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Acceptance and Commitment Therapy Applied to Treatment of Auditory Hallucinations

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Acceptance and commitment therapy (ACT) represents a new generation of behavior therapies that, after having received empirical support in a variety of disorders characterized by experiential avoidance, also offers a promising new treatment for psychosis. In contrast to the traditional treatment, in which both antipsychotic medication and cognitive-behavioral therapy focus on reducing symptoms, ACT proposes active acceptance and at the same time orientation of the person toward the achievement of worthwhile goals for his or her life in spite of symptoms, such as auditory hallucinations. In this case, a 30-year-old male diagnosed with schizophrenia demonstrates the logic and effectiveness of ACT as well as its applicability as part of the routine activities of a clinical psychologist in a public mental health care center.

Keywords: auditory hallucinations; hearing voices; acceptance and commitment therapy

1 Theoretical and Research Basis

Although it is more common to talk about new generations of antipsychotic medication for psychotic disorders, new-generation psychological therapies can also be discussed. We refer here specifically to third-generation behavior therapy or the “third wave” of behavior therapies (Hayes, 2004) and more particularly to the acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). It is well known that ACT was developed for treatment of a diversity of disorders characterized by experiential avoidance. Experiential avoidance is a process in which a person is unwilling to experience a negatively evaluated private event (e.g., feeling, thought, urge, bodily sensation, memory) and thus takes action to reduce or get rid of that private event despite the behavioral costs of doing so.

ACT began to be applied above all to affective disorders of anxiety, substance abuse, and posttraumatic stress (Hayes & Strosahl, 2004), including their comorbidity (Batten & Hayes, 2005). Among its extensions, it is important to stress here the application to persons with schizophrenia and, in particular, to auditory hallucinations, reviewed later in this...
section. First, it is worthwhile recalling some of the aspects of ACT that differentiate it from the previous generation of cognitive-behavioral therapies.

Briefly, ACT encourages individuals to accept and experience private events nonjudgmentally while simultaneously working toward the pursuit of personally defined behavioral goals or values (Hayes, Strosahl, et al., 1999). Therefore, ACT does not concentrate on directly changing private experience nor the symptoms present but on simultaneous acceptance and orientation of the person toward worthwhile goals in spite of the experience and other symptoms. This therapeutic philosophy is relatively different from the second-generation behavioral therapeutic philosophy, represented by cognitive-behavioral therapy, which follows the philosophy of promoting “first-order change.” Thus, for example, for auditory hallucinations, cognitive or cognitive-behavioral therapy proposes that before anything else, the voices be reduced, and then a new understanding of the self is established and relapses are dealt with (Temple, 2004). Cognitive-behavioral techniques include the generation of alternative beliefs, behavioral experiments, logical reasoning, and adopting strategies for decreasing associated distress (Chadwick, Birchwood, & Trower, 1996; Kingdon & Turkington, 1994).

Although these techniques produce important benefits, among them changes in attribution, increased self-esteem, and reduction of associated stress, they have not been demonstrated effective in precisely the reduction of auditory hallucinations (Temple, 2004). In fact, there are insufficient data to indicate that cognitive-behavioral therapy is specifically efficacious for treating psychotic disorder (Gaudiano, 2006b). Perhaps because of these limitations, and certainly also because of the new therapeutic philosophy of third-generation behavioral therapies, the fact is that cognitive-behavioral therapy is oriented toward acceptance and mindfulness focuses (Cather et al., 2005; Chadwick, 2006; Gaudiano, 2005; Temple, 2004).

Furthermore, antipsychotic medication is far from being a satisfactory treatment, which would suffice in itself, even though it is today in the first line of intervention. The first problem is not continuing the medication (nonadherence). Studies show an antipsychotic nonadherence rate of 20% to 89% and a mean of 49.5% (Lacro, Dunn, Dolder, Leckband, & Jeste, 2002). There is also the problem of undesirable secondary effects, among them, without going farther, weight gain. And many clients taking the proper medication continue to hear voices. Furthermore, when antipsychotic medication is effective in reducing the symptoms, for example, the voices, it is not because of specific action on the neurochemical causes (which are unknown anyway) but merely a dampening of aberrant salience (Kapur, 2003). Therefore, who knows if this dampening is at the cost of dampening a person’s other functions. These observations are backed by studies cited by Temple (2004) and Gaudiano (2006b), including the generation of atypical antipsychotics, which have failed to show better efficacy than first-generation antipsychotics (El-Sayeh, Morganti, & Adams, 2006; Lieberman et al., 2005). Third-generation antipsychotics, however, may have a more favorable side-effect profile.

