

# Acceptance and Commitment Therapy for Delusions

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## 8.1 Introduction

This chapter describes the psychological treatment of delusions based on acceptance and commitment therapy (ACT) (Hayes *et al.*, 1999). ACT is one of the most recent developments in functional contextualism for the treatment of a diversity of problems in outpatients (Dougher & Hayes, 1999; Kohlenberg *et al.*, 1993). Although it was first developed for the treatment of emotional problems (Zettle & Hayes, 1986), it did not take long for it to spread to the field of psychotic symptoms (Bach & Hayes, 2002; García-Montes & Pérez-Álvarez, 2001; Pankey & Hayes, 2003), and there are conceptual, clinical and empirical reasons for its application in patients with psychosis (García-Montes & Pérez-Álvarez, 2005; García-Montes *et al.*, 2006).

## 8.2 Delusions as Ways of Making Contact with Experience

According to the DSM-IV-TR (American Psychiatric Association, 2000), delusions are 'erroneous beliefs that usually involve a misinterpretation of perceptions or experiences' (p. 299). Having listed the most frequent types of delusion, the manual admits that the distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with

which the idea is held despite clear contradictory evidence regarding its veracity (American Psychiatric Association, 2000).

This definition has the advantage of acknowledging that the delusional experience makes a certain sense. When it says that the delusion is 'a misinterpretation of perceptions or experiences', it is offering a sort of functional explanation of the delusion. Some time ago, Maher (1974, 1988, 1999) presented a similar understanding of delusions when he asserted that they are false beliefs that arise as normal responses to anomalous experiences. However, it seems that this type of 'anomalous' experience is present in the general population (Bradbury *et al.*, 2009; Shevlin *et al.*, 2007) and that delusional patients are not characterised by having more anomalous experiences than other groups in the nonclinical population (Bell *et al.*, 2007).

Why then do some people react to certain anomalous experiences by developing delusions and others not? One line of research addresses how patients with delusions arrive at conclusions. Huq *et al.* (1988), using a probabilistic reasoning task, found that patients with delusions need less information for decision-making and that, furthermore, they appear to be more confident that their decision is right. This has been called the 'jumping-to-conclusions' bias, and has been replicated a number of times in this client group (Dudley *et al.*, 1997; Moritz & Woodward, 2005). It has also been observed that this bias is related to intolerance of uncertainty (Bentall & Swarbrick, 2003).

Even though this analysis is interesting in terms of psychological processes, other contextual factors influencing the delusional experience cannot be overlooked. According to Myin-Germeys *et al.* (2001), the presence of family members or acquaintances lowers the probability of a person having delusions, while if a person stops their activities, the probability of the symptom appearing is higher. Moreover, the occasions when psychotic patients have delusions are marked by a negative affective state. It has also been highlighted that there is a correspondence between delusions and worrying and the motivations important to the patient at the current point in their lives (Jakes *et al.*, 2004; Rhodes & Jakes, 2000, 2004). So, some delusions can be considered symbolic expressions that employ a different type of metaphor or metonym to refer to a patient's current life experiences.

### 8.2.1 Delusions as Active Forms of Experiential Avoidance

In view of all this, we think delusions are not just metaphorical understandings of anomalous experiences or complex life situations. Freud (1924) said that delusions are like a patch on a tear in the relationship between the self and the outside world. More recently, Bentall *et al.* (1994) proposed a model of delusions of persecution in which their function is to reduce any discrepancies between the 'real self' and the 'ideal self'. This model has been supported by several empirical studies

(Bowins & Shugar, 1998; Kinderman & Bentall, 1996, 2000; Kinderman *et al.*, 2003; McKay *et al.*, 2007).

