THE CASE STUDY GUIDE TO COGNITIVE BEHAVIOUR THERAPY OF PSYCHOSIS

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PREFACE

Within the past year, research has confirmed that non-expert community psychiatric nurses can safely and effectively deliver cognitive behaviour therapy (CBT) to patients with schizophrenia and their carers (Turkington et al., 2002). It is reasonable to expect that other disciplines within mental health would achieve similarly encouraging results (Turkington & Kingdon, 2000). Such interventions are greatly appreciated by patients and carers, improve job satisfaction for the practitioner and lead to improved insight and coping. It is now contended that case management should be supplemented by such viable, high-quality psychosocial interventions if improved outcomes are to be achieved for patients with schizophrenia (Thornicroft & Susser, 2001). It certainly seems that low case loads alone do not produce such outcomes, as the UK 700 study (Burns et al., 1999) has demonstrated: how the increased time available is spent would appear to be fundamentally, and not unexpectedly, important.

This pathway towards the application of CBT principles to their psychotic patients has been trod by increasing numbers of community mental health team professionals over the last ten years in the United Kingdom, Australia, Canada and certain European countries. The dissemination of these techniques in other areas has depended upon local initiatives and has often lacked published case material to support enthusiastic practitioners; thus the pressing need for this casebook. CBT is a collaboration between patient and therapist, so to illustrate the variation that can occur, each chapter begins with a description of a mental health professional’s own personal development and training in CBT for psychosis. The contributors then describe a case to illustrate certain key principles, which are explained in varying depths. The cases have been carefully chosen to give the early practitioner a good feel for the process of therapy in a variety of different psychotic presentations. A brief introduction to the general techniques is given at the beginning of the book, and it ends with a discussion on training, supervision and implementation issues.

The first case describes the key principles of working with a patient who has a systematised, grandiose delusion which is antipsychotic-resistant. Douglas Turkington, a psychiatrist, stresses the importance of maintaining
collaboration, working up a formulation and generating interesting homework exercises. Laura McGraw, a community nurse (with the assistance of Alison Brabban), describes her experience of introducing CBT to a patient whom she has known for many years. She describes the complexities for the patient and the therapist of making sense of their experiences and of working towards a shared explanation on which reality testing and activity scheduling can begin. Lars Hansen, a senior trainee psychiatrist, shows how to work with hallucinatory experiences, some of which are seen as pleasant and supportive by the patient. Isabel Clarke illustrates her model of therapy with a patient with long-standing problems whom she met through her work as a senior clinical psychologist in a rehabilitation service. David Kingdon, together with Nicky, shows how practising consultant psychiatrists can integrate CBT into their workload to produce improved quality of management—in this particular case by understanding the link between Nicky’s underlying guilt and psychotic symptoms. With Damien, a process of therapy is clearly described for those very difficult patients who abuse hallucinogenic drugs thereby exacerbating psychotic symptoms. Ron Siddle, a nurse therapist, shows us how to work with those voices that command actions and are linked to depression. Such patients, unless effectively treated, are of course at high risk of eventual suicide. Paul Murray provides a detailed description of a patient who received a brief intervention as part of the Insight into Schizophrenia study (Turkington et al., 2002), but nevertheless seemed to gain significant benefits from it. Nick Maguire, a clinical psychologist, describes two patients with paranoid delusions, and shows clearly not only how to help the patients to recognise that their delusions are beliefs and not facts but, in a guided discovery manner, to help the patients to test them gradually in a real situation. His model for doing so is clearly explained. Pauline Callcott, a nurse therapist, describes work with a very traumatised and fearful woman using CBT for psychosis, combined with some of the treatment methods used in post-traumatic stress disorder. This had mixed results—symptoms improved but admission was necessary and remains quite a controversial way of working with psychotic patients. Jeremy Peltan, a nurse therapist with the Insight project, describes how to engage the family as co-therapists and shows how beneficial that can be in improving joint understanding and coping, which can be of real and lasting benefit to psychotic patients who, it would seem, can be helped to move into ‘the real world’. The casebook should provide great encouragement to those mental health professionals who have always intuitively believed that such interventions could be appropriate for the many patients experiencing severe mental health problems. We hope that by clear case illustrations, and by describing the research evidence available, we
may also help those who are more sceptical to understand why we believe these developments to be so important in the management of such disorders.