Things being such as they are, it would not only be necessary to think about the well-known benefits of psychological treatments along with medication (Gaudiano, 2006a) but contributions that reconsider the question from another angle. Thus, for example, the therapeutic goal would not be so much elimination of the symptoms, at least when impossible or at the cost of other “eliminations,” as acceptance and achievement of valuable life goals.
This would mean reconsidering the criteria of efficacy. So, for example, a therapy for psychotic symptoms could be effective even without removing the hallucinations, if these do not impede performance of important matters in life (education, employment, family, social relations, etc.).

This perspective is precisely what third-generation behavior therapy, and particularly ACT, offers. Its goals are to promote a “second-order change,” attempting to change the function and not the form of the symptoms, modifying the verbal context and the person’s perspective. Thus, for example, for auditory hallucinations, ACT proposes that the voices be accepted, without judging them, identifying worthwhile goals and working toward these in spite of them. The techniques consist of a variety of strategies, including mindfulness and acceptance exercises, clarification of values and goals, and the use of metaphors (Bach, Gaudiano, Pankey, Herbert, & Hayes, 2006).

Empirical support for ACT for psychosis up to now has come from two controlled studies and several case studies. The first controlled study was carried out by Bach and Hayes (2002). Eighty clients were randomly assigned either treatment-as-usual or treatment-as-usual plus four individual ACT sessions delivered in inpatient through outpatient, in a hospital discharge process. Clients who received ACT reported decreased symptom-associated distress, decreased believability of symptoms, and increased symptom frequency compared to the control group. This apparently paradoxical result of increased frequency of symptoms and decreased stress and believability is explained by the authors in terms of their acceptance of the symptoms. ACT also reduced rehospitalization 50% versus treatment-as-usual.

The second controlled study was carried out by Gaudiano and Herbert (2006) as a replicate and extension of the previous one. Forty clients were randomly assigned to an enhanced treatment-as-usual or an enhanced treatment-as-usual plus individual ACT sessions in place of other milieu therapy provided the clients with the conventional condition. This design enabled the possible effect of the additional treatment with ACT in the Bach and Hayes (2002) study to be monitored. The clients who received ACT showed greater improvement in clinician-rated mood symptoms, self-reported distress related to hallucinations, and impaired social functioning and clinically significant symptom change in overall psychopathology compared to the control group. In contrast to the previous study, the frequency of hallucinations diminished from pre- to posttreatment as well as in the control group. However, as in the previous study, believability of hallucinations also diminished (which only occurred in this case in the ACT condition). ACT also reduced rehospitalization by 38%.

A case study carried out by García-Montes and Pérez-Álvarez (2001) is probably the first extension of ACT to treatment of hallucinations in the literature. It dealt with a 17-year-old boy diagnosed with schizophrenia whose main symptom was ego-dystonic auditory hallucinations. He received antipsychotic medication without this apparently affecting the hallucinations. The hallucinations were conceptualized in terms of experiential avoidance and were treated for that with ACT. The treatment was extended during two sessions a week for 9 weeks. After the first sessions, a progressive reduction was observed in the voices until they practically disappeared. This led to a 40% reduction in the antipsychotic medication without his condition deteriorating. Nevertheless, 7 months after psychological treatment ended, the client had a personal crisis that led to a relapse in the voices, medication had to be increased, and he again entered the conventional “psychiatric circuit.” The case is discussed in terms of the paradox of ACT related to the conventional clinical logic.
and the need for family members and the clinicians themselves to accept the patient’s symptoms.

Another case study by the same authors (García-Montes & Pérez-Álvarez, in press) refers to “negative symptoms” of a young man 28 years of age. He was given ACT in the widest context of the existential perspective. ACT followed the manual for individual psychotherapy in the treatment of experiential avoidance (Hayes, Batten, et al., 1999). The main existential point emphasized was responsibility in decision making using the exercise “Choosing: Coke Versus 7-Up,” described in Hayes, Batten, et al. (1999).

The result was the recovery of his “sense of living” instead of the “inertia” of “negative schizophrenia” in which the patient had become submerged. Another case study refers to the delusional symptomology of a client 28 years of age diagnosed with schizophrenia (García-Montes, Luciano, Hernández, & Zaldivar, 2004). Based on conceptualization of “delusional verbalization” as avoidance, the therapy was directed at clarifying values (Wilson & Luciano, 2002). The result was a noticeable decrease in delusional verbalization concomitant with increased action directed at values. The last case study referred to here is the one by Bach et al. (2006) as an illustration of the application of ACT to chronic mental illnesses. The only thing to be emphasized here from this case (a 28-year-old man diagnosed with schizoaffective disorder) is the potential of ACT to ally itself with the client in the pursuance of worthwhile goals, beginning by clarifying them and identifying acts that go against them.

