GRUPO EDITORIAL DE PSICOFUNDACIÓN

Papeles del Psicólogo (2025) 46(3) 211-223

Papeles del Psicólogo
Psychologist Papers

https://www.papelesdelpsicologo.es/ • ISSN 0214–7823 • eISSN 1886–1415

PAPELES DEL PSICÓLOGO
PSYCHOLOGIST PAPERS

Revista del Consejo General de la Psicología de España

Article

Acceptance and Recovery Therapy by Levels for Psychosis (ART): A Contextual and Integrative Model

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ARTICLE INFO

Received: January 20, 2025
Accepted: April 30, 2025

Keywords
Psychosis
Therapy
Cognitive impairment
Acceptance and commitment therapy
Behavioral-contextual science

ABSTRACT

Acceptance and recovery therapy for psychosis (ART) is an innovative psychological intervention designed to address psychotic spectrum disorders from a contextual and integrative perspective. Rooted in acceptance and commitment therapy (ACT) and the principles of behavioral-contextual science, which emphasize the study of behavior in interaction with its environment, ART provides tailored therapeutic strategies to meet the specific challenges of psychosis.This interdisciplinary approach integrates ACT techniques with elements from other therapeutic models, always framed within a person-centered and context-sensitive perspective. Furthermore, ART allows for the flexible adaptation of interventions, adjusting them to each individual's cognitive and functional level. This article presents the key components of the ART model and explores its potential to improve clinical practice by fostering more personalized, values-based care. Ultimately, ART contributes to the development of more effective and meaningful interventions for individuals experiencing psychosis.

Terapia de Aceptación y Recuperación por Niveles para la Psicosis (ART): un Modelo Contextual e Integrador

Palabras clave
Psicosis
Terapia
Deterioro cognitivo
Terapia de Aceptación y Compromiso
Ciencia conductual-contextual

RESUMEN

La Terapia de Aceptación y Recuperación para la Psicosis (ART) es un modelo innovador de intervención psicológica diseñado para abordar los trastornos del espectro psicótico desde una perspectiva contextual e integradora. Basado en la Terapia de Aceptación y Compromiso (ACT) y en los principios de la ciencia conductual-contextual, que enfatizan el estudio del comportamiento en su interacción con el entorno, ART ofrece estrategias terapéuticas adaptadas a los desafíos específicos de la psicosis. Su enfoque interdisciplinario combina técnicas de ACT con elementos de otros modelos terapéuticos, siempre enmarcados en una perspectiva centrada en la persona y su contexto. Además, ART propone una adaptación flexible de sus intervenciones, ajustándolas al nivel de deterioro cognitivo y funcional de cada individuo.Este artículo describe los componentes clave del modelo ART y su potencial para mejorar la práctica clínica, promoviendo una atención más personalizada y basada en valores, con el objetivo de ofrecer intervenciones más eficaces y significativas para personas con experiencias psicóticas.

Cite this article as: Díaz-Garrido, J. A., Laffite-Cabrera, H., Morris, E., Martínez-Huidobro, M. F., Roncancio-Medina, T., Zúñiga-Costa, R., Valenzuela-Hernández, M., & Pérez-Álvarez, M. (2025). Acceptance and Recovery Therapy by Levels for Psychosis (ART): A Contextual and Integrative Model. *Papeles del Psicólogo/Psychologist Papers, 46*(3), 211-223. https://doi.org/10.70478/pap.psicol.2025.46.24
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The treatment of psychosis has evolved from disease-centered approaches to models that prioritize functional recovery and adaptation to the environment. Research has shown that the psychotic experience cannot be explained solely from a biological perspective but rather results from the interaction between biological, psychological, and social factors (McCutcheon et al., 2021; Torrey, 2023; Dumas-Mallet & Gonon, 2020). In this context, current interventions have adopted a person-centered approach, where the assessment of cognitive and functional impairment, along with negative symptomatology, is recognized as a key element to promote recovery and improve quality of life (Anda et al., 2019; Gebreegziabhere et al., 2022; McCutcheon et al., 2023; López-Navarro & Al-Halabí, 2022a, 2022b). This has prompted the development of more integrative therapeutic models, designed to fit individual needs and promote autonomy and functionality rather than focusing solely on symptom reduction (Mc Glanaghy et al., 2021; Morris et al., 2024; Pérez-Álvarez & García-Montes, 2022, 2023).

Nonetheless, there continue to be limitations in the conceptualization and management of psychosis. The preponderance of exclusively biomedical or psychological models has resulted in fragmented treatments, which do not always consider the diversity of experiences of those experiencing psychotic episodes. This highlights the need for more integrative and adaptive approaches, which adapt the therapeutic strategies to the particularities of each individual, respecting their autonomy and decision-making capacity.

Theoretical Foundations of ART

Acceptance and recovery therapy for psychosis (ART) falls within these integrative approaches, combining principles of acceptance and commitment therapy (ACT) with specific adaptations for psychosis. Its approach promotes psychological flexibility, understood as the person's ability to remain in contact with the present moment, to accept their internal experiences without avoiding them, and to act according to their values, even in the presence of distress (Hayes et al., 2011). ART adapts the intervention to the level of cognitive and functional impairment of each person, with strategies adapted to their individual values and goals (Díaz-Garrido et al., 2021a, 2021b).

ART incorporates neuropsychological assessment as a key tool to adjust interventions to individual cognitive abilities. This approach facilitates adaptive and progressive learning processes, without focusing exclusively on the etiology of the disorder (Green et al., 2020; Kahn & Keefe, 2013; Vita et al., 2024). In addition, ART emphasizes an active recovery, where the person has a central role in the management of his or her treatment, promoting informed decision making regarding psychological, pharmacological, or combined therapeutic options. Recent evidence indicates that, in certain cases, minimal or no use of antipsychotic medication may be associated with better long-term functional outcomes, reinforcing the importance of a personalized approach (Cooper et al., 2020; Francey et al., 2020; Morrison et al., 2018).

