Psychological therapy for psychosis: An update

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Group discussion: issues in using CBT for psychosis

• What are the similarities and differences between CBT for psychosis and CBT for other disorders?
• Are there any specific challenges therapists may face in using CBT with people with psychosis?
• Any fears or concerns about working with psychosis?
• What typical problems faced by people with psychosis can CBT help with?
What I will talk about

• Overview of CBT
• Overview of psychological formulation of psychosis
Cognitive Behaviour Therapy

- works from the patient’s point of view
- is collaborative
- builds up strengths
  (does not strip away defences)
- Builds on good basic psychotherapeutic skills
  (warmth, empathy, concern)
- central task is making sense of and explaining psychosis
- process of therapy, strategy and use of techniques is guided by assessment and formulation
Cognitive behaviour therapy for psychosis

Individually formulated - not a package treatment

Targets:
- drug resistant psychotic symptoms
- emotional disturbance
- social disability
- risk of relapse

Therapy targets in CBT for psychosis

- Establishing a relationship
- Assessing and making sense of psychosis
- Promoting self regulation
- Providing a framework for understanding anomalies of experience
- Assisting the search for less distressing meanings
- Identifying and managing emotional problems
- Promoting adaptive behaviour
The six stages of Cognitive Behaviour Therapy for Psychosis

1. Engagement and assessment
2. Promoting self regulation of psychotic symptoms
3. Developing a shared model of psychosis
4. Addressing delusions and beliefs about voices
5. Addressing dysfunctional assumptions about self and others
6. Addressing social disability and risk of relapse
CBT for psychosis?

Sorry, your highness, but you're really not the dictator of Ithuvania, a small European republic. In fact, there is no Ithuvania. The hordes of admirers, the military parades, this office -- we faked it all as an experiment in human psychology. In fact, your highness, your real name is Edward Belcher, you're from Long Island, New York, and it's time to go home, Eddie.
“It’s time we face reality, my friends. ... We’re not exactly rocket scientists.”
Understanding the inexplicable:

A rationale for CBT for psychosis

- David Fowler,
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Robbie was came into contact with mental health services via the court. He had been violent and aggressive to strangers in the street. On first meeting he was actively suspicious and guarded. He said there was a group out to get him. This included the police but also several other people who were following him and keeping an eye on him. He expected to be attacked at any moment. He had been hearing voices for several months which told him about the threat. Most of the time he tried to stay at home which was better, although he was still preoccupied with the threat and the voices often said when he would be attacked. When he went out he felt terrible, really frightened because lots of people were looking at him and he could trust no-one.
Problems in making sense of psychosis

- Heterogeneity in underlying processes and symptom presentation
- Severity and complexity of symptoms
- Changes in symptom profiles over time
Contemporary concepts of psychosis

Traditional assumptions
• Signs and symptoms reflect underlying disease process
• Discontinuous with normality
• Inevitable decline
• Not amenable to psychosocial intervention (weak effects for psychotherapy)

Contemporary assumptions
• Signs and symptoms reflect beliefs and experiences which arise from psychological and social as well as biological processes
• Continuous with anomalies of normal experience
• Considerable heterogeneity in course and outcome
• Amenable to psychosocial interventions (CBT)
A Cognitive Perspective

Psychosis as a life crisis which sets a series of adaptive demands for the individual
People with psychosis are actively attempting to make sense of the world in order to regulate threats which derive from psychotic experiences and from the social world.
Making sense of the problems of people with psychosis

- Normal models of emotions (depression, anxiety, PTSD...)
- Vulnerability-stress models
- Cognitive models of psychotic symptoms
What characterises psychotic symptoms?

• Anomalous experience (altered feelings, thoughts, perceptions)

• Elaborations of experience (hearing things, seeing things, believing things....)

• Content (the devil is after me...you are useless..kill yourself)
Is psychosis understandable?

Similarities: There is a continuity between normal beliefs and anomalous experiences and symptoms of delusions, hallucinations and thought disorder.

Differences: People with psychosis are more distressed, preoccupied with, and convinced about their beliefs and experiences.
Implications of the assumption of continuity

• Psychotic experiences (hallucinations, delusional experience, thought disorder) are on a continua with anomalies of normal experience (deja vu, magical thinking etc)

• Delusional beliefs reflect a search for meaning
Why does anomalous experience occur?

