EXPOSITION IN EXISTENTIAL TERMS OF A CASE OF “NEGATIVE SCHIZOPHRENIA” APPROACHED BY MEANS OF ACCEPTANCE AND COMMITMENT THERAPY

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ABSTRACT

The present work attempts to show, through a case study, the possibilities of Acceptance and Commitment Therapy (ACT) applied from existential thought. First of all we describe the symptoms referred to by a patient diagnosed as suffering from “negative schizophrenia”. These symptoms are then analyzed in existential terms, with special emphasis on the notion of “personal identity”. This is followed by a description of the intervention carried out applying the techniques and principles of ACT, and an account of the patient’s evolution over two years. Finally, we defend the appropriateness of acceptance in problems of an existential nature, at the same time as arguing for situating people’s difficulties in a vital more than purely psychological framework.

Key words: Existentialism, Acceptance and Commitment Therapy, schizophrenia, identity.

1. Introduction.
Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999) constitutes one of the most recent developments of radical behaviourism in the treatment of diverse problems presented by outpatients (Dougher & Hayes, 1999; Kohlenberg, Hayes & Tsai, 1993). Briefly, it can be said that the objective of the therapy is twofold. On the one hand, the aim is for clients to accept those aspects of their experience that they have been trying unsuccessfully to modify (anxiety, obsessions, sadness, etc.); on the other, it is attempted to avoid this paralyzing the person’s life, so that he or she can aim for those goals that are of personal importance (social relationships, work relationships, etc.) even while experiencing anxiety, obsessions or any other situation that has acted as a block up to that point.

As it can be seen, with respect to classical cognitive-behavioural approaches, Acceptance and Commitment Therapy (ACT) represents a change of therapeutic focus. Intervention is no longer aimed at eliminating or reducing the psychological symptoms, but sets out rather to achieve a distancing of the person with respect to those symptoms, so that, for example, anxiety does not represent an impediment to speaking in public (if this goal is important in the patient’s life).
Bearing in mind the above, ACT proposes six goals that should be covered over the course of the intervention (Hayes, Strosahl & Wilson, 1999): 1) To break the client’s preconceptions about the therapy, creating a kind of desperation about the solution he is seeking; 2) To make him see that, in part, the problem is precisely the attempts to control the symptoms; 3) For the client to accept that which cannot be changed or which it is considered valuable to have; 4) For him to distinguish between “I” and “me”, or, to put it another way, between the person and his behaviour; 5) To take the client’s values as the framework for acceptance of the experiences that are to be changed; and 6) To establish a commitment to work in line with these values.

As regards the techniques used in order to fulfil these objectives, prominent among them are the use of paradoxes and metaphors, the review of linguistic conventions and the use of experiential exercises, in addition to conventional behavioural therapy techniques (exposition, shaping, etc.).

Recently, the second author highlighted the theoretical and technical affinities between ACT and traditional clinical approaches such as psychoanalysis, strategic therapy and existential therapy (Pérez, 1996, 2001). In any case, the similarities between ACT and existential psychotherapy would be deep-rooted, and, could in some way be traced back to the conceptual coincidences between the work of B. F. Skinner and phenomenological-existential thought (Day, 1969; Fallon, 1992; Kvale & Grenness, 1967). The present work is intended as a practical exploration of such coincidences, and of the possibilities offered by an ACT intervention from an existential perspective. We shall first present the case of a client diagnosed as “negative schizophrenic” and his situation at the time of coming to us for therapy. Subsequently, we shall analyze the client’s symptoms in existential terms, with the emphasis on personal identity as a concept that can articulate the patient’s problem and the search for a solution. This will be followed by a brief exposition of the intervention and its results. Finally, we shall draw some tentative conclusions on the basis of the case treated. In this regard, we might already point out that these conclusions are in a similar direction to those of Kvale and Grenness (1967), who argued for a development of radical behaviourism (in our case, ACT) from a phenomenological-existential perspective.

2. Exposition of the case and its symptomatology.

At the time of consulting us, E. was 28 years old and lived in a central neighbourhood of a town in northern Spain with his mother and grandparents. Over the previous 11 years, he had received a wide variety of diagnoses, the most common being that of “schizophrenia”. Likewise, he had been prescribed a considerable range of treatments of all kinds, including more than 20 types of drugs, among them various antipsychotic products. There had been equal variety as regards other types of treatment or intervention, which even included an exorcism, practised on the client with no success whatsoever.

