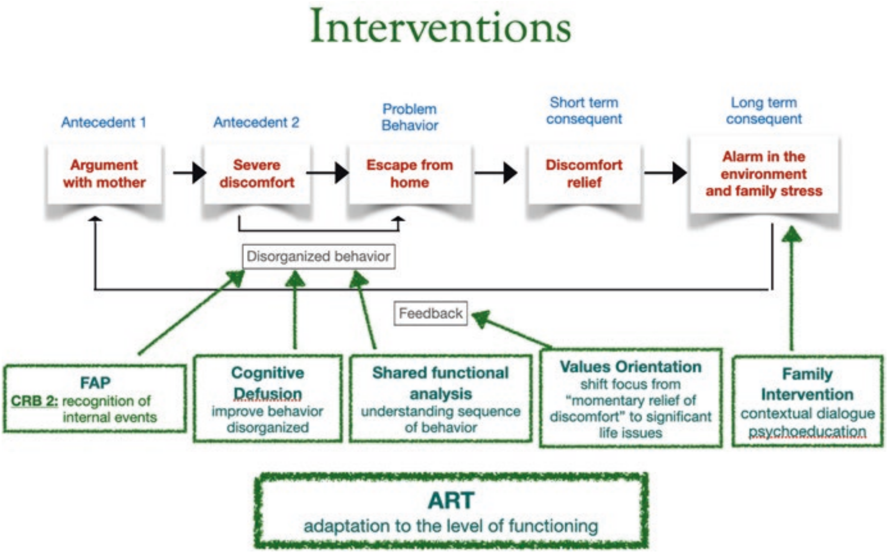

Fig 19.2 Interventions

functional analysis carried out jointly with the professionals. As stated in the everyday objectives proposed since the formulation of FAP, Patricia has improved her communication with her mother and conflicts between them have been significantly reduced. Even when differences of opinion or any other type of problem arise, the patient can manage her emotions better, to distance herself from them and dysfunctional behaviours such as escaping from home have been reduced. Consequently, the rest of the problematic behaviours have also been reduced. At present, there is greater collaboration in household chores, she has established routines and schedules, has substantially reduced her consumption of toxic substances, and has improved her adherence to psychopharmacological treatment. Attendance at the day centre has been regular, and her activities are being oriented towards her next academic training in the field of hairdressing and cosmetics. She spends quality time with her family and friends and engages in healthy leisure activities to direct her life IN THE RIGHT DIRECTION, while having the support of professionals and significant people in her life in this process.

Figure 19.2 shows a review of the intervention.

19.3 Case 2: Moving Forward in a More Calmly, Safely Way

First-Hand Experience *"I started to feel bad in high school, with my schoolmates I felt like a misfit, invisible, as if I did not exist. Sometimes, I did things to make myself visible. I could not study, I wanted to leave. I was lost and disoriented. Later*

I started going to a meditation centre where they gave talks about mental connection and destiny. I have experienced a lot of emotional instability, anguish, and psychosis. My main supports in life are my family and mental health professionals and I want to highlight how much they have helped me. My experience has been hard, but I have come a long way by communicating with them and accepting reality. Accepting the treatment and trusting the team has been fundamental. I have now stabilized, and I have a calm life. I feel more peace and self-confidence. The work in the unit and in day centres has been so positive for my psychosocial rehabilitation. I feel recovered: I am active, and I have some projects, like getting my driving license or studying something for the future".

19.3.1 Clinical Case

Luis is a 26-year-old, single and childless, with basic education and no work experience, that lives with his mother and sister. He grew up and spent part of his childhood in Colombia, homeland of his father's family, without incidents, although with hard experiences. At the age of 4, he moved to Gran Canaria with his mother and sister due to insecurity in the country. His father died at that time.

At the age of thirteen, he started to be seen by mental health services due to family and school problems. When he was 19, he went to the emergency department for behavioural disturbances in his family home. He presented cognitive distortions, and paranoid ideas of harm and felt that his thoughts were being controlled by someone else: he was perplexed and suspicious, with unmotivated laughter and probable hallucinations. He was first admitted to acute care and diagnosed with paranoid schizophrenia. When his positive symptoms subsided and he was discharged, he continued his follow-up with psychiatry, clinical psychology, nursing and social work professionals in the outpatient mental health unit.

In the following years, he went several times to the emergency department and had other acute admissions, sometimes presenting grandiose and mystical delusions, frequently intense anguish, significant obsessive symptomatology and suicidal ideation. Given his negative symptomatology and Luis' request for help to organize his time, he was referred to the Day Centre for Psychosocial Rehabilitation (DCPR), which he attended several times a week for years.

At the age of 25, he attempted suicide in the context of intense psychotic distress, and he was hospitalized following several fractures and admitted for the fourth time in acute care.

When discharged, Luis was transferred to the Medium Stay Unit (MSU), a clinical and intensive rehabilitation unit. Initially, the pharmacological treatment comprising antipsychotics, antidepressants and anxiolytics had been adjusted and multidisciplinary interventions had been carried out, involving the participation in nursing activities and occupational therapy. After some improvement, family permission was tried, which was long due to COVID regulations. This required an early return to the MSU and again to acute care due to high anguish with new suicide attempts and risk of committing suicide.

After the last discharge from acute care, the psychotherapeutic approach based on ART begins.

