Enhancing the Therapy Relationship in Acceptance and Commitment Therapy for Psychotic Symptoms

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The article demonstrates how acceptance and commitment therapy (ACT) may effectively alter the function of positive psychotic symptoms and how functional analytic psychotherapy (FAP) may provide a complimentary framework for interpersonal change. ACT differs with many psychosis approaches in that it does not attempt to reduce psychotic symptoms; instead, it aims to increase psychological flexibility (e.g., acceptance) in the presence of psychotic symptoms while actively pursuing valued living. The study involves, John, a 21-year-old college student, who presented with depressive symptoms, delusional and brief visual hallucinatory episodes, and severe social isolation. ACT interventions emphasize acceptance of, and mindful reactions to, psychotic symptoms while pursuing valued life goals. As John’s main goal of treatment was to develop more intimate interpersonal relationships, FAP techniques were introduced as behaviors that seemed to be distancing him from peers manifested themselves in session. The benefits and challenges of integrating ACT and FAP are discussed.

Keywords: acceptance and commitment therapy; psychosis; functional analytic psychotherapy

1 Theoretical and Research Basis

Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999) has been applied to, and generated empirical support for, an increasingly diverse set of clinical problems, including depression (Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Zettle & Hayes, 1986; Zettle & Rains, 1989), chronic pain (Dahl, Wilson, & Nilsson, 2004; Vowles & McCracken, 2008; Wicksell, Melin, & Olsson, 2007), anxiety (Dalrymple & Herbert, 2007; Forman et al., 2007; Ossman, Wilson, Stroasli, & McNeill, 2006; Zettle, 2003), epilepsy (Lundgren, Dahl, Melin, & Kies, 2006; Lundgren, Dahl, Yardi, & Melin, 2008), substance abuse (Gifford et al., 2004; Twohig, Shoenberger, & Hayes, 2007), chronic skin picking (Twohig, Hayes, & Masuda, 2006a), trichotillomania (Woods, Wetterneck, & Flessner, 2006), obsessive–compulsive disorder (Twohig, Hayes, & Masuda, 2006b), and diabetes self-management (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007; see Hayes, Luoma, Bond, Masuda, & Lillis, 2006, for review). ACT, though rooted in the behavioral tradition, represents in some ways an important ideological shift from traditional
behavioral and cognitive interventions in that it explicitly encourages acceptance rather than reduction of the primary symptomatic complaints with which the client presents to therapy (Hayes, 2004). Instead of reducing symptoms, ACT aims to increase psychological flexibility by reducing experiential avoidance—an unwillingness to experience unwanted thoughts, emotions, and other internal experiences (i.e., symptoms; Hayes et al., 2006).

The ACT treatment model is designed to establish psychological flexibility with interventions that target six core processes. Although rooted in behavioral theory, the ACT model does not follow a traditional functional analysis (i.e., antecedents, behavior, consequences). Instead, ACT posits that the primacy of verbal processes (e.g., experiential avoidance and cognitive fusion as described below) in psychopathology renders such traditional analyses incomplete. These targeted ACT processes, which are incorporated into ACT case conceptualization, represent middle-level terms that are neither hypothetical entities nor technical functional analytic terms but rather are functional abstractions designed to be shortcuts for applying basic principles and theories to complex clinical situations (Viladarga, Hayes, Levin, & Muto, in press).

The six core ACT processes include acceptance, defusion, self-as-context, contact with the present moment, values, and committed action. A full description of each process is beyond the scope of this case study. However, each process is briefly described as it relates to ACT treatment goals. Acceptance can be viewed as the opposite to experiential avoidance and the ACT therapist promotes it by encouraging client willingness to experience unwanted internal experiences fully and without avoidance. Defusion interventions target problems with fusion, described as the process whereby private verbal stimuli (e.g., thoughts), as opposed to public stimuli, dominate an individual’s effort to regulate behavior. Defusion interventions thus attempt to decrease the functional control exerted by specific thoughts without changing their content (e.g., increase awareness of the process of thinking). Self-as-Context describes one’s verbal constructions of self that are rigidly defended. ACT interventions (e.g., defusion) attempt to reduce entanglement with self-defining thoughts and increase the experience of self as a context from which thoughts occur.

