

Paul French

Cognitive Behaviour Therapy for Psychosis

Think you're crazy think again: A cognitive therapy approach to managing psychosis

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Northwest of England



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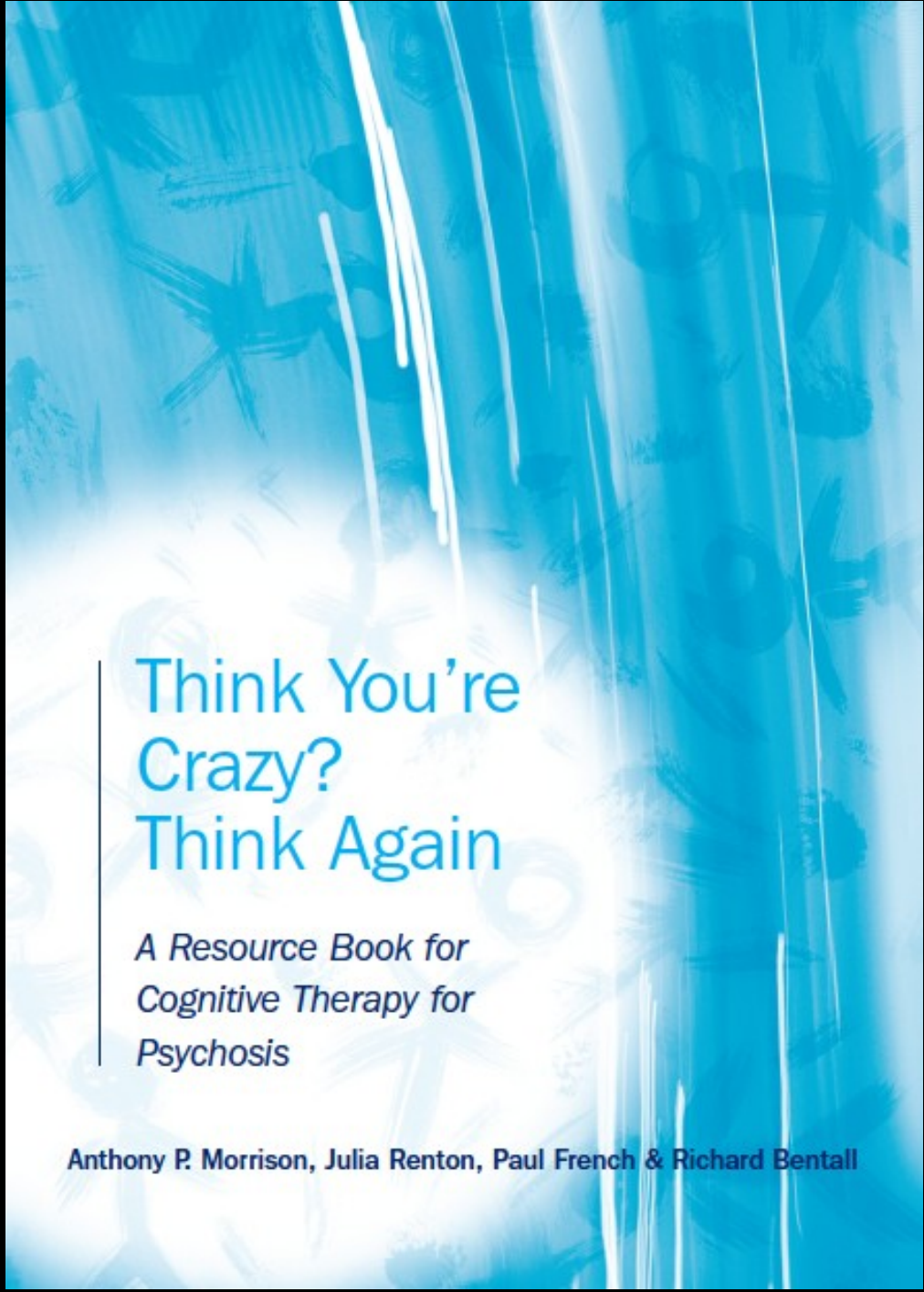
Home of the worlds richest football club





- Tony Morrison
 - Richard Bentall
 - Shon Lewis
 - Max Birchwood
 - Andrew Gumley
 - Graham Dunn
 - Linda Davies
 - David Fowler
 - Peter Jones
-
- Alison Yung
 - Adrian Wells
 - Doug Turkington

Collaborators



Think You're
Crazy?
Think Again

*A Resource Book for
Cognitive Therapy for
Psychosis*

Anthony P. Morrison, Julia Renton, Paul French & Richard Bentall

Objectives

- Understand the rationale for the use of CT for people with psychosis
- Develop case formulations based on a cognitive model
- Consider treatment strategies based on such formulations
- Have practiced implementation of such strategies

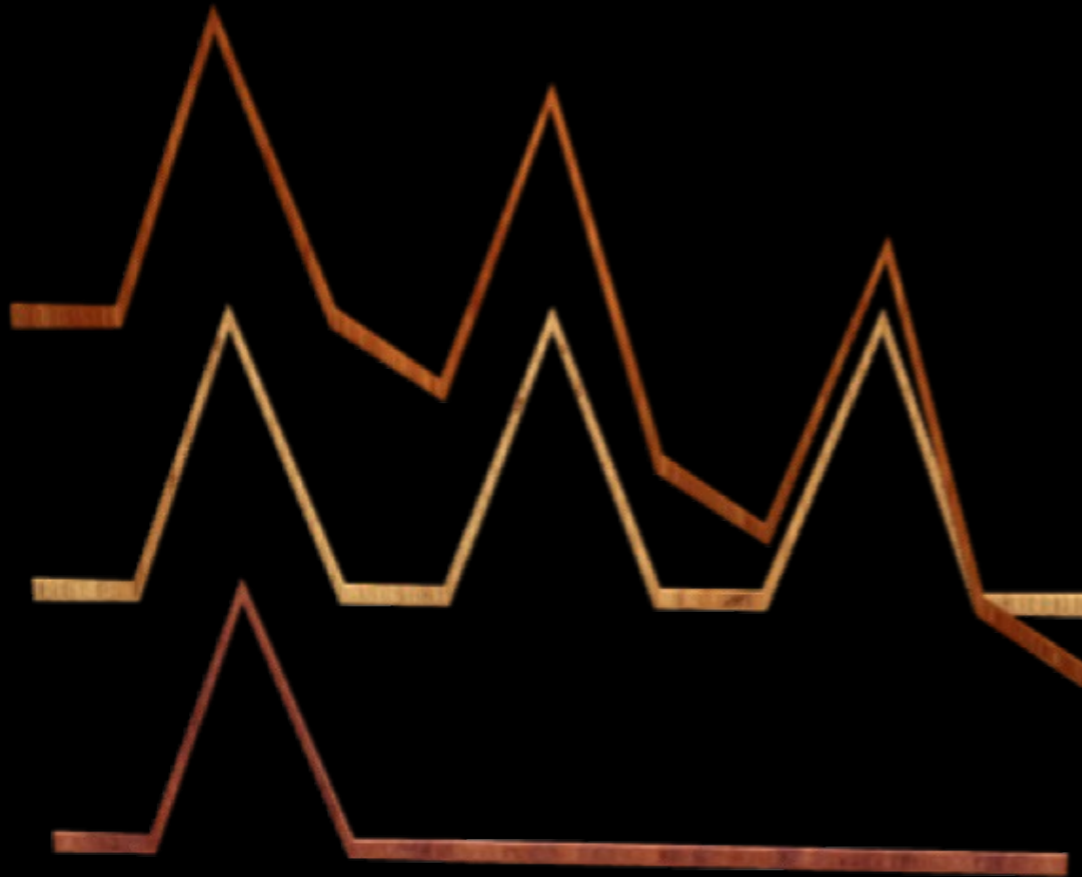
- “I remember when I had my first episode; I was about 21 at the time. I didn’t have a care in the world, I had my own house and a long term relationship, and things couldn’t have been more perfect. So when I found my self hiding under the quilt worried that my boyfriend was some how trying to kill me, well you can imagine, it’s a very scary thought. Who could I tell without them thinking I was mad? I was even worried about discussing it with the people close to me at the time; after all I thought my boyfriend was trying to kill me. Maybe every body else was, perhaps they were all plotting against me some how”
- “This was just one of many irrational thoughts that came into my head and there were many more. Looking back on it now the things I thought then seem so silly now but of course they didn’t at the time”

- “I just wanted answers or at least a listening ear; instead I was handed over a prescription of antidepressants and told there was basically nothing wrong with me. If there was nothing wrong with me what was the prescription for?”

