

CBT for Psychosis: An Introduction

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Introduction

Many readers of this book will recall a time when the predominant view within psychiatry was that talking therapies were not recommended for people diagnosed with schizophrenia. The past 10 years have seen a rapid expansion of an evidence base that has overturned this traditional view. Cognitive behavioural therapy (CBT) for schizophrenia is now recommended as part of routine clinical practice within a number of countries, including the United Kingdom and the United States. One consequence of this rapid rate of change is the need for widespread dissemination of this psychological intervention. Attempts have been made to meet this need through the publication of a number of treatment manuals, as well as an increase in the availability of training events.

The evidence base of CBT for schizophrenia was first developed through a generic intervention aimed at the relatively stable 'medication-resistant' group. However, as those readers who are trained clinicians will be aware, a diagnosis of schizophrenia is associated with a wide range of presentations. Consequently there have been recent developments within distinct protocols aimed at specific presentations and phases of the disorder. The aim of this book is to bring together these recently developed evidence-based protocols.

Although the interventions described within this book have key differences, which have been developed for specific target groups, they all rely on the basic engagement skills that are required when working with individuals diagnosed with a psychotic disorder. This chapter therefore aims to cover generic information, which will form the background to all following chapters. The chapter will cover four main areas: (i) a brief introduction to the symptoms associated with schizophrenia, (ii) the generic cognitive model of schizophrenia, (iii) generic clinical skills required when adopting CBT for schizophrenia, and (iv) a brief review of the evidence base of CBT for schizophrenia.

Schizophrenia

Schizophrenia is the most commonly diagnosed form of psychotic disorder. The most common symptoms are hallucinatory experiences and delusional beliefs. These are often referred to as the 'positive' symptoms of schizophrenia. The vast majority of CBT protocols for psychosis are aimed at these positive symptoms.

Hallucinations

Hallucinations are frequently considered to be sensory perceptions of stimuli that are not really there. While auditory hallucinations are the most common form, and have received the most attention from clinical researchers, they may occur within any sensory modality. Although the perceived auditory stimuli may be of general noises or music, they are most often in the form of a voice, or voices. They may be judged to originate from either inside the head or outside the head, may be experienced as male, female or alien voices, and there may be either single or multiple voices. The type of communication originating from the voice may come in many forms including 'voices commenting' in which the perceived voice makes frequent comments on the actions and thoughts of the voice hearer and 'command hallucinations' in which the voice-hearer is given direct instruction on how to act (see Chapter 2).

The work of Marius Romme and Sandra Escher in the late 1980s helped to highlight the relatively prevalent occurrence of voice hearing and to challenge the traditional psychiatric view, in which voices are the symptom of an illness. Their seminal work started with Romme, a social psychiatrist, and one of his voice-hearing patients appearing on a Dutch television programme and inviting viewers to contact them if they had heard voices. Hundreds of viewers responded with the majority having never received

psychiatric attention. This event led to a research programme focussing on how individuals, who had heard voices, but remained outside the psychiatric system differed to those who had received a diagnosis (Romme and Escher, 1989).

Since then, several studies have suggested that around 3 percent of the population will experience hearing a voice at some point during their lives (Johns *et al.*, 2004). These experiences will vary enormously within a number of different dimensions, and require careful assessment. One aspect of the voice-hearing experience which has received attention is that voice-hearers develop relationships with their voices, and that these relationships need to be considered during therapy. This perspective makes sense when one considers that an individual may have heard the same voice, which they attribute to a single person, every day for many years.

Perhaps the main impact of the work of Romme and Escher was to introduce the concept of 'normalization' into therapy. That is, to discuss with voice hearing clients the fact that there are many other voice-hearers, many of whom cope with or even enjoy their voice hearing experiences. This can often liberate a client from feeling trapped and alone with their experience. An introduction to voice-hearing groups can further facilitate this process.

The main issue for all therapists to consider would seem to be whether an individual's voice hearing experience is causing them distress. Traditional psychiatry would have viewed all voice hearing experiences as a symptom of illness, which required treatment. However, recent work suggests that we cannot assume a voice-hearing experience is distressing. Given that therapy is aimed at the reduction of distress, it would seem that non-distressing voices should not be a target for therapy. However, it should be remembered that voice-hearing experiences can fluctuate rapidly and that careful assessment is required.

