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Acceptance and Commitment Therapy for Voices

Neil Thomas, Eric Morris, Fran Shawyer and John Farhall

7.1 Introduction

Auditory hallucinations are one of the most common symptoms of schizophrenia, frequently persisting despite treatment with antipsychotic medication, resulting in ongoing distress and functional disability. Consequently, they have become a common target for psychological interventions (Chadwick & Birchwood, 1994; Farhall *et al.*, 2007; Haddock *et al.*, 1998; Thomas *et al.*, 2010; Trower *et al.*, 2004), and have been one of the main treatment targets in early applications of acceptance and commitment therapy (ACT) to psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006; Shawyer *et al.*, 2012). ACT has particular synergies with intervention for auditory hallucinations, a phenomenon characterised by verbal content, which may be a source of fusion (see Chapter 2) and for which acceptance has already been heralded as important in promoting adaptation (Romme & Escher, 1989). In this chapter we consider the specific ways in which we have applied ACT to the experience of hearing voices in our work with medication-resistant psychosis in Melbourne and with early psychosis in London.

7.2 Formulating how Voices are a Problem

ACT is primarily concerned with assisting people to disengage more effectively from unproductive struggle with uncontrollable experiences and to promote fuller engagement in life. There are at least three layers of the experience of hearing voices that may contribute to client struggle and interference with valued living:

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(1) *Intrusiveness and salience of experience*. Voices are attention-capturing. They are an intrusive and hard-to-escape auditory experience and, in the context of psychosis, one which may be experienced as particularly personally meaningful and salient (Kapur, 2003). The capture of attention by hallucinatory experience can divert a person from valued living, and when regarded as unwelcome, this can become a source of frustration, demoralisation or anxiety, often generating attempts to suppress or control it.
(2) *Verbal content*. Voices are a verbal phenomenon, providing potential material for cognitive fusion. In particular, voices frequently include emotive material such as criticism, threats, warnings and harmful commands.
(3) *Interpersonal qualities of voice experience*. People are frequently drawn into reacting to hallucinatory experience as if being addressed by another person. Patients often ascribe their voices identities and intentions, see them as sentient others existing in external reality and view them as possessing great power (Chadwick & Birchwood, 1994). Meanwhile, behaviourally, people are commonly drawn into verbal responses to their hallucinations (either aloud or in thought), generating a dialogue. Common responses include arguing with voices, telling them to go away and trying to engage, persuade or appease them. These responses are unhelpful because they maintain attention on the voice experience, possibly also maintaining activation of neural networks involved in the generation of voices, reinforcing the phenomenon itself. In addition, the resistant responses to voices that are particularly common seem to be associated with distress (Romme & Escher, 1989; Farhall & Gherke, 1997).

Hence, ACT for voices most often has the primary aim of helping a patient more effectively disengage attention from these salient aspects of hallucinatory experience and break associated habitual behavioural responses. In line with the standard ACT model, this involves promoting a process of letting go of resistance to (or unworkable engagement with) voices (*acceptance*) when such resistance interferes with living a valued life. This process can be supported by *cognitive defusion*, by adopting the stance of a mindful observer of voice experience (*present moment*, *self-as-context*) and by fostering an attitude of willingness to experience voices while pursuing valued action (*values*, *committed action*).

7.3 Overall Considerations in Conducting ACT with Voices

The application of ACT to psychotic phenomena such as voices requires some modification of its application to nonpsychotic disorders:

(1) *Gentle rate of progress*. Applying ACT to people with psychotic disorders necessitates a greater degree of gentleness and caution than when applying it

to anxiety or depressive disorders. Compared with other psychological therapies, ACT is quite a confronting intervention. It contains elements which aim to shake up the patient's view of reality, and to disrupt an established equilibrium of avoiding distressing experiences as a primary means of coping. Psychotic patients, who may have considerable existing difficulties in making sense of the world, may become overwhelmed relatively easily, and stepping outside of their usual avoidant repertoire might elicit significant anxiety and arousal. Each of these responses has the potential not only to threaten engagement in therapy but also to increase psychotic symptomatology. Hence we carefully track a patient's responses to therapy activities, through observation and by asking for feedback, in order to inform the pace and direction of therapy. With individual exercises, we typically seek permission from the patient each time an exercise is conducted and make it clear that they can stop at any time.