The purpose of this case is to show the feasibility of applying ACT as part of the routine activity of a clinical psychologist in a public mental health center. The above applications, both the controlled studies and the case studies, were carried out in university clinics, and application of ACT was supposed to be an activity added on to the usual treatment. The case is appropriate at the same time it is challenging for ACT. The persistence of the voices in spite of the medication suggests an alternative strategy such as ACT, oriented toward symptom acceptance instead of elimination and the active involvement of the client instead of the passive role of patient awaiting the disappearance of symptoms that did not just occur. This strategy has in its favor the client’s cooperation, already shown in his compliance with the medication, even without its expected benefits. Within his depression, Victor is eager to approach the problem of the voices from another angle. This strategy also counts on the cooperation of the clinical team. All in all, the ACT strategy is still challenging in the face of clinical conventions.

## 2 Case Presentation

Victor is a 30-year-old Spanish male, diagnosed with schizophrenia when he was 24, who has been in a psychosocial rehabilitation program at a mental health center in the Spanish health care system for 3 years. As part of the process of rehabilitation, Victor has a protected job at a public professional training school, which will train him as a bricklayer. Victor has been receiving antipsychotic medication since he was diagnosed with schizophrenia. He has also received anxiolytics and antidepressants at various times. For 1 year, he was taking aripiprazole (10mg; two daily), amisulpride (400mg; two daily), lorazepam (5mg; two daily) and fluoxetine (20mg; 1 weekly). All this medication continued during the
psychological therapy described here. Although his adherence to the medication is adequate, his affective state is a mild depressive mood, and the auditory hallucinations and delusions persisted, although the delusions seem to be losing credibility. In any case, the hallucinations are currently his main problem. In fact, the case was referred by the clinical team psychiatrist to the resident intern psychologist to specifically focus on the hallucinations. The center’s team is made up of a psychiatrist, a clinical psychologist, a social worker, an occupational therapist, a nursing tutor, and a resident intern psychologist.

3 Presenting Complaints

Specifically, Victor’s main difficulties when he was referred had to do with auditory hallucinations, which were impeding him from going to work or continuing with the rest of his rehabilitation activities. In fact, he had been absent from work for several weeks precisely because of the presence of very frequent distressful auditory hallucinations resistant to medication.

4 History

Victor is the youngest of three siblings and lives with his parents. He has no relationship with a partner. There is no psychiatric background in the family. His childhood was apparently normal. He refers only to an episode of sexual contact with an older boy when he was 7. At the present time, he continues living this memory with guilt and shame. He has had no substance abuse problems. He has a primary education and has had vocational training. He worked in an automobile body shop for a short time but had to leave his job because he did not get along with his boss. There is no reference to other employment.

Victor received psychiatric attention consisting of psychological assistance and antidepressants (unspecified) when he was 17, having been diagnosed with a major depressive episode, after a sentimental relationship broke up. At 23, he says, he began to experience auditory hallucinations (ego-syntonic), “encouraging voices,” coinciding with the first time he left home to work in a nearby city. That experience was a very stressful period for Victor because of the bad relations with his boss at work, as mentioned above. At 24, delusions of grandeur and erotomania appeared (he was going to be a pop star and women noticed him in the street; he was going to be the partner of a famous singer). At this time, the content of the voices was somewhat ego-dystonic, related to the content of the delusions, as hostile and persecutory (insults, threats, suicide orders). That same year, he was admitted to a hospital psychiatric unit after psychotic decompensation, which is when he was diagnosed with paranoid schizophrenia. Three years later, at 27, he was referred to the mental health center to participate in a psychosocial rehabilitation program, where he remains. This psychosocial rehabilitation program is given at a day care center, which Victor attends daily, morning and afternoon, from Monday to Friday, spending the night and weekends at the family home. Apart from the clinical sessions with the psychiatrist or psychologist, Victor’s activities at the center are primarily a protected job, which he does as part of his vocational training. The social worker on the team contacts Victor every day to record his attendance and take care of any other matter that might come up. Otherwise, Víctor has no other
problems, such as disorientation, psychomotor delay, mannerisms, or language or thought disorders. He is able to concentrate on tasks, including the topic focused on during the sessions. His main problem is the hallucinations, which do not cease to perturb his life.