19.3.2 Clinical Formulation

Luis' main identified problems are described below:

(a) *Symptoms, expression of intense discomfort:*

Affective symptoms are related to inflexible avoidance (Van Os & Kapur, 2009). Luis presented some depressive symptoms, which are associated with increased relapse, suicidal behaviour (McGinty et al., 2018) and interpersonal problems (Vallina et al., 2019). Luis described depressive ruminative thoughts about feeling trapped by his problems, hopeless about the future, with no realistic current goals and having difficulty enjoying free time. He expressed significant frustration for not being a policeman or civil guard as he wished, for not having been able to continue his studies and he felt also guilty for "not having improved earlier". Luis frequently presented anxiety, which plays an important role in threatening interpretations and the maintenance of delusions (Freeman, 2016). He was particularly anxious about some interpersonal situations, about his own emotional distress resulting from the fear of experiencing a psychotic crisis, and about new situations such as "getting back to normality" and dealing with the community outside the hospital.

Positive psychotic symptomatology. Auditory-verbal hallucinations persisted. These are paranoid interpretations which, together with overvalued mystical ideas, occupied his attention daily, mentally dialoguing with them. As Chadwick and Birchwood (1995) describe positive hallucinations during a stage of little meaningful activity cause him to respond with involvement, which has made Luis' social life difficult. Unpleasant hallucinations generated him anger or confusion, tending to fight them through action. For example, in a crowded shopping centre, he heard former high schoolmates threatening him. This made him angry, and he changed his behaviour, becoming "more arrogant, as if prepared for a possible fight".

As precipitating factors for Luis' emotional distress, we found situations that entailed a high demand on his cognitive and/or emotional resources, such as emotionally charged social interactions, a high level of environmental stimulation (complex external stimulation) or the experience of ego-dystonic mental content (complex internal stimulation), which is difficult to understand and cope.

(b) *Deficits or limitations in his behavioural repertoire:*

Difficulty in developing information and identifying own and other people's emotions. This can be explained to a large extent by deficits in basic cognition (Dickinson et al., 2004) and social cognition.

Tendency towards rigid rationalization. Luis tended to solve all problems with rigid rationalization, thinking about them and trying to find an explanation, which led him to ruminate about experiences both from distant and recent past. He was very attentive to his mental contents (thoughts, emotions, psychotic symptoms) and he judged them, getting caught it vicious circles that generated significant distress and isolation. The excessive self-reflection to fight against one's own experiences difficult the situation (Sellers et al., 2017) and feedback into the control-focused attention and lack of social involvement (Pérez-Álvarez, 2008).

Poor development of skills to tolerate and/or manage distress, partly conditioned by deficits and lack of learning experiences in his difficult past.

Avoidance of situations perceived as stressful and *hyper-reflexivity* (transdiagnostic phenomena) was very prominent in Luis and played a role both in the maintenance of emotional distress and its symptomatic expression and in the maintenance of the deficits, reducing the learning opportunities and experiences.

(c) *Significant problems in his psychosocial functioning, influenced by the limitations and symptoms experienced:*

Self or aggressive behavioural alterations at times of high distress. This affected family dynamics. There was an environment of emotional tension. His family expressed intense fear of new suicide attempts and, in general, of the loss of control.

Isolation, with loss of social network outside the family of origin and desire to have it.

Lack of value-directed actions. He carried out few meaningful activities, which made him feel "lost".

(d) *As predisposing factors* to the symptomatic expression of his intense emotional distress and limitations in his behavioural repertoire, the following are considered:

Biography with traumatic experiences in early stages, such as the suicide of his father, the experience of loneliness, rejection in adolescence and school dropout. This had led Luis to a personal narrative very focused on death and the absence of his father, as well as his social inadaptation in the adolescence. He presented marked emotions that were difficult to manage regarding his main family figures: a certain envy and guilt in relation to his sister, intense anger towards his father and moderate anger towards his mother and maternal grandfather because, as adult reference figures, "they could not help me" (they could not avoid his intense suffering and the development of the psychosis) either due to a perception of excessive control or the lack of it.

Consumpsion of cannabis and alcohol at an important stage for the development of his personality and relationships with others.

Family culture with a tendency towards self-control and complex communication, sometimes deviant or with a tendency towards abstract, mystic contents, which in Luis' case generated confusion and fusion with mental contents.

Figure 19.3 summarizes the formulations of the described problems and related factors.