Based on Bentall *et al.*'s model, García-Montes *et al.* (2004) proposed that delusions are '*active forms*' of experiential avoidance.<sup>1</sup> According to the canonical definition, experiential avoidance (which we call '*passive forms*' of experiential avoidance here) takes place when a person is not willing to make contact with their private experiences and behaves in a way that attempts to change both the form and frequency of those experiences and the conditions that generate them (Hayes *et al.*, 1996). In passive experiential avoidance, what the patient tries to avoid is the symptom itself (obsessions, anxiety, etc.). In delusions, on the other hand, experiential avoidance, in our opinion, is more elaborate, such that the symptom itself becomes a form of avoidance of some other matter. Delusions are ways of elaborating a reality that does not exist, while at the same time escaping from the one that does. This is especially clear in delusions of grandeur, in which the patient shows themselves and others an image and a social position that are not real and that they are unlikely ever to have. In persecutory delusions there may also be active forms of experiential avoidance related to, for example, guilt the patient feels over certain past behaviour, reversing their position as the author of something reprehensible and making them the victim. All of this, obviously, occurs without affecting passive forms of experiential avoidance that are just as important in maintaining the delusional symptomology, so that avoiding certain thoughts or ideas which the verbal community considers inappropriate may make them appear even more intensely.

The authors of ACT have at least partly picked up on this conception of delusion when they say that, in therapy, delusions are seen '*not so much as a target of avoidance, but as means of avoidance*' (Bach *et al.*, 2006, p. 96, their emphasis). However, as we understand it, the '*active*' aspect of delusions must still be stressed: that is, how they serve to not only escape or avoid but at the same time verbally *construct* an alternate reality or world. We think that this distinction between '*active*' and '*passive*' forms of experiential avoidance is not merely academic. In principle, it aligns with conceptions of psychopathology of diverse origins that underline the distinction between '*neurotic*' or '*emotional*' disorders and '*psychotic*' ones (e.g. Freud, 1924/1993; Jaspers, 1963/1996; Wolpe, 1970). Furthermore, it agrees with research on the role of language in human behaviour developed in the Relational Frame Theory (RFT) paradigm (Hayes *et al.*, 2001). Thus, this differentiation between active and passive forms of experiential avoidance highlights how a person can lose contact with things by pursuing only verbal success (e.g. someone who interprets a fond greeting as a sexual proposition in order to keep up his '*seductive*' self-concept). When most severe, these active forms of experiential avoidance can even create insensitivity to the practical consequences of one's behaviour, leading to one becoming installed in a sort of '*private world*' where the only thing that is important is to be in agreement with oneself (e.g. if after repeatedly being clearly rejected by someone who does not

want to have an intimate relationship, the person believes they were really rejected because the other party is afraid to have such a wonderful lover). Finally, the active forms of experiential avoidance emphasise the importance of a psychopathological model that situates the patient's symptoms in their biographical context with regard to their personal aspirations (Chadwick, 2006; Chadwick *et al.*, 1997; García-Montes & Pérez-Álvarez, 2003).

### 8.3 Intervention with ACT

In this section, the six core goals of ACT (Hayes *et al.*, 1999) are briefly described in relation to working with delusions. It should be kept in mind that in our explanations, the order is more logical than chronological, and that in clinical practice, several different aspects can be worked on in the same session, always paying attention to the subjects that are relevant to the patient at any given time. Several clinical dialogues taken from an intervention with a 19-year-old patient we call Luis are given as examples of the techniques. Luis was diagnosed with 'delusional disorder' 1 year before he came to the office for the first time. He is the younger son in a family that currently consists of his mother and older brother, living in the south of Spain. Luis's father died suddenly 8 months before his psychological problems appeared, while on vacation in the Canary Islands. During the time between his father's death and the onset of his psychological problems, Luis was fired from his job, which he had held while studying, because of staff cuts. Also during that time, his girlfriend broke off their relationship of over 2 years. At the time we saw Luis, he showed paranoid ideation related to his persecution by the secret service, which also involved several celebrities (mainly famous musicians).