- Problems in source or self-monitoring (Frith, 1992; Bentall, 1990), or contextual processing (Hemsley, 1986, 2005; Bach et al., 2004)

- Confusion between experience of internal origin (thoughts, memories, images) and experience of external origin (visual, auditory, tactile stimulation)

- This may occur as a final common pathway of neurocognitive dysfunction (desynchrony, cognitive slippage, sensory disintegration) and top down processing (expectations, wishes)
What is the consequence of source monitoring problems?

- Hearing or seeing things when they are not there
- Feelings of significance or coincidence in association with non-significant sensations
- As the process is usually automatic people will tend to be unaware of the underlying process or problems and only aware of the consequence
- They are likely to seek an external attribution for the anomaly
The search for meaning

- Delusions and beliefs about voices reflect a search for meaning which is a natural reaction to anomalous experience combined with strong emotion.

- The search for meaning results in delusional beliefs which commonly imply external causation for problems, few people seek alternative explanations for delusions (Freeman et al, J. Clin, Cons. Psychol., 2004).

- A combination of lack of belief flexibility and reasoning errors (jumping to conclusions) and emotional biases shape delusions (Garety et al, J. Abnorm, Psychol, 2005).
The voice seemed to be coming out of the street lamp. Then it stopped. It was spooky.
And then, all of a sudden, the pieces of the puzzle fell into place...
Psychosis, self schemata and emotions

- People with psychosis commonly have extreme negative self schemata (I am bad, unlovable, useless, inadequate) and negative other schemata (others are untrustworthy, threatening, devious) (Fowler et al, Psych Med. In Press)

- Such schemata are strongly associated with paranoia and distress independently of mood (Smith et al, Submitted)

- Distress associated with voices is associated with depression and appraising voices as dominant negative interpersonal others (Vaughan and Fowler, 2004)

- Negative beliefs about self and others and depression in psychosis is strongly associated with a history of victimisation experiences (abuse, bullying) and stigmatisation (Fowler et al, Submitted)
The evolution of voices and delusional beliefs

Fig 2: Developmental History of Delusions and beliefs about voices

Vulnerability
(biological factors, family environment, interpersonal threats and trauma:

( BELIEFS ABOUT SELF AND OTHERS )

TRIGGERING FACTORS
(drugs, stressful life events)

CHARACTERISTICS OF EARLY PSYCHOTIC EXPERIENCES
(Ranges, type and meaning of anomalous experiences)

INITIAL APPRAISALS
(Early delusions and beliefs about voices: effects on emotions)

SUBSEQUENT ANOMALOUS EXPERIENCE

SUBSEQUENT LIFE EXPERIENCE

SYSTEMATISED DELUSIONS AND BELIEFS ABOUT VOICES
Coping and safety behaviours

• Worrying about delusions and voices is associated with distress (Freeman et al, 2003, Morrison et al 2004)

• People naturally attempt to adapt behaviourally to voices and delusions (Falloon and Talbott, 1981) some of these behaviours act as safety behaviours which are likely to maintain threat appraisals and distress (Freeman et al, 2002)
The reinforced concrete and my Walkman shielded me from the scientists.
Getting “stuck in psychosis” (Fowler, 2000; Garety et al, Psych. Med. 2001)

Figure 4.3 Maintenance of threatening reactions to psychosis.
Bored dogs are often subject to the phenomenon of cat mirages.
The cognitive model of psychosis and its clinical implications

The cognitive perspective suggests that psychosis is more amenable to understanding than is commonly believed.

- Helping people understand the nature of their personal vulnerability to psychosis is a core process of cognitive therapy.

- Cognitive therapy involves helping people to become aware of errors in the way they think about psychotic experience and react behaviourally and to compensate for these.

- The aim is to help the person construct a less distressing and more adaptive way of understanding their predicament.
Does CBT for psychosis work?
Stages in the development of CBT for psychosis

1) Early isolated behavioural case reports
   (e.g. Shapiro and Ravenette, 1959; Watts et al, 1973)

2) Development of CBT for psychosis from coping, and CBT for other disorders
   (Fowler and Morley, 1989; Fowler, 1992; Chadwick and Lowe, 1990; Tarrier et al 1993; Kingdon and Turkington, 1990; Perris, 1989)

3) Comprehensive CBT therapy manuals and RCTs

4) Systematic reviews and guidelines (e.g. Cochrane: Jones et al, 1999) WHO, Royal College/BPS guidelines


6) Explanatory and process studies: PRP
Does CBT work?

