# Cognitive behavioural therapy for psychosis: Lessons from history and hopes for the future

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Adults who live with chronic psychosis are amongst the most severely disabled group affected by mental illness, yet they are the least likely to receive a structured psychological intervention. Antipsychotic medication has been the mainstay of treatment for psychosis for over half a century and those with psychotic illnesses have traditionally been seen as 'too unwell' or too disintegrated to be able to engage with, or benefit from, psychological treatment. It has been these very experiences of being overwhelmed by psychotic experiences that became the catalyst for the application of psychological theories and interventions to support those in the midst of psychosis.

## History of psychological interventions for psychosis

### Early pioneers

The emergence of psychological interventions for psychosis occurred in parallel across a number of settings, most notably in the UK and the Netherlands. In the UK, the success of the Oxford group in promoting cognitive behavioural therapy (CBT) for Axis I disorders led researchers to apply CBT principles in their work with people experiencing psychotic symptoms. Some of the early lead contributors included David Kingdon, Douglas Turkington, Paul Chadwick, Max Birchwood, Nick Tarrier, Philippa Garety and Daniel Freeman. The core CBT strategies developed for psychosis date from the pioneering work of these innovators.

Around the same time the Dutch social psychiatrist, Marius Romme, began to explore the meaning and experience of 'voice hearers' in that country (Romme & Escher, 1989). After interviewing a voice hearer on television, the station was inundated with calls from other voice hearers, many of whom were able to manage their experience without significant distress and debilitation. Romme continued to work with voice hearers leading to the establishment of the consumer-led Hearing Voices Network (www.hearing-voices.org/) and the self-help group Foundation Resonance which have spread worldwide.

These developments, in combination with the growing UK experience with CBT for psychosis, led to a rethinking of the nature of psychosis and in particular the assumption of mainstream psychiatry, that psychosis represents a discontinuation from normal experience. It has become clear that hearing voices and holding disturbing 'delusional' beliefs are, like all human experiences, subject to the influence of attributions, beliefs and coping behaviours that can alleviate or amplify distress.

### Advances since the 1990s

Evidence from the first randomised controlled trials of CBT for psychosis were promising, demonstrating significant improvement in target symptoms after brief intervention. A series of clinical manuals were developed showing how to apply CBT approaches to psychotic symptoms, followed in the early 2000s by positive meta-analyses (e.g., Gould, et al., 2001). More recently, CBT targeting psychosis has begun to be routinely delivered in a range of settings (individual, group, first episode, acute phase etc). The sense of therapeutic nihilism has lifted, with optimism reinforced by the inclusion of CBT for psychosis by the UK National Institute for Health and Clinical Excellence (NICE) guidelines (www.nice.org.uk/nicemedia/pdf/CG82NICEGuideline.pdf)

The high level of optimism that accompanied the emergence of this approach was followed in time by a more sober appraisal of the effectiveness of CBT in this population, a population often challenged by poverty and poor health. Subsequent meta-analyses (e.g., Newton-Howes & Wood, 2011) revealed more modest effect sizes (albeit similar to effect sizes for antipsychotic medication).

### New directions

Today, the role of psychological intervention in the management of psychotic symptoms is an established component of treatment. Interestingly however, despite symptom reduction, there has been limited evidence that standard CBT treatment changes factors thought to cause and maintain psychosis. Such factors include cognitive biases, insomnia, rumination and safety behaviours. Dissatisfied with the relatively modest gains demonstrated in RCTs, research has targeted these maintaining factors with a view to maximising effectiveness.

A number of cognitive biases have been demonstrated to be present in psychosis and potentially maintain symptoms and associated distress. Richard Bentall (2004) pioneered this work and focussed on attributional style in individuals with persecutory delusions. In general findings suggest that, faced with negative events, those experiencing persecutory delusions exhibit excessive use of external personal (other blaming) attribution.

Various groups, including the Maudsley Review Training Program (see Waller et al., 2011) and the Meta Cognitive Training in Schizophrenia program in Germany (see Moritz et al., 2010 ), have developed treatment packages that target these biases. The Moritz program is available on the web (www.uke.de/kliniken/psychiatrie/index_17380.php). Each of these groups are reporting positive results.

Due to the distinction made between psychosis and neurosis in the 20th Century, the role of emotion in psychosis has been neglected. Relatively recent psychological models of psychotic symptoms (Freeman & Garety, 2002; Freeman et al., 2003) have returned emotions to centre stage. These models suggest that distress associated with delusions is determined by similar processes that maintain anxiety, such as meta-worry, meta-cognitive beliefs, safety behaviours and insomnia.