#### 8.3.1 Create a State of Creative Hopelessness

This goal attempts to help the patient establish contact with the strategies that they have been using to escape from the situation they are in, but which in the end have proven fruitless.

One way to start could be to ask the patient to think about everything they have done to try and live a better life. It is important for the therapist to recognise both the sense that these attempted solutions make to the patient and their desire to carry them out (Bloy *et al.*, 2011). The following dialogue illustrates this validation and provides a metaphor that can be used to help the patient realise the results of the strategies they have put into practice:

THERAPIST: I've taken note of everything you have done to get out of your situation. It all sounds rather logical to me. For example, you've tried

to look for proof that the secret service is after you. Surely anyone who believed that would also try to find proof to find out for sure whether they are really looking for him. And I don't doubt that you want to get out of this situation. However, something doesn't make sense to me.

LUIS: What?

THERAPIST: You see, what you have done is quite logical and I am sure that you have tried hard, but what doesn't make sense is that, even though they are logical decisions made with good intentions, you are not getting good results. You are getting more and more closed in, more afraid... Your situation reminds me of a friend I had at school who was afraid of dogs. One day when she was going to school with her lunch in her bag, a dog started following her as soon as she left the house. My friend was so afraid that, to keep the dog away, she gave it a piece of her lunch. The dog stopped to eat it and my friend went on her way to school. But do you know what happened the next day when she went to school?

LUIS: The dog was there again?

THERAPIST: That's right! The dog was there again! And do you know what my friend did?

LUIS: She gave him some of her lunch again.

THERAPIST: Almost! She had to give it *two* pieces, and, of course, it kept on following her. Do you know what happened the next day?

LUIS: The dog was there again?

THERAPIST: That's right. The dog was there again. My friend was having more and more trouble with the dog and finally she stopped going to school. Do you see what I am trying to tell you?

As suggested by Hayes *et al.* (1999), it can be hard for patients to 'understand' things. Their 'understanding' usually translates into what has been said being incorporated into the control strategies they are already using and which have led them to the situation they are in. So it might be advisable to highlight paradoxes that keep rules from being followed. The clinical dialogue would be something like this:

THERAPIST: A serious problem we have is that, to begin with, you've come here to get something to feed the dog...

LUIS: Well... I came because I can't stand this situation anymore...

THERAPIST: That's right... and, in the past, every time you've felt like you couldn't stand it anymore you've done something to calm yourself down... Given the dog some lunch...

LUIS: Yes...

THERAPIST: So, anything that I told you now, any clue that I gave you, might be used to feed the dog...

LUIS: I don't understand exactly what you are trying to tell me.

THERAPIST: Perfect! Maybe the fact that 'you don't understand' might be something different from feeding the dog... Let's see what happens...

This is intended to make the patient come into emotional contact with uncertainty. Patients with delusions, as we have mentioned, are characterised by very low tolerance to uncertainty (Bentall & Swarbrick, 2003), so this stage of therapy would work equally well as exposure therapy. Additionally, as Baruch *et al.* (2009) said so well, ‘the therapeutic relationship also provides a context in which *in vivo* interpersonal behaviors may be evoked and addressed’ (p. 243). Such techniques should always be used within a safe therapeutic relationship. The bottom line is that the patient has to find out that there are different ways of reacting to uncertainty and that the therapist is not going to require them to do anything in particular in situations or experiences that are difficult for them to understand or which do not lend themselves to rational analysis.

### 8.3.2 Clarify and Strengthen the Patient’s Values

When this point is undertaken, it should be kept in mind how the psychotic patient’s values may be characterised by what Stanghellini (2001) has called ‘*antagonomy*’; that is, by a:

... refusal to conceptualize the world through the simplifying views given by common sense. Since conventional knowledge is experienced as a dangerous source of loss of individuality, their rejection manifests itself as the deliberate attempt to disconnect oneself from the others in which conventionality is embodied (p. 214).