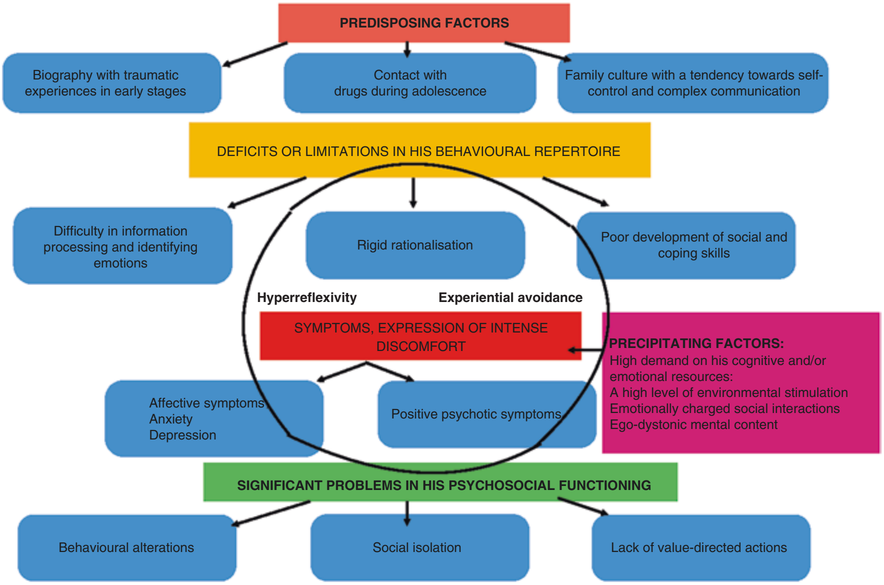

Fig 19.3 Formulations of the described problems and related factors

19.3.3 Intervention and Progress

The work with Luis has been aimed at improving his well-being and life-satisfaction. For this purpose, we have tried to reduce his hyper-reflexivity and avoidance and we have intervened specifically in the different levels of problems he presented: in his psychosocial functioning, in his emotional distress and in his limitations (promoting rehabilitation and development of skills), helping him to modulate the effect of predisposing and precipitating factors.

Luis has been treated using ART (Díaz-Garrido et al., 2021). A fundamental aspect is that the model understands the therapeutic relationship based on humanistic values, such as unconditional acceptance, empathy and authenticity and also understands human behaviour in a global and holistic way, as a part of a unique story. It uses a transdiagnostic approach, avoiding a focus on reductionist stigmatising labels.

Other outlined principles of ART model that were especially useful in planning Luis' intervention include the following:

- Multidimensionality, guarantees the continuity of care through different dimensions and contexts of the person: integration into normalized community activities and coherent integration of elements from other models, such as the empty-chair technique from Gestalt orientation (Martín, 2007). The use of contextual dialogism maintained both with the professionals of the different departments involved, in order to consider the vision that each one contributed to the case, and especially with the family, stands out. The family's approach to difficult experiences and current dynamics made it possible to listen to the different voices and perspectives of each person, achieving a certain systemic psychological flexibility. For example, in a family meeting, his mother affirmed that "it is the first time that I feel that we are three, three different people", redefining a new position of the family members and thus marking the identification of an important change.

- Interdisciplinarity, highlights the important of the work of the extended therapeutic team in which, in addition to psychiatrists, clinical psychologists and nurses, there are also nursing assistants, occupational therapists, social workers, social integrators, etc. Their work has favoured his learning of various instrumental activities, his perseverance, and his implementation in community contexts.
- Adaptation to the cognitive and functional impairment level, for which, in addition to the clinical interview and observation, specific scales were administered, resulting in an assessment of "mild impairment", which implied slight adaptations in the interventions (such as sessions with less content, informal mindfulness practice and the use of clarifications and physical elements in some metaphors).

Before starting, it is essential to highlight the *strengths and resources* of Luis and his family, because their contribution has made it possible to move forward in his recovery process. These include the following:

- High motivation to feel better and desire to get involved. He wanted professional help and put his trust in it. Professionals who previously treated Luis also played a part in this motivation, which constituted a helpful experience for him.
- Luis' prosocial values such as respect for others, solidarity and humility.
- Personal values such as honesty, responsibility, desire to improve, perseverance and determination.
- Well-preserved autonomous functioning.
- Tendency towards introspection, which favoured a good level of psychotherapeutic work.
- Involved family, highly resilient, having faced traumatic experiences, oriented to the development of its members and to encourage their own responsibility and autonomy.
- Having basic needs covered, with accommodation in the family housing and financial availability, which made it possible to participate in community activities that required costs.

Interventions have taken place in the flexible ACT phases described by García Montes and Pérez-Álvarez (2016):

(a) *Creative hopelessness* to contact with the need for change, with the difficulty to move towards vital goals with the strategies used so far. Luis attributed his difficulty in achieving his current goals to his father's suicide. This narrative, which in short term was used as a strategy to soothe the contact with his problems and his lack of committed action, in long term kept him in the vicious circle of avoidance, remaining trapped in his mind. During the sessions, we discussed what Luis needed and demanded about his past experiences, but we also encouraged him to focus his attention on the present and on the future, on his current life and what he was doing in it. He became aware of the fact that the previous narrative extremely focused on his hard past was not helping him to feel better and was not useful to move forward to where he wanted to be.

(b) *Control as a problem*, promoting the understanding that internal events cannot be controlled and that avoidance strategies such as hyperactivity or isolation have a high cost.

Luis had tried to control unpleasant emotions such as sadness, fear, or boredom by organizing free time in a very structured way to avoid discomfort. The control and scheduling of activities made it hard to enjoy leisure and free time in a relaxed way, experiencing it as "dangerous unproductivity".

We tried to foster greater understanding and acceptance of his mental states.