(2) *Experience of voices as external*. Unlike thoughts, the content of verbal material generated from voices is not usually experienced as originating from the self. In addition, the patient may have delusional beliefs about the existence of their voices in external reality, often held with a level of conviction that leads to reactance when threatened. In this context, therapists need to exercise caution around referring to voices as 'internal' experiences, or differentiating voice content from external reality. Therefore, we tend not to utilise the common ACT differentiation between 'internal' and 'external' experiences in considering their controllability in work with voices. Instead, we help people to consider the extent to which experiences such as voices are 'controllable' versus 'uncontrollable', without special reference to their location or origins. This allows us to maintain a central focus upon the workability of different ways of dealing with psychotic experience, joining with the patient in developing the most workable ways of living with such experiences while pursuing a meaningful life. When there is some existing flexibility present, we might help the patient recognise that voice content, as with any speech or thought content, is not 'real' in the same sense as objects in the external world – but only with care. If there is a danger of inadvertently eliciting reactance or becoming drawn into a debate about whether or not voices are real, we would steer the focus away from these issues on to the basic agenda of considering what works in dealing with such experiences.

(3) *Use of metaphor*. Given the difficulties in abstract thinking, metacognition and memory that can be present in psychotic disorders, people with psychosis may have difficulties understanding standard ACT metaphors. We use metaphors and exercises quite selectively, preferring those that are most easily understood, especially those which provide vivid illustrations of experience or demonstrate more workable ways to respond to voices (e.g. the tug-of-war-with–the-monster (see Appendix H) and swamp metaphors

(see Hayes *et al.*, 1999)), rather than those that are more abstract. To make metaphors more memorable, we often act them out physically, use illustrations or draw things out with the patient, and seek opportunities to practise or roleplay their application to voices when we can.

7.3.1 Sequence of Therapy

In general, therapy will proceed by addressing each of the ACT processes in parallel, with each therapy session incorporating a number of elements of the ACT model, and helping the patient to make links between them. For example, one might introduce a defusion exercise, discuss how this could be applied to letting go of struggle with voices and then consider how the patient might use it in the context of engaging in a valued activity. Nonetheless, a natural starting point is often formed by noting the costs of struggle with voices and introducing the patient to the idea of acceptance as an alternative response, with an increasing focus on values, willingness and action as therapy progresses.

7.3.2 Acceptance: Letting Go of Struggle with Voices

In promoting acceptance, the main therapeutic aims are to:

(1) Help the client see ways in which they become caught up in struggle or engagement of attention with voices.
(2) Help the client recognise habitual responses to voices that are ineffective or counterproductive, in light of valued directions.
(3) Introduce an alternative attitude of letting go of voices: abandoning attempts to control the experience and instead disengaging attention from it.

A range of ACT methods can be applied to this, as described in detail elsewhere (e.g. Hayes *et al.*, 1999). The following are specific methods which we have found particularly helpful.

7.3.2.1 Discussing Responses to Voices

A useful starting point is to develop a detailed understanding of voice experience, including basic information on voice phenomenology: number of voices, gender, loudness, frequency, duration, content and so on (see Chapter 2). This can then lead to a more focused discussion of responses to voices. The aim here is to identify both helpful and unhelpful responses in order to begin establishing which appear to be workable and which appear not to work and/or to be increasing the problem. For example, what are some of the different things the client finds themselves doing in response to voices? How have they attempted to cope with this experience? How

helpful have these responses been in the short term? What have been their effects in the long term? Are there any costs associated with using them?

In doing this, coping strategies may be identified that appear to be effective, such as keeping oneself occupied or listening to music. While these do not represent acceptance of the phenomenon, we would encourage the use of them within an ACT framework – effective strategies for the relief of distress, even if only of short-term benefit, may be a 'workable' way to get on with valued living. Meanwhile, we would be alert to any attempts to suppress or change the voices, which will either restrict the patient's life or draw the patient into more engagement with the voices. Hence the therapist's role is to help the patient make a distinction between responses that do work and those that are engaged in habitually but seem to be ineffective or counterproductive. This has much in common with conducting an assessment of responses to voices for coping strategy enhancement (Tarrier, 1992). However, with an ACT approach the main thing that one should be drawing out is a recognition that while there are some things that can be done to minimise the impact of voices, ultimately it is hard to either directly suppress them or to modify them by interacting with them. This puts the issue of workability on the agenda, setting the scene for the promotion of acceptance and willingness as an alternative to elimination or control.