- “I made further attempts to visit the surgery and by this time things had got considerably worse for me. Months had passed and I now had a new theory maybe I had a brain tumour and this was the reason why I was ill. I had swapped one fear for another, and it was only then the doctor decided to refer me to some one else. At last I thought my prayers had been answered, however, yet again it proved a very difficult road ahead.”

- “I was eventually referred to somebody who then referred me again to someone else and at this point I felt like the lost luggage you get at the airport, nobody knew quite what to do with me, this was extremely unnerving.”

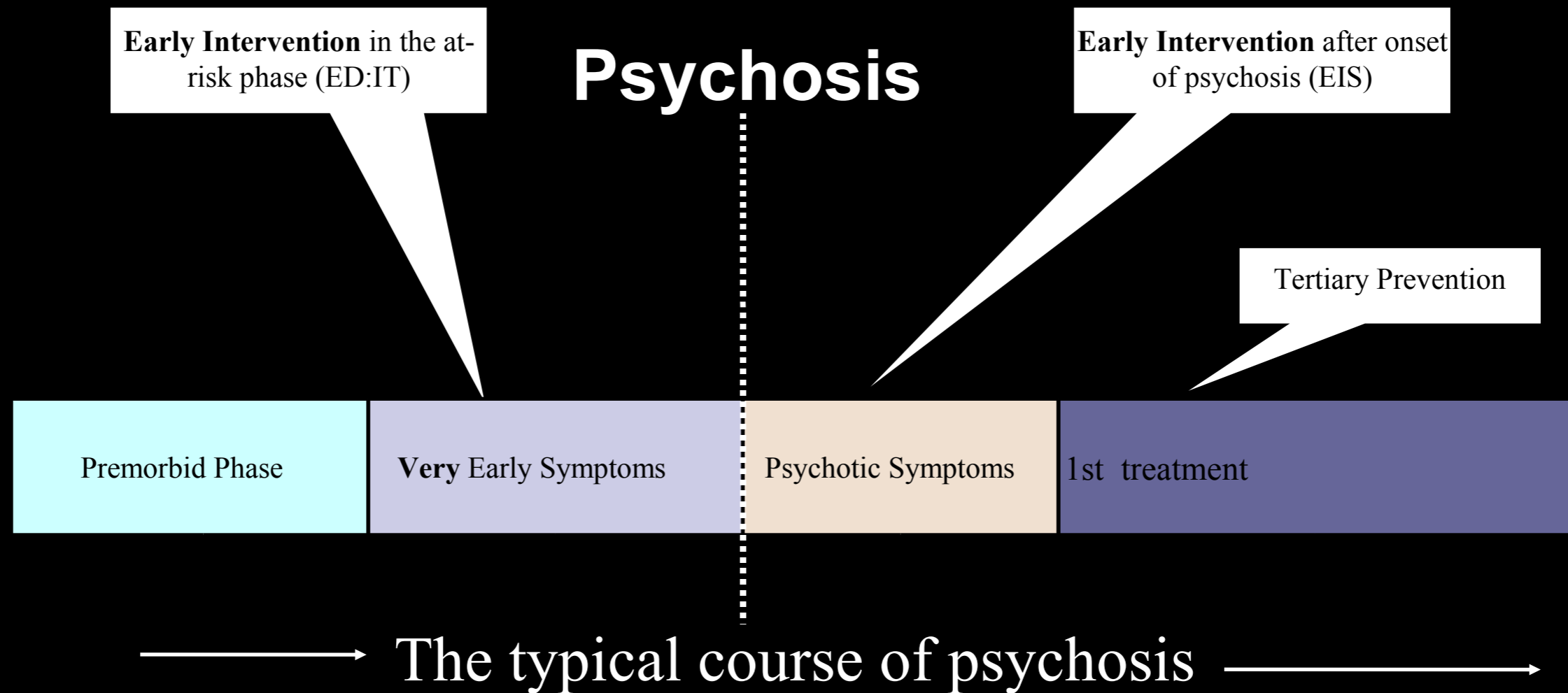
Prognosis (Roughly Speaking)



- Multiple episodes (decline)
- Multiple episodes (no decline)
- Single Episode

Psychosis: The Early Course

Adapted from Larsen
et al.,



- What is Psychosis?

W hat is psychosis

- ‘psychosis marked by an inability to distinguish reality from unreality’
- Consider:
 - eating disorders ‘I am fat’
 - depression ‘I am worthless’
 - OCD ‘I must do this to stop my family dying’
 - panic / health anxiety ‘I have a brain tumour’

Why symptoms?

- Lack of reliability and validity with syndromes (eg Bentall, 1990)
- More likely to facilitate understanding of underlying mechanisms

Why Voices?

- Most common symptom of schizophrenia
- 60% of such patients hear voices
- Often most distressing & disabling symptom
- Single symptom approach

Can psychosis be normal?

Voices

- Often unrelated to psychopathology (Romme et al., 1992; Posey & Losch, 1983)
- 35-40% students (Barrett & Etheridge, 1992; Posey & Losch, 1983; Morrison et al., 2000)
- 5% general population annual incidence (Tien et al., 1991)
- 10-25% lifetime incidence (Slade & Bentall, 1988)
- Bereavement

Why Delusions?

- Garety's work
 - not absolute conviction
 - vary on many dimensions
 - jumping to conclusions - rapid, overconfident reasoning
 - 'self-evident truths', 'not amenable to reason or modifiable by experience'
- common
 - reference 67%
 - persecution 64%
 - control 48%

Can psychosis be normal?

Delusions

- Verdoux et al. (1998)
 - up to 70% of general population endorsed delusional beliefs
- Peters et al. (1999)
 - not the content of beliefs that distinguished between delusional patients on a psychiatric ward and the general population, but rather the degree of conviction, distress and preoccupation (c.f. differentiation between individuals with obsessive-compulsive disorder from normal individuals who have intrusive thoughts with very similar content (Rachman and De Silva, 1978; Salkovskis and Harrison, 1984))
- Large polls cited by Kingdon & Turkington (1994) and Garety and Hemsley (1985)
 - ghosts 25%
 - telepathy 25-50%

Why CT for psychosis?

- Response to drugs can be delayed several weeks
- 70% of first episode patients respond to neuroleptics
- 60-70% of these will relapse within 2 years despite drug prescription
- Side effects:
 - tardive dyskinesia in 35-72% of patients (66% of these irreversible)
 - neuroleptic malignant syndrome in 0.2-1.4% (can be fatal - 19-30% die within few days; conservative estimate => 190,000 deaths up to '92)
 - autonomic~ dry mouth etc.
- Variable compliance
- Client satisfaction

Principles of Cognitive Therapy for Anxiety Disorders

- ∇ A cognitive model is required from which to empirically derive effective treatments
 - You are not mad - you are normal
 - Either it is real or you believe it to be real
 - How you appraise events causes what you feel
 - Test it out - drop your safety behaviours
 - What you attend to and how you attend to it is important

Principles of Cognitive Therapy for Psychosis

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Intervention strategies

- Formulation
- Normalisation
- Working with metacognitive beliefs
- Generating possibilities for intrusions
- Safety behaviours
- Selective attention
- Activity scheduling
- Relapse prevention

Positive Beliefs

- Chadwick and Birchwood (1994)
 - voices believed to be benevolent were engaged
- Miller, O'Connor & DiPasquale (1993)
 - 50% of inpatients reported some positive effects of hallucinating
 - most commonly cited benefits:
 - hallucinations were relaxing or soothing
 - voices provided companionship
- French et al 2001
 - Positive beliefs can impact on DUP

Clinical Implications

- Normalise experience of symptoms and distress - **not that different**
- Offer formulation as additional option
- Identify and modify (if indicated):
 - interpretations (including imagery)
 - safety behaviours
 - strategies for control
 - attentional focus
 - positive and negative beliefs

Intervention

- Formulation driven
- Based on cognitive model
- Follow principles of C T
- Follow session structure of C T