E.’s parents were divorced when he was six years old, after which his father moved to another province, where he now lives with his new wife and E.’s four stepbrothers and stepsisters. Thus, E. grew up with his mother and
his grandparents. It is difficult to establish the point at which E.’s problems began. Until he was 17 he had been a diligent student, a keen reader and good at sports. However, in the eyes of E., things were already not right. As he told us, ‘I’ve lived in hell at all times and in very different ways at the different stages of my life, from my earliest memories until now.” Even so, E., acknowledges a certain change on reaching age 17, since, until that age, he had the idea that everyone was like him “inside”. Indeed, E.’s complaints focused, from the start, on his “private world”, or, as he would say, on his “sensations”: “My inside,” he told us, “changes constantly and rapidly, especially when I try to do something on my own initiative. Doing something on my own initiative, for me, is equivalent to trying to break down the barrier between my world and that which I believe there is outside”. According to what he told us, he often found himself deprived of his knowledge and abilities as though by magic. These symptoms appeared without warning and in some way increased his confusion and insecurity. Likewise, from the start, E. saw that his peace of mind depended to a large extent on the view he felt others had of him as a person: “I don’t see others, I don’t have the right to judge them, but others do have the right to judge me,” he said. This dependence on other people’s criteria leads him to continual self-reproach and profound isolation: “I cannot express my resentment against this cruel, mediocre and limited outside world, and I accept my role without being able to avoid it”.

As indicated above, these symptoms began to manifest themselves publicly when E. was 17 years old. From then until age 20, E. received various types of pharmacological treatment and outpatient psychiatric attention. Despite being advised to continue his studies, E. lost all interest in them, as well as his “ability to concentrate”. As he himself recounts, in these three years he lived a totally “unproductive” life. His only interest was music, to which he devoted a great deal of his time.

On giving up the psychiatric treatment, at the age of 20, he spent a few months during which he remained in his darkened room for whole days, hardly eating and immobilized by the unease produced by the sensations he experienced. When these sensations stopped, he began to feel something that he claims he had never had before: positive thoughts about the future. Little by little the “positive” days began to outnumber those on which E. stayed shut away in his room. This encouraged him to go on holiday with his father to a nearby village, where he met his first girlfriend. E. recalls that “it all went well, but I felt anxiety as well as pleasure”. That made him feel like a fraud, “a psychotic with a double life”, to use his own expression. After that summer, he decided take up his studies for the third time. Everything went well until before the Christmas holidays he had another crisis. In his words, “I lost control of my body, fused with other people and immersed in continuous paranoia, totally helpless. At that moment I saw channels inside my body through which there circulated an energy that ‘burnt’ me if I stayed still; I could bear it with a kind of internal ‘muscles’ (located in my head) if I was lying down on my back”. Tired of these types of “sensations” and of “fighting” them, he decided to take his own life by getting into the bathtub with a hairdryer in his hand. Having failed in this suicide attempt, he spent three weeks trying to starve himself to death,
which led to his being forcibly admitted to a psychiatric hospital and prescribed a strong dose of antipsychotic medication. After being discharged from hospital, E. again tried to commit suicide, this time by consuming a massive dose of drugs that he had obtained by “saving up” week-by-week those prescribed by the psychiatrist. This new attempt to take his own life led to another forcible admission to the psychiatric unit. After being discharged, E. spent two entire years without leaving the house, at the end of which he began to go out compulsively: “at first I didn’t even get undressed to go to bed, and I spent all day walking or at relatives’ houses, until I began to bore them. I was at the disposal and at the mercy of everyone, with the idea that the solution to my unease might appear at any moment, and that I shouldn’t turn down any invitation”, he told us. During this time he continued to take antipsychotic medication until, six months before coming to see us, he decided to stop it. E. came to us in search of a new remedy for his “bodily sensations”, for his “fusion” with people and, in general, for the “useless pain” he felt in his life.

3. Re-exposition of the case in existential terms.

So far we have aimed to give as clear and objective an account as possible of E.’s life up to the time we met him. However, we should like to go further and ask ourselves whether there is any possibility of making sense of the problems this client presents. In our opinion, such an explanation would involve understanding that E. attempts to deny certain constituent aspects of the construction of his identity, specifically, the “condemnation to freedom”, his relationships with and dependence upon other people and the experience of his own body.

We shall begin by looking at the first aspect: “condemnation to freedom”. This concept was identified simply and brilliantly by the important Spanish philosopher José Ortega y Gasset:

Life is given to us, since we find ourselves in it without knowing how or why; but that which is given to us, life, is not given to us ready-made. Rather, we have to make it, each one his own. Life is a task, and it gives us a lot to do! (Ortega y Gasset, 1979/1996, p. 98).

But this doing is always multiple, so that, on choosing one thing as opposed to another or others, people define themselves both positively and negatively. To use the words of Ortega once more:

Each instant and each place opens up before us various paths. From any circumstance, even extreme ones, avoidance is possible. What cannot be avoided is that we have to do something, and that we have to do what is, in the end, the hardest thing: to choose, to prefer. How many times have people said they would prefer not to prefer? (Ortega y Gasset, 1957/1995, p. 52).

In any case, it seems clear that freedom (or choosing, if you will) produces fear (Fromm, 1987) in that it implies the construction of one’s own being. It is appropriate here to consider Jean-Paul Sartre’s (1943/1993) assertion that, for human reality, being is choosing oneself. Therefore, while the person does not choose (or, rather, plays at not choosing) s/he is not (or, rather, plays at not being). For
indeed, s/he who has chosen nothing is potentially everything, even though s/he may de facto be nothing. The case of E. could be seen, then, as an obstinate attempt at non-being; that is, a way of trying to elude his necessary freedom of action, and thus his construction as a person. In this regard, it should be underlined that, as mentioned above, until the age of 17 E. adjusted perfectly to the normative models of his cultural context: good student, sportsman, keen reader, etc. These types of behaviour for which, we should remember, E. did not feel ultimately responsible, may shape what Laing (1960) has called a “false self”. As Laing (1960) stresses, this bending oneself to the norms or expectations of others is in part a betrayal of one’s possibilities, but it is also a technique for concealing and preserving one’s “true” possibilities, that is, a way of playing at not being that which one does.