7.3.2.2 Letting Go of Struggle

A number of metaphors and exercises exist for highlighting the fact that struggle can be counterproductive (e.g. 'quicksand', 'Chinese fingertrap'), including attempts to suppress thoughts (e.g. white bear-type exercises) or emotions (e.g. the polygraph metaphor; see Appendix E) (Hayes *et al*., 1999). However, probably the most important message to convey in work with voices is to let go of struggle, which we have found most usefully illustrated by tug-of-war with the monster (Appendix H). We implement this metaphor with the therapist and client physically enacting a tug-of-war: the therapist plays an unbeatable monster pulling the patient towards an imaginary abyss (if patients are reluctant, we might do this while sitting down, or the therapist might act out the exercise by themselves). The therapist then guides the patient in noticing how all-consuming the struggle is and prompts them to consider alternative ways of responding (noting that the monster is infinitely strong and unbeatable), eliciting the response that dropping the rope is more workable than trying to win the battle. This exercise can then be discussed in relation to the experience of hearing voices ('With the voices, what can you do to drop the rope?'). This exercise can also be adapted to incorporate other aspects of the ACT model, such as values ('If your son were sitting in the corner of the room while you were doing this, how easy would it be to talk with him?'), defusion (e.g. the 'monster' verbalising voice content) and committed action ('What would dropping the rope to focus on this value look like?').

Struggle is not always evident. In some people, it may be minimal, and they simply wish to live with their voices more effectively, and in this case they might be directly introduced to the defusion, mindfulness and values methods in order to

facilitate this. In others, however, voices may be seen as benevolent and actively engaged with, often at the cost of engagement in life in the nonpsychotic world (and possibly functioning to avoid it). In such situations, it may be more helpful to start with an initial focus on clarifying values, which might lead on to exploration of what gets in the way of the person acting in line with valued activity, and in turn a consideration of the effects of engaging with voices.

7.3.3 Defusion

As voices are a verbal phenomenon, fusion may be particularly applicable in understanding how the patient can become drawn into them. In some ways, voices can be similar to negative thoughts, often having emotive aspects which may be related to the patient's self-concept. However, given that the content of voices is not owned as internally generated, the most important source of fusion may alternatively be the meaning imposed upon the experience of hearing them. In line with the three-layer model, fusion may relate to:

(1) The intrusiveness and salience of the experience, e.g. 'I can't do anything because of the voices', 'I can't get away from the voices', 'It's essential I listen', 'This is a punishment'.
(2) The verbal content of the voices, e.g. specific criticism, threats, warnings.
(3) Interpersonal meaning imposed upon the voices, e.g. 'They are trying to wind me up', 'They'll harm me', 'They won't like it if I go out', 'I have to stop them getting the better of me'.

There is, nonetheless, typically overlap between voice content and the patient's thoughts, so in practice defusion directed at voice content can often incorporate related thoughts and vice versa.

Following on from promoting the idea of letting go of voices, defusion can often be introduced by discussion of the ways in which the patient can find themselves automatically responding to particular voice or thought content. For example:

> So it seems that at times you can dismiss what the voices are saying, not get caught up with it, you can get on with doing stuff and let them 'mumble away' in the background. And at other times you find yourself getting hooked in. They say something and then you're having the thought, 'What if that's true?' or 'I can't let them say that', and before you know it you're arguing with them and they're getting more and more persistent… So it sounds like one of the key things that can help is finding ways not to get hooked in.

This can lead on to basic manoeuvres which encourage distancing, such as writing down particular voice or thought content on paper, explicitly referring to voice or

thought content as 'words' or using basic distancing metaphors such as referring to content as being like a radio station that plays nothing but bad news.