Contact with the present moment describes the level of contact with current environmental contingencies and the aim of ACT interventions is to increase client awareness of their experiences (e.g., thoughts, feelings, sensations, etc.) occurring in the moment to increase likelihood of new and more effective responses to private and public events. Values describes a client’s verbal construction of abstracted long-term reinforcement contingencies, and ACT interventions help clients identify and clarify values to establish an overarching purpose for acceptance of unwanted experiences and behavior change. Finally, committed action describes the congruence between the client’s verbally identified values and actual overt behavior, and ACT interventions aim to generate sustained behavior in the service of identified values. In combination, these processes can work together to promote psychological flexibility in which the client demonstrates willingness to fully experience any public or private event that occurs when pursuing valued life goals.

Several case studies (García-Montes, Luciano, Hernández, & Zaldivar, 2004; García-Montes & Pérez-Álvarez, 2001, in press; Veiga-Martínez, Pérez-Álvarez, & García-Montes, 2008) and two clinical trials (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) have provided evidence that ACT may be useful for individuals suffering from psychotic symptoms. ACT’s stark shift in focus from symptom reduction to valued living is very clear with
respect to treatment for psychosis, as ACT does not attempt to reduce psychotic symptoms that, on the surface, may seem unacceptable. Instead, ACT focuses on altering how an individual responds to hallucinations and delusions rather than trying to diminish their frequency or alter their content. For example, ACT would ask a psychotic client, “Can you accept that a hallucination is occurring and still act according to your values in its presence, rather than trying to control or get rid of it?” Considering the persistent and treatment-resistant nature of hallucinations and delusions, initial trials showing that ACT reduced hospitalization rates for psychotic individuals are quite encouraging and demonstrate ACT’s promise in this area (Bach & Hayes, 2002; Gaudiano & Herbert, 2006).

Enhancing the Therapy Relationship in ACT

Given that the ability to remain present and fully experience the ongoing moment is a central focus in ACT and extends to the therapy session itself, the therapeutic relationship takes on particular significance (Pierson & Hayes, 2007). ACT encourages therapists to create a therapeutic context that is explicitly unlike the outside social-verbal community, as this altered context facilitates awareness of and distance from social-verbal conventions that have produced problems with experiential avoidance and cognitive fusion. In this way, intrapersonal ACT targets may be practiced, reinforced, and modeled within the therapeutic context. For example, ACT therapists try to disrupt normal language processes by using metaphors, rather than linear logic, to help the client accept and fully experience emotions as they are occurring in the session. It should be noted, however, that Veiga-Martinez et al. (2008) cautioned against the overuse of metaphors with psychotic clients. ACT exercises, when successful, often result in substantial in vivo emotional experiencing and expression, which the therapist strives to accept and experience fully him or herself.

Whereas the core ACT processes are by and large defined as intrapersonal, the ultimate goals of ACT are often interpersonal. In other words, though acceptance of intrapersonal symptoms such as delusions, is a targeted process in ACT, the ultimate goal in ACT is behavioral change. The behavioral change agenda established by the client and ACT therapist is a product of the client’s chosen values, and many of these values in turn are often (but not always) interpersonal in nature. For example, ACT does not encourage acceptance of hallucinations or delusions for its own sake, but such acceptance is encouraged in order for the client to act according to a value, such as asking a woman to dinner, reconnecting with one’s family, and so forth.

The therapeutic relationship also provides a context in which in vivo interpersonal behaviors may be evoked and addressed. When in vivo interpersonal behaviors occur, functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991; Tsai et al., in press) techniques may be useful tools to complement ACT interventions. FAP has been described as both a stand-alone intervention and as an enhancement to other established treatments, including cognitive behavior therapy (Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002), behavioral activation (Kanter, Manos, Busch, & Rusch, in press), and ACT (Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004; Dougher & Hackbert, 1994; Kohlenberg & Callaghan, in press). As an enhancement, the goal of FAP is to sensitize therapists to opportunities available that help shape interpersonal behavior as it occurs live in the therapeutic relationship. FAP aims to improve interpersonal functioning by applying basic behavioral
principles, such as reinforcement and shaping, within the context of the therapeutic relationship (e.g., shape self-disclosure to promote acceptance of vulnerability and trust between the client and therapist).

In FAP, therapists focus on in-session client behaviors occurring in the context of the therapeutic relationship, termed *clinically relevant behavior* (CRB). There are two types of CRB: CRB1 relates to in-session instances of client behaviors conceptualized as problematic based on the client's case conceptualization and treatment goals, and CRB2 relates to in-session instances of client improvements. The goal in FAP is to evoke and shape CRB2 and decrease CRB1 over the course of treatment by applying natural, contingent reinforcement to CRB2s, and blocking, extinguishing (i.e., ignoring), or punishing CRB1.

