

Introduction to Mindfulness and Acceptance-based Therapies for Psychosis

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1.1 Introduction to Psychosis

'Psychosis' is an umbrella term covering a range of associated symptoms, including perceptual, cognitive, emotional and behavioural disturbances. The term tends to refer to 'positive' symptoms of unusual beliefs (delusions), anomalous perceptual experiences (illusions and hallucinations) and disturbances of thought and language (formal thought disorder) (described in Peters *et al.*, 2007). These are invariably accompanied by emotional difficulties such as anxiety and depression (Birchwood, 2003; Freeman & Garety, 2003; Johnstone *et al.*, 1991). In addition, a significant proportion of people diagnosed with a psychotic disorder, particularly schizophrenia, are likely to experience 'negative' symptoms such as avolition and anhedonia (described in Kuipers *et al.*, 2006). The median incidence of psychotic disorders is estimated at 15.2 per 100 000, with estimates ranging between 7.7 and 43.0 per 100 000 (McGrath *et al.*, 2004), indicating a high degree of variability in incidence across geographic regions. The reported lifetime risk remains at approximately 1% (Saha *et al.*, 2005).

One of the diagnostic peculiarities of psychosis is that two individuals can receive the same diagnosis but have completely different sets of symptoms that have no overlap or commonality. This perhaps points to some of the complexities of the disorder, which the current accumulated evidence suggests is likely a manifold interaction between a range of genetic, biological, psychological and social factors, with probable multiple aetiological pathways (Oliver & Fearon, 2008).

Furthermore, psychotic symptoms are not exclusively reported by those with a diagnosis of psychotic disorder (such as schizophrenia, schizoaffective disorder or delusional disorder), but also occur in varying degrees in other mental-health problems, including bipolar affective disorder, mood disorders and personality disorders (particularly borderline personality disorder (BPD)). Additionally, some authors have vigorously criticised the schizophrenia diagnosis, arguing that the associated breadth and diversity of clinical phenomenology actually represents a lack of construct validity and reliability (Bentall, 2003; Boyle, 2002).

The mere presence of psychotic symptoms, no matter how apparently bizarre they may be, is not sufficient to warrant a diagnosis. Key to a psychotic disorder is recognition that the symptoms must co-occur with significant interruption to the individual's life. Schizophrenia is associated with significant long-term disability (Thorncroft *et al.*, 2004; World Health Organization, 2001) and, in addition to positive and negative psychotic symptoms, depressive symptoms are also strong predictors of poor quality of life in this client group (Saarni *et al.*, 2010). For those who continue to live with distressing psychotic symptoms and emotional disturbance, advances in treatments for psychosis are of paramount importance.

Alongside the devastation that psychosis can cause to the lives of individuals and their families, there are also significant economic costs. Estimates suggest that in 2002 the direct (e.g. service charges) and indirect (e.g. unemployment) costs associated with psychotic disorders were approximately \$62.7 billion in the United States (Wu *et al.*, 2005). Similar estimates within the United Kingdom have indicated costs of approximately £4 billion (McCrone *et al.* 2008).

1.2 Interventions

The first line of treatment for psychosis is almost always antipsychotic medication. However, there are limitations to pharmacological treatments, including issues of compliance, intolerable side effects and poor symptomatic response to antipsychotic medication (Curson *et al.*, 1988; Kane, 1996; Lieberman *et al.*, 2005). These findings, in conjunction with the recognition of the importance of social and psychological factors in psychosis (Bebbington & Kuipers, 1994; Garety *et al.*, 2001; van Os, 2004), have contributed to the development of psychological interventions for people with psychosis. Such interventions include family therapy, cognitive behavioural therapy (CBT) and social and cognitive rehabilitation. They are not proposed as alternatives to medication, but are used as adjunctive therapies.

1.2.1 Cognitive Behavioural Therapy

The main assumption underlying CBT is that psychological difficulties are maintained by vicious cycles involving thoughts, feelings and behaviours (Beck *et al.*, 1979). Therapy aims to break these cycles by helping people to learn more adaptive ways

of thinking and coping, which leads to a reduction in distress. In the 1980s and 1990s, research on psychotic symptoms led to treatments that adapted the successful use of CBT for anxiety and depression to the more complex problems of psychosis (Fowler *et al.*, 1995; Kingdon & Turkington, 1991). Cognitive models of psychotic symptoms (e.g. Garety *et al.*, 2001; Morrison, 2001) have informed the development of therapeutic approaches, highlighting that it is not the unusual experiences themselves that are problematic, but the appraisal of them as external and personally significant. CBT for psychosis (CBTp) aims to increase understanding of psychosis and its symptoms, reduce distress and disability arising from psychotic symptoms, promote coping and self-regulation and reduce hopelessness and counter-negative appraisals (of self and illness) (see Johns *et al.*, 2007 for an overview).