ART extends its impact beyond individual interventions by implementing an integrated care model grounded in the concept of an expanded therapeutic team. It promotes collaboration among psychologists, psychiatrists, nursing staff, and social workers, while also involving other key contributors to recovery, such as individuals with lived experience of psychosis who have achieved greater functionality, as well as healthcare, security, cleaning, and administrative personnel (Díaz-Garrido et al., 2021b; Laffite et al., 2021).

This approach recognizes the role of all the figures that make up the socio-therapeutic context, from mental health professionals to other people in recovery who may serve as coping models. Thus, ART is presented as an integrative model that combines recent research with flexible clinical application, tailored to the individual needs of those experiencing psychosis.

Thus, ART is positioned as a structured therapeutic model that integrates empirically supported psychotherapeutic tools within a flexible intervention framework, adapted to the individual needs and capacities of people with psychosis.

ART Clinical Strategies

ART is based on four clinical strategies that operationalize its therapeutic application within the ACT framework: contextual dialogism, Zone of Proximal Development (ZPD), More Knowledgeable Other (MKO), and expanded therapeutic team. These strategies allow the intervention to be tailored to each individual's needs, supporting functional recovery aligned with their values and abilities.

Additionally, the strategies address the need to adapt treatment to each person's social context and support dynamics. Not only does ART integrate tools from ACT and other therapeutic approaches, but it also develops specific clinical processes designed to optimize support and integration in various recovery settings.

Contextual Dialogism

Contextual dialogism is a therapeutic strategy aimed at creating a space for open and collaborative conversation, fostering the shared construction of meaning among the person with psychosis, their support network, and mental health professionals. Inspired by the principles of Open Dialogue (Seikkula et al., 2001; Seikkula & Arnkill, 2016, 2019), this approach encourages psychological flexibility by allowing multiple voices to be heard and validated, reducing cognitive and emotional rigidity.

The purpose of contextual dialogism is to facilitate the understanding and validation of the psychotic experiences, reducing isolation and promoting a collective understanding. Through dialogue, a more flexible perspective on reality is fostered, allowing experiences to be reframed and narratives to be generated that support recovery. Several studies have supported its effectiveness in reducing cognitive rigidity and the construction of shared meanings (Bergström et al., 2018; González-García et al., 2023.

Principles of Open Dialogue and Their Application in ART

Contextual dialogism in ART takes as a reference the principles of Open Dialogue, promoting the participation of the person with psychosis and, whenever possible, their support network, including family, friends, and other significant individuals. Through the co-construction of shared meanings, it seeks to integrate multiple perspectives into a more cohesive and functional narrative.

The process follows the fundamental principles of Open Dialogue, such as transparency and horizontal communication. No decisions are made, nor are conversations held about the individual without their presence or consent, ensuring that all exchanges occur within a framework of trust and active participation. The process encourages the construction of a new, shared narrative that incorporates all perspectives without imposing a single interpretation of events.

To facilitate this process, a variety of narrative techniques are employed, including:

- **Externalization:** Differentiating the person's identity from their psychotic experience, promoting a less invasive relationship with their symptomatology.
- **Reflection aloud by the therapeutic team:** Allows all perspectives to be explored without imposing directives.
- **Joint reformulation of the psychotic experience:** The person and their support network construct alternative narratives that reduce the sense of chaos or fatality.
- **Use of open and circular questions:** Expanding the understanding of the events experienced and facilitating the integration of new meanings.

Key Differences With Open Dialogue

While contextual dialogism shares principles with Open Dialogue, ART introduces key differences, aligned with its clinical framework based on ACT and functional contextualism:

- **Therapeutic structure.** While Open Dialogue encourages conversations without a predefined direction, in ART contextual dialogism takes place within a structured framework, designed to encourage flexibility and facilitate processes of cognitive defusion, understood as the ability to distance oneself from thoughts without merging with their literal content.
- **Orientation to personal values.** Beyond generating new shared explanations, the aim is for the person to link their response to what they consider significant in their life, promoting a meaningful recovery.
- **Complementarity with therapeutic strategies.** ART incorporates tools such as deliteralization, emotion regulation, and acceptance of psychotic experiences, whereas in Open Dialogue interventions may be less structured.
- **Relationship with the psychotic experience.** In ART, contextual dialogism helps the person gain distance from their experiences without invalidating them, promoting the integration of new perspectives and facilitating a less threatening relationship with their subjective experience.

To illustrate the application of contextual dialogism, let us consider the following case:

Sofia, 25 years old, has begun to experience critical voices that have led her to isolate herself from her environment. In a contextual dialogism session, her mother and her partner are invited to participate. During the conversation, the mother expresses her fear that the voices signify irreversible deterioration, while her partner acknowledges that they have avoided talking about it for fear of making it worse. Through open-ended questions, exploration of these concerns is facilitated and a broader view is promoted: Sofia shares that the voices increase when she feels isolated and that, although they frighten her, she has also found them to be more manageable when she has support.

In this case, the dialogue facilitated in ART not only allowed the experience to be reframed from a shared perspective, but—unlike in Open Dialogue—principles of psychological flexibility and alignment with personal values were incorporated, helping Sofia to identify strategies that allow her to deal with her experiences without focusing exclusively on their content.

Application of Contextual Dialogism in ART

Following the "immediate help" principle of Open Dialogue (Seikkula et al., 2001), in ART contextual dialogism sessions are initiated as early as possible to provide a safe communication space from the first stages of the intervention. These sessions last approximately 90 minutes, with a recommended frequency of twice a week, adapted to the availability of the support network and the individual needs of the person.

The role of the therapist in this approach is non-hierarchical, functioning as a facilitator of dialogue rather than imposing interpretations or guidelines. This attitude of openness allows the person to explore his or her internal discourse with less rigidity, favoring cognitive distancing and the generation of new meanings.

Contextual dialogism in ART contributes to the expansion of the ZPD by providing an environment in which the individual can progress with structured support. As thinking becomes more flexible and new perspectives are validated, the individual develops greater capacity to cope with psychotic experiences and respond adaptively to their environment.