To facilitate occurrence of CRB, and to make sure that CRBs are in fact similar to corresponding out-of-session client problems and goals, FAP attempts to create therapy relationships that represent an idealized version of the kinds of intimate relationships that client’s often seek in their outside lives. When CRB does occur, FAP therapists shape a more effective in-session interpersonal repertoire by responding in naturally reinforcing ways (e.g., providing feedback consistent with the therapist’s genuine private emotional reactions). The assumption in FAP is that if CRB truly resembles out-of-session problematic and improvement behaviors, than CRB2s that are naturally shaped in the context of a real interpersonal interaction can be expected to generalize to out-of-session interpersonal relationships.

The following case describes a male client who presented with a long history of depression and paranoid delusions and was treated with a combination of ACT and FAP. ACT interventions targeting the paranoid delusions were the primary focus in early sessions. As the client's values that related to interpersonal relationships were identified, FAP interventions were introduced and incorporated into treatment. The specific content of this case highlights how ACT may successfully intervene with respect to paranoid delusions that are traditionally seen as intractable intrapersonal variables and how FAP may complement ACT interventions to enhance the focus on interpersonal variables and produce additional behavior change.

### 2 Case Presentation

The case involved, John, a 21-year-old Caucasian male at the time of treatment. At the beginning of treatment John was a full-time college student, unemployed, and living at home with his biological parents. He was an average student with good motivation and worked hard academically. John was socially withdrawn and spent most of his free time playing videogames alone. John had several friends and acquaintances from high school and the university; however, he described these peer relationships as lacking in depth. He was the youngest child in his family with four older sisters who had several children, with whom he had frequent interactions. He reported being close with his mother but distant from his father and siblings, describing most of his family interactions as stressful and unfulfilling.
3 Presenting Complaints

John reported seeking treatment to ameliorate feelings of depression, specifically his frequent low mood and inability to “pull himself out of it,” especially when alone. Painful complications of an intestinal disorder often triggered his low mood and negative thinking, and he reported recurrent suicidal thoughts and feelings that “life is bad and not getting any better.” His depressive symptoms included recurrent negative thoughts, hopelessness, suicidal ideation, self-criticism, poor appetite, and trouble sleeping. John also reported significant distrust of others (i.e., that people were out to get him, going to attack him, or going to use personal information against him) and fleeting hallucinations (e.g., briefly seeing bizarre images in the mirror or his peripheral vision). Over the course of the first several sessions, John also reported significant psychotic symptoms, as discussed below. He reported dissatisfaction with peer relationships, distance and conflict in family relationships, and ineffectiveness in his pursuit of romantic relationships.

4 History

John could never recall a time in his life during which he did not feel miserable and depressed. He reported being quiet and the school “outsider” in both grade school and high school. John reported experiencing paranoid delusions since high school but could not identify a specific time when his hallucinations first appeared. John also reported a history of self-injurious behavior with the last incident of self-injury occurring several months before treatment began. This self-report was confirmed by scars on his lower legs. Surprising, given the severity of his symptoms, John had never previously sought or received any type of mental health treatment. In addition to mental health problems, John suffered from severe abdominal pain and other physical complications due to a chronic intestinal disorder.

5 Assessment

John met Diagnostic and Statistical Manual of Mental Disorders IV-TR (*DSM-IV TR*; American Psychiatric Association, 2000) criteria for dysthymic disorder, early onset. Asperger’s disorder was considered as a diagnosis, as John displayed impairment in social interactions and perspective taking and intense interest in a narrow range of activities (i.e., online computer gaming). However, Asperger’s disorder was ruled out as it became clear that he maintained several relationships and displayed appropriate nonverbal communication skills and improved reciprocity as the therapeutic relationship developed.