Intervention - Process

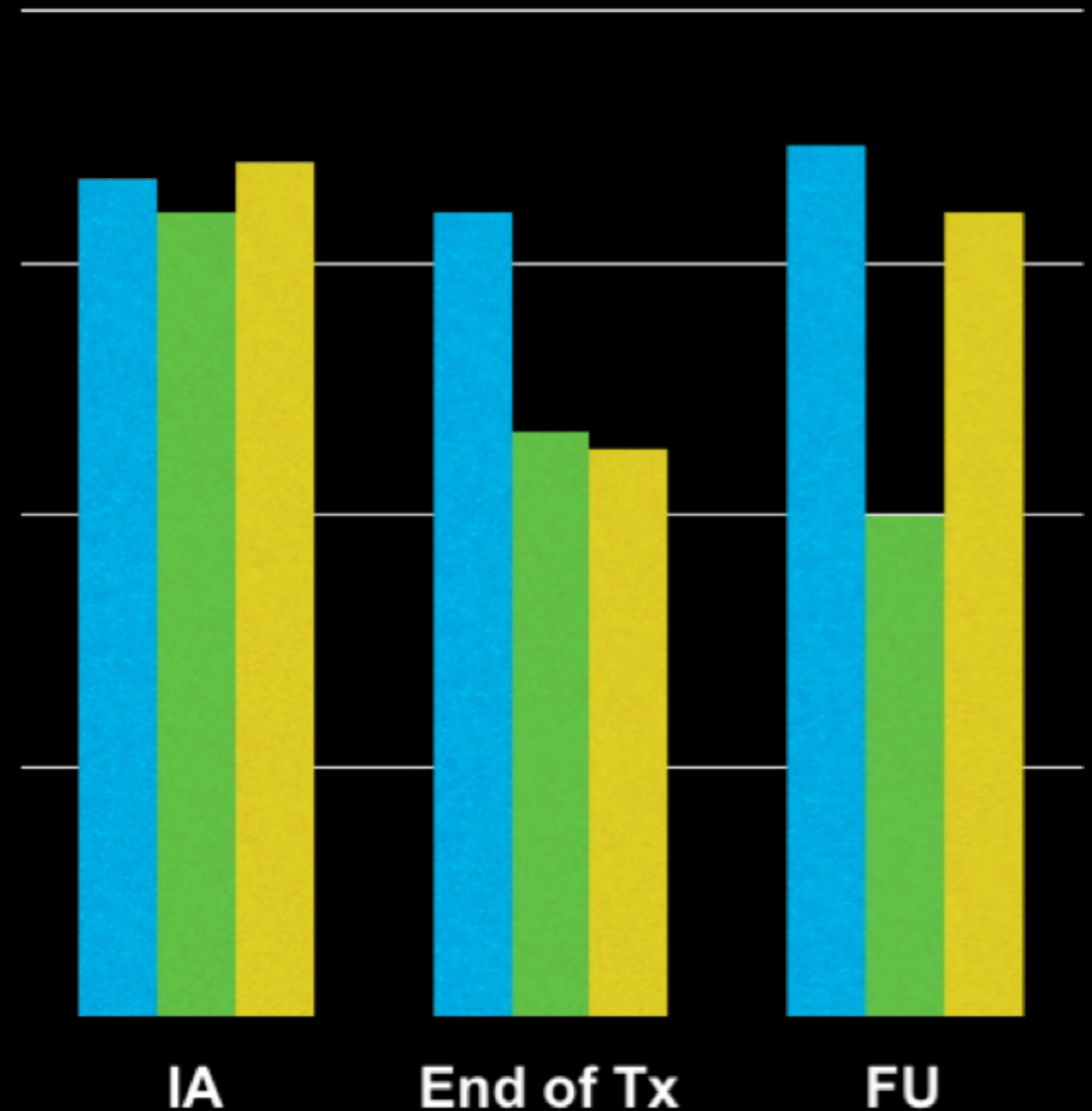
- Assessment
- Establish shared problem list
- Translate into 'smart' goals
- Formulation
- Develop therapeutic relationship
- Interventions derived from formulation
- Relapse prevention

Differences

- Check if involved in symptoms
- Make allowances for memory & attention
 - Written copies of hw tasks, rationale etc
 - Session summary sheets
 - Shorter, more frequent sessions
 - Importance of tape as homework
 - Importance of structure & instilling process
 - Shorter agenda
 - Importance of therapeutic relationship & engagement

Sensky et al 2001

- Multi site RCT
- Compared CBT to BF to TAU



APA Guidelines on Schizophrenia (1997)

- “Several controlled and uncontrolled studies have extended Beck’s cognitive therapy to schizophrenia, with **encouraging clinical results**, including reduction or removal of delusions and hallucinations.
- Furthermore, the techniques are still undergoing modification. At this stage of development, they are **not recommended for routine clinical use.**

NICE Guidance

- 2002 - 13 RCT's
- 2009 - 31 RCT's, (n=3052)
- Offer CBT to all people with schizophrenia. This can be started either during the acute phase or later, including in patient settings.
- CBT should be delivered on a one to one basis over at least 16 planned sessions and follow a treatment manual

NICE 2009 treatment should

- Establish links between their thoughts feelings or actions and their current or past symptoms and/or functioning
- Assist the re-evaluation of peoples beliefs or reasoning relates to the target symptom
- Help people monitoring their own thoughts, feelings or behaviours with respect to their symptoms
- Promote alternative ways of coping with the target symptom
- Reduce distress
- Improve functioning

