Cognitive Therapy for Psychosis

... or

‘Good Clinical Practice’

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AGENDA

- Controversies about evidence
- Availability
- What is CBTP?
- Language
- New studies & applications
Evidence for CBT for Psychosis
(Wykes et al, 2008)

- Average effect size for target symptom (33 studies*) = 0.40
- Average effect size for “rigorous” RTCs (12 studies) = 0.22
- Significant effects (ranging from 0.35 – 0.44) for:
  - Positive symptoms (32 studies)
  - Negative symptoms (23 studies)
  - Functioning (15 studies)
  - Mood (13 studies)
  - Social anxiety (2 studies)

*20 from UK, 5 from USA, 2 from Germany, Australia, Netherlands, 1 from Canada, Italy, Israel; 27 individual CBTp, 7 group CBTp
Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials

D. Lynch¹, K. R. Laws² and P. J. McKenna³,⁴*

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² School of Psychology, University of Hertfordshire, Hatfield, UK
³ Benito Menni CASM, Barcelona, Spain
⁴ CIBERSAM, Spain
Over-simplification and exclusion of non-conforming studies can demonstrate absence of effect: a lynching party?

A commentary on ‘Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials’ by Lynch et al. (2009)

D. Kingdon*
CBT and ‘befriending’ in schizophrenia resistant to medication

SANS – Scale for Assessing Negative Symptoms

Brief CBT Intervention Study
Results: at 1 yr (n=336)

Brief CBT significantly reduced time spent in hospital for those who relapsed (CBT mean 47 days vs TAU mean 80 days) and delayed time to rehospitalisation (OR, 1.837, 1.108, 3.04, p=0.018).

Turkington et al, 2006
Availability of CBT
(West Southampton - Kirschen & Kingdon, 2006)

142 patients identified with schizophrenia (expect about 200)
69 (49%) had been referred for CBT

IAPT-SMI: Demonstration sites & Competency framework
There is a strong focus on individualised engagement of the patient building on good psychiatric practice.

Agendas are less explicit, feelings are elicited with great care and homework is used sparingly.

Assessment is based on clinical practice.

Emphasis is placed on understanding the first episode in detail, which may hold the key to current beliefs.

Information on current beliefs and how they were arrived at is assembled into a formulation.
What happened: Post-trauma intrusions

How I make sense of it

Beliefs about yourself and others and strategies

What do you do when this happens

Life experiences (inc. trauma)

How does it make you feel

Formulation (Morrison)
A formulation for making sense of patients’ beliefs and experiences

- Predisposing factors
- Precipitating factors
- Perpetuating factors
- Protective factors

Current problems

- Thoughts
  - Social
  - Physical
- Feelings
- Behaviour

Underlying concerns (schemas)
<table>
<thead>
<tr>
<th>Predisposing</th>
<th>Precipitating</th>
<th>Perpetuating</th>
<th>Protective</th>
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**Current concerns**

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<tr>
<th>THOUGHTS</th>
<th>FEELINGS</th>
<th>ACTIONS</th>
<th>SOCIAL</th>
<th>PHYSICAL</th>
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**UNDERLYING CONCERNS**
What happened: Post-trauma intrusions

How I make sense of it

Beliefs about yourself and others and strategies

What do you do when this happens

Life experiences (inc. trauma)

How does it make you feel

Formulation (Morrison)
Overall aim of CBT for schizophrenia

AIM
To reduce distress and disability

Work with delusions (systematised & high conviction)

Work with hallucinations (persistent/abusive)

Work with negative symptoms
Work with delusions
"I propose we trade services - you cure me of my delusions and I'll protect your navy."
Resistant delusions

- if going round in circles
  - ‘Agree to differ’
  - review key issues & concerns that have emerged: e.g. ‘I don’t want to end up like my mother’, ‘I haven’t got a girlfriend’, ‘I’m useless’
  - it may be possible now to work directly with these
  - behaviour often changes first ..... 

- Other psychological techniques may be helpful: e.g. inference chaining
Work with voices
I KEEP HEARING THESE VOICES, DOC.
Coping strategies

- **Behavioral control**
  - e.g. relaxation, warm bath, go for walk

- **Socialisation**
  - e.g. friends, day centres

- **Medical care**
  - e.g. control of medication, call care worker

- **Symptomatic behaviour**
  - e.g. get drunk or drugged, punch policeman

- **Cognitive control**
  - e.g. TV, music, crosswords
Work with negative symptoms
NEGATIVE SYMPTOMS

- manage positive symptoms
  - especially ideas of reference, voices & thought broadcasting which can be reactivated as social and other activity increases
- manage any depression, anxiety & agoraphobia/social phobia
- optimise medication regimes
NEGATIVE SYMPTOMS

● Consider the protective function of the symptoms, e.g.:
  – avoidance of over-stimulation
  – protection from relapse of positive symptoms