Published trials with people with treatment resistant psychosis

Effect size

- **London-East Anglia trial: CBT versus case management** 0.86
  (9 months individually formulated CBT)
  29% improvement in BPRS symptom ratings
  65% CBT versus 17% CM made 25% improvement in symptoms

- **Manchester trial: CBT versus supportive counseling** 0.57
  (8 weeks, CBT package techniques)

- **Wellcome trial: CBT versus befriending** 1.18
  (Sensky, Turkington, Kingdon et al, Arch.Gen, Psych 2000)
Change in BPRS scores CBT vs CM (Kuipers, Fowler, Garety et al, Brit.J.Psychiat. 1998)

Graph of Brief Psychiatric Rating Scale (BPRS) scores

Assessment Number

Key for x-axis: 0=initial assessment, 1=3-month assessment, 2=6-month assessment, 3=9-month assessment, 4=18-month assessment
Change in Delusional Variables

Conviction  Distress  Preoccupation
Systematic review of trials of CBT (odds ratio)
Participants receiving CBT have a 22% greater chance of making a 50% improvement in mental state at post treatment than alternative condition (Pilling et al Psych Med 2002)
CBT and promoting recovery from acute psychosis

- **Compliance therapy** (4-6 sessions CBT)

- **Cognitive therapy** (Intensive individual and group CBT)
  Improvements in recovery time, relapse and social functioning (Drury et al, Brit. J. Psychiatry 1996)

- **SOCRATES** (Intensive short term CBT in early phase)
  Significant improvement in recovery from positive symptoms, limited effects on relapse/social functioning (Lewis et al, BMJ, 2004)
CBT shows significant improvements on negative symptoms

- Toronto study: Rector and Beck (Schiz Res. 2004)
- Bangor Study: (Startup et al, Psych Medicine, 2004)
- Newcastle-London study: (Sensky et al Archives Gen Psychiatry, 2001)
Effectiveness studies

Non-specialist therapists (nurses) in normal clinical practice after brief training


Have significant but smaller effects particularly on general psychopathology rather than specific psychotic symptoms

Adherence issues?
CBT in relapse prevention

**Ayr study:** Formulation based CBT plus booster sessions reduces relapse (Gumley et al, Psych. Med. 2004)

**PRP study:** Multicenter trial of CBT and family work in relapse prevention (Garety, Kuipers, Fowler, Bebbington, Dunn)
CBT in relapse prevention (Gumley et al, 2003)

- Targeted at high risk of relapse groups
- Therapy initiated at recovery: traditional CBT approach (psychoeducation, warning signs, management of relapse, fear of relapse)
- Booster sessions at incipient relapse
- At 12-months, 11 (15.3%) CBT group 19 (26.4%) TAU admitted
- 13 (18.1%) CBT relapsed compared to 25 (34.7%) in TAU
- CBT group showed greater improvement in negative symptoms (mean difference CBT - TAU in change from baseline at 12 months -1.73, p = 0.035, 95% CI –3.33, -0.13), global psychopathology (-4.10, p = 0.0012, 95% CI –6.55, -1.65), performance of independent functions (2.70, p = 0.027, 95% CI 0.32, 5.08) and prosocial activities (3.99, p =0.0072, 95% CI 1.10, 6.88).
- (Rector and Beck, 2003, Schiz. Res., Sensky et al, 2001; also show benefits in negative symptoms, gen psychopathology from traditional CBT approach)
Sample: people presenting with second or subsequent acute psychotic relapse in 5 centres in London, Essex and Norfolk

Design
1) Alone: CBT (140) vs TAU (140)
2) Family CBT (30) vs FI (30) vs TAU (30)
   9 months treatment, 2 year f/u

Recruitment completed June 2004  n=304

Measures:
1) relapse, readmission, cost
2) symptoms, social functioning, quality of life
3) process measures
Conclusions

• There is strong evidence for effects of CBT on symptom reduction and distress with people who have distressing chronic treatment resistant psychotic symptoms.

• There is some evidence to suggest that use of CBT may improve recovery from positive symptoms after acute psychosis.

• There are promising indications of evidence for CBT in preventing relapse/readmission the PRP study will provide a definitive indication.