Irrespective of whether or not voices are seen as existing in external reality, voice (and thought) content can also be highlighted as comprising ideas which are sometimes useful and sometimes not useful. We have found the monkey metaphor (e.g. Bowden & Bowden, 2010) to be a helpful illustration of workability. Here, the patient imagines themselves shipwrecked on a desert island. While trying to prepare shelter, they notice a little monkey who seems intent on getting their attention by bringing them things: sometimes useful (firewood, bananas), sometime less useful (damp leaves, rancid coconuts) and sometimes unpleasant (handfuls of poo).

While exercising some caution around the more abstract metaphors, further defusion methods can be used to highlight the effects of distancing on the impact of verbal content and reinforce that (1) thought/voice content is distinct from literal reality (e.g. 'finding a place to sit', Hayes *et al*., 1999, pp. 152–153), (2) opinions are different from facts (e.g. 'bad cup', Hayes *et al*., 1999, p. 169) and (c) thought/voice content does not lead to action. Differentiating thoughts from action is often particularly important, both in undermining the effect of voices in limiting behaviour and in reducing the influence of command hallucinations. For example, the patient might be instructed to pick up a pen while repeating the words 'I can't pick up the pen' (Bach, 2005). With care, this exercise can be elaborated to incorporate fused voice content (e.g. 'If you pick up the pen, we'll get you') or thought content relating to voices (e.g. 'I can't pick up the pen while I'm hearing voices', 'The voices won't let me pick up the pen', 'If I pick up the pen, the voices will win'), as well as to replace picking up pens with behaviours analogous to those which the voices might be seen as interfering with.

7.3.4 Mindfulness: Present Moment and Self as Observer

The ACT processes of getting in touch with the present moment and taking the perspective of an observer ('self-as-context') are mainly conveyed through the use of mindfulness exercises. We have tended to introduce mindfulness exercises into sessions as early as we are able to, usually presenting them to the patient as a general skill and applying them to the experience of voices once the patient has gained some familiarity with them. We tend to use mindfulness practices which involve focusing one's attention on a particular anchor, such as one's breath or an external object, rather than exercises involving opening up awareness without focus. We start carefully, first giving a brief description of the process in order to reduce uncertainty ('For a couple of minutes, notice your breathing, and notice when your mind gets hooked on to other things') and beginning with a brief exercise to check for aversive reactions and build trust. Although the duration is gradually increased, it is usually unrealistic to expect clients to be willing to commit to the

45-minute meditations used in mindfulness-based stress reduction. Instead we have usually used mindfulness exercises of up to 20 minutes' duration, plus 10- or 15-minute CD-guided practises for home use, which we actively encourage. Most often, we have used versions of the 'raisin exercise' (Kabat-Zinn, 1990, pp. 27–29; Segal *et al*., 2002, pp. 101–110), 'mindfulness of the breath' (Kabat-Zinn, 1990, pp. 47–58) and the 'body scan meditation' (Kabat-Zinn, 1990, pp. 75–93; Segal *et al*., 2002, pp. 110–120) used in mindfulness-based cognitive therapy. We also often incorporate the brief '5-5-5' (Harris, 2008, p. 156) or 'centring' (Eifert & Forsyth, 2005, p. 125) exercises at the beginnings of sessions.

When the patient is experiencing voices, we use two types of mindfulness instruction, which we incorporate into standard mindfulness exercises:

(1) *Focus away from voices*. Here mindfulness is used to help the patient develop the response of disengaging from attentional focus on voices and from automatic responses to them. For example, 'Whenever you find yourself distracted by sounds or voices, bring your attention back as best you can… allow those sounds and voices to remain there as part of your awareness, while turning the focus of your attention back to the breath…'

(2) *Focus towards voices*. The other use of mindfulness is to turn attention towards voices and to explore them from an observer stance, without responding to them. In conjunction with focusing away from voices, this may be useful in promoting acceptance of the phenomenon. For example, 'If voices are present, you might wish to experiment with directing your attention towards them, exploring them as another element of your experience… bringing a curiosity to observe what these experiences are like as sounds… observing their qualities as sounds, their location, their volume, patterns of pitch and rhythm… simply observing them, not trying to push them away, not engaging with them, just noticing them as part of your current experience… and just allowing these and other sounds be there, just as they are, while remaining present and focused on each passing moment.'