Zone of Proximal Development in ART

The ZPD, a concept formulated by Vygotsky (1978), refers to the distance between what a person can do independently and what they can achieve with external support. This approach is based on the idea that learning and development occur optimally when the person receives adequate guidance to progress beyond their current level of competence.

In ART, the ZPD functions as a framework for structuring the intervention, adapting the therapeutic challenges to the current capabilities and resources of each individual. Unlike approaches that assume immediate or uniform change, the ZPD in ART encompasses not only cognitive development, but also experiential and functional dimensions, supporting autonomy in recovery. It is activated through interaction with an MKO, who may be a therapist, a member of the support network, or even another person in recovery with higher functioning. This approach facilitates progressive learning, allowing the person to expand their coping strategies and overcome new challenges within a structured supportive environment.

Chadwick's (2006) model has been fundamental in the application of ZPD in psychosis, highlighting the importance of metacognition to improve self-reflection and emotion regulation. His approach has allowed the development of interventions that promote greater awareness of one's own cognitive and emotional

processes, thus facilitating better management of psychotic symptomatology.

ART integrates these advances by applying the ZPD in real learning contexts. Instead of focusing solely on metacognition, ART uses the ZPD as a tool for the progressive acquisition of functional competencies, promoting autonomy through guided experiences tailored to each individual (López-Navarro et al., 2022).

To illustrate the application of the ZPD in ART, consider the following case: Laura, age 35, has stopped going outside alone for fear of experiencing anxiety and hallucinations in uncontrolled environments. She expresses that she would like to regain independence, but the thought of going out without support creates great discomfort for her.

ZPD-based intervention:

1. Current level of competence: Laura does not feel able to go out on her own, but is willing to try if she has structured support.
2. Adapting the level of support: The therapist designs a progressive plan in which Laura first practices in a safe environment, walking in the company of a family member or therapist in quiet spaces.
3. Gradual reduction of support: As Laura gains confidence, she begins to make short journeys unaccompanied, using strategies previously rehearsed in therapy (e.g., attentional focus, emotion regulation, and advance planning of safe routes).
4. Autonomy: Over time, Laura regains the confidence to go out on her own, using the acquired strategies without needing external support.

More Knowledgeable Other

The concept of MKO, formulated by Vygotsky (1978), refers to the individual who facilitates learning by providing structured support to those developing new skills. In ART, this idea is expanded to include not only therapists or members of the support network, but also higher functioning peers and non-clinical personnel who participate in the therapeutic environment, such as security, cleaning, or administrative workers.

What is essential is not the professional role of the MKO but their ability to serve as an accessible and credible role model, promoting learning through modeling and shaping. For this process to be effective, certain key characteristics must be met:

- Perceived similarity: The person identifies with the other and sees their achievements as attainable.
- Affective value: A relationship of trust and respect is established.
- Prestige and effectiveness: The strategies applied have been effective in other cases.

In addition to the impact on the person in recovery, ART emphasizes the training and support of those who exercise this role. To this end, the model incorporates continuous training spaces aimed at strengthening emotion management, acceptance, and values-based action within the broader therapeutic team. This process not only improves the coherence and consistency of the intervention but also contributes to the well-being of those involved in the recovery process (Díaz-Garrido et al., 2021b; Laffite et al., 2021).

By conceiving recovery as a social and shared process, ART makes the MKO central to the individual's functional evolution. Through guided and progressive learning in a safe environment, this approach facilitates the development of new skills and expands the possibilities for action and autonomy in daily life.

Example of MKO application:

Javier, 27, has experienced several hospitalizations due to psychotic episodes and has difficulty maintaining social interactions outside the clinical setting. He expresses a desire to regain the confidence to attend family gatherings without feeling overwhelmed.

Intervention with the Most Knowledgeable Other:

1. Selection of an attainable model: In Javier's therapeutic group, Carla is identified—she has also had psychotic experiences and has worked on regaining her social skills. Her story is similar to Javier's and represents an attainable model.
2. Guided learning process: Carla and Javier participate in group sessions where they practice social situations in a safe environment, with the therapist supervising the interaction.
3. Real-life progressive experience: Carla accompanies Javier in a social activity in the community, providing support in moments of anxiety and reminding him of strategies she herself has used.
4. Autonomy and transfer of skills: Over time, Javier begins to attend family gatherings on his own, applying what he has learned in the process.

Levels of Cognitive and Functional Impairment in People With Psychosis

The need to adapt interventions to improve comprehension, learning, and memory in people with psychosis has been widely recognized in the literature (Chadwick, 2006; Morris, 2019; Pankey & Hayes, 2003). ART proposes a personalized approach, based on a systematic assessment of cognitive and functional impairment, allowing specific strategies to be designed to optimize therapeutic effectiveness.

Classifying levels of cognitive and functional impairment allows interventions to be tailored to individual needs, increasing their effectiveness. This approach aligns with models that combine ACT with cognitive rehabilitation techniques, promoting psychological flexibility and well-being in people with acquired brain injury (Sathananthan et al., 2022).

Cognitive impairment in psychosis varies according to individual and contextual factors (McCutcheon et al., 2023), so its assessment should be dynamic and revisable. Although comprehensive neuropsychological assessments would be ideal, technical and resource limitations often require the use of accessible tools to build a useful clinical profile to guide therapeutic adaptations. For more on recommended neuropsychological tools, see Laffite et al. (2022, 2023).

Based on the results of the neuropsychological assessment, ART establishes a level of cognitive and functional impairment, defined on the basis of key areas such as attention, memory, executive functions, processing speed, and overall functionality:

No Cognitive Impairment or Subclinical (<1 SD)

The person maintains cognitive functioning within the expected range, with skills of abstraction and symbolic thinking that allow them to benefit from standard interventions. When scores in attention, memory, executive functions, and processing speed do not exceed 1 standard deviation (SD) below average, no significant adaptations are required. Interventions follow the classic ACT model, incorporating the specificities of ART, according to individual progress.