Another form of trying to escape from the “condemnation to freedom” could be seen in the importance E. concedes to “initiative”. As we have seen, E. longs to “have” an initiative so that he can act. This implies, in fact, a mechanistic (almost mechanical) conception of his own activity. “It’s as though I had a program,” he remarked to us in one of the sessions. E.’s behaviour would thus be a pure reflex determined by “intentions”, so that his responsibility for his acts becomes non-existent. Such behaviour was frequently found in the sessions. Thus, for example, in carrying out a written task we set for him on the assessment of values (Hayes, Strosahl & Wilson, 1999), he avoided practically all responsibility with regard to the life-goals considered. Instead of using verb forms such as “I want”, “I would like”, “I aim”, etc., he used expressions with “I see” or “I see my-
alienation of my own possibilities (Sartre, 1943/1993, p. 291,).

Thus, E., on being contemplated by others, ceases to be pure possibility (transcendence) and becomes something concrete (act, facticity, behaviour): the nuisance who comes asking for a cigarette, the clumsy chap who bumps into him on the way out of the supermarket, etc. His infinite possibilities are now reduced by the presence of another person who confers upon him an objectivity and concreteness as a being. It is not surprising that E. perceives that, while the rest judge, he finds himself incapable (“without the right,” as he would say) of judging others. “In the phenomenon of the look,” says Sartre (1943/1993, p. 296), “one’s neighbour is, necessarily, that which cannot be object”.

Moreover, as regards the “fusion” E. experiences with respect to his perceptions of others’ opinions of him, nor is this surprising from this existential position: “it seems to us that the other fulfils for us a function of which we are incapable and which, nevertheless, is incumbent upon us: to see ourselves as we are [...] we are resigned to seeing ourselves through the eyes of others.” (Sartre, 1943/1993, p. 380).

However, it appears that E. does not resign himself to being seen through others’ eyes, and struggles, in one way or another, against this “fusion”. For E., the look of the other represents an illegitimate interference in the determination of his identity.

A third difficulty in the formation of the identity can be seen in the “struggle” that E. maintains against his “bodily sensations”. These types of sensations varied widely, with an example of them being the feeling of discomfort one has when putting on a pair of trousers for the first time. As Sass (1992) points out, this type of experience of the strangeness of one’s own body represents a loss of tacit forms of knowing. Instead of E. finding himself living in his body and immersed in his sensory world, there is a strong separation between his consciousness (perceived as a world of infinite possibilities) and his body (as the empirical realization of his body). This denial of bodily experiences can be seen, in fact, as a negation of one’s own identity. One is one’s body – as Merleau-Ponty (1945/1999) would say –, at least to the extent that one has a capital of experience, and, reciprocally, my body is like a natural subject, like a provisional sketch of my total being. It could be argued that this type of bodily sensation is involuntary, so that it has nothing to do with the matter of identity, seeing as the person’s freedom is not compromised. In any case, we should not forget that freedom also involves assuming one’s responsibilities for that which s/he has not created or desired, but that one cannot escape one’s condition (Sartre, 1943/1993). On denying one’s own nature as a corporeal being, E. rejects the conditions from which the exercise of his liberty is possible. Nor need it be said that in the pure subjectivity of consciousness neither these nor other limitations exist.

Thus, in our view, E.’s problem can be seen as a question of identity or a disorder of the Self (Parnas, 2001) The problems in the formation of his identity would be rooted in the experience of freedom of action, in the relationship with others and in E.’s relationship with his own body. Needless to say, all of these aspects
are profoundly existential and, at the same time, are matters that tend to emerge as a result of the transition from adolescence to adulthood (Harrop & Trower, 2001).

4. The intervention in behaviourist terms.

They are multiple ways of presenting the intervention carried out. For the sake of clarity, we feel it appropriate to use as a guiding criterion the objectives that ACT aims to achieve. The order in which these appear should be understood more as a matter of logic than of chronology. We feel it might even be said that a good application of the therapy requires flexibility on the part of therapists as regards the objective (or objectives) towards which they are working at a given time. It should also be underlined that what is presented here is simply a summary of the intervention carried out, and that the selection criterion for presenting some issues and omitting others is that of being able to illustrate clearly the goals of the therapy. Having clarified these matters, we shall continue by presenting the work with E., which was carried out over a period of five months with two sessions per week.

4.1. Creative despair.

The ultimate objective of this phase is for the patient to experience how all his attempts at a solution have failed, and that, therefore, the solution may be that there is no solution. We feel it important to recall that, as pointed out by Hayes et al. (1999), it is an experience the client must have, more than something he should understand intellectually. In fact, confusion is a typical reaction, and is desirable at this point.