Different emotions, including the unpleasant ones, were normalized, and the need to accept the inevitability of some degree of suffering in human beings was raised. Both at the individual and group level, within the Social Cognition and Interaction Training (SCIT) (Roberts et al., 2009), emotions were treated as human, universal and functional, without pathologizing them. He participated in the SCIT carried out in the unit, contextualized. Metacognition was addressed in an interactive way, in which patients had the opportunity to share personal experiences of social situations, encouraging group identification of emotions, emerging and alternative thoughts, as well as congruent values and actions. Participation in the group provided both elements for the continuous evaluation of his cognitive and psychosocial functioning, and conditions favouring psychological flexibility. Luis was able to talk about his emotions, understanding them as shared human experiences, for which identification with peers and some self-revelation were important (Chadwick, 2009).

To help Luis identify, understand and respond to his emotions with greater awareness, we functionally analysed the most salient recent emotional experiences, encouraging him to name them, identify in which situation (internal or external) they had arisen and how he responded. It was extremely important that he became aware of the transitory nature of emotions. We tried out some mindfulness exercises and encouraged non-formal practice, which involved the adoption of an attentional focus in the present activity and an observer attitude of his mental contents without becoming confused by them. Focused attention was especially promoted, both in moments of wellbeing and in those in which the discomfort just disappears, to raise awareness and personal narrative about them. Luis was able to recognize the emotions and distance himself from them, so that, being less overwhelmed, he could feel freer to take what he needed and try to address it. He stopped talking in general, non-specific terms such as "I experienced suffering yesterday" to specify "I was angry when I was talked like that" or "I was bored, but I joined in playing parchesi with others and I got better".

Luis was looking to feel in control of several areas in his life. It was a matter of gradually fostering greater self-confidence and acceptance of some uncertainty in the future. Key was his growing capacity to focus his attention on the present reality and the dialogue in which he was also experiencing his ability to tolerate unresolved doubts. Today, Luis can set future-oriented goals more calmly: “I’m interested in this right now…but we will see”.

(c) *Cognitive defusion* to promote the distancing from certain mental contents in which he was trapped, limiting his functioning. We worked on changing the relationship with different mental contents, such as some mystical overvalued ideas that directed his attention and action towards focusing on auditory hallucinations. We deeply conversed about telepathy and mental connection, some beliefs he took from a potential sect that he frequented for months. He found some alternative interpretations that explained his experiences without causing him confusion and isolation. We differentiated these beliefs from others that belong to a spiritual dimension (beliefs in the intangible: the soul, God and the experience of prayer), taking care of important values for him, which also transmitted security, tranquility and transcendent meaning to his existence.

A change in the relationship with psychotic experiences was promoted, encouraging mental flexibility. Specifically, paranoid interpretations were addressed as possible hypotheses instead of convictions, favouring the generation of alternatives and the evaluation of the degree of certainty given to them. The work carried out in the SCIT group and the individual sessions in which personal situations were analysed were useful for this purpose. For example, sometimes when he went home on leave, he thought that his mother could know everything he was doing. When asked about this, he described specific situations in which he wanted to hide something (which was objectively conspicuous) and his mother suspected what was going on. We asked about the occasions in which he informed his mother of what he had done or was planning to do, without her having the slightest idea beforehand, which was the most common. He began to understand that this happened occasionally, due to objective signs, which differed from his mother being able to know “everything” he did. Gradually, Luis increased his ability to interpret many interpersonal situations in different ways.

Regarding the change in relationship with his hallucinations, Luis talked about their characteristics and contents. The understanding of symptoms as being linked to his biography was promoted. Luis was able to recognize desires and fears in the content of the voices and these could be considered and addressed from a value-directed action. For example, he heard a neighbour say “you are mine” while her image came frequently to his mind. He interpreted that she wanted to be his partner, which was an obstacle for him to pay attention to other girls, as he did not want to be unfaithful to her. Through therapeutic work, he became aware that it was him who wanted to have a partner and that he had found that neighbour attractive. Another example was that he heard his schoolmates tell him “Let’s fix this”. At times he experienced it as a threat and tried to show himself as superior or as an authority figure who establishes order, sometimes even believing that he was a policeman. At other times, he could interpret it as a reconciliation request made by people from his past. Luis became aware that it was him who wanted to make up for his experience of relationships with peers, which had been difficult in the past.

He realized that he spent a lot of time talking internally with the voices, thinking about them and changing his behaviour accordingly. He decided to try to spend as little time as possible on them to direct his energies to his goals.

Luis was astonished as he came to understand more about his mental functioning and the fact that sometimes his fears and desires could be perceived in this way. Most importantly, as his relationship with his hallucinations changed, he was able to experience them without feeling anguish or limiting his behaviour.

(d) *"A transcendent sense of self"* (Hayes & Strosahl, 2004) to foster a sense of himself in touch with what he had experienced throughout his existence.

Luis also sought a sense of control with a closed definition of himself, which made it difficult to access new experiences, especially in a social context. In order to favour a more flexible sense of self, sometimes, when he provided rigid adjectives about his way of being, after validating the experiences on which he relied, other experiences were provided that made him consider that the opposite adjectives were also applicable, fostering a more dialectical perspective of himself. For example, when Luis said, "I am shy, reserved, because…", we added "Yes, although yesterday you gave a presentation in front of several people".