Over the course of the first several sessions, John reported multiple nonbizarre persecutory delusions (e.g., the government was tapping his phone calls or a sniper on the water tower was aiming at him) and bizarre visual hallucinations (e.g., briefly seeing a dog instead of a fire hydrant or briefly seeing a demon in the mirror) that led to significant social withdrawal. Several diagnoses were considered. First, diagnoses of schizophrenia or
Table 1
Scores for Beck Depression Inventory-II and Outcome Questionnaire-45

<table>
<thead>
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<th>Intake</th>
<th>Termination</th>
<th>Follow-up</th>
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<tr>
<td>BDI-II</td>
<td>18</td>
<td>8</td>
<td>5</td>
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<tr>
<td>OQ-45</td>
<td>112</td>
<td>77</td>
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<td>SD</td>
<td>65</td>
<td>41</td>
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<td>IR</td>
<td>30</td>
<td>24</td>
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<tr>
<td>SR</td>
<td>17</td>
<td>12</td>
<td>11</td>
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Note: BDI-II = Beck Depression Inventory-II; OQ-45 = Outcome Questionnaire-45 total score; SD = symptom distress; IR = interpersonal relations; SR = social role.

schizoaffective disorder were not given because his delusions were deemed to be nonbizarre, and he had clear insight into the pathological nature of the bizarre hallucinations (less so for the delusions) and did not evidence sufficiently significant social/occupational dysfunction to meet criteria. Nevertheless, the hallucinations were still of clinical significance and, therefore, ruled out delusional disorder. A diagnosis of paranoid personality disorder was originally given but then retracted because although John did display paranoid symptoms, he lacked the rigidity, hostility, criticalness toward others, and inability to collaborate that often characterizes that disorder. For these reasons, a psychotic disorder, not otherwise specified diagnosis was chosen.

Additional assessment included the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) and the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996), and these were administered at intake and posttreatment. The BDI-II is a widely used measure of depression symptoms with well-established psychometrics (Beck et al., 1996; Whisman, Perez, & Ramel, 2000). The OQ-45 is a reliable and valid symptom-outcome measure (Lambert et al., 1996) that tracks three clinical domains including symptom distress, interpersonal relationships, and social roles. John scored in the moderately depressed range on the BDI-II and the clinically significant range on the OQ-45 total score and each subscale (see Table 1). Starting at Session 11, John began self-monitoring the frequency of, and his reaction to, psychotic symptoms in a simple diary card format. Specifically, he was asked to track the frequency of psychotic symptoms that occurred between sessions and mark whether or not he reacted to them “mindfully” (see below for description).

6 Case Conceptualization

From an ACT perspective (Bach & Moran, 2008) John’s depressive and paranoid symptoms were conceptualized as related in that cognitive fusion with paranoid thoughts and hallucinations resulted in experiential avoidance that in turn resulted in depression. Put more technically, paranoid thoughts and hallucinations exerted control over John’s overt behavioral repertoire, resulting in substantial avoidance, because these private verbal and visual stimuli tended to dominate over external stimuli. This avoidance, in turn, resulted in isolation, low mood, little contact with positive reinforcement, and other symptoms of depression.
For example, following paranoid episodes (e.g., believing that snipers were waiting for him on a tower) or hallucinations (e.g., sensing that a stationary object moved), John would worry that he was going crazy and would retreat into his room and play videogames for long periods, withdrawing completely from social contact. Likewise, to avoid fears that people would use personal knowledge against him, John would avoid interpersonal interactions all together, leading to long periods of social isolation and exacerbating his depressive mood. This pattern was manifested in-session within the therapeutic relationship, as John had severe reservations about sharing personal information with the therapist early in treatment. Similarly, due to a long history of distrusting others, John had great difficulties with emotional expression, and this often occurred in earlier sessions as John described the minutia of details of his past week experience rather than describing directly how he was feeling.

John would spend long periods ruminating about paranoid themes (“They must be talking about me because they looked at me and laughed,” or “They probably don’t like me because they think I’m crazy”). As per the ACT model, it was conceptualized that John’s ruminating about these issues and fully believing the literal content of (i.e., was fused with) the paranoid thoughts resulted in the paranoid thoughts gaining more control over his behavior. The paranoid thoughts dominated over potential environmental stimuli that otherwise would be more influential over his behaviour and led to increased social isolation, distrust of others, and fears that he was losing his sanity. This cognitive fusion with paranoid thoughts occurred in session as he acknowledged a fear that his therapist thought that he was crazy.

Despite John’s fervent distrust of others, he reported a strong desire to establish close friendships, pursue a romantic relationship, and one day raise a family. The primary ACT treatment goals for John were to increase responding mindfully to paranoid thoughts (i.e., being present in the moment by noticing the thought without engaging in its content) and to move toward his values (i.e., close, genuine relationships) despite the presence of paranoid thoughts. In vivo intrapersonal targets included increasing mindful reactions to internal experiences evoked by the therapeutic relationship (e.g., noticing and accepting paranoid thoughts regarding the therapist) and pursuing his valued goals (e.g., developing a real relationship with the therapist).