● Assess how much pressure the patient and family perceive:
  – Reduce pressure where possible
  – Review immediate expectations
  – Use realistic long-term planning, e.g. ‘take a year off then reconsider going to college when you feel ready’
  – Reduce level of activity if it is causing distress
Insight scores
(David’s Insight Scale 1990)

Three components:

a. Acceptance of need for treatment

b. Acceptance that they have an illness

c. Acceptance that voices or delusions are originating from themselves
Insight scores
(David’s Insight Scale 1990)

- Three components:
  a. Acceptance of need for treatment
  b. Acceptance that they have an illness
  c. Acceptance that voices or delusions are originating from themselves

- Improvements in a. & c. correlate with improved overall outcome
Insight scores
(David’s Insight Scale 1990)

- Three components:
  a. Acceptance of need for treatment
  b. Acceptance that they have an illness
  c. Acceptance that voices or delusions are originating from themselves

- Improvement in b. correlates with increased depression
“It’s a taboo subject.

One day I was in a taxi and the taxi-driver said, ‘What’s wrong with you?’

I said, ‘I’ve got thoughtbroadcasting and bizarre behaviour.

He said, ‘Oh no, you haven’t. Tell me you haven’t got it’.

So, I don’t talk about it. They might take it the wrong way.”

Copyright: Moira Blackwell 2004
Down with schizophrenia

Lumping together a diverse range of conditions under a name that patients fear and doctors don’t understand helps no one, says David Kingdon

IN 2011, schizophrenia will be 100 years old. This also happens to be the year in which the main classification systems for psychiatric disorders are due to be revised. The question is: does the term “schizophrenia” deserve to survive into its second century?

Most patients would say no. In my work I find the diagnosis very difficult to use because it depresses patients and their carers and stigmatises them at home and at work. Patients constantly tell me how unhelpful they find it, and many simply reject the term.

Indeed, the classification has little if any scientific basis. Previously known as “dementia praecox” – early-onset dementia – schizophrenia has been used to cover a collection of diverse states ever since Swiss psychiatrist Eugen Bleuler coined the name in 1911. Conditions continued to be added until the 1970s, when it was decided that the classification had become impossibly wide. The “solution” was to focus on the nature of the symptoms (whether a patient has certain types of delusions, for example, or hears voices) but to ignore the content of those symptoms (what the patient is afraid of, or what the voices say). There is now a checklist of symptoms that helps doctors decide whether someone has schizophrenia recently renamed “integration disorder”) will not change the root cause of the stigma – general ignorance of mental illness.

The problem with this argument is that a century of trying to unpick the biological basis of schizophrenia has made very little progress, and has been has transformed the way that voices are considered, and helped many individuals to cope with stigmatising and unhelpful labels, and to deal with their hallucinations more positively. Psychosocial research into schizophrenia is also beginning to reveal the impact of environmental factors such as stimulant and hallucinogenic drugs, stress and childhood trauma. This has led to the idea of subgroups of the condition, such as stress-sensitivity psychosis, traumatic psychosis, anxiety psychosis and drug-related psychosis. Although more research is needed to better delineate these groups, this terminology is proving to be much more acceptable to patients. It is also more accurate, and may be less stigmatising. Our studies recently found that where 63 per cent of diagnosed patients have negative attitudes towards the term schizophrenia, only 16 per cent were negative about such new terms. Medical students asked to contrast these terms with schizophrenia were twice as likely to hold positive views about a patient’s chance of recovery (BMJ, vol 334, p 221).

Renaming schizophrenia is highly controversial. It is difficult for psychiatrists and researchers to acknowledge that the concept they have been using for almost 100 years makes no sense. The drug industry is also likely to be resistant. Dividing patients into smaller groups means that not every drug will work in every group, reducing the potential market.
Use of alternative terminology

- User views of ‘schizophrenia’ & newer terms
  - Negative: 63% schiz v. 16% *(Kingdon et al, 2010)*

- Correlation between case note diagnosis & selection of group
  - Users (n=59): poor
  - Carer (n=20): moderate

- Reliability (agreement) of selected case note diagnosis: four psychiatrists blind-rating: ICC – 0.81

- *Structured clinical interview for psychosis subgroups (SCIPS)* *(Kinoshita et al, 2012)*
Attitudes to schizophrenia: does changing terminology make a difference?