In order to encourage a more integrated sense of self, we jointly reviewed his biography. He needed to work more on his difficult adolescence and early youth, when he experienced intense anguish, and social maladjustment and learned that his father's death had been a suicide. More experiential exercises were helpful and adapted (Morris, 2019) by describing them in advance and stating the objective, respecting his needs and pace. Particularly necessary was the work related to his father, where the empty-chair technique was important, so that unresolved issues and emotions could be addressed. At first, he expressed intense anger at his father, and he accused him of abandonment, of having caused him and his family suffering and blaming him for practically all his problems in life. Then he began to ask himself questions and to consider the enormous difficulty in coping with the suffering he probably experienced. Gradually, he began to express some compassion for him, while also differentiating himself from this father: "I would not have done it. You have to try to solve things and let yourself be helped too". Subsequently, he spoke about this very occasionally and more calmly, saying that he was more aware of it and without it being the centre of his discourse.

(e) *Value orientation*

Luis wanted to maintain a good relationship with his family, have a quiet life, open up to some new social relationships, do sports, continue studying or working, and feel proud of himself. We supported him in identifying and committing to these goals.

This is fundamental in the recovery process, as proposed by Le Boutillier et al. (2011) with the acronym CHIME: Connectedness with other human beings; Hope with choices and actions committed to life; flexible Identity, able to observe if mental contents are useful; Meaning, giving meaning and dignity to all experiences, including the painful ones; Empowerment, acting based on values rather than fears.

Luis admission in a unit that tries to function as a therapeutic community, together with his continuity in the Day Centre for Psychosocial Rehabilitation, his home leaves and group work fostered the identification, empathy and connection with others. The process of recognizing himself and giving meaning to different experiences favoured his personal identity, to the point where he voluntarily exposes his first-hand experience in front of others, as he did in the "Patient's Classroom" (a space in the General Hospital aimed at promoting patients' knowledge and proactivity in their treatment process). Personal and shared recognition of his achievements, as well as meaningful short-term goals, have fostered a hopeful outlook. The identification of values and his own choices to move towards them make him aware of his capacity of self-direction, feeling more protagonist in his life and more satisfied with himself.

(f) *"Willingness and commitment" t*o address and commit to goals relevant to him despite discomfort.

He decided to attend the "Digital Competences" course at a school near his home, even though he felt ambivalent at the beginning and preferred to avoid attending. Nevertheless, he kept going even if he faced some uncomfortable situations during the course. He feels satisfied with the experience he shared with his peers and with his certified learning. Luis continues to attend the DCPR three times a week. At first, he felt that the previous one was very related to a stage of great psychopathological instability and suffering. His ability to identify and communicate the problem and propose a solution was validated and strengthened. He now attends a new centre. He has agreed with professionals on the activities that are meaningful to him: sport, English and debates.

Family relationships are of great value to him, he focuses on taking care of them and respecting himself. He expresses his needs more assertively and manages disagreements more calmly. He collaborates with his mother and his sister in household chores. He also goes with them on family outings and shares pleasant moments with them, such as watching series with his sister, with whom the relationship has grown closer. He enjoys simple things like walking his dog every day.

For Luis, studies and sport are important and he has been analysing the level at which he wants and can participate in these activities in different spaces. For example, as he has always liked martial arts, he decided to sign up for some classes at a gymnasium, attending for several weeks even though he found them hard.

He thinks it would suit him well to work and is gradually opening to different options. For this reason, he has recently been referred to the Employment Support Program and is being counselled.

19.3.4 Conclusion

The ART model brings together very valuable elements for therapeutic work with people with psychosis due to its humanity, subjectivity, ethics, knowledge and research, making it a model that accepts complexity and diversity, that integrates elements from other orientations with coherence and flexibility and is directed towards people's recovery, beyond symptomatic remission.

19.4 Case 3: Recovering a Meaningful Life

First Hand Experience *"I am willing to introduce myself: my name is Carmen. Maybe my story will help other people that have gone through experiences like mine, or to better understand what it is like to live with a diagnosis like mine in a hospital for some many years. I often wonder "Why me?" I have tried to be strong, but it has not been easy. I remember that my childhood was normal. I think I was a happy child, with a comfortable life, with no big complications. My parents worked outside home, my sibling and I went to school, and we all got along well. When I got to high school, things started to change I felt alone, it was difficult for me to connect with others, I was not one of the "popular girls". They started to behave in a very cruel way towards me, they insulted me saying "You are so ugly, you are horrible". I was not able to ask for help, to talk to my family about what was happening to me. I lived in isolation and shame. When I got to the university it was even worst, they continued insulting me…and I broke down. That's when I made my first suicide attempt. At that time, I had already asked for help, but it did not help me, they did not give me any answers. That is when treatments and admissions started. I believe I have improved over the years thanks to the constant support of my family. I think that if I died tomorrow, I would not have done much, but now I want to do other things to fill my life. The relationship with my family is still good, although I have always clashed a lot with my mother. In the last few months, I have noticed that she is calmer, I think my siblings have something to do with it. She does not get so upset about anything anymore. I try not to clash with her so much, I do not like arguing with her. I consider my family as my strength; I would not have been able keep moving forward on without them. Other things that have helped me to be more stable is my desire to move forward in life, to recover and to prosper. Now I go to language lessons, and I would like that to help me find a job. I like teaching and libraries. The illness has robbed me of a lot of things and although I am better, things are still complicated. People still talk to me when I walk down the street, but I am now able to do things that were unthinkable before. I could not go out alone, go into a shop. They insulted me over the loudspeaker, they shouted at me. During this year, the Hearing Voices Group experience has helped me a lot, I have felt supported, and I have been able to talk about what was happening to me. At the beginning, I did not believe that other people were going through the same things as me, or with the same intensity. But yes, and we have supported each other a lot. I wish I could get out of the hospital and live in a supervised flat, with support. Find friends. I always wanted to have friends, but I did not know how. For a long time, I was looking for people's attention. I would like not to hear voices, not to be shouted at in the street, but I think I could still live out of here. The last time I was at home, I could hear my* *neighbours constantly criticising me, but I kept doing my own thing, on the computer…and I ignored them".*