If voices do not arise within a session, we may play quiet recorded speech to provide an analogous stimulus from which to disengage. This might initially be done with neutral prerecorded material (e.g. podcasts), building up to more emotionally salient material that corresponds more closely to voice content. Voice-like material can be created by using a voice recorder to record examples of voice content and playing them back on a loop (this has practical advantages over the therapist role-playing voice content themselves, freeing them up to provide the client with instructions). The process of recording this material may itself be useful in promoting distancing from the content.

In promoting self-as-context, we discuss the idea of an 'observer self' as distinct from a 'thinking self' with clients. This can be combined with instruction during mindfulness exercises, such as, 'Notice as you sit here that part of you is simply an

observer of these thoughts and experiences as they pass by… Recognise that this part of you is always there, constant, able to stand back and observe these passing experiences, moment by moment'. Depending upon the patient's cognitive capacity, we may also utilise metaphors emphasising the constancy of the observer self, such as in the mountain-meditation (Kabat-Zinn, 1994, p. 135), chessboard (see Appendix A) (Hayes *et al.*, 1999, p. 190) and sky-and-weather (Harris, 2009) metaphors.

7.3.5 Willingness: Values and Committed Action

Clarification and consolidation of personal values and promotion of commitment to action in spite of the presence of aversive symptoms complete the range of ACT interventions. The patient is supported in identifying things in life which are personally important to them and which provide a more important guide to behaviour than habitually falling into behavioural patterns dominated by engagement with or avoidance of voice activity. Alongside this, there is promotion of the principle of being willing to experience discomfort related to voice activity or fears related to voices, in order to live a more fulfilling life. The idea of willingness is well ~~illustrated~~ by the swamp metaphor (Hayes *et al.*, 1999), which illustrates that one may be willing to tolerate wading through unpleasantness in order to get to a valued destination.

Values themselves can be clarified using a range of activities, including card sorts (e.g. Ciarrochi & Bailey, 2008), identification of values in specific domains (e.g. relationships, leisure, work/education and health/well-being; Harris, 2007) and imagining looking back on one's life from one's 80th birthday (Hayes *et al.*, 1999). In addition, the therapist is attentive to value-related themes that may arise during the course of therapy. Such exercises can be conducted without specific reference or adaptation to voices, although the therapist may need to steer the patient into identifying real-world values if the values and goals which are elicited are delusion-based. It should also be borne in mind that, while the process of identifying personal values can be quite motivating in people with nonpsychotic disorders, who can draw on their resources to reorient their lives, people with psychotic disorders often have significant social problems which present barriers to valued action (e.g. lack of friends, poverty, unemployment). Hence, in working with values, our usual aims for behaviour change are not so much based around major and long-term life goals, but rather involve fostering a stance towards life that embodies approach rather than avoidance. Hence we would encourage patients to identify small, achievable, value-congruent activities that can be carried out over the next day or two, or simply to experiment with doing things outside of their usual comfort zone, in order to learn what they find vital and meaningful. If identified goals end up reflecting further engagement with voices or delusions, one might return to drawing out the underlying broader values in order to identify expression of them in the nondelusional world.

In providing a metaphor for committed action in the face of voice activity, a useful exercise is taking your voices for a walk (adapted from Hayes *et al.*, 1999, p. 163), in which the therapist walks alongside the patient while the patient walks a particular route, and the patient's task is not to get caught up with or buy into things that the therapist says as they do so. In this way the therapist can roleplay the patient's voice or thoughts. This can begin with neutral material (e.g. 'What's that over there?') and move on to include imperatives which encourage the patient to act independently of voice content (e.g. 'Turn left!') and finally examples of common voice content. The exercise can be readily translated to other activities, such as playing music. This can be a very powerful exercise, but caution is required as the patient may readily become overwhelmed if they strongly fuse with distressing content. It is important to prepare well by setting clear parameters with the patient (e.g. agree on voice content to be roleplayed), emphasising that the therapist is just playing a role and debriefing frequently during the exercise (don't wait till the end). This exercise can then lead on to discussion of the patient's commitment to engage in identified valued activities.

7.4 Case Study

In this section we outline the case example of Hazel, a 33-year-old white British woman who had been persistently hearing voices and was referred for psychological therapy in a recovery-orientated mental-health team following a period of increased anxiety, worry and social isolation. Hazel had a history of experiencing command hallucinations and deliberate self-harm. She was unemployed and single, on a disability allowance and living in supported accommodation.