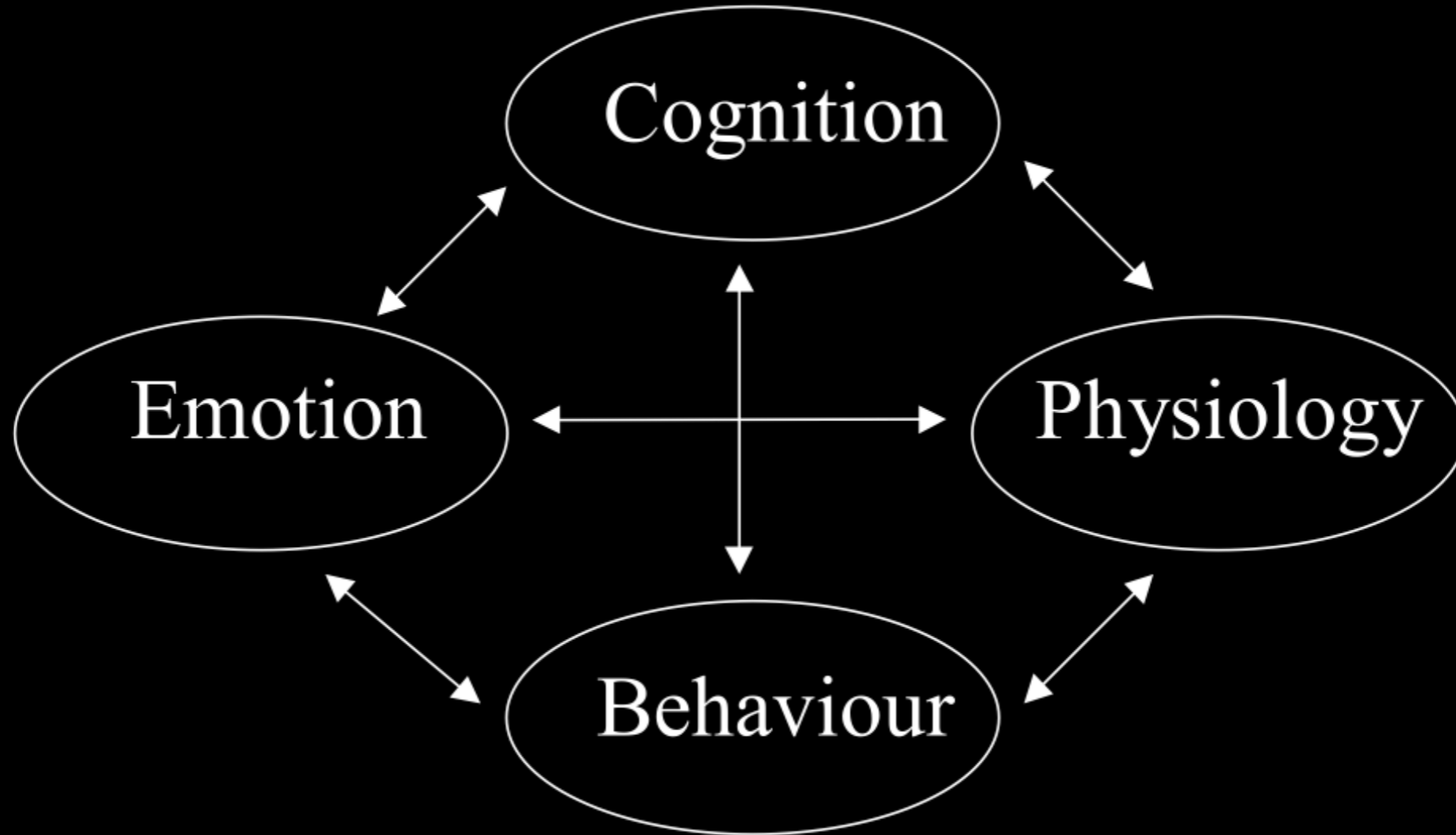
Exercise

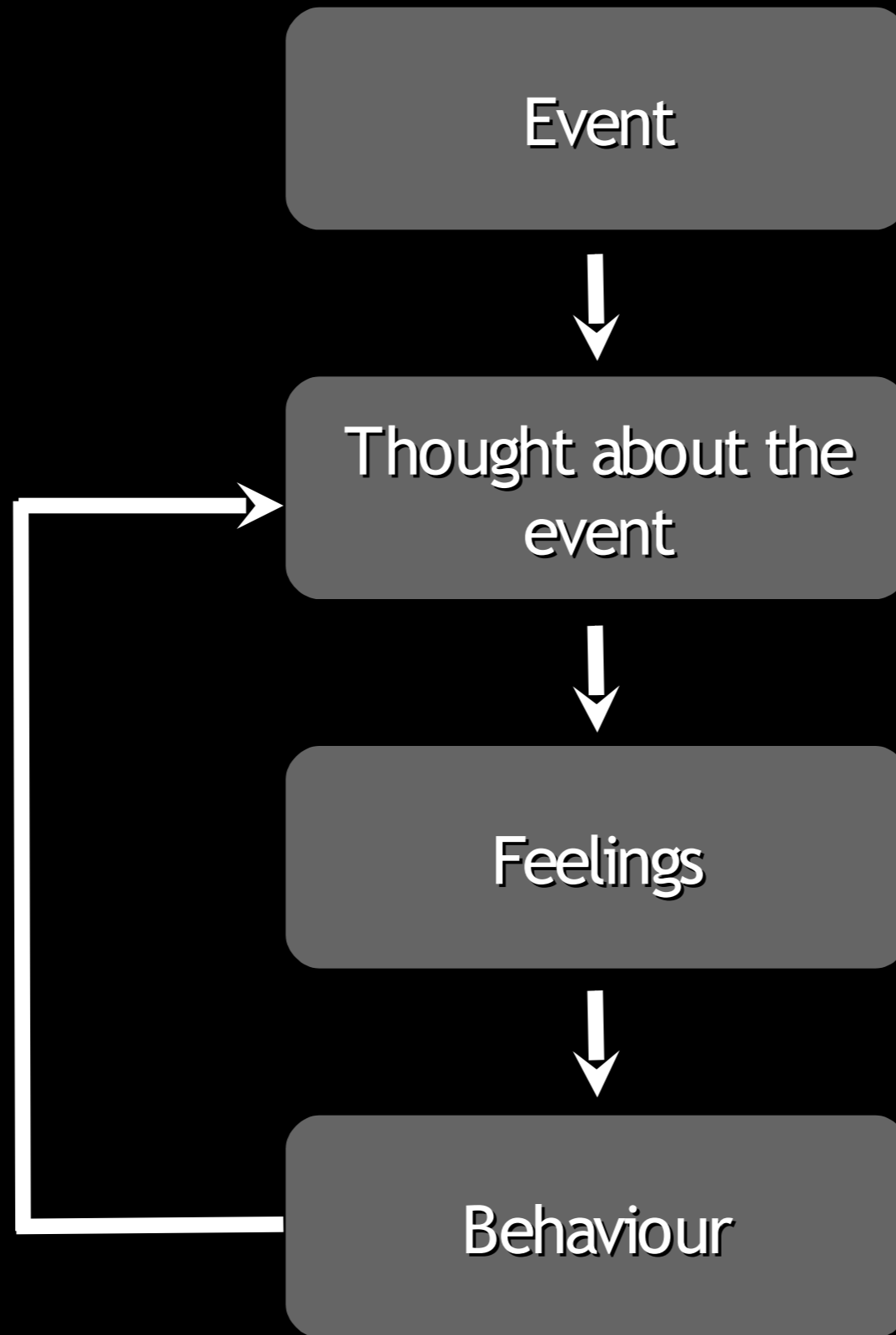
- What would you think if you started to see the emergence of an intense white light clearly in your mind?
- What would you think if gradually through that light emerged the face of Jesus?
- How would that make you feel?
- How would you understand that experience?
- Could your experiences have any bearing on how you understand this experience and how it makes you feel?

- On the next slide carry out the following instructions
- Stare at the blue dots while you count slowly to 30.
- Then close your eyes and tilt your head back. A circle of light will slowly appear. Keep looking at it.
- What do you see?



Environment



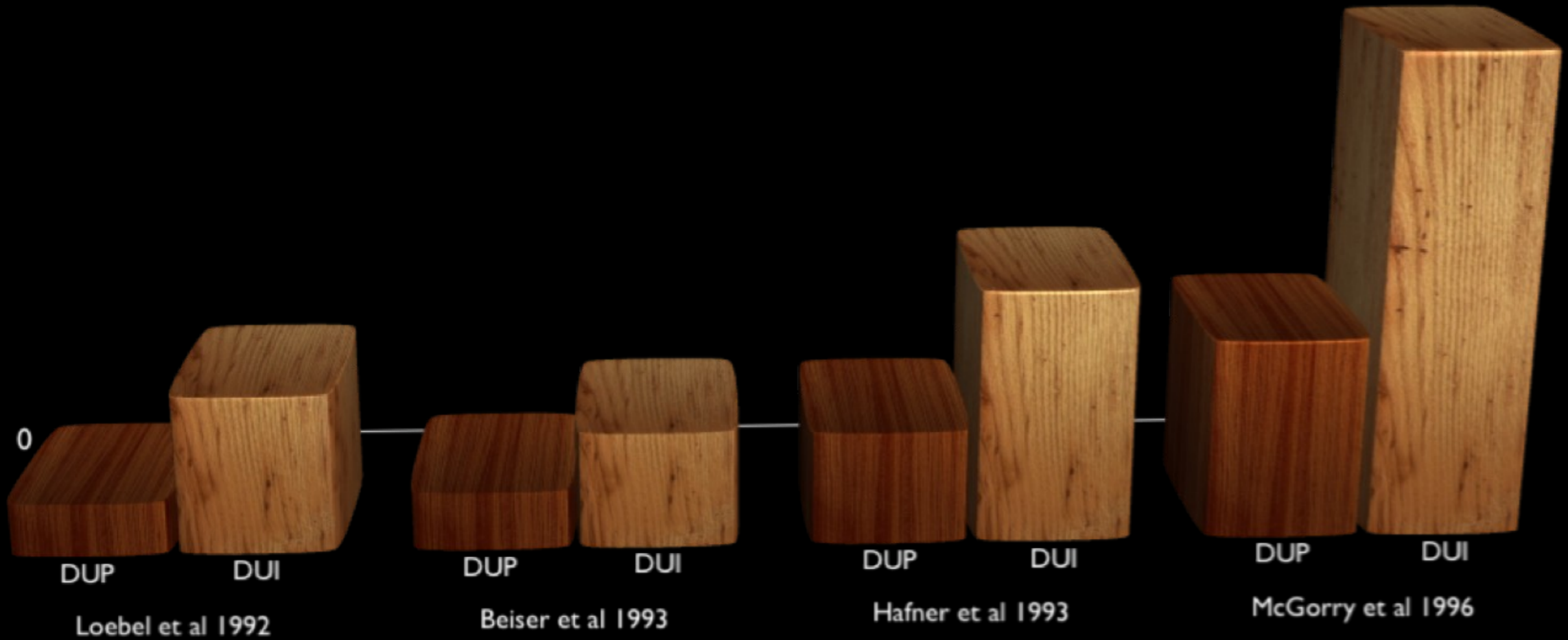


New Developments

Phase specific interventions
Interventions without medication
Metacognitive therapy

DUP D ata

500



Detecting Early Psychosis

Young people with early symptoms/signs of psychosis...