Example: Ana, age 26, has experienced psychotic episodes, but her cognitive performance is within normal parameters. She can understand complex metaphors in therapy, reflect on her experience, and apply coping strategies autonomously. Her treatment focuses on psychological flexibility without requiring additional adaptations.

Mild Cognitive Impairment (1-2 SD)

Difficulties are observed in attention, memory, processing speed, executive functions, social perception, emotional processing, and metacognition. At this level, minimal adaptations are implemented, such as simplifying metaphors, increasing repetition, verifying comprehension, and reducing the symbolic load in interventions.

Example: Jose, age 34, has difficulty sustaining attention in prolonged sessions and takes longer to process information. Although he understands the therapeutic strategies, he needs key concepts to be repeated and metaphors to be more concrete. To facilitate his learning, visual examples are used and information is reinforced through summaries and outlines.

Moderate Cognitive Impairment (>2 SD)

Significant deficits are present in the ability to maintain attention, remember information, understand language, and perform symbolization and abstraction processes. Interventions are adapted by reducing the complexity of the tasks, using simpler language, concrete metaphors with guided meanings, and visual support with images or objects. In addition, behavioral strategies are prioritized to promote autonomy, along with a higher frequency of sessions focused on functional recovery.

Example: Elena, 40 years old, has difficulty remembering what was covered in previous sessions and needs clear and structured instructions. She finds it difficult to understand abstract concepts, so physical and visual objects are used in therapy. Her sessions are shorter and are reinforced with repetitive practical exercises to help consolidate the information.

Severe and Highly Limiting Cognitive Impairment (>3 SD)

Severe cognitive limitations are identified that affect daily functioning. Interventions focus on rehabilitation and reinforcement of basic and instrumental daily living skills. In this context, ART principles are applied through modeling and shaping of functional behaviors, adapted to the specific abilities of each individual.

Example: Manuel, age 55, has difficulty remembering recent events, maintaining a structured conversation, and processing new information. In his treatment, instructions must be direct and concrete, with visual aids and frequent repetition. Structured routines and training in basic skills are used, such as remembering his daily schedule or practicing functional responses in social interactions, with the support of the therapeutic team and his support network.

These strategies ensure that ART interventions are both relevant and effective, optimizing the functionality and quality of life of people with psychosis. Below, Table 1 summarizes the specific adaptations proposed by ART according to the level of cognitive and functional impairment, facilitating their practical application.

Table 1
ART Adaptations According to Level of Impairment and Neuropsychological Functions Assessed (Adapted From Laffite et al., 2023)

Neuropsychological function	Mild impairment	Moderate impairment
Attention	Slightly shorter sessions with reduced content. Use of guiding metaphors to redirect attention.	Shorter sessions with limited content. Use of guiding metaphors to redirect attention.
Memory	Maximum of two ACT components per session (acceptance, defusion, goals, action). Plus repetition and visual or written support.	Individual interventions with more repetition. Use of graphic or written materials adapted to strengths and deficits.
Executive functions	Structure of the session at the beginning. Use of diagrams and reminders of previous and current content.	Structured information at the beginning and in writing. Diagrams and frequent reminders of the content of the sessions.
Processing speed	Adapted pace of language with more marked pauses to facilitate comprehension.	Adapted pace of language with more marked pauses to facilitate comprehension.
Metacognition and social cognition	Recognition and discrimination of emotions. Clear and simple language with outstanding communicative elements.	Recognition and discrimination of emotions. Clear and simple language with outstanding communicative elements.
Abstraction	Reduction of the symbolic or metaphorical content in language.	Complete elimination of the symbolic or metaphorical content in language.

Table 2 presents ART's therapeutic strategies, organized by levels of intervention. These strategies allow for a flexible and personalized approach, aligned with the values of each individual. In addition, the table serves as a practical guide for adapting interventions according to cognitive and functional impairment, as well as the individual characteristics of each case.

Therapeutic Processes Based on ACT

ART integrates the six main processes of ACT (Hayes et al., 2011), especially within the therapeutic intervention phase:

1. **Generating creative hopelessness:** Helping the person to recognize the ineffectiveness of previous distress-control strategies, promoting openness to new ways of coping.
2. **Control as the problem, not the solution:** Exploring how struggling with psychotic symptomatology can intensify suffering, encouraging a more flexible relationship with internal experiences.

Table 2
Adaptation of Techniques and Therapeutic Aspects According to Intervention Levels (Adapted From Zúñiga et al., 2023)

Category	Acute	Stable without deterioration	Stable, slight deterioration	Stable, moderate deterioration	Stable, severe impairment
Type of language used	Clear and precise language to avoid misinterpretation. No prolonged silences, use of paraphrases.	Usual language, paying attention to interpretative aspects.	Limited use of symbolism. Speak slowly to facilitate understanding.	Simple and repetitive language. Exercises guided by the therapist.	Simple and direct language. Conversation completely guided by the therapist.
Functional recovery	Focused on personal values.	Focused on personal values.	Simple value-based actions, such as establishing daily routines.	Behavioral activation linked to values and instrumental activities of daily life.	Very simple actions linked to values and basic activities of daily life.
Mindfulness	Short sessions with emphasis on anchors and verbal guidance.	Gradually progress towards autonomy in simple practices.	Prioritize informal and simple practices, with a greater number of guided practice sessions.	Short, physically centered practices, always guided.	Guided practices only; alternatives such as yoga or tai chi.
Spiral process	Abbreviated, focused on reducing discomfort.	Full spiral, the whole process is feasible.	Slow progression, prioritizing functional exposures.	Partial use of the spiral, without completing it.	The spiral does not apply.
Metaphors	Metaphors related to general discomfort. Constant guidance to clarify meanings.	Specific metaphors for current problems.	Limited use of metaphors, reinforced with physical elements.	Prioritize simple metaphors and physical exercises, avoiding symbolism.	Restricted use of metaphors; assess individual ability to apply them.
Contextual dialogism	Introduce as soon as possible.	Viable.	Viable.	Use of classic family therapy.	Use of classic family therapy.