Based on FAP conceptualization (Kanter, Weeks, et al., 2009), six in-session CRB1s and their corresponding CRB2s were identified, with the basic goal of decreasing CRB1s and increasing CRB2s through therapist differential contingent responding to them as they occur in the therapy session. First, John displayed a CRB1 of becoming more interpersonally distant in reaction to paranoid thinking (e.g., responding to paranoid thinking about the therapist by disengaging from treatment during the session), with the corresponding desired CRB2 of responding to paranoid thinking in socially pragmatic or intimacy-building ways (e.g., openly discussing and assessing the accuracy of paranoid thoughts and fears regarding the therapist). Second, John displayed a broader class of CRB1 related to general social-distancing behaviors (e.g., frequent tangential and off-topic comments), with the corresponding desired CRB2 of alert and engaged social behavior (e.g., self-correcting tangents and/or apologizing for off-topic discussion). Finally, unclear and circuitous expression of emotions was considered CRB1, and the corresponding desired CRB2 was direct emotional expressions to the therapist (e.g., reporting emotional states).
7 Course of Treatment and Assessment of Progress

Treatment comprised 37 weekly and biweekly sessions over the course of approximately 1 year. A psychiatric consultation was suggested multiple times early in treatment, but John declined because he was opposed to any medication treatment. Treatment included ACT and FAP interventions, first focusing on intrapersonal behaviors (i.e., paranoia, rumination) followed by a focus on interpersonal behaviors. Given John’s interpersonal style and distrust of others, a full introduction of FAP interventions was delayed until a stronger therapeutic relationship was developed (Session 6). Building this relationship was an explicit focus of early sessions.

Sessions 1-5: Setting the Stage for Change

ACT metaphors and experiential exercises were utilized to convey ACT principles and to set the stage for change. A values assessment revealed that John wished to experience close, intimate relationships with friends, family, and pursue a romantic relationship. Creative hopelessness techniques (Hayes et al., 1999) were introduced to highlight the ineffectiveness of John’s previous attempts to control internal experiences. John readily connected with the idea that his current coping strategies to reduce depressive symptoms and delusions/hallucinations impeded his ability to establish real, genuine connections with others (e.g., not disclosing personal information to friends may remove fears of persecution but may also contribute to shallow relationships and loneliness). To this end, willingness to experience fears that arise when connecting with others was introduced as a treatment goal. Along these lines, an important distinction for John was differentiating the initial discomfort resulting from paranoid thoughts from subsequent discomfort resulting from his reactions to paranoid thoughts (e.g., feeling distressed by paranoid thinking vs. feeling lonely as a result of isolating himself from others when experiencing paranoid thoughts).

Session 6: Introduction of In Vivo Interventions

In vivo client behavior began to be targeted in Session 6. John reported not caring anymore about treatment and was only showing up because the therapist wanted him in session. Although John quickly qualified this statement by saying, “Not that I can ever know that you want me here because I would doubt your sincerity,” from a FAP conceptualization, this was seen as an approximation toward a CRB2 (i.e., asking the therapist whether he cared for him). As such, the therapist naturally, contingently reinforced the attempt by sharing that he was in truth “looking forward to the session all day.” John responded with nervous laughter and became significantly more engaged for the rest of the session.

From an ACT conceptualization, the same interaction was conceptualized as an in vivo ACT example of cognitive fusion (responding to the thought that the therapist was insincere as literally true). As per ACT, it was discussed whether it was possible for John, in that moment, to accept the live experience of the therapist appreciating him while experiencing the thought that the therapist was insincere. A cognitive defusion/mindfulness intervention then followed, specifically the leaf on the stream metaphor (Hayes et al., 1999) was used to introduce the skill of observing a stream of thoughts without engaging in the content of
each one. In addition, the concept of self-as-context was introduced whereby John was encouraged to observe thoughts “from behind his eyes” as a separate entity, free to notice thoughts and feelings without explicitly responding to each one.