Hazel described her therapy goal as follows: 'Basically, I am trying to take charge of my life, and not let the voices dictate what I can and can't do.'

7.4.1 Current Mental-health Problems

Hazel reported ongoing experiences of hearing voices, which frequently criticise her and give her advice about what to do. She described the voices as 'evil' and said they were trying to make her 'do bad things' in order to destroy her. She stated that the voices did not want her to experience happiness and interfered with her having trusting relationships.

Hazel expressed a fear of hearing the voices' commands and feeling compelled to act, despite not hearing compelling commands to harm others/herself for 2 years. She worried about physically hurting others as a result of commands, so tried not to get close to people. She felt very ashamed of acting on the voices' commands; she ruminated about this when going to sleep at night. She also worried

about embarrassing herself by talking out loud to the voices when in public, which sometimes stopped her from going out.

Hazel reported frequently having intrusive thoughts about shameful memories, and about losing control by acting on command hallucinations. She coped by using distraction and trying to block the thoughts.

Hazel reported a depressed mood and anxiety, with diminished enjoyment, pessimism, poor sleep, reduced motivation and fearful feelings on leaving home.

7.4.2 Mental-health History

Hazel sayid she had been hearing commanding voices for 9 years, following the birth of her first child, when she was diagnosed with schizophrenia (ICD 10, F20.0). She also described past problems with engaging in deliberate self-harm (cutting herself). Hazel had been prescribed a stable dose of clozapine, and felt that it reduced the voices' intensity.

7.4.3 Relevant Background

Hazel was brought up by her maternal grandparents, and had little contact with her parents. She was placed into care when she was 9 years old, after her grandmother passed away. This lasted until she was 14 years old, when she lived with her mother for a year. At 15, Hazel returned to care, following allegations that her mother sexually abused her. Hazel lived in a variety of foster homes until 18, when she lived with her father; she describes this as a stable period.

Hazel became homeless at 23 years old, following her father's death. She moved in with a man, and discovered after a short period that she was pregnant. Hazel gave birth to her son and three weeks after the birth was admitted to a psychiatric unit, with a first episode of psychosis. Hazel had two sons to her partner. The relationship broke down after the birth of their second boy, when her partner physically assaulted her. Hazel decided to give her infant children up for adoption after hurting her youngest child, while acting on command hallucinations; she no longer has contact with her children.

She described having no friends and said that the closest people in her life were her father and her two sons. Hazel felt she had a responsibility to stay alive for her sons, hoping to rekindle their relationship when they are older. She reportd that she tends to keep to herself and not initiate friendships as she felt it was 'safer this way'.

7.4.4 Assessment and Formulation

Hazel reported hearing many voices, which she described as 'like a crowd at a football pitch', occurring three to five times a day and lasting up to an hour. They

were as loud as her own voice. These were second- and third-person hallucinations heard outside of the head, male and female, and unidentified. Hazel described the content as 90% unpleasant and negative. She stated that the voices call her names, comment on her choices and actions, but there have been no recent threats or commands. She described the voices controlling her by causing physical pain if she did things they disapprove of, rather than giving direct commands. She believed she would feel compelled to act if given commands, and was fearful of this happening.

Hazel stated that she did not know what caused the voices, but believed the voices were real people contacting her in some way (80% conviction); she also reported that perhaps her voices were created by her mind (50% conviction). She perceived her voices as powerful and knowledgeable. Hazel denied trying to get in contact with the voices, or finding them helpful. She did not believe that she had any control over when the voices occurred.

Hazel described attempting to suppress the voices through distraction (listening to music), trying to think of other things and keeping busy. She also reported trying not to upset the voices, by avoiding social contact, particularly situations involving a degree of vulnerability.

7.4.5 ACT Case Formulation

The therapist focused on assessing the workability of Hazel's experiential avoidance of voices, and how this was supported by fusion with beliefs about the power and threatening nature of the voices. This perpetuated avoidance and escape in contexts that could provide opportunities for valued action, and rumination about the consequences of disobeying the voices. He considered how fusion between the voice-hearing experience and elicited feelings of shame, memories of voice compliance leading to unwanted outcomes and Hazel's history of unfulfilling relationships had become reasons for avoiding social interactions that could build friendships and any intimate relationship.