Douglas Turkington
David Kingdon
18 December 2001
INTRODUCTION

“We can talk”, a major American journal announced in 1997: “Schizophrenia is no longer a disorder in which psychological approaches have no place” (Fenton & McGlashan, 1997). Many people, including users of services, their carers and staff, are now trying to understand why people who are going through a troubled period in their life, feel or behave the way they do, and think about frightening, confusing, depressing or distressing matters. Irrespective of whether they are users or patients, carers, friends, nurses, social workers, doctors or psychologists, it is important that they have the capacity to control their emotions effectively. Some people seem able to do this intuitively, but most of us need help. We hope this book can provide some of that help by giving examples of how a variety of people from different backgrounds have spent time trying to understand and offer assistance in these circumstances.

People who have participated in the use of CBT—of one form or another—will be described. This will include not only users or patients who have experienced psychotic symptoms, but also those who have worked with them as carers or therapists. Both groups vary considerably in their experiences of symptoms and of using CBT with these symptoms. Participation and collaboration in therapy has been an essential basis for any progress that is seen. In their guided discovery of the experiences that have led to their meeting for therapeutic purposes, the patient and therapist will both have taken a lead.

Over the years, we have also been closely involved in training and supervising mental health workers and describe some of the positive and negative experiences involved. Similarly, the implementation of CBT in mental health services has progressed and is gradually becoming embedded in clinical services—but not uneventfully. Again this will be discussed and evidence for the effectiveness of CBT in psychosis will be reviewed briefly.

Finally, we would recommend that you read one or more of the available texts on CBT in psychosis, as they differ and complement each other in a
variety of ways. Hazel Nelson’s book (1997) is thorough and detailed in its description of therapy. David Fowler and colleagues (1995) have produced a book which is enlivened by case studies and broad clinical experience, while the text by Paul Chadwick and colleagues (1996) provides a very clear exposition of the use of the ABC framework in CBT. Our own text (Kingdon & Turkington, 1994) provides a theoretical basis for normalising symptoms and working systematically with them. However, in case such books are not readily available, we will present below a brief description of the key issues.

TECHNIQUES USED

Basis in cognitive behaviour therapy

The use of CBT in schizophrenia has been drawn from Beck’s theory of emotional disorders (Beck, 1976). It has been founded on a tradition of evaluation, using experimental and research studies of defined therapeutic techniques. These techniques are problem-oriented and are aimed at changing errors or biases in cognitions (usually thoughts or images) involving the appraisal of situations and modifying assumptions (beliefs) about the self, the world and the future. The Cognitive Therapy Scale (Young & Beck, 1980) is used in research studies to ensure fidelity to the treatment model described by Beck and colleagues, but it is also a valuable tool in training. There have been adaptations to this for general use (e.g., Milne et al., 2001) and also for use in psychosis (Haddock et al., 2001). It describes the general therapeutic skills used in psychological treatment and the more specific conceptualisation, strategy and techniques used in cognitive therapy. The use of CBT in schizophrenia builds on these skills and techniques, although there are some differences in emphasis.

General skills

The general therapeutic skills described are those that are applicable to any psychological approach. They are aimed at enhancing what have been described as “non-specific factors” (Truax & Carkhoff, 1967)—the development of accurate empathy, non-possessive warmth, unconditional positive regard and non-judgementalism.

These skills also include agenda setting, which needs to be performed quite sensitively with patients with schizophrenia. Developing and agreeing an agenda may not be easy for them because of thought disorder, negativity or preoccupation with delusions and hallucinations, and this may involve
more prompting and suggesting, while retaining collaboration and eliciting feedback, than would occur when setting agendas for patients with different disorders. The agenda may even be implicit rather than explicit; for example, an initial session usually concentrates on engagement and assessment, so the agenda may simply be “to find out what problems you’re having at the moment and begin to understand how they came about”. Developing such understanding, displaying interpersonal effectiveness, and collaboration are further general skills. Pacing and the efficient use of time are important in engaging and retaining the patient in therapy. As silences can be anxiety-provoking and increase symptoms they are generally to be avoided but, on the other hand, patients need time to respond when their concentration is impaired and the pace of sessions needs to be judged carefully. The length of sessions may also need to be responsive to the mental states of patients. If they are becoming tired or particularly distressed, sessions may be wound down early. Occasionally if a complex delusional system or a particularly sensitive area is being explored, more time can be taken (within the constraints of the therapist’s working schedule).