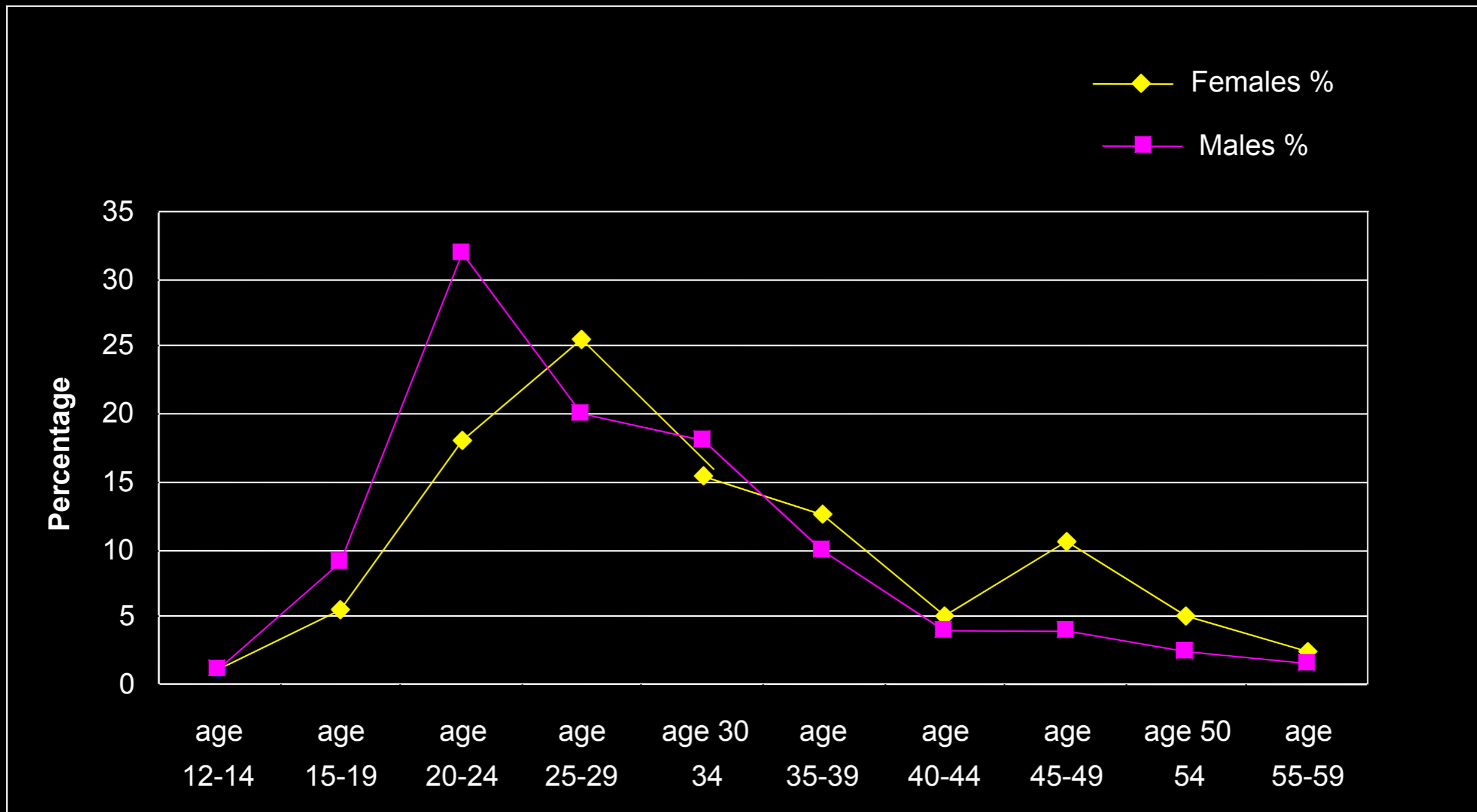
- may try & seek help for their distress

or

- may try & avoid other people

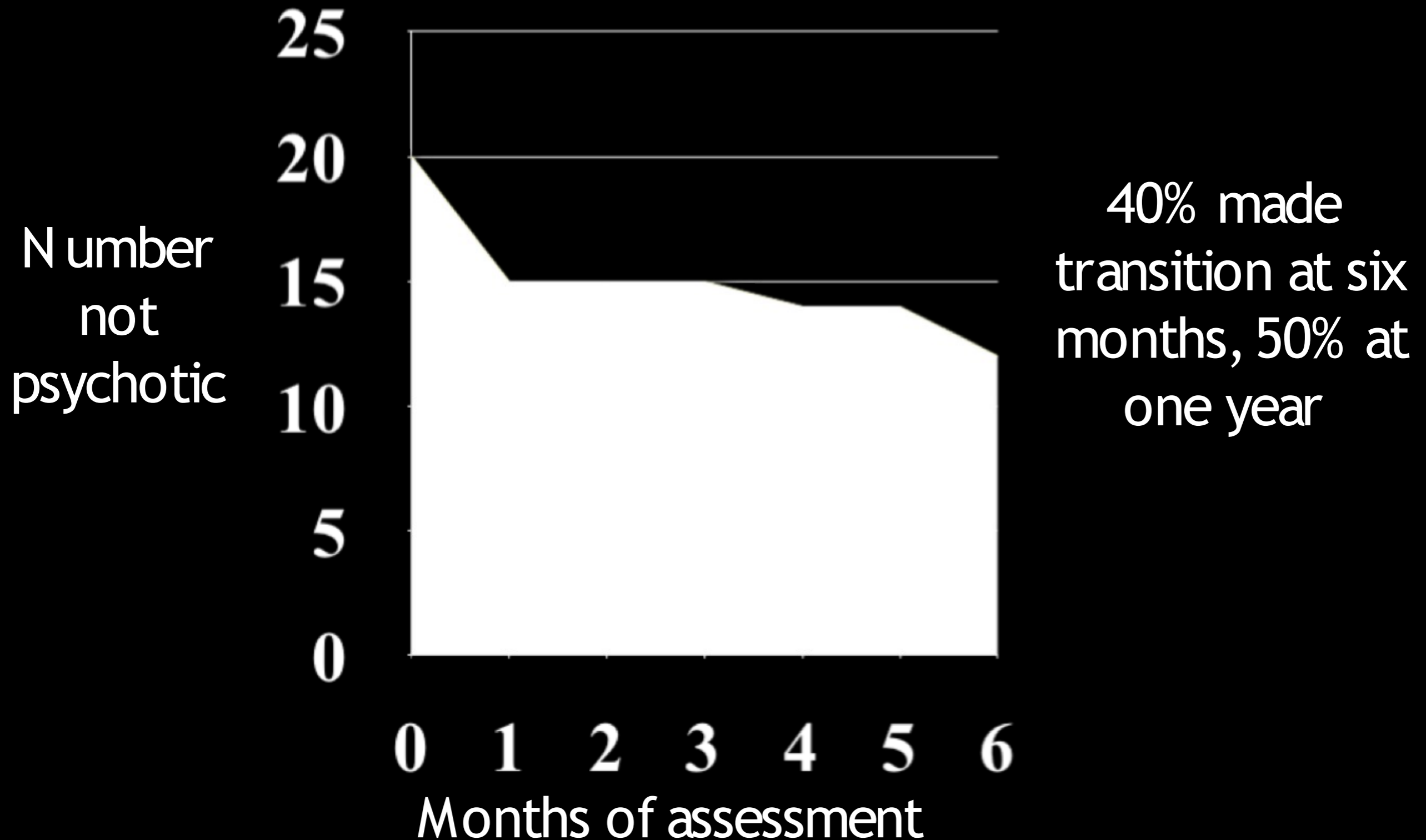
but are often vague about their difficulties or deny they are having problems

Age of onset for schizophrenia



Prediction of Psychosis

Yung et al 1998 British Journal of Psychiatry



PACE referral criteria

- Age between 14 and 30 years

AND

- Family history of DSM-IV psychotic disorder and reduction on GAF scale of ≥ 30 ,

AND/OR

- Attenuated symptoms, occurring several times during the week for at least one week

AND/OR

- Brief, limited or intermittent psychotic symptoms (BLIPS) for less than one week and resolving spontaneously