Note: Acute: Critical period with predominance of positive symptoms and disorganization; Stable without deterioration: Remission phase without significant cognitive impairment; Stable with mild/moderate/severe deterioration: Progression in functional and cognitive impact.

3. **Language deliteralization:** Facilitating distancing from psychotic thoughts without trying to eliminate them, promoting less cognitive fusion with the hallucinatory or delusional content.
4. **Self as context:** Developing a more flexible and less fused identity with psychotic symptoms and the associated stigma, supporting a broader self-perspective and reducing rigidity in self-perception.
5. **Values clarification:** Identifying what gives meaning to life beyond symptoms, providing direction for recovery.
6. **Acceptance and commitment:** Integrating coping strategies based on committed action, promoting behaviors aligned with personal values even in the presence of difficult internal experiences.

These processes are applied transversally throughout the different phases of psychosis, integrating dialogic principles in the work with families, groups, and therapeutic teams. In addition, ART adapts its interventions according to the level of cognitive and functional impairment, ensuring that strategies are accessible and applicable for each person.

Intervention in ART

The ART intervention is organized around a progressive and adaptive scheme, adjusting therapeutic strategies according to the individual's progress and context. Its application is flexible, allowing its implementation in community facilities, short- and long-stay hospital units, as well as in outpatient sessions, within both public and private services.

To promote treatment adherence and understanding of therapeutic goals, sessions follow a clear and predictable organization. A structured framework facilitates active participation in the recovery process, ensuring that therapeutic strategies are accessible and understandable (Morris, 2019).

Phases of ART intervention

ART structures its intervention in three main phases, which allow for a therapeutic progression adapted to the level of functional and cognitive impairment:

Evaluation and Orientation Phase

A detailed assessment of cognitive and functional impairment is carried out, establishing therapeutic objectives according to the person's values and determining the most appropriate strategies.

Therapeutic Intervention Phase

Multidimensional strategies are implemented, integrating ACT, contextual dialogism, ZPD, and other evidence-based therapeutic strategies. The intervention is adapted according to clinical progress and individual needs.

Sessions can be conducted in individual, group, or family format, depending on the therapeutic objectives and the context of application. Group sessions follow a structured approach based on ACT phases (O'Donoghue et al., 2018), allowing for the progressive integration of therapeutic processes in a format adapted to the needs of the participants. This format facilitates experiential learning, peer interaction, and the consolidation of therapeutic skills in a safe environment.

Consolidation and Maintenance Phase

Achievements are reinforced, fostering autonomy and long-term functional recovery. At this stage, the intervention focuses on

committed action, promoting behaviors aligned with the individual's personal values.

Therapeutic Objectives in ART

The objectives of ART correspond to those described by Wilson and Luciano (2002), with an approach adapted to functional recovery in psychosis:

1. **Values clarification:** Identifying what really matters to the person, beyond the diagnosis.
2. **Acceptance of private events linked to what cannot be changed:** Reducing the struggle with persistent symptoms and encouraging psychological flexibility.
3. **Strengthening of the self as a context:** Developing an identity that is less fused with psychotic symptoms, allowing for greater flexibility in self-perception.

ART emphasizes that recovery does not mean "curing" the person, but rather expanding their possibilities for action in the present. The intervention is oriented toward building a meaningful life, using acceptance as a central tool rather than fixating exclusively on goals that depend on changes in symptomatology (Morris, 2019).

Therapeutic Strategies According to the Clinical Stage

ART adapts its therapeutic strategies based on the clinical stage, guaranteeing a tailored intervention at each stage of the therapeutic process.

Preventive and Early Intervention

In the initial phases, ART prioritizes the promotion of psychological flexibility and the prevention of chronic distress. The use of rigid diagnostic labels is avoided, and work focuses on identifying patterns of experiential avoidance, facilitating strategies that expand the behavioral repertoire and reduce vulnerability before limiting functioning dynamics become established.

Stigma—whether social, self-inflicted, or iatrogenic—represents a significant obstacle to recovery (Díaz-Garrido et al., 2021b; Laffite et al., 2023). In particular, iatrogenic stigma, generated by overprotective attitudes in the healthcare system, can reinforce expectations of incapacity, leading to restrictive diagnoses, premature hospitalizations, and the inadvertent promotion of disability. This limiting approach not only restricts the autonomy of the person but also reduces their capacity for self-determination and development. Furthermore, attributing mental health problems exclusively to biological causes has been associated with greater professional stigma and poorer therapeutic outcomes, especially when there is a discrepancy between the "patient's" perspective and that of the healthcare team (Rosenthal Oren et al., 2021; Valery & Proteau, 2020).

To counteract these effects, ART promotes a therapeutic vision that challenges clinical pessimism and rigid narratives about psychosis. The need is emphasized to form therapeutic teams capable of questioning limiting beliefs, broadening the understanding of the recovery process, and fostering dialogues aligned with the Personal Recovery movement. This involves a paradigm shift: replacing the presumption of incapacity with a perspective that prioritizes values, individual abilities, and the construction of a meaningful life.

Main strategies in this phase:

- Identifying and working on patterns of avoidance and cognitive rigidity, analyzing how these dynamics limit recovery, and promoting more adaptive alternatives.
- Development of psychological flexibility through metaphors and experiential exercises, using symbolic comparisons and experiential activities to help the person generate new perspectives and ways of coping with their experience.
- Introduction of emotion regulation strategies and adapted mindfulness, providing tools that help the person to observe and manage their emotions without reacting impulsively to them.
- Working with the support network to foster a context that facilitates recovery, promoting family and community dynamics that reinforce autonomy and reduce invalidation.

Outpatient Treatment and Follow-Up in the Public/Private System

In this phase, ART focuses on the consolidation of therapeutic strategies for functional recovery, ensuring the maintenance of the achievements reached and the continuity of the committed direction towards personal values. Intervention is not only aimed at relapse prevention but also at the integration of coping strategies into daily life, promoting active participation in areas that are meaningful to the individual.