7.4.6 The ACT Approach

Hazel participated in 10 ACT sessions, initially focused on values clarification and then moving on to developing willingness by building the skills of defusion and acceptance (mindfulness). Each session started with a present-moment exercise, promoting active noticing for Hazel and the therapist, and then moved on to a discussion of valued actions taken and the practice of acceptance/defusion towards barriers. Sessions ended with planning of valued actions and a review of the main points (written on a summary sheet).

7.4.6.1 Initial Phase (Sessions 1–3)

Introducing defusion and acceptance through metaphor and mindfulness In the first session, the rationale for mindfulness was introduced as a means of noticing experiences and the tendency to get caught up in them, and of practising 'just observing'. The therapist introduced the idea of 'you and your mind' as a way of talking about the process. Hazel appeared both intrigued and amused, finding it funny to hear the therapist talk this way: 'You are crazier than I am'.

The workability of coping with voices by struggling or obeying was explored through the tug-of–war-with-the-monster metaphor (Appendix H), which became the scaffolding story for the sessions.

Hazel was given a mindfulness CD for home practice. In the second session, she reported using the CD 'even though the voices don't like it' and attributed a shoulder pain to their displeasure. Hazel described persisting despite the pain, in order to exercise freedom from the voices. She reported some benefit from the CD as a means of shifting her attention, rather than being 'locked' on the voices.

During the sessions, the therapist modelled acceptance and defusion towards his own mental experiences through using self-disclosure about in-session experiences, as well as past occasions of fusion and experiential avoidance. Hazel responded positively to these discussions, and expressed surprise that the therapist struggled with intrusive thoughts.

Clarification of values and fostering committed action The therapist used the lifetime achievement award exercise (a variant of the 'what do you want your life to stand for?' exercise, Hayes *et al*., 1999, 215–218) to explore what Hazel would want to be doing in valued life domains, if she had a free choice. This exercise appeared to touch upon the sacrifices Hazel had made in order to cope with the voices: she recounted tearfully wanting to be able to have friends, an intimate relationship and a family. Hazel stated she would like to act in a 'loving and kind' way towards people in her life. She indicated that changing her behaviour to act more consistently with her values would involve experiencing fear and the possibility of the voices causing her pain, expressing disagreement and giving her commands. The therapist linked these actions with using mindfulness and letting go as possible ways of enabling her to do these things.

7.4.6.2 Mid-therapy (Sessions 4 – 7)

Use of imagery Hazel engaged in several imagery exercises in order to develop defusion and acceptance. Some were variants of the physicalising exercise (Hayes *et al*., 1999, pp. 170–171), in which the client imagines experiences as physical objects with properties such as size, shape and so on; this was done with the voices, intrusive thoughts and self-harm urges in turn.

The leaves-on-the-stream exercise (Appendix B) was introduced as both a mindfulness exercise and a written task. In the latter case, the therapist drew out the

stream and used a set of Post-it notes as leaves, and encouraged Hazel to notice current experiences, placing them on the stream.

Finally, Hazel and the therapist acted out the taking-your-voices-for-a-walk exercise (Hayes *et al.*, 1999, p. 163). This involved imagining walking in a valued direction, while the therapist played 'the voices', saying the types of thing that Hazel usually heard. Three stances towards the voices were practised: one of struggling with them, another of obeying them and finally one of 'dropping the rope'/showing willingness. They reflected on the experience of each during the exercise and considered their workability in terms of valued action.

7.4.6.3 End Sessions (Sessions 8 – 10)

Towards the end of therapy, Hazel reported that she had been 'dropping the rope' more and engaging in conversations with others at her accommodation, as well as sharing more, despite the voices' comments. At times this resulted in enjoyable interactions, though they were disappointing on other occasions. Hazel stated that she was able to practise being mindful towards this, with a greater sense of meaning in what she was doing.