Due, then, to this desire for ‘specialness’ and ‘individuality’, it could be said that individuals with delusions, and patients with psychosis in general, are the opposite of patients with emotional disorders. If they have not found anything worth resisting their discomfort for, they maintain a ‘hard core of values’ which lead them to rectify their own reality to accommodate the ideals that provide them with a sense of identity. Therefore, in the case of patients with delusions, the difficulty is not so much that they lack values as that these values are disconnected from their practical realisation in the world. Thus, in this field of values, the basic goal with this client group should be to seek ways in which they can convert their ideal values into pragmatic matters. A metaphor which might illustrate the implementation of this in therapy would be the following:

- THERAPIST: Since you like Arabian architecture, can you tell me about a building or monument you especially value?
- LUIS: I like the Alhambra in Granada a lot.
- THERAPIST: Good. Then imagine that you are one of the architects put in charge of building the Alhambra in Granada. You and your fellow architects have drawn the plans. It is a monumental design. Perfect. But how do you go about it making it? What elements do you need to build it?

- LUIS: Stones, no?
- THERAPIST: Exactly, but stones are not beautiful, are they? Do you think stones are as beautiful as the Alhambra?
- LUIS: No, of course not.
- THERAPIST: Imagine that a fellow architect suddenly told you that stones are not sufficiently beautiful and noble to be used in such a majestic building. What would happen?
- LUIS: I suppose we would argue.
- THERAPIST: What would you tell him?
- LUIS: That stones are the only material there is to build the Alhambra with and that if we don't use them we won't be able to build it at all.
- THERAPIST: Good, that's right. Although it is true that stones in themselves are not beautiful. What is beautiful is the form the stones take on when they *make* the Alhambra, no? Does this remind you somehow of your ideal of having an intimate relationship with someone? What are the elements you could use to build intimate relationships with others?

ACT has a values assessment form (Hayes *et al.*, 1999, pp. 224–228) with which a patient can decide the guiding values in their life in a series of areas (intimate relationships, family relations, social relations, etc.), set concrete goals linked to them and finally determine the actions that will enable each of these goals to be met. Any barriers in their achievement will also be identified. Although this specification may have certain advantages, it is also true that it could lead to a certain rigidity in a person's behaviour and keep them from a more dynamic and sensitive adaptation to circumstances that come up. An alternative way of helping a patient come into contact with their values might be the therapeutic dialogue itself, where daily situations in which emotional reactions arise can be discussed. The following clinical dialogue with Luis illustrates how a person can be made more aware of their values:

- THERAPIST: So, you were upset because the lady cut in line in front of you at the supermarket?
- LUIS: Yes, I was really angry. I started to think that she was a secret service agent... and that made me even more nervous. And I started to make a fuss right then and there...
- THERAPIST: Can you tell me about a similar situation in which you felt angry or annoyed, even if it didn't happen this week?
- LUIS: Yes, something similar happened when I was going to take my driving test a few months after my father died. They were calling people out and they didn't call me. I thought the secret service was there again, trying to annoy me, and I started to argue with the examiner...
- THERAPIST: And, for example, when you were a child, were you that upset when someone cut in line?
- LUIS: Yes! A lot! I used to get into a lot of trouble for that!

THERAPIST: It seems like respect for order is very important to you. It also seems like you sometimes get into trouble by trying to make people stay in line. What could you do if someone didn't go to the end of the line and tried to cut in?

It would also be pertinent to emphasise that there are certain behaviours that may not be consistent with one's own values but which nonetheless have to be followed. These are called 'social practices'. These practices, according to the Spanish philosopher José Ortega y Gasset (1883–1955):

... are human forms of behavior the individual assumes and complies with because, in one way or another, to some extent or other, he has no other choice. They are imposed on him by living together in his surroundings, by 'others', by 'people', by ... society (Ortega y Gasset, 1957, p. 76)

A person's values can only be realised in a social medium that is made up of practices. The following clinical dialogue can illustrate the point we want to make:

LUIS: I hate saying hello to people. Friends of my mother come to our house and I have to say 'hello', I have to pretend that I care about them... I feel so false. I'd rather stay in my room.