Prediction of Psychosis

Klosterkötter et al. Arch Gen Psychiatry. 2001;58:158-164

- N = 110
- Recruited from a specialist clinic
- Assessed using the BSABS
- Follow up over 9.6 years
- In this sample of nonpsychotic outpatients, of those who reported at least one prodromal symptom on the BSABS, 70% subsequently developed the psychosis

Assessments for identification

- Brief Psychiatric Rating Scale (BPRS) Lukoff, Neuchterlein & Ventura (1993)
- Positive And Negative Syndromes Scale (PANSS) Kay, Fiszbein & Opler (1987)
- Comprehensive Assessment of At Risk Mental States (CAARMS) Pace clinic Yung et al 2002
- Structure Interview for Prodromal Symptoms (SIPS) Scale of Prodromal Symptoms (SO PS) Prime clinic McGlashen, Miller, Woods, Rosen, Hoffman & Davidson
- Bonn Scale for the Assessment of Basic Symptoms (BSABS) Klosterkoette, Schultze-Lutter

What prevention strategy

Mrazek and Haggerty (1994) have discussed the idea of preventative interventions and identified three prevention strategies. These are:

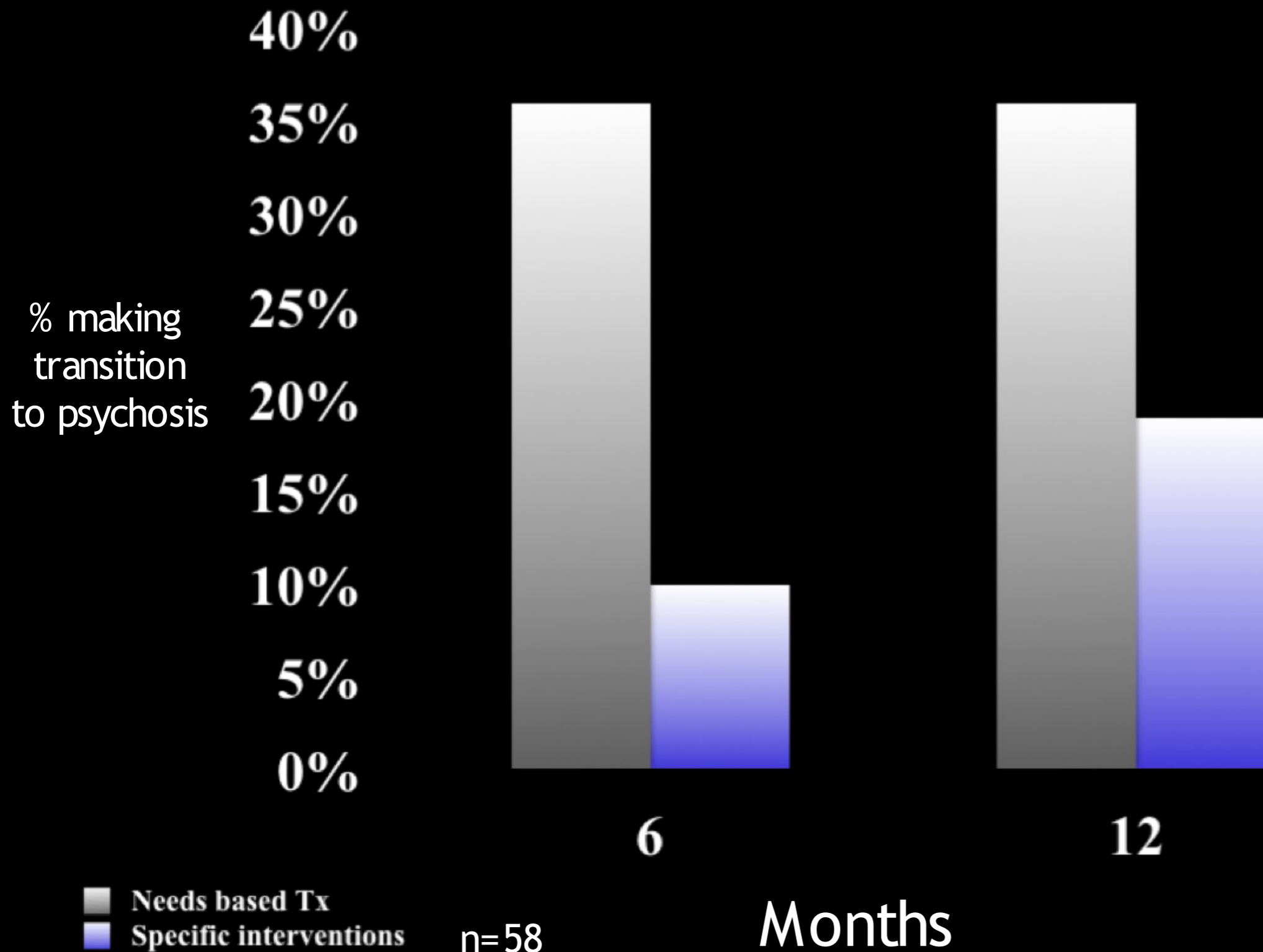
Universal all of the population

Selective specific risk factors

Indicated minimal, but detectable,
signs of psychosis

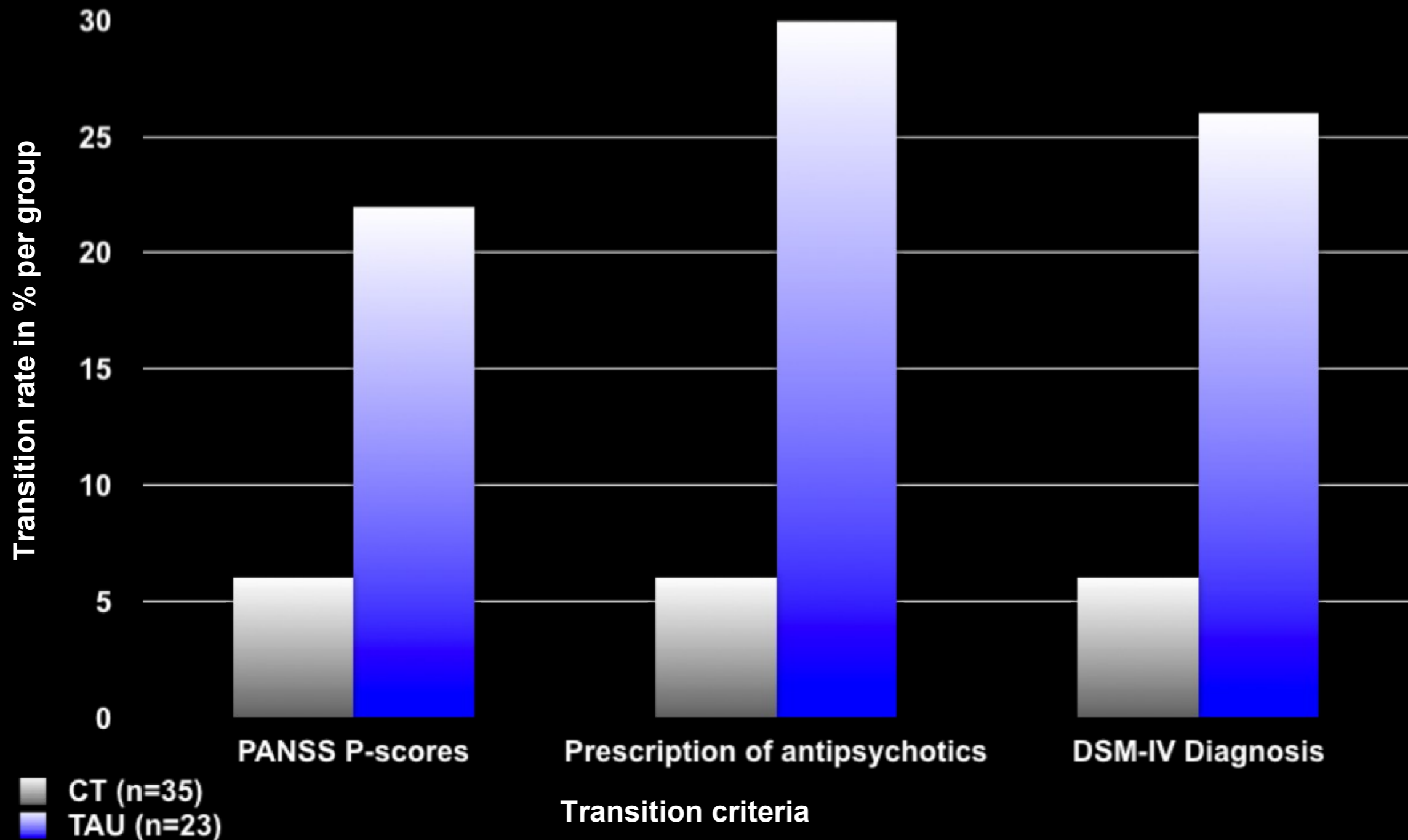
Prevention of psychosis

McGorry et al 2002 Archives of General Psychiatry

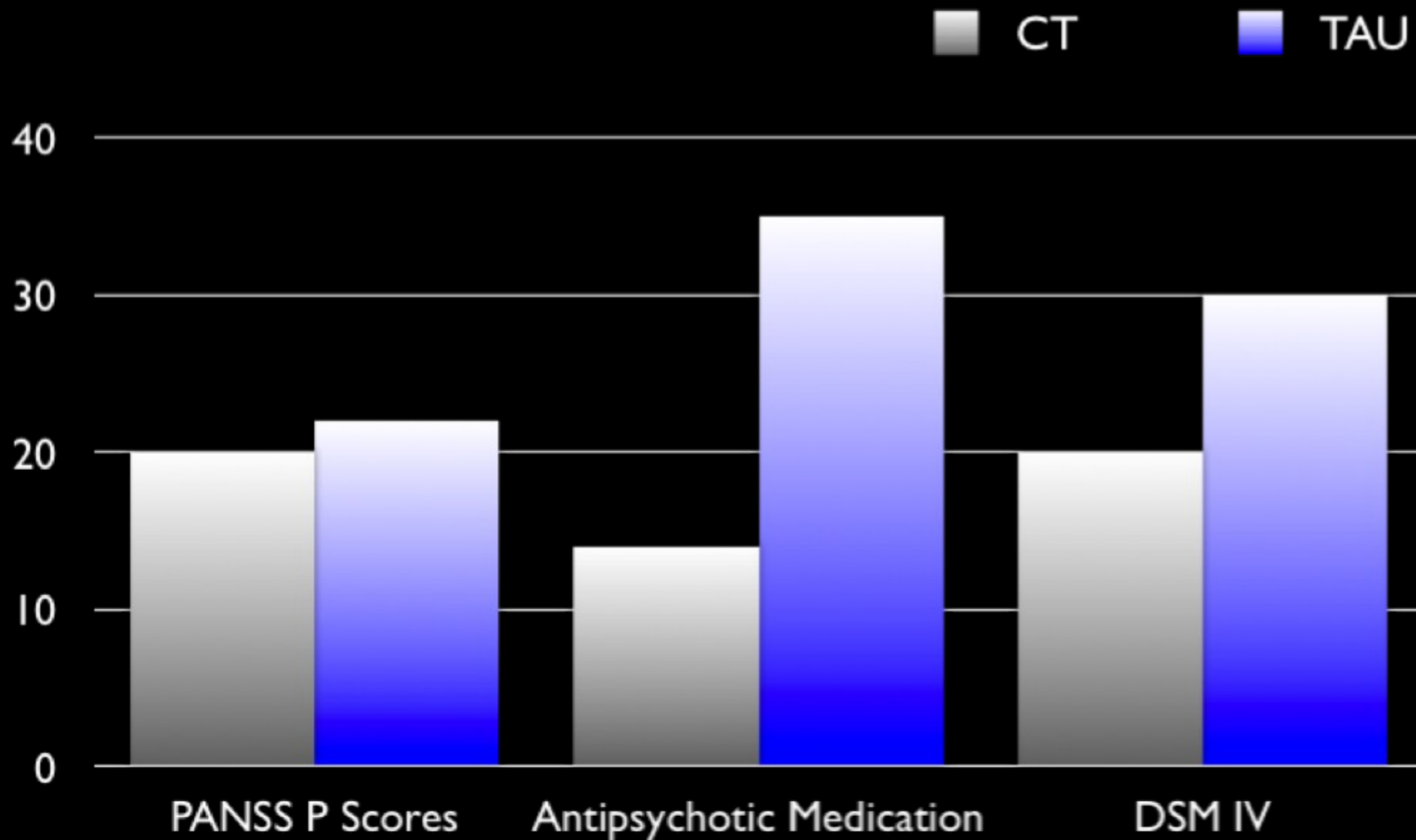