19.4.1 Personal History and Appearance of the Problem

Carmen, the pseudonym proposed by the protagonist, is a woman in her forties. Much of her life has been marked by great suffering and years of hospitalisation in medium and long-stay units. She is the youngest of five siblings and has a good relationship with her widowed mother and her siblings, despite the years she has been hospitalised.

She reports having had a normal development during her childhood and pre-adolescence. In adolescence, she began to experience difficulties with her peers. During this time, she began to be bullied by a group of schoolmates, which made her become more reserved and to tend to isolate herself. For some months, she attends a private psychologist who helps her to cope during this stage. She enrolled at the University to study philology, but during the first year of her career (at the age of 19), her first episode takes place and is admitted to the Acute Unit of the Hospital. When she was discharged, already diagnosed with paranoid schizophrenia, she was referred to a Mental Health Unit.

Since then, the evolution has been slow and with a very poor response to psychopharmaceuticals. She displays a very intense symptomatology, in the form of voices (from her neighbours) insulting her or "talking to each other" about aspects of her intimacy. She reacted to this experience with an intense anguish and desperation, which led to two self-harming attempts. Admissions to the Short Stay Unit (SSU) or private centres followed one after another. She was treated with Electroconvulsive Therapy in some of these episodes without significant improvement.

Due to the poor response to treatment, the severity of the symptoms, the level of suffering and the family's difficulties in managing the problem at home, Carmen is referred to an MSU, where she remained for 2 years. She achieved a certain degree of stability, but a significant positive symptomatology persisted, so she is referred to the Clinical and Rehabilitation Unit, where she has remained since 2015.

Currently, Carmen continues to experience delusions of harm and paranoid ideation, phenomena related to the course and content of thought, such as mind reading or mental blocks. She feels invaded by voices (generally from TV or radio) that talk about her. For this reason, she avoids watching TV, listening to music, etc., which are activities she used to enjoy in the past. On the other hand, she is a woman with cultural inquisitiveness, who likes languages (as long as she is not feeling anxious) and who lives her hospital stay with a lot of frustration. She is very selective with people and does not make friends easily. She has never had a partner or significant friendships. Her relationship with the staff is ambivalent and has caused significant problems. She reacts and refers towards some of the staff with defensive and hostile behaviour relatively frequently.

Looking into the future is unlikely that she returns home due to her mother's age. She is a candidate for the alternative or residential accommodation program as she needs some supervision. She raises the need for discharge very frequently but finds it difficult to get involved in drawing up a realistic plan that would lead her to take steps towards discharge. She continuously complains about "the bad luck she has had for not being able to live a normal life like her siblings".

19.4.2 Intervention

The intervention that is carried out tries to apply ACT within the context of psychotic symptoms. There is great deal of evidence of its use among this complex spectrum that generates so much suffering in people who suffer from it (García-Montes & Pérez-Álvarez, 2016). In this case, the aim is to help Carmen reconsider the unsuccessful fight against the symptoms that have accompanied her since her early adult life and to explore new paths that bring her closer to what she wants to achieve despite them. In the same way, the aim is to deepen the experience of positive symptomatology as active form of experiential avoidance, to increase competences that allow to integrate these events in a less incapacitating way and to increase her coping capacity. "Experiential avoidance" is the phenomenon that occurs when a person is unable to have contact with private experiences and strives to decrease the frequency of contact with the contexts that causes them. It is a behavioural mechanism that can be apparently effective in short term but can become chronic, limiting the person's life. Delusional symptomatology could be considered an active, highly elaborated form of experiential avoidance in which the person not only avoids but also tries to build the reality they wish to achieve or the insurmountable obstacles that would justify not having achieved it (García-Montes & Pérez-Álvarez, 2005).

The contribution made by ART is of great value as an intervention model that focuses on changing the relationship with what disturbs us (Díaz-Garrido et al., 2021). The principles of the model (contextual, multidimensional, transdiagnostic, interdisciplinary and adapted to the level of impairment and functionality of the person) fit with an intervention that tries to adapt to Carmen's needs, reality and context.

Third-generation therapies bring a new and revolutionary perspective on the relationship with internal events. Unlike second-generation therapies, which look at understanding and changing cognitions, the contextual approach seeks to improve the relationship with them, developing tolerance to that which causes suffering, without trying to actively change it. This new outlook does not have to imply an absolutist and definitive separation between cognitive and contextual therapies. In fact, a good therapist must be able to use the therapeutical tools that are needed for each case and at each specific moment, whether they are grounded in cognitive, behavioural or any other model, as long as they make sense and maintain internal coherence within the therapeutic process of each patient. It could be said that second and third-generation therapies opt for different paths but arrive to a similar destination. That is to say, in second-generation therapies, through a series of interventions, it is sought that those irrational thoughts or beliefs that cause the suffering are replaced by less harmful ones, for example, the thought "I am worthless" can be replaced by "I am valuable". Third-generation therapies do not opt for a direct change, as this could be counterproductive and generate an exhausting and unsuccessful inner struggle, and therefore they propose a process of observation, acceptance and distancing, which will progressively generate a change in the person's relationship with their internal events. In short, second and third-generation therapies do not have to confront each other, and their principles can be complementary and have similar objectives. Their joint use, adapted to each case, can enrich the intervention.