Evidence from randomised controlled trials (RCTs) has shown that CBT delivered on a one-to-one basis is efficacious for individuals with psychosis, particularly those with persistent positive symptoms (Smith *et al.*, 2010; Wykes *et al.*, 2008; Zimmerman *et al.*, 2005). A meta-analysis of 33 studies by Wykes *et al.* (2008) revealed a modest overall effect size of 0.40 for target symptoms and effect sizes ranging between 0.35 and 0.44 for positive symptoms, negative symptoms, functioning, mood and social anxiety. A recent study identified CBTp as being most effective when the full range of therapy procedures, including specific cognitive and behavioural techniques, are implemented (Dunn *et al.*, 2011). While CBTp offers symptom improvement in some areas for a number of people, it is not a panacea.

1.2.2 Developments in CBT: Contextual Approaches

Additional developments in the field of behavioural and cognitive therapy approaches have led to the evolution of a cluster of therapies termed 'contextual CBTs' (Hayes *et al.*, 2011). This evolution has been in response to several anomalies present within the CBT model, including debate about whether cognitive change/restructuring is actually the necessary component of therapy (Hayes, 2004; Longmore & Worrell, 2007). While not ignoring the importance of cognition, contextual approaches emphasise the historical and situational context an organism is situated within as a means for focusing upon central processes to be targeted to effect behavioural change. Critically, contextual approaches deemphasise the importance of changing the content and frequency of cognition, moving instead towards the use of acceptance and mindfulness procedures to alter the context in which these experiences occur, thereby increasing behavioural flexibility.

A number of approaches fall under the umbrella of contextual CBT, including dialectical behaviour therapy (DBT) (Linehan, 1987), functional analytic psychotherapy (FAP) (Kohlenberg & Tsai, 1991), mindfulness-based cognitive therapy (MBCT) (Teasdale *et al.*, 1995), integrative behavioural couples therapy (IBCT) (Jacobson & Christensen, 1996), Acceptance and Commitment Therapy (ACT) (Hayes *et al.*, 1999), metacognitive therapy (MCT) (Wells, 2000) and person-based cognitive therapy

(PBCT) for psychosis (Chadwick, 2006). These therapies include components such as mindfulness, experience with the present moment, acceptance, values and greater emphasis on the therapeutic relationship. While they may incorporate more traditional behavioural and cognitive techniques, they tend to be more experiential in nature and involve second-order strategies of change as well as first-order ones. Within these therapies, ACT, PBCT and mindfulness groups have mostly been implemented in the psychological treatment of psychosis.

1.2.3 Acceptance and Commitment Therapy

ACT is a modern behavioural approach that incorporates acceptance and mindfulness to help people disentangle from difficult thoughts and feelings in order to facilitate engagement in behavioural patterns that are guided by personal values. It has firm roots in behavioural traditions and is underpinned by a behavioural analytic account of language: relational frame theory (RFT) (Blackledge *et al.*, 2009). Broadly, the ACT stance focuses on changing one's relationship to internal experiences (thoughts, feelings) rather than altering the form or frequency of these experiences (Hayes *et al.*, 1999). The approach is transdiagnostic and uses the same theoretical model to formulate and target common processes underlying a wide range of symptomatically diverse problems (such as depression, BPD and diabetes).

ACT's six core theoretical processes are set out visually in a hexagonal shape (known colloquially as the 'hexaflex'; see Figure 1.1) and move in synchrony towards increasing psychological flexibility or 'the ability to contact the present moment more fully as a conscious human being, and to change or persist in behaviour when doing so serves valued ends' (Hayes *et al.*, 2006, p. 7). These processes are highly interrelated and, although represented as distinct entities in the model, share considerable overlap. More recently, the processes have been clustered into