THERAPIST: Well, imagine that you are out driving on your way to meet a girl you are head over heels in love with. You are a few miles from her house and, suddenly, the police stop you. What would you do?

LUIS: Stop, of course...

THERAPIST: And you wouldn't feel 'false'? Aren't you just doing the opposite of what you feel like doing?

LUIS: But if I didn't stop the car, I would probably end up in jail and it would take even longer to get to see my girlfriend.

THERAPIST: Exactly! Sometimes you have to do things you don't feel like doing and that could, at first, seem to be the opposite of what you want. We've talked about how important your mother is and how important it is to you that she knows and loves you as you really are. It is not a matter of you greeting your mothers' friends because you like to, just as it is not a matter of whether you feel like stopping your car when the police order you to do it... It is enough just to respect the social norms.

Finally, the goals or targets related to the patient's values need to be kept in mind, in that they must be coordinated with the patient's 'real possibilities' and be kept continually present so that the patient does not lose sight of the 'contingencies of life'. This is especially important in the case of patients with delusions (Veiga-Martínez *et al.*, 2004). It is therefore a matter of matching up the person's life goals and the real circumstances of their life. Instead of asking a patient with delusions

about their general ‘values’, use the concrete situations they bring up in sessions to determine their goals. The following dialogue with Luis illustrates how this might be done:

- LUIS: I don't know if the teachers or other students are spying on me. When I go to the university some people stare at me for a long time. They could in the secret service, I don't know.
- THERAPIST: By the way, how are you doing at the university? Do the classes interest you? Do you like your subjects this year? How's it going?
- LUIS: I'm really bored in class and with the other students.
- THERAPIST: Do you like any one subject more than the rest? Is there anything that makes you want to go to class? Did they recommend a good book to you? Have you heard an idea that interested you? Did you have subjects in high school that were more interesting than your classes at the university now? When did you enjoy studying most? Did you feel better in summer when you were working at your aunt and uncle's bar?

From here on, the therapist, again using therapeutic dialogue, should discuss possible life goals with the patient, always openly, and keeping in mind that it is the capacity for enthusiasm perceived in the client's behaviour that will make later goals clear.

### 8.3.3 Suggest the Possibility that the Problem is Control

Now it is time for the patient to realise that there are certain aspects of their experience that it is impossible for them to control. This is done under the premise that ‘the cost associated with putting these experiences “in the closet” (emotional avoidance, escape, and numbing) is greater than the damage the original experiences would have done if they were allowed in without defense’ (Hayes *et al.*, 1999, p. 115).

One way of presenting the impossibility of controlling certain aspects of life would be to use the polygraph metaphor (see Appendix E) (Hayes *et al.*, 1999, pp. 123–124). The therapist describes the metaphor and the patient is asked to identify situations in their life that are like the polygraph. The therapist could also highlight examples of different emotional problems in other patients in which control strategies have proven counterproductive. The idea would be to take away the specialness of the psychotic symptoms and liken them to emotional problems that are traditionally considered less severe or disabling (Bach, 2004; Pankey & Hayes, 2003). In the case of patients with paranoid delusions, like Luis, it might be worth stressing this metaphor, especially with regard to possible attempts to control fear when paranoid ideas or feelings of failure appear, in which delusions might be a form of avoidance or justification. Patients with delusions of grandeur could

especially benefit if the therapy successfully links the metaphor to their feelings of inferiority in certain social situations. In short, it is a matter of establishing the appropriate equivalencies between the polygraph described in the metaphor and active or passive attempts at avoidance of certain experiences, which as discussed, explain the delusional symptomatology as active forms of experiential avoidance.