In Carmen's case, not only the contextual principles have been followed, but we have also tried to generate a collaborative style based on Motivational Interviewing (MI) (Miller & Rollnick, 2015). Although it is an approach that emerged in the early 1990s from the field of addictions, in recent years it has been extended to other areas related to education, health or penal mediation, in those contexts in which the aim is to strengthen the person's motivation and commitment to change. The word "change" may at first seem counterproductive in the context of third-generation therapies. However, in the spirit of both MI and the contextual approach a balance is advocated between "acceptance and change" or, in the word of ACT itself, between "acceptance and commitment to action towards values". The therapist, therefore, becomes a guide who helps the patient to maintain this balance and to adapt flexibly to the direct contingencies of the moment. The aim is not, however, to find the mechanism of cognitive change that MI promulgates, but to provide a communicative style that facilitates this collaborative work and respects the person's values.

Finally, the group element is introduced with the implementation of a "Group of Unusual Experiences", following the *Hearing Voices* model proposed by Romme and Escher (2005), which can also help to understand the experience of symptoms in a less limiting, more normalised way and together with a group of residents who have lived with the symptoms for a long time. In this sense, the combination of the group element as a source of support and reference seems appropriate to maintain motivation and find other spaces to achieve the therapeutical goals set.

Another important aim of the intervention was to help her to increase her emotional regulation and decrease the hostile reactions that occurred with some frequency with the staff in the unit. As a result of these psychotic experiences, there was a repetitive pattern of self-referentiality to which she tended to defend herself with anger in certain situations and with certain people. Along the therapeutic process, it was possible to explore some aspects of her autobiography in which she had experienced situations of humiliation by schoolmates and to which she had reacted with avoidance and isolation. In current situations, she tended to justify herself by arguing that she would "never let herself be humiliated again", and she was angry in some moments which reminded her to painful situations she had experienced before.

Initially, the aim was to generate an experience of creative hopelessness, making her realise the cost of avoidance and how limiting it was in terms of taking steps towards her recovery. The metaphor of "feeding the dog" was used in many sessions as a common thread. As she tried to increase the number of activities she wanted to do, there was a tendency to feel overwhelmed by discomfort and to maintain a very chronic pattern of avoidance. The metaphor helped to understand the importance of continuing to move forward despite the symptomatology.

In the same way, it is a matter of clarifying goals and desires and providing means to try to achieve them, minimising the impact that psychosis has had on her so far. Values work is fundamental in ACT. These are defined as global, desired and verbally constructed life directions that are present as a vital horizon and that give actions a direction and purpose (Wilson & Luciano, 2019). In this case, this element is crucial since the impact that Carmen's pathology has in her life, as well as the dynamics of a long-term admission without a clearly established end, facilitate resignation and the role of "passive patient" who can do little to reverse the situation.

The clarification of values was addressed through exercises that help to find concreteness in her life goals. Despite chronicity, she maintains interests and the desire to continue building a more productive life, as well as being discharged from the unit. During some sessions, a narrative assessment of values (Wilson & Luciano, 2019) was carried out to explore vital areas such as family, friendship, education, or autonomy, and to discover concrete steps that could be taken in each of them. The elaboration of different cards where she expressed a goal (continue my career, improve my health, get discharged, improve relations with my family or have more friends) was used as a support. These cards were displayed on the wall of the office where the sessions were normally held and were reread to make them more concrete or to increase her commitment to them.

It is of great value to understand the psychotic symptomatology that she presents in terms of the psychological inflexibility that leads Carmen to experience and re-experience life circumstances in a limited way due to the experiential avoidance, lack of clarity in her values, literality in her private experiences or resignation to her suffering. The exercises proposed in the course of therapy are intended to help her to recognise the futility of trying to control her symptoms and to understand the great vital cost of allowing herself to be permanently driven by these internal experiences. The aim is to address hyper-reflexivity (reducing the so present self-referential reflective processes) by distancing herself and increasing her diminished sense of self, involving herself in areas of personal activity that are relevant to her. For a long time, when Carmen felt distressed and invaded, she tended to become emotionally overwhelmed and to manifest very significant distress that led her to remain in her room, free of stimuli, limiting her participation in activities and to increase the intake of medication to relieve her discomfort at those moments. In a way, we could affirm that the setting of the unit also tried to exert some control over the symptoms, taking away her capacity to act on them. The possibility of accompanying these situations in another way was raised, encouraging her to continue doing what she had committed to do and offering strategies to minimise the intensity of the episodes.

Another important goal in the process was the reflection on symptom control. To create a distance from language, the exercise "Mind walk" was introduced. While walking around the compound gardens, she was constantly told things that had to do with her internal dialogues or messages from the voices ("they want to humiliate you", "they laugh at you", "they think you will not get what you want"), to which Carmen reacted with discomfort and tried to argue. These exercises enabled a greater connection and understanding of what was happening to her and to talk in greater depth about the experience of the voices, as well as validating the experience of suffering sustained for so many years, especially in her adolescence.