(Kingdon, D., Selveraj, S., Vincent, S., Mehta, R. & Turkington, D, 2008)
Attitudes to subgroups

<table>
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<tr>
<th>Opinion</th>
<th>Schizophrenia</th>
<th>Sensitivity Psychosis</th>
<th>Drug Psychosis</th>
<th>Anxiety Psychosis</th>
<th>Traumatic Psychosis</th>
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<td>Danger to others</td>
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<td>Unpredictable</td>
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<td>Not improve</td>
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<td>Feel different</td>
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<td>Never recover</td>
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<td>Cannot pull self</td>
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[\% expressing negative opinion]
The Day My Bum Went Psycho

Andy Griffiths
Early-onset 'Sensitivity' Psychosis

Post 'Traumatic Stress Psychosis'

Late-onset 'Anxiety' Psychosis

Drug-related Psychosis

Bipolar disorder

Delusional disorder

OCD

PTSD

Depressive Psychosis

‘Borderline personality disorder’

Social anxiety

Psychosis

Schizoid Personality

Antisocial Personality

Aspergers

Participants meeting DSM IV criteria for borderline personality disorder and schizophrenia

- 3 groups (n=111):
  - 59 with a diagnosis of schizophrenia
  - 33 with a diagnosis of BPD,
  - 19 with a diagnosis of both BPD and schizophrenia

- No difference in characteristics of ‘voices’ across the groups (except distress in BPD)
Those with a diagnosis of schizophrenia reported significantly less total trauma than those with BPD or both schizophrenia and BPD \((p<0.001)\). Significantly lower levels in schizophrenia with all five types of trauma than the other two groups:

- emotional abuse \((p<0.001)\),
- physical abuse \((p<0.01)\),
- sexual abuse \((p<0.001)\),
- emotional neglect \((p<0.001)\)
- physical neglect \((p<0.005)\)

*Emotional abuse is the key predictor*
Dealing with trauma/abuse experiences in psychosis

Focus on managing distress and beliefs – shame, guilt, anger - rather than experiences
Clarify beliefs about voices

Discuss belief that you have to do what voices say

Re-assess risk
Anger management is very relevant – reduces incidents

Alongside CBTP
Engage early – not when patients are trying to put experience behind them

Don’t forget negative symptoms
Beck et al (2011) CBT for negative symptoms targeting self-defeating attitudes (50 sessions!)
Studies (ongoing)

- MRC COMMAND – completed recruitment (2-300)
- Texas RCT – cognitive remediation + CBT: recruiting
- RfPB ACTION – CBT for medication-refusers
- US Veteran’s Admin RCT – on-going (70/120)
- Beijing RCT – good unpublished results
- NIMH RAISE – Early intervention ‘package’
- MRC EME – ‘Worry intervention’
- NIHR – Mindfulness for voices
- NIHR DIALOG+ - patient feedback + CBT response
- HTA CBT for Clozapine-resistant psychosis
- DoH DRE Adapted CBT for diverse communities
The effects of reducing worry in patients with persecutory delusions: study protocol for a randomized controlled trial

Daniel Freeman¹*, Graham Dunn², Helen Startup³ and David Kingdon³

Abstract

Background: Our approach to advancing the treatment of psychosis is to focus on key single symptoms and develop interventions that target the mechanisms that maintain them. In our theoretical research we have found worry to be an important factor in the development and maintenance of persecutory delusions. Worry brings implausible ideas to mind, keeps them there, and makes the experience distressing. Therefore the aim of the trial is to test the clinical efficacy of a cognitive-behavioral intervention for worry for patients with persecutory delusions and determine how the worry treatment might reduce delusions.

Methods/Design: An explanatory randomized controlled trial - called the Worry Intervention Trial (WIT) - with 150 patients with persecutory delusions will be carried out. Patients will be randomized to the worry intervention in addition to standard care or to standard care. Randomization will be carried out independently, assessments carried out single-blind, and therapy competence and adherence monitored. The study population will be individuals with persecutory delusions and worry in the context of a schizophrenia spectrum diagnosis. They will not have responded adequately to previous treatment. The intervention is a six-session cognitive-behavioral treatment provided over eight weeks. The control condition will be treatment as usual, which is typically antipsychotic medication and regular appointments. The principal hypotheses are that a worry intervention will reduce levels of worry and that it will also reduce the persecutory delusions. Assessments will be carried out at 0 weeks (baseline), 8 weeks (post treatment) and 24 weeks (follow-up). The statistical analysis strategy will follow the intention-to-treat principle and involve the use of linear mixed models to evaluate and estimate the relevant between- and within-subjects effects (allowing for the possibility of missing data). Both traditional regression and newer instrumental variables analyses will examine mediation. The trial is funded by the UK Medical Research Council (MRC)/NHS National Institute of Health Research (NIHR) Efficacy and Mechanism Evaluation (EME) Programme.

Discussion: This will be the first large randomized controlled trial specifically focused upon persecutory delusions. The project will produce a brief, easily administered intervention that can be readily used in mental health services.