Cognitive therapy differs from other therapeutic interventions in its manner of conceptualisation and strategy, and the specific techniques, used. The concept of guided discovery is very important when working with patients with schizophrenia. Therapy is a journey of exploration into patients’ beliefs, understanding them and finding out more about them, as far as possible, without preconceptions. That does not mean, of course, that the therapist will agree with the conclusions that the patients have reached, but he or she will understand how the conclusions developed, which will be explained further in discussion of the management of delusions and hallucinations. There is a focus on key cognitions; that is, “voices”, delusional beliefs and behaviours—e.g. ways of coping with “voices” or avoidant behaviour in response to delusions of reference. The use of an ABC formulation can be valuable in clarifying the association between Antecedents, Beliefs and Consequences and assist patients to review their voices and beliefs constructively (see Chadwick, Birchwood & Trower, 1996).

A broad strategy for change is developed collaboratively with the patient from a formulation. The formulation will include discussion of predisposing factors (e.g. early childhood experiences), precipitating factors (life stresses, e.g. leaving home, adverse illicit drug experience) and perpetuating factors (e.g. continued unrealistic expectations and criticisms, or social circumstances). The development of key symptoms and beliefs will form part of this formulation.

The application of specific cognitive behaviour techniques will be described. Patients with schizophrenia may find difficulty in collaborating
with homework assignments and we tend to avoid the term. Instead we discuss “finding out” about something (e.g. satellite broadcasts: if the patients believe that these are influencing their thoughts). Where patients find difficulty with diaries, detailed recall of specific days can be used, e.g. “Do you remember what you did yesterday?”, “What time did you get up?”, “What time did the voices start?”, “Where were you and what were you doing?”, “What were they saying?”.

Engagement

Developing a working alliance with patients with schizophrenia can be difficult where they have paranoid symptoms or have had difficulties with services in the past. They may not feel listened to and may expect you to dismiss their beliefs as ‘mad’. However, when they find that the therapist is interested in their symptoms, their content, what they mean to them and how they have developed, engagement can be effectively secured. Studies in this area consistently find that, once they agree to participate in a study, less than 15% drop out. Engaging them in such studies or therapy can be difficult but the opportunity to state their case about their beliefs is frequently taken up with alacrity. This can be further improved by allowing them to lead a discussion, where they are able to do so, taking their concerns as primary—but prompting with known information when silence occurs—with the ultimate aim of having sessions that are relatively relaxing and comfortable. When it becomes hard work or distressing, it is generally better to pull back and use relaxation methods or casual conversation to conclude the session. Sometimes the patients will want to work through painful issues, but this needs to be carefully paced.

Tracing antecedents of symptoms

Understanding the circumstances in which delusional ideas or hallucinations began, even when they may be 30 years previously, can be invaluable in finding out why particular beliefs have arisen. For example, paranoid delusions and hallucinations may have occurred for the first time during a drug-induced psychosis (“bad trip”) and need to be relabelled as originating with, although not currently caused by, that experience. Also, voices may relate to a specific traumatic event that is often accompanied by a depressive episode. A good conventional psychiatric assessment of the personal history can allow the pathological process to be charted using “guided discovery”. This is particularly important for patients who have
been ill for a number of years, as the mists of time have often obscured the original precipitants. A direct approach—“When did you first think that….” or “When were you last well or OK?”—may elicit the information needed, but may sometimes be less successful where distressing events are involved. Developing the story through personal history—beginning with birth and progressing to childhood, adolescence and the period preceding illness—may, by association, draw out the relevant precipitants where they exist. Accounts from relatives, clinical records or family doctor notes may be useful to prompt the patient. There remain a small number of patients who are unable to locate specific precipitants but can be overcome by the minor stresses of life.

**Understanding patients’ explanations**

Patients use a variety of explanations for their symptoms, and these are elicited. Romme and Escher (1989) found that people who experienced auditory hallucinations described them as being caused by “trauma repressed”, “impulses from unconscious speaking”, “part of mind expansion”, “a special gift or sensitivity”, “expanded consciousness”, “aliens”, “astrological phenomena” and, more rarely, “a chemical imbalance or schizophrenia”. To this can be added spiritual beliefs (“God or the Devil speaking”) and technological explanations (satellites or radar, etc.).

To understand patients’ explanations it may first be necessary to allow them to lead and explore the models of their mental health problems. It is often helpful to normalise, but this is not to minimise or be dismissive of their symptoms. A vulnerability/stress model is useful in explaining the illness, and is credible scientifically. Some patients have vulnerabilities that may have been inherited or caused by some physical effects on the brain, and the presence of stressful events (which might include chemical interaction, e.g. illicit drugs or viral illness) which may have precipitated the illness. For some people their vulnerability is very low, but the stress they have experienced has been high and overwhelming. Others seem very vulnerable to stress, and illness precipitates readily.

