COGNITIVE BEHAVIOURAL THERAPY IN PSYCHOSIS

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In more conventional psychiatric terminology, the title for this editorial could have been "CBT for schizophrenia". And because the conclusions are, broadly, that the use of psychosocial interventions, such as CBT, should be strongly encouraged for all people experiencing distressing psychotic phenomena, many readers might assume that this would have been a perfectly acceptable alternative. But psychosocial perspectives do not only support the use of therapies such as CBT, they also suggest that we should adopt a rather different approach to psychotic phenomena. In this context, we should not merely prescribe "CBT for schizophrenia", assuming that 'schizophrenia' is a valid concept and that psychosocial approaches can be prescribed as if they were non-medical drugs. There is clear evidence that psychosocial perspectives can help understand psychotic phenomena, and psychosocial interventions are effective in helping people. To unlock the true value of these perspectives, however, traditional mental health services may need to consider rather different ways of working.

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One of the more striking phenomena seen in mental health care over the past 20 years has been the rise in the prominence and prevalence of CBT (cognitive behavioural therapy). In its original form[1]. CBT is a straightforward and pragmatic approach to psychotherapy based on some key elements of cognitive psychology as applied to mental health problems. Thus, it is assumed that people make sense of and interpret their world, and that the way in which we understand and explain the events that happen to us has profound implications for our emotions, our subsequent thought processes and our behaviours. Once, in this model, we understand how people think about a particular situation, we can understand why they present with the range of problems that we experience in mental health services.

The interventions that follow from this model are helpfully straightforward (helpful, not only because they are effective for clients, but helpful because they are straightforward – a welcome contrast to the complex and esoteric nature of some earlier psychotherapies). Working with the client in a collaborative model, the CBT therapist will gently uncover the individual patterns of understanding and explaining of events that appear logically and causally related to the client's particular problems. Then, together, they will discuss the evidence for and against the client's point of view – clearly with an aim to explore the possibility of alternative perspectives – and the consequences. Over time, and in a collaborative fashion, the client and therapist explore alternative ways of looking at the world.

These approaches have been applied energetically to problems such as depression and anxiety – leading to a UK Government initiative to provide CBT for very large numbers of people. They have also been applied – successfully – to psychotic problems. Over the past few years, there have been a large number of research studies exploring cognitive factors in psychosis[2]. These have yielded significant insights into the framework of understanding (in both broad-brush and detail) of people experiencing problems such as auditory hallucinations[3] and paranoid beliefs[4]. These have outlined both what might be termed cognitive biases[2] and the experiences of abuse and social deprivation that may be the source or cause of these biases[5]. These approaches tend to follow a broad bio-psycho-social model[6], with some significant implications that will be discussed below.

The interventions themselves are effective. There have been several well-conducted randomised controlled

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trials that have demonstrated that CBT is superior to routine mental health care[2] and superior to befriending or supportive psychotherapy[7]. Meta-analytic studies have recommended that CBT (or related interventions) should be a standard element of the treatment package offered to people with a diagnosis of 'schizophrenia'[8-10].

In the UK, the National Institute for Health and Clinical Excellence – NICE – offers guidance to clinicians (in the form of recommended pathways for treatment) and commissioners (in that those people charged with commissioning and planning services need to ensure that the resources are in place such that these treatment options are available). These recommendations are drawn up by expert clinicians on the basis of systematic evidence reviews. In the case of psychosis, NICE now recommend that cognitive behavioural approaches should be a routine element of care[11].

So the first conclusion, and recommendation, in this area is that clinicians, service planners, commissioners and politicians (because the resourcing of mental health services is always a political decision) should recognise that CBT and cognitive behavioural approaches are effective and popular – in fact, essential – elements of care for people with psychotic problems. But it would be a mistake merely to suggest that we should prescribe CBT for somebody "with schizophrenia". The picture is a little bit more complex, and more positive, than that.