As we have described, E came to us in search of help in order to palliate the unease produced by his bodily sensations and his “fusion” with other people. One of the first things we asked of him was to tell us, in as much detail as possible, about each one of his attempts to solve his problems to date. After his highly detailed account, we asked him to tell us whether any of these solutions had been fruitful. Obviously, E’s response was “no”, as it was precisely for that reason he had asked for our help. The following step, therefore, was to suggest to him that we did not understand why none of this had worked: “There have been really good attempts at a solution, and quite varied, … and nevertheless…,” we said to him. In our opinion it is especially important in this phase of the therapy to use indirect language. The final objective is that the client asks himself questions, more than that he finds a solution. At some points it seemed that E. was truly desperate, even with regard to our treatment: “I don’t think it’s going to work,” he said. Nevertheless, on other occasions, it appeared he hadn’t thrown in the towel: “the more pain you have, the more you want to fight”. Although it is frequent to use some type of metaphor to illustrate the situation in which the client finds himself (see Hayes, Batten, Gifford, Wilson, Afairi & McCurry, 1999; Hayes, Strosahl & Wilson, 1999), in this case this convention was not followed. We continued to work repeatedly, at different points of the therapy, on the uselessness of any solution tried.

We also worked on despair in relation to almost all the existential aspects from which E. aimed to escape. Thus, for example, with regard to the question of freedom, we used Sartre’s well-known phrase “condemnation
“to freedom”. E. was made to see that he had the option of not choosing, but that the only way he could do so was by “choosing not to choose”. The reactions of E. were of confusion, and sometimes of anger. We applauded his expressions of confusion, on the grounds that he understood everything (“because understanding this means not understanding it”). We thus responded to the effect of a paradox with another paradox. In the face of his expressions of anger towards the therapist (“I'd like to punch him in the face,” he was heard to say), we asked him to take note of them, to feel them and to continue with the course of therapy. Here we feel it important to underline the importance the paradox may have in dealing with matters of a vital or existential nature. Such matters are not easily grasped using linear logical schemes. The paradox therefore serves as an appropriate instrument for making contact with the contradictory nature of existence (Van Deurzen-Smith, 1997).

4.2. Control as a problem.

From ACT it is considered that a large proportion of psychological problems can be understood as vain attempts to suppress or modify certain private experiences (emotions, thoughts, etc.) (Hayes, Wilson, Gifford, Follette & Strosahl, 1996; Luciano & Hayes, 2001). The object of this phase of the therapy would be, therefore, that the client realizes that his attempts to control his private experiences may meet with more or less success in the short term, but that in the long term things tend to get worse. In the case of E., he himself, in the second session, introduces the idea of control as a problem. Thus, with regard to the pain he feels, he tells us “when you don’t want it, it comes.” In the third session he indicates something similar in relation to the search for a solution to his problems: “the more I need a solution, the further away I feel.” At that point we used the “polygraph metaphor” (see Hayes, Strosahl & Wilson, 1999). In order to present it we asked E. to imagine that at that very moment we pulled a gun on him and, pointing it at him, threatened to kill him if he didn’t paint the wall of the room with paint and a brush that we had brought for that purpose. “Would you do it?”, we asked him. E. told us that he would, and we congratulated him for having saved his own life. We then proposed to him a different situation: this time, E. would be connected to a polygraph capable of detecting the slightest feeling of unease in him, and once again, we made an outrageous threat: “If this polygraph detects the slightest sensation of unease in your body, I’ll shoot you.” We asked him if, on this occasion, he would save his life. In this case, it seems E. did not feel capable of surviving. We used these situations to consider the matter of control of pain, bodily sensations, anger, etc. (polygraph situation), as opposed to control of publicly observable behaviour (wall-painting situation). E. then told us that, on occasions, he had tried not to control his unease. We asked him why, to what end, and he told us he had done it as another attempt to stop the sensations. We asked him why, to what end, and he told us he had done it as another attempt to stop the sensations. Our aim was to try and make him see that, perhaps, “not controlling” so that something ceased was actually a form of control. “What do I have to do, then?”, he asked. “Nothing?” We insisted that, quite possibly, not doing anything is doing something. The reader will note that here we have returned to the subject of despair, since all the objectives of the therapy are necessarily intertwined.
4.3. Distance with respect to language

The aim here is that the client achieves a degree of perspective with regard to his thoughts. ACT does not attempt to modify the client’s thoughts, however uncomfortable, upsetting or painful they may be. All the same, it is attempted to make sure the client does not lose sight of the fact that such thoughts are just that: thoughts, that is, something the person him/herself produces, and not objective realities.