Alternative explanations for specific symptoms may be developed through discussion. Prompting the patients may be necessary, but the more the patients are able to provide their own alternative explanations the more likely they are to accept them. Anxiety symptoms are frequently misunderstood; e.g. the thought that ‘my boss is controlling my mind’ can arise from the giddiness associated with hyperventilation, or “I’m being shocked” from paraesthiae.
Delusions

Two factors appear important in delusion formation (Hemsley & Garety, 1986): prior expectation, i.e. “what you expect affects what you believe”; and the current relevant information provided by the environment, i.e. “the events occurring at the time and circumstances you find yourself in”. Working with delusions involves establishing engagement, tracing the origins of the delusion, building a picture of the prodromal period, identifying significant life events and circumstances, identifying relevant perceptions (e.g. tingling, muzziness) and thoughts (e.g. suicidal, violent), and reviewing these negative thoughts and any dysfunctional assumptions. Patients are particularly prone to taking things personally, getting things out of context and jumping to conclusions.

The content of the delusion needs to be explored: the nature of the evidence that the patient has assembled for the delusion; and the evidence he or she can produce that seems to argue against the delusion. Alternatives are developed: “Are there any other possible explanations?”; “If someone said that to you, how would you respond?” The process continues by gentle prompting: “What about…?”; “Do you think just possibly…?” Where delusions are resistant or if the discussion appears to be going round in circles, a technique described as inference chaining may be valuable. However, if the patient is becoming agitated, distressed or hostile, discontinue the session. Discussion with a cognitive therapist who is experienced in this area, if available, may allow the recommencement of therapy. Inference chaining can proceed through the factual implications of a belief, e.g. “If you have a transformer in your brain, doesn’t it need electricity to work?” or emotional consequences, “OK, I do have some problems with this belief that you have…but if other people accept what you are saying, what difference would that make to you.” This can then be followed through to specific concern, e.g. “I’d be respected”, “By whom in particular?”; “My family”. These issues can then be worked with: “Although I may not be able to accept your belief” (e.g. that you are the Jesus Christ), “I may be able to help you to look at how you can gain the respect of your parents.”

Hallucinations

Working with hallucinations involves initial assessment of the relevant dimensions, i.e. conviction, preoccupation, distress, content, frequency and pattern of occurrence. Any “voices” are discussed and differentiated from illusions and delusions of reference. Agreement will usually be reached that they resemble “someone speaking to you as I am doing now” (or perhaps
shouting or mumbling). The individuality of the perception is established: “Can anybody else hear what is said? . . . not parents, friends, etc.?” This is agreed although it may involve the person checking with others about whether they can be heard. Beliefs about the origin of voices are explored: “Why do you think they can’t hear them?” Often the patient is unsure of his or her origin or produces delusional beliefs. Techniques for delusions (see above) can be used if appropriate. Possible explanations will then be explored: e.g. “it may be schizophrenia”. Stressful situations in which voices can arise may usefully be described as they can help to normalise the experience, i.e. many people under certain forms of stress can hallucinate. This can be induced through sleep deprivation (Oswald, 1984), sensory deprivation states (Slade, 1984) and other stressful circumstances, such as bereavement, hostage situations (Grassian, 1983), PTSD and severe infections. In other words, ‘voices can be stress related—because you hear them does not mean that you are a different sort of person from everybody else. When people are put under certain types of stress, e.g. sleep deprivation, they may also hallucinate.’

The aim is to raise the possibility that voices are internal—the person’s own thoughts. The analogy with dreams and nightmares may help with this: ‘a living nightmare’. Medication and coping strategies, e.g. listening to music, a warm bath, attending ‘Hearing voices’ groups (of other patients who suffer similarly), then become more relevant. Also, exploration of the content of voices can occur. Where this is abusive, violent or obscene, perhaps making commands, the voices are often related to previous traumatic events or depressive episodes, and specific work can then be efficacious. Voices may seem omnipotent (Chadwick & Birchwood, 1994) but: ‘Just because a voice says something, however loudly and forcefully, does not mean it is true . . . or that you have to act upon it.’

**Thought disorder**

Disorder of the form of thought, however caused, interferes with communication, and techniques have been developed for clarifying verbal communication in these circumstances (Turkington & Kingdon, 1991). They involve allowing patients’ speech to flow, then gently prompting them to focus down on specific themes as they emerge. Usually the themes selected are those which, on the surface, sound distressing—e.g. distressing events that may be mentioned. Neologisms and metaphorical speech are clarified by gentle questioning, and once a theme is selected the patients are drawn back to it each time they stray. The process is one that enables communication. It can be improved by audiotaping sessions and then reviewing them,
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as pertinent themes may emerge from such reviews for discussion at the next session.