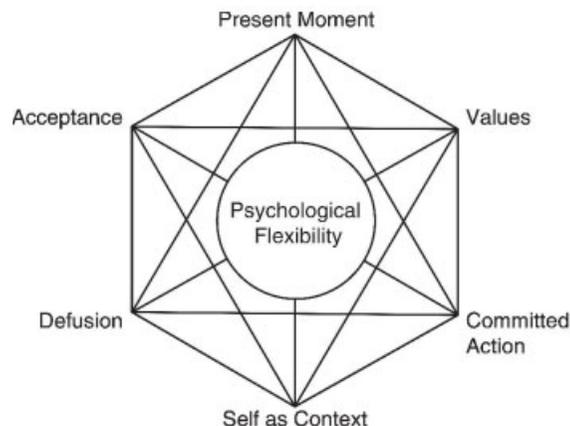


Figure 1.1 The ACT model of psychological flexibility

Table 1.1 Central ACT processes (adapted from Luoma *et al.*, 2007)

<i>Process</i>	<i>Definition</i>
<i>Open</i>	
Acceptance	The active and aware embrace of private events that are occasioned by our history, without unnecessary attempts to change their frequency or form, especially when doing so would cause psychological harm.
Defusion	The process of creating nonliteral contexts in which language can be seen as an active, ongoing relational process that is historical in nature and present in the current context.
<i>Aware</i>	
Self as Context	A continuous and secure 'I' from which events are experienced, but which is also distinct from those events.
Present Moment	Ongoing, nonjudgmental contact with psychological and environmental events as they occur.
<i>Active</i>	
Values	Verbally constructed, global, desired and chosen life directions.
Committed Action	Step-by-step process of acting to create a whole life, a life of integrity, true to one's deepest wishes and longings.

three broader sets of response styles: open, aware and active (Hayes *et al.*, 2011) (see Table 1.1).

1.2.3.1 *Open*

The processes of acceptance and defusion work synergistically to build the broader skill of developing openness towards internal content that occurs 'under the skin' (thoughts, emotions, memories, perceptions). Psychotic symptoms, by their nature, have a number of qualities that tend to increase the likelihood that people will respond to them with suppression or avoidance. Symptoms, such as voices, are often highly distressing, critical and personally salient (Close & Garety, 1998; Nayani & David, 1994). Experiences associated with delusional ideation have been shown to be highly linked with appraisals of shame, humiliation and entrapment (Birchwood *et al.*, 2000) and therefore much more likely to lead to experiential avoidance. Research bears this out, demonstrating that people with distressing psychosis tend to utilise more suppression and avoidance and less acceptance strategies (Morrison *et al.*, 1995; Perry *et al.*, 2011). Conversely, psychotic experiences can be extremely engaging, in that they can be magical, interesting and have high personal meaning, especially in the context of a life devoid of meaningful activity and social connection. As such, these experiences may be used as a method to escape a dreary, mundane existence, but this may come at high personal cost in the long term.

Acceptance is the process by which clients are encouraged to embrace their thoughts and feelings without trying to resist, avoid or suppress them via

‘experiential avoidance’. This is not merely a process of tolerance or resignation, but a full willingness to step towards and make space for psychological phenomena, including psychotic symptoms, without engaging in unworkable struggle against them.

Alongside the process of acceptance, building of defusion further supports an open stance towards internal experience. Defusion aims to help clients step back from internal experiences such as thoughts, memories or appraisals of external experiences (voices or other anomalous experiences) and see them for what they are, rather than what they say they are, thereby reducing unhelpful literal, rule-based responding to internal events. From an ACT perspective, fusion increases the likelihood of a narrowing of an individual’s behavioural repertoire in the face of such experiences, thereby limiting opportunities for values-based actions. Defusion works to expand and add to that repertoire by undermining adherence to thoughts and verbal rules that promote restriction, narrowing or avoidance. For example, an ACT therapist might usefully work on defusion related to a thought such as ‘I can’t tolerate this paranoia’ that occurs in the context of high anxiety and avoidance of valued activities such as connecting with friends. An intervention might focus on assisting the client to first notice this as a thought and then develop a more defused stance towards it, so that subsequent actions are guided more by values (actively connecting with friends) rather than fusion (‘I must avoid situations that lead to paranoia’). This is contrasted with more traditional cognitive approaches, in which interventions target the veracity of thoughts or appraisals and, where distorted, adjust or correct them.

1.2.3.2 *Aware*

The self as context is the perspective from which all internal experiences are observed and in which they are held. By promoting an awareness of this particular perspective, detachment to distressing thoughts, images, beliefs or hallucinations that may arise is cultivated through a mindful contact with the present moment. The idea that language gives humans a sense of ‘self’ and perspective explains the inclusion of spirituality in human existence, because the ‘mind’ has no boundaries (Hayes, 1984). Mindfulness can help individuals learn to notice, but not judge, passing thoughts, feelings or images, in order to develop a more centred stance towards internal experiences, so as to support engagement with core values.