***A single blind randomised controlled trial Cognitive Therapy vs. Treatment
As Usual***

**Preliminary Results from 12 months Follow-up
Morrison, French et al 2004**

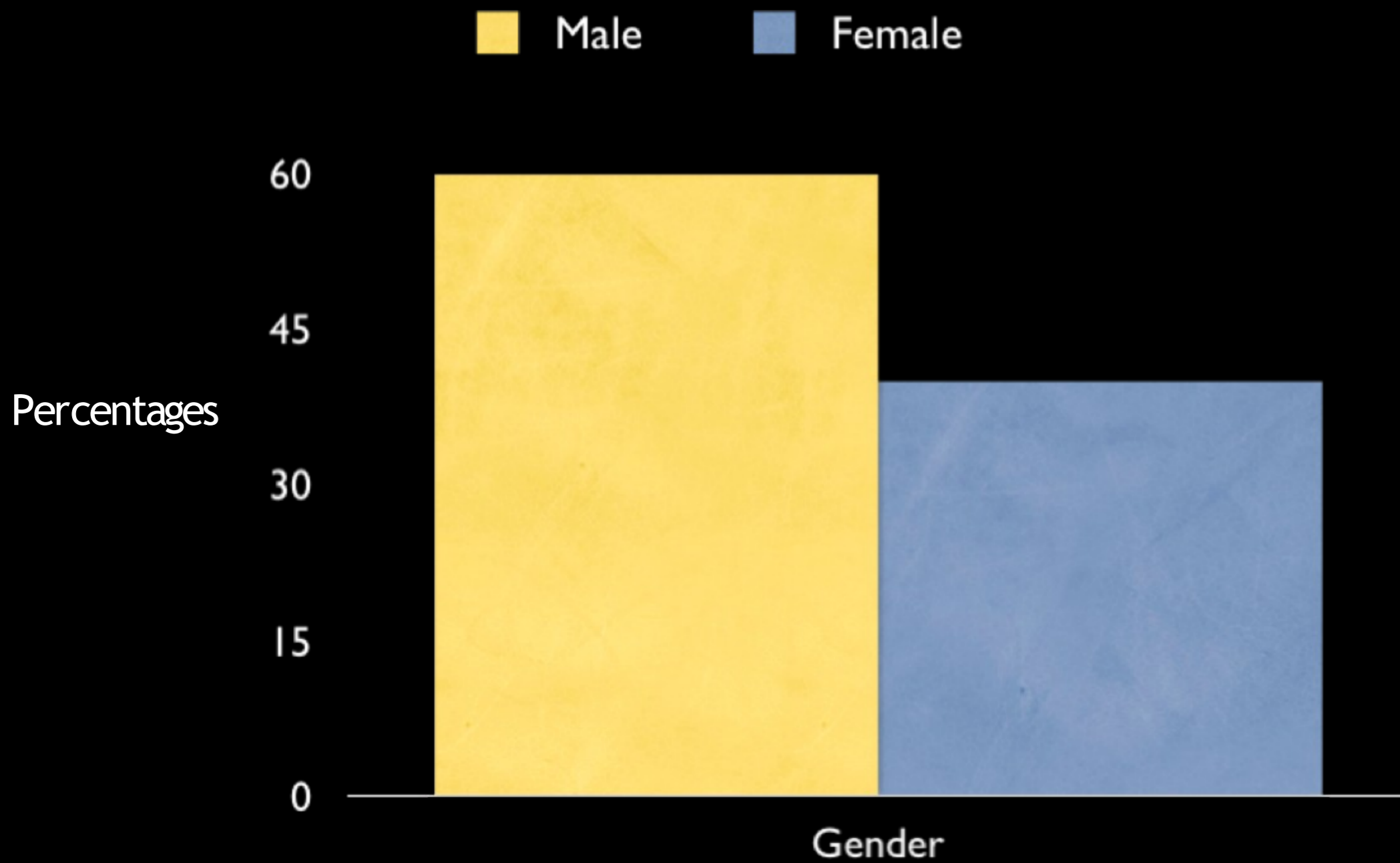


A single blind randomised controlled trial
Cognitive Therapy vs. Treatment As Usual
Results from 36 months Follow-up Morrison,
French et al 2006
Results from 36 months Follow-up Morrison,
French et al 2006



ED IE2:Age range baseline data n= 189

- Average age 20.86 years
- Range 14 - 34
- Median 20 years



Education

- Average number of years in education 12.5 years
- Range 6 - 20
- Median 12.5

Global Assessment of Functioning

- Average GAF score at baseline -1 = 51.2
- Range baseline -1 21 - 87

- Average score highest 60.1
- Range highest 25 - 91
- This is a 15% drop across all randomised

- Average at baseline 0 = 52.2
- Range baseline 0 = 21 - 87

Change the appraisal

- Don't just go for a reduction in frequency
- Ensure that the appraisal of the experiences is formulated

Case

- Young man was referred from one of the wards. Provisional diagnosis: schizophrenia, drug induced psychosis, personality disorder. Had ideas that he was related to royalty. Very difficult to sustain contact with him due to his moving around. His main problem was that he wanted to find his biological mother.