In order to illustrate this aspect with E. we used the “sunglasses metaphor”. It was suggested to E. that a person’s mind might be like a pair of sunglasses tinted in different colours according to the moment. On some occasions they are black, and things appear to us as replete with difficulties and problems. At other times the glass might be rose-tinted, so that the world appears marvellous. E. was made to see that the problem is not that we wear some capricious glasses that change colour according to the occasion. The problem would be that, for the majority of people, it is quite difficult to realize that we are wearing sunglasses. In order to illustrate the type of problem that occurs when we are unaware that we are wearing sunglasses. In order to illustrate the type of problem that occurs when we are unaware that we are wearing sunglasses (that we have a mind that evaluates, judges, etc.), we gave E. a blank sheet of paper and a blue pencil. We asked him to imagine he was wearing glasses tinted in exactly the same colour as the pencil. “If you were wearing the blue glasses, could you write with this pencil on the paper?” we asked him. E.’s response was “no”, as the paper and pencil would appear to be the same colour. Immediately afterwards, we tried to make him see that perhaps something similar happened to him in many other situations in his life in which he thinks he is incapable of doing certain things (e.g., “feeling like this I can’t go to the beach”), but nevertheless can do them. Realizing that one is wearing tinted sunglasses would mean that, for example, one could go to the beach thinking that one is incapable of doing so. After we had proposed the metaphor to E., he told us he thought it very difficult to do such a thing. We then asked him straight away if, when he said it was “very difficult”, he realized that he was wearing glasses, that this thought was also influenced by the colour of the lenses.

In a similar direction, and also with a view to creating a distance with respect to language, we asked E. to say the word “chocolate” just once. After he had done so, we asked him what sensations he had felt. E. told us he really felt as though he were eating chocolate. It is important to stress how the client insisted, in this exercise, on the vividness with which he experienced the taste of chocolate on saying the word. We then asked him, instead of just once, to say “chocolate” many times over and as quickly as possible. Together with him we repeated the word for one minute, until we finally asked him if, when he said the word so many times, the taste came into his mouth. E. said no, that in this case he didn’t taste chocolate. We then told him it was important for him to note that, although at the beginning he experienced quite vividly the sensation that accompanied the word “chocolate”, subsequently, on repeating it so many times, the word lost all the power it had and appeared as it really is, simply a word, a sound. We took advantage of the occasion to suggest something similar might be happening when E. thinks “I can’t” or “I haven’t the right”, or other thoughts. People experience
these thoughts quite intensely, even though, at bottom, they are nothing but words.

Another exercise we have employed many times in session, and whose orientation is similar, is that known as “taking the mind for a walk” (Hayes, Strosahl & Wilson, 1999, Bach & Hayes, in press). The first time we used it we began by asking E. how many people were in the room at that moment, to which E. responded that there were two. We told him that in fact there were four people: E., the therapist, E.’s mind and the therapist’s mind. In order to continue with the exercise we proposed to E. that, for 10 minutes, the therapist would act as E.’s mind and E. would act as himself. Thus, both E. and his mind would leave the consulting room and take a walk around the corridors of the Faculty. Then, and for another 10 minutes, E. would act as the therapist’s mind and the therapist as himself. Finally, and for a similar length of time, E. and the therapist would walk separately, taking note of the fact that, indeed, each has a mind that evaluates, judges, criticizes, affirms, denies, orders, and so on. The only rule of the exercise is that the person acting as the person is not allowed to ask his mind to change the subject, avoid a matter, etc. The person must go where he wants, regardless of what the mind tells him. During the time the therapist acted as E.’s mind, he made sure to insist on the type of thoughts about which E. usually complained. Thus, special emphasis was placed on how others would be judging us and on how ridiculous and minuscule E. was in the eyes of other people. The exercise was repeated on two more occasions. We believe this exercise can be especially useful in cases of people most strongly fused with their thoughts, in that it permits the physical representation of the difference between the person and his/her cognitive content.

4.4. The distinction between the person and his/her behaviour.

Here, the aim is for the person to put some distance between him/herself and his or her behaviour. This approach is based on the belief that patients, on realizing that they are not reducible to their behaviours, will be in a better situation to accept and integrate certain aspects of their personality that have been actively avoided.

Thus, in the case of E. we used the “chess metaphor” (Hayes, Strosahl & Wilson, 1999; Pérez, 1996). E. was asked to imagine a chessboard on which there are black pieces (his uncomfortable bodily sensations, his thoughts of inferiority with respect to others, etc.) and white pieces (sensations of well-being, of being in control of situations, etc.). They are fighting each other. The black pieces form one team and the white pieces another. We asked E. whom he could be in the situation we have presented. E. quickly replied “the white pieces”. We then asked him to go a little further and imagine whom he might be if his previous answer were incorrect. First of all he told us he didn’t identify with anything but the white pieces, but after we repeated the question he said: “... you’re going to tell me I’m the board”. And indeed, that was the point we wanted to reach. With E. as the board, he contains both white pieces (pleasant sensations, thoughts of control and power, etc.) and black pieces (unpleasant bodily sensations, feelings of inferiority, impotence, etc.). But the board is not the pieces, so that E. is
equivalent to neither the black pieces nor the white pieces, but transcends them both.