**Sessions 7-15: Willingness and Committed Action**

John committed to pursuing his goal of connecting with others in the presence of paranoid fears. He reported being particularly empowered by the passenger on the bus metaphor (Hayes et al., 1999) in which disturbing thoughts and feelings are equated to back-seat drivers who might never be silenced, and attempts to silence them hand over control of the bus (i.e., control of his life) to the passengers. John began to track the frequency of paranoid and hallucinatory experiences and mindful reactions to them (Figure 1). Mindful reactions were defined broadly as noticing the occurrence of thoughts without evaluation and being willing to experience discomfort in the service of his values.

John was assigned several interpersonal committed action assignments, including sharing genuine feelings and fully engaging in conversation with selected friends (in John’s words, “behind-your-eyes” conversations), asking for feedback on how others viewed an interaction, and sharing personal information. John reported spending more time with friends despite paranoid fears (e.g., remaining at a restaurant despite sitting with his back to the window), engaging in more serious conversations, and participating in social events despite intense reservations (e.g., attending a party despite feeling closed in and crowded).
Though John demonstrated more willingness in social interactions, he continued to avoid sharing personal information and remained distrustful and concerned that others would think he was crazy. This occurred in session as a CRB1 when John feared that the therapist thought he was crazy. FAP interventions targeted shaping effective in vivo interpersonal reactions in the context of fully accepting the existence of paranoid thoughts. John was encouraged to find appropriate in-session moments to seek feedback on an interaction (e.g., “Do you [therapist] think I’m crazy for saying that?”) and was naturally reinforced accordingly (e.g., “Sometimes I [therapist] do find some things you say a bit odd but as you can see I’m not talking to you any differently”).

**Sessions 16 to 27: Increased Social Engagement**

John reported a strong urge to self-harm following a verbal altercation with a coworker. John acknowledged that it was difficult to reveal his desire to self-harm to the therapist because he did not want to let the therapist down. The passenger on the bus metaphor was revisited, and it was highlighted that both not cutting and disclosing the information to the therapist were examples of John making choices with feelings and not because of feelings. The therapist interpreted John’s sharing his discomfort as an emotional expression, a CRB2, and reinforced this expression by staying matter of fact when responding, not overresponding in a way that might suggest he thought John was crazy, and sharing how proud he was that John was clearly improving in terms of increasing willingness and value-consistent behaviors.

As the therapeutic relationship became stronger, tangential and off-task comments (CRB1) began to be targeted directly (e.g., “It’s actually difficult to stay focused and help you when you interject like that”). Noticing tangents and using segues to transition into different topics when interacting with others was added as committed action assignments. While in session, the therapist encouraged and reinforced corresponding CRB2s such as John self-correcting when noticing being tangential or introducing other topics with clear transitions (e.g., “On a completely random note”).

John reported a slight decrease in psychotic symptoms but, more important therapeutically, his self-monitoring revealed that he frequently responded to these episodes in a mindful and willing manner. This made progress possible in several additional interpersonal committed action assignments such as disclosing personal information, expressing emotions with others, and sharing close, genuine interactions with a larger social circle. John started to connect more closely with several friends (e.g., he disclosed to friends that he was anxious about a close family member’s upcoming surgery) and began to pursue romantic relationships.

**Sessions 28-37: Support/Relapse Prevention**

As psychotic symptoms became less of a concern for John (i.e., increased acceptance of disturbing thoughts, fears, and visions), treatment shifted more to discussion of progress and ways to manage current and future environmental stressors. Treatment continued to center on progress toward valued goals, especially committed action assignments to apply interpersonal skills shaped in vivo to other relationships. Examples included engaging in
genuine, and at times emotional, interactions with close friends, and seeking feedback from others instead of assuming that his behavior was *off-putting*. By the end of treatment, John had obtained a part-time job on the grounds crew at a golf course and was pleased overall with his personal relationships. Over time, John came into each session with minor, everyday problems to discuss. Though John expressed concerns about terminating he was confident he “could now deal with the ups and downs of life” on his own.

**Outcome Evaluation**

As shown in Table 1, John’s BDI-II score dropped from an 18 at intake to an 8 at termination, indicating subclinical depressive symptoms. Though John’s Full QO-45 and subscale scores remained in the clinical range, his full QO-45 score and symptom distress scores demonstrated a clinically significant change (Lambert et al., 1996). Of note, the remaining two subscales (interpersonal relationships and social roles) also improved and fell just short of clinical significance. Nevertheless, John reported more frequent and engaging interactions with friends and increased comfort with disclosing personal information with others. John also actively pursued two romantic relationships, and, though he had not yet accomplished his goal of a relationship with a monogamous partner by the end of treatment, John was extremely satisfied with this initial step.