It should be mentioned that auditory hallucinations do not necessarily constitute aversive unwanted symptoms. Hallucinations can have practical, even desirable, functions for many people (Romme & Escher, 2000). In fact, Victor’s own first hallucinations were more stimulating (“encouraging voices”) than threatening (hostile and persecutory). That form is more important than function is at the basis of such interventions as ACT, which is directed at changing the context of the hallucinations instead of eliminating them. As a matter of fact, a recontextualization of the hallucinations, making them less stigmatizing, could begin by simply calling them voices, as we have done here in several different places in the text.

5 Assessment

The instruments available and the variables of interest measured before, during, and after therapy are described below. More relevant results are given in Section 7, on evaluation of therapeutic progress.

General Psychopathological Condition

Brief Psychiatric Rating Scale (BPRS; Lukoff, Nuechterlein, & Ventura, 1986). The BPRS is a 24-item semistructured clinical interview used to assess common psychiatric symptoms. In addition to hallucinations and delusions (“unusual thought content”), it covers negative schizophrenic symptoms (blunted affect, motor retardation), somatic concern, anxiety, depression, and others. Each of the symptoms evaluated receives a score of 1 to 7, as described below. Factor analyses of BPRS have validated Thought Disturbance (positive symptoms including hallucinations and delusions), Anergy (negative symptoms), Affect (anxiety, depression), and Disorganization subscales (Mueser, Curran, & McHugo, 1997). The total BPRS score, its four subscales, and each individual item have shown sensitivity to therapeutic change (Burlingame, Seaman, Johnson, Whipple, & Richardson, 2006).

Auditory Hallucination Experience

Interview With a Person Who Hears Voices (Romme & Escher, 2000). This is a structured interview on the experience of hearing voices (the nature of the experience, characteristics of the voices, what triggers the voices, what the voices say, their impact, etc.), which was the basis for the functional analysis the conceptualization of the case is based on.

Scale for the Experience of Hearing Voices. This is a Likert-type scale of 1 to 7, on diverse aspects of the experience with voices, designed for this study. The specific aspects evaluated were the following, with reference to both positive and negative voices: frequency (not often to constant), volume (very soft to very loud), annoyance (not annoying to very annoying), clarity (very confused to very clear), confrontation (very easy to confront to very hard), things not done because of the voices (few to many), and valuable things done
in spite of the voices (few to many). These points were taken from cognitive-behavioral therapy evaluation of auditory hallucinations (Chadwick et al., 1996; Perona-Garcelán, Cuevas-Yust, Vallina-Fernández, & Lemos-Giráldez, 2003) and ACT (Hayes, Strosahl, et al., 1999), particularly as regards avoidance (things not done because of the voices or done in spite of them). This scale was applied at the beginning of each session and referred to the voices heard in the period between sessions.

Values and Experiential Avoidance

Value Narrative Form (Hayes, Strosahl, et al., 1999, p. 226). This consists of generating a brief narration about a series of domains (couples or intimate relationships, family relations, social relations, employment, educational and training, recreation, etc.) in which concrete values can be found that could be therapeutic goals.

Social network map. The social network map is a graphical representation used at the mental health center to see client progress in social relations (that need to be improved). It consists of three concentric circles crossed by two diameters forming four equal sections, each one representing an area of personal relationships (family, work, “clinic team,” and friends). The people who are included in the social network are represented by dots, and the closer or farther from the center they are, the stronger or weaker the intensity or closeness of that relationship as perceived by the participant. The more dots there are in the friends, family, and work sections, the more improvement there is in the social network. To the contrary, a decreasing number of dots in the “clinic team” section or, if appropriate, their increased distance from the “intimate circle” would indicate independence from professional care.

Job attendance graph. This is a simple graph recording daily attendance at work. This record is routinely made by the nursing tutor (remember that this is protected employment directed at psychosocial rehabilitation).

The social network, especially relationships outside of the family and the clinic team, and work, which includes professional training, were the domains most highly valued and on which the goals of therapeutic relevance were based. The evaluation of these variables is important to the therapy applied here not only because they are worthwhile goals in themselves but also because they show the role of experiential avoidance. For example, if the patient performs activities that are important to his life in spite of having auditory hallucinations, when the hallucinations impeded their performance before, then the therapy will have been effective, even though the symptoms continue. In this case, what would have changed is not so much the form of the hallucinations as their function, which is no longer dysfunctional (although it would be preferable not to have them).