With a similar aim we carried out the exercise “observer of oneself” (Hayes, Strosahl & Wilson, 1999). We should begin by pointing out that, as the second author of the present work has indicated (Pérez, 2001), this exercise is functionally coincident with the existential de-identification technique used for the purpose of “acquisition of strength” in the face of fear of death (Yalom 1980/1984). In the case of the “observer of oneself” exercise we began by asking E., with his eyes closed, to be aware of his body at that moment – his position on the chair, his breathing, his tension or relaxation, the thoughts that came to him, etc. We insisted that it was not a case of changing anything, but simply of making contact with these experiences. Meanwhile, we told him he should also notice that there is part of him we shall call “observer of himself”, which is the one who is noticing these experiences. We then asked him to recall in as much detail as possible a painful event in his life. At the same time we stressed once more that he should notice how once again it is the “observer of himself” that is experiencing this painful event. This procedure was repeated with a happy event. We also repeated it in relation to his body when it was extremely thin and to how it was now, etc. Throughout the entire exercise we insisted on how important it was, not just that E. “believed” there existed an “observer of himself”, but that he really lived through the experience of it being “him” (as observer of himself) who had been sad and happy, who had had a thin body and a fatter one, who had been nervous and calm, etc. As it can be seen, the exercise aims to construct a “transcendental” sense of the self at the same time as putting a distance between what one does (or has done) and what one is. It is unnecessary to underline the importance of this in cases where personal identity is compromised, such as that which concerns us here.

4.5. Work on values.

As regards values, in our view they are the most important aspect of ACT. The creators of the therapy recognize that the acceptance of negative thoughts, of unpleasant emotions, and so on, only makes sense and is legitimate to the extent that it permits the client to be directed towards those goals that are personally important to him or her (Dougher, 1994; Hayes, Strosahl & Wilson, 1999). In the case of E., work on values certainly occupied a large proportion of the time spent with him. Earlier we saw how E. played at not being, that is, at not choosing, at not valuing. It is not surprising, therefore, that a large part of the work on values was devoted to showing him the inexorable necessity of valuing, and, above all, the need to invent values. We therefore began by distinguishing decisions from choices. As Pérez (1996) points out, decisions result from a logical analysis that weighs up different options. Decisions consist in the selection of an alternative for certain reasons. On the other hand, a choice is an alternative selected without a reason, even though reasons may exist. In order to emphasize this distinction, we used a variation of the exercise “choosing: Coke versus 7-Up”, cited in Hayes, Batten, Gifford, Wilson, Afairi & McCurry (1999). In our case, we took a pencil and an eraser from the room we were working in and asked E. to choose one or the other. After E. had made his choice we asked him to tell...
us why he had chosen the object in question and not the other one. E. gave us a series of reasons that we recognized as coherent and sensible. We then asked him whether or not it was true that, for equally good reasons, he could have chosen the other object. E. replied that it was true – that he could indeed have chosen the other object. Thus, we repeated the exercise, asking him to choose again. We again asked him for his reasons, we again recognized them as valid and we again asked him whether, with these reasons (or tastes or preferences), he couldn't have chosen the other alternative. The exercise was repeated until, finally, E. responded that he had chosen one of the objects instead of the other “just because” (i.e., for no reason). This was precisely the point we were trying to reach. We wanted to show in this way that, in the end, any choice we make in life is one’s own responsibility, with no room for hiding behind tastes, preferences, reasons or motives for evading such responsibility. It is not necessary here to stress the importance that existential philosophy has given to the “invention” of values and to the anguish that results from recognizing that people’s freedom is the basis of their values, without that freedom having its own foundations (Sartre, 1943/1993). The exercise presented aims precisely at the client’s acceptance of this anguish of recognizing him or herself as the ultimate basis of his or her choices.

Another matter that we tried to clarify in relation to values concerned the fact that they are always translated into specific actions, and are independent of certain private states. Thus, we used the “striped socks” metaphor (Hayes, Strosahl & Wilson, 1999). We asked E. whether he liked striped socks. He said he didn’t. We then asked him to imagine he was the Dean of the Faculty and had the possibility of using his influence to make everyone wear striped socks, even though he didn’t like them at all. We asked E. what he could do to make everyone wear striped socks. E. began to suggest an extensive series of actions that would lead to everyone in the faculty wearing this type of socks, from giving them away as presents at the door, to awarding “extra points” to students who wore them continuously throughout the academic year. We then made him realize that, if he didn’t saying anything, everyone would think he were a fan of striped socks. In other words, we tried to make him see that it is actions that lead to achieving certain goals, and that such actions may be independent of the desires one has. “Your tastes,” we told him, “don’t leave traces, but your actions do.”

The relationship between values and acceptance was also illustrated with the “rubbish bin” metaphor. We asked E. to imagine that the wastepaper bin in the office was full of all sorts of rubbish, the most disgusting things he could think of. We asked him if he would put his hand in it – to which he obviously responded, “no”. “And what would happen,” we asked him, “if at the bottom of the bin there was a present someone had given you and that was special for you, or something else that was very important for you. Would you put your hand in?” We tried to make him see that in such a situation it wouldn’t make sense to ask him “not to be disgusted”: reaching into the bin would be an unpleasant experience. Putting his hand into the waste bin for the sake of it, without having anything to fish out of it, would be foolish. But putting up with the disgust in order to take out
something of importance does make sense. Likewise, it would not be appropriate for E. to feel unpleasant bodily sensations for the sake of it, for no reason. However, there may be something for which it is worth having these or other symptoms. The thing is that, in E.’s case, he also has to invent the important thing at the bottom of the bin, since values are chosen freely by people themselves. Also in relation to values we used, with E., the questionnaires and exercises for their clarification. Since these are highly structured instruments, we refer the reader to the therapy manual that provides details of the procedure (Hayes, Strosahl & Wilson, 1999).