Figure 1 graphs John’s self-monitored frequencies of times he experienced psychotic symptoms and corresponding mindful responses. Self-monitoring began at Session 11 and continued throughout treatment. John reported having 21 psychotic symptoms between Sessions 11 and 20 and responding mindfully only 29% (6 out of 21) of the time. Between Sessions 21 and 30, John reported somewhat fewer psychotic symptoms (17) but, more important from an ACT conceptualization, responded mindfully to 76% (13 out of 17) of them. A caveat is required when interpreting the significant drop in psychotic symptoms during Sessions 31 to 37 (only 1 reported with 100% mindful response). This large drop appears to be at least partly the result of the altered function of psychotic symptoms. Near the end of treatment, John often reported that he recalled experiencing some episodes but had difficulty recalling their content when completing his diary card at the end of the day. Hopefully, this was because these episodes were no longer as noteworthy or as impactful as before. Despite this caveat, it is important to note that the goal of treatment was not the reduction of psychotic symptoms but to increase the ability to respond differently (mindfully) and more effectively (value-consistent way) to them. Although John’s QO-45 score was still in the clinical range at posttreatment, John’s chronic medical condition (e.g., intestinal pain) may have inflated QO-45 scores as many items ask about physical symptoms.

**8 Complicating Factors**

Several complicating factors were addressed in John’s treatment. First, John reported a history of self-harm and current suicidal thoughts without intent. Given his lack of intent, treatment centered on how suicidal thoughts acted as an antecedent for long periods of rumination and increased depression. Similar to psychotic symptoms, suicidal thinking without intent persisted, yet he noted that this thinking troubled him less and rarely affected
his daily life functioning near the end of treatment. Regarding self-harm, John mentioned in therapy once that during the previous week he desired to self-harm but successfully applied mindfulness techniques and the feelings eventually abated.

Second, John experienced highly variable levels of abdominal pain, which clearly influenced his mood and in-session behavior. This was challenging therapeutically because at times it was difficult to assess general therapeutic progress relative to specific variability in pain levels.

Although ACT and FAP are theoretically parallel and quite compatible, an interesting complicating factor arose with respect to their integration. Specifically, in some instances, ACT adopts a therapeutic posture that is in stark contrast with the outside social-verbal community, calling normative social-verbal conventions into question, whereas FAP typically calls for a therapeutic relationship that is quite similar to those outside of therapy, to facilitate the generalization of gains made in therapy to outside relationships. For example, in Session 6 John reported that he could never “know that you [the therapist] want me here because I would doubt your sincerity.” Viewing this behavior intrapersonally from an ACT perspective, this thought might call for a defusion intervention in which the therapist does not take the thought seriously and encourages John to do the same. Some defusion interventions, such as asking the client to repeat the thought over and over, say it in a funny voice, or responding, “Thank your mind for that thought” would be quite odd if not coming from a therapist and, therefore, would be discouraging in FAP (to be fair, an ACT therapist might also find that such interventions, if not delivered compassionately and honestly, might be problematic).

This complication suggests an incompatibility between ACT and FAP only to the extent that ACT does not focus on or prioritize interpersonal as well as intrapersonal variables, which it often does. In the current case, resolving this complication required a clear and hierarchical case conceptualization of in-session client behavior in which interpersonal CRB2s were prioritized over intrapersonal CRBs. Although John had been progressing in terms of accepting paranoid symptoms, he still had difficulty knowing how to effectively respond interpersonally. From an FAP perspective, the therapist recognized the statement as an interpersonal CRB2 (e.g., attempting to seek the therapist’s opinion in a socially inviting way) and focused on positively reinforcing a more effective interpersonal repertoire. More important, the FAP intervention occurred in an ACT context (i.e., accepting discomfort related to disclosing that he cared about the therapist’s opinion and fears of rejection) while shaping an interpersonal repertoire capable of establishing valued relationships in a way that was generalizable to real-world interactions. In general, consistent with ACT, instead of challenging the content of his thoughts (“I can never know whether the therapist is sincere”), John was encouraged to mindfully note the thought without accepting it as true or untrue. In tandem, FAP interventions shaped more effective interpersonal skills in the context of being mindful of intrapersonal obstacles. Most important, intra- and interpersonal interventions functioned as effective interventions to support John in his pursuit of genuine, intimate relationships.