Delusions

Delusions are the most common symptom associated with a diagnosis of schizophrenia, being present in around 75 percent of those receiving hospital care (Maher, 2001). A common definition of a delusion is that of a fixed false belief that is held in the face of evidence to the contrary. Delusional beliefs often need to be understood within the context of hallucinatory experiences. For example, a belief that someone is themselves the son of God may be fuelled by the experience of hearing a voice that tells them so. The most common of these beliefs are *Delusions of Persecution*, which tend to be associated with a paranoid presentation. Such delusions typically involve the belief that one is being spied on and/or is under threat

due to some kind of organized conspiracy. The sufferer may feel threatened by government agencies, God or the Devil, their neighbours or by family members. Fenigstein (1996) described paranoia as a disordered mode of thought dominated by an intense, irrational, but persistent mistrust or suspicion of people and a corresponding tendency to interpret the actions of others as deliberately threatening or demeaning. *Delusions of Grandeur* are associated with a belief that one is a powerful and/or famous figure (e.g. Jesus). It is quite common for such individuals to also believe that they are being persecuted, and that the persecution is a result of their famous identity. Another form of this symptom is *Delusions of Control*, in which an individual believes their thoughts and actions are being controlled by an outside agent. A commonly reported experience within schizophrenia is that certain external events are perceived to contain special messages, for example within a news broadcast or within the lyrics of a song on the radio, and these are termed *Delusions of Reference*.

As with auditory hallucinations it is important to consider whether the symptoms associated with a diagnosis of schizophrenia are found within a non-clinical population, and if so what this means regarding clinical interventions. Several surveys have highlighted the prevalence of beliefs in the paranormal and other unusual beliefs within the non-clinical population. One important study highlighted how the beliefs of a psychiatric population could not be distinguished from those of new religious movements on the basis of content alone, but only by consideration of the dimensions of controllability and distress (Peters *et al.*, 1999). There are also reports of a range of paranoid beliefs occurring throughout the non-clinical population (Freeman *et al.*, 2005).

As with hallucinations, the therapist needs to consider whether the experiences an individual is reporting is distressing or not, and therefore whether they should be a target of therapy. While an individual may be expressing highly unusual beliefs, for example, relating to alien abduction, this may not be a cause of concern to them. Again, careful assessment is required.

Cognitive Behavioural Models of Psychosis

The early application of psychological models to schizophrenia was predominantly a simplistic application of learning theory, which gave rise to basic interventions. However, the development of cognitive behavioural models for affective disorders had a significant impact on psychosis research within the late 1990s. This work highlighted the extent to which the development and maintenance of a psychotic presentation could be understood with reference to psychological processes already associated

with anxiety and depression. The traditional psychiatric view of schizophrenia was challenged in that therapists were encouraged to engage directly with the content of psychotic symptoms.

Early work was based on the view that the basic cognitive model could be applied to the symptoms of psychosis. Perhaps the primary rule within the cognitive approach is that it is not experiences which distress you, but the way you make sense of them. Thus, someone ignoring you is only upsetting if you believe that they saw you and that they ignored you on purpose. The same principle was applied to voice hearing experiences by Paul Chadwick and Max Birchwood (1994, 1995). They showed that the distressing affect and behaviour arising from hallucinations were not simply the result of the content of the voices, but reflected the voice hearers' appraisal of the voices. They suggested that the hallucination is, therefore, seen as an activating event (A), which is then appraised by the individual in the context of their belief system (B), and which consequently leads to emotions and safety behaviours (C). The authors argue that this forms a cognitive-emotional-behavioural mechanism that maintains the belief in the power and dominance of the voice.

Two influential cognitive models of the positive symptoms of psychosis have since been proposed by Philippa Garety and colleagues (2001) and Tony Morrison (2001). Both of these models incorporate the role of negative core beliefs, hypervigilance for threat, scanning for confirmatory evidence and safety behaviours. In essence they concur that a psychotic presentation may evolve out of the presence of unusual experiences, with a critical factor being how these experiences are interpreted. Such experiences may include hearing voices, strong déjà vu, dissociative experiences such as derealization and intrusive thoughts or images. Psychosis is associated with such experiences being interpreted as negative, threatening and external and leading to hypervigilance and safety behaviours. For example, an individual who 'hears a voice', and decides that this perceptual experience is due to a lack of sleep is likely to have a different outcome to an individual who decides that the Devil is speaking to them with bad intent.