Intrusion into awareness

No one will tell me my blood type
People are looking at me
Once when had head shaved my head looked blue

Culturally Unacceptable interpretation of intrusion

They will not tell me because it will confirm
I am a member of the royal family
Everyone knows I am someone special
I must be blue blooded

Faulty self and social knowledge

Perhaps I am related to royal family
An old man said I had marks indicating connection to the royals
Friend told me that people are following me
If you get blood type you can tell if you are a royal
No one should be trusted

Experience

Real mother left me aged 5, with step father.
Step father physically and mentally abusive.
Used to go into fantasy world

Mood and physiology

Stomach problems
Anxiety
Depression
Anger

Cognitive and behavioural responses

Watch out for people in the street and pubs looking at me
Dissociation



Interventions

- Initially some case management interventions including assertive outreach in order to maintain contact. Has had 9 different addresses ranging over 3 counties in 6 months.
- He did not engage with any other services offered, ie CMHT, outpatient, 42nd street.
- Crisis management

Cognitive interventions

- Listen to story without judgement
- Sit on the fence
- Explore alternative explanations
- Develop formulations introducing role of intrusions and interpretations
- Positive data log self esteem

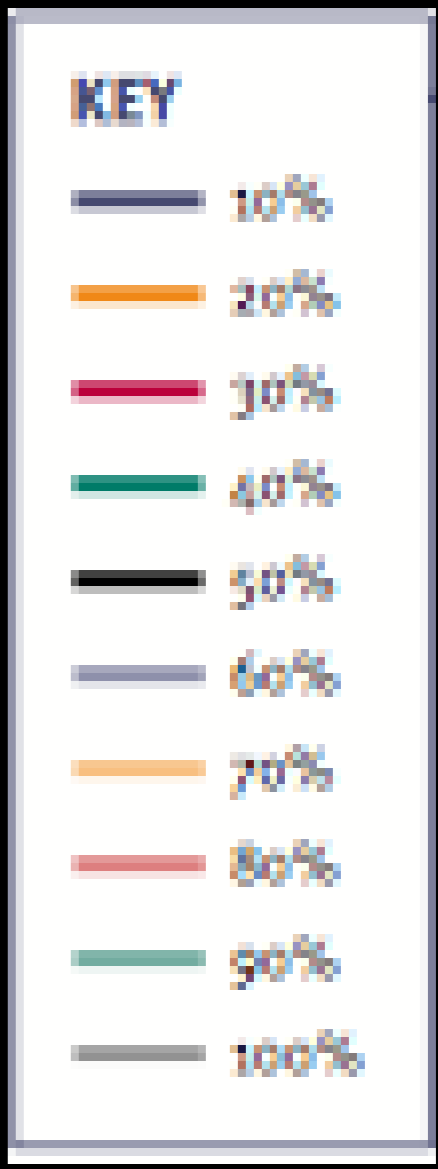
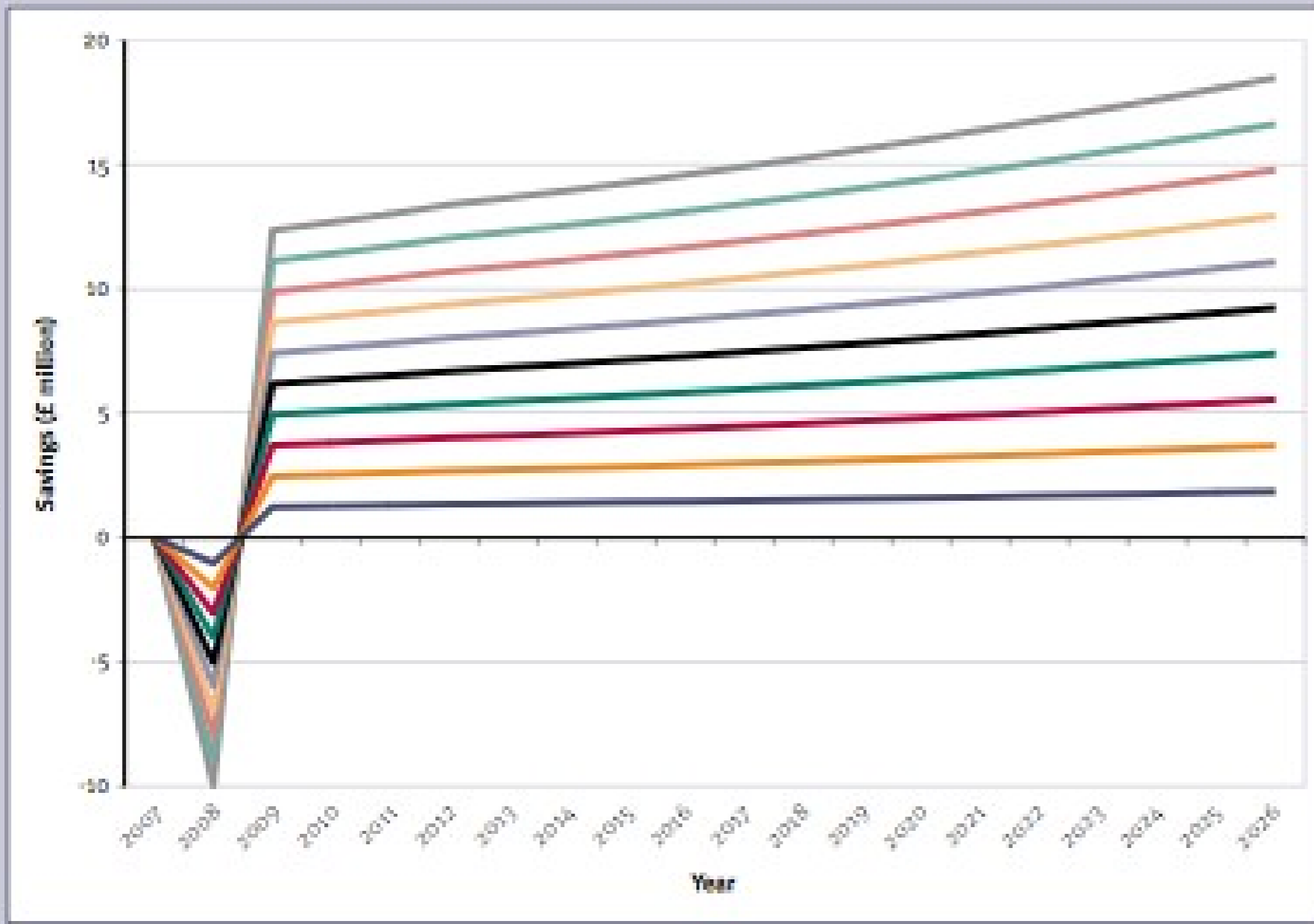
Do

- Utilize the structure associated with CBT
- Go for an early success experience
- Formulate the individuals problems
- Tolerate a few missed sessions
- Believe in the model
- Provide opportunity for a flexible response

Don't

- Tell them what is wrong
- Attempt to force people into a model
- Spend time purely empathising
- Give up easily
- Discharge because of one or two missed appointments
- Increase/introduce new antipsychotics just because of emergent symptoms

POTENTIAL SAVINGS FROM EXPANDING PROVISION OF EARLY DETECTION SERVICES FOR SCHIZOPHRENIC DISORDERS, 2007 TO 2026



Questions & discussion