Main strategies in this phase:

- Strengthening of committed action and values-driven work to promote social and professional reintegration.
- Application of cognitive defusion techniques to reduce fusion with psychotic thoughts.
- Use of adapted mindfulness to improve emotion regulation and foster greater acceptance of the inner experience.
- Group follow-up spaces to reinforce adherence to coping strategies and sustain active involvement in recovery.

Intervention in Psychosocial Rehabilitation for Medium- and Long-Term Inpatient Settings

For people with greater functional impairment, ART adapts its intervention to a psychosocial rehabilitation context, prioritizing autonomy and training in basic and instrumental skills.

Key strategies in this phase:

- Interventions focused on reinforcement of functional skills, using consequence-based learning strategies to promote adaptive behaviors.
- Modeling and shaping of functional skills, allowing the person to learn through observation and imitation of adaptive behaviors in everyday environments.
- Implementation of structured routines to facilitate independence, ensuring the repetition of essential activities

and promoting the consolidation of functional habits in daily life.
- Training and support of the extended therapeutic team, enabling professionals and caregivers to provide coherent and effective support within psychosocial rehabilitation contexts.
- Cognitive rehabilitation, focused on improving functions such as memory, attention, and executive skills through adapted structured exercises.

Approach During Acute Symptomatology

During episodes of decompensation, ART adapts its interventions to reduce the functional impact of symptoms and stabilize symptomatology without resorting exclusively to distress-control strategies. Individual, group, and family techniques are implemented focusing on acceptance and reduction of the struggle with psychotic symptoms.

Key strategies in this phase:

- Adapted mindfulness techniques and emotion regulation in crisis. Mindfulness exercises designed for psychosis are used, helping the person to observe their experiences without reacting automatically, thus reducing anxiety and emotional reactivity.
- Brief interventions based on the deliteralization of language. Strategies are applied to help individuals distance themselves from intrusive thoughts or hallucinations, avoiding a rigid fusion with their content without invalidating the experience.
- Restructuring the meaning of the psychotic experience through contextual dialogism. Through collaborative exploration, a more flexible and less threatening understanding of the psychotic experiences is fostered, promoting the co-construction of meaning with the support network.
- Working with the family and support network to reduce invalidation and the impact of the crisis on the environment. Psychoeducation and communication strategies are provided to enhance social support and minimize responses that reinforce isolation or struggling with symptoms.

Specific Strategies for the Management of Psychotic Experiences

ART approaches psychotic experiences from an approach focused on functional recovery, avoiding control strategies that reinforce the internal struggle. To this end, specific techniques have been adapted and developed that allow the person to modify their relationship with these experiences without invalidating or amplifying them (Díaz-Garrido et al., 2021b; Laffite et al., 2022, 2023).

Intervention on Hallucinations: Contextual Focus on Voices

Contextual focus on voices is a therapeutic strategy used in ART to address auditory hallucinations without resorting to control or reinterpretation strategies. Although it shares principles with previous approaches, such as therapy focusing on voices (Bentall et al., 1994), its approach has key differences.

This original approach proposed the reduction of hallucinatory distress through reattribution and cognitive reinterpretation, with the aim that the individual would stop perceiving the voices as external messages and begin to consider them as their own production.

Although ART also seeks to reduce the emotional impact of hallucinations, its approach is not based on modifying the attribution of their origin or their content. Instead, it focuses on transforming the relationship individuals develop with their hallucinations. Rather than aiming for their elimination or engaging in cognitive restructuring, ART encourages an interaction that lessens the internal struggle, reduces the discomfort, and supports a life aligned with personal values.

To this end, mindfulness techniques adapted for psychosis (Chadwick, 2014, 2019; Laffite et al., 2024) are combined with strategies of deliteralization and cognitive defusion, promoting a greater distance from the verbal content of the voices without invalidating the experience. These techniques help reduce fusion with auditory messages and diminish their emotional impact, fostering a more flexible and less invasive relationship with the hallucinations.

The procedure of focusing on the voices within ART is developed through three phases:

1. **Attention to the physical characteristics of the voices.** This begins with a sensory approach, in which the person observes and describes the acoustic qualities of their auditory hallucinations without interpreting or reacting to their content. This allows for greater awareness of the phenomenon and reduces emotional reactivity.
2. **Work with the verbal content of the voices.** Through strategies of deliteralization, cognitive defusion, and experiential exercises, the aim is to modify the relationship with the message of the voices, encouraging greater psychological distance without invalidating the experience. Exercises such as "taking the voices for a walk" can be used, where the person can listen to recordings of their voices in different contexts to encourage gradual and functional exposure. Other strategies include modifying the pitch and pace of the voices, or thought labeling, all designed to reduce the fusion with their verbal content and generate greater psychological flexibility.
3. **Acceptance of discomfort and values orientation.** In this phase, the individual is trained to maintain their committed direction despite the presence of the voices. Metaphors such as the "bus" or the "swamp" (Wilson & Luciano, 2002) are used to illustrate how it is possible to move toward a values-led life without completely eliminating the auditory hallucinations.

To illustrate the application of this technique in clinical practice, consider the following case:

Marcos, 29, has experienced auditory hallucinations since adolescence. The voices are often critical and dismissive, causing him anxiety and isolation. So far, he has tried to ignore them or argue with them, which increases his frustration. In therapy, he expresses that he wants to learn to relate to his voices so that they do not interfere with his daily life.

Intervention based on Contextual Focus on Voices:

1. Attention to the physical characteristics of the voices. In the first sessions, Marcos is guided to observe his voices without interpreting them. He is asked to describe their pitch, volume, pace, and distance, without focusing on their content. He discovers that some voices sound louder in times of stress and that their volume decreases when he is focused on an activity. This exercise reduces their emotional impact and automatic reaction to them.
2. Working with the verbal content of the voices. Marcos learns strategies of deliteralization and cognitive defusion. The "taking the voices for a walk" exercise is used, in which he records phrases similar to those he hears and then plays them back at different times of the day. He notices that although the content of the voices remains the same, their impact varies depending on the context and his emotional state. This helps him create psychological distance and perceive the voices as less threatening.
3. Acceptance of discomfort and values orientation. Over time, Marcos works on adjusting his relationship with the voices to his personal values. The metaphor of the "bus" is used, where he imagines that his voices are noisy passengers, but he continues to drive toward his goals. He accepts that the voices may be present without preventing him from moving forward in his life. As part of his plan of action, he begins to resume social activities that he had previously avoided, focusing on what he considers important beyond his hallucinations.