While many of the treatment implications of these two models overlap, one of the key theoretical distinctions is the extent to which the core unusual experiences are 'normal' or are anomalous biologically based phenomena. Garety *et al.* (2001) refer to the potential role of a genetic vulnerability for the propensity to some of these experiences, whereas Morrison focuses on the extent to which these phenomena are normal and that it is the interpretation of these experiences that is critical. In particular, Morrison focuses on the role of common 'intrusive experiences' such as intrusive thoughts and images that may form the basis of an unusual experience for some individuals. However, both models highlight the critical role of the appraisal of the unusual experience in determining whether an

individual arrives at a 'psychotic' explanation. Therefore, while incorporating the generic cognitive model of anxiety and depression, these models also enable the formulation of the development of psychotic symptoms. A major strength of these models is that they incorporate a wide range of psychological processes that have been associated with psychosis, and have the potential to be flexible enough to enable the formulation of the heterogeneous range of psychotic presentations.

Cognitive behavioural models of psychosis (e.g. Birchwood, 2003; Garety *et al.*, 2001; Morrison, 2001) all emphasize the central role of emotional dysfunction as a precursor, and consequence of, the symptoms of psychosis. These influential models also suggest that cognitive appraisals and perceptions concerning the nature of psychotic symptoms (including hallucinations) will influence the maintenance or recurrence of symptoms through coping responses, emotional dysfunction and cognitive processes such as reasoning biases.

CBT for Psychosis

In recent years a number of predominantly UK based clinical researchers have publicized the potential for an individualized formulation based cognitive behavioural approach to schizophrenia (e.g. Morrison, 2002; Kingdon and Turkington, 2005). Such an approach, as for other disorders, is based on the integration of developmental experiences and current beliefs and behaviours. The aim is to develop a personal account of the development and maintenance of currently distressing experiences that is less threatening than the beliefs that are currently held. This aim is particularly relevant for people diagnosed with schizophrenia, as their current explanations are usually limited to, for example, in persecutory delusions, either (a) 'It is all true, people are out to get me' or (b) 'I am insane, I cannot trust my thoughts, I must take medication for ever'.

It is important to note that cognitive behavioural therapies for psychosis have developed in line with theoretical developments in our understanding of psychotic phenomena. CBT for psychosis aims to help an individual make sense of psychotic experiences by making links between emotional states, thoughts and earlier life events. Assisting people to make sense of psychotic and emotional experience by discussing psychological formulations can help them make connections between seemingly unconnected events or beliefs and disabling, distressing psychotic symptoms. The individualized, emotion-focussed nature of CBT for psychosis facilitates the engagement process. However, there are a number of generic issues that therapists need to be aware of when working with individuals diagnosed with a psychotic disorder.

Engagement within CBT

Fowler *et al.* (1995) suggest that CBT starts with a comprehensive engagement and assessment phase. This establishes a working collaborative therapeutic relationship, and allows for the collection of information that will inform cognitive-behavioural formulation. Specifically, therapists must be sensitive to issues of mental state, active hallucinations and specific delusional beliefs when engaging, assessing, sharing formulations and conducting interventions.

The clinician should be mindful that a voice hearer, for instance, may initially not wish to discuss their experiences and that a level of trust may first need to be gained. Problems for engagement may include the voice hearer being concerned that they may be sectioned or have their medication increased if they discuss their voices. This issue can be addressed overtly with the clinician stating whether or not these assumptions are correct. It may also be the case that the voice is telling the voice hearer not to discuss anything with the clinician, and may even make threats of violence or death. The clinician will not be in a position to know this information until trust is gained, and they should therefore be mindful of this possibility and observe any discomfort or anxiety when they enquire as to voice content.

The clinician will need to establish a level of trust before the client will disclose their specific and sometimes delusional beliefs. As well as being fearful of how the clinician may respond, it may be that the client has incorporated the clinician and the psychiatric system into a paranoid belief. As with hallucinations, the clinician should not be too distracted by the level of conviction a patient exhibits for a belief that has been diagnosed as delusional. A wider assessment should be conducted in order to clarify the clinical problems of most significance.