6 Case Conceptualization

Given the ineffectiveness of the medication and Victor’s own futile effort to control the voices, an alternative perspective such as the ACT is proposed, tending to “rescue” the
client from his own “self-reflexive loop.” The auditory hallucinations are a private verbal event that becomes extremely unpleasant for Victor, especially the negative voices (ego-dystonic). The participant is merged with his voices, living the insults as if they were something that is really “out there.” The effort that Victor has been making to control this experience has paradoxically become the problem, isolating him from important courses of action while at the same time the auditory hallucinations become uncontrollable for him. When he is with friends or at work, and the voices insult him, Victor withdraws from that situation to try to reduce his anxiety and control the voices. The attempts at controlling these private events have been useless and have gradually led Victor to isolate himself from important social situations and work. The efforts to avoid certain experiences seem to contribute to their occurring more and more, thus significantly altering the course of his life. Life has been suspended while all efforts are concentrated on controlling the uncontrollable, in this case, the auditory hallucinations. (See Bach et al., 2006, for a more detailed conceptualization of ACT in psychosis.)

7 Course of Treatment and Assessment of Progress

Course of Treatment

ACT was employed on the basis of conceptualization of the case in terms of experiential avoidance, focusing on reduction of experiential avoidance, acceptance of private events, and commitment to behavior change (Hayes, Strosahl, et al., 1999; Wilson & Luciano, 2002). It was agreed with the patient that the therapy would be brief, about fifteen 50-minute sessions during a 6-month period (between November and April), with one session per week at the beginning and bimonthly thereafter. There were actually 15 sessions, including pre- and postassessment. The client kept the appointments adequately.

As ACT is an idiographic therapy, it does not follow a session-by-session protocol but sets goals along the thread of case progress. In this case, the goals were arranged as follows. The first session was devoted to written tests and preparing a plan for collaboration. The second and third sessions were devoted to understanding the hallucinations in the framework of this therapy. Understanding hallucinations in the framework of ACT emphasizes acceptance as an alternative to avoidance, challenging the normal change agenda. In fact, this challenge is the first step in the ACT, or Creative Hopelessness: Challenging the Normal Change Agenda. In this respect, the therapist draws out the system that has been strangling the client by exploring several key questions, such as what the client wants, what he or she has tried, and how it has worked (Hayes, Strosahl, et al., 1999, pp. 92-98). Session 4 was devoted to clarifying values and the identification of barriers that could impede their achievement. The therapy method used for this was Assessment of Values, Goals, Actions, and Barriers (Hayes, Strosahl, et al., 1999, pp. 222-229). The 5th through 10th sessions were devoted to application of the following methods: Control Is the Problem Not the Solution, Building Acceptance by Defusing Language, and Building Awareness of the Observing Self (Hayes, Strosahl, et al., 1999; Wilson & Luciano, 2002).

For Control Is the Problem Not the Solution, the metaphor “pebble in the shoe” was used to show how something annoying that we cannot stand makes us stop constantly along the
way. Victor gradually began to recognize in a concrete way how his attempts to control the voices were limiting his opportunities to take advantage of important situations. Making use of Victor’s growing ability to realize the concrete way in which experiential avoidance occurred and what this was costing him, he was driven to creative desperation. The message was more or less that “it doesn’t matter how much you try, while you are concentrating on avoiding the suffering the voices cause, your life is going by and you are unable to do anything useful with it.” This was a very relevant moment for the therapy, which the participant would remember again and again at different times during it. Seeing that the hallucinations were gaining ground in his life was a powerful motivation for him to begin risking doing something other than the usual avoidance.

In Building Acceptance by Defusing Language, the experiential exercises in “Deliteralizing,” which treated the voices as “just words,” and “Taking Your Mind for a Walk” should be emphasized (Hayes, Strosahl, et al., 1999, pp. 162-163). In this exercise, the therapist and Victor went for a walk in the garden at the mental health center. The therapist followed closely behind Victor, giving him orders in an unpleasant tone. Once, Victor turned around to answer the therapist, who was acting as the voice. From this time on, during his sessions, we were able to treat how Victor was dealing with his hallucinations literally, and he found that it is possible to hear a hostile voice, even feel bad because of it, and still keep on doing something else, making a psychological space for the voices at the same time he remains in contact with what is of true interest.

With regard to Building Awareness of the Observing Self, the “Observer Exercise” should be stressed (Hayes, Strosahl, et al., 1999, pp. 192-196). In this exercise, Victor, with his eyes closed, let ideas flow as well as feelings and bodily impressions that were happening to him but not doing anything about them, simply observing with the self as the context. During this exercise, he experienced an episode of rather intense anxiety. The therapist told Victor to pay attention to something else he was experiencing, the feelings in his feet or his hands, and then go back to observation of that anxiety. When the anxiety had diminished, Victor was able to have an authentic experience of the self as context, observing his own anxiety without doing anything about it.