Psychosocial models of psychosis

The rise in the popularity of CBT paralleled, was fuelled by, and fuelled, a rise in the application of cognitive, psychological, models of psychosis[4]. This includes sustained scepticism about psychiatric diagnosis. Both psychologists and social psychiatrists (those psychiatrist who stress both the importance of social determinants of mental ill-health, and the benefits of psycho-social interventions) have raised concerns about the reliability, validity, utility and ethics of psychiatric diagnosis[4, 5, 12, 13]. These criticisms have particularly focussed on the publication of DSM-5 (the latest version of the American Psychiatric Association's diagnostic franchise), but have been ubiquitous in English-speaking mental health communities for years[14].

The diagnosis of 'schizophrenia' has come under particular criticism[15]. Although 'schizophrenia' is a very common and very well-recognised diagnosis, many critics have pointed out that it has proved impossible to find a coherent syndrome that maps onto the diagnosis of schizophrenia – with, for example, more people with a diagnosis of 'dissociative identity disorder' possessing more of the symptoms of 'schizophrenia' than did people with that diagnosis[16]. It similarly appears that, despite commonplace expectations, the predictive validity of the diagnosis of 'schizophrenia' is extremely poor[15]. It's worth just noting how researchers and clinicians in this area occasionally interpret their findings. A good example being the observation that, since schizophrenia is generally considered to be a life-long condition, if a person with that diagnosis shows recovery or even remission of their problems, they shouldn't be considered to have "really" had 'schizophrenia' in the first place (a seductive, but flawed, piece of logic). Moreover, although medication clearly has its place, research-active psychiatrists such as Moncrieff have convincingly argued that the diagnosis of 'schizophrenia' is of little help in predicting which patient will respond to which medication regime; with a symptom-specific or 'drug-centred' model having much greater utility[13].

By taking a symptom-based approach, psych ological models of individual psychotic phenomena such as hallucinations and delusions have been developed.

There is widespread consensus that auditory hallucinations stem from misattributed cognitions – that is, cognitive events that are not recognised by the individual as being internally-generated, and instead are attributed to external sources. It's probably fair to say that we don't yet know which types of cognitions (subvocal speech, disconnected memories or traumatic flashbacks, or intentions) are associated with hearing voices, but it is likely to be different for different people. And, as with many other problems, a wide range of personal, physical, environmental, psychological and situational factors seem to impact on the central source-monitoring or reality-monitoring processes involved. It is likely to be the case that these source-monitoring processes are related to findings indicating that auditory hallucinations are associated with the functioning of key areas of the auditory processing areas of the brain[17]. For researchers, we need theoretical models of auditory hallucinations, which allow for individual variation within a general framework. In terms of individual CBT therapy, too, individual clinical formulations are highly distinctive, with different explanatory frameworks for different people. Moreover, while some people have few difficulties when they hear voices, for other people these experiences can be highly distressing. CBT can be effective for helping people experiencing hallucinations[2], but must remain highly individualised, relying on complex and sophisticated individual case formulations bringing together many of the issues discussed here[6].

As with many other psychological phenomena, paranoid beliefs lie on a continuum with quite every-day feelings of suspiciousness and mistrust. It is therefore unsurprising that a wide range of events and circumstances that may engender mistrust – poverty, bullying, social isolation, racism, and overt abuse – have all been associated with the development of paranoid ideas. It also appears that several different psychological mechanisms may contribute to the development of paranoid beliefs, perhaps, most notably, psychological mechanisms related to the anticipation of social threat, which may involve dopaminergic pathways (again allowing for some integration of psychological and biological mechanisms), jumping-to-conclusions, and attributional style[4].

A psychological approach

For psychologists, our thoughts, our emotions, our behaviour and therefore, our mental health are largely dependent on our understanding of the world; that is, our thoughts about ourselves, other people, the future, and the world. Biological factors, social factors, circumstantial factors affect us as those external factors impact on the key psychological processes that help us build up our sense of who we are and the way the world works. This underpins our learning (the way in which we are shaped as human beings) and thereby the social determinants of mental health.

Psychological science has explored and explained many of these processes in great detail and complexity. People are making sense of their world, their developing complex, shifting, emotionally laden understandings of the world. This can lead to problems, even psychotic problems. With this set of theoretical assumptions, psychologists are sceptical of diagnoses and a 'diagnosis-treat' approach to the commissioning, conception and delivery of services.