ART not only addresses auditory hallucinations but also considers other sensory modalities, such as kinesthetic (altered perceptions of one's own body) and multimodal hallucinations linked to traumatic experiences. Given that these experiences may involve multiple senses simultaneously, an effective therapeutic strategy is the integration of adapted mindfulness practices (Laffite et al., 2024).

Intervention on Delusions. Spiral Process

ART approaches delusions from an experiential approach, using the metaphor of "Spiral Process" to modify the person's relationship with their beliefs without resorting to direct confrontation. Rather than debating or invalidating the content of the delusion, priority is given to exploring its functionality and its impact on the person's life.

The Spiral Process is a key ART strategy designed to reduce fusion with delusional beliefs and foster learning based on direct experiences (Diaz-Garrido et al., 2021b; Laffite et al., 2022, 2023). Its purpose is not to change the content of the delusion but to help the individual develop a more flexible relationship with their experience, promoting acceptance, mindfulness, and connection with their personal values.

This process is based on the construction of an empathic and respectful therapeutic alliance, adopting a neutral stance towards the delusional narratives. Instead of focusing on modifying these beliefs, the aim is for the person to live a meaningful life, guided by their values, even in the presence of the delusion.

ART and the function of delusions. From a phenomenological and contextual perspective, some authors have proposed that delusions are not mere distortions of reality, but attempts to make sense of unusual or disturbing experiences (Deamer & Wilkinson, 2021; García-Montes et al., 2013, 2021). In this approach, delusions form part of a personal narrative that helps the person to structure and give meaning to experiences that may be destabilizing.

In addition, it has been proposed that delusions may act as experiential avoidance strategies, allowing the person to avoid painful emotions, thoughts, or memories (García-Montes et al., 2013, 2021). In this sense, delusional content could serve as an alternative explanation that diverts attention from disturbing internal aspects, functioning as a psychological regulation mechanism.

ART aligns with this perspective, recognizing that delusions not only serve a regulatory function in behavior but also reflect active attempts to cope with challenging private events. Rather than attempting to modify their content, ART facilitates the exploration of their meaning and their role in the person's history, promoting more flexible ways of relating to these beliefs.

From this standpoint, ART seeks to reduce the experiential avoidance associated with delusions by encouraging acceptance of internal experiences and promoting a more open relationship with them. By decreasing the need to suppress or avoid these experiences, individuals are better able to engage in actions aligned with their personal values, even in the presence of difficult thoughts or emotions.

The Spiral Process integrates different therapeutic strategies, including:

- **Fostering of the therapeutic alliance** and a non-punitive audience. Priority is given to building a bond based on trust and validation, avoiding directive or confrontational approaches. The aim is to provide a safe space where the person can express their experiences without fear of being judged or punished, facilitating openness to the therapeutic process.
- **Functional analysis of delusions** to understand their function in the person's life. The antecedents and consequences of delusions are explored to identify their function in behavioral regulation. Rather than considering delusions as cognitive distortions, the analysis focuses on how they operate within the individual's behavioral repertoire, the reinforcers that maintain their use, and how they facilitate the avoidance of aversive private events or the functional reorganization of experience.
- **Controlled exposure** to triggers using "functionality traps", promoting a less rigid relationship with the delusional belief. Exercises are designed in which individuals can observe their responses to specific situations that activate their delusion, assessing whether the delusion helps or limits them in pursuing their values. This allows for the development of functional doubts about the need to cling to the belief.
- Use of **experiential tools**, such as metaphors and mindfulness, to generate new perspectives. Through mindfulness exercises and therapeutic metaphors, individuals are encouraged to distance themselves from their delusional narrative without directly confronting it. Strategies such as the "passenger on the bus" metaphor or adapted mindfulness are used to allow the observation of thoughts without rigid adherence to their content.

Each of these strategies encourages a narrative that is less fused with the delusional content, promoting engaged action and guiding the person toward a valuable and functional life.

Stages of the Spiral Process. The stages of the Spiral Process are depicted in Figure 1, where each phase reflects a progressive step within a dynamic and adaptive framework. From functional analysis to values-based commitment, these stages support gradual movement from the periphery of the delusion toward a more integrated narrative aligned with personal values.

This approach not only recognizes the uniqueness of each individual but also facilitates the development of adaptive strategies to cope with the challenges associated with psychosis, promoting functional recovery without the need to completely eliminate the delusional experience. To illustrate the application of the Spiral Process in ART, the following case is presented:

Luis believes that his coworkers are conspiring against him to sabotage his performance. Because of this, he avoids meetings, minimizes his interactions, and has turned down promotion opportunities for fear of being exposed.

Phase 1: Establishment of the Alliance and Functional Analysis

In the first sessions, the therapist avoids directly confronting the certainty of the delusion. The focus is on how this belief affects Luis's life and what emotions he attempts to manage through his isolation. The antecedents of the delusion are explored, identifying that it arose after an experience of exclusion in a previous job. His experience is validated without reinforcing it, using therapeutic mirroring to create space for exploration. The distinction between the perception of threat and its impact on his daily life is also introduced, avoiding questioning the veracity of the delusion.

Phase 2: Functional Self-Exposure and Functionality Testing

Luis begins to engage in small interactions at work without automatically avoiding his coworkers.

1. Behavioral experiments are designed, such as writing predictions about what he believes will happen in a meeting and comparing them with the reality afterward.
2. Deliteralization exercises are used, helping him notice how the context influences the interpretation of his experiences.
3. The metaphor of the "observer at the window" is introduced, promoting psychological flexibility in the interpretation of his thoughts.