Session 11 was devoted to the method consisting of “making sense of voices” (Romme & Escher, 2000) within the ACT framework. Specifically, this method tried to relate the content of the voices to other experiences, both biographic and current. Starting out with some concrete examples, Victor and the therapist talked about the possible sense the voice in question could make. So, for example, a voice that warned him about something bad that could happen to him if he went out with his friends on the weekend (“Be careful”) was related to his mother’s being worried that something could happen to him. In fact, Victor’s mother usually warned him about the dangers of going out at night and stayed awake until Victor came home. This contextualization of the voice changed its hostile value and turned it into a “worried voice.” This work with the contents of the hallucinations made it easier for him to perceive them as less controlling. As may be seen, the idea is to consider the content of the voices, which in the beginning would be ill advised by ACT but which here was at the service of the function it fulfills in the biographical context of the person. In fact, it placed the voices in a new context or frame of reference.

Sessions 12 through 14 were devoted to reviewing the methods applied, the goals achieved, and any setbacks. Victor gradually began to be able to remain in different contexts outside
of therapy without leaving because of the voices. His progress was more important outside than inside the session. Remaining in those situations enabled him to keep working on the goals agreed on. Victor was able to continue his professional training task to greater advantage, meet with new friends, and take part in family conversations, which in turn was pleasant for him. Momentary “reversals” when he was overcome by anxiety were made use of for another creative desperation experience, by analyzing the barriers that Victor found as he began his new relationship with his symptoms. It should be pointed out in this respect that in this case, in contrast to a previous one already commented on (García-Montes & Pérez-Álvarez, 2001), it was possible to make use of his “relapses” as therapeutic opportunities because of better cooperation with the clinic team. Finally, Session 15 was devoted to posttreatment assessment.

Assessment of Progress

Beginning with the general psychopathological condition as measured by the BPRS, a noticeable improvement is observed after treatment in the various symptoms considered, including the hallucinations and delusions, as shown in Figure 1. Scores on individual items were referred to instead of the subscales or factors so hallucinations and delusions could be separated. Otherwise, both would have been absorbed by the thought disturbance factor. This way, it can be seen how delusions and other symptoms decrease, even when the therapy concentrates only on hallucinations, which was the problem for which the client was referred. Furthermore, it should be recalled that the individual items are as sensitive to change as the subscales (Burlingame et al., 2006).

The hallucinations, although they are still there, go from a score of 5 (moderately severe) in the month of November to 3 (mild) in the month of May. This reduction is not as much because of hallucinations’ not being as frequent as their becoming less perturbing to daily life. Indirectly, this change could indicate greater acceptance of the experience of hearing voices. Remember that the goal of the therapy was not so much elimination of the hallucinations as their acceptance so that they were no longer a barrier for Victor.

Although his delusions were not a goal of the therapy, their disappearance may have been favored by certain aspects of it, such as clarification of values and proposing them in objective realistic terms. However this may be, an improvement in delusions associated with improvement in hallucinations may be explained by Maher (1988), whose hypothesis is that delusions are a response to abnormal experiences, such as hallucinations. A parallel reduction in hallucinations was observed in a case study in which the behavioral treatment concentrated only on hallucinations (Perona-Garcelán & Cuevas-Yust, 1998). In any case, Victor already began to be critical of his own delusional ideas at the beginning of therapy, and they gradually lost credibility throughout it.

The experience of auditory hallucinations, measured with the Scale for the Experience of Hearing Voices, is presented in relation to the daily record of his attendance at work (Figure 2).

The combined presentation of the two variables shows the progress of therapy better than separate variables, considering that the purpose of therapy was commitment to the activity directed at achieving worthwhile values in his life, in this case, going to work and the
professional training involved in it, in spite of certain uncomfortable events, in this case, the auditory hallucinations. This combined presentation was done monthly during the months the therapy lasted.

In the beginning, during the first 3 months, attendance at work was irregular and the voices were annoying and frequent. In the following 2 months, the voices were no less frequent or annoying, but attendance at work was practically perfect (actually, Victor missed only the days he went to therapy). This point should be stressed, because it shows decreased avoidance, defined by better attendance at work, in spite of equally frequent and disturbing voices. It should be recalled that reduction in avoidance in spite of the symptoms is the goal of the therapy. The point is that this can also open the way to decreasing the frequency and annoyance of the voices to the extent that the person stays on the path of his values: attendance at work and others. Thus, in effect, in the 6th month (April), attendance at work was at its highest, whereas hallucinations were less frequent and less annoying. This lower frequency