A number of treatment protocols that directly target these factors are providing promising results. For example, the Emotional Processing and Meta-Cognitive Awareness program directly targets worry and rumination in paranoid participants. They demonstrate reductions in distress associated with delusions after three one-hour sessions, without directly targeting the delusion (Hepworth, Startup & Freeman, 2011).

Other important avenues of inquiry and innovation have occurred with the development of Social Rank theory of voices associated with Max Birchwood, and the influence of third wave approaches such as mindfulness for psychosis (for example, see Chadwick's (2006) Person Based Cognitive Therapy for Voices).

In the space of 15 years, CBT has gained a foothold. Initial enthusiasm has made way for a more realistic assessment of effectiveness that has been met with a renewal of research. The empirical findings thus far have afforded clinicians a range of interventions, some that closely resemble those developed for the mood and anxiety disorders and others that look more directly at factors thought to maintain psychosis.

## Application of CBT to distressing psychotic symptoms

The CBT approach to hallucinations and delusions allows the client and therapist to explore voices and the beliefs associated with them (e.g., the malevolence of the voices, their omnipotence, the clients' beliefs about how they should respond to them, their identity etc) and in the case of delusions, the intricacies of the client's delusional network and how it interrelates with the client's identity and life. This is performed with inquisitive neutrality as the therapist collaboratively uncovers networks linking belief, emotion and behaviour, giving both parties an understanding of how the client experiences the world. Hypotheses are formed to explain the maintenance of distress. Treatment moves on to identify and target those parts of the system and those beliefs about the voices that interfere with the client's goals or quality of life.

A collaborative formulation is derived by linking an individual's vulnerability and stressors, identifying the thinking patterns and behaviours that maintain the dysfunctional parts of their symptom profile. This can then be targeted with cognitive therapy, behavioural experiments, exposure, coping skills training, and safety-behaviour identification and removal, in order to weaken beliefs that unnecessarily undermine the client's wellbeing. For a detailed description of CBT for psychosis see Chadwick, Birchwood and Trower (1996). The authors' clinical suggestions for working with psychotic symptoms are presented below, and reflections on an expanded model of CBT to address the broader social implications of psychosis are provided opposite.

For those familiar with working with CBT principles in other areas of practice, there are some important adjustments that are made when working with psychotic symptoms. If willing, patient and flexible, clinicians can contribute to an area long neglected that can be highly stimulating and rewarding. Many clients with whom we have worked have reflected that this therapy was the first time they felt listened to, taken seriously, treated with humanity and instilled with hope. If this was all psychological intervention could achieve it would be worthwhile, however CBT for psychosis appears to be offering much more. ■

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### CLINICAL SUGGESTIONS FOR WORKING WITH PSYCHOTIC SYMPTOMS

- Take your time and don't panic if you feel treatment is stagnating. Engagement and the development of trust take more time than when working with other conditions.
- Conduct a thorough personal history. Themes often emerge that link development to the context of delusions or hallucinations. For example, the authors have often observed a history of childhood bullying and other forms of ostracism, the internalisation of a low social rank and later paranoia and derogatory, malevolent hallucinations.
- Assessment tools can assist in psychological formulation of the maintenance of psychotic symptoms. Examples include the Psychotic Symptom Rating Scale (PSYRATS; Haddock et al., 1999) and the Beliefs About Voices Questionnaire-Revised (BAVQ-R ; Chadwick, Lees & Birchwood, 2000). Draft a shared formulation with the client (incorporate attachment theory and early schemas) and collaboratively develop a treatment plan (for an example, see Shearsby, Walker and Steel, 2007).
- Early CBT literature recommended clinicians "let the waves of psychosis roll over you" during initial sessions, intended to encourage clinicians to limit expectations regarding comprehension and formulation. It is better to sit, listen and let curiosity guide you than to expect a clear formulation to emerge.
- As best you can, maintain neutrality in the style of a detached, uninvested scientist. It is counterproductive to prematurely challenge a belief. Your role is to gather evidence and assess it collaboratively.
- Accept that strong convictions are common and are not reserved for those experiencing psychosis.
- Remember the golden rule – no distress, no psychological treatment. Only aim to modify what is required to reduce distress and for functioning to increase. The aim is not to remove all forms of delusional thinking necessarily.
- Before commencing CBT, consider the function of the symptoms and the ramifications of symptom modification – e.g., a delusion may be protective of a person's self respect. If they no longer believe they have special powers, they may conclude they're worthless and be at risk.
- We all attempt to cope with stressful situations, even if this coping is ineffective or destructive. If possible, maximise the individual's current coping style and offer additional strategies.
- Test reaction to hypothetical contradiction, as this can often indicate whether the person will benefit from cognitive approaches – e.g., if the person believes they have a chip in their brain that empowers them to control others, you may ask: what would you think if we x-rayed your brain and the chip wasn't there? If the response indicates that clear disconfirmatory evidence would not alter conviction, you may reconsider your approach or even the utility of cognitive therapy.