4.6. Commitment.

Commitment means that people are capable of directing their life in those directions they consider important despite uncomfortable private states that may appear. To illustrate this idea of “commitment” we used the bus metaphor (Hayes et. al., 1999). We asked E. to imagine he was a bus driver, and that, at a certain moment, some difficult passengers, rough-looking and apparently threatening, boarded his bus. Such passengers could be the uncomfortable bodily sensations, the feelings of inferiority on speaking to people, etc. When E. tried to drive the bus in a certain direction, these passengers stood beside him and starting shouting and threatening him. What did E. do then? In the majority of cases E. declined to follow the direction he had begun to take, so that the passengers (the bodily sensations, the unease, etc.) went back to the rear of the bus and quietened down. Every time E. tried to go in certain directions that were important for him, these passengers began to shout and move up close to him. Thus, in order to keep them calm and as quiet as possible, E. had systematically succumbed to their blackmail. We asked E., given this situation, what he could do, as driver, to take the roads on which he wanted to drive. E. soon realized that the only way of achieving this would be to put up with the passengers’ shouting and complaining, not giving in to their blackmail. We made sure to stress that it was E. who, after all, was at the wheel of the bus, and we asked him to recall if at any time these passengers had actually removed him from his post as driver. It would seem that these passengers that were feared so much were more loud-mouthed than powerful. We suggested to him that perhaps their only power was similar to that we saw words to have in the exercise where he had to say “chocolate”. In order for E. to experience this, we proposed an exercise. This exercise involved going to the students’ room and asking the person there about a party that was due to take place that weekend. E. had to do this and note how the passengers moved close to where he was sitting and began to shout and threaten him. On returning from the students’ room, E. remarked that he had had feelings of inferiority, that he didn’t know what to do, and that he had the sensation of non-existence. “That was all that mattered there,” he told us. We then told him that the important thing was that he had taken the bus where he wanted, and that his driving was more meritworthy the more threatening passengers appeared. Driving without passengers is very easy, so that there is little merit in driving the bus in that situation. What is difficult, and therefore meritworthy, is driving when the passengers get up from their seats and cause trouble.
4.7. Diagnosis of the case.

Finally, but no less relevantly, we should point out that to conclude the clinical sessions we “diagnosed” E. has having a problem of an “excess of lucidity”. To this end we took advantage of an earlier conversation in which E. complained that, when he described many of his problems to other people, they always told him such things weren’t that important, and happened to everyone. We told him frankly that, in our opinion, dependence on others’ judgements, discomfort with certain bodily sensations or unease about personal responsibility were quite common in people. What made E.’s case different was that he felt these things more acutely than others, so that, in short, his problem was an “excess of lucidity”. What was important was that such lucidity should not paralyze E.’s life. His task was to live in full awareness of the difficulties and contradictions life holds – a task which, as we made clear to E., is not at all easy. Perhaps you have to be mad.

5. Monitoring and evolution of the case.

On following the evolution of the case, we should stress the fact that we avoided the use of questionnaires or other pencil-and-paper tests. As pointed out elsewhere, it does not appear that this type of “test” is very sensitive to the kinds of change that ACT aims to achieve. On the other hand, a good way of confirming the correct functioning of the therapy would seem to be that of taking note of clients’ achievements in their life, which will be all the more valuable the more they are made with the symptoms that previously paralyzed them (García, 2002). In this regard, E. became involved in more and more activities, and made concrete achievements as the therapy advanced, and especially after its conclusion. Nevertheless, it should also be pointed out that E. made no reference whatsoever to changes in his “internal situation”, that is, in his felt experiences. Therefore, the changes we shall describe here concern solely E.’s public behaviours.

Thus, one month and 10 days after the beginning of the treatment, E. began once more to play the guitar and read, and made visits to one or two museums. It should be stressed that playing the guitar again involved a special effort for E., since this activity requires good coordination of the fingers. E. frequently complained of his clumsiness and lack of control over his fingers. Six weeks after the beginning of the therapy, E. began helping his mother to look after his grandmother, who has since died, but who at that time was suffering from degenerative dementia. Two months after the beginning of the treatment he began playing the electric guitar, which he considered as a big step forward. Ten weeks after our first interview E. took responsibility for the first time in session for not having done a certain task we set for him over the weekend. Instead of using an expression such as “I couldn’t”, etc., he told us that he “didn’t want to do it”. After three and a half months he began visiting shopping centres, going to the beach and doing press-ups. He admitted in session that he was “a little more active”. During this time he also began to take an interest in computers and, especially, in “surfing the net”. Four and a half months after the beginning of the treatment he signed up for a short computing course. Also at this time,
he began to go out some nights with a group of friends. The therapy ended after five and a half months.