When individuals have experienced traumatic events it is especially important to allocate time early-on in CBT for the opportunity to discuss this. Therapists should be mindful of sensitively assessing trauma-related intrusions (e.g. intrusive memories, dreams), arousal (e.g. heightened startle response, hypervigilance) and avoidance symptoms (e.g. specific behavioural avoidance of reminders, thought and memory suppression). Also, therapists should assess the meaning of any trauma to an individual and any trauma related secondary appraisals (e.g. 'I will never get over this' or 'I just can't trust myself anymore').

Sometimes individuals will understandably and deliberately avoid discussion of their traumas or indeed their symptoms more generally. Trauma memories (which might relate to previous experiences in the psychiatric system such as being sectioned) can be accompanied by extreme emotional responses. A gentle approach in the assessment stage,

assisting and facilitating feelings of safety when disclosing information about traumatic experiences, can become a systematic strategy to help to overcome avoidance and manage the processing of strong emotion and extreme negative thinking that can accompany disclosure. Sometimes it may be appropriate for the therapist to directly address the client's negative thinking about what the therapist may think of the client after the disclosure. Often trauma or symptom disclosure can be accompanied by thoughts that the therapist will regard the person negatively. Reality testing of such views within sessions using careful and systematic cognitive therapy approaches (where the therapist's opinions can be regarded as a test) can be useful in starting work on addressing extreme negative views of self (e.g. I am bad, dirty, unclean, disgusting) and others (e.g. others will view me as bad and dirty and reject me).

Individuals who have been abused are likely to find it particularly difficult to establish trust within a therapeutic relationship, and this should be acknowledged. There is also the possibility that the client may have previously disclosed their trauma history, but not been believed, which will further complicate the development of trust. More specifically, the clinician should be mindful of the setting of their clinical sessions. If this is within a psychiatric institution, the client may have experienced some traumatic events within such an institution that may contribute to heightened vigilance, the triggering of stressful memories and avoidance. This should be dealt with as early as possible by openly discussing whether this issue is relevant to the particular client, and how it can best be dealt with.

The initial aim for the clinician will be to establish engagement but also simultaneously educate the patient into the broad framework of the cognitive behavioural approach. That is, collaborative, goal focussed and time-limited. Given that CBT usually involves a certain amount of homework, and the need to build on the contents of previous sessions, care should be taken to ascertain whether any cognitive functioning deficits interfere with this process. Should this be the case then, wherever possible, adaptations should be made. This is likely to include repetition of the contents of a session, and making sessions shorter. As CBT interventions are short-term it is useful to include other professionals involved in the long-term care of the patient in the process, especially towards the end of the intervention. This will be essential if the sessions have focussed on some form of relapse prevention plan or crises plan to be implemented, if required, in the future.

Any therapeutic intervention should begin with a collaborative development of treatment goals, so as the patient feels some ownership of the process. This process will be of particular importance for those who have experienced many years of coercion within the psychiatric system,

including involuntary sections and forced medication. These individuals are likely to be suspicious of any offer of help from a professional they consider to belong to that system, and extra effort must be made to create a collaborative therapeutic relationship.

The clinician should be alert to the possibility of the patient trying to get them to offer help that they cannot provide. For example, this may include wanting the therapist to help them get the police to arrest their neighbours who are believed to be persecuting them. The clinician should adopt an empathic position, but are unable to act until having heard more about the problems. Inexperienced therapists may fear saying anything that may seem to collude with the contents of the patients symptoms, out of fear of reinforcing their 'madness'. However, if the therapist states that they (currently) simply do not know enough about the situation to be able to be sure what is going on, then they are likely to maintain the therapeutic relationship without committing themselves to any specific belief.

Assessment within CBT

There are a range of issues to consider when conducting a full assessment. It is likely that an individual diagnosed with schizophrenia will suffer with emotional and functional problems, and the clinician should be cautious not to assume which of these are the most significant. Although the content of this chapter focuses on positive symptoms, any initial assessment should also cover physical health, social and occupational functioning and suicidal ideation.

Although an individual is diagnosed with schizophrenia and for instance, experiences auditory hallucinations, the clinician should not assume that the hallucinations are a source of significant distress. A careful assessment is needed in order to assess what the most significant problems are, and whether hallucinations and delusions are involved. In the example of voice hearing, the patient may experience a number of different voices that are attributed to different individuals. Some of these voices may be friendly and helpful, while others are more threatening and cause distress. In this scenario, if the clinician appears to assume that the patient would be better off not hearing any voices at all then this may distance them from the goals of the patient.