As we think about the multiple and various needs of people experiencing psychosis, of course we should offer one-to-one CBT. But we should also be offering a wider range of services and approaches. We should be working with employers, as interventions aimed at improving people's well-being (helping people remain in work when distressed, to return to work or to find employment) are effective and cost-effective. We should be working with community services, the education services and wider civil society to protect vulnerable children – to identify and prevent bullying and abuse, and to offer children all relevant services to support and maintain their well-being and offer some resilience. In each case, scientifically elegant analyses of psychological processes leading to interventions. In the services of the future, then, we would have sophisticated assessments and formulations, with multi professional teams delivering a broad variety of interventions - an appropriate package of interventions in each case. That means that we would need to see a relatively large number of colleagues trained in interventions such as CBT.

Quasi-medical treatment or psychological intervention?

This analysis suggests that we should think rather differently about the way we use CBT. It is too tempting to adopt unquestioningly some of the assumptions of a 'disease model' – to regard CBT as yet another treatment for a disorder. For physicians or medical psychiatrists, it could feel normal to issue a prescription for CBT to treat a case of 'schizophrenia' in just the same way that one might issue a prescription for antidepressants to treat a case of depression or a prescription for antibiotics to treat a case of pneumonia. The assumptions behind a 'disease-model' approach simply break down as we adopt the 'human-centred' model of a psychological approach.

It is, of course, possible to adopt a simplistic approach – many of the assumptions behind the UK's NICE guidelines and the programme to implement CBT in UK healthcare settings (the IAPT or Improving Access to Psychological Therapies programme) are based in this model. But this makes certain inappropriate assumptions. With highly invalid diagnoses (making the very idea of 'schizophrenia' highly dubious), no reliable biological markers of underlying pathology (which would, of course, be difficult to discover for non-existent syndromes) and multiple social and psychological determinants of individually specific patterns of problems, a 'diagnosis-treat' model of applying CBT is unlikely to be appropriate.

Instead, we should aim to offer sophisticated assessments and formulations, with multi professional teams delivering a broad variety of interventions - an appropriate package of interventions in each case. The evidence in favour of its effectiveness means that any reasonable planner would ensure that CBT is part of that package. But it means a little more than that.

As we begin to plan new psychosocial interventions for people who are distressed by psychotic experiences, we can see a range of possible services that may all fall under the broad definition of CBT. Some people will benefit from face-to-face therapy along traditional CBT lines, exploring how people respond to and think about

key challenges in their lives. This would explore how people think in social situations, deal with stress and, crucially, understand and respond to their own psychotic experiences. For many people, this could be an effective alternative to medication. These types of services are effective, but are only part of the picture. In addition, we know that family therapy can be highly beneficial, especially in reducing the probability of future episodes of distress. We also know that 'relapse prevention' can be very helpful. This approach helps people – especially people who have recurrent episodes of hypomania – to identify the early warning signs of an imminent relapse and to take steps to avoid it[18]. Many people benefit from simple interventions to help them manage their medication more effectively and assertively. And, in addition to all these possibilities, various forms of more conventional psychotherapy may be valuable; from individual interpersonal psychotherapy through to the more radical – but yet effective – Soteria Project, alternatives to conventional medical treatments are effective and diverse[19].

These are challenging ideas. And they may well be challenging to implement. To provide this diverse variety of interventions, services will need to employ colleagues trained in a wide variety of quite specific, in each case skilled, therapies. Since these interventions should be integrated – delivered as part of a complex, individualised, formulation, rather than on prescription as if they were non-medical drugs - psychological therapies such as CBT should be integrated into, and fully part of, mental health and well-being services rather than being an add-on.

A wide range of interventions based loosely on the principles of CBT are, therefore, highly applicable to psychosis and the distress associated with psychotic phenomena. CBT interventions have a good track record, have performed well in meta-analyses and are now recommended by official bodies. So clinicians and service planners should certainly consider how these interventions could be provided. But CBT is not quite the same as a drug, and planning for the use of CBT is not quite the same as prescription. People make sense of their situation, and developing complex, shifting, emotionally laden understandings of the world. These can occasional contribute to psychosis. CBT and related psychological interventions can be of great help, but shouldn't be regarded as equivalent to medication.

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