At the first follow-up, after six weeks, E. told us he was doing two short courses (word processing and horticulture), was downloading music from the internet, was temporarily head of his building’s residents’ association (substituting his mother) and was continuing to look after his grandmother, whose health had worsened considerably. He surprised us during the session on asking us to open the window because he was hot (he had never previously asked us to change anything). After we had pointed this out to him, E. told us that in the six weeks since the end of the treatment he had also taken an analgesic when he had a headache, something he had never done before in his life. The next time we contacted E., five months after the end of the treatment, he appeared to have left off some of his activities. Thus, he remarked that he had dropped out of the Friday-night meetings with friends because “he’s miserable and he ruins it for everyone else”. Nevertheless, seven months later, he told us he had done two more short courses (page-making applied to graphic design and graphic design and illustration). He also told us he had several difficulties for adapting to the work team, especially at first. A year and four months after the final clinical session, E. obtained his first paid work, carrying out a survey in a working-class neighbourhood of his town. With the money he earned he bought a computer to practise with various programs for graphic design and page-making, which had become a hobby for him. Likewise, he remarked that he had made new friends, though he was still keeping some distance between them and himself. Two months later he began a course of paid practical experience in a printing firm, given his interest in matters related to graphic design. Finally, a year and ten months after the end of the treatment, E. began working full-time at the printing firm where he had done the practical experience.

6. Discussion.

In our view, the conclusions that can be drawn from the present case study are limited by the very nature of the work we have described. With just one client, we cannot infer causal relationships between the intervention and the subsequent evolution of the case. Even so, we feel it equally fair to stress the fact that E.’s case had developed over a long period, so that, since the age of 17, his life had lacked any kind of stable direction. It is also important to stress that the client was not being treated simultaneously with any type of drug that might obscure or call into question the effectiveness of the intervention carried out, as often occurs in other works (García & Pérez, 2001). Another aspect worth underlining is the excellent therapeutic relationship maintained between E. and the person attending him. It would not be unreasonable to think that the effects of the intervention through ACT were enhanced by this factor. In any case, radical behaviourism, of course, also recognizes the relevance of the therapist–patient relationship (Kohlenberg & Tsai, 1991).

Bearing all of this in mind, we feel it appropriate to make some remarks in relation to the problem and intervention presented here. The first point concerns the present case
and, in general, the importance of the construction of the identity in the development and course of schizophrenia. This idea is far from novel, having been mentioned by numerous authors (Chadwick, Birchwood, & Trower, 1996; Harrop & Trower, 2001; Laing, 1960/1993; Niv, 1980; Sass, 1992). Here we simply wish to add that, before anything else, the construction of the identity is an existential question that, obviously, is not without its difficulties in modern culture (Harrop & Trower, 2001; Sass, 1992). Therefore, a comprehensive approach to schizophrenia cannot ignore either the patient’s social context or the vital problems s/he is facing at the time. In the case of E. we saw the importance of, for example, the concept of the “condemnation to freedom” and, in general, the work on values aimed at enabling the client to develop activities that progressively opened up new roads for him.

A second consideration concerns the relevance that should be attributed to existential questions in therapy supposedly based on acceptance. The founding authors of ACT have studied the types of circumstances in which acceptance would be a good intervention strategy. Thus, for example, they cite those situations in which the very process of change is in contradiction to the desired result (Hayes, 1994) or certain complex contingencies in which a given achievement is necessarily accompanied by some losses (Dougher, 1994). In our view, existential facts (the bodily nature of the human being, our condemnation to freedom, the social nature of man, the finite nature of life, etc.) constitute the area in which acceptance becomes not just a good therapeutic instrument, but the only technique possible. It thus becomes essential for the psychologist (of whatever orientation) to be acquainted with the basic questions that affect any person by the very fact of being human. Indeed, the high profile in recent years of acceptance as a psychological intervention technique demonstrates both the limits of psychotherapy in the solution of human problems and the growing “psychologization” of these problems, which affects more and more sectors of the population. In the face of this, there is a need for a psychology that does not lose sight of the vital and social context in which people act and develop. Thus, not uncommonly, the psychologist’s task is, paradoxically, to “de-psychologize” the problems with which the client comes to the consulting room (Gutiérrez & García, 2001; Pérez, 2001). We feel that in the case presented here it can be appreciated how important it was to play down the psychological variables (believing or not believing that one will achieve the goal, wanting to or not, feeling comfortable or uncomfortable, etc.) as determinants of behaviour. On the other hand, we highlighted throughout the intervention the weight carried by action in the construction of a person’s life and identity.

Finally, we believe it important for both authors coming from the behavioural tradition and those representing existential psychotherapy to be acquainted with the type of work carried out from either perspective, with the goal of achieving mutual enrichment. There are clearly important affinities between the two traditions, and which have long since been identified (Day, 1969; Fallon, 1992; Kvale & Grenness, 1967). The question now is for these actual affinities to become
elective, thus giving rise to new combinations and, in turn, to improvements in health (Pérez, 2001).

REFERENCES