Trial registration: Current Controlled Trials ISRCTN23107626
Worry intervention for delusions
(Freeman et al, 2012, 2013)

- Psychoeducation about worry,
- Reviewing of positive and negative beliefs about worry,
- Increasing awareness of the initiation of worry and identification of individual triggers,
- Learning to ‘let go’ of worry,
- Use of worry periods,
- Substituting problem-solving in place of worry,
- Relaxation exercises,
- A simple individualised formulation of each person’s worry was developed and homework between sessions was agreed,
- Written information was provided in the form of a leaflet called ‘winning against worry’.
‘Mindfulness is a new relationship with experience, where we

● Accept/Welcome all experience
● Experience it with full awareness
● Understand that it is just a fleeting object of awareness, so do not define self by it (not me, not mine)
● Let it go
● Judge neither it nor self’
How satisfied are you with your...

mental health?
physical health?
job situation?
accommodation?
leisure activities?
friendships?
partner/family?
personal safety?
medication?
practical help you receive?
consultations with mental health professionals?
Developing culturally-sensitive CBT for psychosis

- Differing help seeking pathways/behaviours
- Access and referral routes differ – imams, faith healers, etc: effective or impact on early intervention
- Collaboration/individualisation does not compensate for lack of understanding of cultural background
- Language/terminology – e.g. patois in AC
- Individualism vs collectivism (family) – esp. SA Muslim
- Religion – impact in SAM & African-Caribbean
- Gender & family issues
- Interpreters – family complications, confidentiality
- Supernatural vs Scientific
- Expectations of therapist
- Self-disclosure: key for AC – not so for SAM

(Rathod et al, 2010)
Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial🌟

Shanaya Rathod a, Peter Phiri a,b,*, Scott Harris c, Charlotte Underwood a, Mahesh Thagadur a, Uma Padmanabi a, David Kingdon b
RCT CBT in Schizophrenia (Beijing n=60)
RCT CBT in Schizophrenia (Beijing n=60)

SAI – Scale for assessment of insight
PSP - Personal and Social Performance Scale
Emotional Wellbeing

Informing, guiding, supporting...

Tip of the day

Clear clutter from your house, your car, your desk and let new and flowing energy into your life.

I’m interested in learning about...

News

Seven principles of better adoption of evidence in practice, from new MeReC bulletin

Most read...

Finding your way...

www.emotionalwellbeing.southcentral.nhs.uk
Psychosocial Treatment - Psychosis

As we have done previously, we are using the term psychosis. Most relevant guidance described here continues to use the term 'schizophrenia'. General information on psychosocial treatments (meaning psychological and family work) is given first and then more specific information for professionals.

Information for service users and carers (NICE) on psychological treatment:

Psychological treatment

As well as medication you should be offered a psychological treatment called cognitive behavioural therapy (CBT for psychosis). This will involve meeting with a therapist on a one-to-one basis for at least 16 sessions. If you live with your family or are in close contact with them, you and your family should also be offered a psychological treatment called family intervention. Treatment should last for between 3 months and a year and include at least 10 sessions.

You may also be offered one of the arts therapies (e.g. art therapy), particularly if you have symptoms such as withdrawing from family and friends and losing interest in things that were once enjoyable. Therapy should usually take place in groups with people with similar problems.

Your therapist should make sure that you, and your family or carer if appropriate, are happy with how the psychological treatment is progressing. If you start psychological treatment during a hospital visit for an acute episode, it should continue once you have left hospital until you have completed the course.

There are other types of psychological treatment, such as counselling, supportive psychotherapy and social skills training. These are not thought to be as effective as CBT, family intervention and arts therapies for people with schizophrenia. However, your personal choice should be taken into account, especially if the other treatments are not available in your area and you wish to talk about your feelings, thoughts and symptoms.

You should not be offered a treatment called adherence therapy because there is not enough good evidence that it can help people with schizophrenia.

You should be offered social, group and physical activities (such as exercise) as part of your treatment programme, especially as you begin to get better. The activities should be recorded in your care plan.

Full details of the types of treatment and the supporting evidence is given in the NICE guideline on Schizophrenia (Chapter 8).

Books

Freeman, D. & others. Overcoming paranoia and suspicious thoughts. Robinson.

Gunley A. & others. Staying well after psychosis. Wiley-Blackwell. Psychosis leaflet - understanding voices

Morrison A & others. Think you are crazy; think again. Routledge. Psychosis leaflet - understanding how others think

Mueser K. & others. The complete family guide to schizophrenia. Guilford.

Romme M. & others. Living with voices. 50 stories of recovery. PCCS books.

Turkington D. & others. Back to life; back to normality. Cambridge.

Leaflets

Psychosis leaflet - CBT

Psychosis leaflet - understanding voices

Psychosis leaflet - understanding how others think

Psychosis leaflets - getting motivated

CBT for psychosis - slides

Training
Conclusions

- CBT techniques continue to evolve in the treatment of psychosis

- Further dissemination requires increased availability of training and implementation of evidence-based care pathways (PbR-linked)