Establishing a separation between the contextual and contained "Self" is a complex aspect in which we continue to intervene. Carmen remains very fused to the symptomatology experienced in these years. Her "Self" is closely linked to the verbal contents and, although she expresses her desire to be "understood and taken seriously" by her close referents, she tends to show herself to others through her symptoms and more negative life events. Many of the verbalisations she makes have to do with continual complaints about her experiences, about "not being able to have a normal life like her siblings", about her "bad luck". In this sense, it is often necessary to invite her to focus on the present moment. The exercise "Observing herself" at different moments in her life was proposed. Another frequently used exercise consisted of asking her to express her complaint in a comical way, which helped to reduce tension and break the loop that limited us from continuing with the work to be done.

The commitment to the chosen direction continues to be addressed despite the difficulties. One exercise that proved very helpful was to imagine the goals in front of her and to move forward with a blindfold over her eyes. In a second instance, she had to move forward with the blindfold under her arm. It helped her to value the importance of continuing to move forward despite everything we carry on our backs, but in a way that limits us as little as possible.

19.4.3 Progress and Results

The aim of this intervention has mainly been focused on trying to get Carmen to accept those symptoms that were distressing her and from which she was trying to escape without success, as well as encouraging her not to remain paralysed and to move towards goals that were valuable to her.

The intervention has offered the possibility to expand the knowledge and practice of ACT, while at the same time integrating this with other elements of great value for promoting change. ACT seeks to create the required conditions for the person to appreciate the paradox of their behaviour, to realise that what they are doing is in the opposite direction to what they really want to achieve, and seeks to enhance clinical interactions that allow the patient to become fully aware of the flow of private events, so that they notice them and can plan their actions according to what their values demand at that moment rather than acting according to the literalness of private events (Hayes et al., 2015). In this sense, together with the tools that ACT provides (metaphors, paradoxes, or experiential exercises), we have opted for a collaborative intervention style that emanates from MI. It focuses fundamentally on the processes of change, trying to activate the person's own motivation and resources so that they become the protagonist of this process and increase their capacity to commit themselves to get where they want. MI can enrich the practice of ACT in that it situates the clinician as a figure who guides the process, without forcing it, through reflective listening, constant attention to ambivalences that may arise and avoiding falling into the traps of the expert, the label or judgement. In short, it is about intervening from a respectful stance that aims to generate a dynamic of change and hope, which understands the dilemmas and helps the person to be the one who resolves them. ART enriches the intervention and broadens the focus so that the person's reality, capacity and functionality are taken into account.

The results of the intervention, in general, show a clinical improvement and encourage the continuation of the line of work initiated. At present, Carmen carries out valuable actions within the community on a daily basis: she attends an Official Language School where she studies German and English, she goes for walks, goes shopping and runs errands independently and spends the weekends at her family home. At the moment, the renunciations that have accompanied her for so many years are no longer there, and she continues to take action despite the hallucinatory experiences she continues to have. Relationships with staff have significantly improved, with no conflicts and being able to resolve everyday situations with greater serenity. The changes observed throughout the intervention have been maintained, although we continue to work along these lines.

The application of ACT opens up a promising path: despite the severity and chronicity, we can set goals and move forward within a framework in which people are the protagonists of their stories and continue to have goals and values that help them to keep moving forward as far as they consider. It also challenges the professionals who accompany them in the process: the need to not conform and to continue to look for alternatives to suffering, to maintain a hopeful outlook and to try to ensure that, despite everything, life continues to have a meaning, since as Ortega y Gasset said, "life takes on meaning when we make of it an aspiration to renounce nothing".

19.5 Conclusions

The recent increase of publications related to the care of people with PSD grounded in the philosophy and principles of ACT and other therapies that place the person at the centre of their rehabilitation process highlight the need for a paradigm shift in the treatment of psychosis, where the primacy of positive symptomatology gives way to addressing the negative one and the cognitive impairment. The assessment of the level of cognitive and functional impairment and the design of techniques and interventions adapted to achieve individualized rehabilitative goals that reduce disability and the deterioration in the affected person's quality of life should be the main objective for a progressive change of perspective when approaching the person affected by PSD. ART is a contextual model, with ACT principles, which follows a transdiagnostic approach, avoiding reductionist and stigmatising labels; interdisciplinary, in the broad sense of the word, including not only specialized health professionals but also social workers, social integrators, auxiliary staff, etc.; multidimensional, guaranteeing continuity of care in the different areas of the person's life (individual, familiar and community, through inclusive interventions); integrative, incorporating its own elements and contextualizing those coming from other approaches, adapting the intensity of the interventions to the clinical and functional needs of the individual with PSD at different times of life.

This chapter illustrates the therapeutic and rehabilitative process, based on ART, of three people diagnosed with psychosis, which was carried out within the public healthcare system. It highlights the feasibility and usefulness of ART in the comprehensive treatment of people with PSD within the public system, as well as the subjective satisfaction reported by the people treated in their recovery process. We hope it contributes to the deepening and extension of framework based on knowledge and centred on the person.

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

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