It would also be fundamental for the therapist to play down the importance of certain private experiences that people usually attribute importance to in order to achieve the kind of life they want. The importance usually given to thoughts as immediate precursors of behaviour could lead patients with delusions to react to the appearance of bizarre ideas with alarm and worry; escape/avoidance behaviour might begin, which would increase the probability of the patient having the same kinds of idea or thought in the future. It would therefore be of use to dedramatise certain bizarre ideas the patient has with an exercise based on self-irreverence. In this respect, García Montes & Pérez Álvarez (2001) have suggested that during sessions, the client be requested to vocalise any strange, wild or out-of-place idea that occurs to them. Luis, for example, was told to say any strange idea that occurred to him. The therapist reacted by encouraging him to intentionally look for other ideas that were even more threatening to him, and in which his safety was more compromised. When Luis said, for example, that not only was the Spanish secret service after him, but that there was a connection with all the European services, this idea was recognised as being much more threatening than the other, but still capable of being surpassed – it was agreed that other, still more intimidating and distressing ideas might occur to him. It might also be beneficial to the patient to write down ideas that occur to them in their daily life and bring them to the next session. The therapist should remind them to bring as many as they can and that the ideas should be very strange. This would favour a ‘proximal development zone’ between the therapist and the patient (Chapter 10 of Chadwick (2006) for a long discussion of the ‘proximal development zone’). It will make it more likely that the patient will limit themselves to making contact with the bizarre ideas they have and will not try to control them, if they see a distant and irreverent attitude in the clinician. While doing this exercise, the therapist should act with respect, avoiding at all times what Bach (2004) calls ‘a patronizing position’.

Finally, a metaphor that might be especially useful with patients with delusions is the one known as the ‘passengers on the bus’ (see Appendix C) (Hayes *et al.*, 1999, p. 157–158). It should be emphasised how easily parallels can be drawn between the person’s delusions and the annoyed passengers on the bus. The metaphor also emphasises how important it is to stay in control of the bus (steer towards matters of personal value) even when the passengers are bothering the driver (that is, even with delusions or other bizarre ideas in the way). Once this metaphor has been presented, the client should be asked what they can do. As a general rule, people answer metaphorically with solutions they have used in real life. At this point, it is important for the clinician to try to make the client think about the results of the strategy that they used in practice and whether it was able to ‘throw

the passengers off the bus'. It is a matter of establishing equivalencies between any solutions the patient might have for the presence of the annoying passengers on one hand and those they put into practice in their life to try and fight against their delusions or any other type of thought on the other. One solution, for example, that occurred to Luis was to stop the bus until the annoying passengers got off. He was asked whether he had ever put that solution into practice in his life, whether he had somehow stopped his activities until the delusional ideas stopped appearing, and whether in the end he had been able to make the passengers get off the bus. Since the strategies that he had implemented had not had good results, his attention was called to something more important than the passengers: the direction in which the bus was going. Where does the patient want to take the bus? Are they driving it in the direction they want? The therapist can assure them of one thing: if they drive the bus in the direction they want, the passengers will annoy them even more, especially at the beginning. However, if the client decides to steer the bus in a certain direction, it will go in that direction, even if the passengers shout and threaten them the whole time.

#### 8.3.4 Create a Distance from Language

When approaching delusions as active forms of experiential avoidance, we mentioned that the patient places themselves in an alternate or private reality through language. This new reality, which is the delusion, begins to influence the person's behaviour, although to different degrees depending on the case.