The initial assessment should be conducted with flexibility and in an environment where the patient feels most comfortable. This may mean going for a walk while the patient has a cigarette, or meeting in their own home. There will be many areas to cover in an assessment, and it may help to let the patient start with whichever area they feel is most important. This may be current symptoms, current social problems or earlier life events.

The clinician can guide the conversation towards those issues that have been missed in later sessions. During the early sessions the therapist should be building a model of how the patient constructs their position. There are many possible models the patient may hold. These include believing they have a genetic vulnerability to their current mental health problem, that medication does help, that stress can exacerbate symptoms, and that they do not believe their delusional beliefs when well. Whereas another individual may believe their condition is purely stress related and not biologically based, and that medication is useless. Other people may believe that there is nothing wrong with them, but that they do hear voices which *sometimes* trouble them, and would like some coping strategies for this. It is important to consider what the clinician and patient need or need not agree on, in order to help the patient achieve their goals. The patient does not need to believe they are suffering from a biologically based illness called schizophrenia in order to benefit from a therapeutic intervention. Attempting to induce such ‘insight’ is likely to cause many to drop out of the process. Therefore, the clinician can be flexible as to what model of mental illness they collaboratively share with the patient, in order to help them achieve their goals. During the course of therapy, new information and reconsideration of old information may cause this model to evolve.

The Evidence Base for CBT for Psychosis

Although single case reports of psychological interventions for psychosis date back more than 50 years (e.g. Beck, 1952), significant developments in this area did not occur until the 1980s. Early behavioural interventions were aimed at symptom management and were predominantly embedded within the traditional psychiatric view of schizophrenia. During the mid 1990s a small number of mainly UK based researchers conducted the first trials in cognitive behavioural therapy for psychosis (CBTp). The encouraging results led to clinical trials being conducted within other countries, and to large scale randomized controlled trials being funded within the UK. The rapid growth in the number of clinical trials aimed at evaluating CBTp has led to an increasing number of meta-analyses. The most recent and comprehensive review has been able to incorporate a large enough number of clinical trials in order to investigate the role of a number of variables that may be associated with outcome (Wykes *et al.*, 2008). Of the trials 34 met inclusion criteria, with 22 of these being individual CBTp (i.e. one to one therapy) aimed at the positive symptoms of psychosis. The overall effect size for CBTp was moderate, and was broadly similar (around 0.4) whether the analysis was based on outcome in relation to positive symptoms, negative symptoms, mood or social functioning.

The evidence to date predominantly provides support for CBTp as an intervention for individuals suffering from ‘treatment-resistant’ psychosis in a chronic, but stable phase. However, most trials have adopted a generic approach to CBTp and despite being aimed at the positive symptoms of psychosis, there has been little differential impact between psychotic and non-psychotic symptoms. Consequently, relatively little is known about the effectiveness of CBTp for other phases of the disorder. Also, little is known as to which elements of CBTp are the most important in producing change, and there are few markers as to who would benefit most from this intervention.

The modest overall outcomes of most CBTp trials may be, in part, a product of the choice of measure used for the assessment of outcome. The most widely used assessment tool has been the Positive and Negative Syndrome Scale (PANSS, Kay *et al.*, 1987) for schizophrenia, which is predominantly a symptom-based measure developed for use in drug trials. It has been shown to be a poor measure of the psychological distress associated with psychotic symptoms (Steel *et al.*, 2007). The use of the PANSS is in contrast to the view that CBTp should not be considered a quasi-neuroleptic (i.e. targeting symptoms) but seen as an intervention aimed at reducing emotional distress (Birchwood and Trower, 2006). Also, the use of a generic form of CBTp aimed at a heterogeneous population may contribute to limited effect sizes. This limitation would seem all the more significant given that a large number of clinical researchers question the scientific validity of the diagnosis of schizophrenia (Bentall, 2007) upon which most trials are based. Of interest, the study which exhibited the largest effect size within the Wykes *et al.* (2008) review, adopted a specific protocol for a specific form of psychotic presentation (command hallucinations) and used an appropriate outcome measure (Trower *et al.*, 2004).

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