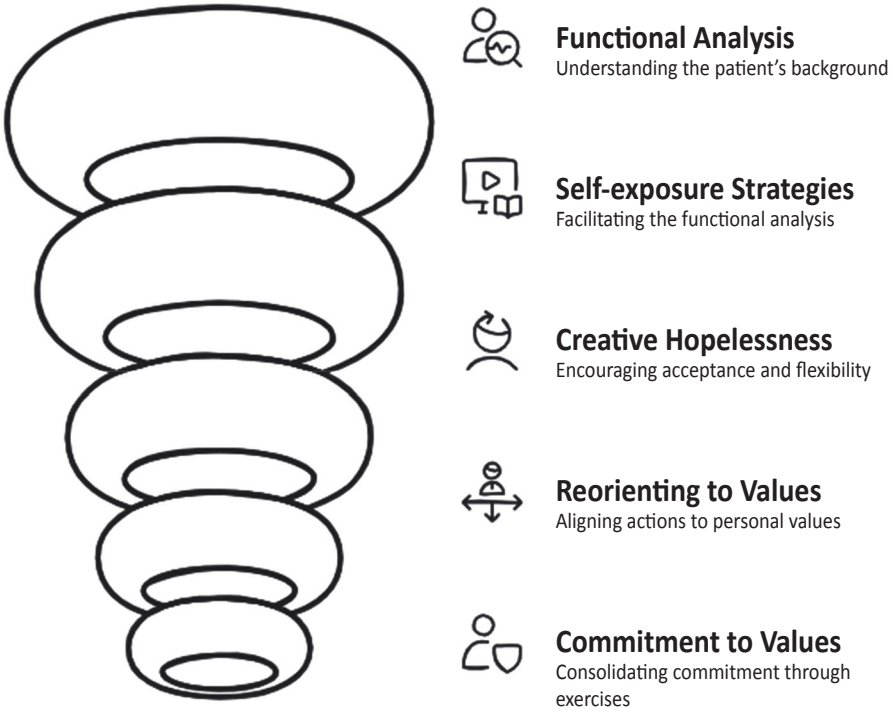
Phase 3: Creative Hopelessness and Emotion Regulation

Luis begins to notice that his attempts to avoid his coworkers have not reduced his discomfort but have instead reinforced his isolation and anxiety at work.

1. The ineffectiveness of his previous control strategies is explored, assessing whether they have improved or worsened his well-being.
2. The metaphor of the swamp is used, illustrating how the struggle against his thoughts has led him to feel more trapped.
3. Adapted mindfulness is introduced, allowing him to observe his thoughts without reacting impulsively to them.

Figure 1

Graphical Representation of the Stages of the Spiral Process



Note. The spiral illustrates the gradual progression through the stages of the Spiral Process: functional analysis, functional self-exposure, creative hopelessness, reorienting towards values, and commitment to personal values. Author's own work.

Phase 4: Redirection Towards Committed Values and Actions

Luis recognizes that beyond his fear, he values job stability and professional development.

1. He works on connecting his actions with these values, promoting small behavioral changes.
2. The metaphor of the "bus" is used, where he learns that he can keep driving his life forward despite his anxious thoughts.
3. He engages in actions such as attending meetings without avoiding eye contact and soliciting feedback on his performance.

Discussion

ART falls within contemporary approaches that seek to address psychosis from a contextual, flexible, and functional recovery-oriented perspective. Based on Acceptance and Commitment Therapy (ACT), it not only integrates strategies from previous models but also develops and adapts interventions to suit different levels of cognitive and functional impairment. Its purpose is to provide a structured framework that allows the treatment to be customized to individual needs.

Although it shares principles with previous models, ART is not simply a combination of existing approaches but a proposal that structures its application in a systematic and adaptive manner. Although ACT already promotes an idiographic framework, ART operationalizes this flexibility through a progressive, tiered intervention model based on levels of cognitive and functional impairment, thereby enhancing clinical precision. Similarly, Open Dialogue emphasizes the co-construction of meaning within a supportive network, while ART incorporates these processes within a structured therapeutic framework, aligned with psychological flexibility and connection to personal values.

Other models have approached psychosis from similar perspectives. Metacognitive Therapy (Moritz & Woodward, 2007) focuses on modifying cognitive biases, while ART avoids intervening directly in the veracity of beliefs and focuses on the relationship that the person establishes with them. Likewise, Mindfulness-Based Therapy for Psychosis (Chadwick, 2019) has shown benefits in reducing emotional reactivity to hallucinations—a strategy that ART also adopts, but in combination with intervention in support networks and adaptation to different levels of cognitive and functional impairment.

From a broader perspective, ART emphasizes the importance of a multilevel and interdisciplinary approach in psychosis intervention. Beyond individualized care, it considers the impact of the environment on recovery, facilitating connection with support networks and promoting learning within this context. By integrating cognitive and functional impairment into treatment planning—and by involving both the support network and the extended therapeutic team—ART provides a flexible structure that allows interventions to be tailored with greater precision. In this sense, it is not intended to replace existing models, but rather to provide a framework that facilitates their application in clinical practice and optimizes collaboration between different therapeutic agents.

To date, clinical experience with ART has shown promising results in terms of functional recovery and improved quality of life. However, empirical studies evaluating its efficacy have not yet been published, so its differential impact compared to other models requires more rigorous research. For its consolidation, it will be essential to conduct feasibility, efficacy, and effectiveness studies in different clinical contexts.

The development of therapeutic approaches to psychosis continues to evolve, and ART is presented as a proposal under construction, the refinement of which will depend on the evidence accumulated in the coming years. Its emphasis on functional recovery and the personalization of interventions make it a model with clinical potential, but its consolidation requires rigorous empirical evaluation to determine its efficacy and establish its place within the current landscape of psychosis interventions.

Sources of Funding

This work did not receive specific funding from public sector agencies, or commercial or non-governmental organizations.

Conflict of Interest

The authors expressly declare that there is no conflict of interest.

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