In this respect, an exercise that has often been found to be useful in the treatment of psychotic patients (Bach, 2004; García-Montes & Pérez-Álvarez, 2001) is the one known as 'taking your mind for a walk' (Hayes *et al.*, 1999, pp. 162–163). This is a dramatisation exercise in which the patient is separated from their mind. The patient is usually first asked how many people are in the room, to which the patient usually answers two: the therapist and the patient themselves. The therapist comments that there are really four people: the patient, their mind, the therapist and the therapist's mind. The exercise consists of the patient playing themselves and the therapist playing the patient's mind, as they take a walk for about 10 minutes. Afterwards, the therapist plays themselves and the patient plays the therapist's mind, again for 10 minutes. Finally, for another 10 minutes, the patient and the therapist split up and walk alone, and the patient is made to realise that, although no one is representing their mind, it is still functioning: evaluating, warning, criticising, commenting, relating, remembering, interpreting and so on. The purpose of this exercise is to teach the patient to act independently of their mind. In this respect, it is worth mentioning that the exercise involves a certain amount of evaluation of the extent to which the patient is controlled by their delusions. It would be indicative of a high degree of fusion with thoughts if the patient always did what their mind said, or if they always did the opposite. In either case, the patient's behaviour

is controlled directly or inversely by the ‘mind’. We found with Luis that when the therapist played his mind, he did exactly the opposite of what was suggested to him. If the mind told him not to go to a café because secret service agents were usually there, Luis went to that café; if he was told to cross the street because the person coming towards him was a spy, Luis stayed on the same side of the street and passed by that person. When he came back to the office after the exercise was over, it was explained to him that doing the opposite of what his mind said was still being controlled by it. In the following session, work on creative hopelessness was continued, in an attempt to get Luis to understand that the intervention being proposed was not based on his symptoms, but on the values and goals he pursued in life.

In the same way, it can be helpful for the clinician to give examples of common cases in which a person has a certain thought but does not act accordingly (Bach, 2004). For example, someone who is on a diet may think about eating a piece of chocolate cake and not do it.

### 8.3.5 Help Create a Transcendental Sense of Self

ACT distinguishes three senses of the self: the conceptualised self, ongoing self-awareness and the observing self (Hayes *et al.*, 1999; Wilson & Luciano, 2002).

It has been mentioned that delusions, especially of persecution, partly compensate for the discrepancy between the ‘real self’ and the ‘ideal self’ (Bentall *et al.*, 1994). This is because the delusional person has established an ideal self – a ‘conceptualised self’ – which is in constant conflict with experience. It is important to develop a sense of the self as an ‘observing self’, detached from a concrete self-conception, which gives the person a margin for making contact with the varied experiences of life.

A metaphor commonly used for this is the ‘chessboard metaphor’ (Appendix A) (Hayes *et al.*, 1999, pp. 190–192):

- THERAPIST: According to what you’ve told me, your chessboard does not seem to be in the right place. It seems like you are playing the game in an annoying and unpleasant position. In the distance you can see a place where you would like to be playing. But for now you are concentrating more on the game than on where you are playing it. Would you like to change places? Would you like to change your life?  
 LUIS: Yes. I don’t like the way my life is going. I should move, or move the chessboard. What do I have to do to go from being the one who should win the game and move the board?  
 THERAPIST: Mmmm... I see that you are waiting for me to tell you what the next move the white pieces have to make is.  
 LUIS: What?  
 THERAPIST: Could you change without knowing how to do it? Could you move the chessboard when the black pieces are winning?

Another exercise that can be used is the ‘observer self’ (Hayes *et al.*, 1999, pp. 193–196). This basically involves setting the conditions for the client to make contact with the variety of thoughts, emotions, feelings, roles, appearances and so on that they have had during their life. All this variety has not caused a certain aspect of their identity as a person to be diminished. In spite of such varied states, behaviours and roles, there is something that has remained constant in any experience the client has had: the ‘self’ that observes the experience. The purpose of this exercise is for the patient to make contact with that experience of personal continuity. To do this, they are asked to sit in a comfortable chair and close their eyes. They are told to make contact with the situation at the present moment. They should note the contact of their body with the chair and with their clothes, with the floor, their breathing, the noises in the room and so on. When they have done this, different situations present themselves. For example, they are asked to remember a moment when they were a child a few years old, and another when they were older; or a time when they were happy and another when they were sad. The important thing is that as the exercise goes on, the client notes that there is something in all of the situations, no matter how contradictory they are, that has remained constant. That ‘something’ is ‘the observer self’. It should be pointed out that the client is not dealing with an ‘idea’, but an experience.