The last session reviewed the work done, reinforcing the actions that Hazel had taken through mindfulness and acceptance, and linking them with valued directions. Hazel reported benefiting from ACT, particularly in discovering that she did not need to obey the voices' commands. She and the therapist summarised this in her own words in a 'Learning from ACT' handout:

(1) I know now that I can operate without having to listen to everything that the voices are saying. Just because the voices are there, doesn't mean I need to do what they are saying. I can do what I want to do, not what the voices want.
(2) In friendships I am more willing to get closer to people, and to keep trying with sharing.

7.4.7 Outcomes

The outcome measures for the therapy are listed in Table 7.1. As can be observed, Hazel reported improvements across a range of areas at the close of therapy.

7.4.7.1 Psychotic Symptoms

Hazel reported hearing voices at the end of therapy, although there were changes, with the voices being less frequent (occurring two to three times a week) and perceived as less disruptive to her life. Hazel also reported believing that the voices were coming from her own mind (70% conviction), rather than being real people talking to her (30% conviction). She stated that her voices were not powerful, compared to her; she was also less fearful of them, although she was still slightly apprehensive about the pain she perceived as occurring because of her disobedience.

Table 7.1 Hazel's scores on therapy measures

Measure	*Pretherapy*	*Post-therapy*	*Outcome*
Beck Depression Inventory	51	9	Improvement
Beck Anxiety Inventory	24	8	Improvement
MANSA (Quality of Life)	43	71	Improvement
Social Functioning Scale	93.5	100	–
Voices Acceptance and Action Scale			Improvement
Acceptance	46	63	
Action	30	50	
KIMS Acceptance without Judgement	14	41	Improvement

7.4.7.2 Depression and Anxiety

Hazel's responses on the Beck Depression Inventory-II and the Beck Anxiety Inventory demonstrated clinically significant improvements in the levels of depressive and anxiety symptoms at the end of therapy.

7.4.7.3 Valued Action, Quality of Life and Social Functioning

Hazel reported increased levels of activity at the end of therapy, particularly related to her valued directions of friendships and relating to others in an open and caring manner. Her responses on the Manchester Short Assessment of Quality of Life (MANSA) (Priebe *et al.*, 1999) suggested clinically significant improvement, with gains made in the areas of friendship (she reported having a friend, post-therapy), accommodation, satisfaction with people she was living with and leisure activities.

Similarly, on the Social Functioning Scale (Birchwood *et al.*, 1990), there were improvements in Hazel's reported levels of interaction with others, particularly in describing approaching others post-therapy, rather than fearing and avoiding them, as well as a reduction in levels of social withdrawal.

7.4.7.4 Changes in Mindfulness towards Voices and Thoughts

On the Voices Acceptance and Action Scale (VAAS) (Shawyer *et al.*, 2007), at the start of therapy Hazel endorsed items suggesting that she had a low degree of *autonomy* in terms of her actions from the voices, and low *acceptance* of this as an experience. At the end of therapy her responses suggested a greater sense of autonomy and acceptance (both significant changes).

On the acceptance with judgement subscale of the Kentucky Inventory of Mindfulness Skills (KIMS) (Baer *et al.*, 2004), Hazel reported low acceptance of her experiences, with frequent judgements about whether they were good/bad, healthy and so on. Following therapy, Hazel's responses suggested that she had greater nonjudgement towards her experiences.

7.4.8 Discussion

This case description provides an example of how ACT may be helpful for those who are distressed and disabled by auditory hallucinations, particularly those experiencing command hallucinations.

The use of acceptance and defusion builds mindfulness skills, pragmatic means by which to enable engagement in valued actions, which can provide greater contact with potentially reinforcing contexts, and the shaping of approach behaviours to feared situations.

The therapeutic relationship models a compassionate and validating stance towards how the client copes with voices – in this case, this was particularly helpful, as it helped to build engagement: Hazel reported feeling understood, and not criticised by the therapist for past actions that were attached to a sense of shame. Of note also was that the *experiential* nature of ACT seemed like a novel context for Hazel, as she reported thinking that the therapist was 'crazier' than her and that the exercises had encouraged her to consider fundamentally what was important to her, the costs of coping in the usual way and an alternative approach that she could use. Hazel continued to experience auditory hallucinations, but she now had a few more options available in terms of how she could respond to these experiences, and the means to potentially improve her quality of life and engage in recovery-orientated goals.

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