1.2.3.3 *Active*

The heart of ACT work is in assisting clients to become more engaged with and active in their lives, through a process of identifying and constructing sets of values and using them to inform the development of goals and specific action plans. Goals are set in ways that increase the likelihood they will be met, for example by setting initial small, measureable, meaningful tasks, which are increasingly built into larger and larger patterns of committed action. To use a sailing metaphor, the verbal construction and articulation of values is comparable to the setting of sails,

which are then used to ‘catch the wind’, or the natural reinforcement that occurs as values-directed behaviour is engaged in. In sailing, catching the wind can be both exhilarating and scary; so can taking steps towards values. The therapist’s job is to help the client cue into these sensations and to assist in ongoing adjustments to help the client stay on course.

At the time of publication, there are four RCTs evaluating the use of acceptance and mindfulness approaches for people with psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006; Shawyer *et al.*, 2012; White, 2011). Although they have modest sample sizes, the findings are promising, and indicate that such interventions are efficacious for people with distressing psychosis.

1.2.4 Mindfulness and Person-based Cognitive Therapy for Psychosis

Over the last 10–15 years, mindfulness approaches have become increasingly prominent in the psychological literature (Hayes *et al.*, 2005), and have been applied in an increasingly broad range of difficulties. An evidence base has developed to indicate that mindfulness is effective for a wide variety of problems, including eating disorders, affective disorders, anxiety, stress and substance-misuse problems, and as a complementary treatment for physical disorders (Baer, 2003; Hayes *et al.*, 2006).

Mindfulness can be described as ‘paying attention in a particular way: on purpose, in the present moment and non-judgementally’ (Kabat-Zinn, 1994, p. 3). It can involve a focusing of attention and an acceptance of present-moment experiences (Linehan, 1993), as contrasted with cognitive processes such as rumination, worry, planning and automatic engagement with activity without awareness (Baer *et al.*, 2004).

Evidence is emerging to indicate that mindfulness can be useful for people with distressing symptoms of psychosis. Chadwick (2006) has developed a mindfulness-based therapy programme which has the aim of influencing how people relate to their psychotic experiences. The programme focuses on facilitating awareness of the body, mindfulness (with prompting), introducing homework audiotapes and emphasizing the therapeutic process. Two small trials have provided some initial evidence that mindfulness can be helpful with this group (Chadwick *et al.*, 2005, 2009). A qualitative study carried out by Abba *et al.* (2007) helped to illuminate the processes by which mindfulness can help with the experience of psychosis. A three-stage process was identified. The first stage involved learning to maintain a centred awareness alongside the experience of psychosis as an alternative to becoming lost in the experience; this process developed a new position – the person and the presence of the voice, paranoia or thought/image. The second stage involved a focus on allowing voices, thoughts and images to come and go without reaction or struggle. The final stage emphasised a reclaiming of power through acceptance: observing that all unpleasant experiences happen in the same way as other human experiences – they are just one part of human experience.

Alongside this work, Chadwick (2006) integrated mindfulness into a broader CBT to develop the PBCT protocol for distressing psychosis. This aims to alleviate the distress associated with clients' reactions to their psychotic experiences and move towards their acceptance of these experiences and improved well-being. The therapy is deeply embedded in Rogerian therapy, in particular Rogerian acceptance (Rogers, 1961). It also involves an integration of cognitive therapy and mindfulness with Vygotsky's 'zones of proximal development' (ZoPD) (Vygotsky, 1978) as the structure of the therapeutic process. This model, and its application within group settings, is more comprehensively described in Chapter 10.

1.3 Conclusion

This volume aims to draw together current thinking and developments in the use of contextual CBTs with people who experience distressing psychosis. The various contributions represent theories and practice as they have developed, often independently, across a variety of locations, including the United Kingdom, Spain, Australia and the United States. The reader will gain an understanding of how the problems related to psychosis are conceptualised and treated using acceptance- and mindfulness-based therapy approaches, with a particular emphasis on ACT and PBCT, in both individual and group formats. In addition, there are chapters on the development of experiential interventions for paranoia and understanding and on working with spirituality from a metacognitive perspective, as well as on the experiences of service users (clients/patients) in engaging in these forms of therapy. Many of the chapters describe protocols demonstrated through case studies and vignettes of contemporary contextual CBTp. Finally, many of the common experiential exercises used in these therapies, and referred to in the chapters, are described in the appendices at the end of the volume.

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