Figure 1
General Psychopathological Condition, Pre- and Posttreatment

Note: Ten of the 21 Brief Psychiatric Rating Scale (Lukoff, Nuechterlein, & Ventura, 1986) subscales are shown on the graph. Included are those in which the participant scored on some of the pre- or posttreatment measures. The scale is from 1 to 7 (1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, and 7 = extremely severe).
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and annoyance of the voices was kept up in the following month, when posttreatment measurements were taken, including the BPRS, to which we have already referred. Furthermore, attendance at work kept up this regularity until a health problem that had nothing to do with therapy (severely sprained ankle) required him to be absent from work during the month of May, not shown in Figure 2. This decrease in frequency and annoyance of the voices was demonstrated by the BPRS. In any case, from the perspective of the therapy applied, more important than reduction of symptoms, in this case, auditory hallucinations, is the orientation toward the worthwhile goals: attendance at work and the enlargement of the social network referred to below. The fact that the hallucinations diminished and his general psychopathological condition improved may be understood as a “secondary effect” of activity involved in ACT. There is evidence that behavioral activation is effective in the improvement of depression and anxiety (Dimidjian et al., 2006; Hopko, Lejuez, Ruggiero, & Eifert, 2003), which may in turn have favorable repercussions on hallucinations (Freeman & Garety, 2003).

Victor’s social network map before and after therapy is shown in Figure 3.

In general, the number of dots increases, showing how the social network has enlarged. Specifically, there is an increase in the friends and work areas. Victor has recovered two friends (“two dots”) with whom he had lost touch in recent years and who were included in the “intimate circle.” Furthermore, it should be stressed that these friends are outside of the sphere of mental health, to which his relationships with friends had been limited before (the “two dots” he already had). In the area of work, Victor established a relationship with three other classmates (“three dots,” in the outermost circle). The area of family relations, which already had “five dots,” remains stable. Relationships with the “clinic team” are

![Figure 2](http://ccs.sagepub.com)

**Figure 2**

Attendance at Work (left-hand axis = percentage of days per month) and Frequency/Annoyance of Voices (right-hand axis)

Note: For frequency, 1 = *not often* and 7 = *constantly*. For annoyance, 1 = *not annoying* and 7 = *very annoying*. The scores on these variables are represented in the graph for the months therapy lasted. They were arrived at by calculating the mean on the questionnaires filled out session by session each month (four measured during the months with weekly sessions, two during the months with bimonthly sessions).
maintained but are farther out of the “intimate circle,” which suggests therapeutic independence in this case.

8 Complicating Factors

*Closed-eye exercises with persons with schizophrenia.* The experiential exercises that require closing one’s eyes and paying attention to the flow of inner experience can be distressing for persons with schizophrenia, sometimes causing auditory hallucinations. This is a complication caused by the short time these clients can be exposed to that situation and because of the great anxiety they experience during the session. However, it is also an opportunity for exposure to private events that are a barrier for the participant. One way to handle this situation may be by reducing the time his or her eyes are closed and focusing on his or her body. When the client, with his or her eyes closed, refers to intense anxiety or a confusing voice that makes him or her nervous, he or she should be encouraged to focus on it. If the anxiety is considerable, he or she can be asked to go back in the exercise and focus on his or her body or on the therapist’s voice. Reducing the anxiety with this maneuver was an important learning opportunity in this case.
9 Managed Care Considerations

Coordinated teamwork was very relevant to case management. For example, much of Victor’s professional training was also worked on by the Mental Health Center social worker who knew the case. All of this introduced the possibility of attempting therapeutic aspects for Victor that in some way “overflowed” purely clinical intervention. The therapy had a psychosocial rehabilitation program as a backdrop and a set of professionals who were working on the case. The therapy benefited from that rehabilitation backdrop to the same extent that the rehabilitation process and professional work also benefited from the “ACT philosophy” in managing the case.

10 Follow-Up

After 2 weeks of ending therapy with the voices, the therapist went to an interview with the family (father, mother, nephew, and patient) along with another two professionals from the center. At the interview, some conflictive family interaction was dealt with. At the end of the interview, the therapist had an individual session with Victor, making paradoxical use of the language, congratulating the family on discussing “normal” things, because this meant that Victor’s “illness” was not the subject of household discussion. Three weeks after therapy ended, we were informed by personnel at the mental health center that Victor had begun, by his own initiative, a carpentry course so he could look for employment. Six months after the end of therapy, the family informed the Mental Health Center that Victor was still keeping up his therapeutic success. Although the case description would have been more elegant if the same data had been collected during monitoring as in pre- and post-treatment, they would not have minimized the data reported by the health center staff and family. Therefore, these data contribute “external validity” to the results.