Negative symptoms

There is evidence that CBT improves negative symptoms (Sensky et al., 2000). Techniques involve eliciting specific positive symptoms, especially ideas of reference, thought broadcasting and hallucinations, which may emerge under stress. Patients may become essentially agoraphobic or socially phobic because of a fear of reactivating distressing positive or panic symptoms. They may also require a convalescence period after an acute episode, and a reduction in pressure and the postponement of some immediate expectations may be indicated. The protective function of stress avoidance, e.g. sleeping during the day and getting up in the quiet of the night, needs to be considered. Avoidance of stimulation may be a reasonable coping strategy while work with positive symptoms and stress management is pursued. Retaining hope is essential, so the development of realistic five-year plans may reduce the immediate pressures to "get better and get back to work/college". The aims may be the same, but the timescale is more realistic.

Clinical subgroups

Although a symptomatic approach is valuable in working with patients with psychoses, there are limitations to it in that, for example, hallucinations may present quite differently and cause different levels of distress in a person presenting with a range of psychotic symptoms than in someone for whom this is the predominant symptom relating to previous life events. This has increasingly led us to consider whether psychoses, including the schizophrenias, can be subgrouped (see Kingdon & Turkington, 1998). If valid and reliable groups can be developed, this could help with their management in determining responses to medication, psychological treatment, family work and rehabilitation measures. Such groups would also be expected to give indications of prognosis and assist substantially in research and training. Differentiation into bipolar disorder and schizophrenia has, arguably defined a spectrum rather than discrete entities. Previous descriptions of "the group of schizophrenias", as it was originally described (Bleuler, 1950), have included those appearing in International Classifications of Diseases, such as simple, hebephrenia, catatonia, paranoid or schizoaffective, and symptomatic classifications (e.g. Liddle et al., 1994), such as positive, negative or disorganised. These classifications have not proved useful
in clinical practice, yet there seems to be very general agreement that substantial differences between groups of patients exist. We have described four such groups (Kingdon & Turkington, 1998) that have proved helpful in planning treatment strategies, based on individual formulations. For convenience, these have been provisionally described as:

**Gradual onset**

- “sensitivity psychosis”: individuals who develop psychosis gradually in adolescence with predominant negative symptoms;
- “trauma-related psychosis”: individuals with traumatised backgrounds (usually from sexual abuse) with abusive hallucinations as predominant and most distressing symptoms.

**Acute onset**

- “anxiety psychosis”: individuals who initially develop anxiety and depressive symptoms in response to a life event, are often socially isolated, who suddenly ‘know’ the reason for their distress and generally develop a single ‘core’ delusion elaborated into a delusional system with or without hallucinations;
- “drug-related psychosis”: individuals whose initial presentation is with drug-precipitated psychosis followed by persisting psychotic symptoms, of the same nature and content, as the initial episode.

Management is focused on these specific symptoms, but the “core” delusion in “anxiety psychosis”, for example, rarely responds to direct reasoning approaches although these help to establish a relationship with the patient, and often prompts investigation into underlying issues, e.g. isolation or poor self-esteem.

**Medication issues**

All the studies into CBT in schizophrenia have stressed the importance of medication. It is sometimes necessary to wait for medication to reduce acute psychotic symptoms before using CBT, especially with thought disorder, although the use of a CBT approach often allows negotiation on the use of medication or hospitalisation to occur. ‘Compliance therapy’, a brief form of CBT, has been specifically aimed at this. Where patients begin to understand that their voices are internal phenomena and that their beliefs just might be self-induced, they are more likely to take medication to alleviate these problems. Conversely, if medication has a positive effect, this reinforces work on helping them to accept voices as their own thoughts.
CONCLUSION

Cognitive behaviour therapy is a major advance in treating schizophrenia. In combination with medication, it offers effective interventions for a range of positive and negative symptoms and is very acceptable to most patients and carers. The techniques involved build on basic training for cognitive therapists and psychologists, and also case managers, nurses and psychiatrists, who are experienced in working with patients with schizophrenia. Manuals are available to assist with the development of skills. In some areas, training courses for mental health workers have been developed but there are currently far too few trained personnel; however, this situation may change with the emerging evidence of effectiveness and increased training opportunities (see later chapters).
## CASES: SUBGROUPS AND PROMINENT SYMPTOMS

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<th>Sensitivity psychosis</th>
<th>Hallucinations—abusive</th>
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** Prominent symptom  

1 'Post-traumatic stress psychosis'