A typical complicating factor when treating psychotic individuals is refusal to seek or maintain antipsychotic medication treatment because such treatment is the standard of care. In the current case, John refused medication treatment, but his psychotic symptoms were not severe and his functioning was relatively high for psychotic individuals, allowing
John to be treated on an outpatient basis without additional psychiatric involvement. Given his level of functioning, John’s insistence on medication-free treatment was not seen as problematic and actually was consistent with the ACT treatment model. In other words, unlike the case of John, for many psychotic patients, taking antipsychotic medication may be in the service of experiential avoidance and fusion with the belief that one can only get on in life without psychotic symptoms. Given that previous studies (reviewed above) have only delivered ACT in the context of antipsychotic medication, this one successful case study does not provide sufficient evidence to recommend ACT as a stand-alone intervention for psychosis.

9 Managed Care Considerations

As John was treated at a university clinic that offered a sliding fee scale, managed care considerations were unnecessary.

10 Follow-Up

John returned for follow-up approximately 1 month after treatment ended. His depression remained low (BDI-II = 5) and his general symptom severity was similar to posttreatment (OQ-45 = 81; see Table 1 for subscale scores). Mood disorder, psychotic disorder, and paranoid, schizotypal, and schizoid personality disorder portions of the structured clinical interview for the DSM-IV (SCID; First, Spitzer, Williams, & Gibbon, 1997) and SCID-II (Spitzer, Williams, Gibbon, & First, 1989) were administered, and John no longer met criteria for any disorder. An informal discussion 6 months after termination indicated that John was still employed, his mood was still stable, and his social network had continued to broaden after termination. Though psychotic symptoms were reportedly still occasionally present, they interfered only mildly with interpersonal interactions and general functioning.

11 Treatment Implications and Recommendations to Clinicians and Students

This case illustrates the utility of a combination of ACT and FAP when treating psychotic behaviors. ACT techniques created the context for change by establishing closer relationships as a valued goal incongruent with current coping strategies (i.e., avoidance) and targeted intrapersonal variables, such as experiential avoidance and cognitive fusion. Evidence is accumulating that targeting such variables with ACT techniques may lead to clinically significant gains for psychotic individuals. This is a very exciting development, and we feel there is now sufficient evidence to suggest that clinicians try ACT techniques for psychotic individuals, especially higher-functioning ones as in the current case.
This case adds to a growing body of research on FAP as an effective enhancement to other treatment approaches, especially those in the cognitive-behavioral tradition that are theoretically aligned with FAP, thus facilitating the integration. When successful, FAP case conceptualization provides a simple clarity that may aid the therapist in responding to otherwise tricky behavior. In fact, an in-depth single-subject analysis has suggested that the incorporation of key FAP techniques into other approaches may produce large and sudden changes in behavior (Busch et al., in press; Kanter et al., 2006).

In the current case, following initial ACT techniques, FAP provided a means to shape behavior specific to John’s stated value—closer relationships—in a context that resembled other relationships, thereby aiding generalization. For ACT therapists, integration with FAP highlights the importance of being sensitive to in vivo ACT processes and in-session instances of client behavior that bear on the client’s interpersonal values (CRB). A general recommendation suggested by the integration is that ACT therapists should be wary of applying ACT techniques that produce a therapeutic relationship that is functionally very different from other, important intimate relationships in the client’s life. The current integration applied ACT techniques in a way that was consistent with other relationships, allowing FAP techniques to be applied fully. In this case, integrating FAP and ACT effectively helped John address intrapersonal barriers and develop the specific interpersonal skills needed to successfully pursue valued behavior.

One final issue with respect to integrating ACT and FAP is theoretical and may be of interest to students with a behavioral background. Specifically, though both ACT and FAP have behavioral roots, FAP retains traditional behavioral language and principles in its conceptualization, and ACT instead incorporates a language of middle-level terms that have been created specifically for ACT clinicians, and these new terms do not obviously link to traditional behavioral language (they do link, however; see Hayes, Barnes-Holmes, & Roche, 2001). Thus, integrating the two may pose some theoretical difficulties for those hoping to retain traditional behavioral language and conceptualizations. FAP, however, is inherently flexible and can be integrated into other treatments without incorporating non-behavioral language, as long as the treatment targets of the treatment with which it is being integrated can be conceptualized in terms of CRB. This case, therefore, additionally demonstrates the potential broad applicability of FAP across treatments of differing theoretical origins.

References


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