11 Treatment Implications of the Case

The client continued taking the antipsychotic medication during the psychological therapy, so strictly speaking, the improvements referred to could not necessarily be attributed to the treatment employed. However, the client had been taking the medication for several years previous to it with no change having been observed until now, when the psychological treatment was introduced. In fact, the antipsychotics do not seem in this case to have been dampening aberrant salience (Kapur, 2003). Future applications of the ACT could include, among other goals, reducing medication, because it is hard to find persons with schizophrenia who are not on medication, along the line that a study on the previous case indicated (García-Montes & Pérez-Álvarez, 2001) and even along the more ambitious line of trying to avoid medication and hospitalization (Seikkula & Olson, 2003). This said, neither would it do any harm to use the medication along with psychological therapy.

On the other hand, it is interesting to note that the values worked on in this case had to do in some way with the content of Victor’s delusions (being a pop star). The acceptance of some course of action as worthwhile had to be subjected to criteria of feasibility, trying
to keep the participant in contact with reality. That is why the orientation to values is present in all of the sessions, exploring whether Victor’s courses of action were effective in relation to them. When values are approached in therapy, they must be coordinated with the “real possibilities” of the client and be present continually so as not to lose the “contingencies of life” from view. There is nothing wrong with wanting to be a pop star, but for this client and in this context, it represented a course of action disconnected from reality.

12 Recommendations to Clinicians and Students

We would like to make three recommendations with regard to the use of metaphors, another with regard to insight, and still one more with regard to acceptance by the therapist. An additional comment will be made on clients who are suitable for ACT.

Concerning the use of metaphors, in this case, fewer than usual in ACT therapy were used. Many of the metaphors used were also relatively simple (for example, life is a road or a battle) and often picked up by the therapist from the client’s verbalizations. The number of metaphors and how complicated they are when translating them into daily life should be suitable to the level of the client. In this case, an excess of very abstract symbolic stimulation could confuse the client more than it orients him. The therapist must be able to accommodate himself to the client, which in all other respects is completely in agreement with the ideographic philosophy of ACT.

Regarding insight, the psychological therapy is supposed to wait until the client reaches a certain critical awareness of his symptoms or at least is open to new perspectives. The case presented here may be said to be in the organization phase (Romme & Escher, 2000, p. 60), which would be optimum for a therapy such as ACT. However, this therapy can itself create the very insight that other psychological therapies would make the first condition. For example, the case described by Bach et al. (2006) may be an example of how the therapist can ally himself with the client’s goals even when these seem contrary to continuing with therapy.

With regard to acceptance by the therapist of the client’s symptoms, the question is that the ACT means a whole new clinical culture. According to conventional clinical culture, treatments remove the symptoms and in fact measure their efficacy by how well they are eliminated. In contrast, an ACT therapist has to accept the client’s symptoms himself and resist the demands of both client and institutional context until, eventually, the context is appropriate for the still-new therapy in clinical environments. In general, clinics should begin to “tolerate the ambiguity” of the symptoms of the patients, before feeling “obligated” to give a diagnosis or a prescription (Seikkula & Olson, 2003). The therapists should be open to adverse events in the therapy (the client continues hearing voices) and get on with the therapeutic values, accompanying the client on his path to a more worthwhile life (notice the metaphor of the therapy as a path). The case presented here shows that using ACT is feasible in the current context of a mental health center, as long as the clinicians “accept” the client’s symptoms.

The client’s characteristics, including adequate cognitive functioning and good family relationships, seem to be appropriate for ACT. Doubtless, ACT requires adequate cognitive functioning to understand its concepts and metaphors. Even so, it should be borne in mind
that practical experientiation is as important as or more important than cognitive functioning for ACT. Its methods consist particularly of experiential exercises, so that the therapeutic change probably depends more on the experience lived than on intellectual understanding. Many of the metaphors can be found in the client’s own repertoire, even though he or she is not particularly aware of their use. Family relationships are also important for ACT. It is not enough for the client to have a good relationship with his or her family; the family must be tolerant of his or her symptoms and cooperate in the same direction as the ACT. In this sense, it might be advisable for the ACT to involve the family, particularly for persons with schizophrenia. In fact, future studies might determine its advisability. That is, even when cognitive functioning is adequate and good family relationships are appropriate for ACT—the same as, by the way, for any other therapy—it may not be said that ACT requires that the clients have better conditions than other psychological therapies. It remains to be seen whether ACT can be accessible to even more clients than other psychological therapies.

References


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