# Extending CBT to promote human rights

It is almost impossible to enter a public in-patient psychiatric unit and not be struck by the neglect, impoverishment and alienation that characterises these places. I (PW) distinctly recall the horror I felt when I started working in just such a facility. I considered this an impossibility in a developed country. I couldn't understand why my colleagues were not similarly shocked; barely raising an eyebrow when highly distressed and confused clients sought support and care. And then I noticed a process of desensitisation occurring within me and I realised that this must be the mechanism by which often good, ethical, caring people could adjust to the awful reality of this area of health care. Fortunately, a particularly wise nurse encouraged me to imagine that each client was a son, sibling, parent or grandparent and then consider how I felt about conditions and treatments. This stayed with me throughout my time and became a useful guide when faced with the complex ethical issues that inevitably arise.

In time I discovered that this ward was like many others and in fact there were far worse. I became increasingly aware that too many good people were either leaving this clinical area in disgust or somehow dissociated and perhaps became part of the problem. This experience was reflected consistently in independent reviews of the state of the human rights in the Australian mental health sector. They were consistently criticised on the basis of neglect, social exclusion, stigma, limited resources and coercion (Richmond, 1983; Burdekin, 1993; Mental health Council of Australia, 2005). Involuntary detention, enforced community treatment, physical restraint, seclusion and public humiliation are common experiences for those diagnosed with psychosis. Once a diagnosis is made the symptoms are rarely explored but instead clients are encouraged to remain silent. Content of psychosis is seen as essentially irrelevant except as signs of biological illness.

## An expanded model of CBT for psychosis

We have sought to provide an expanded model of CBT for psychosis that attempts to address the broader social implications of mental illness – one that moves clinicians beyond the traditional role treating individual's distress independent of context and extends them into the realm of advocacy. We argue (Walker, Steel & Shearsby, 2011) that to increase our relevance to clients and potentially our clinical effectiveness, mental health clinicians and more specifically psychologists must expand their role to include consideration of human rights. Some elements of CBT intrinsically confront the infringement of individual's human rights (freedom of expression, right to self-determination and independence). We argue that clinicians need to expand their range of targets for intervention to include the following elements that may not have been assumed to be standard components of a manualised CBT approach.

- **Collaborative alliance**

Client and clinician meet as equals (as far as possible) utilising a non-judgemental framework to understand the distress clearly. This validates meaning and distress of symptoms, is necessarily non-coercive and encourages expression rather than the commonly experienced sense of being 'silenced'.

- **Therapist as witness**

The process of documenting and expressing psychotic experiences is often valued by clients. It is valuable in collecting relevant data for formulation and for the process of cognitive therapy, but is also useful in providing advocacy on behalf of the client.

- **Shared formulation**

This offers dignity by valuing the client's perspective and hope of the alleviation of distress.

- **Clients as participatory agents**

CBT is an active treatment requiring clients to engage in a process with their therapist. This contrasts with the passivity of many other mental health interventions, where the client is encouraged to wait patiently for their medication to take effect, encouraged to withdraw from work and study and keep their expectations of vocational achievement low, encouraged to refrain from discussing the content of delusions and voices, and occasionally removed from society entirely with inpatient admission and all too frequent seclusion.

- **CBT and the bio-psycho-social context**

Most often ignored, we argue for the inclusion of the broader social and institutional context of an individual's illness experience. That is, alongside someone's medical history, family history and assessment of mental state we should take into account and include in our treatment planning socioeconomic status, access to services, cultural identity, experience of stigma etc. We must not ignore, but in fact include in our formulations the trauma of a psychiatric admission and the coercive and at times distressing treatment that some people receive.

- **The CBT practitioner as human rights advocate**

CBT may be most effective when we directly address some of the real difficulties associated with negotiating the mental health system as well as symptoms. This can take many forms; educating clients on their rights, confronting the use of stigmatising or otherwise derogatory language, and running groups on wards that encourage clients to express and problem solve some issue pertaining to their human rights.

It is our view that in order to alleviate the suffering of people struggling with psychosis, advocacy within the mental health system and the restoration of meaning and dignity to life must be critical components of psychological intervention. ■

*The list of references cited in this article can be accessed from the online version of the article (www.psychology.org.au/publications/inpsych/2013/april/walker)*