### 8.3.6 Developing Willingness

As shown by Bach & Moran (2008), defining willingness is extremely difficult. For a start, according to Hayes *et al.* (1999), willingness is not the same as what one wants. Indeed, a person may not feel like suffering and nevertheless be willing to do so if they thereby achieve something they particularly value. In this sense, willingness assumes a hierarchical order of purposes and confronts a person with the conflictual nature of life. In other words, one’s will is always exerted when there are several possibilities for acting, each with certain inevitable costs.

Bach (2004) has stressed the therapeutic possibilities that the ‘swamp metaphor’ (Hayes *et al.*, 1999, p. 248) and the ‘looking for Mr Discomfort’ exercise (Hayes *et al.*, 1999, p. 247) have with the seriously mentally ill. The swamp metaphor suggests that the patient has decided to go on a trip somewhere they can see quite clearly, such as a mountain peak that can be seen from the valley where they are now. Sometime after the journey has begun, an enormous foul-smelling swamp comes into sight which will make the journey hard to finish without difficulty, such as getting wet, having to move slowly through the water and so on. However, there is no other choice; if the patient wants to get to the peak, they have to cross the swamp. Obviously, they can also decide not to go on. It could be suggested that life is something like this. We do not go into the swamp because we want to, but rather because we want to get to the peak.

Looking for Mr Discomfort is an exposure exercise recommended for contexts in which problems appear (a walk down the street, going into a shopping mall, etc.). The patient has to look back on their experiences to see what they have been avoiding, so that they can come into contact with the experiences as they are, and even welcome them. When the patient begins to feel these experiences, the therapist should advise them to pay attention to the atmosphere they are in. It is intended that the client learn to exist in the world with the experiences that were blocking them and causing them to retreat to their private world.

It may be easily understood that developing willingness situates therapy in life and incorporates relapses as just one more aspect of it. In fact, it could be said that relapses constitute an essential component of this goal, in as much as they offer an opportunity for willingness to be developed in its own setting: the patient's life. Thus, at the end of the clinical sessions, it was suggested to Luis that the therapy had not really yet begun, and that the true therapy would come from what he did from that time forward in his life. The basic thing is not whether he begins to believe in his delusional ideas again, or whether he tries to control his symptoms; what is really important is whether, when he makes a mistake, he is willing to continue on towards the peak, knowing that there will be another swamp ahead that may also be hard to cross.

## **8.4 Conclusion**

As we have attempted to show, treatment of delusions using ACT is nowhere near simple. It requires the creation of situations in which the client is exposed to experiences that they have been actively avoiding, while keeping up a warm, secure therapeutic relationship. It is a good idea to normalise the delusions, comparing them to another type of symptomology or life experience, but at the same time the desire for 'specialness' and 'individuality' that characterises psychotic patients must be kept in mind. The patient's behaviour should be directed towards the values that are important to them, without this making them too rigid or causing them not to pay attention to present circumstances. We believe that for an intervention to be successful, it is essential that the therapist be convinced that the final goal of treatment is not about symptoms, but that the client redirects their life in a more effective and adaptable manner.

Luis's case shows how changes in the level of belief he gave to his delusions were always preceded by a change in the circumstances in his life. So as Luis began to build up a new relationship, he was gradually able to pass his courses and achieve a new circle of friends. His worries about the secret service began to dissipate, until 2 years later he was able to see them from a completely critical point of view.

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## Note

- 1 In regard to the distinction between 'active' and 'passive' forms of experiential avoidance, following Millon's personality model (Millon, 1969), 'active' should be understood as 'self-initiating' or 'engaging', whereas 'passive' should be understood as 'appeasing' or 'reactive'.

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